



HEALTH

HIV AND AIDS

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NUTRITION

EDUCATION

CHILD PROTECTION

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GENDER

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2014 ANNUAL RESULTS REPORT HEALTH

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

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Pakistan, 2015. On 2 March 2015, (left-right) Fazal Abbas administers a measles vaccination to 2-year-old Rashid, who is being steadied by his mother, Nishat, at a vaccination centre in a basic health unit in Damuanna Village in Sheikhpura District, in Punjab Province, Pakistan. Rashid's 5-year-old brother, Waheed (partially visible at right), their mother and two other children with them watch closely. Nishat regularly brings Rashid and Waheed to the health facility to be vaccinated. "I know that it is important so I never postpone it," she says. "Either the vaccinator comes to our village or I bring my children here." More than 1 million children in the district were vaccinated – with nearly 100 per cent coverage of children under the age of 5 – during a recent measles immunization campaign conducted by the district health authorities with support from UNICEF.

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EXECUTIVE SUMMARY

Overall, 2014 was a year of marking progress towards meeting global goals for reducing child mortality. Under-5 mortality has declined at a faster rate than at any other time during the past two decades, and among the poor in all regions. The global under-5 mortality rate has been reduced by half – from 90 deaths per 1,000 live births in 1990 to 46 per 1,000 in 2013, the latest year for which firm estimates are available for all countries. Still, it is clear that unfinished business remains in order to end preventable deaths and reduce regional disparities, particularly in sub-Saharan Africa and South Asia, which account for four out of five of all under-5 deaths. The post-2015 sustainable development agenda aims to address this unfinished business and the disproportionate results across regions and within nations, as well as across social groups. At the same time, post-2015 work is positioned to address emerging health concerns.

The year 2014 was particularly crucial for the health sector as development partners, including governments, worked to accelerate progress towards the Millennium Development Goals focused on maternal and child health. For UNICEF, 2014 also marked the first year of transition to its Strategic Plan 2014–2017, which outlines performance targets for the organization to continue its commitments and contributions to child rights, especially for the most disadvantaged children, and sets apart health as an outcome area separate from the umbrella of young child survival and development. In this context, UNICEF worked at the global, regional and country levels to support the improved and equitable use of high-impact maternal, newborn and child health interventions and the promotion of healthy behaviours. UNICEF also maintained a leading role in key global maternal and child health partnerships to leverage additional resources in countries, and generated new evidence to strengthen child health programmes.

Recognizing that nearly half of all under-5 deaths occur during the neonatal period, UNICEF defined and drove forward a global agenda for newborn survival. It also provided continued leadership in global efforts to eradicate polio, linked to strengthening routine immunization. At the same time, UNICEF reached unprecedented numbers of children who live in fragile settings and responded with life-saving health programming during emergencies, with

particular emphasis on Ebola and cholera. The Ebola outbreak re-emphasizes the importance of strong, resilient systems to respond to emerging threats to child health. Strengthening health systems was a key theme of 2014 – along with an emphasis on resilience across all programmes – that will continue to shape UNICEF work in 2015 and beyond.

With support from UNICEF, 62 countries now have costed implementation plans for maternal, newborn and child health care, and in 68 countries, a policy for home visits of newborns has been adopted after being developed and/or revised, and is now in use. In addition, 114 countries reported no stockouts of oral rehydration solution – a life-saving treatment for diarrhoea – lasting more than one month at the national level. And 129 countries reached at least 90 per cent coverage at the national level for children under 1 year of age receiving measles-containing vaccine and diphtheria-tetanus-pertussis (DTP)-containing vaccine, and 52 countries reached at least 80 per cent coverage in every district or equivalent administrative unit for children under 1 year of age receiving measles-containing vaccine. In addition, 59 countries reached at least 80 per cent coverage in every district or equivalent administrative unit for children under 1 year of age receiving DTP-containing vaccine, and 53 countries had greater than or equal to 90 per cent national coverage of DTP3 and 80 per cent coverage of DTP3 in all districts. These results were supported by UNICEF's procurement of 2.71 billion doses of vaccines for 100 countries, at a value of US\$1.48 billion, reaching 40 per cent of the world's children, and also reflect the organization's support to 15 countries in strengthening national immunization supply chain systems.

Partnership was crucial to UNICEF's focus on ending preventable maternal, newborn and child deaths. Key 2014 successes included the unanimous endorsement of the Every Newborn Action Plan by the World Health Assembly and subsequent roll-out of the strategy at the country level; by the end of the year, six priority countries had national plans to include an appropriate newborn component. Another achievement was the creation of a formal partnership with the Global Fund to Fight AIDS, Tuberculosis and Malaria to unlock US\$164 million in additional resources for scaling up in-

egrated community case management (iCCM) to reduce child mortality due to diarrhoea, pneumonia and malaria. Working as part of the Global Polio Eradication Initiative, UNICEF succeeded in helping reduce polio cases in Nigeria from 53 in 2013 to 6 in 2014, bringing the country closer to its goal of being declared polio-free in 2015. Additionally, as a GAVI partner, UNICEF supported the introduction of pneumococcal and rotavirus vaccines in 21 countries in 2014, a major step towards protecting children against severe diarrhoea and pneumonia – the two leading killers of children globally.

UNICEF also generated technical guidance, knowledge exchange and learning and new evidence in support of policy advocacy, with more than 70 papers on health topics co-authored by UNICEF staff published in peer-reviewed journals in 2014.

Reduced access to children and families in fragile and conflict settings was the foremost challenge encountered during the course of the year. As a result, for example, the global goal to eliminate maternal and neonatal tetanus will not be met in 2015. In addition, Pakistan saw a significant increase in the number of type-1 wild poliovirus cases. The Ebola crisis eroded hard-won progress towards the Millennium Development Goals in Guinea, Liberia and Sierra Leone, where basic child health services and facilities for safe childbirth were severely weakened or interrupted, as health systems strained to manage the emergency response. UNICEF prioritized the Ebola response and provided many staff to assist – playing a key role at the community level to expand provision of care – but this surge support redirected capacity that had been committed to other programme priorities, delaying results in those areas.

Even in non-emergency countries, lack of capacity in national health systems – which impacts UNICEF's ability to deliver on time across all programme areas – is the main challenge that UNICEF works with partners to overcome. Lack of trained health workers; weak supply chains and persistent bottlenecks that prevent reliable supply of life-saving commodities; gaps in resources that hinder implementation of adopted policies; and insufficient capacity at the national and/or subnational level for management, monitoring and strengthening of the health system persist in many countries. For example, between 1990 and 2013, the global proportion of women delivering with skilled attendance rose only slightly, from 57 per cent to 68 per cent. And only about half of women worldwide receive the

recommended minimum of four antenatal care visits. Where one or more of these challenges exists, UNICEF and partners must redouble efforts to achieve results in the programme areas outlined below.

For example, in many countries, lack of quality, disaggregated data, unreliable health management information systems and limited capacity for data analysis are constraints that impact both programme effectiveness and monitoring. UNICEF supports countries to tackle these challenges at various levels. In 2014, UNICEF continued the long-standing work of partnering with countries to enhance national capacity for data generation through household surveys via our support to Multiple Indicator Cluster Surveys (MICS). New funding in 2014 enabled UNICEF to scale up engagement to bolster civil registration and vital statistics, a multi-sectoral area of work that will continue into 2015. As described under Programme Area 2 below, UNICEF support to innovative data collection methods using mobile phones created new, real-time data on vaccine stock-outs, supporting more transparency and accountability in district health management. Trainings and technical support enhanced national and district-level capacity for data analysis to strengthen health systems, and UNICEF continued development of user-friendly analytical tools (for example, the EQUIST tool, which is planned to be completed in 2015). UNICEF also generated, supported and engaged in global-level analysis of data on health outcomes and coverage of priority interventions, such as the 2014 progress report, *Committing to Child Survival: A promise renewed* and the 2014 report of the Countdown to 2015, *Fulfilling the Health Agenda for Women and Children*.

At the global level, the mushrooming of initiatives following the launch of the United Nations Global Strategy for Women's and Children's health in 2010 helped to accelerate progress, but also resulted in a fragmentation of the health architecture that caused some lack of clarity and duplication of roles, costing both time and resources that affected all programme areas. Building on recent organizational review processes, UNICEF continued efforts to strengthen those internal processes where enhanced efficiency and effectiveness could support more results across all programme areas. For example, operational processes including identification, recruitment and deployment of staff have been identified as bottlenecks affecting speedy polio programme implementation.

Moving forward, with the joint strategy for health and nutrition coming to an end in 2015, UNICEF plans to develop a new health strategy to define longer-term engagement at the country, regional and global levels, in particular in the context of the forthcoming sustainable development goals (SDGs) and the updated United Nations Secretary-General's Global Strategy for Women's and Children's Health, Every Woman Every Child. Working with partners, UNICEF is leading the consultative process to develop the Operational Framework for the new Global Strategy. In this context, the organization's work on health, linked to other sectors such as nutrition and sanitation, will continue to be positioned in line with the Every Woman Every Child movement.

One priority will be to enhance UNICEF's engagement in strengthening health systems, including strengthening linkages across technical areas (such as between polio eradication and routine immunization), starting with a series of consultations in early 2015. Another will be to continue the focus on newborns, and accelerate implementation of the

Every Newborn Action Plan in countries. Across all programming, UNICEF will explore innovative ways of delivering quality results in fragile contexts, taking into consideration the conditions in countries with the highest burdens of child deaths. The polio endgame strategy will also be a major focus during the year, as we work to ensure that the resources and skills developed in support of these efforts are used to ensure that every child – everywhere – receives the full range of recommended vaccines.

UNICEF spent more than US\$1.2 billion on health in 2014, US\$22 million of which was due to generous contributions of thematic funds. Given their flexibility, thematic funds are critical to the strategic success of UNICEF in implementing health programmes. The Government of Sweden was the largest thematic resource partner to health, with contributions reaching nearly US\$10 million in 2014. The Dutch and Italian National Committees for UNICEF, along with many others, also continued their commitment to this outcome area. UNICEF remains grateful to these donors for their support.

STRATEGIC CONTEXT

Major progress has been achieved in improving child survival throughout the past 25 years. The under-5 mortality rate has declined by almost half in this time, dropping from 90 deaths per 1,000 live births in 1990 to 46 in 2013. The number of children who died before their fifth birthday was cut in half between 1990 and 2013, from 12.7 million per year to 6.3 million per year, saving 17,000 lives every day (*see Figure 1*). Globally, the annual rate of reduction has more than tripled since the early 1990s. As a result of this accelerated progress, almost 100 million children under age 5 – including 24 million newborns – have been saved over the past two decades (*see Figure 2*).

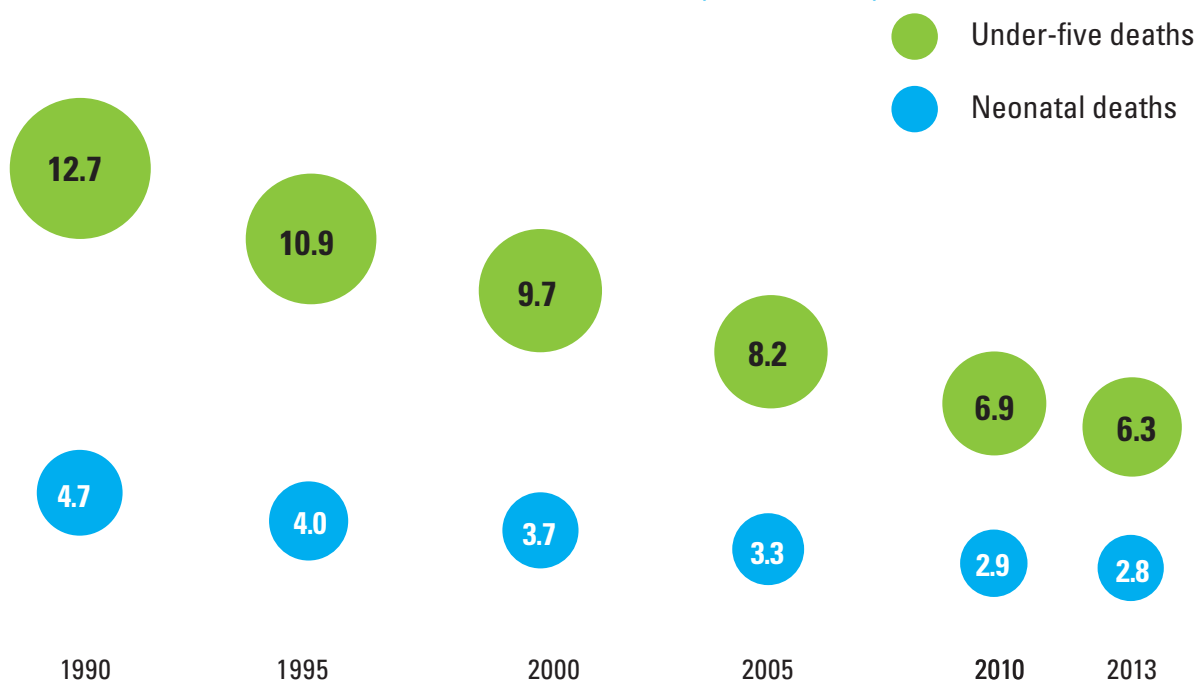
In 2014, the goals and targets of the post-2015 sustainable development agenda were crafted in the context of this progress. Since the SDGs aim to build and improve upon the Millennium Development Goals, health has been seen as an integral part of the agenda, particularly under draft SDG 3, which calls on countries to “ensure healthy lives and promote well-being for all at all ages.” The 13 targets of Goal 3 cover newborn, child and ma-

ternal mortality, and call on countries to address such issues as diseases and universal health coverage.¹ The process of developing the proposed goals and targets was undertaken by the Member State-led Open Working Group, in which UNICEF was involved as a technical expert, providing input through the Technical Support Team and being on call during the live negotiations.

With the World Health Organization (WHO), UNICEF also co-convened a consultation to discuss the role of health in the post-2015 agenda.² Out of 7 million MY World votes – based on a global survey of citizens led by the United Nations and partners – health ranks as the second priority for the post-2015 agenda (after education).³ All of these events and consultations have been pivotal to the inclusivity of the post-2015 process, marking an era of development that recognizes the importance of the participation of recipients. This in turn has immense implications for how health services will be provided and received in future international development efforts. UNICEF is also providing technical input for the development of a global set of health

FIGURE 1

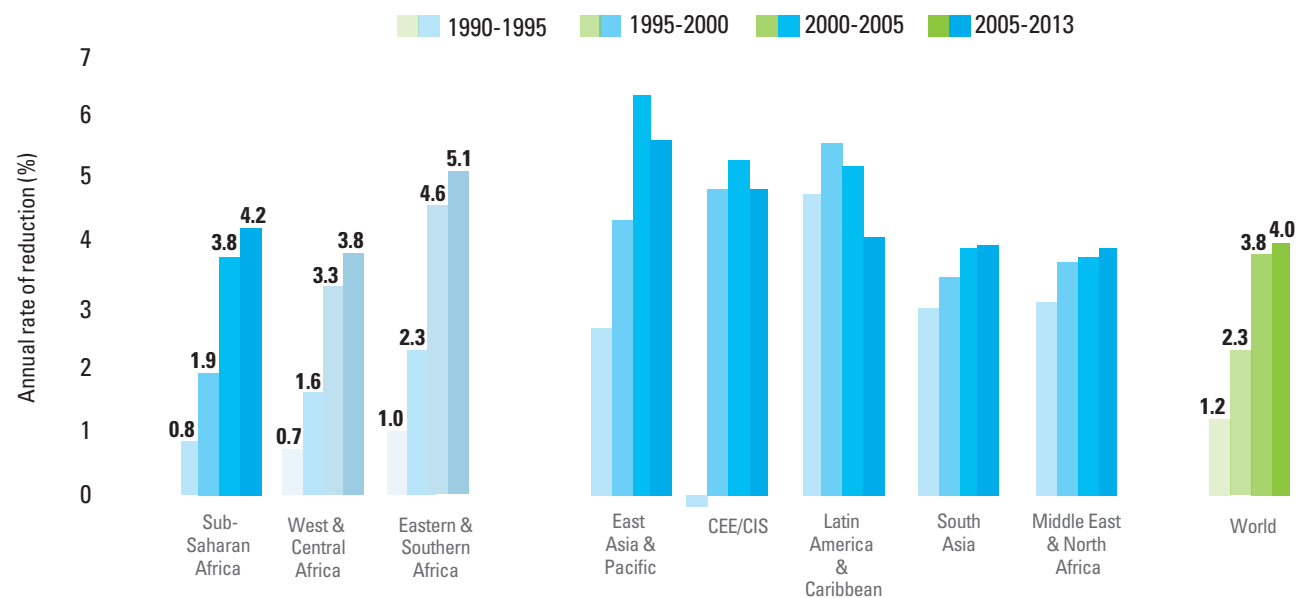
GLOBAL UNDER-5 AND NEONATAL DEATHS, 1990–2013 (IN MILLIONS)



Source: United Nations Children's Fund, *Committing to Child Survival: A promise renewed*, UNICEF, New York, September 2014, p. 13; PDF available at http://files.unicef.org/publications/files/APR_2014_web_15Sept14.pdf.

FIGURE 2

ANNUAL RATE OF REDUCTION IN THE UNDER-5 MORTALITY RATE, %, BY REGION, SINCE 1990



Source: United Nations Children's Fund, *Committing to Child Survival: A promise renewed*, UNICEF, New York, September 2014, p. 15; PDF available at http://files.unicef.org/publications/files/APR_2014_web_15Sept14.pdf.

indicators through the United Nations Statistical Commission.

Alongside the SDG processes, UNICEF is actively involved in the update of Every Woman Every Child, the United Nations Secretary-General's Global Strategy for Women's and Children's Health. This work includes leading the consultative process to develop the Operational Framework for the new strategy. The update of the strategy is a concrete response to the clear message conveyed by countries to development partners in 2014, that the proliferation of health initiatives that took place in the lead-up to the Millennium Development Goal deadline should not be replicated in the post-2015 agenda, and that it is time to deliver on the various commitments to increase coordination, manage better, and strengthen accountability. This opportunity has driven the organization to focus even more on how UNICEF as an agency, and the global health partnerships and initiatives in which it engages, are heeding this message at the country level. For example, UNICEF is looking at how it can strengthen linkages across technical areas and increase harmonization to reduce duplicative requests on government. An important question is whether technical assistance from UNICEF and partners is enhancing local capacity and supporting domestic investment. This question underpinned UNICEF's contribution to the business planning process of the emerging Global Financing Facility, which represented another key shift in the sector during 2014.

Together with a growing coalition of governments, civil society and the private sector, UNICEF also continued bolstering efforts to step up action to end preventable deaths, reduce illness, and enhance health outcomes for women and children under the banner of A Promise Renewed, the global movement to end preventable newborn and maternal deaths. This included advocacy at the global and national levels, technical assistance to countries, support to innovative approaches and technologies, and promotion of national-level accountability in all seven of the regions in which UNICEF works. As described in more detail under Programme Area 3 below, these are examples of UNICEF's engagement and leadership role in the various global health partnerships and initiatives that define the strategic context in which it works to drive global policy changes and local results for children.

Despite the advances noted above, the toll of under-5 deaths over the past two decades remains

staggering: Between 1990 and 2013, a total of 223 million children worldwide died before their fifth birthday. Sub-Saharan Africa continues to shoulder the greatest burden – 1 in 11 children born in the region still dies before age 5, nearly 15 times the average in high-income countries (1 in 159).

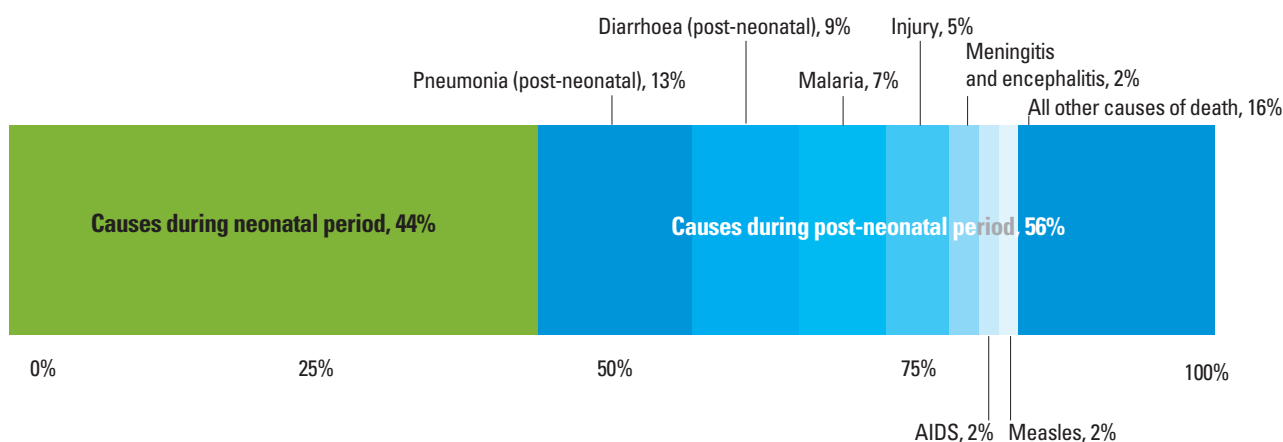
Although child deaths from leading infectious diseases have declined significantly, millions of children still lack access to quality care, vaccines and affordable life-saving commodities such as antibiotics to treat pneumonia, oral rehydration salts to treat diarrhoea or medicines to treat malaria. In 2013, pneumonia, diarrhoea and malaria accounted for about one third of all under-5 deaths ([see Figure 3](#)), and pneumonia alone accounted for 13 per cent of all such deaths. The gaps in coverage that perpetuate these preventable deaths are evident in the data: as of April 2015, of 86 UNICEF country offices reporting data for the period 2010–2014, only 2 had achieved 80 per cent total coverage of children under 5 with oral rehydration solution; of 85 countries reporting data for the same period, only 14 countries had achieved coverage of more than 80 per cent total coverage of care seeking for the symptoms of acute respiratory infection. Similarly, of 45 malaria-endemic countries reporting data, none had reached 80 per cent total coverage of insecticide-treated net use by children under 5.

