

Nutrition

The case for support



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A child from a government school in Haryana, India, getting iron folic acid tablet. In January 2013, the Ministry of Health and Family Welfare (MHFW), Government of India, launched the nationwide Weekly Iron and Folic Acid Supplementation (WIFS) programme. The WIFS programme includes adolescent boys and girls in Classes VI-XII in government, government-aided and municipal schools. It also covers out-of-school adolescent girls through the Integrated Child Development Services platform of the Ministry of Women and Child Development. UNICEF India was consulted to improve WIFS programme performance.

CONTENTS

| Page

1	Overview of strategies and results	2
	1. Situational analysis/context	3
	2. Problem statement	4
	3. Proposed solutions	5
	4. UNICEF's role	9
	5. Areas of focus and expected results	11
	6. Key assumptions, risks and mitigation measures	13
2	Resource requirements	15
	2015–2017	
3	Background and additional information	16

1 | Overview of strategies and results



On 28 November 2014, Rikta, 15, walks beside her mother, Shohiton Begum – who is holding Rikta’s brother, Monmoon, 2 years and 5 months old, with one hand and using a rope to lead a goat with the other – on property recently purchased by Ms. Begum’s brother in the village of Nayarpara, Jamalpur District, Dhaka Division, Bangladesh. They look after the property in return for living on it for free and growing produce on the land. Ms. Begum uses the produce for her family’s food and sells a portion to generate income. She has saved enough money to purchase goats. Two years ago, the family often went without food, relying on the income of the children’s father, Mostak, who drives a rickshaw van – work that is unsteady. The family was selected to participate in a project that is part of a nutrition security programme and Ms. Begum received seeds and tools to set up a vegetable garden as well as nutrition counselling to improve her family’s diet and food intake.

Investing in nutrition brings substantial economic gains. Interventions to reduce stunting are among the most cost beneficial in development, with highly competitive cost-benefit ratios. For example, in an analysis across 40 countries, the median cost-benefit ratio of scaling up nutrition-specific interventions was 16, meaning that every dollar invested in stunting reduction would bring around \$16 in returns in productivity gain.

1 Situational analysis/context

Low- and middle-income countries are now facing a double burden of malnutrition – undernutrition (i.e., stunting, wasting and micronutrient deficiencies) and overnutrition (i.e., overweight and obesity). Although the prevalence of undernutrition (and often associated infectious diseases) remains high, there is a considerable concurrent rise in overweight and obesity rates (and the associated chronic, non-communicable diseases [NCDs]). Globally, in 2014, 159 million children under 5 were stunted, representing a global stunting prevalence of 24 per cent; and 50 million children under 5 were wasted.¹ Stunting rates are similar for boys and girls, and across regions and countries with available data, stunting remains more prevalent in the poorest households.² The estimated number of children under 5 who are overweight is growing rapidly, from 31 million in 1990 to 41 million in 2014. In 2014, an estimated 6.1 per cent of children under 5 were overweight and obese in 2014. Micronutrient deficiencies (including vitamin A, iron, iodine, zinc and folic acid) are common among women and children. Ensuring adequate micronutrient status in women of reproductive age, pregnant women and children improves the health of expectant mothers, and the growth, development and survival of their children.

In the last five years, the global nutrition landscape has undergone unprecedented change. Globally, there is increased recognition of the importance of investing in stunting reduction, given its critical link to child development and overall national development. There is also greater understanding of links between the different forms of undernutrition, e.g., wasting and stunting, and undernutrition and overnutrition, e.g., stunting in early life being associated with metabolic changes that could lead to overweight and NCDs later in life. Stunting has been endorsed as a key indicator for monitoring maternal, infant and young child nutrition by the World Health Assembly (as well as indicators relating to anaemia in

women of reproductive age, low birthweight, child overweight, exclusive breastfeeding and wasting).³ There is greater understanding of the short- and long-term consequences of malnutrition in all its forms, especially during the first 1,000 days of life between pregnancy and a child's second birthday where any such deficits are potentially irreversible;⁴ evidence-guided key interventions during this period;⁵ and sophisticated estimates of the costing and cost-benefit of implementing these interventions at scale.^{6,7} Lastly, greater consensus supports adopting multi-sectoral approaches combining both nutrition-specific and nutrition-sensitive interventions (such as biofortified vitamin A-rich orange sweet potato for increasing maternal and child vitamin A intake) to bring about a more holistic sustainable response to improve child nutrition.⁸ In addition to this harmonization across key issues, concerted efforts have gone into developing the enabling environment for nutrition, epitomized by the Scaling Up Nutrition⁹ (SUN) movement's effort to galvanize country-led commitment for nutrition into results.

Furthermore, there is greater recognition that investing in nutrition also brings substantial economic gains. Interventions to reduce stunting are among the most cost-beneficial in development, with highly competitive cost-benefit ratios. For example, in an analysis across 40 countries, the median cost-benefit ratio of scaling up nutrition-specific interventions was 16, meaning that every dollar invested in stunting reduction would bring around US\$16 in returns in productivity gains.¹⁰ Other analyses of specific interventions have demonstrated

1 United Nations Children's Fund, World Health Organization, World Bank, 'UNICEF-WHO-World Bank: Joint child malnutrition estimates – Levels and trends', 2015, <www.who.int/nutgrowthdb/estimates/en/>, accessed 9 December 2015.

