NutriDash | Facts and Figures
Nutrition Programme Data for the SDGs (2015-2030)
ACKNOWLEDGEMENTS

This report was prepared by UNICEF’s Nutrition Section, Programme Division.

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We wish to especially recognize governments, specifically the state, regional and provincial ministries of health divisions, and the non-governmental organizations and staff who are working to improve the nutrition of women and children every day.
What would our world look like if every child had the nutrition they needed to survive and thrive?

In a well-nourished world, children would be free of stunting, wasting and other forms of malnutrition. They would grow to be healthy, strong and resilient. They would be bright, capable and engaged members of their communities. Most of all, they would be architects in building a better future.

A world without malnutrition is possible. Many of the most evidence-based and cost-effective solutions for preventing malnutrition are already at our fingertips. We know that early and exclusive breastfeeding saves lives and provides infants with the best start in life. We know that safe and nutritious foods, fed in adequate quantities, are essential for healthy physical growth and brain development in children. And we also know that micronutrient supplementation and food fortification can contribute to keep mothers healthy during pregnancy and provide children with the vitamins and essential nutrients they need to grow strong and smart.

Prevention should always come first. Luckily, we also know what needs to be done when prevention efforts fail. The early detection and treatment of severe wasting and other forms of severe acute malnutrition is a life-saving intervention – and we must do much more to reach every child in need.

With the endorsement of the Sustainable Development Goals (SDGs), ending hunger and malnutrition by 2030 is now a collective global commitment. Goal 2, to end hunger, achieve food security and improve nutrition, includes indicators to track progress on the reduction of stunting, wasting and overweight in children and as well as low birthweight in newborns and anaemia in women of reproductive age. Making progress on these indicators will be vital to achieving Goals 1, 3, 4 and 8 to eliminate poverty, end preventable child deaths, improve child learning outcomes, and boost economic growth and prosperity.

To get there, we need good data. We need to know how many children are benefiting from the interventions that work, and we need to know where the gaps and disparities are to improve coverage, quality and equity. UNICEF’s NutriDash monitoring platform does just that, and this report – Nutrition Facts and Figures – provides an overview of the status of key interventions to address malnutrition as the SDG era begins.

The report indicates that we are moving in the right direction. In 2015 there were 10.7 million mothers reached with counselling for infant and young child feeding. More than 10 million children benefited from more nutritious foods through home fortification with multiple micronutrient powders – triple the number of children reached only four years earlier. 70 per cent, or 273 million children, received two doses of vitamin A supplements. The world has never been closer to controlling iodine deficiency: only 19 out of 127 countries with data remain deficient. And admissions for severe acute malnutrition have increased to more than 3 million children from 81 countries.

At the same time, the report highlights places where progress has been slow. There is a need to improve training for health workers: only one in six countries includes counselling on infant and young child feeding in pre-service curricula for medical doctors. Only one in five countries has infant and young child feeding indicators included in its Health Management Information System. And treatment for severe acute malnutrition remains largely out of reach for children in non-emergency contexts, particularly in South Asia.

These robust data shape our road map moving forward. With better knowledge of the progress, challenges and gaps, UNICEF, governments and partners can improve programming to reach the children and families most in need of these essential nutrition interventions.
INTRODUCTION

Prevention: Stopping malnutrition before it starts

From conception through to a child’s second birthday – the first 1,000 days of life – children’s organs and systems develop rapidly, and good nutrition is the key to unlocking children’s potential. The quality of children’s diets before age 2 is more important than at any other time in life. Nutritious diets fuel children’s growth, build strong immune systems, and boost brain development and learning. In contrast, the consequences of poor nutrition during the first 1,000 days are devastating and largely irreversible.

Stunting, or chronic malnutrition, stops children from growing to their full height, while also inflicting lasting damage on the inside: impaired brain development, diminished learning, and decreased productivity and future earnings into adulthood. Wasting, or acute malnutrition, is easy to recognize: it leaves children desperately thin, frail and sick.

However, malnutrition is preventable. With adequate maternal nutrition during pregnancy; exclusive breastfeeding during the first 6 months of life; nutritious and safe foods from the age of 6 months while breastfeeding continues; and access to key vitamins and essential nutrients, sometimes in the form of micronutrient supplements and fortified foods – we have the power to stop malnutrition before it starts.

Treatment: Life-saving services for survival

The world is unfortunately still far from preventing malnutrition in all its forms, everywhere. There are a shocking 52 million children suffering from wasting around the world, and 17 million of them severely – putting them at imminent risk of death.

