

NutriDash

GLOBAL REPORT

2014



unite for
children

unicef 

Cover:

A healthy child is a child prepared to face tomorrow. Malagasy mothers prioritize the health of their children. If you take the time to teach them, they will step up.

Photo credit: Dr. R Hantasaholy Rakotondrasoa

NutriDash

GLOBAL REPORT

2014

unite for
children

unicef 



A woman feeds her child a nutritious porridge, made from locally available products, at the health post in the village of Maderia in Gemechis, a woreda (district) of the Oromia Region. She and other women learned how to prepare the porridge during a session led by a health extension worker. Health extension workers are government-paid health workers, often working in their community of origin, who provide community-based health promotion and disease-prevention services.

Photo credit: Christine Nesbitt 2014

CONTENTS

List of figures and tables	vi
List of acronyms	ix
Acknowledgements	x
Executive summary	1
Introduction	5
Methodology	9
Findings	
1. Infant and young child feeding	13
2. Management of severe acute malnutrition	29
3. Universal salt iodization	45
4. Vitamin A supplementation and deworming	55
5. Home fortification with micronutrient powders	61
Conclusions and way forward	69
Annex	71

LIST OF FIGURES AND TABLES

Figures

Figure 0.1	NutriDash programme performance along the results chain	6
Figure 0.2	Number of countries with nutrition strategies incorporated into non-health sectors	8
Figure 1.1	Overview of specialized products included in national nutrition or IYCF strategy or policy	15
Figure 1.2	Overview of the Code implementation and enforcement	16
Figure 1.3	Percentage of countries that have adapted the 2010 WHO Guidelines on HIV and infant feeding to national policy, by region	17
Figure 1.4	Percentage of facilities with IYCF counselling, by region	18
Figure 1.5	Percentage of health workers who received in-service training in IYCF, by region	19
Figure 1.6	Average percentage of community workers trained in IYCF, by region	21
Figure 1.7	Percentage of countries using formative research for IYCF strategy development, by region	23
Figure 1.8	Percentage of countries with IYCF communication strategies available or implemented, by region	23
Figure 1.9	Number of weeks that mass media messages on IYCF are broadcast, by region	24
Figure 1.10	Number of countries undertaking IYCF activities in response to humanitarian crises, by type of activity	25
Figure 1.11	Number of countries that monitored and reported specific IYCF indicators at health facilities and at the community level in 2014	26
Figure 1.12	Bottleneck analysis: Infant and Young Child Feeding	27
Figure 2.1	Number of children admitted for SAM treatment globally, 2009–2014	35
Figure 2.2	Indirect programme treatment coverage for SAM, by country	39
Figure 2.3	Gap between SAM burden and admissions for treatment, by region	40
Figure 2.4	Bottleneck analysis: SAM management	43
Figure 3.1	Salt iodization standards at production level (n = 66)	47
Figure 3.2	Salt iodization standards at import level (n = 57)	47
Figure 3.3	Salt iodization standards at the household level (n = 62)	47

Figure 3.4	Number of countries with mandatory or voluntary USI legislation, by region	48
Figure 3.5	Countries with salt iodization (n = 69) of salt commodities mandated by law	49
Figure 3.6	Degree to which external USI quality-control rules were enforced in practice (n = 60)	51
Figure 3.7	Proportion of domestically produced salt that complied with regulations (n = 58)	51
Figure 3.8	Summary of key indicators for national salt iodization programmes	53
Figure 4.1	Mechanisms used to deliver VAS in 63 countries, by region, 2014	57
Figure 4.2	Delivery mechanisms reaching more than 80 per cent of children 6-59 months old	57
Figure 4.3	Proportion of deworming treatments for preschool-aged children delivered via different delivery mechanisms	58
Figure 5.1	Number of countries with MNP interventions, 2011, 2013 and 2014	62
Figure 5.2	Number of MNP interventions implemented for each age group, 2011, 2013 and 2014	63
Figure 5.3	Percentage of MNP interventions integrated into other programmes, by type of programme (n = 46 interventions)	63
Figure 5.4	Scale of MNP interventions by country	64
Figure 5.5	Proportion of interventions by MNP formulation (n = 53 interventions)	64
Figure 5.6	Percentage of MNP interventions by delivery platforms (n = 53 interventions)	65
Figure 5.7	Frequency of distribution of MNP interventions (n = 53 interventions)	65
Figure 5.8	MNP consumption schedule by number of interventions and number of sachets over a six-month period (n = 53)	66
Figure 5.9	Weekly MNP intake by number of interventions (n = 53)	66
Figure 5.10	Number of children reached by MNP programmes in 2014 and planned for 2015, by region	67
Figure 5.11	Challenges faced in implementing MNP by reporting countries	68
Figure A.1	Reporting rates by countries on SAM indirect programme treatment coverage	71

Tables

Table 0.1	Number of countries that indicated no activity in 2014 for each programme area, by region	10
Table 1.1	Overview of respondents for the IYCF module, 2013 and 2014	14
Table 1.2	Number of countries implementing the UNICEF community IYCF package, by region	22
Table 1.3	Number of countries with data on HIV-exposed infants enrolled in follow-up, by region	25
Table 2.1	Evolution of the number of SAM management programmes, by region, 2009–2014	30
Table 2.2	Summary of global SAM management programme data, by indicator, 2009–2014	31
Table 2.3	Components of the enabling environment for SAM management, 2011-2014	33
Table 2.4	Key enabling environment elements and country performance for SAM management	34
Table 2.5	Number of children admitted for SAM treatment, by region, 2009-2014	35
Table 2.6	National and target area programme treatment coverage for SAM	38
Table 2.7	National district geographical coverage for delivering SAM treatment, number of countries per bracket, by region	41
Table 2.8	National Health facility geographical coverage for delivering SAM treatment, number of countries per bracket, by region	41
Table 2.9	Indicators in NutriDash for SAM management bottleneck analysis	42
Table 2.10	Number of countries providing information for each of the six SAM management bottleneck analysis determinants	42
Table 3.1	Performance scoring for USI, 2013 and 2014	46
Table 3.2	Percentage of domestic salt production from medium- and large-scale producers	49
Table 3.3	USI programme performance scores, 2013 and 2014	52
Table A.1	Completion Annex	72
Table A.2	Score calculation for countries that produce or iodize salt in-country	75
Table A.3	Score calculation for countries that do NOT produce or iodize in-country	78

LIST OF ACRONYMS

BFHI	Baby-Friendly Hospital Initiative
CDC	Centers for Disease Control and Prevention
CEE	Central and Eastern Europe
CHDs	Child Health Days
CIS	Commonwealth of Independent States
CMAM	community-based management of acute malnutrition
CWs	community workers
GAIN	Global Alliance for Improved Nutrition
GAVA	Global Alliance for Vitamin A
GINA	Global database on the Implementation of Nutrition Action
HF-TAG	Home Fortification Technical Advisory Group
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IDD	iodine deficiency disorder
IGN	Iodine Global Network
ILO	International Labour Organization
IYCF	infant and young child feeding
KIO ₃	potassium iodate
M&E	monitoring and evaluation
MAM	moderate acute malnutrition
MICS	Multiple Indicator Cluster Surveys
MNP	micronutrient powder
MoRES	Monitoring of Results for Equity Strengthening
NGO	non-governmental organization
NIDs	national immunization days
QA	quality assurance
QC	quality control
RUTF	ready-to-use therapeutic food
SAM	severe acute malnutrition
SI	salt iodization
SIAs	supplementary immunization activities
STH	soil-transmitted helminths
SUN	Scaling Up Nutrition (Movement)
UNICEF	United Nations Children's Fund
USI	universal salt iodization
VAC	vitamin A capsule
VAD	vitamin A deficiency
VAS	vitamin A supplementation
WBW	World Breastfeeding Week
WFP	World Food Programme
WHO	World Health Organization

ACKNOWLEDGEMENTS

We are grateful to the UNICEF nutrition staff and focal points at the country and regional levels, as well as government staff for their enormous contribution to this exercise.

Additional thanks are given to the organizations that helped develop the questionnaires and coordinate data entry: Action Against Hunger, the Home Fortification Technical Advisory Group, the Iodine Global Network, Global Alliance for Improved Nutrition, Helen Keller International, Médecins sans Frontières, the Micronutrient Initiative, SPRING (Strengthening Partnerships, Results, and Innovations in Nutrition Globally, sponsored by the United States Agency for International Development), U.S. Centers for Disease Control and Prevention, the World Food Programme and the World Health Organization.

We are also grateful for the contributions of funding from the Bill & Melinda Gates Foundation, the Centers for Disease Control and Prevention and the United States Fund for UNICEF.

We wish to especially recognize governments, specifically the state, regional and provincial ministry of health divisions, and the non-governmental organizations and staff who are working to improve nutrition interventions every day.

EXECUTIVE SUMMARY

National nutrition information systems are key tools for improving programme performance. As more and more countries commit to scaling up nutrition and making investments to end malnutrition in all its forms, they need reliable data to inform programming and improve the scope and reach of nutrition interventions. NutriDash – the UNICEF-supported Nutrition Dashboard – aims to support this process. NutriDash is 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.

While some data is captured through systems such as the Global database on the Implementation of Nutrition Action managed by the World Health Organization (WHO)¹ and UNICEF's annual reporting process, quality routine data on the reach and progress of nutrition programmes has not always been systematically captured at the country level or collated for regional and global comparison. NutriDash fills this critical gap by collecting annual country-level programme data to support management, advocacy and resource mobilization at all levels. In addition, a supply forecasting module guides countries in making supply projections for the coming year to ensure timely delivery and response.

The *NutriDash 2014 Global Report* presents aggregated findings from five programme areas:

1. infant and young child feeding (IYCF);
2. the management of severe acute malnutrition (SAM);
3. universal salt iodization (USI);
4. vitamin A supplementation (VAS) and deworming, a new module to NutriDash in 2014; and
5. home fortification with micronutrient powders (MNP).

Findings from these individual programme areas can subsequently be used to inform national level decision making – including the selection of nutrition indicators to be included in national health information systems, resource mobilization and advocacy at all levels – as well as to support regional and global oversight and inform technical support planning.

The structure of each of the programme modules was designed to follow the UNICEF corporate equity planning and monitoring approach, using the determinants of service coverage framework and collecting information on the enabling environment, implementation (supply, demand and quality) and monitoring and evaluation (M&E). This information was further used to identify programme barriers as part of a bottleneck analysis approach.

In order to capture data on nutrition services implemented globally in 2014, a total of 159 countries were targeted for data collection. Data were collected and validated between June and October 2015. A summary of key findings from this data collection period follows.

¹ World Health Organization, 'Global database on the Implementation of Nutrition Action (GINA)', <<http://www.who.int/nutrition/gina/en/>>.

Status of programmes

There was an overall increase in the number of countries reporting on the five programme areas: In 2014, 93 countries reported on the implementation of IYCF programmes (up from 80 countries in 2013). For the management of SAM, the number of countries with SAM programming continued to rise. Since 2009, an additional 14 countries reported operational services for the management of SAM, totalling 80 countries in 2014. Most newly reported programmes were in East Asia, Central and Eastern Europe, and Latin America. These, however, were predominantly countries where UNICEF played a significant supporting role in the management of SAM services. There were other countries with small-scale inpatient (or even some outpatient) services where UNICEF did not provide support. Due to the current method of primarily collecting data from UNICEF offices, many of these small-scale services were not being reported to NutriDash. Every effort will be made to capture data on these additional small-scale services during the next round of data collection. In 2014, 84 countries reported having salt iodization programmes, compared to 73 in 2013. UNICEF supported the USI programme in 48 (57 per cent) of these countries. For VAS, 73 countries submitted data to NutriDash in 2014, of which 68 were included in the list of 82 priority countries for VAS. Forty-four countries reported on deworming in 2014. For MNP, the number of countries implementing interventions in 2014 increased from 43 to 50. These 50 countries implemented a total of 59 interventions in 2014.

Enabling environment

Each programme module in NutriDash includes indicators on the relevant legislation, standards and policies required to build a strong enabling environment for service delivery. More generally, NutriDash also collects information about whether or not sectors outside of health have developed nutrition-sensitive policies or strategies, or have incorporated nutrition-sensitive elements into policy or strategy documents. Most responding countries (87 out of the 92 respondents, or 95 per cent) had one or more such nutrition-sensitive policies or strategies, often in multiple sectors. Seventy-seven countries (84 per cent) had nutrition-sensitive policies or strategies in one to four of the following sectors: agriculture, education, gender, social welfare, and water and sanitation. Ten countries (11 per cent) reported having policies in all these sectors, while three countries (3 per cent) had no such policies or strategies. Two responding countries (2 per cent) did not know if such policies existed.

A large number of countries reported having IYCF relevant policies. In 2014, 97 per cent of countries (89 out of 92) had adopted an IYCF policy, 73 per cent (67 out of 92) had policies reflecting the International Code of Marketing of Breast Milk Substitutes, and 67 per cent (62 out of 92) had a policy covering IYCF in humanitarian situations. In terms of government investments, half of the responding countries (47 out of 92) reported government contributions to IYCF activities. IYCF training for health professionals is in need of improvement, with only 14 per cent of countries (13 out of 92) reporting to have comprehensive pre-service training on IYCF for doctors, and 21 per cent of countries (19 out of 92) having such training for nurses and other health professionals.

The enabling environment for SAM management is overall quite strong. However, there is variation among programmes and a need to better understand the relationship between the enabling environment and programme size and quality. In 2014, 95 per cent of countries (69 out of 73) reported that the treatment of SAM was part of national health and nutrition policies, and 44 per cent (32 out of 73) reported budget lines for both supplies and programming for SAM in their annual health sector operational plans – a 50 per cent increase from the previous year.

There are varying standards for salt iodization at all levels across the responding countries. While 82 per cent of countries (69 out of 84) reported mandatory legislation, only 41 per cent of countries (35 out of 84) had a policy comprehensive enough to meet the USI definition.² Most countries have integrated the control of iodine deficiency into national policies, strategies and plans; however, only 31 per cent of countries (26 out of 84) are funding iodine deficiency control activities as part of the national budget. Sixty-five per cent (55 out of 84) have a coordination body for USI programmes, but only 34 per cent of these are considered effective.

In terms of MNP programmes, 88 per cent of responding countries (44 out of 50) included MNP interventions as part of the national strategy in 2014, and another five countries are in the process of developing a national strategy. In 2014, 32 per cent of countries (16 out of 50) included MNP on the national list of essential commodities for health and nutrition, while five countries are in the process of including MNP as an essential commodity.

Implementation

The implementation of IYCF counselling programmes is strong, with 77 per cent of countries (71 out of 92) providing community-based IYCF counselling, and 84 per cent (77 of 92) reporting that IYCF counselling was regularly implemented in the health system. UNICEF's community IYCF counselling package was used by 79 per cent of countries (73 out of 92) to varying degrees. While 70 per cent (64 out of 92 countries) are disseminating messages about IYCF, only 46 per cent of countries (42 out of 92) have an IYCF communication strategy in place.

In 2014, the number of SAM admissions increased to 3.21 million from 2.91 million children the previous year. However, the overall rate of admissions, based on the rate of increase seen in previous years, has reached a plateau, and lags far behind the global SAM burden of 16 million children.³ There is an urgent need to make progress in South and East Asia, and to better understand specific bottlenecks in Eastern and Southern African countries in order to maintain momentum and continue effective treatment scale-up.

For salt iodization, 56 per cent of countries (47 out of 84) have sustainable, industry funded supply systems in place for the required fortificant. This was almost a three-fold increase from 2013 and very few stock-outs were reported. With regard to quality, however, while rules and procedures for external quality control exist in many countries, their enforcement remains inconsistent. There is also a need to further improve demand and communication strategies as only 43 per cent of countries (36 out of 84) reported having a communication strategy to address bottlenecks and reach audiences along the salt supply chain.

VAS coverage in 2014 was 69 per cent among all priority countries.⁴ Polio-led events, including National Immunization Days (NIDs), achieved consistently high VAS coverage, averaging 90 per cent. However, with the phase-out of such campaigns, countries will need to identify a new strategy for maintaining these gains in future years. Child Health Days (CHDs) have also been effective in achieving wide coverage (on average 86 per cent) and are the ideal delivery mechanism to replace NIDs moving forward. These regular events, generally conducted every six months, are organized to deliver two or more health or nutrition services to infants, children under 5 years old, and/or pregnant and lactating women.

² The iodization of all human and livestock salt, including salt used in the food industry.

³ United Nations Children's Fund, World Health Organization, and World Bank, 'Joint Child Malnutrition Estimates', 2014, <<http://data.worldbank.org/child-malnutrition/regional-wasting-prevalence-and-the-who-severity-levels>>.

⁴ United Nations Children's Fund, 'Vitamin A Deficiency: Child health events enable many countries in West and Central Africa to achieve over 80 per cent coverage of vitamin A supplementation', <<http://data.unicef.org/nutrition/vitamin-a.html>>.

Nutridash countries make up 45% of the global pre-SAC population requiring deworming for soil-transmitted helminthiases.⁵ The majority of mass deworming activities in 2014 took place during CHDs, which achieved an average programme coverage of 79 per cent coverage from 44 events. Routine delivery achieved lower coverage for both VAS and deworming, and national level strategies are thus crucial to ensuring that countries do not rely solely on delivery through routine contacts in the future.

Reporting countries reached 3 million children with MNP in 2014, a similar number to the previous year; however, these numbers fell short of planned targets due to limited funding, among other challenges.

Monitoring and evaluation

Many countries continue to face challenges in monitoring and evaluation (M&E). As was the case in 2013, a number of countries cited challenges in mainstreaming IYCF indicators into health management information systems (HMIS) and ensuring routine reporting at the community level. Fifty-five per cent of reporting countries (40 out of 73) incorporated SAM indicators into their HMIS, although many key indicators still cannot be accurately reported. Trends in the monitoring systems for salt iodization are generally positive. In 2014, 62 per cent of countries (52 out of 84) reported having a monitoring system in place, compared to 51 per cent (43 out of 84) of countries in 2013. However, the enforcement of such systems and salt iodization legislation remains weak. The monitoring of MNP interventions also requires strengthening across all regions. In 2014, 86 per cent of countries (43 out of 50) reported having a monitoring system in place for MNP interventions; however, few countries (17 out of 50) had integrated MNP monitoring into government health or community monitoring systems, and monitoring was cited as one of the top five programming challenges for many countries.

Conclusions and the way forward

Each of the chapters outline a global level bottleneck analysis that identifies the main barriers to each programme. Focusing on addressing these issues can help improve programme quality and performance, and strengthen the comprehensiveness and quality of reporting at the country level.

The next round of NutriDash data collection will take place in early 2016 and will streamline and improve the system. Country-level usage of the data has been robust to date with 37 countries accessing the online pages. The online NutriDash system will be further strengthened by improving the reporting outputs. Additionally, bringing forward the timing of data collection and developing a quicker process for data quality checking and cleaning will ensure that 2015 data are more readily available for analysis and use by countries, including for internal planning and performance monitoring.

⁵ World Health Organization, 'Neglected tropical diseases', <http://www.who.int/neglected_diseases/preventive_chemotherapy/1f/en/>.

INTRODUCTION

A. Background and purpose

There is growing recognition that nutrition is crucial to sustainable development. Goal 2 of the 2015 Sustainable Development Goals is to “end hunger, achieve food security and improved nutrition, and promote sustainable agriculture.” Increasingly, countries are responding by making investments to improve nutrition programming for women and children. As the 2015 Global Nutrition Report makes clear, sustainable development, facilitated by investments in nutrition, is good for everyone.⁶

UNICEF, working with national governments and other partners, supports countries in scaling up nutrition programming with a focus on equity. As detailed in its guidance document, ‘UNICEF’s approach to scaling up nutrition for mothers and their children’,⁷ UNICEF aims to support country-led action to improve maternal and child nutrition, and make its work more strategic, effective, responsive and contextually relevant.

Good data are crucial to this process. For improved programme performance, countries need robust routine reporting systems to ensure effective monitoring and evaluation (M&E). As an implementing agency in over 130 countries, UNICEF plays a critical role in shaping and strengthening nutrition information systems, which in turn supports strong programming. UNICEF uses its technical resources to work with governments and partners to ensure that information needs are defined and systems are put in place to ensure those needs are met. The organization therefore supports countries in their efforts to monitor changes in undernutrition indicators and how nutrition-relevant country investments and projects are contributing to these changes.

The Nutrition Dashboard (known as NutriDash) seeks to draw together programme data at national, regional and global levels on an annual basis. It includes an online database with country-specific and regionally and globally aggregated data. This data can be used to track progress over time at these different levels, as well as to contribute to advocacy objectives, support resource mobilization and identify specific support needs.

This 2014 Global Report outlines the objectives of NutriDash and describes its methodology. It then summarizes the key findings from each of the five modules for which data was collected with an aggregated descriptive overview for each:

1. Infant and young child feeding (IYCF)
2. Management of severe acute malnutrition (SAM)
3. Universal salt iodization (USI)
4. Vitamin A supplementation (VAS) and deworming
5. Micronutrient powder interventions (MNP)

⁶ Haddad, Lawrence, et al., 2015, *Global Nutrition Report: Actions and Accountability to Advance Nutrition and Sustainable Development*, p.7, <<http://ebrary.ifpri.org/utills/getfile/collection/p15738coll2/id/129443/filename/129654.pdf>>.

⁷ United Nations Children’s Fund, ‘UNICEF’s approach to scaling up nutrition’, <<http://wphna.org/wp-content/uploads/2015/10/2015-06-Scaling-Up-Nutrition-UNICEF.pdf>>.

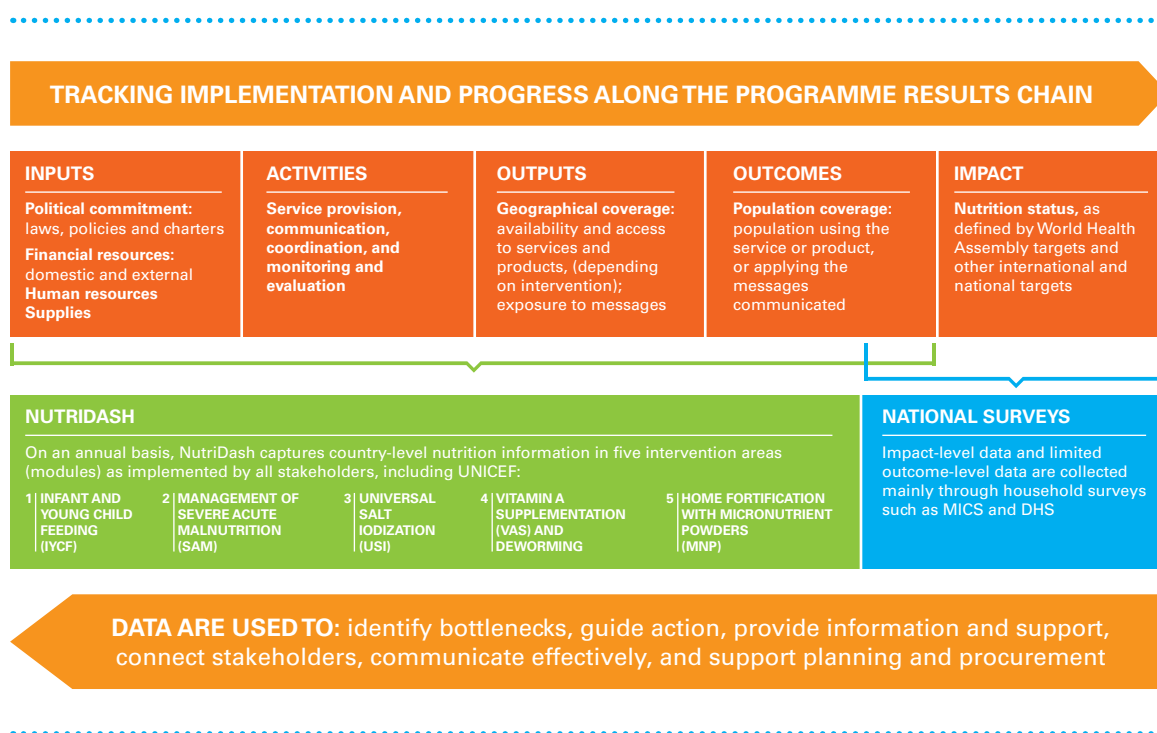
These five modules correspond to nutrition-specific programmes that are at the core of UNICEF’s work and that of its global partners. They do not aim to capture data on UNICEF-supported programmes alone, but rather to include information on all nutrition interventions happening in countries, whether supported by UNICEF or not. Data were also collected on general nutrition indicators relating to the enabling environment, the results of which are outlined briefly at the end of this chapter. The report is relevant for both national decision-makers and global health and nutrition actors.

B. Objectives and added value of NutriDash

Frequent results monitoring is critical to programme improvement. Nutrition monitoring tools – such as the nationally representative Demographic and Health Surveys and the Multiple Indicator Cluster Surveys (MICS) – are effective in tracking the nutritional status of populations in low- and middle-income countries, as well as compiling data on acute malnutrition, infant and young child feeding, micronutrients and consumption of adequately iodized salt. Limited data are collected through initiatives such as the Global database on the Implementation of Nutrition Action (GINA) managed by the World Health Organization (WHO). However, quality data on **programme coverage and performance** have not been systematically captured and reported to the same degree. The main objective of NutriDash is therefore to **strengthen routine monitoring and reporting at global, regional and country levels in order to improve programme performance**.

Programme performance monitoring includes a mix of indicators along the results chain, from inputs to impact (see Figure 0.1). The indicators for each programme have been selected to reflect the nature and maturity of each programme.

Figure 0.1 NutriDash programme performance along the results chain



By visually presenting relevant nutrition programme data over time, NutriDash aims to:

- Inform programme planning and design, including supply forecasting for nutrition commodities;
- Assess nutrition programme performance, including the identification of bottlenecks;
- Support reporting, decision making, advocacy and resource mobilization at the country, regional and global programme levels;
- Provide a central location from which to access country nutrition data over time and the tools with which to compare these data to global and regional progress.

The added value of NutriDash is its ability to systematize and harmonize data collection in key nutrition programme areas. By offering an online questionnaire with built-in guidance, NutriDash efficiently supports UNICEF country offices by providing a standard set of indicators and information for countries to collect, based on global guidance and corporate monitoring initiatives (e.g., UNICEF's equity planning and monitoring approach). This guidance helps countries determine what data to collect for their own programme monitoring and identify indicators to include in their HMIS as well as in UNICEF's own corporate reporting systems.

NutriDash's added value also lies in its ability to support countries in the supply forecasting process. The supply forecast modules for SAM and MNPs present data from previous years for triangulation and provide guidance to support countries in their planning. The supply forecast module also enables UNICEF's Supply Division to coordinate with producers to ensure an adequate pipeline for the coming year.

In terms of country-level usage of the online system, 37 countries accessed the reporting platform in 2015. New reporting features such as automatically generated PowerPoint and PDF documents of performance will also increase the utility of the site and the data.

C. NutriDash and global nutrition data

Prior to 2013, UNICEF and its partners collected programmatic data on SAM management, IYCF, MNP and USI through various paper or email surveys or online platforms, publishing results in separate reports.⁸ With the creation of NutriDash in 2013, reporting on these programme areas was harmonized under a single platform, enabling a more systematic tracking of programme performance and global progress in these areas.

In 2014, VAS was added as a reporting module in NutriDash. Previous data collection took place through an annual exercise by countries in reporting coverage and supply forecasts using computer-based tables. The addition of VAS to NutriDash provided an online platform from which to report on the robust information collected on delivery mechanisms, co-delivered interventions and other programmatic details in addition to the coverage reported in 'State of the World's Children'. Reporting on deworming initiatives is also new to NutriDash in 2014. UNICEF began collecting data on deworming interventions in 2013, and prior to that year the coverage was occasionally reported by WHO.

⁸ Further information about previous data collection activities for SAM management, IYCF, SI and MNP interventions can be found in the pilot 2013 NutriDash Global Report.

