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

Annual Results Report 2016

Health



UNICEF's Strategic Plan 2014–2017 guides the organization's work in support of the realization of the rights of every child, especially the most disadvantaged. At the core of the Strategic Plan, UNICEF's equity strategy – emphasizing the most disadvantaged and excluded children, caregivers and families – translates UNICEF's commitment to children's rights into action. What follows is a report summarizing how UNICEF and its partners contributed to health in 2016 and the impact of these accomplishments on the lives of children, caregivers and families.

This report is one of nine on the results of UNICEF's efforts this past year, one on each of the seven outcome areas of the Strategic Plan, one on gender and one on humanitarian action. It complements the 2016 Executive Director Annual Report (EDAR), UNICEF's official accountability document for the past year.

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A mother plays with her baby during a village health team member meeting at Omot Health Centre II, Agago district, Uganda. With UNICEF support and funding from the Korea International Cooperation Agency, village health teams are trained to identify danger signs and rapidly refer pregnant women, mothers and children to health centres for care. The programme aims to enhance the continuum of care of maternal and child health services and address the barriers that prevent mothers and children from seeking health care in the Acholi region of northern Uganda.

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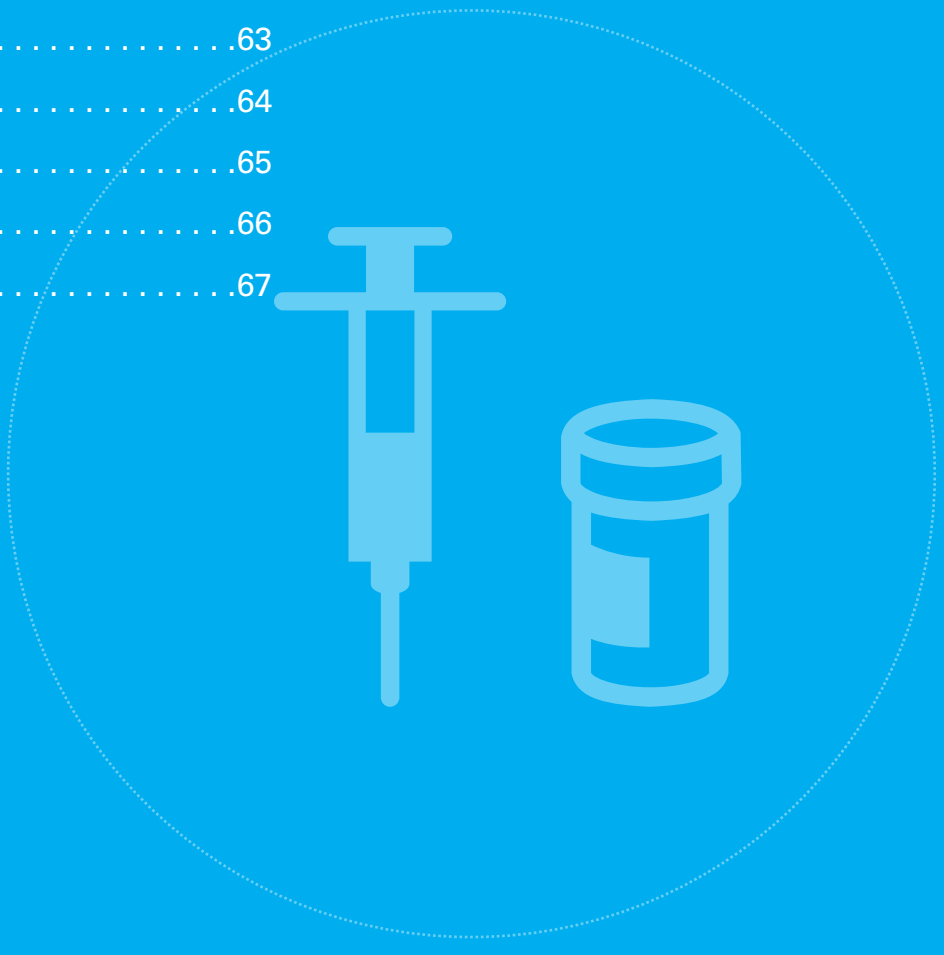
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EXECUTIVE SUMMARY

Globally, remarkable progress has been achieved in the past two decades in reducing preventable maternal and child mortality. The number of children who died before their fifth birthday declined dramatically, from 12.7 million in 1990 to 5.9 million in 2015. Fewer women died during childbirth, with the maternal mortality ratio decreasing from 385 deaths per 100,000 live births in 1990 to 216 in 2015.

Yet, despite progress, inequalities persist; 80 per cent of the under-five mortality burden is concentrated in Asia and sub-Saharan Africa, with the latter shouldering half of that burden. In addition, the new global challenge is to reduce stillbirths and the 45 per cent of deaths that occur in the first 28 days of life, the most vulnerable period. In 2016, a quarter of the world's children lived in war zones, among widespread violence; were internally displaced or forced to migrate; or suffered the harsh consequences of climate change, leaving them extremely vulnerable to disease, hunger, multiple forms of abuse and a severe lack of access to essential services. The sheer number of people living in insecurity is emerging as a powerful inequity beyond the well-known urban-rural, wealth and gender divides, compelling the United Nations Children's Fund (UNICEF) to redouble its efforts to reach those who suffer most.

Against this backdrop of inequities, the health Sustainable Development Goal (SDG 3) aims at ensuring healthy lives and promoting well-being for all by 2030. To reach this goal, UNICEF's Strategic Plan and the new Strategy for Health 2016–2030 focus on strengthening health systems at all levels, but particularly the community level, to bring both preventive and basic curative health services to the most vulnerable children.

UNICEF's work and results in 2016

To further reduce maternal and child mortality, UNICEF continued to strengthen high-impact health interventions such as increasing childbirth in health facilities, immunization coverage and child health services in high-burden countries and communities.

UNICEF supported governments in increasing births in health facilities through influencing national policies, plans and monitoring mechanisms and contributing to improvements in the provision of services. In 2016, 42 countries reported having 100 per cent of their existing basic emergency obstetric care facilities operational 24 hours a day, 7 days a week (target 47). But because progress has been slow, UNICEF and the World Health Organization are placing an increased emphasis on the quality of care within facilities. In addition, to create the needed political momentum to shore up domestic investments and further accelerate progress, the work of UNICEF and partners has led 52 countries to adopt a tool that allows them to track progress under the Every Newborn Action Plan (target 28).

Immunization remains one of the most cost-effective and proven health interventions to reduce illness and mortality. In 2016, UNICEF, in collaboration with governments, helped vaccinate 61 million children against measles and 58 million children against diphtheria, tetanus and pertussis (DTP) with DTP3 vaccine. To address the stagnation seen in immunization coverage and reach more of the children left behind, UNICEF supported governments in 138 countries to strengthen their immunization programmes, implement the Reach Every District Strategy, strengthen the supply chain, reach the urban poor as a new target population and support demand for immunization services. Although the wild poliovirus re-emerged in Northern Nigeria, underscoring the need for vigilance, disease surveillance and a renewed commitment to polio eradication, 2016 was still a success story as only 37 polio cases were recorded in the world. This success is a remarkable feat compared to the 350,000 children paralyzed a year in the late 1980s when 40 cases were reported every hour. A polio-free world remains within reach. In 2016, UNICEF remained the largest supplier of vaccines and procured 2.5 billion doses of vaccines for 95 countries to a value of US$1.643 billion (which includes services to governments and partners), reaching 45 per cent of the world's children. In addition, in 2016, 11 million women in 10 high-risk countries received supplementary vaccinations to protect them and their babies from maternal and neonatal tetanus, which is associated with unsanitary conditions during childbirth.

UNICEF seeks to reduce the burden of mortality due to preventable illnesses such as pneumonia, diarrhoea and malaria. To save more lives and bring treatment closer to those children who live too far from a health centre, UNICEF supports the integrated community case management (iCCM) platform which acknowledges the centrality of community health workers. In 2016, with UNICEF support, 74,381 such workers were trained on iCCM to strengthen community-based health services. To support these community health workers, UNICEF worked with governments and local partners in strengthening their supply chains and ensured zero stockouts for oral rehydration salts in 126 countries of the 139 UNICEF programme countries (meeting the target). No stockouts for artemisinin-based combination therapy were recorded in 95 countries (target 97). Oral rehydration salts and artemisinin-based combination therapy are life-saving medicines for diarrhoea and malaria.

UNICEF's new Strategy for Health 2016–2030 brings to the fore that all health systems should strive to close the gap in access to health services for the most disadvantaged,

while tailoring programming to a variety of contexts such as low and high capacity, or fragile and humanitarian. Mindful of this imperative, UNICEF developed and disseminated its Health Systems Strengthening guidance; supported countries to monitor and enhance health systems strengthening at the district level to reach the most marginalized; developed much-needed costing tools to assist countries to enhance the planning and implementation of community-based health services; and assisted countries in developing investment cases to access financing through the Global Financing Facility for maternal, newborn, child and adolescent health. With UNICEF support, in 2016, 50 countries developed, budgeted and implemented maternal and child health communication plans highlighting that Communication for Development remains a strong comparative advantage for UNICEF.

UNICEF strives to bring care, treatment and lifesaving interventions during emergencies, where mortality and morbidity are heightened risks. In 2016, UNICEF responded to 344 humanitarian situations in 108 countries. UNICEF and partners helped vaccinate more than 24 million children age 6 months to 15 years against measles; vaccinate 30 million people in Angola and the Democratic Republic of the Congo to contain a yellow fever outbreak; and provide insecticide-treated bednets to more than 1 million families in malaria-prone areas. The mainstreaming of risk reduction into national health policies, which underscores the importance of climate change, showed excellent progress in 2016. Cholera preparedness was often prioritized at subnational levels in endemic areas. Lastly, UNICEF leveraged its expertise in rapid deployment and behaviour change communication to reach 162 million people with Zika prevention messages in 18 countries in Latin America and the Caribbean.

UNICEF actively engaged in increasing the efficiency of the global health infrastructure, notably by finalizing the Operational Framework to help countries implement the United Nations Secretary-General's Global Strategy on Women's, Children's and Adolescents' Health. To implement the Global Strategy, UNICEF chaired the H6 – a health partnership of the United Nations system – and developed a results-oriented workplan. In 40 of the 75 high-burden countries, a focal point was identified to coordinate the H6 work aligned with national priorities. UNICEF remains engaged in strategic global partnerships including Gavi, the Global Fund, the Global Polio Eradication Initiative, the Partnership for Maternal, Newborn and Child Health and the Measles and Rubella Initiative among others.

In 2016, UNICEF spent US$1.39 billion on health, of which US$220 million was allocated from regular resources, and US$13 million from thematic fund contributions. These multi-year flexible funds are critical to the strategic success of health programme implementation where increasingly earmarked contributions leave funding gaps and capacity in essential areas of work. The Government of Sweden was the largest thematic resource partner, followed by the National Committees of Italy and the United Kingdom. UNICEF remains grateful to these resource partners for their continued support.

Looking ahead

Many challenges lay ahead in 2017 and beyond. UNICEF is preparing to meet the double objectives of addressing the unfinished agenda of Millennium Development Goal (MDG) 4, which pledged to reduce preventable maternal and child mortality, while supporting government-led efforts to achieve the SDGs. The ambitious targets set out in the SDG agenda, such as ending preventable child deaths, demand a holistic approach to child health, starting with the period before conception to the health and well-being of adolescents. In addition, UNICEF must be prepared to respond at scale to new and emerging challenges to child health, including non-communicable diseases, adolescent mental health and climate change. To meet these new challenges, UNICEF is drafting its 2018–2021 Strategic Plan that builds on the lessons learned under the current Strategic Plan and integrates new indicators to measure progress in new areas of work. UNICEF's equity-focused approaches will ensure that the most disadvantaged children benefit from health policies, plans and programmes that will help realize their right to health.

Considering the worsening of humanitarian situations around the world, UNICEF will increase its focus on resilience and risk-informed programming to ensure that local and national health systems have the capacity to respond to emergencies with quality results.

Sustained resources for high-impact interventions such as maternal and child health are critical to UNICEF's programmes. However, the sustainability of the results achieved through these programmes requires increased programming to strengthen health systems, including more effective supply chains, quality primary health care and the institutionalization of community health workers within broader health systems to spearhead behaviour changes and care-seeking within communities.

In 2016, thematic contributions were only 2 per cent of total resources earmarked for health. Additional thematic funding would ensure that UNICEF can support priority interventions for strengthening health systems to ensure the sustainability of results achieved from vertically funded programmes. As noted above, a systems approach will be critical to address the unfinished business of the MDGs, ensure sustainability of results achieved, build resilience and realize the ambitious SDG targets. Thematic funding would enable UNICEF to make sustainable investments towards its goals within the new Strategy for Health 2016–2030 and engage in the second decade of life so all children, including adolescents, can survive, thrive and transform.

STRATEGIC CONTEXT

Global trends for child health

The number of children who died before their fifth birthday declined dramatically from 12.7 million in 1990 to 5.9 million in 2015. Globally there has been accelerating progress in reducing the under-five mortality rate – its annual rate of reduction increased from 1.8 per cent in 1990–2000 to 3.9 per cent in 2000–2015. The remarkable decline in under-five mortality since 2000 has saved the lives of 48 million children under age five – children who would not have survived to see their fifth birthday if the under-five mortality rate from 2000 onward remained at the same level as in 2000.[1]

Despite this commendable progress, deep inequities persist within and across countries (*see Figure 1*). In 2016, sub-Saharan Africa and South Asia accounted for more than 80 per cent of global under-five mortality, with sub-Saharan Africa alone shouldering half of that burden. Most child deaths are caused by diseases that are readily preventable or treatable with proven, cost-effective and quality-delivered interventions, including: immunizations, breastfeeding, handwashing and treatments for preventable diseases such as pneumonia, diarrhoea and malaria. However, many of these interventions still fail to reach those who need them the most. Moreover, new challenges have emerged in the battle to reduce child mortality, with 45 per cent of under-five deaths now concentrated in the first 28 days of life. An acceleration of the pace of progress is urgently required to achieve the Sustainable Development Goal target of 25 or fewer deaths per 1,000 live births, particularly in high-mortality countries in sub-Saharan Africa. A total of 47 countries need to increase their pace of progress, and among these, 30 countries must at least double their current rate of reduction with 11 of those needing to at least triple their rate of mortality reduction.

Efforts to improve the health and well-being of children are complicated further by the increase in protracted crises and the emergence of new global health threats. The United Nations inter-agency humanitarian appeal for 2016 stood at US$21 billion – a stark increase from US$2.7 billion in 1992 – to meet the needs of 86.7 million people in 37 countries. According to the World Bank, 35 countries and territories faced the twofold challenge of fragile situations and a reversal in progress in maternal, newborn and child health.[2] New epidemics, such as Zika, affect newborns, the most vulnerable of population groups. The discovery of previously undetected wild poliovirus cases in Nigeria in August 2016 is a potent reminder of the need for continued vigilance in the fight against the spread of infectious diseases. Mass migration across national borders underscores the need for global health agencies, including UNICEF, to invest in innovative approaches for routine surveillance and reinforce the resilience of national health systems.

Changes observed between 2015 and 2016

The transition from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs) requires a reconceptualization of 'child health'. Whereas the MDGs aimed to reduce under-five mortality, the SDGs aim to end preventable child deaths and give every child the best possible chance to thrive, from preconception through adolescence. This inclusive agenda is reflected in the Secretary-General's 2016 Global Strategy for Women's, Children's and Adolescents' Health. The need for a universal and life-cycle approach to the health-related SDGs is also reflected in UNICEF's Strategy for Health 2016–2030 and guidance on health systems strengthening. Developed in 2016, these two documents set out a road map for health programmes and policies that move beyond the MDG era's focus on individual diseases towards a systems-based approach that addresses the continuum of care throughout childhood and adolescence.

The year 2016 saw a more concerted focus on quality care for women and newborns in health facilities. This increased emphasis on quality care represents a shift from earlier approaches that aimed to simply increase the number of women who deliver their babies with a skilled birth attendant. Further investment, coupled with relevant policies and programmes, will be needed to expand quality care and promote universal health coverage, an explicit goal of SDG 3.

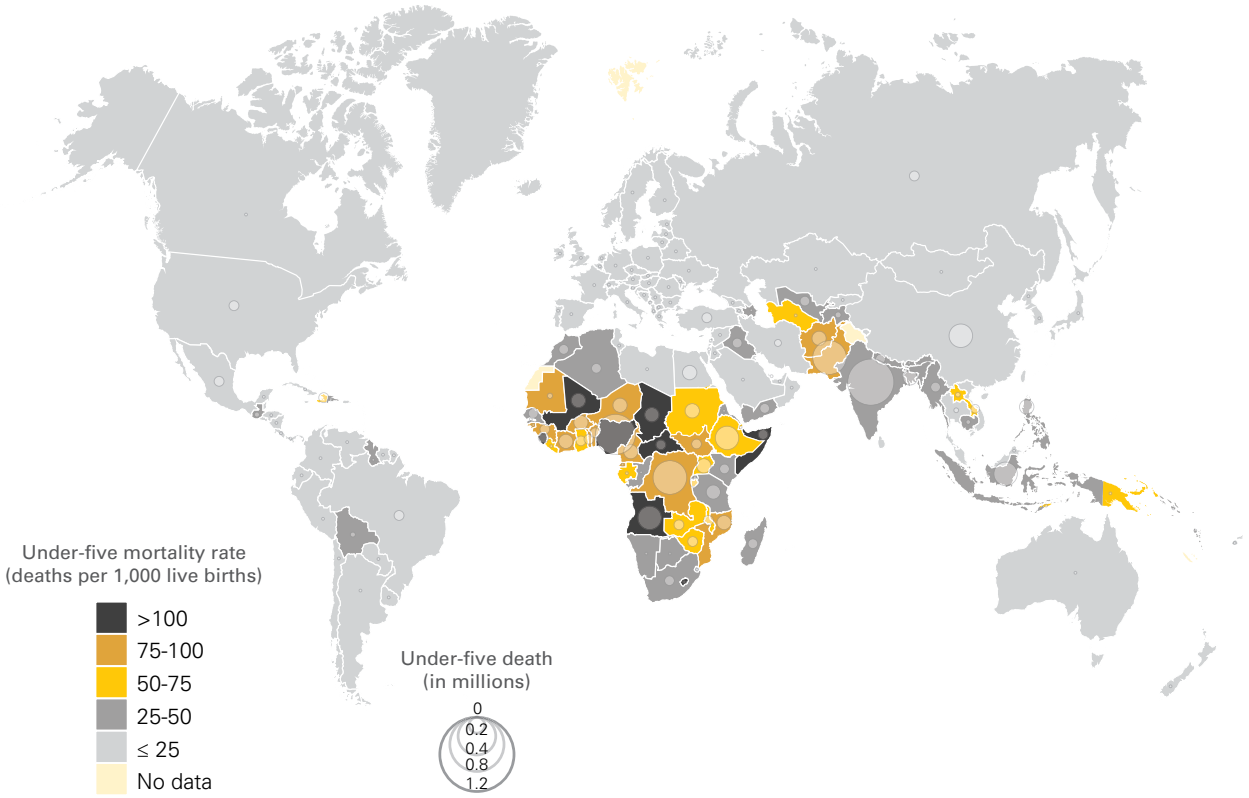
Another area that gained prominence is adolescent health. In 2016, *The Lancet* reported that addressing the health and well-being of adolescents, a billion-strong age cohort, underscores the need to work across sectors. UNICEF and the World Health Organization (WHO) responded to this call to action by developing a Global Framework for Accelerated Action for the Health of Adolescents. Centred on the need to address the vulnerability of adolescents as they transition to adulthood, the framework acknowledges the critical role of adolescent health and well-being in advancing the SDGs.

The 2016 global health landscape also placed increased importance on climate change and its impact on children. According to UNICEF's 2016 flagship report, *One is Too Many* – published ahead of the twenty-second session of the Conference of the Parties to the United Nations Framework Convention on Climate Change – approximately half of the nearly 1 million childhood pneumonia deaths in 2015 were linked to air pollution.

Tackling global challenges, including the adolescent agenda, rapid urbanization, children on the move due to insecurity, climate change and health emergencies, requires UNICEF

FIGURE 1

Under-five mortality rate and under-five deaths by country, 2015



Source: United Nations Inter-agency Group for Child Mortality Estimation, as published in UNICEF: Committing to Child Survival – A promise renewed – Progress report 2015, UNICEF, New York 2015.

to continue promoting collaboration and building bridges across the sectors that influence the health and well-being of all children. The Zika outbreak in Brazil and other upper-middle-income countries provided opportunities in 2016 to work across sectors, including health; nutrition; early childhood development (ECD); water, sanitation and hygiene (WASH); rehabilitation services; and social protection systems.

The SDGs one year on: Challenges and changes in the global narrative, partnerships and resources

Unlike the MDGs, the SDGs hold all countries accountable to the same 2030 health targets: achieving 25 or fewer under-five deaths per 1,000 live births; reducing neonatal mortality to at least as low as 12 per 1,000 live births; and lowering maternal deaths to fewer than 70 per 100,000 live births. Striking a balance between the need for universality, country specificity and an equitable focus on the most marginalized populations presents a challenge that can only be surmounted with political leadership, smart investments and evidence-based strategies. With the support of UNICEF and members of United Nations Country Teams, many governments are already taking steps to domesticate the SDG process in national health sector plans, making sure that every child counts.

The dawn of the SDGs marks a period of transition for the global health architecture in general and child health in particular. Together with WHO, the Bill & Melinda Gates Foundation and other partners, UNICEF is leading the effort to reshape the child health narrative, globally and nationally. By looking at the first two decades of life, this new narrative seeks to overcome the MDG legacy of siloed global initiatives and vertical funding focused on individual diseases. Strong health systems that are accountable to families and communities are critical to operationalizing this shift. Equally important is the continued advocacy, leadership, investment and collaboration of national governments, civil society, the private sector and other constituencies concerned about child health and well-being.

UNICEF continues to strengthen and nurture strategic partnerships to achieve results for women and children. Collaboration with partners such as Gavi, the Global Fund,

and the Measles and Rubella Initiative, to name but a few, will remain essential to the implementation of the new health strategy. In addition, UNICEF is actively cultivating new types of collaboration to spark innovation and investment for areas such as health systems strengthening and universal health, working with partners such as the Cundill Centre for Child and Adolescent Mental Health in Canada, Johns Hopkins University, the World Bank, WHO and the United States Agency for International Development (USAID).

Although child health remains UNICEF's largest programme – with US$1.39 billion in expenditure in 2016 –the high proportion of earmarked funding and downward trend in flexible resources creates uncertainty about the programme's medium- and long-term sustainability. In 2016, total expenses from regular resources (the most flexible type of resources) declined by US$28 million between 2014 and 2016. UNICEF received US$13 million in thematic contributions for Health, a 13 per cent decrease compared with 2015. This resource constraint compels UNICEF to intensify resource mobilization efforts for child health, in particular through flexible thematic funding, which would ensure the sustainability of results obtained through high-impact interventions. In addition, thematic funds allow UNICEF to create resilience within programming by addressing funding gaps.

How UNICEF is positioned to address these challenges

To address challenges in the health sector, UNICEF promotes an integrated approach to child health and well-being that places the focus on strengthening health systems, building capacity and integrating services by the platform through which children are reached, in a child-centred rather than disease-specific approach that brings together the six technical areas outlined in UNICEF's theory of change: child health (pneumonia, diarrhoea, malaria, HIV/AIDS and childhood tuberculosis); health in humanitarian action; health systems strengthening; immunization; maternal and newborn health; and polio. This shift in how UNICEF conceives of the theory of change is in line with the shift that must be promoted in the global health sector programming and funding – away from disease-specific initiatives and towards sustainable investments in equitable health systems. UNICEF's leadership, extensive field presence, experience in strengthening community health and enhancing the links between health facilities and communities, and improving the quality of primary health care demonstrate its comparative advantage as a partner of choice in strengthening these aspects of health systems to deliver on a comprehensive multisectoral child health agenda as part of the goal of universal health coverage.

As the world's largest procurer of child vaccines, UNICEF holds a distinct comparative advantage in delivering life-saving interventions to marginalized children and families. Vaccine procurement and delivery are merely the first steps in delivering on UNICEF's mission to improve the health and well-being of the world's children. By supporting programmes such as community-based care, communication for development and social mobilization strategies, UNICEF empowers caregivers and communities to seek and demand improved health outcomes for women and children. At the national and global levels, UNICEF also continues to influence the policy agendas that create enabling environments for child health and well-being. Through policy advocacy, technical support for national strategies and budgets, supply chain strengthening and data collection and analysis, UNICEF supports government-led efforts to design and implement evidence-based health programmes.

In 2016, in accordance with the United Nations' overall aim to strengthen inter-agency coordination and coherence, UNICEF chaired the H6, a partnership comprised of the six United Nations entities responsible for health, namely, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United National Population Fund (UNFPA), UNICEF, the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), WHO and the World Bank Group. As chair, UNICEF led the establishment of the regional H6 coordination mechanism in the Middle East and North Africa region to focus on reproductive, maternal, newborn, child and adolescent health in diverse and crisis-prone countries. In addition, H6 provided joint support and technical assistance to Cameroon, the Democratic Republic of the Congo, Kenya, Mozambique and Uganda to develop strong reproductive, maternal, newborn, child and adolescent health investment cases in collaboration with the Global Financing Facility. UNICEF's strong comparative advantage on equity-focused programmes is leveraged to influence country investments in maternal, newborn, child and adolescent health through other funding channels, such as Gavi or the Global Fund.

UNICEF's specific challenges

UNICEF seeks to remain fit for purpose in the SDG era, which means being equipped with the expertise needed to deliver on the SDGs and highlighted in the Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health. However, UNICEF is facing an increasingly difficult challenge in recruiting skilled technical professionals for hardship positions. Mobilizing resources for health systems strengthening, the Thrive component of the Global Strategy for Women's, Children's and Adolescent Health, and programming responsive to country needs (high-burden versus middle-income countries) requires flexible and long-term investments. As a result of resources for child health tied up in large global vertical programmes, this presents a distinct challenge, particularly at a time when resource partners increasingly want to see immediate, short-term results.

RESULTS BY PROGRAMME AREA

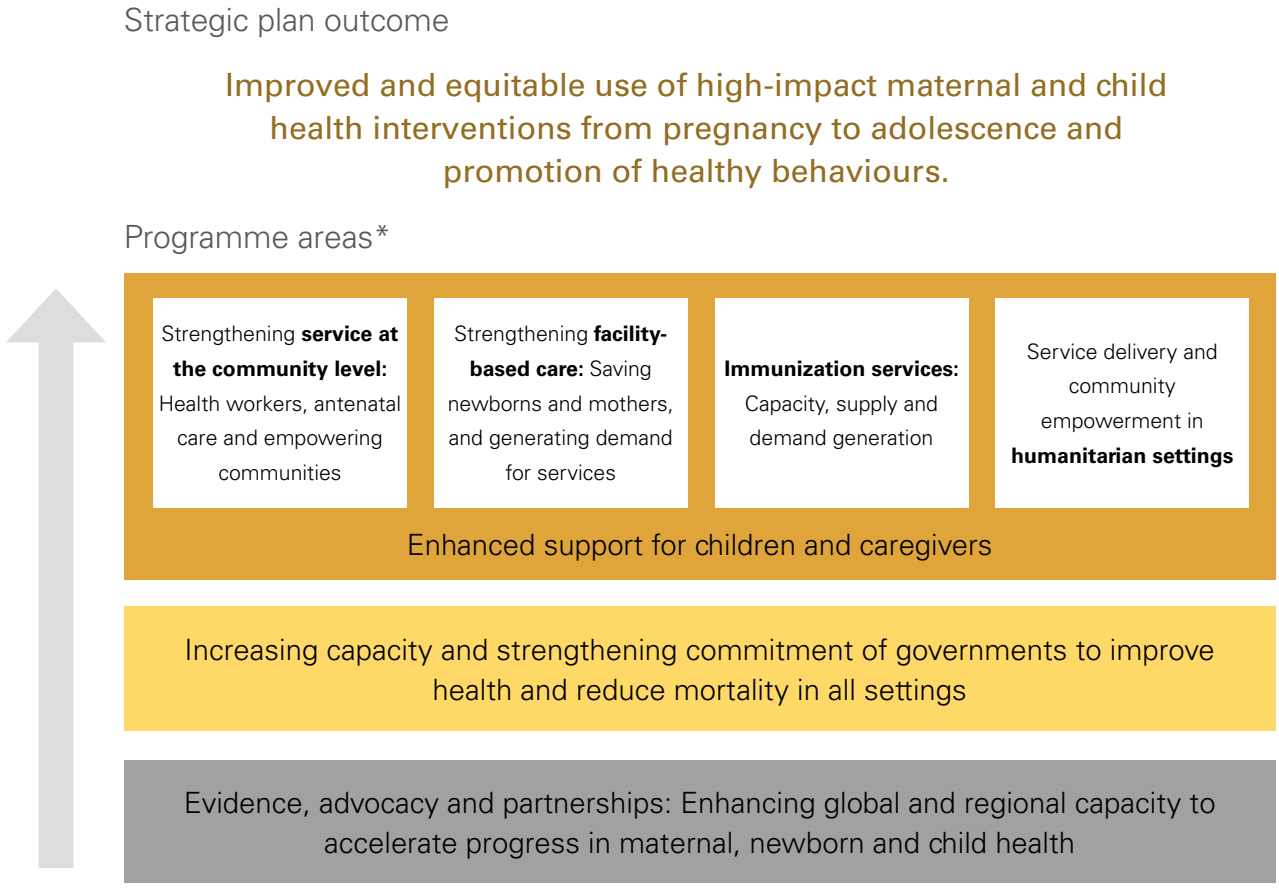
This report presents the results achieved in the third year of UNICEF's Strategic Plan 2014–2017. UNICEF's work in the health sector remains guided by the primary outcome indicator to which the organization has committed: "Improved and equitable use of high-impact maternal and child health interventions from pregnancy to adolescence and the promotion of healthy behaviours." As the theory of change is underpinned by the concept of equity, UNICEF places a strong focus in health on reaching the most excluded children so that all children have a chance to survive and thrive.

Results are presented under three programme areas: (1) enhanced support for children and caregivers; (2) increasing capacity and strengthening the commitment of governments to improve health and reduce mortality in all settings; and (3) evidence, advocacy and partnerships: enhancing global and regional capacity to accelerate progress in maternal, newborn and child health (*see Figure 2*).

These three programme areas bring together the six technical areas outlined in UNICEF's Strategic Plan: child health (pneumonia, diarrhoea, malaria, childhood tuberculosis and HIV/AIDS); health in humanitarian action; health systems strengthening; immunization; maternal and newborn health; and polio. This model helps break down silos to better integrate programming and communicate the results of UNICEF's work at different levels of the health system.

FIGURE 2

Results reporting framework for the 2014–2017 Strategic Plan



** Strategic Plan output indicators reported under relevant programme areas*

Results against UNICEF's 2014–2017 Strategic Plan outputs are discussed on programme against activities, achievement, progress and challenges (see annexes for further details).

Thematic funds are critical to UNICEF's health work because much of the funding received is earmarked towards specific goals. Thematic funds support UNICEF's strategic objectives by providing continuity in technical assistance, health systems strengthening and social and behaviour change and also addressing the funding gaps in programme delivery to achieve sustainable results. In 2016, 54 countries, the UNICEF West and Central Africa Regional Office and UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS) benefited from US$13 million thematic funding. Owing to the Government of Sweden's sizeable country-specific contribution, the Democratic Republic of the Congo received 56 per cent of all thematic funds for health (*see case study in Programme Area 2*). The US$1.5 million global thematic funds were allocated in consultation with regional offices to respond to priority funding gaps. Examples of how thematic funding supports programme delivery are provided throughout this report.

PROGRAMME AREA 1: ENHANCED SUPPORT FOR CHILDREN AND CAREGIVERS

In 2016, UNICEF continued to focus on strengthening four delivery platforms through which children are reached within health systems: (1) community health workers; (2) antenatal care facilities; (3) immunization services; and (4) health in humanitarian settings. Each section starts with summary tables of the outcome and output indicator data related to one of the four focus areas. Discussion of the targets within the context of 2016 activities, achievements, challenges and UNICEF progress towards meeting its 2014–2017 Strategic Plan follows.

Strengthening service at the community level: Health workers, antenatal care and empowering communities

In the context of high level child mortality, in particular due to pneumonia, diarrhoea, malaria, and acute malnutrition, UNICEF is promoting task shifting from health facilities to community health workers to expand children's access to treatment. Community health workers, drawn from their own communities, are trained to deliver health interventions within the communities they know so well and are key to reach the most vulnerable children. Hence, UNICEF has identified empowering and institutionalizing community health workers as a priority strategy to combat health inequities.

Community health workers platforms are critical to achieving results in health, notably by delivering integrated community case management (iCCM) of the leading childhood killer diseases, but also by increasing demand for health services through community engagement and communication for behaviour and social change.

TABLE 1

2016 outcome results towards child health

Outcome	Baseline	2016 update	2017 target	SDG
Countries with at least 80 per cent of women attended at least four times during their pregnancy by any provider (skilled or unskilled) for reasons related to the pregnancy	18	53 out of 117 UNICEF programme countries with data (2010–2016)	25	3.8.1; 3c
Countries with at least 80 per cent of children aged 0-59 months with diarrhoea receiving oral rehydration salts (ORS)	0	3 out of 98 UNICEF programme countries with data (2010–2016)	20	3.8.1; 3b
Countries with at least 80 per cent of children aged 0-59 months with symptoms of pneumonia taken to an appropriate health provider	7	18 out of 96 UNICEF programme countries with data (2010–2016)	20	3.8.1; 3c
Countries with at least 80 per cent of children aged 0–59 months with fever who had a finger or heel stick for malaria testing	0	0 out of 49 UNICEF programme countries [malaria-endemic only] with data (2010–2016)	15	3.3.3; 3c
Malaria-endemic countries with at least 80 per cent of children aged 0-59 months sleeping under an insecticide-treated net	0	2 out of 49 UNICEF programme countries [malaria-endemic only] with data (2010–2016)	25	3.8.1

TABLE 2

Strengthening child health services at the community level: 2016 output results

Output	Baseline	2016 target	2016 value	2017 target
Countries in which a policy for community health workers to provide antibiotics for pneumonia is in place	66	86	**66**	100
Countries without stockouts lasting more than one month at national level for ORS	117	126	**126**	132
Countries in which the target number of community health workers are trained to implement integrated community case management	22	30	**18**	40
Malaria-endemic countries in which the target number of health workers in UNICEF-supported programmes are trained in rapid diagnostic testing for malaria in children	5	8	**8**	10
Malaria-endemic countries without stockouts lasting more than one month at national level of all artemisinin-based combination therapy	94	97	**95**	99

FIGURE 3

Protect, Prevent and Treat framework



Source: United Nations Children's Fund, One is Too Many: Ending child deaths from pneumonia and diarrhoea, UNICEF, New York, November 2016, p.18.