While polio remains endemic in only three countries (Afghanistan, Nigeria and Pakistan), it continues to pose a risk to children everywhere, especially in countries that have not made routine immunization a priority. For example, outbreaks in Cameroon, Equatorial Guinea, Iraq, Somalia and the Syrian Arab Republic can be traced to Nigeria and Pakistan. UNICEF procurement of 1.7 billion doses of oral polio vaccine reaches 500 million children every year, and the organization's social mobilization work helps persuade families to accept the vaccine when it reaches them. Intensive efforts over the past decade have seen acceptance of the polio vaccine at their highest levels ever in countries where polio remains endemic. But the goal of eradication is yet to be met. Progress and challenges related to expanding the quality and coverage of routine immunization and polio are described under Programme Area 1 below.

The first 28 days of life – the neonatal period – remain the most vulnerable time for a child's survival. Neonatal deaths account for 44 per cent of all under-5 deaths. More than one third, or almost 1 million, neonatal deaths occur on the day of birth,

FIGURE 3

GLOBAL DISTRIBUTION OF DEATHS AMONG CHILDREN UNDER 5, BY CAUSE, 2013



Globally, nearly half of all deaths among children under 5 are attributable to undernutrition

Source: United Nations Children's Fund, *Committing to Child Survival: A promise renewed*, UNICEF, New York, September 2014, p. 21; PDF available at http://files.unicef.org/publications/files/APR_2014_web_15Sept14.pdf.

UNICEF's work in the health sector in 2014 continued to be guided by our corporate commitment to equity.

and 73 per cent, or 2 million, occur during the first week of life. Yet in 2012, one in three babies – or an estimated 44 million babies – entered the world without the help of a skilled health-care provider, putting them at even greater risk during this most vulnerable time.

One of the key constraints to maternal and neonatal mortality reduction is the shortage of skilled health-care providers. The global rate of women delivering with skilled attendance has risen only slightly between 1990 and 2013, from 57 per cent to 68 per cent. Only about half of women worldwide receive the recommended minimum of four antenatal care visits. Even for babies and mothers who have contact with the health system, quality care is lacking in many cases, and evidence suggests the need for better coordination between health service delivery and birth registration and data management.

Preventable newborn deaths, much like under-5 deaths, are increasingly concentrated in the world's poorest countries. Together, low-income and lower-middle-income countries account for 85 per cent of all neonatal deaths, even though they are home to only 62 per cent of the world's newborns. By contrast, only 2 per cent of neonatal deaths occur in high-income countries, and 13 per cent occur in upper-middle-income countries. This is why UNICEF's work in the health sector in 2014 continued to be guided by our corporate commitment to equity. In particular, realizing the right of every child to the highest attainable standard of health and development and reducing under-5 and neonatal mortality rates continue to define UNICEF's work for children's health.

In 2014, UNICEF responded to 294 humanitarian situations in 98 countries, including support to deliver health interventions to millions of children and newborns. In the Philippines, in protracted crises in the Democratic Republic of the Congo and the Sudan, or in long-term conflict and violence in Iraq, South Sudan, the Syrian Arab Republic and Ukraine, a key lesson learned was the imperative of promoting multisectoral approaches to children's well-being and resilience; the value of real-time monitoring of

community and other available data on the situation of children, and real-time data to track delivery of essential services and supplies; and the importance of fostering strong and cohesive partnerships. In response to the Ebola outbreak, UNICEF mounted its largest-ever supply operation, distributing more than 5,500 metric tons of essential supplies – equal to 95 jumbo cargo jets – to Guinea, Liberia and Sierra Leone. The Ebola outbreak posed

additional demands on staff and resources, but also presented an opportunity to develop innovative programme strategies, and strengthen multi-sectorial approaches. A key lesson learned was that progress for children is quickly eroded in crises when health systems are weak; this is driving a renewed commitment to health systems strengthening as a core area of work across all the Programme Areas described below.

PLANNING AND RESULTS OUTLINED BY PROGRAMME AREA

As outlined in the results framework of the Strategic Plan 2014–2017, UNICEF's work in the health sector is guided by the primary outcome indicator to which the organization has committed: "Improved and equitable use of high-impact maternal, newborn and child health interventions and the promotion of healthy behaviours"

To deliver output-level results in countries, UNICEF promotes an integrated approach to child survival and development 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 health programme areas outlined in UNICEF's theory of change: child health (pneumonia, diarrhoea and malaria); health in humanitarian action; health systems strengthening; immunization; maternal and newborn health; and polio.

This shift in how we conceive of the theory of change is in line with the shift which must be promoted in global health sector programming and funding – away from disease-specific initiatives and towards sustainable investments that build government capacity, encourage domestic finance and promote strong, equitable health systems. For example, these principles guide development of the Global Financing Facility, and are also in line with the stated commitment of the European Union to invest in stronger health systems. Country experience shows that integrated UNICEF engagement at operational, intermediary and strategic levels is essential to achieve sustainable results – from identifying, proposing and operationalizing solutions to

systemic problems, to building government capacity and support for a costed national plan, to advocating at global and regional levels for the policies and resources that enable continued progress.

For example, in the Democratic Republic of the Congo, UNICEF is supporting ongoing health reform at the intermediary level, with provincial teams responsible for approximately 20 health districts shifting their organization from a vertical programme approach towards integrated health district support. Alongside this change, the UNICEF office is similarly reorganizing internal planning and financing processes in order to provide consolidated quarterly programme support to the province instead of fragmented support by technical area (immunization, nutrition, etc.). UNICEF is also providing technical assistance directly in the provincial health teams in order to integrate the mortality reduction strategies into the provincial and district health plans and for their implementation. As part of this health reform, in 2014 UNICEF joined partners in moving towards a province-wide approach with common strategies, and a single health contract ('contrat unique') at the provincial level between development partners and the provincial authorities, which would improve the current arrangement in which provinces may manage more than 30 different contracts. Negotiations in 2014 to finance an integrated action plan at the intermediate level have yielded results in two provinces (Bandundu and Equateur), where in early 2015 UNICEF agreed with the World Bank, the Global Fund for AIDS, Tuberculosis and Malaria and the GAVI Alliance to pool resources and fully cover all 98 health districts during the next three years.

Results for 2014 are also presented with this integrated framework in mind, organized generally by the health outputs identified in the Strategic Plan, rather than by technical programme area, as in past reports. Specifically, Programme Area 1

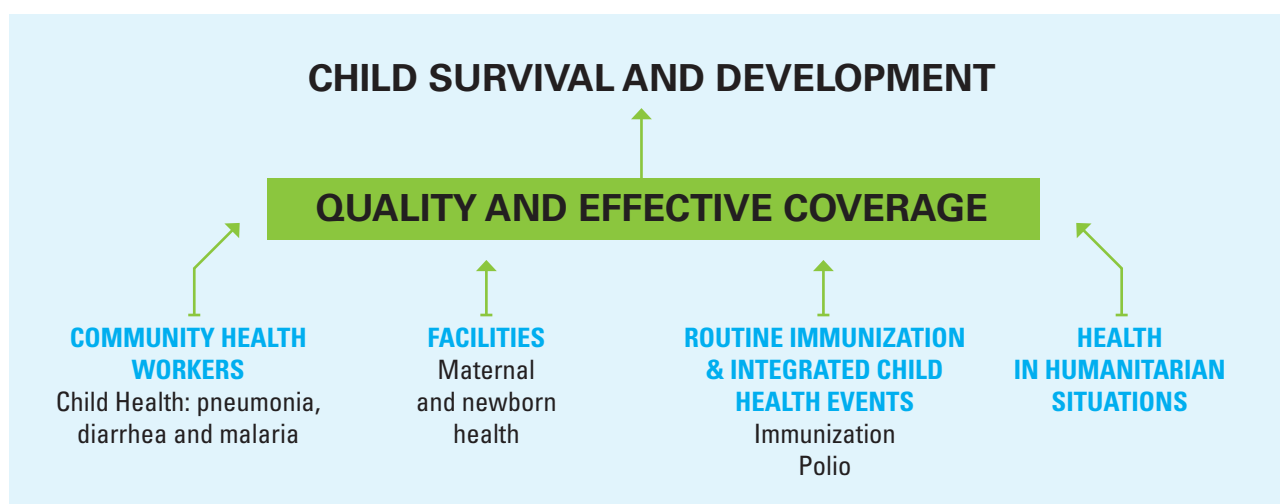
below refers to Outputs a and d in the Strategic Plan Results Framework; Programme Area 2 reports on results related to Outputs b, c and e; Programme Area 3 reports on results related to Output f. Results against key output indicators are cited in the text.

PROGRAMME AREA 1

ENHANCED SUPPORT FOR CHILDREN AND CAREGIVERS

In order to enhance support for children and caregivers for healthy behaviours, and to increase the quality and coverage of priority maternal, newborn and child health interventions to accelerate reductions in mortality, in 2014 UNICEF focused on strengthening four delivery platforms within health systems in countries: (1) community health workers; (2) antenatal care facilities; (3) immunization

services including through integrated child health days and immunization campaigns; and (4) health in humanitarian situations. As described above and shown below, this approach integrates the technical areas identified in the health Theory of Change including child health, health in humanitarian action, immunization, maternal and newborn health, and polio.



COMMUNITY HEALTH WORKERS: ADDRESSING GENDER EQUITY IN THE HEALTH SYSTEM

In Ethiopia, as in India and Pakistan, community health workers are female. In other countries, such as Malawi, they are predominately male, while in countries such as Ghana, there is a balance of male and female health workers. While the contexts vary, in many cases, being a community health worker can enhance the potential of young women for career advancement in the health field.

As part of the Catalytic Initiative/Integrated Health Systems Strengthening programme in Ethiopia, Ghana, Mali, Malawi, Mozambique and Niger, 50,000 community health workers participated in training on iCCM between 2010

and 2014, and 75 per cent of them were female.

In Ethiopia, more than 30,000 female health extension workers, working at about 14,000 health posts throughout the country, have been trained in iCCM since 2010. The Federal Ministry of Health in Ethiopia is currently reviewing the career paths of these women to allow them to advance to a diploma level, including the possibility of progressing to a formal nursing career. By providing opportunities for women to further their careers, such positive changes are beginning to address the question of gender equity in the country's health sector.

COMMUNITY HEALTH WORKERS, ANTENATAL CARE AND COMMUNITY RESPONSE

In every country, the poorest and most marginalized children are the least likely to have access to the health interventions and quality care they need to survive and thrive. To reach these children, more than two thirds of countries in sub-Saharan Africa are now implementing integrated community case management (iCCM) for malaria, pneumonia and diarrhoea. As of 2014, 12 countries had reached the target number of community health workers trained to implement integrated community case management. Fifty-nine countries have in place a policy for community health workers to provide antibiotics for pneumonia, and in 68 countries a policy for home visits of newborns has been adopted after being developed and/or revised, and is in use. Since 2010, UNICEF-supported iCCM programmes in Africa have trained and deployed more than 60,000 front-line community health workers, reaching millions of children who would otherwise have been missed.

The Government of Malawi, for example, is training community health workers with support from UNICEF; these 'Health Surveillance Assistants' treat women and children in homes or village clinics. Through the Health Surveillance Assistants and related strategies, Malawi has achieved record reductions in under-5 mortality: Between 1990 and 2013, the country's estimated rate of child mortality dropped from 245 under-5 deaths per 1,000 live births to just 68. To sustain such progress, UNICEF is assisting the Government of Malawi in linking community-based programmes with health facilities that provide specialized medical services, and in training district health officers in techniques that strengthen their management of the health system.

Because community health workers meet women and children close to where they live – often even visiting inside the home – these programmes not only help save children's lives, but they also help empower women to access care for themselves and their children. Women with access to community health workers do not have to wait until they have the time, money or permission to make a long journey to a health centre. This is important, because in many cases, children die not because their mothers fail to recognize that they need care, but because mothers are simply not able to get them to a distant health centre in time.

In 2014, UNICEF established a formal partnership with the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) to help identify countries where investments for mothers and children could be better aligned with investments in basic maternal, newborn and child health. UNICEF formed a Task Team during the year to provide technical assistance to 18 countries: Burkina Faso, Burundi, Comoros, Côte d'Ivoire, the Democratic Republic of the Congo, Eritrea, Ghana, Ethiopia, Kenya, Madagascar, Mauritania, Nigeria, the Niger, Malawi, Uganda, Somalia, South Sudan and Zambia. In these countries, UNICEF worked with the Governments to review existing child health strategies, develop iCCM gap analysis, draft iCCM components within Global Fund applications, and assist with resource mobilization for co-financing the non-malaria components, such as amoxicillin and respiratory rate timers for pneumonia, and oral rehydration salts and zinc for diarrhoea.

By the end of 2014, eight countries had received US\$164 million for malaria, health-systems strengthening and strengthening iCCM, including US\$71 million from approved Global Fund grants and US\$93 million in co-financing committed from governments, UNICEF, the Reproductive, Maternal, Newborn and Child Health Trust Fund and other donors. In a similar effort, UNICEF initiated a project with the Global Fund and the United Nations Population Fund to strengthen antenatal care services and enhance the availability of basic commodities for pregnant women.

In addition to their role in treating feverish children in general, community health workers also play an important role in disease-specific responses. For example, in Haiti, despite a reduction in the reported number of cholera cases in 2014, the ongoing outbreak in the highly populated West Department demonstrated that sustained efforts are required to reduce the transmission and eliminate the epidemic. In 2014, UNICEF supported deployment of rapid mobile teams in all 10 departments, and the provision of oral rehydration salts, ringer lactate and chlorine tablets. With partners, in September UNICEF supported the vaccination of 184,517 people from seven high-risk areas against cholera. UNICEF also provided technical and financial support at both national and departmental levels for cholera response, including a telephone hotline, salaries and supervision. In addition, 5,625 inmates and personnel from 16 prisons were vaccinated in December through a supplementary campaign. Through a partnership, UNICEF responded to more than 1,300

DEMOCRATIC REPUBLIC OF THE CONGO: UNLOCKING ADDITIONAL RESOURCES TO PROVIDE APPROPRIATE CARE FOR NEARLY 1 MILLION CHILDREN

In early 2014, the Global Fund entered into a partnership agreement with UNICEF to maximize the availability of essential medicines and commodities for mothers and children, including pneumonia and diarrhoea treatment to complement Global Fund malaria inputs. The partnership, which aims to reach nearly 1 million children, works to enhance the comprehensive management of febrile illness in children and protect against the misuse of antimalarial medicines for treatment of non-malarial fevers.

Specifically, UNICEF and the Global Fund agreed to jointly identify countries where HIV and malaria investments for mothers and children could be better aligned with investments in basic maternal, newborn and child health. A starting point was the provision of basic commodities, such as amoxicillin for the treatment of pneumonia, and oral rehydration salts and zinc for the treatment of diarrhoea in children. UNICEF works with governments to review and revise national strategies to strengthen this alignment and helps mobilize additional funding where necessary to purchase related supplies and equipment.

The primary focus in 2014 was supporting countries in developing Global Fund malaria and health-system strengthening concept notes. In the Democratic Republic of the Congo, an opportunity was identified early on to put the collaboration into action to support the set-up of 1,952 community care sites for the diagnosis and treatment of uncomplicated malaria in 119 health zones throughout the country, under a comprehensive iCCM approach. Specifically, either through technical aid by UNICEF staff or dedicated consultants per country and/or sharing of various tools, UNICEF focused on:

- Reviewing existing child health strategies;
- Developing iCCM gap analysis;
- Supporting the drafting of iCCM components within Global Fund malaria and health-systems strengthening concept notes; and
- Assisting with resource mobilization for co-financing the non-malaria components of iCCM that are not covered by Global Fund grants (e.g., amoxicillin and respiratory rate timers for pneumonia, and oral rehydration salts and zinc for diarrhoea).

During the year, UNICEF also brokered partnerships with the World Bank and GAVI to support performance-based funding for community health workers and support for procurement and supply systems that were put in place in the 119 health zones and target districts. Such initiatives will include investments from UNICEF's own funds, and will also catalyse funding from other sources. For example, UNICEF plans to invest US\$6 million of its resources to leverage more than US\$17 million accorded by the Global Fund to the Democratic Republic of the Congo for its malaria-control objectives, indicating the importance of this intervention to the country. In the Democratic Republic of the Congo, the project will extend in progressive phases throughout two target provinces, Bandundu and Equateur, by the end of 2017.

During the first years of implementation, it is expected that nearly 1 million Congolese children will benefit from provision of appropriate care.

cholera alerts, out of which 84 per cent were targeted rapid responses and 16 per cent were prevention activities, including sensitization of 560,000 people and the distribution of cholera kits to 45,000 people.

The Ebola virus disease provided a stark example of the game-changing role of community health workers, and the critical need for community engagement and participation, evidence-based communication strategies and resilient community health worker programmes. Nine million children live in

the areas affected by Ebola; of these, approximately 5,000 were infected and more than 15,000 lost one or both parents or their primary caregiver.⁴ Ebola overstretched health and nutrition services that already struggled to cope with demand before the outbreak. Extremely limited and poorly equipped facilities, coupled with inadequate staffing, meant most health systems were completely unprepared to deal with an outbreak of Ebola's nature and scale. In addition, fear of infection led patients and some staff to avoid health facilities, further disrupt-

ing health and nutrition services. As a result, significant numbers of children failed to receive their routine vaccinations and were at risk of contracting diseases such as measles. In Guinea, consultations and hospitalizations were down by about 50 per cent in 2014, as compared with the previous year. In Sierra Leone, the number of children receiving basic immunization fell by 21 per cent and the number of children treated for malaria was down 39 per cent. In Liberia, only 37 per cent of women giving birth did so at a health facility between May and August 2014, down from 52 per cent in 2013.⁵

In response to the Ebola crisis, UNICEF developed the 'community care centre' model and supported the establishment of 65 such centres with more than 500 beds in Guinea, Liberia and Sierra Leone. Community health workers played a pivotal role in helping communities manage suspected Ebola cases close to home, and in referring patients for appropriate treatment. UNICEF also led the revision of basic service protocols for the Ebola context, which were rolled out across the affected countries and include protocols for immunization, maternal and newborn health and iCCM to help connect children with treatment in the absence of facilities and to counter the trends described above.

SIERRA LEONE: REACHING COMMUNITIES AFFECTED BY EBOLA VIRUS DISEASE

A key lesson learned from the Ebola response is that hard-won progress towards reducing child mortality can be quickly erased when health systems are weak; we have also learned key ways to strengthen health-care delivery.

Evidence from Sierra Leone demonstrates that the location of care centres at the community level reduces the time between symptom onset and presentation by more than 30 per cent, compared with higher-level facilities. This underlines that investment in health-care systems at the community level – by strengthening cadres of community health workers – is clearly a link to building community resilience. The cadres of health workers that have been trained and equipped during the response to the crisis will be valuable assets for transitioning into early recovery and the development of a more robust primary health-care system.

In a game-changing effort, 50,000 community volunteers, health workers, teachers, religious leaders and youth were mobilized to reach more than 1.4 million households in a door-to-door information campaign. More than 4,900 health personnel were trained in infection prevention and control. The mobilized community health workers, care centres, treatment protocols and – most of all – community trust built up during the emergency period will now form the foundation on which the health system must be rebuilt. UNICEF is already working with partners to strengthen these, alongside vaccination campaigns and regular maternal, child health and nutrition programmes and the overall mobilization of community-based organizations, so they can take root and grow.

FACILITY-BASED CARE: FOCUS ON NEWBORNS

Neonatal deaths account for 44 per cent of all under-5 deaths; each year nearly 1 million newborns die on the day they are born. To address the global burden of newborn mortality, UNICEF, together with WHO, Save the Children and other partners, led a global initiative to develop an action plan providing countries guidance centred on evidence-based strategies. Every Newborn: An action plan to end preventable deaths was informed by country consultations in high-burden countries, and focuses on maternal and newborn care around the time of birth. Every Newborn focuses on nine high-impact interventions that are typically provided in health facilities:

- 1. Management of preterm birth, including the use of antenatal corticosteroids for preterm labour;**
- 2. Skilled care at birth;**
- 3. Basic emergency obstetric care;**
- 4. Comprehensive emergency obstetric care;**
- 5. Basic newborn care, such as drying and keeping babies warm and early initiation of breastfeeding;**
- 6. Neonatal resuscitation;**
- 7. Kangaroo mother care;**
- 8. Treatment of severe infections; and**
- 9. Inpatient supportive care for sick and small newborns.**

REACHING EVERY NEWBORN: FROM INDIA TO PARAGUAY

In September 2014, the Government of India launched the Indian Newborn Action Plan to end preventable newborn deaths and stillbirths and reduce maternal deaths. The plan aligns with global mortality targets and spells out six key principles, including quality of care around the time of birth, convergence, partnerships and accountability. To support implementation, UNICEF India worked closely with national and state governments to carry out gap analyses, advocate for increased health financing and support a health monitoring system. In Rajasthan, the largest Indian state, where approximately 83,000 infant deaths were reported in 2013, UNICEF supported the state government to initiate the Monitoring Results for Equity Systems (MoRES) approach to identify, analyse and prioritize gaps and bottlenecks hampering reduction of neonatal and infant deaths. The analysis identified gaps such as low initial and continual service utilization, poor-quality service provision and unhygienic practices during delivery. Based on these findings, UNICEF directly engaged with the district authorities to improve the effectiveness of existing interventions by enhancing service protocols and standards, while simultaneously supporting state authorities to create an enabling environment through differential human resources deployment, flexible budgetary use, and denominator-based monthly traceable indicators. At the

national level, UNICEF supported the Ministry of Health in carrying out a gap analysis that influenced budget and policy for implementation with an equity focus. As a result, the 2014 Reproductive, Maternal, Newborn, Child, and Adolescent Health budget increased at least 20 per cent, addressing the key bottlenecks in the areas of human resources, supply and demand. UNICEF also supported sharing of lessons learned in India more widely: as part of South-South collaboration, the Ministry of Public Health of Afghanistan undertook a visit to India to learn about facility-based newborn care practices, the referral system and institutional deliveries in remote areas.

