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CHILD PROTECTION
SOCIAL INCLUSION
GENDER EQUALITY
HUMANITARIAN ACTION

Annual Results Report 2016

Nutrition

UNICEF's Strategic Plan 2014–2017 guides the organization's work in support of the realization of the rights of every child. At the core of the Strategic Plan, UNICEF's equity strategy – which emphasizes reaching the most disadvantaged and excluded children, caregivers and families – translates this commitment to children's rights into action.

The following report summarizes how UNICEF and its partners contributed to nutrition in 2016 and reviews the impact of these accomplishments on children and the communities where they live. This is one of nine reports on the results of efforts during the past year, encompassing gender and humanitarian action as well as each of the seven Strategic Plan outcome areas – health, HIV and AIDS, water, sanitation and hygiene, nutrition, education, child protection and social inclusion. It is an annex to the Annual Report of the Executive Director of UNICEF for 2016, the organization's official yearly accountability document.

Bardipada, India. A young mother holds her baby girl, born just 10 days ago. The girl was born weighing 2 kilograms and is receiving nutritional services and care from a UNICEF-supported programme to prevent stunting in early childhood.

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EXECUTIVE SUMMARY

Good nutrition is an investment in the future of children and nations. Nutritious diets fuel children's growth, drive brain development, strengthen learning potential, enhance productivity in adulthood and pave the way to more sustainable and prosperous societies.

With the launch of the Sustainable Development Goals (SDGs) in 2015, the world is preparing to tackle the ambitious objective of ending all forms of malnutrition by 2030, as part of Goal 2 to end hunger, achieve food security and improved nutrition, and promote sustainable agriculture. UNICEF's global, regional and national nutrition strategies are closely aligned with the SDG framework, and in 2016, UNICEF continued to provide leadership in 14 global nutrition partnerships and countless national partnerships to accelerate progress on nutrition.

With the support of UNICEF and its development partners, countries have made substantial progress in reducing malnutrition over the past decade: There are 42 million fewer stunted children in the world than there were just 15 years ago. Yet, malnutrition remains a persistent problem in every region of the world. Today, 156 million children under 5 are stunted and their physical growth and brain development compromised. The lives of 50 million wasted children under 5 are at risk if they do not receive timely and quality care. In rich and poor countries alike, a sharp rise in overweight and obesity – affecting 42 million under-fives globally – is presenting a different but equally serious public health problem.[1]

To address these pressing concerns, in 2016, UNICEF's 599 nutrition staff members[2] supported 121 countries across all regions in scaling up nutrition programmes, particularly in regions with the highest burdens of undernutrition, including Eastern and Southern Africa, South Asia, and West and Central Africa.

UNICEF's work and results in 2016

At the end of year three of the Strategic Plan 2014–2017, UNICEF has made significant progress globally towards achieving Outcome 4 – *the improved and equitable use of nutritional support and improved nutrition and care practices*. Based on the Strategic Plan framework and using the theory of change, nutrition output and outcome results were achieved in four programme areas: (1) infant and young child feeding; (2) micronutrient supplementation and fortification; (3) nutrition in emergencies and the treatment of severe acute malnutrition; and (4) general nutrition.

In the **infant and young child feeding (IYCF) programme area**, 2016 was a landmark year in knowledge generation and advocacy. UNICEF's publication *From the First Hour of Life: Making the case for improved infant and young child feeding everywhere* was the first global stocktaking report on infant and young child feeding practices. The report achieved wide coverage in high-impact media outlets. The Breastfeeding Advocacy Initiative, led by UNICEF and the World Health Organization (WHO), added three new members in 2016, expanding its partnership to 21 organizations. Partners leveraged several high-level advocacy opportunities and achieved consensus on a messaging framework and seven key policy recommendations to guide its work.

At the country level, UNICEF strengthened national capacity to provide facility and community-based IYCF counselling services by ensuring that a sufficient number of health staff and community workers were adequately trained to support mothers and caregivers. In 2016, 109 out of 121 countries (90 per cent) reported having the capacity to provide IYCF counselling services to communities. In 2016, UNICEF, WHO and the International Baby Food Action Network carried out a landmark review of national implementation of the International Code of Marketing of Breast-milk Substitutes – the first time that all three organizations have worked together to consolidate databases on Code implementation globally. The status of Code implementation is a critical measure of the policy environment for breastfeeding: 135 countries had at least some form of legal measure in place covering some provisions of the Code, compared with only 103 countries in 2011, representing significant progress over the past years.

In the **micronutrient supplementation and fortification programme area**, UNICEF worked to improve policies around anaemia prevention, salt iodization and food fortification, while supporting vitamin and nutrient supplementation and fortification for children and women most in need. According to the latest coverage figures, 273 million children aged 6–59 months – more than 70 per cent – received two annual doses of vitamin A supplements in priority countries (from a baseline of 68 per cent in 2011 and towards a target of 80 per cent). In least developed countries, where needs are greatest, 87 per cent of children aged 6–59 months reaped the benefits of two annual doses of vitamin A protection in 2016.

Globally, the number of countries implementing home fortification programmes with micronutrient powders has tripled over the past five years, increasing from 22 countries in 2011 to 65 countries in 2016. More than 10 million children were reached with such programmes in 2016, including 8.3 million with UNICEF support. UNICEF has continued to be a global leader in salt iodization programmes for more than 25 years. In 2016, 18 countries met the Strategic Plan target of having 90 per cent of households consuming iodized salt. UNICEF, along with global partnerships such as the Food Fortification Initiative,

builds the capacities of government and the food industry to implement large scale food fortification. The number of countries with legislation to mandate staple cereal fortification increased from 82 in 2014 to 86 in 2016, towards a target of 90 countries.

A staggering number of humanitarian situations in 2016 took a heavy toll on children and their families and resulted in alarming levels of food insecurity and malnutrition. As part of the programme area of nutrition in emergencies and the treatment of severe acute malnutrition, UNICEF delivered life-saving services and supplies to reach the most vulnerable children. In 2016, 78 out of 121 UNICEF country programmes working on nutrition responded to new and ongoing humanitarian situations, an increase from 69 country programmes the previous year. UNICEF continued to provide support for emergency preparedness in 2016: 64 countries reported having a nutrition sector plan or policy that included a risk management strategy to address crises, nearly reaching the 2016 target of 65 countries.

Children with severe acute malnutrition need urgent treatment to protect their lives. With UNICEF support, in 2016, 2.4 million children with severe acute malnutrition (72 per cent of the 2016 target) were admitted for therapeutic treatment in humanitarian situations, with a recovery rate of 87 per cent. Within both development and humanitarian settings, 3.4 million children with severe acute malnutrition were admitted for treatment, with a recovery rate of 89 per cent. With the launch of the No Wasted Lives coalition in 2016, UNICEF and partners will accelerate progress in this programme area by improving prevention and treatment approaches, enhancing advocacy and coordinating resource partner investments.

The **general nutrition programme** supports the results of the other nutrition programme areas by working with governments to develop evidence-based, multi-sectoral policies, strategies and programmes. The proportion of countries with a nutrition sector policy or plan developed or revised with UNICEF support has increased steadily over the past three years, from 74 per cent in 2014 to 79 per cent in 2016. UNICEF maintained its leadership role as chair of the Scaling Up Nutrition (SUN) lead group in 2016, and the number of country members of the SUN global movement grew from 5 in 2010 to 57 countries and three Indian states in 2016.

UNICEF supports countries in improving nutrition data, which are critical to evaluating whether key interventions are achieving their intended coverage and impact with equity. In 2016, 96 out of 121 countries reported national information management systems that disaggregate data on nutrition (93 in 2015), indicating good progress towards the target of 100 countries by the end of the Strategic Plan period. UNICEF's contribution to the global knowledge base for nutrition is well reflected by the 55 publications in peer-reviewed journals throughout 2016, exceeding the target of 50 products per year.

Looking ahead

Three years into its Strategic Plan, UNICEF is on track to meet the targets in the nutrition outcome area. The key challenges experienced throughout 2016 – the multitude of emergency situations and the need to improve multi-sectoral action, support national governments to deliver on their priorities and the SDG agenda, build national capacities and strengthen systems, and address human and financial resource constraints – will shape UNICEF's programming going forward. Improved linkages between nutrition, health, water and sanitation and early childhood development will be vital to achieving results during the final year of the Strategic Plan and will also drive progress towards the 2030 Agenda for Sustainable Development.

Resource mobilization is an ongoing challenge for nutrition programming. In 2016, nutrition in emergencies and severe acute malnutrition treatment accounted for the greatest programme expenses – 37 per cent of the total. This investment was critical in allowing UNICEF to respond rapidly to immense humanitarian needs and the high burden of severe acute malnutrition globally. Yet, with the number and scale of emergencies expected to increase throughout 2017, a more flexible funding stream is urgently needed. In 2016, flexible thematic contributions declined to US$3.4 million, representing just 1 per cent of the overall nutrition budget.

In the face of the increasing scale of humanitarian emergencies, the need for investments in large scale prevention programmes and national coordination systems before an emergency has never been clearer.
An increase in thematic funds would allow UNICEF to make larger and more strategic investments in the prevention of undernutrition, engage more actively in systems strengthening, and leverage a larger number of platforms and sectors to deliver nutrition outcomes for children and women.

STRATEGIC CONTEXT OF 2016

Nutrition in numbers

Nutritious diets fuel healthy bodies, boost developing brains and set children on the path to lifelong health, learning and prosperity. Enriched with these benefits, well-nourished children are the lifeblood of sustainable development.

There were fewer children in the world suffering from stunting, or chronic malnutrition, in 2016 than ever before, yet the sheer number of children affected is cause for alarm. While stunting rates declined by almost 40 per cent between 1990 and 2015, there are still 156 million stunted children under 5 worldwide, two thirds of them in low- and middle-income countries. In contrast to global trends, the number of stunted children in Africa is rising due in part to more rapid population growth in the region, with the steepest increases in West Africa (*see Figure 1*).[1]

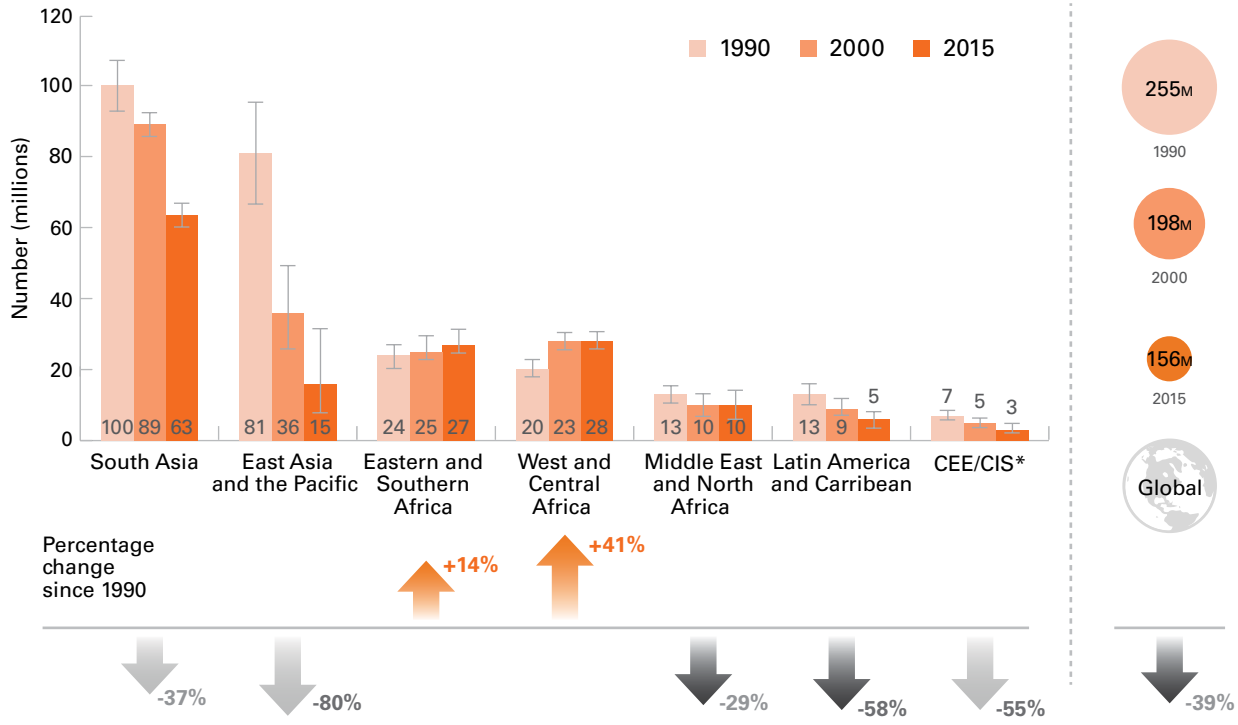
In 2016, 50 million children under 5 faced the life-threatening risk of wasting, or acute malnutrition, the majority of them in Asia (*see Figure 2*). Acute malnutrition is not only a concern for children living through droughts, disasters and conflict; in fact, most children suffering from wasting live in non-emergency contexts.

At the same time, 42 million children are now overweight, an increase of 11 million since 2000, as a result of increased access to and consumption of processed foods, industry marketing strategies and overall lower levels of physical activity. Even in Africa, the number of overweight children has increased by more than 50 per cent since 2000 (*see Figure 3*).

These different forms of malnutrition are not on opposite ends of a spectrum. Indeed, many countries are now facing a devastating triple burden of malnutrition – with coexisting burdens of stunting and wasting, vitamin and nutrient deficiencies, and overweight and obesity. This triple burden can be seen at the population level, within communities and even within the same individual. For example, an overweight child may suffer from micronutrient deficiencies.[3] UNICEF and its partners are increasingly using the language of 'all forms of malnutrition' to recognize the complex and interconnected relationship between these different forms of malnutrition.

FIGURE 1

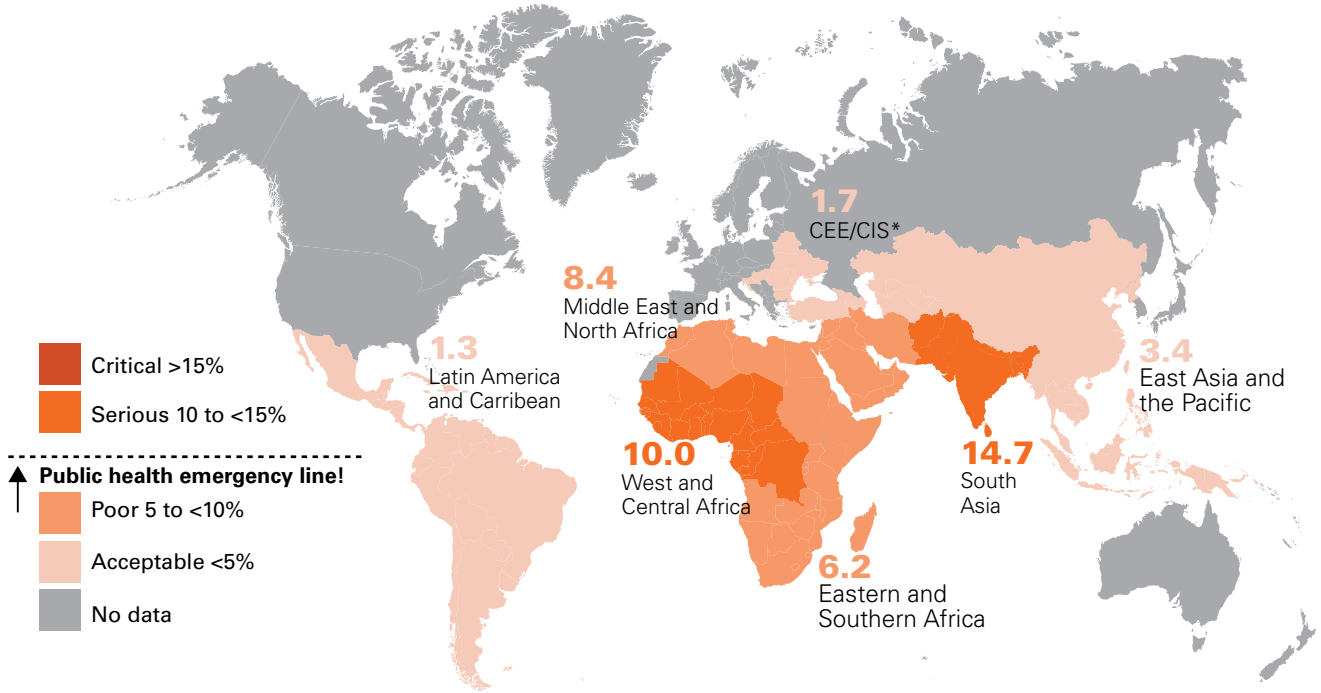
Number of children under 5 who are stunted, by region, 1990-2015



Note: The CEE/CIS region does not include Russia due to missing data; Consecutive low population coverage for the 2015 estimate (interpret with caution). Source: UNICEF, WHO, World Bank Group joint malnutrition estimates, 2016 edition.

FIGURE 2

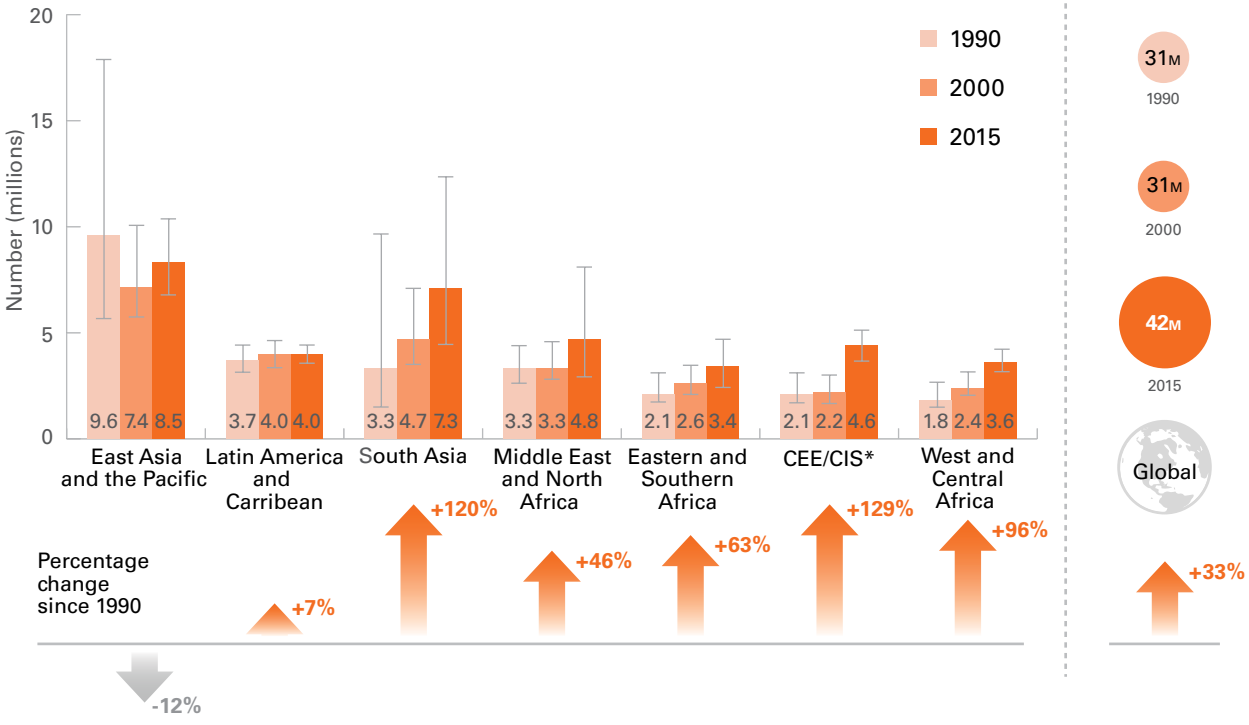
Percentage of children under 5 who are wasted, by region, 2015



Source: UNICEF, WHO, World Bank Group joint malnutrition estimates, 2016 edition. Disclaimer: This map is stylized and not to scale. It does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers

FIGURE 3

Number of overweight children under 5 (in millions), by region, 1990–2015



Notes: South Asia Consecutive low population coverage for the 2015 estimate (interpret with caution). The CEE/CIS region does not include Russia due to missing data; Consecutive low population coverage for the 2015 estimate (interpret with caution). Source: UNICEF, WHO, World Bank Group joint malnutrition estimates, 2016 edition.

Regardless of how malnutrition manifests in a child, its prevention calls for a similar set of tried and tested interventions: adequate maternal nutrition before and during pregnancy and lactation; adequate breastfeeding in the first two years of life; nutritious and safe foods in early childhood; vitamin and nutrient supplements and fortified foods as appropriate; and access to basic services and a healthy environment. These investments in nutrition, particularly within the earliest years of life, can yield dramatic results for children, their families and communities.

The evolving nutrition landscape

The global momentum to improve nutrition has been steadily increasing, with governments and stakeholders around the world acknowledging good nutrition as a key driver of development in the Sustainable Development Goals (SDGs) – a set of 17 goals endorsed by the international community in 2015 that are anchored to the 2030 Agenda for Sustainable Development, a larger plan of action for the next 15 years.

Investments in nutrition bring substantial economic and development gains – a fact that was documented with renewed vigour in 2016. The third Global Nutrition Report, a stock-take of the state of the world's nutrition published in 2016, determined that the economic consequences of inaction on nutrition result in losses of 11 per cent of gross domestic product every year in Africa and Asia alone – whereas preventing malnutrition delivers investment returns of $16 for every $1 spent.[4] To meet global nutrition milestones, governments and resource partners will need to triple their commitments to nutrition over the next decade. Also in 2016, the leading medical journal *The Lancet* released ground-breaking evidence on the benefits of breastfeeding, including the vast economic savings that countries everywhere would enjoy with increased breastfeeding. Moreover, *The Lancet's* Early Childhood Development Series emphasized the importance of nutrition at the centre of multi-sectoral interventions for children and their families in the early years.

UNICEF and the global nutrition community have worked for years to reduce the burden of severe acute malnutrition, but despite important progress, an unacceptable number of children remain out of reach. The launch of the No Wasted Lives coalition in 2016 by UNICEF, the Government of the United Kingdom, the European Commission, Action Against Hunger and the Children's Investment Fund Foundation was a turning point in galvanizing action to double the number of children receiving treatment for severe acute malnutrition to 6 million a year by 2020 (*see programme area 3*) – an ambitious goal that will contribute heavily to achieving the SDG targets on reducing preventable child deaths and child wasting.

The United Nations General Assembly passed a resolution in April 2016 proclaiming a Decade of Action on Nutrition 2016–2025, setting a clear timeline to implement measures outlined in the Framework for Action of the Second International Conference on Nutrition in order to achieve the World Health Assembly's global nutrition targets by 2025 and attain the SDG target of ending all forms of malnutrition by 2030.

A new phase of the Nutrition for Growth compact was launched during an event held in Brazil in August 2016. During the first Nutrition for Growth summit in June 2013, 94 stakeholders from governments, donor agencies, civil society and the private sector pledged US$23 billion and made commitments to take urgent action on nutrition. The second summit was an opportunity to renew those commitments to scale up nutrition while expanding support among new leaders and advocates, and preparing for a pledging summit in 2017.

During the Strategic Plan period (2014–2017), new opportunities for nutrition financing, including the Power of Nutrition funding mechanism, were launched. Such action drew attention and funding from resource partners and could significantly increase revenue streams for maternal and child nutrition in the coming years.

Challenges on the path to sustainable development

2016 was a year of crisis and upheaval across the globe. A staggering number of humanitarian situations in 2016, many of them climate-related, threatened the health and well-being of millions of children and their families. Protracted conflicts, natural hazards and devastating food insecurity gripped communities around the world, threatening lives and livelihoods. Coordinated efforts were critical to respond rapidly to these challenges, using risk-informed programming to identify hazards, address vulnerabilities and strengthen systems to sustain development gains in the face of shocks and stresses.

Population growth will prove a challenge in the coming years, particularly in meeting the SDG target of reducing the number of children under 5 who suffer from stunting by 40 per cent in countries with the highest stunting burdens. UNICEF will put equity at the forefront of its efforts to drive progress towards SDG targets. For example, the stunting target for South Asia could be readily achieved by focusing exclusively on India and Pakistan – yet such a strategy would be highly inequitable, leaving behind children in lower-burden countries.

The path to achieving the SDGs will be contingent on the strength of multi-sectoral actions – particularly between nutrition; water, sanitation and hygiene (WASH); health; early childhood development (ECD) and social protection – and strengthening these alliances has never been more urgent. This work must balance support to policy and strategy development with community engagement and behaviour change.

UNICEF will need to continue linking SDG goals to global, regional and country programme priorities, supporting governments to prioritize strategies to achieve the SDGs and promoting better governance and accountability at the national and sub-national levels. At the same time, the SDG era inspires UNICEF to ground its programming in a rights-based approach to policy development, strategy design and programme delivery, and to be transformative in both results and ways of working for children.

UNICEF's transformative role

UNICEF is well placed to support countries and their development partners throughout the SDG era given the organization's focus on equity, its capacity for multi-sectoral action and its commitments to children – whose nutrition and well-being are the foundations of sustainable development.

Throughout the Strategic Plan period, UNICEF's global nutrition strategy, which outlines what good nutrition means and what steps are needed to get there, has become closely aligned with the ambitious SDG framework, as well as with global and regional agendas. The strategy is a critical factor driving UNICEF's achievements in 2016.

Nevertheless, the changing face of child malnutrition has strained UNICEF's resources and highlighted the need to better clarify its strategy and role in supporting countries to tackle new and emerging problems. UNICEF's operational approaches to improving nutrition programming for mothers and children call for action across the life cycle and provide opportunities for 'double duty' actions to address the triple burden of malnutrition in different contexts. With its wide country presence and history of strong partnerships and multi-sectoral programming, UNICEF remains poised to lead countries in scaling up nutrition through the remainder of the Strategic Plan period and beyond.

RESULTS BY PROGRAMME AREA

Strategic approach

UNICEF's nutrition programmes focus primarily on the critical window of the first 1,000 days, from pregnancy through a child's second birthday, when the greatest nutritional gains can be achieved. At the end of the third year of UNICEF's Strategic Plan 2014–2017, the nutrition programme has made significant progress globally in achieving Outcome 4 – *the improved and equitable use of nutritional support and improved nutrition and care practices*.

The 2016 results for UNICEF's nutrition programme are organized according to four programme areas: (1) infant and young child feeding; (2) micronutrient supplementation and fortification; (3) nutrition in emergencies and the treatment of severe acute malnutrition; and (4) general nutrition. Results from the HIV and nutrition programme area are discussed throughout the other programme areas. While the four programme areas are presented separately for the purposes of this report, in practice they are deeply integrated and part of a holistic approach to achieving success in Strategic Plan Outcome 4.

The Strategic Plan results framework sets specific targets at three levels: outputs, which reflect UNICEF's contributions most directly; outcomes, which are the results of shared action; and impact, which reflects the collective action of States with the support of development partners.

Based on the theory of change, this section describes the inputs, resources and activities of each of the four different programming areas of nutrition, which are intended to achieve specific programme area outputs and support the overall projected impact of stunting reduction in children and anaemia reduction in women of reproductive age. UNICEF's progress on Strategic Plan indicators is referenced within each programme area and framed in relation to 2016 results as well as baselines and targets. A full table of indicators and results is included in Annex. Each indicator is discussed in relation to UNICEF's approaches to achieving progress, with examples of how this was done at the country level in 2016. Each programme area section concludes with a discussion of challenges, reflections and future directions.

A 'results chain' schematic linking resources to outputs and outcomes in the Strategic Plan is provided in the introduction to each programme area chapter. The programme activities listed under each output serve as the sub-headings in each programme area chapter. Output indicators are included within the schematic and flagged for the reader throughout the chapter (e.g., P4.a.1; P4.a.2; etc.). It is important to note that the schematic can only present a partial story; in reality, the relationship between nutrition expenses and results is interconnected across programme areas. For example, a successful complementary feeding programme would have benefited from expenses from the infant, young and child feeding programme (to support facility and community-based counselling interventions), expenses from the micronutrients programme (for the supply of micronutrient powders) and funds from the general nutrition programme (to support broader nutrition policy development).

As outlined in the theory of change, UNICEF uses time-tested, robust intervention strategies to achieve results both globally and within countries. Such strategies include capacity development; evidence generation, policy dialogue and advocacy; partnerships; South-South cooperation; promotion of innovation; integration and cross-sectoral linkages; and service delivery. The link between these strategies and results achieved is explored closely in each programme area.

In 2016, UNICEF engaged in a broad range of nutrition programming in 121 countries, propelled by 599 technical staff members located across all regions, but principally in those with the highest burdens of malnutrition, including Eastern and Southern Africa, South Asia and West and Central Africa. Below is a summary of results achieved in 2016:

NUTRITION HEADLINE RESULTS IN 2016

PROGRAMME AREA 1 – Infant and young child feeding

BUILDING THE FUTURE WITH EACH HEALTHY BITE

- Rates of exclusive breastfeeding are high in many countries:

  As of 2016, 41 countries had exclusive breastfeeding rates of more than 50 per cent among infants younger than 6 months.

- Most countries are providing community-based counselling for infant and young child feeding:

  In 2016, 90 per cent of countries (109 out of 121) had the capacity to provide infant and young child feeding counselling services to communities.

PROGRAMME AREA 2 – Micronutrient supplementation and fortification

A VITAMIN BOOST FOR THE MOST VULNERABLE

- More countries are able to provide vitamin A supplementation to children in need:

  In least developed countries, where needs are greatest, 87 per cent of children aged 6–59 months reaped the benefits of two annual doses of vitamin A protection in 2016.

- Home fortification programmes are reaching a record number of children worldwide:

  The number of countries implementing home fortification programmes tripled over the past five years, reaching 65 countries in 2016. More than 10 million children benefited from these programmes in 2016, including 8.3 million with UNICEF support.

PROGRAMME AREA 3 – Nutrition in emergencies and treatment of severe acute malnutrition

STRENGTHENING SYSTEMS, SAVING LIVES

- More children with severe acute malnutrition are receiving life-saving treatment:

  In 2016, 3.4 million children with severe acute malnutrition were admitted for treatment in development and humanitarian settings, with a recovery rate of 89 per cent.

- National planning and emergency preparedness is improving:

  In 2016, 64 countries had a nutrition sector plan or policy that included a risk management strategy to address crises such as conflict or disasters, nearly reaching the 2016 target of 65 countries.

PROGRAMME AREA 4 – General nutrition

ENABLING AN OPTIMAL ENVIRONMENT FOR GOOD NUTRITION

- More countries are seeking UNICEF's support to improve their nutrition policies and strategies:

  The proportion of countries that have a nutrition sector policy or plan developed or revised with UNICEF support has increased steadily, from 74 per cent in 2014 to 79 per cent in 2016.

- More countries are making national commitments to scaling up nutrition:

  The Scaling Up Nutrition (SUN) movement has grown from 5 countries in 2010 to 57 countries and three Indian states in 2016, and the SUN Lead Group continues to be chaired by UNICEF's Executive Director.

- UNICEF is a global knowledge leader in nutrition:

  UNICEF nutrition programme staff published 55 peer-reviewed articles in 2016, exceeding the target of 50 papers per year.

PROGRAMME AREA 1: INFANT AND YOUNG CHILD FEEDING

BUILDING THE FUTURE WITH EACH HEALTHY BITE

The quality of children's diets is more important before age 2 than at any other time in life. UNICEF focuses its infant and young child feeding (IYCF) programmes on this critical developmental period, when good nutrition has the power to transform and strengthen the foundations of children, families, communities and nations.

Healthy diets are about the foods that children eat and the behaviours of their caregivers. Optimal IYCF includes: initiation of breastfeeding within the first hour of life; exclusive breastfeeding for the first six months; and continued breastfeeding until age 2 or longer. At 6 months of age, children should be introduced to their first foods, known as complementary foods, which should be safe, nutritionally adequate and provided in response to a child's needs and hunger signals. The protection, promotion and support of IYCF practices are central to preventing all forms of child malnutrition, including stunting and wasting as well as overweight and obesity.