2 <<http://data.unicef.org/nutrition/malnutrition.html>>, accessed 28 September 2015.

3 World Health Assembly resolutions and documents, available at <www.who.int/nutrition/topics/wha_nutrition/en/index.html>, accessed 9 December 2015.

4 United Nations Children's Fund, Emory University, Tufts University, 'Long-term Consequences of Chronic Undernutrition in Early Life' UNICEF, New York, 15 August 2012.

5 'Maternal and Child Nutrition', Series Papers, *The Lancet*, 6 June 2013, available at <www.thelancet.com/series/maternal-and-child-nutrition>, accessed 9 December 2015.

6 Horton, Susan, et al., 'Scaling Up Nutrition: What will it cost?', World Bank, Washington, D.C., 2010.

7 Copenhagen Consensus (2012) Expert panel findings, Copenhagen Consensus 2012, Washington, DC: Copenhagen Consensus Center.

8 'Maternal and Child Nutrition', Series Papers.

9 Scaling Up Nutrition website, at <scalingupnutrition.org>, accessed 11 December 2015.

10 United Nations Children's Fund, *Global Nutrition Report 2014*, UNICEF, New York, <globalnutritionreport.org/2014/11/13/global-nutrition-report-2014/>, accessed 9 December 2015.



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On 12 August 2014, food is being divided and rationed at Kule Camp in Gambella region of Ethiopia.

significant gains; for example, preventing childhood blindness through vitamin A supplementation results in productivity gains of more than US\$1,840 per child; prevention of iron deficiency anaemia through iron supplementation programmes could increase future earnings by as much as 25 per cent.¹¹ Moreover, health-care-related costs associated with obesity are rising, accounting for as much as 8 per cent of expenditures on health care. In China, for example, the economic costs associated with obesity exceed more than 2 per cent of gross domestic product.¹²

11 The Partnership for Maternal, Newborn and Child Health (PMNCH) www.who.int/pmnch/en/, 'Investing in nutrition for women and children: essential for sustainable development'

12 The Partnership for Maternal, Newborn and Child Health (PMNCH) www.who.int/pmnch/en/, 'Investing in nutrition for women and children: essential for sustainable development'

2 Problem statement

Optimal nutrition lays the foundation for lifelong health, learning and economic and social performance, and it is one of the most important investments that can be made in order to realize the rights of every child, especially the most disadvantaged. However, despite significant progress in the coverage and quality of nutrition programmes, there is still a long way to reach the millions of malnourished children globally. Addressing malnutrition in all its forms is critical. Undernutrition causes almost half of child deaths under 5 globally,¹³ and it is essential to

13 Black, Robert E., et al., 'Maternal and child undernutrition and overweight in low-income and middle-income countries' *The Lancet*, vol. 382, no. 9890, 6 June 2013, pp. 427-451. (The total deaths attributed to nutritional conditions, stunting, wasting, fetal growth restriction, sub-optimum breastfeeding and deficiencies of vitamin A and zinc constituted 45 per cent of under-five deaths in 2011.)

protect and promote children's rights to survival and development. Childhood obesity, on the other hand, is associated with a wide range of health complications and an increased risk of premature onset of illnesses, including diabetes and heart disease. However, since the effects of overnutrition in childhood are not as acute or life-threatening as those of undernutrition, obesity might be under-recognized as a public health issue for this age group.

Of note, the world faces serious global pressures which impact diets and nutritional status, including climate change, transitioning diets (shift towards diets with higher intake of refined carbohydrates, added sugars, fats, and animal-source foods and away from diets rich in legumes, vegetables and coarse grains), population growth, urbanization, humanitarian crises and conflicts, and continuing poverty and widening inequalities. Individuals, communities and systems need to be supported to improve their resilience, cushioning against shocks and volatility, so that attainments in nutrition and development are sustained.

With the number of emergencies worldwide continuing to rise over time, effective and timely humanitarian response, which incorporates both life-saving and resilience-building interventions, is critical. Ultimately, reducing stunting and wasting among children under 5 and anaemia prevalence in girls and women of reproductive age require continued support, especially in countries with fragile security situations, political and economic instability, changing food prices and areas prone to man-made and natural disasters. Investments are key for emergency preparedness, context-appropriate nutrition programming and information systems, coordination, as well as scalable and flexible programming in stable, fragile and emergency contexts.

In order to have an improved understanding of often rapidly developing situations as well as to be able to plan and implement efficiently, significant investments are also required to support national capacities to collect data, monitor and evaluate the nutritional status of children, as well as to assess the effectiveness and impact of interventions put in place to respond to those needs.



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On 23 May 2015, a health worker uses a wooden stadiometer to measure a boy's height in Nyarugusu refugee camp, in Kigoma Region, United Republic of Tanzania. The stadiometer bears the UNICEF logo.

3 Proposed solutions

Contextually relevant, cost-effective and evidence-based policies and strategies for the reduction of undernutrition and/or overweight across the life cycle exist (see Figure 1). The main programme areas of work are those that: protect, promote and support appropriate feeding and access to adequate food; reduce micronutrient deficiencies; prevent and treat severe acute malnutrition (SAM); improve nutritional care for those with infectious diseases (including mothers affected by HIV/AIDS and their children); increase synergies with health, water, sanitation and hygiene (WASH), early childhood development (ECD) and social protection; promote strengthened linkages with agriculture; and promote linkages with health and education to prevent childhood obesity.