In Paraguay, UNICEF engaged the President, the Ministry of Public Health and Social Welfare, and the Pan American Health Organization to launch a national mobilization programme to raise awareness of maternal and newborn mortality in order to reduce deaths. The programme was preceded by an innovative advertising campaign to bring public attention to the deaths of infants and newborns: On 18 June 2014, the major toy stores of Asunción, Paraguay's capital, were closed and toys in mourning dresses were displayed in the shops' windows. In addition, the hashtag #ZeroPreventableDeaths was widely used in social media.

UNICEF and WHO convened global partners to develop the plan, which was unanimously endorsed by all 193 Member States at the World Health Assembly in May 2014. By the end of the year, Ghana, India, Indonesia and Pakistan had finalized national newborn action plans, and Namibia and Rwanda had revised their plans to include an appropriate newborn component.

To build momentum for scaling up newborn care, UNICEF focused on country-level planning, capacity building and monitoring, and held national workshops in all seven UNICEF regions. Country consultations were held to conduct systematic assessments to monitor bottlenecks to the scale-up of newborn care and to develop action plans to address these bottlenecks in the countries with the highest numbers and rates of newborn deaths: Afghanistan, where UNICEF supported a Maternal and Perinatal Death Review System and a com-

munity-based newborn care package; Bangladesh, India, Nepal and Pakistan, where UNICEF assisted with supporting local production and use of chlorhexidine for cord care. In Africa, support focused on programmes such as developing a 2015–2016 operational action plan for improving newborn health for rapid deployment in priority health districts (Cameroon); developing a National Newborn Health Strategy and Action Plan for 2014–2018, including consensus on operationalization (Ghana); scale-up of Kangaroo Mother Care in all districts and efforts to train the health workforce and mobilize communities to increase access to and coverage of essential newborn care ahead of the launch of a national ENAP (Malawi); and similar engagement in the Democratic Republic of the Congo, Kenya, Nigeria, Uganda and the United Republic of Tanzania. In the East Asia and Pacific region, UNICEF held national workshops in seven countries to develop newborn action plans. With UNICEF support

India and Nigeria hosted major national newborn health-related events to highlight the action plan, and Bangladesh and Malawi initiated the process of developing national newborn action plans.

Access to skilled birth attendance is improving, but progress is far too slow. Between 1990 and 2012, the global rate of skilled attendance at delivery rose by a mere 12 percentage points – from 57 per cent of births to 69 per cent. The good news is that progress has accelerated since 2000 across all regions, although coverage is still inadequate. In 2012, an estimated 44 million of the 138 million babies whose births were recorded worldwide were born without the assistance of a doctor, nurse or midwife.

When complications arise during delivery, the lives of the mother and the baby depend on immediate access to emergency care. Available data indicate, however, that an alarming proportion of women with obstetric complications do not get life-saving emergency care. In 2014, based on data reported by 90 UNICEF programme countries, on average only 43 per cent of designated Basic Emergency Obstetric and Newborn Care facilities are operational 24 hours a day, seven days a week. In a study of 15 countries in sub-Saharan Africa and Asia, a low of 3 per cent and a high of only 56 per cent of women with obstetric complications were treated in an emergency obstetric and neonatal care facility. This illustrates the lack of availability of these services for the women and newborns facing the highest risk. In 14 of the 15 countries studied, at least half of pregnant women with direct obstetric complications did not receive care from any facility.

Data on delivery in health facilities, referred to as institutional delivery, are more widely available and can serve as a proxy indicator for measuring global access to basic emergency obstetric care. Similarly, the rate of Caesarean sections serves as a proxy for global access to comprehensive emergency obstetric care. The number of institutional deliveries is increasing worldwide. The proportion of women delivering in a health facility rose 26 percentage points, from 37 per cent in 1990 to 63 per cent in 2012. East Asia and the Pacific, South Asia and Latin America and the Caribbean registered the largest increases between 1990 and 2012. Yet in the two regions with the highest birth rates, fewer than half of births take place in a health facility; in South Asia the rate is 44 per cent and in sub-Saharan Africa it is 48 per cent. Improving both the coverage and quality of facility-based care for

mothers and newborns will remain a priority for UNICEF in 2015.

IMMUNIZATION SERVICES

Reducing inequities in vaccination coverage rates, improving immunization supply chain management, and engaging communities remain major priorities for UNICEF.

In 2014, UNICEF took action to support impressive results in immunization: for example procurement of 2.71 billion doses of vaccines for 100 countries, at a value of US\$1.48 billion, and the supply of vaccines that reached 40 per cent of the world's children. Social mobilization and communication for development helped reach more households with messages to help build caregiver understanding of the benefits of vaccination and reduce refusals. With support from UNICEF, 129 countries reached at least 90 per cent coverage at the national level for children under 1 year of age receiving measles-containing vaccine and diphtheria–tetanus–pertussis (DTP)-containing vaccine, and 52 countries reached at least 80 per cent coverage in every district or equivalent administrative unit for children under 1 year of age receiving measles-containing vaccine. In addition, 59 countries reached at least 80 per cent coverage in every district or equivalent administrative unit for children under 1 year of age receiving DTP-containing vaccine, and 53 countries had greater than or equal to 90 per cent national coverage of DTP3 and 80 per cent coverage of DTP3 in all districts.

In 15 countries, UNICEF supported measles elimination and rubella control, involving more than 160 million children, and conducted meningitis A campaigns in 5 countries. Among 59 target countries, 35 have eliminated maternal and neonatal tetanus, compared with 34 in 2013 – and an additional 14 million women of reproductive age received tetanus vaccinations in seven countries.

UNICEF and GAVI partners developed a comprehensive immunization supply-chain strategy in 2014 (see Programme Area 2 for details). UNICEF also supported the introduction of pneumococcal and rotavirus vaccines in 21 countries to prevent diarrhoea and pneumonia, accompanied by technical support, capacity building for service providers to strengthen their management of health information systems, and enhanced planning of immunization services. In order to prioritize hard-to-reach communities, UNICEF developed a five-

step approach for equity assessment and strategy development, based on the experience in ten countries with serious inequities in immunization. This approach involves:

- Review of inequities in coverage;
- Identification of communities affected by inequities;
- Identification of main barriers to vaccination for these underserved communities;
- Development of strategies to be adopted; and
- Mainstreaming equity in policies.

Efforts to increase the procurement and coverage and improve the supply chain of vaccines are fruitless if caregivers refuse to accept vaccination for their children. Communication for development (C4D) is a systematic and evidence-based strategic process to promote positive and measurable behaviour and social change, both individual and collective, particularly through demand creation and community empowerment strategies. UNICEF's

REACHING ADOLESCENT GIRLS

UNICEF's role as a GAVI partner and participation in the Human Papilloma Virus (HPV) vaccine initiative provides a distinctive platform for advancing the health of very young adolescent girls, in partnership with ministries of health and education and other stakeholders. In Benin, Côte d'Ivoire, Gambia, Ghana, Malawi, Senegal, Sierra Leone and Zimbabwe, UNICEF has been using the Adolescent Health Intervention Assessment Toolkit to support national assessments for integration of additional health services for girls 9–13 years old related to the HPV vaccine. For example, the assessment in Ghana identified options for integration, including an mHealth intervention that offers adolescents information on reproductive health through a Short Message Service (SMS) platform via their mobile phones; work is ongoing to identify which options to prioritize in implementation. In Malawi, key messages and information on adolescent health and development were disseminated during social mobilization and outreach activities as part of the second year of vaccination delivery.

C4D strategies focus on the interface between the provision and uptake of health services to minimize barriers and maximize opportunities for healthy behaviour. In the case of immunization, the goal is to decrease vaccine refusal. In Mozambique, UNICEF engaged religious leaders through the Council of Religions (a national body made up of both Christians and Muslims) to create guides that quote passages from religious texts to better facilitate religious leaders' acceptance of vaccination campaigns. School clubs and youth associations were also mobilized to encourage vaccination, and children were appointed 'guardians of health' or 'sentinels for the vaccination calendar' for younger siblings (those under 1 year of age). In Lebanon, based on findings of a vulnerability mapping tool that revealed sector-specific needs, in collaboration with the Ministry of Public Health and WHO, UNICEF identified 210 high-risk areas for polio outbreaks in regions with low immunization coverage and high concentrations of vulnerable Lebanese and Syrian refugees. Mass media and traditional Syrian storytellers were then engaged to communicate the importance of polio immunization, and to train health workers on vaccine management. As a result of this integrated approach, 96 per cent of targeted under-5 children were immunized through national and subsequent mop-up campaigns.

Approaching C4D from multiple angles and using various platforms can increase impact; new strategies using SMS messages help reach diverse populations, and older communication technologies such as radios can be used in new ways. For example, edutainment – content that is designed to educate as well as entertain – has been a most successful medium to communicate with caregivers in the Democratic Republic of the Congo, Kenya, Liberia, Mozambique and Sierra Leone.

In Afghanistan, India and Pakistan integrated technical support to the communications and social mobilization programmes focused on polio eradication. In Pakistan, UNICEF helped with preparation of the High-Risk Union Council Low Transmission Season Plans for December 2014–May 2015, Communications Campaign development and PolioPlus initiatives, including the introduction of health camps in areas with clustered refusals or poor access. In Afghanistan, UNICEF reviewed existing communications materials, supported synergies between the Expanded Programme of Immunization and Polio Eradication teams in advance of inactivated polio vaccine (IPV) introduction, and helped establish partnerships with BBC Pashtu/Voice of America. In

REACHING EVERY CHILD: ERADICATING POLIO IN NIGERIA

In Nigeria, to reach children in some of the country's hardest-to-reach areas, UNICEF works with local leaders to conduct risk assessments ahead of every polio campaign. Together with its partners, it continues immunization activities, with a particular focus on known high-risk areas and communities with repeated vaccine refusal.

To reach every child, UNICEF works to organize health camps during and in between campaigns, providing polio vaccines together with a broader primary health-care package. UNICEF also supports ongoing household and community engagement in a low-profile manner to build acceptance for polio vaccination. Voluntary community mobilizers go house to house to educate, follow up on and mobilize families to improve their health, including rallying families for polio and routine immunization. In 2014, more than 3 million children received the polio vaccine at health camps and nearly 3.3 million children were monitored during immunization rounds. Vaccination in camps for internally displaced people is another priority. UNICEF also engages

with religious and traditional leaders to harness their influence to educate the public about polio and positively influence acceptance of the vaccine.

In close collaboration with WHO and the GAVI Secretariat, UNICEF co-leads the planning of the introduction of inactivated polio vaccine into routine immunization systems. In Nigeria, the inactivated polio vaccine was successfully introduced during polio campaigns in Borno, Yobe and parts of Kano in 2014, to further enhance population immunity.

The results are exciting. Today, poliovirus is geographically restricted to only two states, compared with nine states in 2013. The number of social mobilizers increased from 2,153 in January 2013 to almost 10,000 in October 2014. The largest polio communication network in the world now includes more than 1,500 female members of the Federation of Muslim Women's Associations in Nigeria, 1,400 polio survivors and 250 religious focal persons.

HIGHLIGHTS OF HUMANITARIAN PROGRAMME RESULTS ACHIEVED IN 2014 WITH SUPPORT FROM UNICEF:

34 countries have mainstreamed risk reduction/resilience, including climate change, into national health strategies and plans, 7 more than in 2013.

78 per cent of targeted families in humanitarian situations received two insecticide-treated mosquito nets, compared with 30 per cent of targeted families in 2013.

77 per cent of targeted children aged 6–59 months in humanitarian situations were vaccinated against measles.

In India, UNICEF supported development of the Social Mobilization Network Transition Plan, prepared a Mass-Media Plan for the Polio Eradication Unit support to routine immunization, and conducted a thorough budget review of expected 2015 costs to support resource mobilization efforts.

Essentially linked to routine immunization, eradication of polio remains a priority, and in 2014, UNICEF secured funding for and supported the delivery of 1.7 billion doses of polio vaccine. Together with WHO, UNICEF worked with 66 countries to help them prepare for a polio-free world by switching from oral polio vaccines, which have some associated risks, to IPVs, which are delivered through the routine immunization programme. With UNICEF support, seven countries have now completed introduction of the IPV vaccine.

The communications response in Nigeria, Pakistan and Somalia was guided by new social data that emerged in 2014 from a partnership established in 2013 with Harvard University Polling, which allowed the programmes to appropriately target information and monitor the pulse of the community over time. Although the total number of cases decreased from 416 in 2013 to 359 in 2014, insecurity led to increases in Afghanistan and Pakistan. In March 2014, India was certified as polio-free, proving that even the most hard-to-reach and vulnerable children can be reached despite demographic, economic and sociocultural challenges. The biggest polio success story in

2014 was Nigeria, where the number of cases fell from 53 in 2013 to 6 in 2014, moving the country closer to the goal of being declared polio-free in 2015.

HEALTH IN HUMANITARIAN SETTINGS

In general, children are hardest to reach in settings that are fragile, or affected by conflict or emergency. But because UNICEF is present in countries even before the onset of an emergency and has long-term partnerships with sectoral ministries, local organizations and civil society, the organization can deliver direct and rapid support in the early stages of humanitarian response. In Yemen, for example, UNICEF provided life-saving interventions to nearly 1 million children and women (100 per cent of target groups) through community-based activities such as measles campaigns and integrated outreach activities. In Iraq, in order to reduce the risk of communicable diseases, UNICEF and WHO supported the Ministry of Health in immunizing more than 5.6 million children against polio. In the conflict-affected states of South Sudan, UNICEF-supported integrated vaccination campaigns against measles and

polio that have reached almost 1 million children aged 6 months–15 years. In the Philippines, using flexible and adapted programming, UNICEF helped restore routine immunization services that had been disrupted following the Haiyan typhoon.

The children of the Syrian Arab Republic continue to suffer from the consequences of escalating violence and continuous displacement due to the ongoing conflict, which further intensified and expanded into many parts of the country in 2014. From late 2013 into early 2014, disruption of routine immunization, severe damage to the country's health infrastructure and large-scale displacement led to the first polio outbreak since 1999. In response, UNICEF and partners successfully conducted polio immunization and communication campaigns reaching nearly 3 million children under 5. Maternal health, control of diarrhoea, acute respiratory infections and neonatal care also remain a focus of the health response. UNICEF built the capacity of health facility and community-based service delivery platforms by training more than 1,200 doctors, nurses, midwives and technicians on health services, and some 2,000 volunteers and health workers on communication skills for social mobilization. Further support to scaling up life-saving services to children in both accessible and inaccessible loca-

UNDERSTANDING AND RESPONDING TO THE NEEDS OF REFUGEE CHILDREN IN LEBANON

After four years of regional crisis, in 2014 the number of Syrian refugees in Lebanon surpassed 1.1 million – equivalent to an additional 25 per cent of Lebanon's pre-crisis population, and the largest refugee burden of all countries hosting Syrian refugees. To understand what is needed most in this setting, in partnership with the UN Refugee Agency and the World Food Programme, UNICEF supported the second round of the Vulnerability Assessment of Syrian Refugees in Lebanon, which provides representative estimates on the entire registered Syrian population on a number of indicators including health. In addition, UNICEF jointly conducted a youth-focused situation analysis with United Nations Population Fund (UNFPA), United Nations Educational, Scientific and Cultural Organization, Save the Children and the UN Refugee Agency to provide health-related information on vulnerabilities of Syrian refugee youth. The analysis resulted in prioritiza-

tion of youth as a cross-cutting theme in 2015. To support the Government of Lebanon in enhancing maternal and child health care overall, to benefit both refugee and Lebanese children, UNICEF supported the provision of medical equipment, essential medicines and cold-chain systems in primary health-care facilities. In 2014, 185 primary health-care facilities received support for the provision of 431,855 consultations. To further improve service delivery, UNICEF completed a situation assessment on the primary health-care services that identified gaps and priorities in 139 primary health-care facilities. With the Ministry of Public Health and other health-sector partners, UNICEF will use the results to develop a plan to address the identified issues. Through capacity building and development of Inter-Agency Guidelines for Gender-Based Violence Interventions in Humanitarian Settings, gender was also mainstreamed into health-sector work.

tions is ensured by the establishment of three hubs in Aleppo, Damascus and Qamishli, in addition to the already existing zonal offices in Homs and Tartous. The field offices have been fully staffed with international and national professionals for key sectors including health.

UNICEF's Supply Division support to emergencies was particularly intense in 2014. There were record months in August, September and October – each seeing more than 1,000 metric tonnes of life-saving supplies being sent to nine countries in the WCA-RO and MENA regions. By December, supplies to Guinea, Liberia and Sierra Leone for the Ebola response reached 5,500 metric tons – exceeding that sent to all other emergencies combined. The Ebola supply response required the mobilization and coordination of expertise across Supply Division to establish new supply chains for new products in constrained markets. UNICEF and partners demonstrated the agility and leadership required to effectively respond to iterative programming needed to deal with a fast-evolving epidemiology. In November, the UNICEF Supply Division hosted the first-ever consultation on the Ebola virus disease personal protective equipment industry, which gathered leading manufacturers and buyers to address the constrained global market for personal protective equipment such as protective suits. Procurement agencies agreed to aggregate demand projections and formally share these with industry through a newly established information portal. Market stability was further enhanced by the harmonization of product specifications. As a result, a 30 per cent gap in current global production capacity was rapidly reduced as new prequalified suppliers expanded the supplier base. A tender for personal protective equipment resulted in a 60 per cent reduction in the price of coveralls.

A commitment to building resilience means UNICEF is providing increased support for preparedness activities. The cholera situation in Haiti has improved,

with a reduction of about 53 per cent in 2014 compared with 2013 due to an effective surveillance and response system that was put into place. The capacity for emergency preparedness and response has also significantly strengthened, and contingency plans now exist for 9 out of 10 departments. In Kenya, United Nations agencies worked together at all stages for a joint proposal by UNICEF and WHO to the United Nations Central Emergency Response Fund: this included proposal development, the development of strategic and contingency plans, planning for preparedness, coordination support and implementation. Further examples of UNICEF's support for health in humanitarian settings can be found in the humanitarian sector report.

CONSTRAINTS AND CHALLENGES

A primary challenge encountered across each of the platforms described above was reduced access in fragile and conflict settings. As a result, for example, the global goal to eliminate maternal and neonatal tetanus will not be met in 2015. In addition, Pakistan saw a significant increase in the number of type-1 wild poliovirus cases. In Guinea, Liberia and Sierra Leone, the Ebola crisis undermined hard-won progress towards Millennium Development Goals 4 and 5 and undermined community confidence in facilities. And surge support underpinning UNICEF's response to the outbreak redirected capacity that had been committed to other programme priorities, delaying results such as the development of a global emergency training. In both emergency and non-emergency countries, lack of capacity in national health systems is the main challenge that UNICEF works with partners to overcome, as weaker systems require more support and investment to achieve the same results for children. For example, lack of trained health workers, weak supply chains and persistent bottlenecks that prevent reliable supply of life-saving commodities persist in many countries, making progress slow.

PROGRAMME AREA 2

INCREASING CAPACITY AND STRENGTHENING COMMITMENT OF GOVERNMENTS TO IMPROVE HEALTH AND REDUCE MORTALITY IN ALL SETTINGS

UNICEF's approach to increasing capacity and strengthening commitment of governments and local partners to develop and implement health policies and strategies is based on the principle

that implementation of equity-focused strategies designed to remove empirically identified bottlenecks in the health system will improve the effectiveness of that system in deprived areas. The end

result should be reductions in health disparities, improved resilience in the context of outbreaks and emergencies, and overall improvements in population health. The importance of this approach has been reinforced by the Ebola emergency in West Africa, which has been, to many, a heart-breaking example of how weak health systems can fail to prevent and control disease outbreaks, thus magnifying existing disparities and eroding overall population health.

UNICEF has always engaged in health systems strengthening (HSS), but the organization's priorities, approaches and tools have evolved over time, and particularly over the past five years. Today, UNICEF's approach to HSS is explicitly focused on the most marginalized women and children, as both an ethical and practical priority. It takes account of the need for, and complementarity of, interventions at the national and subnational levels – and of the centrality of district-level management and community-based interventions using paid community health workers for the overall performance of a national health system. The UNICEF HSS approach also focuses on aspects of management, service delivery, quality assurance and community engagement (including communications), as illustrated by the Effective Vaccine Management work described below. In general, a seven-step process guides UNICEF to support countries in this programme area:

- 1. Identify the most deprived populations through an assessment of inequities;**
- 2. Understand priority causes of mortality, morbidity and malnutrition in these deprived populations;**
- 3. Select the related evidence-based health interventions that can prevent or cure the main causes of mortality, morbidity and malnutrition in deprived populations;**
- 4. Using local data, understand the bottlenecks that constrain coverage of these priority interventions;**
- 5. Analyse the underlying causes of the bottlenecks;**
- 6. Develop strategies and budgets that address these bottlenecks; when possible, project costs and impacts to support comparisons of cost-effectiveness and disparity reduction; and**

7. Support decentralized implementation of strategies and monitor their impact on bottlenecks.

In 2014, UNICEF invested in developing capacity in country and regional offices to understand and implement its approach to health-systems strengthening at the national and district levels. Support for district-level health-system strengthening was provided in Eastern and Southern Africa (Malawi and Zambia), West and Central Africa (the Democratic Republic of the Congo), the Middle East and North Africa (Djibouti, Egypt, the Sudan and Yemen) and Central and Eastern Europe (Kyrgyzstan). This involved using simple tools and training materials to improve operational plans and budgets, quality assurance mechanisms and coverage of high-impact interventions, as part of the organization-wide commitment to equity and the implementation of MoRES.