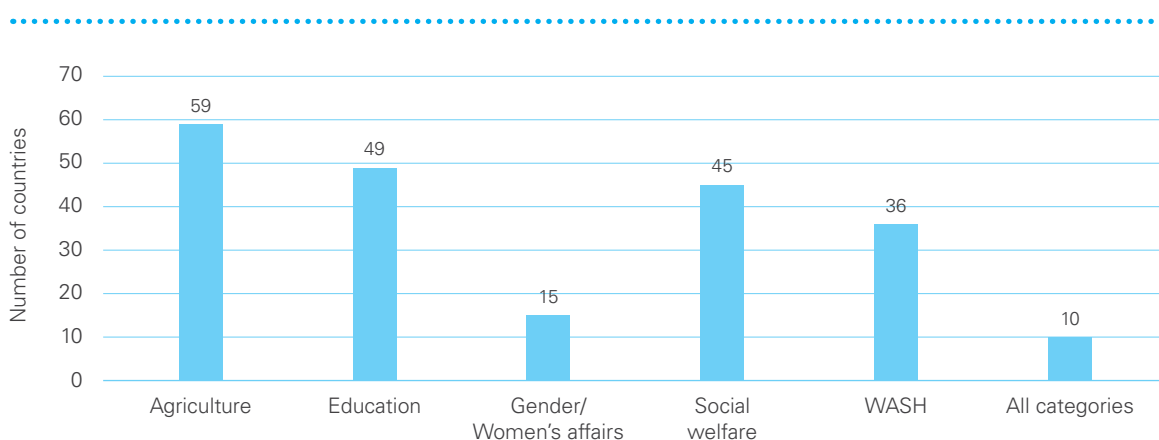
D. General findings and cross-cutting themes

While most questions in NutriDash are programme-specific, the 2014 questionnaire did include some more general nutrition indicators related to the enabling environments of all programmes.

For 2014, NutriDash collected information about whether or not sectors outside health had developed nutrition-sensitive policies or strategies or incorporated nutrition-sensitive elements into policy or strategy documents. Ninety-one per cent of responding countries (84 out of 92) had one or more such policies or strategies, often in multiple sectors. Figure 0.2 shows the number of countries with nutrition strategies incorporated into non-health sectors.

Of the 92 responding countries, 77 (84 per cent) had nutrition-sensitive policies or strategies in one to four of the following sectors: agriculture, education, gender, social welfare or water and sanitation. Ten countries (11 per cent) reported having policies in all these sectors. Three countries (3 per cent) had no such policies or strategies and two responding countries (2 per cent) did not know if such policies existed.

Figure 0.2 Number of countries with nutrition strategies incorporated into non-health sectors



Note: Categories are not mutually exclusive.

In 2014, countries were also asked to provide data on the availability of social protection programmes that included children under age 2. Eighty per cent of respondents (74 out of 92) had social protection programmes that included children under 2 in the target group. The activities in one third of these programmes (in 27 countries) are supported by UNICEF. A slightly different question was asked in 2013, wherein 38 per cent of countries (30 out of 79) reported to have social protection programmes with a child nutrition component, for which cash transfers were the most common strategy.

METHODOLOGY

NutriDash functions as an information management platform for comprehensive data on key nutrition interventions. It consists of a data capture side in the form of online questionnaires and a reporting side that allows users to download the full dataset, display key information for each country and aggregate and present data at regional and global levels.

A. Data collection

The questionnaires for each module were developed in partnership with other global actors and experts. The questionnaires were then shared with UNICEF regional and country offices for further refinement. The MNP questionnaire, for example, benefited from a strong collaboration with the Centers for Disease Control (CDC) and consultation with the Home Fortification Technical Advisory Group (HF-TAG). The Iodine Global Network (IGN) was an important contributor to the USI questionnaire. The VAS modules were developed in partnership with the Micronutrient Initiative and deworming modules were developed with WHO. For 2014, the questionnaires were further strengthened with additional guidance per question and built-in quality and feasibility checks for data entry.

To facilitate data collection, instructions for the NutriDash platform were sent to nutrition and health staff in every UNICEF country office, plus the three area offices covering the Caribbean Islands, the Pacific Islands and the Gulf States.

A total of 159 countries were targeted for data collection. Data collection related to 2014 programming took place between June and October 2015. For all six modules, UNICEF country offices were strongly encouraged to gather all stakeholders together – particularly government counterparts – and enter data jointly, using this opportunity to discuss the programmatic context in their country. While the questionnaires included indicators relevant to all nutrition programming, a select number of indicators reflected UNICEF-supported programmes only.

UNICEF headquarters and the seven regional offices provided guidance and follow-up. UNICEF staff exclusively entered data for the SAM management and IYCF modules. For the MNP module, access was also given to governments, non-governmental organizations (NGOs) or other partners to enter data for those interventions that were not supported by UNICEF. For the USI programme, both UNICEF and the Global Alliance for Improved Nutrition (GAIN) were given access to enter data and in some countries, government entered data directly. UNICEF staff or government partners entered data for the VAS and deworming modules in order to improve reporting in countries where UNICEF does not lead these programmes.

B. Quality control, data cleaning and analysis

Built-in, automated data quality checks and flags within the online questionnaires have vastly improved the data quality for 2014. After data was collected, they were cleaned and analysed using Microsoft Excel. Following input, data were verified and reviewed to identify inconsistencies, duplications and gaps within and across all NutriDash modules, and also against past data collected through the pilot collection in 2013. When necessary, UNICEF headquarters and regional colleagues communicated with the country contacts to clarify or confirm the data points.

In total, UNICEF had follow-up contact with 103 countries, ranging from minor fact checking to more substantive queries and subsequent changes across the programme modules. The outcome of this exercise was improved data quality. In 2016, UNICEF will conduct training with countries to address common areas of concern and reduce the number of follow-ups in subsequent years.

C. Response rates

In general, for all programme areas, there was a higher reporting rate in 2014 compared to the pilot year. This allowed for a rich collection of data across reporting areas.

In submitting data to NutriDash, countries were able to select and respond to certain modules for which they had a programme, while deactivating others that were not relevant to their country context (a new feature added in 2014). This means that the denominator of responding countries varied across indicators and excluded countries that did not reply. Although each country was invited to respond to all modules, not all programme areas were relevant for all countries (see Table 0.1).

Table 0.1 Number of countries that indicated no activity in 2014 for each programme area, by region

	CEE/CIS*	East Asia and the Pacific	Eastern and Southern Africa	Latin America and the Caribbean	Middle East and North Africa	South Asia	West and Central Africa	Total deactivated
SAM	10	2	1	4	0	0	1	18
IYCF	2	0	1	1	0	0	1	5
MNP	12	1	8	2	3	4	8	38
USI	1	1	1	1	0	0	3	7
Deworming	7	2	1	0	1	2	0	13
VAS coverage	10	2	0	6	0	0	0	18

* CEE/CIS - Central and Eastern Europe and the Commonwealth of Independent States

NutriDash findings are presented as proportions and the relevant denominators are indicated. Findings should be interpreted in light of the limitations of the data, including the low response rate for some modules and certain questions.

Wherever possible, this report has aimed to make comparisons in data between 2013 and 2014. However, the following should be noted with respect to trends:

- In some cases, the question changed substantially enough that no comparison was possible.
- In some cases, a trend was noted, but flagged to be interpreted with caution given that the question was phrased slightly differently in 2014.
- In some cases, comparisons are provided with the caveat that the responding countries in 2014 were different from those in 2013.

Comparisons will become more accurate over time as the NutriDash tool continues to improve with ongoing feedback from countries and fewer modifications to the questions are required.



A young mother, Manju Malla, voluntarily demonstrates how to properly breastfeed an infant. She teaches young mothers about sitting positions, embracing the infant close to the bosom and how to hold the breast to ensure that the child can comfortably drink the mother's milk. She was one of the hundreds of mothers in the earthquake-devastated Gorkha district where UNICEF helped to reach out with better breastfeeding practices.

Photo credit: UNICEF/UNI192885/Shrestha 2015

1

INFANT AND YOUNG CHILD FEEDING

A. Background

Optimal IYCF practices are essential for child survival, growth and development. Together, optimal breastfeeding and appropriate complementary feeding practices are key to preventing all forms of malnutrition, from stunting and wasting to overweight and obesity.

The WHO/UNICEF Global Strategy for Infant and Young Child Feeding defines optimal breastfeeding as: early initiation (i.e., within the first hour of life), exclusive breastfeeding for the first six months, and continued breastfeeding until age 2 or beyond, in addition to the provision of safe and nutritionally adequate complementary foods.

Although some countries have made significant strides in improving exclusive breastfeeding rates, progress at the global level has been limited. Complementary feeding practices are often poor and there remains much work to be done in improving dietary quality and nutrient density in particular.

To improve IYCF practices, UNICEF supports countries in their efforts to strengthen policies and legislation around IYCF, to train and build the capacities of governments to support IYCF programming, and to increase the availability of counselling and support to caregivers both in health facilities and communities.

The NutriDash IYCF module collects data on the enabling environment, programme implementation in the health system and at the community level, and the monitoring of IYCF indicators. In the 2014 IYCF module, new questions were added about policies related to IYCF in humanitarian situations and in the context of HIV. Some questions about counselling were significantly rephrased and new questions were added about the coverage of IYCF counselling. The monitoring section was also refined. Lastly, the concept of providing 'scores' for the enabling environment and monitoring mechanisms was discontinued in 2014 because it was deemed more useful to look at separate interventions instead of providing an aggregated score.

Several indicators for a bottleneck analysis are included in the NutriDash questionnaire, but data on the key indicators of effective coverage – the actual IYCF practices themselves – are collected via household surveys and not incorporated in NutriDash.

Table 1.1 Overview of respondents for the IYCF module, 2013 and 2014

Year	Number of countries contacted	Number of countries that completed the IYCF module	Number of countries that de-activated the IYCF module	Number of countries that completed the IYCF module in both years
2013	158	80	–	66
2014	159	92	5	

B. Response rate

In 2014, 92 countries completed the IYCF module in NutriDash. This is an increase from the previous year, in which only 80 countries responded. In total, 66 countries responded to the questionnaire in both years.

C. Enabling environment

NutriDash assessed a country's enabling environment for IYCF with indicators on the existence of an IYCF policy, a policy or law giving effect to the Code and enforcement of any such laws, and on the inclusion of counselling and support for IYCF in pre-service curricula for health professionals. The question on maternity protection included in the 2013 version of NutriDash was removed since the International Labour Organization (ILO) has a comprehensive database on this issue.⁹

IYCF targeted policies

The vast majority of responding countries (97 per cent, or 89 out of 92 respondents) had **some type of IYCF policy** (either integrated or stand-alone). This was an improvement from only 87 per cent of countries in 2013. Of the countries that responded in both years, 25 did not have a policy in 2013 but did have one in 2014.

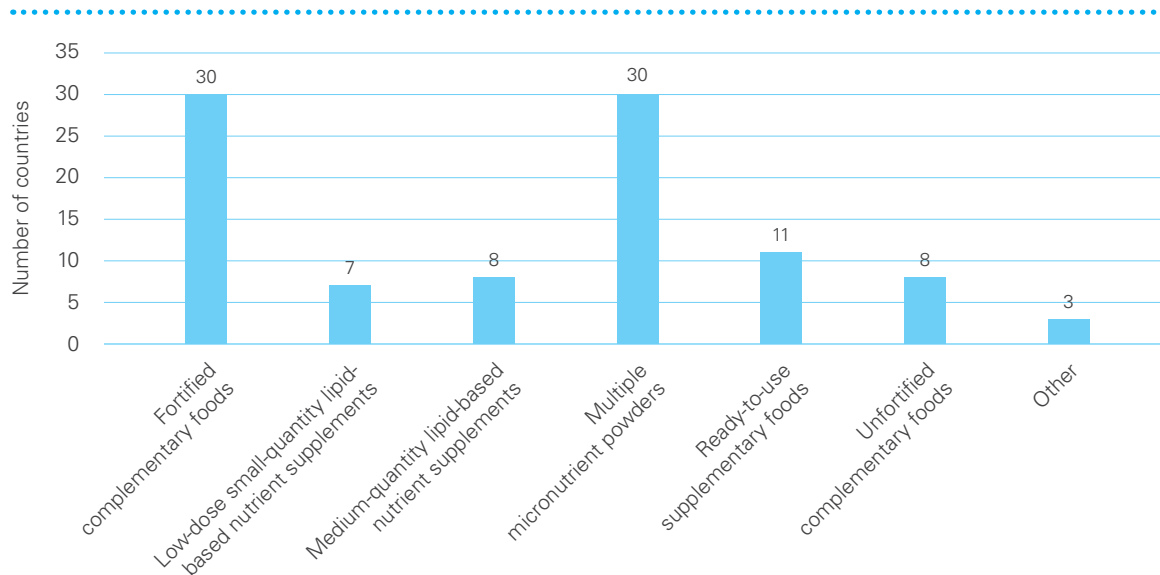
Of the 89 countries with an IYCF policy in 2014, 64 per cent (57 countries) had a stand-alone IYCF policy and 36 per cent (32 out of 89) had integrated IYCF into other policies, including nutrition (16 countries), health (33 countries), a combination of both (12 countries), and other policies (11 countries).

In 2014, 42 per cent of responding countries (39 out of 92) had **specialized products included in their national nutrition or IYCF strategy or policy (Figure 1.1)**. Of these products, the most frequently included were fortified complementary foods and micronutrient powders (77 per cent, or 30 of the 39 countries for each).

National legislation on the International Code of Marketing of Breast Milk Substitutes and subsequent World Health Assembly resolutions (the Code)

The status of Code implementation at the national level and the mechanisms for monitoring its enforcement are strong indicators of the enabling environment for IYCF in a given country. The Code aims to protect and promote breastfeeding by regulating the marketing of breast milk substitutes, bottles and teats.

⁹ International Labour Organization, 'Maternity and paternity at work: Law and practice across the world', <http://www.ilo.org/global/topics/equality-and-discrimination/maternity-protection/publications/maternity-paternity-at-work-2014/lang-en/index.htm>.

Figure 1.1 Overview of specialized products included in national nutrition or IYCF strategy or policy

Overall, 73 per cent of responding countries (67 out of 92) had laws reflecting the Code. Of the 67 countries reporting such laws in 2014:

- 42 per cent (28 countries) had laws that reflected the full provisions of the Code (compared to 29 countries in 2013);¹⁰
- 51 per cent (34 countries) had laws that reflected the Code partially; and
- 7 per cent (5 countries) had a voluntary arrangement.

There is reason to be optimistic that these numbers will further increase in the next few years. Of the 25 countries without a law, 18 are in the process of drafting one.¹¹ These include:

- 4 in CEE/CIS;
- 1 in East Asia and the Pacific;
- 5 in Eastern and Southern Africa;
- 2 in Latin America and the Caribbean;
- 1 in Middle East and North Africa; and
- 5 in West and Central Africa

Monitoring compliance is crucial to ensuring that these laws are enforced in practice. In 2014, 88 per cent of countries (59 out of 67) with a Code had an entity responsible for monitoring and enforcement (an increase from 49 countries with a monitoring body in 2013), and 34 countries carried out Code monitoring in 2014. The entities responsible for this monitoring function include a government department (49 countries), a committee (15 countries), an NGO (9 countries) or another mechanism (4 countries).¹²

¹⁰ This is related to the responding countries for 2013 and 2014.

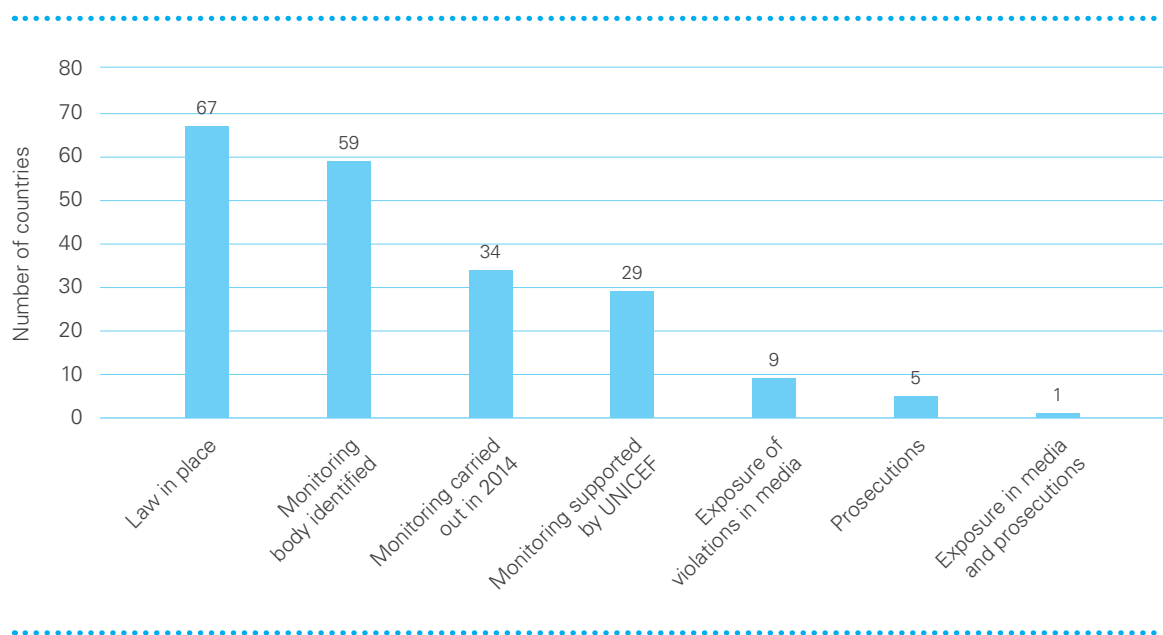
¹¹ There are two countries that adopted legislation in 2015 before completing the NutriDash data, but they are not included in this category since this report reflects the situation in 2014.

¹² Countries were able to select more than one option.

Countries with laws reflecting the Code monitored their compliance to varying degrees. In 2014, 39 per cent of countries (26 out of 67) carried out monitoring two or more times. UNICEF supported compliance monitoring in 29 out of 67 countries (43 per cent). This was a reflection of UNICEF’s strong commitment to the issue, but it raised concerns about the sustainability of law enforcement in these countries.

Despite these monitoring efforts, only 15 out of 67 countries undertook punitive actions in response to violations of the law (information about the number of countries with violations of the law is not available) (see Figure 1.2 for a breakdown). Of the countries that undertook punitive actions, four were in CEE/CIS, two in East Asia and the Pacific, two in Eastern and Southern Africa, two in Latin America and the Caribbean, two in the Middle East and North Africa, two in South Asia and one in West and Central Africa.

Figure 1.2 Overview of the Code implementation and enforcement

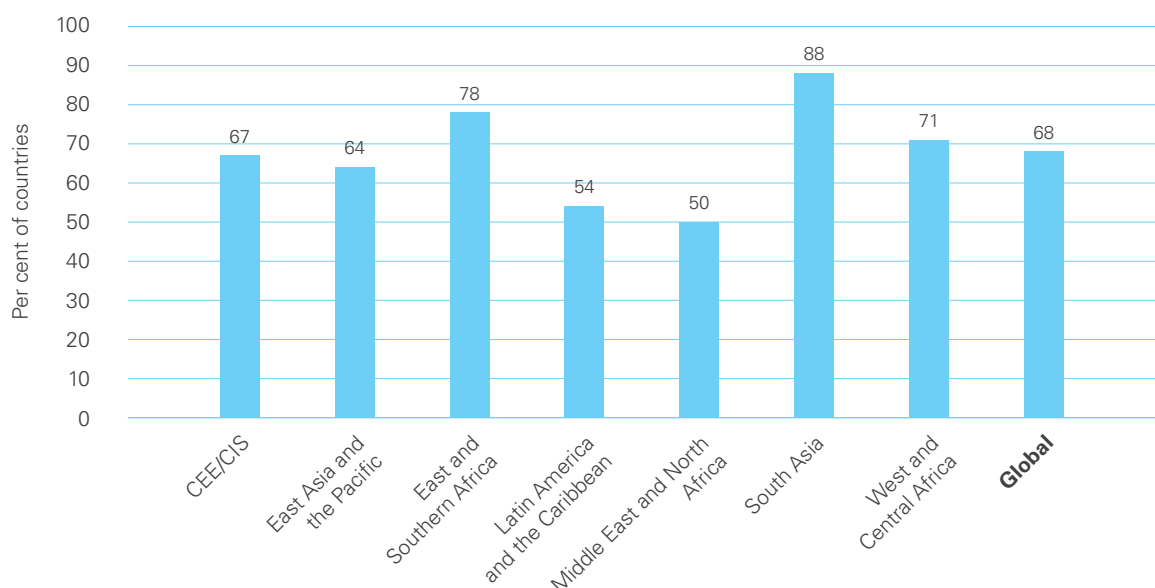


IYCF policies regarding difficult situations

In 2014, 67 per cent of countries (62 of 92) had incorporated IYCF in humanitarian situations into a policy document. The Eastern and Southern Africa region had the highest number in this regard, with 16 of 18 responding countries in the region having such a policy. The region with the fewest number of national policies incorporating IYCF in humanitarian situations was the CEE/CIS region, with only 5 out of 15 countries.

In terms of IYCF in the context of HIV, 68 per cent of responding countries (63 out of 92) had integrated the 2010 WHO guidelines on infant feeding in the context of HIV into national policy (see Figure 1.3 for a regional breakdown). The Eastern and Southern Africa region had the highest HIV prevalence and the second-highest rate of countries with policies that included IYCF in the context of HIV. The region with the highest number of countries with policies including HIV was South Asia, where there is a high HIV prevalence and a very high burden.

Figure 1.3 Percentage of countries that have adapted the 2010 WHO Guidelines on HIV and infant feeding to national policy, by region



Government expenditures on IYCF

Investments from national governments to support IYCF programming are critical to making and sustaining improvements over the long term. In 2014 NutriDash respondents were asked for the first time about national contributions for IYCF: Fifty-one per cent of countries (47 out of 92) reported that there had been **IYCF interventions supported by the government's budget** (besides salaries). Only 22 of those countries were members of the Scaling Up Nutrition (SUN) movement, wherein increased mobilization of financial resources for nutrition is one component of the strategic process.

West and Central Africa had the lowest percentage of countries with government-supported IYCF activities (19 per cent, or 4 out of 21 respondents), whereas South Asia had the highest percentage of countries (88 per cent, or 7 out of 8 respondents). In the other regions, 69 per cent of countries (9 out of 13) in Latin America and the Caribbean, 67 per cent (10 out of 15) in CEE/CIS, 64 per cent (7 out of 11) in East Asia and the Pacific, 50 per cent (3 out of 6) in the Middle East and North Africa, and 39 per cent (7 out of 18) in Eastern and Southern Africa had government-supported IYCF activities.

Pre-service curricula

The inclusion of IYCF counselling in pre-service curricula for doctors, nurses and other health professionals is crucial to strengthening support for IYCF within the health system. In NutriDash 2014, this indicator was disaggregated to measure the training of doctors separately from nurses and other health professionals.

Very few countries (only 14 per cent, or 13 of 92 countries) indicated they had comprehensive **pre-service training on IYCF** for doctors, and 64 per cent (59 countries) indicated they had minimal pre-service training. In terms of training for nurses and other health professionals, only 21 per cent, or 19 countries had comprehensive training and 63 per cent, or 58 countries, had minimal pre-service IYCF training. Fourteen per cent, or 13 responding countries did not have any pre-service training on IYCF at all for doctors, nurses or other medical professionals. These numbers were concerning given the importance of pre-service training in setting the tone for IYCF care and support in the health system.

D. Implementation

IYCF at the health system level

Mothers need support at both the health facility and the community level to improve IYCF practices and ensure that those improvements are maintained.

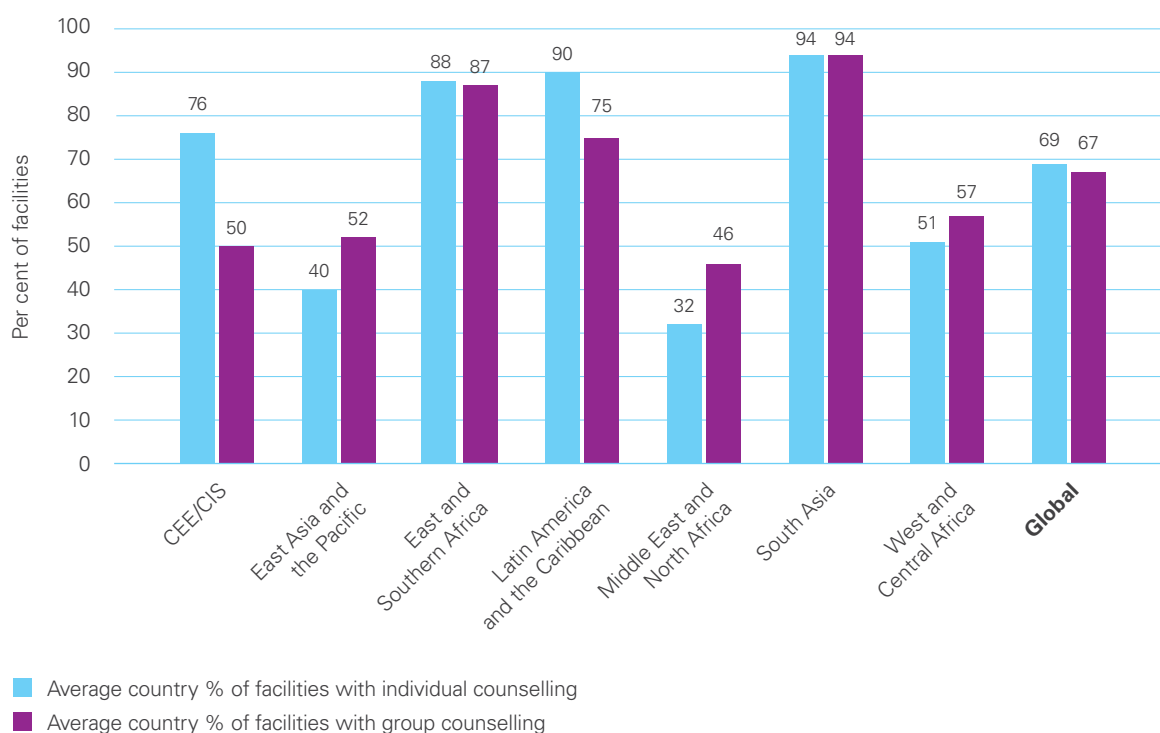
Counselling

The health system can play a crucial role in providing IYCF counselling and support to mothers via individual counselling sessions or group sessions. The vast majority of countries (84 per cent or 77 of 92 responding countries) reported that **IYCF counselling was regularly implemented in the health system**, slightly more than in 2013.

In 2014, 45 per cent of countries (41 out of 92) were able to provide information about the number and percentage of **primary health care facilities that provided individual counselling**. Of those, an average of 69 per cent of facilities provided this service, with the South Asia region reporting the highest percentage (on average, 94 per cent).

In terms of group counselling, 46 per cent of countries (42 out of 92) were able to report on the number and percentage of primary health care facilities that provided **group communication/ education sessions** on a regular basis. Of these, an average of 67 per cent of facilities provided this service, with the South Asia region again reporting the highest percentage (on average, 94 per cent).

Figure 1.4 Percentage of facilities with IYCF counselling, by region



In terms of coverage, only 25 per cent (23 out of 92) countries have information available about the number of mothers of children under age 2 that were reached with IYCF counselling at health facilities in 2014. Going forward, it will be important to bridge this data gap in order to more accurately measure coverage and impact.

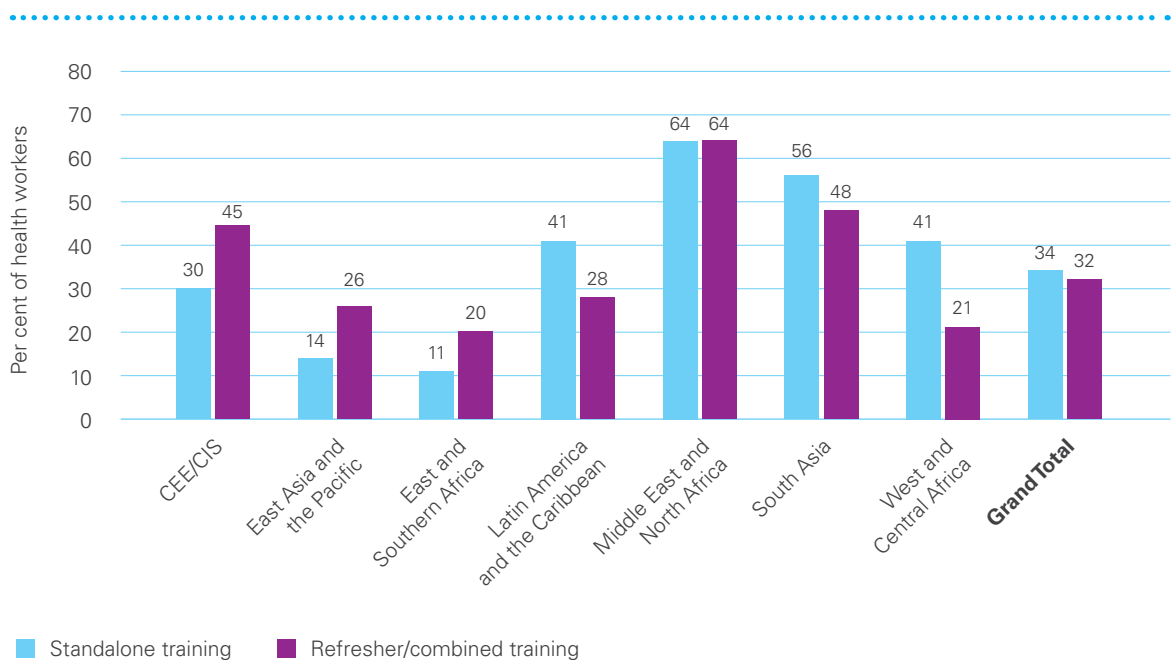
In-service training of health workers

The availability of training for facility-based health workers varied across countries. A total of 86 per cent, or 79 countries, provided information about the number and percentage of eligible **health workers who received in-service training on IYCF** in the last three years **as a stand-alone IYCF counselling course** of at least three days, including practical skills building. The global average percentage of staff trained is only 34 per cent, ranging from 11 per cent in Eastern and Southern Africa to 64 per cent in the Middle East and North Africa.