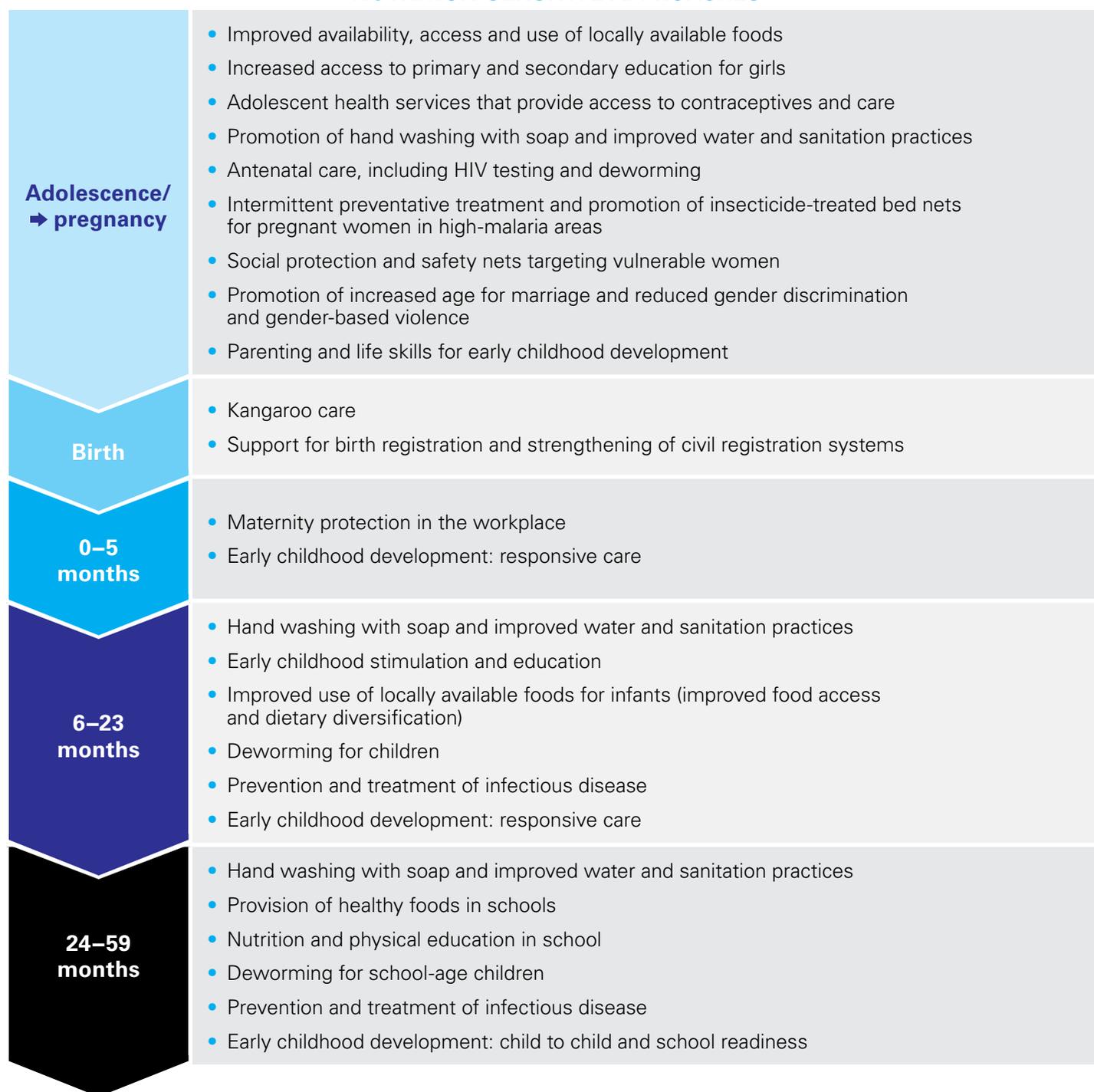
FIGURE 1: Key practices, services and policy interventions for preventing and treating stunting and other forms of undernutrition, and overweight and obesity, throughout the life cycle