In different countries, the MoRES approach to health systems strengthening is called by different names. In Bangladesh, UNICEF's Evidence-Based Planning and Budgeting model is an entry point to incremental capacity building of health managers in planning and strengthening the health system as a whole for decentralized decision-making processes. The process helps local health managers to identify, analyse and prioritize key problems, develop key solutions specific to their local context, and implement innovative approaches for reducing maternal, neonatal and child mortality and morbidity. It has also improved capacity of district-level staff to monitor results for achieving effective coverage of MNCH services and immunization coverage and link with the Health Management Information System. The immunization programme, being more advanced and truly decentralized, allowed government budgets to be secured for the newly identified corrective actions within the Reach Every Community programme. For the MNCH programme, thanks to funds allocated by UNICEF to the Government, budgets were secured and used according to the local needs. In all districts and programmes supported by UNICEF in which the new planning and budgeting process are introduced, evidence shows that these budgets are used wisely and in a timely way. These results have inspired other partners to engage in similar support: Save the Children enhanced support to the scale-up of MNCH services, and the International Centre for Diarrhoeal Disease Research in Bangladesh is supporting the Ministry of Health in developing equity profiles for MNCH services in 64 districts.

In the Plurinational State of Bolivia, implementation of planning tools with a focus on equity strengthened the subnational planning processes in maternal and child health, HIV and AIDS, water, sanitation, hygiene and nutrition with participation from stakeholders beyond the health sector. These included communities, the Committee on Water and Sanitation, social organizations and women's groups, and municipal, provincial and national officials, among others. Data captured in the bottleneck analysis provided a convincing argument for the allocation of additional national resources of the Government of Potosi towards the evidence-based strategies indicated by the planning tools, and the experience in Potosi has generated interest at the national level and in other departments in the country, indicating that initial investment may have a roll-over, amplified effect.

In the Philippines, building on earlier Investment Case/Evidenced-based Planning and Budgeting in three cities, UNICEF collaborated with the Philippine Department of Health in 2014 to develop a National Handbook on Local Investment Planning for Health. This national-level policy tool addresses key issues and challenges – including the previous lack of a coherent set of policies around health planning and management – and will serve as the over-arching guiding document on subnational health planning in the Philippines in the coming years. Recognizing that prohibitive out-of-pocket expenditures perpetuate the vicious cycle of ill health and poverty for many Filipino families, UNICEF also supported a partnership with the Department of Health, WHO, the World Bank and the Philippine Health Insurance Corporation to design a Primary Health Care package. Developed in 2014 and launched in early 2015, the package will deliver quality health care for the poorest 11 million children, including health profiling, diagnostic tests and medicines for children under 5. A separate package is currently being tailored for premature newborns. The new package, developed under the umbrella programme of *Tamang Serbisyo para sa Kalusugan ng Pamilya (Tsekap)*, redefines Philhealth's existing primary care benefits package by expanding the coverage of primary health-care services designed to address the most common health problems found at the barangay level.

In the Sudan, UNICEF supported the Federal Ministry of Health to adopt a district health-systems strengthening approach to improve maternal and child health. Sixteen interventions were prioritized at the national level to serve as a menu for states

to select five to seven high-impact interventions. UNICEF then organized a training on bottleneck analysis for 47 national and state-level ministry officials. A core group was identified from among these participants to lead implementation – including training, data collection and bottleneck analysis – in four pilot states (Gadarif, Kassala, River Nile, and Sinnar) in a first phase in 2014, to be followed by scale-up to all states. To help compensate for data gaps, UNICEF also contracted the Liverpool School of Tropical Medicine to carry out a household survey using Lot Quality Assurance Sampling, with data collection supported using mobile phone-based software to improve data quality, increase speed and reduce costs.

In Uzbekistan, national scale-up of improvement of maternal, neonatal and maternal health care services is focused on achieving sustainable results at both the national and subnational levels. At the national level, UNICEF supports the development of evidence-based maternal and child health policies and regulatory framework: State Programmes, relevant standards, protocols and degrees, a Quality Improvement Concept, and improvement of the health information system, including introduction of international live birth definition in health statistics, health facility surveys, development of maternal and child mortality database software, and introduction of training packages in pre-service and post-service curricula. At the subnational level, apart from capacity development of health managers and professionals (newborn and child survival packages), UNICEF support has been focused on integrated quality assessments of maternal, newborn and child health services in targeted regions and on the development of local quality improvement plans. Based on identification of system bottlenecks, local improvement plans have been developed and are being implemented in targeted facilities. Special attention is paid to supportive supervision as a key element with the twofold purpose of complementing the training component through on-the-job mentoring and strengthening institutional capacity for monitoring the performance of health providers. Midterm real-time monitoring in target regions, using Lot Quality Assurance Sampling and carried out in 2014 with UNICEF support, revealed improvements in some indicators that outpaced the set 2015 targets: for example, in inpatient facilities, the percentage of MCH care system managers who have implemented the gained knowledge on the newborn and child survival packages in their regular practice increased from 14 per cent in 2013 to 41 per cent in 2014 (2015 target was at least 30

per cent), and for outpatient facilities, the percentage of children aged 2 months to 5 years who were examined by general practice doctors according to approved protocols/standards increased from 23 per cent in 2013 to 57 per cent in 2014, outpacing the 2015 target of at least 50 per cent.

These country experiences demonstrate that successful transition of UNICEF from vertical programming to technical assistance and upstream work is possible with sufficient technical credibility, political will in the country, and willingness to work together in new ways.

Availability of data that is fit for purpose, reliable, timely and able to be disaggregated enough to allow substantive equity analysis is a key determinant of country capacity for the monitoring and evaluation and responsive actions necessary for sharpening plans, enhancing programmes and strengthening health systems. RapidPro is one of the innovative tools UNICEF is supporting to empower governments to access more real-time health information. RapidPro is an open-source software that uses text message exchange via SMS technology to transform the way governments and development partners connect, engage and collaborate with communities. For example, a parliamentarian in Uganda's capital may pose a question to her constituents via SMS using RapidPro-based software and receive thousands of real-time responses from rural communities in minutes. Coined an 'app store for international development', RapidPro can be used to build customized platforms for citizen reporting, enabling even the most marginalized to link in, or speak out. Since its launch in September 2014, almost 30 million messages have been sent or received through Rapid Pro. Some examples of issues addressed by these messages are below.

Knowing what is needed where and ensuring a smooth and predictable supply chain is key to strengthening supply chains and vaccine management. One application of RapidPro is mTrac, an innovation using mobile phones and SMS to digitize the transfer of Health Management Information System data. Launched by the Ministry of Health in Uganda, the initial focus of mTrac was to speed up the transfer of weekly Health Management Information System reports on disease outbreaks and medicines, provide a mechanism for community members to report on service delivery challenges, and empower district health teams by providing timely information for action. For example, during an Ebola outbreak in 2012, mTrac was used in Uganda

WHAT IS MoRES?

Developed as part of UNICEF's refocus on equity, the Monitoring of Results for Equity System (MoRES) is a programming and monitoring approach to strengthen existing planning, programme design and monitoring practices. It emphasizes improved identification and analysis of rights deprivations and inequities; use of a common analytical framework (i.e., the determinant framework) that can be adapted by sectors; and frequent monitoring of data. The emphasis on frequent tracking of priority bottlenecks and barriers aims to support governments and partners in addressing the critical gap and time lag between routine monitoring of programme inputs/outputs and the monitoring of final outcomes or impact.

In Egypt, with UNICEF support, MoRES analysis helped the Ministry of Health and Population enhance its Integrated Perinatal Health and Child Nutrition Programme, resulting in improved case detection of anaemia among screened children in three districts, as well as improvements in four districts in the proportion of pregnant women receiving antenatal care during the first trimester. In Nigeria, application of MoRES has contributed to strengthening the birth registration system, and frequent monitoring of bottlenecks/barriers through RapidSMS has enhanced accountability of registrars and managers and improved more timely and accurate registration and reporting. For example, between January 2011 and December 2013, more than 13 million children were registered in Nigeria as highlighted through the RapidSMS platform.

In the Dominican Republic, a 2013 MoRES exercise conducted in five hospitals in the most disadvantaged regions identified bottlenecks and solutions to overcome them at hospitals, primary health care units and in communities. This analysis informed the Ministry of Health's decision to expand the Baby-Friendly Hospital Initiative in 2014, adding four new components aimed at reducing maternal and neonatal mortality by increasing access to antenatal care, clean childbirth, prevention of sepsis and timely birth registration.

through a series of SMS messages alerting health workers to the outbreak, the case definition (symptoms), isolation procedures, the location of the nearest isolation facilities and the hotline to the national response team for reporting suspected cases.

The information gathered through mTrac is aggregated, tabulated and graphed on an online dashboard and made available to district health management teams, allowing district health managers to redistribute drugs to health facilities that need them most and request timely replenishment of stocks from the National Medical Stores. To date, more than 16,000 health workers in 3,200 health facilities in Uganda have been registered and trained, and are actively using mTrac for reporting critical health data. Real-time monitoring of vaccine supplies enabled stock-outs to be addressed and led to an increase in immunization coverage of DPT1 from 52 per cent to 98 per cent within one year. The initiative also integrates governance and accountability through citizen feedback and anonymous hotline and public dialogue sessions, which have allowed District Health Management Teams to address issues raised by community members, such as those related to quality of care and health worker absenteeism. Plans are under way to scale up mTrac in six more countries in 2015.⁶

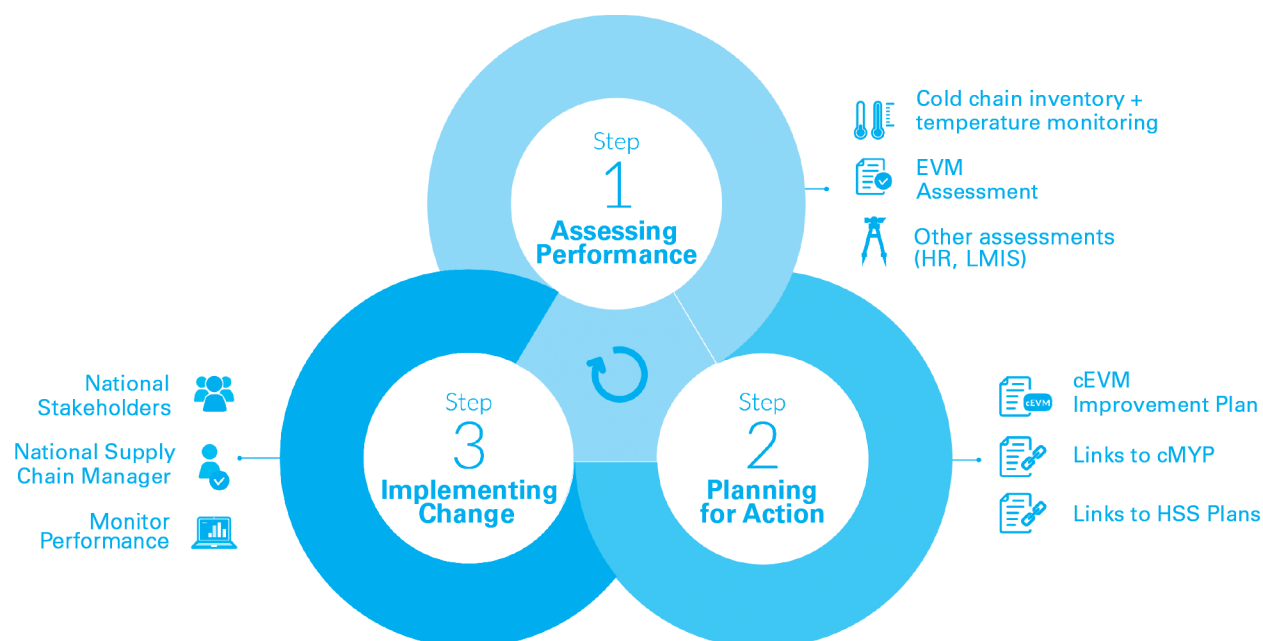
In August 2014, as part of the Ebola response, a similar RapidPro based platform called mHero was

created to allow health workers, government authorities and other key stakeholders to engage in real-time, targeted communication via two-way SMS, interactive voice response and direct calls. During the pilot in Liberia, mHero sent such messages to 482 health workers in four counties to validate health workers' phone number, location, job title, supervisor, facility, bank account information (critical for timely payments) and use of facility attendance logs. UNICEF is also using mobile technology and real-time data to engage frontline staff in Afghanistan, Nigeria and Pakistan and help them with their polio vaccination efforts through satisfaction surveys, flash polls, knowledge and message reinforcement and motivational messages.⁷

The fact that few country immunization supply chains currently meet the WHO minimum performance standards demonstrates that increased capacity and stronger systems are especially important in the area of immunization. In 2014, under the auspices of the recently established global collaboration known as the WHO and UNICEF Immunization Supply Chain Hub, UNICEF supported 15 countries in strengthening national immunization supply chain systems using the Effective Vaccine Management (EVM) approach – a holistic, three-step process to diagnose, prioritize, plan and implement improvements relating to immunization supply chains (*see Figure 4*).

FIGURE 4

THE EVM APPROACH



The goal of EVM is for country supply chains to be led, managed and staffed by qualified people with professional recognition and authority, who use data that are timely and of good quality to manage the systems, with vaccines stored and transported in well-maintained and managed equipment. In this way, quality vaccines are more likely to reach all children. In 2014, UNICEF supported implementation of EVM plans in 20 countries. For example in South Asia, UNICEF's regional office provided technical and financial support to conduct Effective Vaccine Management assessments of the supply chains in Bangladesh, Nepal and Pakistan, and preparatory work for an assessment in Afghanistan. An improvement plan has been completed in Bangladesh and is being prepared in Nepal and Pakistan. The increased interest of major donors in immunization supply chain and logistics systems (notably GAVI, which is providing funding to countries through HSS cash grants and to UNICEF and WHO through the GAVI Business Plan), helps UNICEF address systemic barriers to routine immunization delivery and thus leverage 'vertical'

programme investments to amplify the long-term benefits for health systems.

CONSTRAINTS AND CHALLENGES

Lack of quality, disaggregated data, unreliable health management information systems, and limited capacity for data analysis are constraints that impact both programme effectiveness and monitoring in many countries. Persistent bottlenecks that prevent the reliable supply of life-saving commodities, gaps in resources that hinder implementation of adopted policies, and insufficient capacity at the national and/or subnational level for management, monitoring and strengthening of the health system are additional challenges that persist in many countries. The programmes described above help mitigate these. For example, trainings and technical support enhanced national and district-level capacity for data analysis to strengthen health systems in Malawi, supported by the development of user-friendly analytical tools like the EQUIST tool.

PROGRAMME AREA 3

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

At the global level, UNICEF maintained its pledge to 'A Promise Renewed', the movement to end preventable maternal, newborn and child deaths. With support from UNICEF and other United Nations agencies, more than 180 governments have endorsed the movement's goal since its launch in 2012. In 2014, Ghana, Namibia, the Philippines and the United Republic of Tanzania engaged with 'A Promise Renewed' by taking such actions as sharpening national strategies for reproductive, maternal, newborn, child and adolescent health (RMNCAH); announcing costed targets that extend beyond 2015; adopting tools to monitor progress such as country-specific scores cards; and mobilizing civil society, the private sector and individual citizens around the movement's goals.

To date, as many as 60 countries have undertaken efforts under the banner of 'A Promise Renewed', all with the goal of stopping women and children from dying of easily preventable causes. In Latin America, UNICEF is taking a lead role in communication and advocacy around A Promise Renewed, including supporting high-level advocacy and policy dialogue to mobilize political and technical leadership to reduce

inequalities in health in nine priority countries (Brazil, the Dominican Republic, El Salvador, Haiti, Mexico, Nicaragua, Panama, Paraguay and Peru) in the second half of 2014 and into 2015.

In 2014, several governments, including those of Ghana, Kenya, Malawi, Namibia and the United Republic of Tanzania, launched nationally owned scorecards to monitor progress against national reproductive, maternal, newborn, child and adolescent health targets. Developed with support from UNICEF, WHO and the African Leaders Malaria Alliance, the scorecards provide policymakers with a tool for monitoring, publicizing and, where necessary, strengthening subnational strategies designed to improve the health and well-being of women, newborns, children and adolescents.

UNICEF also maintained its leadership role in many other global maternal and child health partnerships, including the following: H4+, a collaboration between UNICEF, the United Nations Population Fund, WHO, the World Bank and UN Women; the International Health Partnership; the Reproductive, Maternal, New-

born and Child Health Trust Fund and its associated steering committee; the Partnership for Maternal Newborn and Child Health based at WHO; GAVI; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Global Polio Eradication Initiative; the Secretary-General's strategy Every Woman Every Child, Countdown to 2015, maternal neonatal tetanus elimination and the Measles & Rubella Initiative. UNICEF also played an influential role in the design of the World Bank's new Global Financing Facility for Reproductive, Maternal, Newborn, Child and Adolescent Health. Work in 2014 focused on the business planning stage of the Financing Facility; the results of this engagement will be seen in how many countries are able to scale up action according to a costed investment plan in 2015 and beyond.

In 2014, UNICEF remained deeply engaged in technical partnerships focused on ending preventable child deaths; these include the Diarrhoea and Pneumonia Working Group (co-chair with the Clinton Health Access Initiative) of the Community Case Management Task Force, the Roll Back Malaria Partnership and the Every Mother Every Newborn initiative. Advocacy at the global level aims to drive policy change and action in countries, supporting progress that is already under way. In 2014, 62 of 75 priority countries for Countdown to 2015 had costed implementation plans for maternal, newborn and child health care, up from 52 in 2013, and 43 countries had developed, budgeted and implemented a maternal, newborn and child health communication plan, up from 16 in 2013.

CONTINUED COMMITMENT TO ROLLING BACK MALARIA

UNICEF is one of the founding members of the Roll Back Malaria Partnership, and during 2014 continued to serve on the partnership's Board and Executive Committee, in addition to a new position as chair of the Malaria Advocacy Working Group. UNICEF's technical support through the Roll Back Malaria Harmonization Working Group helped to ensure submission of strong malaria concept notes for financing from the Global Fund's New Funding Model. UNICEF also contributed to scaling up country malaria programmes in support of the Roll Back Malaria Global Malaria Action Plan, with a particular focus on malaria prevention and control in women and children.

UNICEF's Supply Division leads another important stream of UNICEF global-level engagement in the health sector. Children's health was at the core of the US\$3.38 billion in supplies and services that UNICEF procured for programmes and partners in 2014. In total, US\$1.48 billion was used to procure 2.7 billion doses of vaccines, reaching 40 per cent of the world's children. In line with the ambitious timeline of the Global Polio Eradication Initiative and Endgame Strategic Plan, in 2014 UNICEF concluded a tender process that made accessible sufficient quantities of affordable IPV to support country introductions of the vaccine. The vaccine was made available to GAVI-supported countries for as little as approximately US\$1 per dose in 10-dose vials. For middle-income countries, 10-dose presentations became available through UNICEF from July 2014 at a price of approximately US\$2.04 – US\$3.28. In addition, the awards by UNICEF include a price of US\$1.90 per dose for IPV in five-dose vials and US\$2.80 for IPV in single-dose vials. With this tender completed, more than 120 countries are moving forward with plans to introduce at least one dose of IPV into their routine immunization schedules.

A scale-up in demand for essential medicines identified by the UN Commission on Life-Saving Commodities for Women and Children made an impact on procurement to countries. For example, the number of countries where UNICEF provides amoxicillin dispersible tablets has nearly quadrupled in only three years, and now stands at 27. Procurement of other health commodities – including pharmaceuticals, syringes, diagnostic and other health technologies, hospital equipment and cold-chain refrigerators and freezers – totalled US\$505 million.

As the largest buyer of children's vaccines, UNICEF uses its considerable influence to create competitive supply markets that are sustainable but also fairly priced. In this regard, efforts led by UNICEF focused on achieving improved accessibility, affordability and quality of products, while supporting market sustainability where shortcomings exist. Working together with partners, UNICEF secured savings in health commodities, including savings of more than US\$253 million in procurement in 2014.

Collaboration among health partners at the global level to achieve results is key to UNICEF's achievements in supply. A strong focus on supply chain strengthening continued to be reflected in 2014 in UNICEF's very active membership in the GAVI supply chain task force, support to the development and implementation of its strategy, the GAVI 2015 Business Plan and in leadership of specific working groups. UNICEF, along

with donors and implementation partners including the Global Fund, the United States Agency for International Development (USAID), the United Kingdom's Department for International Development (DFID), Norway, the World Bank, GAVI, UNFPA, WHO, and the Bill and Melinda Gates Foundation, committed to support and align important areas across the supply chain and has issued a joint supply chain vision statement. UNICEF's partnership with the Global Fund, DFID and others in the largest-ever procurement of long-lasting insecticidal nets received international recognition from the world's leading supply and procurement professional organization, the Chartered Institute of Procurement and Supply. Additionally, UNICEF continues to work closely with the Bill and Melinda Gates Foundation and GAVI on a range of pentavalent vaccine-related issues, resulting in generation of anticipated savings that exceeded original expectations.

In 2014, UNICEF also funded and supported global research on improving delivery of maternal, newborn and child health services to disadvantaged populations, including research on evidence-based planning; district health systems strengthening; integrated community case management of diarrhoea, malaria, pneumonia and acute malnutrition in non-emergency and emergency contexts; child health days; quality of care around the time of birth; and oral cholera vaccine as part of integrated cholera response. In addition, in 2014, UNICEF continued to support real-time monitoring using mHealth technology, health information systems, birth registration systems, research and evaluation.

