



GOAL AREA 1

Every child survives and thrives

Global Annual
Results Report 2019

unicef 
for every child

Cover image: © UNICEF/UN0317965/Frank Dejongh
A mother is washing and cuddling her baby, in the village of
Tamroro, in the centre of Niger.

In Niger, only 13 percent of the population has access to basic
sanitation services.

Expression of thanks: © UNICEF/UN0303648/Arcos
On 23 April 2019, in Cucuta in Colombia, a baby undergoes a health
check at the UNICEF-supported health centre.



Expression of thanks

UNICEF is able to support the realization of children's rights and change children's lives by combining high-quality programmes at scale, harnessing innovation and collecting evidence, in partnership with governments, other United Nations organizations, civil society, the private sector, communities and children. It leverages wider change nationally and globally through advocacy, communications and campaigning. UNICEF also builds public support around the world, encouraging people to volunteer, advocate and mobilize resources for the rights and well-being of children, and works with a wide range of partners to achieve even greater impact.

UNICEF's work is funded entirely through the voluntary support of millions of people around the world and our partners in government, civil society and the private sector. Voluntary contributions enable UNICEF to deliver on its mandate to support the protection and fulfilment of children's rights, to help meet their basic needs, and to expand their opportunities to reach their full potential.

We wish to take this opportunity to express deeply felt appreciation to all our many and varied resource partners for support to Goal Area 1 in 2019, and particularly those that were able to provide thematic funding. The flexibility of such funding provides for long-term planning and the sustainability of programmes, and allows UNICEF to offer strategic, technical, operational and programming support to countries in all regions for both upstream and decentralized work. Thematic funding reflects the trust that resource partners have in the capacity and ability of UNICEF to deliver quality support under all circumstances, and makes a vital contribution to positive change in the lives of marginalized children and communities worldwide, as described in this report.

"I'm proud the UK supports UNICEF and its vital work to give every girl 12 years of quality education and end preventable maternal, new-born and childhood deaths. As we tackle the coronavirus pandemic, the importance of global cooperation has never been more apparent. By working together, we can improve and save lives around the world, creating a future where every girl is in school and can realise her full potential."

– UK International Development Secretary Anne-Marie Trevelyan

Seventy-three years after UNICEF was established and 30 years since the adoption of the Convention on the Rights of the Child, the organization's mission to promote the full attainment of the rights of all children is as urgent as ever.

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

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

The following report summarizes how UNICEF and its partners contributed to Goal Area 1 in 2019 and reviews the impact of these accomplishments on children and the communities where they live. This is one of eight reports on the results of efforts during the past year, encompassing gender equality and humanitarian action as well as each of the five Strategic Plan goal areas – 'Every child survives and thrives', 'Every child learns', 'Every child is protected from violence and exploitation', 'Every child lives in a safe and clean environment' and 'Every child has an equitable chance in life' – and a supplementary report on Communication for Development (C4D, also referred to as social and behaviour change communication, SBCC). It supplements the 2019 Executive Director Annual Report, UNICEF's official accountability document for the past year.

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Executive Summary

Animata Diallo is cuddling her newborn baby in the PMI health center of Odienné, Cote d'Ivoire.

Thirty years ago, a promise was made to the world's children. That promise, crafted by global leaders and enshrined in the Convention on the Rights of the Child, states that all children have rights that are universal, inalienable and indivisible. All of UNICEF's actions emanate from that promise and the dedicated aim to see it fulfilled for every child.

UNICEF Goal Area 1 seeks to fulfil that promise by working across four interconnected sectors – health, nutrition, HIV/AIDS and early childhood development (ECD) – so that each child has the best possible chance to survive early childhood, be nourished and stimulated as they grow, and

benefit from the diets, services and practices they need to thrive through adolescence and into adulthood. At the core of Goal Area 1 is a strategy aimed at strengthening health, food and social protection systems as platforms for achieving child survival, growth and development outcomes that contribute to Sustainable Development Goals (SDGs) 2, 3, 4 and 5.

In 2019, programme expenses across 152 countries in Goal Area 1 totalled US\$2.15 billion or 38 per cent of UNICEF's total expenses. This included US\$950 million for humanitarian action in 82 countries.

Key results achieved in 2019

Throughout the year, the programmes represented in Goal Area 1 employed a multisectoral approach aimed at ensuring life-saving and life-changing services for children and their families. Through these programmes, 27.4 million children were born in UNICEF-supported health-care facilities in 52 focus countries. UNICEF and partners supported the vaccination of 65.7 million children with three doses of diphtheria, tetanus, pertussis (DTP)/pentavalent vaccine in 64 priority countries, and in 25 countries with high pneumonia prevalence, 9.5 million children with suspected pneumonia received appropriate antibiotics. Some 307 million children under 5 were reached with services to prevent stunting and other forms of malnutrition, 60 million adolescents were reached with services to prevent anaemia and other forms of malnutrition, and about 5 million children benefitted from services for the early detection and treatment of severe wasting and other forms of severe acute malnutrition. Some 45 countries have multisectoral ECD packages on track for sustainable scaleup; up from 33 in 2018. And UNICEF-supported programmes provided antiretroviral treatment (ART) to almost 1 million pregnant women living with HIV to prevent its transmission to their child.

At the output level, UNICEF progress rates were over 90 per cent for all nine of the results areas under Goal Area 1.

To improve the quality of care, UNICEF supported water, sanitation and hygiene (WASH) in 3,008 health-care facilities that were lacking basic infrastructure. Chad and the Democratic Republic of the Congo eliminated maternal and neonatal tetanus. In humanitarian situations, UNICEF and partners supported measles vaccination of 41.3 million children, 1.69 million people received insecticide-treated nets, and UNICEF responded to 74 public health emergencies worldwide including Ebola, Zika and measles. Sixty-seven countries had inclusive, multisectoral and gender-responsive national plans for adolescent health, 31 of which were supported by UNICEF.

Nutrition programmes continued to expand in 2019, with more children and caregivers reached with interventions to prevent malnutrition in all its forms and treat severe acute malnutrition in early childhood, often through the strategic integration of actions across the food, health, education and social protection systems. For example, the number of caregivers receiving counselling on infant and young child feeding through facility- and community-based platforms rose to 24 million in 2019, and 17.7 million children benefitted from home fortification programmes to improve the nutrient quality of complementary foods. The number of countries with programmes to improve the diversity of children's diets reached 114, the number of countries implementing mandatory iodized salt, vitamin A fortified oil, and/or wheat or maize flour fortified with essential micronutrients reached 147, and 250 million children benefitted from UNICEF-supported vitamin A supplementation programmes. Access to maternal nutrition services improved, with the number of countries integrating nutrition counselling with antenatal care programmes reaching 68 in 2019. UNICEF supported the scale-up of services to treat children with severe wasting in 69 countries across seven regions, reaching about 5 million children, with 88 per cent of them recovering.

UNICEF supported testing of over 600,000 infants born to pregnant women living with HIV within their first 2 months of life, providing caregivers the information they needed to initiate life-saving ART for the infant. Some 13.5 million adolescent girls and 9 million adolescent boys were tested for HIV through UNICEF support and all UNICEF priority countries implemented policies and/or strategies integrating key HIV interventions into child-centred service points. Sri Lanka joined the list of 13 countries validated for the elimination of mother-to-child transmission of HIV by the World Health Organization (WHO).

The shift towards employing multisectoral ECD packages, essential in ensuring that children have the best chance to thrive as they grow, continued in 2019. Forty-five countries reported having reached at least 'established' status to scale up multisectoral ECD programmes (having Government ownership plus costed action plans), exceeding the milestone of 24 set for 2019. Eighty-three countries, 16 more than last year, reported having a national ECD policy or action plan, which provide an enabling policy environment as the foundation for sustainable scale-up of ECD interventions. UNICEF delivered organized ECD programmes to more than 610,000 children under 5 years of age affected by humanitarian situations, reaching 76 per cent of the targeted population (exceeding the Strategic

Plan milestone for 2019 of 75 per cent). The number of countries that reported on ECD in Emergencies (ECDiE) programming increased from 38 in 2018 to 46 in 2019, reflecting the growing recognition of ECDiE as integral in humanitarian response programming.

Throughout the world, UNICEF remained at the forefront of humanitarian responses. To fulfil its dual protection and assistance mandate, UNICEF actively strengthened, and continues strengthening, the humanitarian–development nexus by integrating proactive risk reduction, emergency preparedness and response with longer-term resilience-building.

Nowhere is UNICEF's integrated service approach, buttressed by its extensive field presence, exemplified more clearly than in Yemen. The protracted conflict has severely compromised the availability, quality, access and utilization of health and nutrition services – fundamentally threatening children and their families' rights to health and survival.

Through the World Bank-funded Emergency Health and Nutrition Project, UNICEF and the World Health Organization work with local authorities to strengthen the country's capacity to provide basic health and essential nutrition services to the population – using the existing health system, while simultaneously building rural community resilience by establishing a network of community health workers. This approach provides immediate support while creating the foundations for a post-conflict rehabilitation phase. Practically, this means that investments are strengthening human capital, restoring and equipping health-care facilities and improving their functionality, along with water and sanitation services, particularly in areas at high risk of malnutrition and disease.

Looking ahead

The end of 2019 saw the emergence of coronavirus disease 2019 (COVID-19), which has since become an unprecedented global pandemic. UNICEF's mandate to protect the rights of children, its capacity to act quickly in times of crisis and its global presence, place it in the centre of the emergency response as a critical actor shaping medium-term recovery while continuing to ensure integrated survive and thrive programmes. UNICEF's experience in programmes such as immunization and HIV/AIDS provides a direct contribution to the effective inclusion of women, children and adolescents in COVID-19-related testing, contact tracing, service delivery and eventual immunization initiatives. The pandemic also reinforces the importance of amplified parenting and caregiver support. As first providers of health, nutrition, early learning and stimulation, parents and caregivers are a key accelerator in achieving results for all children. As the architects of the experiences and opportunities for children's health,

and development, they need to be supported as much as other front-line workers. And while UNICEF is actively supporting the pandemic response, it has the significant challenge of ensuring that children, adolescents and pregnant women do not fall out of care and that essential service provision continues. Failure to do so would not only have a devastating impact on survival outcomes, but also broader implications for population-level health, nutrition and child development status and grave consequences such as drug resistance and increased HIV transmission.

As UNICEF reflects on the findings of its midterm review, and works to accelerate progress towards the SDG targets, it is also supporting governments in estimating the scale of human and material resources required to mount effective national, regional and global responses to protect children's rights. Strengthening the capacities and



In Brazil, UNICEF and the government are working together to promote better eating habits among children.

resilience of systems and communities to the impacts of the COVID-19 pandemic and other public health threats is ongoing. When there are sufficient technical and financial resources, political will, engagement of communities and strong primary health care, food and nutrition, and social protection systems, services can be expanded to reach women, infants and children.

There is much work to do. To fully implement the survive and thrive agenda and continue playing a critical role in reaching the wide-ranging SDG targets, UNICEF will need stable, predictable and increased resources such as thematic funding – the most flexible type of

contribution – which facilitates longer-term planning, cost savings and sustainability. Thematic funds translate into effective programmes that are better targeted to support governments in upholding the right of all children, especially the most vulnerable, to live full and healthy lives.

UNICEF Goal Area 1 programmes will continue harnessing their unique ability to set global agendas for children’s rights to health, good nutrition, well-being and development, and continue to demonstrate that strong programme integration remains a critical way forward – not only to achieving planned results, but also in ensuring that these investments are sustainable.



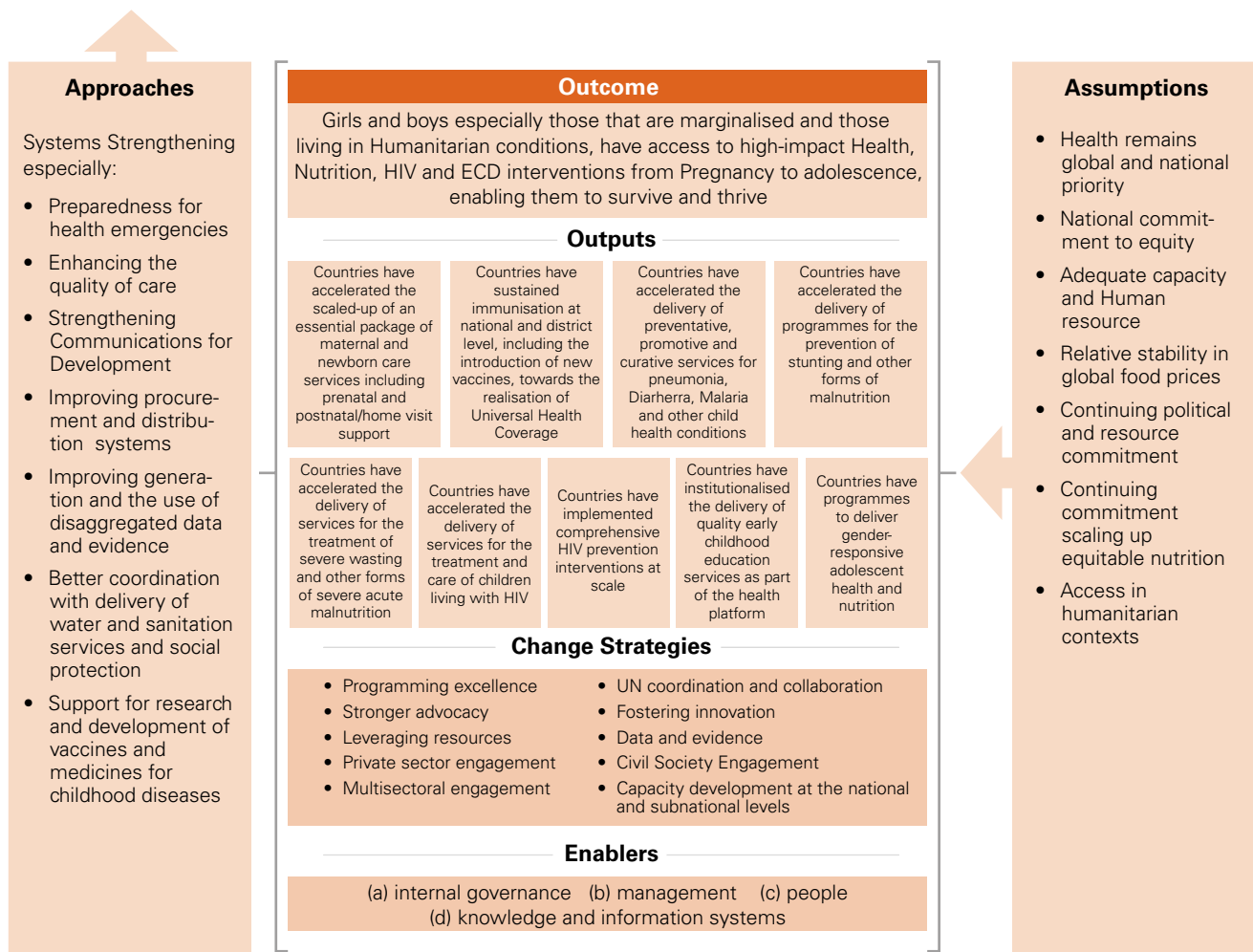
Strategic context: Children survive and thrive

A portrait of Nakaayi Sharifah's first born child. Nakaayi Sharifah, 27, was the first to give birth at Kawempe Referral Hospital on the 1st of January welcoming the new decade with a beautiful baby girl. Baby Nakaayi is Sharifah's first child and she was so excited to bring her into the world. Her labor was quite short as she arrived at the hospital at around 6pm on the 31st and delivered at about half past 12 on the 1st. Sharifah is still deciding what to call her newborn, but she has decided on either Samirah or Amirah. I decided to deliver from this hospital because it has all necessary equipment for child birth . Sharifah is looking forward to taking her new baby home and embarking on the journey of motherhood.

Supporting the fulfilment of children’s right to survive and thrive is the focus of Goal Area 1 in the UNICEF Strategic Plan, 2018–2021. The theory of change suggests that girls and boys, especially those who are the most vulnerable and marginalized, will have the best chance in life if a number of critical, quality services are available to them at specific times throughout their lives. Basic survival requires that girls and boys are accessing quality and inclusive health services, that expectant and new mothers and young children are receiving adequate nutrition, and that they are protected from HIV/AIDS and preventable childhood diseases. These same children then have a chance to thrive when they continue to eat nutritious foods; have access to quality water, sanitation and hygiene; are stimulated and cared for at home and in their communities; and enjoy an early childhood education that gives them opportunities to learn and grow.

The many factors influencing a child’s survival, growth and development are highly interdependent, requiring a holistic approach. Specifically, UNICEF focuses on nine results areas that directly contribute to basic survival and the ability to thrive. The targets for each correspond to UNICEF’s contributions to larger national and global Sustainable Development Goal (SDG) targets for under-five mortality, neonatal mortality, maternal mortality, stunting, wasting, overweight, HIV infection and death rates, and early childhood development (ECD). The UNICEF Strategic Plan midterm review highlighted the need to increase some output targets and milestones in order to re-align with the SDG targets and accelerate progress.

FIGURE 1: Schematic overview of Goal Area 1



Global trends

Millions of children have a significantly better chance of survival today than in 1990. Globally, the risk of death for children under 15 years of age has declined among all age groups, and progress has accelerated since 2000 in reducing neonatal and under-five mortality, including in many low-income countries: neonatal mortality rate fell to 18 deaths per 1,000 live births in 2018 from 37 in 1990 (52 per cent decline); and the under-five mortality rate fell to 39 deaths per 1,000 live births in 2018 from 93 in 1990 (59 per cent decline). For children aged 5-14 years, the probability of dying before their fifteenth birthday dropped from 15 deaths per 1,000 in 1990 to 7 in 2018.

Despite the progress, children continue to die from preventable causes on an enormous scale, with a shocking 291 million children under age 15 having died between 1990 and 2018. The vast majority of child deaths still occur in sub-Saharan Africa and South Asia, as well as in poor households worldwide. Globally, pneumonia, diarrhoea and malaria remain the leading causes of death for children under 5, accounting for 15 per cent, 8 per cent and 5 per cent of deaths, respectively. If the current trends hold, 52 million children under 5 will die between 2019 and 2030.

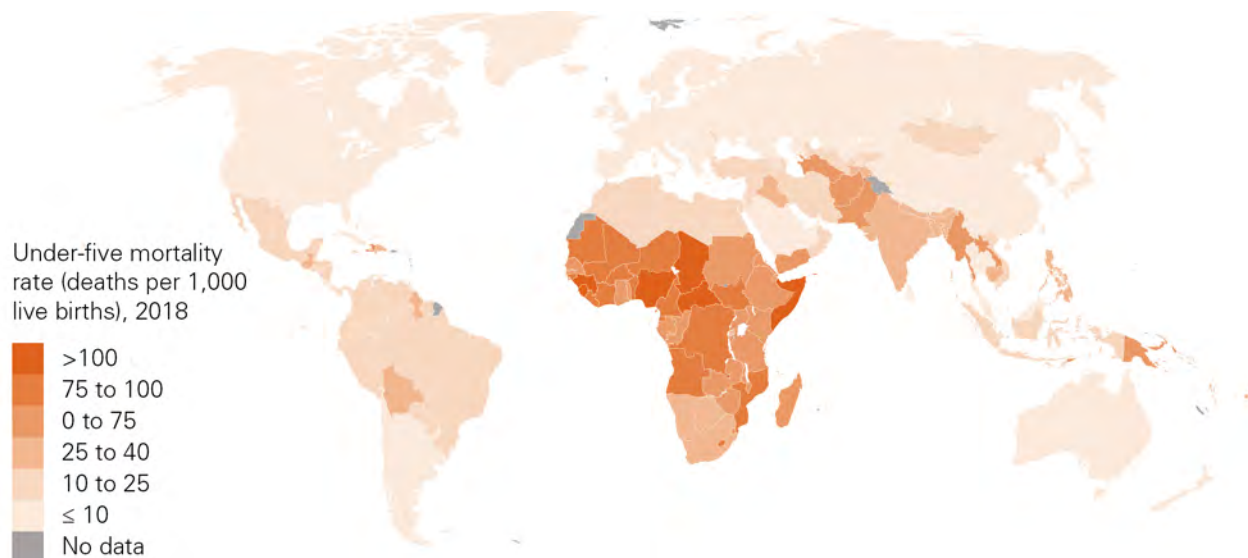
Children face the highest risk of dying in their first month of life (globally, 18 deaths per 1,000 live births). Worldwide, an estimated 2.5 million newborns died in the first month of life in 2018. About a third of all neonatal deaths occur on the day of birth, and close to three quarters in the first week of life. Further, more than 2 million babies are

stillborn each year. Neonatal deaths account for 47 per cent of all under-five deaths and, if the current trend continues, 26 million newborns will die between 2019 and 2030. Approximately 60 countries need to accelerate their progress to reach the SDG neonatal mortality target by 2030.¹

Maternal health is improving. Latest estimates show that from 2000 to 2017, the global maternal mortality ratio (MMR) declined by 38 per cent – from 342 to 211 deaths per 100,000 live births. However, some 295,000 women needlessly died in childbirth in 2017. Notably, the 2.9 per cent average annual rate of reduction in the MMR is less than half the 6.4 per cent annual reduction needed to achieve the Sustainable Development Goal of 70 maternal deaths per 100,000 live births. This calls for urgent action to increase both access to antenatal care and the number of skilled birth attendants.

At all stages of development, from the womb through childhood and into adolescence, too many children are not receiving the nutrition they need to grow, develop and reach their full potential. The UNICEF *State of the World's Children Report, 2019*² notes that at least a third of all children under 5 are either undernourished or overweight, at least half suffer from micronutrient deficiencies, and at least two thirds are not fed the minimally diverse diet needed to grow healthy. While the number of stunted children has declined steadily over the past decade, 149 million children still suffer from stunting while wasting

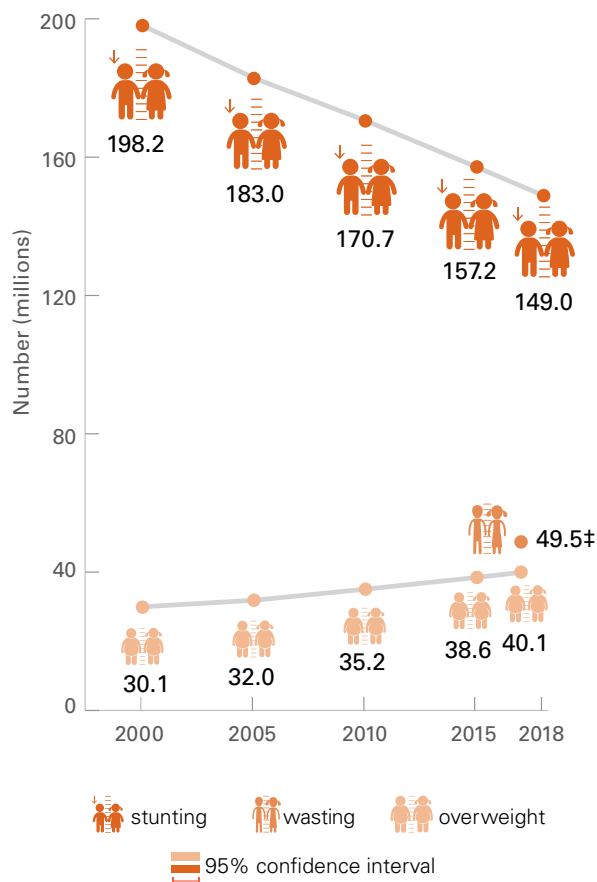
FIGURE 2: Under-five mortality rate, by country, 2018



Source: United Nations, 'United Nations Inter-agency Group for Child Mortality Estimation, Levels & Trends in Child Mortality: Report 2019', United Nations, New York, 2019, p.12.

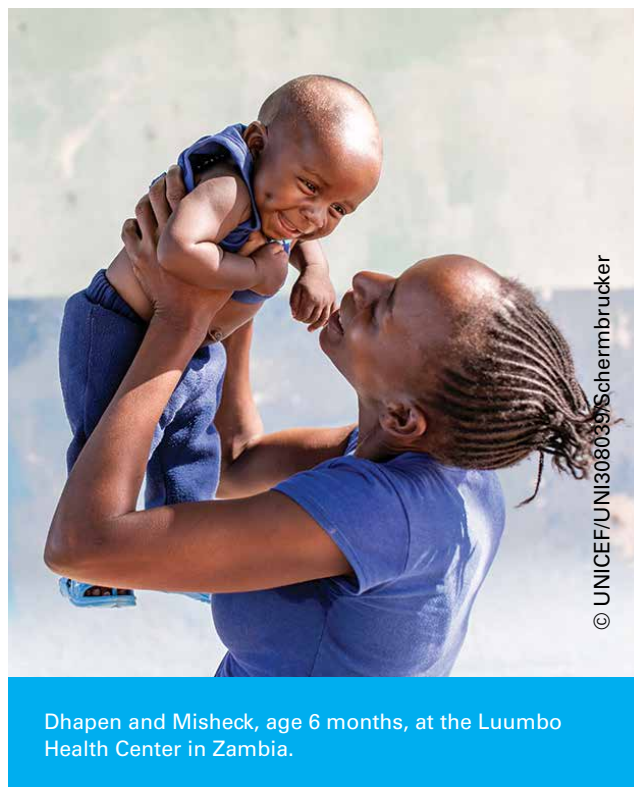
threatens the lives of 49.5 million children, particularly in Asia. The number of children with wasting has remained virtually stagnant for more than two decades, while the number of children who are overweight – 40 million – continues to increase in all regions, including Africa.

FIGURE 3: Number (millions) of stunted, overweight and wasted children under 5, global, 2000–2018



Source: United Nations Children's Fund, World Health Organization and World Bank, 'Levels and Trends in Child Malnutrition: UNICEF/WHO/World Bank Joint Malnutrition Estimates - Key findings of the 2019 edition.'

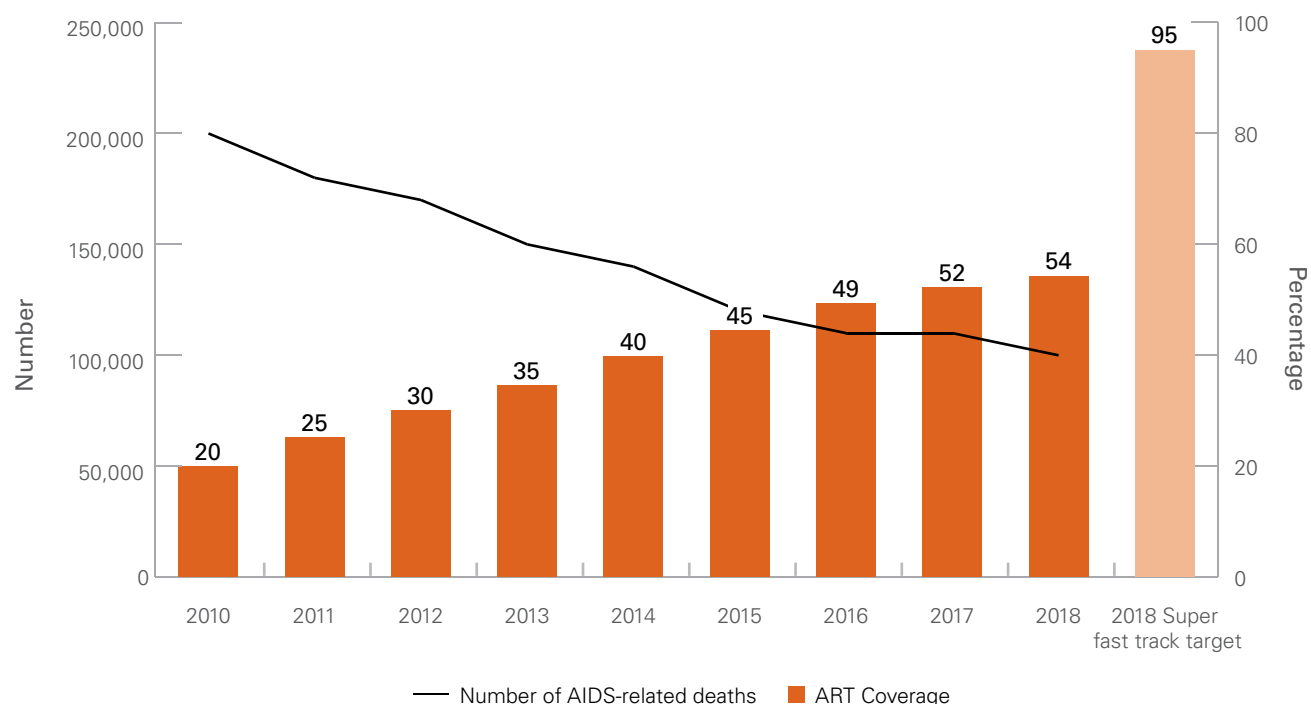
A core principle of the 17 SDGs is that no one should be left behind. UNICEF works to ensure that the needs of pregnant women, children and adolescents are addressed in the global HIV response which has seen considerable advancements over the past decade. For example, from 2010 to 2018 global coverage of antiretroviral treatment (ART) among pregnant women living with HIV nearly doubled, from 44 per cent in 2010 to 82 per cent in 2018. Paediatric ART coverage also surged over the same period,



from 20 per cent to 54 per cent, and the annual number of new infections among one of the world's most vulnerable populations – adolescent girls and young women – declined by 25 per cent among those aged 15–24 years. These successes contributed to major improvements in crucial indicators of HIV-related health and well-being, including a 51 per cent reduction in the annual number of AIDS-related deaths among children aged 0–14 years and a 28 per cent reduction for the 10–19-year-olds. Considerable work continues to achieve the HIV-related targets among pregnant women, children and adolescents identified in the SDGs for health and well-being (SDG 3), education (4), general equality (5), reduced inequality (10), peace, justice and strong institutions (16), and partnerships (17).

However, achieving the SDG targets of ending preventable deaths of newborns and children under 5, ending the HIV epidemic and achieving universal health coverage are still a distant vision for pregnant women, children and adolescents. An estimated 1.6 million adolescents (10–19 years old) were living with HIV in 2018, an increase of 4 per cent since 2010. And, despite a 25 per cent decline in new infections since 2010, new infections in this population are still more than three times higher than the global target set for 2020. Globally, young people (15–24 years old) account for a sizable share (20–40 per cent) of new HIV infections among key populations with alarming increases in Indonesia, the Philippines and Thailand.

FIGURE 4: Trends in coverage of ART and number of AIDS-related deaths among children 0–14 years, 2010–2018

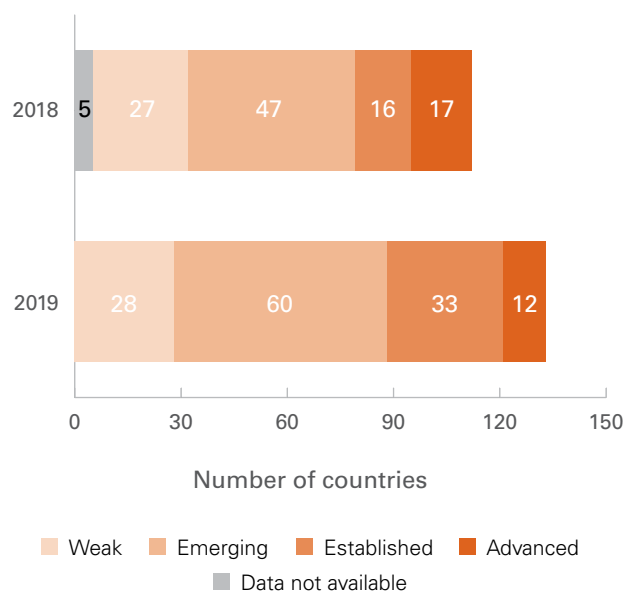


Source: Global AIDS Monitoring and UNAIDS 2019 Estimates

Global momentum for multisectoral ECD services and enabling policy environments continued growing with UNICEF support. Some 105 countries, up from 80 in 2018, were implementing multisectoral ECD programmes with government ownership in 2019, with a package of at least two interventions addressing stimulation and responsive care in the early years. Of these, 45 countries are scaling up these multisectoral programmes with established costed action plans and 60 have ‘emerging’ systems with the potential to go to scale in the near future (see Figure 5). Eighty-three countries (16 more than in 2018) reported having a national ECD policy or action plan that sets the foundation for sustainable scale-up of ECD services. UNICEF reached over 610,000 children under 5 in humanitarian situations with ECD interventions in 2019. Forty-six countries reported on ECD in emergency programmes, up from 38 in 2018, reflecting the growing recognition of ECD as integral to humanitarian interventions.

The increased commitment is timely, given that the available data show the world is off track to meet the SDG indicator of 4.2.1 (percentage of children under 5 developmentally on track). Additionally, only 60 per cent of children in UNICEF programme countries were receiving early stimulation and responsive care.

FIGURE 5: Status of multisectoral ECD package at scale, 2018–2019



Addressing challenges through strategic shifts

Important strategic shifts are taking place in UNICEF's work in light of the clear need to accelerate efforts to reach the SDG targets for children. Heeding the call of the United Nations Secretary-General, UNICEF is working with the H6 (World Health Organization [WHO], Joint United Nations Programme on HIV/AIDS [UNAIDS], United Nations Population Fund, UN Women, World Bank Group) and other partners to realize the SDG 3 Global Action Plan: For Healthy Lives and Well-Being for All. The Secretary-General advocates positioning the H6 as a role model for United Nations reform efforts, providing UNICEF a key opportunity to leverage its expertise towards improving children's rights in both humanitarian and development settings. UNICEF is also expanding ties with the private sector by developing shared-value partnerships while protecting children from harmful commercial marketing.

To address key health challenges, UNICEF will accelerate its work on primary health care in countries with high child mortality rates, focusing on three areas that will make the greatest difference. Chief among these is strengthening primary health care at the community level by improving the integration of services and platforms through which children are reached, such as communities, schools and health-care facilities. Second, UNICEF and partners are building stronger routine immunization programmes and creating synergy with supplementary immunization activities for polio, tetanus and measles. Third, strategic interventions aim to improve front-line worker capacity, strengthen supply chains, the quality of care, and the collection and management of data/digital health information.

In keeping with the United Nations Reform agenda, UNICEF supported efforts to harmonize the collective work of United Nations agencies on nutrition. In 2019, after extensive consultations with the Food and Agricultural Organization of the United Nations, World Food Programme and WHO, the UN Standing Committee on Nutrition and the UN Network for Scaling Up Nutrition (SUN) were merged into a single entity, UN Nutrition, to be established in 2020.

With the release in 2019 of the *State of the World's Children: Children, food and nutrition*, UNICEF drew global attention to the triple burden of malnutrition and issued a call to action to put children's right to food and nutrition at the centre of food systems. UNICEF then began developing a 2020–2030 nutrition strategy to guide programming over the next decade towards the global goal of ending malnutrition in all its forms by 2030.

Partnerships are needed to accelerate global progress towards the full realization of rights enshrined in the Convention on the Rights of the Child, and achievement of the SDGs. UNICEF and other United Nations agencies are working on a Global Action Plan on Child Wasting

responding to growing calls for a more coordinated, streamlined approach to addressing child wasting. To improve coordination and the nutrition response to humanitarian crises, UNICEF will continue to convene more than 40 partners of the Global Nutrition Cluster, providing technical support to 21 countries facing humanitarian crisis.

Additional core HIV capacity and investments are needed to strengthen systems both within UNICEF and across sectors to fully reap the benefits of new and existing platforms and promote healthy gender norms that contribute to ending AIDS in children and adolescents. There is also a need to strengthen national routine and surveillance systems to collect age–sex disaggregated data and risk factors. Integrated prevention must be explored with a combination of approaches that address biomedical, behavioural and structural issues through a gender-transformative lens. HIV testing and treatment services will continue to be integrated within broader maternal, neonatal and child health services, and services need to be differentiated for the most-at-risk adolescents. Rapid introduction of improved formulations for HIV treatment of children must be maintained. This will include accelerating the registration and distribution of preferred medicines; accurate forecasting of demand; and training, mentorship and support for health workers. UNICEF leverages its unique global technical expertise in maternal and child health and its multisectoral mission to bring the needs of women, children and adolescents to global partnerships such as the UNAIDS Three Frees partnership to fast-track ending AIDS in children and adolescents; the Global Prevention Coalition whose mandate is to catalyse implementation of quality prevention programmes; and the Adolescent HIV Prevention and Treatment Implementation Science Alliance and the Coalition of Children Affected by HIV.

Finally, given the reality that only 60 per cent of children in UNICEF programme countries were receiving early stimulation and responsive care, there is an urgent need to accelerate progress. The Early Childhood Development Action Network partnership, for the ECD global community, continues to be a gateway of knowledge and information for improving the quality of key interventions and building capacity for their delivery.

UNICEF will sustain momentum on implementation of multisectoral ECD intervention packages in both humanitarian and development contexts. This will be done through increased investment in capacities and skills of front-line workers, parents and caregivers. Enabling environments also need to be strengthened through technical support and advocacy so governments and the business sector can better implement family friendly policies.



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Results: Health

Mothers have light moments as they await vaccination of their children at the Nabilatuk health center, Kaabong District, Uganda.

Guided by the Convention on the Rights of the Child (the most complete statement of children's rights ever produced), UNICEF health programming is consciously and systematically informed by human rights approaches and principles with a focus on those children who are the most deprived, disadvantaged or discriminated against. Guided by a life-course approach consistent with the scale, depth and breadth of the global challenges that threaten children's health and well-being, UNICEF strives to deliver results at scale, through integrated and multisectoral programming.

By 2021, health results delivered through the UNICEF Strategic Plan, 2018–2021 aim to contribute to: reducing the under-five mortality rate from 46 per 1,000 to 30 per 1,000; reducing the neonatal mortality rate from 19 per 1,000 to 14 per 1,000; and reducing the maternal mortality ratio from 260 per 100,000 to 192 per 100,000. All three impact indicators are aligned with Sustainable Development Goal (SDG) 3 targets on ending preventable deaths of newborns and children under 5 years of age and reducing the global maternal mortality ratio by year 2030.

Four health results areas contribute to Goal Area 1: (1) maternal and newborn health, (2) immunization, (3) child health and (4) adolescent health. Using primary health care (PHC) as a foundation for the realization of universal health coverage (UHC), programming brings caregivers and families closer to health systems so that children's right to health can be respected, protected and fulfilled.

In 2019, health programmes were implemented in 119 countries with the help of 1,079 technical staff. Expenses in the health sector totalled US\$1.33 billion, of which 17 per cent was from regular resources. Expenses from thematic funds represented US\$38 million. The global value of UNICEF health-related supplies, including those purchased by partners, was US\$ 2.199 billion.

In 2019, working together with other United Nations agencies, governments, civil society and private sector actors, UNICEF delivered health results in Goal Area 1 in both development and complex humanitarian environments. At the outcome level, 13 of 16 indicators were on track to reach the 2021 Strategic Plan targets. At the output level, 13 of 17 of the 2019 milestones were met or exceeded and all four result areas recorded progress rates over 90 per cent.

Despite this strong performance, impact- and outcome-level progress in maternal, newborn, child and adolescent health and immunization are beset by inequities and too slow to achieve the SDGs by 2030. Hence, the midterm review of the Strategic Plan determined the need for acceleration. This requires increasing both Strategic Plan targets and programmatic efforts, notably in strengthening PHC. UNICEF plans to contribute to PHC revitalization by improving front-line worker capacity, supply chains, the quality of care, and digital health information and data. In addition, UNICEF plans to increase its engagement with school health as a platform for the integrated delivery of preventive and promotive interventions for adolescents, including mental health. Another key priority stemming from the midterm review will be to mainstream climate change and environmental degradation within health programmes.

The emergence and rapid spread of coronavirus disease 2019 (COVID-19) will severely challenge health systems and risk reversing decades of progress made in reducing preventable deaths. Early estimates show that a 15 per cent reduction in coverage of basic life-saving services for 6 months would result in 253,550 additional child deaths and 12,190 additional maternal deaths.³ More than ever, accelerating the revitalization of PHC in countries with the highest burdens of maternal, newborn and child mortality will be a priority for sustainable results.

A high concentration of disease- and intervention-specific vertical investments has undoubtedly helped substantially reduce child mortality. Flexible resources enable critical horizontal interventions, such as integrated programmes, multisectoral approaches, system strengthening for quality PHC, addressing programme gaps in countries that do not have vertical funding; and in developing programmes on the thrive agenda. Without these, the SDGs will not be realized for all children. While UNICEF remains incredibly thankful to its resource partners, the current level of global thematic funding to health of around US\$3 million is insufficient to strategically address funding gaps. A flexible global thematic source of at least US\$20 million could enable UNICEF horizontal interventions to ensure that children stay alive, healthy and well.



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This boy is only a few minutes old. Aïcha Koné was the first mother who gave birth at the Hospital of Port Bouet, a suburb of Abidjan, the capital of Côte d'Ivoire, at 00.11 am on 1 January 2019.

Results Area 1: Maternal and newborn health

Aligned with the SDGs, reducing maternal mortality and ending preventable neonatal mortality are critical to the first goal of the UNICEF Strategic Plan. Programming focuses equally on all stages of the continuum of care, including pre-conception, antenatal care, safe delivery, postnatal care, and maternal and newborn tetanus elimination. In 2019, UNICEF placed particular emphasis on improving the quality of care at the time of birth; accelerating global efforts to transform care for small and sick newborns; moving from a survival-only approach to a more holistic early childhood development (ECD) approach encompassing survival, growth and development; and linking facility-based care with follow-up care in the community as the next frontier for newborn survival.

UNICEF is on track to meet Strategic Plan targets for skilled birth attendance and institutional delivery, and has already met the target for postnatal care for mothers.

UNICEF supported 31 countries (2021 target: 30) with high neonatal and maternal mortality in implementing plans

to strengthen the quality of maternal and newborn care. In the 52 high-burden countries that embraced the Every Newborn Action Plan (ENAP) tracking tool in 2016 (the baseline year for the Strategic Plan), UNICEF and partners supported a cumulative 112 million live births in designated health-care facilities between 2016 and 2019. To improve the quality of care, UNICEF supported water, sanitation and hygiene (WASH) in 3,341 health-care facilities, of which 3,008 (90 per cent) were located in the 52 ENAP focus countries. In 2019, Chad, the Democratic Republic of the Congo and one region of Nigeria were validated for maternal and neonatal tetanus elimination (MNTE), and more than 6 million women of reproductive age received two or more doses of tetanus toxoid-containing vaccines through UNICEF-supported supplementary immunization activities in six high-risk countries.

UNICEF invested US\$221 million in maternal and newborn health programmes, with US\$61 million of expenses drawn from regular resources.

Outcome and output indicators for maternal and newborn health

FIGURE 6: Outcome results on maternal and newborn health, 2019

Outcome	Baseline	2019 value	2021 target
Percentage of pregnant women receiving at least four antenatal visits (SDG 3.8.1)	Total: 51% Aged 15–19: 52%	60% Aged 15–19: 52%	Total: 65% Aged 15–19: 57%
Percentage of live births attended by skilled health personnel (home and facilities) (SDG 3.1.2)	73%	76%	77%
Number of live births delivered in health-care facilities through UNICEF-supported programmes (SDG 3.1.2)	25 million	112 million	120 million
Percentage of (a) mothers and (b) newborns receiving postnatal care (SDG 3.8.1)	(a) Total: 48% Aged 15–19: 48% (b) 33%	a) 60% Aged 15–19: 57% (b) 44%	(a) Total: 52% Aged 15–19: 52% (b) 43%

FIGURE 7: Output results for maternal and newborn health, 2019

Output	Baseline	2019 milestone	2019 value	2021 target
Number of countries reporting that the national Health Management Information System (HMIS) includes an indicator for newborns benefiting from kangaroo mother care	12	25	20	51
Number of countries that are verified/validated as having eliminated maternal and neonatal tetanus	44	47	47	59
Number of countries implementing plans to strengthen quality of maternal and newborn primary health care	18	15	31	30

Context

The good news is that the neonatal mortality rate fell to 18 deaths per 1,000 live births in 2018 from 37 in 1990 – a 52 per cent decline. However, globally, an estimated 2.5 million newborns died in the first month of life in 2018 – approximately 7,000 newborns every day. The share of neonatal deaths accounts for 47 per cent of all under-five deaths. In addition, more than 2 million babies are stillborn each year. Globally, over 800 women still die every day from causes related to pregnancy or childbirth. Improving the survival chances of babies and their mothers remains an urgent global challenge.

A new UNICEF analysis shows that uneven coverage of skilled birth attendance and lack of access to emergency obstetric and newborn care are endangering millions of lives of mothers and their babies across the world, predominantly in Africa and parts of Asia where maternal mortality levels are highest.⁴ Over 5 million families spend over 40 per cent of their non-food household expenses on maternal health services every year, highlighting the huge gap in delivering affordable, quality maternal care to the world's poorest mothers.

Improving services and community demand

Antenatal care

Quality antenatal care (ANC) is essential for pregnant women to obtain a package of basic health, nutrition, and HIV services, care and support to ensure a good pregnancy outcome. By the end of 2019, according to the most recent household survey data, the proportion of pregnant women receiving at least four antenatal visits in the 52 ENAP countries had increased from a baseline of 51 per cent to 60 per cent (2021 target: 65 per cent). For adolescent mothers (aged 15–19 years), stagnation at 52 per cent underscores persistent challenges in ensuring that pregnant adolescents have access to antenatal care.

Prioritizing the most marginalized women, especially pregnant adolescents, remains a priority. For instance, in Eritrea, UNICEF provided support to the Ministry of Health to enable integrated, mobile outreach services to 41 remote areas as part of community-based health services, providing more than 2,000 pregnant and lactating women with antenatal and postnatal care. Results Area 4 details

how UNICEF addresses the specific needs of pregnant adolescents.

In 2019, UNICEF Supply Division delivered 2.2 million courses of sulphadoxine–pyrimethamine to 13 countries for intermittent preventive malaria treatment in pregnancy, equivalent to 726,422 pregnant women provisioned with the chemoprevention for all three focused ANC visits.

Skilled birth attendants

Access to skilled health personnel at birth is critical to curb maternal and newborn mortality and disabilities. The proportion of live births attended by skilled health personnel in the 52 ENAP countries has increased from 73 per cent at baseline to 76 per cent in 2019, just one percentage point shy of the 2021 target – signalling that service coverage is increasing at the expected rate. In these countries, the number of health-care facilities that conduct deliveries increased by 39 per cent over the previous year (147,705 in 2019 compared with 106,614 in 2018). However, acceleration will be needed in several countries to meet the SDGs. Additional investments will be required to ensure universal access to skilled personnel, which is an important component of PHC.



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Mua Thi Dung, 20, holds her infant son while community health worker Su visits her at home in a remote village in Vietnam. As a cultural norm of the Mong ethnic minority, mothers and their newborns rarely leave their homes in the first few months after birth, making regular postnatal visits extremely important.

Between 2016 and 2019, in 52 ENAP countries, a total of 112 million live births (27.4 million in 2019 alone) occurred in health-care facilities through UNICEF-supported programmes (2021 target: 120 million). In addition to high-burden ENAP countries, the maternal and newborn health programme contributed to the safe delivery of 3.4 million newborns in 44 countries, an increase of 1 million births compared with 2018.

For instance, in Somalia – with support from the Department for International Development (DFID); Gavi, the Vaccine Alliance; and others – UNICEF helped some 45 basic and emergency obstetric and neonatal care units serve nearly 180,000 pregnant women, with nearly 46,000 deliveries assisted by skilled birth attendants, while 76,000 new mothers and newborns benefited from postnatal care.

Continuous investment in training personnel on obstetric and newborn care, particularly in settings experiencing resource constraints, is vital to prevent and reduce maternal and neonatal mortality. In Liberia, UNICEF and partners piloted a task-sharing approach that facilitates effective and efficient delivery of advanced emergency obstetric and newborn care in health-care facilities with limited numbers of doctors. Among the 16 clinicians trained under the initiative, 2 successfully managed 45 out of 54 cases of neonatal asphyxia (83.3 per cent). These clinicians are all women, thus contributing to women's empowerment and gender goals as well as maternal and newborn health.

Improved quality of care is essential in securing the trust of future mothers and increasing service uptake. Readily available, quality supplies are key. In 2018, some 32 countries procured pre-packaged kits that compose the Obstetric Surgical kit (which also includes the Midwifery kit) – a total value of US\$4.9 million.

Postnatal care for mothers and newborns

To boost neonatal survival, postnatal care delivers essential and evidence-based interventions, including immediate assessment of the baby, breastfeeding within one hour of birth, umbilical cord care, and the reinforcement of postnatal care messaging among families and caregivers.

The proportion of mothers receiving postnatal care increased from 48 per cent at baseline to 60 per cent in 2019, according to the most recent survey estimates from the 52 ENAP countries – exceeding the 2021 target of 52 per cent. Based on the most recent survey estimates for the same countries, 44 per cent of newborns received postnatal care, at home or in a health-care facility, in 2019, exceeding the 2021 target of 43 per cent.

In Zambia, for instance, UNICEF and partners strengthened postnatal care by developing the capacities of 120 Safe Motherhood Action Group members (to strengthen counselling of mothers on maternal and newborn care at community level) and of 100 health-care providers on essential newborn care, and helped 144 nurses receive supportive mentorship. As a result, 74 per cent and 84.9 per cent of mothers in Central and Western provinces, respectively, received postnatal care within 72 hours of delivery.

Community demand for services

Ensuring community demand for services is essential to guarantee service utilization. Utilizing its comparative advantage in Communication for Development (C4D, also known as social and behaviour change communication [SBCC]), UNICEF applied evidence-based strategies across countries. C4D helps address sociocultural barriers to health-seeking behaviour and caregiving practices, while strengthening community engagement and accountability for mothers' and newborns' health.

In Mali, in addition to equipping maternity wards and neonatal units with quality materials and commodities, UNICEF emphasized raising awareness within the communities to ensure families would use the services. Using films, community dialogues and engaging men, UNICEF reached over 2,000 people in five health districts. In addition, 4 'schools of husbands' (*écoles de maris*) and 56 'student husband champions' were set up to promote gender-sensitive health services. The schools are vital in helping men learn, understand and respect the health rights and needs of women and girls, while 'champions' can further promote these rights among their peers.

Quality of care

Evidence shows that antenatal care and institutional delivery alone do not reduce maternal and neonatal mortality. Quality services, dignity and respect are equally essential. With support from the Bill & Melinda Gates Foundation, the Quality Improvement initiative is improving the provision and experience of care in countries with high maternal and neonatal death rates.

In 2019, UNICEF worked closely with the World Health Organization (WHO) and national governments to jointly implement the quality-of-care model in 211 health-care facilities across 18 districts in five countries (Bangladesh, Ghana, Kenya, Malawi and the United Republic of Tanzania). The number of countries in the global Quality of Care Network increased from 10 to 11, with the addition of Kenya.

Bangladesh, Ghana and the United Republic of Tanzania remain the three front-runner countries and offer valuable experiences for the Network. Ghana has become a model country with remarkable achievements in the quality improvement project known as the Mother Baby Friendly Health Facility Initiative. The quality of care baseline assessment score increased from 59 per cent to 71 per cent (target: 75 per cent) in the intervention health-care facilities. Key interventions included improved pre-discharge postnatal care counselling, improved capacity to provide essential care at birth, and the use of social media platforms to discuss referrals and complicated obstetric cases with specialists. In addition, 35 health staff in Upper West Region were trained on the national kangaroo mother care (KMC) guidelines and were able to help mothers practise KMC in the three intervention hospitals – 67 per cent of eligible preterm/low-birthweight babies received KMC, and 80 per cent survived.

Quality improvement progress is fundamental for West and Central Africa since the region has the highest newborn mortality rate. Six countries have been integrated into the Quality Equity Dignity network (Côte d'Ivoire, the Democratic Republic of the Congo, Ghana, Liberia, Nigeria and Sierra Leone) and 18 countries have implemented key strategic interventions. In South Asia, staff from 27 hospitals (14 in Pakistan, 7 in Sri Lanka, 6 in Bangladesh) were trained and mentored through in-country workshops, on-site coaching and webinars as they established their quality improvement programmes.

To further improve the quality of care provided to mothers and newborns, UNICEF works across the health and WASH sectors. UNICEF had improved access to WASH in 3,341 health centres by the end of 2019. Of this total, 3,008 (90 per cent) were located in the 52 ENAP focus countries, demonstrating UNICEF's multisectoral approach to quality of care.

Work undertaken in Uganda underscores the multisectoral nature of improving the quality of care in health-care facilities. Thirty-five facilities benefited from improved, gender-sensitive WASH facilities, while 76 were refurbished and supported with lighting. As a result, facility-based deliveries in the model sites in Karamoja and West Nile subregions increased by 13 and 8 per cent, respectively.

Over and above trained health personnel and functioning health-care facilities with WASH services, respectful maternity care is a core human right. This was implemented in Bangladesh, Ghana, Kenya, Malawi and the United Republic of Tanzania. The mechanisms to improve the provision of rights-based care were established, and the process to report abuse was instituted in pilot facilities.

An assessment conducted in intervention facilities showed a reduction of all forms of abuse between the baseline and follow-on assessment. Client satisfaction with maternity care also improved significantly (85 per cent reported) with a correlated increase in service utilization.

UNICEF West and Central Africa Regional Office and partners have taken the lead in Africa in the fight against violence in health-care facilities during pregnancy, childbirth and hospitalization – by organizing the first African Forum on the Experience of Care for Women, Newborns, Children and their Families. The Respectful Maternity Charter was launched during the Forum by the White Ribbon Alliance.

Another critical component for improving the quality of care is the prevention of possible serious bacterial infections (PSBI), particularly in vulnerable communities without access to health-care facilities. UNICEF supported the roll-out of a simplified antibiotic regimen for PSBI cases where referral is not possible. Initially rolled out in Indonesia, the Niger, Pakistan and the United Republic of Tanzania, lessons learned were shared in a South–South inter-country meeting featuring four observer countries (Myanmar, Uganda, Yemen and Zimbabwe).

Maternal and neonatal tetanus elimination

Globally, one newborn perishes of neonatal tetanus every 17 minutes. Improving front-line services, as part of quality neonatal care, is essential in eliminating maternal and neonatal tetanus, a condition that mothers and newborns can contract when deliveries occur in unhygienic conditions. As maternal and neonatal tetanus is a strong marker of inequity, UNICEF remains at the forefront of eliminating a disease that strikes the underserved and most vulnerable women and newborns.

Globally, as of 2019, some 47 of the 59 countries identified as high risk in 1999 have achieved elimination of the disease, fully meeting the 2019 milestone. Chad and the Democratic Republic of the Congo successfully achieved MNTE (*see Case Study 1*) – crucial progress for the West and Central Africa region. In addition, the North West geopolitical zone of Nigeria was also validated for MNTE. In 2019, more than 6 million women of reproductive age received two or more doses of tetanus toxoid-containing vaccines through UNICEF-supported supplementary immunization activities in Afghanistan, Nigeria, Pakistan, South Sudan, the Sudan and Yemen.⁵ These successes are attributed to strong commitment from national governments, careful phasing of implementation, and integration of tetanus toxoid vaccination with other health interventions to reach the most inaccessible women.

CASE STUDY 1: Chad: Eliminating maternal and newborn tetanus

A very high proportion of tetanus cases worldwide occur in mothers and their newborns. The World Health Organization estimates that in 2017 (most recent estimates), 30,848 newborns died from neonatal tetanus. Mothers and infants die in excruciating pain within days of delivery, but this infectious disease is easily preventable through immunization and hygienic birth practices. A series of three vaccinations provides lifetime immunity to a woman and all her future children.⁶

The support of UNICEF partners such as Kiwanis International and the Latter-Day Saints Charities has helped to increase equitable access to life-saving immunizations for some of the most vulnerable mothers and children in the world.

In Chad, UNICEF took a holistic approach to reaching women of reproductive age and ensuring they received appropriate tetanus toxoid vaccination.

UNICEF worked with the Government to enhance the technical capacity of 339 health-care personnel in charge of vaccinations and 40 trainers in child health at facility and community levels in 17 UNICEF-supported districts. Fourteen medical doctors were trained in district management and public health, 92 health workers were trained in Integrated Management of Neonatal and Childhood Illness and 104 in focused antenatal care. All three training packages directly impacted immunization through enhanced capacity for district planning of health services, the adoption of a comprehensive approach to young children's health and enhanced focus on tetanus toxoid vaccination as part of antenatal care.

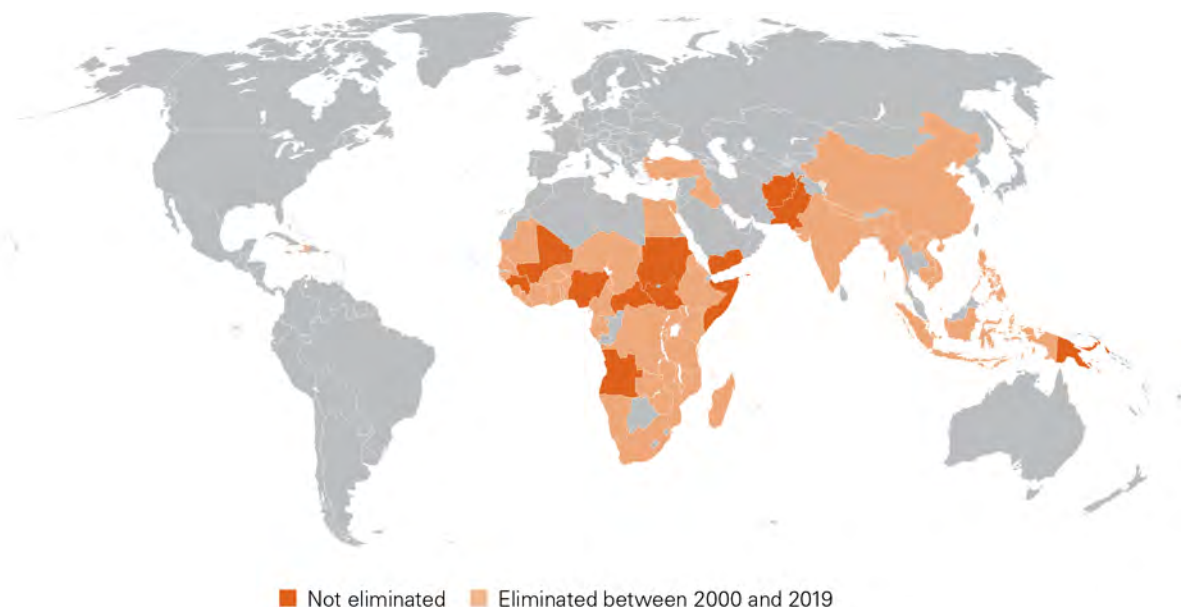
As a result, Chad was certified as having eliminated neonatal tetanus in February 2019.



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Idéita Kaltouma with her baby girl at Békamba's Health Center in Mandoul Ouest, South West Chad.

FIGURE 8: Elimination status of maternal and neonatal tetanus, 2019



Source: Immunization, Vaccines, and Biologicals database; World Health Organization (2019).

Challenges in achieving further gains persist; access remaining a fundamental issue. Competing immunization priorities such as measles and polio endemicity and outbreaks such as circulating vaccine-derived polio create further obstacles and delays, for instance in Afghanistan, Angola, Pakistan and Papua New Guinea.

Eliminating maternal and newborn tetanus is feasible. In an investment case,⁷ UNICEF demonstrates that achieving MNT will avert approximately 70,000 neonatal deaths over 10 years of vaccine protection, resulting in approximately 4.4 million life-years gained. It will cost US\$2,900 per death averted and US\$45 per life-year gained. A strategic investment of US\$198 million over three years would help eliminate maternal and newborn tetanus.

Maternal and newborn health in humanitarian settings

In humanitarian settings, non-discriminatory and accessible front-line services are even more critical to ensuring the provision and continuity of life-saving care for mothers and their infants. For instance, in Somalia, UNICEF ensured that 28,545 emergency-affected pregnant women had access to skilled birth attendants to reduce complications and mortality.

In Ethiopia, using C4D, UNICEF consistently advocated for the use of locally tailored and community networks to enhance community engagement to increase the use of maternal, newborn and child health services. In Gambela

refugee camps, the approach increased antenatal care from 30 per cent to 65 per cent; postnatal care, 32 per cent to 80 per cent; and the proportion of fully vaccinated children, 60 per cent to 92 per cent.

UNICEF is proposing revisions to its Core Commitments for Children in Humanitarian Action to include new commitments on maternal and newborn health, adolescent health and health system strengthening in fragile settings, as well as commitments on public health emergencies. Newborn care during humanitarian crises is a serious concern. The *Newborn Health in Humanitarian Settings: A Field Guide* was disseminated in Ethiopia, Kenya and Uganda.

Strengthening national and subnational capacity

UNICEF capitalizes on a number of comparative advantages, including strengthening subnational-level governance, which requires improving data collection and use to inform decision-making. Developing subnational capacity is especially important to operationalize the 'leave no one behind' principle. Kangaroo mother care is a proven, low-cost tool to ensure low-birthweight neonates survive by implementing continuous skin-to-skin contact. The UNICEF Strategic Plan monitors the number of countries that include an indicator on newborns benefiting from KMC in their national health management information systems (HMIS) to ensure equity.

By the end of 2019, twenty countries had included this indicator in their HMIS, including Kenya, Uganda, the United Republic of Tanzania and Yemen. While this represents a gain of eight countries from the baseline, it is short of the milestone of 25. Nonetheless, the number of facilities providing KMC increased by 38 per cent (4,021 in 2019 compared with 2,924 in 2018).

UNICEF is placing more emphasis on the adoption of KMC and associated monitoring mechanisms within countries. Pakistan developed a provincial newborn health strategy and KMC guidelines while actively promoting intervention and care for sick and small newborns. In Iraq, KMC was integrated into the national maternal and newborn health initiative, while the Comoros, Eritrea and Lesotho drafted guidelines on early and essential newborn care and KMC.

Another aspect of building national capacity and improving the quality of care involves increasing skills in maternal and perinatal death surveillance and response (MPDSR),

which plays a unique role in shoring up the evidence base for advocacy, policy, planning and accountability to reduce preventable maternal and neonatal deaths under ENAP.

In 2019, UNICEF provided technical support for MPDSR implementation in Ghana, Namibia, Sierra Leone and Uganda, particularly for capacity-building, updating national MPDSR guidelines, revising data collection tools in accordance with global standards, and establishing MPDSR systems including digitization. UNICEF trained 44 trainers from South Asia to introduce perinatal death review and strengthen stillbirth reduction.

Thanks to global thematic funds, UNICEF is addressing ongoing challenges with perinatal mortality in high-burden areas of countries in Europe and Central Asia. In collaboration with partners, UNICEF finalized a perinatal audit tool that is now being used to better measure the distribution of facilities that find providing quality care challenging (*see Case Study 2*).

CASE STUDY 2: Uzbekistan: Global thematic funds help improve quality of care for mothers and newborns through perinatal audit

Administrative data show that stillbirth and early neonatal mortality have been increasing in recent years in Uzbekistan. However, perinatal death audit has never been introduced.

In 2019, thanks to global thematic funds, UNICEF supported the Ministry of Public Health in improving the quality of maternal and newborn care by adapting and implementing perinatal audit. In the words of Dr. Malika Usmanova, deputy director of Tashkent City Perinatal Center, “perinatal audit is a well-developed mechanism for learning all the circumstances of each newborn death, including any interruptions in the medical care system that could have been prevented.”

A national technical working group on perinatal death audit is now established, WHO-recommended guidelines on perinatal death audit are adapted, and the Ministry of Public Health has approved national guidelines and reporting forms. In the six facilities that started implementing perinatal audit, 56 health-care providers have been trained on the methodology. Additionally, supportive supervision visits helped teams develop SMART⁸ recommendations to improve the quality of care provided to newborns.

The results and lessons learned from the pilot implementation helped develop recommendations for further scale-up, the recommendations direct staff to apply various interventions, focusing on the needs of the most at-risk group of babies. Interventions include ensuring oxygen availability, advanced respiratory support for newborns, optimal thermal care and more rigorous infection control.

Under the new health-care reforms strategy, Uzbekistan is moving towards improving quality of care, implementing evidence-based technologies, and providing more internationally comparable data. If every newborn is counted and data are collected, analysed and used more effectively, health-care managers will be empowered to take the right decisions to protect babies. The perinatal death surveillance and response system is a good starting point to ensure neonatal survival.



A nurse checks on a preterm baby at the Republican Perinatal centre supported by UNICEF just outside the city of Tashkent, Uzbekistan.

Leveraging collective action

National plans for maternal and newborn health

As a partner in the ENAP global road map to reduce newborn mortality, UNICEF is committed to ending preventable neonatal and maternal deaths. UNICEF continues to work with countries and development partners to integrate ENAP within national health-sector plans.

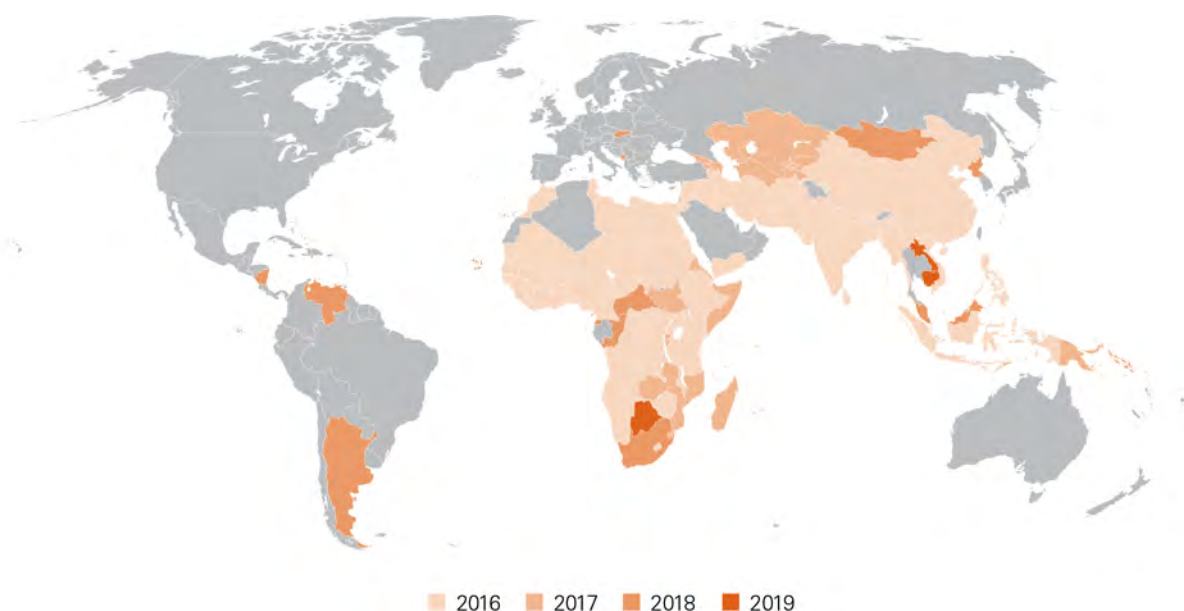
As of 2019, some 67 countries had reported adopting ENAP, up from 53 in 2018. For instance, Somalia endorsed its ENAP, while Angola and Mozambique finalized their newborn action plans. Tunisia and Yemen now have costed national newborn action plans. In Eastern and Southern Africa, ENAP and strategic plans for integrated reproductive, maternal, newborn, child and adolescent health and nutrition were supported in 16 countries and technical assistance was provided to 20 countries.

Because evidence is crucial to translate action into results, accelerated use of the ENAP tracking tool remains central. The total number of countries reporting on ENAP continues to progress steadily: from 10 countries in 2014, to 52 in 2016 (which are the focus ENAP countries tracked in the strategic plan), and 93 in 2019 (with the addition of Botswana, Cambodia and the Lao People's Democratic Republic) (see Figure 9).

Progress under the Every Newborn Action Plan

- 47 countries (up from 44 in 2018) report having a national quality-improvement programme and 45 countries have a plan in place to implement quality-of-care guidelines (up from 38)
- 78 countries have a national newborn mortality target (up from 73)
- 30 countries have a stillbirth target (up from 28)
- 80 countries have developed a response system on the notification of maternal death within 24 hours (up from 77)
- 57 countries have a perinatal-death review system in place (up from 48)
- 52 countries have a national guideline or strategy for care of small and sick newborns (up from 46)
- 42 countries have a human-resource strategy for skilled attendants at birth, and 32 countries have a strategy to retain these cadres
- 63 countries (up from 52) have included all seven essential medical products and technologies in their National Essential Medicines List

FIGURE 9: Adoption of Every Newborn Action Plan tracking tool by year, 2016–2019

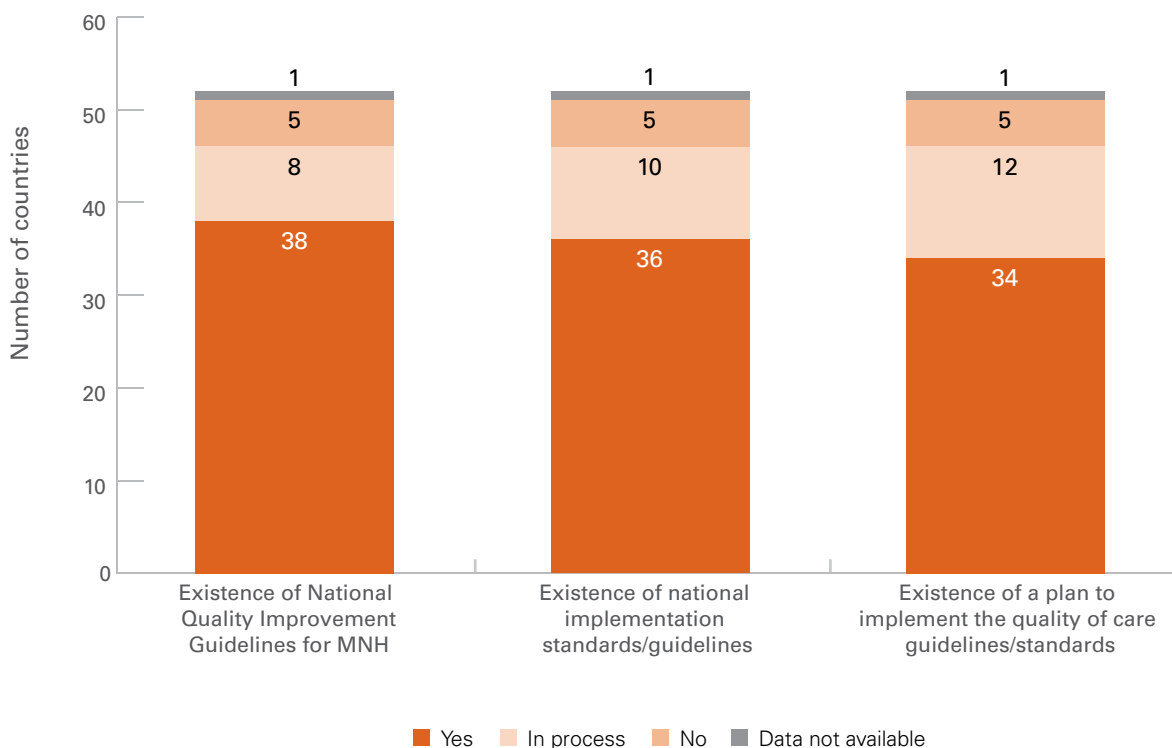


Source: UNICEF New York (2019).

The year 2019 saw an acceleration of the work on improving care for sick and small newborns, a key group for which mortality reduction is urgent. For instance, the number of care units for small and sick newborns increased by 28 per cent (3,709 in 2019 compared with 2,893 in 2018). UNICEF worked closely with ENAP partners to bring global focus on this vulnerable group of neonates. This was exemplified by the release of the global report on transforming care of small and sick newborns, close engagement with WHO for developing standards for small and sick newborn care, technical support for planning and ensuring thought leadership to the Newborn Essential Solutions and Technologies project to implement care for small and sick newborns in four African countries (Malawi, Kenya, Nigeria, the United Republic of Tanzania), and inclusion of a coverage target for small and sick newborn care in the results framework for the next ENAP phase (2020–2025).

UNICEF continues to support countries to implement plans to strengthen the quality of maternal and newborn PHC according to the WHO–UNICEF Quality, Equity, Dignity Network guidelines. By the end of 2019, some 31 countries (double the 2019 milestone of 15) were implementing these plans. With this rapid expansion, the 2021 target of 30 countries has been met at the mid-point of the Strategic Plan period. In West and Central Africa, 12 countries (a doubling from 2018) implemented these critical plans. The additions were Benin, the Gambia, Guinea-Bissau, Nigeria, Mauritania and Togo. Lesotho and Malawi also contributed to reaching this strategic plan goal. Figure 10 shows that the 52 high-burden countries were making strides towards adopting and implementing guidelines and standards to strengthen maternal and newborn PHC. Lastly, an additional 18 countries outside of the ENAP focus countries also made progress on this indicator.

FIGURE 10: Number of countries implementing plans to strengthen the quality of maternal and newborn primary health care, 2019



Source: UNICEF New York (2019). Note: MNH, maternal and newborn health.

Global and regional partnerships

Partnerships continue to be crucial for UNICEF to deliver on its mandate of saving maternal and newborn lives. UNICEF worked closely within the H6 Partnership (WHO, Joint United Nations Programme on HIV/AIDS [UNAIDS], United Nations Population Fund, UN Women, World Bank Group), which has become a crucial pillar of interaction with other United Nations agencies. UNICEF collaborated with WHO on implementing the quality-of-care model in five countries, on tracking progress of the ENAP and in developing the draft results framework for the second phase of ENAP (2020–2025). In addition, UNICEF co-chaired the ENAP working group on newborn care in humanitarian situations and worked with WHO and Save the Children to develop a road map for every newborn in humanitarian and fragile settings for the period 2020–2025.

Other partnerships include the Every Women Every Child movement, the Maternal and Neonatal Tetanus Elimination Initiative partnership, and the Partnership for Maternal, Newborn and Child Health (PMNCH).

Partnerships were also essential to leverage resources for results at the regional level. In South Asia, partnership with the WHO Regional Office for South East Asia and other H6 members has been instrumental in promoting key newborn survival interventions such as KMC and PSBI management. Working with the Muskoka Fund, the UNICEF West and Central Africa Regional Office placed special emphasis on the first community-based PHC forum and the first African Forum on Experience of Care for Women, Newborns, Children and their Families. The UNICEF Eastern and Southern Africa Regional Office conducted a regional scoping study on the enabling environment for WASH services in health-care facilities across its 21 countries to enhance programming. In Latin America and the Caribbean, UNICEF chaired the Neonatal Alliance and supported the regional annual partners meeting advocating for better health care for newborns.

The Every Child Alive campaign continued to target countries with the highest newborn mortality and support the goal of ensuring mothers and newborns have access to affordable quality care. By leveraging a commitment made by the Minister of Health to children at the Every Child Alive campaign launch, the UNICEF Mali office successfully advocated for the Government to provide free health care to all children under 5 years of age as well as pregnant women.

In 2019, UNICEF produced 19 publications on maternal and newborn health, of which 9 were peer-reviewed articles.

UNICEF and WHO jointly launched a much-needed report, *Survive and Thrive, Transforming care for every small and sick newborn*,⁹ to advocate for accessible high-quality, affordable hospital care and community health services

before, during and after birth for mothers and vulnerable newborns, including those who are underserved and marginalized and those living in humanitarian settings or conflict. It sheds light on the transformative care for the 30 million vulnerable newborns currently left behind.

For the first time, WHO and UNICEF estimated the global burden of low birthweight,¹⁰ showing that nearly 15 per cent of babies worldwide are born with low birthweight. As Julia Krasevec, a UNICEF statistics and monitoring specialist, highlights, “we cannot help babies born with low birthweight without improving the coverage and accuracy of the data we collect. With better weighing devices and stronger data systems, we can provide better quality of care to these newborns and their mothers.” The data provide support for various initiatives, including the World Health Assembly Nutrition Targets, ENAP and the Global Strategy for Women’s, Children’s and Adolescents’ Health.

Conclusion

While much work has been done, several challenges remain. And these will be exacerbated by the COVID-19 pandemic which threatens to disrupt access to routine maternal and newborn care services. Securing the continuity of these essential life-saving services must be prioritized in planning a response to the disease.

Investment at scale, particularly public investment, remains a major challenge to scaling up maternal and newborn survival interventions. Unrelenting emergencies in some regions hamper further gains in MNTE.

Strengthening PHC is of critical importance to reduce maternal and neonatal mortality by 2030, and even more so in the context of the new pandemic. PHC has been recognized as the cornerstone for expanded access to quality health services. Investments in infrastructure, human resources and systems are urgently needed to protect essential maternal and newborn care and, where feasible in the context of COVID-19, accelerate the full implementation of these services in order to ‘build back better’. To accelerate progress, UNICEF is committed to providing global leadership in scaling up newborn care, strengthening the quality of care provided in high-burden countries, and promoting accountability and action. In countries with the highest newborn mortality burden, UNICEF looks to intensify its multisectoral effort particularly on integrating WASH in health-care facilities and improving maternal health and nutrition to reduce low birthweight. Lastly, to accelerate results on maternal and neonatal disease elimination, greater coordination between maternal health and immunization programmes will be leveraged along with increased strategic dialogue with resource partners to expand the funding base.



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A brave little boy is receiving his measles vaccine during the vaccination campaign in Impfondo, Republic of the Congo.

Results Area 2: Immunization

Note: Immunization data are for 2018 unless otherwise specified.

Immunization is one of the most successful public health interventions. However, global immunization coverage has stagnated at around 86 per cent between 2008 and 2018, indicating that UNICEF and partners are not on track to achieve the ambitious Global Vaccine Action Plan immunization targets. Despite intensive efforts, which have helped reduce the number of wild polio cases by more than 99 per cent since 1988, polio has not been eradicated and measles outbreaks are still common due to low immunization coverage rates in many, primarily disadvantaged, communities. The benefits of immunization are still unequally shared, both within and between countries, and often missing those children and communities in urban slums, remote rural or conflict-affected contexts.¹¹

Despite these challenges, UNICEF continues to make progress. UNICEF and partners supported the vaccination of 65.7 million children with three doses of the diphtheria-

tetanus-pertussis (DTP3) vaccine in 64 priority countries in 2018. In humanitarian settings, UNICEF supported measles vaccination of 41.3 million children (95 per cent of the target).

Several important milestones were achieved. Assessments show an improvement in country capacity for effective vaccine management: 14 countries demonstrated vaccine management capacity, surpassing the 2019 milestone of 11; and 46 countries implemented a national health-sector supply chain strategy/plan, surpassing the 2019 strategic plan milestone by 10.

The year saw continued introductions of human papillomavirus (HPV) vaccine in eight countries. And an additional two countries introduced meningococcal A vaccine. Forty-seven countries (out of 59) have eliminated maternal and neonatal tetanus. Nigeria succeeded in maintaining its polio-free status for a third year, paving the way for the potential certification of Africa as polio-free in 2020. However, 2019 saw a surge in cases of vaccine-derived poliovirus in Africa, including in Nigeria.

UNICEF made substantial contributions to defining the vision and priorities for immunization in the upcoming decade. The framework for Gavi's new five-year strategy (2021–2025) was endorsed by the Gavi Executive Board. In addition, the global Immunization Agenda 2030 (IA 2030) was developed and is expected to be endorsed by the World Health Assembly in 2020. The overarching goal is to sharpen the equity focus to leave no one behind. This also emphasizes sustainability and the integrated delivery of immunization services within broader PHC services.

The immunization results area accounted for 42 per cent (US\$560 million) of all UNICEF health expenditure in 2019. In addition, UNICEF provided procurement services to governments and other development partners resulting in US\$1.855 billion worth of supplies and services delivered to 105 countries, including US\$1.219 billion on behalf of Gavi. UNICEF procured 2.43 billion¹² doses of vaccines for 99 countries with a value of US\$1.656 billion and supplied vaccines to reach 45 per cent of the world's children under 5 years old.

Outcome and output indicators for immunization

FIGURE 11: Outcome results on immunization

Outcome	Baseline	2019 value*	2021 target
Percentage of children vaccinated against (a) yellow fever and (b) meningitis in high-burden countries	(a) 44% (b) n/a	(a) 49% (b) n/a	(not defined)
Percentage of children who are vaccinated for: (a) first dose of measles-containing vaccine; (b-i) three doses of diphtheria, tetanus and pertussis (DTP)-containing/Penta vaccine; (b-ii) number of countries in which percentage of children vaccinated with DTP/Penta 3 containing vaccine is at least 80% in every district (SDG 3.b.1)	(a) 78% (b-i) 80% (b-ii) 9	(a) 81% (b-i) 81% (b-ii) 8	(a) 85% (b-i) 85% (b-ii) 30
Interruption of wild polio transmission (SDG 3.3)	Three remaining endemic countries	Three remaining endemic countries	Global certification of polio eradication

Note: * 2019 values are based on 2018 data; n/a, not available.

FIGURE 12: Output results for immunization

Output	Baseline	2019 milestone	2019 value*	2021 target
Number of countries that have introduced (a) yellow fever and (b) meningitis vaccines in their national immunization schedule	(a) 21 (b) 4	(a) 23 (b) 14	(a) 21 (b) 11	(a) 25 (b) 26
Number of countries implementing activities to prepare for, prevent, manage or communicate adverse events following immunization (AEFI) or other vaccine-related events	48	38	54	48
Number of countries with effective vaccine management (EVM) composite country score >80%	11	11	14	19
Number of countries implementing a national health sector supply chain strategy/plan	27	36	46	48
Percentage of polio priority countries that had less than 5% missed children at district level during the last polio vaccination campaign in at least half of all districts in the country (humanitarian)	100%	85%	95%	85%
Percentage of UNICEF-targeted children in humanitarian situations vaccinated against measles (humanitarian)	76%	95%	95%	95%

Note: * 2019 values are based on 2018 data.









Context

Per WHO–UNICEF estimates, in 2018, some 116 million children completed vaccination with DTP3, up from 90 million in 2000, representing nearly a 30 per cent increase.¹³ However, coverage rates have stalled over the current decade and, as of 2018, some 65 countries have yet to achieve the Global Vaccine Action Plan target of 90 per cent or greater national coverage of DTP3/Pentavalent 3. Globally, 19.4 million children under 1 year of age did not receive the three recommended doses of DTP-containing/Pentavalent vaccine in 2018, and an estimated 13.5 million children in the same age group did not benefit from any vaccination, the so-called ‘zero-dose’ children. More specifically, 82 per cent of the under-vaccinated children resided in the 64 UNICEF priority countries.

Immunization is one of the most cost-effective public health interventions, averting an estimated 2–3 million deaths every year. The cost–benefit of immunization is clear. Over the period 2021–2030, the return is at least \$20 per \$1 invested.¹⁴ As a rights-based organization, UNICEF remains committed to ensuring that every child and woman fully realize their right to benefit from immunization. Leveraging immunization as an entry-point to identify those children and communities that are left behind, UNICEF uses a multisectoral approach to build stronger PHC systems with the aim of prioritizing the most disadvantaged. This vision and the pathway to its implementation is detailed in the UNICEF Immunization Roadmap 2018–2030 (*Figure 13*).

FIGURE 13: UNICEF priorities for achieving Strategic Plan outputs and outcomes for immunization

All children and women benefit fully from their right to immunization, prioritizing those most disadvantaged

Contexts	FRAGILE STATES	EMERGENCIES	LOW CAPACITY	MEDIUM CAPACITY	HIGH CAPACITY			
Objectives	Global and national policies are based on evidence and address the immunization needs of the most disadvantaged and under-served populations		National systems are positioned to provide immunization services and quality vaccines		Communities value and demand their right to immunization services			
								
	Evidence-based policies promote immunization outcomes in an effective and efficient manner	Global and national immunization programmes accelerate equity improvements for the disadvantaged	Sustainable financing for immunization programmes is achieved	Countries have access to uninterrupted, sustainable, affordable supply of quality vaccines and immunization related supplies in the context of long-term healthy markets	Effective and efficient supply chain systems are in place for all children and women to receive potent vaccines	Children, adolescents and women access and use immunization services	Frontline workers (FLW) enabled to link immunization services with community demand	Interventions to promote and sustain public demand for quality immunization services are designed and implemented
Population Platforms	CHILDREN		ADOLESCENTS		MATERNAL			

Source: UNICEF Immunization Roadmap 2018–2030.

Improving services and community demand

Immunization programmes that leave no one behind

“More children than ever before are being reached with vaccines today. We are delighted to work with UNICEF and all the partners around the world who are working tirelessly to ensure all children, especially those in the world’s poorest countries, can be protected from life-threatening infectious diseases.”

—Violaine Mitchell, interim director of vaccine delivery, Bill & Melinda Gates Foundation

Immunization equity is attained when no avoidable differences exist in vaccination coverage between groups, communities and countries. In 2018, more children were vaccinated than ever before (Figure 14). Health systems

are keeping up with immunization despite the increasing numbers of births: 81 per cent of children received three doses of DTP-containing/Penta vaccine (2021 target: 85 per cent) in 64 priority countries. The challenge of keeping pace with the increasing number of births is most acute in Africa, where 8.5 million under- and unvaccinated children (out of a global total of 19.4 million children) lived in 2018.¹⁵ Furthermore, inequities in vaccination persist at the subnational level. Only 8 of the 64 priority countries achieved 80 per cent coverage in every district, against a target of 30 by 2021.

The plateau in coverage is compelling the global immunization community to address inequity. UNICEF continued to advocate for the prioritization of children in ‘zero-dose’ communities – such as those in urban slums, remote rural areas and conflict settings, and other minority and marginalized groups – for the delivery of immunization and other basic health services. The concept of zero-dose children is being used to align efforts, allocate resources and define success. This shift in approach is warranted since the number of zero-dose children globally is twice the number that receive only partial vaccinations in 2018 (Figure 15). The zero-dose concept highlights the need for stronger programme integration and could help guide efforts towards revitalizing PHC to reach UHC in these communities.