In 2014, 78 per cent, or 72 countries, provided information about the number and percentage of eligible **health workers who received in-service training or refresher training on IYCF** in the last three years **as part of a broader training programme**. The global average percentage of staff trained this way was only 32 per cent.

As in the previous year, these data did not provide information on the quality or content of the counselling; however, they provided insight into the overall level of importance afforded to IYCF training within each country.

Figure 1.5 Percentage of health workers who received in-service training in IYCF, by region



Note: Countries with incomplete data or with more people trained than eligible have been excluded

Baby-friendly hospital initiative

The implementation of the Baby-friendly hospital initiative (BFHI) provided a measure of the skilled IYCF support available in the health system. In 2014, 74 per cent of countries (68 out of 92) reported that they were implementing the BFHI to a certain extent.

Incorporating the BFHI's guidance into national policy is an important step towards ensuring its sustainability over time. A total of 64 countries reported that they had incorporated all or some of the BFHI Ten Steps to Successful Breastfeeding into national standards for maternity facilities. Of these:

- 42 countries had incorporated all of the Ten Steps into national standards
- 22 countries had incorporated some of the Ten Steps into national standards

The impact of incorporating the Ten Steps into national standards will need to be better determined. It could, for example, be an important precursor to ensuring sustainable implementation of the Ten Steps in country health systems.

In terms of the number of baby-friendly hospitals, 55 per cent of countries (51 out of 92) were able to provide a figure which, when combined, made for a total of 10,986 certified facilities (on average, 32 per cent of maternity facilities were certified). In addition, 41 per cent of countries (38 out of 92) were able to report on the number of facilities certified or recertified in the previous five years (the total number of those facilities was 8,736). In 2014, one country reported that no hospitals were certified but that all were practicing the Ten Steps. Only 18 countries were able to report on the number or percentage of births in facilities certified as baby-friendly.

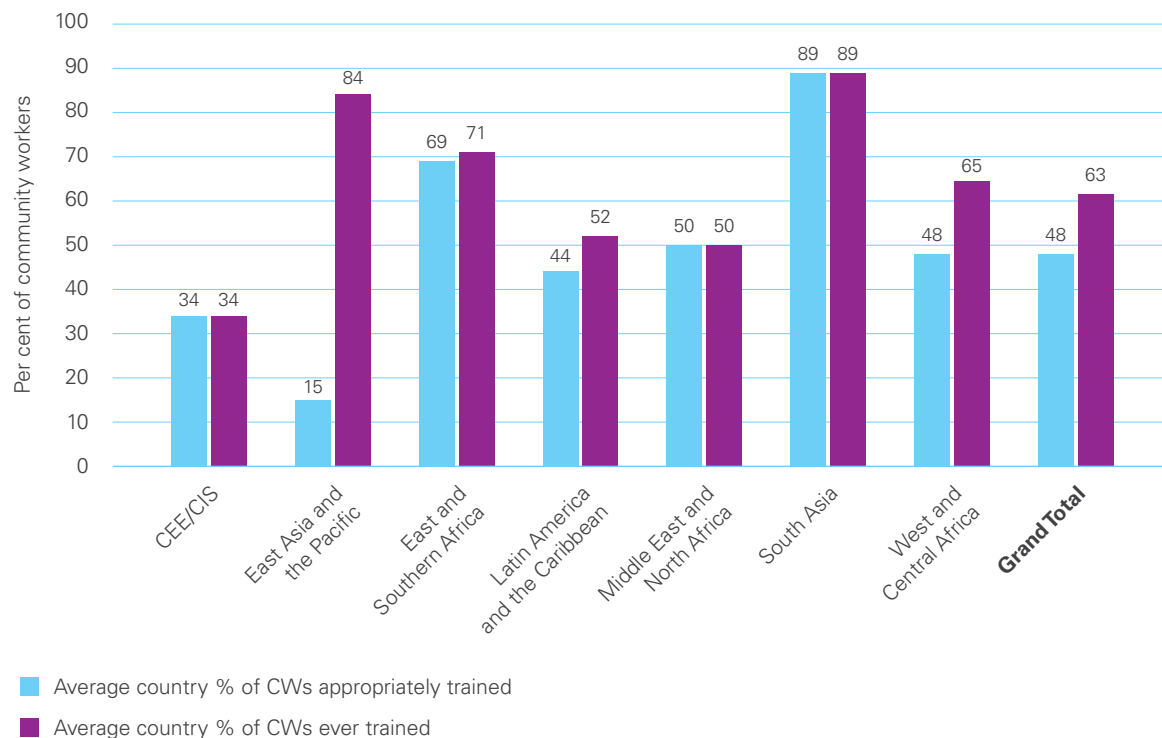
IYCF at the community level

Community-based counselling and training of community workers

Community-based counselling is a key component of strong IYCF programming and is particularly important in places where the health system is weak or inaccessible. In 2014, 77 per cent (71 out of 92) countries provided community-based IYCF counselling, compared with 70 per cent (55 of 80) the previous year.

In 41 per cent of countries (38 out of 92), training on **IYCF was held for health community workers (CWs)** at some point during the last three years. Forty-one countries were able to report on the number and percentage of eligible CWs who were trained for a minimum of three days on IYCF counselling, including practical skills building (referred to as 'appropriately trained'). The global average percentage of CWs appropriately trained was 48 per cent, ranging from 89 per cent in South Asia to 15 per cent in East Asia and the Pacific. As expected, the number and percentage of community workers ever trained on IYCF promotion was larger, sitting at 63 per cent on average (Figure 1.6).

Of the 71 countries with community-based IYCF counselling, 62 per cent (44 countries) had a mechanism in place for **supportive supervision of IYCF counselling by the government**. This is similar to 2013, where 56 per cent of countries (44 out of 79) were conducting supervision of community workers. However, in 2014, only 66 per cent of countries (29 out of 44) could report on the frequency of supervision, which varied from once a year (in five countries) to every six months (in seven countries) to every one to three months (in 17 countries). In both 2013 and 2014, the majority of countries provided supervisory visits at least every three months, if not more frequently.

Figure 1.6 Average percentage of community workers trained in IYCF, by region

Note: Countries with incomplete data or with more people trained than eligible have been excluded

IYCF training for non-health sector CWs has been held in 38 per cent of responding countries (35 out of 92). In most countries, this involved more than one sector. IYCF training was held most frequently within several sectors: agriculture, education, social protection (each mentioned by 17 countries); social welfare (mentioned by 15 countries); and WASH (mentioned by 14 countries). These findings were interesting since sectors beyond health need to be involved in delivering nutrition-sensitive interventions.

In 2014, the **community IYCF counselling package** developed by UNICEF was used by 79 per cent of countries (73 out of 92), compared to 73 per cent (58 out of 79) in 2013. Table 1.2 provides a regional breakdown of the package usage by region. It showed that globally:

- 24 countries used the package in its entirety and also used the supportive supervision, mentoring and monitoring module. (This figure increased substantially since 2013, where only five countries were using the full package and module);
- 11 countries used it in its entirety without the supportive supervision module;
- 12 countries used an abbreviated version; and
- 26 countries incorporated elements of the package into other packages.

Table 1.2 Number of countries implementing the UNICEF community IYCF package, by region

Indicator	CEE/CIS	East Asia and the Pacific	Eastern and Southern Africa	Latin America and the Caribbean	Middle East and North Africa	South Asia	West and Central Africa	Global
Number of target countries	22	27	22	36	20	8	24	159
IYCF Module de-activated	2	0	1	1	0	0	1	5
No response	5	16	3	22	14	0	2	62
Total number responded	15	11	18	13	6	8	21	92
Entire UNICEF package adapted, with full 5-day training, plus supervision module	1	5	7	0	2	1	8	24
Entire UNICEF package adapted, with full 5-day training, without supervision module	1	0	4	1	1	2	2	11
UNICEF package used, but abbreviated training of 2–3 days, with supervision module	0	3	0	2	0	0	1	6
UNICEF package used, but abbreviated training of 2–3 days, without supervision module	3	1	0	1	0	0	1	6
Some elements of UNICEF package incorporated into other packages	5	1	6	3	1	4	6	26
Package not used	5	1	1	6	2	1	3	19

Communication and demand generation

Countries employ various strategies to communicate with target populations and stimulate demand for IYCF support and services. To better understand these strategies, NutriDash respondents provided information on IYCF research and its use, the existence of communication strategies and the frequency of mass media messaging on IYCF.

In 51 per cent of countries (47 out of 92), **formative research on IYCF** was conducted in the past five years, and of these, 66 per cent (31 countries) used the research results to develop a communication strategy on IYCF. Figure 1.7 provides a regional breakdown.

As Figure 1.8 shows, 46 per cent of countries (42 out of 92) had an IYCF communication strategy in place. Five of these countries had a stand-alone IYCF communication strategy and the remaining 34 countries included IYCF as part of a broader communication strategy. In addition, three countries had a communication strategy which was not implemented. In 2014, 40 countries implemented communication activities without having an official strategy in place, and 10 countries had neither an official strategy nor had they implemented any IYCF communication activities.

Figure 1.7 Percentage of countries using formative research for IYCF strategy development, by region

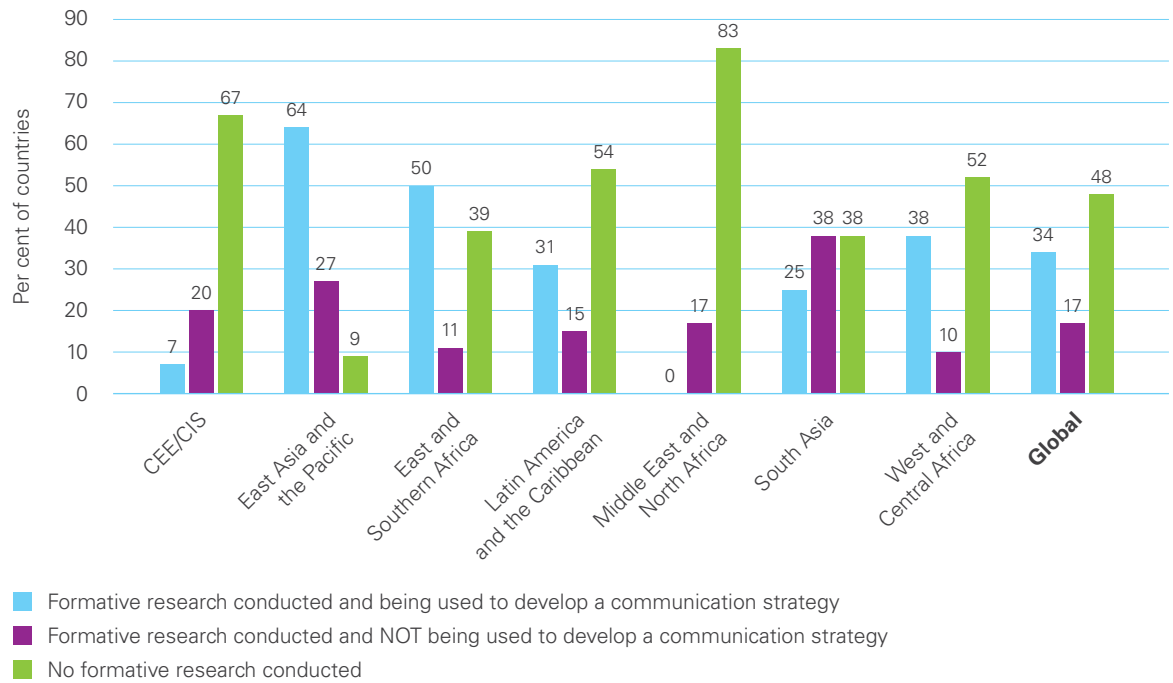
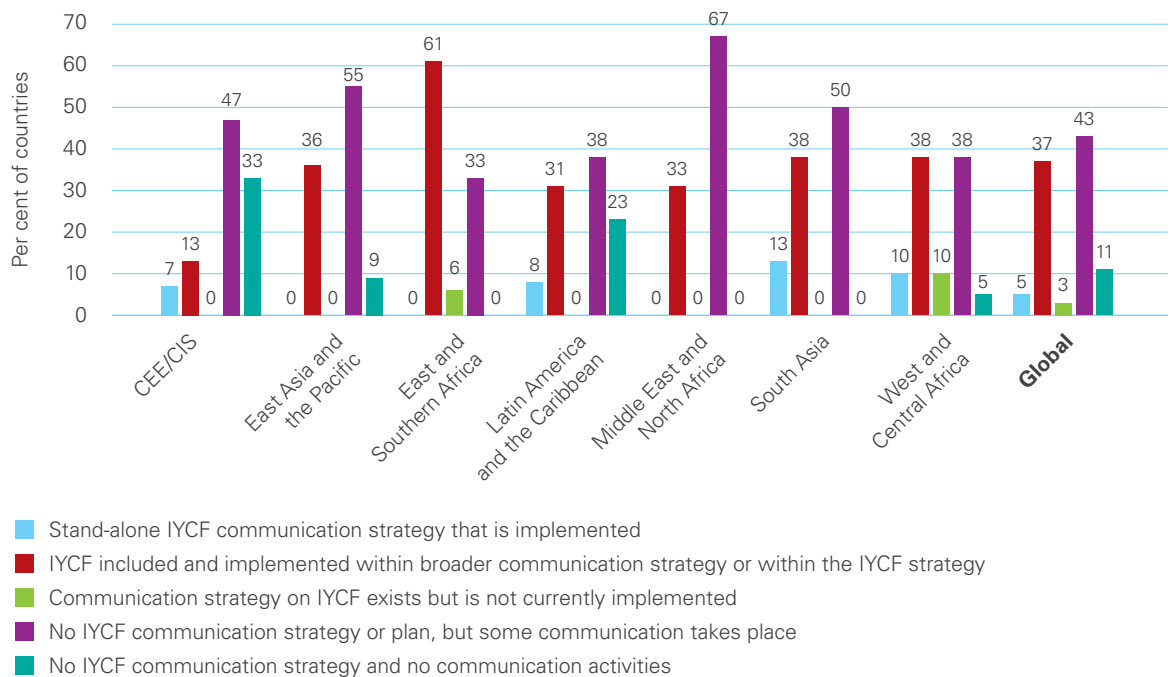


Figure 1.8 Percentage of countries with IYCF communication strategies available or implemented, by region

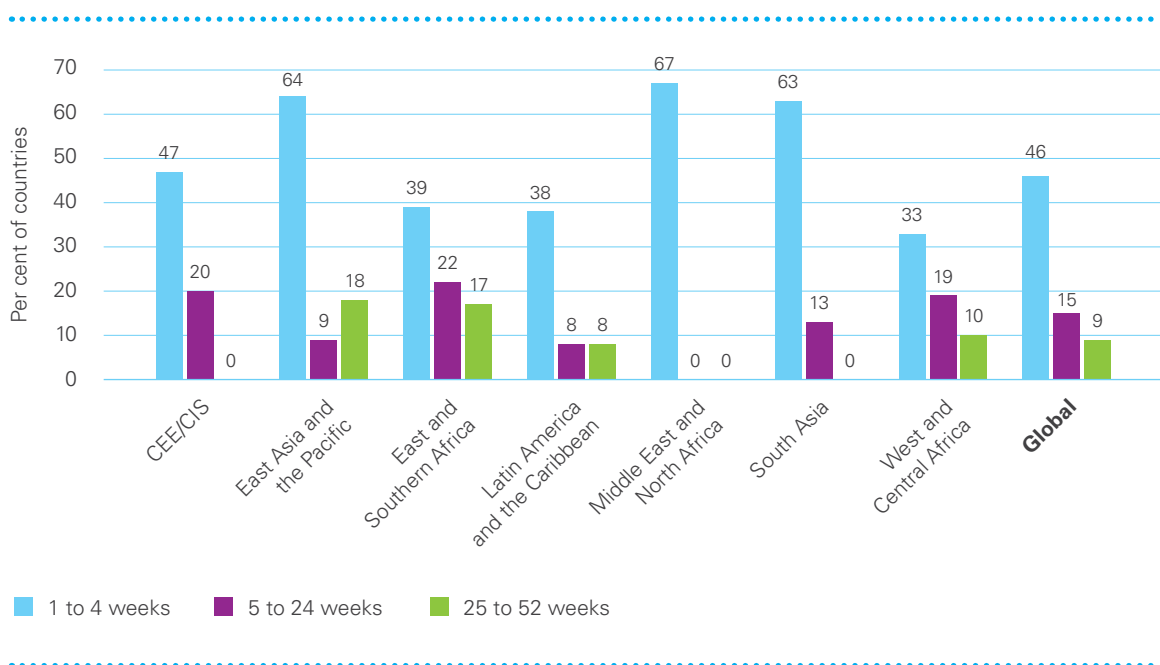


In terms of mass media communication, 70 per cent of countries (64 out of 92) **disseminated messages on IYCF** in 2014, with varying durations. Messages were delivered for:

- 1-4 weeks in 42 countries;
- 5-24 weeks in 14 countries; and
- 25-52 weeks in 8 countries.

Figure 1.9 shows the duration of mass media messaging per region. World Breastfeeding Week (WBW) is commemorated globally during the first week of August, although some countries opt to commemorate it at another time. Some countries extend the mass media activities to more than a week. The information about the duration of mass media communication on IYCF as reported in NutriDash suggests that in countries with shorter durations of messaging (one to four weeks), there may be little such communication outside of WBW, though this would require further analysis to ascertain.

Figure 1.9 Number of weeks that mass media messages on IYCF are broadcast, by region



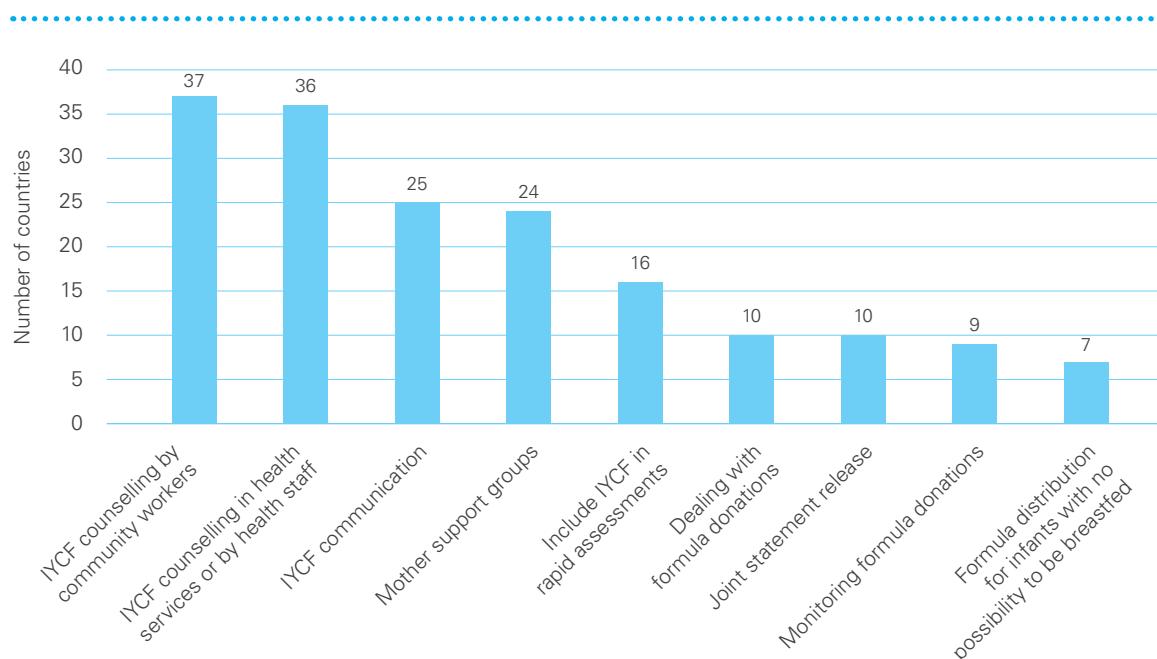
The paucity of countries with IYCF communication strategies, specifically evidence-based strategies, combined with what seems to be a focus on short-term mass media campaigns, suggests that there is room for improvement in this area.

Implementing IYCF in difficult circumstances

A number of countries implemented activities related to IYCF in difficult circumstances. In 2014, 52 per cent of countries (48 out of 92) reported undertaking IYCF activities as part of the response to a **humanitarian situation**. This was an increase over 2013, when 45 per cent of countries (36 out of 79) responded that they had implemented an IYCF activity in response to an acute or protracted emergency.

In 2014, the percentage of countries undertaking such activities varied widely across regions – from 100 per cent in responding countries in the Middle East and North Africa region to no respondents in CEE/CIS. Practically all countries that reported on this issue had implemented at least two and often up to five or six different activities. The activities mentioned are included in Figure 1.10.

Figure 1.10 Number of countries undertaking IYCF activities in response to humanitarian crises, by type of activity



Note: Categories are not mutually exclusive.

With regard to the follow-up on HIV-exposed infants in the context of preventing mother-to-child transmission, only 20 per cent of respondents (18 out of 92 countries) were able to report on the number of HIV-exposed infants enrolled in follow-up. Table 1.3 presents the regional breakdown of countries that were able to report on this indicator in 2013 and 2014.

Table 1.3 Number of countries with data on HIV-exposed infants enrolled in follow-up, by region

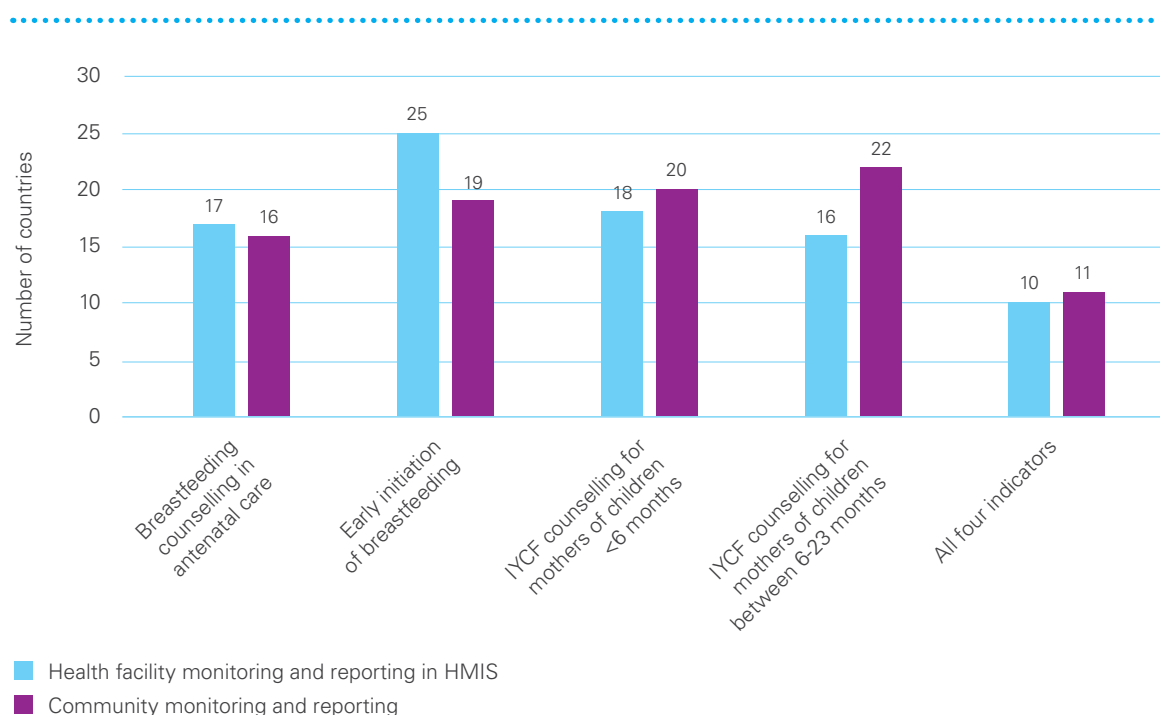
Region	2013	2014
CEE/CIS	2	4
East Asia and the Pacific	1	0
Eastern and Southern Africa	4	4
Latin America and the Caribbean	4	5
Middle East and North Africa	0	1
South Asia	0	0
West and Central Africa	4	4
Global	15	18

E. Monitoring and evaluation

As was the case in 2013, the mainstreaming of IYCF indicators in HMIS and routine reporting on IYCF at the community level both remained a challenge.

Countries were asked to identify which IYCF indicators were monitored and/or reported in the HMIS and at the community level. Results were not comparable from the previous year, as the 2014 questionnaire allowed for a more detailed look at the types of indicators being monitored and reported in the HMIS and at the community level. These are outlined in Figure 1.11.

Figure 1.11 Number of countries that monitored and reported specific IYCF indicators at health facilities and at the community level in 2014



Note: Categories are not mutually exclusive.

The IYCF module also sought information on the number of countries monitoring **feeding practices of HIV-exposed children at the age of 3 months**. In 21 per cent of countries (19 out of 92), these practices were monitored and recorded but not reported, and in 12 per cent of countries (11 out of 92) the information was reported.

F. Conclusions

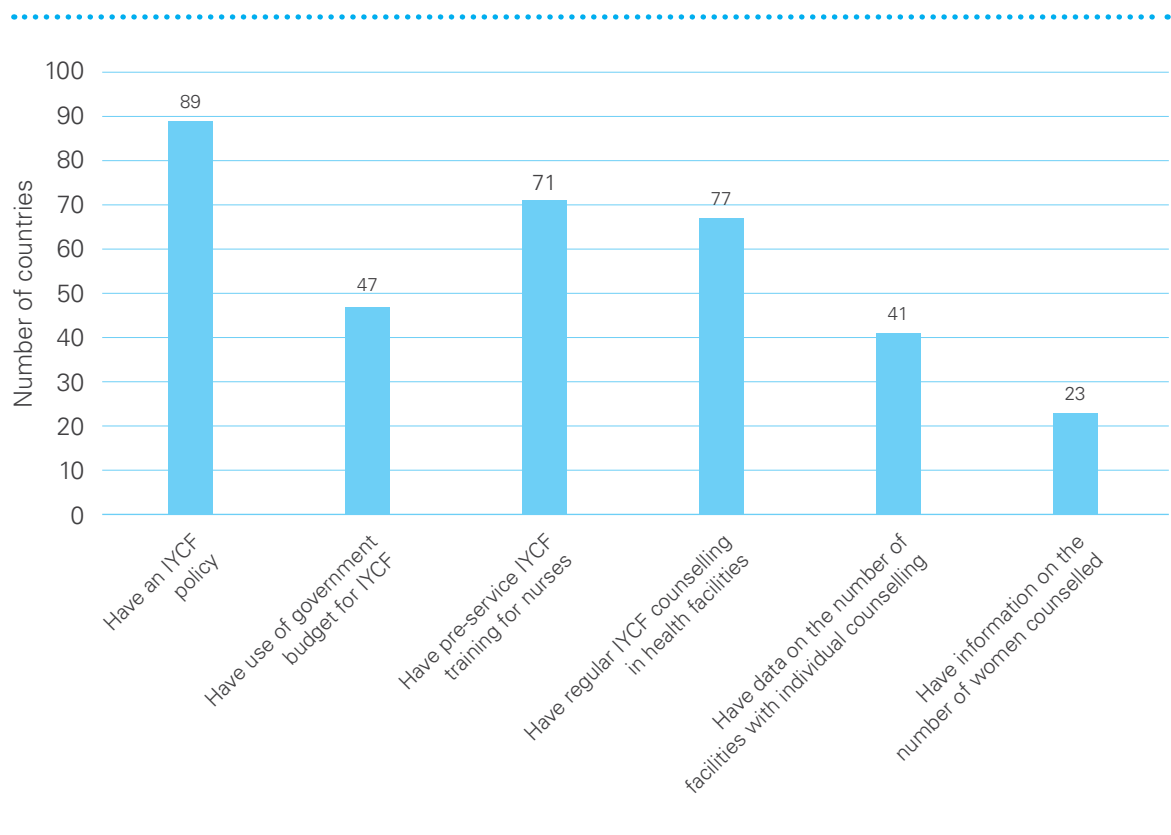
In 2014, the response rate to the IYCF module improved, from 80 to 92 countries, with 66 responding in both years. This provided a rich response.