Intersectorality is essential in the integrated Protect, Prevent and Treat framework as set forth in the Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (*see Figure 3*). The integration of key interventions amplifies the synergistic effects of health, WASH and nutrition to reduce the pneumonia and diarrhoea mortality and morbidity burden in children younger than 5 years old.

Training community health workers to diagnose and treat illnesses; ensuring access to reliable supplies of oral rehydration salts (ORS), zinc and amoxicillin; rapid diagnostic tests for malaria and availability of anti-malaria commodities (e.g. artemisinin-based combination therapy) are cornerstones of the iCCM platform. Oral rehydration salts and zinc are cost-effective treatments for childhood diarrhoea, reducing the severity and duration of symptoms and the risk of recurrence in the immediate short term. UNICEF also supports the provision of long-lasting insecticidal nets through various channels and behaviour change strategies to ensure uptake of healthy behaviours. UNICEF promotes timely care-seeking for febrile children (including those who have any symptoms of malaria, pneumonia, diarrhoea, childhood tuberculosis and/or HIV) as a key intervention in reducing childhood morbidity and mortality.

According to UNICEF's 2014–2017 Strategic Plan results, 18 countries trained the targeted number of community health workers to implement iCCM (target 30). In total, 74,381 community health workers were trained on iCCM as part of UNICEF-supported programmes. In many instances, lack of adequate funding constrained the full implementation of training programmes in 2016. Despite these constraints, UNICEF was able to provide in-country support to expand the iCCM platform. In Ethiopia, UNICEF helped train 4,234 community health workers on iCCM. By the end of the year, iCCM for malaria, pneumonia, diarrhoea and severe acute malnutrition was available in 97 per cent of the country's health posts. In South Sudan, where UNICEF developed the capacity of community structures, partners and systems to effectively deliver services for children, 1,176 health-care providers were trained on iCCM of malaria and integrated management of newborn and childhood illnesses – including 956 community-based distributors and supervisors and 220 clinical officers, nurses and community health workers.

UNICEF continued to work to ensure access to appropriate commodities to strengthen the ability of community health workers to treat and save children. The number of countries without stockouts for oral rehydration salts increased from 117 in 2015 to 126, meeting the Strategic Plan target for 2016. In addition, 95 malaria-endemic countries had no stockouts for artemisinin-based combination therapy, nearly meeting the target of 97 countries. This achievement is owed to improved monitoring, forecasting, and strong procurement and supply mechanisms. UNICEF trained health workers to use rapid malaria diagnostic testing in eight countries, meeting the 2016 target. In Angola, UNICEF provided rapid diagnostic tests reaching 44,000 households to ensure appropriate malaria case management and referrals for children and pregnant women; follow-up and effective monitoring of use of artemisinin-based combination therapy; and active disease surveillance. UNICEF procured and distributed 44,000 long-lasting insecticidal nets targeting 70,316 children under 5 years old and 17,579 pregnant women. The distribution of bednets was accompanied by health education and behaviour change activities to ensure caregivers not only understood the benefits of these nets in protecting their families against malaria, but also acted upon these messages.

UNICEF promotes shifting the treatment of pneumonia from health facilities to community health workers to ensure that the poorest children and those who live in isolated areas can have access to life-saving interventions. Treatment of pneumonia with antibiotics is used as a tracer of this policy shift. The number of countries that allow community health workers to treat pneumonia with antibiotics increased from 62 in 2015 to 66 in 2016. Over the years, significant progress has been achieved in low-income countries in sub-Saharan Africa and Asia, where the policy on antibiotics is most needed to reach vulnerable children.

UNICEF has been actively working to help disseminate the WHO guidelines on treating childhood pneumonia with amoxicillin dispersible tablets and has assisted countries in updating their national policies on antibiotics, particularly the highest-burden countries such as the Democratic Republic of the Congo, Ethiopia, Kenya, the Niger and Nigeria. UNICEF is currently translating into Spanish materials on community-based management of pneumonia with amoxicillin dispersible tablets for dissemination in Latin America and the Caribbean, a region where most countries have yet to update their national policies in this regard. In 2016, following a pneumonia and diarrhoea treatment project that UNICEF conducted in four sub-Saharan countries, positive policy changes were implemented in two of Kenya's highest pneumonia-burden districts. These results are being used to support changes at the national level.

In 2016, UNICEF continued its work to develop adaptable pneumonia-specific training and communication materials for providers and caregivers to supplement the tools used for iCCM and the Integrated Management of Childhood Illnesses; support the introduction of amoxicillin dispersible tablets and associated supply chain management guidance; and increase awareness of pneumonia as a leading killer disease of young children. Work by UNICEF and partners advocating for the adoption and implementation of a policy on treatment with antibiotics has contributed to an overall 47 per cent decline in pneumonia deaths in under-five children from 2000 to 2015.[3] Progress remains to be made in middle-income countries in Latin America and the Caribbean, the Middle East and North Africa, and the Pacific Islands, where regulatory frameworks impede task shifting from health professionals to community health workers, limiting these workers' ability to administer antibiotics. More advocacy targeting these countries will be needed in 2017.



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Mothers and children receive treatment and information from their community health workers in the camp for internally displaced persons, Baidoa, Bay region, Somalia.

UNICEF provided support in 2016 to strengthen the community health worker platform to deliver integrated packages of child health services. To increase results for children and address multiple health issues at once, UNICEF applied a phased approach to implement and integrate HIV and tuberculosis within the iCCM model in Malawi, Nigeria and Uganda. The Family Centred Approach for paediatric HIV was adapted in the Democratic Republic of the Congo and Zimbabwe.

UNICEF developed guidance and methodology to strengthen the health system at the community level, including an investment case, tools and training materials for costing the community health platform. The Community Health Planning and Costing Tool was pilot-tested in Malawi and Sierra Leone in 2016 with the view of helping governments and managers plan for community health programming and develop investment cases (*see Programme Area 2 for details*). In addition, UNICEF supported the launch of the Financing Alliance for Health, which works with governments and partners to find innovative financing mechanisms in support of community health systems. UNICEF also held a global consultation on childhood tuberculosis integration through strengthening of community and primary health systems and performed country case studies on childhood tuberculosis integration in Malawi and Uganda. The partnership with the Global Fund was strengthened by renewing the memorandum of understanding to leverage grants for community health systems and integrated case management of childhood illnesses.

In 2016, as a result of UNICEF advocacy and support to countries, iCCM scale-up was globally recognized as an important step towards increasing the accessibility of diagnosis and treatment within the broader universal health coverage efforts. UNICEF hosted an iCCM workshop in Nairobi that brought together 19 countries to share knowledge, lessons learned and experiences across countries to accelerate progress from approved Global Fund grants for iCCM. Under the new funding model of the Global Fund, 36 countries included iCCM in their malaria and health systems strengthening grants in 2016, for a total of US$125 million in funding. Eight countries (Afghanistan, Benin, Burundi, Chad, Malawi, Sierra Leone, Uganda and Zambia) included iCCM in their 'above allocation' funding to maintain the scale and scope of their iCCM programmes. In 2017, UNICEF will continue to advocate for funding access to strengthen community health and primary health care with the view of integrating child health interventions more strongly in those platforms.

Beyond treating illnesses, community health workers play a critical role in delivering a range of preventive and promotive health services to the communities and families that would otherwise have no access to health-enhancing and life-saving interventions. Community health workers also provide antenatal care services and can refer women to health facilities in the case of suspected complications. In 2016, UNICEF supported the deployment of health extension workers in 13 regions in Namibia. These workers are contributing to increased service uptake for antenatal care, deliveries, immunization and family planning and are reducing home births. The workers have promoted awareness among women and their partners of the danger signs that can occur during pregnancy.

In Zimbabwe, UNICEF played a critical role in improving the package and quality of health service delivery at the community level by supporting a comprehensive review of the village health worker program including training materials and management systems. As a result, the

Lady Health Workers bring health services to communities in Pakistan

In 2016, an evaluation of a pilot project, in which Lady Health Workers used UNICEF-developed 'Green Books' to record care provided to children, led to a scale-up in 8 districts in Punjab, with scale-up to all 36 districts in Pakistan planned for 2017.

With support from the Reproductive Maternal Neonatal Child Health Trust Fund, social mobilization and behaviour change communication interventions were also launched, including innovative approaches to health education using couples as health workers to change the behaviour of both male and female family members.

Concerns about maintaining consistent health education messages disseminated by Lady Health Workers in remote areas were addressed through an innovative pilot in which short videos on birth preparedness, skilled birth attendants and essential newborn care were developed. The Lady Health Workers were provided with portable projectors to screen these videos and were trained to use them to engage community discussions. The pilot began in Punjab, where 87,294 people (58,687 women/adolescents) attended the sessions, and was subsequently adopted in Balochistan and Pakistan-administered Kashmir.

proportion of villages with trained Village Health Workers increased from 61 per cent in 2015 to 73 per cent in 2016. In Burkina Faso, UNICEF supported the Ministry of Health to strengthen home-based care for pregnant women and newborns in 18 districts of the North and Centre-North regions, providing access to health care to nearly 284,000 pregnant women and 236,000 newborns. Under the programme, community health workers refer or accompany pregnant women to antenatal care visits, help them prepare a birth plan, refer or accompany them for birth at a health facility and conduct check-ups within women's homes. Within this initiative, 4,874 pregnant women and 1,553 newborns have benefited from a home visit; 90 pregnant women and post-partum mothers as well as 16 newborns were referred to health centres due to danger signs.

Strengthening facility-based care: Saving newborns and mothers, and generating demand for services

UNICEF took action to support the integration of maternal and newborn health services through global advocacy and country programme support, underpinned by the conceptual framework drafted in 2016 to guide approach and prioritization (*see Figure 4*).

TABLE 3

2016 outcome results towards improved maternal and newborn care

Outcome	Baseline	2016 update	2017 target	SDG
Countries with at least 80 per cent of live births attended by a skilled health personnel (doctor, nurse, midwife)	51	100 out of 142 UNICEF programme countries with data (2010–2016)	60	3.1.2
Countries with at least 60 per cent of a) mothers and b) newborns receiving postnatal care within two days of childbirth	(a) 16 out of 51 UNICEF programme countries with data (2010–2014) (b) 20 out of 57 UNICEF programme countries with data (2010–2014)	a) PNC for mothers: 54 out of 78 b) PNC for newborns: 34 out of 73 UNICEF programme countries with data (2010–2016)	(a) 25 (b) 25	3.8.1; 3c

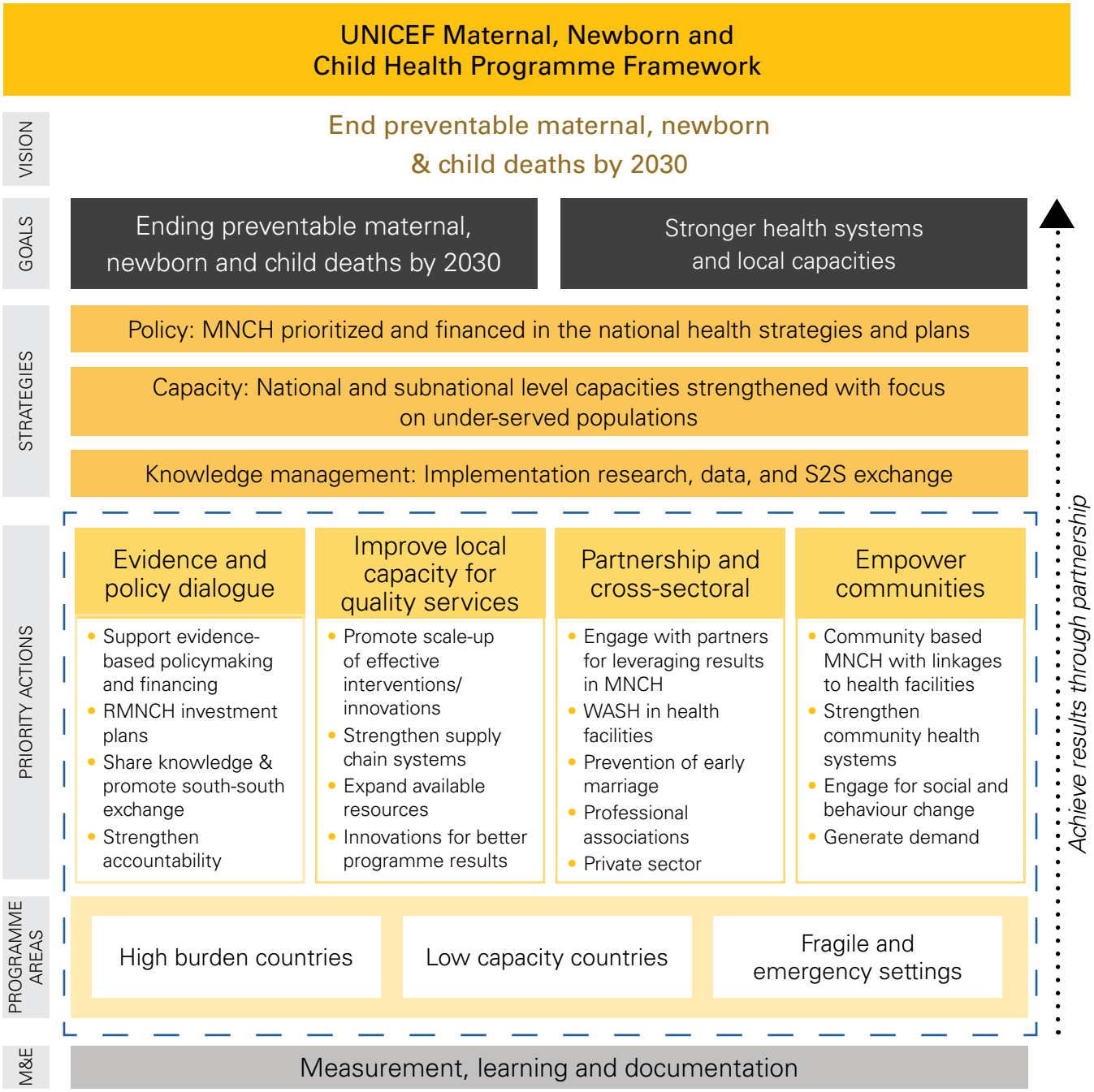
TABLE 4

Strengthening maternal care: 2016 output results

Output	Baseline	2016 target	2016 value	2017 target
Countries with 100 per cent of basic emergency obstetric care facilities operational on 24/7 basis	35	47	**42**	54

FIGURE 4

UNICEF's maternal, newborn and child health programme framework



Source: UNICEF New York, 2016

As neonatal mortality accounts for 45 per cent of all under-five deaths, UNICEF, WHO, Save the Children and other partners launched the seminal Every Newborn Action Plan (ENAP) initiative in 2014 to address the global burden of neonatal mortality. ENAP is a road map that aims to save 3 million lives a year by introducing quality care at the time of birth and support for small and sick babies. UNICEF co-led the ENAP country implementation working group with WHO, which identified priorities for action and provided harmonized technical assistance at national, regional, and global levels. The Bill & Melinda Gates Foundation continues to support UNICEF's ENAP coordination efforts to deliver results for children. Through ENAP and related efforts to increase the percentage of women who deliver their babies in health facilities, UNICEF is positioning countries to achieve the SDG targets on maternal and newborn care. In 2016, UNICEF saw significant progress in the area of newborn health.

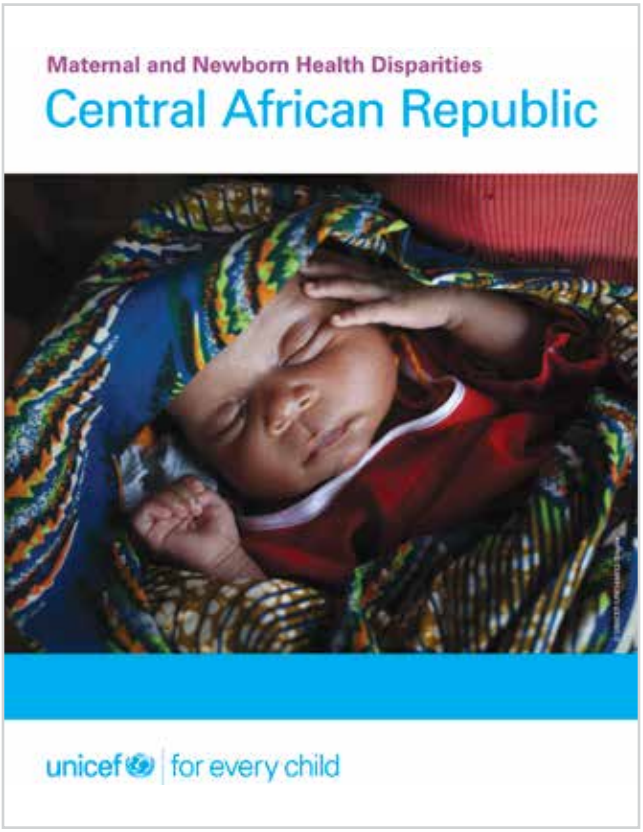
Access to care is an integral component of expanding universal health coverage as called for by the SDGs, but quality of care is equally important if greater gains in mortality reduction are to be realized. Under UNICEF programming, quality of care is an overarching concept for maternal, newborn and child health and is included within ENAP.

Under UNICEF's Quality of Care initiative (a separate initiative from ENAP), Bangladesh, Ghana and the United Republic of Tanzania (the three forerunner countries) successfully completed baseline surveys and trained the teams in charge of improving quality within health facilities, including support to breastfeeding. The scope of quality improvement work was expanded to other regions through knowledge dissemination by webinars and regional workshops. In addition, and to foster cross-sector work with WASH, UNICEF's health and WASH units prepared a joint guidance document to help country offices integrate WASH in health-care facilities.

The pillars of Quality of Care improvement training

- Supply and demand are equally important;
- Experience of care is a marker of quality;
- Quality improvement teams must include community representation;
- Data are used to guide action on gaps;
- Success is measured by impact on clinical outcomes.

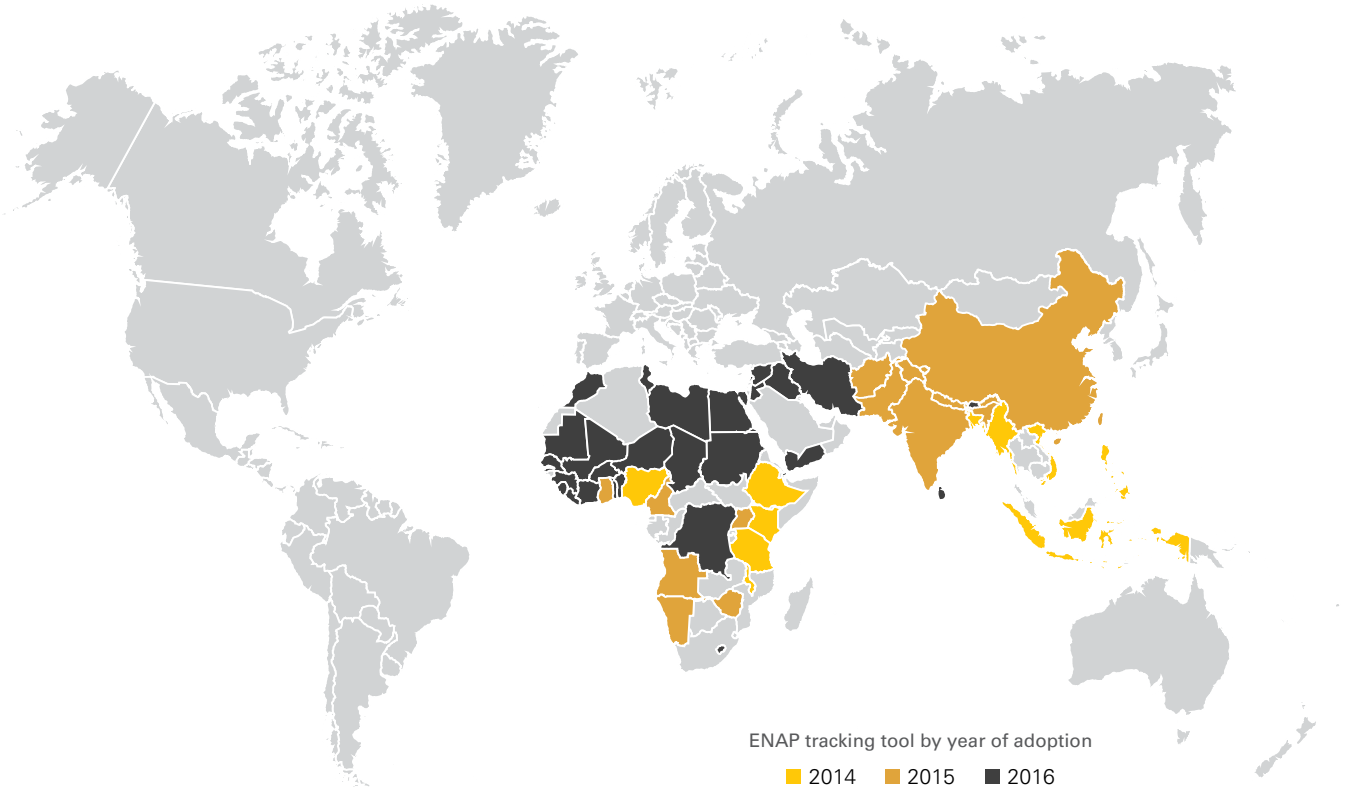
Thematic funds received through the West and Central Africa Regional Office were instrumental in accelerating multi-country action on maternal, newborn and child health in 2016. The Regional Office played a pivotal convening role as Chair of the Technical Committee of the French-funded Muskoka Initiative and organization of the regional Every Newborn Action Plan Forum, which brought participants from 17 countries, including the eight ENAP focus countries. A regional Every Newborn Action Plan Task Force is being established to harmonize partners' support and intensify technical assistance. By the end of 2016, 13 countries had developed implementation plans for maternal, newborn and child health, four of which are costed (Burkina Faso, Cameroon, Ghana and Guinea-Bissau).



In order to lay the foundation for further evidence and equity-based work, in 2016 UNICEF developed maternal and newborn health equity profiles in 26 focus countries, highlighting significant disparities by maternal age and education, income quintiles and subnational areas. These profiles have compelled governments to address equity gaps in their national planning processes.

In 2016, a total of 23 countries developed a newborn action plan, which was costed in 17 of those countries. Initially, 28 focus countries[4] with high neonatal mortality rates

FIGURE 5
Every Newborn Action Plan tracking tool by year and country of adoption, 2014–2016



Source: UNICEF New York, 2016.

needed to adopt the ENAP progress-tracking tool in order to identify barriers to progress. However, the tool can be used by all countries with neonatal mortality rates above 10 per 1,000 live births, either at national or subnational levels. As of 2016, 52 countries adopted the tool to better gauge gains made against neonatal mortality (*see Figure 5*). The rapid adoption of the tool in 2016 – particularly in sub-Saharan Africa – is owed in large part to UNICEF and partners organizing two regional meetings in the Middle East and North Africa and West and Central Africa regions encouraging countries to use the tool.

Another key achievement in 2016 was the organization of inter-agency maternal and newborn health regional workshops in three UNICEF regions (Middle East and North Africa, South Asia, and West and Central Africa), which led 37 countries to adopt ENAP follow-up plans to sustain momentum and progress.

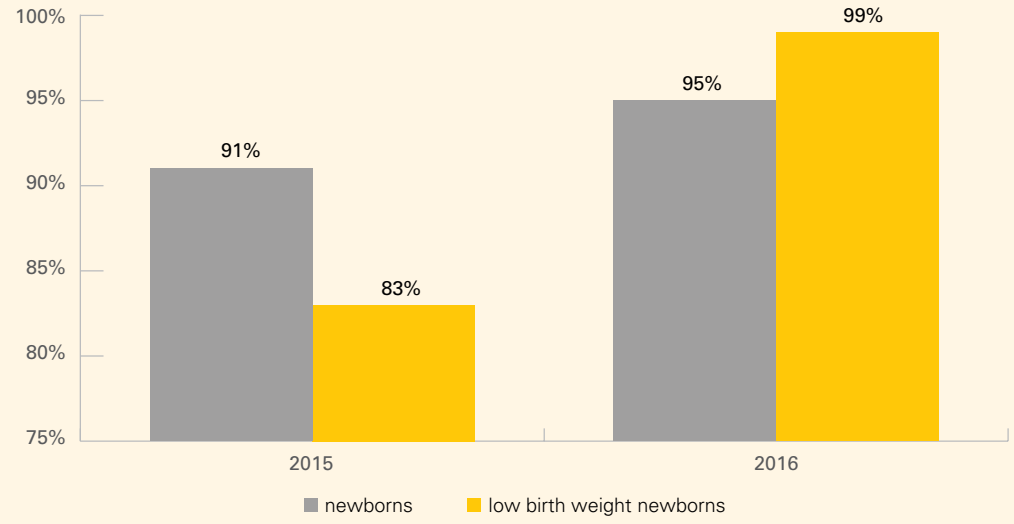
UNICEF and partners developed plans to scale up evidence-based interventions on chlorhexidine for cord care and possible serious bacterial infection in high neonatal mortality settings. Chlorhexidine in gel formulation was introduced in the UNICEF Supply Catalogue, expanding choices for health workers and new mothers, and was procured for the first time from two suppliers in Africa. In addition, specific plans have been developed on expanding the coverage of Kangaroo Mother Care and inpatient sick newborn care.

UNICEF's engagement towards newborn survival

In 2016, UNICEF provided technical assistance to the Ministry of Health of Liberia to track progress on newborn health as part of the West and Central Africa ENAP. Under this initiative, UNICEF advocated for the inclusion of stillbirth reporting in routine reporting systems. This will generate the evidence needed to address intrapartum causes of death and prevent neonatal mortality. UNICEF also procured 200,000 units of chlorhexidine for umbilical cord care, sufficient to cover all annual births, and provided instructional materials for caregivers and health clinics on its appropriate use for newborn care.

In Ghana, UNICEF supported 24 health facilities with newborn care equipment to provide quality emergency obstetric and neonatal care services in six districts of Northern and Upper East regions. Survival among the 1,044 sick newborns admitted at the Upper East Regional Hospital showed marked improvement between 2015 and 2016, particularly for low birthweight babies through Kangaroo Mother Care (*see Figure 6*).

FIGURE 6
Newborn survival, Upper East Regional Hospital, Ghana, 2015–2016



Source: UNICEF Ghana, 2016

UNICEF strengthened its partnerships with the Nursing and Midwifery Training Schools in Ghana's Northern and Upper East regions to improve pre-service training on essential newborn care. In addition, 43 midwives, doctors, nurses and anaesthetists from the three northern regions were supported as master trainers in Helping Babies Breathe and Infection Prevention and Control. As an essential part of quality of care, UNICEF strongly advocated for and provided support that enabled the Ghana Health Service to develop national standards and assessment tools for WASH in health-care facilities.

Progress in helping pregnant women deliver in health facilities

Within the past 25 years, the proportion of births delivered with the assistance of a skilled health attendant has increased remarkably from about two thirds of births in 1990 to three quarters of births over the 2010–2015 period. However, progress was uneven among regions. According to UNICEF data[5], in CEE/CIS, East Asia and the Pacific as well as in Latin America and the Caribbean, about 9 in 10 births occur in health facilities. However, in sub-Saharan Africa – where the burden of maternal and newborn deaths is highest – only half of all births occurred in a health facility, with a wide urban-rural gap. In 2016, globally, an estimated 40 million babies were born without the assistance of any skilled health personnel.

Skilled providers are crucial for overseeing labour and delivery while providing life-saving care or referral in case of complications such as haemorrhage or sepsis. However, a high proportion of women with obstetric complications still do not get life-saving emergency care. UNICEF focuses on strengthening the provision of basic emergency obstetric services that are functional 24 hours a day, seven days a week to address the majority (80 per cent) of medical complications that can occur during labour and to ensure timely management of pregnancy and childbirth.

In 2016, 42 countries, such as Ghana, Nepal, Rwanda and Uganda, reported that they had 100 per cent of basic emergency obstetric care facilities that are operational 24 hours a day, seven days a week. Progress on this target has been slow as additional investments from domestic resources would be required for greater achievements. Nonetheless, progress was seen in more challenging contexts. For instance, in the Sudan, the percentage of basic emergency obstetric care facilities that are operational 24 hours a day, seven days a week increased from 59 in 2015 to 63 in 2016. In Zimbabwe, through thematic funds and the Health Development Fund, successes have been scored in strengthening the overall health system with additional facilities offering comprehensive emergency obstetric care services (from 70 per cent to 86.2 per cent); providing basic emergency obstetric care (from 70 per cent in the first quarter to 77.5 per cent at the end of the third quarter); and increasing the proportion of district hospitals with at least three doctors from 67.4 per cent at the beginning of 2016 to 75 per cent by the end of the third quarter.



Zinhle, 29, holds her son, Ayandiswa, 2 weeks old, wrapped against the warmth of her body in the Kangaroo Mother Care unit in the Prince Mshyieni Memorial Hospital in Durban, South Africa. Zinhle's son was born premature.

Case Study: UNICEF's work to prevent teen pregnancy in Argentina

In Argentina, 14.7 per cent of babies are born to adolescent girls under 20 years of age, which translates to 300 babies born daily to young girls, including 8 born to mothers younger than 15 years old. Although a law on sexual education has existed since 2006, few adolescents are reached by health messages and their needs are often unmet by public services.

In 2016, to build gender-based equity in health, and in line with UNICEF's Strategy for Health 2016–2030 for adolescents, UNICEF Argentina worked with the Ministry of Health and partners to generate evidence, promote policy dialogue and provide technical assistance to reduce pregnancy among young girls. This work is positioning UNICEF as a key player in the area of adolescent health.

Financial resources allocated as of 2016 totalled US$1,211,572 and supported research into how the Argentinian health system responds to pregnancy in adolescents younger than 15 years old. In addition, project funds were invested in developing public policies that can adequately respond to teen pregnancy at the national, provincial and local levels.


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UNICEF brought sensitive topics, such as adolescent pregnancy and suicide, to the forefront of the policy agenda at provincial and national levels, which resulted in signed cooperation agreements. In conjunction with the Ministries of Health and Education, UNICEF introduced health advisory services in 32 secondary schools in four priority provinces (Chaco, Corrientes, Jujuy and Salta) to improve adolescents' access to health services, with 70 health and education workers trained in rights-based approaches. Adolescent-led forums were held in Chaco and Jujuy to garner insights into pregnancy and suicide to inform policy makers, with more than 200 adolescents participating in each forum.



UNICEF also supported an innovative community-based initiative to address adolescent pregnancy, sexual abuse and suicide in Calchaqui Valley. Indigenous communities and the education, health, protection and justice sectors participated, along with adolescents themselves. A locally-adapted protocol to address sexual abuse has been developed and validated, with the active participation of 200 adolescents. The initiative aims to reach 16,000 adolescents – most of them from vulnerable indigenous communities – by bringing to light any abuse taking place and involving the community to combat it.

Developed with the non-governmental organization Fundación para Estudio e Investigación de la Mujer (FEIM), an innovative campaign called #DeciloComoQuieras, pero informate antes (Say it as you want, but get informed first) to prevent unplanned adolescent pregnancy reached more than 430,000 young people.

An important lesson learned shows that although the legal framework in Argentina clearly safeguards confidentiality, behaviour change communication will be required to change adults' biases and negative attitudes towards adolescents.

In 2017, UNICEF will scale up its work beyond the four priority provinces, and will help train more than 90 health and education workers from 14 provinces in rights-based approaches to support adolescents. By the end of 2017, the Ministry of Health is expected to publish a comprehensive road map in support of adolescents younger than 15 years old. This road map will help guide the provision of proper services, adequate multisector care, the prevention of adolescent pregnancy and abuse.

UNICEF remains strongly committed to improving the coverage and quality of facility-based care for mothers and newborns. With an increasing number of women giving birth in health facilities, a renewed focus on the quality of care — in terms of service provision and women's experience within health facilities — is becoming more critical in gaining women's trust and accelerating progress in mortality reduction around the time of birth. UNICEF is concurrently working with governments and partners to promote financial protection against catastrophic expenses associated with emergency obstetric care for poorer households and to remove the financial barriers that would deter many women from seeking life-saving care.

UNICEF works towards improving adolescent health

Globally, there are 1.2 billion adolescents, yet their needs are neither well recognized nor addressed in many countries. This is particularly true for adolescent girls, who are at higher risks of adverse pregnancy outcomes than older women. UNICEF is working to integrate the 'second decade of life' under its new Strategy for Health 2016–2030 to focus on adolescent needs. In 2016, UNICEF identified adolescent health priorities and developed country programming guidance to support the 'health and well-being' pillar of its strategy.

UNICEF, in conjunction with WHO and partners, developed the Accelerated Action for Health of Adolescents Framework. In addition, UNICEF developed adolescent health country profiles for 14 flagship countries and case studies on Bangladesh and Mongolia to help the governments with adolescent programming. These case studies served as a springboard for developing multisectoral national programmes with the participation and inputs from adolescents. Mongolia conducted a comprehensive adolescent health situation assessment and identified a vast unmet need for mental health services. Bangladesh used human papilloma virus (HPV) vaccination assessments to collaborate with non-governmental organizations on adolescent-centred programme design and also revised the adolescent health strategy. A webinar on adolescent health was conducted in collaboration with the Bill & Melinda Gates Foundation and a Global Early Adolescent Health Study was produced with country support to Argentina, Malawi, Mongolia and Uzbekistan.