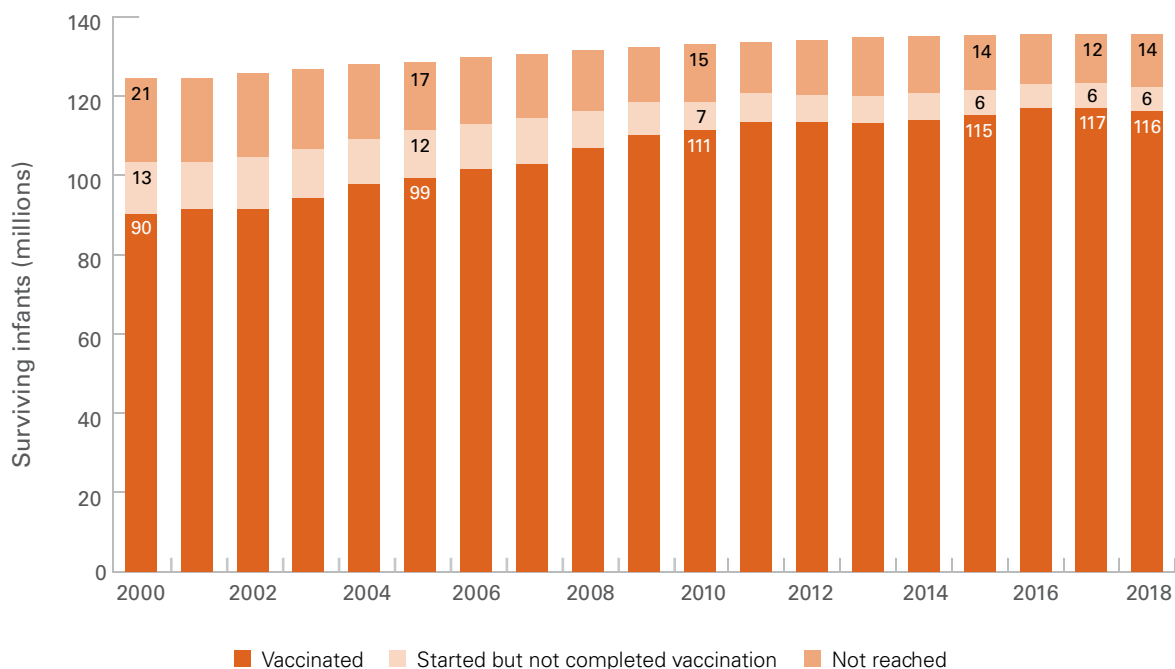
Mamadou Kassé, 29, a vaccinator at the Sofara community health centre, records information on the children attending his vaccination session in the remote Kankelena village, Mopti region, Mali.

FIGURE 14: Number of vaccinated children, selected vaccines, 2011-2018, in 64 priority countries

Vaccine	2011	2016	2018
Third dose of DTP-containing vaccine (DTP3)	61,054,000 (77%)	65,255,000 (81%)	65,674,000 (81%)
Third dose of pneumococcal conjugate vaccine (PCV3)	3,501,000 (4%)	33,303,000 (41%)	37,893,000 (46%)
Last dose of rotavirus vaccine	451,000 (1%)	17,215,000 (21%)	30,406,000 (37%)

Source: WHO–UNICEF estimates of national immunization coverage, 2018 revision; United Nations, Department of Economic and Social Affairs, Population Division, World Population Prospects: The 2019 Revision, United Nations, New York, 2019.

FIGURE 15: Global immunization performance, 2000–2018



Source: 2018 WHO–UNICEF Estimates of National Immunization Coverage, 2019.

The UNICEF Coverage and Equity (C&E) Assessment guide aims to better inform in-country coverage improvement plans and activities, ensuring these are inclusive of the most underserved children and contribute to reducing zero-dose children. In essence, C&E prioritizes focus where it is required the most and this has already yielded rich results.

- As part of the C&E improvement in immunization in Papua New Guinea, in two remote local level governments and two urban settlements totalling approximately 174 communities, UNICEF helped the Government reach 9,100 children, 50 per cent of whom were below 2 years of age and vaccinated for the first time.
- In Kenya, UNICEF is supporting the Child to Child strategy whereby primary school children are enlisted as immunization mobilizers and defaulter tracers. As a result, more than 3,200 pupils were enlisted from 45 primary schools and were able to register and follow up on the vaccine completion of 6,867 children. The strategy identified 566 defaulters and two zero-dose children for follow-up.
- In Liberia, in partnership with the NGO Last Mile Health, UNICEF supported 743 community health assistants in conducting defaulter tracking to identify the children who missed routine immunizations and who lived more than 5 km from a health centre.

As a result of this innovative work, C&E assessments are now inherent Gavi requirements for countries requesting health system and immunization strengthening support.

Another example of how to operationalize the equity agenda is UNICEF's work on urban immunization. With support from UNICEF, 20 countries used the urban immunization toolkit to integrate the needs of the urban poor into planning, implementation and monitoring of immunization services as part of Gavi's health system-strengthening approach. Consequently, in Madagascar, an innovative approach to catch up missed children in urban areas included the establishment of vaccination posts in large urban markets of Antananarivo, the capital city.

To further address inequities and uphold children's rights, UNICEF and partners are also focusing on gender-related barriers to vaccination uptake. Following up on initial work conducted in 2018, UNICEF developed materials to help countries identify these barriers, including a draft compendium of indicators from across sectors and a draft instruction guide for its application. UNICEF and the Gates Foundation co-chaired the Equity Reference Group for Immunization which influences the overall direction and prioritization of immunization equity in the next decade and helps focus global attention on gender influences in inequities. In the South Asia Regional Office, the Extended Programme on Immunization (EPI) team and the gender section developed a toolkit on 'Immunization and Gender' to increase the skills of EPI managers and immunization practitioners to understand key gender-related barriers that might affect care-seeking behaviour in vaccination.

Accelerated immunization initiatives

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

Measles and rubella present risks for severe health complications, disability and death. The global coverage of measles-containing vaccine first dose (MCV1) was 86 per cent and MCV2 was 69 per cent in 2018. This remained below the 95 per cent coverage threshold required to stop the spread of this highly contagious virus. In 2018, some 19.2 million infants did not receive MCV1 through routine immunization.¹⁶ Major outbreaks were reported in the Democratic Republic of the Congo, Georgia, Kazakhstan, Kyrgyzstan, Madagascar, New Zealand, the Pacific Islands, the Philippines, Thailand and Ukraine.¹⁷ Worldwide, more than 140,000 people died from measles in 2018.¹⁸ In some cases, conflict, insecurity or a breakdown in services complicates the task of reaching children with quality vaccine services. In other cases, mistrust of vaccines, misinformation or complacency fuel parents' hesitation or refusal to vaccinate their children.

Despite this challenging context, in 2018, some 81 per cent of children received MCV1 in the 64 UNICEF priority countries (2021 target: 85 per cent).

The combined measles–rubella vaccine is essential in preventing measles and protecting pregnant women from contracting rubella. UNICEF supported successful integrated measles–rubella supplementary immunization activities in the Democratic People's Republic of Korea and Papua New Guinea, which achieved 98 and 90 per cent coverage, respectively.



Four-year-old Mohammed Abdullah is vaccinated in Aden, Yemen during a UNICEF-sponsored Measles and Rubella vaccination campaign. In Yemen, years of conflict have led to an outbreak of the deadly virus.

Yellow fever is also an important priority, since 47 countries across African and Central and South America have endemic regions for this acute viral haemorrhagic disease. Yellow fever recently re-emerged in Brazil as a threat of concern, with an increasing number of cases confirmed beyond the limits of the Amazon region, considered endemic for the disease.

In 2018, some 49 per cent of children in 24 high-burden countries were vaccinated against yellow fever (16.7 million children). For instance, the campaign targeted over 5 million individuals in the eight localities of the densely populated Gezira state of Sudan. UNICEF is now helping the country prepare to introduce yellow fever vaccination in its immunization schedule, targeting children under the age of one. However, global coverage has been affected by insufficient progress in the introduction of yellow fever vaccine in Ethiopia, South Sudan and Uganda, owing in large part to competing priorities and subsequent prioritization of resources. Meningococcal meningitis is another disease UNICEF focuses on in its accelerated immunization initiatives. Most cases and outbreaks occur in the 26 countries of sub-Saharan Africa located in the so-called 'meningitis belt', all of which are UNICEF priority countries. In 2019, outbreaks were reported in Burkina Faso, Chad, Ghana and Togo. A total of 14,756 cases and 842 deaths were reported from meningitis belt countries during the year.

Eleven priority countries introduced the vaccine in their routine immunization programmes (2018 data). Nine of these countries are in the meningitis belt (Burkina Faso, Chad, the Central African Republic, Côte d'Ivoire, Ghana, the Gambia, Mali, the Niger and the Sudan), the others were Iraq and the Syrian Arab Republic.

Over 315 million 1- to 29-year-olds were vaccinated with MenAfriVac from December 2010 to July 2019 in 23 countries in the meningitis belt. Over 20 million children were vaccinated in 2019 through catch-up campaigns in Nigeria and the Gambia which introduced the vaccine in its routine immunization programme. The introduction of MenAfriVac has resulted in a significant reduction in epidemics due to meningitidis serogroup A¹⁹ and no such case was reported in 2019.

Towards a polio-free world

With 2019 came a mix of success and challenges in the global polio eradication efforts. Nigeria marked three years without a single child being paralysed by the wild poliovirus (WPV), paving the way for the potential certification of the African continent as WPV-free in 2020. The Global Commission for the Certification of Poliomyelitis Eradication declared the eradication of WPV Type 3, meaning that only one out of three types of WPV remains. However, there was little time to celebrate as wild polio cases spiked in Afghanistan and Pakistan, with 29 and 146 cases, respectively, compared with 21 and 12 cases in 2018. In addition, cases of circulating vaccine-derived poliovirus (cVDPV) surged in Africa and parts of Asia.

What is cVDPV?

Circulating vaccine-derived poliovirus (cVDPV) outbreaks are usually very rare. Children vaccinated with the oral polio vaccine can carry live vaccine virus while their bodies build up antibodies. These children continue to shed the vaccine virus in their faeces for a few days. When supplementary immunization activity coverage is suboptimal, unvaccinated children continue to keep the vaccine virus in circulation. While circulating in such environments, the excreted virus can mutate and regain its ability to cause paralysis. Such mutated strains are called cVDPV and cause outbreaks. In 2019, globally, 353 cVDPV2 cases and 11 cVDPV1 cases were reported.

As one of the key partners of the Global Polio Eradication Initiative (GPEI), UNICEF continued its critical work on vaccine procurement and management, social mobilization and communication, with a strategic focus on the two polio endemic countries (Afghanistan and Pakistan) as well as countries affected by cVDPV outbreaks, including Nigeria.²⁰

To better tackle the challenges that led to increased polio cases in 2019, the GPEI launched a revised Polio Endgame Strategy 2019–2023 focused on strengthening immunization services and address, beyond polio vaccination, the broader needs of communities deprived of basic services. A regional hub was established in Amman, Jordan to enhance coordinated support to Afghanistan and Pakistan, and permanent Rapid Response Teams were created to accelerate the programme's response to outbreaks.

The world faced a dramatic increase in the number of cVDPV outbreaks globally (18 countries in 2019 up from 9 in 2018). The GPEI has finalized a new strategy to control cVDPV2 and address the evolving polio epidemiology. The strategy supplements the existing endgame strategy launched in May. It entails strengthening the speed and quality of responses to cVDPV2 outbreaks, optimizing the management of available vaccine stocks, introducing an improved polio vaccine, and creating an enabling environment for sustained vaccine uptake and trust in the programme. Underpinning all activities is communication and C4D, which are fundamental to ongoing outbreak responses, as well as the introduction of a new vaccine. The concerted efforts led to the closing out of polio outbreaks in the Democratic Republic of the Congo, Kenya, Mozambique, the Niger and Papua New Guinea. UNICEF delivered over 1 billion doses of inactivated polio vaccine and oral polio vaccine to more than 75 countries in 2019, including endemic and polio outbreak countries as well as to meet routine requirements. Of the polio endemic and

outbreak countries that reported data, 95 per cent were able to vaccinate 95 per cent of children below 5 years of age in at least half of the districts targeted for vaccination.

Women are at the forefront of polio eradication efforts globally. UNICEF, together with GPEI partners, continues to adapt local strategies to engage women in the critical decision to vaccinate their children – as mothers, caregivers and heroes on the front line of eradication. Female vaccinators are crucial to building community trust, especially in communities where cultural norms prevent men from entering households. Today,²¹ female front-line health workers make up 87.5 per cent of vaccinators in Nigeria, 63 per cent in Pakistan, and 40 per cent in Afghanistan (female front-line workers in urban areas).²² In May 2019, the GPEI Polio Oversight Board officially endorsed the GPEI Gender Equality Strategy, a concrete effort to address gender-related barriers to immunization and significantly improve participation of women in the GPEI with a commitment to reaching gender parity over the 2019–2023 implementation period.

Gender-conscious efforts have helped ensure that polio vaccination remains a truly equitable health service. Data from previous years show that girls and boys in polio-endemic countries receive equal protection from the virus; however, more recent data have shown that significant

barriers affect women in countries with strict gender norms, which may impact the gender equity of health-seeking behaviour.

Demand for immunization

Demand creation and community empowerment through evidence-driven strategies aim to impart necessary information and knowledge, instil confidence in the quality and safety of services provided, and promote positive and measurable behaviour change.

UNICEF believes in people-centred care whereby health services are tailored to people's needs and provided in partnership with people as equal partners – respected, informed, engaged, supported and treated with dignity and compassion.

Tools such as 'Journey to Immunization' actively involve everyone who benefits from services to develop innovative solutions that are viable, appropriate and acceptable in their context. In 2019, UNICEF provided technical support in Human-Centred Design to Ethiopia, Indonesia, Madagascar, Somalia, South Sudan and Zimbabwe, ensuring tailored and context-based demand-promotion activities to shore up families' uptake of vaccination.



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Four-year-old Ajwa shows the ink mark on her little finger, which confirms that she has received polio vaccine during the Polio – National Immunisation Day at Lahore railway station, Punjab Province, Pakistan.

In Guinea-Bissau, UNICEF supported the nationwide measles vaccination campaign for children under 5 with strong community mobilization and C4D interventions. UNICEF mobilized 29 community radios, 88 traditional leaders and religious organizations, volunteers, women's associations, non-governmental organizations (NGOs) and community-based organizations to encourage people to adopt behaviours conducive to routine vaccination and birth registration. For the first time, an initiative to register children below 7 years of age was associated with the vaccination campaign. Through six Sectoral Social Mobilization Committees, the intervention was particularly successful in reaching the most vulnerable and nomadic communities in remote areas.

In polio priority countries, UNICEF worked together with key local stakeholders to recontextualize communication strategies utilizing research and social data analysis to promote vaccination and other positive health practices such as hand washing and breastfeeding. In Pakistan, over 18,500 community-based vaccinators engaged with communities with the support of local influencers in polio high-risk areas, making significant gains in rebuilding community trust and reducing the number of children missing out on vaccination, in addition to promoting key health and hygiene practices beyond polio.

Immunization in humanitarian settings

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

Working with partners in humanitarian situations, UNICEF continued to provide leadership in supporting measles campaigns, reaching 41.3 million children with life-saving measles vaccines. The majority of children (33 million) were located in just eight countries, including 20 million children in the conflict-affected Syrian Arab Republic and Yemen.

UNICEF continued to work with partners to re-establish vaccine cold chains, provided vaccines and technical support, and helped build the capacities of health workers to provide vaccinations in countries disrupted by conflict and humanitarian emergencies.

With Gavi support, UNICEF contributed to establishing and sustaining services in newly accessible areas in the Syrian Arab Republic. UNICEF prioritized the restoration of basic services, with a focus on under-served and high-risk areas. The expansion of vaccination services reached over 500,000 children with DTP3 and over 3 million children with polio vaccine, exceeding 2018 results. During the year, UNICEF and partners responded to several outbreaks, including diphtheria, cholera and Ebola virus disease (EVD). For instance, in Yemen, 3.8 million children aged 6 weeks to 15 years were vaccinated against diphtheria in 14 governorates.

Through UNICEF engagement in the International Coordinating Group (which includes WHO, Médecins Sans Frontières and the International Federation of Red Cross and Red Crescent Societies), 6.4 million people were vaccinated in response to cholera outbreaks in 19 countries. For instance, in the Sudan, UNICEF supported two rounds of oral cholera vaccination campaigns in Blue Nile and Sennar states. More than 1.5 million people at risk of cholera were vaccinated in the first round and an additional 1.5 million in the second round (93 per cent of target).

Since the declaration of the tenth outbreak of EVD in the Democratic Republic of the Congo, high-impact health activities such as vaccination campaigns had been suspended in the Ebola-affected areas to avoid transmission. Through strong advocacy, UNICEF obtained approval for the resumption of mass measles vaccination in these areas. In addition, UNICEF used C4D to help communities understand the aim and purpose of the Ebola vaccine. Following UNICEF advocacy work, the vaccination protocol was improved to allow children under 1 year of age and pregnant women to get the Ebola vaccine. To date, 1,402 children and 1,189 pregnant women have been vaccinated against EVD.

The examples above showcase UNICEF's emergency immunization responses in various challenging settings in support of the most vulnerable populations. To strengthen these responses, UNICEF, in partnership with the International Federation of Red Cross and Red Crescent Societies, co-led the development of the Outbreaks and Emergencies strategic priority area of the Immunization Agenda 2030, setting the vision for the next decade.

Strengthening national and subnational capacity

Programmes positioned to provide quality immunization services

UNICEF supported governments and partners to implement tailored strategies to improve coverage and equity at national and subnational levels. In South Asia, UNICEF built the capacity of 143 EPI managers (22 in India, 121 in Pakistan) from national, provincial and district levels to identify and address equity gaps using existing data. In Pakistan, this capacity-building exercise is generating data to target and track missed children, which in turn will be used to inform the priorities of the Gavi Full Portfolio Planning process.

UNICEF assisted nine countries expected to undertake this planning process, including the development of Gavi Health Systems Strengthening proposals, focusing on more equitable and sustainable coverage while using a portfolio approach to facilitate planning and review phases.

Front-line workers are an essential link between immunization services and the communities they serve. These workers need to have effective interpersonal skills to increase trust, acceptance and demand for vaccines thereby addressing vaccine hesitancy.

A comprehensive Interpersonal Communication for Immunization Package (IPC/I) toolkit was produced specifically to strengthen health workers' role as a trusted source of information on vaccines and improve their communication skills with caregivers. Some 79 UNICEF and EPI programme staff from 20 countries, including Afghanistan, Iraq, Myanmar and Pakistan, were trained to lead in-country IPC/I action planning and training for front-line workers. A five-year IPC global action plan was finalized to guide the roll-out of the IPC/I package. This aims to strengthen institutional and workforce capacity-building and increase effectiveness.

In 2018, some 54 countries (from a baseline of 47) implemented activities to prepare for, prevent, manage and/or communicate adverse events following immunization or other vaccine-related events. The result well surpasses the 2021 target of 48 countries, showing consistent progress towards building national capacity to respond to adverse events, ensuring vaccine safety and maintaining public trust. Through multiple platforms, UNICEF proactively advocates that governments regularly assess and update their national plans to manage the communication response to adverse events following immunization. This has certainly contributed to progress.

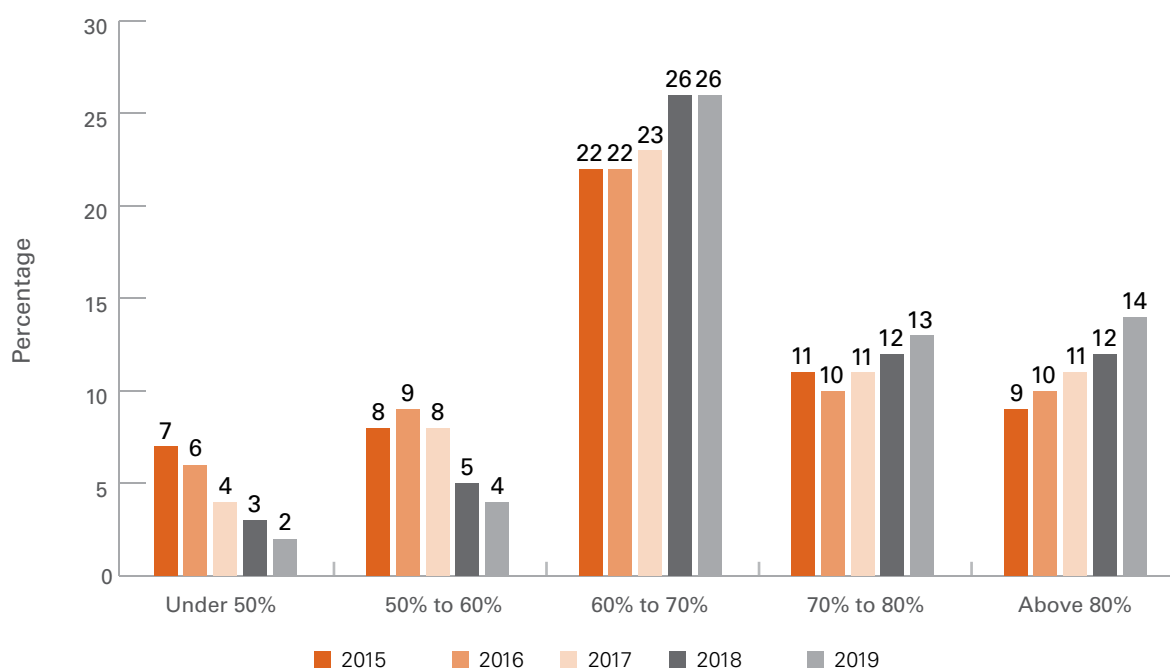
Immunization supply chain strengthening

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

UNICEF works with governments to ensure that effective and efficient immunization supply chains are in place for all children and women to receive potent vaccines. The organization continued to work with countries on implementing the comprehensive effective vaccine management (EVM) process. EVM measures whether national immunization supply chain systems comply with WHO standards in terms of supply system capacity to ensure vaccine availability, quality and efficient use of resources. Between 2009 and 2019, a total of 149 nationwide EVM assessments were carried out in 72 countries.

An EVM score above 80 per cent indicates that adequate immunization systems and capacities are in place. In 2019, fourteen countries reached this score (2019 milestone: 11). Cameroon and Iraq are the two additions from last year. In Cameroon, for instance, the EVM exercise helped formulate recommendations to improve temperature management, storage capacity, vaccine distribution, waste management and supervision.

FIGURE 16: Progress on effective vaccine management, 2015–2019



Source: UNICEF New York (2019).

In 2019, UNICEF co-chaired the Immunization Supply Chain Steering Committee and played a leading role on the global supply agenda. UNICEF, WHO and other partners developed and launched EVM2.0, an updated version providing greater clarity on every aspect of immunization supply chain performance.

Iraq was the first country to roll out EVM2.0, with support from UNICEF, Global Health Development and the Eastern Mediterranean Public Health Network. The tool helped develop and cost an improvement plan along with a bottleneck analysis workshop focusing on 30 low-performing districts. UNICEF's engagement, in collaboration with WHO and the National Immunization Technical Advisory Group, supported the adjustment of the national routine immunization schedule to better suit country requirements and resource availability. These efforts are expected to yield cost savings of more than US\$70 million per year, freeing resources for other essential health and nutrition services. EVM2.0 was also rolled out in Cameroon and the Democratic Republic of the Congo.

The cold chain is a critical link in the immunization supply chain and, therefore, to achieving UHC. One way to strengthen the cold chain is through the Gavi-funded Cold Chain Equipment Optimization Platform (CCE OP). At the end of 2019, some 49 countries were approved under the CCE OP, funding a mix of solar- and grid-powered cold-chain equipment targeted at the last mile. These units were bundled with 30-day temperature recorders to ensure potency of the vaccines. In 2019, UNICEF supported 10 countries in new CCE OP applications and 2 applications for additional funding. CCE procurement is currently under way for 40 countries and deployment has commenced

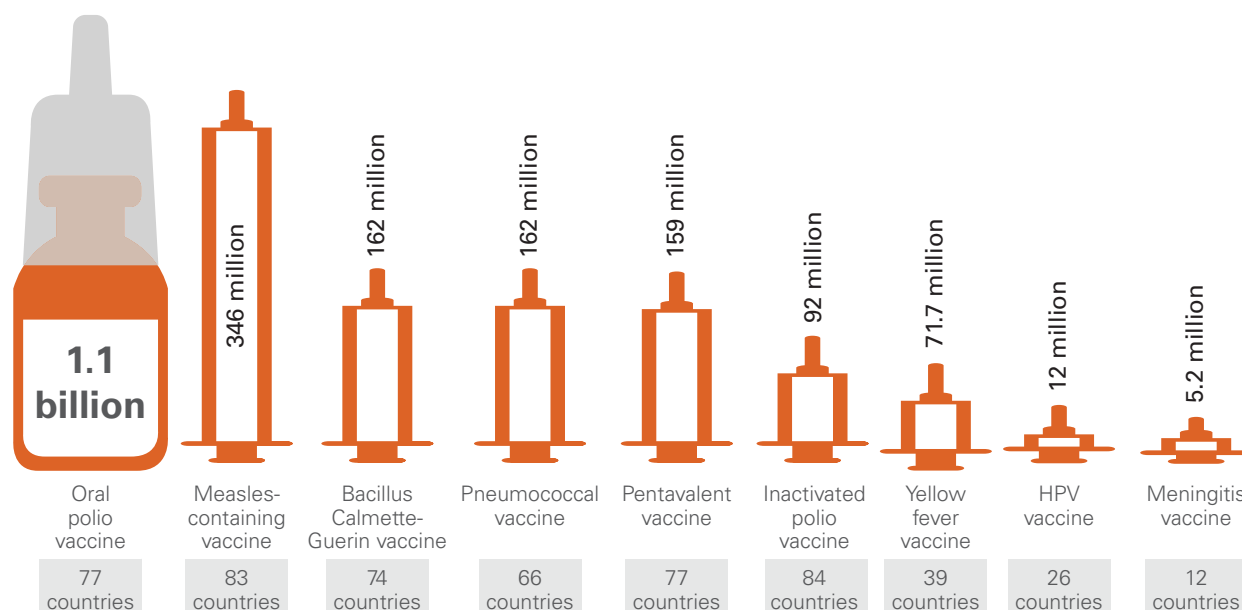
in 28 countries. As of the last quarter of 2019, a total of 39,522 CCE units had been procured with 20,006 installed. The total CCE OP procurement value amounted to US\$119 million.

Temperature monitoring is also an important component of immunization supply chain strengthening to ensure vaccines are protected from heat or freezing. Temperature monitoring studies were initiated in Afghanistan and the Maldives, and all cold rooms are mapped in the Maldives and Nepal.

UNICEF supported the immunization supply chain (iSC2) Country Network Approach to bridge information gaps, leverage global resources and competencies, and support country-level priorities on supply chain strengthening. UNICEF led the approach in 15 iSC2 priority countries in Africa, the Middle East and South Asia. In 2019, UNICEF procured cold-chain equipment to the value of US\$85 million to 77 countries, of which solar-powered systems accounted for US\$61.3 million to 37 countries. In the coming years, these investments are expected to translate into gains in coverage, equity and the greater realization of children's rights.

As the largest buyer of vaccines in the world, UNICEF continues to harness the power of markets for children's rights and health. An ongoing goal is to ensure the security of supply of essential life-saving vaccines at affordable and stable prices. In 2019, UNICEF procured 2.43 billion vaccine doses for 99 countries to reach 45 per cent of the world's children under 5 years old (Figure 17). Collaboration with partner organizations continues to be essential to the timeliness and reach of vaccine procurement and shipping operations.

FIGURE 17: Main procured vaccine types, number of doses, 2019



Source: UNICEF Supply Division database, Annual Report 2019.

Leveraging collective action

New vaccine introduction

Immunization programmes have increased in complexity as new vaccines and new age groups have been added to the immunization schedule. These vaccines include pneumococcal conjugate vaccine (PCV), meningitis, rotavirus, rubella and HPV. The pneumococcal and rotavirus vaccines are particularly critical against deadly childhood diseases such as pneumonia and diarrhoea, while HPV vaccine is central to the elimination of cervical cancer.

To support priority countries with vaccine introduction, UNICEF specifically assists with programme strategy, financing for sustainability, vaccine procurement and supply, immunization supply chain readiness and enhancement, C4D for service uptake, and training.

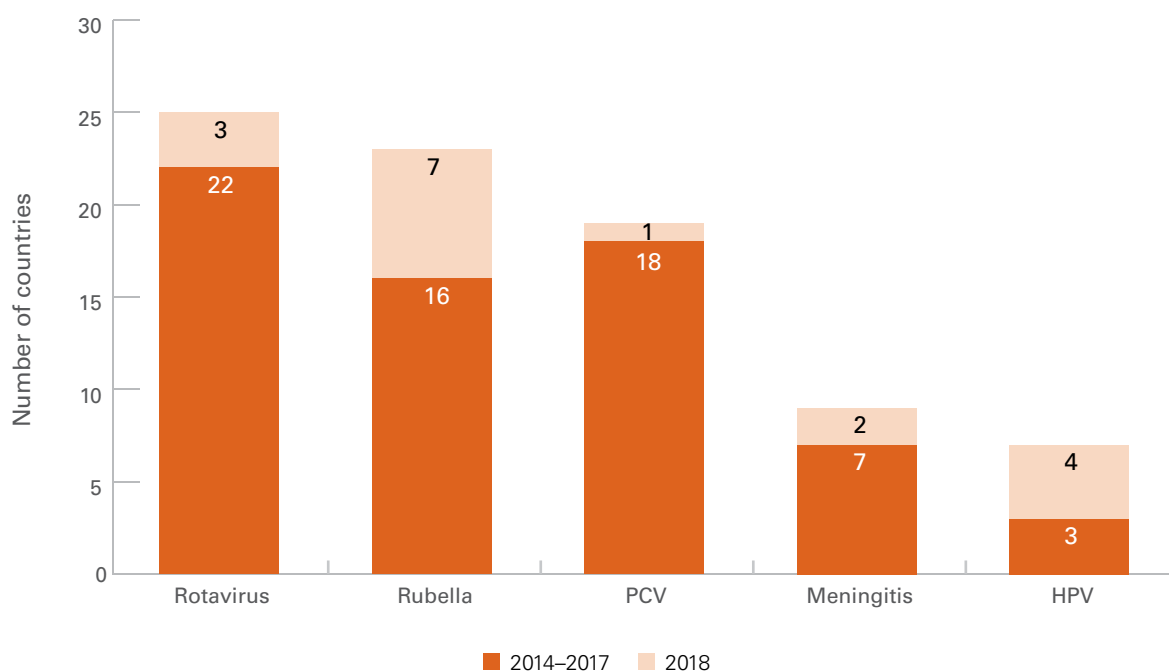
Between 2014 and 2018, UNICEF supported introduction of PCV in 19 priority countries and rotavirus vaccine in 25 priority countries.

Eleven countries had introduced meningitis vaccine by the end of 2018, a significant increase from a baseline of four countries but still below the 2019 milestone of 14.

By the end of 2018, some 21 countries had introduced yellow fever vaccine in their national immunization schedule (2019 milestone: 23 countries). Ethiopia, South Sudan and the Sudan are slated to introduce the vaccine in their national schedules.

HPV vaccine is the cornerstone of cervical-cancer prevention and an important component of adolescent health promotion. As of 2018, eight UNICEF-supported countries had introduced HPV vaccine in their immunization schedule (*see the adolescent health results area for further details on HPV vaccine*).

FIGURE 18: New vaccines introduced with UNICEF support, number of countries, 2014–2017 and 2018



Source: UNICEF analysis of WHO–UNICEF Joint Reporting Form (2019). Notes: Partial introductions are excluded; HPV, human papillomavirus vaccine; meningitis vaccine; PCV, pneumococcal conjugate vaccine.

Immunization financing

During 2019, UNICEF expanded its work on immunization financing both at the global level and in selected countries in close collaboration with key global partners. UNICEF contributed to shaping revisions to Gavi's policies for eligibility and co-financing, which will come into effect with Gavi 5.0.

UNICEF continued the work started in 2018 on improving planning and budgeting for immunization. This is being used as a foundation to steer global guidance on strategic and operational planning in addition to initial work on costing tools.

UNICEF Supply Division leads efforts to ensure that Gavi co-financing payments are received from countries. By the end of the year, 48 out of 54 countries had fully met their 2019 obligations (*Figure 19*). Only Liberia had overdue co-financing obligations and will officially go into default status for 2019. This is a significant achievement, even more noteworthy given the increasing number of countries that are self-financing their vaccine costs.

To reach children sustainably, UNICEF works towards helping countries secure continuous vaccine supplies and minimize stock-outs. The Vaccine Independence Initiative is a successful revolving fund managed by UNICEF. It provides country subscribers with flexible financing to cover financial gaps affecting vaccine procurement and enables continuity of vaccine supplies. This fund proved vital in the context of the measles outbreak in the Pacific Islands. UNICEF East



A mobile UNICEF vaccination team travels by boat on the Kasai River in the Democratic Republic of the Congo to reach remote locations.

Asia and Pacific holds a buffer stock corresponding to three months' supply of all routine vaccines, which enabled the immediate release of measles-containing vaccine stocks to Fiji, Samoa and Tonga, bolstering in-country stocks, enabling emergency response vaccination to occur while emergency orders were placed.

FIGURE 19: Co-financing performance, 2018–2019

Gavi co-financing status, end of year	2018		2019	
	No. countries	Proportion of countries	No. countries	Proportion of countries
Obligation met	45	90%	48	96%
Obligation partially met	4	8%	1	2%
Obligation unmet	1	2%	1	2%
Country-tailored approach	3		3	
Obligation waived	1			
Programme cancelled			1	
Total	54		54	

Source: UNICEF Supply Division (2019).

National health-sector supply chain strategies

Strengthening health-sector supply chain strategies and plans is essential to support the effective delivery of health services and accelerate equity improvements for the most disadvantaged children. By the end of 2019, some 46 of the 64 immunization priority countries were implementing a national health-sector supply chain strategy, on course to meet the 2021 target of 48 (14 of these 46 countries are also UNICEF priority countries for maternal, newborn and child health). Progress is noteworthy in Africa (Ethiopia, the Gambia, Mauritania, Sao Tome and Principe, Somalia, Uganda and Zambia) and in East Asia and the Pacific (the Democratic People’s Republic of Korea, Myanmar and Solomon Islands). Strong advocacy has led to increased awareness within countries on the importance of strong supply chains to deliver commodities.

In 2019, some 34 UNICEF country offices (up from 31 in 2018) supported supply chain strengthening interventions (Figure 20). UNICEF support was concentrated in sub-Saharan Africa with a total of 21 countries. The comprehensive EVM approach remains the entry-point to broader-based supply chain strengthening initiatives.

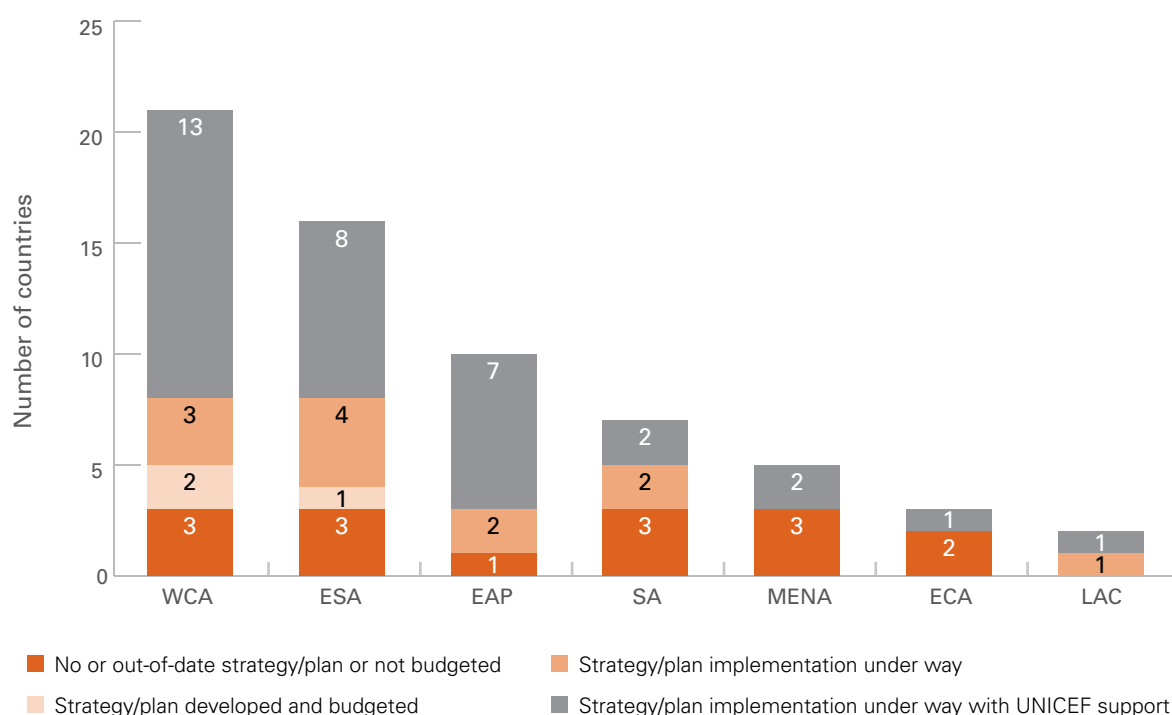
Leveraging collective action at global and regional levels

The reporting year was significant for the global immunization community. UNICEF helped shape the global immunization discourse, through continued collaboration with Gavi, by mainstreaming equity – including gender-related barriers – as well as immunization demand and acceptance within the new Gavi 5.0 strategy. This new strategy is expected to draw an estimated US\$9 billion for global immunizations over the period 2021–2025.

Regional priorities on immunization vary. UNICEF Eastern and Southern Africa Regional Office collaborated with the West and Central Africa Regional Office and WHO to issue a joint call to action to reverse the growing trend of unvaccinated children in Africa. The call aims to engage UNICEF and WHO country representatives to support advocacy for prioritization of immunization in government agendas.

The GPEI provided US\$323 million to UNICEF in 2019. The Measles & Rubella Initiative provided US\$23 million of funding. Other essential partnerships include networks for MNTE.

FIGURE 20: Supply chain strengthening interventions, by region, 2019



Source: UNICEF New York (2019).

Notes: EAP, East Asia and the Pacific; ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; SA, South Asia; WCA, West and Central Africa.

UNICEF strengthened its global thought leadership on a number of technical topics. In the first year of the UNICEF-led global Immunization Demand Hub, partners agreed on a clear vision, objectives and the establishment of working groups to coordinate technical resources and thought leadership to countries in five critical areas: (1) data working group on behavioural and social drivers of vaccination; (2) digital engagement and misinformation; (3) service experience; (4) behaviourally informed interventions; and (5) engagement of civil society organizations (CSOs). A key priority for the Hub is providing country and regional offices with coordinated technical support and resources. The Hub Face-to-Face meeting hosted in Kathmandu, Nepal was an opportunity to develop the joint UNICEF–WHO Programme Guidance for Accelerating Demand across South and South-East Asia. In addition, UNICEF’s Human-Centred Approach to Health²³ with US Centers for Disease Control and Prevention (CDC) support has set up an ‘architecture’ for countries to request technical assistance to address demand-related challenges. For instance, Ethiopia, Indonesia, Somalia, South Sudan and Zimbabwe launched activities to address subnational demand-related challenges to increase coverage with equity.

In 2019, UNICEF played a critical role in guiding the development of Gavi’s new Gender Policy, as well as efforts to incorporate gender within both Gavi 5.0 and IA 2030. UNICEF, in collaboration with Gavi, also led the development of materials to support country identification of gender-related barriers and a draft video targeting staff and partners to explain gender-related barriers to immunization (including potential strategies for health programming). UNICEF also provided gender-related inputs to the revised Coverage and Equity Assessment guidelines under development with partner agencies.

To strengthen the evidence and knowledge base, UNICEF produced 23 publications, including 6 peer-reviewed articles, on immunization in 2019.

Conclusion

The implementation of the second year of the UNICEF Strategic Plan, 2018–2021 saw successes in immunization. Despite these achievements, millions of children remain unprotected from vaccine-preventable diseases. Moreover, children are likely to die from vaccine-preventable diseases such as measles as countries postpone or scale-back their immunization activities in the face of COVID-19. The response will likely need to adapt immunization delivery modalities to reduce the risk of contributing to COVID-19 transmission and incorporate physical distancing principles as well as prepare for catch-up campaigns.

Addressing the complex challenges to reach those children left behind requires strategic responses adapted to the context of the COVID-19 pandemic. Both the IA 2030 and the Gavi strategy for 2021–2025 reflect many of the strategic shifts that UNICEF identified within its Immunization Roadmap 2018–2030. These key shifts include commitment and ownership at national and subnational levels, and improved accountability; integrated delivery and contribution to PHC strengthening; a focus on equity and zero-dose children, who tend to be concentrated in remote rural areas, urban slums and conflict-affected areas; strengthened community acceptance, trust and demand; emphasis on quality of services and context-appropriate delivery; a shift towards vaccinations across the life course; and scaling up innovations.

At a time when integrated interventions are more urgently needed and more efficient than ever to work with new and established partners and make more targeted investments, flexible funding streams will be crucial to help overcome siloed and disease-focused interventions. These flexible resources will be vital to maintain high immunization coverage in low, medium- and high-capacity countries, and to support adaptation to the new realities in the context of COVID-19.



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Health worker Helen Emmanuel talks to Sarfatu Jaidal, 19, about her three-year-old daughter Lydia Jaidal, in the village of Gah, Adamawa state, northeastern Nigeria. Community health workers are critical in preventing and treating pneumonia.

Results Area 3: Child health

Significant progress has been made in the coverage of child health interventions; however, the current trajectory across key indicators shows insufficient performance to meet the ambitious targets of the Strategic Plan to reduce deaths from common childhood illnesses. Access to and utilization of high-impact interventions to reduce child deaths resulting from pneumonia, diarrhoea and malaria – the leading causes of mortality for children under the age of 5 years – as well as issues around quality of paediatric care, including availability of essential commodities, will need to be addressed to change this curve. The added complexity of fragile and humanitarian settings further undermines achievements.

Nonetheless, there is a strong drive and desire to change the trajectory, and good progress was made in key areas. Between 2016 and 2019, in 25 child health focus countries, 26 million children (9.5 million in 2019) with suspected pneumonia received antibiotics through UNICEF-supported programmes; 190,315 community health workers

(CHWs) (milestone: 120,000) had enhanced their skills to operationalize integrated Community Case Management (iCCM); and 25 countries had institutionalized CHWs into their health systems, fully meeting the Strategic Plan target. In 2019, UNICEF distributed insecticide-treated nets to 24.83 million people in 21 countries, including 1.69 million in humanitarian situations in 18 countries (total 5.4 million since 2016). This year, all 25 target countries achieved the milestone of no stock-outs of oral rehydration salts (ORS) at the national level.

Work in the thrive agenda continues to expand, including through the strengthening of delivery of ECD and disability interventions through health platforms, as well as injuries, non-communicable diseases (NCDs), and addressing environmental pollution and climate change.

The child health programme dedicated US\$269 million in expenditures, of which US\$71 million was disbursed from regular resources.

Outcome and output indicators for child health

FIGURE 21: Outcome results for child health, 2019

Outcome	Baseline	2019 value	2021 target
Percentage of children with diarrhoea receiving zinc and oral rehydration salts (ORS) (SDG 3.8.1)	8%	16%	32%
Percentage of children with symptoms of pneumonia taken to an appropriate health-care provider (SDG 3.8.1)	60%	69%	71%
Number of children with suspected pneumonia receiving appropriate antibiotics through UNICEF-supported programmes (SDG 3.8.1)	6 million	26 million	30 million
Percentage of children in malaria-endemic countries sleeping under an insecticide-treated net (SDG 3.8.1)	40%	53%	58%

FIGURE 22: Output results for child health, 2019

Output indicator	Baseline	2019 milestone	2019 value	2021 target
Percentage of countries that maintain no stock-outs lasting more than one month at national level for oral rehydration salts (ORS)	92%	100%	100%	100%
Number of countries that have introduced pneumococcal conjugate vaccine (PCV) into their national immunization schedule	46	55	49	64
Number of countries that have institutionalized community health workers (CHWs) into the formal health system	21	21	25	25
Number of community health workers that underwent skills-enhancement programmes to operationalize integrated community case management (iCCM) through UNICEF-supported programmes	94,099	120,000	190,315	160,000
Number of people receiving insecticide-treated nets as per international recommended standards through UNICEF-supported programmes (humanitarian)	2.2 million	4.3 million	5.4 million	6.3 million

Context

Globally, pneumonia, diarrhoea and malaria remain the leading causes of death for children under 5 years of age. Among these infectious diseases, pneumonia alone kills 800,000 children each year. The death toll is heavily concentrated among the poorest and most marginalized, who suffer from lack of good nutrition, clean air, immunization and health services.²⁴ Diarrhoea continues to claim the lives of more than 400,000 children every year. Lastly, malaria is the third leading cause of death among children under 5, accounting for 272,000 deaths or 67 per cent of all malaria deaths worldwide.²⁵

Among children and adolescents aged 5–14 years, injuries overtake infectious diseases as the leading cause of death. Road traffic injuries, drowning, burns and falls are among the top causes of mortality and disability in this age group.

Another important challenge for child health comes from NCDs, which undermine children's and adolescents' right to health, nutrition, education and play. Each year, about 1.2 million children and adolescents below 20 years old die from treatable NCDs, such as chronic respiratory diseases and cancers. NCD deaths in childhood and adolescence account for 13 per cent of overall NCD mortality.²⁶

Evidence is growing that environmental pollution is a major factor of ill health and death among children. Over half a million children under 5 died from air pollution-related causes in 2016. More specifically, toxic air causes the death of an estimated 600,000 children due to pneumonia and other respiratory problems.²⁷ An estimated 300 million children globally, including 17 million babies, currently live in areas where the air is toxic – exceeding international limits at least six-fold. Unlike adults, even low levels of toxic exposure can have deleterious effects on children during a sensitive time for brain development. Some estimates show that lead exposure, for instance, accounts for 63.2 per cent of the global burden of developmental intellectual disability while causing 1.06 million deaths worldwide.²⁸

Climate change has far-reaching consequences on children's lives, notably because children are more vulnerable to vector-borne diseases than adults. Climate change is known to increase the frequency of droughts, floods and other severe weather patterns. Over half a billion children live in extremely high flood risk areas, while nearly 160 million live in high or extremely high drought risk areas.²⁹ This climate crisis, a children's rights crisis, particularly impacts children already suffering multiple deprivations.

Improving services and community demand

Pneumonia prevention and treatment

UNICEF continues to contribute towards the goals set out in the Global Action Plan for Pneumonia and Diarrhoea to achieve a target of 3 pneumonia deaths per 1,000 live births by 2025. Evidence shows that community management of all non-severe cases of childhood pneumonia could result in a 70 per cent reduction in mortality from pneumonia in children under 5.³⁰

There has been strong progress on care-seeking for children with pneumonia in the 25 high-burden countries, with a 10-percentage point increase in this indicator compared with 2018. Against a baseline of 60 per cent, 69 per cent of children with symptoms of pneumonia were taken to an appropriate health-care provider in 2019 (2021 target: 71 per cent). According to the latest household surveys, increased care-seeking for pneumonia in Indonesia and Nigeria contributed to this notable progress.

Access to antibiotics is critical for treating pneumonia. Amoxicillin is the recommended first-line treatment for pneumonia in children. Paediatric formulations are critical to ensuring that CHWs treat children with the correct dose for maximum effectiveness. In 25 high-burden countries, a cumulative total of 26 million children (9.5 million in 2019) with suspected pneumonia received appropriate antibiotics through UNICEF-supported programmes (2021 target: 30 million). UNICEF helped provide antibiotic treatment to another 0.7 million children outside the 25 focus countries. To that end, UNICEF delivered 273.4 million 250 mg amoxicillin dispersible tablets – equivalent to 27.3 million pneumonia treatments for under one-year-olds – reaching 38 countries.

- In Kenya, with UNICEF's contribution to capacity development of health workers, the proportion of children under 5 receiving appropriate treatment for pneumonia in four target counties increased from 72 per cent in 2018 to 89 per cent in 2019.
- Mali is making good progress towards reaching children in need. In 2019, UNICEF helped supply 67 per cent of CHWs with equipment and drugs for the Integrated Management of Neonatal and Childhood Illness in five priority regions. As a result, 742,000 cases of pneumonia (66 per cent in 2019 compared with 47 per cent in 2018) were treated by CHWs or referred to health centres.
- In Papua New Guinea, UNICEF supported the development of a new policy for village-level CHWs to provide antibiotics for pneumonia, which has been incorporated in the Village Health Volunteer guidelines. Once the guidelines are endorsed by the National Department of Health, children diagnosed with pneumonia will be treated using antibiotics, if necessary, by the village health volunteers.

Key remaining barriers to ensure uninterrupted access to essential antibiotics requires an increased focus on improving procurement and supply chain management and ensuring sustainable financing, especially for commodities used at the community level.

Diarrhoea prevention and treatment

In the second year of the UNICEF Strategic Plan, 2018–2021, some progress has been made in providing zinc and ORS to children in need. The proportion of children with diarrhoea benefiting from ORS and zinc doubled from the baseline to 16 per cent in 2019. However, more work needs to be done to reach the target of 32 per cent by 2021. UNICEF delivered 74 million ORS sachets to 53 countries in 2019, of which 10.8 million were in ORS and zinc co-packs. In addition, the organization delivered 143.9 million zinc tablets to 45 countries, of which 53.9 million were in ORS and zinc co-packs. The presentation in a co-pack form has the potential to substantially increase access to treatment with both commodities, and the addition of ORS–zinc co-pack to the WHO Essential Medicines List in 2019 will likely increase uptake and, consequently, benefit more children.

UNICEF worked around the world to stimulate community demand for services, notably through its well-established C4D activities. In Afghanistan, UNICEF supported a zinc–ORS promotion campaign through radio channels and the distribution of 400,000 story books to support community

dialogue sessions delivered at health-care facilities. These sessions were conducted in 200 communities resulting in increased utilization of zinc–ORS for childhood diarrhoea, improved institutional delivery, vaccination and hand-washing practices. More than 660,000 community members, caregivers, adolescent girls and religious leaders were reached through community dialogues and radio dramas on various topics related to child protection, including the prevention of violence and exploitation, child marriage and child recruitment into armed groups.

Malaria prevention and treatment

UNICEF partners closely with WHO, Roll Back Malaria and others to attain the goal of a malaria-free world as set out in the Global Technical Strategy for Malaria 2016–2030.

Access to and use of long-lasting insecticidal nets (LLINs) remains one of the first lines of defence against malaria. Thanks to the support provided by UNICEF and partners, 53 per cent of children in malaria-endemic countries slept under an insecticide-treated net in 2019, up from 40 per cent at baseline (2021 target: 58 per cent). UNICEF Supply Division supported the procurement of over 48.1 million LLINs for 33 countries – the highest ever in UNICEF’s history of LLIN procurement. This number of nets should be protecting at least 96 million people and could potentially save the lives of nearly 270,000 children under the age of 5 over the lifetime of the net.



Twenty-three year old Lorenza Sulemane sits with her three children under their mosquito net in a tent at the Picoco Accommodation Centre in Beira, Mozambique, after cyclone Idai hit the centre of the country.

UNICEF supported the distribution of insecticide-treated nets to 24.83 million people in 21 countries. In addition to the standard distribution methodologies (mass distribution campaigns and at routine distribution points for immunization services and antenatal care, including integrated campaigns), UNICEF also explored 'novel' LLIN distribution strategies such as community and school-based distribution points. The Democratic Republic of the Congo has been a leader in piloting family-based distribution of LLINs and malaria commodities.

In addition to prevention, UNICEF ensures that quality treatments reach the children who need them most. UNICEF has been actively supporting the uptake and incorporation of medicines against severe malaria in three key countries (the Democratic Republic of the Congo, Nigeria and Uganda) with support from Unitaid. This three-year project will conclude in 2020 and will yield considerable information on strengthening in-country referral systems to manage severe diseases, among other lessons learned.

The ability to quickly diagnose malaria is essential for treating the disease and preventing progression to its most lethal form. Supply Division procured 4.2 million malaria rapid diagnostic tests for 19 countries. Treatment-wise, 34.98 million artemisinin-based combination therapy (ACT) malaria treatments were delivered, in addition to 2.6 million treatments for seasonal malaria chemoprevention in West Africa, equivalent to 655,200 children provisioned with chemoprevention for all four cycles of Seasonal Malaria Chemoprevention campaigns.

Child health in humanitarian settings

Investments in PHC were expanded in a number of humanitarian settings and remote communities. These packages of iCCM and/or integrated management of childhood illness (IMCI) were often combined with immunization outreach, helping to bring health services to thousands of disadvantaged women and children.

In humanitarian settings, malaria prevention is essential. Between 2016 and 2019, some 5.4 million people in humanitarian situations (milestone: 4.3 million) received LLINs through UNICEF-supported programmes. In 2019, LLIN distribution reached 1.69 million people in 18 countries (up from 1.46 million in 2018). Additionally, more than 700,000 children under 5 in humanitarian situations received antibiotics for pneumonia.

UNICEF is co-chair of the Vector Control in Humanitarian Emergencies working group which is providing recommendations and a call to action on investing and supporting this critical area to fight not only malaria but also other vector-borne diseases such as Zika, chikungunya and dengue.

In Mozambique, to prevent the spread of malaria, 240,000 LLINs were distributed to households affected by Cyclone Idai, which benefited at least 70,840 children under 5 in

Sofala and 25,120 LLINs benefited approximately 7,400 in Cabo Delgado. UNICEF procured and distributed an additional 20,000 malaria treatments and 40,000 rapid diagnostic tests in the emergency-affected districts. Mozambique is also a leader in the use of digital technologies and support for iCCM to ensure appropriate and comprehensive treatment of febrile children, including mitigating any potential malaria epidemics following the cyclone.

Nurturing care for early childhood development

Recognizing the importance of the early years for child development, UNICEF worked closely with key partners in supporting countries to operationalize the Nurturing Care Framework (NCF), which has gained considerable momentum as a comprehensive approach to health, well-being and development. UNICEF and NCF partners clarified the central role of the health sector in the operationalization of the framework, and focused programming on integrating and strengthening key components of nurturing care in routine health interactions between families and caregivers.

UNICEF continues to promote the use of the Care for Child Development (CCD) package, which leverages the health system to provide much needed ECD interventions.

In the Middle East and North Africa, UNICEF is proving support to institutionalize and implement CCD using health, nutrition and other relevant services as an entry-point. In 2019, UNICEF worked with Egypt and Tunisia to support the institutionalization of the CCD package into the IMCI and the Parenting Programme, respectively. In Eastern and Southern Africa, UNICEF used community health platforms to deliver nurturing care interventions for ECD with the aim of strengthening cross-sectoral synergies to deliver expanded, yet contextualized, packages of services at the community level.

Around 1 billion people in the world live with developmental delays and disabilities, including an estimated 93 million children aged under 14 years.³¹ UNICEF is increasingly mainstreaming developmental delays and disabilities interventions within its health programmes.

UNICEF expanded support for these children by identifying recommended methods and tools for early identification and intervention, behaviour change and stigma reduction, and developing a model for programming which has been adapted and is being implemented in Bulgaria, Peru and Uganda (*see Case Study 3*). This process also solidified UNICEF's role in this area along with WHO and other key partners.

The implementation of CCD in Peru placed a strong focus on young children with disabilities. The country finalized a set of three booklets for use in hospitals, home visits, ECD centres and other settings, with clear strategies for caregivers to promote a nurturing and stimulating environment for a child with a disability.

CASE STUDY 3: Uganda: Early support brings promise to children with disabilities

In Uganda, children under 5 years of age account for 33 per cent of the country's population of persons with disabilities, according to the Uganda Bureau of Statistics.

Due to stigma and attitudinal barriers, children born with developmental delays or disabilities are often viewed as bad omens for the family and society at large. Many parents of children with disabilities – especially because so many are poorly educated, resourced and supported – believe that their babies are ill-fated and do not have a future. Some parents even kill their children, deliberately allow them to die by starvation, or deny them medical attention in the belief that there is mercy in children with disabilities dying rather than having to endure a painful and lifelong disability.

Mubende and Kassanda districts have the highest populations of children with disabilities in Uganda. They also face child-related deprivations such as high levels of stunting, high under-five death rates, and an Early Childhood Development Index below the national average. As a result, children with disabilities often are not identified until they turn 6 years, the school starting age.

In a programme started in 2018, UNICEF teamed up with a local NGO, the Children and Wives of Disabled Soldiers Association (CAWODISA), to identify young children with disabilities in Mubende and Kassanda. Supported by the H&M Foundation, the programme also provides children with early intervention services, which are normally more effective than those offered later in life.

The programme uses a twin-track approach to ensure that all children, including those with developmental delays and disabilities, are included in mainstream health and social services. Children requiring individualized services addressing their disability-specific needs are receiving these in addition to mainstream services. UNICEF will train local health workers and teachers to screen babies and toddlers aged under 3 years for disabilities. This will provide at least 720 children with disabilities across the two districts with early interventions, helping to improve their developmental outcomes and improve outcomes for their families and communities.

UNICEF has also engaged local political and community leaders, as well as health, education and community-development sectors, to remove stigma and prevent discrimination faced by children with disabilities. Through specially organized community dialogue and advocacy activities, such as radio talks, UNICEF and CAWODISA have reached over 10,000 people across all 573 villages in Mubende and Kassanda in support of children with disabilities.



A mother and her child are bonding, Kaabong Hospital, Uganda.

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Addressing childhood injuries and non-communicable diseases

UNICEF, WHO and other partners are expanding a multisectoral and life-course approach so that children can survive and thrive throughout the first two decades of life.

As a nascent area of work, UNICEF embarked on increased leadership in the prevention of child injuries and drowning, which are major contributors to child death; in particular by improving data collection to inform policymaking. UNICEF prevents and reduces road traffic fatalities and injuries through multisectoral efforts in health, education, child protection and beyond. In Paraguay, the Philippines and South Africa, UNICEF partners with the United Nations Road Safety Fund to integrate road safety for children into urban planning. In the Philippines, UNICEF, with the support of the Abertis Foundation, is leading a child road traffic injury prevention programme for high-risk schools.³² In the United Arab Emirates, UNICEF curated content to increase awareness among parents and caregivers to prevent childhood unintentional injuries such as burns, drowning, falling, poisoning, road traffic accidents, suffocation and choking, and heat stroke.

NCDs such as cardiovascular diseases, diabetes and chronic respiratory diseases are on the rise among children. For instance, overweight and obesity affected 40 million children under the age of 5 in 2018 and over 340 million children and adolescents aged 5–19 years in 2016.³³

UNICEF works to reduce risk factors for NCDs. In Jordan, for example, to increase the uptake of PHC services to combat NCDs, UNICEF worked with the Government to provide 200 community health volunteers with on-the-job training to enable them to screen community members for diabetes and hypertension at 40 health fairs. UNICEF is working towards mainstreaming health into existing intersectoral platforms (e.g., education, social protection, WASH) to increase behavioural and lifestyle changes.

Preventive and promotive interventions remain the cornerstone of UNICEF's response to NCDs. As a multisectoral organization, UNICEF believes that schools provide a unique platform to address the five NCD risk factors: unhealthy diet, tobacco use, harmful use of alcohol, physical inactivity and air pollution. With the right investments and supportive systems, integrated school programmes that address NCDs, injuries, mental health, life skills, prevention of HIV and other sexually transmitted infections, and environmental health, can protect children's health and well-being. (See 'Adolescent health' for further details on the actions UNICEF is taking in this area, p. 51).

Environmental pollution and climate change

In 2019, UNICEF and the Centre for Global Health Inequalities Research (Norwegian University of Science and Technology) started to develop a strategic framework to respond to environmental pollution and climate change

as part of UNICEF health programmes. Partnerships are being formed in the area of environmental health. In East Asia and the Pacific, UNICEF identified several key partners for air pollution and child health, and other environment and climate issues.

UNICEF is also taking action at the country level. In Georgia, the latest Multiple Indicator Cluster Survey indicated that 41 per cent of children aged 2–7 years had elevated blood lead levels ($\geq 5 \mu\text{g/dL}$). Even more concerning is that 16 per cent of the children tested exhibited significantly higher blood lead levels ($\geq 10 \mu\text{g/dL}$), with the poorest children more likely affected, revealing marked social inequities. Young children are particularly vulnerable to the toxic effects of lead and can suffer profound and permanent adverse health effects, particularly affecting the development of the brain and nervous system. Exposure of pregnant women to high levels of lead can cause miscarriage, stillbirth, premature birth and low birthweight.³⁴

Thanks to global thematic funds, UNICEF is supporting the Government of Georgia in addressing this pressing environmental issue by introducing exposure to environmental pollution as part of the national health management information system, in addition to supporting the development and implementation of a national plan of action to address the issue.

Much development is taking place in East Asia and the Pacific to combat environmental pollution. The UNICEF regional office issued guidance on the effects of air pollution on children's health which was disseminated to target country offices.

In Mongolia, UNICEF is using global thematic funds with the goal of reducing the impact of air pollution on maternal and child health (a priority area for action). UNICEF supported the development and roll-out of training modules for health-care professionals to learn about air pollution



Nkosilathi Nyathi, a youth activist from Zimbabwe, participates in a panel discussion during the High-level Event on Climate Change and Children Rights, part of the 2019 UN Climate Change Conference (COP 25) in Madrid, Spain.

and its impact on maternal and child health, and a range of information, education and communication materials. In coordination with WHO, UNICEF also continued to support strengthening PHC services as a first line of support for children and (pregnant) women to cope with air pollution-related health issues. The Ulaanbaatar Governor's Office agreed to replicate part of the interventions in Songino Khaikhan district using its own budget of US\$240,000.

To reduce emissions and pollution, UNICEF and partners have been supporting renewable energy solutions in health-care facilities as part of the Cold Chain Equipment Optimization Platform. For instance, in 2019, UNICEF supported the provision and installation of 846 solar direct drive refrigerators in Yemen, 471 in Afghanistan, 220 in Sierra Leone and 123 in Angola.

Strengthening national and subnational capacity

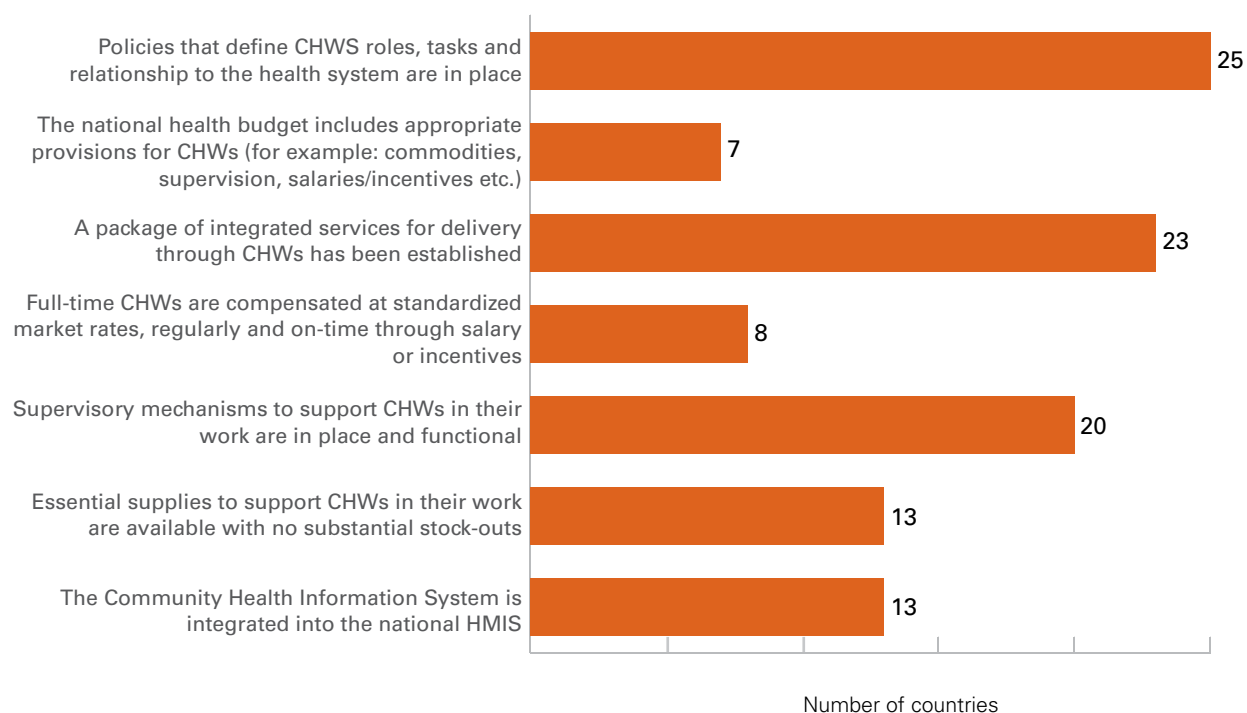
Institutionalizing community health workers in the formal health system

Institutionalizing CHWs into the formal health system is a critical component of bringing PHC to the last mile. For institutionalization to occur, as a first step, policies defining

roles, tasks based on local needs, and relationships to the health system must be in place at country level. By the end of 2019, all 25 focus countries had policies in place that met current criteria for institutionalization. UNICEF continues to help governments establish a package of care, incentive and compensation structures, supervision, and supply chain models.

To strengthen the quality of the institutionalization process, UNICEF tracks progress on seven components (*see Figure 23*). Within the institutionalization process, some areas are doing better than others. By the end of 2019, a total of 23 countries had established packages of integrated services that can be delivered through CHWs, while 20 countries had instituted supervisory mechanisms that are essential to support CHWs. More work needs to be done on national budgetary inclusion of appropriate provisions for CHWs (7 countries) and CHW compensation (8 countries). About half of the countries have supplies and information systems in place. Besides the 25 priority countries for child health, another 47 countries forged ahead with CHW institutionalization. UNICEF continues to provide sustained advocacy, policy and technical support to achieve full institutionalization of community health workforces, including within PHC for UHC.

FIGURE 23: Community health workers institutionalization, by component, 2019



Source: UNICEF New York (2019). Notes: CHWs, community health workers; HMIS, health management information system.

In Eastern and Southern Africa, UNICEF strengthened and institutionalized community health systems by supporting countries in developing and implementing relevant national strategies and policies, designing integrated community-based service packages and resolving community health system bottlenecks. For instance, Eritrea, the United Republic of Tanzania (including Zanzibar), Zambia and Zimbabwe have all finalized national community health strategies. With support from UNICEF set-aside flexible funding, Eritrea is improving access to care for hard-to-reach populations with the help of Barefoot Doctors linked to mobile health units.

Effective PHC at the community level is essential for reducing child mortality. As a key partner in the Community Health Roadmap, UNICEF works to elevate community health in national agendas, strengthen community health systems, and ensure that health care is available and accessible to all children. In 2019, eight additional countries adopted the Community Health Roadmap, increasing the number of participating countries to 14. Mechanisms in place through the Integrating Community Health collaboration, which concluded a three-year memorandum of understanding among UNICEF, United States Agency for International Development (USAID) and the Bill & Melinda Gates Foundation in December 2019, continued to provide technical assistance to the seven countries supported. This support was also extended to a wider set of countries participating in South–South exchange on learning agendas for community health through the participatory knowledge

management platform and the Community Health Community of Practice. UNICEF advised three countries on developing financing strategies for community health through the Financing Alliance for Health.

Enhancing the skills of community health workers to support case management

UNICEF continues to improve the capacity and skills of CHWs across Goal Area 1 as part of PHC. This includes expanding their skills and capacities beyond survive to also address the thrive agenda.

Investments in CHWs rank among the most effective and sustainable means of delivering services to underserved populations. As Mamadou Kasse, a CHW from Mali says, “life conditions here are very difficult because of the increasing insecurity. Women and children are the ones suffering the most. This is what motivates me to do what I do.”

Between 2016 and 2019, a total of 190,315 CHWs (35,840 in 2019 alone) participated in UNICEF-supported skills enhancement programmes on iCCM. Sixty per cent of these workers were trained in four countries in sub-Saharan Africa (Burkina Faso, Nigeria, Uganda and Zimbabwe). The 2019 result exceeds the Strategic Plan target of 160,000, demonstrating excellent momentum. An additional 16,985 CHWs outside high-burden countries also had their iCCM skills enhanced.



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Community health workers travel by motorbike to reach rural communities, Irié, Guinea.

Health systems enhancement also fosters gender equity. Among the 25 high-burden countries, 15 provided sex-disaggregated data showing that 17,862 male and 15,256 female CHWs sharpened their skills through targeted programmes. This highlights that community health systems continue to provide opportunities to women.

In West and Central Africa, the gender dimensions that influence CHWs' work was further assessed in selected countries (Côte d'Ivoire, Mali and Senegal), with the support of the regional network of anthropologists, to better inform national policy review and development.

Reliable and quality supplies for child health

Nearly 1 million children under 5 die each year from pneumococcal diseases such as pneumonia and meningitis, making PCV an important public health intervention. By 2019, forty-nine countries (2019 milestone: 55) had introduced PCV in their immunization schedule, with Gavi funding. While this represents an addition of three countries from the baseline (including Haiti and Nigeria in 2019), more work needs to be done. Introducing new vaccines into a routine immunization schedule can be hampered by competing priorities that also require immediate financing, such as disease outbreak response. UNICEF also supported the introduction of rotavirus vaccine in three countries to protect children from rotavirus infection, which is the leading cause of severe diarrhoea among young children.

A trained PHC workforce also needs reliable access to life-saving commodities, such as antibiotics, ORS, zinc, ACT and rapid diagnostic tests for malaria. This underscores the important role that supply chain strengthening plays in the overall strength of health systems, especially at community and facility levels, to bring commodities to those who live far from health centres.

To that end, the Strategic Plan tracks the percentage of countries that maintain no stock-outs lasting more than one month at national level for ORS. In 2019, no UNICEF-supported country reported any such stock-outs at national level. This is progress over previous years – particularly in West and Central Africa.

In Côte d'Ivoire, UNICEF was able to fully support the implementation of the iCCM programme in 13 health districts, focusing its efforts on the 2,123 CHWs trained and equipped in 2018. Through the National Supply Drug Store, 215,000 amoxicillin treatments and 81,100 ORS and zinc treatments were provided to CHWs in their respective health areas. The Global Fund to Fight AIDS, Tuberculosis and Malaria and the President's Malaria Initiative provided rapid diagnostic tests and ACT to train CHWs. To ensure sustainability, UNICEF and the Global Fund appealed to the Government to provide the full essential package of medicines to CHWs in 2020. An annual budget line of US\$2 million, as part of the 'willingness to pay' budget, was earmarked in the national budget to cover the procurement for this.

Leveraging collective action

To meet SDG targets, accelerating progress on pneumonia, the main infectious cause of death among children under 5, is urgent. UNICEF leverages PHC strengthening to improve pneumonia outcomes and advocates for pneumonia to be a key tracer for UHC for children. In 2019, UNICEF and key partners, including the Every Breath Counts Coalition and Save the Children as part of the UNICEF–Save the Children Pneumonia Partnership, increased efforts to raise awareness on the need for accelerated action to end child pneumonia deaths. Activities included launching an advocacy brief on World Pneumonia Day, together with country profiles for nine 'beacon' countries prioritized in a partnership between UNICEF and Save the Children.³⁵ In West and Central Africa, UNICEF successfully harnessed resources from the Scaling Pneumonia Response Innovations (SPRINT) initiative to scale up interventions against pneumonia (Ghana and Senegal) and from UNICEF set-aside flexible funding to strengthen PHC systems through integrated and multisectoral approaches.

Keeping malaria prevention, diagnostics, care and treatment on the international agenda is crucial to reduce child mortality. UNICEF works at the global level to strengthen national strategic and investment plans, including as a partner in the High Burden High Impact initiative to focus on the 11 countries with the highest malaria burden.

Additional support is provided across the range of malaria interventions (support for provision of malaria prevention, case management and data collection) at country level in malaria-endemic countries. UNICEF also provided direct support or procurement services for malaria-commodity procurement and delivery to nearly 40 countries globally.

UNICEF is working with the Global Fund to support health systems and effective HIV, tuberculosis and malaria programming; and ensure that investments are underpinned by the guidance and knowledge base required to maximize impact at country level.

As part of the collaboration, UNICEF has actively revitalized the financial task team for iCCM, to support countries on service integration, strengthening governance and accountability, building capacity for community assessment, adopting policy, and strengthening district health information systems (DHIS2).

A West and Central Africa regional forum held in Benin in November 2019 shared the results of bottleneck analyses to scale up community health and iCCM and to identify innovative solutions. To galvanize country action on resource mobilization for children, the UNICEF West and Central Africa Regional Office strengthened its partnerships with the Global Fund and the Muskoka fund to support CHW programme implementation in five countries, and supported four countries to develop their community health road maps with the partnership of the Rockefeller Foundation and USAID.

UNICEF further clarified the role of the health sector in the operationalization of the Nurturing Care Framework. To build capacities and foster learning, the West and Central Africa office and WHO supported 13 countries to develop country road maps for nurturing care.

Regionally, important initiatives are boosting the thrive agenda. For instance, the Latin America and Caribbean region developed a conceptual framework on road injury and experiences from pilot interventions in three countries which were presented at the Fédération Internationale de l'Automobile conference. UNICEF also contributed to a global report on NCDs; strategic representation in the NCD Global Interagency Task Team; and a global consultation on adolescent mental health measurements to obtain data for improved policymaking.

Evidence and knowledge generation are essential to mobilize investments in child health. In 2019, UNICEF produced 22 publications on child and community health, including 12 peer-reviewed articles and key technical guidance documents.

As a member of the United Nations Interagency Task Force on NCDs, UNICEF works to reduce risk factors, including physical inactivity and substance abuse, among children and adolescents. The recently released programme guidance for early life prevention of NCDs will steer UNICEF's responses to NCDs.

Antimicrobial resistance (AMR) – caused by overuse and misuse of antimicrobial agents in humans, animals and plants – is a growing threat to child survival and health in countries at all income levels. As a response, UNICEF



Aldiyar, 1.5 years old, is playing with his mother Ainur and Maira, a trained coordinator of the resource center for medical workers opened with UNICEF support, Turkestan, Kazakhstan.

released its institutional guidance on AMR, *Time is Running Out*. UNICEF continues to focus on reducing infections, promoting access to antimicrobials and their optimal use, and increasing AMR awareness and understanding.

Conclusion

The second year of the UNICEF Strategic Plan, 2018–2021 concluded with very good results on key child health interventions. However, this progress is being immediately threatened by COVID-19. After risk–benefit evaluations, essential health services are being adapted to continue to be delivered safely for both providers and patients. UNICEF is working with partners to continue to prioritize child health services in this extremely challenging context.

Considering the ambition of the SDGs, a number of health system constraints continue to hamper progress on child health, especially in middle- and low-income countries. Health financing is a serious impediment to the provision of health care, with insufficient funding dedicated to comparatively neglected diseases – pneumonia and diarrhoea – that contribute to the largest proportion of child deaths. All of these difficulties are further exacerbated in fragile and humanitarian settings where vulnerable children require even more assistance.

Urgent action is required to accelerate progress on child health to prevent an erosion from COVID-19 and to eventually meet the SDGs. Continued prioritization and investments that spur integration are needed in child survival programming with a clear focus on equitable access and quality PHC, as well as multisector engagement. In particular, stronger community health systems can provide quality interventions to prevent and manage pneumonia, malaria and diarrhoea, and other childhood diseases such as tuberculosis, malnutrition and HIV, as integrated packages along the life course, including for children beyond 5 years of age. There is an urgent need to leverage additional investments to scale up evidence-based interventions and tools, and harness innovations, including emerging digital technologies and data science to scale up high-quality, high-impact interventions to reach global child survival goals. Flexible funds enable UNICEF to ensure integration of interventions, address critical gaps, leverage resources and strengthen PHC at community level. These flexible funding streams are now more critical than ever to uphold the rights of children during the COVID-19 pandemic.

At the same time, UNICEF needs to expand support to countries to integrate child development and disability in PHC and develop integrated multisectoral programmes that respond to NCDs, childhood injuries, environmental pollution and climate change.



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Sixteen year old Zarasoa lives in Ifarantsa, Anosy region, Madagascar. Thanks to advice from the community health worker and the doctor, Zarasoa gained skills to avoid getting pregnant early and can continue to study.

Results Area 4: Adolescent health

UNICEF is on track, having achieved all planned Strategic Plan milestones in 2019 for adolescent health and well-being. However, to address the challenges undermining adolescents' right to thrive, UNICEF is accelerating its efforts in mobilizing political will and resources for implementation, using integrated platform-based interventions and strong youth engagement.

As of 2019, in 52 high-burden countries, 74 per cent of live births to adolescent mothers aged 15–19 years were attended by skilled health personnel (2021 target: 71 per cent). UNICEF supported eight countries in introducing HPV vaccine in their immunization schedule. In five countries reporting coverage and where UNICEF had supported introduction in earlier years, nearly 1 million adolescent girls to date received the full schedule of HPV vaccination as a protection against cervical cancer.³⁶

By the end of the year, 67 UNICEF programme countries (milestone: 35) had inclusive, multisectoral and gender-responsive national plans for adolescent health in place and UNICEF was supporting their implementation in 31 countries. School health programming is becoming a primary platform for integrated delivery of preventive and promotive interventions for adolescent health and well-being. In 2019, some 79 countries were implementing school health programmes in at least two intervention areas, with UNICEF actively supporting 33 countries.

Investment in adolescent health programming totalled US\$16 million, including US\$4 million from regular resources to ensure that UNICEF could sustain a quality response to an emerging priority for health.

Outcome and output indicators for adolescent health

FIGURE 24: Outcome results for adolescent health

Outcome	Baseline	2019 value	2021 target
Percentage of live births attended by skilled health personnel (mothers aged 15–19)	67%	74%	71%
Percentage of adolescent girls vaccinated against HPV in selected districts in target counties	WUENIC estimates on this indicator are currently not available		

Note: HPV, human papillomavirus; WUENIC, WHO–UNICEF Estimates of National Immunization Coverage.

FIGURE 25: Output results for adolescent health

Output indicator	Baseline	2019 milestone	2019 value	2021 target
Number of countries that have nationally introduced HPV vaccine in their immunization schedule	3	12	Data will be available in July 2020	24
Number of countries having an inclusive, multisectoral and gender-responsive national plan to achieve targets for adolescent health and well-being	46	35	67	45

Note: HPV, human papillomavirus.

Context

The world is now home to the largest cohort of adolescents in history – 1.2 billion people between the ages of 10 and 19 years. While adolescents have a better chance of improving their health and well-being now more than ever, an estimated 1.2 million still die each year – mostly from preventable causes. Many suffer impediments to realizing their right to access the essential information, quality services and protective environments they need to stay healthy and well.

For adolescent girls, the onset of puberty brings additional threats. Poverty and discriminatory cultural norms can restrict girls' rights and life choices and exclude them from educational, social and economic opportunities. Each year, an estimated 23 million adolescent girls become pregnant. Maternal mortality – in many cases linked to child marriage – is a leading cause of death for girls aged 15–19.

Mental health conditions also take an immense toll. Depression and anxiety, account for 16 per cent of the global burden of disease among 10- to 19-year-olds.^{37, 38}

Suicide is among the top five causes of adolescent deaths in high-, middle- and low-income countries, with higher rates among adolescent girls.³⁹ Although investment in early, effective intervention for the mental health of young people was identified as a 'best buy' over a decade ago, current evidence suggests that adolescent mental health remains a neglected yet pressing issue.^{40, 41}

Adolescents are also at great risk of cervical cancer caused by HPV. Cervical cancer is the fourth most common cancer in women, with an estimated 266,000 deaths and 528,000 new cases in 2012. A large majority of the global burden occurs in less-developed regions, where it accounts for almost 12 per cent of all female cancers.⁴²

Around the world, UNICEF joins forces with adolescents to improve the policies, programmes and services that affect their health and well-being. It works with governments in health and other areas – such as education, nutrition, gender, child protection, HIV and AIDS, and WASH – to increase investments and help countries develop comprehensive plans that address the rights and needs of all adolescents, especially the most marginalized.

Improving services and community demand

Adolescent pregnancy prevention

UNICEF uses a multisectoral approach to promote the health and well-being of adolescent girls. This includes supporting girls' secondary education and skills-building, preventing child marriage and early unions, and preventing and responding to gender-based violence in emergencies, in addition to strengthening adolescent-friendly health services. In the words of Elke Wisch, UNICEF representative in Madagascar, "our interventions are done through an integrated approach to ensure that every child, especially every young girl, has access to their right to basic social services."

Addressing early and unintended pregnancy is a cornerstone of UNICEF adolescent health work, one of five targeted priorities of its Gender Action Plan, 2018–2021. More than 5.7 million adolescent girls in 46 countries received prevention and care interventions through child-marriage-related programming, including through cross-sectoral links to health-related services, such as those targeting adolescent pregnancy.

UNICEF-supported ministries of health develop and implement national strategies as well as initiatives to prevent adolescent pregnancies.

- To address the human rights and needs of adolescents in Bangladesh, UNICEF supported four model districts with the establishment of 183 Adolescent Friendly Health Services, which were scaled up to a total of 603 now serving the needs of 99,920 adolescents.
- In Jamaica, recognizing the importance of non-traditional access points for adolescents outside health-care facilities, UNICEF supported the Ministry of Health and Wellness in establishing the Teen Hub, which served the needs of more than 6,500 adolescents. The Teen Hub provided pregnancy testing and counselling on effective family planning methods in addition to HIV counselling and testing. The successful model is being expanded to five additional locations.

The health of pregnant adolescents and their newborn infants continued to be a priority for UNICEF. Among mothers aged 15–19 who live in high-burden countries, 52 per cent received at least four antenatal visits (2021 target: 57 per cent). The addition of survey data from Afghanistan, Nigeria, the Philippines, Sierra Leone and Zimbabwe led to a one percentage point decrease compared to 2018.

Access to skilled birth attendants is extremely important for adolescent girls as they face additional vulnerabilities and greater risk of obstetric complications. In 2019, UNICEF supported 52 ENAP countries with the provision of quality maternal care for adolescent mothers contributing to 74 per cent of live births to mothers aged 15–19 being attended by skilled health personnel (compared with 69 per cent in 2018). This result is well above the Strategic Plan target of 71 per cent. Progress was driven by the most recent household surveys from Indonesia, Sierra Leone and Zimbabwe. Lastly, based on the latest survey data inclusive of China, 57 per cent of adolescent mothers received postnatal care, exceeding the 2021 target of 52 per cent.

UNICEF supported the provision of care for newborns and young mothers, capacity-building of health workers to provide adolescent-responsive and quality maternal care, and strengthened health data systems to collect information on adolescent pregnancies.

For example, in Madagascar, 64 per cent of girls aged 15–19 give birth at home. Working with the Government, United Nations agencies and CSOs, UNICEF helped formulate the National Policy for Adolescent Health to enhance services adapted for adolescents. Moreover, 44 youth-friendly health centres in the Anosy region were supported to provide medical check-ups, counselling and awareness-raising, including on pregnancies and deliveries (through neonatal resuscitation and midwifery kits, treatments, and HIV tests for pregnant women). More than 38,000 teenagers – both in and out of school – received health check-ups through these centres, which offered antenatal consultations to over 5,000 pregnant adolescents⁴³ and HIV testing to nearly 6,000 adolescents, including pregnant girls.

HPV vaccination and cervical cancer elimination

Cervical cancer is a leading cause of death among women of reproductive age in low- and middle-income countries. WHO has called for eliminating the disease as a global public health problem. The HPV vaccine remains the most effective prevention method. UNICEF is committed to achieving the global target of fully vaccinating 90 per cent of girls with the HPV vaccine by 15 years of age. Since 2018, UNICEF and partners have been helping accelerate the scale-up of HPV vaccine in low- and lower-middle-income countries. In 2019, UNICEF procured a total of 12 million doses of HPV vaccine for 26 countries.

While data on HPV vaccine introduction for 2019 will not be available until July 2020, UNICEF supported eight countries (milestone: 12) in introducing HPV vaccine in their immunization schedules (Côte d'Ivoire, the Gambia, Kenya, Liberia, Malawi, Solomon Islands, Uzbekistan, Zambia). In five countries where UNICEF had supported introduction in earlier years (Honduras, Rwanda, Sri Lanka, Uganda, the United Republic of Tanzania), nearly 1 million

adolescent girls to date were reported to have received the full schedule of HPV vaccination and, therefore, protection against cervical cancer.⁴⁴

In 2019, UNICEF continued to provide technical assistance and build capacity in countries by improving awareness in communities and creating demand among adolescent girls and their caregivers. Strong support for demand creation around vaccines has proven essential to obtain trust and results.

For instance, in Uzbekistan, UNICEF supported the Ministry of Health to introduce HPV vaccine among 9-year-old girls, reaching 96 per cent coverage despite an antivaccination movement. To overcome vaccination resistance, stakeholders were trained on the basic principles of working with adolescents and on key issues related to adolescent health and well-being. A total of 34,677 specialists – 21,448 teachers and 13,229 school-based health-care providers – strengthened their knowledge through cascade training. An intensive awareness-raising campaign was launched to increase knowledge of the media, parents and caregivers about HPV vaccination, including on the role of fathers and addressing gender stereotypes. More than 250 media professionals were oriented on issues relating to immunization, which significantly improved their ability to formulate correct messages for parents.

