GOAL AREA 1
Every child survives and thrives

Global Annual Results Report 2018
Tania Begum with her 14-day-old child Alif at her mother’s house in Haktullah village, Badarpur union, Patuakhali district of southern Bangladesh. At nine days old, Alif was successfully treated for a cold, eye infection and jaundice at a special care newborn unit of Patuakhali Sadar Hospital. (April 2018)

A boy plays and learns at a UNICEF-supported early childhood development centre in Ulaanbaatar, Mongolia. UNICEF improves the quality of education, by investing in training for teachers and providing toys and learning materials. This centre is in a ger, a traditional Mongolian living structure. (September 2018)

Yatè Seyba, 3 years old, plays with her Tam-tam at the early childhood development centre in the village of Kendie in Mali. But with assistance from the H & M Foundation and UNICEF Sweden, children in this remote village can play and learn. (December 2018)

A young girl enjoys a meal at Tadika Sinaran Ria in Sausindak Penampang, Sabah, Malaysia

Véronique Yobouet, 30, of Yopougon, Côte d’Ivoire, cuddles her daughter. Véronique lost a lot of blood while giving birth to her daughter, but survived thanks to a uterine balloon tamponade, an innovative device that helps stop haemorrhage and save lives.

Eight-month-old Awa Tamboura is measured for malnutrition at the Reference Health Centre in Bamako, Mali. Upon admission, she weighed only 4kg.

Asse, 14 years old, while free of HIV, is one of Cameroon’s many adolescents affected by HIV and AIDS. Her father recently died from AIDS-related infection, and her mother is living with HIV. Cameroon is one of 10 countries in Africa that have benefitted from UNICEF’s point-of-care technologies project.

A girl displays her work at an early education community centre in Djibouti. UNICEF has provided support to the Ministry of Women and Family to establish early learning community centres.

A girl displays her work at an early education community centre in Djibouti. UNICEF has provided support to the Ministry of Women and Family to establish early learning community centres.

Saba, a girl from Bajel - Hudaydah in Yemen, recovered from severe acute malnutrition and complications of fever and diarrhoea. Al Qatea Therapeutic Feeding Centre (TFC), which is supported by UNICEF and run by Tayba Foundation for Development, provided life-saving treatment and care.
We wish to express deeply felt appreciation to our resource partners for support to Goal Area 1 in 2018. We wish to thank particularly those that were able to provide thematic funding. The flexibility of such funding provides for long-term planning and the sustainability of programmes, and allows UNICEF to offer strategic, technical, operational and programming support to countries in all regions for both upstream and decentralized work. Reflecting the trust that resource partners have in the capacity and ability of UNICEF to deliver quality support under all circumstances, such funding contributes to positive change in the lives of marginalized children and communities and has made possible the results described in this report.

Special thanks go to the governments of Luxembourg, the Netherlands and Sweden, and to the U.S. Fund for UNICEF, for their thematic contributions to nutrition. In particular, UNICEF recognizes the Government of the Netherlands for its commitment and support to improving nutrition in 2018. The Korean Committee for UNICEF, UNAIDS, The Global Fund, UNITAID, and the United States Government have been instrumental in support to HIV programmes. Dedicated support from DFID, NORAD the LEGO Foundation, the H&M Foundation, the Conrad Hilton Foundation, Alex and Ani and the Bill & Melinda Gates foundation have furthered progress for early childhood development in 2018.

Special thanks also are given to the Governments of Luxembourg, Denmark and Sweden for their generous thematic contributions to health as well as the National Committees for UNICEF, particularly the German Committee for UNICEF, the US Fund for UNICEF and the Dutch Committee for UNICEF.
Seventy years after UNICEF was established, the organization’s mission to promote the full attainment of the rights of all children is as urgent as ever.

The UNICEF Strategic Plan 2018-2021 is anchored in the Convention on the Rights of the Child and charts a course towards attainment of the Sustainable Development Goals and the realization of a future in which every child has a fair chance in life. It sets out measurable results for children, especially the most disadvantaged, including in humanitarian situations, and defines the change strategies and enablers that support their achievement.

Working together with Governments, United Nations partners, the private sector, civil society and with the full participation of children, UNICEF remains steadfast in its commitment to realize the rights of all children, everywhere, and to achieve the vision of the 2030 Agenda for Sustainable Development, a world in which no child is left behind.

The following report summarizes how UNICEF and its partners contributed to Goal Area 1 in 2018 and reviews the impact of these accomplishments on children and the communities where they live. This is one of eight reports on the results of efforts during the past year, encompassing gender equality and humanitarian action as well as each of the five Strategic Plan goal areas – ‘Every child survives and thrives’, ‘Every child learns’, ‘Every child is protected from violence and exploitation’, ‘Every child lives in a safe and clean environment’, and ‘Every child has an equitable chance in life’, and a short report on Communication for Development (C4D). It supplements the 2018 Executive Director Annual Report (EDAR), UNICEF’s official accountability document for the past year.
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The survival of girls and boys, especially the most marginalized and those living in countries where there is a humanitarian crisis, depends on high-impact health interventions, adequate nutrition for them and their mothers, and protection from HIV. As they get older, these children will thrive when they continue to eat nutritious food, access quality primary health care (PHC), are stimulated and cared for at home and in their community and enjoy early childhood education that gives them opportunities to learn and grow.

Guided by a life-cycle approach, in 2018, health, nutrition, HIV and early childhood development (ECD) programmes were brought together under Goal Area 1 of the UNICEF Strategic Plan, 2018–2021. The Goal Area has functional linkages with Water, Sanitation and Hygiene (WASH) in Goal Area 4 and was deliberately designed to accelerate progress towards achieving key Sustainable Development Goal (SDG) indicators on under-five mortality (3.2.1), neonatal mortality (3.2.2), maternal mortality (3.1.1), stunting, wasting and overweight (2.2.1 and 2.2.2),
reducing the number of new HIV infections (3.8.1 and 3.3.1) and early childhood development (4.2.1). Building multisectoral linkages where feasible UNICEF mobilized commitment at all levels and invested in reorienting its programming to strengthen PHC and the health system as a platform for achieving child survival, growth and development outcomes.

There is growing recognition that multisectoral approaches, in addition to health system approaches, are important to achieve the intended outcomes of Goal Area 1. Multiple other systems – most importantly, the food system – need to work in a coordinated manner to improve children’s lives and set them on the path to survive and thrive. In 2018, more health centres and health-outreach facilities provided a broad spectrum of maternal, newborn, child and adolescent health services. Adding the right nutrition services at the right time fostered healthy diets and improved feeding practices, and UNICEF worked to integrate HIV interventions into maternal and child health. The Nurturing Care Framework, which encompasses five components (health, nutrition, responsive caregiving, security and safety, and opportunities for early learning), further embedded ECD into the PHC platform.

These concerted efforts to accelerate progress do not work in isolation, and UNICEF relies on national governments and ever wider and stronger national and international partnerships to achieve the results reported here. Effectively, in 2018 more children, including of HIV-positive mothers, had a better beginning in life, starting with antenatal care. Some 33 per cent of pregnant women received iron and folic acid supplementation, surpassing the 2018 milestone of 32 per cent; and 57 countries integrated nutrition counselling within pregnancy care programmes, surpassing the 2018 milestone of 55 countries. Also, 57 per cent of pregnant women received at least four antenatal visits and 55 per cent of mothers received postnatal care. For these outcome level results, targets are set for 2021 as 65 per cent and 52 percent, respectively. Regional differences persist, with West and Central Africa behind other regions. The 52 countries that embraced the global Every Newborn Action Plan (ENAP) reported 75 per cent of live births attended by skilled personnel (2021 outcome target: 77 per cent), and that 32 per cent of newborns (2021 outcome target: 43 per cent) received postnatal care. In the ten countries that are home to more than 75 per cent of stunted and wasted children in the world, UNICEF with its partners focuses on the drivers of children’s growth and development during the first 1,000 days from conception to age 2, while supporting the early detection and treatment of severe acute malnutrition (SAM) as part of a package of routine services for children.

Services for the prevention of mother-to-child transmission (PMTCT) of HIV are an integral part of wider antenatal services. PMTCT services include the provision of life-saving antiretroviral therapy (ART) to pregnant and lactating women living with HIV to keep them alive and well and to stop them from passing on the infections to their infants. In 2018, out of a 2021 target of 1.19 million, 1.04 million pregnant women living with HIV received antiretroviral treatment, and 650,000 (2021 target: 890,000) infants born to pregnant women living with HIV were tested for HIV within their first two months of life. However, a lack of adequate and convenient testing services and the failures of decentralized systems to quickly and efficiently get newly diagnosed children on ART slowed progress.

More children were vaccinated and better fed. Of all infants under six months, 42 per cent were exclusively fed with breastmilk (2021 outcome target: 45 per cent). In 2018, UNICEF and partners supported the vaccination of 65.5 million children with three doses of diphtheria–tetanus–pertussis (DTP) containing/Penta vaccine in 64 priority countries, effectively preventing premature deaths and disabilities. Sufficient vitamin A is vital for young child development and survival, and globally two high doses of the micronutrient were provided to more than 255.7 million children in 2018, exceeding the 2021 outcome target of 250 million. This progress is currently slowed by the reduction in national polio campaigns, a convenient vehicle for Vitamin A provision in the past. Alternative channels are being explored. In low- and middle-income countries, 29 per cent of children aged 6–23 months globally were fed meals from the minimum number of food groups in 2018, and UNICEF aims to increase this figure to at least 35 per cent by 2021. The number of children being treated for SAM has continued to rise in recent years; however, coverage of care remains low due to limited domestic funding and system capacity.

Yovana Ramos Rocca, 30, holds her 21-day-old baby son, Logan Dario Valdez Ramos, who was born at the health centre in the Paruro Province of Peru. Despite improving newborn mortality rates, challenges remain in the rural region where they live.
More and more is being done to help children thrive, including through strengthening of ECD as part of health platforms. As of 2018, some 80 countries began the process of adopting multisectoral packages, consisting of at least two interventions, to address early stimulation and care, and are preparing for scale-up. Of these, 33 countries (surpassing the milestone of 16 countries in 2018) have established systems with at least two elements: government ownership and costed action plans. Forty-seven countries have ‘emerging’ systems where there is government ownership. The nurturing interaction between caregivers and children these systems foster is critical as it can boost brain development in early childhood. Challenges persist in overcoming limited awareness of the need to start these early enough.

An example of progress at country level is the integration of stimulation and play interventions as part of a Communication for Development (C4D) strategy to improve feeding practices. Another is the creation of ECD ‘demonstration centres’ that provide counselling for caregivers on nutrition, care and stimulation. With support by UNICEF more countries strengthened national legislation to prevent all forms of malnutrition in 2018. Globally, 49 countries had a national stunting prevention strategy in 2018, surpassing the milestone of 28 countries.

As children get older, ending preventable deaths and promoting their overall health and development continue to be fundamental. UNICEF child health programming in 2018 therefore centred on the prevention and treatment of leading diseases such as pneumonia, diarrhoea and malaria, leading causes of death in children under 5. UNICEF worked to strengthen community systems that foster linkages between health facilities and communities to ensure quality and accessible PHC that goes beyond just health services, in providing support for nutrition and early childhood development. Between 2016 and 2018, in 25 countries with high pneumonia prevalence, 16.1 million children with suspected pneumonia received antibiotics through UNICEF-supported programmes. In 2018, as part of concerted campaigns to fight malaria, UNICEF distributed insecticide-treated nets to 28.27 million people in 17 countries, including 1.46 million people in humanitarian situations (total 3.72 million since 2016).
Progress was made in 2018 in establishing national policies for adolescent health and well-being and building country capacity to implement multisectoral and gender-responsive adolescent health programmes. In 52 high-burden countries, 69 per cent of live births among mothers aged 15–19 years were attended by skilled health personnel, on track to meet the 2021 outcome target of 71 per cent. At the same time, it has been a challenge to achieve a similar increase in the frequency of antenatal visits in this age group. Human papillomavirus is a severe threat to the health of adolescent girls, and four countries (out of a target of five) introduced a vaccine against it into their national immunization schedules. Seventeen countries had programmes or policies for the prevention of childhood overweight (such as measures to regulate the marketing of food and beverages for children or food standards in school settings), surpassing the 2018 milestone of eight countries.

For adolescents, good nutrition is as essential as for younger children, as it affects their education and development. Globally in 2018, UNICEF collaborated with national governments in 30 countries and 7 regions to roll out comprehensive programmes to improve the quality of diets and the nutritional status of adolescent girls and boys. These programmes promoted improved access to information, education, counselling, services and commodities. In 2018, some 58 million adolescent girls and boys were provided with services to prevent anaemia and other forms of malnutrition through UNICEF-supported programmes, surpassing the 2018 milestone of 55 million. Primary prevention efforts for HIV among adolescents have not achieved the same attention as PMTCT, and progress in reducing new infections has been slower. Around 1.8 million adolescents aged 15–19 are living with HIV, including both those who are newly infected and those who have lived their whole lives with HIV. Adolescent girls and young women are especially vulnerable, in particular because of the many social, cultural, economic, legal and political factors that contribute to their risks of acquiring HIV and not being reached by HIV services. UNICEF is working across sectors to best respond to this population’s unique needs.

As in previous years, 2018 required our engagement in providing immediate assistance to countries with humanitarian crises. While a significant part of these responses addressed immediate needs, UNICEF also aimed to improve resilience and subsequent recovery, actively bridging the humanitarian–development divide. One element was the focus on integrated responses in health, nutrition, HIV and ECD. Through outpatient or temporary services, UNICEF and partners provided health and nutrition services, distributed ECD kits, integrated malaria prevention and detection, and promoted handwashing with soap and good hygiene, complemented by other services as necessary.

During 2018, in humanitarian emergencies, and often working through temporary facilities or with campaigns, UNICEF and partners vaccinated 19.2 million children against measles, distributed insecticide-treated nets to over 1.4 million people, treated 3.4 million children with SAM (with 88 per cent of them recovering), and provided infant and young child feeding programmes in 38 countries in humanitarian crisis. With a significant increase of children affected by emergencies, the number given the opportunity of play and stimulation through ECD kits nevertheless more than doubled from just over 180,000 in 2017 to over 470,000 in 2018. HIV testing and counselling was part of responses where possible, including in Rohingya refugee camps in Bangladesh.

In 2018, UNICEF and partners also responded to several outbreaks that often required a multisectoral response, including measles, diphtheria, cholera and Ebola. UNICEF was able to strongly support several countries with cholera responses, reaching more than 6 million people with two doses of oral cholera vaccine. In 2018, the Global Nutrition Cluster, led by UNICEF, supported the coordination of life-saving nutrition in emergency interventions for 23.5 million people (81 per cent of those targeted) with programmes in 22 countries.
The survival of girls and boys, especially the most marginalized and those living in settings where there is a humanitarian crisis, depends on accessing impactful health services, adequate nutrition for them and their mothers, and protection from HIV. These children will thrive when they continue to eat well, are stimulated and cared for at home and in their community and enjoy early childhood education that gives them opportunities to learn and grow. These essential elements have been brought together in Goal Area 1 of the UNICEF Strategic Plan, 2018–2021 (see Figure 1). This marks a departure from the previously distinct sectors, and an ambition for a holistic approach to helping children survive and thrive.
Goal Area 1 works through nine results areas: maternal and newborn health, immunization, child health, prevention of stunting and other forms of malnutrition, treatment of severe acute malnutrition, treatment and care of children living with HIV, HIV prevention, early childhood development (ECD), and adolescent health and nutrition.

The interdependency of these issues is evident and has been well supported by research. They share the same social determinants (the conditions in which people are born, grow, live, work and age). These conditions or circumstances are shaped by families and communities, and by the distribution of money, power and resources at global, national and local levels. Changing these determinants from a single sector’s perspective is unproductive and may not yield the same results.

The concept of ‘nurturing care’ describes the importance of integrating ECD interventions with basic health and nutrition: health depends on good nutrition, while illness affects how children eat and process food. Timely interventions in early infancy can protect children from HIV and set them up for healthier lives. Well-nourished children are healthier and learn and develop better, while learning early supports healthy behaviours. Bringing these elements together with the child at the centre is what makes a difference for girls and boys.

The Sustainable Development Goals (SDGs) require integrated policy and programming to be achieved. The integration of UNICEF Goal Area 1 addresses this need. Its results areas are directly linked to the respective SDG targets for reducing under-five mortality, neonatal mortality, maternal mortality, stunting, wasting, overweight, and HIV infection and death rates. Results in ECD are directly linked to developmental goals in education. The overarching consideration of adolescents across Goal Area 1 resonates well with the priority adolescents’ development is given in the SDGs.

Underlying assumptions demarcate the framework of Goal Area 1: it requires health, ECD and scaling up of nutrition to remain global and national priorities, with adequate capacity and human resources. With the overarching priority to reach the most marginalized and those living in humanitarian settings first, it requires continued national and international commitment to equity, and access to those living in humanitarian settings. While sustained political and resource commitments are vital and can actively be advocated for, success in Goal Area 1 also depends on relative stability in global food prices.
Global trends

More children than ever survive. Mortality in the 1–4 years age group declined by a remarkable 60 per cent from 2000 to 2017. Neonatal mortality declined by 41 per cent, while mortality among children aged 1–11 months, the post-neonatal period, declined by 51 per cent. Among children aged 5–14 years, mortality declined by 37 per cent. Between 1990 and 2015, maternal mortality declined by 44 per cent, but still 830 women die from pregnancy- or childbirth-related complications globally every day. This leaves children in the care of other family members with consequences for the quality of their early development. Adolescent mothers face additional risks and vulnerabilities. Children’s vulnerability to HIV remains a significant global challenge. In 2017 alone, an estimated total of 430,000 new infections occurred worldwide among those aged 0–19 years, which was nearly one quarter of the global total of 1.8 million new infections. These new infections constitute more than 14 per cent of the 3 million children under the age of 20 living with HIV. One reason that so many deaths and new infections continue to occur is that antiretroviral therapy (ART) coverage for children continues to be worse than that for adults. Although the share of children aged 0–14 years living with HIV who were receiving ART rose from 22 per cent in 2010 to 52 per cent in 2017, it remains below the level among adults (59 per cent).

At the same time, prevention of mother-to-child transmission (PMTCT) programmes have been considered one of the most notable success stories of public health over the past decade. In 2017, the latest year for which FIGURE 2: Under-five and neonatal mortality rates, 1990-2017

![Figure 2: Under-five and neonatal mortality rates, 1990-2017](image-url)
data are available, integrated services involving multiple collaborating partners have enabled 80 per cent of the 1.4 million pregnant women living with HIV to receive antiretroviral medicines (ARVs) to keep them alive and well and to stop them from passing on the infection to their infants. The adoption by most of the world’s countries of Option B+, in which all pregnant women living with HIV are initiated immediately upon diagnosis on lifelong ART, has been especially transformative. Only 52 per cent of children have access to ARTs (see Figure 3 for a summary of coverage and deaths).

Many children still do not thrive: 250 million children in low- and middle-income countries are at risk of not achieving their developmental potential. At the same time, governments worldwide spend on average less than an estimated 2 per cent of their education budgets on early childhood programmes. In 67 countries with available data, nearly 57 million children aged 36–59 months do not attend an early childhood education programme. Figure 4 compares the number of countries that had adopted ECD packages in 2017 and 2018.

**FIGURE 3:** Trends in coverage of ART and number of AIDS-related deaths among children (0–14 years), 2010–2017

**FIGURE 4:** Number of countries that have adopted ECD packages for children at scale in 2018 compared to 2017
Children who do not receive the nutrition they need are at risk of stunted cognitive and physical development. Yet, at least 151 million children suffer from stunting and millions more are at risk from poor nutrition. Figure 5 shows trends in stunting, wasting and overweight.

Other forms of malnutrition, including wasting, micronutrient deficiencies and overweight, continue to threaten children’s well-being. Many countries are facing a double or triple burden of malnutrition, with coexisting forms of malnutrition that impact the same community, household or individual. Only three out of five children are breastfed exclusively until six months of age. In many parts of the world, children’s first foods lack diversity, nutrients and energy. Only one in six children aged 6–23 months in developing countries is eating enough nutritious meals from a variety of food groups to ensure healthy growth and development. The diets of adolescents are often poor; micronutrient deficiencies and overweight are persistent challenges.

In a significant development, in 2018 the Astana Declaration on Primary Health Care (PHC) reaffirmed a vision of achieving universal health coverage (UHC) and reinforcing PHC as a platform for delivering nutrition, HIV prevention and treatment, and ECD results. This is well matched by a global shift towards making food systems more accountable in supporting healthy diets for children and adolescents. The adoption of the nurturing care approach by the G20, culminating in the G20 ECD Initiative in October 2018, further integrates these interconnected approaches. The years 2017–2018 saw unprecedented progress in ECD. Building on a strong evidence base from emerging evidence in neuroscience and calls to action such as from The Lancet, key stakeholders worked closely to affect a shift in the ECD landscape from understanding the rationale of ECD to enhanced implementation and progress in rolling out multisectoral packages.

Addressing challenges

Progress to ensure that no one is left behind has not been rapid enough to meet the targets of the 2030 Agenda. The rate of global progress is not keeping pace with the ambitions of the agenda, requiring urgent action by countries and stakeholders at all levels. Partnerships have become a key vehicle for UNICEF to accelerate progress towards the SDGs.

UNICEF is leading or coordinating key global partnerships that contribute to the achievement of the respective targets, such as the No Wasted Lives coalition, which is accelerating progress on severe wasting, and the Global Breastfeeding Collective, which is working to increase investments in breastfeeding. The Scaling Up Nutrition (SUN) movement is a key mechanism where national governments lead change, and UNICEF continues to chair its Lead Group. The Global Action Plan for Healthy Lives and Well-being for All (SDG3+GAP) is a commitment by 12 global health and development organizations, it complements existing and approved agency-specific strategies, and is intended as a framework to support implementation through collective action, and to catalyse new collaborative effort, including in areas such as PHC, digital innovation and systems strengthening. Within the Joint United Nations Programme on HIV/AIDS (UNAIDS) partnership, and under the UNAIDS Unified Budget and Results Action Framework (UBRAF), UNICEF co-convenes strategic areas with the World Health Organization (WHO) on eliminating mother-to-child transmission of HIV (EMTCT) and keeping mothers, children and adolescents alive, and with the United Nations Educational, Scientific and Cultural
Organization (UNESCO) and the United Nations Population Fund (UNFPA) on HIV prevention among young people.

Mobilizing resources is increasingly more challenging. Many countries are graduating to middle-income status, constraining the mobilization of external resources. Holistically addressing the survive and thrive agendas requires flexible financing, such as thematic funds. UNICEF focuses its strategy on mobilizing domestic resources, while shifting to upstream work, involving the private sector and partnering with non-traditional donors.

Statistically sound and internationally comparable data are essential for developing evidence-based policies and programmes, as well as for monitoring countries’ progress towards national goals and global commitments, including the SDGs. UNICEF builds strong data sets by tracking more than 100 key indicators on the well-being of women and children.

Humanitarian crises continue to challenge gains, and the ability to sustain change. These are countered through consistent risk-informed programming and inserting sustainability elements into humanitarian action, for example through skill building.

Building and maintaining cohesion between sectors in Goal Area 1 has practical challenges. UNICEF continuously strengthens programme planning and management tools for closer multisector integration.

A girl eats a Ready-to-Use Therapeutic Food (RUTF) at the Mama Mwilu Health Centre in the Democratic Republic of Congo. Ongoing conflict means that UNICEF and partners treat malnourished children and train community health workers to promote best nutritional practices.
The UNICEF Strategic Plan, 2018–2021 upholds the organization’s commitment to child health and well-being by addressing the unfinished business of the Millennium Development Goals and progressively addressing the new challenges of the Sustainable Development Goals (SDGs). Guided by a life-cycle approach consistent with the scale, depth and breadth of the global challenges that threaten children’s health and well-being, UNICEF programmes intend to contribute to the outcome “Girls and boys, especially those that are marginalized and those living in humanitarian conditions, have access to high-impact health, nutrition, HIV and early childhood development interventions from pregnancy to adolescence.”

To deliver output-level results, a shift is taking place towards the delivery of a range of integrated services through strengthened primary health care (PHC) and a multisectoral approach to health, where health, nutrition, HIV and early childhood development (ECD) services share PHC as a common platform for delivery. This will increasingly replace disease-specific interventions. The programming lens continues to focus on children’s rights and equity. For health, the theory of change that underpins the new Strategic Plan posits the following: if countries accelerate the scale-up of an essential package of maternal and newborn care services, including prenatal and postnatal/home visit support, and if they
have sustained immunization programmes at national and district levels, including introduction of new vaccines, and if they accelerate the delivery of preventive, promotive and curative services for pneumonia, diarrhoea, malaria and other child health conditions, then girls and boys, especially those who are marginalized and those living in settings where there is a humanitarian crisis, have the chance to survive and thrive in their communities.

UNICEF has committed to focusing on PHC for the period of the Strategic Plan as an effective means to achieve Goal Area 1 results (all children survive and thrive) and to contribute to the global SDG target (3.8.1) on universal health coverage.

Four results areas for health contribute to Goal Area 1: (1) maternal and newborn health, (2) immunization, (3) child health and (4) adolescent health. Using primary care as a foundation to the realization of universal health coverage, programming brings caregivers and families closer to health systems so that children's right to health can be respected and promoted. In 2018, health programmes were implemented in 120 countries with the help of 980 staff. Expenses in the health sector totalled US$1.3 billion,16 of which 16 per cent was from regular resources. Expenses from thematic funds represented US$18.6 million. The Government of Luxembourg was the largest contributor of global thematic funds to health in 2018. The global value of UNICEF health-related supplies, including those purchased by partners, was US$1.971 billion.

Working together with other United Nations agencies, governments, civil society and private sector actors, UNICEF delivered impressive health results in Goal Area 1. Between 2016 and 2018, in 52 countries with high neonatal and maternal mortality, a total of 84 million live births (27 million in 2018) were delivered in health facilities through UNICEF-supported programmes against the 2021 Strategic Plan target of 120 million. In 2017, the most recent year for which data is available, an estimated 65.5 million children were vaccinated with three doses of diphtheria–tetanus–pertussis (DTP) containing/Penta vaccine in 64 priority countries, and an additional 8 million women were protected against tetanus in four high-risk countries through supplementary vaccination. In humanitarian situations, 19.6 million children (96 per cent of the targeted 20.0 million for 2018) were vaccinated. Between 2016 and 2018, in 25 countries with high-burdens of childhood illnesses, 16.5 million children with suspected pneumonia received antibiotics. The organization further scaled up work on community-based PHC: between 2016 and 2018, some 154,475 community health workers enhanced their skills to better serve their communities. UNICEF distributed insecticide-treated nets to 28.27 million people in 17 countries, of which 1.46 million people lived in humanitarian situations across 11 countries. In adolescent health, 50 countries (2021 target: 45) had an inclusive, multisectoral, gender-responsive national plan to support adolescent health and well-being, and four countries completed nationwide HPV vaccination of adolescent girls. Lastly, UNICEF supported governments' and partners' responses to 87 public health emergencies and actively contributed to the construction of national policy infrastructure to guide long-term responses.

In addition to the results from health programme delivery presented above, 24 countries made progress on institutionalizing community health workers, 36 countries developed plans to strengthen supply chains, and 23 countries were implementing plans to strengthen the quality of maternal and newborn PHC. These health-systems strengthening investments enhance PHC as the means to achieve universal health coverage for children's health and well-being.

These results demonstrate the value of strengthening health systems and PHC by reinforcing linkages between households, communities and facilities so no child is left behind. The following sections detail the 2018 achievements by results area.

## Results Area 1: Maternal and newborn health

Aligned with the 2030 Agenda for Sustainable Development, reducing maternal mortality and ending preventable neonatal mortality are critical to the first goal of the new UNICEF Strategic Plan, 2018–2021. Programming focuses equally on all stages of the continuum of care, including pre-conception, antenatal care (ANC), safe delivery, postnatal care, and maternal and newborn tetanus elimination. In the 52 high-burden countries that embraced the global Every Newborn Action Plan (ENAP) tracking tool in 2016 (the baseline year for the Strategic Plan), UNICEF and partners supported a cumulative 84 million live births between 2016 and 2018 in designated health facilities. In 2018, these countries reported 76 per cent of live births attended by skilled personnel, 57 per cent of pregnant women receiving at least four antenatal visits, and 57 per cent of mothers and 33 per cent of newborns receiving postnatal care. Except for newborn postnatal care, strong progress is visible across all indicators against the 2021 targets.

At output level, all planned (2018) milestones were successfully achieved. By the end of the year, 16 countries (target: 15 countries) were monitoring kangaroo mother care as part of the essential newborn care package to save newborns. The planned 2018 milestone towards maternal and newborn tetanus elimination (MNTE) was met with the validation of MNTE in Kenya. In support of health-systems strengthening, 23 countries were implementing plans to
strengthen the quality of maternal and newborn health care (milestone: 9). UNICEF invested US$226 million in the maternal and newborn health programmes, with a quarter of expenses from regular resources.

**Outcome and output indicators for maternal and newborn health**

**Context**

Between 1990 and 2017, the neonatal mortality rate dropped around 51 per cent, from 37 deaths per 1,000 live births to 18 deaths per 1,000 live births. Yet globally, an estimated 2.5 million newborns died in the first month of life in 2017 – approximately 7,000 every day – mostly in the first week after birth. Some 2.6 million babies are stillborn. Inequities in accessing care and the poor quality of health services are substantial obstacles in improving maternal and newborn survival and reducing stillbirths.

To address these inequities, ENAP was adopted in 2014 as an essential global road map to curtail the preventable deaths of 3 million newborns. ENAP focuses on high-impact interventions around the time of birth, when 80 per cent of neonatal deaths occur.

To address the global burden of neonatal mortality, the UNICEF equity-based model puts front-line services in place to reach those furthest behind first. The renewed impetus in 2018 towards PHC and community-based health care aims to facilitate access to affordable, quality health care, good nutrition and clean water to save these young lives.

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### TABLE 1: Outcome results for maternal and newborn health, 2018

<table>
<thead>
<tr>
<th>Outcome indicator</th>
<th>Baseline</th>
<th>2018 value</th>
<th>2021 target</th>
<th>SDG target no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of pregnant women receiving at least four antenatal visits</td>
<td>Total: 51%</td>
<td>57%</td>
<td>Total: 65%</td>
<td>3.8.1</td>
</tr>
<tr>
<td></td>
<td>Aged 15–19: 52%</td>
<td>Aged 15–19: 53%</td>
<td>Aged 15–19: 57%</td>
<td></td>
</tr>
<tr>
<td>Percentage of live births attended by skilled health personnel (home and facilities)</td>
<td>73%</td>
<td>76%</td>
<td>77%</td>
<td>3.1.2</td>
</tr>
<tr>
<td>Number of live births delivered in health facilities through UNICEF-supported programmes</td>
<td>25 million</td>
<td>84 million</td>
<td>120 million</td>
<td>3.1.2</td>
</tr>
<tr>
<td>Percentage of (a) mothers and (b) newborns receiving postnatal care</td>
<td>(a) Total: 48%</td>
<td>a) 57%</td>
<td>(a) Total: 52%</td>
<td>3.8.1</td>
</tr>
<tr>
<td></td>
<td>Aged 15–19: 48%</td>
<td>Aged 15–19: 55%</td>
<td>(a) Total: 52%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) 33%</td>
<td>(b) 33%</td>
<td>(b) 43%</td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 2: Output results for maternal and newborn health, 2018

<table>
<thead>
<tr>
<th>Output indicator</th>
<th>Baseline</th>
<th>2018 milestone</th>
<th>2018 value</th>
<th>2021 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries reporting that the national Health Management Information System (HMIS) includes an indicator for newborns benefiting from kangaroo mother care</td>
<td>11</td>
<td>15</td>
<td>16</td>
<td>51</td>
</tr>
<tr>
<td>Number of countries that are verified/validated as having eliminated maternal and neonatal tetanus</td>
<td>41</td>
<td>45</td>
<td>45</td>
<td>59</td>
</tr>
<tr>
<td>Number of countries implementing plans to strengthen quality of maternal and newborn primary health care</td>
<td>3</td>
<td>9</td>
<td>23</td>
<td>30</td>
</tr>
</tbody>
</table>
Improving services and community demand

Building on the achievements of the previous strategic plan (2014–2017), UNICEF is committed to helping countries accelerate the scale-up of essential packages of maternal and newborn care services, including antenatal, postnatal and home-visit support.

Antenatal care

Quality ANC is essential for pregnant women to obtain a package of basic health, nutrition and HIV services, care and support to ensure a good pregnancy outcome. By the end of 2018, the proportion of pregnant women receiving at least four antenatal visits had increased from a baseline of 51 per cent to 57 per cent (2021 target: 65 per cent). For adolescent mothers (aged 15–19 years), the 2018 result of 53 per cent was a small increase from the 52 per cent baseline, underscoring persistent challenges in bringing an important health intervention to pregnant adolescents. The 2021 target of 57 per cent also reflects the awareness of structural and system impediments (for additional details on adolescent health, see Results Area 4 later in this report).

UNICEF works in a variety of country contexts to improve maternal and neonatal survival. As an example, in the Central African Republic, a low-income country classified as a fragile situation by the World Bank,16 one newborn out of every 24 dies during the first month of life – an alarming rate. To address this high mortality, working directly with communities is essential. Between 2017 and 2018, the proportion of mothers and caregivers with knowledge of core family practices more than doubled, increasing from 20 to 56 per cent. More than 152,000 pregnant women (69 per cent of the expected total) attended at least one ANC consultation, while 31 per cent attended four visits. Linking communities with accessible, quality PHC was paramount, while capacity in 72 per cent (of the total 354) health facilities was strengthened. Qualified staff helped assist 51 per cent of deliveries.
In areas with endemic malaria, quality ANC programmes also address malaria infection during pregnancy to prevent and reduce the risk of maternal malaria, maternal and fetal anaemia, low birth weight and neonatal mortality. In 2018, UNICEF Supply Division procured 7 million preventative courses of sulfadoxine–pyrimethamine for intermittent preventive treatment in pregnancy, equivalent to 2.35 million pregnant women provisioned with the chemoprevention for all three focused ANC visits.

## Skilled birth attendants

Access to skilled health personnel at birth is critical to curb maternal and newborn mortality and disabilities. The percentage of live births attended by skilled health personnel increased from 73 at baseline to 76 in 2018, just one percentage point shy of the 2021 target. This reflects the joint efforts of governments and development partners, in particular in high-mortality countries.

Between 2016 and 2018, in 52 ENAP countries, a total of 84 million live births (27 million in 2018 alone) were delivered in health facilities through UNICEF-supported programmes against the 2021 target of 120 million. In addition to these high-burden countries, the maternal and newborn health programme contributed to the safe delivery of 2.4 million live births in 57 additional countries. This represents considerable progress against planned targets and the translation of a stronger commitment to mothers and newborns. Securing the trust of future mothers through improved quality of care is an important driver of service uptake. In 2018, some 35 countries procured pre-packaged kits that compose the Obstetric Surgical kit and Midwifery kit – a total value of US$4.1 million. UNICEF-supported interventions included the training of health-facility staff on basic emergency obstetric and newborn care, delivery of essential commodities and improving water, sanitation and hygiene (WASH) in health facilities, supporting maternal and perinatal mortality review, strengthening referral systems, promoting antenatal and postnatal home visits, and community engagement to promote social accountability.

- In Guinea, the four special baby-care units established in 2017 continued to provide 24/7 quality services, saving nearly 4,000 sick newborns’ lives in 2018. In addition, a total of 76 health facilities in difficult-to-access areas were equipped with essential medicines, management tools for early diagnosis and basic emergency care to maximize the chance of survival of mothers and newborns including infants exposed to HIV. Some 46 per cent of these 76 facilities were also equipped with solar-energy sources to boost the quality of delivery services for an estimated 20,000 mothers annually and ensure that at least 15,000 newborns will benefit from functional newborn-resuscitation services.

- In Zimbabwe, the long-standing partnership with the Health Development Fund helped improve the availability of essential maternal and newborn medicines and commodities within PHC facilities, with availability reaching above 90 per cent. The provision of 8,000 blood coupons helped pregnant women access free blood within hospitals. In addition, UNICEF supported the training of 40 trainers in helping babies and mothers survive.
Postnatal care for mothers and newborns

To boost neonatal survival, postnatal care is a delivery strategy for essential and evidence-based interventions which includes immediate assessment of the baby, breastfeeding within one hour of birth, umbilical-cord care, and the reinforcement of postnatal-care messaging among families and caregivers. The proportion of mothers receiving postnatal care increased favourably from 48 per cent at baseline to 57 per cent in 2018, exceeding the 2021 target of 52 per cent. However, globally, the percentage of newborns receiving postnatal care, whether at home or in a health facility, was 33 per cent in 2018, below the 2021 target of 43 per cent.

The slower progress for newborns is due to a combination of factors. Many countries lack a home-visitation platform or, when it exists, health workers can be overburdened with competing responsibilities. Weak health systems result in missed opportunities at the facility level. In addition, structural determinants such as rural residence, maternal education, social norms and wealth continue to impede progress. This underscores the need for greater global and domestic investments to bring the care that is essential to newborn survival.

Nonetheless, the following examples indicate that progress is being made in-country. In Guinea-Bissau, nearly 22,000 newborns received essential care including umbilical-cord care and cold protection, while caregivers were educated on exclusive breastfeeding and vaccination. In Pakistan, 350,000 newborns benefited from umbilical-cord care with chlorhexidine.

A critical aspect of postnatal care and neonatal survival is early breastfeeding (see Figure 6). UNICEF and the World Health Organization (WHO) recommend that children initiate breastfeeding within the first hour after birth and be exclusively breastfed for the first six months. In 2017, only 47 per cent of newborns globally were put to the breast within one hour after birth. Improving breastfeeding practices could save an estimated 800,000 children under five. To promote the benefits of breastfeeding, in South Africa, UNICEF provided 1,300 health facilities with breastfeeding campaign materials. In Papua New Guinea, within two hospitals, breastfeeding was initiated early for nearly 46,000 low-birth-weight newborns.
FIGURE 6: Importance of initiating breastfeeding within the first hour of life

For newborns, every minute counts

Risk of infection and death increases the longer the delay

<1 hour is optimal

Breastfeeding <1 hour after birth saves lives and provides benefits that last a lifetime.

The longer babies need to wait, the greater the risk.

Waiting 2-23 hours increases their risk of death* by 1.3 times.

Waiting 1 day or more increases their risk of death* by more than 2 times.

*Risk of death is presented for the first 28 days of life and in comparison to those who initiated in <1 hour.


Community demand for services
Ensuring community demand for services is essential to guarantee service utilization. Utilizing its comparative advantage in Communication for Development (C4D), UNICEF applied evidence-based strategies across countries. C4D helps address sociocultural barriers to health-seeking behaviours and caregiving practices while strengthening community engagement and accountability for mothers’ and newborns’ health.

In Burkina Faso, field reports validated by knowledge, attitude and practice surveys identified traditional beliefs that lead mothers to discard their colostrum instead of feeding it to their babies. Informed by these findings, C4D content and strategies included interpersonal communication via door-to-door visits, community dialogue, community radio programmes and video shows. As a result, key messages on newborn health reached approximately 1.2 million men, women, children and community leaders.
In Guinea-Bissau, C4D strategies were specifically deployed to empower families living in hard-to-reach areas through the establishment of health committees chaired by traditional healers.

In Tajikistan, the maternal and child health handbook developed by UNICEF reached more than 43,000 women, providing effective information which led to positive shifts in attitudes and practices among caregivers.

Quality of care

Research has shown that giving birth in a health facility with a skilled attendant is not sufficient to reduce maternal and newborn deaths and severe morbidity. Aligned with the Every Woman Every Child Global Strategy for Women’s, Children’s and Adolescents’ Health, the Quality of Care Network aims to provide every pregnant woman and newborn with good-quality care throughout pregnancy, childbirth and the postnatal period in a multi-country initiative.

Maternal and newborn quality-of-care standards are successfully being implemented in Bangladesh, Ghana and the United Republic of Tanzania, the front-runner countries since 2016. Intervention districts in these three countries are acknowledged as learning sites for the Quality of Care Network. Life-saving comprehensive and basic emergency obstetric services along with newborn care services are also made available 24/7 in 40 of the 43 intervention facilities across the three countries. A core set of interventions, including the use of partographs to monitor labour, handwashing by service providers before and after procedures, early initiation of breastfeeding and pre-discharge postnatal counselling, have significantly improved in all intervention facilities. UNICEF trained nearly 44,000 health-care providers and community health workers in the area of maternal and newborn health, and renovated and provided essential medications and supplies to 273 health facilities.

In Ghana, kangaroo mother care coverage has improved in all three implementing hospitals from a baseline of 14–86 per cent to 65–99 per cent in 2017. The rate of early initiation of breastfeeding has remained high at around 92 per cent.

In the United Republic of Tanzania, hygiene practices during deliveries and handling of newborns increased from 20 per cent at baseline to 80 per cent, significantly contributing to a decrease in the risk of infections.

In Bangladesh, institutional delivery in the participating upazilas (subdistricts) stood at 51 per cent, which is higher than the national average and the 20 per cent rate of institutional deliveries recorded in the Every Mother Every Newborn quality improvement registers. In upazilas with health facility-based quality-of-care interventions, 90 per cent of newborns were put to the breast soon after birth.

The synergistic effects of these interventions significantly contributed to reduced preventable maternal and newborn deaths within health facilities. For example, in Ghana, neonatal case fatality rates declined by 58 per cent (from 10.2 per cent to 4.3 per cent); institutional stillbirth rates declined by 30 per cent (from 25 per 1,000 births to 17 per 1,000 births), while the maternal mortality ratio declined by 70 per cent (from 389 per 100,000 live births to 118) in 24 health facilities in four districts between January 2017 to February 2018. In Bangladesh, the case-fatality rates of sick newborn admissions declined from 11.9 per cent to 4.8 per cent between January and August 2018.

To further improve the quality of care provided to mothers and newborns, UNICEF works across the health and WASH sectors. The scarcity of WASH services in health-care facilities significantly jeopardizes the quality and use of health services thereby contributing to maternal infection and death. WHO Standard 8 of quality of care underscores that WASH is essential to provide safe, respectful and dignified maternal and newborn care in health-care facilities.19 UNICEF had improved access to WASH in 3,555 health centres by the end of 2018. Of this total, 3,017 health-care facilities (90 per cent) were located in the 52 ENAP focus countries, demonstrating a multisectoral approach by UNICEF to quality of care.

Maternal and neonatal tetanus elimination (MNTE)

One newborn perishes of neonatal tetanus every 15 minutes globally. Improving front-line services, as part of quality neonatal care, is crucial in the drive to eliminate maternal and neonatal tetanus, a condition that mothers and newborns can contract when deliveries occur in unhygienic conditions. As maternal and neonatal tetanus is a strong marker of inequity, UNICEF remains at the forefront of eliminating a disease that strikes the underserved and most vulnerable women and newborns.

Globally, as of 2018, some 45 out of the 59 countries identified as high risk in 1999 have achieved elimination of the disease, fully meeting the Strategic Plan target (see Figure 7). The year 2018 saw the validation20 of Kenya in addition to partial validation of southern Mali (covering 90 per cent of Mali’s population). Sindh province of Pakistan and the Democratic Republic of the Congo were pre-validated for MNTE. In 2018, more than 8 million women of reproductive age received two or more doses of tetanus-toxoid-containing vaccines through UNICEF-supported supplementary immunization activities in the Democratic Republic of the Congo, Nigeria, the Sudan and Yemen. These successes reflect strong national commitment, collaborative efforts between technical partners and the buy-in of local communities. Uninterrupted financial flow from resource partners and swift procurement services of UNICEF Supply Division were instrumental in ensuring the smooth implementation of planned activities.
Factors that constrained further progress include insecurity and conflict, limited access to the target population, and competing immunization priorities such as measles, polio and yellow-fever vaccination campaigns. Nearly all of the 14 countries that have yet to achieve MNTE are facing other disease outbreaks as well as experiencing humanitarian crises and protracted conflicts. In these settings, outbreak response campaigns are often prioritized over MNTE. The remaining target countries have to tailor the local MNTE action plans to achieve elimination by 2020.

To make further gains on behalf of newborns, UNICEF and WHO developed a strong MNTE investment case focusing on the 14 at-risk countries. The document emphasizes the four strategies that must be implemented simultaneously for high impact: (1) conducting tetanus-vaccination campaigns targeting all women of reproductive age in at-risk districts; (2) increasing tetanus-vaccination coverage among pregnant women during ANC visits; (3) promoting clean delivery and clean cord-care practices; and (4) enhancing neonatal tetanus surveillance. The donors conference held at the end of 2018 reaffirmed that resource and technical partners are committed to achieving the global MNTE target by 2020. Meanwhile, global attention is expanding its focus on sustaining elimination. UNICEF and WHO re-validated Algeria, Cameroon, Djibouti and Timor-Leste for maintaining their MNTE status in 2018. Close inter-agency work between UNICEF, WHO and the United Nations Population Fund (UNFPA) is leading to the finalization of guidelines for sustaining MNTE.

Maternal and newborn health in humanitarian settings

The work to protect mothers and their infants does not stop in humanitarian settings where front-line services are even more crucial to ensure life-saving care. UNICEF, Save the Children and many other partners launched Newborn Health in Humanitarian Settings: A field guide. The publication defines newborn care packages by levels of care – community, health centre and hospital – and helps front-line actors prioritize essential newborn care in emergencies. The health programme provided technical assistance on newborn care in humanitarian crises to Rohingya refugee camps in Cox’s Bazar (Bangladesh),
Iraq, Papua New Guinea and Yemen. Part of the Rohingya refugee response included the provision of care to 3,766 neonates (104 per cent of the target). In Yemen, efforts continued to support facility- and community-based maternal and newborn care at household level. Through community midwives, UNICEF reached 634,002 pregnant and lactating women at their homes: 413,025 received ANC, 228,487 had access to skilled birth attendants and 81,985 received postnatal care.

**Strengthening national and subnational capacity**

UNICEF capitalizes on a number of comparative advantages, including strengthening subnational-level governance which requires improving data collection and use to inform decision-making. Developing the subnational capacity in-country is especially important to operationalize the ‘leave no one behind’ principle. Monitoring the number of countries that include an indicator on newborns benefiting from kangaroo mother care in their national health management information systems (HMIS) is one way the Strategic Plan ensures that programmes are equitable. By the end of the year, 16 countries had included this indicator in their health management information system, exceeding the 2018 milestone of 15. This represents a gain of five countries from the baseline, showing good momentum towards the 2021 target of 51 countries.

In Kurigram, Bangladesh, on-site and distant technical assistance helped providers improve routine entry of data related to Every Mother Every Newborn (EMEN) quality standards into customized registers and dashboards within the District Health Information System 2 software (DHIS2). Through hands-on training, providers and statisticians learned to conduct data-quality validation at facility level. The EMEN dashboard is updated on a quarterly basis and is accessible to all for data visualization and use.

In the United Republic of Tanzania, following the training of district quality-improvement mentors and health-care workers from 14 EMEN strategic health facilities, all participating facilities established quality-improvement teams. These teams regularly assess the quality of reproductive, maternal, neonatal, child and adolescent health (RMNCAH) care provided. A core part of this exercise is to identify quality gaps, and develop and implement micro plans to address the identified priority.
gaps. Remarkably, through trained district mentors, the two participating district councils scaled up this successful approach and established quality improvement teams in the remaining 98 EMEN strategic health facilities. Expanding access to quality RMNCAH services demonstrates that the districts and the region are committed to scaling up good practices beyond the EMEN project area.

UNICEF fosters innovations to strengthen local capabilities with the aim of reducing maternal and newborn mortality. In Côte d’Ivoire, UNICEF supported the introduction of the intra uterine balloon tamponade to save the lives of mothers with postpartum haemorrhage. With funding from the French Development Agency, 409 qualified health workers from 121 health facilities in 12 districts enhanced their skills to manage postpartum haemorrhage and the resuscitation of newborns during the first minute after birth.

UNICEF also works with the private sector to bring innovations to those who need them the most. The partnership with Bempu, the inventor of the wristband that alerts caregivers of the risk of hypothermia in low-birth weight newborns, helps empower families to protect their newborn babies. The product is being used in Papua New Guinea. Another innovation, used in Uganda for instance, is NeoNatalie, a low-cost inflatable simulator designed to teach basic neonatal-resuscitation skills. UNICEF is exploring a partnership with Newborn Essential Solutions and Technologies (NEST). NEST will equip district hospitals with low-cost essential equipment for newborn care while working to scale up in other countries.

Leveraging collective action

Given the importance of domestic financing to sustain maternal and newborn care, and complexity in the global partnership, UNICEF has been working with countries and development partners to integrate ENAP within national health-sector plans.

National plans for maternal and newborn health

As of 2018, some 53 countries had reported adopting ENAP, an increase of 11 countries compared to 2017 (see Figure 8). For instance, in West and Central Africa, reducing neonatal mortality and stillbirths has become a priority, propelling ENAP adoption from 3 countries in 2016 to 10 in 2018 (against a regional target of 8 countries). In Europe and Central Asia, 8 countries developed ENAP programmes with a special focus on quality improvement and care for sick and premature newborns (Tajikistan), harnessing the power of parents and communities (Armenia, Kazakhstan and Turkmenistan) and improving the quality of data and analytics through perinatal-mortality audits (Kazakhstan and Turkmenistan).

FIGURE 8: Adoption of Every Newborn Action Plan tracking tool by year, 2016–2018
Because evidence is crucial to translate action into results, accelerated use of the ENAP tracking tool is paramount. Progress has been steady: from 10 countries in 2014, to 18 in 2015, 52 in 2016 (which are the focus ENAP countries tracked in the strategic plan) and 75 in 2017. In 2018, some 90 countries, mostly from Eastern and Southern Africa, Europe and Central Asia, and East Asia and the Pacific, reported using the tracking tool. Regional meetings, technical assistance and follow-up from headquarters and regional offices helped catalyse this expansion.

Progress under the Every Newborn Action Plan

- 44 countries report having a national quality-improvement programme and 38 of these have a plan in place to implement quality-of-care guidelines
- 77 countries have developed a response system on the notification of maternal death within 24 hours
- 48 countries have a perinatal-death review system in place
- 46 countries have a national guideline or strategy for care of small and sick newborns
- 39 countries have a human-resource strategy for skilled attendants at birth, and 28 countries have a strategy to retain these cadres
- 52 countries have included all seven essential medical products and technologies in their National Essential Medicines List

By the end of 2018, some 23 countries (from a baseline of 3) were implementing plans to strengthen the quality of maternal and newborn PHC, vastly exceeding the 2018 milestone of 9 countries. This puts UNICEF on a fast track to meeting its 2021 target of 30 countries. The momentous progress shows the organization’s ability to galvanize partners at the national, regional and global levels on behalf of mothers and their newborns.

Global and regional partnerships

In the area of policy strengthening, UNICEF, with the financial support of the Bill & Melinda Gates Foundation, launched a programme to reduce preventable newborn deaths by scaling up Possible Serious Bacterial Infection management among babies 0–59 days old in Indonesia, the Niger, Pakistan and the United Republic of Tanzania in October 2017. In 2018, the programme kick-started active advocacy and coordination among stakeholders, and started reviewing and updating national policies in cooperation with government counterparts.

New partnerships to accelerate the realization of quality maternal care were developed in Eastern and Southern Africa, and Middle East and North Africa. UNICEF mobilized technical and financial support for the Campaign on Accelerated Reduction on Maternal Mortality in Africa (CARMMA) through the African Union Liaison Office. The Partnership for Maternal, Newborn and Child Health was introduced in the Middle East and North Africa region in 2018. The active participation in the Every Woman Every Child-Latin America platform resulted in joint activities with the Inter-American Development Bank to compile evidence on multisectoral and health-specific interventions to improve neonatal health in the region. The partnership also fostered the development and launch of a guide to implement the Every Woman Every Child Strategy in Latin America. UNICEF chaired the Neonatal Alliance and provided direct support to regional partners meeting in Colombia focusing on newborn health.

UNICEF recognizes the vital role that the private sector can play in achieving sustainable results for children. In 2018, the memorandum of understanding with Johnson & Johnson secured a commitment of US$10 million that will focus on maternal, newborn and adolescent health by helping strengthen health systems. This pledge is invaluable in helping the global community meet the SDGs by 2030. The partnership with Proctor & Gamble – Pampers directly contributes to the goals of maternal and neonatal tetanus elimination as delineated in the UNICEF Strategic Plan. Initiated in 2016, the partnership has raised more than US$60 million to date. From 2016 to May 2018, Pampers funding contributed to MNTF in 24 countries.

One strength of UNICEF is its unmatched ability to win support for the cause of children from decision makers and the wider public. UNICEF launched the Every Child Alive global campaign on 20 February 2018 to accelerate progress towards ending newborn deaths and ensuring every child survives and thrives to the age of five. The campaign aims to mobilize US$130 million, the immediate investment needed to help governments deliver affordable, quality health-care solutions for every mother and newborn. The initial emphasis is on 10 priority countries, where more than half of newborn deaths occur: Bangladesh, Ethiopia, Guinea-Bissau, India, Indonesia, Malawi, Mali, Nigeria, Pakistan and the United Republic of Tanzania. Efforts to localize the campaign are under way regionally as well. For instance, the Regional Office for South Asia has developed multisectoral plans to sensitize the public through social media and social-policy advocacy. To this end, 32 communication teams were trained on integrated advocacy in support of the headline results of saving half a million newborns by 2021.

The power of evidence helps drive change for mothers and newborns. In 2018, UNICEF produced 20 publications on maternal and newborn health, of which 18 were peer-reviewed articles. One particularly significant contributions was “Equity dimensions of the availability and quality of reproductive, maternal and neonatal health services in Zambia” (Tropical Medicine and International Health). The report Every Child Alive: The urgent need to end newborn deaths calls for strong cooperation among governments,
businesses, health-care providers, communities and families to give every newborn a fair chance to survive, to work collectively to achieve universal health coverage and a world in which no newborn dies of a preventable cause.

Conclusion

The implementation of the first year of the UNICEF Strategic Plan, 2018–2021 concluded with successes and impressive results in the area of maternal and newborn health. The focus on improving the quality of care and capacity-building contributed to greater coverage in antenatal and postnatal care, as well as an increased number of facility-based live births with the help of skilled personnel. However, some outstanding gaps remain. To accelerate progress, more ENAP countries will need to include health management information system indicators on specific newborn interventions, set targets for stillbirth reduction, strengthen the newborn-health component in emergency preparedness plans and further engage with communities. Financing gaps at the domestic and global levels persist. In addition, the lack of flexible funding streams for UNICEF health work such as global thematic funds further constrains the ability to deliver greater results and sustain them over time. Areas for greater investment and collaboration include maternal and neonatal tetanus elimination, national newborn action plans and the Every Child Alive campaign.

Results Area 2: Immunization

Note: Immunization data are for 2017 unless specified.

Immunization remains one of the most successful and cost-effective public health interventions. To prevent premature deaths and disabilities, UNICEF and partners supported the vaccination of 65.5 million children with three doses of DTP-containing/Penta vaccine in 64 priority countries. In humanitarian settings, UNICEF supported measles vaccination of 19.6 million children – 96 per cent of the targeted 20.0 million.

Strong progress was evident at output level as several 2018 milestones were achieved. Effective vaccine management assessments indicate that vaccine management practices are improving. The year saw continued positive trends in the introduction of human papillomavirus (HPV), pneumococcal, rotavirus and rubella vaccines. Also, 45 countries have eliminated maternal and neonatal tetanus.

The immunization results area represented 43 per cent (US$556 million) of all UNICEF health expenditure in 2018. Nine per cent of these expenses was disbursed from regular resources. UNICEF provided procurement services to governments and other development partners resulting in US$1.536 billion worth of supplies and services delivered to 107 countries, including US$1.047 billion on behalf of Gavi, the Vaccine Alliance. UNICEF procured 2.36 billion doses of vaccines for 99 countries with a value of US$1.453 billion and supplied vaccines to reach 45 per cent of the world’s children under five years old.

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A child is being vaccinated for measles and rubella by mobile health staff in Nabua village, Vientiane Province, Lao People’s Democratic Republic.
### TABLE 3: Outcome results for immunization, 2018

<table>
<thead>
<tr>
<th>Outcome indicator</th>
<th>Baseline</th>
<th>2018 value</th>
<th>2021 target</th>
<th>SDG target no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of children vaccinated against (a) yellow fever and (b) meningitis in high-burden countries*</td>
<td>(a) 44 (b) not available</td>
<td>(a) 41 (a) n/a</td>
<td>under development</td>
<td>not available</td>
</tr>
<tr>
<td>Percentage of children who are vaccinated for: (a) first dose of measles-containing vaccine; (b-i) three doses of diphtheria–tetanus–pertussis (DTP) containing/Penta vaccine; (b-ii) number of countries in which percentage of children vaccinated with DTP/Penta 3 containing vaccine is at least 80% in every district*</td>
<td>(a) 78% (b-i) 80% (b-ii) 9</td>
<td>(a) 79% (b-i) 80% (b-ii) 8</td>
<td>(a) 85% (b-i) 85% (b-ii) 30</td>
<td>3.b.1</td>
</tr>
<tr>
<td>Interruption of wild polio transmission</td>
<td>Three remaining endemic countries</td>
<td>Three remaining endemic countries</td>
<td>Global certification of polio eradication</td>
<td>3.3</td>
</tr>
</tbody>
</table>

*This indicator has a one year reporting lag

### TABLE 4: Output results for immunization, 2018

<table>
<thead>
<tr>
<th>Output indicator</th>
<th>Baseline</th>
<th>2018 milestone</th>
<th>2018 value</th>
<th>2021 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries that have introduced (a) yellow fever and (b) meningitis vaccines in their national immunization schedule*</td>
<td>(a) 21 (b) 2</td>
<td>(a) 22 (b) 9</td>
<td>(a) 21 (b) 9</td>
<td>(a) 25 (b) 26</td>
</tr>
<tr>
<td>Number of countries implementing activities to prepare for, prevent, manage or communicate adverse events following immunization (AEFI) or other vaccine-related events*</td>
<td>47</td>
<td>32</td>
<td>52</td>
<td>48</td>
</tr>
<tr>
<td>Number of countries with effective vaccine management (EVM) composite country score &gt;80%</td>
<td>9</td>
<td>10</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Number of countries implementing a national health sector supply chain strategy/plan</td>
<td>24</td>
<td>30</td>
<td>36</td>
<td>48</td>
</tr>
<tr>
<td>Percentage of polio priority countries that had less than 5 per cent missed children at district level during the last polio vaccination campaign in at least half of all districts in the country (humanitarian)</td>
<td>64%</td>
<td>85%</td>
<td>100%</td>
<td>85%</td>
</tr>
<tr>
<td>Percentage of UNICEF-targeted children in humanitarian situations vaccinated against measles (humanitarian)</td>
<td>81%</td>
<td>95%</td>
<td>96%</td>
<td>95%</td>
</tr>
</tbody>
</table>

*This indicator has a one year reporting lag
Context

In 2017, the global number of children vaccinated – 116.2 million – was the highest ever reported. The number of under-vaccinated children fell by over 1.8 million between 2010 and 2017. Yet globally 19.9 million children were under-vaccinated in 2017, exposing them to vaccine-preventable mortality, illness and disability. Under-vaccination is concentrated in 64 UNICEF priority countries (16.7 million under-vaccinated children) which include middle-income countries where under-vaccination is becoming a serious public health issue. As a result, an alarming global surge of measles outbreaks was seen in 2018, including in high and middle-income countries.

Immunization reaches more households than any other health intervention and provides the health system with important touchpoints with children and parents. Immunization is a key intervention to achieve universal health coverage and an entry point to build strong and sustainable primary health systems, as well as offering related services in nutrition, HIV and ECD through common delivery platforms. Children who are un- and under-vaccinated are those who are not reached by the health system. As such, immunization status is a good indicator on inequity.

The UNICEF vision is to ensure that all children and women benefit fully from their right to immunization, prioritizing those most disadvantaged. Three outcome and six output indicators are reported in the Strategic Plan to this end (see Figure 9). The UNICEF Immunization Roadmap 2018–2030 details corporate priorities to achieve these results now and into the next decade.

Improving services and community demand

To foster the realization of universal health coverage through immunization, UNICEF focuses on coverage and equity, accelerates the implementation of key immunization initiatives, works towards a polio-free world, undertakes evidence-based activities to generate demand for services, and ensures that the most vulnerable children and women are vaccinated, even in challenging humanitarian settings.

A focus on coverage and equity

Immunization equity is attained when no avoidable differences exist in vaccination coverage between groups, communities and countries. In 2017, more children were vaccinated than ever before (see Figure 10).

FIGURE 9: UNICEF priorities for achieving Strategic Plan outputs and outcomes for immunization

<table>
<thead>
<tr>
<th>Contexts</th>
<th>FRAGILE STATES</th>
<th>EMERGENCIES</th>
<th>LOW CAPACITY</th>
<th>MEDIUM CAPACITY</th>
<th>HIGH CAPACITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives</td>
<td>Global and national policies are based on evidence and address the immunization needs of the most disadvantaged and under-served populations</td>
<td>National systems are positioned to provide immunization services and quality vaccines</td>
<td>Communities value and demand their right to immunization services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence-based policies promote immunization outcomes in an effective and efficient manner</td>
<td>Global and national immunization programmes accelerate equity improvements for the disadvantaged</td>
<td>Sustainable financing for immunization programmes is achieved</td>
<td>Countries have access to uninterrupted, sustainable, affordable supply of quality vaccines and immunization related supplies in the context of long-term healthy markets</td>
<td>Effective and efficient supply chain systems are in place for all children and women to receive potent vaccines</td>
<td>Children, adolescents and women access and use immunization services</td>
</tr>
<tr>
<td>Population Platforms</td>
<td>CHILDREN</td>
<td>ADOLESCENTS</td>
<td>MATERNAL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Despite increasing numbers of births, health systems are keeping up with immunization: 80 per cent of children received three doses of DTP-containing/Penta vaccine (against a 2021 target of 85 per cent) in 64 priority countries. However, inequities prevail at subnational level. Only 8 countries achieved 80 per cent coverage in every district, against a target of 30 by 2021. In effect, this leaves globally 19.9 million children unprotected from vaccine-preventable diseases (16.7 million in UNICEF priority countries) in 2017. Children in fragile or conflict-affected countries are worse off. For example, in the context of South Sudan, the Syrian Arab Republic and Yemen, it has been challenging to maintain coverage, let alone increase it. Overall, the picture is more positive on the scale-up of rotavirus and pneumococcal conjugate vaccines, with the number of vaccinated children increasing as more countries introduce these vaccines into their national immunization schedules, improving the breadth of protection against a range of vaccine-preventable diseases.