Major evaluations completed included an external evaluation of the Integrated Health Systems Strengthening Programme that focused on expanding and improving community-based treatment for common childhood illnesses across six high-mortality countries in Africa, and an independent evaluation of the Investment Case programme in Asia. The findings of these evaluations help highlight result-based approaches and are being used to inform planning, budgeting and policies to scale up high-impact interventions for addressing maternal, newborn and child health and nutrition in six countries.

To disseminate new evidence and knowledge around community health workers and iCCM, UNICEF hosted the 2014 global iCCM Evidence Review, which took place in Ghana. The objective of this consultation was to systematically review the current state of the art of iCCM implementation by bringing together researchers, donors, government, implementers and partners

to review the current landscape and status of evidence in key iCCM programme areas. Countries are now using the evidence generated in order to draw out priorities, lessons and gaps for improving child and maternal-newborn health. UNICEF staff have co-authored more than 70 peer-reviewed journal publications on topics such as polio, quality of care around the time of birth and iCCM of diarrhoea, malaria and pneumonia. UNICEF also produced guidance notes, working papers and policy briefs on a range of topics, including vaccine management for polio; evidence-based planning for health; and an advocacy brief on the post-2015 SDGs⁸, among others. Twenty-four research papers on iCCM in Ethiopia were published in the Ethiopian Medical Journal entitled 'Integrated Community Case Management (iCCM) at Scale in Ethiopia: Evidence and experience', with guest editors from Johns Hopkins University, UNICEF ESARO and Save the Children. These papers aim to contribute to improving the prioritization and use of lessons learned to advance implementation of pneumonia and diarrhoea treatment for children in Ethiopia, Kenya and the United Republic of Tanzania. UNICEF ESARO also published an additional paper on comparisons of iCCM costs in Ethiopia, Kenya and Zambia based on bottleneck analysis, along with a survey of community health workers from 20 countries with information on over 40 activities provided by more than 200,000 CHWs in the region. In addition, ESARO supported the finalization of a report on availability, supply systems and access to pneumonia treatments in Ethiopia, Kenya, Uganda and the United Republic of Tanzania to help guide further investments through community-based platforms across Eastern and Southern Africa.

In Latin America, four regional studies were initiated on topics identified as priority gaps: a review of key determinants of access to quality maternal, newborn and child health services and relations between models of service, government expenditure on health and equitable access; cost-effectiveness of different approaches to reducing neonatal mortality through the use of List software; regional analysis of Retinopathy of the Premature; and review of health system response to violence against children. The latter three are being conducted in collaboration with the Pan American Health Organization. A compendium of lessons learned and good practices in UNICEF health and nutrition programming in the region, and an initial regional health epidemiological profiling was also performed in order to highlight the main causes of mortality and burden of disease in children aged 0–18 years. This has underscored the urgency for UNICEF to consider its contribution towards the prevention of non-communicable diseases and their

main risk factors. Consequently, work has started in relation to non-communicable diseases, including regional research on existing legislation on junk food, drinks and marketing practices in schools and social media (results expected in 2015), as well as a partnership with Sesame Street for a regional project on healthy living, in collaboration with the communication division and the Mexico, Colombia and Costa Rica country offices.

The goal of creating new evidence is to help provide policymakers and practitioners within country health systems the latest evidence on what works, so they are better equipped to design and deliver quality health programmes that reach more children and save more lives.

Ongoing commitment to enhance regional-level co-ordination also yielded results. For example, in West and Central Africa, despite frequent and persistent emergencies, in 2014 a regional cholera alert and cross-border initiatives contributed to early detection, mobilization and outbreak containment. The regional epidemiological surveillance and regional office alert contributed to the early detection of and response to the outbreak in the very first week, as compared with the 2011 outbreak, when an eight-week delay was observed between the outbreak's onset and subsequent humanitarian response. A cross-border meeting held in Niamey in April 2014 gathered Ministry of Health and agencies from Cameroon, Chad, the Niger and Nigeria and triggered cholera preparedness efforts in those countries, contributing to breaking the cycle of transmission before the outbreak spread out of control, and reducing the human and financial costs of a large-scale epidemic.

As part of the response to the Ebola outbreak, a preparedness workshop was held to stress the multiple dimensions of the crisis outside the health systems and the need to invest in preparedness and partner advocacy. The communication for development, health and child protection sections in the regional office extracted key practices. For example, communications strategies were rapidly adjusted on the basis of epidemiology; survivors were mobilized to share lessons; guidelines and quality benchmarks for community engagement were developed; active participation of religious leaders was facilitated; and coordination was prioritized within programme scale-up. Adaptation of key health interventions to the delivery mode during the context of the Ebola outbreak included mass drug administration of ACT, periodic intensification of routine immunization, and a 'no touch' policy for community health workers.

GLOBAL COLLABORATION FOR BETTER PNEUMONIA DIAGNOSIS

For a child who may have pneumonia, every breath counts. Currently, in many countries, to diagnose pneumonia in a child health-care workers use a timer for manually counting the breaths the child takes during a one-minute period. Evidence shows that manual counting is associated with increased uncertainty, and results in terms of both specificity and sensitivity are low. UNICEF Supply Division's Health Technology Centre in Copenhagen, in collaboration with the Programme Division in New York, is jointly leading an innovation project entitled Acute Respiratory Infection Diagnosis Aid (ARIDA) to enable development of products that can improve pneumonia diagnostics through automated measurement of breath rates. A more accurate diagnostics approach will result in fewer deaths through more accurate prescription of medicines, cost savings through less use of wrongly prescribed medicines, as well as reduction in the risk of resistance towards antibiotics because of more targeted use over the long term. ARIDA launched a Target Product Profile on World Pneumonia day in 2014 to explain the needs and requirements of UNICEF's users in low resource settings in order to guide developers on the desired performance of ARIDA devices.

CONSTRAINTS AND CHALLENGES

At the global level, the health architecture was fragmented by the mushrooming of initiatives following the launch of the United Nations Global Strategy for Women's and Children's health in 2010, which helped to accelerate progress but also caused lack of clarity and duplication of some roles, costing both time and resources that affected all programme areas. Operational processes, including identification, recruitment and deployment of staff, have been identified as bottlenecks that need to be overcome in global and regional programmes. Building on recent organizational review processes, UNICEF continued efforts to strengthen those internal processes where enhanced efficiency and effectiveness could support more results across all programme areas. To sustain progress, UNICEF plans to develop a new health strategy to define longer-term engagement at the country, regional and global levels, in particular in the context of the SDGs and the updated Every Woman Every Child strategy.

REVENUE

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

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

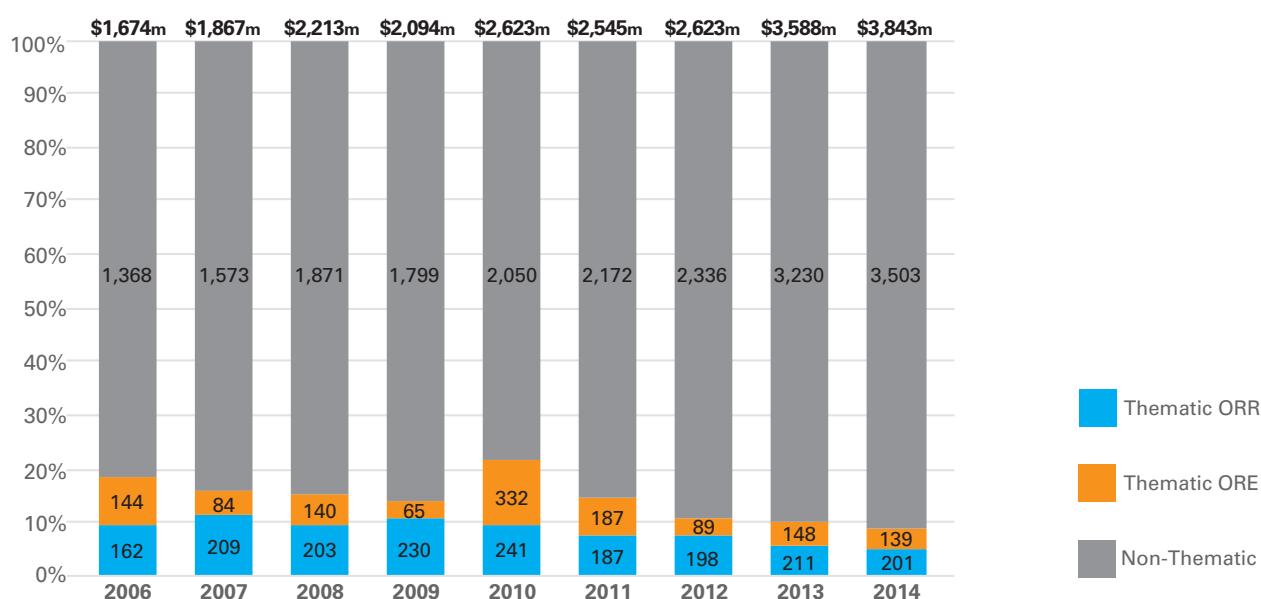
- maintain its independence, neutrality and role as a trusted partner, with adequate and highly skilled capacity at country level, for country-driven, innovative and efficient programming;
- achieve key results for all country programmes of cooperation; and
- respond quickly and flexibly to changing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

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

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

FIGURE 5

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



THE VALUE OF THEMATIC FUNDING (OR+)

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

Contributions from all resource partners to the same outcome area and humanitarian action 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 at global, regional and country levels that is the same for all resource partners. Due to reduced administrative costs, thematic contributions are subject to a lower cost recovery rate, to the benefit of UNICEF and resource partners alike. For more information on thematic funding, and how it works, please visit www.unicef.org/publicpartnerships/66662_66851.html.

PARTNER TESTIMONIAL

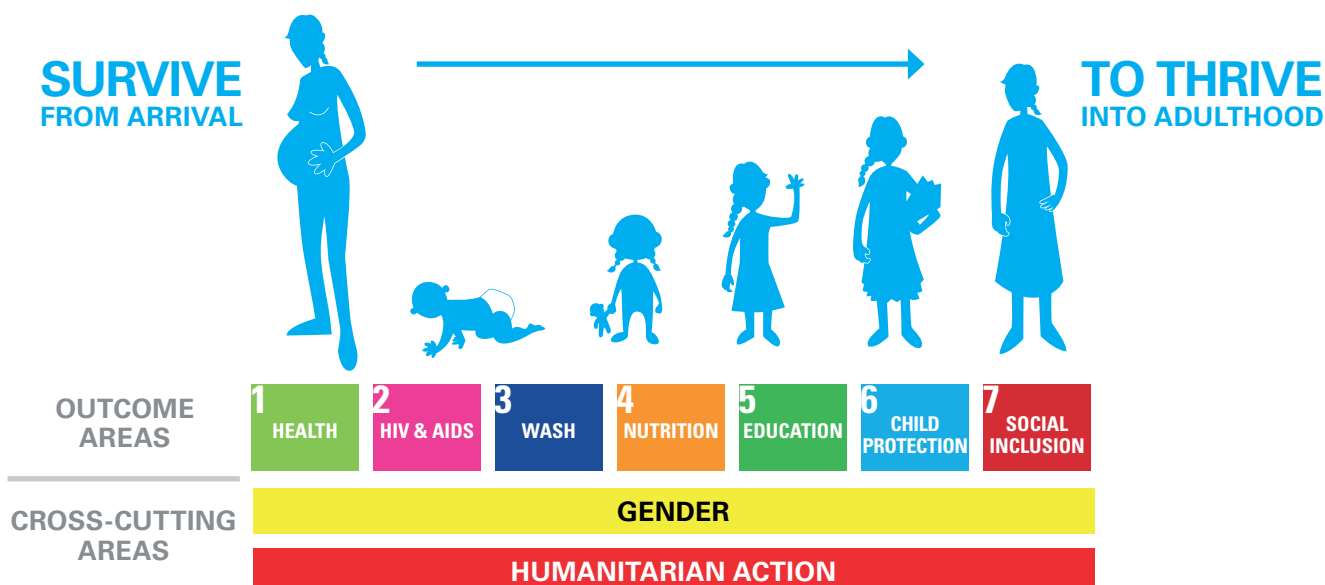
*"Helping children in need is the most important investment that we can make to achieve development, human rights, peace and stability. **UNICEF** is a key partner in this respect. [...]"*

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

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

Børge Brende
Minister of Foreign Affairs,
Government of Norway

UNICEF Strategic Plan 2014-17 Thematic Windows:

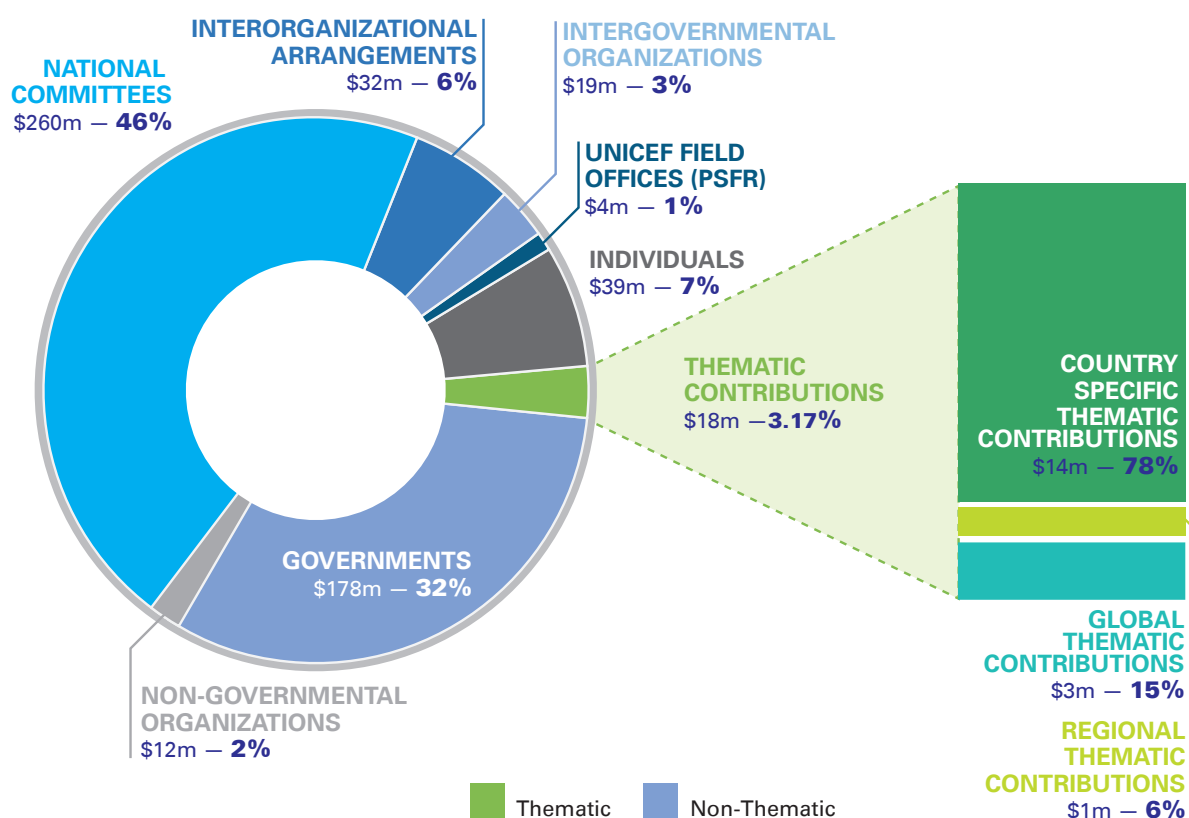


Of the US\$562 million other resources to health in 2014, almost 97 per cent were highly earmarked funds (*see Figure 6*).⁹ The remainder were thematic contributions. Of the US\$18 million in thematic contributions, only 15 per cent was received at the global level, the most flexible earmarked funding. This flexible funding was extremely useful in supporting UNICEF's Ebola response, an area of work in which flexibility and the ability to tailor the response to a

changing context demonstrated in stark terms how essential this type of funding can be. In the future, we see an important role for thematic funding in enabling scale-up of programming around health-systems strengthening, adolescent health and non-communicable disease, where flexible funding can be used to test innovative approaches and explore new programming modalities that will be necessary to make progress in these complex areas.

FIGURE 6

OTHER RESOURCES BY FUNDING MODALITY AND PARTNER GROUP, HEALTH, 2014: US\$562 MILLION



Sixty-two per cent of thematic contributions received for health came from five government partners (*see Table 1*). The Government of Sweden was the largest thematic resource partner to health, the majority of which was contributed at the country level for the Democratic Republic of the Congo and Zimbabwe. The Government of Luxembourg provided global-level thematic funding, while Flanders (Belgium) provided country-level thematic funding to South Africa and New Zealand provided regional-level thematic funding to the East Asia and the Pacific Regional Office.

The Dutch Committee for UNICEF provided just over

11 per cent of all thematic contributions to health, earmarked at the country level for Burkina Faso, Burundi, Djibouti, Nepal, Sierra Leone and the United Republic of Tanzania. Significant global thematic contributions were also received from the National Committees of Italy, Korea, Portugal and Spain.

UNICEF seeks to broaden and diversify our funding base, including thematic contributions. There were 25 partners that contributed to thematic funding for health in 2014 (*see Table 1*), compared with 34 that contributed to the broader theme of young child survival and development in 2013.

TABLE 1**THEMATIC CONTRIBUTIONS BY RESOURCE PARTNER TO HEALTH, 2014**

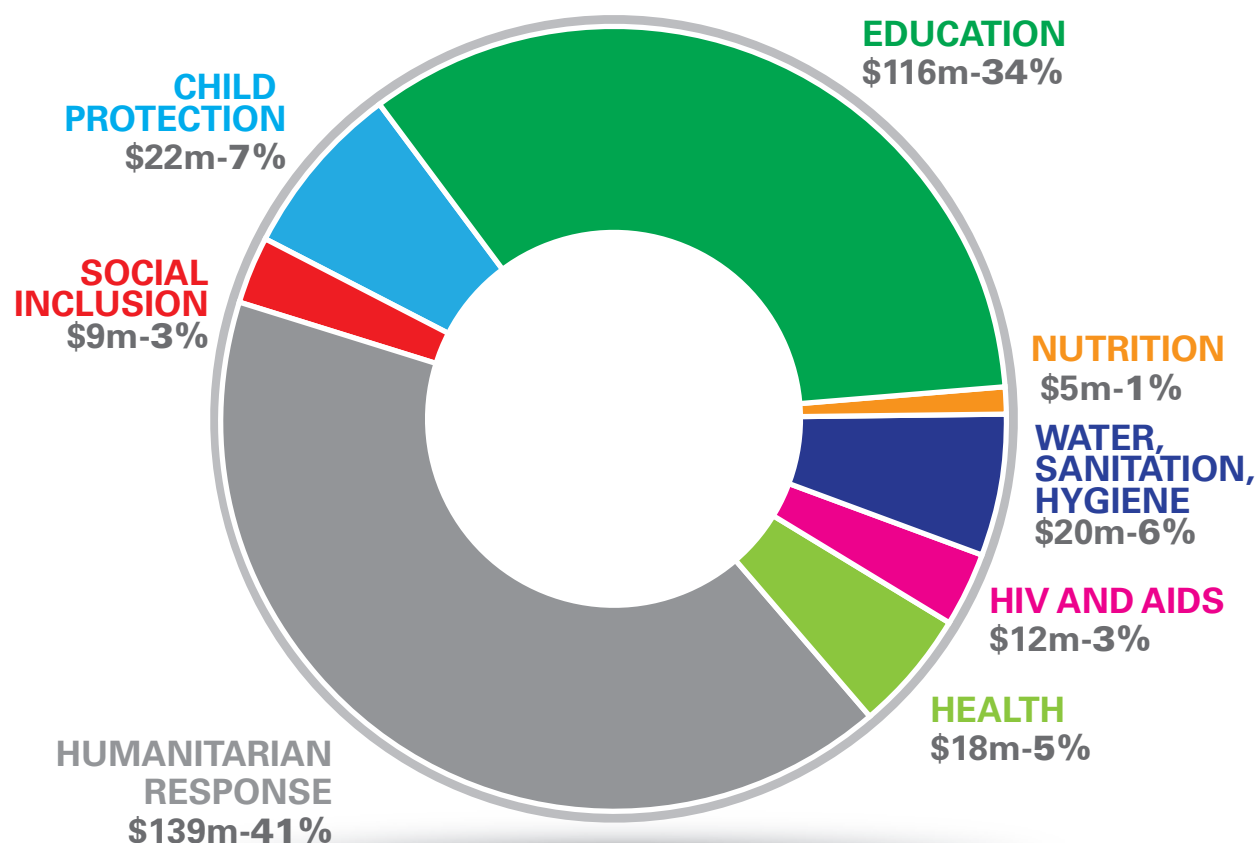
Resource partner type	Resource partner	Amount (in US\$)	Percentage
Governments 62%	Sweden	9,947,253	55.80%
	Luxembourg	680,272	3.82%
	Flanders International Cooperation (Belgium)	343,879	1.93%
	New Zealand	93,935	0.53%
	Canada	12,599	0.07%
National Committees 37%	Dutch Committee for UNICEF	2,015,510	11.31%
	Italian Committee for UNICEF	1,614,911	9.06%
	Korean Committee for UNICEF	800,000	4.49%
	Spanish Committee for UNICEF	675,740	3.79%
	Portuguese Committee for UNICEF	576,631	3.23%
	Hellenic National Committee for UNICEF	273,598	1.53%
	United States Fund for UNICEF	184,800	1.04%
	United Kingdom Committee for UNICEF	101,188	0.57%
	German Committee for UNICEF	87,698	0.49%
	Canadian Committee for UNICEF	86,052	0.48%
	Slovenian Committee for UNICEF	65,098	0.37%
	Lithuanian Committee for UNICEF	51,724	0.29%
	Swiss Committee for UNICEF	44,315	0.25%
	Luxembourg Committee for UNICEF	43,831	0.25%
	Polish Committee for UNICEF	31,388	0.18%
	Austrian Committee for UNICEF	3,522	0.02%
	New Zealand Committee for UNICEF	1,565	0.01%
	Australian Committee for UNICEF	904	0.01%
Field Offices PSFR 1%	UNICEF Paraguay	84,580	0.47%
	UNICEF India	5,870	0.03%
Grand total		17,826,862	100.00%

The decline in thematic funding pools overall, including having received no gender equality thematic contributions (see Figure 7), needs to be addressed to fulfil the shared commitment made by UNICEF partners to provide more flexible and pooled funding. In the Quadrennial Comprehensive Policy Review resolution, Member States called for enhanced cost-effectiveness, highlighting pooled funding modalities as a means of achieving this objective. Subsequently, dialogue

in financing the Strategic Plan structured by the UNICEF Board called for partners to enhance the flexibility and predictability of resources aligned to the organization's strategic mandate. Board Members further chose to highlight the importance of thematic funds as an important complement to regular resources for both development and humanitarian programming and the links between the two, in line with UNICEF's universal mandate and in support of country-specific priorities.