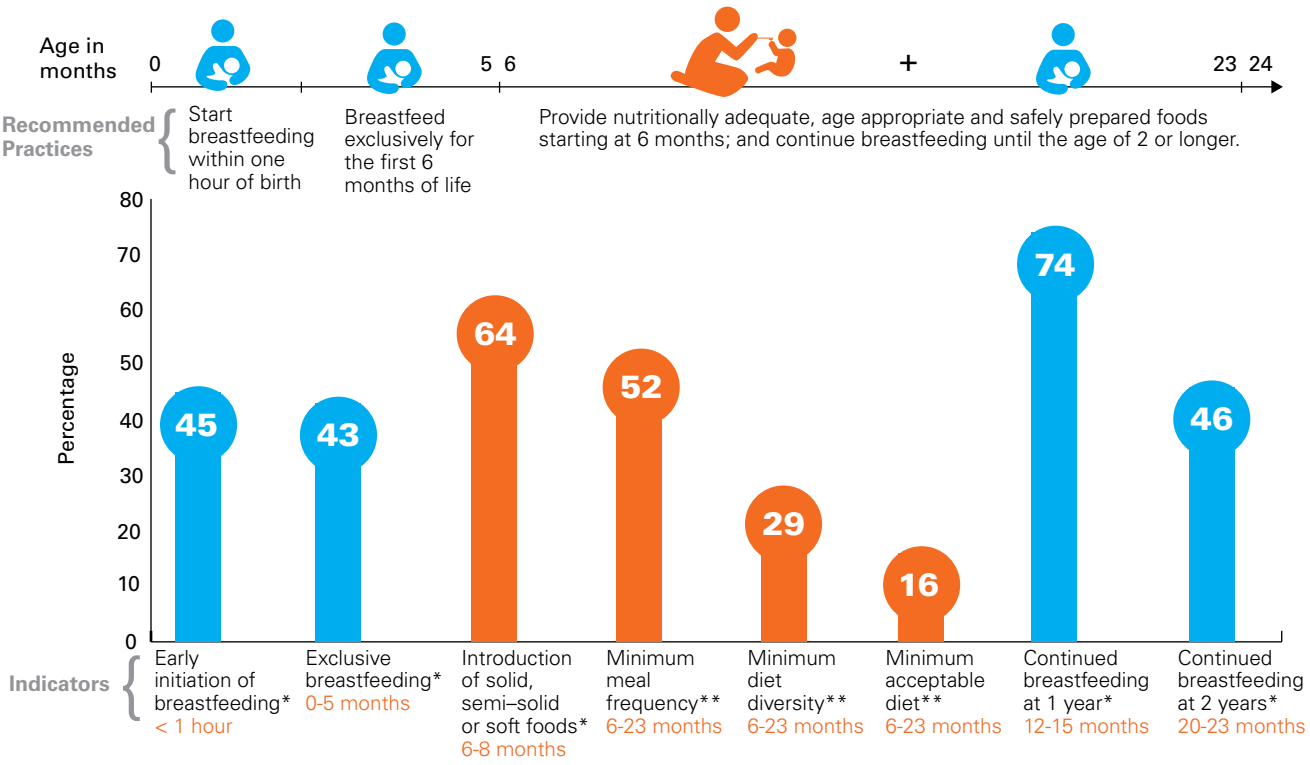
A report[5] published in 2016 by UNICEF paints a stark picture of the state of IYCF practices worldwide: Fewer than half of newborns are put to the breast within the first hour of life and breastfed exclusively for six months. The number of children eating a minimally diverse and frequent diet – a minimally acceptable diet – is shockingly low: Only one in six children in low- and middle-income countries is fed a diet that meets the minimum requirements for healthy growth and development (*see Figure 4*).

UNICEF strives to address the immense social, economic and political barriers that prevent children from receiving the right foods at the right time in their development. Some of these barriers include insufficient political and financial commitment; poverty and food insecurity; knowledge gaps among health and nutrition providers, caregivers and communities; the lack of adequate maternity protection; and the marketing of breastmilk substitutes.

FIGURE 4

Global continuum of feeding practices

Across the continuum, too few children are getting the nutrition they need to survive, grow and develop



Per cent of children put to the breast within one hour of birth, exclusively breastfed (0-5 months); introduced to solid, semi-solid or soft foods (6-8 months), with a minimum meal frequency, minimum diet diversity and minimum acceptable diet (6-23 months) and continued breastfeeding at 1 year (12-15 months) and 2 years (20-23 months), 2015*.

*Source: Unicef global databases, 2016 based on MCIS, DHS and other nationally reprsented sources. Note: Data included in these global averages are the most recent for each country between 2010-2016. *Aggregates for these indicators use China, 2008; **Aggregates for these indicators do not include China due to lack of data and while >50% of the global population was met, almost all of the data for these indicators are from low and lower middle income countries.*

Providing children with safe and nutritious diets is not the responsibility of families alone; national leadership and investments are critical. UNICEF works with governments to harness commitments, strengthen policies and legislation, build the capacities of key actors in IYCF programming, and increase the availability of counselling and skilled support to caregivers in both health facilities and communities.

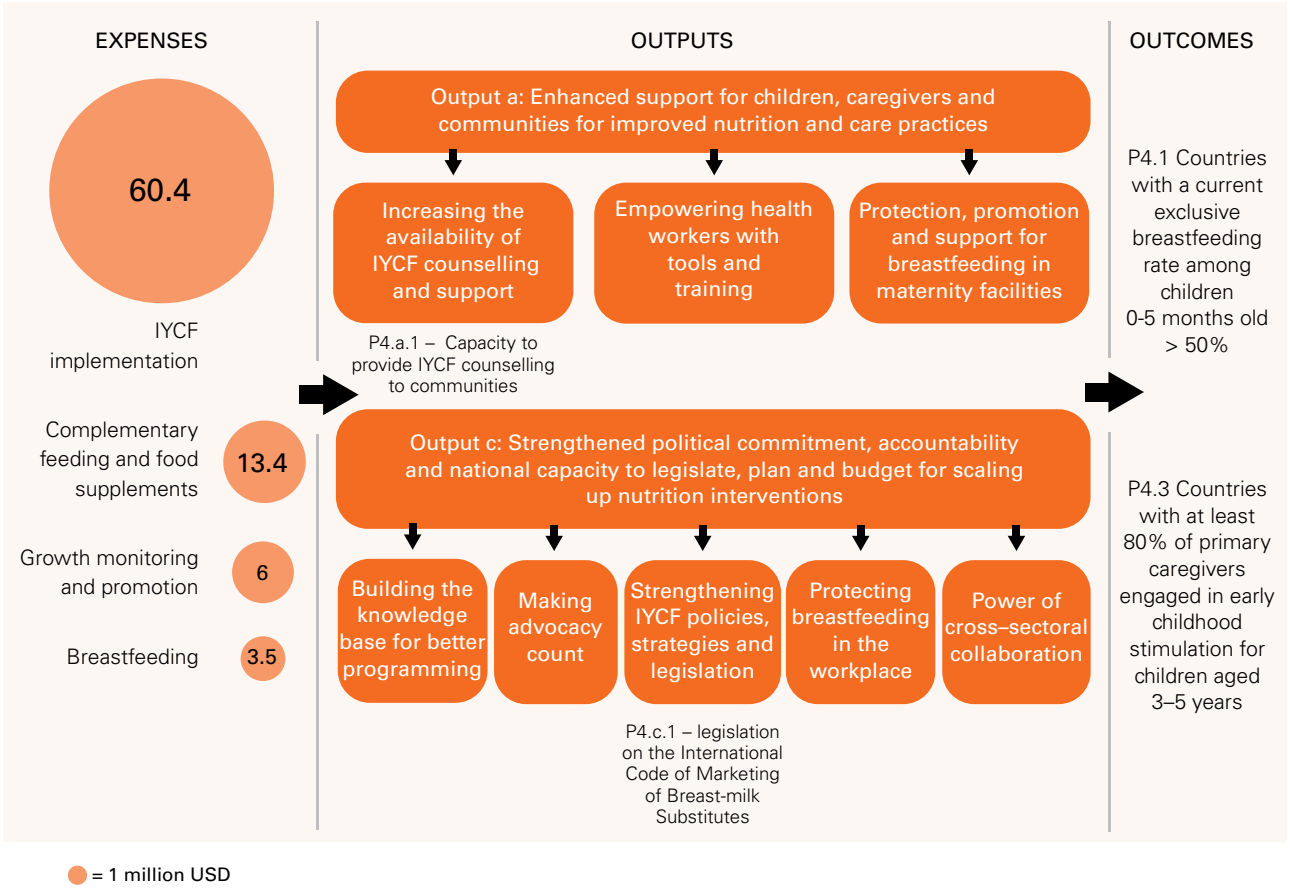
The experiences of Burkina Faso, Guinea-Bissau, Kenya, Myanmar, Swaziland, Timor-Leste, Togo and Zambia in recent years show that it is possible to rapidly increase or maintain exclusive breastfeeding rates above 50 per cent in a relatively short time frame with investments in effective legislation, community-based promotion and communication strategies, and the provision of skilled counselling and support at scale. As of 2016, 41 countries had exclusive breastfeeding rates of more than 50 per cent among infants younger than 6 months. Further, 30 of these countries had experienced no significant decline in these rates since 2010 (P4.1).

The landmark First Foods meeting in 2015 sparked renewed global focus on complementary feeding, and several countries took concrete steps towards programme scale-up in 2016. Nigeria, for example, organized a national meeting on complementary feeding, leading to recommendations to develop a national IYCF strategy and strengthen the capacities of front-line health workers in IYCF.

Results chain for infant and young child feeding

The results chain for IYCF outlines the linkages between programme spending, key interventions and progress on UNICEF's Strategic Plan output and outcome indicators (*see Figure 5*). The output 'bubble' in Figure 5 lists the activities supporting each output, and these also serve as sub-headings in this programme area chapter.

FIGURE 5
Results chain for infant and young child feeding



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

To illustrate the results chain using one example, UNICEF's US$60.4 million in expenses to promote the scale-up of IYCF programmes impacts the capacity of countries to provide counselling to improve IYCF practices at scale within communities. Community-based counselling in turn helps to increase exclusive breastfeeding rates (indicator P4.1) within countries and globally, protecting children from death and boosting their development potential. Full data on each IYCF indicator are presented in the pages that follow and in Annex.

Expenditures to support programme implementation

In 2016, US$83 million was spent on the IYCF programme, with the largest amount allotted to 'IYCF implementation', which primarily includes three types of interventions: systems strengthening, capacity development and service delivery. Spending in 2016 increased from the previous year, when expenses totalled US$74.9 million. This increase may reflect the scale-up of complementary feeding programmes in a number of countries as well as the emphasis on preventive nutrition interventions more generally.

Key outputs and results in 2016

Increasing the availability of IYCF counselling and support

Skilled support is critical to improving breastfeeding and complementary feeding practices. Such support can be provided within health facilities by doctors, nurses, midwives, counsellors or within the community, in the form of individual, family or group counselling led by community workers. UNICEF is working to strengthen national capacity to provide community counselling services, which in

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Nyagai Jany, 17, breastfeeds her newborn daughter in the maternity clinic at the Bentiu Protection of Civilians site in South Sudan. The baby girl is the young mother's first child.

turn provides caregivers with the knowledge and skills to improve feeding practices. In 2016, 90 per cent of countries (109 out of 121) reported having the capacity to provide IYCF counselling services to communities. The number of countries with the capacity to provide IYCF counselling services to 70 per cent of communities increased from 14 countries (at baseline) to 29 countries in 2016, towards a target of 40 (P4.a.1).

Mother support groups can be an effective platform for encouraging optimal IYCF practices within community settings. Community health workers and/or experienced mothers model optimal breastfeeding and complementary feeding practices, share information and experiences, and offer support to other women in an atmosphere of trust and respect. In Burkina Faso, the number of pregnant and lactating women participating in mother-to-mother support groups increased from about 70,600 to more than 166,100 between 2015 and 2016. Mother-to-mother support groups are a key component of Burkina Faso's IYCF scale-up plan in five regions, which drove an almost 18 percentage point increase in the rate of early initiation of breastfeeding and an almost 17 percentage point jump in the rate of exclusive breastfeeding between 2012 and 2016. During the same period, the proportion of children aged 6–23 months receiving the minimum acceptable diet increased steadily, from 3 per cent to more than 22 per cent. Continued funding to expand the coverage of community-based interventions will be critical to maintaining these successes in the coming years. In 2017, such groups will be adapted to serve as a platform for improving screening for severe acute malnutrition in the country, and continued funding will be critical to maintaining these successes.

In 2016, Guinea-Bissau saw a significant improvement in breastfeeding practices due to the development and scale-up of robust community health programmes delivered by community health workers, mother support groups and nutrition treatment centres countrywide. UNICEF worked with the Ministry of Health and its partners to increase coverage of IYCF practices included in a package of 16 key family practices. The key practices were promoted by a network of more than 2,000 community health workers who delivered IYCF counselling at household level, covering about 55 per cent of the total population of children under 5. More than 4,400 mothers and caregivers were counselled on optimal IYCF practices, as well as good hygiene and sanitation, HIV prevention and parenting skills. Household surveys conducted among those women in the target regions revealed a dramatic rise in rates of early initiation of breastfeeding, from 41.9 per cent in 2015 to 81 per cent in 2016, and of exclusive breastfeeding rates from 67.7 per cent in 2015 to 79 per cent in 2016.

To address low rates of exclusive breastfeeding and poor diets among children under 2 in the Sudan, UNICEF worked with the Ministry of Health to develop a network of mother support groups as part of the roll-out of a national infant and young child feeding strategy. In 2015, 660 mother support groups were established, and with UNICEF support in 2016, this network expanded to 1,480 mother support groups, reaching 475,400 mothers and caregivers with IYCF counselling, as well as through individual counselling at the health-centre level. The rapid expansion of mother support groups surpassed the planned target of 300 groups, in part due to the sense of ownership that was nurtured within government and civil society. UNICEF piloted a monitoring and reporting system in 2016 that will soon be rolled out in all Sudanese states.

UNICEF's work in Nigeria offered an opportunity to study the impact of the generic IYCF community counselling package, currently used in 42 countries. In 2016, the Nigeria Federal Ministry of Health and Kaduna State Ministry of Health rolled out the IYCF community counselling package, with support from UNICEF and the US-funded Strengthening Partnerships, Results and Innovations in Nutrition Globally project. The package was adapted to the Nigerian context and translated into six local languages. Training was provided to community volunteers, who then established peer support groups. Findings from a mid-process evaluation suggest that IYCF support groups can provide community members, particularly women, with the knowledge, skills and platform they need to support one another in improving feeding practices. UNICEF and the Government are committed to moving the programme from 29 states to a full roll-out in 36 states in 2017.

In India, community counselling and mother support groups are a key part of UNICEF support to the Ministry of Health and Family Welfare, as part of the Government of India's Mothers Absolute Affection flagship programme launched in August 2016. The programme's objectives are to boost breastfeeding practices through skilled support for breastfeeding at delivery points in public health facilities, to generate community awareness, to strengthen interpersonal communication through accredited social health activists, and to monitor healthy facilities and publicly recognize those with good results. UNICEF has helped develop training packages, guidelines and toolkits for front-line health workers to guide programme implementation, and 10 states have now launched the programme and prepared action plans for programme implementation, drawing budgets from the National Health Mission.

Nutrition in the first two years of life provides a good opportunity to support early childhood development (ECD). IYCF counselling should include stimulation and nurturing caregiver-child interactions during the time of feeding (*see also the chapter on cross-cutting programme areas*). Combined ECD and IYCF interventions are particularly important to enhancing the impact on cognitive development during this period of rapid brain growth[6] and this is tracked as an outcome indicator in the Strategic Plan.

The results of UNICEF's IYCF programming in humanitarian situations are explored further in the nutrition in emergencies chapter.

Spotlight on Innovations: Expanding reach with mobile nutrition messaging

In **Ghana**, mobile phones are used to connect mothers with lactation counsellors, community health officers, nurses and health facilities. Laptops for e-trackers were procured in 2016 and are being installed in 82 community-based health planning services in 21 health centres.

In **Sri Lanka** in 2016, UNICEF partnered with the South Asia Infant Feeding Research Network to explore the use of mobile technology in transmitting key health information to mothers. More than 2,300 voice messages and 4,400 SMS messages on IYCF, growth monitoring, child-care practices and good hygiene practices have been shared with mothers in the programme. The impact of this intervention will be evaluated in 2017 and will contribute to the design of an intervention package on IYCF counselling using mobile phones.

A community health worker holds a cooking demonstration for a group of women and their young children at a health centre in the village of Khangrah, Muzaffargarh District, Punjab Province, Pakistan.

Empowering health workers with tools and training

To provide high-quality support and guidance, health workers – whether they are based in facilities or communities – need to be well trained and guided by the latest evidence (*see box: 'Case study: Community counselling to boost breastfeeding and improve diets in the Niger'*). Training and capacity building of health workers was a key component of the Maternal, Infant and Young Child Nutrition Strategy launched this past year in South Sudan. UNICEF provided technical support to the Government to finalize the strategy, guidelines and a training package. With the Ministry of Health and Nutrition Cluster partners, UNICEF organized three rounds of IYCF master trainer trainings on the package in Juba in 2016 for non-governmental organizations (NGOs) and United Nations agency field offices. The master trainers trained a total of 2,990 staff (83 per cent of the target) from NGOs and state ministries of health. In 2016, UNICEF in South Sudan signed partnership agreements with 47 NGOs, all of which include integrated maternal infant and young child feeding components. A total of 347,300 mothers with children under 2 were reached during individual counselling sessions, and a further 987,100 people, including more than 6,000 men, were reached through group counselling.

Over the past year, UNICEF continued to expand capacity in countries via its IYCF e-learning course, a partnership with Cornell University. In 2016, UNICEF revised and updated the course to include modules on 'essentials of nutrition for women' and 'monitoring to strengthen IYCF programmes', which were launched in September 2016. There were 1,483 new course registrants in 2016, bringing the total number of enrolments to more than 10,000 since the course was launched in 2012. Course participants come from 176 different countries. The course continued to be highly rated in 2016, with 98 per cent of respondents rating it as either 'excellent' (52 per cent), 'very good' (37 per cent) or 'good' (9 per cent).

The protection, promotion and support for breastfeeding within maternity facilities

This past year marked a revival of the World Health Organization (WHO)/UNICEF Baby-Friendly Hospital Initiative (BFHI). In commemoration of its twenty-fifth anniversary in October, the two organizations co-hosted a BFHI Congress in Geneva, with more than 300 participants from 130 countries and more than 20 development partners and United Nations staff. The Congress commemorated successes and lessons learned, established networks and provided inputs for updating the operational guidance for the initiative. The new guidance will provide tools and strategies for making the protection, promotion and support of breastfeeding in maternity facilities both sustainable and scalable.

To inform the updated guidance, UNICEF and WHO sought case studies of implementation from a broad range of countries and territories and edited them into a compendium of case studies that will be officially published in 2017. As an example, South Africa's case study describes how support for breastfeeding and for the BFHI increased after the country adopted a major policy (the Tswane Declaration) on the protection, promotion and support for breastfeeding in 2011. By the end of 2015, 73 per cent of deliveries took place in facilities certified as baby-friendly.

The BFHI has been rolled out in almost all countries in the world, and several studies have confirmed its positive impact on breastfeeding practices and child health.[7] In Egypt, 97 new health facilities in 12 governorates received BFHI certification in 2016. Also in 2016, backed by UNICEF technical support to the Croatia Ministry of Health, all 31 public maternity hospitals in the country and all 11 neonatal intensive care units met BFHI criteria, placing Croatia among the leading BFHI countries in the world. Since it was first introduced, the BFHI has contributed to an increase in exclusive breastfeeding in Croatia: Exclusive breastfeeding rates during the first two months rose from 51 per cent in 2007 to 67 per cent in 2014.[8]

Case study: Community counselling to boost breastfeeding and improve diets in the Niger

UNICEF, with the support of the European Union, is helping to improve breastfeeding and the quality of children's diets in the Niger with enhanced training and the scale-up of community-based IYCF counselling.

In 2015, data collected using Lot Quality Assurance Sampling (LQAS) as part of monitoring of progress, covering the 71 health facility catchment areas across 17 municipalities (UNICEF/European Union and NGOs partnership), revealed slow progress against key IYCF indicators, particularly that of access to a minimally acceptable diet (i.e., enough meals a day with food from a minimum number of food groups): Only 3 per cent of children aged 6–23 months were receiving a minimally acceptable diet a year after intervention. Furthermore, more than 50 per cent of trained health workers were not able to indicate the main principles of complementary feeding. UNICEF and partners undertook a further bottleneck analysis to better understand these challenges and confirmed that existing traditional perceptions and beliefs were slow to change, even after the initial standard community IYCF training. To address these barriers, UNICEF and partners conducted a re-training of health workers, focusing on the modules with low retention, and facilitated supportive supervision of their work throughout 2016. UNICEF continued to track progress every 10 months and followed up with corrective actions.

Drawing on these lessons, the project was expanded from 8 to 20 districts in 2016. Currently, 4,620 villages out of 18,647 nationally have the capacity to provide community IYCF counselling through more than 13,700 trained community health volunteers. More than 4,700 of these community health volunteers were trained in 2016, nearly achieving the planned target of 5,000. In addition, more than 3,100 mother-to-mother support groups have been established (more than 1,800 of which were formed in 2016), which provided counselling and support to more than 497,000 mother-infant pairs in 2016.

UNICEF also supported IYCF training for more than 1,300 facility-based health workers, covering 357 integrated health centres and 600 health posts. This training also helped health facility workers to better support and supervise community volunteers. UNICEF also provided technical and financial resources to help the Government of the Niger finalize and adopt a revised national IYCF strategy.

A UNICEF-supported annual evaluation of outcomes using LQAS revealed significant progress between 2015 and 2016 in the 17 intervention areas (home to approximately 10 per cent of the population): The rate of early initiation of breastfeeding increased from 64 per cent to 76 per cent and exclusive breastfeeding increased from 65 per cent to 73 per cent. The corrective actions taken to improve health worker skills in 2016 also proved fruitful: The proportion of health workers able to recall complementary feeding recommendations jumped from 53 per cent in 2015 to 81 per cent in 2016. The improved skills of health workers also impacted the quality of children's diets: The minimum acceptable diet increased from 3 per cent to 28 per cent.

As the project moves forward, the quality of IYCF training will be further improved by integrating ECD components. Challenges have included inadequate financial and human resources (outside of the 17 project communes), as well as weak coordination and management, which have delayed the adoption of national legislation on the marketing of breastmilk substitutes and constrained the revision of a pre-service training curriculum for health workers. Further, deeply rooted sociocultural practices – such as the role and status of women, especially young mothers – take time to change and will need to be addressed through multi-sectoral actions that go beyond IYCF promotion and counselling. Access to thematic funding streams would give UNICEF greater flexibility to drive progress on these issues.

The main BFHI challenges have been ensuring sustainability and scalability of the interventions, both financially and with regard to capacity, to help all mothers and newborns benefit from support for breastfeeding. To address these challenges, the updated guidance will recommend that countries better integrate BFHI standards into maternal and newborn care and within hospital quality assurance systems. The case studies show that this is feasible when different government departments collaborate to integrate their standards.

Building the knowledge base for better programming

UNICEF continues to provide global leadership and guidance on infant and young child feeding. In 2016, UNICEF published the global report *From the First Hour of Life: Making the case for improved infant and young child feeding everywhere*. The report marked the first global stock-take on child feeding practices, including the first estimates available for complementary feeding practices in low- and middle-income countries since data collection first began.[9] The report received wide media coverage in high-impact media outlets such as Reuters, *Le Monde* and *The New York Times*.

UNICEF also contributed to the development of normative guidance in 2016. These WHO/UNICEF guidelines on HIV and infant feeding, published in 2016, represent the only WHO guidance published with another United Nations agency – evidence of UNICEF's strong technical contribution and leadership on the issue. UNICEF is already working to implement its recommendations in countries. Throughout 2016, UNICEF also contributed to guidance on HIV and infant feeding in emergencies (to be published in 2017), and infant feeding in emergencies for Europe and the Middle East.

As the face of malnutrition shifts and rates of overweight and obesity continue to rise, countries are increasingly looking to UNICEF for guidance to tackle these emerging issues. In 2016, UNICEF and the National Public Health Institute of Mexico conducted a review of labelling regulations and practices for foods and beverages targeting children and adolescents in Latin American countries, including Argentina, Chile, Costa Rica and Mexico, as part of efforts to prevent childhood obesity and improve infant feeding practices. Based on the findings, the two organizations made recommendations for the regulation of food labels, including the need to harmonize approaches across Latin America.

Making advocacy count

UNICEF leveraged a number of advocacy opportunities in 2016 to raise the visibility of IYCF on a global scale. Momentum to improve breastfeeding practices continued to be driven by the global Breastfeeding Advocacy Initiative, a partnership of 20 organizations led by UNICEF and WHO and funded by the Bill & Melinda Gates Foundation. The initiative advocates for national commitment to and investments in breastfeeding programmes and policies. Three new partners joined the initiative in 2016, and partners achieved some important milestones, including consensus on a messaging framework – informed by audience research conducted with 2,400 influencers across six countries – and seven key policy recommendations to guide its work. These achievements are significant given the time and resources needed to secure consensus among a large and complex group of partners.

UNICEF participated in a global launch event for *The Lancet* Breastfeeding Series in January 2016, disseminated key messages through its communication channels, and organized a number of subsequent events within countries to raise awareness, including Burkina Faso, China, Indonesia, Thailand and the United Republic of Tanzania. After the global launch, UNICEF organized a webinar with the main study author for 150 participants to share the growing evidence base for breastfeeding with national actors and UNICEF country offices.

Over the course of 2016, the Breastfeeding Advocacy Initiative worked to strategically position breastfeeding on the agendas of several high-profile events, including a well-attended panel session during the Women Deliver Conference in Copenhagen, a round table for journalists during the conference and a side event on breastfeeding during the World Health Assembly in May 2016. The Initiative developed advocacy documents including a brief on breastfeeding and gender equality and maternal health, and a statement on breastfeeding, gender empowerment and sustainable development and a call to action during the 60th annual session of the Commission on the Status of Women.

Global media outreach for World Breastfeeding Week 2016 performed well compared with similar annual UNICEF campaigns. From 1 to 7 August, there were 69 mentions of UNICEF and breastfeeding in top-tier media, including *Le Figaro Madame* and *Forbes*, outlets that do not often disseminate UNICEF news. Further, UNICEF's senior adviser on infant and young child nutrition published a successful op-ed in *The Guardian*, which was shared more than 5,000 times on social media within four days of publication. UNICEF and partners also shared assets and generated engagement using the hashtags 'breastfeeding' and 'brelfies', reaching hundreds of millions of social media users.

Strengthening IYCF policies, strategies and legislation

Throughout 2016, UNICEF provided technical support to governments to fully implement the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions (known together as 'the Code'), through the adoption of national legislation. The Code aims to protect and promote breastfeeding by prohibiting the promotion of breastmilk substitutes.[10] In 2016, UNICEF provided technical support and guidance to the governments of Albania (*see box 'Case study: Strengthening Code legislation in Albania amid mounting industry pressures'*), Bangladesh, Ghana, Guyana, Indonesia, Kenya, Kiribati, Liberia, Marshall Islands, Papua New Guinea, Senegal, Thailand and Zambia to either draft national measures or strengthen existing Code legislation that fell short of the international standard.

In 2016, WHO, UNICEF and the International Baby Food Action Network published a report on global implementation of the Code entitled *Marketing of breast-milk substitutes: National implementation of the International Code – Status report 2016*. The report marks the first time that all three organizations have worked together to consolidate databases on Code implementation globally. As detailed in the report, 135 countries had at least some form of legal measure in place covering some provisions of the Code, as of March 2016. This represents significant progress since 2011, when only 103 countries had relevant legal measures in place. A total of 39 countries have comprehensive legislation or other legal measures reflecting all or most provisions of the Code. An additional 31 countries have legal measures incorporating many provisions of the Code, and a further 65 countries have legal measures that contain a few provisions.[11]

The joint report illustrates how widely the quality of Code implementation varies across countries. Some countries have good legislation in place but lack a monitoring body, while others have identified a monitoring body but the work of that group may not be carried out consistently. In 2016, only 55 countries submitted relevant information regarding monitoring, only 32 reported having a mechanism in place and even fewer reported that the mechanisms were functional. Just six countries reported having dedicated budgets and funding for monitoring and enforcement.[11]

UNICEF country offices also report on the adoption of national Code legislation as part of the organization's strategic monitoring questions, reflected in indicator P4.c.1 of the Strategic Plan. These data, combined with the data from the joint report, provide insight into how well the legislation is implemented, including whether it is monitored and enforced.

Case study: Strengthening Code legislation in Albania amid mounting industry pressures

In Albania, UNICEF's advocacy and technical advice led to new revisions to national law 8528 that were adopted by the Albania parliament in May 2016. The decision to revise the law was the result of an analysis conducted in 2015 to measure discrepancies between national measures and the provisions of the Code. The assessment identified the need to expand the range of breastmilk substitutes covered under Albania's laws, to clarify labelling requirements for such products, and to strengthen response to violations.

In 2016, UNICEF provided technical guidance to develop a package of by-laws, including one on labelling requirements for breastmilk substitutes. To support the law enforcement capacities of the state health inspection body, UNICEF helped develop guidelines and inspection tools for monitoring of compliance with the recently approved law. As a result of these efforts, the law is now monitored and enforced by a government institution, in addition to the previous monitoring supported by UNICEF through the local International Baby Food Action Network partner.

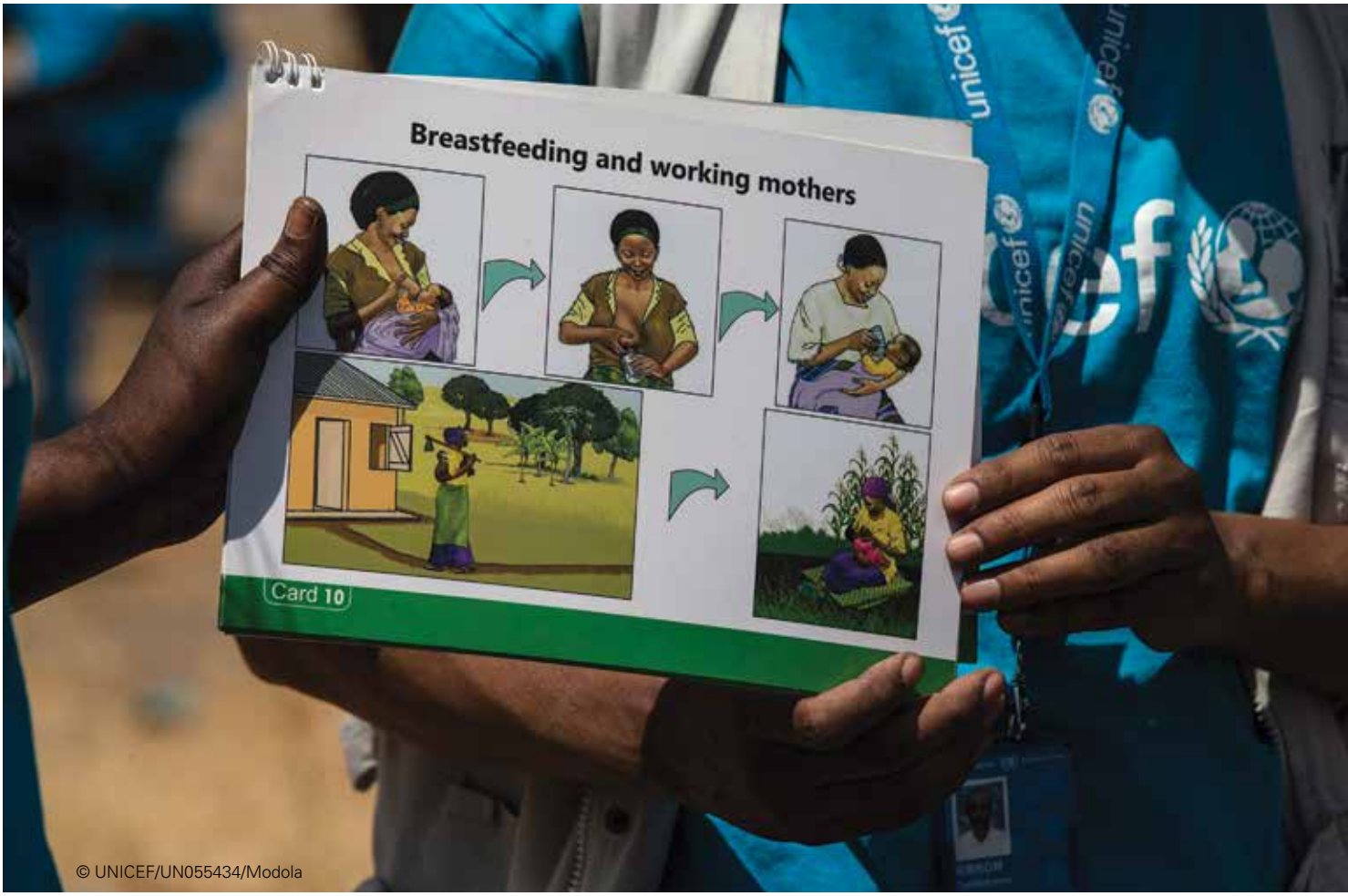
Intense pressure and counter-lobbying from the breastmilk substitutes industry was ongoing throughout the period of law revision. The industry tried to influence the decisions of the Parliamentary Commission, where changes to the law were discussed, falsely claiming that the official draft law contradicted relevant European Union directives and the provisions of the Code itself. The industry also used tactics to suggest that only infant formula should be covered under the law and not any follow-up formula, growing up milks, feeding bottles or teats. In response, UNICEF and the International Baby Food Action Network developed technical briefs on the importance of breastfeeding in the context of child health and nutrition in Albania, using the results of a cost-benefit analysis supported by UNICEF on interventions to improve child nutrition. Despite aggressive industry lobbying, the revisions to the law were approved as recommended by UNICEF and partners.