Immunization services: Capacity, supply and demand generation

Immunization remains one of the most fundamental, proven and cost-effective public health interventions.[6] Each year, 19.4 million children are either incompletely vaccinated or not vaccinated at all.[7] UNICEF's immunization work supports the objectives and priorities outlined in the 2011–2020 Global Vaccine Action Plan[8] so all children and women may benefit from their right to immunization, prioritizing those most disadvantaged. This commitment is reflected in UNICEF's strategic goals and active engagement within global immunization partnerships such as Gavi, the Global Vaccine Alliance, and the Measles & Rubella Initiative.

TABLE 5

2016 outcome results on immunization, maternal and neonatal tetanus elimination, and polio

Outcome	Baseline	2016 update	2017 target	SDG
Countries that are verified/validated as having eliminated maternal and neonatal tetanus	34	41	54	3.8.1
Polio-endemic or newly infected countries that become polio-free	Endemic countries: 3; Reinfected countries: 5 (as of 01 January 2014)	Endemic countries: 2 Reinfected countries: 1 (2015)	0 endemic	3.8.1; 3b
Countries with i) at least 90 per cent coverage at national level, ii) at least 80 per cent coverage in every district or equivalent administrative unit for children < 1 year receiving (a) measles-containing vaccine, (b) DTP-containing vaccine	a) Measles: i. 131, ii. 60 b) DTP: i. 135, ii. 63	a) Measles: i. 120, ii. 52 (2015) b) DTP: i. 126, ii. 55 (2015)	a) Measles: i. 157 ii. 157 b) DTP: i. 157 ii. 157	3.8.1; 3b

TABLE 6

2016 output results on strengthening immunization services

Output	Baseline	2016 target	2016 value	2017 target
Polio-affected countries with less than 1 per cent of children under 5 years old missing polio vaccination due to refusal	12	35	**21**	45
Countries without stockouts lasting more than one month at the national level of measles vaccine	142	145	-	145
Countries without stockouts lasting more than one month at the national level of DTP-containing vaccine	148	148	-	148
Countries in which 80 per cent of women of reproductive age in high-risk areas receive two doses of tetanus vaccine through campaigns	25%	100%	**60%**	100%
Polio-priority countries (endemic, outbreak, other) in which planned supplemental implementation activities were cancelled, postponed or reduced in size during the previous six months due to gaps in vaccine supply	2	1	**7**	0

At the global level, coverage has stagnated, with 86 per cent of all children receiving three doses of diphtheria, tetanus and pertussis (DTP)-containing vaccines in 2016. Based on UNICEF's 2014–2017 Strategic Plan results at the outcome level, 126 countries reached at least 90 per cent coverage at the national level with three doses of DTP-containing vaccines, with 55 countries achieving at least 80 per cent coverage in every district (or equivalent administrative unit). Moreover, 120 countries reached at least 90 per cent coverage at the national level for children under 1 year of age receiving measles-containing vaccine, with 52 countries achieving at least 80 per cent coverage in every district.[9]

In 2016, UNICEF supported governments in 138 countries to strengthen their immunization programmes to reduce inequities by (1) identifying disadvantaged communities through equity assessments, (2) strengthening immunization supply chain systems, (3) increasing access to life-saving vaccines between countries, (4) supporting the introduction of new vaccines and measles elimination goals, and (5) embedding Communication for Development (C4D) strategies in immunization programming. In 2016, UNICEF supported governments to vaccinate 61 million children against measles (target 78 million), and vaccinate 58 million children with DTP3 (target of 76 million).

1. UNICEF supported countries in identifying disadvantaged communities through equity assessments (e.g., in the Democratic Republic of the Congo, Haiti, Mozambique and Uganda in 2016) and integrating these findings into national and subnational programming strategies. For example, UNICEF is implementing the updated Reaching Every Community guidelines, thereby strengthening the equitable delivery of immunization services.

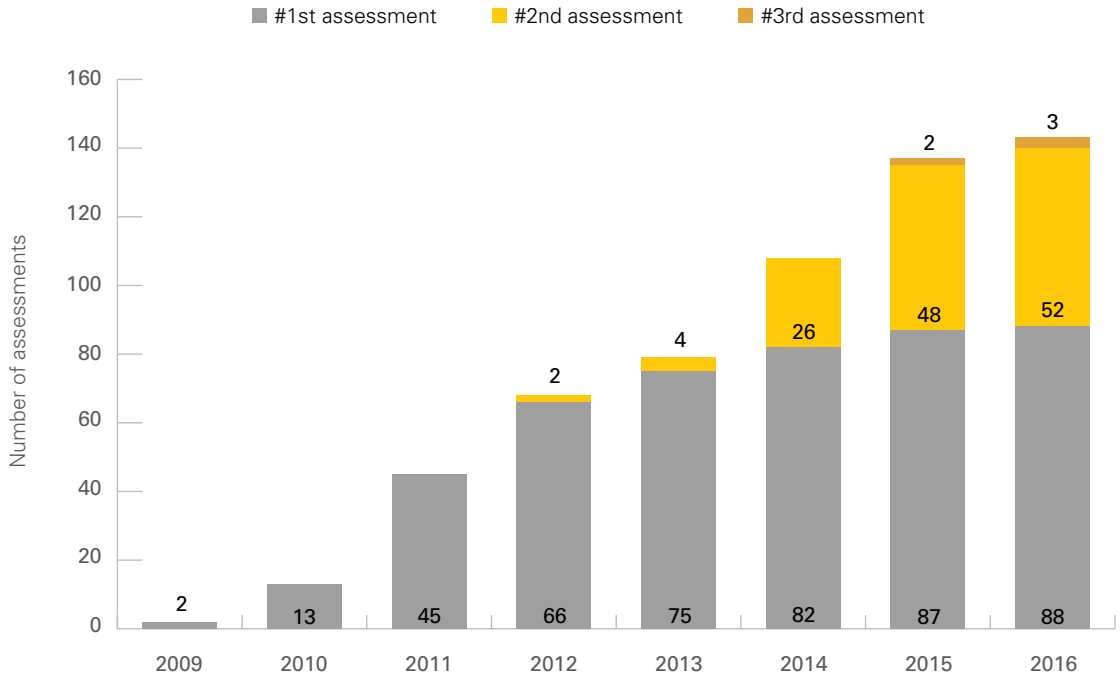
   In 2016, to further address inequities in the backdrop of increasing urbanization and slum dwelling in Africa and Asia, UNICEF reviewed the evidence on immunization, urbanization and slums. Findings show that current national immunization programmes and delivery strategies do not meet the needs of the urban poor and slum dwellers as these strategies are focused on reaching the most remote and rural areas. Therefore, UNICEF will intensify its work with partners to address the lack of immunization services in these marginalized settings.[10] In Zambia, UNICEF, in collaboration with the government and the European Union, is working in this direction by supporting an MDG acceleration initiative in urban and peri-urban areas. The project aims to reach 4.1 million Zambians, among them 20 per cent children under 5, 25 per cent adolescents, and 22 per cent women of childbearing age.

   Through technical assistance, UNICEF supported 40 countries to address immunization inequities. In some countries, UNICEF leveraged the power of new technologies to better identify and serve disadvantaged communities. UNICEF supported the design and scale-up of programmes that connect caregivers to health services via Short Message Service (SMS) reminder messages in hard-to-serve areas (both urban and rural); collected, analysed and visualized real-time information to identify underserved communities; and provided community members a direct channel to send feedback to health authorities about service quality and related issues. For instance, the social accountability and real-time monitoring features of mTrac helped the Government of Uganda take actions that contributed to increasing immunization coverage from 52 per cent to 98 per cent in prioritized communities in a single year (*see* www.mtrac.ug). In central Java, RapidPro was used to register newborns, send reminders to caregivers about vaccinations and help programmes with vaccine stock management. The pilot was completed in 2016 and is being scaled up in 2017. UNICEF supported governments and partners in delivering immunization services in poor

urban communities of metropolitan Manila by facilitating the process of prioritizing high-risk communities (especially those in slum environments), conducting bottleneck analysis, updating vaccination micro-plans, supporting community education and engagement, and monitoring delivery of services to ensure that no child is left behind.

2. UNICEF works with governments to strengthen immunization supply chain systems to ensure access to potent vaccines and efficient use of resources, as underscored in the joint WHO-UNICEF publication 'Achieving Immunization Targets with the Comprehensive Effective Vaccine Management (EVM) Framework'. Progress in EVM scores has shown an improvement in immunization coverage (*see Figure 7*). The 2016 EVM Global Data Analysis highlighted that while much progress has been made on temperature monitoring and cold chain storage capacity, maintenance remains weak. In addition, while vaccine management has improved at the national level, limited progress is seen at the point of service delivery. To address these weaknesses and follow up on EVMs in a systematic manner, each country develops immunization strengthening plans that are then integrated into national workplans and budgets to ensure greater improvements and sustainability.

FIGURE 7
Cumulative number of EVM assessments, 2009-2016



Source: World Health Organization and UNICEF, Effective Vaccine Management: Global data analysis – 2009–2015.

UNICEF was also instrumental in building the capacity of national stakeholders in supply chain management and has launched a new initiative to establish and strengthen national logistics working groups in, for instance, Afghanistan, Bangladesh, Chad, Ethiopia, India, Myanmar, Nigeria, Pakistan, Somalia and South Sudan. These groups provide oversight, guidance and accountability by improving coordination among immunization partners to improve vaccine availability and potency as well as supply chain efficiency. UNICEF launched new e-learning modules on immunization supply chain management on the UNICEF Agora website, with more than 2,000 enrolments, including 800 from UNICEF staff in 2016 alone. In 2016, UNICEF provided technical assistance in 52 countries in supply chain strengthening. For instance, with UNICEF's support, the immunization supply chain in Nigeria was strengthened. All 36 states, in addition to the federal level, have established logistics working groups that monitor supply chain data and progress on agreed improvement plans. A national logistics information system was established to provide visibility on vaccines up to the district level. Additionally, UNICEF supported the Government of Nigeria to close the cold chain gap, extending the reach of the vaccine supply chain to hard-to-reach areas. Another example comes from the work of UNICEF in supporting the Government of Pakistan. The country has greatly reduced the risk of vaccine

wastage by implementing central temperature monitoring systems in its cold rooms. Pakistan was also supported in developing a multi-year cold chain optimization plan that was recommended for funding by Gavi, the Vaccine Alliance.

3. To reduce the inequitable access to life-saving vaccines between countries, UNICEF supported the introduction of new vaccines into national immunization programmes. In addition, UNICEF helped introduce existing vaccines into routine immunization schedules. For instance:

    - Rubella vaccine was introduced through catch-up vaccination campaigns in seven countries.
    - Pneumococcal conjugate vaccine was introduced in Kyrgyzstan, Mongolia and Myanmar.
    - Meningitis vaccine was introduced in Burkina Faso, Ghana and the Sudan.
    - Rotavirus vaccine was introduced in India, Liberia, and Sao Tome and Principe with C4D interventions.
    - Human papillomavirus (HPV) vaccines were introduced in Burundi and Uganda.

    UNICEF also supported the research and evidence base to develop the second year of life consensus (i.e., establishing health visits in the second year of life as a platform for vaccination and other health interventions) at the 2016 Strategic Advisory Group of Experts meeting.[11] This policy platform supports the introduction of a second measles dose in the second year of life. This initiative is being piloted in Ghana, where UNICEF, with financial support from the Centers for Disease Control and Prevention, has taken the lead on generating demand through social mobilization. A roll-out in the Philippines is planned for 2017. UNICEF is developing the Second Year of Life Planning, Costing and Financing Tool to help Ministries of Health and others plan, cost and finance the platform. Lastly, to help countries implement the initiative, WHO and UNICEF are developing global guidance entitled 'Establishing and Strengthening Immunization in the Second Year of Life: Practices for immunization beyond infancy', which will be finalized in 2017.

4. In 2016, in order to support measles elimination goals under the Global Vaccine Action Plan, UNICEF and partners supported the vaccination of more than 160 million children against measles through supplemental immunization activities in more than 30 countries.

5. In 2016, UNICEF made concerted efforts to better embed C4D strategies in immunization programming and, as a result, developed a comprehensive Communication for Immunization Framework with partners to identify and address gaps, align partners' activities, and inform the development of key performance indicators (*see Figure 8*).

Aligned with this framework UNICEF also

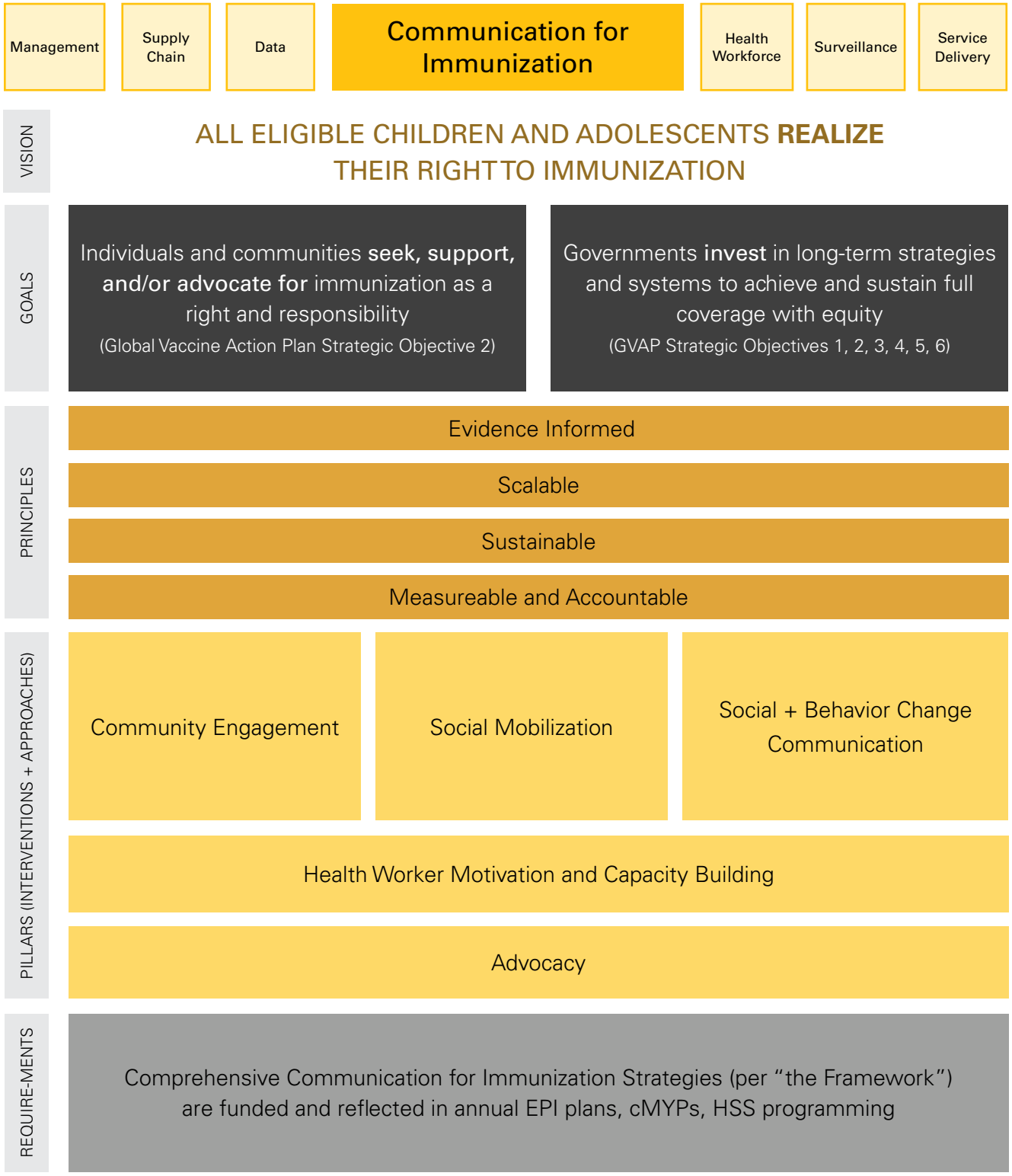
- Launched a global initiative to enhance the capacity of front-line workers, especially their interpersonal skills, to engage with communities and caregivers, as part of a joint project with John Hopkins University and other partners;
- Developed a comprehensive suite of 'human-centred design' tools (i.e., centred on the lives of communities and their environments) to investigate and respond to situations where communities do not use immunization services despite the availability and accessibility of affordable services. The toolkit is based on emerging insights from the social and behavioural sciences as well as human-centred design processes and principles adapted from the private sector (*see* www.hcd4i.org);
- Launched an e-learning module on Agora about communication for immunization; and
- Advocated successfully for the incorporation of C4D priorities in key planning documents, such as country multi-year plans and Gavi's health systems strengthening approach.

At country level, the work on C4D was supported in 41 countries in 2016. For example, in Eritrea the UNICEF country office supported a study on Knowledge, Attitude and Practices on immunization that resulted in a better integration of immunization into comprehensive maternal, neonatal and child health C4D strategies. In Kenya, a strong C4D intervention accompanied the measles and rubella vaccination campaign to overcome vaccine hesitancy and combat anti-vaccination messages circulating in the country. Immunization ambassadors and religious and traditional leaders were mobilized to ensure that families and caregivers understood and accepted the vaccination.

To provide clarity on UNICEF's immunization priorities until 2030 (in alignment with the SDGs and UNICEF's Strategy for Health 2016–2030) a process was launched to develop UNICEF's 2017–2030 Immunization Road Map. This road map will (1) provide clarity on UNICEF's immunization focus and priorities until 2030, (2) identify the required shifts in the current modus operandi, and (3) strengthen links with UNICEF's overall role in global health as well as with global immunization partners. UNICEF will operate the following key shifts under the road map: use vaccination as the marker for child equity; increase the emphasis on immunizations for mothers and adolescents; leverage multisectoral approaches; drive health systems strengthening by focusing on the interface between health systems and the marginalized and underserved communities; strengthen integrated delivery and supply chain systems; engage in the early stages of immunization-related developments and innovations; and strengthen its role in working with frontline workers to promote public demand for immunization.

FIGURE 8

Communication for Immunization Framework



Source: UNICEF New York, 2016

Immunization is a good entry point into antenatal care programmes to help reduce mortality from neonatal tetanus, a condition that newborns can contract when deliveries are conducted in unhygienic conditions. Three countries were validated in 2016 as having eliminated maternal and neonatal tetanus, including Equatorial Guinea, Indonesia and the Niger, with the addition of the Punjab province of Pakistan. Furthermore, UNICEF supported 10 countries (Chad, Ethiopia, Guinea, Kenya, Nigeria, Pakistan, Papua New Guinea, the Philippines, South Sudan, and the Sudan), in conducting tetanus toxoid immunizations campaigns, reaching an estimated 11 million women of reproductive age. As 18 countries have yet to achieve maternal and neonatal tetanus elimination – in large part due to structural barriers, humanitarian and emergency settings, or insecurity – UNICEF will address programme impediments through the Strategic Advisory Group of Experts Working Group on Maternal and Neonatal Tetanus.

In the framework of gender-responsive adolescent health interventions, UNICEF, in conjunction with Gavi and other partners, supports governments in introducing the HPV vaccine in-country to help protect young girls against cervical cancer. UNICEF procured 2,662,900 HPV vaccine doses to Gavi-eligible countries in 2016. This relatively low number suggests that progress under HPV immunization programmes has been slow and constrained. High costs are a key barrier to implementation, as vaccination is not systematically integrated within immunizations systems. Programmes to introduce HPV immunization as part of national immunization schedules are being factored into UNICEF's new Strategic Plan under the second decade of life engagement to help address these challenges.

Progress in polio eradication

In 2016, there was a total of 37 cases of wild poliovirus in the three endemic countries – Afghanistan, Nigeria (due to a resurgence of the wild polio virus in Borno State of Nigeria in August[12]) and Pakistan[13] – the fewest number of children infected by polio in history. The number of children missed in vaccination campaigns also decreased significantly, resulting in improved population immunity in some of the world's most challenging contexts. Outbreaks that started in 2013–2014 in complex areas of Central Africa, the Horn of Africa and the Middle East have been successfully stopped.

Over the past few years, UNICEF has continued to be a leading and convening partner in the Global Polio Eradication Initiative. To sustain gains made towards polio eradication, UNICEF monitors the number of countries where caregivers refuse polio vaccination for their children under five, with a goal of less than one per cent refusal. In 2016, UNICEF was engaged in polio eradication in 30 countries and 21 had refusal rates below one per cent (up from 19 countries in 2015). For instance, in West and Central Africa, 13 of the 15 polio-affected countries achieved the one per cent target, up from eight countries in 2015 and three countries in 2014. UNICEF is responding to challenges by improving strategies for tracking and managing refusals at the community level, increasing the involvement of religious and community leaders and improving communication through community mobilizers. In Ukraine, UNICEF successfully conducted a comprehensive communication campaign that reached about 70 per cent of the population. As a result, 71 per cent of parents supported vaccination in 2016, compared with 46 per cent in 2012 and 28 per cent in 2008.

Subnationally, clustered levels of refusal continue to be monitored by UNICEF and partners and addressed through social mobilization, engagement of influencers, stepped-up interpersonal communication skills for front-line workers, enhanced microplans and the organization of follow-up visits to reach missed children.

By the end of 2016, based on UNICEF's Strategic Plan results, seven polio-priority countries cancelled, postponed or reduced in size planned supplemental implementation activities during the previous six months due to gaps in vaccine supply (target 1 for 2016). Six of the 16 reporting polio-priority countries in West and Central Africa (Burkina Faso, the Central African Republic, the Democratic Republic of the Congo, Gabon, Mali and Mauritania) had to redirect their vaccine supplies to control the polio outbreak in Nigeria and the Lake Chad Basin. The vaccination campaigns have either been reduced in size or rescheduled for 2017, when the polio vaccine supply is expected to normalize.

In collaboration with the Global Polio Eradication Initiative, UNICEF continued to focus on reaching every last child in Afghanistan and Pakistan with the goal of stopping the endemic transmission of the wild poliovirus. Afghanistan and Pakistan represent the last mile in conquering the virus warranting coordinated and sustained efforts within and across the two countries. In both countries, insecurity, rather than vaccination refusals, remains a major challenge. Nonetheless, the year 2016 saw exciting progress. In Pakistan, 20 polio cases were recorded, down from 54 cases in 2015 and 306 in 2014. In Afghanistan, 13 cases were reported in 2016, down from 20 in 2015 and 28 in 2014. These significant results stemmed from multi-pronged interventions in which UNICEF, WHO and other partners supported governments in coordinating polio eradication programmes through emergency operations centres to increase oversight and coordination at national and regional levels. These centres strengthened accountability and surveillance mechanisms through the implementation of national emergency action plans.

Key to UNICEF's polio eradication effort was the financial support of the Bill & Melinda Gates Foundation, Rotary International, the US Centers for Disease Control and Prevention and the Governments of Canada, Japan and Germany. In Afghanistan, UNICEF provided vaccines, strengthened the cold chain and supported the dispatch of mobile medical teams in high-risk polio districts in addition to raising polio awareness through 7,700 social mobilizers. UNICEF partnered with BBC Media Action, which produced and broadcast 35 weekly radio shows with integrated polio

and vaccination messages reaching 4 million people. In Pakistan, UNICEF and the government reached 80 million people through the 'Sehat Muhafiz' ('guardians of health') campaign designed to increase caregivers' trust in vaccinators. Community-based vaccination in which frontline workers interact with caregivers at their doorstep helped vaccinate 3 million children in the highest-risk polio reservoir areas through a UNICEF-supported network of 12,500 (predominantly women) locally accepted workers. Thanks to the efforts of these vaccinators, in 2016 Pakistan achieved the highest immunization coverage figures in these areas in the country's history, with the proportion of children missed in national campaigns falling from 25 per cent in 2014 to 5 per cent by the end of 2016. Likewise, in Afghanistan, the percentage of missed children fell from 12 per cent in January 2016 to 7 per cent by the end of the year.

In 2016, UNICEF and partners successfully completed the global switch from trivalent oral polio vaccine to bivalent oral polio vaccine in 155 eligible countries and territories, with the ultimate goal of replacing all oral polio vaccines. UNICEF procured and delivered over 1.4 billion oral polio vaccine doses to more than 70 countries.

In December 2016, UNICEF was named co-chair of the Global Polio Eradication Initiative's Transition Management Group, which works to meet Goal 4 of the Polio Eradication End Game and Strategic Plan 2013–2018 by ensuring that the investments made to eradicate polio contribute to broader future health goals. By November 2016, 13 of the 16 priority countries had completed an inventory – or mapping – of all polio assets within their countries, enabling governments to match assets against government health priorities.

Service delivery and community empowerment in humanitarian settings

In 2016, a quarter of the world's children lived in war zones among widespread violence, were internally displaced or forced to migrate, or suffered the harsh consequences of climate change, leaving them extremely vulnerable to disease, hunger, multiple forms of abuse and a severe lack of access to essential services. The sheer number of people living in insecurity is emerging as a powerful inequity beyond the well-known urban-rural, wealth and gender divides, compelling UNICEF to reach those who suffer most.

TABLE 7

2016 output results on service delivery and community empowerment in humanitarian settings

Output	Baseline	2016 target	2016 value	2017 target
Countries that have mainstreamed risk reduction/resilience, inclusive of climate change, into national health strategies and plans	27	38	**50**	40
Cholera-endemic (or at risk for cholera) countries with comprehensive multisectoral cholera preparedness plans	26	35	**29**	40
UNICEF-targeted children 6–59 months in humanitarian situations vaccinated against measles	70%	89%	**81%**	95%
UNICEF-targeted children 6 months to 15 years in humanitarian situations vaccinated against measles	72%	87%	**72%**	95%
UNICEF-targeted families in humanitarian situations that receive two insecticide-treated nets in malaria-endemic areas	30%	92%	**49%**	100%

Globally, UNICEF and partners responded to 344 humanitarian situations in 108 countries in 2016. Level three[14] health emergencies were declared in Iraq, Nigeria, South Sudan, the Syrian Arab Republic and Yemen. Level two emergencies included Cameroon, the Central African Republic, Chad, Haiti and the Niger.

In 2016, in Yemen, UNICEF and partners helped vaccinate more than 4.8 million children against polio (target 5 million), 650,000 children against measles (target 770,000) and ensured that 1 million children benefited from treatment of childhood illnesses, particularly through mobile health teams and outreach services, exceeding the 815,000 target. In 2017, UNICEF will support the implementation of a national health and nutrition emergency programme in collaboration with WHO and the World Bank to rehabilitate the primary health care system. The project, aiming to reach an estimated 7 million beneficiaries, will deliver a set of critical health services to women and children including immunization, nutrition and integrated management of childhood illnesses in health facilities.

UNICEF protects Syrian children through the Accelerated Implementation of Routine Immunization

While the Syrian Arab Republic had one of the best immunization programmes in the Middle East, the country's health system collapsed under the protracted conflict – now in its sixth year – giving rise to polio and measles outbreaks in 2013 and 2014 and an alarming decline in immunization rates. To improve immunity against vaccine-preventable diseases in young children, UNICEF, WHO and partners conducted three multi-antigen Accelerated Implementation of Routine Immunization rounds in 2016 across the country.

Accelerated Implementation of Routine Immunization specifically aimed at reaching all under-five children living in besieged areas in the northern part of the Syrian Arab Republic. Through cross-border operations from Turkey, UNICEF capitalized on the cessation of hostilities to help immunization partners vaccinate children with pentavalent vaccine, oral and inactivated polio vaccines and measles-containing vaccines.

Despite massive challenges, UNICEF and partners reached nearly 1.5 million children at least once over three rounds of the campaign. Many children in besieged areas were vaccinated for the first time in many years and this strategy paved the way for the resumption of routine immunization where these services had completely stopped. Through diligent microplanning and with support of humanitarian actors within the Syrian Arab Republic and in neighbouring countries, many Syrian children are now protected against multiple vaccine-preventable diseases.



On 26 April 2016, (left to right) siblings Ahmed, 5, and Louai, 4, and infant Yasmine, 1 month, held by her cousin Fatima, were finally vaccinated as part of Syria's first-ever nationwide routine immunization campaign since the start of the six-year conflict.

Further, the ongoing conflict and drop in vaccination coverage prompted the Gavi board to recommend support for vaccine costs and cold chain strengthening. UNICEF is now leading the coordination of partners in this area in addition to preparing a proposal to access Gavi funding in support of immunization in the country.

In humanitarian settings, UNICEF continued to work with governments to vaccinate children 6 months to 15 years old against measles. In 2016, more than 24 million children in that age range were vaccinated (target of 33 million), including more than 12 million children under age 5 (target 15 million). Based on the results of measles risks assessments, countries determine which age range to best focus on and maximize measles vaccination efforts. Overall, funding shortfalls (for instance, in Nigeria and South Sudan), limited routine stocks of measles vaccine (the Sudan) and overestimated targets in humanitarian settings at the country level (Somalia) explain why the Strategic Plan targets outlined in Table 7 were not fully met for 2016.

In humanitarian contexts, protecting families against malaria is critical to reduce excess mortality. In 2016, UNICEF provided long-lasting insecticide-treated bednets to more than 1 million families in malaria-prone areas (against a target of 2 million). Some bottlenecks in reaching a higher number of families with bednets include funding constraints that impeded securing an adequate number of bednets and the difficulty in estimating an accurate target in humanitarian settings (e.g., a reduced number of refugees in Ethiopia and Kenya in 2016). However, it should be noted that many families, even in emergency settings, actually received bednets within the ambit of mass and routine distribution campaigns.

In 2016, 29 countries had comprehensive multisectoral preparedness plans against cholera, up from 26 countries in 2015. The slow progress is explained in part by the fact that in some countries, while a cholera preparedness plan exists, it is not multisectoral and in other cases, plans may have been prepared for a subnational area only. To meet challenges in preparedness, UNICEF's C4D, WASH and health sections increased collaboration with the West and Central Africa regional cholera platform. UNICEF established a regional group of cholera experts covering three countries, with the group based in the Niger Country Office.

In 2016, Haiti suffered the double burden of category four Hurricane Mathew and a cholera outbreak, prompting UNICEF to mount its biggest humanitarian operation since the 2010 earthquake. UNICEF, in collaboration with WHO, supported the Ministry of Health in conducting a cholera vaccination campaign, reaching 756,191 of the targeted 817,000 people, including more than 288,000 children 1–14 years old. UNICEF played a major role in assisting the Ministry of Health in reviewing and developing a medium-term plan (2016–2018), a subcomponent of the 10-year National Cholera Elimination Plan.

The mainstreaming of disaster risk reduction in national health strategies showed excellent progress; 50 countries did so in 2016, exceeding the 2017 target of 40. Climate change preparedness is being mainstreamed with a renewed impetus, particularly in the Pacific Islands, where rising sea levels and catastrophic climate-related events represent an existential threat to children and their families. UNICEF's Emergency Health Unit provided support to Fiji and the Pacific Islands on climate change adaptation in coordination with WHO and UNFPA.

The indicators tracked in the Strategic Plan aim to ensure and measure continuity between development and humanitarian actions. In addition to ensuring this continuity, UNICEF prepares for and responds to numerous complex and diverse humanitarian crises.

In 2016, UNICEF responded to an unprecedented yellow fever outbreak in Angola (including in large urban centres) that quickly spread to the Democratic Republic of the Congo through cross-border population movements. The emergency response required close coordination between UNICEF's Programme and Supply divisions, and the International Coordination Group on Vaccine Provision. UNICEF and partners helped the local authorities vaccinate 30 million people against yellow fever (target 33 million) in reactive and pre-emptive vaccination campaigns.

UNICEF deployed financial and human resources to combat Zika, the mosquito-borne disease that results in devastating consequences in newborns, including microcephaly, birth defects and long-term disability. In Latin America and the Caribbean, working with WHO and others, UNICEF's health team was instrumental in defining the Zika regional plan and strategy that allowed the organization to implement actions in most countries of the region with a strong C4D component. UNICEF was able to reach more than 162 million people in 18 countries in Latin America and the Caribbean with Zika prevention messages through mass social and digital media campaigns. The UNICEF Latin America and Caribbean Regional Office, in collaboration with UNICEF headquarters, was also central in advocating for and introducing the more holistic and multisectoral concept of care and support for Zika-affected families into the global, regional and country Zika response. This model includes care for children with congenital Zika virus syndrome through psychosocial support, social protection, early childhood development interventions and nutrition support. In Brazil, UNICEF created the Networks for Inclusion based on cross-sectoral interventions that include health, education, and protection to strengthen caregivers' skills.

On 14 January 2016, WHO declared the end of the Ebola virus disease outbreak. In collaboration with the United Nations Development Programme, the World Bank and other partners, UNICEF'S West and Central Africa Regional Office played a major role in elaborating recovery plans for Guinea, Liberia and Sierra Leone. UNICEF support focused on coordinating humanitarian assistance; assessing internal capacity and defining priorities; and building and sustaining local rapid response capacity, particularly at the decentralized level.

UNICEF took several steps to strengthen its organization-wide capacity to respond to emergencies in 2016. To strengthen its capacity to prepare and respond to health emergencies with a health systems strengthening approach, UNICEF launched the Health Emergencies Preparedness Initiative and established an internal cross-divisional Technical Working Group. To support this new Health Emergencies Preparedness Initiative, UNICEF worked with the Centers for Disease Control and Prevention, USAID, WHO and the World Food Programme to develop supply lists based on a range of identified diseases, create technical specifications, and develop a supply quantification tool and disease-specific notes designed for staff and partners. UNICEF then procured and prepositioned 156 items (of which 70 were new) to a value of $579 million. UNICEF's Diarrhoeal Disease kit to address cholera outbreaks was also redesigned and upgraded. In partnership with Columbia University, UNICEF developed online training modules focusing on maternal and newborn health, sexual and reproductive health, WASH and communicable diseases in emergencies. These modules will be rolled out in 2017.

A *Newborn Health in Humanitarian Settings: Field Guide* was published in 2016 in collaboration with Save the Children and partners. The guide has been pilot tested in Somalia and South Sudan and lessons learned will be used to update and refine it. Newborn care in emergencies guidance was developed and emergency preparedness was added as a core area in the Every Newborn Action Plan progress tracking tool. Work is in progress to develop the contents of ready-to-order, pre-packaged emergency newborn care kits.