NUTRITION-SPECIFIC INTERVENTIONS

<p>Adolescence → pregnancy</p>	<ul style="list-style-type: none"> ■ Food fortification including salt iodization ■ Iron and folic acid or multiple micronutrient supplementation for pregnant women ■ Intermittent (weekly) iron and folic acid supplementation for women of reproductive age ■ Fortified food supplements for undernourished mothers ■ Nutrition counselling for improved dietary intake during pregnancy
<p>Birth</p>	<ul style="list-style-type: none"> ■ Delayed cord clamping ■ Initiation of breastfeeding within one hour (including colostrum) ■ Appropriate infant feeding practices and anti-retroviral therapy for HIV-exposed infants
<p>0–5 months</p>	<ul style="list-style-type: none"> ■ Exclusive breastfeeding – counselling and lay support on breastfeeding through community-based and facility-based contacts ■ Control of the marketing of breast milk substitutes ■ Appropriate infant feeding practices and anti-retroviral therapy for HIV-exposed infants ■ Vitamin A supplementation in first 8 weeks after delivery ■ Use of fortified foods, micronutrients supplementation and home fortification with multiple micronutrients for undernourished women ■ Nutrition counselling for improved dietary intake during lactation ■ Communication for behavioural and social change
<p>6–23 months</p>	<ul style="list-style-type: none"> ■ Timely, adequate, safe & appropriate complementary feeding ■ Continued breastfeeding ■ Control of the marketing of breast milk substitutes ■ Appropriate infant feeding practices and anti-retroviral therapy for HIV-exposed infants ■ Micronutrient supplementation, including vitamin A, zinc treatment for diarrhoea ■ Management of SAM ■ Food fortification, including salt iodization ■ Home fortification with multiple micronutrients ■ Zinc supplementation with oral rehydration salts for diarrhoea treatment and management
<p>24–59 months</p>	<ul style="list-style-type: none"> ■ Counselling and nutrition advice to women of reproductive age/adults ■ Communication for behavioural and social change to prevent childhood obesity ■ Vitamin A supplementation ■ Management of SAM (and moderate acute malnutrition) ■ Food fortification including salt iodization ■ Zinc supplementation with oral rehydration salts for diarrhoea treatment and management

■ Red refers to interventions for women of reproductive age and mothers.
 ■ Blue refers to interventions for young children.

NUTRITION-SENSITIVE APPROACHES



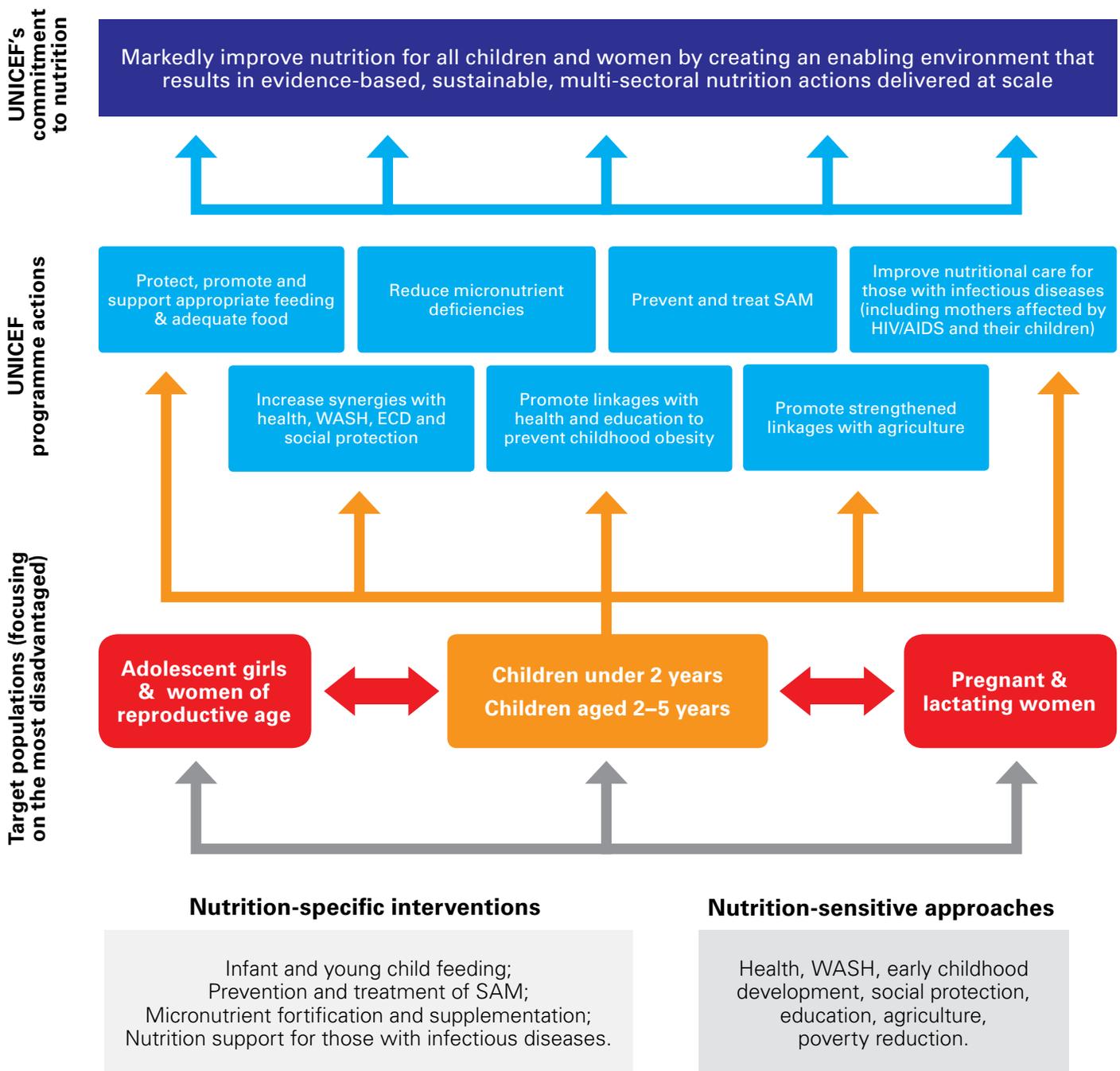
The recent 2013 *Lancet* series on maternal and child nutrition lists key nutrition-specific and nutrition-sensitive approaches and interventions for addressing undernutrition and overweight (see Figure 2). While *The Lancet* focuses on the interventions in a development context, it is assumed that these are just as valid in emergency and fragile contexts.