Based on the momentum created by HPV vaccine introduction, the HPV+ initiative aims to leverage political commitment and programmatic outreach to reach adolescent girls with a package of age- and gender-appropriate health interventions. In 2019, the HPV+ project was introduced to the Second Decade Matrix Group (the technical advisory group for adolescent-related programmes with members from all UNICEF sectors) to establish and strengthen cross-collaboration and dialogue with other sectors in the organization. In collaboration with the Europe and Central Asia and Eastern and Southern Africa regional offices, relevant work has started in two countries (the Republic of Moldova and the United Republic of Tanzania).

The project has convened additional sectors besides health, such as education, nutrition, HIV/AIDS and WASH, to include essential services for adolescents that are aligned with a PHC perspective – such as immunization, nutritional supplementation, and education on sexual reproductive health and reproductive rights (SRHR) and menstrual hygiene management. Furthermore, the project is including a mental health and psychosocial support component in the Republic of Moldova, focusing on the prevention of bullying in schools and better parenting strategies.

In terms of partnerships to bolster action on HPV vaccine introduction, UNICEF helped develop the Global Strategy to Eliminate Cervical Cancer through HPV vaccination and other interventions led by WHO. UNICEF is a member of HPV elimination working groups and provided support to selected countries through the United Nations Joint Global Programme.

To further the knowledge base on HPV vaccine, UNICEF developed 10 HPV vaccine communication field guides, case studies on Malawi and Senegal and an analytical report, *HPV Vaccination Programme Communication in Six Priority UNICEF Countries*.

Adolescent mental health

PHC is the foundation for quality mental health care. When mental health is integrated into facility and community-based primary health and nutrition services, access to care and treatment is improved, and physical and mental health problems can be more effectively managed. In addition to strengthening the capacity of health-care facilities, this involves strengthening school-based mental health and psychosocial promotion and services (i.e., school health programmes that include counselling and psychosocial support and referrals) and awareness-raising through community-based engagement, mass media and social media.

- In China, a comprehensive adolescent mental health service package piloted in 14 counties helped improve adolescents' awareness of mental health issues and encouraged them to access mental health services. More than 1,400 adolescents in pilot sites sought mental health counselling services through health-care facilities, and around 17,000 adolescents benefited from in-school services. An estimated 310,000 adolescents used the online counselling services via a government hotline, a website, Weibo and WeChat.
- In Tajikistan, UNICEF supported the Government through capacity-building of 220 school psychologists, 100 school administrators and 209 peer supporters on adolescent mental health. As a result of the mental health services provision model in nine districts, more than 14,000 adolescents received mental health support in schools and through referral to PHC – 16 per cent of all adolescents aged 10–17 in the targeted 220 schools.

Strengthening national and subnational capacity

To strengthen national and subnational capacity in delivering health services, UNICEF assists countries in building a more responsive PHC that is integrated and multisectoral. UNICEF helps develop the interpersonal skills of health workers, introduce new tools and develop cross-sectoral linkages to help adolescents receive friendly health services. UNICEF continues to facilitate this expansion by supporting PHC facilities and ensuring services are delivered according to quality-of-care standards.

- In Zambia, consistent with government policy to deliver services that are responsive to the health needs of adolescents, UNICEF supported the

establishment and revitalization of Adolescent Friendly Spaces: 130 health workers and 193 peer educators were trained for that purpose and helped increase access. A total of 31 additional Spaces were established; the current number of Spaces supported by UNICEF is 210 in 38 districts (179 in 2018).

- In the Central African Republic, children- and adolescent-friendly services were established in 32 health-care facilities. Fifty-six adolescent peer educators provided support activities.

Building a more responsive PHC system is essential in the area of adolescent mental health and well-being, especially when it comes to preventing self-harm – the third leading cause of death among adolescents.

The WHO–UNICEF Helping Adolescents Thrive (HAT) initiative developed an evidence-informed intervention package aimed at promoting mental well-being, preventing mental ill health, and reducing risky behaviours among adolescents. In addition to in-depth discussions with 10- to 19-year-old boys and girls across Belize, Kazakhstan and South Africa, a consultation convened field experts, practitioners, researchers, young people and national government leaders to inform the HAT implementation toolkit, which will be available for dissemination in 2020. UNICEF will continue working closely with WHO and other technical partners to implement the HAT initiative at country level.

In Europe and Central Asia, addressing adolescents' mental health and well-being is gaining prominence, particularly given high levels of self-harm and suicide in several countries. UNICEF is engaging with youth in developing new models to help adolescents realize their rights, thrive, and improve their socio-emotional skills and mental well-being. Young people are engaged as partners in designing innovative approaches, including through peers, school platforms, hackathons and e-mental health for reducing stress, anxiety, depression, self-harm and suicide. Building on the experiences of Kazakhstan, six countries in the region are keen to work in this area.

In Mongolia, with the support of global thematic funds, UNICEF helped train an additional 30 PHC service providers to support adolescent-friendly mental health services. In addition, school social workers and doctors were trained to strengthen school services on adolescent mental health.

School health

The reporting year saw much expansion of school health as an area of work, including implementation of stronger programming. The school health model aims to provide health services and education so children can adopt healthier habits and lifestyles, as well as creating a healthy school environment to foster well-being.

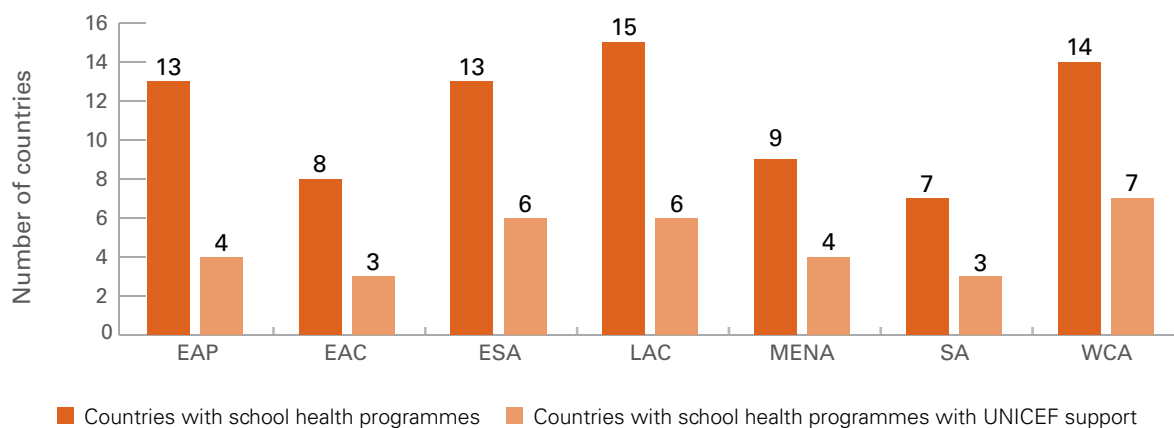


From left to right: Maria, Catalina, Sofia and Julieta, all 11-years-old, play after school in Montevideo, Uruguay. The friends like to spend time together after the school day ends.

In 2019, UNICEF scaled up the ‘health-promoting schools’ concept and school-based health programming globally for older children and adolescents. The education system is a critical platform to promote health and well-being and, in some settings, an important entry-point to provide critical services such as basic health, nutrition and WASH. UNICEF has intensified collaboration across sectors (education, health, nutrition, WASH) by articulating an integrated approach to health-promoting schools in the midterm review of its Strategic Plan.

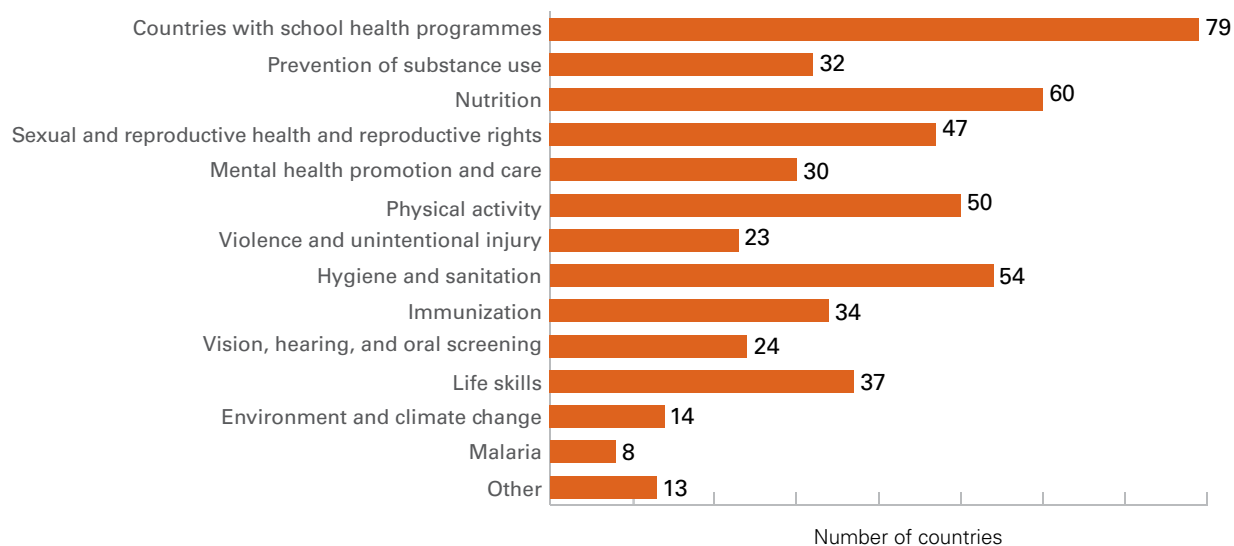
In 2019, some 79 countries were implementing school health programmes in at least two intervention areas, with UNICEF actively supporting 33 countries (Figure 26). More than half of the countries that reported having school health programmes included nutrition, SRHR, physical activity, hygiene and sanitation as part of their programmes (Figure 27).

FIGURE 26: Countries with school health programmes and with UNICEF support, by region, 2019



Source: UNICEF New York (2019). Notes: EAP, East Asia and the Pacific; ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; SA, South Asia; WCA, West and Central Africa.

FIGURE 27: School health, by programme component, 2019



Source: UNICEF New York (2019).

UNICEF and the World Food Programme launched a School Health and Nutrition Partnership in December 2019 with the aim of reaching the most vulnerable children in the least-developed and most fragile countries with an essential package of health, nutrition and WASH interventions. UNICEF developed the concept note and prioritized health interventions such as health education, dental and audiovisual screenings, tetanus–diphtheria vaccine booster dose and a comprehensive school-based malaria programme. UNICEF also provided guidance to roll out this new partnership in six pilot countries (Chad, Ethiopia, Mali, the Niger, Somalia, South Sudan).

UNICEF continues to be engaged in the Global Health Promoting Schools (HPS) initiative as an active member of the External Advisory Group to support the development of global HPS standards. UNICEF brought together a vast repository of school health strategies, guidelines and materials from 35 countries across three regions (Eastern and Southern Africa, West and Central Africa, Latin America and the Caribbean) to be included in the global review.

Leveraging collective action

National plans for adolescent health

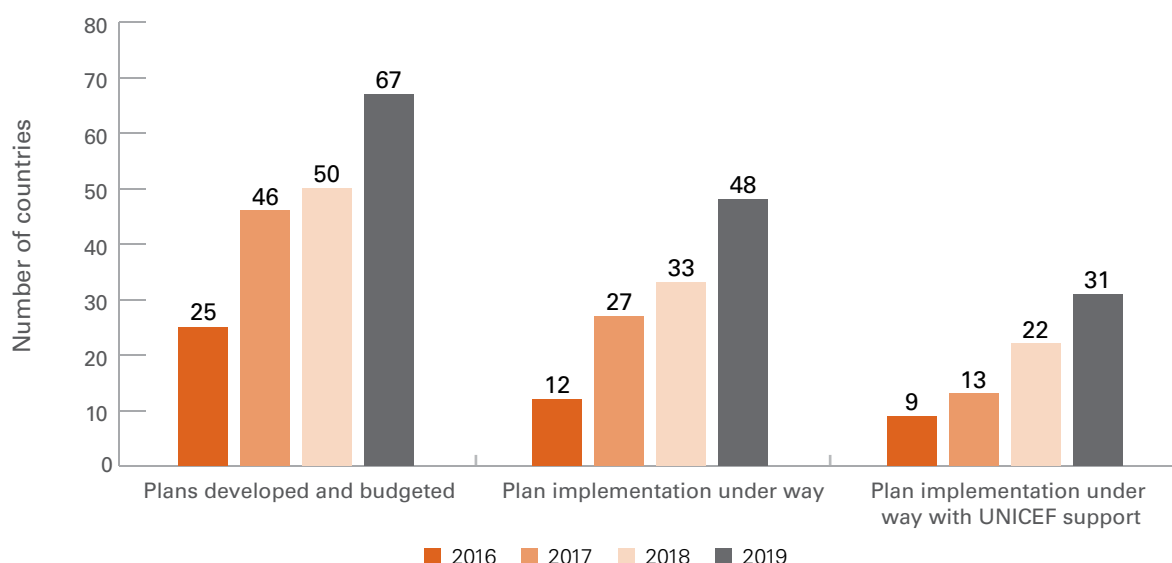
In 2019, some 48 country programmes identified promoting adolescent girls’ health as a Gender Action Plan priority. There was significant progress on the development of inclusive, multisectoral and gender-responsive national plans for adolescent health. By the end of the year, 67 countries had these plans in place, exceeding the 2021

target of 45. The inclusion of adolescents in the global Every Woman Every Child strategy (2016–2030) and the technical assistance extended by UNICEF and other United Nations agencies contributed to raising awareness of adolescent needs and the development of these plans at country level. Implementation of these national plans is under way in 48 countries, with UNICEF supporting 31 (up from 22 in 2018).

- In Sierra Leone, UNICEF rolled out a multisectoral national strategy on the reduction of adolescent pregnancy and child marriage (2018–2022).
- In Ecuador, UNICEF and the United Nations Population Fund (UNFPA) provided technical assistance to the Government to adequately implement the National Policy on Preventing Adolescent Pregnancy, including training staff to assess the quality of adolescent-friendly health services.

AA-HA!, the international guidance on adolescent health rolled out in 2018, continues to serve as a basis for developing adolescent health plans. For instance, in Uzbekistan, UNICEF used global thematic funds to plan for a needs assessment, landscape analysis and national prioritization based on the AA-HA! framework and international best practices in the field of adolescent health policy development. This includes a substantial participatory component, which recognizes that adolescents themselves are the best-informed witnesses to their daily lives. In addition, a national team was trained on the basic principles of working with adolescent and other knowledge related to development of adolescent health policy.

FIGURE 28. Countries with an inclusive, multisectoral and gender-responsive national plan to achieve targets for adolescent health and well-being, 2016–2019



Source: UNICEF New York (2019).

In Latin America and the Caribbean, eight countries attended a regional meeting on the AA-HA! guidance. The setting served as a basis to review national strategic and operational plans on adolescent health, signalling regional interest and action in this important area.

Partnerships for adolescent health

UNICEF works towards strengthening the global adolescent health network to accelerate country progress. Together with WHO, PMNCH, UNFPA, the United Nations Major Group for Children and Youth, and NGO partners, UNICEF launched *Adolescent Health: The Missing Population in Universal Health Coverage in 2019*.⁴⁵ This paper underscores that policymakers must take urgent action to address the leading causes of adolescent ill health. This led to a Call to Action for Adolescent Wellbeing, which aims to engage adolescents in all legal, policy and programme processes that affect them; to develop strong multisectoral policy approaches; and to strengthen political commitment and funding for adolescents. To date, this call to action has gained the endorsement of over 25 Member States, 5 United Nations agencies, and over 40 youth networks, CSOs and private sector partners.

In 2019, UNICEF continued to create the necessary space for young people to actively participate on issues of adolescent health and well-being. An Adolescent Health and Wellbeing symposium co-hosted by UNICEF and the Gates Foundation in Dakar, Senegal convened young people from across Africa, representatives from 13 UNICEF country offices, United Nations agencies, government leaders and civil society partners. The symposium showcased country-level programming and promoted multisectoral collaboration to accelerate results on adolescent health and well-being in sub-Saharan Africa. UNICEF also established a new six-year partnership with the AstraZeneca Young Health Program to catalyse a global movement for youth-led prevention of NCDs.

Another example of how UNICEF actively supports the engagement of young leaders comes through Leading Minds, a forum for discussion on mental health among young people with knowledge and power brokers that took place in Florence, Italy.

To further promote adolescent health and well-being, UNICEF produced various knowledge products. UNICEF authored or co-authored 13 publications on adolescent health, including 5 journal articles; and collaborated with PMNCH and other technical partners on the publication of a knowledge summary on adolescent mental health, also bringing advocacy to the fore during a joint side event at the United Nations General Assembly. The UNICEF Middle East and North Africa Regional Office conducted a Rapid Landscape Analysis of Adolescent Health and Wellbeing as part of the United Nations Inter-Agency Technical Task Team on Young People's framework of joint actions to shed light on progress and gaps, and to highlight key opportunities to make a positive impact on adolescent health and well-being in the region.



Nyedieng loves to play volleyball. It is one of her preferred activities during break time.

In 2019, UNICEF articulated its commitments to mental health and psychosocial support, across all sectors in both development and humanitarian contexts, in a Mental Health and Psychosocial Support Technical Note launched in 2019. Additionally, a Landscape Assessment now documents UNICEF's work in adolescent mental health globally over the past decade and identifies priority areas of action. These priorities include promoting whole-of-government approaches, increasing efforts towards prevention and early intervention, building population-level data and programme evidence, and scaling up new service delivery models.

Conclusion

Great progress in the area of adolescent health and well-being has been made during the first two years of the UNICEF Strategic Plan, 2018–2021. However, UNICEF anticipates a disruption in prioritizing services for adolescents, including those delivered through schools, due to COVID-19. The organization will work with partners to safeguard adolescents' right to health and well-being.

UNICEF is committed to working with its partners to further advance the health rights and well-being of adolescents and accelerate results towards the SDGs. PHC responsive to priorities of adolescents in communities – teen pregnancy, mental health and well-being, immunization, nutrition, HIV/AIDS, NCDs, WASH, environmental pollution, and the effects climate change – is critical to this acceleration. In the years to come, UNICEF would like to prioritize integrated services delivered through front-line health-care facilities and workers, multisectoral approaches through schools and social welfare and community engagement, including through the use of digital approaches. Critical to this is the engagement of adolescents themselves, the availability of health outcome data and securing flexible funding to advance this work, even more so in the context of COVID-19.

Lessons learned

The aim of the UNICEF Strategic Plan is to meaningfully realize children's rights, thereby contributing to achieving the universally agreed SDGs. Under the health portfolio, UNICEF demonstrated robust performance in meeting a substantial number of corporate commitments and, ultimately, striving for a world that is more equitable for children.

The four results areas that bring UNICEF's health work together show that 'leaving no one behind' by targeting the most vulnerable children and women first remains a priority in how UNICEF approaches its health work.

The midterm review of the Strategic Plan was an opportunity to delineate several lessons learned, which UNICEF will build upon to strengthen the implementation of its unique mandate for children's rights. However, as a matter of urgency, UNICEF and partners need to work in concert to prepare for and address unprecedented levels of mortality and morbidity seen in the wake of COVID-19. These are bound to be far worse in low- and middle-income countries, particularly those with fragile health systems which are already struggling to provide basic health services.

There are now multiple and evolving global health narratives. Time is of the essence to operationalize these with country actions. UNICEF has been working with partners to reach SDG 3, through the Every Woman Every Child movement, PHC for UHC and, most recently, the SDG 3 Global Action Plan for Healthy Lives and Wellbeing. These frameworks and approaches need to be urgently operationalized, particularly in the context of COVID-19, to accelerate progress so children do not die needlessly. The pandemic highlights that without resilient PHC and preparedness, the world remains at risk of untold consequences, including mortality, hunger and economic devastation.

Similarly, another important lesson learned is reducing the fragmentation of the global health architecture to increase coherence and efficiency with a view to aligning the response to COVID-19. UNICEF is already working with other United Nations agencies in this direction, particularly on procuring critical supplies. UNICEF will continue to work as part of the H6 group to improve outcomes in sexual, reproductive, maternal, newborn, child and adolescent health, particularly through the creation of regional and country platforms to coordinate work on the ground.

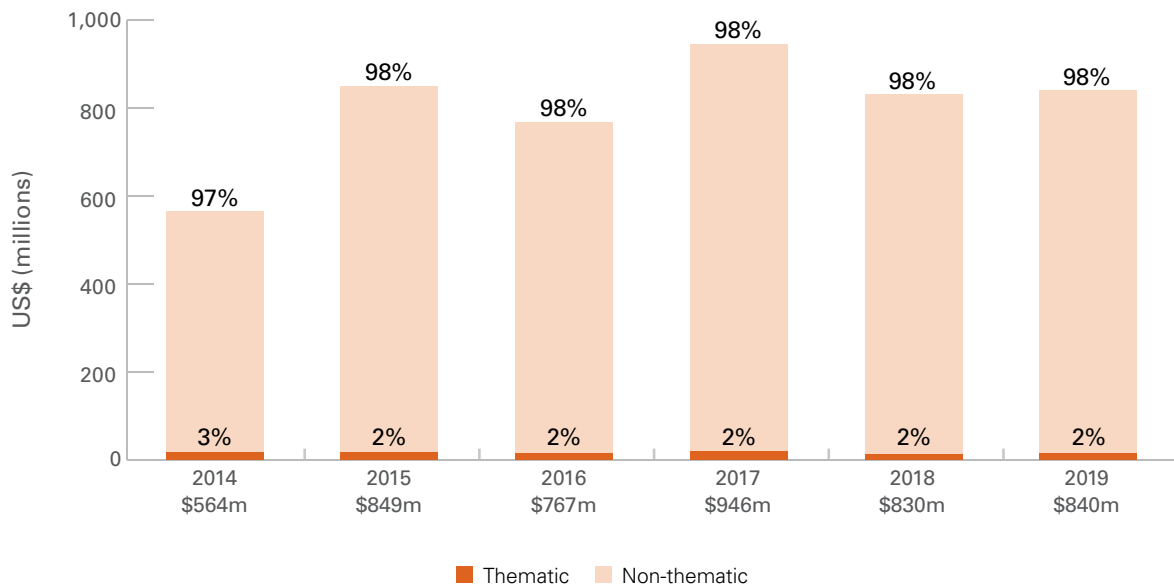
Addressing critical gaps in strengthening PHC in high-burden settings through integrated delivery is another important lesson learned. Sharp focus is needed on the provision of care for small and sick newborns, reaching zero-dose children with vaccines, and ensuring timely diagnosis, care and treatment of pneumonia. This requires addressing the barriers in planning and delivery of integrated services, addressing key gaps in commodities and capacities, and long-term investment in strengthening health systems and flexible funds focused on sustainable results rather than short-term gains.

Implementing health systems strengthening (HSS) has not been easy. UNICEF's transition to HSS, to which it is committed, will be complex. In many contexts, available funding streams and their quality, national leadership and addressing immediate gaps in service delivery have constrained the full application of an HSS approach. This tension is a fundamental obstacle to UNICEF's transition to HSS. In addition, UNICEF's contribution to this area is further limited by the division of labour among United Nations organizations and partners that often take the lead in this area of work. Solutions include leveraging resources at country level and flexible funding to support UNICEF work on HSS, including its staff, as well as improving measurement and communication of UNICEF HSS work for greater visibility, impact and trust.

While the unfinished agenda on maternal, newborn and child mortality remains a critical focus for UNICEF, the organization needs to do more on 'thrive' to address the health rights and well-being needs of millions of children and adolescents. UNICEF's contribution to the Lancet Commission's 'A Future for the World's Children?' emphasizes the urgency in protecting children's environment, a key to their health.⁴⁶ Children are most vulnerable to the lifelong environmental effects caused by climate change arising from anthropogenic greenhouse gas emissions and from industry-linked pollution of the air, water and land. Mainstreaming preventive, promotive and curative interventions for mental health, NCDs, injuries, environmental pollution, nurturing care and disability in PHC requires urgent funding. The thrive agenda cannot make further progress without substantial investments to provide the integrated and multisectoral services children and adolescents desperately need. The increasingly integrated and multisectoral nature of the work that still needs to be done to deliver greater results for children – strengthening health systems, building climate resilience, addressing gender barriers to health, and others – requires additional flexible funding streams for health, which to date remain insufficient for this work. Further flexible investments such as thematic funds and regular resources would allow UNICEF to expand its work for the benefit of all children.

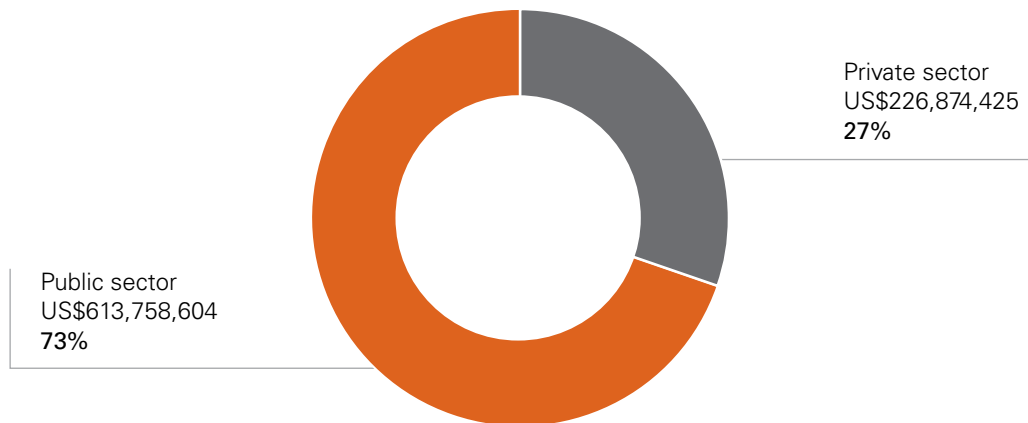
Financial report*

FIGURE 29: Health 'other resources-regular' contributions, 2014–2019



*All funding data as of 6 April 2020, pending audit and certification.

FIGURE 30: Total Health funds received by type of donor, 2019: US\$840 million



Health income in 2019

In 2019, partners contributed US\$840 million 'other resources – regular' for health, a 1 per cent increase over the previous year. Public sector partners contributed the largest share of 'other resources – regular' to health, at 73 per cent. The top five resource partners to UNICEF health in 2019 were the World Bank, Gavi, the U.S. Fund for UNICEF, and the governments of Germany and the United Kingdom

of Great Britain and Northern Ireland (see Figure 31). The largest contributions were received from the World Bank for the Emergency Crisis Response Project in Yemen and for Provision of Essential Health Services in South Sudan, and from the Government of the United Kingdom for responding to the nutrition crisis in Yemen (see Figure 31; and body of the report for details on these programmes).

FIGURE 31: Top 20 resource partners to health by total contributions, 2019

Rank	Resource partners	Total (US\$)
1	World Bank*	400,320,957
2	Gavi, the Vaccine Alliance	202,102,773
3	U.S. Fund for UNICEF*	194,809,784
4	Germany*	76,089,240
5	United Kingdom	68,947,050
6	United States	44,507,964
7	United Nations Joint Programme	42,568,091
8	European Commission	25,117,018
9	UNFPA-managed United Nations Partnerships and Joint Programmes*	24,781,588
10	The Global Fund to Fight AIDS	23,114,705
11	Islamic Development Bank	16,629,456
12	The GAVI Fund	15,965,785
13	Canada	15,722,551
14	Japan	13,800,863
15	UNDP-managed United Nations Partnerships and Joint Programmes*	11,924,648
16	Nutrition International	6,766,193
17	Sweden	6,535,405
18	France	4,854,170
19	United Kingdom Committee for UNICEF	4,838,457
20	German Committee for UNICEF	4,449,648

* Includes cross-sectoral grants SC190052 (Health, WASH), SC170533 (Health, Nutrition, WASH), SC170314, SC181116, SC190305 (Health, Nutrition, Social Inclusion), SC170579, SC180970, SC181209, SC190340 (Health, Nutrition), SC190614 (Health, Nutrition, Safe and Clean Environment), SC190746 (Health, Safe and Clean Environment), SC181205 (Health, Nutrition, Education, WASH, Safe and Clean Environment, Gender Equality), SC190741 (Health, Nutrition, Education, Child Protection, WASH)

FIGURE 32: Top 20 Grants to health, 2019

Rank	Grant description	Resource partners	Total (US\$)
1	Third Additional Financing for Yemen Emergency Crisis Response Project*	World Bank	139,182,077
2	Fourth Additional Financing for the Yemen Emergency Crisis Response Project*	World Bank	67,941,375
3	Responding to the Nutrition Crisis, Yemen	United Kingdom	53,615,434
4	Provision of Essential Health Services Project, South Sudan	World Bank	51,070,772
5	Third additional financing for Emergency Health and Nutrition Project, Yemen*	World Bank	40,231,800
6	Support to the Health Development Fund, Zimbabwe	United Nations Joint Programme	37,190,454
7	Second additional financing for Emergency Health and Nutrition Project, Yemen*	World Bank	31,726,169
8	Second Additional Financing for Yemen Emergency Crisis Response Project*	World Bank	30,920,286
9	GAVI's Partners' Engagement Framework (PEF) 2019-2020 Targeted Country Assistance	GAVI The Vaccine Alliance	27,244,259
10	Building Resilience in Sahel (Mali, Mauritania, Niger)*	Germany	25,082,508
11	Enhancing Girls' and Boys' resilience, Sudan*	Germany	21,784,357
12	Activities to Eradicate Polio	United States	20,238,880
13	Support for UNICEF staffing Global Polio Eradication Initiative	U.S. Fund for UNICEF	19,999,402
14	Accelerating the reduction of maternal, neonatal and child mortality, Niger**	Islamic Development Bank	16,329,456
15	Global child health & goals of the Global Polio Eradication Initiative	U.S. Fund for UNICEF	15,316,621
16	Support the implementation of Health Systems Strengthening, South Sudan	GAVI The Vaccine Alliance	14,807,235
17	Procurement of vaccines and cold chain equipment of the HRP 2017/18, MENARO	GAVI The Vaccine Alliance	13,340,000
18	Health, Nigeria	European Commission	13,089,827
19	Expanding and Consolidating Community Based Vaccination, Pakistan	U.S. Fund for UNICEF	13,058,659
20	Support to countries with measles outbreak	GAVI The Vaccine Alliance	12,560,000

* Cross-sectoral grants SC181116, SC190305, SC170314 (Health, Nutrition, Social Inclusion), SC190340, SC170579, SC180970, SC181209 (Health, Nutrition), SC190746 (Health, Safe and Clean Environment), SC181205 (Health, WASH, Safe and Clean Environment, Gender Equality, Nutrition, Education), SC190741 (Health, Nutrition, WASH, Education, Child Protection)

**Contribution was provided by the Islamic Development Bank to the Government of Niger, and UNICEF received funds through the agreement with the Government to support the implementation of Health Programme.

UNICEF thematic funds maintain a four-year funding period that covers the entire Strategic Plan period (2018–2021). In the first two years of the Strategic Plan, thematic funding contributions for health reached US\$27 million with US\$14 million received in 2019, of which almost 59 per cent came from government partners. The Government of Sweden was the largest thematic resources partner in 2019, providing almost 26 per cent of all thematic health contributions received (see Figure 33).

Of all thematic health contributions that UNICEF received in 2018 and 2019, only 17 per cent were global-level contributions (see Figure 33). These are the most flexible sources of funding to UNICEF after regular resources and can be allocated across regions to individual country programmes, according to priority needs.

UNICEF is seeking to broaden and diversify its funding base (including thematic contributions) and encourages all partners to give as flexibly as possible. In 2019, eighteen partners contributed thematic funding to health. Sizeable thematic contributions were received from the Government of Luxembourg for global health thematic funding, and from the Government of Denmark towards health activities in Burkina Faso, Mali and the Niger.

In 2019, the allocation of global health thematic funds prioritized work under strengthening PHC in four countries within the Europe and Central Asia and East Asia and Pacific regions, and expanding UNICEF programmes to address the thrive, health and well-being agenda. The recommendation was developed through close consultation with regional and country offices to expand

FIGURE 33: Thematic contributions by resource partners to health, 2019

Resource partner type	Resource partners	Total (US\$)	Percentage of total
Governments 58.78%	Sweden	3,681,986	25.73%
	Denmark	3,581,021	25.03%
	Luxembourg	795,455	5.56%
	Canada	181,337	1.27%
	Iceland	171,471	1.20%
Private Sector 41.22%	German Committee for UNICEF	2,762,452	19.31%
	U.S. Fund for UNICEF	875,466	6.12%
	Spanish Committee for UNICEF	704,994	4.93%
	Swiss Committee for UNICEF	519,678	3.63%
	Danish Committee for UNICEF	348,631	2.44%
	Czech Committee for UNICEF	218,759	1.53%
	Swedish Committee for UNICEF	208,529	1.46%
	New Zealand Committee for UNICEF	68,586	0.48%
	Italian Committee for UNICEF	66,172	0.46%
	United Kingdom Committee for UNICEF	47,932	0.33%
	Canadian Committee for UNICEF	34,967	0.24%
	Netherlands Committee for UNICEF	28,703	0.20%
	Slovenian Committee for UNICEF	12,572	0.09%
Grand total		14,308,709	100.00%

Grant numbers are provided for IATI compliance: SC1899010002, SC1899010005, SC1899010010, SC1899010012, SC1899010013, SC1899010015, SC1899010016, SC1899010021, SC1899010022, SC1899010023, SC1899010029, SC1899010030, SC1899010032, SC1899010034, SC1899010035, SC1899010036, SC1899010037, SC1899010038, SC1899010039, SC1899010040, SC1899010041, SC1899010042, SC1899010043, SC1899010044, SC1899010045, SC1899010046, SC1899010048, SC1899010049, SC1899010050, SC1899010051, SC1899010053, SC1899010054, SC1899010055, SC1899010056, SC1899010059, SC1899010060, SC1899010061, SC1899010062, SC1899010063, SC1899010064, SC1899010065, SC1899010066, SC1899010067, SC1899010068

work in areas that most need flexible funding. In total, 78 per cent of funds were allocated to country offices where the groundwork on PHC strengthening and thrive can demonstrate the most immediate results for child and adolescent health and well-being. In particular, the allocation of thematic funds was made to develop

programmes for protecting children from environmental pollution. The remaining funds were allocated to regional offices (12 per cent) and headquarters (10 per cent) for dedicated cross-country support, regional and global partnerships and guidance.

FIGURE 34: Health thematic contributions at country, regional and global levels, 2018–2019

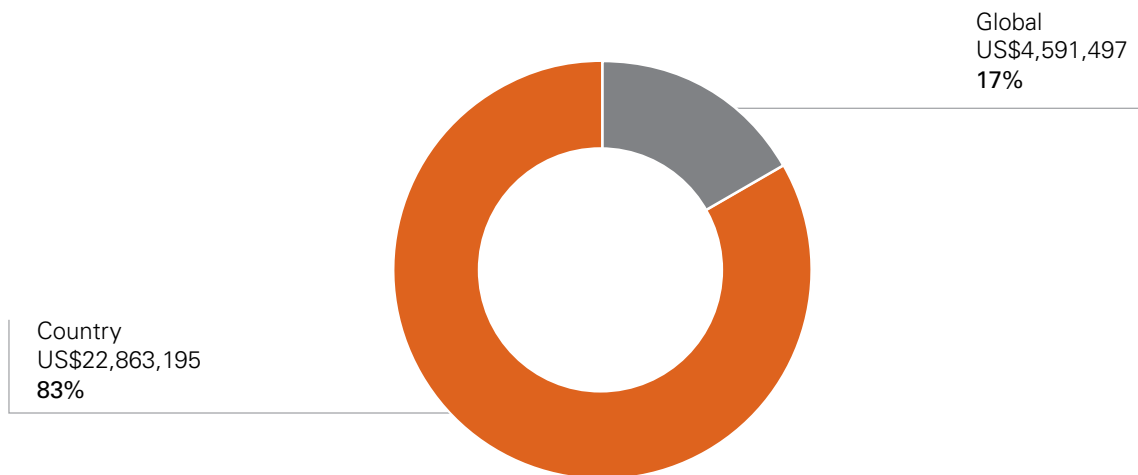


FIGURE 35: Allocation of global health thematic funding to offices and programmes, 2019

Offices	Focus area	Allocation (US\$)
Georgia Country Office	Integrated primary health care to mainstream child growth, development and lead exposure	215,000
Uzbekistan Country Office	Strengthen perinatal death surveillance, develop adolescent health strategy and leverage investments to address MNCAH data gaps	215,000
Mongolia Country Office	Mainstream air pollution and child health, and pilot multi-sectoral approach to address adolescent mental health as part of primary health care (PHC)	215,000
Viet Nam Country Office	Operationalize operationalizes child stimulation and nurturing care in PHC, including tracking implementation through mobile health platform	215,000
Europe and Central Asia Regional Office	Regional advocacy, partnerships, technical support for strengthening PHC at country level	66,154
East Asia and Pacific Regional Office	Regional advocacy, partnerships, technical support for strengthening PHC at country level	66,154
HQ Programme Division/Health Section	Global advocacy, partnerships, technical support for strengthening PHC at country level Global thematic reporting, resource mobilization and partnership development	110,256
	Total	1,102,564

Notes: HQ, Headquarters; MNCAH, maternal, newborn, child and adolescent health; PHC, primary health care.

Expenses for health in 2019

Note: expenses are higher than the income received because expenses comprise total allotments from regular resources and other resources (including balances carried over from previous years), while income reflects only earmarked contributions from 2019 to health (see Annex).

Expenses vs. 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).

Health remains the largest portfolio within UNICEF. To realize children's rights to health, the organization spent US\$1.33 billion in 2019 or 23 per cent of all of its expenses (Figure 36). Health expenses represented 62 per cent of the US\$2.15 billion expenses for Goal Area 1.

Health expenses from regular resources (the most flexible type of resources) stood at US\$227 million (or 17 per cent of total expenses, Figure 37), proportionately similar to previous years. 'Other resources – regular' (ORR), the least flexible fund type, continue to account for the vast majority of expenses, totalling 66 per cent of expenses in the sector. Finally, the proportion of expenses from 'other resources – emergency' (ORE) was 17 per cent (US\$223 million), also proportionately equivalent to 2018.

By region, health expenses continue to be driven primarily by the goal of reducing maternal, neonatal and child mortality, and accelerating progress towards Agenda 2030. A total of US\$650 million (49 per cent of health expenses) was spent in sub-Saharan Africa. West and Central Africa accounted for 26 per cent of expenses (US\$346 million, see Figure 38), while Eastern and Southern Africa accounted for 23 per cent (US\$310 million). South Asia, a region that also experiences a high burden of maternal and neonatal mortality, accounted for 20 per cent of expenses (US\$262 million). By fund type, the Middle East and North Africa region continued to drive the majority of expenses from emergency resources at 44 per cent of ORE (US\$97 million). This reflects the protracted conflicts in the Syrian Arab Republic and Yemen where UNICEF provided support to guarantee children's access to immunization and other integrated services.

FIGURE 36: Expense by sector, 2019

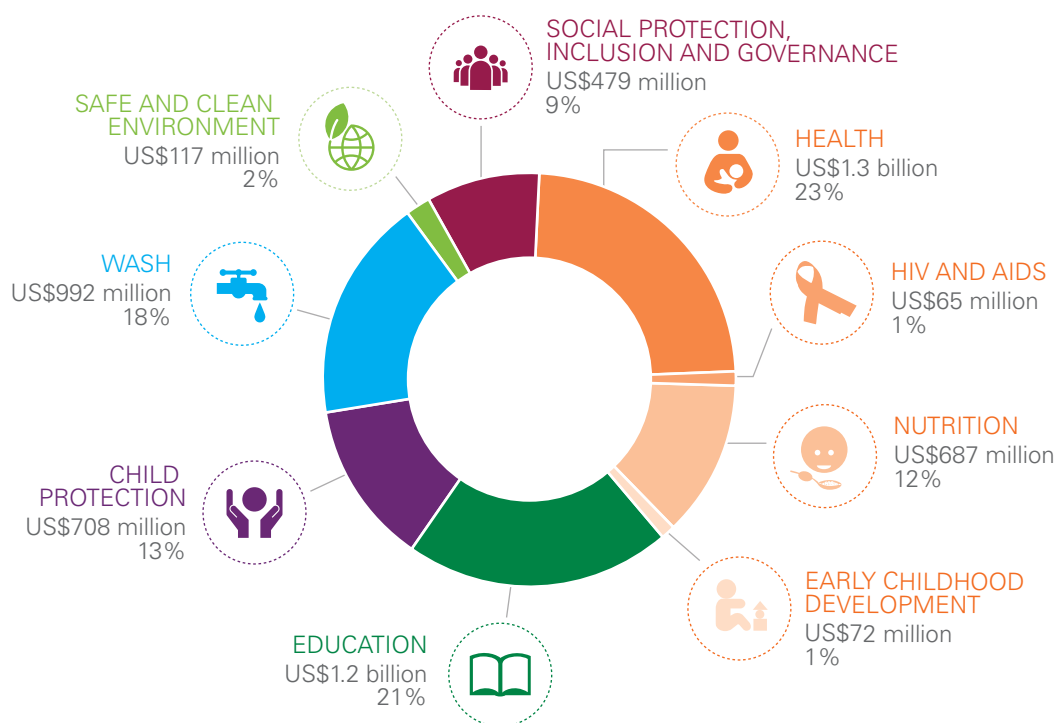


FIGURE 37: Trend of expense for health, by fund type, 2014–2019

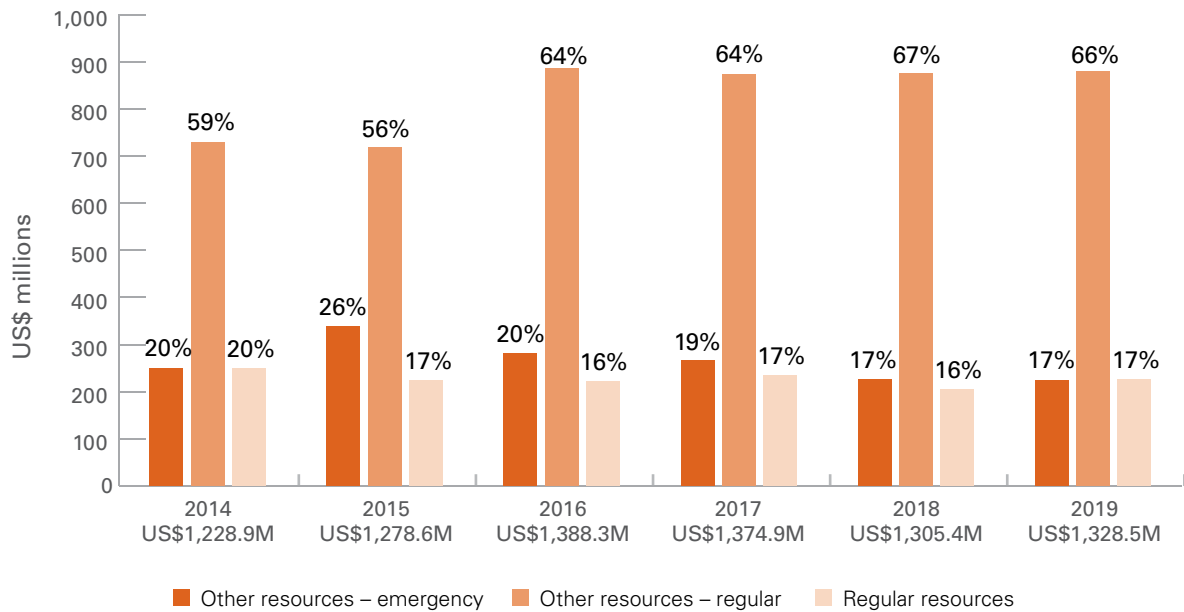
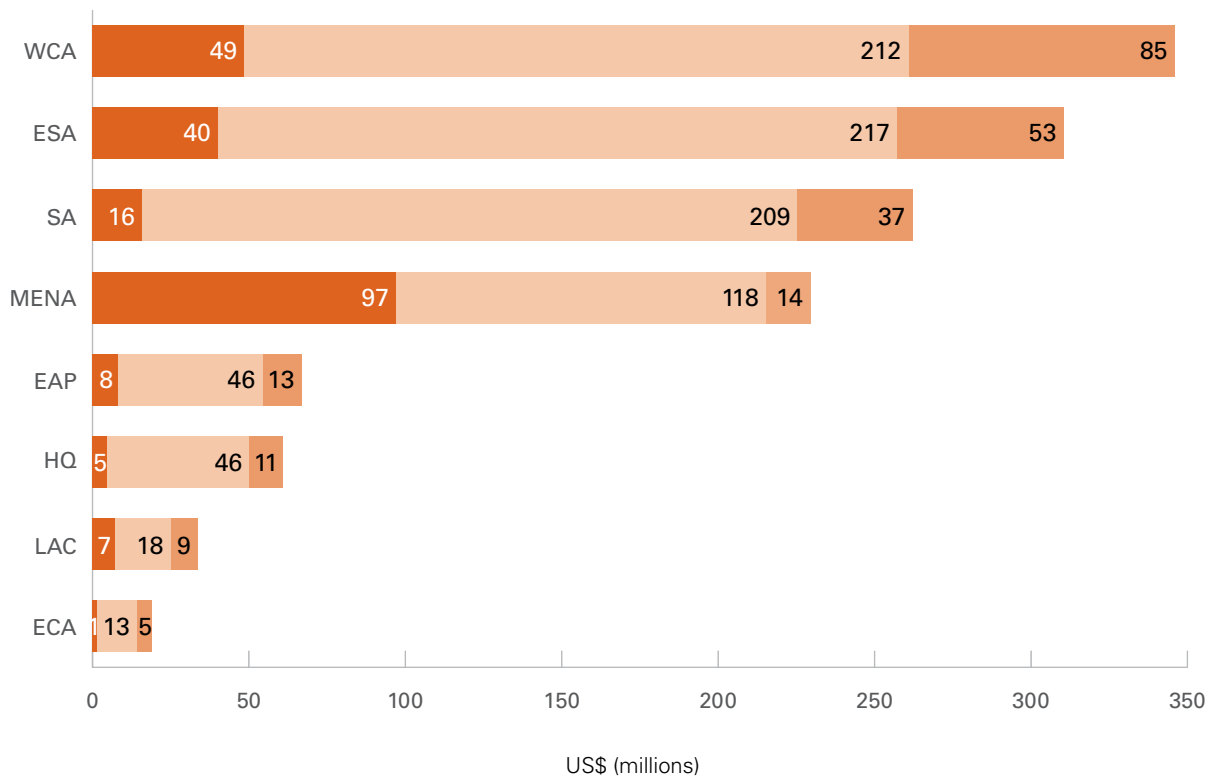


FIGURE 38: Expense for health by fund type, and per region, 2019



Notes: EAP, East Asia and the Pacific; ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; HQ, headquarters; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; SA, South Asia; WCA, West and Central Africa.

The top 20 countries accounted for US\$896 million in health-sector expenses, 67 per cent of all health spending in 2019 (Figure 39). Many of these countries experienced humanitarian crises, natural disasters as well as protracted conflicts. As in 2018, Pakistan was the largest country programme in terms of health expenses with US\$129 million (up from US\$124 million). UNICEF continued to provide a sustained response in polio eradication and immunization services, maternal and newborn care, and health systems strengthening. Yemen was the organization's second largest programme in 2019 with US\$107 million in expenses, a US\$22 million increase from 2018.

Thematic funds, due to their flexibility, remain essential to UNICEF work. In 2019, UNICEF spent US\$38 million for health from thematic funds, a substantial increase from US\$18.6 million in 2018. This increase was chiefly due to a larger amount of thematic ORE (US\$17 million) expended in the health sector, in addition to US\$20 million

from thematic ORR. Thematic funds continue to support essential health programmes in high-mortality countries and regions. As in previous years, most funds were spent in West and Central Africa (US\$14 million or 37 per cent) as a result of country-specific thematic funds.

By programme area, expenses remain similarly distributed to 2018. As in previous years, immunization remains the largest portfolio with US\$560 million (42 per cent of total health expenses), followed by support of child health (20 per cent or US\$267 million), and health systems-strengthening and response to public health emergencies (20 per cent or US\$262 million). Expenses in the maternal and newborn health programme accounted for 17 per cent of the total (US\$221 million). Lastly, the adolescent health and nutrition programme, an emerging area of work, totalled US\$18 million. By fund type, regular resources supported over a quarter of child health, maternal and newborn health, and adolescent programme expenses (See Figure 41).

FIGURE 39: Expense for health by top 20 countries and fund type, 2019

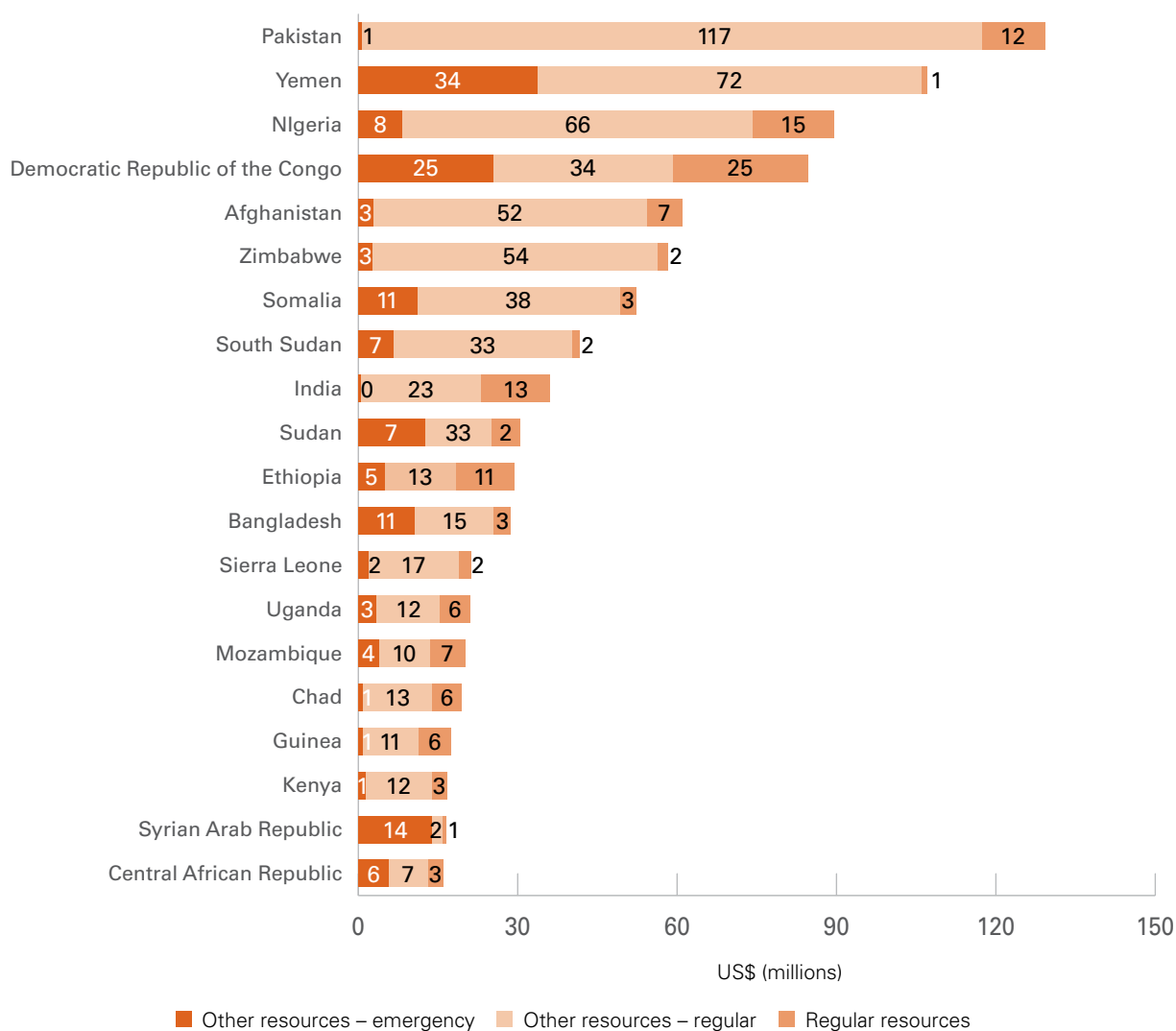
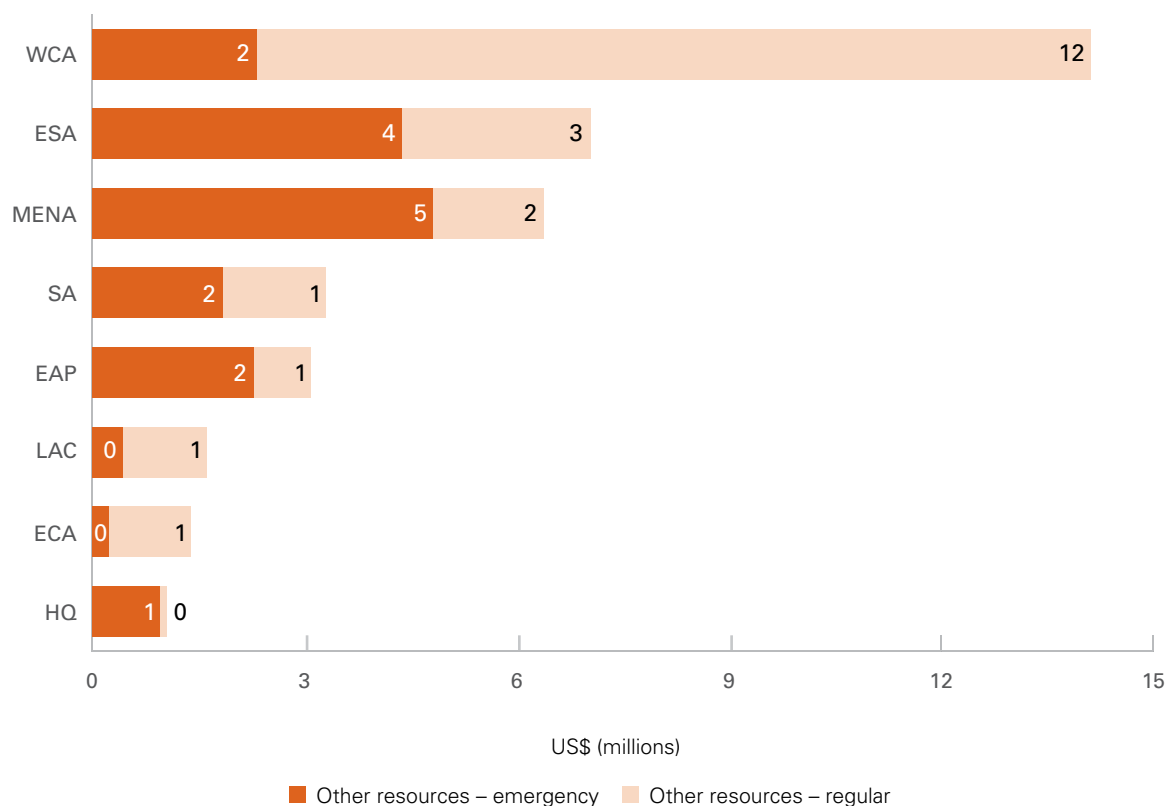


FIGURE 40: Expense for health from thematic funding source by region, 2019



Notes: EAP, East Asia and the Pacific; ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; HQ, headquarters; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; SA, South Asia; WCA, West and Central Africa.

FIGURE 41: Expense for health by results area and fund type, 2019 (US\$)

Programme area	Other resources – emergency	Other resources – regular	Regular resources	Grand total
Immunization	50,004,162	460,764,949	49,695,743	560,464,854
Child health	72,169,487	125,360,935	71,134,007	268,664,430
Health systems strengthening and response to public health emergencies	57,026,687	164,386,476	41,066,235	262,479,399
Maternal and newborn health	43,205,076	117,348,234	60,814,840	221,368,149
Adolescent health	485,529	10,940,712	4,104,646	15,530,886
Grand total	172,886,779	878,801,306	226,815,472	1,328,507,719

FIGURE 42: Expense for health by cost category, 2019 (US\$)

Programme area	Other resources – emergency	Other resources – regular	Regular resources	Total
Transfers and grants to counterparts	74,378,703.27	229,106,539.37	52,582,575.97	356,067,818.61
Supplies and commodities	67,820,459.07	244,108,205.64	30,683,215.33	342,611,880.03
Staff and other personnel costs	32,512,502.18	110,792,351.72	75,324,768.36	218,629,622.25
Contractual services	16,659,810.35	171,011,107.66	23,835,204.25	211,506,122.26
Incremental indirect cost	13,743,758.74	58,948,891.04	–	72,692,649.78
General operating and other direct costs	9,830,708.49	32,909,592.69	21,922,538.57	64,662,839.75
Travel	4,430,442.14	17,723,950.38	12,508,650.65	34,663,043.18
Other	3,230,917.15	13,866,054.12	8,669,281.40	25,766,252.68
Equipment, vehicles and furniture	283,639.96	334,625.49	1,289,237.23	1,907,502.68
Grand total	222,890,941.37	878,801,318.10	226,815,471.75	1,328,507,731.22

As in previous years, expenses for health by cost category were concentrated under ‘transfers and grants to counterparts’ (US\$356 million) and ‘supplies and commodities’ (US\$342 million), representing 53 per cent of total health expenses (see Figure 42). These investments allowed UNICEF to support counterparts in implementing high-impact, integrated and multisectoral health interventions and strengthen PHC to meet the goals of Agenda 2030. About a third of total expenses relate to technical services in the form of consultants, institutions and UNICEF staff to support national programme and policy development, leveraging domestic and global investments, capacity development, research and evaluation, and programme management.

Funding gaps for health

Given the depth and magnitude of the challenges highlighted in this report, access to flexible funding is more urgent than ever. Greater global thematic resources for health would allow UNICEF to complement earmarked funding by addressing gaps and ensuring integrated programming in support of Goal Area 1 results. UNICEF estimates an initial funding gap of US\$20 million per year in global thematic funds. This level of funding would provide the much-needed flexibility to support the results of the organization’s Strategic Plan, the SDGs, and ultimately help children survive and thrive.



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Results: Nutrition

A child enjoys some nutritious food after a cooking demonstration in Bétou, the Congo. The demonstrations raise awareness about how to prepare nutritious and safe foods for children.

Good nutrition is the right of every child. Well-nourished children are more likely to survive and thrive. They are better placed to lead healthy lives, access equal opportunities, and participate fully in their communities and nations.

In 2019, the UNICEF flagship *State of the World's Children Report* was launched on the theme of 'Children, food and nutrition', highlighting poor diets as a key driver of child malnutrition in all its forms and proposing an agenda for realizing every child's right to adequate nutrition over the next decade.⁴⁷ This same rights-based approach guides all UNICEF nutrition programmes, with the goal of setting children on the path to grow and develop well in the womb, during childhood, and throughout the life course. These programmes aim to reach children, adolescents and women wherever they live, in low- and middle-income countries, and in both development and humanitarian contexts.

Prevention and treatment of malnutrition are central to the intended outcome of Goal Area 1 – “that all girls and boys, especially those who are marginalized and those living in humanitarian crises, have access to high-impact health, nutrition, HIV and early childhood interventions from pregnancy to adolescence.” UNICEF prioritizes interventions to prevent all forms of malnutrition – including stunting, wasting, micronutrient deficiencies, overweight and diet-related non-communicable diseases. Where prevention falls short, the early detection and treatment of children with life-threatening wasting is critical to saving lives and returning children to healthy growth and development.

UNICEF nutrition programmes cover three results areas that contribute to the overall Goal Area 1 outcome: (1) the prevention of stunting and other forms of malnutrition; (2) the improvement of adolescent health and nutrition; and (3) the treatment and care of children with severe wasting and other forms of severe acute malnutrition. The theory of change holds that if countries accelerate the delivery of programmes for the prevention of malnutrition in early childhood, accelerate gender-responsive adolescent health and nutrition programmes, and accelerate the delivery of services for the treatment of severe acute malnutrition, then girls and boys, especially those who are marginalized and those facing humanitarian crises, will be more likely to survive and thrive.⁴⁸

The nutrition results achieved over the Strategic Plan period, 2018–2021, are expected to contribute to: reducing the proportion of children suffering from stunting, from 29.6 per cent to 24.1 per cent; reducing the proportion of children suffering from wasting, from 12.4 per cent to less than 8.7 per cent; and ensuring no increase in the number of overweight children from 7.8 per cent. These 2021 impact indicators are aligned with the Sustainable Development Goal (SDG) 2 targets for ending malnutrition and the SDG 3 target of ending preventable deaths in newborns and children under 5 years of age by 2030.

During its midterm review, UNICEF committed to additional strategies for accelerating results in the final two years of its Strategic Plan. One of these strategies is strengthening engagement with food systems to improve the quality of children's food, food environments and food practices

in settings where children live, eat, learn, play and meet (*see Results Area 2*). Maternal nutrition was also elevated to a distinct nutrition programme result. As part of the midterm review, UNICEF also recommitted to accelerating the scale-up of integrated school- and community-based interventions, including in humanitarian contexts, to ensure that all children – wherever they live – enjoy the nutritious diets, essential nutrition services and positive nutrition practices they need to survive and thrive.

In 2019, UNICEF implemented nutrition programmes in 130 countries, with the support of 645 nutrition staff members. UNICEF country-driven programmes improve maternal and child nutrition at key moments throughout the life course, from early childhood, to middle-childhood and adolescence, and during pregnancy and breastfeeding. Knowledge generation is at the heart of this work, with evidence guiding advocacy, policies and programmes.

UNICEF addresses the drivers of malnutrition through a systems approach that aims to make five key systems – food, health, water and sanitation, education, and social protection – better equipped and more accountable for preventing malnutrition in all its forms. Adopting a systems approach to improve diet quality, for example, involves influencing: the food system, to produce diverse and nutritious foods that are available and affordable to families; the health system, to provide well-trained staff to counsel caregivers on the benefits of nutritious diets; the water and sanitation system, to provide free, safe and palatable drinking-water as part of a healthy diet and for the safe preparation of foods; the education system, to deliver nutrition services and improve knowledge and skills on good nutrition and active living; and the social protection system, to provide safety nets that make nutritious foods accessible to the most vulnerable families.

At the launch of the UNICEF Strategic Plan, 2018–2021, the organization established three delivery compacts and three learning compacts with 86 country offices and 7 regional offices as a foundation for accelerating progress towards ending malnutrition and achieving the SDGs.⁴⁹ Through these compacts, and with global thematic funding from the Government of the Netherlands, UNICEF achieved the following 2019 headline results:

- 307 million⁵⁰ children under 5 were reached with services to prevent stunting and other forms of malnutrition in early childhood
- 60 million were reached with services to prevent anaemia and other forms of malnutrition; and⁵¹
- About 5 million children were reached with services for the early detection and treatment of severe wasting, in both humanitarian and development contexts.

At the end of 2019, these results put UNICEF on track to achieve the Strategic Plan nutrition targets. Guided by the acceleration strategies identified in its midterm review, UNICEF is working to close gaps and drive faster progress towards the SDG targets.



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A mother and her baby receive a 'banana bag' as part of a programme to improve first foods and feeding practices in Northern Chin and peri-urban Yangon, Myanmar (see page 78).

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

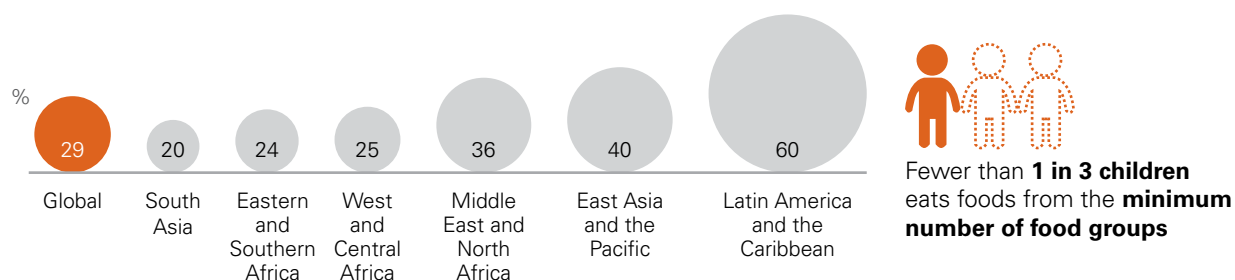
UNICEF nutrition programmes share a universal premise: prevention always comes first. UNICEF works to build the foundations of good nutrition by improving children's and women's access to nutritious, safe and affordable diets; supporting quality nutrition, health, water and sanitation services; and promoting optimal feeding, hygiene and care practices. As outlined in the 2020 UNICEF Conceptual Framework on the Determinants of Maternal and Child Nutrition,⁵² this foundation of good nutrition allows children to grow, thrive, and remain healthy and resilient throughout their lives.

Improving the quality of children's foods and feeding practices – particularly during the first 2 years of life – is the cornerstone of preventing malnutrition in all its forms. Globally, only 42 per cent of children under 6 months of age are exclusively breastfed, and only 29 per cent of children aged 6–23 months in low- and middle-income countries are eating foods with the minimum dietary diversity needed to ensure healthy growth and development (see Figure 43).⁵³ Women's diets are also poor during pregnancy and breastfeeding, and the prevention of maternal malnutrition is critical to the survival and development of mother and baby.

UNICEF's commitment to prioritizing prevention is reflected in its Strategic Plan Results Framework, with most nutrition programming and expected results falling under Output 1: "Countries have accelerated the delivery of programmes for the prevention of stunting and other forms of malnutrition."

Understanding the barriers to and drivers of good diets is essential to preventing malnutrition in children under 5 and their mothers – particularly during the critical developmental period from pregnancy to the child's second birthday. Before and during pregnancy, nutrition counselling and supplementation with essential nutrients (e.g., iron and folic acid) and food fortification programmes (e.g., salt iodization and wheat flour fortification) improve women's nutrition and children's growth and development, and help ensure a healthy pregnancy and delivery for mothers and babies. In early childhood, UNICEF programmes aim to increase and sustain breastfeeding, improve the quality of young children's diets, and support supplementation and food fortification to prevent nutrient deficiencies in settings where nutritious diets are out of reach (Figure 44).

FIGURE 43: Percentage of children aged 6–23 months receiving the minimum dietary diversity, by UNICEF region, 2018



Source: UNICEF (2019).⁵⁴ Note: Regional and global estimates based on the most recent data for each country between 2013 and 2018.

FIGURE 44: UNICEF support for early childhood nutrition



Note: IYCF, infant and young child feeding.

At the midway mark of its current Strategic Plan, UNICEF recognizes the need to accelerate context-specific action to drive faster progress in reducing all forms of malnutrition in children under 5. For example, UNICEF is redoubling its efforts on the prevention of stunting and wasting by focusing on the 10 countries where more than 75 per cent

of stunted and wasted children live. In all contexts, UNICEF is scaling up maternal and child nutrition programmes to improve the quality and diversity of young children's diets and ensure that food environments support nutritious, safe, affordable and sustainable diets for children.



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An obstetrician helps a new mother learn to breastfeed baby Alinur in a hospital neonatal ward in Turkestan, Kazakhstan. Through a resource centre supported by UNICEF and the Health Administration of the Akimat of Turkestan Region, thousands of nurses, doctors and social workers are receiving training to improve their competencies in nutrition and early childhood development, in line with the recommendations of UNICEF and WHO.

Outcome and output indicators for the prevention of stunting and other forms of malnutrition

FIGURE 45: Outcome results for prevention of stunting and other forms of malnutrition, 2019

Outcome indicator (+ key United Nations partners)	Baseline	2018 value	2019 value	2021 target
1.12 Percentage of women with anaemia	37%	Not available	Not available	27%
1.13 Percentage of infants under 6 months exclusively fed with breastmilk (SDG 2.2.1 and 2.2.2) (WHO, World Bank)	41%	41.4%	44.5%	45%
1.14 Percentage of children fed a minimum number of food groups (SDG 2.2.1 and 2.2.2) (FAO, WFP, WHO)	29%	28.6%	28.2%	35%
1.15 Percentage of households consuming iodized salt (WHO)	86%	87.9%	90.2%	≥90%
1.16 Number of children who received: (a) two annual doses of vitamin A supplementation in priority countries ⁵⁵ (b) multiple micronutrient powders through UNICEF-supported programmes ⁵⁶	(a) 221 million (b) 11 million	(a) 255.7 million (b) 15.6 million	(a) 249.9 million (b) 17.7 million	(a) 250 million (b) 12 million

Notes: FAO, Food and Agriculture Organization of the United Nations; WFP, World Food Programme; WHO, World Health Organization.

FIGURE 46: Output results for prevention of stunting and other forms of malnutrition, 2019

Output indicator	Baseline	2018 value	2019 value	2019 milestone	2021 target
1.d.1. Percentage of pregnant women receiving iron and folic acid supplementation	29%	34.2%	36.6%	35%	41%
1.d.2. Number of countries that have integrated nutrition counselling in their pregnancy care programmes	47	57	68	60	70
1.d.3. Number of countries with: (a) a national strategy to prevent stunting in children (b) programmes to improve the diversity of children's diets ⁵⁷	(a) 41 (b) 30	(a) 49 (b) 32	(a) 54 (b) 47	(a) 34 (b) 22	(a) 46 (b) 30
1.d.4. Number of countries that are implementing policy actions or programmes for the prevention of overweight and obesity in children ⁵⁸	15	17	23	12	20
1.d.5. Number of countries that are implementing salt iodization programmes with an effective coordination body for reducing iodine deficiency ⁵⁹	26	33	35	32	46

Improving services and community demand

Counselling to caregivers to improve feeding and care practices

UNICEF supports counselling for caregivers to equip them with the knowledge and skills to improve breastfeeding and complementary feeding practices. Counselling may be provided within health-care facilities or through community platforms; delivered by skilled health workers alone or with the support of experienced mothers; and provided in both individual and group settings. Globally, the number of caregivers receiving such counselling through health-care facilities and community platforms rose from 23 million in 2018 to 24 million in 2019. These counselling sessions took place in all contexts; nearly 73 per cent of those counselled were in countries facing humanitarian crisis.⁶⁰

Counselling on infant and young child feeding (IYCF) is a proven intervention for improving breastfeeding and complementary feeding, contributing to the prevention of all forms of malnutrition. In the United Republic of Tanzania, as part of the National Multisectoral Nutrition Action Plan 2016–2021, counselling coverage between 2016 and 2019 increased from 5 per cent to 35 per cent at the community level, and 20 per cent to 54 per cent at the facility level. Breastfeeding and complementary feeding practices improved during this time.⁶¹ A midterm review in 2019 found that the main drivers in improving IYCF indicators were an increase in the coverage of IYCF counselling by trained health workers at subnational level; and IYCF counselling provided by community health workers (CHWs) at least once a month to caregivers (including men and fathers), and pregnant and breastfeeding women.

Spotlight on innovations: Facilitating remote support to improve infant and young child feeding in the Maldives

In the Maldives, UNICEF supported the launch of the first child nutrition mobile phone app, 'Yagooth', to improve caregivers' access to information and advice on early childhood nutrition. There are plans to further strengthen the app in 2020, including identifying ways to increase interactivity and two-way communication. The app was launched with the understanding that the health system alone is insufficient to meet the needs of caregivers on nutrition, and that caregivers value the Internet as an easy access source of information.

Community-based counselling is particularly critical during humanitarian crises and in settings with limited access to health services. With UNICEF support, 45 countries implemented IYCF services as part of the response to a humanitarian situation, compared with 40 the previous year.⁶² 43 of these countries provided counselling in health services or by health staff (31 in 2017); 39 provided IYCF counselling by community workers (30 in 2017); 21 countries established baby-friendly spaces (16 in 2017); and 17 monitored formula donations (16 in 2017).

Zimbabwe scaled up IYCF counselling services as part of a stunting reduction programme enacted in response to Cyclone Idai. UNICEF provided mentorship and financial support to ensure the IYCF programme remained integrated within routine health-care delivery as well as community systems. More than 360,000 primary caregivers received IYCF counselling (double the annual target). Through technical and financial support to Nutrition Action Zimbabwe, UNICEF piloted the care group approach for improved coverage of community-level IYCF messaging and counselling. A total of 389 male advocates and 341 elderly women champions for IYCF were identified as influential members of the communities. The proportion of districts implementing the minimum package to prevent stunting in children increased from 52 per cent to 63 per cent in 2019, exceeding the target of 60 per cent.

With the support of UNICEF and partners, South Sudan significantly expanded IYCF counselling services to caregivers, despite the challenging humanitarian context: 1.7 million caregivers were reached with IYCF counselling in 2019, a 77 per cent increase from the previous year. This expansion was part of a broader strategy on maternal and child nutrition, supported through partnerships with 40 civil society organizations (CSOs), the World Food Programme (WFP), the World Health Organization (WHO) and the South Sudan Ministry of Health. As part of the scale-up, and with support from UNICEF, the number of service delivery points providing IYCF counselling rose significantly, from 858 in 2018 to 1,145 in 2019.

It is particularly important to ensure that caregivers of children with development delays and disabilities are given counselling and support for feeding, including nutrition solutions and care practices if the child has difficulties chewing or swallowing. UNICEF is working to strengthen nutrition programmes to be more disability inclusive. UNICEF invests in developing the capacities of health workers and strengthening partnerships with local CSOs to support the scale-up of IYCF counselling services in all contexts. In 2019, UNICEF supported the Burkina Faso Ministry of Health to expand its IYCF programme to 7 out of 13 regions. This included developing the capacities of more than 7,600 CHWs and more than 3,100 community volunteers, and ensuring ongoing supervision through collaboration with 12 CSOs. With these enhanced skills, more than 558,700 pregnant and breastfeeding women (93 per cent of the annual target) were provided with counselling on IYCF, early childhood stimulation and hygiene.



A mother breastfeeds her newborn in Venezuela. In response to repeated power outages affecting much of Venezuela, UNICEF and its partners are supporting essential health and nutrition services for vulnerable women and children in Caracas, Miranda, Zulia, Bolivar, Táchira.

UNICEF supported similar efforts to expand the number of health workers trained to provide IYCF counselling in Nigeria. In 2019, UNICEF supported training for more than 3,200 health workers in IYCF counselling and promotion, an increase from the 1,065 trained in 2018 and 5 percentage points above the target set for 2019. With this increased capacity, more than 958,700 caregivers in Nigeria received IYCF counselling nationwide in 2019, mainly through mother-to-mother support groups established and supported by UNICEF. This is an increase from the 613,300 reached in 2018 and represents 80 per cent of caregivers targeted. A total of 195 local government areas, representing 54 per cent in the targeted states, have community-based nutrition support groups and this is a 35-percentage point increase over 2018. Support groups target mothers, fathers, mothers-in-law, grandmothers and adolescents – educating family members to address misconceptions that undermine optimal child feeding.

Several countries, such as China, are updating their IYCF counselling packages to include overweight prevention messages, reflecting the changing face of malnutrition. The package is designed to equip health workers to support mothers, fathers and other caregivers in improving IYCF practices. In addition, UNICEF is supporting a review of the generic IYCF package to strengthen the early childhood development (ECD) elements, such as responsive feeding and stimulation; the revision will be completed in 2020.

Social and behaviour change communication (SBCC), an element of UNICEF's approach to Communication for Development (C4D), is effective in targeting poor feeding practices and building demand for counselling and other nutrition services. In West and Central Africa, where the practice of giving water to infants is a key barrier to exclusive breastfeeding, UNICEF launched a C4D campaign to target this practice (*see Box: 'Stronger with breastmilk only'*).

West and Central Africa: Stronger with breastmilk only

In 2019, UNICEF launched a regional Communication for Development (C4D) campaign in West and Central Africa, 'Stronger with Breastmilk Only', intended to discourage the practice of giving water to infants during the first 6 months of life, which is a key barrier to exclusive breastfeeding in the region. The multi-year campaign, launched with the World Health Organization and Alive & Thrive, aims to address myths and cultural norms and includes: a call to protect, promote and support exclusive breastfeeding; a fact sheet on exclusive breastfeeding; and background materials on the social and behavioural determinants of infant feeding.

Launched in Côte d'Ivoire, the campaign aims to accelerate implementation of family-friendly policies and drive positive social change to improve exclusive breastfeeding rates in the region. With the support of UNICEF and partners, more than 40 members of parliament from 15 countries adopted the Abidjan Declaration, committing to strengthening systems and adopting key actions for improving breastfeeding. Ghana and Nigeria have also launched national campaigns. Next steps include translating the parliamentarians' engagement into action and putting in place a monitoring mechanism, as well as identifying ways to best support countries.

Interventions to improve the quality and diversity of children's diets

The UNICEF Strategic Plan, 2018–2021 (SP) makes improving the diversity of children's diets a priority, recognizing that young children's access to a range of nutritious foods, including animal-source foods, vegetables and fruit, is central to the prevention of stunting and other forms of malnutrition. In low- and middle-income countries, 28.2 per cent of children aged 6–23 months globally were fed meals from the minimum number of food groups in 2019, indicating no significant increase from 2018. This was in part due to better reporting by countries that had not reported previously. With the scale-up of programmes to improve dietary diversity in young children, supported by global thematic funding from the Government of the Netherlands, UNICEF is aiming to increase this figure to at least 35 per cent by 2021 (outcome indicator SP1.14).

In 2019, there were 114 countries with programmes to improve the diversity of children's diets (108 in 2018). Of these, 31 countries were leveraging social protection services to improve dietary quality (30 in 2018); 57 were using C4D to promote nutritious diets (48 in 2018); 69 had initiatives to increase access to and use of diverse, local nutritious foods at household level (47 in 2018); and 89 countries were integrating nutrition education activities that promote responsive parenting, responsive feeding and stimulation during early childhood (75 in 2018). Forty-seven countries reported having all of these criteria in 2019, a substantial jump from 32 in 2018. These results far surpass the 2021 target of 30 countries (SP1.d.3(b)), suggesting that a comprehensive and multifaceted approach to improving the quality of children's diets is being realized.

UNICEF is supporting a number of countries to lay the foundations for programming to improve dietary diversity through evidence generation and piloting to inform scale-up. In the Syrian Arab Republic, UNICEF used focus group sessions to gather evidence on IYCF practices with caregivers of young children; the results were used to inform the development of C4D messages around dietary diversity for stunting prevention. More than 7,000 mothers of children aged 6–23 months received messages on dietary diversity through group counselling sessions under the dietary diversity pilot project being undertaken in three governorates. Implementation began in 2019 and the results will be used to inform the scale-up of IYCF counselling and development of the IYCF operational plans to support the Syrian Ministry of Health. In Myanmar, an innovative approach to promoting dietary diversity is improving children's diets yielding results that will inform future scale-up (see *'Spotlight on innovations: "Banana bags" for better complementary feeding in Myanmar'*).

Many countries use community events and outreach to reach caregivers with counselling and C4D to improve dietary diversity. In India, UNICEF intensified efforts to improve the coverage of these services at *anganwadi* centres (village outposts) and through home visits. This included supporting a change in guidelines to ensure that children received 5–6 contacts with health and nutrition staff before their first birthday. The number of *anganwadi* centres supporting group nutrition counselling, including on complementary feeding, increased from 427,000 in 2018 to more than half a million in 2019. Programme evidence documented in Bihar and Uttar Pradesh highlighted the effectiveness of community-based events for improving complementary feeding at scale. During a month-long communication drive, 64.2 million people attended such events and 196 million people received nutrition information and key messages through home visits.

Caregivers' abilities to provide a diverse diet for young children depend on the availability and affordability of nutritious foods. Nutrition-responsive social protection programmes, such as food, voucher or cash transfers, can mitigate the effects of poverty on the nutrition of vulnerable children and families. At least 75 countries have social protection programmes aimed at improving nutrition (Figure 47). For example, 75 countries conducted school feeding programmes (65 in 2017), and 56 countries provided nutrition-responsive cash transfers (49 in 2017).

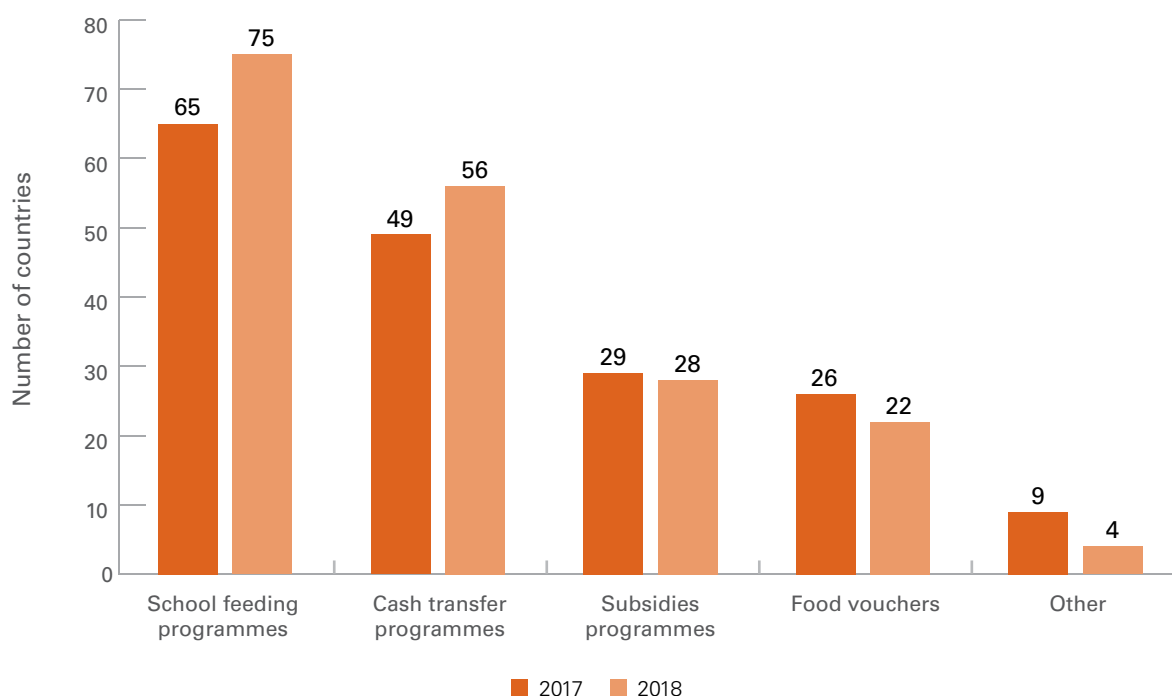
When targeted to meet the nutritional needs of vulnerable populations, cash-transfer programmes for families with children under 5 have proven benefits for the nutritional status and health outcomes of children. In Nepal, for example, the child cash grant programme, which provides support to needy families in 14 districts, has been

Spotlight on innovations: 'Banana bags' for better complementary feeding in Myanmar

UNICEF, in partnership with Save the Children International and 17 Triggers, piloted an innovation in Northern Chin and peri-urban Yangon, Myanmar, to improve complementary feeding practices. Developed through participatory engagement with mothers of young children, the 'banana bag' contains tools and materials to promote dietary diversity, while doubling as a play mat for children. These materials include different bowl sizes according to age group, simple kitchen tools for mashing and containing children's foods, hygiene items and a hand puppet for interactive play. The bags were promoted by midwives and front-line health workers, along with interactive digital content that caregivers can access using their mobile phones.

Mothers involved in the initiative reported diversifying the foods they fed their children, getting the right frequency and portion sizes for their children, and seeing benefits in their children's health. The pilot will inform a scale-up strategy for 2020 and beyond, looking at different cost-effective, sustainable modalities for production and distribution. Findings from field observation trials are being captured and will be made widely available. The banana bag will eventually be integrated into the Government's infant and young child feeding counselling and social protection programmes.

FIGURE 47: Countries implementing nutrition-responsive social protection programmes



Source: NutriDash (2018).

implemented by the Government with support from UNICEF since 2010. A recent assessment found that recipient households are using the grant effectively to contribute to expenditures on food, medicine and access to health services. Similarly, in Burkina Faso, the national cash transfer programme supported by the World Bank and implemented by the Ministry of Social Affairs, is currently reaching over 50,000 of the most vulnerable households in four provinces. As part of this programme, households receive support and guidance on optimal IYCF and other key family care practices through C4D approaches, with UNICEF support.

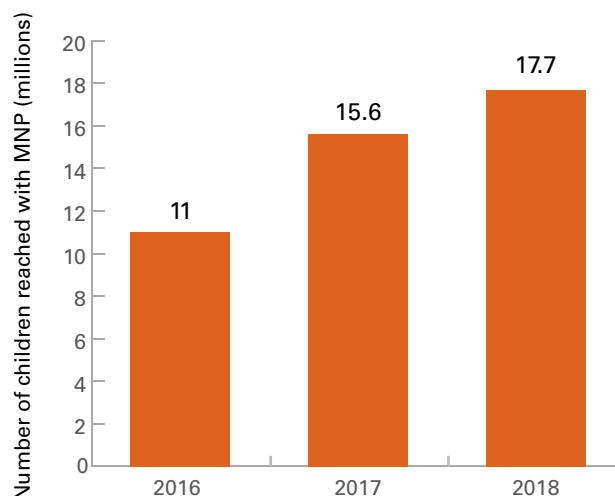
Home fortification and supplementation to enhance the quality of children's diets

UNICEF supports home fortification with micronutrient powders (MNPs), integrated within IYCF programmes, as a critical strategy for enhancing the quality of children's diets in settings where nutrient-poor diets prevail. Through its country programmes, UNICEF has been working closely to deliver this intervention in all contexts: more than three quarters of all MNP interventions globally were delivered as part of integrated IYCF programmes.