FIGURE 7

**THEMATIC CONTRIBUTIONS TO STRATEGIC PLAN OUTCOME AND CROSS-CUTTING AREAS, 2014:
US\$341 MILLION**



FINANCIAL IMPLEMENTATION

Contributions from our resource partners support and make possible the results UNICEF achieves. In 2014, health expenditures were greater than those of any other sector (*see Figure 8*).

Predictable funding to regular resources enhances UNICEF's ability both to innovate and to engage in programming with longer time frames for enhanced results. As in the case of health systems strengthening, such programmes have the potential for longer-term positive impacts for children. Flexible funding, especially in emergencies, en-

ables UNICEF to respond more quickly and with more tailored interventions to reach children – especially the most marginalized and disadvantaged.

For the funding summary amounts shown below (*see Table 2 and Table 3*), expenses are higher than income: While income reflects only earmarked donor contributions to the specific outcome area in 2014, the expenses are against total allotments, including regular resources and other resources (balances carried over from prior years) that are contributing to the same programme outcome area.

FIGURE 8

EXPENDITURE BY OUTCOME AREA, 2014

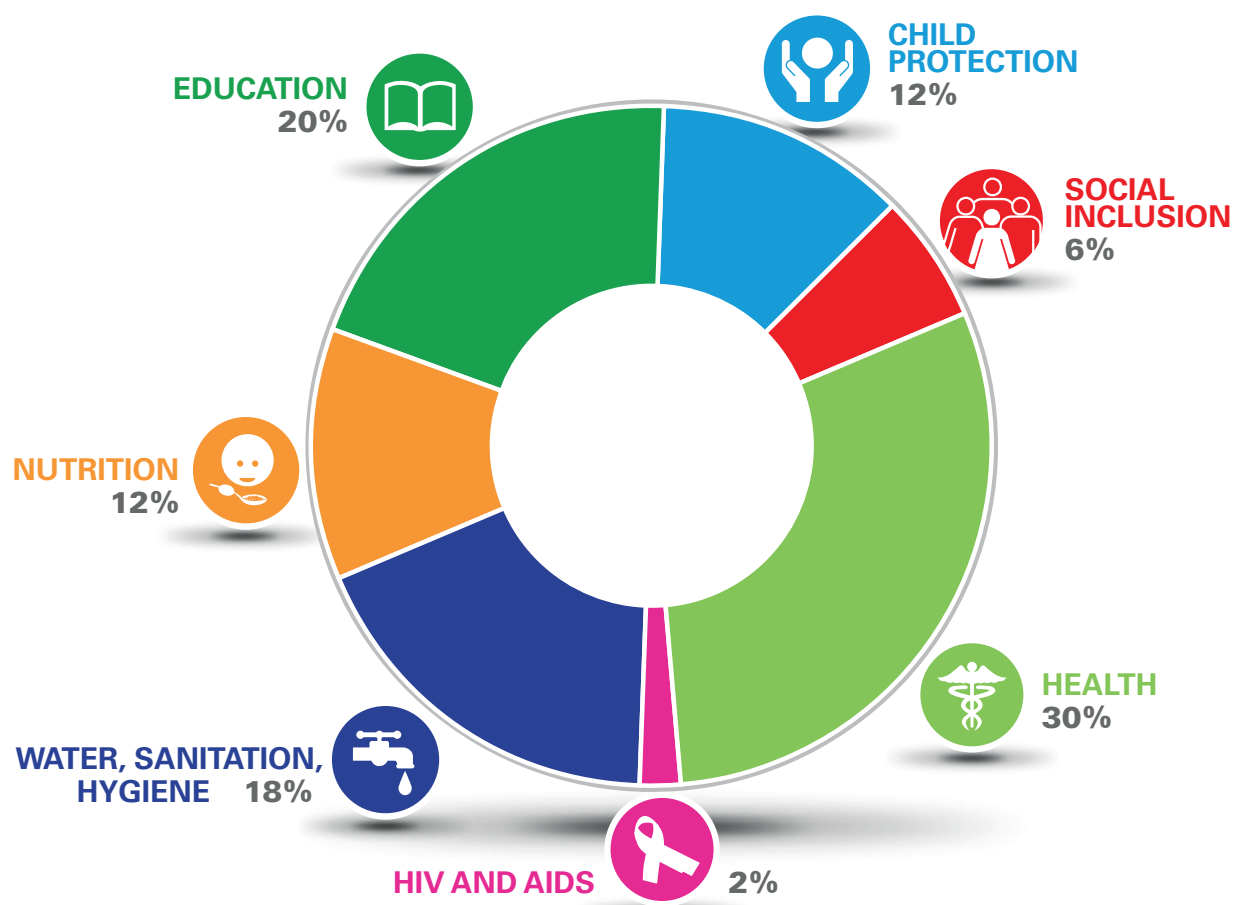
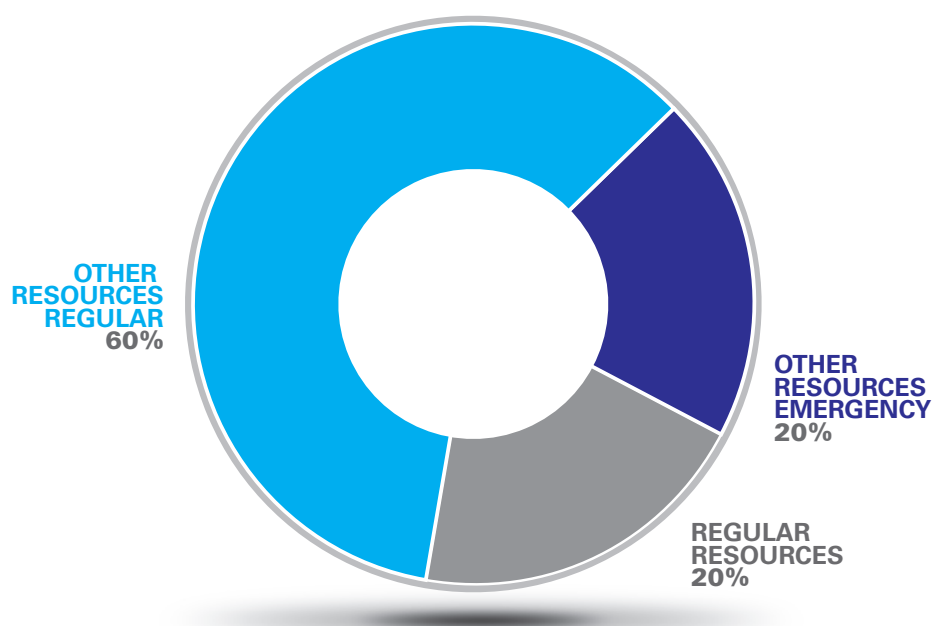


TABLE 2**EXPENDITURE BY FUNDING SOURCE FOR HEALTH, 2014**

Fund category	Expenditure	%
Other resources (emergency)	250,129,359	20%
Other resources (regular)	729,517,594	59%
Regular resources	249,330,250	20%
Grand total	1,228,977,204	100%

TABLE 3**EXPENDITURE OF ORR FOR HEALTH BY THEMATIC AND NON-THEMATIC CONTRIBUTIONS, 2014**

Fund category	Expenditure	%
Other resources (regular):		
Thematic	22,416,668	3%
Non-thematic	707,100,926	97%
Total ORR	729,517,594	100%

FIGURE 9**EXPENDITURE BY FUNDING SOURCE FOR HEALTH, 2014**

These expenditures supported programming to achieve the results described in this report, with emphasis on seven broad areas (see Table 2 and Figure 10). UNICEF's response to the Ebola crisis in

West Africa and ongoing engagement to support health for children affected by conflict in the Middle East and North Africa account for the majority of emergency expenditures.

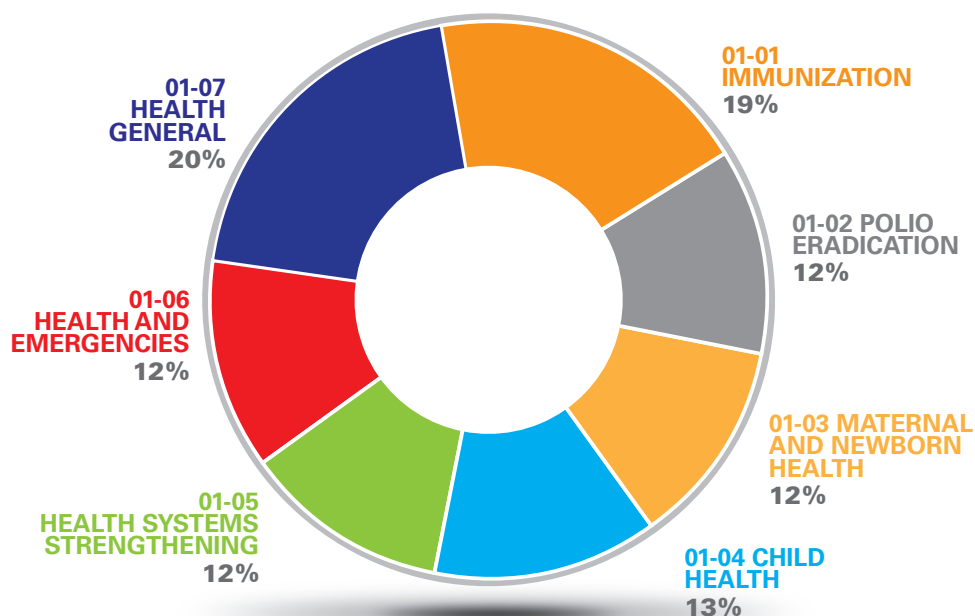
TABLE 4

EXPENDITURE BY PROGRAMME AREA FOR HEALTH, 2014

Programme area	Other resources (emergency)	Other resources (regular)	Regular resources	Grand total	% to total
Immunization	36,112,251	142,293,465	51,951,129	230,356,844	19%
Polio eradication	7,428,641	122,956,118	20,345,357	150,730,116	12%
Maternal and newborn health	21,647,231	95,632,975	27,054,070	144,334,275	12%
Child health	19,193,513	112,495,300	32,732,709	164,421,522	13%
Health systems strengthening	32,542,760	79,242,481	31,178,468	142,963,710	12%
Health and emergencies	108,464,436	18,792,696	20,977,421	148,234,553	12%
Health – general	24,740,527	158,104,560	65,091,097	247,936,184	20%
Grand total	250,129,359	729,517,594	249,330,250	1,228,977,204	100%

FIGURE 10

PERCENTAGE OF EXPENDITURE BY PROGRAMME AREA FOR HEALTH, 2014



Following the regional burden of disease and concentration of child mortality, UNICEF expenditure in the health sector focused on West, Central and Eastern Africa and South Asia, (*see Table 5 and Figure 11*).

As noted above, UNICEF's work to support health for the unprecedented number of children and families affected by the ongoing crises in the Middle East and North Africa contributed to increased total expenditure in that region.

TABLE 5

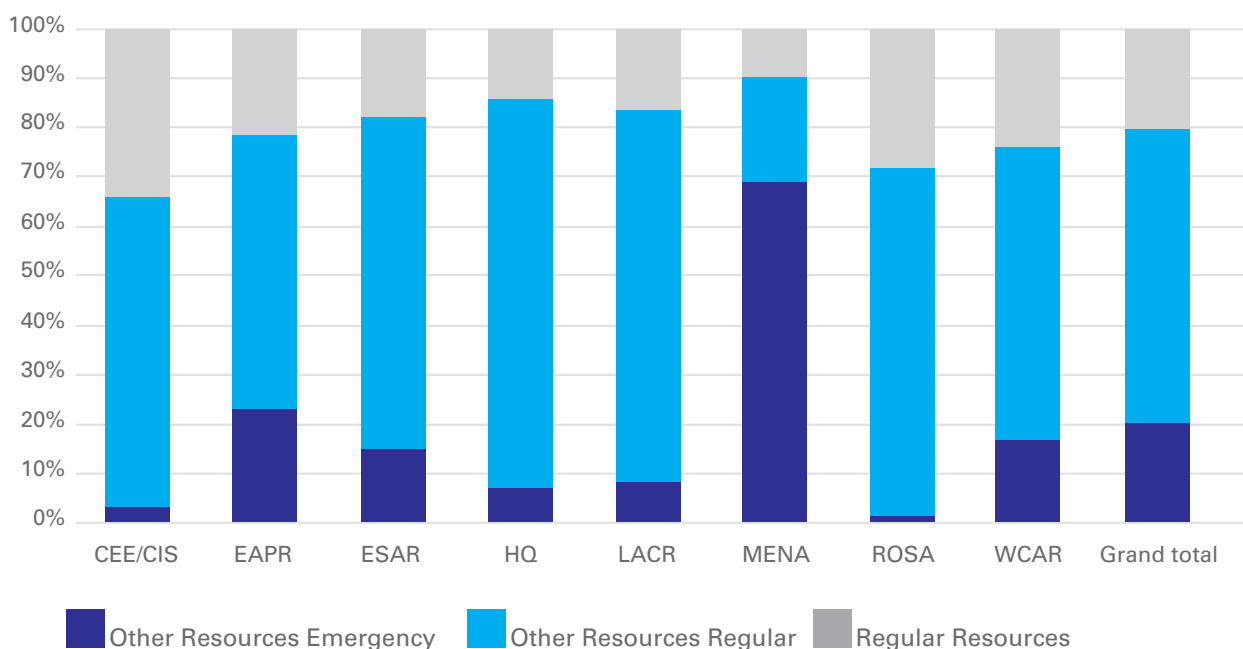
EXPENDITURE BY REGION AND FUNDING SOURCE FOR HEALTH, 2014

Region	Other resources (emergency)	Other resources (regular)	Regular resources	Grand total
CEE/CIS*	445,468	9,086,397	4,887,986	14,419,851
East Asia and the Pacific	16,677,292	39,535,501	15,665,196	71,877,989
Eastern and Southern Africa	48,499,886	219,446,212	58,180,082	326,126,180
Headquarters	4,373,463	49,283,438	9,313,166	62,970,067
Latin America and the Caribbean	2,092,055	18,840,216	4,090,037	25,022,308
Middle East and North Africa	98,586,561	29,250,332	14,558,682	142,395,576
South Asia	2,627,877	99,264,478	38,498,740	140,391,094
West and Central Africa	76,826,757	264,811,019	104,136,361	445,774,138
Grand total	250,129,359	729,517,594	249,330,250	1,228,977,204

* Central and Eastern Europe and the Commonwealth of Independent States.

FIGURE 11

EXPENDITURE BY REGION FOR HEALTH, 2014



FUTURE WORKPLAN

Moving forward, UNICEF programming in the health sector needs to create stronger linkages across technical areas; for example, between polio, health systems strengthening and routine immunization, including using polio assets for the wider health agenda as part of the legacy strategy, between child health and early childhood development, and between tetanus vaccination programmes and maternal health. Fostering these linkages will be a key consideration in the increased emphasis on health systems strengthening. In line with the evolving negotiations around the SDGs, targets and indicators, and in order to fulfil UNICEF's commitments as articulated in the Strategic Plan and Gender Action Plan, future work in the sector will include an enhanced focus on adolescent girls, and integration of emergency capacity and 'resilience' as a cross-cutting theme.

The SDGs provide an opportunity to leverage the political and social space to create better public support and knowledge, enhance national plans and policies, and receive diverse funds and resources in order to address the health issues that are captured in the SDGs, particularly Goal 3 on health.

With regard to external partnerships and advocacy, UNICEF aims to take a leadership role in the renewal and implementation of Every Woman Every Child, including defining the role for A Promise Renewed in achieving results for children at the country level, and leading development of the Operational Framework of the updated Global Strategy. UNICEF will build on its engagement with the new Global Financing Facility to leverage funds in UNICEF programme countries, as well as build on the memorandum of understanding signed in 2014 with the Global Fund for AIDS, Tuberculosis and Malaria to expand the focus of the Fund's investments to benefit broader efforts in maternal and child health.

Following the endorsement of the Every Newborn Action Plan in 2014 and establishment of a global coalition in support of it, UNICEF will now turn its efforts to implementation, with the goal of every mother and every newborn having access to quality care. For 2015, six countries are in the process of preparing specific action plans (China, Guinea-Bissau, Nigeria, Pakistan, Sierra Leone and Zimba-

bwe). An additional three countries have strengthened newborn components within existing plans for RMNCAH: Chad, the Democratic Republic of the Congo and Mali. Work is in progress in Ethiopia and Lesotho to strengthen the newborn component within existing plans. Angola, the Central African Republic and Somalia have not yet started the development of plans and will need more support. As in previous years, participation in GAVI and the Global Polio Eradication Initiative will be central to realizing success in immunization and polio. And, UNICEF will continue to support Guinea, Liberia and Sierra Leone to transition from emergency response to recovery and build back better health systems following the Ebola crisis.

The Global Financing Facility in Support of Every Woman Every Child was announced by the World Bank Group, Canada, Norway and the United States at the United Nations General Assembly in September 2014. The facility is being developed in close collaboration with a broad range of stakeholders, including the H4+ agencies (UNICEF, UNFPA, WHO, UNAIDS, UN Women and the World Bank Group); civil society organizations; and other development partners working in the areas of reproductive, maternal, newborn, child and adolescent health. It will support countries in their efforts to mobilize additional domestic and international resources required to scale up and sustain essential health services for women, children and adolescents. Facility resources will be provided to countries in conjunction with low-interest loans and grants from the International Development Association. A special focus area for the facility will be to support the scale-up of civil registration and vital statistics systems to contribute to universal registration by 2030.

Internally, with the existing joint strategy for health and nutrition expiring in 2015, a new health strategy will be developed to define longer-term engagement at the country, regional and global levels, in the context of the global health architecture. Enhancing and sharpening UNICEF's engagement in strengthening national and decentralized health systems will be a priority, starting with a series of consultations in early 2015. As part of an enhanced commitment to resilience across both relief and development programmes, a Health in Emergencies Training will be initiated to build the capacity of

UNICEF staff globally to prepare and respond as a key partner in emergencies at the country, regional and global levels, yet not the sector lead for health.

UNICEF expects 2015 will present some programmatic challenges. Although the maternal and neonatal tetanus elimination strategy has been successful in 60 per cent of the targeted countries (35 out of 59), given that elimination will not be reached in the coming year as initially envisioned UNICEF will need to work closely with WHO to discuss next steps and a new target date for completion. Ebola-affected countries will continue to need extra support as they transition from emergency response to recovery and rebuilding. With regard to polio, efforts will continue to focus on the 'end game', with particular attention to border areas of Afghanistan and planning for the polio legacy.

Other areas where UNICEF expects to move forward include health systems strengthening, malaria prevention and control, adolescent health and

non-communicable diseases. For example, in Latin America and the Caribbean, emphasis is given to maternal and neonatal mortality, to the reduction of inequities and to analysis of health system strengthening measures that would ensure equitable progress in the key indicators. Using analysis of epidemiological trends of mortality and burden of diseases in the population of children 0–18 years old, as well as of the overall context and country capacities, UNICEF will continue efforts to scale up engagement in strategic regional discussions on emerging areas of work, such as the prevention of non-communicable diseases, adolescent health and the health response to violence. All of these areas are currently underfunded, and relative inflexibility of resources prevents the investment required for sustainable scale-up. In 2015, unless new funding enables significant expansion of programming compared with previously planned amounts, funding shortfalls will persist, with possible negative impacts on achievement of planned targets.

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, Flanders (Belgium), New Zealand and Canada for their generous contributions and partnership, as well as the National Committees for UNICEF, particularly the Dutch Committee for UNICEF, the Italian Committee for UNICEF, the Korean Committee for UNICEF, the Spanish Committee for UNICEF and the Portuguese Committee for UNICEF, for their consistent support to children's health.

