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HEALTH
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EDUCATION
CHILD PROTECTION
SOCIAL INCLUSION
GENDER
HUMANITARIAN ACTION

Annual Results Report 2015

Nutrition

UNICEF's Strategic Plan 2014–2017 guides the organization's work in support of the realization of the rights of every child, especially the most disadvantaged. At the core of the Strategic Plan, UNICEF's equity strategy – emphasizing the most disadvantaged and excluded children, caregivers and families – translates UNICEF's commitment to children's rights into action. What follows is a report summarizing how UNICEF and its partners contributed to nutrition in 2015 and the impact of these accomplishments on the lives of children, caregivers and families.

This report is one of nine on the results of UNICEF's efforts this past year, one on each of the seven outcome areas of the Strategic Plan, one on gender and one on humanitarian action. It is an annex to the 'Report on the midterm review of the Strategic Plan, 2014–2017 and annual report of the Executive Director, 2015', UNICEF's official accountability document for the past year. An additional results report on the UNICEF Gender Action Plan 2014–2017 has also been prepared as an official UNICEF Executive Board document.

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Nyajime-guet is four years old and has severe acute malnutrition (SAM) and tuberculosis. She was too weak to sit or walk when she was first admitted to a UNICEF-supported hospital at the protection of civilians site in Juba, South Sudan. After five days of treatment, Nyajime is slowly starting to recover. Although it is still difficult for her to walk, she can now sit and sometimes can give a little smile. A quarter of a million children under five are estimated to be suffering from severe acute malnutrition in South Sudan, more than double the estimate before the conflict broke out in December 2013.

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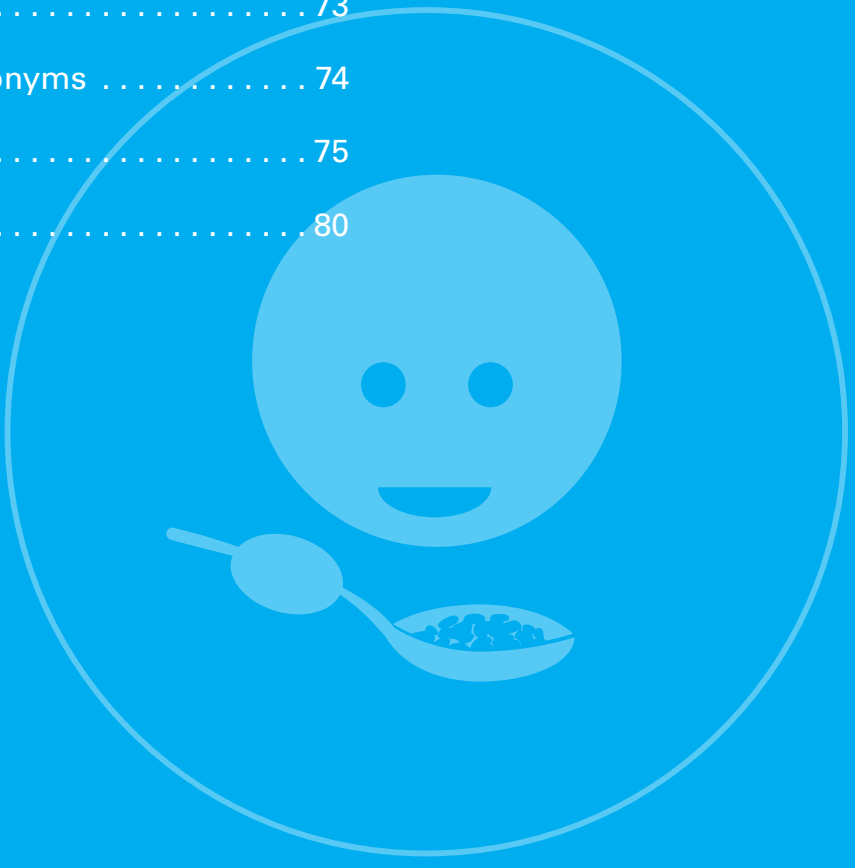


EXECUTIVE SUMMARY

Good nutrition lays the groundwork for realizing the rights of every child. Well-nourished children are more likely to survive, grow and learn; they are better placed to participate in and contribute to their communities; and they are more resilient in the face of crisis.

With the adoption of the Sustainable Development Goals (SDGs), the case for investing in nutrition has never been greater. Good nutrition drives economic progress, development and human capital. The benefits of good nutrition cycle across generations, sustaining positive outcomes at all levels of society – from the livelihoods of communities to the development goals of nations.

The global momentum for scaling up nutrition is growing, and with UNICEF's support, many countries are making progress in reducing malnutrition in all its forms. Global estimates indicate that the number of stunted children under 5 declined from 169 million in 2010 to 159 million children in 2014, and this is substantiated by success stories in a number of countries, such as Ethiopia, Ghana, India, Kenya, Rwanda and the United Republic of Tanzania.[1] Inequalities in stunting and other forms of malnutrition persist, however: Children from the poorest 20 per cent of the population are more than twice as likely to be stunted as those from the richest 20 per cent.[2] And while acute malnutrition, or wasting, still threatens the lives of 50 million children globally, there are also 41 million overweight children in the world – about 10 million more than there were two decades ago.[3] These problems do not lie at opposite ends of a spectrum, but instead are complex, overlapping and intertwined. There is clearly still much work to be done.

To address these needs, in 2015, UNICEF engaged in a broad range of nutrition programming in 127[4] countries, propelled by 485 technical staff members located across all regions, but principally in those with the highest burdens of malnutrition, including East and South Africa, South Asia and West and Central Africa. UNICEF's work adopts a life cycle approach to nutrition that extends from programmes to policy level, from prevention to treatment, from development to humanitarian situations.

UNICEF is a leading voice for nutrition globally and plays a central role in 14 global nutrition partnerships. With its partners, and through its direct support to countries, UNICEF works to harness political commitment for women's and children's nutrition and ensure its central place on the development agenda.

UNICEF's work and results in 2015

The first 1,000 days from the start of a woman's pregnancy to a child's second birthday offer an extraordinary window of opportunity for preventing malnutrition in all its forms. UNICEF targets most of its interventions to this critical period, with a focus on equity. In the second year of Strategic Plan 2014–2017, UNICEF met most of its expected results in the nutrition outcome area (outcome 4), the objective of which was "*the improved and equitable use of nutrition support and improved nutrition and care practices.*" These results are organized according to four programme areas:[5] 1) infant and young child feeding; 2) micronutrients; 3) nutrition in emergencies and the management of severe acute malnutrition; and 4) general nutrition.

In the **infant and young child feeding** (IYCF) programme area, UNICEF continued to build the capacities of governments and other stakeholders to implement and support IYCF programming. This resulted in concrete improvements to IYCF policies and increased the availability of IYCF counselling and support in both health facilities and communities. In 2015, 89 per cent of countries (108 of 122) had the capacity to provide IYCF counselling services to communities, up from 85 per cent of countries (105 of 123) in 2014.[6] Countries with capacities to provide infant and young child feeding counselling services to at least 70 per cent of communities increased from a baseline of 14 countries to 25 (out of 107; 24 per cent) in 2015.[7] UNICEF continued to develop capacity in countries through its IYCF e-learning course, developed together with Cornell University. There were 1,167 new course registrants in 2015, bringing the total number of enrollments to more than 9,000 registered in 174 countries since the course was first launched in 2012.

With UNICEF's advocacy and technical support, the enabling environment for breastfeeding is improving in a number of countries. By 2015, the International Code of Marketing of Breast-milk Substitutes had been adopted as legislation in 80 countries, up from only 64 countries at the launch of the Strategic Plan period. As co-leads of NetCode,[8] UNICEF and the World Health Organization (WHO) finalized monitoring protocols to accelerate progress on Code adoption and support countries in improving their monitoring processes. The landmark 'First Foods' complementary feeding meeting in 2015, hosted by UNICEF and other partners, resulted in clear guidance for countries to accelerate progress on complementary feeding and implement national programmes at scale.

Bhim Kumari Shrestha carries her 3 year old son Himal on her back as she collects vegetables on her field in the village of Dhusuni Sivalaya VDC, Kavrepalanchok district, Nepal. Himal and his brother were identified and treated for malnutrition in the aftermath of the earthquake as part of a UNICEF-supported emergency nutrition programme.

Photo credit: UNICEF/UNI189210/Shrestha

UNICEF continued to co-lead the Global Breastfeeding Advocacy Initiative with WHO to increase political commitment and financial investment in breastfeeding programmes. In 2015, three new prominent members joined the partnership; an advocacy strategy was finalized; and strategic audience research was leveraged to inform future work.

In the programme area of **micronutrients**, UNICEF continued its support for vitamin A supplementation (VAS) via outreach events such as Child Health Events and immunization campaigns. In 2015, according to preliminary data, nearly 270 million children in priority countries received two doses of VAS, representing 70 per cent[9] of targeted children. UNICEF's VAS programmes were successful even in highly challenging environments, such as in post-earthquake Nepal, which achieved 90 per cent VAS coverage. During the Strategic Plan period, UNICEF aims to support 40 countries to have at least 90 per cent of households consuming iodized salt (from a baseline of 6 countries), and in 2015, 20 countries had already met that target. With UNICEF support, home fortification programmes – with caregivers fortifying food using micronutrient powders (MNPs) – reached an estimated 5 million children in 2015, up from an estimated 3 million in 2014.

In many countries, there was also progress in improving legislation to address micronutrient deficiencies. For example, in 2015, 91 out of 122 countries had a current national policy or plan to address anaemia in women of reproductive age,[10] compared to 74 out of 123 in 2014. Of these countries, 54 per cent had a specific approach for addressing anaemia among adolescent girls, compared to only 46 per cent the previous year. In addition, the number of countries with legislation to mandate staple cereal fortification increased to 85 countries, from 82 countries the previous year.[11]

In the programme area of **nutrition in emergencies and the management of severe acute malnutrition** (SAM),[12] UNICEF continued to support countries through leadership, coordination and the provision of technical support and supplies. In 2015, UNICEF supported the implementation of SAM management in both development and humanitarian contexts: nearly 2 million children with SAM were admitted for treatment in humanitarian situations (reaching 65 per cent of the 2015 target), with a recovery rate of 72 per cent.[13] Of the 3.2 million SAM admissions in all settings (development and humanitarian), 2.56 million children were successfully treated, achieving a recovery rate of 82 per cent. This is compared with the 2012 baseline of 2.7 million admissions and 1.66 million

successfully treated, with a recovery rate of 85 per cent.[14] UNICEF scaled up its support for SAM bottleneck analysis in a number of countries, including Afghanistan, Malawi and the United Republic of Tanzania. This exercise improved national planning and strengthened SAM management services, improving ownership, buy-in and support from governments and partners.

In 2015, UNICEF worked to safeguard the nutritional status of women and children during large-scale humanitarian crises, including the earthquake in Nepal; droughts in the Sahel and East Africa; in the context of protracted conflicts in South Sudan, the Syrian Arab Republic and Yemen; in response to the European refugee and migrant crisis; and through the recovery phase after the Ebola epidemic. Nutrition interventions were used by more than half of all UNICEF country offices responding to humanitarian situations in 2015. UNICEF worked with a number of countries to improve nutrition emergency plans and policies. In 2015, 63 out of 93 countries (68 per cent) reported having a nutrition sector plan or policy that included risk management strategies to address disaster and crisis, up from 56 countries in 2014. UNICEF advocates for countries to integrate IYCF counselling and support into emergency preparedness and response to support mothers and caregivers and provide safe IYCF spaces. In 2015, more than 6 million caregivers of children aged 0–23 months in 69 countries (80 per cent of the target) received IYCF counselling in humanitarian situations.

In the cross-cutting programme area of **general nutrition**, UNICEF made progress in strengthening the enabling environment for nutrition at global and country levels. In 2015, UNICEF continued to play an active and strategic role in the Scaling Up Nutrition (SUN) movement, with SUN membership increasing to 56 members, from 5 in 2010. With UNICEF's support, a number of countries enacted or improved national policies, plans and strategies on nutrition and worked to enhance impact through multi-sectoral collaboration. There was an increase in the number of countries undertaking a gender review of their nutrition policy or strategy in the current development plan cycle, with UNICEF support, from 16 in 2013 to 21 in 2015. However, progress has been slow, and further efforts are needed to help countries in this area. Global and regional partnerships facilitated UNICEF's work throughout 2015, with the number of key partnerships co-led or coordinated by UNICEF increasing to 14 from a baseline of 6. UNICEF also made important contributions to the global evidence base on nutrition in 2015, publishing more than 50 research papers across the sector, exceeding its target of 50 such publications per year.

UNICEF programming in nutrition continues to grow: expenses in the sector totalled US$484 million in 2014 and rose to just over US$603 million in 2015. This reflects the global momentum for scaling up nutrition and the growing recognition that nutrition is a cost-effective and high-impact investment. Of note, however, is that in 2015, only 2 per cent of the sector's total expenses were flexible thematic resources. Increasing these flexible revenue streams would help UNICEF tailor its strategies to ensure the greatest impact, develop new areas of programming, and invest in systems strengthening and resilience, while ensuring results for the most vulnerable children.

Looking ahead

Two years into its Strategic Plan, UNICEF is on track to meet most of its targets in the nutrition outcome area. Yet some of the challenges confronted in 2015 and the lessons learned will certainly shape UNICEF's engagement in nutrition programming in the future. With increasing demands for UNICEF to take on multiple roles in the nutrition sphere – at the programme and policy level and in varying contexts – the sector will have to refine its strategies to ensure that it can fulfil its goals and continue to deliver results for children. UNICEF will continue improving linkages between nutrition, health, water and sanitation, and early childhood development to better address these challenges in the coming year.

Moving forward, UNICEF's contributions to global nutrition will be particularly critical to supporting the 2030 Agenda for Sustainable Development – and will help lay the groundwork for the achievement of all SDG targets.

STRATEGIC CONTEXT

Good nutrition lays the foundation for healthy, thriving and productive nations and remains one of the greatest investments to be made in improving global welfare.[15] Well-nourished children are healthier, more resistant to disease and crises, and perform better in school. As they grow, they are better able to participate in and contribute to their communities. The benefits of good nutrition thus carry across generations and act as the glue binding together a nation's overall development. As the world looks to Agenda 2030, national investments in nutrition will prove critical in reaching the SDG goals.

While the potential benefits of good nutrition are great – malnutrition, in its multiple forms, was a problem faced by almost every country in the world in 2015. Nearly half of all deaths in children under 5 can be attributed to undernutrition. And in rich and poor countries alike, a sharp rise in overweight and obesity is presenting a different but equally serious public health problem. There is still much work to be done, but investments in nutrition are beginning to yield concrete and compelling results. Global estimates indicate that the number of stunted children under 5 declined from 169 million in 2010 to 159 million children in 2014 (*see Figure 1*), further substantiated by success stories of national stunting declines reported in a number of countries.[16] Yet chronic inequalities in stunting and other forms of malnutrition persist: children from the poorest 20 per cent of the population are more than twice as likely to be stunted as those from the richest quintile.[17]

Acute malnutrition, or wasting, threatens the lives of 50 million children globally (*see Figure 2*), and is most prevalent in South Asia. At the same time, there are 41 million overweight children in the world – about 10 million more than there were two decades ago[19] (*see Figure 3*). These problems do not lie at opposite ends of a spectrum, but rather, are complex, overlapping and intertwined. In fact, many countries are now facing a devastating triple burden of malnutrition – with coexisting burdens of stunting and wasting, micronutrient deficiencies, and overweight and obesity.

The global pressures of climate change, loss of ecosystems and land degradation, population growth, urbanization, disease threats, the changing global food system and ongoing humanitarian crises exacerbate malnutrition and complicate effective response to it.

FIGURE 1

Number of children under 5 who are stunted, by region, 1990-2014[18]

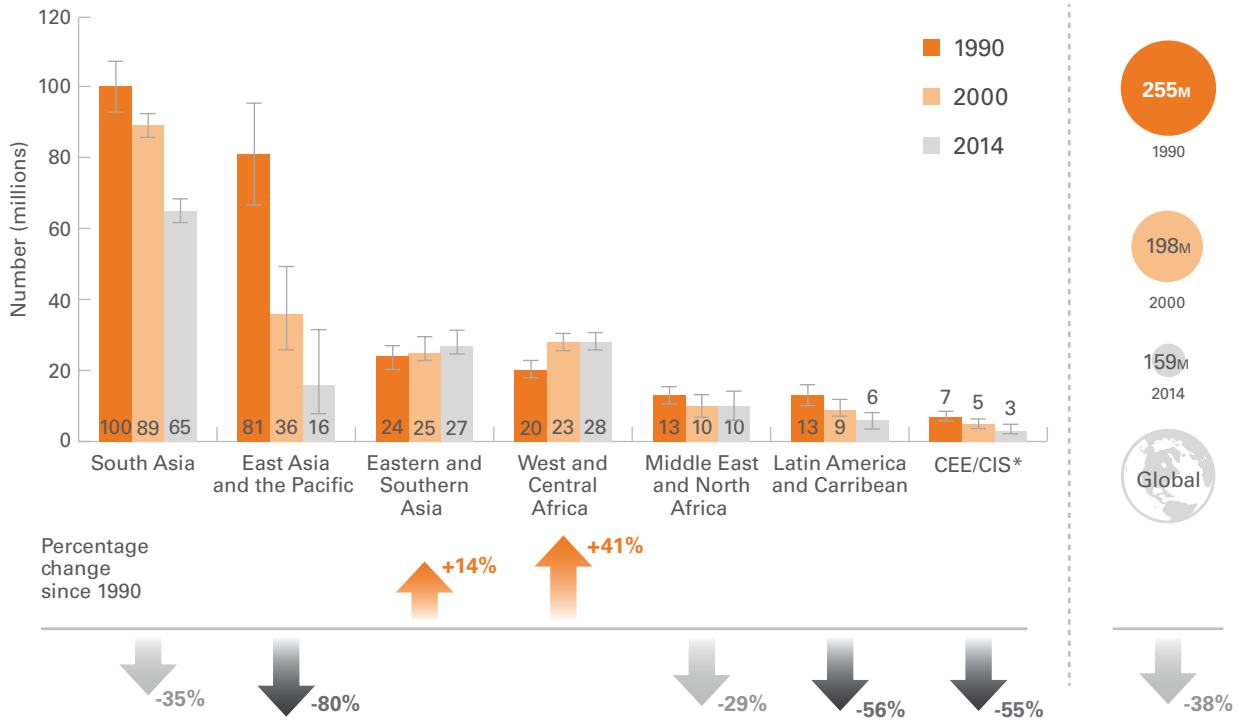
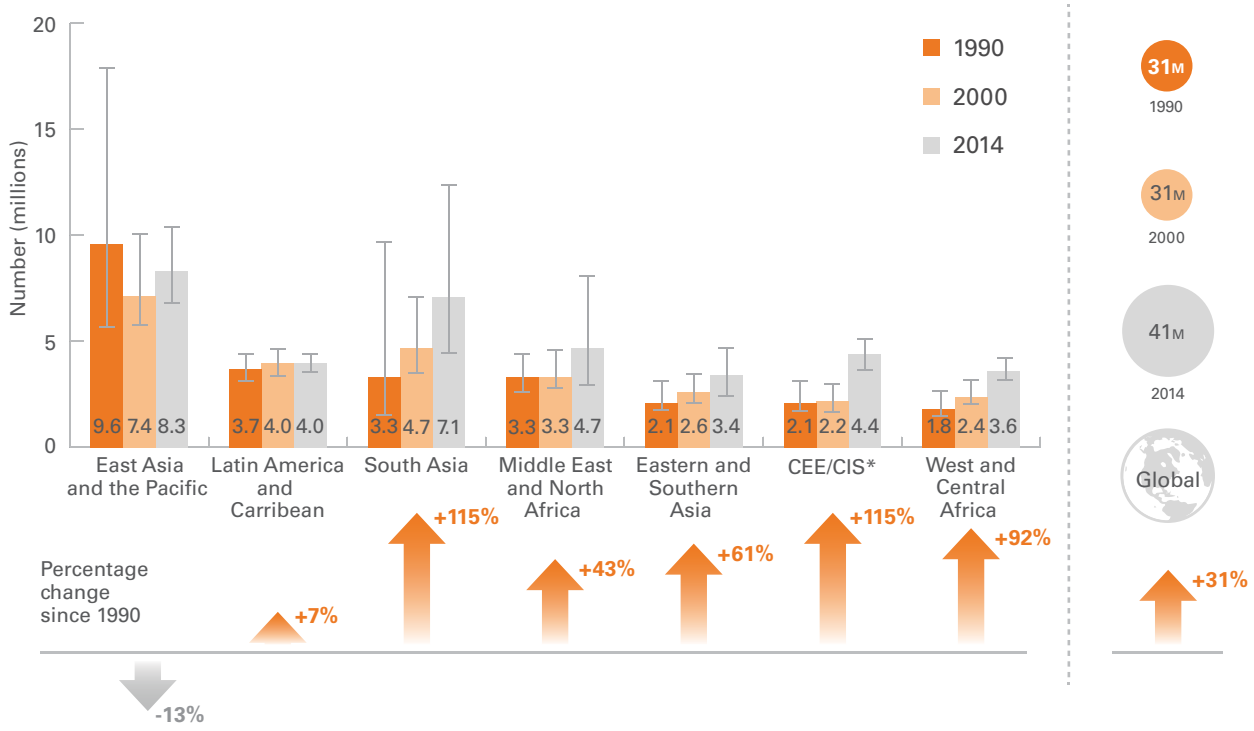


FIGURE 2
Percentage of wasted children, by region, 2014

FIGURE 3
Number of children under 5 (in millions) who are overweight, by region, 1990–2014[20]



The bedrock of sustainable development

The good news is that the global momentum for improving nutrition has never been better. This is due in part to the SDGs, which crucially shifted focus towards the role of good nutrition in the development of nations. Goal 2 ambitiously aims to end hunger, achieve food security and improve nutrition, and promote sustainable agriculture. This specific target on nutrition will support the achievement of many other SDG targets, including ending poverty, achieving gender equality, ensuring healthy lives, promoting lifelong learning, improving economic growth, building inclusive societies and ensuring sustainable consumption.

The fact that there is a specific nutrition target is important, given that nutrition was somewhat neglected in the Millennium Development Goals. UNICEF advocated for the inclusion of several specific nutrition indicators in SDG Goal 2, including stunting, wasting and overweight in children under 5. The lack of specific indicators on breastfeeding and micronutrients, however, will require consistent monitoring and advocacy to ensure that these interventions are not neglected. In preparation for the post-2015 era, UNICEF updated strategic guidance that responds to the changing and interconnected development environment and will guide its actions throughout the Strategic Plan period.

With the world's attention turned to Agenda 2030, there has been greater recognition that investing in nutrition brings substantial economic and development gains. Interventions to reduce stunting are among the most cost-beneficial in development, with highly competitive cost-benefit ratios. In an analysis across 40 countries, the median cost-benefit ratio of scaling up nutrition-specific interventions was 16, meaning that every dollar invested in stunting reduction yielded around 16 dollars in productivity gains.[21] Preventing childhood blindness through vitamin A supplementation can result in productivity gains of more than US$1,840 per child. Providing iron supplementation to end iron deficiency anaemia could increase future earnings by as much as 25 per cent.[22] Without these preventative strategies, poor nutrition can hinder and even harm economic growth. Health care-related costs associated with obesity are rising, accounting for as much as 8 per cent of expenditures on health care. In China, for example, the economic costs associated with obesity exceed more than 2 per cent of GDP.[23] The case for investing in nutrition is clear and the potential positive impacts can span generations of families and communities.

Shaping the global nutrition landscape

Addressing all forms of malnutrition – including stunting, wasting, micronutrient deficiencies and overweight and obesity – is critical to achieving UNICEF's strategic goals and essential to protecting children's rights to survival and development. In the past few years, there has been greater consensus on the importance of intervening during the 1,000-day critical period from pregnancy to a child's second birthday. The greatest nutritional gains can be achieved during this period, while nutrient deficiencies and critical losses may never be fully regained. In addition, the integration of early childhood development (ECD) and nutrition programming during this critical phase can result in cost savings and gains in both child development and nutrition outcomes.[24]

There is also greater understanding of the short- and long-term consequences of undernutrition in all its forms, the links between stunting and wasting, and the increased mortality risk of manifesting both forms at the same time.[25,26] *The Lancet* series on obesity, launched in February 2015, highlighted the slow progress in tackling global obesity rates over the last decade and offered eight major recommendations to address the pace of change.[27] And the WHO Commission on Ending Childhood Obesity issued its final report in January 2016.[28] The evidence on these emerging issues shapes and informs UNICEF's programme logic and highlights the need for a comprehensive and evidence-based nutrition response.

Since its launch in 2010, the SUN movement has been one of the greatest driving forces in strengthening nutrition at global and national levels. By translating country-led commitment for nutrition into results, SUN mobilizes support for nationally driven processes to reduce stunting and other forms of malnutrition. During the 2014–2015 period, 15 new countries joined the SUN movement, bringing the total membership to 56 countries. UNICEF continues to play a key role in SUN at the global, regional and national levels, chairing UN networks for nutrition in a number of countries and supporting coordinated efforts.

In 2015, the United Nations Standing Committee on Nutrition launched the UN Global Nutrition Agenda (UNGNA v. 1.0),[29] with a commitment to improving United Nations coordination. The UNGNA provides a framework for aligning the work and accountabilities of the UN agencies that have a mandate in nutrition – Food and Agriculture Organization (FAO), International Fund for Agricultural Development (IFAD), UNICEF, World Food Programme (WFP) and WHO – by combining strengths in order to achieve greater impact together. The past

year was also the first in the follow-up to the Second International Conference on Nutrition (ICN2), which articulated a comprehensive global nutrition agenda. The Rome Declaration on Nutrition and Framework for Action[30] were endorsed at ICN2, committing world leaders to establishing national policies aimed at eradicating malnutrition and transforming food systems to make nutritious diets available to all.

UNICEF provides data and significant analytical support for the annual Global Nutrition Report – a multi-stakeholder initiative. In 2015, the report focused on sustainable development, highlighting the potential for business to advance nutrition goals and also the critical relationship between climate change and the need to build nutrition-friendly and sustainable food systems.

UNICEF as a key partner for change

Over the past few decades, UNICEF has become a partner of choice in nutrition programming, contributing leadership and technical expertise to support countries in both humanitarian and development contexts. Efforts to scale up and bolster nutrition are working, benefiting women and children and their communities in many countries. Knowledge generated through UNICEF programming is being adapted and applied to improve nutrition programming more widely. In addition, the results of a meta-analysis of UNICEF's nutrition programme evaluations, published in 2014, were used to inform 2015 programme objectives.[31]

UNICEF advocates a holistic approach to nutrition programming, using both nutrition-specific and nutrition-sensitive strategies to achieve results. Reducing the global burden of malnutrition and achieving the 2014–2017 Strategic Plan outcome of "*improved and equitable use of nutritional support and improved nutrition and care practices*" for vulnerable women and children requires cooperative action at global, regional and community levels. To achieve this, UNICEF takes a life cycle approach to nutrition that extends from programmes to policy level, from prevention to treatment, from development to humanitarian situations.

Working with national governments and other partners, UNICEF supports countries in scaling up nutrition programming with a focus on equity. As detailed in its 2014 guidance document, 'UNICEF's approach to scaling up nutrition for mothers and their children',[32] UNICEF aims to support country-led action to improve maternal and child nutrition, and make its work more strategic, effective, responsive and contextually relevant. Good data are crucial to this process and can help drive future improvements in programme performance. UNICEF helps countries invest in and strengthen routine health and nutrition information systems by providing technical guidance and building capacity among partners to collect and use programme data for decision-making. To support this work, in 2013 UNICEF established the NutriDash platform, an online data capture and reporting tool with the goal of strengthening routine monitoring and reporting at global, regional and country levels. NutriDash tracks indicators on the policy environment, government expenditures, demand for services and supply forecasting, to determine effects from inputs to impact. The data improves programme performance by identifying bottlenecks and supporting decision-making, advocacy and resource mobilization at all levels.

In 2015, the global nutrition context was shaped by a number of humanitarian crises, including protracted conflicts in South Sudan, Syria and Yemen; the refugee and migrant crisis across Europe; the Ebola epidemic in West Africa; and the earthquake in Nepal. The impact of El Niño and prolonged droughts in the Sahel and East Africa will continue to be felt throughout the coming years. To respond to these challenges, UNICEF uses risk-informed programming to identify potential hazards and improve programming for communities at risk, while investing in resilience building and systems strengthening in countries to promote long-term sustainability.

UNICEF's comparative advantage in nutrition stems from its large country presence, with support for nutrition programmes in more than 120 countries. The organization's strengths lie in its strong programming and technical capacity, and long-standing experience in the implementation of nutrition programmes. UNICEF also 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.

A community-based health worker provides infant and young child feeding counselling to a mother at an integrated health post (Posyandu) in Klaten District, Central Java Province, Indonesia.

RESULTS BY PROGRAMME AREA

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 second year of UNICEF's 2014–2017 Strategic Plan, the nutrition sector has already made significant progress globally in achieving outcome 4 – *the improved and equitable use of nutritional support and improved nutrition and care practices*. Using strategies of improved service delivery, evidence generation, comprehensive policy dialogue and advocacy, stronger integration with partners, cross-sectoral linkages and capacity building, UNICEF is stimulating crucial change in the nutrition environments of many countries.

The 2015 results for UNICEF's nutrition sector are organized according to four programme areas: 1) infant and young child feeding; 2) micronutrients; 3) nutrition in emergencies and the management of severe acute malnutrition;[33] and 4) general nutrition. Results from the HIV and nutrition programme area, presented last year as a separate chapter, have been combined throughout each programme area in recognition of their cross-cutting nature. While the four programme areas are presented separately for the purposes of this report, in practice they are deeply integrated and part of a holistic approach to achieving success in outcome 4.

Drawing on the theory of change,[34] this chapter describes the specific inputs and activities across the different programming areas of nutrition, which are intended to achieve programme area outputs and support the overall intended impact of stunting reduction in children under 5 years, and anaemia reduction in women of reproductive age. UNICEF's progress on Strategic Plan indicators are referenced within each programme area and presented in relation to baselines and targets; a full table is also included in the annex. In addition, a results schematic linking resources to outputs and outcomes in the Strategic Plan is provided at the beginning of each programme area section.[35]

UNICEF aims to strengthen the supply and demand for nutrition support and improved nutrition and care practices, and to build an environment in which countries with a high burden of undernutrition as well as those with problems of overweight and obesity are able to implement cost-effective and evidence-based policies and strategies to reduce malnutrition in both development and humanitarian situations.

UNICEF programming in nutrition continues to grow; expenditures in the sector were US$484 million in 2014 and rose to just over US$603 million in 2015 – signalling the global momentum for scaling up nutrition and the growing recognition that nutrition is a cost-effective and impactful investment.

PROGRAMME AREA 1: INFANT AND YOUNG CHILD FEEDING

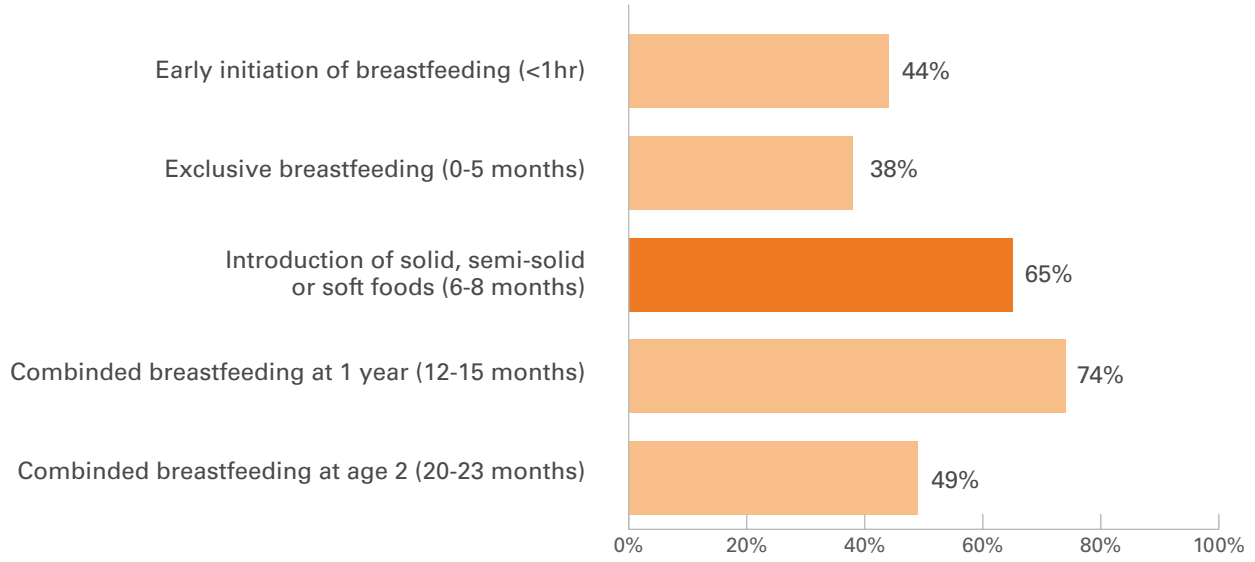
What and how infants and young children are fed is critical to their health, development and survival, and the basis for a good start in life. Optimal infant and young child feeding (IYCF) practices include early initiation of breastfeeding (i.e., within the first hour of life), exclusive breastfeeding for the first six months and continued breastfeeding until age 2 or beyond, with the provision of safe and nutritionally adequate complementary foods. The promotion and protection of IYCF practices is central to preventing all forms of child malnutrition, including stunting and wasting as well as overweight and obesity.

In accordance with the Global Strategy on Infant and Young Child Feeding,[36] UNICEF's goal in this programme area is to protect, promote and support practices that improve maternal and child nutrition. UNICEF's IYCF programme supports country efforts to strengthen policies and legislation around IYCF, to train and build the capacities of governments and other stakeholders to support IYCF programming, and to increase the availability of counselling and support to caregivers both in health facilities and communities.

Rates of exclusive breastfeeding in children 0–5 months old are an important indicator for measuring success in outcome 4, *the improved and equitable use of nutritional support and improved nutrition and care practices.* Over the course of its Strategic Plan, UNICEF will support more than 40 countries to achieve and maintain an exclusive breastfeeding rate of at least 50 per cent among children aged 0–5 months old (baseline: 27 countries [2007–2013]) **(P4.1)**.[37] While exclusive breastfeeding rates have increased over the past 20 years, the global rate remains low; only 38 per cent of children under 6 months are exclusively breastfed *(see Figure 4).*

UNICEF's IYCF programming strives to systematically address the various social and political barriers responsible for slow progress, including insufficient political and financial commitment; knowledge gaps about breastfeeding's multiple benefits among health care providers, communities and families; the lack of adequate maternity protection;[38] and the strong influence of breastmilk substitutes companies. With UNICEF's support, some countries have made significant strides; thirty-two countries are on course to meet the global World Health Assembly target on exclusive breastfeeding (> 50 per cent).[39] In addition, countries like Bangladesh, Benin, Burkina Faso, Ghana, Nepal, Nigeria, Peru, Viet Nam and Zimbabwe have increased breastfeeding rates

FIGURE 4
Feeding practices for children 0–23 months, globally



Note: 2015 population-weighted averages are based on nationally representative household surveys from 2010–2015 (with the exception of China [2008] and India [2005–2006 and 2007]).

Source: UNICEF database 2015.

"Thirty-two countries are on course to meet the global World Health Assembly target on exclusive breastfeeding."

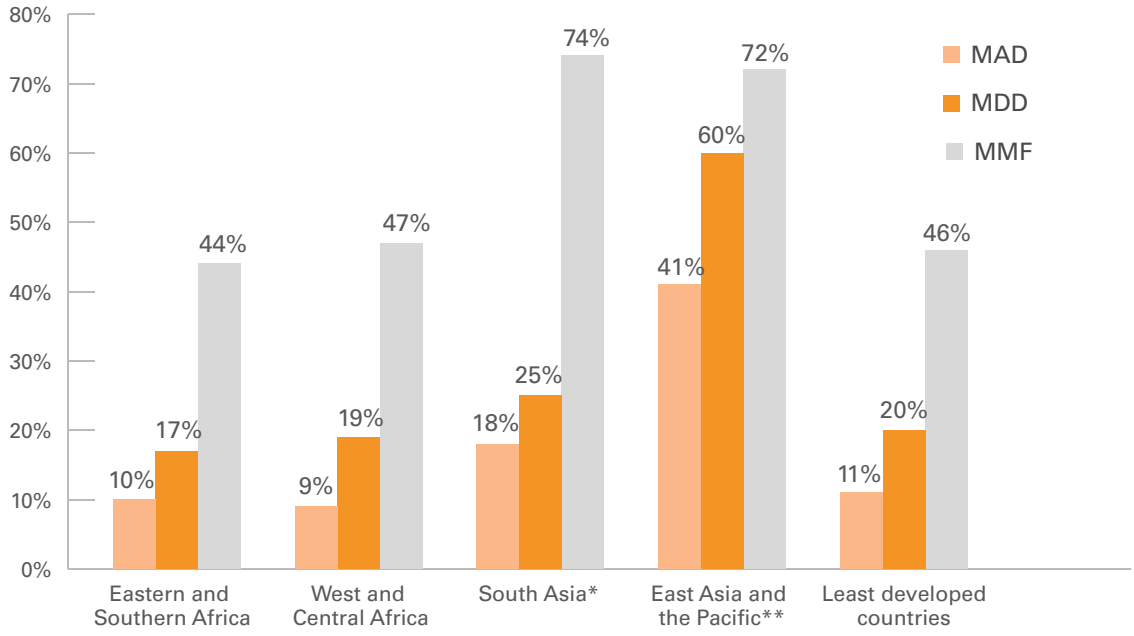
in the last 3–4 years or maintained rates above 50 per cent *(see box 'Spotlight: breastfeeding success stories' for details)*. These are important achievements that will contribute to reductions in infant and child mortality and improvements in sustainable development for these nations.

Since the launch of the Global Breastfeeding Advocacy Initiative *(see pages 17-18)*, breastfeeding is gaining greater global attention. There is a concurrent need to improve complementary feeding practices and align them with global recommendations for dietary diversity, meal frequency and overall adequate diet. As shown in Figure 5, the proportion of young children with an adequate diet is very low in all regions. Efforts to improve monitoring and reporting on complementary feeding indicators, in particular on the minimum acceptable diet[40] are working in a number of countries; for example, in Eastern and Southern Africa, 13 countries are now monitoring and reporting on this indicator (towards a target of 16 countries). This work will continue to be strengthened through policy development and efforts to improve counselling and support for caregivers at facility and community levels.

In 2015, expenses for UNICEF's IYCF programme totalled US$74,949,729, of which 32 per cent was regular resources (RR), 44 per cent was other resources (regular) (ORR), and 24 per cent other resources (emergency) (ORE).[42] Figure 6 illustrates the relationship between programme spending, outputs and outcomes.

