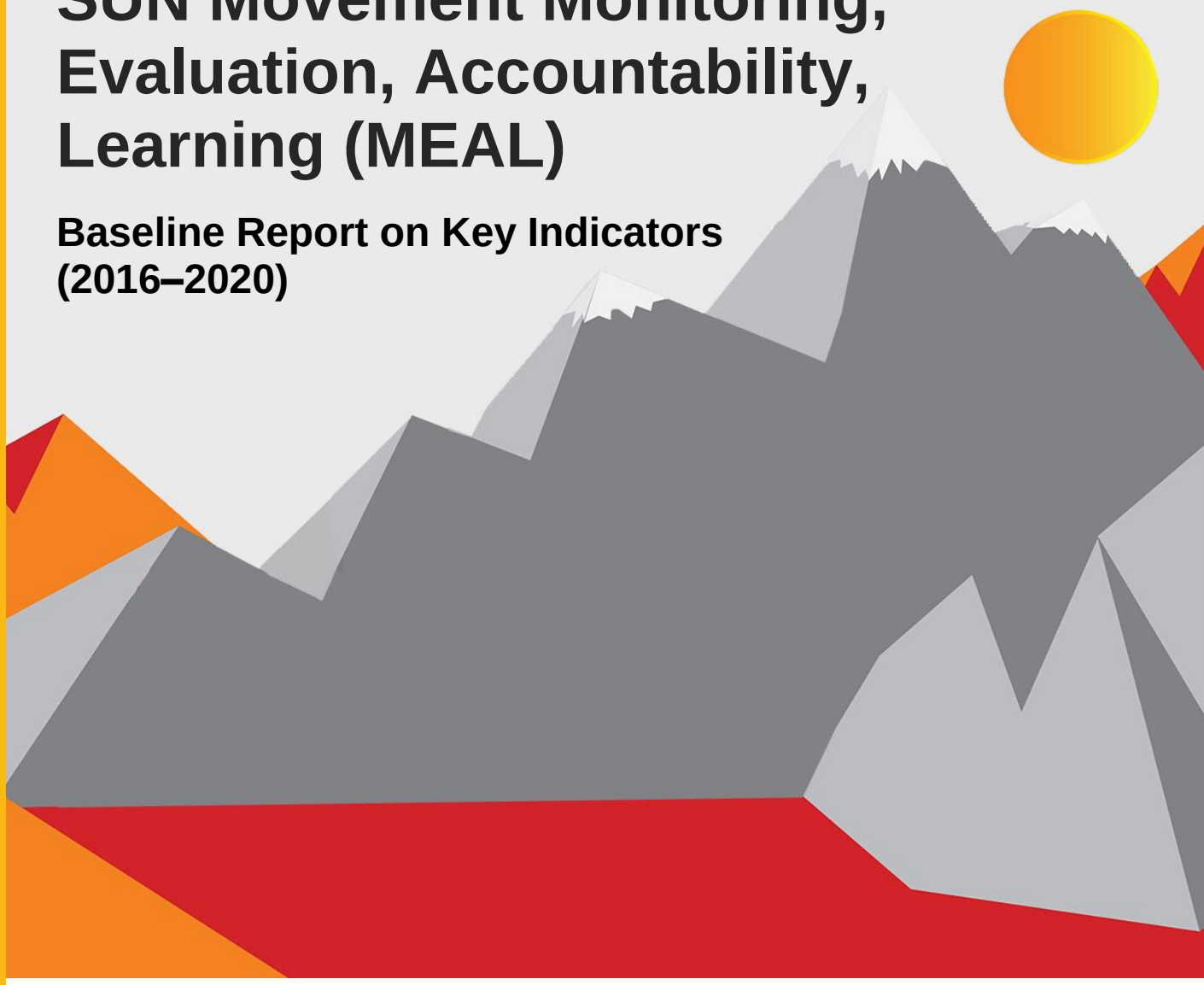
SUN Movement Monitoring, Evaluation, Accountability, Learning (MEAL)

Baseline Report on Key Indicators (2016–2020)



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Disclaimer:
This Baseline Report is meant to serve the SUN Movement for 2016–2020. The most recent data point for the indicators is 2016. For each indicator, we have specified the year of reference and the source of data, This Baseline Report aims to provide an overview of indicators that have available data for most SUN Countries. Limitations in the coverage data of certain indicators as well as new information collected through the 2017 Joint Annual Assessment are presented in a separate Annex on “Work in Progress in the MEAL System” *(forthcoming)*.

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List of Acronyms

AOI	Agriculture Orientation Index
AARR	Average annual rate of reduction
BFHI	Baby-Friendly Hospital Initiative
BMI	Body Mass Index
CAR	Central African Republic
CI	Confidence Interval
CMAM	Community-based management of acute malnutrition
CRS	Credit Reporting System
CSO	Civil society organization
DHS	Demographic and Health Survey
DPT3	Diphtheria, Tetanus, Pertussis immunization
DRC	Democratic Republic of Congo
EBF	Exclusive breastfeeding
ECDAN	Early Child Development Action Network
EMIS	Education Management Information Systems
EWEC	Every Woman Every Child Global Movement
FACT	Fortification Assessment Coverage Toolkit
FFI	Food Fortification Initiative
GAIN	Global Alliance for Improved Nutrition
GDP	Gross Domestic Product
GDSP	Global Database of Shared Prosperity (World Bank)
GNR	Global Nutrition Report
GTS	Global Technical Strategy for Malaria 2016–2030 (WHO)
Hb	Haemoglobin
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
IBFAN	International Baby Food Action Network
IGME	UN Inter-agency Group for Child Mortality Estimation
IGN	Iodine Global Network
ILO	International Labour Organization
ISN	Information Systems for Nutrition
ITN	Insecticide treated nets
IYCF	Infant and Young Child Feeding
JAA	Joint Annual Assessment
JMP	Joint Monitoring Programme for Water Supply and Sanitation (WHO/UNICEF)
LiST	Lives Saved Tool
M&E	Monitoring and evaluation
MAD	Minimum Acceptable Diet
MDD	Minimum Diet Diversity
MDG	Millennium Development Goals
MEAL	Monitoring, Evaluation, Accountability, Learning
MI	Micronutrient Initiative (former name of Nutrition International)
MICS	Multiple Indicator Cluster Survey
MN	Micronutrient
MQSUN+	Maximising the Quality of Scaling Up Nutrition project
MSP	Multi-stakeholder platforms

N or n	Sample size (number in a trial or sample)
NCD	Non-communicable Disease
NCD-RisC	NCD Risk Factor Collaboration
ORS	Oral Rehydration Solution
PNG	Papua New Guinea
PW	Pregnant women
R4D	Results for Development
REACH	Renewed Efforts Against Child Hunger and undernutrition initiative
SAM	Severe Acute Malnutrition
SBN	SUN Business Network
SD	Standard Deviation
SDG	Sustainable Development Goal
SMART	Standardized Monitoring and Assessment of Relief and Transition (survey methodology)
SMS	SUN Movement Secretariat
SPRING	Strengthening Partnerships, Results, and Innovations in Nutrition Globally project
SUN	Scaling Up Nutrition Movement
TB	Tuberculosis
UIC	Urinary Iodine Concentration
UN-HABITAT	United Nations Human Settlements Programme
UNICEF	United Nations Children's Fund
UNN	United Nations Network
WASH	Water, Sanitation and Hygiene
WHA	World Health Assembly
WHO	World Health Organization
WRA	Women of Reproductive Age

INTRODUCTION

As the world is coming to grips with multiple forms of malnutrition, decision makers in Government, development partners, civil society organizations, and businesses in the SUN Movement aim to demonstrate how their human and financial resources are converted into results that deliver nutrition impacts at the country level.

Achieving results will require a strong Monitoring, Evaluation, Accountability and Learning (MEAL) system which reflects the underlying theory of change of the SUN Movement (Figure 1) and is well suited to the systemic nature of the changes that SUN is seeking to catalyze in the 59 countries. The MEAL system will require appropriate indicators of progress in these areas, as well as sufficient capacity to produce the necessary data and to assess the results of the SUN Movement's achievements, in order to improve effectiveness over time.

FIGURE 1 – THE THEORY OF CHANGE TO ACHIEVE IMPACT AT COUNTRY LEVEL

The SUN Movement Secretariat has worked with a core group of representatives from governments, donors, UN agencies, civil society, academia and private sectors. This core group, functioning as the MEAL Advisory Group, has contributed to the development and finalization of the MEAL Results Framework (see Appendix A). The following analysis and results provide an overview of the current status of the 59 SUN countries for the key indicators identified.

METHODOLOGY

The MEAL Results Framework (Appendix A) identified a wide range of desired results and associated indicators to provide evidence on progress toward their achievement. Indicators were organized into groups that corresponded with steps in the Theory of Change (see Box A).

BOX A

The MEAL Results Framework is developed from the Theory of Change to show:

STEP 1	How **multiple stakeholders from different sectors come together** to address all forms of malnutrition.
STEP 2	How **multiple stakeholders from different sectors change their behaviours** to commit towards common results.
STEP 3	How **multiple stakeholders mobilize resources and align their implementation** to optimize coverage of their actions.
STEP 4	How **effective results are achieved through aligned implementation**.
STEP 5	How **better nutrition status is achieved** for children, adolescents, women and men.
STEP 6	How **key SDGs are realized by 2030** through better nutrition.

Data were gathered from a variety of sources for each indicator, with a focus on data that were collected using a standard methodology. Wherever possible, data were accessed from publicly available repositories that had been reviewed for quality (e.g. UNICEF Global Databases, WHO Global Health Observatory, World Bank databases). Data on average annual rate of reduction (AARR) were shared by the Global Nutrition Report. See Appendix B for a complete list of indicators and their data sources. Appendix C shows the alignment of indicators with internationally agreed frameworks and other monitoring initiatives.

The data analysis process[1] looked at the coverage for each indicator across SUN countries and the reference year of data collection. Summary statistics were calculated for all countries as well as by region, year of joining the SUN Movement, humanitarian risk status (based on the INFORM Index ranking in 2016-2017[2]), and country income classification (World Bank data). See Appendix D for the list of SUN countries and their characteristics.

To facilitate comparisons across indicators and countries, individual country values were grouped into colour-coded categories that represent a continuum in performance. The classification was based on established standard cut-offs (e.g. public health significance of child stunting, anaemia prevalence, etc.) whenever these were available. In the absence of standard cut-offs, colour-coding was based on performance relative to other SUN countries. See Appendix E for a discussion of the limitations in terms of data sources and availability.

[1] Data were analyzed using Stata15.1 software (StataCorp, 2017).
[2] INFORM identifies countries at a high risk of humanitarian crisis that are more likely to require international assistance. The INFORM model includes three dimensions of risk: Hazards & Exposure, Vulnerability and Lack of Coping Capacity. http://www.inform-index.org/

FINDINGS

Improvement of the enabling environment for nutrition has a wide range of features and relates to broader issues of governance. The enabling environment has been the focus of the SUN Movement during Phase 1 from 2012 to 2015 and will continue to be a cornerstone during Phase 2 from 2016 to 2020.

We look here at two main areas related with Step 1 and Step 2 of the Theory of Change.

TABLE 1: MEAL FRAMEWORK EXCERPT SHOWING THE ENABLING ENVIRONMENT INDICATORS AND AVAILABILITY OF EVIDENCE

Theory of Change	Types of results	Availability of evidence (as per August 2017)
STEP 1: **Multiple stakeholders from different sectors come together** to tackle malnutrition and build an enabling environment for improving nutrition with equity.	• Existence of Multi-Stakeholder Platforms (MSP)	**YES, included in Baseline as Indicator 1.1**
	• Existence, composition and functionality of networks/alliances (UN agencies, CSOs, business, donors, academia)	**YES, included in Baseline as Indicator 1.2, including Functionality Index baseline data for 2016 for UN, Civil Society and Business Networks.**
STEP 2: **Multiple stakeholders from different sectors change their behaviours** and commit to achieving common nutrition results for everyone, everywhere.	• Progress in the four SUN Movement processes and related progress markers and evidence	**YES, included in Baseline as Indicator 1.3** JAA conducted since 2014
	• Existence of information systems for nutrition	**YES, included in Baseline as Indicator 1.4** Mapping conducted in 2016
	• Existence of nutrition targets in national plans based on WHA and NCD global targets[3]	**YES, included in Baseline as Indicators 1.5 and 1.6** Mapping conducted in 2016
	• Integration of (under and over) nutrition in development plans made up to 2015[4]	**YES, included in Baseline as Indicators 1.7 and 1.8** Study conducted by IDS
	• Mobilization of high-level advocates (champions, parliamentarians, media)	**YES (Included in this Baseline) – Indicator 1.9** Data reported in the annual SUN Movement Report
	• Integration of nutrition in the development plans/2030 Agenda and in new sectoral policies including risk reduction strategies made since the beginning of 2016	Delayed to 2018 Part of UN Network Reporting

[3] This indicator is assessed separately for this Baseline. Included nutrition plans have been reviewed as part of the mapping conducted in 2016. From 2017 onwards, this indicator will be part of the systematic review of the nutrition action plans using the quality checklist.

[4] This indicator is assessed separately for this Baseline and is based on a study conducted by IDS on all available development plans up to 2015. From 2018 onwards, all plans developed since 2016 will be systematically reviewed by the UN Network for Nutrition (TBC)

Theory of Change	Types of results	Availability of evidence (as per August 2017)
Step 2, continued	• 'Good' quality of new national multi-sectoral, multi-stakeholder action plans / common results framework made since the beginning of 2016	In progress (not included in Baseline - Forthcoming report) Systematic review of new plans made since 2016 using the Quality Checklist
	• Compliance of partners with the SUN Movement Principles Engagement Guidance	In progress (Not included in Baseline - Forthcoming report) Questions added in 2017 JAA
	• Capacity of Multi-Stakeholder Platforms to coordinate their partners response to identified annual priority action areas in the Joint-Annual Assessments	In progress (Not included in Baseline - Forthcoming report) Questions added in 2017 JAA
	• SMART-ness of nutrition commitments by Governments and networks / alliances (CSO, business, UN system, donors) made since the beginning of 2016	In progress (Not included in this Baseline - Forthcoming report) Questions added in 2017 JAA

Step 1 - Multiple stakeholders from different sectors coming together

List 1: Enabling environment for nutrition

Existence of Multi-Stakeholder Platform

MEAL Indicator 1.1: Existence of Multi-Stakeholder Platforms (MSP)

By 2016, 56 SUN countries report having a functioning MSP in place, with four of these countries (Kenya, Botswana, Congo Brazzaville and Togo) reportedly having an interim mechanism in place. Three countries (Papua New Guinea, Gabon and Central African Republic) joined the SUN Movement in 2016 and are still in the process of setting this up.

Updates on the composition of the Multi-Stakeholder Platforms (MSP) and contact details of the Government Focal Points are available through the SUN Movement Secretariat.

Existence and Functionality of Networks/Alliances

MEAL Indicator 1.2: Existence, composition and functionality of networks/alliances (UN agencies, CSOs, business, donors, academia)

Another key feature of the enabling environment is the existence, composition and functionality of networks/alliances, including UN agencies, CSOs, businesses, donors and academia. Based on data reported in the 2016 Progress Report, of the 56 countries with data, 19 have 4 networks

(UN, business, donors and CSO), 18 have three networks, 8 have two networks and 11 have only the UN Network (Table 2).

Updates on the composition of the SUN Networks and contact details of the members are available through the respective Secretariats.

TABLE 2: COUNTRY GROUPING BY NUMBER OF NETWORKS AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Number and type of networks in place*					
	1 Network in place	2 Networks in place†		3 Networks in place		4 Networks in place
	UN Network	+ CSN	+ SDN	+ CSN and SDN	+ SBN and SDN or CSN	UNN + CSN + SDN + SBN
2010–2011 (N=24)	Gambia, Namibia (n=2)	Mauritania (n=1)	—	Benin, Burkina Faso, Ghana, Mali, Nepal, Peru, Rwanda, Senegal, Uganda (n=9)	—	Bangladesh$^{\Delta}$, Ethiopia, Guatemala, Indonesia, Kyrgyzstan, Lao PDR, Malawi$^{\Delta}$, Mozambique, Niger, Tanzania, Zambia, Zimbabwe (n=12)
2012–2014 (N=30)	Comoros, Congo, Costa Rica, Lesotho, Somalia, South Sudan, Vietnam (n=7)	Guinea-Bissau^, Sri Lanka, Togo, Philippines (n=4)	Haiti, Swaziland, Yemen (n=3)	Burundi, Chad, DRC, Guinea, Liberia, Myanmar, Sierra Leone (n=7)	El Salvador$^{\Delta}$, Tajikistan (n=2)	Cambodia^, Cameroon, Côte d'Ivoire^, Kenya, Madagascar, Nigeria, Pakistan (n=7)
2015–2017‡ (N=2)	Botswana Sudan (n=2)					

Acronyms: CSN=Civil Society Network, SBN=SUN Business Network, SDN=SUN Donor Network, UNN=United Nations Network
* Based on country information reported in the 2016 Progress Report and Global Network information up to the end of 2016.
† There are no countries with only the UNN and the SBN Δ Reported by the Global SUN Business Network
^Reported in the 2016 Progress Report but not confirmed by the Global Network
‡ Data not available for Papua New Guinea, Central Africa Republic and Gabon

UN NETWORK FUNCTIONALITY INDEX

The UN Network developed a functionality index to assess if its country networks have the minimum elements in place for optimal functionality. The functionality index is comprised of six indicators: i) Nomination of a UN Network chair, ii) Appointment of three or more UN network focal points, iii) Completion of UN Network work plan, iv) Completion of UN Network reporting exercise, v) Completion of UN Nutrition Inventory, and vi) Development of UN Network strategy or agenda. In 2016, 14 countries (25%) had most elements in place, 25 (44%) had some elements in place, 16 (28%) had very few elements in place and two were considered as non-functioning.

Table 3 provides a snapshot of UN Network level of set-up per country, ranging from the early stages of set-up with few or no elements in place to advanced set-up with most elements in place. Details on individual country scores for the six indicators are included in Appendix F. The potential contribution of the REACH partnership to enhancing the functionality of the UN Network should also be considered. Countries where REACH currently operates and those that have had REACH involved in the past are included as a footnote underneath Table 3.

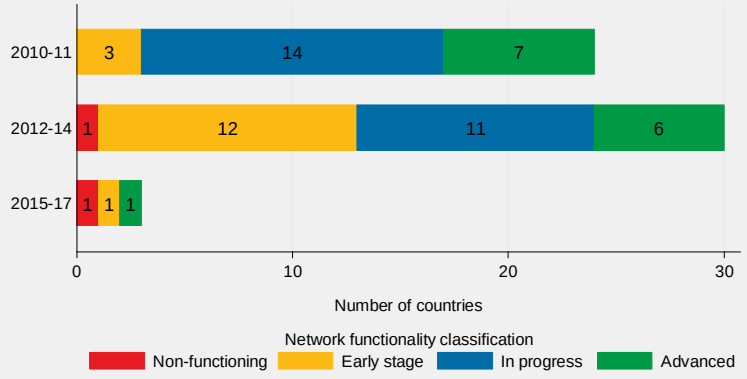
TABLE 3: COUNTRY GROUPING BY UN NETWORK FUNCTIONALITY INDEX SCORE AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	UN Network Functionality Index Score			
	Advanced (5-6)	In progress (3-4)	Early stages (1-2)	Non-functioning (0)
2010–2011 (N=24)	Burkina Faso, Kyrgyzstan, Malawi, Mali, Mozambique, Rwanda, Zambia (n=7)	Bangladesh, Benin, Gambia, Guatemala, Indonesia, Lao PDR, Mauritania, Namibia, Nepal, Niger, Senegal, Tanzania, Uganda, Zimbabwe (n=14)	Ethiopia, Ghana, Peru (n=3)	–
2012–2014 (N=30)	Chad, Côte d'Ivoire, DRC, Kenya, Myanmar, Pakistan (n=6)	Comoros, Congo, Guinea, Guinea-Bissau, Haiti, Lesotho, Madagascar, Philippines, Sierra Leone, Somalia, Tajikistan (n=11)	Burundi, Cambodia, Cameroon, Costa Rica, El Salvador, Liberia, South Sudan, Sri Lanka, Swaziland, Togo, Viet Nam, Yemen (n=12)	Nigeria (n=1)
2015–2017 (N=3)‡	Sudan (n=1)	–	Papua New Guinea (n=1)	Botswana (n=1)

‡ No data for Central African Republic and Gabon
Current REACH country (those with a facilitator present during 2016): Burkina Faso, Burundi, Chad, Guinea, Haiti, Mali, Myanmar, Lesotho, Rwanda, Senegal, Sierra Leone, Tanzania, and Zimbabwe (n=13); Former REACH country: Bangladesh, Ethiopia, Ghana, Lao PDR, Mauritania, Mozambique, Nepal, Niger, and Uganda (n=9)

As shown in Figure 1.2a, results suggest that countries that have been part of the SUN Movement for a longer period of time are more likely to have UN Networks that are at a higher level of functionality.

Figure 1.2a
Functionality level of UN Networks by year joined the SUN Movement



SUN BUSINESS NETWORK FUNCTIONALITY INDEX

The SUN Business Network has also developed a functionality index, comprised of five indicators in 2016[5]: i) network established or being established, ii) coordinator appointed, iii) action plan in place, iv) strategy developed and aligned to national nutrition plans, and v) funding secured for at least the first semester in 2017. As shown in Table 4, six countries (10%) had all five elements in place, five countries (9%) had some elements in place, and ten countries (17%) had very few elements in place. Nearly two thirds of SUN countries (n=36) did not have a functioning business network at the end of 2016. Details on individual country scores for the five indicators are included in Appendix F.

TABLE 4: COUNTRY GROUPING BY SUN BUSINESS NETWORK FUNCTIONALITY INDEX SCORE AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	SUN Business Network Functionality Index Score			
	Advanced	In progress	Early stages	None
2010–2011 (N=24)	Indonesia, Mozambique, Tanzania, Zambia (n=4)	Ethiopia, Guatemala, Kyrgyzstan, Niger (n=4)	Bangladesh, Lao PDR, Malawi, Zimbabwe (n=4)	Benin, Burkina Faso, Gambia, Ghana, Mali, Mauritania, Namibia, Nepal, Peru, Rwanda, Senegal, Uganda (n=12)
2012–2014 (N=30)	Nigeria, Pakistan (n=2)	Kenya (n=1)	Cambodia, Cameroon, Côte d'Ivoire^, El Salvador, Madagascar, Tajikistan (n=6)	Burundi, Chad, Comoros, Congo, Costa Rica, DRC, Guinea, Guinea-Bissau, Haiti, Lesotho, Liberia, Myanmar, Philippines, Sierra Leone, Somalia, South Sudan, Sri Lanka, Swaziland, Togo, Viet Nam, Yemen (n=21)
2015–2017 (N=3)‡	—	—	—	Botswana, Papua New Guinea, Sudan (n=3)

^ Reported in the 2016 Progress Report
‡ No data for Central African Republic and Gabon

[5] For 2017, SBN is proposing to include two additional indicators: the private sector's inclusion into national nutrition plans and membership tracking mechanisms.

SUN CIVIL SOCIETY NETWORK FUNCTIONALITY INDEX

The SUN Civil Society Network also developed a functionality index, comprised of five indicators for 2016: i) establishment of a civil society alliance or coalition, ii) steering group or executive committee in place, iii) sub-national/decentralized coordination structure in place, iv) funding secured for at least the first semester in 2017, and v) active engagement in MSP. As shown in Table 5, seven countries (12%) had all five elements in place, 29 countries (51%) had some elements in place, five countries (9%) had very few elements in place and 16 countries (28%) had no civil society alliance or coalition in place. Details on individual country scores for the five indicators are included in Appendix F.

TABLE 5: COUNTRY GROUPING BY SUN CIVIL SOCIETY NETWORK FUNCTIONALITY INDEX SCORE AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	SUN Civil Society Network Functionality Index Score			
	Advanced	**In progress**	**Early stages**	**None**
2010–2011 (N=24)	Bangladesh, Nepal, Rwanda, Senegal, Tanzania (n=5)	Benin, Burkina Faso, Ghana, Guatemala, Kyrgyzstan, Lao PDR, Malawi, Mali, Mauritania, Mozambique, Niger, Peru, Uganda, Zambia, Zimbabwe (n=15)	Ethiopia, Indonesia (n=2)	Gambia, Namibia (n=2)
2012–2014 (N=30)	Chad, Sierra Leone (n=2)	Burundi, Cambodia, Cote d'Ivoire, DRC, El Salvador, Guinea, Kenya, Liberia, Madagascar, Myanmar, Nigeria, Pakistan, Sri Lanka, Togo (n=14)	Cameroon, Philippines, South Sudan (n=3)	Comoros, Congo, Costa Rica, Guinea-Bissau, Haiti, Lesotho, Somalia, Swaziland, Tajikistan, Viet Nam, Yemen (n=11)
2015–2017 (N=3)‡	–	–	–	Botswana, Papua New Guinea, Sudan (n=3)

‡ No data for Central African Republic and Gabon

Step 2: Multiple stakeholders from different sectors change their behaviours to commit toward common nutrition results

Progress in the four SUN Movement processes

MEAL Indicator 1.3: Progress in the four SUN Movement processes and related progress markers and evidence

Starting from 2014, countries in the SUN Movement have been conducting annual joint assessments around four processes (see Box B). The results are presented in the SUN Progress Report as aggregates as well as individual country profiles.

BOX B: COUNTRY JOINT ASSESSMENT

Process 1: Bringing people together in the same space for action

Process 2: Ensuring a coherent policy and legal framework

Process 3: Aligning actions around a Common Results Framework

Process 4: Financial tracking and resource mobilisation

We look at the average total weight of the four processes among SUN countries using the most recent year available (2014, 2015 and 2016). We also indicate the countries that have progressed (↗), those that have stalled (→) and those that have regressed (↘) from previous year or years. For countries with only one data point, we have indicated the most recent year in brackets.

TABLE 6: COUNTRY GROUPING BY AVERAGE SCORE FOR THE FOUR SUN PROCESSES AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Four SUN Processes average (%)^			
	0–39%	40–54%	55–69%	≥70%
2010–2011 (N=22)*	Guatemala ↘ (n=1)	Bangladesh↘, Burkina Faso→, Ghana↗, Kyrgyzstan↗, Mali→, Mauritania↗ (n=6)	Benin→, Gambia↗, Lao PDR↗, Mozambique↗, Nepal↗, Peru→, Senegal→, Zambia→, Zimbabwe↗ (n=9)	Indonesia↗, Malawi→, Namibia↗, Rwanda↗, Tanzania↗, Uganda↗ (n=6)
2012–2014 (N=28)†	Cameroon↗, Chad↘, Guinea-Bissau↘, Lesotho (2015), Myanmar↘, Somalia(#)↗, South Sudan↘, Swaziland (2015), Tajikistan→, Togo→, Yemen↘ (n=11)	Burundi↗, Cambodia↗, Costa Rica↗, DRC→, Haiti (2014), Nigeria↗, Philippines (2016), Viet Nam↗ (n=8)	Congo↗, El Salvador↗, Guinea↗, Kenya↗, Pakistan↗, Sierra Leone↗ (n=6)	Côte d'Ivoire↗, Madagascar↗, Sri Lanka↗ (n=3)
2015–2017 (N=1)‡	–	Botswana (2016) (n=1)	–	–

^ For most recent year; direction of arrow represents direction of change over time. (based on data available by the end of 2016)
* No data for Ethiopia, Niger † No data for Comoros, Liberia ‡ No data for CAR, Gabon, PNG, Sudan (#) From very low baseline

Table 7 summarizes the change among those countries with at least two data points.

TABLE 7: TREND IN COUNTRY PROGRESS TOWARDS THE SUN MOVEMENT STRATEGIC OBJECTIVES

Year joined SUN Movement	Trend over time in average score for the four SUN processes^			
	Regressed	Stalled	Progressed	
2010–2011 (N=21)	Bangladesh ↘ Guatemala ↘ (n=2)	Benin → Burkina Faso → Mali → Malawi → Peru → Senegal → Zambia → (n=7)	Gambia ↗ Kyrgyzstan ↗ Mauritania ↗ Namibia ↗ Rwanda ↗ Uganda ↗ (n=12)	Indonesia ↗ Lao PDR ↗ Mozambique ↗ Nepal ↗ Tanzania ↗ Zimbabwe ↗
2012–2014† (N=23)	Chad ↘ Guinea Bissau ↘ Myanmar↘ South Sudan ↘ Yemen ↘ (n=5)	Tajikistan → Togo → DRC → (n=3)	Burundi ↗ Cameron ↗ Costa Rica ↗ El Salvador ↗ Madagascar ↗ Pakistan ↗ Somalia (*) ↗ Vietnam ↗ (n=15)	Cambodia ↗ Congo ↗ Côte d'Ivoire ↗ Kenya ↗ Nigeria↗ Sierra Leone ↗ Sri Lanka ↗
2015–2017‡	–	–	–	

^ Based on data available by the end of 2016 (*) From very low baseline;
† Excludes countries with only one data point (Philippines, Lesotho, Swaziland ‡ Data not available for Papua New Guinea, Central Africa Republic, Gabon and Sudan; excludes Botswana with only one data point

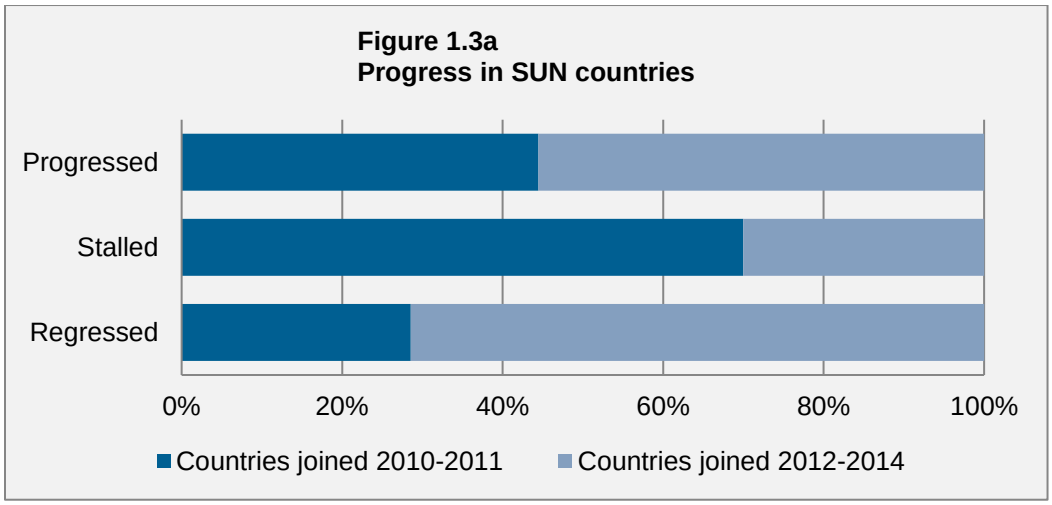
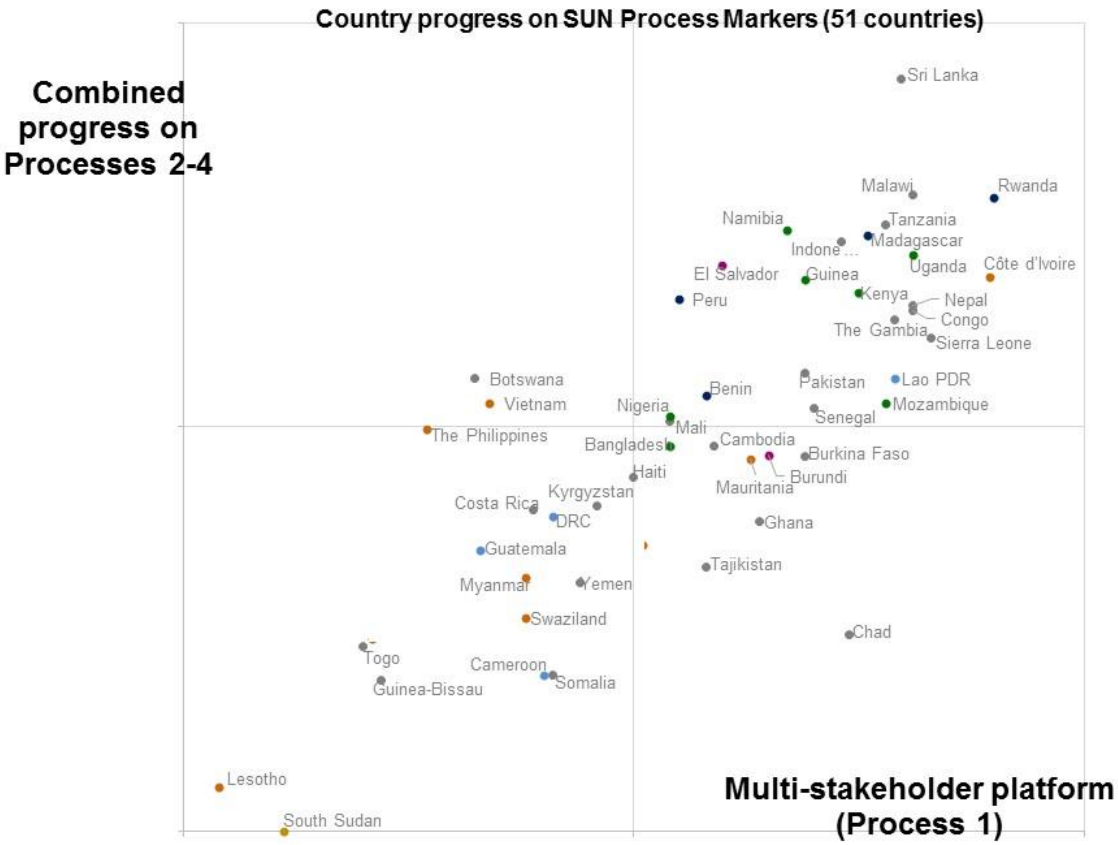


Figure 1.3b shows the association between the MSP score (Process 1) and the combined score on the other three processes using the most recently available year (2014, 2015 and 2016)

Figure 1.3b: Association between SUN country scores for Process 1 and Processes 2–4



Data source: SUN UN Network , based on SUN country self-assessment 2014, 2015 and 2016 (most recent available year presented), no data available for Central African Republic, Gabon, Papua New Guinea and Sudan.

We also look at the existence of 3 or 4 Networks and the score for Process 1- MSP as well as the existence of 3 or 4 Networks and the overall score for the four processes using the most recent available data.

Figure 1.3c
Average score for SUN Process 1 - MSP by year joined the SUN movement and number of SUN networks

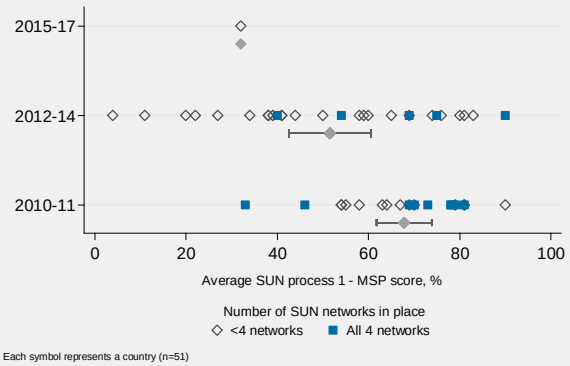


Figure 1.3d
Average score for SUN Process 1 - MSP by year joined the SUN movement and number of SUN networks

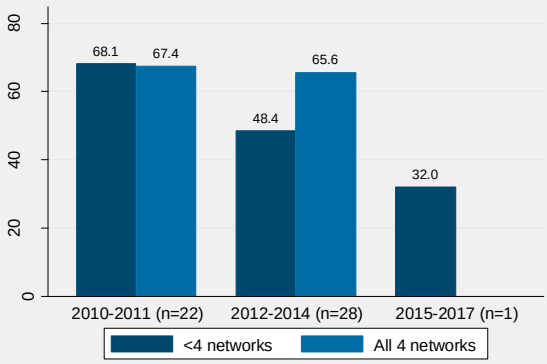


Figure 1.3e
Average score for the four SUN Processes by year joined the SUN movement and number of SUN networks

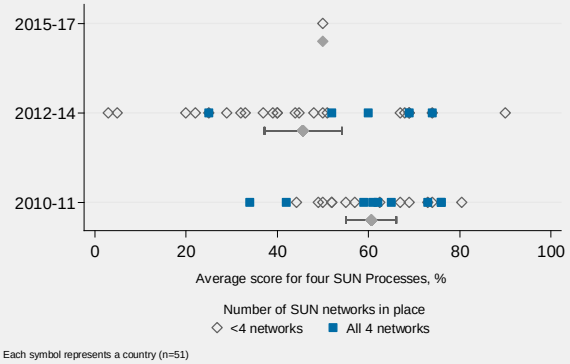


Figure 1.3f
Average score for the four SUN Processes by year joined the SUN movement and number of SUN networks

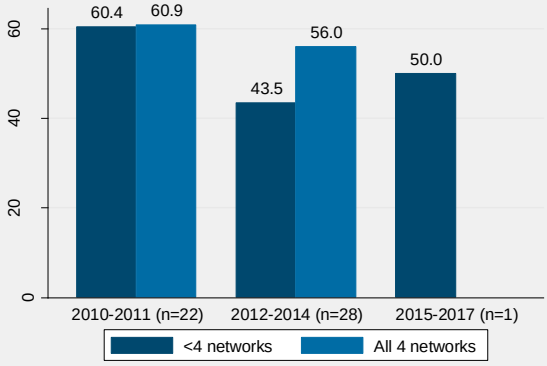


Figure 1.3g
Average score for SUN Process 1 - MSP by year joined the SUN movement and number of SUN networks

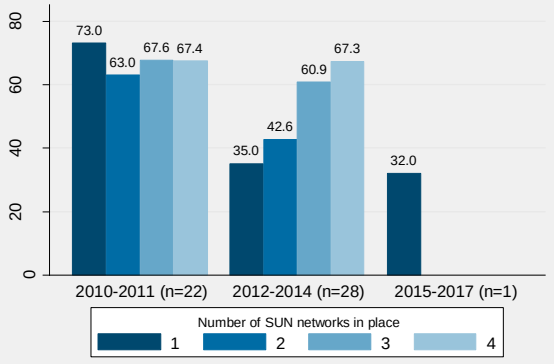
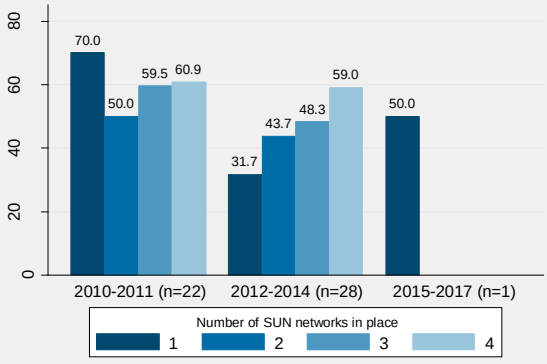


Figure 1.3h
Average score for the four SUN Processes by year joined the SUN movement and number of SUN networks



Existence of Nutrition Targets in national plans

MEAL Indicators 1.4: Existence of WHA targets in national plans

SUN countries are aiming to meet by 2025 the World Health Assembly (WHA) global targets for improving maternal, infant and young child nutrition. Inclusion of these goals in national policies and strategies is essential for establishing robust information systems to measure progress toward the agreed targets.

Based on a review of country policies and monitoring and evaluation frameworks in 2016, many SUN countries have not yet included these indicators in their plans, as shown in Table 8. In 2016, 33 of the 59 SUN countries assessed had explicitly stated one or more of the WHA global nutrition targets in their national nutrition policy and strategy documents. Only ten countries have included all six targets. No documents were available for 15 countries. Countries that joined the SUN Movement in the first couple of years have incorporated a higher number of targets into their national policies/plans compared to those that joined the Movement later (see Figure 1.4b; linear regression $t=-2.51$, $p<0.015$).

TABLE 8: COUNTRY GROUPING BY NUMBER OF WHA TARGETS IN NATIONAL PLANS AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Number of WHA targets tracked^				
	None found	None	1–2	3–4	5–6
2010–2011 (N=24)	Kyrgyzstan, Senegal (n=2)	Gambia, Ghana, (n=2)	Benin, Indonesia, Mauritania, Zambia (n=4)	Bangladesh, Burkina Faso, Mali, Mozambique, Namibia, Niger, Peru, Tanzania, Uganda (n=9)	Ethiopia, Guatemala, Lao PDR, Malawi Nepal, Rwanda, Zimbabwe (n=7)
2012–2014 (N=30)	Cameroon, Comoros, DRC, Lesotho, Pakistan, Somalia, South Sudan, Swaziland, Tajikistan, Togo (n=10)	Chad, Costa Rica, Côte d'Ivoire, Guinea, Guinea-Bissau, Haiti, Liberia, Yemen (n=8)	Burundi, El Salvador (n=2)	Cambodia, Congo, Madagascar (n=3)	Kenya, Myanmar, Nigeria, Philippines, Sierra Leone, Sri Lanka, Viet Nam (n=7)
2015–2017 (N=5)	Botswana, Papua New Guinea, Sudan (n=3)	Gabon	–	Central African Republic	–

^Based on data available by the end of 2016

Figure 1.4a
Number of SUN countries with WHA targets in national plans by region

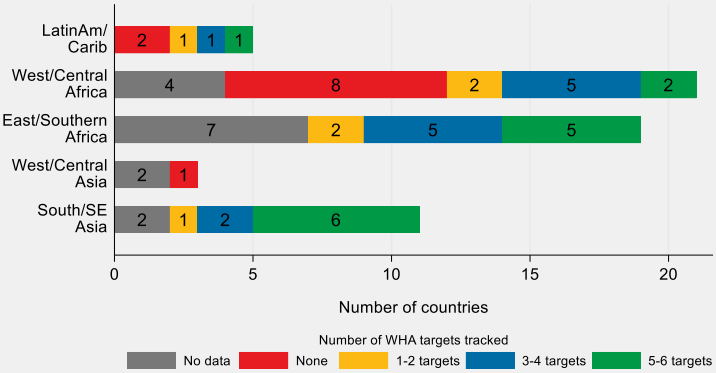
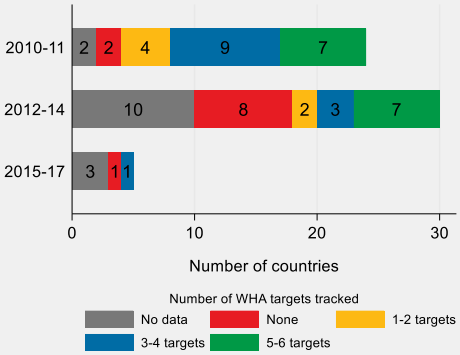


Figure 1.4b
Number of SUN countries with WHA targets in national plans by year joined the SUN movement



MEAL Indicators 1.5: Existence of NCD targets in national plans

Even fewer SUN countries have included the three diet-related NCD targets in their national policy and strategy documents (see Table 9). The most commonly included target is for adult overweight/obesity which is being tracked by 13 SUN countries. Tracking of diabetes prevalence and sodium intake is even less common (only two countries included these indicators in their nutrition documents to date).

TABLE 9: COUNTRY GROUPING BY NUMBER OF NCD TARGETS TRACKED AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Number of NCD targets tracked^				
	None found	None	1	2	3
2010–2011 (N=24)	Kyrgyzstan, Senegal (n=2)	Bangladesh, Benin, Burkina Faso, Ethiopia, Gambia, Ghana, Indonesia, Lao PDR, Mali, Mauritania, Mozambique, Nepal, Peru, Rwanda, Tanzania, Uganda, Zambia (n=17)	Guatemala, Malawi, Namibia, Niger (n=4)	–	Zimbabwe (n=1)
2012–2014 (N=30)	Cameroon, Comoros, DRC, Lesotho, Pakistan, Somalia, South Sudan, Swaziland, Tajikistan, Togo (n=10)	Burundi, Chad, Congo, Costa Rica, Côte d'Ivoire, Guinea, Guinea-Bissau, Haiti, Liberia, Madagascar, Nigeria, Yemen (n=12)	Cambodia, El Salvador, Kenya, Philippines, Sri Lanka, Viet Nam (n=6)	Myanmar, Sierra Leone (n=2)	–
2015–2017 (N=5)	Botswana, Papua New Guinea, Sudan (n=3)	Central African Republic, Gabon –	–	–	–

^Based on data available by the end of 2016

Data on the existence of national policies for non-communicable diseases (hypertension and diabetes) were available for 50 SUN countries, based on reporting for year 2015.

TABLE 10: COUNTRY GROUPING BY EXISTENCE OF NCD POLICIES AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Existence of national policies for NCDs	
	Yes	No or Don't Know^
2010–2011 (n=22)*	Guatemala, Indonesia, Kyrgyzstan, Malawi, Rwanda, Uganda, Zambia (n=7)	Bangladesh, Benin, Burkina Faso, Ethiopia, Gambia, Ghana, Lao PDR, Mali, Mauritania, Mozambique, Nepal, Niger, Peru, Senegal, Zimbabwe (n=15)
2012–2014 (n=25)†	Costa Rica, Kenya, Lesotho, Madagascar, Nigeria, Tajikistan (n=6)	Burundi, Cambodia, Cameroon^, Chad^, Comoros, Congo, El Salvador, Guinea, Haiti, Myanmar, Pakistan, Philippines, Sierra Leone, Somalia, Sri Lanka, Swaziland, Togo, Viet Nam^, Yemen (n=19)
2015–2017 (n=3)‡	Papua New Guinea, Sudan (n=2)	Central African Republic (n=1)

* No data for Namibia, Tanzania
† No data for Côte d'Ivoire, DRC, Guinea-Bissau, Liberia, South Sudan
‡ No data for Botswana, Gabon

Information Systems for Nutrition

MEAL Indicator 1.6: Existence of information systems for nutrition

In 2016, Nutrition International conducted a mapping of the information systems for nutrition in SUN countries. The mapping was organized around three components, each with a group of indicators (see Table 11). Country information was used to score each indicator (maximum score of 12 per component) and calculate an overall Information Systems for Nutrition Index score (maximum score of 36). An average of 56 SUN countries (95%) had data available for the various indicators.

TABLE 11: SUMMARY OF INFORMATION SYSTEMS FOR NUTRITION (ISN) INDEX COMPONENTS AND INDICATORS

Index Component	Indicators	Countries with data	Scoring
Government commitment and enabling environment	*Policy & Planning Documents*		3
	• Common Results Framework	59	
	• Existence of M&E Framework	58	
	• Budget exercise completed	56	
	Tracking Global Targets		Counted separately
	• 6 WHA targets	58	
	• 3 NCD targets	58	
	Institutionalization & Coordination		4
	• Government coordinating body for ISN	57	
	• Central repository for data	59	
	• Data is publicly accessible	59	
	• Stakeholder mapping completed	59	
National assessment data	National Surveys (DHS, MICS, SMART)	59	6
	Micronutrient or Fortification Survey	59	2
	Household Consumption & Expenditure Survey	59	2
	Food Security or Vulnerability Assessment Mapping	59	2
National performance monitoring data	Health facility-based nutrition services		3
	• Micronutrient supplements in pregnancy	56	
	• Breastfeeding promotion	59	
	• IYCF counseling	59	
	• Management of acute malnutrition	49	
	Nutrition programmes		3
	• Vitamin A supplementation	56	
	• Community-based management of acute malnutrition (CMAM)	49	
	• Fortification of staple foods	57	
	• Universal Salt Iodization	48	
	Sectoral Information Systems		6
	• Health	59	
	• Agriculture	52	
	• Education	59	
	• WASH	53	
	• Social Protection	57	
	• Early Childhood Development	27	

More details on the individual components of the ISN Index can be found in Appendix G of this report. As shown in Table 12 and Figures 1.6a-f below, there appears to be a strong relationship between a country's year of joining the SUN Movement and overall score on the Information Systems for Nutrition Index, as well as the score for each of the three components that make up the index. Index scores are also positively correlated with a country's score for the four SUN processes and score for SUN Process 3 which focuses on the Common Results Framework indicators.

TABLE 12: COUNTRY GROUPING BY ISN INDEX TOTAL SCORE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	ISN Index Total Score (out of 36)			
	0–9	10–18	19–27	28–36
2010–2011 (n=24)	–	Benin, Namibia (n=2)	Bangladesh, Burkina Faso, Ethiopia, Gambia, Ghana, Indonesia, Kyrgyzstan, Lao PDR, Mauritania, Mozambique, Niger, Peru, Rwanda, Senegal, Tanzania, Uganda, Zambia, Zimbabwe (n=18)	Guatemala, Malawi, Mali, Nepal (n=4)
2012–2014 (n=30)	Comoros (n=1)	Burundi, Cameroon, Chad, Congo, Costa Rica, Côte d'Ivoire, Guinea-Bissau, Haiti, Lesotho, Liberia, Somalia, South Sudan, Swaziland, Tajikistan, Togo, Yemen (n=16)	Cambodia, DRC, El Salvador, Guinea, Madagascar, Pakistan, Philippines, Sierra Leone, Sri Lanka, Viet Nam (n=10)	Kenya, Myanmar, Nigeria (n=3)
2015–2017 (n=5)	Botswana, Gabon, Papua New Guinea (n=3)	Central African Republic, Sudan (n=2)	–	–

Figure 1.6a
Information Systems for Nutrition Index
Average Component Scores by Year Joined SUN Movement

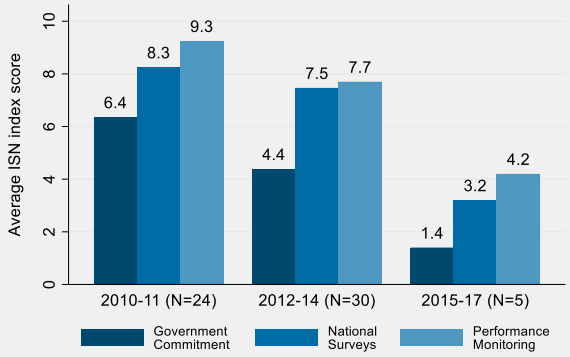


Figure 1.6b
Information Systems for Nutrition Index
Average Total Score by Year Joined SUN Movement

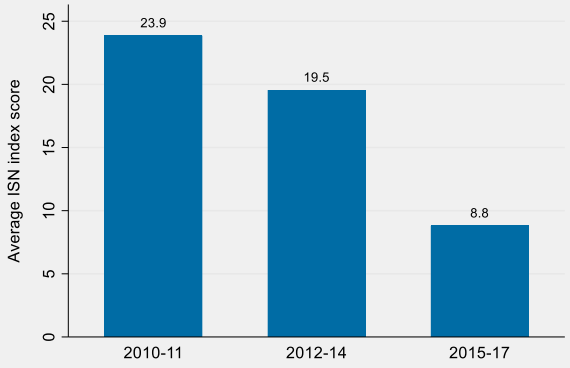


Figure 1.6c
Information Systems for Nutrition Index
Average Total Score by number of networks

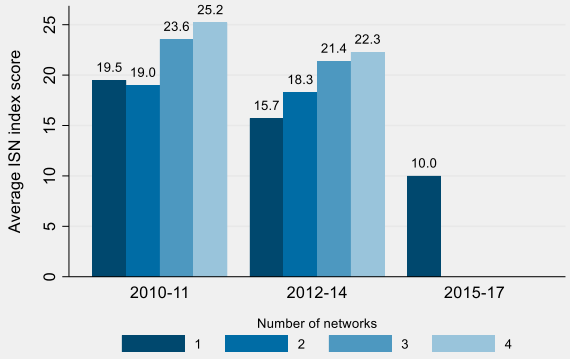


Figure 1.6d
Information Systems for Nutrition Index
Average Total Score by Country Income Classification

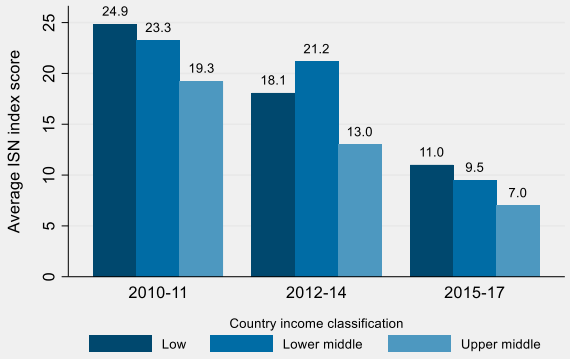


Figure 1.6e
Information Systems for Nutrition Index Score by average score for four SUN processes

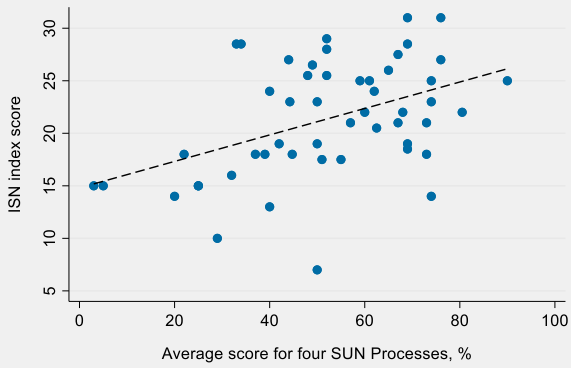
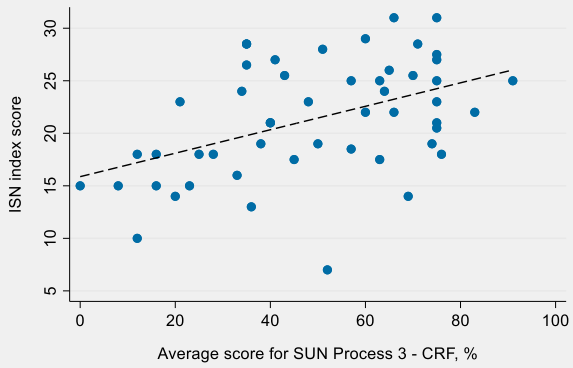


Figure 1.6f
Information Systems for Nutrition Index Score by average score for SUN process 3 - CRF score



Integration of Nutrition in National Development Plans

MEAL Indicators 1.7 and 1.8: Integration of nutrition in development plans developed up to 2015

In the framework of the 2030 Agenda for Sustainable Development, many countries are updating their national plans building on strong linkages with sectoral policies and plans and on the engagement with multiple stakeholders.

In 2016, data were available for 56 SUN countries with their rank in relation to other countries in the world for the integration of undernutrition and overnutrition in national development plans and economic growth strategies developed by 2015.[6] While some of these plans and strategies are still ongoing, most countries are in the updating process, especially in view of the 2030 Sustainable Development Agenda. As an indicator of progress, the MEAL system will actively search and assess plans that have been developed since the beginning of 2016. This is part of an ongoing discussion with the UN Network to ensure that a systematic review is in place from 2018 onwards.

In the meantime, as shown in Table 13, 22 SUN countries are ranked in the top 30 (country rank out of 126 countries) for the presence of undernutrition in national development plans and economic growth strategies. Among these, 14 of 22 are countries that joined the SUN Movement in the first couple of years.

TABLE 13: COUNTRY GROUPING BY WORLD RANK FOR UNDERNUTRITION IN NATIONAL DEVELOPMENT PLANS AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Country rank in the world (1 to 126)			
	Top 30	31–60	61–90	Bottom 30
2010–2011 (n=24)	Bangladesh, Benin, Gambia, Guatemala, Malawi, Mali, Mauritania, Mozambique, Nepal, Niger, Peru, Rwanda, Senegal, Tanzania (n=14)	Burkina Faso, Ghana, Indonesia, Lao PDR, Uganda, Zambia (n=6)	Namibia (n=1)	Ethiopia, Kyrgyzstan, Zimbabwe (n=3)
2012–2014 (n=27)†	Cambodia, DRC, Lesotho, Madagascar, Sierra Leone, Swaziland, Tajikistan, Togo (n=8)	Chad, Costa Rica, Côte d'Ivoire, Guinea, Guinea-Bissau, Myanmar, Philippines, Somalia (n=8)	Burundi, Cameroon, Comoros, Congo, Haiti, Kenya, Liberia, Pakistan, Sri Lanka (n=9)	El Salvador, Nigeria (n=2)
2015–2017 (n=5)	–	–	–	Botswana, CAR, Gabon, PNG, Sudan (n=5)

† No data for South Sudan, Viet Nam, Yemen

[6] Source: Global Nutrition Report 2015 data based on research conducted by the Institute of Development Studies (IDS), 2015.

The results are quite different when the presence of overnutrition in national development plans is assessed (see Table 14). Only 3 SUN countries are ranked in the top 30 (country rank out of 116) and nearly half (27 of 56 countries with data) are ranked in the bottom 30.

TABLE 14: COUNTRY GROUPING BY WORLD RANK FOR OVERNUTRITION IN NATIONAL DEVELOPMENT PLANS AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Country rank in the world (1 to 116)			
	Top 30	31–60	61–90	Bottom 30
2010–2011 (n=24)	Gambia, Senegal (n=2)	Bangladesh, Mauritania, Mozambique, Rwanda, Uganda (n=5)	Benin, Burkina Faso, Ghana, Kyrgyzstan, Niger, Tanzania (n=6)	Ethiopia, Guatemala, Indonesia, Lao PDR, Malawi, Mali, Namibia, Nepal, Peru, Zambia, Zimbabwe (n=11)
2012–2014 (n=27)†	Cambodia (n=1)	Comoros, Costa Rica, Côte d'Ivoire, El Salvador, Lesotho, Philippines, Togo (n=7)	Congo, Guinea, Guinea-Bissau, Haiti, Kenya, Pakistan, Sri Lanka (n=7)	Burundi, Cameroon, Chad, DRC, Liberia, Madagascar, Myanmar, Nigeria, Sierra Leone, Somalia, Swaziland, Tajikistan (n=12)
2015–2017 (n=5)‡	—	—	Central African Republic (n=1)	Botswana, Gabon, PNG, Sudan (n=4)

† No data for South Sudan, Viet Nam, Yemen

Mobilization of high-level advocates for nutrition

MEAL Indicator 1.9: Mobilization of high-level advocates (champions, parliamentarians, media)

The SUN Movement Secretariat routinely tracks the engagement of high-level advocates for nutrition and also receives regular updates on advocacy events and meetings.