With UNICEF guidance, a number of countries have adopted national scale-up plans on IYCF during the Strategic Plan period. Throughout 2016, UNICEF supported the Government of Mauritania in developing a 10-year IYCF scale-up plan. The plan was launched around the common results framework of the 10-year multi-sectoral nutrition strategic plan (2016–2025). UNICEF provided technical support to the Government for implementation of this plan and finalized a set of communication tools based on a multi-channel communication approach. UNICEF also worked with the Government of South Sudan in 2016 to develop the country's first maternal infant and young child nutrition strategy, guidelines and training package.

Protecting breastfeeding in the workplace

Maternity protection covering leave and supportive workplace policies is necessary to encourage breastfeeding and promote gender equity. With funding from the Bill & Melinda Gates Foundation, UNICEF established a public-private partnership programme in Bangladesh with two 'ready-made garment groups' (workers' advocacy groups) to strengthen support for working mothers to breastfeed. The programme aims to benefit at least 7,000 female workers and 760 infants and young children under 2 years of age. A factory baseline assessment revealed poor knowledge on breastfeeding and child feeding practices in both employers and workers. UNICEF held a workshop to design and formalize an intervention package to support working women in the formal workplace, covering areas of maternity protection and breastfeeding support.

In Kenya, through a partnership with the Kenya Private Sector Alliance, UNICEF supported the training of 32 senior-level managers on breastfeeding support in the workplace, maternity protection and the national Breast Milk Substitute Regulation and Control Act of 2012. Participants included ministry of health officials, NGOs, the Central Organization of Trade Union Officials, and the Federation of Kenyan Employers. These interventions are highly innovative and lessons will be drawn up to allow for scale-up and implementation in other countries.



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A UNICEF nutrition specialist talks with mothers about nutrition and health at the start of a Rapid Response Mechanism mission in Thonyor, Leer County, South Sudan.

The power of cross-sectoral collaboration

Part of UNICEF's comparative advantage is its ability to leverage cross-sectoral programming for greater impact. Since 2011, UNICEF's nutrition and social protection sectors in Nepal have collaborated with the Ministry of Health to provide a child cash grant to families with children under 5, along with the promotion of IYCF in five remote and disadvantaged districts of the Karnali zone. In 2016, the Government doubled the amount of the cash grant and UNICEF helped the Ministry strengthen the links with IYCF practices, including by organizing group counselling and cooking demonstrations, and by training more than 300 health workers and more than 1,470 community health volunteers. A 2015–2016 programme endline survey revealed that 84 per cent of children had received the cash grant, and 84 per cent of households (covering 3,647 in total) had used the grant to purchase food commodities.

The programme impacted breastfeeding in Karnali: Early initiation rates increased from 58 per cent at the 2010 baseline to 67 per cent in 2016, and the rate of exclusive breastfeeding increased from 69 per cent to almost 80 per cent. Additionally, the proportion of Karnali children accessing a minimally acceptable diet increased from 11 per cent to almost 20 per cent. At a broader impact level, the project contributed to reductions in stunting, wasting and underweight in the programme districts, from 66 per cent, 13 per cent and 51 per cent, respectively, in 2010 to almost 57 per cent, 7.5 per cent and 33 per cent, respectively, in 2015. Based on these results, the Government of Nepal opted to scale up the cash grant programme in an additional three districts, to be implemented with UNICEF support in the coming year.

Challenges, reflections and future direction

There is an ongoing need to improve supervision and quality assurance for community-based interventions. UNICEF will continue to support governments in strengthening programme supervision and monitoring, while implementing lessons learned from the evaluation of the community IYCF counselling package, to be concluded in mid-2017. Countries will also require support in integrating responsive feeding and stimulation within the IYCF counselling package to promote ECD at the community level. In the coming year, UNICEF will also support the roll-out of national policies on HIV and infant feeding based on the latest WHO-UNICEF guidance.

Global momentum to improve complementary feeding practices continued into 2016, yet many countries are still facing complex challenges in programme implementation. In the coming year, UNICEF will document programmatic successes in improving complementary feeding practices to support systems strengthening and intervention quality, develop an updated user-friendly IYCF programming guide, and produce a series of short videos on complementary feeding practices to strengthen the capacities of front-line health workers.

With the rapid increase in childhood overweight and obesity in several regions and, importantly, given the harmful impact of these conditions on people's lives in the short and long term, UNICEF will take on new leadership in their prevention, which will include advocacy, policy, programme and knowledge guidance. As food systems[12] shift and dietary patterns continue to transition, UNICEF will also need to ensure that IYCF issues are positioned as central in food systems and the food security agenda.

Resource mobilization continued to be a challenge for the IYCF programme in 2016. There is a need for greater human resources to meet increasing demands, particularly for guidance and protocol development, and to support countries in implementing complementary feeding programmes that are informed by sound situation analysis and formative research. Resources to advance work around childhood overweight and obesity have also been limited but are critically needed to tackle this issue of increasing urgency. More predictable and flexible thematic funding would ensure that the IYCF programme continues achieving results while responding to timely and emerging issues within the rapidly changing nutrition landscape.

PROGRAMME AREA 2: MICRONUTRIENT SUPPLEMENTATION AND FORTIFICATION

A VITAMIN BOOST FOR THE MOST VULNERABLE

Micronutrients may be small but they are powerful. These vitamins and essential nutrients are vital building blocks of children's mental and physical development – and without them, children suffer from stunting, wasting, cognitive delays, weakened immunity, disability and even death. During pregnancy, deficiencies in iron, folate, iodine or other essential nutrients can be catastrophic to a woman's own health and to the survival and development of her growing child.

An adequate and diverse diet of nutritious foods is the ideal way for children to receive all the micronutrients they need to thrive. Yet, many children and their families face a nutrient gap as the result of prohibitive costs and limited knowledge about or availability of nutritious foods. In these cases, interventions such as supplementation programmes, the fortification of industrially produced foods and the fortification of homemade foods – together with the prevention and treatment of infectious diseases

UNICEF's approaches to delivering vitamins and other essential nutrients to children and women

Dietary diversification: improving availability of and access to nutrient-rich foods (*see programme area 1: Infant and young child feeding*);

Micronutrient supplementation: providing in the form of supplements (drops, syrups or tablets) nutrients that are not sufficiently available in the regular diet;

Home fortification*: using multiple micronutrient powders to boost the nutritional value of foods prepared for children in the home; and

Mass fortification: adding micronutrients to industrially-produced staple foods and condiments, such as flour, rice, oil, or salt.

Note: biofortification, or breeding specific micronutrients into staple food crops, is becoming a promising strategy for preventing deficiencies in key vitamins and essential nutrients such as vitamin A, zinc and iron. Globally, this work is led by HarvestPlus; UNICEF has had limited involvement thus far.[13]

**WHO has started to use the term 'point-of-use fortification', as micronutrient powders can be added to energy-containing foods at home or in any other place where meals are consumed, such as schools, nurseries and refugee camps. Given UNICEF's focus on integrating micronutrient powder programmes with infant and young child feeding programmes (and thus use of these products at home), UNICEF continues to use the term 'home fortification'.*

– provide some of the best opportunities for preventing undernutrition *(see box 'UNICEF's approaches to delivering vitamins and other essential nutrients to children and women').*

In 2016, UNICEF continued to deliver high-impact micronutrient interventions to reach the most vulnerable children and women, while engaging with governments to improve supplementation and fortification policies and strategies. Within targeted countries, UNICEF's micronutrient programmes include: vitamin A supplementation for children aged 6–59 months; home fortification with micronutrient powders for young children; iron and folic acid supplementation for adolescent girls and women; salt iodization; and staple grain fortification.

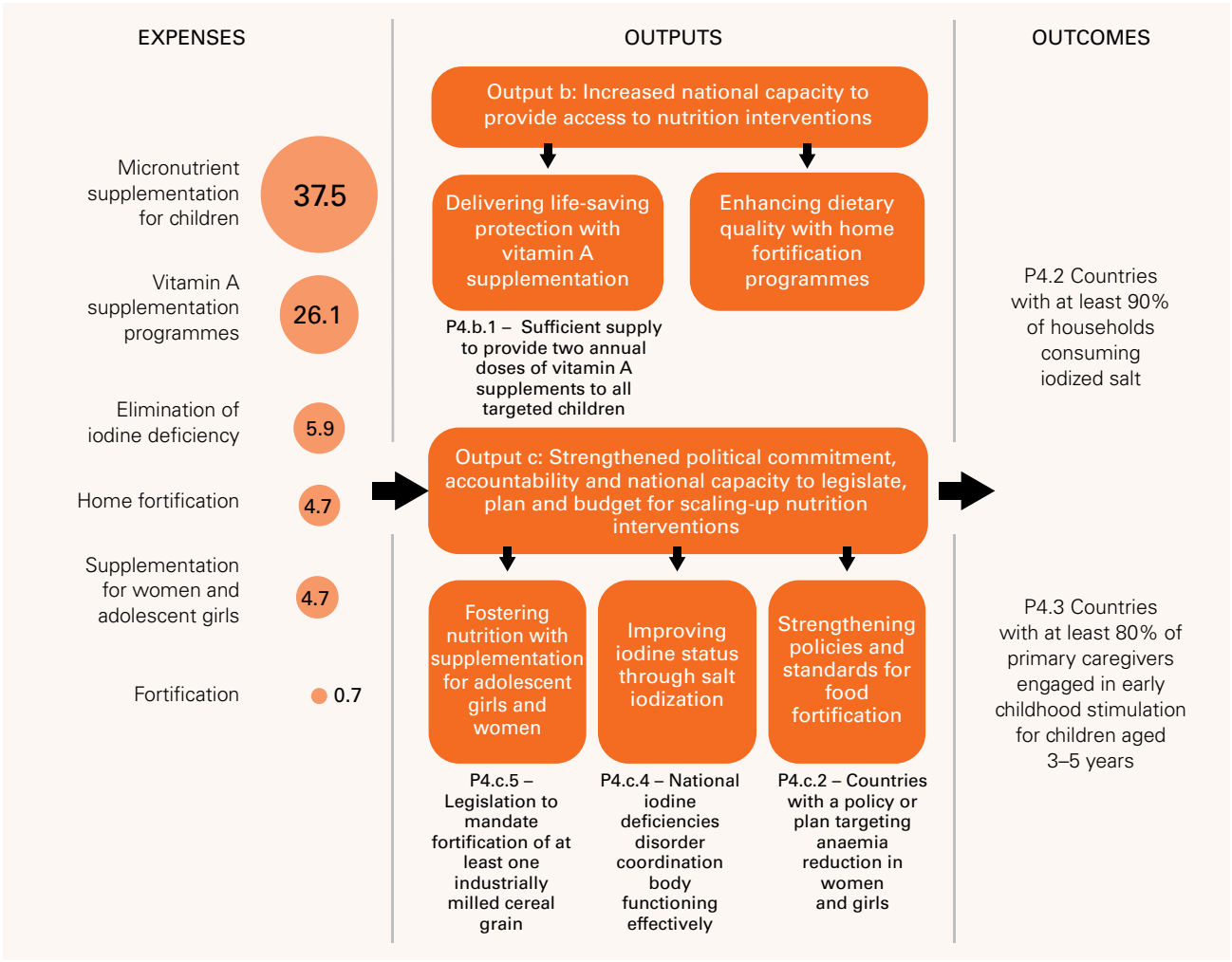
At the global level, UNICEF convened a number of key partnerships, generating evidence to inform policy and providing global leadership on the elimination of micronutrient deficiencies with a focus on equity. In 2016, UNICEF continued to play a leadership role in the executive boards and coordination committees of the Food Fortification Initiative, Global Alliance for Vitamin A, Home Fortification Technical Advisory Group, Iodine Global Network, International Zinc Nutrition Consultative Group, Micronutrient Forum and the Micronutrient Initiative. This involvement has helped UNICEF to steer the global agenda, contribute to the global knowledge base and develop technical guidance to support countries. UNICEF also generated a vast amount of evidence on micronutrients interventions in 2016, publishing 22 articles in peer-reviewed literature. Notably, this included nine articles from Cambodia that were published in a UNICEF-edited special issue on 'Nutrients and National Strategies to Impact Health', published in the scientific journal *Nutrients*. In 2016, UNICEF also published 'Multiple Micronutrient Powder: Supply and market outlook', highlighting global market trends in supply, demand, shortages, surplus and availability.[14]

Results chain for micronutrients

The results chain for micronutrients explains the linkages between programme spending, key interventions and progress on UNICEF's Strategic Plan output and outcome indicators (*see Figure 6*). The output 'bubble' in Figure 6 lists the activities supporting each output, and these also serve as sub-headings in this programme area chapter.

To illustrate the results chain using one example, the US$26.1 million spent in 2016 on vitamin A supplementation programmes impacts national capacity to supply vitamin A capsules to all children under 5 (P4.b.1), which in turn improves effective coverage of this intervention (P4.4), providing life-saving protection to children in need. Full data on each micronutrients indicator are presented in the pages that follow and in Annex.

FIGURE 6
Results chain for micronutrients



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

Expenditures to support programme implementation

In 2016, US$79 million was spent on micronutrients programming, the same amount as the previous year. In 2016, the greatest resources, US$37.5 million, were allotted to supplementation programmes for young children to prevent anaemia and other micronutrient deficiencies.

Key outputs and results in 2016

Delivering life-saving protection with vitamin A supplementation

UNICEF supports national-level vitamin A supplementation programmes for children aged 6–59 months in 82 priority countries. Such programmes can improve child survival by 12–24 per cent and are some of the most equitable and cost-effective nutrition interventions.

To support countries, UNICEF is the main provider of vitamin A capsules, through an in-kind donation programme financed by the Government of Canada and implemented

through the Micronutrient Initiative. In 2016, UNICEF supplied 57 priority countries with free vitamin A capsules and supported country efforts in improving inventory management and reducing wastage in the supply chain to meet the Strategic Plan indicator on vitamin A supply. The number of countries with sufficient supply to provide vitamin A supplementation to all targeted children decreased slightly, from 62 in 2015 to 61 in 2016 (P4.b.1).[15]

To benefit from vitamin A supplementation's life-saving protection, children in priority communities must receive two high-dose vitamin A supplements every year. This is measured as an outcome indicator in UNICEF's Strategic Plan (P4.4). According to the latest globally endorsed coverage figures, 273 million children aged 6–59 months – 70 per cent – received two annual doses of vitamin A supplements in priority countries (from a baseline of 68 per cent in 2011 and towards a target of 80 per cent).[16] The situation in least developed countries was better, with 87 per cent of children aged 6–59 months reaping the benefits of full protection.

Vitamin A supplementation is often delivered as part of immunization campaigns, which have been very effective at achieving high coverage in many countries. In the Niger, for example, the first doses of vitamin A and deworming medication were integrated within the polio vaccination campaign using a door-to-door strategy, while the second doses were administered through health centres, health posts and a mobile team. Coverage of both doses exceeded 100 per cent, likely due to the inclusion of some refugees, who were not part of the initial target. In Benin, UNICEF supported the Government to successfully link vitamin A supplementation to polio national immunization days in the first semester. However, given the progress towards polio eradication in Benin, no second polio campaign was scheduled. UNICEF responded by transitioning the integration of vitamin A supplementation into a maternal neonatal tetanus campaign for the first time in Benin, to secure coverage for the second semester. Both rounds achieved vitamin A supplementation coverage of more than 90 per cent.

While vitamin A supplementation has been scaled up successfully in many settings through National Immunization Days for polio, many countries have faced challenges in sustaining high coverage since the delivery platform achieved its polio eradication goals and was scaled back. Weak routine health systems in other countries in West and Central Africa, South Asia and Eastern and Southern Africa have posed challenges to delivering vitamin A supplementation with high coverage.

The Government of Canada has a long history of supporting UNICEF's vitamin A supplementation work, and in 2016, UNICEF received funding to improve child survival and well-being in 15 countries in sub-Saharan Africa, where under-five mortality is high. This support will assist countries to deliver vitamin A supplementation and other cost-effective life-saving nutrition and health services, using Child Health Days as a delivery platform, or by integrating services into routine systems. This is critical because effective vitamin A supplementation programmes require commitment, planning and reliable funding – and a lack of consistent financing or logistical challenges can result in reduced coverage, or even a missed round of delivery, denying coverage to all children.

As part of this grant, in the United Republic of Tanzania, UNICEF helped extend the previous Child Health Day approach to a Child Health and Nutrition Month approach, offering a more comprehensive set of services, including vitamin A supplementation, deworming and screening for acute malnutrition, which was scaled up nationally in 2016. In 2016, UNICEF also helped develop national guidelines and training manuals for Child Health and Nutrition Months, to provide details on how vitamin A supplementation should be integrated with the delivery of other services. Rounds one and two of the 2016 Child Health Nutrition Months were successful in reaching 89 per cent and 91 per cent of targeted children, respectively. Despite the volatile socio-political and economic situation in Burundi, UNICEF and the Government organized two nationwide Mother and Child Health Weeks, using 963 public health centres and 129 schools as satellite distribution sites under the supervision of a health centre. Vitamin A supplementation and deworming medication were delivered alongside catch-up vaccination for women and children as well as hand washing promotion. The Mother and Child Health Weeks successfully reached more than 80 per cent of children with vitamin A supplementation in both rounds, and further piloted the distribution of micronutrient powders and innovative real-time monitoring and reporting via RapidPro technology (information sent by SMS for improved supply tracking and coverage reporting).

UNICEF is also supporting countries as they transition vitamin A supplementation into routine services. For example, UNICEF has supported the Government of Senegal with a dual strategy that progressively scales up vitamin A supplementation within routine health service contacts, while at the same time implementing Child Health Days (*Journees de Survie de l'Enfant*) sub-nationally in low-performing regions and districts. This approach allows for the progressive strengthening of systems to deliver integrated services, while guaranteeing that the most vulnerable children continue to be reached. Thematic revenue streams would allow UNICEF to support countries in transitioning to new delivery platforms, where needed, while also strengthening health systems to eventually deliver vitamin A supplementation via routine health services.

UNICEF works to raise awareness among governments and stakeholders on the perils of missed delivery, advocating for improved supply forecasting and providing technical assistance to guide supply chain improvements. Even settings with historically high vitamin A supplementation coverage are vulnerable to delivery challenges. The state of Bihar, one of India's poorest, had maintained exceptionally

high vitamin A supplementation coverage since 2011. However, in mid-2014, a major supply disruption prevented the state government from procuring vitamin A. UNICEF took a number of steps to revive the programme, stressing the impact of missed delivery, conducting advocacy meetings, providing technical support to draft supply requirements and improve forecasting, facilitating close coordination between stakeholders, and promoting regular follow-up of the procurement process at state and district levels. As a result of this work, the state of Bihar delivered two rounds of vitamin A supplementation in all 38 districts, with a state coverage of 86 per cent, reaching 12.6 million children. UNICEF also engaged external monitors and medical colleagues to monitor vitamin A supplementation in the 10 high-priority districts.

In 2016, UNICEF published a statistical snapshot on vitamin A supplementation coverage, providing an overview of global and regional trends and reviewing evidence on the effectiveness of current delivery platforms. UNICEF, the Centers for Disease Control and Prevention, Helen Keller International and the Micronutrient Initiative hosted an all-Africa workshop in Senegal in 2016, attended by participants from 23 countries in sub-Saharan Africa, representing both nutrition and immunization sectors, policymakers and managers from ministries of health, technical partners from the Global Alliance for Vitamin A, and Global Affairs Canada. The workshop re-examined vitamin A supplementation programmes in sub-Saharan Africa in light of epidemiologic and programmatic changes to develop broad, country-specific road maps for the next five years. An outcome statement was developed by meeting participants, reflecting the renewed commitment and sense of urgency.[17]

A child smiles as she eats a meal at the school in the village of Mbuene, Magude District, Maputo Province, Mozambique. This is the only meal of the day for many of the students at the school.

Enhancing dietary quality with home fortification programmes

Home fortification programmes provide caregivers with micronutrient powders (MNPs) to sprinkle on the foods they prepare for young children. Such programmes are effective in preventing anaemia and other micronutrient deficiencies and have the potential to improve the quality of complementary foods and feeding practices. Given the high nutrient needs of children aged 6–23 months and the fact that only one in six children has access to a minimally acceptable diet, home fortification programmes using MNPs provide a good opportunity to maximize nutrient intake with each bite.

In 2016, UNICEF continued to support governments in scaling up the reach of MNPs as an integral part of infant and young child feeding programmes. This work involved advocacy for national policies and legislation, promoting behaviour change to reach target populations, generating new evidence on integrated IYCF and MNP programming, and expanding monitoring and evaluation systems. At global level, UNICEF is also working with other partners of the Home Fortification Technical Advisory Group to issue guidance on the use of MNPs in malaria-endemic regions, given that in those settings, MNP programmes should be implemented alongside measures to prevent, diagnose and treat malaria.

Globally, the number of countries implementing home fortification programmes has tripled over the past five years, increasing from 22 countries in 2011 to 65 countries in 2016. UNICEF is the largest procurer of MNPs and plays a leading role in developing the market, ensuring supply and stimulating demand. More than 10 million children were reached with MNP programmes in 2016, including 8.3 million with UNICEF support.[18]

UNICEF advocates for home fortification strategies at national level as part of the IYCF continuum and provides technical advice on their implementation. UNICEF helped develop a home fortification strategy for Mozambique.

Case study: Community-led research to jump start MNP distribution in northern Nigeria[19]

Chronic malnutrition and anaemia in children are enduring problems in Nigeria, particularly in north-east Nigeria, where children under 5 are four times more likely to suffer from stunting than those living in the south-east.[20] The most common complementary foods are low in iron and other essential nutrients, leaving many children suffering from anaemia and other nutritional deficiencies.

The use of MNPs had not been implemented in northern Nigeria before 2015. UNICEF, with funding from the European Union, conducted formative research in 2015 to develop a culturally appropriate behaviour change communication strategy before introducing MNP into the northern Nigerian context. The research aimed to develop a locally branded product – complete with packaging, logo and a name specifically tailored to this population and cultural context – to increase the likelihood of community acceptance, and, in a larger sense, to inform the design of an integrated nutrition programme.

UNICEF supported the Government to launch the participatory formative research in Kebbi and Adamawa states of northern Nigeria. The research included in-depth interviews with caregivers of children aged 6–23 months and community leaders, as well as workshops with community members to brainstorm product characteristics. The findings were adapted into intervention materials and product packaging, while a final phase of the research aimed to build consensus among key stakeholders from the Government, United Nations bodies, local NGOs and other donor organizations.

By 2016, the findings of the research had already helped initiate emergency distribution of MNPs in 18 camps for internally displaced persons and in 210 health facilities catering to more than 2.3 million internally displaced people in three north-eastern states affected by the Boko Haram crisis. With UNICEF's support, the MNPs and messaging reached about 183,000 children in camps for internally displaced persons and host communities of those states.

In 2017, UNICEF will support the Government of Nigeria in conducting a large-scale pilot to test the effectiveness of various delivery mechanisms to identify the most effective approach for achieving high coverage and ensuring equity in reach. The results will be used to inform the development of a national strategy and scale-up plan that will aim to reach 11.3 million children aged 6–23 months by 2019.

Funding from the Government of the Netherlands was used for training and the procurement of MNPs, reaching an estimated 37,500 children aged 6–23 months in 2015–2016, before being launched countrywide.

UNICEF country offices have been working to improve the quality of complementary foods with the help of MNPs. In Nigeria, a programme integrating MNP with IYCF promotion reached more than 131,500 children as part of the emergency response to the Boko Haram insurgency (*see box: 'Case study: Community-led research to jump start MNP distribution in northern Nigeria'*). In Rwanda, UNICEF has observed that MNP use is contributing to improved dietary diversity as caregivers have acquired new knowledge about the importance of including a variety of foods in children's diets. Administrative reports in Rwanda indicate high coverage of MNPs (87 per cent as of April 2016), and a follow-up study from two districts indicates that child anaemia has decreased from 43 per cent at baseline in 2014 to 27 per cent in 2016. In all, the programme is reaching about 300,000 children.

Counselling and support to caregivers is critical to making home fortification an accepted household practice. This lesson was learned in Afghanistan, where very few targeted children received and used MNPs when they were distributed without any counselling support by health facilities in 2016. Based on this lesson, future MNP programmes in Afghanistan will include a comprehensive capacity-building package for health workers, focusing on behaviour change communication messaging to improve both MNP uptake and complementary feeding practices.

Fostering nutrition with supplementation for adolescent girls and women

UNICEF supports supplementation programmes for adolescent girls and women to prevent iron deficiency anaemia and improve maternal and child health. Such programmes provide iron and folic acid supplements and are critical to advancing equitable nutrition status, given that adolescent girls and pregnant women are particularly susceptible to anaemia. In 2016, UNICEF Supply Division began work to identify suppliers for the WHO-recommended product for intermittent iron and folic acid supplementation among menstruating adolescent girls and women, which thus far is not available globally.[21]

National policies and strategies on anaemia reduction in women of reproductive age are an important indicator of programme performance, as reflected in UNICEF's Strategic Plan (P4.c.2). In 2016, 79 out of 121 countries had such a policy or plan (from a baseline of 70 and towards a target of 100), compared with 91 out of 122 countries in 2015. Of these countries, 41 also had a specific approach within their national policy to combat anaemia among adolescent girls (from a baseline of 27, towards a target of 50).

Despite the slight decline at global level, a number of countries have made important strides in supplementation programmes for girls and women in 2016 (*see box 'Case study: Spearheading a weekly iron and folic acid supplementation programme in Afghanistan'*). In Georgia, UNICEF-led policy advocacy influenced the Government's decision to launch a national folic-acid supplementation programme for women of reproductive age.

In 2016, as part of a grant from the Government of the Netherlands, UNICEF invested in social and behaviour change communication and supported strategy development and programme delivery to address anaemia among adolescents in Ethiopia and Mozambique. This was a real innovation in both countries, reaching more than 4 million adolescents. The Government of Mozambique decided to roll out its iron-folic acid supplementation and deworming for adolescent girls countrywide in 2016.

The relationship between poverty, gender and nutritional status is complex and UNICEF is well placed to respond multi-sectorally with interventions that address gender, social protection and nutrition together. In Bangladesh, adolescent girls were targeted by a set of nutrition interventions under the Ending Child Marriage initiative. The programme reached 35,850 girls with a set of age-specific, direct nutrition interventions, implemented through UNICEF and NGO partner Building Resources Across Communities, and contributing to breaking the inter-generational cycle of undernutrition among adolescent girls. In 2016, UNICEF Bangladesh also conducted a study to assess anaemia and iron deficiency among pregnant women living in areas of low and high iron in ground water, concluding that routine supplementation with iron and folic acid during pregnancy should be continued. Consequently, UNICEF supported the Institute of Public Health Nutrition to organize a National Anaemia Consultation in Bangladesh, which generated recommendations for future programming, including a recommendation to provide multiple micronutrients in addressing anaemia to help meet the World Health Assembly global nutrition target on anaemia reduction in women.

Such UNICEF-supported policy advancements and other outputs will feed into an overall impact of fewer women of reproductive age with anaemia globally by the end of the Strategic Plan period. The baseline for this indicator is 38 per cent of pregnant women with anaemia and 29 per cent of non-pregnant women with anaemia. UNICEF is supporting countries working towards achieving the global nutrition target of a 50 per cent reduction in anaemia in women of reproductive age by 2025.

Case study: Spearheading a weekly iron and folic acid supplementation programme in Afghanistan

UNICEF and the Ministry of Public Health of Afghanistan launched an anaemia reduction programme in 2016, targeting school-going adolescent girls between the ages of 10 and 19. The programme uses the school platform to address high levels of iron deficiency and anaemia among girls, and includes weekly iron and folic acid supplementation, bi-annual deworming and monthly nutrition information, education and counselling. More than 100 per cent of targeted adolescent girls in 10 provinces (984,482 out of 761,969) received iron and folic acid supplements on a weekly basis and deworming doses twice a year.[22]

To improve the enabling environment for the programme, UNICEF and the Government rolled out a community engagement strategy to encourage the acceptance of the programme. Interactive sensitization materials were developed for parents, religious leaders, teachers and students to improve knowledge and acceptance of the programme before roll-out. Provincial ministry of education and school management shura and health personnel were strategically trained together to create an enabling local environment in advance of the roll-out.

To build capacity within provinces, UNICEF facilitated a training of trainers on the programme in Kabul, followed by provincial trainings for 10 provinces, covering 5,625 teachers (49 per cent of them female), 2,109 school management shura members (20 per cent female), 1,047 religious leaders and 341 academic supervisors (22 per cent female).

Formative research was also completed for an 'out of school' component of the programme. The findings of this research will inform strategies for systematically reaching out-of-school adolescent girls next year.[23] In early 2017, the programme also expanded to the remaining 21 provinces. The training of trainers was completed at regional level followed by provincial cascade training, which is currently ongoing. Supplementation of the corresponding students in these provinces will begin when school opens at the end of March 2017.

The main bottlenecks of the programme so far have been lack of community awareness about anaemia and the benefits of iron and folic acid supplementation for adolescent girls, as well as constraints to reporting, data collection and security in some provinces where schools are closed. To overcome the bottleneck on community awareness, the Ministry of Public Health and the Ministry of Education are working on a national-level media campaign that will be launched in early 2017 across the country. UNICEF and these government ministries are also working to involve school management shura in community mobilization and raising community awareness on the importance of supplementation for adolescent girls. UNICEF is using third-party monitors to improve monitoring and address security issues, where possible, and will host refresher trainings to address constraints around reporting and data collection.

Improving iodine status through salt iodization

Salt iodization is the most effective strategy for preventing iodine deficiency disorders, and UNICEF has been a global leader in salt iodization programmes for more than 25 years. In just more than two decades, the number of iodine-deficient countries worldwide dropped from 110 to 20 – a sign that the complete control of iodine deficiency by 2020 is within reach. In October 2016, UNICEF joined other partners during the Micronutrient Forum Global Conference to celebrate the remarkable achievement of the elimination of iodine deficiency disorders in the Americas, while also highlighting that the challenge now is to sustain this achievement.[24]

In a 2016 report based on a previous technical consultation, UNICEF and the Iodine Global Network identified priority areas for the monitoring of salt iodization programmes and population iodine status. The two partners also developed a road map and defined research gaps for the refinement of programme guidance to track country progress. UNICEF and partners have already started to address these gaps by partnering with leading research institutions to define the optimal range of iodine status among pregnant women (a primary target group for iodine nutrition programmes), improve techniques to assess the prevalence of iodine deficiency in a population and improve monitoring tools for salt iodization programmes. Through research conducted in China, Croatia and the Philippines, UNICEF also helped to demonstrate that a well-functioning salt iodization programme meets optimal iodine nutrition for infants, toddlers, school-age children, as well as adult women, including those who are pregnant and lactating.

Tuyisenge adds micronutrient powder to food she has prepared for her 23-month-old daughter, Delphine, in the village of Uwabumenyi, Nyamagabe District, Rwanda. The family attends group nutrition counselling meetings in the community.

National legislation on mandatory salt iodization, along with coordination between industry and government, are critical building blocks to achieving universal salt iodization. In 2016, UNICEF continued to advocate for enacting and improving such legislation and supported governments in their implementation. In Bangladesh, for example, the first draft of the Salt Law Amendment was prepared and is under review by a technical advisory group to the Government. For such legislation to be most effective, an active coordination body convening all stakeholders – including government, industry and civil society – is critical. Of 90 reporting countries, 61 had established a national coordination body, yet only 26 of these were classified as effective (P4.c.4).