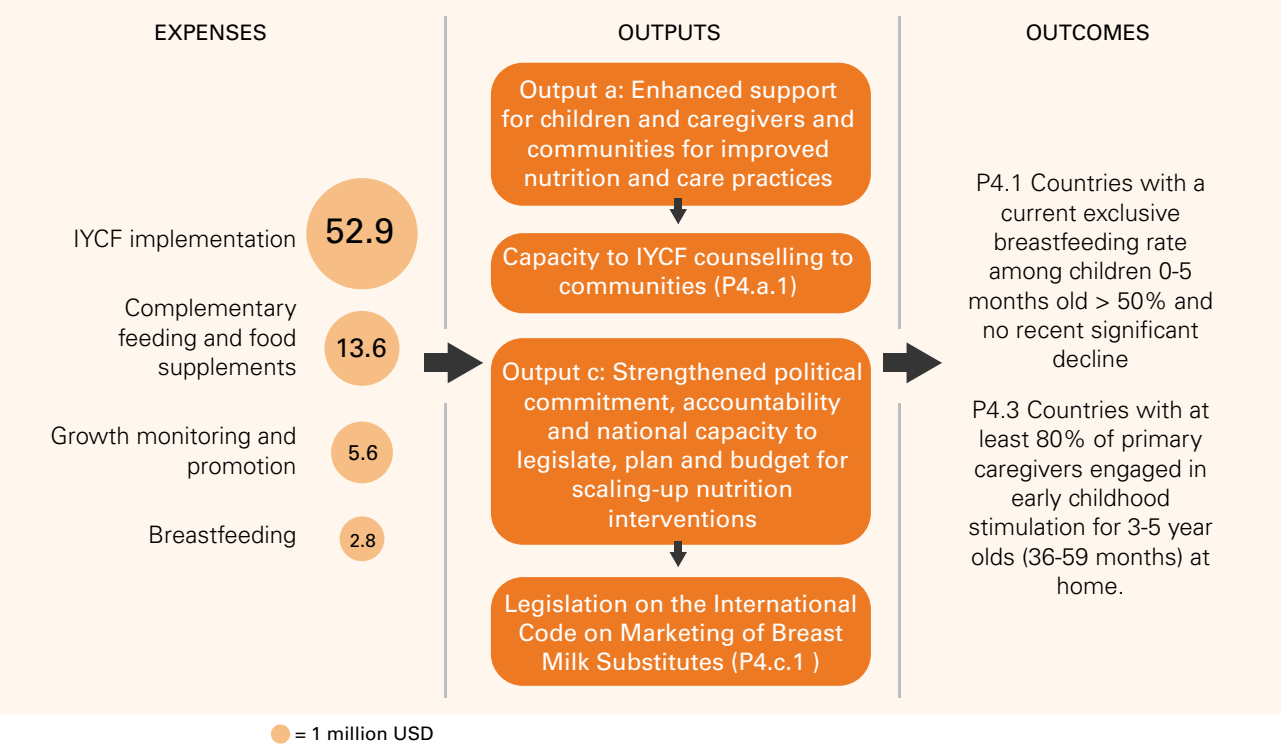
FIGURE 5

Proportion of children aged 6–23 months fed with a minimum acceptable diet (MAD), minimum dietary diversity (MDD) and minimum meal frequency (MMF) by region, 2015[41]



** India not included.*
*** China not included.*
Source: *UNICEF database 2015.*

FIGURE 6
Results chain for infant and young child feeding[43]



Infant and young child feeding output-level results

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

Increasing the availability of IYCF counselling and support: Skilled support – within both the health system and the community – is critical to improving IYCF practices. In 2015, UNICEF worked to integrate counselling and support for mothers and caregivers within the health care system and address the shortage of health workers trained to support breastfeeding and complementary feeding. In Ghana, for example, this support led directly to an improvement in the national health services' capacity to provide quality IYCF counselling services. The number of districts with technical capacity to scale up IYCF increased from 50 in 2013 to 80 in 2014 to 115 in 2015 (out of 216 districts). Thirty-four of the 115 districts have had more than 50 per cent of eligible staff trained on IYCF in the last three years, up from 20 in 2014. The remaining 81 districts still below the 50 per cent mark require additional funding to ensure adequate coverage of properly trained staff.

Expanded community-based counselling and support are central to improving IYCF, particularly in settings where the health system is weak. Such programmes must be tailored to the contexts in which families live, using concrete actions to understand and change behaviours, improve feeding practices, and strengthen social networks *(see box 'A closer look at the gender dimensions of community-based counselling' below)*. In 2015, 89 per cent of countries (108 of 122) reported capacity to provide IYCF counselling services to communities, up from 85 per cent (105 out of 123 countries) in 2014. The number of countries with capacities to provide infant and young child feeding counselling services to at least 70 per cent of communities increased from a baseline of 14 countries in 2013 to 25 (out of 107) in 2015, falling just short of the 2015 target of 27 countries **(P4.a.1– slow progress)**.[44] During emergencies, IYCF counselling is crucial; mothers and caregivers need safe spaces to feed their children and skilled support to address the barriers inherent in these settings. Results in this area are explored further in the nutrition in emergencies chapter.

UNICEF supports training to improve IYCF counselling in facilities and communities. As part of an IYCF counselling scale-up in Nigeria, UNICEF's community IYCF package

A closer look at the gender dimensions of community-based counselling

Community-based IYCF counselling comes in many forms – individual, family or peer-based – depending on what works best in each country-specific setting. Mother-to-mother support groups, which facilitate peer support between mothers to encourage optimal IYCF practices, are popular in all parts of the world, in low and high income countries alike. These groups are usually facilitated by trained community-based workers or volunteers and succeed in allowing women to share experiences in breastfeeding, prepare nutritious complementary foods, and feel supported by one another as they learn about nutrition and best care practices for young children.

Community-based counselling often provides an opportunity to address gender roles in the family and encourage the involvement from male partners in baby care, from changing diapers to providing complementary foods to babies after they have reached 6 months of age. Fathers tend to be included in household and family-based counselling, whereas mother-to-mother support groups are usually women-only spaces involving mothers of the same generation. Grandmothers may also be included in counselling at the household level, given the dominant role they often play in family decision making and child-rearing practices.

was taught to 13 master trainers as well as 1,063 health workers and 2,755 community volunteers. Individual and group counselling was provided at facility and community levels in more than 1,495 communities across 15 states. Overall, more than 600,000 caregivers received IYCF counselling by the end of 2015. In Ethiopia, UNICEF supported an integrated refresher training session on IYCF for more than 33,000 health extension workers and more than 55,000 health development army members in the four agrarian regions. In addition, training was provided to 19,000 women-to-women support group facilitators, which resulted in improved coverage and quality of nutrition programmes. In an example of South-South collaboration, a nutrition specialist from the UNICEF country office in Zimbabwe visited the Sudan for one month and carried out master training for 46 UNICEF, Ministry of Health and partner NGO staff, and conducted the first state-level training of trainers. By the end of September 2015, 428 state-level trainers of trainers had improved their skills in all 18 states. Those trained subsequently trained lead mothers who have established community-based IYCF counselling groups. By end-2015, 660 IYCF support groups had been established, reaching more than 400,000 caregivers.

Significant gains have been made in improving breastfeeding rates in a number of countries. In three focus districts of the European Union-funded Maternal and Young Child Nutrition Security Initiative in Asia project (MYCNSIA) in Indonesia, exclusive breastfeeding increased by 20 percentage points[5] and stunting decreased by almost 6 percentage points between 2011 and 2015 *(see box 'Case study: 'Scaling up IYCF counselling to improve outcomes in the poorest households in Indonesia' below)*. In Burkina Faso, UNICEF continued to support the government in its 10-year IYCF scale-up plan to combat stunting and made great strides in improving exclusive breastfeeding *(see box 'Spotlight: breastfeeding success stories' for details)*. An integrated package of IYCF services was provided at the community level in 7 out of 13 regions, reaching 31 per cent of children under two countrywide, surpassing the planned target of 19 per cent in 2015.

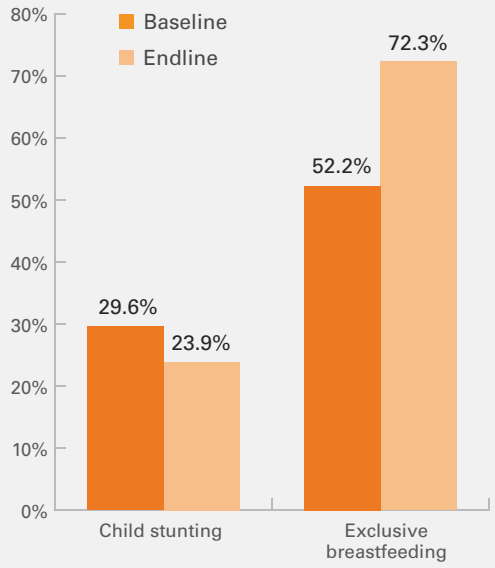
"89 per cent of countries reported capacity to provide IYCF counseling services to communities, up from 85 per cent in 2014."

Case study: Scaling up IYCF counselling to improve outcomes in the poorest households in Indonesia

Indonesia benefits from an impressive network of community-based workers *(kaders)* within local integrated health posts known as *Posyandu*. The *Posyandu* are effective at providing counselling on maternal nutrition and IYCF to mothers of young children, particularly in underserved communities living far from health centres. However, there was no system in place to provide these community-based workers with the necessary skills, knowledge and supportive supervision to counsel mothers. One of the major capacity building focuses of the EU-funded Maternal and Young Child Nutrition Security Initiative in Asia (MYCNSIA) project in Indonesia was to address this gap with a roll-out of the programme in selected districts in three high-risk provinces.

Beginning in 2011, UNICEF/MYCNSIA supported the Ministry of Health to adapt the global UNICEF community IYCF counselling package to the local context and establish mechanisms for large-scale roll-out in Indonesia. The package engages an interactive adult learning approach to build the knowledge and skills of community-based workers on counselling, problem-solving, negotiation and communication, as well as recommended breastfeeding and complementary feeding practices. In addition to the standard content of the package, the Indonesia version emphasizes maternal nutrition and the father's role in supporting good feeding practices. The package has now been adopted nationally, and has been used in 115 districts with support from local governments, NGOs, the Millennium Challenge Account, WFP and UNICEF.

FIGURE 7
Decreases in stunting and increases in exclusive breastfeeding from baseline to endline (all children) in programme districts, Indonesia



Source: United Nations Children's Fund, 'Nutritional Status of Children and Women in Sikka, Klaten and Jayawijaya Districts: Results of the baseline and endline surveys', UNICEF, Jakarta, Indonesia, 2015.

The cascade training model method was employed to facilitate large-scale roll-out of the counselling package: A national pool of eight master trainers worked with 40 district and health centre facilitators who were responsible for training village midwives and community health workers. Supportive supervision tools were designed to assist village midwives in assessing how effectively health workers provided information and counselling to mothers and other family members to identify weak areas requiring more support and mentoring. Health centre staff members also learned to use these tools to support the village midwives in supervising community health workers. These supportive supervision tools have now been adapted by the Ministry of Health for nationwide use.

UNICEF/MYCNSIA also integrated IYCF into training packages for non-health services providers. In Klaten District, the Maternal Nutrition and IYCF package was adapted for use by agricultural extension workers, with a greater emphasis on complementary feeding, including the use of locally produced foods. Agricultural extension workers tend to be male, providing a channel to reach men. UNICEF/MYCNSIA is also supporting the development of an integrated package for early childhood development workers in Pemalang District, comprising IYCF, early stimulation, health, WASH and child protection.

As of mid-2015, approximately 5,250 people in the three districts, mostly at the community level, had been trained in IYCF counselling. Over the course of the project, in the three programme districts, exclusive breastfeeding increased from 52 per cent at baseline to 72 per cent in 2015, and stunting decreased from a baseline of 30 per cent to just under 24 per cent *(see Figure 7)*.

Continued on the next page...

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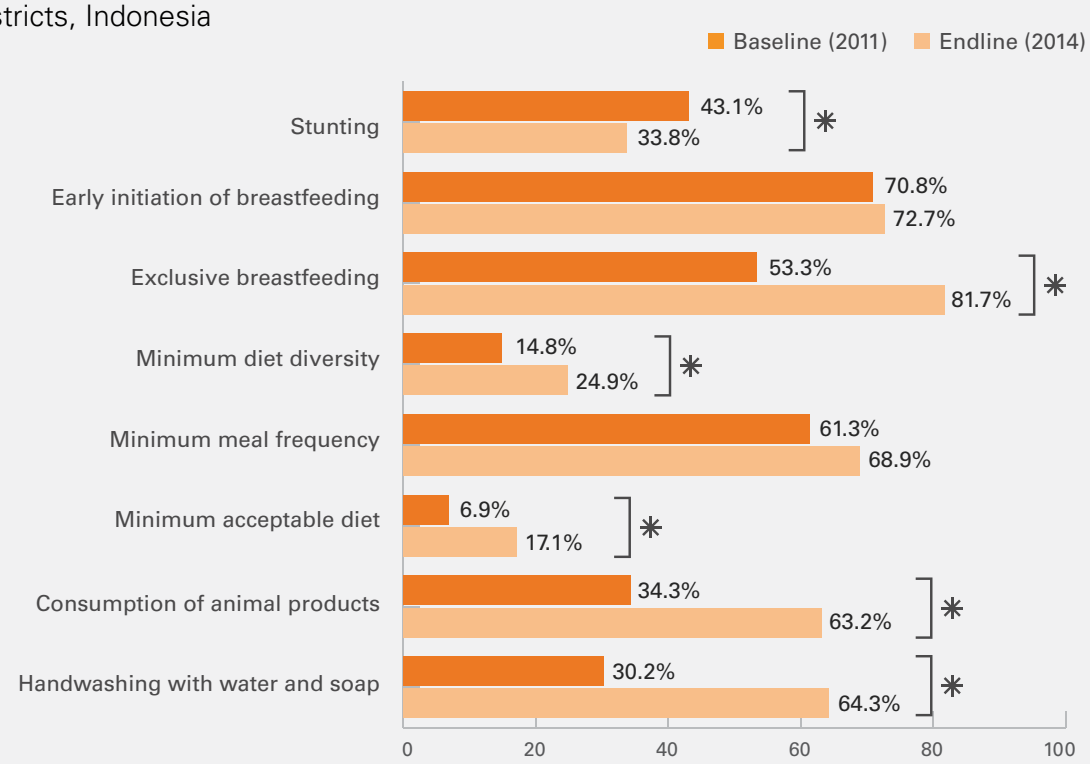
The programme was particularly successful at achieving results for children from the poorest households, with stunting decreasing from 43 per cent to 39 per cent, and exclusive breastfeeding increasing from 53 per cent to 82 per cent in the poorest quintile *(see Figure 8)*. Complementary feeding practices also improved, particularly with respect to dietary diversity, with an increase in the consumption of meat from just over 34 per cent to just over 63 per cent in the poorest wealth quintile. This resulted in an overall increase in the percentage of children receiving the minimum acceptable diet from just under 7 per cent at baseline to just over 17 per cent at endline.

These results illustrate a clear link to UNICEF's equity principles: IYCF practices and outcomes improved among the poorest children in programme areas, providing evidence that the delivery platforms reached the most marginalized families.

"In three programme districts (in Indonesia), exclusive breastfeeding increased from 52 per cent at baseline to 72 per cent in 2015, and stunting decreased from a baseline of 30 per cent to just under 24 per cent."

FIGURE 8

Indicators among the poorest wealth quintile at baseline and endline, in programme districts, Indonesia



Source: *United Nations Children's Fund, 'Nutritional Status of Children and Women in Sikka, Klaten and Jayawijaya Districts: Results of the baseline and endline surveys', UNICEF, Jakarta, Indonesia, 2015.*

To be even more effective, IYCF counselling should include support for ECD and stimulation. UNICEF works to foster integration and cross-sectoral linkages with ECD to improve child-caregiver interaction, cognitive development and overall child development and well-being. In 2015, 26 out of 76 countries (34 per cent) reported having at least 80 per cent of primary caregivers engaged in early childhood stimulation for children aged 3–5 years at home (baseline 16; target 30) **(P4.3 – on track).**[47] This progress has been accompanied by investments in capacity development, as 67 out of 116 countries (58 per cent) reported having curriculum on IYCF that includes training on early childhood stimulation and development for community worker/health service providers, compared to 56 out of 101 countries (55 per cent) in 2014.

Over the past year, UNICEF continued to expand capacity in countries via its e-learning course on infant and young child feeding, a partnership with Cornell University. In 2015, UNICEF revised and updated the course to include a module on women's nutrition and on monitoring results for equity system (MoRES) to strengthen IYCF programmes and revised the modules on IYCF in emergencies and on HIV to reflect the latest guidance. There were 1,167 new course registrants in 2015, bringing the total number of enrolments to more than 9,000 since the course was launched in 2012. Course participants come from 174 different countries, and 92 per cent of these are low- and middle-income countries.[48] The course continued to be highly rated in 2015 *(see quote)*, with 99 per cent of respondents rating it as either 'excellent' (54 per cent), 'very good' (34 per cent) or 'good' (11 per cent).

Strengthening cross-sectoral capacity: UNICEF works cross-sectorally to foster nutrition-sensitive actions and build the capacities of partners in key sectors. In Ethiopia, for example, UNICEF has supported the implementation of a complementary food project in the agrarian regions since 2013, with the aim of improving access to locally produced quality complementary food for children aged 6–23 months. In 2015, additional food processing equipment and materials were distributed, and health extension workers, agriculture development agents and women development army members[49] received training on processing complementary food in 180 *kebelles* in 20 *woredas*,[50] reaching 46,311 children aged 6–23 months. In order to complement these efforts and enhance links with agriculture, UNICEF provided training for 6,282 agricultural development agents on nutrition-sensitive agriculture and the importance of dietary diversity.

Promoting behavioural change communication: Across communities and within families, UNICEF uses social and behavioural change communication to improve knowledge, behaviours, socio-cultural practices and social norms related to infant and young child nutrition. The efforts are yielding long-term rewards, as improvements in child feeding practices are starting to be seen in some countries. In Indonesia, for example, complementary feeding indicators, such as dietary diversity and

> "The UNICEF/Cornell course provided knowledge and skills I would never have afforded . . . from anywhere else in Uganda. I am now a better nutritionist. I feel challenged to put into practice all that has been imparted to me through the community based supplementary feeding programme I am currently in charge of. I am better placed to assist the mothers in the programme. Also, I have encouraged my friends to register for the course".
>
> – Nutritionist, Uganda

Spotlight: Breastfeeding success stories[51]

In **Bangladesh**, 91,505 pregnant and breastfeeding women in the Southern region (90 per cent of target population) received nutrition counselling. Thereafter, exclusive breastfeeding climbed from 49 per cent in 2011 to 66 per cent in 2014, and early initiation of breastfeeding improved from 49 per cent to 77 per cent.

In **Burkina Faso**, on the heels of the scale-up of IYCF programming, exclusive breastfeeding increased from 25 per cent to 47 per cent between 2011 and 2015.

In **Ghana**, after a push to include community-based counselling in all 10 regions, exclusive breastfeeding rates increased from 46 per cent in 2011 to 52 per cent in 2014 and early initiation of breastfeeding increased from 46 per cent to 55.6 per cent.

And in **India**, after national and state governments began implementing a comprehensive eight-pronged strategy to support breastfeeding in 2006, data from a national survey in 2014 indicates that early initiation of breastfeeding increased from 24.5 per cent in 2006 to 44.6 per cent in 2014. In the seven states with the highest burden of neonatal mortality, the combined rate of early initiation of breastfeeding increased from 12.5 per cent in 2006 to 34.4 per cent in 2014.[52]

consumption of animal products, and hygiene behaviours like consistent use of soap and water for hand washing, were reported in increasing numbers in 2015 among the poorest families, indicating both equity of reach and programme effectiveness *(see box 'Case study: Scaling up IYCF counselling to improve outcomes in the poorest households in Indonesia' above)*.

Inappropriate feeding practices have been a concern in Rwanda, where only 18 per cent of children receive the minimal acceptable diet. To address these bottlenecks, UNICEF helped the government implement a national campaign targeting caregivers, pregnant and breastfeeding women, and service providers with messages on good nutrition practices. To date, the campaign has reached more than 8.5 million people through mass media channels. In Mexico, UNICEF implemented two communication for development (C4D) pilot programmes to address social norms that promote unhealthy nutrition habits, and an evaluation will be undertaken in 2016.

Cross-sectoral linkages and partnerships have been effective in strengthening behaviour change communication for IYCF. In Guatemala, an equity based C4D strategy drove a 28 percentage point improvement in prenatal care practices and a 12 percentage point increase in exclusive breastfeeding. In India, expanded partnerships with the Indian Academy of Paediatrics, HealthPhone, Vodafone, and the government, were key to disseminating nutrition videos containing messages on care during pregnancy and breastfeeding.

Many UNICEF country offices commemorated World Breastfeeding Week in August 2015 under the theme of 'breastfeeding and work – let's make it work'. In Bangladesh, UNICEF supported a press conference, print media advertisement and an advocacy event to raise awareness about the barriers to breastfeeding in the workplace. In Kenya, World Breastfeeding Week was launched with help from Safaricom Limited, one of the leading corporate organizations in the implementation of the Better Business Practices for Children in Kenya. Here, UNICEF developed a video with good practice examples of workplace support for breastfeeding in both the formal (Safaricom) and informal (at a flower farm) sectors. In Thailand, UNICEF organized a media trip to a breastfeeding-friendly workplace and held a forum (with participation from more than 70 countries) for sharing the good practices of five companies in establishing breastfeeding-friendly workplace programmes.

At global level, UNICEF used a multimedia approach, creating videos, a photo essay, blog posts and social media messages, which were widely disseminated throughout the week. In collaboration with the Global Staff Association, UNICEF issued an electronic questionnaire on breastfeeding spaces to all UNICEF offices. The results suggested gaps in UNICEF's own workplace accommodations for nursing mothers. Of the 73 offices that responded to the survey (including 64 country and zonal offices, three headquarters offices and six regional offices), only 29 (or 40 per cent) said they had a breastfeeding space either on-site or nearby. Of these, 22 spaces were in country and zonal offices, five in regional offices and two in headquarters. Eighteen of the breastfeeding spaces are restricted to UNICEF staff only; nine are open to staff and visitors.

Global guidance and norms setting: UNICEF contributed to the development of a number of IYCF guidance documents in 2015, including guidelines on infant feeding in the context of Ebola. In December 2015, UNICEF hosted a meeting for key actors (WHO, USAID, and the Elizabeth Glaser Pediatric AIDS Foundation) to plan the dissemination of the 2015–2016 WHO guidelines on HIV and infant feeding. UNICEF also became a member of a WHO-led steering committee for the review and updating of the Baby-Friendly Hospital Initiative (BFHI), which will be undertaken in 2016.

In 2015, UNICEF also drafted guidance on programming in child obesity and nutrition for women and adolescent girls, and began work on a set of criteria for engagement with the food and beverage industry. A draft, presented at the 10th WHO European Action Network meeting, examined how food marketing targets children. A working group on the topic will be launched at the beginning of 2016. Due to shortages in staff time and competing priorities, the update of the IYCF programming guide and the IYCF-E (infant and young child feeding in emergencies) operational guidance were shifted to the 2016 work plan.

"In Guatemala, an equity based C4D strategy drove a 28 percentage point improvement in prenatal care practices and a 12 percentage point increase in exclusive breastfeeding."

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

Advocating for national investments: National investments in IYCF programmes are crucial to ensuring that results are sustainable over the long term. Yet, according to NutriDash 2014, only half of responding countries (47 out of 92) reported government contributions to IYCF programmes.[53] Increasing these investments is a central focus of UNICEF's advocacy work with national governments.

In 2015, UNICEF and WHO continued to lead the Global Breastfeeding Advocacy Initiative, a partnership of 18 organizations[54], funded by the Bill & Melinda Gates Foundation, whose goal is to advocate for national

commitments to and investments in breastfeeding programmes and supportive policies. Three new members joined the partnership in 2015. UNICEF and partners finalized their advocacy strategy, produced policy briefs on breastfeeding and the SDGs, met to define collective strategic actions, and worked with a strategic communications firm to develop an innovative communications approach based on audience research conducted in China, India, Mexico, Nigeria, the United States and in Europe. UNICEF and WHO, on behalf of the partnership, registered a commitment[55] in support of the Global Strategy on Women's, Children's and Adolescents' Health (2016–2030), and successfully advocated for the inclusion of breastfeeding in the Strategy.

More than 150 participants including government officials, UN agencies, international NGOs and academic institutions convened at the 'First Foods'[56] 2015 global meeting funded by UNICEF to accelerate progress on complementary feeding.[57] The meeting resulted in a set of recommendations to guide countries in implementing complementary feeding programmes at scale as well as providing a road map for action in India specifically. A supplement including several of the presentations and the meeting recommendations will appear in the journal *Maternal & Child Nutrition* in 2016.

In 2015, UNICEF seized opportunities for IYCF advocacy at global and regional levels. Following the 132nd Inter-Parliamentary (IPU) Assembly, held in Hanoi in April, UNICEF and Alive & Thrive co-hosted a conference to advocate for the role of parliamentarians in fulfilling the child's right to nutrition and development through improved national policies and legislation. In September, UNICEF and IPU, with the National Assembly of the Republic of Namibia, organized a regional parliamentary workshop to promote child nutrition in the Southern African Development Community region. Members of parliament from nine countries adopted a set of priority actions[58] for parliaments and their members. In 2015, the Government of Turkmenistan hosted a high level meeting to commemorate the twentieth anniversary of its State Health Programme. UNICEF supported and coordinated a strategic side event and advocated for the strengthening of national regulations on the marketing of breastmilk substitutes and for improved support for IYCF in health facilities and communities.

National-level investments in IYCF programming will lead to improved child nutrition. In Nepal, an innovative child cash grant was linked to the promotion of optimal IYCF practices. The grant specifically focused on improving the consumption of foods rich in key micronutrients such as vitamin A in five of the most deprived districts of Nepal. Evaluations conducted in these districts showed that children whose families received the cash grant were 52 per cent more likely to consume vitamin A-rich foods[59] than children who were not exposed. Owing to these programme benefits, the consumption of vitamin A-rich foods increased in Nepal from 25 per cent in 2009 to 43 per cent in 2015.

"The consumption of vitamin A-rich foods increased in Nepal from 25 per cent in 2009 to 43 per cent in 2015."

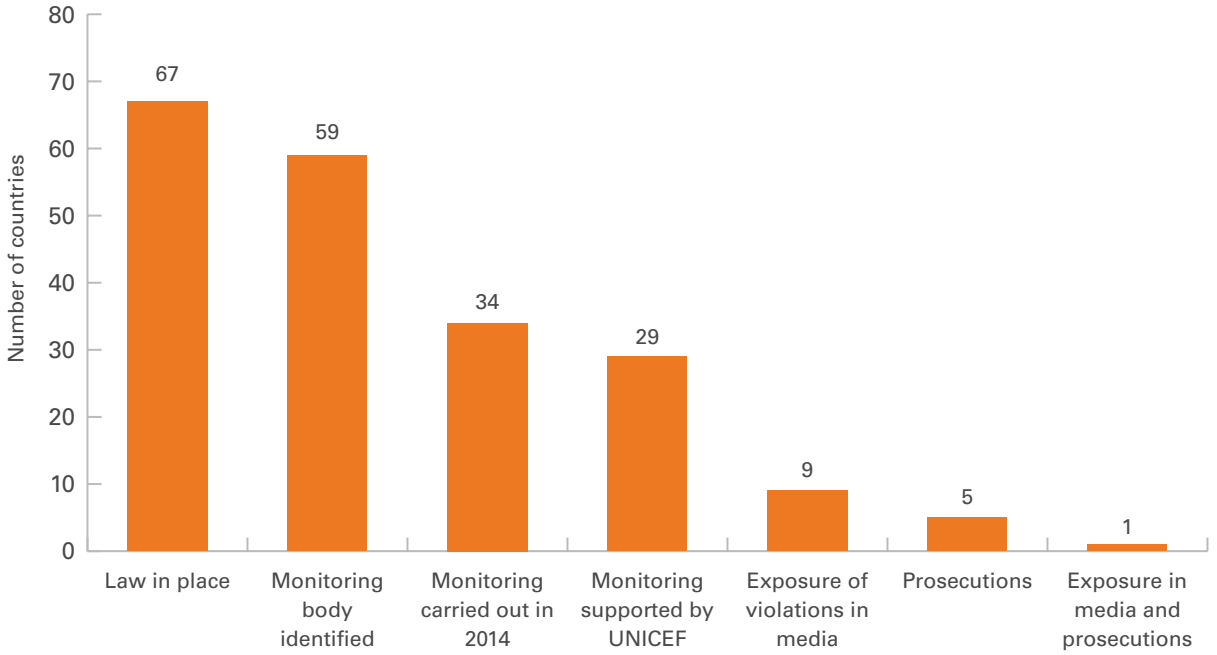
Strengthening IYCF policies and legislation: Throughout 2015, UNICEF provided technical support to governments to strengthen policies and legislation to protect and promote optimal IYCF practices. One of the most important ways that countries can strengthen legislation is by adopting provisions of the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly Resolutions (the Code) into national legislation. The Code aims to protect and promote breastfeeding by prohibiting the promotion of breastmilk substitutes, including infant formula, bottles and teats. In the first two years of the Strategic Plan, the number of countries where the Code was adopted as legislation increased from a baseline of 64 countries in 2013 to 73 in 2014 to 80 in 2015 **(P4.c.1 – on track)**.[60] This is due in part to concerted advocacy and technical assistance provided by UNICEF and its partners.

With UNICEF's support and technical guidance over the past few years, Code regulations were adopted in Iraq, Jordan and Kosovo (under UNSC1244) in 2015. UNICEF also provided guidance to the governments of Albania, Moldova and Namibia to strengthen Code regulations and develop adequate monitoring and enforcement mechanisms, working closely with Ministries of Health, Justice and relevant regulatory authorities. In Thailand, policy advocacy efforts by UNICEF, the Department of Health and other partners reached a major milestone when the Cabinet approved the draft Breast-milk Substitutes Code Act in December 2015. UNICEF provided technical support and advocated for approval of the draft Act, and such work will continue to ensure that it secures approval from the National Legislative Assembly. A Code violation monitoring framework and training guidelines were also developed with technical and financial support from UNICEF.

The status of Code implementation at the national level and the mechanisms for monitoring its enforcement are strong indicators of the enabling environment for IYCF in a given country. Countries are at different stages of Code implementation: some have a law in place, but lack a monitoring body; others have identified a monitoring body, but the work of that group may not be carried out consistently. In 2014, 88 per cent of countries (59 out of 67) with a Code had an entity responsible for monitoring and enforcement (an increase from 49 countries in 2013), and 34 of those countries consistently carried out Code monitoring *(see Figure 9)*. However, few countries (15 out of 67) reported taking punitive action in response to law violations.[61]

The process of adopting new legislation is complex and lengthy; it can often take years between the time

FIGURE 9
Overview of Code implementation and enforcement



Source: UNICEF, NutriDash database, 2014

advocacy and technical assistance are provided to the date when the legislation finally comes into effect. In an effort to accelerate progress and better support countries in adopting and strengthening Code legislation, WHO and UNICEF established NetCode (Network for the Global Monitoring and Support for Implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly Resolutions) in late 2014, and began work in 2015. NetCode is funded by BMGF and aims to strengthen the capacities of Member States and civil society to monitor the Code and to facilitate the development, monitoring and enforcement of national Code legislation by Member States. In 2015, NetCode finalized a set of monitoring protocols, which will be crucial tools for countries to track progress in legislation, monitoring and enforcement. The protocols will also help countries address common challenges and identify factors that can either help or hinder full implementation of the Code.

Some countries have adopted more general policies or strategies on IYCF that will come into effect during the Strategic Plan period. In the state of Maharashtra, India, a comprehensive state Maternal and Infant and Young Child Nutrition Policy led by the Department of Public Health was developed in 2015 and is awaiting state cabinet approval. In Mali, UNICEF helped revise the national IYCF strategy and signed partnership agreements with local NGOs to accelerate the scaling up of community-based nutrition interventions in two target districts. In the Sudan, the endorsement of the National Strategy for Infant and Young Child Feeding in May 2015 led to the roll-out of a network of 660 community-based mother support groups able to provide quality IYCF counselling. In Kenya, significant progress was made towards addressing poor complementary feeding practices by targeting ten focal counties in two-year plans to improve the proportion of children with minimum acceptable diets. UNICEF also aided South Africa and the United Republic of Tanzania in setting up systems to track and provide post-partum nutritional support to HIV-exposed infants.

Maternity leave legislation and supportive workplace policies are necessary to encourage breastfeeding and promote gender equity. From 2013–2015, UNICEF worked with the International Labour Organization to expand the Nutrition Security and Maternity Protection Programme in the Philippines, by developing a comprehensive integrated framework for implementing RA10028 (The Republic Act 10028 or Expanded Breastfeeding Act of 2009), with a particular focus on small businesses and the informal workplace. Practical guidelines were developed for employers as well as a toolkit, which defines the various components of maternal and young child nutrition security in the workplace. A total of 88 lactation stations were established and made fully operational as part of the programme.

With BMGF funding in Kenya, UNICEF and the Ministry of Health facilitated training on breastfeeding support in the workplace, maternity protection, and the national Breast Milk Substitute (regulation and control) Act for senior level managers, Ministry of Health officials, non-governmental organizations, Central Organization of Trade Union officials and the Federation of Kenya Employers. UNICEF also supported the establishment of a committee on breastfeeding in the workplace within the Kenya Ministry of Health in early 2015, whose goal was to develop a baby-friendly workplace model to enhance optimum breastfeeding practices. In Bangladesh, UNICEF developed a baby-friendly workplace initiative model, with the aim of providing designated workspaces for women to breastfeed.

Reflections and lessons learned

Throughout the 2015 reporting period, UNICEF continued to co-lead key global partnerships, such as the Global Breastfeeding Advocacy Initiative and NetCode. These partnerships have been crucial opportunities to raise the global spotlight on infant and young child feeding practices and advocate for commitments and investments from governments. At the same time, such partnerships require significant financial and human resources to coordinate and roll out activities successfully, and there is a learning curve in determining how to best leverage the strengths of the various partners while speaking with a united voice.

UNICEF positioned itself strategically around complementary feeding in 2015, and the landmark 'First Foods' meeting was a key opportunity to bring partners together to plan actions to scale up programmes and provide recommendations and a framework for follow-up with countries moving into 2016. In 2016, UNICEF will seize several opportunities to advocate for strong and comprehensive infant and young child feeding programmes, including during the Nutrition for Growth summit in Brazil. Sound IYCF programmes are essential for healthy child growth and development; recent evidence indicates that breastfeeding benefits all children, in high- and low-income countries alike.

There is still much work to be done, beginning with strengthening the integration of IYCF into maternal, newborn and child health programmes; too often, opportunities are lost to fragmented response. As a first step, UNICEF is developing an operational manual with the NGO Alive & Thrive to provide guidance for improving such integration within programming.

In 2015, competing priorities and time constraints made it challenging to identify new funding opportunities. There is a continued need for more human resources to meet increasing demands, particularly for guidance and protocol development and for support to countries to implement complementary feeding programmes that are informed by sound situation analysis and formative research. Resources to initiate work around childhood overweight and obesity are also limited and this creates a challenge in supporting countries in this area of increasing importance. More predictable and flexible thematic funding would ensure the IYCF programme continues achieving results that best serve the most disadvantaged children.

PROGRAMME AREA 2: MICRONUTRIENTS

Globally, millions of children suffer the consequences of micronutrient deficiencies, including stunted growth, cognitive delays, weakened immunity, disability and disease, and even death. For the millions of pregnant women with iron deficiency anaemia, the lack of essential vitamins and minerals can be catastrophic to their own health and to the survival and development of their child.

The good news is that micronutrient interventions are some of the least costly and most effective investments for improving global welfare.[62] UNICEF's micronutrient programmes deliver high-impact results with a focus on reaching the most vulnerable populations. In 2015, UNICEF continued its work to improve access to vital micronutrients for women and children using the following strategies: dietary diversification (to improve the availability of nutrient-rich and locally available foods), supplementation (to provide nutrients not available as part of the regular diet), mass fortification (the process of adding micronutrients to industrially produced staple foods) and home fortification (the process of adding micronutrients to foods prepared in the home). These strategies, together with prevention and treatment of infectious diseases to minimize micronutrient depletion, can mitigate micronutrient deficiencies among the most vulnerable groups.

Vitamin A supplementation programmes have made notable progress towards the goal of effective two-dose coverage with UNICEF's leadership and the support of

A child in Kavre District, Nepal, receives a vitamin A capsule as part of the post-earthquake nutrition response.

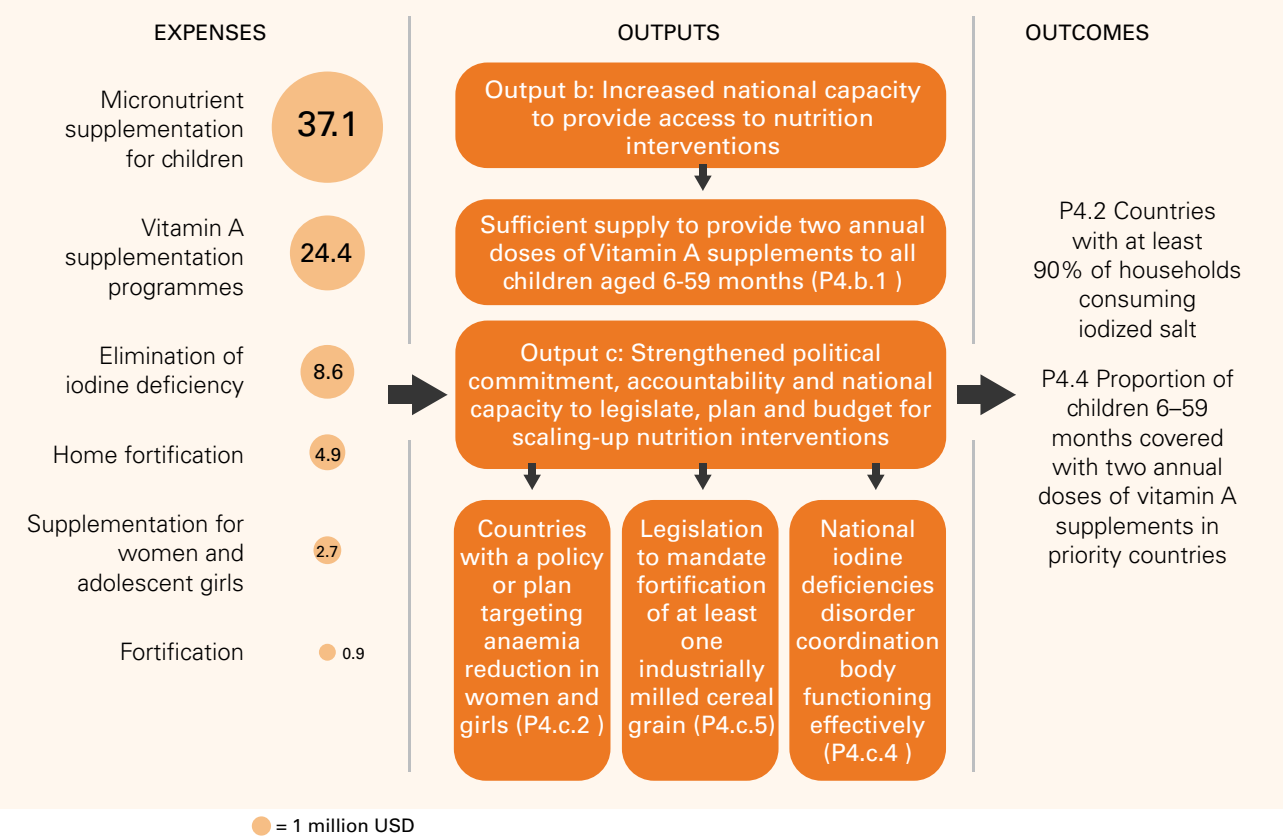
partners, including Helen Keller International and the Micronutrient Initiative, and with long-term financing from the Government of Canada. In 2000, only five countries in sub-Saharan Africa had effective two-dose coverage, but by 2014, this number had more than tripled to 17 countries in that region *(see Figure 11)*. Despite these achievements, there is a need for better data on low-income settings and urgent action in the sub-Saharan Africa region, where countries still face some of the highest rates of under-five mortality in the world.