In 2018, UNICEF identified three contexts where underserved children tend to reside: conflict, urban poor and remote rural. In addition, the cross-cutting area of gender-related barriers to immunization was identified as a priority. To operationalize the ‘leave no one behind’ principle, UNICEF developed tools and approaches to target programming and investments. Based on a review of 15 coverage and equity assessments implemented during 2015–2017, the Coverage and Equity Analysis guide was updated to improve and harmonize the process of locating un- and under-vaccinated children in order to programme pro-equity approaches. For instance, in Sierra Leone, the Coverage and Equity Analysis guide proved instrumental in highlighting areas with: low coverage and high numbers of unvaccinated children, outbreaks of vaccine-preventable diseases and frequent vaccine stock-outs. The assessment also informed resource prioritization for health and immunization systems support at country level through Gavi’s targeted country assistance and health system and immunization strengthening framework.

Another example to operationalize the equity agenda is UNICEF work on urban immunization. The organization has developed an urban immunization toolkit currently implemented across 11 countries by Gavi stakeholders to address inequities in urban slums (Angola, the Democratic Republic of the Congo, Djibouti, Ghana, Haiti, Indonesia, Kenya, Kyrgyzstan, Pakistan, Somalia and Uganda). Through this urban focus, for instance, the Government of Pakistan reached 450,000 children with life-saving vaccines including more children in urban slums in 10 megacities.

**FIGURE 10: Immunization coverage in priority countries**

![Immunization coverage in priority countries](source: WHO/UNICEF (2017))
Accelerated immunization initiatives

To reduce preventable disability and mortality, UNICEF is implementing accelerated immunization initiatives against measles, yellow fever and meningococcal meningitis.

Children who are not vaccinated against measles and rubella are at risk of severe health complications, lifelong disability and death. The fetus of a woman who becomes infected with rubella virus in early pregnancy has a 90 per cent chance of developing congenital rubella syndrome. Vaccination is key in reducing this disability and mortality.

Between 2010 and 2017 global coverage with the first dose of measles-containing vaccine (MCV1) stagnated at 85 per cent – insufficient to prevent outbreaks of this highly infectious disease. However, coverage with the second dose (MCV2) increased significantly, reaching 67 per cent in 2017. Globally, the average rubella coverage stood at 57 per cent in 2017.

Given the outbreaks of measles in the Americas in 2018, the region lost its status of having eliminated the disease and measles is again considered endemic in all regions worldwide. Globally, 98 countries reported more measles cases in 2018 than in 2017, eroding progress against this preventable, but highly contagious and potentially deadly disease. Significant outbreaks occurred in Brazil, India, Madagascar, Pakistan, the Philippines, Serbia and Ukraine, while a major outbreak in Venezuela led to the re-establishment of endemic measles transmission there. Over 80,000 people in 47 of 53 European countries contracted measles in 2018, with 72 deaths. A surge in outbreaks is a timely reminder that hard-won gains can be quickly lost. Outbreaks in North America and in Europe emphasize that measles can spread rapidly, even in countries with well-established health systems. Without constant attention, national immunization systems can easily deteriorate, particularly when faced with political and economic upheaval. Beyond the preventable loss of life, dealing with a disease outbreak can cost 20 times the vaccinations that could have prevented it.

In 2017, some 79 per cent of children were vaccinated with their first dose of measles-containing vaccine in the 64 UNICEF priority countries (2021 target: 85 per cent). In 2018, to support measles-elimination goals under the Global Vaccine Action Plan, UNICEF and partners supported the vaccination of nearly 86 million children with measles-containing vaccine through supplemental immunization activities. Under the collaboration between Gavi and Measles & Rubella Initiative, the Big 6 Initiative targets its support to the Democratic Republic of the Congo, India, Indonesia, Ethiopia, Nigeria and Pakistan, which are home to the largest numbers of unvaccinated children.

Yellow fever is an acute viral haemorrhagic disease transmitted by infected *Aedes* mosquitoes. Globally, 47 countries across Africa and Central and South America have regions that are endemic for yellow fever. The burden of yellow fever in Africa is estimated at 84,000–170,000 severe cases and 29,000–60,000 deaths annually. Yellow fever recently re-emerged in Brazil as an alarming threat, with an increasing number of cases confirmed beyond the limits of the Amazon region, considered endemic for the disease.

In 2017, some 41 per cent of children in 24 high-burden countries were vaccinated against yellow fever. Routine immunization coverage for yellow fever continues to be well below ideal. UNICEF, with partners, will be commissioning a coverage assessment in 2019 to understand the barriers and bottlenecks and develop appropriate strategies to improve coverage. This will help establish targets for these 24 countries during the Mid-Term Review of the Strategic Plan. During the year, a total of 7.3 million people in the Congo, Ethiopia and Nigeria were vaccinated against yellow fever during outbreak response. In addition, Nigeria and Ghana conducted preventive mass vaccination campaigns to vaccinate a total of 33 million people against the disease.

Most meningococcal meningitis cases and outbreaks occur in the 26 countries of sub-Saharan Africa located in the so-called ‘meningitis belt’. In 2018, the transmission of serotype C continued in Nigeria, a localized cluster of cases attributed to serogroup W was detected in Liberia, and Fiji experienced a non-acute outbreak. In Fiji, for instance, UNICEF and WHO secured meningitis C vaccine to help vaccinate over 300,000 children and adolescents aged 1–19 years. WHO/UNICEF Estimates of National Immunization Coverage (WPENIC) on the percentage of immunized children against meningitis are not available yet.

Towards a polio-free world

The final year of the 2013–2018 Polio Eradication and Endgame Strategic Plan saw Nigeria maintain its ‘zero wild polio virus (WPV) status’ for the second consecutive year, and Madagascar being certified WPV free. Afghanistan and Pakistan recorded 21 and 12 WPV cases, respectively, increases from 14 and 8 cases in 2017.

As one of the key partners of the Global Polio Eradication Initiative (GPEI), UNICEF continued its critical work on vaccine procurement and management, social mobilization and communication, with a strategic focus on the three polio endemic countries, namely Afghanistan, Pakistan and Nigeria, as well as eight countries with circulating vaccine-derived poliovirus (cVDPV) outbreaks in 2018 – the Democratic Republic of the Congo, Indonesia, Mozambique, the Niger, Nigeria, Papua New Guinea, Somalia and the Syrian Arab Republic.

Backed by data-driven, gender-focused Communication for Development strategies and well-trained social-mobilization networks, UNICEF teams in polio-priority countries continued striving to reach and inoculate children against polio and promote life-saving practices such as vaccination, exclusive breastfeeding and handwashing to children, women and men in the ‘hardest to reach’ communities.

**WPV-endemic countries:** Nigeria maintained its WPV-free status for the second year running. The country
continued using innovative approaches to reach and vaccinate children in the most hard-to-reach areas through the UNICEF-supported Volunteer Community Mobilization network comprising over 19,000 members. While there are grounds for optimism around the country achieving ‘polio free’ status in 2019, primary challenges such as lack of access and inability to conduct high-quality vaccination and surveillance in many areas of Borno State remain.

Afghanistan and Pakistan further strengthened cross-border coordination and partnership through the jointly developed Southern and Northern Corridor Action Plans and successfully implemented six subnational vaccination campaigns. UNICEF also initiated planning for an innovative strategy in both countries integrating nutrition, immunization, health, water and sanitation to increase vaccination in polio high-risk regions.

CVDPV outbreak countries: Faeces from children vaccinated with the oral polio vaccine can carry live vaccine virus while their bodies build up antibodies. Circulating in the environment, the excreted virus can mutate and, in rare circumstances, go on to infect others, especially in areas with poor sanitation and low vaccination rates. This is called cVDPV.

In 2018, cVDPV outbreaks occurred in the Democratic Republic of the Congo, Indonesia, Mozambique, the Niger, Nigeria, Papua New Guinea, Somalia and the Syrian Arab Republic, which necessitated a shift and refocus of capacities within UNICEF and GPEI partners to adequately prepare and respond to outbreaks. Kenya conducted five polio campaigns using a door-to-door strategy in 12 high-risk counties, reaching approximately 2.8 million children under five (95 per cent of target). In the Lake Chad Basin region, approximately 4 million and 2.5 million children under five years of age (100 per cent of targets) were vaccinated during two national and local vaccination campaigns. The Democratic Republic of the Congo successfully inoculated over 175 million children, while the Central African Republic vaccinated 910,000 under-five children against polio. In Papua New Guinea, an integrated immunization campaign reached 97 per cent of children under 15 years of age. UNICEF continues to mobilize critical resources for polio outbreak preparedness and response.

Polio-free countries: India, in its fourth year since the South-East Asia region was certified polio free, continued supporting the polio-free programme through its Social Mobilization Network (SMNet) that targeted 2 million households in high-risk communities in Bihar and Uttar Pradesh, and successfully vaccinated 4.2 million children during four polio vaccination rounds.

Demand for immunization

Demand generation for immunization is vital to ensure equitable access to and uptake of immunization services. Demand creation and community empowerment through evidence-driven strategies aim to impart the necessary information and knowledge, instil confidence in the quality and safety of services provided, and promote positive and measurable behaviour and social change.
CASE STUDY 1: Pakistan: Social mobilization to vaccinate 37 million children against measles

In Pakistan, the latest survey showed that only 73 per cent of children received measles vaccines, leaving many children susceptible to measles outbreaks. In 2017 alone, 6,780 people contracted measles, an incidence rate of over 35 per cent. From 2015 to 2017, some 110 children died from measles.

The willingness to vaccinate children is low, indicating the need for demand-generating actions. Between October 2017 and February 2019, a dedicated campaign ran in areas that were deemed high risk based on analysis of overall vaccine coverage (using diphtheria–tetanus–pertussis). The advocacy, communication and social-mobilization strategy focused on interpersonal communication, bearing in mind low levels of literacy. It was jointly funded by Gavi, the Vaccine Alliance and the Government of Pakistan at US$34 million, and actively supported by the country’s 24,000 community-based vaccinators from the polio eradication programme.

Additional official websites and social media channels were developed specifically for the Federal Expanded Programme on Immunization. Over 19 million users received text messages and robocalls, including through WhatsApp for the first time. Social-media outreach achieved over 15 million views. About 1,500 social media posts were posted by over 1,300 distinct users. Remarkably, nearly a third of active users were women, in a country where about 85 per cent of Internet users are men. The campaign was monitored using the UNICEF open-source real-time data monitoring tool, RapidPro. The findings were vital in improving quality and execution through feedback and quick follow-up on corrective actions.

It is estimated that 37 million children were reached (94 per cent coverage). The interpersonal dimension, through interaction with vaccinators as well as the use of social media and communication platforms, allowed better response to queries and concerns, which aided the success of the campaign. Building on this experience, a large-scale qualitative and quantitative study of immunization health workers’ motivation, morale and challenges in service delivery is planned for 2019 to strengthen this crucial element for future campaigns. As a result of the campaign, Pakistan now intends to use RapidPro to regularly monitor and report on immunization activities in the future.

FIGURE 11: Pakistan measles vaccination campaign by the numbers

AEFI, adverse events following immunization; IPC/I, Interpersonal Communication for Immunization Package.
Communication for immunization also remains a priority for the Polio Programme in Afghanistan that vaccinated 9.9 million children during three national and six subnational immunization days, synchronized with Pakistan. In addition to financial and technical support to the vaccination campaigns, the UNICEF-led national polio communication strategy tracked reasons for refusals, addressed misinformation and reached missed children using household and community engagement approaches. This involved working systematically with key local influencers such as respected local mullahs (religious leaders), doctors, health workers and immunization communication networks in high-risk districts.

Pakistan’s five national polio vaccination campaigns mobilized 260,000 front-line workers targeting 38 million children per campaign, while five subnational campaigns targeted 20 million children. UNICEF expanded the highly successful community-based vaccination approach to all core reservoirs in 24 districts, targeting over 4 million children through a network of close to 25,000 front-line workers, of whom 85 per cent were women. In addition, a data-driven Communication for Eradication strategy targeted 50,000 ‘still refusing’ parents by engaging 5,000 key influencers, 1,200 social mobilizers and all mosques in the high-risk union councils. A child-to-child mobilization approach was strengthened through games introduced in 15 schools in the highest-risk union councils in Peshawar, reaching 10,000 children. A communication component was integrated into the rapid-response team for improved communication response based on clear social profiling and a WhatsApp strategy to counter negative propaganda.

Women are critical in the fight against polio. From reaching every child with polio vaccines to ensuring their children receive the protection they deserve, women are at the heart of polio eradication efforts. In GPEI immunization activities, female front-line workers have increased the effectiveness of health-service delivery. In many settings, only women can access households to vaccinate children. Female social mobilizers have improved attitudes towards polio vaccination and the perceptions of risks associated with the disease. Women on the front line communicate directly with female caregivers and indirectly with other women in the community. The recruitment of local women, in particular, enables greater capacity for trust.

UNICEF deploys similar approaches for the HPV vaccine. In 2018, UNICEF provided C4D technical assistance to countries introducing HPV vaccine: Ethiopia, Senegal, the United Republic of Tanzania and Zimbabwe.
Immunization in humanitarian settings

In the context of crises, ensuring immediate preventive measures and responding swiftly to disease outbreaks is of the foremost importance and at the core of the humanitarian public health response.

Working with partners in humanitarian situations, UNICEF continued to provide leadership in measles campaigns reaching 19.6 million children with life-saving measles vaccines – 96 per cent of the targeted 20.0 million, surpassing the 2018 milestone and humanitarian benchmark of 95 per cent. The majority of children vaccinated live in Burkina Faso, Chad, Indonesia, Libya, the Syrian Arab Republic and Yemen. More countries (48) conducted measles vaccinations in 2018 compared with 2017 (36 countries). However, establishing appropriate denominators for humanitarian settings remains notoriously challenging, notably due to population movements and difficulties in estimating population size and age groups.

Displacement is affecting immunization in the Syrian Arab Republic and for Rohingya who fled to Bangladesh. In the Syrian Arab Republic, where more than half of the population is estimated to have been displaced, UNICEF is working with a severely damaged health system. Nearly half of all hospitals have been closed, destroyed or are only partly functional; 60 per cent of health workers have either left the country or been killed. Nevertheless, DTP3 coverage rose in the Syrian Arab Republic by 6 per cent to 48 per cent, while 2.6 million children under the age of five were vaccinated through polio and measles campaigns. For measles, an additional 1.4 million children above the age of five were also reached. A key factor was dedicated support, from Gavi, to rehabilitating the cold chain. In the camps in Bangladesh, 90,800 Rohingya and host-community children received Penta 3 vaccine. An outbreak of diphtheria was countered by a mass vaccination campaign against that disease.

In 2018, UNICEF and partners responded to several outbreaks, including measles, diphtheria, cholera, and Ebola.

In Yemen, more than 2.0 million children 6 weeks to 15 years were vaccinated with Penta vaccine in response to a diphtheria outbreak, and over 5 million children under the age of five were vaccinated against polio (87 per cent coverage). Instrumental was the UNICEF operationalization of 1,700 Extended Programme on Immunization (EPI) centres, refresher training activities, solar direct drive
refrigerators, freeze-alert devices, cold boxes and diesel. This actively helped strengthen capacity for later recovery across the humanitarian–development nexus.

UNICEF and partners were able to provide strong support to several countries experiencing cholera outbreaks, reaching more than 6 million people with two doses of oral cholera vaccine.

The Democratic Republic of the Congo faced two outbreaks of Ebola virus disease in 2018. The second outbreak, in North Kivu, is now the second largest Ebola outbreak in history, unfolding against a backdrop of long-standing conflict, population movement, protracted humanitarian crisis, and a weak health system. As of 21 March 2019, a total of 980 cases have been reported (915 confirmed), including 610 deaths.26

As part of the Ebola response, vaccines are given to health workers who are on the front line to treat people infected by Ebola virus disease and those they have come in contact with, and to the contacts of those contacts as well, to ensure the broadest coverage possible. UNICEF is playing a leading role in providing information on vaccination to the communities affected by this Ebola outbreak.

As seen through the examples above, UNICEF has deployed emergency immunization responses in various and challenging settings in support of the most vulnerable populations.

**Strengthening national and subnational capacity**

To strengthen national and subnational capacity, UNICEF implemented tailored national strategies that are critical to leaving no child behind; including working to build the capacity of front-line workers to increase demand for immunization services; enhanced capacity to monitor adverse events following immunization to quickly correct course and maintain public trust. To strengthen supply chains, UNICEF works towards enhancing effective vaccine-management practices to ensure vaccine availability and efficient use of resources; strengthening cold chains; and building capacity in vaccine procurement.

**Immunization services that leave no one behind**

UNICEF supported governments and partners to implement tailored strategies to improve coverage and equity at national and subnational levels. In addition to ongoing work in urban slums and in fragile or conflict-affected countries, UNICEF provided support for planning and implementing vaccination outreach activities to deliver vital immunization services to populations and communities in geographically challenging and remote locations. For example, in Eritrea, UNICEF facilitated the delivery of life-saving vaccines to 41 hard-to-reach communities; in Ethiopia, UNICEF helped...
prioritize 2,608 vulnerable communities, home to 80 per cent of unvaccinated children; in Zimbabwe, it installed 104 solar-driven cold-chain facilities in the remotest locations; in the Central African Republic, it aided vaccination of over 30,310 children in hard-to-reach communities (including nomadic, internally displaced persons, mine sites and fishing colonies); and in Ghana, it supported the development of immunization micro-plans for 91 priority districts to improve coverage and equity.

Front-line workers (FLWs) are an essential link between immunization services and the communities they serve. Caregivers see FLWs as a trusted source of information. Consequently, FLWs must be able to communicate the vital importance of immunization so caregivers actively seek immunization services. Therefore, it is essential that FLWs have effective interpersonal skills to increase demand for vaccines, address vaccine hesitancy, and gain the trust of caregivers, families and communities.

Effective training improves FLWs’ communication skills and enhances outreach services. During 2018, UNICEF and partners further developed the Interpersonal Communication for Immunization Package (IPC/I) to build FLW capacity and address a key barrier to immunization uptake. This was pretested in Malawi, Pakistan and Uganda. The Europe and Central Asia Regional Office used this toolkit to train more than 300 health professionals in Bosnia and Herzegovina (see Case Study 2), Kyrgyzstan and Serbia.

In India, UNICEF and partners supported the development and roll-out of IPC/I training to build the skills of 2.7 million FLWs in 36 states. BRIDGE (Boosting Routine Immunization Demand Generation) aims to increase demand, address vaccine hesitancy and support institutional strengthening. National and state governments are leveraging over US$10 million for the programme under the National Health Mission.

Vaccines are designed to be effective and safe; severe reactions following immunization are extremely rare. Yet adverse events can occur. The reporting of adverse events following immunization is the first step to making sure that vaccine products are safe and are being safely administered. Functional vaccine safety monitoring systems need to be in place to address adverse events: to take corrective action and communicate effectively with populations. In 2017, some 52 countries (from a baseline of 47) implemented activities to prepare for, prevent, manage and/or communicate adverse events following immunization or other vaccine-related events. The result surpasses the 2018 milestone of 32 countries and the 2021 target of 48 countries showing greater progress towards building national capacity to respond to adverse events, ensuring vaccine safety and maintaining public trust.

**Immunization supply-chain strengthening**

Immunization supply chains ensure that vaccines travel from their port of entry at central level to the point of use in health facilities or outreach settings. During this period, vaccines need to be protected from freezing and excessive heat. The objective is to ensure quality vaccines are available and effective at the point of use.

UNICEF works with governments to ensure that effective and efficient immunization supply chains are in place for all children and women to receive potent vaccines. The organization continued to work with countries on the comprehensive effective vaccine management (EVM) process. EVM measures whether national immunization supply-chain systems comply with WHO standards in terms of the capacity of the supply system to ensure vaccine availability, quality and efficient use of resources. Between 2009 and 2018, a total of 139 nationwide EVM assessments were carried out.

**CASE STUDY 2: Bosnia and Herzegovina: Global thematic funds strengthen the health system**

While routine childhood immunization services are mandatory and free of charge, Bosnia and Herzegovina has one of the lowest immunization coverages in Europe and Central Asia. Combined diphtheria–tetanus–pertussis 3 vaccine coverage is 75 per cent. Only 68 per cent of children are fully immunized; with only 4 per cent for Roma children.

To address anti-vaccine attitudes and lack of knowledge, UNICEF used US$60,000 in thematic funds to strengthen the interpersonal communication skills of 180 health professionals and front-line workers. UNICEF will also advocate institutionalizing the Interpersonal Communication for Immunization Package module within regular in-service training for doctors and nurses.
An EVM score above 80 per cent indicates that adequate immunization systems and capacities are in place in country (see Figure 12). The number of countries with this score grew from a 2015 baseline of 9 to 12 surpassing the 2018 milestone of 10. UNICEF supported EVM assessments in Azerbaijan, the Comoros, Georgia, Haiti, India, Lesotho, Mali, Rwanda, Uganda and Ukraine. In 2018, of the 10 countries that have conducted EVM assessments, Rwanda and Uganda have exceeded the average EVM score of 80 per cent. Most importantly, all the countries have seen an increase in their average scores (five countries have increased by 2–10 per cent, three have increased by 10–20 per cent and two have increased by more than 20 per cent).

Another success has been the improved timeliness of vaccine arrival reports. These reports record the quality of vaccines inspected in country within 24 hours of arrival, and are submitted to UNICEF to track and monitor the quality of vaccines as they are delivered to countries worldwide. In 2018, UNICEF received 100 per cent of vaccine arrival reports, with notable improvement of timeliness.

The cold chain is a critical link in the immunization supply chain and, therefore, to achieving universal health coverage. One way to strengthen the cold chain is through the Gavi-funded Cold Chain Equipment Optimization Platform (CCE OP). At the end of 2018, some 41 countries were approved under the CCE OP funding window (often with UNICEF support), signifying that about 70,000 cold-chain units of optimal quality will be installed by 2020; these will be procured by UNICEF. This will extend the reach of the supply chain and accommodate new vaccine introductions. For instance, in Liberia, UNICEF procured and facilitated the installation of new solar-powered cold-chain equipment, which helped increase the cold-chain vaccine storage capacity by 39 per cent in 115 county health facilities, most of them in hard-to-reach areas, thereby assuring immunization service delivery. In 2018, UNICEF procured cold-chain equipment to the value of US $77.8 million, of which solar-powered systems accounted for US $54.3 million. Adding related installation services, the procurement amounts to US $97.9 million. In the forthcoming years, these investments are expected to translate into gains in coverage and equity.

Exposure to heat or freezing can damage vaccines as they travel from the central warehouse to remote health facilities. Hence, temperature monitoring is an important component of the immunization supply chain strengthening. Achievements in 2018 included revising the Temperature Monitoring Studies handbook based on lessons learned. This also forms the basis of a popular online e-learning module with around 500 yearly enrolments since 2016. UNICEF provided catalytic funding to ensure countries can perform temperature-monitoring.
studies in their cold rooms (e.g., in Burkina Faso, the Democratic Republic of the Congo, Mali, Mauritania and Nigeria). These studies are critical to prevent any freezing or heat spots. Armenia and Georgia conducted temperature-monitoring studies that identified some temperature deviations that were addressed through improvement plans.

The year 2018 marked the most successful (to date) UNICEF Vaccine Procurement Practitioners Exchange Forum to improve vaccine procurement including forecasting, planning and budgeting. Representatives from ministries of finance, health and procurement from 23 countries attended the event; one day was dedicated to facilitating exchange between countries and suppliers to increase knowledge sharing on national needs and requirements, and suppliers’ ability to meet those needs.

**Leveraging collective action**

To mobilize action for greater immunization results, UNICEF supports the design and implementation of plans at the national level, such as the introduction of vaccines in national immunization schedules. At the global level, UNICEF continues to be a strong voice on financing, a powerful shaper of vaccine markets, a lead actor within global and regional immunization partnerships, as well as a leader in the production of evidence and knowledge.

**New vaccine introduction**

Immunization programmes have become more complex in recent years as new vaccines and new age groups have been added in an evolving immunization landscape. These vaccines include pneumococcal conjugate vaccine (PCV), rotavirus, HPV, rubella and meningitis (see Figure 13). The pneumococcal and rotavirus vaccines are particularly critical against killer childhood diseases such as pneumonia and diarrhoea.

To ensure that children have continuous access to life-saving vaccines, vaccines must be introduced into national immunization schedules. The strong collaboration between UNICEF, Gavi and WHO (among others) helps governments rapidly introduce new vaccines into national immunization schedules. Since 2010, some 113 countries have introduced new vaccines. Since 2014, UNICEF has supported 17 priority countries in PCV introduction and 24 priority countries in rotavirus vaccine introduction.

By the end of 2017, twenty-one countries had introduced yellow fever vaccine in their national immunization schedule nearly meeting the 2018 milestone of 22 countries. The Eliminating Yellow Fever strategy was launched in Africa, and all high-risk countries are developing plans to operationalize the strategy. Nine countries introduced meningitis vaccine, a steep increase from a baseline of two countries (target: 26).
HPV vaccine is the cornerstone of cervical-cancer prevention and an important component of adolescent health promotion. In 2018, UNICEF C4D teams supported HPV vaccine introductions in Ethiopia, Malawi, Senegal, the United Republic of Tanzania and Zimbabwe, with a target population of 2,769,811 eligible girls.

**Immunization financing**

Sustainable financing for immunization programmes is critical. During 2018, UNICEF expanded its work on immunization financing both at the global level and in selected countries. At the global level, UNICEF chaired the Gavi Alliance Task Team on immunization financing and sustainability. A comprehensive analysis on how vaccines and other immunization expenses are budgeted within ministry of health budgets in 55 countries highlighted major bottlenecks. This suggests that budget execution was relatively low in many countries, impacting the delivery of services. Important country engagement included continuous technical assistance to Kenya’s National Immunization Programme to build technical capacity on immunization financing and a cost-effectiveness study of four vaccines in the Sudan which will be used to advocate for increased budget allocation for immunization after Gavi transition.

**Co-financing:** To minimize default risk in countries, and ensure that Gavi’s objectives are achieved, mechanisms are in place to support countries meet their co-financing obligations and sustain financing for immunization programmes. UNICEF manages and monitors co-financing of Gavi-supported vaccines in 56 countries. As a result, an increasing number of countries fully meet their annual obligations, and a decreasing number default in a context of growing financial obligations *(see Figure 14).* The number of countries that did not meet their obligations by the end of 2018 is substantially lower than reported in previous years (one country, excluding countries with a country-tailored approach). During 2018, some 49 countries fully met their co-financing obligations, 2 partially met their obligation and only 1 country had a fully outstanding obligation. Gavi-eligible countries paid a total of US$91 million (out of US$98 million in obligations) to UNICEF for co-financing during 2018.
To reach children sustainably, UNICEF works towards helping countries secure continuous vaccine supplies and minimize stock-outs. The Vaccine Independence Initiative is a successful revolving fund managed by UNICEF. It provides country subscribers with flexible financing to cover financial gaps affecting vaccine procurement and enables continuity in vaccine supplies. More than 20 countries in Africa, the Pacific and South-East Asia have used the fund to pre-finance vaccines, injection supplies and cold-chain equipment. For instance, the Vaccine Independence Initiative has allowed all 13 Pacific Islands countries and territories to successfully maintain uninterrupted vaccine and immunization supplies. Using this mechanism, the Federated States of Micronesia procured cold-chain equipment by investing national resources instead of relying on donor support.

Market shaping

As the largest buyer of vaccines in the world, UNICEF continues to harness the power of markets for children's rights and health. An ongoing goal is to ensure the security of supply of essential life-saving vaccines at affordable and stable prices. In 2018, some 2.36 billion vaccine doses were procured for 99 countries to reach 45 per cent of the world’s children under five years old. In absolute terms, this amounts to a 3 per cent decrease in the volume of vaccines shipped compared with the 2.440 billion doses supplied in 2017. The decrease is explained by better planned preventive campaigns to reduce the risk of outbreaks, in addition to routine vaccinations undertaken in 2018. A significant success in 2018 was the lower prices for PCV, which helped contribute to the equity agenda.

The organization’s market-shaping power has helped reduce PCV and HPV vaccine costs to help non-Gavi middle-income countries introduce these new vaccines.

After the planned withdrawal of trivalent oral polio vaccine (tOPV)27 to bivalent oral polio vaccine (bOPV) in April 2016, a global shortage of inactivated polio vaccine (IPV) left 33 countries not supplied with IPV. In 2018, the supply situation improved, allowing UNICEF to offer IPV to all these countries and for them to include the vaccine in their routine immunization programmes. UNICEF procured a total of 65.98 million doses of IPV for 80 countries in 2018.

Tetanus vaccine has been replaced by tetanus–diphtheria vaccine in 152 countries, to accelerate implementation of the long-standing 1987 WHO policy recommendation to ensure greater protection against diphtheria.

In response to humanitarian crises, 85 vaccine shipments were made to 19 countries – a total of 24.7 million doses – including pentavalent vaccines, tetanus–diphtheria, measles–rubella and measles vaccines.

In 2018, seven vaccine tenders were issued, representing 41 per cent of the total portfolio of vaccines managed by UNICEF. For the first time, all the 2018 tenders included a questionnaire to collect valuable baseline data on environmental sustainability to eventually help suppliers reduce their carbon footprint.

The UNICEF Supply Division supplied 20,485,000 doses of measles-containing vaccine (MCV) to 13 countries through the Measles & Rubella Initiative. Through the International Coordination Group, it has supplied 6,215,850 doses of yellow fever vaccine to three countries, 5,822,880 doses of oral cholera vaccine (OCV) to seven countries, and 325,830 doses of meningococcal vaccine to three countries. A total of 107 million doses of monovalent type 2 oral poliovirus vaccine (mOPV2) were supplied to six countries in 2018; 10 million doses of bOPV were shipped to Papua New Guinea in response to a vaccine-derived polio virus outbreak.

Collaboration with partner organizations continues to be essential to the timeliness and reach of vaccine procurement and shipping operations. Essential partners include the Bill & Melinda Gates Foundation, Gavi, the Global Polio Eradication Initiative, the Johns Hopkins University/Rotavirus Accelerated Vaccine Introduction Network, and the Measles & Rubella Initiative. Collective efforts towards accurate demand forecasting continue to help Supply Division improve its planning, adjust its response to product availability, and shape market demand.

National health-sector supply-chain strategies

Strengthening health-sector supply-chain strategies and plans is essential to support the effective delivery of health services and accelerate equity improvements for the disadvantaged. By the end of 2018, some 36 of the 64 immunization priority countries were implementing a national health-sector supply-chain strategy, surpassing the 2018 milestone of 30 countries. An additional seven countries outside of the priority country list were also implementing these strategies and plans. A major achievement was the inauguration of the national warehouse, which is a state-of-the-art facility for immunization and medical supplies, in the Democratic Republic of the Congo.

In 2018, thirty-one UNICEF country offices supported supply-chain strengthening interventions. Immunization supply chains and the comprehensive EVM approach remain the entry point to broader-based supply-chain strengthening initiatives. A main priority is to strengthen the availability of essential health commodities at district and community levels. A UNICEF literature review revealed that stock-outs at these levels occur on average 48 per cent of the time, with the main drivers being financial bottlenecks, inadequate distribution and poor data-management practices. To foster sustainable supply chains, UNICEF supported 14 countries in developing Supply Chain Maturity Scorecards designed to assess the capacity and preparedness of local supply chains.
Leveraging collective action at global and regional levels

UNICEF regional offices play an important role in quality assurance and technical assistance to UNICEF country offices, including the coordination of Gavi-related work. In 2018, UNICEF managed Gavi regional working groups in four regions (Europe and Central Asia, Middle East and North Africa, Eastern and Southern Africa, and West and Central Africa). The regional working groups ensure that Gavi processes and policies are implemented consistently across the regions and that the technical assistance provided by UNICEF and other stakeholders are complementary and are producing results. Finally, the regional groups ensure accountability on agreed priorities and act as platforms to share lessons learned and best practices.

Regional priorities vary. For instance, in the Middle East and North Africa, an area of focus is to understand how private health providers contribute to immunization coverage and equitable access to vaccination. A UNICEF analysis of 20 countries in the region showed that the role of the private sector is varied. For example, in the Sudan the private sector has a limited role, as national vaccine programmes are administered in urban areas and non-governmental organizations deliver the majority of services in conflict areas. However, in Jordan providers offer many vaccines outside of the national programme and for-profit private providers are prominent. The study concluded that the private sector offers options for populations that can afford to pay for vaccination services and want access to vaccines outside of the national programmes, and this is an area of work for UNICEF to expand.

Partnerships, including multi-stakeholder and funding partnerships, are essential to our work. Gavi remains one of the most important partnerships for the organization’s work in immunization. In 2018, UNICEF received US$31.8 million for Targeted Country Assistance with outlined activities and deliverables under 725 milestones. By November 2018, UNICEF reported that 70 per cent of these were completed or on track. Positive results include technical assistance that is more focused on coverage and equity, such as in Uganda where assistance was provided to 37 districts and urban areas. Technical assistance is increasingly focused at subnational level, for instance in Pakistan where UNICEF provided assistance to roll out the CCE OP, strengthen immunization supply chains and build capacity for demand generation. However, challenges remain, such as delays in recruiting quality staff in some duty stations or delays in hiring quality consultants.

UNICEF is also implementing more than US$4.4 million in Gavi Strategic Focus Areas, including supply chain, demand, sustainability and data. The work focuses on catalytic investments such as piloting and testing new approaches and technologies and supporting their
scale-up. For example, the digital EVM Assessment tool 2.0 was field-tested in Bhutan and Iraq, providing important insights into how the technology works in field settings. These milestones are aligned with priorities identified through the Gavi Joint Appraisal process and complement the work in Gavi Health Systems Strengthening investments.

Other global partnerships include the Global Polio Eradication Initiative, which provided US$279 million to UNICEF in 2018. The Measles & Rubella Initiative provided US$2 million of funding. Other essential partnerships include networks on MNTE.

UNICEF is providing global thought leadership on a number of technical topics.

- UNICEF, together with the Bill & Melinda Gates Foundation, continued to chair the Equity Reference Group for Immunization, which highlighted the need to focus immunization programming on urban poor, remote rural and conflict-affected populations, and on those affected by gender-related barriers, to achieve greater equity through policies and programming. The Equity Reference Group conducted in-depth analyses on these priority thematic areas of work. The recommendations are reflected in Gavi policies as well as in reports and meetings of the Global Vaccine Action Plan and Regional Immunization Technical Advisory Groups. This remains a learning agenda for UNICEF and, as such, implementation research is critical as it is driven by real-time responsiveness.

- With support from the Gates Foundation, UNICEF led the process to establish an inter-agency Hub for Vaccination Acceptance and Demand that includes WHO, the Centers for Disease Control and Prevention, the Gates Foundation, the International Federation of Red Cross and Red Crescent Societies, John Snow Inc., and the Gavi Secretariat and civil society constituency. The hub aims to advance the understanding of ‘vaccination demand’ in a more rigorous, evidence-informed and holistic manner among partners, donors and key programme stakeholders.

UNICEF is co-chairing the Gavi Supply Chain working group and together with WHO, Gavi Secretariat, Clinton Health Access Initiative, Village Reach, PATH, John Snow Inc. and the Gates Foundation, partners collaborate to improve immunization supply chains.

Harnessing the power of evidence is an essential change strategy within the new Strategic Plan. Considering the growing public concern about vaccine safety, solid evidence and appropriate dissemination is critical. Evidence continues to be the foundation for sound immunization policies. In 2018, UNICEF produced 11 publications, including three peer-reviewed articles, on immunization. One particularly significant contribution was ‘Enhancing immunization during second year of life by reducing missed opportunities for vaccinations in 46 countries’ (*Vaccine*).

In addition, UNICEF developed technical guidance, communication resources and tools for decision makers, planners and front-line workers.

Since 2016, UNICEF has explored e-learning as an approach to disseminate guidance to countries. An addition to the organization’s e-learning portfolio in 2018 was a training manual on Vaccination in Acute Humanitarian Emergencies. By the end of 2018, a total of 2,061 participants (589 from UNICEF) had completed one of the e-learning vaccination courses available at our learning partner.

**Conclusion**

The implementation of the first year of the Strategic Plan saw successes in immunization. UNICEF and partners were able to help governments vaccinate 65.5 million children in 64 priority countries against diphtheria, tetanus and pertussis.

However, 19.9 million children remain under- and un-vaccinated, polio eradication in Pakistan and Afghanistan has experienced setbacks, measles is re-emerging as a public health threat while vaccine hesitancy has become a major bottleneck.

UNICEF strategic priorities to tackle these complex challenges are outlined in the UNICEF Immunization Roadmap, which is operationalized through regional and country offices. UNICEF priorities are based on the organization’s comparative advantage and are aligned with strategic plans such as the Global Vaccine Action Plan, the Gavi 4.0 strategy and the Polio Eradication Strategy. UNICEF strategic shifts going forward are to:

1. operationalize the equity agenda and focus on urban, remote rural and conflict-affected areas with strong gender considerations;
2. strengthen maternal and adolescent immunization delivery platforms;
3. strengthen integrated delivery and supply-chain systems;
4. strengthen the immunization front-line workforce and their communication and community-engagement skills; and
5. increase the emphasis on building national capacity for social and behavioural change communication.

Working in partnership remains critical, especially in 2019, as many of the global strategies will be reviewed and updated, including the post-2020 global vaccine strategy, Gavi’s new strategic plan, the GPEI strategy to transition polio assets, and the Measles & Rubella Initiative positioning and priorities. These will be opportunities for further collaboration. Greater investments, including flexible funding streams, for UNICEF health work will help accelerate immunization results. Flexible resources will be crucial to maintain high immunization coverage in medium- and high-capacity countries.
Results Area 3: Child health

Ending preventable child deaths and promoting the health and development of all children are fundamental goals of the 2030 Agenda. UNICEF child-health programming centres on the prevention and treatment of leading child-killer diseases such as pneumonia, diarrhoea and malaria; and procurement and use of life-saving commodities at health-facility and community levels, including in humanitarian settings. UNICEF works to strengthen community systems that foster linkages between health facilities and communities to ensure quality and accessible PHC that can address child survival, health and well-being. This includes substantially investing in health education to generate demand for and correct use of health services.

Between 2016 and 2018, in 25 countries with high pneumonia prevalence, 16.5 million children with suspected pneumonia received antibiotics through UNICEF-supported programmes. Significant progress was reported across all outcome-level indicators on care-seeking, uptake of oral rehydration salts (ORS) to treat diarrhoea, prompt and effective treatment for malaria, and the prevention of malaria infections by ensuring children and pregnant women sleep under long lasting insecticide-treated nets (LLINs).

At output level, nearly all planned targets were achieved. Between 2016 and 2018, a total of 154,475 community health workers (target 100,000) had enhanced their skills to operationalize integrated Community Case Management (iCCM). Twenty-four out of 25 targeted countries had institutionalized community health workers into their health systems. In 2018, UNICEF distributed LLINs to 28.27 million people in 17 countries, including 1.46 million people in humanitarian situations (total 3.72 million since 2016) to protect them from malaria. Although 23 of 25 countries did not experience ORS stock-out for over one month, reaching the target in all countries requires further effort, and investment in national and subnational supply-chain strengthening and procurement planning.

Work in the thrive agenda is expanding, including through the development of the Nurturing Care Framework (NCF) and strengthening delivery of early childhood development (ECD) interventions through health platforms, addressing the linkages between climate change/air pollution and child health, non-communicable diseases and the urban agenda.

The child health programme made US$253 million in expenditures, of which 18 per cent was disbursed from regular resources, and US$8.3 million from thematic funds (3 per cent of expenditures).

Outcome and output indicators for child health

<table>
<thead>
<tr>
<th>Outcome indicator</th>
<th>Baseline</th>
<th>2018 value</th>
<th>2021 target</th>
<th>SDG target no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of children with diarrhoea receiving zinc and oral rehydration salts (ORS)</td>
<td>8%</td>
<td>12%</td>
<td>32%</td>
<td>3.8.1</td>
</tr>
<tr>
<td>Percentage of children with symptoms of pneumonia taken to an appropriate health provider</td>
<td>60%</td>
<td>59%</td>
<td>71%</td>
<td>3.8.1</td>
</tr>
<tr>
<td>Number of children with suspected pneumonia receiving appropriate antibiotics through UNICEF-supported programmes</td>
<td>6 million</td>
<td>16.5 million</td>
<td>30 million</td>
<td>3.8.1</td>
</tr>
<tr>
<td>Percentage of children in malaria-endemic countries sleeping under an insecticide-treated net (ITN)</td>
<td>40%</td>
<td>58%</td>
<td>58%</td>
<td>3.8.1</td>
</tr>
</tbody>
</table>
Between 1990 and 2017, the number of children who died before their fifth birthday declined dramatically, from 12.6 million to 5.4 million. Despite this immense progress, pneumonia, diarrhoea and malaria still account for 30 per cent of under-five deaths. In addition, the last two years has seen unfortunate reversals in the declines of malaria cases. Persistent inequities in access to quality services and life-saving commodities perpetuate child deaths from these preventable diseases.

UNICEF is taking on the challenge of adequate access to care and supporting and educating the public to proactively seek health care, including life-saving treatments at both facilities and from community health workers. Evidence shows that appropriately trained community health workers can bridge treatment gaps for ill children who live too far from a health centre or face other barriers to accessing care. A strong supply chain and supportive supervision from facility-level health staff helps these workers provide promotive, preventive and timely curative services with effective diagnostic aids and medicines. Community-based management of childhood illnesses continues to be a proven strategy to reduce preventable child mortality.

TABLE 6: Output results for child health, 2018

<table>
<thead>
<tr>
<th>Outcome indicator</th>
<th>Baseline</th>
<th>2018 milestone</th>
<th>2018 value</th>
<th>2021 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of countries that maintain no stock-outs lasting more than one month at national level for oral rehydration salts (ORS)</td>
<td>92%</td>
<td>100%</td>
<td><strong>91%</strong></td>
<td>100%</td>
</tr>
<tr>
<td>Number of countries that have introduced pneumococcal conjugate vaccine (PCV) in their national immunization schedule*</td>
<td>44</td>
<td>48</td>
<td><strong>47</strong></td>
<td>65</td>
</tr>
<tr>
<td>Number of countries that have institutionalized community health workers into the formal health system</td>
<td>16</td>
<td>19</td>
<td><strong>24</strong></td>
<td>25</td>
</tr>
<tr>
<td>Number of community health workers who underwent skills-enhancement programmes to operationalize integrated community case management (iCCM) through UNICEF-supported programmes</td>
<td>51,000</td>
<td>100,000</td>
<td><strong>154,475</strong></td>
<td>160,000</td>
</tr>
<tr>
<td>Number of people receiving insecticide-treated nets as per international recommended standards through UNICEF-supported programmes (humanitarian)</td>
<td>1.3 million</td>
<td>3.3 million</td>
<td><strong>3.72 million</strong></td>
<td>6.3 million</td>
</tr>
</tbody>
</table>

*This indicator has a one year reporting lag

Context

Improving services and community demand

UNICEF has committed to helping countries accelerate the delivery of preventive, promotive and curative services for diarrhoea, pneumonia, malaria and other child health conditions such as severe acute malnutrition, HIV and tuberculosis. Spearheading a greater integration of health services, UNICEF also ensures the uninterrupted supply of medicines and equipment, and community demand for services in development and humanitarian settings alike. Results are also sustained through expansion of ECD programmes including for children with disabilities, and a new focus on interventions to reduce NCDs in early years to help children thrive into adolescence and adulthood.

Diarrhoea prevention and treatment

ORS and zinc are simple and effective treatments against diarrhoea mortality in home and community settings. ORS is estimated to prevent 70–90 per cent of deaths due to acute watery diarrhoea, while zinc is estimated to decrease diarrhoea mortality by 11.5 per cent.

In the first year of the UNICEF Strategic Plan, 2018-2021, good progress has been made in providing zinc and
ORS to children in need. The proportion of children with diarrhoea benefiting from ORS increased from 8 per cent at baseline to 12 per cent in 2018 (target of 32 per cent by 2021). UNICEF supplied 56.4 million ORS sachets in 2018, of which 22.4 million were in ORS and zinc co-packs. In addition, the organization supplied 103.1 million zinc tablets, of which 98.3 million were in ORS and zinc co-packs. For instance, in the Democratic People’s Republic of Korea, given the humanitarian context, UNICEF provided the Ministry of Public Health with 9.6 million ORS sachets, resulting in 100 per cent coverage for the management of diarrhoea cases in under-five children.

UNICEF worked around the world to stimulate community demand for services by developing communication materials and integrating behaviour-change interventions within programmes and supported media campaigns to help families and caregivers increase their knowledge and use of community-based services. UNICEF leverages its multisectoral advantage by strongly linking health, nutrition, education, WASH and C4D to improve health outcomes.

- In Afghanistan, 1 million children in 15,000 schools received a copy of Jamila’s Storybook to learn about diarrhoea prevention and treatment, empowering them with effective knowledge. More than 1,500 district education officers, school managers and school health teachers in 24 provinces helped increase community knowledge and use of zinc and ORS to treat childhood diarrhoea. Working cross-sectorally, 35 social mobilizers were trained to integrate zinc-plus-ORS key messages into existing WASH interventions. Information on diarrhoea management was also incorporated into 500 WASH community dialogues in four provinces.

- In the Democratic Republic of the Congo, UNICEF strengthened over 47,000 community management structures in 22 of 26 provinces to disseminate information on key family practices. An estimated 27 million people learned more about routine immunization, exclusive breastfeeding, hand-washing and the treatment of diarrhoea. C4D messaging and increased availability of medicines are mutually reinforcing. In 43 health zones, over 1.5 million under-five children and nearly 177,000 pregnant women received 3 million family kits containing essential drugs including ORS, which helped treat nearly 449,000 diarrhoea cases, the equivalent of 53 per cent of children under-five in 11 targeted provinces, compared with the national target of 55 per cent.
Pneumonia prevention and treatment

UNICEF and WHO set clear goals in the Global Action Plan for Pneumonia and Diarrhoea to end preventable child deaths from pneumonia by 2025. The Action Plan seeks to reduce the incidence of severe pneumonia among under-five children by 75 per cent; reduce mortality from pneumonia to fewer than 3 per 1,000 live births; and ensure that 90 per cent of cases have access to appropriate case management with antibiotics. Evidence shows that community management of all cases of childhood pneumonia could result in a 70 per cent reduction in mortality from pneumonia in under-five children.

UNICEF addresses multiple barriers along the pneumonia pathway, including prevention, promotion, care-seeking, availability of trained and equipped community health workers, monitoring and support to community health workers, as well as primary care facility health workers, availability of amoxicillin dispersible tablets (DT) and strengthening national planning for childhood pneumonia programming.

There has been little progress on care-seeking for children with pneumonia in the 25 high-burden countries. Against a baseline of 60 per cent, 59 per cent of children with symptoms of pneumonia were taken to an appropriate health provider in 2018 (2021 target of 71 per cent). This 1 per cent lower global aggregate is chiefly due to lower reported coverage in Nigeria, the second most populous priority country for child health (Multiple Indicator Cluster Surveys, 2016, the most recent household survey). Knowledge of the danger signs of pneumonia remains poor among caregivers. The survey reports that only 39 per cent of caregivers in Nigeria were able to recognize at least one of the two danger signs of pneumonia and that nearly 46 per cent of women had no access to newspaper, radio or television, the three main media sources of information. This lack of access to vital information is compounded by the lack of media campaigns for pneumonia control. In addition, PHC, a mainstay of Nigeria’s health delivery system, continues to face tremendous obstacles. The lack of skilled, motivated, and institutionalized community health workers is an added barrier to reaching children with treatment and care. To address these challenges, UNICEF is strengthening PHC initiatives through European Union funding. In addition, the initiative aims to improve knowledge on pneumonia through evidence-based advocacy, improve practices at the community and household levels, and strengthen partnerships with relevant stakeholders. In three priority states, UNICEF supported iCCM services in 3,000 hard-to-reach settlements leading to a 16 per cent increase in service uptake between November 2018 and January 2019.

Access to antibiotics is critical to treat pneumonia. In 25 high-burden countries, a cumulative total of 16.5 million children (5.5 million children in 2018 alone) with suspected pneumonia received appropriate antibiotics through UNICEF-supported programmes (target of 30 million by 2021). UNICEF helped provide antibiotic treatment to another 1.36 million children in an additional 38 countries. At least 380,000 under-five children in humanitarian situations received antibiotics for pneumonia.

UNICEF procured 268.4 million 250 mg amoxicillin DT – equivalent to 26.8 million pneumonia treatments for under five-year-olds – reaching 38 countries.

Amoxicillin is the recommended first-line treatment for pneumonia in children. It is an effective broad-spectrum antibiotic for use against bacterial infections and especially the treatment of children with bacterial pneumonia. Paediatric formulations are critical in ensuring that community health workers treat children with the correct dose for maximum effectiveness.

However, not all countries have switched policies to promote amoxicillin or scaled it up, and there are major gaps in financing for procurement of essential medicines. To address these challenges and ensure children have access to life-saving medicines, UNICEF, independently and through partnerships, continues to shape global and local delivery markets, including improving quality assurance and supply. UNICEF seeks to transfer financing of amoxicillin DT procurement to governments to ensure treatment of pneumonia is sustainable and embedded in government programmes. The UNICEF indicative price per treatment course for a child under one year of age is US$0.22, and US$0.44 for a child over one year of age. UNICEF will continue to advocate that countries include amoxicillin DT in their national Essential Medicines Lists, adopt WHO treatment guidelines, register amoxicillin DT in country programmes, and orientate facilities and sub-national health management units to introduce and scale up amoxicillin DT.
Malaria prevention and treatment

UNICEF partners closely with WHO, Roll Back Malaria and others to attain the goal of a malaria-free world as set out in the Global Technical Strategy for Malaria 2016–2030. As a high-impact front-line service, community case management can reduce overall and malaria-specific under-five mortality by 40 and 60 per cent, respectively, and severe malaria morbidity by 53 per cent. UNICEF works at the global level to strengthen investment plans, including as a partner in the new High Burden High Impact (HBHI) initiative to focus on the 11 countries with the highest malaria burden. Additional support is provided across the range of malaria interventions at country level in malaria-endemic countries. UNICEF also provided direct support or procurement services for malaria-commodity procurement and delivery to over 30 countries globally.

Access to and use of LLINs is one of the first lines of defence against malaria. Thanks to UNICEF and partner support, some 58 per cent of children in malaria-endemic countries slept under an insecticide-treated net in 2018, up from 40 per cent at baseline and meeting the 2021 target. This commendable result underscores the great strides made towards preventing child mortality from malaria. In support of this work, the Supply Division procured 13.2 million LLINs for 30 countries.

UNICEF helped provide 28.27 million people with LLINs across 17 countries including in highly complex operating and insecure environments. For example:

- In the Democratic Republic of the Congo, 7.6 million people benefited from LLINs provided through mass distribution in three provinces with the aim of universal coverage. More than 91,000 community health workers were deployed in 37 health zones of two provinces. Besides the community approach, school-based LLIN distribution was implemented in three provinces reaching an additional 812,092 students in 5,132 primary schools. The children also served as community influencers on LLIN usage in their communities.

- In Sudan, 6.9 million people benefited from LLINs. Strengthening community mobilization was essential to ensure uptake and use of the nets. Key messages sensitized more than 818,000 mothers and caregivers on the importance of sleeping under LLINs and timely care-seeking. Approaching child health holistically, messages included infant and young child feeding practices, handwashing with soap, diarrhoea treatment with ORS and immunization.

- In Indonesia, UNICEF helped support the distribution of LLINs to 5.6 million people, including over 300,000 in a humanitarian situation.
At the regional level, stronger commitments to malaria control are being made. In Eastern and Southern Africa, systematic investments in malaria-prevention programmes in eight countries are aiming at elimination. West and Central Africa is also looking at comprehensive programming to bring down malaria morbidity and mortality. In the Middle East and North Africa, Djibouti, the Sudan and Yemen, which have some of the highest malaria burdens in the region, are also investing in malaria prevention.

In addition to prevention, UNICEF ensures that quality treatments reach the children who need them most. The ability to quickly diagnose malaria is essential to treat the disease. Supply Division procured 10.5 million malaria rapid diagnostic tests (with a value of US$5.04 million for 22 countries). Rapid diagnostic tests, which can be easily administered at point of care, are a critical tool for community health workers and in front-line health facilities and is the first step in the iCCM pathway to treat febrile children. Treatment-wise, 19.2 million artemisinin-based combination therapy malaria treatments were procured, in addition to 1.1 million treatments for seasonal malaria chemoprevention in West Africa, equivalent to 266,512 children provisioned with the chemoprevention for all four cycles of Seasonal Malaria Chemoprevention campaigns.

In humanitarian settings, malaria prevention is paramount. By the end of 2018, some 3.72 million people in humanitarian situations (target 3.3 million) had received LLINs per international recommended standards through UNICEF-supported programmes. In 2018, across 11 countries, LLIN distribution reached 1.46 million people, 80 per cent of whom lived in just three countries – Ethiopia, Nigeria and the Sudan. The ongoing humanitarian situation in Nigeria, the country with the highest malaria burden in the world, explains the increase in the number of people needing to be protected with LLINs.

In the Democratic Republic of the Congo, UNICEF also supported the mass distribution of antimalarial drugs and LLINs to 450,000 people in Ebola-affected areas, helping to reduce both the incidence of malaria and risk of nosocomial Ebola virus disease transmission in health facilities.

UNICEF has helped generate evidence on the role and importance of community health workers and community systems in the early identification, continuation of services and response during emergencies as well as disease outbreaks. UNICEF programming in fragile settings included supporting community health workers during the Ebola outbreak in Guinea, Liberia and Sierra Leone and resilience in an acute emergency setting in South Sudan.

Early childhood development

The first 1,000 days of life shape a child’s future. The landmark Care for Child Development (CCD) package is an evidence-based strategy jointly developed by UNICEF and WHO to leverage the health system in support of ECD. UNICEF continued to assist countries to promote responsive caregiver–child interactions so that families can help their children survive, grow, thrive and develop their full potential.

In 2018, the Health Section together with ECD, Disability and C4D sections launched a new initiative to address the needs of young children with developmental delays and disabilities. The initiative promotes a twin-track approach to inclusion. First, existing ECD services – including health services – must be adapted and accessible to children with developmental delays and disabilities. Second, the initiative seeks to address the disability-specific needs of children with developmental delays and disabilities. This new model, built on universal approaches to promoting early stimulation and responsive caregiving, will be tested in Bulgaria, Peru and Uganda in 2019.
Helping children thrive

UNICEF, WHO and other partners are expanding a multisectoral and life-course approach so that children can survive and thrive throughout the first two decades of life. In addition to the holistic Nurturing Care Framework guidance, UNICEF is developing its guidance on a range of thrive issues including the prevention of non-communicable diseases and mental health. The examples below show the range of new areas of health programming that some countries are initiating as they respond to changing epidemiology and social contexts.

- In Armenia, a new project seeks to improve access to services and the participation of people with disabilities. A new statistical reporting form on child injuries and trauma was incorporated into the e-health system to ensure that disaggregated data on the causes, age structure and other patterns of injury are available. An awareness campaign to foster the social inclusion of children with disabilities produced four video stories about children with disabilities that were widely disseminated, advocating for positive social norms and showcasing children with disabilities in school, with friends, growing up in a loving family environment and having various interests from sports to arts.

- Many countries and territories across several regions (Azerbaijan, the Democratic People’s Republic of Korea, the Dominican Republic, North Macedonia, the State of Palestine and Turkey) are supporting efforts on early identification and early interventions for children with developmental delays and disabilities. Other efforts focused on expanding services accessed by older children with disabilities (El Salvador).

- Other countries, particularly in East Asia and the Pacific, are also engaging in child injury-prevention efforts, from improving data capture to policy reviews and development, strengthening multisectoral and all-of-government/all-of-society platforms along the way (China, the Philippines and Viet Nam).

A boy with cerebral palsy laughs during a therapy session at Yerazi Tun (Dream House) Rehabilitation and Development Centre in Yerevan, Armenia. UNICEF helped the government introduce a community-based rehabilitation programme promoting early social inclusion for children with severe and moderate disabilities.
Strengthening national and subnational capacity

PHC is reaffirmed as the fundamental stepping stone to achieving universal health coverage and the realization of the SDGs. Community-based promotive, preventive and curative health care is an essential building block of these health-delivery platforms which intend to overcome silos in the health sector. Integrated community case management (iCCM) is a community-based management approach to treat leading child-killer diseases. For this reason, UNICEF is sharpening its focus on ensuring that supervised and supported community health workers (CHWs) are institutionalized in formal health systems, that they have opportunities to enhance their skills and performance, and that they are guaranteed access to reliable health supplies and commodities.

Institutionalizing community health workers in the formal health system

Institutionalizing CHWs into the formal health system is a critical component of bridging the gaps in access to basic care. For institutionalization to occur, as a first step, policies defining roles, tasks based on local needs and relationships to the health system must be in place at country level. By the end of 2018, from a baseline of 16 countries, 24 of the 25 countries with high burdens of child illnesses had policies in place that met current criteria for institutionalization. The result exceeded the 2018 milestone by five countries, demonstrating rapid progress. Somalia is the last targeted country that is yet to proceed with full CHW institutionalization but progress is being made. Institutionalization has already taken place in Somaliland and Puntland, and expansion in the South Central Region is under discussion.

Besides these 25 priority countries, another 22 countries (in addition to an existing total of 37) forged ahead with CHW institutionalization. UNICEF is providing sustained advocacy, policy and technical support to achieve full institutionalization of community health workforces, including within PHC for UHC. This includes planned work towards establishing a package of care, incentive and compensation structures, supervision and supply-chain models.

To support CHW institutionalization, UNICEF contributed to the development of a new CHW guideline launched at the Global Conference on Primary Health Care in Astana, Kazakhstan as a strong basis for standardization and institutionalization of community health within PHC. UNICEF co-leads with WHO the effort to spur countries’ adoption of these recommendations. Additionally, UNICEF and partners developed and launched a CHW programme functionality tool, the updated CHW Assessment and Improvement Matrix. Such instruments will help countries expand communities’ access to health care and other basic social services with the integration of water, sanitation and hygiene (WASH), nutrition, social welfare, education, and governance into PHC services.

Six countries are actively committed to strengthening and scaling up PHC at the community level (Burkina Faso, Liberia, Mozambique, Malawi, the Niger and Uganda) through a UNICEF co-led partnership called the Community Health Roadmap. These countries have identified national investment priorities for community health, including CHW cadres. These experiences will help leverage additional investments to further expand a PHC model centred on human rights and response to the needs of families and communities.

Motorcycles provided with the support of the Japanese government allow community health workers to travel to the farthest villages to provide care to leave no one behind. Southern Madagascar.
CASE STUDY 3: Armenia, Kosovo and Montenegro: Global thematic funds strengthen home visiting programmes

Armenia: To foster a more supportive parenting environment, UNICEF and the Ministry of Health used US$60,000 in global thematic funds to strengthen the skills of 725 primary health care providers in five regions. Home visitors were trained to assess a child’s health comprehensively. Caregivers’ knowledge on newborn care was also strengthened.

Kosovo: 170 health professionals, social workers and education officers enhanced their skills through the home-visiting training package. An estimated 14,000 home visits in 15 municipalities brought integrated young-child well-being services to 7,630 children and 2,027 pregnant women, including 900 home visits among Roma, Ashkali and Egyptian communities.

Montenegro: A multi-disciplinary pool of trainers was created, consisting of 24 nurses from across the country. The training sought to enhance quality, preventive services for mothers, families and young children, using the Europe and Central Asia regional home-visiting resource modules, ‘Supporting families for nurturing care’.

Enhancing the skills of health workers
UNICEF continues to improve the capacity and skills of health workers at the PHC level, including training, mentoring and supervision. This includes expanding health workers’ skills and capacities beyond survive to also address the thrive agenda, especially in Europe and Central Asia, East Asia and the Pacific, and Latin America and the Caribbean.

Experience shows that investments in CHWs ranks among the most effective and sustainable means of delivering services to underserved populations (see Figure 15). Between 2016 and 2018, a total of

FIGURE 15: Thematic funds help strengthen community health systems

Mauritania: 226 community health workers (CHWs) were trained (out of 500 targeted by 2020). Among them, 108 have been settled in their communities with the support of management committees and under the supervision of the health workers closest to their villages.

Togo: More than 1,200 CHWs were trained, equipped, supervised and motivated to deliver quality care while engaging communities. A reduction in malaria, pneumonia and diarrhoea case loads was evident, with Seasonal Malaria Chemoprevention coverage reaching 96 per cent (target: 95 per cent).

Angola: CHWs reached approximately 330,000 people through door-to-door visits. This was supplemented with formative supervision, the development of a national community health strategy, and technical support to community-based organizations.

Zimbabwe: the first-ever comprehensive national community health strategy was developed to strengthen various community platforms for the integrated delivery of community-based services.

South Sudan: an investment case for the Boma Health Initiative was developed and disseminated. To support rebuilding local health systems with community health system as the central focus, US$60 million are being leveraged from the World Bank.

Kenya: 250 new CHWs were trained (bringing the total to 1,233 trained by UNICEF) to provide a comprehensive package of maternal, newborn and child services including cord care, kangaroo mother care and iCCM.

United Republic of Tanzania: high-level policy briefs were developed to support domestic advocacy for CHWs. Global Fund investment to support CHWs are being leveraged.
154,475 CHWs (60,376 in 2018 alone) enhanced their skills to operationalize iCCM. This represents a threefold increase from the baseline, exceeding the 2018 cumulative milestone of 100,000, that is, substantial progress. An additional 23,583 CHWs outside of the high-burden countries enhanced their skills on iCCM as well.

- In Côte d’Ivoire, 2,159 CHWs from 12 health districts were trained on an integrated package including promotional, preventive and curative interventions. All of these CHWs were equipped with a medicine box, boots, torches, timers for respiratory frequency, bags, vests, management tools, caps and identification badges.
- In the Niger, 826 new CHWs were trained, increasing the total number of CHWs to 4,170 and improving iCCM coverage in 23 out of 72 health districts. To enhance iCCM implementation, targeted villages were mapped and the required number of CHWs were identified, recruited, trained, deployed, equipped with a commodities kit and supervised.
- In Nigeria, 7,200 CHWs in seven states were retrained to carry out iCCM and conduct home visits to mothers and newborns. They advised mothers on exclusive breastfeeding, handwashing and illness danger signs, especially in hard-to-reach settlements.