- **Nutrition-specific interventions**, if scaled up and utilized, can significantly reduce stunting, micronutrient deficiencies and wasting as well as the risk of overweight and obesity. These interventions largely focus on women, in

particular pregnant and lactating women, and children under 2 years of age, particularly in the most disadvantaged populations.

- **Nutrition-sensitive approaches** address the underlying determinants of undernutrition and future overweight and obesity and may serve as platforms for nutrition-specific interventions. Although evidence is sparse to support nutrition-sensitive approaches in some sectors, there is some evidence to support scale-up in specific country and local contexts, including agriculture, social transfers, ECD, education and WASH.

FIGURE 2: Nutrition-specific and nutrition-sensitive interventions and approaches that address the double burden of undernutrition (stunting, wasting and micronutrient deficiencies) and overweight and obesity



The intervention approaches and prioritization of activities should be highly context-specific, informed by a rights-based equity-focused situational analysis in order to tailor strategies to address the multiple determinants of malnutrition. The key target populations for nutrition programming are children under

2 years of age, as well as children aged 2–5 years and pregnant and lactating women. A secondary, yet critical, focus should be on adolescent girls and women of reproductive age, as investment in them improves their well-being and therefore helps break the intergenerational cycle of child undernutrition.

UNICEF's comparative advantages include:

- **A strong country presence that enables engagement with government to support sector and cluster coordination for nutrition;**
- **Strong programming and technical capacity with long-standing experience in the implementation of nutrition programmes;**
- **Investment in several global and national partnerships to harmonize strategic, policy and programmatic efforts around nutrition;**
- **Ability to work closely with different sectors across the organization such as WASH, health, HIV and AIDS, C4D, education and others.**

4 UNICEF's role

Over the past few decades, UNICEF has amassed considerable experience in nutrition programming, in both humanitarian and development contexts. As detailed in the 2013 flagship report *Improving Child Nutrition: The achievable imperative for global progress*,¹⁴ UNICEF was able to demonstrate success, and at scale. Efforts to scale up nutrition programmes are working, benefiting women and children and their communities in many countries. In addition, lessons have been learned from the evaluations of UNICEF's nutrition programmes, both broadly and among innovative programmes that focus on community management of acute malnutrition. Knowledge generated through programming is being adapted and applied to improve and do better nutrition programming.

Importantly, in 2014, UNICEF updated its strategic guidance, '*UNICEF's approach to scaling up nutrition programming for mothers and their children*', putting forward operational guidance to support country-led efforts to equitably accelerate progress in scaling up and accelerating effective coverage of high-impact interventions. In this way, UNICEF seeks to continuously improve performance through a robust, systematic approach to results-based nutrition programming.

UNICEF's comparative advantage in nutrition is defined by several factors:

- **Strong country presence** that enables engagement with government to support sector and cluster coordination for nutrition. UNICEF works closely with governments to align its work and the work with partners with national policies and plans. By supporting national governments to undertake regular situational analyses and bottleneck analyses, UNICEF helps to tailor the best evidence-based interventions to tackle the causes of malnutrition and identify the most vulnerable populations in need. This inclusive process ensures that UNICEF programmes are aligned with and respond to the national priorities.
- **Strong programming and technical capacity** with long-standing experience in the implementation of nutrition programmes, including community engagement and nutrition education through communication for development (C4D).¹⁵ UNICEF works with national governments and partners to develop capacity, strengthen systems and

¹⁵ Communication for Development (C4D) is a systematic, planned, and evidence-based approach to promote positive and measurable behavioural and social change. C4D is both a strategy and an approach to engage communities and decision-makers at local, national and regional levels, in dialogue towards promoting, developing and implementing policies and programmes that enhance the quality of life for all (McCall 2011). The approaches that make up the C4D strategy include: (1) behaviour change communication (BCC); (2) social mobilization (including strengthening an enabling media and communication environment); (3) communication for social change; and (4) advocacy. A central tenet of UNICEF is that C4D is most effective when combined with changes in the social-ecological environment within which children and families live.

¹⁴ United Nations Children's Fund, *Improving child nutrition: The achievable imperative for global process*, UNICEF, New York, April 2013, <www.childinfo.org/files/NutritionReport_April2013_Final.pdf>, accessed 9 December, 2015.



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On 24 March 2015, a variety of nutritious foods are arranged on a tray, during an outreach session in the village of Adone, Ta Oi District, Saravane Province, Lao PDR. Ms. Daovanh, a local volunteer from the Lao Women's Union, has arranged the food to teach women about meals that are healthy and balanced for their children. The village is home to the Pacoh ethnic group.

continuously improve the performance of its nutrition programmes. By generating evidence, developing technical guidance and sharing knowledge, UNICEF ensures that country programmes are supported to bring strong technical leadership to programming.

- UNICEF invests in several **global and national partnerships** to harmonize strategic, policy and programmatic efforts around nutrition. Notably, UNICEF is committed to its work with the SUN movement, as well as working with the United Nations network and all partners to deliver on this commitment to nutrition.
- UNICEF has the ability to **work closely with different sectors** across the organization. Drawing on expertise and experience in sectors such as WASH, health, HIV, C4D, education and others, UNICEF can coordinate actions to implement multi-sectoral programmes. UNICEF also supports the promotion of gender equality and the empowerment of girls and women through its nutrition programming.