Many countries are making progress in adopting relevant IYCF policies, including those reflecting the provisions of the Code. The enforcement of such mechanisms remains weak however, and continued advocacy is required to keep this issue high on national agendas. As in 2014, the majority of countries provide IYCF counselling and many are implementing the BFHI and supporting Ten Steps to successful breastfeeding into hospital standards, which is necessary for sustainability.

Countries also faced important challenges in IYCF programming in 2014, such as the limited availability of routine data on programme coverage. In particular, many countries struggled to provide data on training coverage and the percentage of facility and community-based workers receiving in-service training on IYCF. While these data did not provide information on quality of training, getting a better estimate on the number of health workers trained on IYCF is important to address in the near future.

Figure 1.12 presents a bottleneck analysis for some key aspects related to the enabling environment for IYCF –namely, the policy environment and government funding, human resource capacity, service availability (i.e., IYCF counselling) and the availability of information about the coverage of this key service. Results suggest that information availability is an important bottleneck. Moreover, the allocation of government funding for IYCF is either low, or information on its usage is not readily available.

Figure 1.12 Bottleneck analysis: Infant and Young Child Feeding





Health Coordinator Bintou assists Mariam in feeding plumpynut to her son, Al-Matar, during a feed test at the community health centre in Gao, Mali on April 2, 2014. Al-Matar, 13 months old, is receiving nutritional supplements for severe acute malnutrition (SAM). At the centre, he is weighed, measured and Mariam is given a one week ration (20 portions) of plumpynut supplied by UNICEF.

Photo credit: Sam Phelps

2

MANAGEMENT OF SEVERE ACUTE MALNUTRITION

A. Background

The management of SAM is critical for child survival. SAM management is also a key cost-effective component of the Scaling Up Nutrition framework for addressing undernutrition. Children suffering from SAM are more susceptible to disease and have weakened immune systems, which can cause cyclical illness as well as long-term developmental delays. In 2014, an estimated 16 million children under 5 years of age were severely wasted, with the majority in East and South Asia. The largest burden of SAM cases exists in non-emergency situations. A further estimated 34 million children under 5 years old were moderately wasted (see box).¹³

UNICEF supports the scaled-up implementation of community-based management of SAM through engagement with ministries of health, civil society, and a range of non-governmental and UN agency partners. Support includes coordination, technical and policy support, capacity building and strengthening of the supply chain for management of SAM. UNICEF also engages with the World Food Programme (WFP) and other partners to link to services to address moderate acute malnutrition (MAM).

Severe acute malnutrition (SAM) is defined as severe wasting and very low weight-for-height (below -3 z-scores on the median WHO growth standards). SAM is a leading cause of under-five mortality and children with SAM need urgent treatment to survive. The community-based management of SAM includes provision of ready-to-use therapeutic foods (RUTF) and medical care within the community. Children with SAM and complications are treated via in-patient care.

Moderate acute malnutrition (MAM) is defined by WHO as moderate wasting and a weight-for-height between -3 and -2 z-scores below the median of the WHO child growth standards. Children with MAM in emergencies are often treated with specially formulated supplementary foods and medical care, while in more stable environments the use of locally available foods may be a preferred management option.

¹³ UNICEF/WHO/World Bank, 'Joint Child Malnutrition Estimates', 2014, <<http://data.worldbank.org/child-malnutrition/regional-wasting-prevalence-and-the-who-severity-levels>>

Globally, UNICEF procures the bulk of therapeutic products used in SAM treatment. UNICEF procures approximately 80 per cent of ready-to-use therapeutic food (RUTF), and the majority of therapeutic milk (F75, F100) used in treatment of SAM with complications. UNICEF continues to support local production of RUTF, and has diversified its supplier base to include 18 manufacturers in 14 countries.

The NutriDash supply forecast module supports UNICEF country staff to forecast annual supply needs based on standard calculations that can be adapted to country contexts. UNICEF uses that information to engage with producers to ensure adequate availability of global supplies.

B. Global scale of SAM management services

An estimated 80 countries were reported to provide SAM management services. In 2014, 73 countries reported SAM treatment programmes (both UNICEF and non-UNICEF supported). An additional seven countries did not submit data to NutriDash in 2014 but are known to have SAM management programmes from past data collection exercises, such as UNICEF country office annual reports, the 2009–2012 mappings or the 2013 NutriDash.

Out of the 73 reporting programmes in 2014, the majority of countries provided both inpatient and outpatient services (63 countries).¹⁴ Nine countries reported having inpatient but no outpatient services, and only one country reported having outpatient but no inpatient services.

Table 2.1 Evolution of the number of SAM management programmes, by region, 2009–2014

Region	2009	2011	2012	2013	2014
CEE/CIS	1	1	1	2	4
East Asia and the Pacific	7	10	11	11	11
Eastern and Southern Africa	20	20	20	20	20
Latin America and the Caribbean	5	6	6	9	11
Middle East and North Africa	6	6	6	7	7
South Asia	7	7	7	7	7
West and Central Africa	20	20	20	20	20
Total	66	70	71	76	80

Progress from 2009–2013

The number of countries providing SAM services has slowly but steadily increased in the last six years (Table 2.1). An additional 14 countries have reported operational SAM management services since 2009. Most new programmes are in East Asia and the Pacific, CEE/CIS and Latin America and the Caribbean. These, however, are predominantly countries where UNICEF plays a significant supporting role in the management of SAM services. There are other countries with small-scale inpatient (or even some outpatient) services where UNICEF does not provide support. Due to the current method of primarily collecting data from UNICEF offices, many of these small-scale services are not being reported to NutriDash. Every effort will be made to capture data on these additional small-scale services in the next round of data collection.

¹⁴ Inpatient treatment is defined as hospital-based treatment, and outpatient treatment at the health facility or community level.

Further details on the trends for SAM management, including programme performance, treatment coverage and geographical coverage, are provided in Table 2.2.

Table 2.2 Summary of global SAM management programme data, by indicator, 2009-2014

Indicator	2009	2011	2012	2013	2014
Number of countries implementing SAM services (includes those reporting to NutriDash)	66	70	71	76	80
Number of reported cases admitted to treatment	1,035,771	1,961,722	2,662,712	2,909,410	3,209,372
Performance indicators:¹⁵					
Number of countries reporting on performance indicators	52 countries	61 countries	42 countries	39 countries	51 countries
Countries reporting cure rates $\geq 75\%$	21 countries	21 countries	30 countries	29 countries	38 countries
Countries reporting defaulter rates $< 15\%$	26 countries	20 countries	25 countries	31 countries	38 countries
Programme treatment coverage (admissions/SAM burden):					
Number of countries able to provide information on coverage (includes countries able to report on one or more aspects of treatment coverage – national, target area or implementation progress)	No reliable data for intra-country comparison (due to too much variation between methods of calculation)	No reliable data for intra-country comparison (due to too much variation between methods of calculation)	53 countries	50 countries	55 countries
>50% national treatment coverage			19 countries	15 countries	16 countries
Geographical coverage/access (Number of health facilities with SAM management services/total number of health facilities):					
Number of countries able to provide information on health facilities	No data	28 countries (48%)	49 countries (82%)	46 countries (69%)	55 countries (75%)
Countries with >50% of health facilities delivering SAM nationally		No data	20 countries	14 countries	19 countries
Procurement of RUTF¹⁶	6,231 metric tons	27,000 metric tons	29,000 metric tons	33,000 metric tons	30,000 metric tons

¹⁵ These performance indicators are based on the global SPHERE standards, intended for emergency settings.

¹⁶ Data provided by UNICEF Supply Division.

C. SAM management for different groups

Individuals of any age can be affected by SAM; however, less is known about country-level availability of SAM services for infants under 6 months, chronically unwell children, adolescents and adults. While a large proportion (59 of 73 countries) reported specific SAM treatment for infants under 6 months, few (21 of 73 countries) reported availability of SAM services for chronically unwell, with a small number of countries reporting SAM services for adolescents and adults (10 of 73 countries). Sub-Saharan African countries had the most programmes catering to different groups. Scope and scale of programming for SAM in other age groups will be explored in subsequent data collection.

SAM and HIV

In countries where HIV is common, the 2013 WHO recommendations for SAM management advise that children be routinely tested for the virus, and that those who are positive should begin taking a combination of antiretroviral drugs, special foods and antibiotics to treat SAM. This is because children living with HIV are at higher risk of acute malnutrition, and they take longer to recover when they become malnourished.

For 2014, the NutriDash asked three questions pertaining to HIV and SAM management, linked to policy, service availability and service demand or utilization. Of the 73 countries that reported on SAM management overall:

- 45 countries reported that they had guidelines or protocols on SAM treatment for HIV-infected children that reflected WHO 2013 recommendations;
- 27 countries reported that health facilities provided integrated HIV and SAM treatment, as well as HIV service referrals for children receiving treatment for acute malnutrition;
- Seven countries reported a total of a little over 3,000 children admitted to SAM treatment who tested HIV positive and were referred for treatment.

Six countries reported on all three elements – (i.e., the relevant WHO recommendation on HIV management for children with SAM as part of the national guidelines, the number of health facilities providing integrated HIV and SAM treatment, and the number of children admitted to SAM treatment who tested HIV positive and were referred for treatment). Of these six, three countries were part of the 22 priority countries of the global plan for eliminating new HIV in children.¹⁷

These figures demonstrated that while integrated services were available in some countries, there was still limited information on the scale of services and numbers of children being reached. The fact that more countries did not report indicated the need to strengthen reporting around this intervention area. In addition, there was a need to generate updated estimates on SAM-HIV burden and document effective SAM-HIV programming in order to guide scale-up supportive services for HIV and SAM.

D. Enabling environment

UNICEF defines the enabling environment in terms of social norms, legislation and policy; budget and expenditures; and management and coordination. The NutriDash SAM module focuses primarily on tracking indicators related to legislation and policy, and budget and expenditures, in order to evaluate the enabling environment (see Table 2.3).

¹⁷ The 22 countries accounted for 90 per cent of the global number of pregnant women living with HIV who were in need of services to prevent mother-to-child transmission of HIV in 2009.

Table 2.3 Components of the enabling environment for SAM management, 2011-2014

Year	SAM treatment as part of the national health and nutrition policies	Budget line for SAM supplies in the annual health sector operational plan (national or subnational level)	Budget line for SAM programming in the annual health sector operational plan (national or subnational level)	Budget line for both SAM supplies and programming	Countries incorporating SAM management indicators in the HMIS
2011	-	-	-	-	16 (of 55)
2012	51 (of 60)	-	-	-	41 (of 60)
2013	59 (of 67)	20 (of 67)	27 (of 67)	15 (of 67)	43 (of 67)
2014	69 (of 73)	34 (of 73)	39 (of 73)	31 (of 73)	40* (of 73)

*In 2014, a modification was made to the question: "Are SAM outpatient admissions reported in the Government-run HMIS." 40 countries reported that this was the case and of these, 38 reported admissions being reported at the sub-national level.

National policies and budgets for SAM

Inclusion of SAM management in national policies and budgeting reflects a level of political commitment, which provides a basis for scale-up of nationally owned SAM services. Almost all countries now report SAM treatment as part of national health and nutrition policies. Between 2013 and 2014, the number of countries reporting budget lines for both SAM programming and supplies doubled. Slightly more than half of countries also reported that SAM management indicators are part of the national HMIS systems. The majority of countries reported that their national guidelines and protocols reflect the WHO 2013 SAM recommendations, with some countries having formally planned protocol revisions for 2015 and 2016.

Supply side environment and human resources

Capacity development, human resource management and supervisory systems are essential components of translating updated guidelines and protocols into improved services. In terms of training, 27 per cent (20 out of 73 countries) included SAM management as a topic in the pre-service training of health workers or health professionals. The majority of these countries are in Eastern and Southern Africa (seven countries) and West and Central Africa (seven countries).

Continuous availability of therapeutic supplies is also essential to the provision and uptake of SAM services. Increasingly, countries are taking steps to incorporate RUTF into national supply systems. The number of countries including RUTF on the essential supplies list has continued to rise, from 21 countries in 2012, to 25 in 2013, to 31 in 2014. The majority of these countries are in Eastern and Southern Africa (12 countries) and West and Central Africa (12 countries). Sixty-six per cent (2.1 million) of all children treated globally are admitted in the 31 countries where RUTF is on the essential medical supplies list.

Associations between the enabling environment and programme performance

For 2014, an analysis of the relationship between key enabling environment elements and selected indicators of country performance was undertaken (Table 2.4). For the purpose of this analysis, country performance was defined in terms of programme size (admissions),¹⁸ effectiveness (indirect coverage rates), or as completeness of information systems (bottleneck analysis, see section F).

¹⁸ Of the 57 countries able to report on SAM admissions, the median admissions figure was around 20,000 while the mean figure across all countries was 56,000. In terms of scale, the smallest programme reported 156 admissions and the largest programme reported 365,000 admissions.

The main enabling environment element found more often in better performing countries was the inclusion of RUTF on the essential supplies list. The inclusion of SAM management in pre-service training or the inclusion of SAM programming and supply costs in annual health sector operational plans did not always appear to correlate strongly with better country performance. Continued efforts to embed SAM management within the policy and supply side are necessary but evidently are not always sufficient to translate into actions at scale. Investments in demand side factors and operational programme quality are also critical.

Table 2.4 Key enabling environment elements and country performance for SAM management

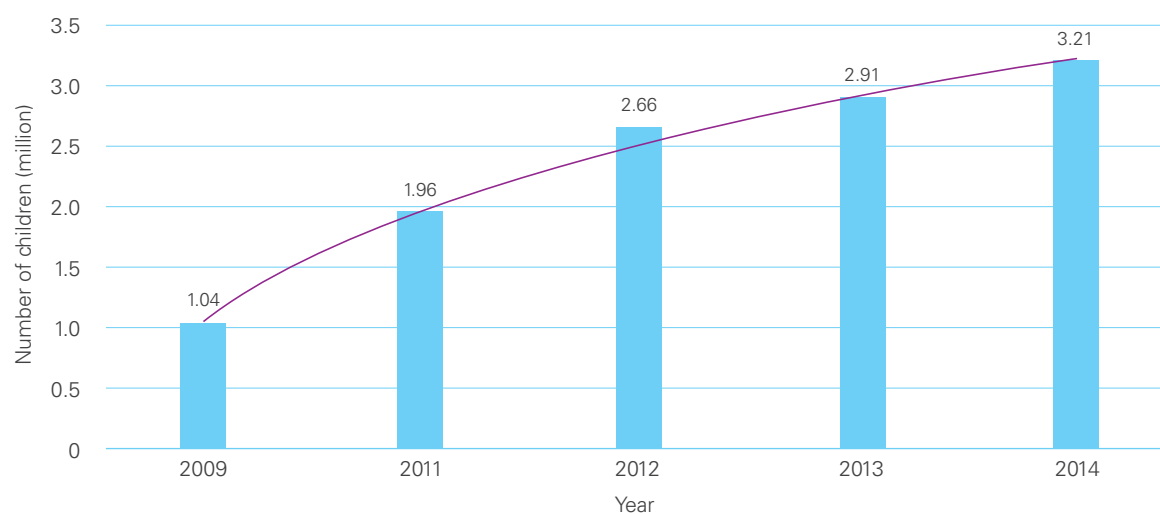
	Percentage of countries with RUTF on essential supplies list	Percentage of countries with SAM as part of pre-service training	Percentage of countries with budget lines for SAM supplies and programming in annual health sector operational plans
All reporting countries (73 total)	42	27	44
All countries reporting admissions (57 total)	49	30	40
All countries reporting over 20,000 admissions (29 total)	69	41	45
Countries representing the top 11 admissions	55	27	64
Countries reporting indirect programme national coverage >50% (16 total)	56	31	31
Countries reporting indirect programme target area coverage >50% (24 total)	58	25	38
Countries reporting all bottleneck analysis indicator data (21 total)	57	29	43

E. Demand and quality

Admissions

In 2014, 57 countries reported a total of 3.21 million children admitted for SAM treatment (Table 2.5). This represents an increase of just over 10 per cent from 2013. Of these, UNICEF supported 3.05 million admissions.¹⁹ Global admissions for SAM treatment continued to increase between 2009 and 2014. The rate of increase in 2014 was in line with 2013 projections, which had predicted a slower increase than that of the 2009 to 2012 period.

¹⁹ UNICEF support is defined as either supply (provision of RUTF, for example) or programmatic (supporting capacity building of health staff, for example).

Figure 2.1 Number of children admitted for SAM treatment globally, 2009–2014

In terms of regional trends:

- West and Central Africa admissions continued to increase since the Sahel crisis in 2012 – by 13 per cent from 2012 to 2013 and again by 13 per cent from 2013 to 2014;
- Eastern and Southern Africa admissions remained steady for the previous few years; admissions fell 11 per cent from 2012 to 2013 but rose to almost 7 per cent from 2013 to 2014;
- Admissions in South Asia were small in absolute numbers but there were large percentage increases over the last few years;
- Admissions in the Middle East and North Africa, East Asia and the Pacific and CEE/CIS remained small.

Table 2.5 Number of children admitted for SAM treatment, by region, 2009–2014

Region	2009	2011	2012	2013	2014	Number of countries reporting admissions in 2014
CEE/CIS	-	-	-	-	400	1
East Asia and the Pacific	4,627	12,671	32,280	33,677	41,333	7
Eastern and Southern Africa	465,740	806,919	892,914	790,264	842,829	18
Latin America and the Caribbean	0	21,660	28,882	19,906	23,003	2
Middle East and North Africa	49,590	128,647	217,935	330,865	315,050	5
South Asia	119,116	207,215	258,366	340,312	412,359	5
West and Central Africa	481,465	784,660	1,235,302	1,394,386	1,574,398	19
Total	1,120,538	1,961,772	2,665,679	2,909,410	3,209,372	57

Quality of treatment

In 2014, out of 2.56 million children treated and discharged, 2.11 million were reported as cured, while almost 241,000 defaulted, 32,000 died and 172,000 were non-respondent.

Given the standard treatment period of approximately 45 days for a child, it should be noted that there is a time lag between admission and exit, which can influence the numbers and account for the gap between admission and exit. Reporting quality also needs to be factored into interpretations of indicators of treatment quality because gaps in reporting across countries within a region have the potential to impact the summary indicators.

The number of new countries able to report on performance indicators increased in 2014. In 2014, 51 countries reported cure rates compared to 39 countries in 2013 and 42 countries in 2012. Additionally, 38 countries reported a cure rate of over 75 per cent (compared to 29 countries in 2013 and 30 countries in 2012) and 38 countries also reported default rates of under 15 per cent (compared to 31 countries in 2013 and 25 countries in 2012).

However, despite the increase in countries reporting and country performance, only 38 countries reported a cure rate of >75% out of the 73 countries reporting in NutriDash. This is still a low rate with more needing to be done to improve reporting completeness and quality, as well as to support countries in improving their cure rates overall. Country-level bottleneck analysis of the programme can help identify key solutions for this issue and UNICEF is rolling out this approach globally.

Disaggregation

In 2014, greater effort was made to gather disaggregated information, particularly with regards to inpatient and outpatient admissions as well as admissions and performance indicator data by gender.

With regards to inpatient / outpatient disaggregation:

- 43 countries (of the 57 countries that reported admissions) reported both inpatient and outpatient admissions; this included three countries with inpatient-only programmes reporting admissions.
- Of these 43 countries, the mean country proportion of inpatient to total admissions was 23 per cent; of the total admissions, the aggregate proportion of inpatient to total admissions was 17 per cent. Globally, the figure stands at 500,000 inpatient admissions and 2.2 million outpatient admissions (of those 43 countries reporting both or with inpatient-only programmes).

With regards to gender disaggregation:

- Only 16 countries (of 57 reporting admissions) were able to report admissions disaggregated by gender, totaling 1.15 million admissions, and constituting 36 per cent of the global total. The split was 550,000 boys and 600,000 girls.
- 10 countries reported performance indicator data disaggregated by gender (i.e., cure and default rates for boys and girls).

Coverage

Reliable coverage information is critical for designing and adjusting programmes, and ensuring access to quality services, particularly for the most deprived and vulnerable. There are two methods for generating coverage data: direct methods based on surveys and indirect methods which use routine data to generate a figure (see calculation methods following). ‘Coverage’ in this document refers to indirect estimates (i.e., data entered in NutriDash by UNICEF staff and partners) as opposed to direct estimates from surveys.

Defining coverage in NutriDash

‘Programme Treatment Coverage’ is an indirect estimate that refers to the proportion of children in need of SAM treatment who received treatment. It is measured as the proportion of admissions of children into SAM programmes out of the total burden of SAM (i.e., all SAM cases).

‘Geographical Coverage’ of SAM treatment services is an indirect estimate of the proportion of districts or health facilities offering SAM treatment.

Note: Geographical coverage is termed ‘Geographic access’ in UNICEF’s internal bottleneck analysis determinants framework, Monitoring of Results for Equity Strengthening (MoRES)

The basis of indirect coverage estimates

The estimated SAM burden forms the basis of SAM programme planning and indirect coverage estimates.²⁰ SAM burden is defined as the estimated number of SAM cases in a population over a specific period, including current (prevalent) cases and new (incident) cases.

These figures are calculated as follows:

- Prevalent cases = prevalence of SAM x population 6-59m
- Incident cases = prevalence of SAM x population 6-59m x incidence correction factor²¹

A simplified calculation of SAM burden = population 6-59m x [prevalence + (prevalence x incidence)]

For example, country X has a 6-59m population of 1,000,000 and a SAM prevalence of 2%. The country uses an incidence correction factor of 1.6. Therefore:

- Prevalent cases = 1,000,000 x 0.02 = 20,000
- Incident cases = 1,000,000 x 0.02 x 1.6 = 32,000
- Total = 20,000 + 32,000 = 52,000 cases

²⁰ SAM burden here refers to country-level programming, and is separate from global modelling of joint estimates of burden and trends.

²¹ If the relevant country-level incidence factor is not known, 1.6 may be used, which gives incidence as factor of prevalence. The incidence is the proportion of new cases of SAM out of the total population of children under 5 that occur over a specific time period. Incidence = Prevalence/average duration of disease. A common estimate of the average duration of an untreated SAM episode is 7.5 months. Using this to estimate incidence over one year (i.e., 12 months) yields: $12/7.5 = 1.6$.

The calculation, which was developed through interagency consensus, is used as a basis for planning and should be triangulated with programme data. UNICEF continues to work with partners to update the process of supply forecasting and address some of the limitations of the current calculation method.²²

Programme treatment coverage

Programme treatment coverage at the country level can be reported in terms of how much of the total SAM burden in the country was reached (national programme treatment coverage) or the SAM burden in a specific target area. Target area programme treatment coverage better reflects progress in relation to sub-national targets, but should be reviewed in relation to national programme treatment coverage (Table 2.6). For 26 countries, the target area burden was the same as the national burden [i.e., these countries were aiming at nationwide coverage]. Overall, target area programme treatment coverage was higher than national programme treatment coverage, indicating that a foundation for scaled up SAM treatment was in place, but further investments were needed to address national SAM burdens.

Table 2.6 National and target area programme treatment coverage for SAM

	National programme treatment coverage	Target area programme treatment coverage
Definition and calculation	$= \frac{\text{new admissions (supported by all actors)}}{\text{national burden}}$	$= \frac{\text{new admissions (supported by all actors)}}{\text{target area burden (i.e., where the programme was actually operating)}}$
Reporting rate	55 out of 73 countries	52 out of 73 countries
Average coverage across countries	37 per cent mean coverage	54 per cent mean coverage

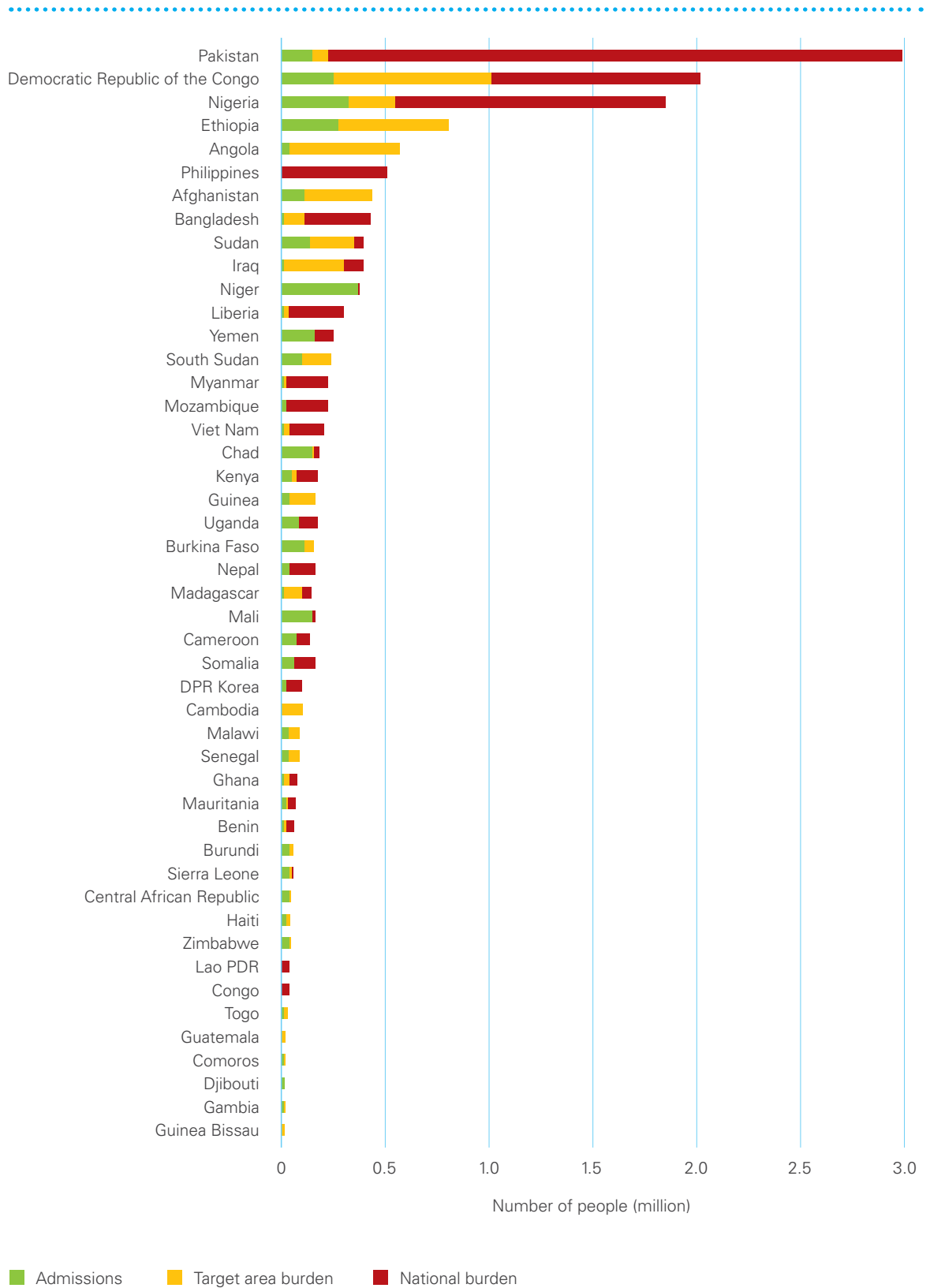
NutriDash for 2014 presented globally available indirect programme treatment coverage by country²³ based on individual country data inputs and calculations. Many countries were achieving high treatment coverage in relation to their programme target area, with fewer countries implementing at the national scale.²⁴ See the annex for the reporting rates for each country.

²² Such limitations include, in some cases, a lack of up-to-date census data, the fact that prevalence does not reflect seasonality, the discrepancy between using weight for height measures versus prevalence based on mid-upper arm circumference (MUAC) as admission criteria, and the average incidence correction factor of 1.6 which is not tailored to country-specific situations.

²³ The graph shows the admissions (in green) in relation to target area burden (in yellow) or national burden (red) which were based on individual country data inputs and calculations. Where target area burden is the same as national burden, national burden is not visible.

²⁴ Out of the 46 countries where data is presented, only 38 countries were able to indicate a reporting rate for their admissions information and a further seven countries had reporting rates below 75 per cent.