Globally, 57 countries implemented home fortification programmes with UNICEF support in 2018 (the latest available estimate), compared with 51 the previous year. Of these, 55 included home fortification as part of a government policy, strategy or plan of action. This

programme expansion allowed 17.7 million children to benefit from home fortification with UNICEF support,⁶³ compared with 15.6 million in 2017, surpassing the 2021 target of 12 million (SP1.16(b)). Half of these children live in countries with humanitarian crises.

FIGURE 48: Scale-up of home fortification programmes supported by UNICEF, 2016–2018 (millions of children reached)



Source: NutriDash (2018).



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Marietta Mounkoro, Nutrition Officer at the UNICEF field office in Sikasso, Mali, meets with six-month-old Chatou and her mother in Zebala village. “Home fortification of complementary foods with micronutrient powders helps meet young children’s day-to-day micronutrient needs and prevent stunting and anaemia.” This intervention, combined with counselling and support to improve infant and young child feeding practices, aims to improve nutrition in Sikasso, the region with the highest stunting rate in Mali.

A number of countries made efforts to expand the coverage of home fortification programmes in humanitarian settings in 2019. With UNICEF support in five regions of the Niger, home fortification was scaled-up from 10 health districts in 2018 to 14 districts in 2019. More than 171,900 children received MNPs in 2019 (compared with about 101,800 in 2018). In Yemen, more than 1.7 million children were reached with MNPs as part of an integrated stunting prevention programming in 2019. This achievement was supported by a network of community health volunteers, which expanded (with UNICEF support) from about 17,000 in 2018 to more than 25,300 in 2019, despite the complexity of operations and access limitations in the country.

To be effective, home fortification programmes must be integrated as part of broader strategies to improve IYCF. This integration was key to success in Cameroon, where MNP distribution was part of a broader strategy for preventing malnutrition (see *Case Study 4*). In 2019, Rwanda’s integrated, nationwide home fortification programme reached about 444,000 children (86 per cent of those targeted) in all 30 districts. This figure includes both children aged 6–23 months and those aged 24–59 months, as the Government began including the latter target group in 2019. UNICEF worked with the national ECD programme, the Ministry of Health and districts to strengthen the supply chain for MNP and other nutrition commodities, including monitoring visits at district level.

Vitamin A supplementation for life-saving protection

Vitamin A supplementation (VAS) is a life-saving nutrition intervention for children in countries with high under-five mortality where deficiency is often a public health problem. UNICEF is the main provider of vitamin A supplements globally, supported by an in-kind donation financed by the Government of Canada and implemented through Nutrition International. In the 2019 supply year, UNICEF supplied 564 million vitamin A capsules to 74 countries, including 514 million as in-kind contributions. Globally, two high doses of vitamin A were provided to about 250 million children in 2018 with support from UNICEF in 70 countries. While this represents a decline from the 255.7 million children reached in 2017, the results exceed the 2021 target of 250 million (SP1.16(a)).

Following declines in the global coverage of VAS in recent years, coverage stabilized in 2018 (the latest estimate) at 61 per cent, which highlights the continuing challenges in reaching all children in need of VAS. UNICEF is supporting countries to strengthen systems as they transition to new delivery platforms for VAS, including immunization and other routine health systems contacts in early childhood (see *‘Building stronger institutions’*).

A number of countries deliver VAS successfully through campaign events or as part of national immunization days (NIDs) or polio campaigns, with a high degree of external

CASE STUDY 4: Cameroon: Integrated approaches to improve the quality of children's diets

In Cameroon, stunting affects 29 per cent of children and micronutrient deficiencies are highly prevalent. In 2019, UNICEF worked to improve the quality of children's diets and prevent anaemia and micronutrient deficiencies through the scale-up of integrated infant and young child feeding (IYCF) counselling and home fortification with micronutrient powders (MNPs) provided by community health workers (CHWs) to reach children aged 6–23 months, with the support of health-care facilities.

Within 25 vulnerable health districts in four priority regions, UNICEF supported the training of more than 2,250 CHWs to provide community-based IYCF counselling to caregivers of young children. With this support, more than 500,000 people (mothers, fathers, other caregivers) benefited from IYCF counselling delivered through various community platforms, including community malnutrition screening (as part of health system services provided by CHWs), home visits, and mother-to-mother support groups. Some 294 mother-to-mother support groups were established in 25 districts.

As part of these community-based interventions, more than 242,600 caregivers of children aged 6–23 months (approximately half of all people reached) received counselling on IYCF practices in conjunction with MNPs and screening for acute malnutrition. This was achieved through strategic partnerships with the government regional health delegations and NGOs. The number of children reached with MNPs rose from about 25,200 in 2018 to more than 103,800 in 2019, representing 70 per cent of children targeted. During this time, the programme expanded from 9 health districts to 25, with the support of the CHWs trained to support caregivers in improving complementary feeding.

Within health-care facilities, UNICEF supported health systems-strengthening through training and capacity development for 486 health workers (about 80 per cent of the total workforce in the targeted health districts) on key IYCF messages and counselling techniques. To support these efforts, UNICEF contributed to designing a training package for health personnel, which includes information on IYCF, home food fortification, and malnutrition screening and referral.

As part of efforts to strengthen the policy environment for the prevention of malnutrition, UNICEF supported the Government in strengthening implementation of the International Code of Marketing of Breast-milk Substitutes, and developing a clear road map for monitoring Code violations. UNICEF also helped strengthen national capacity for multisectoral coordination by helping the inter-ministerial committee for the prevention of malnutrition develop a nutrition action plan for 2019. Coordination meetings were held with multisectoral stakeholders to discuss gaps in nutrition programme delivery, cross-sectoral planning and convergence, resource mobilization, evidence generation and knowledge management.

In 2020, UNICEF will support the Ministry of Public Health to expand the home fortification programme from 25 to 40 health districts; update the nutrition training package; improve the delivery of nutrition services in the health system; and initiate implementation in the food, social protection and water, sanitation and hygiene systems. UNICEF will also provide technical and financial support to women's groups producing complementary food to improve both the quality and quantity of their products. To address challenges related to reporting and weak connections between CHWs and health-care facilities, UNICEF and NGOs will support supervision and monitoring of service delivery at community level.

support and funding. These are often fragile countries or contexts where access, programme reach and overall health system weaknesses may present challenges. UNICEF supported several countries to improve coverage through campaigns in 2019. In Burundi, UNICEF provided support to the Government to conduct two annual 'mother and child health weeks', reaching more than 1.5 million children in each event with VAS, with 85 per cent two-dose coverage.⁶⁴

Similarly, through funding from the Government of Canada to integrate VAS into polio NID campaigns in South Sudan, UNICEF contributed to increasing the number of children reached with VAS from 2.3 million in 2018 to more than

2.7 million in 2019. VAS coverage rose from 63 per cent in 2018 to 76 per cent in 2019⁶⁵ – an increase attributed to strong partnership agreements with CSOs and improved coordination and supervision of VAS delivery, especially at subnational level.

Comprehensive interventions for improving maternal nutrition

UNICEF promotes interventions to improve women's nutritional status before and during pregnancy and while breastfeeding, including for adolescent mothers and other nutritionally at-risk women.

During pregnancy, UNICEF supports countries to deliver a package of nutrition interventions, including nutrition counselling, micronutrient supplementation, pregnancy weight gain monitoring and deworming. Antenatal care visits are a key opportunity to reach pregnant women with these services through the primary health care (PHC) system: the number of countries integrating nutrition counselling with antenatal care programmes increased from 57 in 2018 to 68 in 2019, surpassing the milestone of 60 countries (SP1.d.2).

Pregnant women are particularly vulnerable to anaemia and low iron stores. In 2019, UNICEF supported 73 countries to scale up preventive iron supplementation programmes among pregnant women (53 in 2018). According to 2019 estimates, 36.6 per cent of pregnant women received iron and folic acid (IFA) supplementation (34.2 per cent in 2018) (SP1.d.1), surpassing the milestone of 35 per cent. These efforts contribute to the World Health Assembly global nutrition targets of reducing anaemia among women of reproductive age by 50 per cent and low birthweight among newborns by 30 per cent.

As part of a partnership with the Bill & Melinda Gates Foundation, UNICEF is working to galvanize global leadership and commitment for maternal nutrition by strengthening guidance and the quality of programming in this area using a systems-strengthening approach (see '*Leveraging collective action*').

Food fortification to make nutritious diets accessible for all

Large-scale food fortification is a proven intervention for sustainably controlling micronutrient deficiencies in children. UNICEF works to win support for strengthening related national policies and strategies (see '*Leveraging collective action*'), while supporting governments and industry to develop technical standards and monitor quality and compliance with legislative standards.

Globally, 147 countries had mandatory fortification of one or more food vehicles in 2019 (iodized salt, vitamin A fortified oil, wheat or maize flour fortified with essential micronutrients). Tajikistan, for example, improved quality standards with UNICEF support (see *Case Study 5*). In the Philippines, UNICEF provided technical support to develop a national strategic plan for the mandatory food fortification programme, launch an awareness-raising campaign, and enforce industry compliance with salt, rice, oil and flour fortification standards.

CASE STUDY 5: Tajikistan: Strengthening food fortification standards for better diets

More than half of children under 5 in Tajikistan suffer from iron deficiency and two out of five of these children are estimated to be vitamin A deficient.⁶⁶ In 2019, supported by a prior analysis on the economic consequences of malnutrition,⁶⁷ UNICEF continued its advocacy and support to the Government of Tajikistan to strengthen its policies and programmes to prevent micronutrient deficiencies in young children. With the support of UNICEF and other stakeholders, and building on the existing mandatory legislation on salt iodization, Tajikistan passed new legislation for the fortification of wheat flour and other vehicles in 2019.

UNICEF Headquarters and UNICEF Europe and Central Asia Regional Office conducted a joint technical assistance mission to Tajikistan in 2019 to engage with industries and government stakeholders to improve the coverage of iodized salt and accelerate the fortification of wheat flour with micronutrients. The mission concluded with a broad public-private partnership consultation on food fortification, with key recommendations for formalizing the national alliance for food fortification, developing a national strategic action plan on food fortification, developing standards for wheat flour fortification, and removing taxes, while ensuring adequate supply of potassium iodate to salt industries.

Tajikistan is among the priority countries supported by a global USAID grant to sustainably control iodine deficiency. Efforts in Tajikistan have focused on reinforcing external and internal quality control and monitoring systems for ensuring compliance with the legislative standards on salt. These experiences on salt will inform similar efforts on other fortified foods. As a next step, UNICEF will support the Government to establish a web-based monitoring and surveillance system on food fortification.

UNICEF also led a review of salt iodization in 2019, including iodate supply, salt distribution, monitoring and quality assurance, pricing and coordination. The analysis identified bottlenecks to universal salt iodization in the country, highlighting opportunities to refine strategies and develop tools to strengthen government commitment.

Twenty-two countries reported having legislation for the mandatory fortification of edible oil with at least one micronutrient in 2019. In Ethiopia, UNICEF supported the Government to amend vegetable oil importation guidelines to include mandatory fortification with vitamins A and D, reaching an estimated 80 per cent of the population. UNICEF is supporting the Ethiopian Food and Drug Administration to develop a fortification certification logo that ensures industries use appropriate technologies meeting fortification requirements.

Salt iodization – the most common form of large-scale food fortification worldwide – is a critical strategy for eliminating iodine deficiency disorders and protecting children’s brain development. One hundred and twenty countries out of 121 had mandatory standards for salt iodization in 2019. Aided by the long-standing support from the United States Agency for International Development (USAID) to UNICEF, the proportion of households consuming iodized salt increased to 90 per cent (88 per cent in 2018) (SP1.15), thus reaching the 2021 target.

For salt iodization legislation to be most effective, an active coordination body convening all stakeholders – including government, industry and civil society – is critical. Thirty-five of 58 reporting countries have established an effective national coordination body (33 in 2017), surpassing the milestone of 32 countries (SP1.d.5).

Building stronger institutions

Strengthening health systems to support early childhood nutrition

PHC is a key platform for delivering high-impact, integrated nutrition services to prevent all forms of malnutrition. UNICEF works to strengthen the capacity of national health systems by improving training for health workers on early childhood nutrition and providing supportive supervision and monitoring. UNICEF also supports governments in integrating preventive nutrition interventions within routine health visits, developing guidance to support institutions in providing the best care for mothers and their children, and strengthening nutrition and health information systems.

The UNICEF–WHO Baby-friendly Hospital Initiative (BFHI) aims to protect, promote and support breastfeeding in maternity facilities, including through the provision of timely

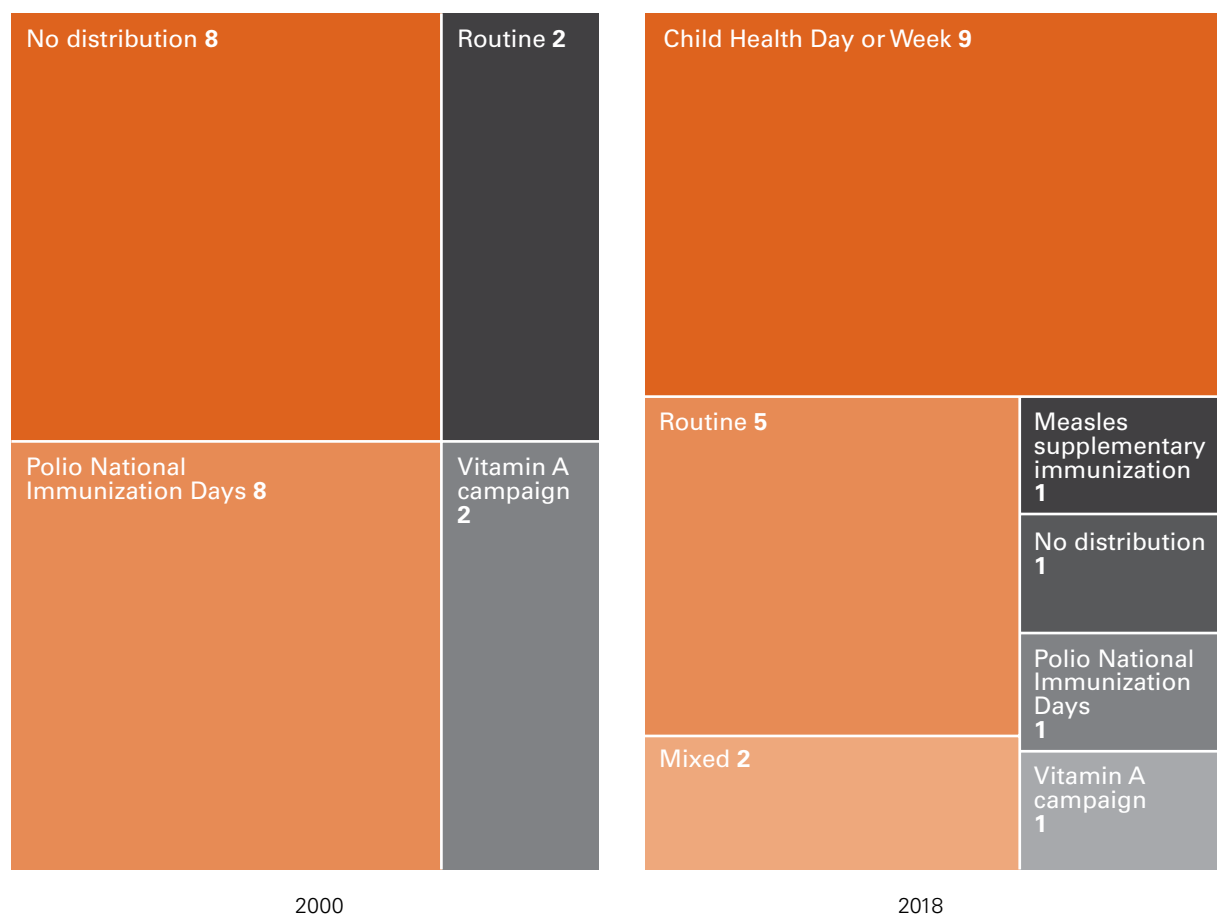
and skilled breastfeeding support as a vital component of quality maternity care. In 2019, UNICEF and WHO rolled out the revised BFHI implementation guidance developed in 2018. The number of countries implementing the Ten Steps to Successful Breastfeeding in maternity facilities increased from 64 in 2017 to 92 in 2018 (the latest estimates).

UNICEF supported a number of countries to adopt or strengthen the BFHI in 2019. In Pakistan, UNICEF helped revitalize the BFHI by revising national guidelines and training 25 master trainers to equip them with the capacity to support provinces in scaling up BFHI in all districts. In Europe and Central Asia, UNICEF and WHO organized a capacity-building regional workshop for maternal and child nutrition programme managers to enhance programming on the BFHI. Participating countries committed to scale up the quality and coverage of BFHI as a standing component of quality improvement programmes.

More countries are developing health worker capacities to deliver interventions for improving maternal and child health in health-care facilities. The number of countries with IYCF counselling and support included in pre-service curricula for medical doctors increased from 66 in 2017 to 68 in 2018 (the latest estimates). In East Asia and the Pacific, UNICEF worked with Alive & Thrive to review pre-service curriculum for maternal, infant and young child nutrition for health-care professionals.

UNICEF helps governments strengthen health systems’ capacities to deliver preventive nutrition interventions sustainably. This is particularly important for VAS programmes, as polio NIDs and Child Health Day campaigns (which have historically been effective platforms for reaching children) are being phased out or moving from national to subnational implementation following progress in polio eradication and resource constraints in many countries. Routine health system contacts, such as immunization and growth monitoring, are providing important alternative opportunities to deliver VAS and other key preventive nutrition interventions. An increasing number and proportion of VAS doses are now delivered through routine systems (*Figure 49*). In 2018 (the latest estimates), about 83 million doses were delivered to children aged 6–59 months through routine systems. This represents 17 per cent of all doses distributed through all platforms and a 3 per cent increase from the previous year.

FIGURE 49: Number of VAS distribution events by platform in 10 high-risk countries



Source: NutriDash (2018).

To support health systems-strengthening for VAS in 2019, UNICEF facilitated a sharing of experiences among countries on fostering a smooth transition to routine health systems without declines in coverage. Some countries, such as Malawi, are scaling up the integration of VAS in routine immunization, whereas others are integrating VAS within existing community-based platforms and workforces. For example, Guinea introduced VAS within a package of services delivered in 40 communes in 2019, with a plan to expand gradually towards national coverage. The country also began integrating the financing of vitamin A capsules into the health system, using government funds for procurement to ensure programme sustainability. Since 2017, Burkina Faso has been using community platforms to reduce operational costs for VAS delivery.

Some countries are testing innovations to better track VAS delivery (see *'Spotlight on innovations: Mobile innovations for better service delivery in Mozambique'*). Benin, for example, is piloting the integration of VAS into health and community-focused information systems. This involves the use of community registers to track individual children and monitor VAS and vaccination status to ensure that all children who receive a first dose of the measles vaccine also receive vitamin A through routine services.

UNICEF conducted a gender equity analysis of VAS programmes in 15 priority countries in 2019, which found no significant difference in VAS coverage between boys and girls. However, the analysis indicated that gender inequities faced by women, who are often the primary caregivers of children under 5, can be a critical barrier to access. Implementation research has been initiated in Malawi to test interventions that address specific gender-based barriers related to access, acceptance and community demand for VAS.

Spotlight on innovations: Mobile innovations for better service delivery in Mozambique

UNICEF is testing mobile innovations to improve nutrition service delivery in communities. A mobile health app called 'Upscale' is being used by community health workers in three provinces of Mozambique to upload real-time vitamin A supplementation data and improve follow-up of children who miss their visits for vitamin A supplementation at the community level.

Developing guidance for improved maternal and child nutrition

The year 2019 was a particularly important year for developing foundational guidance for countries on preventive interventions to support programme scale-up in line with the SDGs and the targets of the UNICEF Strategic Plan, 2018–2021. When new guidance is published, UNICEF will support countries to integrate it within national frameworks.

Through a broad consultative process with regional and country offices and multiple UNICEF sectors in 2019, UNICEF developed global guidance and action frameworks for improving the quality of children's diets during the complementary feeding period. The guidance was rolled out in five regions through regional consultations (described below) and in-country and remote technical assistance to priority countries. By the end of 2019, some 47 countries across seven regions were implementing programmes to improve the quality of young children's diets at scale (32 in 2018).

In Eastern and Southern Africa, the regional consultative meeting on improving young children's diets resulted in regional adaptations of the global action framework, with specific actions identified for the food, health, water and sanitation, and social protections systems to catalyse impact at country level. The regional action framework was endorsed by the Southern African Development Community (SADC) member states in 2019 and is now being implemented to guide country programmes. In Uganda, for example, the complementary feeding action framework informed a new Nutrition Action Plan in 2019. Similarly, based on the actions prioritized during the East

Asia and Pacific consultation, UNICEF advocated for government endorsement of national action frameworks, convening three national launches with key government decision makers in Indonesia, the Philippines and Viet Nam. This led to the prioritization of key actions to improve young children's diets at national and subnational levels.

In 2019, UNICEF strengthened collaboration with regions and countries on the prevention of overweight, launching its first programme guidance on the subject, with a landscape analysis tool to support the roll-out. Methods for conducting assessments of children's food environments are also being developed together with an advocacy and communication strategy tailored to UNICEF.

To advance the food fortification agenda, UNICEF partnered with the Iodine Global Network to disseminate programmatic guidance on monitoring salt iodization programmes and determining population iodine status. UNICEF continued its technical contributions to the Global Fortification Advocacy Group, helping to shape different sessions of the Second Global Summit on Food Fortification and draft an inter-agency manuscript on the unfinished agenda for food fortification in low- and middle-income countries.

In 2019, UNICEF led global efforts to introduce multiple micronutrient supplementation (MMS) to improve maternal nutrition and reduce low birthweight in settings with high prevalence of nutritional deficiencies. Bangladesh significantly scaled up the quality and coverage of maternal nutrition services in 2019 as part of this initiative (*see Case Study 6*).

CASE STUDY 6: Bangladesh: Systems strengthening for improved maternal nutrition

Bangladesh has one of the world's highest rates of maternal malnutrition: underweight and short stature are common, nearly half of pregnant women suffer from anaemia,⁶⁸ and 28 per cent of babies are born with low birthweight.⁶⁹

In response to these challenges, UNICEF supported the Government to develop the Bangladesh National Strategy for Maternal Health 2019–2030, which includes key interventions to improve women's nutrition during pregnancy and breastfeeding. To achieve the objectives of the strategy, the Government is investing in a number of systems-strengthening strategies to support the scale-up of maternal nutrition services across the country.

The World Bank-financed health systems-strengthening initiative supporting 'pay-for-performance' incentives has been critical to driving nutrition programme scale-up and accountability for results. As part of this initiative, the Government receives disbursements tied to the achievement of annual results under key health, nutrition and other development indicators. For maternal nutrition, these disbursements are linked to the provision of three key antenatal care services outlined in the National Strategy: nutrition counselling, iron and folic acid supplementation, and weight gain monitoring.

To improve the delivery of these key services during pregnancy and institutionalize supportive supervision and mentoring, UNICEF is supporting the Government to scale-up comprehensive competency-based training on nutrition for service providers at health-care facilities. With these investments in health systems-strengthening, the coverage of nutrition counselling during antenatal care increased from 32 per cent in 2016 to 56 per cent in 2019 (target: 55 per cent). Iron and folic acid (IFA) supplementation provided in health-care facilities reached 3.7 million pregnant and breastfeeding women in 2019 (a 37 per cent increase from 2.7 million in 2018). With greater investments in the capacity development of health-care providers, the proportion of pregnant women receiving three nutrition services in a single antenatal visit increased from 20 per cent in 2018 to 65 per cent in 2019.⁷⁰

The ability to track these improvements is the result of UNICEF support to the Government to strengthen its health information system in 2019. Maternal nutrition indicators were integrated within the District Health Information System (DHIS2) platform and UNICEF supported the Directorate General of Health Services to develop an e-tracker to support real-time monitoring. The pregnancy registration system was also improved to identify at-risk pregnant women as early as possible.

The Government has been drawing on the established evidence base on the efficacy of multiple micronutrient supplements (MMS) for pregnant women,⁷¹ which shows that the use of MMS can improve birth outcomes and confers the same benefits for reducing anaemia as IFA, while improving overall micronutrient intake. Additionally, the national anaemia consultation in 2016 recommended MMS for pregnant women (instead of IFA) to address the high prevalence of other micronutrient deficiencies that contribute to anaemia.⁷² Consequently, the Government is supporting the introduction of MMS as part of a broader strategy to strengthen maternal nutrition services in two districts. At the same time, the Government has taken the initiative to develop comprehensive national maternal nutrition guidelines that will be finalized in 2020.



Musfica Nargis, a senior staff nurse, performs an antenatal care check up on Keyanur Akhter, who is 10 months pregnant, at Ulipur Upazila Health Complex, Kurigram District, Bangladesh, as part of the maternal and child nutrition programme.

Strengthening capacity for emergency preparedness and response

Strong national systems help countries prepare for, withstand and bounce back from humanitarian crises. To strengthen systems, UNICEF supports countries in developing emergency preparedness and response plans that prioritize the prevention of stunting, wasting and other forms of malnutrition, while ensuring the provision of life-saving interventions to detect and treat severe wasting where prevention fails (*see Results Area 3*). UNICEF leverages its role as Cluster Lead Agency for Nutrition to promote these system-wide actions during humanitarian crises.

One strength of UNICEF in this area comes from its regional offices, which lead and coordinate emergency preparedness and response within and across regions, and promote active learning and knowledge-sharing between countries. In 2019, this included continued multisectoral support to the Sahel region, the multi-country response to Cyclone Idai in the context of slow-onset drought, and cross-regional preparedness around Ebola virus disease (EVD).

Many countries updated their nutrition emergency preparedness and response plans in 2019, with UNICEF support. In Nepal, a new plan was finalized for earthquake, flood and cold waves, and all 77 districts now have nutrition sector contingency plans. In Kenya, UNICEF supported the development and operationalization of a costed national nutrition sector preparedness and response plan in 2019. In Uganda, UNICEF helped the Government integrate nutrition into the Uganda EVD National Preparedness and Response Plan and develop a protocol for nutritional care of infants, young children and adults infected with EVD in treatment units.

Provision of timely surge support during humanitarian crises is an important UNICEF role. In addition to regional office surge support, UNICEF has two global Emergency (Nutrition) Response Team (ERT) members to augment country team capacity in humanitarian crises. In 2019, the ERT were deployed six times to boost the organization's capacity to respond to nutrition crises in Bangladesh, Somalia, the Sudan and Yemen. In 2019, the institutional revision of the Core Commitments for Children in Humanitarian Action (CCCs) proposed adding new commitments to uphold the nutrition rights of school-age children, adolescents and women in humanitarian contexts. The CCCs revision will enable alignment with the new UNICEF Nutrition Strategy, 2020–2030, and an institutional commitment to a prevention-first approach across age groups, alongside treatment where needed.

UNICEF continued to convene more than 40 partner members of the Global Nutrition Cluster (GNC) with the goal of galvanizing partnerships and resources to improve the coordination and quality of emergency response. In 2019, the GNC supported the coordination of life-saving nutrition in emergencies interventions for 25.3 million people (79 per cent of those targeted) with programmes in 21 countries. UNICEF and GNC partners also provided technical support and strategic guidance to countries affected by humanitarian crises, through field missions, document reviews, webinars and capacity-building training, technical and strategic advice, identification of human resources, emergency response team support, and financial support. During the GNC annual meeting, partners identified bottlenecks to scaling up quality nutrition response during emergencies, ranging from suboptimal infant feeding in emergencies to inadequate linkages between humanitarian and development programming and coordination.

In 2019, UNICEF responded to a long-standing gap identified by GNC partners: the absence of a coordinated approach to providing technical support to countries from the more than 40 GNC partners. To address this challenge, and with the support of global thematic funds, UNICEF established the Global Technical Assistance Mechanism for Nutrition in 2019 to provide predictable technical support to GNC partners and governments during nutrition emergencies.

Improving nutrition monitoring for action

UNICEF provides technical support and guidance to strengthen data, monitoring and evaluation systems for nutrition and to build the capacities of governments and partners. While various countries are collecting nutrition data, no international standardized guidance or recommended indicators exist for nutrition data collected through administrative systems. In response to this gap, UNICEF and the Bill & Melinda Gates Foundation convened a global consultation in 2019, which achieved consensus on a standard core set of nutrition data elements and indicators to improve administrative data availability and quality for enhanced programme monitoring.

Globally, in 2019, UNICEF continued to serve as the custodian of nutrition data and information systems to track progress towards the SDGs and other global targets. The UNICEF NutriDash platform supports this work, capturing, storing, analysing and visualizing information on essential nutrition interventions at country, regional and global levels. The NutriDash platform and supporting systems were fully integrated and institutionalized within UNICEF's internal reporting systems in 2019 – a major milestone in continuously improving the platform. Some 123 countries reported data to NutriDash in 2019, compared with 114 in 2018, and UNICEF provided support at all stages of data collection, validation, quality assurance and analysis.

Many governments conduct national nutrition surveys with UNICEF technical support to inform national policies and programmes. In India, the Comprehensive National Nutrition Survey – the first of its kind in the country – provided a wealth of information on the lives of malnourished children and adolescents. The survey resulted in national- and state-level representative data for nutritional status and micronutrient deficiencies among children from birth to 19 years, and estimates of biomarkers for non-communicable diseases. UNICEF advocacy was central to the Government's decision to conduct the survey, and a game changer in the national narrative and policy debate on child nutrition.

UNICEF continued providing support to countries to integrate nutrition indicators within national information systems, plans and strategies in 2019. For example, UNICEF and partners successfully advocated for the inclusion of six nutrition indicators within the core indicators for Ghana's Universal Health Care Road Map.

Engaging with business to prevent all forms of malnutrition

UNICEF continued to engage with business stakeholders to deliver nutrition results for children in 2019. To inform its work in this area, UNICEF generated 10 case studies to capture and document lessons learned from country experiences on engaging with business on nutrition

outcomes for children. These case studies, due to be completed in 2020, will inform the development of UNICEF programme guidance on the subject, to be issued in late 2020.

UNICEF advocates for governments and businesses to better support breastfeeding mothers through key workplace provisions, such as paid leave, nursing breaks and dedicated nursing spaces. The Global Breastfeeding Collective developed advocacy tools and engaged with key stakeholders to advocate for family-friendly policies and support for working mothers to breastfeed (see '*Leveraging collective action*'). In Mexico, UNICEF coordinated with the ministries of Labour and Health and private sector to develop a guideline on the protection and promotion of breastfeeding in the workplace and distributed it among private sector companies.

The Bangladesh Mothers@Work programme, which supports businesses in the ready-made garment sector to create enabling environments for maternity rights and breastfeeding, expanded to 92 factories, reaching about 160,000 working mothers and more than 2,860 young children in 2019. To scale up the programme, a standardized toolkit was developed to guide implementation in factories; a partnership with the Ministry of Labour and Employment was established to systemize roll-out; and a partnership with the Garment and Knitting Association was launched – aiming to reach 2 million female workers in Bangladesh by 2030.



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Divine, age 2, is fed watermelon by her mother, June, in Guadalcanal, Solomon Islands. UNICEF has launched a campaign to reduce stunting in the country, where one in three children is affected by stunting as a result of poor nutrition and frequent illness.

UNICEF leveraged opportunities to engage business in improving food environments for young children and prevent overweight throughout 2019. In Latin America and the Caribbean, UNICEF hosted a regional workshop to share programmatic approaches, lessons learned and best practices on the prevention of overweight. Further examples of UNICEF engagement in this area are described in Results Area 2.

Leveraging collective action

Generating evidence and knowledge for nutrition

The UNICEF flagship report, *The State of the World's Children 2019: Children, food and nutrition: Growing well in a changing world*,⁷³ created a key advocacy opportunity to position UNICEF as a thought leader in global nutrition (See '*Strengthening Systems*', page 187). Globally, the report generated the highest top-tier media coverage of any UNICEF report, with over 3,200 mentions in print, online and broadcast media in six UNICEF languages, over 1 million engagements on social media, and 1.2 million video views on UNICEF global channels.

Recognizing the changing nutrition situation globally, and building on the report findings, UNICEF launched a process to develop a 2020–2030 nutrition strategy to guide its global actions and leadership over the next decade. The Strategy was developed with wide consultation with internal and external stakeholders in nutrition and the wider development community, and will be officially launched in early 2020.

In 2019, UNICEF worked to strengthen the evidence base for a systems approach to nutrition. This included undertaking a systematic review and meta-analysis of the impact of cash transfers on nutrition. UNICEF also generated important new data in 2019, including the first ever global estimates and trends on low birthweight, highlighted in a global report that outlines key actions for improving maternal nutrition and reducing low birthweight worldwide.⁷⁴

To support regional evidence generation and use, UNICEF undertook organizational network analyses across four regions as part of a Gates Foundation-funded initiative that aims to strengthen the capacities of regional bodies to improve nutrition. This work will inform efforts to strengthen the organizational and technical leadership of regional platforms to improve maternal and child nutrition.

In 2019, UNICEF generated evidence to raise awareness among policymakers and donors about the need for comprehensive approaches to address nutrient gaps during pregnancy. As part of this work, UNICEF explored the evidence base and cost-effectiveness of MMS

on pregnancy outcomes to influence commitment to earmarked funding for MMS in high-burden countries. Experiences in introducing MMS in Bangladesh, Burkina Faso, Madagascar and the United Republic of Tanzania highlight the importance of using evidence-based advocacy, combining global and country-specific data and cost-benefit analyses to support these transitions.

To improve equity in nutrition interventions, UNICEF works to generate evidence on preventing malnutrition in the most vulnerable children and women. In Brazil, for example, UNICEF undertook a study on the determinants of child stunting among indigenous (Yanomami) children under 5, one of the most disadvantaged groups in the country, in partnership with the Oswaldo Cruz Foundation. Based on the findings, UNICEF provided recommendations to the Brazilian Ministry of Health for improving the nutrition of indigenous children.

UNICEF continued to be a global knowledge leader in 2019, generating research, using evidence to inform advocacy, policy and programmes, and documenting its experience in scaling up nutrition programmes that help children survive and thrive. With global thematic funds, UNICEF continued to disseminate these experiences in its series *UNICEF WINS – Working to Improve Nutrition at Scale*, to share new programme knowledge, guidance and research on a range of topics in 2019, such as legislation on the marketing of unhealthy foods, food systems and data on child anthropometry. UNICEF also published widely in 2019, expanding the evidence base on nutrition by authoring or co-authoring 89 peer-reviewed publications, compared with 73 in 2018.

Developing national strategies for the prevention of all forms of malnutrition

UNICEF supports countries in developing strong national strategies and action plans for the prevention of malnutrition. The adoption of a national strategy signals government commitment and is tracked as an indicator in the UNICEF Strategic Plan, 2018–2021. Its effectiveness is measured by having key elements in place, such as government budgets allocated to maternal and child nutrition, a focus on evidence-based nutrition interventions, and an emphasis on coverage and service delivery provided at scale. Globally, 54 countries had a comprehensive nutrition policy for the prevention of stunting and other forms of malnutrition,⁷⁵ compared with 49 countries in 2018, surpassing the milestone of 34 countries (SP1.d.3a).

Many countries have adopted new national strategies for stunting reduction with comprehensive action plans to achieve the SDG nutrition targets. Indeed, 94 countries reported that nutrition was a high priority in government plans and policies, compared with 85 the previous year. With UNICEF support in Afghanistan, the National Public Nutrition Strategy (2019–2023) was launched and is fully

aligned with the country's Food Security and Nutrition Agenda. Together, the two strategies form a comprehensive platform for multisectoral programming and will ensure long-term sustainability, improved cost-effectiveness of services, and strengthened links between humanitarian and development programming.

The nutrition landscape in Pakistan was reshaped with a stronger national framework for nutrition in 2019. Informed by the findings of the UNICEF-supported National Nutrition Survey, the Government of Pakistan established a National Nutrition Coordination Council, revision of the national framework for stunting reduction, and new provincial multisectoral strategies and action plans, while initiating a US\$3.2 billion nutrition-specific development budget with UNICEF support. In Kyrgyzstan, the Food Security and Nutrition Programme for 2019–2023, a comprehensive multisectoral policy developed with the support of UNICEF and other partners, sets ambitious targets for stunting reduction and improved maternal nutrition. UNICEF provided technical assistance to develop the programme, which includes priority nutrition interventions across the country, and worked in close partnership with national stakeholders in developing its operational framework.

UNICEF supported the development of the first multisectoral Kenya Nutrition Action Plan 2018–2022, in collaboration with WFP, WHO, and multiple government ministries and implementing partners. The Action Plan guided the development of 19 county-specific County Nutrition Action Plans to ensure that nutrition priorities were reflected in county planning processes and budgets. The drafting of these action plans in 2019 was guided by previous lessons learned and new data on nutrition programming. Through the Scaling Up Nutrition (SUN) movement in Burundi, UNICEF and WFP supported the Ministry of Health and relevant line ministries to develop a groundbreaking multisectoral strategic plan for food security and nutrition (2019–2023) and a national nutrition coordination platform.

UNICEF supports countries in developing integrated nutrition policies and strategies that leverage multiple systems to deliver results for children. For example, 84 countries had nutrition-responsive education policies (76 the previous year); 28 had nutrition-responsive gender policies (25); and 61 had nutrition-responsive social protection policies (the same number as the previous year).

With global thematic funds from the Government of the Netherlands, UNICEF is strengthening synergies in joint nutrition and water, sanitation and hygiene (WASH) policies and programming, with specific focus on four countries (Burkina Faso, the Niger, Nigeria and the United Republic of Tanzania). Seventy-two countries have joint nutrition and WASH programming with support from UNICEF. In Chad, UNICEF supported the Ministry of Public Health to

integrate a WASH component into the Integrated Nutrition and Food Action Plan and revise the national WASH in Nutrition strategy. In Mali, WASH and nutrition integration has been strengthened through a dedicated sub-cluster working group and the validation of the WASH and Nutrition National Strategy in 2019. An integrated UNICEF humanitarian WASH and Nutrition programme in three regions reached 61 health centres (2019 annual target: 25), with the support of the Central Emergency Response Fund and partners. In Kenya, UNICEF supported the integration of nutrition counselling into community-led total sanitation in two arid and semi-arid lands counties in 2019.

With UNICEF advocacy and policy support, countries are developing policies and strategies to tackle increasing rates of overweight in children and women. In Ghana, for example, UNICEF contributed to the development of a non-communicable disease policy and multisectoral strategy that will be critical to addressing high rates (>40 per cent) of overweight and obesity among Ghanaian women. UNICEF tracks the number of countries implementing policy actions or programmes for the prevention of overweight and obesity in children and/or adolescents (SP1.d.4).⁷⁶ Twenty-three countries had such programmes in 2019, compared with 17 in 2018, surpassing the milestone of 12 countries. In Ecuador, with global thematic funding from the Government of the Netherlands, UNICEF developed a multisectoral strategy for addressing overweight and obesity in children aligned with the national nutrition plan. As part of the strategy, UNICEF is advocating for the Government to strengthen food labelling, establish taxes on sugar-sweetened beverages and regulate food marketing practices. The strategy also includes advocacy for national policies to promote breastfeeding, an evaluation of school nutrition policies, and campaigns to promote healthy family eating habits.

To strengthen policies for the prevention of overweight in the Republic of Moldova, UNICEF reviewed the national framework on nutrition in schools and preschools, and provided recommendations to the Government for revising the framework to better uphold children's nutritional rights. As part of this work, UNICEF contributed to revising the existing nutrition guidelines, standards and menus in schools and preschools. To strengthen the broader policy environment, UNICEF successfully advocated for the promotion of safe and nutritious food in schools to be included in the country's revised multisectoral action plan with the Ministry of Education, Culture and Research and Ministry of Health, Labour and Social Protection. Based on a 2019 UNICEF assessment and other evidence, the Government developed an action plan on 10 steps for safe drinking-water and nutrition in schools and preschools. A cross-sectoral coordination council was established under the chair of the State Chancellery involving representatives of key line ministries and public agencies.

Strengthening national legislation to improve maternal and child nutrition

Along with strengthened national strategies, UNICEF supports governments in adopting new laws and improving existing legislation to prevent all forms of malnutrition. This includes legislation to restrict the marketing of breastmilk substitutes, enforce maternity leave and other family-friendly policies, mandate food fortification, and establish taxes on sugar-sweetened beverages and other unhealthy foods, as well as comprehensive restrictions on the marketing of unhealthy foods.

The International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly (WHA) resolutions (known together as ‘the Code’) aims to protect and promote breastfeeding by prohibiting the promotion of breastmilk substitutes, such as infant formula, feeding bottles and teats. UNICEF provides technical support to governments to implement the Code through the adoption, monitoring and enforcement of national legislation.

As a result of UNICEF systematic policy advocacy, Croatia, Romania and Turkmenistan amended their national Code laws with stronger measures in 2019. Uzbekistan adopted legislation to support breastfeeding, including provisions for implementing the Code, and the Chad National Assembly passed a law on the marketing, distribution and use of breastmilk substitutes and complementary foods for children aged 6–36 months. In Burkina Faso, UNICEF provided technical and financial support to revise the national decree on the marketing of breastmilk substitutes to reflect the recommendations of WHA resolution 69.9 on the inappropriate marketing of foods for young children. In the Lao People’s Democratic Republic, sustained UNICEF advocacy led to the Prime Minister signing the National Decree on Breastmilk Substitutes and Designated products.

Through its partnership with the Gates Foundation to strengthen regional bodies for nutrition, UNICEF finalized regional guidelines on the marketing of breastmilk substitutes in SADC member states, which were validated by the SADC Food and Nutrition Steering Committee and endorsed by health ministers. In collaboration with Helen Keller International, UNICEF also conducted a regional legal assessment on implementation and adoption of WHA resolution 69.9.

UNICEF advocates for governments to enact family-friendly policies and legislation, such as parental leave and workplace accommodation for working mothers. In Argentina, UNICEF and CSOs advocated for the adoption of new family leave legislation, with the aim of changing gender-based social norms around childcare. With UNICEF support, the Bhutan Ministry of Health is developing a new policy to deliver an integrated set of health, nutrition and developmental interventions to every mother and child. The backbone of the policy will be conditional cash transfers given to mothers in rural communities, private and corporate organizations who are not entitled to six months paid maternity leave.

Mandatory food fortification legislation helps governments ensure equitable access to nutritious foods. In 2019, UNICEF supported the drafting of a national law on mandatory universal salt iodization in Ukraine, which is scheduled for endorsement in 2020. To strengthen the control of iodine deficiency disorders in the Democratic People’s Republic of Korea, UNICEF provided technical support to train salt producers and develop a national strategy, technical guidelines and standard operating procedures on raw salt iodization. In Viet Nam, sustained advocacy by UNICEF and other stakeholders convinced the Government to overturn a decision to make fortification voluntary rather than mandatory. The business sector had strongly opposed the decree, citing difficulties with production and business operations.

In low- and middle-income countries alike, governments are adopting and strengthening national policies and legislation to tackle overweight in both childhood and adolescence. In Mongolia, for example, UNICEF worked with the Government to implement and monitor the Infant and Young Child Food Act, which aims to prevent overweight and obesity in children under 5. UNICEF’s contributions to these efforts are discussed further in Results Area 2.

Boosting public financing for nutrition

UNICEF advocates for greater financial resources – including domestic budgets – to support policies, strategies and programmes for maternal and child nutrition. In the regions of South Asia and East Asia and the Pacific, UNICEF developed a ‘public finance for a nutrition’ training package to strengthen country capacities to influence allocation and spending decisions, and improve the coverage of nutrition interventions delivered through the health system. The package will be rolled out in 2020.

UNICEF strengthened advocacy efforts in Nigeria to secure political commitments and leverage domestic financial resources to drive nutrition outcomes. This included supporting 24 of its 36 states to develop costed nutrition plans, which proved an enabling factor in mobilizing domestic resources for nutrition. These activities secured political commitment and resulted in the release of US\$4.8 million in domestic funds for nutrition, representing 241 per cent of the 2019 target, and a slight increase from the previous year. Despite these gains, the nutrition budget in Nigeria is still considered insufficient and UNICEF is continuing its advocacy to sustain financial commitments from government at all levels.

With UNICEF technical support and investments in capacity-building, the Government of Nepal significantly increased budget allocation and expenditures for nutrition interventions. Through its food security steering committee, Nepal developed the capacities of 308 local governments and 7 provinces to plan, monitor and allocate funds for the Multisectoral Nutrition Action Plan. With advocacy from UNICEF, the budget allocation for nutrition interventions at local level increased by nearly 50 per cent in 2019 compared with 2018.

Leveraging partnerships to transform the nutrition landscape

Partnerships are critical for accelerating progress on the prevention of malnutrition in all its forms. In 2019, as in previous years, UNICEF occupied a leadership position (as chair, coordination committee member or board member) in 12 global nutrition initiatives,⁷⁷ reflecting its position as a trusted partner in maternal and child nutrition.

In keeping with the United Nations Reform agenda, UNICEF supported efforts to harmonize the collective work of United Nations agencies working on nutrition. In 2019, after extensive consultations with the Food and Agriculture Organization of the United Nations (FAO), WFP and WHO, a decision was reached to merge the UN Standing Committee on Nutrition and UN Network for SUN into a single entity: UN Nutrition. It is expected that UN Nutrition will be established early in 2020, with the support of the United Nations Secretary-General.

Concurrently, UNICEF and WFP worked to strengthen coordination in 2019, committing to bring together the mandates and comparative expertise of each organization to accelerate progress in two key areas of nutrition programming: (1) integrated approaches to prevent and treat child wasting in all contexts; and (2) programmes to improve the nutrition and health of school-age children using schools as the delivery platform. In 2019, joint UNICEF–WFP support was provided to six priority countries in the Sahel and the Horn of Africa, where an estimated 6.5 million children are wasted and 2 million school-age children are not being reached by national school health and nutrition programmes.

The SUN movement continued to galvanize global commitment to ending malnutrition in 2019, with UNICEF maintaining its leadership as chair of the SUN Lead Group. In 2019, SUN membership increased to 61 countries and four Indian states, from 60 countries and three Indian states in 2018. In the Sudan, UNICEF helped strengthen the national SUN coordination body in 2019, contributing to the development of an operational manual for SUN,

which outlines key coordination structures with specific terms of reference at both federal and state levels, to be operationalized in 2020.

UNICEF and its partners continued to make advancements in improving breastfeeding as a result of strategic advocacy through the Global Breastfeeding Collective. In 2019, the Collective collaborated with the SUN movement to convene four training webinars to build the capacities of advocates from 47 countries. To mark the 100th anniversary of International Labour Organization (ILO) convention 183 (on maternity protection), the Collective released case studies from Burkina Faso, Montenegro, Paraguay and Viet Nam to share lessons learned on the implementation of maternity protection legislation.

Through its thought leadership in 2019, the Collective focused its advocacy efforts on the theme of breastfeeding and gender equality. This involved leveraging key high-level advocacy opportunities to increase political commitment, such as the Women Deliver conference and the Family-friendly Policies Summit. The Collective also released advocacy briefs on breastfeeding and gender equality, and breastfeeding and family-friendly policies, which will strengthen country-level advocacy for responsible policies and programmes (implemented by both governments and private sector) that contribute to enhancing maternal and child health and nutrition, ECD and gender equity in the workplace.

With support from UNICEF, SADC developed harmonized minimum regional food fortification standards and launched a regional road map and joint workplan for partners to support regional and country-level actions. Through this initiative, nine SADC member states received capacity-strengthening to implement their food fortification plans in 2019. In collaboration with the Iodine Global Network, the Global Alliance for Improved Nutrition and Nutrition International, UNICEF convened a regional consultative meeting on the elimination of iodine deficiency disorders, resulting in action plans to strengthen universal salt iodization in 16 countries in the region.



Students play after finishing their school-provided lunch at Qanshalay Primary School in Dollow, Somalia.

Results Area 2: Adolescent nutrition and health⁷⁸

Adolescence presents a second window of opportunity for establishing lifelong dietary habits that support nutritional well-being today and for future generations. Good nutrition during middle childhood⁷⁹ and adolescence provides lifelong benefits, such as improved school enrolment, attendance, educational achievement, cognition, and a chance to break the cycle of intergenerational malnutrition and ill health.

Globally, far too many adolescents fail to consume diets that give them the foundation for long, healthy and productive adult lives. Available data indicate that 21 per cent of school-going adolescents consume vegetables less than once a day, 34 per cent consume fruit less than once a day, 42 per cent drink soft drinks daily, and 46 per cent consume fast food at least weekly.⁸⁰ Half of adolescent girls in low-income and rural settings in low- and middle-income countries eat fewer than three meals a day. Adolescent girls may be especially vulnerable to malnutrition, as gendered cultural norms mean they often lack access to nutritious food, education and life opportunities.^{81,82}

Adolescents' diets are influenced by factors such as the marketing of foods high in fats, sugar and/or salt; peer pressure and the desire to fit in with their peers; and school food environments that promote unhealthy diets

and lifestyles and lead to overweight. At the same time, limited access to diverse and nutritious foods can result in deficiencies in essential micronutrients, such as iron. Data available from UNICEF programming countries indicates that nearly half of girls aged 15–19 years are affected by anaemia, increasing the risk of disease and disability, and limiting their opportunities to develop, learn and participate to their full potential.

The UNICEF Strategic Plan, 2018–2021 commits to establishing gender-responsive programmes to address all forms of malnutrition in adolescents, including anaemia. This is covered under Output 2, “Countries have developed programmes to deliver gender-responsive adolescent health and nutrition,” and both health and nutrition programming contribute to achieving this result. By 2021, UNICEF intends to reach at least 100 million adolescent girls and boys annually with services to prevent anaemia and other forms of malnutrition, including undernutrition and overweight. This is aligned with the UNICEF Gender Action Plan, 2018–2021; it also supports the first objective of the UNICEF strategic framework for the second decade: to maximize adolescents' physical, mental and social well-being.

Outcome and output indicators for adolescent nutrition and health

FIGURE 50: Outcome results for adolescent nutrition, 2019

Outcome indicator (+ key United Nations partners)	Baseline	2018 value	2019 value	2021 target
1.12 Percentage of girls aged 15–19 years with anaemia	46%	46.5%	48.1%	36%

FIGURE 51: Output results for adolescent nutrition, 2019

Output indicator (+ key United Nations partners)	Baseline	2018 value	2019 value	2019 milestone	2021 target
1.i.1 Number of adolescent girls and boys provided with services to prevent anaemia and other forms of malnutrition through UNICEF-supported programmes	41 million	58.4 million	59.9 million	70 million	100 million

Improving services and community demand

Laying the foundations for effective nutrition programming for school-age children and adolescents

UNICEF leveraged the evidence generated and global lessons learned in the first year of its current Strategic Plan to inform programme design and scale-up in 2019. This involved gathering programme experiences from countries and developing programme guidance and tools to assist countries in designing, implementing and monitoring nutrition programmes during middle childhood and adolescence. There has been a marked increase in the number of countries implementing such programmes: 58 countries across seven regions implemented programmes to improve the nutrition of school-age children in 2018, compared with 35 in the previous year.⁶³

In 2019, UNICEF provided technical guidance to roll out gender-responsive adolescent nutrition programmes. This includes anaemia control programmes for pregnant adolescent girls and women, particularly in settings with limited access to nutritious diets and where early marriage, early pregnancy and other gender-based inequalities are common. These gender-responsive approaches are critical to driving progress towards the SDGs and the Strategic Plan target on preventing anaemia and other forms of malnutrition.

As adolescent nutrition is still a relatively new area of work for UNICEF, countries are at various stages of programming: some programmes are well established and have been scaled up nationwide, while others are in the design and piloting stage. For example, based on a proof of concept that began in 2018, Nigeria implemented its first adolescent anaemia reduction programme for school-going and out-of-school adolescents in two states in 2019. The programme filled a critical gap in the life-cycle approach to nutrition given the high rates of adolescent pregnancy in the country. More than 210,300 adolescent girls and boys have already been reached with IFA supplementation and nutrition counselling in the targeted states, and efforts are under way to scale up the programme to other states in 2020.

Scaling up essential nutrition services for adolescents

UNICEF supports the delivery of nutrition services for school-age children and adolescents that aim to improve nutrition knowledge and skills; promote nutritious, safe, affordable and sustainable diets; and provide micronutrient supplementation and deworming prophylaxis where nutrient-poor diets prevail. These interventions may be delivered through schools, the health system (*see 'Building stronger institutions'*) or community platforms.

UNICEF has made significant strides in scaling up programmes to prevent overweight and obesity as part of wider efforts to tackle the triple burden of malnutrition in many countries. Globally, the number of adolescents

reached with services to prevent overweight and obesity increased dramatically, from less than 118,000 girls and boys in 2018 to more than 5.7 million in 2019. The number of countries implementing UNICEF-supported programmes to prevent overweight in adolescents also increased, from 18 to 33.

UNICEF addresses deficiencies in essential vitamins and minerals during middle childhood and adolescence through micronutrient supplementation programmes where diets are poor and micronutrient deficiencies are common. These programmes may also include deworming prophylaxis in settings with high burdens of soil-transmitted helminths. The number of countries implementing UNICEF-supported programmes on the prevention of anaemia in adolescents increased from 19 in 2018 to 29 in 2019.

IFA supplementation is the leading intervention for tackling anaemia in adolescent girls and boys globally. UNICEF programmes to reach adolescent girls and boys with services to prevent anaemia and other forms of malnutrition grew through 2019, with 60 million adolescents reached compared with 58 million in 2018 (SP1.i.1). However, further efforts are needed to attain Strategic Plan milestones. In 2019, anaemia affected 48 per cent of girls and young women aged 15–19, compared

with 46.5 per cent in 2018 – although data gaps limit trend analyses. UNICEF is seeking partners to accelerate progress in this area through the scale-up of adolescent nutrition programmes globally, with an aim to reduce this figure to 36 per cent by 2021 (SP1.12).

Some countries, such as Afghanistan and India, have well-established anaemia control programmes for adolescents that have been scaled up nationwide with UNICEF support. In 2019, more than 1 million adolescent girls (85 per cent of those targeted) benefited from Afghanistan's weekly IFA supplementation (WIFS) programme in schools. UNICEF and the Government prepared to expand the WIFS programme to out-of-school adolescent girls through Accelerated Learning Centers (community-based education platforms) in four out of five regions. As part of this initiative, UNICEF supported training on WIFS for teachers in the centres in Central, Eastern and Northern regions, with plans to continue in Southern and Western regions in 2020. UNICEF and the Ministry of Education are now preparing to launch a consolidated WIFS database to enhance supply forecasting, distribution and monitoring. To increase ownership of the WIFS programme, regional monitoring coordination workshops were held in 2019, bringing together decision makers from government ministries in all regions.



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An *anganwadi* worker distributes iron tablets to adolescent girls during home visits in Kanker, Chhattisgarh State, India. The country has the largest universal adolescent anaemia control programme in the world, targeting 116 million adolescent girls and boys with weekly iron and folic acid supplementation and nutrition and health education.

In Ghana, UNICEF and the United States Centers for Disease Control and Prevention led an evaluation of the girls' iron folic acid tablet supplementation (GIFTS) programme to reduce anaemia and improve the health and nutrition of adolescent girls (aged 10–19 years) both in and out of school. The evaluation noted a 26 per cent reduction in anaemia levels among targeted girls within the first 12 months of the programme, with coverage over 90 per cent in the four pilot regions. Adolescent knowledge on iron-rich nutritious foods and dietary practices also improved.⁸⁴ These results proved critical in catalysing government investment in the scale-up of GIFTS nationwide in 2019, reaching 900,000 girls in Ghana each week (27 per cent of eligible girls). Evidence on the effectiveness of GIFTS also helped leverage World Bank funding to procure IFA tablets worth US\$650,000, covering 60 per cent of the annual need.

UNICEF, the Ghana Health Service and Ghana Education Services worked to strengthen the capacities of national-, regional-, district- and subdistrict-level staff to deliver GIFTS. More than 17,200 teachers and 7,970 health staff were trained nationwide on adolescent health and nutrition and GIFTS implementation in 2019. Supportive supervision by trained staff, combined with joint national and regional reviews to share good practices and lessons, and identify bottlenecks and solutions, were key to successful programme scale-up. UNICEF helped staff tackle challenges to the programme, including myths that IFA could be harmful, by having health workers participate

in parent–teacher associations as a resource, forming women's support groups to create demand for GIFTS in communities, and producing communication materials to share facts on IFA during school and community meetings.

Fostering adolescent participation in nutrition programmes

Participation is a key pillar of UNICEF adolescent nutrition programmes. UNICEF fosters opportunities for adolescents to share their opinions related to food, diets and physical activity, and engages young people in the design of nutrition programmes. As part of the development of the *State of the World's Children 2019* report,⁸⁵ UNICEF held workshops with more than 450 young people in 18 countries to talk about what they eat and why, including the obstacles to eating healthily and how they try to improve their diets.

UNICEF is leveraging technology to expand opportunities for young people to participate in decision-making around nutrition. With UNICEF support in Mali, a youth manifesto was convened at a high-level nutrition forum, which contributed to the Government's decision to double its budget for nutrition. In Zimbabwe, UNICEF developed a package of innovative activities to engage young people in better nutrition outcomes. Working with AfricAid, UNICEF delivered an integrated capacity-development session on nutrition and HIV targeted to young people living with HIV.



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Emilia, Mariana, Augustina, Tiago and Mercedes, all 13-years-old, share a picnic of fresh fruit, tangerine muffins, cheese sticks and quince pie close to their school in Montevideo, Uruguay.

In Uruguay, obesity and overweight in school-aged children rose from 25 per cent in 2004 to 43 per cent in 2018, mainly due to an increase in the consumption of ultra-processed foods. UNICEF worked alongside the government to pass a food labelling law that identifies products with excess of sugar, salt and fat, and another that regulates the display of certain ultra-processed foods in school canteens.

To invest in young people as agents of change, UNICEF hosted a successful nutrition ‘hackathon’ coding event, where information and communications technology (ICT) based applications were created to allow adolescents to identify solutions to the nutrition challenges affecting them.

Building stronger institutions

Improving the school food and nutrition environment

UNICEF seeks opportunities to improve food environments in and around schools. This includes advocating for and supporting the scale-up of a context-specific ‘nutrition-in-schools’ package to improve the diets and health practices of children and adolescents.⁸⁶ While schools have traditionally been an underused platform for nutrition, such programmes are an opportunity to strengthen the links between children’s right to learn and their right to adequate food and nutrition. School-based nutrition programmes can also help incentivize school enrolment, delay marriage, increase educational attainment, improve consumption of nutritious foods and target nutrition services to the poorest households.⁸⁷

Many countries made progress in strengthening the enabling environment for nutrition in schools in the first two years of the UNICEF Strategic Plan. According to the latest 2018 estimates, 70 countries integrated physical education within the school curriculum, compared with 35 the previous year; 58 countries had a school feeding programme, compared with 33 the previous year; 50 countries had integrated nutrition education within the school curriculum, compared with 24 the previous year; and 48 had safe drinking-water provided free of charge in schools, compared with 23 the previous year.⁸⁸

In 2019, UNICEF supported an increasing number of countries to implement policy and programme actions to improve children’s school food environments.⁸⁹ With support from Norway, UNICEF piloted tools to assess children’s food environment in and around schools in three countries. These assessments will be used to inform national policies and guidelines on school food environments, and as a validation exercise for work across countries and regions. In addition, in 2019, partnerships were established (with Harvard School of Public Health, Africa Academy of Public Health, Simon Fraser University) to assess school nutrition policies, programmes and food environments.

With the rise of overweight in many countries, UNICEF is supporting interventions to make school food environments more conducive to healthy diets by protecting children from harmful food marketing influences and promoting healthy food choices. In Ghana, UNICEF strengthened leadership and governance for nutrition-friendly schools, including promoting school nutrition policies about the marketing of foods for children, in 250 schools across five regions. In

addition, a first-day-of-school nutrition and health screening was conducted in all schools in 2019 to improve the early detection of developmental delays and other nutrition-related concerns.

With UNICEF support, many countries have scaled up the provision of essential nutrition interventions through the school system. In Ethiopia, UNICEF is supporting deworming prophylaxis and IFA supplementation for adolescent girls in upper primary and secondary schools, and expanding training for teachers and the health task force on school health and nutrition services. In 2019, UNICEF procured 4.3 million IFA supplements to reach more than 70,000 adolescents in schools. As part of the national adolescent strategy, UNICEF supported capacity-building activities in 100 *woredas* for the provision of school health and nutrition packages, adolescent-friendly health services and deworming in schools. Additionally, more than 2,450 health extension workers and teachers, and more than 100 health-care providers were trained to provide school-based nutrition services to adolescent girls.

By leveraging C4D approaches in the Bolivarian Republic of Venezuela, UNICEF launched a nationwide deworming campaign through schools as part of a joint action with the ministries of Health and Education. The campaign included technical support to incorporate key messages about the prevention of intestinal worms and improved sanitation into training videos produced by the Ministry of Health, targeting sanitation staff and teachers. UNICEF also contributed to the design of training workshops for teachers on distributing deworming prophylaxis to children. In Indonesia, UNICEF advocated for the inclusion of multisectoral nutrition education in the national curriculum to improve the knowledge and attitudes of adolescents on healthy eating and physical activity. UNICEF also implemented gender-transformative C4D interventions in two districts to engage and mobilize schools, parents, families and communities to support about 58,000 adolescents to improve eating habits and physical activity patterns. Together with WFP, UNICEF developed nutrition literacy products for primary school children as part of efforts to tackle the triple burden of malnutrition.

To inform the design and scale-up of programmes, UNICEF helped strengthen the evidence base for delivering nutrition interventions through schools in the State of Palestine (*see Case Study 7*). In Mexico, UNICEF collaborated with the Secretariat of Public Education and the National Institute of Public Health to evaluate the ‘school meal service of full-time schools’ programme in three states. Results were presented to the Ministry of Education and representatives from all 32 states, and recommendations have been taken up to improve school nutrition services throughout Mexico. In addition, UNICEF supported the Ministry of Education to implement a monitoring system to follow up the study recommendations at state level. UNICEF also led an assessment of water consumption in secondary schools in Mexico, and is designing an intervention to promote safe water consumption in secondary schools in Mexico City based on the findings.

CASE STUDY 7: State of Palestine: Promoting nutrition-friendly schools

Palestinian adolescents are highly vulnerable and exposed to multiple sources of deprivation and distress, with potentially severe and long-term impacts on their nutritional status and well-being. To address micronutrient deficiencies and anaemia among adolescents and prevent all forms of malnutrition, UNICEF supported the Government to establish a framework for comprehensive school programmes to tackle the double burden of malnutrition.

UNICEF worked closely with the ministries of Education and Health to implement a Nutrition-Friendly Schools Initiative, which was piloted across 24 primary schools in Gaza and the West Bank in 2019. The initiative aims to foster an enabling school environment for nutrition through a package of interventions, including: capacity-building training for teachers, children and parents; improved water, sanitation and hygiene facilities, gardening and school play areas; improved diversity of foods provided in school canteens; screening for anaemia and micronutrient supplementation as needed; community mobilization workshops; and physical education, particularly among girls.

As part of the initiative, UNICEF engaged with government ministries, parents, teachers and other partners to establish a comprehensive nutrition policy for schools, with a clear process, timeline and action plan for accrediting schools as 'nutrition-friendly'. The programme reached more than 7,720 adolescent girls, more than 1,210 boys and 466 teachers in Gaza and the West Bank through training sessions, awareness activities and school-based interventions. UNICEF successfully advocated for the Ministry of Education to develop a national strategy and action plan for the next eight years, including mainstreaming and scaling up the initiative nationwide beginning in 2020.



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Saja Abo Hosoun, age 12-years-old, walks home at the end of her school day in Rafah, southern Gaza Strip, State of Palestine.

In a number of countries, UNICEF conducted advocacy and provided technical assistance to governments to adopt or improve guidelines to promote nutritious and safe school meals. In Argentina, for example, UNICEF supported the publication of regulatory standards for healthy school environments to avoid the promotion of unhealthy foods. To support the Kosovo⁹⁰ Ministry of Health, UNICEF helped establish a technical working group on adolescent nutrition with representation from the Ministry of Education, and contributed to the development of school menus including quality nutritious foods.

Nutrition education in schools helps children and adolescents claim their right to nutrition and encourages them to adopt health and lifestyle behaviours to improve their well-being and that of their families and communities. In Colombia, UNICEF – in collaboration with the Ministry of Education, operators of the school feeding programme and school stakeholders – supported the expansion of the Healthy Lifestyles Strategy, which empowers children and adolescents to make decisions on healthy eating, physical activity and key hygiene practices in schools. The strategy was adapted from the lessons learned from implementing the programme in 16 schools in 2018, resulting in an improved toolkit and training modules. The capacities of teachers were also strengthened to promote healthy eating, physical activity and good hygiene practices. The improved strategy was implemented in 24 new schools with the highest prevalence of overweight and obesity, reaching 3,000 school-age children in 2019; by the end of 2020 it will have benefited more than 18,600 children.

In Central Asia and the Caucasus, there are limited examples of nutrition-responsive school-based programmes to promote healthy nutrition-related behaviour and regulate the school food and nutrition environment. A Joint Action on Nutrition and Physical Activity project by 16 countries in Europe is helping Member States by providing guidance on policy options and creating health-promoting food environments in school settings. The school food and physical activity environment may influence nutrition-related behaviour and so a key area of action is to restrict the marketing of unhealthy food and beverages to children at schools.

While schools are an effective platform that should be leveraged wherever possible, they are not sufficient to reach all children and adolescents. Many of the most vulnerable children and adolescents do not attend school, and it is therefore critical that other delivery platforms – such as community and social groups, the health system, digital media – be used to reach them, as was done in India and Malawi (*see next section*).

Strengthening systems to deliver essential nutrition interventions

UNICEF strengthens the capacities of multiple systems to deliver key nutrition services to school-age children and adolescents. To strengthen health systems in 2019, UNICEF supported the capacity development of health workers, strengthened nutrition and health information systems, and improved supply chains to ensure the delivery of IFA and other nutrition commodities.

UNICEF provided technical assistance to facility- and community-based health workers, and developed guidance and improved curricula and training on the nutrition of school-age children and adolescents. With the support of global thematic funds in Zimbabwe, and in partnership with ministries of Health and Education, UNICEF drafted clinic guidelines for the prevention and management of overweight and obesity among adolescents. The guidelines are expected to be rolled out to health-care facilities in 2020. In Kyrgyzstan, UNICEF provided technical support to revise national guidelines on nutrition and anaemia in girls and women of reproductive age, which will enable more effective screening, prevention and treatment of anaemia.

India's nationwide adolescent nutrition programme reaches 40.6 million adolescent girls and boys aged 10–19 years each month with IFA supplementation, deworming, biannual check-ups, and nutrition and health education. In 2019, a nationwide bottleneck analysis was led jointly by UNICEF and the United Nations Development Programme (UNDP); in response, UNICEF provided support to strengthen the IFA supply chain and address health system bottlenecks – such as inadequate financing, training, reporting and demand generation. As part of these efforts, four national centres of excellence (established in 2018 to provide technical guidance on the programme) expanded their support to state governments by providing training, developing programme-manager toolkits, harmonizing the technical support of partners, developing a monitoring dashboard, and tracking financial allocation and disbursement.

At global and national levels, there are important gaps in data on the nutrition of school-age children and adolescents. UNICEF supported a number of countries to strengthen data collection and reporting on adolescents through the routine health and nutrition information system in 2019. In the Republic of Moldova, UNICEF advocated for the integration of key nutrition indicators for adolescents within the national health and education information system.

With the support of UNICEF and other stakeholders, the Government of Malawi launched its first Multisector Adolescent Nutrition Strategy (2019–2023) and adolescent nutrition programme to address the high burden of malnutrition among adolescents. The programme includes weekly IFA supplementation, deworming, school meals, and the promotion of dietary diversity and fortified foods; it is being implemented in six pilot districts targeting both in- and out-of-school adolescent girls. UNICEF used advocacy, systems-strengthening and C4D as the main means of catalysing action across all districts. The programme is implemented through the education system together with community-based structures to reach out-of-school adolescents.

The programme was scaled up rapidly from one district in the first half of 2019 to six districts by the end of the year. To facilitate this scale-up, UNICEF supported the capacity-strengthening of more than 4,100 teachers and 1,530 CHWs. More than 322,525 of the 458,500 adolescent girls targeted were reached with the package of interventions in 2019, representing 70 per cent coverage. The Malawi experience demonstrates how a well-designed adolescent nutrition programme, under the leadership of Government with a strong enabling environment, can achieve results in a short time. In the United Republic of Tanzania, UNICEF launched a new adolescent nutrition programme guided by a systems-strengthening approach that leverages the potential of the food and education systems (*see Case Study 8*).

CASE STUDY 8: United Republic of Tanzania: Systems-strengthening to improve the diets of school-age children and adolescents

With the support of UNICEF and Norway, the United Republic of Tanzania developed an evidence-based, comprehensive approach to improve nutrition among school-age children and adolescents in 2019.

First, UNICEF supported the Ministry of Health to integrate a nutrition component for the first time in the biannual national school-based malaria survey. The survey reached over 60,000 children aged 6–19 years in all 186 districts of the country, making information about nutritional status, anaemia, diets and physical activity in this age group available for the first time at national level. UNICEF also supported a school-environment assessment in rural and urban areas in the mainland and Zanzibar to assess the food, and water, sanitation and hygiene environment, and how they influence the nutritional status of boys and girls aged 10–14 years.

Secondly, UNICEF worked closely with the ministries of Health and Education to review the national school health programme, including a significant nutrition component, and to develop a national school feeding guideline. This initiative prioritizes the use of locally grown nutritious food and proposes linkages with the agriculture sector and food fortification programmes at the local level. UNICEF partners with these ministries to develop job aids for teachers to provide nutrition education, weekly iron and folic acid (IFA) supplementation and physical activity.

Thirdly, UNICEF supported the Tanzania Food and Nutrition Centre to develop a comprehensive programme to improve nutrition among school-age children and adolescents focusing on: (1) nutrition education (especially the promotion of locally grown foods in synergy with existing agriculture programmes); (2) food fortification in synergy with existing small-scale and national-level programmes; and (3) weekly IFA supplementation. The programme will be implemented through a systems-strengthening approach including health, food, education and social protection systems. Community health workers will work with peer educators to target out-of-school adolescents, and UNICEF will target adolescents from the most vulnerable households through linkages with the National Productive Social Safety Net programme.

The programme will be piloted in Mbeya Region. It will be closely monitored and evaluated by the Government, with support from UNICEF. Indicators to monitor the nutrition of children aged 6–19 years are currently missing in the nutrition information system, and UNICEF will support the Government to address this important data gap. Cost-effective interventions for improving the nutrition of school-age children and adolescents will also be included in the new National Multisectoral Nutrition Action Plan 2021–2025, and gradually scaled up nationwide.

Leveraging collective action

Strengthening policies, strategies and legislation to protect adolescent nutrition

UNICEF supports governments in fostering an enabling environment for adolescent nutrition through the adoption of national strategies, effective policies and protective legislation that uphold the right to nutrition. In Pakistan, for example, UNICEF advocated for the Government to draft an Adolescent Nutrition Strategy, with provincial implementation plans to influence the nutrition status of approximately 47 million adolescents. The strategy was finalized and endorsed by the Nutrition Directorate in 2019.

In collaboration with the World Bank, UNICEF harnessed the power of evidence to drive change in Bangladesh, through a cost-benefit analysis of nutrition interventions that informed a scale-up plan for key nutrition interventions to address micronutrient deficiencies in adolescents. In 2019, a multisectoral National Plan of Action for Adolescent Health Strategy (2017–2030) was approved by the Government, with funds allocated to enable adolescent access to services within 200 facilities each year. UNICEF

conducted policy advocacy on prioritizing adolescent nutrition in 2019, resulting in the modelling of secondary school-based interventions to improve dietary practices and a minimum package of urban nutrition services being defined. With UNICEF support, operational guidelines for adolescent nutrition programmes were developed under the leadership of the National Nutrition Services to guide implementation, with a coordination mechanism established and cascade training made available to education officers and teachers from 50 *upazilas* of 25 districts.

UNICEF supported the national nutrition task force in Armenia to expand work on nutrition of school-age children in 2019, through a gap analysis of existing legislation and regulations on marketing of foods. The findings of a UNICEF-supported assessment of dietary practices in primary school children was used to inform the draft National Strategy on Strengthening Health Systems in Armenia 2020–2025. UNICEF also led the development of tools and checklists, and capacity-building of government functionaries, to monitor school environments and practices. Further, UNICEF supported a large-scale nutrition education campaign in schools, which reached 15,000 students and 30,000 parents.



Friends Amin and Mossaddek, both in sixth grade, eat snacks bought from street vendors outside of their school in Khilgaon, Dhaka, Bangladesh. With the rising prevalence of fast food restaurants, street food stalls and carts in Dhaka, children are often the focus of targeted marketing. Indeed, food stalls often set up shop outside of the city's schools and colleges.

To combat the aggressive marketing of unhealthy foods, UNICEF supported countries to adopt and strengthen protective legislation, such as front-of-package labelling, which refers to information about the nutritional composition of food (e.g., fat, sugar and salt content) on food products. Such labels are intended to help consumers identify whether foods are healthy at the point of purchase. Globally, support was provided to approximately 20 countries, including on front-of-pack labelling and restrictions on the marketing of unhealthy food. The Latin America and Caribbean region has been at the forefront of UNICEF work in this area, with some of the most advanced advocacy and leadership. UNICEF supported efforts to introduce front-of-package labelling in Argentina, Brazil, Ecuador, Mexico and Peru, for example, as well as regulations on the nutritional quality of food sold in school kiosks.

UNICEF continued to advocate for laws to protect children from obesogenic environments in Argentina as part of the National Coalition for the Prevention of Childhood Obesity. UNICEF and human rights observatories presented policy recommendations for tackling obesity to Congress using a children's rights perspective, generating widespread media attention – including front-page coverage in a leading Argentinian newspaper and more than 25 articles, reaching 4 million people. As a result, UNICEF advised on numerous bills, with more than 20 obesity prevention projects now with Congress for debate. A bill promoted by UNICEF on healthy school environments was approved by the Chamber of Representatives' Education Commission and is on track to become law.

Cooperation with other United Nations agencies boosted advocacy efforts in Argentina. UNICEF and the Pan American Health Organization held an advocacy meeting during the Argentinian National Congress to encourage legislators to adopt legislation on effective front-of-package labelling. UNICEF also supported local evidence generation through a study on Latin American retail environments and via the National Nutrition Survey. In 2019, a national plan was launched to prevent child and adolescent obesity, and is being implemented in 14 provinces. The plan faced numerous challenges, including strong industry opposition, making UNICEF's backing as a formal member of its permanent advisory committee pivotal. As part of these efforts, UNICEF supported the publication of regulatory standards for healthy school environments and generated evidence on nutritious school meal plans in four of the plan's prioritized provinces.

UNICEF and partners helped advance legislation for front-of-pack labelling in Mexico in 2019. In its advocacy to the legislative branch (responsible for approving reforms to health law), UNICEF generated evidence to influence policymakers and organized a workshop to learn

from the experiences of other Latin American countries that have adopted front-of-pack labelling. UNICEF also worked with the executive branch to modify guidelines to regulate nutrition labelling. As the result, a draft norm was developed with a focus on children, which will be adopted in 2020. Once this legislation is adopted, food labels will be required to warn consumers about excess calories, sugar, sodium, saturated fats, trans fats, and the presence of caffeine and artificial sweeteners. The legislation will also regulate the use of popular characters and cartoons on food products with one or more warning labels.

Building better food systems for children

Food systems determine whether nutritious foods are available, affordable and sustainable, helping to shape the food environments in which children and adolescents live. In 2019, UNICEF supported various policy- and programme-related measures to influence food systems to deliver nutrition results for children. These included advocacy and support for: adequate foods and diets for children in national guidelines; improved food supply chains; public sector policies that foster healthy food environments; and healthy food environments in places where children live, learn, eat, play and meet. Fifty countries received support to implement specific actions to improve food systems for children.

Following a global consultation at the UNICEF Office of Research-Innocenti in 2018 to define a framework on food systems for children, UNICEF reviewed how existing food-based dietary guidelines (FBDGs) seek to address the specific nutrition needs of children, adolescents, pregnant and breastfeeding women. The review provided recommendations on topics that could be considered in future FBDGs and associated guidance, and made recommendations for the development, documentation and presentation of child-centred FBDGs.

As described in Results Area 1, *The State of the World's Children 2019: Children, food and nutrition*,⁹¹ highlights the triple burden of malnutrition and the opportunities for leveraging the food system to deliver better diets for children, adolescents and women. A detailed discussion of UNICEF's approach to food systems is included in the final chapter on systems-strengthening.

In 2019, UNICEF Europe and Central Asia Regional Office organized a regional symposium on food systems, with the participation of children and adolescents from the region. The children shared their opinions and experiences on the food system and identified solutions for improving their dietary choices. Participants proposed applying a child rights approach as a guiding principle in all food systems and nutrition programming.



Ali Abubakar smiles while recovering from severe acute malnutrition at the UNICEF-supported Damazin Hospital Stabilization Centre in Ad-Damazin, the capital of the Blue Nile State in the Sudan.

Results Area 3: Treatment and care of children with severe acute malnutrition

When efforts to prevent malnutrition fall short, early detection, feeding, treatment and care of children with wasting and other life-threatening forms of malnutrition are critical to save their lives and put them back on the path to healthy development.

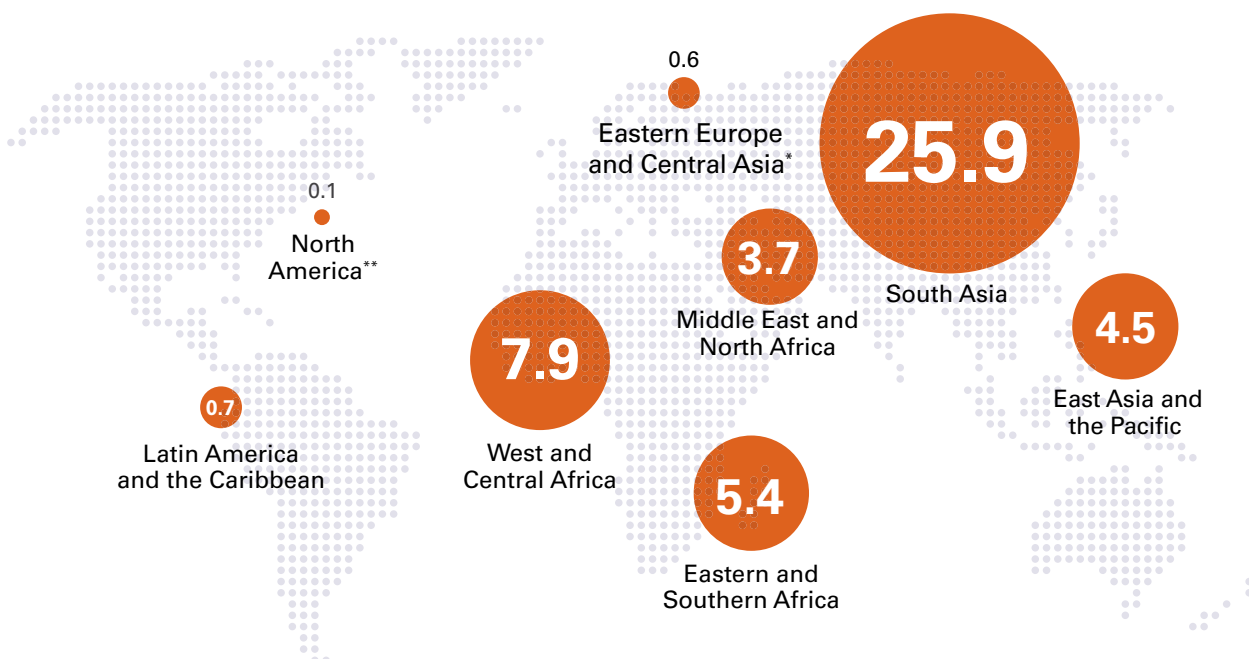
Wasting is the most visible and life-threatening form of malnutrition. Most children affected – 25.9 million – live in South Asia, the global epicentre of wasting (see *Figure 52*).⁹²

The number of children being treated for severe acute malnutrition (SAM)⁹³ has continued to rise in recent years; however, globally, only one in four children with SAM is being reached, in part due to insufficient national investments and limited availability of services. The UNICEF Strategic Plan, 2018–2021 commits to prioritizing the early detection and care of children with SAM in all contexts through Output 3: “Countries have accelerated the delivery of services for the treatment of severe wasting and other forms of severe acute malnutrition.” Under this results area, UNICEF aims to ensure that, by 2021, at least 6 million children with SAM access life-saving treatment and care.

Delivering urgent treatment to wasted children is central to humanitarian response. Countries in humanitarian crisis account for 89 per cent of children accessing SAM treatment globally.⁹⁴ Yet despite the perception of wasting as the result of acute emergencies, two thirds of all children affected by SAM live in non-emergency settings, where poverty is widespread and where basic services, clean drinking-water, and nutritious, safe and affordable diets are out of reach. It is challenging to mobilize resources and national commitments to reach children with SAM in these contexts, leaving far too many children without the urgent care they need.

As with other common childhood illnesses, the early detection and treatment of child wasting should be integrated as part of routine PHC services – delivered through health-care facilities and community-based programmes – to ensure that life-saving services are available to reach all children with SAM, wherever they live.

FIGURE 52: Number (millions) of wasted children under 5, by UNICEF region, 2018



Source: UNICEF et al. (2019).⁹⁵ Notes: * Eastern Europe and Central Asia does not include Russian Federation due to missing data. There is no estimate available for the Europe and Central Asia region or the Western Europe sub-region, due to insufficient population coverage. ** North America estimate based on United States data.



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In a hospital in the Kishim district, in the North of Afghanistan, 10-month-old Fatima is screened by doctors and diagnosed as having severe acute malnutrition. The red colour on the mid-upper arm circumference tape indicates that she is malnourished and in need of treatment.

UNICEF supports nutrition programmes in all 34 provinces of Afghanistan, delivering quality nutrition services for children under 5, adolescents and women in the most deprived regions.

Outcome and output indicators for treatment and care of children with severe acute malnutrition

FIGURE 53: Outcome results for treatment and care of children with severe acute malnutrition, 2019

Outcome indicator (+ key United Nations partners)	Baseline	2018 value	2019 value	2021 target
1.17. Percentage of children with severe acute malnutrition:				
(a) who are admitted for treatment and default ⁹⁶	(a) 7.8%	(a) 8.4%	(a) 7.4%	(a) <15%
(b) who are admitted for treatment and recover, through UNICEF-supported programmes (FAO, WFP, WHO) ⁹⁷	(b) 85.8%	(b) 82.2%	(b) 88.2%	(b) >75%

Notes: FAO, Food and Agriculture Organization of the United Nations; WFP, World Food Programme; WHO, World Health Organization.

FIGURE 54: Output results for treatment and care of children with severe acute malnutrition, 2019

Output indicator	Baseline	2018 value	2019 value	2019 milestone	2021 target
1.e.1. Number of children with severe acute malnutrition (SAM) who are admitted for treatment ⁹⁸	4.2 million	4.1 million	4.9 million	5 million	6 million
1.e.2. Number of countries that provide care for children with SAM as part of an essential package of regular health and nutrition services for children	24	24	27	14	25

Improving services and community demand

Delivering life-saving treatment and care

UNICEF prioritizes the early detection and treatment of children with SAM as an essential intervention to help severely undernourished children survive and thrive, in both development and humanitarian contexts. In 2019, UNICEF supported the scale-up of services to treat and care for children with SAM in 69 countries across all seven regions. With UNICEF support, almost 5 million children were reached with therapeutic feeding and care, compared with 4.1 million in 2018 (SP1.e.1). UNICEF aims to increase this number to 6 million able to access treatment annually by 2021.

The indicators of programme performance and quality in the detection and treatment of children with SAM (at the aggregate global level) have improved steadily in recent years. Of the children admitted for treatment of SAM, 88 per cent fully recovered in 2019 compared with 82 per

cent in 2018. This result also exceeds the quality targets set in the Strategic Plan (SP1.17(b)).

UNICEF is the leading global procurer of ready-to-use therapeutic foods (RUTF) to treat children with SAM, procuring an estimated 75–80 per cent of RUTF globally.⁹⁹ Most RUTF is sourced from programme countries, in line with the UNICEF supply objective to use local products and improve access to supplies at country level.

Increasingly complex humanitarian crises occurred during the first two years of the current Strategic Plan, including those characterized by food crises and near-famine conditions that left children without adequate diets, contributing to their nutritional vulnerability. In the context of humanitarian crises and fragile contexts, 4.1 million children with SAM were treated in 2019, compared with 3.4 million in 2018.¹⁰⁰ Of these children, 93 per cent fully recovered. With the support of implementing partners, UNICEF ensured the delivery of nutrition services to detect and treat children with SAM during complex, protracted humanitarian crises in 2019, such as Somalia, South Sudan (see *Case Study 9*) and Yemen.

CASE STUDY 9: South Sudan: Expanding access to care and reaching the most vulnerable

Protracted conflict, food insecurity, poor quality and diversity of food, infections such as malaria and diarrhoea, and limited access to basic health and nutrition services continued to drive acute malnutrition in South Sudan. In 2019, some 259,700 children under 5 were estimated to suffer from severe acute malnutrition (SAM). In 2019, UNICEF and partners reached 15 per cent more children with treatment for SAM than the previous year, through the scale-up of treatment sites, improved training for health workers and expanded outreach to the most vulnerable populations.