The first draft of the Health Module of the Risk Informed Programme guide was developed. The module is part of a package of cross-sectoral modules and risk assessment guide to help country offices integrate risk assessment into their existing health programmes. The module will be field tested in 2017 with other sectors.

Further examples of UNICEF's health work in the context of humanitarian settings can be found in the Humanitarian Action Annual Results Report.

PROGRAMME AREA 2: INCREASING CAPACITY AND STRENGTHENING COMMITMENT OF GOVERNMENTS TO IMPROVE HEALTH AND REDUCE MORTALITY IN ALL SETTINGS

As noted at the outset, global momentum around the MDGs, particularly MDGs 4 and 5, helped accelerate a reduction in maternal and child mortality. These gains were not shared equitably, however,[15] as national averages conceal deep disparities within countries.

To heighten the emphasis on equity within the context of the SDG agenda, UNICEF is sharpening the focus on strengthening health systems, including district-level services to bridge gaps in the health outcomes of women and children. UNICEF defines health systems strengthening as actions that establish sustained improvements in the provision, utilization, quality and efficiency of health services – broadly defined to include family care, preventive services and curative care – and that produce equitable health, nutrition and development outcomes for children, adolescents and women.[16] UNICEF's health systems strengthening strategy rests on three beams (the areas of focus specific to the three main levels of the health system) and five pillars (which are the areas of focus on specific issues appropriate to the level of the health system and the local context (*see Figure 9*).

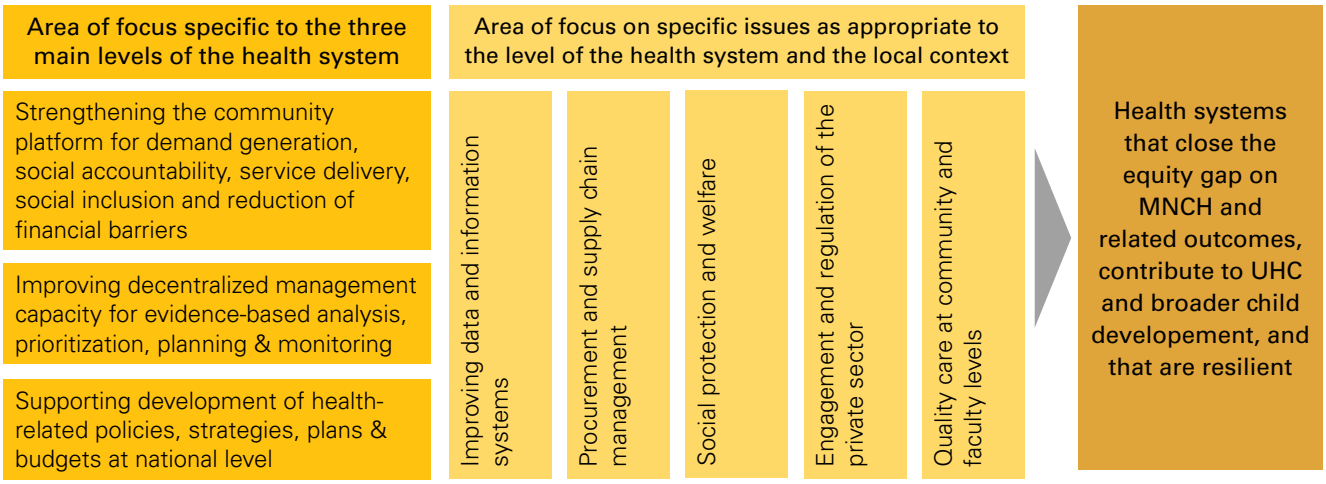
TABLE 8

2016 output results towards increasing the capacity of governments to improve health and reduce mortality in all settings

Output	Baseline	2016 target	2016 value	2017 target
Countries in which barriers and bottlenecks relating to child survival are monitored in at least 80 per cent of district health system strengthening targeted districts	9	32	**24**	40
Countries that have plans with budgets allocated to reduce adolescent pregnancy	83	89	**91**	93
Countries that produce an analysis of sex-differentiated infant and child mortality estimates	42	55	**42**	62

FIGURE 9

UNICEF's areas of work in health systems strengthening for women and children



Source: UNICEF, Approach to Health Systems Strengthening, New York, 2016
Note: MNCH is maternal, newborn and child health. UHC is universal health coverage.

UNICEF supports Turkmenistan in integrating the SDGs into national strategic and planning documents

UNICEF supported the Government of Turkmenistan in integrating the SDGs into the National Strategic and Planning documents on health and nutrition. Through national consultations with the Ministry of Health and Medical Industry and the State Statistical Committee, relevant targets and indicators under SDGs 2 and 3 were nationalized. These targets and indicators were then adopted within the five-year Presidential Programme for 2017–2021 and relevant sectoral plans such as the National Strategy and Action Plan on Maternal, Newborn, Child and Adolescent Health for 2015–2019 and the State Health Programme. UNICEF also supported the Government in establishing appropriate monitoring systems to measure progress against SDG implementation. These indicators include under-five and infant mortality rates, neonatal and maternal mortality rates, and stunting and wasting rates.

By the end of 2016, the Government of Turkmenistan stood ready to collaborate with UNICEF to make sustainable and equitable progress for children in the spirit of the SDG agenda, strengthen accountability mechanisms and increase public investments in quality antenatal, perinatal and neonatal care and early child development (ECD).

An important accomplishment for UNICEF in 2016 was the broad dissemination of its global guidance on health systems strengthening to partners such as Gavi, the Global Fund and various bilateral and implementing partners committed to strengthening national capacity across the health system.

UNICEF has long championed community health services as a key strategy to help the poor and most excluded access high-impact maternal, newborn, and child health interventions and adopt healthy behaviours. However, not enough is known on how a full package of community health services can be financed to support effective programmes.

To address this gap, UNICEF, in partnership with Management Sciences for Health, developed the Community Health Planning and Costing Tool,[17] which was piloted in Malawi and Sierra Leone in 2016.[18] Based on user inputs, the tool calculates costs and required financing to introduce, maintain or scale up comprehensive community health services programmes at the national or subnational levels. Governments and managers can use the results to evaluate programme performance, plan for future programming and develop investment cases to introduce or expand community health services.

By shedding light on financing needs at the community level, UNICEF aims to provide a channel to global financing mechanisms such as the Global Fund and the Global Financing Facility that would help make these crucial health services more widely available and sustainable. In addition, the new toolkit intends to help community health programme managers, planners and policymakers in civil society, government and international organizations accelerate progress under the SDGs.

Creating synergies across sectors

Evidence shows that holistic investments made within and outside the health sector – away from disease-specific approaches – is catalytic in generating child survival gains.[19]

UNICEF is focused on promoting health systems as a platform to deliver multisector packages of intervention and services to address the underlying causes of health challenges and obtain synergistic results in other areas. UNICEF is working with governments to strengthen these links and accelerate gains for children.

Increasing the interoperability of Civil Registration and Vital Statistics and the health system is an important area of cross-sectoral work. Together with partners, including WHO and the World Bank, UNICEF played a strategic role in successfully advocating for the recognition of the health sector's important role in national civil registration and vital statistics. As of 2016, 16 countries (Angola, Botswana, Burundi, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, Somalia, South Sudan, Swaziland, Uganda, the United Republic of Tanzania and Zambia) were applying the game-changing strategy of strengthening interoperability between civil registration and the health sector. The integration of birth registration within health centres in the Sudan resulted in the registration of more than 170,500 newborns in remote localities. In West and Central Africa, lessons learned showed that a combination of strengthened engagement from the health sector and adapted use of innovative technology can revolutionize the rate at which children are registered at birth and receive birth certificates.

UNICEF also capitalizes on immunization contacts to deliver other interventions such as nutrition and vitamin A supplementation. Through the UNICEF Global Affairs Canada partnership, UNICEF is scaling up vitamin A

supplementation activities in six countries (Burundi, Madagascar, South Sudan, the United Republic of Tanzania, Uganda and Zambia) through integration with immunization programmes, bottlenecks analysis and programme monitoring initiatives. In Somalia, nutrition services have been fully integrated with the essential Package of Health Services, enabling 5.7 million Somalis (45 per cent of the population) to access the package in 2016. In Pakistan, UNICEF continued to support health camps in Balochistan, Khyber Pakhtunkhwa, the Federally Administered Tribal Areas and Punjab to increase polio reach and deliver nutrition and other services to highly disadvantaged communities through its Polio Plus programme. Through this programme, 263,553 children were screened for malnutrition and 12,625 were admitted for treatment of severe acute malnutrition, while 121,305 children received micronutrient sachets. In all cases, more girls than boys were reached.

Integrating health and WASH interventions is a crucial step in creating stronger opportunities for maternal, newborn, child, and adolescent health. In Ethiopia, UNICEF supported the ministries of Health, Water and Education to develop a joint guideline on menstrual hygiene management, a neglected sanitation area that contributes to girls missing education every month and dropping out of school, thereby increasing their risk of early marriage. In Zambia, the Ministry of Health officially reviewed the National Infection Prevention and Control guidelines, which now include the WASH-Infection Prevention and Control package. The inclusion of the package is a major accomplishment in standardizing affordable measures to reduce facility-acquired infections. The package was delivered in the 55 targeted health-care facilities in Copperbelt and Lusaka provinces; groundwater points have been provided in 42 facilities, on-site chlorine production units have been provided in 32 facilities and more than 50 per cent of staff of targeted facilities received a five-day WASH/Infection Prevention and Control training. UNICEF is also developing a cross-sectoral vector control activity package that bridges WASH, health and C4D.

Increasing governments' capacity in bottleneck analysis and Monitoring Results for Equity System

A bottleneck analysis is a critical step to generate the data governments will need to adopt adequate policies and programmes that will reach the poor. In 2016, 24 countries (up from 18 in 2015) reported monitoring the barriers and bottlenecks relating to child survival in at least 80 per cent of districts targeted for health systems strengthening.

In partnership with WHO and the University of Oslo, UNICEF provided support to review or develop national health sector plans based on situation and bottleneck analysis in Ethiopia, Kenya, Lesotho, Malawi and Zimbabwe. UNICEF further supported implementation of the Monitoring Results for Equity System (MoRES) and results-based management in 11 countries, allowing them to align their national health strategic plans to the SDGs and Every Woman Every Child. In Cameroon, the Democratic Republic of the Congo, Ghana, Guinea, Liberia and Senegal, data generated through bottleneck analyses and the Equitable Impact Sensitive Tool (EQUIST) were used to influence political commitments, direct policy decisions, advocate financing and budget allocations and leverage resources towards overall programming for children.

Mainstreaming gender in health

Mainstreaming gender programming is another fundamental step in creating more robust, equity-based health systems that can address gender-based discrimination and the specific health needs of women and girls. UNICEF tracks two indicators related to gender-based policies in connection with UNICEF's Gender Action Plan. In 2016, thanks to efforts by UNICEF and members of the United Nations Country Teams such as the United Nations Population Fund, 91 countries, against a target of 89, had plans with budgets to reduce adolescent pregnancy, which represents significant progress from 2015 (84 countries). UNICEF continues to advocate for governments to take action on reducing child marriage and pregnancy because of the important relationship between the two in some contexts. The highest progress came from West and Central Africa (for instance Cameroon, Chad, Equatorial Guinea, the Niger and Togo) which elevated the prevention of adolescent pregnancy to a regional priority with considerable efforts from C4D and gender inputs. Thanks to flexible thematic funding, the Regional Office was able to provide technical support in this direction. In 2016, Cambodia, the Islamic Republic of Iran and the Bolivarian Republic of Venezuela also made headway.

The second policy indicator assesses whether countries produce an analysis of sex-differentiated infant and child mortality estimates. In 2016, 42 countries (against a target of 55) produced this analysis. For instance, Namibia conducted a secondary analysis of its Demographic Health Survey with a focus on gender and child mortality, which will be available for dissemination in 2017. It should be noted, however, that sex-disaggregated analysis of under-five mortality might not always be possible if household surveys or other data are not available.

Case Study: Harnessing the flexibility of thematic funds to strengthen health systems and community health services in the Democratic Republic of the Congo

Despite a wealth of natural resources, the Democratic Republic of the Congo is ranked 176th out 188 countries in the Human Development Report. As a result of a small fiscal space and protracted conflicts, systemic weaknesses in the health system persist, leading to some of the highest maternal and child mortality rates worldwide. Although the country made substantial progress in reducing its under-five mortality rate from 187 deaths per 1,000 births in 1990 to 98 in 2015, the MDG target of 62 was missed. Similarly, the maternal mortality ratio declined from 879 in 1990 to 693 in 2015, but the MDG target of 250 was not met.

The Democratic Republic of the Congo is UNICEF's largest health country programme. Much of the maternal and child mortality burden can be reduced through proven, multipronged interventions that include access to essential medicines, antenatal care, skilled attendants at birth, good nutrition, hygiene and the prevention of mother-to-child transmission of HIV.

To transform a fragile health system into a more resilient one, UNICEF scaled up the systemic approach to reduce maternal and child mortality. Under this approach, all identified deficiencies in the health system are addressed, namely, local availability of essential drugs, financial barriers to health, community participation and health services management. This was complemented by malaria and measles campaigns as well as health and nutrition interventions during emergencies to safeguard health gains. Thematic funds (unearmarked and therefore free of disease-specific funding constraints) are particularly well suited to sustain a holistic intervention that works across sectors to build a stronger health system. In 2016, UNICEF used US$6,896,568 in thematic funds generously provided by the Government of Sweden to that effect. The majority of funds were dedicated to health systems strengthening activities (38 per cent), followed by child health activities (25 per cent).

UNICEF leveraged strategic partnerships with the Global Fund to ensure the availability of essential drugs and commodities to treat children with malaria, pneumonia and diarrhoea within iCCM at the community level. UNICEF also scaled up the flagship 'family kit' approach, an innovative way of reducing maternal and child mortality through the delivery of free health kits under the umbrella of the MDGs 4 and 5 Acceleration Framework. Additionally, through Improved Monitoring for Action, health zones developed scorecards to monitor progress at the clinical and community levels.



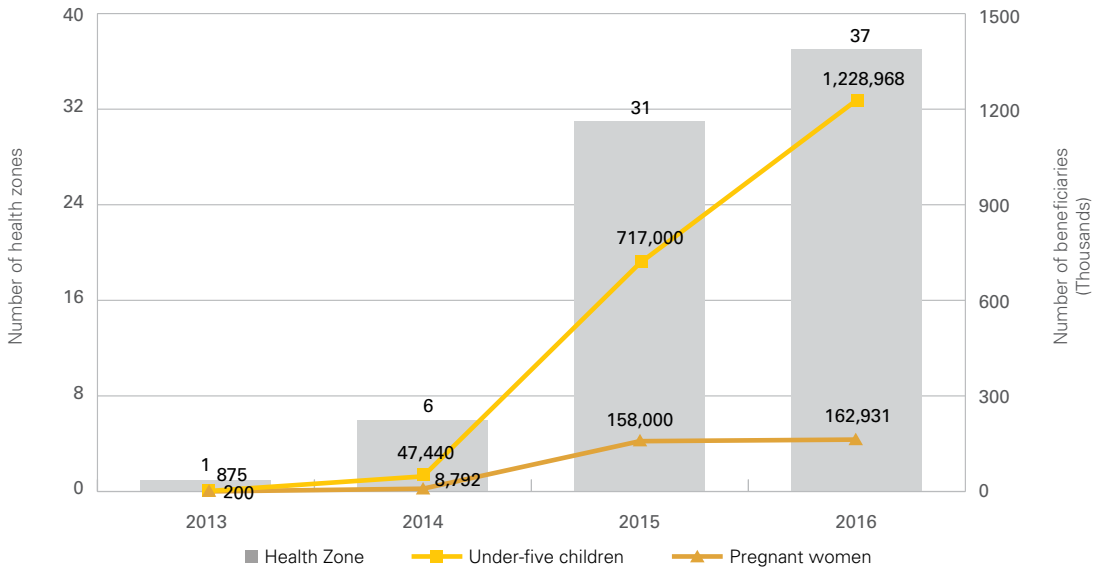
Beneficiaries of family kits.

Under the gradual scale-up of the systemic approach, 2.2 million family kits reached more than 1.2 million under-five children, and nearly 163,000 pregnant women in 37 health zones of 12 provinces. These kits help caregivers treat ill children at home and include a safe delivery kit for pregnant women to take to health centres. The number of health zones that distribute family kits grew from 1 in 2013 to 37 in 2016, increasing women's and children's access to essential services. Pneumonia case management was conducted in 129 health zones (up from 48), treating 143,000 children under 5 years old, compared with 10,000 in 2015, a 14-fold increase (*see Figure 10*).

In partnership with the Government of Sweden, the Global Fund and the Reproductive, Maternal, Newborn and Child Health Trust Fund, UNICEF scaled up the iCCM approach, including the supply of amoxicillin against pneumonia and oral rehydration therapy + zinc against diarrhoea in targeted health zones. To accelerate reductions in mother-to-child transmission of HIV, UNICEF scaled up the delivery of Option B+ in more than 400 health zones, with support from the Global Fund and the President's Emergency Plan for AIDS Relief.

FIGURE 10

Number of health zones distributing family kits and number of beneficiaries, 2013–2016



Source: UNICEF Democratic Republic of the Congo, 2016

Much progress was achieved in monitoring activities. As of 2016 and with UNICEF support, all 516 health zones fully completed scorecards under Improved Monitoring for Action. Completed annually, the scorecard is designed to improve strategic decision-making at national and provincial levels, and strengthens decision-makers' political commitment and accountability. At the operational level, the scorecard allows health zones team members to review and redirect planning to improve the effective coverage of reproductive, maternal, newborn, child and adolescent health high-impact interventions. These scorecards have helped identify and analyse critical systemic bottlenecks in the areas of supply, demand and quality (*see Table 9*).

Thanks to mass campaigns in 2016, more than 10.9 million children were vaccinated against measles in 17 out of 26 provinces. In addition, a campaign in Sud Ubangi Province facilitated the distribution of 1,664,000 long-lasting insecticidal nets to 3.2 million people.

In humanitarian settings, 51,323 children with severe acute malnutrition were treated in 713 health centres, with a cure rate of 84 per cent. In addition, 351,029 children were vaccinated during measles outbreaks, and UNICEF provided 5.8 million doses of yellow fever vaccine during the yellow fever outbreak of 2016.

Community-based organizations were essential in generating demand for services and monitoring family practices at the household level. Scorecards underpinned planning, implementation and course correction. UNICEF is building on the lessons learned from using scorecards by supporting governments develop scorecards on reproductive, maternal, newborn, child and adolescent health to monitor, report and manage progress.

The positive results seen in the past three years in the Democratic Republic of the Congo will most likely be confirmed by the 2017 Multiple Indicator Cluster Survey. Several activities will be scaled up, such as the distribution of family kits, iCCM, community-based nutrition projects and immunization. UNICEF and partners are looking into better articulating development and humanitarian funding streams in order to ensure continuity of health services, in particular when humanitarian assistance ends. Additional thematic funding would help save more lives in the Democratic Republic of the Congo.

TABLE 9

Example of a scorecard for high-impact intervention, Improved Monitoring for Action session – February 2016 – Haut-Katanga Province

Dashboard			Clinical Interventions													Community-Based Interventions								
Determinant	Acceptable lower coverage	Project goal	1. Skilled attendant	2. Essential newborn care	3. Focused ANC	4. Focused ANC-malaria	5. PMTCT	6. Family planning	7. Curative care	8. Immunization	9. IMAC	10. Pneumonia	11. Diarrhoea	12. Malaria	13. Malaria (Supplementary)	1. Exclusive breastfeeding	2. Complementary feeding	3. Diarrhoea (ORS/Zinc)	4. Fever care seeking?	5. Handwashing	6. LLINs 0-11 months	7. LLINs 0-59 months	8. Hygienic toilets	9. Birth registration
Commodity availability	50%	80%	57%	55%	62%	10%	57%	38%	51%	69%	26%	51%	63%	76%	14%	81%	81%	86%	31%	84%	84%	84%	84%	73%
Human resources availability	50%	80%	49%	48%	87%	88%	57%	47%	52%	85%	37%	48%	48%	48%	48%	65%	65%	100%	63%	74%	84%	84%	74%	100%
Geographic access	50%	80%	84%	84%	85%	85%	44%	85%	86%	86%	86%	85%	85%	85%	85%	19%	13%	77%	89%	32%	12%	11%	83%	55%
First use*	40%	70%	69%	28%	49%	49%	68%	47%	19%	42%	44%	11%	2%	6%	6%	18%	10%	89%	35%	73%	11%	7%	77%	33%
Adequate coverage	40%	70%	59%	25%	11%	29%	61%	85%	16%	35%	35%	10%	2%	6%	6%	8%	8%	50%	35%	64%	10%	7%	66%	27%
Quality (effective coverage)	40%	70%	8%	13%	3%	5%	17%	2%	4%	7%	17%	4%	0%	2%	2%	8%	1%	0%	2%	9%	2%	0%	3%	10%
Ownership*	40%	70%														3%	1%	0%	0%	9%	2%	0%	0%	4%

Source: UNICEF Democratic Republic of the Congo, 2016

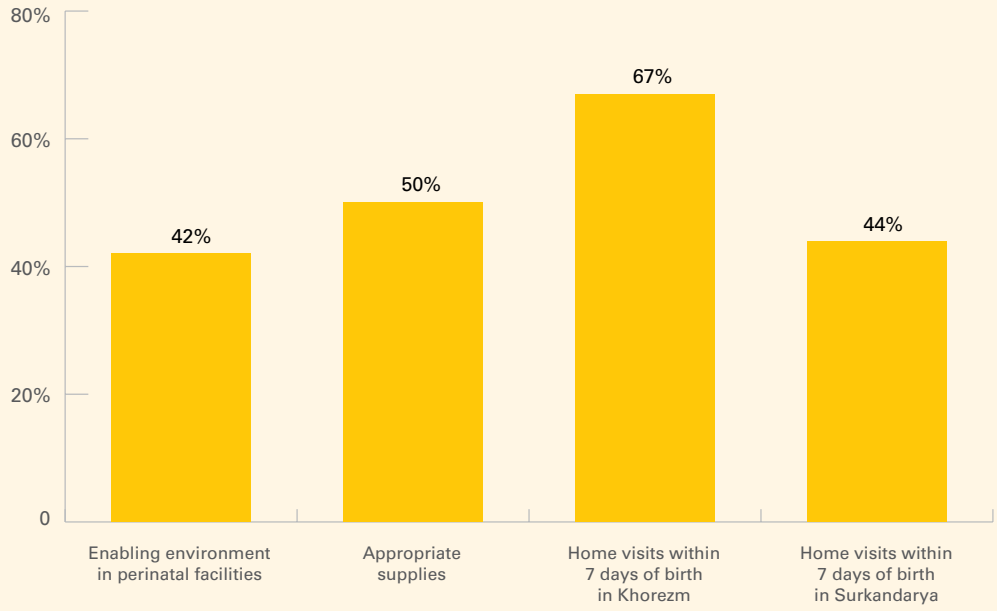
Note: First use refers to the first time a beneficiary uses health services (clinical level) or adopts healthy practices (community level). Ownership refers to target recipients of community interventions who then promote proper practices to others.

UNICEF supports the Government of Uzbekistan with bottleneck analysis

In order to support evidence-based planning to improve the health system at subnational level, also known as district health systems strengthening, UNICEF supported the Ministry of Health and regional health authorities to identify system bottlenecks in two of the most deprived regions of the country (Khorezm and Surkandarya) in order to improve the quality and coverage of maternal, neonatal and child health interventions.

Because very few perinatal facilities have an environment conducive to quality care, service management in perinatal centres and maternity departments at the district level requires exceptional attention. Similarly, the supply side bottlenecks are particularly severe at primary health-care facilities providing paediatric care. Few mothers benefit from a home visiting programme, leaving them without adequate follow-up care.

FIGURE 11
Identified bottlenecks in health facilities in Uzbekistan, 2016



Source: UNICEF Uzbekistan, 2016

The assessment showed the need to improve the quality of integrated supervision at both outpatient and inpatient levels and to ensure the continuity of quality health care. The results of the assessment were presented and discussed in targeted regions and helped raise the awareness of 300 health managers of the main bottlenecks. The way forward was discussed as part of a district health systems strengthening modelling exercise.



This infant holds much more than a pendant. He is grasping his digital medical record which can be scanned to inform a health worker about which vaccine he is due for at his next health visit.

Innovations amplify results

UNICEF is committed to strengthening government capacity in health through the development of innovations that are adapted to and scalable in local contexts. In 2016, UNICEF made headway with exciting innovations to help local governments deliver greater results in maternal and child health.

Khushi Baby is a mobile app that interfaces with a digital necklace equipped with a Near Field Communication chip to record medical histories. Currently, the app is used to track the spectrum of maternal and child health care from pregnancy to two years after birth. Through a wearable medical history, community health workers can track health progress more efficiently and accurately than with the paper form. Khushi Baby's platform also extends into a dashboard for decision-making by district health officials. Combining GPS, biometrics, due lists, high risk alerts, automated data quality checks and automated voice call reminders, Khushi Baby ensures the data are both actionable and accountable.

Khushi Baby's first randomized controlled trial demonstrated that the pendant generated high satisfaction and discussion among mothers who attended immunization camps. Statistically significant results showed that mothers were better able to retain their child's vaccine record in the wearable form than the paper card. In 2016, Khushi Baby concluded two years of qualitative field research and tracked 15,000 vaccinations to arrive at a culturally appropriate solution for mother, nurse and administrator alike. The first government partnership was established with the Udaipur District Health Society in India, and a phased launch across 300 villages (tracking 30,000 mothers and their children) will be completed in 2017. The Office of Innovation and UNICEF India are working with Khushi Baby and the Ministry of Health to revitalize its national mobile health technology (mHealth) strategy around maternal and child health tracking. This collaboration represents a tangible opportunity to scale up the Khushi Baby's platform across India. UNICEF is also exploring expansion opportunities in Africa for 2018.

Khushi Baby goes well beyond the digitization of medical records: it generates discussions and excitement in villages around child health while empowering health workers to deliver the best care to the last mile. The necklace's visibility is a clarion call to families and communities who are empowered to adopt the health-care-seeking behaviours that save lives to ensure no mother or child gets left behind.

RapidPro is the UNICEF Innovation open-source tool that allows two-way communication by text messaging to provide governments and communities with more real-time health information. In Zambia, UNICEF intensified support for the MomConnect Help Desk linked with the RapidPro/CasePro technology. The SMS-based programme reached more than 1 million pregnant women in 2016. The programme shares information throughout the antenatal care and post-natal period by sending antenatal care reminders and messages on early testing and treatment among HIV-positive mothers, nutrition, hygiene and

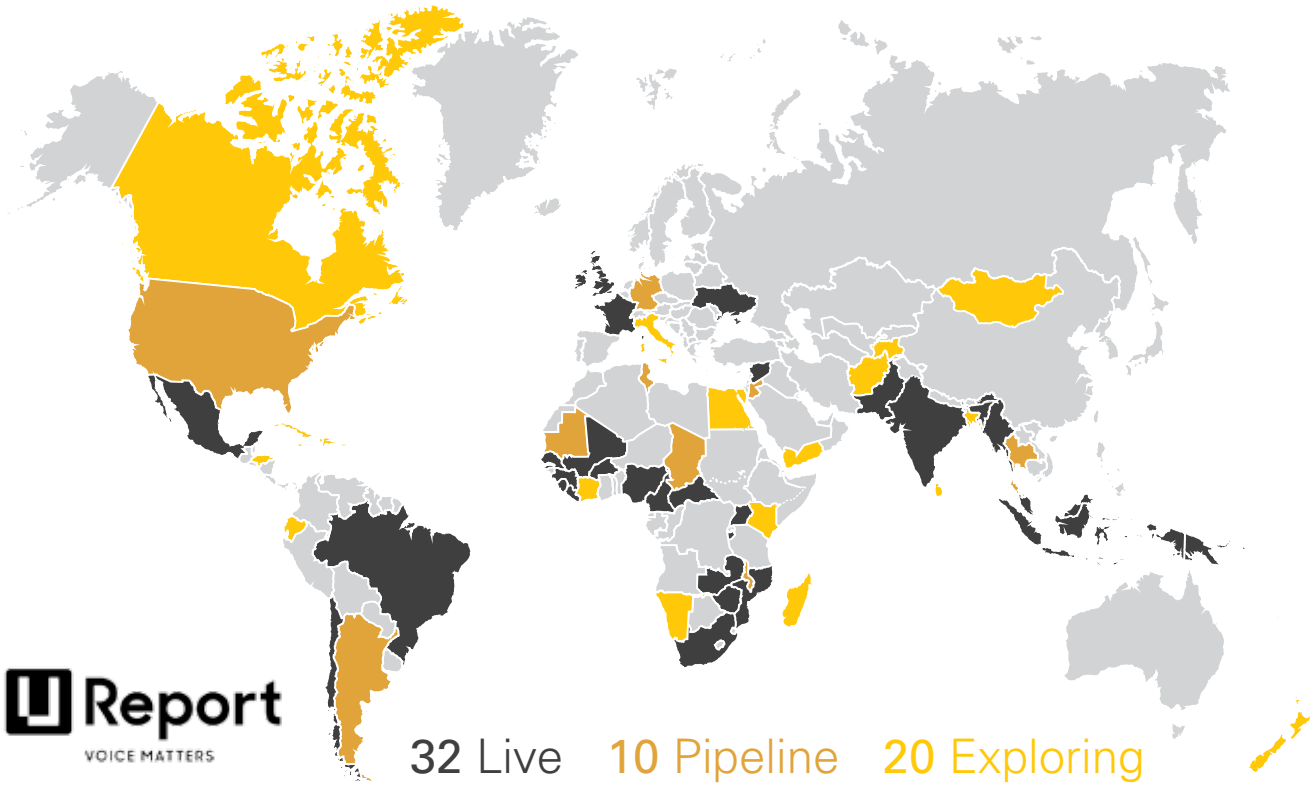
immunization. In addition, RapidPro pilots have been deployed in support of health programming across the 1,000 days of a child's life in 10 countries.

UNICEF continued to expand platforms that generate data in real time to help governments provide faster and better-targeted responses in the health sector. With more than 3 million active users in more than 30 countries in 2016, U-Report has become an important way for young people to make their voices heard, shape the health agenda and participate in their communities and countries. Initially available only on SMS, it is now also available through Facebook Messenger (*see Figures 12 and 13*).

Much in the way that U-Report was used during the Ebola crisis, the tool was activated in a regional approach by the Zika Cell in the Latin America and Caribbean region. Initial polls showed a low-risk perception and gaps in knowledge on the Zika virus in the region. The world's first virtual Zika Information Centre run by bot technology and a number of polls was launched by UNICEF to provide correct information on Zika, including symptoms, modes of transmission from both mosquito and sexual contacts, and the impact of the virus on babies. Boosting prevention called for easy access to Zika-related information. In this regard, potential users can directly access the Zika Information Centre and are then asked to register as U-Reporters. Users who indicate that they (or their partner) are pregnant or wishing to become pregnant receive specific follow-up information, as pregnant women are a priority group in UNICEF's Zika response. UNICEF is in the process of scaling up the Centre and adapting it to local contexts – for instance, in El Salvador and Guatemala – and refining it through U-Reporter feedback.

The Zika Cell also used U-Report with a series of Knowledge, Attitudes and Practice studies to identify gaps in communication strategies (both mass communication and C4D strategies) in the four priority countries – Dominican Republic, El Salvador, Guatemala and Honduras. This poll (http://ureport.in/poll/1708/) highlights that many more U-Reporters received information on how to prevent mosquito bites than on sexual transmission of the Zika virus. While there was no gender difference in receipt of information around mosquito transmission, far fewer male U-Reporters reported receiving information on sexual transmission than female U-Reporters. Identifying these gaps has helped UNICEF define audiences and more effective communication strategies to strengthen the prevention of Zika virus transmission.

FIGURE 12
U-Report around the world



Source: UNICEF Office of Innovation, 2016

FIGURE 13

Zika prevention on U-Report Global



Source: Zika prevention on U-Report Global, 2016

Building government capacity through South-South cooperation

South-South cooperation is one of the core strategies UNICEF employs to implement its Strategic Plan at headquarters, regional and country office levels through opportunities for multi-country exchanges on thematic issues and fostering collaboration. In 2016, UNICEF further explored bilateral China-Africa cooperation to promote maternal, child and newborn health under the China-Africa Engagement Strategy. This is an innovative model of partnership in which UNICEF acts as a broker helping direct China's bilateral aid resources for the benefit of children in Africa, without raising funds directly for UNICEF. Under UNICEF's leadership, the Democratic Republic of the Congo, Ethiopia, Kenya, the Niger, Nigeria, Sierra Leone, the Sudan and Zimbabwe discussed needs, bottlenecks and priorities for action with Chinese Ministries of Health. UNICEF's comparative advantage in the field of maternal, child and newborn health will ensure that these new funds can support new strategies or scale up evidence-based interventions. In addition, UNICEF can ensure that the cooperation takes place in the backdrop of increased domestic investments in the health sector to advance SDG results. The engagement will be coordinated through UNICEF China, with support from the Regional Offices in Africa.

Strengthening the capacity of governments and local actors to uphold their commitment to mothers and children, as shown by the varied examples above, requires

systemic changes to arrive at evidence-based, data-driven policymaking; also necessary are changes in the way health systems operate to serve those who are marginalized and hard to reach by concentrating on district and community health systems and working across sectors.

PROGRAMME AREA 3: EVIDENCE, ADVOCACY AND PARTNERSHIPS – ENHANCING GLOBAL AND REGIONAL CAPACITY TO ACCELERATE PROGRESS IN MATERNAL, NEWBORN AND CHILD HEALTH

UNICEF leadership role in strengthening the global health architecture: Working in partnership to achieve better and more equitable results

UNICEF remains an active member of the many global partnerships and initiatives that make up the global health architecture. In line with the Strategic Plan 2014–2017 Theory of Change, by engaging in partnerships, UNICEF strives to strengthen the coordination, efficiency and productivity of global processes to maximize national results.