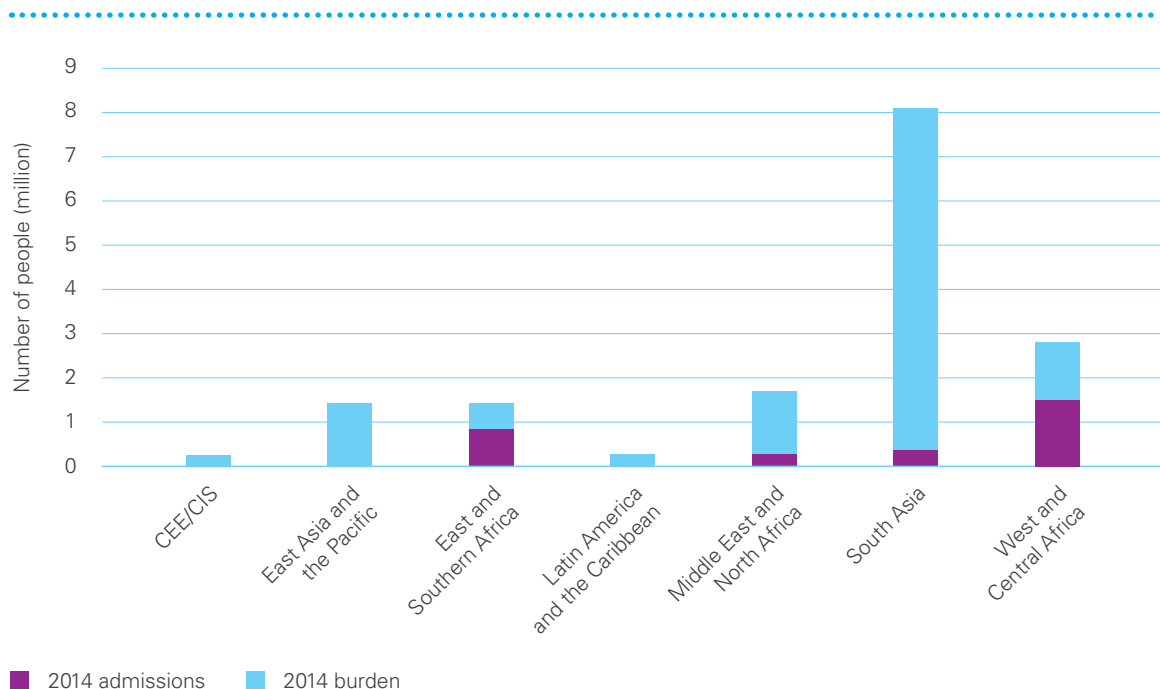
Figure 2.2 Indirect programme treatment coverage for SAM, by country



Note: In the bars where national burden is not visible, the target area burden is the same as the national burden.

The global gap between admissions and SAM burden also varied across regions, with the largest gap in South Asia. Figure 2.3 presents cumulative SAM admissions for 2014 in relation to the 2014 UNICEF/WHO/World Bank joint estimates. While investments in scaling up effective SAM management remain critical, much more needs to be done to reduce the overall burden with preventative measures so that fewer children need treatment.

Figure 2.3 Gap between SAM burden and admissions for treatment, by region



Geographical coverage

UNICEF uses two definitions of geographical coverage:

1. **(Health facility) Geographical coverage:**

$$\frac{\text{Health care facilities delivering treatment for SAM (national or target area)}}{\text{total number of health care facilities (national or target area)}}$$

2. **(District) Geographical coverage:**

$$\frac{\text{Districts delivering treatment for SAM}}{\text{total districts}}$$

These two coverage measures help describe the availability of services at a decentralized level, which is one component of improving the reach of SAM management. Service availability at the district level is necessary to improve access, but a district may have one or many health facilities providing SAM services. The number of health facilities per district is not uniform within and across countries. Both measures are needed to understand the overall distribution of services and geographic gaps in service provision.

Table 2.7 National district geographical coverage for delivering SAM treatment, number of countries per bracket, by region

	0-24%	26-49%	50-74%	75-100%
CEE/CIS	1	0	0	0
East Asia and the Pacific	5	1	0	2
Eastern and Southern Africa	1	2	2	13
Latin America and the Caribbean	0	0	0	2
Middle East and North Africa	1	0	2	2
South Asia	1	1	2	1
West and Central Africa	2	3	3	10
Global	11	7	9	30

Table 2.8 National Health facility geographical coverage for delivering SAM treatment, number of countries per bracket, by region

	0-24%	26-49%	50-74%	75-100%
CEE/CIS	1	0	0	0
East Asia and the Pacific	6	1	1	0
Eastern and Southern Africa	6	3	2	6
Latin America and the Caribbean	0	1	0	1
Middle East and North Africa	4	0	0	1
South Asia	5	0	0	1
West and Central Africa	7	5	3	4
Global	29	10	6	13

Out of the 57 countries able to report on district geographical coverage, roughly half reported coverage of greater than 75 per cent – which is similar to the figures from 2013. When looking at the data in terms of health facility geographical coverage, the trend is reversed, with almost half of countries reporting a low proportion of health facilities delivering SAM management services. This suggests that even in contexts where the majority of districts have SAM management services, the actual availability of services at the health facility level may be quite limited.

SAM supply forecasting

This was the second year that the annual UNICEF SAM supply forecasting data was collected via NutriDash. Previous forecast and admissions data were automatically provided to cross reference calculations for the year ahead. Countries inserted their projected admissions for 2015 as well as the current stock levels and the system generated supply needs and costs for the coming year.

Projected admissions figures for 2014 were compared to reported admissions for 2014.²⁵ Forty countries provided admissions data for both 2013 and 2014. Of those:

- 14 countries surpassed their forecast projections and achieved greater admissions than they had forecasted;
- 26 countries did not reach their forecast projections, with the smallest deficit at 300 admissions and the largest at over 50,000 admissions.

There are a number of factors that can contribute to these differences including changes in context after annual planning processes, supply side issues related to planning data or funding, as well as implementation issues.

²⁵ Some countries with large admissions numbers have been omitted.

For the 2015 forecast, a total of 58 countries submitted data into the supply forecasting tool. An estimated 3.25 million children were projected to be reached with treatment for SAM in 2015, underscoring the continued deceleration of SAM management scale-up. Supply needs for RUTF were projected at over 34,000 metric tons or almost 2.5 million cartons of RUTF.

F. Bottleneck analysis

UNICEF promotes bottleneck analysis as part of its corporate equity planning and monitoring approach.²⁶ NutriDash 2014 included indicators designed to facilitate national bottleneck analysis, according to the determinants framework – enabling environment, supply, demand and quality. Indicators for the six determinants of coverage were drawn from global guidance and have been tested at the country level (see Table 2.9).²⁷ Much of the data is collected routinely – for example, tracking the number of health facilities delivering treatment, the number of staff trainings, the number of SAM admissions and performance indicators. UNICEF continues to roll out this approach at the country level by promoting more regular bottleneck analysis and monitoring of progress in addressing bottlenecks at the country level.

Table 2.9 Indicators in NutriDash for SAM management bottleneck analysis

Determinant	Indicator
Commodity	Percentage of health facilities in programme target area that did not have stock-outs of RUTF in the last 3 months
Human resources	Percentage of health workers in programme target area that have been trained on SAM management
Geographical access	Percentage of health facilities offering SAM treatment in programme target area
Utilization	Percentage of children <5 in programme target area with SAM who were admitted for SAM treatment
Continuity	Percentage of children <5 in programme target area with SAM who did not default from SAM treatment
Quality	Percentage of children in programme target area <5 with SAM who were cured

While the majority of countries can report on some of the determinants of coverage, only 21 countries were able to provide data on all six determinants of coverage. More countries were able to provide information on geographic access, initial utilization, continuity and quality of services than were able to provide data on commodities and human resources (i.e., RUTF stock-outs or proportion of health workers trained in SAM) (Table 2.10).²⁸ Further investment in routine nutrition information systems, particularly filling data gaps and using information in analysis of SAM programming, will further help comprehensively identify, address and monitor bottlenecks.

Table 2.10 Number of countries providing information for each of the six SAM management bottleneck analysis determinants

	Supply	Human resources	Geographic access	Initial utilization	Continuity	Quality
Global	27	34	56	56	50	52

²⁶ United Nations Children's Fund, 'Narrowing the Gaps to Meet the Goals', 2010, <www.unicef.org/media/files/Narrowing_the_Gaps_to_Meet_the_Goals_090310_2a.pdf>.

²⁷ United Nations Children's Fund, 'Reaching Universal Health Coverage through District Health System Strengthening: Using a modified Tanahashi model sub-nationally to attain equitable and effective coverage', Maternal, Newborn and Child Health Working Paper, 2013, <www.unicef.org/health/files/DHSS_to_reach_UHC_121013.pdf>.

²⁸ Four countries from East Asia and the Pacific, five from Eastern and Southern Africa, one from Latin America and the Caribbean, two from Middle East and North Africa, one from South Asia and eight from West and Central Africa.

G. Conclusions

In 2014, 3.21 million children were reached with services to manage SAM – an increase from the 2.91 million children reached in 2013. An estimated 3.25 million children were projected to be reached in 2015 through action in countries reporting to Nutridash, signaling a continued plateau in global SAM admissions.

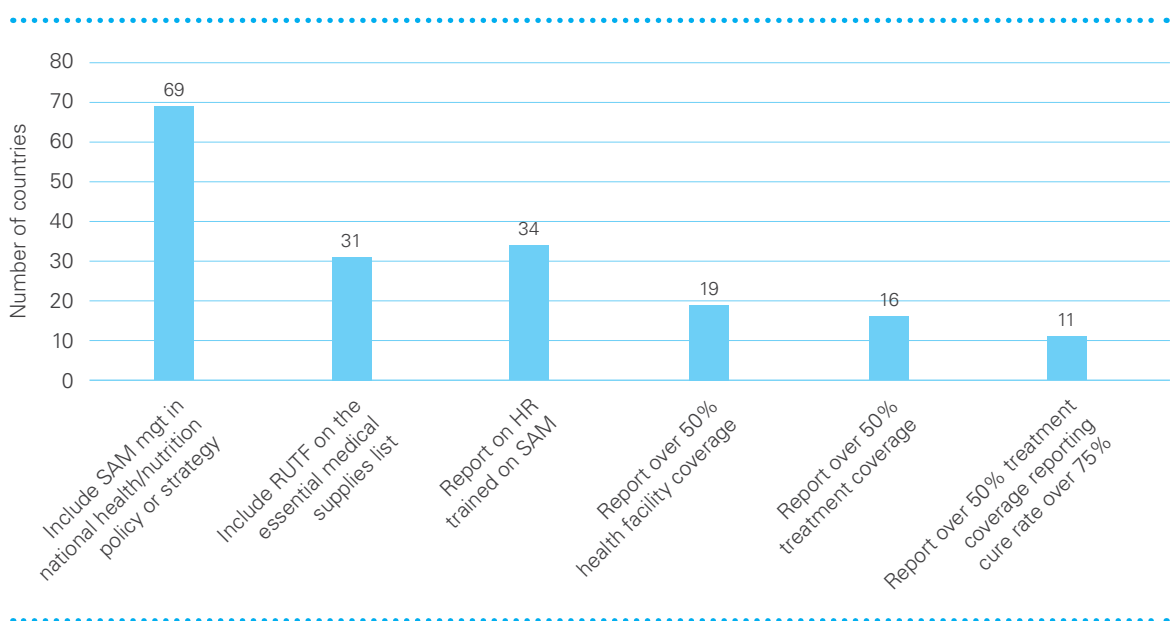
While the number of countries providing SAM services has slowly but steadily increased in the last six years, the expansion of treatment services has a long way to go to reach the estimated 16 million children who suffer from SAM. Improved coverage of decentralized quality SAM services is critical, especially in East and South Asia, where the gap between treatment coverage and the disease burden is particularly wide. The scale of SAM services for other age groups and integrated SAM-HIV programming is limited at global level, and presents an important platform for discussions on equitable scale up of SAM programming. Linkages between services for SAM treatment and prevention will also be essential.

Certain elements of the enabling environment – such as RUTF being on the essential supplies list – have a positive association with the number of admissions or indirect estimates of treatment coverage. It is clear that investments in the enabling environment are essential, alongside investments on quality care at a decentralized level.

Investments in data and routine information systems for SAM services are critical factors in SAM scale-up. Sex and age disaggregated data, more complete reporting and strengthened data collection (such as RUTF stock-outs and trained human resources) will strengthen country, regional and global support of SAM services. This is also in line with the agenda to strengthen health systems agenda.

Country-level data collected in NutriDash 2014 formed the basis for more in-depth bottleneck analysis in 2015 which has translated into further policy and programming action. At the global level, a similar bottleneck analysis underscores the continued need for investments in the enabling environment and in operational capacity. Key areas include supporting the inclusion of RUTF on lists of essentials supplies and tracking staff training; and helping to elevate the number of countries achieving higher coverage and quality of programming, resulting in better cure rates.

Figure 2.4 Bottleneck analysis: SAM management



Mawutor gathering salt from the bottom of a concentrator pan at a salt production operation near Koluedor on the edge of the Songhor Lagoon in Ghana, 18 May 2015.

Photo credit: Nyani Quarmyne 2015



3

UNIVERSAL SALT IODIZATION

A. Background

Iodine deficiency impairs cognitive development among children and is the primary preventable cause of brain damage in children worldwide. Decades of experience has shown that USI is the most cost-effective strategy for eliminating iodine deficiency disorders (IDD) and ensure optimal iodine status. Country-level support for these programmes is strong. As a result, it is now estimated that about three quarters of households worldwide consume adequately iodized salt. This is a significant increase since the inception of many programmes in 1990, when only 20 per cent of the global population had access to iodized salt. Analyses led by the Iodine Global Network suggest that 131 countries globally have adequate iodine intake while only 25 are classified as iodine deficient. Despite these gains, there is a need to remain vigilant in keeping USI on national agendas to ensure programmes are sustained and continually improved over the long term.

UNICEF has a long history of supporting salt iodization programmes to eliminate IDD. This has involved advocacy with governments and salt producers, and partnerships with civil society to create the demand for iodized salt among consumers. At the global level, UNICEF helped create the Iodine Global Network, an interagency alliance that serves as the global authority on iodine nutrition.

In order to assess the structures and systems in place to ensure sustained elimination of IDD, UNICEF developed the NutriDash USI module in 2013. This module examines key programme performance indicators, including those related to the enabling environment, supply, demand generation, and M&E within countries. The results are thus complementary to global monitoring efforts to track output and outcome indicators such as 'proportion of households consuming iodized salt' and 'iodine status of the population'.

In 2014, some modifications were made to the USI questionnaire based on feedback from programme managers and partners. These included the addition of a strengthened 'supply' component, and questions on salt iodization standards at import, production and household level. In addition, programme managers were asked about the existence of a national strategy for salt reduction, and further questions were included on iodized salt packaging and labelling, procurement of potassium iodate (KIO₃) and stock-outs. Lastly, changes were made to the project performance scoring to include the 'supply' component and the weighting was adjusted according to the percentages in Table 3.1.

Table 3.1 Performance scoring for USI, 2013 and 2014

Project performance scoring for USI in NutriDash		
	2013	2014
Main categories	Weight	
Policy environment	30%	20%
National ownership and programme governance	30%	15%
Supply	-	30%
Demand generation	10%	10%
M&E and QA/QC	30%	25%

B. Programme status

In 2014, the USI module was sent to 159 countries, with 84 countries providing responses. The responding countries represent approximately 68 per cent of the world's population. All 84 countries had USI programmes in 2014, with UNICEF supporting the programme in 48 (57 per cent) of these countries.

While there is overlap in the NutriDash indicators from the previous year, this year's data may not be comparable to 2013 because of a variation in the countries responding and some modifications made to the questions based on feedback from partners and countries. Of the 86 countries that reported in 2013, 27 countries did not report in 2014. In addition, 25 new countries reported for the first time in 2014.

The **history and duration** of USI programming varies between countries, but most countries had programmes dating back more than two decades:

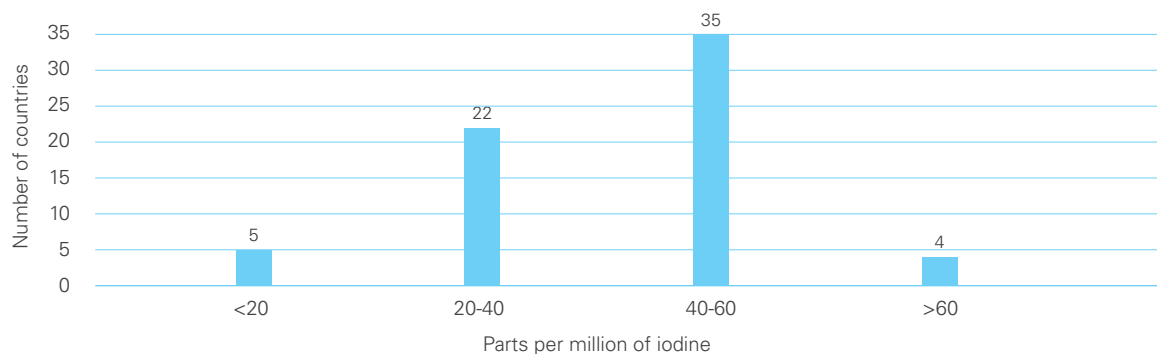
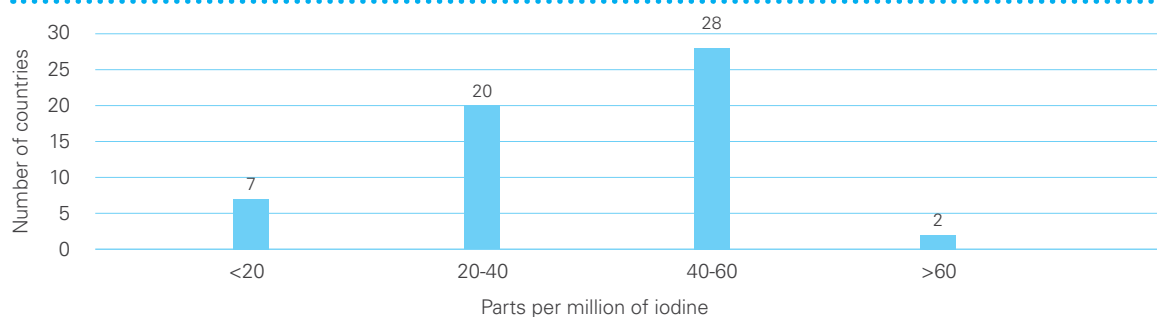
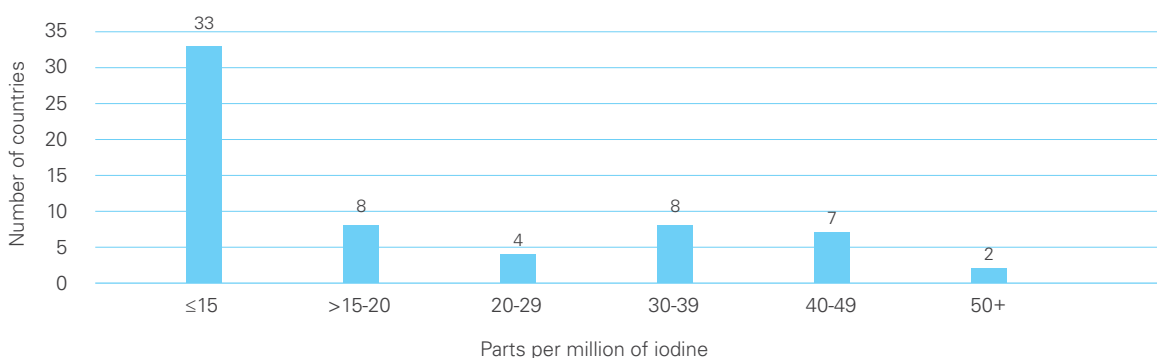
- 17 countries began programming before the 1990s;
- 35 countries began programming during the 1990s;
- 20 countries began programming between 2000-2010;
- 1 country began programming after 2010.

Countries reported varying **standards for the iodine content added to salt** at production, import and household levels.

Figures 3.1 and 3.2 show the number of countries according to the national standard of iodization (in parts per million [ppm] of iodine) at various levels.

As shown in Figure 3.1, the majority of countries have iodization standards, which regulate how much iodine is present in import or in-country production, in the range of 20-60 ppm. Four countries have iodization standards greater than 60 ppm, which is likely higher than necessary. On the other hand, there are five countries that recommend standards less than 20 ppm.

In countries that meet all or part of their national needs through imported salt, the majority of the salt iodization standards specify an iodization range of 20–40ppm iodine (Figure 3.2).

Figure 3.1 Salt iodization standards at production level (n = 66)**Figure 3.2** Salt iodization standards at import level (n = 57)**Figure 3.3** Salt iodization standards at the household level (n = 62)

At household levels, the salt iodization levels specified in national standards vary significantly (Figure 3.3). The salt iodine content (and thus the amount of iodine delivered to populations) should be chosen to meet the physiological iodine needs of all target groups. It is unclear which national standards have undertaken such an analysis when defining recommended salt iodine concentrations at household levels. In 2014, WHO defined iodization targets in relation to national salt consumption levels, and future updates may be guided by these recommendations.²⁹

²⁹ World Health Organization, 'Guideline: fortification of food-grade salt with iodine for the prevention and control of iodine deficiency disorders', 2014, <http://apps.who.int/iris/bitstream/10665/136908/1/9789241507929_eng.pdf>.

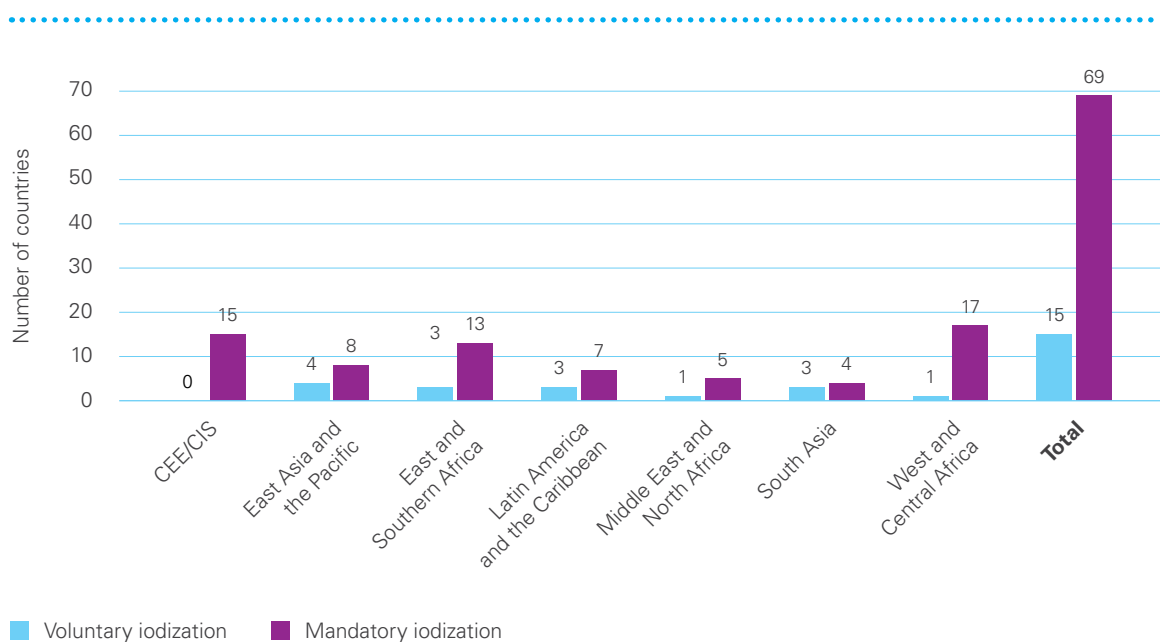
C. Enabling environment

Policy environment

UNICEF, WHO and the Iodine Global Network define USI as “the iodization of all human and livestock salt, including salt used in the food industry.” All countries reporting in 2014 have some form of USI legislation.

Legislation to enact mandatory USI is the most effective way to ensure that adequate amounts of iodized salt are supplied to households. In 2014, 82 per cent of countries (69 out of 84) reported having mandatory legislation in place, while the remaining countries (18 per cent) had voluntary legislation. Figure 3.4 provides a breakdown of the type of legislation according to region.

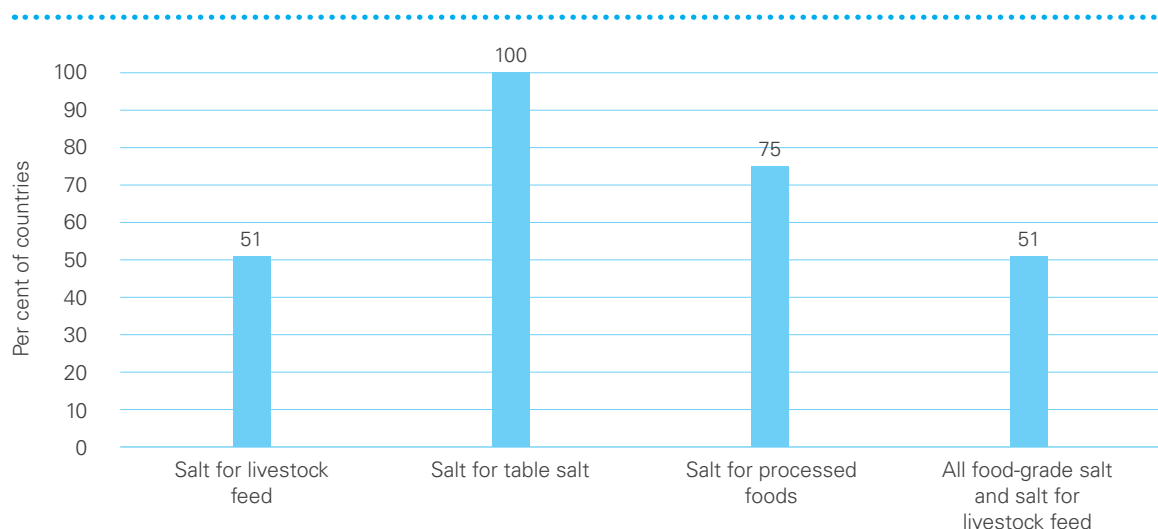
Figure 3.4 Number of countries with mandatory or voluntary USI legislation, by region



Although 69 countries reported having mandatory USI legislation, only 35 (42 per cent) had legislation comprehensive enough to meet the USI definition, i.e., legislation covering table salt, processed foods and livestock feed (Figure 3.5). In all, 75 per cent of the countries reported having legislation covering one or two processed foods, in addition to household salt.

National ownership and programme governance

Integrating the control of iodine deficiency into national nutrition and development plans is critical to ensuring long-term sustainability. A total of 66 of the 84 countries have a policy, strategy or national plan of action for the elimination of IDD. The majority of responding countries (59) have integrated control of iodine deficiency into broader health or nutrition policies or strategies.

Figure 3.5 Countries with salt iodization (n = 69) of salt commodities mandated by law

Note: Categories are not mutually exclusive

Budget allocation for USI in countries is a key measure of a strong enabling environment. In 2014, governments in 26 countries (31 per cent) were funding IDD control activities such as regulatory monitoring, advocacy and communications as well as the procurement of the fortificant required for salt iodization.³⁰ In 2013, only nine countries reported KIO₃ funded by the government, and two indicated that the fortificant funding came from both government and industry.

Reducing salt consumption, while at the same time ensuring optimal iodine intake via salt iodization, are dual public health strategies in many countries. In 2014, 33 countries had a policy, strategy, or plan of action for reducing the intake of salt to prevent chronic disease.

An effective **USI coordination body** includes participation from all key stakeholders, including private sector salt producers and processors. The effectiveness of such a coordination body was based on the development and implementation of an annual work plan with the majority of activities being achieved. Of the 84 countries, 55 reported having a coordination body for their USI programme; however, only 19 (34 per cent) of these bodies were classified as effective.

D. Supply

About half (44 out of 84) of responding countries depend on both **local production and importation** of salt for human consumption. Only 26 of the countries depend solely on imported salt, while 14 countries rely only on local production. For countries that produce salt locally, the majority comes from large and medium salt producers (Table 3.2).

Table 3.2 Percentage of domestic salt production from medium- and large-scale producers

	70% or more	Between 40% and 70%	Less than 40%	Don't know	Not applicable	Grand Total
Number of countries	34	10	10	3	1	58

³⁰ In most cases the fortificant is potassium iodate (KIO₃).

Mechanisms to ensure ongoing supply and procurement of the fortificant required for salt iodization is essential for salt iodization programmes. Sustainability of fortificant procurement and supply is most likely when industry procures the fortificant at full price without any external assistance from government or partners. In 2014, 47 countries (of 60 countries with local salt production) had a fortificant supply funded directly by industry. In 2014, only 22 countries reported depending on external assistance for KIO_3 supply and procurement. In most cases, this external support came from bilateral donor agencies and UN agencies.

In all, 16 countries (20 per cent) reported having stock-outs in 2014. A total of 51 countries reported having sufficient amounts of fortificant, while 17 did not provide information. In countries that reported stock-outs, insufficient availability of fortificant in the country was most frequently cited as the reason.