Health-systems enhancement also fosters gender equality. Among the 25 high-burden countries, 12 provided sex-disaggregated data showing that 10,064 male and 40,241 female CHWs sharpened their skills through targeted programmes. This highlights that community health systems address gender equity by providing opportunities to women.

Reliable and quality supplies

A trained PHC workforce also needs reliable access to life-saving commodities, such as antibiotics, ORS, zinc, artemisinin-based combination therapy and rapid diagnostic tests for malaria. This underscores the important role that supply-chain strengthening plays in the overall strength of health systems, especially at community and facility levels, to bring commodities to the last mile.

To that end, the UNICEF Strategic Plan tracks the percentage of countries that maintain no stock-outs lasting more than one month at national level for ORS. In 2018, in 91 per cent of the countries supported, no such stock-outs were reported. While the target of 100 per cent was not met, ORS stock-outs remained stable from the baseline.

During the reporting period, only Burkina Faso and Chad experienced ORS stock-outs.
• In Burkina Faso, increased demand for health services among pregnant women and under-five children through the free health programme was not matched by ORS restocking. In response, UNICEF provided starter ORS–zinc kits in the five regions with urgent needs while accelerating stock replenishment at the national level.

• In Chad, funding from the French Development Agency helped UNICEF supply 1,250,000 ORS packets. In addition, 19,000 ORS packets were distributed within Interagency Emergency Health Kits (standardized kits of essential medicines, supplies and equipment) in 17 health districts. UNICEF continues to work with ministries of health and partners to strengthen supply management including forecasting, quantification and distribution within a broader health-system strengthening approach that emphasizes strategic health-sector coordination.

UNICEF is piloting an innovative malaria treatment to highlight the operational needs to improve uptake and use of rectal artesunate as a life-saving mechanism. The pilot is being implemented in the Democratic Republic of the Congo, Nigeria and Uganda.

Leveraging collective action

UNICEF continued to help solidify a programmatic shift in the global agenda on child health in which child health and development is addressed through a life-cycle approach, from pre-conception through adolescence. To do so, UNICEF sharpens national and sub-national plans, spurs domestic and global financing, strengthens global and regional partnerships, and generates evidence and knowledge necessary for greater results.

National plans and strategies

To boost results at the national level, UNICEF continued to support adaptation of guidance, tools and training for the integrated management of childhood illnesses. Capacity in data analysis enables UNICEF to identify areas of inequities that require increased investment and support to achieve child-health targets. The direct support to service-delivery mechanisms, combined with efforts to support the institutionalization and strengthening of community health systems, aims to embed community health within national health systems to reach all children, especially the most vulnerable.

Nearly 1 million under-five children die each year from pneumococcal diseases such as pneumonia and meningitis, making pneumococcal conjugate vaccine (PCV) an important public health intervention. By 2018, forty-seven countries (2018 milestone: 48) had introduced PCV in their immunization schedule, with the aid of funding through Gavi; this represents an addition of three countries from the baseline. These vaccine introductions have contributed to the positive trend of increased PCV coverage.

• In India, the government developed and costed action plans in nine states to reduce pneumonia- and diarrhoea-related morbidity and mortality through community-level PHC. Five states introduced pneumococcal vaccine (Bihar, Himachal Pradesh, Madhya Pradesh, Rajasthan and Uttar Pradesh), which was supplemented with integrated efforts to prevent and treat diarrhoea in young children.

• In countries receiving Global Financing Facility support, such as Burkina Faso, Kenya, and Uganda, UNICEF supported the development of investment cases to meet reproductive, maternal, newborn and child health gaps.

To deliver greater results on child health, community health financing is critical and several steps have been taken in this direction. UNICEF, with the Financing Alliance for Health, is helping Burkina Faso, Ghana, Haiti, Liberia, Malawi, Sierra Leone, South Africa, Uganda and Zambia develop new investment strategies required to scale up community health programmes. In addition, the iCCM Financing Task Team has been aligned with ongoing global processes and opportunities to better leverage funding streams.

Leveraging collective action at global and regional levels

At the global level, UNICEF is a key partner in implementing the Global Fund’s catalytic initiative on resilient and sustainable health systems. Since mid-2018, UNICEF has been working to implement a US$3 million grant to deliver maternal, newborn and child health activities through technical assistance, capturing best practices and lessons learned. In West and Central Africa, the addition of Denmark to the Muskoka Initiative has strengthened the push to expand the repertoires of partners that invest significantly in the region, including the Global Fund, Gavi and the Global Financing Facility.

UNICEF is making substantive investments in strengthening malaria partnerships such as those with WHO to support countries implement the High Burden/High Impact malaria response, and with the Global Fund to build capacity in resilient and sustainable systems for health. UNICEF is also a key partner on the new guidelines for malaria control in humanitarian emergencies. The organization also partnered with WHO and the World Food Programme to deliver malaria services in complex environments, such as the Democratic Republic of the Congo, northern Nigeria and South Sudan.

Throughout 2018, UNICEF was a strong voice on tuberculosis (TB) prevention. At the Tuberculosis High-Level Meeting hosted at the 2018 United Nations General Assembly, UNICEF advocated to leverage additional investments to treat 3.5 million children with TB and 115,000 children with multidrug-resistant TB by 2022.

To outline clear steps towards ending TB in children and adolescents, UNICEF, WHO and partners also launched the Roadmap Towards Ending TB in Children and Adolescents.
West and Central Africa is home to 10 per cent of the world’s population, yet witnesses one quarter of new HIV infections in children and adolescents, with only one in four children living with HIV receiving treatment. In partnership with the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNICEF is intensifying technical assistance so that governments can implement and scale up game-changing interventions, such as family HIV testing to increase early child HIV treatment, in nine countries (Burkina Faso, Cameroon, the Central African Republic, Chad, Côte d’Ivoire, the Democratic Republic of the Congo, Equatorial Guinea, Ghana and Nigeria). This approach emphasizes linkages to HIV-sensitive services such as TB, nutrition and ECD, and to broader social services including social protection, WASH and education.

To meet SDG targets, accelerating progress on pneumonia is urgent. UNICEF leverages PHC strengthening to improve pneumonia outcomes through the Every Breath Counts initiative at national and country levels. In Nigeria, UNICEF targets states with a high burden of acute respiratory rate infection/pneumonia. Under a European Union-funded PHC strengthening initiative, UNICEF provides comprehensive support to integrated PHC services at national and subnational levels. UNICEF drew specific attention to the gaps in pneumonia planning and programming through evidence-based advocacy and strengthening partnerships, as well as a focus on improving knowledge and practices at community and household levels and strengthening capacity in integrated service delivery.

A wide spectrum of partnerships and initiatives is in place to drive global momentum around community health. In partnership with the United States Agency for International Development (USAID), the ‘Community Health’ Community of Practice was launched in February 2018 and allows practitioners at country level to learn, share and engage with other professionals to promote better and quality community health.34

Jointly with USAID and the Gates Foundation, UNICEF supports the Integrating Community Health (ICH) collaboration to help countries achieve and sustain effective coverage of proven health interventions at scale to end preventable child and maternal deaths.35 Seven countries (Bangladesh, the Democratic Republic of the Congo, Haiti, Kenya, Liberia, Mali and Uganda) received technical assistance for community health programming. In addition, to coordinate, align and increase investments in PHC at the community level, UNICEF co-leads the development of a Community Health Roadmap in conjunction with USAID, the Rockefeller Foundation, the Gates Foundation and the World Bank.36

In collaboration with WHO, the World Bank, the Early Childhood Development Action Network and the Partnership for Maternal, Newborn and Child Health, UNICEF co-led the development of the Nurturing Care Framework (NCF) for early child development, which was launched at the World Health Assembly in May 2018. Through multisectoral action, this seminal document outlines relevant policies, interventions, indicators and five strategic actions to help young children thrive.

To enhance operationalization of the NCF, UNICEF and WHO convened regional workshops in Eastern and Southern Africa, and the Middle East and North Africa to assist countries in developing action plans, in addition to a package of technical notes and tools to operationalize NCF nationally.

- In Eastern and Southern Africa, seven countries (Ethiopia, Kenya, Malawi, Mozambique, the United Republic of Tanzania, Zambia and Zimbabwe) focused on strengthening health, nutrition, education and protection systems delivery within the context of ECD.
- In the Middle East and North Africa, a major shift was introduced in health and nutrition programming. Results related to ECD in the first 1,000 days are more clearly articulated within the health and nutrition sectors as main points of contact with children, caregivers and families. The Framework has been introduced to reinforce this work and will serve as an important mechanism to coordinate resources needed for implementation at country level.
- In Europe and Central Asia, regional operationalization included the development of a comprehensive ECD strategy. ECD recommendations and resource modules are supporting 17 countries to train health-care professionals and front-line workers.

To mobilize investments towards child health, evidence and knowledge generation are essential. In 2018, UNICEF produced 22 publications on child and community health, including 16 peer-reviewed articles. Contributions from country offices included ‘Malaria Elimination in Indonesia: Halfway there’ (The Lancet) and ‘Child Mortality in South Africa: Fewer deaths, but better data needed’ (The South African Medical Journal).

Quality standards for health care are essential, given that a substantial proportion of child deaths are attributable to the poor quality of health services. Hence, UNICEF contributed to the development of Standards for Improving the Quality of Care for Children and Young Adolescents in Health Facilities.37 Launched in Uganda in May 2018, the standards will be adapted at country level to improve health-care quality.

Conclusion
By the end of 2018, substantial progress had been made in the area of child health, including strides in building the capacity of CHWs as well as their institutionalization within formal health systems. Remaining gaps include the limited funding for prevention and control of pneumonia, diarrhoea, malaria, childhood TB and HIV, as well as community-based health work. Expanding work on non-communicable diseases and the thrive agenda more generally is also constrained by lack of financial and human resources. As a
way forward, greater collaboration with partners and further flexible investments, including thematic funds, can help strengthen the quality of PHC systems, improve the quality of care, and expand service coverage. Global and domestic investments in pneumonia, diarrhoea, malaria, and paediatric HIV and TB are priority areas. Non-communicable diseases, because of their role in mortality and morbidity in older children, also require attention to identify solutions early on so children may thrive throughout the lifespan.

Results Area 4: Adolescent health

Progress was made in developing and implementing multisectoral and gender-responsive adolescent health programmes, increasing coverage of adolescent-responsive health services among 10–19-year-olds, as well as meaningfully engaging youth in efforts to promote and protect their own health and well-being.

As of 2018, in 52 high-burden countries, 70 per cent of live births among adolescent mothers aged 15–19 years were attended by skilled health personnel, on track to meet the 2021 target of 71 per cent. At output level, four countries (target 5) had introduced HPV vaccine into their national immunization schedules (2017 data), while, by the end of 2018, some 50 countries had gender-responsive national plans to support adolescent health and well-being, far surpassing the 2018 milestone of 30.

A modest investment in adolescent health programming included US$18 million, of which 22 per cent originated from regular resources to ensure that UNICEF could respond to this emerging priority.

Outcome and output indicators for adolescent health

### TABLE 7: Outcome results for adolescent health, 2018

<table>
<thead>
<tr>
<th>Outcome indicator</th>
<th>Baseline</th>
<th>2018 value</th>
<th>2021 target</th>
<th>SDG target no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of live births attended by skilled health personnel (mothers age 15–19)</td>
<td>67%</td>
<td>70%</td>
<td>71%</td>
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<tr>
<td>Percentage of adolescent girls vaccinated against HPV in selected districts in target counties</td>
<td>WUENIC estimates on this indicator are currently not available</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>


### TABLE 8: Output results for adolescent health, 2018

<table>
<thead>
<tr>
<th>Output indicator</th>
<th>Baseline</th>
<th>2018 milestone</th>
<th>2018 value</th>
<th>2021 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries that have nationally introduced HPV in their immunization schedule</td>
<td>3</td>
<td>5 (2017 data)</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Number of countries having an inclusive, multisectoral and gender-responsive national plan to achieve targets for adolescent health and well-being</td>
<td>25</td>
<td>30</td>
<td>50</td>
<td>45</td>
</tr>
</tbody>
</table>
Context

There are about 1.2 billion 10–19-year-olds in the world, of whom nearly 90 per cent live in low- and middle-income countries. Achieving the demographic dividend and social progress in these countries depends on having a healthy, educated and employed youth population, and yet the health and well-being of adolescents remain largely overlooked nationally, regionally and globally.

Adolescent girls and young women in developing regions face specific challenges: every year, approximately 12 million girls become married during childhood. An estimated 21 million adolescents aged 15–19 years become pregnant and an estimated 18 million give birth in developing regions. Among younger adolescents, 2 million girls under 15 years become pregnant and 2.5 million girls under 16 years give birth each year. Globally, maternal mortality remains the leading cause of death among adolescent girls aged 15–19 years.

Adolescent mental health is another increasingly pressing area of work given that, globally, self-harm is the second leading cause of mortality among 15- to 19-year-old girls, and the third leading cause for boys. The most prominent issues include high self-harm, suicide/suicide attempt rates, increasing substance abuse, depression, and anxiety conditions for which mental health and psychosocial support services are lacking.

Contributing to the efforts of UNFPA and other agencies, UNICEF is dedicated to a comprehensive and multisectoral approach to adolescent health and well-being which includes increased efforts, in addition to addressing adolescent pregnancy and communicable diseases, but also non-communicable disease, violence and injuries, as well as mental health and wellness.

Improving services and community demand

UNICEF has committed to help countries develop programmes that deliver gender-responsive adolescent health and nutrition services and prioritize outcomes that disproportionately impact girls. Addressing early and unintended pregnancies is an important part of our efforts to protect the health and rights of adolescent girls. It also has a direct impact on improving newborn and maternal health outcomes, given that the leading causes of neonatal morbidity and mortality are prematurity and intrapartum complications, which occur more frequently among adolescent mothers. UNICEF works to promote quality maternal and newborn care services that include a focus on the unique needs of adolescent mothers. UNICEF is also working to scale up HPV prevention as a critical way to protect girls from acquiring cervical cancer later in life.

Adolescent pregnancy prevention

UNICEF employs a multisectoral approach to promote the health and well-being of adolescent girls. This includes girls’ secondary education and skills building, preventing child marriage and early unions, and preventing and responding to gender-based violence in emergencies in addition to strengthening adolescent-friendly health services. Addressing early and unintended pregnancy is a cornerstone of UNICEF adolescent health work: one of five targeted priorities of the Gender Action Plan, 2018–2021. In West Africa and South Asia, working together with child protection, pregnancy prevention starts with the prevention of child marriage. The prevalence of child marriage is decreasing globally, driven in large part by a sharp fall in the past decade in South Asia, from 50 per cent to 30 per cent. More than 5.9 million adolescent girls in 46 countries received prevention and care interventions through child-marriage-related programming, including through cross-sectoral links to health-related services, such as those targeting adolescent pregnancy.

UNICEF supported Ministries of Health develop and implement national strategies and initiatives to prevent adolescent pregnancies, for instance in Argentina, Bolivia, Ghana, Peru, South Africa and Thailand. In 2018, in Thailand, UNICEF developed adolescent pregnancy-prevention models to encourage multisectoral collaboration, including with young people. UNICEF continues to support the online health platform Lovecarestation.com particularly for information on contraception and prevention of early and unintended pregnancy. While 150,000 adolescents used the platform in 2017, over 770,000 did so in 2018. In South Africa, the ‘She Conquers’ campaign aims to improve the lives of adolescent girls and young women through high-impact interventions in 22 priority subdistricts with the worst HIV indicators among adolescents across the country. In 14 priority districts, UNICEF is empowering adolescent girls and young women to avoid unwanted pregnancies, stand against sexual and gender-based violence, access educational and economic opportunities and stay in school.

Maternal and newborn care for adolescent mothers

The health of adolescents mothers and their newborn babies continued to be a priority across all regions. Among mothers aged 15–19 in high-burden countries, 53 per cent received at least four antenatal visits, 70 per cent of live births were attended by skilled health personnel (target 71 per cent in 2021), and 55 per cent received postnatal care. UNICEF supported the provision of care for newborns and young mothers, capacity-building of health-care workers to provide adolescent-responsive and quality maternal care, and strengthened health data systems to collect information on adolescent pregnancies. For instance:
• In Mauritania, with UNICEF support, maternity hospitals and two reference hospitals provided intensive care for newborns and young mothers. This effort reached 1,323 adolescents aged 10–19.

• In Thailand, strategic assistance supported the development and incorporation of adolescent pregnancy data into the existing national reproductive-health data system.

HPV prevention

Cervical cancer is a leading cause of death among women of reproductive age in low- and middle-income countries. This has led WHO to call for the elimination of the disease as a global public health problem. The human papillomavirus (HPV) vaccine is the most effective prevention method. UNICEF contributes to the global goal to eliminate cervical cancer by facilitating the roll-out of HPV vaccine in low- and middle-income countries. Ethiopia, Malawi, Senegal, the United Republic of Tanzania and Zambia were supported to introduce the vaccine in 2018, targeting a total of nearly 3 million adolescent girls.

As an essential step in HPV vaccine introduction, all health workers who administer vaccines were provided with interpersonal-communication skills training and relevant job aids. As a result, health workers were better equipped to gain the trust of parents and adolescents, and to confidently address their questions and concerns about the vaccine.

As the communication and social mobilization lead within Gavi, UNICEF provided comprehensive technical support. Leveraging its comparative advantage, the organization developed national HPV communication and social-mobilization strategies, including risk and crisis communication plans; identified community leaders who were fully briefed; and conducted social-mobilization activities before and during vaccination, particularly to reach out-of-school girls. In addition, media representatives were briefed and engaged, and public knowledge, attitude, practice and behaviours, as well as demand and acceptance, were consistently monitored. Social media were used as a key platform to disseminate messages and to monitor exchanges, including any emerging rumours about the HPV vaccine.

Additional tools for HPV risk-management and crisis communications assessment, and a crisis communication, preparedness and response template to assist planning and preparedness in country were developed by the Eastern and Southern Africa regional office.
Strengthening national and subnational capacity

To strengthen national and subnational capacity in delivering health services, UNICEF assists countries in building a more responsive PHC system. UNICEF helps develop the interpersonal skills of health workers, introduce new tools and develop cross-sectoral linkages to help adolescents across the world to receive health services responsive to their needs.

UNICEF has been facilitating the expansion of adolescent-responsive services by supporting PHC facilities and through technical assistance to ensure services were delivered according to adolescent quality-of-care standards.

- In Bangladesh, UNICEF strengthened adolescent-responsive health services at facilities in six priority districts, reaching 30,433 adolescents. UNICEF supported adolescent health information, education, communication and social behavioural-change communication activities in 40 secondary schools.
- In Argentina, health teams were trained to handle adolescent pregnancy using a multisectoral approach linked to education, social development and child protection. Non-governmental organizations were trained for a large-scale campaign on adolescent sexuality, focused on promoting consensual and protected sex to prevent early and unintended pregnancies.

Adolescent mental health and suicide prevention is a new and important area of work for UNICEF. Working with government counterparts, the organization has gained critical momentum in advancing adolescent mental health and well-being by spearheading national policies, strengthening capacity, piloting interventions and engaging with adolescents themselves. In particular, East Asia and the Pacific, Europe and Central Asia, Latin America and the Caribbean, and the Middle East and North Africa regions have made significant progress in programming. For instance:

- UNICEF Thailand assisted with the development of new tools to help health-service providers identify mental-health conditions such as depression among youth. Using these tools, around 188,000 adolescents were screened for mental-health conditions in 2018.
Leveraging collective action

UNICEF leveraged collective action towards adolescent health by fostering the development and adoption of multisectoral and gender-responsive national adolescent health plans, supporting the implementation of Global Accelerated Action for the Health of Adolescents (AA-HA!), and amplifying the voices of adolescents in the Global Conference on Primary Health Care where the Declaration of Astana was adopted. UNICEF also facilitated the introduction of HPV vaccine into national immunization schedules and the scaling up of these introductions.

Adolescent health

In 2018, some 43 country programmes identified promoting adolescent girls’ health as a Gender Action Plan priority. There was accelerated progress on the development of inclusive, multisectoral and gender-responsive national plans for adolescent health (see Figure 16). By the end of the year, 50 countries (double the baseline number) had these plans in place, exceeding the 2018 milestone of 30 and the 2021 target of 45 countries. The inclusion

CASE STUDY 4: Kazakhstan: UNICEF supports prevention of adolescent suicide

Kazakhstan’s high youth and adolescent mortality rate is particularly driven by high suicide rates. A UNICEF-sponsored study showed that mild or moderate symptoms of depression were reported in 37 per cent of suicide cases. About 20 per cent of adolescents at high risk of suicidal behaviour showed severe depression.

UNICEF proposed a multisectoral model called ‘Adolescent Mental Health Promotion and Suicide Prevention’ (AMHSP). To address stigma-related opposition, UNICEF ensured good alignment with national goals and policies, and political buy-in from national and regional health-policy and decision makers.

The intervention package is a three-pronged approach: (1) interactively raising awareness with adolescents; (2) promoting mental health and health-seeking behaviour; and (3) identifying adolescents at high risk and ensuring and improving referral by health and mental-health specialists. Continuity of care was strengthened through a collaborative approach with school psychologists and general practitioners at primary health care level, comprising multidisciplinary teams to follow up adolescents at risk. Between 2012 and 2018, UNICEF allocated US$750,000 in financial resources to the project.

The AMHSP programme leveraged resources for a national scale-up and, at the end of 2018, AMHSP was budgeted for in 16 out of 17 regions. School coverage reached 39 per cent (out of 3,252 schools). More than 500,000 adolescents benefited from the programme.

The prioritization of adolescent mental-health promotion and suicide prevention resulted in a 51 per cent decrease in mortality related to self-injury in the 15–17-year-old age group nationally. The number of suicide cases decreased from 212 in 2013 to 104 in 2018 within this age group.

The programme helped spur health reforms that integrate mental health in primary health care. Increasing demand for mental-health services helps overcome stigma; it is an important aspect of adapting the health system to the needs of the population. Areas for further work include expanding evidence-based treatment options for high-risk adolescents and working with families with complex needs, since specialized services and competencies are not widely available in the country.

Across different countries, UNICEF has advocated for a change of laws around the age of consent for seeking medical services (Kazakhstan, Kyrgyzstan); facilitated strategic-planning consultations between government ministries and key stakeholders (Brazil, the Philippines, Senegal, Ukraine and Zimbabwe); and supported the development of national adolescent-health strategies and plans (Benin, Burkina Faso, Cabo Verde, Chile, the Congo, Madagascar, Uganda and Togo).

Following the launch of AA-HA! in 2017, UNICEF intensified its support to develop and roll out national policies for adolescent health across all regions. In 2017–2018, WHO and UNICEF jointly organized five intercountry workshops in Eastern and Southern Africa, Latin America and the
GOAL AREA 1 | Every Child Survives and Thrives

The Caribbean, Middle East and North Africa, and West and Central Africa to provide regions with the technical support needed to implement the global AA-HA! guidance. Country teams from over 60 countries were trained in national priority-setting, programming, monitoring and evaluation. UNICEF together with WHO and UNFPA also co-hosted three global webinars to introduce the Global AA-HA! guidance and discuss priority topics including sexual and reproductive health and rights programming for adolescents and key populations, adolescent mental health and the WHO–UNAIDS adolescent quality-of-care standards.

In addition, UNICEF works towards strengthening school health through multisectoral work with the education sector and introducing behaviour change programmes that promote adolescent health and wellbeing. UNICEF joined the global initiative of ‘Making every school a health promoting school’ launched by WHO and the United Nations Educational, Scientific and Cultural Organization (UNESCO) in 2018 and contributed to Global Standards for Health Promoting Schools. School Health and Healthy Schools are models that enable and encourage children and adolescents to adopt healthier habits and lifestyles. Through the ‘healthy school’ model, UNICEF engages the education sector to develop policies, set standards and enact infrastructural changes to create healthy school environments, while ‘school health’ provides health services and health education.

UNICEF, together with UNFPA, WHO, UNAIDS, the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) and the World Bank established the H6+ technical working group for adolescent health and well-being, which also includes UNESCO, the World Food Programme, the Partnership for Maternal, Newborn and Child Health, and the United Nations Major Group for Children and Youth. The technical working group was established to strengthen inter-agency coherence and collaboration on programming.

In Eastern and Southern Africa, UNICEF, UNFPA, UNAIDS and WHO jointly supported the successful start-up of the ‘2gether4SRHR initiative’ (Together for sexual and reproductive health and rights). The initiative is a joint United Nations programme aimed at strengthening integrated services around HIV, sexual and reproductive health and rights, and gender-based violence services, including support for pregnant adolescents and young mothers. The programme was rolled out in five countries.

Within the newly established UNICEF–Bill & Melinda Gates Foundation partnership, prioritization of multisectoral efforts to advance adolescent health and well-being is one of four shared goals.

UNICEF ensured that adolescents participated in the Global Conference on PHC in Astana. UNICEF, WHO, UNFPA, and the United Nations Major Group for Children and Youth conducted a consultation process on PHC with more than 3,000 adolescents in 53 countries in the lead-up to the Global Conference on PHC in Astana, Kazakhstan. The consultation captured valuable insights into adolescents’ perspectives, concerns, challenges, ideas and solutions on issues relating to PHC and universal health coverage. Youth

FIGURE 16: Adoption of inclusive, multisectoral and gender-responsive national plans, 2016–2018
Panellists conveyed key messages at the main conference which contributed to amplifying youth voices in shaping the global PHC agenda.

To complement the in-depth country consultations, UNICEF conducted a global U-Report poll which surveyed the health concerns and practices of more than 385,000 adolescents and youth from 25 countries via short message service (SMS) messages and online platforms. The poll sought to understand the obstacles young people face, their preferences for accessing services, and the actions they are taking to promote their own health and that of their families and communities. The results from the global poll were presented at the Global Conference on PHC and contributed to raising youth voices on PHC.

To further promote adolescent health, UNICEF produced knowledge products. Country-level and regional analyses of the well-being of adolescent girls and the intergenerational effects of adolescent childbearing was undertaken in West and Central Africa for a series of data-driven knowledge products on investing in adolescent girls, for use in developing C4D campaigns. UNICEF produced a peer-reviewed article in *The Lancet* entitled ‘Gendered Influences on Adolescent Mental Health in Low-Income and Middle-Income Countries: Recommendations from an expert convening’.

### HPV vaccine introduction and HPV prevention

UNICEF provided technical support to five Gavi-eligible countries in 2018, to successfully introduce HPV vaccination targeting adolescent girls 9–14 years of age nationwide. A total of four countries based on actual 2017 data (2018 milestone: five) introduced HPV vaccine into their national immunization schedules.

HPV vaccines are best introduced through a catch-up campaign (multi-age cohort) covering all eligible age cohorts from 9 to 14 years, followed by the yearly routine immunization of a single age cohort. The cohort is selected based on local programmatic situations and needs. However, due to globally constrained supplies, catch-up campaigns were delayed except in Zimbabwe. HPV vaccine introduction proceeded as shown in Figure 17.

UNICEF facilitated country decision-making processes to introduce the HPV vaccine through advocacy and evidence-based technical support, and contributed to the development of national HPV-introduction strategies as part of multi-stakeholder working groups led by ministries of health.

The roll-out of the vaccine on a wide scale is the first time that a health intervention has reached adolescent girls systematically and with high coverage. Building on the strong momentum created by the scale-up of HPV vaccine introduction and considering the opportunities to promote a

**FIGURE 17: HPV vaccination campaigns in five African countries**

- **Senegal**: Introduced HPV vaccine in Oct 2018, targeting 172,000 girls aged 9
- **Ethiopia**: Introduced HPV vaccine in Dec 2018, targeting 1,142,000 girls aged 14
- **United Republic of Tanzania**: Introduced HPV vaccine in April 2018, targeting 645,000 girls aged 9 (multi-age cohort vaccination)
- **Zimbabwe**: Introduced HPV vaccine in May 2018, targeting 866,000 girls aged 10–14 (multi-age cohort vaccination)
- **Malawi**: Introduced HPV vaccine in Jan 2019, targeting 280,000 girls aged 9
more comprehensive adolescent health approach, UNICEF developed the HPV+ initiative at the global level in 2018.

HPV+ aims to leverage political commitment and programmatic outreach to reach adolescent girls as an entry point and provide them with other age and gender appropriate adolescent health, development and well-being interventions. An HPV+ investment case was developed to shore up investments. Efforts to mobilize funding and to identify candidate countries to test various delivery approaches will follow.

UNICEF in collaboration with global partners was instrumental in establishing the repository of HPV communication resources available to facilitate demand and acceptance of the HPV vaccine within communities. Resources include a package of 10 field guides which was disseminated to all countries, as well as examples of country plans and materials.

Global HPV vaccine supply remains constrained. Only two manufacturers produce the vaccine and additional manufacturers are not expected to enter the market before 2022. UNICEF, Gavi and other partners worked to streamline the existing supply according to country demand, thus helping a maximum number of countries to introduce the vaccine. Adapting to constraints, UNICEF also maintained and updated country-by-country demand forecasts and managed HPV tenders to leverage its market-shaping power to communicate long-term demand outlook with existing manufacturers and those in the pipeline.

UNICEF continued to be a member of the HPV stakeholders working group which offers opportunities to present the work around HPV vaccine introduction at global, regional and country levels. UNICEF remains a member of the United Nations Joint Global Programme on Cervical Cancer Elimination and Control together with WHO, UNFPA, UNAIDS, UN Women, the International Atomic Energy Agency and the International Agency for Research on Cancer. The partnership is a platform to undertake priority country visits and develop policies and tools.

Conclusion

With adolescent health being a new area of work for UNICEF, great progress has already been achieved during the first year of the Strategic Plan.

While substantial efforts have been made to improve both the quality and coverage of maternal and newborn care, targeted strategies to make health services more responsive to adolescents aged 10–19 years remains a critical area of need. As a subset of all pregnant women, the 15- to 19-year-olds are less likely to receive at least four ANC visits and, despite a higher risk of complications, live births among 15- to 19-year-olds are less likely to be attended by skilled health personnel. Furthermore, substantial regional differences in coverage persist, calling for accelerated and intensified action in sub-Saharan Africa where nearly half of live births remain unattended. The HPV vaccine market remains constrained and domestic financing for its introduction is problematic for countries that do not benefit from Gavi support.

UNICEF will continue collaborating with its partners to invest in the health of adolescents by promoting an integrated response across all sectors in a holistic way. Beyond adolescent pregnancy, other areas important to adolescent health and well-being include communicable diseases (including HIV and sexually transmitted infections), mental health, malnutrition, violence and injury, as well as non-communicable diseases. UNICEF aims to continue support to the five countries that have already introduced HPV and will provide technical support to an additional 11 countries in 2019 to introduce HPV vaccination nationwide. More funding, particularly flexible funding, is needed to carry out further work in the area of adolescent health.
Lessons learned

The UNICEF Strategic Plan, 2018–2021, is the organization’s first to be guided by the Sustainable Development Goals. Its strengths lie in its results framework, itself rooted in the lessons learned during the previous strategic plan (2014–2017). The emphasis on results includes a more systematic focus on accounting for the number of children and women reached through support provided by UNICEF health programmes. By the conclusion of the first year of the Strategic Plan, UNICEF had measurably changed the lives of millions of children and adolescents for the better.

As an overarching lesson, equity-focused programming and advocacy are demonstrably valuable. Equity continues to guide and enhance effectiveness at local and subnational levels where the majority of disparities exist. All four results areas (maternal and newborn health, immunization, child health and adolescent health) target the most disadvantaged first and operationalize the ‘leave no one behind’ principle. First-year results show that the bold commitment to equity yields great returns on health investments.

Community engagement remains a cornerstone of UNICEF work in health. Community health workers, who are on the front line delivering immunization, treatments for malaria, pneumonia and diarrhoea, are at the heart of strong community health systems, which in turn deliver on the promise of universal health coverage. Whether for immunization activities or the delivery of child or adolescent health services, health workers’ interpersonal skills are fundamental to gaining the trust of marginalized caregivers and adolescents. An important lesson is that any mass health campaign must be paired with the strengthening of health workers’ interpersonal skills.

Building in-country capacity is essential. For instance, to strengthen maternal and newborn health, knowledge management through the Healthy Newborn Network, opportunities for South–South knowledge-sharing and regional workshops have proved useful in building national capacity.

The UNICEF approach to health-systems strengthening is critical to achieving all results in Goal Area 1. Working across sectors is fundamental to breaking siloed approaches. Technical assistance for selected national and subnational health systems-strengthening interventions (including quality of care and community health), supply-chain management, social protection, implementation research and digital-health solutions has been key to strengthening PHC for achieving universal health coverage. In addition, UNICEF needs to engage more with the private sector considering its increasing role as a service provider.

Given the relentlessness of emergency situations and public health crises, the importance of risk-informed programming has been reaffirmed in 2018. UNICEF has gained valuable insights into setting more realistic targets for its health response in emergencies. The successful measles vaccination coverage in humanitarian settings is evidence of that. The need for continuous investment in emergency preparedness and resilience is an important lesson learned. Strengthening the humanitarian–development nexus to ensure sustainability and resilient development is equally critical.
Health financial report

For a full overview of UNICEF revenue and contributions to Goal Area 1 in 2018, please see Annex 1.

FIGURE 18: Health-specific ‘other resources – regular’ contributions, 2014–2018

In 2018, partners contributed US$830 million ‘other resources – regular’ for health, a 13 per cent decrease from the previous year. Government partners contributed the largest share of ‘other resources – regular’ to health, at 46 per cent. The top five resources partners to UNICEF health in 2018 were the U.S. Fund for UNICEF, The World Bank Group – IDA, Gavi, and the governments of the United Kingdom of Great Britain and Northern Ireland and the United States of America. The largest contributions were received from the World Bank Group – IDA for health and nutrition emergency in Yemen; from the United Kingdom for responding to the nutrition crisis in Yemen; and from the United Nations Joint Programme for support to the Health Development Fund in Zimbabwe (see body of the report for details on all of these programmes).

FIGURE 19: Other resources revenue by partner group, health, 2018
<table>
<thead>
<tr>
<th>Rank</th>
<th>Resource partners</th>
<th>Total (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>U.S. Fund for UNICEF</td>
<td>173,879,356</td>
</tr>
<tr>
<td>2</td>
<td>World Bank Group – IDA*</td>
<td>103,131,329</td>
</tr>
<tr>
<td>3</td>
<td>GAVI, the Vaccine Alliance</td>
<td>90,228,043</td>
</tr>
<tr>
<td>4</td>
<td>United Kingdom*</td>
<td>80,219,794</td>
</tr>
<tr>
<td>5</td>
<td>United States</td>
<td>63,808,720</td>
</tr>
<tr>
<td>6</td>
<td>European Commission*</td>
<td>50,599,571</td>
</tr>
<tr>
<td>7</td>
<td>Canada</td>
<td>45,748,135</td>
</tr>
<tr>
<td>8</td>
<td>United Nations Joint Programme</td>
<td>41,056,757</td>
</tr>
<tr>
<td>9</td>
<td>Japan</td>
<td>28,501,173</td>
</tr>
<tr>
<td>10</td>
<td>UNICEF Mexico</td>
<td>20,000,000</td>
</tr>
<tr>
<td>11</td>
<td>The Global Fund to Fight AIDS</td>
<td>19,668,289</td>
</tr>
<tr>
<td>12</td>
<td>United Nations Population Fund (UNFPA)</td>
<td>17,008,173</td>
</tr>
<tr>
<td>13</td>
<td>Germany</td>
<td>12,419,365</td>
</tr>
<tr>
<td>14</td>
<td>Netherlands*</td>
<td>9,807,649</td>
</tr>
<tr>
<td>15</td>
<td>Sweden</td>
<td>7,665,968</td>
</tr>
<tr>
<td>16</td>
<td>Republic of Korea*</td>
<td>7,495,172</td>
</tr>
<tr>
<td>17</td>
<td>Nutrition International</td>
<td>6,428,889</td>
</tr>
<tr>
<td>18</td>
<td>UNICEF United Arab Emirates</td>
<td>6,372,143</td>
</tr>
<tr>
<td>19</td>
<td>India</td>
<td>5,093,080</td>
</tr>
<tr>
<td>20</td>
<td>France</td>
<td>4,668,210</td>
</tr>
</tbody>
</table>

* Includes cross-sectoral grants SC170081, SC170579, SC170314, SC180682 (Health and Nutrition), SC180961 (Education, WASH, Health, Nutrition and Child Protection), SC180225 (Health and WASH), and SC180824 (Health, WASH, Nutrition and Education).
<table>
<thead>
<tr>
<th>Rank</th>
<th>Resource partner</th>
<th>Grant description</th>
<th>Total (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>World Bank Group - IDA</td>
<td>Yemen Health and Nutrition Emergency Project*</td>
<td>40,581,796</td>
</tr>
<tr>
<td>2</td>
<td>United Kingdom</td>
<td>Responding to the Nutrition Crisis, Yemen</td>
<td>36,985,491</td>
</tr>
<tr>
<td>3</td>
<td>United Nations Joint Programme</td>
<td>Joint Programme Support to the Health Development Fund, Zimbabwe</td>
<td>36,303,515</td>
</tr>
<tr>
<td>4</td>
<td>World Bank Group – IDA</td>
<td>Second Additional Financing for Emergency Health and Nutrition Project, Yemen*</td>
<td>32,475,771</td>
</tr>
<tr>
<td>5</td>
<td>World Bank Group – IDA</td>
<td>Second Additional Financing for Yemen Emergency Crisis Response Project*</td>
<td>30,073,762</td>
</tr>
<tr>
<td>6</td>
<td>European Commission</td>
<td>Health, Zimbabwe</td>
<td>23,213,443</td>
</tr>
<tr>
<td>7</td>
<td>United States</td>
<td>Polio Programme</td>
<td>21,307,262</td>
</tr>
<tr>
<td>8</td>
<td>UNICEF Mexico (Carlos Slim Foundation)</td>
<td>Polio Activities, Mexico</td>
<td>20,000,000</td>
</tr>
<tr>
<td>9</td>
<td>Gavi, the Vaccine Alliance</td>
<td>Vaccination Campaign Against Measles, Pakistan</td>
<td>19,408,452</td>
</tr>
<tr>
<td>10</td>
<td>U.S. Fund for UNICEF</td>
<td>Support for UNICEF staffing - Global Polio Eradication Initiative (GPEI)</td>
<td>18,797,907</td>
</tr>
<tr>
<td>11</td>
<td>European Commission</td>
<td>Health, Nigeria</td>
<td>16,577,411</td>
</tr>
<tr>
<td>12</td>
<td>Canada</td>
<td>Support to the polio eradication endgame strategic plan</td>
<td>15,813,253</td>
</tr>
<tr>
<td>13</td>
<td>United States</td>
<td>Universal Coverage of Long Lasting Insecticide-treated Nets, DRC</td>
<td>13,985,250</td>
</tr>
<tr>
<td>14</td>
<td>Canada</td>
<td>Enhanced Child Health Days in sub-Saharan Africa</td>
<td>13,177,711</td>
</tr>
<tr>
<td>15</td>
<td>U.S. Fund for UNICEF (Bill &amp; Melinda Gates Foundation)</td>
<td>Global Polio Support 2017 FRR Reducing</td>
<td>12,970,669</td>
</tr>
<tr>
<td>16</td>
<td>Gavi, the Vaccine Alliance</td>
<td>Support the implementation of the Health System Strengthening Programme, India</td>
<td>12,694,080</td>
</tr>
<tr>
<td>17</td>
<td>Gavi, the Vaccine Alliance</td>
<td>Procurement of vaccines and cold chain equipment of the HRP 2017/18, MENARO</td>
<td>12,409,225</td>
</tr>
<tr>
<td>18</td>
<td>U.S. Fund for UNICEF</td>
<td>Community Based Vaccination in Polio Tier Districts of Pakistan-Gates</td>
<td>12,397,068</td>
</tr>
<tr>
<td>19</td>
<td>Gavi, the Vaccine Alliance</td>
<td>GAVI Foundational Support stream of Partners’ Engagement Framework (PEF)</td>
<td>10,995,166</td>
</tr>
<tr>
<td>20</td>
<td>United Kingdom</td>
<td>Somali EPHS Commodity Security Programme</td>
<td>10,204,082</td>
</tr>
</tbody>
</table>

* Cross-sectoral grants SC170081, SC170579, SC170314 (Health and Nutrition).
The flexibility of thematic funding allows UNICEF to respond more effectively. It facilitates longer-term planning, sustainability and savings in transaction costs, leaving more resources for UNICEF programmes.

Thematic funding contributions for health reached US$13.2 million in 2018, a 17 per cent decrease from the US$15.9 million received in 2017. Sixty-five per cent came from government partners. Denmark was the largest thematic-resources partner, providing 30 per cent of all thematic contributions received.

UNICEF is seeking to broaden and diversify its funding base (including thematic contributions), and encourages all partners to give as flexibly as possible. Regrettably, the number of partners contributing thematic funding to health decreased from 19 in 2017 to 18 in 2018.

Sizeable thematic contributions were received from the Government of Sweden for health activities in the Democratic Republic of the Congo, while the German Committee for UNICEF also contributed sizeable country-specific funding for activities in Benin and Sierra Leone. The Government of Luxembourg was the largest overall contributor of global thematic funds to health.

| TABLE 11: Thematic contributions by resource partner to health, 2018 |
|-----------------|-----------------|-----------------|-----------------|
| Rank            | Resource partner         | Total (US$)  | Percentage of total |
| Governments 64.67% |                               |               |                  |
| Governments 64.67% | Denmark                    | 3,976,802      | 30.25%           |
| Governments 64.67% | Sweden                     | 3,584,786      | 27.27%           |
| Governments 64.67% | Luxembourg                 | 733,025        | 5.58%            |
| Governments 64.67% | Iceland                    | 206,937        | 1.57%            |
| National Committees 34.04% | German Committee for UNICEF   | 1,776,246      | 13.51%           |
| National Committees 34.04% | U.S. Fund for UNICEF     | 994,674        | 7.57%            |
| National Committees 34.04% | Dutch Committee for UNICEF  | 494,977        | 3.77%            |
| National Committees 34.04% | Czech Committee for UNICEF | 241,618        | 1.84%            |
| National Committees 34.04% | United Kingdom Committee for UNICEF | 206,663    | 1.57%            |
| National Committees 34.04% | Hellenic National Committee for UNICEF | 170,639 | 1.30%            |
| National Committees 34.04% | Danish Committee for UNICEF | 166,393        | 1.27%            |
| National Committees 34.04% | Polish National Committee for UNICEF | 150,584 | 1.15%            |
| National Committees 34.04% | Slovenian foundation for UNICEF – the institution | 111,902 | 0.85%            |
| National Committees 34.04% | Norwegian Committee for UNICEF | 72,066       | 0.55%            |
| National Committees 34.04% | Lithuanian National Committee for UNICEF | 45,593 | 0.35%            |
| National Committees 34.04% | Spanish Committee for UNICEF | 29,627        | 0.23%            |
| National Committees 34.04% | Slovak Committee for UNICEF | 14,151         | 0.11%            |
| Field offices 1.37% | UNICEF United Arab Emirates | 179,853 | 1.37%          |
| Grand total |                                  | 13,156,537 | 100.00%          |

* Grant numbers are provided for IATI compliance: SC1899010010, SC1899010015, SC1899010023, SC1899010032, SC1899010012, SC1899010013, SC1899010004, SC1899010016, SC1899010024, SC1899010029, SC1899010030, SC1899010033, SC1899010022, SC1899010002, SC1899010014, SC1899010017, SC1899010027, SC1899010009, SC1899010003, SC1899010006, SC1899010007, SC1899010020, SC1899010025, SC1899010021, SC1899010019, SC1899010005, SC1899010011, SC1899010026, SC1899010028, SC1899010031, SC1899010018.
Of all thematic-health contributions UNICEF received in 2018, some 12 per cent were global-level contributions.

Global thematic funds remain the most flexible source of funding to UNICEF after regular resources. The global level is the most valuable thematic funding level in which partners determine which UNICEF objectives they wish to support, and contribute to the most closely aligned thematic-funding pool. This allows UNICEF the flexibility to allocate funds across regions to individual country programmes according to priority needs. It facilitates programme implementation in a more strategic manner, and the ability to adjust and respond to emerging issues. It also allows UNICEF the flexibility to allocate resources to areas of greatest need, including critically under-funded country programme areas and humanitarian-response activities.

A total of US$2,072,158 global thematic health funding from the previous thematic pool, 2014–2017, was allocated to 14 offices in 2018.

### TABLE 12: Allotment of health global thematic funding revenue to offices and programmes, 2018

<table>
<thead>
<tr>
<th>Region</th>
<th>Country</th>
<th>Allotment (US$)</th>
<th>Percentage of total allocation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>WCA</td>
<td>Cameroon</td>
<td>200,000.00</td>
<td>10%</td>
</tr>
<tr>
<td>WCA</td>
<td>Mauritania</td>
<td>200,000.00</td>
<td>10%</td>
</tr>
<tr>
<td>WCA</td>
<td>Togo</td>
<td>200,000.00</td>
<td>10%</td>
</tr>
<tr>
<td>ESA</td>
<td>Angola</td>
<td>400,000.00</td>
<td>19%</td>
</tr>
<tr>
<td>ESA</td>
<td>Kenya</td>
<td>200,000.00</td>
<td>10%</td>
</tr>
<tr>
<td>ECA</td>
<td>Kazakhstan</td>
<td>100,000.00</td>
<td>5%</td>
</tr>
<tr>
<td>LAC</td>
<td>Belize</td>
<td>50,000.00</td>
<td>2%</td>
</tr>
<tr>
<td>ESA</td>
<td>Kosovo</td>
<td>45,000.00</td>
<td>2%</td>
</tr>
<tr>
<td>ESA</td>
<td>Montenegro</td>
<td>45,000.00</td>
<td>2%</td>
</tr>
<tr>
<td>ESA</td>
<td>Bosnia and Herzegovina</td>
<td>60,000.00</td>
<td>3%</td>
</tr>
<tr>
<td>ESA</td>
<td>Armenia</td>
<td>60,000.00</td>
<td>3%</td>
</tr>
<tr>
<td>Regional office</td>
<td></td>
<td><strong>180,000.00</strong></td>
<td><strong>8%</strong></td>
</tr>
<tr>
<td>WCA</td>
<td>WCARO, Senegal</td>
<td>90,000.00</td>
<td>4%</td>
</tr>
<tr>
<td>ESA</td>
<td>ESARO, Kenya</td>
<td>90,000.00</td>
<td>4%</td>
</tr>
<tr>
<td>Headquarters</td>
<td></td>
<td>332,158.16</td>
<td>16%</td>
</tr>
<tr>
<td>HQ</td>
<td>United States</td>
<td>332,158.16</td>
<td>16%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>2,072,158.16</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; ESARO, Eastern and Southern Africa Regional Office; LAC, Latin America and the Caribbean; WCA, West and Central Africa; WCARO, West and Central Africa Regional Office.

*Total may not match sum due to rounding.
Given the transition to the new Strategic Plan, the roll-out of the UNICEF Health System Strengthening approach and the need to demonstrate results from the limited flexible funding in health, the development of community health systems was prioritized as an area for investment in consultation with UNICEF country and regional offices. Allocations were made at regional and country office levels to build on the success of the 2017 Institutionalizing Community Health Conference in South Africa and in consultation with Eastern and Southern Africa, and West and Central Africa regional offices.

Additional allocations were made based on strategic priorities to: (a) mobilize global and country-level political will through the landmark ‘Global Conference on Primary Health Care: Towards Health for All’, and (b) establishing the groundwork for positioning UNICEF as a credible partner in the area of adolescent health and health-system strengthening.

**Expenses for health in 2018**

Note: expenses are higher than the income received because expenses comprise total allotments from regular resources and other resources (including balances carried over from previous years), while income reflects only earmarked contributions from 2018 to health.

To realize children’s rights to health, UNICEF spent US$1.3 billion in 2018. At 62 per cent, health held the largest share of expenses within Goal Area 1, followed by nutrition at 32 per cent.

While health remained the organization’s largest portfolio, expenses decreased by US$69 million from 2017. Health expenses from regular resources (the most flexible type of resources) stood at US$204 million (or 16 per cent of total expenses, Figure 21), proportionately similar to expenses in previous years. Other resources – regular (ORR) accounted for 67 per cent of expenses in the sector, compared with 64 per cent in 2017. Finally, the proportion of expenses from other resources – emergency (ORE) stood at 17 per cent in 2018 (US$226 million), down from 19 per cent in 2017 (US$266 million).

By region, health spending depended on investments required to reduce maternal, neonatal and child mortality. Because sub-Saharan Africa needs to substantially accelerate its pace of progress to meet the SDG targets on maternal and child mortality, 51 per cent of health allocations in 2018 were spent there. West and Central Africa accounted for 28 per cent of expenses (US$369

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**Expenses vs expenditure**

‘Expenses’ are recorded according to IPSAS standards and are accrual based. These are used for official financial reporting. ‘Expenditures’ are recorded on a modified cash basis. They are used for budget reporting since they are aligned with cash disbursements and goods receipts (the way budgets are consumed).

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**FIGURE 21: Trend of expense for health by fund type, 2014–2018**
million, see Figure 22), while Eastern and Southern Africa accounted for 23 per cent (US$305 million). South Asia accounted for 21 per cent of expenses (US$267 million). Expenses from emergency resources (ORE) supported programmes in all UNICEF regions; spending from this fund type continued to be heavily concentrated in the Middle East and North Africa, at 49 per cent of emergency resources for the health sector (US$99 million). This underscores the intensification of the humanitarian situation in Yemen and the ongoing conflict in the Syrian Arab Republic.

The top 20 countries accounted for US$924 million in health-sector expenses, 71 per cent of all health spending in 2018. Of these 20 countries, the top five made up half (US$480 million) of spending. For the first time, Pakistan was the largest country programme in terms of health expenses with US$124 million. The Democratic Republic of the Congo – a post-conflict fragile state – was the organization’s second largest programme in 2018 with US$100 million in expenses.

Thematic funds, due to their flexibility, remain critical to UNICEF health work. In 2018, UNICEF spent US$18.6 million from thematic funds to support essential health programmes in high-mortality countries and regions, covering a total of 76 countries. West and Central Africa benefited from more than two thirds of all thematic expenses (US$13 million or 68 per cent) due to country-specific thematic funds. Thematic funds addressed important gaps in 19 countries in West and Central Africa, 16 countries in Eastern and Southern Africa (US$1.6 million or 9 per cent), 10 countries in East Asia and the Pacific (US$1.1 million or 6 per cent), 6 countries in the Middle East and North Africa, 7 countries in South Asia, 9 countries in Europe and Central Asia, and 9 countries in Latin America and the Caribbean. Nearly 30 per cent of funds supported work on integrated management of childhood illnesses. Thematic funds helped strengthen capacity at regional and global levels. Additional details are available in the annexed financial statement.

By programme area, immunization remains the largest portfolio within health with US$556 million in expenses or 43 per cent of total health expenses. Investments in support of health-systems strengthening and response to public health emergencies represented 19 per cent of expenses (US$253 million), a share similar to the child health programme area. Expenses in the maternal and newborn programme accounted for 17 per cent of the total (US$228 million, of which US$56 million were from regular resources). Lastly, the adolescent health and nutrition programme, an emerging area of work, totalled US$18 million.

FIGURE 22: Expense for health by fund type, and per region, 2018

<table>
<thead>
<tr>
<th>Region</th>
<th>Regular resources</th>
<th>Other resources - regular</th>
<th>Other resources - emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECA</td>
<td>410</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>EAP</td>
<td>16</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>MENA</td>
<td>8</td>
<td>92</td>
<td>99</td>
</tr>
<tr>
<td>LAC</td>
<td>412</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td>44</td>
<td>205</td>
<td>17</td>
</tr>
<tr>
<td>ESA</td>
<td>49</td>
<td>204</td>
<td>53</td>
</tr>
<tr>
<td>WCA</td>
<td>70</td>
<td>257</td>
<td>43</td>
</tr>
</tbody>
</table>

EAP: East Asia and the Pacific; ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; HQ, headquarters; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; SA, South Asia; WCA, West and Central Africa.
FIGURE 23: Expense for health by country and fund type, 2018

TABLE 13: Expense for health by programme area and fund type, 2018 (US$)*

<table>
<thead>
<tr>
<th>Programme area</th>
<th>Regular resources</th>
<th>Other resources – regular</th>
<th>Other resources – emergency</th>
<th>Grand total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization</td>
<td>52,481,569</td>
<td>456,579,940</td>
<td>46,989,233</td>
<td>556,050,742</td>
</tr>
<tr>
<td>Child health</td>
<td>42,912,131</td>
<td>163,526,261</td>
<td>46,756,263</td>
<td>253,194,656</td>
</tr>
<tr>
<td>Health systems strengthening and response to public health emergencies</td>
<td>49,442,795</td>
<td>117,414,616</td>
<td>85,772,828</td>
<td>252,630,239</td>
</tr>
<tr>
<td>Maternal and newborn health</td>
<td>55,549,277</td>
<td>126,045,142</td>
<td>44,109,905</td>
<td>225,704,323</td>
</tr>
<tr>
<td>Adolescent health</td>
<td>3,935,109</td>
<td>11,478,601</td>
<td>2,372,321</td>
<td>17,786,031</td>
</tr>
<tr>
<td>Grand total</td>
<td>204,320,881</td>
<td>875,044,561</td>
<td>226,000,549</td>
<td>1,305,365,991</td>
</tr>
</tbody>
</table>

*Totals may not match sum due to rounding.
By cost category, 70 per cent of health expenses were under three categories combined: ‘transfers and grants to counterparts’ (US$364 million), ‘supplies and commodities’ (US$349 million) and technical assistance (US$201 million) (see Table 14). The higher share of expenses in these categories allows UNICEF to support counterparts in implementing high-impact health interventions and strengthen primary health care under Goal Area 1.
<table>
<thead>
<tr>
<th>Category</th>
<th>Other resources – emergency</th>
<th>Other resources – regular</th>
<th>Regular resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual services</td>
<td>14,444,377</td>
<td>161,737,195</td>
<td>24,980,675</td>
<td>201,162,246</td>
</tr>
<tr>
<td>Equipment, vehicle, furniture</td>
<td>229,548</td>
<td>633,544</td>
<td>890,977</td>
<td>1,754,070</td>
</tr>
<tr>
<td>General operating + operating + other direct costs</td>
<td>5,953,855</td>
<td>36,493,298</td>
<td>18,878,231</td>
<td>61,325,385</td>
</tr>
<tr>
<td>Incremental indirect cost</td>
<td>16,310,660</td>
<td>56,954,399</td>
<td></td>
<td>73,265,058</td>
</tr>
<tr>
<td>Staff and other personnel costs</td>
<td>27,933,853</td>
<td>98,065,572</td>
<td>69,849,435</td>
<td>195,848,861</td>
</tr>
<tr>
<td>Supplies and commodities</td>
<td>57,994,799</td>
<td>266,976,052</td>
<td>24,076,935</td>
<td>349,047,785</td>
</tr>
<tr>
<td>Transfers and grants to counterparts</td>
<td>88,418,985</td>
<td>227,996,676</td>
<td>47,232,676</td>
<td>363,647,337</td>
</tr>
<tr>
<td>Travel</td>
<td>3,521,291</td>
<td>18,284,159</td>
<td>10,982,884</td>
<td>32,788,334</td>
</tr>
<tr>
<td>Other</td>
<td>11,193,182</td>
<td>7,904,665</td>
<td>7,429,068</td>
<td>26,526,915</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>226,000,549</strong></td>
<td><strong>875,044,561</strong></td>
<td><strong>204,320,881</strong></td>
<td><strong>1,305,365,991</strong></td>
</tr>
</tbody>
</table>

*Totals may not match sum due to rounding.*
UNICEF invests in nutrition programmes that set children on the path to grow and develop well in the womb, throughout childhood and across the life course. These programmes reach children, adolescents and women wherever they live, in low- and middle-income countries, and in both development and humanitarian contexts.

The prevention and treatment of malnutrition are central to the intended outcome of Goal Area 1 – that all girls and boys, especially those who are marginalized and those living in humanitarian crises, have access to high-impact health, nutrition, HIV and early childhood interventions from pregnancy to adolescence. Evidence-based and cost-effective nutrition interventions keep children free from all forms of malnutrition, including stunting (low height-for-age), wasting (low weight-for-height), micronutrient deficiencies, overweight and diet-related non-communicable diseases, setting them on the path to survive and thrive. Well-nourished children are well equipped to grow, learn and develop to their full potential; to be resilient in the face of poverty, disease and crisis; and to be change-makers in building stronger communities and nations.

Results: Nutrition
Nutrition interventions must not take place in isolation. UNICEF promotes and supports an integrated approach that combines interventions at community, facility and outreach levels for health, nutrition, HIV and early childhood development. Goal Area 1 was shaped to reflect this imperative for multisectoral integrated programming. Aligned with this, UNICEF adopts a systems-strengthening approach by leveraging the potential of the food, health, education and social protection systems to improve nutrition outcomes for children, adolescents and women.

Within Goal Area 1, UNICEF nutrition programmes cover three results areas that contribute to the overall outcome: (1) The prevention of stunting and other forms of malnutrition; (2) The improvement of adolescent health and nutrition; and (3) The treatment and care of children with severe wasting and other forms of severe acute malnutrition. The theory of change holds that if countries accelerate the delivery of programmes for the prevention of stunting and other forms of malnutrition in early childhood, and if they accelerate gender-responsive adolescent health and nutrition programmes, and if they accelerate the delivery of services for the treatment of severe acute malnutrition, then girls and boys, especially those who are marginalized and those facing humanitarian crisis, will be more likely to survive and thrive.

The nutrition results achieved over the UNICEF Strategic Plan, 2018–2021, period are expected to contribute to: reducing the proportion of children suffering from stunting, from 30 per cent to 24 per cent; reducing the proportion of children suffering from wasting, from 12 per cent to less than 8.7 per cent; and ensuring no increase in the number of overweight children from the current 8 per cent. These 2021 impact indicators are aligned with the Sustainable Development Goal (SDG) 2 targets for ending malnutrition and the target of ending preventable deaths in children under 5.

As described in the theory of change, certain risks and assumptions underlie the achievement of results. The effective scale-up of nutrition programmes assumes, for example, that countries will remain committed to achieving the SDGs, that national and global investments will be sustained over the Strategic Plan period, and that coordination between UNICEF and United Nations partners will continue to drive equitable results for children.

FIGURE 24: Number (millions) of stunted children under 5, by region, 2017


Note: *Eastern Europe and Central Asia region does not include Russian Federation due to missing data; consecutive low population coverage for the 2017 estimate (interpret with caution). There is no estimate available for the Europe and Central Asia region or the Western Europe sub-region. **North America regional average based on United States data only. The sum of UNICEF regional estimates do not add up to the global total as the global total is based on a model for United Nations regions.
To achieve results in 2018 and beyond, UNICEF country-driven programmes include proven interventions to improve maternal and child nutrition at key moments across the life course. These programmes address early childhood nutrition, the nutrition of school-aged children and adolescents, and maternal nutrition, by putting prevention first and ensuring effective treatment and care when prevention fails. Knowledge generation and use is at the heart of this work, guiding advocacy, policies and programmes.

UNICEF’s systems-strengthening approach to maternal and child nutrition guides programming, with the aim of making food, health, water and sanitation, education and social protection systems more accountable for improving nutrition. This means leveraging the potential of food systems to deliver nutritious, affordable and sustainable diets for children everywhere, leaving no child behind. It means strengthening the capacities of health systems to deliver the right health and nutrition services at the right time to foster good nutrition. It also means leveraging water and sanitation systems to prevent nutrient losses and making education systems fit to deliver nutrition services and foster a new generation of well-nourished and nutrition-literate children. For the poorest families, leveraging the potential of social protection systems reduces vulnerabilities and ensures that good nutrition is a right enjoyed by all children.

With global thematic funding from the Government of the Netherlands and other partners, UNICEF is accelerating progress towards its Strategic Plan targets by putting special emphasis on the 10 countries that are home to more than 75 per cent of stunted and wasted children in the world. Much of UNICEF’s efforts will focus on addressing the drivers of children’s growth and development during the first 1,000 days from conception to age 2, while supporting the early detection and treatment of severe acute malnutrition as part of a package of routine services for children. UNICEF has also established learning compacts with regional and country offices to tackle areas in need of increased focus, such as the nutrition of school-aged children, adolescents and mothers, and the prevention of overweight in childhood.

Results Area 1: Prevention of stunting and other forms of malnutrition

The prevention of all forms of malnutrition is essential to ensuring that children survive and thrive. To prevent malnutrition, children need access to nutritious, affordable and sustainable diets; appropriate feeding, care and stimulation practices; and primary health care and sanitation services – from the earliest days of life. These building blocks of good nutrition ensure that children not only survive and thrive but go on to lead healthy and productive lives.

The case for ‘prevention first’ is compelling. Every dollar spent on preventing malnutrition delivers $16 in returns. Prevention protects children from the lifelong physical and cognitive devastation caused by stunting and other forms of malnutrition; it also saves lives and is more cost-effective than delivering treatment alone.

Improving infant and young child feeding (IYCF) practices and the quality of children’s diets from birth to age 2 is the first step to prevention – and there is much work to be done. Only three out of five children under 6 months of age are benefiting from exclusive breastfeeding, and just one in six children aged 6–23 months in low- and middle-income countries is eating enough meals from a diverse range of food groups to ensure healthy growth and development (see Figure 25).
UNICEF’s commitment to prioritizing prevention is reflected in the Strategic Plan Results Framework, with most nutrition programming and expected results falling under Output 1: Countries have accelerated the delivery of programmes for the prevention of stunting and other forms of malnutrition.

UNICEF addresses the drivers of poor diets with programmes that reach children and mothers during the critical developmental period from conception to age 2. Before and during pregnancy, nutrition counselling and supplementation with essential nutrients (such as iron and folic acid) and food fortification programmes (such as salt iodization and wheat flour fortification) improve children’s growth and development and help ensure a healthy pregnancy and delivery for mothers and babies. In early childhood, UNICEF programmes aim to increase and sustain breastfeeding, improve the quality of young children’s diets, and provide supplementation and fortification to prevent nutrient deficiencies in settings where nutritious diets are out of reach.