UNICEF also supports supplementation programmes for adolescent girls and women to prevent iron deficiency anaemia, improve maternal and fetal health, and promote their empowerment. With its long history of advocacy and technical assistance, UNICEF can help countries legislate Universal Salt Iodization, to ensure the fortification of all food-grade salt, used in household and food processing with iodine. Such programmes have existed for decades in some countries, and are the most effective means of preventing iodine deficiency disorders (IDD). In its support for mass food fortification, UNICEF advocates for governments to enact legislation mandating the fortification of staple foods such as wheat, maize and rice with essential micronutrients. UNICEF also supports home fortification programmes worldwide, and its country offices have been key drivers in increasing demand for micronutrient powders (MNPs) for young children. Currently, an estimated 5 million children are being reached with micronutrient powders through programmes implemented in 44 countries.

Expenses for the micronutrients programme totalled US$78,761,579 in 2015, with 54 per cent of funding from regular resources, 37 per cent from other resources (regular), and 9 per cent from other resources (emergency). Figure 10 illustrates the relationship between programme spending, outputs and outcomes.

"Micronutrient interventions are some of the least costly and most effective investments for improving global welfare."

FIGURE 10
Results chain for micronutrients[63]



Micronutrients output-level results

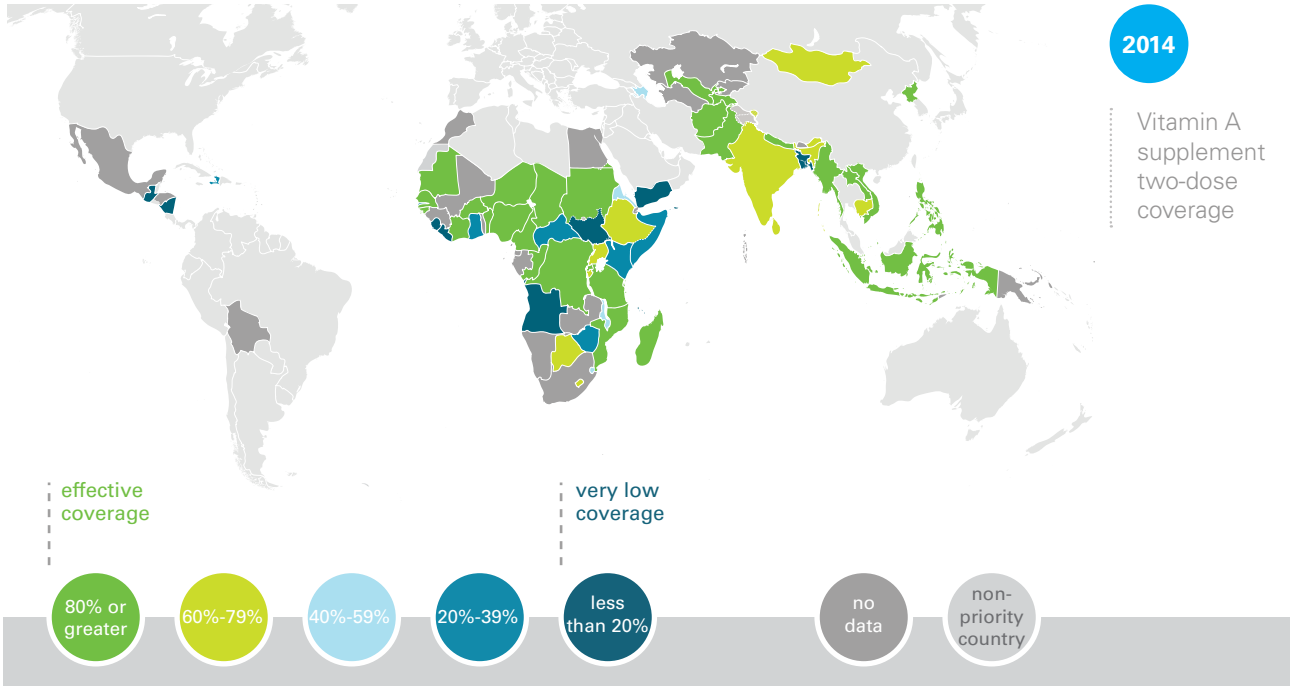
Increased national capacity to provide access to nutrition interventions

Scaling up supply and coverage of vitamin A supplementation: UNICEF supports national-level vitamin A supplementation (VAS) programmes for children aged 6–59 months in over 80 priority countries.[64] Such programmes can improve child survival by 12–24 per cent and are among the most equitable and cost-effective nutrition interventions. With the support of a donation programme financed by the Government of Canada through the Micronutrient Initiative, UNICEF has received more than 8 billion capsules since 1998 and their use has averted an estimated 4 million deaths.

For years, many countries successfully delivered VAS as part of polio immunization campaigns. However, with the phase-out of these campaigns due to polio eradication, countries need a transition strategy to ensure that children continue receiving life-saving interventions. In 2015, UNICEF undertook a detailed historical analysis of programme performance in order to inform future programmatic approaches. The analysis suggested that in most countries, Child Health Events[65] – which deliver vitamin A supplements as part of a locally-tailored package of interventions – are compelling VAS delivery mechanisms and can help ensure access for the most vulnerable, particularly those in fragile communities with poor access to routine health systems. In 2014, 44 Child Health Events achieved a mean VAS coverage of 84 per cent.[66] The inclusion of deworming medication in such events doubled global deworming coverage of pre-school-aged children from 24 per cent to almost 50 per cent, illustrating the importance of Child Health Events in achieving global coverage goals of 75 per cent by 2020.[67] UNICEF's support in the delivery of VAS, deworming and other high-impact interventions is funded in 13 countries by a US$41 million grant from the Government of Canada.

To benefit from reductions in morbidity and mortality in countries where vitamin A deficiency is a problem, children must receive two high doses of vitamin A each year. During the Strategic Plan period, UNICEF aims to ensure coverage of 80 per cent of children aged 6–59 months with two annual VAS dosages in vitamin A priority countries (baseline: 68 per cent in 2011).[68] In 2014, 69 per cent of children aged 6–59 months were covered, with the highest coverage in East Asia and the Pacific (86 per cent) and West and Central Africa (83 per cent). In 2015, preliminary

FIGURE 11
Vitamin A supplementation coverage, 2014



Source: *UNICEF global databases, 2015. Based on administrative reports from countries.*
Note: *Map is stylized and not to scale and does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties. The final boundary between the Sudan and South Sudan has not yet been determined. The final status of the Abyei area has not yet been determined.*

data indicate that 269,846,930 targeted children received two doses of VAS, representing 70 per cent of all targeted children **(P:4.4)**.[69] Global coverage reporting for VAS was previously done through a separate mechanism, but has recently been consolidated as part of UNICEF's NutriDash platform in an effort to streamline reporting mechanisms and also reduce the burden on country offices.

In 2015, UNICEF worked with governments on developing context-specific solutions to deliver VAS. In the Lao People's Democratic Republic, technical and financial support from the MYCNSIA programme enabled coverage rates of VAS and deworming for children under-5 to be sustained above 90 per cent throughout the project period. The Laos Ministry of Health initiated and increased national budget allocation for nutrition commodities and operating costs for health outreach for nutrition-specific interventions. In Ethiopia, 86 per cent VAS coverage (10,192,621 children) was achieved in the first semester of 2015, and 85 per cent coverage in the second semester (a further 10,008,980 children). Coverage was lower in *woredas* using routine supplementation compared to those using a Community Health Day approach. In Madagascar, two rounds of Mother and Child Health Weeks were held in 2015, achieving 87 per cent VAS coverage and 89 per cent coverage for deworming.

UNICEF is dedicated to supporting VAS even, and especially, in highly challenging environments and humanitarian crises. UNICEF helped the Government of Nepal in delivering VAS (and other high-impact interventions) to children in earthquake affected areas, achieving more than 100 per cent coverage in 2015 (*see box 'Case study: Child Nutrition Week delivers essential nutrition services to children after the Nepal earthquake' below*). A previous VAS campaign in Sierra Leone was derailed in 2014 due to the Ebola crisis. In April 2015, however, the first large-scale post-Ebola campaign was launched with support from UNICEF, Helen Keller International and other partners, providing VAS, deworming and mass screening to children aged 6–59 months, followed by a second campaign in November, achieving 95 per cent coverage. UNICEF and partners worked to remedy bottlenecks in the process and improve reach for the most vulnerable. Further details on micronutrients interventions in emergencies are discussed in programme area 3.

UNICEF embraces innovative technologies and strategies to improve VAS coverage. In Nigeria, UNICEF worked with Helen Keller International and the Micronutrient Initiative to help the Government host the bi-annual Maternal, Newborn and Child Health Weeks (MNCHW)

Case study: Child Nutrition Week delivers essential nutrition services to children after the Nepal earthquake

At the end of April 2015, immediately after the devastating earthquake in Nepal, the government declared a state of emergency and requested the United Nations to activate the Humanitarian Clusters. The Nutrition Cluster, led by the Ministry of Health and Population and UNICEF, and comprising 28 national and international partners, devised a three-month emergency response aiming to address the safeguard and improve the nutritional status of affected populations.

As a key part of the response, UNICEF and the Nutrition Cluster held a Child Nutrition Week to deliver micronutrient and other essential nutrition interventions for mothers and children under 5, before the onset of the monsoon rains. In Nepal, an event was planned as a fixed-day, village-based strategy to deliver a package of six nutrition interventions to at least 80 per cent of a target population comprising 467,425 children aged 0–59 months, pregnant women and breastfeeding mothers. The Ministry of Health and Population, supported by UNICEF as Nutrition Cluster lead, developed district-level guidelines for the implementation of the Child Nutrition Week with integrated support from a Health and Nutrition Cluster partner in coordination with the District Disaster Relief Committee, and municipal and village authorities. An onsite coaching approach was used to train over 15,000 health workers, female community health volunteers and volunteers from civil society organizations. Information about the Child Nutrition Week was broadcast through Radio Nepal and 63 local radio stations to raise awareness and encourage participation.

The Child Nutrition Week took place between 28 June and 8 July 2015 and was extremely effective in reaching targets. Among children aged 6–59 months, 314,898 (97.4 per cent of target) received a two-month supply of MNPs, and 360,984 (>100 per cent of target) benefitted from vitamin A supplementation while 24,902 women (88.3 per cent of target) received a two-month supply of iron-folic acid supplements. In addition, 153,478 mothers with a child 0–23 months old (91.4 per cent of target) were counselled on the benefits of breastfeeding and the risks of artificial feeding; 142,026 mothers with a child 6–23 months old (>100 per cent per cent of target) were reached to urge continued breastfeeding and the use of MNPs received, through on-site face to face counselling with mothers of children aged 0–23 months.

Nepal's Child Nutrition Week successfully delivered essential nutrition services to the most vulnerable children and mothers post-earthquake. This is the first time that a Child Nutrition Week approach has been used in South Asia as part of an emergency response. Based on its results, it presents a viable policy option for emergency-affected countries in South Asia and beyond in the future. Furthermore, the Government of Nepal is now considering the use of bi-annual Child Nutrition Weeks to deliver an integrated package of nutrition services as an extension of the routine services provided by the primary health care system.

Source: *Aguayo, Víctor M., Anirudra Sharma and Giri Raj Subedi, 'Child Nutrition Week in Nepal: Delivering essential nutrition services for children after the earthquake and before the monsoon', Lancet Global Health, vol. 3, November 2015.*

in all 36 states and the federal capital territory. This event reached more than 31 million children aged 6–59 months, achieving a national coverage of 81 per cent. In 2015, UNICEF launched a new programme monitoring tool using SMART tablets to better identify bottlenecks and ensure real-time monitoring, reporting and response within the national MNCHW. During the 2015 campaign, the tool identified early stock shortages and critically allowed for timely restocking to avoid disruptions. To further improve the system, UNICEF is currently piloting the use of an innovative Rapid SMS approach to track commodity shortages and ensure follow up restocking, increasing accountability within the system. In the conflict-affected state of Jharkhand in India, UNICEF partnered with the government and non-governmental organizations to provide life-saving VAS to children aged 6–59 months living in the most deprived communities. Promotional messages about VAS were recorded on portable media players to mobilize community attendance. NGO volunteers monitored these hard-to-reach sites using cell-phone based technologies, with real-time data showing that nearly 100,000 children living in hard-to-reach areas benefited from VAS for the first time, and that 63 per cent of hard-to-reach villages reported VAS coverage greater than 80 per cent. As a result, the state government adopted these communications and monitoring strategies for future VAS programmes.

In 2015, UNICEF procured 537.5 million vitamin A capsules (a 4.6 per cent increase from the previous year) including 454 million as a 'contribution in kind' from the Micronutrient Initiative, with support from the Government of Canada. UNICEF supported country efforts

improving inventory management and reducing wastage in the supply chain to meet the Strategic Plan indicator on vitamin A capsule supply. In 2015, four out of the 82 priority countries reported stock-outs, 62 reported sufficient supplies, and 16 countries did not have data **(P4.b.1 – slow progress)**.[70] However, reporting on this indicator needs to be improved given that data was not available for a significant proportion of countries in 2015.[71]

Supporting home fortification programmes: In 2015, UNICEF continued previous support of home fortification programmes worldwide. Such programmes aim to improve the quality of nutrient intake by providing caregivers with MNPs that can be used to fortify homemade foods for young children before consumption. MNP programmes yield strong results in preventing and treating anaemia and other micronutrient deficiencies in young children.

Momentum continues to build for the scale-up of home fortification programmes in many countries. The number of countries implementing programmes more than doubled in less than five years – from 22 countries in 2011 to 43 countries in 2013 to 50 countries in 2014. A total of 3 million children were reached in 2014. These achievements were driven by the efforts of UNICEF and other members of the Home Fortification Technical Advisory Group[72] to improve legislation, stimulate demand, influence behaviour change, and expand and apply monitoring and evaluation systems to reach target populations. UNICEF is the largest procurer of MNPs and has a leading role in developing the market. In 2015, demand for MNPs, through UNICEF, exceeded 727 million sachets for 44 countries, compared to just over 400 million in 2014. To meet this increase, significant efforts were made to engage manufacturers and other technical partners. Overall, the growth helped reach an estimated 5 million children in 2015.

In 2015, UNICEF supported the development and review of national guidelines for implementing MNP programmes in South Sudan. In Rwanda, with the support of the Netherlands, UNICEF procured and distributed MNPs for all children aged 6–23 months (almost 200,000 children) in 10 target districts, with an aim to improve dietary diversification, resilience and food security in vulnerable households and reduce stunting. Results from the One UN nutrition programme intermediate survey in Nyamagabe and Rutsiro districts showed that after implementation of the programme, the level of moderate and severe child anaemia had fallen by 30 per cent since the baseline survey (with a decline from 16 per cent to 11 per cent) in six months. The programme was an example of strong multi-sectoral collaboration, with combined interventions from agriculture, health, social protection and early childhood education.

A number of countries are researching methods to develop or improve MNP programming with UNICEF's support. In Nigeria, UNICEF and the government conducted formative research on the design of a national MNP supplementation programme to develop a culturally appropriate behavior change communication strategy. MNP distribution was initiated in camps for internally displaced people (IDPs) and facilities in the three emergency northeast states, reaching 23,245 children aged 6–24 months by the end of the year. The government, with support from UNICEF and partners, developed a joint roadmap to scale up the intervention in all 37 states in Nigeria by 2019, targeting 11.3 million children aged 6–23 months annually, with a focus on equity.

Market-based approaches for MNP distribution can increase access, coverage and use of MNPs and complement other types of distribution systems, especially when public delivery systems fail to reach all populations. However, success factors for this approach are not completely understood. To address this gap, UNICEF partnered with Population Services International to evaluate programmes in Madagascar, Mozambique, the Lao People's Democratic Republic and Somaliland. The study showed that best results combined strong local branding of MNP products, careful consideration of appropriate retail price based on population ability and willingness to pay, smart investment in promotions to create awareness and demand and precisely chosen distribution points to maximize access to MNPs. The results of this analysis are expected to improve the quality of market-based MNP approaches globally.

In Nepal, UNICEF successfully launched a pilot MNP programme in 2015 in six districts, with good results, and later expanded to an additional nine, and to 14 emergency-affected districts; a costed national scale-up plan is currently being developed by the Government. UNICEF worked to improve guidelines, materials and tools for the programme by adding messages on nutrition and care during pregnancy, early child stimulation and hygiene and sanitation. UNICEF also used communication and social mobilization activities to promote MNP consumption. During the pilot phase, approximately 72,000 children were reached in six districts. After expansion, including to earthquake-affected districts, the programme now reaches 200,000 children in 15 programme districts and an additional 500,000 children in 14 emergency districts, totalling 700,000 thousand overall.

At global level, UNICEF supported a community of practice for home fortification with MNPs, with contributions from over 600 participants from more than 100 countries. UNICEF used five webinars to reach 100 participants from different countries and agencies. To help improve programme performance, UNICEF led efforts to develop a toolkit comprising more than 70 tools and job aids for programme managers that are available for

"The number of countries implementing (MNP) programmes more than doubled in less than five years."

free on the website of the Home Fortification Technical Advisory Group, which UNICEF co-chairs.

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

UNICEF and its partners advocate for improved legislation, help build the capacities of national actors, and expand the knowledge base required to strengthen nutritional practices globally. In 2015, UNICEF held leadership roles on the Micronutrient Initiative, Micronutrient Forum, Home Fortification Technical Advisory Group, Global Alliance for Vitamin A, Food Fortification Initiative, Iodine Global Network and International Zinc Nutrition Consultative Group.

Improving national policies and programmes to support micronutrient supplementation for women and adolescent girls: UNICEF supports supplementation programmes for adolescent girls and women to prevent iron deficiency anaemia and improve maternal and child health. In 2015, over 900 million tablets of iron folic acid were procured for pregnant and adolescent women, an increase of over 100 per cent compared to 2014. These programmes effectively advance equitable nutrition status, given that adolescent girls and women are most susceptible to anaemia and may also face discrimination in accessing nutritious foods within the household. In 2015, 75 per cent of countries (91 out of 122) had a current national policy or plan to address anaemia in women of reproductive age (from a baseline of 70 towards a target of 100). And 54 per cent of countries (49 of 91) also had a specific approach within their national policy to combat anaemia among adolescent girls (from a baseline of 27 towards a target of 50) **(P4.c.2 – on track)**.[73] This is an improvement from 2014, when only 60 per cent of countries (74 out of 123) had a policy or plan and only 46 per cent (34 out of 74) had a specific focus on adolescent girls.

In the second year of its Strategic Plan, UNICEF supported community-based interventions to prevent anaemia during pregnancy, resulting in strong progress. In Mali, after UNICEF partnered with local NGOs to accelerate the scaling up of community-based nutrition interventions, iron/folic acid supplementation reached 26,192 women and increased coverage by 42 per cent from 2012 to 2015 in the two target districts. In Bangladesh, the multi-year regional Maternal and Young Child Nutrition Security Initiative (MYCNSIA) project significantly advanced coverage of iron folic acid supplementation among pregnant women, increasing from 32 per in 2012 to 55 per cent in 2015 in the target area *(see box 'Case study: Scaling up iron-folic acid supplementation for pregnant women in Bangladesh' below).*

UNICEF also targets adolescent girls specifically in its programming. In India, UNICEF worked to scale up the weekly Iron Folic Acid Supplementation Programme in all states to reduce anaemia in adolescent girls. Uttar Pradesh, India's most populous state, has the largest adolescent micronutrient programme in the country, covering 49 million adolescent girls and boys in the state's 75 districts. UNICEF provided support to the state health department to initiate a real-time monitoring system in 45 districts, using trusted local partners, and

Case study: Scaling up iron-folic acid supplementation for pregnant women in Bangladesh

The EU/UNICEF supported Maternal and Young Child Nutrition Security Initiative (MYCNSIA) 2011–15 made significant progress in tackling micronutrient deficiencies in Bangladesh. High levels of undernutrition among Bangladeshi children are due in part to intrauterine growth retardation related to poor maternal nutritional status and low weight gain in pregnancy. A key objective of the project was to provide iron-folic acid supplementation to target groups of pregnant and breastfeeding women and adolescent girls.

The programme was successful, reaching a cumulative total of 91,500 pregnant and lactating women and girls with iron-folic acid supplementation and increasing coverage from 32 per in 2012 to 55 per cent in 2015 in target areas. Overall, anaemia decreased by 12 percentage points among pregnant women (from 53 per cent to 41 per cent).

With UNICEF's support, the National Nutrition Service of Bangladesh also strengthened the enabling environment by developing the National Micronutrient Deficiency Control Strategy (2015–2024), which was later approved by the government.

Evidence and lessons learned from strengthening the service delivery and monitoring of iron-folic acid for pregnant women will be used to remove bottlenecks and improve access to these essential services at both national and local government unit level.

A woman mixes locally packaged multiple micronutrient powder during a nutrition outreach session in Ta Oi District, Saravane Province, Lao People's Democratic Republic.

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used feedback to address programme barriers. After the first year of implementation, this effort successfully streamlined supplies of iron-folic acid and deworming tablets, increased accountability through joint monitoring and enhanced local ownership of data. As a result, the programme was subsequently extended to all 75 districts.

Growing evidence suggests that while multiple micronutrient supplements (MMS) contain similar benefits for anaemia reduction as standard iron and folic acid (IFA) supplementation, MMS provide additional benefits for pregnancy. In 2015, UNICEF supported a systematic review of evidence on MMS during pregnancy to inform the WHO guidelines process, expected to be published in June 2016.[76] UNICEF, WHO and the Micronutrient Initiative subsequently co-hosted a technical consultation on how best to implement programmes to scale up MMS during pregnancy worldwide. The resulting discussions and commissioned papers will support future work on micronutrient supplementation for pregnant women. UNICEF's financial and technical support was key to the meeting's success. UNICEF and the Micronutrient Initiative are planning a global initiative on micronutrient supplementation for adolescents and women in 2016.

Improving iodine status through salt iodization: Salt iodization is the most effective strategy for preventing iodine deficiency disorders (IDD). Since bringing salt

"In 2015, over 900 million tablets of iron folic acid were procured for pregnant and adolescent women, an increase of over 100 per cent compared to 2014"

iodization to the global development agenda in 1990, UNICEF has helped more than 100 countries eliminate IDD through Universal Salt Iodization (USI) programmes. In 2015, UNICEF continued to be a board and steering committee member of the Iodine Global Network, recognizing the critical role of global partnerships in this process. Strengthening legislation is crucial in preventing IDD and in 2015, toward this end, UNICEF assisted nearly 45 countries from the Middle East and North Africa, Eastern and Southern Africa and West and Central Africa regions in reviewing national IDD control programmes and designing strategic plans to address critical programme challenges.

UNICEF estimates that globally, 76 per cent of all households consume adequately iodized salt.[76] During the Strategic Plan period, UNICEF aims to support at least 25 countries in achieving at least 90 per cent of households with iodized salt consumption (from a baseline of 6 countries). In 2015, there were 20 countries with at least 90 per cent of households consuming iodized salt **(P:4.2 – on track)**.[77] This indicator was adjusted slightly from the one used in 2014, which referred to 'adequately' iodized salt. To improve the enabling environment within countries, an effective USI coordination body is needed, ideally with participation from all key stakeholders, including private sector salt producers and processors. Of 84 countries reporting in NutriDash, 55 had established a coordination body for their USI programme, however only 19 (34 per cent) of these mechanisms were classified as effective.[78] There has been no progress on this indicator since 2013, partially due to the fact that the indicator definition was changed to make the criteria more rigorous **(P4.c.4 – off track)**.[79]

Global multi-year grants made available to UNICEF by the Bill & Melinda Gates Foundation (in the context of the partnership between the Global Alliance for Improved Nutrition, or GAIN, and UNICEF) and USAID supported salt iodization programmes in 13 and 11 countries, respectively. With this support, UNICEF commissioned state-of-the art research in 2015 to show that well designed salt iodization programmes protect all population target groups, ranging from infants to pregnant and non-pregnant women, against iodine deficiency. UNICEF also convened a global expert group to reassess metrics of programme success, as these metrics do not adequately capture the remarkable success of salt iodization programmes and do not allow for effective programme improvements.[80] UNICEF and its partners gathered programme managers from 45 countries to identify programme barriers and identify corrective

actions for national salt iodization programmes. At regional levels, UNICEF helped create a favourable policy environment. For example, the UNICEF regional office for West and Central Africa and its partners helped regional economic bodies and the Economic Community of West African States (ECOWAS) develop harmonized standards for salt iodization alongside fortified cooking oil and flour. These standards were validated by the ECOWAS Technical Harmonization Committee in 2015, and adoption by the ECOWAS Council of Ministers is expected in 2016.

At country level, the UNICEF/GAIN partnership supported an equity-based strategy in India to improve iodized salt use among the most vulnerable households. In 2015, UNICEF completed its efforts to improve the use of iodized salt in India's Public Distribution System, including through technical assistance offered to Tamil Nadu's state salt company and sensitization and capacity building along the PDS supply chain. This work resulted in a doubling of the iodized salt supply. Furthermore, UNICEF helped secure the institutionalization of adequately iodized salt use in the mid-day meal programme and supplementary feeding programme of integrated child development services, which will improve access and availability of iodized salt for the most at-risk population groups.

Ethiopia has achieved a dramatic improvement in iodine status. A UNICEF/GAIN programme, funded by the Bill & Melinda Gates Foundation, supported the government to enact favourable legislation and build capacity in regulatory agencies and local salt industries. Whereas the 2005 national survey showed that school age children were severely iodine deficient, with a population median urinary iodine concentration (MUIC) of 24.5µg/l, the 2015 national survey showed the same population group with a MUIC of 105.6 µg/l, indicating iodine sufficiency. These results illustrate the success of the USI programme, with significant support provided by UNICEF/GAIN.

UNICEF advocated for continued vigilance and monitoring to ensure that gains in USI are maintained over the long-term. For example, early successes in Viet Nam proved unsustainable, with household coverage of iodized salt declining from 90 per cent in 2005 to only 45 per cent in 2011. In an effort to understand this decline, UNICEF and partners conducted a review of the programme and published lessons learned in 2015.[81] The paper identified the need for mandatory legislation, including on salt for food processing; industry responsibility to lower the cost of fortificant; increased government commitment to enforcement through routine food control systems and monitoring of iodine status through existing health/nutrition assessments; and stronger collaboration and management of the programme between sectors. These lessons will help UNICEF and partners improve development of USI programmes in other countries. Despite having one of the most successful USI programmes in the world, China has recognized the need for continued vigilance to sustain the success. In 2015, UNICEF helped consolidate programme achievements and supported studies to investigate concerns over the potential for excessive iodine intake. These efforts helped ensure strong continued national support for salt iodization and will inform the new national IDD Prevention and Control Strategy in the country.

Strengthening policies and standards for food fortification: UNICEF strengthens the capacities of governments to legislate food fortification, ensuring the addition of essential micronutrients to staple foods. In 2015, the number of countries with legislation to mandate staple cereal fortification (of at least one industrially milled cereal grain) increased to 85 countries, from 82 countries the previous year. Burundi and Malawi passed legislation to fortify wheat and maize flour and Nigeria updated its standard to include folic acid.

In its role on the executive management team for the Food Fortification Initiative (FFI), a partnership advocating for fortification in industrial grain mills, UNICEF worked to shape the food fortification agenda globally and advocate for better monitoring systems. In 2015, UNICEF co-hosted the landmark Global Summit on Food Fortification,[83] in part to promote this evidence-based and cost-effective public health intervention. In 2015, UNICEF supported the FFI in expanding research on the value of fortification for preventing iron deficiency anaemia, and contributed to the development of tools to fortify and test rice fortification in the field, and an online resource sharing platform. Due to the success of this work, Viet Nam enacted a decree to mandate food fortification to improve vitamin and mineral intake. The legislation requires adding iodine to salt, vitamin A to cooking oil, and iron and zinc to wheat flour. In addition, the decree requires the use of iodized salt in processed foods. Similarly, technical assistance provided by UNICEF and other development partners led to legislation in Malawi mandating the fortification of wheat flour, maize flour, sugar and oil.

Reflections and lessons learned

Vitamin A deficiency estimates have decreased in many parts of the world in the last two decades, but persist in South Asia and sub-Saharan Africa. A global update published in 2015 indicates that 44 per cent of children aged 6–59 months in South Asia and 48 per cent in sub-Saharan Africa are vitamin A deficient.[84] These two regions therefore remain priority settings for life-saving VAS, and UNICEF has delivered VAS through polio vaccination events in numerous countries in these regions. However, with progress towards polio eradication, new delivery mechanisms need to be established that are part of the overall health system and can effectively reach children with VAS and other high-impact interventions; Child Health Events are a promising approach.[85] Despite the aforementioned global update, national-level data on vitamin A deficiency remains outdated in many settings and updates are required to better guide programmatic actions.

A nutrition assistant measures the height of 18-month-old Hassan, at the UNICEF-supported nutrition centre in the township of Kas Koruna, on the outskirts of the city of Mardan, Khyber Pakhtunkhwa Province, Pakistan.

Over the last two decades, remarkable progress towards eliminating IDD has been achieved. The number of countries classified with iodine deficiency has fallen from 113 to 25 since 1990.[86] While there are estimates that 76 per cent of households have access to adequately iodized salt,[87] the current metrics employed to track salt iodization programmes fail to convey the true success of these programmes. For example, only six countries globally are currently classified as attaining Universal Salt Iodization. This shortcoming stems from insufficiencies in the tools employed to measure the iodine content in salt, as well as the exclusive focus on household discretionary salt as the main source of iodized salt and thus iodine in the diet. UNICEF is working with partners to improve monitoring tools that track the performance of salt iodization programmes in an effort to ensure adequate iodine status among all vulnerable groups.

MNPs play an important role in ensuring adequate micronutrient intake and reducing anaemia in young children. Globally, the number of MNP programmes has grown steadily since 2011, with programmes now active in 50 countries worldwide. A limited but growing body of evidence suggests that MNP interventions, often integrated with programmes seeking to improve IYCF, can strengthen complementary feeding practices. However, better integration of MNP and IYCF programmes and improved documentation of results is needed to understand their full potential. MNP programmes also need to be more effectively linked to malaria control programmes, in line with WHO recommendations on the use of MNPs in malaria-endemic settings. Moving forward, UNICEF will work to improve this process by strengthening collaboration with the health sector.

While micronutrient interventions remain crucial to UNICEF's nutrition programming, there is a simultaneous need to continue stimulating and improving access to a more balanced and diverse food supply, in order to reduce the need for supplements and fortification in the future. Cross-sectoral collaboration with the agricultural sector has been successful in countries such as Ethiopia and provides an important entry point for improving the quality of locally available complementary foods.

The micronutrients programme would benefit from more predictable and flexible thematic funding to continue boosting the coverage of key interventions and securing results for the most disadvantaged children.

PROGRAMME AREA 3: NUTRITION IN EMERGENCIES AND THE TREATMENT OF SEVERE ACUTE MALNUTRITION

UNICEF has worked for decades to protect the nutritional status of women and children in emergencies. In the face

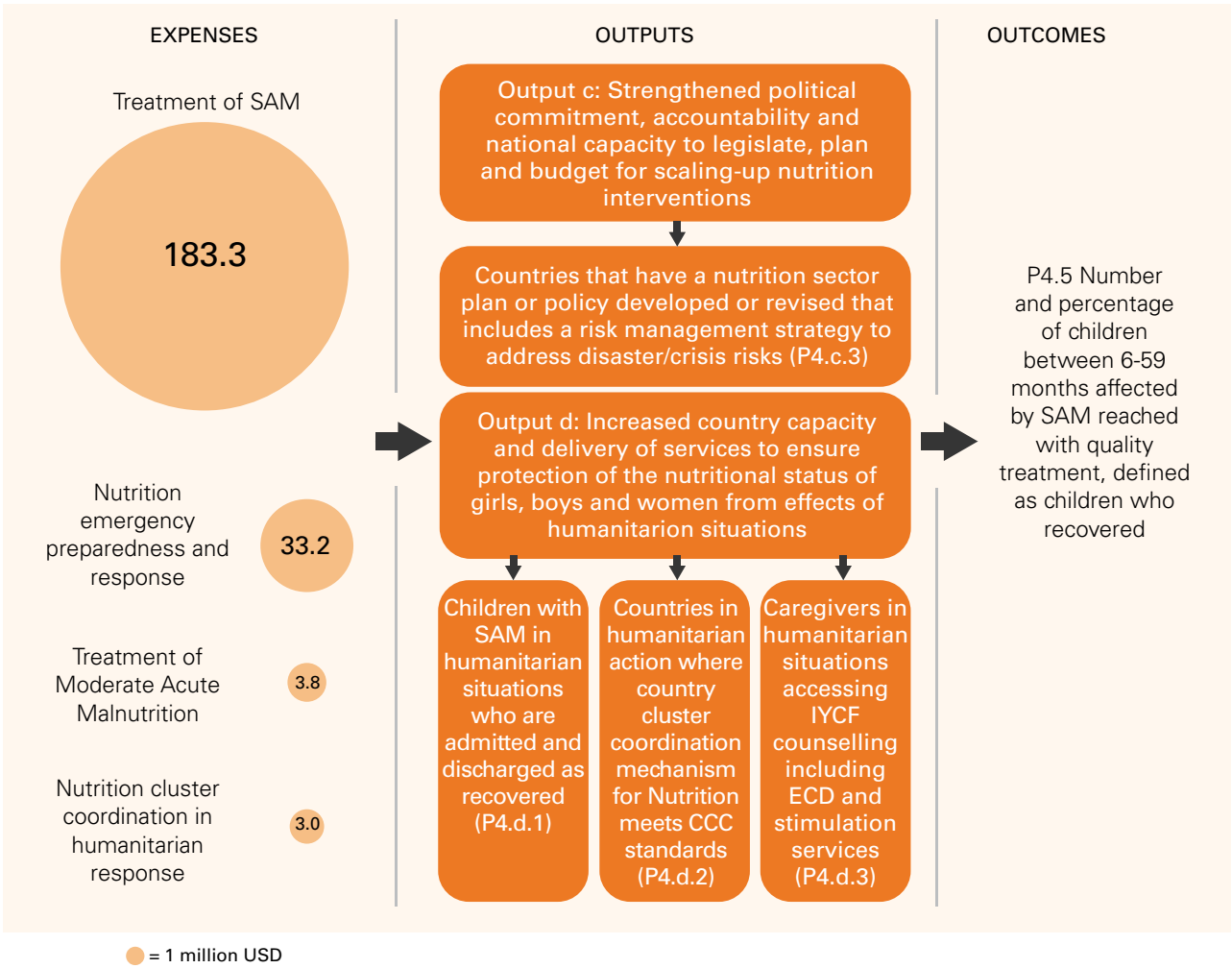
of natural disasters, conflict and fragile states, UNICEF works with governments and partners to design and deliver key nutrition interventions as part of emergency preparedness and response. Guaranteeing equal access to services and timely provision of essential supplies for vulnerable populations are key in humanitarian situations.

Coordination is critical in achieving successful emergency preparedness and response. In countries where the Nutrition Cluster has been activated, UNICEF, as cluster lead agency, has very specific accountabilities in its coordination role beyond those outlined in the Core Commitments for Children. In 2015, more than half of UNICEF country offices used nutrition interventions in their response to new and ongoing humanitarian situations.

UNICEF plays a critical role in accelerating risk-informed programming,[88] including developing new and effective responses to emergencies and ensuring strong coordination. This role is essential because setbacks due to emergencies can undermine development gains, and programmes need to be risk-informed to be resilient and sustainable in fragile contexts. Risk-informed programming thus ensures sustainable progress in nutrition and prevents countries from losing ground when emergencies strike.

The treatment and care of children suffering from severe acute malnutrition (SAM) is a crucial part of emergency response; however, the largest burden of SAM cases exists in non-emergency contexts.[89] Globally, there are an estimated 16 million children under 5 years of age suffering from SAM, the majority in East and South Asia. In 2014 and 2015, UNICEF worked to scale up SAM management in places with limited capacity and coverage, and to highlight the importance of investment in SAM management as part of emergency preparedness. During the course of the Strategic Plan, UNICEF intends to increase the scale and quality of SAM programming, treating 4 million children aged 6–59 months by 2017

FIGURE 12
Results chain for nutrition in emergencies and SAM management[90]



(baseline: 2.7 million children aged 6–59 months). Moreover, UNICEF aims to support at least 47 countries with a SAM programme to expand quality treatment[91] with a recovery rate of more than 75 per cent (baseline: 85 per cent; 29 countries).

UNICEF supports SAM management by building the capacities of governments, facilitating the development and application of norms and standards, and capturing lessons learned and promoting information and knowledge management to contribute to increased reach, coverage and quality of programmes. UNICEF supports the scale up of community-based management of SAM through engagement with ministries of health, civil society and a range of non-governmental and UN agency partners. Support efforts include coordination, technical and policy aid, capacity building, supply delivery and strengthening of the supply chain for management of SAM. UNICEF also engages with WFP and other partners to link services to best address moderate acute malnutrition (MAM).

Although global coverage of SAM management continues to increase, progress has slowed in recent years and remains insufficient to address the needs of the estimated 16 million children worldwide who suffer from SAM. Bottlenecks to scale up must be addressed, coupled with renewed efforts to prevent acute malnutrition before it starts.[92] Within nutrition, these preventative efforts involve promoting breastfeeding, improving complementary feeding practices and access to nutritious foods, planning for emergencies and
building resilience.