UNICEF collaborated with more than 40 implementing partners and government authorities to increase the number of outpatient nutrition sites from 858 in 2018 to 1,145 in 2019. This increase can be attributed to improved physical access, especially in Jonglei, Unity, Lakes and Western Equatoria states, which allowed for more community screening and active case finding. Ready-to-use therapeutic foods and other essential nutrition supplies were pre-positioned during the dry season, which eliminated stock-outs at treatment sites and ensured that services continued to be delivered to children without disruption.



Fourteen-month-old Adut plays with UNICEF nutritionist Jesca Wude Murye. Adut has just been discharged from the UNICEF-supported outpatient therapeutic programme in Aweil, South Sudan, after eight weeks of treatment and care for severe acute malnutrition. She is now continuing her recovery through the targeted supplementary feeding programme. "Prolonged food insecurity in South Sudan not only affects the quantity but the quality of food that children are eating. For young bodies to grow and develop, they need a plethora of minerals and vitamins. But when food insecurity is high, you eat what you can get."

The expansion in treatment sites corresponded with a significant increase in the coverage of care for children with SAM in South Sudan, from 77 per cent in 2018 to 91 per cent in 2019, reaching 237,120 children in 2019 compared with 206,670 in 2018. The quality of SAM treatment also improved, with 91 per cent of children successfully recovering compared with 88 per cent the previous year.

Quarterly assessments and star ratings of nutrition facilities were a significant innovation in 2019 that motivated nutrition facilities to continuously improve quality. A scorecard assessed the performance of non-governmental partners and prioritized those requiring support. Nutrition facilities were provided with tools, equipment, trained personnel and other aspects of programme quality for better and consistent nutrition service delivery.

The rise in treatment coverage and quality is linked to a substantial increase in the number of trained front-line health-care providers. UNICEF trained more than 3,700 health and nutrition workers to provide treatment services in South Sudan, compared with about 2,830 trained in 2018. UNICEF also employed a team of 22 dedicated nutrition monitors across the 10 states to conduct programme monitoring, on-the-job mentorship and supportive supervision as part of the continuous quality improvement project, which contributed significantly to these improvements.

With the World Food Programme, the Food and Agricultural Organization of the United Nations and civil society partners, UNICEF conducted 32 integrated rapid response missions in South Sudan in 2019. These missions reached vulnerable children and women in remote locations and were a critical tool for improving treatment equity in treating and preventing SAM-related mortality. In 2019, these missions helped screen 63,750 children for malnutrition (more than 100 per cent of target). In addition, 47,600 pregnant and breastfeeding women, and more than 11,000 men received counselling on early childhood nutrition (more than 100 per cent of target).

Strong coordination and a clear emergency preparedness plan contributed to timely rapid response missions in flood-affected areas. UNICEF provided technical support and supplies to partners in Jonglei to re-establish temporary SAM treatment sites and outreach services. In partnership with the United Nations High Commissioner for Refugees and civil society partners, UNICEF also supported the early identification and treatment of more than 4,060 children with SAM in nine refugee camps.

UNICEF supported a bottleneck analysis of SAM treatment services in 2019 across all 10 states, which showed that programme utilization, continuity and quality (based on the number of children treated over those in need) were low. It also revealed geographical access as an important bottleneck in specific locations, which will be addressed through further outreach or rapid response missions to those communities.

In South Sudan, UNICEF and partners faced some resistance from local authorities during rapid response missions, which has caused mission delays and cancellations. United Nations agencies are negotiating with local authorities to reduce these barriers.

In non-humanitarian contexts, UNICEF supported governments to scale up care for children with SAM, advocated for greater investments and commitments from governments to make SAM prevention and treatment a priority, and strengthened health systems to better reach the most vulnerable children (*see 'Building stronger institutions'*).

With UNICEF support, many countries are expanding and strengthening the number of services provided through their programmes to detect, care for and treat children with wasting. According to the latest estimates, the number of countries doing early detection, screening and referral at the community level increased from 56 to 79; the number of countries reporting care for children with moderate acute malnutrition (MAM) in addition to services for children with SAM rose from 49 to 69; the number of countries providing outpatient care for children with SAM increased from 72 to 82; and the number of countries providing inpatient

treatment for children with SAM and medical complications rose from 76 to 91.¹⁰¹

In 2019, in coordination with Nutrition Cluster partners, UNICEF supported the scale-up of Yemen's programme for community management of acute malnutrition. National coverage of the outpatient treatment programme for children with SAM rose from 83 per cent in 2018 to 89 per cent by the end of 2019. More than 343,300 children were enrolled for treatment during the year through mobile and fixed outpatient sites, surpassing the annual target. The number of children treated through the programme increased by 23 per cent from 2018. In 2019, of the children treated, 86 per cent successfully recovered; however, further work is needed to address gaps in geographic coverage in some governorates. To better integrate care and psychosocial support in the treatment of children with SAM, training materials were developed and used in nutrition centres to help staff ensure that children

displaying signs of psychosocial distress were referred to social workers. Hygiene kits and water filters were also made available to caregivers and children in the programme to enable them to practise good hygiene at household level and support positive family practices.

In collaboration with other United Nations agencies, UNICEF supported the scale-up of services to treat children with SAM during the humanitarian crisis in Chad. The number of children able to access treatment services increased from about 257,100 in 2018 to more than 368,500 in 2019, exceeding the 2019 target. Improved access to treatment was linked to the expansion of services, as 60 new outpatient services were opened within existing health centres and two therapeutic units were established in hospitals to treat children with SAM and medical complications, bringing the total to 786 service points from 724 in 2018. Treatment was integrated with the promotion of optimal IYCF practices and HIV testing. To facilitate this service expansion, UNICEF supported the training of more than 1,890 health agents and CHWs and helped deploy a network of consultants in the provinces to provide supportive supervision. As part of joint programming with WASH, UNICEF provided more than 73,800 caregivers with hygiene kits (100 per cent of target) and access to safe drinking-water and sanitation within outpatient treatment centres for children with SAM.

Spotlight on innovations: Leveraging technology to inform programme design and monitoring in Malawi

To strengthen the implementation, effectiveness and focus of UNICEF Malawi programmes in the response to Cyclone Idai, UNICEF used real-time data collection, geo-information and satellite imagery to inform programme design. The Rapid Pro-based nutrition commodities tracking system was scaled up nationally and allowed a continuous supply of ready-to-use therapeutic foods for children with severe acute malnutrition.

With an expansive network of 45 partners across government, United Nations agencies, civil society and donors, UNICEF scaled-up treatment for children with SAM in Somalia,¹⁰² in the context of drought, flooding, food insecurity, and suboptimal child feeding and care practices. To respond to the dire situation, UNICEF pre-positioned life-saving supplies, such as RUTF, in flood-affected areas with the support of the Ministry of Health and implementing partners to facilitate continuous service availability. Through 650 mobile and static sites, UNICEF provided care and

treatment to more than 192,700 children with SAM, reaching 93 per cent of all children affected in the country. Most of the children treated came from areas projected to have global acute malnutrition rates above the 15 per cent emergency threshold, underscoring UNICEF's effectiveness in prioritizing SAM services to the areas of greatest need.

Leveraging community-based approaches to identify and treat children with SAM

UNICEF works with governments to decentralize care to the community level to reach more children with SAM by ensuring that RUTF can be distributed through local health centres and that children can be cared for within their own communities. When CHWs and caregivers are trained to screen and identify children with acute malnutrition, they contribute to early detection and treatment, which can prevent deterioration and further medical complications if treatment is sought early.

The United Nations first endorsed the community-based management of SAM in 2007 as the recommended approach for treating children with uncomplicated cases of SAM within the community. The number of countries implementing such community approaches continues to rise, increasing from 56 to 66 according to the most recent 2018 estimates. Of these, 62 are using mid-upper arm circumference (MUAC) screening and referral for malnutrition, compared with 30 the previous year; 57 are tracking community cases (including defaulter tracing and follow up on referrals), compared with 29 the previous year; in 34 countries, the treatment of SAM is provided by community-based health workers, compared with 19 the previous year.

The scale-up of community-based screening in Afghanistan has highlighted the value of community innovations and engagement. UNICEF and the Government developed the capacities of more than 15,000 mothers and caregivers in Herat, equipping them with MUAC tapes, and measurement and referral skills. As a result, the proportion of children with SAM admitted to treatment programmes in the country tripled.

These community innovations hold promise for reaching more children with care earlier than might otherwise be possible. In Eastern and Southern Africa, Madagascar and Somalia are leading in this approach. The Government of Somalia endorsed guidelines on the integrated management of acute malnutrition, which include a revised and simplified protocol emphasizing community management. The final protocol was disseminated and will be followed by country-wide cascade training of health workers in 2020. Data show that SAM treatment services in Somalia have consistently reached more girls than boys, a startling trend given that similar proportions of boys and girls are screened for SAM and assessments show that boys are more malnourished than girls. The strategy and protocol provide an important avenue for addressing the gender disparities engrained in current access to SAM services, including a gender analysis and tailored

approaches to address equity gaps. The new simplified protocol will also help engage men as decision makers at household level who can impact access to services.

Building stronger institutions

Strengthening health worker capacities to treat more children with SAM

UNICEF invests in strengthening the skills and capacities of health workers, in facilities and communities, to improve care for children with SAM. This includes developing curricula, providing training and supervision, and strengthening protocols for managing SAM as part of a continuum of care to support children's growth and development. Pre-service and refresher training for health workers should include the detection and treatment of SAM in children as part of integrated approaches to the management of common childhood illnesses.

Skilled health workers were key to the scale-up of services to detect and treat children with SAM in Pakistan. Working with the Government, UNICEF supported the treatment of 266,700 children with SAM through an expanded network of more than 2,170 treatment sites. These sites were supported by 15,260 service providers, trained by UNICEF, who contributed to a reduction in the death rate to less than 1 per cent.

UNICEF worked with the Government of Mali and partners to develop the capacities of communities and health districts to maintain therapeutic centres nationwide for the care of children with SAM. This involved building the capacities of front-line health workers, supporting early detection, and ensuring adequate RUTF supplies. Overall, 76 per cent of children with SAM were treated in 2019, compared with only 53 per cent in 2018. Many of these children were cared for at the most decentralized level by CHWs, bringing services closer to communities to limit dropout. To facilitate this outreach, more than 1,900 health workers and CHWs were trained on the national protocol to further decentralize treatment to communities and expand coverage and quality of services.

Through systems-strengthening and investments in building the capacities of health workers, UNICEF helped elevate the care of children with SAM higher on the national priority agenda in Tajikistan. As the result of training to improve the capacities of health workers, active case finding increased the number of children admitted for SAM treatment by 21 per cent from 2018, and 93 per cent from 2016. UNICEF technical and financial support, including for the procurement of RUTF, enabled a 32 per cent increase in the coverage of SAM services across the country. At the same time, persistent challenges – such as the lack of therapeutic food, insufficient capacities of health workers, and lack of caregiver information on the prevention and treatment of malnutrition – have meant that most children with SAM are treated in hospitals and only a small proportion of those in need are accessing treatment.



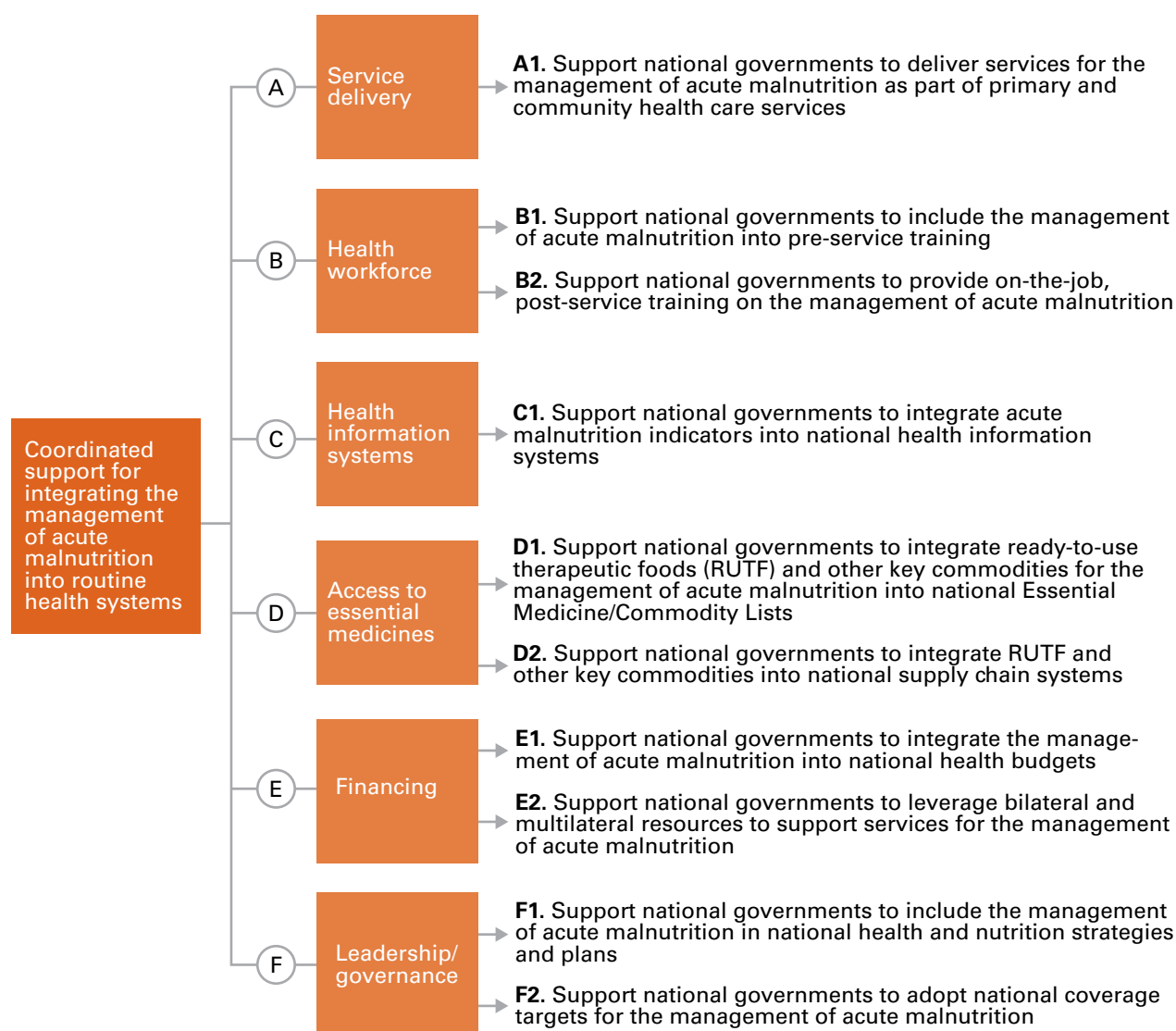
The UNICEF nutrition outreach mobile team reaches vulnerable families in Aleppo, Syrian Arab Republic. Through door-to-door visits, the team screens children under 5 for malnutrition and refers those with acute malnutrition to the nearest health centre. The team also provides support to caregivers to improve infant and young child feeding practices.

Integrating the care of children with SAM into routine primary health care

UNICEF supports governments in integrating the early detection and treatment of children with SAM into routine PHC services. Integration is a sign of government ownership in tackling malnutrition: it is an indication that treatment services are resourced – at least partially – through domestic budgets and are accessible as part of routine health services for children, managed primarily by the Government rather than humanitarian actors. UNICEF is tracking the number of countries that provide care for children with SAM as part of an essential package of regular health and nutrition services for children (SP1.e.2). Twenty-seven countries provided these integrated services in 2019, compared with 24 in 2018, and surpassing the 2021 target of 25 countries.

In line with the universal health coverage agenda, services for the early detection and treatment of SAM should be universally available and accessible to all children to ensure their survival and development. The integration of these services into routine health systems is the most effective and sustainable path for achieving this. Such integration requires coordinated support to strengthen service delivery, workforce capacity, supply and other factors (*Figure 55*). UNICEF supports governments to address these factors with a focus on the most vulnerable children. According to the most recent estimates, 27 countries reported zero stock-outs of RUTF; 32 countries had a pre-service national curriculum for health-care professionals on the community-based management of children with SAM; 43 countries had RUTF on their essential medicines list; and 86 countries provided treatment to children with SAM free of charge.

FIGURE 55: The building blocks of integrated care for children with SAM through health systems



In 2019, India made strategic investments in institutional capacity to reach more children with SAM. A strategic approach was developed on strengthening facility-based SAM care, and UNICEF supported the development of protocols to treat infants under 6 months of age, provide structured stimulation and play therapy, and improve maternal nutrition and the care of children with SAM in paediatric wards. Guidelines for community- and facility-based SAM care have been drafted and are awaiting government finalization and approval. With UNICEF support, 10 states have identified, initiated or strengthened centres of excellence to scale up services for the management of children with SAM at facility and community levels.

The care of children with SAM is fully integrated within routine health services in Burundi, Kenya and Malawi. Through programme scale-up in Burundi in 2019, at least 60,800 children with SAM received life-saving treatment (96 per cent of target). To support this scale-up, services were delivered through 583 facilities across the country, compared with 418 in 2018, and exceeding the target of 430, with the support of UNICEF and global thematic funding from the Netherlands. In the Philippines, significant investments were made in 2019 to integrate care for children with SAM into routine health services, as the result of UNICEF advocacy (*see Case Study 10*).

CASE STUDY 10: The Philippines: Integrating care of children with SAM in routine health care systems

The Philippines was one of the first countries in the East Asia and Pacific region to commit to the integration of services for children with SAM into the routine health system. This included allocating an average of US\$3 million in its annual investment plans for the scale-up of treatment services for children with severe acute malnutrition (SAM).

The Philippines has seen significant progress on reducing the prevalence of child wasting – from 8.1 per cent in 2013 to 5.6 per cent in 2018 – and is on track to achieve the global nutrition target for wasting. The Department of Health generally attributes the decrease in wasting prevalence to (1) the use of locally generated evidence on implementation, (2) supportive leadership and (3) consensus around the importance of integrating services to treat children with SAM into the health system. Through protocols such as the national guidelines for the Philippine Integrated Management of Acute Malnutrition (PIMAM) and the Manual of Operations for the management of SAM and moderate acute malnutrition (MAM), the national Government has been procuring life-saving commodities to treat children with SAM, with the aim of gradually expanding to nationwide coverage.

With the programme now in its fourth year, UNICEF provided technical assistance to the Department of Health to strengthen capacities and services, improve programme planning and develop a health benefit package for the integration of SAM treatment into the National Health Insurance Programme. UNICEF also led the integration of training modules on SAM and MAM in partnership with the World Food Programme. The integration of the two training modules allowed the Department of Health to effectively strengthen the capacities of local government programme officers and front-line workers using a holistic approach.

Technical assistance to ensure high-quality training and offer mentoring support was provided by UNICEF partner, Kalusugan ng Mag-Ina (Health of Mother and Child). Fifty SAM and PIMAM training courses were conducted in 2019, covering 71 provinces and 10 cities, improving the skills and knowledge of more than 1,520 programme managers and primary health-care providers to detect and treat children with acute malnutrition. In addition, in 2019, UNICEF also supported the capacity development of 35 trainers and 880 service providers.

By strengthening existing systems, improving the policy and enabling environment, and demonstrating proof of concept, UNICEF hopes to address or mitigate gaps and thus further improve access to treatment for Filipino children with SAM through the full integration and delivery of quality nutrition services in communities and at health-care facilities. UNICEF, together with University of the Philippines Los Baños Foundation, conducted the country's first Bottleneck Analysis for SAM in 2019, identifying key indicators and adapted tools for collecting data. The findings have been used as a primary reference in drafting the PIMAM Strategic Plan – a core document that will improve the integration of treatment services into routine health systems.

In the context of food insecurity, rising food prices, disease outbreaks and chronic vulnerabilities in Ethiopia, UNICEF provided technical support to revise the national guidelines on the management of acute malnutrition in line with WHO standards. UNICEF supported the integration of care for children with MAM into the routine health system at health-care facility level in 100 woredas. Substantive steps were taken to transition supply management to the Ethiopian Pharmaceutical Supplies Agency, which will support a more government-led distribution of nutrition supplies in emergency and non-emergency settings. With these strengthened systems, the Government provided services to treat children with SAM in 95 per cent of all health-care facilities in the country.

The integration of care for children with SAM within PHC also facilitates better linkages with other routine services for young children, including HIV screening. In Guinea-Bissau, for example, UNICEF promoted the integration of SAM treatment and care with HIV testing through Nutritional Rehabilitation Centres. All 69 Nutritional Rehabilitation Centres in the country offered routine HIV testing for children in 2019. By the end of the year, nearly 700 children under 5 in these centres had been tested for HIV, of which 23.6 per cent were found HIV-positive. To sustain this approach, UNICEF supported the training of health workers within Nutritional Rehabilitation Centres and antiretroviral treatment (ART) sites on SAM treatment and ART protocols.

In Cameroon, UNICEF partnered with the Ministry of Public Health to strengthen the nutrition supply chain, build health workers' capacities and integrate the care of children with SAM into the health system. As part of the scale-up of services in 2019, the number of UNICEF-supported health centres providing treatment services increased to 839, from 796 in 2018. More than 79,200 children with SAM (120 per cent of target) received life-saving treatment in 2019, including more than 3,150 refugee children, with support and coordination by UNICEF and the United Nations High Commissioner for Refugees (UNHCR). Ninety per cent of children recovered. UNICEF also supported the implementation of the 'Wash-in-Nut' strategy which helped to reach 15,000 families with children affected by SAM with appropriate information on hygiene, sanitation practices and WASH kits.

Leveraging budgets for better care for children with SAM

Integrating the early detection and treatment of children with SAM in national health services requires dedicated financing to procure supplies and provide therapeutic care and follow-up. UNICEF supports governments in mobilizing resources and allocating budgets for these commodities and services. Of the 69 countries implementing programmes to detect and treat children with SAM with UNICEF support, 45 are providing domestic funding to support them, beyond staff salaries. In Cambodia, for



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Fatima Saidu plays with her 20-month-old baby Ibrahim Mohammed who was admitted to a therapeutic feeding centre in the University of Maiduguri Teaching Hospital for treatment of severe acute malnutrition and acute watery diarrhoea. Maiduguri, the capital of Borno state, continues to bear the brunt of conflict with terrorist group Boko Haram. This year, in the northeast of Nigeria, UNICEF estimates that more than 360,000 children will suffer from severe acute malnutrition due to food scarcity, displacement and the spread of disease. This hospital is a lifeline for the most severe cases.

example, UNICEF conducted advocacy and facilitated budget negotiations among the social sector and finance ministries, resulting in a 6 per cent increase in budget allocations for RUTF procurement in 2019 over the previous year.

UNICEF generated evidence and advocated for developing a road map for the integration of care for children with SAM into the national budget in the Niger. This enabled the creation of a dedicated government budget line of US\$1.5 million in the 2020 budget for the procurement of RUTF. In its technical support to the Nigeriens Nourish Nigeriens initiative, UNICEF facilitated a nutrition budget tracking analysis to enhance domestic investment in nutrition interventions. UNICEF also participated in advocacy efforts led by the European Union (EU), which led to the Government's unprecedented decision to allocate a budget line to purchase nutrition supplies for the treatment of children with SAM in 2019.

In Mali, the early detection and treatment of SAM has been gravely underfunded. UNICEF commissioned a budget analysis in 2019, which showed that a mere 0.7 per cent of government spending was allocated to nutrition. In this context, UNICEF, the EU and European Commission Humanitarian Office (ECHO) advocated for greater government investments in the detection and treatment of children with SAM. Together, the EU, ECHO and UNICEF provided support to strengthen the integration of SAM care into the health system, including the inclusion of RUTF in the master supply plan and an increase in the Government's allocation to nutrition-specific activities. Negotiations with the Government of Mali resulted in €8 million being allocated by the Government for nutrition. UNICEF will build on this successful experience to engage in advocacy with other partners in Mali to leverage more public finance for children.

Strengthening national supply chains

Strong national supply chains are critical to delivering life-saving therapeutic supplies in a timely manner to the children who need them. UNICEF helps governments improve their supply systems to reach more children with SAM, even in the most remote and fragile settings. In 2019, thirty countries had RUTF and other essential nutrition supplies fully costed in national health budgets, up from 28 in 2018. In Kenya, for example, RUTF was integrated within the government supply chain, contributing to keep essential supplies in almost all health-care facilities – 97 per cent – without stock-outs of nutrition commodities (target: 94 per cent).

In the Sudan, investments in improving the supply chain and logistics allowed UNICEF to establish fixed and mobile health and nutrition outpatient treatment centres to treat more children with SAM. Responding to an expected increase in the number of children with SAM from 250,000 in the previous three years to 300,000 in 2019, UNICEF mobilized more resources to secure the nutrition supply pipeline and provide essential drugs and kits for the

management of acute malnutrition, which resulted in zero stock-outs of nutrition supplies in 2019. With this improved supply management, 260,000 children with SAM were treated through the UNICEF-supported community-based treatment programme (up from 244,000 in 2018), and more than 91 per cent recovered. Economic and political challenges in 2019 made it impossible for the Ministry of Health to allocate resources from the government budget. In response, UNICEF mobilized support from key donors to ensure RUTF needs for the year were met. To prevent stock-outs, the Ministry of Health and UNICEF established a buffer reserve of RUTF, allowing centres to maintain the uninterrupted provision of life-saving services for children with SAM.

Responding to a shortfall of RUTF in Afghanistan, UNICEF is testing a new protocol with a revised dosage of RUTF to treat children with SAM. The revision aims to reduce the amount of RUTF needed for a child to recover by one third. Preliminary analysis of data generated in locations piloting the protocol indicate that lower amounts of RUTF used for treatment may facilitate similar outcomes to standard protocols.

Leveraging collective action

Partnerships and coordination to put SAM on the global agenda

In 2019, UNICEF led global efforts towards a paradigm shift in addressing child wasting over the next decade, supported by global thematic funds. As a result of this leadership and advocacy, and with the collaboration of partners, the United Nations Secretary-General called for United Nations agencies working on nutrition (FAO, UNHCR, UNICEF, WFP and WHO) to prepare the first Global Action Plan (GAP) on Child Wasting.¹⁰³ The Plan aims to respond to the slow progress in achieving the SDG target on reducing childhood wasting, and to growing calls for a more coordinated and streamlined United Nations approach. The decision to develop the GAP was fuelled in part by the momentum created by the former No Wasted Lives coalition.

UNICEF will lead the development of the GAP road map for action, supporting countries to implement context-specific commitments for reducing child wasting. To support implementation, UNICEF launched a new five-year partnership with United Kingdom Department for International Development (DFID; US\$40 million) to accelerate action across 10 countries in Africa and Asia. A new partnership with WHO was also developed to drive the integration of innovative actions for the prevention and treatment of wasting into global normative guidelines and national policy and practice. For example, the treatment of children with SAM by CHWs has the potential to improve service coverage, while ensuring that children receive quality, effective treatment when they need it.



A child waits in the queue to be weighed and screened for acute malnutrition at the Nakapelimoru Health Centre in Karamoja, Uganda. Weight and mid-upper arm circumference are measured and recorded in the register and children leave when their test results are green. At discharge, caregivers receive counselling and support on child feeding and care practices.

Nutrition financial report*

**All funding data as of 6 April 2020, pending audit and certification.*

Financial resources to support nutrition work grew to US\$687 million in 2019, from US\$674 million in 2018 (see 'Expenses for nutrition in 2019', below).

This section presents a financial picture of revenue and expenditures in 2019, including: total revenue for UNICEF in all sectors; resources for nutrition; expenditures for nutrition; future funding gap; and a description of the value for money offered by UNICEF nutrition programmes.

For a full overview of UNICEF revenue and contributions in 2019, see Annex 1.

Nutrition income in 2019

FIGURE 56: Nutrition 'other resources – regular' contributions, 2014–2019

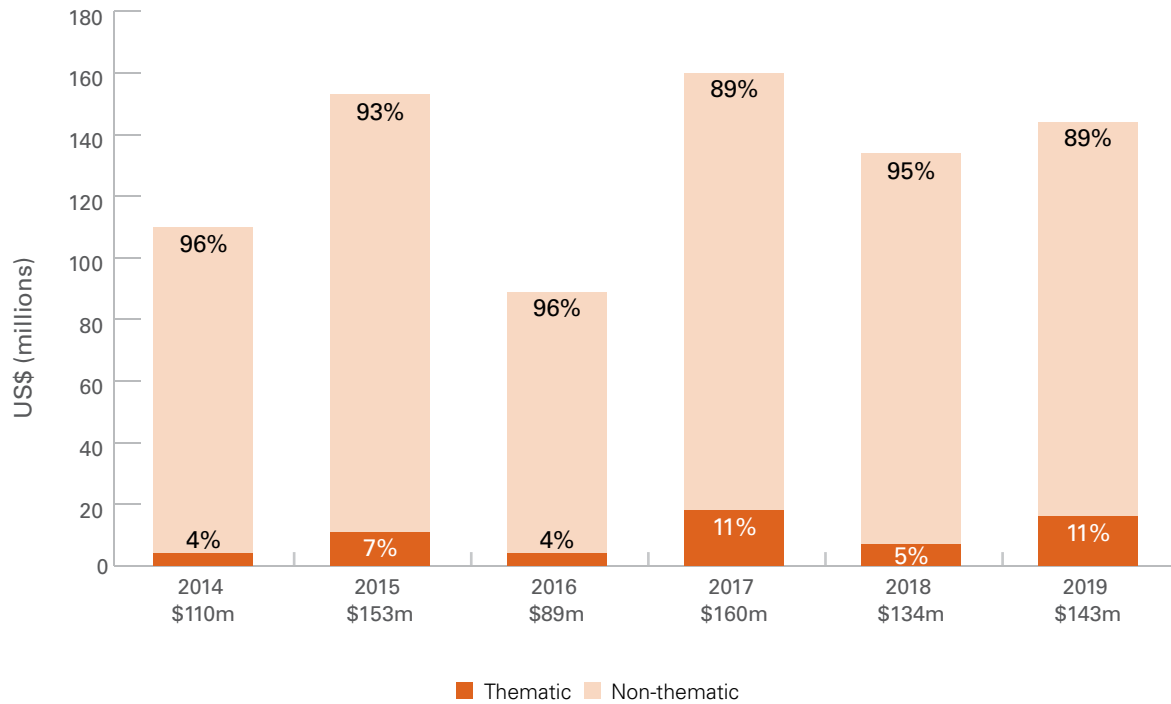
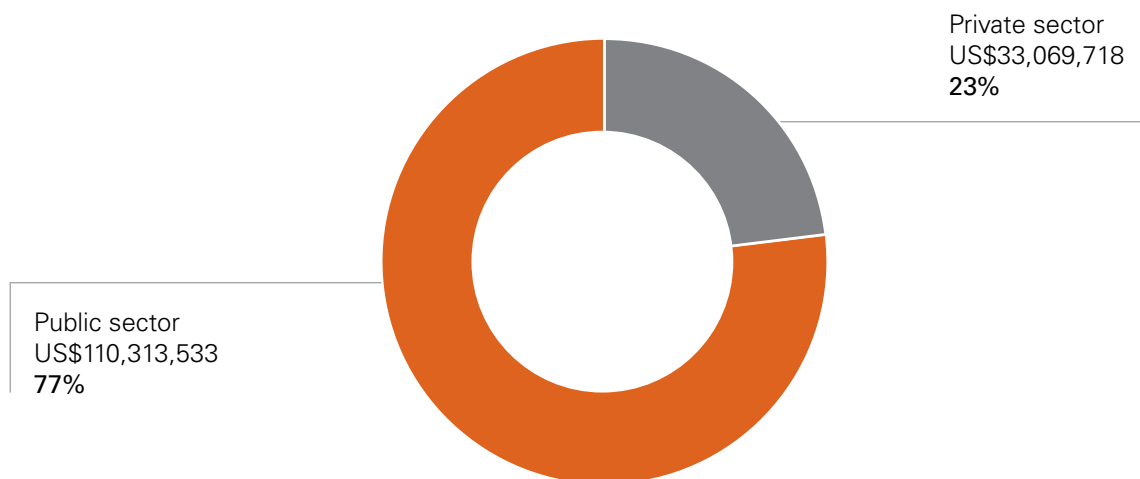


FIGURE 57: Total Nutrition funds received by type of donor, 2019: US\$143 million



In 2019, partners contributed US\$143 million 'other resources – regular' for nutrition, a 7 per cent increase over the previous year. Public sector partners contributed the largest share of 'other resources – regular' to nutrition, at 77 per cent. The top five resource partners to UNICEF nutrition in 2019 were the World Bank, the European Commission, and the governments of Germany, the

Netherlands, and the United Kingdom (*see Figure 58*). The largest contributions were received from the World Bank for the Emergency Crisis Response Project and the health and nutrition crisis in Yemen, and from the Government of Germany for Building Resilience in the Sahel (*see Figure 59*). (*See the results section of the report for further details.*)

FIGURE 58: Top 20 resource partners to Nutrition by total contributions, 2019

Rank	Resource partners	Total (US\$)
1	World Bank*	346,259,683
2	Germany*	60,991,304
3	European Commission*	28,266,627
4	United Kingdom	25,171,792
5	Netherlands	14,500,000
6	UNFPA-managed UN Partnerships and Joint Programmes*	12,178,558
7	UNDP-managed UN Partnerships and Joint Programmes*	11,924,648
8	U.S. Fund for UNICEF	9,253,840
9	United Kingdom Committee for UNICEF	8,115,001
10	Nutrition International	6,284,802
11	United States	4,573,732
12	Nigeria	4,064,293
13	German Committee for UNICEF	3,310,401
14	Danish Committee for UNICEF	2,795,511
15	FAO**	2,380,789
16	Swedish Committee for UNICEF	2,180,431
17	Sweden	2,056,808
18	Republic of Korea*	2,018,018
19	Swiss Committee for UNICEF	1,518,225
20	United Nations Joint Programme	1,461,538

* Includes cross-sectoral grants SC190011 (Nutrition, Education, WASH), SC170533 (Health, Nutrition, WASH), SC170314, SC181116, SC190305 (Health, Nutrition, Social Inclusion), SC170579, SC180970, SC181209, SC180682, SC190340, SC190578 (Health, Nutrition), SC190614 (Health, Nutrition, Safe and Clean Environment), SC181205 (Health, Nutrition, Education, WASH, Safe and Clean Environment, Gender Equality), SC190741 (Health, Nutrition, Education, Child Protection, WASH)

**Including pass-through funding from European Commission

FIGURE 59: Top 20 grants to Nutrition, 2019

Rank	Grant description	Resource partners	Total (US\$)
1	Third Additional Financing for Yemen Emergency Crisis Response Project*	World Bank	139,182,077
2	Fourth Additional Financing for the Yemen Emergency Crisis Response Project*	World Bank	67,941,375
3	Third additional financing for Emergency Health and Nutrition Project, Yemen*	World Bank	40,231,800
4	Second additional financing for Emergency Health and Nutrition Project, Yemen*	World Bank	31,726,169
5	Second Additional Financing for Yemen Emergency Crisis Response Project*	World Bank	30,920,286
6	Building Resilience in Sahel (Mali, Mauritania, Niger)*	Germany	25,082,508
7	Maternal and Child Nutrition Programme, Kenya	United Kingdom	12,874,797
8	Joint Programme on Saving Lives, Sierra Leone*	UNFPA – managed UN Partnerships and Joint Programmes	12,178,558
9	United Nations – DFID KP Merged Districts Joint Programme (KPMD), Pakistan*	UNDP – managed UN Partnerships and Joint Programmes	11,924,648
10	Strengthening Community Resilience in South Sudan Urban Settings*	Germany	10,102,495
11	Global Thematic – Nutrition Programme	Netherlands	10,000,000
12	3rd Additional Financing for the Yemen Emergency Crisis Response Project*	World Bank	8,578,190
13	Joint Integrated Resilience WFP – FAO – UNICEF in the Democratic Republic of the Congo	Germany	7,046,514
14	2019 Vitamin A Good Portion	Nutrition International	5,912,452
15	Nutrition, Cameroon	Germany	5,688,282
16	Strengthening Resilience in South Central Somalia	Germany	5,500,550
17	Nutrition, Nepal	European Commission	5,427,304
18	Nutrition, Mozambique	European Commission	4,999,404
19	Karamoja Nutrition Programme – Inception phase, Uganda	United Kingdom	4,804,232
20	Developing Human Capital in Rwanda	Netherlands	4,500,000

* Cross-sectoral grants SC181116, SC190305, SC170314 (Health, Nutrition, Social Inclusion), SC190340, SC170579, SC180970, SC181209 (Health, Nutrition), SC190746 (Health, Safe and Clean Environment), SC181205 (Health, WASH, Safe and Clean Environment, Gender Equality, Nutrition, Education), SC190741 (Health, Nutrition, WASH, Education, Child Protection)

Notes: DFID, Department for International Development (United Kingdom); FAO, Food and Agriculture Organization of the United Nations; WFP, World Food Programme.

UNICEF thematic funds maintain a four-year funding period that covers the entire Strategic Plan period (2018–2021). In the first two years of the Strategic Plan, thematic funding contributions for nutrition reached US\$23 million, with US\$16 million received in 2019, of which more than 71 per cent came from government partners. The Government of the Netherlands was the largest thematic resource partner in 2019, providing more than 63 per cent of all thematic nutrition contributions.

Of all thematic nutrition contributions that UNICEF received in 2018 and 2019, seventy-eight per cent were global-level contributions. These are the most flexible sources of funding to UNICEF after regular resources and can be

allocated across regions to individual country programmes, according to priority needs.

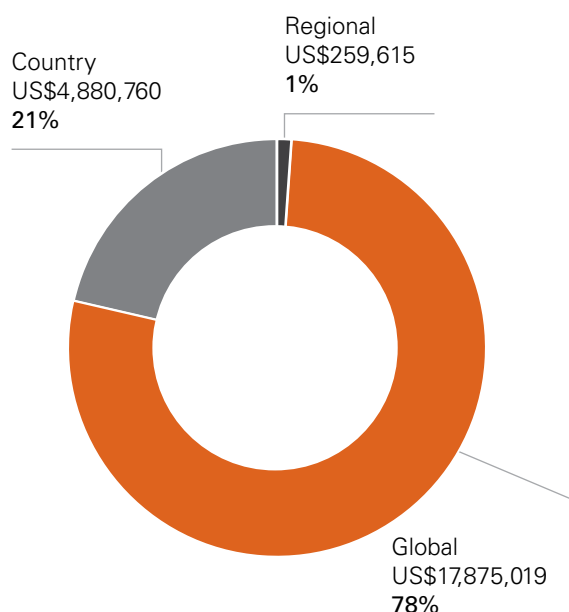
UNICEF is seeking to broaden and diversify its funding base (including thematic contributions) and encourages all partners to give as flexibly as possible. In 2019, nineteen partners contributed thematic funding to nutrition. Sizeable thematic contributions were received from the governments of the Netherlands and Luxembourg and the Swiss Committee for UNICEF for global nutrition thematic funding, while the Government of Sweden provided country-level thematic funding towards nutrition activities in the Sudan (*see Figure 60*).

FIGURE 60: Thematic contributions by resource partners to nutrition, 2019

Resource partner type	Resource partner	Total (US\$)	Percentage of total
Governments 71.37%	Netherlands	10,000,000	63.11%
	Luxembourg	795,455	5.02%
	Sweden	514,233	3.25%
Private Sector 28.63%	Dutch Committee for UNICEF	1,011,913	6.39%
	German Committee for UNICEF	779,314	4.92%
	Swiss Committee for UNICEF	758,326	4.79%
	Polish National Committee for UNICEF	676,179	4.27%
	U.S. Fund for UNICEF	481,758	3.04%
	Danish Committee for UNICEF	230,467	1.45%
	Italian National Committee for UNICEF	229,594	1.45%
	Spanish Committee for UNICEF	111,483	0.70%
	United Kingdom Committee for UNICEF	47,932	0.30%
	Slovak Committee for UNICEF	45,944	0.29%
	Czech Committee for UNICEF	34,560	0.22%
	Turkish National Committee for UNICEF	33,559	0.21%
	Belgian Committee for UNICEF	24,752	0.16%
	Slovenian foundation for UNICEF	23,411	0.15%
	UNICEF Croatia	23,411	0.15%
Hungarian National Committee for UNICEF	23,411	0.15%	
Grand total		15,845,702	100.00%

Notes: Grant numbers are provided for IATI compliance: SC1899030001, SC1899030002, SC1899030014, SC1899030016, SC1899030017, SC1899030018, SC1899030020, SC1899030021, SC1899030022, SC1899030023, SC1899030024, SC1899030025, SC1899030026, SC1899030027, SC1899030028, SC1899030029, SC1899030030, SC1899030031, SC1899030032, SC1899030033, SC1899030034, SC1899030035, SC1899030036, SC1899030037, SC1899030039, SC1899030040, SC1899030041, SC1899030042, SC1899030043, SC1899030044, SC1899030045, SC1899030046, SC1899030047

Figure 61: Nutrition thematic funding contributions at country, regional and global levels, 2018–2019



A second allocation of global thematic funding was made in 2019 to support the prevention of overweight and obesity in children and adolescents in East Asia and the Pacific, the region with the largest burden of overweight and obesity globally. These funds supported the design of regional approaches as well as the work of headquarters in developing global guidance.

Expenses for nutrition in 2019

Overall nutrition spending rose to US\$687 million in 2019, from US\$674 million the previous year. More than half of these funds (US\$387 million) were allocated to support maternal and child nutrition programmes in fragile contexts, including countries in the Horn of Africa, the Sahel, and the Middle East. This includes investments in strengthening national systems and their resilience, where national systems are weak. Spending in the nutrition outcome area was 12 per cent of all UNICEF programme expenses in 2019.

FIGURE 62: Expenses trend for nutrition, 2014–2019 (US\$687 million in 2019)

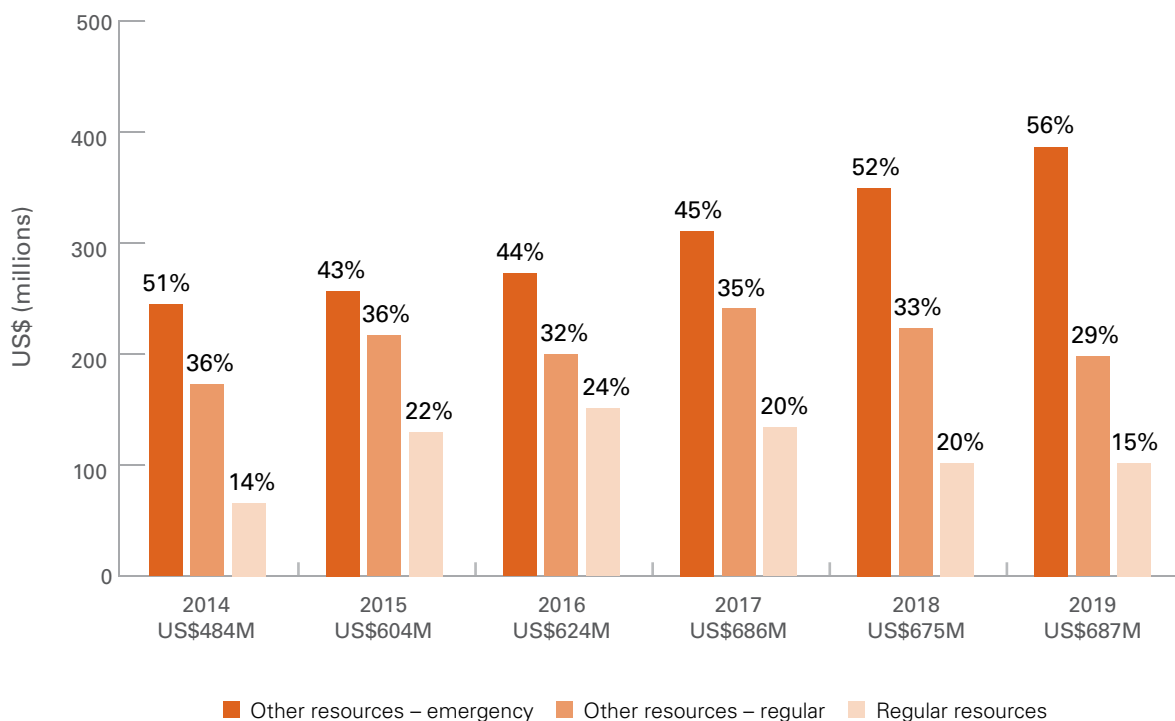


FIGURE 63: Expense by sector, 2019 (total: US\$5.4 billion)

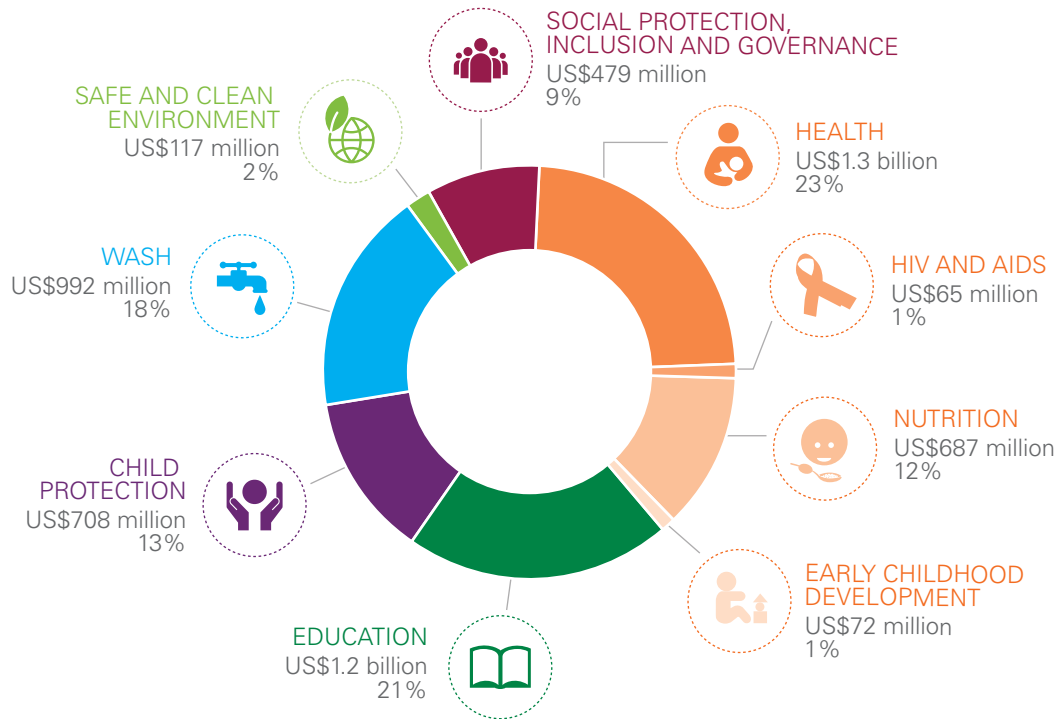
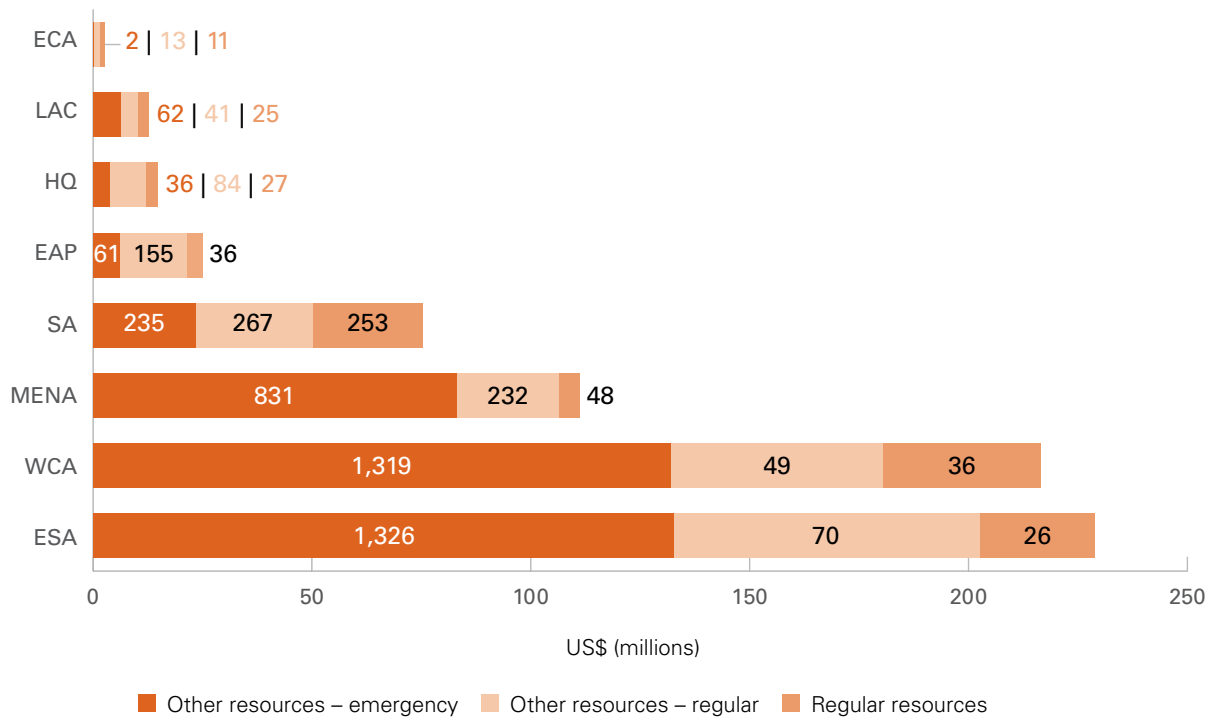


FIGURE 64: Expenses by region and funding source for nutrition, 2019 (total: US\$687 million)



Notes: EAP, East Asia and the Pacific; ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; HQ, headquarters; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; SA, South Asia; WCA, West and Central Africa.

As in previous years, most nutrition spending in 2019 supported programming in Eastern and Southern Africa, West and Central Africa and the Middle East and Northern Africa. This reflects the high burden of undernutrition in these regions, including in the Horn of Africa, the Middle East and the Sahel, and the higher cost of operating in such environments. Greater investments are needed to strengthen the capacity of the national food, health, water and sanitation, education and social protection systems to deliver large-scale nutrition results in low- and middle-income countries. This includes most countries in Asia and Latin America – where the number of children affected by stunting and wasting and the urgency of preventing the emerging overweight and obesity epidemic – is greatest, and resources for prevention of malnutrition in children and women are often limited.

Figure 65 shows the 20 countries with the largest expenses for nutrition in 2019; these countries accounted for three quarters of all expenses for maternal and child nutrition.

Value for money in nutrition

UNICEF reduces programme costs by leveraging domestic funding and the strengths of national systems and partners in different programming contexts both in development and fragile settings, including during humanitarian response. UNICEF programmes prioritize cost-efficiency, and the most effective evidence-informed nutrition interventions, which are both low cost and high impact. For UNICEF, the concept of value for money is deeply connected to principles of equity, ownership and sustainability. Spending in nutrition helps bridge gaps and ensure that the most vulnerable children and women benefit from nutritious diets, essential nutrition services and positive nutrition practices, and that national and sub-national governments increasingly own and drive the nutrition agenda for children and women. It also supports the design and implementation of policies, strategies and programmes that are informed by evidence and are contribute to sustainable development. This approach is the most ethical and has the greatest potential to save lives and ensure children thrive across the life course.

FIGURE 65: Expenses for nutrition – top 20 countries, 2019

Country	Total (US\$)
Yemen	73,261,091
South Sudan	54,285,249
Nigeria	49,427,257
Ethiopia	43,510,176
Democratic Republic of the Congo	43,079,013
Somalia	31,161,058
Chad	27,514,268
Sudan	22,000,769
Niger	21,364,461
India	18,150,999
Malawi	17,231,189
Afghanistan	16,736,201
Kenya	16,557,257
Pakistan	15,714,690
Bangladesh	14,915,032
Mali	14,452,198
Burkina Faso	13,149,708
Uganda	9,591,089
Cameroon	9,565,749
Zimbabwe	8,830,896



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Results: HIV and AIDS

Martha Jere holds her eight-month-old son, Rahim Idriss, at their home in Bilemoni village. Martha was born with HIV in 1996 in Malawi. At the time, an HIV diagnosis was practically a death sentence, especially for children in low income countries. Now 19, and a mother herself, Martha has defied the odds and her son is part of Malawi's AIDS-free generation.

There have been considerable advancements in global HIV responses among children, adolescents and pregnant women over the past decade. For example, from 2010 to 2018 global coverage of antiretroviral treatment (ART) among pregnant women living with HIV nearly doubled, rising from 44 per cent in 2010 to 82 per cent in 2018. Paediatric ART coverage also surged over the same period, from 20 per cent to 54 per cent, and the number of annual new infections among one of the world's most vulnerable

populations, adolescent girls and young women, declined by 25 per cent among those aged 15–24 years. These successes contributed to major improvements in crucial indicators of HIV-related health and well-being for this time period, including a 51 per cent reduction in the annual number of AIDS-related deaths among children aged 0–14 and a 28 per cent reduction for the 10–19 age group.¹⁰⁴

FIGURE 66: Output and outcome indicators for HIV and AIDS, 2019¹⁰⁵

Outcome statement 1: Girls and boys, especially those that are marginalized and those living in humanitarian conditions, have access to high-impact health, nutrition, HIV and early childhood development (ECD) interventions from pregnancy to adolescence.

Impact indicator (sustainable development goal)*	Disaggregaton	Baseline	2017 value	2018 value	2019 value	Target (2021)
E. Estimated rate of AIDS-related deaths (SDG 3.8.1)	Age 0–14	8.08		7.48	6.96	2
	Age 10–19	4.54		4.19	3.83	2
F. Estimated rate of new HIV infections (SDG 3.3.1)	Age 0–14	0.31		0.36	0.34	0.05
	Age 10–19	0.79		0.50	0.47	0.2
Outcome indicators*						
1.18. Percentage of girls and boys living with HIV who receive antiretroviral therapy (SDG 3.8.1)**	Age: 0–14	50%	51%	55%	56%	81%
	Age: 10–19***	68%	N/A	N/A	N/A	81%
1.19. Number of pregnant women living with HIV who receive antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV through UNICEF-supported programmes (SDG 3.3.1)		1,020,0000 (80%)	956,955 (80%)	988,952 (83%)	989,487 (85%)	1,190,000 (95%)

* Except as indicated, data is based on 35 priority countries for HIV. There is a one-year reporting lag. All rates and per centages reflect 2019 revised UNAIDS population data

** Age-sex disaggregated data is not collected or reported through national monitoring systems.

*** Most-recent data for the age group 10-19 years were only available for 13 countries which represent 16 per cent of the adolescent population in the 35 priority countries, and are therefore not representative of the global situation.

FIGURE 67: Strategic Plan output results for HIV and AIDS, 2019

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

Indicator*	Disaggregaton	Baseline	2017 value	2018 value [milestone]	2019 value [milestone]	2020 [milestone]	Target (2021)
1.f.1. Number (and percentage) of infants born to pregnant women living with HIV tested for HIV within their first two months of life		584,000 (42%)	577,967 (49%)	661,986 (57%)	698,204 (62%)		890,000 (64%)
				[700,000] [50%]	[770,000] [55%]	[830,000] (59%)	
1.f.2. Number of adolescent girls and boys tested for HIV and received the result of the last test**	Girls	10.6 million	13.3 million	13.4 million	13.5 million		13.8 million
				[11.5 million]	[12.4 million]	[13.1 million]	
	Boys	7.5 million	9.1 million	9.2 million	9.0 million		9.8 million
				[8.2 million]	[8.8 million]	[9.3 million]	
1.f.3. Number of countries implementing policies and/or strategies for the integration of key HIV/AIDS interventions (HIV testing and counselling, antiretroviral therapy) into child-centred service points and the degree of scale within countries		25	29	35 [27]	35 [29]	[31]	32

Output statement 1.g: Countries have implemented comprehensive HIV prevention interventions at scale*

1.g.1. Number of countries having initiatives to strengthen availability of gender-responsive evidence for the All In framework for prevention of HIV		0	20	23 [5]	25 [10]	[15]	25
1.g.2. Number of countries supporting implementation of at least three high-impact gender-responsive adolescent prevention interventions		25	25	31 [27]	32 [29]	[31]	32

* Except as indicated, data is based on 35 priority countries for HIV. There is a one-year reporting lag. All rates and per centages reflect 2019 revised UNAIDS population data

** While 26 countries reported on girls and 24 countries reported on boys in 2019, the coverage estimate for HIV testing was extrapolated to the adolescent 15-19 population in all 35 countries.

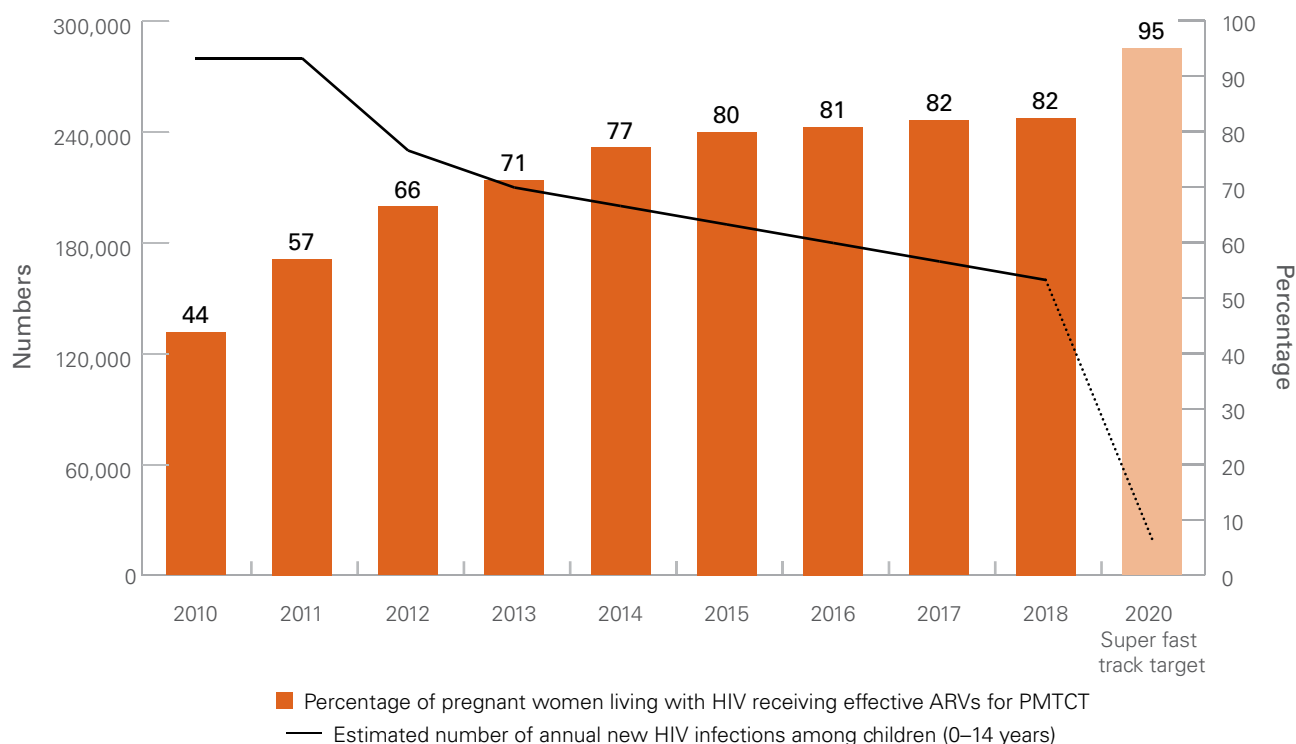
Comprehensive prevention of mother-to-child transmission services, and regional and country-level disparities drove an estimated 160,000 new HIV infections among children (ages 0–14 years) globally in 2018, a rate far too high to reach the Joint United Nations Programme on HIV/AIDS (UNAIDS) super-fast-track target of fewer than 20,000 new infections among children by 2020. While early successes were hopeful, progress has stalled. For example, among pregnant women living with HIV, access to ART rose steeply from 44 per cent in 2010 to 71 per cent in 2013, but since then has increased by only 11 percentage points, to 82 per cent in 2018. The determinants of this stalling include structural and systems barriers hindering access to maternal, newborn, and child health (MNCH) services and HIV services resulting in low ART coverage in pregnant women in the Middle East and North Africa (53 per cent), South Asia (56 per cent) and West and Central Africa (59 per cent).

Similarly, the estimated 310,000 new infections among adolescent girls and young women aged 15–24, is more than three times the UNAIDS super-fast-track target of fewer than 100,000 by 2020 – a special concern given the expected doubling of the adolescent population in sub-Saharan Africa by 2050. Again, there are significant regional

disparities: between 2010 and 2018, the proportion of new infections among adolescents and young people aged 15–24 decreased 23 per cent globally. However, West and Central Africa and Latin America and the Caribbean showed no significant progress, and the Middle East and North Africa and Eastern Europe and Central Asia regions showed significant increases in the number of new infections among adolescents and young people. Globally, the number of new infections for this age group is still five times higher than 2020 super-fast-track targets.

In 2019, the disparities in West and Central Africa elevated UNICEF, the World Health Organization (WHO) and UNAIDS conversations with ministers on health in this region. These conversations resulted in the ‘Dakar Call to Action’, which aims to achieve rapid progress in reducing new HIV infections and deaths among children and adolescents. This commitment was signed by public health leaders, ministries of health, and representatives from partnering agencies from 18 countries in the region. Additionally, UNICEF worked with the Global Fund and the US President’s Emergency Plan for AIDS Relief (PEPFAR) to improve coordination of efforts in the region to ensure allocative efficiency for the work on adolescent girls and young women.

FIGURE 68: Percentage of pregnant women living with HIV receiving most effective antiretroviral medicines for preventing mother-to-child transmission (PMTCT) and new HIV infections among children (0–14 years), 2010–2018



Source: Global AIDS monitoring and UNAIDS 2019 estimates. Notes: ARV, antiretrovirals; PMTCT, prevention of mother-to-child transmission.

“Diagnosis and treatment of children living with HIV is a major challenge. It is unacceptable that only 1 in 4 children living with HIV have access to treatment. Most of the children with HIV are receiving suboptimal treatment regimens. This is a particular concern in the subregion, where drug resistance rates are reaching over 60% in some areas, with only 30% of people on treatment successfully achieving viral suppression. Additionally, special attention is needed to increase HIV services among adolescents, particularly adolescent girls, who are most affected by HIV in the subregion. This is part of the reason why I made adolescent health a priority in the African Region.”

— WHO Regional Director for Africa, Dr. Matshidiso Moeti, addressing the high-level meeting in Dakar, Senegal, 2019

We need to do better. UNICEF remains committed to sustaining the gains and finding new ways to accelerate towards a firm trajectory of ‘ending AIDS’ as a public threat among children, adolescents and pregnant women by 2030, despite the current programming and funding environment. The midterm review found that UNICEF must continue to increase its ambition to improve programme performance on HIV/AIDS, especially in high-burden countries, and explore new ways of doing business if it is to address the challenges – including barriers to service use, retention in care for women and children, and inadequate reach among adolescent girls, boys and men. The midterm review finding validates the need to explore catalytic innovations and is a call to continue to enhance HIV programming including the following.

Midterm review response – Data to differentiate solutions to close remaining gaps and enhance current responses

HIV plans, structures, strategies and activities often fail to be revised or adapted to reflect changing data on critical population gaps and needs, particularly at decentralized levels. In 2019, only 6 of the 35 priority countries identified for intensive UNICEF support reported age-disaggregated data on known HIV status for adolescents; only 14 reported on access to ART; and only 7 reported on viral suppression. Policymakers, donors, and technical and civil society partners are recognizing the need for local and disaggregated data to support the political will make the ‘right investments’ in the ‘right places’ and for the ‘right people’ to maximize the impact of HIV programming and service delivery. To ensure commitments to this urgent need for data informed programming UNICEF continues to support:

- Roll-out of the district-level data analysis tool, NAOMI, with UNAIDS, PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), Imperial College London and Avenir Health to produce district-level data in Eastern and Southern Africa and West and Central Africa
- Establishment of size estimates of countries’ adolescent and young key populations at highest risk of HIV for 35 priority countries jointly with UNAIDS
- Collaborative exploration of how to best use digital data to enhance programming
- Development and use of a new analytic framework to review data on current efforts of prevention of mother-to-child transmission (PMTCT) and prioritization of interventions in a number of sub-Saharan African countries
- Technical assistance for countries to review and clean 2010–2018 district-level PMTCT data
- Service mapping documenting adolescent HIV care best practices, including programmes providing psychosocial support to adolescents living with HIV.

Midterm review response – Sharing knowledge and introducing catalytic innovations

UNICEF continues to lead the way in technological innovation to reach infants with an HIV diagnosis. In 2019, building on experiences gained in Eastern and Southern Africa, UNICEF committed to expand access to point-of-care (POC) diagnostics in 10 countries in West and Central Africa to improve access to HIV testing in infants and viral load monitoring in select populations. This work is considered essential to overcome some of the most challenging gaps in conventional laboratory systems, including the transport of blood samples to central or regional laboratories and the timely return of results for clinical management. Until recently, before POC became available, this diagnostic platform for infant diagnosis was only provided through specialized regional and central laboratories, beyond the reach of most children accessing health care. The positive consequences to health and life could be immense, because 30 per cent of undiagnosed and untreated children born with HIV die by their first birthday and 50 per cent by their second.

Midterm review response – Integration of HIV interventions into primary health care and adjoining sectors

UNICEF is investing in adolescent peer networks in Lesotho, Malawi, South Africa and Zimbabwe to retain teen mothers with HIV in care. Participation and civic-engagement interventions include use of youth and adolescent advisory councils; expanding adolescent-friendly HIV-related health services to include complementary outreach services; integrating comprehensive sexuality

education in schools; social norms and behaviour change programmes that engage adolescents across health, education and sport environments; and use of social media to engage at-risk adolescents and link them to HIV services. In 2019, based on the experience in East Asia and the Pacific, UNICEF developed a strategy for digital programming to reach at-risk adolescents with self-testing and pre-exposure prophylaxis (PrEP), currently being piloted in Côte d'Ivoire.

The complementarity and interdependence of integrated HIV and primary health care (PHC) are evident through priority approaches that UNICEF is supporting across Goal Area 1. PHC is the central platform through which HIV prevention and treatment services are provided. Where PMTCT has been an integral part of wider antenatal and postnatal care services, there is high maternal ART coverage. For example, in Eastern and Southern Africa, ART coverage among pregnant women living with HIV has reached 95 per cent in six high-burden countries

(Botswana, Mozambique, Malawi, Namibia, Rwanda, Zambia), resulting in reductions in mother-to-child transmission rates to 5 per cent or lower in Botswana, Namibia, Rwanda and Zambia. However, this type of integration success is not universal. In West and Central Africa, where progress has been hampered by poorer coverage of antenatal care (ANC) and structural barriers such as user fees, maternal ART coverage is 59 per cent.

There is growing momentum to expand access to integrated HIV testing and ART services in infants and children. With paediatric treatment coverage at 54 per cent compared with an estimated 62 per cent coverage rate for youth and adults aged 15–49 years, UNICEF and WHO are working with other implementing partners to improve access to effective integrated service delivery models that can help to improve results among infants and children, including adult ART clinics, in-service wards and outpatient services for sick children, immunization clinics, nutrition services and community care points.



Solofina Mkanda, a widow and mother of seven children, lives in the Nkhuloawe Village, Malawi. She has tested free of HIV thanks to PMTCT.

Health facilities use mobile phones to keep in touch with clients. Malawi first piloted treatment for all pregnant women in 2011. Since then, health workers have been working tirelessly to test for HIV and prevent new infections in women and their families, and to keep those living with HIV on treatment.

Midterm review response – Leveraging partner responses for children and adolescents

UNICEF is uniquely positioned to continue to promote inclusive and multisectoral integration, and continues to explore how to bring multiple sectors together to build a more comprehensive and more sustainable HIV response. With evident complementarity and potential for multiple dividends, HIV and early childhood development (ECD), HIV-sensitive social protection services, HIV and tuberculosis, HIV and chronic health conditions in childhood and adolescence, and HIV-responsive education services are just some examples of the ways in which UNICEF is pioneering this type of integrated programming. This is a critical area that needs to be expanded and continued in 2020 and the rest of the Strategic Plan period as UNICEF

seeks to continue leading the way in HIV-sensitive multisectoral programming that achieves results for children, adolescents and pregnant women across multiple Sustainable Development Goals.

UNICEF seeks to build, sustain and strengthen partnerships that can deliver benefits to children and adolescents at community, national and regional levels. Often this includes helping to bring organizations and institutions together, to share knowledge, skills, expertise and lessons learned, and then supporting the development and implementation of strategies and interventions (*See Case Study 11*). Leveraging action collectively in this way can further enhance integration and allow for the identification of differentiated approaches that can make overall HIV responses more effective and efficient.

CASE STUDY 11: Adolescent Girls and Young Women Learning Collaborative

Adolescent girls and young women face a number of social, economic and structural factors that have a detrimental effect on their health and well-being, including their vulnerability to HIV infection. There is a growing interest in implementing girl-centred programmes that effectively address their multiple vulnerabilities. Both existing and new programmes would benefit from knowledge-sharing and harmonization within a community of practice on best and promising practices including how interventions are implemented, monitored and evaluated.

To address these knowledge gaps, UNICEF – in collaboration with UNAIDS, the United Nations Population Fund (UNFPA), World Health Organization, the Global Fund and the US President’s Emergency Plan for AIDS Relief (PEPFAR) – launched the Adolescent Girls and Young Women Learning Collaborative in 2019 as a platform for implementers to generate and exchange knowledge. It is intended to enable and enhance multisectoral programming and bring together professionals from multiple sectors.

One underlying premise of the new learning collaborative is that most innovation comes from those working closely on the issues and that there is no shortage of local knowledge and expertise. Programme quality can be optimized and communities strengthened through the exchange of knowledge and learning among programme implementers, peer educators, researchers and policymakers with experiences to share. Evidence-based knowledge will be synthesized and tailored to meet the needs of implementers. Strategies for engagement and uptake include peer-to-peer webinars and discussion forums.

Knowledge products such as webinars and case studies are informed by the lived experiences of adolescent girls and young women and their communities. This is a critical priority because the direct participation and influence of adolescent girls and young women is essential to ensure that relevant gaps are identified, priorities match needs, and the vision and activities of the learning collaborative remain salient over time.

Participatory peer learning is a core strategy of the Adolescent Girls and Young Women Learning Collaborative. In general, the learning collaborative will build on the knowledge and experience of local and regional networks, alliances and institutions. The Collaborative’s design recognizes the expertise among country implementer networks, including the recipients of Global Fund financing through its dedicated strategic initiative for adolescent girls and young women. Other implementing partners are associated with related initiatives such as PEPFAR’s DREAMS partnership, the FP2020 global partnership, and the UNFPA–UNICEF Global Programme to Accelerate Action to End Child Marriage.

One bright spot in 2019 was the highly successful replenishment drive by the Global Fund, which raised a record US\$14,000 million for the 2020–2022 funding cycle, an increase of over US\$1,000 million from the previous replenishment drive. However, this funding is still a relatively small share of the US\$26,000 million need estimated by UNAIDS for 2020 to fast track the response, and much donor funding has flatlined. For example, PEPFAR has received an average 2.5 per cent annual funding increase between 2013 and 2019. Also, UNICEF has experienced annual declines in HIV funding. At almost US\$65 million in 2019, UNICEF's HIV expenditures were US\$10 million less than in 2018, and only about 60 per cent of the US\$107 million that was spent in 2015.

Although the total global estimates of HIV expenditures indicate that the amount of domestic resources continues to increase, many low-income countries with high HIV burdens among children and adolescents do not have the needed fiscal space to completely cover gaps in HIV programme needs and thus remain heavily reliant on external financing. The HIV epidemic will not be controlled by 2030 without sustained donor funding and more efficient use of existing resources. To sustain the response, UNICEF is working to differentiate its investments in critical and catalytic actions to address remaining challenges and leverage other sector investments through joint programming. Good examples include: (1) application of the new analytical framework to improve allocation of resources to catalyse achievement of elimination of mother-to-child transmission of HIV in high-burden countries in Africa and (2) working with social welfare in the United Republic of Tanzania, where UNICEF is leveraging the national social protection programme to identify vulnerable adolescent girls and young women and link them to HIV services.

Challenges will undoubtedly persist in 2020, and they are likely to be accompanied by new and emerging challenges, such as the coronavirus disease 2019 (COVID-19) pandemic. UNICEF HIV programmes must ensure that children, adolescents and pregnant women do not fall out of care and that treatment continuity is maintained in a safe manner. It is the organization's responsibility to adapt its service delivery models to safeguard the tremendous gains made in the HIV response over the past decades.

As the COVID-19 response matures and the impacts of the disease become more severe, there is a heightened risk of increased fear, stigma and discrimination towards people living with HIV. We must ensure that people living with HIV receive enough and accurate information, are not deprioritized for their regular HIV treatment and care services or denied intensive care in the advent of severe coronavirus disease. Understanding of the susceptibility to SARS-CoV-2 infection and the full clinical implications of COVID-19 in children and pregnant women, including those living with HIV, is evolving and currently unknown, but it is essential to monitor the national and subnational situation of access to basic HIV and COVID-19 health care for people living with HIV. The global HIV community has a history of fighting stigma and discrimination, and advocating for the right to health for the most vulnerable. In this pandemic, we can learn from the 40 years of HIV response to ensure a rights-based and community-centred approach to the COVID-19 pandemic.



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Fairs on health and social services, aimed at fostering access to HIV and social basic services by social protection beneficiaries and their dependents, were held in Moma, Mozambique, and address a key UNICEF commitment under the HIV sensitive social protection project.

Results Area 1: Treatment and care of pregnant and breastfeeding women, children and adolescents living with HIV

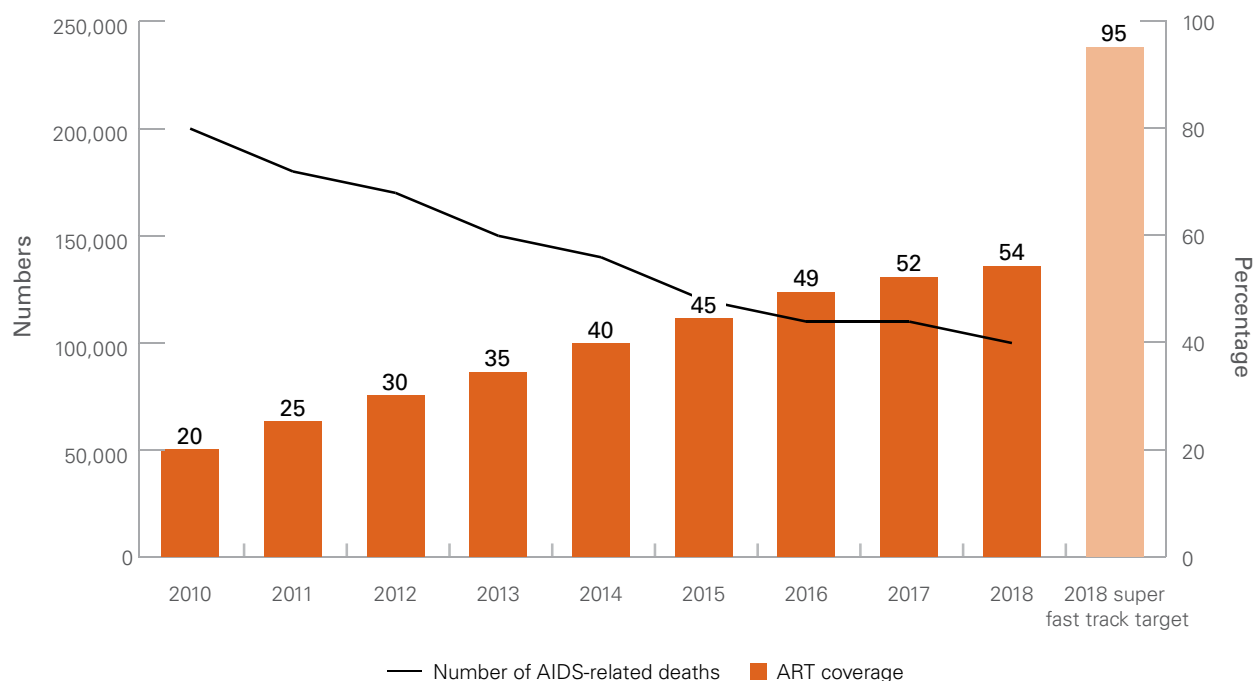
Output Statement 1.f: Countries have accelerated the delivery of services for the treatment and care of children living with HIV

While some progress has occurred from the level of 20 per cent ART coverage in 2010, the ART coverage of children aged 0–14 years in 2018 was just 54 per cent (see Figure 69). This result lags behind not only PMTCT coverage (82 per cent) but also adult ART coverage (62 per cent). The situation is worst in West and Central Africa where only 28 per cent of children living with HIV have access to ART compared with 61 per cent in Eastern and Southern Africa. The gaps in access to timely HIV diagnosis and linkage to quality treatment resulted in 100,000 deaths in children (aged 0–14) in 2018. Children are uniquely vulnerable

because the virus weakens and kills them more rapidly than adults. Untreated, 50 per cent of children who acquire HIV in the womb or at birth will die before their second birthday.

The number of children at risk of dying from AIDS remains high. In 2018, the number of children (0–14 years) that received ART (937,000) fell short of the global target (1.6 million), leaving a gap of 663,000 children worldwide. Among the youngest children (0–4 years), an estimated 530,000 were living with HIV in 2018 and about half (250,000) did not receive ART. A key reason for the poor ART access is the low level of HIV testing. About half of the children born to mothers living with HIV are tested at the recommended 6–8 weeks after birth in PMTCT services. Fewer opportunities exist – or are fully maximized – to provide HIV testing for children who are missed by those services or who acquire HIV during breastfeeding six weeks or more after birth.

FIGURE 69: Trends in coverage of antiretroviral treatment and number of AIDS-related deaths among children, 0–14 years, 2010–2018



Note: ART, antiretroviral treatment.

CASE STUDY 12: Pakistan: Health systems-strengthening response to a facility-acquired HIV outbreak

In 2019, an outbreak of nosocomial HIV infections in Pakistan, primarily among children, highlighted the capacity, monitoring and quality-assurance gaps in the health system. The devastating episode would have been worse without rapid, targeted engagement by UNICEF and partners soon after it was announced. This engagement not only included working to halt the immediate crisis, but also to help put in place new standards, procedures and interventions to help prevent similar catastrophes in the future.

The outbreak occurred in a district in Sindh province in southern Pakistan, with many of the infections traced to the use of unsterilized needles reused to vaccinate children. Since April 2019, a total of 1,021 cases of HIV transmission to children in health-care settings have been documented by the Sindh AIDS Control Programme. The median age of the children at diagnosis was 36 months, with 80 per cent of the children presenting early stages of HIV disease and 20 per cent presenting with advanced stages. With UNICEF support to date, 971 children have been initiated on treatment.

UNICEF played a key role in a broad coalition of partners responding to this outbreak, including crisis response, expanding care and treatment infrastructure, technical support and training for health-care workers. Additionally, UNICEF-supported communication, community mobilization and awareness activities helped to develop an advocacy, social-mobilization and strategic communication plan to address a significant lack of knowledge of HIV and AIDS, high levels of stigma and discrimination against families and HIV-positive children, and a lack of confidentiality.

The main result of this coordinated response was successfully getting children on life-saving treatment. This single province represented a massive and rapid scale-up of the total number of children on antiretroviral treatment (ART) in the country, more than doubling the 610 children who were receiving ART in Pakistan in 2018.



Rebecca and her baby Naybare Sheba, five-months-old at the POC (ISIS Point of Care Clinic) Mbarara RRH (Regional Referral Hospital) South Western Uganda.

"I love being a mother, and watching my baby growing up healthy and playing with other babies. I love coming to the clinic because I get very good care here, I don't wait too long and I can get all my medicines in one place."

The Government of Uganda has implemented a number of interventions for children exposed to HIV including point of care for early infant diagnosis of HIV and oral pellets for children living with HIV.

Towards elimination of mother-to-child transmission

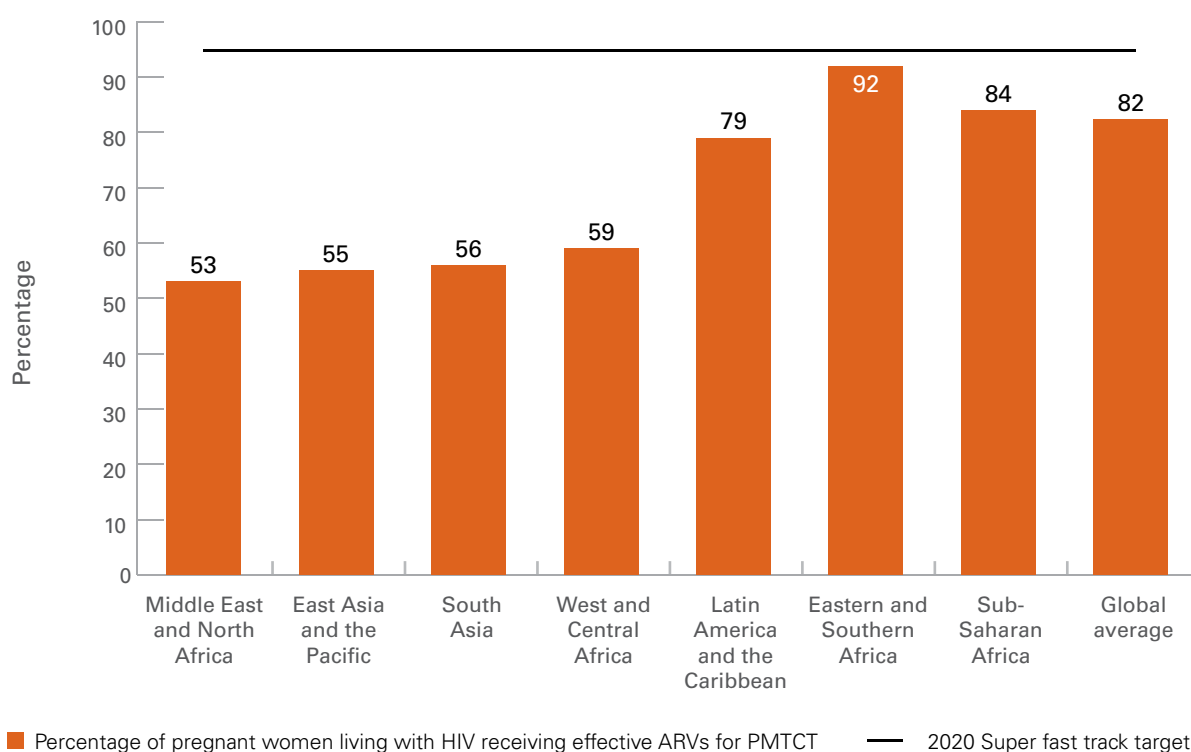
Nearly all HIV infections in young children occur as a result of ‘vertical’ transmission during pregnancy, at birth or during breastfeeding. Programmes for PMTCT of HIV, many of which UNICEF has helped to design, implement and support for years, are an integral part of antenatal and maternal care. The adoption by most of the world’s countries of treatment policies centred on offering lifelong ART to all pregnant women who test positive has been especially transformative in expanding access to treatment. The number of new HIV infections in children in 2018 was an estimated 160,000 around the world, 41 per cent lower than the comparable estimate of 280,000 for 2010.

Many women continue to miss out on PMTCT interventions. Progress is variable across regions, ranging from 92 per cent PMTCT coverage in Eastern and Southern Africa to 53 per cent coverage in the Middle East and North Africa (see Figure 70).

“One of our challenges, in preparation for elimination of mother-to-child transmission of HIV and syphilis plan, was a recognition that we were not doing a favour to the young adolescent moms and the youth moms. When we saw them in anti-natal care we managed them just like any other pregnant women and that was identified as a weakness. Therefore, when we were looking at strategies moving forward, we really thought we should address the needs of the pregnant adolescent. We felt that they needed to speak to one of their own so that they can really understand what we are talking about, whether they are HIV positive or negative. So we looked at a situation where you could have a peer support mechanism.”

— Dr. Angela Mushavi, national PMTCT and paediatric HIV care and treatment coordinator, Zimbabwe Ministry of Health

FIGURE 70: Access to prevention of mother-to-child transmission by region, 2018



Source: Global AIDS Monitoring and UNAIDS 2019 estimates. Notes: ARVs, antiretrovirals; PMTCT, prevention of mother-to-child transmission.

CASE STUDY 13: Narrowing the treatment gap in infants, children and adolescents: A paediatric Service Delivery Framework to achieve the super-fast-track targets

UNICEF and partners developed a framework and tools to assess paediatric programme performance and identify best practices to enhance results and achieve the goals set out in the super-fast-track targets for infants, children and adolescents. The Service Delivery Framework considers service delivery, diagnostics and drugs as the three pillars of an effective HIV response, recognizing that good service delivery is necessary to get the right diagnostics and drugs to children and provide them with the care and support they need to survive and thrive over a lifetime of living with HIV.

The Service Delivery Framework is a tool for dialogue, systematically walking countries through a process of identifying the epidemiological context, programmatic gaps and barriers, and identifying targeted solutions to improve services for infants, children and adolescents living with HIV at national and subnational levels. It is now informing programme work and additional investments in Cameroon, Kenya, Malawi, Mozambique, Nigeria, Uganda and the United Republic of Tanzania. Once effectively implemented, this process creates a continuous quality improvement cycle.