By 2016, 12 SUN countries had identified champions and were also engaging both parliamentarians and media, 7 countries had identified champions and were engaging either parliamentarians or media, 10 countries were engaging both parliamentarians and media, and 8 countries were engaging either parliamentarians or media or had identified champions.

TABLE 15: COUNTRY GROUPING BY MOBILIZATION OF HIGH-LEVEL ADVOCATES AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Number of type of high-level advocates mobilized			
	All 3	2	1	None
2010–2011 (n=24)	Bangladesh, Burkina Faso, Guatemala, Indonesia, Mozambique, Peru, Rwanda, Zambia, Zimbabwe (n=9)	Benin, Gahan, Kyrgyzstan, Lao PDR, Namibia, Nepal, Tanzania (n=7)	Ethiopia, Gambia, Malawi, Mali (n=4)	Mauritania, Niger, Senegal, Uganda (n=4)
2012–2014 (n=30)	Chad, Guinea, Madagascar (n=3)	Congo, DRC, El Salvador, Kenya, Nigeria, Pakistan, Philippines, Sierra Leone, Sri Lanka, Tajikistan (n=10)	Cambodia, Côte d'Ivoire, Somalia, Viet Nam (n=4)	Burundi, Cameroon, Comoros, Costa Rica, Guinea Bissau, Haiti, Lesotho, Liberia, Myanmar, South Sudan, Swaziland, Togo, Yemen (n=13)
2015–2017 (n=4)‡	–	–	–	Botswana, Gabon Papua New Guinea, Sudan (n=4)

‡ No data for Central African Republic

Step 3: Multiple-stakeholders mobilize resources and align implementation

List 2: Finance for nutrition

NATIONAL INVESTMENTS FOR NUTRITION

MEAL Indicator 2.1: National investments for nutrition disaggregated by specific or sensitive, types of programmes, MDAs, sources of funding, allocations expenditures, years

The SUN Movement Secretariat together with other international partners (Results for Development (R4D), Strengthening Partnerships, Results, and Innovations in Nutrition Globally project (SPRING), Maximising the Quality of Scaling Up Nutrition project (MQSUN+), Oxford Policy Management, Global Nutrition Report) have been working together with several SUN countries to advance efforts on financial tracking. The availability of robust and regular finance data is critical for policy-makers – as it enables them to prioritise, guide programme planning, monitor, and evaluate the implementation and results of any given policy. Furthermore, in addition to informing decision-making, tracing investments increases accountability and advocacy opportunities for good nutrition.

2.1 a) Completeness of the budget analysis

The completeness of the budget analysis was analyzed based on four key elements: a) completion of the budget analysis itself; b) the analysis identified both nutrition-specific and nutrition-sensitive components; c) the analysis identified a clear source of funds; and d) there is more than one time point. Based on data shared with the SMS, 42 SUN countries (71%) had completed a budget analysis by end of 2016 (see Table 16).

TABLE 16: COUNTRY GROUPING BY COMPLETENESS OF BUDGET ANALYSIS AND YEAR OF JOINING THE SUN MOVEMENT[☼]

Year of SUN start	Number of key elements in the budget analysis			
	1 of 4	2 of 4	3 of 4	All 4
2010–2011 (n=17)*	Niger (n=1)	–	Benin, Burkina Faso, Gambia, Ghana, Guatemala, Kyrgyzstan, Mauritania, Mozambique, Nepal, Peru, Uganda, Zambia (n=12)	Bangladesh, Ethiopia, Indonesia, Lao PDR (n=4)
2012–2014 (n=24)†	Cameroon, Guinea, Liberia (n=3)	Chad, Congo, Guinea-Bissau, Nigeria, South Sudan, Swaziland, Togo (n=7)	Burundi, Comoros, Côte d'Ivoire, DRC, El Salvador, Kenya, Madagascar, Pakistan, Philippines, Tajikistan, Viet Nam, Yemen (n=12)	Costa Rica, Lesotho (n=2)
2015–2017 (n=1)‡	–	–	Botswana (n=1)	–

☼ Based on data available by the end of 2016; * No data for Malawi, Mali, Namibia, Rwanda, Senegal, Tanzania, Zimbabwe; † No data for Cambodia, Haiti, Myanmar, Sierra Leone, Somalia, Sri Lanka; ‡ No data for CAR, Gabon, Papua New Guinea, Sudan

2.1 b) Nutrition-specific spending – U5 per capita

This indicator only looks at the total per capita spending on nutrition-specific interventions for children under five years of age. “Nutrition-specific” interventions have been defined by the 2013 Lancet Series on Maternal and Child Nutrition and by other publications including the Investment Framework for Nutrition (World Bank 2016). While there are differences across countries due to the structure of the budgets, reported data on nutrition-specific interventions are broadly comparable. On the other hand, the sectoral programmes included in the budget analysis as “nutrition-sensitive” vary considerably from one country to the other, reflecting their priorities and strategies and would not provide a comparable measure.

TABLE 17: COUNTRY GROUPING BY NUTRITION-SPECIFIC SPENDING AND YEAR OF JOINING THE SUN MOVEMENT[☼]

Year of SUN start	U5 per capita spending on nutrition-specific interventions			
	<$1	$1–4	$5–7	≥$8
2010–2011 (n=14)*	Kyrgyzstan, Mozambique, Uganda, Zambia (n=4)	Benin, Burkina Faso, Ethiopia, Lao PDR, Mauritania (n=5)	—	Bangladesh, Guatemala, Indonesia, Nepal, Peru (n=5)
2012–2014 (n=17)†	Burundi, Chad, Côte d’Ivoire, DRC, Guinea-Bissau, Madagascar, Nigeria, Tajikistan, Togo (n=9)	Comoros, Kenya, Lesotho, Pakistan (n=4)	El Salvador, Philippines, Viet Nam (n=3)	Costa Rica (n=1)
2015–2017 (n=1)‡	—	—	—	Botswana (n=1)

☼ Based on data available by the end of 2016
* No data for Gambia, Ghana, Malawi, Mali, Namibia, Niger, Rwanda, Senegal, Tanzania, Zimbabwe
† No data for Cambodia, Cameroon, Congo, Guinea, Haiti, Liberia, Myanmar, Sierra Leone, Somalia, South Sudan, Sri Lanka, Swaziland, Yemen
‡ No data for CAR, Gabon, PNG, Sudan

2.1 c) Ratio of nutrition-specific and sensitive spending

Table 18 presents results of the analysis of the ratio of budgeted spending on nutrition-specific and nutrition-sensitive interventions. While there is no agreed benchmark on the ratio between nutrition-specific and nutrition-sensitive spending, the analysis shows that the nutrition-specific spending is less than 5% in most countries. This might be due to the absence of nutrition programmes and interventions in national budgets but also to limitations with the reporting capacity especially when nutrition is integrated in sectoral programmes.

TABLE 18: COUNTRY GROUPING BY RATIO OF NUTRITION-SPECIFIC TO NUTRITION-SENSITIVE SPENDING AND YEAR OF JOINING THE SUN MOVEMENT[☼]

Year of SUN start	Ratio of nutrition-specific and nutrition-sensitive			
	<1%	1–4%	5–10%	>10%
2010–2011 (n=14)*	Kyrgyzstan, Mozambique (n=2)	Benin, Lao PDR, Mauritania, Zambia (n=4)	Burkina Faso, Indonesia (n=2)	Bangladesh, Ethiopia, Guatemala, Nepal, Peru, Uganda (n=6)
2012–2014 (n=17)†	Burundi, Chad, DRC, El Salvador, Guinea Bissau, Nigeria, Tajikistan (n=7)	Comoros, Côte d'Ivoire, Kenya, Lesotho, Madagascar, Pakistan, Philippines (n=7)	Togo (n=1)	Costa Rica, Viet Nam (n=2)
2015–2017 (n=1)‡	–	Botswana (n=1)	–	–

☼ Based on data available by the end of 2016
* No data for Gambia, Ghana, Malawi, Mali, Namibia, Niger, Rwanda, Senegal, Tanzania, Zimbabwe
† No data for Cambodia, Cameroon, Congo, Guinea, Haiti, Liberia, Myanmar, Sierra Leone, Somalia, South Sudan, Sri Lanka, Swaziland, Yemen
‡ No data for CAR, Gabon, PNG, Sudan

DONOR FUNDING FOR NUTRITION

MEAL Indicator 2.2: Total resource flows for development, by recipient and donor countries and type of flow

Data on donor funding to SUN countries have been analyzed by Results for Development using the 2015 Credit Reporting System (CRS) Database. The analysis below looks specifically at the spending captured under the Basic Nutrition Code which comprises all nutrition interventions addressed to children under five years and women of reproductive age (nutrition-specific) as well as broader interventions targeted to different population groups such as food aid and school feeding (nutrition-sensitive).

2.2 a) Total U5 nutrition spending per stunted child

The analysis below looks at spending (based on the basic nutrition code) per stunted child using the stunting prevalence and the under-five population data for 2015. It links the nutrition spending to the stunting burden in order to compensate for countries that have high prevalence but low population. Results shown in Table 19 appear to indicate that countries with low burden and low population are at the high end of donor spending suggesting that more can be done to compensate for other countries.

TABLE 19: COUNTRY GROUPING BY TOTAL U5 NUTRITION SPENDING PER STUNTED CHILD AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Total U5 nutrition spending per stunted child			
	<$1	$1–4	$5–9	≥$10
2010–2011 (n=24)	Namibia (n=1)	Indonesia, Zimbabwe (n=2)	Bangladesh, Niger, Rwanda, Tanzania, Uganda (n=5)	Benin, Burkina Faso, Ethiopia, Gambia, Ghana, Guatemala, Kyrgyzstan, Lao PDR, Malawi, Mali, Mauritania, Mozambique, Nepal, Peru, Senegal, Zambia (n=16)
2012–2014 (n=29)†	El Salvador, Lesotho, Myanmar, Philippines, (n=4)	DRC, Kenya, Nigeria, Pakistan South Sudan, Swaziland, Tajikistan, Togo, Viet Nam (n=9)	Cameroon, Chad, Comoros, Congo, Côte d'Ivoire, Guinea (n=6)	Burundi, Cambodia, Guinea-Bissau, Haiti, Liberia, Madagascar, Sierra Leone, Somalia, Sri Lanka, Yemen (n=10)
2015–2017 (n=5)	Gabon, Papua New Guinea, Sudan (n=3)	Botswana (n=1)	–	Central African Republic (n=1)

† No data for Costa Rica

2.2 b) U5 per capita high-impact nutrition-specific spending

The analysis below (see Table 20) looks at donor spending (using the basic nutrition code) for a minimum package of high-impact nutrition-specific interventions that are comparable with those costed in the Investment Framework for Nutrition (World Bank 2016). These include: management of acute malnutrition, micronutrient supplementation for children and pregnant-lactating women, IYCF counselling and promotion of breastfeeding, provision of fortified complementary food and food fortification.

TABLE 20: COUNTRY GROUPING BY U5 PER CAPITA HIGH-IMPACT NUTRITION-SPECIFIC SPENDING AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Total U5 per capita for high-impact nutrition specific spending			
	<$1.0	$1.0–1.9	$2.0–3.9	≥$4
2010–2011 (n=24)	Bangladesh, Benin, Burkina Faso, Guatemala, Indonesia, Kyrgyzstan, Namibia, Peru, Rwanda, Tanzania, Uganda, Zimbabwe (n=12)	Ghana, Lao PDR, Niger, Zambia (n=4)	Ethiopia, Mali, Mauritania, Mozambique, (n=4)	Gambia, Malawi, Nepal Senegal (n=4)
2012–2014 (n=29)†	Cambodia, Cameroon, Congo, Côte d'Ivoire, DRC, El Salvador, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Myanmar, Nigeria, Pakistan, Philippines, Sierra Leone, South Sudan, Swaziland, Tajikistan, Togo, Viet Nam (n=21)	Burundi, Chad, Comoros, Somalia Sri Lanka (n=4)	Madagascar (n=1)	Haiti, Sri Lanka, Yemen (n=3)
2015–2017 (n=5)	Botswana, Gabon, Papua New Guinea, Sudan (n=4)	Central African Republic (n=1)	–	–

† No data for Costa Rica

2.2 c) Ratio of nutrition-specific/sensitive spending

The basic nutrition code is commonly used by the donors as a proxy for nutrition-specific spending. Nevertheless, it includes interventions that are nutrition-sensitive and are also significant drivers of spending such as food aid, school feeding and food security projects. The analysis from Results for Development on the 2015 reported data under this code shows that nutrition-specific spending accounts for at least 70% in only one fifth of SUN countries (Table 21). Options have been proposed by the Donor Network to improve their reporting including narrowing the focus of the basic nutrition code to better reflect nutrition-specific spending.

TABLE 21: COUNTRY GROUPING BY RATIO OF NUTRITION-SPECIFIC/SENSITIVE SPENDING AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Ratio of nutrition-specific/sensitive spending			
	<25%	25–49%	50–69%	≥70%
2010–2011 (n=24)	Ethiopia, Indonesia, Namibia, Peru, Zambia, Zimbabwe (n=6)	Bangladesh, Gambia, Ghana, Mauritania, Nepal, Niger, Senegal (n=7)	Malawi, Mali, Mozambique, Tanzania, Uganda (n=5)	Benin, Burkina Faso, Guatemala Kyrgyzstan, Lao PDR, Rwanda(n=6)
2012–2014 (n=29)†	Comoros, Myanmar, Nigeria, Sri Lanka, Viet Nam (n=5)	Chad, DRC, Haiti, Kenya, Madagascar, Pakistan, Philippines, Somalia, South Sudan, Swaziland, Togo, Yemen (n=12)	Côte d'Ivoire, El Salvador, Guinea, Lesotho, Sierra Leone, Tajikistan (n=6)	Burundi, Cambodia, Cameroon, Congo, Guinea-Bissau, Liberia (n=6)
2015–2017 (n=5)	Botswana, Papua New Guinea (n=2)	Sudan (n=1)	Central African Republic, Gabon(n=2)	–

† No data for Costa Rica

Agriculture Orientation Index

MEAL Indicator 2.3: The Agriculture Orientation Index for Government Expenditures

The Agriculture Orientation Index (AOI) for Government Expenditures is a currency-free index that is calculated as the ratio of Agriculture Share of Government Expenditures to the Agriculture Share of GDP, where Agriculture refers to the agriculture, forestry, fishing and hunting sector. An AOI greater than 1 reflects a higher orientation by the government towards the agriculture sector, which receives a higher share of government spending relative to its contribution to economic value-added. An AOI less than 1 reflects a lower orientation to agriculture.[7] For example, if the AOI is 0.5, for every unit spent of the total central government's budget, agriculture gets half of what it should obtain if allocation was according to contribution to GDP. Based on the SDG Report in 2016 and 2017, the AOI has been falling globally and fell from 0.37 to 0.33 in developing countries.

Data on AOI are available for 37 SUN countries with the reference year ranging from 2002 to 2016 (28 countries with data from 2012–2016). All countries except Botswana and Zambia have an AOI less than 1 (Table 22). The AOI values range from 0.0002 to 2.08, with a mean of 0.32 (median 0.19). Countries with a high prevalence of undernourishment have a mean AOI of 0.35 compared to 0.17 among countries with a low prevalence, suggesting that, to some degree, public expenditure on agriculture is seen as part of the response to alleviating undernourishment.

TABLE 22: COUNTRY GROUPING BY AGRICULTURE ORIENTATION INDEX AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	AOI			
	0–0.19	0.20–0.50	0.50–1.00	≥1.00
2010–2011 (n=17)*	Benin, Burkina Faso, Ghana, Guatemala, Indonesia, Kyrgyzstan, Rwanda, Tanzania, Uganda (n=9)	Ethiopia, Mali, Mozambique, Namibia, Nepal (n=5)	Bangladesh, Malawi (n=2)	Zambia (n=1)
2012–2014 (n=18)†	Burundi, El Salvador, Guinea-Bissau, Kenya, Liberia, Nigeria, Pakistan, Togo, Viet Nam (n=9)	Costa Rica, Côte d'Ivoire, DRC, Lesotho, Madagascar, Philippines (n=6)	Congo, Sri Lanka, Swaziland (n=3)	–
2015–2017 (n=2)‡	Central African Republic (n=1)	–	–	Botswana (n=1)

* No data for Gambia, Lao PDR, Mauritania, Niger, Peru, Senegal, Zimbabwe
† No data for Cambodia, Cameroon, Chad, Comoros, Guinea, Haiti, Myanmar, Sierra Leone, Somalia, South Sudan, Tajikistan, Yemen
‡ No data for Gabon, Papua New Guinea, Sudan

[7] SDG Global Database Metadata for SDG Indicator 2.a.1: The agriculture orientation index for government expenditures. https://unstats.un.org/sdgs/metadata/files/Metadata-02-0A-01.pdf

List 3: Interventions and food supply indicators

The indicators included in List 3 refer to coverage of services and supply that are likely to be found in national food and nutrition plans, as well as social protection programmes.

INTERVENTIONS TO ADDRESS MATERNAL & CHILD UNDERNUTRITION

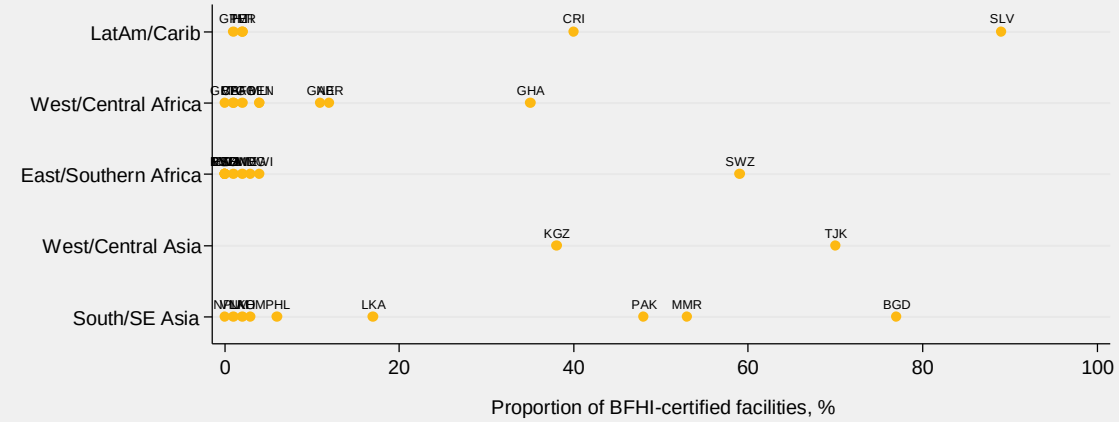
Infant and Young Child Feeding promotion

MEAL Indicator 3.1: Proportion of health facilities that are Baby Friendly Hospital Initiative (BFHI) certified

Launched by WHO and UNICEF in 1991, the Baby-Friendly Hospital Initiative (BFHI) aims to support breastfeeding in facilities that provide maternity services. Certification is given when a health facility adheres to a set of 10 steps that address the domains of policy, human resources, promotion and support, protection from breastmilk substitutes and physical structure to ensure that mothers and babies room together.

A total of 35 SUN countries have data on the proportion of hospitals and maternity facilities that are designated as a “Baby Friendly” institution. Coverage varies widely across these countries (see Figure 3.1a), ranging from zero to 89% with a mean of 16.8% (95% CI 8.0, 25.6) and a median of 3%. Eighty percent (28/35) of countries report low coverage of less than 40%.

Figure 3.1a
Distribution of BFHI facility coverage in SUN countries by region



Each symbol represents a country (N=35).

BFHI facility coverage is high in the two West/Central Asian countries of Kyrgyzstan (38%) and Tajikistan (70%). Coverage is very low in countries in sub-Saharan Africa, with two exceptions: Ghana (35%) and Swaziland (59%). Similarly, in Latin America, Costa Rica (40%) and El Salvador (89%) are the two exceptions in a region where the remainder of countries have coverage levels of 1–2%. In South and Southeast Asia, Bangladesh (77%), Myanmar (53%) and Pakistan (48%) are the region’s leaders in coverage, with the remainder of countries having much lower coverage levels.

TABLE 23: COUNTRY GROUPING BY BFHI COVERAGE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Proportion of health facilities that are BFHI-certified		
	Low (<40%)	Medium (40–59%)	High (≥60%)
2010–2011*	Benin, Burkina Faso, Ethiopia, Gambia, Ghana, Guatemala, Kyrgyzstan, Lao PDR, Malawi, Mali, Mozambique, Nepal, Niger, Peru, Rwanda, Zimbabwe (n=16)	–	Bangladesh (n=1)
2012–2014†	Cambodia, Haiti, Lesotho, Madagascar, Philippines, Sri Lanka, Togo, Viet Nam (n=8)	Costa Rica, Myanmar, Pakistan, Swaziland (n=4)	El Salvador, Tajikistan (n=2)
2015–2017‡	Botswana, CAR, Gabon, Sudan (n=4)	–	–

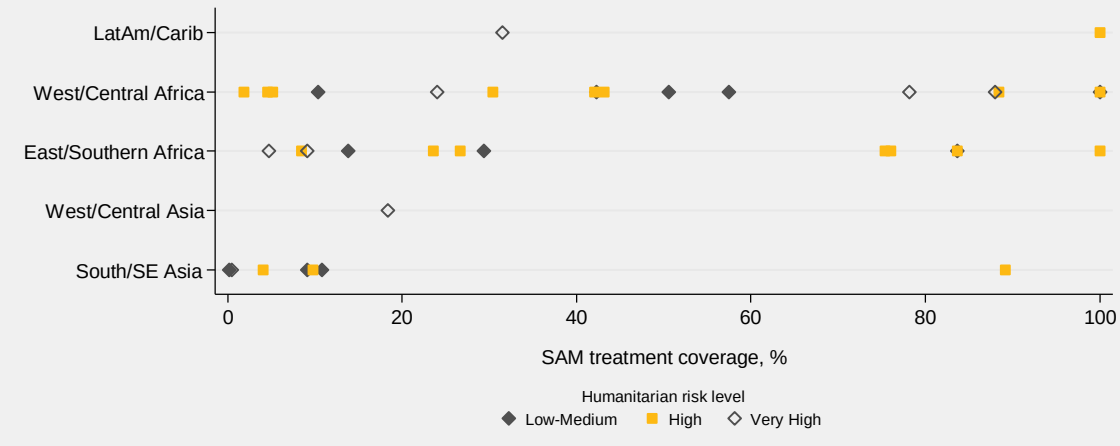
* Data not available for Indonesia, Mauritania, Namibia, Senegal, Uganda, Tanzania, Zambia
† Data not available for Burundi, Cameroon, Chad, Comoros, Congo, Côte d'Ivoire, DRC, Guinea, Guinea-Bissau, Kenya, Liberia, Nigeria, Sierra Leone, Somalia, South Sudan, Yemen
‡ Data not available for Papua New Guinea

Severe Acute Malnutrition treatment

MEAL Indicator 3.2: Proportion of children 6–59 months with severe acute malnutrition admitted for treatment

Based on 2012 data reported by the GNR for 38 SUN countries, 41.4% (95% CI 29.7, 53.1) of children 6–59 months with severe acute malnutrition (SAM) are admitted for treatment. However, as shown in Figure 3.2a, variation in coverage demonstrates the broad differences across countries in this coverage indicator.

Figure 3.2a
Distribution of SAM treatment coverage in SUN countries by region and humanitarian context



SAM treatment coverage based on various country characteristics is shown in Table 24.

TABLE 24: SAM TREATMENT COVERAGE IN SUN COUNTRIES

Characteristic	N	Coverage, %	Characteristic	N	Coverage, %
All SUN countries			**Region**		
Mean (95% CI)	38	41.4 (29.7, 53.2)	Latin America & Caribbean	2	65.8
Median	38	29.9	West/Central Africa	16	47.9
Range	38	0.2, 100.0	East/Southern Africa	12	44.6
Year joined SUN Movement			West/Central Asia	1	18.4
2010–11	17	53.0	South/Southeast Asia	7	17.7
2012–14	19	30.3	**Country Income Level**		
2015–17	2	49.2	Low-income	23	46.2
Humanitarian Risk Level			Lower middle-income	15	34.2
Low-medium	11	29.0	Upper middle-income	0	–
High	19	50.0			
Very High	8	21.1			

TABLE 25: COUNTRY GROUPING BY SAM TREATMENT COVERAGE LEVELS AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	SAM treatment coverage level, 2012			
	<10%	10–39%	40–74%	≥75%
2010–2011 (n=17)*	Bangladesh, Mali, Nepal, Uganda (n=4)	Gambia, Mozambique (n=2)	Benin, Ghana, Senegal (n=3)	Burkina Faso, Ethiopia, Guatemala, Malawi, Mauritania, Niger, Rwanda, Zimbabwe (n=8)
2012–2014 (n=19)†	Cambodia, Congo, Côte d'Ivoire, Pakistan, Philippines, South Sudan (n=6)	Comoros, DRC, Haiti, Madagascar, Sierra Leone, Sri Lanka, Swaziland, Yemen (n=8)	Guinea-Bissau, Liberia (n=2)	Chad, Kenya, Togo (n=3)
2015–2017 (n=2)‡	Sudan (n=1)	–	–	Papua New Guinea (n=1)

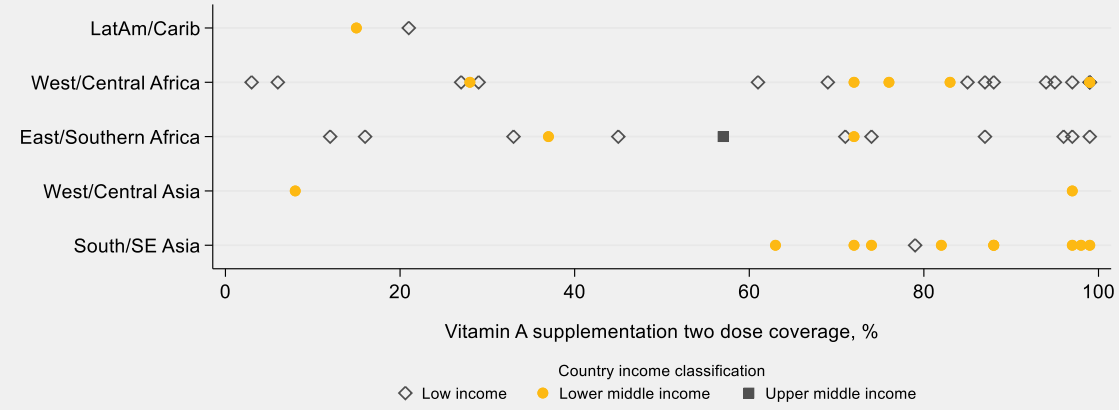
* No data for Indonesia, Kyrgyzstan, Lao PDR, Namibia, Peru, Tanzania, Zambia
† No data for Burundi, Cameroon, Costa Rica, El Salvador, Guinea, Lesotho, Myanmar, Nigeria, Somalia, Tajikistan, Viet Nam
‡ No data for Botswana, CAR, Gabon

Vitamin A supplementation

MEAL Indicator 3.3: Proportion of children 6–59 months receiving Vitamin A supplementation

UNICEF's Global Database for priority countries for national level vitamin A supplementation programmes[8] includes 56 SUN countries. For the 2015 reference year, 47 SUN countries have data on the percentage of children 6–59 months of age who received full coverage (two doses) of vitamin A supplements. On average, these SUN countries achieved 67.5% coverage, ranging from 3 to 99% (see Table 26). The distribution of coverage across SUN countries by regions is shown in Figure 3.3a.

Figure 3.3a
Distribution of vitamin A supplementation coverage in SUN countries in 2015 by region and country income classification



Source: UNICEF Global Database (Oct 2017). Each symbol represents a country (N=47).

TABLE 26: VITAMIN A SUPPLEMENTATION COVERAGE IN SUN COUNTRIES

Characteristic	N	Coverage, %	Characteristic	N	Coverage, %
All SUN countries			**Region**		
Mean (95% CI)	47	67.5 (58.3, 76.7)	Latin America & Caribbean	2	18.0
Median	47	76.0	West/Central Africa	20	69.8
Range	47	3, 99.0	East/Southern Africa	13	61.2
Year joined SUN Movement			West/Central Asia	2	52.5
2010–11	19	69.9	South/Southeast Asia	10	84.0
2012–14	25	68.5	**Country Income Level**		
2015–17	3	44.0	Low-income	26	64.2
Humanitarian Risk Level			Lower middle-income	20	72.4
Low-Medium	15	56.2	Upper middle-income	1	57.0
High	22	78.6			
Very High	10	60.1			

[8] United Nations Children's Fund, Division of Data Research and Policy (2018). Global UNICEF Global Databases: Vitamin A supplementation 2000-2015, New York, October 2017.

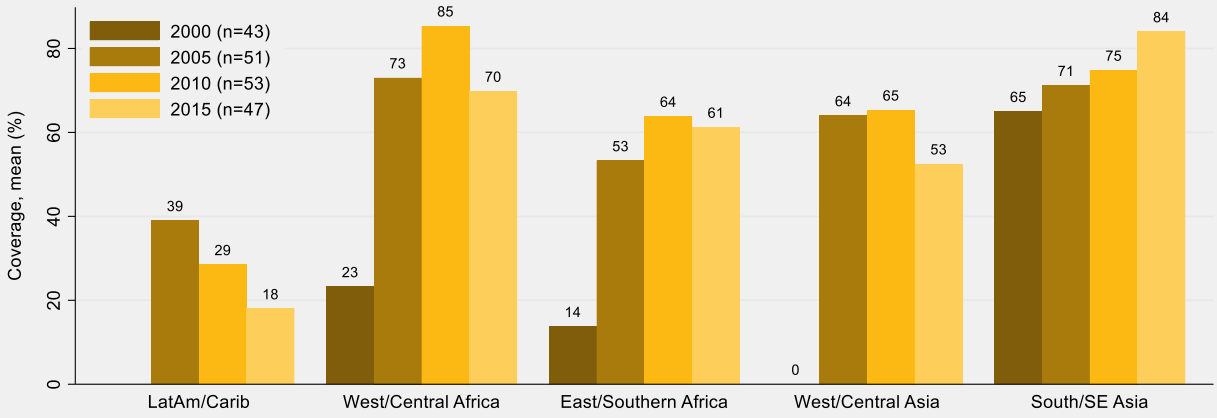
TABLE 27: COUNTRY GROUPING BY VITAMIN A SUPPLEMENTATION COVERAGE LEVELS IN 2015 AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Vitamin A supplementation coverage, 2014			
	0–59%	60–79%	80–89%	≥90%
2010–2011 (n=19)*	Gambia, Ghana, Guatemala, Malawi, Senegal, Zimbabwe (n=6)	Ethiopia, Nepal (n=2)	Indonesia, Lao PDR, Mali, Mauritania, Tanzania (n=5)	Bangladesh, Benin, Burkina Faso, Mozambique, Niger, Rwanda (n=6)
2012–2014 (n=25)†	Comoros, Haiti, Kenya, Somalia, Togo, Yemen (n=6)	Burundi, Cambodia, Côte d'Ivoire, Guinea, Liberia, Nigeria, Philippines, Sri Lanka (n=8)	Chad, Guinea-Bissau, Myanmar (n=3)	Cameroon, Congo, DRC, Madagascar, Pakistan, Sierra Leone, Tajikistan, Viet Nam (n=8)
2015–2017 (n=3)‡	Botswana, Central African Republic (n=2)	Sudan (n=1)	–	–

* No data for Kyrgyzstan, Namibia, Peru, Uganda, Zambia
† No data for Costa Rica, El Salvador, Lesotho, South Sudan, Swaziland
‡ No data for Gabon, Papua New Guinea

Based on coverage trends since the year 2000 (Figure 3.3b), vitamin A supplementation coverage has generally increased in most regions. Countries from South and Southeast Asia show the most consistent increase in coverage over time, whereas coverage in sub-Saharan Africa and West/Central Asia appears to be stagnating between 2005 and 2015. Coverage has decreased over time in both Guatemala and Haiti, the only two countries with data in the Latin America and Caribbean region.

Figure 3.3b: Progress between 2000 and 2015 in vitamin A supplementation coverage in SUN countries



Source: UNICEF Global Database (Oct 2017)

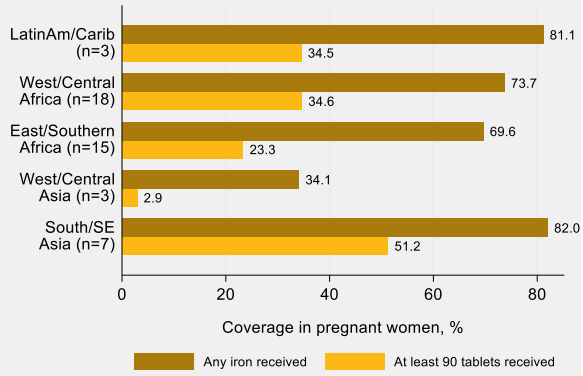
Iron/Folic Acid Supplementation to pregnant women

MEAL Indicator 3.4: Proportion of pregnant women receiving Iron and Folic Acid supplementation

Coverage data on iron supplementation during pregnancy is available through DHS surveys for 46 countries, with the year ranging from 2006 to 2016. Most countries (n=38, 83%) have data from 2012 or more recent.

Overall, 71.5% (95% CI 66, 76) of women reported receiving any iron supplements during their most recent pregnancy, with coverage ranging from 27.7 to 97.8% (median 77.0%). However, only about one third, 30.9% (95% CI 25, 37), reported receiving at least 90 iron tablets (range 0.9 to 75.5%, median 29.6%). As shown in Figure 3.4a, iron supplementation coverage varies considerably across the regions, with the highest coverage in Latin American countries and the lowest coverage in West/Central Asian countries. Iron supplementation coverage with at least 90 tablets during pregnancy (a proxy for adherence) is very low in most regions, except for South/SE Asia region where half of the women reported receiving at least 90 tablets during their most recent pregnancy.

Figure 3.4a
Antenatal iron supplement coverage (any or 90+ tablets) by region



Figures 3.4b and 3.4c show that iron supplementation coverage tends to be slightly higher in countries where surveys were conducted more recently. However, no association was observed between a country's iron supplementation coverage and duration of their involvement in the SUN Movement (data not shown).

Figure 3.4b
Iron supplement coverage for pregnant women by survey year

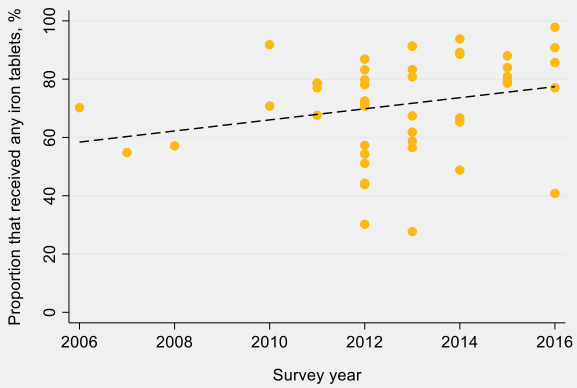
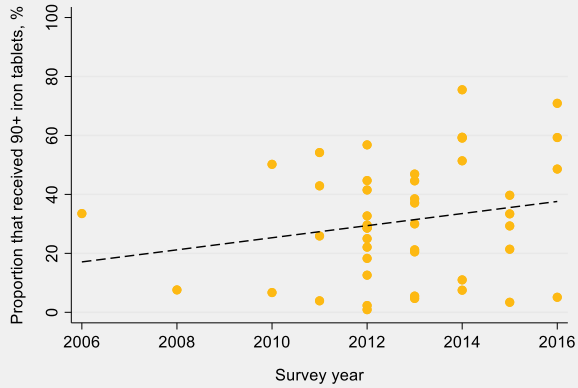


Figure 3.4c
Iron supplement (90+) coverage for pregnant women by survey year



Country-specific performance on this indicator is shown in Table 28.

TABLE 28: COUNTRY GROUPING BY ANTENATAL IRON SUPPLEMENTATION COVERAGE LEVELS AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Women receiving any iron supplements during most recent pregnancy			
	0–39%	40–59%	60–79%	≥80%
2010–2011 (n=22)*	–	Bangladesh, Benin, Ethiopia, Kyrgyzstan, Mali (n=5)	Indonesia, Mozambique, Namibia, Niger, Rwanda, Senegal, Tanzania, Uganda (n=8)	Burkina Faso, Gambia, Ghana, Guatemala, Malawi, Nepal, Peru, Zambia, Zimbabwe (n=9)
2012–2014 (n=24)†	Tajikistan, Yemen (n=2)	Chad, Comoros, DRC, Madagascar, Nigeria, Pakistan (n=6)	Burundi, Cameroon, Congo, Côte d'Ivoire, Guinea, Haiti, Kenya, Lesotho, Sierra Leone, Swaziland (n=10)	Cambodia, Liberia, Myanmar, Philippines, Sri Lanka, Togo (n=6)
2015–2017 (n=1)‡	–	–	–	Gabon (n=1)
	Women receiving at least 90 iron supplements during most recent pregnancy			
	0–14%	15–29%	30–49%	≥50%
2010–2011 (n=21)*	Ethiopia, Kyrgyzstan, Rwanda, Uganda (n=4)	Benin, Guatemala, Mali, Mozambique, Niger, Tanzania (n=6)	Gambia, Indonesia, Malawi, Namibia, Peru, Senegal, Zimbabwe (n=7)	Burkina Faso, Ghana, Nepal, Zambia (n=4)
2012–2014 (n=23)†	Burundi, Chad, Comoros, DRC, Kenya, Madagascar, Tajikistan, Yemen (n=8)	Côte d'Ivoire, Haiti, Liberia, Nigeria, Pakistan (n=5)	Congo, Guinea, Philippines, Sierra Leone, Swaziland, Togo (n=6)	Cambodia, Cameroon, Lesotho, Myanmar (n=4)
2015–2017 (n=1)‡	–	–	–	Gabon (n=1)

* No data for Bangladesh (no data for 90+ tablets), Lao PDR, Mauritania
† No data for Costa Rica, El Salvador, Guinea-Bissau, Somalia, South Sudan, Sri Lanka (no data for 90+ tablets), Viet Nam
‡ No data for Botswana, CAR, Papua New Guinea, Sudan

Nutrition professionals

MEAL Indicator 3.5: Number of trained nutrition professionals /100,000 population (proxy indicator: health worker density)

While no data were available on number of trained nutrition professionals, data on density of physicians and nurses are available for 57 SUN countries[9], with the reference year ranging from 2003 to 2016 for most countries (Haiti is 1998). Data on density of community and traditional health workers are available for 33 SUN countries (reference years 2004 to 2013).

As shown in Table 29, the average density of physicians is 0.38 per 1000 population. While globally 44% of WHO Member States report to have less than 1 physician per 1000 population[10], 86% of SUN countries are in this situation. Physician density tends to be higher in countries with more recent estimates (Figure 3.5a).

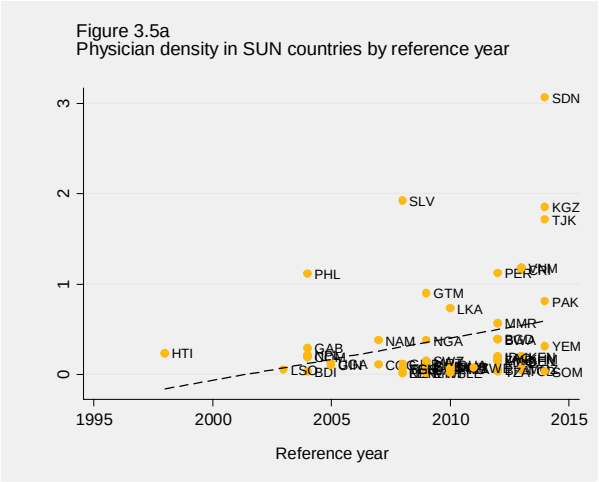
Average density of nurses is 1.09 per 1000 population, ranging from 0.08 to 5.96 across countries. Although the number of nurses is higher than physicians, three quarters (74%) of SUN countries have <1 nurse per 1000 population.

In the 33 SUN countries with data on number of community and traditional health workers, there is an average of 0.47 workers per 1000 population, ranging from 0.001 to 4.29.

TABLE 29: SUMMARY STATISTICS FOR HEALTH WORKER DENSITY IN SUN COUNTRIES

Type of health worker	Density (per 1000 population)			% of countries <1 per 1000 pop
	Mean	Median	Range	
Physicians (n=57 countries)	0.38	0.14	0.01 to 3.06	86%
Nurses (n=57 countries)	1.09	0.68	0.08 to 5.96	74%
Community & Traditional health workers (n=33 countries)	0.47	0.13	0.001 to 4.29	91%
Combined (n=33 countries)	1.44	1.08	0.29 to 5.83	36%

[9] Data not available for Côte d'Ivoire and South Sudan
[10] WHO Global Health Observatory website - http://www.who.int/gho/health_workforce/physicians_density/en/



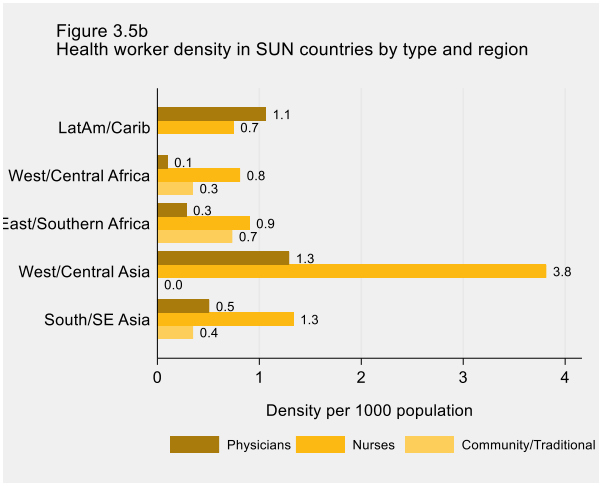


TABLE 30: COUNTRY GROUPING BY HEALTH WORKER DENSITY AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Physician and nurse density per 1000 population			
	<0.5	0.5–0.9	1.0–1.9	≥2.0
2010–2011 (n=24)	Ethiopia, Malawi, Mozambique, Niger, Senegal, Tanzania (n=6)	Bangladesh, Benin, Burkina Faso, Gambia, Mali, Mauritania, Nepal, Rwanda, Zambia (n=9)	Ghana, Guatemala, Indonesia, Lao PDR, Uganda, Zimbabwe (n=6)	Kyrgyzstan, Namibia, Peru (n=3)
2012–2014 (n=28)†	Burundi, Chad, Guinea, Haití, Liberia, Madagascar, Sierra Leone, Somalia, Togo (n=9)	Cameroon, Guinea-Bissau, Lesotho (n=3)	Cambodia, Comoros, Congo, Costa Rica, DRC, Kenya, Myanmar, Nigeria, Pakistan, Swaziland, Yemen (n=11)	El Salvador, Philippines, Sri Lanka, Tajikistan, Viet Nam (n=5)
2015–2017 (n=5)	Central African Republic (n=1)	Papua New Guinea (n=1)	—	Botswana, Gabon, Sudan (n=3)

† No data for Côte d'Ivoire, South Sudan

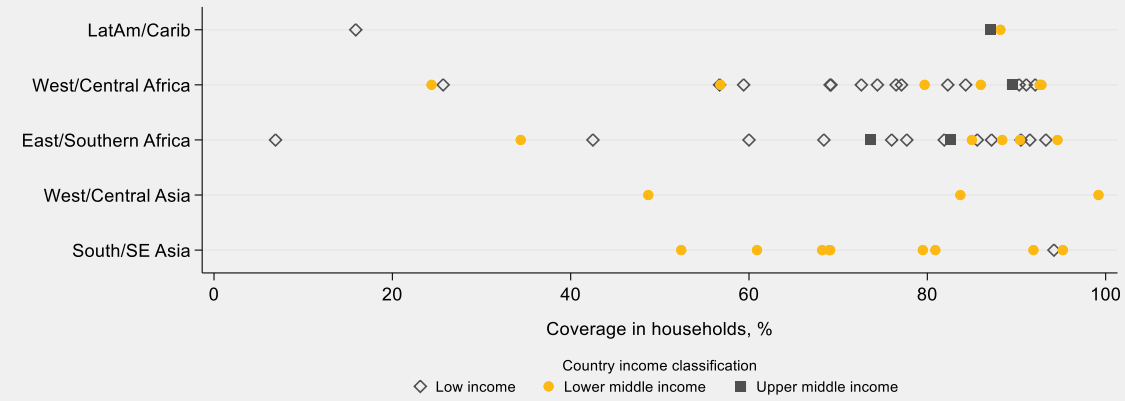
Iodized Salt

MEAL Indicator 3.6: Percentage of households that have iodized salt (>0 ppm)

Data on household iodized salt coverage is available for 56 SUN countries[11], based on survey data covering 2008 to 2016,[12] with most countries (43) with data from 2012 or more recent. Over 80% of these countries (46/56) have mandatory iodized salt legislation in place[13].

Overall, 73.9% of households have iodized salt in these SUN countries, ranging from 6.9 to 99.2% (median 80.3%). Figure 3.6a shows the relatively similar levels of coverage across regions, with the highest level in countries from South and Southeast Asia.

Figure 3.6a
Iodized salt coverage in SUN countries by region and country income classification



Source: UNICEF global database (Jan 2018). Each symbol represents a country (N=56).

There is a slight increase in average iodized salt coverage across the 9-year period represented by the various surveys from SUN countries (see Figure 3.6b). Coverage widely varies across countries regardless of when they joined the SUN Movement, as shown in Figure 3.6c.

Figure 3.6b
Iodized salt coverage in SUN countries by survey year

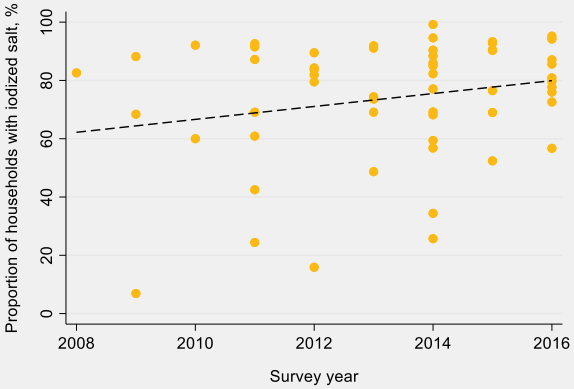
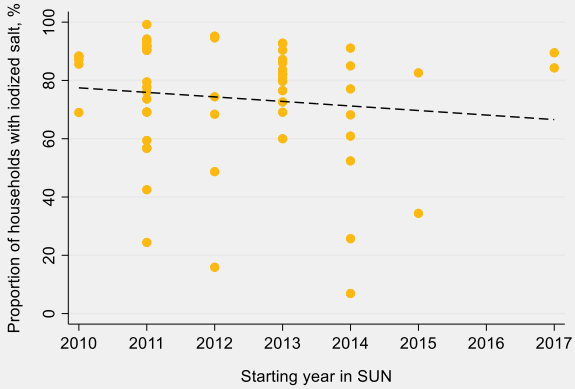


Figure 3.6c
Iodized salt coverage by year joined the SUN movement



[11] Data not available for Costa Rica, El Salvador and Papua New Guinea
[12] Data source: UNICEF Division of Data Research and Policy (2018). UNICEF Global Databases: Percentage of households consuming iodized salt (>0pmm) among all tested households, New York, January 2018.
[13] Pakistan and Somalia do not have iodized salt legislation in place.

TABLE 31: HOUSEHOLD IODIZED SALT COVERAGE IN SUN COUNTRIES

Characteristic	N	Coverage, %	Characteristic	N	Coverage, %
All SUN countries			**Region**		
Mean (95% CI)	56	73.9 (68.2, 79.5)	Latin America & Caribbean	3	63.7
Median	56	80.3	West/Central Africa	21	73.5
Range	56	6.9, 99.2	East/Southern Africa	19	74.2
Year joined SUN			West/Central Asia	3	77.2
2010–11	24	76.9	South/Southeast Asia	10	76.1
2012–14	28	71.4	**Country Income Level**		
2015–17	4	72.7	Low-income	28	71.2
Humanitarian Risk Level			Lower middle-income	24	75.5
Low-Medium	22	78.0	Upper middle-income	4	83.2
High	23	78.4			
Very High	11	56.2			

Worldwide, approximately 70% of all households currently have access to adequately iodized salt[14]. As shown in Table 32, 14 SUN countries have achieved iodized salt coverage in ≥90% of households, 35 have coverage in 50–89% of households and seven have coverage in <50% of households.

TABLE 32: COUNTRY GROUPING BY HOUSEHOLD IODIZED SALT COVERAGE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Household iodized salt coverage level			
	<50%	50–74%	75-89%	≥90%
2010–2011 (n=24)	Mauritania, Mozambique (n=2)	Bangladesh, Benin, Gambia, Ghana, Namibia, Niger, Senegal (n=7)	Ethiopia, Guatemala, Lao PDR, Malawi, Peru, Tanzania, Zambia (n=7)	Burkina Faso, Indonesia, Kyrgyzstan, Mali, Nepal, Rwanda, Uganda, Zimbabwe (n=8)
2012–2014 (n=28)†	Guinea-Bissau, Haiti, Somalia, Yemen (n=4)	Cambodia, Guinea, Madagascar, Pakistan, Philippines, Sierra Leone, South Sudan, Viet Nam (n=8)	Burundi, Cameroon, Chad, Comoros, Cote d'Ivoire, DRC, Lesotho, Myanmar, Tajikistan, Togo (n=10)	Congo, Kenya, Liberia, Nigeria, Sri Lanka, Swaziland (n=6)
2015–2017 (n=4)‡	Sudan (n=1)	–	Botswana, Central African Republic, Gabon (n=3)	–

Note: Cutoffs adapted from Pearce et al. (2013)
† No data for Costa Rica, El Salvador. ‡ No data for Papua New Guinea.

[14] Pearce, Andersson & Zimmermann (2013). Global iodine nutrition: where do we stand in 2013? Thyroid, vol 23(5). DOI: 10.1089/thy.2013.0128.

Inequities in household access to iodized salt based on urban/rural location and wealth quintile are shown in Figure 3.6d and 3.6e, respectively.

Figure 3.6d
Iodized salt coverage by household location and region

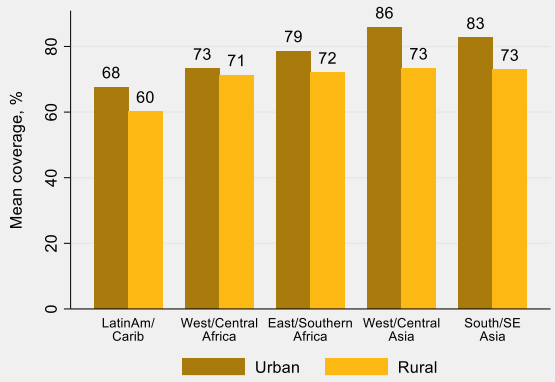
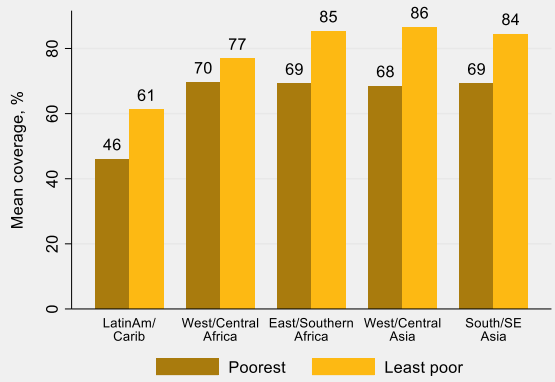


Figure 3.6e
Iodized salt coverage by household wealth quintile and region



Nutrition Minimum Package summary

The following figures provide a summary of coverage in SUN countries for the nutrition-specific interventions included in the MEAL system. Nutrition-specific interventions reach far fewer than half of targeted beneficiaries except for vitamin A supplementation and iodized salt (Figure 3A).

Coverage for interventions that rely on well-functioning health systems (e.g. BFHI, antenatal iron supplementation) tends to be lower in low-income and very high humanitarian risk countries. Vitamin A supplementation and iodized salt coverage is equally high across country income groups. Coverage for these interventions across humanitarian risk groups shows mixed trends, with higher VAS coverage in high humanitarian risk countries compared to others and lower iodized salt coverage in very high humanitarian risk countries.

Figure 3A
Nutrition intervention coverage in SUN countries

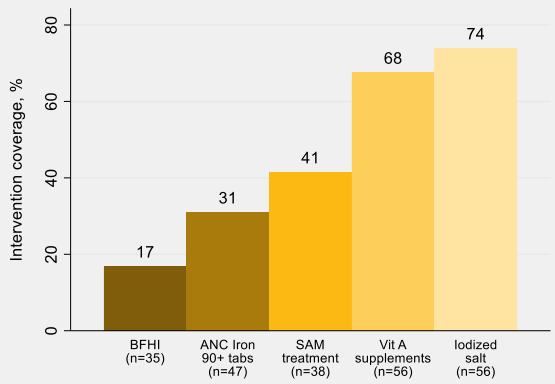


Figure 3B
Nutrition intervention coverage by year joined the SUN Movement

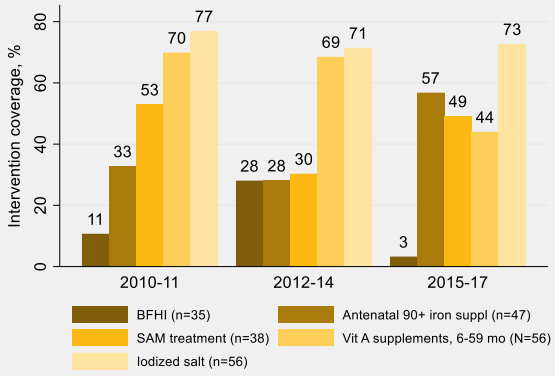


Figure 3C
Nutrition intervention coverage by country income level

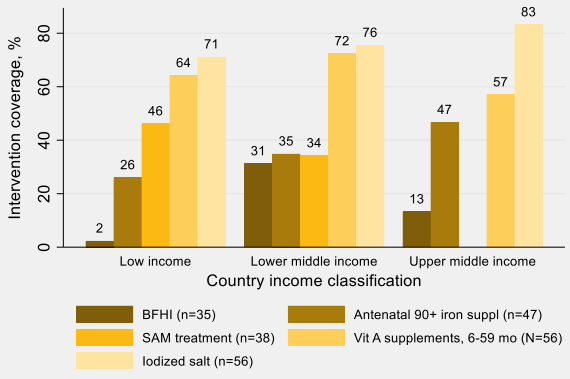
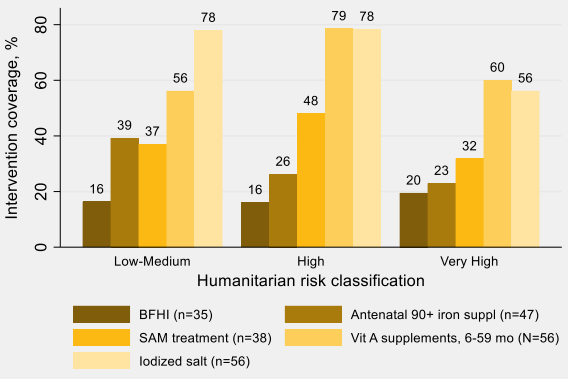


Figure 3D
Nutrition intervention coverage by humanitarian risk level



NUTRITION-SENSITIVE INTERVENTIONS

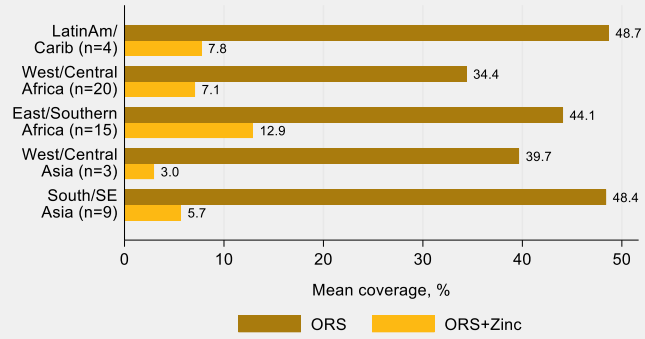
Oral Rehydration Solution (ORS) and Zinc for diarrhoea

MEAL Indicator 3.7: Proportion of children under 5 years old with diarrhoea (in last two weeks) receiving oral rehydration salts (ORS packets or pre-packaged ORS fluids) and zinc supplements

ORS and zinc coverage data are now available from UNICEF for 51 SUN countries, based on surveys ranging from 2007 to 2016. Most countries (n=46, 90%) have data from within the past five years (2012 or more recent).

Among children under-five who experienced a diarrhoea episode just prior to the survey, 8.4% (95% CI 5.7, 11.0) were given ORS and zinc as treatment. ORS and zinc treatment coverage ranges from 0% to 42.3% across SUN countries (median 5.5%). As shown in Figure 3.7a, SUN countries across all regions have low coverage for ORS and zinc combined, whereas ORS coverage is much higher.