In 2015, expenses for UNICEF's nutrition in emergencies and SAM programming totalled US$223,259,127. Of this, US$164,626,831 was allocated to SAM management and US$58,632,296 to nutrition in emergencies. However, the interventions and results achieved in these two programme areas are often linked and mutually reinforcing. Of the combined total expenses in both areas, only 8 per cent were regular resources, while other resources (regular) and other resources (emergency) accounted for 31 per cent and 61 per cent, respectively. Figure 12 illustrates the relationship between programme spending, outputs and outcomes.

Nutrition in emergencies and SAM management output-level results

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

Scaling up SAM management in development and emergency settings: In 2015, UNICEF continued to support countries in expanding SAM programmes to serve more children, and to position SAM management within a comprehensive nutrition package for children under 5 as needed, in line with the country context.

In 2015, UNICEF supported the implementation of SAM management in both development and humanitarian contexts. With UNICEF support, 1.9 million children with SAM were admitted for treatment in humanitarian situations (reaching 65 per cent of the 2015 target), with a recovery rate of 72 per cent **(P4.d.1 – slow progress)**.[93] Of the 3.2 million SAM admissions in all settings (development and humanitarian), 2.56 million children were successfully treated, achieving a recovery rate of 82 per cent. This is compared with the 2012 baseline of 2.7 million admissions and 1.66 million successfully treated, with a recovery rate of 85 per cent **(P4.5 – on track)**.[94] Since the start of the Strategic Plan, nine additional countries have reported operational SAM management

Case study: Delivering rapid nutrition response at scale in South Sudan

South Sudan continues to face a devastating nutritional crisis: violence and mass displacement; widespread destruction of basic services; an exacerbated disease burden late and lacking rains; and a deepening economic crisis have led to widespread food insecurity and malnutrition. The situation is especially dire in conflict-affected Greater Upper Nile but also in Northern Bahr el Ghazal and Warrap states, where global acute malnutrition (GAM) rates have historically remained above emergency levels. In southern Unity state, where humanitarian access is only now being regained, food and livelihood assistance and nutrition and health services are working to avert a famine. Within this context, WFP and UNICEF renewed their partnership for a second year under their joint nutrition response plan.

In 2015, UNICEF and WFP worked with the government and other partners to scale up community management of acute malnutrition (CMAM) and infant and young child feeding (IYCF) programmes. UNICEF signed project cooperation agreements with 39 out of 53 NGOs operational in CMAM and IYCF. In stable areas, wherever possible, UNICEF supported the Ministry of Health to implement outpatient and inpatient therapeutic programmes in government-run health facilities. However, even before the current crisis, 80 per cent of social services were provided by NGOs. In areas with limited or no NGO presence due to insecurity, UNICEF and

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WFP continued to directly implement emergency nutrition services through the integrated rapid response mechanism (RRM). In 2015, the RRM programme reached 540,000 people, including 95,000 children, with multi-sectoral services such as treatment for malnutrition (including food distribution), along with other health, WASH, education and protection interventions.

UNICEF and partners reached far more children with SAM treatment in 2015 than in the previous year: 148,863 children were admitted in therapeutic feeding programmes (an increase of 58 per cent from 2014). The achievement was 99.9 per cent of the148,958 targeted children. About 39 per cent of the total admission was from the conflict-affected states of Greater Upper Nile. Figure 13 provides a comparison of SAM admissions in 2014 and 2015. In 2015, the highest number of outpatient therapeutic programme and stabilization centre sites was reached at 575 and 60 respectively. Throughout the year, the number of service sites fluctuated due to expansion and shrinkage of partners' operational areas due to the conflict. In Unity, 60 per cent of nutrition services were closed in July due to ongoing violence and displacement.

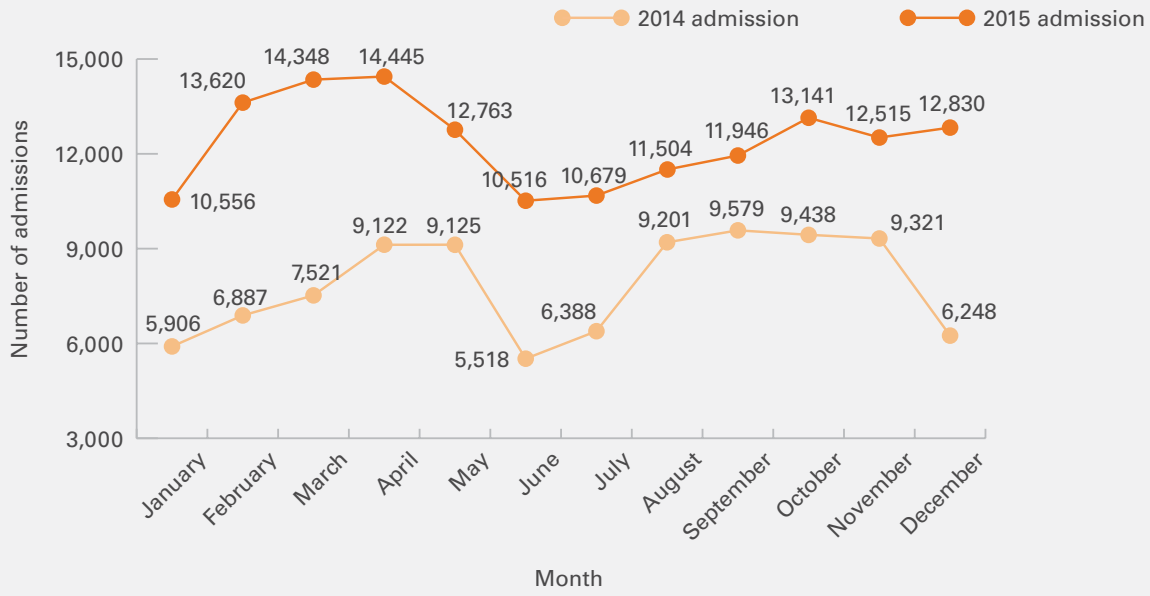
In terms of programme quality, the majority of children among those that were admitted were discharged as cured. Recovery rate over the year was reported as 88.4 per cent, above the 75 per cent Sphere standard and an improvement from 77.3 per cent in 2014, demonstrating an improved quality of services. Similarly, the death rate was 0.3 per cent (decreased from 0.8 per cent in 2014), which implies fewer children died of SAM.

There are several reasons for the increase in SAM admissions in 2015:

- Increased food insecurity and the loss of livelihoods and assets as a result of conflict induced humanitarian crisis;
- The re-establishment and expansion of services in conflict-affected areas;
- The joint scale up programme, in which door-to-door active case finding by social mobilizers was effective at targeting stable, traditionally high burden states *(see more below)*.

Figure 14 provides the number of SAM admissions by county against 2015 targets. The outpatient therapeutic programme performance indicators are shown in figure 15; all indicators are within Sphere standards.

FIGURE 13
SAM admissions in 2014, 2015, South Sudan



Source: *Monthly programme data, UNICEF South Sudan.*

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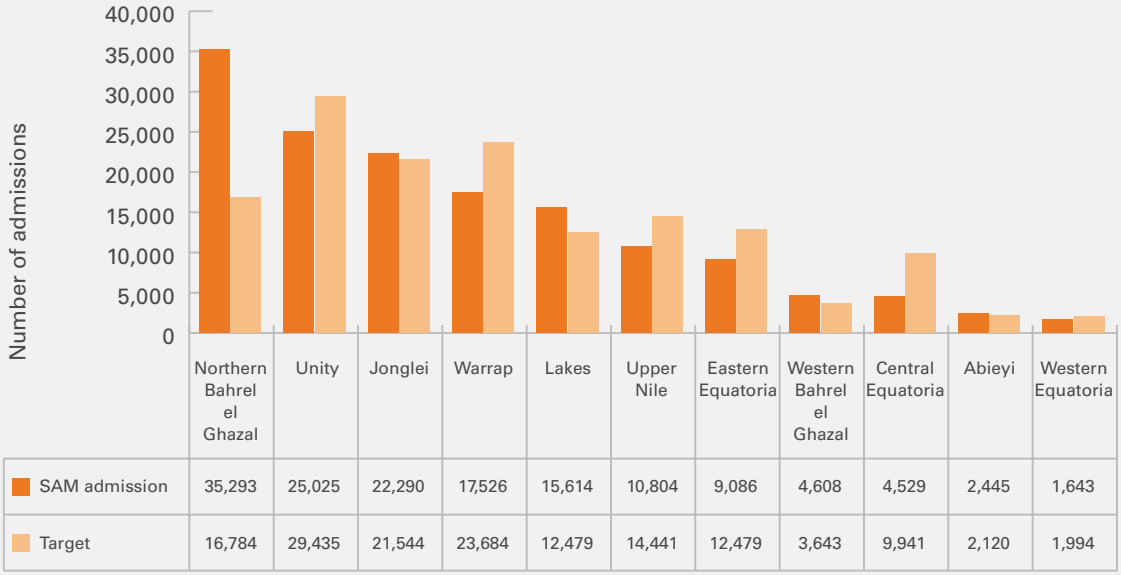
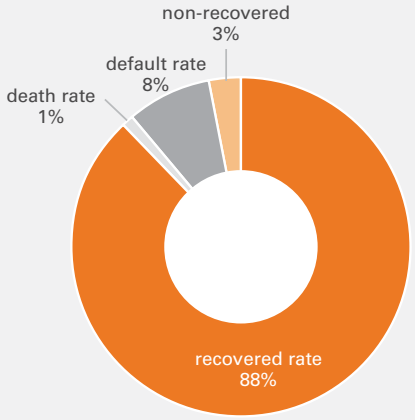
FIGURE 14
SAM admissions against 2015 targets, South Sudan



	Northern Bahrel el Ghazal	Unity	Jonglei	Warrap	Lakes	Upper Nile	Eastern Equatoria	Western Bahrel el Ghazal	Central Equatoria	Abieyi	Western Equatoria
SAM admission	35,293	25,025	22,290	17,526	15,614	10,804	9,086	4,608	4,529	2,445	1,643
Target	16,784	29,435	21,544	23,684	12,479	14,441	12,479	3,643	9,941	2,120	1,994

Source: Monthly programme data, UNICEF South Sudan

FIGURE 15
SAM performance indicators, South Sudan



Source: Monthly programme data, UNICEF South Sudan

In 2015, 59 SMART surveys were conducted, with 58 receiving validation by the Nutrition Information Working Group. Among these validated surveys, about 64 percent reported GAM levels above the 15 per cent WHO emergency threshold. Notably, about two thirds of the counties whose GAM was above the emergency threshold were from the greater Upper Nile region. Additionally, three state level food security and nutrition monitoring system assessments were carried out in March, July and November. The Nutrition Information Working Group has improved the quality of national nutrition information management systems to better inform programme performance and planning.

Social mobilizers, in place since late 2014, likely contributed to the increase in admissions for SAM treatment in 2015. In October 2014, UNICEF, with the state ministry of health and partners, trained social mobilizers, previously used for polio campaigns, to actively search for children with acute malnutrition in areas of the country that, while generally stable, have historically high levels of malnutrition. About 62 per cent of countrywide SAM admissions in the first three months of 2015 were children referred through these social mobilization initiatives.

In 2016, UNICEF/WFP and partners will continue the joint nutrition response plan to further strengthen overall efforts by expanding on the investment gains of 2015 and developing guidelines, protocols, standards and training packages to improve efficiency and response. Moving forward, 65 SMART surveys are planned for 2016. UNICEF will continue to play a central role in maintaining the routine database for treatment of SAM from partners. In addition, UNICEF will undertake a nutrition causal analysis in two high-burden states, and support partners in coverage surveys.

services; however, the global gap between SAM burden (roughly 16 million)[95] and admissions remains vast, with wide regional variation. The largest gap between burden and admissions is in South Asia.

According to current data, 80 countries are providing SAM management services with help from UNICEF.[96] In 2015, supported by USAID/Food for Peace (FFP), UNICEF worked to scale up SAM management in 17 countries with a target of reaching 447,971 children. USAID-FFP has been instrumental in sustaining efficient coverage of treatment as well as identifying critical challenges and barriers to scale up at programme and system levels. In total, 328,571 children with SAM were treated in 18 countries between January and November 2015, representing about 75 per cent of the target. Against the global award, an additional 40,713 children in Haiti (11,207) and Pakistan (29,506) were supported.[97] Particularly successful results included Afghanistan, where 90 per cent of the target was met; Burundi, which reached 100 per cent of targeted children; and Pakistan, which achieved 92 per cent of its target.

In South Sudan, WFP and UNICEF renewed their partnership for a second year to address serious levels of acute malnutrition and food insecurity in the country. Together, the two agencies reached far more children in 2015 than during the previous year: 148,863 children were treated for SAM (an increase of 58 per cent from 2014) and 226,935 children were treated for MAM (a 100 per cent increase) *(see box 'Case study: Delivering rapid nutrition response at scale in South Sudan' above)*. In Somalia, 112,829 children under age 5 with SAM were treated, with 92 per cent recovery rates. Despite this achievement, UNICEF faced immense challenges in achieving coverage due to the volatile security situation in the country: nearly 50 per cent of targeted children, largely in difficult-to-access areas, did not have access to services in 2015.

UNICEF's supply division responded to the drought emergency in Ethiopia with one of its largest-ever orders for ready-to-use therapeutic food (RUTF) and other nutrition supplies. With support from UNICEF, the Government of Ethiopia adopted and quickly scaled up a phased CMAM approach countrywide as part of the emergency response. Ethiopia was already benefitting from a vast regional network of more than 15,000 outpatient and stabilization centres (13,906 outpatient therapeutic programme and 1,167 stabilization centres) staffed by over 38,000 health workers or health extension workers trained in SAM management. From January to December 2015, a total of 350,451 SAM cases were treated, exceeding the 302,000 targeted cases. Emergency funds were also mobilized to hasten delivery of nutrition supplies for emerging needs in the Sahel region. As part of the nutrition response to the earthquake in Nepal, 374 441 children aged 6–59 months (94.3 per cent of target) were screened with mid-upper-arm-circumference (MUAC), and 1,119 children with SAM (67.8 per cent of target) were referred to the CMAM programme. The coverage was lower than the intended 80 per cent, likely due to an overestimation of the expected number of children with SAM.[98]

UNICEF's CMAM programme in Nigeria, one of the largest non-emergency CMAM programmes in the world, demonstrates that high-quality large-scale treatment services can be successfully delivered through a government health system. The programme has grown exponentially over the last five years, with more than 320,000 children admitted for treatment in 2014 alone. Overall performance has significantly improved and the majority of states (nine out of 11) now consistently meet Sphere treatment standards. With technical support from UNICEF and funding from the Children's Investment Fund Foundation (CIFF), the EU and its Humanitarian Aid and Civil Protection Department (ECHO), USAID, the Japan International Cooperation Agency, BMGF, the Central Emergency Response Fund and the UK Department for International Development (DFID), there are now 642 government-run CMAM sites delivering life-saving treatment across 11 states in Northern Nigeria. From 2009 to May 2015, 1,085,498 children were admitted for treatment, curing an estimated 831,686 children and saving an estimated 207,805 lives.[99] In Yemen, UNICEF provided treatment to over 158,000 children under 5 with SAM through enrolment in the outpatient therapeutic feeding programmes and therapeutic feeding centres. UNICEF also continued the implementation of community based interventions with the objective of reducing stunting in 13 districts. The number of mobile teams providing maternal and child health and nutrition services was increased from 25 prior to the conflict to 94 by the end of 2015. The mobile teams ensure community mobilization and access to health and nutrition interventions in highly insecure and hard-to-access areas.

In 2015, UNICEF conducted an assessment of the effectiveness of Pakistan's CMAM programme that provides care for children with uncomplicated severe wasting. The design looked at retrospective case series analyses of 32,950 children aged 6–59 months admitted to the programme with a MUAC below 115 mm (1 January to 31 December 2014). The results indicated that Pakistan's CMAM programme is effective in achieving good survival and recovery rates. Moreover, it suggested that population-level impact could be increased by giving priority to screening children aged 6–23 months and girls, treating children with multiple anthropometric failure (wasted and stunted) and scaling up CMAM where the burden of SAM is greatest. In India, the Ministry of Health and Family Welfare, with the support of UNICEF and other partners, developed a training package for medical officers and nurses in nutrition rehabilitation centres detailing operational guidelines for facility-based management of children with SAM. UNICEF trained over 40 national-level master trainers as well as a pool of state-level trainers in over 17 states. A UNICEF assessment of nutritional rehabilitation centres from January to March 2015 concluded that all states had very low death rates, between 0–1.1 per cent (average death

rate 0.3 per cent). Given that there is no CMAM in India, and that the country has yet to revise its discharge criteria based on the WHO 2013 recommendations, recovery rate is not being reported.

UNICEF worked to generate policy dialogue on SAM and build the capacities of national actors to scale up programming. In 2015, UNICEF participated in a regional meeting in Bangkok to address the low coverage in the East Asia and Pacific region and advocate for the integration of SAM into routine health systems for effective and sustainable coverage. Countries also identified specific planning, actions and technical support needs.

Integrating SAM and HIV screening and management: In high HIV-burden countries, many children with SAM are HIV-positive.[100] The recovery and outcome of HIV-positive SAM cases largely depends on whether the child is identified as having HIV and provided with antiretroviral therapy. HIV testing for children with SAM is a part of normative guidance, including in WHO guidelines on the management of severe acute malnutrition in infants and children,[101] and the Sphere standards in humanitarian response.[102] According to global guidance, children who are tested for HIV and found positive should immediately begin taking a combination of antiretroviral drugs, special foods and antibiotics to treat SAM.

"(In Yemen) the number of mobile teams providing maternal and child health and nutrition services was increased from 25 prior to the conflict to 94 by the end of 2015."

In Burkina Faso, the number of AIDS-affected children receiving antiretroviral therapy increased from 1,328 in 2010 to 2,241 in June 2015, as a result of early identification, testing and diagnosis for exposed children. This work, begun in 2011 by targeting children with SAM and complications in a few hospitals, increased to include eight regional hospitals in 2015 (up from three in 2012). In Malawi, UNICEF worked to integrate HIV and nutrition response to optimize treatment for malnutrition and increase HIV diagnosis. During the flooding and food crisis in Malawi, there was a spike in mortality at nutrition rehabilitation units, particularly among HIV-infected children. Between January and June 2015, in the three most flood-affected districts, a total of 757 children were admitted to nutrition rehabilitation units, with complicated cases of SAM. Seventy-seven per cent of admissions were tested; 26 per cent (151) were HIV positive. Sixty-one percent (92 of 151) of the HIV-positive children diagnosed in the nutrition rehabilitation units were initiated on antiretroviral therapy.

In 2014, 45 countries (of 73 using NutriDash to report SAM management data) reported that they had guidelines or protocols regarding SAM treatment for HIV-infected children that reflected WHO recommendations; 27 countries reported that health facilities provided integrated HIV and SAM treatment, as well as HIV service referrals for children receiving treatment for acute malnutrition; seven countries reported a total of a little over 3,000 children admitted to SAM treatment who tested HIV positive and were referred for treatment. Of the six countries that reported on all elements, half were part of the 22 priority countries of the global plan for eliminating new HIV in children.[103] These figures demonstrated that although integrated services were available in some countries, and exist at the level of policies and guidelines, there was still limited data collection, analysis and reporting on the scale of services and numbers of children being reached by HIV testing and referred for antiretroviral therapy. The fact that more countries did not report indicates the need to strengthen reporting around this intervention area. In addition, updated estimates on SAM-HIV burden and increased documentation of effective SAM-HIV programming are critical in order to guide scale-up supportive services for HIV and SAM.

Improving supply management for the treatment of SAM: The continuous availability of therapeutic supplies is essential to the provision and uptake of SAM services. Globally, UNICEF procures approximately 80 per cent of RUTF, and the majority of therapeutic milk (F-75, F100) used in the treatment of SAM with complications.[104] In 2015, UNICEF secured 34,851 metric tonnes of RUTF, 38 per cent of which was sourced in countries where UNICEF has a SAM programme. UNICEF continues to support local production of RUTF, diversifying its supplier base to include 16 manufacturers in 13 countries. Procurement of RUTF in 2015 reached 2.5 million cartons for 62 countries, the largest quantity to date. In addition, UNICEF managed in 2015 the supply of 476 thousand cartons donated by USAID/FFP.

More and more countries are working to incorporate RUTF into national supply systems. The annual supply forecast was recently added to UNICEF's NutriDash platform to help country staff predict annual supply needs. The supply data is crucial in allowing UNICEF to engage with producers to ensure global supplies are available when needed. According to NutriDash, the number of countries including RUTF on the essential supplies list has grown steadily, from 21 countries in 2012 to 25 in 2013 to 31 in 2014. Sixty-six per cent (2.1 million) of all children treated for SAM globally are admitted in the 31 countries where RUTF is on the essential medical supplies list.

UNICEF presented a proposal to the Codex Committee on Nutrition and Foods for Special Dietary Uses that a guideline for RUTF be developed, an important step in allowing countries to better regulate and manage the

supply and use of quality RUTF in their programmes. The proposal was accepted at the 37th Meeting of the Committee in November 2015. A supply chain specialist funded by the USAID-FFP grant joined UNICEF's supply division in April 2015 to work with governments and partners to successfully oversee their nutrition supply chains. A technical support package is under development and includes supply chain assessment tools, guidelines for quality assurance, tools that help forecast nutrition supplies, and inventory and supply chain performance monitoring. With FFP support in November 2015, the supply division provided technical assistance to the Government of Afghanistan to develop comprehensive Standard Operating Procedures for the nutrition supply chain, providing guidelines for actions ranging from assessing warehouse and storage capacity for nutrition commodities to developing supply pipeline monitoring tools to more clearly track inventory availability along the supply chain to improving the nutrition supply chain management within the health sector in the country.

Regionally, the UNICEF Eastern and Southern African Regional Office (ESARO) scaled up efforts to reduce dependency on a small number of international RUTF manufacturers and to expand local production capacity, resulting in the certification of six local manufacturers. In 2015, financial institutions participating in a UNICEF nutrition industry consultation created bilateral relationships with manufacturers that resulted in a turnaround for quality RUTF manufactured in East Africa. UNICEF ESARO and the UNICEF West and Central Africa Regional Office (WCARO) also commissioned a comprehensive review of nutrition supply chain studies in nine countries. The study, completed at the end of 2015, revealed both bottlenecks to and solutions for ensuring nutrition supply chain integration in the health system in different country settings. While market-influencing strategies have largely stabilized the availability and affordability of essential and lifesaving supplies at the country level, attention is now increasingly placed on strengthening national systems to ensure that essential supplies reach intended recipients efficiently. For example, in 2015, ESARO led a pilot of procurement and supply management integration initiatives in Uganda and Zambia under the agreement between UNICEF and the Global Fund to Fight AIDS, Tuberculosis and Malaria. ESARO also conducted country-based nutrition supply chain reviews in Burundi, Ethiopia, Kenya and Malawi to strengthen planning and logistics for UNICEF and partners.

UNICEF's nutrition supply chain management in Somalia improved due to well-managed quarterly supply planning and the distribution process adopted in early 2015. Only 0.5 per cent of nutrition centres reported shortages of essential nutrition supplies last year; however, preventing

"Procurement of RUTF in 2015 reached 2.5 million cartons for 62 countries, the largest quantity to date."

leakage (the illegal sale of RUTF) in the marketplace is still a challenge. In order to enhance the security of the RUTF pipeline, UNICEF integrated RUTF into the quarterly market monitoring assessments. In addition, UNICEF has been working closely with its partners to promote community awareness of the use of RUTF. To counter difficulties in moving supplies within Yemen, UNICEF established a logistical hub in Djibouti from which supplies can be transported to different ports in smaller and more manageable quantities, thereby reducing transportation costs and minimizing security risks.

Using SAM bottleneck analysis to promote equity: The bottleneck analysis (BNA) approach is at the heart of UNICEF's cross-sectoral, equity-focused programming and monitoring, and can help identify and target barriers that prevent services from reaching the most disadvantaged children. Over the last two years, UNICEF has led governments and partners in conducting bottleneck analysis exercises for SAM management services in a number of different settings (stable and emergency/secure and fragile). In several countries, the findings have fed into national plans to strengthen and scale up SAM management services, ensuring ownership, commitment and funding support from governments and partners. UNICEF, ACF-UK and Coverage Monitoring Network (CMN)[105] have built on this foundation in 2015 through undertaking a pilot to generate further evidence and define indicators.

While many countries are aware of challenges to SAM management services, the added value of the BNA approach is in defining the relative importance of each barrier, determining the order in which issues should be addressed to best increase effective coverage. This approach, which strengthens government and partner consensus in all phases, has been rolled out for SAM management services in six countries[106] to date, though further support is needed to help governments systematically apply the process moving forward.[107]

Afghanistan, Malawi and the United Republic of Tanzania *(see box 'Case study: Addressing barriers and bottlenecks to effective coverage in Afghanistan' below)* undertook bottleneck analysis exercises for SAM management in 2015, leading to concrete outcomes. In Malawi, the exercise identified three key bottlenecks and root causes and proposed solutions, which led to the development of the 2015–2020 CMAM Operational Plan and evaluative exercises including a review of the supply chain. This

Case study: Addressing barriers and bottlenecks to effective coverage in Afghanistan

Afghanistan has implemented bottleneck analysis exercises for SAM management. With a national SAM burden of over 500,000 children, addressing acute malnutrition was highlighted in the national nutrition policy with a target to provide management for 70 per cent of SAM cases by 2015.[108]

Despite expanding the integrated management of acute malnutrition (IMAM) services to all the 34 provinces, the programme was only reaching 30 per cent of the estimated SAM burden. A bottleneck analysis was conducted from August to October 2015 to identify barriers preventing access to services. The aim for BNA is to integrate it into existing nutrition information systems so that swift corrective actions are based on regularly collected and readily available data. In Afghanistan, the SAM BNA was able to draw from routine data and required less new data collection, making it a feasible entry point.

The introduction of the BNA approach went through several steps that included stakeholder participation to allow for government and partner consensus in all phases; joint implementation and ownership by different stakeholders also promoted future sustainability. The first two-day workshop was held with a focus on adapting and understanding the generic indicators and methodology of the BNA exercise. Subsequently, training identified data not routinely collected in the nutrition database, including that on stocks and human resources. The outpatient SAM management service and RUTF supply status were traced back to determine geographic coverage and the availability of therapeutic supplies.

During a four-day workshop, 38 participants from government and partners focused on data from January to June 2015 in order to identify bottlenecks, root causes and effective solutions. The main bottlenecks of SAM management supply services included inadequate human resources (with only 34.8 per cent of clinicians and 36.5 per cent of community health supervisors trained on IMAM) and poor geographic reach (only 38 per cent of health facilities were providing outpatient SAM services).[109] Commodities-related weaknesses stemmed from shortages in which only 60.5 per cent of the outpatient SAM sites did not report stock-outs of RUTF for more than two weeks during January to June 2015. The utilization of the SAM management services was low, with 34.5 per cent of the estimated SAM burden admitted. And quality of the services remained a concern as only 24.7 per cent of admitted SAM cases were cured.[110] Based on the BNA, a detailed regional plan with new and prioritized corrective actions was developed, along with a monitoring framework.

The BNA findings informed UNICEF's annual nutrition 2016–2017 rolling work plan in Afghanistan; during coordination meetings with the government, the results helped plan for scale-up and strengthened IMAM services. Coordination meetings are held periodically to harmonize and streamline nutrition services as a result of the BNA findings. The IMAM technical working group is currently reviewing procedures for stock management and training for stakeholders at national and provincial level is under way. Advocacy to include RUTF in the essential drugs list is continuing. The need to strengthen community-based nutrition programmes and improve the quality of data was also identified. The BNA findings triggered timely corrective actions, with the government prioritizing additional outpatient SAM management services in some provinces where currently there are none.

The Afghanistan BNA exercise for SAM management services demonstrates how effectively the exercise can be used in conflict-affected or fragile countries. Overall, the BNA exercise was a cost-effective programme monitoring approach. Many of the identified bottlenecks stemmed from lack of prioritization of SAM management. This has an impact on the supply, whether in terms of delivery protocols, human resource training or the inclusion of SAM in outreach activities. On the demand side, weak community outreach limits awareness about SAM. The need for better standard operating procedures and improved training for supply chain management, incentives for community health workers, more supportive supervision to ensure quality of services and better documentation of information were some proposed solutions. UNICEF will continue to provide technical support in Afghanistan for conducting BNA periodically but will progressively shift responsibility to the Ministry of Public Health.

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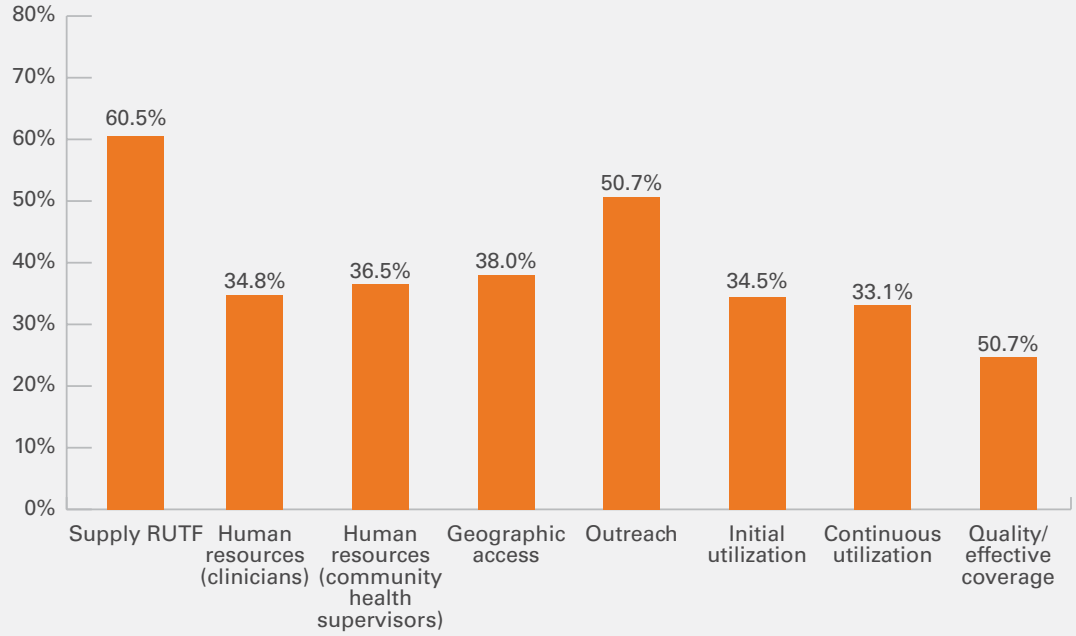
FIGURE 16
National SAM bottleneck analysis, Afghanistan



Source: *2015 IMAM Database, Public Health Department Afghanistan.*

plan, now in effect, includes a provision for district level bottleneck analysis to inform annual district level planning. Demand for BNA from countries is increasing, and more flexible funding would help UNICEF respond effectively to these growing needs in 2016.

Strengthening coordination and rapid 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 and working to ensure that women and children receive equal access to services and essential supplies. Over the course of the Strategic Plan period, UNICEF intends to support 100 per cent of countries in humanitarian action where country cluster or sector coordination mechanisms for nutrition meet CCC standards for coordination (baseline: 20 countries). In 2015, 13 out of 14 countries in humanitarian action met this objective, just short of the target **(P4.d.2 – on track)**.[111,112]

UNICEF and partners further strengthened the humanitarian response at the regional level in 2015. UNICEF ESARO was active in highlighting the continued vulnerability of the Greater Horn of Africa to food and nutrition crises, and worked closely with the FAO, WFP, OCHA and UNHCR regional offices to improve preparedness and action in response to food and nutrition insecurity in the sub region. This resulted in all UN country teams from affected countries preparing integrated response plans for food security and nutrition, and resources were mobilized for support at country and regional level. UNICEF and its partners also worked for more coordinated joint technical support to priority countries at the regional level. These preparations proved timely, given the disruptions caused by El Niño later in 2015. Despite being prone to natural disasters, few Latin American countries with UNICEF offices have nutrition staff responsible for coordinating nutrition responses during emergencies. UNICEF's Latin America and Caribbean Regional Office (LACRO) has addressed this absence by including the role of a regional nutrition cluster coordinator in the tasks of the regional nutrition specialist. The newly established Integrated Nutrition Resilience Group (GRIN)[113] has also developed a matrix to better define and monitor regional and national nutrition emergency preparedness and response capacity.

In 2014 and 2015, UNICEF's coordination was integral to managing the nutrition response during the Ebola crisis. In Guinea, UNICEF-led cluster coordination focused on heavily affected regions, particularly those with the highest malnutrition rates, and reached over 2,000 Ebola-affected children, including some children who had lost one or both parents, and over 7,000 children with SAM

in Ebola-affected communities. UNICEF also supported outreach campaigns to provide nutrition interventions to children under 5. Over 76 per cent of the targeted 1.7 million children aged 6–59 months received vitamin A supplements and 74 per cent of children aged 12–59 months were dewormed despite the Ebola epidemic. During the recovery phase, over 2,000 community health workers received training in IYCF counselling and promotion, and the provision of MNPs. UNICEF also focused on improving the quality of care provided to children with SAM in all 410 government health centers and 38 hospitals.

As the crisis continued in South Sudan with alarming levels of food insecurity and malnutrition, WFP and UNICEF renewed their partnership for a second year under the Joint Nutrition Response Plan (June 2015–May 2016). Since late April 2015, violence has escalated, further deteriorating the humanitarian operations and deep field presence of partners. As populations continue to move into harder to reach areas, the rapid response mechanism (RRM) will likely become the main way to access the affected population. UNICEF, WFP and partners have worked rapidly to negotiate access in order to maintain aid despite the volatile situation in Unity state. The agencies remain flexible in their approaches, deploying RRM teams, helping partners re-establish services where possible, or providing survival kits or supplies to partners when access is most limited. In 2015, the RRM programme provided services such as treatment for malnutrition to 540,000 people, including 95,000 children *(see box 'Case study: Delivering rapid nutrition response at scale in South Sudan' above)*.

UNICEF coordinated rapid and effective support in other countries throughout 2015. Immediately after the earthquake in April 2015, the Government of Nepal declared a state of emergency and requested that the United Nations activate humanitarian clusters. The Nutrition Cluster, led by the Ministry of Health and Population, and including UNICEF and 28 national and international partners, devised a highly effective 3-month (May–July 2015) emergency nutrition response *(see box 'Case study: Child Nutrition Week delivers essential nutrition services to children after the Nepal earthquake' above in the micronutrients section)*. Within 48 hours of the arrival of the first Burundian refugees in Rwanda, UNICEF regional and country offices and their partners deployed supplies to the transit camps. As a result of UNICEF programming, over 56,000 Burundian refugee children had access to education and more than 1,800 received treatment for SAM.

In 2014–2015, the WASH, Nutrition and Education Clusters mapped humanitarian sector coordination mechanisms globally and analysed both best practices and bottlenecks to cluster transition. The recently finalized nutrition cluster transition study highlighted lessons learned from four countries where the Nutrition Cluster operated, including protracted emergency and sudden onset natural disaster scenarios. Along with the country-specific analyses, a generic framework of best practice, working principles and cluster transition benchmarks guidance per sector was produced, to inform the global and country level work moving forward. The study was particularly concerned with Nutrition Cluster transitioning from internationally led mechanisms to nationally led nutrition emergency preparedness and response coordination mechanisms. In collaboration with the Global Nutrition Cluster, UNICEF is planning phase 2 of the transition study to help develop comprehensive guidance for operationalizing investments in nutrition coordination in preparedness, response and transition.

Protecting IYCF in emergencies: Deteriorating WASH and health situations during emergencies combine with displacement and distress to impact a mother's ability to feed and care for her children; IYCF programming is especially crucial to preventing increased morbidity and mortality in those times of crisis. UNICEF advocates for countries to integrate IYCF counselling and support into emergency preparedness and response to support mothers and caregivers and provide safe IYCF spaces. In 2015, more than 80 per cent of UNICEF-targeted caregivers of children aged 0–23 months (more than 6 million) received IYCF counselling in humanitarian situations (from a total of 69 responding countries). The number of caregivers benefitting from the promotion of early childhood stimulation and development as part of IYCF counselling in humanitarian situations decreased from 1,491,211 in 2014 to 770,671 in 2015. This coverage of 16 per cent falls far below the expected 2015 target of 48 per cent **(P4.d.3 – off track)**.[114]

In emergencies, the use of breastmilk substitutes can increase the risks of illness, malnutrition and death and disrupt the protection provided by breastfeeding. At the same time, breastmilk substitutes are a necessity for non-breastfed infants, and strategies must be in place to monitor their distribution. In response to the migrant crisis in Europe, UNICEF, UNHCR, WHO, the Emergency Nutrition Network (ENN) and Save the Children developed interim operational guidance[115] to promote and enable infant and young-child feeding for persons in transit, and to monitor the distribution of breastmilk substitutes. The guidance filled a gap in existing global recommendations that did not adequately take into account the specific support needed for populations in transit. Consistency of services for both breastfed and non-breastfed infants across different transit points is essential in order to equip families with information and ensure equitable access to nutrition and, in particular, IYCF services. An interagency technical discussion group on the issue will begin work in early 2016 to provide consistent guidance.

The conflict in Ukraine has negatively impacted breastfeeding. A 2015 assessment among internally displaced children aged less than 6 months concluded that only 26 per cent of them were exclusively breastfed and many mothers were receiving poor IYCF support

from health workers. UNICEF supported a capacity building workshop on infant feeding in emergencies and worked jointly with other Nutrition Sub-Cluster members to reach an agreement on monitoring the distribution of breastmilk substitutes while strengthening support for breastfeeding. The Government of Ukraine issued a statement on IYCF in emergencies, endorsed by UNICEF and WHO that emphasized the importance of protecting, promoting and supporting breastfeeding. By the end of the year, 73,400 mothers in affected areas and IDP areas had been reached with information on the benefits of exclusive breastfeeding in emergencies.[116]

In Jordan, UNICEF continued to facilitate the IYCF programme, covering refugee camps and host communities (Aqaba, Maan, Karak, Jordan Valley, Irbid and Mafraq). The Raba'a Al Sarhan new arrival registration site included safe and calm areas for mothers to breastfeed, along with a roving IYCF mobile van designed to conduct sessions in the remote, hard-to-reach areas. These efforts were possible due to strong partnerships with a range of community-based organizations, health centres, public and private hospitals and the Ministry of Social Development. Overall, 6,469 pregnant and lactating mothers were provided IYCF education and counseling through IYCF centres and outreach activities in the camps and host communities. In addition, 5,556 children under the age of five benefited from the supplementary feeding programme. IYCF caravans in the refugee camps reached out to at least 60,000 pregnant and lactating mothers (82 per cent of target as of November 2015) with one-to-one counselling sessions on breastfeeding, nutrition support and guidance. An evaluation of this three-year IYCF programme is being conducted and expected to be complete in early 2016.