ABBREVIATIONS AND ACRONYMS

C4D	communication for development	SDGs	sustainable development goals
EVM	Effective Vaccine Management	SMS	Short Message Service
HSS	health systems strengthening	UNFPA	United Nations Population Fund
ICCM	integrated community case management	UNICEF	United Nations Children's Fund
IPV	inactivated polio vaccine	WHO	World Health Organization
MoRES	Monitoring Results for Equity System		
RMNCAH	reproductive, maternal, newborn, child and adolescent health		

END NOTES

1. For details on Goal 3 and Targets 3.1–3.9d, see: Department of Economic and Social Affairs, 'Open Working Group Proposal for Sustainable Development Goals', United Nations, <https://sustainabledevelopment.un.org/sdgsproposal.html>.
2. Health in the Post-2015 Agenda: Report of the Global Thematic Consultation on Health, April 2013; PDF available at: www.worldwewant2015.org/file/337378/download/366802.
3. MY World Data Analytics are available at: <http://data.myworld2015.org>.
4. United Nations Children's Fund, 'Ebola: Getting to zero – for communities, for children, for the future', UNICEF Regional Office for West and Central Africa, 2015.
5. United Nations Children's Fund, 'Ebola: Getting to zero – for communities, for children, for the future', UNICEF Regional Office for West and Central Africa, 2015.
6. United Nations Children's Fund, 'Innovation at UNICEF: from start-up to scale-up', UNICEF, May 2015; PDF available at: <https://docs.google.com/file/d/0BzJYVj06Z302bVMYeVJMNUJWYUk/edit>
7. United Nations Children's Fund, 'Innovation at UNICEF: from start-up to scale-up', UNICEF, May 2015; PDF available at: <https://docs.google.com/file/d/0BzJYVj06Z302bVMYeVJMNUJWYUk/edit>
8. United Nations Children's Fund, 'A Post-2015 World Fit for Children Issue Brief: Child survival and healthy development', UNICEF, November 2014; PDF available at: www.unicef.org/post2015/files/Health_2pager_FINAL_V1_web.pdf.
9. Regular resources are not included since they are not linked to any one Outcome Area or cross-cutting area at the time of contribution by a partner. For an analysis of regular resources per outcome or cross-cutting area, see the report section on [Financial Implementation](#).

Impact and Outcome Indicators

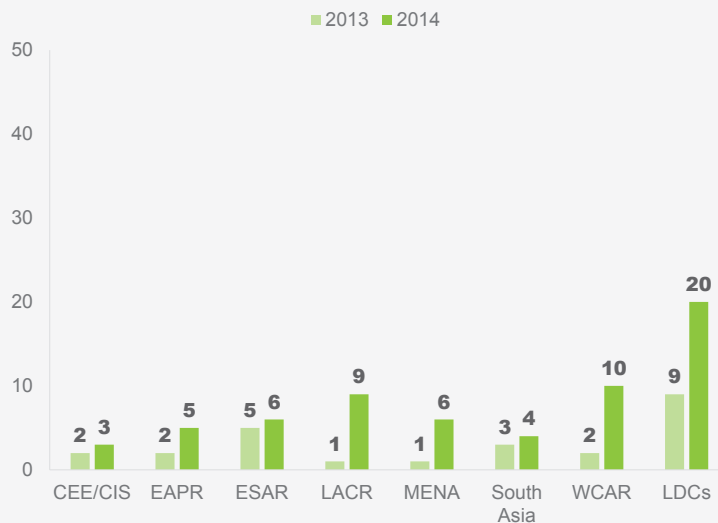
Indicators	Baseline	2017 Target	2014 update or data from most recent year
1a. Under-five mortality rate (as pledged in A Promise Renewed)	47†† (2012)	15 (2035) (global average) 20 (2035) (maximum at country level)	46 (2013)
1b. Neonatal mortality rate	21†† (2012)	7 (2035)	20 (2013)
P1.1 Countries with at least 80% of live births attended by a skilled health personnel (doctor, nurse, midwife or auxiliary midwife)	51 (2010–latest)	At least 60	78 out of 121 UNICEF programme countries with data (2010–2014)
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–latest)	At least 25	39 out of 93 UNICEF programme countries with data (2010–2014)
P1.3 Countries that are verified/validated as having eliminated maternal and neonatal tetanus	34	54	35 (2014)
P1.4 Polio-endemic or newly infected countries that become polio-free (polio-free in this indicator refers to countries which are 'classified' as polio-free after a year from the last case)	Endemic countries: 3 Re-infected countries: 5 (as of 1 January 2014)	All	Polio-free: 1 (2014) Endemic countries: 3 Re-infected countries: 6 (as of 31 December 2014)
P1.5 Countries with (i) at least 90% coverage at national level, (ii) at least 80% coverage in every district or equivalent administrative unit for children < 1 year receiving (a) measles-containing vaccine, (b) DTP containing vaccine	Measles: i. 131†† ii. 60†† DTP: i. 135†† ii. 63††	All countries	Measles (2013): i. 129 ii. 52 DTP (2013): i. 129 ii. 59
P1.6 Countries with at least 80% of children aged 0–59 months with diarrhoea receiving ORS	0	20	2 out of 86 UNICEF programme countries with data (2010–2014)
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–latest)	20	14 out of 85 UNICEF programme countries with data (2010–2014)
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–latest)	15	0 out of 39 UNICEF programme countries (endemic countries only) with data (2010–2014)
P1.9 Malaria-endemic countries with at least 80% of children aged 0–59 months sleeping under an insecticide-treated net	0 (2010–latest)	25	0 out of 45 UNICEF programme countries (endemic countries only) with data (2010–2014)
Sppl. Countries with at least 60% of a) mothers and b) newborns receiving postnatal care within two days of childbirth	NA	TBD	a) 16 out of 51 UNICEF programme countries with data (2010–2014) b) 20 out of 57 UNICEF programme countries with data (2010–2014)

P1.a.1

Countries in which a MNCH communication plan has been developed, budgeted and implemented

Baseline † 16 **2014 update** 43

2017 Target 48



P1.a.2

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

Baseline † / **2014 update** 12

2017 Target 3

Category	Less than 1%	1% or more
Endemic countries	Nigeria Pakistan	Afghanistan
Countries with active transmission	Ethiopia Iraq State of Palestine	Cameroon Equatorial Guinea Somalia Syrian Arab Republic
Priority countries	Angola Benin Burkina Faso Guinea Bissau Jordan Kenya Sierra Leone	Central African Republic Chad Cote d'Ivoire Democratic Republic of Congo Gabon Mali Niger South Sudan Togo Yemen

Source: UNICEF country offices, 2014.

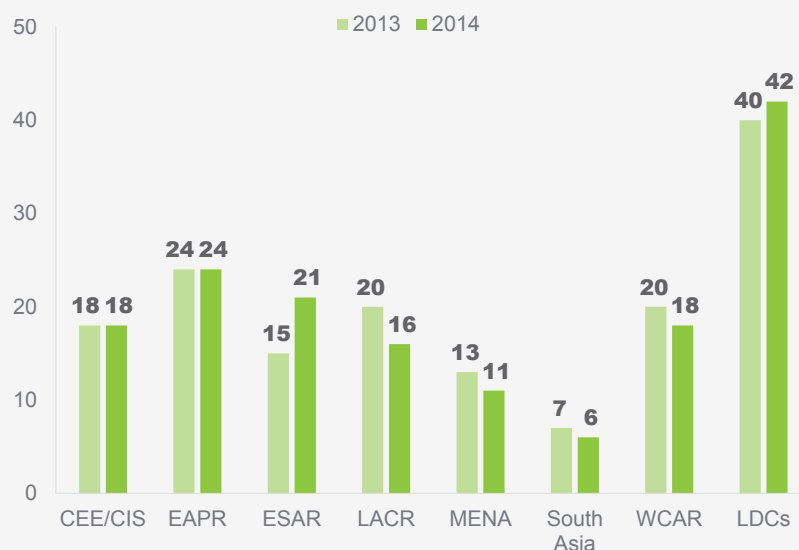
P1.b.1

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

Baseline † 117 **2014 update** 114

2017 Target 157

Source: UNICEF country offices, 2014.

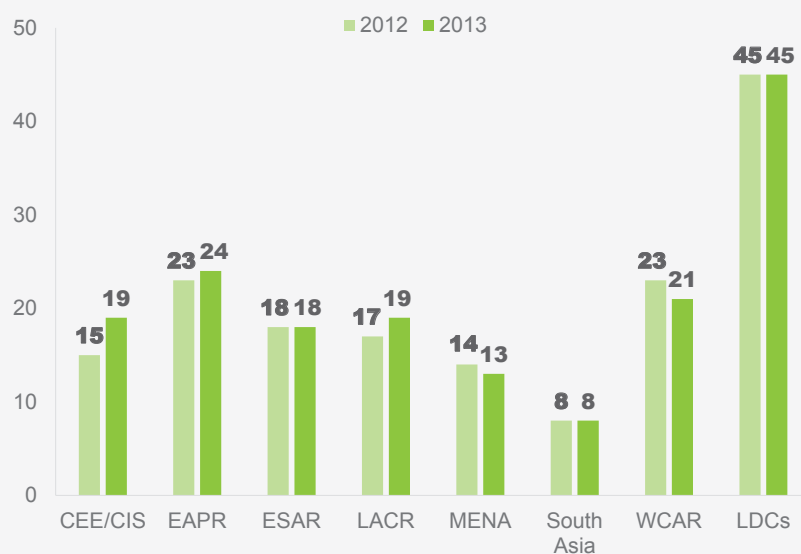


P1.b.2

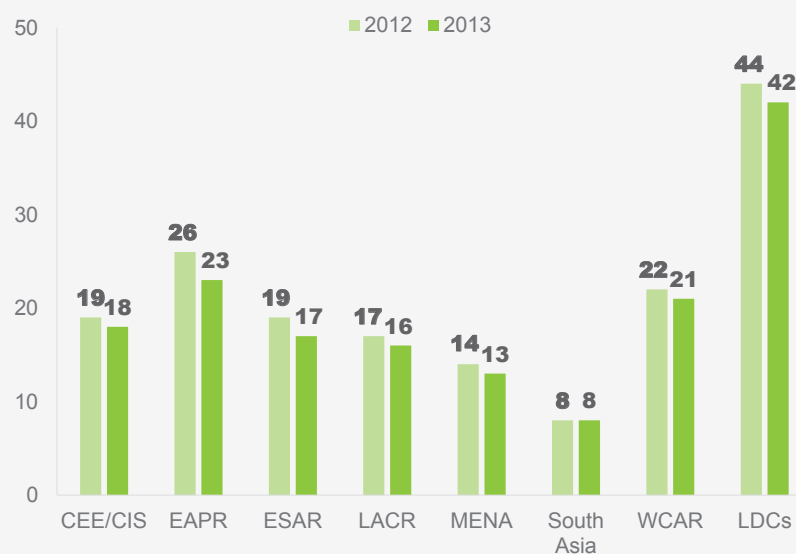
Countries without stockouts lasting more than one month at national level of
(a) DTP containing vaccine;
(b) measles vaccine

Baseline † **2013 update**
a) 118 a) 122
b) 125 b) 116

2017 Target
TBD



(a) DTP containing vaccine



(b) Measles vaccine

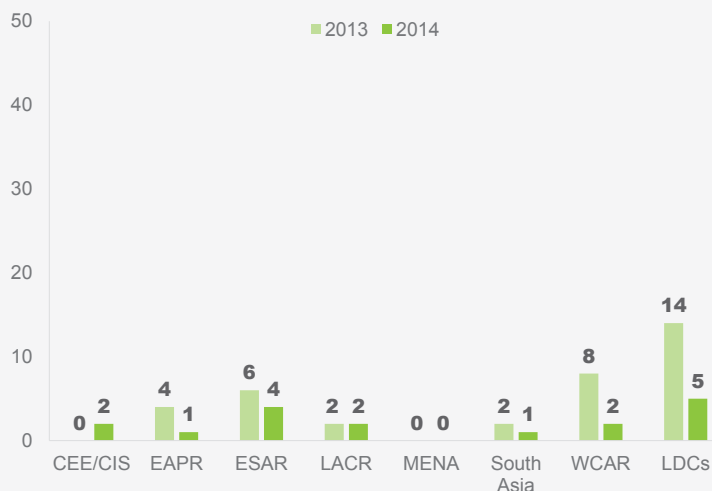
Source: WHO-UNICEF Joint Reporting Form, 2014.

P1.b.3

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

Baseline 22 **2014 update** 12

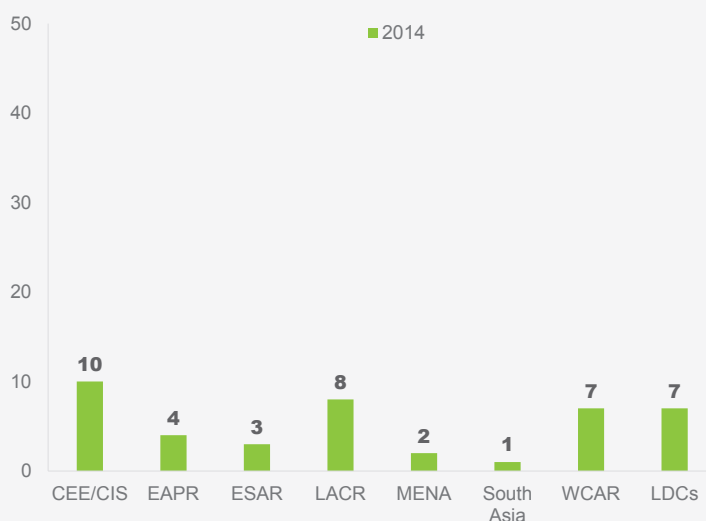
2017 Target 40



SPPL

Countries with 100% of BEmONC facilities are operational on 24/7 basis

2014 35



SPPL

Countries where 80% of women of reproductive age in high risk areas receive 2 doses of tetanus vaccine through campaigns

2014 8

Note: *36 countries have been validated to have eliminated maternal and neonatal tetanus by April 2015. In addition, 32 States of India, all of Ethiopia except Somaliland, 16 regions out of 17 in the Philippines and almost 30 of 34 provinces in Indonesia have been validated to have eliminated MNT by April 2015.

Source: UNICEF country offices, 2014.

Region	59 countries categorized as 'high risk for maternal and neonatal tetanus'		
	80% or more	Less than 80%	Data not available or not applicable
CEE/CIS			Turkey*
EAPR		Indonesia Papua New Guinea	Cambodia China* Lao People's Democratic Republic* Myanmar* Philippines Timor-Leste* Vietnam*
ESAR	Angola Ethiopia Malawi*	Kenya Namibia* South Sudan	Burundi* Comoros* Eritrea* Madagascar* Mozambique* Rwanda* Somalia South Africa* Tanzania, United Republic of* Uganda* Zambia* Zimbabwe*
LACR		Haiti	
MENA		Yemen	Egypt* Iraq* Sudan
South Asia	Bangladesh* Pakistan	Afghanistan Nepal*	India
WCAR	Burkina Faso* Democratic Republic of Congo Mal	Cameroon* Congo* Equatorial Guinea Niger Nigeria	Benin* Central African Republic Chad Cote d'Ivoire* Gabon* Ghana* Guinea Guinea Bissau* Liberia* Mauritania* Senegal* Sierra Leone* Togo*
All regions	8	14	37

SPPL.

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

2014 5

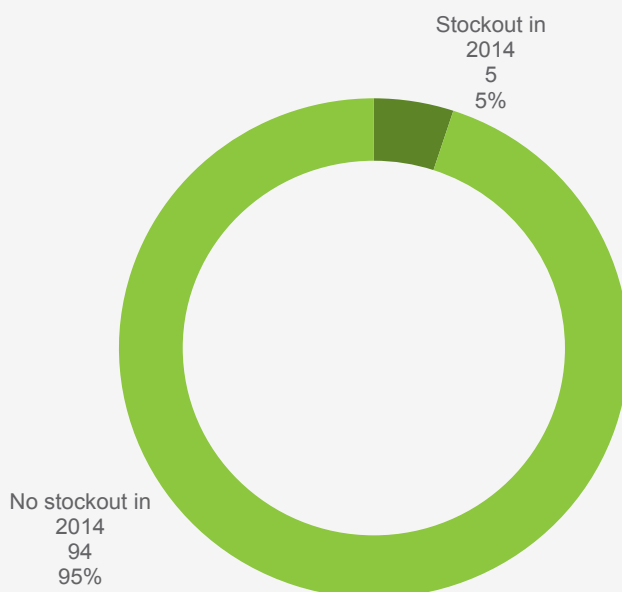
Note: *Among 99 malaria endemic countries, UNICEF programme countries which had a health programme in 2014 and reported data for 2014 are included in this analysis.

Region	Malaria endemic countries*	
	Trained as planned	Trained less than planned
EAPR		Indonesia
ESAR	Ethiopia Madagascar	Angola Eritrea Malawi Rwanda Somalia Zambia
MENA		Yemen
WCAR	Burkina Faso Guinea Niger	Benin Chad Democratic Republic of Congo Equatorial Guinea Guinea Bissau Liberia Mali Sierra Leone
All regions	5	16

SPPL.

Malaria endemic countries without stockouts lasting more than one month at national level of all ACT

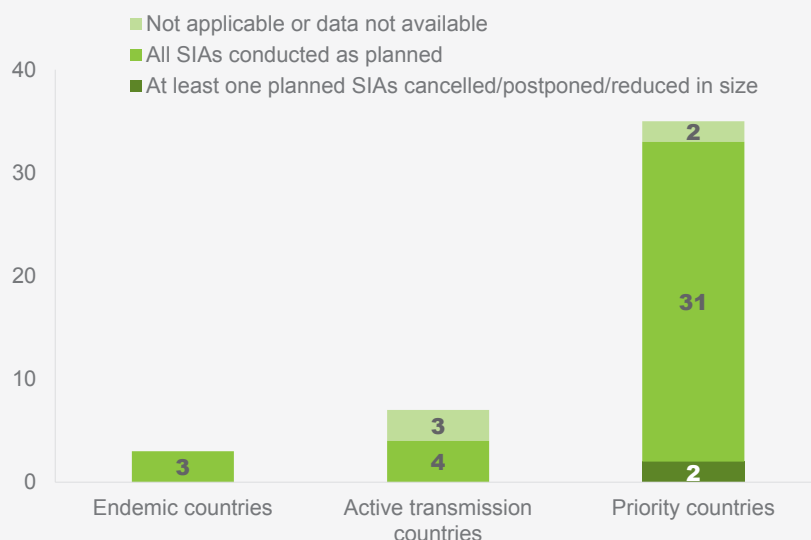
2014 94



SPPL.

Polio priority countries (endemic, outbreak, other) where planned Supplemental Implementation Activities (SIAs) were cancelled, postponed or reduced in size, during the previous 6 months due to gaps in vaccine supply

2014 2



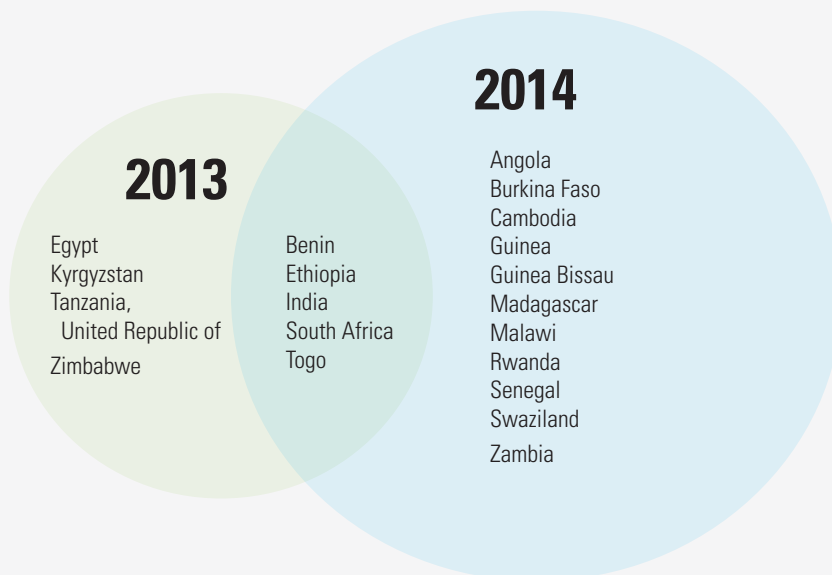
Source: UNICEF country offices, 2014.

P1.c.1

Countries in which barriers and bottlenecks related to child survival are monitored in at least 80% of DHSS targeted districts

Baseline † 9 **2014 update** 16

2017 Target TBD



P1.c.2

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

Baseline † / **2014 update**

a) 45
b) 45

2017 Target

a) 100
b) 80

36 countries in which all relevant essential commodities are registered AND have guidelines

CEE/CIS

Azerbaijan
Kyrgyzstan
Tajikistan
Turkmenistan

LACR

Bolivia
Brazil
Haiti
Mexico

WCAR

Burkina Faso
Cameroon
Central
African
Republic

EAPR

Indonesia
Lao People's
Democratic
Republic

MENA

Egypt
Iraq
Morocco

South Asia

Bangladesh
India
Nepal

ESAR

Burundi
Comoros
Ethiopia
Kenya
Lesotho
Madagascar
Rwanda
South Africa
Swaziland
Zambia

9 countries in which all relevant essential commodities are registered without guidelines

EAPR

Korea,
Democratic
People's
Republic of

WCAR

Benin
Cote d'Ivoire
Liberia
Mauritania

ESAR

Eritrea
Sudan
Somalia
Uganda

9 countries in which all relevant essential commodities have guidelines without registration

CEE/CIS

Uzbekistan

ESAR

Botswana
Malawi
Zimbabwe

EAPR

Myanmar
Papua New Guinea
Vietnam

WCAR

Democratic
Republic of Congo
Guinea Bissau

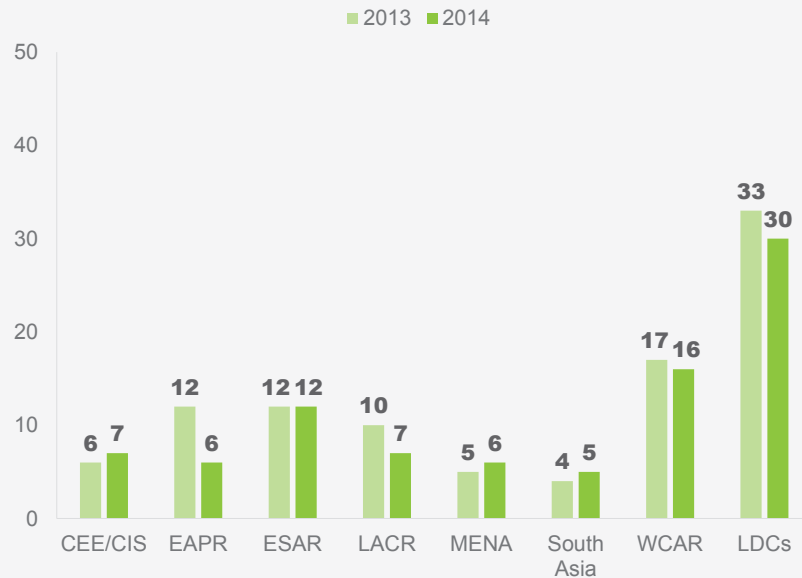
Source: UNICEF country offices, 2014.