At the global level, UNICEF has been instrumental in shaping the global nutrition agenda, working with partners to harmonize efforts to support national policy and strategy development and their implementation. UNICEF has a coordination and programmatic leadership role in nutrition globally. It is a key partner in global networks and initiatives for nutrition, such as SUN, the Standing Committee on Nutrition, the Renewed Efforts Against Child Hunger (REACH) partnership and several micronutrient networks, and is the cluster lead for Nutrition in Emergencies. UNICEF has board presence in organizations such as Micronutrient Initiative and Global Alliance for Improved Nutrition and works closely with partners such as Save the Children, Helen Keller International and Action Contre le Faim. UNICEF also has strategic partnerships with United Nations agencies and other agencies working towards shared goals to advance results for child nutrition (with cases where respective roles and partnership agreements are outlined in memorandums of understanding).

In the area of SAM, UNICEF works to achieve the following targets by 2017:

- **Support at least 47 countries with a SAM programme to reach children between 6–59 months affected by SAM with quality treatment at >75 per cent recovery rate (reported separately for humanitarian situations) [baseline: 29 countries];**
- **Reach 4 million children between 6–59 months affected by SAM with treatment (baseline: 2.91 million children aged 6–59 months).**

At the country level, UNICEF has been able to demonstrate success at the scale in varied contexts. UNICEF is active at the country level before, during and after emergencies. Its approach to humanitarian response includes both life-saving and resilience-building interventions, in line with delivering on UNICEF's Core Commitments for Children in Humanitarian Action. UNICEF has responded to the increasingly challenging programming environment by strengthening its capacity to respond to the needs at the country level. The total number of UNICEF nutrition staff increased from 171 in 2006 to more than 500 in 2015.

UNICEF invests heavily in developing human, institutional and organizational capacity to implement nutrition programmes. UNICEF works to train national governments and partners on leadership, programme implementation and management for nutrition; and to provide up-to-date technical guidance (including curricula) and training, including for community-level workers. Such capacity development activities are tailored to the country context and complemented by knowledge of existing assets that can be deployed and developed to meet emerging needs.

A key programmatic gap that UNICEF intends to fill by playing a significant role is addressing child overweight and obesity. Several countries, particularly those moving from lower income to middle income, are facing a double burden of malnutrition, both under- and over-nutrition. This is creating new programmatic challenges, requiring a response from many sectors, and adding to already stretched systems. A coherent 'healthy growth

strategy' approach¹⁶ will be necessary to prevent poor nutrition in all its forms. UNICEF's work in middle-income settings, especially in the upstream policy space to advocate for improved nutrition, will create a stronger enabling environment to address the double burden.

5 Areas of focus and expected results

For UNICEF, addressing the global burden of malnutrition and achieving the UNICEF Strategic Plan 2014–2017 outcome of "improved and equitable use of nutritional support and improved nutrition and care practices" requires actions at global, regional, national and community levels. This involves coordinating and integrating work across different areas in nutrition and other sectors, taking a life-cycle approach that extends from programmes to policy level, from prevention to treatment, and from development to humanitarian situations (including resilience building), and includes cross-cutting issues, as outlined by the SUN movement's vision.

UNICEF will work to achieve the following targets:

In the area of infant and young child feeding:

- Support 40 countries to maintain an exclusive breastfeeding rate among children aged 0–5 months at >50 per cent (baseline: 27 countries [2007–2013]);

¹⁶ Tim Lobstein, et al., "Child and adolescent obesity: part of a bigger picture," vol. 385, no. 9986, *The Lancet*, 18 February 2015, pp. 2510–2520.



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On 10 May 2015, Birnise Iradukunda, 4, drinks porridge into which supplemental nutrients have been added, to treat her malnutrition, in Mahama refugee camp, in Eastern Province, Rwanda.

- Support 40 countries to enhance capacities to provide infant and young child feeding counselling services to at least 70 per cent of communities (baseline: 14 countries).

- Support high HIV-prevalence countries with a SAM programme to offer HIV testing for children aged 6–59 months admitted to SAM treatment.

In the area of micronutrients:

- Support 40 countries to have at least 90 per cent of households consuming adequately iodized salt (baseline: 6 countries [2007–2013]);
- Support 44 countries to have at least 90 per cent of children aged 6–59 months covered with two annual doses of vitamin A supplements (baseline: 22 countries [2011–2012]).

In the area of severe acute malnutrition:

- Support at least 47 countries with a SAM programme to reach children between 6–59 months affected by SAM with quality treatment at >75 per cent recovery rate (reported separately for humanitarian situations) (baseline: 29 countries);
- Reach 4 million children between 6–59 months affected by SAM with treatment (baseline: 2.91 million children aged 6–59 months).

In the area of nutrition and HIV:

- Support countries (from the 40 maintaining exclusive breastfeeding rates at >50 per cent) to ensure HIV-exposed infants are exclusively breastfed;

In the area of nutrition and emergencies:

- Achieve recovery rate of over 75 per cent for UNICEF-targeted children aged 6–59 months with SAM in humanitarian situations that are admitted to programmes for management of acute malnutrition and recovery;

- Support 100 per cent of countries in humanitarian action where country cluster or sector coordination mechanisms for nutrition meet CCC standards for coordination (baseline: 20 countries).