E. Communication and demand generation

In all, 43 per cent of countries (36 out of 84) have developed a **communications strategy to address bottlenecks** along the salt supply chain ranging from production or importation to the household. The target audiences for the communications strategy are wide ranging: from regulatory staff, transporters, retailers, producers and processors, to policy makers and consumers. Many opportunities remain for well designed communication approaches to better address bottlenecks along the supply chain.³¹

Iodized salt can be clearly identified in many countries, which can stimulate consumer demand. In 71 per cent of countries (60 out of 84), the majority of salt available was reported to be clearly identifiable to consumers by means of a label or logo.

F. Monitoring and evaluation and quality assurance

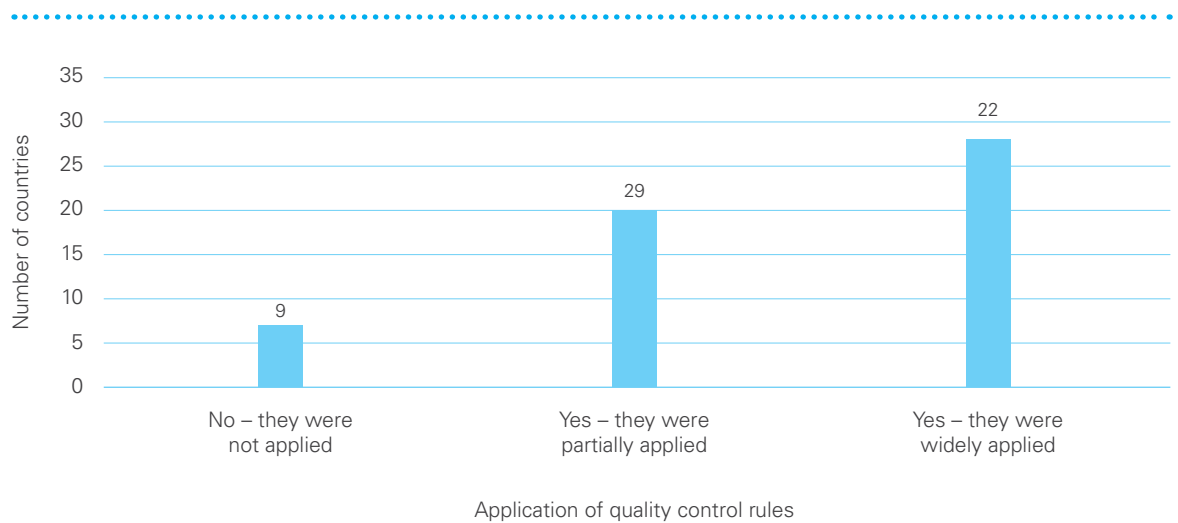
In 2014, 52 out of 84 countries (62 per cent) reported having a monitoring system to track USI programme activities at policy implementation, production and importation levels. Monitoring data was used to achieve corrective action in 44 countries (52 per cent).

Overall, the **monitoring and enforcement of legislation** on USI remains weak. Such legislation is most effective when enforced with penalties for non-compliance. A total of 23 out of 84 countries (27 per cent) reported taking punitive action against salt industries that did not comply with national legislation. At the same time, eight countries (10 per cent) took action to reward a well-performing salt industry, including through public recognition. In six countries (7 per cent), both punitive and rewarding or incentivizing actions were implemented.

While rules and procedures for **external quality assurance** do exist in many countries, their enforcement remains insufficient.³² To illustrate, in 2014, the rules and operating procedures for external quality control by national authorities were clearly established in 60 out of 84 countries (67 per cent). However, 27 of the countries (32 per cent) reported having no quality control rules at all and, as Figure 3.6 illustrates, the rules and procedures for external quality control have been insufficiently applied and enforced by national authorities in 38 countries.

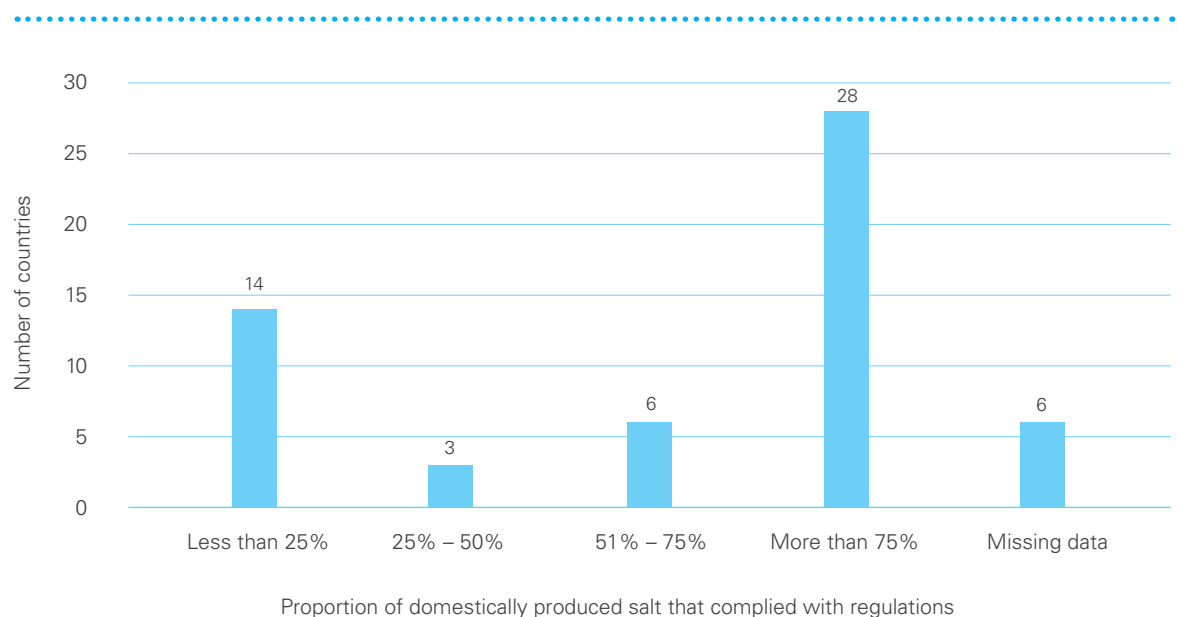
³¹ Bagriansky, J., R. Situma, and R. Kupka, 'Managing USI Communications: MUSIC', IDD Newsletter; 4, November 2015, pp.11-12.

³² External quality assurance refers to activities such as inspections mandated by the national regulatory body and carried out by food control agencies to guarantee food safety and compliance with national standards. These activities are an intrinsic part of the enforcement process as laid out by the regulations for iodized salt, and can take place at the production, import and/or retail levels, depending on the country. External quality control generally includes the inspection of records related to internal QA/QC procedures and the analysis of salt samples.

Figure 3.6 Degree to which external USI quality-control rules were enforced in practice (n = 60)

In terms of **internal quality assurance**,³³ 62 per cent of countries (52 out of 84) have obligations and responsibilities for internal quality assurance at the production level.

Countries were also asked to identify the proportion of domestically produced salt (from salt production sites) that complied with regulations in the past calendar year (Figure 3.7).

Figure 3.7 Proportion of domestically produced salt that complied with regulations (n = 58)

³³ Internal quality assurance takes place at the level of salt production and consists of specific activities that producers need to regularly carry out and document in order to guarantee that their product is of high quality and complies with national standards. This includes both the manufacturing process and monitoring of the final salt product.

As part of the monitoring process, respondents were also asked to identify whether their country had laboratories equipped to analyse iodine levels in both salt and urine. More countries (68, or 81 per cent) have access to a laboratory equipped to analyse iodine in salt compared to 47 countries (56 per cent) with access to a laboratory to analyse iodine in urine. A total of 46 countries (55 per cent) have access to a laboratory equipped to analyse iodine levels in both salt and urine.

Programme performance score

The 2014 performance score is determined by the following five weighted categories: policy environment (20 per cent); national ownership and programme governance (15 per cent); supply (30 per cent); demand generation (10 per cent); and M&E and quality assurance (25 per cent). As mentioned in the introduction to this chapter, the categories and their respective weightings have been adjusted since 2013.

The policy environment score reflects a judgment on the law, the enforcement regulations, the level of integration into national policies, budgets and reviews, and the existence of a standard for packaging. The national ownership and programme governance score reflects an assessment of the allocation of national funds and the existence, composition and functioning of a national coordination body. The supply score is based on the main sources of salt for human consumption, procurement and availability of KIO_3 .

The communication score assesses the existence of a communication strategy around IDD, the level to which iodized salt is recognizable to the consumer, and the level to which IDD is integrated into different types of education and trainings. M&E includes the existence of M&E systems, the use of data for corrective action, internal and external quality control, implementation of incentives or punitive actions, and an assessment of whether the programme has ever been evaluated.

Based on their overall percentage score, which takes into account all programme elements, countries are categorized as having very good, good, fair or insufficient programmes:

- Very good = 75–100 per cent
- Good = 50–74 per cent
- Fair = 25–49 per cent
- Insufficient = 24 per cent or less

Table 3.3 presents a comparison of the number of countries achieving each performance score – from insufficient to very good – in both 2013 and 2014.

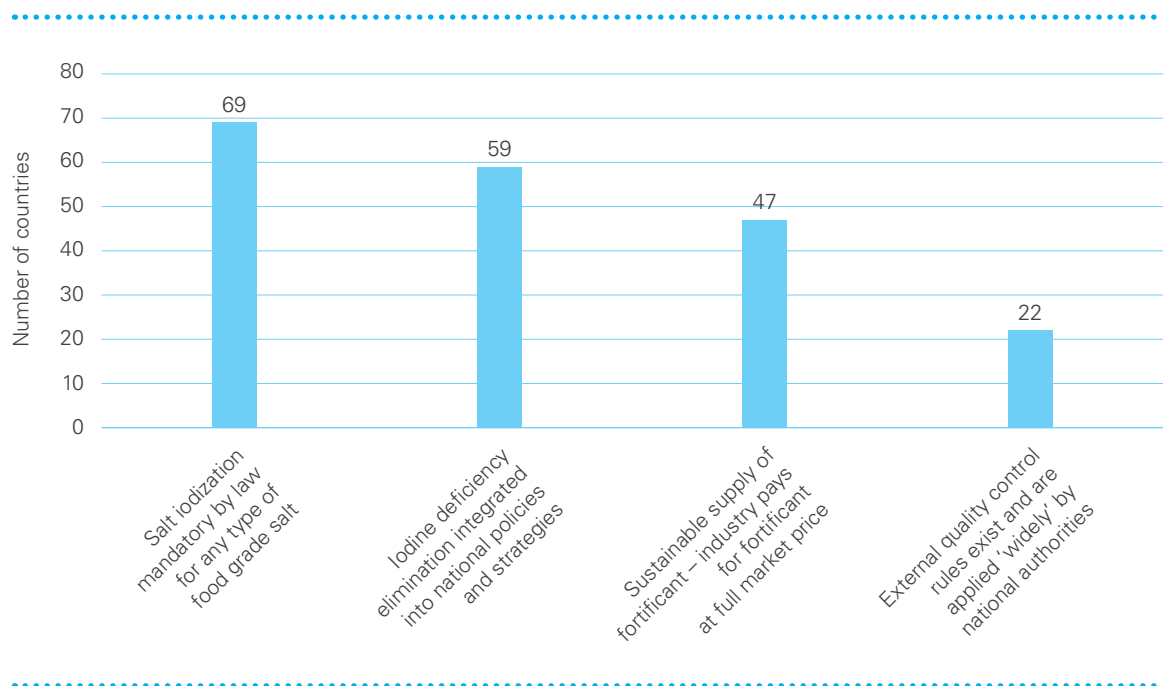
Table 3.3 USI programme performance scores, 2013 and 2014

Performance score	Number of countries	
	2013	2014
Very good	22 (26%)	25 (29%)
Good	29 (34%)	33 (39%)
Fair	23 (27%)	17 (20%)
Insufficient	12 (14%)	9 (11%)

While any comparisons between 2013 and 2014 should be made with caution due to the changes in scoring, overall trends for USI programme performance are marginally positive. In 2014, four countries more scored a rating of 'good', three more scored a 'very good' rating, and three fewer countries received a score of 'insufficient' compared to 2013.

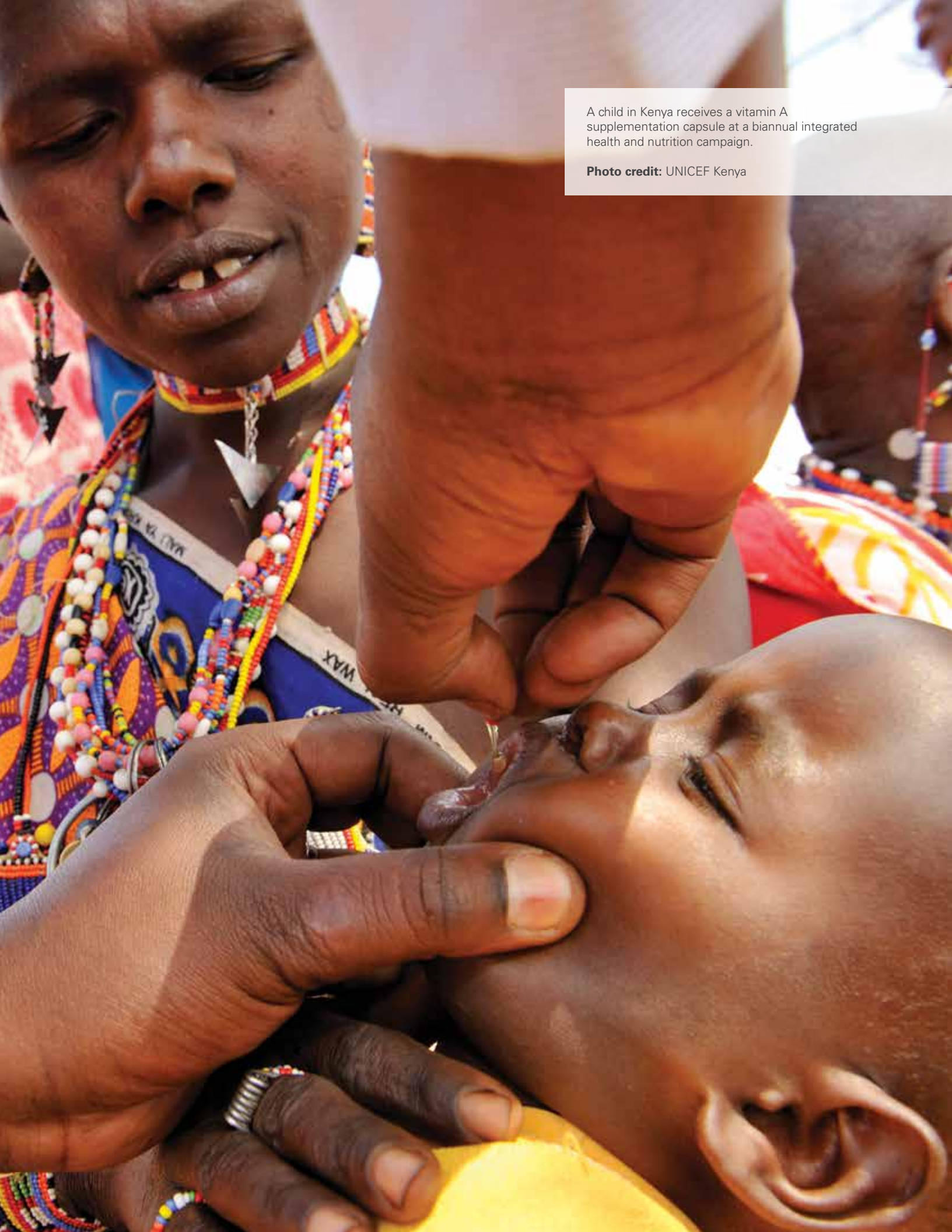
Figure 3.8 presents a summary of key indicators for national salt iodization programmes.

Figure 3.8 Summary of key indicators for national salt iodization programmes



G. Conclusions

The 2014 NutriDash demonstrates that there is strong policy support for salt iodization, as reflected by a high proportion of countries with national legislation on mandatory salt iodization. Nevertheless, a subset of respondent countries did not yet have mandatory legislation in place at the time of reporting. The current success of salt iodization programmes was achieved through largely vertical programmes. However, in the context of increasingly harmonized approaches to addressing malnutrition at the national level, integrating salt iodization and iodine deficiency control measures into national nutrition policies and strategies is likely to become increasingly important. To this effect, additional support should be offered to programmes where such integration has not yet occurred. There appears to be an increasing trend towards increased sustainability of fortificant supply systems in countries where salt production and refinement occurs, as evidenced by the fact that industry pays the fortificant at full market price. Lastly, increased efforts are needed to establish effective external quality control systems for salt iodization, ideally with strong links to the control of other fortified foods.



A child in Kenya receives a vitamin A supplementation capsule at a biannual integrated health and nutrition campaign.

Photo credit: UNICEF Kenya

4

VITAMIN A SUPPLEMENTATION AND DEWORMING

A. Background

In an effort to streamline UNICEF's global reporting systems, data on VAS and deworming programmes targeting children under 5 years of age were integrated into the 2014 NutriDash report. Given that these two interventions were often delivered using the same delivery platforms, they were considered jointly in this section. Global VAS coverage data will continue to be reported in UNICEF's annual State of the World's Children reports and are therefore not detailed here.³⁴ NutriDash also collects the vitamin A capsule (VAC) supply needs of country programmes participating in the global VAC in-kind donation programme. These data are also used to identify supply-related challenges and bottlenecks.

National coverage of deworming, defined as the proportion of preschool-age children requiring deworming that have been treated, will be reported through WHO's Preventive Chemotherapy and Transmission Control Database.³⁵ However, this current report will provide additional coverage estimates by different delivery mechanisms.

Vitamin A supplementation

Vitamin A is essential for reducing under-five mortality, particularly mortality related to diarrhoea and measles. Vitamin A deficiency (VAD) affects about one-third of children living in low- and middle-income settings, mainly in sub-Saharan Africa and South Asia, where VAD prevalence estimates have not decreased over the last two decades.³⁶ WHO recommends one high-dose vitamin A supplement (containing 100,000 IU retinol) for infants 6-11 months, and 200,000 IU retinol every four to six months for children 12-59 months in settings where VAD is a public health problem, given that these supplements can reduce child mortality by 12-24 per cent.³⁷ This recommendation has been implemented successfully in many countries, oftentimes with the support of UNICEF.

³⁴ United Nations Children's Fund, The State of the World's Children reports, <<http://www.unicef.org/sowc/>>.

³⁵ World Health Organization, 'Neglected tropical diseases', <http://www.who.int/neglected_diseases/preventive_chemotherapy/lf/en/>.

³⁶ Stevens, Gretchen, et al., 'Trends and mortality effects of vitamin A deficiency in children in 138 low-income and middle-income countries between 1991 and 2013: a pooled analysis of population-based surveys', *Lancet Global Health*, 3: e528-36, 2015.

³⁷ Imdad, Aamer, et al., 'Vitamin A supplementation for preventing morbidity and mortality in children from 6 months to 5 years of age', *Cochrane Database of Systematic Reviews*, 12, 2010.

The goal of VAS programmes is to reach all children with two annual VAS doses. For the purposes of this report, 'effective coverage' is defined as $\geq 80\%$ coverage per delivery mechanism in a six-month period (January-June or July-December). VAS should be delivered during routine health system contacts, such as for vaccinations, and, if required, should be integrated into national immunization days (NIDs) or other vertical child health and survival programmes such as child health days (CHDs). The first VAS events, initiated in the 1990s, linked VAS with NIDs for poliomyelitis eradication, and this practice is still being maintained in settings affected by poliomyelitis disease. CHDs draw on available human and physical resources of the health sector, often with financial and technical support from development partners. When appropriately planned and targeted, they achieve far greater coverage than the routine primary health care system, which is often too weak to reach children reliably with VAS and other preventive interventions. This is especially true once a child has completed the routine vaccination schedule in late infancy. With the progress achieved towards eradication of poliomyelitis, NIDs are likely going to be phased out in the near future and therefore cease to serve as a delivery platform for VAS, deworming and other interventions. CHDs promise to serve as an alternative delivery platform to NIDs to safeguard against potential coverage drops of high-impact interventions.

Some countries have started to scale back VAS in settings where national programmes to regularly increase vitamin A intakes are successful and VAD has been eliminated. However, in many countries in sub-Saharan Africa and South Asia, there remains a need to strengthen programmes to increase vitamin A intakes and maintain high VAS coverage. Partners in the Global Alliance for Vitamin A (GAVA) have developed a framework to guide countries in assessing their specific situations. This includes guidance on the importance of identifying dietary sources of vitamin A and whether these may be sufficient to warrant assessing VAD at the population level. The guidance assists policy makers in determining whether VAD has been eliminated and therefore, when a scale-back could be considered.

Deworming

Soil-transmitted helminths (STH), or intestinal worms, constitute a serious public health problem in tropical climates with poor sanitation. Globally, 269 million preschool-age children are affected by STH,³⁸ which prevent nutrient absorption and affect both growth and learning. Deworming interventions are thus critical to achieving sustainable nutrition outcomes. The global goal is to eliminate STH-related morbidity in children by 2020. To attain this, there is a need to regularly treat at least 75 per cent of children living in endemic areas. A single annual treatment is required where the STH prevalence is 20-50 per cent, and two annual treatments where the STH prevalence exceeds 50 per cent.³⁹ UNICEF has a long history of supporting the delivery of deworming medications to preschool children through periodic events such as CHDs or integrated immunization campaigns.

B. Programme status

Vitamin A supplementation

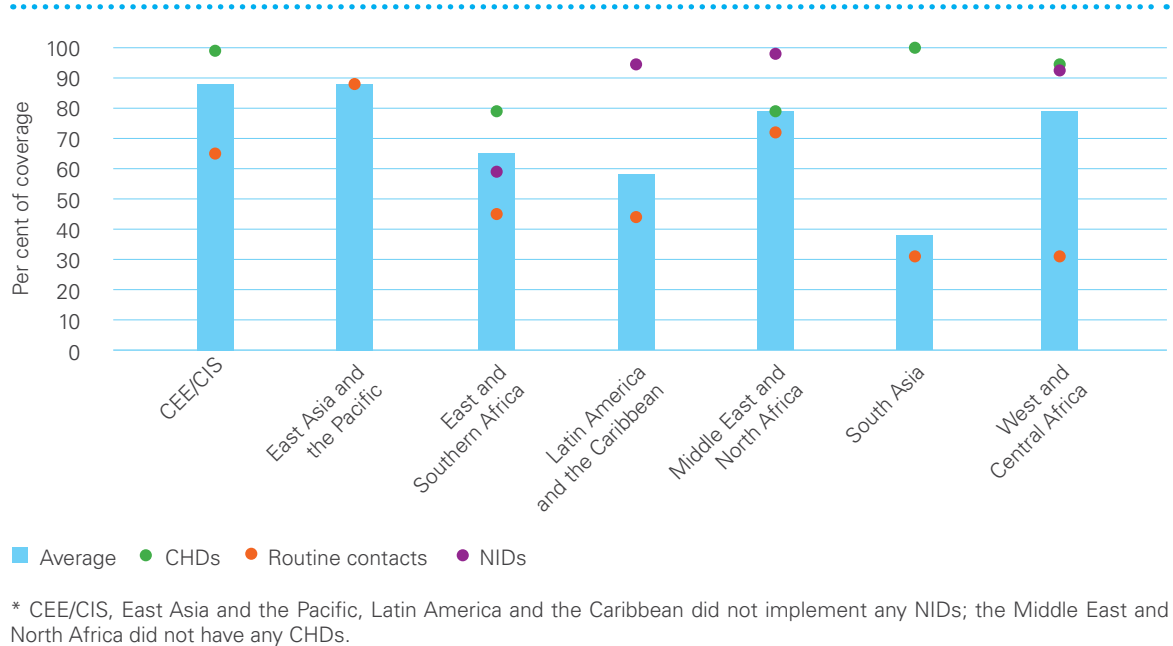
In 2014, the global coverage of the 82 priority countries was 69 per cent.⁴⁰ NIDs achieved the highest coverage of all delivery mechanisms (90 per cent globally), while CHDs followed closely behind at 86 per cent coverage. Routine contacts achieved the lowest coverage at only 47 per cent globally. However, there was some variation between regions (Figure 4.1), and some regions have already phased out NIDs. In each of these regions (CEE/CIS, East Asia and the Pacific, and Latin America and the Caribbean), CHDs reached over 85 per cent on average.

³⁸ World Health Organization, 'Soil-transmitted helminthiases: number of children treated in 2014', Weekly Epidemiological Record, no. 51/52, 2015, 90, 701–712. Full Link can be found here http://www.who.int/neglected_diseases/en/.

³⁹ World Health Organization, 'Deworming to combat the health and nutritional impact of helminth infections,' last updated August 2015, <<http://www.who.int/elena/titles/deworming/en/>>.

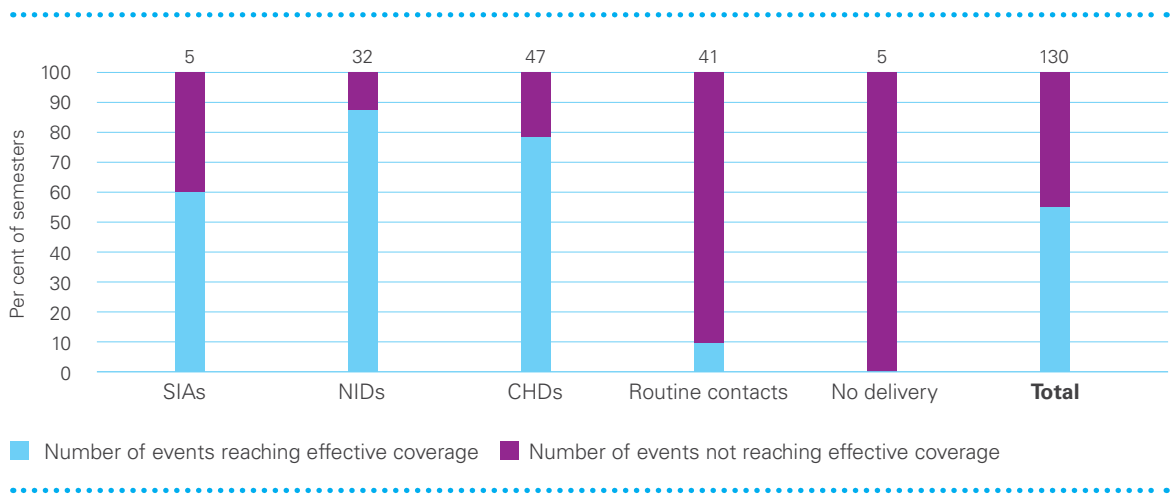
⁴⁰ United Nations Children's Fund, 'Vitamin A Deficiency: Child health events enable many countries in West and Central Africa to achieve over 80 per cent coverage of vitamin A supplementation,' <data.unicef.org/nutrition/vitamin-a.html>.

Figure 4.1 Mechanisms used to deliver VAS in 63 countries, by region, 2014



Data for VAS in 2014 was collected from July to August 2015. A total of 73 countries submitted coverage data for 152 total semesters of delivery.⁴¹ After a quality check review in August, data was accepted for 63 countries (130 semesters). Fifty-five per cent of these semesters of delivery achieved effective coverage (Figure 4.2). NIDs and CHDs had the highest proportion of events with effective coverage (88 per cent of NIDs and 76 per cent of CHDs) followed by Supplementary Immunization Activities (SIAs) which had 60% of events reach effective coverage. Of the 41 semesters of VAS delivery through routine contacts, only four achieved effective coverage.

Figure 4.2 Delivery mechanisms reaching more than 80 per cent of children 6-59 months old



⁴¹ For most countries, only two semesters of delivery are considered for VAS coverage (one coverage figure for January-June, one coverage figure for July-December). A few countries deliver VAS through both campaigns and routine contacts in distinct districts or states. These countries are considered to have more than two semesters of coverage in order to fully account for the multiple delivery mechanisms.

Deworming

Global reported deworming coverage for preschool-aged children has steadily declined from 37.1 per cent in 2010 to 30.6 per cent in 2011 and 24.7 per cent in 2012.⁴² The 2013 global coverage estimate, prior to UNICEF's involvement in the global reporting process, was 23.9 per cent.⁴³ This was subsequently revised to 49.1 per cent after UNICEF's data collection exercise to integrate deworming data from CHDs into the WHO's global deworming database.⁴⁴ In 2014, 44 of 106 countries reported on deworming through NutriDash, again substantially contributing to global reported coverage. Combined, these countries represent almost 45 per cent of the total STH burden.