To deliver these programmes effectively, UNICEF strengthens the capacities of governments to make the food system and other systems more accountable in providing nutritious diets and nutrition services for children. In collaboration with partners, UNICEF works to shift the policy agenda and influence national actors and key stakeholders to invest in preventing malnutrition. UNICEF develops guidance for countries, builds political will for improved nutrition, and works with governments to adopt and strengthen policies and allocate budgets that help make good nutrition a reality for children everywhere.
Output and outcome indicators for prevention of stunting and other forms of malnutrition

### TABLE 15: Outcome results for prevention of stunting and other forms of malnutrition, 2018

<table>
<thead>
<tr>
<th>Outcome indicator (+ key United Nations partners)</th>
<th>Baseline</th>
<th>2018 value</th>
<th>2021 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.12. Percentage of women with anaemia</td>
<td>36%</td>
<td>Not available</td>
<td>27%</td>
</tr>
<tr>
<td>1.13. Percentage of infants under 6 months exclusively fed with breast milk (Goal 2.2.1 and 2.2.2) (WHO, World Bank)</td>
<td>40%</td>
<td>41%</td>
<td>45%</td>
</tr>
<tr>
<td>1.14. Percentage of children fed a minimum number of food groups (Goal 2.2.1 and 2.2.2) (FAO, WFP, WHO)</td>
<td>29%</td>
<td>29%</td>
<td>35%</td>
</tr>
<tr>
<td>1.15. Percentage of households consuming iodized salt (WHO)</td>
<td>86%</td>
<td>87.9%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>1.16. Number of children who received: (a) two annual doses of vitamin A supplementation in priority countries; (b) multiple micronutrient powders through UNICEF-supported programmes</td>
<td>(a) 221 million (b) 11 million</td>
<td>(a) 255.7 million (b) 15.6 million</td>
<td>(a) 250 million (b) 12 million</td>
</tr>
</tbody>
</table>

### TABLE 16: Output results for prevention of stunting and other forms of malnutrition, 2018

<table>
<thead>
<tr>
<th>Outcome indicator</th>
<th>Baseline</th>
<th>2018 value</th>
<th>2018 milestone</th>
<th>2021 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.d.1. Percentage of pregnant women receiving iron and folic acid supplementation</td>
<td>29%</td>
<td>33%</td>
<td>32%</td>
<td>41%</td>
</tr>
<tr>
<td>1.d.2. Number of countries that have integrated nutrition counselling in their pregnancy care programmes</td>
<td>47</td>
<td>57</td>
<td>55</td>
<td>70</td>
</tr>
<tr>
<td>1.d.3. Number of countries with: (a) a national strategy to prevent stunting in children; (b) programmes to improve the diversity of children’s diets</td>
<td>(a) 41 (b) 30</td>
<td>(a) 49 (b) 32</td>
<td>(c) 28 (d) 18</td>
<td>(a) 46 (b) 30</td>
</tr>
<tr>
<td>1.d.4. Number of countries that are implementing policy actions or programmes for the prevention of overweight and obesity in children</td>
<td>16</td>
<td>17</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>1.d.5. Number of countries that are implementing salt iodization programmes with an effective coordination body for reducing iodine deficiency</td>
<td>26</td>
<td>33</td>
<td>29</td>
<td>46</td>
</tr>
</tbody>
</table>
Improving services and community demand

Counselling to caregivers to improve feeding and care practices

UNICEF supports community-based counselling for mothers and caregivers to equip them with the knowledge and skills to improve feeding practices for young children. Globally, 23 million caregivers received counselling on IYCF practices in 2018. Community-based counselling improves feeding practices and helps prevent malnutrition, particularly in settings with limited access to health services. Counselling and support take various forms: they can be provided to individuals or groups and may be facilitated by community health workers or experienced mothers. In many countries, efforts are increasingly being made to reach fathers and increase their involvement in feeding and care practices, such as in Pakistan, where father-to-father support groups for nutrition were established through a Communication for Development (C4D) initiative.

In 2018, UNICEF invested in the potential of community health workers to improve young children’s diets by developing a series of training videos using real home feeding situations in Kenya, Nepal and Nigeria to improve health workers’ knowledge and skills. The ‘First Foods’ video series is available in seven languages and focuses on demonstrating the recommended complementary feeding practices for children aged 6–23 months. There is a complementary series of videos for caregivers on the same topics. UNICEF is increasingly expanding training on child feeding to community workers from other sectors, including agriculture, social protection, education, and water and sanitation: 40 per cent of countries strengthened their community outreach in this way in 2018 (34 countries, compared with 26 in 2017).

Community-based counselling is particularly important during emergencies, when health and nutrition services are disrupted, and caregivers face complex challenges in feeding their children. Of the 58 countries with a humanitarian action appeal, 40 implemented IYCF programmes as part of the humanitarian response; and 30 of those provided counselling services. UNICEF provides counselling and establishes safe spaces for child feeding in times of crisis, reaching more mothers and caregivers than ever before: 178 million caregivers of young children received IYCF counselling during humanitarian crises in 2017 compared with 6.7 million in 2014.

The scale-up of counselling and support for breastfeeding in many countries, combined with strengthened support within health facilities (see ‘Building stronger institutions’ below) and improved policies and legislation (see
‘Leveraging collective action’ below), has contributed to an increase in the global rate of exclusive breastfeeding. Forty-one per cent of children under 6 months of age were exclusively fed with breastmilk in 2018, compared with 40 per cent in 2017. UNICEF expects to contribute to raising the rate of exclusive breastfeeding to 45 per cent by 2021 (Strategic Plan target 1.13). Some countries made important strides in raising their rates of exclusive breastfeeding in 2018: in Burkina Faso rates increased from 47.8 per cent in 2017 to 55.8 per cent in 2018, and in South Sudan the increase was from 45 to 74 per cent between 2010 and 2018. The scale-up of breastfeeding counselling, which expanded to reach 950,300 caregivers in 2018 compared with about 539,500 in 2015, contributed to this progress.

CASE STUDY 5: United Republic of Tanzania: Expanding counselling to improve diets and prevent stunting

By expanding the coverage of counselling on infant and young child feeding, engaging communities and supporting vulnerable households, UNICEF and partners contributed to improved feeding practices and declines in stunting in focus regions of the United Republic of Tanzania in 2018.

About 395,000 pregnant women and caregivers received counselling, representing an increase in the proportion of women benefiting from 17 per cent in 2017 to 36 per cent in 2018, and surpassing the national target of 33 per cent. To support this expansion, more than 4,760 community health workers were trained to provide counselling in more than 2,380 villages, with UNICEF support. The proportion of villages with health workers trained in counselling increased from 64 per cent in 2017 to 72 per cent in 2018, towards an overall target of 75 per cent of villages by 2021. UNICEF led the achievement of these results, with the support of non-governmental organizations (NGOs) and donor governments.

Through a partnership with the Tanzania Social Action Fund and NGOs, UNICEF worked to improve equity by ensuring that nutrition counselling services were provided to families receiving conditional cash transfers in focus regions. To maximize the impact of counselling on stunting reduction, UNICEF worked to integrate components of water, sanitation and hygiene, health, care for child development and growth monitoring, into a holistic package, which was used to train health workers to provide intensive counselling within health-care facilities and the community. There was also a focus on gender to promote the involvement of fathers and other male caregivers in child feeding and care. As a result, the number of men taking part in caregiving for young children increased from about 30,000 in 2017 to more than 39,500 in 2018 in UNICEF-supported regions.

The effectiveness of community-based growth monitoring and promotion, paired with counselling, emerged as a key lesson learned from the programme. Routine community-based growth monitoring and promotion allowed community health workers to provide tailored counselling based on the results of individual child growth measurements, and to ensure close follow-up for children with nutritional problems.

UNICEF was a leading technical partner in implementing the Tanzania National Nutrition Survey in 2018. Preliminary results indicated that, between 2014 and 2018, the prevalence of stunting in UNICEF focus regions declined from 36 per cent to 34 per cent in Mbeya, from 51 per cent to 47 per cent in Iringa, and from 24 per cent to 22 per cent in Zanzibar. Nationally, stunting declined from 35 per cent to 32 per cent, meeting the national target of 32 per cent by 2018/19. The reduction in stunting was accelerated by the improvement in caregiving practices and children’s diets. According to national estimates, the proportion of children receiving a minimum acceptable diet at national level increased from 20 per cent to 30 per cent, surpassing the national target of 25 per cent by 2018/19. The exclusive breastfeeding rate increased from 41 per cent in 2014 to 58 per cent in 2018 according to preliminary estimates.
UNICEF supports countries in integrating early childhood development interventions, such as the promotion of stimulation and nurturing care, as part of IYCF programmes. For example, stimulation and play interventions were integrated as part of a C4D strategy to improve feeding practices in three districts with high rates of malnutrition in Botswana. In Thailand, early childhood development ‘demonstration centres’ provide counselling for caregivers on nutrition, care and stimulation. Such nurturing interaction between caregivers and children is critical during feeding and can boost brain development in early childhood.

C4D approaches are often used to target poor feeding practices and build demand for nutrition services. The C4D approach highlights the impact of beliefs, values and norms on the feeding practices of children and their families, and helps UNICEF translate this information into interactive communications with children and their caregivers. This was the case in Malawi, where UNICEF used a C4D strategy to promote improved child feeding practices via radio, clubs and community mobilization. Through these efforts, more than 810,000 people increased their knowledge on nutrition practices and more than 1,000 community leaders became nutrition champions, encouraging their communities to adopt good nutrition and health-seeking practices. In programme areas, exclusive breastfeeding increased from 67 per cent in 2017 to 81 per cent in 2018; and the proportion of children receiving a minimally acceptable diet increased from 10.5 per cent in 2017 to 14.4 per cent in 2018.49

Interventions to improve dietary diversity
Caregivers’ abilities to implement the recommended feeding practices depend on the availability and affordability of nutritious foods. A 2018 evaluation of the UNICEF counselling package in Nigeria confirmed this, showing that while counselling caregivers on child feeding practices is necessary, by itself, it is not enough to improve the quality and diversity of children’s diets.50

The Strategic Plan makes improving the diversity of children’s diets a priority, recognizing that young children’s access to a range of nutritious foods, including animal-source foods, vegetables and fruit, is central to the prevention of stunting. In low- and middle-income countries, 29 per cent of children 6–23 months globally were fed meals from the minimum number of food groups in 2018,51 the same number as in 2017. With the scale-up of programmes to improve dietary diversity in young children, supported by global thematic funding from the Government of the Netherlands, UNICEF will aim to increase this figure to at least 35 per cent by 2021 (outcome indicator SP1.14).
For the first time, UNICEF is tracking the number of countries with programmes to improve children’s access to a variety of nutritious foods. In 2018, there were 108 countries with programmes to improve the diversity of children’s diets. Of these, 30 countries were leveraging social protection services to improve dietary quality; 37 were increasing access to fortified complementary foods; 47 had initiatives to increase access to and use of diverse, local nutritious foods at household level; and 75 countries were integrating nutrition education activities that promote responsive parenting, responsive feeding, and stimulation during early childhood. Thirty-two countries reported having all of these criteria in 2018, surpassing the milestone of 18 countries (SP1.d.3-b), suggesting that a comprehensive and multifaceted approach to improving the quality of children’s diets is being realized.

In the first year of the Strategic Plan, UNICEF worked with countries to gather evidence, test interventions and gain consensus on programme design for future scale-up. Beginning in 2018, UNICEF launched programmes in 42 countries across all seven regions to improve the diversity of children’s diets. As part of this work, UNICEF developed complementary feeding ‘action frameworks’ to facilitate action-oriented programming and help countries leverage the potential of food, health, WASH and social protection systems to deliver nutritious, affordable and sustainable diets for young children. In Bangladesh, for example, UNICEF developed a proof-of-concept for improving dietary diversity using nutrition vouchers to improve affordability, WASH interventions to encourage safe food preparation, and responsive feeding counselling for caregivers to improve feeding practices.

Home fortification to enhance the nutrient content of children’s diets

UNICEF supports the implementation of home fortification programmes to improve the quality of children’s diets and prevent vitamin and nutrient deficiencies where access to a diverse range of nutritious foods is limited. Such programmes provide caregivers with packets of multiple micronutrient powders (MNP) that can be added to children’s meals to enhance their nutrient quality, and counselling on feeding practices.

UNICEF is the leading global provider of MNPs, procuring 197 million sachets of MNPs in 2018. More than three quarters of all MNP interventions globally are integrated within IYCF programmes, a critical step to improving caregiver knowledge on complementary feeding practices while increasing nutrient intake from complementary foods. Globally, 51 countries implemented home fortification programmes with UNICEF support in 2017 (the latest available estimates). The number of children benefiting from home fortification programmes tripled between 2014 and 2017, increasing from 4 million to 15.6 million children, surpassing the 2021 target of 12 million (SP1.16-b).

Rwanda was the first African country to achieve national coverage of home fortification with MNPs in 2017. UNICEF provided technical support to the Government of Rwanda throughout its programme scale-up, with investments from the Government of the Netherlands and IKEA Foundation, among others. In 2018, UNICEF maintained its support for the programme in all 30 districts of the country, providing MNPs to more than 316,500 children aged 6–23 months. Surveys conducted in previous years in Rwanda showed a reduction in anaemia prevalence and suggested that children receiving MNPs were more likely to receive the minimum acceptable diet than other children.

The number of children reached with micronutrient powders tripled between 2014 and 2017

FIGURE 26: Number of children reached with MNPs with UNICEF support, 2014–2017
Vitamin A supplementation for life-saving protection

UNICEF has implemented vitamin A supplementation (VAS) programmes for more than two decades as a cornerstone of early childhood nutrition. Two high doses of vitamin A provided every year to children aged 6–59 months can protect against blindness, enhance immunity against diseases such as measles and diarrhoea, and reduce preventable deaths in children under 5.

UNICEF is the main provider of vitamin A supplements globally, supported by an in-kind donation financed by the Government of Canada and implemented through Nutrition International. In 2018, UNICEF supplied 517.7 million vitamin A capsules to 58 countries (a 7 per cent increase from 2017), including 461.6 million capsules as in-kind contributions. Globally, two high doses of vitamin A were provided to more than 255.7 million children in 2018, exceeding the target of 250 million (SP1.16).

Many countries deliver VAS successfully through campaign events or as part of national immunization days (NIDs) or polio campaigns, with UNICEF support. In Pakistan, UNICEF procured supplies and ensured the delivery of VAS through NIDs, reaching more than 32 million children aged 6–59 months twice a year, a coverage of more than 91 per cent of children in need. Through integration with NIDs in South Sudan and cooperation agreements with civil society organizations, UNICEF helped increase the proportion of counties conducting VAS and deworming from 61 per cent in 2017 to 76 per cent in 2018. More than 2.3 million children benefitted from VAS in 2018, compared with 1.5 million the previous year.

The coverage of VAS has fluctuated in recent years as some countries shift to new delivery platforms and UNICEF is supporting governments to strengthen health systems and improve this transition (see ‘Building stronger institutions’ below).

Supplementation and other programmes to improve maternal nutrition

UNICEF supports micronutrient supplementation programmes for women to prevent anaemia and improve maternal and child health. These programmes are particularly important in settings where girls and women have limited access to nutritious diets and where early marriage and early pregnancy are common. Sixty-nine countries are providing iron and folic acid supplementation to girls and women of reproductive age, 53 of them with UNICEF support.
Anaemia is the most common nutrient deficiency condition in the world, and pregnant women are particularly vulnerable to low iron stores. Indeed, 36 per cent of pregnant women globally are affected by anaemia, and UNICEF expects to contribute to reducing this figure to 27 per cent by 2021 (SP1.12). Globally, 33 per cent of pregnant women received iron and folic acid supplementation in 2018 (SP1.d.1), surpassing the milestone of 32 per cent. By the end of the Strategic Plan period, UNICEF aims to increase this proportion to 41 per cent. To support programme scale-up, UNICEF procured 876.5 million iron and folic acid tablets in 2018.

With UNICEF support, many countries are increasingly reaching women with nutritional counselling and food supplements to improve diets during pregnancy and lactation and reduce gender-based vulnerabilities. In six states of India for example, 3.4 million pregnant and lactating women received daily nutritious meals at their local anganwadi (village outpost) in 2018, a 44 per cent increase from 2017. More than 2.5 million of these women received hot cooked meals for 21 days or longer. These women came from vulnerable households where they would otherwise be the last to eat and would receive the lowest amount of food due to gender-based discrimination, impacting their health and well-being and increasing the risk of malnutrition in their babies. In addition to the meals, the programme also provided nutrition and health counselling, iron and folic acid supplementation, monthly gestational weight gain monitoring for pregnant women, deworming medication, calcium supplementation, family-planning support and antenatal care services. Anaemia prevention in women and adolescents is a priority in India, which has launched the Anaemia-Free India Initiative and other programmes aiming to break the country’s intergenerational cycle of stunting and malnutrition (see Case Study 8 in Results Area 2).

The health system and social protection system offer important opportunities to improve the nutrition of pregnant women, and UNICEF provides technical assistance to countries in leveraging these contact points. Kenya’s Nutrition Improvement through Cash and Health Education programme (NICHE), piloted in one county in 2018, provides access to cash, decision-making and counselling to improve knowledge about maternal and child nutrition to households with pregnant and lactating mothers and children under age 2. Established by UNICEF with funding from the EU-supported Horn of Africa resilience programme in Kenya, NICHE tested the effect of combining nutrition counselling with cash assistance on improving nutrition outcomes. A study evaluating the outcomes of the pilot found that households receiving NICHE support were more likely to practise enhanced dietary, hygiene and infant care practices, including exclusive breastfeeding and appropriate complementary feeding. Among pregnant women, dietary diversity, routine antenatal care and health facility delivery also increased dramatically.52
Food fortification to make nutritious diets accessible for all

The large-scale fortification of staple grains and other industrially produced foods is effective in safeguarding populations from deficiencies in essential vitamins and nutrients. UNICEF supports governments in implementing large-scale fortification programmes, and 82 countries were mandating the fortification of at least one type of cereal grain with iron and/or folic acid in 2018. Much of this work involves winning support for strengthening national policies and strategies and guiding implementation (see ‘Leveraging collective action’ below).

Salt iodization is the world’s most successful food fortification programme and the most effective strategy for eliminating iodine deficiency disorders and protecting children’s brain development. UNICEF has been a global leader in salt iodization programmes for over 25 years, and this work has made important contributions to preventing iodine deficiency in vulnerable populations. Globally in 2018, the proportion of households consuming iodized salt increased to 88 per cent, from 86 per cent in 2017 (SP1.15). With concerted efforts to strengthen programmes by UNICEF and partners, only 15 UNICEF programme countries are still considered iodine deficient.

For salt iodization legislation to be most effective, an active coordination body convening all stakeholders – including government, industry and civil society – is critical. Thirty-three of 65 reporting countries have established an effective national coordination body, surpassing the 2018 milestone of 29 countries (SP1.d.5). UNICEF is aiming to increase this number to 46 countries by 2021.

Building stronger institutions

Strengthening health systems to support early childhood nutrition

The health system is a key platform for delivering high-impact, integrated nutrition and health services to prevent all forms of malnutrition and set children on the path to healthy growth and development. UNICEF works to strengthen the capacity of national health systems by improving training for health workers on early childhood nutrition, integrating preventive nutrition interventions within routine health visits, and developing guidance to support institutions in providing the best care for mothers and their children. As governments improve their monitoring systems with UNICEF support, there are now 76 countries that track the provision of counselling on infant feeding in their national health information systems.

Antenatal care visits are a key opportunity to counsel women about improving nutrition and infant feeding and care practices. Many countries are strengthening the provision of routine nutrition counselling and support during pregnancy to cover energy and nutrient needs and promote iron-rich foods, vitamin and mineral supplementation, and breastfeeding. The number of countries integrating nutrition counselling with pregnancy care programmes increased from 47 in 2017 to 57 in 2018, surpassing the 2018 milestone of 55 countries (SP1.d.2).

The UNICEF–WHO Baby-friendly Hospital Initiative (BFHI) aims to protect, promote and support breastfeeding in maternity facilities, including by improving the provision of timely and skilled breastfeeding support as a vital component of quality maternity care. In 2018, UNICEF and the World Health Organization (WHO) published updated implementation guidance on the BFHI, including strategies for achieving universal coverage of breastfeeding support in maternity facilities and sustainable improvements in the quality of care.53

UNICEF supports training programmes to build the capacities of health-care providers on maternal and child nutrition, making them better equipped to support children and their families. In line with the updated BFHI guidance, countries such as Jordan, Mongolia and Suriname are scaling up training for health workers to improve breastfeeding support. UNICEF worked with the Jordan Ministry of Health to develop a standardized national service package to support breastfeeding and piloted training for health workers in five hospitals based on the new guidance.

Routine health system contacts provide important opportunities to deliver counselling, supplementation and other key preventive nutrition interventions to children and women. UNICEF helps governments strengthen health systems’ capacities to deliver these interventions sustainably. This work has been particularly important for VAS programmes, as polio NIDs (which historically were an effective platform for reaching all children) have been phased out following polio eradication in many countries. The rapid scale-back of NIDs has resulted in slipping global coverage of VAS in recent years, with only 62 per cent of children in need receiving the life-saving benefits of VAS in 2017 (the latest estimate), compared with 64 per cent the previous year. UNICEF published a report to sound the alarm on this global problem in 2018, with the aim of mobilizing global attention, resources and response.54
As NIDs continue to be scaled back, UNICEF is responding by supporting governments to strengthen the delivery of VAS through health systems. Some countries, such as Mozambique, are integrating VAS into immunization outreach, while others, such as Sierra Leone, are piloting routine delivery at 6 months of age, as part of an integrated 6-month health visit. In Burkina Faso, UNICEF helped transition the delivery of VAS from campaign events to routine distribution by community health workers, demonstrating how a transition to routine delivery can be done without reducing coverage. This cost-effective routine strategy was first introduced in 2017 and reduced operational costs for the Ministry of Health by half while achieving high coverage in rural areas. This approach was successful in reaching more than 3.15 million children (92 per cent coverage), including older children in the 6–59 month age group who tend to make fewer visits to health-care facilities than their younger counterparts. As is the case in many countries, VAS was also integrated with the provision of deworming medication, reaching 93 per cent of children aged 12–59 months. Some challenges in service quality were noted during supervisory missions in 2018; in 2019, UNICEF will provide technical support to develop a national guideline on this new strategy to improve implementation.

Developing guidance for improved maternal and child nutrition

UNICEF developed important guidance documents in 2018 to build the capacities of governments and other stakeholders to prevent stunting and other forms of malnutrition. In collaboration with the Ethiopia Ministry of Health, UNICEF developed an integrated nutrition services implementation guideline in 2018 to guide front-line health workers in implementing nutrition interventions for mothers and children. In Nigeria, UNICEF launched a process to strengthen national micronutrient deficiency control guidelines to respond to high rates of anaemia in women and children, and provided technical assistance to the micronutrient deficiency control task force to develop a road map for anaemia reduction.

As the lead agency for nutrition in emergencies, UNICEF is expected to provide support and strategic direction to governments and partners. In 2018, UNICEF collaborated with partners to develop tools and guidance to respond to emerging programmatic and technical needs in nutrition emergencies. To support governments in strengthening breastfeeding protections and improving the feeding of non-breastfed children, UNICEF developed internal programme guidance on the procurement and use of breastmilk substitutes. With partners in the Infant Feeding in Emergencies Core Group, UNICEF co-led the development of operational guidance on supporting IYCF in
emergencies in 2017. This guidance is now being translated into action, with 65 countries reporting that they have a strategy or national plan of action to support IYCF in emergencies.

Through its role in the Home Fortification Technical Advisory Group, UNICEF developed a technical brief and tools on home fortification with MNPs containing iron in malaria endemic regions. The tools are intended to support countries in designing and scaling up programmes to integrate the delivery of MNPs as part of IYCF programmes. UNICEF also developed new guidance on the monitoring of salt iodization programmes and determining population iodine status.

As childhood overweight and obesity affect an increasing number of countries, UNICEF developed new operational guidance to support policymakers in facing these challenges. The guidance focuses on ensuring better diets for better growth and supports country offices in undertaking a situation and stakeholder analysis to inform the development of a package of interventions and to guide advocacy and policy advice to governments. The guidance provides a menu of options for country offices from which they will select the interventions that are most relevant for their country context. The interventions are grouped in three categories: (1) improving the enabling environment by strengthening regulatory frameworks on overweight prevention and on issues such as health-related taxes and restricting the marketing of unhealthy foods and beverages; (2) interventions across the life course to support healthy practices at home, in the community and in schools; and (3) knowledge management.

**Strengthening nutrition monitoring for action**

UNICEF hosts global databases tracking more than 100 nutrition indicators across 202 countries, including disaggregated data on equity that can contribute to vital improvements in programme monitoring. UNICEF also hosts the NutriDash platform, an online tool for collecting data on nutrition programmes globally, including coverage data (on early childhood nutrition, MNPs, VAS, salt iodization, care for children with severe acute malnutrition, and the nutrition of school-aged children and adolescents) and supply forecasting for nutrition commodities. Reporting is completed by UNICEF country offices, with data collected in partnership with government counterparts, NGOs and scientific organizations. NutriDash includes a general information module with questions on the enabling environment, supply, budgets, existing monitoring systems, emergency preparedness and response, to which 113 countries responded.

Many governments conduct national nutrition surveys with UNICEF support to inform national policies and programmes. In Pakistan, to ensure that stunting prevention strategies were evidence based, the Ministry of National Health Services, Regulation and Coordination, with support from UNICEF and the Department for International Development (United Kingdom), initiated a national nutrition survey in 2018. Gender-responsive analysis of the data will be undertaken in 2019. The survey was complemented by a nationwide complementary feeding assessment, led by UNICEF, the government and partners. The findings provide a solid evidence base for the design of national and subnational complementary feeding programmes, and social and behaviour change communication strategies for improving young children’s diets.

In 2018, UNICEF continued to help countries improve routine health and nutrition information systems by providing technical guidance and building capacity to collect and use programme data for decision-making. Increasingly, countries are collecting disaggregated nutrition data through national information systems, which is critical to evaluating whether key interventions are achieving equity. Ninety-seven countries reported having national information management systems that disaggregate data on nutrition in 2018, the same number as in 2017.

With UNICEF support, many national governments have increased the number of nutrition indicators monitored through surveys and routine systems. As a result of UNICEF advocacy and technical assistance in Ethiopia, eight nutrition indicators were included in the district health information system in 2018 (DHIS2). To improve nutrition information and ensure sustainability, UNICEF also helped establish the Unified Nutrition Information System for Ethiopia, which collects nutrition programme data for evidence-based decision-making. In Bangladesh, UNICEF worked with the government to strengthen the National Nutrition Information System to better prioritize and track key nutrition indicators and results. A new visualization platform was launched, and 88,000 health-care providers received nutrition training across 38 districts. UNICEF also advocated with the World Bank for results-based financing, leading to 2 of the 16 disbursement-linked indicators being on nutrition.

Many countries lack the data needed to track progress towards the SDGs and national targets, and UNICEF is providing guidance to improve data availability and quality. To address the lack of monitoring tools for tracking SDG 2 in Turkmenistan, UNICEF and the Iodine Global Network convened an inter-agency technical group on monitoring iodine deficiency disorders in 2018, resulting in an action plan for better surveillance at the health system level. As a follow-up, the government allocated funds, re-established a national urinary iodine laboratory, trained laboratory specialists and began data collection. With the support of UNICEF and the Food Fortification Initiative, the government also adopted the “fortification, monitoring and surveillance” approach to track the coverage and impact of the national food fortification programme.

In Nepal, UNICEF and the Ministry of Health and Population released the national micronutrient status survey findings in 2018 and the results were launched as part of a consultation with global experts. The survey – the country’s first in two decades – showed significant improvements in the overall nutrient status of women and children, while challenges remained in tackling anaemia and zinc.
deficiency. Similarly, in the United Republic of Tanzania, UNICEF served as lead technical partner for the National Nutrition Survey conducted in 2018. Preliminary results revealed important improvements in malnutrition since 2014, which surpassed national targets: stunting declined from 35 per cent to 32 per cent; the proportion of children receiving the minimum acceptable diet increased from 20 per cent to 30 per cent; and the exclusive breastfeeding rate increased from 41 per cent to 58 per cent.

Improving workplace support for early childhood nutrition

The return to work after birth can present significant barriers for breastfeeding mothers; however, with supportive workplace provisions, such as paid leave, breastfeeding breaks and designated nursing spaces, women can continue breastfeeding while benefiting from paid employment.

To harness the power of business in fostering enabling environments for breastfeeding and early childhood nutrition, UNICEF established the Mothers@Work programme in Bangladesh in 2017, in partnership with the ready-made garment sector, the Government of Bangladesh and civil society organizations. The programme has strengthened workplace support systems, including access to paid leave, nursing breaks, dedicated nursing spaces and child care, leading to improved breastfeeding practices. The programme was scaled up rapidly from five factories in 2017 to cover 80 ready-made garment factories in 2018, reaching more than 150,000 working mothers and 7,500 children under 2. This expansion was facilitated by a partnership between UNICEF and the International Labour Organization (ILO), through its Better Work Bangladesh programme, and will be further scaled up to reach 200 factories in 2020. UNICEF is also establishing partnerships with the garment association, the employer association and global buyers to eventually reach 2 million women workers in the industry by 2030.

Partnerships between government and business to improve workplace breastfeeding support are also expanding in other countries. Following a 2017 law and 2018 regulation in Uruguay enforcing obligatory breastfeeding rooms in all workplaces, UNICEF and the Ministry of Health developed guidance on implementing the new legislation. To engage the private sector in the Plurinational State of Bolivia, UNICEF launched partnerships with the National Bank of Bolivia (one of the largest banks in the country) and Farmacorp (a pharmaceutical retail chain) under the corporate social responsibility approach to promoting integrated early childhood development, exclusive breastfeeding, flexible work and parental leave. This work is aligned with UNICEF and Ministry of Health efforts to establish a national breastfeeding in the workplace policy. In Kenya, a UNICEF partnership with tea estates in Kericho demonstrated significant improvements in young children’s feeding practices, with exclusive breastfeeding rates in women from participating estates increasing from 20 per cent in 2017 to 80 per cent in 2018.

Leveraging collective action

Developing national strategies for the prevention of all forms of malnutrition

UNICEF supports countries in developing strong national strategies and action plans for the prevention of stunting and other forms of malnutrition. The adoption of a national strategy signals government commitment and is tracked as an indicator in the Strategic Plan. Its effectiveness is measured by having key elements in place, such as government budget allocation and evidence-based nutrition-specific and nutrition-sensitive services provided at scale. Globally, 49 countries had a national stunting prevention strategy with the above criteria in 2018, surpassing the target of 28 countries (SP1.d.3a).

With the launch of the Strategic Plan, many countries have adopted new national strategies for stunting reduction with comprehensive action plans aiming to scale up nutrition services to achieve the SDG global target of a 40 per cent reduction in the number of stunted children globally. Nepal launched a new national Multisector Nutrition Plan with UNICEF support in 308 local governments in 2018 and committed to a 50 per cent increase in financial contributions over the previous year (see Case Study 6). Similarly, in Kenya, UNICEF harnessed stakeholder and government support to establish the 2018–2022 Kenya Nutrition Action plan, which includes nutrition-specific and nutrition-sensitive interventions and strategies for reducing the triple burden of malnutrition (i.e., the coexistence of stunting and wasting, vitamin and nutrient deficiencies, and overweight and obesity). In 2018, UNICEF continued its advocacy and technical assistance with the government with the goal of establishing a high-level multisectoral platform for nutrition as defined in the National Food and Nutrition Security Policy implementation framework.
CASE STUDY 6: Nepal: Boosting national budgets to prioritize stunting prevention

Through implementation of the Multisector Nutrition Plan (MSNP 2018–2022) in Nepal, efforts are being made to accelerate the annual rate of stunting reduction from 3.1 per cent to 4.3 per cent to achieve the Sustainable Development Goal stunting target. UNICEF successfully mobilized US$0.7 million from the federal government and US$2.8 million from local governments to implement the MSNP in 208 local governments. The financial contributions of local governments increased by 50 per cent in 2018/19 over the previous fiscal year.

To reinforce overall nutrition planning, a nutrition in emergency management plan was developed by the Ministry of Health and UNICEF in 2018 to respond to earthquakes, floods and cold waves. All 77 districts have nutrition sector contingency plans, and the terms of reference and operating guidelines of the nutrition cluster and flood contingency plans were revised.

The Ministry of Federal Affairs and General Administration took the lead in integrating the MSNP into local-level planning processes through capacity-building of elected leader and officials. UNICEF helped the ministry train more than 10,000 elected representatives from across the 308 local governments to mainstream actions into local-level plans, policies and budgets, and a declaration of commitment was signed to eliminate malnutrition from their municipalities.

With support from UNICEF, the MSNP was scaled up using nutrition counselling and education for caregivers on breastfeeding; timely introduction of complementary foods; improving the quality and frequency of children's diets; micronutrient supplementation (including micronutrient powders and vitamin A supplements) and deworming for children under 5; and iron and folic acid provision for pregnant and lactating women and adolescent girls. In addition, nutrition-sensitive services were provided by local governments, such as treatment of infections, the promotion of good hygiene and sanitation, early stimulation, prevention of child marriage, improved school health and nutrition, and improving nutritious diets through agriculture and livestock. This was complemented with advocacy, awareness raising and capacity-building on programme planning, prioritization and implementation of nutrition programmes.

To stimulate demand for preventive nutrition services and ensure these services were delivered effectively, UNICEF supported training to build the capacities of more than 29,300 female community health volunteers and more than 12,900 health workers. Government ministries and partners have an improved capacity to legislate, plan and budget for improving nutrition among adolescents, women and children. These efforts have contributed to reducing the prevalence of stunting to 35.8 per cent and reducing the prevalence of severe acute malnutrition to 9.7 per cent. They have also helped establish an enabling environment for nutrition at federal, provincial and local government levels by leveraging resources from government sources and development partners.

UNICEF contributions in building institutional capacity, leveraging funds and coordinating partners have been critical to fostering sustainability in the implementation of the nutrition agenda in Nepal. The partnership with the National Planning Commission and the Ministry of Federal Affairs and General Administration at the federal level and with the rural and urban municipalities at local levels has remained critical in leveraging resources from government and other partners.

With the recent decentralization of the political system in Nepal, responsibility and authority for planning and budgeting has shifted to local governments. This change has challenged nutrition programming due to lack of clarity on roles and responsibilities within different levels of government. The procurement of essential nutrition commodities was also shifted to provincial level, without sufficiently building its capacity to manage logistics; and provincial governments have not been able to initiate the procurement processes thus far, resulting in gaps in essential supplies. In response, UNICEF supported the Ministry of Health and Population by procuring nutrition supplies to prevent supply gaps; and, as a result of UNICEF’s advocacy, the ministry agreed to resume federal procurement of essential nutrition commodities beginning in 2019.
By generating evidence and winning support from governments and stakeholders, UNICEF helped drive improvements in nutrition strategies and approaches in many countries. In 2018, UNICEF commissioned research to help advocate for action to reduce Pakistan’s high rates of stunting and to improve the enabling environment for nutrition. With technical support from UNICEF and World Food Programme (WFP), the Government of Pakistan established a high-level health and nutrition task force and developed a national multisectoral nutrition strategy in 2018. UNICEF provided technical support in developing sectoral plans, derived from the provincial strategies, and worked with the planning commission to track public financing for nutrition in provincial planning and development.

As an increasing number of countries face the problem of childhood overweight, UNICEF is helping countries adopt strategies and actions to address these challenges. For the first time, UNICEF is tracking the number of countries implementing policy actions or programmes for the prevention of overweight and obesity in children (SP1.d.4), defined by the implementation of three or more key actions (see Box ‘Policy and programme actions for the prevention of childhood overweight’). Seventeen countries had such programmes or policies in 2018, surpassing the 2018 milestone of eight countries. UNICEF will aim to support 20 countries in developing such actions by 2021. In Mexico, for example, UNICEF, the Food and Agriculture Organization of the United Nations (FAO) and the Pan American Health Organization established a joint initiative to offer strategic recommendations and actions to the government, including strengthening the current overweight reduction strategy, adopting fiscal measures, promoting clear and understandable front-of-package food labelling, and adopting adequate regulation on the marketing of food and beverages targeted to children.

CASE STUDY 7: Ethiopia: Strengthening policies and leveraging systems for improved nutrition

Ethiopia strengthened its policy environment for stunting reduction in 2018 by leveraging multiple systems to improve children’s access to nutritious foods. With UNICEF’s advocacy and technical and financial support, Ethiopia adopted a Food and Nutrition Policy, developed in collaboration with agricultural, education, social protection, water, sanitation and hygiene and other sectors. It guides food, agriculture and health systems on the adequacy, safety and quality of all forms of foods across the processes of production, importation, processing, distribution and purchase. The policy enshrines access to and use of nutritious foods as a basic human right.

Following continued policy dialogue, the ministries of Agriculture and Natural Resources, Livestock and Fisheries, Trade, and Industry included nutrition-specific and nutrition-sensitive interventions into their annual workplans. UNICEF Ethiopia also worked with the Ministry of Labour and Social Affairs to integrate health and nutrition interventions within the productive safety net programme, with urban and rural settings now mandating nutrition interventions, such as vitamin A supplementation, deworming and malnutrition screening. Together with the Food and Agriculture Organization of the United Nations, UNICEF worked with the Ministry of Agriculture to develop and endorse the Nutrition-Sensitive Agriculture strategy and helped integrate nutrition interventions into agricultural programmes by training more than 2,750 agricultural development agents and 1,596 health extension workers on the linkages between agriculture and nutrition, and the role of the agricultural sector in improving nutrition status in households and communities.

The Government of Ethiopia’s commitment to nutrition was also reflected in the establishment of a Food and Nutrition Council. With UNICEF’s guidance and the leadership of the Ministry of Health, each line ministry developed nutrition-related workplans for the year, enabling budget allocations and expenditures for nutrition to be tracked across various government ministries.
Policy and programme actions for the prevention of childhood overweight

*Criteria for this indicator require the implementation of three or more of these actions:

1. Nutrition education for children, including food skills and food literacy; food skills and literacy education for teachers and catering staff.
2. Food standards in preschool settings that make healthy food available and restrict the availability of unhealthy food.
3. Food standards in school settings that make healthy food available and restrict the availability of unhealthy food.
4. Initiatives to make specific healthy foods available in schools (healthy school meals, school gardens, etc.).
5. Subsidies that promote affordability of nutritious foods among low-income parents with young children.
6. Regulation of unhealthy food marketing to children.
7. Health-related food taxes.
8. Nutrition labels with some form of warning symbol or nutritional rating system.
9. Other (e.g., programmes to improve physical activity in schools).

With the adoption or revision of national strategies, many countries are developing a more comprehensive set of actions to respond to malnutrition, using multiple interventions tailored to the context. For instance, with the updating of the WHO–UNICEF guidelines on infant feeding in the context of HIV, UNICEF has been supporting countries to integrate its recommendations within national policies, particularly in settings with a high prevalence of HIV. As a result of this work, the number of countries that had adopted the guidelines into national policy increased to 52 from 48 in 2017.

Strengthening legislation to improve early childhood nutrition

Along with strengthened national strategies, UNICEF supports governments in adopting new laws and improving existing legislation to promote and protect maternal and child nutrition. Some of these address the marketing of breastmilk substitutes, maternity protection and family leave policies, food fortification legislation, and taxes or restrictions on the marketing of unhealthy foods. Improvements to legislation often take years to come into force, and the process may involve evidence generation, advocacy at all levels, policy dialogue with key stakeholders, and technical assistance and guidance to governments in implementation, monitoring and enforcement.

Strong national policies and legislation are essential to improving breastfeeding practices. The International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions (known together as ‘the Code’) aim to protect and promote breastfeeding by prohibiting the promotion of breastmilk substitutes, such as infant formula, feeding bottles and teats. UNICEF provides technical support to governments to implement the Code through the adoption, monitoring and enforcement of national legislation. In 2018, UNICEF supported the governments of Kenya, Kyrgyzstan, Lao People’s Democratic Republic and South Africa to improve their Code legislation or implement Code regulations, and provided technical support to the governments of the Congo, Mauritania and Somalia to draft new legislation.

Translating the Code into effective national legal, regulatory and other measures, and ensuring proper implementation requires a good understanding of the Code’s provisions. To provide insight into these complexities, UNICEF and WHO developed an online training course for policymakers, legislators, health practitioners and others who advise governments. In West and Central Africa, UNICEF, the International Baby Food Action Network (IBFAN) and WHO hosted a capacity-building workshop on Code implementation and monitoring for government counterparts from the region. In 2018, UNICEF, IBFAN and WHO released their biennial status report on national Code implementation in 2018, which showed that 136 out of 194 countries had some form of legal measure in place covering all, many or a few provisions of the Code in 2018.

Many countries have adopted paid leave of six months or longer to enable exclusive breastfeeding and early stimulation and care, in line with ILO recommendations. Longer maternity leave is associated with lower infant mortality: each month of additional paid leave results in nearly eight fewer infant deaths per 1,000 live births. Through UNICEF advocacy in Nepal in 2018, the safer motherhood bill was endorsed by parliament, stipulating 98 days of paid maternity leave in public and private sectors. The leave can be extended up to one year without pay. In the Philippines, UNICEF successfully advocated for the government to ratify the expanded maternity leave bill in the house of congress, which allows for up to 105 days of maternity leave in the formal sector, compared with the previous 65 days.

Food fortification programmes have limited effectiveness without accompanying policies, laws and enforcement measures. With UNICEF support, 74 countries rolled out large-scale food fortification programmes in 2018. UNICEF
helps governments develop effective legislation and provides technical assistance to governments and industry partners to ensure its implementation. To illustrate, UNICEF conducted evidence-based policy advocacy with the Government of Mongolia to win support for improving food fortification legislation to tackle high rates of micronutrient deficiencies in the country. With UNICEF technical assistance, the Mongolian parliament endorsed a law on fortified food in 2018, mandating the fortification of all imported and domestically produced flour. The Government of Mongolia also allocated funds to scale up a nationwide MNP programme to improve the nutrient content of young children’s diets.

Increasingly, countries are exploring legislation to make nutritious foods more affordable or to dissuade the purchase and consumption of unhealthy foods (see Results Area 2). To improve access to nutritious foods in Burkina Faso, for example, UNICEF worked to win support from the government to adopt tax exemptions on certain nutritious foods as a strategy for preventing malnutrition.

**Leveraging partnerships to transform the nutrition landscape**

Partnerships are critical to galvanizing action to prevent malnutrition in all its forms. In 2018, as in previous years, UNICEF occupied a leadership position (as chair, coordination committee member or board member) in 12 global nutrition initiatives, reflecting its position as a trusted partner in maternal and child nutrition.

A key global partnership is the Scaling Up Nutrition (SUN) movement, which continued to unite global nutrition partners in 2018 with its support for nationally driven efforts to end malnutrition. UNICEF continued to chair the SUN Lead Group, where the UNICEF Executive Director’s leadership set a renewed sense of direction, purpose and urgency for the movement. Under UNICEF’s leadership, the SUN movement ended 2018 with a commitment to driving change towards the SDGs by ensuring that: (1) change is led by national governments with new political will and investments; (2) focus remains on the prevention of
monitoring systems. The scorecard results on monitoring, maternity protection, access to skilled counselling, and actions needed to support breastfeeding, such as funding, countries to track their progress against seven policy released an updated breastfeeding scorecard enabling investments in breastfeeding. In 2018, the Collective of increasing political commitment to and financial 20 members led by UNICEF and WHO with the goal Collective. The Collective is a partnership of more than strategic advocacy through the Global Breastfeeding in improving breastfeeding over the past year as a result UNICEF and its partners continued to make advancements humanitarian–development–peace nexus.

UNICEF and its partners continued to make advancements in improving breastfeeding over the past year as a result of strategic advocacy through the Global Breastfeeding Collective. The Collective is a partnership of more than 20 members led by UNICEF and WHO with the goal of increasing political commitment to and financial investments in breastfeeding. In 2018, the Collective released an updated breastfeeding scorecard enabling countries to track their progress against seven policy actions needed to support breastfeeding, such as funding, maternity protection, access to skilled counselling, and monitoring systems. The scorecard results on monitoring, for example, showed that 40 per cent of countries had collected data on breastfeeding in the past five years.

UNICEF continued to convene more than 40 partner members of the Global Nutrition Cluster (GNC) with the goal of galvanizing partnerships and resources to improve the coordination and quality of emergency nutrition response. In 2018, the GNC supported the coordination of life-saving nutrition in emergencies interventions for 23.5 million people (81 per cent of those targeted) with programmes in 22 countries.

In 2018, UNICEF and GNC partners provided technical support and strategic guidance to countries affected by humanitarian crises, through field missions, document reviews, webinars and capacity-building training, technical and strategic advice; identification of human resources; emergency response team support; and financial support. UNICEF also responded to a long-standing gap identified by GNC partners: the absence of a coordinated approach to providing technical support to countries from the more than 40 GNC partners. To address this challenge, UNICEF established the Global Technical Assistance Mechanism for Nutrition that will provide predictable technical support to GNC partners and governments. As GNC lead agency, UNICEF also hosted a meeting bringing together more than 120 participants from government, civil society, United Nations agencies and donors in more than 30 countries. Meeting outcomes included the identification of bottlenecks to scaling up quality nutrition response during emergencies, ranging from suboptimal infant feeding in emergencies to inadequate linkages between humanitarian and development programming and coordination in different countries.

UNICEF engaged at various levels of the Integrated Food Security Phase Classification in 2018, including as part of the Integrated Phase Classification (IPC) Steering Committee, Technical Advisory Group and Nutrition Working Group. Through this engagement, UNICEF contributed to the development of the IPC 3.0 guidance manual and toolkit, which harmonizes food security and nutrition analysis procedures. UNICEF also contributed to the technical analysis in South Sudan and Yemen, and IPC training across Africa. In its technical support for shaping the World Bank-led Famine Action mechanism, UNICEF positioned itself as a partner of choice given its experience in generating nutrition data and in programming to prevent malnutrition and famine.

Through the new Regional Initiative for Sustained Improvements in Nutrition and Growth (RISING), a partnership with the Bill & Melinda Gates Foundation launched in 2018, UNICEF made advancements in the regional frameworks for preventing malnutrition across Africa and Asia. In 2018, UNICEF catalysed regional economic bodies and other regional platforms and networks, including by establishing new partnerships and strengthening existing partnerships to improve technical and organizational leadership and the scale-up of interventions for improving maternal and early childhood nutrition. In Eastern and Southern Africa, UNICEF strengthened collaboration with regional economic commissions and established partnerships with the Intergovernmental Authority on Development and the Southern African Development Community, among other regional platforms.
Generating evidence to inform policy and programmes

UNICEF continued to be a global knowledge leader in 2018, generating research, using evidence to inform advocacy, policy and programmes, and documenting its experience in scaling up nutrition programmes that help children survive and thrive. UNICEF continued to publish these experiences in its series *UNICEF WINS – Working to Improve Nutrition at Scale*, which shared new programme knowledge, guidance and research on a range of topics in 2018, including IYCF, salt iodization, VAS, and food insecurity.\(^6^4\) UNICEF also published widely in peer-reviewed journals in 2018, expanding the evidence base on maternal and child nutrition with UNICEF contributions in 73 articles.

UNICEF and the Global Alliance for Improved Nutrition convened global experts for a Global Consultation on Food Systems for Children and Adolescents to address the absence of children in the global discourse on food systems and identify actions for redesigning food systems to better address the needs and vulnerabilities of children. The meeting marked an important shift in global approaches to tackling malnutrition and led to the development of a conceptual framework on priority actions for food systems to deliver nutritious, affordable and sustainable diets to children and adolescents.\(^6^5\) Outcomes of the consultation will also inform some of *The State of the World’s Children 2019* report on the theme of children, food and nutrition.

Within the global momentum for making food systems fit for children, UNICEF led the development of a supplement in the *Maternal and Child Nutrition* journal on the theme of ‘Higher Heights: A greater ambition for maternal and child nutrition in South Asia’.\(^6^6\) The supplement contained 16 original research and review articles highlighting the need for a coordinated approach to improving children’s and women’s diets, involving the food, health and social protection systems. The research is the product of knowledge partnerships with five universities and will inform programmatic work by UNICEF and regional partners in South Asia in the lead up to 2030.

As part of the RISING partnership, UNICEF initiated a landscape analysis of complementary feeding programmes to understand the trends and predictors of young children’s diets across four regions, which will inform the development of regional complementary feeding frameworks and programme guidance to scale up improved access to complementary foods and feeding practices across priority countries. UNICEF also led regional mappings of maternal nutrition policies and, with partners, convened 32 country delegations in regional consultations on maternal nutrition in South Asia and West and Central Africa to support improved country-level programmes and regional initiatives on maternal nutrition. These consultations translated into national action plans on maternal nutrition. UNICEF also led mappings in Eastern and Southern Africa and East Asia and the Pacific using comparable methodologies, such that comprehensive information is now available on maternal nutrition policies from four regions – a valuable evidence base from which to design programmes.

UNICEF, together with FAO, International Fund for Agricultural Development, WFP and WHO published the *State of Food Security and Nutrition in the World in 2018*, a report describing global trends in nutrition and world hunger, and analysing climate variability as a key force behind the recent rise in food insecurity.\(^6^7\) To build evidence and inform policy around breastfeeding, UNICEF published reports on the early initiation of breastfeeding, highlighting barriers, missed opportunities and policy recommendations,\(^6^8\) and a report on the situation of children who have never been breastfed.\(^6^9\)
Middle childhood through adolescence is a formative period, when children establish health and nutrition behaviours and habits that can endure into adulthood. Rapid growth and development occur during this time, with adolescents gaining 40–60 per cent of their bone mass and half of their adult body weight. New evidence suggests that ‘catch-up’ growth may even be possible during adolescence following stunting in childhood. Capturing this second opportunity for good nutrition can provide lifelong benefits, such as improved school enrolment, attendance, educational achievement, cognition and a chance to break the cycle of intergenerational malnutrition and ill health.

Globally, there has been insufficient investment in the nutrition of school-aged children and adolescents, with serious consequences for their health, well-being and future potential. Anaemia affects a quarter of all children aged 5–12 years and nearly half of all adolescents aged 15–19, limiting their ability to learn, participate and develop into productive adults. Half of all adolescent girls in low- and middle-income countries are eating fewer than three meals a day. In South Asia and Africa, macronutrient intake is low for many adolescent girls, increasing the risk of these girls being underweight. Globally, the fruit and vegetable intake of adolescent girls is inadequate, with many consuming high-fat and calorie-rich foods that likely contribute to the global rise in overweight. Among children in middle-childhood and adolescence, decreased physical activity and poor-quality diets are the key causes of overweight and obesity.

The Strategic Plan makes a commitment to extending the prevention of malnutrition through adolescence. This means addressing gaps in adolescent nutrition knowledge and programming to ensure that children continue to thrive throughout the life course. For the first time, UNICEF is treating adolescent health and nutrition in a separate
results area within the current Strategic Plan, under Output 2 – Countries have developed programmes to deliver gender-responsive adolescent health and nutrition, and both health and nutrition programming contribute to achieving this result. By 2021, UNICEF intends to reach at least 100 million adolescent girls and boys annually with services to prevent anaemia and other forms of malnutrition, including undernutrition and overweight. This work is in line with the UNICEF Gender Action Plan, 2018–2021; it also supports the first objective of the UNICEF strategic framework for the second decade: to maximize adolescents’ physical, mental and social well-being.78

With the Strategic Plan, UNICEF has enhanced its focus on the nutrition of school-aged children and adolescents as its own objective, recognizing good nutrition as a human right, an opportunity to prevent the onset of diet-related non-communicable diseases, and a prerequisite for lifelong health and well-being. Evidence also shows that investments in adolescents generate high economic and social returns, yielding triple dividends in improved adult health, potential and future trajectory.79,80

To be effective, nutrition programmes often require more than one delivery platform and an integrated system of delivery. For example, actions to encourage consumption of healthy diets can include nutrition education in schools and communities, nutrition counselling through health services, improved food environments within schools and communities (via healthy food choices and restricted access to unhealthy foods and sugar-sweetened drinks), increased agricultural production at the household level, and reduction of unhealthy food marketing and advertising.

Given that adolescent nutrition is a somewhat new area for UNICEF and the global nutrition community, year one of the Strategic Plan involved laying the groundwork for programme design and eventual scale-up. This included the development of learning compacts with selected regional and country offices to generate knowledge and collect quality, comprehensive nutrition data for future action (described further in the results sections below). There is a paucity of nutrition data on adolescents; UNICEF is collaborating with global partners to fill this gap and improve the availability and quality of data on adolescent nutrition.

### Table 17: Outcome results for adolescent health and nutrition, 2018

<table>
<thead>
<tr>
<th>Outcome indicator (+ key United Nations partners)</th>
<th>Baseline</th>
<th>2018 value</th>
<th>2021 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.12. Percentage of girls aged 15–19 with anaemia</td>
<td>48%</td>
<td>46.6%</td>
<td>36%</td>
</tr>
</tbody>
</table>

### Table 18: Output results for adolescent health and nutrition, 2018

<table>
<thead>
<tr>
<th>Output indicator</th>
<th>Baseline</th>
<th>2018 value</th>
<th>2018 milestone</th>
<th>2021 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.i.1 Number of adolescent girls and boys provided with services to prevent anemia and other forms of malnutrition through UNICEF-supported programmes</td>
<td>40 million</td>
<td>58 million</td>
<td>55 million</td>
<td>100 million</td>
</tr>
</tbody>
</table>

### Improving services and community demand

#### Laying the foundations for effective adolescent nutrition programming

In the first year of the Strategic Plan, UNICEF explored approaches and consolidated global learning on improving the nutrition of adolescents. Over the next three years, this evidence and experience will inform adolescent nutrition programmes across 49 country offices and strengthen gender dimensions in the programme narrative. To better understand how countries are already engaging in this work, UNICEF mapped adolescent nutrition programmes in 10 countries (Afghanistan, Bangladesh, Cote d’Ivoire, Ethiopia, Ghana, India, Indonesia, Nepal, Nigeria and the United Republic of Tanzania) to examine current practices and opportunities. The mapping underscored the components of gender-responsive adolescent nutrition programming and highlighted valuable programme experience at all stages, from pilot to scale-up.

In 2018, UNICEF also began developing programming guidance for the nutrition of adolescents and for the nutrition of school-aged children, to be published in 2019. The guidance for adolescents aims to identify an evidence-based package of interventions for the prevention of all forms of malnutrition delivered to children between the
ages of 10 and 19 years; provide technical and operational guidance for implementing interventions; and identify synergies with other sectors, including education, health, WASH and social protection, to improve nutrition outcomes among girls and boys. The guidance also provides strategies for addressing the nutritional needs of school-aged children and adolescents in emergencies, an area which has been somewhat neglected in emergency nutrition protocols.

Participation is a key pillar of UNICEF adolescent programmes and the organization is exploring ways to allow adolescents to participate in the design and implementation of nutrition programmes. In partnership with Nutrition International in the United Republic of Tanzania, UNICEF hosted a consultation with government and adolescents from 13 regions who shared their priorities, their perspectives on the factors influencing their nutrition behaviours and access to services, and their views on the most effective platforms for reaching adolescents. The information gathered through the consultation will inform the design phase of the country’s adolescent nutrition programme. In Indonesia, UNICEF designed its adolescent nutrition programme based on a combination of quantitative and qualitative research. This included qualitative inquiry using the ‘reality check approach’, which gathered the perspectives of adolescents, their families and communities on factors influencing their behaviours around eating, drinking and physical activity. This approach minimizes the power distance between researchers and participants, allowing researchers to explore topics from the perspectives of young people themselves and interact with them informally in their home environments to gain valuable insights.

Scaling up essential nutrition services for adolescents

Globally in 2018, UNICEF collaborated with national governments in 30 countries and seven regions to roll out comprehensive programmes to improve the quality of diets and the nutritional status of adolescents. These programmes promoted improved access to information, education, counselling, services and commodities.

Anaemia increases the risk of disease and disability, results in poor productivity and is an indicator of both poor nutrition and poor health in adolescents. As a key indicator of nutritional health and well-being, UNICEF tracks the percentage of girls and young women aged 15–19 with anaemia (SP1.21). In 2018, anaemia affected 48 per cent of this group globally, and UNICEF aims to reduce this figure to 36 per cent by 2021. Iron and folic acid supplementation is the leading intervention for tackling anaemia in adolescent girls and boys globally. Fifty-eight million adolescent girls and boys were reached with services to prevent anaemia and other forms of malnutrition in 2018 through UNICEF-supported programmes, surpassing the 2018 milestone of 55 million (SP1.i.1).
There have been important achievements at the national level in large countries, such as India, which has been scaling up its anaemia control programme country-wide over a number of years. In 2018, there were 44.2 million adolescents benefiting from iron and folic acid supplementation as part of the nation-wide anaemia control programme (see Case Study 8). Similarly, Afghanistan’s weekly supplementation programme reached 1.16 million eligible girls and young women aged 10–19 years (89 per cent) in 2018. The programme is included in the country’s School Health Policy, which was finalized with UNICEF technical support in 2018.

In countries facing a double or triple burden of malnutrition, nutrition programming for adolescents should involve a package of interventions to prevent nutrient deficiencies and address the rise of overweight and obesity, using gender-responsive approaches. This is happening in

**CASE STUDY 8: India: Strengthening institutional capacity to improve the nutrition of adolescents and women**

National efforts to improve the nutrition and health of adolescents and women in India received renewed political and programmatic focus in 2018 with the launch of the National Nutrition Mission (Poshan Abhiyaan). As part of efforts to strengthen institutional support mechanisms, the Government of India, with UNICEF support, established three national centres of excellence to provide technical and policy guidance on: (1) anaemia control; (2) improving women’s diets; and (3) social-led action by women’s collectives.

The national centre for anaemia control provides training, supportive supervision and operational research on anaemia. While India was already home to the largest adolescent anaemia control programme in the world, support from the centre and UNICEF in 2018 helped improve the programme’s quality and coverage. In 2018, iron and folic acid supplementation was provided to 26.3 million adolescent girls and young women, compared with 14.7 million in 2017. Of the 6.5 million pregnant women registered for antenatal care, 5.3 million (86 per cent) received iron and folic and acid supplementation across 14 UNICEF-supported states. Of these states, only 52 out of 475 districts (11 per cent) reported a stock-out of tablets for adolescents in 2018 and no district reported stock-outs of tablets for pregnant women.

UNICEF worked with the Ministry of Health to develop the Anaemia-Free India Initiative in 2018, with operational guidelines and a reporting dashboard that tracks iron and folic acid stocks, coverage of supplementation and other interventions, and progress towards targets. The initiative ensured the pre-positioning of iron and folic acid supplies, improved reporting and resulted in the establishment of a national programme management unit for anaemia.

The national centre on women’s diets convened two national technical consultations on strengthening maternal nutrition through health systems, in collaboration with development partners. This partnership led to the development of a maternal nutrition package, which is being field-tested with 21 development partners. The centre also helped develop maternal diet norms for hospitals, which were released in September 2018. To improve maternal nutrition for the most vulnerable women, the UNICEF-supported ‘one full meal’ programme provided pregnant and breastfeeding women with a free nutritious daily meal at village anganwadi centres, as well as supplementation and nutrition counselling (described earlier in Results Area 1).

In 2018, the national centre of women’s collectives supported the nationwide roll-out of the Swabhimaan initiative, which integrates essential nutrition interventions for more than 6,000 adolescents and women within the national livelihoods and economic empowerment initiative in three eastern states with high rates of undernutrition. In 2018, the programme was scaled up to 14 blocks in three states, from five previously, and will be expanded country-wide through a phased process.

The wide range of partnerships forged between UNICEF, government and various academic institutions and development partners has been critical to accelerating progress on addressing anaemia and improving access to nutritious diets for women and adolescents in India.
Indonesia, where UNICEF and the government designed an integrated package of nutrition-specific and nutrition-sensitive interventions to improve the nutrition of around 70,000 adolescent girls and boys. This includes a social behaviour change communication strategy to improve dietary and physical activity behaviours. A series of multisectoral gender-sensitive learning materials and tools was developed to improve the knowledge and attitudes of adolescents on healthy eating and physical activity, as well as child marriage, adolescent pregnancy, and access to reproductive and family planning services. These interventions will be delivered together with the weekly iron and folic acid supplementation, which is already a national programme, and tested in two districts in 2019 to generate robust local evidence to support scale-up of adolescent nutrition programmes.

Leveraging schools as a platform, UNICEF supported a number of countries in delivering high-impact nutrition interventions within the education system. In 2018, UNICEF supported school-based nutrition programmes in 31 countries. In Ethiopia, the collaboration between the health, nutrition and education sectors was reinforced through UNICEF support in the development of a school health and nutrition programme service package and a training manual for schools at all levels. UNICEF supported the development of a training course on the Adolescent and Youth Health Strategy to strengthen adolescent-sensitive interventions. The continued shift from campaigns to regular service provision at every contact point resulted in reduced coverage, as the latter is dependent upon demand from the users of the health and nutrition services. UNICEF Ethiopia strove to address this challenge by advocating for increased community awareness, demand creation and service quality assurance, with a view to improving service uptake. Through UNICEF-supported adolescent deworming campaigns, more than 1.6 million adolescents received the first dose of deworming medication in 330 selected woredas with high prevalence of intestinal worms.

Building stronger Institutions

Improving the school nutrition environment

The world is moving closer to the goal of universal primary education and there are more children and adolescents attending school than ever before. There are generally more schools than health facilities, especially in rural and deprived areas. While schools have traditionally been an under-used platform, they offer important opportunities to reach school-aged children and adolescents with nutrition education and healthy food environments, micronutrient supplementation and deworming, feeding programmes, and physical activity programming. Schools can also help incentivize school enrolment, delay marriage, increase educational attainment, improve consumption of nutritious foods, and allow targeting of the poorest households. Indeed, trained teachers have been able to treat children for common infections and provide micronutrient supplements to students at low financial cost within health and nutrition education.

With the rise in overweight in many countries, UNICEF is supporting governments to establish national policies to make school food environments more conducive to healthy diets and to equip children and adolescents with the nutrition knowledge to make positive food choices. Overweight is a significant problem facing children and adolescents in Bosnia and Herzegovina, where UNICEF supported the expansion of the government’s Nutrition-friendly School Initiative to four primary schools in two cities. The expansion improved the eating habits of more than 400 primary school children and equipped 170 parents with skills to prepare healthier school meals and 35 teachers with tools to deliver education sessions on healthy eating. Similarly, UNICEF helped the Maldives Ministry of Education design nutrition interventions to address the findings of the 2017 school health screening programme. This included guidance to develop a School Nutrition Policy, a food-based dietary guide and a manual to support school health officers to run nutrition education sessions to improve nutrition literacy and demand. UNICEF is piloting these tools in five schools in different regions, in partnership with the Society for Health Education.