In the area of general nutrition:

- Support 50 countries to have at least 80 per cent of primary caregivers engaged in early childhood stimulation for children aged 3–5 years at home (baseline: 16 countries);
- Support 72 countries to adopt as legislation, monitor and enforce the International Code on Marketing of Breast-milk Substitutes (baseline: 49 countries);
- Support countries to put in place policy or plans targeting anaemia reduction in women (100 countries) and girls (50 countries) (baseline: 70 countries for women; 27 countries for girls);
- Support 70 countries to develop or revise nutrition sector plans or policy that include a risk management strategy to address disaster crisis risks (e.g., natural disaster/climate/conflict) (baseline: 50 countries).

Evidence generation, cross-cutting programming and advocacy:

Complementing the focused programme areas described above, UNICEF recognizes that progress in nutrition also requires investment in relevant cross-cutting issues and systems. Robust evidence and data are critical to achieving the results outlined in this case for support. National statistics organizations require support from UNICEF in their data collection efforts, including household surveys, as well as support in the analysis and use of such data advancing the understanding of correlations between different outcomes and sectors. Some key research and evaluation efforts to strengthen the evidence base for nutrition programming must focus on the cross-cutting needs of particular regions or social groups, rather than on nutrition alone. Focusing on the critical stages of a child's life – in early childhood and the adolescent period – and on cross-cutting issues such as gender, disability and social or ethnic origin emphasizes the need to work on a multi-sectoral basis to enhance results for the most excluded children. Most of the specific programme areas described above will include specific C4D

and/or advocacy efforts, but progress in nutrition also requires cross-cutting C4D and advocacy, such as efforts to strengthen community dialogue, catalyse child participation in community decision making or to increase the overall focus on children in national budgeting. Also, through promoting the understanding and adoption of international norms, standards and instruments, such as the International Code on Marketing of Breast-milk Substitutes, UNICEF can better shape the enabling environment for nutrition.

6 Key assumptions, risks and mitigation measures

Nutrition Programme Outcome 4 is delivered through a series of six outputs (that are described in detail in the Revised Supplementary Programme Note on the Theory of Change for the UNICEF Strategic Plan, 2014–2017) and the assumptions are based on UNICEF's understanding of the nutrition sector. However, since the assumptions are largely beyond the organization's control, it is important to acknowledge them and conduct risk analysis to understand the challenges should the assumptions not prove valid. The major assumptions are:

- Political leaders will continue to promote and support efforts to scale up nutrition and improve equity;
- Global food prices do not increase dramatically; and
- The number of humanitarian crises will not exceed the capacity to respond to them.

Ultimately, reducing stunting and wasting among children under 5 and the prevalence of anaemia in girls and women of reproductive age may be curtailed by contextual and programmatic risks. Contextual risks include those faced by working in countries with fragile security situations, political and economic instability, changing food prices, especially in fragile contexts, and areas prone to man-made and natural disasters. A risk-informed programming approach, which better integrates humanitarian and development assistance, will allow UNICEF to more flexibly and sustainably meet current and future demands. This is a key gap that will need to be filled, as there is increased demand for humanitarian assistance.



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On 13 November 2013, Nonhlanhla Dubazane, 29, from Mphumaleagna, South Africa, breastfeeds her son. When Nonhlanhla first discovered that she was both pregnant and HIV positive she was frightened, but through antiretroviral treatment and uninterrupted breastfeeding, her son, Answer, now 6 months old, is healthy and HIV-free.