In 2015, UNICEF conducted a study of Mali's experience implementing the Care for Child Development (CCD) initiative. Designed to raise the importance of early stimulation in the context of food crises, CCD is a holistic ECD intervention that provides information and recommendations for cognitive stimulation and social support to young children through caregiver-child interactions. The programme in Mali aimed to change the developmental trajectory of affected children, focusing on malnourished children through both clinic and home-based activities. The experience gained through the 100 stimulation centers in the targeted communities (Sikasso, Mopti and Timbuktu) is being considered for expansion at the national level. The Mali study documented the implementation of the programme, which coincided with the security crisis and increased levels of malnutrition, with the following findings: a) programming must consider support for the planning and preparation of family meals in order to facilitate the uptake of nutrition messages; b) paternal/external family involvement should be strengthened within programme delivery; c) the needs of the primary caretaker, not just of the young child, must also be addressed. These results contributed to the evidence for building an efficacious scale-up process in the country.

Delivering essential micronutrients in emergencies: In humanitarian situations, food insecurity, poor WASH conditions and disease can cause micronutrient deficiencies and exacerbate those that already exist. UNICEF works to ensure that vulnerable populations have access to micronutrient supplementation and fortification to prevent and treat such deficiencies. In Nepal, Child Nutrition Week, implemented between June and July 2015 and supported by UNICEF, reached 410,795 children younger than 5, pregnant women and breastfeeding mothers (87.9 per cent of target) with key micronutrient interventions *(see box 'Case study: Child Nutrition Week delivers essential nutrition services to children after the Nepal earthquake' in the micronutrients section above).*

In 2015, UNICEF supported the Federal Government and state governments of Nigeria to scale up the distribution of MNPs to children aged 6–23 months in three states affected by the Boko Haram insurgency. The emergency programme was initially scaled up in 18 government-managed camps for internally displaced persons, and 120 primary health care facilities in strategic locations, reaching nearly 23,000 children in the second half of 2015. The programme continues to expand and, in 2016, an additional 340 health care facilities will begin distribution to help all children in these states gain access to this intervention. In South Sudan, UNICEF met its targets for vitamin A supplementation, reaching 2,066,379 children in 2015.

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

Strengthening planning and guidance: Investments in emergency preparedness, coordination and flexible programming are critical, in both emergency and non-emergency contexts. In 2015, 63 out of 93 countries (68 per cent) reported having a nutrition sector plan or policy developed or revised and a risk management strategy to address crisis risks such as natural disaster or conflict. This represents an increase from 56 countries in 2014 **(P.4.c.3 – on track)**.[117] Moving forward, UNICEF will roll out its risk-informed programming guidance and build capacity for disaster risk reduction, emergency preparedness and emergency response.

In 2015, UNICEF finalized and disseminated its SAM Programme Guidance[118] in English, French and Spanish. The guidance aims to provide the practical guidance at country level required to establish and continue scaling up community-based management of SAM by integrating and strengthening existing systems. UNICEF also developed guidance on 'Including children with disabilities in humanitarian action – Nutrition', which was validated in Nepal in the context of their nutrition earthquake-response programme. In addition, UNICEF drafted a guidance note on risk-informed programming in nutrition, and the approach was piloted in Ethiopia in 2015. The

A mother from Luhansk breastfeeds her baby while taking part in a workshop on breastfeeding in emergencies organized by UNICEF in Kyiv, Ukraine.

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guidance aims to strengthen risk analysis to ensure that programme planning and design are better informed and thus more flexible and adaptable to their contexts. UNICEF also participated on the interagency task team on HIV and food and nutrition, advocating for HIV testing in SAM treatment centres in high-HIV prevalence settings.

Building resilience: Resilience building helps communities anticipate, withstand and bounce back from crises and is critical to UNICEF's work in humanitarian situations. In Ethiopia, the joint UNICEF/WFP/FAO food and nutrition security resilience strategy aims to build communities' resilience through focused programming that includes community-based nutrition, nutrition-sensitive agriculture with livelihood diversification, social protection, food and nutrition-sensitive disaster risk management, robust knowledge management and strengthening of regional and *woreda* government systems. The CMAM programme in Ethiopia is integrated into the health system and the introduction of Mobile Health and Nutrition Teams in Somali and Afar regions has strengthened resilience in these communities and helped to ensure equitable access for the most vulnerable.

Case study: Risk-informed programming for improved nutrition resilience in Kenya

The Kenya nutrition programme was historically dependent on emergency financing for short-term emergency response activities in the chronically food insecure arid and semi-arid livelihood counties where high rates of acute malnutrition (>20 per cent) persist year after year. Under UNICEF's leadership, this changed in 2010, with short term emergency funding being allocated to systems strengthening and the integration of nutrition services into the existing maternal and child health programme. In the 2011/2012 evaluation of the Horn of Africa response, the approach was highlighted as a successful example of improved coordination and service delivery leadership.

Building on this experience, UNICEF aimed to further improve the risk-informed focus of the health system in Kenya. With four-year development funding from the EU, and existing funding from DFID and USAID/Office of U.S. Foreign Disaster Assistance, UNICEF commissioned the development of a nutrition resilience policy framework for Kenya in 2015. The policy aims to strengthen the understanding and application of resilience in nutrition programmes, while also advocating for increased nutrition-sensitive interventions in other sectors such as WASH, food security and social protection. The policy is referenced within the national Ending Drought Emergencies Common Programming Framework.

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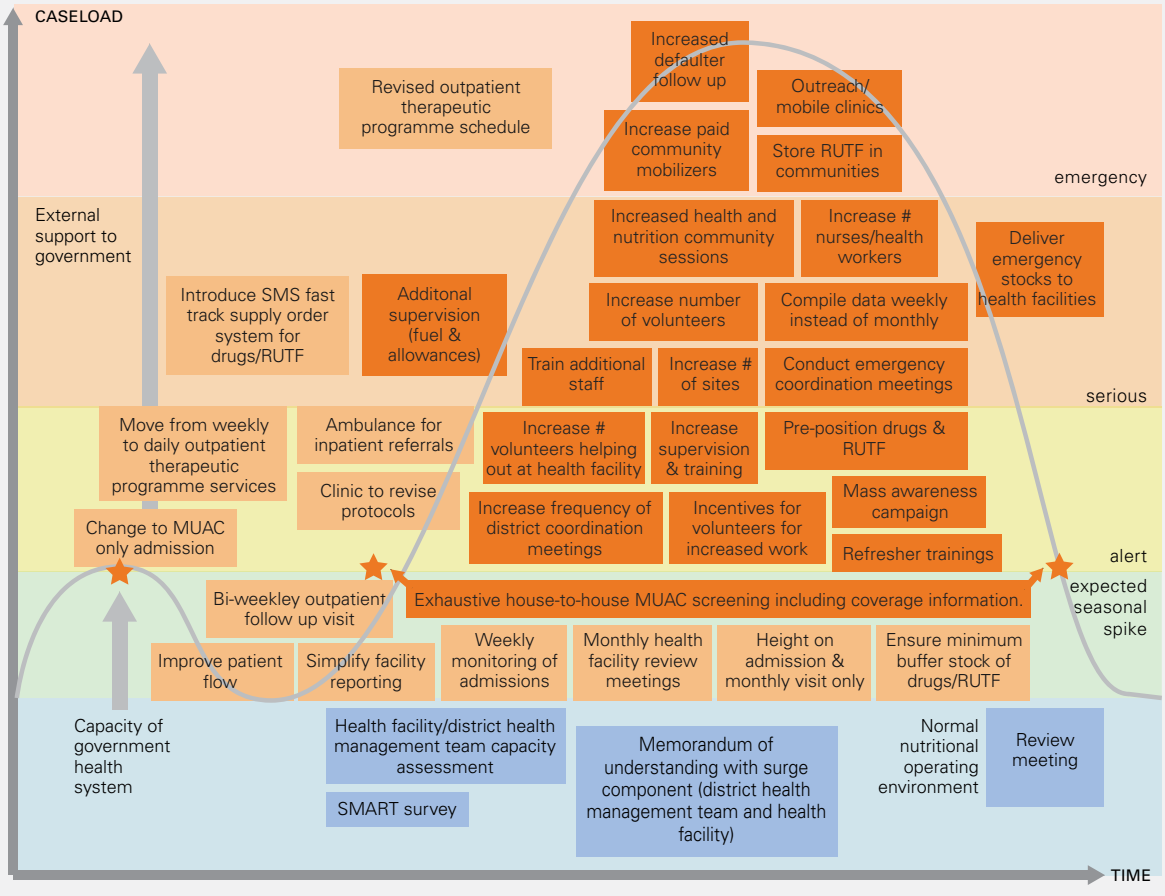
In consultation with the Ministry of Health, and several other governmental authorities for the arid lands, UNICEF used the nutrition resilience framework to develop an integrated nutrition resilience programme for the 23 arid and semi-arid counties, at varying degrees of intensity based on vulnerability and capacity. The Maternal and Child Nutrition Programme (MNCP) is the cornerstone of the nutrition sector, providing integrated support to service delivery, demand creation, evidence generation and policy development for the most vulnerable counties.

A 'surge model' *(see Figure 17)*, supported by UNICEF, was employed as a key MNCP strategy to improve the adaptability of county level health systems in potential emergencies. The surge model allows for scale-up and scale-down as needed to respond to predictable increases in admissions of cases of severe acute malnutrition. The approach was first developed and piloted by Concern Worldwide in 14 health facilities in Marsabit, and after compelling results from a 2015 evaluation, it was incorporated into the MCNP to promote systems strengthening. The evaluation noted the surge model's effectiveness at strengthening health systems and managing increased caseloads of severe acute malnutrition. The surge model also improved coverage and use of data and communication between the health facility and sub-county health management team. Overall, the evaluation recommended a further scale-up within the pilot sub-counties, at a wider scale in Kenya and elsewhere.

FIGURE 17
The surge package, Kenya



Source: Concern Worldwide, 2014.

UNICEF is also supporting the integration of risk-informed county-level actions into the surge model using early warning information routinely collected by the National Drought Management Authority through remote sensing called VCI.[119]

Regionally, in Eastern and Southern Africa, a partnership with the Intergovernmental Authority on Development (IGAD) resulted in its first nutrition policy, which aims to strengthen resilience in Eastern Africa. In 2015, UNICEF developed a nutrition resilience policy framework for Kenya and an integrated nutrition resilience programme for the 23 arid and semi-arid counties *(see box 'Case study: Risk-informed programming for improved nutrition resilience in Kenya')*.

Efforts to build resilience in Nepal were tested after the earthquake hit in 2015. Response to the emergency built on the experience, capacity and systems that were developed through the MYCNSIA programme prior to the earthquake. More than 10,000 female community health volunteers, 4,000 health workers and 1,000 staff members of civil society organizations were trained and mobilized to implement six key nutrition interventions established through the MYCNSIA programme. In addition, the emergency response made use of coordination mechanisms that had been strengthened during the previous years with support from MYCNSIA. Communities were better able to identify and manage cases of severe acute malnutrition as a result of the partially scaled-up IMAM programme. The response to the earthquake revealed a high level of resilience in communities and institutions and highlighted the importance of including resilience building in the design and implementation of all development programmes.

Reflections and lessons learned

The current and ongoing humanitarian crises require considerable resources. A large proportion of UNICEF's funding in nutrition goes to emergencies programming; however, it is mainly earmarked for supplies. While adequate supplies are certainly central to effective emergency response, there is also a need to increase investments in broader systems strengthening, capacity development and resilience building. Strengthening work in resilience building will be an important step towards responding to the increasingly complex environment in which UNICEF works, mitigating risks and ultimately achieving intended nutrition outcomes in the last two years of the Strategic Plan. At the same time, better resources are needed to strengthen knowledge management on emergency response and systematically invest in coordination capacity, along with risk-informed nutrition information systems. Flexible funds in particular would strengthen UNICEF's ability to help countries achieve progress in these areas.

In 2015, strengthened emergency surge systems were supported globally by two roving personnel, but a more systematic and sustainable approach is needed. Limited predictable funding has curtailed long-term strategic planning, and it continues to be challenging to fund

UNICEF and partners treated more than 148,000 severely malnourished children in South Sudan in 2015, including 9 month old Chiengjiuk, pictured here at an outpatient therapeutic programme in Bentiu civilian protection site.

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positions at regional and headquarters levels that support the global and regional programme. In this context, there is a particular need to increase capacity, engage highly qualified nutrition staff and expand skills, tools and resources for programmes.

Governments, financial and technical partners recognize the need for stronger health systems to integrate quality management of SAM at scale. Integration of SAM management into national plans and the basic package of health services remains limited, despite its being recognized as key to sustainability. UNICEF is currently working on documenting models and success factors for integration but will need to expand these efforts in 2016–2017 in order to develop guidance and recommendations for partners, stakeholders and country teams.

While the scale-up of SAM management during emergencies is often critical, there is also a need for effective responses to nutrition emergencies where acute malnutrition is low but other indicators of poor nutrition status or high nutritional risk warrant response. The refugee migrant crisis is one particular example where UNICEF's support for facilitating IYCF at scale can achieve significant impact.

While important progress was made in 2015 to treat SAM, the global burden of SAM remains persistently high, particularly in South Asia. Moving forward, efforts will focus on strengthening data quality, including increasing data disaggregation by gender, supporting bottleneck analysis and working with partners to support advocacy, coordination and CMAM scale-up.

PROGRAMME AREA 4: GENERAL NUTRITION

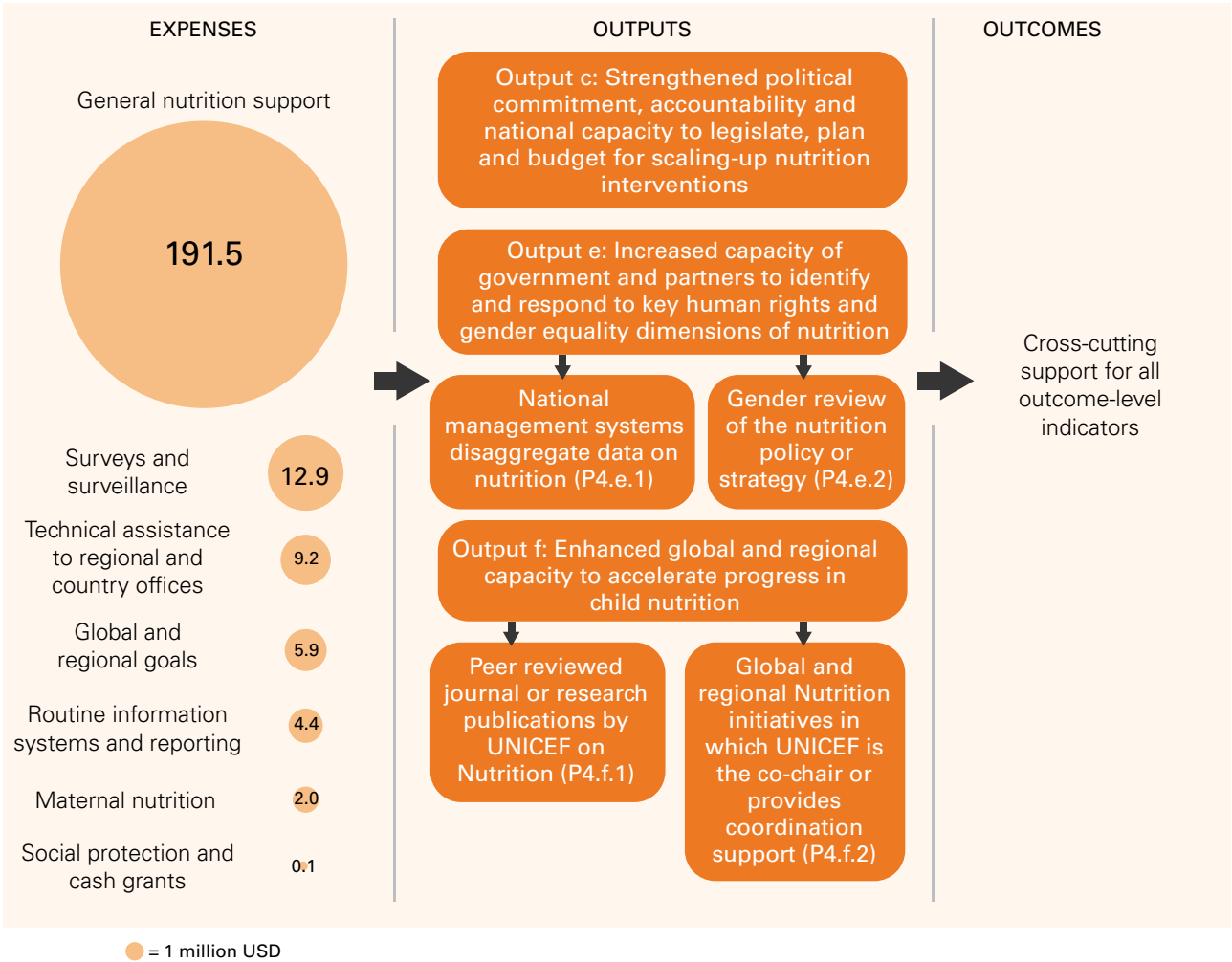
Among the most important tasks of the general nutrition programme is strengthening the enabling environment for nutrition at the national level, and also developing effective and evidence-based nutrition policies and programmes. UNICEF's leadership role in the SUN movement and other global partnerships, discussed further below, is important in ensuring that maternal, infant and child nutrition remains high on the global agenda.

While general nutrition is presented here as a separate programme area, UNICEF's nutrition programmes are deeply integrated and grounded in a holistic approach to achieving success in Strategic Plan outcome 4: *improved and equitable use of nutrition support and improved nutrition and care practices.* The activities and results in this section are therefore cross-cutting in nature and support the work of the other four nutrition programme areas.

UNICEF's general nutrition programming works to strengthen linkages with other sectors to achieve greater impact and ensure sustainable progress within countries. UNICEF works in diverse country contexts, adapting its approach to respond to national priorities, and supporting governments and working closely with communities to implement effective and comprehensive multi-sectoral nutrition programmes.

The general nutrition programme outcomes are interconnected with results of the other programme areas and heavily support their achievements. In 2015, expenses for the general nutrition programme totalled 226,389,991, of which 20 per cent is regular resources,

FIGURE 18
Results chain for general nutrition[120]



38 per cent other resources (regular) and 42 per cent other resources (emergency). Figure 18 illustrates the relationship between programme spending, outputs and outcomes.

General nutrition output-level results

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

Improving policies, strategies and plans: Strong national policies and strategies are essential to fostering the enabling environment for nutrition. At regional and country level, UNICEF generates evidence and engages in policy dialogue and advocacy to guarantee that nutrition commitments are translated into practical plans for action.

UNICEF also provides strategic support to country offices on general nutrition policy and on specific technical focus areas to strengthen capacity. Ninety-three out of 122 reporting countries have a nutrition sector policy or plan developed or revised with UNICEF support over the last five years. In Indonesia, UNICEF supported the development of a background paper to inform the integration of nutrition into the next national medium-term development plan 2015–2019. The paper examined the progress made in reducing malnutrition in Indonesia, and the various opportunities and gaps in government policies, strategies and programmes. As a result, nutrition is now firmly anchored in the national 2015–2019 medium-term development plan, with stunting as a main development indicator, and three provinces and three districts have food and nutrition action plans to guide nutrition actions across multiple sectors.

In 2015, with technical and financial support from UNICEF, the Niger developed its first multi-sectoral policy for nutrition security through a bottom-up participatory process involving communities, civil society, regional and national authorities, municipalities, non-governmental organizations and UN agencies. The policy was built around lessons learned over the last decade by UNICEF and partners and is a response to the critical nutrition crisis in the Niger. The policy engages multiple sectors in addressing malnutrition, including agriculture, livestock, health, education, WASH and gender. Implementation will begin in 2016 with the development of a budgeted action plan. The policy will guide development of the new poverty reduction strategy and the Government's Vision 2035 document and direct the work of UN agencies. Prior to the conflict in Yemen, a multisector nutrition action plan was finalized and presented to sector ministers, with UNICEF support; however, plans to translate the plan into a national nutrition programme were stalled due to the conflict and will resume in 2016.

In Uganda, UNICEF helped the government develop a nutrition policy and strategic plan, and the National Nutrition Advocacy and Communication Strategy, which were jointly launched with USAID during the 2015 Africa Day for Food and Nutrition Security. To reduce stunting, UNICEF developed training packages on parenting, key care practices and community mobilization for nutrition and integrated early childhood development, which were used to train community development officers in all 112 districts. In Nepal, UNICEF provided technical assistance to develop and update 12 key health sector policies, strategies, plans and manuals in 2015. Some examples of this work include an emergency nutrition contingency plan, an IYCF strategy and a health sector strategy for addressing maternal undernutrition. In Cameroon, UNICEF's advocacy work with members of parliament resulted in parliamentarians establishing their own network of 40 elected representatives to promote nutrition. The group signed a letter of engagement in 2015, committing to better integrating nutrition into sectoral plans and strategies, increasing budget allocation and instituting a monitoring mechanism.

At the regional level, UNICEF ESARO worked to harmonize programming within regional bodies. In a strategic engagement with the African Union Commission, UNICEF revitalized the African Taskforce on Food and Nutrition Security, and finalized the African Regional Nutrition Strategy 2014–2025, which was launched at a side event of the Financing for Development Conference in July 2015. Five UNICEF country offices in Southern Africa (Botswana, Namibia, Lesotho, South Africa and Swaziland) began implementing a joint programme to reduce stunting by using collective and country-specific advocacy to influence changes in legislation and conduct research on the determinants of stunting in the sub-region.

Promoting multi-sectoral collaboration: UNICEF's comparative advantage is in having multiple sectors within the agency leverage their respective strengths to collaborate on the goal of improving global nutrition. In particular, multi-sectoral collaboration with WASH, ECD and health helps strengthen the work of each sector and ensures that gains in nutrition (and other sectors) are sustained over the long term.

In Ethiopia, a multi-sectoral nutrition coordination structure was developed at national, regional and zonal levels, with coordination bodies and technical committees. UNICEF, in partnership with Cornell University, conducted capacity building training with these groups to track progress and improve coordination between sectors. The trainings were also advocacy opportunities. As a result of the interactions, health, agriculture, education, labour and social affairs and industry sectors all included nutrition-sensitive actions in their respective plans. UNICEF and Cornell also documented best practices for scale-up and facilitated a South-South sharing visit of national and regional coordination body members to Brazil and Uganda to learn

from their experience achieving high-level political priority for nutrition and improving multi-sectoral collaboration.

In Burkina Faso, UNICEF helped make the health and agriculture sectors more nutrition-sensitive. Under the EU-UNICEF Africa Nutrition Security Partnership, UNICEF worked with the Matourkou Agricultural Training Centre and the National School for Public Health in Burkina Faso to review and integrate nutrition modules into their existing curricula. A new agriculture curriculum was introduced in 2013, and since then, 689 students have benefitted. In public health, more than 3,500 students have benefited from its new training curriculum. In India, with UNICEF's support, the first conference on 'Nourishing India's Tribal Children' brought together five union ministries to discuss tribal nutrition in nine states with high-burdens of malnutrition; Chhattisgarh, Jharkhand, Madhya Pradesh, Maharashtra and Rajasthan subsequently used recommendations from the conference to issue specific nutrition strategies/schemes for tribal areas. Some countries used innovative strategies to coordinate nutrition actions together with multiple sectors. For example, Bangladesh achieved rapid, coordinated scale-up of nutrition action with the help of district nutrition support officers *(see box 'Case study: Achieving rapid, coordinated scale up of nutrition action with district nutrition support officers in Bangladesh' below)*.

UNICEF frequently collaborates with the WASH sector to ensure that nutrition gains are not compromised by disease due to unsanitary environments and poor hygiene conditions. For the second year in a row, UNICEF and partners supported the India Ministry of Health in launching a nationwide campaign to reduce diarrhoea deaths. UNICEF led the development of operational guidelines, supportive supervision checklists, toolkit and selection of communication materials. Key features of the nutrition and WASH interventions included the establishment of oral rehydration salt and zinc corners; remote villages and urban slums were prioritized to promote equity. Globally, UNICEF worked with WASH to support World Toilet Day, under the theme of sanitation and nutrition, drawing attention to poor sanitation and hygiene as some of the key underlying causes of undernutrition. As part of this collaboration, USAID, WHO and UNICEF released guidance on improving nutrition outcomes with better water, sanitation and hygiene. Globally, in 2015, UNICEF procured 250.8 million zinc tablets, of which 99.6 million tablets were in oral rehydration salt and zinc co-packs.

In 2011, the European Union and UNICEF partnered to form the Maternal and Young Child Nutrition Security Initiative in Asia (MYCNSIA), a five-year, €26.42 million joint-action partnership spanning Bangladesh, Indonesia,

Case study: Achieving rapid, coordinated scale up of nutrition action with district nutrition support officers in Bangladesh

Since 2014, UNICEF has piloted the deployment of dedicated district nutrition support officers (DNSOs) to coordinate nutrition actions. Working as counterparts of the government at district level, DNSOs provide technical and management support to local level government actors and partners in planning, monitoring, coordinating and addressing nutrition related bottlenecks. The DNSO approach was helped by a human resource capacity assessment that identified significant technical gaps related to nutrition at sub-national level.

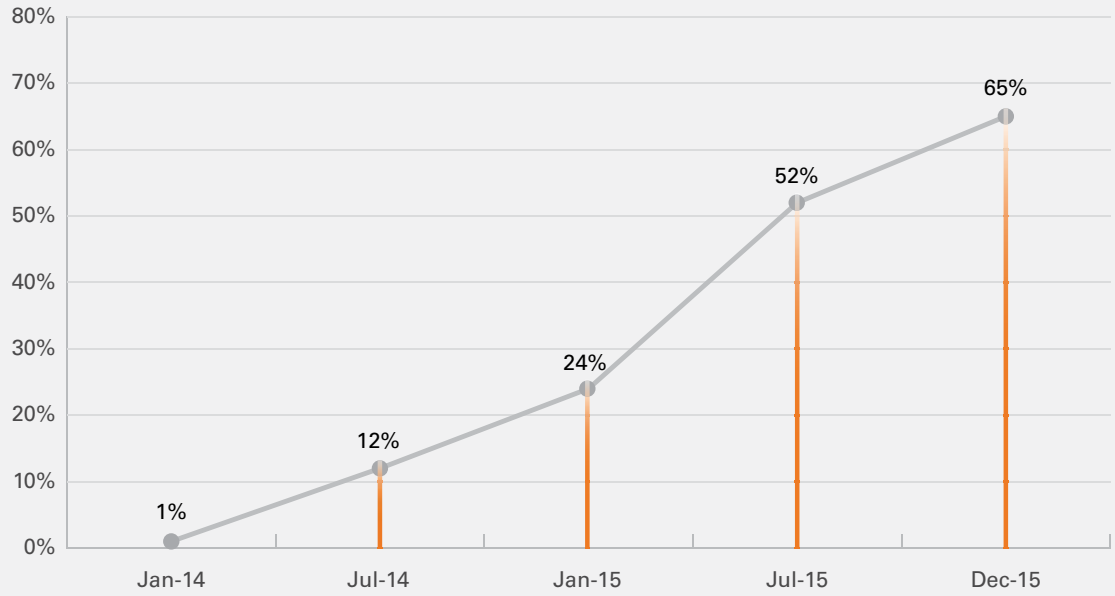
The overarching objective of the DNSO approach is to make sure direct nutrition interventions are mainstreamed through the health sector and to coordinate nutrition-sensitive actions across relevant sectors. In 2015, UNICEF continued its support for 42 DNSOs deployed in 39 highly vulnerable districts and five city corporations,[121] and tracked gains in nutrition service delivery, reductions in supply gaps and coverage of services.

Coverage of direct nutrition interventions has improved significantly in districts where DNSOs are deployed. There has been an especially sharp upward trend in the percentage of facilities providing IYCF counselling: in 2014, only 1 per cent of facilities were providing IYCF counseling, but by late 2015, this number had jumped to 65 per cent (see Figure 19). Similarly, iron-folic acid supplementation among mothers and adolescent girls also grew.

More than 3,000 children under 5 were treated for severe acute malnutrition (SAM) in 79 facilities during 2015. The training, supply and initiation of in-patient management of SAM in target hospitals began in 2014, when there were no facilities equipped to provide treatment. This effort led to an increase of 63 per cent of facilities in 2015 providing nutrition screening and covered around 35 per cent of children under 5 in the vicinity *(see Figure 20)*.

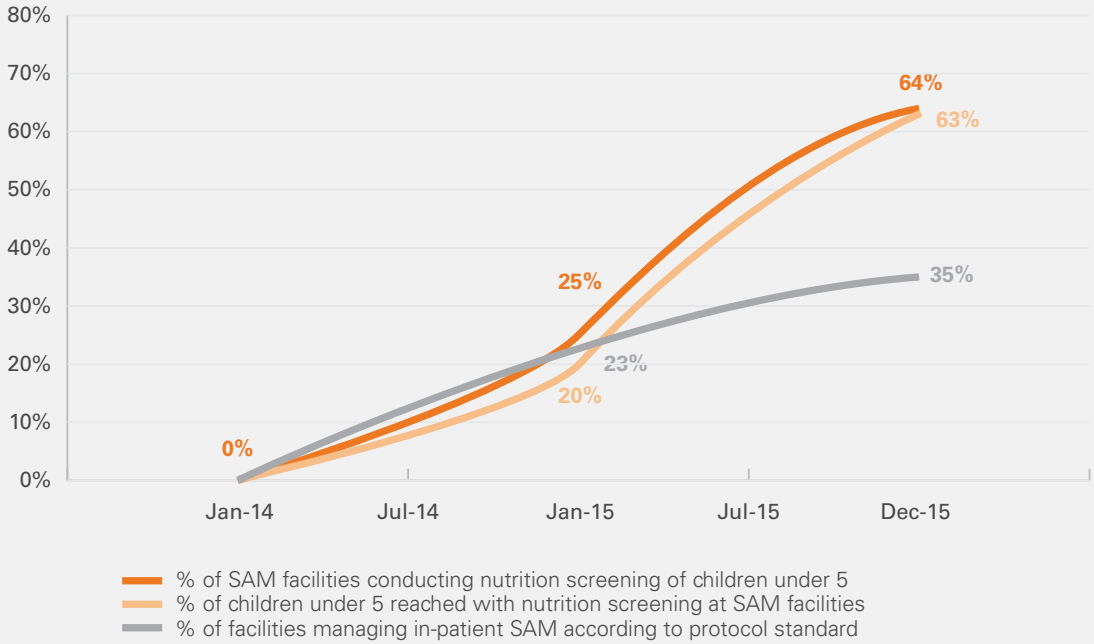
Nutrition coordination platforms have been established in all DNSO districts. These forums have been supporting nutrition programming through bottleneck analysis and have acted as platforms for setting and reviewing nutrition targets at local level.

FIGURE 19
Percentage of facilities providing counselling to caregivers on IYCF practices, Bangladesh



Source: Bangladesh Government health information systems.

FIGURE 20
Achievements in the treatment of SAM, Bangladesh



Source: Institute of Public Health Nutrition database, Bangladesh Ministry of Health.

Bangladesh has used a web-based health management information system for the last couple of years; however, a means for tracking nutrition activities was only recently introduced. In late 2015, 75 per cent of facilities were reporting nutrition data, with 29 per cent of facilities submitting complete reports on nutrition indicators – compared to only 7 per cent and 1 per cent respectively in early 2014.

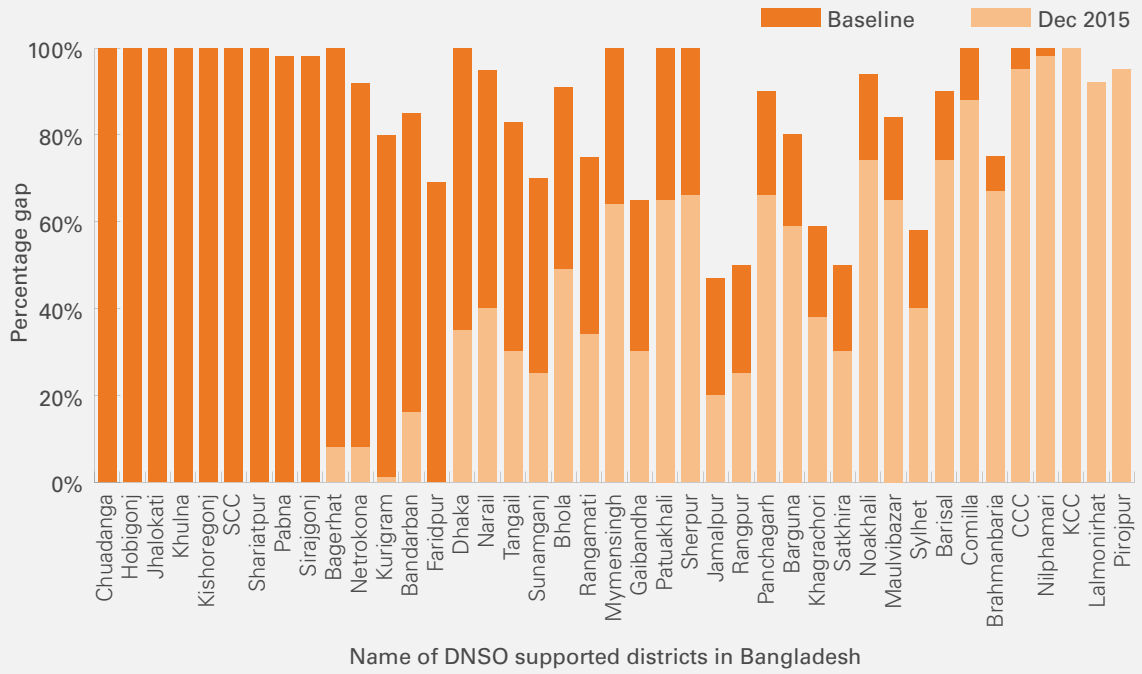
Since 2014, 41 per cent of all health facilities (5,364) have been visited for one-on-one technical support, 45 per cent of those have been visited multiple times. During these visits, DNSOs trained first line supervisors and front line health workers. Between January 2014 and December 2015, 18,279 health cadres (38 per cent) received on-the-job-training.

DNSOs are actively involved from supply gap analysis and distribution of commodities to managing field level facilities. Supply gaps have dramatically decreased since the project began: in 2014, only 5 per cent of facilities (658) were equipped with basic nutrition supplies, but by December 2015, this had increased to 51 per cent (6,708) *(see Figure 21)*. UNICEF supported the government in procuring most of those items.

The DNSO approach in Bangladesh delivered compelling results for children, increasing quality and service coverage and improving reporting. The success of the method demonstrates that investments in local level planning, facilitation and coordination are critical for scaling up nutrition programmes. Using their facilitation, technical and coordination skills, the DNSOs are supporting and enabling government authorities, managers and service providers to carry out their roles in nutrition more effectively. As a result of the clear gains achieved in the pilot programme, the Government of Bangladesh established a cadre of district nutrition officers (64 positions to be deployed in all districts countrywide) within the public service. In lower and upper middle-income countries like Bangladesh, the DNSO approach provides a highly cost effective intervention for improving nutrition programme coverage.

The DNSO approach is currently funded by the Children's Investment Fund Foundation. The cost of a DNSO, covering field activities and supervision, is approximately US$46,000 annually. On average, a district in Bangladesh is composed of six to eight sub-districts, each with a population of 60,000–80,000 people.

FIGURE 21
Reduction of supply gaps, Bangladesh



Source: Data gathered and analysed by DNSOs and reviewed by UNICEF.

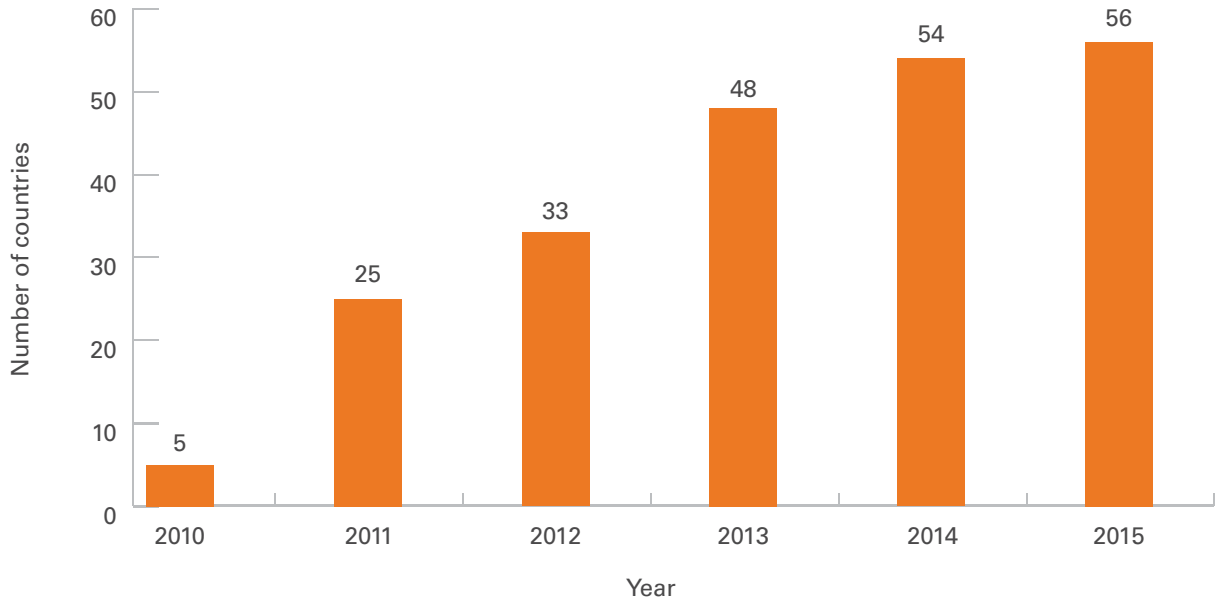
the Lao Democratic People's Republic, Nepal and the Philippines. Key partners at national level included governments, other United Nations agencies and development partners, academic and research institutions and civil society organizations. In addition to the work at country level, MYCNSIA also worked at the regional level to strengthen policies and partnerships with regional institutions such as the Association of Southeast Asian Nations (ASEAN) and the South Asian Association for Regional Cooperation, United Nations agencies working on nutrition and other stakeholders. The programme resulted in reductions in child stunting in some countries *(see box 'Case study: Scaling up IYCF counselling to improve outcomes in the poorest households in Indonesia' in the IYCF section above)* and decreased maternal anaemia *(see box 'Case study: Scaling up iron-folic acid supplementation for pregnant women in Bangladesh' in the micronutrients section above)*.

Leveraging the power of SUN: UNICEF and the global nutrition community continued to unite around the SUN movement to support nationally-driven efforts to end hunger and malnutrition. The movement brings together governments, donor countries, United Nations organizations, civil society and the private sector and offers one of the most effective opportunities to influence political commitment for scaling up nutrition. Since its launch in 2010, the number of SUN countries has grown from 5 to 56 in 2015 (*see figure 22*).

UNICEF uses its position in the UN Network for SUN to actively support SUN progress globally and nationally. UNICEF's Executive Director continued to chair the SUN movement lead group in 2015. In the spirit of the UN Network for SUN's commitment to improve efficiency and effectiveness, UNICEF, FAO, WFP, WHO and the UN Network for SUN/REACH Secretariat organized a workshop to develop a more harmonized approach to assessing and strengthening nutrition capacity.