Household coverage of iodized salt[25] has long been considered an important indicator of programme performance. Globally, more than 85 per cent of households were consuming iodized salt in 2016 – a major achievement for global public health. During the Strategic Plan period, UNICEF aims to support at least 25 countries in achieving at least 90 per cent of households consuming iodized salt. In 2016, 18 countries were meeting this target (P4.2).[26]

In the East Asia and Pacific region, the average coverage of iodized salt surpasses that of other UNICEF regions. However, this achievement is largely due to the impact of China, which has achieved 97 per cent coverage, while the situation in other countries is far less positive. Indeed, several countries have seen a backsliding in both the household coverage of iodized salt and populations becoming iodine-deficient once again. Given this context, UNICEF's East Asia and the Pacific Regional Office organized a technical consultation on universal salt iodization in 2015 to assess bottlenecks and define strategies to sustain, improve and expand coverage. The consultation sparked important achievements in 2016: Three of the backsliding countries either reinstated their mandatory legislation (Viet Nam) or revitalized commitment and strategies to address the issue (Cambodia and Myanmar), with strategic and technical support from the

regional office. China, on the other hand, is considering revoking its mandatory legislation and UNICEF is advocating against this decision. Similarly, UNICEF's regional office for Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS), together with the Iodine Global Network and USAID, organized a second consultative workshop in Sarajevo in 2016, which built on a previous consultation in 2015. The consultation enhanced the system and policy capacities of nine states (Albania, Bosnia and Herzegovina, Bulgaria, the former Yugoslav Republic of Macedonia, Kosovo,[27] Montenegro, the Republic of Moldova, Romania and Serbia), prompting better programme sustainability.

Increasingly, processed foods made with iodized salt (e.g., seasoning products such as bouillon cubes), are helping to maintain iodine adequacy, as demonstrated through UNICEF-supported work in West Africa.[28] Given the impact of processed foods, UNICEF has been advocating for the use of population iodine status in vulnerable groups (women of reproductive age, pregnant women and school-age children) as a primary outcome indicator to measure the success of national salt iodization programmes. Together with household coverage of iodized salt, it provides a more accurate picture of country progress towards eliminating iodine deficiency disorders. In Haiti, UNICEF and partners helped reorient the national iodine deficiency control programme to focus on salt contained in seasoning powders and bread, which can feasibly be iodized. Importantly, and as indicated by a sub-national survey, these products may be enough to fully meet the needs of the Haitian population.[29] Future work will validate these findings.

In 2016, a global USAID grant mechanism provided continued funding to advance salt iodization programmes in 12 countries and four UNICEF regions, as well as support to address global research gaps. With funding from this grant in Madagascar, UNICEF supported the first-ever national iodine survey, which demonstrated that less than a quarter of households had access to well-iodized salt. In 2016, UNICEF supported the Government to respond to this public health crisis by developing a national salt iodization action plan. As a first step, the plan targets medium and small salt producers to support them in ensuring that 80 per cent of all salt produced in Madagascar is iodized. In Ethiopia, UNICEF helped to increase iodized salt coverage from less than 5 per cent in 2005 to more than 90 per cent in 2015. However, the supply of raw salt to centralized facilities has been a bottleneck in ensuring quality, as many small-scale salt producers continued to sell directly to markets. UNICEF advocated for the Government to address this gap, resulting in a new government directive stipulating that all salt be supplied to and distributed via the centralized facility.

Strengthening policies and standards for food fortification

National policies mandating the mass fortification of staple grains are effective in safeguarding populations from micronutrient deficiencies. UNICEF, along with global partnerships such as the Food Fortification Initiative, advocates for governments to enact such legislation and builds the implementation capacities of governments and the food industry. In 2016, the number of countries with legislation to mandate staple cereal fortification (of at least one industrially milled cereal grain) increased to 86 from 85 in 2015 and 82 in 2014 (P4.c.5).[30] This result is from a baseline of 78 countries, towards a target of 90.

Zimbabwe made significant strides in developing the legislative frameworks for national food fortification. In October 2016, the Government signed a major decree to mandate fortification of wheat flour, edible oil, maize meal and sugar, covering domestic and imported products. This achievement was the result of collaboration between the Government, consumers and food producers, as well as UNICEF, Project Healthy Children, the World Food Programme (WFP) and the Food and Agriculture Organization of the United Nations (FAO).[31] With UNICEF's leadership as part of a network of agencies working on food fortification in India, a major breakthrough was achieved in late 2016 when the Food Safety Standards Authority published draft standards for wheat flour fortification with the nutrients iron, vitamin B12 and folic acid that are in line with global recommendations. These improved standards are expected to have a significant health impact, as previous standards did not contain adequate amounts or types of nutrients.

Challenges, reflections and future direction

Micronutrient supplementation and fortification programmes are some of the most evidence-based, low-cost and high-impact interventions in human nutrition and welfare, and many of UNICEF's micronutrient programmes have produced historic public health achievements. But with success has come some apathy and for greater impact, there is a need to revitalize and reposition the narrative on vitamins and other essential nutrients within the changing public health and development agenda.

Funding gaps did not allow for at-scale delivery of vitamin A supplementation to children aged 6–59 months in all settings with high rates of child mortality and vitamin A deficiency; continued vigilance and sustained government funding are required to ensure delivery to children in those settings. Furthermore, a shift in delivery platforms to more routine approaches, such as those used by immunization programmes to reach every community, are critical to ensure sustainable supplementation coverage over the

long term. UNICEF is working with national governments to resolve some of these challenges and support countries in delivering vitamin A supplements, where needed. Any efforts to scale back national vitamin A supplementation should be underpinned by a careful evaluation of the coverage of other vitamin A deficiency control measures and estimates of underlying levels of vitamin A deficiency.[32]

As the reach of MNP programmes continues to expand, there is a need to strengthen the monitoring and evaluation systems of integrated MNP-IYCF programmes within government monitoring information systems. In preparation for its 2018–2021 Strategic Plan, UNICEF is expanding its work on the nutrition of school-age children, adolescents and women. This work will build on the strong foundation of micronutrient interventions for young children. Flexible funding is urgently needed to address these emerging areas.

PROGRAMME AREA 3: NUTRITION IN EMERGENCIES AND THE TREATMENT OF SEVERE ACUTE MALNUTRITION[33]

STRENGTHENING SYSTEMS, SAVING LIVES

A staggering number of humanitarian situations in 2016, many of them climate-related, took a heavy toll on children and their families. In 2016, UNICEF continued to deliver life-saving services and supplies to reach the most vulnerable children and their families in the wake of natural disasters, conflict and other humanitarian situations. In line with its Core Commitments for Children (CCCs) and its Cluster Lead Agency accountabilities, which promote predictable, effective and timely collective humanitarian action, UNICEF supports governments in strengthening emergency preparedness and response. In 2016, 78 out of 121 UNICEF country offices with nutrition programmes responded to new and ongoing humanitarian situations, an increase from 69 countries the previous year. This included 5 countries in CEE/CIS, 11 in East Asia and the Pacific, 18 in East and South Africa, 12 in Latin America and the Caribbean, 9 in the Middle East and North Africa, 6 in South Asia and 17 in West and Central Africa.

The treatment and care of children suffering from severe acute malnutrition (SAM) is a crucial part of saving lives in emergencies. While a significant number of acutely malnourished children live in countries where cyclical food insecurity and protracted crises further exacerbate their vulnerability, many more children with SAM live in contexts unaffected by emergencies. Yet the majority of investments – and therefore admissions – remain in humanitarian contexts, where systems building is often costly and challenging. Although global coverage of SAM management continues to increase, progress remains insufficient: A shocking 17 million children under 5 are estimated to be affected by SAM globally,[34] yet less than 20 per cent are able to access the care they need to survive as part of routine services for children.[35]

Governments face great challenges in building capacity and providing sufficient resources to prevent and treat acute malnutrition. UNICEF works to strengthen national capacity, develop norms and standards, and capture lessons learned to increase the reach, coverage, quality and equity of SAM management programmes. UNICEF supports the scale-up of community-based management of acute malnutrition (CMAM) through engagement with ministries of health, civil society and a range of non-governmental and United Nations partners. Support efforts include coordination, technical and policy support, capacity building, supply delivery and strengthening of the supply chain for the management of SAM. UNICEF also works with WFP and other partners to link care for children suffering from SAM with services to best address moderate acute malnutrition.

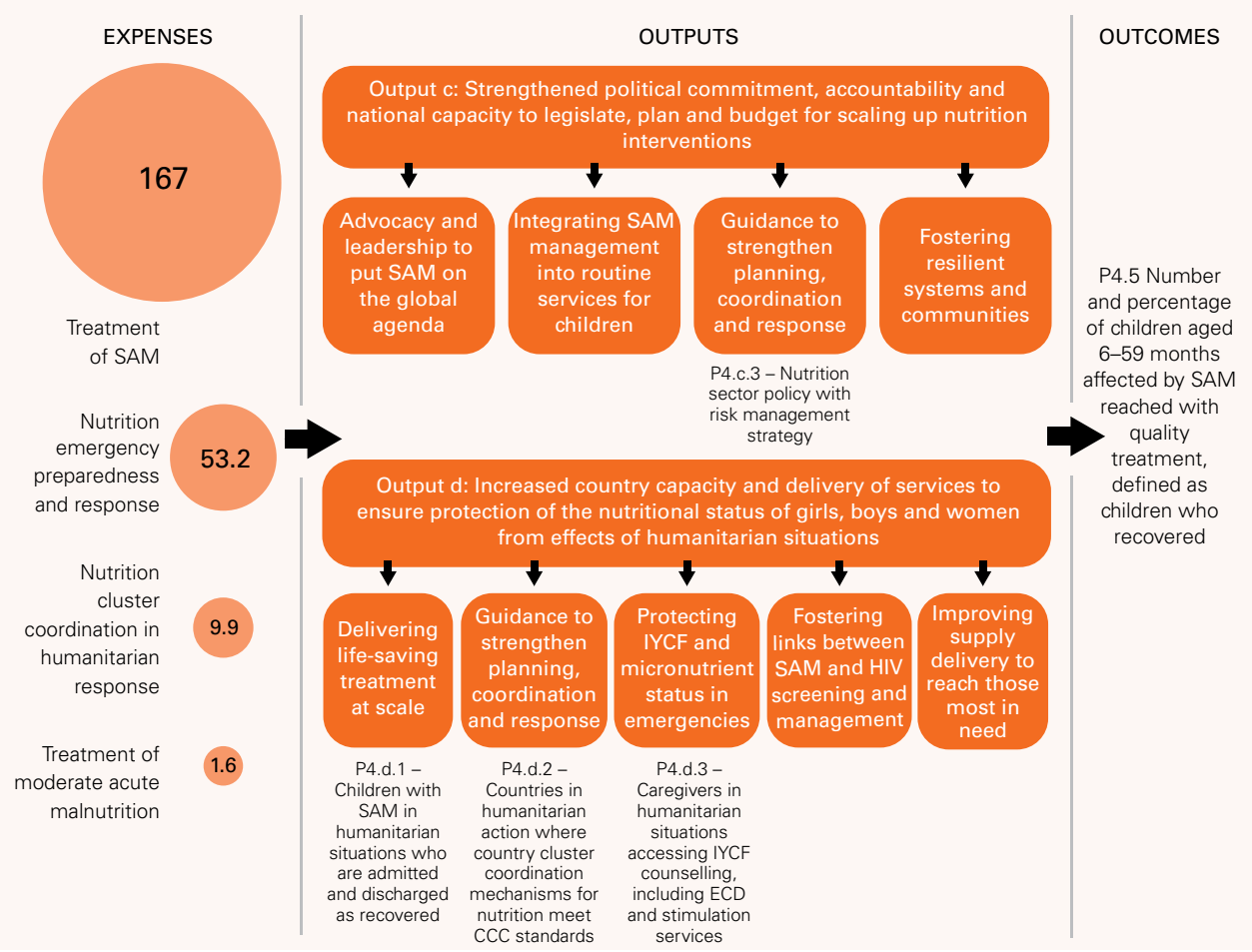
Nutrition programmes need to be risk-informed to be resilient and sustainable in fragile contexts. UNICEF plays a critical role in accelerating risk-informed programming within countries by strengthening national capacity for preparedness and response through risk analysis and modifying programming in relation to context-specific risks to mitigate their impact. Risk-informed programming is essential to ensuring sustainable progress in nutrition and preventing countries from losing ground on development gains when emergencies strike.

Results chain for nutrition in emergencies and the treatment of severe acute malnutrition

The results chain for nutrition in emergencies and the treatment of SAM outlines the linkages between programme spending, key interventions and progress on UNICEF's Strategic Plan output and outcome indicators (*see Figure 7*). The output 'bubble' in Figure 7 lists the activities supporting each output, and these also serve as sub-headings in this programme area chapter.

To illustrate the results chain using one example, UNICEF's US$167 million in expenses for SAM management (in emergencies and non-emergencies) supports the delivery of life-saving supplies and services, often in remote and challenging settings, which in turn supports the outcome of more children being treated and recovering from the condition. Full data on each programme indicator are presented in the pages that follow and in Annex.

FIGURE 7
Results chain for nutrition in emergencies and treatment of SAM



Note: The breakdown of expenses should be taken as an estimate due to differences and inconsistencies in coding at country level. UNICEF provided support to MAM treatment under special circumstances in 11 countries, including 2 Level 3 emergencies- ranging from medical supplies, capacity building to supply provision, based on special circumstances Cross-sectoral activities have been prorated and included in expense figures.

Expenditures to support programme implementation

The greatest proportion of resources for nutrition is earmarked for humanitarian response and the treatment of severe acute malnutrition. In 2016, US$232 million was spent in this area, an increase from 2015, where expenses totalled US$223 million. The increase reflects UNICEF's response to the many large-scale emergencies throughout 2016 and the continuing expansion of services to treat SAM. The bulk of expenditures in this programme area – US$167 million – are for the treatment of SAM. This includes spending on supplies, most notably ready-to-use therapeutic foods, for which UNICEF is the largest global supplier, as well as direct service delivery in both emergency and non-emergency contexts.

Key outputs and results in 2016

Delivering life-saving treatment at scale

In 2016, UNICEF worked to scale up treatment and care for children with SAM in contexts with limited capacity and coverage and highlighted the importance of investment in SAM management as part of emergency preparedness and routine services for children. During the course of the Strategic Plan, UNICEF intends to increase the scale and quality of SAM programming, treating 4 million children aged 6–59 months annually by 2017 (baseline: 2.7 million children aged 6–59 months in 2014). In 2016, UNICEF supported SAM management in 71 countries, covering both development and humanitarian contexts. With UNICEF

support, 2.4 million children with SAM were admitted for treatment in humanitarian situations, reaching 72 per cent of the 2016 target, with a recovery rate of 87 per cent (P4.d.1). Of the 3.4 million SAM admissions in all settings, both development and humanitarian, 2.4 million children were successfully treated, with a recovery rate of 89 per cent (P4.5).

These global achievements are driven by notable scale-up efforts in many of UNICEF's largest country programmes. In the Sudan, for example, UNICEF and partners treated 30 per cent more children in 2016 than the previous year (*see box: 'Case study: Community-based treatment to reach a historic number of children with SAM in the Sudan'*). In Somalia, UNICEF supported drought-affected communities through the provision of water vouchers and integrated mobile health and nutrition services. More than 91,000 severely malnourished children under 5 were treated, with 93 per cent of those admitted being discharged as recovered.

UNICEF reached the most disadvantaged children affected by conflict and drought in various districts of Pakistan in 2016. With the collaboration of Nutrition Cluster partners, UNICEF continued to support the community management of acute malnutrition in 43 districts and tribal agencies (located in the federally administered tribal areas) with 384 outpatient therapeutic sites and 20 stabilization centres to treat children with SAM and medical complications. In total, UNICEF and partners screened more than 1.4 million children aged 6–59 months for acute malnutrition, treating SAM in more than 47,500 children with 94 per cent being discharged as recovered. UNICEF began work to certify a local ready-to-use therapeutic foods supplier, and quality control testing is under way to lower the cost of supplies and improve programme reach.

Amid the backdrop of conflict in the Central African Republic, an estimated 39,000 children under 5 suffered from SAM.[36] With UNICEF support, nutrition services were

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A baby is screened for acute malnutrition using a mid-upper arm circumference armband in a UNICEF-supported outpatient therapeutic site, near the town of Aweil, South Sudan.

A closer look at terminology

Wasting, also known as **acute malnutrition**, is characterized by a rapid deterioration in nutritional status over a short period of time. The most visible consequences of acute malnutrition are weight loss (resulting in moderate or severe wasting) and/or nutritional oedema (i.e., bilateral swelling of the lower limbs, upper limbs and, in more advanced cases, the face).

Acute malnutrition is categorized as **severe acute malnutrition (SAM)** and **moderate acute malnutrition (MAM)**. The immediate cause is either limited dietary intake or a recent bout of illness, or both. Underlying causes include food insecurity, inappropriate care and feeding practices, or limited access to appropriate water, sanitation and basic health services, which can further aggravate the occurrence of acute malnutrition.

Therapeutic feeding programmes for SAM rehabilitate those who are severely malnourished, with the aim of reducing mortality. Management involves a combination of routine medication, therapeutic foods and individualized care. The majority of children can be treated at the community level through community-based management of acute malnutrition (CMAM). Children with SAM and medical complications are treated as in-patients. Children with MAM can be treated with locally available foods and, in some cases, specially formulated supplementary foods through **targeted supplementary feeding programmes.**

scaled up to reach vulnerable children living in enclaves and conflict-affected areas. In 2016, more than 25,000 children with SAM were admitted for treatment in therapeutic programmes (86 per cent of the target), including 20 per cent with medical complications. Through partnerships with implementing NGO partners, UNICEF increased the number of therapeutic units from 338 in 2015 to 409 in 2016, and a mobile strategy allowed nutrition services to be delivered to hard-to-reach populations located in insecure and remote areas. SAM cure rates improved from 83 per cent in 2015 to 87 per cent in 2016.

The Niger continued to face a multifaceted humanitarian crisis, including conflict and displacement, food insecurity and malnutrition, floods and epidemic outbreaks. More than 400,000 children with SAM were expected to require treatment in 2016, including 60,000 with severe medical complications requiring inpatient treatment. More than 365,400 children were treated for SAM in 2016, reaching almost 91 per cent of expected cases. The lack of national capacity to ensure early identification and referral of children with SAM to outpatient treatment services is a major bottleneck in the prevention of medical complications for children with SAM, resulting in more deaths.

Case study: Community-based treatment to reach a historic number of children with SAM in the Sudan

In the Sudan, acute and protracted crises throughout 2016 left half a million children severely malnourished, with the situation further exacerbated by El Niño, epidemics, floods and droughts throughout the year. Inflation in 2016 has increased the cost of procurement and distribution of ready-to-use therapeutic foods, and food prices have reached a five-year high, further exacerbating the already acute food insecurity situation for vulnerable communities, internally displaced persons and refugees.

Within this context, in 2016, UNICEF and partners treated more than 215,000 children with SAM, 86 per cent of the annual target and an increase of 30 per cent from 2015. As part of the joint national CMAM scale-up plan, UNICEF and partners opened 279 new SAM treatment sites (21 inpatient and 258 outpatient), with services available in 71 of UNICEF's 75 high-priority localities and camps. As of the end of October 2016, 1,172 health clinics offered functional treatment services, increasing the proportion of health facilities with SAM treatment from 35 per cent at the end of 2015 to 46 per cent. This is the largest annual increase in the number of children reached since CMAM started as a national programme in 2010, attributed to evidence informed scale-up and system strengthening.

In terms of system strengthening, 87 per cent of outpatient feeding centres reported to have achieved performance targets. In 2016, five dedicated nutrition mentors provided supportive supervision to poor performing or new centres, to carry out on-the-job mentoring while assessing programme performance using a standardized checklist. UNICEF also provided technical support for the supply pipeline in 13 out of 18 states and negotiated national investments in the pipeline of treatment supplies. With a contribution from the Ministry of Health and nutrition resource partners to procure 244,000 cartons of ready-to-use therapeutic foods, UNICEF was able to maintain the supply pipeline without any breaks during the year for 13 states, while the Ministry of Health provided financing for the remaining five states.

In terms of innovation, UNICEF has been piloting a number of approaches to community mobilization over the past three years. An evaluation of approaches to community mobilization in 2016 identified that engaging mothers of children receiving treatment for SAM is a key to success and critical links need to be made to supporting optimal feeding practices. Efforts are underway to model better integration of WASH within nutrition services through provision of hygiene kits and behaviour change communication in 26 outpatient therapeutic programmes in one state in 2017.

Despite the progress made, there were disparities in service coverage across geographic, gender and wealth quintile dimensions, which have been further exacerbated by the restricted access to conflict areas, limited funding and high turn-over of health workers. The joint Ministry of Health/UNICEF/WFP national CMAM scale-up plan was effective in mitigating some of these constraints by integrating nutrition into health delivery platforms, strengthening active case finding through community outreach, and conducting two mass screening exercises in March and September 2016, to reach and treat more children in the most deprived households. UNICEF also partnered with WHO and the Ministry of Health to introduce innovative ways of providing pre-service training through distance learning.

In response to this bottleneck, UNICEF in the Niger successfully advocated with ECHO, the European Civil Protection and Humanitarian Aid Operations, to fund the expansion of the national seasonal malaria chemoprevention campaign into districts with a large number of children with SAM that were not initially targeted through the programme. Led by the Ministry of Health, in partnership with Global Fund implementing partners, the campaign reached 2.23 million children aged 3–59 months in 27 of 38 districts on a monthly basis, enabling identification and treatment of tens of thousands of children with SAM before development of complications. The lean period coincides with the high malaria transmission season from July through October. As a result of the combined programming, there was a 16 per cent reduction in admissions for inpatient SAM treatment during this period compared with the same period in 2015, representing one of the lowest admission periods for the past five years. Given continued population growth in the Niger, the number of children with SAM is likely to persist even with a significant reduction in prevalence, which represents an additional challenge to programme sustainability. Continued funding streams are critical to ensure the survival of children in general, particularly those who are hospitalized with medically complicated SAM. It will also be critical to prioritize prevention, in collaboration with the Government and its development partners across sectors.

UNICEF worked to support the collapsing health system in Yemen and reach children desperately in need of nutrition support, including with life-saving treatment for SAM. Mobile health and nutrition teams and community health volunteers proved particularly effective in this context. In 2016, UNICEF scaled up SAM treatment by establishing 770 new outpatient therapeutic programmes, bringing the total to 2,929. More than 2 million children were screened for SAM, and more than 237,000 were treated. At the same time, the volatile and demanding situation, where access to services is not continuous and food insecurity is widespread, undermined the continuity and quality of programmes: 26 per cent of the children admitted did not complete treatment (defaulted) while 71 per cent were recovered at discharge. The nutrition programme in Yemen was underfunded by 46 per cent in 2016, which limited the achievement of CMAM expansion targets in terms of both geographical and treatment coverage.

Afghanistan faced an escalating humanitarian crisis in 2016, with the sudden influx of Afghan returnees from Pakistan during the second half of the year overstretching local resources and basic services. The Nutrition Cluster, in collaboration with UNICEF, the Ministry of Public Health and the Public Nutrition Department, initiated the emergency nutrition response for returnees in September 2016. A standard package of services included screening and treatment for SAM, vitamin A supplementation and treatment for soil-transmitted helminthes, as well as individual and group counselling on IYCF practices for pregnant and lactating women. Of the more than 23,600 children of returnees who were screened, 2 per cent of children aged 6–59 months had SAM and 3.7 had MAM. Within Afghanistan's national SAM programme, 201,410 children under 5 were treated for SAM in 2016 (117 per cent of the target), with a cure rate of more than 90 per cent.

In Nigeria, greater access in the northeast in 2016 revealed an acute humanitarian crisis with food and nutrition insecurity affecting 4.4 million people and SAM rates far above the emergency thresholds. This finding, coupled with strong advocacy by UNICEF, led the government to declare a nutrition emergency in June 2016. UNICEF and humanitarian partners scaled up an integrated humanitarian response plan, which was expanded to newly accessible areas, with significant upward revision of targets and funding requirements increasing from US$55 million to US$115 million. More than 167,400 children with SAM were treated through therapeutic programmes with a recovery rate of 86 per cent.

Protecting IYCF and micronutrient status in emergencies

UNICEF advocates for countries to integrate IYCF counselling and support into emergency response. This support is critical, as deteriorating health and WASH conditions combined with displacement and distress pose serious obstacles to families in feeding and caring for their children. These same conditions, combined with food insecurity, can also cause micronutrient deficiencies, as well as exacerbate those that already exist. In 2016, UNICEF continued to deliver vitamin supplementation to women and children to prevent and treat such deficiencies.

In 2016, more than 6.3 million caregivers received IYCF counselling in humanitarian situations, with UNICEF support (82 per cent of the target). The number of caregivers benefiting from the promotion of early childhood stimulation and development as part of IYCF counselling in humanitarian situations increased only marginally, from 770,671 in 2015 to 793,390 in 2016, falling below the expected target (P4.d.3). This situation will improve over time with increased attention to the linkages between nutrition and ECD and the efforts of the ECD Action Network.[37]

To contribute to emergency response in conflict-affected areas of eastern Ukraine, UNICEF provided coordination and technical leadership to allow nearly 44,000 pregnant and lactating women to benefit from training on IYCF counselling and educational materials. Training on IYCF was also provided to 800 health professionals in the government-controlled areas of Donetsk and Luhansk oblasts. UNICEF also worked to monitor and prevent the indiscriminate distribution of breastmilk substitutes by training health providers in the distribution of baby food baskets. With technical support from UNICEF, the Ministry of Health established a surveillance system in affected

areas that enables anaemia tracking among infants and pregnant women.

In Yemen, mobile health and nutrition teams provided micronutrient interventions to more than 4.1 million children under 5 in 2016 as part of a package of emergency nutrition interventions. More than 533,000 pregnant and lactating women received IYCF counselling through IYCF corners in health facilities, outreach activities, mobile teams and community volunteers, far beyond the target of 313,119. In South Sudan, more than 735,800 pregnant women and mothers with children under 2 were reached with IYCF support during individual counselling sessions, and a further 650,146 people (including more than 6,000 men) were reached through group counselling. An IYCF training of trainers was rolled out in 7 out of 10 states, with security constraints hindering roll-out in Jonglei, Upper Nile and Western Equatoria. (*See box: Case Study: Case study: Leveraging shared strengths to save lives in the most fragile communities of South Sudan*)

In the context of the Syrian refugee crisis, more than 177,000 pregnant and lactating women and children under 5 in Lebanon received micronutrient supplements (90 per cent of the target). In Djibouti, where children are extremely vulnerable after nearly a decade of drought, UNICEF reached 29,012 children (61 per cent girls) with multiple micronutrient powders (89 per cent of the target), and 31,874 children (53 per cent girls) with vitamin A supplements during immunization campaigns (96 per cent of the target). In the State of Palestine, Gaza's health system was still under severe threat two years after the 51 days of escalated violence, and the ongoing chronic shortages of staff and supplies. In 2016, UNICEF supported the provision of quality health services for children and women in affected communities, including essential drugs and micronutrients, thereby ensuring that nearly 300,000 children and women received micronutrient supplements.

Case study: Leveraging shared strengths to save lives in the most fragile communities of South Sudan

The situation in South Sudan remained challenging in 2016, with access blocked by conflict and lack of road infrastructure, armed attacks targeting humanitarian personnel, and heavy bureaucracy – all of which constrained the third year of humanitarian response.

At a time when most partners' international humanitarian staff had been evacuated, UNICEF and WFP provided life-saving services through 19 integrated rapid response mechanism missions in 2016, delivering food rations, preventive and curative nutrition and health interventions. The missions helped to re-establish access to safe drinking water and hygiene and critical child protection services. UNICEF and WFP screened more than 61,000 children aged 6–59 months and more than 15,000 pregnant and lactating women for acute malnutrition. Of the children screened, 985 had SAM while 3,863 had MAM and were either treated or referred for treatment at the nearest outpatient therapeutic programme or target supplementary feeding programme site. Similarly, a total of 769 acutely malnourished pregnant and lactating women were identified and referred for treatment. The missions were first established in March 2014 and have been pivotal to ensuring that children in remote communities cut off from services have a chance at survival.

Through 47 NGO partnerships, UNICEF provided treatment services in camps for internally displaced persons and for refugees and host communities nationwide through 562 outpatient therapeutic programmes and 51 stabilization centres for SAM, including for those with complications. Overall, UNICEF supported the treatment of 218,504 children aged 6–59 months with SAM across the country, reaching 86 per cent of the annual target, with a recovery rate of 86.3 per cent. Results were achieved through strengthened partnerships, timely supply planning and distribution, and timely pre-positioning of essential nutrition supplies to avoid stock-outs of supplies. In 2016, UNICEF collaborated with WFP to support the development of the first-ever national CMAM guidelines, tools and training package for South Sudan, as well as the adaptation of the IYCF community training package to address maternal and infant and young child feeding, with a linkage to SAM management (*discussed further in programme area 1*). The guidelines will be rolled out to states and counties in 2017, with capacity strengthening of State Ministry of Health nutrition units.

Despite these successes, monitoring reports and coverage surveys revealed substantial bottlenecks in coverage of SAM treatment. Distance to service points and insecurity were the main barriers to service utilization. The Nutrition Cluster and UNICEF are now mapping facilities at state level to address gaps in the continuum of care.

Integrating SAM management in routine services for children

In many countries, SAM is perceived as a consequence of emergencies and therefore limited investments are made to integrate treatment within national plans and systems supported by domestic resources. In 2016, UNICEF advocated for improved integration and supported governments in expanding integrated community case management platforms to improve screening and include treatment at community level. With UNICEF's support in Ethiopia, for example, CMAM is now integrated into the health system's routine services for children with close monitoring (*see box: 'Case study: Fostering the integration of treatment for children with SAM in routine and outreach services to serve the most vulnerable in Ethiopia'*).

In East Asia and the Pacific, the 10 countries with SAM management programmes have an annual caseload of about 4 million children, and yet treatment coverage remains at just 2 per cent, with several countries recording far lower coverage than in previous years. The first-ever technical consultation on SAM in the region was held in 2015 to update a global guidance, assess bottlenecks and chart a way forward. UNICEF set a target for all 10 countries to have endorsed or be applying updated SAM protocols in 2016. At the time of the consultation, only one country in the region, the Democratic People's Republic of Korea, had an up-to-date treatment protocol. Since then, however, five more countries have endorsed revised protocols and strategies; four countries are applying interim updated protocols; and one final country, Indonesia, has agreed to update its protocol, with a draft protocol prepared by UNICEF currently under review. In most of these countries, achieving scale-up of services and improved coverage will depend mainly on fully institutionalizing treatment within the health system, with government financing. In the Philippines and Viet Nam, UNICEF is advocating for the development of a benefits package that includes SAM treatment within the national health insurance schemes. For 2017, UNICEF aims to have the four countries with interim updated protocols fully applying their up-to-date protocols, and for Indonesia to have its protocol officially endorsed.

UNICEF provides technical assistance to countries to undertake bottleneck analyses to identify and target barriers that prevent services from reaching the most disadvantaged children. In several countries, the findings of such analyses have fed into national plans to strengthen and scale up SAM management services and improve integration into health systems with government ownership and resources. UNICEF has made efforts to document such cases, and in 2016, the organization published a compendium of case studies on bottleneck analysis to improve effective coverage of SAM management.

Fostering links between SAM and HIV screening and management

In high HIV-burden countries, many children with SAM are HIV-positive. For these children, recovery depends largely on whether the child is screened and identified as having HIV and provided with antiretroviral therapy along with treatment for SAM. While the integration of SAM

Case study: Fostering the integration of treatment for children with SAM in routine and outreach services to serve the most vulnerable in Ethiopia

Supported by UNICEF advocacy and technical assistance, the Government of Ethiopia launched the National Nutrition Programme in 2016, which integrates CMAM into the routine services provided by the health system and is backed by a robust monitoring framework covering both nutrition-specific and nutrition-sensitive indicators. Thanks to the demonstrated value of UNICEF-supported mobile health and nutrition teams in providing services to the hardest-to-reach women and children, the teams are now part of the Government's health equity strategy. The number of health facilities equipped to treat children using a CMAM approach increased by 11 per cent, from 14,997 facilities in 2015 to 16,687 in 2016, providing treatment to more than 320,800 children with SAM, with a recovery rate of 91 per cent.