UNICEF leveraged funding from ELMA Philanthropies, ViiV Healthcare and the Joint United Nations Programme on HIV/AIDS (UNAIDS) for framework development and its planned implementation in 2020. High-level commitment from health ministries, the World Health Organization, UNAIDS and partners for the framework was obtained at the International Conference for AIDS and STIs in Africa in Rwanda in December 2019. Nigeria has adapted the Service Delivery Framework and, with UNICEF technical assistance, is now finalizing the Pediatric and Adolescent Acceleration Plan 2020–2022. In addition, UNICEF is collaborating with donors to facilitate grants which will roll out the framework in Brazil, Ethiopia, Mozambique, Nigeria, South Africa and Uganda.

The conception and development of the Service Delivery Framework is a best practice example of UNICEF's ability to rapidly mobilize partners to take urgent action and to provide thought leadership for the development of innovative and evidence-based quality improvement approaches to differentiated programming.



Barbara, founder of Uganda HIV advocacy organisation "Pill Power", is giving a speech during a UNICEF-supported session at the 2019 International Conference on AIDS and STIs in Africa (ICASA) called 'Enhancing paediatric service delivery to end HIV/AIDS.

The fact that 160,000 children aged 0–14 were newly infected with HIV in 2018 indicates there is a long way to go to reducing new infections among children to achieve the 2020 global target of fewer than 20,000 new infections. Improving HIV prevention efforts in pregnant and lactating women, providing timely access to ART, and retaining pregnant and breastfeeding women on treatment in care are critical to reducing new infections in children.

Better use of data to differentiate action to achieve elimination of mother-to-child transmission

Data is a powerful tool to drive elimination of mother-to-child transmission (EMTCT) programme improvements. Participants at a 2019 capacity-building workshop delivered by WHO, UNAIDS and UNICEF on the use of HIV disaggregated data for improved programme outcomes identified that disaggregated data:

- When triangulated, provides an effective tool for programme planning and progress tracking, and that mathematical estimates can be a powerful advocacy tool to locate, link and retain 'missing children' (Uganda participants);
- Provides an understanding of the main causes of new infections and identification of gaps and plans to develop and direct interventions to avert incident infections during pregnancy and breastfeeding (Zambia participants);
- Can be used to strengthen individual case-based surveillance in locations where numbers are small (Seychelles participants); and
- Will inform guidelines on re-testing; will help design and scale interventions, such as integrating reproductive health/HIV and mentor mothers; and will identify antenatal risk factors (e.g., seroconversion during pregnancy) (Malawi participants).

Building on this data platform, in 2019, UNICEF, in collaboration with WHO, UNAIDS and PEPFAR, introduced an analytical and programming framework for the 'Last Mile to EMTCT' (see *Case Study 14*) to further reduce persistent new HIV infections in children. The framework identifies the most significant country-specific gaps in policies and practices for providing maternal ART access, retaining in care and identifying new maternal HIV infections during pregnancy or breastfeeding, and provides a menu of evidence-based policy and programmatic actions to address these shortfalls.

CASE STUDY 14: Road map on reaching the 'Last Mile to EMTCT'

In 2019, UNICEF, in collaboration with the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the US President's Emergency Plan for AIDS Relief (PEPFAR) introduced the 'Last Mile to EMTCT', recognizing that the last mile in the long journey to fully defeat vertical transmission has proved to be the most difficult to travel, and that a new structured and coordinated approach is needed to reduce the number of new infant HIV infections at the country level.

The last mile to the elimination of mother-to-child transmission (EMTCT) road map serves as a diagnostic and operational guidance for national programmes that have adopted universal lifelong antiretroviral treatment (ART) for pregnant and breastfeeding women living with HIV. While the road map has global ambitions, it outlines a flexible and consultative process that is highly local in practice, identifying and addressing local priority areas to achieve EMTCT in an efficient and directed manner.

UNICEF used this road map and strategic data to identify and address programme gaps in the prevention of mother-to-child transmission (PMTCT) resulting in: policy and programme adjustments in Malawi; improved retention outcomes in the two years post-childbirth in South Africa; quality newborn care in Namibia; and tracking of PMTCT services in private hospitals and developing a road map for achieving EMTCT in collaboration with WHO and UNAIDS in the Islamic Republic of Iran.

UNICEF will continue to convene global-, regional- and country-level consultations and technical and financial support in 2020 to support use of the road map in high-priority EMTCT focus countries to develop their evidence-based elimination plans.



WHO validation and certification of elimination of mother-to-child transmission

In 2019, Sri Lanka joined the list of 13 countries (Anguilla, Antigua and Barbuda, Armenia, Belarus, Bermuda, Cayman Islands, Cuba, the Republic of Moldova, Malaysia, Maldives, Montserrat, Saint Kitts and Nevis, Thailand) that, to date, have been certified by WHO for EMTCT of HIV. As a key partner of Sri Lanka's National STD/AIDS Control Programme for decades, UNICEF played a significant role in this achievement, participating in in-country assessment activities that confirmed 97 per cent coverage of HIV and syphilis testing of pregnant women, and zero reported cases in newborns. UNICEF also supported improved quality of Sri Lanka's laboratory services, data information systems and linkages between district and central laboratories in the validation process.

Except for Thailand, none of the other 35 priority countries identified for intensive UNICEF support have been certified by WHO for EMTCT of HIV. However, several are on the pathway to elimination, including Botswana, Malawi, Namibia, Uganda and Zimbabwe. UNICEF remains committed to EMTCT and has contributed to the following achievements in EMTCT across the priority countries in 2019.

UNICEF supported pre-validation assessments and programme strengthening

- Ukraine and Uzbekistan brought together international experts on data, programming, human rights and laboratories to conduct pre-validation assessments for EMTCT of HIV and syphilis and provide concrete recommendations on the way forward for WHO validation.
- The Islamic Republic of Iran and Togo developed road maps and plans for EMTCT.
- Guatemala developed plans for 'triple elimination' of HIV, syphilis and hepatitis B.
- Equatorial Guinea developed a plan on triple EMTCT of HIV, syphilis and hepatitis B, leading to inclusion of a dual HIV-syphilis rapid test in the 2020 annual supply plan. As part of the support, UNICEF contributed over 6,250 Bioline dual HIV-syphilis tests, 1,000 Colloidal Gold and 1,000 Uni-Gold HIV tests. With WHO and UNICEF support, the country also adopted the 'test and treat' strategy for HIV that country representatives report has resulted in a 30 per cent increase in the number of people initiating ART. In addition, all HIV and tuberculosis management programme tools have been revised to improve data availability and quality, and UNICEF support has resulted in 42 health workers from six of the seven health provinces having increased paediatric HIV and tuberculosis (TB) and TB-HIV coinfection diagnostic and treatment capacity.

UNICEF-supported capacity development and national and subnational institution results

- Indonesia achieved sixfold increase in numbers of pregnant women tested for HIV and a twofold increase in pregnant women initiated on ART between 2014 and 2019.
- Myanmar expanded PMTCT services in 326 townships (out of a total 330 townships). Through this effort, the PMTCT programme has successfully expanded to several hard-to-reach and conflict-affected areas, including the Wa self-administered region in Shan state and camps for internally displaced persons in Bamao district.
- Viet Nam institutionalized standard operating procedures for triple EMTCT of HIV, syphilis and hepatitis B in the national maternal and child health-care services.
- Eswatini Ministry of Health strengthened the community follow-up system for mothers living with HIV and their babies by training 300 mentor mothers to improve retention in care, and developed a newborn care training package that integrated PMTCT and trained 27 health workers from 11 health-care facilities that offer maternity services.

UNICEF-supported partnership and South-South learning results

- South-South learning exchange collaboration for EMTCT of HIV, syphilis and hepatitis B led by the Thailand International Cooperation Agency and Thailand Ministry of Public Health. Through this partnership, 51 participants from the governments of China, Kazakhstan, Tajikistan, Ukraine and Uzbekistan completed training alongside participants from civil society organizations.
- China-Myanmar and Malaysia-Indonesia collaborations on triple EMTCT of HIV, syphilis and hepatitis B.
- China adopted hepatitis B treatment for high-risk pregnant women and hepatitis B testing for infants born to hepatitis-positive mothers.
- Myanmar strengthened public-private partnerships between private hospitals and the National Action Plan for PMTCT through a series of workshops in Mandalay, Mawlamyine and Yangon. Both the Government and private sector are increasingly focused on EMTCT of HIV and syphilis by 2025.

UNICEF-supported data collection and analysis

- Ugandan Ministry of Health conducted an end-term evaluation for pilot interventions in group ANC to improve PMTCT services for adolescent girls and young women. Evaluation findings are now being used to enhance the group ANC intervention and inform further scale-up.
- Zambia, through the joint 2gether 4 SRHR programme implemented in conjunction with three other United Nations agencies: UNICEF commissioned a national qualitative survey to determine adolescent and young mothers' use of maternal and HIV services and SRHR knowledge. Shared widely, the findings of the study will now be used to develop a national communication strategy, leverage policy change and advocate to reduce barriers to services and support.

mortality. In 2018, fifty-nine per cent of infants born to pregnant women living with HIV received a virological test for HIV within two months of birth. Access to early infant diagnosis (EID) ranges from 69 per cent in Eastern and Southern Africa to 30 per cent in West and Central Africa (see Figure 71).

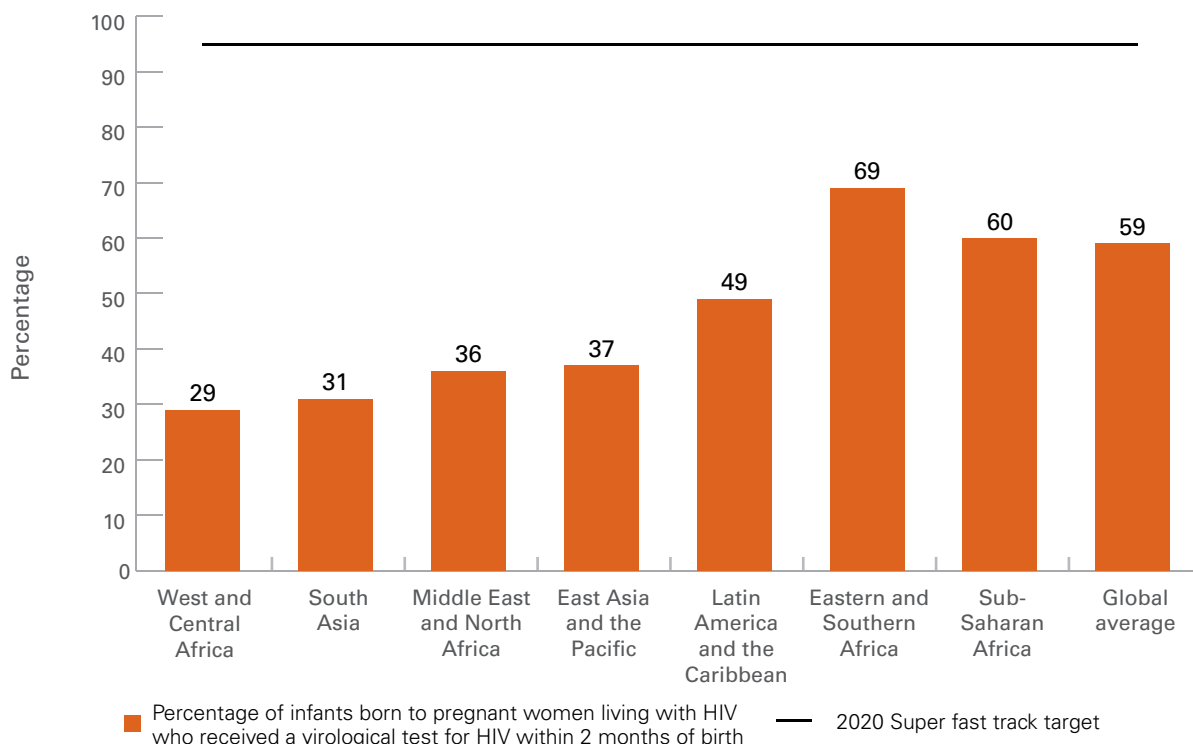
"After I gave birth, they called me back to examine my child. So I took the child, they ran the tests and sent them off to Yaoundé. The hardest moment was when I was waiting for the results which took nine months to return. It was really hard because I couldn't sleep, I was not myself. I would ask myself, is the child healthy or is she sick? When I had my second child, I did not know that things had improved. Because the first time it took a long time. I was so worried that I did not know what to do. They tested the child and then they told me 'wait here for the results'. What happened? They gave me the results of the child! Right there. The results were HIV-negative. I was happy."

— Antoinette, a mother living with HIV in Cameroon

Diagnostic innovations to improve treatment of children with HIV

Complications and difficulties associated with transporting HIV test specimens to central or regional laboratories and lengthy delays in return of results have contributed to the low treatment of children with HIV and associated high

FIGURE 71: Access to early infant diagnosis by region, 2018



Source: Global AIDS Monitoring and UNAIDS 2019 estimates.

Point-of-care diagnostics

UNICEF is supporting introduction of POC diagnostic machines to overcome bottlenecks to infant HIV testing in several countries in Africa. The POC Toolkit, launched in 2018, contains various practical tools and guidance for countries wishing to introduce POC HIV diagnostic machines into existing national diagnostic networks and laboratory systems. To help expand access to POC machines in Francophone countries, the toolkit was translated into French in 2019. As part of the Innovations to Scale Initiative introduced by the Executive Director in 2018, UNICEF invested US\$6 million to cover three years (2019–2022) to introduce POC machines for infant HIV testing in 10 low-performing countries in West and Central Africa (Burkina Faso, Cabo Verde, the Central African Republic, Chad, the Congo, Equatorial Guinea, Gabon, Ghana, Mali and Nigeria). The introduction included conducting a detailed mapping of existing laboratory systems and capacity, and followed with capacity development of laboratory and programme teams from these countries.

"We found that babies are coming from many different entry points. Some babies come to the Paediatric ward when they are sick, some babies come to the Nutrition ward. They come with all of these opportunistic infections. So we are putting a lot of emphasis on the use of point-of-care on these alternative entry points. We need to test them as early as possible, give them the correct ARVs [antiretrovirals] and then, that makes it better for their survival and general health. With this approach, we have seen the time between test and initiation of ART decrease from 90 days to almost 1 day."

— Dr. Linda Nabitaka, Prevention of Mother-to-Child Transmission programme coordinator, Ministry of Health, Uganda

The innovative POC technologies allow mothers, fathers and other caregivers to have information they need to initiate treatment of HIV-positive infants or, for infants who are HIV-negative, to support the mother during the postnatal period to maintain the child's negative status. This initiative is a good example of UNICEF's ongoing focus on differentiated innovative responses to address key barriers to EID and paediatric ART access in a low-performing region.

UNICEF engagement in expanding the use of POC technologies is helping advance dialogue on the value of using the platforms for multiple uses critical to improving care in primary clinics. The same POC platforms used for infant HIV diagnosis can be used for HIV viral load

testing – essential for monitoring client response to ART – and to measure hepatitis C viral load and detect human papillomavirus DNA and tuberculosis. Zimbabwe is one country where UNICEF is involved in exploring opportunities and options for integrated testing for HIV and tuberculosis.

Index family-based testing

UNICEF, in partnership with WHO and UNAIDS, supports countries to improve ART coverage through the implementation of global best practices to find and link undiagnosed individuals to treatment. Index family-based testing uses specially trained workers and volunteers to encourage HIV testing among family members of people newly diagnosed or known to be living with HIV. This initiative is often peer-driven, training people living with HIV to provide HIV testing at the community level and linkages for those who test positive to health-care facilities for confirmatory testing and follow-up.

Index family-based testing produces meaningful results. National case studies developed by UNICEF and government partners show that in Sierra Leone 339 children and adolescents were found to be HIV-positive and referred for treatment; in the Central African Republic, 219 children were diagnosed and initiated treatment; and in Ghana, 82 per cent of 1,014 newly identified HIV-positive children initiated ART (*see Case Study 15*). Additionally, significant yield was achieved among spouses of HIV-positive individuals with a 15 per cent and 35 per cent positivity rate in the Central African Republic and Ghana, respectively.

Success factors for the index family-based testing campaigns include top-level buy-in and ownership (e.g., from the ministry of health and the national AIDS commission); high-level political support (e.g., from the first lady and the health minister); involvement of the community and beneficiaries in all phases of development and implementation; and training and monitoring of service providers. Lessons learned underscore the huge barrier stigma represents, with many participants reluctant to engage in index family-based testing because of concerns about the consequences of disclosure of HIV status. A more hopeful finding was that combining family HIV testing services with other health services such as blood pressure checks, check-ups for children under 5 and other interventions increases uptake of family testing and reduces stigma within households and communities.

This case-finding methodology has been effective in identifying children and adolescents living with HIV and ensuring their linkage to treatment. The development and launch of a region-specific index family-based testing guidance in both English and French, by UNICEF and partners, is supporting the ongoing efforts of countries in West and Central Africa to introduce and scale up index family-based testing.

CASE STUDY 15: Ghana: Index family-based testing: Finding missing paediatric cases

Ghana is one of the nine countries contributing to 90 per cent of new paediatric HIV infections in West and Central Africa and has low paediatric antiretroviral treatment coverage. Despite high immunization coverage of 95 per cent and high antenatal care attendance, the 79 per cent prevention of mother-to-child transmission coverage rate means that one in five pregnant women living with HIV are not taking antiretroviral treatment (ART) and coverage of early infant diagnosis services is 58 per cent. Thus, there are missed opportunities in testing, service integration and linkages in health delivery in Ghana.

To address the paediatric HIV coverage gap, the National AIDS Control Program identified index family-based testing as a methodology to find and treat undiagnosed children. UNICEF supported this leadership through national advocacy for adoption of index family-based testing as a game changer, piloting of the intervention in Central and Western regions of Ghana, support for resource mobilization for scale up through Global Fund application, scale up to additional 256 facilities through training, integration of key elements and indicators in facility-based registers and the health management information system, as well as development of job aids and standard operating procedures.

As of September 2019, a total of 8,723 people living with HIV had been identified as index cases and offered family HIV-testing services. Of those, 7,650 had accepted the offer. A total of 11,475 children and 7,002 adults were listed and, of these, 7,244 children and 4,872 adults were tested. Among those tested, 1,014 children and 1,705 partners were identified as HIV-positive, giving yields of 14 per cent and 35 per cent, respectively. A total of 832 children (82 per cent of those who tested positive) and 1,484 partners (87 per cent) were initiated on ART. The national HIV testing register now includes index family-based testing with the District Health Information Management System (DHIMS2) reporting this data disaggregated by age and gender.

Participants and managers identified several lessons learned, including the following.

- Disclosure to partners, especially in co-habiting and unmarried couples, was difficult as it can pose a risk of violence or separation.
- There is a need for a friendly, confidential space and enough time for counselling. The need is particularly acute in small facilities where participation carries a risk of disclosing individual and family HIV risk and status to clinic staff and clients.
- To reach children attending boarding schools, special testing opportunities during school vacations and collaboration with the education sector are necessary.
- HIV-related stigma and discrimination are key reasons for failing to disclose HIV status or declining offers for family testing. Testing providers will benefit from additional training and tools to provide psychosocial support for disclosure.



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“When I found out I was HIV positive I was shocked and afraid,” says Julia. “My father helped me to stay strong.” Julia’s surviving three sons are all HIV negative.

Julia Tetteh lives with her elderly mother and children in Ayikuma, a small village 45 km north-east of the Ghanaian capital of Accra. She joined the LEAP programme in 2009, a terrible year for her and her family, as she lost one of her twin children to an AIDS-related respiratory illness.

Adolescent ART and retention in care

Pregnant adolescents

UNICEF recognizes the urgency of providing tailored services that meet the needs of pregnant and breastfeeding adolescents, including those living with HIV, and is currently working with governments, civil society and adolescents to address this programming gap in 10 countries in Eastern and Southern Africa (see *Case Study 16*). Country office HIV teams are leveraging various funding streams and leading the implementation of tailored activities for pregnant and breastfeeding adolescents. Activities through this differentiated service-delivery approach include upstream efforts to enhance national strategies and tools and downstream interventions to demonstrate effective models of support for pregnant and breastfeeding adolescents, including those living with HIV.

Differentiated service delivery for children and adolescents living with HIV

Many adolescents have multiple and concurrent needs including mental health and psychosocial services not adequately addressed by many HIV services. Good examples of such services supported by UNICEF include the following. (See also *Case Study 17*)

Service delivery

- In Brazil, UNICEF expanded the Youth Aware initiative targeting adolescent key populations in four new cities. The programme reached more than 3,000 adolescents and young people with HIV testing and treatment services in 2019. The Youth Aware project uses an innovative mobile health unit to bring essential health and HIV services (including HIV testing and counselling) to adolescents and young people who are unable or unwilling to visit a facility, including transgender women, and adolescent and young males who have sex with other males. Youth Aware is a perfect example of adolescent development, participation and civic engagement,



Nineteen-year-old Achta shows condoms during a session to raise awareness about HIV in the community in Moussoro, in the centre of Chad. She's taken advice and information about HIV and contraception.

"I learned a lot. And I will follow the advices they give me, such as using a condom to avoid HIV. I also talk about it with my friends at school. Even with my mother. She's satisfied I take responsibility. In the beginning it was difficult for woman in this country, but it's getting easier."

CASE STUDY 16: Eastern and Southern Africa: Peer-approaches to support pregnant adolescents living with HIV

In Zimbabwe, the peer-support model in the Zvandiri programme has been adapted and implemented in several initiatives to address the personal, social and cultural risk factors adolescents and young people experience in the country. The community programme began in Zimbabwe in 2004 as a support group to provide differentiated care for adolescents living with HIV using community adolescent treatment supporters (CATS) – HIV-positive adolescents and young people aged 18–24 years. The programme also worked to link health-care facilities and youth living with HIV to increase uptake of testing, linkage, adherence, retention in care, mental health and other health services. For example, the unique challenges faced by young mothers accessing HIV testing early in pregnancy and adhering to their medications require tailored programmatic approaches that are often missed by prevention of mother-to-child transmission (PMTCT) services designed for adults.

“Then my husband said, ‘you are now healthy and you have gained weight, so you should stop taking your medication.’ But I argued and said I cannot stop taking my medication because this is what is keeping me alive for the rest of my life. Sometimes when it was my clinic appointment dates he would say, ‘you are not going there’ and I actually threatened him and said if it is like that, then I will actually go and report the matter to the police, and as time went on I came back home. I can now take my medication again and attend my clinic appointments and am free to attend support groups because I don’t have any problems or obstacles.”

— Grace, participant in Young Mentor Mothers Community Initiative

A new pilot project in the country utilizing this model trains young mentor mothers (YMMs), who have received initial training as CATS, to support other young mothers living with HIV during pregnancy and breastfeeding to access testing, treatment and care services for themselves and their infants. The NGO Africaid, in collaboration with the Ministry of Health and Childcare, implemented the YMM pilot project in five districts in Zimbabwe in 2018. The training and support provided to these peer mentors focused on specific topics for young mothers, including early infant diagnosis, HIV treatment adherence for infants, partner testing, nutrition and parenting support. The YMMs support their peers through home visits and SMS reminders as well as through facility- and community-based groups.

By December 2019, forty-eight young mothers living with HIV had been trained as YMMs and linked to 26 facilities within the national PMTCT programme. Results analysed after nine months of implementation showed that 645 (89 per cent) of young mothers supported through the initiative had received viral load test results and 603 (93 per cent) of those were virally suppressed. All HIV-exposed infants over six weeks old were tested and received results, compared with the overall national early infant diagnosis access rate of 64 per cent. Elements of the pilot’s success included ongoing capacity development and support to YMMs, incentives to develop their motivation, and a strong monitoring and evaluation system.

Similarly, in South Africa UNICEF is using the mothers2mothers mentor mother model for PMTCT services to provide peer support to teen mothers living with HIV and their partners at facility and community levels in four districts. This innovative programme provides psychosocial support and health education, and facilitates linkage to health services such as HIV, nutrition, and maternal, newborn and child health services. Of the 883 adolescents and young women supported by peer mentor mothers at two of the clinics, 98 per cent were initiated on antiretroviral treatment and 93 per cent were retained in care at two years post childbirth. Success factors of these peer-centred initiatives include effective bidirectional community–facility linkages and HIV integration and linkage to non-clinical services.

CASE STUDY 17: Thailand: Integrated services for adolescent health and well-being

The importance and value of integrated approaches to address HIV prevention and treatment needs was a guiding principle for much of UNICEF's work in Thailand, which focused on the broader area of comprehensive adolescent health. For example, in 2019 UNICEF contributed significantly to the generation of data, evidence and knowledge on adolescent sexual and reproductive health and reproductive rights, development and employability. Findings from this research will be used to inform decisions and changes in policy development and will provide the framework for collaboration between UNICEF and partners in the focus and design of programmes in 2020 and 2021. The findings also will be used as key evidence for advocacy work by and about adolescents and young people in the second decade of life.

In collaboration with the United Nations Population Fund and World Health Organization, UNICEF supported the Bureau of Reproductive Health in an assessment of youth-friendly health services to understand how existing national standards align with global standards. The findings are being used in the revision of the national guidelines, with the goal to improve service implementation to meet the needs of adolescents. UNICEF also supported the gathering of adolescent reproductive health surveillance data to further enhance understanding of the current state of adolescent reproductive health. Data from 1,598 adolescents were gathered from 197 hospitals.

As part of an overarching effort to enhance cross-country learning, UNICEF played a key role in facilitating an adolescent health study visit between Thailand and Bangladesh country teams. With support from the Thailand country office, eight government officials representing government ministries from Bangladesh benefited from observing best practices on the delivery of adolescent health services through programmes implemented by the Thailand Ministry of Public Health.

with adolescents and young people directly and heavily involved in the key elements of the project's approach – peer support and social mobilization, as well as in training others to be peer educators.

- In Eswatini, UNICEF partnered with Baylor College of Medicine to provide support to 350 adolescents living with HIV including home visits, teen clubs, fast-tracked viral load testing and genotyping for adolescents failing second-line treatment, and SMS-based counselling services. Implementers report that these activities contributed several positive results including a reduction in the loss to follow-up rate among the 350 adolescents from 2.7 per cent to less than 1 per cent. Efforts are under way to scale up these initiatives.

Systems-strengthening

- In Myanmar, a partnership formed with the Clinton Health Access Initiative resulted in the establishment of a laboratory information management system (LIMS) and improved capacity of service providers. Another vital outcome from this partnership was the establishment of an electronic patient management and record system (OpenMRS) for clinical management of adults and children living with HIV.

Differentiated policies, procedures and guidelines

- In Zimbabwe, UNICEF is currently finalizing 'What Adolescents (10–19 years old) Need to Know about Pregnancy and Breastfeeding', a comprehensive and adolescent-friendly information package developed in collaboration with Government, civil society and adolescents, and the organization has supported development of guidelines to improve retention in care in adolescents on ART and capacity development in low-performing districts.
- In Botswana, with support from UNICEF, programming considerations for pregnant and breastfeeding adolescents have been included in the recently developed Third National Multisectoral Framework on HIV 2018–2023; the operational plan for adolescent health and nutrition; the standard packages of HIV prevention, treatment, care and support services; and the integrated reproductive, maternal, newborn, child and adolescent health and nutrition strategy.
- In the United Republic of Tanzania, UNICEF provided lead support for the development of standard operating procedures to enhance HIV counselling and testing for pregnant and breastfeeding adolescents and young women.

- In Tajikistan, UNICEF supported work to improve the quality of life for adolescents living with HIV by increasing the eligibility age for a monthly social (cash) allowance to adolescents living with HIV from 16 to 18 years. The UNICEF efforts in Tajikistan helped increase ART coverage and adherence; improved management of opportunistic infections (e.g., TB); and enhanced legal and psychological support by multidisciplinary teams, including parent-support groups.

Addressing stigma and discrimination to improve adolescent access to ART and retention in care

Stigma is a core barrier to successful HIV testing, care and treatment of children and adolescents. Fear of disclosure, one consequence of HIV-related stigma, is common among all people living with HIV, but it can be particularly complicated and terrifying for adolescents because they are uniquely vulnerable in so many other ways. Even though the situation has improved in many countries where ART has become widely available and death rates have plunged, stigma is a persistent challenge to more successful efforts for effective prevention and treatment services among adolescents.

In Kenya, for example, stigma is a key factor associated with the poor rate of retention in care, adherence to medications and viral suppression among adolescents.

Over the years, implementers, advocates and adolescents living with HIV have reported school expulsions due to HIV status and the negative impact that stigma in schools has on ART adherence.

To respond to the challenges in Kenya, UNICEF is supporting an innovative application of digital solutions to break through stigma and improve adherence to medications among adolescents, along with several other potential outcomes. During the implementation phase in 2019, more than 70,000 adolescent boys and girls aged 10–19 years were reached with information on HIV, SRHR and gender-based violence through the one2one web- and mobile-based platform, and other information-sharing platforms. The programme also includes targeted efforts to improve identification of adolescents living with HIV, linkage to treatment, adherence to medications and viral suppression in five counties. The lessons learned from these efforts will inform both national- and county-level programming for adolescents living with HIV in Kenya – an important distinction because often the specific factors behind stigma and other challenges differ greatly within and between counties.

In the United Republic of Tanzania, a UNICEF-supported cross-sectional study on adolescents living with HIV helped to pave the way for easier access for adolescents to HIV testing and uptake of treatment for those diagnosed as positive – which, ideally, will help to destigmatize HIV. The study informed advocacy efforts that contributed to parliamentary approval of an amendment of the HIV Act, which took effect in November 2019, that allowed adolescents to be tested for HIV without parental consent.



“[NAME CHANGED] Jessica, 13, participates in a support group for HIV-positive children run by Group Pela Vidda (‘For Life’) at a municipal hospital, where many of the children receive medical treatment, in the city of Niterói in Rio de Janeiro State. During these sessions, facilitated by two social workers (right), children share their experiences, ask questions and listen to guest speakers on a variety of topics.”

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A girl in Malawi listening to an HIV programme.

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Results Area 2: Adolescent HIV prevention

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

Scaling up HIV prevention programmes is a major challenge worldwide among all populations, but adolescents fare worse in general. In 2019, as in previous years, adolescents were among the hardest-to-reach populations in HIV responses as they experience multifaceted challenges with risk behaviour, level of knowledge and testing access. In 2018 alone, an estimated 190,000 new infections occurred worldwide among adolescents aged 15–19. Between 2010 and 2018, the number of new HIV infections among adolescents aged 10–19 years decreased by only 24 per cent, off track from the 2020 global target of 75 per cent reduction if ‘ending AIDS’ by 2030 is to be a realistic goal.

Without accelerated action to improve targeted adolescent HIV prevention programmes for those most at risk in the different regions of the world, governments and the international community will continue to incur significant costs of testing, treatment and care of those who become

infected throughout the course of their lives. An estimated 1 million adolescents aged 15–19 were living with HIV in 2018.

Adolescent girls and young women at heightened risk of HIV

The health and well-being of millions of adolescent girls and young women everywhere depends on effective implementation of interventions that reduce their multiple vulnerabilities and improve their capacities. HIV has had a disproportionate effect on this population. Globally in 2018, females accounted for nearly three quarters of all new infections among adolescents aged 10–19 years. Further, the majority (59 per cent, or 970,000) of the 1.6 million adolescents living with HIV are female. In most high-burden countries, especially in Africa, girls are at greater risk of HIV infection than boys. Catalysed and leveraged responses to the HIV-related risks experienced by adolescent girls and young women remain a critical priority for UNICEF and collaborating partners such as the Global Fund, PEPFAR and UNAIDS.

“Gender inequality must be tackled because this is the only way to end the global HIV epidemic and achieve other broader development outcomes because HIV affects adolescent girls and young women disproportionately because of the unequal power dynamics between men and women. The global community will never deliver on ending AIDS if young people are not fully engaged and in the lead, since the young people are the most effective engine for social change.”

“To tackle the persisting barriers, more efforts are needed to challenge harmful laws, policies and practices that negatively impact young people’s access to services including age and spousal consent requirements, early and forced marriages, lack of comprehensive sexuality education, lack of harm reduction services and criminalization against young key populations. Data gives us direction, measures the impact of our work at the grass-root level.”

“There is a need to focus on the needs and priorities of the adolescent girls and young women, and fund initiatives implementing the same intervention. It is clear that participation and inclusion is a core human rights principle. Moreover, the sustainability of HIV response highly depends on our capacity to reach the most marginalized, including young people, to address their specific needs. The effectiveness of programs and interventions targeting young people can be ensured with the full participation of young people in their design, monitoring and implementation.”

— Irene Ogeta, ATHENA Network member and young women advocate

UNICEF and WHO are key technical partners in the Global Fund’s Catalytic Prevention Initiative, which is providing financial assistance to 13 countries to implement quality comprehensive services, using the United Nations Framework for Prevention of HIV in Adolescent Girls and Young Women as a reference. The majority of the countries are in Eastern and Southern Africa and up to US\$200 million has been invested. Maximizing the impact of this notable infusion of funds requires disciplined focus on the art and science of programme delivery at scale and in the most cost-effective manner. Each country has selected a combination of prevention interventions that span the biomedical, behavioural and structural spheres and reflect the country’s epidemiology, priorities and capacity.

Adolescent key populations

Adolescents who identify as a member of one or more most-at-risk groups, also called ‘key populations’ – males who have sex with males, sex workers, transgender populations, people who inject drugs – have multiple vulnerabilities because of their age and the heightened risks and HIV prevalence within these groups. Data are limited on adolescent key populations, including their size, HIV prevalence and access to treatment and prevention services. What is known underscores the importance of reaching and supporting these individuals more effectively, especially given the difficulties in reaching them with

prevention support that works well. Various studies and reports have concluded that young people account for a sizable share (20–40 per cent) of new HIV infections among key populations worldwide.¹⁰⁶

UNICEF continues to invest in efforts to improve the evidence base to inform better programming on young key populations in Indonesia, the Philippines, Thailand and Viet Nam (*see Case Study 18*). UNICEF commissioned a multi-country formative assessment on the needs of adolescents and youth at risk for HIV as a joint effort engaging nearly all the United Nations partners and civil society groups. The findings from this study have been used to promote further integration and innovation by covering areas such as mental health, parental/peer support, communication and education with specific reference to key populations. In China, UNICEF was involved in similar work through its technical assistance for data analysis on adolescents (15–19 years) and young people (20–24 years) at risk for HIV. That work was associated with case-based surveillance undertaken by the Government in partnership with UNAIDS, WHO and the World Bank. Also, findings from the first ever web-based cross-sectional survey on adolescent and young males who have sex with males (15–19 years), using respondent-driven sampling methodology in three large cities in China, will guide programmes that respond to the special needs of members of that population as well as adolescent and young key populations more widely.

CASE STUDY 18: The Philippines: Improving access to adolescent – and key population-friendly comprehensive HIV, health and mental health services

Prioritizing gender-responsive programming is especially important in the Philippines, because HIV risk is highly concentrated among young key populations, especially adolescent and young males who have sex with males. As of May 2019, a third of diagnosed HIV cases in the Philippines were youth (15–24 years), with 93 per cent of them being male. Among diagnosed adolescents (10–19 years), 96 per cent were infected through sexual contact, with 85 per cent of the risk of transmission being some form of male–male sex.¹⁰⁷

UNICEF supported the Government of the Philippines in a multi-level response to improve access to adolescent- and key population-friendly, comprehensive HIV, health and mental health. Areas of support included policies allowing children aged 15–17 to get tested for HIV without parental consent and an HIV situation analysis of Filipino children, adolescents and youth at risk. These data gathered from adolescents and young people, particularly on correct information regarding sexual and reproductive health and reproductive rights (SRHR), parental and peer support, and communication, were used to develop a legislative agenda and the three-year strategic plan of the Committee on Children and HIV/AIDS in 2020.

At the subnational level, UNICEF assisted the Department of Health in the promotion, roll-out and enhancement of adolescent-friendly health-care facility guidelines, which resulted in better articulation of adolescent health targets in the three-year local government rolling work. These guidelines were developed in a collaborative process involving regional, provincial and city coordinators from the Department of Health's Adolescent Health and Development Program. Additionally, UNICEF supported the improvement of adolescent-friendly service delivery systems, including the development of (1) a service delivery network for referrals, (2) integrated HIV services that are adolescent friendly and include a peer education life-skills programme, and (3) national youth hubs in the community providing life-skills education.

Complementary to this work, UNICEF supported the Government of the Philippines to incorporate gender-responsive features into the multi-level response, including:

- Targeting of young people with diverse gender identity and sexual orientation with learning group sessions and peer education;
- Development of learning resources that address discrimination on the basis of sexual orientation and gender identity;
- Ensuring that guidelines for adolescent-friendly health-care facilities and youth hubs mandate access to services regardless of gender or sexual orientation; and
- Strengthening of peer education to include attention to correct information on sexual orientation, gender and gender-based violence as well as SRHR.

Improving quality of adolescent HIV prevention services

Evidence and anecdotal observation strongly suggest that adolescents are poorly served by traditional health services and require services that are differentiated to their personal needs, values, preferences and choices. Adolescents' acceptance of and comfort with HIV prevention services are especially critical for key populations, who are at heightened risk of HIV acquisition and who have perspectives and experiences unique from the general population of adolescents.

"One of the major challenges that we have is differentiating between service provision for both urban youth and rural youth. We can't provide the same service for all of them. Their needs are different, so how we structure our service delivery method is different. For example, for rural youth we have to mobilize through communities through use of posters, word of mouth and community groups. But with urban youth social media is great – we are able to create a post and then the young people within that urban area can easily access services."

— Millicent Sethaile, youth sexual and reproductive health and rights officer at SRHR Africa Trust and HER Voice ambassador, Botswana

Most current strategies for adolescents and young people refer to 'combination' prevention, which includes biomedical, behavioural and structural interventions, thus approaching the issue on several fronts. Reaching adolescents with information and services that are relevant and acceptable to them is often compounded by challenges related to age-of-consent policies, punitive laws and HIV-related stigma that discourage adolescents from seeking services. HIV prevention interventions such as PrEP and HIV self-testing will only be effective when these populations are explicitly considered in market-shaping strategies and when the tools are paired with population-specific support services. The following are examples of UNICEF work to make sure services take into account the needs of adolescents and young people.

Quality improvement

- The Government of Lesotho is improving the ability of providers to meet HIV and broader health needs of adolescents through the Let Youth Lead initiative. As part of the project, young people visit health-care facilities and rate the services they receive, using a detailed scorecard. They ask, among other questions, if the health-care facilities have 'youth corners' or spaces for confidential chats, if staff are readily available or if young people have to wait a long time for service, whether health-care professionals were properly trained to deal with issues, and whether adolescents are given free basic health services. These youth scorecards are one way of ensuring that the minimum standards for adolescent-friendly health services are being met. Implementers report



(Foreground) Peer educator Jay R. Damondon, 22, discusses how to prevent HIV/AIDS and other sexually transmitted diseases with young people in a poor section of Tondo, a neighbourhood of Manila, the capital. He volunteers with the local NGO PRRM (Philippine Rural Reconstruction Movement), a UNICEF-assisted organization that trains youth leaders, counsels young people on health-related issues and supports children who are subject to sexual exploitation or other forms of abuse.

that health worker knowledge on adolescent-friendly health services has increased from 35 per cent to 75 per cent, and correct knowledge of SRHR among young advocates has improved from 30 per cent to 72 per cent.

Non-traditional access points

- In Jamaica, the Ministry of Health and Wellness (MoHW) has recognized the importance of extending non-traditional access points for adolescents outside of health-care facilities. The Teen Hub, an innovative MoHW intervention supported by UNICEF, served more than 6,500 adolescent boys and girls (10–19 years) between January and October 2019 and provided HIV testing and counselling for 496 adolescents (262 girls and 234 boys) aged 16–19.

- In Peru, UNICEF advocated for and supported the development and approval of Health Guidelines for Comprehensive Adolescent Healthcare. The guidelines outline actions for providers to improve access to sexual, reproductive and mental health services and comprehensive care for children and adolescents living with HIV.

Implementation of biomedical prevention

- In Thailand, UNICEF worked with the Ministry of Health to develop an adolescent PrEP strategy and operational guidelines for the national programme.
- In Botswana, UNICEF supported the Ministry of Health to develop a national prevention framework for adolescent girls and young women that includes PrEP.



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Youth leaders stand in a circle, holding hands, to symbolize the slogan 'We can do it together', at a child care centre run by Precious Jewels Ministry, a local NGO that supports AIDS-affected children in Manila, the capital. Youth leaders are themselves affected by AIDS. The UNICEF-assisted centre offers medical assistance, educational activities and counselling, as well as community outreach to raise awareness of HIV/AIDS and combat the stigma associated with the disease.

Holistic and integrated approaches to delivering HIV prevention services to adolescents

We are still struggling to reduce new HIV infections among adolescents, with some success in Eastern and Southern Africa and East Asia and the Pacific, but stagnant or growing epidemics in much of the rest of the world. To be successful, HIV prevention must take a holistic approach to address the multiple challenges that the most vulnerable adolescents experience and to strengthen the institutional response to HIV risk and vulnerability. UNICEF uses a systems-strengthening approach to leverage a range of sectors and structures beyond HIV and health, including education, social welfare, labour and employment, human rights and gender equality.

The midterm review of the current UNICEF Strategic Plan found that, across UNICEF, the HIV section stands out for its highly nuanced approach to gender equality based on analysis of intersectional factors that shape gendered vulnerabilities to HIV. Many of them – including poor access to education, gender-based violence, unequal access to information including on sexual health, a lack of negotiating power and limited economic autonomy – affect adolescent girls and young women and put them at increased risk of HIV infection.

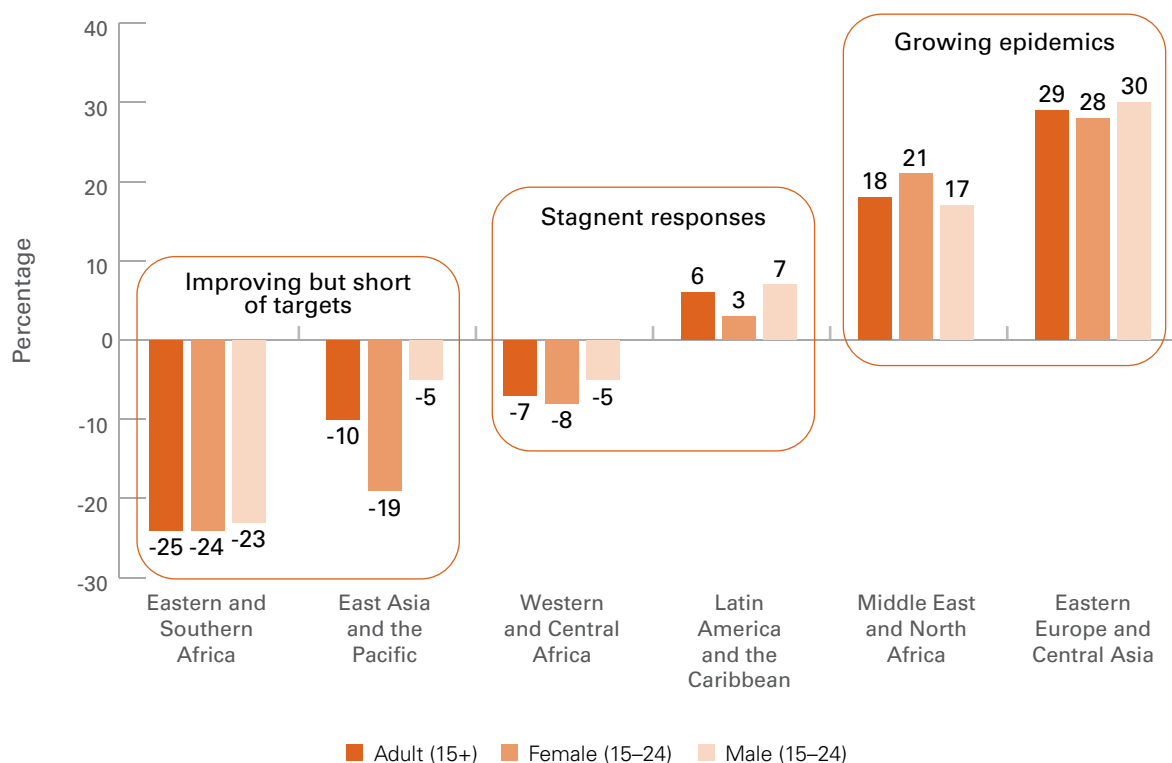
“We need to tailor human rights to HIV interventions and policies. We need to develop research agendas that take a comprehensive approach to integrating biomedical and social context to develop multipurpose new prevention technology, expand the method mix and innovate HIV treatment options with adolescent girls and young women at the center.”

“We should invest in adolescent girls and young women as change agents, decision makers, and experts in their own right to conceptualize, lead, implement and advance their own solutions and initiatives.”

“To reduce the number of new HIV infections among adolescent girls and young women from 390,000 in 2015 to below 100,000 in 2020 we need to learn to re-strategize, learn from each other and adopt positive strategies.”

— Rejoice Eve Namale, ATHENA Network’s #WhatWomenWant and #WhatGirlsWant focal lead for Malawi

FIGURE 72: Change in new HIV infections by region, age and sex, 2010–2018



Source: Global AIDS Monitoring and UNAIDS 2019 estimates.

UNICEF is working to advance holistic, gender-informed programming through various sectors and platforms such as the four-year 2gether 4 SRHR programme, supported by Sweden and launched in December 2017. In partnership with UNFPA and WHO, UNICEF is exploring innovative holistic approaches to reducing HIV vulnerability among adolescent girls and young women. It is currently being implemented in five countries – Lesotho, Malawi, Uganda, Zambia and Zimbabwe – with the expectation that the lessons learned from these five countries will be amplified and shared with other countries so that they can strengthen their responses.

Specific examples of services and approaches that should be scaled up for better prevention results include the following.

Mentoring and social support servicers

- In Lesotho, the 2gether 4 SRHR programme is supporting community-based peer mentoring for 300 pregnant and breastfeeding adolescent girls and young women, their partners and babies, and 300 mothers-in-law in two districts. The initiative includes individual and group education, support and linkage to health and social services, and holistic psychosocial support and income generation. Through the formation of village support groups, an additional 335 adolescent girls and young women have been reached. After the first year, implementers report that self-reported knowledge has improved, use of modern methods of contraception has increased, and testing and knowledge of HIV status and ANC attendance have improved. Evidence from this effort will be used to inform the revision of Lesotho's national Essential Health Package.
- In Malawi, the 2gether 4 SRHR programme, in partnership with mothers2mothers, is implementing a peer intervention that has trained a total of 47 young mentor mothers and 41 adolescent champions (both boys and girls) to provide comprehensive health HIV and gender-based violence services, including information on SRHR - layered with ECD interventions. Altogether, the young mentor mothers have made 2,200 home visits and reached 289 pregnant and breastfeeding adolescents living with HIV, as well as their partners. Nearly 1,200 pregnant adolescents and young women have been screened for HIV and 40 couples with discordant HIV status have participated in positive prevention activities. The programme is seeing increases in services used and information provided, stronger linkages between facilities and communities, and increased opportunities to support early childhood development.

Peer-to-peer education

- In Cuba, UNICEF supported a peer-to-peer education programme that reached more than 30,000 adolescents; a communications activity in all Havana municipalities that reached 111,813 adolescents and young adults aged 15–19 years (55 per cent of them female); and training of 402 professionals from health services and other sectors in the provinces of Guantanamo and Santiago de Cuba on comprehensive health care for adolescents.

Skills-based HIV and sexuality education

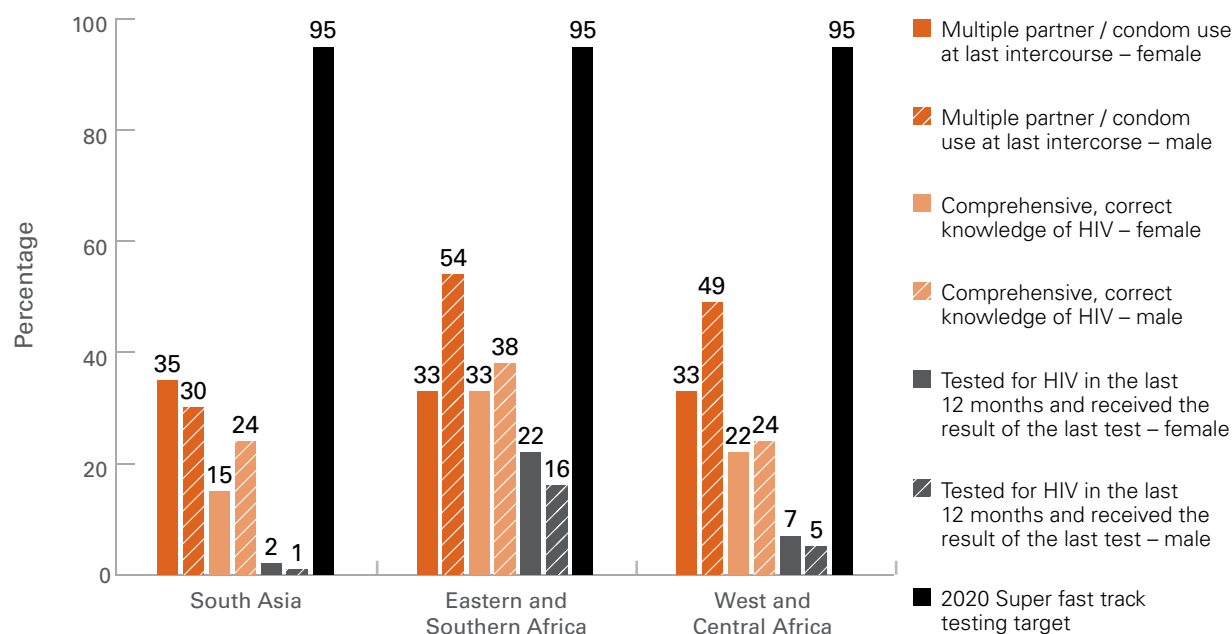
- In Namibia, UNICEF and partners have continued to support the provision of life-skills-based HIV and sexuality education. In partnership with the US Centers for Disease Control and Prevention (CDC), UNAIDS and the German, Swedish and Swiss governments, UNICEF supported efforts to provide psychosocial support and strengthen resilience among adolescent boys and girls. For example, the Galz & Goals Programme of the Namibian Football Association, rolled out to 11 of the country's 14 regions, is now reaching over 4,000 girls with HIV and life-skills-based messages through sports.

Integration of HIV, social protection and economic empowerment

- In the United Republic of Tanzania, UNICEF – in partnership with the Ministry of Health and Social Welfare, the Tanzania Commission for AIDS and the Tanzania Social Action Fund (TASAF) – designed and implemented the Cash Plus programme, an approach integrating social protection and economic empowerment with HIV, SRHR education and adolescent-friendly services. Over 1,300 girls and boys aged 14–19 completed their training and started implementing business plans using start-up grants from the programme. Implementers report preliminary outcomes including increased knowledge of HIV prevention (especially among girls) and more gender-equitable attitudes among boys. Based on these findings, TASAF has included the Cash Plus model as one of the strategies for the Government's Productive Social Safety Net phase 2 and has used this design to reach an additional 16,200 adolescent girls and young women through the Global Fund-supported National Adolescent Girls and Young Women Programme.

Adolescent HIV testing

FIGURE 73: HIV risk, knowledge and testing among young people, aged 18–24 years, by region



Source: Nationally representative population-based surveys, including Demographic & Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), AIDS Indicator Surveys (AIS) and other household-based surveys. Note: Population-weighted average among countries reporting nationally representative population-based surveys, 2012–2018.

Adolescents living with HIV are especially vulnerable to poor health outcomes because they are less likely than adults to know their HIV status and to be on ART. For example, a pooled analysis of nationally representative survey data available in 25 of the priority countries found that, overall, only about 8 per cent of adolescent girls and 5 per cent of adolescent boys were tested and received their test results in the previous year.¹⁰⁸ The challenges of reaching adolescents are multiple and varied, including: where they live (rural or urban setting); whether they are in school; cultural factors (e.g., restrictive gender roles, beliefs about same-sex sexual behaviours and acceptance of child marriage); and the convenience, accessibility and safety of adolescent-friendly diagnostic, ANC and comprehensive HIV services. Additionally, HIV-related stigma and discrimination are nearly universal challenges for all people living with or at risk for HIV, with adolescents and young people often the least equipped emotionally, financially, socially and intellectually to confront such challenges.

The following are examples of UNICEF support for adolescent HIV testing, often the first entry-point to holistic prevention and treatment services.

- In Kenya, UNICEF supported peer-led interventions and youth-centred approaches that (according to programme data) contributed to an additional 200,000 adolescent boys and girls being tested for HIV compared with the previous reporting year. This effort resulted in a total of 1.2 million adolescents aged 10–19 years old having HIV tests in 2019.
- In Guatemala, a national campaign launched in October 2019 seeks to promote HIV testing among adolescents as part of a wider effort to support their health and well-being. Known as *Avivate, Informate, Hoy* ('Get Up, Know, Today'), the UNICEF-supported campaign contributes to efforts to prevent new infections among adolescents by increasing their awareness and understanding of HIV. The rationale for the programme is based on fact that only one fifth of young people between the ages of 15 and 24 in Guatemala have comprehensive knowledge of HIV. The campaign is providing relevant prevention information and communication resources and using digital media and social networks commonly used by adolescents and young people. Information shared includes ways HIV can be transmitted; how to prevent HIV infection; and the importance of attending health services, particularly those designated as 'teen-friendly spaces'.

Digital solutions to reach more adolescents at risk

In partnership with Radio Botswana (RB2), the 'Shuga Radio' serial drama was successfully re-aired in 2019, reaching more than 100,000 adolescents and young people across the country with key HIV and SRHR awareness messages. Digital platforms and interpersonal communication approaches were integrated to further broaden the overall impact of the radio programme. For example, UNICEF entered into a partnership with a non-governmental organization (NGO) to host the drama series on a 'free to listen' interactive voice response platform, '124'. Over eight months, a total of 38,476 people accessed 'Shuga Radio' through the platform. Also, in partnership with a local NGO, the Shuga Radio peer education programme for in- and out-of-school youth was rolled out in two districts, reaching 7,500 young people with information about HIV and SRHR.

Pre- and post-assessments documented positive behaviour change, including improvement in intentions and perceptions, and identified interpersonal communication as the most effective approach to achieve results for adolescents and young people. Building on lessons learned and successes of 'Shuga Radio' season one, a new partnership with MTV's Staying Alive Foundation was established in 2019 to strengthen the quality of the peer education programme through utilization of a tested curriculum and for production of 'Shuga Radio' season two. With support from the Global Volunteer Initiative, the 30 volunteers who had been trained as youth advocates were also trained as peer educators (25) and trainers (5).

In Thailand, UNICEF and Path2Health made significant progress on the promotion of Lovecarestation.com, an online platform providing information and counselling services on adolescent health. In 2019, some 1.8 million people visited lovecarestation.com and received online health information. In addition, nearly 40,000 young people accessed the online clinics and received personalized counselling services. Information on issues related to mental health and referral services were promoted through the platform as well, with 314 service providers trained on psychological first aid, mental health screening and referral procedures.

Innovative digital solutions are also being implemented in Côte d'Ivoire, where UNICEF is combining prevention programming with a digital interface (geo-mapping, risk-profiling and online/offline service delivery) to improve geographical prioritization, targeting of at-risk adolescents, and delivery of HIV self-testing and PrEP services. Zimbabwe also continued implementation of the innovative digital platform U-Report to enhance community dialogue and awareness about HIV and SRHR issues among adolescents and young people.

Reducing stigma and discrimination

Strong and persistent HIV-related stigma is a huge obstacle to more effective responses among adolescents and young people. While adolescent girls, women and key populations often directly experience stigma, HIV-related stigma affects all people in all epidemic contexts. Along with partners, UNICEF is reducing stigma by directly addressing the social, cultural and legal contexts that perpetuate HIV-related stigma.

For example, stigma is often compounded by policy and legal frameworks that promote discrimination against adolescents and young people based on age, gender and affiliation with key populations. In Belarus, legal requirements to report HIV status to kindergartens, schools, colleges, universities and other facilities threatened confidentially and exposed students to bullying and discrimination. UNICEF-supported interventions, including programmes on adolescent leadership training and increasing knowledge on SRHR and ART adherence, helped to create a dedicated, well-informed group of adolescent advocates. This advocacy contributed to the successful removal of these reporting requirements by the Ministry of Health in July 2019.

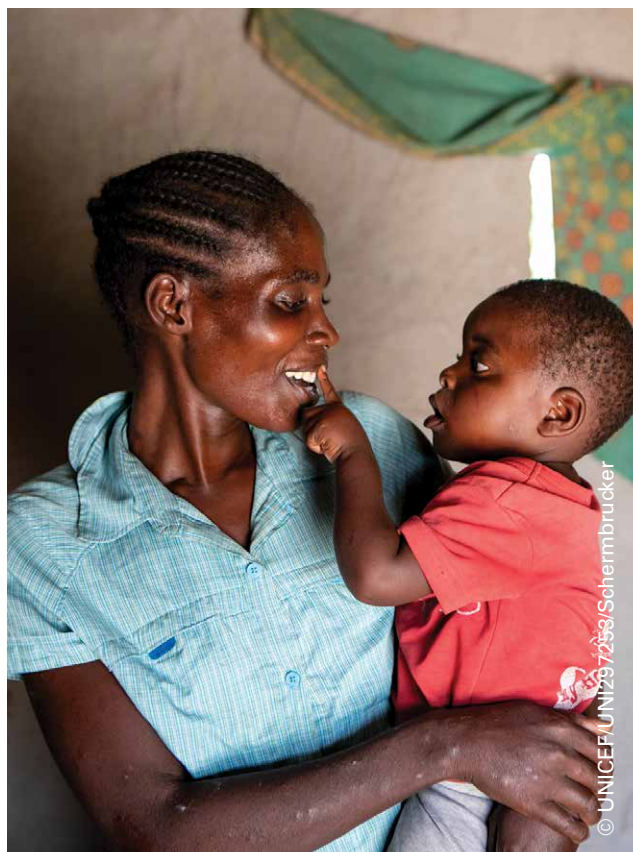
Lessons learned across HIV results areas

Lessons learned from expanding services to EMTCT show that, when there are technical and financial resources, political will, engagement of communities and strong PHC systems, HIV testing and treatment services can be expanded to reach the majority of women. In 2018, eighty-two per cent of women received ART and six high-burden countries in Africa reached the global goal of 95 per cent of pregnant women living with HIV receiving ART – largely as a result of integration of PMTCT programmes into every layer of MCH services. At the same time, UNICEF analysis also suggests that programmes need to be nuanced and look beyond HIV treatment coverage to achieve EMTCT. For example, there is a need to prioritize actions to improve retention in care and adherence to medication, through better service delivery models and strengthened community–facility linkages. In addition, HIV prevention efforts targeting HIV-negative pregnant and breastfeeding women need to be enhanced, as newly acquired maternal infections are an important source of new HIV in children, even where maternal ART coverage is high. This targeted analytical approach to defining EMTCT priority actions, is described in the guidance document *Last Mile to EMTCT*, which was developed by UNICEF in collaboration with partners in 2019. The last mile framework will inform future catalytic work by government, international donors and United Nations agencies.

For HIV treatment access, the key lessons learned include the fact that despite the progress made in expanding access to and availability of paediatric antiretrovirals, treatment coverage in children remains sub-optimal and HIV is still an important cause of morbidity and mortality, especially in sub-Saharan Africa. The issues span across the continuum – from lack of HIV testing to weak linkage to substandard treatment to poor retention in lifelong care. For example, finding children living with HIV is challenging when primary facilities where children seek care have no infant testing capacity and samples have to be sent to a regional or central laboratory. Even if infant diagnosis were more widely available, children who acquire HIV later during breastfeeding would not be picked up by a testing service that focuses on the youngest infants. In addition, treatment programmes for adults typically do not advocate for or support the testing of children of HIV-positive clients. UNICEF analysis indicates that the global targets to provide ART to 1.4 million children (aged 0–14 years) and 1 million adolescents (aged 15–19 years) by 2020 will be missed. Worldwide, about 940,000 children under the age of 15 were receiving ART in 2018.

Without improvements in service models, treatment coverage levels among children (54 per cent) will continue to lag behind adults (63 per cent globally in 2018) and pregnant and breastfeeding women (82 per cent). Further regional and country disparities will continue. UNICEF data indicate that, in 2018, West and Central Africa and Indonesia had the lowest ART coverage in children (40 per cent). Even the high-burden countries in Eastern and Southern Africa only achieved 60–70 per cent coverage. Programme quality is also an issue. Recent studies across a number of countries suggest that children have the lowest rates of virological suppression. To address these gaps, UNICEF is: supporting introduction and expansion of POC HIV testing for infant diagnosis at PHC level; promoting index family-based testing; engaging key implementing partners and donors (Global Fund, WHO, Elizabeth Glaser Pediatric AIDS Foundation, ViiV Healthcare, ELMA Foundation, Paediatric AIDS Treatment for Africa) around a common framework informed by data-and-evidence-based catalytic solutions to remove barriers to access to paediatric HIV treatment and improve retention in care within child health platforms, and developing the capacity of peer support networks to improve service access and retention in care among adolescents living with HIV.

The increasing population of adolescents and young people aged 15–24 years globally is of major concern when considering the potential impact on new adolescent HIV infections. The greatest increase in the youth population will be in sub-Saharan Africa, home to 82 per cent of the 3.5 million adolescents and young people living with HIV in 2018. Today, adolescents and young people account for about 36 per cent of all new HIV infections among those aged 15 and older.



UNICEF supported this family through a SEEVCA site in the Shibuyunji District in Zambia.

With these concerns in mind and to add to the conversation on whether we will have HIV epidemic control by 2030, UNICEF and partners conducted analyses of demographic and HIV epidemic trends projected for 2030 and 2050. With the current efforts, these analyses signal important predictions that call for better differentiation and regionalization of prevention efforts.

- While the number of adolescents and young people is projected to increase by 10 per cent from 2010 to 2050, the number living with HIV is projected to decrease by 61 per cent. In Eastern and Southern Africa, which hosts the largest HIV epidemic, new HIV infections among adolescents and young people are projected to decline by 84 per cent between 2010 and 2050. At the same time, in West and Central Africa, which hosts the second-largest HIV epidemic and the largest growth in the young population, new infections are projected to decline by just 35 per cent.

- Evidence from Eastern and Southern Africa suggests that the number of new HIV infections will depend more on the success of programmes and interventions. In particular, services will need to keep up with the projected population increase of adolescents and young people.
- A regional shift is happening. As the number of new HIV infections decreases in Eastern and Southern Africa, the region with the highest HIV prevalence, the rest of the world is projected to assume an increasing proportion of the global epidemic among adolescents and young people by 2050, with West and Central Africa accounting for 40 per cent of the projected new HIV infections among adolescent girls and young women (compared with 18 per cent in 2010) and 25 per cent of adolescent boys and young men (compared with 12 per cent in 2010).
- Eastern Europe and Central Asia is the only region with a projected increase in the number of adolescents and young people living with HIV.

Further differentiation of prevention efforts will require better disaggregated data. Data support will inform programmatic priorities to make the 'right investments' in the 'right places' and for the 'right people'. UNICEF is working with UNAIDS to improve data disaggregation, especially at the subnational level, to inform geographical prioritization and population targeting. The key lessons learned to date – from UNICEF technical support implementation efforts for the Global Fund catalytic initiative on prevention of new infections in adolescent girls and young women in seven African countries – is the importance of layering biomedical, behavioural and structural interventions for impact.

Community engagement and enhancing local expertise are central to effective HIV programmes. UNICEF is leveraging the community wisdom of individuals living with and at-risk for HIV. Investments in peer-to-peer models support the prevention, testing and treatment outcomes of pregnant and parenting adolescents and key populations. This civic engagement includes use of youth and adolescent advisory councils; expanding adolescent-friendly HIV-related health services to include complementary outreach services; integrating comprehensive sexuality education in schools; and social norms and behaviour change programmes that engage adolescents across health, education and sport environments. Furthermore, recognizing that innovation comes from those working closely on the issues and that there is no shortage of local knowledge and expertise, UNICEF, through the Adolescent Girls and Young Women Learning Collaborative, engages technical and community experts to enable and enhance multisectoral programming and bring together professionals from multiple sectors.

Integration is essential whenever and wherever possible. HIV-related outcomes depend on integration with strong PHC and social protection systems. UNICEF integrates HIV-related services for pregnant women, children and adolescents into service delivery models, including PHC and nutrition services, and utilizes adolescents themselves in a monitoring and quality-assurance role. With evident complementarity and potential for multiple dividends, HIV and ECD, HIV-sensitive social protection services, HIV and tuberculosis, HIV and chronic health conditions in childhood and adolescence, and HIV-responsive education services are just some of the ways in which UNICEF is pioneering integrated programming.

Stigma remains a primary barrier. Both internal and external stigmas are barriers to accessing services, making informed decisions, and health outcomes for all people affected by HIV, but particularly for adolescents who are uniquely vulnerable in many other ways. Programmes must address primary stigma through education and assurance of confidentiality, and integrate longer-term stigma-reduction strategies to address the social, cultural and legal contexts that perpetuate HIV-related stigma.

There will be no response without funding. While the Global Fund continues to receive steady support from donors, it only accounts for about half of the global funding need. Other donor mechanisms are flat or declining, and countries with high HIV burdens among children and adolescents do not have the needed fiscal space to cover HIV programme needs. Additionally, even when funding is available, the needs of pregnant women, children and adolescents are not always prioritized.

The midterm review found that UNICEF has a significant role to play in ensuring that global funds for adolescent girls and young women are invested in evidence-based, high-impact HIV interventions. However, a widespread lack of resources for HIV, including an 80 per cent reduction in UNAIDS allocations to UNICEF since the start of the Strategic Plan, has made it challenging to keep HIV visible as an organizational priority. This has been mitigated by covering staff costs through core resources, and a strategy of programme differentiation aligned to epidemic context, an approach adopted by major partners including PEPFAR and the Global Fund to improve the focus of their grant making.

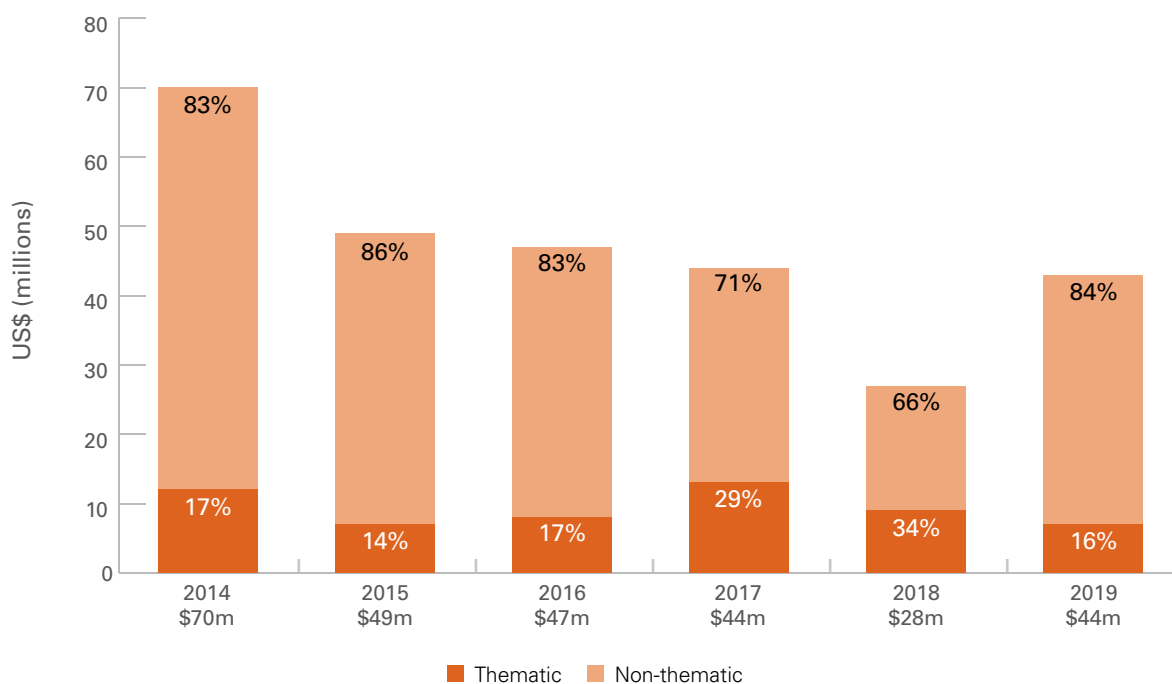
We have come so far from the early days when HIV devastated pregnant women, children and adolescents. The end is in sight and we know how to get there. The commitment, leadership and funding must remain to accelerate towards a firm trajectory of 'ending AIDS' as a public threat among children, adolescents and pregnant women.

HIV financial report*

*All funding data as of 6 April 2020, pending audit and certification.

HIV and AIDS income in 2019

FIGURE 74: HIV and AIDS ‘other resources – regular’ contributions, 2014–2019



In 2019, partners contributed US\$44 million ‘other resources – regular’ for HIV and AIDS, a 54 per cent increase over the previous year (see Figure 74). Public sector partners contributed the largest share of ‘other resources – regular’ to HIV and AIDS, at 78 per cent. The top five resource partners to UNICEF HIV and AIDS in 2019 were the Islamic Development Bank, UNAIDS, the Korean Committee for UNICEF, the Global Fund and UNFPA-managed United Nations Partnerships and Joint Programmes (see Figure 76). The largest contributions were received from the Islamic Development Bank for the Elimination of Mother-to-Child Transmission of HIV project in Cameroon, from the Korean Committee for UNICEF for global HIV and AIDS thematic funding, and from UNAIDS for Unified Budget, Results and Accountability Framework country envelopes 2018–2019 (see Figure 77).

FIGURE 75: Total HIV and AIDS funds received by type of donor, 2019: US\$44 million

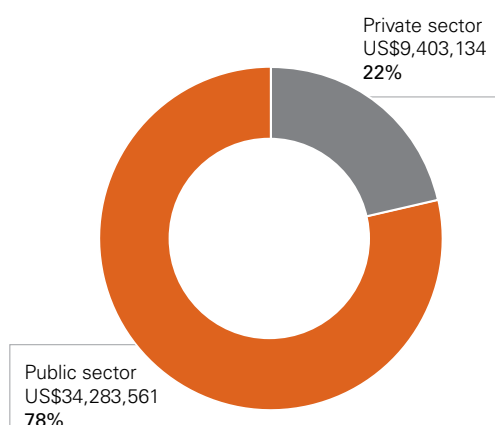


FIGURE 76: Top 20 resource partners to HIV and AIDS by total contribution, 2019

Resource partner type	Resource partners	Total (US\$)
1	Islamic Development Bank	18,470,000
2	UNAIDS	6,813,750
3	Korean Committee for UNICEF	5,677,920
4	The Global Fund	5,634,530
5	UNFPA-managed UN Partnerships and Joint Programmes*	2,931,229
6	United States of America	2,266,847
7	Hong Kong Committee for UNICEF	1,178,563
8	UNITAID	966,442
9	Canadian UNICEF Committee	857,349
10	Dutch Committee for UNICEF	621,160
11	UNDP-managed United Nations Partnerships and Joint Programmes	296,798
12	Finnish Committee for UNICEF	276,439
13	U.S. Fund for UNICEF	192,587
14	Australian Committee for UNICEF Limited	178,289
15	German Committee for UNICEF	167,926
16	French Committee for UNICEF	113,636
17	Kazakhstan	113,030
18	Danish Committee for UNICEF	108,934
19	Ireland	57,870
20	Japan Committee for UNICEF	25,347

* Cross-sectoral grant SC180128 (HIV and AIDS, Gender Equality)

FIGURE 77: Top 20 grants to HIV and AIDS, 2019

Rank	Grant description	Resource partners	Total (US\$)
1	Elimination of Mother to Child Transmission of HIV Project, Cameroon*	Islamic Development Bank	18,470,000
2	Global Thematic HIV and AIDS	Korean Committee for UNICEF	5,677,920
3	UBRAF Country Envelopes 2018-2019	UNAIDS	4,786,900
4	Strengthening integrated sexual and reproductive Health & Rights, ESARO**	UNFPA-managed UN Partnerships and Joint Programmes	2,931,229
5	Strengthening the National response to HIV/AIDS for scaling up prevention, Chad	The Global Fund	2,808,983
6	UBRAF HQ and ROs Activities 2018-2019	UNAIDS	2,135,086
7	Accelerating HIV/AIDS response through resilient, sustainable health systems, Chad	The Global Fund	2,036,461
8	Accelerate Access to Innovative Point of Care HIV Diagnostic (PHASE 2)	UNITAID	966,442
9	Global Thematic HIV and AIDS	Netherlands Committee for UNICEF	621,160
10	Support to DREAMS, Tanzania	United States	458,235
11	Transition to Scale: Adolescent Mentors for Adolescent Mothers, South Africa	Canadian Committee for UNICEF	438,164
12	Grand Challenges Canada's innovation Platform (U-Test) for MNCH, Cote D'Ivoire	Canadian Committee for UNICEF	419,184
13	Achieving an AIDS free generation, South Africa	United States	409,355
14	Global Thematic HIV and AIDS	Hong Kong Committee for UNICEF	393,812
15	Elimination of Mother to Child Transmission of HIV, Cambodia	Hong Kong Committee for UNICEF	392,456
16	Achieving Zero Infection, better Health and Development for Children, China	Hong Kong Committee for UNICEF	392,295
17	Investing Towards Impact for HIV and AIDS in South Sudan	UNDP-managed UN Partnerships and Joint Programmes	296,798
18	Achieving an AIDS free generation, Tanzania	United States	295,735
19	Global Thematic HIV and AIDS	Finnish Committee for UNICEF	276,439
20	VAC Response Plan, Mozambique	United States	236,623

* Contribution was provided by the Islamic Development Bank to the Government of Cameroon, and UNICEF received funds through the agreement with the Government to support the implementation of HIV Programme

** Cross-sectoral grant SC180128 (HIV/AIDS, Gender Equality)

Notes: ESARO, Eastern and Southern Africa Regional Office; HQ, headquarters; MNCH, maternal, newborn and child health; ROs, regional offices; Unified Budget, Results and Accountability Framework (UBRAF); Violence Against Children

FIGURE 78: Thematic contributions by resource partner to HIV and AIDS, 2019

Resource partner type	Resource partner	Total (US\$)	Percentage of total
Private sector 100%	Korean Committee for UNICEF	5,677,920	78.56%
	Dutch Committee for UNICEF	621,160	8.59%
	Hong Kong Committee for UNICEF	393,812	5.45%
	Finnish Committee for UNICEF	276,439	3.82%
	Danish Committee for UNICEF	108,934	1.51%
	German Committee for UNICEF	83,228	1.15%
	U.S Fund for UNICEF	26,495	0.37%
	Japan Committee for UNICEF	25,347	0.35%
	Norwegian Committee for UNICEF	14,035	0.19%
Grand total		7,227,368	100.00%

Note: Grant numbers are provided for IATI compliance: SC1899020001, SC1899020004, SC1899020005, SC1899020006, SC1899020007, SC1899020010, SC1899020012, SC1899020013, SC1899020014, SC1899020015

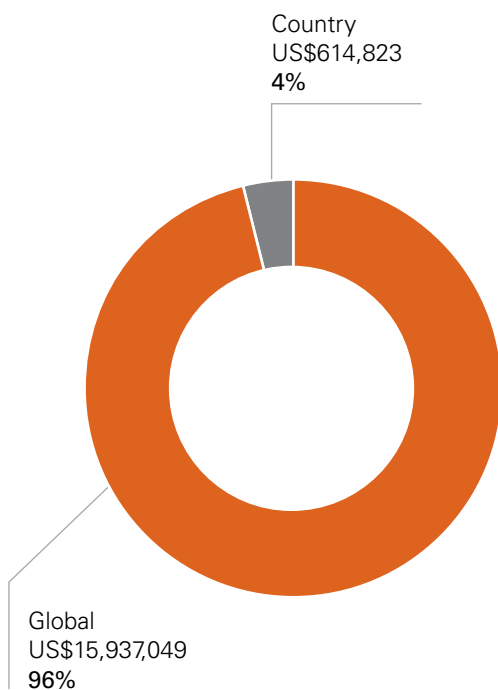
The partnership with Grand Challenge Canada resulted in successful mobilization of US\$1.5 million for ‘U-test’, a joint programme effort with key institutions and constituencies across Côte d’Ivoire and beyond, that is aimed to provide a pathway to scale key innovations in HIV prevention for at-risk adolescents and young people in a major epidemic in West Africa.

The CDC and UNICEF Headquarters have partnered formally through cooperative agreements since 2015. Over the years, this partnership has been able to draw on UNICEF’s comparative advantage as the global leader in the promotion of and action for the protection of children’s rights and help to guide programming in the areas of survival and development. Specifically, the cooperative agreement addresses women’s and children’s health and welfare issues, as they relate to HIV/AIDS. In 2019, this collaboration resulted in mobilization of US\$1.1 million in four countries (Mozambique, Namibia, South Africa and the United Republic of Tanzania).

Of all thematic HIV and AIDS contributions that UNICEF received in 2018 and 2019, ninety-six per cent were global-level contributions. These are the most flexible sources of funding to UNICEF after regular resources and can be allocated to regional and country offices to meet priority needs.

UNICEF would like to thank the nine partners that contributed total HIV thematic funding; the highest contributors were the Korean Committee for UNICEF (78.56 per cent), the Dutch Committee for UNICEF (8.59 per cent), the Hong Kong Committee for UNICEF (5.45 per cent), the Finnish Committee for UNICEF (3.82 per cent) and the Danish Committee for UNICEF (1.51 per cent). The German Committee for UNICEF provided country-level thematic funding towards HIV and AIDS activities in Malawi.

FIGURE 79: HIV and AIDS thematic funding contributions at country, regional and global levels, 2018-2019

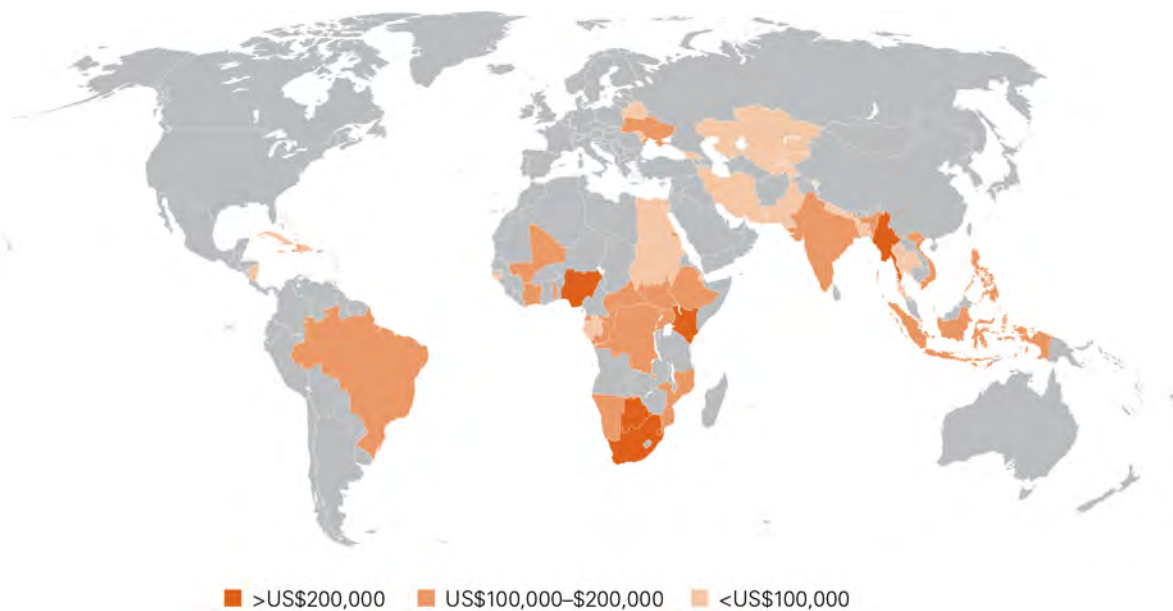


The global thematic funding was allocated based on the criteria below:

- AIDS-related deaths among children and adolescents
- New infections among children and adolescents
- Number of intensive programming countries in the region
- Country's strategic focus on the HIV programme (HIV programme-related outputs and indicators in country programme document)
- Regional funding allocation cap – maximum 30 per cent per region.

In consultation with UNICEF regional offices, it was agreed that most of the funding would be allocated to 35 countries prioritized for intensive UNICEF programming support in the UNICEF HIV/AIDS Global Vision and Strategic Direction document (see Figure 80). Country office allocation from regional shares were mainly to support country activities to end AIDS in children through enhanced efforts to (1) eliminate new HIV infections in children where there are critical gaps, (2) provide treatment and care to children and adolescents, and (3) implement priority multisectoral actions to prevent HIV in adolescents.

FIGURE 80: Allocation of global HIV and AIDS thematic funding to offices and programmes, 2019



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 2019 (see Annex).

HIV and AIDS expenses in 2019

FIGURE 81: Expenses by thematic sector, 2019 (US\$5.650 billion)

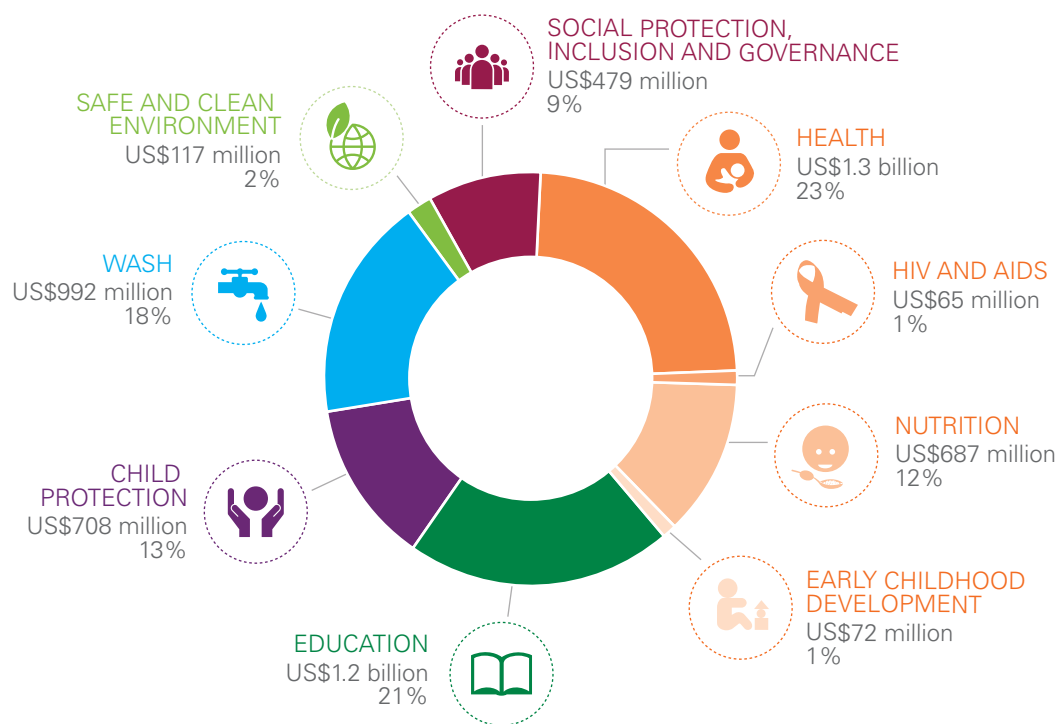
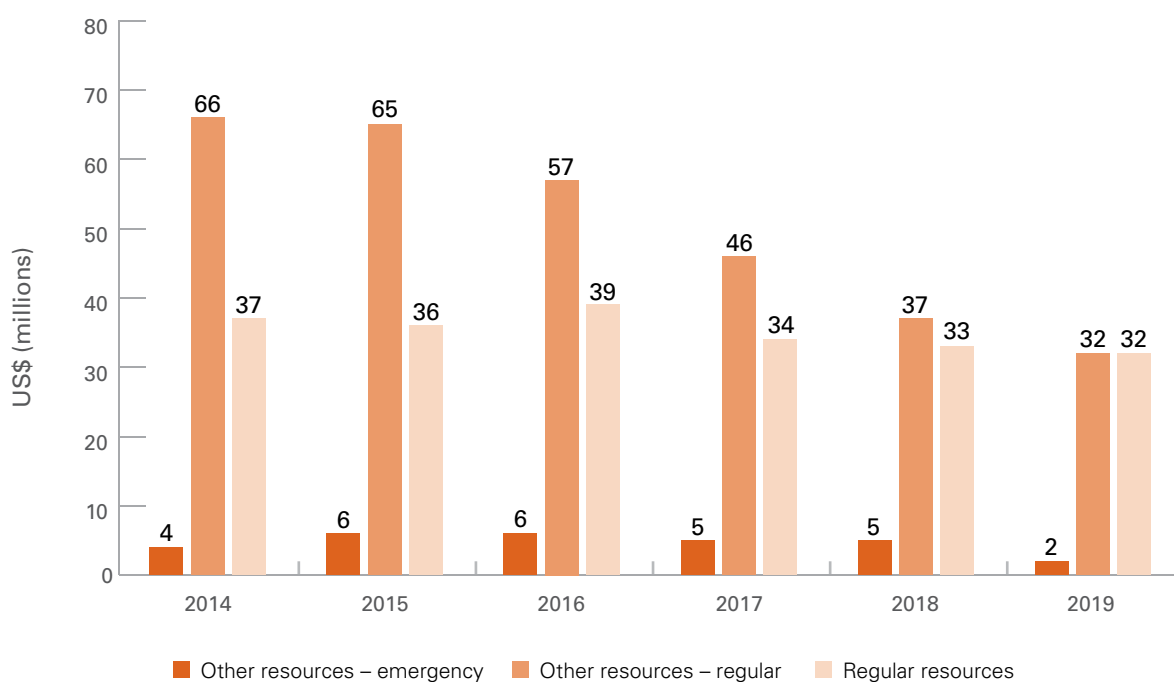


Figure 82: Expense trend for HIV and AIDS by year and fund type, 2014–2019



UNICEF HIV spending continued to decline in 2019: US\$65 million spent in 2019 was US\$10 million less than in 2018 and is only 60 per cent of the US\$107 million spent in 2014. HIV spending in 2018 was 1 per cent of total UNICEF programme expenditures.