At country level, governments are making progress on SUN with capacity development and technical support from UNICEF. The Sudan and Botswana are the newest SUN movement members, having joined in 2015, in part due to extensive policy dialogue and advocacy by UNICEF and WFP. The Sudan's new membership followed the presidential endorsement of the National Nutrition and Food Security Council, which increased government commitment to tackling the problem of malnutrition with an allocation of US$8 million for the national scale-up of CMAM. In Somalia, UNICEF supported advocacy efforts and the establishment of a SUN inter-ministerial committee in Puntland and also facilitated government participation in regional and global SUN initiatives. While SUN has achieved high-level executive political commitment, progress in developing a policy framework and multi-sectoral strategy has been slow. This work is challenged by weak institutional capacities in the sector ministries and civil society and competing political and humanitarian priorities. UNICEF's continued technical assistance will be needed to support the government in developing the policy framework and multi-sectoral strategy in 2016.

FIGURE 22
Number of SUN countries over time



UNICEF's regional offices (East Asia and Pacific Regional Office; Regional Office for South Asia; ESARO; WCARO; and LACRO) and the SUN movement supported four regional workshops[122] on tracking domestic resources. An additional workshop on costing and planning domestic resources (in LACRO) helped 32 countries to improve budgeting and tracking of expenditures in nutrition. These workshops created a venue for participating countries to share methodologies, data sources and estimated figures for nutrition-specific and nutrition-sensitive budget allocations across relevant sectors. In East and South Africa, an intersectoral approach to stunting reduction was further enhanced through a study on supply chain management for nutrition products that consolidated findings based on experiences from five countries in the region. In West and Central Africa, UNICEF's advocacy with SUN civil society alliances resulted in improved national accountability and progress monitoring of nutrition commitments.

Building the investment case for nutrition: UNICEF advocates for increased national investments in nutrition and comprehensive research on links between nutrition and sustainable development. In the Sudan, the Federal Ministry of Health, UNICEF and WFP developed a case for expanded multi-sectoral investment in nutrition, with costing of an evidence-based package of interventions to reduce stunting, wasting and child mortality. The investment case highlighted the impact of increased investment in preventing malnutrition by averting stunting, wasting and child deaths, and their effects on the national economy. There is much work to be done in integrating wider multi-sectoral packages of required interventions, and also projecting their contribution to the reduction of malnutrition.

UNICEF has also undertaken costing work in Kenya and advocated for investments and policy dialogue in Cambodia and Madagascar. In Kenya, funding for nutrition is primarily determined at county level and the allocation of resources varies across counties. In response, UNICEF supported the development of the Advocacy, Communication and Social Mobilization Strategy in 2015 to bridge capacity gaps at national and county level, while supporting multi-stakeholder engagement. To enhance county-level capacity for nutrition financing, UNICEF supported the development of a HiNi costing tool, piloted in Turkana county, and facilitated a financial tracking exercise focused on national nutrition expenditures and resource requirements. To effectively engage counties in budgetary processes, stakeholders were guided through the development of costed county nutrition action plans, which define key results for prioritization and resource allocation. Five plans were finalized in eight counties in 2015. The strategy, costing tool and costed action plans significantly advanced the agenda to increase resource allocation for nutrition at national and county levels in 2015 and created strong county government ownership.

In 2015, a number of African countries turned their attention to planning for and allocating resources to nutrition. In the Eastern and Southern Africa region, UNICEF provided technical assistance and capacity development to seven governments in carrying out

"Since its launch in 2010, the number of SUN countries has grown from 5 to 56 in 2015."

Children eat a communal meal at a UNICEF-supported safe space in the Dalori camp for internally displaced people, in the north-eastern city of Maiduguri in Borno State, Nigeria.

nutrition surveys, conducting costing and tracking of expenditures on nutrition, and planning for and focusing on increased resources on nutrition. In Tanzania, UNICEF's work to secure greater national investments resulted in concrete impacts on stunting reduction within the country *(see box 'Case study: Supporting planning and budgeting for nutrition at local government level in the United Republic of Tanzania' below)*. As a result of UNICEF and civil society advocacy in Kebbi state, Nigeria, the state government and all 21 local government areas committed

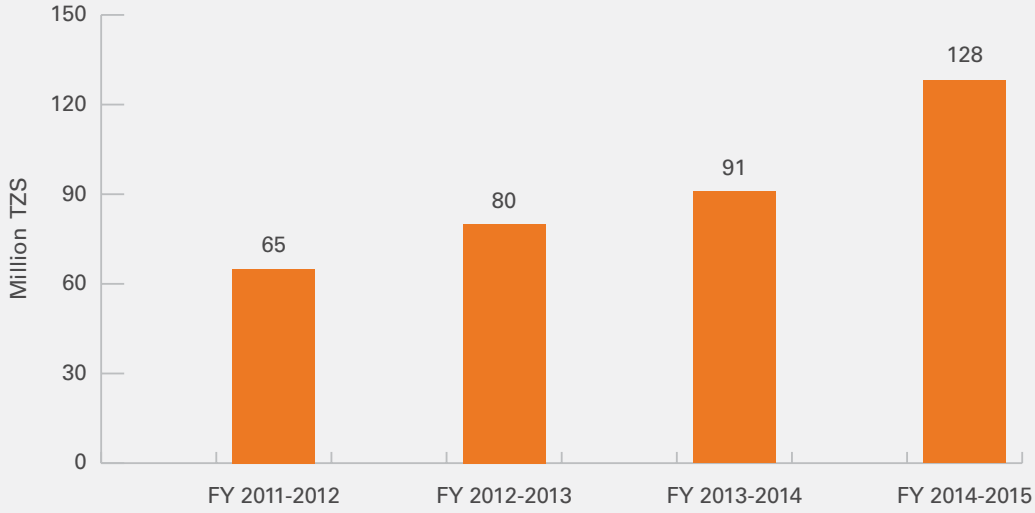
Case study: Supporting planning and budgeting for nutrition at local government level in the United Republic of Tanzania

In 2010, stunting affected 42 per cent of children under 5 in the United Republic of Tanzania. The Government worked to respond to this problem by appointing skilled nutrition officers to all regions and districts in 2011, and also developed a national nutrition strategy and plan to scale up nutrition interventions with a budget of US$450 million for 2011–2016. The plan has eight strategic objectives, 28 outputs and covers eight development sectors. The implementation in 166 district and municipal councils is coordinated by district nutrition officers.

UNICEF supported the Government in developing a planning and budgeting guideline for nutrition in 2012, and each year since has organized annual planning and budgeting sessions on nutrition with district nutrition officers. UNICEF helped train district and regional nutrition officers through a two-week programme in 2014/2015, and organized a joint multi-sectoral nutrition review in 2014 and 2015 to assess implementation of and identify gaps in the national nutrition strategy.

UNICEF's support led to increased domestic and external funding to scale up nutrition in the United Republic of Tanzania. The joint multi-sectoral nutrition review showed a continuous increase in average actual expenditure for nutrition by district and municipal councils, rising from TZS65 million in fiscal year (FY) 2011–2012 to TZS128 million in FY 2014–2015 *(see Figure 23)*.

FIGURE 23
Trends in average spending for nutrition per council (million TZS), Tanzania



Source: *Tanzania Food and Nutrition Center, Joint Multi-sectoral Nutrition Review 2014, 2015.*

The President's Office for Regional Administration and Local Government (PORALG) issued a directive to all councils to allocate a minimum of TZS500 per child under 5 for nutrition interventions during the 2016–2017 period. In addition, all regional administrative secretariats will allocate at least TZS5,000,000 per council to support supervision of nutrition activities by regional nutrition officers. Nationally, domestic allocation for nutrition will be at least TZS5.75 billion for FY 2016–2017. The objective is to progressively increase the allocation to reach TZS20,000 per child under 5 by 2030, which corresponds to the estimated amount needed to reach the

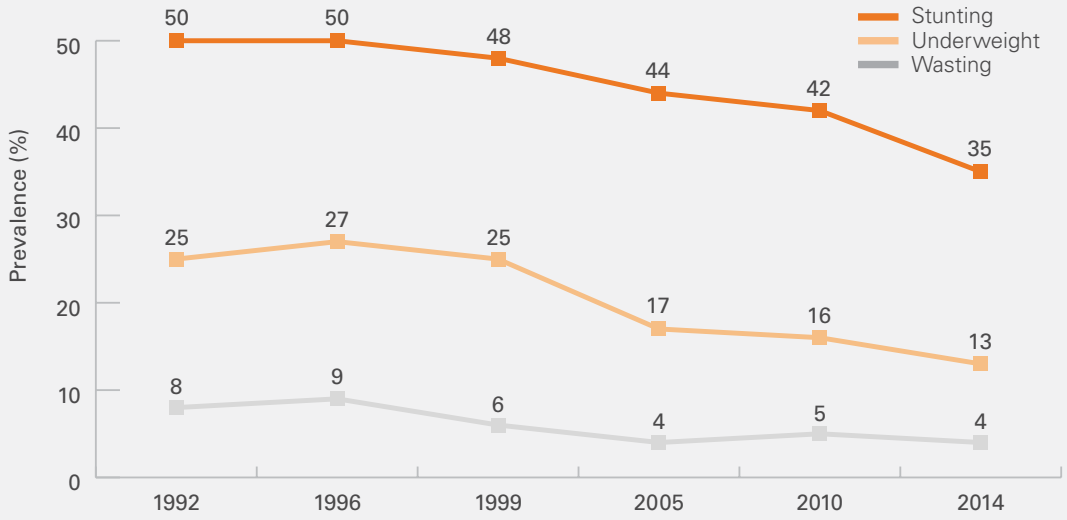
SDG target on stunting. According to the PORALG directive, this funding should support the following nutrition priorities:

- Promotion of optimal maternal infant and young child nutrition practices, including key nutrition-related WASH, ECD and health practices;
- Management of acute malnutrition;
- Prevention and control of micronutrient deficiencies (anaemia reduction, vitamin A supplementation, deworming and Universal Salt Iodization); and
- Planning, budgeting, coordination and advocacy on nutrition.

UNICEF also worked to leverage resources from other resource partners, including by preparing a business case for accelerating stunting reduction in Tanzania, which is funded by DFID with 32 million pounds for the period 2015–2020. The United Republic of Tanzania was selected as a priority country for the Child Investment Fund Foundation, which committed to invest US$100 million to support stunting reduction and the treatment of severe acute malnutrition between 2015 and 2020.

The results of the 2014 national nutrition survey supported by UNICEF indicate that the prevalence of malnutrition in all forms, including stunting among children under age 5, has decreased, falling from 42 per cent in 2010 to 35 per cent in 2014 *(see Figure 24)*.

FIGURE 24
Trends in nutritional status of children under 5 between 1992 and 2014, United Republic of Tanzania



Source: WHO global database on child growth and malnutrition and Tanzania national nutrition survey 2014.

The United Republic of Tanzania's experience illustrates the power of evidence-based advocacy in influencing decision-making. This work, along with strengthened multi-sectoral coordination and accountability, increased resources for nutrition and directly impacted overall outcomes in the country.

to creating budget lines for nutrition, a significant achievement given the historic dearth of government funding for nutrition interventions in Nigeria. UNICEF will aim to replicate the approach in other states in the country.

Globally, new and innovative financing opportunities, including the Power of Nutrition fund and UNITLIFE, are expected to significantly increase revenue streams for nutrition in the coming years. The Power of Nutrition fund, launched in April 2015, has developed an innovative matching offer that guarantees that every dollar from new funding sources targeted to UNICEF's nutrition-specific interventions in select SUN countries will be matched. UNICEF provided substantial support towards initiating Power of Nutrition and UNITLIFE and worked to shape the discussion around SDG targets and indicators for nutrition. Moving forward, the SDGs and the Addis Ababa Action Agenda (which provides a global framework for financing sustainable development) will provide an important platform from which to continue making the case for investments in children's nutrition.

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

Integrating gender and human rights: In 2015, UNICEF worked with governments to integrate gender and women's and girls' rights into nutrition policies and strategies. But globally, only 21 out of 122 countries (17 per cent) reported undertaking a gender review of the nutrition policy/strategy in the current national development plan cycle with UNICEF support **(P4.e.2 – slow progress)**.[123] This was, however, a slight increase from the 2013 baseline of 16 countries. Moving forward, UNICEF will work to better sensitize nutrition staff to UNICEF's Gender Action Plan and assist national governments with gender reviews during national development planning processes.

Strengthening maternal and adolescent nutrition improves child survival and also promotes gender equity and women's empowerment. At its global nutrition meeting in 2015, UNICEF agreed to scale up its programming in this area by reviewing effectiveness of existing country programmes, better integrating nutrition and health interventions, and improving data disaggregation in this area. Work on the gender-related aspects of nutrition will benefit from a recently finished technical paper on 'improving nutrition for women and adolescent girls', which highlights the need for better situation analyses for this population group and guides country offices in implementation. Going forward, UNICEF will document approaches to maternal nutrition in selected countries (e.g., Bangladesh, Ethiopia, and India) with the goal of understanding linkages between maternal nutrition and women's and girls' economical and educational empowerment. After UNICEF conducted a gender review of the country programme in the Niger in 2015, the increasing relevance of gender-based dimensions to nutrition was evident and led to a new focus on the intersecting issues of nutrition, child marriage and girls' education.

Improving programme monitoring for equity: Strong information systems are crucial tools for responding to the key equity, human rights and gender equality dimensions of nutrition. In 2015, 93 out of 122 countries (76 per cent) reported national information management systems that disaggregated data on nutrition compared to 92 countries in 2014 **(P4.e.1 – on track)**.[124] While there have been initiatives at global, regional and national levels to strengthen nutrition information systems, more work and investment are needed in this area.

UNICEF supports countries to invest in and improve routine health and nutrition information systems by providing technical guidance on indicators and building capacity among partners to collect and use programme data for decision-making. Routine information systems support programme monitoring and are an effective way to strengthen systems nutrition services. UNICEF's NutriDash platform is helping countries improve programme performance monitoring and ensure quality.[125] The platform supports equity-led programming by allowing for data disaggregation; however, many countries require further support to collect this data. To illustrate, in 2014, only 16 of 57 countries reporting admissions for severe acute malnutrition were able to report gender disaggregated data, and only 10 countries reported gender disaggregated performance indicator data (i.e., cure and default rates for boys and girls).

National efforts are underway in several countries to improve programme monitoring and reporting for greater coverage and equity. In Somalia in 2015, 69 partners were trained to use the Nutrition Quality Improvement Initiative Dashboard to upload monthly and quarterly data, which allowed comprehensive reporting on all nutrition indicators. The Dashboard allows for decentralized data accessibility, analysis and use, and helps to identify gaps and resolutions, leading to better ownership at all levels.

In 2015, UNICEF continued to apply bottleneck analysis to improve equitable nutrition programming. In Guatemala, in response to a bottleneck analysis on reducing chronic malnutrition, UNICEF developed and implemented a C4D strategy focusing on promoting interventions in the first 1,000 days, using participatory and culturally sensitive methodologies, primarily in predominantly indigenous populations where children are twice as likely to suffer stunting as the general population. UNICEF developed an innovative monitoring system for the project, using pictograms to collect data on knowledge acquisition.

"UNICEF's NutriDash platform is helping countries improve programme performance monitoring and ensure quality."

The initial model, implemented in 72 communities, empowered indigenous populations to communicate key gaps in knowledge and practices facilitating new dialogue on the identified needs and measures to address them. The model will now be expanded to other regions with national support, and UNICEF will also use the methodology to monitor the quality of essential services provision. In an example of South-South cooperation, UNICEF shared its experiences in Guatemala with the Government of Belize and supported it in conducting a bottleneck analysis on chronic malnutrition, which will guide future interventions.

Despite significant effort to increase equity-focused monitoring capacity within the nutrition sector and support bottleneck analysis, it still proves challenging to integrate this approach into programming. To bolster efforts, a technical orientation and an equity-focused monitoring working group were initiated in 2015 and will continue to work to systematically improve performance in this area to effect stronger, more equitable results across nutrition programmes.

Enhanced global and regional capacity to accelerate progress in child nutrition

Strengthening partnerships: Partnerships are key vehicles for accelerating progress on and investment in nutrition, and prove particularly important during humanitarian crises. UNICEF serves as the cluster lead for nutrition in emergencies (see nutrition in emergencies chapter) and is also active in several global, regional and national partnerships, supporting work to shape the global advocacy agenda and coordinating and delivering services. In 2015, the number of key partnerships where UNICEF is the chair or member of a coordination committee or board has increased to 14 from a baseline of 6 **(P4.f.2 – on track)**.[126] These include:

- Scaling Up Nutrition (SUN);
- UN Network [Renewed Efforts Against Child Hunger (REACH)/Standing Committee on Nutrition (SCN)];
- Global Nutrition Cluster (GNC);
- Infant and Young Child Feeding in Emergencies (IFE) Core Group;
- US-based nutrition partner forum;
- Breastfeeding Advocacy Initiative;
- Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breast-milk Substitutes (NetCode);
- Food Fortification Initiative (FFI);
- International Zinc Nutrition Consultative Group;
- Iodine Global Network (IGN);
- The Micronutrient Forum;
- Micronutrient Initiative;
- Home Fortification Technical Advisory Group (HFTAG);
- Global Alliance for Vitamin A.

The results of these partnerships are explored in more detail under each programme area.

In 2015, UNICEF partnered with Dutch company DSM Nutritional Products to develop innovative approaches to scale up micronutrient programmes for women and children worldwide. UNICEF also entered into a coalition partnership with Action against Hunger (ACF), WHO and the University of Copenhagen to facilitate the transition of the CMAM Forum web platform on management of acute malnutrition into a longer-term institutional home.

UNICEF also engages with regional institutions to build capacity and accelerate progress on nutrition. In the East Asia and Pacific region, UNICEF partnered with ASEAN (Association of Southeast Asian Nations) and in South Asia, with SAARC (South Asia Association for Regional Cooperation) to raise the profile of nutrition among regional bodies and of member states. The UNICEF and SAARC collaboration helped to develop the 'South Asia Regional Action Framework for Nutrition' that was endorsed and formally adopted by the SAARC countries in late 2014. The Framework encourages the eight SAARC member states to prioritize the reduction of child undernutrition and provides guidance on coherent approaches to developing integrated policies and programmes to address maternal and child undernutrition.

Generating evidence: The ability to understand and use evidence to enhance capacity accelerates progress in child nutrition. UNICEF's contribution to the global knowledge base for nutrition is well reflected by its publications in peer-reviewed journals and research publications throughout 2015. Since the start of the Strategic Plan, UNICEF has published more than 50 research papers annually across the sector, exceeding the target of 50 products per year **(P4.f.1 – on track)**.[127] These

papers address diverse nutrition topics such as food and nutrition security, IYCF counselling, complementary feeding, SAM discharge criteria, HIV and nutrition, food fortification, multiple micronutrient supplementation and the determinants of stunting.

Reflections and lessons learned

UNICEF's global partnerships were critical in accelerating progress on stunting and other forms of malnutrition in 2015, ensuring that nutrition remained high on the development agenda. As the SUN movement grows and the UN Network for Nutrition reforms, there is increasing pressure on UNICEF to live up to its leadership role in nutrition – especially in terms of delivering results at country level. UNICEF's global presence, with more than 80 programme countries, makes it a partner of choice in nutrition. This has significant implications for human resources and programming, as coordination activities take both time and resources. There are increasing demands for UNICEF to take on multiple roles in the nutrition sphere. The sector will have to develop strategies to ensure that it can fulfil its goals and continue to deliver results for children, while taking on these new responsibilities. Having access to flexible revenue streams would help UNICEF tailor its strategies and interventions to areas in greatest need, with the greatest potential for impact. It would also allow UNICEF to develop new areas of programming and innovation, while ensuring results for the most vulnerable children.

More specifically, flexible funding streams would allow UNICEF to:

- Implement strategic long-term planning in different country contexts;
- Tailor strategies to situational context and identify key gaps;
- Invest in systems – including health systems strengthening – for sustainable results;
- Generate the evidence base to guide programming and address key knowledge gaps in nutrition;
- Strengthen cross-sectoral convergence;
- Ensure that programming is gender responsive and grounded in equity.

UNICEF recognizes the need to further improve maternal and adolescent nutrition programming. Moving forward, UNICEF will scale up evidence-based interventions, review existing country programmes and conduct situational analyses to determine which nutrition-specific and nutrition-sensitive interventions are needed. In addition, UNICEF will aim to better integrate maternal nutrition interventions with health interventions and disaggregate data by age and other risk factors. UNICEF will also continue its multi-sectoral programming, aiming to further strengthen linkages with ECD and WASH in particular. Multi-sectoral programming is also needed to better address gender-based priorities – such as keeping girls in school, ending child marriage and delaying age of first pregnancy – and strengthening gender mainstreaming within nutrition programmes, as outlined in UNICEF's Gender Action Plan.

> "UNICEF has published more than 50 research papers annually across the sector, exceeding the target of 50 products per year."

FINANCIAL ANALYSIS

The year 2015 saw unprecedented political and public resolve – including the adoption of the Sustainable Development Goals (SDGs) – to address some of the greatest global challenges. Also known as Agenda 2030, the SDGs are of great importance to children and the work of UNICEF for the coming 15 years. They set multiple, ambitious, child-centred targets that demand significant and sustained investment for the long term. To be fit for purpose in this evolving context, UNICEF revised its Strategic Plan 2014–2017 resource requirements by outcome area from the US$14.8 billion originally planned to US$17 billion.

Of the two main types of resources, 'regular resources' are un-earmarked, unrestricted funds that help UNICEF respond rapidly to emergencies, maintain programme continuity, identify and address the root causes of inequity, and deliver services in the most remote and fragile contexts. Because regular resources are not earmarked for a specific programme, they can also provide seed capital to develop innovative approaches to some of the world's most challenging issues and ensure a credible reach and specialized expertise on the ground.

Thanks to these foundational resources, UNICEF and partners can bring solutions to scale and contextually replicate them through additional and complementary earmarked funds or 'other resources', which include pooled funding modalities such as thematic funding for UNICEF Strategic Plan outcomes and cross-cutting areas. These other resources are restricted to a particular programme, geographical area, strategic priority or emergency response. Flexible and predictable other resources should complement a sound level of regular resources for UNICEF to deliver its mandate.

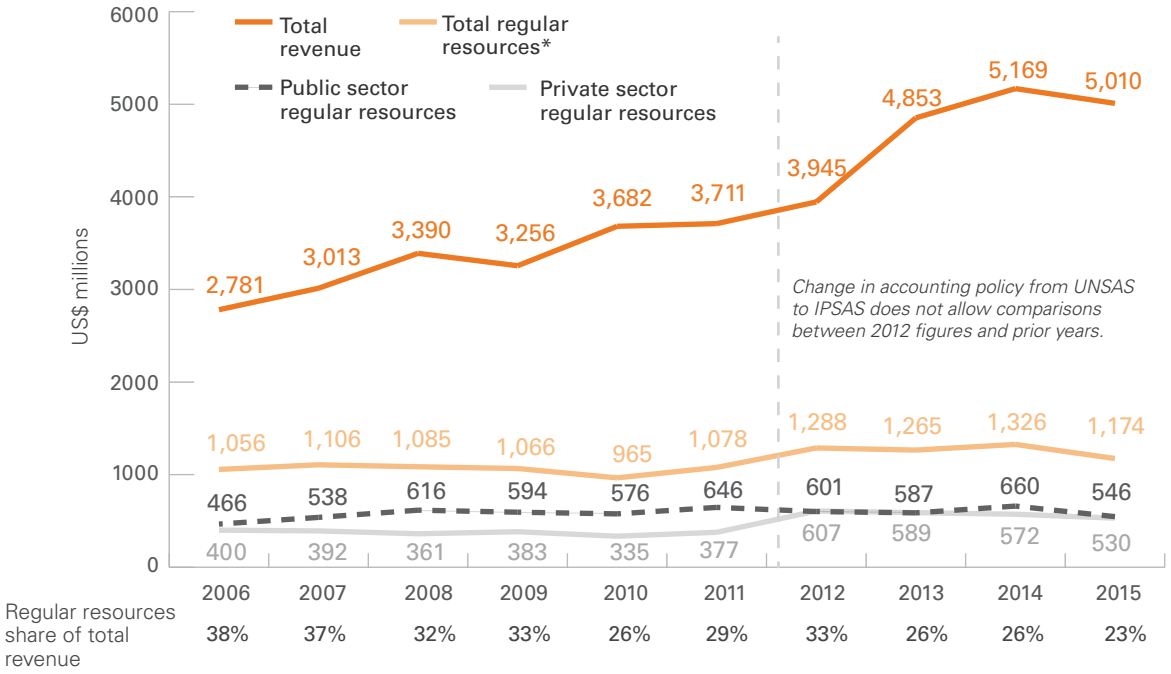
TABLE 1
Strategic Plan integrated results and resources framework by outcome area, 2014–2017: Updated planned amounts (US$ millions)

Outcome	Planned 2014-2017		
	Regular resources	Other resources	Total resources
Health	1,023	3,760	4,783
HIV and AIDS	183	671	854
WASH	548	2,014	2,562
Nutrition	365	1,343	1,708
Education	730	2,686	3,416
Child protection	438	1,611	2,050
Social inclusion	365	1,343	1,708
Totals	**3,652**	**13,429**	**17,081**

* Data as of 1 April 2016.

FIGURE 25

Regular resource share by resource partner category, 2006–2015*



** Total regular resources includes other revenue from interest, procurement services and other sources*

In 2015, funding to UNICEF was more than US$5 billion for the second year in a row, thanks to the organization's loyal and new resource partners. At the same time, slowing economic growth and currency fluctuations – particularly of major European currencies and the Japanese Yen vis-à-vis the US dollar – resulted in an overall decrease of 11 per cent of regular resources compared with 2014. Totalling US$1,174 million, this was the lowest level of regular resources in four years. At 23 per cent of overall revenue, this was the lowest level of regular resources in UNICEF's history, down from 50 per cent at the turn of the new millennium. Un-earmarked contributions from public-sector resource partners decreased by 17 per cent. As a result, UNICEF relied more heavily on softly earmarked funding streams for delivery of critical and otherwise underfunded programmes and activities.

PARTNER TESTIMONIAL

"Children are a priority on Sweden's international agenda. Sweden has a long tradition of standing up for children's rights. UNICEF has been working for children for almost 70 years and is a key partner to Sweden in development cooperation and humanitarian assistance.

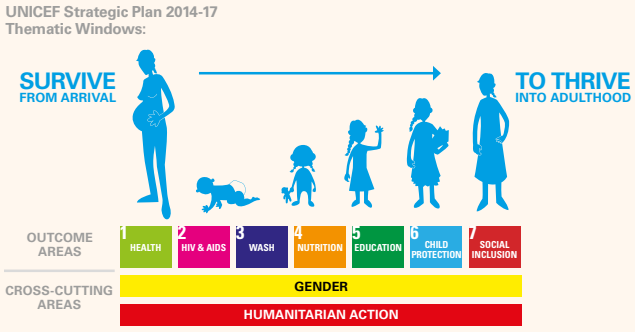
The most excluded and most vulnerable children are reached by UNICEF's thematic funding. As a form of un-earmarked programme support, Sida believes that this financing modality enhances effectiveness since it provides greater flexibility and the possibility to plan activities over the long term, while still being able to act quickly in the event of a crisis. Over the years, Sida's support to UNICEF has moved away from earmarked support towards fewer and larger contributions and increased thematic funding. This trend reflects Sida's confidence in UNICEF as an effective actor and a strong advocate for the implementation of children's rights.

Sida shares UNICEF's belief that all children have a right to survive, thrive and fulfill their potential – to the benefit of a better world. This means equal access to services and care that can make all the difference in children's lives. Children are the next generation who will help build the future. It is our mutual responsibility to give them the best possible conditions. Effectiveness should be the foundation of such an engagement."

– Ms. Charlotte Petri Gornitzka
Director-General, Sida (Swedish International Development Cooperation Agency)

The value of thematic funding (OR+)

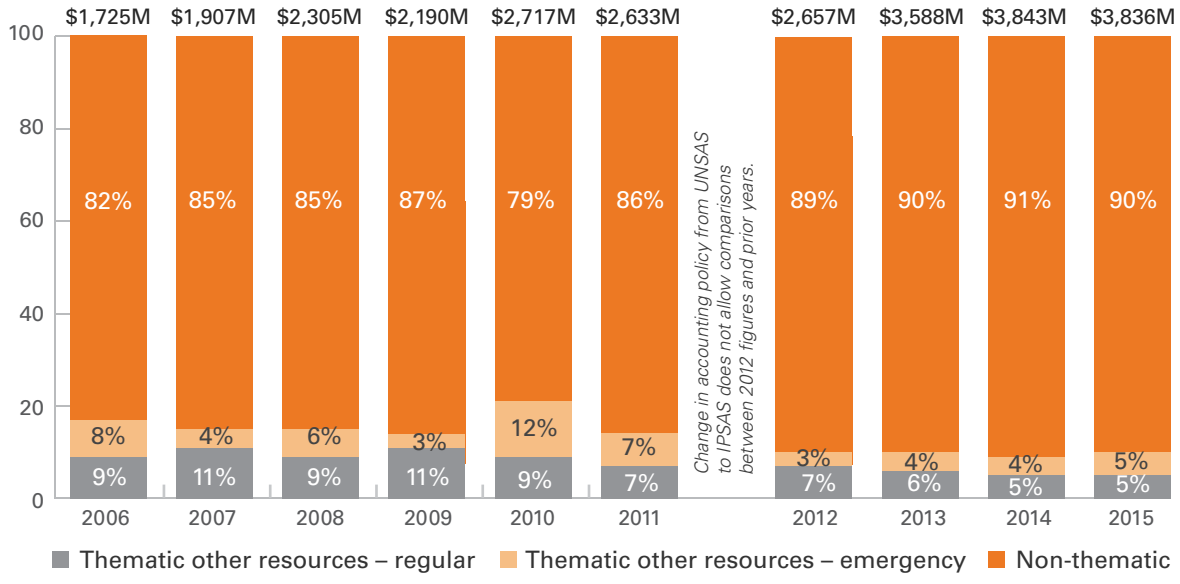
While regular resources remain the most flexible contributions for UNICEF, thematic other resources (OR+) are the second-most efficient and effective contributions to the organization and act as ideal complementary funding. Thematic funding is allocated on a needs basis, and allows for longer-term planning and sustainability of programmes. A funding pool has been established for each of the Strategic Plan 2014-17 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.

Of the US$5,010 million of UNICEF's revenue in 2015, US$3,836 million was earmarked. Of these other resources, US$390 million was softly earmarked as thematic, marking a 14 per cent increase from the US$341 million in 2014. UNICEF's Strategic Plan 2014–2017 called for partners to enhance funding aligned to the organization's strategic mandate. The flexibility and potential predictability of thematic funding makes these pools an important complement to regular resources for both development and humanitarian programming and the links between the two. This is in line with the universal mandate of UNICEF and in support of country-specific priorities.

FIGURE 26
Other resources, 2006–2015: Thematic vs. non-thematic (US$)



Supporting UNICEF's ability to deliver results for children

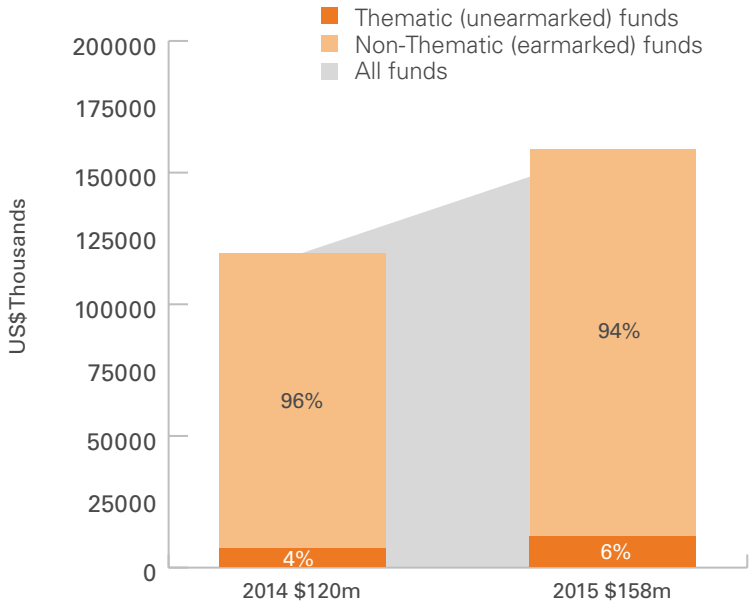
UNICEF's Cases for Support make the case for investing in children, while also spotlighting how the organization is able to deliver robust returns on such investments – for children and for society at large.

Investments in the most vulnerable children not only improve their lives and fulfil the obligation to realize their rights, they also yield benefits for everyone. Improving children's well-being – from providing essential health care and adequate nutrition and securing access to quality education, to protecting children from violence and exploitation – helps to break intergenerational cycles of deprivation that hamper economic development and erode social cohesion.

For each area, the Case describes the key results that UNICEF works to achieve and outlines the theory of change behind these results. This starts with an analysis of the situation of the world's children, focusing on the challenges facing the most deprived, and an overview of the evidence-based solutions that UNICEF promotes. The Cases also focus on lessons learned from our experience across the world and draw attention to current risks and the measures needed to mitigate them. Finally, they detail the resources needed to achieve results and highlight current gaps in funding.

www.unicef.org/publicpartnerships/files/NutritionTheCaseForSupport.pdf

FIGURE 27
Nutrition other resources funding trend, 2014–2015



In 2015, UNICEF received US$158 million total in other resources for nutrition. The most prominent resource partners in this area of UNICEF's work included the United Kingdom, the United States of America, the United Kingdom Committee for UNICEF, the Netherlands and the Korean Committee for UNICEF *(see Table 2)*.

TABLE 2
Top 20 resource partners to nutrition, 2015*

Rank	Resource partners	Total (US$)
1	The United Kingdom	66,349,025
2	United States of America	25,693,832
3	United Kingdom Committee for UNICEF	18,105,673
4	Netherlands	7,609,295
5	Korean Committee for UNICEF	6,652,833
6	Republic of Korea	4,071,700
7	European Commission	3,851,942
8	German Committee for UNICEF	3,744,384
9	Japan	3,700,000
10	Swiss Committee for UNICEF	2,436,981
11	Ireland	2,376,914
12	Italian Committee for UNICEF	2,373,691
13	United States Fund for UNICEF	1,785,939
14	Spain	1,315,789
15	French Committee for UNICEF	846,302
16	Pooled Fund contributions (WFP)	830,077
17	SUN Movement (Multi-Partner Trust Fund Office)	829,943
18	Sweden	774,552
19	Australian Committee for UNICEF	760,182
20	Central Emergency Response Fund (OCHA)	699,844

**Figures do not include financial adjustments.*

Notable contributions included programme funding for activities in Ethiopia, Nigeria, Pakistan, Uganda and Yemen (see Table 3). For example, funding from the United Kingdom Department for International Development (DFID) in Ethiopia supported the expansion of IYCF counselling and the scale-up of a phased approach to the community-based management of severe acute malnutrition (CMAM); this support also helped improve coverage of vitamin A supplementation, among other high-impact nutrition interventions. In Pakistan, USAID funding supported stunting reduction interventions, including IYCF counselling, micronutrient supplementation to reduce anaemia and the scale-up of a CMAM programme that had strong survival and recovery rates.

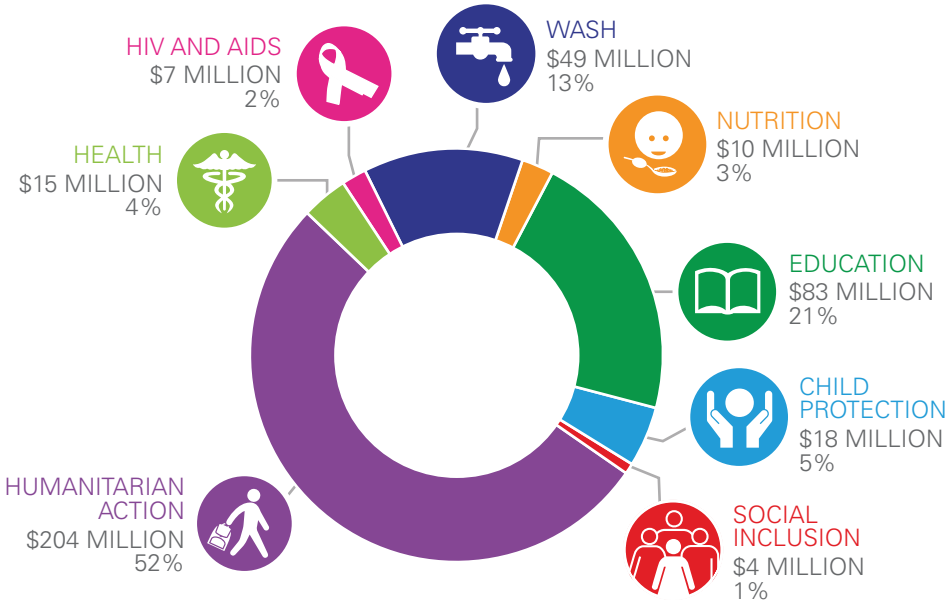
TABLE 3
Top 10 contributions to nutrition, 2015

Rank	Resource partners	Grant description	Total (US$)
1	United Kingdom	Improving Nutrition 2012 -2015, Yemen	28,300,489
2	United States of America	Maternal and Child Nutrition Stunting Reduction Program, Pakistan	20,000,000
3	United Kingdom	Accelerating Reduction in Under Nutrition, Ethiopia	14,423,260
4	United Kingdom	Enhancing Resilience in Karamoja, Uganda	12,381,446
5	United Kingdom Committee for UNICEF	Community Management of Acute Malnutrition, Nigeria	10,578,356
6	The Netherlands	Accelerating Stunting Reduction Among Children under 2, Rwanda	7,609,295
7	Korean Committee for UNICEF	Country thematic funding for nutrition in Democratic People's Republic of Korea, SP 2014–2017	6,000,000
8	United Kingdom	Improving Newborn and Child Nutrition, Nigeria	5,656,758
9	United Kingdom	Nutrition Emergency Response for the Conflict Affected, South Sudan	4,897,645
10	Japan	Emergency Preparedness and Response, and Building Resilience, Burkina Faso	3,700,000

**Figures do not include financial adjustments.*

FIGURE 28

Thematic revenue share by outcome area and humanitarian action, 2015: US$390 million

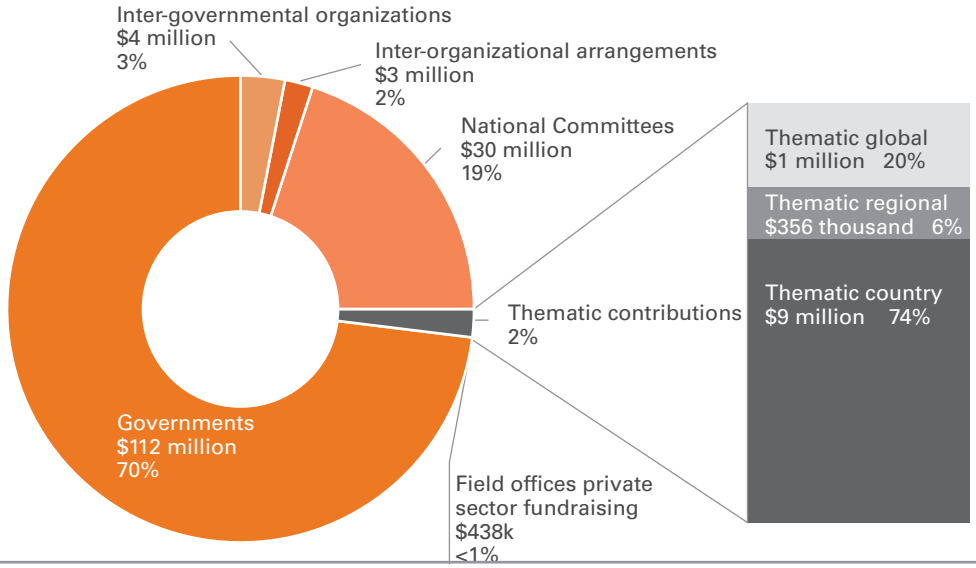


In 2015, UNICEF received US$10 million in thematic contributions for nutrition *(see Figure 28)*, compared to US$5 million in 2014. The nutrition sector is grateful for these contributions, because they are a crucial support to long-term planning and sustainable programming.