The overall number of SAM cases in 2016 was lower than expected due to the early roll-out of the emergency nutrition response and comprehensive food assistance programme. UNICEF collaborated with WFP to support emergency nutrition services for the most disadvantaged in hard-to-reach areas of the country. In order to ensure a continuum of nutrition care in these areas, the supplementary feeding programme and the therapeutic feeding programme were delivered through the Government's health extension programme. As part of that programme, mobile health and nutrition teams provide essential health and nutrition services for the most vulnerable communities in inaccessible areas with no alternative health services. Out of a total 49 mobile health and nutrition teams in Afar and Somali, 26 teams now combine supplemental and therapeutic feeding programmes for the first time, offering life-saving health and nutrition services to women and children who otherwise would be left behind.

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Haoua smiles at her six-month-old daughter, Barahatou, in the Nutritional Recuperation Centre of Matameye, the Niger. Here, health professionals are treating children with severe acute malnutrition, while those with medical complications are referred to hospitals.

management and HIV screening is reflected in global SAM guidance, it is not standard practice in many settings, and UNICEF is working to strengthen these linkages.

UNICEF undertook a mapping exercise in Malawi to identify districts with high food deficits and low uptake of maternal HIV treatment services. In 2016, UNICEF supported three districts in implementing an integrated HIV, tuberculosis and nutrition service delivery, resulting in an increase in active case finding for the three issues. Early results indicate the benefits of integrated programming: Of the 432 HIV-exposed children screened for malnutrition, 56 children (13 per cent) were malnourished and referred to the CMAM programme, and 37 children on antiretroviral therapy were screened for tuberculosis, of which 5 children (14 per cent) tested positive and were enrolled in treatment.

Improving supply delivery to reach those most in need

The continuous availability of therapeutic supplies is essential to the provision and uptake of SAM services. UNICEF procures approximately 80 per cent of ready-to-use therapeutic foods used globally and the majority of therapeutic milk (F-75, F100) used in the treatment of SAM with complications. UNICEF continued to support local production of ready-to-use therapeutic foods, and in 2016, 56 per cent was sourced in programme countries, compared with 38 per cent the previous year.

UNICEF also supports countries in incorporating ready-to-use therapeutic foods into national supply systems. In Burkina Faso, for example, UNICEF advocated for increased government ownership and commitment. As a result, in 2016, the management and distribution of nutrition supplies, previously supported by UNICEF, are now integrated into the supply chain of the national health system through an agreement signed between the Ministry of Health, the national procurement centre and

UNICEF. Furthermore, the Government has committed its own resources to procure supplies for 2017–2019. Some countries have developed innovative tools to improve supply forecasting with UNICEF's support (*see box: 'Spotlight on innovations: Better supply tracking to prevent stock-outs'*).

With UNICEF's guidance, countries continued to improve supply chain management, create efficiencies and prevent stock-outs. In Pakistan, UNICEF worked with a local supplier and provided oversight and quality control testing on lower-cost supplies for CMAM, which may in turn improve programme reach. Negotiations in the Sudan resulted in a 16 per cent price reduction of locally produced ready-to-use therapeutic foods, representing a saving of US$1.1 million, and UNICEF's advocacy resulted in 40 per cent of ready-to-use therapeutic foods being locally procured in 2016.

In 2016, UNICEF and partners launched an effort to improve the quality of products used in SAM treatment, including by providing inputs to the Codex Alimentarius (the food code established by FAO to harmonize international food standards) and by conducting an analysis to improve packaging. Furthermore, with Food for Peace support, UNICEF Supply Division and Nutrition Section in headquarters have provided support to supply chain strengthening, including standard operating procedures and trainings, in Afghanistan, Nigeria and the Sudan. Supply Division also hosted the first Nutrition Practitioners Forum in 2016, which brought together representatives from nine countries primarily in East and West Africa, including government representatives, medical stores chief executive officers from those countries, resource partners and other stakeholders. The outcome consensus note will galvanize further support for the review of existing practices and develop common standards, norms and tools for end user monitoring for ready-to-use therapeutic food.

Spotlight on innovations: Better supply tracking to prevent stock-outs

In the **Niger**, the ready-to-use therapeutic foods supply system is weak and only partially overseen by district health services. UNICEF responded to this challenge by developing a supply tracking software solution (TrackIt) to improve the distribution and logistics of life-saving commodities using real-time tracking of delivery of supplies to implementing partners in the field. TrackIt allows UNICEF to analyse SAM treatment data, correlate these with use of ready-to-use therapeutic foods and essential drugs, compare the data to global performance indicators, and further develop the capacity for supply chain management, especially at district level.

In **Liberia**, UNICEF collaborated with the National Drug Service in utilizing mHero[38] to monitor the distribution of essential medicines, medical supplies and nutrition commodities in four pilot counties. The information generated allowed the Ministry of Health and UNICEF to eliminate disruptions to nutrition services by preventing stock-outs and facilitating the timely distribution of nutrition supplies from central to sub-national levels.

Advocacy and leadership to put SAM on the global agenda

The gap between the global burden of SAM and the number of children reached with treatment each year remains unacceptably wide. Yet despite this, there has been a persistent shortage of global funds to tackle the condition. Domestic budgets often fail to allocate sufficient resources to SAM treatment and care. Moreover, in 2014, donor resources covered only US$450 million globally, less than 25 per cent of funding needs.[39] In response to this pressing challenge, UNICEF, the Government of the United Kingdom, the European Commission, Action Against Hunger and the Children's Investment Fund Foundation launched No Wasted Lives[40] in 2016. The initiative seeks to transfer current treatment innovations to action at scale, set the research agenda to address evidence gaps, and place the management of severe acute malnutrition as a global health priority – accompanied by innovative funding streams to accelerate the scale-up of treatment, with a particular emphasis on community-based care.

In 2016, No Wasted Lives established a technical panel of experts – the Council on Research & Technical Advice on Severe Acute Malnutrition – that will review the current evidence base for treatment and prevention of SAM. The evidence base and setting of a research agenda will aid policymakers and practitioners to put best practices into action, while providing resource partners with the evidence they need to allocate funds and work with NGOs and governments to implement new approaches at scale.

Guidance to strengthen planning, coordination and response

Investments in emergency preparedness, coordination and flexible programming are critical. UNICEF provides technical support and guidance to countries to develop effective plans and strategies for emergency response. An example of this work is the joint strategy developed with WFP in 2016 to improve emergency nutrition response in the Lake Chad Basin. In 2016, 64 countries reported

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A boy is screened for malnutrition in Sa'ada, Yemen. More than 237,000 children were treated for severe acute malnutrition in Yemen in 2016.

having a nutrition sector plan or policy that included a risk management strategy to address crises such as conflict or disasters (P4.c.3), nearly reaching the 2016 target of 65 countries.

UNICEF developed a number of important knowledge products in 2016, including a nutrition in emergencies capacity analysis to galvanize 2017 action, a nutrition in emergencies toolkit for rollout in 2017, an analysis on strengthening transition from cluster to sector coordination to inform UNICEF's guidance as cluster lead agency, as well as completion of the nutrition module from the risk-informed programming guidance. In addition, UNICEF contributed to key global documents on humanitarian action, including the global guidance note on preparedness for emergency response, the El Niño and La Niña Blueprint and the associated standard operating procedures.

Over the course of the Strategic Plan period, UNICEF intends to support all countries in humanitarian action where country cluster or sector coordination mechanisms for nutrition meet CCC standards for coordination. In 2016, 13 out of 14 countries in humanitarian action met this objective, the same number as in 2015 (P4.d.2). Coordination is critical to effective emergency preparedness and response. In countries where the Nutrition Cluster has been activated, UNICEF, as cluster lead agency, has very specific accountabilities in its coordination role beyond those outlined in the CCCs, such as ensuring that coordination mechanisms are established and supported, serving as a first point of contact for government and acting as a provider of last resort.

Fostering resilient systems and communities

UNICEF supports systems strengthening through multi-sectoral actions that help countries better anticipate, withstand and bounce back from shocks and stressors. The United Kingdom's Department for International Development -supported Joint Resilience Project in the Sudan, a partnership between FAO, UNICEF and WFP,

takes a holistic approach to increasing resilience in drought and flood-affected communities in Kassala state. More than 96,000 children and their families living in the 75 most deprived villages in four localities have benefited from an integrated package of health, WASH, nutrition, food security and livelihood interventions. During the second year of its implementation in 2016, stunting among children under 2 decreased from a baseline of 66.9 per cent to 57.5 per cent, and the percentage of households with improved drinking water sources increased considerably, from 43.7 per cent to 70.5 per cent.

Efforts to build resilience in Nepal were tested after the earthquake hit in 2015. Response to the emergency built on the experience, capacity and systems that were developed through the Maternal and Young Child Nutrition Security Initiative in Asia prior to the earthquake. More than 17,800 female community health volunteers, more than 6,800 health workers and more than 1,000 staff members of civil society organizations were trained and mobilized to implement five key nutrition interventions established through the initiative. In addition, the emergency response made use of coordination mechanisms that had been strengthened during the previous years with support from the programme. The response to the earthquake revealed a high level of resilience in communities and institutions and highlighted the importance of including resilience building in the design and implementation of all development programmes.

Strengthening community resilience through disaster risk reduction remained pivotal to UNICEF's work in Pakistan. Building on previously developed risk management plans, 2016 saw a shift in focus to embrace community-based risk management, for which UNICEF advocated and built capacity in disaster-prone districts. In Somalia, UNICEF

Samiullha, age 2, smiles at his mother following UNICEF-supported in-patient treatment for severe acute malnutrition at a hospital in Kabul, Afghanistan.

provided extensive technical support to the Government on the development of the resilience chapter of the national development plan, including a multi-sectoral approach to malnutrition and food insecurity. UNICEF took a lead role in the development with WFP and FAO of the Joint Resilience Programme, which addresses malnutrition using risk-informed programming and a combination of nutrition-specific and nutrition-sensitive interventions in 10 districts across Somalia. The programme is expected to start in 2017.

UNICEF's Latin America and Caribbean Regional Office has been supporting the development of a regional nutrition in emergencies group called GRIN-LAC (Grupo de Resiliencia Integrada de Nutrición) since 2013. The group strengthens disaster risk reduction and emergency preparedness and response, with financial support from the United States Agency for International Development (USAID) Office of Foreign Disaster Assistance and UNICEF coordination. Whereas in the past, regional nutrition in emergency-related initiatives were sporadic and involved a limited number of participants, there are now 32 countries regularly engaged that have initiated concrete improvements, even in places were UNICEF has limited or no in-country technical capacity.

Challenges, reflections and future direction

The launch of the No Wasted Lives coalition in 2016 marked the start of a renewed global conversation to provide care for children with SAM at scale. With its commitment to double the number of children reached with treatment to 6 million by 2020, the initiative is poised to spark a shift in global efforts to address SAM, and offers a path forward to eventually reach every one of the 17 million children in need. By catalysing technical innovation in protocols, products and approaches to preventing and treating acute malnutrition, No Wasted Lives will be a driving force in achieving the SDG goal on ending preventable deaths in children under 5.

A child with SAM is a child in an emergency situation; urgent treatment is critical to prevent death. Yet it is a challenge to communicate that the condition is not only a consequence of emergencies, but rather an ongoing development priority that must be addressed systematically and in tandem with efforts to end stunting and other forms of malnutrition. Supporting governments to incorporate SAM management into routine services and the supervision and monitoring of such management into national health systems remains a priority for UNICEF, alongside efforts to promote quality of care, including care and stimulation during treatment, and supporting household practices to prevent relapse. This is particularly important in East and South Asia, where the gap between treatment coverage of children with SAM and the SAM burden is particularly wide.

Investing in capacities and systems to deliver nutrition services, nutrition information systems and coordination frameworks prior to an emergency are key to preventing deterioration in response to shocks. However, there remain limited experiences and lessons learned on how to effectively establish nutrition risk-informed programmes. UNICEF will continue to work with partners to build the evidence base around risk-informed nutrition programming in 2017, alongside greater evidence and experience for micronutrients and infant and young child nutrition programming in emergencies.

Across the globe, 2016 was a year of crisis and upheaval. Ongoing humanitarian crises required considerable resources and stretched UNICEF's capacity to respond. While the greatest proportion of nutrition funding was allocated to emergencies in 2016, most continued to be earmarked for nutrition supplies to treat SAM. Moving forward, there is a concurrent need to increase investments in broader systems strengthening, capacity development and resilience building. These longer-term investments will help UNICEF respond to an increasingly complex environment, mitigating risk and ultimately achieving outcomes in the final year of the Strategic Plan. Flexible funding streams would also help UNICEF to better support countries in their nutrition development goals and ensure that progress is maintained when emergencies strike.

PROGRAMME AREA 4: GENERAL NUTRITION

ENABLING AN OPTIMAL ENVIRONMENT FOR GOOD NUTRITION

The general nutrition programme area is the 'backbone' of the nutrition programme, supporting a holistic approach to achieving results across all programme areas. The inputs, activities and results in this section are therefore cross-cutting in nature and support the work of the other three nutrition programme areas.

Among the most important tasks of the general nutrition programme area is strengthening the enabling environment for nutrition at the national level, including by supporting governments in developing evidence-based and effective policies and strategies. This work takes place across diverse country contexts, and UNICEF adapts its approaches to respond to national priorities, supporting governments and working closely with communities.

UNICEF's multi-sectoral nutrition programming, particularly with the Health and WASH programmes, is also reported under this programme area, to illustrate the impact of joint interventions at scale. UNICEF is uniquely positioned to undertake such joint actions, which achieve greater impact and facilitate sustainable progress within countries over the long term.

At the global level, UNICEF's nutrition programme works with a wide range of partners to build momentum for ending malnutrition in all its forms. In particular, UNICEF's leadership role in the SUN movement (*further discussed below*) is important in galvanizing national commitments to and investments in women's and children's nutrition.

UNICEF has been engaging throughout the SDG process, contributing to technical consultations on Goal 2 on nutrition. As countries prepare for the SDG era, UNICEF is providing support to align regional and national priorities with global targets, influence budget allocation and chart a way forward for the next 15 years. In Indonesia, for example, UNICEF developed a compendium of technical guidance to localize global SDG targets and indicators. The guidance, published in March 2016, identifies 59 key SDG indicators for children in Indonesia. In April 2016, UNICEF hosted a workshop with the Ministry of National Development Planning, the SDG Secretariat and relevant line ministries, using the guidance to brief them on SDG targets and indicators and the implications for the context of Indonesia.

Through its achievements in improving policies, strengthening multi-sectoral collaboration, forging global partnerships, enhancing investments, improving data and expanding the knowledge base, the general nutrition programme paves the way for better results throughout the Strategic Plan period and beyond.

Results chain for general nutrition

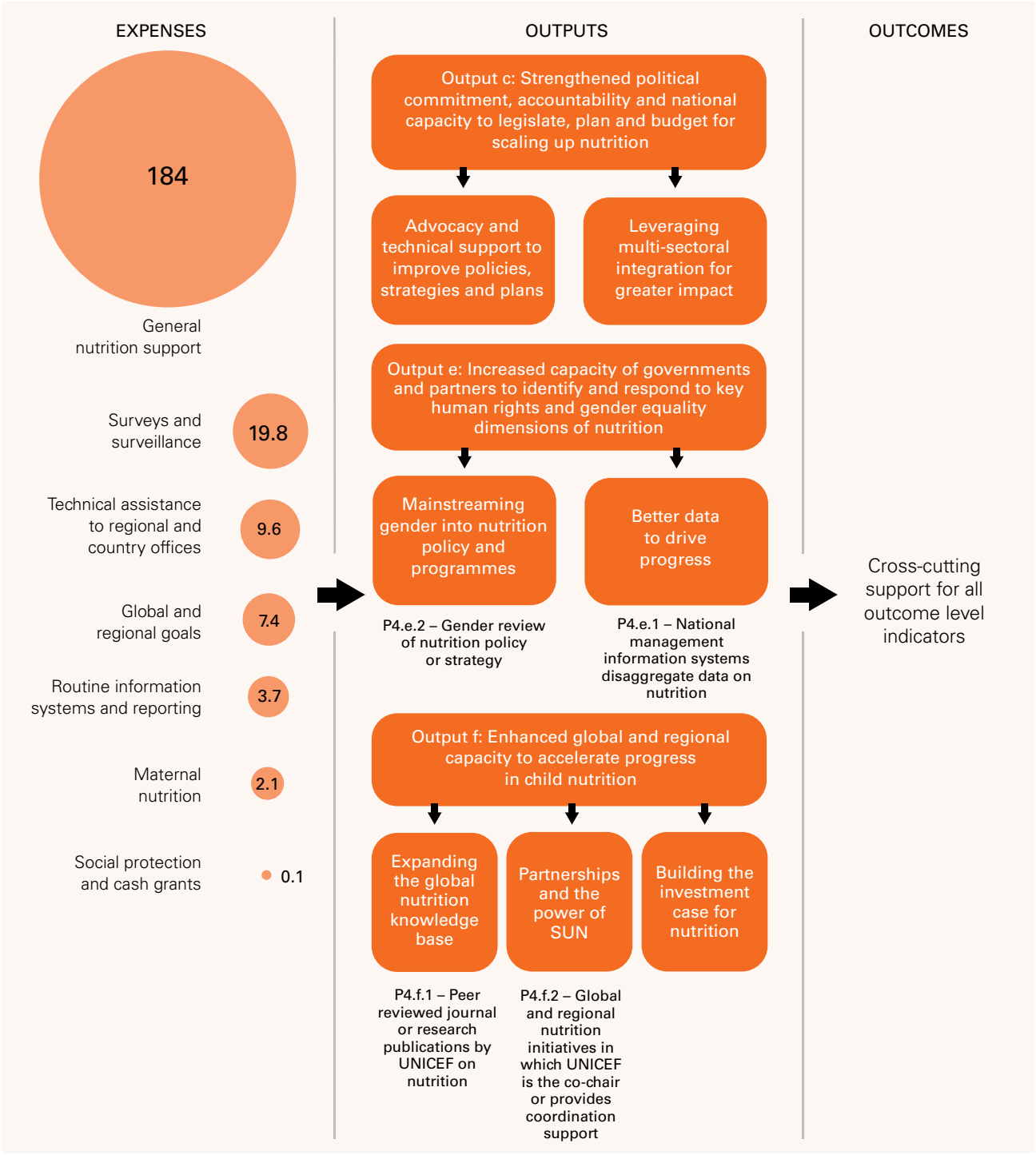
The results chain for general nutrition outlines the linkages between programme spending, key interventions and progress on UNICEF's Strategic Plan output and outcome indicators (*see Figure 8*). The output 'bubble' in Figure 8 lists the activities supporting each output, and these also serve as sub-headings in this programme area chapter.

To illustrate the results chain using one example, the US$19.8 million spent on nutrition surveys and surveillance allows UNICEF to support governments in monitoring nutrition outcomes, including via their national information systems (P4.e.1), and use those data to develop context-specific and responsive programmes. The general nutrition programme outputs are linked with results of the other programme areas and heavily support their achievements.

Expenditures to support programme implementation

In 2016, US$225 million was spent on the general nutrition programme, with the largest amount allotted to 'general nutrition support'. This includes service delivery, capacity development and advocacy efforts to improve nutrition policies and programmes. Spending in 2016 did not change much from the US$226.3 million spent in 2015. Resources for the general nutrition programme remained more stable between 2015 and 2016 compared with the other programmes areas.

FIGURE 8
Results chain for general nutrition



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

Key outputs and results in 2016

Advocacy and technical support to improve policies, strategies and plans

Strong national policies and strategies are essential to fostering the enabling environment for nutrition. At regional and country level, UNICEF works to generate evidence, engage in policy dialogue and advocacy to ensure that nutrition commitments are translated into national strategies, policies and plans of action. The proportion of countries that have a nutrition sector policy or plan developed or revised with UNICEF support has increased steadily since the start of the Strategic Plan period, from 74 per cent in 2014, to 76 per cent in 2015 and to 79 per cent in 2016 (95 out of 121 countries).

Significant advancements in policy and strategy were made in 2016, many of which are directly attributable to UNICEF's support. The Government of the United Republic of Tanzania, for example, launched a National Multi-Sectoral Nutrition Action Plan (2016–2021) with technical guidance and financial support from UNICEF (*see box 'Case study: The path to a national multi-sectoral nutrition action plan in the United Republic of Tanzania'*).

In Ethiopia, UNICEF generated evidence and undertook extensive policy advocacy to support the adoption of the National Nutrition Programme II, and the development of a food and nutrition policy. In Burkina Faso, a new national nutrition policy was launched with UNICEF support in 2016, in line with the multi-sectoral approach in nutrition and the 2025 global nutrition targets. UNICEF contributed to developing the common results framework for reducing various forms of malnutrition. Similarly, in Mauritania, UNICEF helped develop a 10-year multi-sectoral nutrition strategic plan around a common results framework, with stunting and breastfeeding targets. UNICEF is also supporting the Government of Mauritania to develop a 10-year scaling-up IYCF plan. The national nutrition strategy in Côte d'Ivoire was successfully integrated in the national development plan for 2016–2020. With UNICEF support following the adoption of the strategy in 2016,

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A mother and child participate in activities at a resource centre on child nutrition in Munaily Rayon, Mangystau Oblast, Kazakhstan.

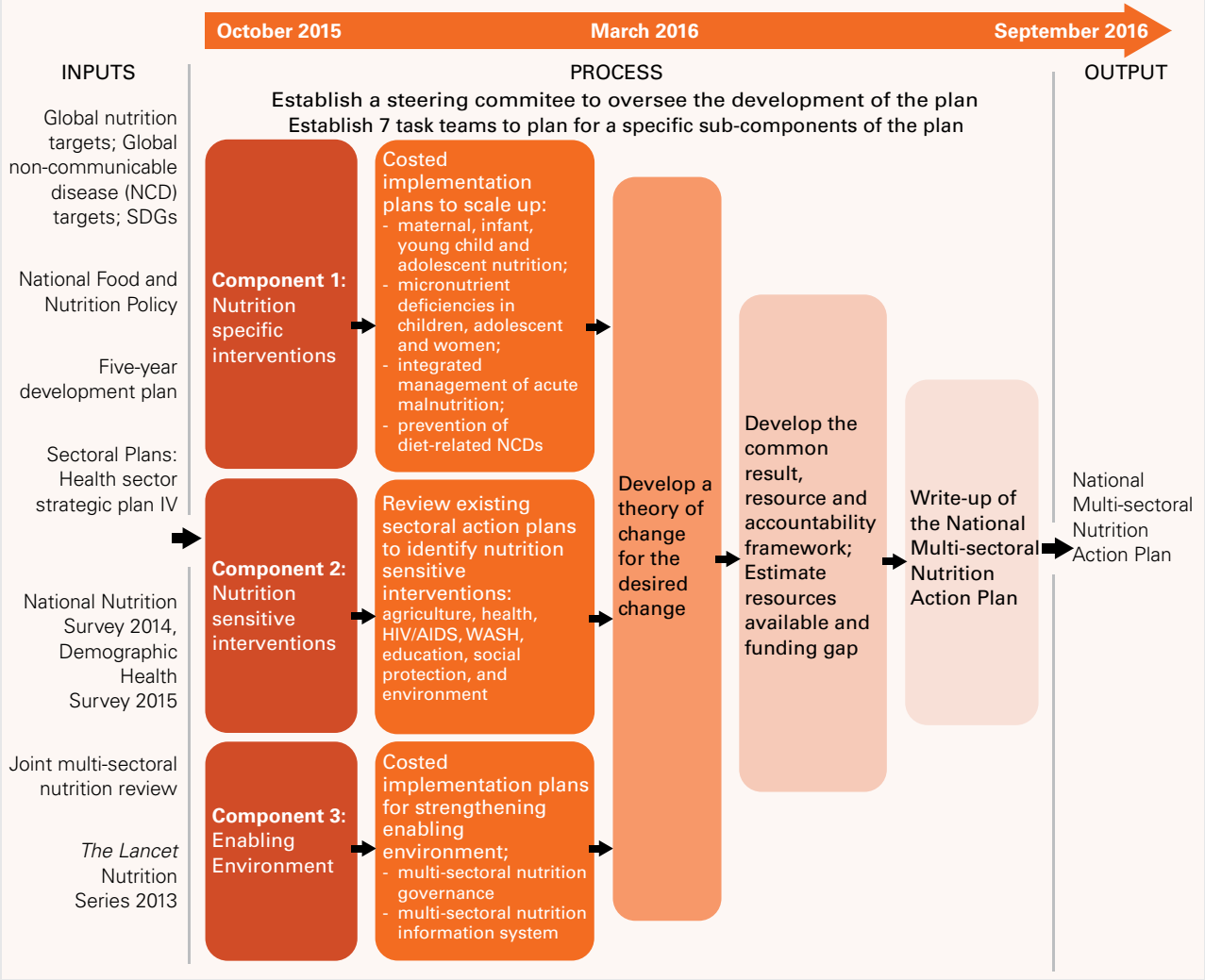
Case study: The path to a national multi-sectoral nutrition action plan in the United Republic of Tanzania

Despite significant progress made over the past 25 years, child stunting remains widespread in the United Republic of Tanzania. The Government has demonstrated increased political will to address stunting, including by joining the SUN movement in 2011 and developing a National Nutrition Strategy (2011–2016).

A 2015 review of the National Nutrition Strategy noted important gaps in the approach, including: (1) unclear objectives for nutrition-sensitive sectors such as WASH or social protection; (2) the absence of detailed action plans; (3) an unclear and unrealistic budget; and (4) the lack of a common results framework to track progress within each sector.

This analysis prompted the Government to act, and the country's SUN focal point asked UNICEF to support the development of the National Multi-sectoral Nutrition Action Plan 2016–2021. UNICEF provided support to prepare a roadmap highlighting key steps to develop the Action Plan (*see Figure 9*). The process was estimated to cost US$350,000 and was funded by UNICEF and other development partners.

FIGURE 9
Road map to develop the National Multi-sectoral Nutrition Action Plan



The role of the private sector, innovation, social and behaviour change communication, and gender issues are mainstreamed throughout

UNICEF identified a lead facilitator and successfully advocated for the process to be inclusive and evidence-based. A multi-stakeholder process brought together government structures from various sectors, NGOs, United Nations agencies and resource partners who were tasked with preparing the seven components of the Action Plan, including nutrition-specific and nutrition-sensitive interventions, as well as interventions to improve the enabling environment for nutrition. UNICEF supported these stakeholders in developing a theory of change for the Action Plan, with the common results framework summarizing the expected impact, outcomes and outputs, key indicators and milestones, planned resources and responsible institutions.

The National Multi-sectoral Nutrition Action Plan 2016–2021 was officially adopted by the Government of Tanzania during the meeting of the High Level Steering Committee for Nutrition in October 2016.

A key challenge in developing the document was achieving a common vision among stakeholders from multiple sectors, NGOs and development partners. This challenge was addressed by adhering to available evidence and the mutually agreed theory of change. Limited capacity in results based management and budgeting among task team members was also a challenge, and specific orientation sessions were organized to address this capacity gap. The political structure of the United Republic of Tanzania created additional challenges as nutrition is considered a 'non-union matter'. This was addressed by involving representatives from both the mainland and Zanzibar in all steps of the process and then preparing specific action plans for each.

There were a number of lessons learned throughout the process. Firstly, a participatory approach is critical to build ownership around the plan. UNICEF played an important role in bringing stakeholders together and serving as a knowledge broker by compiling existing evidence, generating new and specific knowledge to address inequities affecting children and using a bottleneck analysis of key nutrition interventions. Managing and tracking nutrition-sensitive interventions within the multi-sectoral plan was critical. Interventions related to health, WASH and social protection for example, were planned and budgeted for within their respective sectors, yet they were also reported to the results framework to ensure that the Action Plan included the true costs of addressing malnutrition in the country. Moving forward, UNICEF is supporting the Government's implementation of the Action Plan by disseminating expected results, mobilizing resources, aligning annual work plans, coordinating nutrition stakeholders, strengthening governance and improving nutrition information systems.

the Government organized a round table of technical and financial partners, including the African Development Bank and World Bank, to mobilize the necessary resources to implement the plan.

This advocacy and support for budget allocation is critical to ensuring that national plans are translated into concrete actions. In Nepal, UNICEF's high-level advocacy led the Ministry of Finance to allocate US$2 million to the Multi-Sectoral Nutrition Plan. With human resource support from UNICEF, the plan was scaled up in 12 additional districts in 2016, reaching a total of 28 priority districts. District and community-level planning is ongoing to draft budgeted district multi-sectoral nutrition plans for 2017.

Leveraging multi-sectoral integration for greater impact

UNICEF's comparative advantage is that multiple sectors within the agency can leverage their respective strengths to collaborate on the goal of improving nutrition. Multi-sectoral collaboration with WASH, ECD and Health in particular strengthens programme impact and helps ensure that gains in nutrition and other sectors are sustained over the long term.

The UNICEF project 'Improving child nutrition in four countries in sub-Saharan Africa', implemented in partnership with the Government of the Netherlands, delivers a multi-sectoral package of interventions in Burundi, Ethiopia, Mozambique and Rwanda. In addition to nutrition-specific interventions, the programme includes approaches to foster homestead agriculture and livestock rearing; WASH; social protection; ECD; and health. The programme has improved food and micronutrient intake for more than 13.5 million people and improved nutritional resilience for than 685,000 people in 2016. The programme has also facilitated rich opportunities for South-South cooperation and learning between the project countries via shared knowledge exchange.

UNICEF's Global Nutrition strategy articulates that poor sanitation and hygiene practices are essential determinants in the cycle of infectious disease and undernutrition. At global level in 2016, UNICEF initiated a series of webinars on nutrition-WASH collaboration to foster inter-country and inter-regional learning, and a UNICEF Nutrition-WASH Network meeting formed the basis for a subsequent

collaboration and shaped joint support to countries. Regional WASH-Nutrition collaboration has also built momentum in recent years, including in East Asia and the Pacific, where UNICEF's regional office launched a Nutrition-WASH toolkit that has been subsequently adapted by other regions (*see box 'Case study: A toolkit to guide countries in facing the most pressing nutrition-WASH challenges'*).

Given the links between stunting and poor hygiene and sanitation conditions, there is high demand for nutrition-WASH programming from countries. A mapping exercise undertaken by UNICEF in 2016 revealed that six regions and 24 countries have ongoing joint initiatives and programmes. As part of the USAID-funded Maternal and Child Stunting Reduction Programme in Pakistan, UNICEF launched in 2016 a new approach to aligning nutrition and WASH interventions in target districts in Sindh Province, while providing technical assistance to the Government. The programme involves integrated training and capacity building of front-line health workers, community-led approaches and an evidence-based behaviour change strategy. UNICEF conducted three workshops to identify convergence points between the two sectors, including developing a nutrition-WASH performance matrix and common behaviour change entry points. Results will be measured against a joint results framework embedded within a robust programme monitoring plan.

UNICEF advocates for and supports national governments to ensure that nutrition-WASH linkages are embedded in national planning, budgeting, implementation and monitoring. In the Democratic People's Republic of Korea, for example, the Government formulated a country convergence approach that linked the nutrition, health and WASH sectors, with a focus on the first 1,000 days of a child's life. UNICEF supported the design, planning and implementation of national joint nutrition-WASH programmes in Cambodia, Eritrea and Pakistan. In the Philippines, UNICEF supported the capacity building of communities and municipal health staff on IYCF, and the community-based management of acute malnutrition in conjunction with a phased approach to total sanitation.

Case study: A toolkit to guide countries in facing the most pressing nutrition-WASH challenges

Formidable nutrition and WASH challenges remain in the East Asia and Pacific region: An estimated 15 million children under 5 are stunted, 4 million children face severe acute malnutrition and a staggering 659 million people lack access to improved sanitation, including 83 million who still practice open defecation.[41]

Recent evidence shows that in some settings, 40–60 per cent of child undernutrition may be attributed to poor WASH conditions. The new UNICEF global nutrition and WASH strategies, as well as the East Asia and Pacific regional nutrition strategy, all strongly emphasize the importance of joint action to tackle this complex challenge.

The UNICEF Nutrition-WASH Toolkit, published in 2016, is a response to these persistent challenges. It addresses the demand from countries for practical guidance by tools for systematically integrating WASH and nutrition programming from a holistic point of view. The toolkit summarizes the latest evidence and encompasses the entire programming process, from joint analysis to development of a joint vision and theory of change, design of interventions and plans, and monitoring and knowledge management. It also looks at how to optimize the main delivery platforms (including household, school and health facility) and move towards integration rather than convergence.

Part of the development process included workshops held in February 2016 in Cambodia and the Philippines, after which each country went on to finalize its respective theory of change and began designing and planning joint programmes in selected model districts. Following the launch of the final toolkit, a further theory of change workshop was held in November in the Democratic People's Republic of Korea with multiple sectors – a rare occurrence there –, and in-country workshops are envisaged in a total of 10 additional countries in the coming year. Implementing joint actions is expected to make a significant contribution to accelerating progress towards the stunting target and improving the prospects for the most deprived children to survive and thrive, thereby assuring a brighter future for millions of children and securing enhanced cognitive capital for countries to generate sustainable growth.