Children with severe acute malnutrition (SAM) need urgent treatment to survive and thrive. A child with SAM is nine times more likely to die from common infections (e.g. malaria, pneumonia, diarrhoea)1 – but SAM is curable. Early detection and treatment are key to saving lives. Children without medical complications can be treated for SAM with ready-to-use therapeutic foods (RUTF) and care right within their own homes and communities. This approach to community-based care empowers families and communities and is more cost-effective than in-patient hospital treatment.

Global SAM admissions are on the rise, but they are not enough to meet the overwhelming scale of the problem. There is an urgent need to scale up global resources mobilization for SAM to ensure that each and every child in need receives the treatment needed to survive.

About this report

This report provides a snapshot of global progress on key interventions to prevent and treat malnutrition. The data from this report was collected in 2015 via NutriDash, an online annual data capture and reporting system for nutrition programming information, which tracks data for both UNICEF and non-UNICEF supported programmes on a global scale.

The first part of this report reviews progress on the coverage of interventions to prevent malnutrition, including: 1) protection, promotion and support of early and exclusive breastfeeding; 2) counselling for mothers and caregivers on good nutrition and hygiene practices; 3) home fortification with micronutrient powders; 4) vitamin A supplementation; and, 5) the control of iodine deficiency disorders with salt iodization. The description of each intervention includes an overview of the policy environment, regional comparisons and data gaps.

The second part of this report provides an overview of SAM treatment, including trends in SAM admissions, regional caseloads, the availability of treatment supplies, and the policy environment for SAM management. The report concludes with opportunities and recommendations for making better progress moving forward.

Stunting refers to a child who is too short for his or her age. Stunting is the failure to grow both physically and cognitively and is the result of chronic or recurrent malnutrition. The devastating effects of stunting can last a lifetime.

Wasting refers to a child who is too thin for his or her height. Wasting, or acute malnutrition, is the result of recent rapid weight loss or the failure to gain weight. A child who is moderately or severely wasted has an increased risk of death, but treatment is possible.
Exclusively feed breast milk to infants from birth to 6 months.

Vitamin A supplements
- Achieving substantial reductions in child mortality means that all children 6–59 months old living in affected areas need to receive high-dose vitamin A supplements every 4–6 months.

Micronutrient powders
- Home fortification with micronutrient powders aims to ensure that the diet meets the nutrient needs of young children where diets are poor.

Iodine deficiency is a major cause of preventable mental retardation. It is especially damaging during pregnancy and in early childhood.

Adequate complementary foods and feeding practices ensure that children consume nutritious, age-appropriate and safely prepared foods starting at 6 months. Breastfeeding should also continue until age 2 or longer.

Severe acute malnutrition happens when children suffer severe wasting that may or may not be accompanied by swelling of the body from fluid retention.

Recommended treatment from 0-6 months.

Treatment with ready-to-use therapeutic food (RUTF).
A child has her height measured to track growth at the Kono government hospital in Koidu, Sierra Leone.
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PART 1

PREVENTING CHILD STUNTING AND OTHER FORMS OF MALNUTRITION
PREVENTING CHILD STUNTING AND OTHER FORMS OF MALNUTRITION

FOSTERING AN ENVIRONMENT WHERE BREASTFEEDING AND GOOD NUTRITION CAN TAKE HOLD

Infant and young child feeding practices

Infant and young child feeding (IYCF) practices are the cornerstone of good nutrition. Optimal breastfeeding and complementary feeding ensure that infants and young children receive the nutrients they need to grow and develop to their full potential. Providing children with the right foods at the right time in their development offers disease protection, prevents stunting, wasting and micronutrient deficiencies, and reduces the risk of overweight and obesity.

An optimal enabling environment for good nutrition

UNICEF collaborates with governments and partners to create an environment in which the policies and programmes that protect, promote and support adequate infant and young child feeding are effectively implemented and sufficiently funded. An important step in fostering this enabling environment for IYCF is to ensure that a comprehensive policy framework is in place to galvanize programme action. Results show that countries have consistently adopted IYCF policies, with 96 per cent of countries reporting to have one in place, either as a stand-alone policy or as part a broader nutrition or health policy. Further, 75 per cent of countries have adopted the 2010 guidelines on infant feeding in the context of HIV, and have incorporated them into the national IYCF policy framework. New guideline updates on HIV and infant feeding were released in late 2016 and are awaiting adoption in many countries.
The Code: 135 countries have adopted some legal measures, yet most need to be further strengthened

One of the most important legislative measures that countries can take to protect breastfeeding is to fully implement the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions (the Code), through the adoption of national legislation. By integrating the Code’s provisions into national legislation, governments can help protect mothers and health-care workers from the commercial pressures that seek to undermine breastfeeding.