While there were greater resources available for nutrition in 2015 than the previous year, only 2 per cent of those were flexible, thematic funds *(see Figure 29)*, compared with 1 per cent in 2014. Greater thematic resources would allow the sector to improve long-term planning, increase internal capacity within the nutrition sector, strengthen knowledge and evidence generation, and react with flexibility to new areas of work and ongoing challenges.

FIGURE 29

Other resources by funding modality and partner group, nutrition, 2015: US$158 million



** Figures do not include US$2 million in adjustments.*

Of all thematic contributions to the sector, only 20 per cent was given most flexibly as global thematic funding *(see Figure 29)*. Notably, the Government of Luxembourg gave the most flexible thematic contribution to nutrition, at the global level.

Over 65 per cent of thematic contributions received for nutrition came from the Korean Committee for UNICEF, for programming at the country level in the Democratic People's Republic of Korea. Sizeable thematic contributions were also received at the country and regional levels from the Government of Sweden and the U.S. Fund for UNICEF (see Table 4).

UNICEF is seeking to broaden and diversify its funding base (including thematic contributions). The number of partners contributing thematic funding to nutrition decreased slightly from 16 in 2014 to 15 in 2015.

TABLE 4
Thematic revenue to nutrition by resource partner, 2015*

Resource partner type	Resource partner	Total (US$)	Percentage
Governments 16%	Sweden	774,552	7.59%
	Luxembourg	588,235	5.76%
	Flanders International Cooperation (Belgium)	270,856	2.65%
National Committees 82%	Korean Committee for UNICEF	6,652,833	65.17%
	United States Fund for UNICEF	648,491	6.35%
	Dutch Committee for UNICEF	326,797	3.20%
	Swedish Committee for UNICEF	322,941	3.16%
	United Kingdom Committee for UNICEF	180,769	1.77%
	Slovenian Committee for UNICEF	72,921	0.71%
	Belgium Committee for UNICEF	60,599	0.59%
	Spanish Committee for UNICEF	37,438	0.37%
	Norwegian Committee for UNICEF	22,398	0.22%
	Portuguese Committee for UNICEF	9,398	0.09%
	Czech Committee for UNICEF	5,315	0.05%
Field office private sector fundraising 2%	Unicef Thailand	235,000	2.30%
Grand total		**10,208,544**	**100.00%**

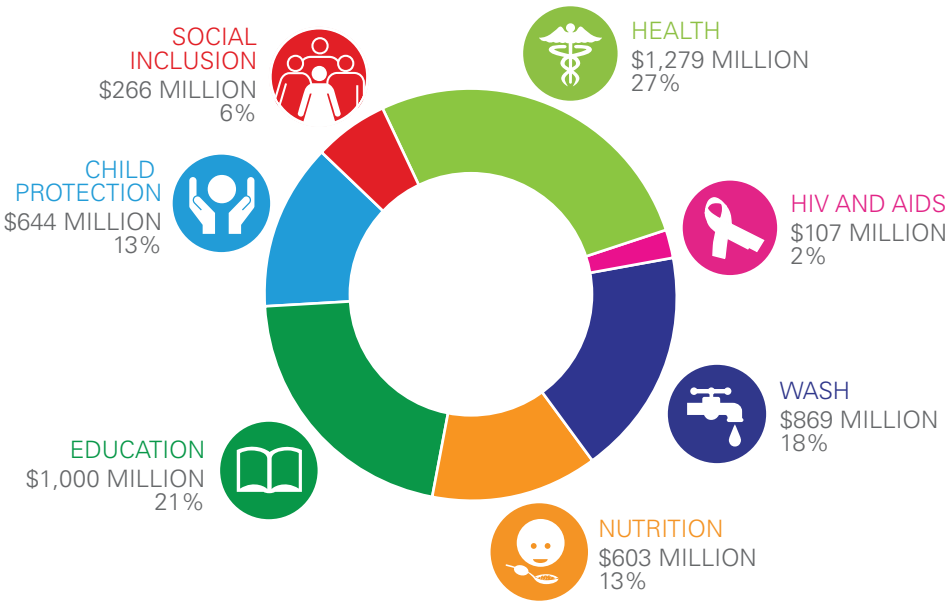
**Figures do not include financial adjustments.*

Spending for nutrition has increased by almost 25 per cent since the launch of the Strategic Plan – from US$484 million in 2014 to US$603 million in 2015. This increase reflects the momentum for scaling up nutrition in countries and the growing recognition that investments in nutrition are proven and cost-effective and yield sustainable results. Expenses are higher than the income received because expenses comprise total allotments from regular resources and other resources (including balances carried over from prior years) to the outcome areas, while income reflects only earmarked contributions from 2015 to the same.

TABLE 5
Total expenses by Strategic Plan outcome area, 2015 (US$)

Prorated outcome area	Other resources – emergency	Other resources – regular	Regular resources	Total
Health	338,059,808	717,316,904	223,258,479	1,278,635,191
HIV and AIDS	6,215,775	65,209,301	35,683,399	107,108,474
WASH	435,792,883	322,797,427	110,088,929	868,679,239
Nutrition	256,609,393	216,904,867	129,963,864	603,478,124
Education	321,097,543	521,573,717	157,763,280	1,000,434,540
Child protection	264,753,532	222,439,310	156,420,873	643,613,715
Social inclusion	63,365,554	84,179,498	118,870,107	266,415,159
Grand total	**1,685,894,488**	**2,150,421,024**	**932,048,930**	**4,768,364,442**

FIGURE 30
Total expenses by Strategic Plan outcome area, 2015



Nutrition programming accounted for 13 per cent of UNICEF's spending in 2015, a share similar to that of the previous year.

The majority of funds spent continued to be directed to emergencies in 2015, which is crucial in allowing UNICEF to carry out its mandate and ensure its Core Commitments to Children. UNICEF would also like to increase its investments in prevention, resilience and systems strengthening – and flexible funding pools are important tools to support these activities.

FIGURE 31
Expenses by year for nutrition, 2014–2015

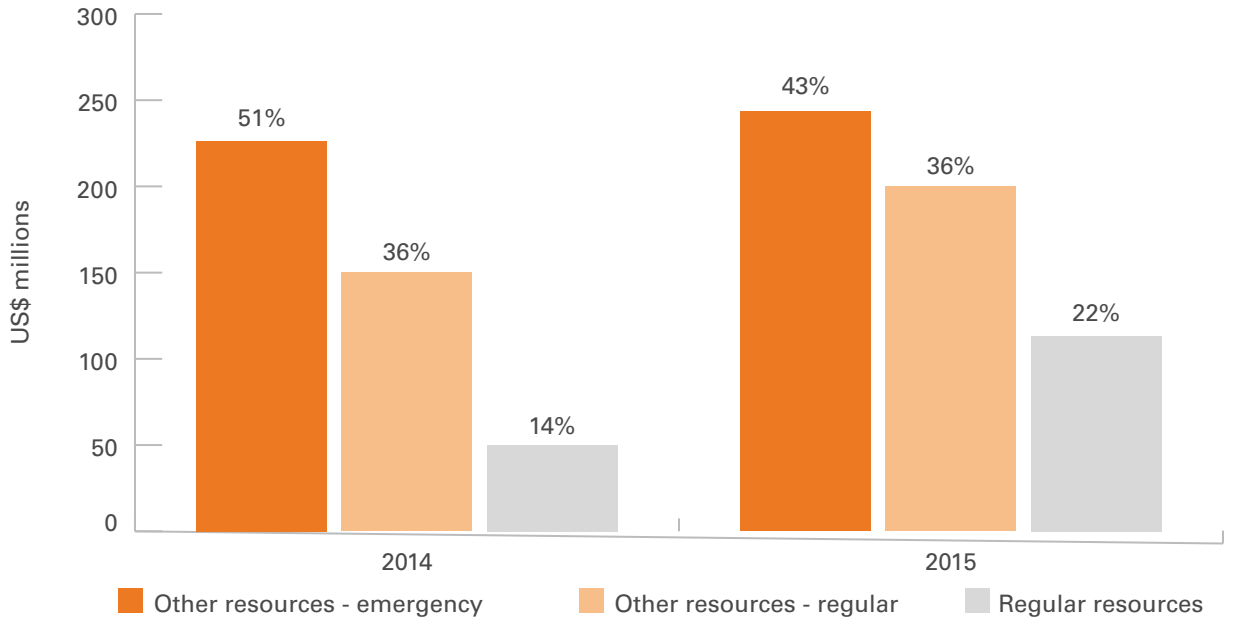


TABLE 6
Total expenses by region for nutrition, 2015 (US$)

Region	Other resources – emergency	Other resources – regular	Regular resources	Total
CEE/CIS	41,081	3,653,300	1,146,898	4,841,279
EAPR	6,034,504	9,153,191	3,864,362	19,052,057
ESAR	84,639,862	84,205,171	36,090,512	204,935,544
Headquarters	(1,603,277)	(338,717)	22,786,699	20,844,704
LACR	2,403,844	3,089,242	2,328,767	7,821,853
MENA	51,665,292	21,336,033	10,020,190	83,021,514
ROSA	24,324,117	18,726,274	24,221,303	67,271,694
WCAR	89,103,971	77,080,374	29,505,134	195,689,479
Grand total	**256,609,393**	**216,904,867**	**129,963,864**	**603,478,124**

As was the case in 2014, most nutrition spending in 2015 supported programming in Eastern and Southern Africa and West and Central Africa. This reflects the high levels of undernutrition in these regions, as well as the humanitarian crises facing many countries in 2015, such as drought in the Sahel and in East Africa, which required strong emergency nutrition responses. Spending in the Middle East and North Africa region increased from just under US$64 million in 2014 to US$83 million in 2015, reflecting the nutrition response to ongoing conflicts in Iraq and the Syrian Arab Republic and the refugee crisis in neighboring countries.

Table 7 shows the 20 countries where the most was spent on nutrition in 2015; these countries accounted for 70 per cent of all nutrition expenses. The nutrition

TABLE 7
Top country or regional offices, by expenses for nutrition, 2015 (US$)

Prorated outcome area	Other resources – emergency	Other resources – regular	Regular resources	Grand total
Ethiopia	8,179,125	36,782,988	4,589,663	49,551,776
Nigeria	1,187,584	31,843,138	5,585,152	38,615,874
South Sudan	31,192,530	823,735	2,967,394	34,983,659
Yemen	11,505,704	17,954,654	2,392,441	31,852,799
Somalia	25,281,578	2,251,208	4,121,492	31,654,278
Sudan	17,962,428	1,735,953	3,671,538	23,369,919
Niger	11,413,214	7,430,435	4,376,472	23,220,121
Mali	9,482,152	9,254,954	2,696,989	21,434,094
Democratic Republic of the Congo	12,919,778	4,799,688	3,282,156	21,001,622
Afghanistan	10,413,029	3,555,977	3,919,898	17,888,904
India	(13,559)	4,173,835	11,996,967	16,157,243
Kenya	10,528,729	3,946,790	1,563,622	16,039,142
Malawi	911,207	4,382,525	10,127,162	15,420,894
Pakistan	7,017,253	4,765,029	2,699,429	14,481,711
Burkina Faso	8,716,425	3,632,315	1,347,286	13,696,025
Chad	12,383,156	415,673	771,966	13,570,794
Iraq	6,965,863	480,389	2,795,165	10,241,417
Uganda	2,722,828	5,529,521	1,877,605	10,129,954
Sierra Leone	4,317,873	3,231,767	1,810,282	9,359,922
Rwanda	121,076	7,704,203	155,195	7,980,474
Total top 20	**193,207,972**	**154,694,776**	**72,747,874**	**420,650,622**

spending in these countries makes sense given that 17 of them have either a stunting prevalence ≥ 40 per cent or a wasting prevalence ≥ 10 per cent.[129] Many of these countries faced humanitarian crises in 2015 related to conflict, natural disasters, disease outbreaks and El Nino-induced drought, and thus significant funds were allocated to support emergency nutrition response.

FIGURE 32
Expenses by programme area for nutrition, 2015

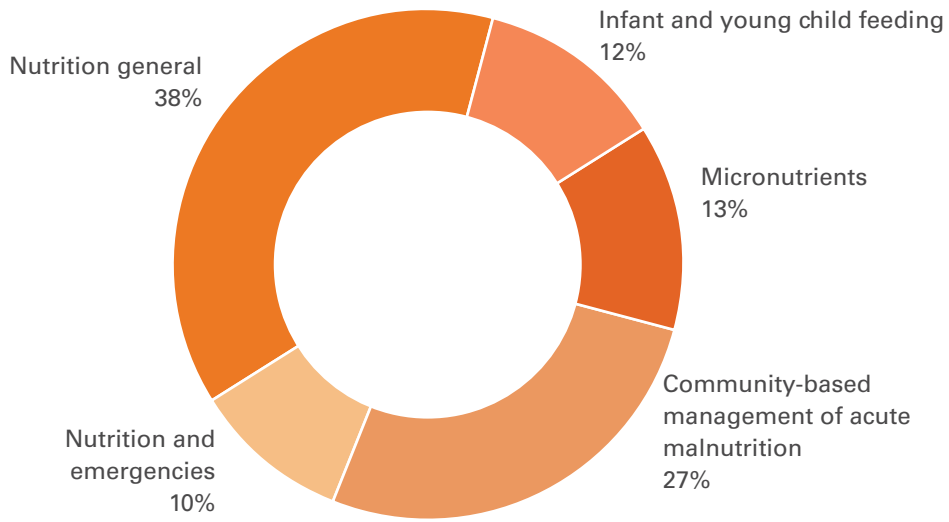


TABLE 8
Expenses by programme area for nutrition, 2014-2015 (US$)

Programme area	Other resources – emergency	Other resources – regular	Regular resources	Total
Infant and young child feeding	**33,355,598**	**61,848,356**	**36,116,670**	**131,320,624**
2014	15,429,864	29,185,759	11,755,271	56,370,895
2015	17,925,734	32,662,596	24,361,399	74,949,729
Micronutrients	**16,005,674**	**55,677,961**	**46,763,561**	**118,447,196**
2014	8,718,517	26,896,676	4,070,424	39,685,616
2015	7,287,157	28,781,285	42,693,137	78,761,579
Nutrition and HIV	**9,319**	**201,362**	**15,507**	**226,188**
2014	9,979	98,176	334	108,490
2015	(660)	103,185	15,173	117,698

Community-based management of acute malnutrition	158,732,055	102,196,614	21,783,786	282,712,455
2014	69,760,267	38,040,345	10,285,012	118,085,624
2015	88,971,788	64,156,269	11,498,774	164,626,831
Nutrition and emergencies	90,022,905	25,305,886	14,480,171	129,808,962
2014	43,669,264	19,787,140	7,720,263	71,176,666
2015	46,353,641	5,518,747	6,759,909	58,632,296
Nutrition general	203,622,147	145,152,013	76,365,669	425,139,830
2014	107,550,414	59,469,228	31,730,197	198,749,838
2015	96,071,734	85,682,785	44,635,472	226,389,991
Grand total	501,747,698	390,382,191	195,525,365	1,087,655,254

In 2015, general nutrition activities accounted for the greatest expense – 38 per cent – of all nutrition sector programme areas. The general nutrition programme includes UNICEF's work to support countries to use evidence-based nutrition strategies and develop and strengthen nutrition policies and programming. Given the cross-cutting nature of the general nutrition programme, expenses in this area are also linked with those in more specific programming areas and support a holistic approach to achieving nutrition results. To illustrate, a complementary feeding programme may be allotted combined funds from the IYCF programme (to support facility and community-based counselling interventions), the micronutrients programme (for supply of micronutrient powders) and the general nutrition programme (for broader nutrition policy development). Given the inherent overlap in programming areas, Table 8 should thus be seen as only a rough breakdown of expenses across nutrition programme areas.

Spending on the management of severe acute malnutrition (SAM) and nutrition in emergencies was also high in 2015, given the high burden of SAM and the number and scale of emergencies. Spending in this area helps UNICEF fulfill its Nutrition Cluster role and ensure timely and effective response to nutrition emergencies.

TABLE 9
Expenses by cost category and year for nutrition, 2014-2015 (US$)

Cost category	Other resources - emergency	Other resources - regular	Regular resources	Total
Contractual services	**19,082,584**	**19,030,453**	**21,167,903**	**59,280,940**
2014	7,603,947	8,216,682	(13,555,607)	2,265,022
2015	11,478,637	10,813,771	34,723,510	57,015,919
Equipment, vehicles and furniture	**1,387,647**	**427,572**	**2,132,589**	**3,947,809**
2014	624,691	179,674	639,754	1,444,118
2015	762,957	247,899	1,492,835	2,503,690
General operating and other direct costs	**19,523,023**	**12,154,764**	**19,818,042**	**51,495,829**
2014	9,463,997	5,169,909	6,203,413	20,837,319
2015	10,059,026	6,984,856	13,614,629	30,658,510
Incremental indirect cost	**30,035,590**	**23,869,690**		**53,905,280**
2014	14,387,266	10,608,857		24,996,122
2015	15,648,324	13,260,833		28,909,157
Staff and other personnel costs	**41,884,445**	**35,062,938**	**43,330,934**	**120,278,317**
2014	17,821,118	15,509,832	19,297,605	52,628,555
2015	24,063,327	19,553,105	24,033,329	67,649,762
Supplies and commodities	**249,739,709**	**161,989,906**	**43,208,175**	**454,937,790**
2014	122,955,561	71,158,579	24,783,840	218,897,980
2015	126,784,149	90,831,327	18,424,335	236,039,810
Transfers and grants to counterparts	**132,036,079**	**130,903,651**	**57,132,199**	**320,071,929**
2014	68,679,122	59,353,956	24,184,748	152,217,826
2015	63,356,957	71,549,695	32,947,451	167,854,103
Travel	**8,058,621**	**6,943,215**	**8,735,524**	**23,737,360**
2014	3,602,604	3,279,834	4,007,749	10,890,187
2015	4,456,017	3,663,381	4,727,775	12,847,173
Grand total	**501,747,698**	**390,382,191**	**195,525,365**	**1,087,655,254**

The majority of nutrition sector expenses support the procurement of supplies – including ready-to-use therapeutic food (RUTF) and therapeutic milks, vitamin A capsules, micronutrient powders and tools used in growth monitoring (height boards, scales, etc.). The supply-oriented expenses of the nutrition programme are clearly reflected in the costing breakdown in Table 9. Supplies needed for emergency response, including those used for SAM management, are costly. The largest yearly quantity of RUTF to date – 2.5 million cartons for 62 countries – was procured in 2015. UNICEF remains the main procurer of RUTF, procuring to fill about 80 per cent of global needs, including in hard-to-reach places. In Yemen, for example, UNICEF remains one of the few agencies directly delivering supplies in remote areas and war zones.

In 2015, significant spending was also directed to transfers and grants to counterparts and implementing partners, to support them in delivering and implementing high-impact nutrition interventions. UNICEF's country experience and wide networks allow it to target funds to the most strategic partners to ensure wide coverage of interventions, especially in fragile settings where the health system is weak. The nutrition sector spends comparatively less on staff and personnel and would benefit from the ability to further strengthen human resources capacity to respond to new demands, including through the use of global-level emergency surge systems with additional roving personnel.

At the half point of the current Strategic Plan, by the end of 2015, expenses reached close to 50 per cent of the revised planned amounts by outcome area. By using expenses as a proxy for revenue, the Strategic Plan remains 50 per cent unfunded. Specifically for nutrition, the gap is 36 per cent up to the end of 2015 for the 2014–2017 planned period. UNICEF looks forward to working closely with its partners to meet these funding needs and fulfil the shared commitments and results towards Agenda 2030.

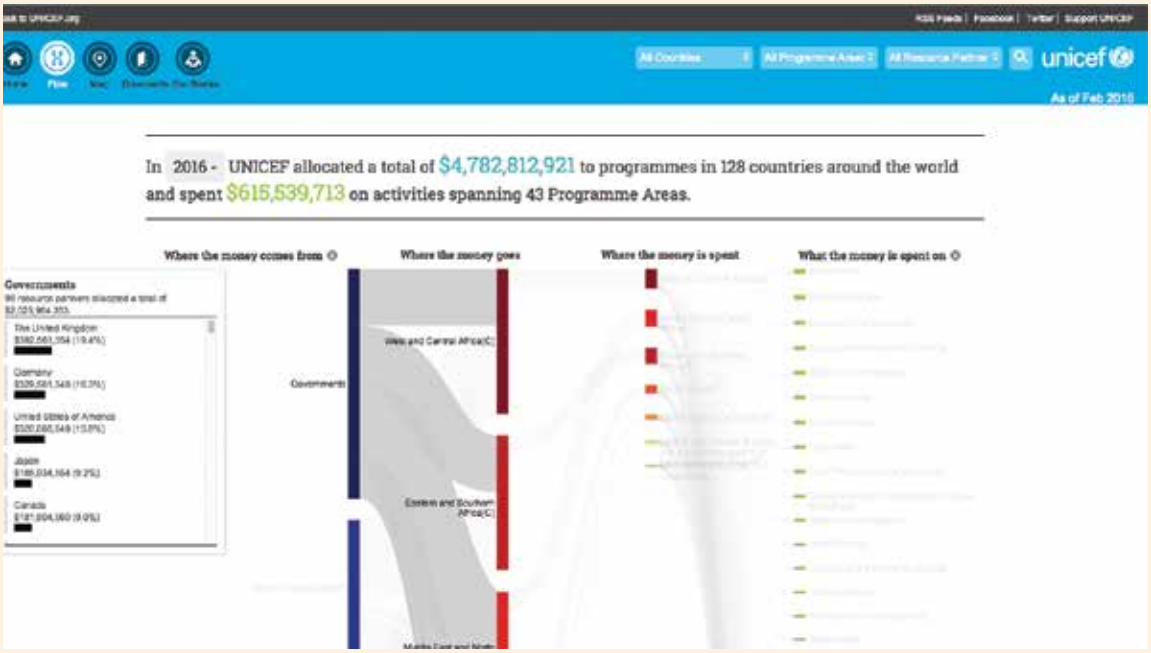
TABLE 10

Strategic Plan integrated results and resources framework by outcome area, 2014–2017: Updated planned amounts, actual expenses and funding gap (US$ millions)*

Outcome	Planned 2014-2017			Actual Expenses			Funding Gap		
	Regular resources	Other resources	Total resources	Regular resources	Other resources	Total resources	Regular resources	Other resources	Total resources
Health	1,023	3,760	4,783	473	2,035	2,508	550	1,725	2,275
HIV and AIDS	183	671	854	73	141	214	109	530	640
WASH	548	2,014	2,562	211	1,385	1,596	336	630	966
Nutrition	365	1,343	1,708	196	892	1,088	170	451	620
Education	730	2,686	3,416	293	1,533	1,827	437	1,153	1,590
Child protection	438	1,611	2,050	302	856	1,158	136	756	892
Social inclusion	365	1,343	1,708	244	265	509	121	1,078	1,199
Totals	**3,652**	**13,429**	**17,081**	**1,792**	**7,107**	**8,899**	**1,860**	**6,322**	**8,182**

** Expenses as a proxy for revenue received.*

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



FUTURE WORKPLAN

Although only in the second year of its 2014–2017 Strategic Plan, UNICEF has already made important progress towards outcome 4: improved and equitable use of nutrition support and improved nutrition and care practices. Many countries have improved coverage of key micronutrient interventions such as vitamin A and iodized salt. Others have seen an increase in rates of exclusive breastfeeding and better IYCF counselling and support for caregivers. And many countries are scaling up SAM management, improving treatment coverage and quality, and addressing bottlenecks – both in humanitarian and development contexts. Despite many large-scale emergency situations in 2015, UNICEF continued to lead and coordinate rapid and effective nutrition response in fragile settings for some of the most vulnerable women and children.

In order for UNICEF to better respond in a more complex and dynamic programming environment in the post-2015 era, flexible funds are urgently needed. While thematic contributions to nutrition doubled from US$5 million in 2014 to US$10 million in 2015, they only account for 2 per cent of all resources to the outcome area. Flexible funding will help support investments in systems strengthening to support long-term sustainability, risk-informed programming and resilience in countries. This will be particularly important because the number and scale of emergencies is expected to increase in 2016 and beyond.

In 2016, UNICEF will continue to support global efforts to prioritize nutrition in Agenda 2030 and advocate for national investments in nutrition to improve sustainable development. At the programming level, UNICEF will support countries towards progress on SDG targets. UNICEF's vast country presence and multi-sectoral approach make it well-placed to advance progress on nutrition SDG targets. At the same time, progress in nutrition will lay the foundations for the achievement of many other SDG targets.

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 seek to collaborate with a wide array of partners, including UN agencies, international and national NGOs, academic institutions, civil society and the private sector, to advocate for and support the scale-up of nutrition programmes. Multi-sectoral collaboration will remain crucial to UNICEF's work. In 2016 the nutrition sector will develop cross-sectoral technical guidance and tools and develop capacity in multi-sectoral actions, particularly with health, WASH and data and analytics. There are important opportunities to strengthen collaboration with ECD to maximize impact on complementary feeding, while sustaining and expanding ECD.

In the last two years of the Strategic Plan, UNICEF will further define its approach to emerging issues in nutrition, including child overweight and obesity, particularly in countries facing those issues in conjunction with high burdens of stunting, wasting and micronutrient deficiencies. The Lancet series on obesity, launched in February 2015, highlighted the 'unacceptably slow' progress in tackling global obesity rates over the last decade, making eight major recommendations for better progress. These will shape UNICEF's Theory of Change moving forward.

UNICEF's role as co-lead of the Breastfeeding Advocacy Initiative will be a key opportunity to support countries in their efforts to scale up support for breastfeeding. In 2016, UNICEF will work to expand the partnership further, to strengthen active engagement with partners, and to leverage advocacy opportunities, such as the Nutrition for Growth meeting, and the Women Deliver conference. UNICEF will also work to link global advocacy with support to countries, and implement advocacy and communication strategies to increase commitment for breastfeeding among stakeholders and target audiences.

UNICEF will also further expand and improve the quality of treatment for SAM, including through the use of innovative technologies to improve efficiency, programme quality and accountability. In 2016, UNICEF will play an active role in strengthening SAM programme design and monitoring through coordinating and supporting the increased application of the bottleneck analysis approach for effective coverage of SAM at country level. Efforts to document processes, lessons, challenges, results and best practices in addressing common and critical bottlenecks will be key to reinforcing the technical capacity of countries for programme scale-up.

While UNICEF's nutrition budget increased in 2015, nutrition is still a neglected area in terms of resources. There remains a significant human resource challenge in meeting growing programme needs from governments and partners. Limited predictable funding has curtailed long-term strategic planning, and it continues to be challenging to fund positions that support global and regional nutrition programmes. For 2016 and 2017, the core functions of the micronutrients programme are covered. However, in addition to required funding on MNP programmes, the nutrition sector is also seeking follow-up funding to support global salt iodization programmes. Work on obesity, complementary feeding and emergencies is also hampered by lack of fund availability.

Momentum has been building for nutrition, and national surveys in a number of countries indicate good progress. It is crucial that UNICEF continue to build on these successes, strengthen existing evidence and act innovatively to ensure that further progress will be reported by the end of the Strategic Plan period. To support this objective, UNICEF will seek to mobilize US$620 million to cover nutrition work for the remainder of the Strategic Plan period. 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. Flexible revenue streams will help address critical funding gaps and ensure timely humanitarian response. They will also be crucial in supporting long-term programming and guaranteeing that UNICEF is responsive and visionary in fulfilling its responsibilities to the world's children.

EXPRESSION OF THANKS

UNICEF wishes to acknowledge the support of all government resource partners and National Committees for their generous contributions to achieve results in nutrition in 2015. Special thanks goes to the Governments of the United Kingdom, the United States of America and the Netherlands; and to the National Committees of the United Kingdom and the Republic of Korea.

A girl eats a meal at the local community health post in Klaten District, Central Java Province, Indonesia. The food has been prepared by volunteer community health workers, who play an important role in the country's health system.

ABBREVIATIONS AND ACRONYMS

ACF	Action Contre la Faim (Action Against Hunger)
ARV	antiretroviral drugs
ASEAN	Association of Southeast Asian Nations
BMGF	Bill and Melinda Gates Foundation
BNA	bottleneck analysis
CCC	Core Commitments for Children
CDC	Centers for Disease Control
CMAM	community management of acute malnutrition
CMN	Coverage Monitoring Network
Code, the	International Code of Marketing of Breastmilk Substitutes
DFID	Department for International Development (UK)
DNSO	district nutrition support officer
DHS	Demographic and Health Surveys
ECD	early childhood development
ENN	Emergency Nutrition Network
ESARO	Eastern and Southern Africa Regional Office
FAO	Food and Agricultural Organization
FFI	Food Fortification Initiative
FFP	Food for Peace (USAID)
GAIN	Global Alliance for Improved Nutrition
GAVA	Global Alliance for Vitamin A
IDD	iodine deficiency disorders
IMAM	integrated management of acute malnutrition
IFAD	International Fund for Agricultural Development
IYCF	infant and young child feeding
MAM	moderate acute malnutrition
MENA	Middle East and North Africa Region
MICS	Multiple Indicator Cluster Surveys
MMS	multiple micronutrient supplements
MNP	micronutrient powders
MoRES	Monitoring Results for Equity System
MUAC	mid-upper-arm-circumference
MYCNSIA	Maternal and Young Child Nutrition Security Initiative in Asia
NetCode	International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions
OCHA	Office for the Coordination of Humanitarian Affairs
ORE	other resources-emergency
ORR	other resources-regular
ORS	oral rehydration solution
REACH	Renewed Efforts Against Child Hunger
RR	regular resources
RUTF	ready-to-use therapeutic foods
SAARC	South Asia Association for Regional Cooperation
SAM	severe acute malnutrition
SCN	Standing Committee on Nutrition
SDG	Sustainable Development Goals
SMQ	strategic monitoring questions
SUN	Scaling Up Nutrition
UNICEF	United Nations Children's Fund
USI	Universal Salt Iodization
VAS	vitamin A supplementation
WASH	water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization

ENDNOTES

1. Stunting prevalence in Ethiopia: Demographic and Health Surveys (DHS) 2005 (51 per cent), mini-DHS 2014 (40 per cent). India: National Family and Health Survey, 2005–2006 (48 per cent), Rapid Survey on Children (RSOC) 2013–2014 (38 per cent). Ghana: DHS 2008 (28 per cent) and 2014 (19 per cent) (data to be verified). Kenya: DHS 2008–2009 (35 per cent), DHS 2014 (26 per cent). Rwanda: DHS 2005 (52 per cent), national screening 2014 (38 per cent). The United Republic of Tanzania: DHS 2004–2005 (44 per cent), the Office for National Statistics (ONS) 2014 (35 per cent).
2. For more information, see: http://data.unicef.org/nutrition/malnutrition.html#sthash.TQconxmZ.dpuf.
3. United Nations Children's Fund/World Health Organization/World Bank, 'Joint Child Malnutrition Estimates', September 2015 edition. For further information, see <http://data.unicef.org/nutrition/malnutrition.html#sthash.EE2e3BGj.dpuf>.
4. Based on programmes reported in NutriDash and Country Office Annual Reports.
5. The nutrition and HIV programme is noted as a separate programme in the Strategic Plan. However, given its cross-cutting nature, particularly with IYCF and the management of severe acute malnutrition, results in this area are integrated throughout the other programme areas.
6. Strategic Monitoring Questions (SMQ) data. In all, 122 countries provided data in 2014, and 123 provided data in 2015.
7. Referring to UNICEF Strategic Plan 2014–2017 indicators.
8. Network for the Global Monitoring and Support for Implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions; co-led by WHO and UNICEF.
9. Baseline 68 per cent in 2011.
10. From a baseline of 70 countries towards a target of 100.
11. For further details, see <www.ffinetwork.org/global_progress/index.php>.
12. Nutrition in emergencies and the management of severe acute malnutrition are structured as separate programme areas in the Strategic Plan. However, they are presented here in the same chapter given the overlap in the two programming areas. It is important to note that much of UNICEF's work on the community-based management of SAM occurs in non-emergency, development contexts.
13. This is the first time that reporting has distinguished between humanitarian and development contexts.
14. Preliminary data, SMQs, 2015, UNICEF.
15. Copenhagen Consensus 2012 Expert Panel findings, Copenhagen Consensus Center.
16. Stunting prevalence in Ethiopia: DHS 2005 (51 per cent), mini-DHS 2014 (40 per cent). India: National Family and Health Survey, 2005–2006 (48 per cent), Rapid Survey on Children (RSOC) 2013–2014 (38 per cent). Ghana: DHS 2008 (28 per cent) and 2014 (19 per cent) (data to be verified). Kenya: DHS 2008–2009 (35 per cent), DHS 2014 (26 per cent). Rwanda: DHS 2005 (52 per cent), national screening 2014 (38 per cent). The United Republic of Tanzania: DHS 2004–2005 (44 per cent), ONS 2014 (35 per cent).
17. For more information, please see: <http://data.unicef.org/nutrition/malnutrition.html#sthash.TQconxmZ.dpuf>.
18. United Nations Children's Fund, World Health Organization and World Bank, 'Joint Child Malnutrition Estimates', September 2015 edition. For further information, see <http://data.unicef.org/nutrition/malnutrition.html#sthash.EE2e3BGj.dpuf>.
19. Ibid.
20. Ibid.
21. International Food Policy Research Institute, *Global Nutrition Report 2015: Actions and accountability to advance nutrition and sustainable development*, IFPRI, Washington, D.C., 2015, <http://globalnutritionreport.org/2014/11/13/global-nutrition-report-2014/>.
22. Behrman, J., 'The Economic Rationale for Investing in Nutrition in Developing Countries', World Development, vol. 21, 1993, pp. 1749–1771.
23. Ibid.
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25. Proceedings of the Global Technical Meeting on the Longterm Consequences of Chronic Undernutrition in Early Life. 15 August 2012, UNICEF Nutrition, Emory and Tufts University. 2012.
26. For more information, see: http://www.ennonline.net/ourwork/reviews/wastingstunting.

27. The Lancet, 'Obesity 2015', 18 February 2015, <www.thelancet.com/series/obesity-2015>.

28. World Health Organization, *Report of the WHO Commission on Ending Childhood Obesity*, WHO Geneva, Switzerland, 2016, <http://apps.who.int/iris/bitstream/10665/204176/1/9789241510066_eng.pdf?ua=1>.

29. United Nations Global Nutrition Agenda, *Delivering on the Commitment to Eradicate Malnutrition in All Its Forms: The role of the UN system*, UNGNA, <http://scalingupnutrition.org/wp-content/uploads/2015/06/UN-Global-Nutrition-Agenda-2015.pdf>.

30. Food and Agricultural Organization and World Health Organization, 'Second International Conference on Nutrition: Conference Outcome Document – Framework for action', Rome, November 2014, <www.fao.org/3/a-mm215e.pdf>, accessed 2 April 2015.

31. United Nations Children's Fund, Evaluation Office, *Meta-analysis of UNICEF's nutrition programme evaluations 2009–2013*, UNICEF, New York, March 2014, <www.unicef.org/evaluation/files/Nutrition_Meta-Analysis__Final_Report_JUNE_9.pdf>

32. United Nations Children's Fund, 'UNICEF's Approach to Scaling Up Nutrition for Mothers and their Children', Discussion Paper, Programme Division, UNICEF, New York, June 2015', <http://www.unicef.org/nutrition/files/Unicef_Nutrition_Strategy.pdf>.

33. These two programme areas are closely linked in practice and are thus combined in the presentation of results.

34. For more information, see <www.unicef.org/strategicplan/files/2014-CRP_14-Theory_of_Change-7May14-EN.pdf>.

35. Expenses for the HIV and nutrition programme – US$117,698 – are cross-cutting and are not included in the programme schematics.

36. For more information, see <www.who.int/nutrition/topics/global_strategy/en/>, accessed March 2016.

37. Reference to indicator in UNICEF's Strategic Plan.

38. According to the International Labour Organization, safeguarding the health of expectant and nursing mothers and protecting them from job discrimination is a precondition for achieving genuine equality of opportunity and treatment for men and women at work and enabling workers to raise families in conditions of security.

39. Global Nutrition Report, 2015, <http://globalnutritionreport.org/2014/11/13/global-nutrition-report-2014/>.

40. Consisting of the minimum meal frequency and minimum dietary diversity. For further details, see: <http://apps.who.int/iris/bitstream/10665/43895/1/9789241596664_eng.pdf>.

41. There are no apparent differences between boys and girls in the regional data.

42. See the 'Financial Analysis' chapter for details of UNICEF's funding types and structure.

43. The breakdown of expenses within the programme should be taken as an estimate due to differences and inconsistencies in coding at country level. Cross-sectoral activities have been prorated and included in expense figures. Spending in HIV and nutrition is not included.

44. Reference to indicator in UNICEF's Strategic Plan. At the mid-term review, the nutrition section made a change to the definition of this indicator. The previous indicator had measured "countries with the capacities to provide IYCF counseling services to at least 70 per cent of communities". The baseline and 2014 figures mentioned are based on data collected from the NutriDash platform.

45. Refers to the difference between two percentages. In this case, from 52.2 to 72.3 per cent for exclusive breastfeeding, and from 29.6 to 23.9 per cent for stunting.

46. Stunting is measured in children under 2 years old.

47. Reference to indicator in UNICEF's Strategic Plan.

48. Course registration and completion statistics available at <http://nutritionworks.cornell.edu/UNICEF/admin.cfm>.

49. A network of community-level volunteers working to improve health and nutrition practices.

50. *Kebelles* are administrative districts in Ethiopia, composed of a number of smaller wards, or *woredas*.