P1.c.3

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

Baseline † 66 2014 update 59

2017 Target 100

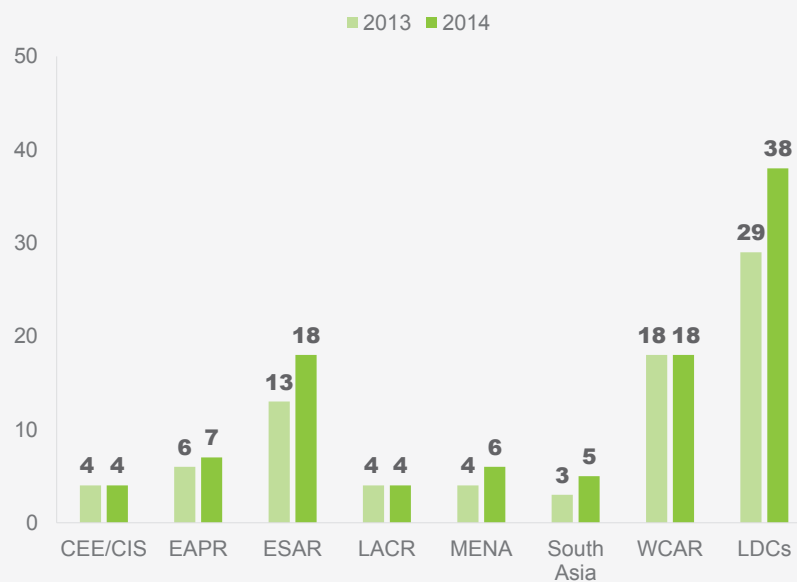


P1.c.4

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

Baseline † 52 2014 update 62

2017 Target TBD



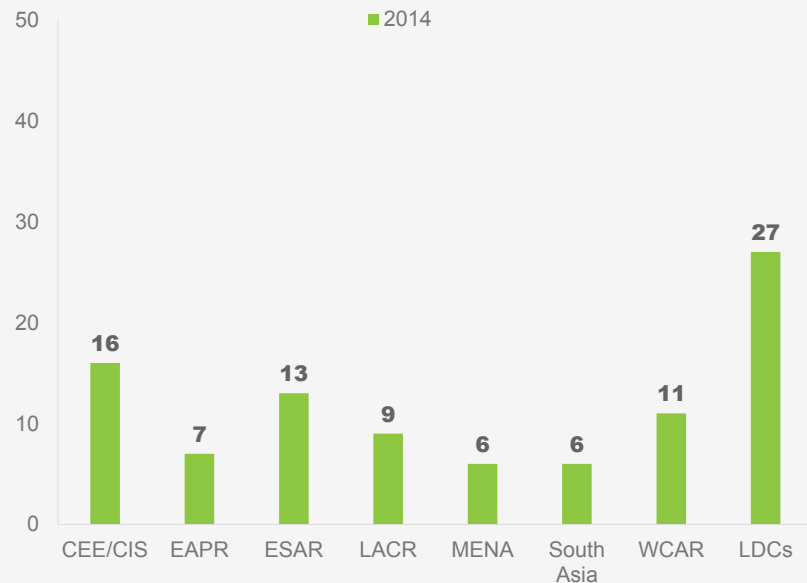
Source: UNICEF country offices, 2014.

P1.c.5

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

Baseline † / 2014 update 68

2017 Target TBD

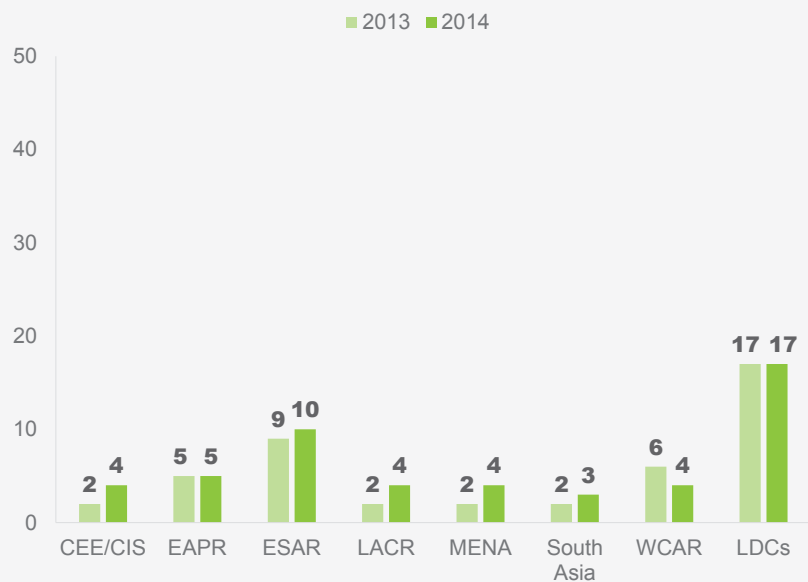


P1.c.6

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

Baseline † 2014 update 34

2017 Target 60

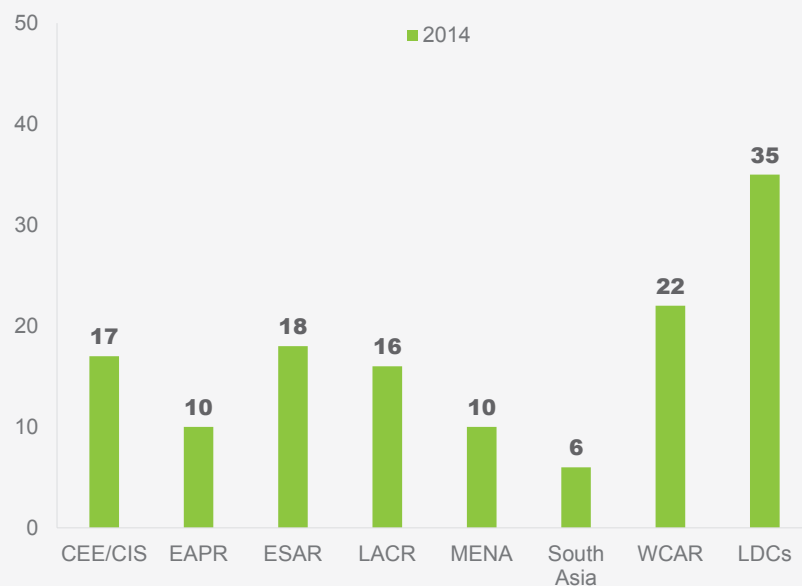


Source: UNICEF country offices, 2014.

SPPL.

Countries for which
a policy on Focused
Antenatal Care has been
developed, adopted and
implemented

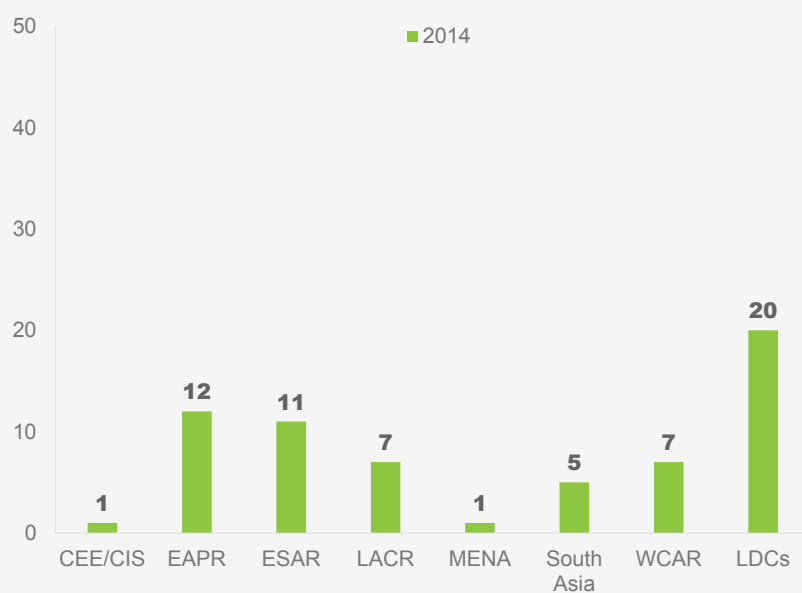
2014 ⁹⁹



SPPL.

Countries that monitor
and produce an RMNCH
Scorecard

2014 ⁴⁴



Source: UNICEF country offices, 2014.

P1.d.1

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

Baseline † / 2014 update 26
(among 40 countries listed on WHO report)

2017 Target 39

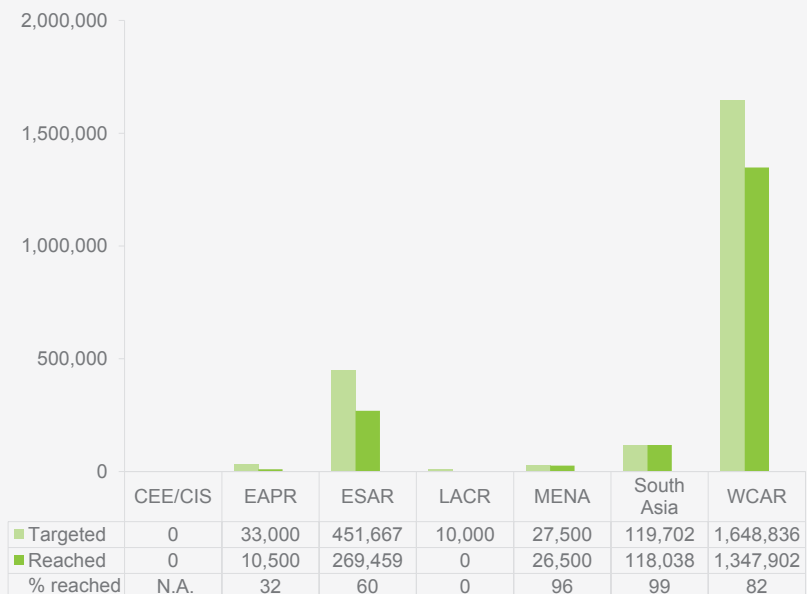
Region	In place	Not in place
EAPR		China, Malaysia, Myanmar, Philippines, Thailand
ESAR	Angola, Burundi, Malawi, Tanzania, United Republic of, Uganda, Zimbabwe	Mozambique, Rwanda, Somalia, Zambia
LACR	Cuba, Dominican Republic, Haiti, Mexico	
MENA		Iran (Islamic Republic of)
South Asia	Afghanistan, Nepal	Pakistan
WCAR	Benin, Burkina Faso, Cameroon, Central African Republic, Congo, Cote d'Ivoire, Democratic Republic of Congo, Guinea, Guinea Bissau, Mali, Niger, Nigeria, Sierra Leone, Togo	Ghana, Liberia, Senegal

P1.d.3

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

Baseline 30% **2014 update**
1,772,399 (77.4%)

2017 Target 100%



Source: UNICEF country offices, 2014.

P1.d.2

Number and percentage of UNICEF-targeted children 6–59 months (or 6 months to 15 years in affected areas) in humanitarian situations vaccinated against measles

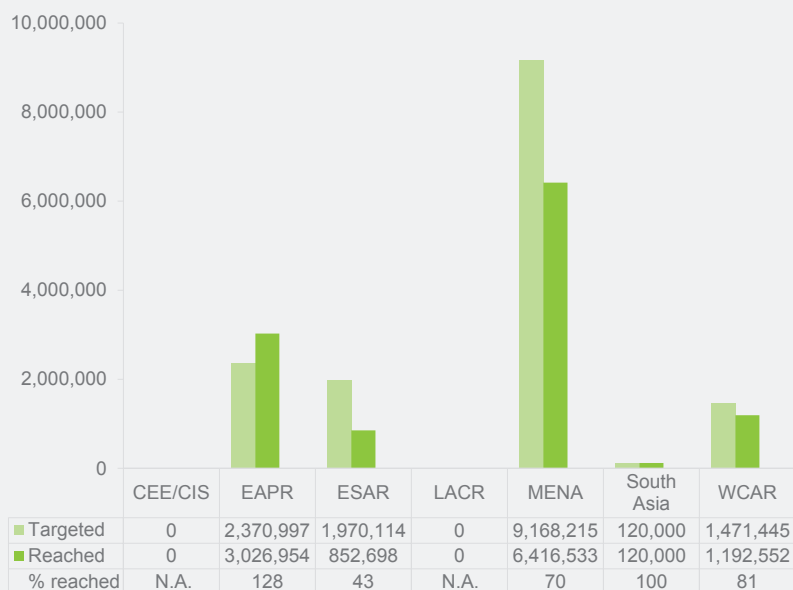
Baseline 70%

2014 update

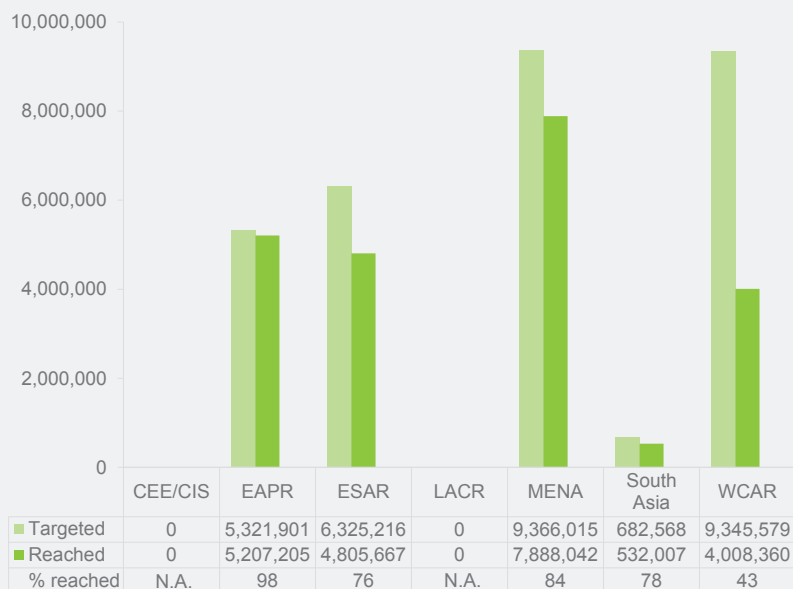
6–59 months:
11,608,737 (76.9%)

6 months to 15 years:
22,441,281 (72.3%)

2017 Target 95%



6–59 months



6 months to 15 years

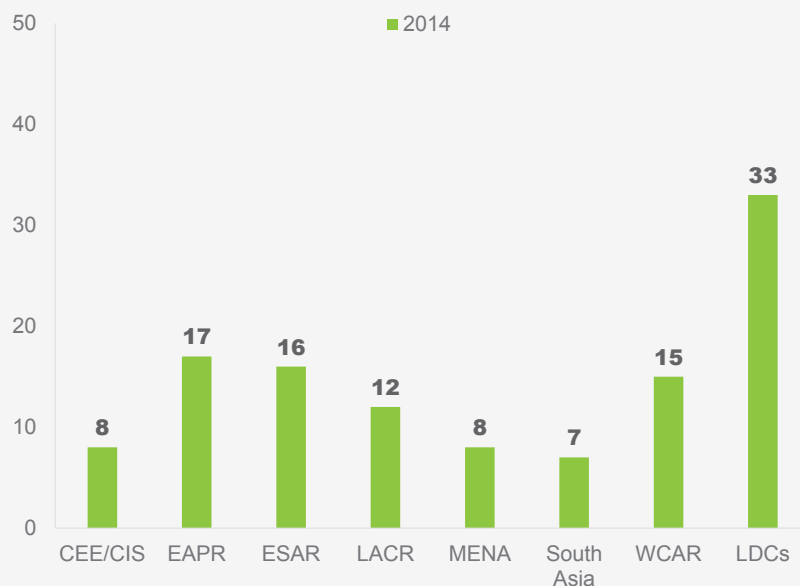
Source: UNICEF country offices, 2014.

P1.e.1

Countries that have plans with budgets allocated to reduce adolescent pregnancy

Baseline † / 2014 update 83

2017 Target TBD

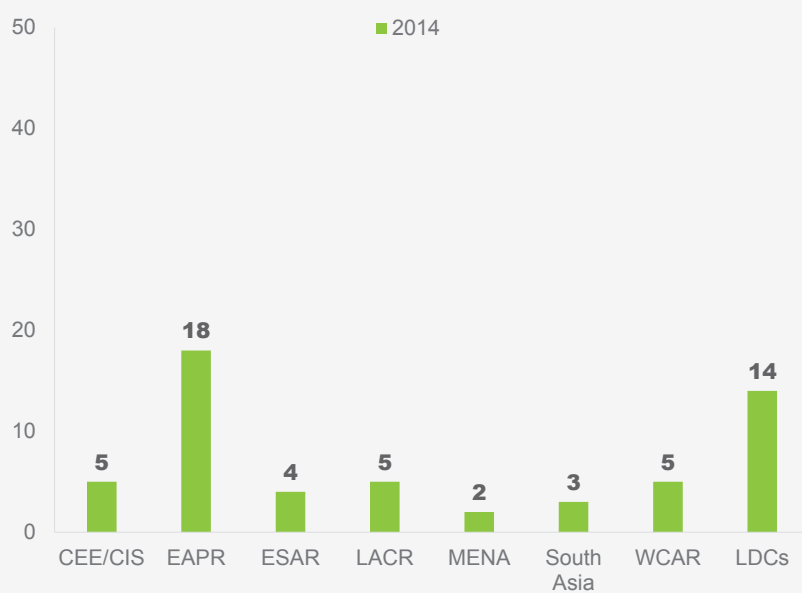


P1.e.2

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

Baseline † / 2014 update 42

2017 Target
TBD



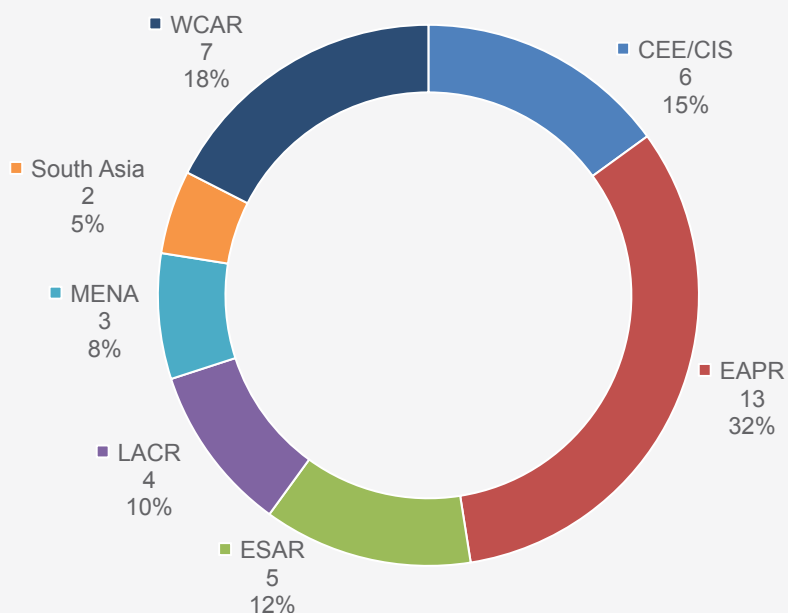
Source: UNICEF country offices, 2014.

P1.f.1

Number of peer-reviewed journal or research publications by UNICEF on maternal, newborn, child or adolescent health

Baseline † / 2014 update 40

2017 Target 45

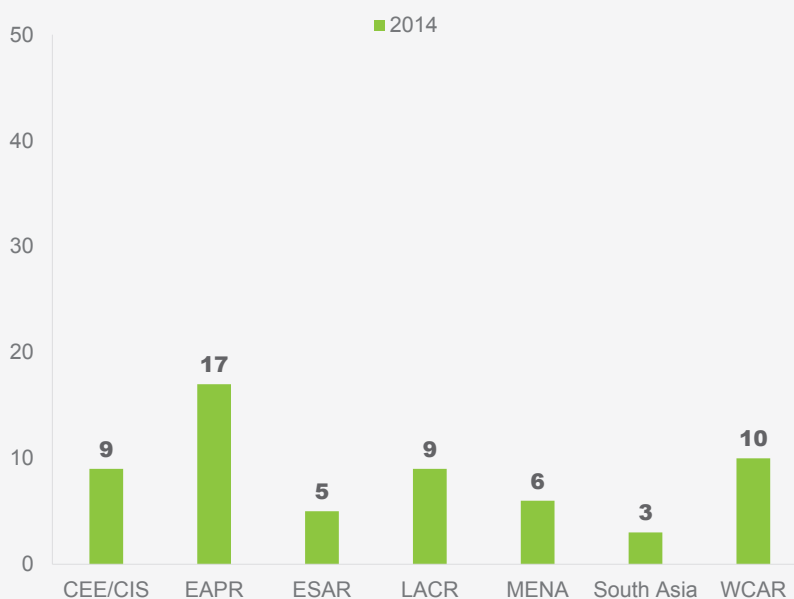


P1.f.2

Number of countries that have conducted a launch of A Promise Renewed followed by annual review

Baseline † / 2014 update 59

2017 Target TBD



Source: UNICEF country offices, 2014.



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