The Nutrition-WASH toolkit is now being adapted for use in other regions, including Eastern and Southern Africa and South Asia.

UNICEF builds national capacity to mainstream nutrition-specific interventions within other sectors. In Bangladesh in 2016, UNICEF worked with the Government to enhance district capacity in delivering nutrition services by deploying 43 District Nutrition Support Officers. Using this strategy, 25,000 front-line health workers and first-line supervisors received onsite technical support and supervision. As a result, nearly 88 per cent of health facilities started reporting on at least one nutrition indicator, while 46 per cent reported on all standard nutrition indicators (compared with 25 per cent and 3 per cent, respectively, in 2014); nutrition supply gaps were reduced by 26 per cent; and 66 per cent of facilities now provide maternal and child nutrition counselling services.

Case study: Nutrition upstream – improving policies, programmes and partnerships for maternal and child nutrition in Asia

The partnership between UNICEF and the European Union through the Maternal and Young Child Nutrition Security Initiative in Asia (2011-2015) provided an opportunity to document the effectiveness of UNICEF's upstream engagement for maternal and child nutrition through 10 case studies in four countries – Bangladesh, Indonesia, Nepal and the Philippines. Using organizational network analysis, key informant interviews and in-depth reviews of national policy and programme frameworks, UNICEF documented its involvement in country partnerships and networks for nutrition, identifying good practices and areas for improvement. In October 2016, the findings were published in *Nutrition Upstream*.[42]

The research findings provided important insights into what effective upstream work looks like. Across all countries, the work of governments and their development partners was catalyzed by growing global momentum, evidence and national data on nutrition. Specifically, the prevention of child stunting has become the driving force at the national level for multi-sectoral commitment to nutrition and is integrated within all major national policies and programmes. The research showed that governments and their nutrition partners have created multi-stakeholder partnerships, networks and platforms to accelerate progress for nutrition at the national level. The number of partner organizations engaging upstream decreases as the work changes from advocacy and policy influencing towards more detailed strategy development and support for programme scale-up.

The research revealed three key successes of UNICEF's upstream work. Firstly, national partners perceive UNICEF as the most influential partner. UNICEF supports governments while allowing them to take the lead, facilitating their commitments to globally agreed targets and evidence-based approaches to tackling malnutrition. Secondly, UNICEF is perceived as a strong coordinator and the main connector between government ministries and national and international partners. These bridge-building capacities make UNICEF an ideal partner for governments in developing multi-sectoral policies and strategies. Thirdly, the research showed that partners see UNICEF as a technical leader with access to the latest evidence. UNICEF effectively links global evidence and upstream guidance to national and subnational programme design and scale-up.

Two key challenges for UNICEF and recommendations for improvement were also noted in the research findings. Firstly, UNICEF country teams, which tend to be small in middle-income countries, are often perceived as 'stretching themselves too thin'. In these settings, UNICEF needs to be more strategic in prioritizing its work and focus on its strengths – situation analysis, technical advice, policy formulation, strategy development and capacity strengthening – to create and sustain large-scale change for maternal and child nutrition at the national level. Secondly, there are fewer partners and networks supporting programme scale-up than other aspects of upstream work, which has resulted in slow progress on some key indicators. To address this, UNICEF should use its influence to build stronger partnerships for programme scale-up with quality, while monitoring trends and progress for greater accountability.

Prior to this research, there had been limited evidence on how to make upstream engagement for nutrition more effective in low-and middle-income countries. This research therefore fills an important evidence gap and highlights the contribution that UNICEF can make to effective partnerships and networks for accelerating progress towards national and global nutrition goals.

Partnerships and the power of SUN

Collaboration and partnerships are key vehicles for accelerating progress on and investment in nutrition, and these are tracked as indicators in the Strategic Plan. In 2016, UNICEF remained the chair, coordination committee or board member of 14 global nutrition initiatives, the same number as in 2015 and well above the target of 10 (P4.f.2).[43]

UNICEF and the global nutrition community continued to unite around the SUN movement in 2016 to support nationally driven efforts to end malnutrition. Since its launch, the number of SUN countries has grown from 5 in 2010 to 57 countries and three Indian states in 2016. UNICEF's Executive Director continued to chair the SUN Movement Lead Group and the Chief of Nutrition served on the Steering Committee of the UN Network for SUN/REACH. In 2016, UNICEF contributed to the design of the SUN Movement 2.0 strategy and helped link global-level discussions to regional- and country-level actions.

Many countries are making progress on SUN with capacity development and technical support from UNICEF (*see box 'A snapshot of UNICEF's added value in supporting SUN in Kenya'*). Papua New Guinea became the 57th member of the SUN movement in April 2016, aided by sustained UNICEF advocacy, which also helped to secure an increase in budget re-allocations to nutrition interventions. UNICEF is also working with the Government of Papua New Guinea to develop a costed multi-sectoral Nutrition Strategic Action Plan 2017–2021, aligning with the National Nutrition Policy 2016–2026 as part of its commitment to support the country in its SUN roll-out.

Building the investment case for nutrition

With the world's attention turned to the 2030 Agenda, there has been greater recognition that investing in nutrition brings substantial economic and development gains. To improve public financing for nutrition, UNICEF advocates for greater national investments; offers guidance during the national budgeting process; supports governments to allocate public resources where the need is greatest; and pushes for monitoring and accountability.

A snapshot of UNICEF's added value in supporting SUN in Kenya

Kenya is one of the few countries in the world on target to achieve the World Health Assembly global nutrition targets by 2025. This progress has been driven in part by Kenya's commitment to scaling up nutrition since joining the SUN movement in 2012. With the Ministry of Health as SUN focal point, efforts to scale up nutrition in Kenya are coordinated by the Nutrition Inter-agency Coordination Committee and supported by the Nutrition Forum and a SUN secretariat.

UNICEF provides technical leadership to support Kenya's SUN priorities, including: (1) providing technical assistance to Government to lead and coordinate the initiative and to support the SUN secretariat; (2) supporting the secretariat to strengthen cross-sectoral coordination in addressing undernutrition at scale; (3) promoting adequate budget allocation for nutrition programming; and (4) improving financial tracking at the national level. This work supported concrete achievements in Kenya in 2016 against the SUN movement's four strategic objectives including:

1. Bringing people together: The six SUN Movement Networks developed a position paper to anchor nutrition governance at the highest levels, and this was integrated into the proposed Food and Nutrition Security Bill.

2. Development of coherent policies and legal frameworks: Nutrition is integrated into the Constitution and National Development Plan in Kenya. The Food Security and Nutrition Policy was passed and the Young Child Nutrition Strategy is being updated. Nutrition is integrated into the education and agricultural sectors, while the 2016 Health Bill makes it mandatory for employers to provide breastfeeding facilities. The 2016 Nutrition Advocacy, Communication, Social Mobilization Strategy ensures coordinated advocacy at the national and county levels.

3. Alignment around a common results framework: The National Nutrition Action Plan 2012–2016 has been rolled out and costed action plans have been finalized in 17 out of 47 counties, while 15 more action plans are underway. A comprehensive Multi-Sectoral National Nutrition Plan is being developed and a budget tracking exercise has led to joint activities with the education, agriculture and social protection sectors.

4. Financial tracking and resource mobilization: There have been increased investments in health and nutrition at both national and county levels and national human resource allocations have also increased.

To provide guidance to countries in influencing the national budgeting process, UNICEF's South Asia and East Asia and Pacific regional offices co-hosted a regional workshop on 'Public Finance for Nutrition in Asia' with the SUN movement secretariat in April 2016, gathering representatives from 18 different countries. The workshop was a continuation of a previous budget analysis workshop held in 2015 and aimed to accelerate efforts among Asian countries to report on nutrition budgets, to cost nutrition plans and to make the investment case for nutrition. Country delegations discussed methodologies to track budget allocations to nutrition and the costing of nutrition actions, and the use of investment case data to leverage additional resources for nutrition.[44] Representatives from 35 African countries also gathered for a workshop on public financing and managing results for better nutrition outcomes. The workshop provided guidance to governments on achieving greater impact from their budgetary investments in agriculture, education, health, social protection and WASH, and analysed the cost of meeting the WHA Global Nutrition targets by 2025.

A number of countries developed nutrition investment cases in 2016. In August 2016, the Nutrition Investment Case for Sudan was officially launched, including a costed advocacy tool developed by the Federal Ministry of Health, UNICEF and WFP that demonstrates the benefits of implementing an evidence-based package of multi-sectoral interventions at scale in terms of lives saved and cases of stunting and wasting averted. The tool's launch is a concrete foundation for multi-sectoral fundraising and demonstrates Sudan's strategic shift in focus on nutrition towards a multi-sectoral lens.

A child holds up a lunch tray she has washed after a nutritious school lunch in Muong Cha, Dien Bien, Viet Nam. UNICEF works with the local government to have lunches subsidized in the remote areas of Dien Bien.

Other countries are gathering evidence to support policy advocacy on nutrition investments. In India, UNICEF collaborated with the Centre for Budget and Governance Accountability, a national think tank, to generate evidence to influence public investments in nutrition at the sub-national level. A special journal issue on national nutrition budget tracking was released in March 2016, and four peer-reviewed working papers on sub-national nutrition budgets have been developed and will be disseminated in early 2017. These efforts to build political commitment and investment in nutrition have been successful. For example, in Nigeria, UNICEF partnered with the World Bank, the Bill & Melinda Gates Foundation and the Nigerian Senate on a high-level policy dialogue on nutrition, which concluded with a strong statement by the Senate for immediate action to allocate US$300 million (Naira 96 billion) for nutrition in the 2017 government budget. This demonstrates how upstream work to increase budgetary commitment to nutrition can lead to concrete increases in resources for nutrition programmes.

Mainstreaming gender into nutrition policy and programmes

National nutrition policies and plans should be gender-sensitive and use a rights-based approach to address inequalities. In 2016, UNICEF worked with governments to integrate gender and the rights of women and girls into nutrition policies and strategies. Globally, only 21 per cent (25 out of 121 countries) reported undertaking a gender review of the nutrition policy or strategy in the current national development plan cycle, with UNICEF support, from a baseline of 16 and towards a target of 40 (P4.e.2). However, there has been improvement on this indicator from 2015, when only 17 per cent (21 out of 122 countries) had undertaken such a gender review. Many reviews indicated the need for disaggregated data to measure results for girls and boys. Upon further reflection, the target for this indicator should be somewhat lower given that it can take countries up to five years to complete a national development plan cycle, and the nutrition policy would likely not be reviewed every year.

Nutrition interventions are central contributors to the empowerment of girls and women. Within countries, gender priorities are increasingly being integrated into nutrition programming. In Pakistan, for example, UNICEF defined gender-sensitive, evidence-based guidelines, strategies and costed communication plans. In 2016, UNICEF also completed gender reviews of WASH, nutrition and health programme areas in Pakistan, in line with the Gender Action Plan, and reviewed proposals, donor reports and theories of change for the next country programme through a gender lens. In the Central African Republic, UNICEF and the Government are targeting women's group leaders to recruit more female community health workers. As a result of this advocacy, the proportion of women community health workers increased from 15 per cent in the initial cohort to almost 20 per cent in subsequent cohorts in 2016. This increase has empowered women and improved the promotion of essential family practices, such as exclusive breastfeeding. (*See the cross-cutting chapter for additional country-level results related to gender-sensitive programming.*)

Better data to drive progress

UNICEF supports countries to invest in and improve routine health and nutrition information systems by providing technical guidance on indicators and building capacity among partners to collect and use programme data for decision-making. Increasingly, countries are collecting disaggregated nutrition data through national information systems, which is critical to evaluating whether key interventions are achieving equity. In 2016, 96 out of 121 countries reported national information management systems that disaggregate data on nutrition, compared with 93 out of 122 countries in 2015 (P4.e.1), and countries are progressing well towards the target of 100 countries by the end of the Strategic Plan period.

Spotlight on innovations: Real-time monitoring for results

In **northern Nigeria**, UNICEF is scaling up the use of RapidPro, an SMS-based tracking system that allows national nutrition partners to collect programme data in real time. Through an agreement with three of the four national mobile phone providers, all text messages are sent at no cost and the programme is now treating more than 400,000 children a year. Before the introduction of RapidPro, programme data took three weeks or longer to travel from the treatment site to the national level, resulting in the late detection of stock-outs. Now, data are sent from implementation sites directly to the national database and stock-out alerts are sent immediately to programme managers.

In **Sri Lanka**, a real-time monitoring surveillance system was piloted with smartphones with technical and financial support from UNICEF in three targeted districts in 2016. More than 10,175 nutritionally vulnerable children under 5 were registered by public health midwives in three targeted districts using the mobile application, enabling improved, real-time child nutrition assessments. The availability of timely and relevant data will contribute towards more evidence-based policies and equity-focused programming on nutrition at all administrative levels.

National efforts are under way in several countries to improve data monitoring and management, often with innovative solutions. In Sri Lanka, with technical and financial support from UNICEF, the National Nutrition Secretariat introduced a more comprehensive and multi-sectoral data management and monitoring system in nine underperforming districts under the multi-sectoral action plan on nutrition. In 2016, UNICEF successfully advocated establishing a real-time monitoring system using smartphones in Sri Lanka (*see box 'Spotlight on innovations: Real-time monitoring for results'*).

Good programme data improve implementation, and UNICEF's NutriDash platform is helping countries undertake programme performance monitoring and ensure quality. NutriDash supports equity-led programming by allowing for data disaggregation; however, many countries require further support to collect these data. To illustrate, only 19 out of 68 countries reporting admissions for SAM were able to report gender-disaggregated data, and only 10 countries reported gender-disaggregated performance indicator data (i.e., cure and default rates).

Monitoring and analysing trends and links between food security and nutrition status is critical in many countries, including Tajikistan, where UNICEF collaborated with WFP to integrate child health and nutrition modules into the Food Security Monitoring System. The last monitoring, conducted in May 2016, revealed that low dietary diversity and inadequate meal frequency remained a concern and had deteriorated since the last survey in 2015. UNICEF used these data to galvanize resources and action to address undernutrition among children in Tajikistan.

The launch of India's Comprehensive National Nutrition Survey in 2016 was a landmark achievement as the first nationally representative and comprehensive nutritional profiling of preschool children, school-age children and adolescents in the country. With UNICEF support, under the leadership and guidance of the Ministry of Health and Family Welfare, the survey was launched in all 30 states of India and data collection will be completed by early 2018. The survey will fill a critical gap in information about the nutritional status of school-age children and adolescents in India who have often been excluded from surveillance. The survey will also provide critical tracking of India's growing triple burden of malnutrition.

Expanding the global nutrition knowledge base

Through evidence generation, research and documentation, UNICEF continued to be a global knowledge leader in maternal and child nutrition. UNICEF's contribution to the global knowledge base for nutrition is well reflected by its publications in peer-reviewed journals throughout 2016. Since the start of the Strategic Plan, UNICEF has published 55 research papers annually across the sector, exceeding the target of 50 products per year (P4.f.1). These papers address diverse nutrition topics, including refugee nutrition; complementary feeding for HIV-exposed infants; food supplements; and environmental predicators of stunting. At the regional level, UNICEF's Stop Stunting in South Asia initiative generated an exceptional amount of knowledge on maternal and child health in the region throughout 2016 (*see box 'Case study: Stop stunting – knowledge leadership to drive results for children'*).

Challenges, reflections and future direction

There is an increasing demand for UNICEF's technical support and guidance in developing multi-sectoral policies, strategies and programmes for countries. UNICEF is the ideal agency to provide such support, and synergies between sectors are improving results for the most vulnerable children and their families. UNICEF therefore values the support of donor partners who strategically invest in multi-sectoral approaches; for example, the Government of the Netherlands has supported the scaling up of multi-sectoral packages of interventions in four countries in sub-Saharan Africa, as well as investing at regional and global levels to support capacity development, monitoring and evaluation, knowledge management and partnerships.

Since the launch of the Strategic Plan, UNICEF has remained a knowledge leader in maternal and child nutrition, and this is evidenced through its work in developing the Stop Stunting knowledge base, as well as in its growing body of published research, which has already exceeded target. The challenge now is for UNICEF to improve its 'implementation science' by better documenting examples of good programming in all regions.

There are increasing demands for UNICEF to take on multiple roles in the nutrition sphere. The sector will have to develop strategies to ensure that it can fulfil its goals and continue to deliver results for children, while adapting and taking on new responsibilities. Having access to flexible revenue streams would help UNICEF tailor its strategies and interventions to places of greatest need and potential impact. It would also allow UNICEF to develop new areas of programming and innovation, implement strategic long-term planning in different country contexts, invest in systems strengthening and strengthen cross-sectoral convergence.

Case study: Stop stunting – knowledge leadership to drive results for children

UNICEF places the 1,000-day window of opportunity – from pregnancy to a child's second birthday – at the centre of its programming. In South Asia, UNICEF is working with regional bodies, governments, development partners, research and academic institutions, civil society organizations and the media to reduce the number of stunted children aged 0–59 months by 12 million between 2014 and 2017, with emphasis on greater equity for greater impact.

The landmark Stop Stunting regional conference, held in 2014, provided a knowledge-for-action platform where state-of-the-art evidence, better practices and innovations were shared to accelerate policies, programmes and research in nutrition and sanitation to reduce the prevalence of child stunting in South Asia. Based on the research presented during the conference, a special issue of the international journal *Maternal and Child Nutrition* entitled 'Stop Stunting in South Asia' was published in May 2016. This open-access issue of 14 original articles and six commentaries from more than 60 authors belonging to 25 organizations covered the rationale for a focus on improving child feeding, women's nutrition and household sanitation as priority areas for investment to prevent child stunting and enhance cognitive capital in the region.[45]

The special issue was launched with global experts at an advocacy event in New Delhi in May 2016 with the aim of positioning child stunting as a major development issue in South Asia and highlighting the cost of stunting to children and nations in the region. The event involved a panel discussion with media and nutrition experts and a photo exhibition, and garnered wide media coverage, particularly in India, where stunting affects 39 per cent of children. The accompanying social media campaign reached more than 1.5 million online audiences within a few weeks.

Ongoing partnerships with six universities are under way to further examine the links between stunting and brain development, and to explore the epidemiology of stunting, wasting, anaemia and feeding practices in South Asia. These partnerships are expected to deliver a series of analytical reports that will inform the policy and programmatic work by UNICEF and its regional partners throughout the SDG era.

NUTRITION: CROSS-CUTTING PROGRAMME AREAS

A number of cross-cutting programme areas support the work of the nutrition programme, including gender; humanitarian assistance;[46] Communication for Development (C4D); ECD; adolescent development and participation; and disability. The sections that follow provide an overview of UNICEF's global approaches to these cross-cutting issues and their integration throughout nutrition programming, followed by country-level examples.

Gender and nutrition

Nutrition strategies are often assumed to be inherently gender-sensitive because they directly address the needs of women and girls; for example, through targeted supplementation programmes to prevent anaemia. While addressing these practical needs is vital, nutrition programming must also consider how gender entrenches unequal power relations within households and community structures, many of which are deeply connected to care and feeding practices. For this reason, UNICEF has put an increasing emphasis on engaging fathers and other male actors in individual and group counselling on IYCF practices.

Gender is a particularly salient theme in UNICEF's work on adolescent nutrition. In 2016, UNICEF conducted a comprehensive review of evidence on adolescent nutrition in South Asia, identifying gender-related areas of urgent action: strengthening the evidence base on the nutrition situation of adolescents; delaying the age of marriage and pregnancy to maximize girls' potential for catch-up growth; ensuring that nutrition programmes address the nutritional needs of pregnant adolescent girls (e.g., via micronutrient supplementation); and, designing and scaling up multi-sectoral national nutrition policies and programmes to reach adolescent girls and boys.

UNICEF supports iron-folic acid supplementation programmes for women and adolescent girls, who are particularly susceptible to iron-deficiency anaemia – a condition that can hold them back from accessing their rights and participating fully in their societies (*see programme area 2 for further details*). Within countries, a gender lens is increasingly being used in nutrition programming. In 2016, UNICEF Pakistan completed a gender review of the nutrition programme area, in line with the Gender Action Plan, and reviewed proposals, donor reports and theories of change for the next country programme.

Communication for Development and nutrition

Within nutrition, C4D works to understand the impact of beliefs, values and norms on the feeding practices of children and their families and translates this understanding into interactive communication with target populations. In 2016, UNICEF headquarters, the Regional Office for Eastern and Southern Africa and selected country offices collaborated to produce a C4D package focused on maternal, neonatal and child health and nutrition. The package provides C4D professionals and other staff with access to a relevant, standard set of tools and technically accurate messages that can be used to engage with local communities, health workers and social mobilizers. These materials can be adapted by country offices according to the context.

UNICEF has implemented a number of C4D and nutrition initiatives in Latin America, including a regional C4D multiplatform initiative launched in Mexico in 2016 to improve the health and nutrition of children aged 3–6 years. The initiative, a collaboration between Sesame Street and UNICEF, has already reached more than 1 million children through a child-friendly television series with national coverage. UNICEF is also piloting a C4D initiative with the company Yakult to improve health and nutrition habits among children and their families. Focus groups and surveys were conducted in 2016, and in 2017, home promoters will deliver recipes as well as health and nutrition tips to 140,000 children and families across Guadalajara and Mexico City.

As part of a C4D collaboration in Kenya, UNICEF developed multi-sectoral manuals used by 10,500 newly recruited and trained community health volunteers who provide health, nutrition, HIV and WASH services in 11 counties. C4D can also be an effective strategy for encouraging care seeking for malnutrition, such as in Malawi, where a C4D approach enhanced uptake and increased demand for SAM services: Admissions increased from more than 30,400 children in 2015 to more than 49,000 children in 2016.

Early childhood development and nutrition

Nutrition is a vital contributor to ECD outcomes. Evidence suggests that interventions that promote stimulation, responsive feeding and good nutrition together have enduring cognitive benefits for children that are greater than when these same interventions are provided alone.[47] While the traditional focus of ECD has been 3–5 years of age, there is a need to expand approaches to better include the ages of 0–2, when the impact of good nutrition is most salient in driving child development.

UNICEF's support to countries in achieving the SDG targets is an opportunity for greater synergy between ECD and nutrition across the development trajectory. This is already happening as part of the scale-up of the care for child development approach, which takes the element of nurturing care through an evidence-based package for community health workers. Nutrition and ECD programming together provides better support for caregivers and better returns on breastfeeding and nutrition because caregivers are more able to engage. UNICEF's advocacy for improved maternity leave policies can also be better linked to the ECD agenda given the benefits of parental bonding during this key development period. The UNICEF IYCF counselling package already includes some ECD elements, which can be adapted to the country context. South Sudan, for example, has integrated child play and stimulation into the IYCF counselling package, with training provided through mother support groups.

The ECD programme in Mali (2014–2016) aimed to improve quality of care, including communication and play, for malnourished and non-malnourished children aged 0–5 years through psychosocial stimulation. The project is implemented through community-based health centres (both inpatient and outpatient) and community-based preschool centres, as well as implementing partners including NGOs and community networks. The percentage of mothers providing support for learning increased from 29 per cent in 2010, at baseline, to 55 per cent in 2016, while the availability of more than two toys in the home improved from 40 per cent to 52 per cent during the same period. By the end of 2016, 17,100 young children had benefited from ECD services and opportunities to foster their growth and development, while more than 34,200 parents strengthened their capacity to provide better quality child care. Key challenges included the timing and ownership of the new approach and limited opportunities for scale-up due to insufficient funds. Next steps include programme scale-up at national level, training across the country to reach as many health officers as possible, and the integration of ECD within the national protocol for the integrated management of childhood malnutrition.

Adolescent development and participation within nutrition

Poor adolescent nutrition underpins the high burden of child malnutrition in many countries. In Indonesia, for example, where 25 per cent of girls marry before they are 18 and give birth before age 20, undernutrition in adolescent girls is a major determinant of low birthweight and stunting in babies, as well as a risk factor for complications during childbirth.[48] At the same time, poor nutrition diminishes the health, welfare and human rights of adolescents themselves; it prevents adolescents from exercising their rights, exacerbates gender inequalities, and hampers their ability to participate in and contribute fully to their societies.

Nutrition in the second decade of life is an emerging area of work for UNICEF. In particular, there is growing recognition that a holistic and rights-based approach to maternal and adolescent girls' health and nutrition is essential, and many countries are working towards developing integrated health, nutrition and education policies and programmes for adolescent girls. In Bangladesh, UNICEF contributed to a national review consultation on key nutrition issues among adolescents, which identified strategic actions and identified new delivery platforms. These results were integrated into the National Adolescent Health Strategy. In addition, countries are increasingly targeting interventions around UNICEF-supported iron-folic acid supplementation programmes for women of reproductive age towards adolescent girls (*see examples in programme area 2*).

Adolescent nutrition is a new focus area in Indonesia, and UNICEF has examined gender bottlenecks and barriers that impact the nutritional status of both boys and girls and household decision-making and access to health services. The research will inform the development of an adolescent nutrition programme to reach 50,000 adolescent girls and boys and contribute to addressing identified barriers. In Malawi, UNICEF and partners reached nearly 2,400 adolescent girls in 81 schools in 2016 with life skills education and interventions to improve nutritional status, reduce HIV transmission and prevent gender-based violence. Teachers reported improved attendance and academic performance among girls. In order to operationalize the programme and advocacy work for adolescent girls, UNICEF Ethiopia developed an Adolescent Girls' Strategy (2016–2020) and results framework with high-impact and evidence-based interventions identified across all programmes.

Disability and nutrition

Nutrition programmes and services can provide opportunities for addressing or mitigating the risk of disability throughout the lifecycle.[49] Historically, nutrition programming has focused almost exclusively on these protective benefits. For example, iron-folic acid supplementation prevents birth defects and vitamin A supplementation protects children from loss of sight due to vitamin A deficiency. Yet the link between nutrition and disability goes much deeper than this. Well-nourished children of all abilities are better placed to participate in and contribute to their communities, and UNICEF's rights-based approach aims to make good nutrition a right enjoyed by all children. To achieve this, nutrition services and programmes must be accessible to all children, including those with disabilities or those with caregivers who have disabilities. Children with disabilities may also require special feeding methods, adapted food, additional time to eat, or specific nutritional requirements that are tailored to meet their individual needs. In this way, nutrition programming has great potential to improve the health and well-being of all children, including those with disabilities.

UNICEF is developing and has contributed to a number of guidance documents that include nutrition interventions that are inclusive of and accessible to children with disabilities. In 2016, UNICEF, in partnership with Handicap International, developed a guidance document on children with disabilities in humanitarian action, which will be launched in 2017. In 2016, UNICEF contributed to the development of WHO global guidance on IYCF and Zika. The guidance includes two main recommendations: (1) infants born to mothers with Zika virus infection, or who live in or have travelled to areas with Zika virus transmission, can be breastfed in line with infant feeding guidelines and (2) some children with congenital anomalies such as microcephaly may have feeding difficulties, and their mothers and families should be provided with specific support and counselling for feeding, including breastfeeding.[50]

Within countries, UNICEF programming is responding to the barriers facing children with disabilities. In the Philippines, UNICEF worked with the national health insurance programme on a comprehensive benefit package for children with disabilities. The package is for 4 million children with disabilities and includes rehabilitative therapy and occupational therapy to optimize activities of daily living, including child feeding.

FINANCIAL ANALYSIS

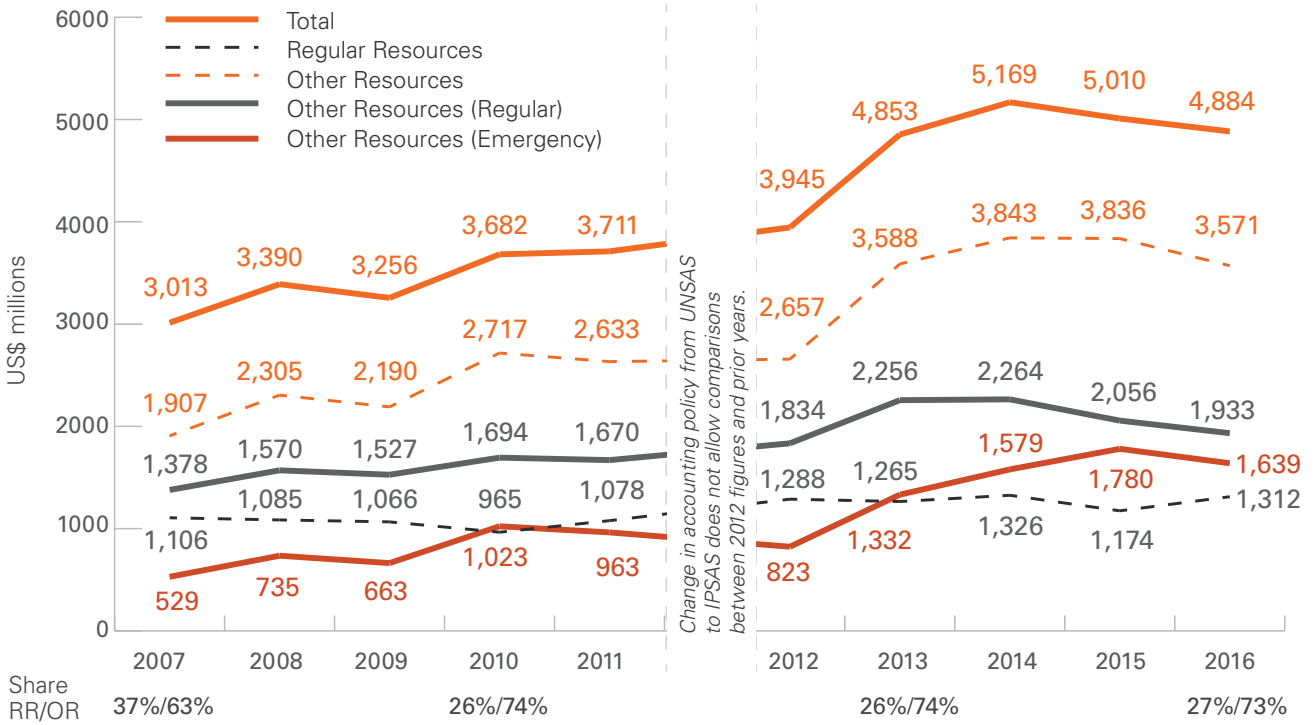
The 2030 Agenda for Sustainable Development envisions a world that invests in its children, and nutrition is one of the smartest investments to be made in improving global welfare. Nutrition interventions are among the most cost-beneficial in global development – with every dollar invested bringing about US$16 in returns in productivity gains.[51]

Financial resources and commitment from partners are fundamental to achieving the SDG agenda and its goals. For UNICEF, the agenda also highlights the increasing importance and volatility of its flexible funding models (*see box, below*). In 2016, UNICEF received US$3.4 million in thematic contributions for its nutrition programme – a sharp drop of about two thirds from the preceding year, and comprising only 1 per cent of total resources earmarked for nutrition. This gave UNICEF little programmatic flexibility, hampering its ability to react strategically to reach children, adolescents and mothers with nutrition interventions and, ultimately, to influence nutrition outcomes.

Partners can contribute to UNICEF through different modalities: regular resources, other resources (non-thematic and thematic), emergency funding and appeals, and pooled funding and trust funds. Regular resources are core resources that provide the greatest degree of flexibility of all UNICEF's funding models. These resources are un-earmarked and unrestricted funds allocated to deliver programmes endorsed by the Executive Board, and play a vital role in maintaining programme continuity in inequitable and fragile contexts, as well as building preparedness and resilience to future shocks. Of the US$4.9 billion UNICEF received in 2016, US$1.3 billion (27 per cent) was regular resources (*see Figure 10*). This 12 per cent increase from 2015 was due to growth in contributions from individual giving (US$629 million compared with US$530 million in 2015), as well as a sizeable one-time increase from the Government of Sweden, which contributed US$117 million – 87 per cent more than the previous year. This was second only to the Government of the United States, which contributed US$132.5 million.

FIGURE 10

Regular resources share by resource category, 2007–2016



* All revenue data as of 3 April 2017.

Other resources – contributions made by donors earmarked to a specific programme or thematic area, including multi-year funding – decreased by 7 per cent, from US$3.8 billion in 2015 to US$3.6 billion in 2016. Contributions to the nine thematic funding pools dropped to US$326 million, a 16 per cent decrease from the previous year. Of the thematic funding pools, funds softly earmarked for humanitarian action against appeals were US$145.4 million, a 29 per cent decrease from 2015, despite growing humanitarian needs (*see Figure 11*). These flexible thematic resources only accounted for a small proportion – 9 per cent – of total other resources.