Figure 3.7a
ORS and zinc coverage for children under-five in SUN countries by region and country income classification



Source: UNICEF Global Database (Feb 2018), n=51 countries, 2007-2016

TABLE 33: COUNTRY GROUPING BY ORS COVERAGE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Percentage of U5 children with diarrhoea who received ORS and zinc			
	<5%	5–9%	10–19%	≥20%
2010–2011 (n=23)*	Burkina Faso, Gambia, Guatemala, Indonesia, Lao PDR, Mali, Mozambique, Namibia, Peru (n=9)	Ghana, Kyrgyzstan, Rwanda, Senegal (n=4)	Bangladesh, Benin, Ethiopia, Mauritania Nepal, Niger, Tanzania, Zimbabwe (n=8)	Malawi, Uganda (n=2)
2012–2014 (n=26)†	Cambodia, Chad, Comoros, DRC, Haiti, Liberia, Madagascar, Pakistan, Philippines, Sierra Leone, South Sudan, Sri Lanka, Tajikistan, Togo, Yemen (n=15)	Burundi, Cameroon, Congo, Cote d'Ivoire, Kenya (n=5)	Guinea, Guinea-Bissau, Nigeria, Viet Nam (n=4)	El Salvador, Swaziland (n=2)
2015–2017 (n=2)‡	Central African Republic (n=1)	—	Sudan (n=1)	—

* No data for Zambia; † No data for Costa Rica, Lesotho, Myanmar, Somalia; ‡ No data for Botswana, Gabon, Papua New Guinea

Deworming

MEAL Indicator 3.8: Proportion of children aged 12–59 months receiving at least one dose of de-worming medication

Coverage data on deworming is available for 47 SUN countries, with surveys ranging from 2006 to 2016. Over three quarters of countries (n=39, 83%) have data from 2012 or more recent. The data are based on the DHS indicator: proportion of children aged 6–59 months given deworming medicating in the six months preceding the survey.

Deworming coverage, on average, across these 47 countries is 42.2% (95% CI 36.8, 47.7), ranging from 7.1% to 80.1% (median 42.6%). Coverage across regions is shown in Figure 3.8a, with the highest coverage in countries from both African regions as well as South/SE Asia.

Deworming coverage varies less across country income classification, ranging from 44.3% (95% CI 36.6, 52.1) in low-income countries to 38.8% (95% CI 30.6, 47.0) in lower middle-income countries and 48.3% (95% CI 23.0, 73.7) in upper middle-income countries.

Figure 3.8a
Deworming coverage for children 6-59 months in SUN countries by region and country income classification

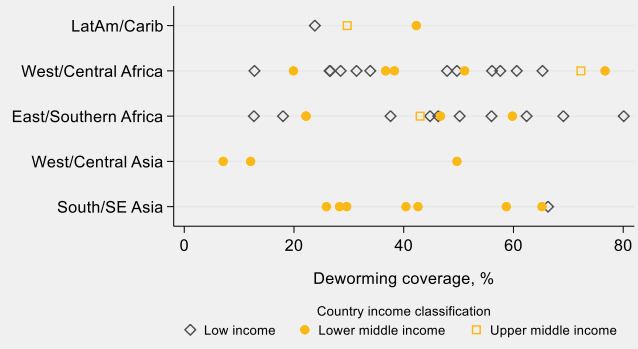


TABLE 34: COUNTRY GROUPING BY DEWORMING COVERAGE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Percentage of children 6–59 mo given deworming medication in the previous six months			
	<25%	25–39%	40–59%	≥60%
2010–2011 (n=22)*	Burkina Faso, Ethiopia, Kyrgyzstan, Zimbabwe (n=4)	Bangladesh, Gambia, Ghana, Indonesia, Mali, Niger, Peru, Tanzania (n=8)	Benin, Guatemala, Malawi, Mozambique, Namibia, Uganda, Zambia (n=7)	Nepal, Rwanda, Senegal (n=3)
2012–2014 (n=24)†	Haiti, Kenya, Lesotho, Nigeria, Yemen (n=5)	Chad, Côte d'Ivoire, Guinea, Pakistan (n=4)	Cambodia, Cameroon, Comoros, Liberia, Myanmar, Philippines, Sierra Leone, Swaziland, Tajikistan, Togo (n=10)	Burundi, Congo, DRC, Madagascar, Sri Lanka (n=5)
2015–2017 (n=1)‡	—	—	—	Gabon (n=1)

* No data for Lao PDR, Mauritania. † No data for Costa Rica, El Salvador, Guinea-Bissau, Somalia, South Sudan, Viet Nam. ‡ No data for Botswana, CAR, PNG, Sudan

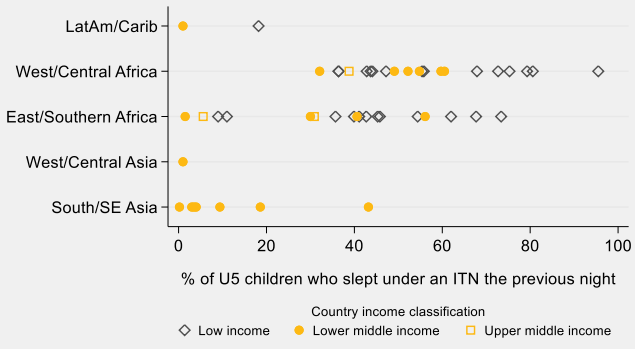
Insecticide treated nets (ITN)

MEAL Indicator 3.9: Use of insecticide treated nets in children aged 0–5 years

Coverage data on ITN use among children under five years is available for 46 SUN countries, with surveys ranging from 2005 to 2016. Over two thirds of countries (n=38, 83%) have data from 2012 or more recent.

Overall, 40.3% (95% CI 33.2, 47.4) of children under five were reported to have slept under an ITN the previous night. Coverage ranges from 0.2 to 96% across these countries, with a median of 43%. However, coverage varies widely by region (see Figure 3.9a), given the different risk factors for malaria across SUN countries and regions. Mean coverage ranges from 12% in South/SE Asia and 10% in Latin America to 38% in East/Southern Africa and 56% in West/Central Africa region.

Figure 3.9a
Under-five ITN coverage in SUN countries by region and country income classification



Consistent with the geographic focus of ITN distribution programmes, ITN coverage is highest in low-income countries at 51% (95% CI 43, 59) compared to 27% (95% CI 16, 38) in lower middle-income countries and 25% (95% CI 5, 45) in upper middle-income countries.

TABLE 35: COUNTRY GROUPING BY ITN COVERAGE AND YEAR OF JOINING THE SUN MOVEMENT (COUNTRIES WITH HIGH TRANSMISSION SETTINGS)

Year of SUN start	Percentage of under-five children who slept under an ITN the previous night			
	<20%	20–39%	40–54%	≥55%
2010–2011 (n=20)*	Guatemala, Indonesia, Namibia, Zimbabwe (n=4)	Mauritania, Mozambique (n=2)	Ethiopia, Gambia, Ghana, Lao PDR, Malawi, Tanzania, Zambia (n=7)	Benin, Burkina Faso, Mali, Niger, Rwanda, Senegal, Uganda (n=7)
2012–2014 (n=22)†	Cambodia, Haiti, Myanmar, Pakistan, Somalia, Viet Nam (n=6)	Burundi, Chad (n=2)	Cameroon, Comoros, Liberia, Nigeria, Sierra Leone, South Sudan, Togo (n=7)	Congo, Côte d'Ivoire, DRC, Guinea, Guinea-Bissau, Kenya, Madagascar (n=7)
2015–2017 (n=4)‡	–	Botswana, CAR, Gabon, Sudan (n=4)	–	–

* No data for Bangladesh, Nepal, Peru (Kyrgyzstan not included); † No data for Costa Rica, Philippines, Yemen (El Salvador, Lesotho, Sri Lanka, Swaziland and Tajikistan not included); ‡ No data for Papua New Guinea

Complete vaccination

MEAL Indicator 3.10: Percentage of 1-year-olds who have received the appropriate doses of the recommended vaccines in the national schedule by recommended age

Data on under-five child vaccination coverage is available for all SUN countries for the year 2016. Here we have analyzed coverage for DTP3 in 2016 as a proxy for full vaccination.

SUN countries achieved a mean of 81.5% (95% CI 77.5, 85.6) for DPT3 coverage in 2016 (range 26 to 99%; median 86%). Global DTP3 immunization coverage was 86% in 2015.[15] Figure 3.10a shows the similar high coverage levels across regions; however, coverage is lower in country contexts with higher humanitarian risk levels (Figure 3.10b).

Figure 3.10a
Vaccination coverage in SUN countries by region and country income classification

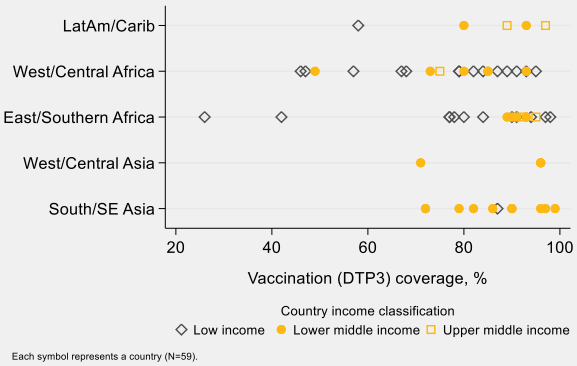


Figure 3.10b
Vaccination (DTP3) coverage by country humanitarian risk classification

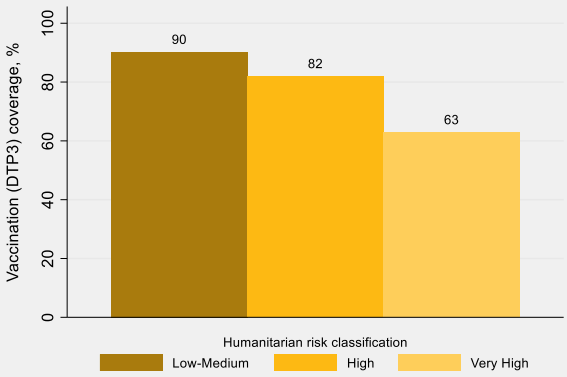


TABLE 36: COUNTRY GROUPING BY VACCINATION COVERAGE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	DTP3 immunization coverage among 1-year-olds, 2015			
	<50%	50–79%	80–89%	≥90
2010–2011 (n=24)	—	Ethiopia, Indonesia, Mali, Mauritania, Niger, Uganda (n=6)	Benin, Guatemala, Lao PDR, Malawi, Mozambique, Nepal, Peru (n=7)	Bangladesh, Burkina Faso, Gambia, Ghana, Kyrgyzstan, Namibia, Rwanda, Senegal, Tanzania, Zambia, Zimbabwe (n=11)
2012–2014 (n=30)	Chad, Nigeria, Somalia, South Sudan (n=4)	Guinea, Haiti, Liberia, Madagascar, Pakistan, Yemen (n=7)	Cameroon, Congo, Côte d'Ivoire, Guinea-Bissau, Kenya, Philippines, Sierra Leone, Togo (n=8)	Burundi, Cambodia, Comoros, Costa Rica, El Salvador, Lesotho, Myanmar, Sri Lanka, Swaziland, Tajikistan, Viet Nam (n=11)
2015–2017 (n=5)	Central African Republic (n=1)	Gabon, Papua New Guinea (n=2)	—	Botswana, Sudan (n=2)

[15] Universal Health Coverage Data Portal, http://apps.who.int/gho/cabinet/uhc.jsp?lang=en

Family planning

MEAL Indicator 3.11: Proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods

Data on family planning coverage are available for 58 SUN countries[16], based on surveys ranging from 2006–2016. Over eighty percent of countries (n=48, 83%) have data from 2012 or more recent.

On average, 49.7% (95% CI 44.3, 55.1) of women 15–49 y in SUN countries reported having their need for family planning satisfied with modern methods (range 5.6% to 89.1%; median 47.4%). A comparison of coverage across regions is shown in Figure 3.11a, with similar levels across most regions but lower coverage in West/Central Africa region. The global median is 78% but much lower (57%) for least developed countries.[17]

Figure 3.11a
Family planning coverage in SUN countries by region and country income classification

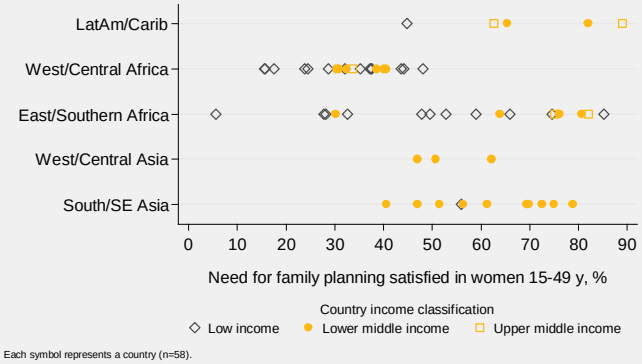


TABLE 37: COUNTRY GROUPING BY FAMILY PLANNING COVERAGE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Need for family planning satisfied with modern method among women 15–49 y			
	<35%	35–49%	50–64%	≥65%
2010–2011 (n=24)	Benin, Gambia, Mauritania, Mozambique (n=4)	Burkina Faso, Ghana, Mali, Niger, Senegal, Uganda (n=6)	Ethiopia, Kyrgyzstan, Lao PDR, Nepal, Peru, Tanzania, Zambia (n=7)	Bangladesh, Guatemala, Indonesia, Malawi, Namibia, Rwanda, Zimbabwe (n=7)
2012–2014 (n=29)†	Burundi, Chad, Comoros, Côte d'Ivoire, DRC, Guinea, Nigeria, South Sudan, Togo (n=9)	Cameroon, Congo, Guinea-Bissau, Haiti, Liberia, Madagascar, Pakistan, Sierra Leone, Yemen (n=9)	Cambodia, Philippines, Tajikistan (n=3)	Costa Rica, El Salvador, Kenya, Lesotho, Myanmar, Sri Lanka, Swaziland, Viet Nam (n=8)
2015–2017 (n=5)	Central African Republic, Gabon, Sudan (n=3)	Papua New Guinea (n=1)	—	Botswana (n=1)

† No data for Somalia

[16] United Nations, Department of Economic and Social Affairs, Population Division (2017). World Contraceptive Use 2017 (POP/DB/CP/Rev2017). http://www.un.org/en/development/desa/population/publications/dataset/contraception/wcu2017/UNPD_WCU2017_Country_Data_Survey-Based.xlsx [accessed 30 August 2017]

[17] United Nations, Department of Economic and Social Affairs, Population Division (2017). *Model-based Estimates and Projections of Family Planning Indicators 2017.* New York: United Nations.

Health system interventions summary

Figures 3E to 3H provide a summary of intervention coverage for health system interventions by various country characteristics. Child vaccination shows the highest coverage overall (82%) but other child health sector interventions reach less than half of their intended beneficiaries. Family planning coverage increases with country income class but decreases in higher humanitarian risk contexts.

Figure 3E
Health system interventions coverage

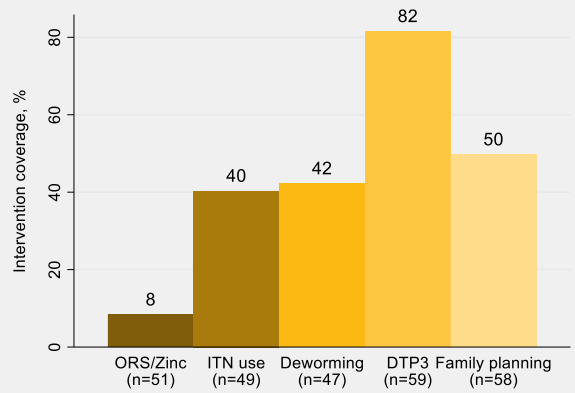


Figure 3F
Health system intervention coverage by year joined SUN

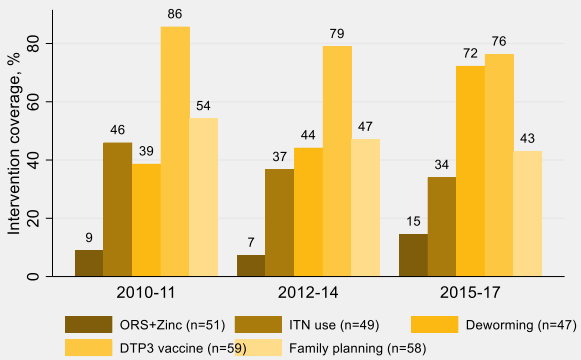


Figure 3G
Health system intervention coverage by country income class

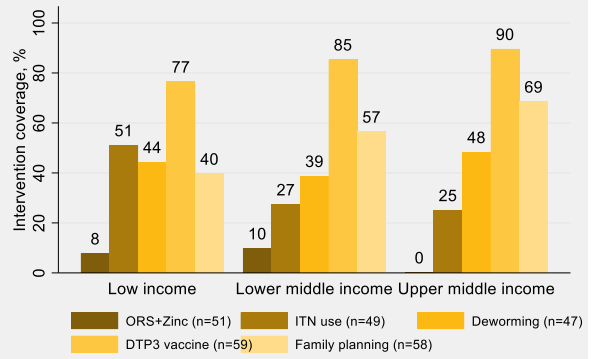
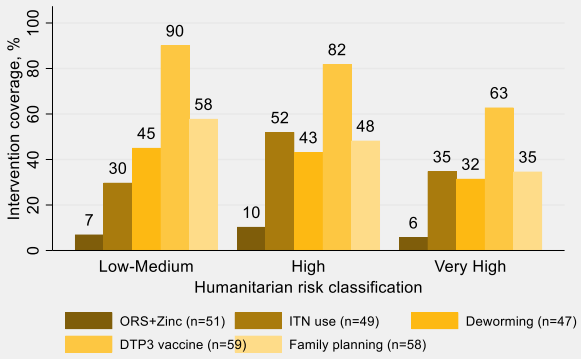


Figure 3H
Health system intervention coverage by country humanitarian risk level



FOOD SYSTEM INDICATORS

Calories from non-staple foods

MEAL Indicator 3.12: Percentage of calories from non-staples in food supply

Data on the share of dietary energy supply derived from non-staple foods (i.e. all food sources except cereals, roots and tubers) are available from FAOSTAT for 53 SUN countries for the reference year 2012 (representing a 3-year average for 2011-2013).

On average, across 53 SUN countries, 40% of calories are from non-staple food sources, ranging from 20% to 68% across countries (median 39%). The distribution in values across countries by region is shown below in Figure 3.12a. As expected, diets are likely higher in quality in upper middle-income countries where the average percentage of calories from non-staples is over 50% (see Figure 3.12b).

Figure 3.12a
Percentage of calories from non-staples in food supply by region and country income classification

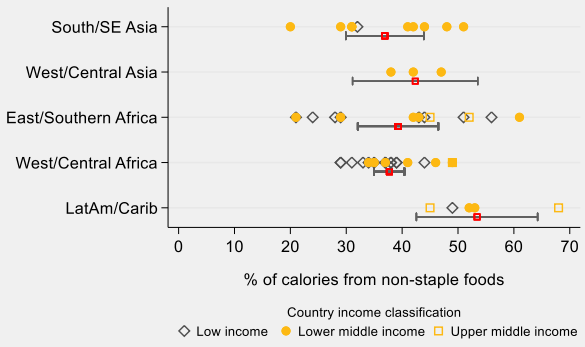
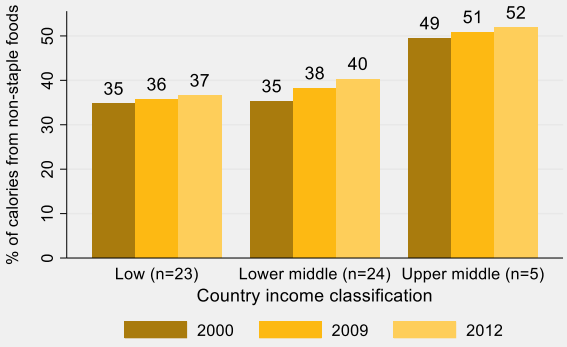


Figure 3.12b
Percentage of calories from non-staples in food supply by year and country income classification



(Source: FAOSTAT)

TABLE 38: COUNTRY GROUPING BY CALORIES FROM NON-STAPLE FOODS AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN	Proportion of calories from non-staple foods, 2012			
	<30%	30–39%	40–50%	≥51%
2010–2011 (n-24)	Bangladesh, Benin, Ethiopia, Malawi, Mozambique, Zambia (n=6)	Burkina Faso, Gambia, Ghana, Indonesia, Lao PDR, Mali, Nepal, Niger, Senegal (n=9)	Kyrgyzstan, Mauritania, Namibia, Peru, Tanzania, Zimbabwe (n=6)	Guatemala, Rwanda, Uganda (n=3)
2012–2014 (n=25)†	Cambodia, Lesotho, Madagascar, Togo (n=4)	Chad, Côte d'Ivoire, Guinea, Guinea-Bissau, Liberia, Nigeria, Sierra Leone, Yemen (n=8)	Cameroon, Congo, Haiti, Kenya, Myanmar, Philippines, Sri Lanka, Swaziland, Tajikistan, Viet Nam (n=10)	Costa Rica, El Salvador, Pakistan (n=3)
2015–2017 (n=4)‡	–	–	Central African Republic, Gabon (n=2)	Botswana, Sudan (n=2)

† No data for Burundi, Comoros, DRC, Somalia, South Sudan. ‡ No data for Papua New Guinea

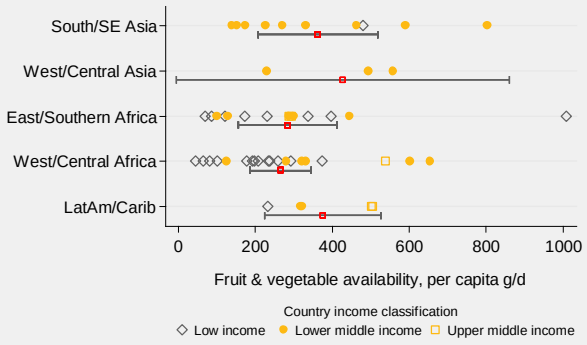
Availability of fruit and vegetables

MEAL Indicator 3.13: Availability of fruit and vegetables (grams)

Data on availability of fruit and vegetables (based on food balance sheet data) were available from FAOSTAT for 53 SUN countries for the reference year 2013. Data refer to the total amount of fruit and vegetables and derived products (in grams) available for human consumption during the reference period (expressed in per capita terms).

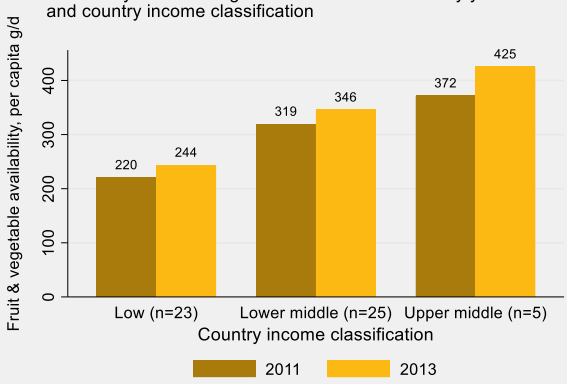
For these 53 SUN countries, a mean of 309 g (95% CI 255, 363) of fruit and vegetables per capita per day were available, ranging from 44 to 1009 g (median 281 g). Mean estimates for SUN countries by region are shown in Figure 3.13a. Availability is positively associated with country income level (Figure 3.13b).

Figure 3.13a
Availability of fruit & vegetables in SUN countries by region and country income classification



Each symbol represents a country (n=53). The red squares indicate the regional mean and confidence intervals.

Figure 3.13b
Availability of fruit & vegetables in SUN countries by year and country income classification



(Source: FAOSTAT)

TABLE 39: COUNTRY GROUPING BY FRUIT AND VEGETABLE AVAILABILITY AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Fruit and vegetable availability, per capita per day			
	≥400 g	250–399 g	100–249 g	<100 g
2010–2011*	Ghana, Kyrgyzstan, Lao PDR, Nepal, Peru, Rwanda (n=6)	Benin, Guatemala, Indonesia, Namibia, Tanzania, Uganda (n=6)	Bangladesh, Malawi, Mali, Mauritania, Mozambique, Niger, Senegal (n=7)	Burkina Faso, Ethiopia, Gambia, Zambia, Zimbabwe (n=5)
2012–2014†	Cameroon, Costa Rica, Philippines, Tajikistan, Viet Nam (n=5)	Congo, Côte d'Ivoire, El Salvador, Guinea, Kenya, Myanmar, Nigeria, Sierra Leone, Swaziland (n=9)	Cambodia, Guinea-Bissau, Haiti, Lesotho, Liberia, Madagascar, Pakistan, Sri Lanka, Togo, Yemen (n=10)	Chad (n=1)
2015–2017‡	Gabon, Sudan (n=2)	Botswana (n=1)	CAR (n=1)	–

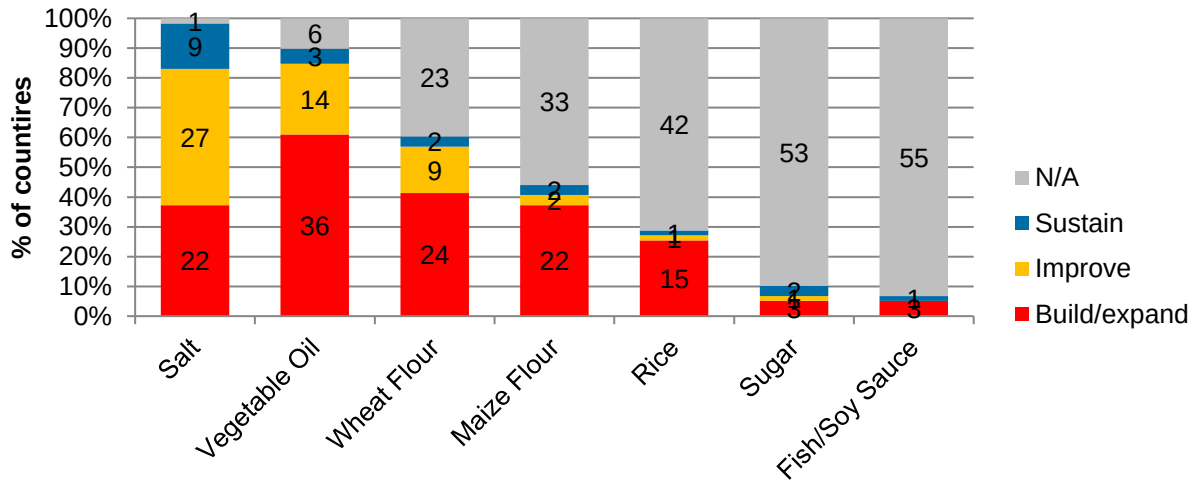
† No data for Burundi, Comoros, DRC, Somalia, South Sudan; ‡ No data for Papua New Guinea

Fortified food supply

MEAL Indicator 3.14: Fortified Food Supply

SUN country fortification status by fortifiable food vehicle is summarized in Figure 3.14a. Countries with SUSTAIN status are those where at least 80% of the fortifiable food vehicle is fortified, and at least 70% is compliant. IMPROVE status means 50–79% of the fortifiable food vehicle is fortified, but compliance (adequate fortification to standard) is under 70%. BUILD/EXPAND status means there is common and widespread consumption of fortifiable food vehicle, but less than 50% of the fortifiable food vehicle is fortified [any amount]. When data are N/A, either the particular food vehicle is not relevant to the country in question[18] or there is not enough information to assess relevance (e.g. sugar).

Figure 3.14a Fortification status in SUN countries by food vehicle
(number and % of countries)



[18] This is primarily due to the fact that it is not commonly consumed in quantities relevant for fortification (i.e. at least 10 g/capita/day for vegetable oil; at least 75 g/capita/day for grains).

TABLE 40: COUNTRY GROUPING BY FORTIFICATION STATUS OF FORTIFIABLE FOOD VEHICLES AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Fortification status of fortifiable food vehicles			
	At least 2 SUSTAIN	At least 1 SUSTAIN or At least 2 IMPROVE	At least 1 IMPROVE	All BUILD/EXPAND
2010–2011 (n=24)	Guatemala (n=1)	Bangladesh, Benin, Ghana, Malawi, Mali, Mozambique, Nepal, Peru, Rwanda, Senegal, Tanzania, Uganda, Zambia (n=13)	Burkina Faso, Indonesia, Kyrgyzstan, Lao PDR, Mauritania, Namibia, Zimbabwe (n=7)	Ethiopia, Gambia, Niger (n=3)
2012–2014 (n=30)	Costa Rica (n=1)	Cameroon, Côte d'Ivoire, El Salvador, Kenya, Nigeria, Pakistan, Sierra Leone, Sri Lanka (n=8)	Cambodia, Chad, Comoros, Congo, DRC, Guinea-Bissau, Lesotho, Madagascar, Philippines, Swaziland (n=10)	Burundi, Guinea, Haiti, Liberia, Myanmar, Somalia, South Sudan, Tajikistan, Togo, Viet Nam, Yemen (n=11)
2015–2017 (n=4)‡	–	Papua New Guinea (n=1)	Botswana (n=1)	Gabon, Sudan (n=2)

‡ No data for Central African Republic

Another source of information on the supply of fortified food in SUN countries is the data provided by the Food Fortification Initiative on the proportion of wheat flour (n=55 countries), maize flour (n=15) and rice (n=11) that is produced in industrial mills and the proportion of industrially milled product that is fortified.

A summary of these data for wheat flour is shown in Table 41. As expected, in countries where mandatory legislation for wheat flour fortification exists, 70% of flour is fortified compared to 21% in countries without mandatory legislation.

TABLE 41: PROPORTION OF WHEAT FLOUR PRODUCED IN AND FORTIFIED BY INDUSTRIAL MILLS

Characteristic	N*	Percent of flour produced in industrial mills	Percent of flour industrially milled that is fortified	Percent of flour fortified
All SUN countries				
Mean (95% CI)	55	88 (82, 94)	55 (43, 67)	50 (38, 62)
Median	55	100	80	55
Range	55	7, 100	0,100	0, 100
Mandatory legislation exists				
Yes	33	88	77 (p<0.001)	70 (p<0.001)
No	22	89	23	21
Year joined SUN Movement				
2010–11	23	87	62	57
2012–14	28	88	55	50
2015–17	4	94	19	17
Region				
Latin America & Caribbean	5	75	80	62
West/Central Africa	18	94	86	80
East/Southern Africa	19	88	41	38
West/Central Asia	3	82	36	35
South/Southeast Asia	10	85	22	21
Country Income Level				
Low-income	26	86	52	47
Lower middle-income	25	92	55	53
Upper middle-income	4	77	80	57
Humanitarian Risk Level				
Low-Medium	21	91	61	55
High	24	85	62	56
Very High	10	89	28	27

*No data for Chad, Gabon, Guinea-Bissau, Lao PDR

Social Protection Programmes

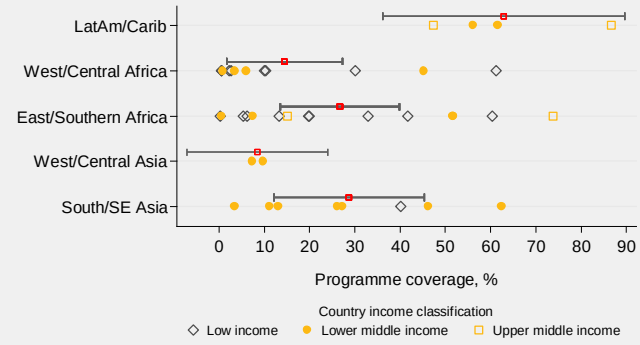
MEAL Indicator 3.15: Proportion of the population covered by social protection floors/ systems

Social protection programmes (also known as social assistance or social safety net programmes) are non-contributory transfers in cash or in-kind and are usually targeted at the poor and vulnerable. Some programmes are focused on improving chronic poverty or providing equality of opportunity; others more on protecting families from shocks and longstanding losses they can inflict for the unprotected poor. Programme examples include cash transfers (conditional and unconditional), in-kind transfers, such as school feeding and targeted food assistance, and near cash benefits such as fee waivers and food vouchers. [19]

Social protection programme coverage data is available for 41 SUN countries, with the year of data ranging from 2007 to 2014.[15] Almost half of these countries (19/41) have data from 2012 or more recent.

At the national level, social protection programme coverage ranges from <1% to 87% (see Figure 3.15a), with an overall mean of 26.2% (95% CI 18.5, 33.8) and median of 15.2%.

Figure 3.15a
Social protection programme coverage by region and country income class



Each symbol represents a country. The red squares indicate the regional mean and confidence intervals.

TABLE 42: COUNTRY GROUPING BY SOCIAL PROTECTION PROGRAMME COVERAGE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Social protection programme coverage level		
	<15%	15–49%	≥50%
2010–2011 (n=20)*	Bangladesh, Burkina Faso, Ethiopia, Ghana, Kyrgyzstan, Mozambique, Niger, Senegal, Zambia (n=9)	Malawi, Mauritania, Namibia, Nepal, Rwanda, Tanzania, Zimbabwe (n=7)	Guatemala, Indonesia, Peru, Uganda (n=4)
2012–2014 (n=17)†	Cameroon, Chad, DRC, Madagascar, Nigeria, Pakistan, South Sudan, Tajikistan (n=8)	Costa Rica, Philippines, Sierra Leone, Sri Lanka, Viet Nam (n=5)	El Salvador, Lesotho, Liberia, Swaziland (n=4)
2015–2017 (n=4)‡	Central African Republic, Papua New Guinea, Sudan, (n=3)	—	Botswana (n=1)

* No data for Benin, Gambia, Lao PDR, Mali
† No data for Burundi, Cambodia, Comoros, Congo, Côte d'Ivoire, Guinea, Guinea-Bissau, Haiti, Kenya, Myanmar, Somalia, Togo, Yemen
‡ No data for Gabon

[19] Source: World Bank ASPIRE database, accessed May 2017

As shown in Figure 3.15b, social protection programmes reach a higher proportion of the population in upper middle-income countries compared to lower middle-income and low-income countries. Coverage is highest among Latin American countries where social protection programmes reach, on average, 63% of the population and 80% of households in the poorest quintile. Coverage is lowest (<15%) in countries from West/Central Africa and West/Central Asia.

Figure 3.15b: Social protection programme coverage by target group and country income level, 2007-2014

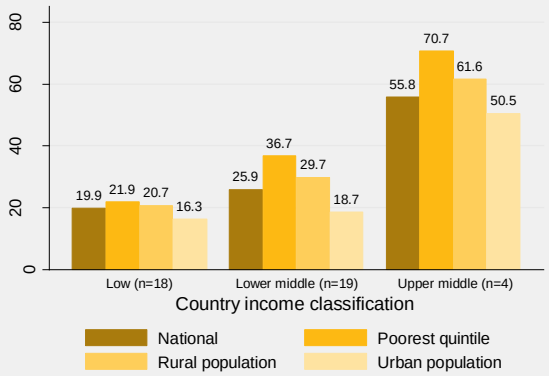
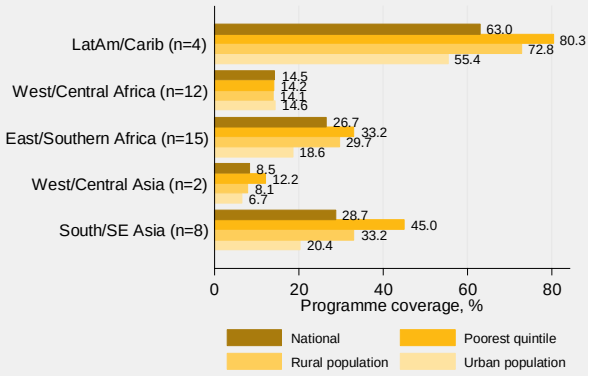


Figure 3.15c: Social protection programme coverage by target group and region, 2007-2014



Stakeholder and action mapping

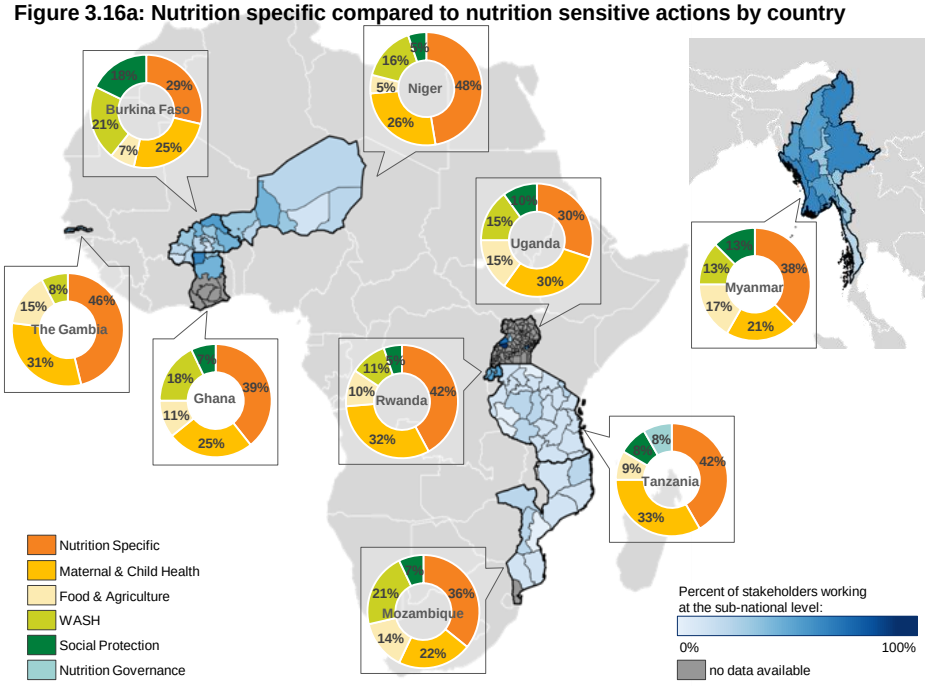
MEAL Indicator 3.16: Geographic distribution of actions at sub-national level

The UN Network has done three different types of stakeholder mapping over the past five years. The most complete type of mapping is the Stakeholder and Action Mapping where they look at all stakeholders (except businesses) and their respective nutrition actions, using a core set of actions as a guide. Where possible, these mapping exercises have included information from the Civil Society Alliances. An example of the data disaggregated to sub-administrative level is provided for Myanmar in Appendix H.

For the purposes of the MEAL Baseline, the mapping data has been aggregated to look at implementation of nutrition-specific and nutrition-sensitive activities across countries and stakeholders' presence where mapping has taken place (see Figure 3.16a). Nutrition-specific actions account for between 30 to 50 per cent of actions in all countries with maternal and child health actions ranging from approximately 20 to 30 per cent (see Table 43 for details related to specific actions and categories). If the data is examined by sector (Figure 3.16b), the majority of countries have nutrition actions spanning four sectors with over half of those actions falling under the health sector (see Table 44 for details related to activities per sector).

There is ongoing discussion regarding how best to classify country performance for this indicator.

Figure 3.16a: Nutrition specific compared to nutrition sensitive actions by country

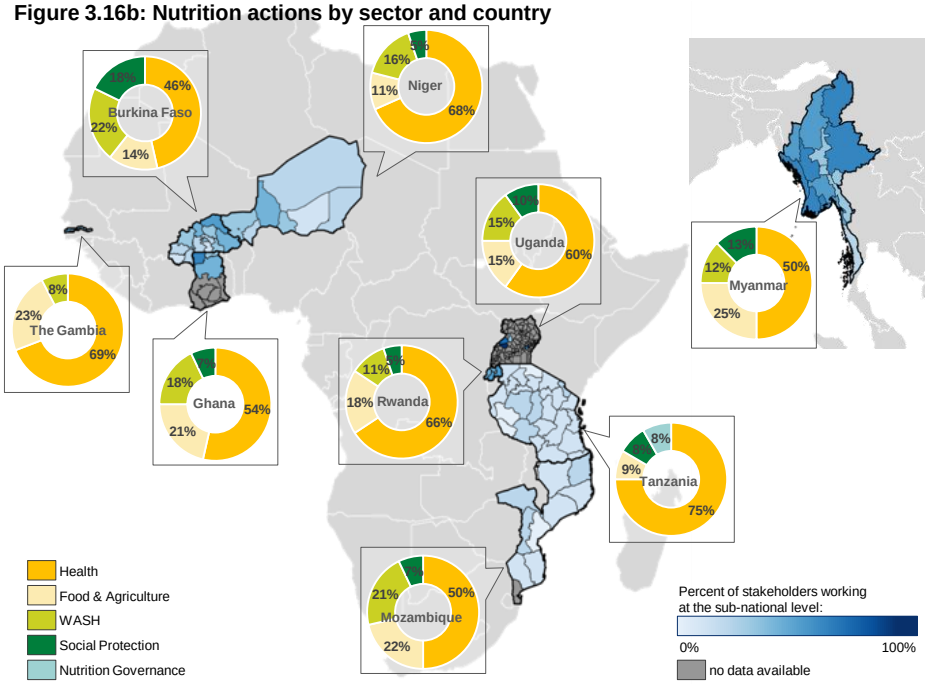


Source: UN Network 2016

TABLE 43: NUTRITION SPECIFIC AND SENSITIVE ACTIONS

Nutrition-specific	Maternal & Child Health	Food & Agriculture
• Calcium supplementation	• Antenatal care	• Animal husbandry
• Complementary foods	• Antiretroviral drugs	• Biofortification
• Food fortification	• Assisted births	• Food preservation and storage
• HIV nutrition	• Child health care	• Food safety
• Iodine supplementation	• Deworming	• Horticulture
• Iron supplementation	• Family planning	**WASH**
• Iron/folic acid supplementation	• Health checks and growth monitoring	• Community Led Total Sanitation
• Management of MAM	• Intermittent preventive treatment of malaria in pregnancy	• Handwashing
• Management of SAM	• Indoor residual spraying	• Household water treatment
• Multiple micronutrient powders	• Insecticide-treated bed nets	• Hygiene education
• Nutrition education	• Oral Rehydration Salts Solution for diarrhea	• Sanitation
• Promotion of breastfeeding	• Prevention of mother-to-child transmission	• Water source
• Promotion of complementary feeding	• Postnatal Care	**Social Protection**
• Salt Iodization		• Alternative income generation
• Vitamin A Supplementation	**Nutrition Governance**	• Boutiques témoins
• Vitamin D supplementation	• Nutrition funding	• Cash transfers
• Zinc Supplementation		• Girls education
		• Non-timber forest products
		• Public works programme
		• School feeding

Figure 3.16b: Nutrition actions by sector and country



Source: UN Network 2016

TABLE 44: NUTRITION ACTIONS BY SECTOR

Health	Food & Agriculture
Antenatal care	Animal husbandry
Antiretroviral drugs	Biofortification
Assisted births	Complementary foods
Calcium supplementation	Food fortification
Child health care	Food preservation and storage
Deworming	Food safety
Family planning	Horticulture
Health checks and growth monitoring	Multiple micronutrient powders
HIV nutrition	Salt iodization
Iodine supplementation	**WASH**
Intermittent preventive treatment of malaria in pregnancy	Community Led Total Sanitation
Iron supplementation	Handwashing
Iron/folic acid supplementation	Household water treatment
Indoor residual spraying	Hygiene education
Insecticide-treated bed nets	Sanitation
Management of MAM	Water source
Management of SAM	**Social Protection**
Nutrition education	Alternative income generation
Oral Rehydration Salts Solution for diarrhea	Boutiques témoins
Prevention of mother-to-child transmission	Cash transfers
Postnatal Care	Girls education
Promotion of breastfeeding	Non-timber forest products
Promotion of complementary feeding	Public works programme
Vitamin A Supplementation	School feeding
Vitamin D supplementation	**Nutrition Governance**
Zinc Supplementation	Nutrition funding

Step 4: Results are achieved through aligned implementation

Progress in the implementation of legislation for nutrition, changes in key drivers of nutrition and improved child feeding practices and population dietary intake are expected results of aligned implementation.

List 4: Enacted Legislations

INFANT FEEDING LEGISLATION

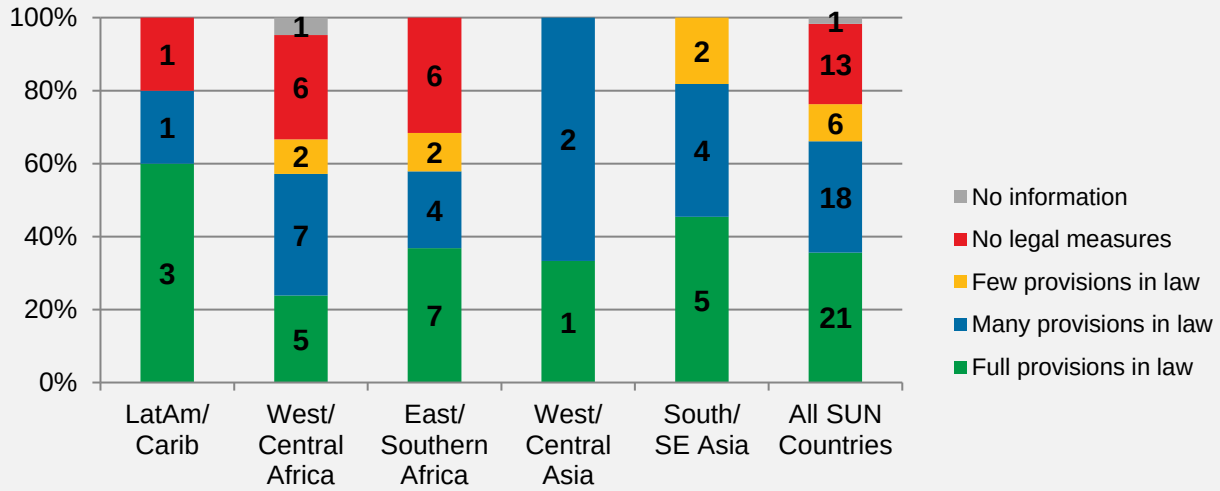
International Code of Marketing Breastmilk Substitutes

MEAL Indicator 4.1: Country has legislation /regulations fully implementing the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22) and subsequent relevant resolutions adopted by the World Health Assembly

Data on national implementation of the International Code of Marketing of Breastmilk Substitutes are available for 58 SUN countries from the WHO/UNICEF/IBFAN Status Report for 2016[20].

Over three quarters of SUN countries (n=45) have legal measures in place to implement the Code. Twelve countries have no legal measures in place and no data is available for two countries. Figure 4.1a shows the level of code implementation in SUN countries by region. Table 45 provides an overview of the countries in each category by year that they joined the SUN Movement.

Figure 4.1a
Legal status of Code in SUN countries by region (number and % of countries)



Adapted from the Global Nutrition Report. Data source: WHO, UNICEF, IBFAN 2016. Marketing of Breast-milk Substitutes: National Implementation of the International Code, Status Report 2016. Geneva: WHO

[20] WHO, UNICEF, IBFAN (2016). Marketing of Breast-milk Substitutes: National Implementation of the International Code, Status Report 2016. Geneva: WHO

TABLE 45: COUNTRY GROUPING BY LEVEL OF CODE IMPLEMENTATION AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Level of code implementation			
	Full	Many	Few	None
2010–2011	Benin, Gambia, Ghana, Guatemala, Mozambique, Nepal, Peru, Tanzania, Uganda, Zimbabwe (n=10)	Bangladesh, Burkina Faso, Indonesia, Kyrgyzstan, Malawi, Mali, Niger, Senegal, Zambia (n=9)	Lao PDR, Rwanda (n=2)	Ethiopia, Mauritania, Namibia (n=3)
2012–2014	Cameroon, Costa Rica, Kenya, Madagascar, Pakistan, Philippines, Sri Lanka, Viet Nam, Yemen (n=9)	Burundi, Cambodia, Comoros, Côte d'Ivoire, DRC, El Salvador, Myanmar, Nigeria, Tajikistan (n=9)	Guinea, Guinea-Bissau (n=2)	Chad, Congo, Haiti, Lesotho, Liberia, Sierra Leone, Somalia, South Sudan, Swaziland, Togo (n=10)
2015–2017‡	Botswana, Gabon (n=2)	–	Papua New Guinea, Sudan (n=2)	–

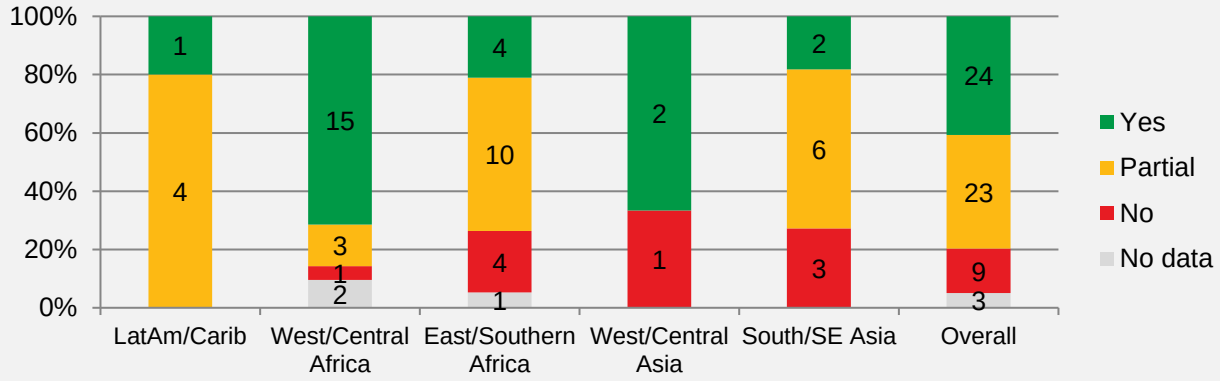
‡ No data for Central African Republic

Maternity Protection Laws

MEAL Indicator 4.2: Country has maternity protection laws or regulations in place in line with the ILO Maternity Protection Convention, 2000 (No. 183) and Recommendation No. 191

Country status for maternity protection laws is available for 56 SUN countries (reference year 2011)[21] and is shown in Table 46, with a summary by region in Figure 4.2a.

Figure 4.2a: Maternity leave protection status in SUN countries by region (number and % of countries)



[21] Data source: GNR

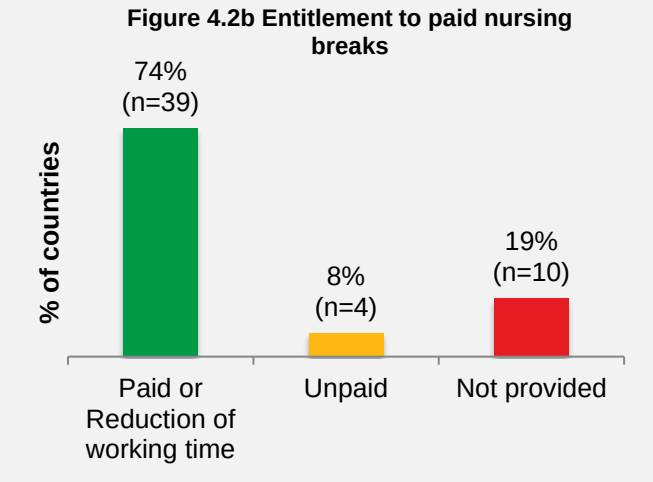
TABLE 46: COUNTRY GROUPING BY MATERNITY PROTECTION POLICIES AND YEAR OF JOINING THE SUN MOVEMENT

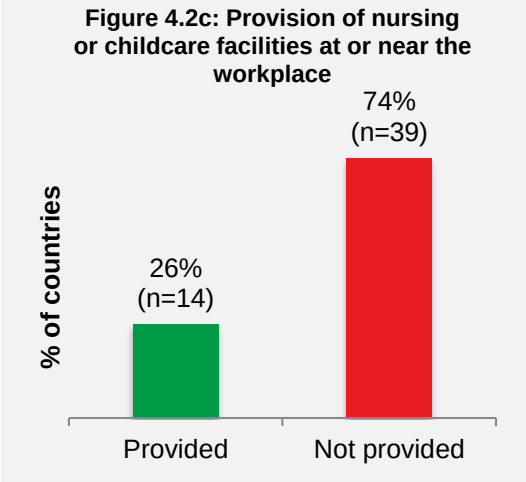
Year joined SUN Movement	Country maternity protection laws status		
	Yes (n=24)	Partial (n=23)	No (n=9)
2010–2011	Bangladesh, Benin, Burkina Faso, Kyrgyzstan, Mali, Mauritania, Niger, Senegal, Zimbabwe (n=9)	Ethiopia, Gambia, Ghana, Guatemala, Indonesia, Lao PDR, Namibia, Peru, Rwanda, Tanzania, Zambia (n=11)	Malawi, Mozambique, Nepal, Uganda, (n=4)
2012–2014†	Cameroon, Chad, Comoros, Congo, Costa Rica, Côte d'Ivoire, DRC, Guinea, Madagascar, Somalia, Tajikistan, Togo, Viet Nam (n=13)	Burundi, Cambodia, El Salvador, Haiti, Kenya, Lesotho, Myanmar, Nigeria, Pakistan, Sri Lanka, Swaziland (n=11)	Guinea-Bissau, Philippines, Yemen (n=3)
2015–2017‡	CAR, Gabon (n=2)	Botswana (n=1)	Papua New Guinea, Sudan (n=2)

† No data for Liberia, Sierra Leone and South Sudan

Using data reported for the GNR, the type of nursing policies in place is available for 53 SUN countries[22]. For the SUN countries where laws state when an employer is expected to provide for nursing or childcare facilities, the requirements differ across countries. Three SUN countries have a law that requires all employers to provide this regardless of the number of workers, eight SUN countries have laws requiring employers with more than a certain number of female workers to provide this; two countries have a law based on an undefined number of women workers, and one country has a law based on a minimum number of workers (regardless of sex).

[22] Data on entitlement to paid nursing breaks not available for Gambia, Kyrgyzstan, Lao PDR, Liberia, Sierra Leone and South Sudan. Data on provision of nursing or childcare facilities not available for Burkina Faso, Gambia, Kyrgyzstan, Liberia, Sierra Leone and South Sudan.





Footnotes to Figures 4.2b and 4.2c:
3.3a: PAID OR REDUCTION = women workers are entitled to daily breaks or a reduction of working time with pay to breastfeed or express breast milk. UNPAID = women workers are entitled to daily breaks or a reduction of working time without pay to breastfeed or express breast milk. NOT PROVIDED = the law does not provide women workers with the right to daily breaks or a reduction of working time to breastfeed or express breast milk.
3.3b PROVIDED = employers are requested to provide nursing or childcare facilities at or near their workplaces (or a reimbursement of childcare costs) NOT PROVIDED = the provision of nursing or childcare facilities or reimbursement of childcare costs is not mandated by law.

TABLE 47: COUNTRY GROUPING BY NURSING POLICY PROVISIONS

Entitlement to paid nursing breaks		
Paid or reduction of working time	Unpaid (n=4)	Not provided (n=10)
Paid (n=36): Botswana, Burkina Faso, Burundi, Cambodia, Cameroon, CAR, Chad, Comoros, Congo, Costa Rica, Côte d'Ivoire, DRC, El Salvador, Gabon, Ghana, Guatemala, Guinea-Bissau, Haiti, Lesotho, Madagascar, Mali, Mauritania, Mozambique, Nigeria, PNG, Peru, Philippines, Rwanda, Senegal, Somalia, Sri Lanka, Swaziland, Tajikistan, Togo, Viet Nam, Zimbabwe **Reduction** (n=3): Sudan, Tanzania, Yemen	Benin, Guinea, Indonesia, Niger	Bangladesh, Ethiopia, Kenya, Malawi, Myanmar, Namibia, Nepal Pakistan, Uganda, Zambia

Not identified for Gambia, Kyrgyzstan, Lao PDR, Liberia, Sierra Leone, South Sudan

Provision of nursing or childcare facilities at or near the workplace	
Provided (n=14)	Not provided (n=39)
Bangladesh, Cambodia, Cameroon, CAR, Costa Rica, El Salvador, Guatemala, Indonesia, Madagascar, Nepal, Niger, Philippines, Sri Lanka, Viet Nam	Benin, Botswana, Burundi, Chad, Comoros, Congo, Côte d'Ivoire, DRC, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Haiti, Kenya, Lao PDR, Lesotho, Malawi, Mali, Mauritania, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, PNG, Peru, Rwanda, Senegal, Somalia, Sudan, Swaziland, Tajikistan, Tanzania, Togo, Uganda, Yemen, Zambia, Zimbabwe

Not identified for Burkina Faso, Gambia, Kyrgyzstan, Liberia, Sierra Leone, South Sudan

FOOD LEGISLATION

Constitutional Right to Food Legislation

MEAL Indicator 4.3: Country has legislation on the Constitutional Right to Food

Data on the assessed level of constitutional protection of the right to food are available for 44 SUN countries for the reference year 2003.

TABLE 48: COUNTRY GROUPING BY RIGHT TO FOOD LEGISLATION STATUS AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Level of Right to Food Legislation			
	Medium low/Low	Medium	Medium high	High
2010–2011 (n=18)*	Burkina Faso, Nepal (n=2)	Benin, Kyrgyzstan, Mali, Mozambique, Niger, Rwanda, Senegal (n=7)	Ghana, Indonesia, Peru, Tanzania (n=4)	Bangladesh, Ethiopia, Guatemala, Malawi, Uganda (n=5)
2012–2014 (n=23)†	Comoros, Lesotho, Viet Nam, Yemen (n=4)	Burundi, Cambodia, Chad, Congo, Costa Rica, Côte d'Ivoire, Guinea, Madagascar, Philippines, Togo (n=10)	DRC, El Salvador, Liberia, Sierra Leone, Tajikistan (n=5)	Haiti, Nigeria, Pakistan, Sri Lanka (n=4)
2015–2017 (n=3)‡	–	Central African Republic, Gabon (n=2)	Sudan (n=1)	–

* No data for Gambia, Lao PDR, Mauritania, Namibia, Zambia, Zimbabwe
† No data for Cameroon, Guinea-Bissau, Kenya, Myanmar, Somalia, South Sudan, Swaziland
‡ No data for Botswana, Papua New Guinea

Legislation to Promote Healthy Diets

MEAL Indicator 4.4: Country has policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars, or salt

The WHO has identified a set of 10 progress monitoring indicators to track country progress in implementing interventions to reduce the burden of NCDs. Indicator 7 is focused on measures taken to reduce unhealthy diets, with four sub-indicators: a) national policies to reduce population salt/sodium consumption; b) national policies that limit saturated fats and virtually eliminate trans-fatty acids in the food supply; c) implementation of the WHO recommendations on marketing of foods and non-alcoholic beverages to children; and d) legislation/regulations fully implementing the International Code of Marketing of Breastmilk Substitutes.