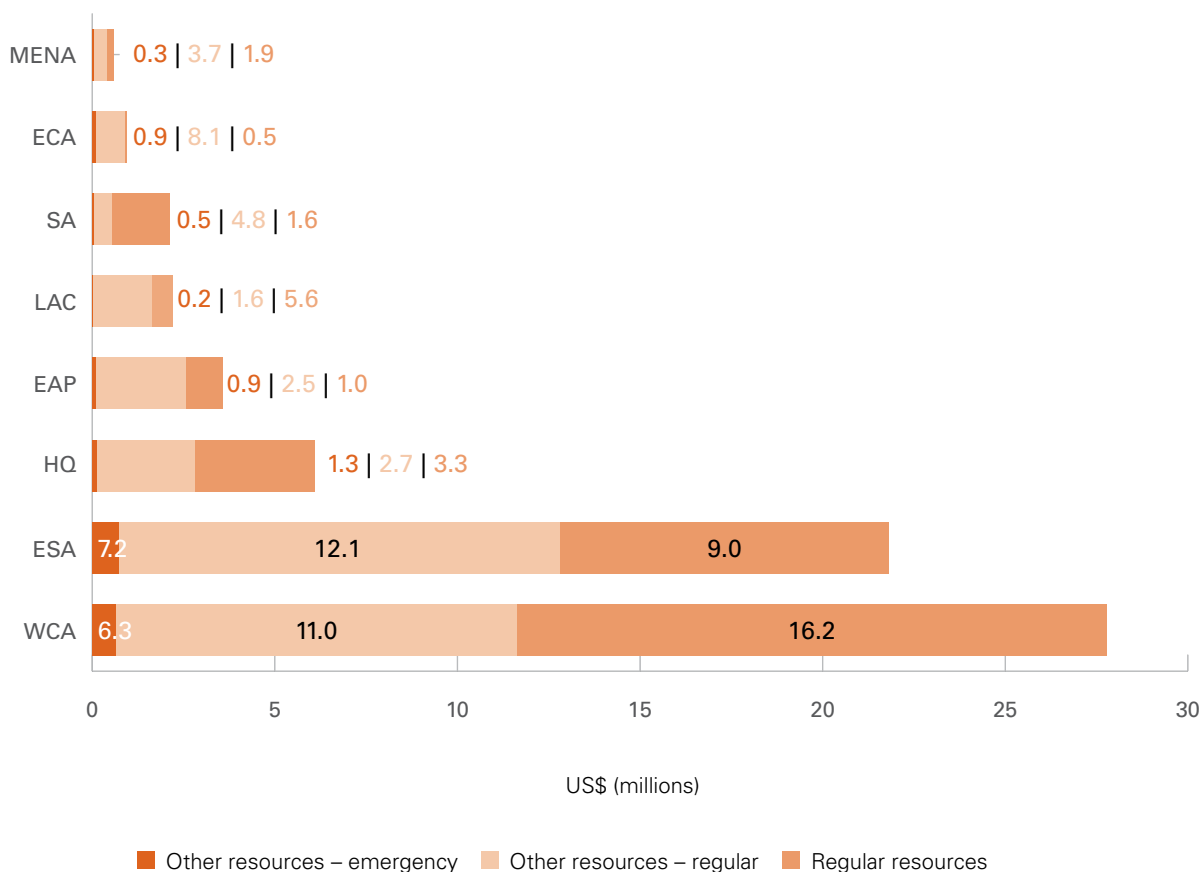
This worrying negative expenditure trend over the past few years is mainly due to declining ‘other resources – regular’ (ORR). In 2019, ORR totals were less than half the amount in 2014. The other main reductions are in regular resources (RR). It should, however, be noted that, with HIV interventions increasingly becoming more integrated in country programmes, actual HIV expenditures may be underestimated in the current calculations.

The declining HIV expenditure trend in recent years is a concern as it is negatively impacting the organization’s ability to respond to remaining gaps and programme quality issues in priority countries. UNICEF direct support and ongoing advocacy on children and AIDS issues is particularly important at this stage of the epidemic and if the world is to ‘end AIDS in children’ with the emerging additional threats posed by the COVID-19 pandemic.

Spending through the HIV and AIDS programme area was based on investment need and therefore varied widely among regions (*Figure 83*). The largest share of overall spending, about US\$28 million (43 per cent of the total), was in West and Central Africa, the region second most highly impacted by HIV after Eastern and Southern Africa. An even greater share (50 per cent) of total global regular resources, the most flexible type of funding, was spent in that region.

In collaboration with other UNAIDS cosponsors, UNICEF in recent years has considered West and Central Africa to be a key focus for HIV and AIDS work. Improving the situation in the region remains a priority because the needs and gaps continue to leave so many people behind. It has the world’s second greatest overall HIV burden, and progress towards meeting key targets for HIV responses in general – and for pregnant women, children and adolescents more specifically – lags considerably compared with global averages and most other regions.

FIGURE 83: Expenses for HIV and AIDS by region and fund type, 2019



Notes: EAP, East Asia and the Pacific; ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; HQ, headquarters; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; SA, South Asia; WCA, West and Central Africa.

Eastern and Southern Africa spent most the remaining total funding, including regular resources. Combined spending in those two regions was more than three quarters of total expenses in 2019, which roughly corresponds to the regions' combined share of the global HIV burden. UNICEF funding through the HIV and AIDS programme area was considerably less in other regions, all experiencing low and concentrated epidemics and with activities focused on strategic programme areas to address programme inequities.

Similar to how the regional shares of thematic funding was allocated, epidemic burden and programme needs helped determine amounts allocated and spent in individual countries. More than two thirds (68 per cent) of all spending in the HIV and AIDS programme in 2019 went to 20 countries; of which, all but 3 are in West and Central Africa or Eastern and Southern Africa. Five countries accounted for a collective 36 per cent of the total spending, including four in West and Central Africa: Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Nigeria and the United Republic of Tanzania.

It is encouraging to note that most of the expenditure at the country level is from regular resources. In the

Democratic Republic of the Congo, for example – where total spending was US\$6.1 million in 2019, the highest expenditure across all countries, the resources were from flexible regular resources. This amounts to 55 per cent money spent in the 20 top countries. In comparison, regular resources accounted for more than 90 per cent of total expenses in Nigeria, the country with the second-highest level of total spending (about US\$5 million). Only two other countries in the top 20 had comparably high shares of regular resources among total spending: Bangladesh and Cameroon.

Thematic funding, nearly all of which (97 per cent) came from 'other resources – regular' (ORR), is essential to supporting the HIV and AIDS programmes effectively at country, regional and global levels because there is greater leeway for how the money can be used.

Global thematic funding allocation criteria were revised in 2019 to better align with burden data and country offices' renewed priorities. Ultimately, of the US\$8.6 million spent, Eastern and Southern Africa had the largest share (37 per cent) of thematic funds in 2019. That share represented more than double the total provided to West and Central Africa.

FIGURE 84: Expenses for HIV and AIDS by top 20 countries and fund type, 2019

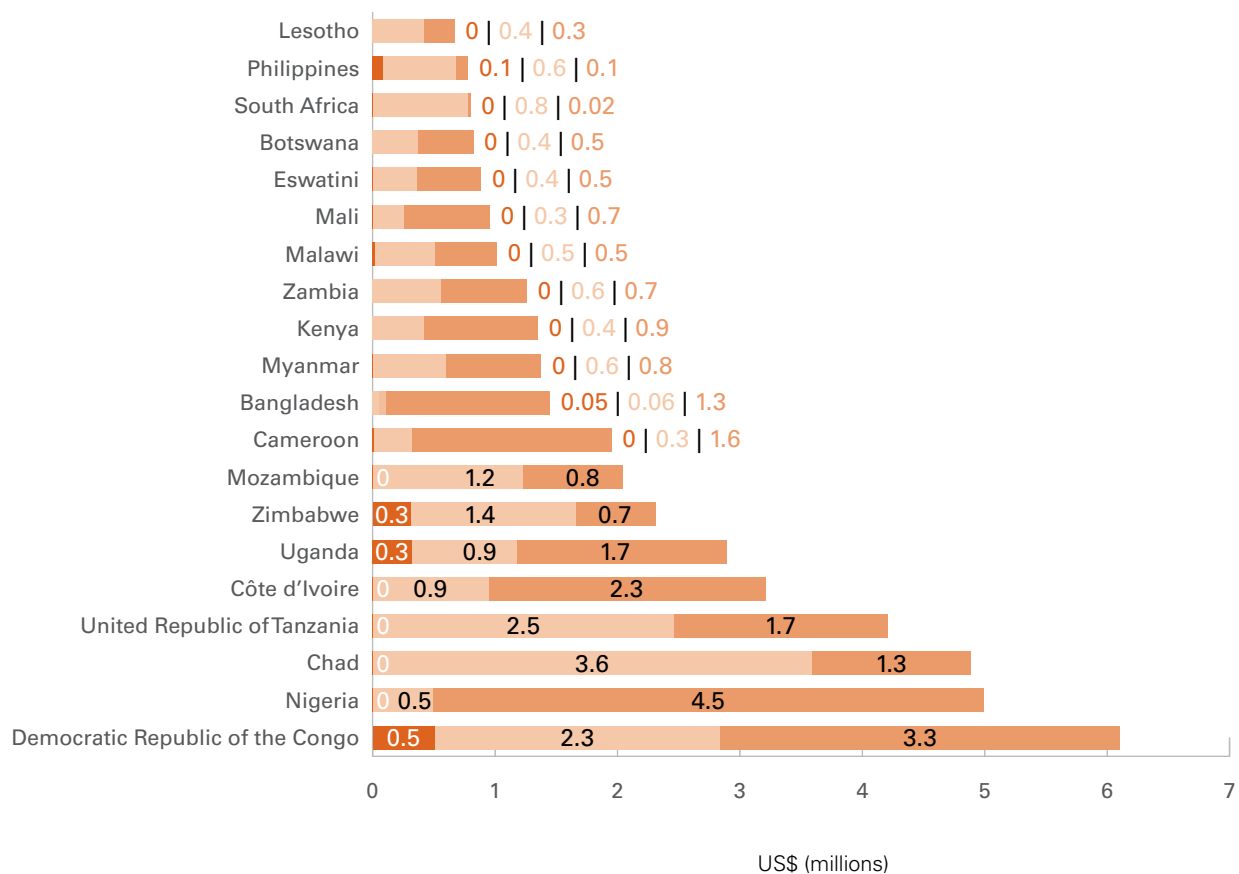
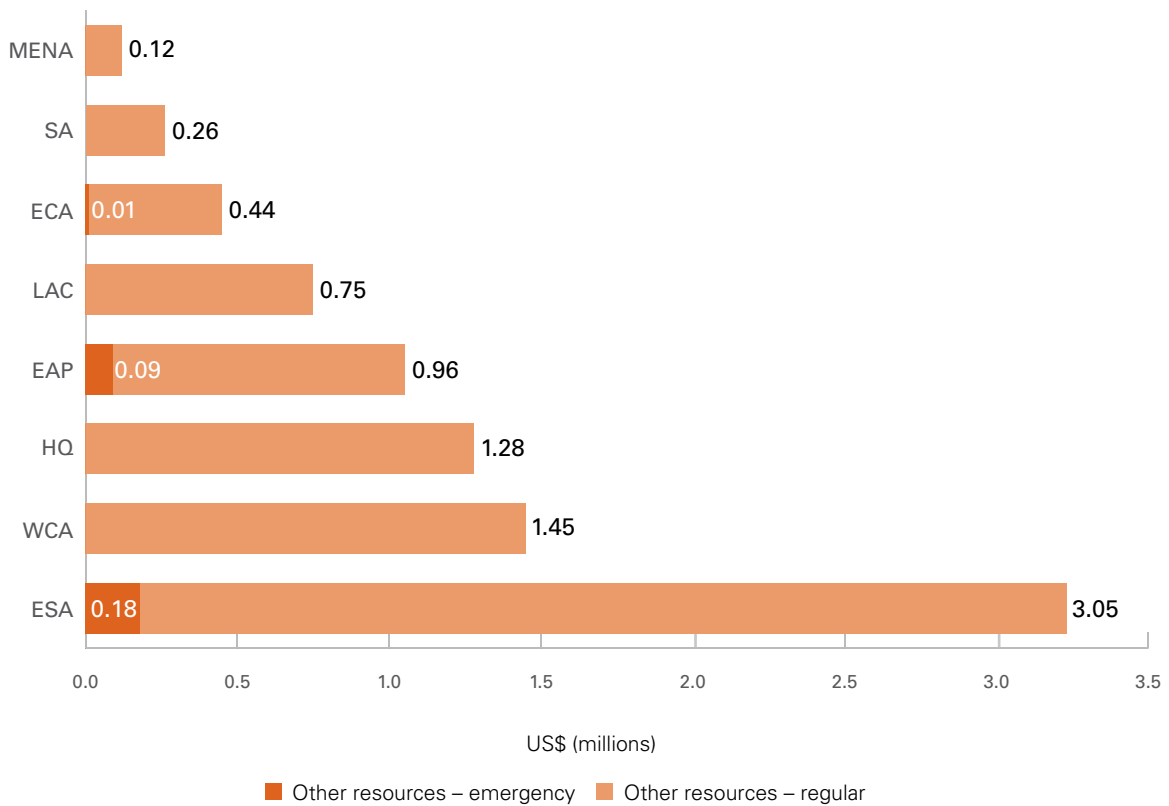
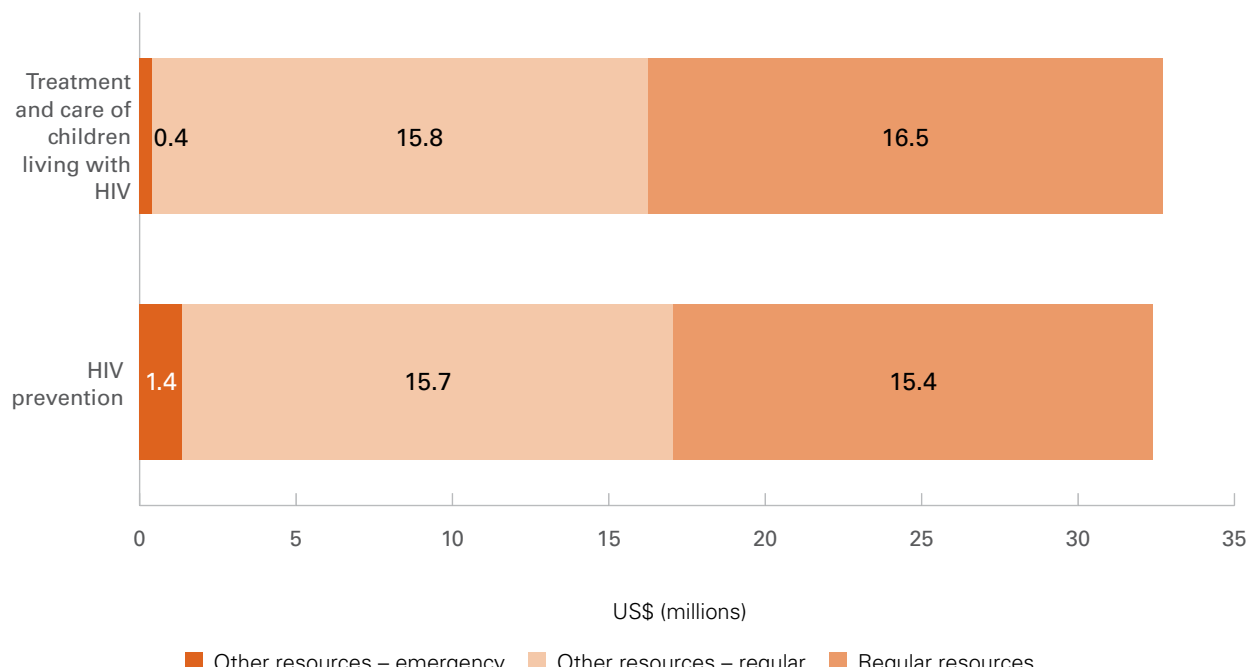


FIGURE 85: Thematic expenses for HIV and AIDS by region and results area, 2019



Notes: EAP, East Asia and the Pacific; ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; HQ, headquarters; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; SA, South Asia; WCA, West and Central Africa.

FIGURE 86: Expenses for HIV and AIDS by results area and fund type, 2019



Overall spending was split almost exactly in half by the two results areas of the HIV and AIDS programme: treatment and care of children living with HIV, and HIV prevention. Slightly less than US\$32 million was spent in each area in 2019.

Overall, nearly half (44 per cent) of investments for treatment and care of children living with HIV were spent in West and Central Africa in 2019.

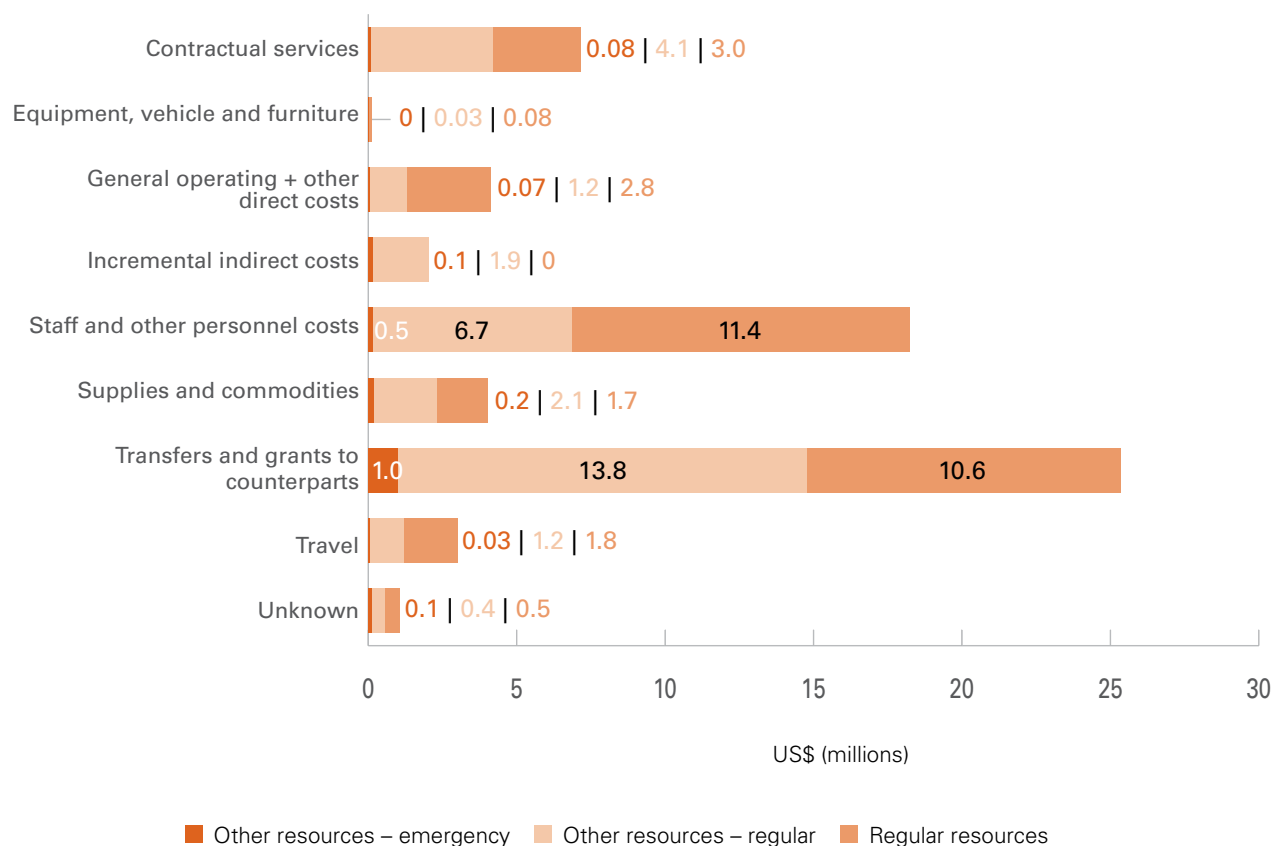
West and Central Africa also topped the regional list in terms of spending on HIV prevention, receiving 41 per cent of total expenses. Technical assistance was the second-highest HIV prevention intervention by spending amount for both results areas in West and Central Africa in 2019.

As indicated in *Figure 87*, the grand total of HIV and AIDS programme expense as well as its three main constituent parts (ORE, ORR and RR) can be broken down into several cost categories. Two of which accounted for about

two thirds of all HIV and AIDS expenses: 'transfers and grants to counterparts' (US\$25 million), and 'staff and other personnel costs' (US\$18 million). The high share of expense in the 'transfers and grants' category highlights the importance UNICEF continues to place on supporting counterparts in implementing high-impact HIV and AIDS interventions to better serve pregnant women, children and adolescents in need.

The declining trend in funding for the UNICEF HIV and AIDS programme area is intrinsically linked to broader financing challenges for the global AIDS response. These challenges are not new. Donor support has declined significantly, and bilateral assistance, notably from PEPFAR, has essentially stagnated despite spiralling costs. The Global Fund, which is the other main funder of the global AIDS response, raised a record US\$14,000 million in 2019 to spend for its 2020–2022 funding cycle; however, this success in itself is not sufficient to counter the impact of the long-standing decline in overall external support for HIV responses.

FIGURE 87: Expenses for HIV and AIDS by cost category and fund type, 2019



Domestic funding remains the single biggest financing source for HIV responses at national level. Much of this statistic is driven by South Africa, home to the world's largest HIV programme, which is 78 per cent domestically funded. Some other countries have made significant efforts to boost domestic AIDS financing, but most are either unable or unwilling to allocate funding at the levels required to meet their needs. With almost 1 million children with HIV not on treatment, 160,000 new infections in children each year and close to 300,000 adolescents acquiring HIV annually, the job is far from done. Moreover, the health and economic impacts of the COVID-19 pandemic are likely to significantly set back what progress has been made, and make it even less likely that greater resources for HIV will be available domestically.

It is anticipated that the overall decreased funding trend for the UNICEF HIV and AIDS programme is likely to continue in 2020. The current central UNAIDS UBRAF allocation to UNICEF of US\$2 million per year is the same as in 2019, but that is 84 per cent lower than in the 2014–2015 UBRAF biennium. The steep decline in these core funds continues to constrain the work of the programme because this money is mainly used to support programme management and salaries for essential staff members at headquarters and regional offices.

On a more positive note, UNICEF raised US\$4.5 million for 2020 activities from the UNAIDS UBRAF country envelopes, a recently established funding stream intended to support country-level programming. Although this funding is an important source of catalytic resources, it is not enough to support the effort needed to achieve the UNICEF Strategic Plan targets.

In response to the ongoing financing problem, the UNICEF HIV/AIDS section has been actively engaged across four areas to close the funding gap.

1. **Lobbying for additional allocation of RR resources:** UNICEF has a unique mandate within the global response to ensure that prevention and treatment for children and adolescents do not fall by the wayside. UNICEF has achieved what some thought was impossible and prevented over 2 million infants from acquiring HIV over the years. This legacy must not fail; UNICEF must continue and sustain its institutional investments in the HIV programme.
2. **Expanding fundraising efforts:** UNICEF has long relied too heavily on just a few major funding partners to support the HIV and AIDS programme globally. In 2019, therefore, UNICEF developed and launched a new resource-mobilization strategy aimed at broadening and diversifying its funding base. This strategy will guide fundraising efforts throughout the year, but, as with other programme areas, the success of this effort will likely be influenced by the global COVID-19 pandemic. That unprecedented event and its consequences represent a new and unpredictable challenge to fundraising for the HIV and AIDS programme area as well as for UNICEF overall.
3. **Enhancing domestic funding efforts:** Notwithstanding the challenges of post-COVID recovery, UNICEF will continue to advocate for more domestic funds to be allocated to HIV programmes in countries.
4. **Leveraging resources from other sectors through shared accountability:** While some aspects of the HIV response require dedicated and targeted health programming, others can be more effectively achieved through linkage to other sectors. In 2020 and beyond, including into the next Strategic Plan period, UNICEF will actively seek to engage with related programmes – especially health, social policy, gender and education – to build shared value partnerships that can drive HIV results.



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Results: Early childhood development

A mother cuddling her baby in the village of Soki, in the center of Niger.

“When you pay attention to the beginning of the story, you can change the whole story.”

— Raffi Cavoukian, singer and founder of Canada’s Centre for Child Honouring

With the coronavirus disease 2019 (COVID-19) pandemic unfolding around the world, UNICEF is committed to staying the course in supporting the development of young children. Prolonged exposure to adversity and deprivations in nutrition and health can have a lifelong impact during the critical window of early childhood development (ECD). Sustaining resources and commitments to holistic ECD is critical and becomes even more urgent in the context of the COVID-19 crisis.

The year 2019 witnessed a significant increase in the recognition of the value of ECD and renewed commitments from key stakeholders to enhancing collaboration and investments in ECD across sectors. Across UNICEF, country offices are accelerating results in ECD, and 60 countries (up from 47 in 2018) were ranked as ‘emerging’¹⁰⁹ in their national ECD programmes which focused on promoting stimulation and nurturing care for young children. This momentum needs to be maintained if we are to achieve the Sustainable Development Goals (SDG) and Strategic Plan (SP) targets. Increased adoption of the Nurturing Care Framework (NCF)¹¹⁰ by governments was evident. High-level advocacy spurred political leaders and stakeholders to enhance their commitment to ECD in emergencies. As always, in leading with rigorous evidence, and in collaboration with a high-level group of technical experts, UNICEF led the way in establishing a global measure of SDG 4.2.1 (called the ECDI 2030), which was endorsed by the United Nations Statistical Commission,

to track ECD outcomes. With partners, UNICEF led well-articulated engagement with governments and the business sector on family-friendly policies (FFPs). These emerging areas presented opportunities for UNICEF to cement relationships with other agencies and partners, towards greater results for children. The momentum is also beginning to be visible as UNICEF support for system-strengthening and teacher development in early learning contributed to 58 per cent of countries now reporting effective early childhood education systems, up from 44 per cent in 2018; however, inequities still persist and UNICEF expenditure in this area was lower in 2019 than in 2018.

The momentum is promising; however, challenges persist: the world is off track to achieve the SDG goal of ECD. Additionally, as of 2019, only 60 per cent of children in UNICEF programme countries were receiving early stimulation and responsive care. Inequities still persist across the globe and demand for support to parents and caregivers is rising. ECD can serve as the platform for provision of that support but can also advance coordinated responses and results towards other SDGs. To accelerate progress towards stimulation and responsive care, UNICEF needs to sustain momentum in implementing multisectoral ECD interventions in humanitarian and development contexts, through increased investment in capacities and skills of front-line workers, and equally importantly in programmes to *support parents and caregivers*, who provide the care children need to thrive. This is especially important as countries grapple with a crisis of care and learning exacerbated by the current pandemic, and caregivers need to prepare for a ‘new normal’. Enabling environments also need to be strengthened through technical support and advocacy for the government and business sector to implement FFPs, especially now as traditional networks of support get disrupted.

Result area/output statement for ECD

Output statement 1.h: Countries have institutionalized the delivery of quality early childhood development services as part of the health platform

As of 2019, only 72 per cent of children 36–59 months of age in 74 countries with comparable data are developmentally on track. Furthermore, only 60 per cent of children in UNICEF programme countries were receiving early stimulation and responsive care, which is critical to

getting children to be developmentally on track. UNICEF has been working towards increasing the proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being (SDG indicator 4.2.1 and UNICEF Strategic Plan, 2018–2021 impact indicator).

This chapter highlights UNICEF’s contribution to the three output indicators that assess whether countries have institutionalized delivery of quality ECD services. These are:

- 1.h.1. Number of countries that have adopted ECD packages for children at scale

FIGURE 88:* UNICEF Strategic Plan ECD output results data, 2019

Output indicator	Disaggregation	Baseline[1]*	2018 value	2019 value	Milestone (2019)	Target (2021)
1.h.1. Number of countries that have adopted ECD packages for children at scale	UNICEF programme countries with data	28	33	45	24	80
	EAP	1	1	5		
	ECA	4	4	8		
	ESA	6	7	9		
	LAC	13	14	14		
	MENA	1	2	3		
	SA	1	2	2		
	WCA	2	3	4		
1.h.2. Number of countries with national ECD policy or implementation plans for scale-up	UNICEF programme countries with data	65	67	83	94	116
	EAP	9	10	12		
	ECA	2	2	4		
	ESA	9	9	11		
	LAC	28	29	31		
	MENA	6	5	6		
	SA	3	3	4		
	WCA	8	9	15		
1.h.3. Percentage of UNICEF-targeted girls and boys in humanitarian situations who participate in organized programmes with ECD kits through UNICEF-supported programmes	UNICEF programme countries with data	80%	69%	76%	75%	80%
	Female	74,803	183,198	237,167		
	Male	73,652	194,591	245,943		
	Disability	1,528	3,425	2,608		
	EAP	93%	88%	101%		
	ECA	101%	64%	76%		
	ESA	92%	109%	64%		
	LAC	58%	77%	85%		
	MENA	57%	64%	44%		
	SA	52%	90%	100%		
WCA	96%	62%	75%			

Notes: * The original baseline was set using data for a subset of countries, while the latest value reflects all UNICEF programme countries with data; EAP, East Asia and the Pacific; ECA, Europe and Central Asia; ECD, early childhood development; ESA, Eastern and Southern Africa; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; SA, South Asia; WCA, West and Central Africa.

- 1.h.2. Number of countries with national ECD policy or implementation plans for scale-up
- 1.h.3. Percentage of UNICEF-targeted girls and boys in humanitarian situations who participate in organized programmes with ECD kits through UNICEF-supported programmes (humanitarian).

Improving services and community demand

Enhanced support for caregivers and parents: Integration of multisectoral packages into existing platforms

As in 2018, with continued emphasis on stimulation and responsive care in the early years, UNICEF supported countries to establish and scale up the delivery of multisectoral ECD interventions. Existing programme

platforms, such as community health centres, home-visiting programmes, parenting networks and preschools are increasingly utilized as entry-points to integrate stimulation and responsive care with maternal health, child health, nutrition and early learning services.

It is also notable that the number of countries in the 'emerging' category of the ECD four-level scale (Figure 89) has sharply increased from 47 in 2018 to 60 in 2019 (see Figure 90). Countries at the emerging level demonstrate the potential to go to scale in the near future with effective technical supports and advocacy efforts.

Dedicated support from country offices for ECD programming has resulted in the strengthening of multisectoral packages, systems for delivery, capacity development, as well as political commitment for sustainable scale-up. Extensive field support and operational guidelines from regional offices and UNICEF Headquarters have also contributed to this progress. Field engagement on the NCF has facilitated multisectoral coordination between health, education, social

FIGURE 89: Early childhood development package four-level rating scale for countries

1. WEAK	2. EMERGING	3. ESTABLISHED	4. ADVANCED
Funded, implemented and monitored by UNICEF and/or local partners only (NGOs, CSO, private sectors, etc.)	There are at least two interventions that address stimulation for children aged 0–59 months adopted by the government but <i>lacking a costed action plan</i> to scale up with government's ownership	There are at least two interventions that address stimulation for children aged 0–59 months adopted by the government with a costed action plan to scale up with government's ownership	Government-led interventions with costed action plan and with both (a) monitoring system and (b) coordination mechanisms

Notes: CSO, civil society organization.

FIGURE 90: Status of multisectoral ECD packages at scale: 2018–2019 progress overview¹¹¹

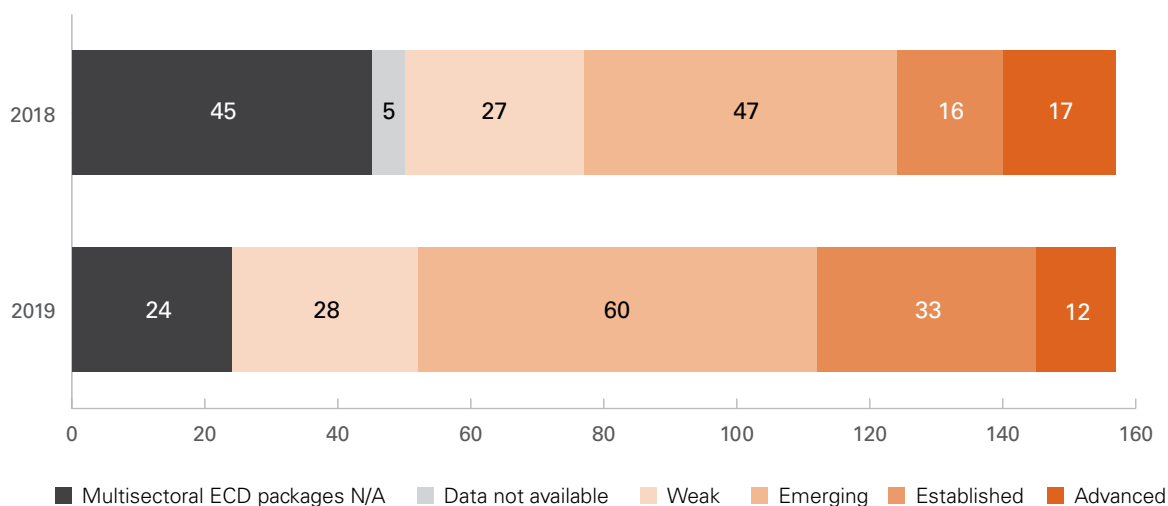
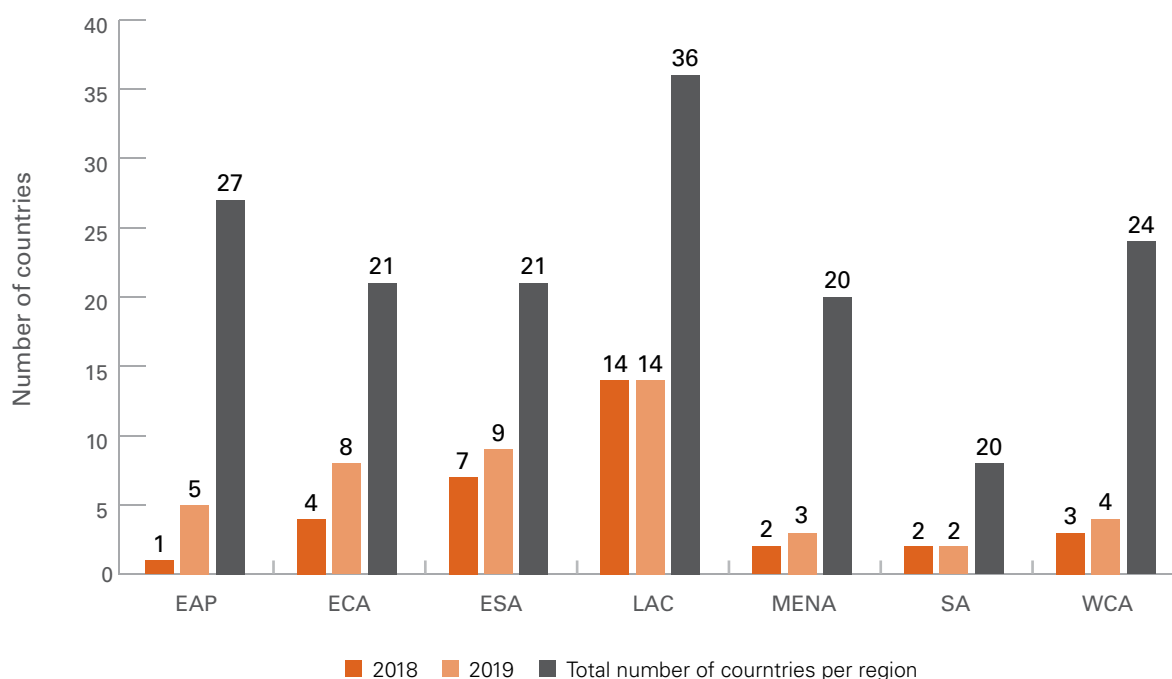


FIGURE 91: Multisectoral ECD packages at scale: 2018–2019 progress overview by region



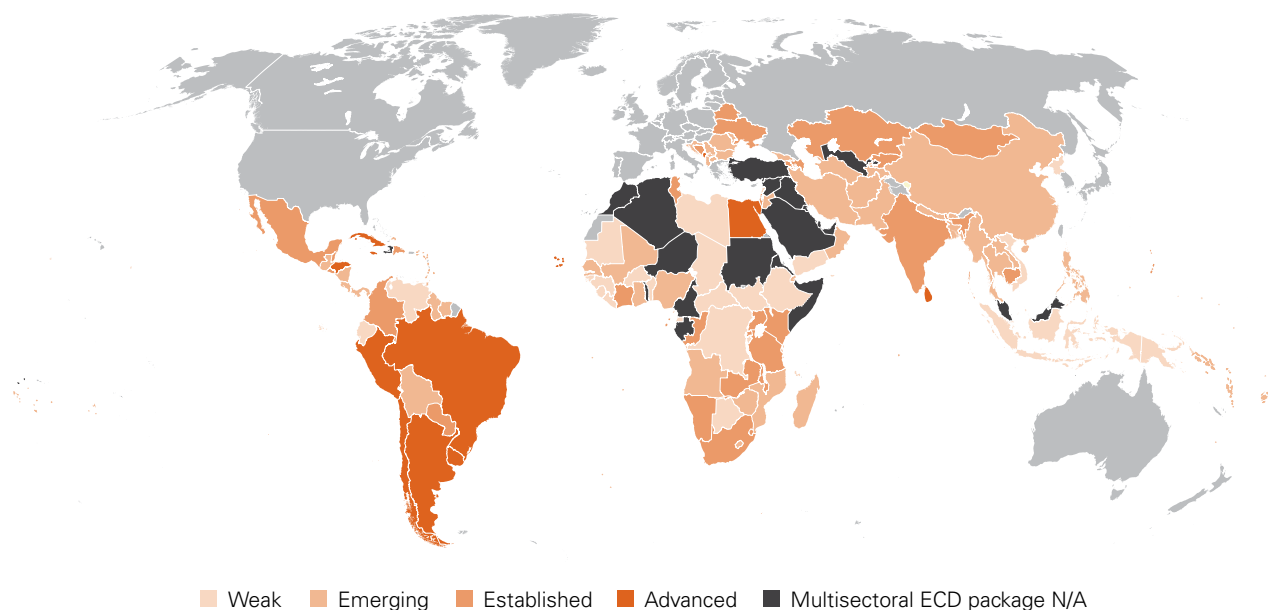
Notes: EAP, East Asia and the Pacific; ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; SA, South Asia; WCA, West and Central Africa.

development and other key sectors towards responsive care and stimulation, resulting in the development and/or adoption of NCF Action Plans in 15 countries in Eastern and Southern Africa and West and Central Africa. Technical support with programme tools such as Care for Child Development (CCD) has also facilitated successful adaptation to national contexts across regions. The prototype of the new 'Caring for the Caregiver' training module was finalized in collaboration with a multidisciplinary team of experts (from UNICEF and partner agencies) to harness front-line workers' skills in a strengths-based counselling approach that increases caregivers' confidence and helps them to develop stress-management, self-care and conflict-resolution skills. All these tools – developed and supported by UNICEF – enabled countries to incorporate emerging evidence into packages of

interventions. Data also highlight the need to complement these efforts by supporting parents and caregivers to implement, model and follow the messages they receive from health, nutrition and education platforms.

While the overall trend in multisectoral packages is encouraging, the momentum needs to be sustained if the Strategic Plan target of 80 countries with at least 'established' status is to be achieved by 2021. In this context, it should be noted that 28 countries are still lagging in the 'weak' category, reflecting insufficient government commitment or ownership of ECD interventions to address stimulation and responsive care in the early years. The need for advocacy and sustained support for these countries is critical and will require a commitment of technical and financial resources.

FIGURE 92: Status of multisectoral ECD packages: A global overview



Using multisectoral packages of interventions – Illustrative example

The existence of multisectoral ECD intervention packages is increasingly gaining momentum globally. The delivery of multisectoral packages through community-based childcare and ECD Centres also addresses early learning for children aged 3 to 6 years, demonstrating a linkage between the first 1,000 days and beyond.

In Latin America and the Caribbean, a CCD enhancement strategy was developed including information on stimulating and communicating with children with developmental delays and disabilities; engaging fathers in caregiving; and integrating CCD training activities through existing delivery platforms. In Peru, CCD has been systematically incorporated into national healthy child visits / growth monitoring services, enhancing the service packages and capacity of front-line workers. In Bolivia, implementation of the Integrated ECD (IECD) model included capacity development of health-care professionals on surveillance and early stimulation, and integration of nutrition and early stimulation interventions with the delivery of Certificates of Live Birth, which facilitated increased health-care coverage for children under 5. These

examples attest to the need for integrating ECD into existing health/nutrition platforms and improving health coverage and holistic development of children under 5.

In Europe and Central Asia, there was an emerging thrust to roll out multisectoral ECD packages at subnational levels with a focus on the most vulnerable populations. In Serbia, building on a recently completed regional evaluation of home visiting, new models of cross-sectoral coordination, integrated parenting support, ECD and early childhood intervention services for the most vulnerable populations are being developed and piloted in selected municipalities. In Azerbaijan, a three-year comprehensive programme on Integrated Community-based Social Services for the Most Vulnerable Children was launched in 2019 jointly by UNICEF and European Union, covering ECD, community-based social and child protection services, to develop, model and generate evidence for successful child service system reform. In Montenegro, UNICEF led concerted advocacy to boost investments in ECD, in line with the NCF. Achievements such as these are not without their challenges. These included insufficient resources, limited coordination at subnational levels and partnerships with non-governmental (NGOs) and civil society organizations (CSOs) to ensure sustainability. *(See also Case Study 19.)*

CASE STUDY 19: Serbia: Improving access to health services for marginalized children

Under the leadership of the Ministry of Health (MoH), UNICEF elevated attention to the most marginalized children excluded from full access to health services, children with disabilities (CWD) and Roma children. The ECD Call for Action co-signed by the ministers of health, education and social welfare represents an important landmark to accelerate the expansion of ECD services, and to support intersectoral coordination. MoH work on increasing access to and quality of ECD, maternal and neonatal services is realized in close coordination with other relevant sectors.

As part of support for downstream work, domestic resources were leveraged in 30 municipalities that prioritized ECD interventions. UNICEF supported development of costed ECD packages for local governments. These investments in documenting successful ECD practices for scaling up will continue, focusing particularly on the work done in the health system around parenting support by paediatricians and nurses, and intersectoral ECD coordination at the local level for the most vulnerable populations, including Roma children and CWD.

In West and Central Africa, a new training module on 'Caring for the Caregiver' was designed with the support of the LEGO Foundation and tested in Mali and Sierra Leone to complement the CCD package to build front-line capacities in counselling. The Gambia, with support of UNICEF, has effectively taken advantage of local structures such as mothers' clubs and school management committees to strengthen the capacity of parents and ECD facilitators/teachers in 32 communities to accelerate early stimulation and learning. As a result, more than 1,500 children are accessing services and benefiting from improved parenting practices and nurturing care. In Guinea, an intersectoral strategy has been established to ensure the inclusion of early stimulation and parent-child interaction in the training package and follow-up elements for community health workers (CHWs) in 40 municipalities during home visits. In Ghana, an ECD study linked to parenting is being used to inform the ECD policy. A comprehensive communication package has also been initiated. In a region fraught with emergencies and challenges, these emerging efforts to integrate stimulation into existing services offer not only a glimmer of hope but also demonstrate the value of sound integrated programming to provide nurturing care for children. However, it is critically important to ensure adequate financial resources and capacities, otherwise the sustainability of these programmes may be in question, and the progress achieved so far may be compromised.

In Eastern and Southern Africa, significant progress was made towards scaling up multisectoral ECD programmes building on existing service delivery points, including community-based platforms. UNICEF support in Malawi promoted the integration of parenting, early stimulation, early learning and nutrition services through Community-based Child Centers. Model centres are linked with health-care facilities and nutrition care groups to ensure crucial aspects in children's first 1,000 days and opportunities for early learning are well addressed. In Eswatini, UNICEF technical and financial support to the Ministry of Healthcare

facilitated integration of early childhood stimulation into the newborn-care health worker training package to accelerate early stimulation for children aged 0–4 years. UNICEF also supported scale up of integrated ECD services that includes tracking developmental milestones to strengthen systems for community-based early childhood stimulation and responsive care. In Burundi, a package of services for nutrition, health, water, sanitation and hygiene (WASH), ECD, and growth promotion and monitoring were implemented with UNICEF support in 9 of 46 districts. UNICEF is also working closely with the Ministry of Health and the United Nations Development Programme (UNDP) to expand the first 1,000 days programme model to more health-care facilities, including in community nurseries. In Zambia, UNICEF technical support and advocacy contributed to the renewed commitment of the Office of the First Lady, ministers of Health, General Education, and Community Development and Social Services to promote multisectoral ECD programming around the concept of the NCF (*see Case Study 20*). It is critical to sustain the momentum to address the inevitable challenges that accompany these interventions.

In the Middle East and North Africa, national governments are increasingly treating multisectoral ECD programmes as national priorities and supporting sustainable scale-up. In Oman, UNICEF support to the Government contributed to the establishment of the national IECD Model to scale. In line with the National Childhood Strategy 2016–2025, the model envisages that children realize their physical, cognitive and psychological potential and arrive in school "ready to learn," with particular emphasis on universal access to kindergarten classes and acceleration of early stimulation and parenting supports through home visiting and other parent engagement programmes. The State of Palestine has established a costed action plan to scale up ECD intervention packages with sustainable resources. UNICEF supported the Human Resources Development Strategy with an ECD component, which will remain the multisectoral reference document for

CASE STUDY 20: Zambia: Ministries united in delivering ECD to communities

In partnership with UNICEF, the Ministry of General Education (MoGE), the Ministry of Health, and the Ministry of Community Development and Social Services piloted a community-level early childhood development (ECD) programme in four villages in Katete District, Eastern Province. Nationally, sustained advocacy to anchor the Nurturing Care Framework (NCF) in Government-owned programmes continued in 2019 with high-level engagements with the Office of the First Lady, ministers of Health, General Education, and Community Development and Social Services. This culminated in a high-level launch of the ECD programme in Katete District by the First Lady and the Minister of Health as part of the thirtieth Anniversary of the Convention on the Rights of the Child in Zambia. The MoGE conducted an Early Childhood Education subsector diagnostic exercise to address bottlenecks related to access and quality. This case illustrates the importance of high-level commitment, embedding ECD considerations into sectoral reviews and analyses, and the potential for ECD platforms to bring together multiple sectors within communities.



Annex and her son Joshua at their home in Gwembe, Zambia. When Joshua was one month old, Annex realised that he had a disability. They are now beneficiaries of the UNICEF supported Emergency Cash Transfer (MCDSS) programme.

ECD until 2025. In partnership with the National Council for Family Affairs, UNICEF supported a multisectoral plan for the institutionalization of the Better Parenting Programme within the ministries of Education, Health, Social Development, Awqaf and Islamic Affairs, and the Police Security Department. In Egypt, UNICEF supported efforts to strengthen the primary health care (PHC) system at the national level through the integration of CCD and the roll-out of integrated training packages in areas populated by the poorest families, and in communities with a refugee population, where about 300,000 primary caregivers benefited from quality counselling on health and nutrition interventions.

In South Asia, UNICEF India supported the design and roll-out of the new home-based young childcare (HBYC) guidelines to address holistic ECD supports through additional home visits from community health-care providers in the post-neonatal period and up to 15 months of age. HBYC guidelines are at the early stage of the roll-out, and 15 per cent of CHWs in UNICEF-supported districts were trained in the new guidelines in 2019. In Maldives, UNICEF provided financial and technical support to the Communication for Development (C4D, also known as social and behaviour change communication, SBCC) strategy on the first 1,000 days of life, which contributed to the improvement of infant feeding practices of over 1,500 parents of children aged 0–23 months. UNICEF support contributed to institutionalizing the capacity of health workers on the 12 islands on the integrated infant and young child feeding programme, including responsive feeding, early nutrition, breastfeeding and nurturing care to pregnant women and parents of children under 2 years.

In East Asia and the Pacific, UNICEF China country office facilitated the development and testing of the National ECD Service Protocol Standards in Primary Health Care Settings in 14 project counties. In addition, the World Health Organization (WHO)–UNICEF Nurturing Care Framework was introduced to better integrate early learning and responsive care for children aged 0–3 years into its family education work. This resulted in increased awareness of the framework in China and the identification of opportunities for its potential integration into the health-care system. The International Guide for Monitoring Child Development was also introduced to improve prevention services such as early developmental monitoring, bolstering parental practices particularly for children with developmental difficulties, and encouraging a shift away from clinic-based care and treatment.

Building stronger institutions

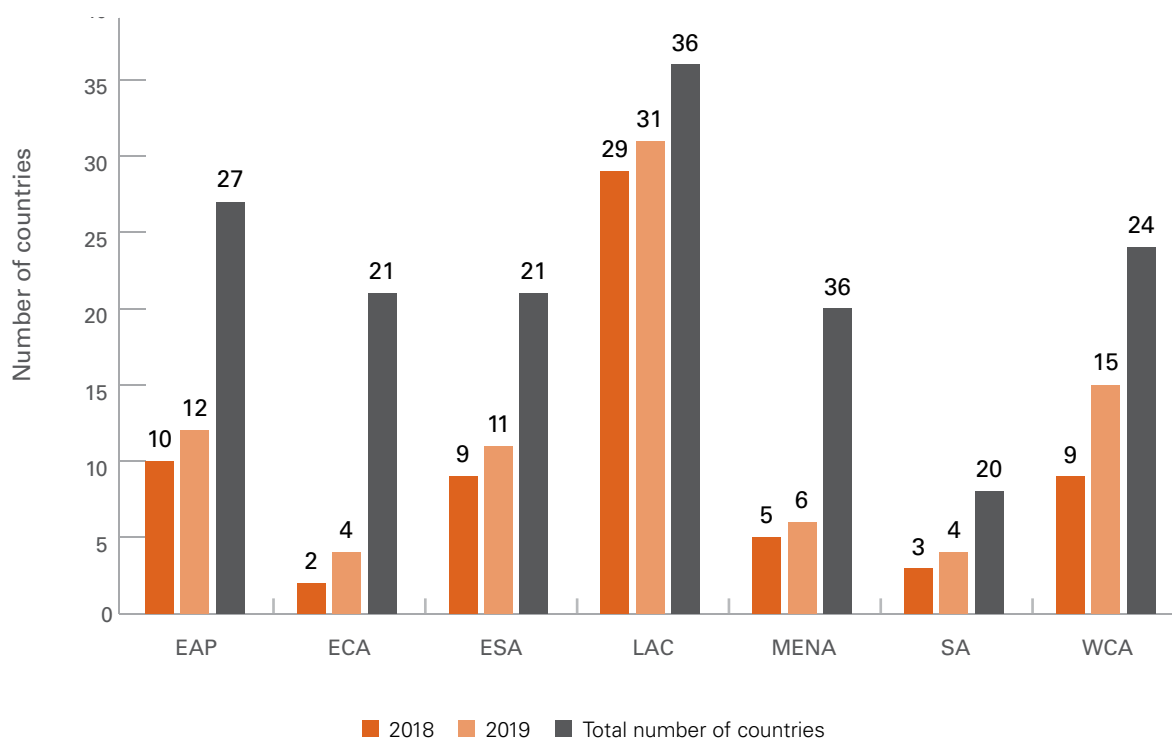
Enhancing enabling policy environments to support and strengthen families – Multisectoral ECD policies and plans

Enabling policy environments are a foundation for sustainable scale-up of ECD interventions. On this front, 83 countries, 16 more than last year, reported having a national ECD policy or action plan. All regions advanced in establishing ECD policy or action plans, most notably in West and Central Africa with an additional six countries. Latin America and the Caribbean remains the ‘champion’ with 31 of the 36 countries in the region having an established ECD policy or action plan. In addition, several countries reported that processes were under way towards establishing a national ECD policy or action plan in the near future.

In 47 of the 51 countries that have established a national ECD action plan, UNICEF continued support for accelerating implementation of these plans, primarily through technical and financial support, advocacy and capacity-building, and, to a lesser extent, through a research and evaluation agenda.

Despite significant progress during the year, the global milestone set for 2019 (i.e., 94 countries having a national ECD policy or action plan) was not reached. At this stage, the Strategic Plan target to increase the number of the countries to 116 by 2021 remains an ambitious goal. Currently, fewer than half the countries in East Asia and the Pacific, Europe and Central Asia, and the Middle East and North Africa have established a national ECD policy or action plan, despite continuous technical support and advocacy by UNICEF. Reports from country offices indicate looming challenges associated with the lengthy and complex processes of national policy development and sustaining previous political commitments, especially in fragile and conflict-affected contexts. Strategic engagement with governments based on the rigorous analysis of the political economy and public financing for ECD will be necessary to accelerate the progress towards the Strategic Plan goal. These enabling environments are critical preconditions for the achievement of Strategic Plan outcomes as well as SDG targets, so UNICEF must stay the course – even in the face of emergencies – and must ‘build back better’, with a focus on enabling environments for supporting parents and families.

FIGURE 93: Numbers of countries with an early childhood development policy or action plan, 2018 and 2019, by region



Notes: EAP, East Asia and the Pacific; ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; SA, South Asia; WCA, West and Central Africa.

Strengthening national and subnational governance, policies and plans – Illustrative examples

UNICEF supported both upstream and downstream work in 2019 to strengthen governance, policies and plans. As more countries establish national-level policies or action plans, momentum is beginning to grow to institutionalize the capacity and mechanisms at the subnational level to implement policy and actions.

Latin America and the Caribbean continued to demonstrate high-level commitment to establish ECD in several national agendas and set up multisectoral coordination mechanisms for effective operationalization of policies and action plans. In Paraguay, extensive UNICEF advocacy efforts contributed to increased investment in ECD as a national priority to improve the lives of young children nationwide. The Government articulated ECD as part of the

implementation of the social protection system (see Case Study 21). In Bolivia, UNICEF provided technical support to the Vice Ministry of Equal Opportunities (VIO) to ensure the new Sub-Council for Intersectoral Coordination of IECD was functioning properly. This Sub-Council, led by the VIO, brought together the ministries of Health, Education, Economy and Finance, and Planning; the Parliamentary Network; the Federation of Municipal Associations; the Bolivian Councillors Association; and NGOs to develop a joint workplan. In 2019, the Sub-Council undertook a normative and competency analysis to help revise the Public Policy Proposal for Early Childhood – developed by VIO – and the preliminary draft of the Early Childhood Law, presented by the Parliamentary Network. Both proposals were supported by UNICEF and are currently under review by the Sub-Council. This is an important example of a lead ministry coordinating ECD efforts with multiple relevant ministries and stakeholders including municipalities and subnational bodies.

CASE STUDY 21: Paraguay: Strengthening national services for the youngest children

In 2019, UNICEF collaborated with partners such as the World Bank, the European Union and civil society organizations to advocate and promote investments in early childhood development (ECD) in Paraguay. These efforts contributed to ECD becoming a national priority. The Technical Unit of the Presidency, the Social Cabinet jointly with the ministries of Health, Education and Children and Adolescents started a new programme on early childhood titled 'Paraguay Growing Together'. This programme will deliver essential service packages benefiting the most vulnerable and marginalized children. Additionally, with UNICEF technical support, the Government launched the social protection programme 'Vamos!', which focuses on early childhood as the initial target population, demonstrating the high political will towards improving the life of children nationwide.

Also in 2019, UNICEF supported capacity-building of staff from both education and health sectors to train families on quality of care and early stimulation, particularly targeted at those families with children with disabilities, using the Care for Child Development (CCD) package. As part of the 'Toys for Life' advocacy campaign, support continued for the strengthening of positive parenting and early stimulation practices for children aged 0–3 years in six municipalities, with a focus on children with disabilities. Additionally, the Ministry of Health expanded the use of CCD among health personnel in the context of the Zika virus response. Finally, UNICEF provided technical support to government institutions in responding to a flood emergency and a housing emergency in indigenous communities, including improvement of data collection for decision-making.



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Rafael Alfonso Araujo holds his daughter Selva, aged 2, outside of their home where Rafael and his wife run a small, independent bakery that provides healthy, homemade food items to government workers in Areguá, Central department, Paraguay. Selva attends a UNICEF-supported “creative and cultural centre” launched by the local Central district government as a model Early Childhood Development (ECD) centre that fosters curiosity and a love of learning in young children.

In Eastern and Southern Africa, Ethiopia's Early Childhood Care and Education Policy Framework, launched in 2010 to guide cross-sectoral coordination, reported limited implementation due to lack of funding and operational plans. To address this challenge, UNICEF supported the Ministry of Education to engage with a range of stakeholders, including the Ministry of Finance and Ministry of Labor and Social Affairs in revising the document, which is now entitled the Early Childhood Development and Education Policy Framework. Under the Framework, ministries are expected to develop sectoral strategies to address ECD more explicitly. This is a key example of the need for *regular updates of plans and policies and intentional articulation of ECD*.

East Asia and the Pacific has made significant progress through updates of existing sectoral policies to reflect ECD more strongly, and through strengthened operationalization of policies at national and subnational levels, which have helped not only policymakers but also to raise the profile of ECD among parents and caregivers themselves. The Government of China issued a framing document titled 'Guiding Opinion of Child Care Services for Infants and Young Children under Three Years Old' in 2019, with multisectoral engagement. The ECD policy focus is also clearly articulated in the National Plan of Action for Children in China. In Viet Nam, the National Early Childhood Development Scheme was further institutionalized at a subnational level. The majority of provinces have developed ECD plans. The development of an official national guidance for implementation at subnational level has commenced based on lessons learned from the UNICEF-supported IECD pilots.

In Europe and Central Asia, Turkmenistan adopted the next generation of an ECD Strategy for 2020–2025 that stipulates multisectoral work to promote nurturing care across health, nutrition, education and social protection



Avalon and her six-year-old son Caleb holding her newborn daughter in Fiji.

sectors, with focus on the most vulnerable populations. It articulates responsibilities of sectors to ensure that children and families benefit from an equitable and affordable package of essential ECD services – including development monitoring, support for parents, strengthening access of all children to pre-primary education, and inclusive community-based support services. In Serbia, building on the ECD Call for Action co-signed by the ministers of Health, Education, and Social Welfare in 2018, UNICEF continued to leverage political commitment to accelerate the expansion of ECD services under the coordination of the Council for Child Rights.

CASE STUDY 22: Pacific region: Growing political commitment for ECD

In 2019, UNICEF advocacy on early childhood development (ECD) catalysed commitments from Pacific countries to improve ECD coordination and service delivery. UNICEF Pacific convened the 2019 Pacific ECD Forum, a gathering of 150 government leaders and partners from 15 countries in October in Fiji. In a historic announcement, the forum endorsed the Pacific Regional Council for ECD, comprised of ministers from education, finance, health and social welfare, with a steering committee comprised of permanent secretaries from the same sectors. UNICEF is the secretariat of this council and works in partnership with Pacific Islands Forum Secretariat. With UNICEF support, several Pacific governments have made significant headway in implementing the Pasifika Call to Action on ECD, specifically on establishing coordination mechanisms for ECD.

In the Middle East and North Africa, Egypt saw the establishment of a National Task Force for ECD Policies. The Task Force is chaired by the National Council for Childhood and Motherhood, and includes representatives from the ministries of Education, Health and Population, Social Solidarity, Planning, Finance, and Culture, and from CSOs, media, academia and religious organizations. In the second half of 2019, the Task Force convened twice to finalize the situation analysis on ECD and provide inputs to the inception phase of National ECD Strategy development. In Morocco, a national conference brought together over 500 participants, resulting in high-level political commitment to promote nurturing care through community health platforms.

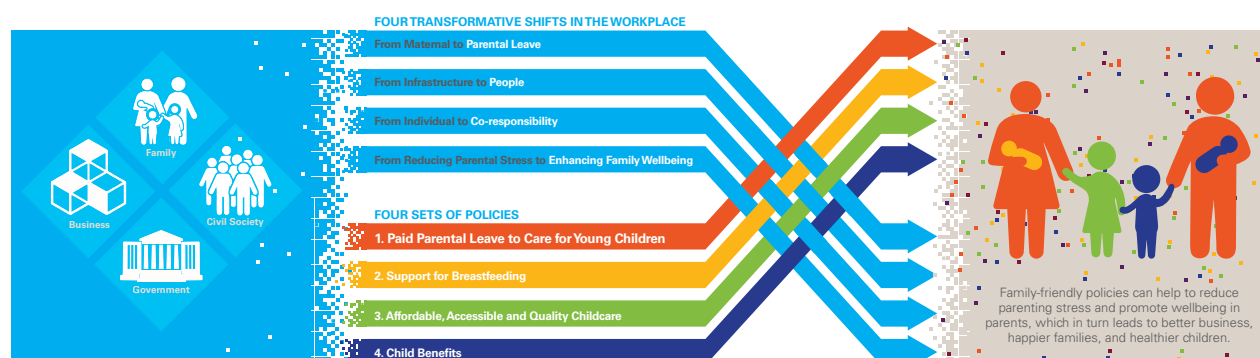
In South Asia, UNICEF Sri Lanka supported the Government to develop draft thematic policies to support the National Early Childhood Care Development (ECCD) Policy. The Ministry of Women and Child Affairs drafted a National Policy for Child Day Care Centres with UNICEF support. Once validated by the Cabinet, the policy will institutionalize a system to support improvement in the quality of day-care providers. In Bangladesh, UNICEF continued support for establishing institutional arrangements to operationalize the ECCD Policy. The National ECCD Coordination Committee, technical committee, district and subdistrict committees were institutionalized. An ECCD policy operationalization resource book and training modules for National Resource Team and District Resource Team were also developed.

In West and Central Africa, Côte d'Ivoire adopted a national ECD policy in 2019 under the steer of the Executive Secretariat in the Prime Minister's office and chaired by the Vice-Presidency. In Sierra Leone, UNICEF advocacy and government leadership for ECD programming resulted in the finalization of the National ECD policy for submission to Cabinet in early 2020. The provisions of the ECD Policy, Early Childhood Care in Education (ECCE) Minimum Standards, and ECCE Curriculum have been included in the 'Learning Through Play' guide focused on strengthening the capacity of the ECD workforce.

The year also witnessed a noteworthy increase in the awareness and uptake of Family Friendly Policies (FFPs) globally, among government and business leaders, as well as the United Nations, civil society and academia. At the global summit, 'Redesigning the Workplace of the Future: Sharing Responsibility for Family-Friendly Policies', the FFPs call to action was launched. It called on governments and businesses to create enabling environments for parents to give their children the best start in life, while boosting productivity and women's empowerment, through four evidence-based policy asks: (1) paid parental leave; (2) breastfeeding support; (3) accessible, affordable and quality childcare; and (4) child benefits.

Growing recognition of the value of FFPs is evident in various countries. In Argentina, at least 120 companies were engaged with UNICEF around FFPs and 30 companies committed to promote internal and/or external changes, including with their suppliers and clients. Ten companies changed their human resources policies, including increased parental leave, support for breastfeeding, work-from-home arrangements, creation of diversity programmes, and other forms of leave such as gender violence leave and assisted fertilization leave. In Rwanda, mobile crèches in tea plantations offer a safe, convenient environment for children to rest and play while their parents work. Having childcare available increases parents' working days, output and income. In Thailand, a new Child Support Grant efficiently reduces poverty for the nation's most vulnerable demographic. Viet Nam's apparel and footwear sector has dedicated itself to improving breastfeeding and FFPs. Since 2017, UNICEF has been collaborating with iCare Benefits, a for-profit social enterprise that provides employee benefits to strengthen breastfeeding support for factory workers.

Figure 94: Family-friendly policies: Four sets of policies and four transformative shifts in the workplace



CASE STUDY 23: Rwanda: SORWATHE: Public-private sector collaboration for scale

SORWATHE is Rwanda's oldest private tea factory, located in Kinyihira, about 70 km north of Kigali. Most of SORWATHE's production is for export, and it is one of the largest tea producers in Rwanda, with an annual production of around 3.6 million kg. The company employs approximately 2,500 workers a day, and 4,500 tea farmers depend on the factory.

SORWATHE established mobile crèches, where mothers can leave their children while they work nearby. The crèches offer a safe, convenient environment where UNICEF-trained caregivers care for and play with the children and prepare nutrient-rich food to supplement their diets. SORWATHE's efforts created interest from the Government of Rwanda to expand the initiative to other tea businesses in the agricultural export sector and demonstrated the value of this work to businesses. As a result, in 2017 UNICEF launched a partnership with the National Agricultural Export Development Board to implement similar childcare solutions for the sector. Successful piloting with SORWATHE provided an opportunity to scale up within the tea sector by embracing an industry approach – which resulted in a partnership with Government, to mainstream the approach across the Rwandan agricultural sector.



Kevin, aged 2, is held by his father at the Sorwathe Tea Factory & Plantation in Rwanda where he works as a tea plucker. Their family, and the lives of many families in their community, were transformed by an initiative undertaken between Sorwathe and UNICEF. An Early Childhood Development (ECD) centre provides on-site care for the children of Sorwathe employees. It also incorporates an outreach program that provides parents with valuable information on nutrition, hygiene and other parenting skills. Perhaps most importantly, ECD actively teaches fathers about the ways in which they can become more involved in the lives of their young children; something that was previously the exclusive domain of mothers.

Renewed focus on ECD in emergencies – Action in humanitarian settings

In 2019, UNICEF made significant progress in the area of ECD in Emergencies (ECDiE) in both programme implementation and leadership in advocacy for the provision of ECD services for young children and families affected by humanitarian contexts.

Globally, UNICEF delivered organized ECD programmes to more than 610,000 children under 5 years of age affected by humanitarian situations, reaching 76 per cent of the targeted population (exceeding the Strategic Plan milestone for 2019 of 75 per cent). The number of countries that reported on ECDiE programming increased from 38 in 2018 to 46 in 2019, reflecting the growing recognition of ECDiE as integral in humanitarian response programming. Meanwhile, disaggregated data for young children remains a challenge. Of 46 countries, 33 reported gender-disaggregated data on the number of children reached (237,167 girls and 245,943 boys), and only 14 countries had access to data on the number of children with disabilities (2,608).

The UNICEF ECD Kit for Emergencies and kits made with a locally procured materials continued to play a pivotal role in delivering programmes for young children, providing access to play, stimulation and early learning opportunities, and improving hygiene practices. The kits also support caregivers and their ability to create safe environments to afford play, stimulation and nurturing care for young children. In 2019, the kits underwent a rigorous evaluation which will help inform overall kit design and field implementation in the future. In 2019 alone, more than 16,000 UNICEF ECD Kits for Emergencies were distributed globally.

On advocacy and inter-agency collaboration, UNICEF continued to raise its profile as a leading agency for ECD in humanitarian action. Through advocacy at high-level events – such as the United Nations High-Level Political Forum for Sustainable Development, the United Nations General Assembly and the Global Refugee Forum – UNICEF elevated ECDiE contexts. Increased awareness and commitment to ECDiE has also led to funding pledges specifically targeting young children living in humanitarian settings. UNICEF illustrated

its own commitment and technical leadership in ECDiE by including, for the first time, ECD-specific commitments in the Core Commitments for Children in Humanitarian Action (CCCs). This inspired other significant outcomes, such as the integration of ECD into the Global Framework for Refugee Education, and the revitalization of the Inter-Agency Network for Education in Emergencies ECD Task Team, which UNICEF now co-leads. UNICEF also provided technical assistance to a range of governments and partners to support embedding ECD in humanitarian planning.

ECD in emergencies – Illustrative examples

In Rwanda, ECD has been integrated into Ebola virus disease (EVD) prevention and risk management interventions. Working with religious networks around faith-based ECD centres, UNICEF strengthened the capacity of community members, including 198 religious ECD volunteers (60 per cent female), in nine districts at high risk for Ebola transmission. In Uganda, community-based ECD centres in 11 refugee-hosting districts served as platforms for multisectoral services to drive healthy stimulation for more than 110,000 children. In Bangladesh, the UNICEF ECD Kits for Emergencies provided nearly 159,000 children under 5 years of age, including 645

children with disabilities, with play-based learning opportunities. In Jordan, ECD services were integrated and scaled up as part of the community-based child protection programme to prevent and respond to Violence Against Children (VAC) and gender-based violence, reaching more than 110,000 children. UNICEF support for ECD centres in the Democratic Republic of the Congo provided more than 2,200 preschool-aged refugee children, including those from South Sudan and internally displaced children, with access to early childhood care services that include improved hygiene facilities.

Elevating the importance of addressing ECD in humanitarian contexts has also pointed to the potential of ECD programmes to promote social cohesion by bringing together different groups around the common interest of young children and their caregivers. In Guyana, ECD and stimulation sessions by UNICEF-trained community volunteers reached 985 children; the sessions proved to have the additional benefit of promoting cohesion between migrants and host communities. In Kyrgyzstan, messages of gender equality and respect for diversity were woven into the ECD curriculum, including an animated series, and delivered through community-based kindergartens. An evaluation of this programme suggested that it helped promote gender-inclusive attitudes and pro-social behaviours in children, parents and teachers.



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Ileen Awad, aged 10 weeks, plays with one of the health workers at UNICEF's Early Childhood Development (ECD) centres in the Sheikh Radwan district, Gaza City, State of Palestine.

CASE STUDY 24: State of Palestine: Early childhood development interventions

In the West Bank and Gaza, UNICEF invested in improving early detection of developmental delays and securing ECD services for young children. UNICEF worked with the ministries of Social Development, Health, and Education and other national ECD partners to provide child-centred and holistic care. Interventions addressed both the needs of young children and the capacity of their caregivers, equipping them with the knowledge, skills and competencies to stimulate all developmental domains of children under 6 years old.

In the West Bank, the first-ever mobile nursery was procured and equipped to provide early detection and stimulation services to remote communities. The mobile nursery, branded by local partners as the 'Happy Bus', will benefit between 5,000 and 10,000 children in the most vulnerable communities. Existing health-care facilities across the West Bank and Gaza assessed 10,602 young children (49 per cent girls) for malnutrition and developmental delays, and were provided with 230,000 copies of the 'Mother and Child' handbook. Water, sanitation and hygiene facilities in four health centres and in one community-based organization were renovated and refurbished to function as ECD-focused child-friendly centres, providing services to approximately 500 children with developmental delays and disabilities yearly.

Leveraging humanitarian assistance and procurement services to deliver interventions through childcare, health and education facilities has also reinforced the linkages between humanitarian and development interventions in the State of Palestine.

CASE STUDY 25: Mali: Mama Yeleen

The Mama Yeleen programme trains female community leaders as 'model mothers' to lead community-based sensitization activities on parenting practices such as nutrition, cognitive stimulation and early learning, which they deliver to mothers in rural and marginalized communities in Mali. This programme is implemented through Communication for Development (C4D) platforms and leverages social and behaviour change communication (SBCC) strategies in the community. The programme targets both sedentary and semi-nomadic communities and is creating an inter-communal exchange platform between Mama Yeleen agents from all intervention villages. The exchange between different communities is helping to promote positive contact between women from different ethnic backgrounds to improve social cohesion in the target regions. In regions where inter- and/or intracommunity conflicts have been recorded, the action of Mama Yeleen is contributing to building stronger ties between communities or among members of the same community or household. The 2019 cohort of 4,000 Mama Yeleen agents reached more than 24,000 mothers in target communities.

Leveraging collective action

The year 2019 witnessed a significant growth of global-level commitment for ECD and enhancement of global ECD partnerships, to which UNICEF has provided technical leadership.

Advocacy and messaging – Early Moments Matter campaign

Throughout the year, the Early Moments Matter (EMM) campaign, with guidance from the UNICEF programme division, has made constant outreach to support parents globally. June 2019 marked UNICEF's first global Parenting

Month, celebrating the people who do the most important job in the world. By expanding the focus from Father's Day to Parenting Month, the Campaign better reflected ECD programming. In 2019, country offices and National Committees for 144 countries supported Parenting Month, compared with 125 in 2018. Under the tagline 'It's about time', UNICEF offices and partners advocated for FFPs to support working parents and raised awareness of nutrition, protection and stimulation for healthy brain development in the earliest years of life. A communication and advocacy Activation Toolkit was produced to guide UNICEF offices and partners worldwide in the roll-out of Parenting Month. With the help of partners, goodwill ambassadors, influencers and supporters, UNICEF was able to reach parents around the world with messages about how to

give children the best start in life. David Beckham kicked off parenting month by recording a video calling for greater investment in FFPs by governments and businesses. This video generated almost 1.2 million views and over 100,000 engagements across UNICEF global channels. Other celebrities also posted compelling content throughout Parenting Month. Throughout the month of June, Parenting Month generated 31,367 mentions on social media with over 1.9 million engagements.

Partnerships and emerging work with the private sector

The high-level summit 'Redesigning the Workplace of the Future: Sharing Responsibility for Family-Friendly Policies' engaged over 20 senior business leaders, business influencers and chambers of commerce from a wide cross-section of regions, economic contexts and business models, to accelerate the creation of enabling environments for parenting. Following the morning summit, UNICEF and the United Nations Global Compact organized a business-focused workshop looking at key issues and challenges for companies to take action on FFPs. The session targeted global business representatives and experts, including participants from the International Finance Organizations, International Labour Organization

and speakers from MAS Holdings (Sri Lanka), Johnson & Johnson (United States of America) and Patagonia (United States). Businesses acknowledged that much still needs to be done to make family-friendly workplaces a reality for all. As a follow-up to the event, requests to strengthen collaboration have been initiated by UNICEF regional and country offices and business networks. The FFPs evidence briefs have been widely shared on the UNICEF website, viewed more than 10,000 times and received positive feedback from partners with plans for collaboration in 2020.

Enhanced inter-agency collaboration through the Nurturing Care Framework

UNICEF continued to co-lead the NCF Global Coordination Group with WHO, the World Bank, Early Childhood Development Action Network, and UNICEF Maternal, Newborn and Child Health to leverage the global partnership to promote strategic multisectoral actions for the healthy growth and development of young children aged 0–3 years. Momentum for NCF has grown with over 30 civil society partners contributing through four working groups: (1) implementation; (2) monitoring and evaluation; (3) advocacy and (4) knowledge management. UNICEF co-leads the implementation and monitoring and evaluation working groups. In West and Central Africa,



Chandira Shrestha cradles her sleeping three-month-old baby as she takes a break from harvesting wheat in a field in Dolakha Bazar, near the town of Charikot in Dolakha District, Nepal.

the Regional Consultation on the operationalization of the NCF for Francophone Countries was convened with the support of the Africa Early Childhood Network to facilitate the implementation of NCF in the health sector, engaging over 80 participants from the ministries of health and other ECD-related ministries from Burkina Faso, Burundi, Cameroon, Côte d'Ivoire, Gabon, Mali, the Niger, Sao Tome and Principe, and Senegal. Moreover, continuous support through UNICEF country offices for the NCF has facilitated cooperative partnerships and multisectoral coordination at the country level between health, nutrition, education, social development, gender and other relevant sectors to promote concerted efforts towards responsive care and stimulation, resulting in the development and/or adoption of NCF action plans in 15 countries in Eastern and Southern Africa and West and Central Africa.

Global measurement for SDG on child development outcome

The ECD Index (ECDI) 2030, the new measure for tracking developmental outcomes among children aged 24–59 months, was endorsed by the Interagency and Expert Group on the SDGs as the measure to track progress on SDG 4.2.1 (the proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being). The ECDI 2030 will provide globally comparable data collected at the population level through household surveys, and more governments will use this new tool to collect data on children's developmental outcomes and report on the SDG indicators. UNICEF leadership in this area was recognized by several stakeholders and partners.

Lessons learned and challenges

To accelerate progress towards this outcome of stimulation and responsive care and the SDGs, UNICEF needs to sustain momentum in implementing multisectoral ECD intervention packages through increased investment in the capacities and skills not only of front-line workers, but also of parents and caregivers, who provide the stimulation.

In 2019, UNICEF technical leadership on ECD with United Nations and external partners continued make progress towards the SDGs. At the same time, the ECD landscape is becoming increasingly crowded with more agencies and partners, including foundations, businesses and academia. While this presents opportunities for expanded collaborations to help children, UNICEF needs strategic engagement to demonstrate its value-add to remain a technical leader in ECD.

On ECDiE in particular, UNICEF advocacy efforts led to increased commitment from global leaders, and it is critical to sustain this momentum as limited attention and resources can hinder progress. UNICEF is well positioned as a leading agency, but further investment is needed in advocacy, programme implementation, resource mobilization and capacity-strengthening to further incorporate ECD into sector-specific and global humanitarian response plans.

Some key lessons from 2019 include the following.

- Sectoral ownership of the intervention packages needs to increase, accompanied by strategic capacity development plans.
- Enabling environments need to be strengthened through technical support and advocacy for the

government and business sectors to implement FFPS.

- A much needed thrust is in the area of parenting support. As first providers of health, nutrition, early learning and stimulation, parents need to be supported as much as other front-line workers. It is a well-established fact that a key accelerator to achieve results for all children is the provision of quality parenting and family support, because parents are the key architects of the experiences and opportunities for children's health, well-being and development. This is becoming even more significant in the wake of COVID-19. As the world moves from the information age to the age of shared experiences, parents are interested in going beyond receiving information to becoming active and empowered agents in their children's development and want to be connected with experiences through online interactions.
- UNICEF needs to continue to invest in advocacy, mobilize additional resources and strengthen its own capacity to better incorporate the needs of young children and ECD priorities into humanitarian responses. More work is needed to ensure that ECD tools and methodologies are well coordinated, integrated, monitored and evaluated across sectors in humanitarian situations.

All of these actions require sustained, regular streams of funding. The current funding landscape for holistic ECD faces challenges around the globe. In 2019, shifting priorities in some countries also resulted in limited resources for ECD.



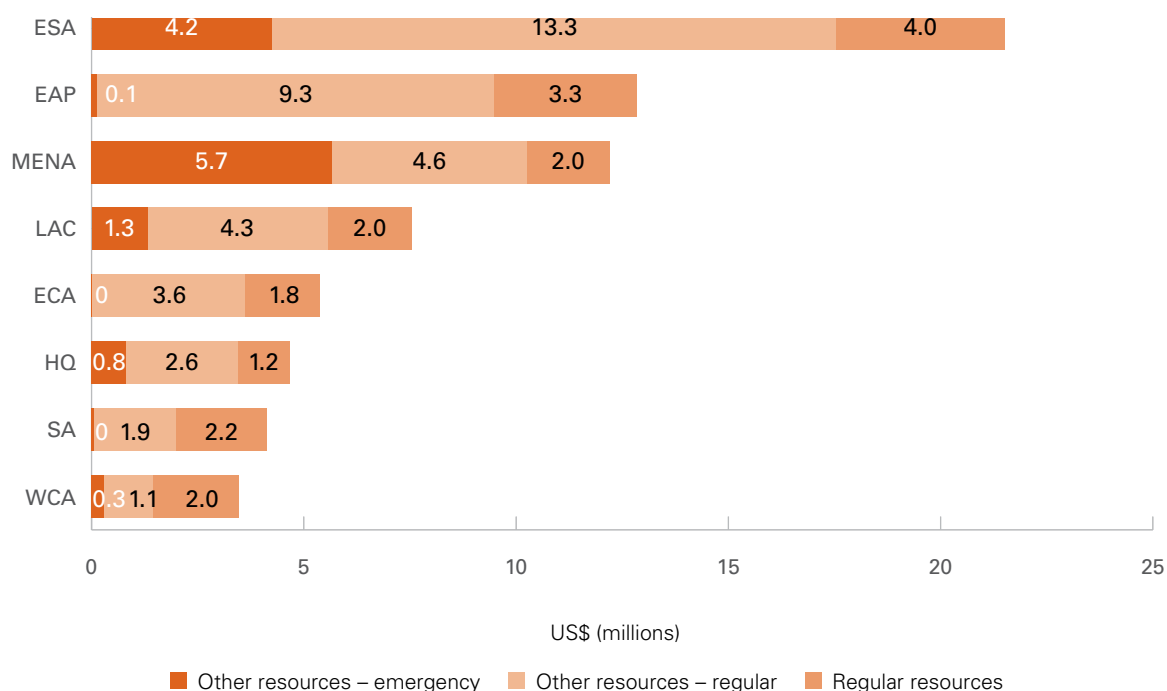
Mother and newborn in the hospital of Daroot Korgon in Kyrgyzstan.

ECD financial report

UNICEF spent nearly US\$72 million on ECD globally in 2019, comprising of US\$18.4 million in regular resources (RR), US\$40.8 million in 'other resources – regular' (ORR) and US\$12.5 million in 'other resources – emergency' (ORE). Considering the growing recognition and global momentum to increase investment in ECD, this amount is disproportionately small as it accounts for only 1 per cent of the total expenditure of the Goal Area 1. In many regions and headquarters, ECD programmes remain heavily dependent on ORR, which make up 57 per cent of the total amount, and supplement the limited emergency or regular

resources allocation (*see Figure 95*). As ORR-funded programmes funded tend to be earmarked for specific activities and geographical areas, this in turn leaves gaps in the resources needed to support system-strengthening to scale up ECD programmes. UNICEF core resources dedicated to ECD, such as 7 per cent set-aside funds, are critical in catalysing system-level changes in countries. Sustainable core funds for ECD are urgently needed if progress towards the Strategic Plan results of child development is to be accelerated.

FIGURE 95: Financial analysis of ECD expenses, by region



Notes: EAP, East Asia and the Pacific; ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; HQ, headquarters; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; SA, South Asia; WCA, West and Central Africa.

Conclusion

Through its programmes and support to governments, UNICEF has supported countries to adopt and scale up multisectoral packages that articulate the need for integrating stimulation of young children into existing platforms. However, progress towards the SDG has been slow and hampered by various challenges. These efforts have also highlighted three challenges, areas in need of strengthening and explicit articulation: (a) the need for explicit articulation of parenting support that stems from rigorous-evidence based programmes, analyses and resources;¹¹² (b) the need to elevate support for enabling environments;¹¹³ and (c) addressing the developmental

needs of young children in humanitarian contexts^{114,115} (including by partners on the ground). All of these actions are particularly important in the next few years, as the world deals with an unprecedented COVID-19 2019 pandemic, which has exacerbated the crisis of care and learning, and turned parents into front-line responders. Progress towards the Strategic Plan goals can be greatly accelerated, if – along with supporting governments, global and regional ECD networks and partners – UNICEF ECD programmes also intentionally elevate the idea of supporting every parent to ensure that they can contribute to the holistic development of every child, everywhere.



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Strengthening systems for child survival, growth and development results

Doreen, beneficiary of the Boda Boda motorcycle transport referral system, shows off her child in Alangi Subcounty, Ganga Parish, Zombo District, Uganda. UNICEF, with financial assistance from the Swedish International Development Cooperation Agency, helps women and children have timely access of health facilities.

Primary health care: A cornerstone of universal health coverage

At the 2019 high-level meeting convened at the United Nations General Assembly, political leaders reaffirmed that health is a precondition for, as well as an outcome and indicator of, the Sustainable Development Goals (SDGs), and recommitted to achieving universal health coverage (UHC) by 2030.^{116,117} In this spirit, the Global Action Plan for Healthy Lives and Well-being for All (SDG 3+GAP) was officially launched, bringing together 12 multilateral health, development and humanitarian agencies¹¹⁸ – including UNICEF – to better collaborate and align support to countries to accelerate progress towards the health-related SDGs.

Within the framework of SDG 3+GAP, UNICEF co-led the primary health care (PHC) accelerator theme and contributed expertise and solutions to other themes such as digital health, sustainable financing, and community engagement. Additionally, UNICEF joined the partnership on PHC Performance Initiative as a core partner with the view of further strengthening its role in PHC monitoring.

At the regional level, the Declaration of Cotonou reinforces the need to increase investments in community-based PHC, institutionalize community health workers (CHWs) and establish a high-level ministerial accountability framework to track progress at all levels. Lastly, the UNICEF Europe and Central Asia Regional Office leveraged global thematic funds to work closely with WHO to include specific support to accelerating PHC across the region through the established Issue-based Coalition comprised of UNICEF, WHO and UNFPA.

Programme integration is core to effective PHC, to enhance synergy between disease control programmes.

As measured by service coverage (*Figure 96*), all four programmes under Goal Area 1 show progress towards the 2021 target even though coverage for the full three doses of diphtheria—tetanus-pertussis (DTP3) vaccination and antiretroviral therapy has plateaued. Among a set of eight indicators tracking progress on integration, half have met or surpassed the 2021 Strategic Plan target. These include the number of CHWs trained on integrated Community Case Management, care for children with severe acute malnutrition (SAM) in regular services, the integration of HIV interventions in child health services and the integration of WASH in health-care facilities. All three indicators for health systems-strengthening (HSS) are showing excellent progress towards the 2021 targets.