While schools are an effective platform that should be leveraged wherever possible, they are not sufficient to reach all children and adolescents. Many of the most vulnerable children and adolescents do not attend school, and it is therefore critical that other delivery platforms—such as community and social groups, the health system and other platforms—be used to reach them. India’s nationwide anaemia control programme offers one of the most powerful examples of effective strategies for reaching out-of-school adolescents. Using existing anganwadi centres, India has been able to extend iron and folic acid supplementation to some of the most vulnerable adolescent girls in the country (see Case Study 8). In Guatemala, UNICEF reached 7,000 adolescents outside the school system using a peer model to promote healthy food practices and provided iron and folic acid supplementation to more than 3,000 adolescent girls in 25 townships.
Strengthening national capacities to deliver essential nutrition interventions

The success of adolescent nutrition programmes will depend on having strong institutional capacity to deliver high-impact nutrition programmes. This will be an important part of UNICEF’s support to governments in operationalizing its new guidance on adolescent nutrition and may involve advocacy and technical assistance for training teachers, health workers and other providers, developing and improving curricula and producing training materials.

Nepal made important advancements in systems strengthening between 2016 and 2018, developing and implementing its weekly supplementation programme for adolescent girls with UNICEF support. The programme tackles the country’s high rates of stunting and anaemia as part of the focus on adolescent nutrition in the country’s National Multisector Nutrition plan (MSNP). The weekly supplementation programme for adolescent girls was first piloted in 2016/17 and, through a partnership with the United States Agency for International Development (USAID) and UNICEF’s technical leadership, the programme expanded to 30 districts by 2018 (see Figure 27). More than 1.1 million adolescent girls and young women aged 10–19 years (81 per cent of those targeted) were reached with iron and folic acid supplementation, deworming and nutrition education as a result of this initiative. Training sessions were conducted to enhance the knowledge and skills of 308 health coordinators, 308 education resource persons and more than 17,700 community health volunteers to deliver the programme, and adolescents were reached using multiple platforms, including schools, health-care facilities and communities. UNICEF work in this area in Nepal has been supported by funding from the European Union, USAID, and the governments of the Netherlands and Norway, among others. Efforts are under way to leverage additional resources from the Government of Nepal and other stakeholders to scale up the programme nationally by 2022.

Leveraging collective action

Strengthening policies to protect adolescent nutrition

Governments bear ultimate responsibility for preventing malnutrition and ensuring that adolescents achieve optimal nutrition and health. Through policy and guideline development and implementation, the adoption of effective legislation and multisectoral coordination, UNICEF supports governments in fostering an enabling environment where adolescents survive and thrive. According to the most recent data from NutriDash, 29 countries had implemented a communication strategy to improve knowledge, attitudes and practices of adolescents on nutrition and healthy diets;
37 countries had a national coordination mechanism to monitor and review actions for improving the nutrition of school-aged children and adolescents; and 39 countries had implemented a strategy for reaching out-of-school adolescents with nutrition services.

Malawi’s national multisector nutrition policy and strategy were finalized in 2018, including a national nutrition education and communication strategy and a 2019–2023 national strategic plan for adolescent nutrition. UNICEF advocated with the government and provided technical and financial assistance to develop this national policy framework, which focuses on improving adolescent nutrition and takes a life-cycle approach to social behaviour change communication to address stunting.

The frameworks address the prevention and treatment of adolescent nutritional disorders, empowerment for improved nutrition and access to livelihoods, and positive behaviour change for improved nutrition.

In Nigeria, UNICEF engaged the government at federal and state levels to design an adolescent nutrition strategy and piloted iron and folic acid supplementation for adolescents in two states in 2018. In Indonesia, UNICEF analysed the extent to which adolescents were considered in national nutrition policies and identified opportunities for action through the scale-up of district-level policies and improved coordination mechanisms across sectors.85

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**CASE STUDY 9: Ghana: Adolescent nutrition programmes to keep girls anaemia-free**

The Girls’ Iron and Folic Acid Tablet Supplementation (GIFTS) programme in Ghana is the first adolescent nutrition programme in sub-Saharan Africa that leverages education and health systems to achieve results. Adolescent girls and boys receive educational information on nutrition behaviours and practices, while girls receive weekly iron and folic acid supplements. In 2018, more than 448,500 girls across four regions received supplements to prevent anaemia.

Phase I of this integrated school-based adolescent nutrition and health programme was rolled out between 2017 and 2018 and involved four regions. An impact evaluation in 2018, led by the US Centers for Disease Control, assessed programme performance across 60 schools in the Northern and Volta regions. The evaluation showed positive results, including a 26 per cent reduction in anaemia levels among targeted girls within the first 12 months of the programme and an overall programme coverage of more than 90 per cent in all 91 districts of the four regions. Also, marked changes were reported for the intake of the various food groups. In the overall population, the reported consumption of dark leafy vegetables increased by 12 percentage points (31.7 per cent to 43.7 per cent), and consumption of red meat increased by 6 percentage points (15.7 per cent to 21.8 per cent).

From October 2017 to July 2018, the programme was implemented in all eligible schools in all four regions. School health educators and teachers delivered the intervention package to adolescents throughout the academic year. The package included iron and folic acid supplementation, and education on health and nutrition in anaemia, malaria prevention and safe water, hygiene and sanitation. Tablets were consumed once a week by each student and data were recorded in the GIFTS register by teachers. Out-of-school adolescents were reached through the health system, with tablets provided at their health contact point.

UNICEF is using routine monitoring data and the evaluation results to advocate for the government to scale up GIFTS to the remaining six regions of the country as part of phase II in 2019.
In regions with high levels of overweight, such as Latin America, UNICEF is helping countries strengthen policies and strategies to improve the food environment for children and adolescents. With support from Beko, UNICEF began implementing a programme to improve diets and prevent overweight and obesity among school-aged children in Brazil, Colombia, Costa Rica, Cuba, Ecuador and Mexico. The programme aims to strengthen national policies, strategies and legislation, develop school standards and interventions, and expand knowledge and evidence on the prevention of overweight and obesity in Latin America.

Some governments are developing specific policies on the marketing of unhealthy foods for children and adolescents with UNICEF support (see Case Study 10). Similarly, in Guatemala, UNICEF contributed to the development of the National Strategic Plan for the Prevention of Overweight and Obesity and provided technical support to the government to improve the Health and Nutrition Surveillance System.

Generating data and evidence on school-aged children and adolescents

With the inclusion of the nutrition of school-aged children and adolescents as one of UNICEF’s organizational nutrition priorities, many countries used 2018 as an opportunity to build the knowledge base for this results area as a

CASE STUDY 10: Argentina: Strengthening policies and legislation to prevent overweight

Overweight and obesity affect more than 28 per cent and 6 per cent of adolescents, respectively, in Argentina. In 2018, UNICEF and other experts provided policy advice to the Government of Argentina to develop an inter-ministerial national plan to prevent child overweight and obesity, which is expected to receive official approval in 2019.

In collaboration with the Pan American Health Organization, UNICEF provided technical and political support to the Ministry of Health to put the need for food labelling on the national agenda. UNICEF also advised legislators on the best evidence-based regulations to prevent child and adolescent obesity. To generate national evidence to inform this work, UNICEF supported the National Directorate of Health Promotion and Control of Noncommunicable Diseases in developing an innovative report compiling new data on overweight in children and adolescents in the country. The report is expected to increase public awareness and provide knowledge to strengthen policy design.

UNICEF also improved coordination and civil society engagement on the issue by helping to expand the national NGO coalition for the prevention of childhood and adolescent obesity, which gained 12 new members in 2018. To influence public policy and boost communication among new members, the Coalition, with UNICEF support, published recommendations on healthy school environments in Argentina and launched an interactive online platform (<http://unicefcampusvirtual.org.ar>).

Argentina has no regulations addressing the prevention of child and adolescent obesity, and industry pressure against such regulations is strong. UNICEF is working with the Secretary of Health, as well as legislators and civil society, to build political will for stronger regulations in a context of rapidly rising rates of overweight and obesity.
foundation for future advocacy and programming. In China, for example, UNICEF commissioned an analysis of food types and eating patterns of students in 67 schools in eight cities, and a report on the consumption of sugar-sweetened beverages in the country was released by the National Health Commission. Recommendations from this report will inform UNICEF advocacy for the scale-up of high-impact interventions, policies and guidelines on the control of childhood overweight and obesity. Similarly, in Mexico, UNICEF financed and managed the evaluation for the government’s school feeding programme at the request of the Ministry of Education. This programme offers meals to children in areas of high poverty and vulnerability – often the only daily meal children receive. The study aimed to evaluate the programme’s adequacy and implementation performance, identifying key bottlenecks such as limited infrastructure for delivering feeding services and limited adoption of hygiene protocols for safe food delivery, which will be addressed with government ministries.

At the global level, UNICEF is working to close the gaps in global evidence on the nutrition of school-aged children and adolescents. In 2018, UNICEF joined a global call to action on adolescent nutrition through the USAID Strengthening Partnerships, Results, and Innovations in Nutrition Globally project (SPRING) and other partners under the theme ‘Better data now to drive better policies and programmes in the future’. To address some of the prevailing data gaps, UNICEF collaborated with global organizations and partners to establish a Technical Advisory Group on metrics related to the nutritional status and practices of school-age children and adolescents, and contributed to developing a global monitoring framework for middle childhood and adolescence. In addition, country offices were supported to establish strong monitoring mechanisms to assess service delivery, use data for evidence generation, and inform scale-up of adolescent nutrition programmes.

Overweight and obesity among children and adolescents is an emerging concern for public health in Costa Rica, according to data from the first weight and height school census, supported by UNICEF. To gather more information, UNICEF collaborated with the Ministry of Health, the Ministry of Public Education and the Costa Rican Social Security Fund to design and implement the national survey on nutritional oversight and physical activity in high schools, which will guide strategies to improve the lifestyles of children and adolescents. As part of the national survey on women, children and adolescents, and supported by the National Education and Nutrition Centers, UNICEF helped develop an anthropometric model for children under 5 years of age, which will yield better information on the factors associated with childhood obesity and support the development of models, interventions and prevention strategies. These activities were coordinated within the SUN movement framework.
Results Area 3: Treatment and care of children with severe acute malnutrition

When efforts to prevent undernutrition fall short, undernourished children need urgent treatment and care to save their lives and set them on the path to survival and healthy growth and development. Children suffering from severe wasting, the most common form of severe acute malnutrition (SAM), have weakened immune systems, making them more susceptible to death, disease and developmental delays, risks that increase as the severity of wasting increases. The early detection, treatment and care of children with SAM is therefore critical to the goal of ensuring that every child survives and thrives (see Box ‘The UNICEF approach to the care and treatment of children with severe acute malnutrition’).

Children who are both stunted and wasted face multiple threats to their survival, growth and development, including a 12-fold greater risk of death than their well-nourished peers. While wasting is often considered an acute condition that can be treated and reversed, new evidence shows that the effects of wasting may also slow linear growth and contribute to stunting, highlighting the links between these two forms of malnutrition.87 The early detection and treatment of children with SAM is thus emerging as an important contributor to stunting reduction, and greater understanding of this relationship will help optimize treatment outcomes and accelerate progress towards the SDG target of ending preventable deaths in children under 5.

The Strategic Plan commits to prioritizing early detection and care for children with SAM in all contexts through Output 3: Countries have accelerated the delivery of services for the treatment of severe wasting and other forms of severe acute malnutrition. Under this results area, UNICEF aims to ensure that by 2021, at least 6 million children with SAM will access life-saving treatment and care.
UNICEF works with governments and partners to scale up treatment and care for children with SAM and advocates for governments to recognize SAM as a critical public health priority both within and outside of emergencies. UNICEF also supports governments to integrate the care of children with SAM into national health systems and strengthen the delivery of life-saving nutrition supplies to the children who need them most.

The UNICEF approach to the care and treatment of children with severe acute malnutrition

Severe wasting and other forms of severe acute malnutrition (SAM) are the life-threatening consequence of hunger, poor nutrient intake and disease. Timely therapeutic treatment and care is critical to save lives. For UNICEF, care for children with SAM involves a combination of therapeutic foods, drugs to treat infection and individualized care, which can help return the child to healthy growth and development. Counselling for caregivers is also important to improve feeding practices, hygiene, stimulation and other household practices that can help prevent undernutrition. Communities can play an important role in identifying and caring for children with SAM. Today, with the support of health workers, community resource persons and access to ready-to-use therapeutic foods, more than 4 million children with SAM are receiving care every year within their own homes and communities.

The number of children with SAM can increase dramatically as a result of conflict, climate-related disasters and other humanitarian situations, making the early detection and treatment of children with SAM an essential component of effective emergency response. UNICEF and the Global Nutrition Cluster delivered emergency nutrition services to children and women in 59 countries affected by humanitarian crises in 2018, and supports governments in planning and preparing for emergencies, including by developing risk-informed programmes that are ready to be scaled up and down in relation to needs. At the same time, two thirds of all children affected by SAM globally live in non-emergency settings, where poverty is widespread and where basic services, clean drinking water and nutritious, safe and affordable diets are out of reach. It has been historically challenging to mobilize resources and national commitments to address SAM in these contexts, leaving far too many children without the care they need. In line with the SDG call to leave no child behind, the UNICEF Strategic Plan commits to accelerating progress to reach more of these children with life-saving treatment to survive and thrive.

The number of children being treated for SAM has continued to rise in recent years. (see Figure 28). Countries have made important progress in strengthening national protocols on the treatment of children with SAM and scaling up services to treat greater numbers of children. Yet the gap between the number reached and those still in need of care remains unacceptably wide. Only a quarter of children with severe wasting globally have access to treatment; in Asia, the proportion drops to 5 per cent.

FIGURE 28: Percentage of children with SAM treated versus those in need, by region, 2013–2017

<table>
<thead>
<tr>
<th>Region</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern and Southern Africa</td>
<td>54%</td>
<td>51%</td>
<td>42%</td>
<td>33%</td>
<td>6%</td>
</tr>
<tr>
<td>Middle East and North Africa</td>
<td>54%</td>
<td>51%</td>
<td>42%</td>
<td>33%</td>
<td>6%</td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>54%</td>
<td>51%</td>
<td>42%</td>
<td>33%</td>
<td>6%</td>
</tr>
<tr>
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<td>54%</td>
<td>51%</td>
<td>42%</td>
<td>33%</td>
<td>6%</td>
</tr>
<tr>
<td>Eastern Europe and Central Asia</td>
<td>54%</td>
<td>51%</td>
<td>42%</td>
<td>33%</td>
<td>6%</td>
</tr>
<tr>
<td>South Asia</td>
<td>54%</td>
<td>51%</td>
<td>42%</td>
<td>33%</td>
<td>6%</td>
</tr>
<tr>
<td>East Asia and the Pacific</td>
<td>54%</td>
<td>51%</td>
<td>42%</td>
<td>33%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Source: NutriDash, 2017
Resources to tackle the immense burden of SAM in these contexts are especially limited, compared with the funding available to treat SAM in emergencies. Global momentum to shift these trends is greater than ever with the launch of the No Wasted Lives coalition (see ‘Leveraging collective action’) and will be critical to ending preventable deaths and achieving the goals of the 2030 Agenda. Greater investments in the prevention of malnutrition, as described under Results Area 1, are also critical to support healthy growth and development, thereby reducing the number of children affected by SAM in the first place.

Output and outcome indicators for treatment and care of children with severe acute malnutrition

| TABLE 19: Outcome results for treatment and care of children with severe acute malnutrition, 2018 |
|---------------------------------|---------------------------------|---------------------------------|
| Outcome indicator (+ key United Nations partners) | Baseline | 2018 value | 2021 target |
| 1.17. Percentage of children with severe acute malnutrition: | | | |
| (a) who are admitted for treatment and default; | | | |
| (b) who are admitted for treatment and recover, through UNICEF-supported programmes (FAO, WFP, WHO) | | | |
| 9% | 8.4% | <15% |
| 84% | 82.2% | >75% |

| TABLE 20: Output results for adolescent health and nutrition, 2018 |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Output indicator | Baseline | 2018 value | 2018 milestone | 2021 target |
| 1.e.1. Number of children with severe acute malnutrition (SAM) who are admitted for treatment | 4.2 million | 4.1 million | 4.5 million | 6 million |
| 1.e.2. Number of countries that provide care for children with SAM as part of an essential package of regular health and nutrition services for children | 24 | 24 | 11 | 25 |

Improving services and community demand

Delivering life-saving treatment and care

When malnutrition persists despite prevention, UNICEF prioritizes the early detection and treatment of children with SAM as a life-saving intervention. In 2018, UNICEF supported the scale-up of services to treat and care for children with SAM in both development and emergency contexts in 73 countries, compared with 67 in 2017. With UNICEF support, more than 4.1 million children were reached with treatment in 2018; of whom, 82 per cent fully recovered, exceeding the quality targets set in the Strategic Plan (SP1.17b). UNICEF aims to increase the number of children with SAM receiving therapeutic treatment and care to 6 million annually by 2021.

UNICEF is the leading global supplier of ready-to-use therapeutic foods (RUTF) to treat children with SAM, procuring between 75 and 80 per cent of RUTF globally.91 In 2018, UNICEF procured 47,763 metric tons of RUTF for 18 countries: the bulk was sourced from programme countries in 2018, in line with the UNICEF supply objective to use local products and improve access to supplies at country level.

Increasingly complex emergencies occurred throughout 2017 and into 2018, including those characterized by food crises and near-famine conditions. When access to preventive nutrition and health services breaks down during emergencies, rapid detection, treatment and care for children with SAM is critical. In the context of humanitarian crises and fragile contexts, 3.4 million children with SAM were treated in 2018, with 88 per cent of them recovering (SP1.e.1).93 The greatest numbers of children were treated in Afghanistan, Chad, the Democratic Republic of the Congo, Ethiopia, Nigeria, the Niger, Somalia, South Sudan, the Sudan and Yemen.

UNICEF also supported governments to scale up care for children with SAM living in non-emergency contexts, advocating for greater investments and commitments from governments to prioritize the prevention and treatment of SAM and strengthen systems to better reach the most vulnerable children (see ‘Building stronger institutions’ below and Case Study 11).
Strengthening community efforts to identify and treat children with SAM

UNICEF works with governments to decentralize care to the community level and reach more children with SAM by ensuring that RUTF can be distributed through local health centres and that children can be cared for within their own communities. When community health workers are trained to screen and identify children with acute malnutrition, they can refer them for treatment and prevent their condition from deteriorating.

The United Nations first endorsed the community-based management of SAM in 2007 as the recommended approach for treating children with uncomplicated cases of SAM within the community. The number of countries implementing such community approaches continues to rise, increasing from 50 to 56 according to the most recent 2017 estimates. Thirty-one countries implemented SAM treatment through community health workers, including providing screening, treatment, tracking and follow-up on referrals.

CASE STUDY 11: Democratic People’s Republic of Korea: Evaluating the scale-up of services to treat children with severe acute malnutrition

About 200,000 children under 5 years of age in the Democratic People’s Republic of Korea were estimated to be affected by undernutrition in 2018. Around 60,000 of these children were suffering from severe acute malnutrition (SAM). With UNICEF support, the Ministry of Public Health successfully treated 55,000 children with SAM and moderate acute malnutrition within provincial paediatric and county general hospitals in 189 out of 210 counties. Of these children, 99 per cent fully recovered.

Nutrition-specific preventive and curative services were provided in the 189 hospitals and treatment sites, including mid-upper-arm circumference screening; early referral for treatment of wasting; counseling and support on infant and young child feeding and caring practices; and vitamin and mineral supplementation with multiple micronutrient powders. UNICEF provided technical assistance to develop an integrated training package for health workers on the community management of acute malnutrition (CMAM), child feeding and micronutrient deficiencies. Around 600 paediatricians, nurses and doctors were trained on the package with UNICEF support.

An external evaluation of the country’s CMAM programme was conducted in 2017, with the programme receiving the highest possible quality rating. In 2018, a two-year action plan to address the recommendations of the evaluation was developed under the leadership of the Ministry of Public Health, with the support of UNICEF, World Food Programme, World Health Organization and other stakeholders. The CMAM evaluation report and the management response to its recommendations were both endorsed and launched in 2018. The management response plan includes a comprehensive review of CMAM programme guidelines and treatment protocols, which will enhance programme efficiency and improve access to treatment for malnourished children living in remote areas.

Despite significant achievements there are still too many children suffering from acute malnutrition in the Democratic People’s Republic of Korea. UNICEF will continue to support early identification and treatment of acute malnutrition through existing Ministry of Public Health systems at provincial, county and village levels. Efforts are under way to strengthen nutrition capacity through trained and empowered provincial CMAM focal points at county and village levels.
Community innovations – such as training mothers to screen their children for SAM using mid-upper-arm circumference (MUAC) measurements – also hold promise for reaching more children in need. In Mali, the ‘MUAC-by-mothers’ approach reached more than 19,100 mothers in one health district, allowing for the identification and referral of 2,806 children with moderate acute malnutrition (MAM) and 520 cases of SAM. To complement large-scale SAM screening campaigns in the Niger, UNICEF partnered with the Ministry of Health, WFP and the NGO ALIMA to scale up a ‘MUAC-by-mothers’ approach, targeting 800,000 women of child-bearing age in Maradi, one of the regions with the highest numbers of children with SAM in the country. The programme covered seven out of nine health districts, training more than 680,000 women on recommended child feeding practices and the use of MUAC techniques to detect SAM.

CASE STUDY 12: Somalia: Community innovations to deliver care to children with severe acute malnutrition from the most vulnerable households

Despite overall improvements in the food security situation in Somalia, humanitarian needs remained acute in 2018, with global acute malnutrition remaining above the 15 per cent World Health Organization ‘critical’ threshold. UNICEF and partners delivered life-saving care to more than 220,700 children with severe acute malnutrition (SAM), representing 87 per cent of children with SAM nationally. The programme achieved treatment outcomes above global standards: 95 per cent of children who were discharged had fully recovered. These achievements were fuelled by the scale-up of community-based innovations to improve the early detection and referral of children with SAM, improved supply and distribution of treatment supplies, and investments in resilience.

To improve early detection, referral and treatment of children with SAM and address barriers to accessing nutrition services, UNICEF and partners implemented the ‘mother-led mid-upper-arm circumference (MUAC)’ initiative, in which mothers and caretakers from marginalized communities were trained to screen and refer malnourished children to health services. UNICEF recognizes that while mothers play a key role in caregiving in Somalia, it is equally important to shift gender norms and encourage fathers to play a role in children’s nutrition. Therefore, in 2019, UNICEF will train male family members to identify wasting and trigger referrals to nutrition services.

In 2018, UNICEF procured and delivered more than 3,000 metric tons of supplies, including more than 231,400 cartons of ready-to-use therapeutic foods (RUTF), which were dispatched through a network of UNICEF warehouses. A review of the integration of SAM and moderate acute malnutrition (MAM) treatment services showed gaps, particularly in the north-eastern, central and southern areas. In response, UNICEF and the World Food Programme (WFP) collaborated to treat MAM with RUTF in districts where UNICEF has an operational presence in the absence of a WFP targeted supplementary feeding programme. This approach, known as the ‘expanded admission criteria’, allowed UNICEF to treat almost 8,000 children with MAM in 2018.

UNICEF has made notable efforts to ensure longer-term impacts of nutrition interventions at all levels, enhance the capacity of households and communities to bounce back from recurrent shocks, and increase the demand for nutrition services. Supported by UNICEF, more than 900 community health workers delivered preventive nutrition services, including screening, identification and referral of children with SAM, and counselling of mothers on optimal child feeding practices. In addition, multiple micronutrient powders were provided to more households.
than 87,000 children aged 6–23 months to improve the quality of their diets. Meanwhile, some 385,300 pregnant women received iron and folic acid supplementation to prevent anaemia.

As the global nutrition lead, UNICEF led the coordination of nutrition services, ensuring that cluster coordination mechanisms remained functional at national and subnational levels and supporting programme implementation. To strengthen systems for SAM care, UNICEF led the updating of the guidelines on the integrated management of acute malnutrition, a key milestone in ensuring that the latest evidence improves the survival and health of malnourished children in Somalia. In 2019, UNICEF and partners expect to embark on country-wide training of health workers on the revised guidelines. UNICEF and the Somali Ministry of Health are leading the revision of the National Multi-sector Nutrition Policy and finalizing a Costed Human Resource Capacity Development Strategy with a clear road map for tackling the nutrition capacity gaps in Somalia to build a stronger nutrition workforce.

Programme implementation and monitoring are still challenged by access restrictions and security-related issues. UNICEF will strengthen programme monitoring activities through greater integration of nutrition operations into government-owned infrastructure to improve alignment with health systems strengthening and capacity-building of government-led nutrition information systems. As part of 2019 planning, UNICEF intends to collaborate with businesses capable of using technology and innovations to capture data from hard-to-reach areas. It is hoped that this will improve the coordination of monitoring and follow-up, and ensure reliable data to inform programmes.

Building stronger institutions

Strengthening national capacities to reach more children with SAM

With investments in strengthening national capacities to deliver care for children with SAM, UNICEF and partners helped governments build effective systems and continue reaching more children in 2018. This included developing and improving national guidelines and protocols, expanding access to care through a greater number of facilities, and training more health providers with the skills and knowledge to identify and provide quality care for children in need.

Pre-service training for health workers should include the detection and treatment of SAM as part of integrated approaches to the management of common childhood illnesses. UNICEF supports pre-service and refresher training for facility and community health workers to ensure that SAM management is prioritized and understood as part of a continuum of care to support children’s optimal growth and development. In Mali, for example, UNICEF’s leadership and technical support were instrumental in integrating psychosocial stimulation into the national protocol for the management of acute malnutrition.

To strengthen systems and improve care for children with SAM in Tajikistan, UNICEF collaborated with the Ministry of Health and Social Protection, WFP and WHO to update the national protocol for the integrated management of acute malnutrition in 2018. The goal of the update was to increase children’s access to treatment for SAM and ultimately reduce stunting and wasting. UNICEF trained more than 450 health workers across the country on the new guidelines. With their improved capacity and effectiveness in detecting more malnourished children, these health workers helped increase the number of children treated for SAM by 51 per cent from the second quarter to the third quarter of 2018. The programme is now being implemented at full scale, providing in-patient treatment for SAM in every district of the country, benefiting more than 2,770 children in 2018.

In 2018, conflict continued to push more families into food insecurity in South Sudan, with nearly 60 per cent of the population facing severe food insecurity between July and August. Within this context, UNICEF helped increase the coverage of care for children with SAM from 60 per cent to 77 per cent between 2015 and 2018, contributing to a decline in the prevalence of SAM from 9.9 per cent in 2010 to 2.7 per cent. More than 206,600 children with SAM (96 per cent of the target) were treated in 2018; around 70 per cent of those children were living in the five states with highest number of malnourished children. These achievements in care can be attributed to several factors: an 86 per cent increase in the number of outpatient therapeutic programme treatment sites, from 462 in 2015 to 858 in 2018; increased partnerships with civil society organizations; and active community case finding to detect more children with SAM. UNICEF also supported the government in harmonizing treatment protocols through the development of new national guidelines.

There are important cross-sectoral drivers of food and nutrition insecurity in South Sudan, and UNICEF is uniquely placed to address them holistically, tackling both stunting and wasting as part of the humanitarian–development nexus. As part of integrated services at outpatient therapeutic sites, UNICEF distributed early childhood development kits, integrated malaria prevention and detection, and promoted hand washing with soap and good hygiene. These sites were also optimized to deliver treatment services for common childhood illnesses, provide birth registration, and counselling on gender-based violence. Strengthened collaboration between UNICEF,
WFP and WHO ensured seamless referrals across the treatment programmes for children with MAM and SAM.

In response to the drought in the west of Afghanistan, UNICEF provided technical assistance to the government to extend treatment for children with SAM from the health centre level to the sub-health centre level. This measure was taken by UNICEF in the province of Badghis to treat more children in areas of origin, given that there were not enough health centres to deliver the services required.

This transition proved effective in delivering care to many children in need: more than 277,600 children (94 per cent of the target) received care for SAM through 1,193 health facilities. UNICEF is advocating for the government to take the sub-health centre treatment approach to scale. This would demonstrate how effective systems-building during emergencies can be transitioned to non-emergency contexts – in this case, to treat more children with SAM across the country and identify malnourished children much earlier, thereby reducing costs.

CASE STUDY 13: Yemen: Rapid nutrition response to sustain systems and provide urgent care

Yemen continued to endure one of the world’s largest and most complex humanitarian crises in 2018. Basic services and institutions were at the brink of collapse and hunger reached an alarming high; for the first time, pockets of the population were classified having catastrophic levels of food insecurity (Integrated Phase Classification Level 5), according to the Integrated Food Security Phase Classification. By October 2018, the price of food commodities had increased by 73–178 per cent compared with the pre-crisis period. The impact of the protracted crisis on children’s nutrition is stark: almost half of all children under 5 are stunted and one third are at risk of acute malnutrition.

In 2018, UNICEF continued to expand essential prevention and treatment interventions, making significant gains against planned targets. Of the approximately 400,000 children estimated to be suffering from severe acute malnutrition (SAM) in 2018, UNICEF planned to treat at least 70 per cent. Working in partnership with 17 international and local non-governmental organizations, UNICEF delivered life-saving treatment and care to 323,000 children with SAM, representing more than 775 per cent of the expected cases and 121 per cent of the annual target. To achieve these results, more than 3.3 million children (120 per cent of the annual target) under age 5 were screened for malnutrition. In addition, 4.1 million children aged 6–59 months received micronutrient supplements (including both vitamin A and multiple micronutrient powders) and 1.6 million caregivers of children aged 0–23 months benefited from counselling to improve infant and young child feeding practices (162 per cent of the 2018 target). To support these activities, 182 new child feeding corners were established, bringing the total number in the country to 1,081.

To further scale up care through the community-based management of acute malnutrition programme in the country, UNICEF, in collaboration with the World Health Organization (WHO) and the Yemen Ministry of Health, established 266 new outpatient therapeutic programmes and stabilization centres to care for children with SAM. The number of mobile teams equipped to screen children and provide nutrition services in hard-to-reach areas increased from 58 in 2017 to 121 in 2018. A total of 933 health workers were trained as part of the scale-up of services at health-care facilities to treat children with SAM and improve child feeding. In total, 83 per cent of the health-care facilities in the country (3,593 facilities) are now delivering SAM treatment services, compared with 77 per cent (3,378 facilities) in 2017. The quality of SAM care also improved in 2018, with 83 per cent of children recovering successfully, compared with 77 per cent in 2017. The number of children who defaulted from the programme without completing treatment also dropped, from 20 per cent in 2017 to 15 per cent in 2018.

UNICEF covered the costs of referring malnourished children to and from stabilization centres and provided daily accommodation allowances for caregivers. This support gave vulnerable families better access to these life-saving services. To improve the quality of care, UNICEF and WHO developed the capacities of the technical supervisors at the centres and updated supervision checklists, registration and reporting tools. To detect greater numbers of children, UNICEF supported the integration of SAM screening into cholera response by training health workers to identify malnourished children and provide care for SAM and education on child feeding practices.

More than 80 per cent of resources for the national nutrition programme were covered by UNICEF in 2018. This included 7,000 metric tons of ready-to-use therapeutic foods (RUTF) delivered to cover the needs of children with SAM in 22 governorates. Other supplies included antibiotic amoxicillin, deworming tablets, micronutrient
Integrating care for children with SAM into health systems

The provision of care for children with SAM within health systems is a sign of government ownership in tackling malnutrition; it means that rather than being perceived as the consequence of an acute emergency, SAM is addressed as an ongoing public health nutrition priority to be managed primarily by the national government rather than humanitarian actors. This distinction is critical: when SAM services are integrated within health systems they are resourced – at least partially – through domestic budgets and are accessible as part of basic health services for children. UNICEF is tracking the number of countries that provide care for children with SAM as part of an essential package of regular health and nutrition services for children (SP1.e.2). Twenty-four countries were providing these integrated services in 2018, surpassing the target of 11 countries and nearly achieving the 2021 target of 25 countries.

Following the successful integration of treatment for SAM as part of routine services in Ethiopia, the Federal Ministry of Health and the National Disaster Risk Management Commission agreed to also integrate the management of MAM. As a result of UNICEF advocacy, the Government of Ethiopia aligned its nutrition programmes with international standards in 2018, including its guidelines for the management of acute malnutrition. The new guidelines will improve early detection and treatment outcomes due to the change in admission and discharge criteria.

The number of health-care facilities providing treatment for children with SAM rose to more than 18,700 in 2018 (94 per cent of facilities, 4 per cent more than in 2017). Government capacities to deliver, monitor and coordinate nutrition services also improved, as evidenced by key health management information system indicators. More than 2,400 health personnel across the country received training to improve their skills in SAM treatment and related services. More than 332,100 children with SAM in Ethiopia received treatment for SAM in 2018 with UNICEF support, achieving 90 per cent of the target; and more than 90 per cent of these children recovered successfully.

The integration of screening for malnutrition into national health campaigns in Burkina Faso contributed to more malnourished children being identified earlier. Given the deteriorating food security situation in 2018, UNICEF gained support from the Ministry of Health to implement systematic nationwide screening for SAM integrated within four seasonal malaria chemoprophylaxis distributions and VAS campaigns. UNICEF supported training of community health workers to conduct screening and contributed to the operational costs of supervision. About 3.2 million children under 5 were screened for malnutrition, with about 31,300 children treated for MAM and 6,000 referred to health services for SAM treatment. Services to treat children with acute malnutrition were scaled up to 1,955 health-care facilities (100 per cent coverage) in 2018. In 2019, UNICEF will aim to screen and identify more children with SAM by strengthening the referral system, increasing
supervision visits with health workers and improving the quality of services in the communities most affected by food insecurity.

As part of a comprehensive strategy to improve child nutrition in Nigeria and invest in building resilient systems, the number of children with SAM admitted for treatment has increased exponentially in recent years, from fewer than 7,000 in 2009 to more than 700,000 in 2018. This was achieved with UNICEF advocacy and support to improve national ownership and sustainability, which created an important foundation for effective scale-up in response to the emergency in 2018. In the emergency states of Borno, Yobe and Adamawa, more than 368,900 children with SAM received treatment in 2018, exceeding the target. Of these children, 94 per cent recovered, a result achieved with the help of community nutrition mobilizers and a 60 per cent increase in the number of health-care facilities providing treatment. Indeed, treatment services were provided in 651 UNICEF-supported outpatient sites, representing 75 per cent of health-care facilities against a target of 70 per cent. There are still more than 2 million children with SAM in Nigeria not accessing treatment, especially in the north-west, due to limited resources. In 2019, UNICEF will intensify its support to the government to integrate nutrition services in the Universal Health Coverage package and increase the coverage of preventive interventions. Priority will also be given to integrating RUTF procurement into the procurement of other health supplies for childhood illnesses.

Many children with SAM are HIV-positive, and recovery depends largely on whether the child is screened and identified as having HIV and provided with antiretroviral therapy along with treatment and care for SAM. The integration of SAM management and HIV screening is reflected in global guidance; however, it is not standard practice in many settings, and UNICEF is working to strengthen linkages between these platforms. In Malawi, for example, UNICEF fostered links between the delivery of high-impact child health interventions, such as care for SAM, and screening for HIV, which contributed to increasing the percentage of children living with HIV on antiretroviral therapy from an estimated 54 per cent in 2017 to an estimated 68 per cent in 2018.

Improving national investments in care for children with SAM

Integrating the early detection and treatment of children with SAM within national health services requires sufficient funds – including for supplies, therapeutic care and follow-up – and UNICEF supports governments in mobilizing resources and allocating budgets for these products and services. Of the 83 countries implementing SAM programmes, 45 are providing government funding for SAM programmes beyond staff salaries.

Within countries, UNICEF convenes government ministries and key stakeholders to advocate for investments in SAM care. In Burkina Faso, UNICEF and the European Union coordinated advocacy efforts by all nutrition partners,
resulting in a US$2.59 million government contribution to purchase 48,000 boxes of RUTF in 2018 (enough to treat 53,330 children with SAM). This was a 40 per cent increase in domestic resource allocation from 2017 and an important step in ensuring programme sustainability. The Government of Burkina Faso also allocated resources to conduct the national Standardized Monitoring and Assessment of Relief and Transitions (SMART) survey (an assessment of the magnitude and severity of humanitarian crisis), funding more than 60 per cent of the total budget. Similarly, in Nigeria, UNICEF secured political commitment from the government to leverage domestic resources for nutrition through its advocacy with key stakeholders in government and the private sector. This led to the release of US$3.18 million from 19 state governments, surpassing the annual target of US$2 million. At the same time, these investments are still not enough to reach all the children in need across the country.

While some progress is being made, in most countries, lack of prioritization and inadequate investment in SAM treatment and care is costing far too many young lives every year. Addressing this global funding crisis is one of the main objectives of the No Wasted Lives coalition, of which UNICEF is a leading partner (see ‘Leveraging collective action’).

**Strengthening national supply chains**

Effective national supply chains are critical to delivering life-saving RUTF and medicines in a timely manner to the children who need them. UNICEF helps governments improve their supply systems to reach more children with SAM, even in the most remote and fragile settings. The inclusion of RUTF on the government’s list of essential medicines can improve access and financing to support supply and distribution. Forty-two countries have RUTF on the list of essential medicines, up from 38 in 2017; and 66 countries have RUTF and other essential nutrition supplies fully costed in national health budgets, up from 63 in 2017.

Improvements were made to Malawi’s supply chain with UNICEF support, resulting in no RUTF stock-outs in health-care facilities in 2018. UNICEF collaborated with the Ministry of Health to develop an innovative SMS-based stock monitoring system to improve district monitoring capacity. A national multisector nutrition information system was developed for real-time integrated reporting by different ministries at district level, including gender, education, social protection, WASH, agriculture and health, and monthly reports were used to improve programme alignment, decision-making and course correction. As a result of UNICEF advocacy in 2018, therapeutic nutrition supplies were added to the essential medicines list and were integrated into the Ministry of Health’s national supply chain management system. The number of facilities providing care for children with SAM also increased from 722 in 2017 to 724 in 2018: they treated 89 per cent of targeted children. These improvements in supply and institutional capacity helped save the lives of more than 36,400 children with SAM.

Supply chain effectiveness is particularly challenging during emergencies – and planning and preparation are critical to protecting the health and well-being of vulnerable populations. In Kenya, emergency preparedness and risk mitigation plans were updated before the floods anticipated in 2018. UNICEF partnered with the Kenya Red Cross Society to pre-position supplies in regional hubs and continue screening for malnutrition across 10 high-priority counties. These actions averted deaths, especially as the emergency was coming to an end in early 2018. The surge model – used to monitor thresholds and scale up response during emergencies – was expanded to 10 arid counties from 8 in 2017, improving health system responsiveness to seasonal spikes in the admission of acutely malnourished children. Overall, the coverage of the surge model increased from 29 per cent in 2017 to 40 per cent in 2018. UNICEF partnered with the Kenya Medical Supplies Authority to integrate the nutrition supply chain through the national government channel to improve efficiency and sustainability. Each facility now reports its requirements through the logistics information management system, enabling timely reporting, monitoring of stock-outs and release of supplies; door-to-door delivery of supplies to health-care facilities prevented delays and wastage at county-level intermediary stores.

Through its supply division, UNICEF seeks opportunities to increase local production of RUTF; improve its cost-effectiveness and ensure products are culturally acceptable. Interest in non-peanut-based RUTF is increasing, particularly in some Asian countries, where peanuts are not a staple food in local diets. UNICEF is increasingly requesting manufacturers to consider using alternative ingredients, such legumes and cereals instead of peanuts, to increase availability and cultural acceptance.34

**Improving nutrition information systems**

UNICEF helps governments invest in and improve nutrition information systems by providing technical guidance on indicators and building capacity to collect and use data for decision-making. Tracking nutrition information is also vital to emergency response, and UNICEF supports governments in monitoring and collecting national and subnational data on nutrition to inform critical decisions before, during and after a crisis.

Despite huge investment in nutrition in South Sudan over the last five years, no information had been available on key nutrition indicators since 2010. As the result of a UNICEF-led information initiative in 2018, national-level data were generated on stunting, acute malnutrition and other key indicators, supported by near real-time data. UNICEF built the capacities of government and non-governmental actors; advocated for enhanced use of evidence in planning; and provided technical inputs to ensure rigorous review and validation of survey results. The average reporting rate of nutrition sites in South Sudan improved gradually from 86 per cent in 2016 to 98 per cent in 2018.
Leveraging collective action

Partnerships and coordination to put SAM on the global agenda

The global response to acute malnutrition has been inadequate for too long, but with renewed global commitment spurred by the No Wasted Lives Coalition this is changing. UNICEF and global partners formed the Coalition in 2016 in response to unacceptably slow progress in ending acute malnutrition. Its goals are to make acute malnutrition a political and public health priority; to discover and disseminate better ways to detect, prevent and treat acute malnutrition; and to mobilize funds and maximize the effectiveness of current spending.

No Wasted Lives partners have committed to doubling the number of children with SAM receiving treatment every year. Alongside increased financial and technical support to regional and country offices in 2018, No Wasted Lives continued to develop into a credible, recognized platform for galvanizing data, advocacy, research and operations to improve early detection and treatment of wasting globally. This included establishing three regional posts, in Eastern and Southern Africa, South Asia and West and Central Africa, with the support of the Children’s Investment Fund Foundation, to guide regional scale-up. In 2018, the Coalition convened a consultation on the emerging evidence on wasting in South Asia, which helped mobilize the commitment of global experts to strengthen the evidence base for policy and programme response to wasting in the region.

Evidence generation to support better care for children with SAM

UNICEF helps set the research agenda and generates and disseminates new knowledge on what works in the treatment and care of children with SAM. A key part of this work in 2018 involved piloting and generating evidence on a simplified protocol for SAM care, to improve coverage, cost-effectiveness and quality. UNICEF and WFP, with No Wasted Lives and NGO partners ALIMA and International Rescue Committee, piloted the simplified protocol, which involves training caregivers to screen for MUAC (described under ‘Improving services and community demand’); basing treatment criteria on MUAC or oedema; using RUTF to treat MAM and SAM; simplifying the dosage; and providing antibiotics for SAM.
In Eastern and Southern Africa, UNICEF commissioned a study on the quality of care for children with SAM, which involved a review of the protocols for the management of acute malnutrition in 21 countries in the region, as well as findings from new emerging research on the use of simplified protocols, burden calculation, nutrition supply chain integration and end-user monitoring. The results were presented during a regional consultation in 2018, where progress was being assessed on plans that had been developed during the SAM ‘deep dive’ consultation in 2017, when countries in the region committed to accelerating coverage of care for children with SAM.

Similarly, in West and Central Africa, a scoping exercise was conducted to build the evidence base for a simplified approach. Results provided evidence for proceeding with the protocol, with good nutritional outcomes, cost-effectiveness and only a small proportion of children with SAM going undetected. Areas in need of further research were identified, such as optimum dosage, whether the protocol reduces the incidence of SAM and how this impacts mortality, and how the delivery of simplified protocols by community health workers affects coverage and effectiveness. Upcoming research will aim to answer these questions, and more operational experience will help clarify the implications and feasibility of this approach in real contexts and determine where and how to take the simplified protocol to scale.

Many countries have insufficient data to identify bottlenecks, track progress and make timely corrective actions. To address this challenge, in 2018 UNICEF supported eight countries in West and Central Africa to undertake a bottleneck analysis for the management of SAM. This was done with key nutrition stakeholders, including government, NGOs and United Nations partners. The results indicated that the coverage of SAM care is low, varying from 40 per cent to 68 per cent, with critical bottlenecks including the availability of skilled providers, poor availability of essential supplies due to poor supply management, financial challenges including low domestic funding, inadequate continuity of treatment due to poor quality of services, and limited capacities of community systems and actors. Corrective actions were identified and translated into country action plans. The regional office will continue to work with countries to strengthen routine information systems and nutrition data through a data investment project supported by the Bill & Melinda Gates Foundation, extending the bottleneck analysis to the health sector and beyond.

Because SAM is an acute condition that can change rapidly, it is challenging to estimate the number of children affected. Prevalence data from surveys generated at one point in time can fail to detect children who develop SAM later in the year, thereby underestimating the number of children affected. To address this challenge, UNICEF and the Harvard T.H. Chan School of Public Health began a study to understand how the SAM incidence correction factor varies across country contexts. This is the first standardized effort to estimate country-level incidence correction factors used to calculate the number of children affected by SAM. The initiative promises to make a critical contribution to improving the accuracy of global and national estimates for SAM.
Nutrition financial report

Financial resources to support nutrition work grew from US$665 million in 2017 to US$674 in 2018 (see ‘Expenses for nutrition in 2018’, below). This annex presents a financial picture of revenue and expenditures in 2018, including: total revenue for UNICEF in all sectors; resources for nutrition; expenditures for nutrition; future funding gap; and a description of the value for money offered by UNICEF nutrition programmes.

For a full overview of UNICEF revenue and contributions in 2018, please see Annex 1.

In 2018, partners contributed US$133 million ‘other resources – regular’ for nutrition, a 16 per cent decrease from the previous year (Figure 30). Government partners contributed more than half of the ‘other resources - regular’ for nutrition. The top five resources partners to UNICEF nutrition in 2018 were the World Bank Group – International Development Association (IDA), the European Commission, the governments of the Netherlands and the United Kingdom, and the United Kingdom Committee for UNICEF (see Table 21).

FIGURE 29: Total nutrition funds received by type of donor, 2018 (US$133 million)

Field Offices
US$1,293,413
1%

Governments
US$68,536,141
51%

National Committees
US$29,016,419
22%

Inter-organizational Arrangements
US$3,730,525
3%

Inter-Governmental Organizations
US$31,158,964
23%

FIGURE 30: Nutrition ‘other resources – regular’ contributions, 2014–2018
### TABLE 21: Top 20 resource partners to nutrition by contributions, 2018

<table>
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<th>Rank</th>
<th>Resource partners</th>
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<td>1</td>
<td>World Bank Group – IDA*</td>
<td>103,431,329</td>
</tr>
<tr>
<td>2</td>
<td>European Commission*</td>
<td>35,287,892</td>
</tr>
<tr>
<td>3</td>
<td>Netherlands*</td>
<td>18,439,388</td>
</tr>
<tr>
<td>4</td>
<td>United Kingdom</td>
<td>17,326,006</td>
</tr>
<tr>
<td>5</td>
<td>United Kingdom Committee for UNICEF</td>
<td>14,277,086</td>
</tr>
<tr>
<td>6</td>
<td>Germany</td>
<td>9,420,666</td>
</tr>
<tr>
<td>7</td>
<td>United States</td>
<td>7,925,684</td>
</tr>
<tr>
<td>8</td>
<td>U.S. Fund for UNICEF</td>
<td>6,243,756</td>
</tr>
<tr>
<td>9</td>
<td>Republic of Korea*</td>
<td>5,870,000</td>
</tr>
<tr>
<td>10</td>
<td>Norway</td>
<td>3,395,387</td>
</tr>
<tr>
<td>11</td>
<td>Nigeria</td>
<td>2,635,170</td>
</tr>
<tr>
<td>12</td>
<td>Sweden</td>
<td>2,608,756</td>
</tr>
<tr>
<td>13</td>
<td>Swiss Committee for UNICEF</td>
<td>2,082,780</td>
</tr>
<tr>
<td>14</td>
<td>Italy</td>
<td>1,999,147</td>
</tr>
<tr>
<td>15</td>
<td>New Zealand*</td>
<td>1,577,479</td>
</tr>
<tr>
<td>16</td>
<td>Japan</td>
<td>1,553,261</td>
</tr>
<tr>
<td>17</td>
<td>United Nations Joint Programme</td>
<td>1,519,339</td>
</tr>
<tr>
<td>18</td>
<td>World Food Programme</td>
<td>1,191,625</td>
</tr>
<tr>
<td>19</td>
<td>French Committee for UNICEF</td>
<td>1,006,631</td>
</tr>
<tr>
<td>20</td>
<td>Spanish Committee for UNICEF</td>
<td>955,382</td>
</tr>
</tbody>
</table>

* Includes cross-sectoral grants SC170081, SC170579, SC170314, SC180682, SC180345 (Health and Nutrition), SC180981 (Education, WASH, Health, Nutrition and Child Protection), and SC180824 (Health, WASH, Nutrition and Education).

The flexibility of thematic funding allows UNICEF to respond more effectively. It facilitates longer-term planning, sustainability and savings in transaction costs, leaving more resources for UNICEF programmes.

Thematic funding contributions for nutrition totalled US$7.2 million in 2018, with 74 per cent coming from government partners. The Government of the Netherlands was the largest thematic resources partner, providing 56 per cent of all thematic contributions received (see Table 23). Thematic contributions were received from the Government of Luxembourg for the global thematic nutrition pool, Sweden contributed country-specific funding for nutrition in Bolivia and the U.S. Fund for UNICEF contributed country-specific funding.

UNICEF is seeking to broaden and diversify its funding base, and encourages all partners to give as flexibly as possible. The number of partners contributing thematic funding to nutrition was the same in 2018 as in 2017.
### TABLE 22: Top 20 contributions to nutrition, 2018

<table>
<thead>
<tr>
<th>Rank</th>
<th>Resource partners</th>
<th>Grant description</th>
<th>Total (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>World Bank Group – IDA</td>
<td>Yemen Health and Nutrition Emergency Project*</td>
<td>40,581,796</td>
</tr>
<tr>
<td>2</td>
<td>World Bank Group – IDA</td>
<td>Second additional financing for Emergency Health and Nutrition Project, Yemen*</td>
<td>32,475,771</td>
</tr>
<tr>
<td>3</td>
<td>World Bank Group – IDA</td>
<td>Second Additional Financing for Yemen Emergency Crisis Response Project*</td>
<td>30,073,762</td>
</tr>
<tr>
<td>4</td>
<td>Netherlands</td>
<td>Developing Human Capital in Rwanda</td>
<td>7,679,985</td>
</tr>
<tr>
<td>5</td>
<td>European Commission</td>
<td>Nutrition, Mozambique</td>
<td>7,170,047</td>
</tr>
<tr>
<td>6</td>
<td>The Netherlands</td>
<td>Kids in Need of Durable Solutions in the Sudan*</td>
<td>6,759,403</td>
</tr>
<tr>
<td>7</td>
<td>United Kingdom</td>
<td>Maternal and Child Nutrition Programme, Kenya</td>
<td>6,609,793</td>
</tr>
<tr>
<td>8</td>
<td>European Commission</td>
<td>Nutrition, Nepal</td>
<td>5,892,688</td>
</tr>
<tr>
<td>9</td>
<td>Germany</td>
<td>Strengthening Resilience in South Central Somalia</td>
<td>5,854,801</td>
</tr>
<tr>
<td>10</td>
<td>European Commission</td>
<td>Nutrition, Kenya</td>
<td>5,228,556</td>
</tr>
<tr>
<td>11</td>
<td>United Kingdom Committee for UNICEF</td>
<td>Community Management of Acute Malnutrition, Nigeria</td>
<td>5,153,227</td>
</tr>
<tr>
<td>12</td>
<td>European Commission</td>
<td>Multi-sector, Libya*</td>
<td>4,547,521</td>
</tr>
<tr>
<td>13</td>
<td>United Kingdom</td>
<td>Scaling up Nutrition-Specific Interventions for Improving Child and Adolescent Nutritional Status in Malawi</td>
<td>4,090,351</td>
</tr>
<tr>
<td>14</td>
<td>Republic of Korea</td>
<td>Strengthening Equitable Delivery of Community-based Health and Nutrition, Afghanistan</td>
<td>4,000,000</td>
</tr>
<tr>
<td>15</td>
<td>Netherlands</td>
<td>Nutrition, Global Thematic funding</td>
<td>4,000,000</td>
</tr>
<tr>
<td>16</td>
<td>United States</td>
<td>Improving Nutrition in Mozambique</td>
<td>3,655,023</td>
</tr>
<tr>
<td>17</td>
<td>European Commission</td>
<td>Nutrition, Djibouti</td>
<td>3,645,868</td>
</tr>
<tr>
<td>18</td>
<td>Norway</td>
<td>Better Diets Better Growth</td>
<td>3,395,387</td>
</tr>
<tr>
<td>19</td>
<td>United Kingdom</td>
<td>National Nutrition Surveys, Pakistan</td>
<td>3,221,958</td>
</tr>
<tr>
<td>20</td>
<td>United Kingdom Committee for UNICEF</td>
<td>Strengthening Nutrition &amp; Education Connection, India</td>
<td>2,745,833</td>
</tr>
</tbody>
</table>

* Cross-sectoral grants SC170081, SC170579, SC170314 (Health and Nutrition), SC180961 (Education, WASH, Health, Nutrition and Child Protection), and SC180824 (Health, WASH, Nutrition and Education).
Of all thematic nutrition contributions UNICEF received in 2018, some 68 per cent were global-level contributions.

Global thematic funds remain the most flexible source of funding to UNICEF after regular resources. The global level is the most valuable thematic funding level in which partners determine which UNICEF objectives they wish to support and contribute to the most closely aligned thematic funding pool. This allows UNICEF the flexibility to allocate funds across regions to individual country programmes according to priority needs. It facilitates programme implementation in a more strategic manner, and allows UNICEF to adjust and respond to emerging issues. It also gives UNICEF the flexibility to allocate resources to areas of highest need, including critically under-funded country programmes and humanitarian responses.

A total of US$52,427,544 global thematic nutrition funding was allocated to 95 offices in 2018, including allocations from the previous thematic pool, 2014–2017.
Based on key nutrition programme areas, objectives and targets of the UNICEF Strategic Plan, 2018–2021, the allocations were made by the nutrition network, taking global thematic funding partners expectations into account and in close consultation with said partners.

In terms of recommended focus, special emphasis was given to improving women’s nutrition during pregnancy and improving children’s diets in the first two years of life. Thematic funds were also allocated to support early detection and treatment of severe acute malnutrition (SAM) as part of a package of routine services for children, in all contexts. Thematic funds contributed to strengthening policies and scaling up of programmes in emerging areas of work, such as the nutrition of school-age children and adolescents, and the prevention of overweight and obesity in childhood and adolescence.

Through a consultative process with Regional Nutrition Advisors, 80 per cent of funds were allocated to country offices, a little over 9 per cent to regional offices, a similar proportion to headquarters, and 1 per cent to the UNICEF Office of Evaluation.

Expenses for nutrition in 2018

Overall nutrition spending rose to US$674 million in 2018 (see Figure 32), from US$665 million the previous year. In particular, resources earmarked for emergencies (‘other resources – emergency’) increased to US$350 million in 2018, from US$311 million in 2017, allowing UNICEF to respond effectively to the increasing scale and scope of humanitarian need.

Spending in the nutrition outcome area was 12.5 per cent of all expenses (see Figure 33). In 2018, the treatment and care of children with SAM (Results Area 3) accounted for the greatest programme expenses at US$417 million. This spending pattern recognizes the importance of UNICEF support to delivering life-saving treatment and care to children with acute malnutrition, including in the context of increasingly complex humanitarian crises. Programming expenses in this area include the procurement of ready-to-use therapeutic foods (RUTF) to treat children with SAM, which together with spending on other nutrition supplies totalled US$241 million in 2018 (see Table 25). While spending in this area is critical to save lives, there is a need to sustain and increase resources for preventive nutrition interventions – most of those covered in results areas 1 and 2. Investments in prevention are cost-effective and have the power to break the cycle of malnutrition before it starts.

ORE, other resources – emergency; OR, other resources – regular; RR, regular resources.

Note: expenses are higher than the income received because expenses are comprised of total allotments from regular resources and other resources (including balances carried over from previous years), while income reflects only earmarked contributions from 2018 to nutrition.

FIGURE 34: Expense by outcome area, 2018 (total: US$5.4 billion)

- Nutrition: 13%
- Health: 24%
- Early childhood education: 1%
- Social policy, Inclusion and Governance: 8%
- Safe and clean environment: 2%
- WASH: 17%
- Education: 22%
- Child protection: 22%
- HIV and AIDS: 1%
As in previous years, most nutrition spending in 2018 supported programming in Eastern and Southern Africa and West and Central Africa (see Figure 34). This reflects the high burden of undernutrition in these regions, as well as the humanitarian crises facing a number of countries in 2018, particularly in north-east Nigeria, Somalia and South Sudan. In addition to vital emergency response, greater investments are needed in preparedness and systems strengthening during protracted crises to build resilience in fragile settings – flexible resources would further support these efforts. There is also an urgent need to boost spending in non-emergency contexts, particularly in Asia, where the number of children affected by SAM remains high, and resources for treatment and care are limited.

Table 25 shows the 20 countries where the most money was spent on nutrition in 2017; these countries accounted for 73 per cent of all nutrition expenses. The nutrition spending in these countries makes sense given that 12 of them have either a stunting prevalence greater than or equal to 40 per cent or a wasting prevalence greater than or equal to 10 per cent. Many of these countries faced humanitarian crises in 2017 related to conflict, natural disasters, disease outbreaks and drought; thus, significant funds were allocated to support subnational and national emergency nutrition response.

As in previous years, most nutrition sector expenses supported the procurement of supplies (see Table 26), including RUTF; therapeutic milks; vitamin A capsules; micronutrient powders and tools used in growth monitoring, such as height boards and scales. In 2018, significant investments were made through counterparts and implementing partners to support them in delivering and implementing high-impact nutrition interventions. UNICEF’s strategic partnerships allow the organization to target funds effectively and efficiently to ensure wide coverage of interventions, especially in fragile settings where national systems may be weak.
Funding gaps for nutrition

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

Value for money in nutrition

UNICEF reduces programme costs by leveraging the strengths of a range of implementing partners in different contexts and supporting local actors, particularly during humanitarian response. UNICEF programmes prioritize cost-efficiency, and many of the most effective nutrition interventions – such as breastfeeding and the provision of essential micronutrients – are both low cost and high impact. For UNICEF, the concept of value to money is deeply connected to principles of equity. Spending in nutrition helps bridge gaps and ensure that essential nutrition services reach the most marginalized children and their families. This approach is not only the most ethical – it also has the greatest potential to save lives.
Results: HIV and AIDS

Ending AIDS as a global public health threat is a long-standing priority that has been at the centre of UNICEF work for more than two decades. Although the level and extent of the risks vary, HIV is a threat to the health and well-being of children and adolescents wherever they live. Eradicating this threat is essential to improving children’s ability to survive and thrive, the overarching objective of Goal Area 1 of the UNICEF Strategic Plan, 2018–2021.

Primary health care is the central platform through which a number of HIV prevention and treatment services are provided. For example, the prevention of mother-to-child transmission of HIV (PMTCT) is an integral part of wider antenatal services, as is the provision of life-saving antiretroviral therapy (ART) to infants and children in child health services. The nutritional status of mothers and children affects their ability to live with HIV, while nutrition counselling, health counselling and community health
outreach services are common entry-points for prevention information. The uptake of (or demand for) HIV treatment is affected by the same social determinants that shape the demand for health, nutrition and early childhood services. At the system level, HIV services are as dependent on effective health systems as are health and nutrition services.

HIV prevention and treatment are the paired, interlinked themes of the UNICEF HIV programme. They frame the two main indicators that broadly measure the impact of global efforts towards the overall goal of ‘ending AIDS’ in children and adolescents – the number of new HIV infections and the number of AIDS-related deaths – and they align with the Joint United Nations Programme on HIV/AIDS (UNAIDS) ‘super-fast-track’ framework for ending AIDS among children, adolescents and young women by 2020 and global prevention targets. Those targets call for, among other things, the annual number of new infections to be sharply reduced by 2020 to 20,000 among children (aged 0–14 years) and 100,000 among adolescent girls and young women (aged 10–24). Such goals and SDG target 3.3 – ending the AIDS epidemic – cannot be met without substantial and sustainable gains in equitable access to quality HIV treatment and prevention services.

The two outcome indicators under the Strategic Plan are good proxies for tracking progress towards reducing both new infections in children and mortality in children, adolescents and their mothers. Children and adolescents are the focus of Outcome Indicator 1.18 (‘Percentage of girls and boys living with HIV who receive ART’), with pregnant and breastfeeding women the focus of Outcome Indicator 1.19 (‘Number of pregnant women living with HIV who receive antiretroviral medicine [ARVs] to reduce the risk of MTCT of HIV through UNICEF-support programmes’).

Output and outcome indicators for HIV and AIDS

### TABLE 26: Outcome results for HIV and AIDS, 2018

<table>
<thead>
<tr>
<th>Outcome indicator</th>
<th>Baseline</th>
<th>2018 value</th>
<th>Target (2021)</th>
<th>SDG target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of girls and boys living with HIV who receive ART:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children aged 0–14</td>
<td>50%</td>
<td>53%</td>
<td>81%</td>
<td>3.8.1: Coverage of essential health services</td>
</tr>
<tr>
<td>Adolescents aged 10–19*</td>
<td>68%</td>
<td>Insufficient data</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>Number of pregnant women living with HIV who receive antiretroviral medicine to reduce the risk of MTCT of HIV through UNICEF-supported programmes</td>
<td>1,020,000</td>
<td>1,035,844</td>
<td>1,190,000</td>
<td>3.3.1: Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations</td>
</tr>
</tbody>
</table>

*Note: There is a one-year lag for HIV estimates; estimates published in 2018 represent 2017.*

*Eight of the 35 priority countries reported on the ART indicator for adolescents aged 10–19 in 2018.*

At the Strategic Plan impact level, it is estimated that programmes to increase access to ART in children and programmes for PMTCT have resulted in a 35 per cent reduction in the annual number of new infections among children and a 45 per cent reduction in the annual number of child deaths globally between 2010 and 2017 (see Figures 35 and 36).

These impacts can be attributed to improved outcomes, with contributions by UNICEF and many partners in the HIV response whose efforts are described in the pages of this report. The proportion of children living with HIV who receive ART increased from 22 per cent in 2010 to 52 per cent in 2017; and the percentage of pregnant and breastfeeding women who received ARVs for PMTCT increased from 51 per cent to 80 per cent during the same time period.