As of 2016, 135 countries have adopted some legal provisions of the Code into national legislation (WHO/UNICEF/IBFAN, 2016). These numbers are promising; however, most of these need to be further strengthened and work remains to ensure that Code legislation is fully implemented, monitored and enforced.

NutriDash collects data from UNICEF programme countries. NutriDash findings confirm that more investment is needed in monitoring and enforcing the Code. In 2015, 51 per cent of the countries had a Code monitoring body, but monitoring activities took place in only 33 per cent of countries. Despite the fact that violations were found in 28 per cent of countries, only six per cent publicized such violations, and three per cent proceeded to prosecution.
PREVENTING CHILD STUNTING AND OTHER FORMS OF MALNUTRITION

STRENGTHENING NATIONAL CAPACITY TO PROVIDE COUNSELLING ON INFANT AND YOUNG CHILD FEEDING

Capacity at the health facility level

Countries need a cadre of knowledgeable and skilled health professionals trained to provide counselling to mothers and caregivers on the recommended infant and young child feeding practices. In 2015, 90 per cent of countries provided regular infant and young child feeding counselling in primary health-care facilities, and nearly 79,000 health workers received in-service training. While in-service training is an important step in the continuum of learning, there are often recurrent costs, and pre-service training can be financially more sustainable. Whereas most of the countries include some kind of infant and young child feeding counselling in pre-service curricula, only 15 per cent of countries had it comprehensively included in curricula for medical doctors, and only about 25 per cent of countries had it comprehensively included in the curricula for nurses and other health professionals.

Capacity at the community level

Community-based infant and young child feeding counselling was implemented in 80 per cent of countries, with more than 160,000 community health workers trained in 2015. Training community health workers is essential, but community outreach by non-health sector community workers can also help improve infant and young child feeding knowledge and practices. According to the data, 39 per cent of countries have trained non-health sector workers on infant and young child feeding, including those working in social protection (47 per cent), agriculture (38 per cent), water, sanitation and hygiene (35 per cent) and education (32 per cent).

Only 1 in 6 countries has IYCF counselling comprehensively included in pre-service curricula for medical doctors.

Only 1.5 in 6 countries has IYCF counselling comprehensively included in pre-service curricula for nurses and other health professionals.

39% of countries have trained non-health sector workers on IYCF.
Coverage of infant and young child feeding counselling

Counselling on infant and young child feeding can empower mothers and caregivers and boost children’s nutritional status during the critical window of the first 1,000 days. In 2015, 42 countries reported reaching approximately 10.7 million mothers with children under two with counselling. And 64 countries reported that 170,000 primary health-care facilities provided individual counselling on a regular basis. These figures provide only a partial snapshot of the current situation of infant and young child feeding counselling. There is a need to improve the availability and quality of data by strengthening national information systems and nutrition surveillance systems.

10.7 million mothers of children under 2 years old were reached with infant and young child feeding counselling in 2015
Note: n=42 countries.

170 thousand primary health-care facilities provided individual infant and young child feeding counselling on a regular basis in 2015
Note: n=64 countries.

Only 1 in 5 countries has infant and young child feeding indicators included in its Health Management Information System.

Data needs: We know as much as data tell us

Monitoring progress on infant and young child feeding counselling is still a challenge for many countries. While most countries have a Health Management Information System (HMIS), nutrition indicators are not always included comprehensively. Only one in five respondent countries has IYCF indicators included in its HMIS, meaning that most countries are not able to adequately monitor key indicators, including the number of mothers reached with counselling.
PREVENTING CHILD STUNTING AND OTHER FORMS OF MALNUTRITION

MAXIMIZING THE NUTRIENTS IN EACH BITE WITH MICRONUTRIENT POWDERS

Integration with IYCF programmes

Home fortification with micronutrient powders offers one of the best opportunities for improving children’s diets when nutrient needs cannot be met with locally available foods alone.

Micronutrient powders (MNP) are best introduced as part of an IYCF strategy. When combined with counselling for mothers on complementary feeding, MNP interventions are particularly effective at improving children’s diets and preventing micronutrient deficiencies, such as iron-deficiency anaemia. In 2015, 76 per cent of countries implemented MNP interventions integrated with IYCF programmes to improve the quality of infants’ diets.

Reach of MNP programmes

In 2015, MNP interventions were implemented in 65 countries, reaching more than 10 million children aged 6–59 months. The scale and reach of MNP programmes varied across the regions, with Latin America and the Caribbean, East Asia and the Pacific and South Asia accounting for two thirds of all children reached.