Bold and sustained investments in HSS remain urgent. UNICEF is prioritizing this agenda with available discretionary resources. In 2019, investments from UNICEF set-aside flexible funding for PHC started showing progress. For example, more than US\$0.6 million was used for this purpose in the Sudan. Further investment, particularly in high-burden and resource-poor settings, will be critical to sustain this work. UNICEF is also undertaking a global process of building internal capacity in HSS. To further the evidence base on HSS, UNICEF authored or co-authored 30 publications, including 13 journal articles. In addition, concrete progress was made in HSS through UNICEF programmes.

Applying the health systems-strengthening approach across UNICEF programmes

In 2019, HSS was adopted as a foundation for strengthening PHC – for example, quality of care, the institutionalization of CHWs in the health system and supply chain management.

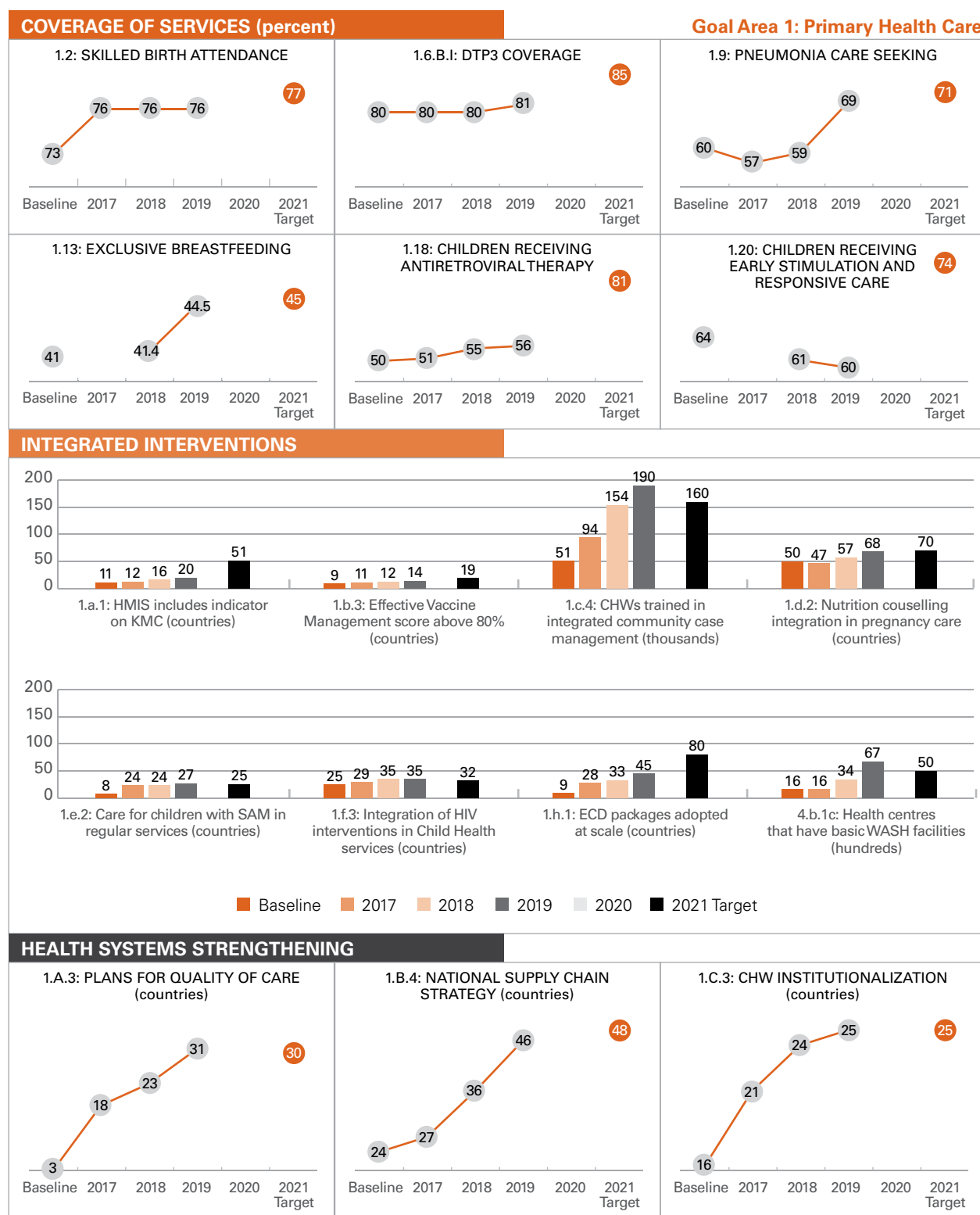
Quality of care

By the end of the year, 47 of the 52 countries reporting on the Every Newborn Action Plan had a national quality improvement programme and 45 countries had a plan in place to implement quality-of-care guidelines. To strengthen the quality of care, UNICEF improved access to WASH in 3,341 health centres in its country programmes (*see Health: Results Area 1 for more details*).

Institutionalizing community health workers

Institutionalizing CHWs into the formal health system is a critical component of bringing care to the last mile. For institutionalization to occur, as a first step, policies defining roles, tasks based on local needs and relationships to the health system must be in place at country level. By the end of 2019, all 25 countries with high burdens of child illnesses had policies in place that met criteria for institutionalization. In addition, UNICEF helped governments establish a package of care, incentive and compensation structures, supervision and supply chain models (*see Health: Results Area 3 for more details*).

FIGURE 96: Results on addressing inequities, promoting integrated health policies and programmes, and health systems-strengthening, 2019



Source: UNICEF New York (2019). Notes: CHW, community health worker; DTP, diphtheria-tetanus-pertussis; ECD, early childhood development; HMIS, health management information system; KMC, kangaroo-mother care; WASH, water, sanitation and hygiene.

Supply chain management

By the end of 2019, forty-six countries were implementing a national health-sector supply chain strategy and 34 UNICEF country offices supported supply chain strengthening interventions (*see Health: Results Area 2 for details*).

Among the supply chain strengthening tools, the UNICEF-developed Maturity Model was deployed in 21 countries. The model helps stakeholders identify and address the main bottlenecks hindering delivery and scale-up of essential health and nutrition services. For instance, in the Central African Republic, the model identified supply chain inefficiencies as one of the main obstacles limiting access to ready-to-use therapeutic food (RUTF) and subsequent high-level of SAM among children under 5. The lack of product availability at health-care facilities, triggered by ineffective distribution channels, was compounded by commercial exploitation and the misuse of supplies. The Maturity Model helped the Government and other stakeholders elaborate a comprehensive roadmap with targeted interventions to effectively and sustainably address barriers. These coordinated supply chain strengthening efforts, which included on-the-job training of PHC workers, the optimization of the public distribution network, and deployment of end-user monitoring tools to measure how and understand why the products were misused, had a significant impact on expanding the distribution coverage and accessibility of RUTF products to both caregivers and families.

Building decentralized management capacity through district-level health systems strengthening

The district health systems strengthening (DHSS) approach remains an important way of operationalizing the equity agenda at the subnational level to achieve UHC and realize children's rights to health. UNICEF works at the district level to improve evidence-based planning and performance management, general health management capacity, and accountability mechanisms; and to address other contextual barriers to the adoption of good management practices. To strengthen its DHSS approach, UNICEF completed a management response to the two-year formative HSS evaluation and adopted matrix management of its HSS work.

Numerous examples of progress exist regionally and at country level. For instance, the Eastern and Southern Africa Regional Office supported subnational evidence-based planning in six countries. In partnership with the South Africa-based Foundation for Professional Development, UNICEF is working with ministries of health and partners in four countries to chart a course on national approaches to subnational health management capacity development to professionalize health management.

Uganda is progressing particularly well in scaling up DHSS. UNICEF helped roll out a subnational HSS progression model to assess capacity across 31 focus districts implementing reproductive, maternal, newborn and child health bottleneck analyses. The DHSS approach was standardized and harmonized across various programmes within UNICEF and aligned with the government vision and strategy.

Enhancing the quality and use of data: Strengthening administrative data systems and digital health

Health management information systems and community health information systems

UNICEF continues to support in-country health management information systems (HMIS) in partnership with the University of Oslo District Health Information System 2 (DHIS2) platform. During the year, nine countries received support: Angola, Bangladesh, Botswana, Ethiopia, Malawi, Pakistan, Somalia, Uganda and the United Republic of Tanzania.

UNICEF has been working to address the dearth of data at the community level, one of the major obstacles to delivering quality services at that level. To this end, UNICEF developed a set of core indicators for community health service delivery that can be adapted in different country contexts and levels of community health information system maturity.

Locally, the progress made in Bangladesh towards improving immunization coverage rates is hailed as a successful regional example of DHIS use. The impressive work in the area of immunization and HSS continues to be driven by quality and equity.

Birth registration and civil registration and vital statistics

Strengthening administrative systems also means ensuring the health system collaborates effectively with the civil registration and vital statistics (CRVS) system. UNICEF aims to bring health and CRVS stakeholders together in support of people's rights to civil registration and in improving data so children can access their rights from birth.

In Mali, Senegal and South Sudan, the Birth Registration for Maternal and Newborn Health initiative shows that integrating birth notification into community-based health care and enhancing the inter-operability between CRVS and the health system is key to progress.

In West and Central Africa, UNICEF made it a priority to transform birth registration services through health service delivery, notably through the deployment of RapidPro. For the first time in years, there was an increase in the regional birth registration average with a rise from 45 per cent in 2017 (the second lowest in the world) to 51 per cent in 2019.

Digital health

UNICEF is now a recognized leader in the field of digital health along with WHO. UNICEF continued to support countries to embed digital health solutions in health programmes to improve the quality and reach of essential health services, while simultaneously improving the quality, availability and use of data. Common digital health interventions that were supported include client registers with decision-support tools, patient SMS reminders, electronic supply chain systems, eLearning and health worker supervision/performance-management tools and mobile phone-based telemedicine solutions. Digital systems to enhance programming were also supported, such as geographic information system (GIS) and dashboards for DHIS2. For example, in Ethiopia and Mozambique, UNICEF supported evidence-based assessment of gaps in geographic access to health services by populations in need (disaster-stricken and pastoralist populations).

UNICEF works closely in partnerships such as the Health Data Collaborative and the Digital Health Donor Alignment community, and across sectors (e.g., child protection, WASH, education, HIV and nutrition).

Through global opportunities such as the Global Digital Health Forum and the West and Central Africa Regional Office Regional Community Health forum, UNICEF advocated for digital health innovations at community and PHC-facility level to adopt the 'Digital Health for PHC Approach'. The goal is to strengthen the linkages with, and use of, formal health services, while supporting the institutionalization and strengthening of the community health system as a whole. As a result, the Global Fund, the World Bank and the Global Financing Facility have committed resources and support to countries for digital health implementation at scale.

UNICEF, in collaboration with Living Goods, Health Enabled and Kati Collective, finalized maturity assessment tools for digital health at different levels of the health system. These tools can guide countries on how to measure their readiness to adopt, implement and sustain digital health solutions for PHC. In addition, UNICEF and the US Centers for Disease Control and Prevention (CDC) finalized the Electronic Immunization Registry (EIR) Maturity model tool with a facilitators' guidance, with Rwanda being the first country to use EIR.

Thematic funds enabled UNICEF Viet Nam to develop a mobile integrated early child development programme to collect vital information about the health of marginalized mothers and children in real time. The system is based on two global digital goods (OpenSRP and RapidPro) in compliance with the UNICEF approach to digital health and WHO digital recommendations. Ultimately, the project is expected to have a significant impact on the lives of 35,000 children aged 0–8 years and 25,000 parents.

The year saw increased cooperation on digital health implementation through the Donor Coordination Group, which includes the Bill & Melinda Gates Foundation, the World Bank, the United States Agency for International Development (USAID), CDC, the US President's Emergency Plan for AIDS Relief (PEPFAR) and WHO. Initial success was achieved in providing guidance on planned digital health solutions implementation for Burkina Faso, Chad, Mali, the Niger and the United Republic of Tanzania.

Equitable impact sensitive tool

Funded initially by the Bill & Melinda Gates Foundation, the equitable impact sensitive tool (EQUIST) focuses on proposing cost-effective interventions and prioritizes key bottlenecks that constrain their coverage.

In 2019, UNICEF, in partnership with WHO, expanded the scope of EQUIST to include adolescent health guidance for conducting the adolescent health services bottleneck analysis (AHSBA). Two joint training sessions on AHSBA were conducted for governments, UNICEF and WHO personnel from 18 countries. Additionally, UNICEF provided support to eight countries on the EQUIST nutrition module.

Regionally, UNICEF supported 11 countries on EQUIST to strengthen capability on data for decision-making, bottleneck analysis and development of investment cases. At country level, EQUIST was introduced in Iraq and further strengthened in Bangladesh to include subnational analysis to help health policymakers and programme managers make better-informed and targeted decisions.

Enhancing preparedness of the health system to prevent and respond to health emergencies

In 2019, UNICEF responded to 74 health emergencies worldwide that included Ebola virus disease (EVD) in the Democratic Republic of the Congo, cholera in 10 countries, Zika in 4 countries and measles in 9 countries. The end of the year was marked by the emergence of the COVID-19 in China which rapidly spread to more than 100 countries. Now a pandemic, COVID-19 is severely testing health systems worldwide. UNICEF is redoubling efforts to address this new emergency in order to save lives, maintain health services and strengthen systems.

The 2019 EVD outbreak in the Democratic Republic of the Congo was declared a public health emergency of international concern by WHO in July 2019. A holistic and multipronged approach proved crucial. The lessons learned in 2017 and 2018 on promoting community participation were quickly put into practice. Operationalizing existing community animation units, UNICEF and partners reached nearly 32 million people at risk of contracting Ebola with prevention messages which helped build community trust. Edouard Beigbeder, UNICEF country representative emphasized that “when survivors tell communities the reason they are alive is because they sought treatment early, people believe them and are getting help sooner.” In the area of infection, prevention and control, UNICEF helped improve access to water and sanitation in 3,400 facilities in 27 health zones, while improving access to safe drinking-water for more than 2 million people. Support to affected communities included posting paediatricians in Ebola treatment centres to adapt medical care, which reached more than 15,000 children.

Engagements in other public health emergencies continued to expand in 2019 and included preparedness and response to meningitis (Burkina Faso, Chad, Ghana and Togo), yellow fever (Nigeria and South Sudan), dengue (Côte d’Ivoire, Jamaica, Pakistan and the Sudan) and Lassa fever (Liberia and Sierra Leone). In South America, UNICEF supported the Zika response in at least four countries. UNICEF supported priority countries in mainstreaming planning for public health emergencies in the Emergency Preparedness Platform.

UNICEF continued to be a leader in global emergency health advocacy and played a strong role in partnerships. For instance, UNICEF represented the Global Outbreak Alert and Response Network and the Global Task Force on Cholera Control. The organization actively participated in the development of joint policies, strategic response plans and risk assessments during Ebola and cholera responses. These efforts help ensure that children remain at the centre of public health emergency responses. UNICEF continues

to advocate with governments to invest sustainably in public health emergency preparedness, collaborating with the private sector where feasible, as a moral imperative and cost-effective intervention that saves the lives of the most marginalized children.

Resilient primary health care

The health of the most disadvantaged populations, particularly children, depends heavily on health systems that are resilient to shocks and threats. Building and maintaining such capacity is UNICEF’s aim in bridging humanitarian and development work (*see Case Study 26*). In line with the SDGs, UNICEF developed new and updated tools for risk-informed programming, preparedness and working in fragile and crisis-affected contexts, all of which focus on reaching the furthest left behind and building resilience. In 2019, UNICEF strengthened and systemized its approach to linking humanitarian action and development programming. Based on a review of evidence, UNICEF issued a procedure to operationalize these links in different contexts, building on good practices already implemented.

To build resilience, UNICEF makes adjustments to country and emergency programmes that strengthen linkages between humanitarian and development programming. In Latin American and the Caribbean, UNICEF used the findings of a multi-country evaluation of the Zika response to mainstream the initial emergency response into regular programming. Findings are being used to inform public health work, C4D strategies, ECD and the agenda on children with disabilities. At the country level, examples of the linkages between humanitarian and development programmes include the following.

- Supporting the decentralization and strengthening of PHC systems in areas most subject to natural disaster and conflict (e.g., Ethiopia and India).
- Ensuring CHWs are paid and supported; ensuring systems are in place for rapid expansion of community health-care services as and when required (e.g., Afghanistan, the Democratic Republic of the Congo, Ethiopia).
- Preventing and treating SAM, diarrheal diseases, malaria and pneumonia at community level (e.g., Bangladesh, Ethiopia, Mali, Somalia).
- Ensuring a robust disease outbreak surveillance system is in place (e.g., Indonesia).
- Ensuring strengthened and adaptable supply chains that can rapidly scale up the delivery of essential drugs and health-care material in response to emergencies.

CASE STUDY 26: Yemen: The Emergency Health and Nutrition Project: Leveraging the existing health system to save lives

Yemen has been experiencing one of the most protracted and devastating conflicts in the world. The deterioration of the health system has had serious implications on the availability, quality, access and utilization of health services, threatening children and their families' rights to health and survival.

Through the Emergency Health and Nutrition Project (EHNP), WHO, UNICEF and local authorities, with support from the World Bank, aim to strengthen the system's capacity to provide basic health and essential nutrition services to the population in a cross-cutting approach.

UNICEF has shifted the focus of the intervention to reaching the local population via the existing health system while also building rural community resilience by establishing a network of CHWs. Using existing facilities, staff and infrastructure helps build the foundations for a post-conflict rehabilitation phase whenever that becomes viable. Practically, this means that investments focus on improving and strengthening human capital, restoring and equipping health-care facilities thereby improving functionality, and improving water and sanitation services, particularly in areas at high risk of diseases.

In addition to improving key health outcomes, the project aims to increase cost efficiencies and traceability of funds. Working in coordination with international partners has ensured a division of labour based on comparative advantages in key policy and technical areas.

In 2019, UNICEF leveraged its comparative advantage to cover the operational costs of 2,000 primary health-care facilities so they could remain functional; establish networks of community health workers to provide comprehensive packages of health and nutrition services, including integrated community case management of childhood illnesses, reaching over 2.5 million children under 5; and scaled up care for newborns and sick newborns from 8 to 18 governorate-level hospitals. In the words of Dr. Suaad Al-hetari of Al Sabeen hospital, "in spite of the situation Yemen is in, we have doctors and nurses fighting to keep these babies alive."

To date, positive outcomes include achieving full functionality at 51 per cent of health-care facilities, reaching nearly 15 million people with health, nutrition and population services, and 1.68 million and 1.97 million people with access to improved water and sanitation sources, respectively. The end targets for several indicators have already been surpassed. The EHNP is recognized as the main pillar in the international support system that protects Yemen's health infrastructure and preserves Yemenis' right to health within humanitarian situations and beyond.



Nurse Hindia Al-Zoubah checks on a 5-day-old baby girl who is making good progress in the neonatal intensive care unit at the Al Sabeen Maternal Hospital in Sana'a, Yemen.

Monitoring progress on the quality of the linkages made between humanitarian and development programming is critical to ensuring the rights of all children are realized consistently and without discrimination. For Goal Area 1 specifically, these indicators are the number of countries that (1) are implementing a national health sector supply chain strategy or plan; (2) have institutionalized CHWs into the formal health system; and (3) provide care for children with SAM as part of an essential package of regular health and nutrition services for children. In 2019, all three indicators have either met or surpassed the Strategic Plan goals, indicating good progress on these essential dimensions.

Enhancing UNICEF technical capacity for health systems strengthening

UNICEF continued to build its own capacity on HSS at global, regional and national levels through the blended HSS course offered in collaboration with the University of Melbourne. In 2019, some 148 UNICEF staff completed

the course, bringing the total number of graduates in three years to 347 from 70 countries. Graduates are using their skills and knowledge in regular and emergency programming, in peer-to-peer learning, development of country plans, providing targeted technical assistance on multisectoral systems, PHC, and harmonizing HSS actions in global funding mechanism such as Gavi, the Global Financing Facility and the Global Fund.

Additionally in 2019, UNICEF and partners launched a Massive Open Online Course (MOOC) on HSS which was taken by over 10,000 public health-care professionals from 167 countries. The MOOC is designed to strengthen the capacity of governments and partners in resource allocation at national, subnational and community levels; health financing; human resources for health, supply chain, quality of care and mixed health systems. Over 70 per cent of learners are active, which is unusually high and considered a mark of success for MOOC.



Residents of Kayepus in Lopoko in Napak District, Uganda, attending an outreach interaction with a visiting delegation of DFID/USAID officials accompanied by implementing partners. The donor visit was aimed at examining the quality of the current and planned Health Systems Strengthening (HSS) activities in terms of effectiveness, sustainability and likely impact paying attention to the community component of HSS.



A boy enjoys a healthy snack as part of an evidence-based communication initiative to encourage good nutrition and healthy lifestyles in school-age children in Cuba. UNICEF is strengthening its engagement with food systems to improve the quality of children's food, food environments, and food practices in settings where children eat, learn, play and meet.

Strengthening food systems for child survival, growth and development

Food systems¹¹⁹ influence the nutritional quality, safety, availability and affordability of children's diets as well and children's and caregivers' nutrition practices, wherever they live. The food system needs to operate in ways that empower children, adolescents and families to demand nutritious foods. Secondly, it needs to ensure that nutritious foods are available, affordable and sustainable. Finally, it needs to create healthy food environments wherever children eat, learn, play, live or meet. Governments must set standards that are aligned with children's best interests and create a level playing field for producers and suppliers. Producers and suppliers need to ensure that their actions – including food production, labelling and marketing – are

aligned with such standards. Evidence shows that when nutritious foods are affordable, convenient and desirable, children and families make better food choices.

In many parts of the world, global and local food systems are failing children and undermining their right to adequate food and nutrition. Food producers and suppliers often fail to account for children's unique nutritional needs when determining what foods to produce, process, package, store and market. Nutrient-rich and safe foods are unaffordable for many households, while energy-rich and nutrient-poor processed foods are widely available, affordable and marketed. Food environments are often

profit-driven rather than child-centred, making it challenging for children and families to make good food choices. Poor households, in both rural and urban areas, are most impacted by these inadequacies in global and local food systems.¹²⁰

The importance of food environments

Food environments are key systemic drivers of child, adolescent and family dietary patterns. Food environments are failing to offer nutritious, safe, affordable and sustainable diets to children, while increasingly offering unhealthy foods that are poor in nutrients and rich in calories. Food environments determine the availability, affordability, convenience and desirability of various foods and strongly influence dietary consumption of children and families. UNICEF recognizes the special importance of food environments for improving child diets.

UNICEF engagement with food systems

UNICEF programming in food systems began to take shape during the first two years of the current Strategic Plan. UNICEF highlighted the absence of children in the global discourse on food systems in the Global Consultation on Food Systems for Children and Adolescents at UNICEF Office of Research-Innocenti and identified actions for redesigning food systems to better address the food- and nutrition-related needs and vulnerabilities of children. UNICEF also worked with countries to gather evidence, test interventions and gain consensus on programme design for future scale-up to improve the availability and affordability of nutritious foods for children.

With the release of the *State of the World's Children: Children, food and nutrition* in 2019, UNICEF highlighted the global crisis of poor child diets and called for a renewed agenda that puts children's right to adequate food and nutrition at the heart of food systems. The report also calls for improved coordination with the health, water and sanitation, education and social protection systems to ensure adequate diets, services and dietary practices for children, adolescents and women.

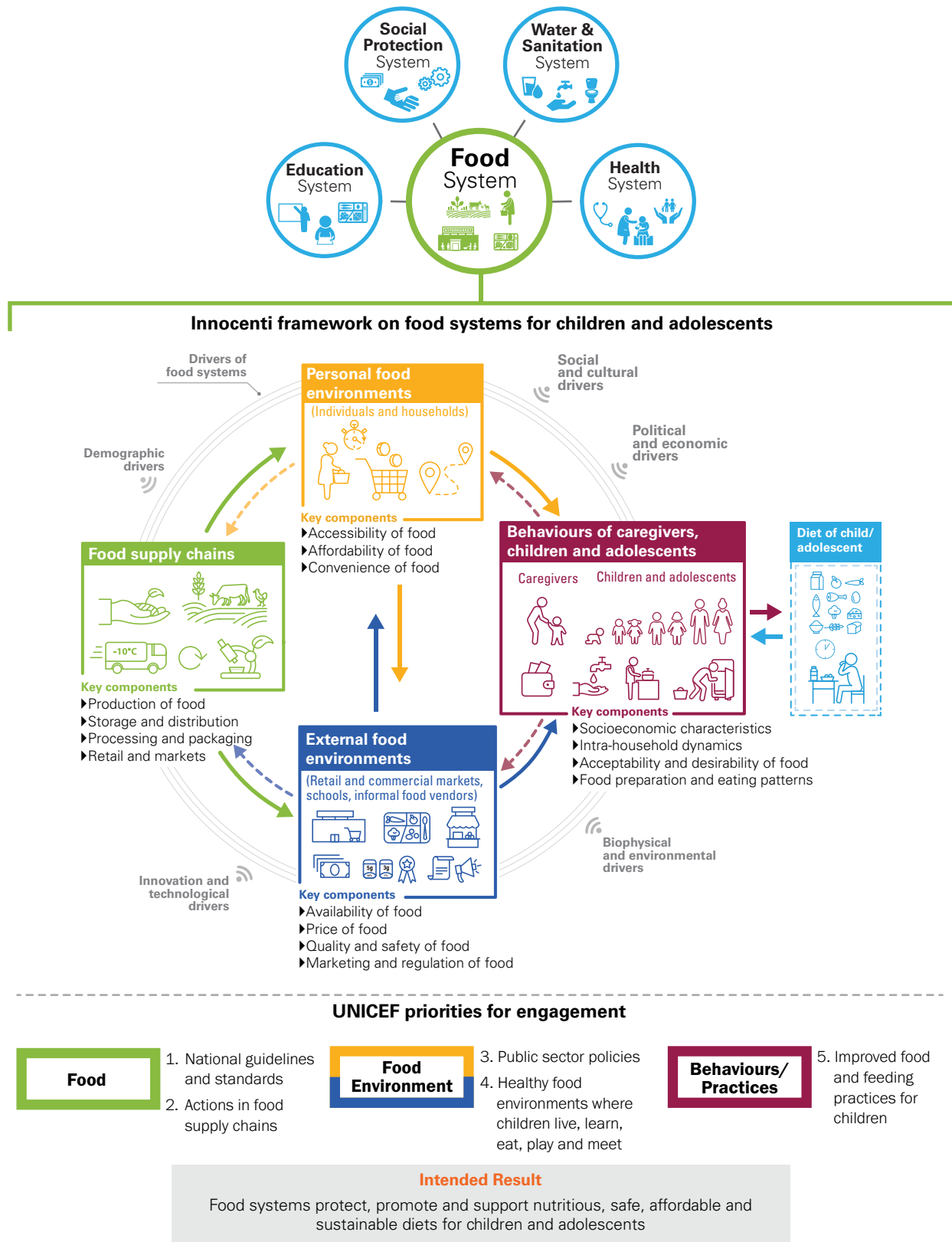
The launch of the *State of the World's Children* report coincided with the development of the UNICEF 2020–2030 Nutrition Strategy, which will guide the organization's response to ending child malnutrition in all its forms over



Daw Nang Pon and her granddaughters Ma Nang Su Lay Kham and Ma Nang Kham Si, ages 4 and 6, wash fresh vegetables for a meal with the water supplied from the nearby natural spring in Nyo Hmu village, Hsi Hseng township, Shan state, Myanmar.

FIGURE 97: UNICEF food systems approach

Systems approach for child diets and child survival, growth, and development



Source: UNICEF and Global Alliance for Improved Nutrition (2019).¹²¹

the next decade. The Strategy describes UNICEF's intention to activate multiple systems with the potential to deliver nutrition interventions at scale and leverage them to achieve nutrition results that go beyond their own sectoral objectives.

As described in the 2020–2030 Nutrition Strategy, UNICEF will work to improve the quality of children's foods, food environments and food practices. This will involve leveraging the policies, programmes and actors of the food system to make them more accountable for improving the diets of children and adolescents in all contexts. The intended result of this work is that food systems promote and support nutritious, safe, affordable and sustainable diets and positive nutrition practices to prevent child malnutrition in all its forms (Figure 97).

Priorities for engagement¹²² with the food system are as follows.

Adequate foods and diets for children in national guidelines and standards: UNICEF will advocate for and support the development of national guidelines on breastfeeding and complementary feeding, and national nutrition standards for foods aimed at children, including complementary foods and school meals. UNICEF will also advocate for and support the development of food-based dietary guidelines that address the needs of children and are environmentally sustainable. In line with such guidelines and standards, UNICEF will advocate for nutritionally adequate foods for children in the context of education, social protection and public sector programmes.

Better foods and diets for children through actions in food supply chains: In settings where industries are centralized, UNICEF will support mandatory, large-scale food fortification programmes for salt, wheat flour, rice, cooking oil or other context-specific foods to address nutrient intake gaps. To respond to nutrient intake gaps in children aged 6–23 months, UNICEF will advocate for the production and use of fortified complementary foods. UNICEF will also advocate for the reduction of sugar, salt, saturated and trans fats in processed foods, which contribute to excess energy intake in children, adolescents and families.

Healthy food environments for children through public sector policies: UNICEF will advocate for and support policies that protect children from harmful food marketing practices and facilitate nutritious food choices. This will involve supporting the effective implementation of the International Code of Marketing of Breast-milk Substitutes and related World Health Assembly resolutions, as well as WHO-led global recommendations on the marketing of foods and non-alcoholic beverages to children. UNICEF will advocate for consumer-friendly front-of-package labelling,¹²³ financial incentives and disincentives, and targeted food subsidies to facilitate nutritious food choices and limit the consumption of unhealthy foods.

Healthy food environments where children live, learn, eat, play and meet: UNICEF will advocate for and support healthy food environments in schools, public spaces, eating outlets, communities and digital media; and will advocate for better access to retail outlets such as shops, markets and supermarkets offering healthy food options, while limiting access to unhealthy ones. UNICEF will advocate for access to free, safe and palatable drinking-water in public spaces and schools as central to a healthy diet; and will support women to breastfeed anytime and anywhere, including through the creation of breastfeeding-friendly spaces.

Improved food and feeding practices for children: UNICEF will support the design and implementation of social and behaviour change communication programmes that use innovative, fun, memorable and engaging communication strategies to promote healthy feeding and dietary practices, leveraging the cultural and social aspirations of children, adolescents, families and communities. UNICEF will also promote nutrition education in school curricula to provide school-age children with the knowledge and skills they need about good diets.

UNICEF also contributed to expanding policy guidance around food systems in 2019. In recognition of the importance of food environments for children, UNICEF issued a policy brief on *Protecting Children's Right to a Healthy Food Environment* (with the United Nations Special Rapporteur on the Right to Food), which outlines the responsibilities of governments and other duty-bearers in upholding children's right to food and nutrition. This includes giving special consideration to children's specific needs and vulnerabilities, including protecting children from unhealthy food environments that undermine their right to healthy food and adequate nutrition. A rights-based approach to improving children's food environments is vital to guaranteeing that vulnerable populations – which are disproportionately affected by malnutrition – have equitable access to nutritious food. UNICEF also engaged on improving urban food environments (with EAT¹²⁴) for children through a participatory session with youth during the Child Friendly Cities Summit in Germany, and with a policy brief on making urban food environments fit for children.

Looking ahead

In 2020, UNICEF will continue to develop tools and programming strategies while supporting country-level scale-up of food systems interventions. In 2021, UNICEF will take approaches to larger scale across six regions, while improving the quality of implementation, and evaluating programme effectiveness.



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Maya Ag Oumar, 12 months of age, is from Mali. She suffered from severe acute malnutrition with medical complications, and her mother travelled 135 kilometres from their hometown to bring her to the hospital. Maya recovered with therapeutic milk and medications supplied by UNICEF with the support of global humanitarian thematic funds – flexible resources that allow UNICEF to provide support where it is needed most and to save the lives of children like Maya.

Implementation research

UNICEF defines embedded implementation research as “the integration of research within existing programme implementation and policymaking to improve outcomes and overcome implementation bottlenecks.” It is primarily designed to prioritize research on questions of local relevance, generate feasible recommendations in ‘real-time’ and underwrite policy and system strengthening. In this innovative approach to systems-strengthening, research is made integral to decision-making and strengthening PHC.

Progress on implementation research

The year marked significant breakthroughs in using innovative research methods and technologies to enhance health programming. Of 74 implementation research projects, UNICEF completed 40 projects in over 19 high-burden countries from 2015–2019. Supported programmes included: immunization (24), birth registration (4), nutrition (5), HIV/AIDS (5) and maternal, newborn and child health in emergencies (2). Of the completed projects, approximately 80 per cent have been used to improve local programmes for children, UNICEF’s measure of implementation research success.

Initially piloted within immunization programmes, implementation research has now been expanded to nutrition, birth registration, newborn and child health in humanitarian settings, the prevention of mother-to-child transmission of HIV, social policy and C4D. For instance:

- Malawi completed implementation research on the integration of vitamin A supplementation into routine child health services and conducted a research prioritization workshop on gender-related barriers to accessing nutrition and child health services

- Benin, Burkina Faso and Côte d'Ivoire all completed implementation research projects on Enhanced Child Health Days including vitamin A
- Iraq has completed a broad agenda of research on the status of maternal, newborn and child health.

UNICEF sponsored and participated in the first Global Conference on Implementation Science, showcasing research from Bangladesh (focused on Cox's Bazar), Ethiopia, Nigeria and Pakistan. The conference gave UNICEF substantial visibility as a partner and leader in implementation science.

Conclusion

There is increasing acknowledgement among global health practitioners that strong health systems are an essential foundation for PHC, itself a major component of UHC, health and well-being. While UNICEF has many years' experience with campaigns and vertical disease-prevention initiatives, there is a limit to the sustainability of their impact, and there is ample evidence that they have failed to reach the last mile in high-burden countries. Long-term improvements in child health outcomes in these settings demand universal access to affordable, quality primary and referral care, undergirded by qualified human resources, reliable supply chains, adequate financing, collection and use of data for management, good governance, and the participation and engagement of community-level beneficiaries – in short, strong health systems that link public and private sectors.

The progress made in strengthening health systems over the past two years, and the promising advances gained in support of more appropriate food systems, show the value of UNICEF programmes in these areas. The results presented in this chapter demonstrate that investing in systems strengthening creates immediate as well as lasting effects on maternal, child and adolescent health and well-being, ultimately reducing the need for direct support to services. For these results to be achieved, thematic funds remain essential. HSS work, because it is cross-cutting, exemplifies the need for flexible funds that are not earmarked for a particular disease. The more such funds are made available, the more results will be achieved in this area.



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High-level priorities

Denee Warner, 28, holds her 19-month-old son Justice Warner outside Marilyn's Nursery in Cottonground in Saint Thomas Lowland Parish on Nevis island, St. Kitts and Nevis.

The world is currently not on track to meet the Sustainable Development Goals (SDGs). Failing to achieve goals and targets translates to needless loss of life despite the existence of known, low-cost and proven solutions to preventable and treatable causes. This reality compels UNICEF to take bold steps, working collaboratively with its trusted partners, to create a world that helps children survive and get the best start in life.

In Health, UNICEF has identified two main strategic pathways to achieve timely progress to meet the many challenges threatening children. The first is to accelerate the revitalization of primary health care (PHC) in countries with the highest burdens of maternal, newborn and child mortality. The second is to further develop and implement thrive programmes.

Toward accelerating the revitalization of PHC in high-burden countries, UNICEF has identified four areas for high impact. First, there is urgent need to ramp up the delivery of integrated front-line services through community, school or health-care facility platforms with strong community engagement to ensure service uptake. Second, UNICEF will continue to focus on equity and ‘zero-dose’ children (who have never been vaccinated), including missed communities in remote rural areas, urban slums and conflict-affected areas, by strengthening routine immunization programmes and creating synergy with supplementary immunization activities for polio, tetanus and measles. Third, as financing is at the core of ensuring sustainability and reach, UNICEF will leverage global and domestic resources to secure additional investments in health systems, infrastructure and human resources. Finally, UNICEF will support health systems strengthening by improving front-line worker capacity, supply chains, the quality of care and digital health information and data. The Global Action Plan for Healthy Lives and Well-being for All, launched in 2019, will be a key initiative to support PHC in high-burden countries, working through accelerators identified through the complementary expertise of 12 multilateral health, development and humanitarian agencies, including WHO.

Simultaneously, UNICEF will endeavour to develop and scale up thrive programmes. UNICEF-supported health programmes are increasingly responding to child and adolescent health and well-being (thrive) priorities. These include child development, child disability, injury, non-communicable disease (including mental health), environmental pollution, climate change adaptation, and sexual and reproductive health and reproductive rights. Developing quality programmes that address health and well-being priorities through expanded PHC, responsive to local contexts, is another key priority, including in geographical areas of high-burden countries that have the readiness and resources.

In Nutrition, with the launch and roll-out of the 2020–2030 Nutrition Strategy in 2020, UNICEF will set forth its commitments to supporting countries in responding to the changing realities of children, food and nutrition globally, with context-specific actions adapted to country needs and capacities. UNICEF will support the scale-up of policies, strategies and programmes to prevent the triple burden of malnutrition through a systems approach to nutrition that leverages the capacity of national systems – particularly the food, health, water and sanitation, education and social protection systems – to deliver nutritious diets, essential nutrition services, and positive nutrition practices for children, adolescents and women. UNICEF will strengthen coordination among nutrition partners in both development and humanitarian contexts through its leadership role as Nutrition Sector and Cluster Coordinator, Chair of the Scaling Up Nutrition Lead Group, lead implementing agency of the Global Action Plan on Child Wasting, and other global partnerships, including the recently created UN Nutrition.

In responding to the coronavirus disease 2019 (COVID-19) pandemic, UNICEF will aim to ensure that children’s right to adequate nutrition is protected, including through efforts to mitigate the impact of disrupted food systems, strained health and education systems, and lost livelihoods. To lead these efforts, UNICEF will support country programmes to scale up the five nutrition programme priorities with the greatest potential to protect child survival, growth and development: 1) breastfeeding and complementary feeding; 2) micronutrient supplementation, deworming and home fortification; 3) school feeding and school-based nutrition; 4) maternal nutrition during pregnancy and breastfeeding; and 5) early detection and treatment of severe wasting. As part of its approach, UNICEF will look for opportunities to accelerate policy change, programme design and implementation, harness new technology and innovations, and scale up linkages between nutrition and social protection to reach children and families most at risk during the ensuing economic downturn.

In HIV and AIDS, there are several priority strategies that aim to improve HIV outcomes for mothers, and prevent HIV in their children, including: prioritizing HIV prevention in pregnant and breastfeeding women; increasing access to comprehensive antenatal care (globally, only about 60 per cent of pregnant women receive the recommended number of antenatal care visits); consistent HIV testing and linkage to antiretroviral treatment (ART) for children found to be positive; and – once ART is initiated – addressing the factors that lead to poor retention in care, including weak health systems, over-reliance on facility-based services with weak community facility linkages, inadequate decentralization of services, and reliance in many countries on user fees, which deter service uptake.

Strategies to improve HIV prevention outcomes for adolescents include combining approaches that address biomedical, behavioural and structural issues through a gender-transformative lens; innovative use of digital technologies; and appropriate cash incentives in a peer-supported enabling environment free of gender-based violence and stigma. Data must also continue to be refined for adolescents to monitor the HIV epidemic; address broader health issues including mental health; respond to HIV awareness, education and communication gaps among adolescents/youth; and harness parental and peer support.

In ECD, UNICEF will continue enhancing a multisectoral approach to early childhood development programming with focus on capacities and skills of front-line workers, parents and caregivers. A key accelerator to achieving results for all children is the provision of quality parenting and family support, because parents are the key architects of the experiences and opportunities for children's health, well-being and development. Parents will also be the first-line responders to the COVID-19 pandemic,

responsible for their children's learning, health, well-being and care. UNICEF can build awareness of parents about the pandemic, provide access to up-to-date information, and support with tools and resources to guide parental responses.

As the Ebola outbreak and now the COVID-19 pandemic remind us, children's rights and survival, growth and development gains can be quickly reversed, resulting in thousands of lives needlessly lost. The pandemic's wider consequences for children, women and their families – particularly those already in humanitarian situations – are yet to be seen. While the impact and long-term fallout of the crisis is already extraordinary, UNICEF is striving to maintain continuity of its programmes and operations while responding to the pandemic and adapting to its impact. Vertical funds to combat specific diseases remain important, but flexible funding – such as thematic funds and regular resources – has never been more urgent for implementing a response fit for twenty-first century challenges.



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Christelle, a 3-month-old baby, is waiting to be weighted and vaccinated in the health centre of Gonzagueville, a suburb of Abidjan, in the South of Côte d'Ivoire.

Anna, the 29-year-old mother of 4 children, is wearing a mask to protect herself against the Coronavirus.

Abbreviations and acronyms

ANC	antenatal care	EVM	effective vaccine management
ART	antiretroviral treatment	FAO	Food and Agriculture Administration of the United Nations
C4D	communication for development	FFP	family-friendly policies
CCCs	Core Commitments for Children in Humanitarian Action	GAP	Global Action Plan
CCD	Care for Child Development	GIS	geographic information system
CCE OP	Cold Chain Equipment Optimization Platform	Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
CDC	Centers for Disease Control and Prevention (United States)	GPEI	Global Polio Eradication Initiative
CHW	community health worker	HMIS	health management information system
COVID-19	coronavirus disease 2019	HPV	human papillomavirus
CSO	civil society organization	HSS	health systems strengthening
DFID	Department for International Development (United Kingdom)	IA 2030	Immunization Agenda 2030
DHIS2	District Health Information System 2	iCCM	integrated Community Case Management
DTP3	diphtheria-tetanus-pertussis vaccine (three doses)	ICT	information and communications technology
EAP	East Asia and the Pacific	IECD	Integrated Early Childhood Development
ECA	Europe and Central Asia	IFA	iron and folic acid
ECD	early childhood development	ILO	International Labour Organization
ECDI	ECD index	IYCF	infant and young child feeding
ECHO	European Commission Humanitarian Office	KMC	kangaroo mother care
EMTCT	elimination of mother-to-child transmission	LAC	Latin American and the Caribbean
ENAP	Every Newborn Action Plan	MAM	moderate acute malnutrition
EPI	Extended Programme on Immunization	MENA	Middle East and North Africa
ESA	Eastern and Southern Africa	MMS	multiple micronutrient supplements
EU	European Union	MNP	micronutrient powder
EVD	Ebola virus disease	MNTE	maternal and neonatal tetanus elimination
		NCD	non-communicable disease

NCF	Nurturing Care Framework	SDG	Sustainable Development Goal
NGO	non-governmental organization	SMS	short message service
NID	national immunization day	SP	Strategic Plan
ORE	other resources – emergency	SRHR	sexual and reproductive health and reproductive rights
ORR	other resources – regular	SUN	Scaling Up Nutrition
ORS	oral rehydration salts	UBRAF	Unified Budget, Results and Accountability Framework
PCV	pneumococcal conjugate vaccine	UHC	universal health coverage
PEPFAR	US President’s Emergency Plan for AIDS Relief	UNAIDS	Joint United Nations Programme on HIV/AIDS
PHC	primary health care	UNDP	United Nations Development Programme
PMNCH	Partnership for Maternal, Newborn and Child Health	UNESCO	United Nations Educational, Scientific and Cultural Organization
PMTCT	prevention of mother-to-child transmission (of HIV)	UNFPA	United Nations Population Fund
POC	point of care	UNHCR	United Nations High Commissioner for Refugees
PrEP	pre-exposure prophylaxis	UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
PSBI	possible serious bacterial infections	USAID	United States Agency for International Development
RR	regular resources	VAS	vitamin A supplementation
RUTF	ready-to-use therapeutic foods	WASH	water, sanitation and hygiene
SA	South Asia	WCA	West and Central Africa
SADC	Southern African Development Community	WFP	World Food Programme
SAM	severe acute malnutrition	WHO	World Health Organization
SBCC	social and behaviour change communication		

Annex 1: Financial report*

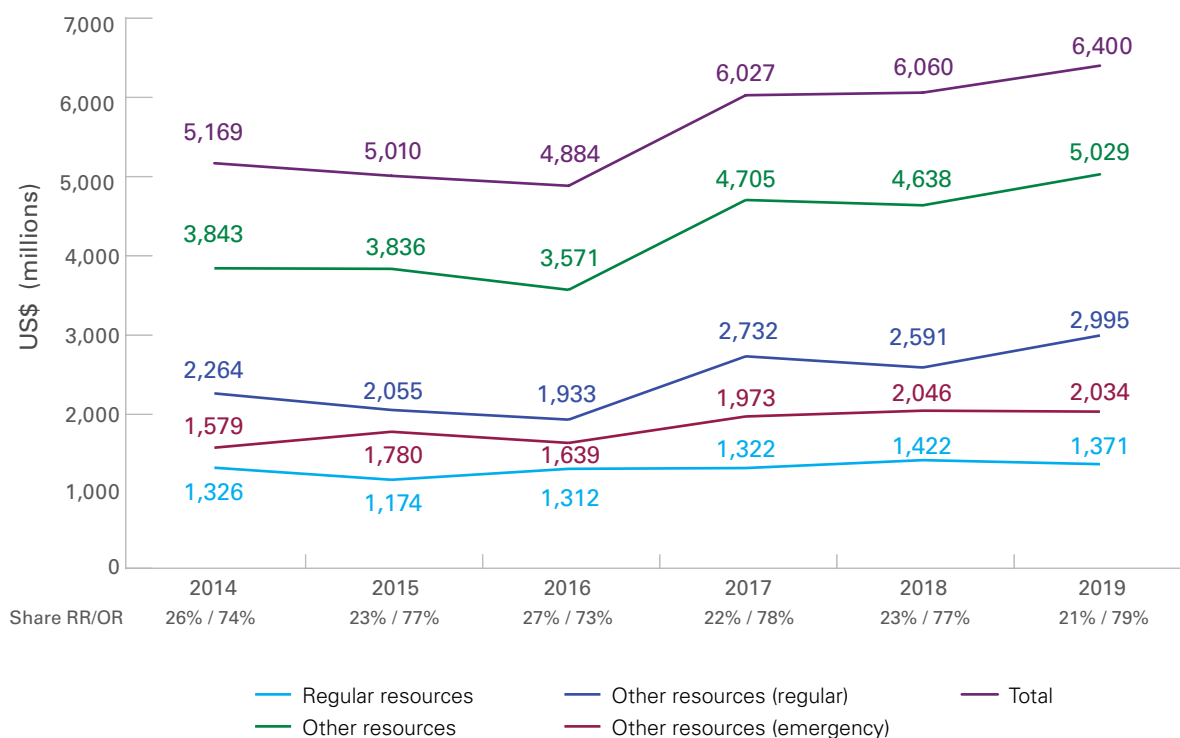
*All funding data as of 6 April 2020, pending audit and certification

UNICEF income in 2019

In 2019, total income to UNICEF reached US\$6,400 million. This was an increase of 6 per cent compared with 2018, due to an increase in earmarked funds to specific programmes (other resources). Un-earmarked funds (regular resources) income decreased to US\$1,371 million in 2019 from US\$1,422 million in 2018. Regular resources

also decreased as a proportion of total income to UNICEF to 21 per cent, down from 23 per cent in 2018. Other resources income increased by 8 per cent, up from US\$4,638 million in 2018 to US\$5,029 million in 2019. (See Figure A1-1)

Figure A1-1: Income by funding type, 2014–2019*



* Figures are based on 'income', which here represents contributions received from public sector and revenue from private sector.

While 'other resources' contributions increased compared with 2018, contributions to the 10 thematic funding pools decreased by 10 per cent, from US\$386 million in 2018 to US\$346 million in 2019 (see Figure A1-2). Thematic funding also decreased as a percentage of all 'other resources', from 8 per cent in 2018 to 7 per cent in 2019. This is 6 per cent below the milestone target set out in the UNICEF Strategic Plan, 2018–2020, of thematic funding being 13 per cent of all 'other resources' in 2019. The trend of decreasing overall amount of thematic funding, as well as decreasing ratio of thematic funding as a

percentage of the total, is concerning and goes against Funding Compact commitments. In the Funding Compact between governments and the United Nations Sustainable Development Group, United Nations Member States have committed to double the share of non-core contributions that are provided through single agency thematic funding, such as UNICEF thematic funding pools. In alignment with this commitment, UNICEF aims to double thematic funding as a share of all 'other resources' to 15 per cent by 2021. To reach this goal, UNICEF encourages partners to channel more contributions through these softly earmarked funds.

'Income' refers to the total amount committed in the year that the agreement was signed, plus any adjustments, for funds received from private sector partners and disbursements received in a particular year from public sector partners, while 'contributions' refers to disbursements received in a particular year, exclusive of adjustments, from both private and public partners.

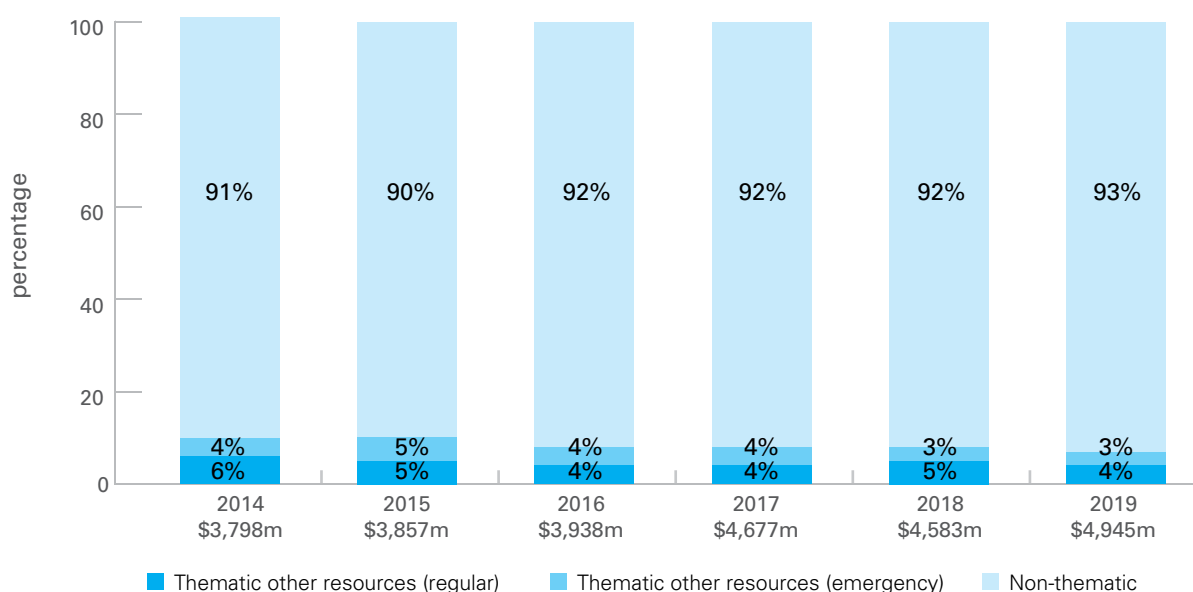
Regular resources (RR): Un-earmarked funds that are foundational to deliver results across the Strategic Plan.

Other resources (OR): Earmarked funds for programmes; supplementary to RR and intended for a specific purpose, such as an emergency response or a specific programme in a country or region.

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

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

FIGURE A1-2: Other resources contributions, 2014–2019: Share of thematic funding*



* 2014–2016 contributions restated to reflect change in accounting policy for comparison with 2017–2019.

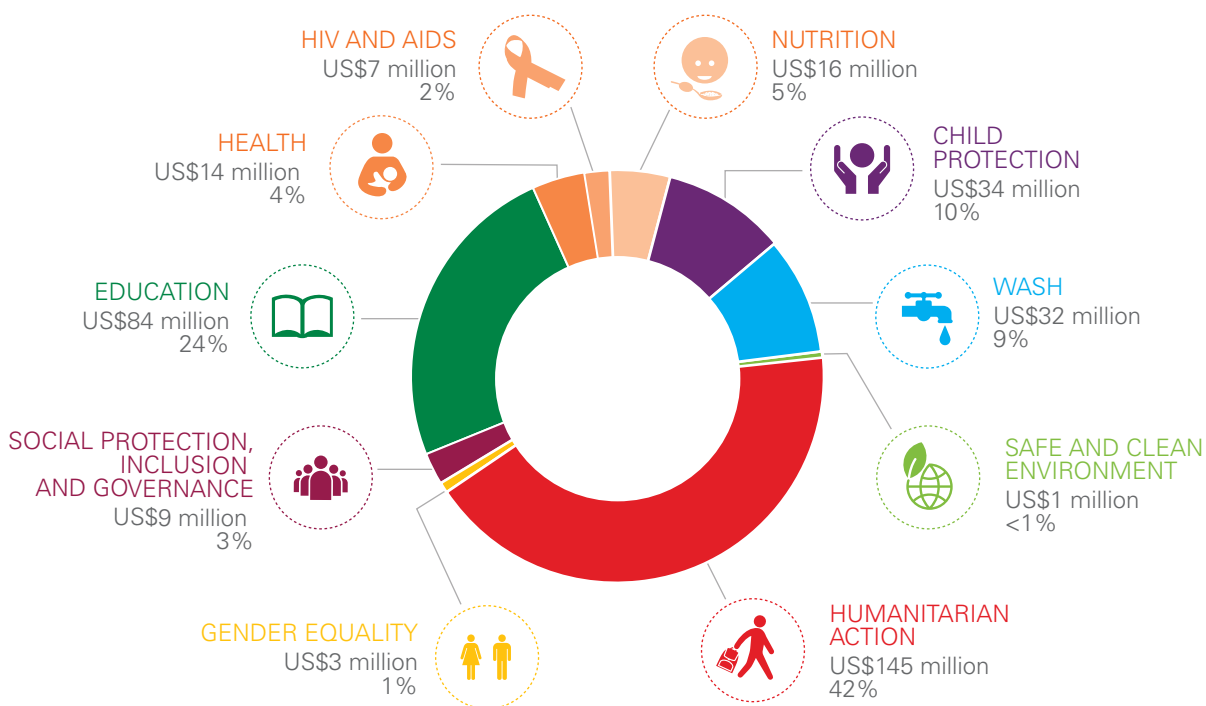
Thematic funding remains a critical source of income for UNICEF programme delivery. Through thematic funding contributions at global, regional and country levels, partners support UNICEF-delivered results at the highest programme level in each of those contexts for the greatest impact. They act as an ideal complement to regular resources, as they can be allocated on a needs basis. The flexibility of thematic funding allows UNICEF to respond more effectively. It facilitates longer-term planning, sustainability and savings in transaction costs, leaving more resources for UNICEF programmes.

For partners, contributions to UNICEF’s 10 thematic funding pools are in keeping with the principles of good multilateral resource partnerships. Thematic contributions have the greatest potential of ‘other resources’ to produce high-level results directly aligned to the Strategic Plan, as endorsed by the UNICEF Executive Board, and supported by the aims

of the Paris Declaration on Aid Effectiveness. They yield a higher return on investment than more tightly earmarked contributions, as lower management and reporting costs result in a larger percentage of funds going towards programming. They also simplify renewal and allocation procedures, and reduce the administrative monitoring burden for partners.

Regrettably, overall contributions to the thematic funding pools decreased from US\$386 million in 2018 to US\$346 million in 2019 (see Figure A1-3). The largest public sector contributors to the thematic funding pools in 2019 were the governments of Norway, Sweden and the Netherlands, while the largest private sector contributions were facilitated by the German Committee for UNICEF, the U.S. Fund for UNICEF and the United Kingdom Committee for UNICEF.¹²⁵

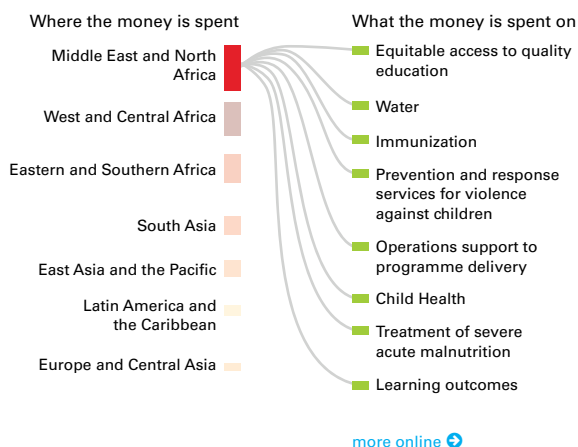
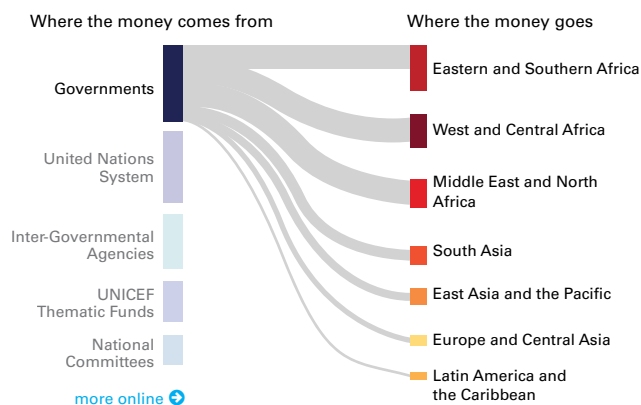
FIGURE A1-3: Thematic contributions by thematic pool, 2019: US\$346 million



The allocation and expenditure of all thematic funding contributions can be monitored on the UNICEF transparency portal (open.unicef.org) and the results achieved with the funds, assessed against Executive Board-approved targets and indicators at country, regional and global levels, are consolidated and reported across the suite of Global Annual Results Reports.

Specific reporting for country and regional thematic funding contributions is provided separately for partners giving at those levels.

Transparency: Follow the flow of funds from contribution to programming by visiting <https://open.unicef.org/>.

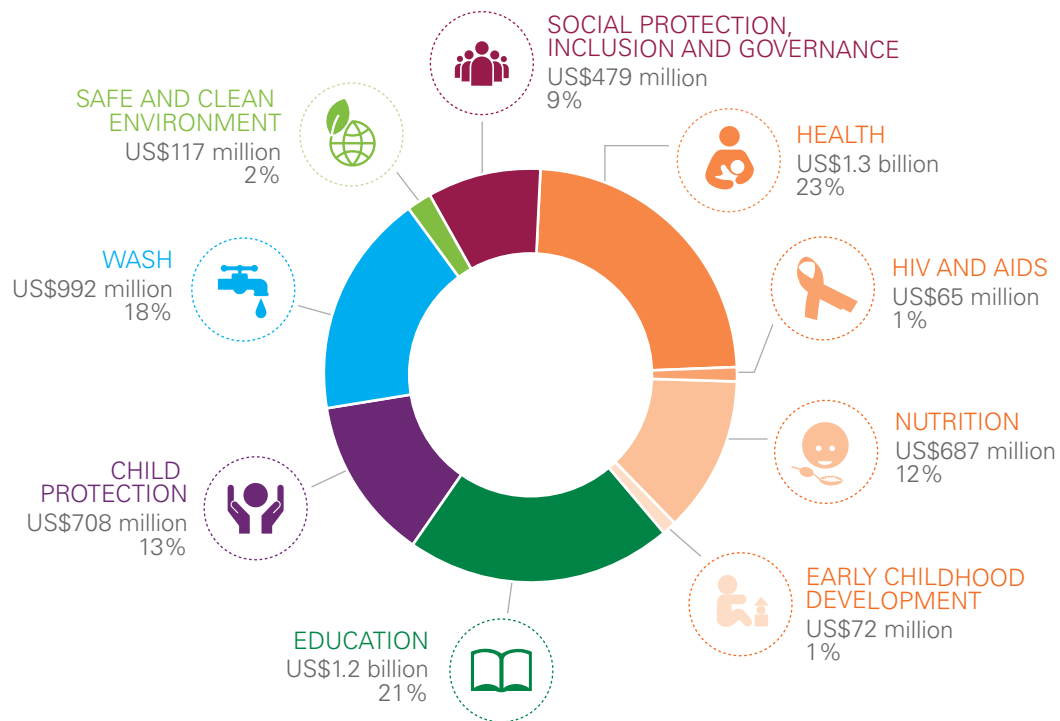


UNICEF expenses in 2019

Note: Expenses are higher than the income received because expenses are comprised of total allotments from regular resources and other resources (including balances carried over from previous years), whereas income reflects only earmarked contributions to Goal Area 1 in 2019. In 2019, total expenses for UNICEF programmes amounted to US\$5,650 million.

'Expenses' are recorded according to International Public Sector Accounting Standards (IPSAS) 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 A1-4: Total expenses by strategic outcome area, 2019: US\$5650 million



"The Grand Duchy of Luxembourg remains committed to the United Nations Development System, allocating 1% of its Gross National Income to its Official Development Assistance and focusing its efforts on least developed countries. By making multi-year, flexible commitments to UNICEF's thematic funds, Luxembourg continues to be a long standing, reliable partner to the United Nations Children's Fund. These contributions prove instrumental in safeguarding opportunities for children around the world to live and fulfil their potential. Luxembourg's financial commitments enable UNICEF to focus on strengthening equal access to quality basic education, gender equality, access to clean water, sanitation and hygiene, food security and nutrition, addressing HIV/AIDS among adolescents, reinforcing maternal health systems and striving towards young child survival and development. These thematic priorities are fully aligned with Luxembourg's Development Cooperation Strategy 'The Road to 2030'. Luxembourg believes that development cooperation and engagement with multilateral organisations, while supporting ongoing reforms in the international development systems, form the foundation of success of the global efforts towards poverty eradication, environmental sustainability and human rights."

— Paulette Lenert, Minister for Development Cooperation and Humanitarian Affairs, Luxembourg

Endnotes

1. Child Mortality: Report 2019.
2. United Nations Children's Fund, *The State of the World's Children 2019: Children, Food and Nutrition – Growing Well in a Changing World*, UNICEF, New York, 2019, <www.unicef.org.au/Upload/UNICEF/Media/Documents/SOWC-Report-2019.pdf>, accessed 17 April 2020.
3. Robertson, Timothy, and Emily D. Carter, 'Early Estimates of the Indirect Effects of the Coronavirus Pandemic on Maternal and Child Mortality in Low- and Middle-Income Countries', *The Lancet*, 21 April 2020, <<https://dx.doi.org/10.2139/ssrn.3576549>>, accessed 10 June 2020
4. United Nations Children's Fund, 'Healthy Mothers, Healthy Babies: Taking Stock of Maternal Health', June 2019, <<https://data.unicef.org/resources/healthy-mothers-healthy-babies/>>, accessed 20 February 2020.
5. More details can be found at <www.unicefusa.org/stories/how-tetanus-vaccines-give-newborns-fighting-chance-yemen/36684>.
6. Ferguson, Sarah, 'Immunization: With Help from UNICEF and Partners, Chad Eliminates MNT', 26 April 2019, <www.unicefusa.org/stories/help-unicef-and-partners-chad-eliminates-mnt/35853>, accessed 18 April 2020.
7. Laing, K., et al., 'An Investment Case for Maternal and Neonatal Tetanus Elimination', *Vaccine*, vol. 38, no. 9, 24 February 2020, pp. 2241–2249, <<https://doi.org/10.1016/j.vaccine.2019.11.052>>, accessed 18 April 2020.
8. Results that are Specific, Measurable, Achievable, Relevant and Time bound.
9. World Health Organization and United Nations Children's Fund, *Survive and Thrive: Transforming Care for Every Small and Sick Newborn*, WHO, Geneva, 1999, <www.healthynewbornnetwork.org/hnn-content/uploads/Survive-and-Thrive_Final.pdf>, accessed 18 April 2020.
10. United Nations Children's Fund and World Health Organization, *UNICEF–WHO Low Birthweight Estimates: Levels and Trends 2000–2015*, WHO, Geneva, 2019, <www.unicef.org/media/53711/file/UNICEF-WHO%20Low%20birthweight%20estimates%202019%20.pdf>, accessed 18 April 2020.
11. Strategic Advisory Group of Experts on Immunization, *The Global Vaccine Action Plan 2011–2020. Review and Lessons Learned*, World Health Organization, Geneva, 2019, <<https://apps.who.int/iris/bitstream/handle/10665/329097/WHO-IVB-19.07-eng.pdf?ua=1>>, accessed 18 April 2020.
12. 1 billion = 1,000 million, i.e., 1,000,000,000.
13. United Nations Children's Fund and World Health Organization, 'Progress and Challenges with Achieving Universal Immunization Coverage: 2018 WHO/UNICEF Estimates of National Immunization Coverage (Data as of July 2019)', WHO, Geneva, 2019, <www.who.int/immunization/monitoring_surveillance/who-immuniz.pdf?ua=1>, accessed 18 April 2020.
14. Johns Hopkins University – International Vaccine Access Center, *Methodology Report: Decade of Vaccines Economics (DOVE) Return on Investment Analysis*, August 2019, <<http://immunizationeconomics.org/dove-roi>>, accessed 18 April 2020.
15. 'Progress and Challenges'.
16. Patel, Minal K., et al. 'Progress Toward Regional Measles Elimination — Worldwide, 2000–2018', *Morbidity and Mortality Weekly Report*, vol. 68, no. 48, 6 December 2019, pp. 1105–1111, <<http://dx.doi.org/10.15585/mmwr.mm6848a1>>, accessed 18 April 2020.
17. The Measles & Rubella Initiative, *2018 Annual Summary*, [2019], <https://s3.amazonaws.com/wp-agility2/measles/wp-content/uploads/2019/10/967305_Trifold_noBleed.pdf>, accessed 18 April 2020.
18. Patel, Minal K., et al. 'Progress Toward Regional Measles Elimination — Worldwide, 2000–2018', *Morbidity and Mortality Weekly Report*, vol. 68, no. 48, 6 December 2019, pp. 1105–1111, <<http://dx.doi.org/10.15585/mmwr.mm6848a1>>, accessed 18 April 2020.
19. *Neisseria meningitidis* (meningococcus) is a leading cause of bacterial meningitis and 12 serogroups have been identified. Epidemics in the African meningitis belt have been primarily caused by *N. meningitidis* serogroup A.
20. Countries with active outbreaks in 2019: Angola, Benin, Burkina Faso, Central African Republic, Chad, China, the Democratic Republic of the Congo, Ethiopia, Ghana, Malaysia, Myanmar, the Niger, Nigeria, Pakistan, the Philippines, Somalia, Togo and Zambia.

21. Latest updated data: GPEI Semi-Annual Status Report January–June 2019; July–December 2019 Report in preparation.
22. While 40 per cent of front-line workers in urban areas are female, women comprise only 13 per cent of all front-line workers in Afghanistan. This low number can, to a large extent, be attributed to an increasingly volatile security situation, hindering women's participation in the health workforce overall. Afghanistan is making efforts to ensure the safety of all front-line workers and increase women's participation to reach the target of having women comprise at least 50 per cent of front-line workers in urban areas.
23. <www.hcd4health.org/>.
24. The Global Forum on Childhood Pneumonia, 'Declaration', Barcelona, Spain, January 2020, <<https://stopppneumonia.org/wp-content/uploads/2020/02/Final-Global-Forum-Childhood-Pneumonia-Declaration-07.02.2020.pdf>>, accessed 18 April 2020.
25. World Health Organization, *World Malaria Report 2019*, WHO, Geneva, 2019.
26. United Nations Children's Fund, *Programme Guidance for Early Life Prevention of Non-Communicable Diseases*, UNICEF, New York, August 2019.
27. United Nations Children's Fund, 'Fact Sheet: The Climate Crisis is a Child Rights Crisis', 6 December 2019, <www.unicef.org/rosa/press-releases/fact-sheet-climate-crisis-child-rights-crisis>, accessed 18 April 2020.
28. Institute for Health Metrics and Evaluation, *GBD Compare*, IHME, University of Washington, Seattle, WA, 2017.
29. United Nations Children's Fund, *Unless We Act Now: The Impact of Climate Change on Children*, UNICEF, New York, 2015.
30. Theodoratou, Evropi, et al., 'The Effect of Case Management on Childhood Pneumonia Mortality in Developing Countries', *International Journal of Epidemiology*, vol. 39, Suppl. 1, April 2010, pp. i155–i171, <<https://doi.org/10.1093/ije/dyq032>>, accessed 28 April 2020.
31. Kuper, Hannah and Phyllis Heydt, *The Missing Billion: Access to Health Services for 1 Billion People with Disabilities*, The London School of Hygiene & Tropical Medicine, London, United Kingdom, July 2019, <www.lshtm.ac.uk/TheMissingBillion>, accessed 22 February 2020.
32. United Nations Children's Fund, 'Keeping Children Safe on Philippine Roads', December 2019, <<https://tinyurl.com/qm7b6yl>>, accessed 18 April 2020.
33. World Health Organization, 'Obesity and Overweight', 3 March 2020, <www.who.int/news-room/fact-sheets/detail/obesity-and-overweight>, accessed 16 April 2020.
34. World Health Organization, 'Lead Poisoning and Health', 23 August 2019, <www.who.int/news-room/fact-sheets/detail/lead-poisoning-and-health>, accessed 18 April 2020.
35. The profiles and brochure can be accessed via: Stop Pneumonia and Every Breath Counts, 'World Pneumonia Day: Championing the Fight against Pneumonia', 12 November 2019, <<https://stopppneumonia.org/latest/world-pneumonia-day/>>, accessed 18 April 2020.
36. 2019 estimate based on 2018 coverage data.
37. Trautmann, Sebastian, Jürgen Rehm and Hans-Ulrich Wittchen, 'The Economic Costs of Mental Disorders: Do Our Societies React Appropriately to the Burden of Mental Disorders?', *EMBO Reports*, vol. 17, no. 9, 4 August 2016, pp. 1245–1249, <<https://doi.org/10.15252/embr.201642951>>, accessed 18 April 2020.
38. Kataria, I., et al., 'Reducing Noncommunicable Disease Risk Factors in Adolescents: An Investment Case for Kenya', Evidence Brief, RTI International, November 2018.
39. Nugent, R., et al., 'Investment Case for Reducing Noncommunicable Disease Risk Factors in Adolescents', Research Brief, RTI International.
40. Juma, Pamela A., et al., 'Multi-Sectoral Action in Non-Communicable Disease Prevention Policy Development in Five African Countries', *BMC Public Health*, vol. 18, no. 1, 2018, p. 953.
41. World Health Organization, *Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation*, WHO, Geneva, 2017.
42. World Health Organization, 'Human Papillomavirus (HPV)', March 2018, <www.who.int/immunization/diseases/hpv/en/>, accessed 18 April 2020.
43. Ralaivita, Abela, 'Making the Right Choices in Adolescence Would Guarantee a Better Future', United Nations Children's Fund Madagascar, 24 October 2019, <www.unicef.org/madagascar/en/stories/making-right-choices-adolescence-would-guarantee-better-future>, accessed 18 April 2020.
44. 2019 estimate based on 2018 coverage data.
45. Lehtimäki, Susanna, Nina Schwalbe and Liam Sollis, *Adolescent Health: The Missing Population in Universal Health Coverage*, <www.unicef.org/media/58171/file>, accessed 18 April 2020.
46. Clark, Helen, et al., 'A Future for the World's Children? A WHO–UNICEF–Lancet commission', *The Lancet*, vol. 365, 18 February 2020, pp. 605–658, <[www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)32540-1/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32540-1/fulltext)>, accessed 6 June 2020.
47. *The State of the World's Children 2019*.
48. United Nations Children's Fund, 'Theory of Change Paper', *UNICEF Strategic Plan, 2018–2021*, UNICEF Executive Board, Second Regular Session 2017. While the strategic plan refers specifically to the acceleration of programmes, UNICEF also seeks to improve the implementation of programmes to increase both their quality and scale.

49. Delivery compacts: to improve dietary diversity in early childhood; to improve the nutrition of adolescents; and to scale up care for children with severe acute malnutrition. Learning compacts: to improve women's nutrition during pregnancy and beyond; to improve the nutrition of school-age children for better learning outcomes and prevent overweight and obesity in childhood.
50. UNICEF reporting is based on 2018 verified data from NutriDash, the UNICEF online global data platform on nutrition programme, <www.unicefnutridash.org>.
51. United Nations Children's Fund, 'Strategic Monitoring Questions', UNICEF, New York, 2019.
52. United Nations Children's Fund, *UNICEF Nutrition Strategy 2020–2030*, forthcoming.
53. *The State of the World's Children 2019*.
54. *The State of the World's Children 2019*.
55. This indicator has a one-year reporting lag.
56. This indicator has a one-year reporting lag.
57. The calculation methodology for this indicator has been updated, leading to an increase in reported results compared with the baseline, milestones and target.
58. The 2016 baseline for this indicator was based on 30 countries. However, for this report, all UNICEF programme countries and territories working on prevention of overweight and obesity were included. This expands the basis for this indicator to 40 and 56 countries in 2017 and 2018, respectively.
59. This indicator has a one-year reporting lag.
60. United Nations Children's Fund, NutriDash programme monitoring platform, 2018. Humanitarian data refer to those countries with a Humanitarian Action for Children appeal in 2019.
61. Tanzania Food and Nutrition Centre and President Office – Regional Authorities and Local Governments, 'Bottleneck analysis', 2019.
62. Data are from NutriDash, 2018 (the latest available estimates).
63. NutriDash programme monitoring platform, 2018. Data are subject to a one-year reporting delay.
64. This figure has not yet been verified for acceptance in the global VAS database.
65. Food Security Cluster. Food Security and Nutrition Monitoring Report, June 2019.
66. National Nutrition Survey, Tajikistan, 2016.
67. United Nations Children's Fund and World Bank, 'Situation Analysis on Improving Economic Outcomes by Expanding Nutrition Programming in Tajikistan', UNICEF and World Bank, New York, 2012.
68. Ahmed, Faruk, Noreen Prendiville and Anuradha Narayan, 'Micronutrient Deficiencies Among Children and Women in Bangladesh: Progress and Challenges', *Journal of Nutritional Science*, vol. 5, 2016, art. e46.
69. Blencowe, Hannah, et al., 'National, Regional, and Worldwide Estimates of Low Birthweight in 2015, with Trends from 2000: A Systematic Analysis', *Lancet Global Health*, 15 May 2019, pp. e849–e860, <[https://dx.doi.org/10.1016/S2214-109X\(18\)30565-5](https://dx.doi.org/10.1016/S2214-109X(18)30565-5)>, accessed 18 April 2020.
70. Health-care facility data based on women accessing antenatal care services.
71. Keats, Emily C., et al., 'Multiple-Micronutrient Supplementation for Women During Pregnancy', *Cochrane Systematic Review – Intervention*, 15 March 2019, <<https://doi.org/10.1002/14651858.CD004905.pub6>>, accessed 18 April 2020.
72. Bangladesh Directorate General of Family Planning, 'National Anaemia Consultation Report', July 2016.
73. *The State of the World's Children 2019*.
74. *UNICEF–WHO Low Birthweight Estimates*.
75. Countries rated as having a comprehensive policy or strategy have six or seven of the following interventions included: protection, promotion and support of breastfeeding (children aged 0–2 years); promotion and support of appropriate complementary feeding (children aged 6–23 months); promotion of adequate dietary diversity (children aged 6–23 months); home fortification with micronutrient powders (children aged 6–59 months); vitamin A supplementation; deworming of preschool-aged children; prevention of overweight for preschool children.
76. Policy and programme actions for the prevention of childhood overweight (criteria for this indicator require the implementation of three or more of these actions: (1) Nutrition education for children, including food skills and food literacy; food skills and literacy education for teachers and catering staff. (2) Food standards in preschool settings that make healthy food available and restrict the availability of unhealthy food. (3) Food standards in school settings that make healthy food available and restrict the availability of unhealthy food. (4) Initiatives to make specific healthy foods available in schools (healthy school meals, school gardens, etc.). (5) Subsidies that promote affordability of nutritious foods among low-income parents with young children. (6) Regulation of unhealthy food marketing to children. (7) Health-related food taxes. (8) Nutrition labels with some form of warning symbol or nutritional rating system. (9) Other (e.g., programmes to improve physical activity in schools).
77. These initiatives include: Food Fortification Initiative; Global Alliance for Vitamin A; Global Breastfeeding Collective; Global Technical Assistance Mechanism for Nutrition (G-TAM); Global Nutrition Cluster; Home Fortification Technical Advisory Group; Infant and Young Child Feeding in Emergencies Core Group; Iodine Global Network; Micronutrient Forum; Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly Resolutions; Scaling Up Nutrition movement; and UN Nutrition.

78. This results area also describes outputs related to improving the nutrition of school-age children (aged 6–10 years), as many of the interventions overlap with those provided to adolescents and use common delivery platforms, notably schools.
79. The terms ‘middle childhood’ and ‘school-age children’ refer to children aged 5–14 years.
80. Keats, Emily C., et al., *Diet and Eating Practices among Adolescent Girls in Low and Middle-Income Countries: A Systemic Review*, Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) project, Arlington, VA, 2018.
81. Ivers, L.C., and K.A. Cullen, ‘Food Insecurity: Special Considerations for Women’, *American Journal of Clinical Nutrition*, vol. 94, no. 6, 2011, pp. 1740S–1744S.
82. Spear, B.A., ‘Adolescent Growth and Development’, *Journal of the American Dietetic Association*, vol. 102, no. 3 (Supplement), 2002, pp. S23–S29.
83. NutriDash, 2018; data have a one-year reporting delay.
84. GIFTS baseline and follow-on report, 2018
85. *The State of the World’s Children 2019*.
86. Essential nutrition interventions in and around schools: Nutrition literacy: curriculum to improve knowledge on good diets and healthy dietary practices; communication to promote good diets, positive eating/dietary practices. Nutritious foods and diets: nutritious school meals, including fortified foods, to improve children’s diets; safe drinking-water in schools. Healthy food environments: policies and guidelines to ensure healthy foods and drinking-water in and around schools; standards and regulations to eliminate marketing of unhealthy foods and beverages. Supplementation and deworming: micronutrient supplements to protect children from vitamin and other deficiencies; deworming prophylaxis to protect children from helminth infections and anaemia. Physical activity: curriculum to include physical education and promote active living; communication to promote physical activity and active living.
87. Bundy, Donald A., et al., ‘The School as a Platform for Addressing Health in Middle Childhood and Adolescence’, ch. 20 in *Disease Control Priorities*, 3rd ed., Vol. 8 *Child and Adolescent Health and Development*, edited by Donald A.P. Bundy, et al., The World Bank Group, Washington, D.C., 2017, pp. 269–286.
88. NutriDash, 2018.
89. Policies and regulations on marketing of food and beverages high in fat, sugar and salt, ban on vending machines, and improving the availability of safe drinking-water in schools.
90. All references to Kosovo in this report should be understood to be in the context of United Nations Security Council resolution 1244 (1999).
91. *The State of the World’s Children 2019*.
92. United Nations Children’s Fund, World Health Organization and International Bank for Reconstruction and Development/The World Bank, *Levels and Trends in Child Malnutrition: UNICEF / WHO / World Bank Group Joint Child Malnutrition Estimates – Key Findings of the 2019 Edition*, WHO, Geneva, 2019, <www.who.int/nutgrowthdb/jme-2019-key-findings.pdf?ua=1>, accessed 18 April 2020.
93. NutriDash, 2018. Estimates based on countries with a Humanitarian Action for Children appeal.
94. United Nations Children’s Fund, World Health Organization and International Bank for Reconstruction and Development/The World Bank, *Levels and trends in child malnutrition: key findings of the 2019 Edition of the Joint Child Malnutrition Estimates – UNICEF Regions*, WHO, Geneva, 2019.
95. Wasting in children aged 0–59 months is defined as a weight-for-height below –2 SD (standard deviations) from the WHO Child Growth Standards median for a child of the same height and sex. Moderate acute malnutrition is defined by moderate wasting (weight-for-height below –2 and above or equal to –3 SD) and/or (in the case of children aged 6–59 months) mid-upper-arm-circumference (MUAC) of less than 125 mm and above or equal to 115 mm. Severe acute malnutrition is defined by the presence of severe wasting (weight-for-height below –3 SD), bilateral pitting oedema (kwashiorkor) and/or (in the case of children aged 6–59 months) an MUAC of less than 115 mm.
96. 2018 SAM admissions do not represent the full year of reporting since the majority of the countries reported data as of October or November 2018. UNICEF is currently revising the methodology to address this issue and an updated figure will be published in the data companion and scorecard for 2019.
97. 2019 SAM admissions capture a full year from October 2018 to September 2019.
98. The 2018 SAM admissions do not represent the full year of reporting, since the majority of the countries reported data as of October or November 2018. UNICEF is currently revising the methodology to address this issue and an updated figure will be published in the data companion and scorecard for 2019.
99. United Nations Children’s Fund, ‘Ready-to-Use Therapeutic Food – Market Update’, UNICEF Supply Division, February 2019, <www.unicef.org/supply/files/RUTF_4_Market_and_Supply_Update.pdf>, accessed 19 March 2020.
100. Figures for SAM admissions in humanitarian settings reflect the number of children admitted for treatment in countries with a Humanitarian Action for Children appeal. To capture admissions over a 12-month period, the 2019 figure is based on data collected from the last quarter of 2018 to the third quarter of 2019. This differs from the methodology used to calculate the 2018 figure, which is based on admissions during the first three quarters of the year only.
101. NutriDash, 2018. Figures are subject to a one-year reporting delay.

102. Food Security and Nutrition Analysis Unit for Somalia – Gu 2019 analysis.
103. *Global Action Plan on Child Wasting: A Framework for Action to Accelerate Progress in Preventing and Managing Child Wasting and the Achievement of the Sustainable Development Goals*, no date, <www.who.int/internal-publications-detail/global-action-plan-on-child-wasting-a-framework-for-action>, accessed 18 April 2020.
104. Unless otherwise indicated, country, regional and global data are sourced from Global AIDS Monitoring and UNAIDS 2019 Estimates.
105. The UNICEF Strategic Plan, 2018–2021 prioritizes 35 countries for HIV activities. Collectively, those countries are home to more than 8 out of 10 children and adolescents worldwide who were newly infected with HIV, were living with HIV or who died from AIDS-related causes in 2019, and were where responses were particularly slow and results among children, adolescents and pregnant women were especially weak. Strategic Plan countries are Angola, Botswana, Brazil, Burundi, Cameroon, Chad, China, Côte d'Ivoire, the Democratic Republic of the Congo, Djibouti, Dominican Republic, Eswatini, Ethiopia, Ghana, Haiti, India, Indonesia, Islamic Republic of Iran, Kenya, Lesotho, Malawi, Mozambique, Myanmar, Namibia, Nigeria, the Philippines, Rwanda, South Africa, Thailand, Uganda, Ukraine, United Republic of Tanzania, Uzbekistan, Zambia and Zimbabwe.
106. UBRAF 2016–2021, 2019 Global Report.
107. Department of Health, Epidemiology Bureau, 'HIV/AIDS and ART Registry of the Philippines (HARP)', Manila, Philippines, May 2019.
108. UNICEF databases of population-based household surveys, 2013–2018.
109. Please refer to the four-level rating scale in Figure X2/89.
110. Nurturing Care for Early Childhood Development, <<https://nurturing-care.org/>>.
111. In most cases, drops in numbers of countries in the 'Advanced' group are likely to be due to the revision of scale (truncating categories) in 2019, and not due to lack of progress.
112. United Nations Children's Fund, 'UNICEF Parenting', <www.unicef.org/parenting/>, accessed 10 June 2020.
113. UNICEF briefs on family-friendly policies, <www.unicef.org/early-childhood-development/family-friendly-policies>.
114. Plan International, 'Early Childhood Development is Essential in Emergencies', New York, no date, <<https://plan-international.org/healthy-start/early-childhood-development-essential-emergencies>>, accessed 10 June 2020.
115. INEE, 'Early Childhood Development', New York, no date, <<https://archive.ineesite.org/en/early-childhood-development>>, accessed 10 June 2020.
116. United Nations High-Level Meeting on UHC political resolution: United Nations General Assembly, 'Resolution Adopted by the General Assembly on 10 October 2019: 74/2. Political Declaration of the High-level Meeting on Universal Health Coverage', United Nations, New York, 18 October 2019, <<https://undocs.org/en/A/RES/74/2>>, accessed 10 June 2020.
117. UHC2030, 'Moving Together to Build a Healthier World: The UN High-Level Meeting (UN HLM) on Universal Health Coverage, 23 September 2019, New York', <www.uhc2030.org/un-hlm-2019/>, accessed 10 June 2020.
118. The 12 agencies are Gavi, the Vaccine Alliance; the Global Financing Facility for Women, Children and Adolescents (GFF); The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); the Joint United Nations Programme on HIV/AIDS (UNAIDS); United Nations Development Programme (UNDP); United Nations Population Fund (UNFPA); UNICEF; Unitaid; United Nations Entity for Gender Equality and the Empowerment of Women (UN Women); the World Bank Group; World Food Programme (WFP) and the World Health Organization (WHO).
119. The food system comprises the policies, programmes, services and actors needed to ensure a population's access to nutritious, safe, affordable and sustainable diets.
120. High Level Panel of Experts on Food Security and Nutrition, *Nutrition and Food Systems: a Report By the High-Level Panel of Experts on Food Security and Nutrition*, Committee on World Food Security, Rome.
121. United Nations Children's Fund and Global Alliance for Improved Nutrition, *Food Systems for Children and Adolescents. Working Together to Secure Nutritious Diets*, UNICEF, New York, 2019.
122. United Nations Children's Fund, *Nutrition Strategy 2020–2030* (forthcoming).
123. Front-of-package labelling refers to the inclusion of information about the nutritional composition of food (e.g., fat, sugar and salt content) on food products. Such labels are intended to help consumers identify healthy and unhealthy foods at the point of purchase.
124. EAT is a global, non-profit startup dedicated to transforming our global food system through sound science, impatient disruption and novel partnerships.
125. For more information on thematic funding and how it works, see: <www.unicef.org/publicpartnerships/66662_66851.html>.



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