### TABLE 27: Output results for HIV and AIDS, 2018

<table>
<thead>
<tr>
<th>Output statement: Countries have accelerated the delivery of services for the treatment and care of children living with HIV</th>
<th>Baseline</th>
<th>2018 value</th>
<th>Target (2021)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (and percentage) of infants born to pregnant women living with HIV tested for HIV within their first two months of life*</td>
<td>584,000 (42%)</td>
<td>649,755 (54%)</td>
<td>890,000 (64%)</td>
</tr>
<tr>
<td>Number of adolescent girls and boys tested for HIV and received the result of the last test**</td>
<td>18.1 million</td>
<td>22.6 million</td>
<td>23.6 million</td>
</tr>
<tr>
<td>Girls aged 15–19</td>
<td>10.6 million</td>
<td>13.4 million</td>
<td>13.8 million</td>
</tr>
<tr>
<td>Boys aged 15–19</td>
<td>7.5 million</td>
<td>9.2 million</td>
<td>9.8 million</td>
</tr>
<tr>
<td>Output statement: Countries have implemented comprehensive HIV prevention interventions at scale</td>
<td>Baseline</td>
<td>2018 value</td>
<td>Target (2021)</td>
</tr>
<tr>
<td>Number of countries implementing policies and/or strategies for the integration of key HIV/AIDS interventions (HIV testing and counselling, antiretroviral therapy) into child-centred service points and the degree of scale within countries</td>
<td>25</td>
<td>35</td>
<td>32</td>
</tr>
<tr>
<td>Number of countries having initiatives to strengthen availability of gender-responsive evidence for the All In framework for prevention of HIV</td>
<td>0</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>Number of countries supporting implementation of at least three high-impact gender-responsive adolescent prevention interventions***</td>
<td>25</td>
<td>31</td>
<td>32</td>
</tr>
</tbody>
</table>

*Note: There is a one-year lag for HIV estimates; estimates published in 2018 represent 2017.

*Twenty-eight countries reported on the infants tested indicator in 2018.

**Twenty-five countries reported on the adolescents tested indicator in 2018.

***High-impact gender-responsive adolescent prevention interventions could include condom distribution, HIV testing services, pre- and post-exposure prophylaxis (PrEP and PEP), keeping girls in school, cash transfers and community mobilization, among others.

FIGURE 36: Global trends in coverage of antiretroviral therapy (ART) and number of AIDS-related deaths among children (0–14 years), 2010–2017

Source: Global AIDS Monitoring 2018 and UNAIDS 2018 estimates.
Note: ART coverage excludes single-dose nevirapine.

FIGURE 37: Percentage of pregnant women living with HIV receiving most effective antiretroviral medicines for preventing mother-to-child transmission (PMTCT) and new HIV infections among children (0–14 years), 2010–2017

Source: Global AIDS Monitoring 2018 and UNAIDS 2018 estimates.
UNAIDS estimates are used to measure annual progress against Strategic Plan indicators. The latest data available to UNICEF for reporting purposes reflect estimates for 2017. At the Strategic Plan outcome level, there was an increase in the percentage of children aged 0–14 living with HIV who received ART to 53 per cent in 2017 from 51 per cent in 2016 in the 35 countries prioritized by UNICEF for intensified action. The numbers of pregnant women living with HIV who receive ARVs through UNICEF-supported programmes also increased during the same period: by more than 17,000 in the 35 priority countries and more than 20,000 in Eastern and Southern Africa, the region accounting for nearly 84 per cent of the total.

The indicators underscore that treatment and prevention are equally important and intrinsically linked. Greater uptake of ART and critical supportive services has a direct impact on AIDS-related mortality. At the same time, it has been shown to have a major preventive impact because people who are virally suppressed – achieved only through regular and effective ART use – are far less likely to transmit HIV to others. This significant preventive impact of treatment is relevant for every kind of transmission route.

Efforts in recent years to maximize the full treatment and preventive benefits of ART have had variable results across regions and populations. Access to ART by pregnant and breastfeeding women who are living with HIV has increased significantly. The 80 per cent of pregnant women living with HIV who received lifelong ART in 2017 to reduce new infections in children and to keep their mothers alive equates to 1.035 million women globally.

In terms of HIV treatment access, there has been less progress for children, particularly adolescents. While 59 per cent of adults living with HIV received treatment in 2017, only 52 per cent of children (0–14 years) and 37 per cent of adolescents (15–19 years) did so. They represent 3 million children and adolescents living with HIV who received treatment.

The huge gaps in ART access are painfully evident in estimates of some 130,000 AIDS-related deaths in the 0–19 age population in 2017 alone. That these deaths could have been prevented underscores why access to treatment must be accelerated. The fact is, children (and particularly adolescents) living with HIV are not getting the treatment they need – and not just for purposes of slowing the
progression of HIV to AIDS and saving their young lives, but also for purposes of preventing transmission to those who are HIV negative. In its HIV response, UNICEF is helping countries to further scale up paediatric ART treatment.

Primary prevention efforts for adolescents have not achieved the same attention as PMTCT, and progress in reducing new infections has been slower. The estimated 1.8 million adolescents aged 15–19 living with HIV includes those who have lived their whole lives with HIV as well as many who are newly infected. Adolescent girls and young women are especially at risk in terms of the latter: every year since 2000, they have accounted for at least two thirds of annual new HIV infections among all those aged 15–19 worldwide. That is partly explained by the fact that, globally, only 19 per cent of girls aged 15–19 have comprehensive knowledge of HIV, including how to prevent it, and only 41 per cent know where to get tested for HIV. There are many factors – social, cultural, economic, legal and political – that contribute to adolescent girls’ and young women’s vulnerability to HIV, and UNICEF in its response is working across multiple sectors to address these.

Adolescents remain especially at risk and underserved by HIV prevention services; where such services exist, they are fragmented and poorly targeted, and they do not adequately address adolescents’ needs. Between 2010 and 2017, the number of new HIV infections among adolescents aged 10–19 years decreased by only 17 per cent, which is far short of the global target for 2020. UNICEF’s targeted work among adolescents has sought to improve the quality of HIV testing, treatment and prevention services, boost community demand for services and reach those who have been left behind.

Not only has progress regularly lagged in many critical areas for the global HIV response, but there are signs of slowing momentum in others that had once experienced rapid improvements. Millions of children, pregnant women and mothers have not seen any benefits of progress, as access to life-saving ART and HIV prevention services is far from universal. There is a still a long way to go and a need for more rapid and consistent acceleration.

HIV efforts in 2018 were concentrated in 35 countries prioritized for intensified action. Collectively, those countries are home to 9 out of 10 children and adolescents worldwide who were newly infected with HIV, were living with HIV or died from AIDS-related causes in 2017 (Table 28). Results in 2018 reflect substantial efforts to boost availability and uptake of high-quality HIV treatment and prevention interventions among some of the most vulnerable children and adolescents.

To help close the treatment gap, UNICEF is supporting point-of-care (POC) diagnostic technologies to increase access to early infant diagnosis (EID) and to improve linkages to HIV treatment. The innovative technologies were directly responsible for more than 70,000 tests conducted on HIV-exposed infants in 2018. As a result, mothers, fathers and other caregivers of these infants had critical information about whether the child should immediately start HIV treatment or be closely monitored and supported during the postnatal period to remain HIV-negative. The positive consequences to health and life could be immense because, if untreated, 30 per cent of children born with HIV die by their first birthday and 50 per cent by their second.

POC has the potential to reach many more children with early testing. Initial work in POC, funded by Unitaid and implemented with UNICEF, the Clinton Health Access Initiative (CHAI) and the African Society for Laboratory Medicine (ASLM), focused on 10 countries in Africa (7 in Eastern and Southern Africa and 3 in West and Central Africa) with important lessons learned about the value of same-day testing and receipt of results in terms of increased uptake of ARVs in children and their retention in care. The work is now being introduced and rolled out in 10 additional countries in West and Central Africa, with a US$6 million UNICEF investment.

It is estimated that since 2000, programmes for PMTCT of HIV have averted 1.8 million new paediatric infections. This is a remarkable public health success. Of concern, however, is that access to ARVs for PMTCT remains variable across regions and countries. PMTCT coverage

### TABLE 28: Share of global HIV burden among 35 priority countries, children and adolescents aged 0–19 years

<table>
<thead>
<tr>
<th></th>
<th>New HIV infections among children and adolescents</th>
<th>Children and adolescents living with HIV</th>
<th>AIDS-related deaths among children and adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global</td>
<td>430,000</td>
<td>3,000,000</td>
<td>130,000</td>
</tr>
<tr>
<td>35 priority countries</td>
<td>370,000</td>
<td>2,700,000</td>
<td>110,000</td>
</tr>
<tr>
<td>35 priority countries as a proportion of global total</td>
<td>86%</td>
<td>90%</td>
<td>88%</td>
</tr>
</tbody>
</table>

Note: All estimates have been rounded to the nearest second digit. Percentages are based on exact values, so they may not reflect a direct calculation of the rounded estimates.

Source: UNAIDS 2018 estimates.
has slowed or gone backwards in recent years, and no country on the path to the elimination of mother-to-child transmission (EMTCT) is in sub-Saharan Africa, the region with the largest burden of HIV infection.

Nearly 180,000 infants are estimated to have acquired HIV through ‘vertical’ transmission in 2017. Key determinants of new HIV infection among children include incidence or newly acquired maternal infection during pregnancy and breastfeeding, poor retention in care and limited access to ARVs for PMTCT, particularly in West and Central Africa, where access to antenatal care (ANC) tends to be lower than in most other regions. To respond to these challenges, UNICEF hosted virtual consultations in 16 priority countries in Africa to guide new investment from the Global Fund to End AIDS, Tuberculosis and Malaria (Global Fund) to improve programme quality. UNICEF is also supporting countries in conducting data reviews to define priority actions in going the ‘last mile’ towards EMTCT, for example, in their efforts to reach pregnant women with HIV testing services and retain pregnant women living with HIV in treatment and care.

Adolescents have long been among the hardest-to-reach populations in HIV responses. UNICEF programming for adolescents is multisectoral and takes into account that preventing HIV requires addressing the biomedical, behavioural and structural factors of adolescent vulnerability in combination. Such work to bring programmes to scale is especially important for the health and well-being of adolescent girls and young women, who are disproportionately at risk of HIV infection and vulnerable. Gender-based violence and gender inequality further heighten the vulnerability of women and girls to HIV, particularly where access to education, age-appropriate HIV information, and even basic sexual and reproductive health services are unavailable or inaccessible.

UNICEF advocacy to remove the barriers to HIV service delivery and to support the implementation of ‘combination’ HIV prevention activities in 2018 helped to expand and improve high-impact HIV programmes targeting adolescents and youth in nearly all of the 35 priority countries. In Africa, UNICEF leveraged partnerships with the Global Fund in programmes for adolescent girls.

Maximizing results under the UNICEF strategy: New programming approaches for HIV

The UNICEF Strategic Plan, 2018–2021 has set a clear course for how, why and where to capitalize on the organization’s comparative advantages in its HIV work. Under the plan, UNICEF has adopted new programming approaches for HIV that aim to achieve the greatest impact for children and adolescents in ways that promote and sustain efficiency, effectiveness and equity. The following are key principles and strategies.

Context-specific priorities and interventions: UNICEF varies its response in each country where it works according to factors including the incidence of HIV among pregnant women, mothers, children and adolescents; the opportunities and risks in the national health system; and the level of support and action from domestic and international partners. Three broad types of response are being implemented:

1. Intensified responses in 35 priority countries with high HIV burdens or high levels of vulnerability and risk among the populations UNICEF serves;
2. Targeted responses in 27 countries where severe inequities prevent many individuals vulnerable to HIV, especially members of key populations, from accessing vital HIV services and support;
3. Data and programming responses in 63 countries, where UNICEF supports efforts to track epidemics and advocate for child-focused responses.

Integration of HIV prevention and treatment: UNICEF is working to integrate HIV interventions into maternal and child health, child protection and education sectors with clear indicators to drive efforts and leverage resources. In addition, the UNICEF HIV-specific programme is demonstrating and documenting the impact of integrated HIV activities on child survival, child protection and education.

Strengthened and leveraged partnerships: UNICEF is engaging with the Global Fund, the US President’s Emergency Plan for AIDS Relief (PEPFAR) and other partners to help leverage additional financial resources on behalf of children in HIV responses. At the same time, it is strengthening its partnerships with people living with and affected by HIV – especially mothers, children and adolescents.

Innovation and knowledge: UNICEF is prioritizing support for the development and use of emerging innovations that can improve programme performance and quality or help to sustain and accelerate the HIV response. Generating and sharing knowledge about such innovations and other important programming interventions is a critical part of this strategy.
and young women in seven countries and a funding grant from the Government of Sweden in five countries. HIV prevention is a core component of these partnerships, but they extend beyond HIV to include girls’ overall well-being. The Swedish-funded initiative, 2gether4SRHR, integrates HIV prevention, care and treatment with sexual and reproductive health (SRH) services and the prevention of gender-based violence; it is assisted by UNICEF jointly with the United Nations Population Fund (UNFPA), UNAIDS and the World Health Organization (WHO). The Global Fund partnership is assisted by UNICEF jointly with WHO.

UNICEF engagement in HIV and AIDS consistently leverages other investments in the sector through strategic partnerships and collaborations, ensuring that every dollar spent on HIV reaches its fullest potential for impact. Spending on HIV prevention is highly cost-effective because it saves lives and averts the costs of lifelong treatment. UNICEF programmes in treatment and care prioritize best practices and evidence-based approaches that are of high impact.

According to projections, the increase in the population of children and adolescents between 2018 and 2030 will be greatest in sub-Saharan Africa, where the HIV burden is the highest. Continued attention and sustained commitment of resources are needed to ensure that progress to date in the HIV response for children and adolescents is not lost and the productive lives of future generations are unaffected by the epidemic.

Results Area 1: Treatment and care of children living with HIV

**Output Statement 1.f: Countries have accelerated the delivery of services for the treatment and care of children living with HIV.**

Nearly all HIV infections in young children occur as a result of ‘vertical’ transmission during pregnancy, at birth or during breastfeeding. Programmes for PMTCT of HIV, many of which UNICEF has helped to design, implement and support for years, are an integral part of antenatal and maternal care.

The adoption by most of the world’s countries of treatment policies centred on offering lifelong ART to all pregnant women who test positive has been especially transformative in expanding access to treatment. The number of new HIV infections in children in 2017 was an estimated 180,000 around the world, 33 per cent lower than the comparable estimate of 270,000 for 2010.101

Yet, the fact that so many children aged 0–14 were newly infected with HIV in 2017 indicates there is a long way to go to reducing new infections among children to 20,000 by 2020. Accelerating access to and uptake of ART, and retaining all pregnant and breastfeeding women living with HIV on treatment and care, is the only way to quickly and consistently reduce infections among young children.

Progress has stalled, and many women continue to miss out on PMTCT interventions. Access among pregnant women to ARVs rose steeply from 51 per cent in 2010 to 77 per cent in 2013, but then increased by only 3 percentage points to 80 per cent in 2017. The lack of more substantial and sustained progress in ART coverage for PMTCT is the main contributor to the 3 million children worldwide living with HIV in 2017.

Regaining momentum on coverage and reaching or exceeding EMTCT validation criteria102 requires targeted efforts to offer tests to all pregnant women, particularly those missed by traditional PMTCT services that rely on ANC in primary health clinics. In West and Central Africa, where access to both ANC and PMTCT services is lower than in Eastern and Southern Africa, UNICEF is using maternal, newborn and child health (MNCH) and HIV data to identify and reach women and their families who have not benefited from HIV testing. Community outreach approaches include testing pregnant women during ‘child health weeks’ and coordination and partnership with well-established community structures such as churches, a model successfully piloted in Nigeria.

Yet, even with the evident shortcomings, PMTCT efforts continue to be much more successful than efforts to ensure that all children and adolescents living with HIV are on age-appropriate, effective HIV treatment. While some progress has occurred in recent years, albeit from very low levels, the proportions of children aged 0–14 years and adolescents aged 15–19 years on ART in 2017 were just 52 per cent and 37 per cent, respectively.
These gaps persist for reasons including a lack of adequate and convenient testing services and the failures of decentralized systems to quickly and efficiently get newly diagnosed children on ART. UNICEF responses to the testing challenges include strong support for innovative testing models and mechanisms such as EID through POC diagnostics and family-based case finding. Its support for integration of services is a main response to the lags and obstacles associated with decentralized systems in which, for example, ANC and HIV services are not closely coordinated.

In terms of supply, UNICEF procured 4.8 million packages of ARVs for 38 countries worth US$31.5 million in 2018, essentially providing an estimated 116,000 adults and 79,000 children (weighing 10–13.9 kg) with first-line therapy for one year. The total procurement value of the packs was US$15.2 million.

Much UNICEF work in these areas is coordinated with global and local partners. Within the UNAIDS partnership, and under the UNAIDS Unified Budget and Results Action Framework (UBRAF), UNICEF and WHO now co-convene Strategic Result Area 2 (EMTCT and keeping mothers, children and adolescents alive).

The available data underscore the reality that there is no one-size-fits-all approach to ‘ending AIDS’. UNICEF differentiates its response in each country where it works according to the incidence of HIV among pregnant women, mothers, children and adolescents; the opportunities and risks in national health systems; and the existing level of support and action from domestic and international partners. A top priority in all contexts is knowing the specific populations that are most at risk and most vulnerable and seeking to reach them through evidence-and analysis-based assessments of where HIV prevention programmes should be concentrated and intensified. The challenge now, for UNICEF and its partners, is to help package combination prevention actions relevant to the different epidemic contexts.

Where epidemiological evidence indicates the need for improved case finding, PMTCT or ART coverage or access, or better-quality HIV services in general, the UNICEF response is to focus on issues obstructing the scale-up of programmes in order to meet national, regional and global goals. UNICEF has adopted this intensified response in the 35 priority countries, which make up the largest burden and are referred to in the Strategic Plan targets.

Improving services and community demand

One focus for improving testing and treatment service uptake has been on building and responding to community demand. UNICEF-supported community interventions have included maternal and family-based case finding and testing; community-based peer-support initiatives (including women living with HIV serving as mentors to other women accessing HIV services and male-partner engagement); and community leadership building, including for networks of adolescents who reach out to peers and support them in HIV testing, treatment and adherence. Examples of such initiatives are provided below.

As part of efforts to increase PMTCT ART uptake in Malawi, UNICEF supported the Ministry of Health to assess the effectiveness of integrating HIV testing for women attending a family health unit in a busy urban health facility. Peer navigators supported mothers who tested positive for HIV and linked them to ART services. Of the 1,393 mothers tested during the pilot study period, 100 per cent of those identified as positive were promptly initiated on ART (compared with 36 per cent at baseline).

In Togo, UNICEF supported the establishment of 20 new sites for PMTCT within MNCH centres in 2018, bringing the total number of sites to 756, or 94 per cent of all the centres in the country. One hundred new centres were also equipped in 2018 for the comprehensive care and treatment of people living with HIV. To strengthen the identification and care of children, 322 out of 700 targeted health facilities in the 2014–2018 programme cycle integrated routine HIV testing of children and adolescents.

PMTCT programmes are often more effective for women and girls when their male partners are involved in positive, direct ways. The importance of male-partner engagement was one of five ‘promising practices’ identified by a final review of the Optimizing HIV Treatment Access for Pregnant and Breastfeeding Women (OHTA) initiative, conducted with the Johns Hopkins University in 2018. UNICEF sent a final report in 2018 to the governments of Norway and Sweden, which provided funding for the initiative. OHTA aimed to strengthen the ability of healthcare systems to provide a full range of PMTCT services in four countries: Côte d’Ivoire, the Democratic Republic of the Congo, Malawi and Uganda.

In September 2018, UNICEF and UNAIDS agreed that family testing – in which family members (especially children) of people living with HIV are brought in for testing themselves – would be one of five ‘game changers’ in a road map of priority actions to accelerate implementation of the ‘Catch Up’ plan in West and Central Africa (see Case Study 14). This innovative approach has already been shown to have beneficial impacts in several countries in the region.

In 2018, UNICEF supported the Central African Republic in implementing a family HIV-testing campaign in four high HIV prevalence cities (Bambari, Berbérati, Carnot and Paoua). A total of 10,230 families of people living with HIV were reached by the campaign, which resulted in 6,776 children being tested; 83 children identified as HIV-positive were initiated on ART. In 2018, Sierra Leone also implemented community-based family HIV testing, with 25,119 families screened over the course of the year. A total of 284 children and adolescents were diagnosed as living with HIV, with all subsequently referred for treatment.
Targeted work among vulnerable adolescents and young people has sought to improve the quality of HIV testing, treatment and prevention services, and boost community demand. The long-standing UNICEF approach concentrates in part on creating conditions for adolescents to be involved directly and extensively in all phases of the initiatives and interventions it supports. This can help to ensure that services are as adolescent friendly as possible and that they respond to the intended beneficiaries’ needs and expectations.

In Lesotho, UNICEF is working in partnership with the non-governmental organizations (NGOs) Skillshare and Sentebale to empower youths to advocate for quality health services for adolescents and young people in five districts through social accountability. Sixty-two youth advocates were trained to monitor adolescent-friendly health services (AFHS) in health centres in five districts in 2018. Similarly, 40 health-service providers were trained on national AFHS standards and the role of youth advocates in monitoring services. This initiative is responsible for more than 20,000 adolescents being reached by the end of 2018 with comprehensive knowledge of HIV and prevention through a peer-to-peer support system.

In Malawi, for example, UNICEF focused on mobile HIV testing for at-risk adolescents in 2018. Additional interventions supported by UNICEF were also targeted at adolescents and young people in households that receive cash transfers, and adolescent boys and young men who have sex with boys/men. They included creating peer-support groups and facilitating HIV testing and information sharing about HIV prevention.

In Zambia, UNICEF supported the scale-up of adolescent-friendly services at health facilities, with strong community health worker engagement. With the expanded services, 831,227 HIV tests were conducted nationwide among adolescents aged 10–19 years in 2018. Ninety-eight per cent of these adolescents diagnosed with HIV were started on ART in 2018, an exceptionally high linkage rate that is largely due to the ‘test and treat’ policy that the country has adopted.

In Chad, a programme with the Ministry of Youth and Centre for Reading and Cultural Expression raises awareness of HIV with youth leaders who serve as peer mentors. With UNICEF support, Chad has established HIV testing and counselling services at youth centres across the country. A total of 365,840 young people were tested in 2018, up from 169,812 tested in 2017.

CASE STUDY 14: West and Central Africa: Family testing as a priority approach to improve responses among children

West and Central Africa is lagging in almost every relevant HIV indicator. The region has the lowest paediatric testing and treatment coverage rates in the world, and only about 21 per cent of HIV-exposed infants have access to early infant diagnosis (EID) for HIV.

These low numbers prompted international partners, including UNICEF, and countries in the region to develop and launch a West and Central Africa ‘Catch Up’ plan in 2016 that aims to galvanize collaborative, coordinated action to improve PMTCT services and broader HIV responses in the region. As part of their engagement in and support of that plan, UNAIDS and UNICEF identified nine priority countries in the region (Burkina Faso, Cameroon, the Central African Republic, Chad, Côte d’Ivoire, the Democratic Republic of the Congo, Equatorial Guinea, Ghana and Nigeria) for intensified technical assistance in 2018. One major area of UNICEF support, begun in 2018, was the provision of technical assistance in those priority countries to scale up family testing to help overcome gaps in HIV case finding among children and young people in particular.

Family-centred approaches are based on reaching out to and encouraging undiagnosed family members of people living with HIV to be tested themselves. This approach has shown promise in identifying children and adolescents living with HIV, many of whom have at least one HIV-positive parent. This targeted approach typically has a relatively high ‘yield’ in terms of finding children living with HIV who have been ‘missed’ by health responses and HIV programmes for a variety of reasons. Because such efforts are undertaken in family situations, where people are more likely to know and support each other’s health-seeking behaviour, they can have a major difference in increasing both uptake of antiretroviral therapy and retention in HIV care.

Important considerations early on include whether local health systems have the capacity to provide paediatric antiretroviral therapy formulations as per relevant WHO recommendations once children have been identified and linked to treatment, and whether care providers are equipped with the skills and tools to implement family-centred testing and report on it.
In Jamaica, in 2018 UNICEF supported the Ministry of Health to train 130 health workers to conduct audits and implement adolescent-friendly service standards in public health facilities. As a result, 26 facilities across the country are now implementing such standards and have also designated particular days for adolescent health clinics. These clinics are operated on the weekend or during the after-school period to ensure access by young people seeking the services. An additional 30 facilities are expected to join the roll-out in 2019.

In Ukraine, UNICEF supported a national campaign organized for young people during February and March 2018 that increased HIV testing in youth-friendly facilities by 44 per cent compared with the same period in 2017. Through a social media campaign, #QuestHIVTest, more than 7,600 teens participated in a collaborative mapping project using web-based geospatial tools to identify and share details on adolescent-friendly testing and outlets. Contents related to HIV testing and healthy lifestyles reached more than 2 million young people online.

There is growing and conclusive evidence that infants and children exposed to, infected with or affected by HIV may experience higher rates of neurocognitive and developmental delays and that early childhood development (ECD) services and good parenting can mitigate and minimize these detrimental effects. Much of the ECD-focused work of UNICEF in 2018 centred on small demonstration initiatives intended to provide proof of concept for future expansion and utilization.

For example, an initiative led by Partners in Hope Malawi that was based on WHO–UNICEF Care for Child Development guidelines held ECD sessions for nine months with more than 100 mothers with HIV. One key result was a two- to fivefold increase in the availability of homemade toys and parents/caregivers reading and singing to children. In South Africa, the NGO Clowns Without Borders implemented a UNICEF-supported parenting programme, Sinovuyo Teen. Encouraging results included data from target communities showing less violence, more supportive parenting, less alcohol and drug use, and more planning to protect teens in the community.

In China, UNICEF supported pilot projects in partnership with the government on ECD, EMTCT and injury protection. Through these projects, an estimated 200,000 children aged 0–3 years and their caregivers in nearly 800 villages and more than 60 townships in five provinces were reached with comprehensive ECD services through home visits and community outreach.

HIV treatment and prevention are critical interventions in humanitarian contexts – and especially so in settings where violence (and gender-based violence in particular) is driving or contributing to the humanitarian crisis. The UNICEF focus on the ongoing delivery of HIV treatment services is something of a test case for how chronic health conditions can be managed in humanitarian crises. UNICEF has worked to develop guidance on how HIV treatment programmes can be risk responsive through simple measures such as providing multi-month prescriptions to clients when a crisis is looming. In humanitarian settings, UNICEF helps ensure HIV prevention is robust for women, children and adolescents by supporting education, counselling, and the provision of prevention tools and support.

As befits its overall mandate, UNICEF HIV efforts in humanitarian responses and other emergency contexts are focused particularly on the gaps and needs of pregnant women and children in areas such as HIV testing and education, uptake and reliability of ART, and preventing and mitigating the consequences of sexual violence. For example, Bangladesh was home to more than 740,000 Rohingya refugees whose plight can be characterized as one of the world’s worst humanitarian emergencies in 2018. UNICEF support in 2018 facilitated HIV testing and counselling for 43,000 pregnant women in Chittagong, Cox’s Bazar, Dhaka, Khulna and Sylhet.

Disabilities are rarely a core priority of HIV treatment and prevention efforts focused on children, adolescents, pregnant women or mothers. Yet by emphasizing a holistic approach to its HIV work, UNICEF has sought to ensure that all initiatives and programmes it supports take into account disability issues in their design and implementation.

### Building stronger institutions

As part of its support to countries in their push for EMTCT validation and better HIV results among all children and adolescents, UNICEF is focusing on two areas that hold promise for building more resilient and enhanced structures and systems: (1) integrated approaches and (2) the use and effective deployment of new and innovative technologies and interventions that offer promise to improve access to quality HIV services. It has placed particular emphasis on supporting countries towards EMTCT and scaling up POC diagnostic technologies for EID.

Gaps in comprehensive antenatal and postnatal care services represent missed opportunities to reach pregnant women with HIV testing, ART and care, and there is a direct correlation between the quality of MNCH systems and the quality of PMTCT services. Improving access to HIV services for pregnant women, children and adolescents relies on stronger linkages between HIV and health and social systems. MNCH services require improvement in countries with low maternal ART coverage, particularly in West and Central Africa, where fewer than half of pregnant and breastfeeding women were covered by PMTCT services in 2017.103
In Sierra Leone, UNICEF and WHO supported the phased introduction of dual HIV–syphilis testing to improve timely detection of the two diseases in women attending ANC. In Senegal, UNICEF supported campaigns in five regions aimed at reinforcing the capacities of health care workers on the use of a dual HIV–syphilis rapid test, HIV testing of pregnant women and children more broadly, and family testing. Through these campaigns, 150 pregnant women living with HIV who had not been reached earlier by health teams were found and provided HIV care and treatment. The dual HIV-syphilis diagnostic test was also introduced in Cabo Verde, largely as a result of UNICEF advocacy with the government. UNICEF arranged for procurement of the dual tests and supported the training of health technicians to administer and interpret the tests.

Technical support brokered by UNICEF in Guinea-Bissau in 2017 resulted in the adoption that year of new clinical guidelines and protocols that were printed and widely distributed to ART clinics and laboratories, and the training of 75 health workers in implementing a provider-initiated HIV testing and counselling approach. These efforts contributed to an increase in the number of children tested for HIV in general paediatric services of five major hospitals: 1,614 in 2018 compared with 1,357 in 2017.

In Cameroon, UNICEF supported the government to decentralize planning of HIV activities for pregnant women, adolescents and children from the national to regional level to accelerate responses. This decentralized approach resulted in 2,359 out of 3,919 children and adolescents living with HIV who were initiated on ART in 10 priority districts, an increase in coverage from 24 per cent (2017) to 60 per cent (2018) in those districts.

In collaboration with partners, UNICEF supported the Government of Côte d’Ivoire in developing the 2018 HIV Acceleration Plan. UNICEF coordinated partners to monitor, follow up and boost delivery of results in 24 priority districts, and supported a review of HIV indicators with the district teams to identify gaps and barriers.

In Zimbabwe, UNICEF supported formal training in 2018 for 270 service providers in 10 districts on activities aimed to better integrate HIV services, including longitudinal tracking and tracing of mother-infant pairs, regular mentoring and supportive supervisions. In Kenya, UNICEF provided technical assistance in the development of new guidelines on care for children living with HIV. The increased efforts to reach and support adolescents in Kenya resulted in more than 1 million adolescents aged 10–19 years receiving HIV tests between January and September 2018, of whom 3,471 were identified as living with HIV.

UNICEF procured 5.3 million HIV kits, including combination HIV–syphilis diagnostic kits, for 38 countries in 2018, at a value of US$5.84 million. This is an increase of 3 per cent over 2017. Some 11,500 of those were HIV self-test kits procured for use in Belarus, Rwanda and Somalia (valued at US$25,800).

Towards eliminating mother-to-child transmission

Globally in 2018, over 80 per cent of pregnant women living with HIV received ART for their own health and to reduce MTCT of HIV. However, the progress is variable between and within regions and countries. To improve access, UNICEF has been providing support to countries on the basis of the level of the response required and the strength of the health system.

Although none of the 35 priority countries has yet to be validated by WHO as having eliminated MTCT, several – including Eswatini (formerly Swaziland), Namibia, South Africa, Uganda and Zimbabwe – have met one of the validation criteria: 95 per cent ART coverage among pregnant women living with HIV. In Botswana and South Africa, this high coverage translates to an MTCT rate of less than 5 per cent, which is the global target.

UNICEF has contributed to such achievements in numerous ways. In Namibia, in preparation for the EMTCT validation country assessment planned for 2019, UNICEF in 2018 supported the Ministry of Health and Welfare to conduct a routine data-quality assessment of the PMTCT and syphilis programmes in 10 health districts and 70 health facilities that were sampled. UNICEF also partnered with WHO and UNAIDS to provide technical and financial support for the development of a road map for the EMTCT of HIV and congenital syphilis between 2019 and 2023, which resulted in the development of regional and district EMTCT action plans in seven regions.

In Eswatini, UNICEF supported high-level advocacy to develop a new EMTCT framework, which was rolled out to 83 per cent of health facilities in 2018. To inform the new framework, UNICEF supported an EMTCT assessment to generate critical data to determine service-delivery gaps.

In Haiti in 2018, UNICEF supported two workshops and the training of care providers on PMTCT guidelines and on the new standards of HIV care, including follow-up post-training missions and dissemination of operational plans for the new standards.

India is progressively scaling up access to PMTCT services. In 2018, under the joint United Nations support to HIV/AIDS prevention, care and support coordinated by UNAIDS, UNICEF supported the Gujarat State AIDS Control Society in its scaling up efforts. The overall objectives of the PMTCT programme in Gujarat are to ensure that all pregnant women (an estimated 1.47 million annually) have access to ANC and are registered, all women who register receive an HIV test, all HIV-positive mothers and infants have access to PMTCT and are retained in care, and PMTCT data are accurately captured in the national HIV/AIDS database.

As the lead technical agency on PMTCT of HIV in Myanmar, UNICEF contributed to health workers’ capacity and government leadership to provide PMTCT services in 320 townships (out of a total of 330 in the country). Health staff received PMTCT training especially on POC HIV testing,
ART and referral mechanisms for HIV-infected mother-baby pairs to ART centres. The training was conducted both pre-service and on-the-job at township and other subnational levels.

UNICEF has been supporting many other countries in their efforts to match the recent EMTCT achievements. In 2018, Malaysia joined the list of countries validated by WHO for EMTCT of HIV and syphilis. UNICEF was one of the partners that supported the Ministry of Health in achieving PMTCT coverage goals and monitoring progress. Malaysia’s experience highlights the value of government commitment; a robust PMTCT programme fully integrated into universally available MNCH services; high-quality and comprehensive systems to collect and analyse data; and extensive partnerships across sectors, including the active participation of civil society in planning and evaluation.

In Viet Nam, UNICEF led the United Nations joint team to support the development of the national action plan to eliminate HIV, syphilis and hepatitis B. The plan was approved in November 2018. In China, UNICEF supported efforts to validate triple elimination by 2020 in three provinces, Guangdong, Yunnan and Zhejiang, and provided technical assistance towards the development of a validation framework for the national PMTCT programme.

Cuba offers an example of a successful approach in lower- and middle-income countries where the majority of gaps remain. At the end of 2018, Cuba marked the second year with zero cases of MTCT of HIV and syphilis after being certified by the Pan American Health Organization (PAHO) in 2015 – the first country in the world to achieve the dual certification. In 2018, UNICEF and PAHO worked together to help develop the validation tools used by Cuban health authorities, and completed a joint mission to Havana to assess progress and provide technical support.

Scaling up point-of-care early infant diagnosis

Currently, only 52 per cent of children access early infant HIV testing at six to eight weeks as recommended by WHO. By offering POC testing as an integral part of infant health services at facilities, children can receive HIV test results on the same day as the clinic visit and ideally be linked immediately to ART. UNICEF has therefore prioritized the introduction and scale-up of such POC diagnostic technologies.
UNICEF has been one of the lead partners – along with CHAI and ASLM – in the implementation of a Unitaid-funded project to introduce and scale up POC EID tests in 10 countries in Africa (see Case Study 15). UNICEF has been instrumental in introducing innovation in several other countries that are on the cusp of making greater improvements in EID, which is critical to reducing infant morbidity and mortality.

In Malawi, UNICEF pioneered the use of drones to address the challenges of delayed test results due to challenges of transporting diagnostic samples from remote peripheral sites, and in 2017 supported the government to open a drone air corridor in 2017. In 2018, UNICEF supported a study on the use of drones by John Snow International; the findings are being used by the Ministry of Health and others to design a drone project in two districts for EID.

**CASE STUDY 15: Early infant diagnosis and programme integration in the scale-up of point-of-care diagnostics**

UNICEF is working with Unitaid and other global health partners to support the introduction and roll-out of point-of-care (POC) technologies, particularly in Africa, to increase access to HIV diagnostics. This work is considered essential to overcome some of the most challenging gaps in conventional laboratory systems, including the transport of blood samples to central or regional laboratories and the timely return of results for clinical management. Until recently, before POC became available, this diagnostic platform was only provided through specialized regional and central laboratories, beyond the reach of most children accessing health care.

UNICEF is supporting several activities to boost POC product entry, expand reliable access to POC options, and place products strategically within health systems. For example, with financial support from Unitaid, in 2018 UNICEF continued to work with two main implementing partners (African Society for Laboratory Medicine and the Clinton Health Access Initiative) to introduce and scale up POC early infant diagnosis (EID) across 10 early adopter countries.

While these countries are currently at different stages of implementation, early successes have encouraged further expansion. In Mozambique, for example, POC EID increased the proportion of infants initiating antiretroviral therapy within two months sevenfold. Expanding to nine sites in Cameroon in 2018, EID coverage increased to 69 per cent, a rate far higher than the national average of 51 per cent in 2017. In Cabo Verde, POC is now available nationally.

Further expansion in West and Central Africa will leverage existing technology and promote multi-disease testing. For example, more than 2,800 GeneXpert systems have already been procured for tuberculosis (TB) testing in focus countries of the US President’s Emergency Plan for AIDS Relief (PEPFAR). Pilots conducted in Malawi and Zimbabwe in 2017 and 2018 demonstrated that adding HIV EID functionalities to existing GeneXpert devices expanded POC testing without compromising or having any negative impact on TB services. In fact, programmes for both HIV and TB saw cost savings in the two countries.

Such results prompted UNICEF to announce a financial commitment of US$6 million to introduce and roll out POC EID in 10 additional countries in West and Central Africa between 2018 and 2021. Access to EID in this region is the lowest in the world: currently, only 21 per cent of infants are tested for HIV at the recommended six to eight weeks of age. This project will contribute to achieving the UNICEF Strategic Plan target of 890,000 infants born to pregnant women living with HIV tested within their first two months of life by 2021.

A lab technician runs a POC early test in Port-Bouët, a suburb of Abidjan, Côte d’Ivoire. UNICEF has supported the roll-out of POC EID technologies to increase HIV testing and accelerate the initiation of treatment for those who need it.
In Lesotho, UNICEF technical and financial support included piloting EID for HIV-exposed infants aged under two months, which was then scaled up by the government in partnership with the Elizabeth Glaser Pediatric AIDS Foundation. The assistance has contributed to improvements in the share of children aged 0–14 years living with HIV estimated to be on treatment to 60 per cent in 2017 (from 45 per cent in 2015).

**Psychosocial support for children living with HIV**

HIV is far more than simply a health concern for many people living with the virus. Children and adolescents living with the virus often feel ashamed, isolated (particularly from peers) and depressed, which may lead to some refusing to accept their status or declining to start or continue ART or otherwise engage in clinical care. Psychosocial support can help adolescents cope more effectively with each stage of the infection and enhance their quality of life. Supporting them to initiate treatment or remain adherent to ART strengthens their own health and reduces the risk of transmitting the virus to their partners (see Case Study 16).

**Leveraging collective action**

Another key part of UNICEF work towards completing the ‘last mile’ in EMTCT is supporting countries and other partners to collect more disaggregated and robust data on where and when (i.e., during the pregnancy or breastfeeding period) new, vertically transmitted infections in children are occurring to better target investments. In partnership with UNAIDS and WHO, UNICEF is supporting countries in analysing the sources of new infections in children and using the analyses as an evidence basis for directing investment towards reducing new infections in children. Work in this area has found that in Eastern and Southern Africa, a high proportion of children are infected when women drop out of care or acquire new HIV infections, whether during pregnancy or breastfeeding.

The persistent treatment gap for paediatric ART continues to have major consequences for the health of millions of children worldwide. As stated earlier in this report, only 52 per cent of children living with HIV received ART in 2017 – and, of them, only about half were receiving optimal treatment regimens. Consequently, rates of viral suppression in children are consistently lower than among adults. UNICEF considers it a top priority of its HIV response to draw attention to these gaps and mobilize

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**CASE STUDY 16: Kazakhstan: Enhancing quality psychosocial support for better HIV outcomes among children and adolescents**

Recent UNICEF work in Kazakhstan illustrates the importance of providing psychosocial support for children and adolescents living with HIV. Nearly 2,000 adolescents and young people aged 15–24 are living with HIV in Kazakhstan.

UNICEF in 2018 supported the development of the National Guide on Psychosocial Support for HIV-Positive Children and Adolescents, a national policy incorporating international expertise and practices. UNICEF convened multidisciplinary teams of service providers during the development phase to ensure the standards would be aligned with and relevant to acceptable clinical practice. The new national standards extend beyond the medical needs of children and adolescents and seeks to ensure that appropriate, individual support packages are developed to meet their psychological, educational, cognitive, social and emotional needs from the moment they are diagnosed with HIV to their transition into adult care.

With UNICEF guidance and supervision, trained HIV specialists have developed internal working plans to integrate the new standards into the routine practice of their medical organizations. Additional implementation work by UNICEF has included increasing the skill sets and confidence of providers in engaging with and retaining adolescents living with HIV in support services. In 2018, this was done in part by training a national group of 90 clinicians and social workers from seven regions of the country. These individuals and others to be trained in the future will further transmit such knowledge and techniques to others throughout the country.

As part of its work of building capacity to respond to mental health needs in the broader Central Asia region, UNICEF supported regional cooperation and multi-country learning through a regional seminar on paediatric HIV treatment and an International Therapeutic Summer Camp in Issyk-kul, Kyrgyzstan, in July 2018. Organized in collaboration with the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Children’s HIV Association (CHIVA) and the Paediatric European Network for Treatment of AIDS (PENTA), the events promoted skills-building activities around psychosocial support to over 200 clinical care providers, psychologists, social workers, caregivers, children and adolescents living with HIV from Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan.
action to overcome them. Advocacy with partners has focused on the development of treatment formulations that are appropriate, safe and effective for young children (see Case Study 17).

As noted elsewhere in this report, UNICEF and partners are helping to drive integrated health and development agendas within countries and more broadly. These efforts are closely associated with priorities suggested by the 2030 Agenda for Sustainable Development and local HIV and health responses, which are increasingly being coordinated jointly, as HIV is seen as a health and wellness priority that can only be addressed effectively through a holistic approach.

Much recent UNICEF work to support HIV integration (e.g., HIV services delivered within MNCH programmes) is happening in settings with lower-prevalence epidemics, with a more recent emphasis in West and Central Africa. In 2017, UNICEF played a lead role in supporting the development and endorsement, by African Union leaders, of a West and Central Africa ‘Catch Up Plan’ to rapidly accelerate access to HIV treatment and close the gap between that region and others. By engaging with global and local partners, UNICEF is helping to drive progress in the region towards the UNAIDS ‘super-fast-track’ targets and other major global HIV treatment and prevention targets.

In 2018, UNICEF supported the Organisation of African First Ladies against HIV/AIDS for Development (OAFLAD) in its launch of the ‘Free to Shine: Africa United Against Childhood AIDS’ campaign at the global level and in countries. The high-profile campaign aims to reinforce the political commitment of African nations to end childhood AIDS and keep mothers healthy, with a focus on EMTCT of HIV. The advocacy messaging and broader approach build on the UNAIDS ‘Start Free, Stay Free, AIDS Free’ framework for children to catalyse regional action around EMTCT of HIV and syphilis by 2030.

UNICEF joined OAFLAD in kicking off the Free to Shine campaign in January 2018, and, as of the end of 2018, the campaign had been launched in 21 countries. Several first ladies are actively engaged in developing and re-forming national HIV responses. In Namibia, for example, UNICEF, UNFPA and UNAIDS worked closely with the Office of the First Lady to accelerate results for adolescents living with HIV, with particular attention on adolescent girls and young women. Within the OAFLAD PMTCT agenda, UNICEF reinforced the importance of retention interventions to ensure pregnant and breastfeeding women living with HIV are receiving adequate care and treatment.

UNICEF and WHO lead the Global Breastfeeding Collective, a partnership of more than 20 international agencies that calls on donors, policymakers, philanthropists and civil

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**CASE STUDY 17: Partnerships and engagement to overcome paediatric ART gaps**

Over the past few years, UNICEF and other global stakeholders have come together to enable more focused and coordinated action to make age-appropriate optimal antiretroviral therapy (ART) formulations more rapidly available to infants, children and adolescents living with HIV. UNICEF actively engages in the World Health Organization (WHO) led Paediatric ARV [Antiretroviral] Drug Optimization technical working group and the Paediatric ARV Working Group. The primary roles of these groups are to convene global partners to influence the strategic prioritization of paediatric drugs and formulations in research and development, and to accelerate product entry in programme countries.

In 2018, UNICEF participated in the fourth meeting on paediatric drug optimization, which was convened to update the list of medium- and long-term priorities for paediatric drug and formulation development, and to identify additional research gaps in this area. Collaborators included researchers, clinicians, programme managers from international agencies and other stakeholders. Through the group’s work, the 50 mg dolutegravir tablet, now recommended by WHO as a first-line option for adults, will be recommended for use in children weighing at least 20 kg, which means it can now be used in children as young as 6 or 7 years of age.

To accelerate product entry, in December 2018 UNICEF participated in a high-level public–private dialogue that is organized annually by the AIDS Free Working Group (co-convened by WHO and the Elizabeth Glaser Pediatric AIDS Foundation) and Caritas International on scaling up diagnosis and treatment of paediatric HIV under the Vatican Initiative. UNICEF committed to: supporting and facilitating intensified efforts in the roll-out of point-of-care early infant diagnosis; promoting family-based testing; supporting health ministries to expand paediatric care and treatment within broader maternal and newborn health services; and developing, testing and disseminating training tools for treatment initiation with optimal paediatric formulations. UNICEF is working at the country level to ensure national programmes are responding to WHO recommendations in a timely manner and adopting optimal child regimens as soon as possible.
society to increase investment in breastfeeding worldwide. The collective’s work has integrated issues in child health, HIV and nutrition.

In late 2018, the Global Breastfeeding Collective released an advocacy brief on breastfeeding and HIV reiterating the low risk of HIV transmission through breastmilk when mothers adhere to treatment throughout the breastfeeding period and highlighting the need to support women living with HIV to adhere to treatment regimens and breastfeed safely.

HIV and nutrition intersect in important ways: malnutrition is both an underlying cause of mortality and a risk factor for HIV among children and adolescents. In countries with high HIV burdens, the UNICEF integrated approach entails HIV testing linked to treatment and care of children who present with severe acute malnutrition at nutrition treatment centres, hospitals and child health clinics, and the promotion of WHO infant feeding guidelines based on evidence that MTCT of HIV is reduced when the breastfeeding mother is on ART.

Results Area 2: HIV prevention

Output Statement 1: Countries have implemented comprehensive HIV prevention interventions at scale.

Scaling up HIV prevention programmes has long been a major challenge worldwide among all populations. But adolescents remain especially at risk and underserved by prevention efforts. In 2017 alone, an estimated 250,000 new infections occurred worldwide among adolescents aged 15–19. Added to the estimated 180,000 new infections among children aged 0–15, the total of 430,000 new infections was nearly one quarter of the global total across all ages.

Between 2010 and 2017, the number of new HIV infections among adolescents aged 10–19 years decreased by only 17 per cent. New infections among adolescents and young people must be reduced substantially – by 75 per cent – if ‘ending AIDS’ is to be a realistic goal in the short or medium term. Without effective HIV prevention programmes targeted to adolescents and young people, their governments and the international community will continue to incur the significant costs of testing, treatment and care of all those who become infected throughout the course of their lives.

As long as efforts to curb the epidemic among adolescents and young people remain insufficient, it will be nearly impossible to sustain the HIV response by 2030 or in the foreseeable future. UNICEF supports countries in accelerating and scaling up HIV prevention interventions that are age-appropriate, context-specific and informed by the data and the evidence of what works. UNICEF partners with countries in introducing innovative approaches and new technologies and addressing the factors that keep those most at risk of HIV infection from accessing HIV prevention services of good quality.

The health and well-being of millions of girls and young women everywhere depends on effective implementation of interventions that reduce their multiple vulnerabilities and improve their capacities. HIV has had a disproportionate effect on this population. Globally in 2017, females accounted for two thirds of all new infections among adolescents aged 10–19 years. The majority (57 per cent, or 1 million) of the 1.8 million adolescents living with HIV are female. In most of the 35 priority countries, girls are at greater risk of HIV infection than boys.

The HIV-related risks and vulnerability are most acute in sub-Saharan Africa. Women in Eastern and Southern Africa, for example, are on average infected with HIV five to seven years earlier than men, with the risk especially high between the ages of 15 and 24. Addressing the HIV-related risks experienced by adolescent girls and young women remains a critical priority for UNICEF.

Adolescents who identify as a member of one or more most-at-risk groups, also called ‘key populations’ – men who have sex with men (MSM), sex workers, transgender populations, people who inject drugs – are ‘doubly vulnerable’ because of their age and the heightened HIV risks within these groups. Data are limited on adolescent key populations, including their size, HIV prevalence, and access to treatment and prevention services. What is known underscores the importance of reaching and supporting these individuals more effectively. Global reports have estimated HIV prevalence to be above 4 per cent for young gay men and other MSM under the age of 25, and over 5 per cent for individuals in that age range who inject drugs. By comparison, UNAIDS estimates global HIV prevalence to be 0.4 per cent in young women aged 15–24 and 0.2 per cent in young men aged 15–24.

Most current strategies for adolescents and young people refer to ‘combination’ prevention, which includes biomedical, behavioural and structural interventions, thus attacking the issue on several fronts. Reaching adolescents with information and services that are relevant and acceptable to them presents challenges under many circumstances, but in the context of HIV these challenges are often compounded by such factors as age-of-consent policies, punitive laws and HIV-related stigma that discourage adolescents from seeking services that can keep them HIV free – or if living with HIV, then
can keep them alive through treatment and prevent them from transmitting the virus to their partners. UNICEF is working to address these factors through its advocacy and programmes.

A key part of the problem is that so few countries regularly report data that could prompt more effective interventions and engagement by governments and external partners such as UNICEF. Adolescent-specific results along the HIV clinical ‘cascade’, which correlates with the UNAIDS ‘super-fast-track’ targets, show both the challenges and shortfalls in routine data reporting and use. Only five of the 35 priority countries reported on age-disaggregated data on known HIV status for adolescents; only eight reported on access to ART; and only seven reported on viral suppression.111

The impact of the lack of adolescent-specific data is linked with limited progress in the HIV response for this population. Testing for HIV remains the first step towards getting into quality, effective HIV care for adolescents (and anyone else living with HIV). However, uptake of testing among adolescents and young people seems to be far below what is needed. A pooled analysis of nationally representative survey data available in 25 of the priority

## CASE STUDY 18: ‘All In’ impacts in 2018: Supporting evidence-based change at country level

The All In to End Adolescent AIDS (‘All In’) platform is a coordinated effort to improve HIV prevention and treatment services and outcomes among adolescents. It focuses on 25 priority countries that collectively account for an estimated 86 per cent of all new HIV infections.112

The first main task of ‘All In’ was to conduct baseline reviews in the 25 countries to identify gaps, needs, and potential partners and entry-points. That process found that current adolescent HIV prevention and treatment efforts in most countries are fragmented, poorly coordinated and not implemented at scale. In most contexts, adolescent key populations fare even worse and are further removed from access to supportive or effective programming.

The findings of the comprehensive reviews guided implementation discussions and actions throughout 2018. UNICEF and other partners, including UNAIDS and the PACT (a coalition of youth organizations and networks), are collaborating to use the assessments to raise awareness of adolescent-specific needs and prompt more evidence-based responses from national governments and other stakeholders.

At the 2018 International AIDS Conference, UNICEF and UNAIDS released a report on ‘All In’ in Eastern and Southern Africa that highlighted lessons learned and proposed strategies for the region’s countries to improve HIV prevention and treatment responses among all adolescents. The information and observations in such reports and the 25 country assessments are intended to enable the identification of adolescent subpopulations, interventions and geographic areas; initiate dialogue on issues that affect their uptake of HIV services, such as age-of-consent policies; and facilitate the inclusion of adolescents in relevant policy changes and planning.

One key lesson was about the critical need to engage adolescents and youth networks in policy dialogue with governments and key stakeholders, so that approaches to addressing adolescent HIV are responsive to their needs.

By supporting such efforts, UNICEF is promoting national-level data collection and implementation while also building capacity for subnational data-driven programming. The next overarching phase is in the area of implementation, as countries make use of the gathered data to scale up high-impact interventions, such as quality HIV testing, treatment and care, and ‘combination’ HIV prevention strategies such as cash transfers, condom promotion, social and behavioural change programmes and voluntary medical male circumcision; develop and strengthen enabling policies; and introduce and scale up new technologies such as HIV self-testing, pre-exposure prophylaxis (PrEP) and digital technologies. This approach is essential for increased and sustained HIV responses overall at country level.

In Kenya, for example, results of ‘All In’ assessments led to revisions in the national Health Management Information System (HMIS) data collection tools for HIV to include age disaggregation. Training for subnational personnel on the revised tool was undertaken by the national government in preparation for national roll-out in 2018. Similarly, advocacy efforts in 2018 by UNICEF and other partners led to revision of the national HMIS to include key adolescent indicators disaggregated by sex and age in Côte d’Ivoire, Eswatini, Uganda and Zambia.
countries found that, overall, only about 8 per cent of adolescent girls and 5 per cent of adolescent boys were tested and received their test results in the previous year (see Figure 38).

All In to End Adolescent AIDS is a significant platform led by UNICEF to confront gaps and inequities in adolescent HIV responses. Launched in 2015 with UNAIDS and other partners, ‘All In’ focuses on 25 priority countries that are home to most of the world’s adolescents living with or at risk for HIV (see Case Study 18).

‘All In’ objectives are to improve the use of data to scale up and accelerate programmes, foster innovation, generate political will and mobilize resources through advocacy and communication – while engaging adolescents as agents of change throughout the process. All 25 priority countries have conducted baseline reviews of the data, and some countries have additionally done situation analyses or ‘deep-dives’ into adolescent HIV. For example, the four ‘All In’ countries of the East Asia and Pacific region – China, Indonesia, the Philippines and Thailand – each conducted an analysis of the situation of adolescent and young key populations.

Improving services and community demand

Evidence and anecdotal observation strongly suggest that adolescents are poorly served by the traditional health services and require services that are differentiated to their personal needs, values, preferences and choices. As such, reaching adolescents with quality and effective HIV services, and effectively closing the prevention gap, requires new approaches and strategies that both meet their specific treatment and prevention needs and are ‘adolescent friendly’.

Adolescents’ acceptance of and comfort with prevention platforms are especially important for those who are members of one or more key populations, many of whom should be prioritized for novel prevention offerings as they are rolled out and scaled up in more countries and communities worldwide. Such offerings, including PrEP and HIV self-testing, can only have the intended benefits among adolescents at high risk when these populations are explicitly considered in market-shaping strategies (i.e., to improve their access to such offerings), and when these tools are paired with essential support services.

FIGURE 38: Percentage of adolescents aged 15–19 who were tested for HIV in the last 12 months and received the results, by sex, 25 priority countries, 2013–2018


Note: Survey data are included in the chart if data were available for both sexes, data were from the last five years (2013–2018) and the survey was nationally representative.
In response to the sectoral priority of enhancing adolescents’ comprehensive knowledge of HIV prevention and promoting their uptake of testing, UNICEF in Cuba worked with ProSalud (Health Promotion and Disease Prevention Unit of the Ministry of Health) to train 150 adolescents to become promoters and community multipliers for the prevention of sexually transmitted infections (STIs), including HIV. This contributed to reaching 30,160 adolescents (14,779 boys and 15,381 girls) with HIV education and awareness messages, almost double the figure for 2017.

In the Islamic Republic of Iran, UNICEF supported increased capacity to provide HIV-related services to adolescents through adolescent well-being clubs with a focus on at-risk populations. The seven clubs are operational in six provinces covering nearly 9,000 adolescents with high-risk behaviours. UNICEF has provided technical support in areas such as counselling for adolescents and young people to reduce their HIV risk and drug-use prevention among at-risk adolescents, and through outreach to find and support hard-to-reach adolescents.

In Kenya, UNICEF has supported the expansion and capacity of young people’s networks such as Sauti Sika, which currently has more than 5,000 members. With other organizations such as I Choose Life – Africa, Investing in Children and their Societies, LVCT Health and World Vision, it is estimated that UNICEF has provided more than 100,000 adolescents life-skills training from March 2017 to November 2018.

In Nigeria, UNICEF collaborated with UNFPA and the United Nations Educational, Scientific and Cultural Organization (UNESCO) to provide technical support to the National Agency for the Control of Aids, the Federal Ministry of Health and civil society groups for the design and roll-out of #SabiHIV, a national prevention multimedia campaign targeting adolescents and youth (15–24 years). The campaign is aimed at increasing comprehensive knowledge, demand, awareness and referrals for HIV testing, condom promotion and gender-based violence services in four priority states (Benue, the Federal Capital Territory, Kaduna and Lagos). The campaign website had a reach of 135,738 on World Aids Day 2018.

An important part of the UNICEF HIV response in Indonesia focused on addressing the needs of young key populations, among which HIV prevalence is higher than in the general population. UNICEF is supporting the scale-up of a pilot programme in six urban centres (Bandung, Denpasar, Makassar, Medan, Surabaya and West Jakarta) to improve supply and demand for HIV services among these highly vulnerable groups. The programme was integrated into the Ministry of Health’s Youth-Friendly Health Services programme in 2018.

In Rwanda, UNICEF has been supporting the implementation of HIV testing and counselling services for children of female sex workers (FSWs) in partnership with Project San Francisco, an NGO in Kigali. A core component of the project, conducted in Kigali in 2018, included training 350 FSWs as community-based peers to promote HIV testing of children, which led to nearly 8,000 FSWs receiving enhanced counselling and encouragement to bring their children for testing. Over 11,000 women and their children were tested.

In 2018, UNICEF rolled out the Youth Aware initiative in the Brazilian cities of São Luis, Rio de Janeiro, São Paulo and Salvador as part of a scaling up of the project. The Youth Aware project uses an innovative mobile health unit to bring essential SRH services (including HIV testing and counselling) to adolescents and young people who are unable or unwilling to visit a facility, including transgender women, and boys and young men between the ages of 15 and 24 who have sex with other boys/men. Adolescents and young people are directly and heavily involved in the planned actions, as they are key elements of the project’s approach – peer support and social mobilization, as well as in training others to be peer educators. To date, activities in the four new cities have included at least 90 adolescents trained as peer educators on SRH and HIV prevention, testing and treatment; more than 3,400 adolescents and young people tested for HIV; more than 80 identified as living with HIV and linked to treatment services; and more than 16,000 people receiving condoms and information about HIV prevention.

Targeted work aimed at young MSM was supported by UNICEF in the Philippines in 2018. APCOM, an advocacy coalition on behalf of MSM and transgender people in Asia and the Pacific, and LoveYourself, a Manila-based volunteer organization that operates community-based STI/HIV clinics, launched an HIV awareness and prevention campaign targeted to key populations. The campaign is prominently mentioned and displayed on websites, and social-networking apps popular with MSM as well as offline events to augment the online campaign. The main goals are to educate these young men about their sexual health and encourage them to get tested. The campaign helped prompt a 62 per cent increase in HIV testing among its target populations.

In separate initiatives in the Philippines, UNICEF supported planning and the gathering of input from adolescents and young people in advance of the National Young People’s Planning Forum on HIV for the operationalization of AIDS Medium Term Plan 2017–2022.

**Building stronger institutions**

A holistic approach to HIV prevention is vital to address the multiple deprivations that the most vulnerable adolescents experience and to strengthen the institutional response to HIV risk and vulnerability. To be effective, prevention efforts must effectively leverage resources, attention and focus across a range of sectors and structures beyond HIV and health, including education, social welfare, labour and employment, human rights and gender equality. UNICEF is engaged in many of these areas in its support for improved
HIV responses among adolescents. Through a systems-strengthening approach, UNICEF supports integrated HIV prevention, care and treatment services in both schools and health clinics.

UNICEF HIV work, especially in regard to prevention, is highly gender responsive. The prioritization of gender reflects the fact that the main drivers of HIV epidemics are influenced by a range of gender factors and inequalities. Many of them – including early and forced marriage, poor access to education, gender-based violence, unequal access to information (including on sexual health), a lack of negotiating power and limited economic autonomy – affect adolescent girls and young women in many countries and put them at increased risk of HIV infection.

UNICEF developed, with partners, a pilot approach in South Africa that focused on providing peer-based, facility- and household-linked psychosocial and health education support for adolescent girls and young women to access PMTCT, MNCH, women's health and nutrition services. The project was implemented in a district in Gauteng, the country’s most populous province, and enrolled 833 adolescent girls and young women. Results from the pilot were highly promising, as seen in improved rates of retention in care, ART initiation rate and exclusive breastfeeding following the intervention. UNICEF and partners are currently supporting a phased national scale-up through the development of the intervention packages and tools for district-level scale-up and the capacity-building of district teams in Gauteng and KwaZulu-Natal provinces for the provision of services at district level.

In Côte d’Ivoire, gender-focused efforts included the provision of financial and technical support to the national school and adolescent health programme to provide health consultations through the programme’s adolescent-friendly centres. HIV prevention, menstrual hygiene and nutrition counselling are a few of the services offered during such consultations, which by the end of 2018 had been attended by more than 1.7 million individuals. More than 3,000 adolescents (64 per cent girls) living with HIV are receiving quality services provided by the centres.

Disadvantageous gender norms, gender-based violence and limitations in navigating sexual relationships are prominent contributors to vulnerability to HIV among adolescent girls and young women in Jamaica. UNICEF has supported Eve for Life, a local NGO, to design and implement interventions and strategies aimed at addressing these risk factors for several years. In 2018, UNICEF technical and financial support allowed Eve for Life to provide emotional support and resilience-building life skills for nearly 140 adolescent girls and young women who were living with HIV, victims of sexual violence, or both.

Also in 2018, Eve for Life’s trained peer mentors conducted outreach activities among vulnerable adolescents in schools and engaged more than 3,600 girls and boys in life-skills sessions focusing on HIV and pregnancy prevention. UNICEF has started discussions with relevant line ministries to examine this model of peer support, with a view to prompting government investment and scaling up to reach more vulnerable adolescent girls.

In the state of Gujarat, India, UNICEF is involved in awareness-raising efforts aimed at improving the HIV, SRH and broader well-being responses among adolescents. It has provided technical and financial support to local partnerships involved in a joint programme, Prevention and Response to Violence, Abuse and HIV in Children (PARVAH), which has used a training model and consultative workshops to train more than 630 master trainers to date. These trainers are raising awareness among health-care providers, including paediatricians, school teachers and parents, on detection, referral and management of child and adolescent sexual abuse, which is a risk factor for HIV transmission. As part of follow-up work, a total of nine district-level workshops have been undertaken on the prevention, detection and care of child victims of sexual assault.

HIV-sensitive social protection

UNICEF works on social protection in more than 100 countries, focusing particularly on maximizing impacts for children. In several countries, UNICEF is supporting the integration of HIV within national social protection programmes as part of an effort to address many of the structural drivers of HIV among children. UNICEF support has entailed linking across various sectors, including health, social welfare, justice, child protection and social development to achieve layered interventions.

In the United Republic of Tanzania, UNICEF is collaborating with the government and other key stakeholders to develop, implement and evaluate an intervention for adolescents (aged 14–19 years) combining social protection, economic empowerment, and SRH education and services. It targets at-risk adolescents living in households enrolled in the national cash transfer programme with a ‘cash plus’ model. Life-skills training, behaviour-change approaches, community-based mentorship and linkages to HIV and SRH services are part of the package. Officially launched in late 2017 in four districts, by mid-2018 the intervention had increased adolescents’ knowledge of HIV prevention and resulted in more gender-equitable attitudes and greater participation in economic activities among adolescents.