51. In most cases, data were collected through DHS in 2014 but released in 2015.

52. Ministry of Women and Child Development (MWCD), Government of India. Rapid Survey on Children (RSOC) 2013–2014, Factsheets, MWCD, 2015, <http://wcd.nic.in/>, accessed 25 October 2015.

53. 2015 data has not yet been analysed, but the figure is expected to increase.

54. At the beginning of 2016, this number increased to 20 partners.

55. Every Woman Every Child, *Commitments in Support of the Global Strategy for Women's, Children's and Adolescents' Health*, October 2015, p. 95, see <www.everywomaneverychild.org/news-events/news/1140-commitments-compendium-in-support-of-the-global-strategy>.

56. First Foods, 'A global meeting to accelerate progress on complementary feeding for your children', Mumbai, November 2015, <www.firstfoodsforlife.org>.

57. Alive & Thrive, FAO, GAIN, WFP, WHO, UC Davis and USAID.

58. The outcome document is available at <www.ipu.org/splz-e/namibia15.htm>.

59. Odds Ratio=1.52, 95 per cent Confidence Interval=1.27-1.81.

60. Reference to indicator in UNICEF's Strategic Plan.

61. Data collected through NutriDash, 2014.

62. Copenhagen Consensus 2008, <www.copenhagenconsensus.com/sites/default/files/bpp_fortification.pdf>.

63. The breakdown of expenses within the programme should be taken as an estimate due to differences and inconsistencies in coding at country level. Cross-sectoral activities have been prorated and included in expense figures.

64. Priority countries are those with high under-five mortality rates or where deficiencies are a public health problem.

65. These types of mass campaign-style events may also be referred to as Child Health Days; Mother and Child Health Weeks; Maternal, Newborn and Child Health Weeks, Community Health Day, etc.

66. Effective VAS coverage is greater than 80 per cent.

67. Kumapley, Richard Senam, Roland Kupka, Nita Dalmiya , 'The Role of Child Health Days in the Attainment of Global Deworming Coverage Targets among Preschool-Age Children', PLoS Neglected Tropical Diseases, 9(11): e0004206. doi:10.1371/journal.pntd.0004206, published 6 November 2015.

68. Please note that this indicator was revised and baseline was revised.

69. Reference to indicator in UNICEF's Strategic Plan. Data are from UNICEF global databases and represent results achieved by all agencies.

70. Reference to indicator in UNICEF's Strategic Plan.

71. The number of non respondents was the same as for other indicators; however, given that the goal for this indicator was stated as an absolute number, the non-reporting distorts the figures by putting progress below the target already without even considering countries that had supply chain breaks.

72. See <www.hftag.org>.

73. Reference to indicator in UNICEF's Strategic Plan.

74. Other results from this programme related to IYCF and provision of MNPs are explored elsewhere in this report.

75. Haider BA, Bhutta ZA, 'Multiple-micronutrient Supplementation for Women during Pregnancy (Review)', Cochrane Review, 2015.

76. UNICEF global database 2015. This data point related to 2013.

77. Reference to indicator in UNICEF's Strategic Plan.

78. Data from NutriDash, 2014.

79. Reference to indicator in UNICEF's Strategic Plan.

80. Previous suboptimal monitoring tools have not been able to demonstrate the large public health benefits provided by salt iodization programs. UNICEF helped to identify the work required to improve those indicators. Such work is expected to improve support to salt iodization programmes, and to improve their effectiveness. In 2015, UNICEF received funding support for salt iodization from the Bill & Melinda Gates Foundation and USAID and this will help to improve progress to improve salt iodization rates.

81. Codling, Karen, et al., 'The Rise and Fall of Universal Salt Iodization in Vietnam: Lessons learned for designing sustainable food fortification programs with a public health impact', *Food and Nutrition Bulletin*, vol. 36, no 4, December 2015, pp. 441–454, <http://fnb.sagepub.com/content/36/4/441>.

82. For further details, see <www.ffinetwork.org/global_progress/index.php>.

83. <www.gainhealth.org/events/future-fortified>.

84. Stevens, Gretchen A., et al., 'Trends and Mortality Effects of Vitamin A Deficiency in Children in 138 Low-income and Middle-income Countries Between 1991 and 2013: A pooled analysis of population-based surveys' *Lancet Global Health*, vol. 3, no. 9, September 2015, pp. e528–e536.

85. Aguayo, Victor M., Anirudra Sharma, and Giri Raj Subedi, 'Delivering Essential Nutrition Services for Children After the Nepal Earthquake', *Lancet Glob Health*, vol. 3, no. 11, November 2015, pp. e665–e666, <www.thelancet.com/journals/langlo/article/PIIS2214-109X(15)00184-9/fulltext?rss=yes>.

86. Iodine Global Network, 'Global Scorecard 2014: Number of iodine deficient countries more than halved in past decade', IDD Newsletter, February 2015.

87. United Nations Children's Fund, *The State of the World's Children 2014 in Numbers: Every child counts*, UNICEF, New York, 2014.

88. At its core, risk-informed nutrition programming is different in that it challenges us to:
    1) Analyse all potential hazards—not just natural disasters or just conflict—to education populations, programmes and systems.
    2) Deliver collaborative, multi-sectoral programme strategies inclusive of sectors such as child protection, school health and nutrition, social protection, disaster risk reduction and climate change adaptation.
    3) Deliver nutrition strategies that continue seamlessly across the humanitarian and development cycles. This may mean that humanitarian interventions pay more attention to systems strengthening, and development interventions pay more attention to risk reduction.
    4) Ensure our investments in nutrition systems and programmes are protected from the impact of hazards.

89. Nutrition in emergencies and the management of severe acute malnutrition are structured as separate programme areas in the Strategic Plan; however, they are presented here in the same chapter given the overlap in the two programming areas. It is important to note that much of UNICEF's work on the community based management of SAM occurs in non-emergency, development contexts.

90. The breakdown of expenses within the programme should be taken as an estimate due to differences and inconsistencies in coding at country level. UNICEF supported MAM in special circumstances where WFP could not provide MAM support. Cross-sectoral activities have been prorated and included in expense figures. Spending in HIV and nutrition is not included.

91. The Sphere Project, 'Management of Acute Malnutrition and Micronutrient Deficiencies Standard 2: Severe acute malnutrition', <www.spherehandbook.org/en/management-of-acute-malnutrition-and-micronutrient-deficiencies-standard-2-severe-acute-malnutrition/>.

92. Including, for example, efforts to improve water and sanitation, control disease, end poverty and improve access to health services, among others.

93. Reference to indicator in UNICEF's Strategic Plan. Data from SMQ database. This is the first time that reporting has distinguished between humanitarian and development contexts.

94. Reference to indicator in UNICEF's Strategic Plan.

95. UNICEF/WHO/World Bank Joint Child Malnutrition Estimates, September 2015 edition.

96. United Nations Children's Fund, *NutriDash 2014 – Global Report on the Pilot Year*, UNICEF, New York, 2015.

97. Most countries had only received reports from January to October/November at the time of reporting. Reports will be updated in the final report in March 2016 with data for the whole year. Three countries (Mali, Sierra Leone and Yemen) received supplies/funds in October or November and the reporting timeline came too close to report on progress; two countries (South Sudan and Nigeria) have planned for USAID/FFP resources to be utilized in 2016.

98. This number was estimated on the basis of the proportion of children aged 6–59 months with weight-for-height Z score lower than –3 (severe wasting) before the earthquake, whereas the detection of children with severe wasting during Child Nutrition Week was based on a mid-upper-arm-circumference of less than 115 mm. Evidence indicates that the use of a mid-upper arm-circumference of less than 115 mm can lead to lower numbers of severely wasted children than would the use of a weight-for-height Z score WHZ lower than –3.
Source: Aguayo, Victor M., Anirudra Sharma, and Giri Raj Subedi, 'Delivering Essential Nutrition Services for Children After the Nepal Earthquake', *Lancet Glob Health*, vol. 3, no. 11, November 2015, pp. e665–e666, <www.thelancet.com/journals/langlo/article/PIIS2214-109X(15)00184-9/fulltext?rss=yes>.

99. For more information, see <www.ennonline.net/fex/50/samnigeriaeditorial>.

100. Fergusson, P., and A. Tomkins, 'HIV Prevalence and Mortality Among Children Undergoing Treatment for Severe Acute Malnutrition in Sub-Saharan Africa: A systematic review and meta-analysis', *Transactions of the Royal Society of Tropical Medicine and Hygiene*, vol. 103, no. 6, June 2009, pp. 541—548.

101. World Health Organization, *Guideline: Updates on the management of severe acute malnutrition in infants and children*, WHO, Geneva, 2013, <www.who.int/nutrition/publications/guidelines/updates_management_SAM_infantandchildren/en/>.

102. The Sphere Project, Humanitarian Charter and Minimum Standards in Humanitarian Response, 2011, <www.spherehandbook.org/>.

103. The 22 countries accounted for 90 per cent of the global number of pregnant women living with HIV who were in need of services to prevent mother-to-child transmission of HIV in 2009.

104. NutriDash, 2014.

105. With initial inputs from the Food and Nutrition Technical Assistance Project.

106. Malawi, Afghanistan, Pakistan, Sudan, Kenya and the United Republic of Tanzania.

107. For more information, see: 'SAM Management Bottleneck Analysis: A compendium of learning', UNICEF, January 2016.

108. Draft National Nutrition Policy of Afghanistan 2012–20120.

109. Assessment of nutritional status.

110. Note that this bottleneck analysis applies a different denominator to the globally accepted Sphere standards for recovery rate and is therefore not comparable (the minimum standard for recovery is >75 per cent by Sphere standards and calculated as the proportion of discharges recovered). See <www.sphereproject.org/handbook/>.

111. Reference to indicator in UNICEF's Strategic Plan.

112. 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.

113. Grupo de Resiliencia Integrada de Nutrición.

114. Reference to indicator in UNICEF's Strategic Plan.

115. UNICEF, UNHCR, Save the Children, ENN & reviewers, 'Interim Operational Considerations for the Feeding Support of Infants and Young Children under 2 Years of Age in Refugee and Migrant Transit Settings in Europe', 2015, http://www.ennonline.net/interimconsiderationsiycftransit.

116. Information from the 31 December 2015 Situation Report.

117. Reference to indicator in UNICEF's Strategic Plan.

118. See <www.unicef.org/eapro/UNICEF_program_guidance_on_manangement_of_SAM_2015.pdf>.

119. Vegetation Condition Index.

120. The breakdown of expenses within the programme should be taken as an estimate due to differences and inconsistencies in coding at country level. Cross-sectoral activities have been prorated and included in expense figures.

121. Sylhet and Khulna DNSOs are covering both districts and city corporations. In Dhaka, one DNSO is covering two city corporations.

122. Workshops were held in April 2015 in: **Asia** (Bangkok) for Bangladesh, Indonesia, Maharashtra State, Nepal, Pakistan, Philippines, Tajikistan and Viet Nam; **Latin America** (Guatemala) for Costa Rica, Guatemala, El Salvador, Peru; **Africa** (Abidjan – Francophone) for (Benin, Burkina Faso, Burundi, Cameroon, Comoros, Côte d'Ivoire, Madagascar, Mali, Mauritania, Democratic Republic of the Congo, Senegal, Chad and Togo); **Africa** (Entebbe – Anglophone) for Ghana, Kenya, Lesotho, South Sudan, Gambia, Uganda and Zambia.

123. Reference to indicator in UNICEF's Strategic Plan.

124. Reference to indicator in UNICEF's Strategic Plan.

125. NutriDash is an online annual data capture and reporting system for nutrition programming information at global scale.

126. Reference to indicator in UNICEF's Strategic Plan.

127. Ibid.

128. Figures for headquarters do not represent a shortfall; rather, funds were likely channelled through headquarters to country offices.

129. UNICEF, *State of the World's Children*, 2015.

ANNEX

Visualizing achievements

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

Green

Indicator level

Achievement of the indicator is at or above 100% of the milestone

Outputs and outcome area level

Average achievement of indicators in the output or outcome area is at or above 100%

Amber

Indicator level

Achievement of the indicator is between 60% and 99% of the milestone

Outputs and outcome area level

Average achievement of indicators in the output or outcome area is between 60% and 99%

Red

Indicator level

Achievement of the indicator is less than 60% of the milestone

Outputs and outcome area level

Average achievement of indicators in the output or outcome area is less than 60%

Nutrition

Average achievement rate:

99% 

Impact Indicator	Baseline*	2017 Target	2015 Update **
4a. Number of children under 5 years who are moderately and severely stunted	169 million (2010)	approx. 100 million (2025)	159 million (2014)
4b. Percentage of women of reproductive age with anaemia	38% pregnant, 29% non-pregnant (1995-2011)	50% reduction of anaemia in women of reproductive age	Updated data not available
Outcome Indicator	**Baseline***	**2017 Target**	**2015 Update****
P4.1 Countries with a current exclusive breastfeeding rate among children 0-5 months old ≥50% and no recent significant decline	27 (2007-2013)	40	28 out of 104 UNICEF programme countries (2010-2015)
P4.2 Countries with at least 90% of households consuming iodized salt	6 (2007-2013)[1]	25	Updated data not available due to definition changes
P4.3 Countries with at least 80% of primary caregivers engaged in early childhood stimulation for children aged 3-5 years (36-59 months) at home	16 (2005-2013)	30	26 out of 76 UNICEF programme countries with data (2005-2014)
P4.4 Children aged 6-59 months covered with two annual doses of vitamin A supplements in vitamin A-priority countries	68% (2011)	80%	69% (2014)
P4.5 Children aged 6-59 months affected by severe acute malnutrition (SAM) reached with quality treatment, defined as children who recovered	Admissions: 2.7 million (2012) Recovered: 85% (2012)	Admissions: 4 million Recovered: >75%	Admissions: 3.2 million (2014) Recovered: 82% (2014)

1 This indicator has been revised in accordance with the revision of the global indicator. Baseline is to be computed once the definition of the revised indicator is finalized.

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

Output a

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

Average output achievement

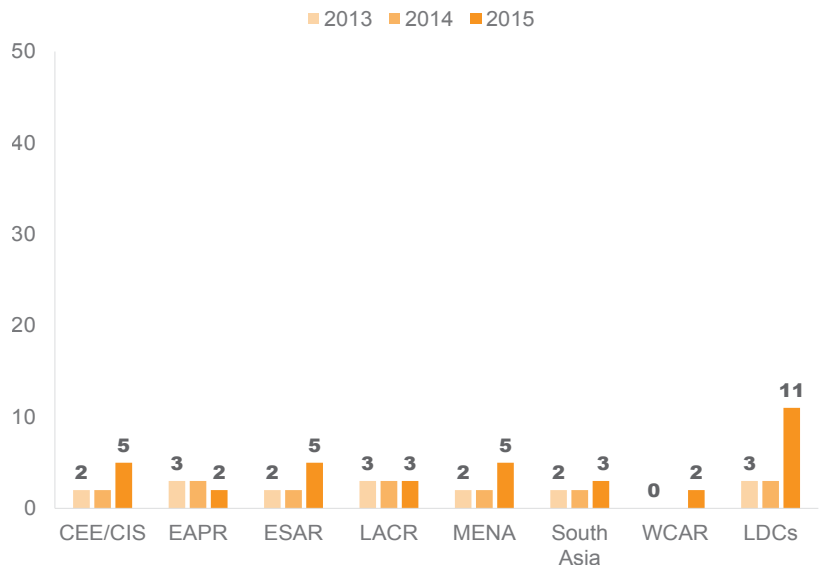
93%

P4.a.1

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

2013 Baseline	14
2014 Result	20
2015 Result	25
2015 Milestone	27
2017 Target	40

Achievement 93%



Output b

Increased national capacity to provide access to nutrition interventions

Average output achievement

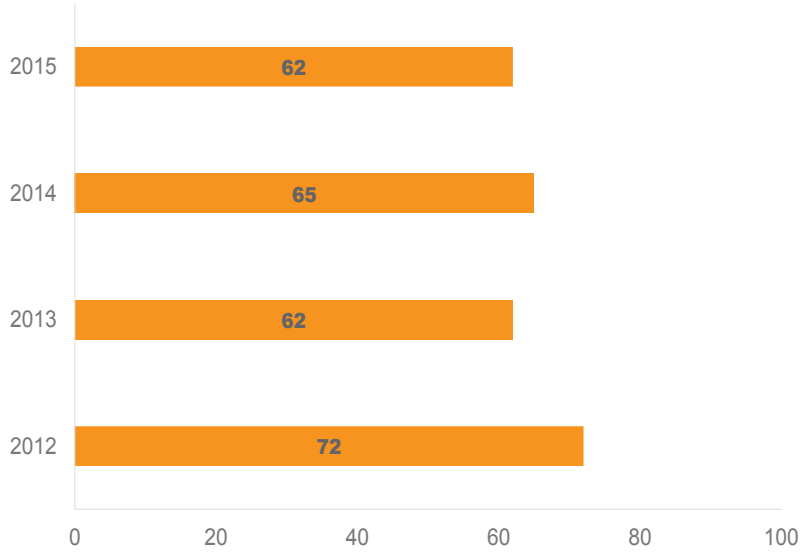
81%

P4.b.1

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

2012 Baseline	72
2013 Result	62
2014 Result	65
2015 Result	62
2015 Milestone	77
2017 Target	82

Achievement 81%



Output c

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

Average output achievement

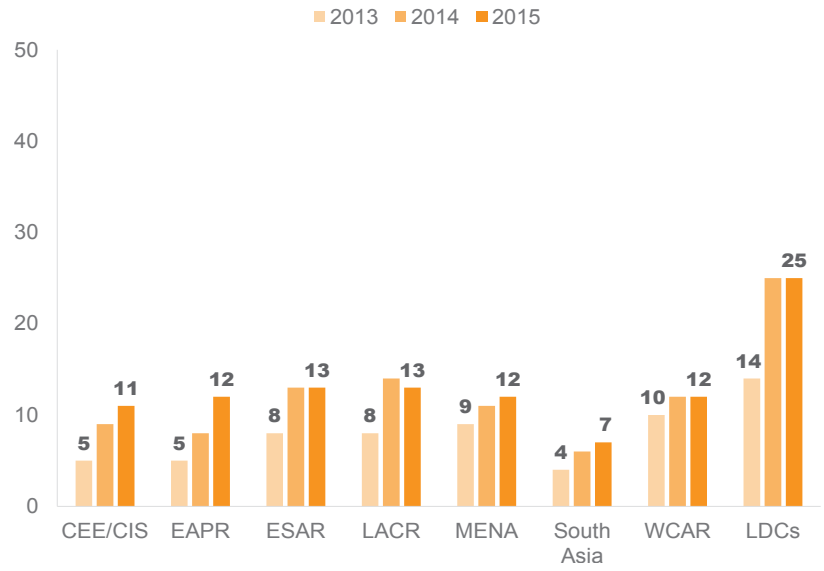
109%

P4.c.1

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

2013 Baseline	64
2014 Result	73
2015 Result	80
2015 Milestone	75
2017 Target	85

Achievement 107%

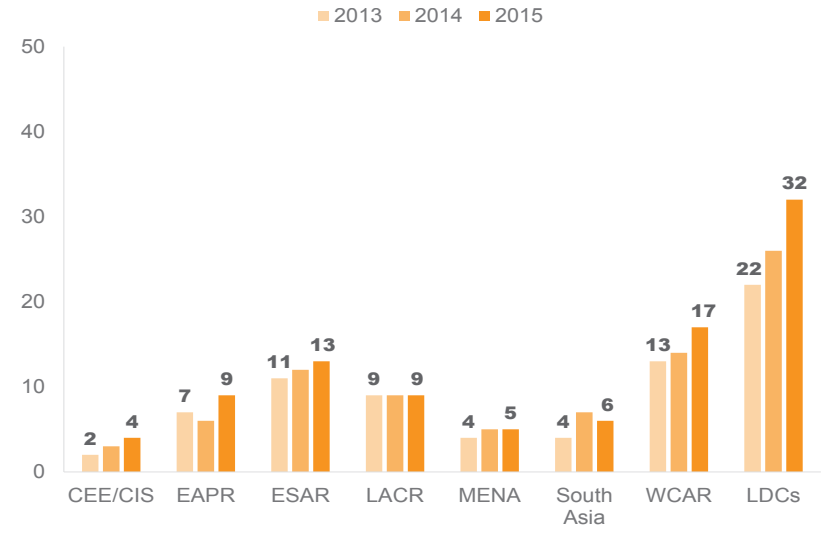


P4.c.3

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

2013 Baseline	50
2014 Result	56
2015 Result	63
2015 Milestone	60
2017 Target	70

Achievement 105%

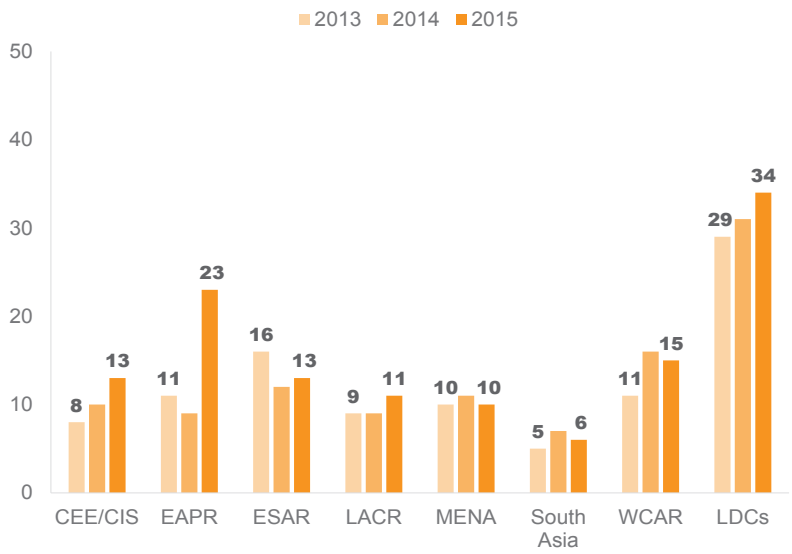


P4.c.2 (a)

Countries with a policy or plan targeting anaemia reduction in women

2013 Baseline	70
2014 Result	74
2015 Result	91
2015 Milestone	85
2017 Target	100

Achievement 107%

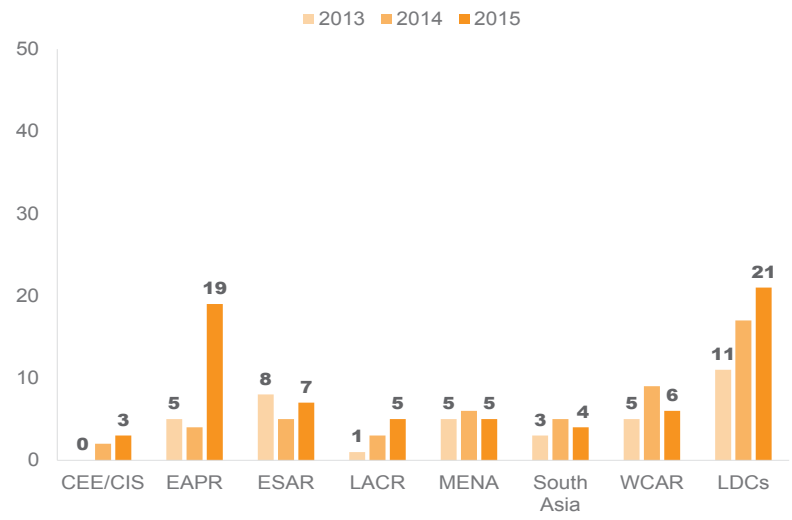


P4.c.2 (b)

Countries with a policy or plan targeting anaemia reduction in girls

2013 Baseline	27
2014 Result	34
2015 Result	49
2015 Milestone	39
2017 Target	50

Achievement 126%

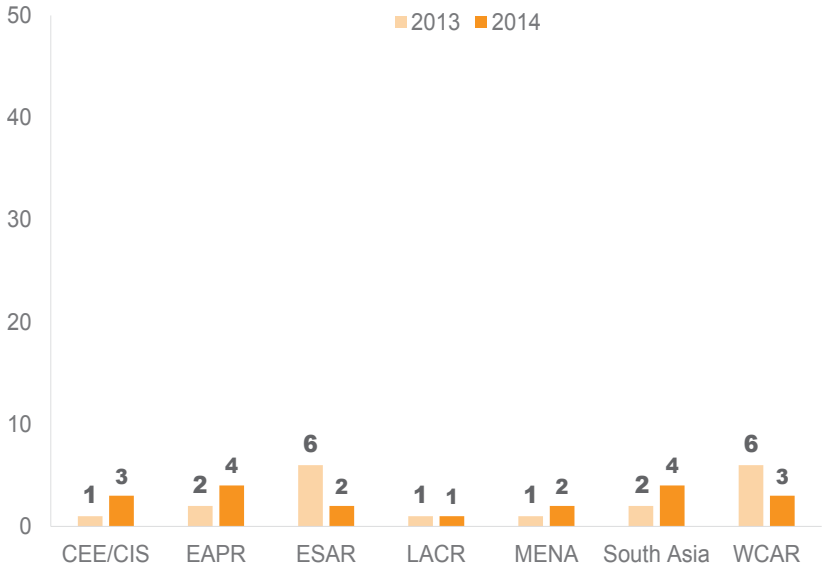


P4.c.4

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

2013 Baseline	19
2014 Result	19
2015 Result	-
2015 Milestone	35
2017 Target	45

Note: 2015 result is not yet available.

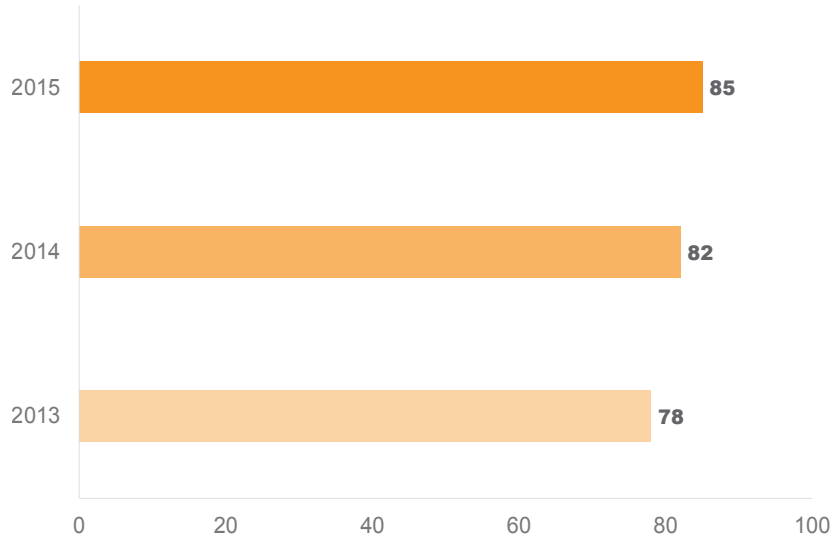


P4.c.5

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

2013 Baseline	78
2014 Result	82
2015 Result	85
2015 Milestone	83
2017 Target	90

Achievement 102%



Output d

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

Average output achievement

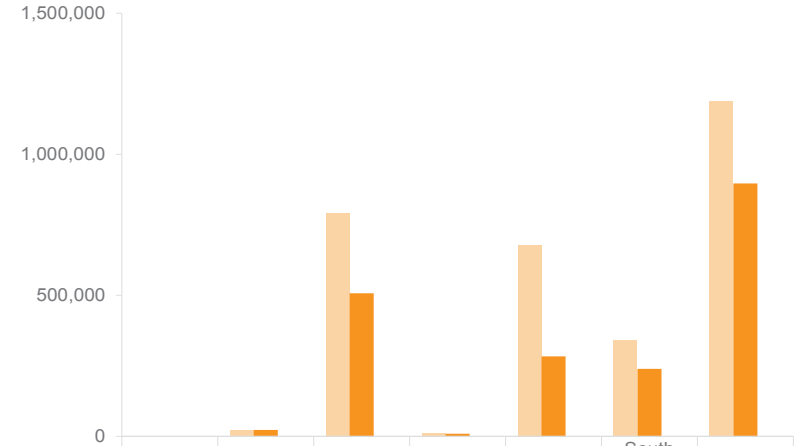
75%

P4.d.1 (a)

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

2014 Baseline	81%
2015 Result	65%
2015 Milestone	85%
2017 Target	95%

Achievement 76%



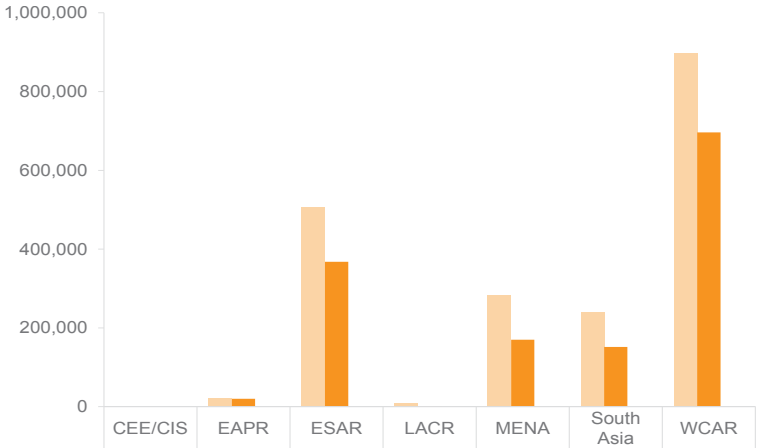
	CEE/CIS	EAPR	ESAR	LACR	MENA	South Asia	WCAR
Targeted	0	20,480	792,081	12,099	677,462	339,109	1,186,697
Admitted	0	22,547	507,383	9,040	283,627	238,981	896,652
% admitted	-	110	64	75	42	70	76

P4.d.1 (b)

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

2014 Baseline	74%
2015 Result	72%
2015 Milestone	>75%
2017 Target	>75%

Achievement 96%



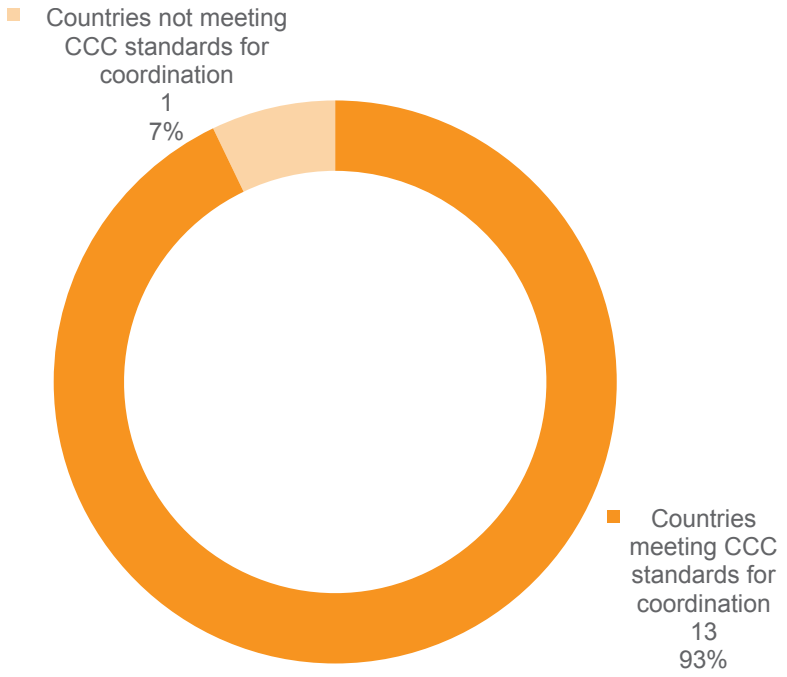
	CEE/CIS	EAPR	ESAR	LACR	MENA	South Asia	WCAR
Targeted	0	22,547	507,383	9,040	283,627	238,981	896,652
Recovered	0	20,003	368,015	371	170,050	151,578	696,397
% recovered	-	89	73	4	60	63	78

P4.d.2

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

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

Achievement 93%

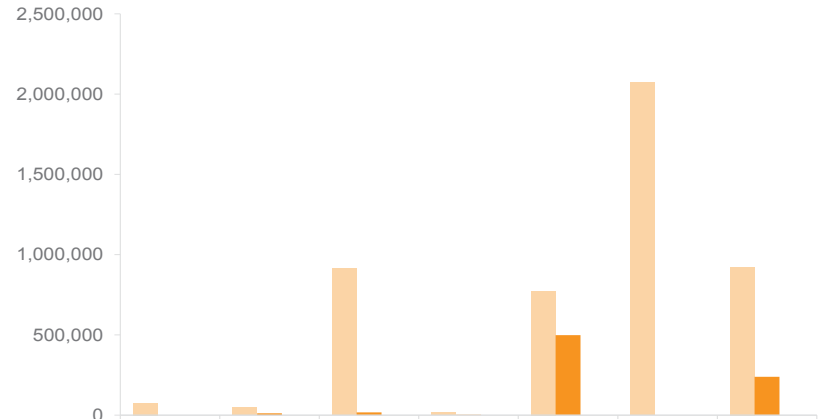


P4.d.3

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

2014 Baseline	45%
2015 Result	16%
2015 Milestone	48%
2017 Target	55%

Achievement 33%



	CEE/CIS	EAPR	ESAR	LACR	MENA	South Asia	WCAR
Targeted	76,400	45,937	912,438	16,551	773,950	2,074,123	923,602
Reached	0	12,000	17,763	2,996	498,693	0	239,219
% reached	0	26	2	18	64	0	26

Output e

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

Average output achievement

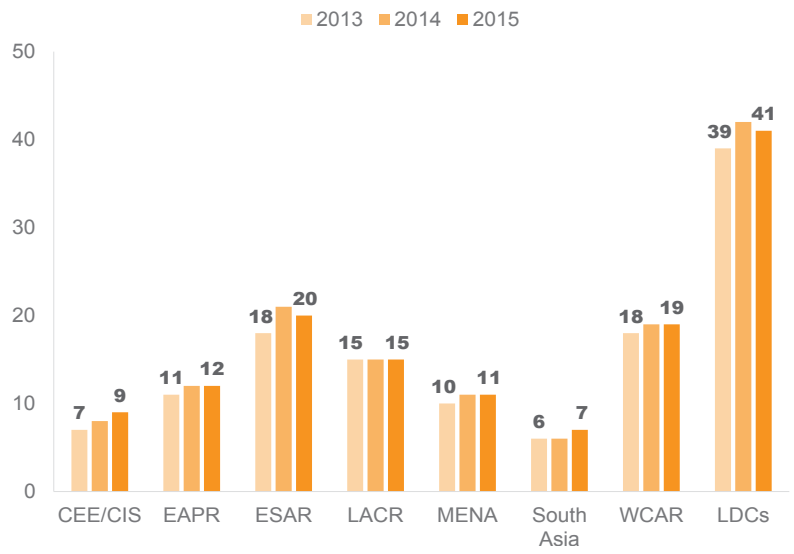
88%

P4.e.1

Countries with national management information systems that disaggregate data on nutrition

2013 Baseline	85
2014 Result	92
2015 Result	93
2015 Milestone	93
2017 Target	100

Achievement 100%

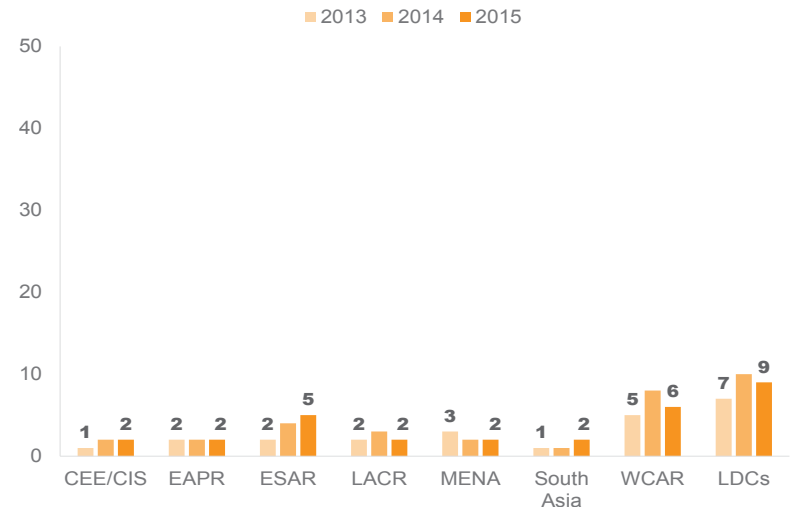


P4.e.2

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

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

Achievement 75%



Output f

Enhanced global and regional capacity to accelerate progress in child nutrition

Average output achievement

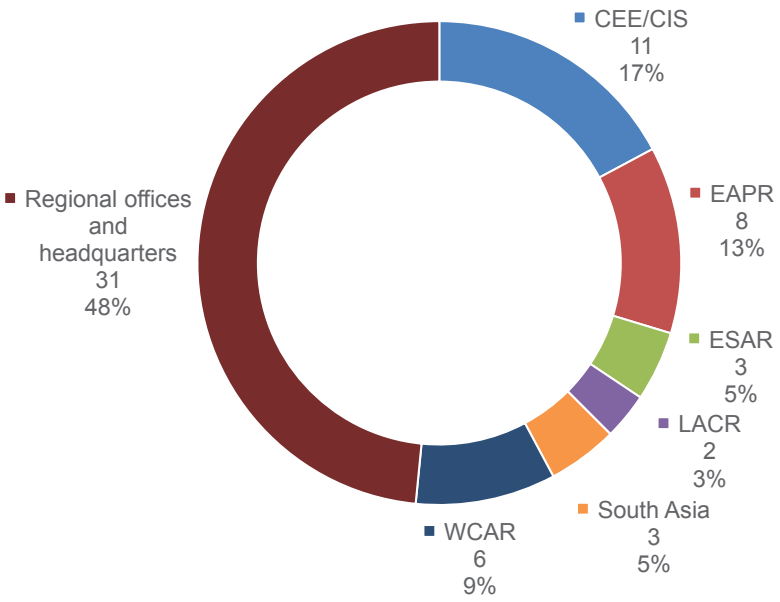
147%

P4.f.1

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

2014 Baseline	45
2015 Result	59
2015 Milestone	50
2017 Target	50

Achievement 118%



P4.f.2

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

2013 Baseline	6
2014 Result	9
2015 Result	14
2015 Milestone	8
2017 Target	10

Achievement 175%

Global initiatives

- Breastfeeding Advocacy Initiative
- Food Fortification Initiative
- Global Alliance for Vitamin A
- Global Nutrition Cluster
- Home Fortification Technical Advisory Group
- Infant and Young Child Feeding in Emergencies Core Group
- International Zinc Nutrition Consultative Group
- Iodine Global Network
- Micronutrient Forum
- Micronutrient Initiative
- Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breast-milk Substitutes
- Nutrition Partner Forum (in the United States of America)
- Scaling Up Nutrition (SUN Movement)
- UN Network for SUN (Scaling Up Nutrition) [Renewed Efforts Against Child Hunger and undernutrition/Standing Committee on Nutrition]

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