UNICEF continues to support the Secretary-General's Global Strategy for Women's, Children's and Adolescent's Health (known as the Global Strategy), which is championed by the Every Woman Every Child initiative. Together with the Government of India and Partners in Population and Development, UNICEF produced the Operational Framework for the Global Strategy, which was formally launched at the World Health Assembly in May 2016. UNICEF also played a lead role in developing the monitoring framework for the Global Strategy and continued to co-lead the Every Woman Every Child Multisectoral Working Group.

The H6 serves as the technical implementing arm of the Global Strategy. In 2016, UNICEF chaired H6, a partnership comprised of the six United Nations entities responsible for health (UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank Group). The H6 is mandated to coordinate and deploy technical support, as requested by national governments and the in-country counterparts of each member agency. Under UNICEF's leadership in 2016, the H6 produced a results-oriented workplan and identified H6 focal points in more than half of the 75 high-burden priority

TABLE 10

2016 output results towards enhancing global and regional capacity to accelerate progress in maternal, newborn and child health

Output	Baseline	2016 target	2016 value	2017 target
Countries in which a maternal, neonatal and child health (MNCH) communication plan has been developed, budgeted and implemented	16	46	**50**	48
Countries in which all relevant (out of the 13) essential commodities are registered	45	53	**56**	57
Countries in which all relevant (out of the 13) essential commodities are registered and for which there are guidelines for use in facilities and communities	45	47	**53**	49
Countries with costed implementation plans for maternal, newborn and child health care	52	70	**65**	75
Countries in which a policy for home visits of newborns is developed and/or revised, adopted and in use	68	76	**71**	80
Countries for which a policy on focused antenatal care has been developed, adopted and implemented	99	113	**108**	120
Countries that monitor and produce a reproductive, maternal, newborn and child health (RMNCH) scorecard	44	54	**49**	59
Peer-reviewed journal or research publications by UNICEF on maternal, newborn, child or adolescent health	40	43	**43**	45
Countries that have conducted a launch of A Promise Renewed, followed by annual review	59	66	**48**	69

countries. UNICEF led the process for establishing the regional H6 coordination mechanism in the Middle East and North Africa region to support diverse and crisis-prone countries develop sound reproductive, maternal, neonatal, child and adolescent health programmes. In addition, UNICEF represented the H6 at the Every Woman Every Child High Level Advisory Group, emphasizing child health with a focus on the unfinished goals under the MDGs, adolescent health, ECD and humanitarian crises as top priorities for action.

As part of H6, UNICEF provided technical assistance to countries to access the Global Financing Facility, a multi-stakeholder initiative that helps eligible recipients develop costed investment strategies for reproductive, maternal, newborn, child and adolescent health and generate innovative funding sources for national RMNCAH priorities. UNICEF supports the efforts of the Global Financing Facility by helping governments prepare their investment cases. By applying EQUIST, an equity-focused tool developed by UNICEF to map, prioritize and allocate resources for reproductive, maternal, newborn, child and adolescent health priorities, UNICEF helped countries analyse maternal and child health outcomes by geographic context and socio-economic status and worked with governments to create a needs-based strategy for resource allocations. In 2016, UNICEF applied EQUIST to support the preparation of Global Financing Facility investment cases in Cameroon, the Democratic Republic of the Congo, Kenya, Mozambique and Uganda. Myanmar, Senegal and possibly Bangladesh plan to follow the same approach, with technical support from UNICEF, in 2017.

This past year saw the transformation of one of UNICEF's major global health initiatives, A Promise Renewed, which is a global effort to end preventable child deaths. Launched in 2012 by the Governments of Ethiopia, India and the United States, the initiative aimed to accelerate national progress towards MDG 4 by supporting government-led efforts to sharpen national reproductive, maternal, newborn, child and adolescent health strategies.

UNICEF continues to support national and regional efforts towards A Promise Renewed, notably by helping governments develop and implement national reproductive, maternal, newborn, child and adolescent health scorecards. In 2016, 49 countries (target 54) produced and monitored a scorecard. Sierra Leone, for instance, had a scorecard before the Ebola outbreak, and is now restarting this process to monitor its progress post-Ebola. The Dominican Republic, Honduras, Peru and Yemen have all started a scorecard in 2016. Since the shift to Every Woman Every Child at the global level, progress at country and regional levels on A Promise Renewed is being voluntarily reported. In 2016, 48 countries (target 66) reported A Promise Renewed launch or review.

In Latin America and the Caribbean, an inter-agency coordination body called A Promise Renewed for the Americas (APR-LAC) has been actively advocating for the reduction of inequities in health, through evidence generation (such as the UNICEF-led 2016 Health Equity report) and capacity building for equity measurement in selected countries.

UNICEF remains engaged in numerous global partnerships dedicated to specific aspects of reproductive, maternal, newborn, child and adolescent health, supporting the technical, advocacy and operational aspects of their various programmes.

In collaboration with Gavi, UNICEF coordinated technical assistance to 58 countries as part of Gavi's Partnership Engagement Framework, which aims to promote a bottom-up, country-centric approach to planning national immunization programmes. This new model provides UNICEF with an opportunity to scale up technical capacity at the global, regional and country levels.

UNICEF also remains a close partner of the Global Polio Eradication Initiative and Every Mother Every Newborn (UNICEF co-chaired the Working Group in 2016), the Global Health Data Collaborative, the Partnership for Maternal, Newborn & Child Health and the Measles and Rubella Initiative.

In most partnerships, UNICEF provides strategic leadership, implementation oversight and technical inputs, as is the case with partnerships such as the global iCCM Task Force, the iCCM Financing Task Team, the Diarrhoea/Pneumonia Working Group, the Interagency Task Team for the elimination of mother-to-child transmission of HIV, and the Start Free, Stay Free, AIDS Free partnership for the post-elimination of mother-to-child transmission era.

Partnerships also constitute a critical component of UNICEF's emergency response. In 2016, UNICEF worked with the Global Taskforce for Cholera Control, the Global Outbreak Alert and Response Network and the Global Health Cluster, which strengthened collaboration and coordination across global agencies, produced technical guidance, and facilitated access to surge capacity to improve the health response in humanitarian and crisis settings. In addition, effective coordination with WHO, the Centers for Disease Control and Prevention and other partners allowed UNICEF to provide coordinated support in health emergencies.

New partnerships forged in 2016 include new coalitions with the tuberculosis and maternal and child health programmes within WHO, USAID, Save the Children and others. To boost results for maternal, neonatal and child survival, research contracts were developed with the International Centre for Diarrhoeal Disease Research (Bangladesh), the Novrongo Research Centre (Ghana) and the National Institute of Medical Research (the United Republic of Tanzania). Collaborations were established with Johns Hopkins University in the United States and the Cundill Centre for Child and Adolescent Mental Health in Canada. In addition, partnerships were developed on EQUIST, in particular with the World Bank, WHO, USAID,

as well as public health institutions such as the Institute for Health Metrics and Evaluation (IHME), The Hospital for Sick Children (SickKids), University of Pelotas, focusing on synergy and complementarity of tools and approaches in the SDG framework and coherent country partnerships. UNICEF health section continues to explore partnership with the private sector in areas of maternal, newborn and child health with a particular focus on innovative approaches.

Resource mobilization and advocacy

UNICEF leveraged more than US$100 million for community health systems through the Global Fund, USAID, Gavi and other donors. UNICEF's work in enhancing equity and community demand in immunizations allowed it to raise an additional US$4.2 million grant from the Bill & Melinda Gates Foundation to carry out this work over the next four years. In addition, the Prince Alwaleed Philanthropies (a new resource partner) provided a US$10 million per year grant over five years towards measles elimination.

In 2016, UNICEF developed a strategy to position polio eradication more strongly in the global health agenda, emphasizing the links to universal health coverage and global health security. UNICEF's Polio Programme improved its positioning within the European Union market and beyond, with Italy and Korea pledging US$4 million. In total, US$486 million were raised in 2016 for the Global Polio Eradication Initiative, including pledges for UNICEF's Polio Eradication Programme.

The Maternal and Neonatal Tetanus Elimination Partners meeting was successfully held in 2016 to galvanize partners and intensify resource mobilization. Technical partners have strengthened collaboration through the newly constituted Strategic Advisory Group of Experts Working Group to accelerate efforts and achieve maternal and neonatal tetanus elimination. Partnership agreements with key private-sector resource partners were renewed to help leverage US$5 million per year from P&G Pampers and Kiwanis international, with the goal of raising US$42 million by the end of 2020.

UNICEF's prominent role in procurement and supply for children's health

UNICEF plays an important role in building the capacity of governments' procurement and logistics systems, particularly through strengthened supply chain management of vaccines and commodities. In 2016, UNICEF's Supply Division hosted a study visit from Zimbabwe's Ministry of Health and the National Pharmaceutical Company (Central Medical Stores) and similar visits from Ethiopia and Senegal. The Supply Division led a consultation with the chief executive officers of Central Medical Stores/Directors of National Supply Chains from Ethiopia, Kenya, Nigeria, Malawi and Zambia, to share country-level challenges in managing health commodities and strengthening the supply chain in the context of health system strengthening.

Around the world, UNICEF's health interventions are sustained by the dedication of its Supply Division. In 2016, the total global value of procurement was US$3.519 billion, which included US$1.73 billion procurement services to governments, Gavi, United Nations agencies, the Global Fund, non-governmental organizations, international funding agencies, the World Bank and other development banks. The value of health-related supplies was US$2.183 billion. In 2016, UNICEF remained the largest supplier of vaccines and procured 2.5 billion doses of vaccines for 95 countries to a value of $1.643 billion (which includes procurement services to governments and partners), reaching 45 per cent of the under five children globally. As the largest buyer of vaccines, UNICEF continues to play a lead role in shaping the vaccine market, ensuring fair prices and sustainability so greater numbers of children can benefit from life-saving vaccinations. In 2016, UNICEF met its supply outcome target to reduce the price of a complete schedule of childhood vaccines to US$18 per child, and to bring the price of pentavalent vaccine to less than US$1 a dose – half of the prevailing price.

Among the efforts to strengthen immunization coverage and equity, UNICEF played an active role in helping countries access the Cold Chain Equipment Optimization Platform, Gavi's dedicated channel to financial resources to improve cold chain equipment. In 2016, UNICEF helped Cameroon, the Democratic Republic of the Congo, Haiti, Kenya, Madagascar, the Niger, Pakistan, South Sudan, Uganda and Uzbekistan prepare and submit their application to Gavi to improve their cold chains. In addition, UNICEF procured cold chain equipment to a value of US$32.7 million to strengthen the supply chain.

Essential medicines are an integral part of expanding universal health coverage under SDG 3.8.[20] UNICEF's Strategic Plan monitors the number of countries that properly register the 13 essential medicines identified by the UN Commission on Life-Saving Commodities for Women and Children and the availability of guidelines for their use. In 2016, 56 countries registered these essential commodities, exceeding the 53 target. Additionally, 53 countries had guidelines for their use in facilities and communities (above the 47 target). As an example of procurement of essential commodities, in 2016 UNICEF procured 142,827 kilograms of assorted amoxicillin, of which 80,491 kilograms were child-friendly formulations equivalent to 32.2 million treatments for children under age one for childhood pneumonia (27.9 million treatments of amoxicillin dispersible tablets and 4.3 million treatments of amoxicillin oral suspension).

UNICEF supplied malaria-related commodities to reduce mortality from this major killer disease. UNICEF procured 20.4 million malaria rapid diagnostic tests, 20.16 million



An airlift of urgent medical and other supplies from UNICEF is unloaded at Sana'a International Airport, as the conflict in Yemen continues to exact a heavy toll on children and their families.

artemisinin-based combination therapy malaria treatments; and more than 41 million long-lasting insecticidal nets for 325.34 incountries in 2016. In addition, UNICEF procured co-packaged oral rehydration salts/zinc diarrhoea treatment kits in 26 countries (which is more than double from 2015), meeting a 2016 supply outcome target.

Lastly, UNICEF hosted the first Zika virus industry meeting drawing participants from 34 vaccine and diagnostic equipment companies, partners and donors. Together with WHO and the Pan American Health Organization, UNICEF also designed an advance purchase commitment of US$10 million funded by USAID. This pull mechanism will accelerate the development of a Zika virus diagnostic device.

Evidence generation

In 2016, UNICEF produced two major reports entitled *One is Too Many: Ending child deaths from pneumonia and diarrhoea and Clear the Air for Children*. These reports serve as high-level advocacy documents that provide the evidence necessary to compel all stakeholders, including policymakers, to protect children's health, particularly in the context of climate change and its negative consequences.

To support in-country programming against pneumonia, a four-country study demonstrated that service providers and caregivers alike were satisfied with the new user-friendly amoxicillin product presentations (dispersible tablets and oral suspension), which led to improvements in services and treatment uptake against pneumonia. A dissemination of these findings is planned in 2017.

In 2016, UNICEF-generated evidence related to maternal, newborn and child health met the target of 43 peer-reviewed publications. While this is less than the 76 publications in 2015, that year was particularly high, as there was a UNICEF-sponsored special supplement in the Ethiopian Medical Journal on iCCM. Not including the special supplement, UNICEF has made steady progress since 2014, remaining on-target for improving UNICEF contributions to peer-reviewed evidence on and for children. At headquarters, UNICEF published an additional 36 peer-reviewed papers, which also substantially contributed to UNICEF programming evidence for children. UNICEF's goal for this Strategic Plan period is to continue to build UNICEF as an evidence-based organization.

Among the peer-reviewed papers, articles on iCCM demonstrated that high-impact child health interventions implemented within a community-based delivery platform can lead to significant reductions in child mortality.

Several studies and evaluations provide the findings that will help inform UNICEF's future work on strengthening community health systems to advance maternal and child health under the SDGs.

In Latin America, studies included the *Health Equity Report 2016, Violence against Children in Latin America and Caribbean Countries: A Comprehensive Review of National Health Sector Efforts in Prevention and Response*, and the *Child Health and Poverty Equity Gap Reduction in Latin America* regional report. In the Middle East and North Africa region, the flagship report *Progress for Children with Equity in the Middle East and North Africa* will draw the baseline against child-related indicators for the SDGs in the region. In Eastern and Southern Africa, published studies included a study on the determinants of child mortality reduction and linkages between the community-based approach, health systems strengthening and health service utilization,

The effects of climate change and environmental degradation on children, with potential solutions

Climate change and environmental degradation – heatwaves, droughts and floods which are increasing in frequency and intensity – seriously impact children's health, especially the most marginalized. Paradoxically, as developing countries are asked to embark on low-carbon development in order to reduce greenhouse gas emissions, many children in those countries have little to no access to modern energy services in the first place. Energy is required in health facilities, to operate at night, sterilize equipment and store vaccines. Finally, over-reliance on biomass such as firewood, or fossil fuels such as coal for cooking and heating results in poor ventilation and leads to poor indoor air quality, which is especially harmful to children who spend a relatively large amount of time indoors. For example, almost 50 per cent of pneumonia deaths among children under 5 years old are found to be due to particulate matter inhaled from indoor air pollution, and there is evidence of linkages to a series of other health issues, including low birthweight, tuberculosis, ischemic heart disease, as well as nasopharyngeal and laryngeal cancers.

Impact on children

- Increase in temperatures can lead to increase in malaria, infectious diseases and even death from heat waves/cold spells.
- More floods will lead to more child deaths.
- Droughts lead to loss of crops and livestock, which can contribute to malnutrition.
- An increase in water- and vector-borne diseases makes children sick.
- During climate-related disasters, access to health services is affected.
- Children are increasingly exposed to chemicals and microbes (e.g., heavy metals, pesticides) in water, air, food and soil, which affect not only child mortality but also early childhood development, potentially resulting in long-term damage.
- Forest fires due to slash-and-burn practices in agriculture lead to increased air pollution, affecting those closest to the fires.

Solutions to protect children's health

- Build climate/flood-resilient health facilities.
- Scale up the use of clean cook stoves.
- Provide sustainable energy in health facilities.
- Grow climate-resilient crops.
- Provide solar energy for heating/cooling.
- Improved water/waste management.

and on operational research and best practices in scaling up evidence-based facility and community-based reproductive, maternal, newborn and child health services and delivery models.

An external evaluation of the three-year project on pneumonia and diarrhoea treatment scale-up in four sub-Saharan countries – supported by the Department of Foreign Affairs, Trade and Development – showed increases in (1) the level of awareness for childhood diarrhoea and pneumonia, (2) demand for appropriate treatments among providers and caregivers, and (3) the number of children under 5 years old treated for diarrhoea and pneumonia.

In 2016, UNICEF completed data collection to build case studies in Bangladesh, the three Ebola-affected countries (Guinea, Liberia and Sierra Leone) and South Sudan, on community health in emergencies. This is generating important evidence-based knowledge for risk-informed and resilient child health programming.

Because cross-sector work is crucial in catalysing results for health, a systematic review of social determinants of child health was undertaken. The study confirmed the paucity of evidence for specific interventions and policies outside of the health sector, except in the case of WASH and nutrition. Background papers were prepared for the attention of policymakers and academics, highlighting the importance of multisectoral actions for health.

The evidence base was further strengthened by the publication of policy briefs, technical guidelines and working papers, including, for instance, the interoperability of civil registration and vital statistics and health systems, WASH in health facilities, and emergency obstetric care.

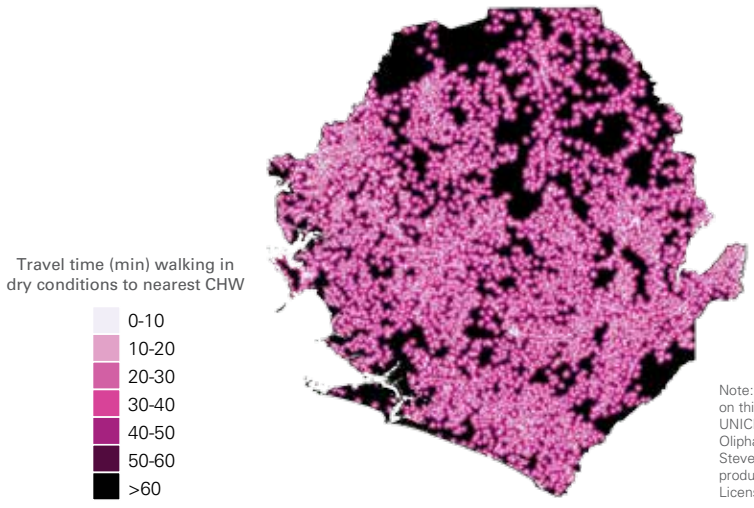
Evidence and health-related advocacy at the global level aim to drive in-country policy change. In 2016, maternal and newborn health plans and policies benched against UNICEF's Strategic Plan indicators showed progress in the area of C4D, with 50 countries having developed, budgeted and implemented a maternal, newborn and child health communication plan (surpassing the 46 target). The number of countries with costed implementation plans for maternal, newborn and child health care stood at 65 (target 70). In addition, 108 countries developed, adopted and implemented a policy focused on antenatal care (slightly below the 113 target). In 71 countries, a policy for home visits of newborns was developed and/or revised, adopted and in use, with progress in Burkina Faso.

UNICEF generates evidence to put community health workers on the map

The Ebola outbreak in 2014 and 2015 underscored that health gains could rapidly erode in the absence of a resilient health system. Because community health workers are critical to building robust, responsive and resilient health systems, UNICEF sought to obtain essential background characteristics about such workers and spatial data to optimize the geographic deployment of the workers based on population health needs and epidemiology. UNICEF, in collaboration with Ministries of Health, conducted the first national georeferenced censuses of community health workers in Liberia, Malawi, the Niger and Sierra Leone.

In Sierra Leone, for instance, the mapping of 14,622 community health workers showed that about 80 per cent of such workers are literate; 70 per cent have attained secondary education, 65 per cent of them are male, and 55 per cent of the population were within 1 kilometre of a community health worker (*see Figure 14*). The Sierra Leone Ministry of Health is using the data to review the national community health worker policy, reduce the high rates of stockouts, and prepare for the integration of community health worker volunteers into the formal health system, including the national human resource management tool. In all countries, the mapping provided the data necessary to inform situation analysis, policies and programmes towards achieving universal health coverage.

FIGURE 14
Travel time to community health workers by walking (in minutes), Sierra Leone, 2016



Note: Boundaries and names shown and the designations used on this map do not imply endorsement or acceptance by UNICEF or the United Nations. Analysis and map by NP Oliphant. Acknowledgements to Nicolas Ray, Fred Mosei, and Steve Ebener for use of AccessMod5 to model travel time. Map produced using QGIS 2.18.6 under the GNU General Public License (http://www.gnu.org/liceses)

Source: UNICEF/MOHS Sierra Leone, 2016



Health workers supported by UNICEF and the Directorate of Health visit 14-day old Muhannad and his mother in their shelter in Debaga displacement camp in Erbil Governorate, Kurdistan Region of Iraq.

New agenda and emerging areas of work

Under the Health Strategy 2016–2030, UNICEF is turning its attention to the prevention of non-communicable diseases and associated risk factors (in particular overweight and obesity). In 2016, UNICEF's Latin America and Caribbean Regional Office created an internal coordination group on non-communicable diseases, and prepared the first global proposal in this area. In addition, UNICEF spearheaded a review of labelling regulations and practices for food and beverages, targeting children and adolescents in the region. UNICEF has also begun working with Ministries of Health to develop national strategies against non-communicable diseases (Uruguay) and helped galvanize policymakers in Argentina to relaunch the National Health and Nutrition Survey after a 12-year hiatus. In the area of strategic representation, UNICEF is an active member of the Interagency Task Force on the Prevention and Control of Non-communicable Diseases (led by WHO), which reports to the United Nations Economic and Social Council.

In the CEE/CIS region, UNICEF is pursuing strategic engagement aimed at system-level changes, including the development of policies and financing models to produce greater results. UNICEF is also investing in the 'child and adolescent well-being' pillar of the Strategy for Health, notably through the prevention of adolescent suicide and disability from injuries.

Constraints and challenges

In 2016, insecurity continued to hamper access to the most vulnerable children and women, in particular in fragile and humanitarian settings, presenting a real challenge in implementing the equity agenda. In the context of intensified conflicts in which humanitarian aid staff and convoys were directly attacked, the ability to deliver life-saving interventions to those who needed them most was further curtailed. At the country level, dealing with repeated emergencies — from disease outbreaks to droughts and floods — can derail resilient programming towards broader development efforts.

Government health sectors remain constrained by insufficient technical capacity, high staff turnover and low health financing. Capacity at the subnational level is particularly weak. While greater efforts have been put forth to reduce the fragmentation of the global health architecture and the mushrooming of health initiatives, partnership management and inter-agency coordination are still weak in many countries limiting the benefits of working together on unified goals. Sustained advocacy will be necessary for governments to recognize the importance of multisector collaboration and overcome the challenges linked to its complex implementation. In addition, good-quality health data, disaggregated well enough to detect inequities and act upon them, are a persistent issue requiring further strengthening of local capacity.

Funding shortfalls have constrained UNICEF's ability to provide additional technical assistance and unequivocally impacted the ability to make further progress under its Strategic Plan in 2016. Among the many examples, the lack of funding has affected the scale-up of iCCM to combat leading childhood killer diseases and the ability to train a greater number of community health workers who are a vital link between children and life-saving treatments. The lack of funding has hampered much needed progress on the elimination of maternal and neonatal tetanus as the innovative Tetanus Toxoic Uniject could not be secured to reach marginalized women in hard-to-reach areas. Funding shortfalls have also limited progress to date on adolescent health work, posing a challenge in achieving results under the new Strategy for Health. Greater progress on maternal and newborn health will also require further investments.

Overall, the lack of unearmarked resources for health programming remains a major challenge. UNICEF's health systems strengthening approach is substantially underfunded, limiting UNICEF's capacity to develop and implement longer-term capacity strengthening programmes for sustainable results. Additional thematic funding is critical for UNICEF to make further progress on strengthening entire heath systems – away from disease-specific funding constraints, thereby bringing proven life-saving interventions to the women and children who need them most – and supporting integrated delivery packages that are increasingly required to meet the ambitious SDGs.



A young cholera patient receives treatment at a cholera treatment centre in Cap-Haïtien, Haiti.

CROSS-CUTTING AREAS NARRATIVE

UNICEF's health sector work is amplified by cross-cutting strategies that allow the organization to make greater gains in children's health outcomes. As is the case with all of UNICEF's work, the human-rights based approach, i.e., a framework of action rooted in international human rights norms and standards, underpins all of the cross-cutting efforts. All the achievements discussed in this subsection refer to 2016.

Gender

All of UNICEF's work on gender is defined by the Gender Action Plan 2014-2017, which is aligned with UNICEF's Strategic Plan. UNICEF contributes to enhancing gender outcomes through actions such as strengthening maternal health – in particular for pregnant adolescent girls; advocating for more female community health workers and providing training to improve care-seeking and the adoption of essential healthy practices; working towards increasing the introduction of HPV vaccination to protect young girls against cervical cancer; and strengthening gender-responsive adolescent health, including strategies to reduce adolescent pregnancy and anaemia, and for the prevention of HIV and female genital mutilation/cutting. Mainstreaming gender in programming is a critical step in creating health systems that can address gender-based discrimination and the specific health needs of women and girls. In health, gender mainstreaming is measured by two strategic indicators. The first indicator monitors the number of countries that have plans and budgets allocated to reduce adolescent pregnancy, as adolescent health is a specific and targeted priority within the Gender Action Plan. The second indicator assesses whether countries produce an analysis of sex-differentiated infant and child mortality estimates (*see Programme Area 2 for results on these two indicators*).

UNICEF's new Strategy for Health 2016–2030 reaffirms the importance of strengthening services for adolescent girls who are pregnant or have already delivered one or more children and reducing adolescent pregnancy and associated risks. In line with this strategy, and to build gender-based equity in health, UNICEF works with governments, civil society organizations, community leaders, and most importantly, adolescents themselves, to design meaningful programmes, plans, and policies aimed at not only sensitizing adolescents on why delaying pregnancy is a smart investment, but also empowering them. Under the new strategy, UNICEF will increasingly work to make HPV vaccinations available to a greater number of adolescent girls as a critical way to prevent cervical cancer.

Communication for Development

In addition to the C4D work previously described, UNICEF developed a set of C4D indicators for health that were disseminated to regional and country offices to improve the analysis of cross-cutting programming. These included C4D quality benchmarks to monitor the extent to which offices are using globally accepted standards for quality C4D implementation. This is an important development to help offices use quality C4D interventions more systematically in health. In addition, UNICEF's C4D section co-authored a paper in the journal *Global Health: Science and Practice* on UNICEF's lessons learned in the Ebola response. These lessons were crucial in understanding that social mobilization and communication need to be placed at the centre of interventions, even in the case of emergency response programming.

Early childhood development

UNICEF continues to generate evidence on the importance of ECD. For instance, the ECD *Lancet* series proposes pathways to implement ECD at scale. Entitled 'From Science to Scale', the series emphasizes 'nurturing care', especially of children younger than 3 years of age, and presents analysis on affordable programmable interventions, impact and the cost of inaction to scale up evidence-driven policy and programme formulation.

UNICEF's ECD Matrix, through technical engagement, created the first-ever mapping of sectoral interventions that could be combined into multisectoral programme packages to support young child development (including health, growth and learning). For instance, the UNICEF West and Central Africa Regional Office operationalized the regional priority on child growth and development.

In the CEE/CIS region, UNICEF has been leading a Young Child Health, Development and Well-Being initiative focusing on child development for children age 0 to 3 years. Under this programme, UNICEF's work is centred on a strategy aiming to build the capacity of health home visitors who can then provide child development information and support to all families and enhanced support and/or referrals to health and other services for families with identified needs. UNICEF addresses a range of risk factors in the young child's environment – from harsh discipline to maternal depression – that could compromise the health, development and well-being of young children. In this regard, UNICEF has developed a set of regional recommendations and training resource

modules. A number of countries in the CEE/CIS region are using these materials to operationalize their Young Child Health, Development and Well-Being programmes. In Serbia, for example, nine primary health-care centres finalized ECD capacity-building programmes. With improved ECD services, 80 trained paediatricians reached 5,500 children, (including 1,334 Roma children), while 90 trained nurses reached 10,050 families, out of which 4,191 were Roma. UNICEF's regional ECD capacity-building package for visiting nurses will be fully adapted to the Serbian context in 2017.

Adolescent development and participation

Until recently, the adolescent agenda has not adequately responded to adolescent health priorities and needs. UNICEF is well poised to broaden the adolescent health agenda to include issues such as adolescent nutrition, mental health, non-communicable diseases and prevention of injuries. Countries will be supported to design and deliver quality services for adolescent health and nutrition – including menstrual hygiene management, HIV prevention and treatment, undernutrition and over-nutrition, mental health and HPV – using the most appropriate existing platforms such as health centres, schools and community settings. Other key strategies will include community and adolescent engagement to promote positive social norms and empower adolescents through information and skills to make healthy choices and influence decisions relating to their well-being.

UNICEF is actively engaged in generating new evidence on adolescent neuropsychological development. Discoveries about the adolescent brain provide an opportunity to strengthen programming. A compendium of papers summarizing presentations from an Adolescent Neuroscience Symposium was finalized in 2016 and practical guidance is being prepared to support country offices in 2017. UNICEF also launched a research initiative to develop a global framework for the measurement of adolescent participation. A literature review was completed and a conceptual framework is being developed jointly with partners and will be supported by tools that can be used for both advocacy and measurement in 2017.

Under UNICEF's Strategy for Health 2016–2030, engagement in the second decade of life will take a more prominent place in programmes and interventions. Generating data and evidence on adolescent health is an important step in designing quality interventions and providing a base for policy and advocacy. In China, UNICEF supported a stakeholder analysis on adolescent health that informed the development of the National Adolescent Health and Development Strategy. In Argentina, UNICEF is supporting the study on Policy Review, Financing and Structure of Adolescent Health Programmes. This will provide evidence and a baseline about the relation between adolescents and the health system.

Disability

To realize its equity agenda, UNICEF ensures that children with disabilities are included at all levels so they may benefit from programmes, including health that can help them reach their full potential. In-country, UNICEF leverages the health system as an entry point to identify children with disabilities, provide early intervention and ensure access to mainstream services.

In Tajikistan, UNICEF supported the Ministry of Health and Social Protection in initiating collaborative work among different stakeholders to establish a functional service delivery system to improve coverage and quality of early detection and intervention for children with developmental delays and disabilities. The multi-stakeholder working group, consisting of governmental and non-governmental partners, reviewed existing screening tools and instruments and adapted some of them to the context of Tajikistan. The group conducted a mapping exercise of existing projects and available resources at the community level to support the introduction of early detection and early intervention services for girls and boys with disabilities.

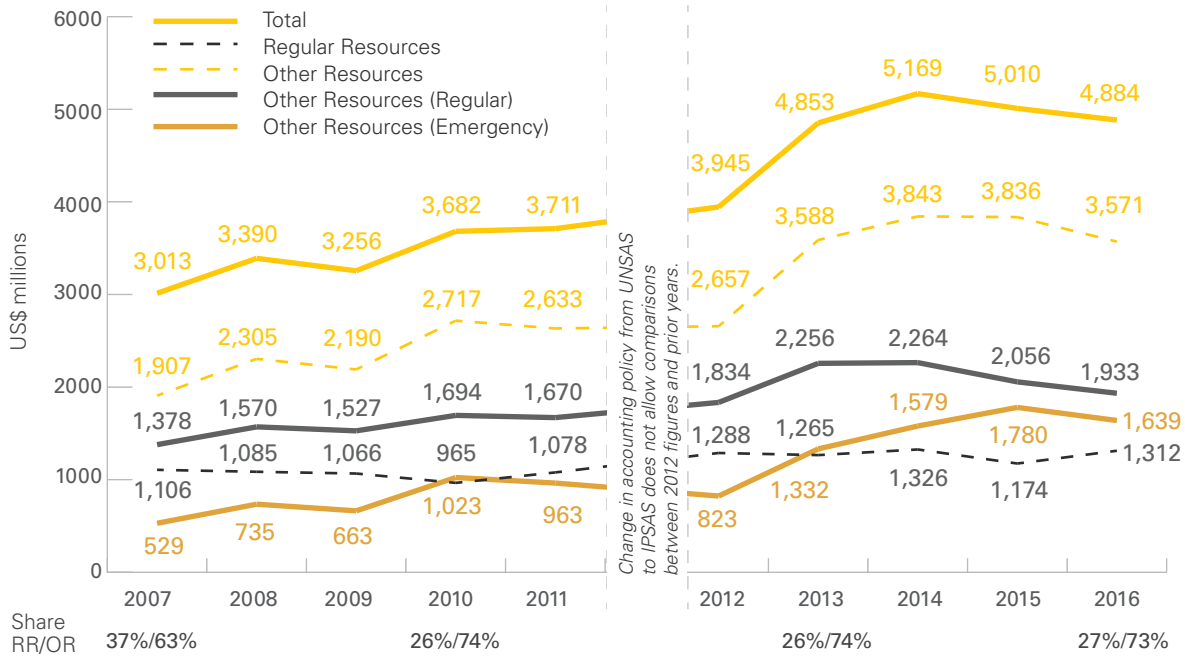
In the Philippines, through technical assistance, UNICEF supported PhilHealth in developing a nationwide health insurance package for children with disabilities, reaching an estimated 5 million beneficiaries in 2016. This innovative package is comprehensive, evidence-based and equity-focused, enabling families to provide the necessary care for children with disabilities. It offers social support as well as services related to hearing, eyesight-related disabilities and physical disability.

FINANCIAL ANALYSIS

The 2030 Agenda for Sustainable Development envisions a world that invests in its children, recognizing the need to mobilize financial resources and commitment from partners for the achievement of its Goals.