Total number of children 6–59 months who received micronutrient powders in 2015:

$$10,166,753$$

PREVENTING CHILD STUNTING AND OTHER FORMS OF MALNUTRITION

MICRONUTRIENT POWDERS ARE REACHING MORE THAN 10 MILLION CHILDREN IN 65 COUNTRIES

What do the numbers tell us?

Globally, the number of countries implementing MNP programmes has tripled since 2011, increasing from 22 countries to 65 countries. More than 10 million children were reached with such programmes in 2015. The scale of MNP interventions varied in 2015, from national scale (12 countries), to sub-national scale (13 countries), to pilot programme (18 countries), to emergency programme (16 countries), to those where the scale was unknown (6 countries).
PREVENTING CHILD STUNTING AND OTHER FORMS OF MALNUTRITION

DELIVERING LIFE-SAVING PROTECTION WITH VITAMIN A SUPPLEMENTATION

Effective coverage

Vitamin A supplementation helps maintain strong immune systems and can improve a child’s chance of survival by 12 to 24 per cent. In vitamin-A deficient countries, each child aged 6–59 months should receive two doses of vitamin A supplementation every year to be fully protected. Countries that succeed in reaching more than 80 per cent of children twice a year are considered to have strong programmes – known as ‘effective coverage’.

A snapshot of coverage across regions

In 2015, 273 million children, or 70 per cent of children in need, were fully protected from vitamin-A deficiency. However, nearly one third of children were not reached with the two doses needed to protect them from malnutrition, disease and death. More children were reached in least-developed countries – 77 per cent – where needs are greatest. Yet, in these countries, 32 million of the most vulnerable children remained unprotected in 2015.

Across regions, the lowest two-dose coverage rates were in Eastern and Southern Africa and South Asia, while the highest coverage was in East Asia and the Pacific, where more than 80 per cent of targeted children benefited from the full two dose protection. In West and Central Africa, effective two-dose coverage was almost achieved.

Two in three children in need are now fully protected – but work remains to ensure that all children reap the benefits of this life-saving intervention
PREVENTING CHILD STUNTING AND OTHER FORMS OF MALNUTRITION

FACING THE HURDLES TO SUSTAINED VITAMIN A SUPPLEMENTATION COVERAGE OVER THE LONG TERM

The challenge of sustainability

Effective vitamin A supplementation coverage is an important national achievement; however, many countries face challenges in sustaining high coverage over time. In some countries, vitamin A supplementation is integrated with events that occur twice a year. The drawback, however, is that such events require consistent funding every six months to ensure they take place, and such financing may be inconsistent. This can result in missed rounds and even one missed round denies the benefits of full coverage to all children. Vitamin A supplementation was scaled up successfully in many settings through National Immunization Days for polio, but some countries faced challenges in sustaining high coverage once polio eradication was achieved and the campaigns were scaled back.

Fluctuations in coverage put children at risk

Vitamin A coverage has improved dramatically in the last 15 years. In 2000, less than one in three children was fully protected, while in 2015, more than two out of three children in need are reaping the benefits of full coverage. Despite this success, two-dose coverage has been inconsistent between years and a number of regions have experienced fluctuations in coverage over a short period of time. These coverage gaps are particularly apparent in West and Central Africa, South Asia and Eastern and Southern Africa – and they jeopardize the survival, growth and development of children in these regions.

More than a decade of data show dramatic programme scale-up – and the need to avoid coverage dips that can put young lives at risk

Why is the control of iodine deficiency disorders important?

Iodine deficiency impedes childhood development and is the most common cause of preventable brain damage.\(^6\) Universal salt iodization is one of the most cost-effective strategies for eliminating the adverse effects of iodine deficiency – collectively termed ‘iodine deficiency disorders’ (IDD).

Remarkable progress has been achieved over the past two decades in controlling IDD. Globally, 102 countries (out of the 127 countries with data) have adequate iodine status, and only 19 countries remain iodine deficient according to global estimates.\(^6\) This is the closest the world has ever come to controlling iodine deficiency – and such progress has been made possible because of the increase in the number of households consuming adequately iodized salt since the mid-1990s. Globally, 87 per cent of households are now using iodized salt, although coverage varies considerably by region.