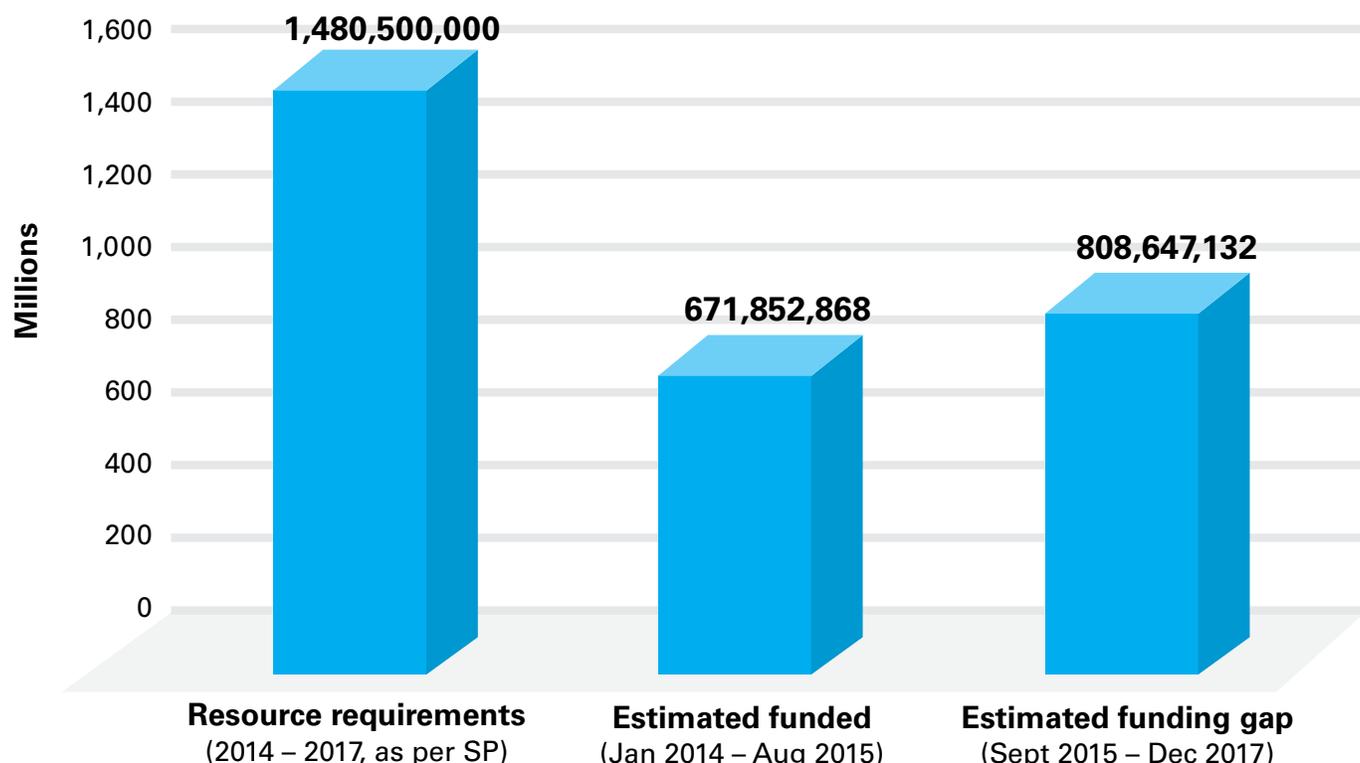
Achieving sustainable programme success requires continued support from governments. Programmatic risks are also highly dependent on the context, yet limited resources (financial and human), humanitarian situations, remote access, capacities and effectiveness of partnerships and changing supply and demand for nutrition interventions can affect the success of programmes.

In order to address these risks, UNICEF will work to:

- Strengthen global technical guidance, aligned with emerging evidence, and advocate for continued investments in nutrition;
- Provide setting-specific and context-relevant strategies (based on situation analyses, bottleneck analyses);
- Implement risk-informed programming that specifically assesses the vulnerabilities and risks, with measures to address these and build resilience of communities and families;
- Document and use lessons learned to identify and replicate good practices; and
- Work with a wide network of stakeholders, especially national governments, to support sustainable programmes and develop the capacity of partners to plan for and respond to humanitarian crises. ■

2 | Resource requirements 2015–2017

Overall funding gap for nutrition (in US\$):



Details of funding gap by programme area 2015–2017 (in US\$):

	2015	2016	2017	Total
Nutrition	134,774,522	336,936,305	336,936,305	808,647,132
Infant and young child feeding	20,000,167	50,000,418	50,000,418	120,001,004
Micronutrients	17,045,238	42,613,096	42,613,096	102,271,430
Nutrition and HIV	35,668	89,170	89,170	214,007
Community-based management of acute malnutrition	26,960,021	67,400,053	67,400,053	161,760,127
Nutrition and emergencies	10,031,991	25,079,978	25,079,978	60,191,948
Nutrition general (maternal nutrition, social protection, surveillance)	47,223,984	118,059,960	118,059,960	283,343,903
Evidence, advocacy and cross-cutting	13,477,452	33,693,630	33,693,630	80,864,713

3 | Background and additional information

Additional information:

Infant and young child feeding:

- IYCF Programming guide, <www.unicef.org/nutrition/files/Final_IYCF_programming_guide_2011.pdf>.
- Care for Child Development Package, <www.unicef.org/earlychildhood/index_68195.html>.

Micronutrients:

- Home Fortification Technical Advisory Group, <www.hftag.org>.

SAM and nutrition in emergencies:

- Core Commitments for Children in Humanitarian Action, <www.unicef.org/publications/files/CCC_042010.pdf>.
- Humanitarian Charter and Minimum Standards in Humanitarian Response, <www.spherehandbook.org/en/1-food-security-and-nutrition-assessment/>.
- Guidance note. Integrating of ECD activities into Nutrition Programmes in Emergencies: Why, What and How (UNICEF & WHO), <www.who.int/mental_health/emergencies/ecd_note.pdf>.

Nutrition and disability: Nora Groce, et al., 'Stronger Together: Nutrition-Disability Links and Synergies', Leonard Cheshire Disability and Inclusive Development Centre, United Kingdom, 2013; open PDF from <www.unicef.org/disabilities/files/Stronger-Together_Nutrition_Disability_Groce_Challenger_Kerac.pdf>.

Global Partnership on Children with Disabilities, Task Force on Nutrition and Children with Disabilities, 'A Survey Report on Nutrition Programme Initiatives for Children with Disabilities in Low- and Middle-Resourced Countries', Global Partnership on Children with Disabilities, 2012-2013; open PDF from <www.unicef.org/disabilities/files/GPcwd_TF_on_CWD_Nutrition_Survey_Report.pdf>.

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On 16 April 2015, a breastfeeding mother in Mexico. Only 14.4 per cent of children are exclusively breastfed during six months in Mexico, which is one of the lowest rates regionally. The average for the Latin America region is 37.9 per cent.



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