For this section, we summarize data for SUN countries on indicator 7c, based on Member State responses to the WHO's 2017 NCD Country Capacity Survey[23] which represents the situation at the end of 2016.

As shown in Table 49, only six SUN countries (Central African Republic, Mali, Mozambique, Peru, Swaziland and Tajikistan) report having fully achieved progress in restrictions on marketing of foods and beverages to children. A similar level of progress is evident for the other two indicators dealing with promoting healthy diets for the entire population.

TABLE 49: NUMBER OF SUN COUNTRIES REPORTING PROGRESS TOWARDS IMPLEMENTING HEALTHY DIET POLICIES

Policy	Policy status			
	Fully achieved	Partially achieved	Not achieved	No data[a]
Restrictions on marketing of foods and beverages to children	6‡		47	6
Reduce population salt/sodium consumption	6*	4**	47	2
Limit saturated fats and eliminate trans-fats in the food supply	7†		49	3

[a] No data includes the following categories: Don't know and No response
* Central African Republic, Costa Rica, Kyrgyzstan, Lesotho, Mali, Tajikistan; ** Bangladesh, Botswana, Peru, Swaziland
† Central African Republic, Costa Rica, Kyrgyzstan, Mali, Peru, Swaziland, Tajikistan
‡ Central African Republic, Mali, Mozambique, Peru, Swaziland, Tajikistan

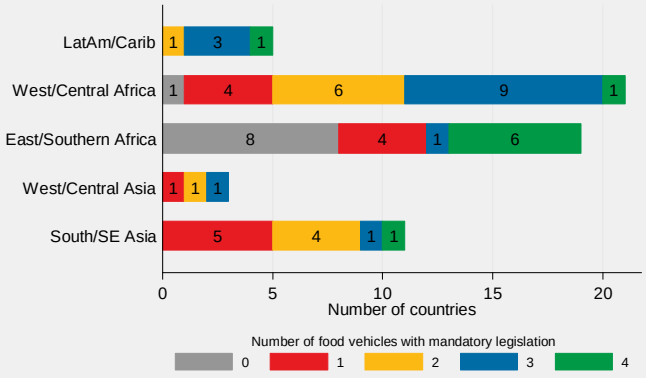
[23] Noncommunicable Diseases Progress Monitor, 2017. Geneva: WHO. [Accessed 13/10/2017.] http://apps.who.int/iris/bitstream/10665/258940/1/9789241513029-eng.pdf?ua=1

Legislation for Mandatory Food Fortification

MEAL Indicator 4.5: Country has legal documentation that has the effect of allowing or mandating food fortification

Data on country legislation for mandatory and voluntary food fortification is available for all SUN countries from the Global Fortification Data Exchange[24]. Over half (55.9%) of SUN countries have legislation mandating fortification of wheat flour and 44.1% have legislation mandating vegetable oil fortification (Table 51). A smaller number of SUN countries have legal documentation that mandates maize flour or rice fortification. Fortification of salt is mandatory in 46 of the 52 countries with data for this food vehicle.

Figure 4.5a
Number of countries and food vehicles with mandatory legislation by region



As shown in Figure 4.5a, nine SUN countries have mandatory legislation for four food vehicles, with the majority of these (n=6) in East/Southern Africa. However, this region also has the largest number of countries (n=8) with no documented mandatory legislation of any food vehicle.

TABLE 50: COUNTRY GROUPING BY MANDATORY FOOD FORTIFICATION LEGISLATION STATUS AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Number and type of food vehicles with mandatory food fortification legislation*			
	At least one staple food + salt + oil	At least one staple food + salt or oil	At least one food vehicle	None
2010–2011 (n=24)	Benin, Burkina Faso, Ghana, **Malawi**, Mauritania, **Mozambique**, Niger, Senegal, **Tanzania, Uganda** (n=10)	Guatemala, Indonesia, Kyrgyzstan, Mali, Nepal, Peru Zimbabwe (n=7)	Bangladesh, Ethiopia, Gambia, Lao PDR, Zambia (n=5)	Namibia, Rwanda (n=2)
2012–2014 (n=30)	**Burundi**, Côte d'Ivoire, Guinea, Haiti, **Kenya, Nigeria, Philippines**, Togo, Viet Nam, Yemen (n=10)	Cambodia, Cameroon, Congo, **Costa Rica**, El Salvador, Liberia, Sierra Leone (n=7)	Chad, Guinea-Bissau, Lesotho, Madagascar, Myanmar, Pakistan, Sri Lanka, Tajikistan (n=8)	Comoros, DRC, Somalia, South Sudan, Swaziland (n=5)
2015–2017 (n=5)	–	Papua New Guinea (n=1)	Central African Republic, Gabon (n=2)	Botswana, Sudan (n=2)

* Country names in **bold** font have mandatory food fortification legislation for four food vehicles

[24] FFI, GAIN, IGN, MN Forum. Global Fortification Data Exchange. [Accessed 13/03/2018.] http://www.fortificationdata.org

TABLE 51: PROPORTION OF SUN COUNTRIES WITH LEGAL DOCUMENTATION MANDATING FORTIFICATION OF A FOOD VEHICLE

Characteristic	N	Wheat	Maize	Rice	Oil	Salt (N=52)*
All SUN countries, % (n)	59	55.9 (33)	18.6 (11)	5.1 (3)	44.1 (26)	88.5 (46)†
# countries with voluntary legislation		0	n=1	0	n=6	0
Year joined SUN Movement						
2010–11	24	70.8 (17)	25.0 (6)	0	50.0 (12)	100.0 (21/21)
2012–14	30	53.3 (16)	16.7 (5)	6.7 (2)	46.7 (14)	81.5 (22/27)
2015–17	5	0	0	20.0 (1)	0	75.0 (3/4)
Region						
Latin America & Caribbean	5	100.0 (5)	60.0 (3)	20.0 (1)	20.0 (1)	100.0 (5)
West/Central Africa	21	71.4 (15)	4.8 (1)	0	61.9 (13)	85.7 (18)
East/Southern Africa	19	36.8 (7)	36.8 (7)	0	36.8 (7)	83.3 (10/12)
West/Central Asia	3	66.7 (2)	0	0	33.3 (1)	100.0 (3)
South/Southeast Asia	11	36.4 (4)	0	18.2 (2)	36.4 (4)	90.9 (10)
Country Income Level						
Low-income	28	60.7 (17)	21.4 (6)	0	57.1 (16)	83.3 (20/24)
Lower middle-income	26	53.9 (14)	15.4 (4)	7.7 (2)	38.5 (10)	92.0 (23/25)
Upper middle-income	5	40.0 (2)	20.0 (1)	20.0 (1)	0	100.0 (3/3)
Humanitarian Risk						
Low-Medium	23	47.8 (11)	8.7 (2)	8.7 (2)	30.4 (7)	100.0 (19/19)
High	25	76.0 (19)	36.0 (9)	4.0 (1)	60.0 (15)	91.3 (21/23)
Very High	11	27.3 (3)	0	0	36.4 (4)	60.0 (6/10)

* Missing data for Botswana, Comoros, Namibia, Rwanda, Somalia, Sudan, Swaziland (in most cases, informal sources suggest that legal documentation exists, but it is pending confirmation)
† DRC, Liberia, Pakistan, Sierra Leone, South Sudan and Sudan do not have documented legislation mandating salt fortification.

Legal Standards for Fortification of Food Vehicles

MEAL Indicator 4.6: Country has legal documentation specifying nutrient levels for fortification

Data on whether a country has legal documentation indicating standardized fortification levels of specific food vehicles with one or more priority nutrients is available for all SUN countries from the Global Fortification Data Exchange[25]. As shown in Table 52, half of SUN countries have legislation specifying fortification standards for wheat flour and vegetable oil. Only 12 countries have these standards for maize flour and three countries (Costa Rica, Papua New Guinea, Philippines) have standards for rice fortification. Ninety percent (90%) of SUN countries with documentation have salt fortification standards.

TABLE 52: PROPORTION OF SUN COUNTRIES WITH LEGISLATION SPECIFYING NUTRIENT LEVELS FOR FORTIFICATION OF A FOOD VEHICLE

Characteristic	N	Wheat	Maize	Rice	Oil	Salt (N=52)*
All SUN countries, % (n)	59	52.5 (31)	20.3 (12)	5.1 (3)	50.9 (30)	90.4 (47/52)
Year joined SUN						
2010–11	24	62.5 (15)	29.2 (7)	0	66.7 (16)	100.0 (22/22)
2012–14	30	53.3 (16)	16.7 (5)	6.7 (2)	46.7 (14)	84.6 (22/26)
2015–17	5	0	0	20.0 (1)	0	75.0 (3/4)

* Missing data for Botswana, Comoros, Guinea-Bissau, Namibia, Somalia, Swaziland, Zimbabwe

TABLE 53: COUNTRY GROUPING BY NUMBER OF FOOD VEHICLES WITH LEGISLATION ON FORTIFICATION STANDARDS AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Number of food vehicles with fortification standards legislation			
	3+ food vehicles	2 food vehicles	1 food vehicle	None
2010–2011 (n=24)	Benin, Burkina Faso, Ghana, Guatemala, Indonesia, Malawi, Mali, Mozambique, Niger, Rwanda, Senegal, Tanzania, Uganda, Zimbabwe (n=14)	Bangladesh, Gambia, Nepal, Peru, Zambia (n=5)	Ethiopia, Kyrgyzstan, Lao PDR, Mauritania (n=4)	Namibia (n=1)
2012–2014 (n=30)	Burundi, Costa Rica, Côte d'Ivoire, El Salvador, Guinea, Kenya, Nigeria, Philippines, Sierra Leone, Togo, Viet Nam, Yemen (n=12)	Cambodia, Cameroon, Congo, Guinea-Bissau, Liberia (n=5)	Chad, DRC, Haiti, Lesotho, Madagascar, Myanmar, Pakistan, South Sudan, Sri Lanka, Tajikistan (n=10)	Comoros, Somalia, Swaziland (n=3)
2015–2017 (n=5)	Papua New Guinea (n=1)	–	Central African Republic, Gabon (n=2)	Botswana, Sudan (n=2)

[25] FFI, GAIN, IGN, MN Forum. Global Fortification Data Exchange. [Accessed 13/03/2018.] http://www.fortificationdata.org

List 5: Drivers of nutrition

List 5 indicators are all included in the SDGs, with the exception of two indicators (diarrhoea and measles). These indicators represent key drivers of nutrition, embedded in sectors such as health, WASH, food systems, education, social protection and gender. This section of the report presents broad “sectoral results” and we recognize that each system may include additional indicators to monitor the coverage of related services or contextual factors which are not included here.

WATER, SANITATION AND HYGIENE

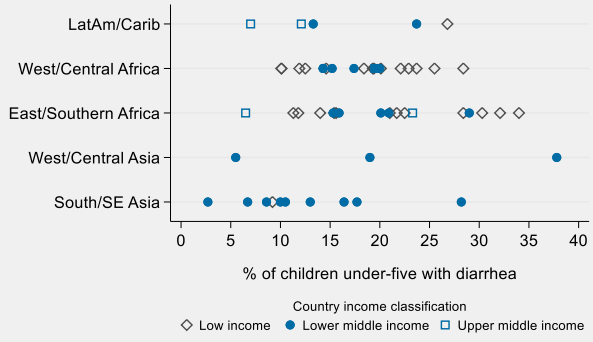
Diarrhoea prevalence

MEAL Indicator 5.1: Prevalence of diarrhoea in children under 5 years of age

Data on diarrhoea prevalence in children under 5 years of age were available for 58 SUN countries (no data for Papua New Guinea), based on nationally representative surveys (e.g. DHS, MICS). The reference year ranged from 2006 to 2016 for most countries, with Botswana only having data from 2000. Fifty countries (86%) have data from 2012 or more recent.

Mean prevalence of diarrhoea in children under five is 17.9% (95% CI 15.9, 19.9) and ranges across countries from 2.7 to 37.8% (median 17.6%). The overall distribution for this indicator across countries by region is shown in Figure 5.1a. Diarrhoea prevalence is over 10 percentage points higher (p<0.001), on average, in very high humanitarian risk contexts compared to low-medium risk contexts (Figure 5.1b) but similar across country income levels(data not shown).

Figure 5.1a
Distribution of under-five diarrhea prevalence in SUN countries by region and country income classification



Each symbol represents a country (n=58).

Figure 5.1b
Diarrhea prevalence by country humanitarian risk classification

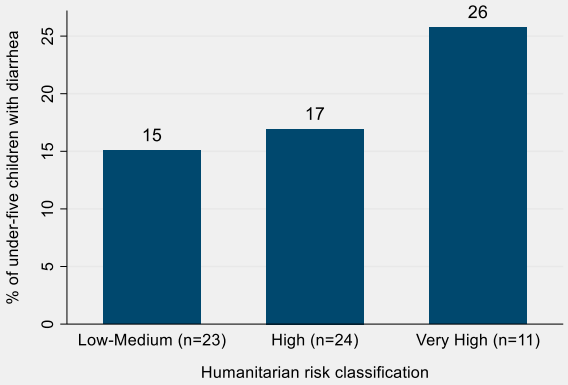


TABLE 54: COUNTRY GROUPING BY DIARRHOEA PREVALENCE AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN	Diarrhoea prevalence in children under five years of age			
	≥25%	18–24%	12–17%	<12%
2010–2011 (n=24)	Malawi, Uganda (n=2)	Burkina Faso, Gambia, Guatemala, Mauritania, Namibia, Niger, Senegal, Zambia, Zimbabwe (n=9)	Ghana, Indonesia, Mali, Mozambique, Peru, Rwanda, Tanzania (n=7)	Bangladesh, Benin, Ethiopia, Kyrgyzstan, Lao PDR, Nepal (n=6)
2012–2014 (n=30)	Burundi, Chad, Haiti, Liberia, Pakistan, South Sudan, Yemen (n=7)	Cameroon, Comoros, DRC, Kenya, Somalia, Tajikistan, Togo (n=7)	Cambodia, Congo, Côte d'Ivoire, El Salvador, Lesotho, Myanmar, Nigeria, Sierra Leone, Swaziland (n=9)	Costa Rica, Guinea, Guinea-Bissau, Madagascar, Philippines, Sri Lanka, Viet Nam (n=7)
2015–2017 (n=4)‡	Sudan(n=1)	Central African Republic, Gabon (n=2)	—	Botswana (n=1)

‡ No data for Papua New Guinea

Access to basic drinking water service

MEAL Indicator 5.2: Proportion of population using safely managed drinking water services

The WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation uses service ladders to benchmark and compare progress across countries, and these have been updated and expanded to facilitate enhanced monitoring during the SDG period. The new ladders build on the established improved/unimproved facility type classification, thereby providing continuity with MDG monitoring, and introduce additional criteria relating to the level of service provided to households.

Improved drinking water sources are those which by nature of their design and construction have the potential to deliver safe water. During the SDG period, the population using improved sources will be subdivided into three groups according to the level of service provided: safely managed, basic and limited drinking water service (see Table 55).

While data on population water access is available for all 59 SUN countries for the reference year 2015, only four SUN countries have data permitting the calculation of access to safely managed water services. Consistent with the JMP report for 2017[26], we assess the proportion of the population with access to *at least basic water service levels*, which includes both basic and safely managed water services.

[26] Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Geneva: World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), 2017.

TABLE 55: COMPARISON OF POPULATION WATER ACCESS DEFINITIONS

Original (MDG) Definition	SDG Definition specifying Service Level
Improved source *Improved sources include: piped water, boreholes or tubewells, protected dug wells, protected springs, rainwater, and packaged or delivered water.*	**Safely managed** Drinking water from an improved water source that is located on premises, available when needed and free from faecal and priority chemical contamination
	Basic Drinking water from an improved source, provided collection time is not more than 30 minutes for a round trip, including queuing
	Limited Drinking water from an improved source for which collection time exceeds 30 minutes for a round trip, including queuing
Unimproved source	**Unimproved** Drinking water from an unprotected dug well or unprotected spring
Surface water	**Surface water** Drinking water directly from a river, dam, lake, pond, stream, canal or irrigation canal

Source: Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Geneva: WHO and UNICEF, 2017.

Based on these data, 69% of the population in SUN countries used at least a basic drinking water service (i.e. an improved source within 30 minutes' round trip to collect water; range from 37 to 100%, median 68%) in 2015, compared to 89% of the global population[27]. Figure 5.2a shows the distribution in population access in SUN countries by region and country income classification. Access to water service by country characteristics is shown in Table 56.

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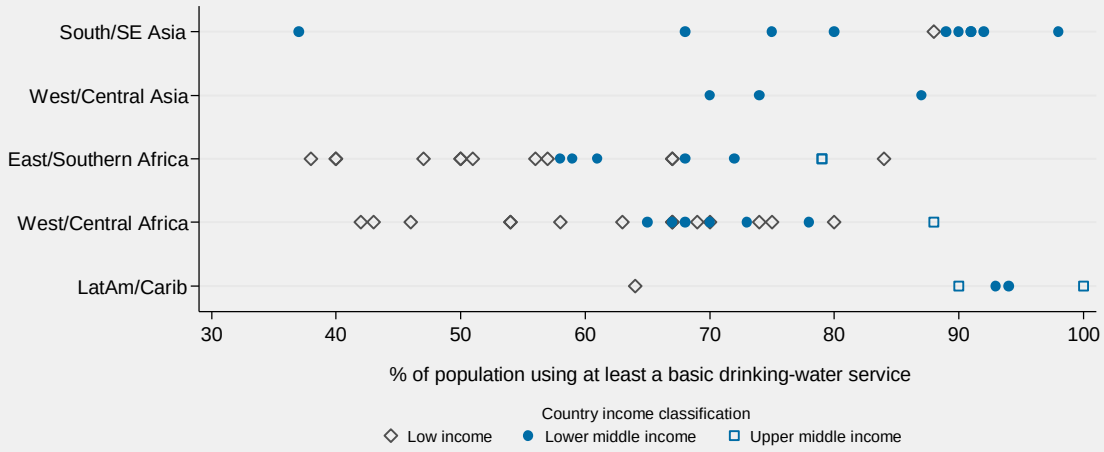
Figure 5.2a
Access to at least basic water service in SUN countries by region and country income classification



[27] Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Geneva: World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), 2017.

TABLE 56: PROPORTION OF POPULATION IN SUN COUNTRIES WITH ACCESS TO WATER BY SERVICE TYPE

Characteristic	N	Water service type		
		At least basic	Limited	Unimproved
Mean	59	68.9 (64.6, 73.2)	9.9 (7.8, 12.0)	14.1 (11.5, 16.7)
Median	59	68.0	8.0	13.0
Range	59	37.0, 100.0	0, 38.0	0, 42.0
Year joined SUN Movement				
2010–11	24	69.9 (62.7, 77.1)	10.4	14.6
2012–14	30	69.0 (63.3, 74.8)	9.0	14.2
2015–17	5	63.4 (45.2, 81.6)	13.2	11.8
Region				
Latin America & Caribbean	5	88.2 (75.7, 100.7)	2.6	7.8
West/Central Africa	21	65.3 (60.0, 70.6)	10.0	18.7
East/Southern Africa	19	59.1 (52.8, 65.4)	16.0	15.7
West/Central Asia	3	77.0 (66.7, 87.3)	9.0	3.0
South/Southeast Asia	11	81.7 (71.4, 92.1)	2.9	8.5
Country Income Level				
Low-income	28	59.3 (54.1, 64.6)	13.1	20.6
Lower middle-income	26	76.7 (70.1, 81.3)	7.2	9.3
Upper middle-income	5	87.2 (79.4, 95.0)	6.2	3.0
Humanitarian Risk Level				
Low-Medium	23	79.6 (75.2, 84.0)	6.0	9.2
High	25	64.4 (57.7, 71.1)	11.0	15.1
Very High	11	56.8 (47.8, 65.9)	15.2	22.1

TABLE 57: COUNTRY GROUPING BY POPULATION ACCESS TO WATER AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Proportion of population with access to at least basic water service			
	<55%	55–69%	70–84%	≥85%
2010–2011 (N=24)	Burkina Faso, Ethiopia, Mozambique, Niger, Tanzania, Uganda (n=6)	Benin, Malawi, Rwanda, Zambia, Zimbabwe (n=5)	Gambia, Ghana, Lao PDR, Mali, Mauritania, Namibia, Senegal (n=7)	Bangladesh, Guatemala, Indonesia, Kyrgyzstan, Nepal, Peru (n=6)
2012–2014 (N=30)	Chad, DRC, Madagascar, Somalia, South Sudan (n=5)	Burundi, Cameroon, Congo, Guinea, Guinea-Bissau, Haiti, Kenya, Myanmar, Nigeria, Sierra Leone, Swaziland, Togo (n=12)	Cambodia, Comoros, Côte d'Ivoire, Lesotho, Liberia, Tajikistan, Yemen (n=7)	Costa Rica, El Salvador, Pakistan, Philippines, Sri Lanka, Viet Nam (n=6)
2015–2017 (N=5)	Central African Republic, Papua New Guinea (n=2)	Sudan (n=1)	Botswana (n=1)	Gabon (n=1)

Overall SUN country progress in improving population access to clean drinking water is shown in Table 58. Over half of SUN countries (n=31, 53%) met the MDG target for drinking water (88%) in 2015. Of those that did not meet the target, eight countries (14%) showed good progress, nine countries (15%) showed moderate progress, and six (10%) showed limited or no progress.[28] Progress across country by region and year joined the SUN Movement is shown in Figures 5.2b and 5.2c, respectively.

TABLE 58: COMPARISON BETWEEN 2000 AND 2015 OF POPULATION ACCESS TO WATER BY SERVICE TYPE IN SUN COUNTRIES

Type of service	2015 (N=59)	2010 (N=58)	2000 (N=58)
At least basic	68.9 (64.6, 73.2)	65.5 (61.0, 70.0)	57.9 (52.9, 62.9)
Limited	9.9 (7.8, 12.0)	8.9 (7.0, 10.7)	7.7 (6.0, 9.3)
Unimproved	14.1 (11.5, 16.7)	16.6 (13.9, 19.3)	21.3 (17.9, 24.8)

Figure 5.2b
SUN country progress in meeting the MDG target for drinking water by region

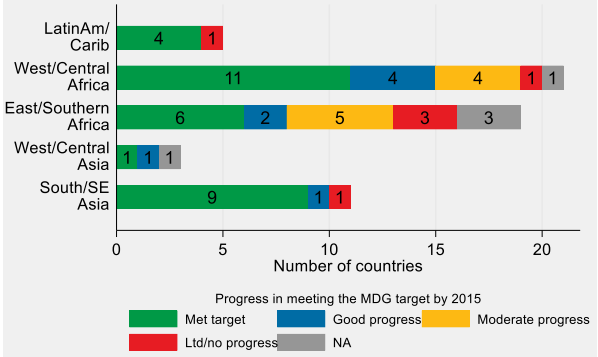
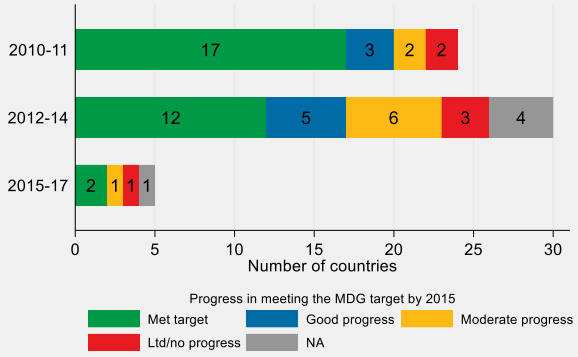


Figure 5.2c
SUN country progress in meeting the MDG target for drinking water by year joined the SUN movement



Access to basic sanitation service

MEAL Indicator 5.3: Proportion of population using a safely managed sanitation service [including a hand-washing facility with soap and water]

Improved sanitation facilities are those designed to hygienically separate excreta from human contact. During the SDG period, the population using improved facilities will be subdivided into three groups according to the level of service. The updated and expanded definitions of improved sanitation facilities to be used during the SDG period are shown in Table 59. However, in 2017, only three SUN countries have sufficient data to assess “safely managed” sanitation facilities.

Based on data available for all 59 SUN countries for the reference year 2015, we report here on the proportion of the population with access to *at least a basic sanitation facility* (see Table 60).

[28] No assessment was available for five SUN countries (Congo, Somalia, South Sudan, Sudan, Yemen).

On average, 41.5% of the population in SUN countries used at least a basic sanitation facility (i.e. improved facilities) in 2015, compared to 68% of the global population[29]. An additional 16% of the population used limited sanitation facilities (i.e. improved but shared facilities). On average, 20% of the population in SUN countries still practiced open defecation (range 0 to 71%, median 15%), compared to 12% globally.

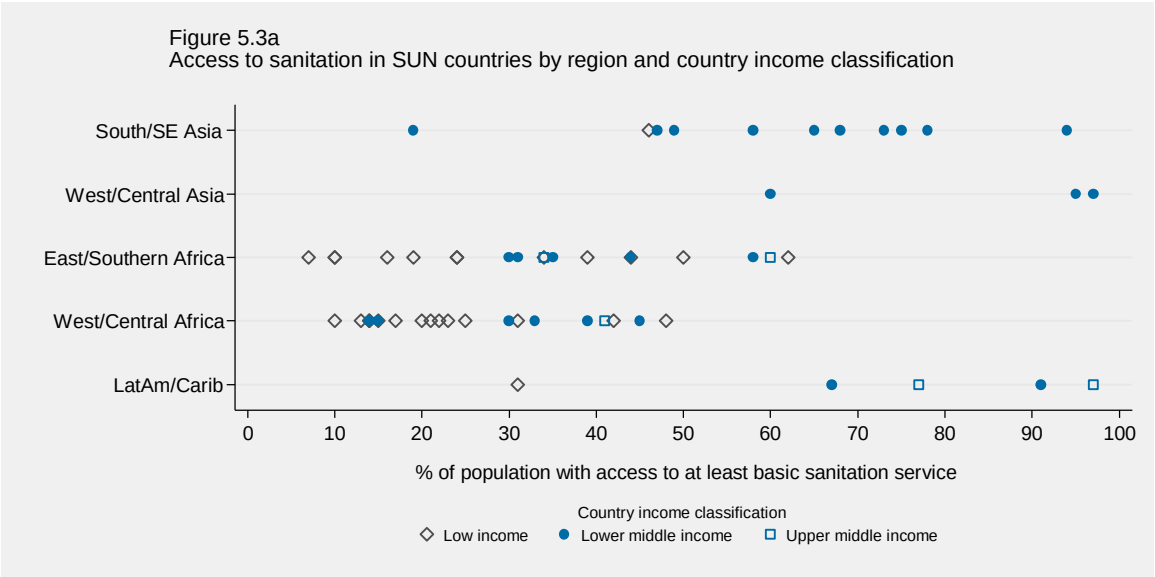
TABLE 59: COMPARISON OF POPULATION SANITATION ACCESS DEFINITIONS

Original (MDG) Definition	SDG Definition specifying Service Level
Improved facility *improved facilities include flush/pour flush to piped sewer systems, septic tanks or pit latrines; ventilated improved pit latrines, composting toilets or pit latrines with slabs.*	**Safely managed** Use of improved facilities that are not shared with other households and where excreta are safely disposed of in situ or transported and treated offsite
	Basic Use of improved facilities that are not shared with other households
	Limited Use of improved facilities shared between two or more households
Unimproved facility	**Unimproved** Use of pit latrines without a slab or platform, hanging latrines or bucket latrines
Open defecation	**Open defecation** Disposal of human faeces in fields, forests, bushes, open bodies of water, beaches or other open spaces, or with solid waste

Source: Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Geneva: WHO and UNICEF, 2017.

The distribution of access to at least basic sanitation services across countries grouped by region is shown in Figure 5.3a.

Figure 5.3a
Access to sanitation in SUN countries by region and country income classification



[29] Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Geneva: World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), 2017.

TABLE 60: PROPORTION OF POPULATION IN SUN COUNTRIES WITH ACCESS TO SANITATION BY SERVICE TYPE

Characteristic	N	Type of sanitation service			
		At least basic	Limited	Unimproved	Open defecation
Mean	59	41.5	15.5	22.9	20.1
Median	59	35.0	14.0	20.0	15.0
Range	59	7.0, 97.0	1.0, 57.0	0, 65.0	0, 71.0
Year joined SUN Movement					
2010–11	24	41.2	16.2	21.7	21.0
2012–14	30	42.7	15.3	22.1	20.0
2015–17	5	36.0	13.6	33.8	16.8
Region					
Latin America & Caribbean	5	72.6	11.4	9.6	6.8
West/Central Africa	21	25.3	23.0	25	26.8
East/Southern Africa	19	33.2	13.3	31.2	22.3
West/Central Asia	3	84.0	3.3	5.7	6.7
South/Southeast Asia	11	61.1	10.3	15.5	13.5
Country Income Level					
Low-income	28	26.1	17.4	29.6	27.0
Lower middle-income	26	54.2	14.1	18.2	13.7
Upper middle-income	5	61.8	12.4	10.4	15.4
Humanitarian Risk Level					
Low-Medium	23	55.7	15.0	13.4	16.0
High	25	33.0	17.5	31.0	18.4
Very High	11	31.2	12.1	24.5	32.5

TABLE 61: COUNTRY GROUPING BY POPULATION ACCESS TO AT LEAST BASIC SANITATION SERVICES AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Proportion of population with access to at least basic sanitation service			
	<20%	20–34%	35–59%	≥60%
2010–2011 (N=24)	Benin, Ethiopia, Ghana, Niger, Uganda (n=5)	Burkina Faso, Mali, Mozambique, Namibia, Tanzania, Zambia (n=6)	Bangladesh, Gambia, Malawi, Mauritania, Nepal, Senegal, Zimbabwe (n=7)	Guatemala, Indonesia, Kyrgyzstan, Lao PDR, Peru, Rwanda (n=6)
2012–2014 (N=30)	Chad, Congo, Liberia, Madagascar, Sierra Leone, Somalia, South Sudan, Togo (n=8)	Comoros, Côte d'Ivoire, DRC, Guinea, Guinea-Bissau, Haiti, Kenya, Nigeria (n=8)	Burundi, Cambodia, Cameroon, Lesotho, Pakistan, Swaziland (n=6)	Costa Rica, El Salvador, Myanmar, Philippines, Sri Lanka, Tajikistan, Viet Nam, Yemen (n=8)
2015–2017 (N=5)	Papua New Guinea (n=1)	Central African Republic (n=1)	Gabon, Sudan (n=2)	Botswana (n=1)

Only nine SUN countries (15%) met the MDG target for sanitation in 2015. Of those that did not meet the target, seven countries (12%) showed good progress, seven countries (12%) showed moderate progress, and over half (n=31, 53%) showed limited or no progress.[30] Progress across country by region and year joined the SUN Movement is shown in Figures 5.3b and 5.3c, respectively.

TABLE 62: COMPARISON OF SANITATION ACCESS IN SUN COUNTRIES BETWEEN 2000 AND 2015

Type of service	**2015** (N=59)	**2010** (N=58)	**2000** (N=58)
At least basic	41.5 (34.9, 48.1)	38.3 (31.8, 44.7)	32.5 (26.1, 38.9)
Limited	15.5 (12.8, 18.2)	14.2 (11.7, 16.8)	11.5 (9.2, 13.8)
Unimproved	22.9 (18.4, 27.4)	23.9 (19.4, 28.4)	25.9 (20.8, 30.9)
Open defecation	20.1 (15.4, 24.9)	22.9 (17.9, 27.9)	30.1 (23.8, 36.3)

[30] No assessment was available for five SUN countries (Congo, Somalia, South Sudan, Sudan, Yemen).

Figure 5.3b
SUN country progress in meeting the MDG target for sanitation by region

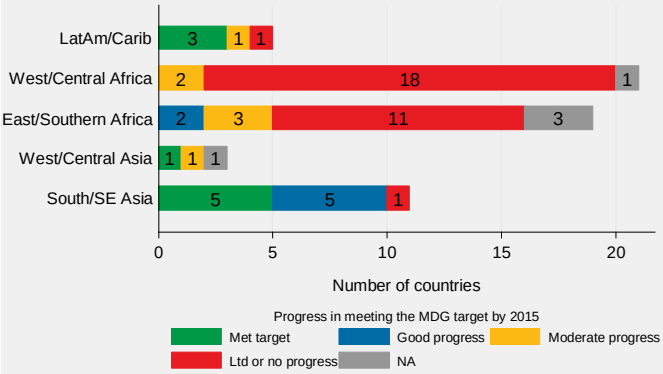
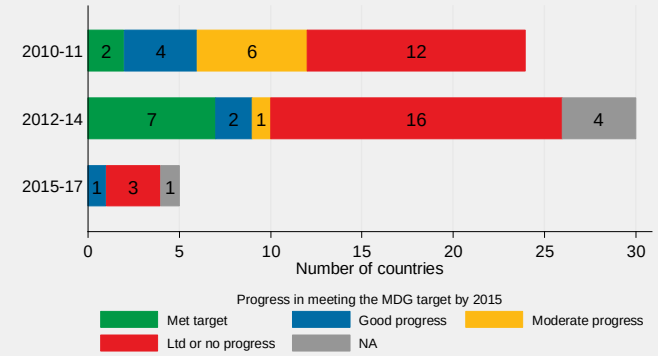


Figure 5.3c
SUN country progress in meeting the MDG target for sanitation
by year joined the SUN movement



Hygiene

The presence of a handwashing facility with soap and water on premises has been identified as the priority indicator for global monitoring of hygiene under the SDGs. Households that have a handwashing facility with soap and water available on premises will meet the criteria for a basic hygiene facility (see Table 63). Only 46 SUN countries currently have comparable data available on hygiene service levels.

TABLE 63: POPULATION HYGIENE SERVICE LEVEL DEFINITIONS

Service Level	Definition
Basic	Availability of a handwashing facility on premises with soap and water *(Handwashing facilities may be fixed or mobile and include a sink with tap water, buckets with taps, tippy-taps, and jugs or basins designated for handwashing. Soap includes bar soap, liquid soap, powder detergent and soapy water but does not include ash, soil, sand or other handwashing agents.)*
Limited	Availability of a handwashing facility on premises without soap and water
No facility	No handwashing facility on premises

Source: Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Geneva: WHO and UNICEF, 2017.

TABLE 64: PROPORTION OF POPULATION IN SUN COUNTRIES WITH ACCESS TO HANDWASHING FACILITIES BY SERVICE TYPE

Characteristic	N	Type of handwashing facility		
		Basic, %	Limited, %	No Facility, %
Mean	46	31.2	23.4	45.3
Median	46	16.5	20.5	51.0
Range	46	1, 90	1, 75	1, 98
Year joined SUN Movement				
2010–11	21	29.0	27.9	43.3
2012–14	24	33.5	19.8	46.8
2015–17	1	23.0	19.0	57.0
Region				
Latin America & Caribbean	4	69.3	20.0	11.0
West/Central Africa	16	10.6	20.2	69.1
East/Southern Africa	16	19.5	28.5	52.1
West/Central Asia	3	70.3	18.3	11.3
South/Southeast Asia	7	66.6	23.4	10.3
Country Income Level				
Low-income	23	16.2	26.0	57.7
Lower middle-income	21	44.5	20.2	35.4
Upper middle-income	2	64.0	27.0	9.0
Humanitarian Risk Level				
Low-Medium	17	38.0	21.8	40.4
High	21	25.3	24.4	50.4
Very High	8	32.3	24.4	43.0

TABLE 65: COUNTRY GROUPING BY POPULATION ACCESS TO HYGIENE SERVICES AND YEAR OF JOINING THE SUN MOVEMENT

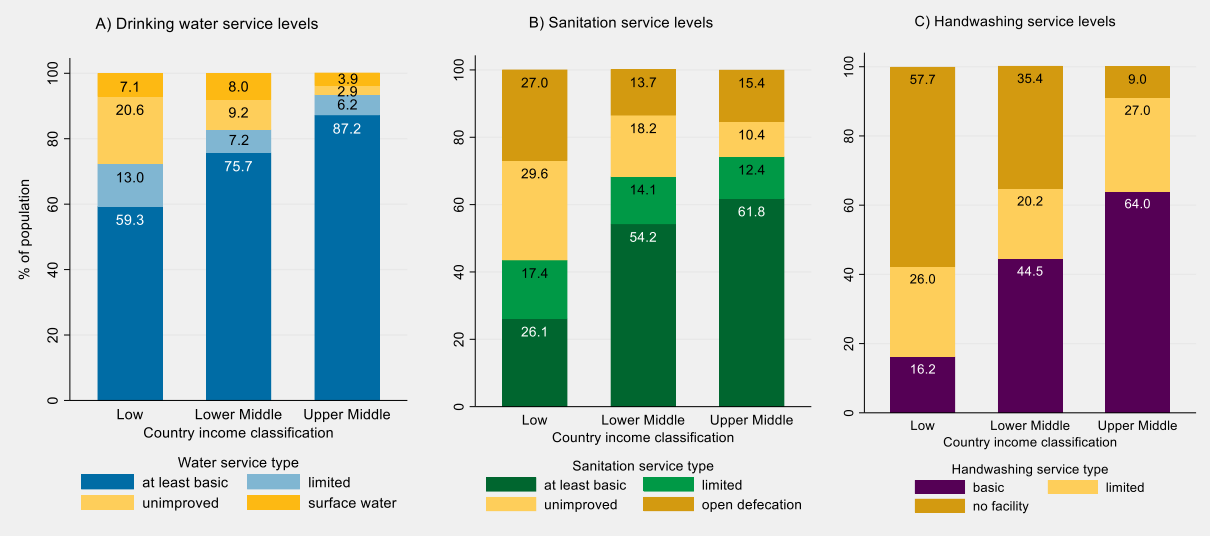
Year of SUN start	Proportion of population with access to basic handwashing facilities			
	<10%	10–19%	20–49%	≥50%
2010–2011 (N=21)*	Ethiopia, Gambia, Rwanda, Uganda (n=4)	Benin, Burkina Faso, Ghana, Malawi, Mali, Mauritania, Mozambique, Senegal, Zambia (n=9)	Bangladesh, Namibia, Tanzania, Zimbabwe (n=4)	Guatemala, Indonesia, Kyrgyzstan, Nepal (n=4)
2012–2014 (N=24)†	Cameroon, Chad, DRC, Guinea, Guinea-Bissau, Lesotho, Liberia (n=7)	Comoros, Kenya, Nigeria, Somalia, Togo (n=5)	Côte d'Ivoire, Haiti, Swaziland, Yemen (n=4)	Cambodia, Costa Rica, El Salvador, Madagascar, Myanmar, Pakistan, Tajikistan, Viet Nam (n=8)
2015–2017 (N=5)‡	—	—	Sudan (n=1)	—

*No data for Lao PDR, Niger, Peru; †No data for Burundi, Congo, Philippines, Sierra Leone, South Sudan, Sri Lanka ‡ No data for Botswana, Central African Republic, Gabon, Papua New Guinea

WASH Summary

In summary, Figure 5A-C provide a summary of SUN country access to drinking water, sanitation and hygiene services in 2015 by country income level, using the JMP ladders for classification of service level.

Figure 5: WASH service levels by country income classification



HEALTH

Malaria

MEAL Indicator 5.4: Malaria incident cases per 1000 population

Estimates of malaria incident cases per 1000 population for the year 2015 are available for all 59 SUN countries. However, five countries (Costa Rica, Kyrgyzstan, Lesotho, Sri Lanka and Tajikistan) had no malaria transmission in 2015.

The mean incidence of malaria per 1000 population is 136 (95% CI 101, 171) across SUN countries (median 104, range 0–449). Large regional variation is evident (see Figure 5.4a) and consistent with malaria transmission patterns.

Figure 5.4a: Malaria incident cases in 2015 by region

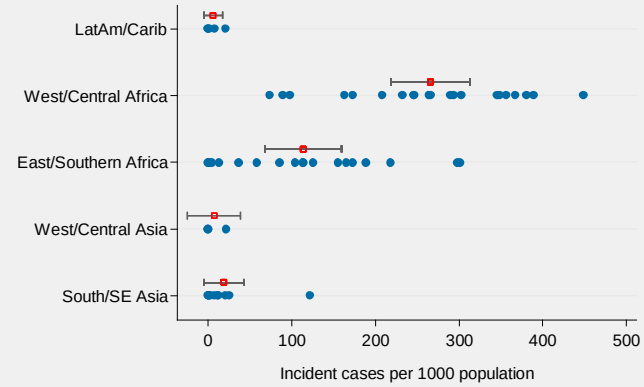


TABLE 66: COUNTRY GROUPING BY MALARIA INCIDENCE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Malaria case incidence rate per 1000 population, 2015			
	250+	100–249	10–99	<10
2010–2011 (n=24)	Benin, Burkina Faso, Ghana, Mali, Mozambique, Niger, Rwanda (n=7)	Gambia, Malawi, Tanzania, Uganda, Zambia, Zimbabwe (n=6)	Ethiopia, Indonesia, Lao PDR, Mauritania, Namibia, Peru, Senegal (n=7)	Bangladesh, Guatemala, Kyrgyzstan, Nepal (n=4)
2012–2014 (n=30)	Cameroon, Côte d'Ivoire, Guinea, Nigeria, Sierra Leone, Togo (n=6)	Burundi, Chad, Congo, DRC, Kenya, Liberia, Madagascar, South Sudan (n=8)	Cambodia, Guinea-Bissau, Myanmar, Somalia, Yemen (n=5)	Comoros, Costa Rica, El Salvador, Haiti, Lesotho, Pakistan, Philippines, Sri Lanka, Swaziland, Tajikistan, Viet Nam (n=11)
2015–2017 (n=5)	Central African Republic (n=1)	Gabon, Papua New Guinea (n=2)	Sudan (n=1)	Botswana (n=1)

The WHO's *Global Technical Strategy for Malaria 2016–2030* (GTS) set milestones to track progress in malaria control efforts, including the reduction of malaria case incidence by at least 40% by 2020. Of 54 SUN countries with malaria transmission in 2015, 15 are estimated to have achieved a reduction in incidence rates of 40% or more between 2010 and 2015, and can be considered on track to achieve the GTS milestone of a further reduction of 40% by 2020 (Table

67). Another 17 SUN countries achieved reductions of 20–40%. According to the World Malaria Report in 2016, less than half (40) of the world's 91 malaria-endemic countries are on track to meet the GTS milestone of a 40% reduction in malaria case incidence by 2020, with progress particularly slow in countries with a high malaria burden.

TABLE 67: COUNTRY GROUPING BY ESTIMATED CHANGE IN MALARIA INCIDENCE RATE, 2010–2015, AND YEAR OF JOINING THE SUN MOVEMENT[A]

Year of SUN start	Change in malaria incidence rate, 2010-2015			
	Decrease >40%	Decrease 20–40%	Change <±20%	Increase >20%
2010–2011*	Bangladesh, Ethiopia, Indonesia, Malawi, Uganda (n=5)	Burkina Faso, Ghana, Mozambique, Nepal, Niger, Senegal, Tanzania (n=7)	Benin, Gambia, Guatemala, Lao PDR, Mauritania, Zambia, Zimbabwe (n=7)	Mali, Namibia, Peru, Rwanda (n=4)
2012–2014†	Comoros, DRC, El Salvador, Haiti, Myanmar, Philippines, Swaziland, Tajikistan, Viet Nam, Yemen (n=10)	Burundi, Cambodia, Congo, Côte d'Ivoire, Liberia, Pakistan, Sierra Leone, Togo (n=8)	Cameroon, Chad, Guinea, Guinea-Bissau, Nigeria, South Sudan (n=6)	Kenya, Madagascar, Somalia (n=3)
2015–2017‡	Botswana (n=1)	CAR, PNG (n=2)	Sudan (n=1)	Gabon (n=1)

Source: World Malaria Report 2016, Annex 3E (p.92–93)
* No malaria transmission in Kyrgyzstan. † No malaria transmission in Costa Rica, Lesotho and Sri Lanka

Measles

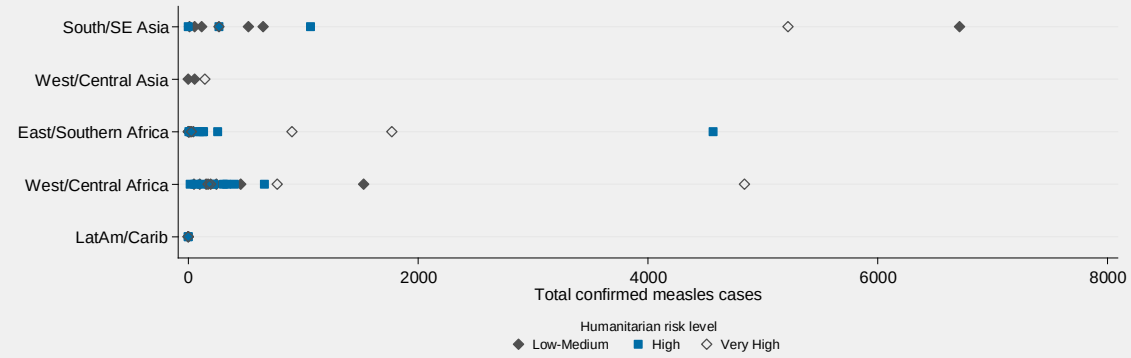
MEAL Indicator 5.5: New cases of measles

Most countries submit monthly reports on suspected and confirmed measles cases identified through their national disease surveillance systems to the WHO[31]. In general, the number of reported cases of measles reflects a small proportion of the true number of cases occurring in the community. Many measles cases do not seek health care or, if diagnosed, are not reported.

For the year 2016, 58 SUN countries reported data (no data reported by Guinea-Bissau) but eight countries reported zero cases and six countries reported fewer than 10 confirmed cases for the year. As shown in Figure 5.5a, there is a wide range in number of confirmed cases reported, with Nigeria reporting 17,581 cases and all other countries reporting less than 7000 cases. Although the median number of cases reported across SUN countries is 112, the median for countries considered as very high humanitarian risk contexts is 266.

[31] http://www.who.int/immunization/monitoring_surveillance/burden/vpd/surveillance_type/active/measles_monthlydata/en/

Figure 5.5a
Reported measles cases in SUN countries by region and humanitarian risk classification in 2016



Each symbol represents a country. Excludes Nigeria with 17,581 reported cases.

TABLE 68: COUNTRY GROUPING BY REPORTED MEASLES CASES AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Number of reported measles cases, 2016			
	≥1000	100–999	10–99	<10
2010–2011 (n=24)	Bangladesh, Ethiopia, Indonesia (n=3)	Burkina Faso, Ghana, Mali, Mozambique, Nepal, Niger, Senegal, Tanzania, Uganda (n=9)	Benin, Gambia, Mauritania, Namibia, Rwanda (n=5)	Guatemala, Kyrgyzstan, Lao PDR, Malawi, Peru, Zambia, Zimbabwe (n=7)
2012–2014 (n=29)†	DRC, Nigeria, Pakistan (n=3)	Cameroon, Chad, Congo, Guinea, Kenya, Liberia, Myanmar, Philippines, Sierra Leone, South Sudan, Sri Lanka, Togo, Viet Nam, Yemen (n=14)	Burundi, Cambodia, Côte d'Ivoire, Lesotho, Madagascar, Somalia, Tajikistan (n=7)	Comoros, Costa Rica, El Salvador, Haiti, Swaziland (n=5)
2015–2017 (n=5)	Gabon, Sudan (n=2)	Central African Republic (n=1)	—	Botswana, Papua New Guinea (n=2)

† No data for Guinea-Bissau

Adolescent birth rate

MEAL Indicator 5.6: Number of births during a given reference period to women aged 15–19 years /1000 females (and aged 10–14)

The adolescent birth rate is the annual number of births to women aged 15 to 19 per 1,000 women in that age group. Data on births to women aged 15-19 years are available for all 59 SUN countries from the United Nations Population Division.[32,33] The reference year ranges from 2004 to 2016, with 41 countries (69%) having data from 2012–2016.

Across SUN countries, the adolescent birth rate is 99.4 per 1000 women aged 15–19 years (95% CI 87.6, 111.3), compared to the global rate in 2015 of 44.1[34]. It ranges from 16.9 to 229.0 (median 92.4); notable differences are observed across regions (Figure 5.6a).

Figure 5.6a
Adolescent birth rate in SUN countries by region and country income class

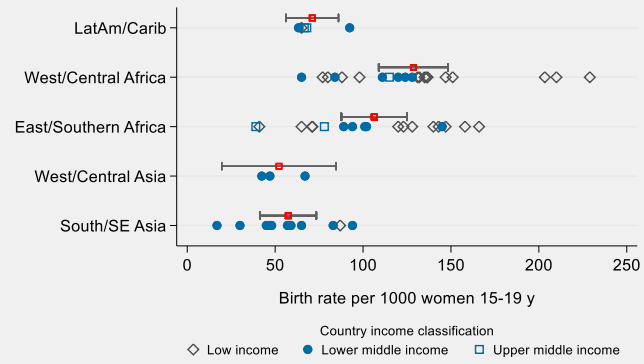


TABLE 69: COUNTRY GROUPING BY ADOLESCENT BIRTH RATE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Annual number of births to women aged 15 to 19 per 1,000 women in that age group			
	≥150	100–149	44–99	<44 (global rate, 2015)
2010–2011 (n=24)	Mali, Mozambique, Niger (n=3)	Burkina Faso, Malawi, Tanzania, Uganda, Zambia, Zimbabwe (n=6)	Bangladesh, Benin, Ethiopia, Gambia, Ghana, Guatemala, Indonesia, Lao PDR, Mauritania, Namibia, Nepal, Peru, Senegal (n=13)	Kyrgyzstan, Rwanda (n=2)
2012–2014 (n=30)	Chad, South Sudan (n=2)	Cameroon, Congo, Côte d'Ivoire, DRC, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Nigeria, Sierra Leone, Somalia (n=12)	Burundi, Cambodia, Comoros, Costa Rica, El Salvador, Haiti, Lesotho, Pakistan, Philippines, Swaziland, Tajikistan, Togo, Viet Nam, Yemen (n=14)	Myanmar, Sri Lanka (n=2)
2015–2017 (n=5)	Central African Republic (n=1)	Gabon, Sudan (n=2)	Papua New Guinea, Sudan (n=1)	Botswana (n=1)

[32] United Nations, Department of Economic and Social Affairs, Population Division (2015). 2015 Update for the MDG Database: Adolescent Birth Rate (POP/DB/Fert/A/MDG2015).
[33] No central source of data was found on births to women aged 10 to 14 years and so this target group is not represented in this analysis.
[34] United Nations, SDG Indicators Global Database, https://unstats.un.org/sdgs/indicators/database/?indicator=3.7.2#footnotes (updated 28 July 2017).

New HIV infections

MEAL Indicator 5.7: Number of new HIV infections per 1,000 uninfected population by age group, sex, and key populations

Data on new HIV infections per 1000 uninfected population were available for 51 SUN countries for the reference year 2015 in the WHO Global Health Observatory.

Estimates ranged from 0.01 to 23.6, with a mean of 2.4 (95% CI 1.1, 3.7; median 0.5). The distribution is shown in Figure 5.7a. Analysis by region illustrates the large disparity for this indicator, with notably higher prevalence in countries in East and Southern Africa, in particular.

Figure 5.7a
Distribution of new HIV infections in SUN countries by region and country income classification, 2015

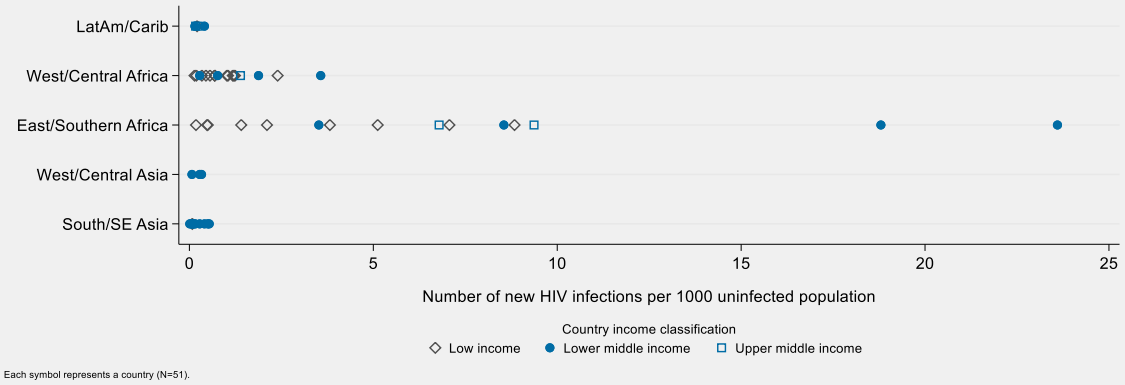


TABLE 70: COUNTRY GROUPING BY NEW HIV INFECTIONS AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Number of new HIV infections per 1000 uninfected population			
	≥2.00	0.50–1.99	0.25–0.49	<0.25
2010–2011 (n=22)*	Malawi, Mozambique, Namibia, Tanzania, Uganda, Zambia, Zimbabwe (n=7)	Benin, Gambia, Ghana, Indonesia, Mali, Rwanda (n=6)	Burkina Faso, Guatemala, Kyrgyzstan, Mauritania (n=4)	Bangladesh, Nepal, Niger, Peru, Senegal (n=5)
2012–2014 (n=25)†	Cameroon, Kenya, Lesotho, Swaziland (n=4)	Chad, Côte d'Ivoire, Guinea, Liberia, Madagascar, Sierra Leone, Togo (n=7)	DRC, Myanmar, Somalia, Tajikistan, Viet Nam (n=5)	Burundi, Cambodia, Costa Rica, El Salvador, Haiti, Pakistan, Philippines, Sri Lanka, Yemen (n=9)
2015–2017 (n=4)‡	Botswana, CAR (n=2)	Gabon, PNG (n=2)	—	—

* No data for Ethiopia and Lao PDR. † No data for Comoros, Congo, Guinea-Bissau, Nigeria, South Sudan. ‡ No data for Sudan

Tuberculosis (TB) Incidence

MEAL Indicator 5.8: Tuberculosis incidence per 100,000 population

WHO-generated estimates of TB incidence (including disaggregation by age and sex and incidence of TB/HIV) are available for 59 SUN countries for the year 2016.

Overall mean incidence of tuberculosis in SUN countries is 225 per 100,000 population (95% CI 185, 265), with a range from 10 to 724 (median 177).

Incidence is highest in countries from the South/Southeast Asia (median incidence 268) and East and Southern Africa regions (median incidence 237).

Figure 5.8a
Distribution of TB incidence in SUN countries by region and country income classification, 2015

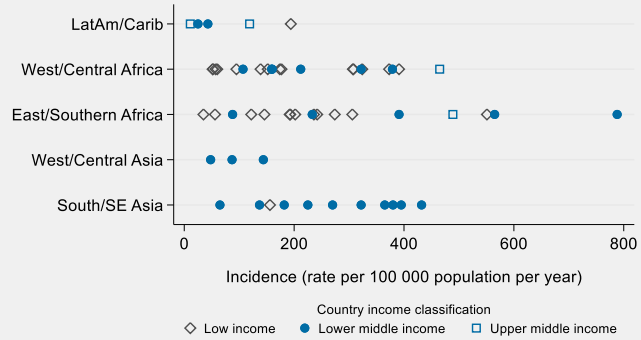


TABLE 71: COUNTRY GROUPING BY TB INCIDENCE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	TB incidence per 100,000 population, 2015			
	≥350	200–349	100–199	<100
2010–2011 (n=24)	Indonesia, Mozambique, Namibia, Zambia (n=4)	Bangladesh, Tanzania, Uganda, Zimbabwe (n=4)	Ethiopia, Gambia, Ghana, Kyrgyzstan, Lao PDR, Malawi, Mauritania, Nepal, Peru, Senegal (n=10)	Benin, Burkina Faso, Guatemala, Mali, Niger, Rwanda (n=6)
2012–2014 (n=30)	Congo, Guinea-Bissau, Lesotho, Myanmar, Philippines, Swaziland (n=6)	Cambodia, Cameroon, DRC, Kenya, Liberia, Madagascar, Nigeria, Pakistan, Sierra Leone, Somalia (n=10)	Burundi, Chad, Côte d'Ivoire, Guinea, Haiti, South Sudan, Viet Nam (n=7)	Comoros, Costa Rica, El Salvador, Sri Lanka, Tajikistan, Togo, Yemen (n=7)
2015–2017 (n=5)	CAR, Gabon, PNG (n=3)	Botswana (n=1)	—	Sudan (n=1)

FOOD SYSTEMS

The prevalence of undernourishment and prevalence of moderate or severe food insecurity in the population are the two key indicators selected for monitoring progress toward SDG target 2.1, to end hunger and ensure access by all to safe, nutritious and sufficient food.

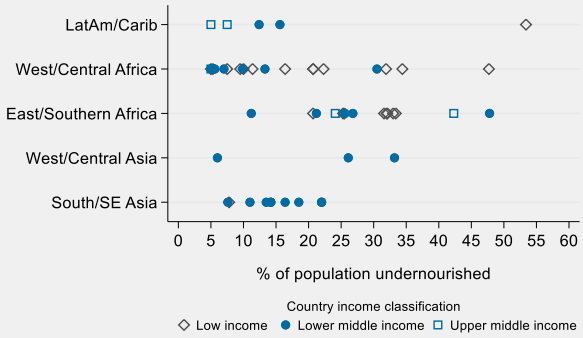
Prevalence of undernourishment

MEAL Indicator 5.9: Prevalence of undernourishment

The prevalence of undernourishment (SDG indicator 2.1.1) is the main hunger indicator used by the FAO. It measures the share of the population that consumes an amount of calories that is insufficient to cover the energy requirement for an active and healthy life (as defined by the minimum dietary energy requirement). The global average for 2015 is estimated to be 10.8%[35]. Data on prevalence of undernourishment were available for 53 SUN countries for the reference period 2014–2016. Four of these countries (Costa Rica, Gabon, Ghana and Mali) were reported to have levels <5% but the estimate of 5% was used for this analysis.