**Globally, 87% of households were using iodized salt**

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<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage of Households Using Salt with Any Iodine</th>
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<tbody>
<tr>
<td>East Asia and the Pacific</td>
<td>91%</td>
</tr>
<tr>
<td>South Asia</td>
<td>89%</td>
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<tr>
<td>Eastern and Southern Africa</td>
<td>82%</td>
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<tr>
<td>West and Central Africa</td>
<td>82%</td>
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<tr>
<td>Middle East and North Africa</td>
<td>69%</td>
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<tr>
<td>Latin America and the Caribbean</td>
<td>No data</td>
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<tr>
<td>CEE/CIS</td>
<td>No data</td>
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<tr>
<td>Least developed countries</td>
<td>72%</td>
</tr>
<tr>
<td>World</td>
<td>87%</td>
</tr>
</tbody>
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Percentage of households consuming salt with any iodine, preliminary as of October 2015

Source: Preliminary estimates of UNICEF global databases, 2017. Note: Regional estimates are presented only where adequate population coverage (≥ 50 per cent) is met. As a result CEE/CIS as well as Latin America and the Caribbean regions are presented as having no data.
PREVENTING CHILD STUNTING AND OTHER FORMS OF MALNUTRITION

STRENGTHENING NATIONAL GOVERNANCE AND OWNERSHIP
TO ELIMINATE IODINE DEFICIENCY DISORDERS

National governance and ownership

Enacting national legislation on mandatory salt iodization is one of the first and most important steps that governments can take to ensure that all households have access to adequately iodized salt. It is also critical for governments to integrate the control of iodine deficiency into national nutrition plans and results frameworks to promote national ownership, to improve programme governance, and to guarantee long-term sustainability of the intervention. Global data show that the policy environment for IDD control is strong: 90 per cent of countries have mandatory salt iodization legislation in place and 82 per cent have a policy, strategy or a national plan of action for the control of IDD.

Effective coordination body for the elimination of IDD

The data also reveal, however, that establishing an effective coordination body for IDD elimination is still a challenge for many countries. The ‘effectiveness’ of the coordination body is defined by the inclusion of all key stakeholders, including private-sector salt producers, and it is based on the development and implementation of an annual workplan with the majority of activities being achieved. While 67 per cent of countries reported the existence of a coordination body for their USI programmes, only 32 per cent of countries reported that body to be effective.

The majority of countries have mandatory salt iodization legislation in place... and have a policy, strategy or a national plan of action for the control of IDD.

...and have a policy, strategy or a national plan of action for the control of IDD.

However, having an effective coordination body for the elimination of iodine deficiency disorders in place is still a challenge for many countries.

Only 1 in 4 countries has an effective coordination body.

The extraordinary progress made in controlling iodine deficiency over the past decades has been possible due to the sustained commitment of governments.
A health worker uses a mid upper-arm circumference (MUAC) measuring tape on a child suffering from severe acute malnutrition (SAM) in Bani Al-Hareth, Sana’a, Yemen. ©UNICEF/UN057347/Almang
PART 2
TREATING SEVERE WASTING
AND OTHER FORMS OF
SEVERE ACUTE MALNUTRITION
TREATING SEVERE WASTING AND OTHER FORMS OF SEVERE ACUTE MALNUTRITION
TACKLING THE GLOBAL BURDEN OF SEVERE ACUTE MALNUTRITION

The heavy toll of severe malnutrition
Severe wasting is the most widespread form of severe acute malnutrition (SAM). SAM is responsible for an estimated 1–2 million preventable child deaths every year. Children suffering from SAM have low immunity to disease, making them more susceptible to recurrent infections and long-term developmental delays. Children with SAM face an increased risk of death and require urgent life-saving treatment.

SAM is preventable and curable: early detection and treatment can save lives. The care and treatment of children with SAM involves a combination of routine medication, therapeutic foods and individualized care. Most children can be treated by their families, in their own homes and communities, using ready-to-use therapeutic foods.

The World Health Assembly (WHA) has set clear targets to fast-track the reduction of children affected by wasting by 2025, including by expanding prevention efforts. As prevention expands, there is still a need to provide life-saving care. SAM management is a crucial cost-effective component of the scaling up nutrition framework for addressing the burden of undernutrition. Furthermore, early detection and treatment of SAM can also contribute to stunting reduction.

17 million children’s lives are in peril due to severe acute malnutrition

Severely wasted children: Where do they live?
According to the JME 2017 estimates, 52 million children under 5 suffering from acute malnutrition (wasting), two thirds of them in Asia and more than a quarter in Africa. An estimated 17 million of these children are suffering from severe wasting. The map above illustrates the prevalence of wasting at country level; however, prevalence alone does not necessarily reflect absolute numbers of children affected. In countries with large populations, for example, there may be a very high number of children affected by severe wasting, but the overall prevalence of severe wasting in the country is low. Efforts to prevent and treat SAM must therefore address the urgent needs of children in settings with both high and low SAM prevalence.