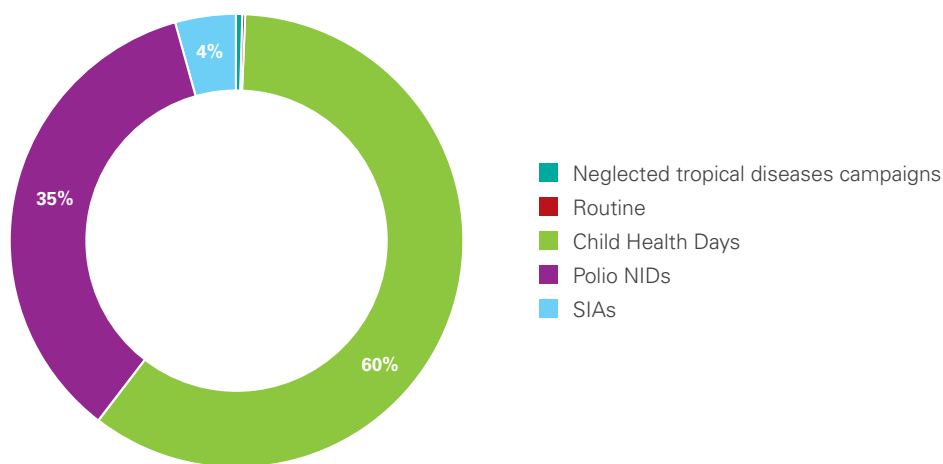
Coverage and delivery mechanisms

In total in 2014, more than 214 million deworming treatments were delivered via 76 reported events, achieving an average coverage of 81 per cent.

In all, 59 per cent of mass deworming activities in 2014 were part of CHDs (Figure 4.3). These events achieved an average of 79 per cent coverage from 44 events. NIDs delivered 30 per cent of deworming treatments, achieving a very high coverage of 94 per cent from 18 events. Other delivery mechanisms included measles campaigns, other immunization events, tropical disease campaigns and routine delivery.

Of the 35 countries that reported and required two rounds of deworming, 83 per cent conducted both rounds while 17 per cent conducted only one round. In many cases deworming and VAS were delivered using the same platform. However, in approximately 22 per cent of events, the coverage of these interventions differed by more than 5 per cent, and 13 per cent of events varied by more than 10 per cent.

Figure 4.3 Proportion of deworming treatments for preschool-aged children delivered via different delivery mechanisms



⁴² World Health Organization, 'Soil-transmitted helminthiases: estimates of the number of children treated in 2012', *Weekly Epidemiological Record*, vol. 89, no. 13, 2014, PMID: 24707519.

⁴³ World Health Organization, 'Soil-transmitted helminthiases: number of children treated in 2013', *Weekly Epidemiological Record*, vol. 90, no. 10, 2015, pp. 89–96, PMID: 25745678

⁴⁴ Kumapley, R.S., R. Kupka, and N. Dalmiya, 'The Role of Child Health Days in the Attainment of Global Deworming Coverage Targets among Preschool-Age Children', *PLoS Neglected Tropical Diseases* vol. 9, no. 11, 2015, PMID: e0004206, DOI:10.1371/journal.pntd.0004206.

C. Challenges, bottlenecks and conclusions

The analysis of country-level coverage data from deworming and VAS programs illustrates that these programs often achieve unequal coverage estimates. In many cases, these differences cannot be explained by differences in delivery platforms or differences in target age ranges. Such coverage gaps are therefore lost opportunities for children and efforts should be made to address underlying bottlenecks.

To ensure a sustained, high coverage of VAS and deworming among preschool children, delivery mechanisms should be tailored to the performance of a country's health system. The following recommendations can be made:

- In settings with weak health systems, planning should be improved such that CHDs are included in multi-year strategic plans, and performance data are reviewed and analysed to identify areas needing additional resources to obtain high coverage in the future. These events should reinforce the health system. This planning will be particularly important in countries transitioning from NIDs.
- In settings with stronger health systems, CHDs may already be part of country plans and serve as a primary delivery strategy for VAS, deworming and other interventions. As such, efforts should be made to ensure financing is sustainable, delivery strategies are tailored at the sub-national level to achieve high coverage and CHDs are integrated into routine management systems, for both commodities and monitoring.
- In countries with strong health systems, but where some populations still have lower access or the country has recently transitioned to routine services, the area of focus differs. Routine delivery needs to be strengthened, enhanced outreach activities through CHDs or other approaches should be integrated as part of the primary health care workers' responsibilities to ensure they are conducted without additional incentives, and those with poor access need to be identified and a strategy for reaching them periodically (every six months) developed.



Saniati, 45, is the grandmother of Mikaela (aged 1 year) and a local health cadre who received training from UNICEF. Saniati owns a small snack stand, sells clothes and volunteers in a cadre, spreading information about the benefits of breastfeeding and child nutrition within her community.

Photo credit: Josh Estey/UNICEF

5

HOME FORTIFICATION WITH MICRONUTRIENT POWDERS

A. Background

The provision of micronutrient powder (MNP) is an important strategy for improving the dietary quality of complementary food for young children and other vulnerable populations. Increasingly, MNP is also being used during humanitarian action to prevent micronutrient malnutrition among affected populations. In MNP programmes, caregivers mix the product into the foods they prepare for children in the home. The approach works well, in part, because it enables caregivers to improve their family's diet without a significant change to dietary practices or lifestyle. In institutional settings, such as schools or day care centres, MNP can be mixed into the food before it is served to children, resulting in high intake adherence among those who attend such institutions regularly. Given that most MNP contains at least iron, they are effective at improving iron status and reducing anaemia in children from 6 to 23 months or beyond.⁴⁵

UNICEF is one of the leading supporters of home fortification programmes worldwide. At the country level, this work involves supplying MNP, advocating for strong MNP programming, developing demand and behaviour change strategies, and ensuring that programmes are monitored and evaluated. At the international level, UNICEF co-chairs the global interagency Home Fortification Technical Advisory Group, which has published guidelines and tools for the planning and implementation of MNP programs.⁴⁶

The NutriDash MNP module allows for the tracking of multiple MNP interventions within the same country (see box 'Defining MNP interventions'). Each intervention is tracked separately against indicators related to the enabling environment, supply and delivery, and monitoring.

In 2014, the MNP questionnaire was revised to include questions about the inclusion of MNP in the list of national health essential commodities, whether the MNP programme was implemented in the development or emergency context, whether there are MNP interventions that prescribe breaks between interventions and what type of MNP indicators were included in the national monitoring systems.⁴⁷ The questionnaire refocused on children under 5 years of age, the overall number of questions decreased to reduce reporting burdens and other questions were refined based on user feedback.

⁴⁵ World Health Organization, 'Use of multiple micronutrient powders for home fortification of foods consumed by infants and children 6–23 months of age: Guideline', <http://www.who.int/nutrition/publications/micronutrients/guidelines/guideline_mnp_infants_children/en/>.

⁴⁶ Home Fortification Technical Advisory Group, Toolkit, <<http://www.hftag.org/resources/toolkit/>>, accessed 17 December 2015.

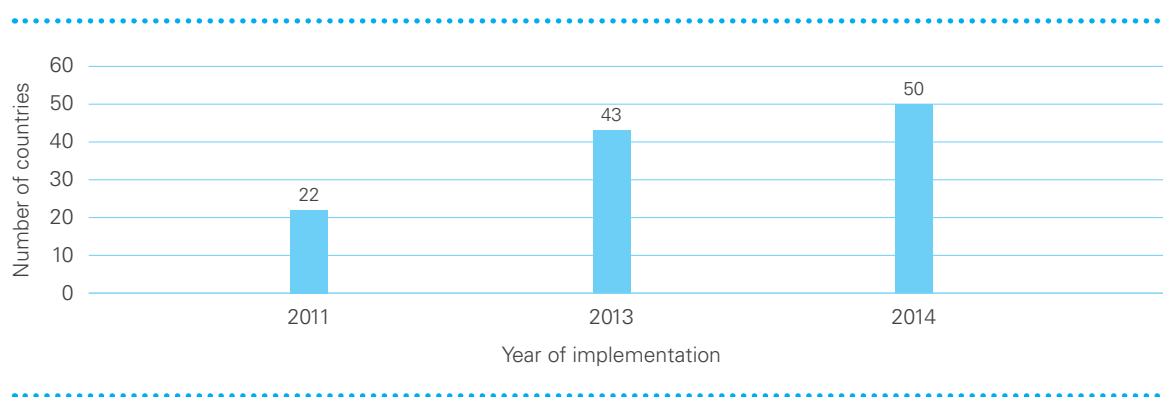
⁴⁷ Consumption should be, at minimum, for a period of two months, followed by a period of three to four months off supplementation, so that use of the micronutrient powders is started every six months as described in the WHO guideline, <http://www.who.int/nutrition/publications/micronutrients/guidelines/guideline_mnp_infants_children/en/>.

Defining MNP interventions

An intervention is defined by its **target group** and the **MNP formulation** used. If two different groups are being targeted, this is considered to be two different interventions. If two different MNP formulations are being used for the same target group, then these are also considered to be two separate interventions.

If one intervention is exactly the same as another (same target group, same product) but is implemented by a different agency/organization in isolation from the first, it should also be considered a separate intervention.

Figure 5.1 Number of countries with MNP interventions, 2011, 2013 and 2014



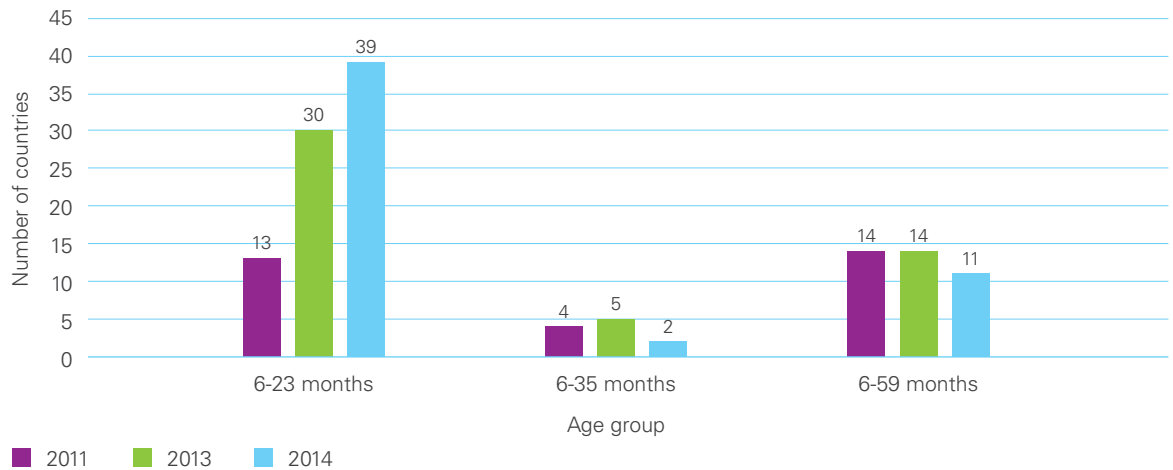
B. Programme status

Globally, the number of MNP programmes has continued to grow steadily since 2011 (Figure 5.1). In 2014, 68 countries responded to the MNP module, of which 50 reported to be implementing MNP interventions. This represented an increase of seven countries implementing MNP interventions compared to 2013.

In 2014, a total of 59 interventions were implemented across the 50 countries. Full data were available for 53 of these interventions, and partial information was available for the other six. Therefore, the denominator for interventions may vary depending on where data was provided. In 2014, 90 per cent of MNP interventions were implemented in development contexts and the remainder in emergency contexts.

Compared to the previous year, the 2014 findings showed an increase in the number of interventions being implemented for the 6–23 month age group (Figure 5.2). This may be due to the increased positioning of MNP interventions as an integral part of IYCF programming, which prioritizes improving the nutrition status of children in the first 1,000 days.

Figure 5.2 Number of MNP interventions implemented for each age group, 2011, 2013 and 2014



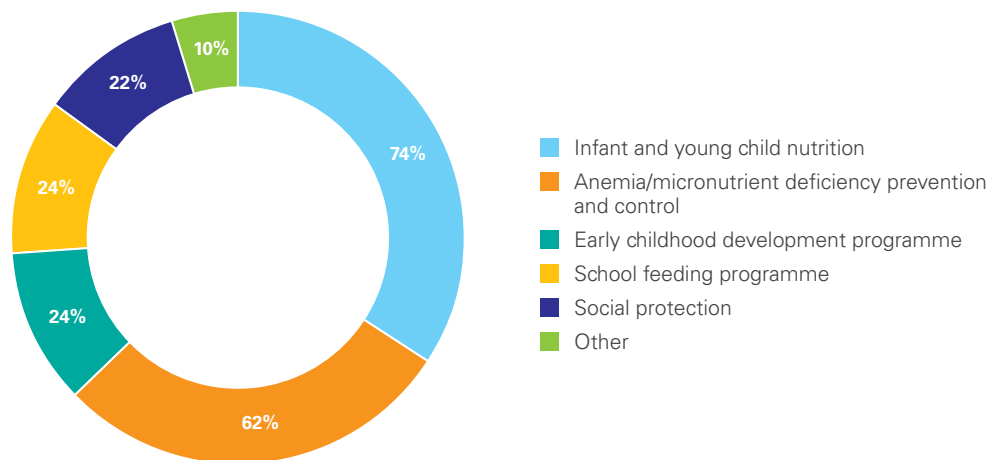
C. Enabling environment

As with other programmes, an important part of measuring the enabling environment is determining whether home fortification with MNP is included in the national nutrition plan or strategy. In 2014, MNP interventions were part of national nutrition strategies in 44 countries, while 16 countries included MNP on the national list of essential commodities for health and nutrition (in an additional five countries, the inclusion process was ongoing).

MNP interventions are often implemented alongside other programmes (Figure 5.3). The majority of MNP interventions were integrated into other nutrition or nutrition-related programmes, mostly programmes for IYCF or efforts to control anaemia and micronutrient deficiencies.

In 2014, 16 of the 59 MNP interventions were partially or totally funded by national governments, three by the private sector and the rest by development partners.

Figure 5.3 Percentage of MNP interventions integrated into other programmes, by type of programme (n = 46 interventions)

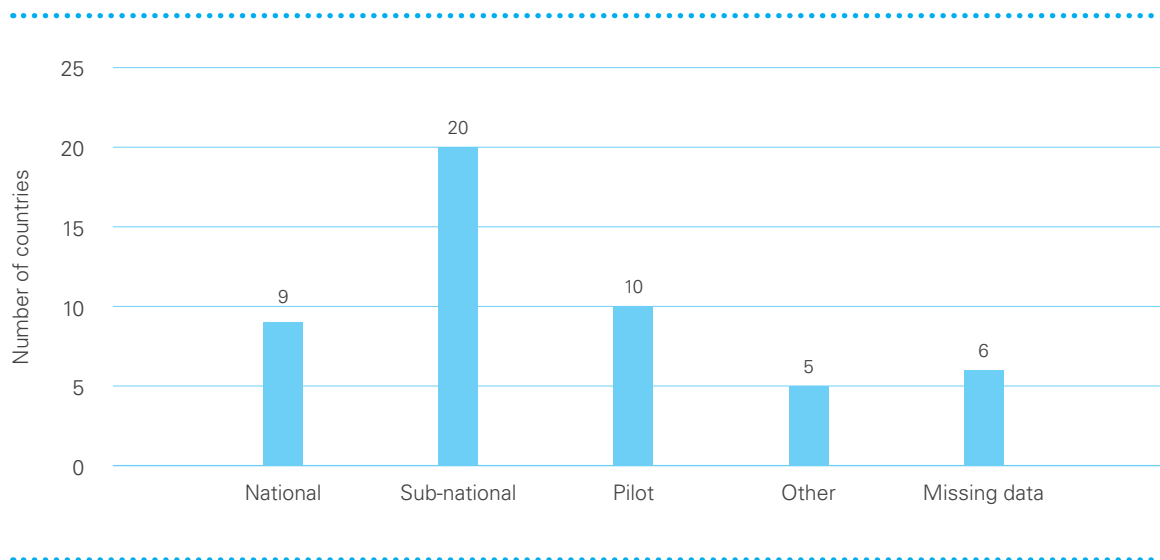


Note: Responses allowed for MNP integration into more than a single sector.

D. Supply & delivery

In 2014, nine countries were implementing MNP interventions on a national scale,⁴⁸ and another 22 countries planned to bring MNP interventions to national scale in 2015 (Figure 5.4).

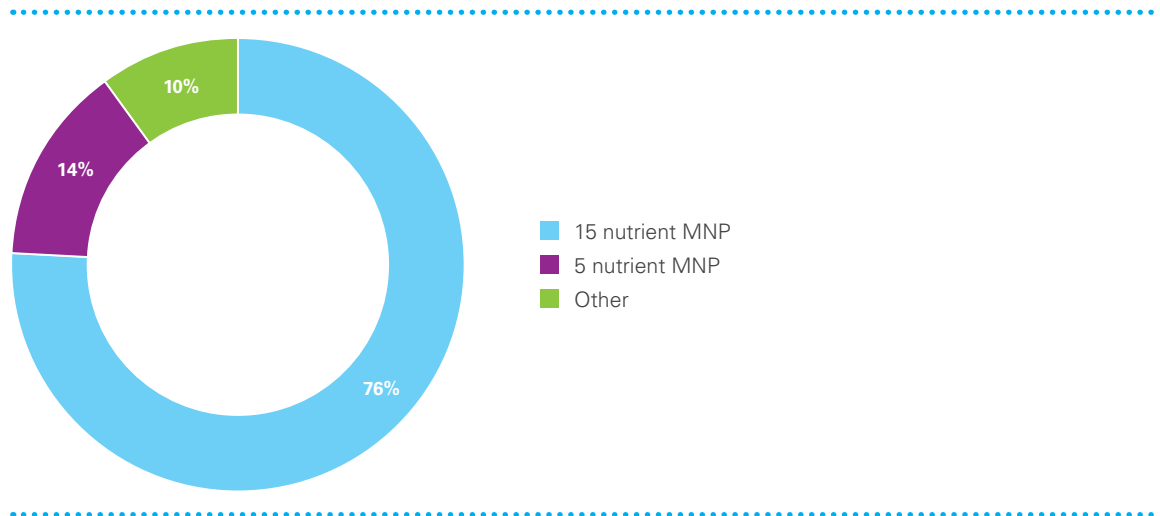
Figure 5.4 Scale of MNP interventions by country



The number of national level interventions reduced slightly in 2014, from 13 to 9. The reduction is associated with some countries facing funding challenges and others being affected by humanitarian emergencies, as well as differing response rates between the years of data collection.

Most of the MNP interventions reported using the 15-nutrient MNP formulation (Figure 5.5).

Figure 5.5 Proportion of interventions by MNP formulation (n = 53 interventions)

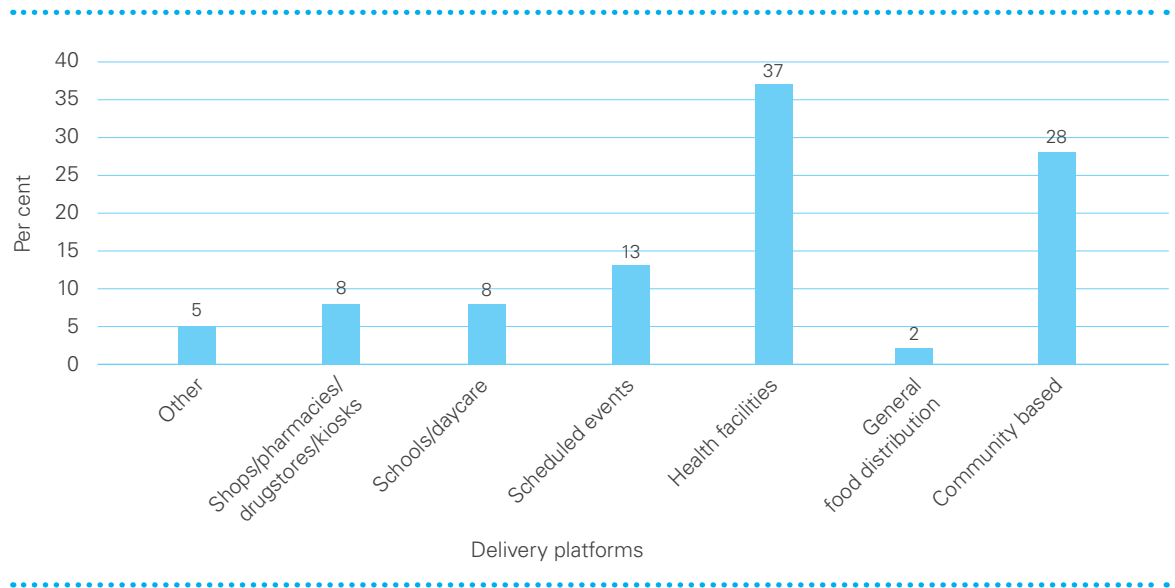


⁴⁸ MNP programme is defined as being at national scale when the targets of eligible groups or geographical areas, as defined by the country, have been reached.

Ensuring that populations have financial access to MNP is critical to advancing equity. In 2014, 83 per cent of MNP interventions (44 out of 53 interventions for which information was available) provided MNP for free, while the remaining 17 per cent provided MNP at a cost to participants. Out of the nine interventions that charge the participants, three charged full price, one charged a subsidized price while the remaining five did not indicate whether full or subsidized price was charged.

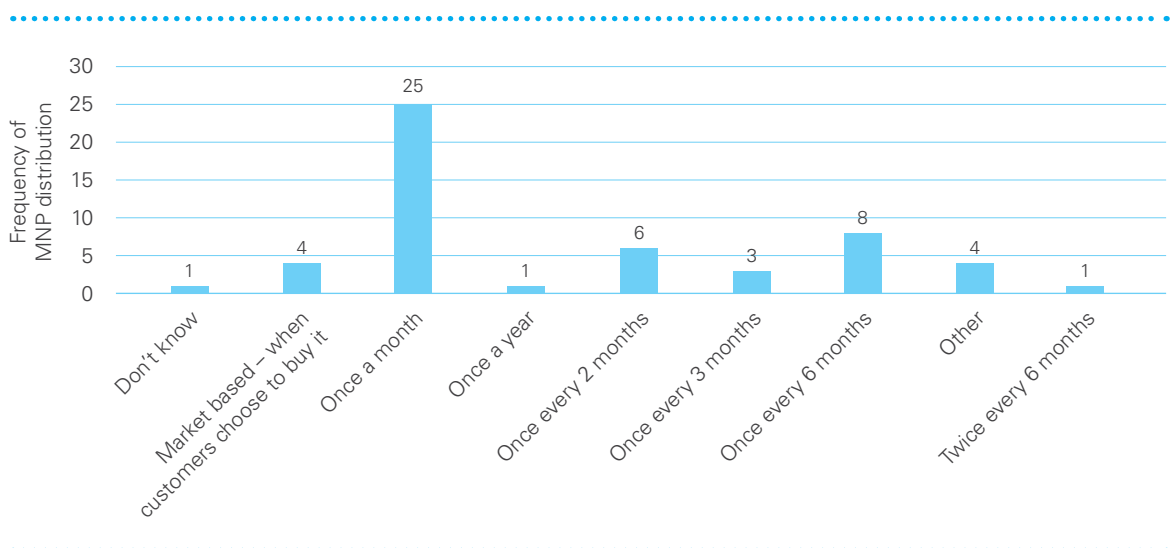
In 2014, respondents provided information about the delivery channels used by MNP interventions. Health facilities (37 per cent) and community-based platforms (28 per cent) were the most common delivery channels. The data for all delivery platforms is presented in more detail in Figure 5.6.

Figure 5.6 Percentage of MNP interventions by delivery platforms (n = 53 interventions)



Distribution of MNP differs across interventions. For the majority (25) of interventions, MNP is distributed once a month (Figure 5.7).

Figure 5.7 Frequency of distribution of MNP interventions (n = 53 interventions)



Countries were also asked to report on the recommended MNP consumption schedule. The most common MNP consumption schedule noted was 60 sachets over a six-month period (Figure 5.8). A total of 25 countries prescribed a three to four month break as part of their MNP schedule, meaning that MNP was consumed for two or three months followed by a three to four month pause.⁴⁹ The majority of interventions (30) recommend using one MNP sachet daily (Figure 5.9).

Figure 5.8 MNP consumption schedule by number of interventions and number of sachets over a six-month period (n = 53)

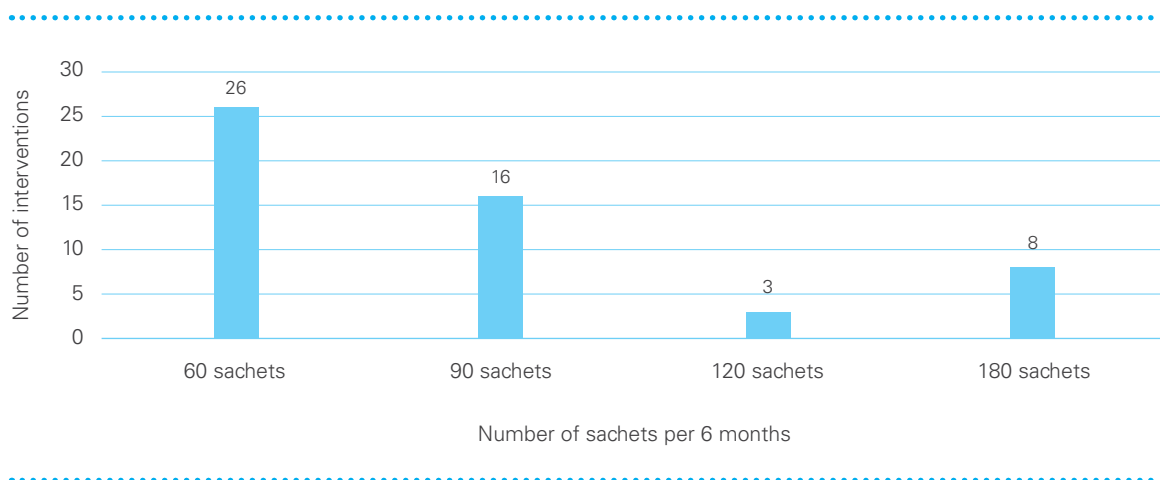
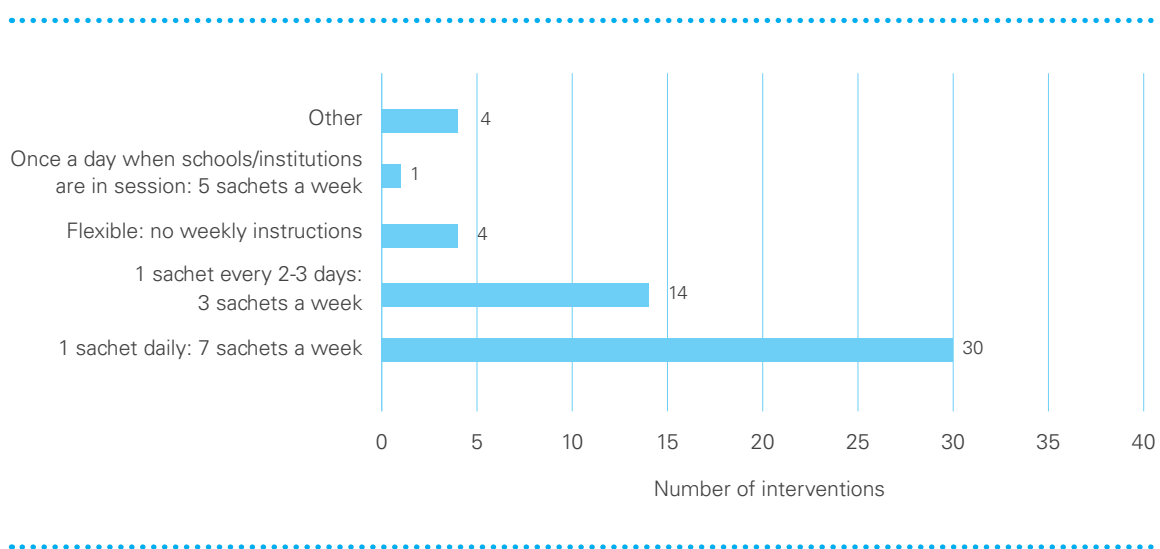


Figure 5.9 Weekly MNP intake by number of interventions (n = 53)



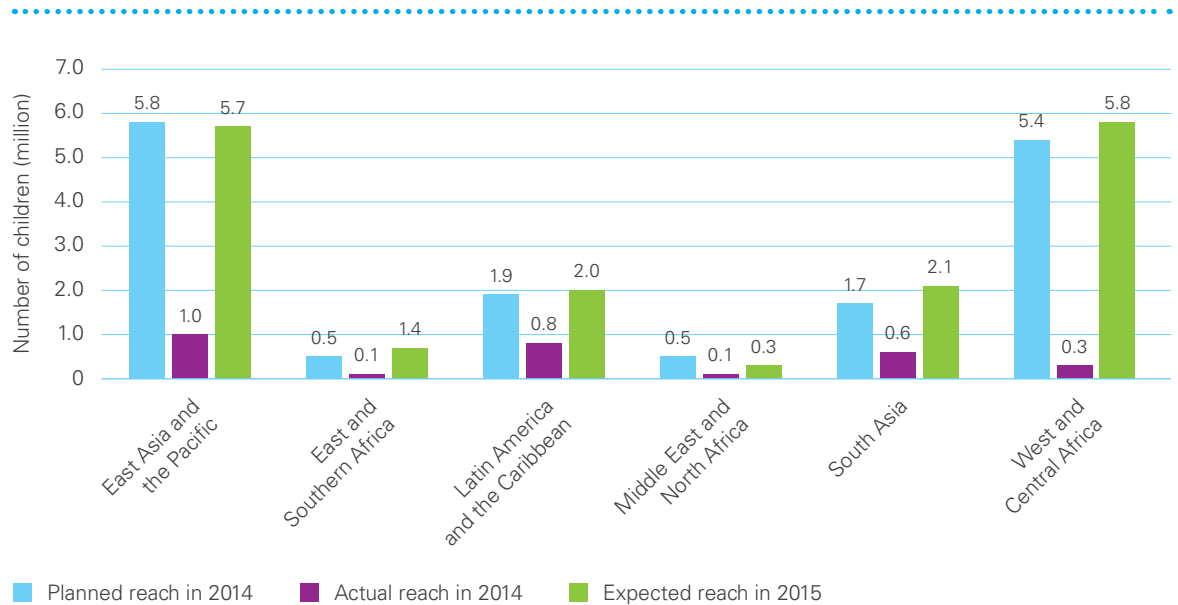
⁴⁹ Consumption should be at a minimum of two months, followed by a period of three to four months off supplementation, so that use of the micronutrient powders is started every six months as described in the WHO guideline.