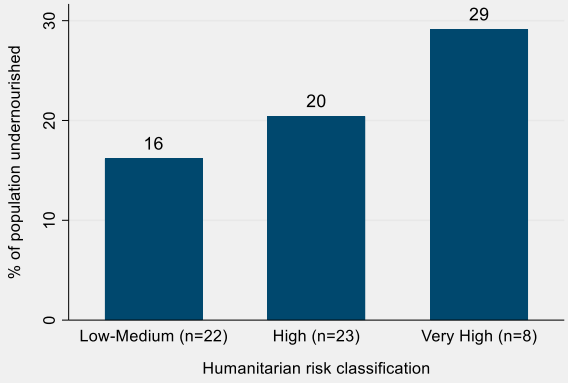
On average, 20.0% (95% CI 16.6, 23.4) of the population is considered undernourished in these SUN countries. Prevalence of undernourishment ranges from <5% to 53.4% (median 18.5%). Undernourishment prevalence is similar across country income classification (23% in LIC and 17% in LMIC and UMIC) but markedly higher in countries with very high humanitarian risk classification (see Figure 5.9b).

Figure 5.9a
Prevalence of undernourishment in SUN countries by region and country income classification, 2015



Each symbol represents a country (n=53). Source: FAOSTAT

Figure 5.9b
Prevalence of undernourishment by humanitarian risk level, 2015



[35] FAO,IFAD, UNICEF, WFP and WHO (2017). The state of food insecurity and nutrition in the world 2017: building resilience for peace and food security. Rome, FAO. (note: 2015 estimates by World Bank country income classification: Low income, 26%; Lower middle income, 14%; Upper middle income, 8%)

TABLE 72: COUNTRY GROUPING BY UNDERNOURISHMENT PREVALENCE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Prevalence of undernourishment, 2014-2016			
	≥30%	20–29%	10–19%	<10%
2010–2011 (n=24)	Ethiopia, Namibia, Rwanda, Tanzania, Zambia, Zimbabwe (n=6)	Burkina Faso, Malawi, Mozambique, Uganda (n=4)	Bangladesh, Guatemala, Lao PDR, Senegal (n=4)	Benin, Gambia, Ghana, Indonesia, Kyrgyzstan, Mali, Mauritania, Nepal, Niger, Peru (n=10)
2012–2014 (n=25)†	Chad, Congo, Haiti, Liberia, Madagascar, Tajikistan (n=6)	Guinea-Bissau, Kenya, Pakistan, Sierra Leone, Sri Lanka, Swaziland, Yemen (n=7)	Cambodia, Côte d'Ivoire, El Salvador, Guinea, Lesotho, Myanmar, Philippines, Togo, Viet Nam (n=9)	Cameroon, Costa Rica, Nigeria (n=3)
2015–2017 (n=4)‡	Central African Republic (n=1)	Botswana, Sudan (n=2)	—	Gabon (n=1)

† No data for Burundi, Comoros, DRC, Somalia and South Sudan. ‡ No data for Papua New Guinea

Prevalence of food insecurity

MEAL Indicator 5.10: Prevalence of moderate or severe food insecurity in the population

The prevalence of moderate or severe food insecurity in the population (SDG indicator 2.1.2), is based on the Food Insecurity Experience Scale (FIES), a new global standard developed by FAO to produce reliable population estimates of food insecurity that are comparable across different countries and cultures. The FIES is an experience-based measure of food insecurity severity, relying on people's direct responses to questions regarding their access to adequate food. Given that few countries to date have collected FIES data in national surveys, FAO has produced provisional baseline country estimates for more than 140 countries using data commissioned to be collected through the Gallup® World Poll. However, only a limited number of countries have given approval for FAO to publish their national estimates.[36]

Data on the prevalence of moderate/severe food insecurity are currently available for 15 SUN countries for the reference year 2015. Estimates for South Sudan are markedly higher than any other, with an estimated 94% prevalence of moderate/severe food insecurity and 83% severe food insecurity. For the other 14 SUN countries, the average prevalence of moderate or severe food insecurity is 43.9% (95% CI 32.9, 54.8), with a range from 14.3% to 67.3% (median 48.7%). Prevalence of severe food insecurity ranges from 2.1% to 35% across these countries (median 13.6%).

[36] FAO, IFAD, UNICEF, WFP and WHO (2017). The state of food security and nutrition in the world 2017. Rome, FAO.

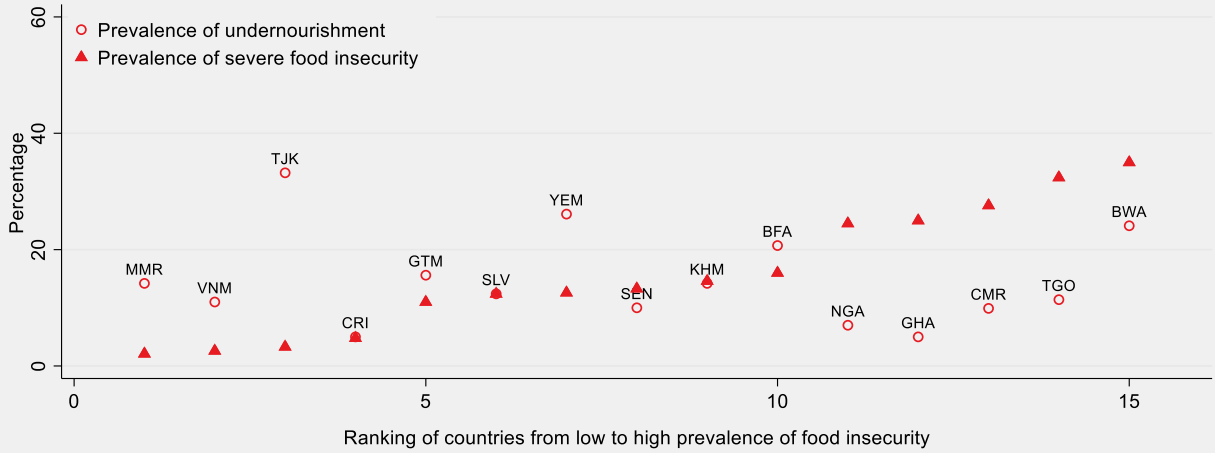
TABLE 73: COUNTRY GROUPING BY FOOD INSECURITY PREVALENCE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Prevalence of moderate/severe food insecurity, 2015			
	≥60%	50–59%	30–49%	<30%
2010–2011 (n=3)*	–	Burkina Faso, Ghana (n=2)	Guatemala (n=1)	–
2012–2014 (n=11)†	South Sudan, Togo, Yemen (n=3)	Cameroon, Nigeria (n=2)	Cambodia, El Salvador (n=2)	Costa Rica, Myanmar, Tajikistan, Viet Nam (n=4)
2015–2017 (n=1)‡	Botswana (n=1)	–	–	–

* No data for Bangladesh, Benin, Ethiopia, Gambia, Indonesia, Kyrgyzstan, Lao PDR, Malawi, Mali, Mauritania, Mozambique, Namibia, Nepal, Niger, Peru, Rwanda, Senegal, Tanzania, Uganda, Zambia and Zimbabwe
† No data for Burundi, Chad, Comoros, Congo, Cote d'Ivoire, DRC, Guinea, Guinea-Bissau, Haiti, Kenya, Lesotho, Liberia, Madagascar, Pakistan, Philippines, Sierra Leone, Somalia, Sri Lanka and Swaziland.
‡ No data for Central African Republic, Gabon, Papua New Guinea and Sudan

The prevalence of severe food insecurity, as measured by FIES, is expected to approximate the prevalence of undernourishment, as both indicators reflect the extent of severe food deprivation.[37] However, as shown in Figure 5.10a, a comparison of estimates for the 14 SUN countries with data for both indicators suggests there may be data problems leading to biased estimates of one or the other in some contexts. Similar to a comparison of estimates for 129 countries in the State of Food Security and Nutrition in the World 2017 report, countries with higher levels of severe food insecurity tend to have lower estimates of undernourishment and many of these countries are located in sub-Saharan Africa. The two West/Central Asian countries show much higher undernourishment prevalence compared to severe food insecurity.

Figure 5.10a
Prevalence of undernourishment and severe food insecurity in SUN countries, 2015



[37] FAO, IFAD, UNICEF, WFP and WHO (2017). The state of food security and nutrition in the world 2017. Rome, FAO.

GENDER

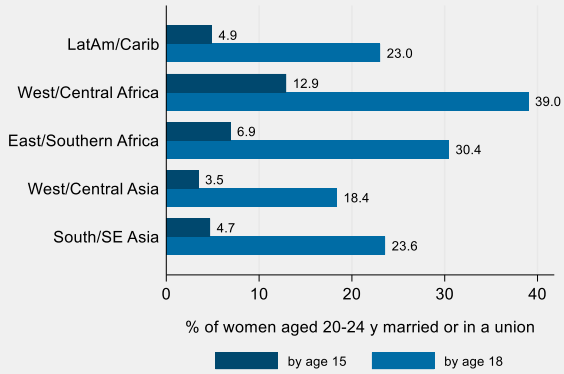
Early marriage

MEAL Indicator 5.11: Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18

Data on early marriage are available for 58 SUN countries, with the reference year ranging from 2006 to 2016. Forty-nine countries (84%) have data between 2012–2016.

The mean proportion of women aged 20–24 years who were married or in a union before age 15 is 8.3% (range 0.1 to 29.7%, median 7.0%) and before age 18 is 8.3% (range 5.3 to 76.3%, median 30.5%). The global estimate for 2015 is 7.5% before age 15 and 26.7% before age 18.[38]

Figure 5.11a
Early marriage in SUN countries by age and region



Estimates by region are shown in Figure 5.11a. Early marriage is much more common in low income countries (Figure 5.11b) and increases with increased humanitarian risk levels (Figure 5.11c).

Figure 5.11b
Early marriage in SUN countries by country income classification

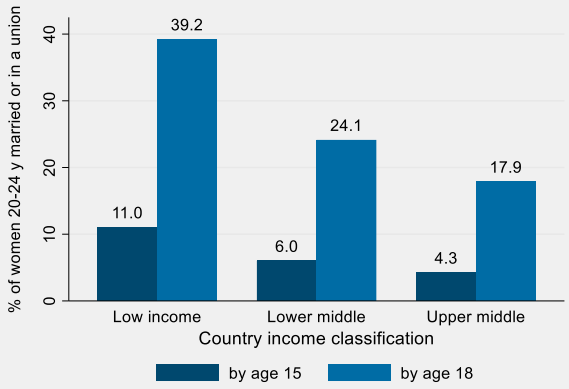
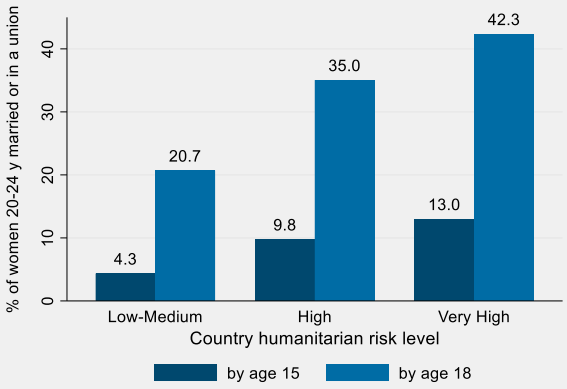


Figure 5.11c
Early marriage in SUN countries by humanitarian risk classification



[38] SDG Indicators Global Database, https://unstats.un.org/sdgs/indicators/database/?indicator=5.3.1 [accessed 29 August 2017]

SUN country performance for the early marriage indicator is shown in Table 74.

TABLE 74: COUNTRY GROUPING BY EARLY MARRIAGE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Proportion of women aged 20–24 years married or in a union before age 18			
	≥40%	30–39%	20–29%	<20%
2010–2011 (n=24)	Bangladesh, Burkina Faso, Ethiopia, Malawi, Mali, Mozambique, Niger (n=7)	Gambia, Lao PDR, Mauritania, Nepal, Senegal, Tanzania, Uganda, Zambia, Zimbabwe (n=9)	Benin, Ghana, Guatemala, Peru (n=4)	Indonesia, Kyrgyzstan, Namibia, Rwanda (n=4)
2012–2014 (n=30)	Chad, Guinea, Madagascar, Nigeria, Somalia, South Sudan (n=6)	Cameroon, Comoros, DRC, Liberia, Sierra Leone, Yemen (n=6)	Burundi, Congo, Costa Rica, Côte d'Ivoire, El Salvador, Guinea-Bissau, Kenya, Pakistan, Togo (n=9)	Cambodia, Haiti, Lesotho, Myanmar Philippines, Sri Lanka, Swaziland, Tajikistan, Viet Nam (n=9)
2015–2017 (n=4)‡	Central African Republic (n=1)	Sudan (n=1)	Gabon, Papua New Guinea (n=2)	–

‡ No data for Botswana

EDUCATION

Female secondary school enrollment

MEAL Indicator 5.12: Female secondary school enrollment

Data on female secondary school enrollment are available for 55 SUN countries[39], with the reference year ranging from 2007 to 2016 (49 countries with data in 2012 or more recent).

On average, 51.1% of girls are enrolled in secondary school in SUN countries. Female secondary school enrollment (% gross) ranges from 4.6 to 125.6% (median 46.8%).[40]

Large gaps in girls' access to education are evident in low- and lower middle-income countries (Figure 5.12a). The distribution in female secondary school enrollment by region is shown in Figure 5.12b.

Figure 5.12a
Female secondary school enrollment by country income classification

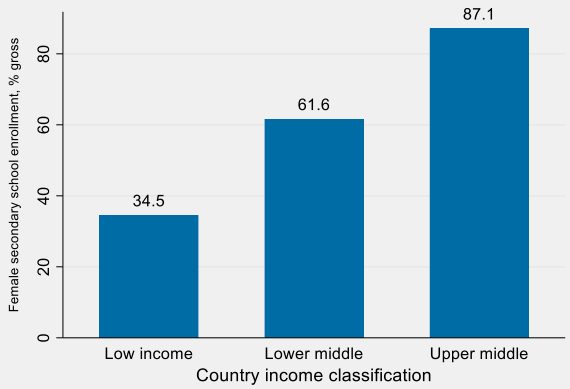
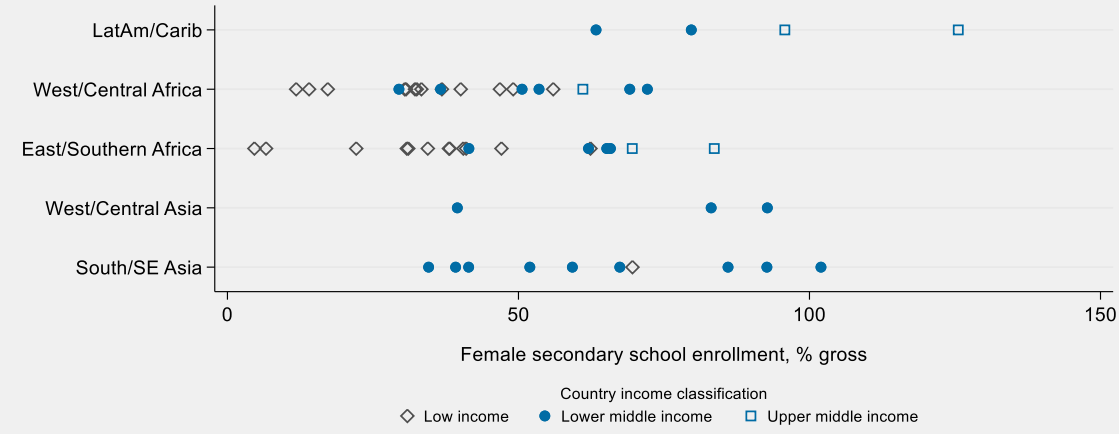


Figure 5.12b
Female secondary school enrollment distribution by region and country income class



Each symbol represents a country. The red squares indicate the regional mean and confidence intervals.

[39] Data from three countries was considered too out-of-date to be contextually relevant: Guinea-Bissau (2000), Viet Nam (1998), Zambia (1988).

[40] Female secondary enrollment rate is the total female enrollment in secondary education, in all programmes, regardless of age, expressed as a percentage of the female population of official secondary education age. The rate can exceed 100% due to the inclusion of overaged and underaged students because of early or late school entrance and grade repetition.

Gender parity index – The ratio of female-to-male values of a given indicator. A GPI of 1 indicates parity between the sexes. (*one source suggests that while an index of 1.0 is perfect parity, 0.97–1.03 is considered a "zone of gender parity"*)

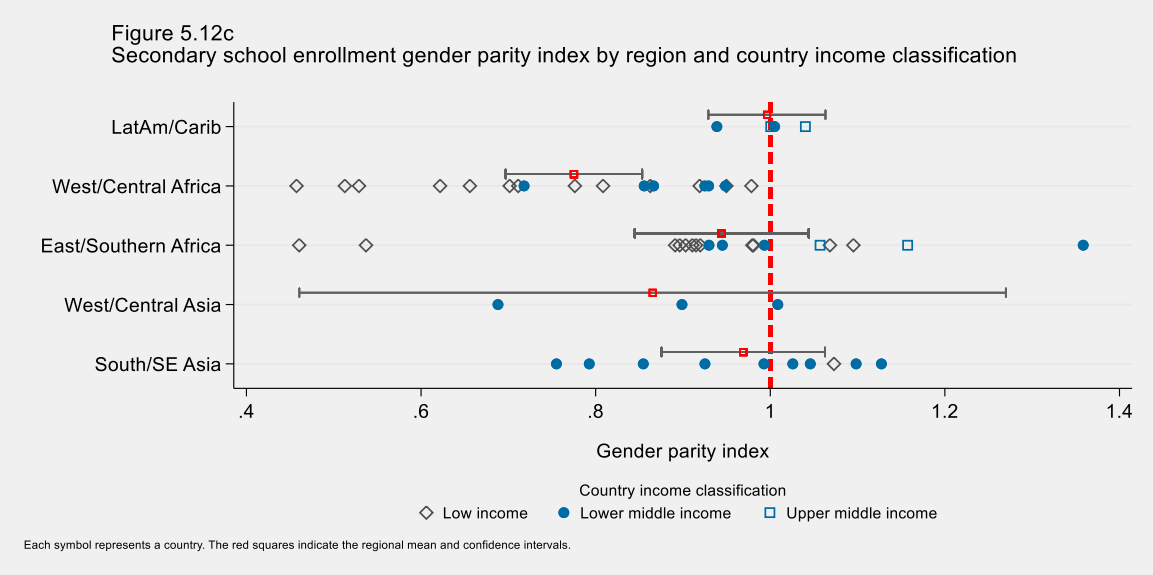


TABLE 75: COUNTRY GROUPING BY FEMALE SECONDARY SCHOOL ENROLLMENT AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Female secondary school enrollment rate			
	<30%	30–49%	50–64%	≥65%
2010–2011 (n=23)*	Mauritania, Niger, Uganda (n=3)	Benin, Burkina Faso, Ethiopia, Malawi, Mali, Mozambique, Rwanda, Senegal, Tanzania, Zimbabwe (n=10)	Gambia, Guatemala, Lao PDR (n=3)	Bangladesh, Ghana, Indonesia, Kyrgyzstan, Namibia, Nepal, Peru (n=7)
2012–2014 (n=27)†	Chad, Somalia, South Sudan (n=3)	Burundi, Cambodia, Côte d'Ivoire, DRC, Guinea, Liberia, Madagascar, Pakistan, Sierra Leone, Togo, Yemen (n=11)	Cameroon, Comoros, Congo, Lesotho, Myanmar (n=5)	Costa Rica, El Salvador, Kenya, Nigeria, Philippines, Sri Lanka, Swaziland, Tajikistan (n=8)
2015–2017 (n=5)	Central African Republic (n=1)	Papua New Guinea, Sudan (n=2)	Gabon (n=1)	Botswana (n=1)

* No data for Zambia; † No data for Guinea-Bissau, Haiti and Viet nam

CHILD PROTECTION

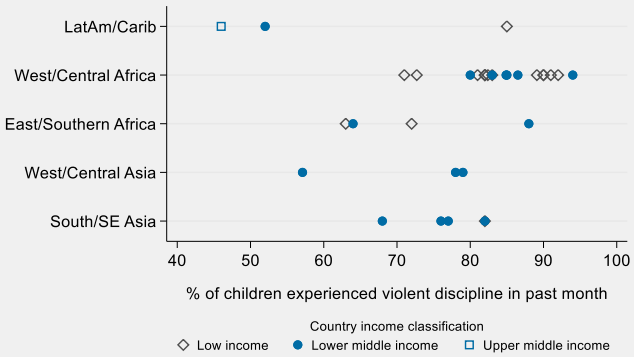
Violent discipline among children

MEAL Indicator 5.13: Proportion of children 2–14 years old who experienced any violent discipline (psychological aggression and/or physical punishment)

Data on violent discipline among children are available for 34 SUN countries, with the reference year ranging from 2005 to 2016 (26 countries with data in 2012 or more recent).

On average, in the countries where this indicator was assessed, 78.6% of children 2–14 years old experienced any violent discipline in the past month. Country estimates range from 46 to 94% (median 82%).

Figure 5.13a
Use of violent discipline in SUN countries by region and country income class



Each symbol represents a country (n=34, 2005-2016)

TABLE 76: COUNTRY GROUPING BY USE OF VIOLENT DISCIPLINE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Proportion of children 2–14 y who experienced any violent discipline			
	≥85%	80-84%	75-79%	<75%
2010–2011 (n=13)*	Benin, Gambia, Ghana, (n=3)	Bangladesh, Burkina Faso, Mauritania, Nepal, Niger (n=5)	Lao PDR (n=1)	Kyrgyzstan, Malawi, Mali, Zimbabwe (n=4)
2012–2014 (n=19)†	Cameroon, Côte d'Ivoire, Guinea, Haiti, Liberia, Swaziland (n=6)	Congo, DRC, Guinea-Bissau, Nigeria, Sierra Leone, Togo (n=6)	Myanmar, Tajikistan, Yemen (n=3)	Chad, Costa Rica, El Salvador, Viet Nam (n=4)
2015–2017 (n=2)‡	Central African Republic (n=1)	—	—	Sudan (n=1)

* No data for Ethiopia, Guatemala, Indonesia, Mozambique, Namibia, Peru, Rwanda, Senegal, Tanzania, Uganda, Zambia
† No data for Burundi, Cambodia, Comoros, Kenya, Lesotho, Madagascar, Pakistan, Philippines, Somalia, South Sudan, Sri Lanka
‡ No data for Botswana, Gabon, Papua New Guinea

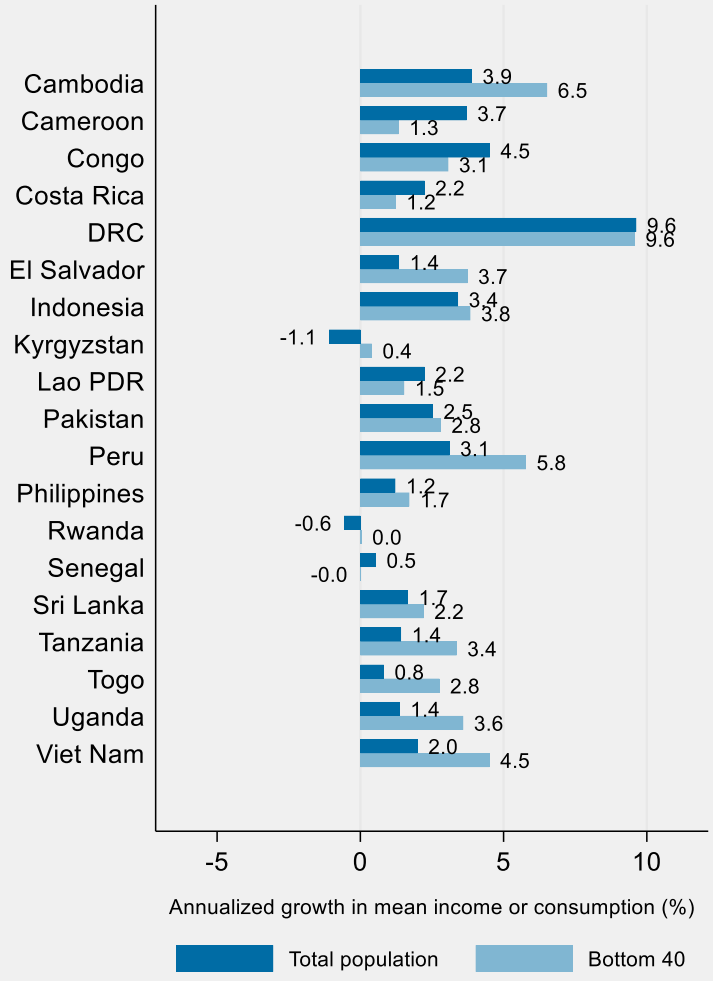
SOCIAL PROTECTION

Shared prosperity

MEAL Indicator 5.14: Growth rates of household expenditure and income per capita among the bottom 40% of the population and the total population

Shared prosperity is measured as the growth in the average income or consumption of the bottom 40% of the population. The larger the growth rate in the income of the bottom 40%, the more quickly prosperity is shared with the most disadvantaged sectors in society.

Figure 5.14a
Shared prosperity in SUN countries



Data on the annualized growth in mean household per capita income or consumption (according to surveys) are available from the Global Database of Shared Prosperity[41] for 19 SUN countries with reference periods ranging from 2004 to 2015.

The bottom 40% of the population in all of the 19 SUN countries monitored experienced positive income growth, as shown in Figure 5.13a. In 11 of the 19 countries, the income growth among the bottom 40 exceeded that of the total population.

Globally, in order to reach the goal of ending poverty by 2030, the growth in income among the bottom 40% needs to exceed the growth in income at the mean by at least 1 percentage point in each country.[42] The average growth rate in the bottom 40% in these 19 countries was 3.1% (95% CI 1.9, 4.2) whereas the average growth rate in the total population was 2.3% (95% CI 1.2, 3.4). This results in a “shared prosperity premium” of 0.8% across these SUN countries.

[41] Source: GDSP (Global Database of Shared Prosperity), World Bank, Washington, DC, http://www.worldbank.org/en/topic/poverty /brief/global-database-of-shared-prosperity.
[42] World Bank Group. 2016. Poverty and Shared Prosperity 2016: Taking on Inequality. Washington, DC: World Bank. (p.6–9)

When analyzed by country income classification groups, the average growth premium was 1.0% in low-income countries (n=6), 0.6% in lower middle-income countries (n=11) and 0.8% in upper middle-income countries (n=2). Due to the small number of countries with data, no further sub-group analysis was conducted.

TABLE 77: COUNTRY GROUPING BY SHARED PROSPERITY PREMIUM AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Shared prosperity premium		
	<0%	0–0.9%	≥1%
2010–2011*	Lao PDR, Senegal (n=2)	Indonesia, Rwanda (n=2)	Kyrgyzstan, Peru, Tanzania, Uganda (n=4)
2012–2014†	Cameroon, Congo, Costa Rica, DRC (n=4)	Pakistan, Philippines, Sri Lanka (n=3)	Cambodia, El Salvador, Togo, Viet Nam (n=4)
2015–2017‡	–	–	–

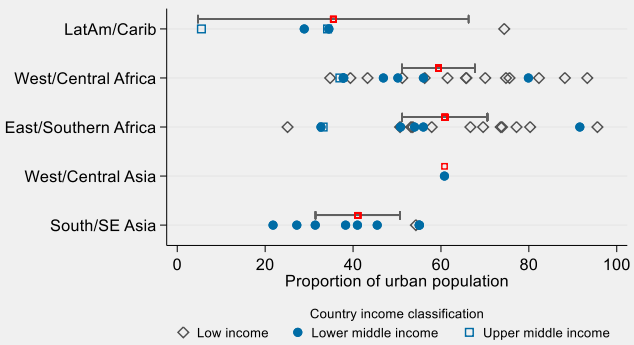
* No data for Bangladesh, Benin, Burkina Faso, Ethiopia, Gambia, Ghana, Guatemala, Malawi, Mali, Mauritania, Mozambique, Namibia, Nepal, Niger, Zambia, Zimbabwe
† No data for Burundi, Chad, Comoros, Côte d'Ivoire, Guinea, Guinea-Bissau, Haiti, Kenya, Lesotho, Liberia, Madagascar, Myanmar, Nigeria, Sierra Leone, Somalia, South Sudan, Swaziland, Tajikistan, Yemen
‡ No data for Botswana, CAR, Gabon, Papua New Guinea, Sudan

Urban population living in slums

MEAL Indicator 5.15: Proportion of urban population living in slums, informal settlement or inadequate housing

Slums, informal settlements and inadequate housing are the face of poverty and inequality in cities, and no transformative action will be achieved in the world without addressing the challenge of urban poverty represented by them. The proportion of urban population living in slums, informal settlements or inadequate housing is currently being measured by the proportion of urban population living in slums.[43] According to the United Nations Human Settlements Programme (UN-HABITAT), slums are areas where households lack durable housing, sufficient living space, secure tenure, or easy access to safe water or adequate sanitation facilities.

Figure 5.15a
Urban population living in slums in SUN countries by region and country income classification



[43] https://unstats.un.org/sdgs/metadata/files/Metadata-11-01-01.pdf

Data on the proportion of the urban population living in slums were available for 54 SUN countries from UN-Habitat (reported in the SDG Indicators Global Database), with the reference year 2014 for all countries except El Salvador (2005). In these countries, an average of 54.7% (95% CI 49.2, 60.2) of the urban population was living in slum conditions. This ranged from 5.5 to 95.6% across countries (median 54.2%).

TABLE 78: COUNTRY GROUPING BY URBAN POPULATION LIVING IN SLUMS AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Proportion of urban population living in slums			
	70–100%	55–69%	40–54%	<40%
2010–2011 (n=23)*	Ethiopia, Mauritania, Mozambique, Niger (n=4)	Bangladesh, Benin, Burkina Faso, Malawi, Mali (n=5)	Nepal, Rwanda, Tanzania, Uganda, Zambia (n=5)	Gambia, Ghana, Guatemala, Indonesia, Lao PDR, Namibia, Peru, Senegal, Zimbabwe (n=9)
2012–2014 (n=28)†	Chad, DRC, Guinea-Bissau, Haiti, Madagascar, Sierra Leone, Somalia, South Sudan (n=8)	Burundi, Cambodia, Comoros, Cote d'Ivoire, Kenya, Liberia, Yemen (n=7)	Congo, Guinea, Lesotho, Myanmar, Nigeria, Pakistan, Togo (n=7)	Cameroon, Costa Rica, El Salvador, Philippines, Swaziland, Viet Nam (n=6)
2015–2017 (n=3)‡	Central African Republic, Sudan (n=2)	–	–	Gabon (n=1)

* No data for Kyrgyzstan † No data for Sri Lanka, Tajikistan ‡ No data for Botswana, Papua New Guinea

BOX C: UNDERLYING DRIVERS OF STUNTING

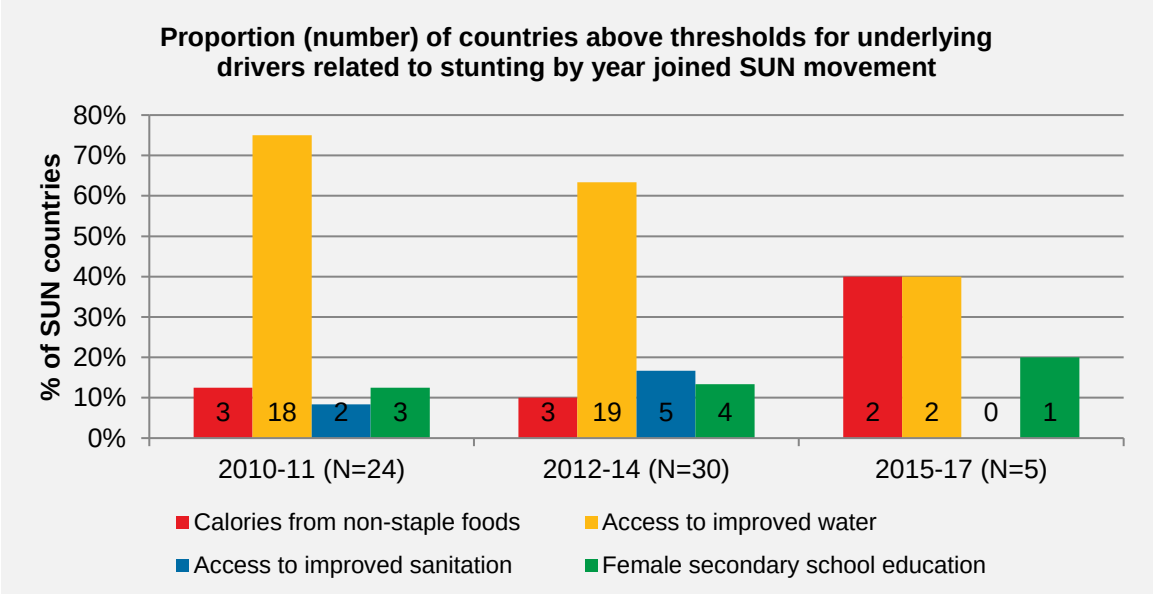
The GNR 2016 looked at ways to help countries be more strategic in identifying underlying drivers that are lagging relative to others. They established several thresholds for specific underlying drivers of stunting and assessed how many countries have a "vulnerability" to stunting in this underlying area. Table 79 ranks SUN countries by their number of vulnerabilities for four of these indicators – calories from nonstaple foods, access to improved water, access to improved sanitation and female secondary school enrollment rate. Only one SUN country is above the thresholds for all four indicators.

TABLE 79: COUNTRY GROUPING BY NUMBER OF VULNERABILITIES TO STUNTING >15%*[44]

Number of vulnerabilities	Number of countries	Names of countries (n=59)
0	1	Costa Rica
1	5	Botswana, Kyrgyzstan, Peru, Sri Lanka, Tajikistan
2	9	El Salvador, Guatemala, Indonesia, Myanmar, Pakistan, Philippines, Rwanda, Uganda, Viet Nam
3	25	Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Cameroon, Comoros, Congo, Côte d'Ivoire, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Lao PDR, Lesotho, Liberia, Malawi, Mali, Namibia, Nepal, Senegal, Sudan, Swaziland, Zimbabwe
4	19	Central African Republic, Chad, DRC, Ethiopia, Haiti, Kenya, Madagascar, Mauritania, Mozambique, Niger, Nigeria, Papua New Guinea, Sierra Leone, Somalia, South Sudan, Tanzania, Togo, Yemen, Zambia

*Vulnerability defined as being below the threshold for the following four underlying drivers:

- Calories from nonstaple foods <51%
- Access to improved water <69%
- Access to improved sanitation <76%
- Female secondary school enrollment rate <81%



[44] Adapted from GNR 2016, Table 6.1, p.65

List 6: IYCF and Dietary Intake Indicators

The UNICEF Global database on Infant and Young Child Feeding was updated in January 2018 and provides the most current estimates as well as trends over time for exclusive breastfeeding, early initiation of breastfeeding and complementary feeding practices.[45]

IYCF INDICATORS

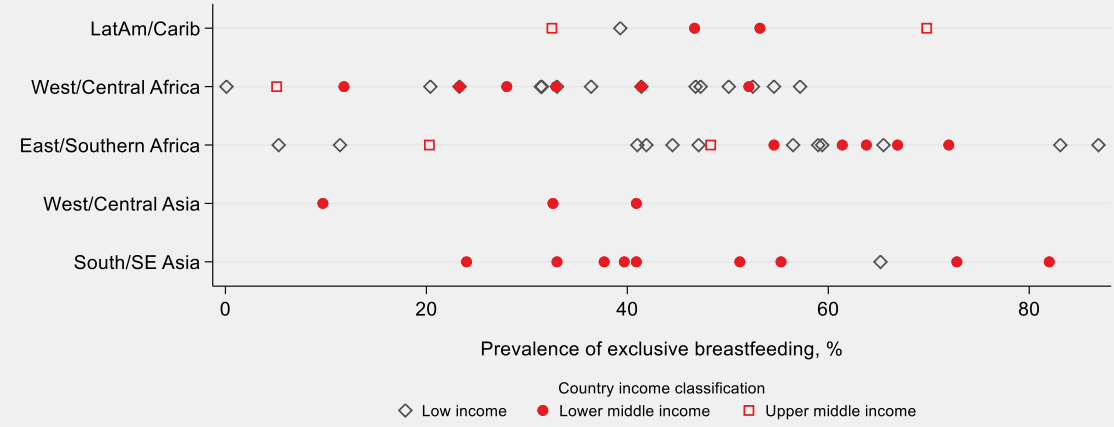
Exclusive breastfeeding

MEAL Indicator 6.1: Exclusive breastfeeding for the first six months

Data on current EBF prevalence is available for 58 SUN countries (no data for Papua New Guinea) with the latest year of assessment ranging from 2008 to 2016. Most countries (n=51, 86%) have data from surveys conducted in 2012 or more recent.

EBF rates range from 0.1 to 86.9% across SUN countries, as shown in Figure 6.1a, with a mean prevalence of 43.7% and median of 43.2% (see Table 84). Twenty-three SUN countries (40%) have EBF rates of at least 50% or higher. EBF rates are markedly lower (14 percentage points lower, p=0.051) in very high risk humanitarian contexts compared to low-medium and high risk countries. EBF rates globally are estimated at 36%[46].

Figure 6.1a
Distribution of exclusive breastfeeding rates by region and country income classification



Based on GNR 2017 EBF trend data for 32 SUN countries[47], an average annual increase of 1.9% in EBF rates is observed, ranging from -15.8 to 10.7% (median 3.2%). The mean average annual increase is positive for countries in Latin America/Caribbean (n=3; mean 2.3%; 95% CI 0.3, 4.3), West/Central Africa (n=14; mean 3.6%; 95% CI 1.4, 5.9) and East/Southern Africa (n=10; mean 3.7%; 95% CI 0.3, 7.1). However, EBF rates have declined by -15.8% in

[45] United Nations Children's Fund, Division of Data Research and Policy (2018). UNICEF Global Databases: Infant and Young Child Feeding, New York, January 2018.
[46] Global Nutrition Report 2017, median based on 137 countries with data.
[47] The EBF AARR data do not reflect the updated country estimates for EBF released by UNICEF in January 2018.

Kyrgyzstan, the only country with trend data in West/Central Asia region, and there is a mean average annual *decrease* in EBF for South/SE Asian countries (n=4; -4.5%; 95% CI -11.4, 2.4).

Three countries (Burkina Faso, Kenya and Swaziland) have an average annual increase in EBF of ~10%. Only nine countries show no change or worsening levels of EBF. Figure 6.1c shows country rate of change in EBF based on when they joined the SUN Movement. The line of best fit suggests that greater gains are being made among countries that joined more recently.

TABLE 80: COUNTRY GROUPING BY EBF PREVALENCE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Exclusive breastfeeding prevalence, infants 0-5 months of age^			
	≥50%	35–49%	15–34%	<15%
2010–2011	Bangladesh↘, Burkina Faso↗, Ethiopia, Ghana↘, Guatemala↗, Malawi↘, Nepal↘, Peru↗, Rwanda↗, Tanzania↗, Uganda, Zambia (n=12)	Benin↗, Gambia↗, Indonesia, Kyrgyzstan↘, Lao PDR, Mali, Mozambique↗, Namibia, ↗Zimbabwe↗ (n=9)	Senegal↘, Mauritania, ↗Niger↗ (n=3)	–
2012–2014	Burundi, Cambodia↘, Guinea-Bissau↗, Kenya↗, Lesotho↗, Liberia, Myanmar↗, Sri Lanka, Swaziland↗, Togo↗ (n=10)	DRC↗, El Salvador↗, Haiti, Madagascar↘, Pakistan, South Sudan (n=6)	Cameroon↗, Congo↗, Costa Rica, Guinea, Nigeria↗, Philippines, Sierra Leone↗, Tajikistan, Viet Nam↗ (n=9)	Chad↘, Comoros, Côte d'Ivoire, Somalia, Yemen (n=5)
2015–2017 (n=4)‡	Sudan↗ (n=1)	–	Botswana, Central African Republic (n=2)	Gabon (n=1)

^ Arrows represent trend over time in EBF prevalence in countries with this data (based on data provided by the GNR 2017)
‡ No data for Papua New Guinea

Figure 6.1b
EBF prevalence in SUN countries by year joined the movement

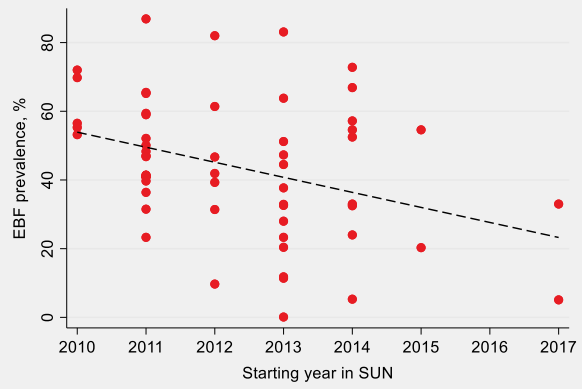
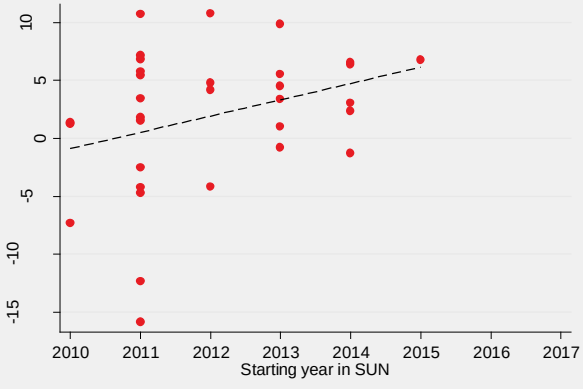


Figure 6.1c
EBF trends by year country joined the SUN movement



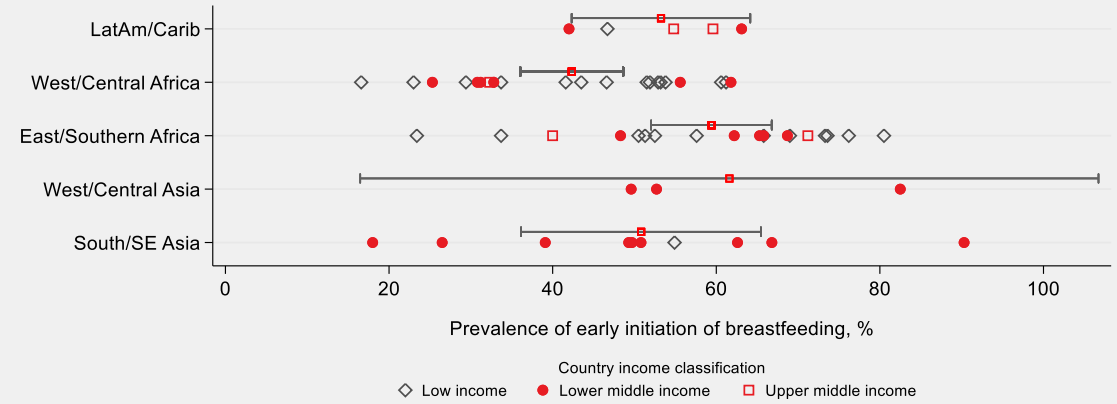
Early initiation of breastfeeding

MEAL Indicator 6.2: Proportion of children born in the last 24 months who were put to the breast within one hour of birth

Data on early initiation of breastfeeding is available for 58 SUN countries (no data for Papua New Guinea) with the latest year of assessment ranging from 2008 to 2016. The majority of countries (n=51, 88%) have data from surveys conducted in 2012 or more recent.

Early initiation rates range from 16.6 to 90.3% across SUN countries (see Figure 6.2a), with a mean of 51.3% and median prevalence of 52.2% (see Table 84). This is comparable to recent global estimates of median prevalence of 52% in the Global Nutrition Report in 2017 (n=125 countries) and 53% using data from recent DHS (2000-2013) for 57 LMIC.[48]

Figure 6.2a
Distribution of early initiation of breastfeeding by region and country income classification



Each symbol represents a country (N=58). The red squares indicate the regional mean and 95% confidence intervals.

TABLE 81: COUNTRY GROUPING BY EARLY INITIATION OF BREASTFEEDING PREVALENCE AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Proportion of children born in the last 24 months who were put to the breast within one hour of birth			
	≥65%	50–64%	25–49%	<25%
2010–2011	Ethiopia, Kyrgyzstan, Malawi, Mozambique, Namibia, Rwanda, Zambia (n=7)	Bangladesh, Gambia, Ghana, Guatemala, Mali, Mauritania, Nepal, Niger, Peru, Tanzania, Uganda, Zimbabwe (n=12)	Benin, Burkina Faso, Indonesia, Lao PDR, Senegal (n=5)	–

[48] Oakley, L., L. Benova, D. Macleod, C.A. Lynch & O.M.R. Campbell (2017) Early breastfeeding practices: descriptive analysis of recent Demographic and Health Surveys. *Maternal & Child Nutrition* (early online publication), DOI: 10.1111/mcn.12535.

2012–2014	Burundi, Lesotho, Madagascar, Myanmar, Sri Lanka (n=5)	Cambodia, Costa Rica, DRC, Kenya, Liberia, Sierra Leone, South Sudan, Togo, Yemen (n=9)	Cameroon, Comoros, Congo, Côte d'Ivoire, El Salvador, Guinea-Bissau, Haiti, Nigeria, Philippines, Swaziland, Tajikistan, Viet Nam (n=12)	Chad, Guinea, Pakistan, Somalia (n=4)
2015–2017‡	Sudan (n=1)	–	Botswana, CAR, Gabon (n=3)	–

‡ Data not available for Papua New Guinea

Figures 6.2b and 6.2c provide an overview of early initiation of breastfeeding rates by residence and household wealth quintile in SUN countries by region. There is greater variation in early initiation rates across urban/rural and socioeconomic levels in countries from the Latin America/Caribbean countries compared to other regions.

Figure 6.2b
Early initiation of breastfeeding by residence and region

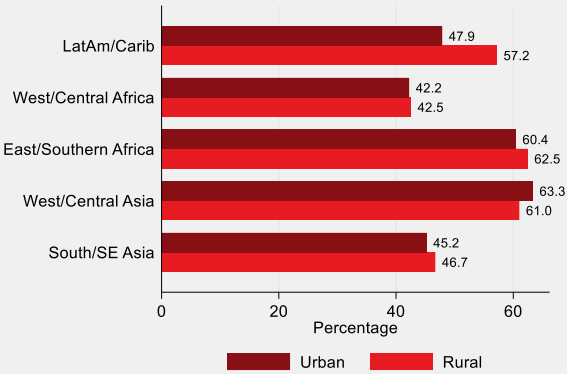
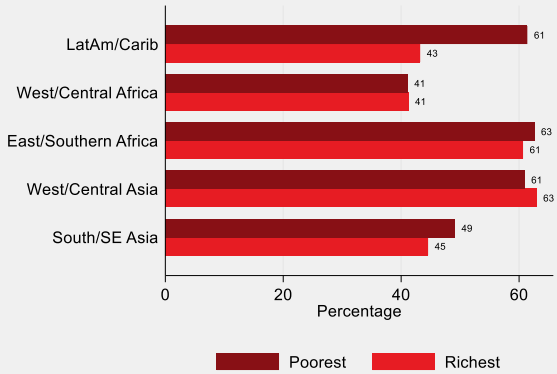


Figure 6.2c
Early initiation of breastfeeding by wealth quintile and region



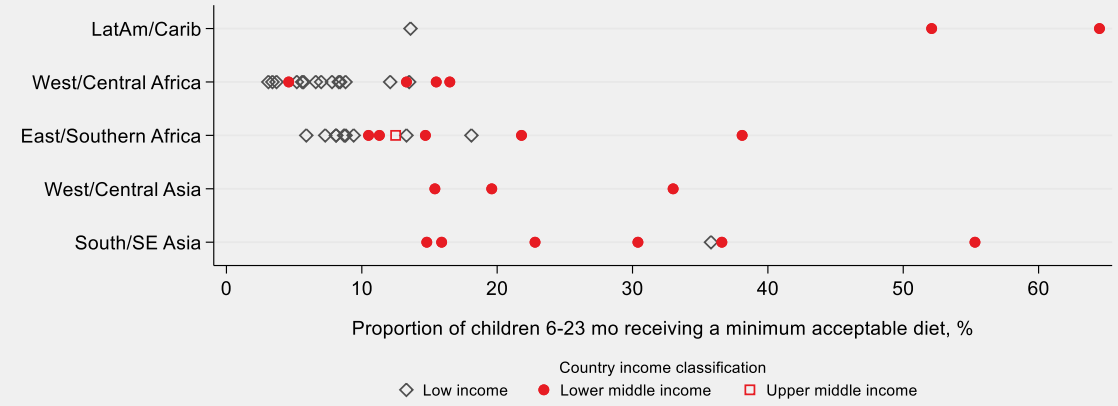
Minimum acceptable diet

MEAL Indicator 6.3: Proportion of children aged 6 to 23 months who receive a Minimum Acceptable Diet (MAD)

Receiving a minimum acceptable diet (MAD) refers to meeting both the minimum number of meals and minimum diet diversity. Data on the proportion of children 6–23 months of age who receive a minimum acceptable diet are available for 46 SUN countries (78%), with the reference year ranging from 2010 to 2016 (41 countries with data from 2012 or more recent).

Only 16.4% (95% CI 12.2, 20.6) of children 6–23 months receive a minimum acceptable diet, which refers to meeting both the minimum number of meals and minimum diet diversity. This is comparable to recent global estimates of 14% (median, n=60 countries) in the Global Nutrition Report 2017 and 16% in a recent report from UNICEF.[49] With a median of 12%, the distribution of MAD prevalence ranges from 3.1 to 64.5% across SUN countries and is highly skewed toward the lower end of the distribution (Figure 6.3a). MAD prevalence varies widely across regions, with the lowest estimates in countries in the sub-Saharan Africa region (Table 84).

Figure 6.3a
Minimum Acceptable Diet distribution in SUN countries by region and country income classification



[49] UNICEF (2016). From the first hour of life: a new report on infant and young child feeding. https://data.unicef.org/wp-content/uploads/2016/10/From-the-first-hour-of-life-1.pdf

The proportion of children receiving MAD also varies by residence (Figure 6.3b) and wealth quintile (Figure 6.3c), with children living in rural and the poorest households most at risk of inadequate feeding practices.

Figure 6.3b
Proportion of children 6-23 mo receiving MAD by residence and region

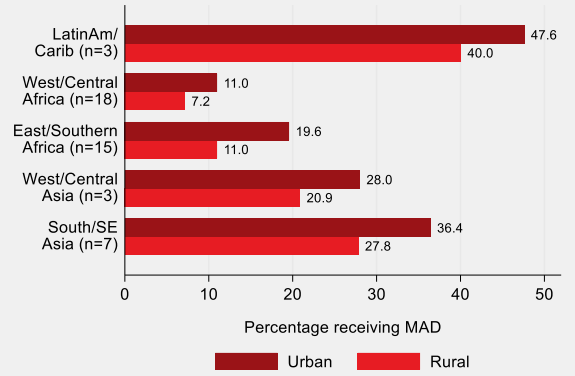
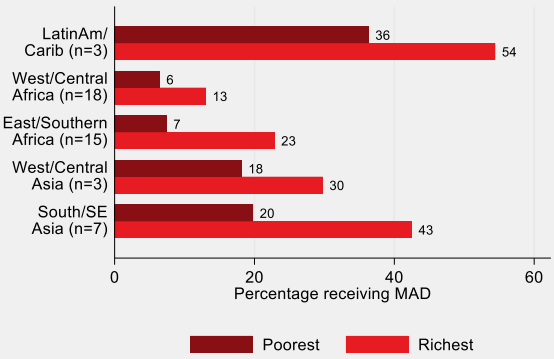


Figure 6.3c
Proportion of children 6-23 mo receiving MAD by wealth quintile and region



The evidence suggests that less than one in ten children 6-23 months receives a minimum acceptable diet in one third of SUN countries (n=20; Table 82)

TABLE 82: COUNTRY GROUPING BY MINIMUM ACCEPTABLE DIET PREVALENCE AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Proportion of children 6-23 months who receive a Minimum Acceptable Diet (MAD)			
	≥40%	20–39%	10–19%	<10%
2010–2011 (n=21)*	Guatemala(n=1)	Bangladesh, Indonesia, Kyrgyzstan, Nepal (n=4)	Benin, Ghana, Mozambique, Namibia, Rwanda, Zambia (n=6)	Burkina Faso, Ethiopia, Gambia, Malawi, Mali, Niger, Senegal, Tanzania, Uganda, Zimbabwe (n=10)
2012–2014 (n=23)†	El Salvador, Viet Nam (n=2)	Cambodia, Kenya, Swaziland (n=3)	Cameroon, Haiti, Lesotho, Myanmar, Nigeria, Pakistan, Tajikistan, Togo, Yemen (n=9)	Burundi, Chad, Comoros, Côte d'Ivoire, DRC, Guinea, Guinea-Bissau, Liberia, Sierra Leone (n=9)
2015–2017 (n=2)‡	–	–	Sudan (n=1)	Central African Republic (n=1)

* No data for Lao PDR, Mauritania, Peru
† No data for Congo, Costa Rica, Madagascar, Philippines, Somalia, South Sudan, Sri Lanka
‡ No data for Botswana, Gabon, Papua New Guinea

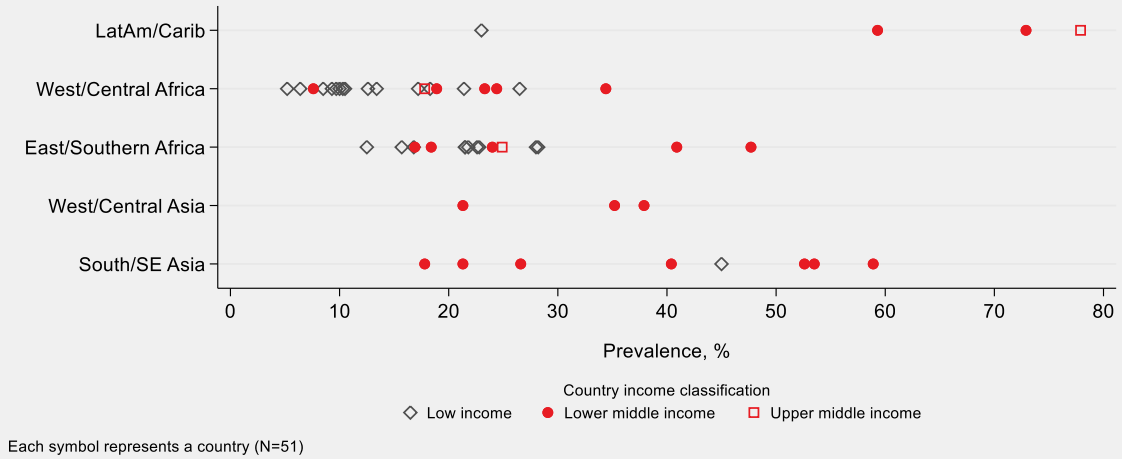
Minimum diet diversity

MEAL Indicator 6.4: Proportion of children aged 6 to 23 months who receive a Minimum Diet Diversity (MDD)

The recommended minimum variety of foods for infants and young children 6-23 months of age is now defined as receiving foods from at least five out of eight food groups during the previous day.[50] Data on minimum diet diversity (MDD) are available for 51 SUN countries, with the reference year from 2008 to 2016 (44 countries with data in 2012 or more recent).

An average of 26.1% (95% CI 21.4, 30.9) of children 6–23 months in these SUN countries are eating a minimally diverse diet, ranging from 5.2 to 77.9% (median 21.5%; see Table 84). This is comparable to recent global estimates of 30% (median, n=60 countries) by the Global Nutrition Report 2017 and 29% in a recent report by UNICEF.[51]

Figure 6.4a
Minimum Diet Diversity distribution in SUN countries by region and country income classification



Wide regional variation is observed in the proportion of young children who are fed at least five food groups in SUN countries (Figure 6.4a; Table 84). For children living in countries in sub-Saharan Africa, the situation is dire with less than one in four children receiving minimum levels of diet diversity. Latin American countries have the best rates of diet diversity. Across all regions, fewer children living in rural areas and from the poorest households are fed at least five food groups (Figure 6.4b and Figure 6.4d). Diet diversity increases with higher country income classification; however, rural residence and wealth quintile still play a role (Figure 6.4c and 6.4e).