Percentage of children under 5 years old who are wasted
Source: UNICEF, WHO, World Bank Group joint malnutrition estimates, 2017 edition. Note: The map shows the proportion of children in each country that are affected by either severe or moderate acute malnutrition. These proportions do not necessarily reflect the number affected depend on the total population and proportion. Data are the most recent available estimate between 2010 and 2016; exceptions where older data (2005–2009) are shown are denoted with an asterisk (*) and where only data prior to 2005 are available the dark grey colour denoting no recent data is used.
Globally the number of children admitted to SAM treatment programmes has increased steadily, from 1.4 million in 2009 to 3.53 million children in 2015. While overall admissions continue to rise globally, the rate of increase is slow compared with previous years. At the regional level, admission trends are highest in the West and Central Africa region (1.75 million children admitted in 2015) and the East and Southern Africa region (0.86 million in 2015). While lower in absolute numbers, the regions of East Asia and the Pacific, the Middle East and North Africa, and South Asia have seen an increase in the number of children admitted for SAM treatment since 2009.

Admissions to SAM programmes continues to increase in all regions

3.5 million children were admitted to SAM treatment programmes in 2015
TREATING SEVERE WASTING AND OTHER FORMS OF SEVERE ACUTE MALNUTRITION
STRENGTHENING POLICIES AND SYSTEMS TO SAVE LIVES

The building blocks of strong programmes

An enabling environment is a critical foundation for the delivery of SAM programmes. UNICEF defines the enabling environment in terms of legislation, policy, budget, expenditure, management and coordination components. In 2015, the majority of countries had guidelines and protocols for the management of SAM. However, many faced challenges in allocating sufficient national budgets for SAM supplies and programming. SAM treatment is free in the majority of the countries, however, most governments did not commit funding for supplies and programming for SAM treatment (see graph on page 25).

For the most part, SAM management programmes focus on young children. Ninety-one per cent of the countries focused their programmes on children aged 6–59 months, and 77 per cent of countries also included on infants aged 0–6 months.

Integrating care in community-based services

The integration of SAM in community-based services is critical to improving treatment coverage. Integrated community case management is a strategy to extend management of childhood illness beyond health facilities so that more children have access to life-saving treatments. The package mainly cures diarrhoea, pneumonia and malaria. Forty-one countries have included some components of SAM treatment in the integrated community case management of childhood illness (iCCM) package, to help increase availability of care at the community level. Components include: mid-upper arm circumference screening, treatment of SAM by community health workers (including the provision of ready-to-use therapeutic food (RUTF)), tracking of those who discontinue treatment, and referrals. While 41 countries reported integrating community-based treatment of SAM in the iCCM package, only 17 of these countries reported including RUTF as part of SAM treatment delivered in communities.

In Africa, one third of the countries include the use of RUTF for the treatment of SAM as part of the integrated community case management of childhood illness (iCCM)

![Graph showing the number of countries in different regions that have included SAM treatment in the iCCM package, with and without RUTF]

There is strong commitment to treat SAM – yet inadequate funds are being allocated to programming and supplies

A majority of the countries have protocols for the treatment of SAM in children; however, there is an urgent need to have treatment costs committed in national budgets.

A snapshot of the enabling environment for SAM treatment, by region

TREATING SEVERE WASTING AND OTHER FORMS OF SEVERE ACUTE MALNUTRITION

REACHING CHILDREN IN NEED WITH LIFE-SAVING TREATMENT AND CARE

Supporting services and systems

In 2015, a total of 81 countries reported providing SAM management services, and of those, 67 did so with support from UNICEF. The map illustrates the areas where UNICEF country programmes support the provision of care for children with SAM. SAM is often associated with emergencies, and this association has impacted access to treatment. Children affected by humanitarian situations are most likely to access treatment, while those in non-emergency settings, where the number of children affected by SAM is the highest, are often left behind. This imbalance reveals the inequities in access to SAM treatment, and highlights the need for equitable scale-up of SAM services.

UNICEF provides technical and financial support for coordination, policy, capacity building, supply chain management and monitoring and evaluation of programmes addressing SAM. UNICEF works in close partnership with governments, non-governmental organizations, civil society, and UN agencies to deliver SAM treatment and care at community and facility levels.

Delivering life-saving supplies

UNICEF continues to procure the majority of ready-to-use therapeutic food (RUTF) and therapeutic milks (F75 and F100) used to meet global needs in the treatment of SAM. The uninterrupted availability of therapeutic supplies is critical to ensuring the availability and quality of SAM services. Some 62 per cent of the countries reported that UNICEF was the only provider of therapeutic products in their country in 2015. Although the number of countries incorporating RUTF into the national supply system and the essential supplies list has gradually increased, only 40 per cent of countries had included RUTF in the essential medicine by 2015. Supply tracking is also in need of improvement in most countries: only 37 per cent of countries had information on RUTF stockout aggregated and available at national level.