UNICEF worked closely with Zimbabwe’s Ministry of Public Service, Labour and Social Welfare in 2018 in several areas of HIV prevention and social protection among adolescent girls and young women. In collaboration with PEPFAR’s DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) partnership, UNICEF reached more than 20,000 adolescent girls and young women through the integrated national case-management system and the Harmonized Social Cash Transfer programme in six districts with high HIV burden.

Through ‘All In’ and related investments, UNICEF has been supporting the expansion and scale-up of HIV-sensitive
social protection services for adolescents at risk for HIV within national social protection programmes. One aspect of such work in many contexts is the provision of technical assistance to systematically link at-risk adolescents in eligible households to social and health services (see Case Study 19).

Reducing stigma and discrimination

Strong and persistent HIV-related stigma is a huge obstacle to more effective responses among adolescents and young people. Adolescent girls, women and key populations may often experience stigma most acutely, but stigma affects people living with HIV in all epidemic contexts. Stigma is often compounded by policy and legal frameworks that discriminate against adolescents and young people based on age, gender and affiliation with key populations and prevent many from being reached with HIV prevention services. ¹¹³

For adolescents, age-of-consent issues are among the most prominent legal and policy obstacles to their ability to access the knowledge and services they need to protect themselves and others from HIV. In many countries, including several with high HIV burdens, there are minimum/mandatory age requirements for individuals to obtain certain services without parental consent, including

CASE STUDY 19: Africa: Building and nurturing HIV-sensitive social protection in four countries

Adding comprehensive care packages to cash transfers is a prominent element in many HIV-sensitive social protection programmes supported by UNICEF. Evidence has shown that adolescent girls in households benefiting from social cash transfers have a reduced HIV risk through delayed sexual debut. The positive effects can be even more extensive and long-lasting through ‘cash plus care’ models that UNICEF is supporting, many of which include interventions that offer adolescent-sensitive clinical care. Among the UNICEF-supported programmes in which ‘cash plus care’ is a feature were initiatives in four African countries in 2014–2018.

With a grant from the Government of the Netherlands, UNICEF provided financial and technical support to Malawi, Mozambique, Zambia and Zimbabwe for the operationalization and scaling up of HIV-sensitive social protection among children and adolescents. Activities differed substantially in design and execution across the four countries, allowing for local adaptation and the exploitation of existing national processes and systems.

In Mozambique in 2018, for example, UNICEF supported the design of ‘cash plus care’ programmes such as the provision of ‘child grants’ to benefit different groups of children (e.g., children aged 0–2 years, child-headed households, and orphaned children in poor and vulnerable households). In Zambia, UNICEF supported the evaluation and scale-up of a package of services that aims to increase the utilization of HIV services by adolescents. One main component of its support in Malawi was for the design and implementation of a system to refer cash-transfer beneficiaries to HIV-related social services. In Zimbabwe, the work included a focus on ensuring linkages among the country’s flagship cash-transfer programme, education, child-protection and HIV-related services.

As a result of such support, beneficiaries in all countries report having better information about and access to social services that have enhanced their well-being. Most importantly, they are using such services more frequently. The initiatives’ positive impacts also extend beyond core health and well-being by helping to empower beneficiaries and their families. More extensive, consistent and sustained engagement can help reduce HIV-related social stigma and thus make communities more welcoming and supportive of people living with and vulnerable to HIV.

Community fairs on health and social services to foster access to HIV were supported by UNICEF in Moma, Mozambique in 2018.
getting an HIV test, initiating ART, and seeking out and obtaining sexual health information and services. Some countries have successfully reduced parental consent requirements for one or more of these vital HIV-related services – for example, South Africa lowered the age of consent to 12. But in many other countries, 18 remains the minimum age for one or more of these services.

UNICEF continues to work with local and regional partners to advocate for policies and approaches that will increase and broaden, not restrict, the ability of adolescents to seek out and receive information, support and services associated with HIV and their overall health; to promote the alignment of laws and practices; and to raise awareness among practitioners so that laws are implemented as intended, in consideration of adolescents’ evolving capacities and while ensuring their best interests (see Case Study 20).

UNICEF has been involved in preparing a comprehensive training package as part of its support to the Government of Pakistan’s efforts to reduce discrimination in health-care settings through capacity-building and sensitization for health-care providers. Stigma reduction is incorporated into guidelines on HIV treatment, PMTCT and paediatric care, and all training provided to health workers in reproductive, maternal, newborn, child and adolescent health settings. A separate session on the negative impact of stigma on the HIV response is part of the training package.

Communication for Development (C4D) is critical to changing the attitudes, norms and behaviours that reinforce, and thus perpetuate, the conditions that contribute to vulnerability to HIV among all adolescents (and girls in particular), including the stigma that is present in nearly every society and context. One of the best-known C4D initiatives supported by UNICEF in Africa is Shuga, whose serial dramas on TV and radio use entertaining yet serious stories to empower adolescents, especially girls and young women, to make more informed decisions on sexual matters that could put them at risk of contracting HIV.

In other C4D initiatives, UNICEF worked closely in 2018 with governmental and NGO partners in Botswana to reach over 45,000 adolescents and young people with information on how to protect themselves from HIV and how to access services they might need. The information was disseminated through various platforms including radio and social media. In Zambia, UNICEF-supported C4D strategies have included efforts to correct misperceptions

CASE STUDY 20: The Philippines: Advocacy results on age-of-consent policies and standards.

As part of its efforts to promote adolescents’ rights and welfare, UNICEF regularly works with local partners on issues associated with age-of-consent laws and policies that require parental or guardian consent to get an HIV test, to access HIV treatment or to access other important services such as sexual and reproductive health (SRH) information and support. Such requirements often serve as barriers for adolescents to become more fully informed and linked to HIV services.

UNICEF work in this area showed notable progress in 2018, including in the Philippines. In close partnership with the National AIDS Council, the Council for Children’s Welfare and Save the Children, UNICEF supported the development of a national policy in the Philippines on proxy consent and case management for minors, particularly those living with HIV. This built on earlier work through the Proxy Consent Pilot Project, a six-city initiative to sensitize providers on proxy consent for minors by using practical training and implementation tools.

The HIV and AIDS Policy Act of 2018 now includes a proxy-consent protocol that allows children aged 15–17 to get tested for HIV without parental consent. This new law includes provisions allowing adolescents to secure proxy consent through a social worker or a medical professional, who then actively supports the adolescent’s active linkage to care and services. It also includes guidance for treatment initiation and support for family reunification.

UNICEF and partners worked with the Council for the Welfare of Children to provide technical assistance to local governments in developing and executing the protocol and case-management plan. Prolonged collaboration with multiple stakeholders was an important feature of the work, which included consultations with children and young people themselves; a review of frameworks and documentation related to adolescent access to services; defining the structure of the protocol; developing tools and guidance; and pretesting it with health-care providers and building their capacity.

The proxy-consent protocol is being integrated into a national SRH/HIV service-delivery model. At the local level, the model is implemented in partnership with civil society organizations as well as youth networks that are engaged with service delivery.
about HIV through community meetings by training and enlisting community health navigators and traditional healers. In collaboration with the Ministry of Education, UNICEF also provided support to more than 1,000 ‘anti-AIDS’ school clubs, some of which used participatory theatre to convey information and address concerns about HIV testing and reluctance over condom use.

UNICEF supported HIV-sensitization efforts in eight health districts in Chad, using participatory theatre through which hundreds of thousands of pregnant women were mobilized to attend ANC services and to accept HIV and STI testing; and in Burkina Faso using radio programmes, video and theatre activities to promote male participation in ANC and HIV services. The latter benefited from the active engagement of traditional and religious leaders.

**Leveraging collective action**

In its HIV-focused work among adolescents, UNICEF now co-convenes UBRAF Strategic Result Area 3 (HIV prevention among young people) with UNESCO and UNFPA under the UNAIDS partnership. The three agencies are coordinating country technical support and working together on advancing knowledge management, joint advocacy and communications, and data management.

In 2018, UNICEF, UNESCO, UNFPA and the United Nations Development Programme (UNDP) and other UNAIDS co-sponsor organizations, networks of key populations and experts collaborated closely to develop an online toolkit for adolescent and young key populations to support the scaling up of programmes for these groups. The toolkit builds on the ‘All In’ initiative and brings together a range of materials and instruments that cover the entire programming arc from size estimation through resource allocation to service delivery and monitoring. It is an example of UNICEF emphasis on supporting countries and other partners to obtain better data and understanding of the most vulnerable populations, to improve the quality of programmes and to scale up in a sustainable way (see Box ‘Programming toolkit for scaling up HIV prevention programmes with and for adolescent and young key populations’).

UNICEF leads the adolescent component of a new joint United Nations initiative focusing on helping the governments of Lesotho, Malawi, Uganda, Zambia and Zimbabwe to scale up and deliver quality integrated HIV/STI services for adolescent girls and young women living with HIV and underserved and at-risk adolescents. The effort leverages the joint contributions of UNAIDS, UNFPA, WHO and UNICEF (see Case Study 21).

In the United Republic of Tanzania, in 2018 UNICEF collaborated with the Bill & Melinda Gates Foundation and other partners to support the development of a national plan on adolescent health and well-being for 2019–2022. The plan aims to reduce the rate of teenage pregnancies, HIV infections, violence among adolescent girls and boys, dropout rates and anaemia prevalence among adolescent girls, and improve employability skills among adolescents and young people. UNICEF support included engaging with adolescent girls and boys in the design of the framework. UNICEF supported similar initiatives in Malawi, Mozambique and Uganda.

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### Programming toolkit for scaling up HIV prevention programmes with and for adolescent and young key populations

UNICEF led the development in 2018 of the adolescent and young key populations (ayKP) toolkit, an online collection of resources that can be used by countries to help plan and scale up their HIV prevention programmes with and for adolescents and young people (aged 10–24 years) from key populations: sex workers (aged 18 years or older) or sexually exploited children aged (under 18), adolescent boys and young men who have sex with men, adolescents and young people who are transgender or gender non-conforming, and adolescents and young people who or who inject drugs. The kit is intended for use by programme planners and implementers of HIV prevention programmes and policy makers working in government at national or subnational level, in the private sector or with civil society organizations (CSOs), including CSOs or networks of key populations or young people.

To date, 250 tools ranging from guidance documents to practical, ‘how-to’ resources have been contributed and curated by representatives of young key population organizations and networks, implementing organizations, donors and United Nations agencies; most were created or published since 2014. (The toolkit was in beta version at the time this report was being prepared.)

The toolkit is structured in eight modules and divided into themes within each module. Four modules contain tools for tracking major stages of programme planning and implementation (Assess, Plan, Resource and Monitor), while the other four modules may apply to any stage of a programme (Advocate, Collaborate, Innovate and Exchange). In most cases, each tool has relevance for several of the modules. The toolkit is searchable using filters to select the most appropriate tools for a topic, key population or user category. Tools in the kit can be downloaded as PDFs or linked from the website: <http://childrenandaid.org/aykpToolkit>.
UNICEF established a partnership with Oxford University (United Kingdom) and the University of Cape Town (South Africa) that will expand research on adolescent mothers learning to improve programmes for adolescent girls and young women. In 2018, WHO and UNICEF, in collaboration with UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and other partners, organized the first of a series of workshops targeting implementers of interventions for adolescent girls and young women supported through Global Fund grants. Global partners, country government representatives and civil society partners met in Zimbabwe in November 2018 to discuss promising practices in four implementing countries: Botswana, Eswatini, Lesotho and Malawi. The workshops contributed to South–South collaboration, experience-sharing and addressing challenges (see Case Study 22).

UNICEF in 2018 made significant technical contributions to the Kenya Population-based HIV Impact Assessment (PHIA), a household survey designed to measure the reach and impact of HIV prevention, care and treatment interventions in child, adolescent and adult populations, including pregnant women, the general population and key population groups. The main UNICEF input was to the adolescent questionnaire. UNICEF also trained 430 interviewers on household data entry, locating enumeration areas, rostering of households, and the use of open-data software and biomarker collection, including from children, adolescents and pregnant women. UNICEF also provided critical analytical studies to inform strategy and target-setting in the development of new guidelines for key populations, launched in 2018.

As part of an ambitious, multi-country grant, UNICEF is supporting knowledge dissemination and South–South learning to improve programmes for adolescent girls and young women. In 2018, WHO and UNICEF, in collaboration with UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and other partners, organized the first of a series of workshops targeting implementers of interventions for adolescent girls and young women supported through Global Fund grants. Global partners, country government representatives and civil society partners met in Zimbabwe in November 2018 to discuss promising practices in four implementing countries: Botswana, Eswatini, Lesotho and Malawi. The workshops contributed to South–South collaboration, experience-sharing and addressing challenges (see Case Study 22).
CASE STUDY 22: Africa: Supporting the Global Fund’s strategic investments in HIV prevention for adolescent girls and young women

Gender inequalities and discrimination, gender-based violence and harmful gender norms and practices underlie women’s and girls’ heightened vulnerability to HIV. To help overcome the gaps in the prevention response for this population, UNICEF works strategically with global partners, governments and in-country partners to leverage funding for adolescents and young girls and to ensure effective implementation of evidence-based programming.

A key partner is the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), which is investing “catalytic funding” to improve programmes to reduce new HIV infections among adolescent girls and young women in 13 sub-Saharan Africa countries. UNICEF engagement in most of the focus countries has covered all phases of the Global Fund programming cycle, starting with making available adolescent data collected through the All In initiative and other mechanisms during grant-proposal development.

In nine priority countries, UNICEF is providing technical support to grant recipients in areas such as mapping existing interventions for adolescent girls and young women; supporting analysis of subnational data to prioritize comprehensive interventions with biomedical, behavioural and structural components; defining intervention packages; and creating systems and processes to monitor and evaluate grant progress.115 UNICEF is also involved in efforts to identify what an effective and scalable package of interventions to prevent new infections might look like in each country. The technical assistance it is providing has benefited a wide range of national and local stakeholders with critical responsibilities in Global Fund processes, including country coordinating mechanisms, principal recipients and national AIDS councils.

UNICEF has also helped to foster alignment between investments at the national level. For example, in partnership with UNAIDS and the Global Fund it has supported the Government of the United Republic of Tanzania in areas such as data disaggregation and use, coordination of programming for adolescent girls and young women, knowledge-sharing and evidence-based decision-making.

including that address gender-based violence. The outputs and outcomes from such research are expected to influence emerging strategies for PMTCT among pregnant and breastfeeding adolescents and young women.

In Ukraine, UNICEF supported the establishment of a knowledge hub that reached some 4,000 service providers working with adolescents. Content disseminated through 13 webinars and e-training aimed to increase their knowledge of adolescent health and HIV issues.

UNICEF promotes the use of social media and other communication platforms to inform and support adolescents and young people. Using digital tools to enhance youth participation was a common strategy in UNICEF support to numerous countries in 2018.

The PACT and Youth Voices Count (YVC), two networks serving young people, partnered with UNICEF to launch a U-Report poll in 2017. As a follow-up, YVC conducted an in-depth online survey to better understand what adolescents and young people knew and thought about HIV and SRH services in their communities. The survey reached 270,000 individuals between the ages of 10 and 24 years in 21 countries. Respondents were asked to comment on the availability, accessibility, acceptability and quality of youth-friendly HIV and SRH services, including if they were offered stigma-free. UNICEF supported the analysis of the findings in 2018. They highlighted pervasive stigma in health facilities and throughout communities in general. The results of the poll are being used by youth groups at various levels for advocacy and action.

Elsewhere in Africa, the U-Report platform developed by UNICEF has continued to play a critical role as an innovative digital technology for adolescents to learn more about HIV transmission, prevention and treatment. In Mozambique, for example, U-Report has been helpful in refuting the misconception that HIV can be transmitted by mosquito bites and the idea that unplanned pregnancy is the only risk of unprotected sex. UNICEF and three government ministries (Health, Education, and Youth and Sport), UNFPA and the youth association Coalizão (‘Coalition’) adapted the U-Report platform to create a comprehensive national HIV communication programme centred on peer-to-peer education. The initiative (SMS Biz) has facilitated the engagement of nearly 200,000 adolescents and youth.

Another UNICEF-supported intervention in Kenya is a hotline that offers information on HIV, SRH and gender-based violence in five counties through the one2one web and mobile-based platform. The hotline targets youth and provides free information on HIV, sexuality and SRH in a confidential and non-judgemental way over the phone and social media networks such as Facebook, Instagram and Twitter. In 2018 alone, more than 45,000 adolescents aged 10–19 years (62 per cent of them girls) were reached through this hotline.
The value and importance of digital platforms was reported from Thailand, where in 2018 more than 770,000 adolescents used a UNICEF-supported online health platform, lovecarestation.com. This was a significant jump from 150,000 users in 2017. More than 7,200 young people registered in 2018 for its online counselling and referral services, the majority (nearly 74 per cent) being girls aged 10–25 years. Throughout 2018, teenage pregnancy, HIV prevention and mental health were popular search topics on the health platform overall. The overall programme is led by a partnership between UNICEF and the NGO Path2Health Foundation, with the support of the Ministry of Public Health and the US Centers for Disease Control and Prevention.

UNICEF supported several youth-led innovations in Nanjing, China, to promote greater access among adolescent young key populations to high-quality HIV and SRH services. One of these, a mobile app titled ‘Secret Client’, targets those vulnerable individuals and is aimed at destigmatizing HIV testing, promoting greater service uptake among youth and addressing barriers for youth to using existing HIV services. Surveys are administered through the app to record the ‘youth-friendliness’ of testing services. Another innovation in China delivers a peer-based online-to-offline (O2O) package (see Case Study 23).

**CASE STUDY 23: China: Digital tools in an ‘adolescent-friendly’ service approach to reach vulnerable young men**

The critical need for HIV prevention and treatment interventions to be ‘adolescent friendly’ can be seen in an eightfold increase in the annual number of new infections among university students in Guangzhou, China’s third-largest city, from 2010 to 2017. A disproportionate share of those infections were among adolescent boys and young men who have sex with boys/men.

With the Chinese Association of STD [sexually transmitted disease] and AIDS Prevention and Control (CASAPC), the Guangdong Provincial Association for STD and AIDS Prevention and Control, the Guangzhou Center for Disease Control and Prevention, and Super Young, a community-based organization of young volunteers, UNICEF supported the implementation of a peer-based online-to-offline (O2O) package to improve access to and uptake of HIV and sexual and reproductive health services among adolescents and youth. The O2O package includes a smartphone-enabled care series with digital technology for risk assessment, peer counselling and support, and referrals to offline programmes. Its components include online and offline mobilization activities, peer-based approaches, venue-based HIV testing and self-testing, service referrals to other sexual and reproductive health (SRH) services and interventions to ensure an enabling environment.

Due to stigma, cost and distance to services, among other factors, many adolescent boys and young men who have sex with other boys/men have insufficient awareness of HIV risk factors, or are unable or unwilling to access to HIV prevention and treatment services that they find comfortable and which meet their specific needs. The O2O programme seeks to overcome such gaps by involving adolescents in the design of targeted services and providing peer support, focusing on improving trust and legitimacy among intended clients, and using digital social networks commonly used by adolescent MSM to connect to offline HIV education, prevention and treatment services.

A pilot in 2017 had strong results, and in 2018, with the cooperation of local government and community-based organizations, the O2O package was expanded to additional cities, including Chengdu and Nanjing. The programme is supported by the Government of China and achieved institutional support by being included in the 2018 Adolescent-Friendly HIV Service Manual. Staff from the China Centre for Disease Control and Prevention were trained on the intervention during the fifth National Conference on HIV/AIDS held in September 2018.
Lessons learned

UNICEF support has been crucial to the development and implementation of projects, interventions and programming decisions – many of them highly innovative approaches to HIV testing, prevention and treatment – that have helped people living with and vulnerable to HIV around the world. But these improvements have not been rapid or extensive enough to help everyone in need. Reaching and supporting those individuals is necessary to reduce new infections and ‘control’ epidemics in equitable, rights-based ways that are open and acceptable to all.

The gaps in the response are evident. For example, ART access through PMTCT programmes for pregnant and breastfeeding mothers is a key Strategic Plan indicator and UNICEF has made good progress against it. Yet progress has slowed in recent years, and in some regions there is even some loss of ground. UNICEF will continue to keep up the pressure by advocating for funding of PMTCT responses and encouraging countries to strive for EMTCT. Going beyond PMTCT ART coverage, there is a need to reduce incidence of maternal infections and retain women in prenatal and postnatal care. Many pregnant women start ART too late; even where ART is offered through ANC services, many pregnant women do not access ANC services early enough in the pregnancy to benefit from ART in time. (Recent studies suggested Dolutegravir-based ART is a potential ‘game changer’ in terms of its effectiveness in pregnant women who present late for ANC.)

Pragmatic and evidence-based considerations must continue to guide how and where UNICEF targets its support and emphasis. For example, in most contexts young mothers are a subgroup within the broader category of adolescent girls and young women with discrete HIV-related vulnerabilities and needs. For PMTCT programmes to achieve the ‘last mile’ to elimination, rapid innovation is needed on the clinical platform to accommodate their special needs; a multifaceted web of services and support that responds to their needs and those of their children must be created to better ensure their care will continue; and special attention should be paid to primary prevention in pregnancy for members of this subgroup.
Another gap is that child, and especially adolescent, ART access remains well below targets. Ramping up testing services is the critical initial step. This includes testing of HIV-exposed infants, among whom coverage is still extremely low, as well as looking beyond PMTCT parameters to identify undiagnosed children and adolescents through service entry-points including family testing using an adult index case.

Successful treatment is not simply about making ARVs available: the medicines can only work effectively, and thus help people stay healthy and far less likely to transmit the virus to others (including through MTCT), when they are taken consistently and correctly, as prescribed. Systems and structures must be in place to assure robust and uninterrupted supply chains, and to provide ART in ways that are as convenient and predictable as possible. People on treatment need information and support that is tailored to their unique needs and circumstances, to adhere to their ART regimens.

The importance of expansive analysis and thinking is also evident in relation to several priority interventions UNICEF is currently supporting and championing. Both POC diagnostics for early infant diagnosis and family testing (or ‘index case’ testing) seek to address the need to diagnose children living with HIV and start them on treatment immediately. Making these promising, evidence-supported interventions as effective as possible also means simultaneously acknowledging and responding to a number of challenges that currently compromise the link between testing and treatment. These include inadequate capacity to provide treatment at a decentralized level, a situation that requires supportive task-shifting policies and capacity-building strategies for front-line health providers; the need for innovative models of providing treatment for children who are HIV-positive where the numbers of such children are small or diminishing (due to reasons including successful PMTCT in Eastern and Southern Africa or low-prevalence contexts in other regions); and preventing ARV stock-outs, a persistent problem that requires strengthened support for supply-chain systems. And, once on treatment, challenges exist in ensuring retention and achieving viral suppression for the paediatric population.

The overall linked goals of UNICEF’s HIV work in every context are to prevent new HIV infections among children and to keep those already infected alive and healthy. The most important form of integration in the context of these goals centres around streamlining and strengthening systems to make packages of effective care more convenient to deliver and to receive. This requires reorganizing services and more closely coordinating different functions and responsibilities, and collaborative partnerships.

Multiple outcomes across key domains of health and well-being are comparably weak for adolescent girls, reflecting an acute need for more systemic and structural responses to girls’ vulnerability and risk. The available data lend further credence to the belief that efforts to ‘end AIDS’ should focus on the contexts, populations and individuals most at risk and vulnerable, including through evidence- and analysis-based assessments of where HIV-testing programmes should be concentrated and intensified. Moreover, the full picture of girls’ health, development and well-being in the most highly affected countries suggests a critical need to identify better ways to integrate responses across sectors and platforms for the most vulnerable girls.

Both the UNICEF Strategic Plan, 2018–2021, and the 2030 Agenda for Sustainable Development reflect and promote the idea that solutions to the HIV epidemic are multidimensional and rely on understanding how to better support people living with and at risk from the virus across all aspects of their lives.
HIV and AIDS financial report

Income for HIV and AIDS in 2018

For a full overview of UNICEF revenue and contributions in 2018, please see Annex 1.

In 2018, partners contributed US$28 million ‘other resources – regular’ for HIV and AIDS, a 36 per cent decrease over the previous year (Figure 38). National Committee partners contributed the largest share of ‘other resources -regular’ to HIV and AIDS, 42 per cent (Figure 39). The top five resources partners to UNICEF HIV and AIDS in 2018 were the Korean Committee for UNICEF, UNAIDS, UNFPA, Unitaid, and the United States. The largest contributions were received from the Korean Committee for UNICEF for the global thematic HIV and AIDS pool, from UNAIDS for UBRAF Country Envelopes 2018–2019, and from UNFPA for strengthening integrated sexual and reproductive health and rights in Eastern and Southern Africa (see earlier pages of this chapter for details on all of these programmes).

The flexibility of thematic funding allows UNICEF to respond more effectively. It facilitates longer term planning, sustainability and savings in transaction costs, leaving more resources for UNICEF programmes.

FIGURE 39: HIV and AIDS other resources regular contributions, 2014-2018
TABLE 29: Top 10 resource partners to HIV and AIDS by contributions, 2018

<table>
<thead>
<tr>
<th>Rank</th>
<th>Resource partners</th>
<th>Total (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Korean Committee for UNICEF</td>
<td>7,169,677</td>
</tr>
<tr>
<td>2</td>
<td>UNAIDS</td>
<td>7,046,164</td>
</tr>
<tr>
<td>3</td>
<td>UNFPA*</td>
<td>2,926,765</td>
</tr>
<tr>
<td>4</td>
<td>Unitaid</td>
<td>2,042,933</td>
</tr>
<tr>
<td>5</td>
<td>United States</td>
<td>1,915,230</td>
</tr>
<tr>
<td>6</td>
<td>UNDP</td>
<td>1,379,486</td>
</tr>
<tr>
<td>7</td>
<td>Hong Kong Committee for UNICEF</td>
<td>1,249,369</td>
</tr>
<tr>
<td>8</td>
<td>French Committee for UNICEF</td>
<td>1,041,599</td>
</tr>
<tr>
<td>9</td>
<td>Dutch Committee for UNICEF</td>
<td>857,787</td>
</tr>
<tr>
<td>10</td>
<td>United Kingdom Committee for UNICEF</td>
<td>542,580</td>
</tr>
</tbody>
</table>

* Includes cross-sectoral grant SC180128 (Gender Equality and HIV and AIDS)
Thematic funding contributions for HIV and AIDS reached US$9.3 million in 2018, a 28 per cent decrease over the US$12 million received in 2017. All thematic contributions came from National Committee partners. The Korean Committee for UNICEF was the largest thematic resources partner, providing 56 per cent of all thematic contributions received.

UNICEF is seeking to broaden and diversify its funding base (including thematic contributions), and encourages all partners to give as flexibly as possible. Regrettably, the number of partners contributing thematic funding to HIV and AIDS decreased from 14 in 2017 to 9 in 2018.

Sizeable thematic contributions were received from the Korean, Dutch and Hong Kong Committees for UNICEF for the global thematic HIV and AIDS pool, while the United Kingdom Committee for UNICEF provided country-level funding to HIV and AIDS activities in Eswatini.

Of all thematic HIV and AIDS contributions UNICEF received in 2018, 95 per cent were global-level contributions (Figure 40).

**TABLE 30: Top 20 contributions to HIV and AIDS, 2018**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Resource partners</th>
<th>Grant description</th>
<th>Total (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Korean Committee for UNICEF</td>
<td>HIV and AIDS, Global Thematic Funding</td>
<td>7,169,677</td>
</tr>
<tr>
<td>2</td>
<td>UNAIDS</td>
<td>UBRAF Country Envelopes 2018–2019</td>
<td>4,924,100</td>
</tr>
<tr>
<td>3</td>
<td>UNFPA</td>
<td>Strengthening integrated sexual and reproductive health &amp; rights, ESARO*</td>
<td>2,926,765</td>
</tr>
<tr>
<td>4</td>
<td>Unitaid</td>
<td>Accelerate Access to Innovative Point of Care HIV Diagnostic (PHASE 2)</td>
<td>2,042,933</td>
</tr>
<tr>
<td>5</td>
<td>UNAIDS</td>
<td>UBRAF HQ and ROs Activities 2018–2019</td>
<td>2,000,000</td>
</tr>
<tr>
<td>6</td>
<td>French Committee for UNICEF</td>
<td>Access to HIV paediatric treatments for young people, WCARO</td>
<td>914,286</td>
</tr>
<tr>
<td>7</td>
<td>Dutch Committee for UNICEF</td>
<td>HIV and AIDS, Global Thematic Funding</td>
<td>858,896</td>
</tr>
<tr>
<td>8</td>
<td>Hong Kong Committee for UNICEF</td>
<td>Achieving Zero Infection, better Health and Development for Children, China</td>
<td>807,776</td>
</tr>
<tr>
<td>9</td>
<td>UNDP</td>
<td>Investing Towards Impact for HIV and AIDS in South Sudan</td>
<td>690,553</td>
</tr>
<tr>
<td>10</td>
<td>UNDP</td>
<td>Joint UN Programme of Support on AIDS, Uganda</td>
<td>688,933</td>
</tr>
<tr>
<td>11</td>
<td>United States</td>
<td>PEPFAR HIV/AIDS, Mozambique</td>
<td>432,261</td>
</tr>
<tr>
<td>12</td>
<td>Hong Kong Committee for UNICEF</td>
<td>Strengthening the delivery of quality services to eliminate mother/child HIV</td>
<td>418,094</td>
</tr>
<tr>
<td>13</td>
<td>Hong Kong Committee for UNICEF</td>
<td>HIV and AIDS, Global Thematic Funding</td>
<td>418,094</td>
</tr>
<tr>
<td>14</td>
<td>United Kingdom Committee for UNICEF</td>
<td>HIV and AIDS, Thematic Funding Swaziland</td>
<td>404,130</td>
</tr>
<tr>
<td>15</td>
<td>Canada</td>
<td>Thematic HIV and AIDS</td>
<td>401,569</td>
</tr>
<tr>
<td>16</td>
<td>Finnish Committee for UNICEF</td>
<td>HIV and AIDS, Global Thematic Funding</td>
<td>293,827</td>
</tr>
<tr>
<td>17</td>
<td>United States</td>
<td>Achieving an AIDS Free Generation, Tanzania</td>
<td>269,134</td>
</tr>
<tr>
<td>18</td>
<td>United States</td>
<td>Achieving an AIDS Free Generation, South Africa</td>
<td>220,511</td>
</tr>
<tr>
<td>19</td>
<td>United States</td>
<td>Achieving an AIDS Free Generation, South Africa</td>
<td>189,150</td>
</tr>
<tr>
<td>20</td>
<td>German Committee for UNICEF</td>
<td>Galz and Goals – Unlocking young peoples’ potential for Social Change and Health</td>
<td>176,402</td>
</tr>
</tbody>
</table>

* Cross-sectoral grant SC180128 (Gender Equality and HIV and AIDS)
Global thematic funds remain the most flexible source of funding to UNICEF after regular resources. The global level is the most valuable thematic funding level in which partners determine which UNICEF objectives they wish to support, and contribute to the most closely aligned thematic funding pool. This allows UNICEF the flexibility to allocate funds across regions to individual country programmes according to priority needs. It facilitates programme implementation in a more strategic manner, and the ability to adjust and respond to emerging issues. It also allows UNICEF the flexibility to allocate resources to areas of highest needs, including critically under-funded country programme areas and humanitarian response activities.

A total of US$8,488,265 global thematic HIV and AIDS funding was allocated to 53 offices in 2018.

TABLE 31: Thematic contributions by resource partner to HIV and AIDS, 2018

<table>
<thead>
<tr>
<th>Resource partner type</th>
<th>Resource partner</th>
<th>Total (US$)</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Committees</td>
<td>Korean Committee for UNICEF</td>
<td>7,169,677</td>
<td>76.89%</td>
</tr>
<tr>
<td></td>
<td>Dutch Committee for UNICEF</td>
<td>858,896</td>
<td>9.21%</td>
</tr>
<tr>
<td></td>
<td>United Kingdom Committee for UNICEF</td>
<td>455,300</td>
<td>4.88%</td>
</tr>
<tr>
<td></td>
<td>Hong Kong Committee for UNICEF</td>
<td>418,094</td>
<td>4.48%</td>
</tr>
<tr>
<td></td>
<td>Finnish Committee for UNICEF</td>
<td>293,827</td>
<td>3.15%</td>
</tr>
<tr>
<td></td>
<td>Japan Committee for UNICEF</td>
<td>40,296</td>
<td>0.43%</td>
</tr>
<tr>
<td></td>
<td>Norwegian Committee for UNICEF</td>
<td>38,260</td>
<td>0.41%</td>
</tr>
<tr>
<td></td>
<td>Danish Committee for UNICEF</td>
<td>27,950</td>
<td>0.30%</td>
</tr>
<tr>
<td></td>
<td>U.S. Fund for UNICEF</td>
<td>22,204</td>
<td>0.24%</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td><strong>9,324,505</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

Grant numbers are provided for IATI compliance: SC1499020046, SC1899020002, SC1899020004, SC1899020002, SC1899020009, SC1899020011, SC1899020006, SC1899020001, SC1899020007, SC1899020005, SC1899020010, SC1899020012, SC1499020063, SC1899020009

FIGURE 41: HIV and AIDS thematic funding contributions at country, regional and global levels, 2018
The criteria for allocation of global thematic HIV and AIDS funding include:

- HIV prevalence among 15- to 24-year-olds and adults
- New infections among children under 14 and adolescents and young people aged 15–24
- Persons living with HIV aged 0–24 years
- Number of UNAIDS fast-track countries in the region.

When deciding on allocation of thematic funding to the country offices, the regional offices were invited to take into consideration the following:

- Is the country among the UNAIDS fast-track countries?
- Has the country office provided core funding and human resources for HIV?

- Will the thematic allocation leverage donor contributions?
- What has been the country offices’ record on thematic expenditures & donor reporting?
- Are there emerging issues in HIV for which funding is unavailable?

In discussion with the regional offices, it was agreed that most of the funding would go to 35 countries prioritized by UNICEF for intensified responses. The regional shares for allocation to the country offices were in support of country efforts to end AIDS in children through enhanced efforts to: (1) eliminate new HIV infections in children where there are critical gaps, (2) provide treatment and care to children and adolescents, and (3) follow up on the ‘All In’ assessments with priority multi-sectoral actions to prevent HIV in adolescents.
Expenses for HIV and AIDS in 2018

Note: Expenses are higher than the income received because expenses comprise total allotments from regular resources and other resources (including balances carried over from previous years), while income reflects only earmarked contributions from 2018 to HIV and AIDS.

Expenses versus expenditure

‘Expenses’ are recorded according to IPSAS standards and are accrual-based. These are used for official financial reporting. ‘Expenditures’ are recorded on a modified cash basis. They are used for budget reporting because they are aligned with cash disbursements and goods receipts (the way budgets are consumed).

Although UNICEF’s commitment to HIV and AIDS remains solid and strong, the scope and reach of its work have been constrained to some extent by an ongoing reduction in overall available expenses. Most notably (as shown in Figure 43), the annual amount of funding from other resources – regular (ORR) has fallen steeply, from US$66 million in 2014 to US$37 million in 2018. The decline is largely due to a sharp and sudden reduction of UNAIDS’ UBRAF funding to UNICEF beginning in 2016. One result is that HIV and AIDS now constitutes just 1 per cent of all UNICEF programme expenses (see Figure 44).

Formerly the largest single source of financing by far, ORR resources in 2018 comprised only a little more than half of the US$75 million UNICEF spent on the HIV and AIDS sector. The remaining expenses are from regular resources, which unlike ORR have remained relatively stable at around US$35 million a year since 2014. One silver lining in recent trends is the HIV and AIDS expenses that are the most flexible – those from regular resources – are the stable ones. But the overall decline represents an increasing concern nevertheless. Year-on-year reductions in overall expenses have had negative impacts on UNICEF’s ability to support, develop and otherwise influence critical HIV and AIDS programmes and interventions globally and locally, including those most important for pregnant women, mothers, children and adolescents.
**FIGURE 45:** Expense for HIV and AIDS by fund type, and per region, 2018

- **WCA:** West and Central Africa
- **ESA:** Eastern and Southern Africa
- **HQ:** Headquarters
- **ECA:** Europe and Central Asia
- **EAP:** East Asia and the Pacific
- **LAC:** Latin America and the Caribbean
- **SA:** South Asia
- **MENA:** Middle East and North Africa

**Legend:**
- **Other resources – emergency**
- **Other resources – regular**
- **Regular resources**

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

**FIGURE 46:** Expense for HIV and AIDS by country and fund type, 2018

- **South Africa**
- **Guinea**
- **Myanmar**
- **Bangladesh**
- **China**
- **Zambia**
- **Kenya**
- **Ethiopia**
- **Cameroon**
- **Somalia**
- **Malawi**
- **Mozambique**
- **Zimbabwe**
- **Uganda**
- **United Republic of Tanzania**
- **Cote d’Ivoire**
- **Ukraine**
- **Dem. Rep. of Congo**
- **Chad**
- **Nigeria**

**Legend:**
- **Other resources – emergency**
- **Other resources – regular**
- **Regular resources**
UNICEF HIV and AIDS spending has continued to be focused on areas with the greatest investment and support needs. About three quarters of all expenses in 2018 therefore were directed to Eastern and Southern Africa and West and Central Africa, the two regions with the highest HIV burdens and biggest challenges in closing prevention and treatment gaps for pregnant women and children.

Similar considerations are relevant at the country level as well. Twenty countries – all but one in sub-Saharan Africa116 – accounted for nearly 70 per cent (US$51 million) of all 2018 HIV and AIDS expenses, with the majority of that amount (US$22 million) going to just five countries. The country programme in Nigeria, the most populous country in Africa and home to a generalized epidemic, was the biggest beneficiary by far: US$7 million, almost 10 per cent of all UNICEF HIV and AIDS expenses for the year.

About 88 per cent of the financing for Nigeria consisted of regular resources, the more flexible and stable sort of source compared with ORR. The share of regular resources across all 20 countries was far lower, however, at 48 per cent. Meanwhile, ORR comprised nearly all expenses for four of them (China, Guinea, Somalia and South Africa) and more than 50 per cent in six others (Chad, Democratic Republic of the Congo, Ethiopia, Mozambique, Myanmar and Zimbabwe). The heavy reliance on ORR for those countries’ HIV and AIDS spending could be an important signal for where financing efforts are likely to be even more difficult in future years.

Ukraine was an outlier of sorts in 2018 among the 20 countries that collectively received most HIV and AIDS expenses. It was the only one in which UNICEF spending increased from the previous year, with the majority (88 per cent) of its expenses coming from a third source (other resources – emergency). Financing from that source, which totalled about US$5 million, was made available only to a handful of other countries among the top 20, and in each case was a small share.

About 40 per cent of the US$9.2 million UNICEF spent from thematic funds went to Eastern and Southern Africa. Some additional funding for UNICEF’s overall HIV and AIDS work also came from allocations from headquarters to provide technical support for countries and help bridge funding gaps for critical human resources.

### TABLE 32: Expense for HIV and AIDS by programme area and fund type, 2018 (US$)*

<table>
<thead>
<tr>
<th>Results area</th>
<th>Other resources – emergency</th>
<th>Other resources – regular</th>
<th>Regular resources</th>
<th>Grand total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment and care of children living with HIV</td>
<td>3,963,826</td>
<td>19,644,236</td>
<td>19,069,883</td>
<td>42,677,945</td>
</tr>
<tr>
<td>HIV prevention</td>
<td>1,038,211</td>
<td>17,072,491</td>
<td>14,231,214</td>
<td>32,341,916</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>5,002,037</strong></td>
<td><strong>36,716,727</strong></td>
<td><strong>33,301,096</strong></td>
<td><strong>75,019,861</strong></td>
</tr>
</tbody>
</table>

*Totals may not match sum due to rounding.

### TABLE 33: Expense for HIV and AIDS by cost category, 2018 (US$)*

<table>
<thead>
<tr>
<th>Cost category</th>
<th>Other resources – emergency</th>
<th>Other resources – regular</th>
<th>Regular resources</th>
<th>Grand total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual services</td>
<td>369,561</td>
<td>2,455,415</td>
<td>2,582,099</td>
<td>5,407,074</td>
</tr>
<tr>
<td>Equipment, vehicles and furniture</td>
<td>16,261</td>
<td>39,042</td>
<td>141,787</td>
<td>197,090</td>
</tr>
<tr>
<td>General operating and other direct costs</td>
<td>97,964</td>
<td>1,384,071</td>
<td>3,175,880</td>
<td>4,657,915</td>
</tr>
<tr>
<td>Incremental indirect cost</td>
<td>304,484</td>
<td>2,335,957</td>
<td>2,640,441</td>
<td></td>
</tr>
<tr>
<td>Staff and other personnel costs</td>
<td>358,914</td>
<td>7,942,812</td>
<td>11,208,613</td>
<td>19,510,338</td>
</tr>
<tr>
<td>Supplies and commodities</td>
<td>2,213,656</td>
<td>3,581,982</td>
<td>2,179,851</td>
<td>7,975,490</td>
</tr>
<tr>
<td>Transfers and grants to counterparts</td>
<td>1,233,250</td>
<td>16,724,437</td>
<td>11,956,131</td>
<td>29,913,818</td>
</tr>
<tr>
<td>Travel</td>
<td>39,547</td>
<td>1,696,236</td>
<td>1,562,204</td>
<td>3,297,986</td>
</tr>
<tr>
<td>Other</td>
<td>368,400</td>
<td>556,776</td>
<td>494,531</td>
<td>1,419,708</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>5,002,037</strong></td>
<td><strong>36,716,727</strong></td>
<td><strong>33,301,096</strong></td>
<td><strong>75,019,861</strong></td>
</tr>
</tbody>
</table>

*Totals may not match sum due to rounding.
UNICEF HIV and AIDS spending centred on two broad programme areas: treatment and care of children living with HIV, and HIV prevention. The amounts and shares of expenses within those two areas reflected context-specific investment gaps and needs, and thus varied widely by regions.

Treatment and care was the more extensively financed programme area, accounting for about 57 per cent of the US$75 million in overall expenses from all sources. Expenses for that programme area alone in the two regions with the biggest disease burdens, Eastern and Southern Africa and West and Central Africa, totalled 40 per cent of the US$75 million. Prevention funding was the highest in absolute terms in West and Central Africa, but it comprised greater shares of UNICEF expenses in many other regions. For example, spending on HIV prevention exceeded that for treatment and care in three of eight regions (Latin America and the Caribbean, Middle East and North Africa, and South Asia). A main reason for that result is that each of those regions has relatively low HIV disease burdens.

The cost categories for HIV and AIDS expenses in 2018 were broadly similar to previous years even though the total amount has continued to decline annually. The single largest share of expenses (40 per cent, or US$30 million) was within the ‘transfers and grants to counterparts’ category. The prominence of this category underscores UNICEF’s desire and commitment to be an essential partner in the implementation of high-impact HIV and AIDS interventions. The emphasis UNICEF places on building and sustaining quality capacity in human resources is further signalled by an additional US$20 million in spending being accounted for in ‘staff and other personnel costs’. The scope of the declining trend in available resources can clearly be seen in another category, ‘general operating and other direct costs’. At US$4.7 million, expenses in 2018 in that category were far lower than the US$8.6 million spent in 2014.

**Funding gap for HIV and AIDS for 2019**

UNICEF’s HIV and AIDS programme is facing funding challenges associated with two key trends, one external and one internal, that are related to a significant extent: changes in the global health and development landscape and in UNAIDS’ financial resources and capacity.

The advent of the 2030 Agenda for Sustainable Development signalled a shift toward integrated development planning and programming at the global, regional and national levels, a move that has intensified in the health area as countries place attention and resources on universal health coverage (UHC). HIV is still a priority within this evolving structure, but it is increasingly seen as best addressed through multiple, diffused ways in addition to more straightforward provision of ARVs and HIV-specific prevention efforts – for example, by improvements in cross-sectoral areas such as education, economic development and social protection.

As a high-profile and influential promoter of integration and efficiency, UNICEF supports this trend. But there are legitimate concerns about the consequences for HIV responses. Donors are less likely to be able and willing to support HIV-specific programming at any level, as can be seen in the plateau in levels of external financing for HIV in the past few years. Critical financing mechanisms such as the Global Fund and PEPFAR rely on and are guided by the changing priorities of donor governments that are unable or unwilling to boost financing for HIV responses abroad for a variety of reasons.

To some extent, the impacts of this global trend away from HIV-specific financing have been mitigated by increases in domestic financing for HIV responses. Many governments and domestic partners are taking on more financial responsibility for HIV and health programming. Unfortunately, not all countries have the fiscal space to do this or are run by governments that are willing to provide adequate financial support for responses that meet the needs of all people, including the most vulnerable and marginalized. There is still a major role for external financing and targeted engagement by multilateral entities such as UNICEF. Governments, NGOs and people living with and vulnerable to HIV all continue to welcome the engagement and input of UNICEF and other partners as essential to making better progress to halting and reversing HIV epidemics.

UNICEF’s ability to engage to the fullest extent possible is limited by recent declining trends in its HIV and AIDS financing. The current central UBRAF allocation to UNICEF in 2018–2019 is US$2 million per year, which is 84 per cent lower than in the 2014–2015 UBRAF biennium and 67 per cent lower than in the 2016–2017 biennium. The major, rapid reductions in UNAIDS support have forced UNICEF to cut staffing for HIV and AIDS programming at global and regional levels by half, a development that has compromised the organization’s ability to fully leverage regional and country offices to identify and advance HIV results. There is a growing risk that UNICEF Strategic Plan targets in HIV and AIDS will be difficult to meet.

In 2018, UNICEF sought to address this risk by harnessing additional funding opportunities, including by raising US$4.9 million from the UBRAF country envelopes funding. The same amount of catalytic funding from that source was received for 2019. While helpful, that is not nearly enough to meet the Strategic Plan targets or UNICEF’s goals and expectations toward ending AIDS as a public health threat in a meaningful way. UNICEF aims to broaden its range of funding partners and make the case, which is supported by evidence in countries worldwide, that stepping back from HIV responses at a moment when a positive trajectory toward ending AIDS is in sight would represent a shortsighted and dangerous approach to global health and development.
Early childhood development (ECD) has recently emerged as an integral part of the global development agenda. For the first time, ECD is expressly articulated in the Sustainable Development Goals (SDGs) as a target with measurable indicators. There has also been in *The Lancet* a paradigm shift in how ECD is implemented. Recognizing that nature and nurture interact fundamentally to stimulate the cognitive, social and emotional development of young children, UNICEF programming strategies have shifted from siloed approaches to multisectoral ECD packages, encompassing health, nutrition, HIV, education and protection. Strongly linked to the provision of primary health care (PHC), this approach embeds ECD interventions in a wider system that addresses common social determinants across these sectors.

Results:
Early childhood development
Goal Area 1 is shaped to reflect the imperative for multisectoral programming. This multisectoral approach also has economic benefits – ECD investments have an annual return rate of close to 13 per cent.¹¹⁸ Moreover, the cost of including ECD programmes in pre-existing platforms is only an additional US$0.50 per capita per year.¹¹⁹ With the support of partners, and the science in hand, UNICEF is well positioned to improve the life course of the 250 million children under five years of age, in low- and middle-income countries, who have yet to achieve their full potential for their age.¹²⁰ ECD is a powerful equalizer of opportunity, and its long-term effects should increase the ability of children not only to survive, but to thrive.

UNICEF emphasized the importance of ECD within its previous Strategic Plan – the rationale for why ECD matters – to coalesce support around this essential work. At the beginning of the new Strategic Plan, 2018–2021, UNICEF is leveraging the success of its advocacy and shifting its focus towards how it will implement and scale up ECD. This shift in focus has already produced significant results, and UNICEF and partners can now accelerate this progress towards scale-up.

The years 2017–2018 saw unprecedented progress in ECD. Building on a strong evidence base, and with a call to action, key stakeholders worked to effect a shift in the ECD landscape from understanding the rationale of ECD (the ‘why’), to enhanced implementation and progress in rolling out multisectoral ECD packages (the ‘how’). A total of 80 countries have initiated the process of institutionalizing the delivery of quality ECD services. Of these, 33 countries (against the UNICEF Strategic Plan milestone of 16 countries in 2018) have established systems with at least two elements: government ownership and costed action plans. In addition, 47 countries have ‘emerging’ systems where there is government ownership. Clearly the milestone for 2018 has been exceeded, and progress toward the Strategic Plan target of 80 countries is evident. The shift towards enhanced implementation and scale-up attests to the accelerated momentum for multisectoral ECD packages; however, many countries require continued support to move from weak or emerging systems to established, proficient and more advanced approaches.

Result area/output statement for ECD

**Output statement 1.h: Countries have institutionalized the delivery of quality early childhood development services as part of the health platform.**

UNICEF has been working towards assessing the percentage of children who are developmentally on track in literacy–numeracy, and physical, learning and social–emotional skills (SDG indicator 4.2.1). As part of this work, the methodology for assessing 2- to 4-year-old children was recently endorsed by the United Nations Statistical Commission and the Inter-agency and Expert Group on SDG Indicators. When finalized, the measure for this indicator will provide globally comparable data collected at the population level from mothers and caregivers in household surveys.

UNICEF is also working to contribute to the UNICEF Strategic Plan, 2018–2021 outcome: “Girls and boys, especially those that are marginalized and those living in humanitarian conditions, have access to high-impact health, nutrition, HIV and ECD interventions from pregnancy to adolescence.” Furthermore, UNICEF also contributes to a related output in its Strategic Plan: “Countries have institutionalized the delivery of quality early childhood development services as part of the health platform.”

This chapter highlights UNICEF’s contribution to the three indicators used to assess whether countries have institutionalized the delivery of quality ECD services. The output indicators are as follows:

- 1.h.1. Number of countries that have adopted ECD packages for children at scale
- 1.h.2. Number of countries with national ECD policy or implementation plans for scale-up
- 1.h.3 Percentage of UNICEF-targeted girls and boys in humanitarian situations who participate in organized programmes with ECD kits through UNICEF-supported programmes (humanitarian).
<table>
<thead>
<tr>
<th>Output indicators</th>
<th>Disaggregation</th>
<th>Number of countries reporting (2017)</th>
<th>Number of countries reporting (2018)</th>
<th>Baseline</th>
<th>2017 Value</th>
<th>2018 Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.h.1. Number of countries that have adopted ECD packages for children at scale.</td>
<td>Global value</td>
<td>148</td>
<td>152</td>
<td>9</td>
<td>28</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>EAPR</td>
<td>27</td>
<td>27</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>ECAR</td>
<td>20</td>
<td>21</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>ESAR</td>
<td>19</td>
<td>21</td>
<td></td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>MENA</td>
<td>15</td>
<td>16</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LACR</td>
<td>36</td>
<td>36</td>
<td>13</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SAR</td>
<td>7</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>WCAR</td>
<td>24</td>
<td>24</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1.h.2. Number of countries with national ECD policy or implementation plans for scale-up.</td>
<td>Global value</td>
<td>152</td>
<td>152</td>
<td>67</td>
<td>65</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>EAPR</td>
<td>27</td>
<td>27</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ECAR</td>
<td>21</td>
<td>21</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ESAR</td>
<td>21</td>
<td>21</td>
<td>9</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MENA</td>
<td>16</td>
<td>16</td>
<td>6</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LACR</td>
<td>36</td>
<td>36</td>
<td>28</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SAR</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>WCAR</td>
<td>24</td>
<td>24</td>
<td>8</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>1.h.3. Percentage of UNICEF-targeted girls and boys in humanitarian situations who participate in organized programmes with ECD kits through UNICEF-supported programmes.</td>
<td>Global value</td>
<td>23</td>
<td>38</td>
<td>64%</td>
<td>80%</td>
<td>84%</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>14</td>
<td>32</td>
<td>50%</td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>14</td>
<td>32</td>
<td>50%</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disability</td>
<td>4</td>
<td>8</td>
<td>3%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Humanitarian</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Development</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>EAPR</td>
<td>2</td>
<td>5</td>
<td>93%</td>
<td>88%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ECAR</td>
<td>2</td>
<td>4</td>
<td>101%</td>
<td>64%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ESAR</td>
<td>3</td>
<td>8</td>
<td>92%</td>
<td>109%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MENA</td>
<td>2</td>
<td>4</td>
<td>57%</td>
<td>64%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LACR</td>
<td>8</td>
<td>8</td>
<td>58%</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SAR</td>
<td>1</td>
<td>2</td>
<td>52%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>WCAR</td>
<td>5</td>
<td>7</td>
<td>96%</td>
<td>62%</td>
<td></td>
</tr>
</tbody>
</table>

EAP, East Asia and the Pacific; ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; N/A, not available SA, South Asia; WCA, West and Central Africa.

Improving services and community demand

Strengthened implementation and capacity through multisectoral packages

The shift towards multisectoral ECD packages has gained significant momentum. As of 2018, 80 countries had begun the process of adopting multisectoral packages consisting of at least two interventions to address early stimulation and care, and are preparing for scale-up. These countries are in diverse stages of systems strengthening. On a six-point scale of weak to champion (see Table 35), 47 countries have ‘emerging’ systems to roll out multisectoral ECD packages, indicating that there is some government ownership and the potential to scale up in the coming years. Thirty-three countries reported ‘established’ systems in 2018 (exceeding the milestone of 16), with 16 having costed action plans under government ownership. The remaining 17 countries were ‘proficient’, ‘advanced’ or even ‘champions’ of ECD. Nine ‘proficient’ countries have a national coordination mechanism under the government’s ownership and costed national plans for scaling up. Five ‘advanced’ countries have a costed action plan and a monitoring mechanism under the government’s ownership, and the three ‘champions’ have a costed action plan, a monitoring system and a national coordination mechanism under the government’s ownership.

While the momentum in multisectoral packages is encouraging in some countries (see Table 35), 31 other countries reported that they do not have data on multisectoral packages, or their packages are weak (the latter indicates UNICEF and its development partners provide support to ECD programmes without government engagement). Challenges pertaining to accessibility, reliability and quality of data underscore the need for further support in establishing baselines and enhancing data collection, as well as engaging governments in the importance of ECD.

ECD is now included in the primary health care (PHC) approach to strengthening community health delivery. Several countries are working on implementing the UNICEF ECD Programme Guidance121 and operationalizing the Nurturing Care Framework (see Figure 47),122 which encompasses health, nutrition, responsive caregiving, security and safety, and opportunities for early learning. The ECD community has called for greater attention to stimulation, play and parenting, which require enhanced multisectoral approaches. The Care for Child Development (CCD) package,123 and the ECD Programme Guidance are helping to catalyse this process. The CCD package guides health workers and other counsellors as they help families build stronger relationships with their children and optimize care for their children at home. CCD recommends play and communication activities for families to stimulate their children’s learning.

Using multisectoral packages of interventions – Illustrative examples

Multisectoral ECD is gaining momentum in several regions across the globe. In Latin America and the Caribbean, UNICEF successfully positioned comprehensive early childhood care at the highest political levels in Peru. This was achieved through presenting the Nurturing Care Framework to authorities in the health, education, social development, women and vulnerable populations and culture sectors. To promote adequate childcare competencies, UNICEF designed and implemented training programmes for ECD managers and service providers from relevant sectors, and created 64 internship sites across Peru to strengthen child growth and development monitoring services and systems. This suggests that UNICEF has attained high-level government support for ECD multisectoral interventions; however, rolling out these programmes at scale will require sustained efforts.

### TABLE 35: Number of countries that have adopted ECD packages for children at scale in 2018 compared to 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Requires partner support</th>
<th>In process</th>
<th>Adopted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weak</td>
<td>Emerging</td>
<td>Established</td>
</tr>
<tr>
<td>2018</td>
<td>27</td>
<td>47</td>
<td>16</td>
</tr>
<tr>
<td>2017</td>
<td>24</td>
<td>37</td>
<td>16</td>
</tr>
</tbody>
</table>

In East Asia and the Pacific, ECD programming in Cambodia has reached more than 5,000 parents and caregivers in 145 villages, in 5 targeted Integrated Early Childhood Development (IECD) districts, through interpersonal communication on appropriate behaviours for parenting. For children up to 2 years old, this programme also includes positive parenting, prevention of unnecessary family separation, and hygiene and sanitation. This work attests to the potential for ECD programmes to increase system-strengthening interventions through nutrition and education platforms.

Multisectoral ECD is also being implemented in Indonesia. At the national level, UNICEF supported the development of the Holistic-Integrative ECD (HI-ECD) National Action Plan. At the subnational level, UNICEF supported the Government of Indonesia to operationalize a community-based HI-ECD model in four districts across three provinces. Through the HI-ECD model, young children receive support for health, nutrition, education and protection, both at ECD facilities and at home. Key interventions include early learning and parenting services, provision of learning and play materials, and technical support for local governments to form HI-ECD coordination mechanisms and regulations. More than 700 teachers and principals from formal and community-based ECD centres have received on-the-job training in HI-ECD. This programme has demonstrated the potential for integrating health and education interventions. Thus far, the programme has benefited 10,135 young children (50 per cent girls) aged 0–6 years. In addition, more than 7,000...
CASE STUDY 24: India: Multisectoral early childhood development packages: Promoting responsive caregiving using the mother and child protection card

In India, UNICEF led the revision and field-testing of the Mother Child Protection (MCP) Card. The MCP Card now includes components of responsive parenting, including the role of fathers and community workers. Adding these components has made the MCP Card a robust tool for implementing multisectoral early child development (ECD) and home-based childcare programmes. The Card has evolved by enhancing maternal, newborn and childcare services, and integrating them with ECD, health and nutrition programmes. The ministries of Health and Women and Child Development jointly approved the revised MCP Card, and in 2018 the Indian Prime Minister officially launched this tool.

In Mozambique, a road map for the health sector is being developed that will include holistic ECD. The Ministry of Health is leading efforts for stimulation in treatment of acute malnutrition in patients, thus solidifying the role of the nutrition department as a champion for ECD. The Ministry of Health is also implementing new child health registers with developmental monitoring indicators at Well and Sick Child Clinics. In Botswana, UNICEF accelerated its multisectoral collaboration efforts in 2018, bringing education and nutrition teams together towards the goal of multisectoral community-based ECD. Programme objectives include reducing malnutrition through improved feeding practices in districts with the highest malnutrition rates, and improving early learning in community preschools and playgroups. While in Uganda, engagement with local government in target districts led to the establishment of new coordination mechanisms for ECD integration in 23 districts, 314 sub-counties and 1,278 parishes. Consequently, 26 districts (81 per cent of the target) regularly review implementation of integrated ECD.

In West and Central Africa, advocacy for the demand to integrate stimulation within ongoing interventions is emerging, but will require continued support to accelerate this momentum. In Sao Tome and Principe, UNICEF continued to roll out the Parental Education Programme. Using group sessions, 155 families from 19 communities caregivers (75 per cent female) benefited from improved ECD services in the four districts. Rigorous monitoring and evaluation protocols are being developed to document the programme’s impacts on ECD services and on young children’s developmental outcomes.

In South Asia, UNICEF assisted with the incorporation of early stimulation and nutrition into a parenting-support package in Nepal. This package reached 700 communities and included training that civil society organizations (CSOs) such as Plan International have asked to use as part of their package for hard-to-reach communities. UNICEF-supported programmes are therefore being replicated by partner organizations, thus expanding their reach.

In Eastern and Southern Africa, with support from the Conrad Hilton Foundation, UNICEF worked in Kenya, Malawi and the United Republic of Tanzania to promote children’s development through the integration of the Care for Child Development package into the health platform. In Kenya, the policy on newborn, child and adolescent health care now incorporates the Nurturing Care Framework (NCF). Multisectoral coordinating committees at the county level, as well as champions at every level, are being identified to operationalize the NCF. Efforts are also being made to include indicators on developmental milestones in health-care facilities.
representing the poorest 10 per cent of the population were sensitized to the importance of ECD, stimulation and early learning. In Mali and Sierra Leone, efforts have begun to advocate for such approaches. Challenges to successful implementation of ECD include limited awareness of the need to start early, subnational capacities and governance issues.

In the Middle East and North Africa, under the leadership of the Ministry of Social Solidarity (MoSS) and UNICEF, ECD has become a national priority in Egypt. UNICEF and the Government of Egypt devised an ECD situation analysis that will inform the development of its national ECD strategy. Notably, there was also progress in the work on the Early Learning and Development Standards (preschool, 0–6 years) and the costing of different models of ECD services. With UNICEF advocacy, the government allocated US$14 million for the private sector and CSOs to establish nurseries nationwide. To this end, UNICEF supported the design of two nursery models (home-based nurseries and ECD Voluntary Centres). UNICEF partnered with Queen's University Belfast and Ain Shams University to document the models, the impact of the intervention and assess the feasibility of scale-up. UNICEF also supported the government to amend Child Health Cards to include new growth monitoring standards and ECD messages, thus promoting a multisectoral approach to child development. The government will supply the revised Child Health Cards to 2.5 million parents and caregivers annually. As in other regions, continuing emphasis on stimulation in health service delivery, parental support and advocacy will be critical to maintain the success of these programmes.

CASE STUDY 25: Thailand: Demonstration centres supporting scale-up: Emerging initiatives

In 2018, UNICEF supported the Government of Thailand with parenting programmes, which are a core element of national strategies to support the development of children aged 0–6. The draft National ECD Plan highlights parenting as one of seven key national outcomes. The four lead ministries for ECD have launched National Parenting Guidelines on Holistic Child Development. UNICEF supported technical inputs for the guidelines, which provide information for ECD professionals and parents, and also helped to disseminate the guidelines through parent networks and ECD demonstration centres. In 2018, UNICEF supported the Government of Thailand with enrolling 10,300 children in 147 ECD demonstration centres. The ECD Demonstration Programme is a scaled-up model for ECD packages that provide capacity building for caregivers to implement ECD via multisectoral platforms. The demonstration centres provide caregivers with enhanced knowledge about nutrition, stimulation and protection, and how these affect young children. The centres have also developed guidelines for implementing nutrition and hygiene as part of their ECD services. Targets for capacity development of ECD caregivers and educational supervisory visits were achieved at demonstration centres in nine provinces. The demonstration centres completed scale-up with face-to-face mentoring for 1,950 ECD professionals and 382 health-care professionals. Establishing standards and professionalization of the workforce are both key elements of strengthening systems in Thailand.