[50] UNICEF/WHO/FANTA (2017). Meeting Report on reconsidering, refining and extending the World Health Organization Infant and Young Child Feeding indicators (June 20-22, 2017). New York: UNICEF.
[51] UNICEF (2016). From the first hour of life: a new report on infant and young child feeding. https://data.unicef.org/wp-content/uploads/2016/10/From-the-first-hour-of-life-1.pdf

Figure 6.4b
Proportion of children 6-23 mo receiving MDD by residence and region

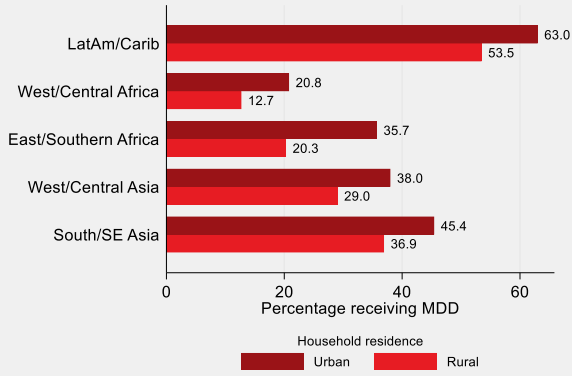


Figure 6.4c
Proportion of children 6-23 mo receiving MDD by residence and country income classification

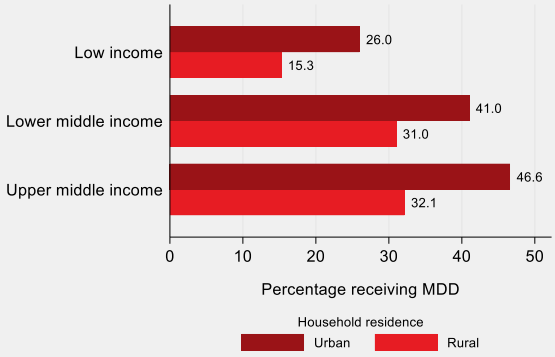


Figure 6.4d
Proportion of children 6-23 mo receiving MDD by wealth quintile and region

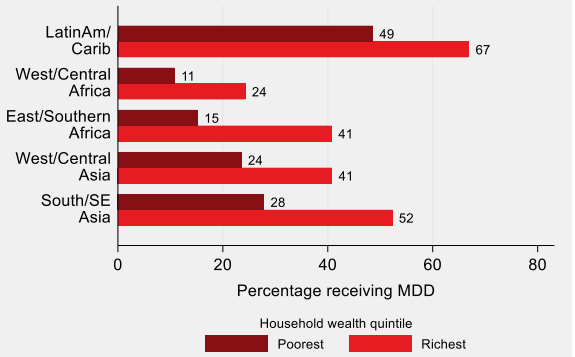


Figure 6.4e
Proportion of children 6-23 mo receiving MDD by wealth quintile and country income classification

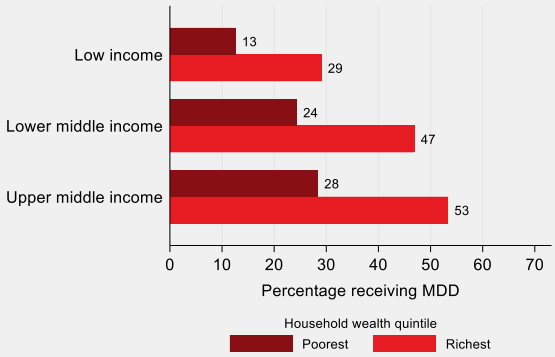


TABLE 83: COUNTRY GROUPING BY MINIMUM DIET DIVERSITY PREVALENCE AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Proportion of children 6-23 months who receive a Minimum Diet Diversity (MDD)			
	≥50%	25–49%	15–24%	<15%
2010–2011 (n=22)*	Guatemala, Indonesia, Peru (n=3)	Bangladesh, Kyrgyzstan, Mozambique, Nepal, Rwanda (n=5)	Benin, Ghana, Malawi, Namibia, Tanzania, Uganda, Zambia, Zimbabwe (n=8)	Burkina Faso, Ethiopia, Gambia, Mali, Niger, Senegal (n=6)
2012–2014 (n=26)†	El Salvador, Philippines, Viet Nam (n=3)	Cambodia, Kenya, Nigeria, Swaziland, Tajikistan(n=5)	Burundi, Cameroon, Comoros, Congo, DRC, Haiti, Lesotho, Madagascar, Myanmar, Pakistan, Togo, Yemen (n=12)	Chad, Côte d'Ivoire, Guinea, Guinea-Bissau, Liberia, Sierra Leone (n=6)
2015–2017 (n=3)‡	–	Central African Republic (n=1)	Gabon, Sudan (n=2)	–

* No data for Lao PDR, Mauritania
† No data for Costa Rica, Somalia, South Sudan, Sri Lanka
‡ No data for Botswana, Papua New Guinea

Summary of IYCF Practices in SUN Countries

Table 84 presents an overview of IYCF practices in SUN countries by key characteristics.

TABLE 84: PREVALENCE OF IYCF PRACTICES IN SUN COUNTRIES

Characteristic	Early initiation of breastfeeding (<1 hour)		Exclusive breastfeeding (0-5 mon)		Minimum Acceptable Diet (MAD, 6-23 mon)		Minimum Diet Diversity (MDD, 6-23 mon)	
	N	Prevalence, %	N	Prevalence, %	N	Prevalence, %	N	Prevalence, %
All SUN countries								
Mean (95% CI)	58	51.3 (46.9, 55.7)	58	43.7 (38.5, 49.0)	46	16.4 (12.2, 20.6)	51	26.1 (21.4, 30.9)
Median	58	52.2	58	43.2	46	12.3	51	21.5
Range	58	16.6, 90.3	58	0.1, 86.9	46	3.1, 64.5	51	5.2, 77.9
Year joined SUN Movement								
2010–11	24	57.7	24	51.0	21	15.7	22	26.7
2012–14	30	46.9	30	40.0	23	17.5	26	26.1
2015–17	4	46.1	4	28.3	2	11.8	3	22.8
Region								
Latin America & Caribbean	5	53.2	5	48.3	3	43.4	4	58.3
West/Central Africa	21	42.3	21	34.3	18	8.3	20	15.3
East/Southern Africa	19	59.4	19	52.0	15	13.1	16	24.0
West/Central Asia	3	61.6	3	27.7	3	22.7	3	31.5
South/Southeast Asia	10	50.8	10	50.2	7	30.2	8	39.5
Country Income Level								
Low-income	28	51.0	28	44.0	25	9.5	26	17.6
Lower middle-income	25	51.6	25	45.1	20	25.3	22	34.3
Upper middle-income	5	51.6	5	35.2	1	12.5	3	40.2
Humanitarian Risk Level								
Low-Medium	23	53.9	23	45.6	16	19.7	19	32.3
High	24	51.6	24	47.5	21	16.1	23	24.0
Very High	11	45.3	11	31.5	9	11.4	9	18.8

Countries that have been part of the SUN Movement for longer tend to show higher rates of exclusive breastfeeding and early initiation of breastfeeding, independent of their income classification (Figure 6B). Improved complementary feeding practices are found in higher income countries (Figure 6C) and lower humanitarian risk countries (Figure 6D).

Figure 6A
Infant & Young Child Feeding Practices in SUN countries

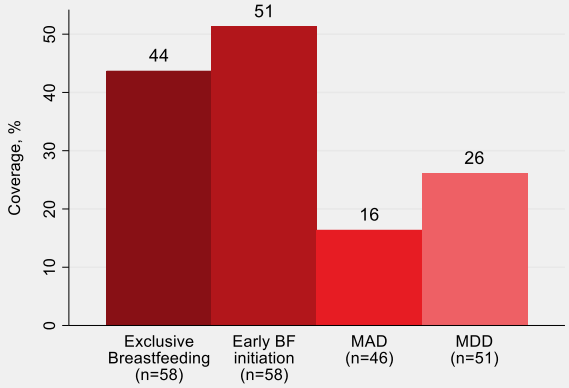


Figure 6B
Infant & Young Child Feeding Practices by year country joined SUN

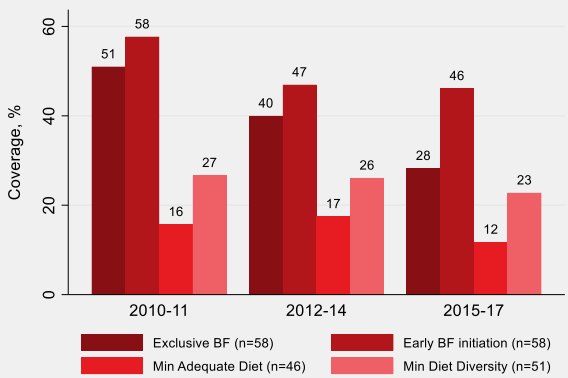


Figure 6C
Infant & Young Child Feeding Practices in SUN countries
by country income classification

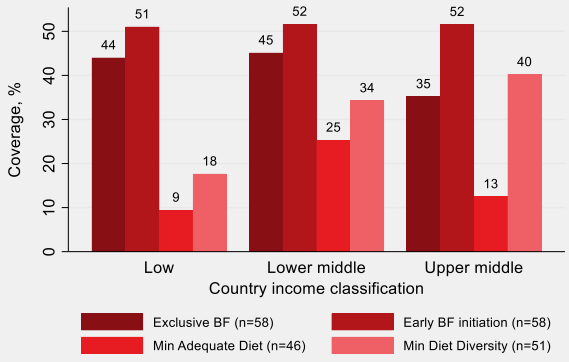
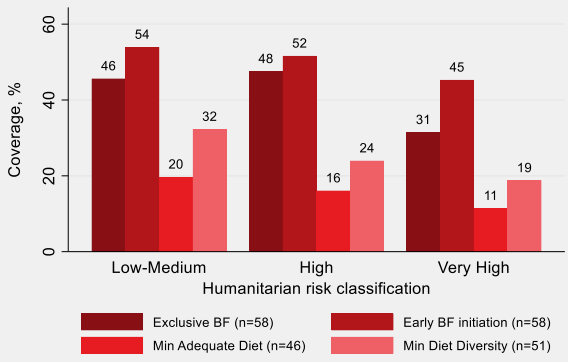


Figure 6D
Infant & Young Child Feeding Practices in SUN countries
by humanitarian risk classification



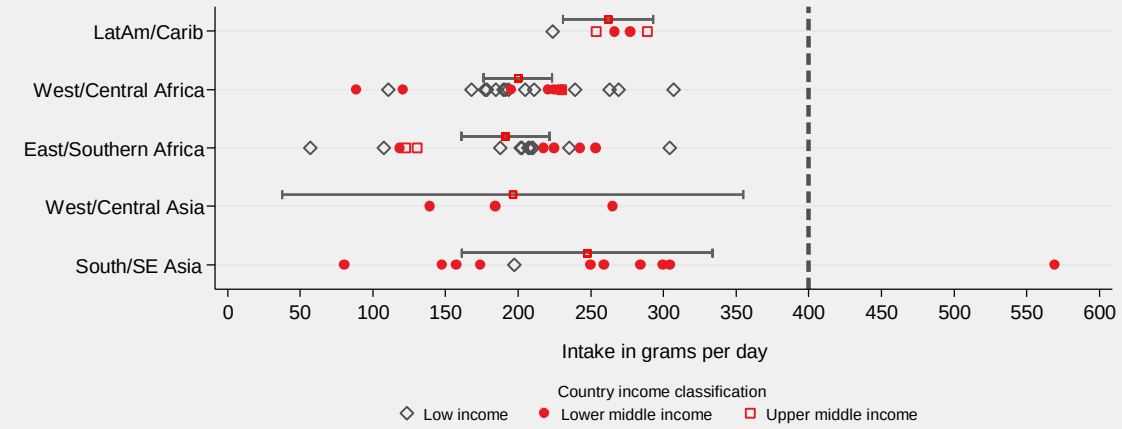
DIETARY INTAKE INDICATORS

Fruit and vegetable intake

MEAL Indicator 6.5: Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day

Data on per capita fruit and vegetable intake (grams per day) were available for 58 SUN countries (no data for South Sudan) from the Global Dietary Database for the reference years 1990, 2005 and 2010. Overall, mean intake of fruit and vegetables in 2010 was 211 g per day (95% CI 191, 231) and ranged from 57 to 570 g (median 209 g) (see Figure 6.5a and Table 85). Only one country, Lao PDR, had a population mean intake over 400 g per day, the recommended minimum intake level (Table 86). Trends were relatively constant over the years 1990, 2005 and 2010 across regions and country income levels, as shown in Figures 6.5b and 6.5c, respectively.

Figure 6.5a
Fruit & vegetable intake distribution in SUN countries by region and country income classification



Each symbol represents a country (N=58). The red squares indicate the regional mean and 95% confidence intervals.

Figure 6.5b
Mean fruit and vegetable intake by region and year

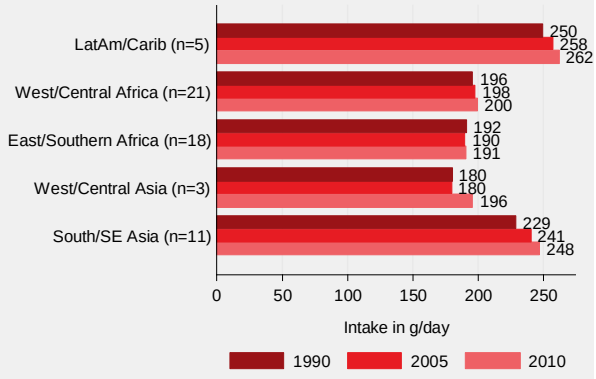


Figure 6.5c
Mean fruit and vegetable intake by country income classification and year

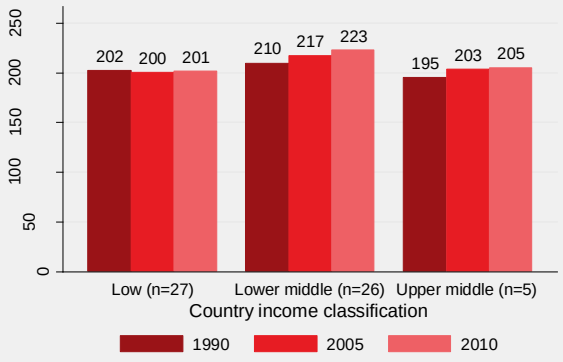


TABLE 85: FRUIT AND VEGETABLE INTAKE LEVELS (GRAMS PER CAPITA PER DAY) BETWEEN 1990 AND 2010

Characteristic	N	1990	2005	2010
All SUN countries				
Mean (95% CI)	58	205 (186, 224)	208 (188, 228)	211 (191, 231)
Median	58	209	206	209
Range	58	55, 287	56, 555	57, 570
Year joined SUN Movement				
2010–11	24	205	211	214
2012–14	30	211	211	215
2015–17	5	168	176	177
Region				
Latin America & Caribbean	41	250	258	262
West/Central Africa	18	196	198	200
East/Southern Africa	19	192	190	191
West/Central Asia	3	180	180	196
South/Southeast Asia	11	229	241	248
Country Income Level				
Low-income	28	202	200	201
Lower middle-income	26	210	217	223
Upper middle-income	5	195	203	205
Humanitarian Risk Level				
Low-Medium	23	214	219	224
High	25	199	201	204
Very High	10	199	199	201

TABLE 86: COUNTRY GROUPING BY FRUIT AND VEGETABLE INTAKE LEVELS AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Adult fruit and vegetable intake level (g per capita per day)			
	≥400 g	200–399 g	100–199 g	<100 g
2010–2011	Lao PDR (n=1)	Bangladesh, Benin, Ghana, Guatemala, Malawi, Mali, Mozambique, Peru, Rwanda, Senegal, Tanzania, Uganda, Zambia (n=13)	Burkina Faso, Gambia, Indonesia, Kyrgyzstan, Mauritania, Namibia, Nepal, Niger, Zimbabwe (n=9)	Ethiopia (n=1)
2012–2014†	–	Burundi, Cambodia, Comoros, Costa Rica, Côte d'Ivoire, DRC, El Salvador, Guinea, Haiti, Kenya, Madagascar, Myanmar, Nigeria, Sierra Leone, Sri Lanka, Swaziland, Viet Nam, Yemen (n=18)	Chad, Congo, Guinea-Bissau, Lesotho, Liberia, Philippines, Somalia, Tajikistan, Togo (n=9)	Cameroon, Pakistan (n=2)
2015–2017	–	Gabon, Sudan (n=2)	Botswana, CAR, Papua New Guinea (n=3)	–

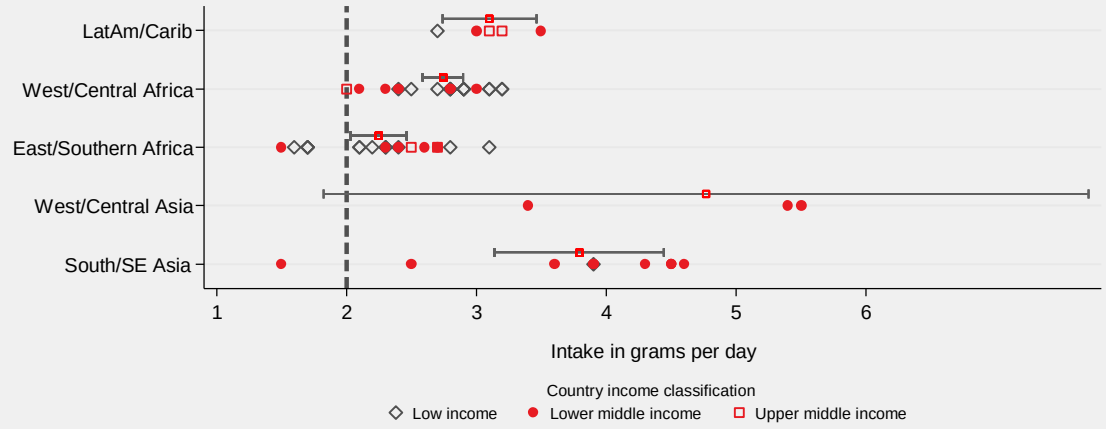
† No data for South Sudan

Sodium intake

MEAL Indicator 6.6: Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years

Data on mean intake of sodium in grams per day for adults were available for all SUN countries.[52] Mean intake is 2.9 grams per day (95% CI 2.7, 3.1), with a range from 1.5 to 5.5 g (median 2.8 g). As shown in Figure 6.6a, most countries have intakes higher than the 2 g per day maximum recommended by the WHO.

Figure 6.6a
Adult sodium intake distribution in SUN countries by region and country income classification



Each symbol represents a country (N=58). The red squares indicate the regional mean and 95% confidence intervals.

TABLE 87: COUNTRY GROUPING BY SODIUM INTAKE AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Mean sodium intake for adults, grams per day			
	≥4.0 g	3.0-3.9 g	2.0-2.9 g	<2.0 g
2010–2011	Kyrgyzstan, Lao PDR (n=2)	Bangladesh, Gambia, Guatemala, Mali, Mauritania, Nepal, Peru, Senegal, Zimbabwe (n=9)	Benin, Burkina Faso, Ethiopia, Ghana, Mozambique, Namibia, Niger, Tanzania, Uganda, Zambia (n=10)	Indonesia, Malawi, Rwanda (n=3)
2012–2014†	Cambodia, Myanmar, Philippines, Tajikistan, Viet Nam (n=5)	Costa Rica, El Salvador, Guinea-Bissau, Pakistan, Sri Lanka, Yemen (n=6)	Cameroon, Chad, Congo, Côte d'Ivoire, DRC, Guinea, Haiti, Lesotho, Liberia, Madagascar, Nigeria, Sierra Leone, Somalia, South Sudan, Swaziland, Togo (n=15)	Burundi, Comoros, Kenya (n=3)
2015–2017	–	–	Botswana, CAR, Gabon, PNG, Sudan (n=5)	–

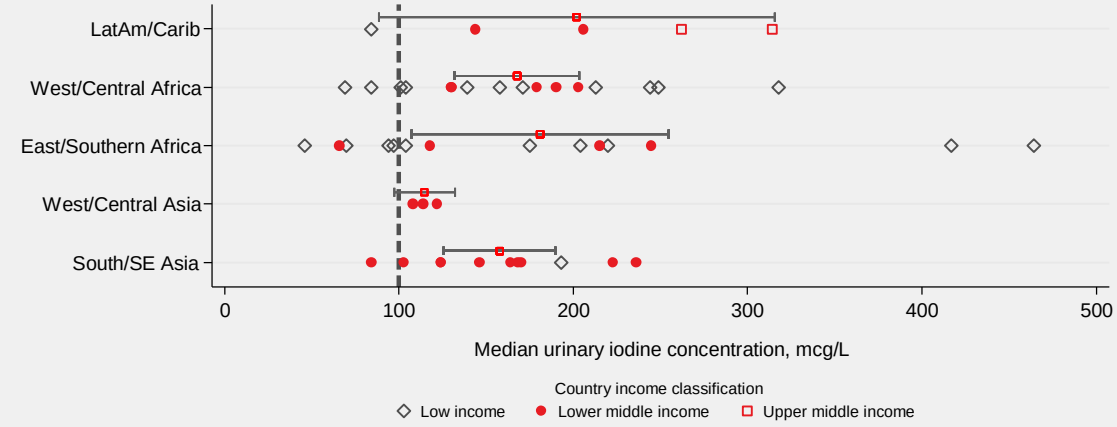
[52] Powles J, Fahimi S, Micha R, et al. (2013) Global, regional and national sodium intakes in 1990 and 2010: a systematic analysis of 24 h urinary sodium excretion and dietary surveys worldwide. *BMJ Open*; 3:e003733. doi: 10.1136/bmjopen-2013-003733

Iodine intake

MEAL Indicator 6.7: Median urinary iodine concentration in children aged 6–12 years

Data on median urinary iodine concentration (UIC) in school-age children, a proxy for assessing adequacy of iodine intake in the general population, were available for 49 SUN countries, with the reference year ranging from 2002 to 2015[53]. Population iodine sufficiency is defined using median UIC in school-age children with the following cut-offs: <100 μg/L insufficient iodine intake, 100–299 μg/L adequate iodine intake and ≥300 μg/L excessive iodine intake[54].

Figure 6.7a
Distribution of median UIC in school-age children in SUN countries by region and country income classification



Each symbol represents a country (N=49). The red squares indicate the regional mean and 95% confidence intervals.

Despite less than optimal iodized salt coverage in SUN countries, only nine SUN countries[55] have evidence of insufficient iodine intake based on median UIC in school-age children.

[53] Iodine Global Network (2017). Global Scorecard of Iodine Nutrition in 2017. http://www.ign.org/cm_data/IGN_Global_Scorecard_AllPop_and_PW_May2017.pdf

[54] WHO, UNICEF, ICCIDD 2007 Assessment of the iodine deficiency disorders and monitoring their elimination. World Health Organization, Geneva, Switzerland. WHO/NHD/01.1.

[55] Countries with median UIC <100 μg/L in school-age children: Burkina Faso (84), Burundi (70), Haiti (84), Madagascar (46), Mali (69), Mozambique (97), South Sudan (94), Sudan (66), Viet Nam (84)

TABLE 88: COUNTRY GROUPING BY MEDIAN URINARY IODINE CONCENTRATION AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Median urinary iodine concentration in children aged 6–12 years			
	Excessive ≥300 mcg/L	Adequate 200–299 mcg/L	Adequate 100–199 mcg/L	Insufficient <100 mcg/L
2010–2011*	Benin, Uganda (n=2)	Indonesia, Peru, Tanzania, Zambia, Zimbabwe (n=5)	Bangladesh, Ethiopia, Ghana, Guatemala, Kyrgyzstan, Lao PDR, Malawi, Mauritania, Nepal, Niger, Senegal (n=11)	Burkina Faso, Mali, Mozambique (n=3)
2012–2014†	Costa Rica, Somalia (n=2)	Cambodia, Chad, Côte d'Ivoire, DRC, El Salvador, Lesotho, Liberia (n=7)	Cameroon, Guinea, Kenya, Myanmar, Nigeria, Pakistan, Philippines, Sierra Leone, Sri Lanka, Tajikistan, Togo, Yemen (n=12)	Burundi, Haiti, Madagascar, South Sudan, Viet Nam (n=5)
2015–2017‡	–	–	Papua New Guinea (n=1)	Sudan (n=1)

* No data for Gambia, Namibia, Rwanda; † No data for Comoros, Congo, Guinea-Bissau, Swaziland; ‡ No data for Botswana, CAR, Gabon

Micronutrient intake through fortified foods

MEAL Indicator 6.8: Percentage of the population consuming food that is fortified according to standards

Data on population consumption of fortified food is limited to a few countries that have conducted Fortification Assessment Coverage Toolkit (FACT) surveys with support from GAIN. As shown in Table 89, six SUN countries have conducted FACT surveys between 2013 and 2015.

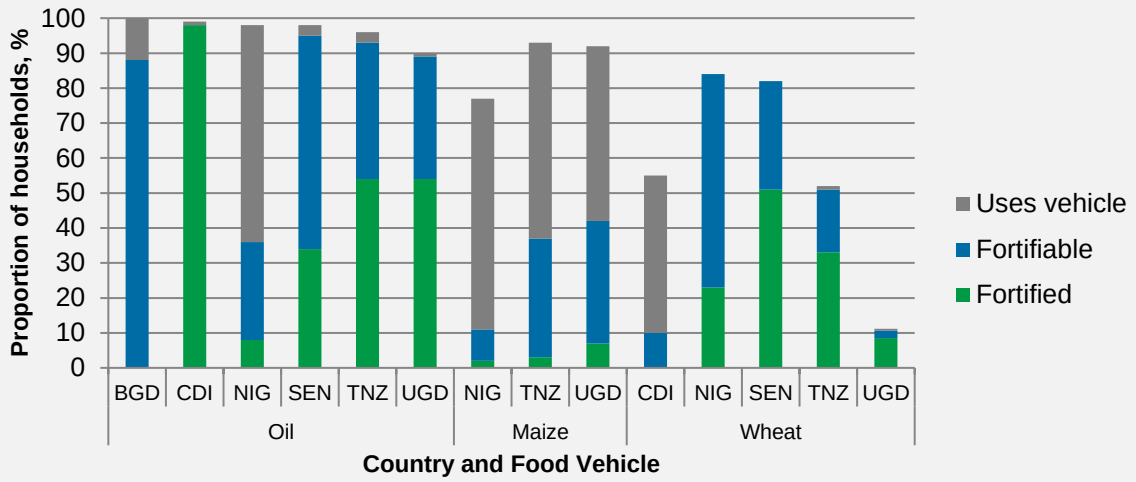
TABLE 89: SUMMARY OF FOOD FORTIFICATION COVERAGE IN SUN COUNTRIES WITH COVERAGE SURVEYS*

Food vehicle	Bangladesh	Côte d'Ivoire	Nigeria†	Senegal	Tanzania	Uganda
Edible oil						
Legislation, start date	Mandatory, 2013	Mandatory, 2007	Mandatory, 2000	Mandatory, 2009	Mandatory, 2010	Mandatory, 2003
Micronutrient	Vit A	Vit A	Vit A	Vit A	Vit A, E	Vit A
Coverage						
% uses vehicle	100	99	98	98	96	90
% fortifiable	88	98	23–36	95	93	89
% fortified	not tested	98	7–8	34	54	54
Maize flour						
Legislation, start date	—	—	Mandatory, 2000	—	Mandatory, 2011	Mandatory, 2003
Micronutrient	—	—	Folic acid, Vit A, zinc	—	9 MN, including folic acid, vit A, iron, zinc	8 MN, including folic acid, vit A, iron, zinc
Coverage						
% uses vehicle	—	—	12–77	—	93	92
% fortifiable	—	—	3–11	—	37	42
% fortified	—	—	0–2	—	3	7
Wheat flour						
Legislation, start date	—	Mandatory, 2007	Mandatory, 2000	Mandatory, 2009	Mandatory, 2010	Mandatory, 2003
Micronutrient	—	8 MN, including folic acid, iron, zinc	7 MN, including folic acid, vit A, iron, zinc	folic acid, iron	9 MN, including folic acid, vit A, iron, zinc	9 MN, including folic acid, vit A, iron, zinc
Coverage						
% uses vehicle	—	55	14–84	82	52	11
% fortifiable‡	—	10	14–84	82	51	11
% fortified^	—	not tested	5–23	51	33	9

*Adapted from Aaron et al. (2017) http://jn.nutrition.org/content/147/5/984S.full
† Estimates from two locations – Lagos and Kano; ‡ Food vehicle used by household is process industrially.
^Food vehicle used by household is confirmed to be fortified by brand identification and quantitative laboratory analysis.

Figure 6.8a demonstrates the variability in potential fortification coverage and actual coverage across food vehicles in the selected SUN countries. The majority of oil production is fortifiable in most SUN countries and some countries have made very good progress in achieving high coverage of this food vehicle. However, in the case of maize, while a large proportion of the population consumes it as a staple food, the bulk of production of this food vehicle is not fortifiable (i.e. not centrally manufactured) and very little is currently fortified in the countries assessed. There are also situations where the food vehicle is not a staple, such as in Uganda where use of wheat was found to be very low.

Figure 6.8a Fortification coverage in SUN countries by food vehicle



*Data adapted from Aaron et al. (2017) http://jn.nutrition.org/content/147/5/984S.full

Step 5: Women, children, adolescents and families thrive leading to the end of malnutrition by 2030

List 7: Nutrition Status Indicators

One of the aims of MEAL is to **strengthen data and evidence on how multiple forms of malnutrition manifest in SUN countries**. The following sections summarize what is known about the current nutritional status of the population in SUN countries and examine progress across the Movement towards WHA global nutrition targets and NCD diet-related targets.

NUTRITIONAL STATUS OF CHILDREN UNDER FIVE

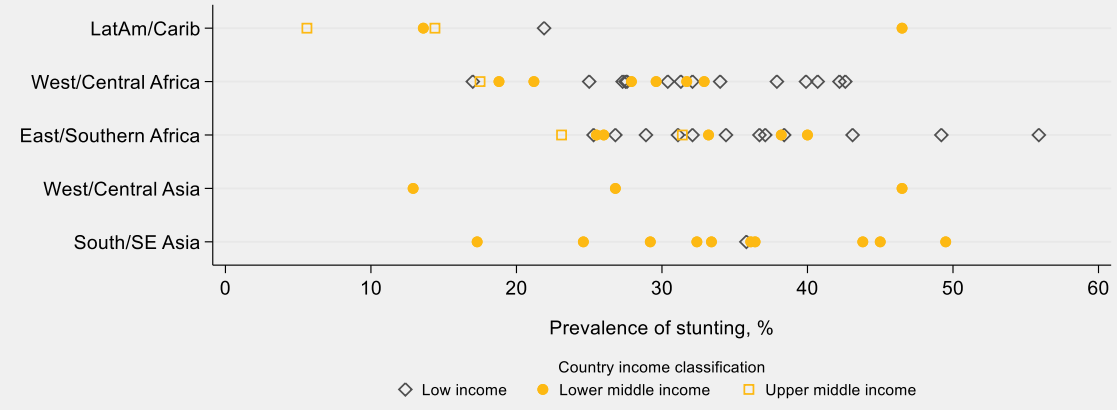
Child Stunting

MEAL Indicator 7.1 – Prevalence of low height-for-age <-2 SD in children under five years of age

Data on current stunting prevalence is available for all SUN countries but the latest year of assessment ranges from 2007 to 2016. Most countries (n=50, 85%) have data from surveys conducted in 2012 or more recent[56],[57].

Across the 59 SUN countries, under-five stunting prevalence is 31.6% (95% CI 29.0, 34.2) and affects 89.6 million children, which corresponds to around 56% of the global burden of 159 million children. The distribution of stunting across SUN countries is shown in Figure 7.1a, below. One out of five (n=12) SUN countries have a stunting prevalence over 40% which is considered very high.

Figure 7.1a
Distribution of stunting among children under five years by region and country income classification



Each symbol represents a country (N=59).

[56] Countries with stunting data prior to 2012 include: Botswana (2007), CAR (2010), Costa Rica (2008), Lao PDR (2011), Madagascar (2009), Mozambique (2011), PNG (2010), Somalia (2009), South Sudan (2010)
[57] Source of data: UNICEF-WHO-World Bank: Joint Child Malnutrition Estimates: Levels and Trends (updated May 2017) https://data.unicef.org/topic/nutrition/malnutrition/

TABLE 90: PREVALENCE OF STUNTING IN CHILDREN UNDER FIVE YEARS IN SUN COUNTRIES

Characteristic	N	Prevalence, %	Characteristic	N	Prevalence, %
All SUN countries			**Region**		
Mean (95% CI)	59	31.6 (29.0, 34.2)	Latin America & Caribbean	5	20.4
Median	59	31.7	West/Central Africa	21	30.2
Range	59	5.6, 55.9	East/Southern Africa	19	34.5
Year joined SUN			West/Central Asia	3	28.7
2010–11	24	31.5	South/Southeast Asia	11	34.9
2012–14	30	31.0	**Country Income Level**		
2015–17	5	35.5	Low-income	28	34.0
Humanitarian Risk Level			Lower middle-income	26	31.5
Low-Medium	23	26.5	Upper middle-income	5	18.4
High	25	34.0			
Very High	11	36.6			

TABLE 91: COUNTRY GROUPING BY CURRENT STUNTING PREVALENCE AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Prevalence of stunting in children under five years of age			
	≥40%	30–39%	20–29%	<20%
2010–2011	Guatemala, Lao PDR, Mozambique, Niger, Zambia (n=5)	Bangladesh, Benin, Ethiopia, Indonesia, Malawi, Mali, Nepal, Rwanda, Tanzania (n=9)	Burkina Faso, Gambia, Mauritania, Namibia, Uganda, Zimbabwe (n=6)	Ghana, Kyrgyzstan, Peru, Senegal (n=4)
2012–2014	Burundi, DRC, Madagascar, Pakistan, Yemen (n=5)	Cambodia, Cameroon, Chad, Comoros, Guinea, Lesotho, Liberia, Nigeria, Philippines, Sierra Leone, South Sudan (n=11)	Congo, Côte d'Ivoire, Guinea-Bissau, Haiti, Kenya, Myanmar, Somalia, Swaziland, Tajikistan, Togo, Viet Nam (n=11)	Costa Rica, El Salvador, Sri Lanka (n=3)
2015–2017	Central African Republic, Papua New Guinea (n=2)	Botswana, Sudan (n=2)	—	Gabon (n=1)

Average annual rate of reduction

Based on GNR 2017 trend data for 41 SUN countries[58], the average annual rate of reduction (AARR) is 3.0% (range -4.7 to 12.6%; median 2.9%). The mean AARR is above zero for each sub-region, ranging from 2.6% in two regions to 5.6% in Latin America (see Table 92).

TABLE 92: STUNTING AARR BY REGION

Region	n	Mean	95% CI
All Countries	35	3.0	1.9, 4.1
Latin America/Caribbean	3	5.6	0.2, 11.1
West/Central Africa	14	2.0	0.3, 3.7
East/Southern Africa	9	3.3	1.5, 5.2
West/Central Asia	2	5.2	-5.2, 15.7
South/SE Asia	7	2.8	2.1, 3.6

TABLE 93: COUNTRY GROUPING BY STUNTING AARR DIRECTION AND YEAR JOINED THE SUN MOVEMENT

Year joined SUN Movement	Average annual rate of reduction in stunting		
	Negative direction (<0%)	Stalled (0–0.5%)	Positive direction (>0.5%)
2010–2011 (n=16)*	Gambia, Mauritania (n=2)	–	Bangladesh, Burkina Faso, Ethiopia, Ghana, Guatemala, Indonesia, Kyrgyzstan, Malawi, Nepal, Peru, Rwanda, Senegal, Tanzania, Zimbabwe (n=14)
2012–2014 (n=18)†	Chad, Togo (n=2)	Sierra Leone, Yemen (n=2)	Cambodia, Cameroon, Congo, DRC, El Salvador, Guinea-Bissau, Kenya, Lesotho, Liberia, Myanmar, Nigeria, Philippines, Swaziland, Viet Nam (n=14)
2015–2017 (n=1)‡	Sudan (n=1)	–	–

* No data for Benin, Lao PDR, Mali, Mozambique, Namibia, Niger, Uganda, Zambia
† No data for Burundi, Comoros, Costa Rica, Côte d'Ivoire, Guinea, Haiti, Madagascar, Pakistan, Somalia, South Sudan, Sri Lanka, Tajikistan
‡ No data for Botswana, Central African Republic, Gabon, Papua New Guinea

[58] The AARR data for stunting do not reflect the updated estimates for 9 SUN countries released by the JME in December 2017.

Low birthweight

MEAL Indicator 7.2 – Prevalence of infants born <2500 g

Data on low birthweight are available for 56 SUN countries, with the reference year ranging from 2005 to 2012 for most countries; data for Comoros and Gabon are from the year 2000.

An estimated 14.4% (95% CI 12.6, 16.1) of babies are born with low birthweight in SUN countries, with a median prevalence of 12.6% and range from 5.1 to 34.7% across countries. Prevalence is over 30% in three countries (Mauritania, Pakistan and Yemen). A comparison of prevalence in SUN countries across regions is shown in Figure 7.2a.

Figure 7.2a
Distribution of low birthweight in SUN countries by region and country income classification

Each symbol represents a country (N=56).

TABLE 94: COUNTRY GROUPING BY LOW BIRTHWEIGHT PREVALENCE AND YEAR JOINED THE SUN MOVEMENT

Year joined SUN Movement	Prevalence of low birthweight (<2500 g)			
	≥20%	15–19%	10–14%	<10%
2010–2011 (n=24)	Bangladesh, Ethiopia, Mauritania, Niger (n=4)	Benin, Mali, Mozambique, Namibia, Nepal, Senegal (n=6)	Burkina Faso, Gambia, Ghana, Guatemala, Lao PDR, Malawi, Uganda, Zambia, Zimbabwe (n=9)	Indonesia, Kyrgyzstan, Peru, Rwanda, Tanzania (n=5)
2012–2014 (n=28)†	Comoros, Haiti, Pakistan, Philippines, Yemen (n=5)	Chad, Côte d'Ivoire, Madagascar, Nigeria, Sri Lanka (n=5)	Burundi, Cambodia, Cameroon, Congo, Guinea, Guinea-Bissau, Lesotho, Liberia, Sierra Leone, Tajikistan, Togo (n=11)	Costa Rica, DRC, El Salvador, Kenya, Myanmar, Swaziland, Viet Nam (n=7)
2015–2017 (n=4)‡	–	–	Botswana, Central African Republic, Gabon, Papua New Guinea (n=4)	–

† No data for Somalia and South Sudan; ‡ No data for Sudan

Child Overweight

MEAL Indicator 7.3 – Prevalence of weight-for-height >2 SD in children under five years

Data on child overweight are available for all 59 SUN countries, with survey dates ranging from 2004 to 2016. Most countries (n=50, 85%) have data from 2012 or more recent[59]. Across SUN countries, 4.6% (95% CI 3.8, 5.4) of under-five children are overweight (see Table 95), a total of 11.2 million children. Over three-quarters of SUN countries (n=46, 78%) have levels below 7%, consistent with the WHO global target threshold associated with no increase in child overweight.

Figure 7.3a
Distribution of under-five overweight by region and country income classification

Each symbol represents a country (N=59).

TABLE 95: PREVALENCE OF OVERWEIGHT IN CHILDREN UNDER FIVE YEARS IN SUN COUNTRIES

Characteristic	N	Prevalence
All SUN countries		%
Mean (95% CI)	59	4.6 (3.8, 5.4)
Median	59	3.8
Range	59	1.0, 13.8
Year joined SUN		
2010–11	24	4.0
2012–14	30	4.6
2015–17	5	7.5
Humanitarian Risk Level		
Low-Medium	23	5.5
High	25	4.4
Very High	11	3.2

Characteristic	N	Prevalence
Region		%
Latin America & Caribbean	5	6.0
West/Central Africa	21	3.3
East/Southern Africa	19	5.7
West/Central Asia	3	5.2
South/Southeast Asia	11	4.5
Country Income Level		
Low-income	28	3.9
Lower middle-income	26	4.8
Upper middle-income	5	7.7

[59] Countries with overweight data prior to 2012 include: Botswana (2007), CAR (2010), Costa Rica (2008), Lao PDR (2011), Madagascar (2004), Mozambique (2011), PNG (2010), Somalia (2009) and South Sudan (2010)

TABLE 96: COUNTRY GROUPING BY CHILD OVERWEIGHT PREVALENCE AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Prevalence of overweight in children under five years of age			
	≥10%	7–9%	4–6%	<4%
2010–2011	Indonesia (n=1)	Kyrgyzstan, Mozambique, Peru, Rwanda (n=4)	Guatemala, Malawi, Namibia, Zambia, Zimbabwe (n=5)	Bangladesh, Benin, Burkina Faso, Ethiopia, Gambia, Ghana, Lao PDR, Mali, Mauritania, Nepal, Niger, Senegal, Tanzania, Uganda (n=14)
2012–2014	Comoros (n=1)	Costa Rica, Lesotho, Sierra Leone, Swaziland (n=4)	Cameroon, Congo, DRC, El Salvador, Kenya, Madagascar, Pakistan, South Sudan, Tajikistan, Viet Nam (n=10)	Burundi, Cambodia, Chad, Côte d'Ivoire, Guinea, Guinea-Bissau, Haiti, Liberia, Myanmar, Nigeria, Philippines, Somalia, Sri Lanka, Togo, Yemen (n=15)
2015–2017	Botswana, Papua New Guinea (n=2)	Gabon (n=1)	—	Central African Republic, Sudan (n=2)

Based on GNR 2017 trend data for 33 SUN countries[60], the mean average annual rate of reduction (AARR) suggests there has been no significant change in under-five overweight prevalence. Table 97 provides a summary of the mean AARR by region.

TABLE 97: UNDER-FIVE OVERWEIGHT AARR BY REGION

Sub-region	Overweight AARR		
	N	Mean	95% CI
All Countries	33	-0.5	-3.9, 2.8
LatAm/Carib	2	-0.6	-3.3, 2.1
West/Central Africa	13	2.3	-4.1, 8.6
East/Southern Africa	9	-0.9	-6.6, 4.8
West/Central Asia	2	-13.2	-17.8, -8.7
South/SE Asia	7	-1.5	-7.3, 4.3

[60] The AARR data for child overweight do not reflect the updated estimates for 9 SUN countries released by the JME in December 2017.

TABLE 98: COUNTRY GROUPING BY CHILD OVERWEIGHT AARR DIRECTION AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Average annual rate of reduction in child overweight	
	Negative direction (<-1.5%)	Positive direction (>-1.5%)
2010–2011 (n=15)*	Ethiopia, Gambia, Kyrgyzstan, Mauritania, Nepal, Rwanda (n=6)	Bangladesh, Burkina Faso, Ghana, Guatemala, Indonesia, Malawi, Senegal, Tanzania, Zimbabwe (n=9)
2012–2014 (n=17)†	Congo, El Salvador, Philippines, Togo, Viet Nam, Yemen (n=6)	Cambodia, Cameroon, Chad, DRC, Guinea-Bissau, Kenya, Lesotho, Myanmar, Nigeria, Sierra Leone, Swaziland (n=11)
2015–2017 (n=1)‡	Sudan (n=1)	–

* No data for Benin, Lao PDR, Mali, Mozambique, Namibia, Niger, Peru, Uganda, Zambia
† No data for Burundi, Comoros, Costa Rica, Côte d'Ivoire, Guinea, Haiti, Liberia, Madagascar, Pakistan, Somalia, South Sudan, Sri Lanka, Tajikistan
‡ No data for Botswana, Central African Republic, Gabon, Papua New Guinea

Child Wasting

MEAL Indicator 7.4 – Prevalence of weight-for-height <-2 SD in children under five years of age

Data on child wasting are available for all 59 SUN countries based on survey data ranging from 2004 to 2016. Most countries (n=50, 85%) have data from surveys in 2012 or more recent[61].

Across SUN countries, 8.0% of under-five children are wasted (see Table 99), a total of 23.3 million children. The distribution of wasting across countries by region is shown in Figure 7.4a.

Figure 7.4a
Distribution of under-five wasting by region and country income classification

Each symbol represents a country (N=59).

[61] Countries with wasting data prior to 2012 include: Botswana (2007), CAR (2010), Costa Rica (2008), Lao PDR (2011), Madagascar (2004), Mozambique (2011), PNG (2010), Somalia (2009) and South Sudan (2010)

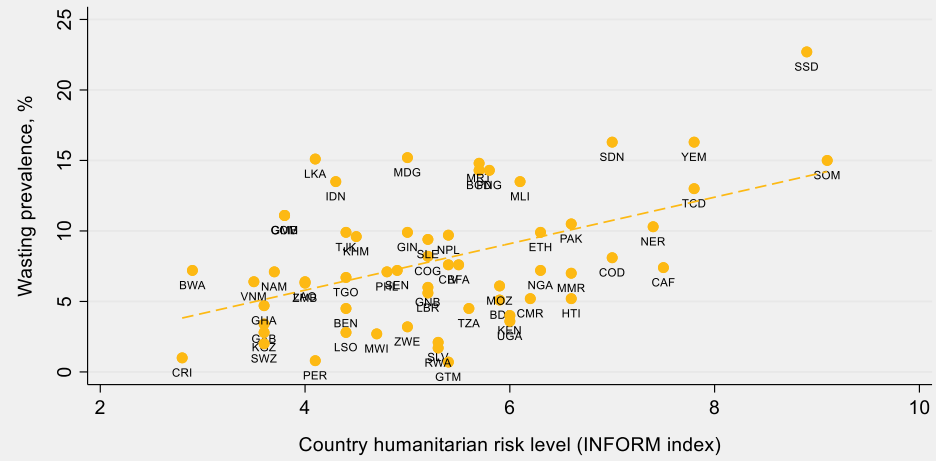
Prevalence of wasting by key characteristics is shown in Table 99. Wasting rates are lowest in Latin American countries and higher in countries from the South and Southeast Asian region. As expected, child wasting levels are higher in SUN countries with higher humanitarian risk levels (see Figure 7.4b).

TABLE 99: PREVALENCE OF WASTING IN CHILDREN UNDER FIVE YEARS IN SUN COUNTRIES

Characteristic	N	Prevalence, %
All SUN countries		
Mean (95% CI)	59	8.0 (6.8, 9.2)
Median	59	7.2
Range	59	0.7, 22.7
Year joined SUN		
2010–11	24	7.0
2012–14	30	8.5
2015–17	5	9.7
Humanitarian Risk Level		
Low-Medium	23	6.5
High	25	7.6
Very High	11	12.0

Characteristic	N	Prevalence, %
Region		
Latin America & Caribbean	5	2.0
West/Central Africa	21	8.2
East/Southern Africa	19	7.7
West/Central Asia	3	9.7
South/Southeast Asia	11	10.4
Country Income Level		
Low-income	28	8.4
Lower middle-income	26	8.3
Upper middle-income	5	3.9

Figure 7.4b
Wasting prevalence by country humanitarian risk level



Only 16 SUN countries have wasting levels below 5%, 26 are between 5–9%, ten countries are between 10–14% and six countries have a wasting prevalence of 15% or higher (Table 100).

TABLE 100: COUNTRY GROUPING BY CURRENT WASTING STATUS AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Prevalence of wasting in children under five years			
	15+%	10–14%	5–9%	<5%
2010–2011 (n=24)		Bangladesh, Gambia, Indonesia, Mali, Mauritania, Niger (n=6)	Burkina Faso, Ethiopia, Lao PDR, Mozambique, Namibia, Nepal, Senegal, Zambia (n=8)	Benin, Ghana, Guatemala, Kyrgyzstan, Malawi, Peru, Rwanda, Tanzania, Uganda, Zimbabwe (n=10)
2012–2014 (n=30)	Madagascar, Somalia, South Sudan, Sri Lanka, Yemen (n=5)	Chad, Comoros, Pakistan (n=3)	Burundi, Cambodia, Cameroon, Congo, Côte d'Ivoire, DRC, Guinea, Guinea-Bissau, Haiti, Liberia, Myanmar, Nigeria, Philippines, Sierra Leone, Tajikistan, Togo, Viet Nam (n=17)	Costa Rica, El Salvador, Kenya, Lesotho, Swaziland (n=5)
2015–2017 (n=5)	Sudan (n=1)	Papua New Guinea(n=1)	Botswana, Central African Republic (n=2)	Gabon (n=1)

Analysis of trend data suggests that wasting rates are proving difficult to reduce across the SUN Movement. As shown in Table 101 below, for the 38 countries with a recent previous wasting estimate (32 of 38 within the previous 5 years), the majority remained in the same wasting level group or higher. Only 9 of the 38 countries moved to a lower level category in the period under analysis.

TABLE 101: COMPARISON OF WASTING LEVELS BETWEEN PREVIOUS AND CURRENT ESTIMATES

Prior wasting status	Current wasting status			
	<5%	5–9%	10–14%	15+%
<5%	9	3		
5–9%	4	10	2	
10–14%		4	3	1
15+%			1	1

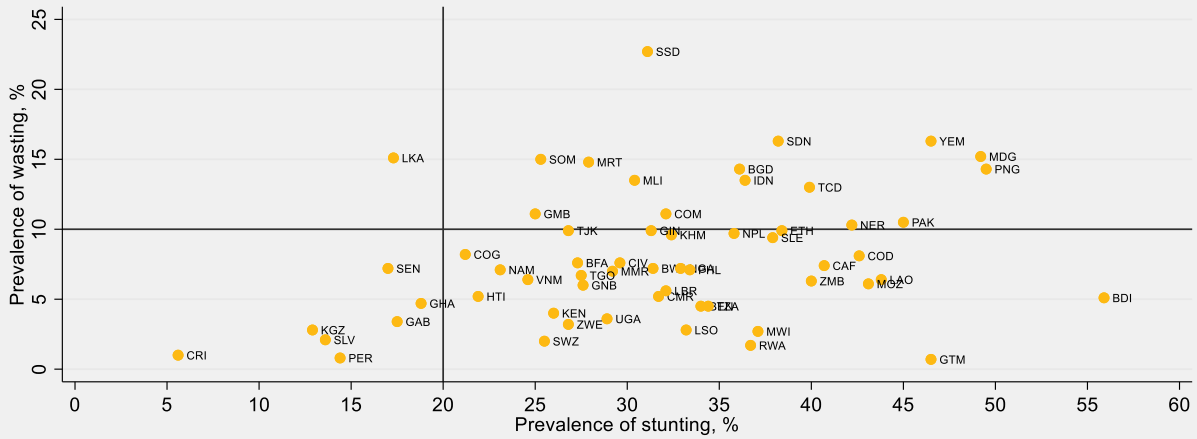
N=38 countries

Comorbidity analysis

We also explored whether some SUN countries experience a high burden of multiple forms of child malnutrition using the new prevalence thresholds established through the WHO-UNICEF Technical Advisory Group on Nutrition Monitoring (TEAM).[62] For stunting, a prevalence of 20% or higher is considered "High" whereas for overweight and wasting, high prevalence is defined as 10% or higher. Figures 7A and 7B show which countries have coexisting high levels of child malnutrition.

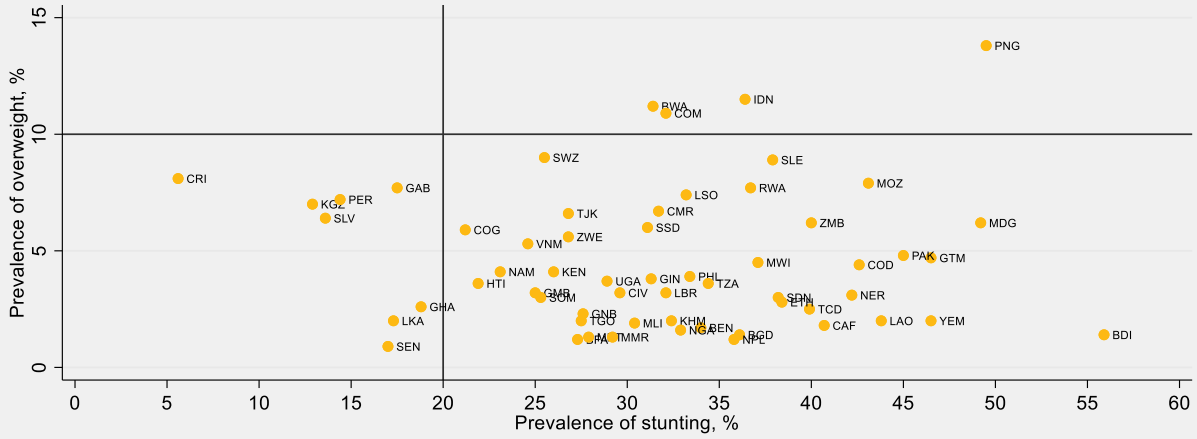
One in four (n=15) SUN countries experience concurrent high levels of child wasting and stunting (Figure 7A).

Figure 7A
Prevalence of stunting and wasting in SUN countries



Only four SUN countries currently experience concurrent high levels of child stunting and overweight (Figure 7B).

Figure 7B
Prevalence of stunting and overweight in SUN countries



[62] United Nations Children's Fund, World Health Organization, World Bank Group (2018). Levels and trends in child malnutrition: Key findings of the 2018 Edition of the Joint Child Malnutrition Estimates.

ANAEMIA IN WOMEN

Anaemia data are from WHO Global Health Observatory estimates for 2016 for both non-pregnant and pregnant women ages 15–49 years. Data are available for all 59 SUN countries (see Table 102).

TABLE 102: PREVALENCE OF ANAEMIA IN WOMEN BY PREGNANCY STATUS (2016 ESTIMATES)

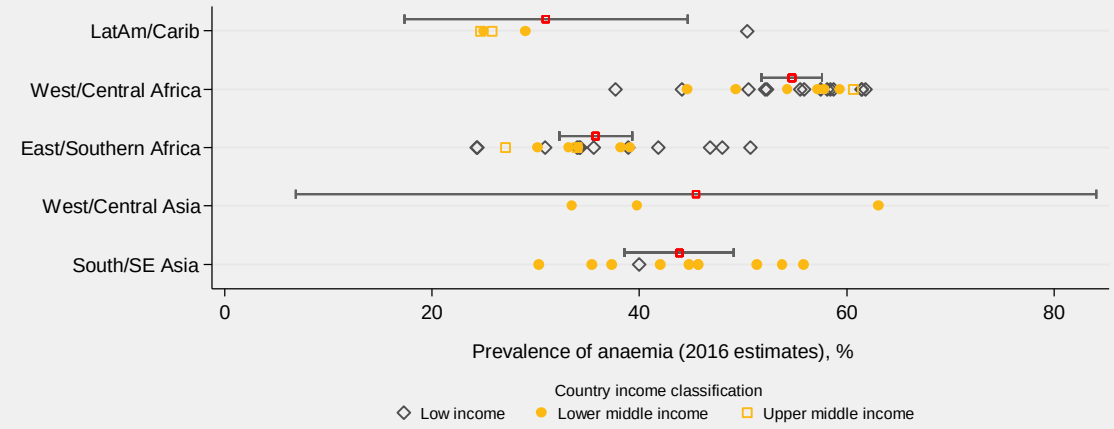
Characteristic	N	Pregnant	Non-pregnant	WRA
All SUN countries				
Mean (95% CI)	59	44.1 (41.0, 47.1)	37.7 (34.6, 40.8)	38.2 (35.1, 41.3)
Median	59	44.6	36.5	37.2
Range	59	24.3, 63.0	14.6, 70.2	14.9, 69.6
Year joined SUN Movement				
2010–11	24	43.2	36.3	36.9
2012–14	30	44.6	38.4	38.8
2015–17	5	45.2	40.1	40.5
Region				
Latin America & Caribbean	41	30.1	23.4	23.7
West/Central Africa	18	54.7	47.1	47.8
East/Southern Africa	19	35.8	31.0	31.4
West/Central Asia	3	45.4	45.5	45.4
South/Southeast Asia	11	43.8	35.8	36.2
Country Income Level				
Low-income	28	46.4	40.2	40.8
Lower middle-income	26	43.5	36.6	37.1
Upper middle-income	5	34.4	28.9	29.2
Humanitarian Risk Level				
Low-Medium	23	41.8	34.4	34.9
High	25	43.8	37.2	37.8
Very High	11	49.6	45.8	46.1

Anaemia in pregnant women

MEAL Indicator 7.5 – Prevalence of haemoglobin <110 g/L in pregnant women

Mean prevalence of anaemia (Hb <110 g/L) among pregnant women in SUN countries is 44.1% (95% CI 41.0, 47.1) and ranges from 24 to 63% (median 45%).

Figure 7.5a
Distribution of anaemia in pregnant women by region and country income classification



Each symbol represents a country (N=59). The red squares indicate the regional mean and 95% confidence intervals.

TABLE 103: COUNTRY GROUPING BY ANAEMIA PREVALENCE IN PREGNANT WOMEN AND YEAR OF JOINING THE SUN MOVEMENT

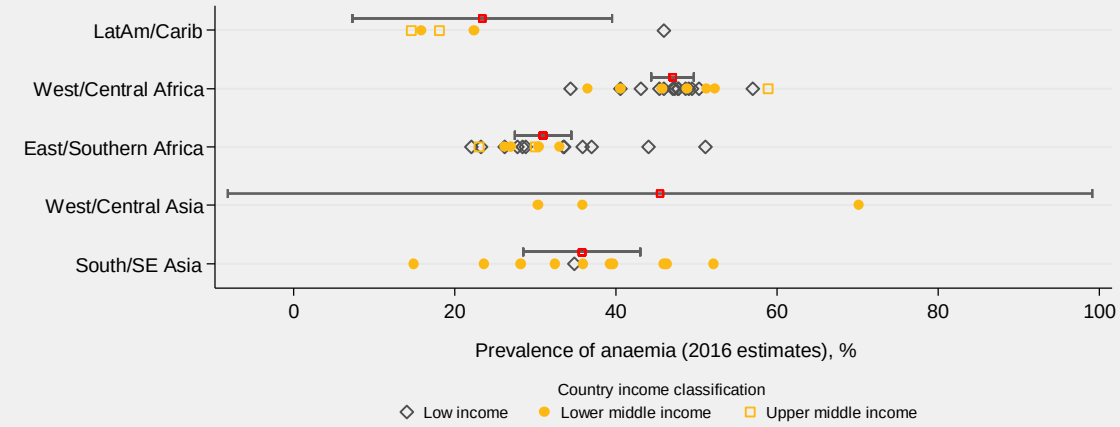
Year joined SUN Movement	Prevalence of anaemia as a public health problem in pregnant women			
	Severe (≥40%)	Moderate (30–39%)	Moderate (20–29%)	Mild (5–19%)
2010–2011	Bangladesh, Benin, Burkina Faso, Gambia, Ghana, Indonesia, Lao PDR, Malawi, Mali, Mauritania, Mozambique, Nepal, Niger, Senegal, Tanzania (n=15)	Kyrgyzstan, Uganda, Zambia, Zimbabwe (n=4)	Ethiopia, Guatemala, Namibia, Peru, Rwanda (n=5)	–
2012–2014	Cambodia, Cameroon, Chad, Congo, Côte d'Ivoire, DRC, Guinea, Guinea-Bissau, Haiti, Myanmar, Nigeria, Pakistan, Sierra Leone, Somalia, Togo, Yemen (n=16)	Burundi, Comoros, Kenya, Lesotho, Liberia, Madagascar, Philippines, South Sudan, Sri Lanka, Swaziland, Tajikistan, Viet Nam (n=12)	Costa Rica, El Salvador, (n=2)	–
2015–2017	CAR, Gabon, Papua New Guinea (n=3)	Botswana, Sudan (n=2)	–	–

Anaemia in non-pregnant women

MEAL Indicator 7.6 – Prevalence of haemoglobin <120 g/L in non-pregnant women

Mean prevalence of anaemia (Hb <120 g/L) among non-pregnant women in SUN countries is 37.7% (95% CI 34.6, 40.8) and ranges from 15 to 70% (median 36.5%).