For UNICEF specifically, the SDGs agenda has highlighted the increasing importance of its flexible funding modalities, but also the consequences of the unpredictability and volatility of thematic funding to the health area of work. Regular resources, which are un-earmarked and unrestricted funds allocated to deliver programmes on the basis of formulas and appeals prescribed by the Executive Board, play a vital role in maintaining programme continuity in inequitable and fragile contexts, as well as building preparedness and resilience to future shocks. Of the close to $4.9 billion that UNICEF received in 2016, US$1.3 billion (27 per cent) were regular resources. This 12 per cent increase over 2015 was due to growth in contributions from individual giving (US$629 million compared with US$530 million in 2015), as well as a sizeable one-time increase from the Government of Sweden, which contributed US$117 million, 87 per cent more than the previous year. This was second only to the Government of the United States, which contributed US$132.5 million.[21]

FIGURE 15
Regular resources share by resource partner category, 2007–2016



Regular resources: Un-earmarked funds that are foundational to deliver results across the Strategic Plan.

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

Other resources – regular: Funds for specific, nonemergency programme purposes and strategic priorities.

Other resources – emergency: Earmarked funds for specific humanitarian action and post-crisis recovery activities.

All revenue data as of 3 April 2017.

FIGURE 16
Other resource revenue, 2009-2016: Thematic versus non-thematic (US$)

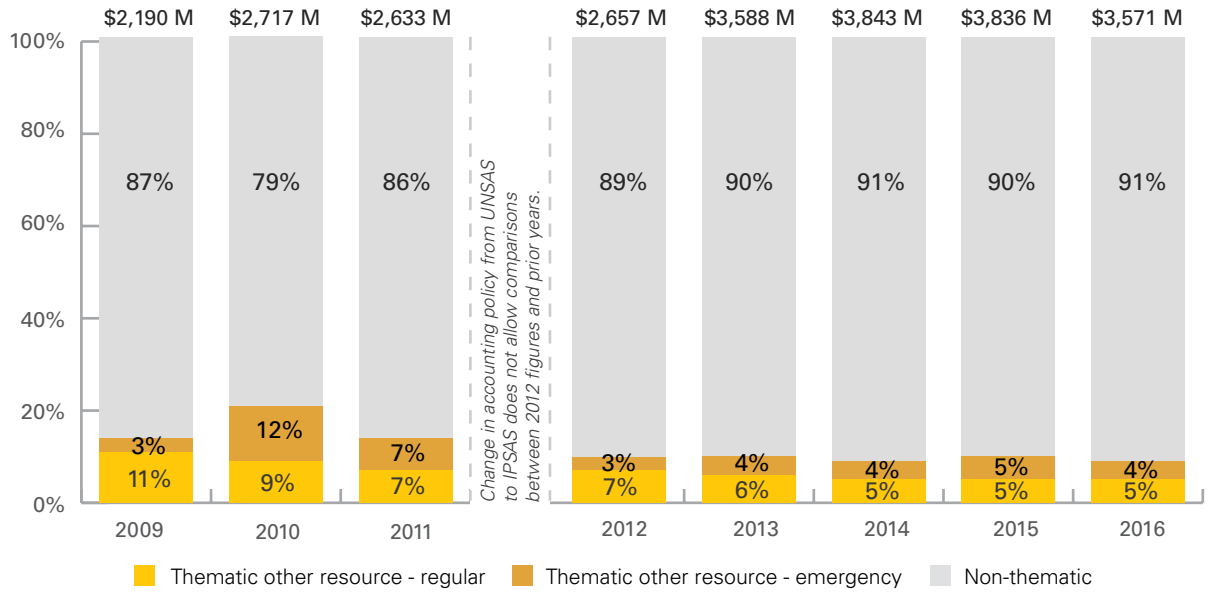


FIGURE 17
Health other resources funding trend, 2014–2016

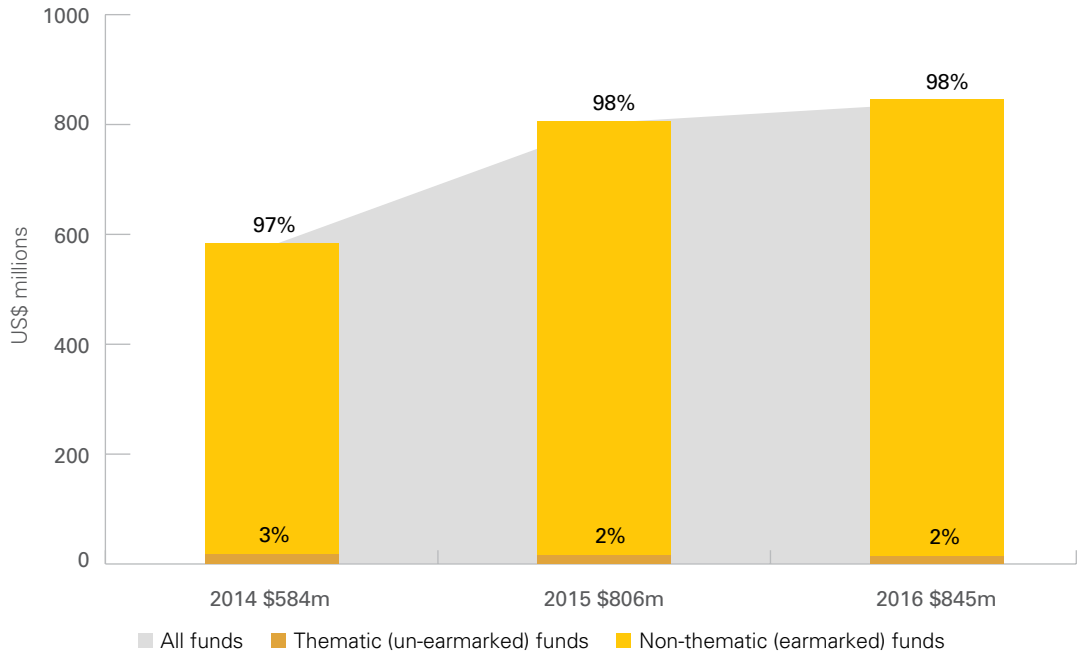


TABLE 11

Top 20 resource partners to health, 2016*

Rank	Resource Partners	Total (US$)
1	United States Fund for UNICEF	191,342,649
2	The United Kingdom	90,045,605
3	European Commission	61,822,186
4	Gavi	52,679,608
5	Canada	46,225,025
6	Japan	45,080,540
7	United States of America	41,090,603
8	The Global Fund to Fight Aids, Tuberculosis and Malaria	22,443,165
9	Germany	21,937,013
10	UNICEF Mexico	20,000,000
11	Joint Programmes managed by UNICEF as an Administrative Agent*	17,690,319
12	Republic of Korea	15,490,517
13	WHO	10,555,427
14	UNICEF Saudi Arabia	10,005,929
15	Central Emergency Response Fund (UN)	9,234,767
16	Swedish Committee for UNICEF	8,635,803
17	Sweden	8,364,684
18	Pooled Fund contributions (UNFPA)	7,157,515
19	The Micronutrient Initiative	6,925,729
20	German Committee for UNICEF	6,616,181

** Figures include financial adjustments.*

*** Cross-sectoral fund for Health and Nutrition (SC120327).*

Contributions made by donors earmarked to a specific programme or thematic area, including multi-year funding, decreased by seven per cent over 2015 to US$3.6 billion in 2016. Contributions to the nine thematic funding pools dropped to US$326 million, a 16 per cent decrease from the previous year. Of those, funds softly earmarked for humanitarian action against appeals was US$145.4 million, a 29 per cent decrease from 2015, despite growing humanitarian needs. This specific funding mechanism is a vital complement to regular resources, often used to address inequities that the allocation of regular resources is not able to address. Thematic funding is also used to build capacities of countries, partners and UNICEF to mitigate the impact of, and respond to, current and future emergencies, bridging development and humanitarian work.

In 2016, UNICEF received US$845 million in other resources for health, a 5 per cent increase from the previous year (*see Figure 17*). The top five resource partners in this area of UNICEF's work included the United States Fund for UNICEF, the Government of the United Kingdom, the European Commission, Gavi and the Government of The top three contributions included support from the United States Fund for UNICEF to the work of the Global Polio Eradication Initiative, and from the Carlos Slim Foundation for polio activities in Mexico.

TABLE 12

Top 10 contributions to health, 2016*

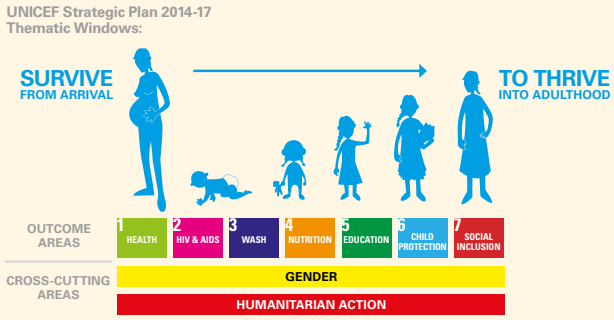
Rank	Resource Partners	Grant Description	Total (US$)
1	United States Fund for UNICEF	UNICEF Global Polio Eradication Initiative for 2016	37,495,783
2	United States Fund for UNICEF	Global Polio Eradication Initiative (GPEI), support for UNICEF staffing	21,996,475
3	UNICEF Mexico	Polio Activities, Mexico	20,000,000
4	The United Kingdom	Saving Lives in Sierra Leone, Sierra Leone	18,390,711
5	United States Fund for UNICEF	UNICEF Global Polio Eradication Initiative for 2015	17,950,000
6	Joint Programmes managed by UNICEF as an Administrative Agent	Joint Heath Nutrition Programme, Somalia**	17,690,319
7	European Commission	Health, Nigeria	15,884,115
8	The United Kingdom	Reduction of malaria-, pneumonia-, diarrhoea-related morbidity, Uganda	15,481,185
9	Gavi	Health Systems Strenghening Programme (HSS), India	15,450,000
10	Japan	Project for Infectious Diseases Prevention for Children, Afghanistan	15,437,605

** Figures include financial adjustments.*

*** Cross-sectoral fund for Health and Nutrition (SC120327).*

The value of thematic funding

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



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

PARTNER TESTIMONIAL

With Sweden's priority on maternal and child health as well as on sexual and reproductive health and rights, UNICEF is a strategic partner to the Swedish International Development Cooperation Agency (Sida) – not only in scaling up coverage and quality of services for women, children and adolescents, but also for strengthening health systems in low-income countries. Sida has as a main priority an increased respect for human rights, including the rights of the child. As the United Nations agency with an operational mandate to implement the United Nations Convention on the Rights of the Child, UNICEF is uniquely positioned to use the resources of Sweden not only in long-term development cooperation, but also for its engagement in humanitarian action for children.

Thematic funding enhances effectiveness, as it enables UNICEF to reach the most excluded and most vulnerable children, as well as strengthens the ability to support long-term strategic activities. Through its flexibility, thematic funding also promotes innovation, sustainability and better coordination, and reduces transaction costs. Over the years, Sida's support to UNICEF has increasingly been channelled as thematic funding, reflecting Sida's confidence in UNICEF as an effective actor and strong advocate for the implementation of children's rights.

– Lennart Båge,
Assistant Director General of Swedish International Development Cooperation Agency

In 2016, UNICEF received US$13 million in thematic contributions for Health (*see Figure 18*), a 13 per cent decrease compared to 2015. Thematic contributions were only two per cent of total resources earmarked to health. Of thematic contributions to the sector, only $2 million (12 per cent) was given most flexibly as global thematic funding (*see Figure 19*).

Seventy-one per cent of thematic contributions received for health came from government partners (*see Table 13*). The Government of Sweden was the largest thematic resource partner, providing 65 per cent of all thematic contributions received, largely earmarked for the Democratic Republic of the Congo and the Plurinational State of Bolivia. The Government of Luxembourg provided global thematic funding, while the Government of Iceland earmarked its contribution to health in the State of Palestine.

FIGURE 18

Thematic revenue share by outcome area and humanitarian action, 2016: US$326.3 million

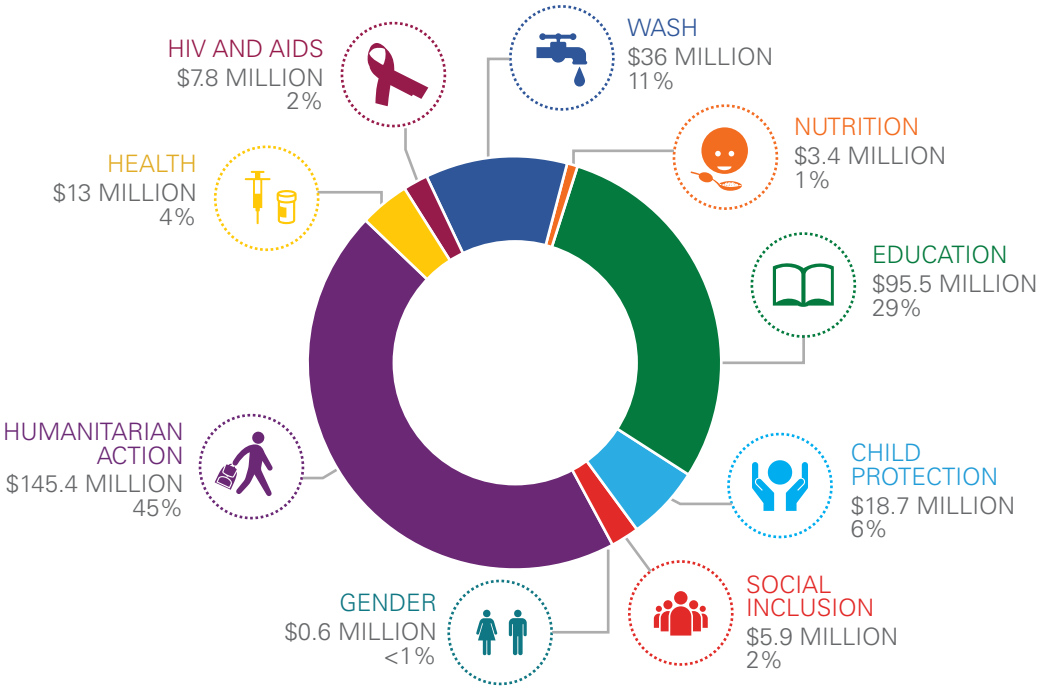
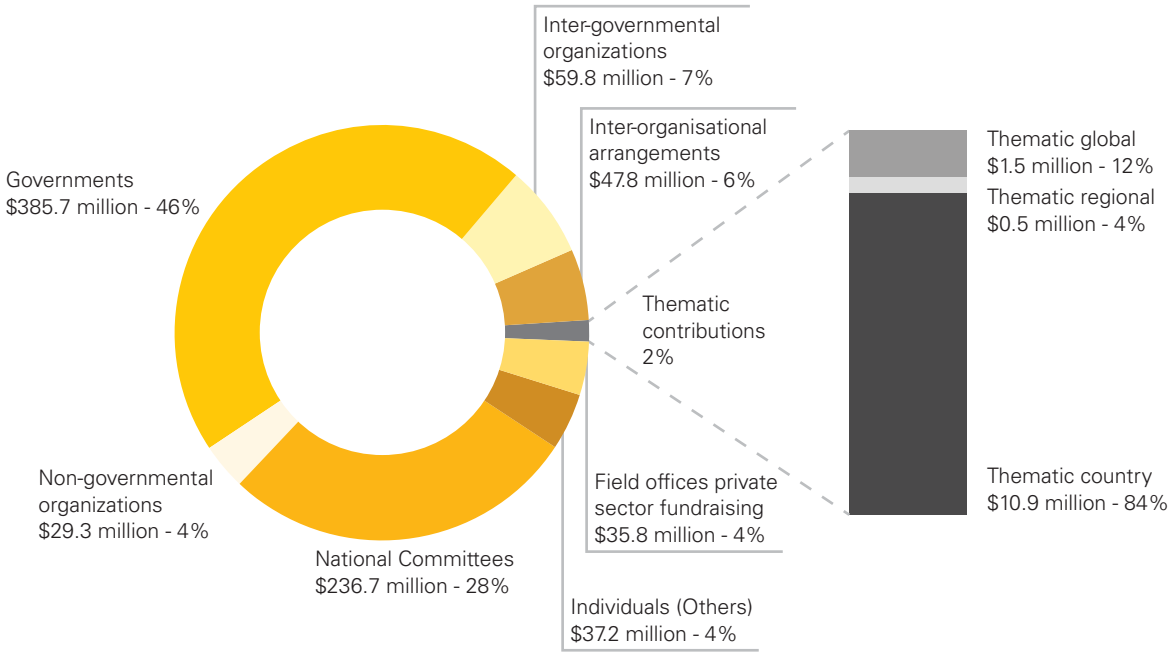


FIGURE 19

Other resources for health by funding modality and partner group, 2016: US$845 million*



** Figures include financial adjustments.*

Sizeable thematic contributions were received from the Italian Committee for UNICEF towards health in the West and Central Africa region and also as more flexible global thematic funding. The United Kingdom Committee for UNICEF, among others, provided a sizeable contribution for activities in Djibouti, while the Polish National Committee for UNICEF focused on global thematic funding as well as activities in Mali and Nepal. The Dutch Committee for UNICEF earmarked its thematic funding to health activities in Burkina Faso and the Republic of Tanzania, while the United States Fund for UNICEF and the Czech Committee for UNICEF provided global thematic funding, as well as earmarked contributions to Brazil, Haiti and Nepal, as well as Bhutan (*see Table 13*).

UNICEF is seeking to broaden and diversify its funding base (including thematic contributions). The number of partners contributing thematic funding to health increased to 23 in 2016 from 21 in 2015.

TABLE 13

Thematic revenue for health by resource partner, 2016*

Resource Partner Type	Resource Partner	Total (US$)	Percentage
Governments 71%	Sweden *(SC1499010030, SC1499010068)*	8,440,005	64.59%
	Luxembourg *(SC1499010050)*	661,376	5.06%
	Iceland *(SC1499010111)*	100,000	0.77%
National Committees 27%	Italian Committee for UNICEF *(SC1499010077, SC1499010078)*	976,286	7.47%
	United Kingdom Committee for UNICEF *(SC1499010055, SC1499010097, SC1499010116, SC1499010120, SC1499010121)*	663,605	5.08%
	Polish Committee for UNICEF *(SC1499010100, SC1499010101, SC1499010122, SC1499010124)*	436,693	3.34%
	Dutch Committee for UNICEF *(SC1499010080, SC1499010089)*	394,908	3.02%
	United States Fund for UNICEF *(SC1499010069, SC1499010104, SC1499010105, SC1499010115)*	229,253	1.75%
	Czech Committee for UNICEF *(SC1499010092, SC1499010114)*	226,995	1.74%
	French Committee for UNICEF *(SC1499010106, SC1499010108)*	179,063	1.37%
	Norwegian Committee for UNICEF *(SC1499010087)*	102,817	0.79%
	Luxembourg Committee for UNICEF *(SC1499010112)*	93,813	0.72%
	Slovenian Committee for UNICEF *(SC1499010085, SC1499010107)*	75,888	0.58%
	German Committee for UNICEF *(SC1499010103, SC1499010109)*	56,461	0.43%
	Lithuanian Committee for UNICEF *(SC1499010102, SC1499010126)*	46,674	0.36%
	Finnish Committee for UNICEF *(SC1499010123)*	15,074	0.12%
	New Zealand Committee for UNICEF *(SC1499010113)*	11,364	0.09%
	Japan Committee for UNICEF *(SC1499010110)*	10,363	0.08%
Field Offices PSFR 2%	UNICEF Malaysia *(SC1499010118)*	115,525	0.88%
	UNICEF Romania *(SC1499010125)*	106,183	0.81%
	UNICEF Indonesia *(SC1499010119)*	28,475	0.22%
	UNICEF Nepal *(SC1499010117)*	15,000	0.11%
	UNICEF Romania *(SC1499030047)*	81,406	0.62%
Grand Total		**13,067,226**	**100%**

** Figures include financial adjustments.*

Grant numbers are provided for IATI compliance.

Global thematic funds remain the most flexible source of funding to UNICEF after regular resources. The allocation and expense of thematic contributions can be monitored on UNICEF's transparency portal open.unicef.org; the results achieved with these funds against Executive Board-approved targets and indicators at country, regional and global level are consolidated and reported on across the suite of Annual Results Reports. Specific reporting for country and regional thematic contributions is provided separately for partners providing flexible multi-year thematic funding at those levels, and yet, only 2 per cent of total health contributions to UNICEF are thematic, and out of this small envelope, only 12 per cent are geographically unrestricted.

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



To realize children's rights to health, UNICEF allocated US$1.39 billion in 2016, including funds used in a cross-thematic manner or to cover operational and other costs. The health sector continued to hold the largest share of expenses at 27 per cent of all expenses across the seven outcome areas (*see Figure 20*) ahead of education (21 per cent) and WASH (19 per cent).

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 since they are aligned with cash disbursements and goods receipts (the way budgets are consumed).

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

Health expenses from regular resources stood at US$220 million, ahead of education and social protection at US$154 million each. Even though total expenses in the health sector grew from US$1.22 billion in 2014 to US$1.39 billion in 2016, regular resources (the most flexible type of resources) declined by US$28 million over the same period, totalling 16 per cent of expenses in 2016 and down from 20 per cent in 2014 (*see Table 14 and Figure 21*). This decline is explained by the fact that 1) regular resources have not grown in percentage terms, and 2) more regular resources were provided to the HIV and AIDS and nutrition sectors to compensate for the reduction of other resources (OR) to these areas of global health. It is important to note that resources for health have remained highly earmarked throughout the Strategic Plan period with a marked increase in expenses from ORR (other resources–regular) increasing from 56 per cent in 2015 to 64 per cent in 2016. The proportion of expenses from ORE (other resources–emergency) peaked at 26 per cent (US$338 million) in 2015 and decreased to 20 per cent (US$280 million) in 2016 *(see Figure 21)* reflecting the strong efforts that led to the control the Ebola outbreak in West Africa in 2015.

FIGURE 20
Expense by outcome area, 2016: US$5,094 million

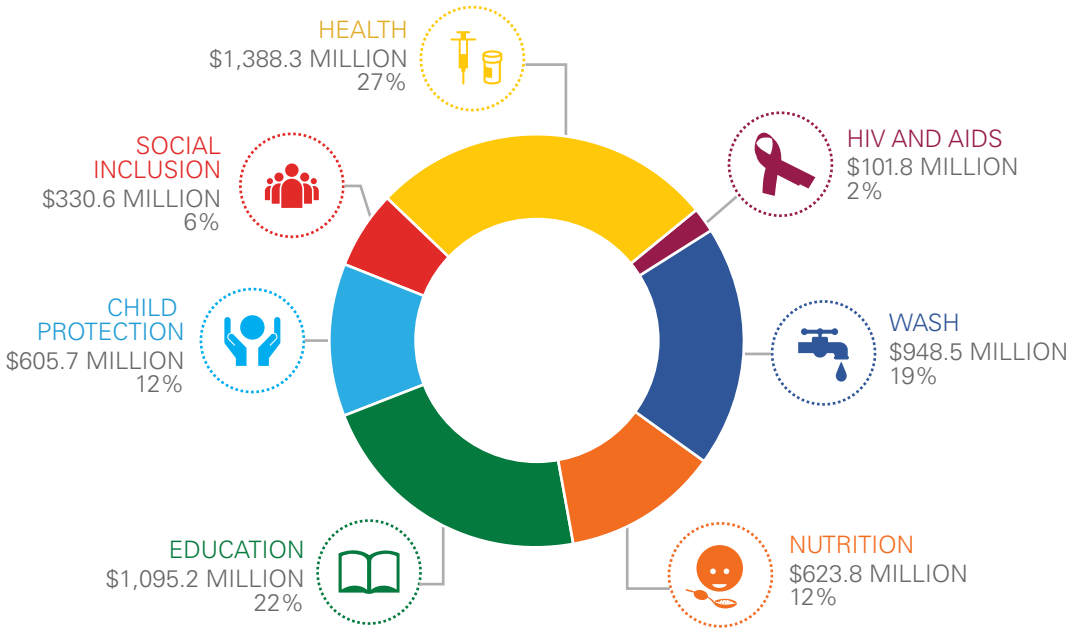
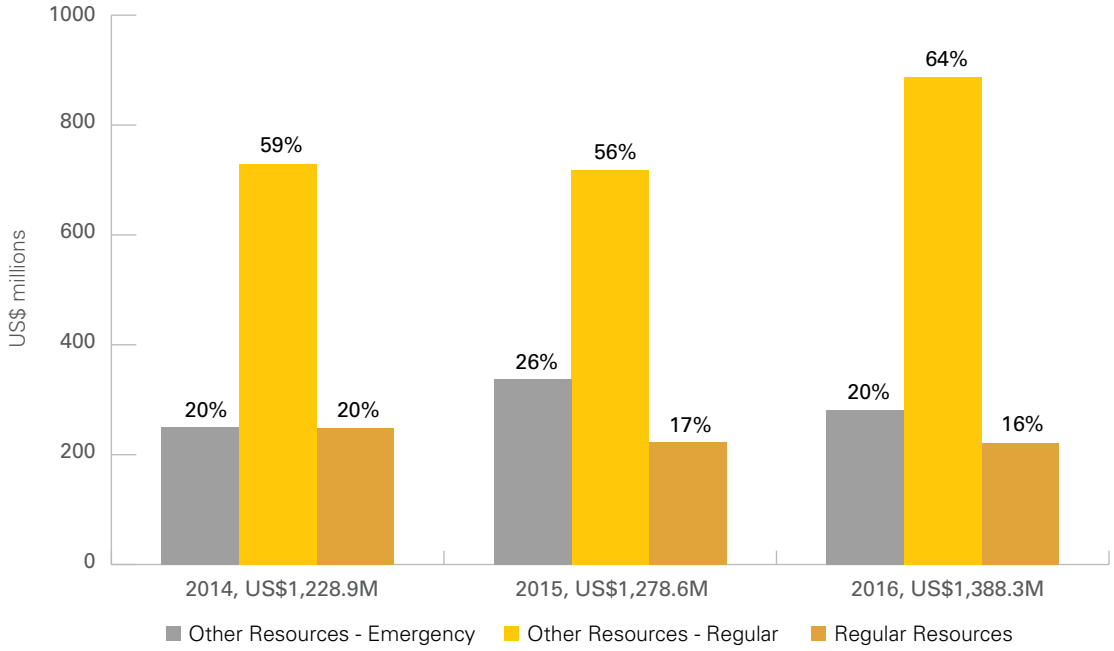


TABLE 14
Expenses for health, 2014–2016

	Other resources - emergency	Other resources - regular	Regular resources	Grand total
2014	250,129,359	729,517,594	249,330,250	1,228,977,204
2015	338,059,808	717,316,904	223,258,479	1,278,635,191
2016	280,879,081	886,551,487	220,885,223	1,388,315,792
Grand Total	**869,068,249**	**2,333,385,985**	**693,473,952**	**3,895,928,186**

FIGURE 21
Expenses for health by fund type, 2014–2016



Health spending varied by region based on investments required to reduce maternal and child mortality. Because sub-Saharan Africa is still shouldering the highest under-five and maternal mortality burdens, more than two-thirds of all health allocations in 2016 were spent there. West and Central Africa accounted for 36 per cent of expenses (US$493 million), while Eastern and Southern Africa accounted for 27 per cent (US$378 million). South Asia and the Middle East and North Africa accounted for 26 per cent expenses with 15 and 11 per cent or US$202 million and US$158 million respectively (*see Figure 22*). Although expenses from emergency resources supported programmes in all UNICEF regions, spending from this fund type was heavily concentrated in the Middle East and North Africa, at US$114 million (72 per cent of all expenses in the region) underscoring the scale and intensity of the humanitarian situation in the Syrian Arab Republic and neighbouring countries hosting Syrian refugees as well as the ongoing conflict in Yemen (*see Figure 23*).

FIGURE 22
Expenses for health by region, 2016: US$1.39 billion

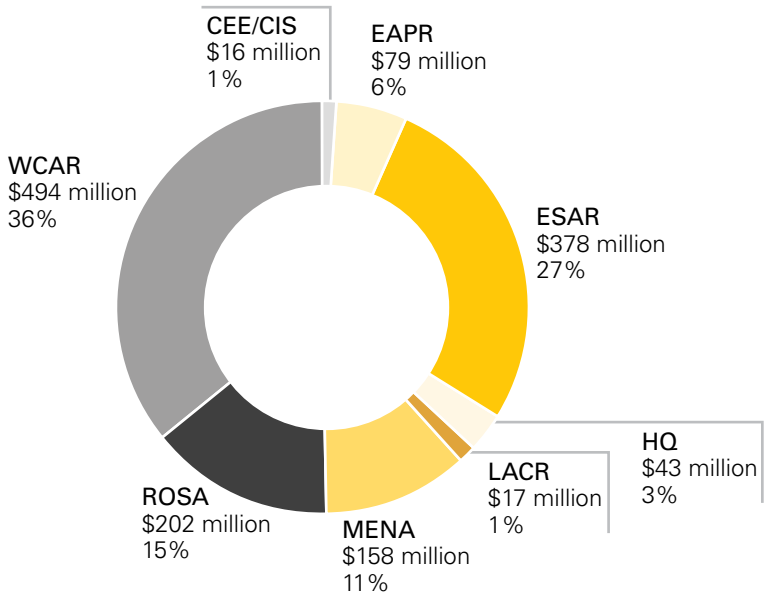
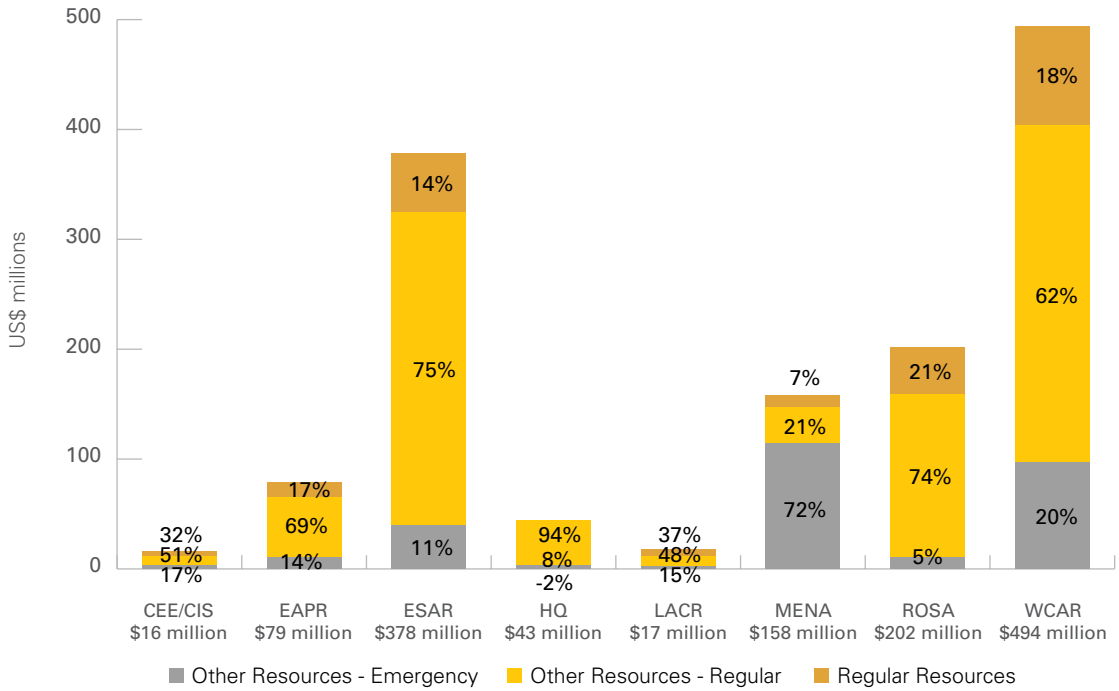


FIGURE 23
Expenses for health by region and funding type, 2016: $US 1.39 billion



The top 20 countries accounted for nearly US$948 million in health-sector expenses, or more than two-thirds of all health spending, with the top five countries making up a third of total health spending (US$470 million). The Democratic Republic of the Congo – a post-conflict fragile state – remains UNICEF's largest country programme for health. UNICEF continued to invest substantially in health systems strengthening in the country, with nearly US$143 million spent in 2016 (a 29 per cent increase from 2015). The second largest country programme was Nigeria at US$113 million with a 13 percent increase from 2015 to combat the resurgence of the wild poliovirus in 2016.

The most significant increase in expenses in a single country was seen in Pakistan with expenses jumping by 80 per cent to US$75 million in 2016, up from US$42 million in 2015. The majority of this increase was driven by spending of US$35 million on social mobilization and communication. Similarly, investments in Afghanistan increased by 44 per cent to reach US$65 million in 2016, up from US$45 million in 2015. Spending in 2016 reached US$26 million for polio eradication, US$11 million for social mobilization and communication, US$9.5 million for maternal and newborn health, US$6 million for health systems strengthening, and US$3 million for emergency preparedness. The country with the greatest decrease in expense compared with 2015 was Sierra Leone, which saw a drastic 51 per cent decline in expenses in 2016. While the country turned the tide against Ebola, a weak health system persists, warranting further support.

TABLE 15

Top 20 country or regional office expense for health, 2016 (US$)

Country	Other resources - emergency	Other resources - regular	Regular resources	Grand total
Democratic Republic of the Congo	32,309,989	84,708,531	25,945,689	142,964,209
Nigeria	4,362,155	86,003,785	23,239,678	113,605,618
Pakistan	3,152,489	57,961,196	13,509,707	74,623,392
Somalia	10,007,143	57,195,953	6,392,623	73,595,719
Afghanistan	91,649	54,122,593	10,586,820	64,801,062
Ethiopia	8,622,927	42,254,880	9,643,943	60,521,750
Zimbabwe	47,467	48,440,174	1,446,261	49,933,902
India	-128	25,499,400	14,879,100	40,378,372
Uganda	1,496,539	24,820,589	7,298,943	33,616,071
Sierra Leone	6,679,801	21,221,437	2,908,435	30,809,674
Kenya	1,408,085	26,500,121	1,863,344	29,771,550
Syrian Arab Republic	27,021,823	1,517,576	614,890	29,154,289
Guinea	17,954,618	7,231,176	2,312,402	27,498,195
South Sudan	12,512,160	12,884,141	2,034,421	27,430,721
Yemen	17,415,218	8,351,081	1,314,044	27,080,343
Chad	5,163,864	17,282,137	3,414,209	25,860,210
MENA, Jordan	21,278,151	2,310,708	1,866,515	25,455,373
Sudan	8,378,018	13,609,564	3,092,035	25,079,617
Lebanon	21,068,593	2,277,887	110,247	23,456,727
Democratic People's Republic of Korea	5,014,828	15,821,817	1,353,375	22,190,020
Total Top 20	**203,985,389**	**610,014,747**	**133,826,680**	**947,826,815**

By programme, immunization, a bedrock of UNICEF's health activities, accounted for the largest share of total expenses at 19 per cent (US$264 million) followed by polio eradication activities at 18 per cent (US$246 million) (*see Figure 24 and Table 16*). Expenses under the polio programme increased by 62 per cent between 2015 and 2016 to sustain efforts towards a polio-free world (*see Table 16*).