82% of the countries that provide SAM treatment are directly supported by UNICEF
TREATING SEVERE WASTING AND OTHER FORMS OF SEVERE ACUTE MALNUTRITION
PROGRESS CAN AND MUST BE MADE

More children are being treated for SAM than ever before: with UNICEF support, admissions increased from 3.2 million children from 57 countries in 2014 to 3.5 million children in 68 countries in 2015. The recovery rate of those discharged was 88 per cent. However, there is still only a shocking one in five children with SAM receiving lifesaving care. The regional burden and targets, compared with admissions in 2015, make clear that there are still far too many children who require treatment but are being left behind. The discrepancy between this immense burden and those reached is highest in Central and Eastern Europe and the Commonwealth of Independent States, East Asia and the Pacific, and South Asia.

Globally, only 1 in 5 children with severe acute malnutrition has access to treatment.

The gap between children in need and those treated is unacceptably wide, particularly in South Asia.

The national burden, target area and admissions for treatment of severe acute malnutrition by region
Source: NutriDash, 2015. Note 1: The regional burden estimates are from NutriDash which has used the following formula: Prevalence x population (6-59 months) x 2.6.
Mother with her daughter at the Anganwadi centre in Phudi village, Khunti district, India, receiving counselling on child feeding and care. ©UNICEF/UNI88308/Crouch
An end to child malnutrition is within in our grasp. We know more than ever how to prevent malnutrition before it starts – and when preventive efforts fail, we have treatment services that work and can save lives.

This report provides a snapshot of the reach of these high impact preventive and treatment interventions for child malnutrition as well as the policy factors enabling or constraining them. With these global programme performance data, UNICEF and its partners are better equipped to support the design and implementation of programmes that deliver results for children and mothers in need, wherever they live.

Enabling an optimal environment for good nutrition

Fostering an enabling environment for nutrition – including strong policies and legal frameworks – creates the conditions where good nutrition can take hold. Most countries are improving national legislation and regulatory systems: 96 per cent have an infant and young child feeding policy in place, and 90 per cent have mandatory salt iodization legislation. However, adequate investment to implement and enforce these policies remain a challenge. For example, despite widespread legislation on salt iodization, only one in four countries has an effective coordination body for the elimination of iodine deficiency disorders.

Reaching all children with preventive interventions

Overall, the coverage of nutrition programmes is expanding. Home fortification programmes using micronutrient powders have reached more than 10 million children aged 6–59 months in 65 countries, a significant rise from 2011 when only 22 countries reported implementing such programmes. Globally, 90 per cent of countries are providing regular infant and young child feeding counselling in primary health-care facilities. And almost 70 per cent of children in targeted countries are fully protected from vitamin A deficiency. However, more needs to be done to cover all targeted children.

Providing urgent treatment to save lives

The number of countries offering treatment services for severe acute malnutrition has increased over the years. While the number of children affected by SAM is higher in non-emergency contexts, these children are less likely to access treatment, and therefore there is an urgent need to expand treatment services beyond emergency settings, as part of routine services for children. Many countries have enabling policies in place for the treatment of severe acute malnutrition, yet funding and resource allocation remains a pressing challenge.

Improving data and monitoring

There is a need to further strengthen nutrition data and monitoring in most countries. Nutrition indicators are still only included to a limited extent in national management information systems: only one in five countries included infant and young child feeding indicators within its health monitoring systems, making it difficult to know how many children and caregivers are benefiting from counselling and other interventions.

Many countries have taken positive steps towards improving the availability and quality of nutrition data; however, the quality and timeliness of nutrition programme data remains a challenge. UNICEF will continue to work closely with its country offices and their respective governments to provide technical support and guidance to improve the quality of routine programme data, resulting in more effective programming.

Moving forward

NutriDash has primarily focused on specific dimensions of infant and young child nutrition, micronutrient supplementation, food fortification, and the provision of care for children with severe acute malnutrition. In the coming years, NutriDash will expand the scope of its data collection to incorporate new and emerging areas of nutrition programming, such as the work on adolescent nutrition, maternal nutrition and prevention of childhood overweight and obesity.
NOTES ON THE DATA