Figure 7.6a
Distribution of anaemia in non-pregnant women by region and country income classification



Each symbol represents a country (N=59). The red squares indicate the regional mean and 95% confidence intervals.

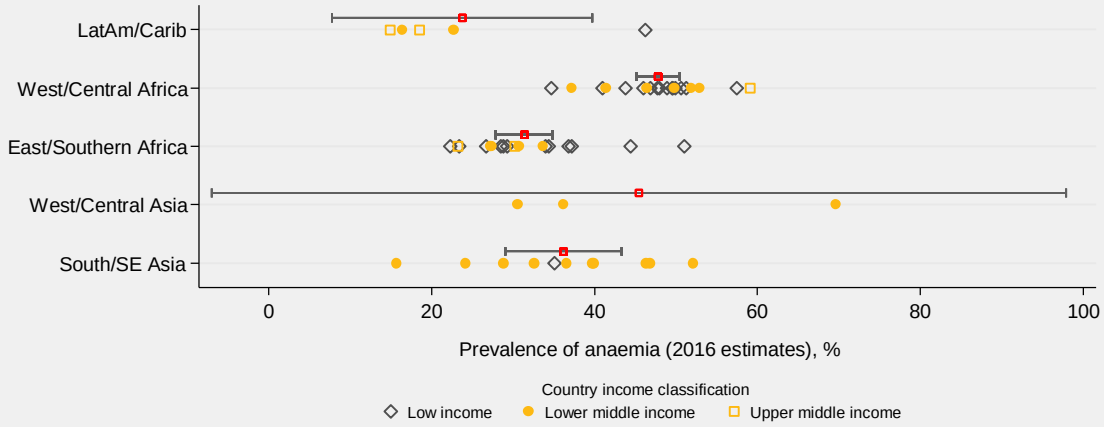
TABLE 104: COUNTRY GROUPING BY CURRENT ANAEMIA PREVALENCE IN NON-PREGNANT WOMEN AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Prevalence of anaemia as a public health problem in non-pregnant women			
	Severe (≥40%)	Moderate (30–39%)	Moderate (20–29%)	Mild (5–19%)
2010–2011	Benin, Burkina Faso, Gambia, Ghana, Mali, Mozambique, Niger, Senegal (n=8)	Bangladesh, Kyrgyzstan, Lao PDR, Malawi, Mauritania, Nepal, Tanzania, Zambia (n=8)	Ethiopia, Indonesia, Namibia, Rwanda, Uganda, Zimbabwe (n=6)	Guatemala, Peru (n=2)
2012–2014	Cambodia, Cameroon, Chad, Congo, Côte d'Ivoire, DRC, Guinea, Guinea-Bissau, Haiti, Myanmar, Nigeria, Pakistan, Sierra Leone, Somalia, Togo, Yemen (n=16)	Liberia, Madagascar, South Sudan, Sri Lanka, Tajikistan (n=5)	Burundi, Comoros, El Salvador, Kenya, Lesotho, Swaziland, Viet Nam (n=7)	Costa Rica, Philippines (n=2)
2015–2017	CAR, Gabon (n=2)	Botswana, Papua New Guinea, Sudan (n=3)	–	–

Anaemia in women of reproductive age (WRA)

The mean prevalence of anaemia among WRA (all women 15–49 y, pregnant and non-pregnant) in SUN countries is 38.2% (95% CI 35.1, 41.3) and ranges from 15 to 70% across countries, as shown in Figure 7.6b. Over 186 million WRA are affected by anaemia in this group of countries.

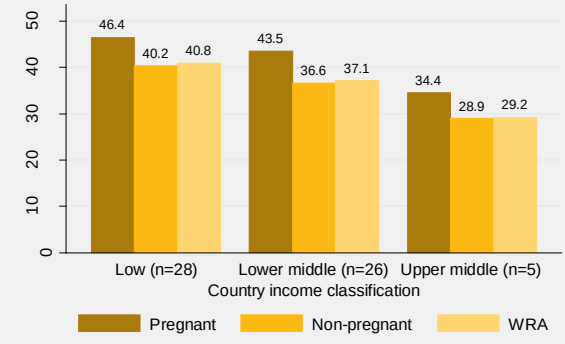
Figure 7.6b
Distribution of anaemia in WRA by region and country income classification



Each symbol represents a country (N=59). The red squares indicate the regional mean and 95% confidence intervals.

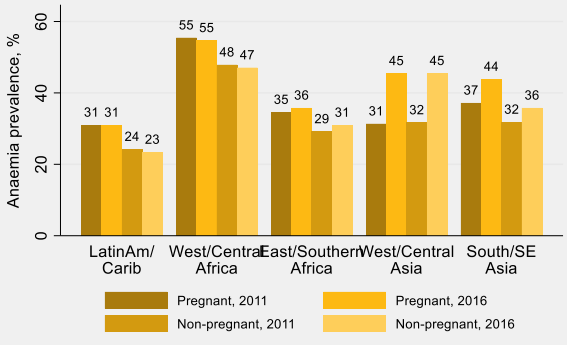
There is notable regional variation in anaemia among WRA, with the highest rates in West and Central African SUN countries. Furthermore, as shown in Figure 7.6d, anaemia levels have increased between 2011 and 2016 in SUN countries from the West/Central Asia and South/Southeast Asia regions. Anaemia levels in the other regions have remained constant over this time period.

Figure 7.6c
Anaemia prevalence in women 15-49 years
by pregnancy status and country income level



N=59 countries, estimates for 2016

Figure 7.6d
Anaemia prevalence in women 15-49 years by pregnancy status,
year and region



N=59 countries

Based on GNR 2017 trend data for SUN countries, the average annual rate of reduction in anaemia among WRA in SUN countries is 0.5%. Regional variation is evident here as well (see Figure 7.6e).

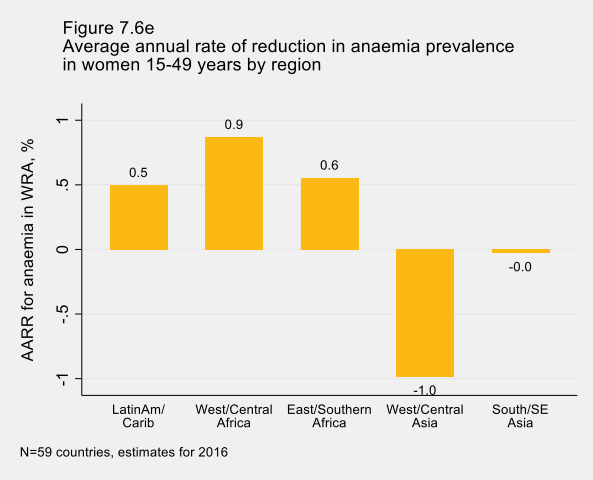


Table 105 shows which countries are showing some progress and those with no progress or worsening levels.

TABLE 105: COUNTRY GROUPING BY WRA ANAEMIA AARR DIRECTION AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Average annual rate of reduction in WRA anaemia	
	No progress or worsening (<-1.5%)	Some progress (>-1.5%)
2010–2011 (n=24)	Ethiopia, Gambia, Indonesia, Kyrgyzstan, Lao PDR, Malawi, Mozambique, Niger, Rwanda, Zambia (n=10)	Bangladesh, Benin, Burkina Faso, Ghana, Guatemala, Mali, Mauritania, Namibia, Nepal Peru, Senegal, Tanzania, Uganda, Zimbabwe (n=14)
2012–2014 (n=30)	Cambodia, Comoros, Costa Rica, Cote d'Ivoire, El Salvador, Guinea, Guinea-Bissau, Haiti, Myanmar, Nigeria, Pakistan, Sierra Leone, Somalia, South Sudan, Sri Lanka, Viet Nam, Yemen (n=17)	Burundi, Cameroon, Chad, Congo, DRC, Kenya, Lesotho, Liberia, Madagascar, Philippines, Swaziland, Tajikistan, Togo (n=13)
2015–2017 (n=5)	Botswana, Central African Republic, Gabon, Papua New Guinea, Sudan (n=5)	—

Source: Global Nutrition Report 2017

NUTRITIONAL STATUS OF ADULTS – ANTHROPOMETRIC INDICATORS

Underweight (low BMI) in Women

MEAL Indicator 7.7 – Proportion of women aged 15–49 years with low body mass index

Data on age-standardized prevalence of underweight in women, defined as a BMI <18.5 kg/m^2, are available for 58 SUN countries from the recent analysis of population-based studies by the NCD Risk Factor Collaboration (NCD-RisC)[63]. We summarize the results for SUN countries for the years 2010 and 2016.

In 2016, 9.2% (95% CI 8.1, 10.3) of women were considered underweight in SUN countries, with prevalence ranging from 1.4% to 22.8% (median 9.2%). Prevalence of underweight is highest in countries from the South/Southeast Asia region (see Figure 7.7a and Table 106).

Figure 7.7a
Distribution of underweight among women by region and country income classification

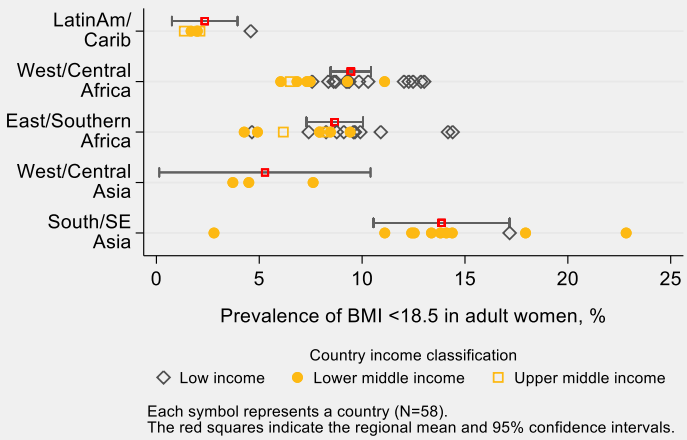


TABLE 106: PREVALENCE OF UNDERWEIGHT IN ADULT WOMEN IN SUN COUNTRIES, 2010 & 2016

Characteristic	N	2010	2016	Characteristic	N	2010	2016
All SUN countries				**Region**			
Mean (95% CI)	58	10.3 (9.1, 11.6	9.2 (8.1, 10.3)	Latin America & Caribbean	5	2.8	2.3
Median	58	10.2	9.2	West/Central Africa	21	10.4	9.5
Range	58	1.5, 25.6	1.4, 22.8	East/Southern Africa	18	9.7	8.7
Year joined SUN Movement				West/Central Asia	3	6.1	5.3
2010–11	24	10.6	9.5	South/Southeast Asia	11	15.8	13.9
2012–14	29	10.5	9.4	**Country Income Level**			
2015–17	5	7.8	7.1	Low-income	27	11.3	10.1
Humanitarian Risk Level				Lower middle-income	26	10.3	9.1
Low-Medium	23	9.4	8.3	Upper middle-income	5	5.4	4.8
High	25	10.5	9.4				
Very High	10	12.1	10.8				

[63] NCD Risk Factor Collaboration. (2017). Worldwide trends in body-mass index, underweight, overweight, and obesity from 1975 to 2016: a pooled analysis of 2416 population-based measurement studies in 128.9 million children, adolescents, and adults. *The Lancet*, *390*(10113), 2627–2642.

Underweight prevalence is estimated to be over 15% among adult women in three SUN countries in the South/Southeast Asia region (Table 107).

TABLE 107: COUNTRY GROUPING BY PREVALENCE OF LOW BMI IN WOMEN AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Prevalence of BMI<18.5 kg/m^2 in adult women, 2016			
	≥15%	10–14%	5–9%	<5%
2010–2011 (n=24)	Bangladesh, Nepal, (n=2)	Burkina Faso, Ethiopia, Indonesia, Lao PDR, Niger, Senegal (n=6)	Benin, Gambia, Ghana, Malawi, Mali, Mauritania, Mozambique, Namibia, Rwanda, Tanzania, Uganda, Zambia (n=12)	Guatemala, Kyrgyzstan, Peru Zimbabwe (n=4)
2012–2014 (n=29)†	Viet Nam (n=1)	Burundi, Cambodia, Chad, Congo, DRC, Madagascar, Myanmar, Pakistan, Philippines, Sri Lanka (n=10)	Cameroon, Comoros, Côte d'Ivoire, Guinea, Guinea-Bissau, Kenya, Liberia, Nigeria, Sierra Leone, Somalia, Togo, Yemen (n=12)	Costa Rica, El Salvador, Haiti, Lesotho, Swaziland, Tajikistan (n=6)
2015–2017 (n=5)	—	Central African Republic (n=1)	Botswana, Gabon, Sudan (n=3)	Papua New Guinea (n=1)

† No data for South Sudan

Underweight in adult women has decreased between 2010 and 2016 across all regions and country income classes, with a similar trend over time for men (Figure 7.7b & 7.7c). However, prevalence of underweight remains significantly higher ($p<0.05$) in 2016 among both women and men living in low-income countries compared to those living in upper middle income countries (Figure 7.7c).

Figure 7.7b
Trend in underweight prevalence among adult women and men between 2010 and 2016 by region

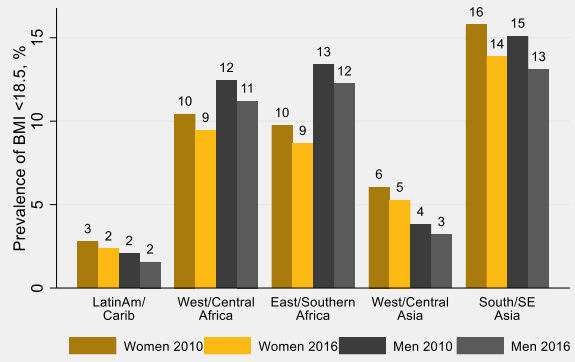
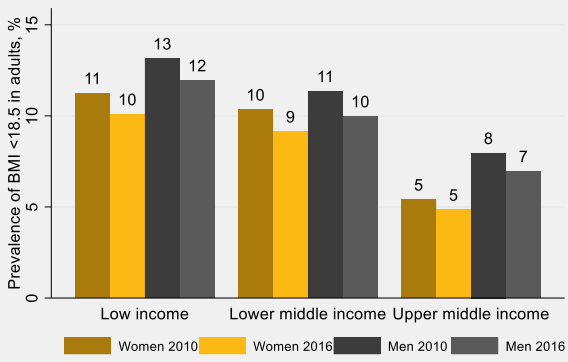


Figure 7.7c
Trend in underweight prevalence among adult women and men between 2010 and 2016 by country income class



A comparison of underweight prevalence in adolescent girls 10-19 years of age (defined as BMI <-2 SD) and adult women also shows significant variation across regions, with much lower prevalence of underweight in adolescent girls compared to adult women in countries from Africa and South/SE Asia (Figure 7.7d). Prevalence of underweight is more similar for these two age groups in countries in Latin America and West/Central Asia.

Low-income countries have a much lower prevalence of underweight in adolescent girls compared to adult women (Figure 7.7e and Figure 7.7f).

Figure 7.7d
Comparison of underweight in adolescent girls vs. adult women in 2010 & 2016 by region

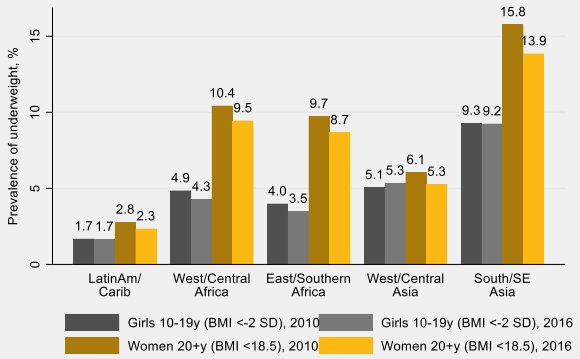


Figure 7.7e
Comparison of underweight in adolescent girls vs. adult women in 2010 & 2016 by country income class

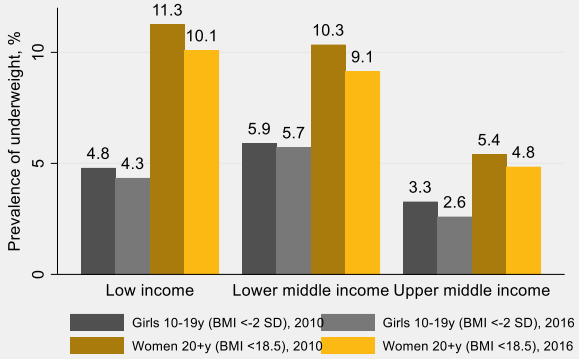
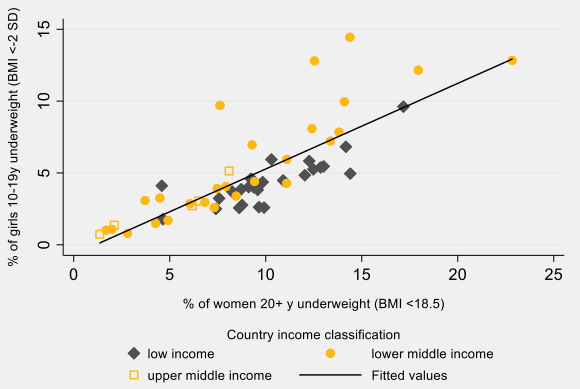


Figure 7.7f
Comparison of underweight in adolescent girls vs. adult women, 2016



Adult overweight and obesity

MEAL Indicator 7.8 – Proportion of overweight (BMI ≥25 kg/m^2) and obese (BMI ≥30 kg/m^2) women aged 18+ years

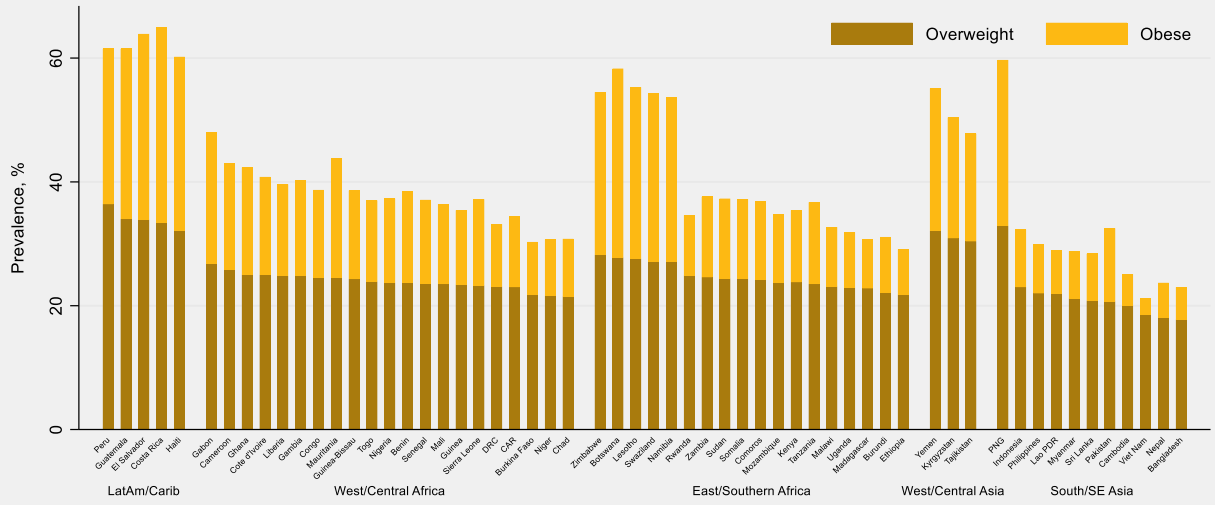
Data on age-standardized prevalence of overweight and obesity in adults are available for 58 SUN countries (no data for South Sudan) from the recent analysis of population-based studies by the NCD Risk Factor Collaboration (NCD-RisC)[64]. We summarize the results (modeled estimates) for SUN countries for the years 2010 and 2016.

Overweight and obesity in women

Among adult women, the prevalence of overweight in 2016 was 24.9% (95% CI 23.9, 26.0) across SUN countries, ranging from 17.8 to 36.4% (median 23.9%). The prevalence of obesity among adult women in 2016 was 15.0% (95% 13.0, 16.9), ranging from 2.7 to 31.5% (median 13.1%).

The combined prevalence of overweight and obesity in women for SUN countries in 2016 is 39.9% (95% CI 36.9, 42.9), with a range of 21.3 to 65.0% and median 37.1%. The distribution of overweight and obesity across countries and regions is shown for women in Figure 7.8a.

Figure 7.8a
Prevalence of overweight and obesity in adult women in SUN countries, 2016 estimates



Although there is no agreed-upon cut-off point to define when the prevalence of overweight and obesity becomes a problem of public health significance, the GNR uses a level of 35% to divide countries into high and low prevalence groups.[65] Using this cut-off, 36 SUN countries (61%) are considered to have a high prevalence of overweight and obesity among women (Table 108). The distribution across regions is shown for women in Figure 7.8b.

[64] NCD Risk Factor Collaboration. (2017). Worldwide trends in body-mass index, underweight, overweight, and obesity from 1975 to 2016: a pooled analysis of 2416 population-based measurement studies in 128.9 million children, adolescents, and adults. *The Lancet*, *390*(10113), 2627–2642.

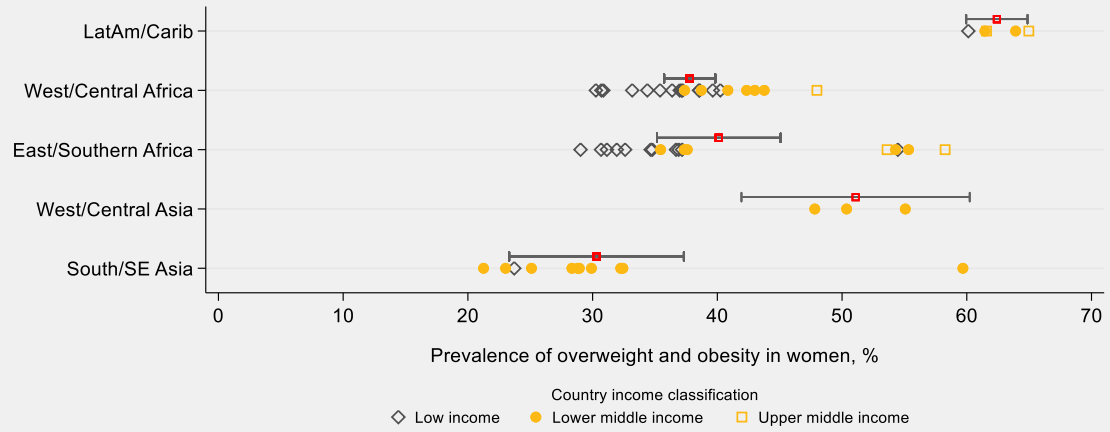
[65] GNR 2015, p.21

TABLE 108: COUNTRY GROUPING BY OVERWEIGHT AND OBESITY PREVALENCE IN WOMEN AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Prevalence of overweight and obesity (BMI ≥25) in women, 2014			
	≥40%	35–39%	30–34%	<30%
2010–2011 (n=24)	Gambia, Ghana, Guatemala, Kyrgyzstan, Mauritania, Namibia, Peru, Zimbabwe (n=8)	Benin, Mali, Senegal, Tanzania, Zambia, (n=5)	Burkina Faso, Indonesia, Malawi, Mozambique, Niger, Rwanda, Uganda (n=7)	Bangladesh, Ethiopia, Lao PDR, Nepal (n=4)
2012–2014 (n=29)†	Cameroon, Costa Rica, Côte d'Ivoire, El Salvador, Haiti, Lesotho, Swaziland, Tajikistan, Yemen (n=9)	Comoros, Congo, Guinea, Guinea-Bissau, Kenya, Liberia, Nigeria, Sierra Leone, Somalia, Togo (n=10)	Burundi, Chad, DRC, Madagascar, Pakistan (n=5)	Cambodia, Myanmar, Philippines, Sri Lanka, Viet Nam (n=5)
2015–2017 (n=5)	Botswana, Gabon, Papua New Guinea (n=3)	Sudan (n=1)	Central African Republic (n=1)	—

† No data for South Sudan

Figure 7.8b
Distribution of overweight and obesity among women in 2016 by region and country income classification



Each symbol represents a country (N=58). The red squares indicate the regional mean and 95% confidence intervals.

Overweight and obesity in men

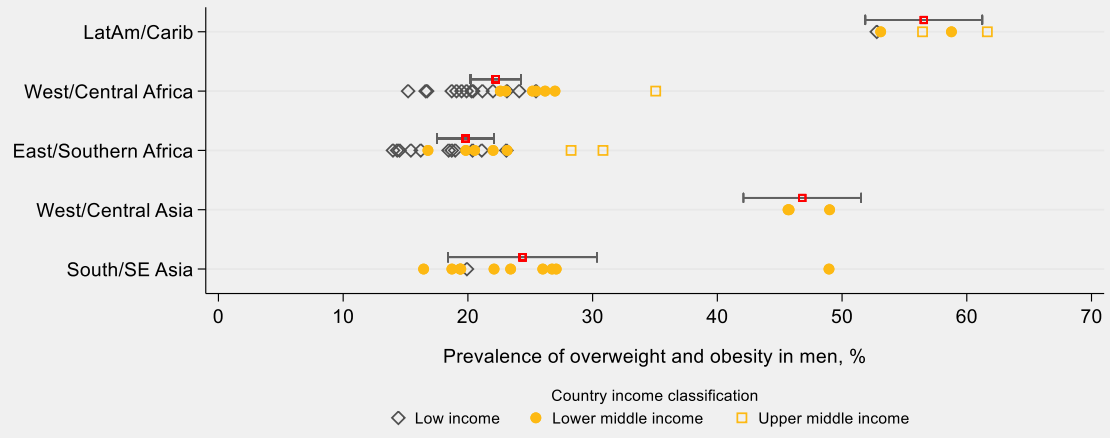
On average, 26.1% of men in SUN countries are overweight or obese based on 2016 estimates (median 22.0%, range 14 to 61.7%). The prevalence of male overweight was 19.9% and male obesity was 6.2% in 2016 (Table 109). The distribution across regions is shown for men in Figure 7.8c.

TABLE 109: PREVALENCE OF OVERWEIGHT AND OBESITY IN ADULT MEN AND WOMEN IN SUN COUNTRIES, 2016

Characteristic	N	Women		Men	
		Overweight	Obesity	Overweight	Obesity
All SUN countries*					
Mean (95% CI)	58	24.9 (23.9, 26.0)	15.0 (13.0, 16.9)	19.9 (17.9, 21.9)	6.2 (4.9, 7.5)
Median	58	23.9	13.1	17.2	4.5
Range	58	17.8, 36.4	2.7, 31.5	12.0, 40.7	1.7, 21.8
Year joined SUN Movement					
2010–11	24	24.6	14.0	19.1	5.4
2012–14	29	24.8	14.8	20.2	6.5
2015–17	5	27.0	20.6	22.2	8.7
Region					
Latin America & Caribbean	5	34.0	28.4	38.3	18.3
West/Central Africa	21	23.9	13.9	17.3	4.9
East/Southern Africa	18	24.7	15.4	15.9	3.9
West/Central Asia	3	31.1	20.0	33.8	13.0
South/Southeast Asia	11	21.5	8.8	19.4	5.0
Country Income Level					
Low-income	27	23.6	12.4	16.2	4.2
Lower middle-income	26	25.2	15.3	21.9	7.0
Upper middle-income	5	30.3	27.0	29.6	12.8
Humanitarian Risk Level					
Low-Medium	23	25.5	16.3	21.4	6.8
High	25	24.6	14.3	18.6	5.6
Very High	10	24.4	13.6	19.6	6.3

*No data for South Sudan

Figure 7.8c
Distribution of overweight and obesity among men in 2016 by region and country income classification



Each symbol represents a country (N=58). The red squares indicate the regional mean and 95% confidence intervals.

Trends in Adult Overweight and Obesity

Analysis of trends in adult overweight and obesity between 2000 and 2016 demonstrate an increase over time in all SUN countries for both sexes, consistent with global trends. A comparison of the increase in adult overweight and obesity prevalence by country income classification is shown in Figure 7.8d and across regions in Figure 7.8e.

Figure 7.8d
Prevalence of overweight and obesity between 2000 and 2016 by sex and country income classification

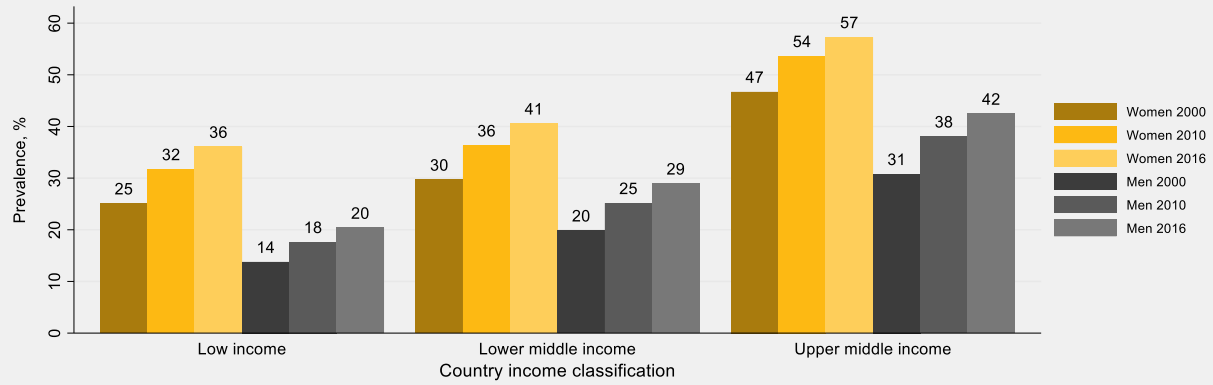
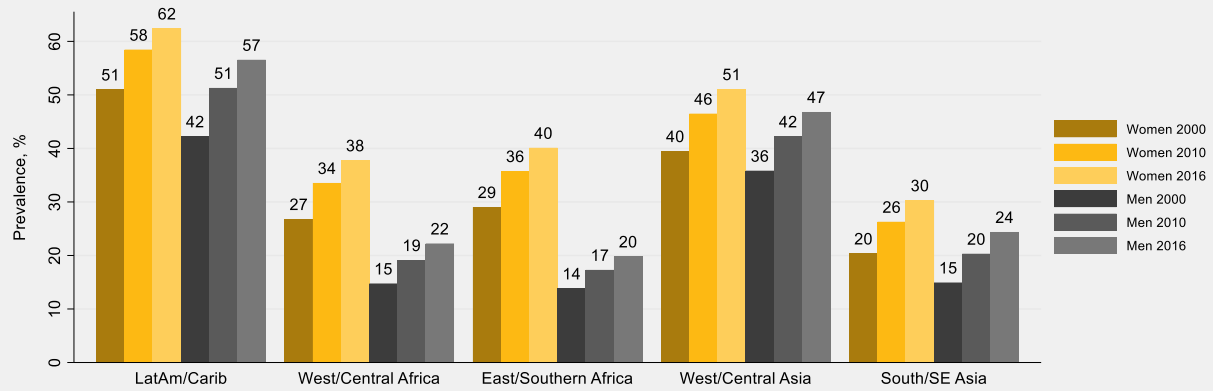
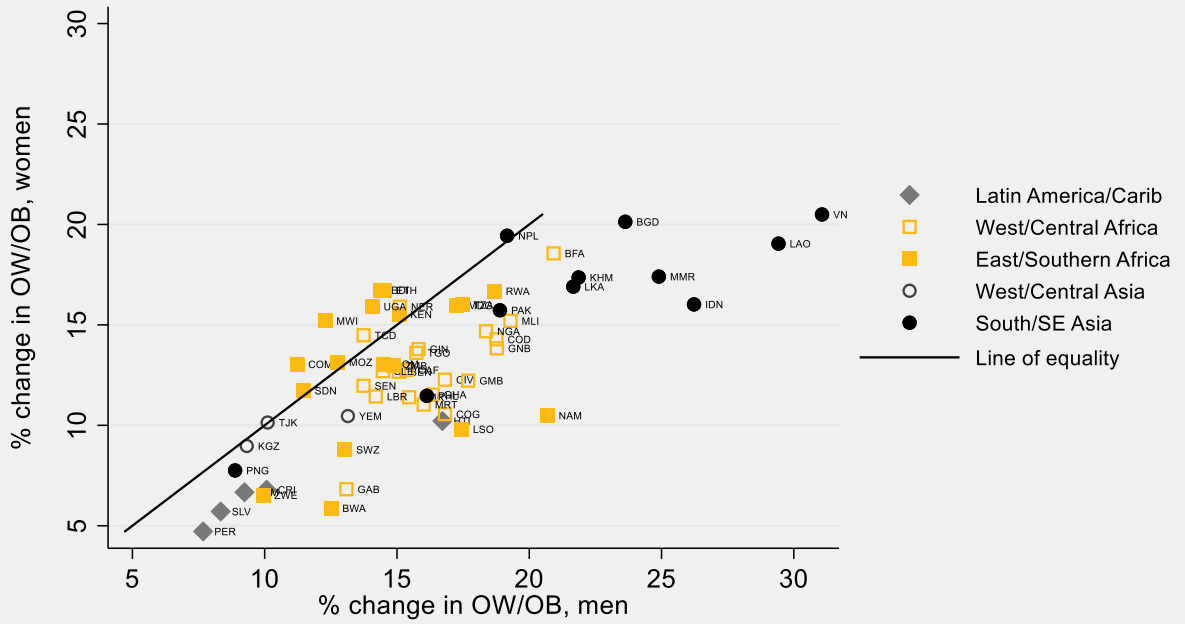


Figure 7.8e
Prevalence of overweight and obesity between 2000 and 2016 by sex and region



The average increase in overweight and obesity prevalence between 2010 and 2016 for the 58 countries with data is 13% for women and 16% for men. In most SUN countries (n=46), the percentage increase between 2010 and 2016 is higher among men than women (Figure 7.8f).

Figure 7.8f: Comparison of percent change in overweight/obesity between 2010 & 2016 in men vs. women

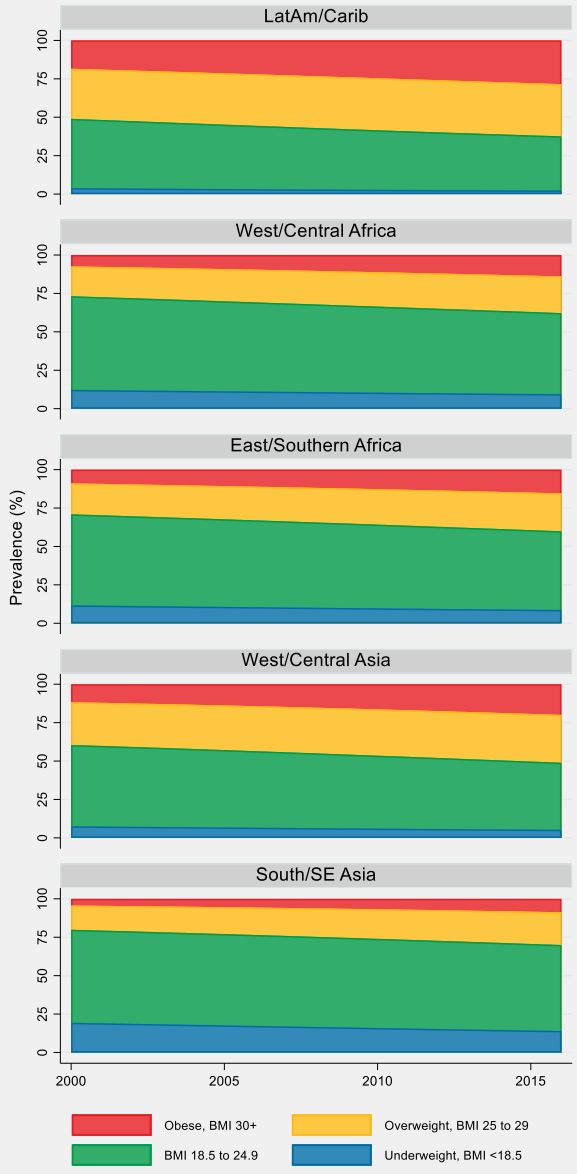


Based on analysis of projected prevalence of male and female obesity in 2025 and the predicted probability of each country meeting the WHA target (probability ranged from 0 to 0.13 for male and 0 to 0.05 for female obesity), all 58 SUN countries with data are considered “off course” to meet the 2025 WHA target for adult obesity (both male and female obesity).[66]

[66] Data source: Global Nutrition Report 2017

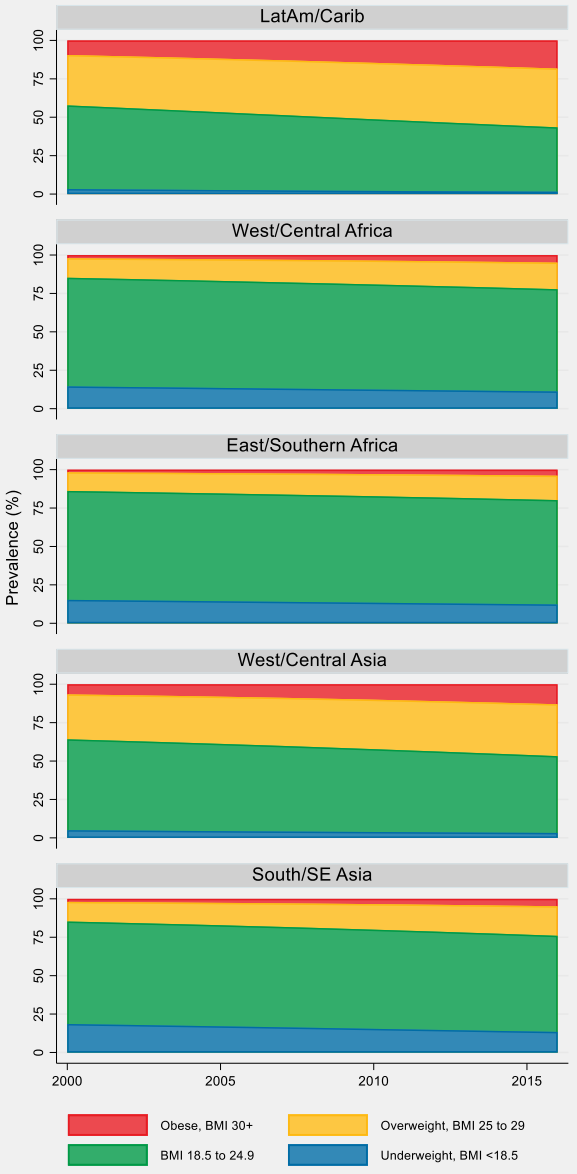
In all regions, the increase in the prevalence of overweight and obesity among women (Figure 7.8g) and men (Figure 7.8h) between 2000 and 2016 was larger than the decline in the prevalence of underweight.

Figure 7.8g
Trends in prevalence of BMI categories in adult women by region



n=58 countries, NCD-RisC 2016 age-standardized estimates for women 18+ years

Figure 7.8h
Trends in prevalence of BMI categories in adult men by region



n=58 countries, NCD-RisC 2016 age-standardized estimates for men 18+ years

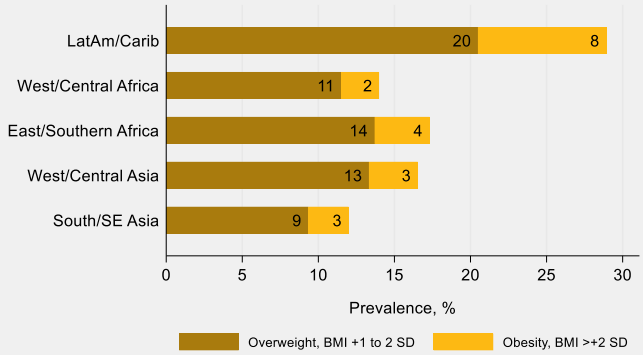
Adolescent overweight & obesity

MEAL Indicator 7.9 – Proportion of overweight and obesity in adolescents

Data on adolescent overweight and obesity are available for 58 SUN countries (no data for South Sudan) from the recent analysis of population-based studies by the NCD Risk Factor Collaboration (NCD-RisC).[67] Modeled estimates are available for boys and girls from age 5 to 19 years. For the MEAL indicator, we report the results for girls 10-19 years of age, in line with the WHO definition of adolescence.[68] In this age group, overweight is defined as BMI more than 1 SD to 2 SD above the median and obesity is defined as BMI more than 2 SD above the median.

Across SUN countries, 12.6% of adolescent girls are considered overweight and 3.4% are obese in 2016. The combined prevalence of overweight/obesity in girls 10-19 years is 16.1% (95% CI 14.4, 17.7), with a range from 7.1 to 36.8% (median 14.7%). Large regional variation is noted (Figure 7.9a), with highest prevalence in Latin American countries.

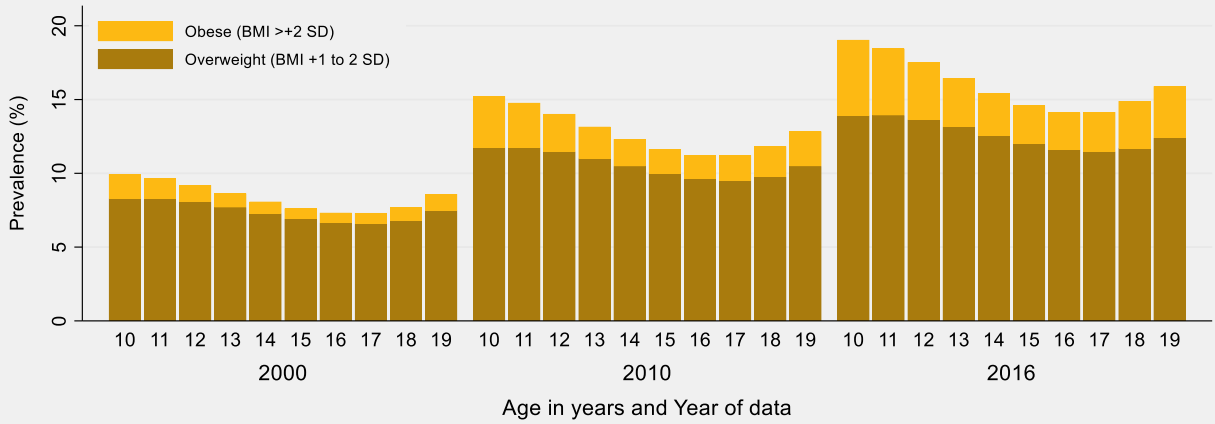
Figure 7.9a
Prevalence of overweight & obesity in adolescent girls in 2016 by region



n=58 countries (no data for South Sudan)

Figure 7.9b shows a comparison of prevalence of overweight and obesity in adolescent girls by age between 2000 and 2016, highlighting the variation across age but also the increase in prevalence over time for all ages.

Figure 7.9b
Prevalence of overweight and obesity in adolescent girls by age in 2000, 2010 and 2016



Source: NCD-RisC estimates for 58 countries (no data for South Sudan)

[67] NCD Risk Factor Collaboration. (2017). Worldwide trends in body-mass index, underweight, overweight, and obesity from 1975 to 2016: a pooled analysis of 2416 population-based measurement studies in 128.9 million children, adolescents, and adults. *The Lancet*, *390*(10113), 2627–2642.

[68] WHO (2017). Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation. Geneva: World Health Organization (WHO/FWC/MCA/17.05)

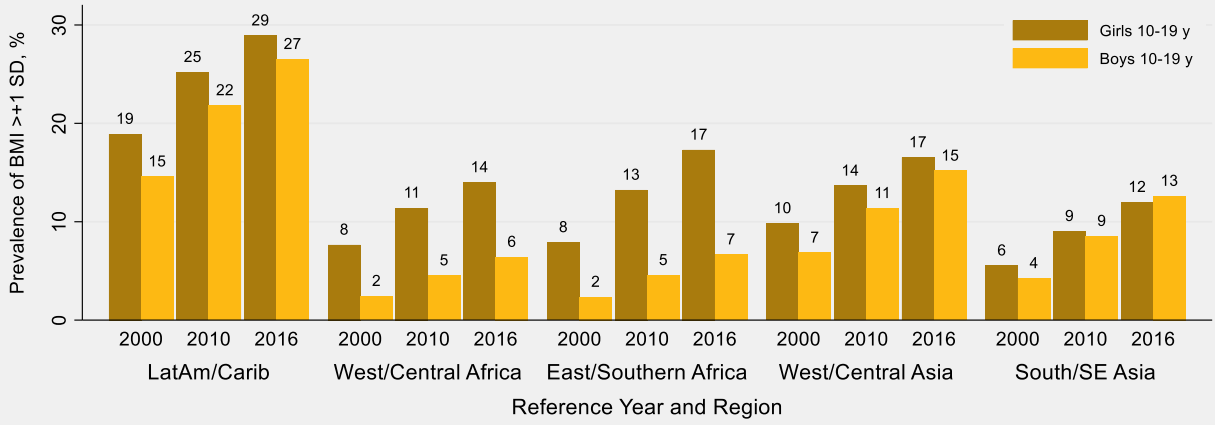
TABLE 110: COUNTRY GROUPING BY ADOLESCENT GIRLS OVERWEIGHT AND OBESITY PREVALENCE AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Prevalence of overweight/obesity (BMI >+1 SD) in adolescent girls, 2016			
	≥20%	15–19%	10–14%	<10%
2010–2011 (n=24)	Guatemala, Peru, Zimbabwe (n=3)	Kyrgyzstan, Mauritania, Mozambique, Namibia, Rwanda, Tanzania, Uganda, Zambia (n=8)	Benin, Burkina Faso, Ethiopia, Gambia, Ghana, Indonesia, Lao PDR, Malawi, Mali, Niger, Senegal (n=11)	Bangladesh, Nepal (n=2)
2012–2014 (n=29)†	Costa Rica, El Salvador, Haiti, Lesotho, Swaziland (n=5)	Cameroon, Comoros, Cote d'Ivoire, Kenya, Somalia, Yemen (n=6)	Burundi, Chad, Congo, DRC, Guinea, Guinea-Bissau, Liberia, Madagascar, Nigeria, Philippines, Sierra Leone, Sri Lanka, Tajikistan, Togo (n=14)	Cambodia, Myanmar, Pakistan, Viet Nam (n=4)
2015–2017 (n=6)	Botswana, Papua New Guinea (n=2)	Gabon, Sudan (n=2)	Central African Republic (n=1)	—

† No data for South Sudan

A comparison of prevalence of overweight/obesity between adolescent boys and girls across regions (Figure 7.9b) reveals that while there has been an increase in overweight/obesity for this age group across all regions, there are notable regional differences in prevalence among boys vs. girls. Boys have much lower prevalence in SUN countries in Africa whereas prevalence is equally low among boys and girls in countries in south and southeast Asia.

Figure 7.9b
Prevalence of overweight and obesity in adolescent girls and boys in 2000, 2010 and 2016 by region



Source: NCD-RisC estimates for 58 countries (no data for South Sudan)

NUTRITION-RELATED NCD STATUS IN ADULTS

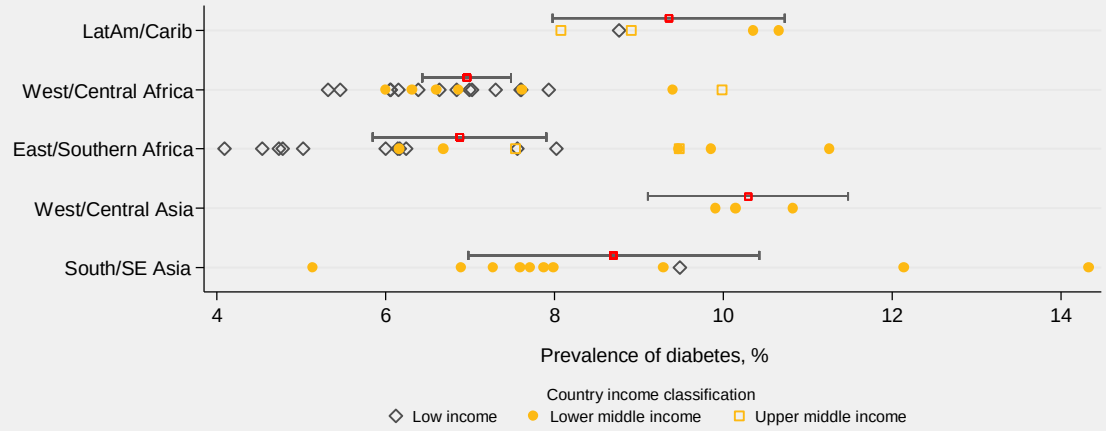
Diabetes in adults

MEAL Indicator 7.10 – Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years

Data on the age-standardized adult (aged 18 years and older) prevalence of diabetes are available for 58 SUN countries from the recent analysis of population-based studies by the NCD Risk Factor Collaboration (NCD-RisC)[69]. For this analysis, diabetes was defined as fasting plasma glucose ≥7.0 mmol/L or history of diagnosis with diabetes, or use of insulin or oral hypoglycaemic drugs.

Based on estimates for 2014, the prevalence of diabetes in SUN countries is 7.6% in women and 7.7% in men (see Table 112). Levels are very similar across regions, as shown in Figure 7.10a. Global age-standardised diabetes prevalence was 9.0% in 2014 in men and 7.9% in women.

Figure 7.10a
Distribution of diabetes prevalence among women by region and country income classification



Each symbol represents a country (N=58). The red squares indicate the regional mean and 95% confidence intervals.

[69] NCD Risk Factor Collaboration. (2016). Worldwide trends in diabetes since 1980: a pooled analysis of 751 population-based studies with 4·4 million participants. *The Lancet*, *387*(10027), 1513–1530.

TABLE 111: COUNTRY GROUPING BY DIABETES PREVALENCE IN WOMEN AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Prevalence of diabetes in women, 2014			
	≥9%	7.5–8.9	6.0–7.4%	<6.0%
2010–2011 (n=24)	Bangladesh, Guatemala, Kyrgyzstan, Mauritania, Nepal (n=5)	Gambia, Indonesia, Lao PDR, Namibia, Peru, Zimbabwe (n=6)	Benin, Ghana, Malawi, Mali, Mozambique, Senegal, Tanzania, Zambia (n=8)	Burkina Faso, Ethiopia, Niger, Rwanda, Uganda (n=5)
2012–2014 (n=29)†	El Salvador, Lesotho, Pakistan, Swaziland, Tajikistan, Yemen (n=6)	Comoros, Congo, Costa Rica, Haiti, Liberia, Myanmar, Sri Lanka (n=7)	Cambodia, Cameroon, Chad, Côte d'Ivoire, DRC, Guinea, Guinea-Bissau, Kenya, Nigeria, Philippines, Sierra Leone, Somalia, Togo (n=13)	Burundi, Madagascar, Viet Nam (n=3)
2015–2017 (n=5)	Botswana, Gabon, Papua New Guinea, Sudan (n=4)	Central African Republic (n=1)	–	–

† No data for South Sudan

On average, diabetes prevalence increased between 2010 and 2014 by 8.6% (95% CI 7.8, 9.4) among women and 9.2% (95% CI 8.5, 10.0) among men in SUN countries (N=58). The percent increase across country income classification is shown in Figure 7.10b and across region in Figure 7.10c.

Figure 7.10b
Mean percent change in diabetes between 2010 and 2014 by sex and country income classification

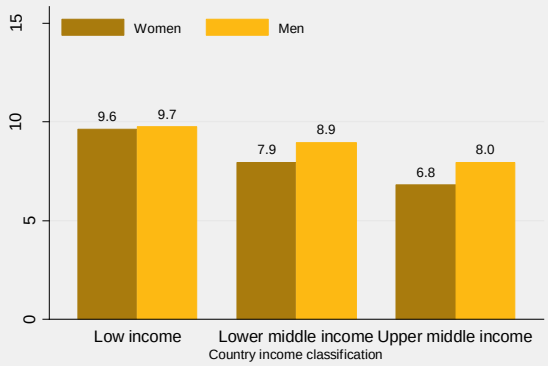
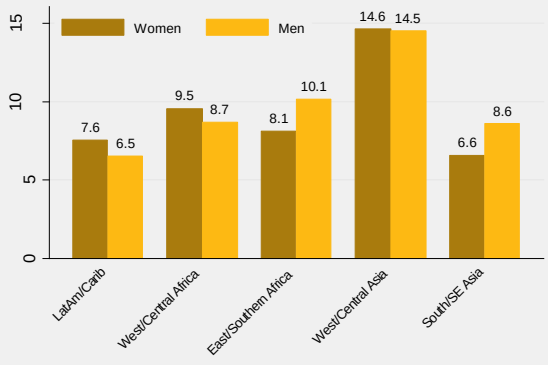


Figure 7.10c
Mean percent change in diabetes between 2010 and 2014 by sex and region



Based on analysis of projected prevalence of male and female diabetes in 2025 and the predicted probability of each country meeting the WHA target (probability ranged from 0.05 to 0.34 for male and 0.06 to 0.42 for female diabetes), all 58 SUN countries with data are considered “off course” to meet the 2025 WHA target for both male and female diabetes.

TABLE 112: PREVALENCE OF DIABETES IN ADULTS IN SUN COUNTRIES BY YEAR AND SEX

Characteristic	N	2014		2010	
		Women	Men	Women	Men
All SUN countries*					
Mean (95% CI)	58	7.6 (7.1, 8.2)	7.7 (7.2, 8.3)	7.0 (6.5, 7.5)	7.1 (6.6, 7.6)
Median	58	7.4	7.4	6.8	6.8
Range	58	4.1, 14.3	4.2, 15.4	3.7, 12.8	3.7, 13.8
Year joined SUN Movement					
2010–11	24	7.2	7.4	6.7	6.8
2012–14	29	7.6	7.6	6.9	7.0
2015–17	5	10.2	9.8	9.3	9.0
Region					
Latin America & Caribbean	5	9.4	8.6	8.7	8.1
West/Central Africa	21	7.0	7.5	6.4	6.9
East/Southern Africa	18	6.9	6.5	6.4	5.9
West/Central Asia	3	10.3	10.9	9.0	9.5
South/Southeast Asia	11	8.7	9.0	8.1	8.3
Country Income Level					
Low-income	27	6.5	7.1	5.9	6.5
Lower middle-income	26	8.6	8.3	8.0	7.6
Upper middle-income	5	8.8	8.2	8.2	7.6
Humanitarian Risk Level					
Low-Medium	23	8.0	7.7	7.4	7.1
High	25	7.1	7.5	6.6	6.9
Very High	10	8.0	8.4	7.3	7.7

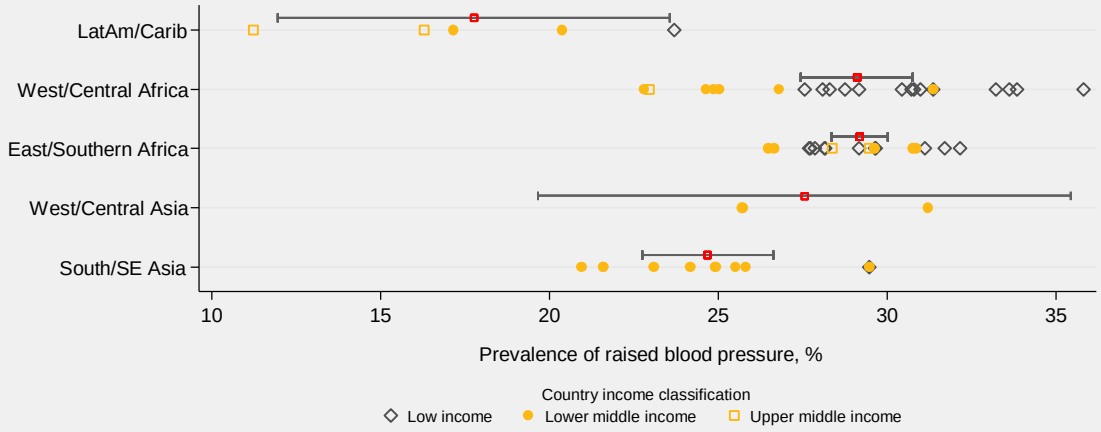
*No data for South Sudan

Hypertension in Adults

MEAL Indicator 7.11 – Age-standardized prevalence of raised blood pressure among persons aged 18+ years

Data on the age-standardized adult (aged 18 years and older) prevalence of raised blood pressure (defined as systolic blood pressure ≥140 mmHg or diastolic blood pressure ≥90 mmHg) are available for 58 SUN countries from the recent analysis of population-based studies by the NCD Risk Factor Collaboration (NCD-RisC)[70]. Global age-standardised prevalence of raised blood pressure was 24% in men and 20% in women in 2015.[71]

Figure 7.11a
Distribution of hypertension prevalence among women by region and country income classification



Each symbol represents a country (N=58). The red squares indicate the regional mean and 95% confidence intervals.

The mean prevalence of raised blood pressure for SUN countries in 2015 is 27.2% (95% CI 26.0, 28.4) for women and 27.2% (95% CI 26.4, 28.0) for men (see Table 113). Figure 7.11a shows the variation in prevalence of raised blood pressure for SUN countries within each region.

[70] NCD Risk Factor Collaboration. (2017). Worldwide trends in blood pressure from 1975 to 2015: a pooled analysis of 1479 population-based measurement studies with 19·1 million participants. *The Lancet*, *389*(10064), 37–55.
[71] Ibid.