E. MNP programme reach

According to NutriDash, only 3 million children aged 6–59 months were reached with MNP in 2014 against the planned target of 15 million (Figure 5.10).

Many countries reported that lack of funding for the delivery of MNP programmes resulted in this limited reach against the planned targets. Other factors included inadequate monitoring systems as well as limited implementation of behaviour change interventions. For 2015, countries expected to reach 17 million children aged 6–59 months, of whom 14 million are 6–23 months old.

Figure 5.10 Number of children reached by MNP programmes in 2014 and planned for 2015, by region

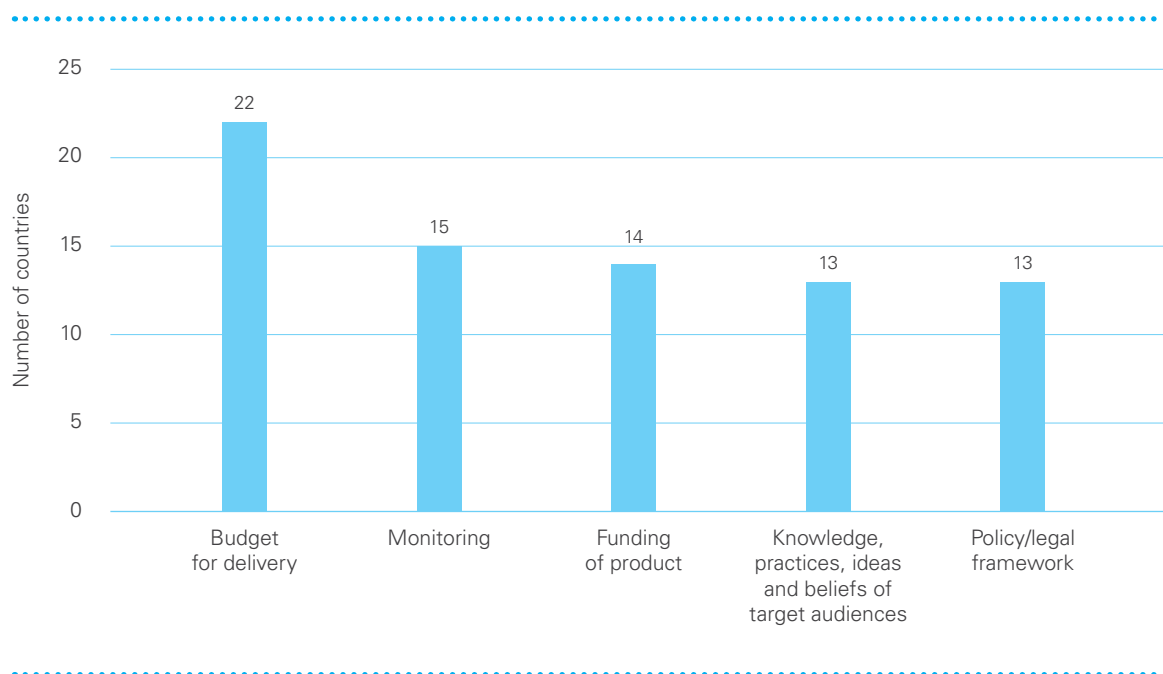


At the time of data collection, no MNP programmes existed within CEE/CIS

F. Monitoring

The monitoring of MNP interventions still requires strengthening across all regions. While in 2014, 43 countries (of the 50 implementing interventions) reported having a monitoring system in place for MNP interventions, programme monitoring was rated as one of the top five challenges. Other reported challenge areas included the limited capacity of health facilities to monitor and analyse data, overall weak health systems and limited resources for monitoring.

About a third of countries (17 of 50) reported having integrated their monitoring of MNP interventions into government health systems or community-level monitoring systems. The indicators being tracked varied from intervention to intervention, but most indicators focused on measuring the distribution of MNP sachets.

Figure 5.11 Challenges faced in implementing MNP by reporting countries

Challenges, bottlenecks and conclusions

Insufficient resources for programme delivery was reported as the most common challenge faced by MNP programmes (Figure 5.11). Responses further indicated that the rapid expansion of MNP programmes in recent years has required rapid learning and increased technical support in specific programme areas, including monitoring, design and implementation of behaviour change interventions.

Overall, more countries were implementing MNP interventions in 2014 as compared to 2013. In most of them, the enabling environment improved, with the majority of MNP interventions being integrated into broader programmes such as IYCF. In addition, MNP was part of the essential health and nutrition commodities list, signifying national ownership of MNP interventions.

With countries having projected a reach of up to 17 million children for 2015, it became apparent how crucial it is to improve procurement and secure funding to ensure programme sustainability over the long term. Furthermore, the other challenges identified by countries, such as the monitoring, design and implementation of behaviour change interventions, were all those that required urgent attention.

CONCLUSIONS AND WAY FORWARD

The importance of having good data to measure programme performance and coverage cannot be overstated. In its second year of existence, NutriDash has contributed to this objective by strengthening routine monitoring and reporting at global, regional and country levels. The ability of NutriDash to systematize and harmonize reporting on nutrition indicators and guide supply forecasting can provide critical support to countries in improving their programme performance.

A. Progress and challenges across programme areas

The 2014 findings revealed some common threads through all the programmes, including areas that had improved since the pilot year and those that appeared stalled or required further intervention.

The enabling environment

Many countries made progress on the enabling environment, particularly with respect to policy, though in some cases the policies needed better enforcing. Almost all countries (97 per cent) had some form of IYCF policy and an additional 25 new countries reported having a policy in 2014 compared to 2013. Similarly, all responding countries reported having USI legislation – an improvement from 2013 where 10 per cent of countries had no legislation at all. Eighty-eight per cent of countries (44 out of 50) integrated MNP into their national nutrition and development strategies, whilst in five countries the national nutrition strategy was still being developed. Overall trends for SAM were positive, with more countries reporting that SAM management had been integrated into national nutrition policies, strategies and budgets. However, more analysis is needed to determine how the enabling environment can help support larger scale programmes in different country contexts.

Communication and demand generation

Strategies were weak in a number of programme areas. While many countries communicate IYCF messages, the quality of such communications is likely low given that many lack a communication strategy or the formative research needed to inform such a strategy. Similarly in the case of USI, only 43 per cent of countries had a communication strategy that addressed bottlenecks and reached audiences along the supply chain. In terms of demand, SAM programmes saw an increase in admissions from 2.91 million children in 2013 to 3.21 million children in 2014; however, the rate of global increase continued to plateau from the previous year and was still far from the total burden of SAM cases. For MNP, there was an increase in children reached from the previous year; however, the total reach still fell short of planned targets.

Supply

For the programme areas that involved supply forecasting, results were generally positive. For USI, an impressive 47 countries had sustainable supplies of KIO₃ funded directly by industry and few reported problems with stock-outs. In terms of SAM management, the number of countries reporting that RUTF was part of the essential supplies list rose from 21 countries in 2012 to 31 in 2014. In terms of vitamin A programming, 55 countries submitted forecasts for the in-kind donation of vitamin A supplements for 2016, and an additional 12 provided data on the procurement of VACs through other sources.

Monitoring and Evaluation

While an increasing number of countries are implementing systems for M&E, this is often cited as an area in need of improvement. The mainstreaming of IYCF indicators in the HMIS as well as routine reporting on IYCF at the community level remain a challenge, and information about training coverage is often not available. While rules and procedures for external quality control of USI do exist in many countries, their enforcement remains insufficient. The M&E of MNP programmes also requires further strengthening.

B. Moving forward

In 2014, there was an increase in the number of countries responding to NutriDash, resulting in a more accurate picture of nutrition interventions at the global level. Despite the increased response rate, it was not always the same countries reporting year after year, making it difficult to suggest comparisons. Reporting will need to be further improved in order to monitor and report on trends.

Data quality will continue to improve over time as reporting becomes more systematic and questionnaires are further refined with feedback from participating countries. While the 2014 NutriDash findings were an important starting point for national conversations on nutrition programming, further details will help to strengthen programmatic decision-making in the future.

In order to improve the quality of responses in future years, and reduce the need for follow-up with countries, UNICEF will conduct a series of training webinars on NutriDash data entry. UNICEF will also allow for more comprehensive reporting in certain programme areas from 2015. For example, a separate MAM module will be developed to complement the SAM treatment data and allow for analysis of the continuum of care in and across countries.

The next round of NutriDash data collection will take place in early 2016 and will streamline and improve the system moving forward. Country-level usage of the data, which has been robust to date (with 37 different countries accessing the online pages), will be further enhanced by ensuring a quicker process for data quality check and cleaning. This will make 2015 data more readily available for analysis and use by countries, including for internal planning and performance monitoring.

Figure A.1 Reporting rates by countries on SAM indirect programme treatment coverage

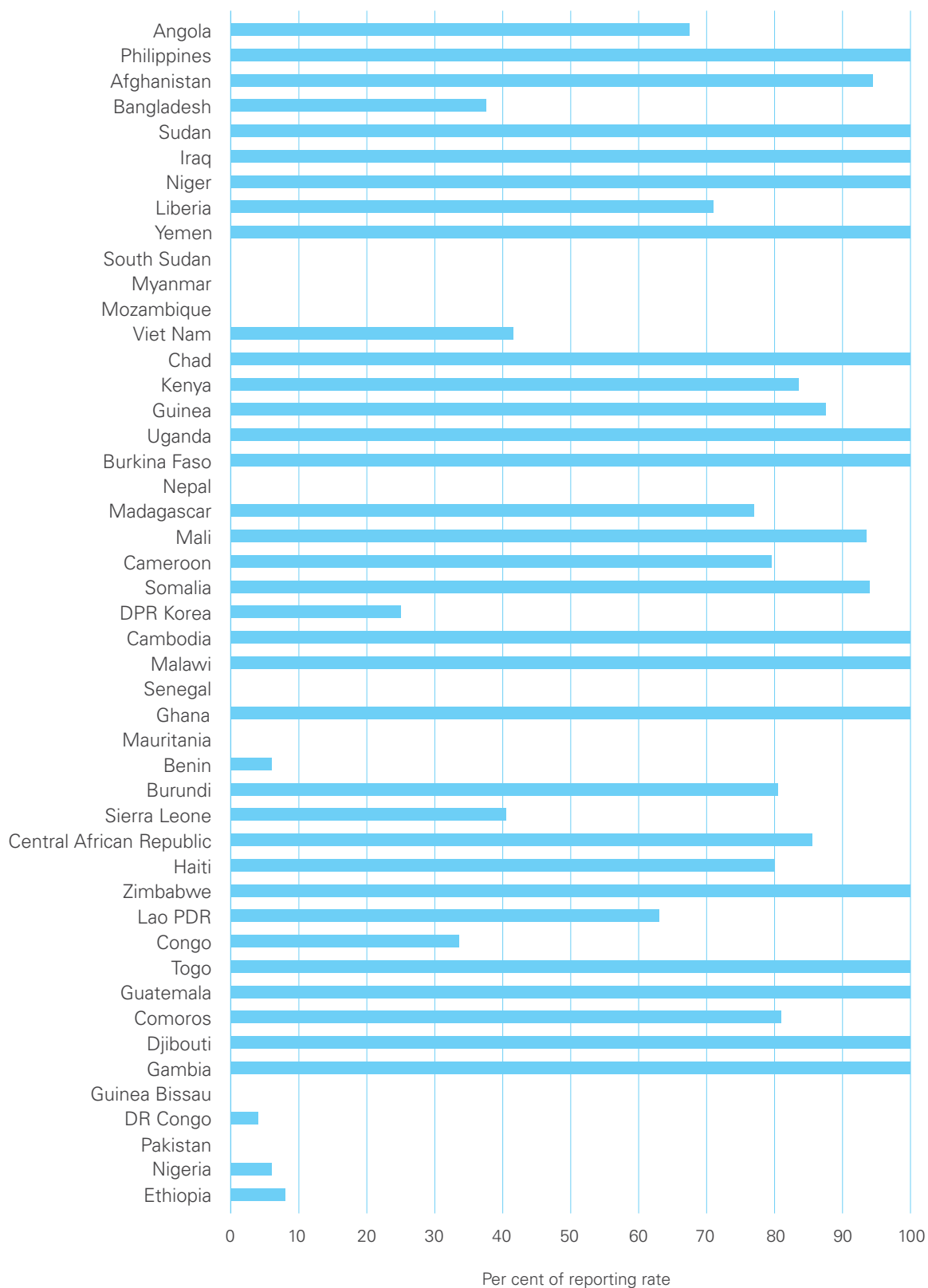


Table A.1: Completion Annex

Country	SAM	IYCF	MNP	Salt Iodization	Deworming	Vit A Coverage
Afghanistan	●	●	●	●	●	●
Albania	⊘	●	⊘	●	⊘	⊘
Angola	●	●	⊘	●	●	●
Argentina	◐	◐	○	○	●	○
Armenia	●	●	⊘	●	⊘	⊘
Azerbaijan	⊘	●	⊘	●	⊘	●
Bangladesh	●	●	●	●	○	●
Belarus	◐	●	⊘	●	●	⊘
Benin	●	●	●	●	●	●
Bhutan	●	●	⊘	●	●	●
Bolivia	●	●	●	●	●	●
Bosnia and Herzegovina	⊘	●	⊘	●	⊘	⊘
Botswana	●	●	⊘	◐	●	●
Brazil	⊘	●	●	●	●	●
Burkina Faso	●	●	●	●	●	●
Burundi	●	●	●	●	●	●
Cambodia	●	●	●	●	●	●
Cameroon	●	●	●	⊘	●	●
Central African Republic (CAR)	●	●	⊘	⊘	●	●
Chad	●	●	⊘	⊘	●	●
China	⊘	●	●	●	⊘	⊘
Colombia	○	●	○	○	○	⊘
Comoros	●	●	⊘	●	●	●
Congo	●	●	●	●	●	●
Costa Rica	○	○	○	○	●	○
Cote d'Ivoire	●	●	⊘	●	●	●
Croatia	◐	●	○	●	○	○
Cuba	●	●	○	●	●	○
Democratic Republic of Congo	●	●	●	●	●	●
Djibouti	●	●	●	●	●	●
Ecuador	⊘	●	●	●	⊘	●
El Salvador	●	●	⊘	●	●	●
Equatorial Guinea	○	●	○	○	○	○
Eritrea	●	●	⊘	●	⊘	●
Ethiopia	●	●	●	●	●	●

● Complete ◐ Partially complete ○ Incomplete ⊘ Deactivated / No programme

Table A.1: Completion Annex (cont.)

Country	SAM	IYCF	MNP	Salt Iodization	Deworming	Vit A Coverage
Gambia	●	●	⊘	●	●	●
Georgia	⊘	⊘	⊘	●	○	○
Ghana	●	●	⊘	●	●	●
Guatemala	●	●	●	●	●	●
Guinea	●	●	●	●	●	●
Guinea Bissau	●	●	○	●	●	●
Guyana	●	●	●	●	●	○
Haiti	●	●	●	●	●	●
Honduras	○	○	○	○	●	⊘
India	●	●	⊘	●	●	●
Indonesia	●	●	●	●	●	●
Iraq	●	●	⊘	●	●	●
Jamaica	●	●	⊘	●	⊘	◐
Kazakhstan	⊘	●	⊘	●	○	⊘
Kenya	●	●	●	●	●	●
Korea, Democratic People's Republic of	●	●	●	●	●	●
Kosovo	⊘	●	⊘	●	⊘	⊘
Kyrgyzstan	●	●	●	●	●	○
Lao People's Democratic Republic	●	●	●	●	●	●
Lebanon	●	●	●	●	⊘	●
Lesotho	●	●	⊘	●	●	●
Liberia	●	●	○	●	●	●
Macedonia (The former Yugoslav Republic of)	⊘	●	⊘	●	●	◐
Madagascar	●	●	●	●	●	●
Malawi	●	●	●	●	●	●
Maldives	●	●	⊘	●	●	●
Mali	●	●	●	●	●	●
Mauritania	●	●	○	●	●	●
Mexico	●	◐	○	○	○	◐
Moldova	◐	●	○	●	●	◐
Mongolia	●	●	●	◐	○	●
Morocco	○	○	○	●	●	◐
Mozambique	●	●	○	●	○	○
Myanmar	●	●	●	●	●	●
Namibia	●	●	⊘	●	●	●

● Complete ◐ Partially complete ○ Incomplete ⊘ Deactivated / No programme

Table A.1: Completion Annex (cont.)

Country	SAM	IYCF	MNP	Salt Iodization	Deworming	Vit A Coverage
Nepal	●	●	●	●	●	●
Nicaragua	●	●	●	●	●	●
Niger	●	●	●	●	●	●
Nigeria	●	●	◐	●	●	●
Occupied Palestinian Territory	●	●	●	●	●	●
Pakistan	●	●	●	●	●	●
Panama	○	●	○	○	●	●
Paraguay	○	◐	○	○	○	○
Peru	○	○	◐	○	○	○
Philippines	●	●	●	●	●	●
Rwanda	●	●	○	●	●	●
Sao Tome and Principe	◐	◐	◐	○	○	●
Senegal	●	●	●	●	●	●
Serbia	●	●	◐	●	●	◐
Sierra Leone	●	●	●	●	●	●
Somalia	●	●	●	●	●	●
South Sudan, Republic of	●	●	◐	●	●	●
Sri Lanka	●	●	●	●	●	●
Sudan	●	●	●	●	●	●
Suriname	◐	●	◐	●	○	◐
Swaziland	◐	◐	◐	◐	○	●
Tajikistan	●	●	○	●	◐	●
Tanzania, United Republic	●	●	○	○	●	●
Thailand	◐	●	◐	●	◐	◐
Timor-Leste	●	●	●	●	●	●
Togo	●	●	◐	●	●	●
Turkmenistan	○	●	○	●	○	○
Uganda	●	●	●	◐	●	●
Uruguay	◐	◐	○	◐	○	◐
Uzbekistan	◐	●	◐	●	●	●
Vietnam	●	●	●	●	●	●
Yemen	●	●	◐	●	●	●
Zambia	○	○	●	●	◐	○
Zimbabwe	●	●	●	●	●	●

● Complete ◐ Partially complete ○ Incomplete ◐ Deactivated / No programme

Table A.2: Score calculation for countries that produce or iodize salt in-country

MAIN CATEGORIES	Weight
Policy environment	20%
National ownership and program governance	15%
Supply	30%
Demand Generation	10%
M&E and QA/QC	25%

Category	Score	Weight
POLICY ENVIRONMENT		20%
Is salt iodization mandatory by law for any type of salt commodity? If yes for which commodities?		40%
a) yes for table/household salt ONLY	0.5	
b) yes for one or more processed foods ONLY	0.4	
c) yes for livestock feed ONLY	0.1	
a) + b) table/household salt AND one or more processed foods	0.9	
a) + c) table/household salt AND live stock feed	0.6	
b) + c) one or more processed food items AND live stock feed	0.5	
a) + b) + c)	1	
No	0	
“Is there a legal document outlining operationalization and rules and responsibilities for iodizing salt? Does it specify the type of packaging / labelling that must be used for iodized salt?”		30%
Yes, it exists and specifies type of packaging and type of labelling	1	
Yes, it exists and specifies type of packaging (No for labelling)	0.8	
Yes, it exists and specifies type of labelling (No for packaging)	0.6	
Yes it exists but does not specify packaging and labelling	0.6	
No, it does not exist	0	
Is there a policy/strategy/national plan of action for the elimination of Iodine Deficiency Disorders? Is it integrated in governments regular policy and/or programme reviews?		30%
There is a strategy/plan and it is integrated into government’s regular policy and/org programme reviews	1	
There is a strategy/ plan but NOT included in reviews	0.5	
There is no strategy/plan	0	

Category	Score	Weight
NATIONAL OWNERSHIP AND PROGRAMME GOVERNANCE		15%
Is IDD elimination a FUNDED line item in the government budget?		40%
Yes	1	
No	0	
Does a national coordination body exist that coordinates IDD elimination? If yes, does the coordination body include both government and salt industry?		20%
yes it exists and includes both	1	
yes it exists and includes only salt industry	0.5	
yes, it exists and includes only government	0.5	
no it does not exist	0	
Did the coordination body have an annual workplan in 2014? Were the majority of activities in the workplan achieved in 2014?		40%
Yes it had a workplan and the majority of activities were achieved	1	
Yes it had a workplan but only a minority of activities were achieved (NOT a majority)	0.5	
it did not have a workplan	0	

Table A.2: Score calculation for countries that produce or iodize salt in-country (cont.)

Category	Score	Weight	Category	Score	Weight
SUPPLY AND DISTRIBUTION			DEMAND GENERATION		
30%			10%		
What part of domestic salt supply comes from medium and large-scale producers?			What is the proportion of iodized salt that is not clearly recognisable as iodised to the consumer through label and/or logo?		
30%			50%		
70% or more	1		less than 10% is not recognizable	1	
between 40% and 70%	0.6		less than 20% is not recognizable	0.6	
less than 40%	0.2		less than 50% is not recognizable	0.2	
don't know	0		more than 50% is not recognizable	0	
Payment for KIO3?			Is a communication strategy in place that addresses identified bottlenecks from production/import of iodized salt to reaching the population?		
30%			50%		
Industry pays full market price	1		no	0	
Industry pays subsidized price (Subsidized by government)	0.6		no, but communication activities take place	0.3	
Industry pays subsidized price (Subsidized by donors)	0.1		yes	1	
KIO3 fully funded by government (Industry receives KIO3 for free)	0.4				
KIO3 fully funded by donors (Industry receives KIO3 for free)	0				
Was there any stockouts of KIO3 at production level in 2014?					
40%					
Yes	0				
No	1				

Table A.2: Score calculation for countries that produce or iodize salt in-country (cont.)

Category	Score	Weight	Category	Score	Weight
MONITORING (PROGRAMME AND REGULATORY MONITORING)			25%		
Does a national monitoring system exist which tracks programme activities (policy implementation, production, supply, communication etc.)?			10%		
No	0				
Yes	1				
Are monitoring data reported and used for corrective action/programme adjustments?			10%		
No	0				
Yes	1				
Are rules and operating procedures for external quality control (inspections and sample taking at production/import and commercial level) by national authorities clearly established?			10%		
No	0				
Yes	1				
Do the rules and procedures include monitoring of correct packaging?			10%		
No	0				
Yes	1				
Have the rules and procedures for external quality control been applied by national authorities in the past calendar year?			10%		
no - they were not applied	0				
yes - they were partially applied	0.5				
yes - they were widely applied	1				
Are standards and responsibilities for internal quality assurance at production level clearly established?			10%		
No	0				
Yes	1				
What proportion of domestically produced salt comes from salt production sites that complied with the obligations for internal quality assurance in the past calendar year?			20%		
don't know	0				
0-25%	0.2				
25-50%	0.5				
50-75%	0.7				
>75%	1				
In the past calendar year, were there any examples of punitive or rewarding actions (including public recognition) relating to the compliance of salt producers with quality assurance standards for iodized salt?			10%		
There were neither punitive nor rewarding actions	0				
Yes there were rewarding actions (recognition)	0.5				
Yes there were punitive actions	0.5				
There were both	1				
Does the country have access to a laboratory equipped to analyse iodine levels in salt and urine?			10%		
None of the two	0				
Yes for salt only	0.5				
Yes for urine only	0.5				
Yes for both	1				

Table A.3: Score calculation for countries that do NOT produce or iodize in-country

MAIN CATEGORIES	Weight
Policy environment	25%
National ownership and program governance	25%
Demand Generation	10%
M&E and QA/QC	40%

Category Score	Weight
POLICY ENVIRONMENT	25%
Is salt iodization mandatory by law for any type of salt commodity? If yes for which commodities?	40%
a) yes for table/household salt ONLY	0.5
b) yes for one or more processed foods ONLY	0.4
c) yes for livestock feed ONLY	0.1
a) + b) table/household salt AND one or more processed foods	0.9
a) + c) table/household salt AND live stock feed	0.6
b) + c) one or more processed food items AND live stock feed	0.5
a) + b) + c)	1
No	0
“Is there a legal document outlining operationalization and rules and responsibilities for iodizing salt? Does it specify the type of packaging / labelling that must be used for iodized salt?”	30%
Yes, it exists and specifies type of packaging and type of labelling	1
Yes, it exists and specifies type of packaging (No for labelling)	0.8
Yes, it exists and specifies type of labelling (No for packaging)	0.6
Yes it exists but does not specify packaging and labelling	0.6
No, it does not exist	0
Is there a policy/strategy/national plan of action for the elimination of Iodine Deficiency Disorders? Is it integrated in governments regular policy and/or programme reviews?	30%
There is a strategy/plan and it is integrated into government’s regular policy and/org programme reviews	1
There is a strategy/ plan but NOT included in reviews	0.5
There is no strategy/plan	0

Category Score	Weight
NATIONAL OWNERSHIP AND PROGRAMME GOVERNANCE	25%
Is IDD elimination a FUNDED line item in the government budget?	40%
Yes	1
No	0
Does a national coordination body exist that coordinates IDD elimination? If yes, does the coordination body include both government and salt industry?	40%
yes it exists and includes both	1
yes it exists and includes only salt industry	0.5
yes, it exists and includes only government	0.5
no it does not exist	0
Did the coordination body have an annual workplan in 2014? Were the majority of activities in the workplan achieved in 2014?	20%
Yes it had a workplan and the majority of activities were achieved	1
Yes it had a workplan but only a minority of activities were achieved (NOT a majority)	0.5
it did not have a workplan	0

Table A.3: Score calculation for countries that do NOT produce or iodize in-country (cont.)

Category	Score	Weight
DEMAND GENERATION		10%
What is the proportion of iodized salt that is not clearly recognisable as iodised to the consumer through label and/or logo?		50%
less than 10% is not recognizable	1	
less than 20% is not recognizable	0.6	
less than 50% is not recognizable	0.2	
more than 50% is not recognizable	0	
Is a communication strategy in place that addresses identified bottlenecks from production/import of iodized salt to reaching the population?		50%
no	0	
no, but communication activities take place	0.3	
yes	1	

Category	Score	Weight
MONITORING (PROGRAMME AND REGULATORY MONITORING)		40%
Does a national monitoring system exist which tracks programme activities (policy implementation, production, supply, communication etc.)?		20%
No	0	
Yes	1	
Are monitoring data reported and used for corrective action/programme adjustments?		20%
No	0	
Yes	1	
Are rules and operating procedures for external quality control (inspections and sample taking at production/import and commercial level) by national authorities clearly established?		20%
No	0	
Yes	1	
Do the rules and procedures include monitoring of correct packaging?		10%
No	0	
Yes	1	
Have the rules and procedures for external quality control been applied by national authorities in the past calendar year?		20%
no - they were not applied	0	
yes - they were partially applied	0.5	
yes - they were widely applied	1	
Does the country have access to a laboratory equipped to analyse iodine levels in salt and urine?		10%
None of the two	0	
Yes for salt only	0.5	
Yes for urine only	0.5	
Yes for both	1	



A child eating rice porridge with a micronutrient sprinkle supplement added. Taken at a mothers' circle project supported by UNICEF on Nov. 25, 2012, in Naungkalar Village, Tha Ton Township, Mon State, Myanmar.

Photo credit: Adam Dean 2012

Nutrition Section
Programme Division
United Nations Children's Fund
3 United Nations Plaza
New York, NY 10017, USA
nutridash@unicef.org
www.unicef.org/nutrition