Thematic resources are the second-most flexible funding mechanism and a vital complement to regular resources, often used to address inequities that the allocation of regular resources is unable to address. Thematic funding allows UNICEF to engage more effectively by facilitating longer-term planning, sustainability and savings in transaction costs, leaving greater resources for programmes. Thematic funding is also used to build the capacities of countries, partners and UNICEF to mitigate the impact of, and respond to, current and future emergencies, bridging development and humanitarian work.

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

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

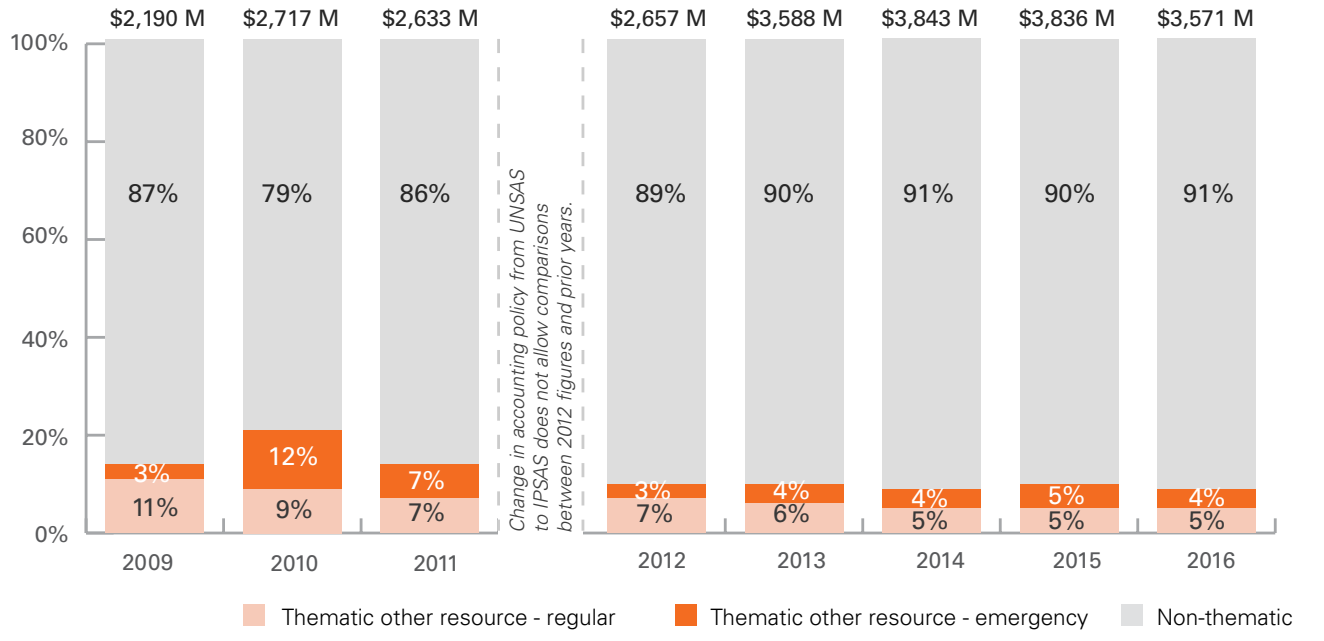
Other resources – regular: Funds for specific, non-emergency programme purposes and strategic priorities.

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

Other resources – thematic: see box: '*The value of thematic funding*'

FIGURE 11

Other resources revenue, 2009–2016: Thematic versus non-thematic (US$)



Resources for nutrition

In 2016, UNICEF received US$240 million in other resources dedicated to nutrition, a 52 per cent increase from the previous year. The majority of the largest contributions were earmarked for programmes in fragile contexts. The top five resource partners in this area of UNICEF's work were the United Kingdom, the European Commission, the United States of America, the Central Emergency Response Fund (United Nations) and the Joint Programmes managed by UNICEF as an Administrative Agent (*see Table 1*). Support for major programmes included: the United Kingdom's contribution for integrated programming in Yemen and for reducing undernutrition in Ethiopia; support from the Joint Programmes managed by UNICEF - on Health and Nutrition in Somalia; and the European Commission's contribution to nutrition response for the Sahel (*see Table 2*).

TABLE 1

Top 20 resource partners to nutrition (other resources), 2016*

Rank	Resource partners	Total (US$)
1	The United Kingdom	65,392,968
2	European Commission	48,483,488
3	United States of America	32,663,016
4	Central Emergency Response Fund (UN)	24,173,202
5	Joint Programmes managed by UNICEF as an Administrative Agent**	17,690,319
6	United Kingdom Committee for UNICEF	14,025,035
7	Germany	12,947,996
8	Netherlands	9,079,393
9	Country-Based Pooled Funds (CBPFs) ***	5,901,085
10	Ireland	5,703,891
11	Canada	5,375,718
12	United States Fund for UNICEF	4,727,973
13	Republic of Korea	3,328,223
14	One UN Fund ****	3,123,557
15	WFP	1,826,324
16	Spanish Committee for UNICEF	1,250,578
17	Swiss Committee for UNICEF	1,175,829
18	German Committee for UNICEF	1,089,562
19	Australian Committee for UNICEF	1,066,217
20	France	961,657

** Figures include financial adjustments.*

*** Cross-sectoral fund for health and nutrition (SC120327)..*

**** Country-Based Pooled Funds (CBPFs): CBPFs are multi-donor humanitarian financing instruments established by the Emergency Relief Coordinator. They are managed by United Nations Office for the Coordination of Humanitarian Affairs at the country level under the leadership of the Humanitarian Coordinator. Donor contributions to each CBPF are un-earmarked and allocated by the Humanitarian Coordinator through an in-country consultative process. As of 2016, CBPFs operate in 18 countries.*

***** Includes cross-sectoral fund for nutrition and social inclusion (SC120390).*

TABLE 2

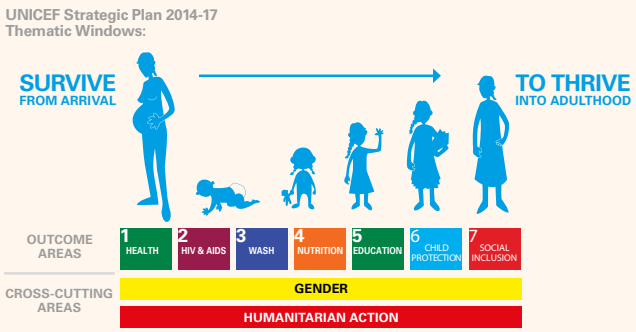
Top 10 contributions to nutrition, 2016*

Rank	Resource partners	Grant Description	Total (US$)
1	The United Kingdom	Integrated Programme to Address Malnutrition, 2016-2018, Yemen	20,750,574
2	Joint Programmes managed by UNICEF as an Administrative Agent	Joint Health and Nutrition Programme, Somalia**	17,690,319
3	The United Kingdom	Accelerating Reduction in Under Nutrition, Ethiopia	15,244,457
4	European Commission	Sahel Nutrition Response 2016	13,795,377
5	Germany	Support to Malnourished Children and the Drought-Affected Population, Ethiopia	10,954,127
6	The United Kingdom	Integrated Basic Nutrition Response to the Humanitarian Crisis, Nigeria	7,648,513
7	European Commission	Nutrition, Nepal	6,066,036
8	The United Kingdom	Health Development Fund (Pooled Fund), Zimbabwe	5,610,781
9	United Kingdom Committee for UNICEF	Community Management of Acute Malnutrition (CIFF 6%), Nigeria	5,551,500
10	European Commission	Nutrition, Kenya	5,267,152

** Figures include financial adjustments.*

*** Cross-sectoral fund for health and nutrition (SC120327).*

The value of thematic funding



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

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

Despite the important increase in earmarked revenue for nutrition programmes in 2016, thematic contributions to nutrition saw a steep decline in 2016. As discussed earlier in this section, UNICEF received US$3.4 million in thematic contributions for nutrition, a 67 per cent decrease compared with 2015 (*see Figure 12*) and the lowest share of thematic contributions across all UNICEF outcome areas (*see Figure 13*). Thematic contributions represented only 1 per cent of total resources earmarked to nutrition in 2016 – a matter of grave concern, as it gave UNICEF little programmatic flexibility and introduced a heavy reporting burden to meet the specific needs of multiple partners.

Global thematic funds remain the most flexible source of funding to UNICEF after regular resources. Of these thematic resources for nutrition, US$1.6 million (47 per cent) was given most flexibly as global thematic funding (*see Figure 14*). The allocation and spending of thematic contributions can be monitored on UNICEF's transparency portal, open.unicef.org; the results achieved with these funds against Executive Board-approved targets and indicators at the country, regional and global levels are consolidated and reported

FIGURE 12

Nutrition other resources funding trend, 2014–2016

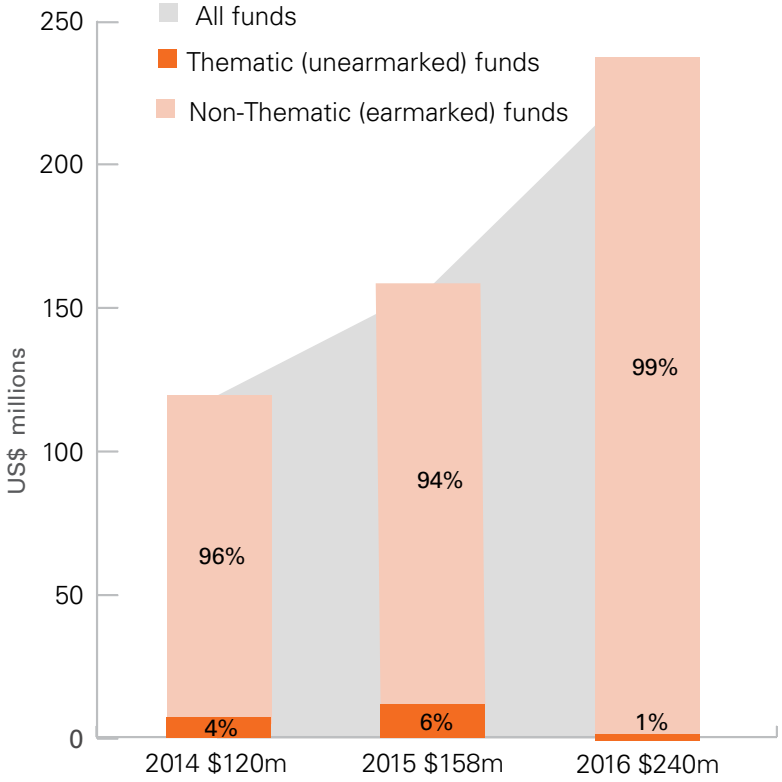


FIGURE 13

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

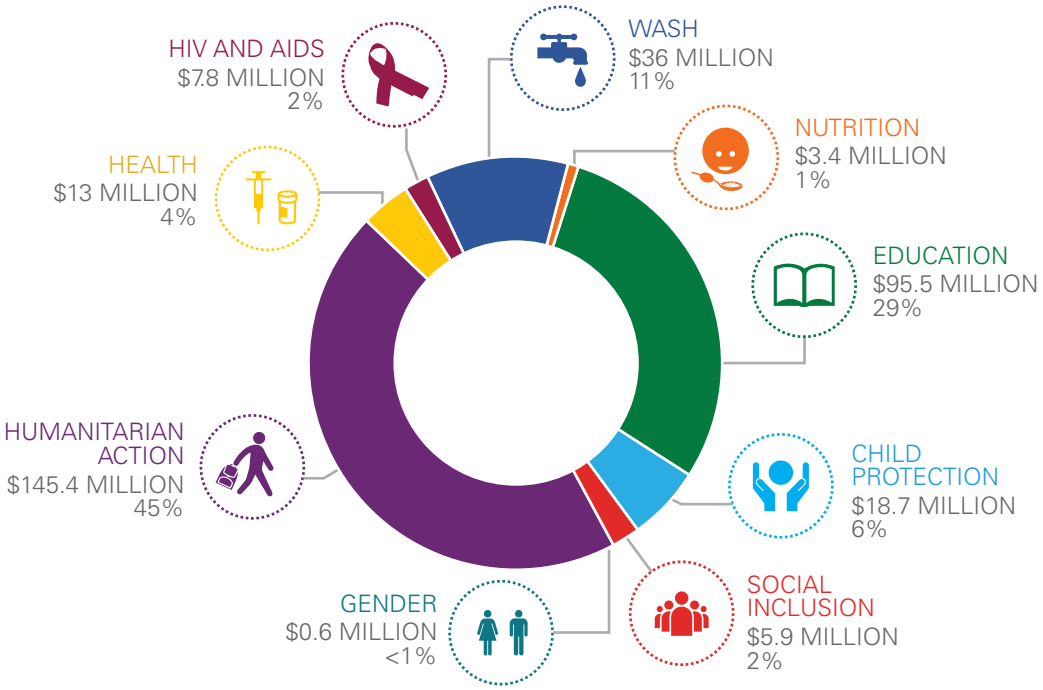
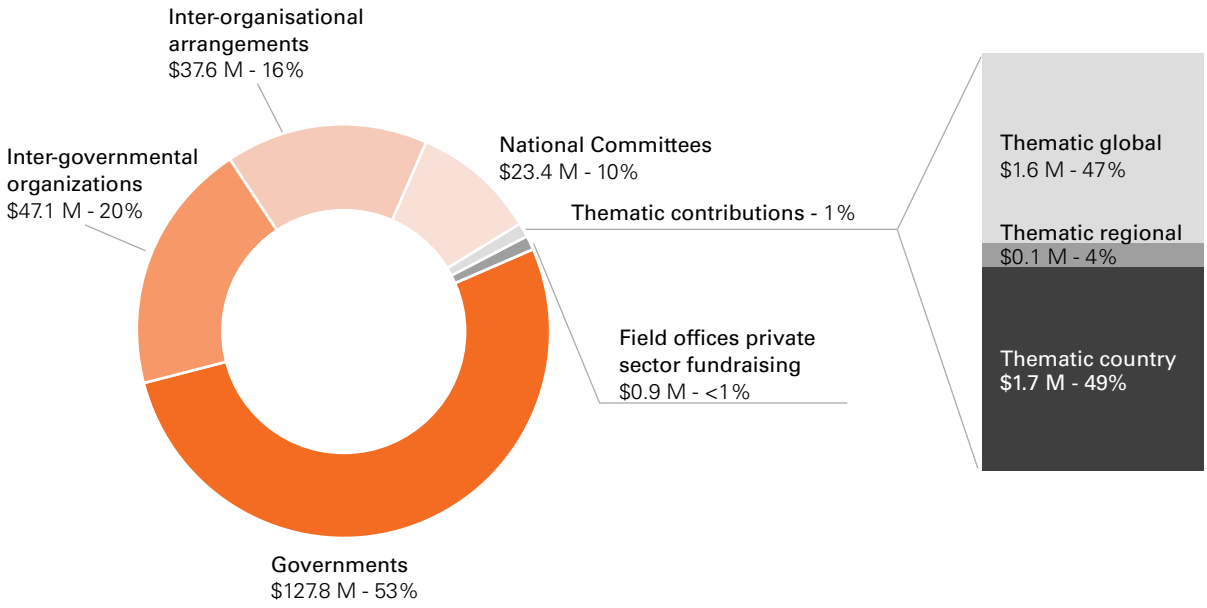


FIGURE 14

Other resources by funding modality and partner group, nutrition, 2016: US$240 million*



**Figures include financial adjustments.*

on across the suite of Annual Results Reports. Specific reporting for country and regional thematic contributions are provided separately for partners providing flexible multi-year thematic funding at those levels.

Proportionate to the decrease in the thematic funding, the number of thematic donors to nutrition also decreased substantially between 2015 and 2016, dropping from 15 donors to 10. About three quarters of thematic funding was raised by UNICEF's National Committees, most significantly from the Spanish Committee for UNICEF, whose contributions were largely un-earmarked, global thematic funding, followed by the United Kingdom Committee for UNICEF, which earmarked its contributions to Malawi and Papua New Guinea, and the Dutch Committee for UNICEF, which contributed specifically to Madagascar and Mozambique. The remaining 27 per cent of thematic contributions received for nutrition came from the Government of Luxembourg, at the global thematic level, and the Government of Sweden, earmarked for the Plurinational State of Bolivia (*see Table 3*).

TABLE 3

Thematic revenue to nutrition by resource partner, 2016*

Resource Partner type	Resource partners	Total (US$)	Percentage
Governments 27%	Luxembourg *(SC1499040017)*	661,376	19.48%
	Sweden *(SC1499040009)*	246,031	7.25%
National Committees 73%	Spanish Committee for UNICEF *(SC1499040047, SC1499040064)*	919,602	27.08%
	United Kingdom Committee for UNICEF *(SC1499040053, SC1499040061)*	578,590	17.04%
	Dutch Committee for UNICEF *(SC1499040031, SC1499040049)*	476,188	14.02%
	United States Fund for UNICEF *(SC1499040041, SC1499040057, SC1499040063, SC1499040067)*	224,631	6.62%
	Polish Committee for UNICEF *(SC1499040066)*	140,417	4.14%
	Slovak Committee for UNICEF *(SC1499040059, SC1499040060)*	120,884	3.56%
	Belgian Committee for UNICEF *(SC1499040020, SC1499040065)*	14,862	0.44%
	Danish Committee for UNICEF *(SC1499040062)*	12,949	0.38%
Grand Total		**3,395,528**	100.00%

** Figures include financial adjustments.*

Grant numbers are provided for International Aid Transparency Initiative compliance.

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

Expenses for nutrition

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

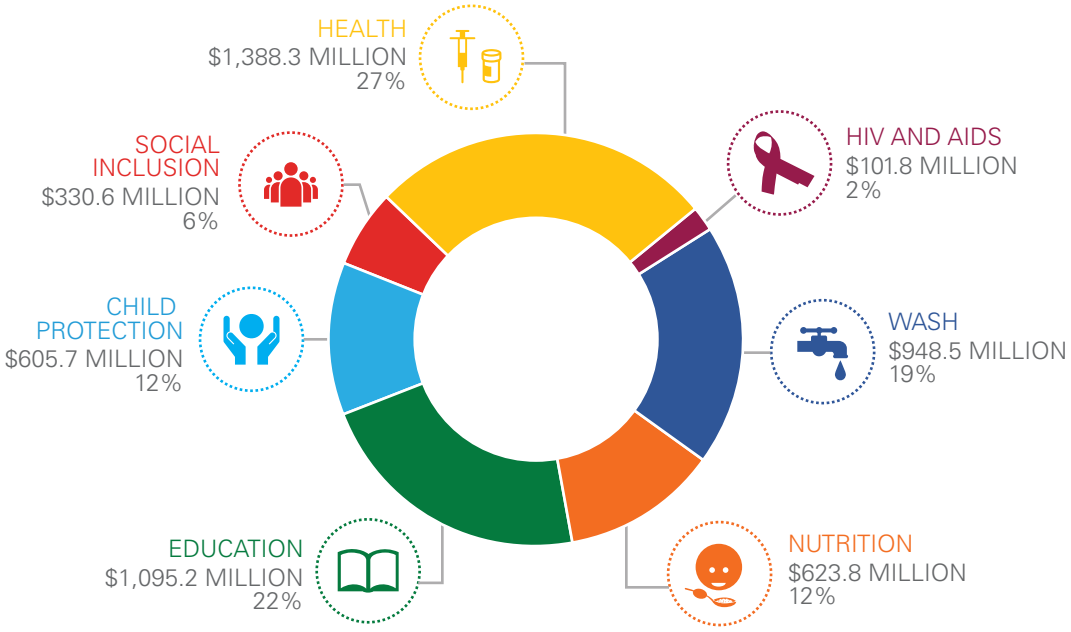
Overall nutrition spending increased to US$624 million in 2016 (*see Figure 15*), from US$603 million the previous year. In particular, resources earmarked for emergencies (other resources – emergency) have increased with each year of the Strategic Plan, and this has been essential given the increasing scale and scope of humanitarian need (*see Figure 16*).

Expenses versus expenditure

Expenses are recorded according to *International Public Sector Accounting Standards* and are accrual-based. These are used for official financial reporting. Expenditures are recorded on a modified cash basis. They are used for budget reporting since they are aligned with cash disbursements and goods receipts (the way budgets are consumed).

FIGURE 15

Expense by outcome area, gender equality and humanitarian action, 2016: US$5,094 million



In 2016, programme area 3 (nutrition in emergencies and the treatment of severe acute malnutrition) accounted for the greatest nutrition programme expenses – US$232 million – followed closely by programme area 4 (general nutrition). This spending pattern is understandable given the multitude of emergencies in 2016 and the ongoing high burden of SAM globally. Spending in this area helps UNICEF ensure timely and effective response to nutrition emergencies and also fulfil its Nutrition Cluster role. At the same time, there is a need to sustain and increase resources for preventive nutrition interventions – most of those covered in programme areas 2 and 3 – in order to break the cycle of undernutrition before it starts.

As was the case in previous years, most nutrition spending in 2016 supported programming in Eastern and Southern Africa and West and Central Africa (*see Figure 17*). This reflects the high burden of undernutrition in these regions, as well as the humanitarian crises facing many of these countries in 2016, including as ongoing drought in the Sahel and in Eastern Africa, which required strong emergency nutrition responses. Flexible funding for nutrition would allow UNICEF to further improve its work on prevention and emergency preparedness in these regions.

FIGURE 16

Expenses trend for nutrition, 2014–2016

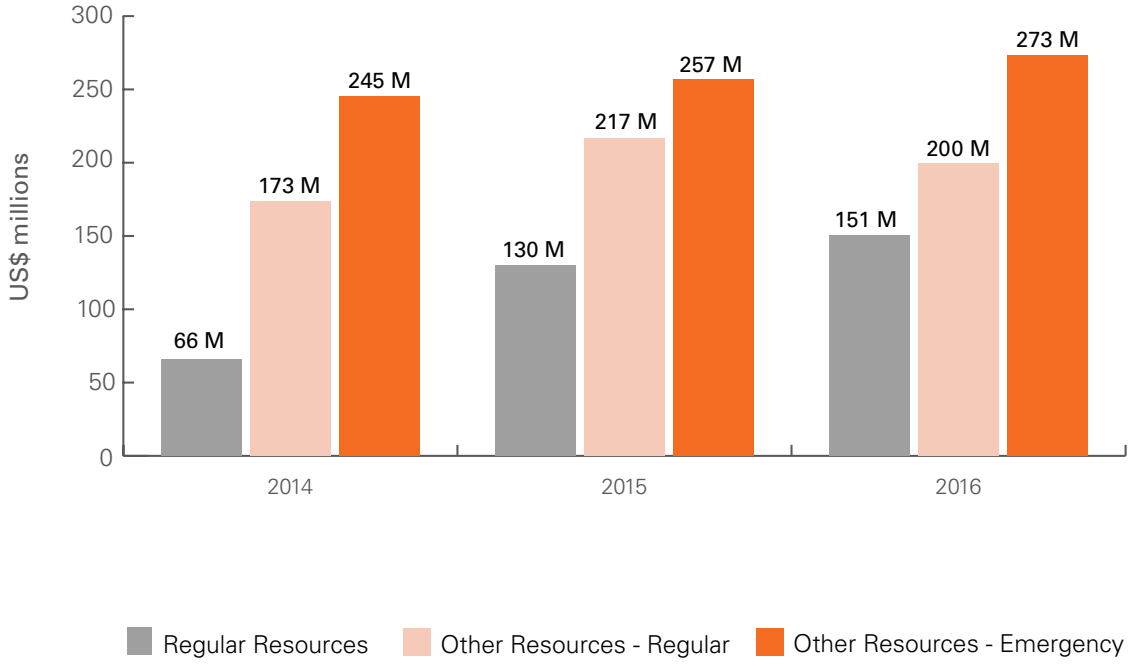


FIGURE 17

Expenses by region and funding source for nutrition, 2016: US$624 million

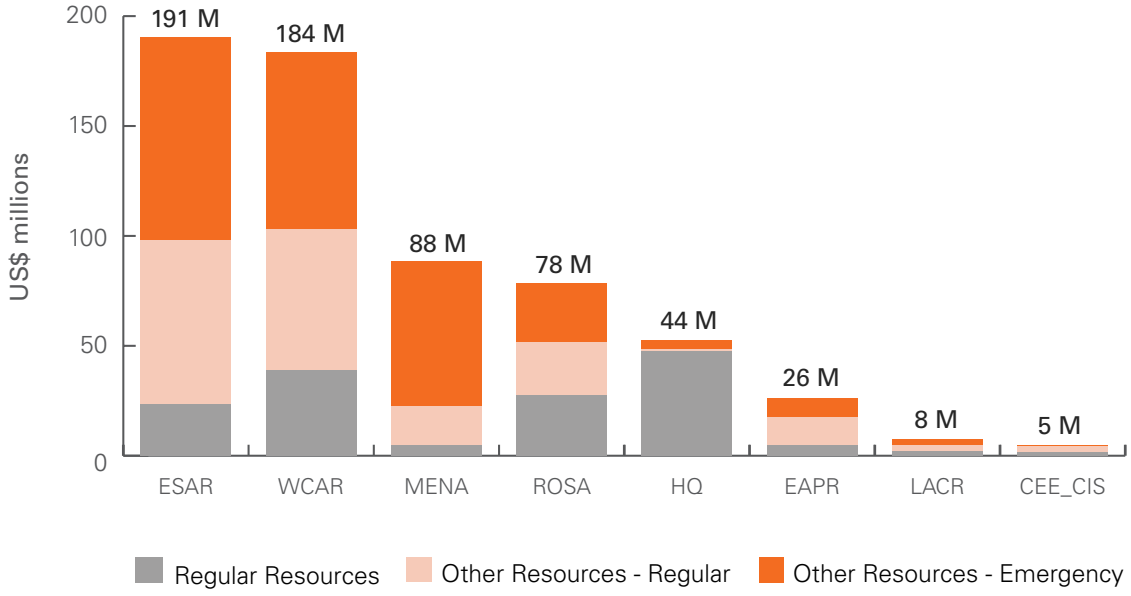


Table 4 shows the 15 countries where the most money was spent on nutrition in 2016; these countries accounted for almost 60 per cent of all nutrition expenses. The nutrition spending in these countries makes sense given that 12 of them have either a stunting prevalence greater than or equal to 40 per cent or a wasting prevalence greater than or equal to 10 per cent. Many of these countries faced humanitarian crises in 2016 related to conflict, natural disasters, disease outbreaks and El Niño-induced drought, and thus significant funds were allocated to support emergency nutrition response.

TABLE 4

Expenses for nutrition by top 15 countries, 2016

Country	Total (US$)
Ethiopia	49,785,499
Nigeria	45,891,283
Yemen	42,101,080
South Sudan	32,727,204
Niger, the	25,385,558
Sudan, the	25,007,475
Somalia	23,013,349
India	18,895,984
Afghanistan	18,827,141
Pakistan	17,157,757
Democratic Republic of Congo	16,669,387
Mali	15,965,858
Nepal	15,129,981
Kenya	14,974,255
Malawi	11,778,184

As in previous years, the majority of expenses in the nutrition sector supported the procurement of supplies (*see Table 5*), including ready-to-use therapeutic foods and therapeutic milks, vitamin A capsules, micronutrient powders and tools used in growth monitoring, such as height boards and scales. UNICEF remains the main procurer of ready-to-use therapeutic foods, procuring to fill about 80 per cent of global needs.

In 2016, significant investments were made through counterparts and implementing partners to support them in delivering and implementing high-impact nutrition interventions. UNICEF's strategic partnerships allow the organization to target funds effectively and efficiently to ensure wide coverage of interventions, especially in fragile settings where national systems may be weak. The nutrition sector spends comparatively less on staff and personnel and would benefit from the ability to further strengthen human resources capacity to respond to new demands, including through the use of global-level emergency surge systems with additional roving personnel.

TABLE 5

Expenses for nutrition by cost category, 2016

Cost category	Total (US$)
Supplies and commodities	232,985,554
Transfers and grants to counterparts	169,884,355
Contractual services	79,044,006
Staff and other personnel costs	71,290,848
Incremental indirect cost	29,575,499
General operating and other direct costs	27,079,411
Travel	10,773,794
Equipment, vehicles and furniture	3,155,511

Investing in nutrition brings significant gains for the development of children and nations. Greater thematic resources for nutrition would allow UNICEF to more efficiently improve long-term planning, increase internal capacity, strengthen knowledge and evidence generation, and react with flexibility to ongoing challenges and new areas of work. In its cases for support,[52] UNICEF estimates that the funding gap for nutrition for 2017, the last year of the current Strategic Plan, will be US$337 million. There is still a long way to go to harness these resources, and UNICEF looks forward to working with its partners to meet these funding needs to fulfil shared commitments and results towards the 2030 Agenda.

FUTURE WORKPLAN

As the world embarks on the SDG era, UNICEF's vast country presence and multi-sectoral approach make it well placed to advance progress on global nutrition targets. At the same time, progress in nutrition will lay the foundations for the achievement of many other SDGs.

Three years into its 2014–2017 Strategic Plan, UNICEF has made substantial progress towards Outcome 4: *improved and equitable use of nutrition support and improved nutrition and care practices*. Many countries have seen an increase in rates of exclusive breastfeeding and better IYCF counselling and support for caregivers, while others have improved coverage of key micronutrient interventions such as vitamin A and iodized salt. Moreover, many countries are scaling up SAM management, improving treatment coverage and quality, and addressing bottlenecks – both in humanitarian and development contexts. Despite many large-scale emergency situations in 2016, UNICEF continued to lead and coordinate rapid and effective nutrition response in fragile settings for some of the most vulnerable women and children.

In the final year of the Strategic Plan, UNICEF will prioritize several key strategic areas: improving complementary feeding practices, scaling up the treatment of severe acute malnutrition to treat more children in need, scaling up nutrition programmes for adolescent girls, and strengthening collaboration across sectors.

To improve complementary feeding, UNICEF will support more countries in programme scale up throughout 2017, including by updating the IYCF community counselling package and by developing guidance on home fortification in various settings. The No Wasted Lives coalition will be a galvanizing force in harnessing greater resources and expanding the reach of SAM treatment to more effectively address the immense global burden. Integrated programming across sectors, particularly WASH, health, and ECD, will continue to be critical in achieving these objectives.

Flexible funds are needed more urgently than ever to tackle these priorities and to be effective in influencing the 2030 Agenda, while responding to an increasing number of emergencies around the globe. In 2016, thematic contributions declined to US$3.4 million and accounted for only 1 per cent of total nutrition revenue. Increased thematic funding streams would help UNICEF respond in a more complex and dynamic programming environment while driving results at country level. Flexible funding will help support investments in the prevention of undernutrition, improved systems strengthening to support long-term sustainability, risk-informed programming and resilience building in countries. This will be particularly important because the number and scale of emergencies is expected to increase in 2017 and beyond.

Planning is under way for the next Strategic Plan (2018–2021), and UNICEF is realigning its programmes to, inter alia, prevent stunting and other forms of malnutrition; treat severe wasting and other forms of severe acute malnutrition; and improve the nutrition of adolescent girls and boys. UNICEF will organize its work on nutrition around 4 programme areas: (1) early childhood nutrition; (2) nutrition of school-age children, adolescents and women; (3) emergency nutrition; and (4) knowledge, partnerships and governance for nutrition. Along with this work, UNICEF will work towards recasting the nutrition narrative in 2017, focusing on the overarching theme of early childhood nutrition for the growth and development of children and nations.

A number of emerging areas of focus will require resources and strategic vision to move forward. The expanding organizational focus on adolescent development and participation and gender will be reflected through a new formal work stream on the nutrition of school-age children, adolescents and women. The area of child overweight continues to be an emerging area of work, and greater resources are needed to support these efforts, which in 2017 include conducting a programme stock-take, developing technical guidance and hosting an inter-agency meeting to address child overweight and obesity. Lastly, there is a dearth of information and knowledge sharing on nutrition innovations, despite the important work taking place in countries. In response, UNICEF will aim to develop an innovation strategy for nutrition in 2017, to identify innovative practices – both technical and programmatic – in nutrition.

Moving into 2017, more flexible resources will be critical to addressing the significant and growing demands from governments and partners to strengthen policy, programme, advocacy and knowledge generation in nutrition. A continuous and flexible funding stream for nutrition would support long-term programming and guarantee that UNICEF and its partners can fulfil their collective responsibilities to promote, protect and support the rights of the world's children, towards a world free from hunger and malnutrition.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EXPRESSION OF THANKS

UNICEF wishes to acknowledge the support of all government resource partners and National Committees for their generous contributions to achieve results in nutrition in 2016. UNICEF would like to extend an additional note of thanks to its main thematic resource partners: the Government of Luxembourg and the Government of Sweden; and the National Committees of the Netherlands, Spain, the United Kingdom and the United States.