Implementation of the NCF has also gained momentum in Europe and Central Asia. In partnership with the Serbian Ministry of Health, efforts have focused on strengthening stimulation and care in paediatric health care, training of nurses and developmental counselling units. The core play and stimulation messages of Care for Child Development were integrated into the country’s ECD training package for strengthening the impact of PHC professionals. These efforts are continuing in 24 selected PHC centres (of 158 across Serbia). In two years, the initiatives have benefited 20,000 young children and their families, including 6,000 from Roma communities. These data demonstrate that the PHC approach provides a robust platform to implement ECD programmes, particularly within marginalized populations such as Roma communities.
Building stronger institutions

Enhancing enabling environments – Multisectoral ECD policies and plans

In addition to rolling out multisectoral packages in key targeted areas, establishing policies and national implementation plans is a critical component of ECD. Of the 157 countries surveyed in 2018, 67 reported that their countries have ECD policies or plans – a slight increase from 65 in 2017.

There are, however, 90 countries without an ECD policy or a national implementation plan, and thus significant room for improvement during the current Strategic Plan period. UNICEF will continue to support countries to strengthen their implementation policies and plans, and support the integration of emerging scientific evidence, costed action plans, coordination mechanisms, governance structures and monitoring systems.

Strengthening national and subnational governance, policies and plans – Illustrative examples

To ensure the realization of ECD policies and plans, UNICEF supported both upstream and downstream work to strengthen governance, policies and plans. An example of this is in Viet Nam, where UNICEF provided technical support for capacity building and a series of multisectoral consultative meetings with the ministries of Labour and Social Services, Health, Education and Training, and Agriculture and Rural Development. This resulted in the development of the first National ECD Scheme (2017–2025), which has been submitted to the Prime Minister. This multisectoral approach to ECD is currently being piloted in 3 provinces, 9 districts, 27 communes and 305 villages. While the initial pilots are limited in scope, the National ECD Scheme sets forth Viet Nam’s ECD programming until 2025, thus committing the country to comprehensive ECD expansion.
In Sri Lanka, for the first time, the Finance Commission – which recommends funding amounts for budget allocation to subnational provincial councils – established a unique ‘vote’ for ECD. The vote ensures that there is a dedicated budget line for ECD services in all subnational budgets. As a result, each of the nine provincial councils has received funding of up to US$22,500 for ECD-related programming. This was influenced and informed by UNICEF advocacy, and as well demonstrates the importance of allocating dedicated funding to ECD.

The UNICEF evaluation of ECD in Nepal has catalysed work on its national 2019–2030 strategy for ECD. When established, the strategy will strengthen coordination across sectors and ensure children receive multisectoral services that will foster their development at this critical stage of their lives. To ensure integration of ECD in local planning, a Local Integrated Early Childhood Development Planning package has been developed with UNICEF support. This package was used by 16 municipalities to develop local integrated ECD plans and enabled them to implement multisectoral services. The transition from a unitary government to the Federal Democratic Republic of Nepal has presented challenges to ECD programmes, because the devolved government structure lacks resources and capacity at the local level to absorb these new functions. Moreover, the local government has limited awareness, technical expertise and access to quality data.

In China, key policy and advocacy related to multisectoral initiatives to promote ECD has gained traction. UNICEF’s partnership with and technical assistance to the government resulted in increased commitment to develop a national ECD policy framework. UNICEF helped relevant ministries prepare for discussions on ECD at the G20 Development Working Group meeting and the G20 Summit. Additionally, UNICEF-commissioned analysis of ECD in China was used to advocate for the development of a universal minimum package of ECD services. Advocacy efforts are under way to influence China’s investments in ECD across the Mekong Delta and in selected African countries, where South–South cooperation is a key strategy for the advancement of ECD globally.

In Kenya, subnational governance of ECD was strengthened with the creation of an interim ministerial coordination committee for nurturing care. Political commitment (including strong advocacy by the First Lady of Siaya County) is helping to accelerate the scale-up of policies, programmes and services to support the Nurturing Care Framework. In Ethiopia, UNICEF supported the Federal Ministry of Health to develop the Roadmap for Ethiopian Children, which focuses on promoting ECD. In Tunisia, an ECD strategy (2017–2025) was developed in partnership with UNICEF and the World Bank. This strategy covers the period from pre-pregnancy to 8 years of age. Led by the Ministry of Family, Women, Childhood and the Elderly, it was designed in a participatory manner, together with 10 other ministries, civil society, the private sector, local authorities and technical experts.

FIGURE 49: Regional progress: Number of countries within each region that have a national ECD policy or implementation plan for scale-up

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

CASE STUDY 26: Rwanda: Ensuring implementation of early childhood development policy

In 2018, UNICEF continued to support the Government of Rwanda in developing the 2016 National ECD Policy and Strategic Plan at decentralized levels. This was achieved through capacity building of local stakeholders, and advocacy with district authorities related to including ECD in their plans and budgets. UNICEF also supported an increase in the availability of quality ECD and family services to younger children and their families. As value for money is an important aspect of any scale-up, UNICEF supported the Government of Rwanda Housing Authority to develop cost-effective designs for ECD Spaces, which serve 27,036 young children (aged 0–6 years).

18 model ECD centres were established in 16 districts, of which 15 were managed by the government. The national ECD standards framework and the training curriculum were revised to improve services for children with disabilities. UNICEF also supported the government to raise awareness about child caregiving, and to improve the home environment for optimal child growth and development. The number of families receiving this support increased from 6,625 to 9,735, and 2,813 of these families were reached through home visits that targeted pregnant women and lactating mothers. The case of Rwanda illustrates the need for elevating enabling environments, demand, coordination mechanisms and standards to achieve progress.

Renewed focus on ECD in emergencies – Action in humanitarian settings

UNICEF and partners have played a central role in mitigating some of the detrimental effects of living in fragile settings. Through psychosocial support, emphasis on play and stimulation, and support for caregivers, ECD interventions provide a buffer against ‘toxic stress’, which may adversely affect a child’s developing brain. ECD services in humanitarian and fragile settings are increasingly recognized as essential to end preventable deaths of newborns and children under 5 years of age, as well as to drive economic recovery and peacebuilding. The reinstatement of the Inter-Agency Network for Education in Emergencies ECD task team was also an important achievement, and UNICEF will continue to lead the task team and draft a workplan for 2019.

In 2018, while the proportion of children in humanitarian situations receiving ECD kits decreased by 11 per cent (from 2017), the total number of children receiving ECD kits increased significantly, from 182,679 to 476,215 across 7 regions (84 countries). Evaluation of the kits has enhanced UNICEF’s understanding of their effectiveness and informed improvements for future implementation pertaining to sustainability, cultural and contextual relevance, and scalability.

At the country level, UNICEF supported 10 countries with ECD interventions in emergencies: Jordan, Lebanon, Turkey, Bangladesh, Mali, the Niger, Burkina Faso, the Democratic Republic of the Congo, Kenya and Uganda. This included support for regional and national advocacy for ECD and for the development of an ECD Regional Strategy.

In Jordan, three ECD parenting components were introduced to the Makani Centres, the country’s flagship programme. These ECD components reached 32,336 parents (83 per cent mothers), exceeding the annual target of 27,000. Post-assessments of these initiatives showed that 80 per cent of parents and caregivers who completed the programme better understood and applied positive and developmentally appropriate practices. Fathers made up only 17 per cent of those reached in 2018, but UNICEF Jordan is increasingly engaging fathers, such as with the Early Moments Matter social media campaign, to encourage a greater role for fathers in nurturing their children. Significant work, however, is required to increase behaviour change among male caregivers.

UNICEF worked to secure funding from the Norwegian Agency for Development Cooperation (NORAD) for Mali, Burkina Faso and the Niger to implement multisectoral ECD in humanitarian settings through the Care for Child Development Package. UNICEF technical and financial assistance related to CCD methodology also supported the governments of Anguilla, Antigua and Barbuda, and the British Virgin Islands to enhance the capacity of approximately 150 multisectoral stakeholders, including ECD practitioners and family members. Key partnerships with the LEGO Foundation, Alex and Ani, and H&M Foundation were established to leverage resources and collaborations for children, including those living in humanitarian settings. Thus, UNICEF’s ability to leverage private funding for ECD programmes is emerging as a crucial element of its programmes in humanitarian situations.
An emerging focus on ECD programming in settings where there is a humanitarian crisis has resulted in leveraging existing delivery platforms to test innovative services for families with young children. For example, in Sierra Leone and Mali, with support of funding from the LEGO Foundation, UNICEF supported the design and piloting of a Caring for the Caregiver module. This module focuses on vulnerable mothers and is likely to become an essential part of multisectoral ECD packages in settings where there is a humanitarian crisis.

CASE STUDY 27: State of Palestine: Scaling up early childhood interventions in a humanitarian context

In the State of Palestine, UNICEF is supporting the scale-up of early childhood development and early childhood intervention (ECI) by focusing on helping the most vulnerable children, such as those with developmental delays and disabilities. To catalyse the national multisectoral ECD/ECI programme, UNICEF worked with the Ministry of Health (MoH), Ministry of Education and Higher Education, Ministry of Social Development (MoSD) and the United Nations Relief and Works Agency for Palestine Refugees to develop a costed ECD Action Plan for 2018.

The MoSD introduced the Child Development Assessment Indicators for National Quality Standards of childcare centres in 2018. The MoH also endorsed scale-up of ECI services through health centres in the National Health Strategy 2018–2023. Innovative ECD and ECI services were introduced in 47 health centres, kindergartens and nurseries in 7 districts of the West Bank and Gaza, and a total 242 professionals (107 doctors and nurses, 135 teachers and social workers) developed knowledge and skills related to ECI service provision. Over 5,479 families with young children benefited from parenting support for ECD, and 2,187 children from 0 to 3 years of age benefited from early detection and intervention services.

CASE STUDY 28: Caring for the caregiver: A building block for children’s well-being

In 2018, UNICEF, in partnership with the LEGO Foundation, carried out a range of activities focused on facilitating increased and enhanced opportunities for responsive care and playful learning for children most in need. UNICEF developed and tested a new ‘Caring for the Caregiver’ training module to complement the Care for Child Development (CCD) package. The new module is aimed at improving workforce intercommunication and counselling skills when interacting with vulnerable caregivers, especially vulnerable mothers coping with stress and lack of psychosocial support. The module was adapted and tested in Mali and Sierra Leone. As part of the pilot testing, 16 front-line workers received five days training on this module in Mali, and 17 days in Sierra Leone. Findings from these pilot tests were used to improve the draft training module, and UNICEF will continue to adapt and test the module to increase its efficacy.
Leveraging collective action

Advocacy and messaging – Early Moments Matter campaign

In 2018, a Father’s Day campaign focused on sharing parenting tips for healthy brain development. The campaign engaged over 2 million people in 125 countries, with a potential reach of 1.6 billion users on social media. With support from the LEGO Foundation, UNICEF also launched the Parenting Hub, a web platform to help parents better understand the importance of nutrition, protection and stimulation in ECD. Additionally, UNICEF and the H&M Foundation launched the Baby Talk for Dads, a campaign to encourage fathers to talk to their babies to help stimulate their cognitive, social and emotional development. With the H&M Foundation, UNICEF also produced a Mini Parenting Master Class on baby talk with Dr Marina Kalashnikova, which, as of November 2018, had 754,500 views and a reach of 1.8 million on Facebook.

Driving demand for ECD – Working with communities

In Rwanda, through private sector engagement, approximately US$100,000 was leveraged by tea companies to build and manage early childhood care centres, covering the provision of meals, water, sanitation and hygiene (WASH) facilities and caregiving. In Serbia, Father’s Day 2018 was marked through a digital campaign involving the business sector and athletes. Nationally, traditional and social media boosted the ECD’s advocacy plan, generating more than 450 million exposures and reaching more than 550,000 accounts on social media channels. Additionally, UNICEF developed a strategic partnership with television and newspapers to advocate about ECD and poverty.

In line with the #EarlyMomentsMatter global campaign, UNICEF Argentina also generated a Father’s Day strategy to talk about parental leave and the importance of the first 1,000 days of life.
In Timor-Leste, concerted efforts linked advocacy and Communication for Development activities to maximize reach and engagement of different stakeholders to promote and protect children’s rights. An innovative advocacy tool, the UNICEF Café, was also formally launched. The Café focuses on ECD, engaging people from diverse backgrounds and inspiring public discussion on child development. Media engagement continued through the establishment of an ECD Journalists’ Network, periodic media briefings and public events, resulting in the publication of 1,284 reports on issues related to children. National television and radio, plus three community radio stations, broadcast weekly children’s radio programmes, with 145 child reporters and listener group members, and produced 164 audiovisual products on child rights, potentially reaching 80 per cent of the country’s population, ensuring children’s voices are heard.

Partnerships and emerging work with the private sector

UNICEF is working with its partners to meet the in-country demand for ECD programmes. Noteworthy results have been achieved with key partners of the UNICEF headquarters team, including the LEGO Foundation, the Conrad Hilton Foundation, H&M Foundation, and Alex and Ani. Several country offices engage in a wide variety of partnerships with other donors, the private sector, faith-based organizations and goodwill ambassadors to advocate for ECD. Recognizing the value of working with private sector partners, UNICEF launched the Family Friendly Policies (FFP) Initiative at the Social Good Summit in September 2018. Executive Director Henrietta Fore, appearing alongside the Prime Minister of New Zealand, Jacinda Ardern, issued an aspirational call for action to governments and the private sector. UNICEF is continuing to advocate for greater investment in family-friendly policies – including paid parental leave, support for breastfeeding, quality childcare and child support grants – and to show their value for a triple bottom line of financial profit, women’s empowerment and ECD.

Many countries are partnering with the private sector. In Argentina, the ‘Diamond of Care’ model was developed by UNICEF Argentina as an effective ECD strategy that emphasizes government, private sector, communities, CSOs and families. As a result, 10 companies changed their human resources policies by increasing parental leave, creating breastfeeding spaces, implementing remote working, generating diversity programmes, and creating other forms of leave such as gender violence leave and assisted fertilization leave. In the Dominican Republic, with UNICEF support, six companies trained 358 of their employees on parental responsibility. One of the associated companies will begin offering a 10-day paid paternity leave, instead of the two days regulated by Dominican Republic law, and a supermarket chain installed 14 breastfeeding rooms for employees and shoppers.

Social–emotional learning in early childhood development as a pathway to peacebuilding

The Pathways to Peace Social Emotional Learning initiative was rolled out to support 3- to 5-year-old children in Cambodia, Papua New Guinea and Viet Nam, and has reached more than 32,000 children, teachers, parents and ECD experts. From 2016 to 2018, 2,389 children, 420 trainers and teachers, and 4,550 parents were directly engaged in this programme. Building on this success, last year the SEL (Socio-Emotional Learning) initiative was rolled out in 14 additional provinces in Viet Nam. SEL materials were also adapted to local languages and cultural contexts. In Viet Nam, this initiative has helped to sensitize national- and district-level ECD practitioners about the importance of SEL in the development of young children. The link between SEL and peacebuilding is changing how ECD is implemented, and evidence suggests that SEL programming could help to maintain stability in fragile states. The Early Childhood Peace Consortium, a network supported by UNICEF, has been an essential platform for technical expertise as well as advocacy for this critical area of work.

Enhanced global and regional partnerships – Early Childhood Development Action Network

In 2018, UNICEF and the World Bank worked with an international network of partners to create the Early Childhood Development Action Network (ECDAN). ECDAN focuses on assisting countries with creating effective and equitably delivered ECD programmes. It does so through sharing knowledge, technical tools, resources, advocacy materials and coordination to ensure ECD programming is successful. It also seeks to increase demand and encourage behavioural change. The G20 recently endorsed ECDAN as the coordinating body and platform for sharing best practices for the implementation and scale-up of ECD programmes, such as the Nurturing Care Framework and the Partnership for Maternal and Newborn Child Health. UNICEF is also partnering with regional networks including the Africa Early Childhood Network (AfECN) and the Asia-Pacific Regional Network for Early Childhood (ARNEC) to build knowledge platforms, mobilize advocacy and enhance capacities for ECD in countries.
Lessons learned and challenges

There were a number of factors in 2018 that catalysed the significant advancement of ECD programmes. Targeted support for eight countries, made possible by the 7 per cent set-aside funds for ECD, was essential for country offices to lead in ECD scale-up and to learn from the implementation process. In addition, the ECD Programme Guidance supported the acceleration of scale-up and fundraising. Establishing multisectoral governance and coordination mechanisms in many countries, communications campaigns, publication of high-level knowledge products, supporting systems for delivery and strong technical guidance also led to many of the successes of ECD programmes in 2018. Several programmatic directions also accelerated ECD results, such as the four UNICEF-recommended packages of interventions. These include:

1. Home visitation programmes that supplement centre-based care and parenting programmes in the first 1,000 days.
2. Early learning and protection through development of a pre-primary frameworks, interactive play and communication, school readiness programmes that focus on the early years, teacher training, and establishing early learning standards and guidelines.
3. Caring for the Caregiver programmes that promote ECD skills in pregnant mothers and fathers’ engagement with children.
4. Family support and strengthening through cash transfers, child benefits, grants and safety nets for families.

Some of the key challenges for ECD include subnational implementation, limited technical capacities for promoting multisectoral ECD, ensuring effective dissemination of messages on stimulation, articulating responsive parenting in capacity building for front-line workers, and suitable tools for services. Moreover, reliable metrics should be integrated into information management systems and available for programme evaluation. Lastly, sustained political will and commitment during government transitions, as well as public financing, continue to present formidable challenges.

A young mother kisses her baby in the village of Sokoura, in the western Côte d’Ivoire. Love and stimulation are essentials of early childhood development.
In 2018, UNICEF spent US$50,558,633 on ECD, which amounts to 1 per cent of the total budget, according to data released by the Division of Financial and Administrative Management. Additionally, in most regions, and in UNICEF headquarters, ECD sustains itself primarily through ‘other resources’, to supplement the limited emergency or regular resources (see Figure 49). Against a backdrop of evidence showing that core resources have a catalytic (if not multiplier) effect on results, core investments in ECD programmes are urgently needed. There is a gap between funds needed to scale up programmes and funds received. Further, the types of activities funded by other resources are often quite specific, prioritized by the donor and focused on limited geographic areas and contexts. To strengthen the systems that are required for scaling up ECD programmes towards achieving the Strategic Plan’s directive to impact every young child, core resources are required.

**Value for money: Economic benefits of investing in ECD**

Investments in ECD are not only the right thing to do, they are the smart thing to do. The return on investment for individuals amounts to a 25 per cent increase in earnings as an adult, while the return on investment for societies is about 13 per cent annually, if all children in low- and middle-income countries are educated to a basic level of literacy and numeracy. Moreover, ECD programmes are affordable: on average, ECD programmes cost US$0.50 per capita per year, while the cost of inaction is high. Governments spend 2–3 times the cost of ECD programmes in related health and education programmes by not making these initial investments from the start of a child’s life.
Conclusion

UNICEF is committed to ensuring that all children survive and thrive. Nurturing the start to a child’s life is a moral imperative and, in the past two years, UNICEF has supported countries in translating this imperative into programmatic implementation. The science provided the basis, and the political landscape demanded action. UNICEF has heeded this call and is contributing to the accelerated momentum through convening global technical expertise, high-level advocacy, clear programme guidance and partnerships. In 2019, integrated programming and systems strengthening will continue to be priorities. To this end, countries will be supported to move from ‘emerging’ systems to those that are more ‘established’, ‘advanced’ and even ‘champions’. From a programmatic perspective, the objectives of ECD addresses children as direct beneficiaries, alongside parents and caregivers, who create enriched environments for young children. UNICEF and its partners must continue to build on the significant success of ECD programmes. Therefore, integrated programming will focus on the following:

- Strengthening health and community networks: embedding early stimulation and responsive care through building capacity of front-line workers in counselling and leveraging existing tools (e.g., mother child card/digitized, infant and young child feeding and focus on the first 1,000 days).
- Supporting families with services, time and resources: quality, accessible, affordable early childhood care and development, parental leave and child benefits (a focus on the second 1,000 days and beyond).
- Caring for the caregiver: expanding existing packages to focus on parental health and well-being, and the interaction between parents and children in conditions of high stress (with a focus on prenatally onwards).

The stakes are high: Young children's brains are waiting to be built.
Strengthening systems for child survival, growth and development results

The preceding chapters provide several examples of integrated programming for health, nutrition, HIV and early childhood development (ECD) interventions. This kind of cross-sectoral work often involves systems strengthening in areas that are common to multiple programmes. Reports from other goal areas of the Strategic Plan show examples of UNICEF work in strengthening national systems as part of its programming in the education, social protection, child protection and water, sanitation and hygiene (WASH) sectors. This concluding chapter shows UNICEF work on strengthening health systems and reshaping food systems to sustainably deliver the health, nutrition, WASH, HIV and ECD results of Goal Area 1. This chapter also provides an overview of UNICEF’s response in humanitarian situations and during public health emergencies towards improving global health security.
Improving primary health care through health system strengthening

The case for primary health care

Between 2017 and 2018, primary health care (PHC) as a central strategy to achieve universal health coverage (UHC) regained currency. In 1978, the Alma Ata Declaration recognized health as a fundamental right for every person, and PHC as the vehicle for ‘health for all’. The 2018 Astana Declaration on Primary Health Care reaffirmed this vision in a 21st century, whole-of-society approach. The declaration cemented a renewed commitment to a right to the highest attainable standard of health without discrimination. UNICEF and the World Health Organization (WHO) are at the forefront of implementing a vision of PHC that has three components. First, it includes both individual and population-level services that meet people’s health needs throughout the lifespan. Second, it addresses the broader determinants of health through evidence-informed policies and actions across all sectors. Third, it empowers families and communities to act as change catalysts as self-carers and caregivers (see Figure 50).

PHC is acknowledged globally to contribute to the Sustainable Development Goal (SDG) target 3.8.1 on UHC, and is an important platform for achieving Goal Area 1 results. UNICEF promotes and supports PHC that includes a package of combined interventions on community-based, facility-based and outreach services for maternal, newborn, child and adolescent health and nutrition, WASH, HIV and ECD. Operationalization of PHC depends on health systems strengthening (HSS): actions that establish sustained improvements in the provision, utilization, quality and efficiency of health services, including both preventive and curative care, as well as the resilience of the system as a whole.

UNICEF’s HSS Approach lists areas of priority where the organization has existing capacity or has determined a need to prioritize. These are represented in the schematic (see Figure 51). More recently, there has been acknowledgement of the need to provide additional support in the areas of health.

FIGURE 51: UNICEF programming and primary health care

Integrated UNICEF Health, Nutrition, HIV and ECD programmes

Supported by the actions below to strengthen health systems

- Food systems
- Child protection
- WASH
- Education system
- Social protection
- Community engagement/systems
- Social accountability
- Supply chain management
- Quality of care
- Data and digital health
- Governance and partnerships (CSO, Pvt. Sector)
- Decentralized management
- National planning and financing
- Health workforce
Bold investments in HSS are urgently required. UNICEF is prioritizing this agenda to the extent possible with available discretionary resources. In 2018, UNICEF allocated US$10 million set-aside resources to support work in six countries (the Central African Republic, Chad, Madagascar, Malawi, Mali and the Sudan) to strengthen their front-line PHC, and additional resources are expected in 2019.

UNICEF is undertaking a global process of building internal capacity in HSS. In addition, during 2018, concrete progress was made in HSS through UNICEF programmes. Key achievements are highlighted in the following sections.

Applying the HSS approach across UNICEF programmes

UNICEF is now prioritising the HSS Approach in a number of regional and country office programmes.

Quality of care

By the end of 2018, 44 of the 90 countries reporting on the Every Newborn Action Plan had a national quality-improvement programme and 38 of these had a plan in place to implement quality-of-care guidelines. Maternal and newborn quality-of-care standards are successfully being implemented in Bangladesh, Ghana and the United Republic of Tanzania, the front-runner countries since 2016. A core set of interventions (including the use of partographs to monitor labour, hand washing by service providers before and after procedures, early initiation of breastfeeding, and pre-discharge postnatal counselling) have significantly improved in all intervention facilities. UNICEF is working across the health and WASH sectors to further improve the quality of care provided to mothers and newborns. UNICEF improved access to WASH in 3,555 health centres in 2018.

Institutionalizing community health workers

Institutionalizing community health workers (CHWs) into the formal health system is a critical component of bridging the gaps in access to basic care. For institutionalization to occur, as a first step, policies defining roles, tasks based on local needs, financing and relationships to the health system must be in place at country level. Since 2016, some 30 countries have demonstrated progress in meeting this initial criterion for institutionalization. UNICEF is providing advocacy, policy and technical support to achieve full institutionalization of CHWs as a key component of PHC. This includes planned work towards establishing a package of care, incentive and compensation structures, supervision and supply-chain models. Six countries are actively committed to strengthening and scaling up PHC at the community level (Burkina Faso, Liberia, Mozambique, Malawi, the Niger and Uganda) through a UNICEF co-led partnership called the Community Health Roadmap. These countries have identified national investment priorities for community health, including CHWs. These experiences will help leverage additional investments to further expand a PHC model responsive to the needs of families and communities.

Procurement and supply chain management

In 2018, UNICEF Supply Division, as the group leading on UNICEF’s global approach to HSS in the area of strengthening procurement and supply chain management, introduced a new approach on this in 14 countries. With the support of the Health Section, these countries are focusing on people and practice, policy and regulatory frameworks, information management, system design, financing and resource mobilization and operationalization. Learning from this work, which is now disseminated via an online platform, will inform its further introduction in new locations in 2019 and beyond.
By the end of 2018, some 43 countries were implementing a national health-sector supply-chain strategy. Thirty-one UNICEF country offices supported supply-chain strengthening interventions. Immunization supply chains and the comprehensive effective vaccine management (EVM) approach remain the entry point to broader-based supply-chain strengthening initiatives. A main priority is to strengthen the availability of essential health commodities at district and community levels.

**Building decentralized management capacity through district level HSS**

The district health systems-strengthening (DHSS) approach is an important way of operationalizing the equity agenda at the subnational level to achieve UHC. It aims to help governments better use data to identify the bottlenecks in the health system that create gaps in access to and utilization of health services towards ensuring quality and effectiveness of interventions. For example, Uganda has automated a reproductive, maternal, newborn, child and adolescent health dashboard using the district health information system version 2 (DHIS2) and enables more real-time, evidence-based monitoring, decision-making, and action at decentralized level. The dashboard sits alongside four other near real-time monitoring dashboards on: data quality assurance; bottleneck analysis; a tracker which monitors the status of proposed solutions; and stock management.

**CASE STUDY 29: Malawi: An innovative stock monitoring system**

In Malawi, the use of an innovative real-time short message service (SMS) based stock monitoring system, developed by UNICEF and the Ministry of Health, improved district capacity to monitor nutrition supplies, resulting in no stock-outs of ready-to-use therapeutic food at health facilities in 2018. With UNICEF support, a National Multi-Sector Nutrition Information System was developed for real-time integrated reporting by different ministries at district level. Monthly reports were used to guide programme alignment, decision-making and course correction.

**Enhancing the quality and use of data: Strengthening administrative data systems and digital health**

UNICEF has been supporting in-country health management information systems (HMIS) in partnership with the University of Oslo DHIS2 platform. Countries supported include Bangladesh, Burkina Faso, Botswana, Kenya, Malawi, Mali, Mozambique, Pakistan, Senegal, the United Republic of Tanzania and Uganda.

For example, in Bangladesh in 2018, the architecture of the national Health Management Information System (HMIS/DHIS2) was strengthened. The DHIS2 in the country will, in 2019, also incorporate nutrition indicators. Health systems in Bangladesh were further strengthened through the leadership development of senior officials at the ministry and by completing District Evidence Based Planning and Budgeting in eight districts. In Ethiopia, eight nutrition indicators were included in the district health information system (DHIS2).

In 2018, UNICEF completed a five-year Global Affairs Canada-funded Birth Registration for Maternal Newborn and Child Health (BR4MNCH) in Ethiopia, Mali, Senegal and South Sudan, where increases in birth registration or notification and innovative programmes to link health and the civil registration and vital statistics (CRVS) systems were notable. For example, in Senegal, the project contributed to a 6 per cent increase in the national under-five birth registration rate between 2014 and 2017.

At the global level, UNICEF’s participation in several global data collaboratives in 2018 helped define metrics and indicators to monitor maternal, newborn, child and adolescent health. Foremost among these is the Health Data Collaborative (HDC). The HDC is working with countries to improve health data and build capacity to track progress towards the health-related SDGs and UHC. In supportive of stronger linkages between administrative data systems, in February 2018, ‘The Future for Women and Children: UNICEF and WHO Joint Statement on Strengthening Civil Registration and Vital Statistics (CRVS)’ was released at the CRVS Innovations Conference.

Digital health can help solve problems of time, distance, quality and coordination in the delivery of health services to children, especially when they are designed with users at the centre of the process. Free updates via each user’s preferred mobile channel can provide, for instance, newborn advice to mothers in remote villages, patient tracking and quality-of-care support to front-line health workers, and community data flows that strengthen health systems.
UNICEF first programmatic guidance, the *Approach to Digital Health* and *Designing Digital Interventions for Lasting Impact: A human-centred guide to digital health deployments* were released in 2018, marking the beginning of a new approach to the topic.

To foster innovation in ECD/ECI (early childhood intervention) programming, UNICEF assisted the State of Palestine with introducing the RapidPro platform as a real-time digital monitoring solution. This provides support to families with children with developmental delays or disabilities. RapidPro also supports early detection as well as the provision of early intervention services.

In Mozambique, UpScale is an interactive mobile phone application that guides community health workers through the diagnostic process, provides treatment recommendations, issues targeted behaviour change messages for patients, and collates inputted data. The mHealth system also strengthens the links between community health workers and health-care facilities by promoting supervision and performance through an integrated tablet-based application for health-care facility supervisors.

Funded by the Bill & Melinda Gates Foundation, the equitable impact sensitive tool (EQUIST) focuses on cost-effective interventions and prioritizes key bottlenecks that constrain their coverage. The tool uses the most effective and equity-focused strategies that can address these bottlenecks. It now includes a nutrition module and more country databases. The tool allows country managers to develop scenarios that will not only allow them to estimate the number of lives saved but also allow them to estimate the stunting averted.

UNICEF offices and in-country partners use EQUIST to develop plans for maternal, newborn and child health (MNCH) programmes, immunization-acceleration plans, as well as investment cases to apply for funding from the Global Financing Facility and Gavi-HSS. In 2018, the Democratic Republic of the Congo and Ghana used EQUIST to prioritize districts and provinces to reach the most vulnerable families.

In 11 countries of Eastern and Southern Africa, UNICEF deployed EQUIST to conduct bottleneck analyses and develop prioritized plans to address the identified bottlenecks. Additionally, the regional office played a catalytic role in institutionalizing strategic engagement on public finance issues at country level. This includes production of budget briefs, fiscal-space analyses and investment cases, advocacy to strengthen government budget transparency practices, the ongoing application of more than 40 tools to improve the impact of spending, and a dozen initiatives to train budget officials and parliamentarians on public financing for children. For instance, in Angola, the budget briefs contributed to a nearly US$400 million increase in the approved budget for health and education in fiscal year 2018, which likely benefited more than 16 million children. In West and Central Africa, countries undertook in-depth equity and bottleneck analyses of health and nutrition programmes. These analyses guided the development of UNICEF country programmes, national strategic plans and investment cases in at least 15 countries. To leverage domestic resources to scale up and sustain health programmes, UNICEF developed a methodology to link EQUIST with the WHO OneHealth Costing Tool. Eleven countries were supported to develop investment cases for immunization, of which two secured support from the Global Financing Facility. In Nigeria, for instance, UNICEF provided technical and financial support to finalize the National Strategic Health Development Plan 2 and the State Strategic Health Development Plans. These documents provide guidance to enhance systematic programming, coordination and accountability, and are investment cases for advocacy and resource mobilization for MNCH.

**Enhancing preparedness of the health system to prevent and respond to health emergencies**

In 2018, UNICEF responded to 87 health emergencies worldwide that included Ebola virus disease (EVD) in the Democratic Republic of the Congo, cholera in more than 14 countries, Zika in India, and measles in around 25 countries. In response to the two outbreaks of EVD in the Democratic Republic of the Congo, UNICEF mounted an integrated response across sectors, including risk communication and community engagement, WASH, infection prevention and control, psychosocial support, comprehensive care management, nutrition, education, supplies and logistics. Despite the complexity and insecurity, UNICEF facilitated population acceptance and effectiveness of the response by reaching nearly 10 million people through interpersonal communication and community engagement; and more than 700 health facilities and 700 schools received WASH services. Psychosocial support played a key mediation role for other response pillars, including through follow-up of contacts, preparing families for safe and dignified burials, and facilitating admission of patients to Ebola treatment centres. Regionally, UNICEF increased its investments in emergency preparedness and early response for EVD in Burundi, Rwanda, South Sudan and Uganda.

Engagements in other public health emergencies continued to expand in 2018 and included preparedness and response to yellow fever outbreaks in Brazil and Ethiopia, Lassa fever in Nigeria, and other viral haemorrhagic fevers such as Marburg and Rift Valley fevers in sub-Saharan Africa. UNICEF continued its support to the Zika response in South America.
In 2018, the UNICEF public health strategy continued to evolve towards an integrated, multisectoral response involving health (immunization, primary and community-based health), WASH (including vector control), Communication for Development (C4D, including risk communication and community engagement), child protection (including psychosocial support), education and nutrition, as well as the UNICEF Supply Division and the Emergency Operations Division.

UNICEF continued to be a leader in global emergency health advocacy and played a strong role in partnerships. In 2018, UNICEF successfully organized the Global Outbreak Alert and Response Network (GOARN) Steering Committee meeting. The GOARN meeting achieved multiple breakthroughs, including the development of the first Joint Strategic Response Plan from the get go, the inaugural activation of the World Bank’s Pandemic Emergency Financing Facility, the first activation of Central Emergency Response Fund at the onset of an outbreak, and an unprecedentedly high level of agency coordination on risk communication and communication engagement between UNICEF, WHO and partners.

UNICEF provided core technical support to the Alliance for Child Protection in Humanitarian Action on their guidance note on Protection of Children during Infectious Disease Outbreaks to help relevant actors take children’s protection needs into account in preparedness for and during responses to infectious diseases outbreaks.

**Resilient PHC**

Health systems need to be sufficiently adaptable to reconfigure resources in response to new threats, robust enough to withstand shocks, and equipped with monitoring and accountability systems that can detect and respond to new challenges and scale up in emergencies. Building and maintaining such capacity is UNICEF’s aim in bridging humanitarian and development work. In 2018, UNICEF rolled out its Guidance on Risk Informed Programming, including a Health Module. The guidance outlines how to analyse risks that may erode progress in child and maternal health, and how to design or adapt sector policies and programmes to strengthen the resilience of populations and the health system – helping to ensure that all children, adolescents, young people and mothers are alive and thriving.

In Yemen, UNICEF is supporting the Ministry of Public Health in establishing a paid cadre of community health workers in rural areas with linkages to PHC facilities, with 1,800 workers deployed to date. To build resilience further, UNICEF is promoting decentralized planning, implementation and monitoring of health services. To prevent health system failures in acute emergencies, rapid-response capacity has been established in each of the 333 districts for use during various emergencies that require an immediate health, WASH and C4D response.

As part of a comprehensive strategy to tackle undernutrition in Nigeria and invest in building resilient systems over the past decade, UNICEF advocacy and support helped improve government ownership and sustainability of the nutrition programme (including monitoring systems, better coordination, and national investments in care). The number of children with severe acute malnutrition (SAM) admitted for treatment increased from fewer than 7,000 in 2009 to more than 600,000 in 2018. These advancements in systems-building also created an important foundation for effective scale-up in response to the emergency in 2018. In the emergency states of Borno, Yobe and Adamawa in 2018, more than 368,900 children with SAM received treatment, exceeding the target, and 94 per cent of them recovered.

**Enhancing UNICEF technical capacity for HSS**

UNICEF continued to build its own capacity on HSS at global, regional and national levels.

To this end, in 2018 UNICEF continued to offer, in collaboration with the University of Melbourne, the blended HSS course which uses distance and face-to-face sessions and was available to participants from across the organization’s departments and divisions. During the year, 132 staff members from diverse backgrounds including health, nutrition, HIV/AIDS and the Supply Division completed the course. This brings the total of staff trained in two years to 217 from 65 country offices and all regions.
Strengthening food systems for child survival, growth and development

In many parts of the world, children do not receive the diets they need – in quantity, frequency and quality – to survive, grow and develop to their full potential. Poor dietary diversity, inadequate dietary patterns, and consumption of poor-quality or unsafe foods contribute to this reality. Poor-quality diets cut across all age groups from infancy through school-age years and adolescence, as well as across regions and countries, threatening children’s survival, health, development and future potential.

Multiple systems – most importantly, the food system – need to work in a coordinated manner to improve children’s diets and set them on the path to survive and thrive. Food systems are defined as the systems that grow, harvest, process, package, transport, market, consume and dispose of food and food-related items. While they have the potential to deliver healthy, affordable and sustainable diets for children and adolescents, today’s food systems are failing children.

Actors across the food system, including food producers and suppliers, typically do not account for the special needs and vulnerabilities of children and adolescents when determining what foods to grow, produce, distribute and sell. Instead, processed, less nutritious foodstuffs are skilfully marketed and widely available and affordable, while nutritious foods are often more expensive and unaffordable to many. The food environment often does not lend itself to nutritious diets for children and adolescents, nor is it incentivized to do so. At the same time, knowledge and practices on nutritious diets are often inadequate, leading to little demand on food systems to deliver healthier and more nutritious food (see Figure 52).

FIGURE 53: The Innocenti framework on food systems for children and adolescents

The potential consequences of inadequate food systems cut across all Goal Area 1 programmes. Food systems drive the inappropriate promotion of breastmilk substitutes and therefore undermine efforts to protect and promote breastfeeding as the optimal start to life. They fail to support diet diversity and consumption of nutritious foods among young children and thus weaken immune defences against common childhood disease while impairing growth and early childhood development. Along the entire life course, food systems promote energy-rich, nutrient-poor diets which account for the largest share of the global burden of disease and fuel the global rise of overweight and obesity and non-communicable diseases.

Nutrition-blind food systems have wider-reaching indirect health impacts. In enabling food insecurity and malnutrition, they may facilitate HIV transmission by increasing risks of HIV exposure and transmission efficiency, and by lowering adherence to antiretroviral therapy. Inadequate food systems are also main drivers of the use and abuse of antimicrobial medicines in animal health care, resulting in antimicrobial resistance, as well as of environmental degradation and climate change.

Making food systems more accountable to children is therefore critical to achieving the UNICEF Strategic Plan results and the goals of the 2030 Agenda. In addition to their role in supporting healthy diets, food and food systems have much wider importance, affecting progress on all 17 Sustainable Development Goals, spanning from poverty, hunger and health to education, economic growth and equality, environmental sustainability, and partnerships. Given their far-reaching consequences on children, adolescents and other vulnerable groups, food systems need to be transformed to achieve progress towards Goal Area 1 targets.

UNICEF programming around food systems began to take shape during the first year of the Strategic Plan. To begin building consensus on an approach to this work, in 2018, UNICEF and the Global Alliance for Improved Nutrition convened global experts for a Global Consultation on Food Systems for Children and Adolescents to address the absence of children in the global discourse on food systems and identify actions for redesigning food systems to better address the needs and vulnerabilities of children. The meeting marked an important shift in global approaches to tackling malnutrition and led to the development of a conceptual framework on priority actions for food systems to deliver nutritious, affordable and sustainable diets to children and adolescents.

To improve its engagement with food systems and explore ways to improve the availability and affordability of nutritious foods for children, UNICEF worked with countries to gather evidence, test interventions and gain consensus on programme design for future scale-up. UNICEF also developed complementary feeding ‘action frameworks’ to guide programming, including opportunities for leveraging food systems to improve children’s diets. Some countries, such as Bangladesh and Ghana, explored the use of food vouchers and combined nutrition and social protection schemes to improve household access to nutritious foods for young children.

Strategies for engaging with the food system vary by context and the burden of malnutrition. In Argentina, for example, UNICEF is provided technical assistance to the Ministry of Health to adopt food labelling to reduce the consumption of unhealthy foods, while in Burkina Faso, UNICEF is advocating for the adoption of national tax exemptions on nutritious foods as a strategy for tackling undernutrition.

UNICEF will launch a new Nutrition Strategy 2020–2030, outlining its approach to leveraging food systems to improve children’s diets and achieve the goals of the 2030 Agenda, including Goal 2 to end hunger and malnutrition. This will include operational guidance for country programmes.
Implementation research

UNICEF further spearheaded implementation research, which is designed to bring local implementers (i.e., practitioners and decision-makers) and researchers together to increase research capacity among implementers. Implementation research is driven by real-time responsiveness. Key characteristics include continuous engagement between implementers and researchers, and alignment of research activities with implementation, funding and policy cycles.

As an example, the global Decision-maker-Led Implementation Research (DELIR) initiative aimed to generate knowledge to improve the effective implementation of immunization programmes. As part of this initiative, 14 projects from 10 countries (Chad, the Democratic Republic of the Congo, Ethiopia, India, Kenya, Nigeria, Pakistan, Somalia, Uganda and Viet Nam) focused on vaccination coverage, vaccine demand, health and delivery systems for vaccines, and immunization programme management. A recent evaluation shows the value of the platform for the identification of EPI bottlenecks and solutions to improve immunization coverage. It also introduced research into programmes for the first time.

In 2018, implementation research was also expanded beyond these two initial projects focused on immunization. Projects were also ongoing or completed in cross-cutting areas such as nutrition and child protection. In nutrition, six implementation research projects are ongoing in Benin, Burkina Faso, Côte d’Ivoire, Madagascar, Malawi and Mozambique. Results from these studies should become available in 2019.

The year 2018 also saw an excellent example of how implementation research findings can be used in real time to improve programming from a study on HIV/AIDS and prevention of mother-to-child transmission (PMTCT) of HIV in adolescents in Malawi. A study to assist the Malawi Ministry of Health and mothers2mothers (m2m) to develop adolescent-focused PMTCT and mentor-mother programming. In response to the 2017 study, m2m

A girl holds an orange in Soweto South Africa. Multiple systems, including food systems, need to coordinate work to improve children’s diets and set them on a path to survive and thrive.
modified its intervention to include Adolescent Champions, who work alongside older mentor-mothers to deliver a core package of HIV, tuberculosis and nutrition screening, sexual and reproductive health and gender-based violence education, and referral for adolescents. Support was also consequently intensified for young sero-discordant couples and early infant diagnosis.

To build capacity, UNICEF ensures that implementation research is embedded in ongoing programming to obtain relatively quick feedback and adjust programme design in real time. To achieve this goal, capacities need to be developed at the country and regional levels so that UNICEF staff and partners can plan, conduct and use operational and implementation research within their own programming.

These experiences have sparked excitement for and appreciation of implementation research among implementers and policymakers alike. The emphasis on partnership between research teams and decision makers was broadly recognized as a positive approach.

Conclusions

While disease-specific programmes have been highly successful, underinvestment in cross-cutting HSS strategies has exposed limitations in vertical programmes. First, while not yet universal, many have reached maximum coverage due to the weak systems they rely upon. Second, as seen in West Africa, vertical programmes often fail during health emergencies. Third, gains made in vertical programmes are sometimes short lived as disease/issue-specific funding moves to evolving priorities. These challenges underscore the importance of adopting a broader approach to HSS that, together with multisectoral approaches, creates lasting change through equity- and child-sensitive policies and responsible regulation and financing.

The progress made in strengthening health systems, and the promising advances gained in support to more appropriate food systems, show the value of UNICEF’s investments in these areas. The results presented in this chapter demonstrate that investing in systems strengthening creates immediate as well as lasting effects, ultimately reducing the need for direct support to services.

For these results to be achieved, thematic funds have been essential. Without this dedicated support to HSS work, quality and reliable programming that is aligned to the Strategic Plan cycle would not have been possible. The more such funds are made available, the more results will be achieved in this area.

To further improve its work, UNICEF commissioned a formative evaluation of its overall programming in HSS to generate evidence and learn what is needed for successful implementation. The evaluation included four thematic areas – quality of care, emergency contexts, procurement and supply chain management, and district-level governance. It showed that while UNICEF is well positioned to capitalize on its comparative advantage – including in subnational-level governance in the era of decentralization and increased use of data for decision-making – the transition is complex and difficult. Finding that limited progress has been made in terms of structures and systems, it points to a need to further clarify the organization’s niche and make suitable adjustments in its vision and strategy, in investment in staff capacity for HSS, and in advocacy to support change management and build partnerships. UNICEF is preparing a plan to implement these recommendations, including improving coordination structures to increase the effectiveness of its investments in systems strengthening.

A companion to the data provided in this report can be found at: https://www.unicef.org/about/execboard/files/2019-ED_AR-Data_companion-2019.05.09.PDF
In Goal Area 1, an overarching priority for the coming years is the continued strengthening of health systems and the primary health care platform to ensure more children survive and thrive.

The implementation of the Strategy for Health 2016–2030 will play a central role in this. It widens the approach of health programmes to address developmental delays through health interventions, and to support more interventions for adolescents, including for those with mental health needs, and better prevention of HIV in adolescents and young women. This includes a priority to initiate and retain children and adolescents with HIV on treatment, eliminating mother-to-child transmission of HIV, and supporting early infant diagnosis of HIV through the use of point-of-care technologies.
The importance of a systems approach to nutrition was reaffirmed in the first year of the Strategic Plan. New programmes leveraging food and social protection systems to improve children’s access to nutritious, affordable and sustainable diets were launched globally and lay the foundations for scale-up and results over the coming years. Integration of stimulation and responsive caregiving into existing health and early learning platforms is another key priority.

The year 2018 was also foundational for exploring opportunities to leverage education systems to better meet the nutritional needs of school-aged children and adolescents. Improving the diversity of children’s food through a systems approach will continue to be a priority objective to accelerate action on ending malnutrition in all its forms, as will be more investment in parenting support to strengthen the caring environment in homes. UNICEF programming over the remainder of the Strategic Plan period will aim to reach 250 million children with services to prevent stunting and other forms of malnutrition; reach 100 million adolescents with services to prevent anaemia and improve nutrition; and provide life-saving care to 6 million children with severe acute malnutrition.

The quality of interventions in humanitarian situations is another key priority, where coverage alone is not sufficient to improve the lives of children in these most threatening circumstances. Health, nutrition and early childhood development interventions in humanitarian crises strive for further quality increases, to ensure more children benefit from interventions that can also better bridge the humanitarian–development nexus. This will also be critical for managing risks, reducing vulnerabilities and strengthening community resilience.
# Abbreviations and acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ANC</td>
<td>antenatal care</td>
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<td>ART</td>
<td>antiretroviral therapy</td>
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<td>ARV</td>
<td>antiretroviral medicine</td>
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<td>ASLM</td>
<td>African Society for Laboratory Medicine</td>
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<td>CCD</td>
<td>Care for Child Development</td>
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<td>CCE OP</td>
<td>Cold Chain Equipment Optimization Platform</td>
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<td>CHAI</td>
<td>Clinton Health Access Initiative</td>
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<tr>
<td>CHW</td>
<td>community health worker</td>
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<td>DHIS</td>
<td>District Health Information System</td>
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<td>DT</td>
<td>dispersible tablets</td>
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<td>DTP</td>
<td>diphtheria–tetanus–pertussis</td>
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<td>EAP</td>
<td>East Asia and the Pacific</td>
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<td>ECA</td>
<td>Europe and Central Asia</td>
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<td>ECD</td>
<td>early childhood development</td>
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<td>EID</td>
<td>early infant diagnosis</td>
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<td>EMTCT</td>
<td>elimination of mother-to-child transmission (of HIV)</td>
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<td>ENAP</td>
<td>Every Newborn Action Plan</td>
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<td>EPI</td>
<td>Extended Programme on Immunization</td>
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<td>ESA</td>
<td>Eastern and Southern Africa</td>
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<td>EVM</td>
<td>effective vaccine management</td>
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<td>FAO</td>
<td>Food and Agriculture Organization of the United Nations</td>
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<td>GAP</td>
<td>Global Action Plan</td>
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<td>GNC</td>
<td>Global Nutrition Cluster</td>
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<td>GOARN</td>
<td>Global Outbreak Alert and Response Network</td>
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<td>GPEI</td>
<td>Global Polio Eradication Initiative</td>
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<td>HMIS</td>
<td>health management information system(s)</td>
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<td>HPV</td>
<td>Human papillomavirus</td>
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<td>HQ</td>
<td>headquarters</td>
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<td>HSS</td>
<td>health system(s) strengthening</td>
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<td>IATI</td>
<td>International Aid Transparency Initiative</td>
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<td>IBFAN</td>
<td>International Baby Food Action Network</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<td>IPC</td>
<td>Integrated Phase Classification</td>
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<td>IPSAS</td>
<td>International Public Sector Accounting Standards</td>
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<td>IYCF</td>
<td>infant and young child feeding</td>
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<td>LAC</td>
<td>Latin America and the Caribbean</td>
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<td>LLIN</td>
<td>Long-lasting Insecticidal nets</td>
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<td>MAM</td>
<td>moderate acute malnutrition</td>
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<td>MCP</td>
<td>Mother Child Protection</td>
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<td>MENA</td>
<td>Middle East and North Africa</td>
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<td>MNCH</td>
<td>maternal, newborn and child health</td>
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<td>MNP</td>
<td>micronutrient powder(s)</td>
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<td>MNTE</td>
<td>maternal and newborn tetanus elimination</td>
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<td>MSM</td>
<td>men who have sex with men</td>
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<td>MTCT</td>
<td>mother-to-child transmission (of HIV)</td>
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<td>MUAC</td>
<td>mid-upper-arm circumference</td>
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<td>NCF</td>
<td>Nurturing Care Framework</td>
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<td>NGO</td>
<td>non-governmental organization</td>
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<td>ORE</td>
<td>other resources – emergency</td>
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<td>ORR</td>
<td>other resources – regular</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>ORS</td>
<td>oral rehydration salts</td>
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<td>PAHO</td>
<td>Pan American Health Organization</td>
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<td>PCV</td>
<td>pneumococcal conjugate vaccine</td>
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<td>PEPFAR</td>
<td>U.S. President’s Emergency Plan for AIDS Relief</td>
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<td>PHC</td>
<td>primary health care</td>
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<tr>
<td>PMTCT</td>
<td>prevention of mother-to-child transmission (of HIV)</td>
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<td>POC</td>
<td>point of care</td>
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<tr>
<td>RMNCAH</td>
<td>reproductive, maternal, newborn, child and adolescent health</td>
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<td>RUTF</td>
<td>ready-to-use therapeutic foods</td>
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<tr>
<td>SA</td>
<td>South Asia</td>
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<tr>
<td>SAM</td>
<td>severe acute malnutrition</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
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<td>SMQ</td>
<td>Strategic Monitoring Question</td>
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<tr>
<td>SMS</td>
<td>short message service</td>
</tr>
<tr>
<td>SRH</td>
<td>sexual and reproductive health</td>
</tr>
<tr>
<td>SRHR</td>
<td>sexual and reproductive health and rights</td>
</tr>
<tr>
<td>STD</td>
<td>sexually transmitted disease</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
</tr>
<tr>
<td>SUN</td>
<td>Scaling Up Nutrition</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>UBRAF</td>
<td>UNAIDS Unified Budget and Results Action Framework</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>US</td>
<td>United States</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VAS</td>
<td>vitamin A supplementation</td>
</tr>
<tr>
<td>WASH</td>
<td>water, sanitation and hygiene</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WPV</td>
<td>wild polio virus</td>
</tr>
</tbody>
</table>
Endnotes


2. Ibid.

3. Ibid.

4. UNAIDS 2018 estimates.

5. Ibid.

6. Ibid.


8. Ibid.


15. One billion = 1,000 million.


18. Ibid.


20. MNTE pre-validation is an assessment to confirm that all of a country’s districts are at low risk for maternal and neonatal tetanus, and the country is ready for the MNTE validation survey. Validation certifies that the country has achieved the elimination threshold of less than one neonatal tetanus case per 1,000 live births in every district in a year. Partial validation is the attainment of MNTE in some of the regions in a country that undertook phased implementation.


27. tOPV vaccine is being withdrawn because its use threatens seeding of new type-2 circulating vaccine-derived poliovirus (cVDPV2), when the wild type 2 version of this virus was eradicated in 1999.


31. All references to Kosovo in this report should be understood to be in the context of United Nations Security Council resolution 1244 (1999).


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


43. This is the most recent data available from the UNICEF NutriDash monitoring platform.

44. Based on preliminary data from National Nutrition Surveys. These figures should not be considered official UNICEF estimates.

45. Country-reported data based on national surveys; these figures do not represent official country estimates.

51. The minimum dietary diversity indicator refers to the percentage of children aged 6–23 months who were fed at least five out of eight food groups the previous day: (1) breastmilk; (2) grains, roots and tubers; (3) legumes, nuts and seeds; (4) dairy (milk, yoghurt, cheese); (5) flesh foods (meat, fish, poultry, and liver/organ meats); (6) eggs; (7) vitamin A-rich fruits and vegetables; and (8) other fruits and vegetables.


This results area also describes outputs related to improving the nutrition of school-aged children (aged 6–10), as many of the interventions overlap with those provided to adolescents and use common delivery platforms, notably schools.


‘School-aged’ is defined as children between the ages of 5 and 15 years, simplified to ‘children’ throughout the discussion of Results Area 2. ‘Adolescence’ refers to the period between the ages of 10 and 19 years.


Dashboard available at <www.anemiamuktbharat.info>.

Some of these include International Food Policy Research Institute (IFPRI), Alive & Thrive, Nutrition International, National Centre of Excellence and Advanced Research on Diets, Lady Irwin College, National Centre of Excellence and Advanced Research on Anaemia, All India Institute of Medical Sciences and International Institute of Population Institute of Economic Growth.


Bundy, et al., ‘The School as a Platform’.


Data from NutriDash 2017. These figures include incidence of wasting.

2018 SAM admissions do not represent the full year of reporting, since most countries reported data as of October/November 2018. UNICEF is currently revising the methodology to address this issue and an updated figure will be published in the data companion and scorecard for 2019.

92. Figures for SAM admissions in humanitarian settings reflect the number of children admitted for SAM treatment in countries with a humanitarian action for children appeal.

93. The number of children treated in both development and humanitarian contexts is 4.1 million.

94. Ready-to-Use Therapeutic Food.


97. Angola, Botswana, Brazil, Burundi, Cameroon, Chad, China, Côte d'Ivoire, the Democratic Republic of the Congo, Djibouti, Dominican Republic, Eswatini, Ethiopia, Ghana, Haiti, India, Indonesia, Islamic Republic of Iran, Kenya, Lesotho, Malawi, Mozambique, Myanmar, Namibia, Nigeria, the Philippines, Rwanda, South Africa, Thailand, Uganda, Ukraine, United Republic of Tanzania, Uzbekistan, Zambia and Zimbabwe.


99. All data cited in this report are from UNAIDS 2018 estimates, unless otherwise noted.

100. As of February 2019, a total of 11 countries and territories had been validated by WHO as having eliminated mother-to-child transmission of HIV: Anguilla, Antigua and Barbuda, Armenia, Belarus, Bermuda, the Cayman Islands, Cuba, Malaysia, Montserrat, Saint Kitts and Nevis, and Thailand.


102. WHO required process criteria for validation of EMTCT for HIV include the following: 95 per cent of pregnant women receiving antenatal care; 95 per cent of pregnant women receiving HIV testing in pregnancy; and 95 per cent of pregnant women diagnosed with HIV receiving treatment. Further information is available in: World Health Organization, Global Guidance on Criteria and Processes for Validation: Elimination of mother-to-child transmission of HIV and syphilis, WHO, Geneva, 2017.


112. ‘All In’ priority countries: Botswana, Brazil, Cameroon, Côte d’Ivoire, the Democratic Republic of the Congo, Eswatini, Ethiopia, Haiti, Jamaica, India, Indonesia, Islamic Republic of Iran, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Thailand, Uganda, Ukraine, United Republic of Tanzania, Zambia and Zimbabwe.

Based on a review of age-of-consent laws and policies as part of the ‘All In’ initiative, UNICEF and partners, including the United Nations Development Programme, recommend that countries carefully review a wide range of considerations when setting such policies – including HIV infection risks and trends, sexual behaviour and health trends, and the maturity of an adolescent seeking access. Countries are also strongly encouraged to ensure that at a minimum, age-of-consent laws and policies apply equally to all adolescents regardless of sex, sexual orientation or gender identity.

UNICEF is providing technical assistance to Botswana, Cameroon, the Democratic Republic of the Congo, Eswatini, Kenya, Lesotho, Mozambique, the United Republic of Tanzania, Uganda and Zimbabwe.

China is the outlier.


Ibid.


China is the outlier.


Ibid.


In 2018, total revenue to UNICEF reached US$6,676 million. This was an increase of 2 per cent compared to 2017, due to an increase in un-earmarked funds (regular resources). Regular resources revenue reached US$1,807 million in 2018. It increased as a proportion of total revenue to UNICEF to 27 per cent, up from 22 per cent in 2017.

Earmarked funds to specific programmes (other resources) revenue decreased by 6 per cent, down from US$5,153 million in 2017 to US$4,869 million in 2018.

In the following, ‘revenue’ refers to the total amount committed in the year the agreement was signed plus any adjustments, while ‘contributions’ refers to disbursements received in a particular year, exclusive of adjustments.

† 2014-2016 revenue restated to reflect change in accounting policy for comparison with 2017–2018.
‘Other resources’ contributions decreased 2 per cent compared with 2017, while contributions to the 10 thematic funding pools grew, by 6 per cent, from US$363 million to US$386 million. Thematic funding has remained stable at 8 per cent of all ‘other resources’. This is an underachievement compared to the indicator milestone set out in the UNICEF Strategic Plan, 2018–2021, of thematic funding being 12 per cent of all ‘other resources’ in 2018. In alignment with the Funding Compact between governments and the United Nations Sustainable Development Group, UNICEF’s goal is to double thematic funding as a share of all ‘other resources’ to 15 per cent by 2021. To reach this goal, UNICEF encourages partners to channel more contributions through these softly earmarked funds.

Thematic funding remains a critical source of revenue for UNICEF programme delivery. Through thematic funding contributions at global, regional and/or country levels, partners support UNICEF-delivered results at the highest programme level in each of those contexts for the greatest impact. They act as an ideal complement to regular resources, as they can be allocated on a needs basis.

**FIGURE A1-2**: Other resources contributions, 2014–2018: Share of thematic funding*

- **Regular resources (RR)**: Un-earmarked funds that are foundational to deliver results across the strategic plan.
- **Other resources (OR)**: Earmarked funds for programmes; supplementary to RR and made for a specific purpose, such as an emergency response or a specific programme in a country or region.
- **Other resources – regular (ORR)**: Funds for specific, non-emergency programme purposes and strategic priorities.
- **Other resources – emergency (ORE)**: Earmarked funds for specific humanitarian action and post-crisis recovery activities.

For partners, contributions to the 10 UNICEF thematic funding pools gives greater alignment with the principles of good multilateral resource partnerships. Thematic contributions have the greatest potential of ‘other resources’ to produce high-level results directly aligned to the Strategic Plan, as endorsed by the UNICEF Executive Board, and support the aims of the Paris Declaration on Aid Effectiveness. They yield a higher return on investment than more tightly earmarked contributions, as lower management and reporting costs result in a larger percentage of funds going towards programming. They also simplify renewal and allocation procedures and lessen administrative monitoring burden for partners.

Partner Testimonial

*Luxembourg remains strongly committed to the United Nations Development System, devoting one third of its Official Development Assistance to multilateral agencies. By making multi-year commitments to various UNICEF thematic funds, Luxembourg continues to be a strong and reliable partner and provides ongoing support to UNICEF. These contributions are instrumental in ensuring that children around the world are provided with the opportunity to live healthy lives and fulfill their potential. They focus on strengthening basic education, gender equality, water, sanitation and hygiene, nutrition, addressing HIV/AIDS among adolescents, reinforcing maternal health systems and striving towards young child survival and development.*

*These thematic priorities remain fully aligned with Luxembourg’s new Development Cooperation Strategy ‘The Road to 2030’. Luxembourg firmly believes that collective action enhances the effectiveness and efficiency of global efforts towards the achievement of sustainable development.*

– Paulette Lenert, Minister for Development Cooperation and Humanitarian Affairs, Luxembourg

**FIGURE A1-3: Thematic contributions by thematic pool, 2018 (US$386 million)**
Overall contributions to the thematic funding pools increased from US$363 million in 2017 to US$386 million in 2018. The largest public sector contributors to the thematic funding pools in 2018 were Norway, Sweden, Denmark and the Netherlands, while the largest private sector contributions were facilitated by the German Committee for UNICEF, the United Kingdom Committee for UNICEF and the U.S. Fund for UNICEF. For more information on thematic funding and how it works, please visit: <www.unicef.org/publicpartnerships/66662_66851.html>.

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

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

**Transparency**

Follow the flow of funds from contribution to programming by visiting <http://open.unicef.org>.
Expenses for Goal Area 1 in 2018

Note: Expenses are higher than the income received because expenses are comprised of total allotments from regular resources and other resources (including balances carried over from previous years), while income reflects only earmarked contributions from 2018 to each sector.

Expenses versus expenditure

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

To reach the results set out in the Strategic Plan 2018-2021, UNICEF has planned for a total of US$20.3 billion in programme expenses. In 2018, total expenses for UNICEF programmes amounted to US$5.4 billion, leaving an expense gap of US$14.9 billion for the remainder of the Strategic Plan period.

TABLE A1-1: UNICEF Planned resources and actual expenses for 2018-2021, US$ millions (by Goal Area)

<table>
<thead>
<tr>
<th>Goal Area</th>
<th>Planned resources 2018–2021</th>
<th>Actual Expenses 2018</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regular Resources</td>
<td>Other Resources</td>
<td>Total</td>
</tr>
<tr>
<td>Survive and Thrive</td>
<td>1,744.0</td>
<td>6,366.9</td>
<td>8,110.9</td>
</tr>
<tr>
<td>Learn</td>
<td>872.0</td>
<td>3,183.5</td>
<td>4,055.5</td>
</tr>
<tr>
<td>Protection from Violence and Exploitation</td>
<td>523.2</td>
<td>1,910.1</td>
<td>2,433.3</td>
</tr>
<tr>
<td>Safe and Clean Environment</td>
<td>845.8</td>
<td>3,088.0</td>
<td>3,933.8</td>
</tr>
<tr>
<td>Equitable Chance in Life</td>
<td>375.0</td>
<td>1,368.9</td>
<td>1,743.9</td>
</tr>
<tr>
<td>Totals</td>
<td>4,360.0</td>
<td>15,917.3</td>
<td>20,277.3</td>
</tr>
</tbody>
</table>