Data Collection
The data collection process of nutrition programme information via the NutriDash data management tool was conducted between July and September 2016. The country offices responded directly to the online NutriDash questionnaire. A total of 104 countries responded to at least one of the modules, and the response rate by each module is shown in the table below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Number of respondent countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant and Young Child Feeding</td>
<td>98</td>
</tr>
<tr>
<td>Micronutrient Powders</td>
<td>65</td>
</tr>
<tr>
<td>Vitamin A</td>
<td>60</td>
</tr>
<tr>
<td>Salt Iodization</td>
<td>90</td>
</tr>
<tr>
<td>Deworming</td>
<td>65</td>
</tr>
<tr>
<td>Severe Acute Malnutrition</td>
<td>83</td>
</tr>
</tbody>
</table>

Data Cleaning and Validation
The data cleaning and validation processes were carried out between September and November 2016 and followed the same general criteria for every module’s questionnaire. As in the previous year, data were verified to identify inconsistencies, duplications and gaps. It also included homologation of units and categories and validation of all skips between questions. Finally, updates and corrections sent by countries after the data collection period ended were included. All along this process, UNICEF headquarters and regional colleagues were in constant communication with country contacts for clarification and validation of possible changes in data.

Data Limitations
The NutriDash findings should be interpreted in the light of the limitations of the data:

(1) Quality of the data:
Although there is a marked improvement in the quality of the data reported in NutriDash, and countries continue to make efforts to improve the national reporting systems for nutrition programmes, the quality of the data collected through routine monitoring systems will still needs improvement, to ensure accurate reporting and reduced errors. Indicator results with outliers were excluded from the report.

(2) Low response rate for certain modules
In some of the countries the mechanisms to collect indicators for certain modules are not fully established, therefore some modules were not answered by the country where data was not available. The data collection process relies on the nutrition information systems established in country to monitor nutrition programmes. Therefore the strength and reliability of the indicators of this report are dependent on the data collection process at country level.

UNICEF will continue to work closely with governments and partners to improve monitoring systems in country, by (1) advocating for inclusion of key nutrition indicators in health management information systems and (2) improving the quality and reliability of the information collected and used to report on programmes.
ENDNOTES

Introduction

2. Adequate maternal iodine status is important to maintain adequate breast-milk iodine concentrations, and is therefore of relevance for infant health. However, since infants should not receive any salt from birth to 12 months, and iodized salt is the major intervention strategy used, the period from birth to 12 months is not highlighted in this graph.

Prevention of malnutrition
1. WHO and UNICEF Global Strategy for Infant and Young Child Feeding recommends the following practices: immediate skin-to-skin contact after birth and initiation of breastfeeding in the first hour of life; exclusive breastfeeding in the first six months of life; continued breastfeeding in addition to adequate and safe solid, semi-solid or soft foods (or complementary foods) up to two years or beyond; safe and nutritious complementary foods in a caring environment (responsive feeding).

2. Data on the number of children who received micronutrient powders was available in 54 out of the 65 countries implementing micronutrient powder interventions. It also includes China, with 1.37 million children reached with Ying Tang Bao, a micronutrient sachet that also contains protein and different nutrients.

3. This figure also includes children from different age ranges: 6–11 months, 6–17 months, 6–23 months, 6–35 months, 6–59 months.


5. The methodology used to assess the scale of micronutrient powder programmes was based on a geographical coverage of districts implementing such interventions (>80% coverage = national; between 79% and 20% = sub-national; <20% = pilot or when the country classified the intervention as a pilot; emergency = country classified the intervention as emergency). Note that the comparison of countries reporting MNP interventions from 2011 to 2015 did not have necessarily the same sample of countries.


Treatment of Malnutrition


Eastern and Southern Africa
Angola, Botswana, Burundi, Comoros, Eritrea; Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Rwanda, Somalia, Republic of South Sudan, United Republic of Tanzania, Uganda, Zambia, Zimbabwe

Middle East and North Africa
Djibouti, Egypt, Jordan, Lebanon, Morocco, State of Palestine, Sudan, Syrian Arab Republic, Tunisia, Yemen

South Asia
Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka

East Asia and the Pacific
Cambodia, China, Fiji, Indonesia, Kiribati, Democratic People’s Republic of Korea, Lao People’s Democratic Republic, Mongolia, Myanmar, Papua New Guinea, Philippines, Solomon islands, Thailand, Timor-Leste, Vanuatu, Viet Nam

Latin America and the Caribbean
Bolivia (Plurinational State of), Brazil, Colombia, Cuba, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Jamaica, Mexico, Nicaragua, Peru, Venezuela (Bolivarian Republic of)

Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS)
Albania, Armenia, Azerbaijan, Bulgaria, Croatia, Georgia, Kosovo*, Kyrgyzstan, Republic of Moldova, Serbia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkmenistan, Uzbekistan

*All references to Kosovo in this [e.g., publication/report/letter/list] should be understood to be in the context of United Nations Security Council resolution 1244 (1999)