ABBREVIATIONS AND ACRONYMS

BFHI	Baby-friendly Hospital Initiative
C4D	Communication for Development
CCC	Core Commitments for Children
CEE/CIS	Central and Eastern Europe and the Commonwealth of Independent States
CERF	Central Emergency Response Fund (United Nations)
CMAM	community-based management of acute malnutrition
Code, the	International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly Resolutions
EAP	East Asia and the Pacific
ECD	early childhood development
ENN	Emergency Nutrition Network
ESA	Eastern and Southern Africa
IBFAN	International Baby Food Action Network
IYCF	infant and young child feeding
LAC	Latin America and the Caribbean
LQAS	Lot Quality Assurance Sampling
MAM	moderate acute malnutrition
MENA	Middle East and North Africa
MNP	micronutrient powders
NGO	non-governmental organization
SA	South Asia
SAM	severe acute malnutrition
SDGs	Sustainable Development Goals
SMS	Short Message Service
SUN	Scaling Up Nutrition movement
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene
WCA	West and Central Africa
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization

ENDNOTES

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5. United Nations Children's Fund, *From the First Hour of Life: Making the case for improved infant and young child feeding everywhere*, UNICEF, New York, 2016.

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11. World Health Organization, United Nations Children's Fund, International Baby Food Action Network, *Marketing of breast-milk substitutes: National implementation of the International Code*, Status report 2016, WHO, Geneva, 2016, <http://apps.who.int/iris/bitstream/10665/206008/1/9789241565325_eng.pdf?ua=1&ua=1>

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13. See <http://www.harvestplus.org/>.

14. United Nations Children's Fund, 'Multiple Micronutrient Powder: Supply & Market Outlook', UNICEF Supply Division, Copenhagen, 2016, <https://www.unicef.org/supply/files/Multiple_Micronutrient_Powder_Supply_and_Market_Update.pdf>.

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16. Estimates from NutriDash 2015; vitamin A supplementation data for 2016 was still considered preliminary at the time of writing.

17. See <http://www.vas2016symposium.org/resources/outcomestatement>.

18. UNICEF NutriDash, 2015.

19. See <http://www.sightandlife.org/fileadmin/data/Magazine/2015/29_2_2015/3_Integrating_formative_research_into_nutrition_interventions.pdf> and <http://www.sightandlife.org/fileadmin/data/Magazine/2016/Mag2/Participatory_Formative_Research_in_Action.pdf>.

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32. Wirth, J.P., et al., 'Vitamin A Supplementation Programs and Country-Level Evidence of Vitamin A Deficiency', *Nutrients*, vol. 9, no. 3, 2017, p. 190.

33. These two programme areas have been combined for the purpose of this report, given the overlap in SAM programming in emergency situations. However, UNICEF also provides SAM treatment services in non-emergency contexts, and nutrition interventions other than SAM treatment in emergency situations, and this chapter aims to include aspects of this work to the extent possible.

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39. Shekar. M., et.al., 'Investing in Nutrition: The Foundation for Development', World Bank, Results for Development, Bill & Melinda Gates Foundation, Children's Investment Fund Foundation and 1,000 Day, Washington, D.C., 2016.

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41. United Nations Children's Fund/World Health Organization/World Bank Group, 'Joint Child Malnutrition Estimates – Levels and Trends', 2016 edition; United Nations Children's Fund/World Health Organization, Joint Monitoring Programme for Water and Sanitation, 2015.

42. See <https://www.unicef.org/eapro/Nutrition_Upstream.pdf>.

43. Breastfeeding Advocacy Initiative; Food Fortification Initiative; Global Alliance for Vitamin A; Global Nutrition Cluster; Home Fortification Technical Advisory Group; Infant and Young Child Feeding in Emergencies Core Group; International Zinc Nutrition Consultative Group; Iodine Global Network; Micronutrient Forum; Micronutrient Initiative; Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breast milk Substitutes (NetCode); No Wasted Lives Coalition; SUN movement; UN Network for SUN (Renewed Efforts Against Child Hunger (REACH/Standing Committee on Nutrition)).

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ANNEX

Visualizing achievements

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

Green

Indicator level

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

Outputs and outcome area level

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

Amber

Indicator level

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

Outputs and outcome area level

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

Red

Indicator level

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

Outputs and outcome area level

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

Nutrition

Average achievement rate:

89% 

Impact Indicator	Baseline*	2017 Target	2016 Update **
4a. Number of children under 5 years who are moderately and severely stunted	170 million (2010)	approx. 100 million (2025)	155 million (2016)
4b. Percentage of women of reproductive age with anaemia	38% pregnant, 29% non-pregnant (1995-2011)	50% reduction of anaemia in women of reproductive age	Updated data not available
Outcome Indicator	**Baseline***	**2017 Target**	**2016 Update****
P4.1 Countries with a current exclusive breastfeeding rate among children 0-5 months old ≥50% and no recent significant decline	27 (2007-2013)	40	30 out of 104 UNICEF programme countries (2010-2016)
P4.2 Countries with at least 90% of households consuming iodized salt	6 (2007-2013)[1]	25	18[2] out of 104 UNICEF programme countries (2010-2016)
P4.3 Countries with at least 80% of primary caregivers engaged in early childhood stimulation for children aged 3-5 years (36-59 months) at home	16 (2005-2013)	30	26 out of 76 UNICEF programme countries with data (2005-2014)
P4.4 Children aged 6-59 months covered with two annual doses of vitamin A supplements in vitamin A-priority countries	68% (2011)	80%	70% (2015)
P4.5 Children aged 6-59 months affected by severe acute malnutrition (SAM) reached with quality treatment, defined as children who recovered	Admissions: 2.7 million (2012) Recovered: 85% (2012)	Admissions: 4 million Recovered: >75%	Admissions: 3.4 million (2016)[3] Recovered: 89% (2016)

1 This indicator has been revised in accordance with the revision of the global indicator. Baseline yet to be adjusted.
2 Using the preliminary database for the new revised definition of households with any salt. Previous definition defined iodized salt at >15 ppm (parts per million).
3 This figure has been updated since the publication of the Data Companion of the Annual Report of the Executive Director (EDAR).
*2013 unless otherwise indicated. **or data from the most recent year available.

Output a

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

Average output achievement

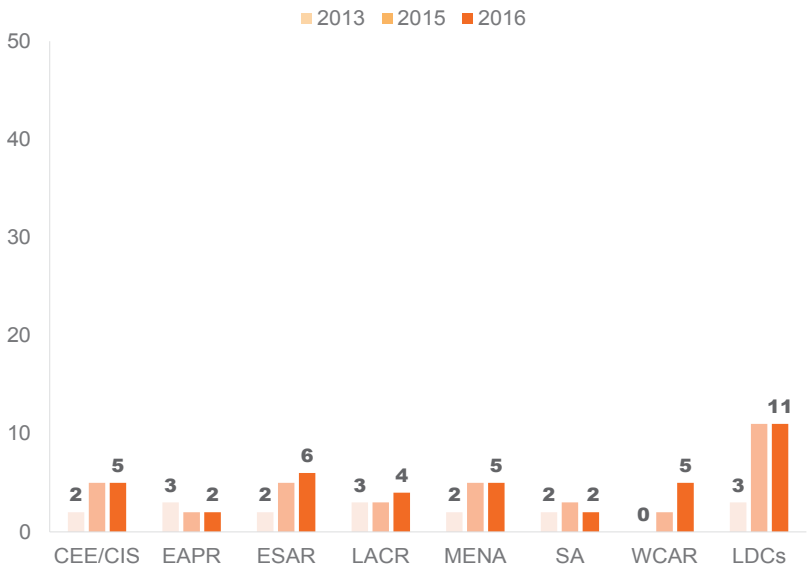
85%

P4.a.1

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

2013 Baseline	14
2014 Result	20
2015 Result	25
2016 Result	29
2016 Milestone	34
2017 Target	40

Achievement 85%



Output b

Increased national capacity to provide access to nutrition interventions

Average output achievement

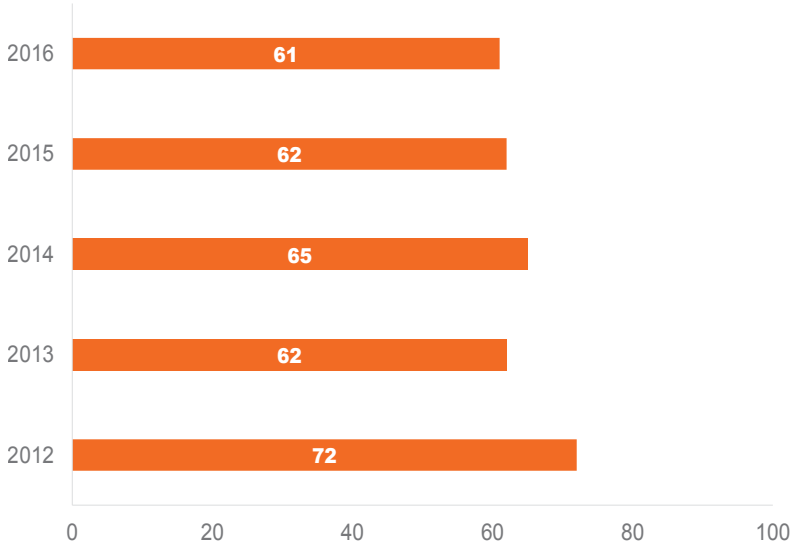
76%

P4.b.1

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

2012 Baseline	72
2013 Result	62
2014 Result	65
2015 Result	62
2016 Result	61
2016 Milestone	80
2017 Target	82

Achievement 76%



Output c

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

Average output achievement

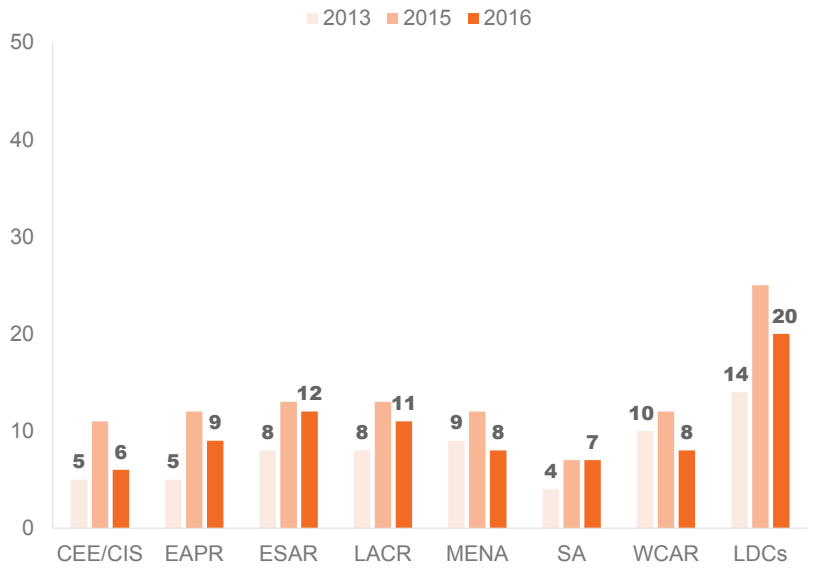
90%

P4.c.1

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

2013 Baseline	64
2014 Result	73
2015 Result	80
2016 Result	61
2016 Milestone	80
2017 Target	85

Achievement 76%

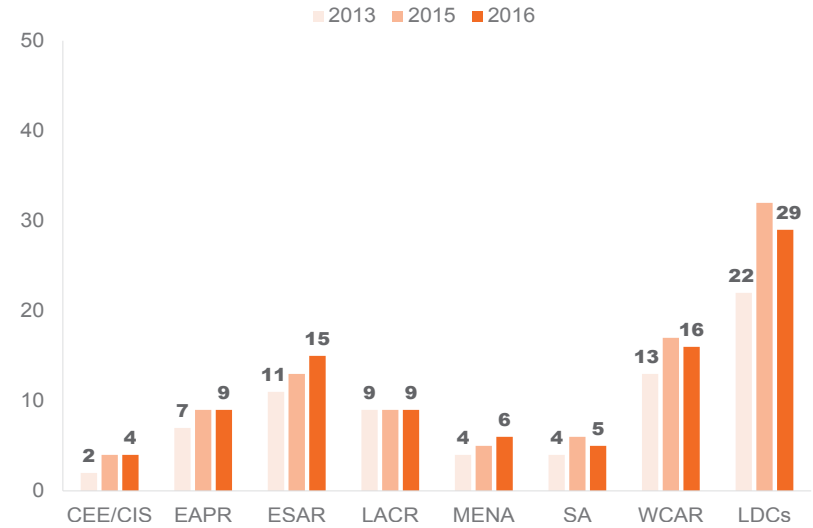


P4.c.3

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

2013 Baseline	50
2014 Result	56
2015 Result	63
2016 Result	64
2016 Milestone	65
2017 Target	70

Achievement 98%

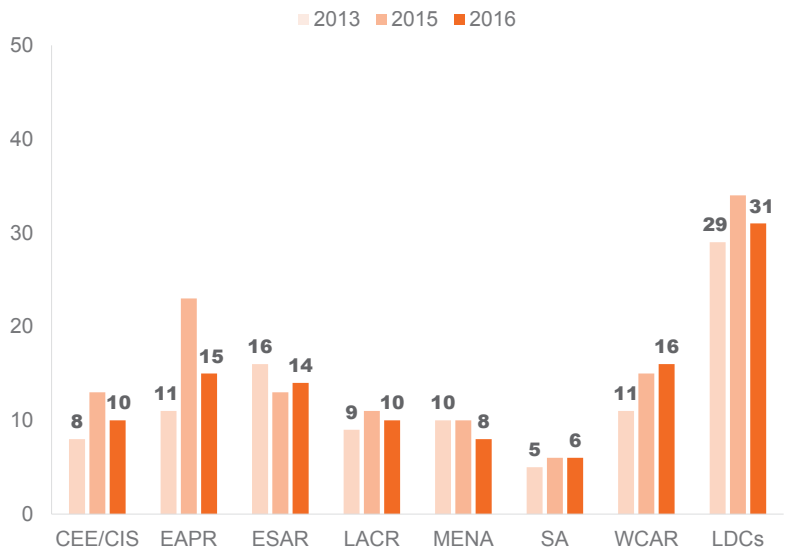


P4.c.2 (a)

Countries with a policy or plan targeting anaemia reduction in women

2013 Baseline	70
2014 Result	74
2015 Result	91
2016 Result	79
2016 Milestone	93
2017 Target	100

Achievement 85%

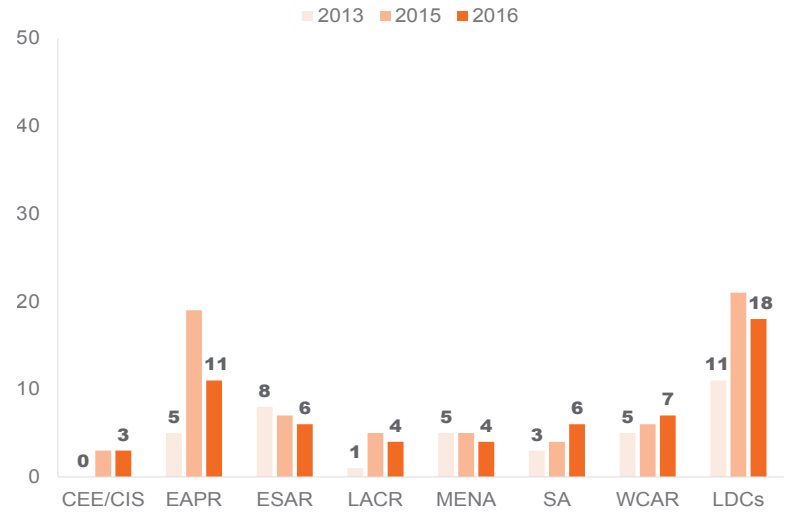


P4.c.2 (b)

Countries with a policy or plan targeting anaemia reduction in girls

2013 Baseline	27
2014 Result	34
2015 Result	49
2016 Result	41
2016 Milestone	44
2017 Target	50

Achievement 93%

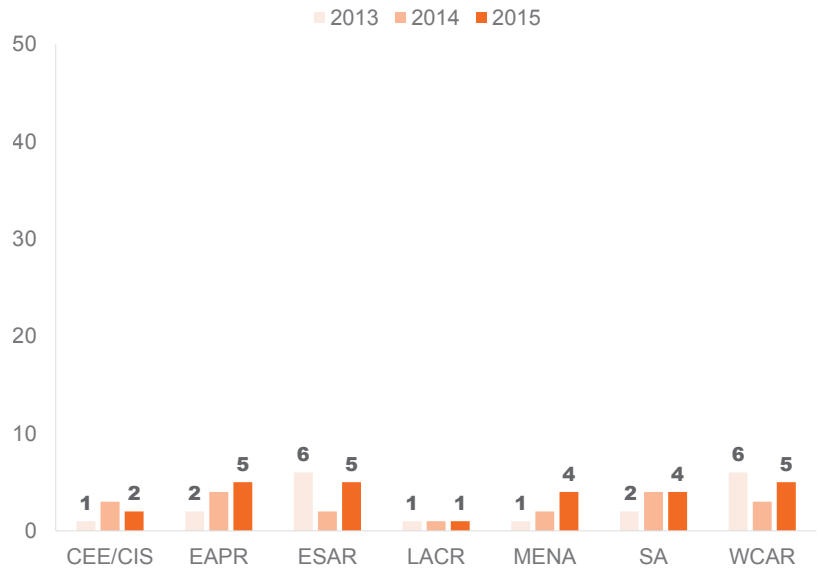


P4.c.4

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

2013 Baseline	19
2014 Result	19
2015 Result	26
2016 Result	-
2016 Milestone	40
2017 Target	45

Note: 2016 result is not yet available.

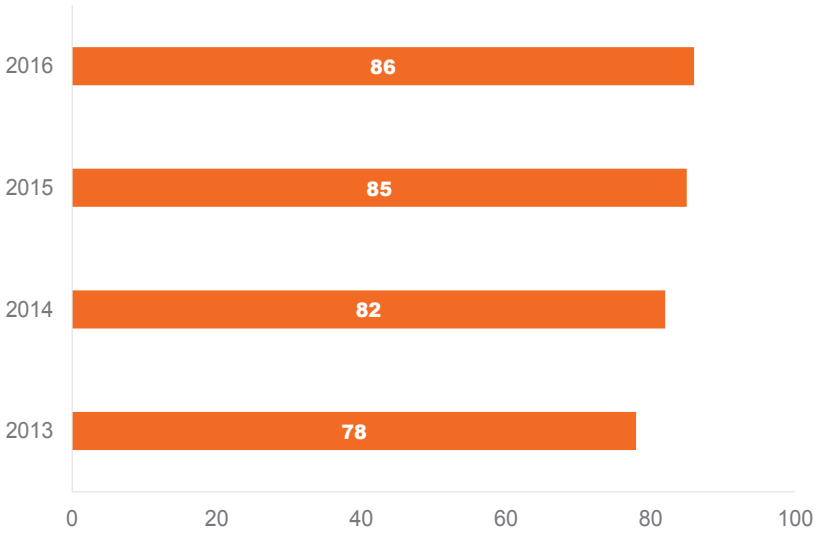


P4.c.5

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

2013 Baseline	78
2014 Result	82
2015 Result	85
2016 Result	86
2016 Milestone	87
2017 Target	90

Achievement 99%



Output d

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

Average output achievement

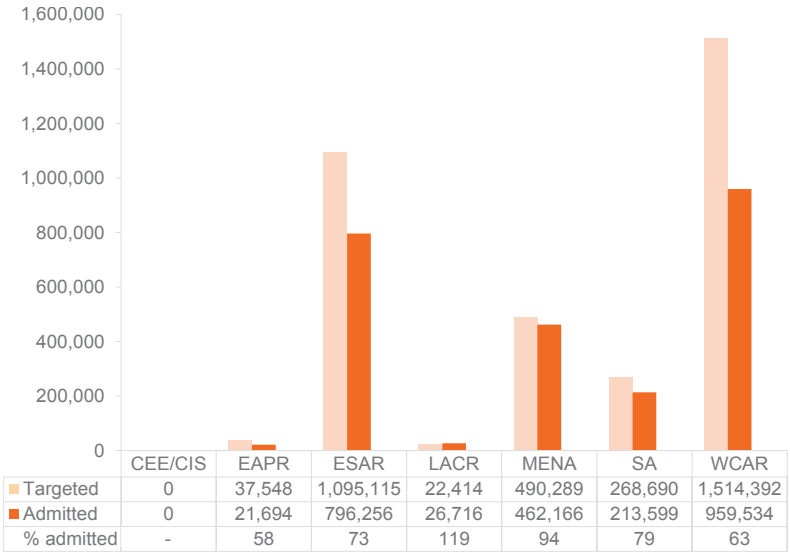
72%

P4.d.1 (a)

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

2014 Baseline	81%
2015 Result	65%
2016 Result	72%
2016 Milestone	90%
2017 Target	95%

Achievement 80%



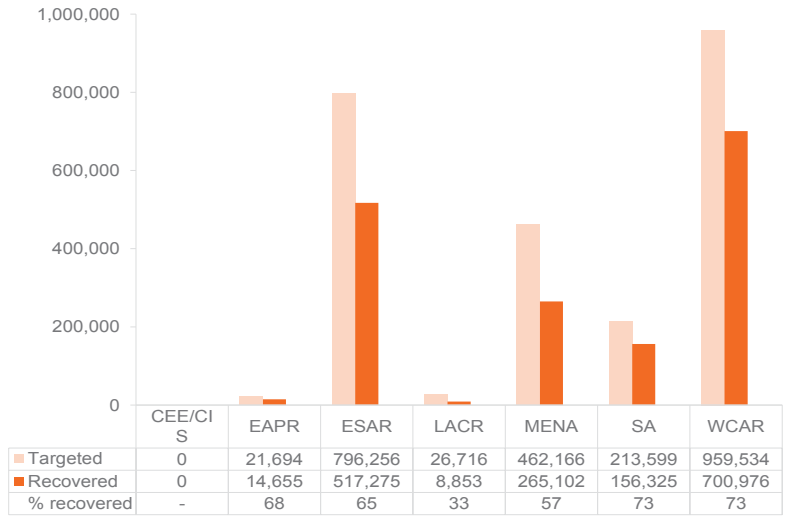
	CEE/CIS	EAPR	ESAR	LACR	MENA	SA	WCAR
Targeted	0	37,548	1,095,115	22,414	490,289	268,690	1,514,392
Admitted	0	21,694	796,256	26,716	462,166	213,599	959,534
% admitted	-	58	73	119	94	79	63

P4.d.1 (b)

UNICEF-targeted children aged 6-59 months with SAM in humanitarian situations who are admitted to programmes for the management of acute malnutrition and recover[1]

2014 Baseline	74%
2015 Result	72%
2016 Result	67%
2016 Milestone	>75%
2017 Target	>75%

Achievement 89%



	CEE/CIS	EAPR	ESAR	LACR	MENA	SA	WCAR
Targeted	0	21,694	796,256	26,716	462,166	213,599	959,534
Recovered	0	14,655	517,275	8,853	265,102	156,325	700,976
% recovered	-	68	65	33	57	73	73

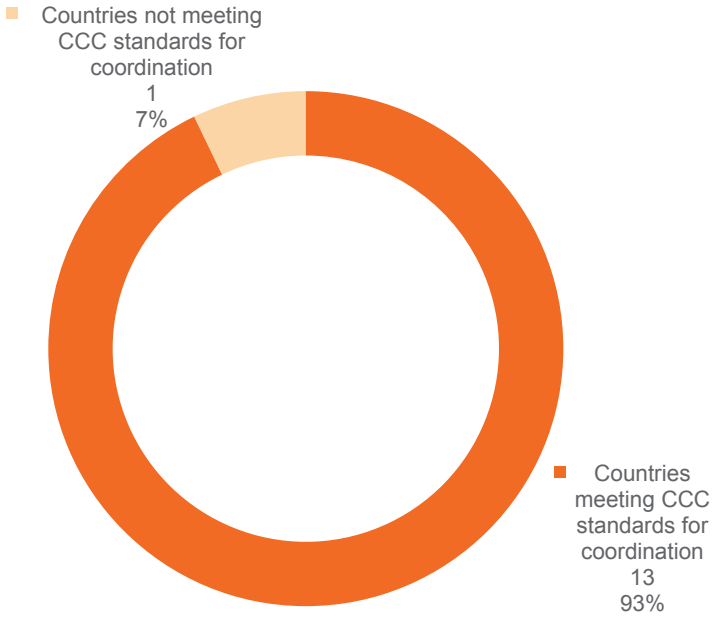
1 As per Sphere standards, the proportion of discharged children who recovered in 2016 was 87 per cent. For further details on the Sphere standards, see <http://www.spherehandbook.org/en/how-to-use-this-chapter-3/>

P4.d.2

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

2014 Baseline	100%
2015 Result	93%
2016 Result	93%
2016 Milestone	100%
2017 Target	100%

Achievement 93%

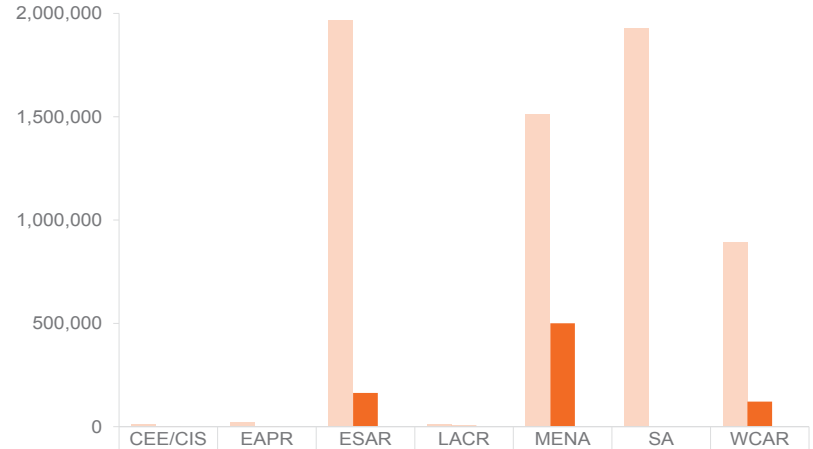


P4.d.3

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

2014 Baseline	45%
2015 Result	16%
2016 Result	13%
2016 Milestone	51%
2017 Target	55%

Achievement 25%



	CEE/CIS	EAPR	ESAR	LACR	MENA	SA	WCAR
Targeted	10,624	19,683	1,969,282	12,047	1,510,566	1,930,701	893,575
Reached	1,567	1,870	163,029	4,800	500,582	0	121,542
% reached	15	10	8	40	33	0	14

Output e

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

Average output achievement

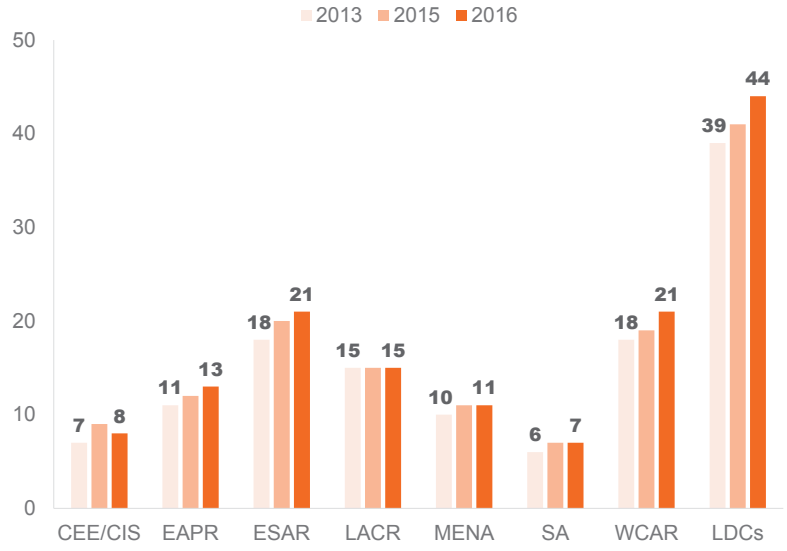
87%

P4.e.1

Countries with national management information systems that disaggregate data on nutrition

2013 Baseline	85
2014 Result	92
2015 Result	93
2016 Result	96
2016 Milestone	96
2017 Target	100

Achievement 100%

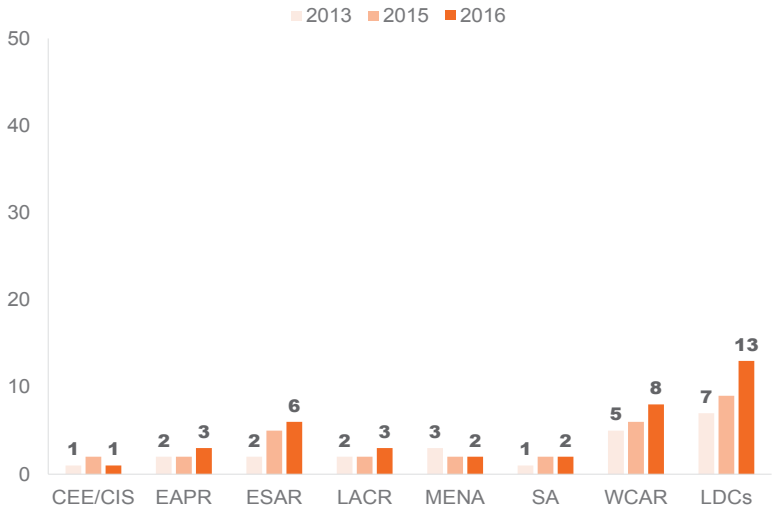


P4.e.2

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

2013 Baseline	16
2014 Result	22
2015 Result	21
2016 Result	25
2016 Milestone	34
2017 Target	40

Achievement 74%



Output f

Enhanced global and regional capacity to accelerate progress in child nutrition

Average output achievement

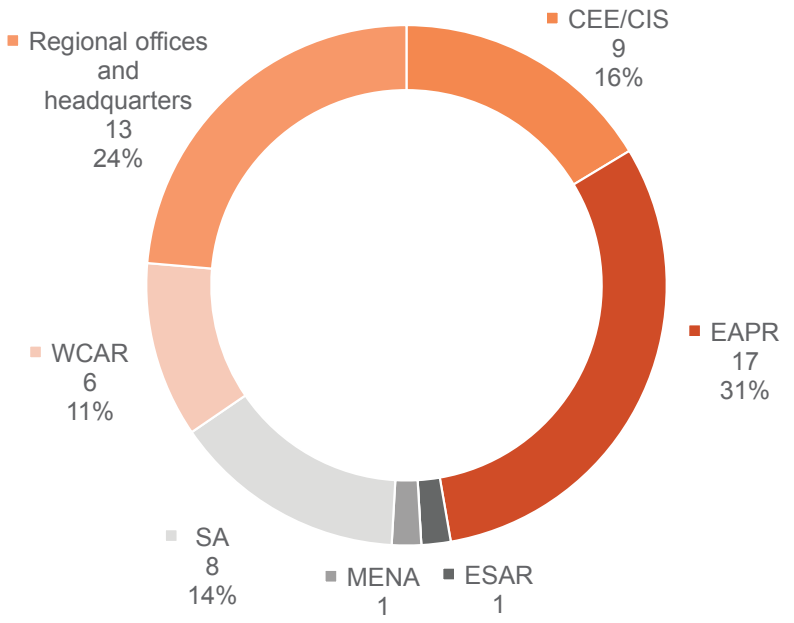
133%

P4.f.1

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

2014 Baseline	45
2015 Result	59
2016 Result	55
2016 Milestone	50
2017 Target	50

Achievement 110%



P4.f.2

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

2013 Baseline	6
2014 Result	9
2015 Result	14
2016 Result	14
2016 Milestone	9
2017 Target	10

Achievement 156%

Global partnerships and initiatives

- Breastfeeding Advocacy Initiative
- Food Fortification Initiative
- Global Alliance for Vitamin A
- Global Nutrition Cluster
- Home Fortification Technical Advisory Group
- Infant and Young Child Feeding in Emergencies Core Group
- International Zinc Nutrition Consultative Group
- Iodine Global Network
- Micronutrient Forum
- Micronutrient Initiative
- Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breast-milk Substitutes
- No Wasted Lives
- Scaling Up Nutrition (SUN Movement)
- UN Network for SUN (Scaling Up Nutrition) [Renewed Efforts Against Child Hunger and undernutrition/Standing Committee on Nutrition]

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