The child health programme saw expenses grow from US$164 million in 2014 to US223 million in 2016, a 36 per cent increase (*see Table 16*). This rise was largely driven by three countries with an additional US$16 million spent in Somalia between 2015 and 2016; an additional US$8 million in the Sudan, and an additional US$11 million in Uganda. Despite this increase, further investments in child health are required to meet the SDGs on child mortality reduction. Expenses related to maternal and newborn health declined by US$25 million between 2014 and 2015, and by US$4 million between 2015 and 2016, to total US$115 million in 2016 (*see Table 16*). Given the SDG focus on neonatal mortality reduction, this area of work clearly needs to be prioritized.

Expenses for health systems strengthening, an area of work that is increasingly central to UNICEF's work, totalled US$169 million in 2016, up from US$148 million in 2014 (*see Table 16)*. While this represents a 12 per cent increase over three years, this is still low in relation to what is required for UNICEF to successfully implement its paradigm shift towards a more holistic approach to health in support of the SDGs.

FIGURE 24
Expenses for health by programme area, 2016: US$ 1.39 billion

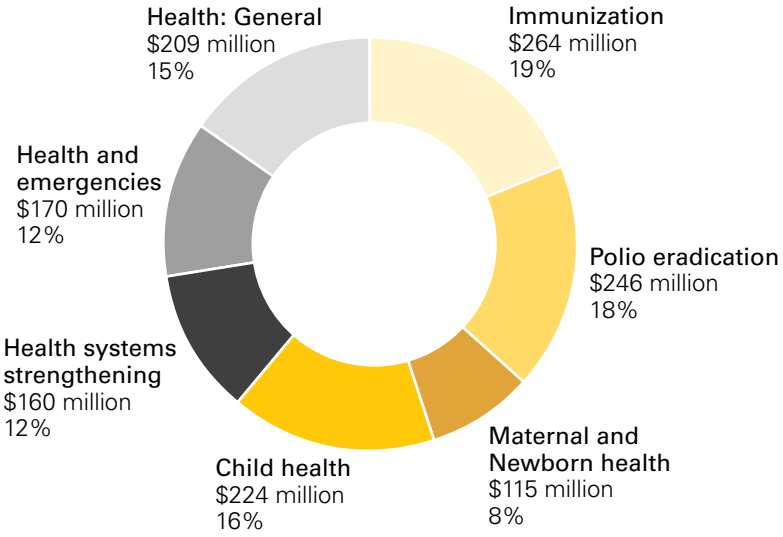


TABLE 16

Expenses for health by programme area, 2014–2016 (US$)

	Other resources - Emergency	Other resources - regular	Regular resources	Grand total
Immunization	**131,194,851**	**480,038,299**	**124,966,610**	**736,199,760**
2014	36,112,251	142,293,465	51,951,129	230,356,844
2015	52,317,446	152,759,685	36,662,161	241,739,292
2016	42,765,155	184,985,150	36,353,320	264,103,625
Polio eradication	**18,263,753**	**474,471,108**	**55,760,946**	**548,495,806**
2014	7,428,641	122,956,118	20,345,357	150,730,116
2015	6,536,807	133,066,877	12,222,036	151,825,720
2016	4,298,305	218,448,113	23,193,553	245,939,970
Maternal and newborn health	**51,818,941**	**246,433,803**	**81,228,459**	**379,481,203**
2014	21,647,231	95,632,975	27,054,070	144,334,275
2015	21,405,305	69,526,597	28,728,805	119,660,707
2016	8,766,406	81,274,232	25,445,583	115,486,221
Child health	**54,325,466**	**402,898,950**	**102,367,154**	**559,591,569**
2014	19,193,513	112,495,300	32,732,709	164,421,522
2015	13,596,297	126,956,784	30,956,519	171,509,600
2016	21,535,655	163,446,866	38,677,926	223,660,448
Health systems strengthening	**66,766,426**	**287,193,370**	**106,607,331**	**460,567,127**
2014	32,542,760	79,242,481	31,178,468	142,963,710
2015	17,570,159	98,469,922	41,146,995	157,187,076
2016	16,653,507	109,480,966	34,281,868	160,416,341
Health and emergencies	**436,978,812**	**43,942,900**	**58,719,137**	**539,640,849**
2014	108,464,436	18,792,696	20,977,421	148,234,553
2015	190,277,304	10,819,661	20,753,719	221,850,684
2016	138,237,071	14,330,543	16,987,998	169,555,612
Health, general	**109,720,000**	**398,407,555**	**163,824,315**	**671,951,871**
2014	24,740,527	158,104,560	65,091,097	247,936,184
2015	36,356,490	125,717,377	52,788,244	214,862,111
2016	48,622,983	114,585,618	45,944,975	209,153,575
Grand Total	**869,068,249**	**2,333,385,985**	**693,473,952**	**3,895,928,186**

By cost category in 2016, three quarters of health expenses were found under 'transfers and grants to counterparts' (US$430 million),'supplies and commodities' (US$427 million) and technical assistance (US$164 million) (*see Table 17*). The higher share of expenses in these three categories allows UNICEF to support counterparts in implementing high-impact health interventions to improve children's lives. General operating costs declined by 14 per cent over the Srategic Plan period and by 17 per cent between 2015 and 2016. Travel expenses have declined by 8 per cent between 2014 and 2016, while staff costs increased by only 1 per cent in the same period (*see Table 17*).

TABLE 17

Expenses by cost category and year for health, 2014-2016 (US$)

Cost Category	Other resources - emergency	Other resources - regular	Regular resources	Total
Contractual services	38,744,966	295,016,749	58,766,699	392,528,414
2014	8,467,370	78,042,283	15,116,251	101,625,903
2015	14,165,710	89,500,602	23,013,968	126,680,280
2016	16,111,886	127,473,864	20,636,481	164,222,230
Equipment, vehicles and furniture	2,962,553	3,907,806	8,320,115	15,190,473
2014	632,793	1,017,875	2,374,155	4,024,823
2015	1,400,367	1,240,893	3,024,625	5,665,884
2016	929,393	1,649,038	2,921,335	5,499,767
General operating and other direct costs	36,847,878	71,792,890	92,614,946	201,255,714
2014	11,154,825	24,776,020	33,640,410	69,571,255
2015	14,216,779	27,112,407	30,645,513	71,974,698
2016	11,476,274	19,904,464	28,329,023	59,709,761
Incremental indirect costs	58,835,427	160,992,087	-	219,827,514
2014	18,315,498	50,621,104		68,936,602
2015	22,827,127	51,244,746		74,071,873
2016	17,692,803	59,126,237	-	76,819,040
Staff and other personnel costs	83,466,351	273,447,169	221,709,381	578,622,901
2014	22,221,640	88,604,833	80,362,027	191,188,500
2015	33,174,553	89,591,757	71,391,858	194,158,169
2016	28,070,158	95,250,578	69,955,496	193,276,232
Supplies and commodities	262,572,135	486,064,826	86,742,856	835,379,816
2014	116,470,838	254,856,077	48,501,653	419,828,568
2015	146,101,297	231,208,749	38,241,203	415,551,248
2016	108,526,649	289,516,995	29,007,793	427,051,437
Transfers and grants to counterparts	263,218,714	698,396,579	163,996,298	1,125,611,591
2014	68,936,049	213,118,881	57,244,422	339,299,352
2015	99,734,211	209,654,182	47,036,462	356,424,856
2016	94,548,454	275,623,516	59,715,414	429,887,383
Travel	13,893,575	54,250,886	32,315,864	100,460,325
2014	3,930,346	18,480,522	12,091,332	34,502,201
2015	6,439,765	17,763,567	9,904,850	34,108,183
2016	3,523,463	18,006,797	10,319,681	31,849,941
Grand Total	760,541,599	2,043,868,990	664,466,159	3,468,876,749

FUTURE WORKPLAN

At the completion of the third year of UNICEF's 2014–2017 Strategic Plan, no modification was made to the Theory of Change for health. Nonetheless, emerging challenges, including the new global threat of Zika and a worsening of humanitarian situations, have prompted the organization to strengthen its risk-informed programming and capacity to respond. UNICEF proactively formulated its approach on health systems strengthening and increased its focus on primary health care and community health platforms to create more resilient health systems that can withstand shocks and prevent excess mortality and morbidity.

Building on global efforts to meet MDG 4 on reducing child mortality, UNICEF seeks to consolidate and accelerate the gains made in the area of child survival, even as the agency pivots towards the comprehensive child health agenda of the SDGs. In 2017, UNICEF aims to demonstrate global leadership across the continuum of child health, as reflected in the 'Thrive' component in the upcoming Strategic Plan (2018–2021). In practice, this means sustaining the momentum around health systems strengthening to increase the quality, sustainability and coverage of health interventions on the ground. UNICEF will also continue to make the organization fit for the future by clarifying the health programme models implemented across a typology of contexts: countries experiencing acute and protracted emergencies; countries graduating from low- to middle-income status; countries grappling with the health needs presented by accelerated rates of urbanization; and contexts characterized by disease outbreaks, climate change, and other emerging challenges to child health and well-being.

Increased time and focus will be invested in high-burden countries, supporting regional and country offices with programme preparations, implementation, and monitoring and evaluation. As noted, UNICEF will prioritize health systems strengthening in particular, focusing on delivery platforms in communities and primary health-care facilities to address the health priorities of children and local populations.

The Every Newborn Action Plan lays out an exciting and ambitious road map for reducing preventable neonatal deaths by systematically scaling the strategies, tools and commodities needed to mitigate the risk of newborn deaths. As such, 2017 will be a critical year for demonstrating results under the plan and a related effort, the Quality Improvement initiative. UNICEF will continue to support the integration of these and other maternal and newborn programmes at global, regional and country levels.

In 2017, UNICEF will redouble efforts to help governments vaccinate greater numbers of children against preventable diseases. UNICEF will finalize and implement its 2017–2030 Immunization Road Map to vaccinate more marginalized children, bolstering its role in improving vaccine supply, distribution and affordability and in fostering demand for immunization through community engagement. Towards measles elimination, UNICEF will continue to work with and leverage important global partnerships, including Gavi and the Measles and Rubella Initiative.

As in previous years, UNICEF remains committed to eradicating polio with the support of partners. While continuing to support regional and country offices, UNICEF priorities and strategies for 2017 include a special focus on the three polio-endemic countries to stop the local transmission of the poliovirus, improve outbreak preparedness and response, increase advocacy and resource mobilization to fill funding gaps, transition polio assets, strengthen immunization services and sustain gains made to reach polio-free status. UNICEF will strengthen its collaboration with WHO to swiftly respond to outbreaks. Discussions are ongoing regarding the creation of a joint outbreak response team in Geneva.

Although progress has been made, 18 countries still need to eliminate maternal and neonatal tetanus. In 2017, UNICEF will develop operational guidance and evidence on delivering equity- focused, facility- and community-based maternal and adolescent immunization interventions including HPV, with a special focus on hard-to-reach areas.

The year 2016 was devastating to the millions of children caught in fragile settings, including conflicts, disasters and epidemics. UNICEF will continue to support these extremely vulnerable children by rolling out the Health Emergency Preparedness Initiative and implementing cross-sectoral vector control activities to fight not only malaria but also dengue, Zika and chikungunya, while continuing to respond to disease outbreaks across the globe. UNICEF's action in countries affected by acute and protracted emergencies will balance preparedness, response and long-term development, with a focus on primary health care and community health platforms for more resilient health systems. Additional technical support will be provided to countries with protracted crisis, such as the Democratic Republic of the Congo, Nigeria and Yemen, among others.

The new UNICEF Strategic Plan (2018–2020) is informed by the lessons learned over the course of the current Strategic Plan (2014–2017). Extensive consultations with UNICEF country offices worldwide underscore the need to better address the comprehensive needs of children and integrate humanitarian action into UNICEF's overall activities (including health) and strategic vision. Many would like UNICEF to be better prepared to respond to the challenges of climate change, with clear guidance on disaster risk reduction. Others emphasized that UNICEF needs to leverage big data to strengthen the capacity of government counterparts. The equity focus remains applicable in all contexts.

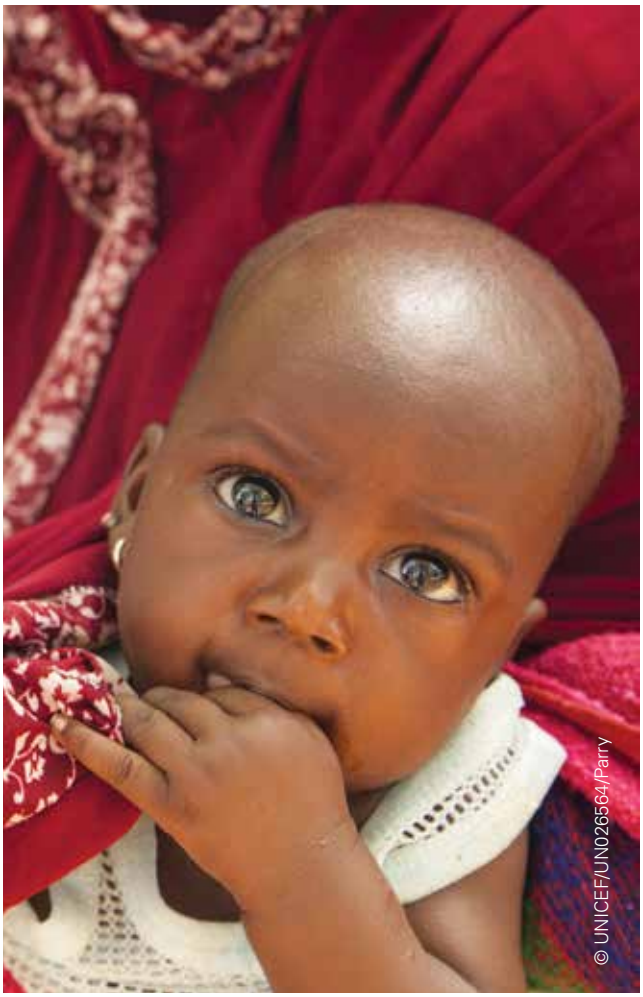
Working together, UNICEF and partners have generated great momentum around 'survive-thrive-transform' as part of Every Woman Every Child. In its new Strategic Plan, UNICEF will intensify its focus on high-burden and fragile countries to accelerate progress towards child mortality reduction (the 'unfinished business'), including better targeting technical assistance to support the achievement of planned results at the country level. The Approaches and Actions outlined in the new Strategy for Health will be embedded in health programming at all levels. This will be complemented by investments in implementation research to strengthen programme delivery on the ground. In order to ensure that results are sustainable, UNICEF will embed relevant aspects of health systems strengthening into vertical programmes so that earmarked resources can be leveraged towards systemic changes.

UNICEF will continue to advocate for a holistic approach to child health and a more efficient global health architecture. To improve UNICEF's programming beyond child survival, a learning agenda on the 'Thrive' component of the Global Strategy will be developed as part of the new Strategic Plan using existing platforms at the country level and multisectoral approaches. Knowledge sharing among countries and partners is critical to consolidate UNICEF's position as a global leader on child health and a repository for resources for children.

However, UNICEF faces funding shortfalls that impede (1) the realization of UNICEF's core commitment to child health; (2) the expansion of proven programmes such as community health services, life-saving services for mothers and newborns; and (3) the organization's ability to address emerging issues highlighted by the SDGs, including adolescent health and non-communicable diseases. This report has shown that flexible funding is essential in supporting fragile countries in an overarching systems approach. UNICEF, and children around the world, would benefit from flexible thematic funds that enable UNICEF to prioritize and deploy resources in response to the fluid and dynamic child health landscape, so that no child is left behind.

EXPRESSION OF THANKS

UNICEF expresses its deep appreciation to all resource partners who contribute to its work to fulfil the right of all children to survive, develop and reach their full potential. Regular resources and thematic funding, in particular, provide for greater flexibility, longer-term planning and sustainability of programmes. These voluntary contributions reflect the trust resource partners have in the ability of UNICEF to deliver quality support to children and families under all circumstances and have made possible the results described in this report. Special thanks are given to the Governments of Sweden, Luxembourg and Iceland for their generous contributions and partnership as well as the National Committees for UNICEF, particularly the Italian Committee for UNICEF, the United Kingdom Committee for UNICEF, the Polish National Committee for UNICEF, the Dutch Committee for UNICEF, the United States Fund for UNICEF, and the Czech Committee for UNICEF for their consistent support to children's health.


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ABBREVIATIONS AND ACRONYMS

C4D	Communication for Development
CEE/CIS	Central and Eastern Europe and the Commonwealth of Independent States
CERF	Central Emergency Response Fund (United Nations)
DTP	diphtheria, tetanus and pertussis
EAP	East Asia and the Pacific
ECD	early childhood development
ENAP	Every Newborn Action Plan
EQUIST	Equitable Impact Sensitive Tool
ESA	Eastern and Southern Africa
EVM	Effective Vaccine Management
HPV	human papillomavirus
iCCM	integrated community case management
IPSAS	International Public Sector Accounting Standards
LAC	Latin America and the Caribbean
MDG	Millennium Development Goals
MENA	Middle East and North Africa
MoRES	Monitoring Results for Equity System
ORS	oral rehydration salts
SA	South Asia
SDGs	Sustainable Development Goals
SMS	Short Message Service
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNSAS	United Nations System Accounting Standards
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
WASH	water, sanitation and hygiene
WCA	West and Central Africa
WHO	World Health Organization

ENDNOTES

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21. For more details on regular resources revenue, please refer to the 2016 Regular Resources Report.<https://www.unicef.org/publications/index_91468.html>

ANNEX: DATA COMPANION

Visualizing achievements

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



Green

Indicator level

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

Outputs and outcome area level

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



Amber

Indicator level

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

Outputs and outcome area level

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



Red

Indicator level

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

Outputs and outcome area level

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

Health

Average achievement rate:

85% 

Impact Indicator	Baseline*	2017 Target	2016 Update**
1a. Under-five mortality rate (as pledged in A Promise Renewed)	47 per 1,000 live births (2012)	43 per 1,000 live births	43 per 1,000 live births (2015)
1b. Neonatal mortality rate	21 per 1,000 live births (2012)	17 per 1,000 live births	19 per 1,000 live births (2015)

Outcome Indicator	Baseline*	2017 Target	2016 Update**
P1.1 Countries with at least 80% of live births attended by skilled health personnel (doctor, nurse, midwife or auxiliary midwife)	51 (2010-2013)	At least 60	100 out of 142 UNICEF programme countries with data (2010-2016)
P1.2 Countries with at least 80% of women attended at least four times during their pregnancy by any provider (skilled or unskilled) for reasons related to the pregnancy	18 (2010-2013)	At least 25	53 out of 117 UNICEF programme countries with data (2010-2016)
P1.3 Countries that are verified/validated as having eliminated maternal and neonatal tetanus	34	54	41 (2016)
P1.4 Polio-endemic or newly infected countries that become polio-free	Endemic countries: 3 Reinfected countries: 5 (as of 1 January 2014)	All polio-endemic and newly infected countries	Endemic countries: 2 Reinfected countries: 1 (2015)
P1.5 Countries with (a) at least 90% coverage at the national level and (b) at least 80% coverage in every district or equivalent administrative unit for children <1 year receiving measles-containing vaccine or diphtheria, tetanus and pertussis (DTP)-containing vaccine	Measles: (a) 131, (b) 60 DTP: (a) 135, (b) 63	Measles: (a) 157, (b) 157 DTP: (a) 157, (b) 157	Measles: (a) 120, (b) 52 (2015) DTP: (a) 126, (b) 55 (2015)
P1.6 Countries with at least 80% of children aged 0-59 months with diarrhoea receiving oral rehydration salts (ORS)	0 (2010-2013)	20	3 out of 98 UNICEF programme countries with data (2010-2016)
P1.7 Countries with at least 80% of children aged 0-59 months with symptoms of pneumonia taken to an appropriate health provider	7 (2010-2013)	20	18 out of 96 UNICEF programme countries with data (2010-2016)
P1.8 Countries with at least 80% of children aged 0-59 months with fever who had a finger- or heel-stick for malaria testing	0 (2010-2013)	15	0 out of 49 UNICEF programme countries (malaria-endemic only) with data (2010-2016)
P1.9 Malaria-endemic countries with at least 80% of children aged 0-59 months sleeping under an insecticide-treated net	0 (2010-2013)	25	2 out of 49 UNICEF programme countries (malaria-endemic only) with data (2010-2016)
P1.10 Countries with at least 60% of (a) mothers and (b) newborns receiving postnatal care within two days of childbirth	(a) 16 out of 51 UNICEF programme countries with data (2010-2014) (b) 20 out of 57 UNICEF programme countries with data (2010-2014)	(a) 25 (b) 25	a) 54 out of 78 UNICEF programme countries with data (2010-2016) (b) 34 out of 73 UNICEF programme countries with data (2010-2016)

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

Output a

Enhanced support for children and caregivers, from pregnancy to adolescence, for improved healthy behaviours

Average output achievement

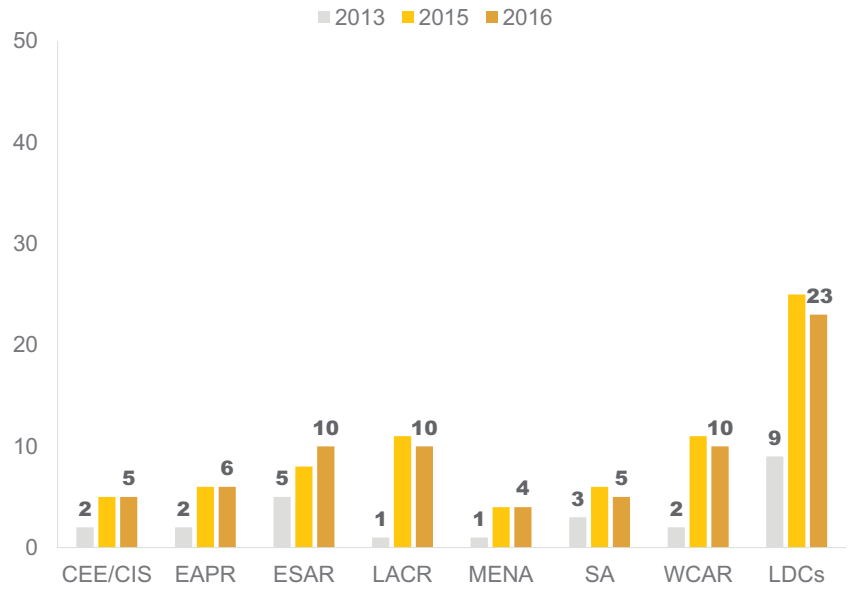
84%

P1.a.1

Countries in which a maternal, neonatal and child health (MNCH) communication plan has been developed, budgeted and implemented

2013 Baseline	16
2014 Result	43
2015 Result	51
2016 Result	50
2016 Milestone	46
2017 Target	48

Achievement 109%

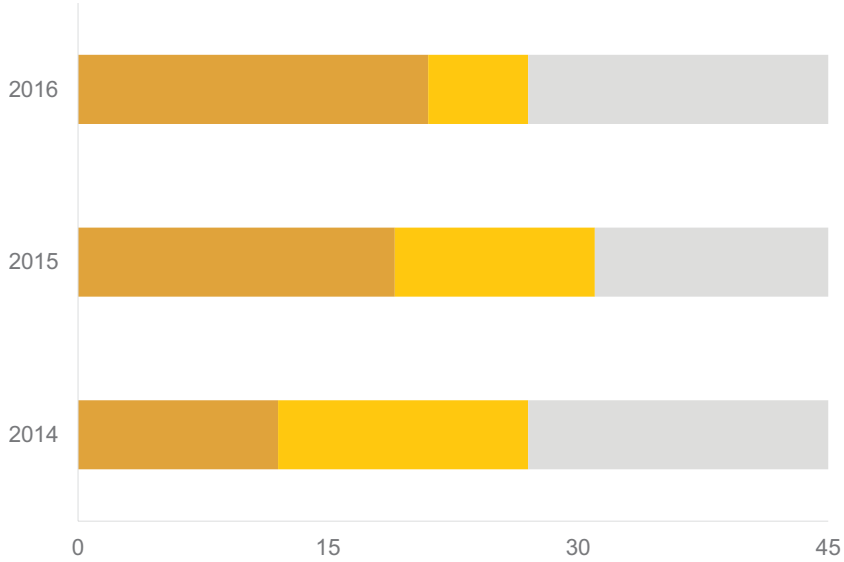


P1.a.2

Polio-affected countries with less than 1% of children under 5 years missing polio vaccination due to refusal

2014 Baseline	12
2015 Result	19
2016 Result	21
2016 Milestone	35
2017 Target	45

Achievement 60%



Output b

Increased national capacity to provide access to essential high-impact maternal and child health interventions

Average output achievement

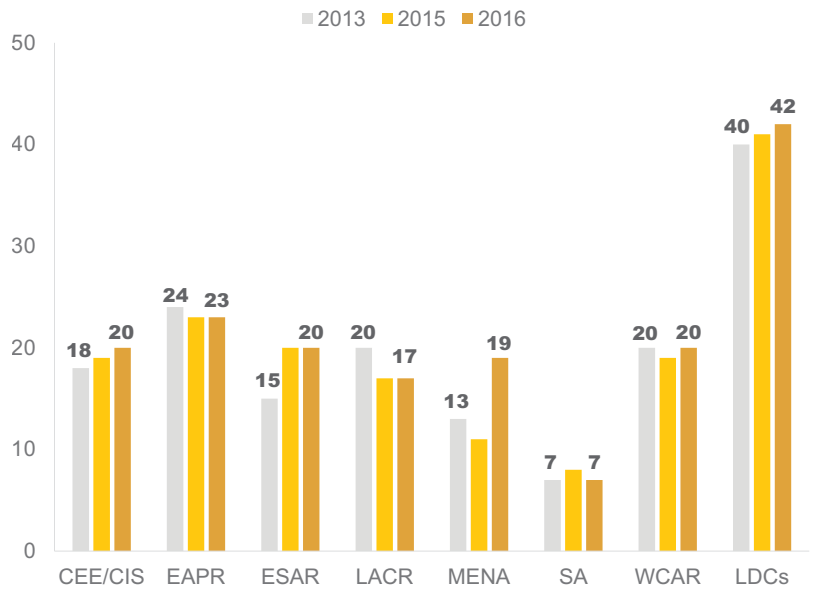
72%

P1.b.1

Countries without stockouts lasting more than one month at national level for ORS

2013 Baseline	117
2014 Result	114
2015 Result	117
2016 Result	126
2016 Milestone	126
2017 Target	132

Achievement 100%

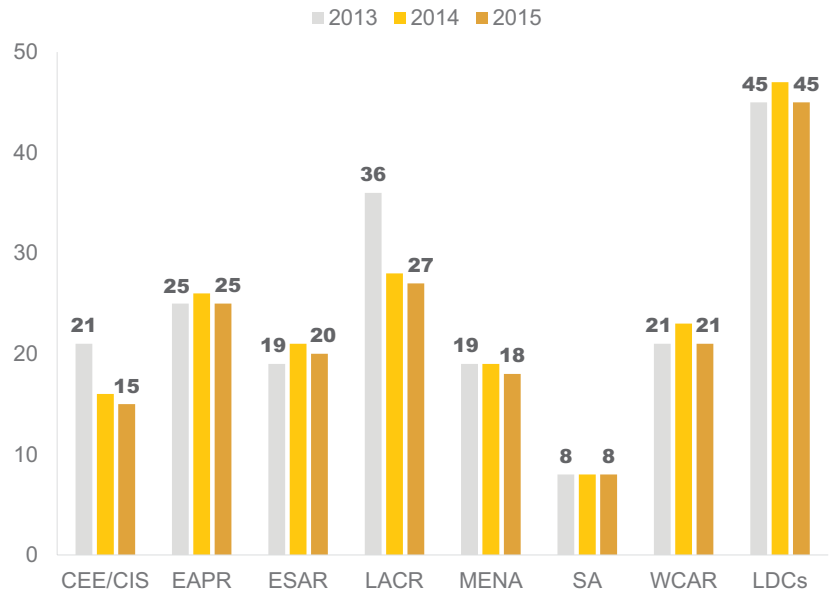


P1.b.2 (a)

Countries without stockouts lasting more than one month at the national level of DTP-containing vaccine

2013 Baseline	148
2014 Result	141
2015 Result	134
2016 Result	-
2016 Milestone	148
2017 Target	148

Note: 2016 data is not yet available. To be reported in 2018.

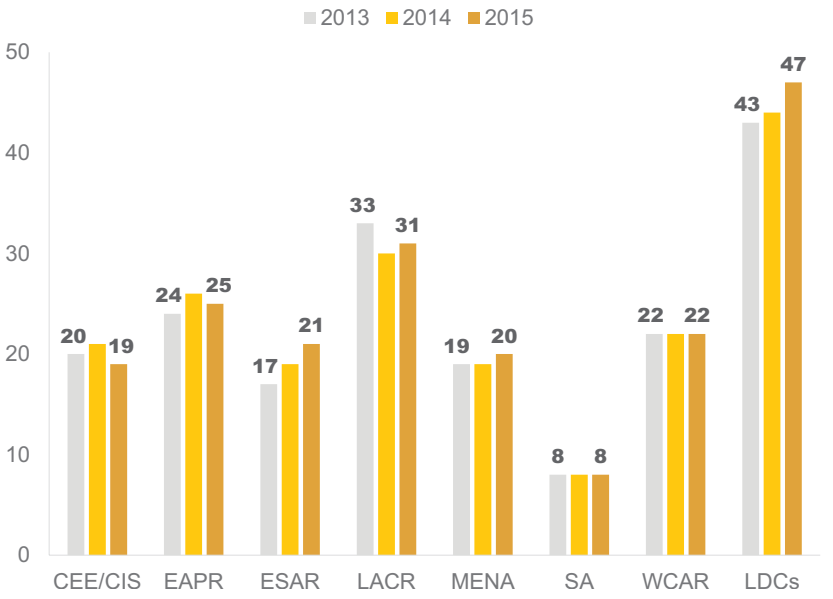


P1.b.2 (b)

Countries without stockouts lasting more than one month at the national level of measles vaccine

2013 Baseline	142
2014 Result	145
2015 Result	146
2016 Result	-
2016 Milestone	145
2017 Target	145

Note: 2016 data is not yet available. To be reported in 2018.

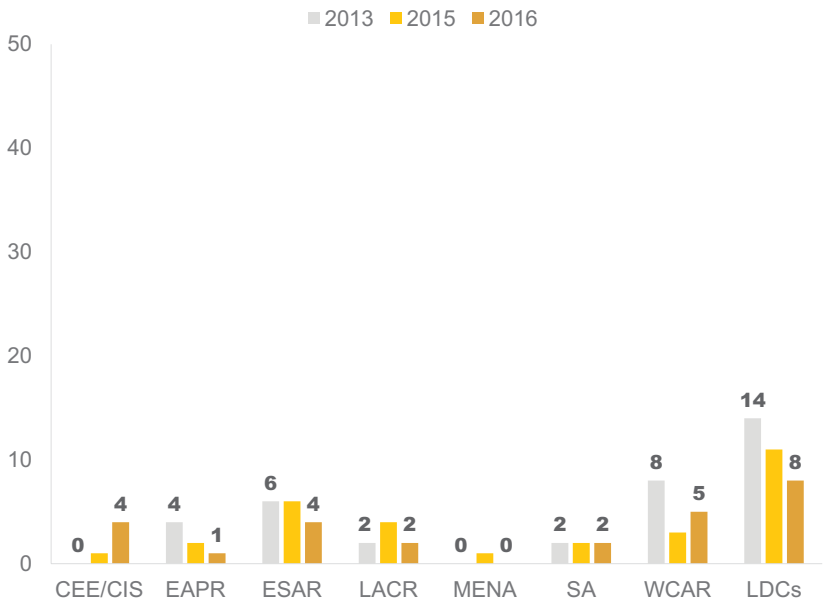


P1.b.3

Countries in which the target number of community health workers are trained to implement integrated community case management

2013 Baseline	22
2014 Result	12
2015 Result	19
2016 Result	18
2016 Milestone	30
2017 Target	40

Achievement 60%

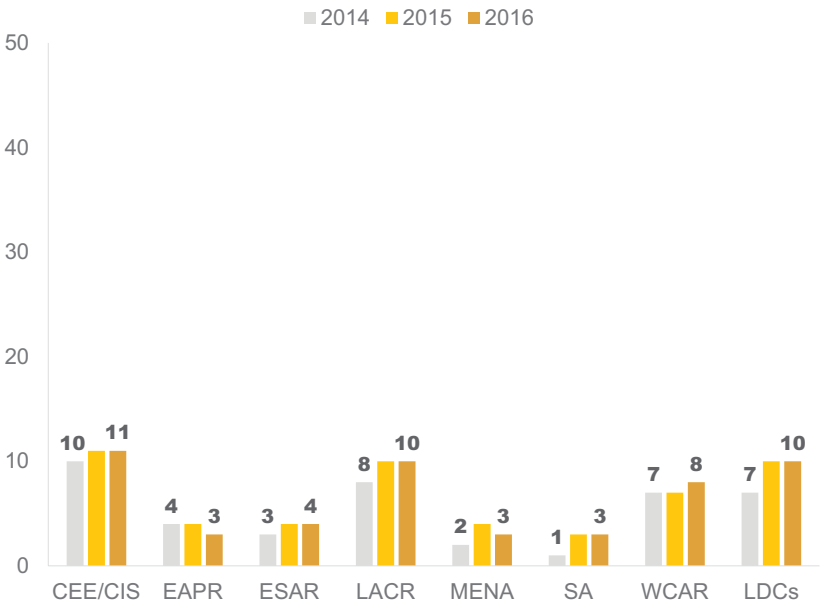


P1.b.4

Countries with 100% of basic emergency obstetric and newborn care (BEmONC) facilities operational on 24/7 basis

2014 Baseline	35
2015 Result	43
2016 Result	42
2016 Milestone	47
2017 Target	54

Achievement 89%



P1.b.5

Countries in which 80% of women of reproductive age in high-risk areas receive two doses of tetanus vaccine through campaigns

2014 Baseline	25%
2015 Result	75%
2016 Result	60%
2016 Milestone	100%
2017 Target	100%

Achievement 60%

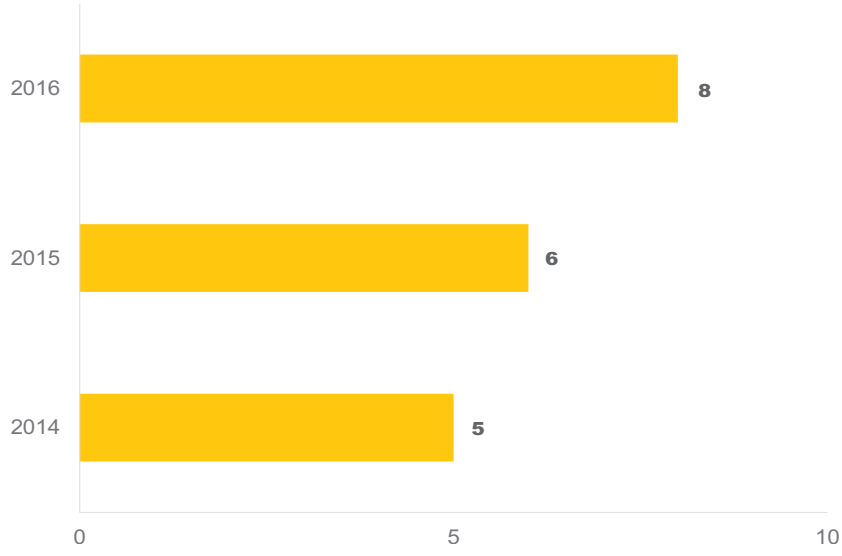
2014		2015		2016	
Angola	89%	Pakistan	99%	Nigeria	99%
Democratic Republic of the Congo	89%	Haiti	98%	Chad	95%
Mali	85%	Ethiopia	88%	Pakistan	91%
Niger	73%	Chad	87%	Philippines	87%
Kenya	62%	Sudan	86%	Papua New Guinea	86%
Haiti	60%	Mali	85%	South Sudan	84%
Papua New Guinea	30%	South Sudan	74%	Kenya	45%
Indonesia	26%	Indonesia	47%	Guinea	33%
Cambodia	-			Sudan	0%
Chad	-			Ethiopia	-
Nigeria	-				
South Sudan	-				

P1.b.6

Malaria-endemic countries in which the target number of health workers in UNICEF-supported programmes are trained in rapid diagnostic testing for malaria in children

2014 Baseline	5
2015 Result	6
2016 Result	8
2016 Milestone	8
2017 Target	10

Achievement 100%

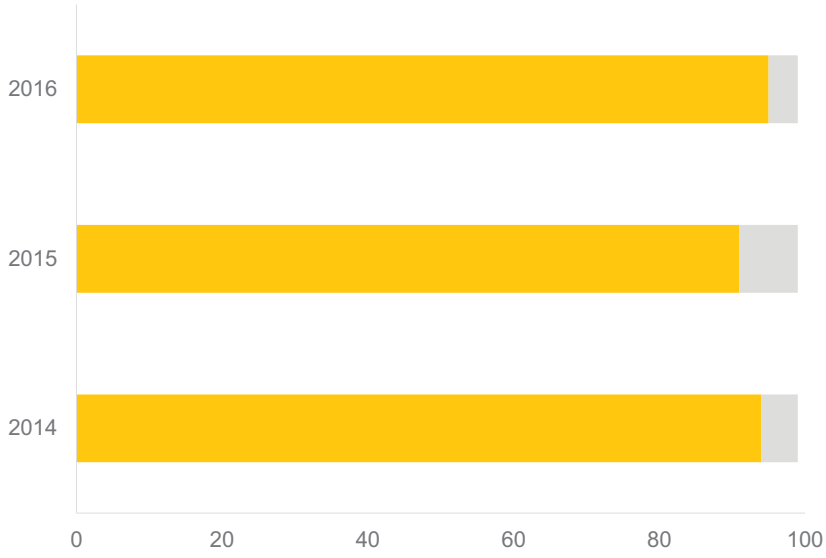


P1.b.7

Malaria-endemic countries without stockouts lasting more than one month at national level of all artemisinin-based combination therapy (ACT)

2014 Baseline	94
2015 Result	91
2016 Result	95
2016 Milestone	97
2017 Target	99

Achievement 98%

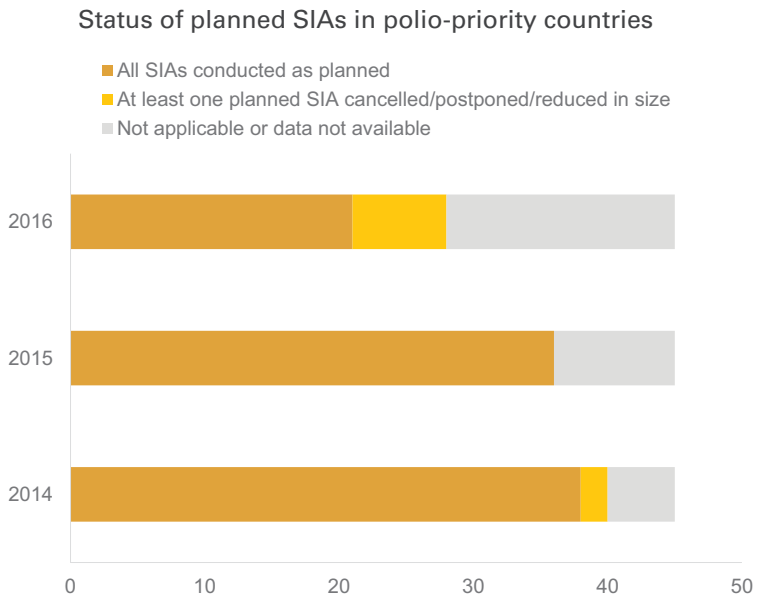


P1.b.8

Polio-priority countries (endemic, outbreak, other) in which planned supplemental immunization activities (SIAs) were cancelled, postponed or reduced in size during the previous six months due to gaps in vaccine supply

2014 Baseline	2
2015 Result	0
2016 Result	7
2016 Milestone	1
2017 Target	0

Achievement 0%



Output c

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

Average output achievement

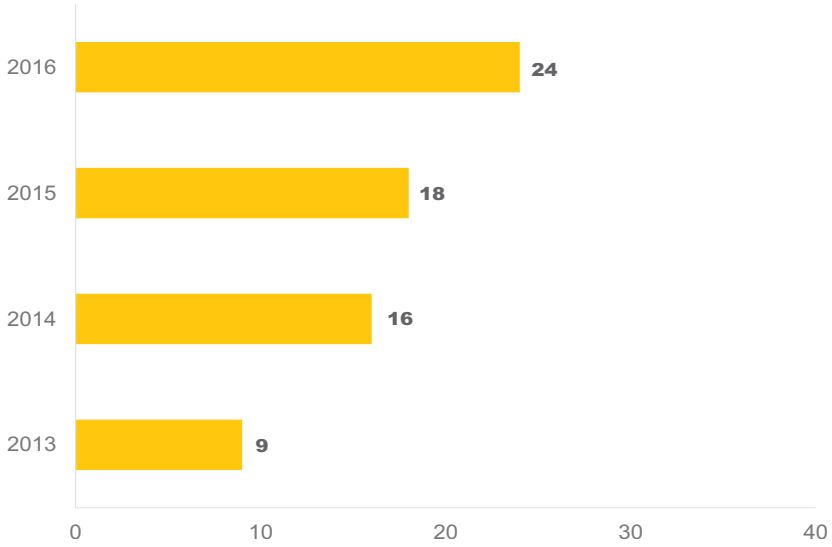
97%

P1.c.1

Countries in which barriers and bottlenecks relating to child survival are monitored in at least 80% of district health system strengthening (DHSS) targeted districts

2013 Baseline	9
2014 Result	16
2015 Result	18
2016 Result	24
2016 Milestone	32
2017 Target	40

Achievement 75%



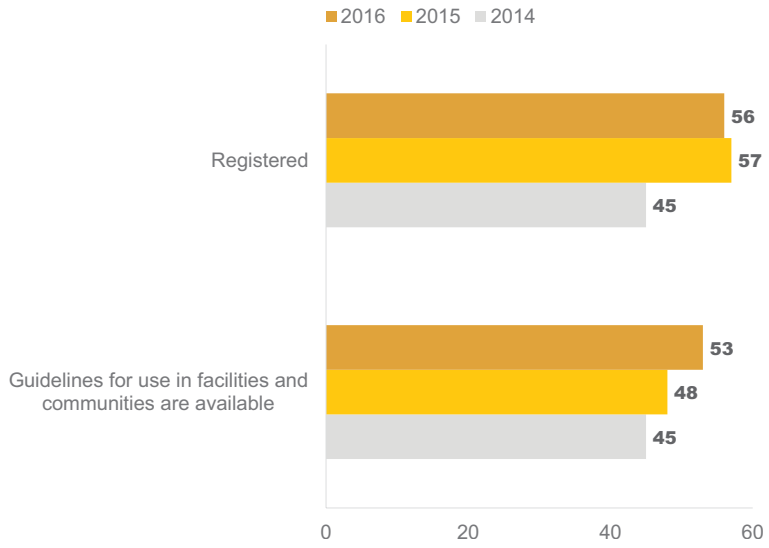
P1.c.2

Countries in which all relevant (out of the 13) essential commodities are (a) registered and (b) for which there are guidelines for use in facilities and communities

2014 Baseline	(a) 45, (b) 45
2015 Result	(a) 57, (b) 48
2016 Result	(a) 56, (b) 53
2016 Milestone	(a) 53, (b) 47
2017 Target	(a) 57, (b) 49

Achievement (a) 106%

Achievement (b) 113%

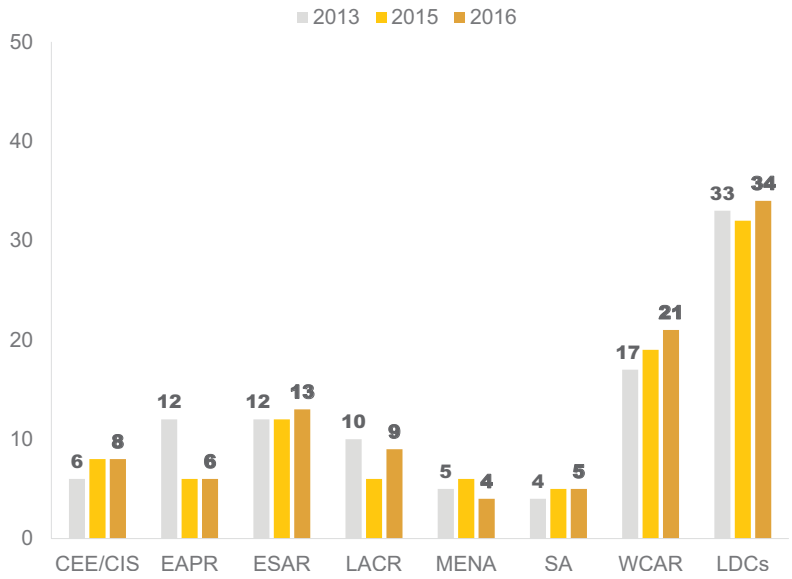


P1.c.3

Countries in which a policy for community health workers to provide antibiotics for pneumonia is in place

2013 Baseline	66
2014 Result	59
2015 Result	62
2016 Result	66
2016 Milestone	86
2017 Target	100

Achievement 77%

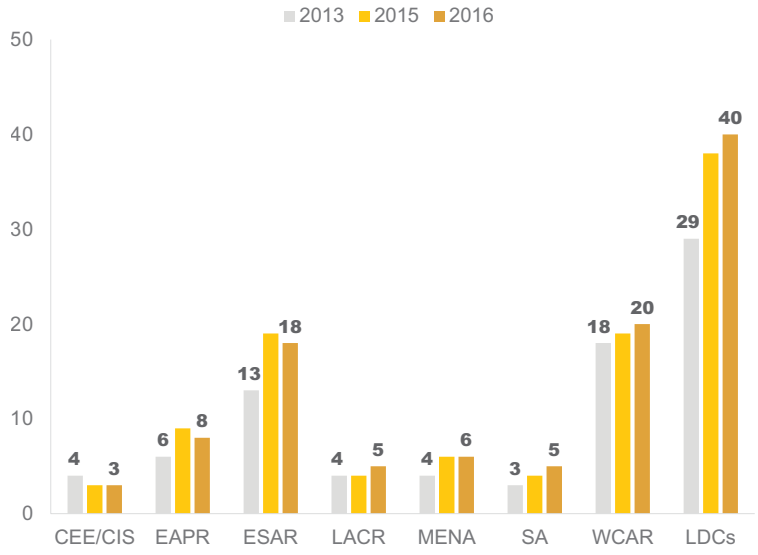


P1.c.4

Countries with costed implementation plans for maternal, newborn and child health care

2013 Baseline	52
2014 Result	62
2015 Result	64
2016 Result	65
2016 Milestone	70
2017 Target	75

Achievement 93%

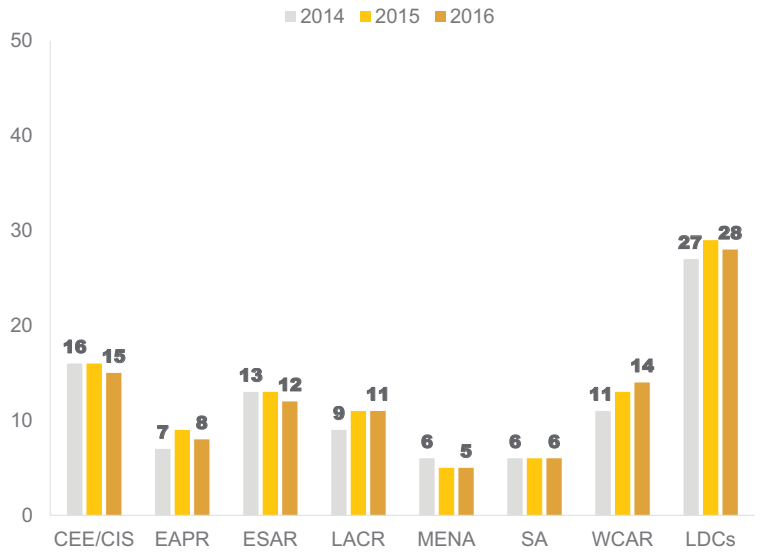


P1.c.5

Countries in which a policy for home visits of newborns is developed and/or revised, adopted and in use

2014 Baseline	68
2015 Result	73
2016 Result	71
2016 Milestone	76
2017 Target	80

Achievement 93%

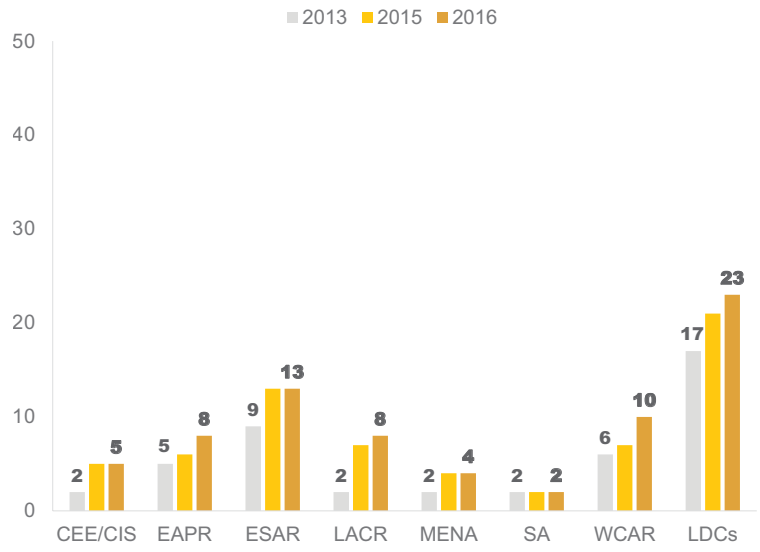


P1.c.6

Countries that have mainstreamed risk reduction/ resilience, inclusive of climate change, into national health strategies and plans

2013 Baseline	27
2014 Result	34
2015 Result	44
2016 Result	50
2016 Milestone	38
2017 Target	40

Achievement 132%

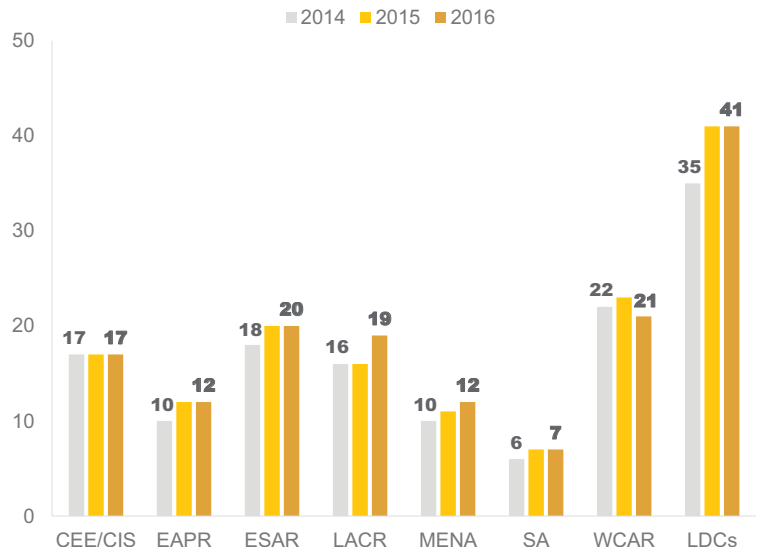


P1.c.7

Countries for which a policy on focused antenatal care has been developed, adopted and implemented

2014 Baseline	99
2015 Result	106
2016 Result	108
2016 Milestone	113
2017 Target	120

Achievement 96%

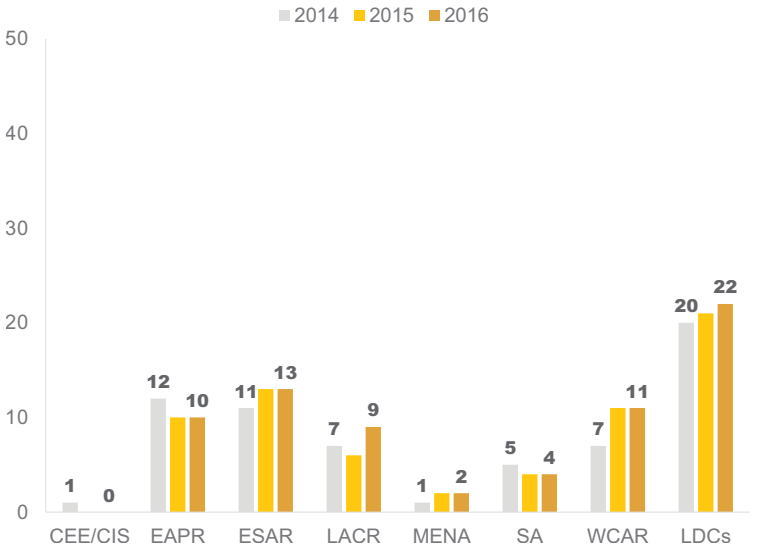


P1.c.8

Countries that monitor and produce a reproductive, maternal, newborn and child health (RMNCH) scorecard

2014 Baseline	44
2015 Result	46
2016 Result	49
2016 Milestone	54
2017 Target	59

Achievement 91%



Output d

Increased country capacity and delivery of services to prevent excess mortality among girls, boys and women in humanitarian situations

Average output achievement

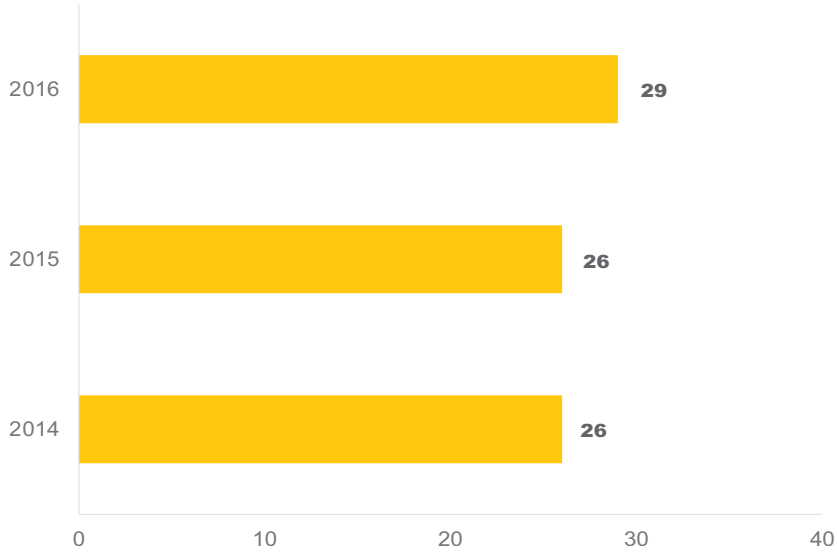
77%

P1.d.1

Cholera-endemic (or at risk for cholera) countries with comprehensive multisectoral cholera preparedness plans

2014 Baseline	26
2015 Result	26
2016 Result	29
2016 Milestone	35
2017 Target	40

Achievement 83%

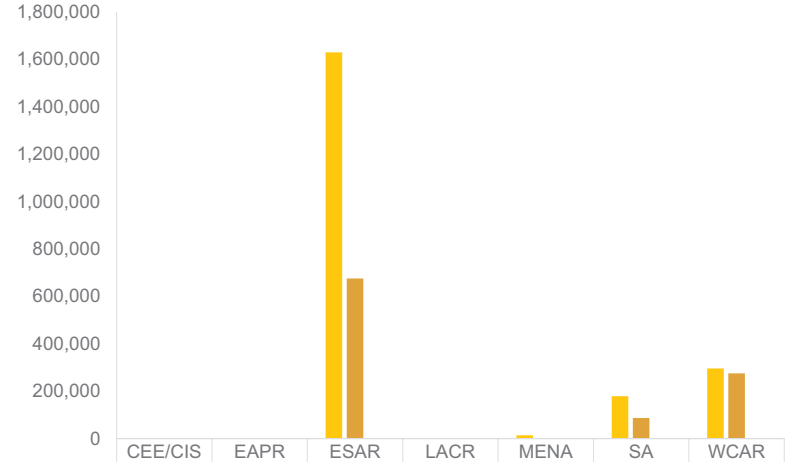


P1.d.3

UNICEF-targeted families in humanitarian situations that receive two insecticide-treated nets in malaria-endemic areas

2013 Baseline	30%
2014 Result	77%
2015 Result	45%
2016 Result	49%
2016 Milestone	92%
2017 Target	100%

Achievement 53%



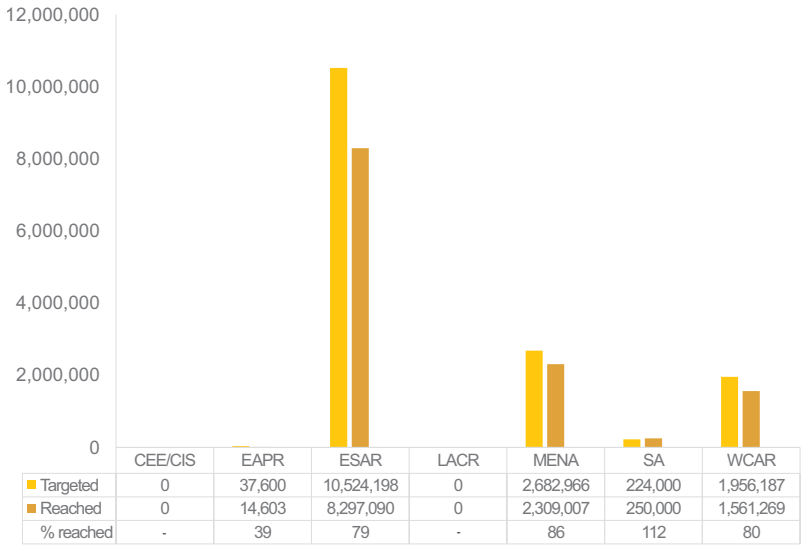
	CEE/CIS	EAPR	ESAR	LACR	MENA	SA	WCAR
Targeted	0	0	1,628,340	0	14,000	179,011	296,040
Reached	0	0	675,005	0	0	87,088	275,236
% reached	-	-	41	-	0	49	93

P1.d.2 (a)

UNICEF-targeted children 6-59 months in humanitarian situations vaccinated against measles

2013 Baseline	70%
2014 Result	77%
2015 Result	71%
2016 Result	81%
2016 Milestone	89%
2017 Target	95%

Achievement 91%



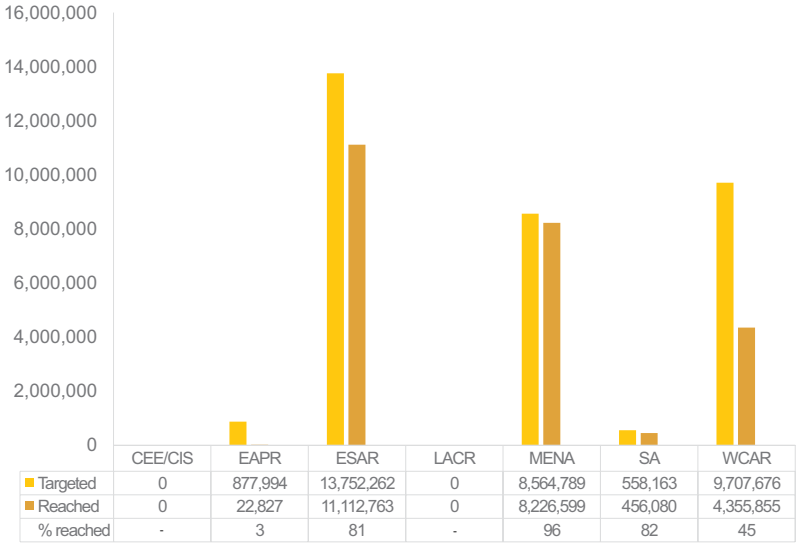
	CEE/CIS	EAPR	ESAR	LACR	MENA	SA	WCAR
Targeted	0	37,600	10,524,198	0	2,682,966	224,000	1,956,187
Reached	0	14,603	8,297,090	0	2,309,007	250,000	1,561,269
% reached	-	39	79	-	86	112	80

P1.d.2 (b)

UNICEF-targeted children 6 months to 15 years in humanitarian situations vaccinated against measles

2013 Baseline	70%
2014 Result	72%
2015 Result	43%
2016 Result	72%
2016 Milestone	87%
2017 Target	95%

Achievement 83%



	CEE/CIS	EAPR	ESAR	LACR	MENA	SA	WCAR
Targeted	0	877,994	13,752,262	0	8,564,789	558,163	9,707,676
Reached	0	22,827	11,112,763	0	8,226,599	456,080	4,355,855
% reached	-	3	81	-	96	82	45

Output e

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

Average output achievement

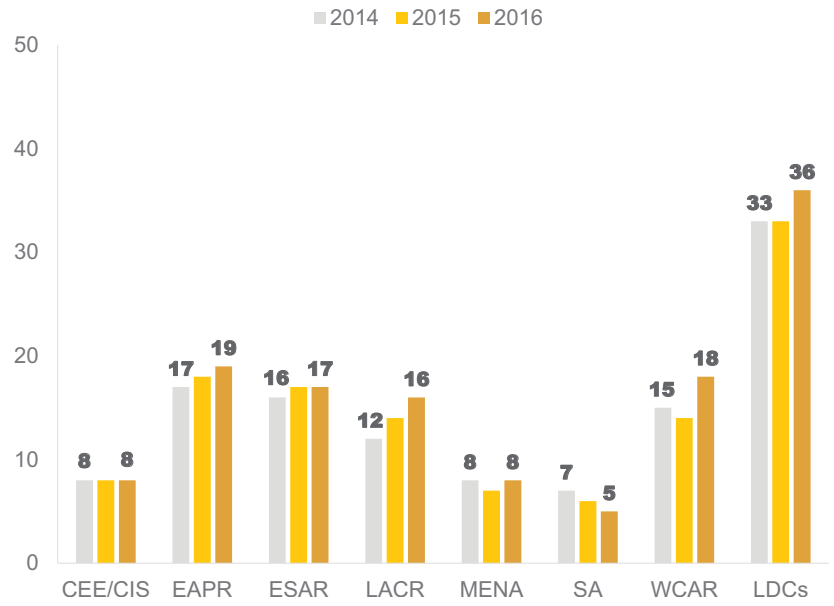
89%

P1.e.1

Countries that have plans with budgets allocated to reduce adolescent pregnancy

2014 Baseline	83
2015 Result	84
2016 Result	91
2016 Milestone	89
2017 Target	93

Achievement 102%

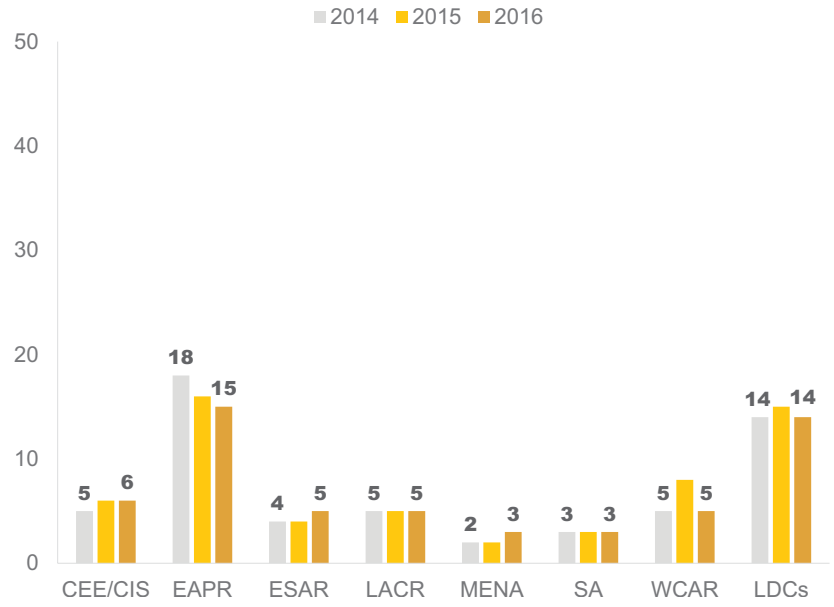


P1.e.2

Countries that produce an analysis of sex-differentiated infant and child mortality estimates

2014 Baseline	42
2015 Result	44
2016 Result	42
2016 Milestone	55
2017 Target	62

Achievement 76%



Output f

Enhanced global and regional capacity to accelerate progress in child health

Average output achievement

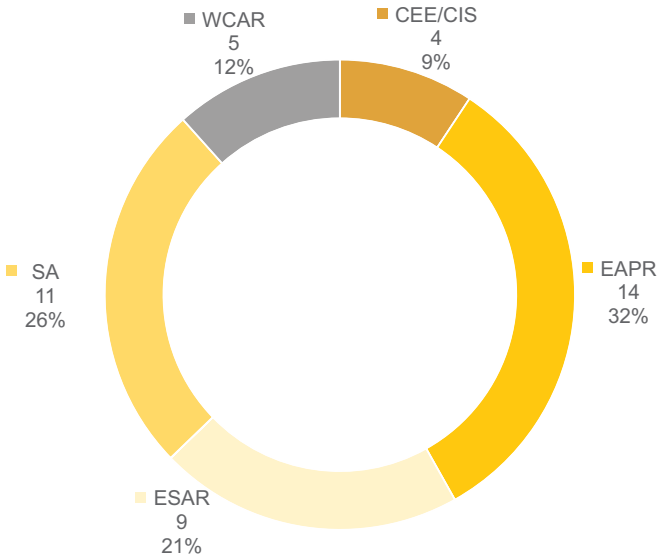
86%

P1.f.1

Peer-reviewed journal or research publications by UNICEF on maternal, newborn, child or adolescent health

2014 Baseline	40
2015 Result	76
2016 Result	43
2016 Milestone	43
2017 Target	45

Achievement 100%

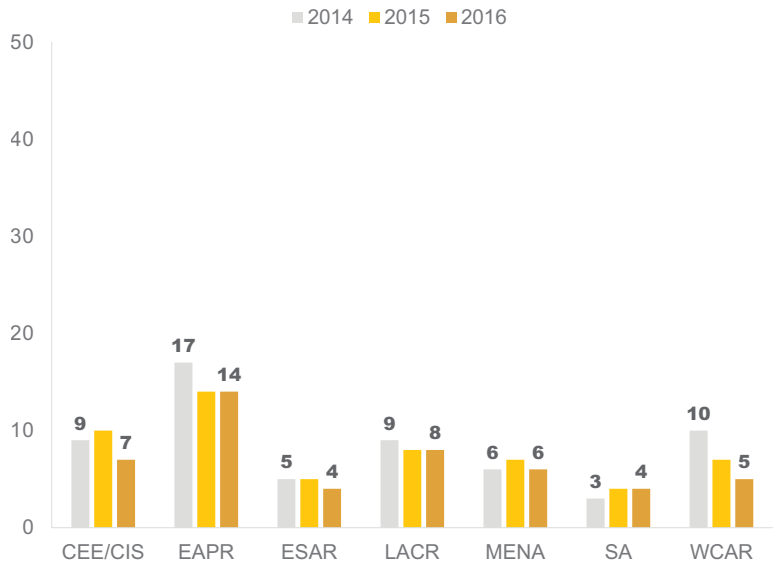


P1.f.2

Countries that have conducted a launch of A Promise Renewed, followed by annual review

2014 Baseline	59
2015 Result	55
2016 Result	48
2016 Milestone	66
2017 Target	69

Achievement 73%





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