TABLE 113: PREVALENCE OF RAISED BLOOD PRESSURE IN ADULTS IN SUN COUNTRIES BY YEAR AND SEX

Characteristic	N	2015		2010	
		Women	Men	Women	Men
All SUN countries					
Mean (95% CI)	58	27.2 (26.0, 28.4)	27.2 (26.4, 28.0)	27.5 (26.4, 28.6)	27.6 (26.8, 28.4)
Median	58	28.1	27.5	28.0	28.0
Range	58	11.2, 35.8	16.1, 33.5	13.2, 35.2	17.5, 34.1
Year joined SUN Movement					
2010–11	24	27.6	27.1	27.8	27.6
2012–14	29	26.9	27.0	27.1	27.3
2015–17	5	27.7	28.8	28.1	29.1
Region					
Latin America & Caribbean	5	17.8	21.0	19.1	21.9
West/Central Africa	21	29.1	28.8	29.7	29.7
East/Southern Africa	18	29.2	27.9	28.9	27.9
West/Central Asia	3	27.6	27.9	27.4	27.6
South/Southeast Asia	11	24.7	25.7	24.5	25.6
Country Income Level					
Low-income	27	30.0	28.8	29.9	29.1
Lower middle-income	26	25.5	26.1	25.7	26.4
Upper middle-income	5	21.7	24.5	23.2	25.6
Humanitarian Risk Level					
Low-Medium	23	25.3	26.1	25.7	26.6
High	25	27.9	27.2	28.1	27.5
Very High	10	29.8	29.9	29.8	30.1

*No data for South Sudan

TABLE 114: COUNTRY GROUPING BY HYPERTENSION PREVALENCE IN WOMEN AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Prevalence of raised blood pressure in adult women, 2015			
	≥30%	25–29%	20–24%	<20%
2010–2011 (n=24)	Burkina Faso, Ethiopia, Mali, Mauritania, Niger, Senegal (n=6)	Benin, Gambia, Kyrgyzstan, Malawi, Mozambique, Namibia, Nepal, Rwanda, Tanzania, Uganda, Zambia, Zimbabwe (n=12)	Bangladesh, Ghana, Guatemala, Indonesia, Lao PDR (n=5)	Peru (n=1)
2012–2014 (n=29)†	Burundi, Chad, Guinea, Guinea-Bissau, Lesotho, Sierra Leone, Somalia, Swaziland, Yemen (n=9)	Cambodia, Comoros, Côte d'Ivoire, DRC, Kenya, Liberia, Madagascar, Nigeria, Pakistan, Tajikistan, Togo (n=11)	Cameroon, Congo, Haiti, Myanmar, Philippines, Sri Lanka, Viet Nam (n=7)	Costa Rica, El Salvador (n=2)
2015–2017 (n=5)	Central African Republic (n=1)	Botswana, Papua New Guinea, Sudan (n=3)	Gabon (n=1)	—

† No data available for South Sudan

Hypertension levels in women and men have decreased slightly between 2010 and 2015 across SUN countries: the percent change in prevalence over this period for women is -1.0% (95% CI -2.0, -0.1) and for men is -1.4% (95% CI -2.2, -0.7). However, the trend over time varies significantly by country income classification (see Figure 7.11b) and region (see Figure 7.11c).

Figure 7.11b
Mean percent change in hypertension prevalence between 2010 and 2015 by sex and country income classification

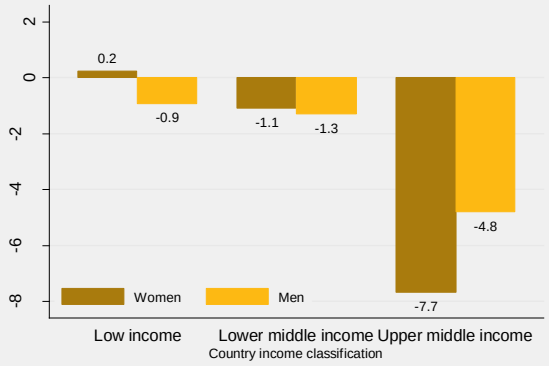
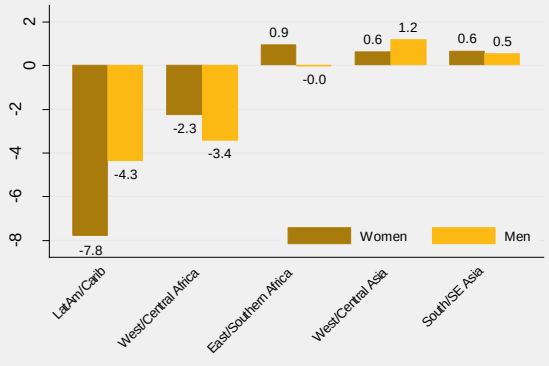


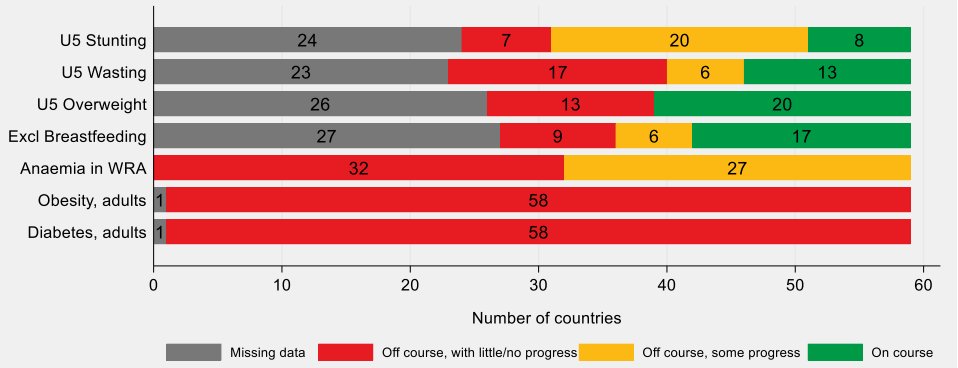
Figure 7.11c
Mean percent change in hypertension prevalence between 2010 and 2015 by sex and region



MEETING GLOBAL TARGETS FOR NUTRITION

Based on the progress needed to meet the global target of a 40% reduction in the number of children U5 who are stunted by 2025, eight SUN countries are on course, 20 are off course but making some progress and seven are making no progress or show worsening levels over time (see Figure 7C). Of the eight countries on course to meet the target, four joined the Movement in 2010–11 and four joined in 2012–14 (p=0.3).

Figure 7C
Progress by SUN countries in meeting global nutrition targets



Note: all data in this figure are based on GNR 2017 estimates and do not reflect updated country estimates published by UNICEF in December 2017.

For wasting, 13 countries are on course to achieve <5% prevalence by 2025, six are not on track but show some progress and 17 show no progress or worsening rates. For 23 SUN countries, there is insufficient data to assess progress to date. Over half (9 of 17, 53%) of the countries who joined the SUN Movement in the first two years (2010–11) are on track to achieve the global wasting target compared to only 4 of 18 (22%) countries who joined in 2012–14 (p=0.06).

Over one third (20 of 33) of SUN countries with trend data are considered to be “on track” to meet the WHA target for overweight among children under 5, defined as having child overweight prevalence <7 percent (WHO global target threshold) and no increase in rates (AARR ≥ 0). Of the 20 “on track” countries, nine joined the Movement in 2010–11 and 11 joined in 2012–14 (p=0.78).

Among the 32 SUN countries with trend data, 17 countries are considered “on track” to meeting the WHA global target of 50% EBF and six countries are showing some progress. Three SUN countries (Burkina Faso, Kenya and Swaziland) have an AARR for EBF of ~10%. Only nine countries show no progress or worsening levels of EBF. Of the 17 countries considered “on track”, six joined the Movement in 2010–11, 10 joined in 2012–14 and one joined in 2015 (p=0.17).

SUN countries "on track" to meet WHA targets

Among the 40 SUN countries with on/off track data for at least one of the four WHA targets related to children under-five (stunting, wasting overweight, EBF), two countries (Kenya and Swaziland) are currently on track to meet all four targets, as shown in Table 115. Four SUN countries (Ghana, El Salvador, Lesotho and Zimbabwe) are currently on track to meet three of four targets. Among the rest, 13 are on track for two targets, 12 are on track for one target and 8 countries are not on track for any of the WHA targets.

TABLE 115: COUNTRY GROUPING BY PROGRESS IN MEETING WHA TARGETS FOR CHILDREN UNDER-FIVE AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Number of under-five WHA targets "on track"				
	All 4	3	2	1	None
2010–2011*		Ghana, Zimbabwe (n=2)	Bangladesh, Benin, Burkina Faso, Guatemala, Kyrgyzstan, Malawi, Peru, Rwanda, Tanzania (n=9)	Gambia, Indonesia, Senegal, Zambia (n=4)	Ethiopia, Mauritania, Mozambique, Nepal (n=4)
2012–2014†	Kenya, Swaziland (n=2)	El Salvador, Lesotho (n=2)	Cameroon, DRC, Guinea-Bissau, Sierra Leone (n=4)	Cambodia, Chad, Congo, Liberia, Myanmar, Nigeria, Viet Nam (n=7)	Madagascar, Philippines, Togo, Yemen (n=4)
2015–2017‡	–	–	–	Sudan (n=1)	–

* Data not available for Lao PDR, Mali, Namibia, Niger, Uganda
† Data not available for Burundi, Comoros, Costa Rica, Côte d'Ivoire, Guinea, Haiti, Pakistan, Somalia, South Sudan, Sri Lanka, Tajikistan
‡ Data not available for Botswana, CAR, Gabon, PNG

STEP 6: Better nutrition contributes to the achievement of SDGs

List 8: Sustainable Development Goals that are linked to better nutrition

Population below international poverty line

MEAL Indicator 8.1 – Proportion of population below international poverty line disaggregated by sex, age group, employment status, and geographical location

SDG target 1.1 seeks to eradicate extreme poverty for all people everywhere. In 2013, an estimated 11% of the global population lived below the international poverty line of $1.90 a day.[72]

Data on the proportion of population living below the international poverty line were available for 58 SUN countries from the World Bank Poverty and Equity Database. The reference year ranged from 2003 to 2016, with 34 countries (58%) with data between 2012–2016.

On average, 32.1% (95% CI 26.1, 38.1) of the population lives below the international poverty line in SUN countries. This ranges widely from 1.6 to 77.8% (median 33.6) across countries and regions, as shown in Figure 8.1a.

Figure 8.1a
Population living below the poverty line by region and country income class

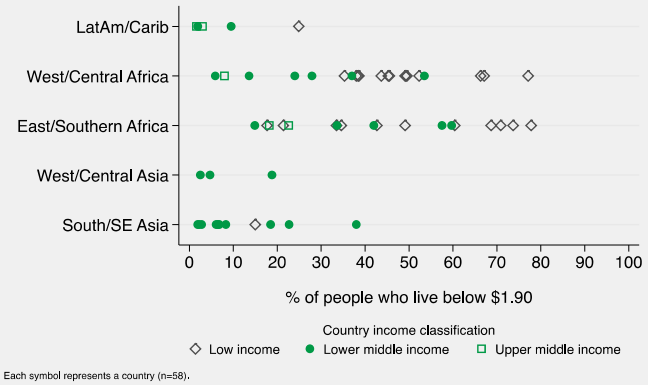


TABLE 116: COUNTRY GROUPING BY POVERTY LEVEL AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Proportion of population below poverty line (<$1.90 per day)			
	≥50%	35–49%	15–34%	<15%
2010–2011 (n=24)	Malawi, Mozambique, Rwanda, Zambia (n=4)	Benin, Burkina Faso, Gambia, Mali, Niger, Senegal, Tanzania (n=7)	Bangladesh, Ethiopia, Lao PDR, Namibia, Nepal, Uganda, Zimbabwe (n=7)	Ghana, Guatemala, Indonesia, Kyrgyzstan, Mauritania, Peru (n=6)
2012–2014 (n=29)†	Burundi, DRC, Guinea-Bissau, Lesotho, Madagascar, Nigeria, Sierra Leone, (n=7)	Chad, Congo, Guinea, Liberia, South Sudan, Swaziland, Togo (n=7)	Cameroon, Comoros, Côte d'Ivoire, Haiti, Kenya, Yemen (n=6)	Cambodia, Costa Rica, El Salvador, Myanmar, Pakistan, Philippines, Sri Lanka, Tajikistan, Viet Nam (n=9)
2015–2017 (n=5)	Central African Republic (n=1)	Papua New Guinea (n=1)	Botswana (n=1)	Gabon, Sudan (n=2)

† No data available for Somalia

[72] Sustainable Development Knowledge Platform, "Progress of Goal 1 in 2017". https://sustainabledevelopment.un.org/sdg1 [accessed 27 September 2017]

Under five mortality rate

MEAL Indicator 8.2 – Under five mortality rate (deaths per 1000 live births)

The mortality rate for children under 5 years of age globally was 43 deaths per 1,000 live births in 2015.[73] The SDG target 3.2 is to end preventable deaths of children under 5 years, with all countries aiming to reduce the under-five mortality rate to at least as low as 25 per 1000 live births by 2030.

Under-five mortality rates (deaths per 1000 live births) are available for all 59 SUN countries for the year 2016.[74]

The overall mean U5 mortality rate is 62.9 (95% CI 55.1, 70.7) and it ranges from 8.8 to 132.5 (median 58.8). Distribution of U5MR across regions is shown in Figure 8.2a. Country classification by levels of seriousness is shown in Table 117.

Figure 8.2a
Under-five mortality rate in 2016 by region and country income class

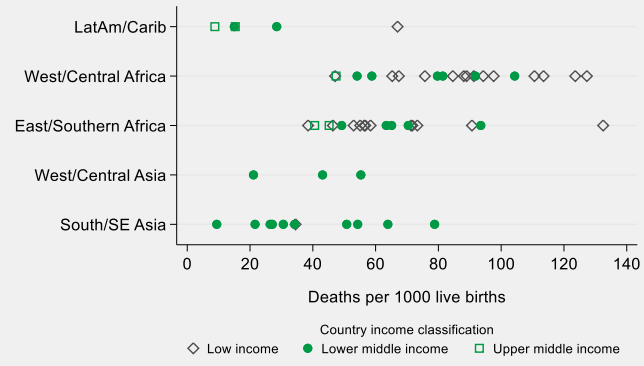


TABLE 117: COUNTRY GROUPING BY UNDER-FIVE MORTALITY RATE AND YEAR OF JOINING THE SUN MOVMENT

Year joined SUN Movement	Under-five mortality rate, 2016			
	≥100	70–99	40–69	<40
2010–2011 (n=24)	Mali (n=1)	Benin, Burkina Faso, Mauritania, Mozambique, Niger, (n=5)	Ethiopia, Gambia, Ghana, Lao PDR, Malawi, Namibia, Senegal, Tanzania, Uganda, Zambia, Zimbabwe (n=11)	Bangladesh, Guatemala, Indonesia, **Kyrgyzstan**, Nepal, **Peru**, Rwanda (n=7)
2012–2014 (n=30)	Chad, Nigeria, Sierra Leone, Somalia (n=4)	Burundi, Cameroon, Comoros, Côte d'Ivoire, DRC, Guinea, Guinea-Bissau, Lesotho, Pakistan, South Sudan, Swaziland, Togo (n=12)	Congo, Haiti, Kenya, Liberia, Madagascar, Myanmar, Tajikistan, Yemen (n=8)	Cambodia, Costa Rica, El Salvador, Philippines, Sri Lanka, Viet Nam (n=6)
2015–2017 (n=5)	Central African Republic (n=1)	–	Botswana, Gabon, Papua New Guinea, Sudan (n=4)	–

Countries in **bold** font have achieved the SDG target of <25 per 1000 live births.

[73] Sustainable Development Knowledge Platform, "Progress of Goal 3 in 2017". https://sustainabledevelopment.un.org/sdg3 [accessed 27 September 2017]

[74] Country-specific under-five mortality rate estimates generated by the UN Inter-agency Group for Child Mortality Estimation (UN IGME) in 2017 (last update 19 October 2017). Downloaded from http://data.unicef.org

Trends in the U5 mortality rate by sex for SUN countries are shown in the figures below. Figure 8.2b shows the progressive decrease over time for both male and female children between 2000 and 2016. Decreases over time have also been shown across country income levels, with the largest change in low-income countries (Figure 8.2c). As expected, U5 mortality rates are higher in high and very high humanitarian risk contexts (Figure 8.2d); however, there are encouraging signs of decreases over time in these countries as well.

Figure 8.2b
Under-five mortality rate by sex and year

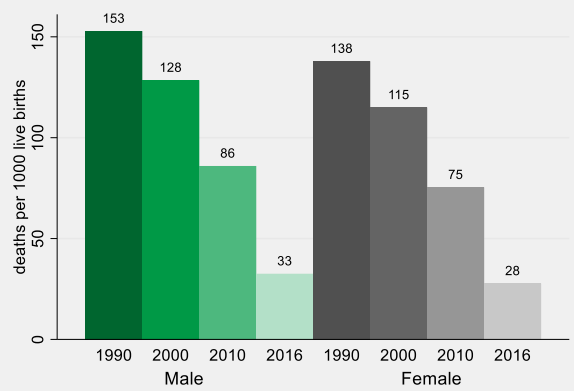


Figure 8.2c
Under-five mortality rate by sex, year and income status

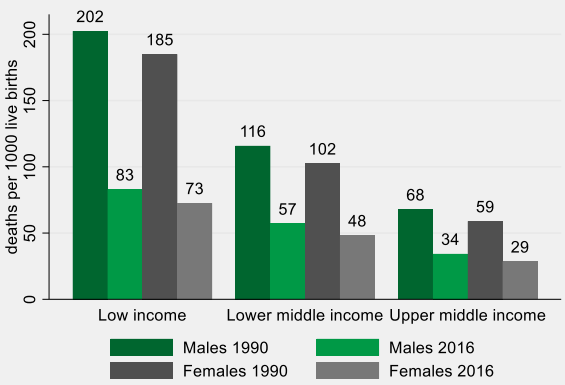
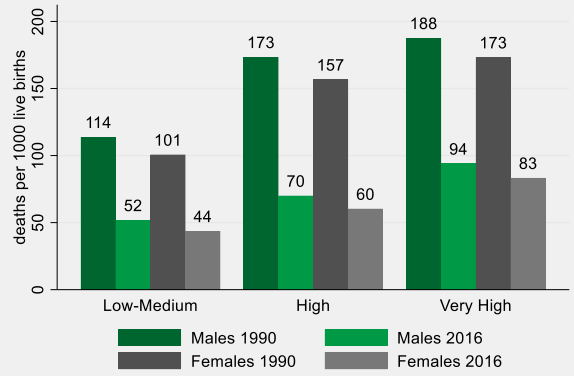


Figure 8.2d
Under-five mortality rate by sex, year and humanitarian risk class



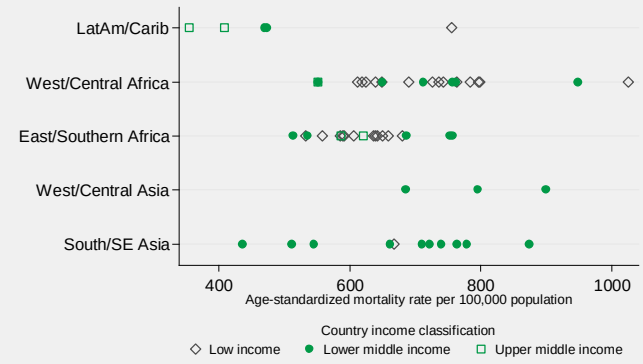
Mortality rate attributed to NCDs

MEAL Indicator 8.3 – Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory infections

SDG target 3.4 is to reduce by one third premature mortality from NCDs by 2030. In 2015, the risk of dying between 30 and 70 years of age from cardiovascular disease, cancer, chronic respiratory disease or diabetes was 19% globally.

Data on the mortality rate attributed to NCDs (cardiovascular disease, cancer, diabetes and chronic respiratory infections) are available for all 59 SUN countries from the Global Health Observatory, with estimates for years 2000, 2010 and 2015.

Figure 8.3a
Mortality rate attributed to NCDs in 2015 by region and country income class



In 2015, the average mortality rate attributed to NCDs for SUN countries was 665 (95% CI 632, 698) and ranged from 355 to 1026 (median 659). The regional average NCD mortality rate is highest in West/Central Asia (793) and West/Central Africa (721), lower in South/SE Asia (674) and East/Southern Africa (622), and lowest in Latin America/Caribbean region (493). Figure 8.3a shows the distribution in NCD mortality rates in SUN countries across regions. Country performance for this indicator is shown in Table 118.

TABLE 118: COUNTRY GROUPING BY NCD MORTALITY RATE AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	Mortality rate attributed to NCDs, 2015			
	>800	701–800	601–700	≤600
2010–2011 (n=24)	—	Benin, Burkina Faso, Gambia, Ghana, Indonesia, Kyrgyzstan, Lao PDR, Mali (n=8)	Malawi, Mauritania, Mozambique, Nepal, Niger, Rwanda, Senegal, Uganda (n=8)	Bangladesh, Ethiopia, Guatemala, Namibia, Peru, Tanzania, Zambia, Zimbabwe (n=8)
2012–2014 (n=30)	Côte d'Ivoire, Sierra Leone, Yemen (n=3)	Cameroon, Chad, Haiti, Myanmar, Nigeria, Pakistan, Philippines, Swaziland, Togo (n=9)	Burundi, Cambodia, Comoros, DRC, Guinea, Guinea-Bissau, Lesotho, Liberia, Madagascar, Tajikistan (n=10)	Congo, Costa Rica, El Salvador, Kenya, Somalia, South Sudan, Sri Lanka, Viet Nam (n=8)
2015–2017 (n=5)	Papua New Guinea (n=1)	Central African Republic, Sudan (n=2)	Botswana (n=1)	Gabon (n=1)

The mortality rate attributed to NCDs is consistently higher in males compared to females across all regions in 2015 (see Figure 8.3b). NCD mortality rates are similar between low income and middle-income countries, but lower in upper middle income countries (see Figure 8.3c); mortality rate decreases over time are observed in both males and females, regardless of country income classification.

Figure 8.3b
Mortality rate attributed to NCDs by sex and region

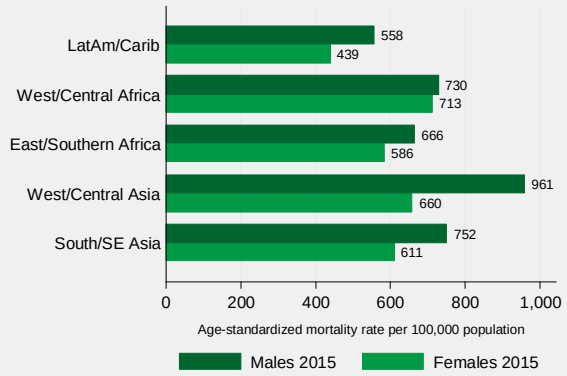
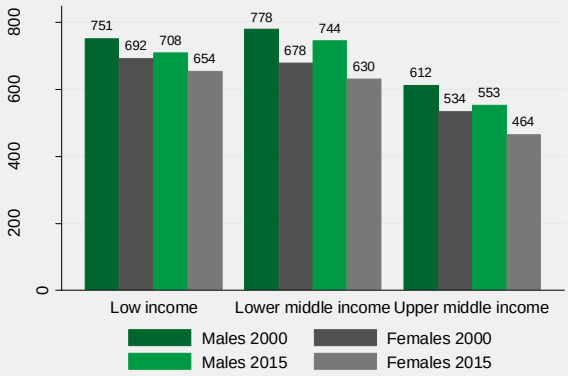


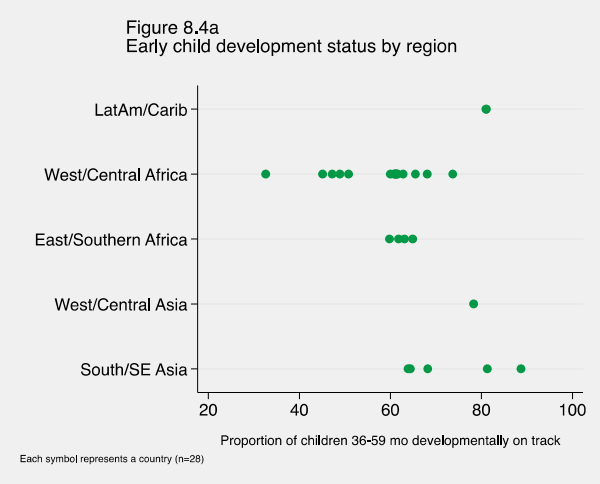
Figure 8.3c
Mortality rate attributed to NCDs by sex, year and income status



Early child development status

MEAL Indicator 8.4 – Proportion of children aged 36–59 months who are developmentally on track in at least three of the following domains: literacy-numeracy, physical development, social-emotional development and learning

SDG target 4.2 seeks to ensure that all girls and boys have access to quality early childhood development, care and pre-primary education. Data on early child development status are available for 28 SUN countries, with the reference year ranging from 2010 to 2016 (23 countries (82%) have data from 2012 or more recent). On average, in these countries, 63.5% of children 36–59 months are developmentally on track in at least three domains. Country estimates range from 32.6 to 88.7% (median 62.3%), with disparities evident across regions (Figure 8.4a) and country income levels (Figure 8.4b).



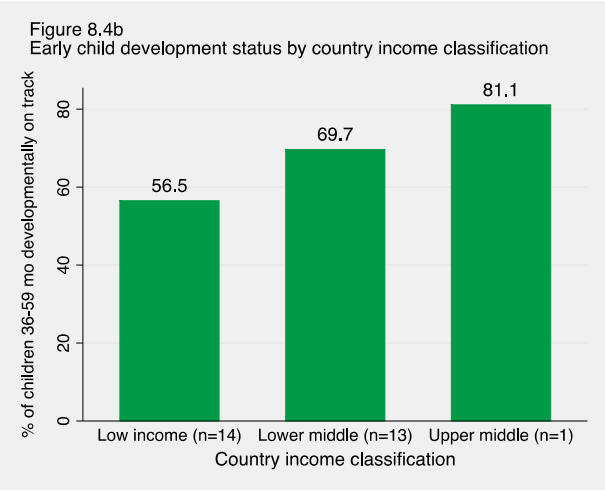


TABLE 119: COUNTRY GROUPING BY EARLY CHILD DEVELOPMENT STATUS AND YEAR OF JOINING THE SUN MOVEMENT

Year of SUN start	Proportion of children 35–59 mo who are developmentally on track in ≥3 domains			
	<60%	60–64%	65-74%	≥75%
2010–2011 (n=12)*	Malawi(n=1)	Bangladesh, Benin, Mali, Mauritania, Nepal, Rwanda, Zimbabwe (n=7)	Gambia, Ghana (n=2)	Kyrgyzstan, Lao PDR (n=2)
2012–2014 (n=15)†	Chad, Guinea, Sierra Leone, Togo (n=4)	Cameroon, Congo, Côte d'Ivoire, Guinea-Bissau, Nigeria, Swaziland (n=6)	Cambodia, DRC (n=2)	Costa Rica, El Salvador, Viet Nam (n=3)
2015–2017 (n=1)‡	Central African Republic (n=1)	–	–	–

* No data for Burkina Faso, Ethiopia, Guatemala, Indonesia, Mozambique, Namibia, Niger, Peru, Senegal, Tanzania, Uganda, Zambia
† No data for Burundi, Comoros, Haiti, Kenya, Lesotho, Liberia, Madagascar, Myanmar, Pakistan, Philippines, Somalia, South Sudan, Sri Lanka, Tajikistan, Yemen
‡ No data for Botswana, Gabon, Papua New Guinea, Sudan

GDP per capita growth

MEAL Indicator 8.5 – Annual growth rate of real GDP per capita

SDG target 8.1 seeks to sustain per capita economic growth in accordance with national circumstances and, in particular, at least 7% gross domestic product (GDP) growth per annum in the least developed countries. Data on the annual growth rate of GDP are available for 57 SUN countries, with data for the years 1990, 2000, 2010, 2015 and 2016.

In 2016, the average annual growth rate of real GDP per capita was 3.6% (95% CI 2.7, 4.5) for these SUN countries. The 2016 growth rate ranged from -9.8 to 8.3% (median 4.3), as shown in Figure 8.5a. Four SUN countries had at least 7% GDP growth per annum in 2016. Trends in growth rates between 1990 and 2016 are shown in Figure 8.5b, showing the higher growth rate in 2016 compared to 2015, especially in low-income countries.

Figure 8.5a
GDP per capita growth in 2016 by region and country income class

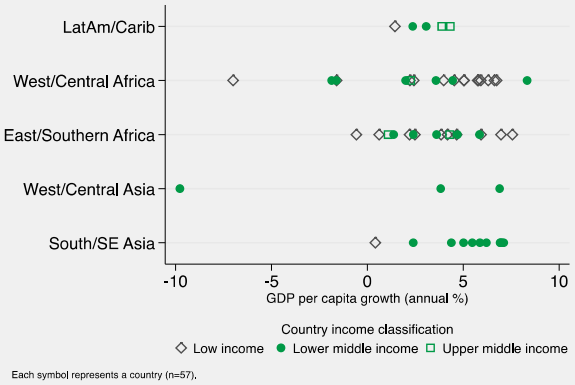


Figure 8.5b
GDP per capita growth by year and country income classification

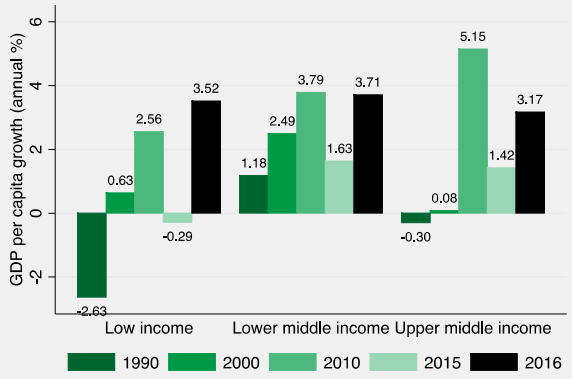


TABLE 120: COUNTRY GROUPING BY GDP PER CAPITA ANNUAL GROWTH RATE AND YEAR OF JOINING THE SUN MOVEMENT

Year joined SUN Movement	GDP per capita growth, 2015 (annual %)			
	≤0	0–3.4	3.5-6.9	≥7.0
2010–2011 (n=24)	–	Gambia, Guatemala, Malawi, Mauritania, Namibia, Nepal, Zimbabwe (n=7)	Benin, Burkina Faso, Ghana, Indonesia, Kyrgyzstan, Mali, Mozambique, Niger, Peru, Rwanda, Senegal, Tanzania, Uganda, Zambia (n=14)	Bangladesh, Ethiopia, Lao PDR (n=3)
2012–2014 (n=28)†	Burundi, Chad, Congo, Liberia, Nigeria, Yemen (n=6)	Comoros, DRC, El Salvador, Haiti, Lesotho, Swaziland (n=6)	Cambodia, Cameroon, Costa Rica, Guinea, Guinea-Bissau, Kenya, Madagascar, Myanmar, Pakistan, Philippines, Sierra Leone, Sri Lanka, Tajikistan, Togo, Viet Nam (n=15)	Côte d'Ivoire (n=1)
2015–2017 (n=5)	–	Gabon, Papua New Guinea (n=2)	Central African Republic, Sudan (n=3)	–

† No data available for Somalia, South Sudan.

SUMMARY OF FINDINGS

Data availability

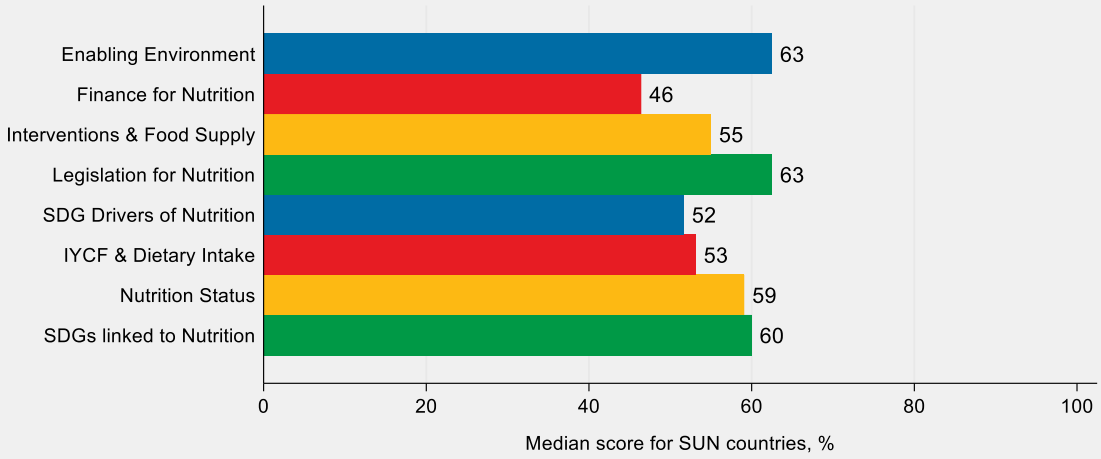
We have a solid basis for the analysis and interpretation of the progress across the SUN Movement countries – 54/59 (92%) of countries have data available for at least 80% of the 79 MEAL system indicators presented in this report, two countries have data for at least 70% and three countries have data for fewer than 70% (of which two are new members and two are conflict-affected countries). Most data gaps are found in the finance domain and for nutrition-specific indicators including nutrition counseling, SAM treatment and adult dietary intake.

Key findings from the analysis on performance across SUN countries

Analysis of SUN country performance overall was calculated using the complete set of MEAL indicators (n=79) and combines data availability with the relative score along the continuum of achievement for each indicator. For example, a country with high intervention coverage would score higher than a country with low coverage and a country with missing data would score zero for that specific indicator. The following section compares the median of these country performance scores across domains and country characteristics.

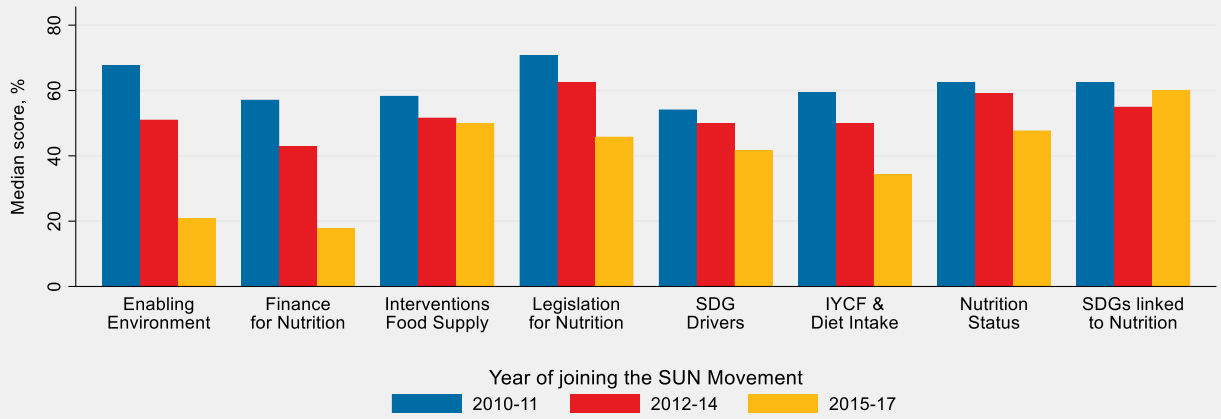
As shown in Figure S1 below, the median performance score across SUN countries was relatively similar across the eight lists of indicators, with the lowest levels of performance on Finance for Nutrition (List 2) and highest performance on the Enabling Environment (List 1) and Legislation for Nutrition (List 4).

Figure S1
Summary of SUN country median scores across MEAL Framework Lists of Indicators



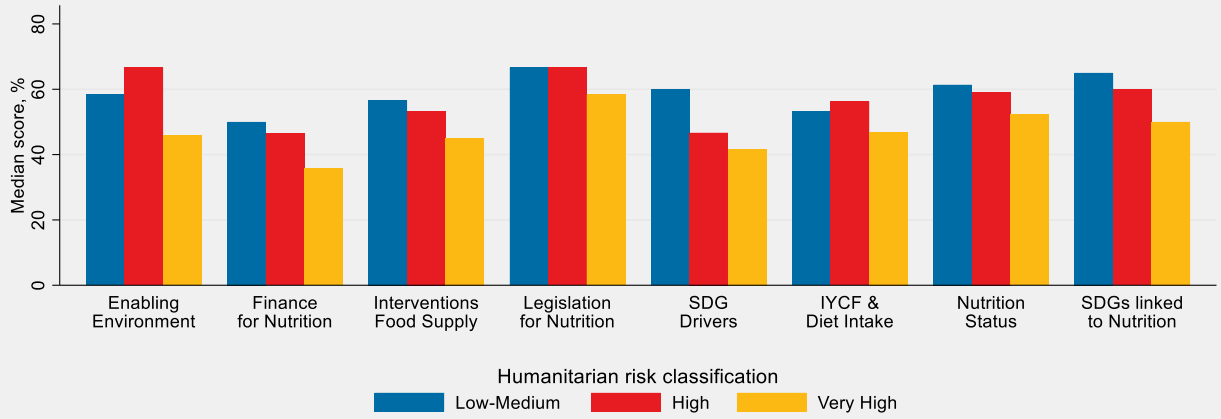
Countries that joined the SUN Movement early (in 2010-2011) consistently show higher performance in all domains than countries that joined later. The largest gaps between the oldest and newest SUN countries are on the enabling environment, finance for nutrition, legislation for nutrition, and IYCF and dietary intake domains (Figure S2). Improved performance is not necessarily driven by SUN; it could simply be that better performing countries decided to join SUN early. Nevertheless, it signals the need for late joiners to learn from early joiners and for the networks to help new joiners quickly find their feet.

Figure S2
SUN country median scores across MEAL Framework Lists of Indicators by year of joining the SUN Movement



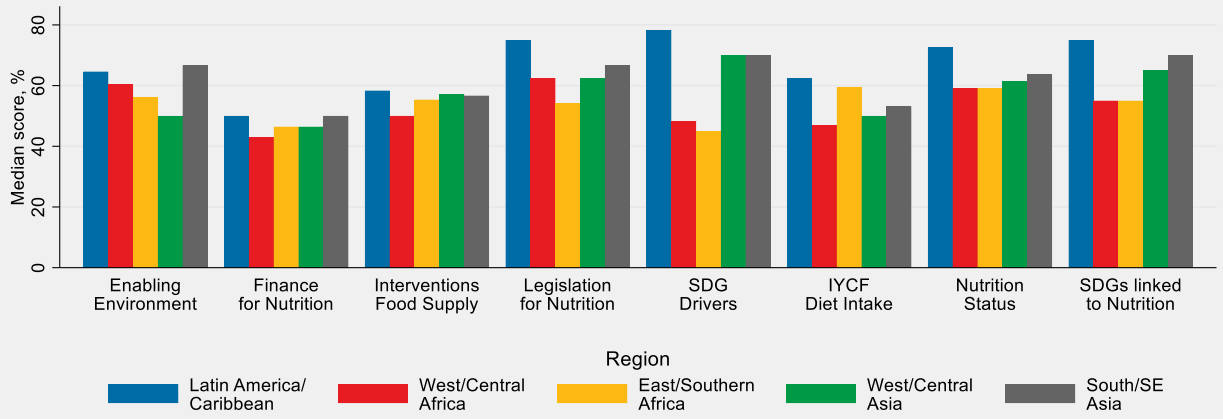
Countries with very high humanitarian risk have significantly lower median scores in all domains than countries classified with high and low-medium humanitarian risk. The largest gaps are on the enabling environment and on SDGs that are drivers of or influenced by good nutrition (Figure S3).

Figure S3
SUN country median scores across MEAL Framework Lists of Indicators by humanitarian risk level



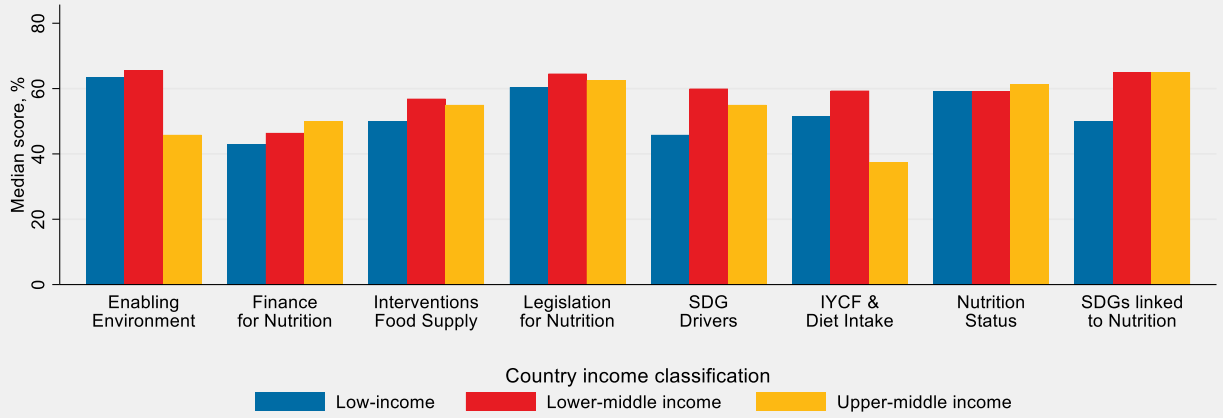
An analysis of country performance by region and by income classification shows mixed progress. Countries in Latin America are performing relatively better across all eight domains while countries in West and Central Africa show a slower pace of progress, especially in finance, interventions and food supply, and IYCF and dietary intake (Figure S4).

Figure S4
SUN country median scores across MEAL Framework Lists of Indicators by region



Lower- and upper-middle income countries perform better overall than low-income countries, but low-income countries are doing comparatively well in the enabling environment, legislation for nutrition, IYCF and dietary intake, and nutrition status domains (Figure S5).

Figure S5
SUN country median scores across MEAL Framework Lists of Indicators by country income classification



Implications of Key Findings for the SUN Movement

IMPLICATIONS FOR COUNTRY ENGAGEMENT:

1. **Provide extra opportunities for learning and technical assistance** to countries that have joined the SUN movement since 2015 so that they establish positive enabling environments and analyze their finance for nutrition.
2. **Give greater priority to countries with very high humanitarian risk** to bridge the current humanitarian/development divide and create an enabling environment for nutrition.
3. **Increase support for accelerated progress in West and Central Africa** through greater access to country-to-country learning and Francophone technical assistance.
4. **Actively engage countries that are performing well across all domains to help countries that have not been moving so quickly.** Incentivize peer-to-peer exchanges and ensure that all participants are enabled to attend learning events.

IMPLICATIONS FOR ACTIONS:

5. **Create an enabling environment to address all forms of malnutrition.** The enabling environment in the SUN Movement is mostly geared towards addressing undernutrition. The majority of SUN countries have yet to include targets for diet-related Non-Communicable Diseases in their nutrition plans, national development plans and economic growth strategies.
6. **Give greater focus to the 1000 Days window of opportunity.** Nutrition and health interventions targeted to young children and mothers reach less than half of their intended beneficiaries with the exception of Vitamin A supplementation, iodized salt and vaccination. Most SUN countries have insufficient funding allocated to effectively scale up nutrition-specific interventions.
7. **Give greater focus to women and adolescent girls.** Compared with global estimates[75], SUN countries are performing significantly worse in female secondary school enrolment, early marriage, adolescent fertility and meeting family planning needs. Early marriage is markedly higher in very-high humanitarian risk countries. Women in SUN countries have high levels of undernutrition, including anaemia, and are disproportionally affected by overweight and obesity compared to men.
8. **Optimize the delivery of high-impact nutrition actions through a range of platforms that go beyond the health sector.** SUN countries are investing significantly in the supply of drinking water and sanitation facilities, expansion of social protection programmes and strengthening of food systems. However, the MEAL baseline findings show that these investments are not yet yielding visible improvements when it comes to the use of sanitation and hygiene facilities, appropriate complementary feeding practices for young children and adult dietary intakes, including consumption of fortified staple foods, fruits and vegetables.

[75] Global estimates are based on countries with data derived from the 2017 Global Nutrition Report available from http://www.globalnutritionreport.org

Next Steps in the development of the MEAL system

1. Engage SUN countries in the use of the Country Dashboards for setting priorities and guiding actions.
2. Perform focused analysis on six specific pathways:
    a. 1000 Days window of opportunity for the prevention of child stunting and wasting.
    b. Adolescent girls and women.
    c. Sustainable Development Goals as makers and markers of nutrition.
    d. Hidden hunger (micronutrient deficiencies).
    e. Overweight, obesity and diet-related Non-Communicable Diseases.
    f. Countries with high and very high humanitarian risk levels.
3. Perform in-depth analyses on selected countries performing at different levels across all domains to evaluate the SUN Movement added value.
4. Build links between the Monitoring and Evaluation components and the Accountability and Learning components of the SUN Movement MEAL system. In particular strengthen country capacity to be able to monitor and evaluate progress on the MEAL indicators going forward.

SUN Movement Monitoring, Evaluation, Accountability, Learning (MEAL)

BASELINE REPORT APPENDICES

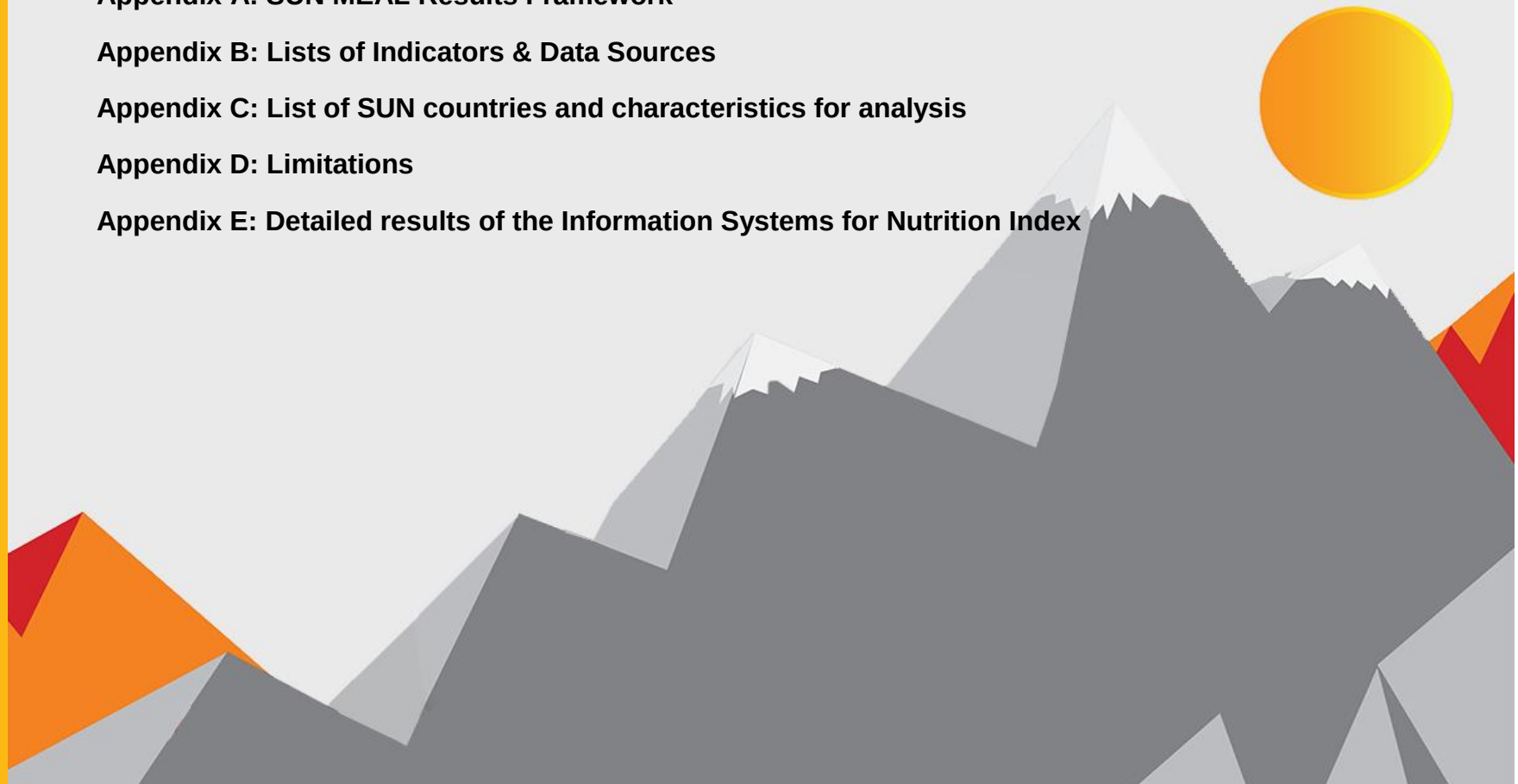
Appendix A: SUN MEAL Results Framework

Appendix B: Lists of Indicators & Data Sources

Appendix C: List of SUN countries and characteristics for analysis

Appendix D: Limitations

Appendix E: Detailed results of the Information Systems for Nutrition Index



APPENDIX A

SUN Meal Results Framework (Country Level – Baseline 2016)

Theory of Change	Types of results	Sustainable Development Goals or specific Targets	Detailed list of indicators and tools	Added value of the SUN Movement Global Support System
STEP 1: Multiple stakeholders from different sectors come together to tackle malnutrition and build an enabling environment for improving nutrition with equity.	• Existence and composition of Multi-Stakeholder Platforms (MSP)		Reference list of indicators (List 1) Part of Joint Annual Assessment (JAA)	• Support countries in their efforts to strengthen their multi-stakeholder platforms. • Support countries in their efforts to strengthen their networks. • Support in-country partners to understand the principles of engagement, set the rules for good partnership and get clarity on how to prevent, identify and manage conflicts of interests.
	• Existence, composition and functionality of networks/alliances (UN agencies, CSOs, business, donors, academia)		Reference list of indicators (List 1) On functionality Reference List specific to each SUN Network	
STEP 2: Multiple stakeholders from different sectors change their behaviours and commit to achieving common nutrition results for everyone, everywhere.	• Progress in the four SUN Movement processes and related progress markers and evidence		Reference list of indicators (List 1) Part of JAA	• Support peer-to-peer learning across countries. • Support countries to review the added value and effectiveness of their multi-stakeholder platforms. • Support countries in the development of their national 2030 agenda. • Support countries to scale up their advocacy and communication efforts. • Engage country champions in key campaigning, advocacy and accountability moments and opportunities. • Support countries by matching their requests for external assistance with global networks and providers. • Support countries to review the quality of their national multi-sectoral, multi-stakeholder action plans / common results framework.
	• Existence of information systems for nutrition		Reference list of indicators (List 1) Mapping done (2016)	
	• Capacity of Multi-Stakeholder Platforms to coordinate their partners response to identified annual priority action areas in the Joint-Annual Assessments		*Forthcoming* Part of JAA (2017)	
	• Compliance of partners with the SUN Movement Principles Engagement Guidance)	SDG 17	*Forthcoming* Part of JAA (2017)	
	• Integration of nutrition in the development plans/2030 Agenda and in new sectoral policies including risk reduction strategies made since the beginning of 2016	SDG 1; SDG 2; SDG 3; SDG 4; SDG 5; SDG 6; SDG 7; SDG 8; SDG 10; SDG 11; SDG 12; SDG 13; SDG 14; SDG 15; SDG 16	Reference list of indicators (List 1) Part of UN Network reporting from 2018	

Theory of Change	Types of results	Sustainable Development Goals or specific Targets	Detailed list of indicators and tools	Added value of the SUN Movement <u>Global</u> Support System
	• 'Good' quality of *new* national multi-sectoral, multi-stakeholder action plans / common results framework made since the beginning of 2016		*Forthcoming* Quality checklist and reference tools	• Support countries to assess the level of integration of nutrition in national development plans and sectoral policies.
	• Mobilization of high-level advocates (champions, parliamentarians, media)		Reference list of indicators (List 1) Part of JAA (2017)	
	• SMART-ness of nutrition commitments by Governments and networks / alliances (CSO, business, UN system, donors) made since the beginning of 2016		Part of JAA (2017) Reference ICN FFA Partnership Book	
STEP 3: Multiple-stakeholders mobilize resources and align implementation to optimize coverage and effectiveness of their actions	• Changes in spending for nutrition • Reduced gap in the financing of evidence-based high-impact nutrition interventions	SDG 1.a; SDG 2.a.1; SDG 10.b;	Reference list of indicators (List 2)	• Address global data priorities including developing methods for data disaggregation and coverage of various population groups. • Support countries to build systems to analyze and use data from multiple sources. • Contribute to monitoring SDGs that are driving nutrition impact in key sectors. • Support developing global reference guidance to address emerging issues (e.g. double duty actions) • Facilitate access to global funding sources. • Support countries to scale up their planned actions by matching their requests for external assistance with global networks and providers. • Support peer-to-peer learning across countries. • Support countries to review evidence on the implementation of high impact actions • Increase visibility of countries' lessons and experience in global advocacy and communication efforts.
	• Increased coverage of services for nutrition • Increased diversity and quality of food supply • Geographic distribution of nationally agreed core actions and of implementation capacity for nutrition	SDG 3.C.1; SDG 3.7; SDG 3.8; SDG 1.3; SDG 6b	Reference list of indicators (List 3)	
STEP 4: Results are achieved through aligned implementation in a far greater way than what could have been achieved by each stakeholder on its own	• Progress in the implementation of legislations for nutrition		Reference list of indicators (List 4)	
	• Changes in key drivers of nutrition, which are embedded in relevant sectors such as health, WASH, food systems, education, social protection and gender	SDG 2.1; SDG 3.3; SDG 3.7; SDG 4.5: SDG 5.3; SDG 6.1; SDG 6.2; SDG 7.1; SDG 10.1; SDG 11.1; SDG 16.2	Reference list of indicators (List 5)	
	• Improved Infant and Young Child feeding practices. • Improved dietary intake among various population groups.	1 WHA nutrition target 1 NCD-diet related target	Reference list of indicators (List 6)	

Theory of Change	Types of results	Sustainable Development Goals or specific Targets	Detailed list of indicators and tools	Added value of the SUN Movement Global Support System
STEP 5: Women, children, adolescents and families thrive leading to the end of malnutrition by 2030 (SDG 2.2).	• Progress towards WHA global nutrition targets • Progress towards NCD diet-related targets. • Progress towards established national level nutrition targets • Improved nutrition status indicators	SDG 2.2 5 WHA nutrition targets. 3 NCD diet-related targets	Reference list of indicators (List 7)	• Strengthen data and evidence on how multiple forms of malnutrition manifest in SUN countries. • Support countries to set SMART nutrition targets and incorporate them in national and sub-national plans.
STEP 6: Better nutrition contributes to the achievement of SDGs.	• Reduced mortality • Increased cognitive ability and school attainment • Increased economic productivity as measured by GDP per capita and reduced extreme poverty • Women's full and effective participation and equal opportunities for leadership	SDG 3.1; 3.2; SDG 3.4; SDG 4.2; SDG 4.1; SDG 8.1; SDG 1.1 and SDG 1.2 SDG 5.5	Reference list of indicators (List 8)	• Strengthen data and evidence on how nutrition contributes to key Sustainable Development Goals. • Strengthen advocacy and communication on the importance of nutrition for the achievement of SDGs

SUN Meal Results Framework (Global Support System Level – *Forthcoming with Accountability*)

Theory of Change	Types of results	Reference	Types of analysis	Types of data & information sources
Responsive, predictable and innovative Global Support System for translating SUN country ambitions into results and impacts.	• Response capacity to requests from SUN countries as recorded by SMS and SUN Networks.	Joint Annual Assessment priority list	• Response capacity to countries' requests by type of client (SUN Government Focal Points, companies, CSO, UN agency and donor) with attention to time lag, coverage, TA quality satisfaction and Value for Money. • Gap analysis to update priorities identified in the 2016-2017 Roadmap. • Segmentation analysis (looking at new/old SUN countries, over/under served countries, fragile and conflict affect countries, etc.) • Analysis of verified public references, articles, blogs and other types of media work	• SMS tracking database. • SUN Network annual reports. • Minutes from Lead Group meetings. • Minutes from Executive Committee meetings. • SUN Movement Annual Progress Reports. • SUN Movement Secretariat Annual Activity Reports. • Technical providers' reports. • SUN Government Focal Point end-of-service satisfaction surveys. • Online verification of public references, articles, blogs • Reports from Lead Group staff
	• Response capacity by SUN Networks and Working Groups to deliver on priorities identified in the 2016-2017 Roadmap.	Priorities from the 2016-2020 Roadmap		
	• Percentage of Lead Group members actively championing nutrition	2016 Lead Group Engagement Strategy		
	• Response capacity by the SUN Executive Committee to provide guidance, unlock opportunities and address challenges.	To be defined		
	• Effectiveness of global partnerships between the SUN Movement and other initiatives (e.g. EWEC, SAW, ECDAN, etc.) including capacity to respond to countries' requests and to address priorities identified in the 2016-2017 Roadmap	Global partnerships MoU JAA priority list Priorities from the 2016-2020 Roadmap		
	• Compliance of global actors with the SUN Movement principles	SUN Movement Principles Engagement Guidance		
	• Functioning of a feedback and complaints mechanism to address partnership challenges and to manage conflicts of interests	SUN Movement Principles Reference Note and Toolkit on Engaging in the SUN Movement Partnership Playbook "Together for the 2030 Agenda"		

APPENDIX B: LISTS OF INDICATORS AND DATA SOURCES

List 1: Enabling Environment for Nutrition

MEAL Indicator Description	Definition	Data Source(s)	Coverage for SUN Countries (n/%)
1.1 Existence and composition of Multi-Stakeholder Platforms (MSP)	Proportion of countries report having a functioning MSP mechanism	SUN Movement Secretariat	56/93%
1.2 Existence, composition and functionality of networks/alliances (UN agencies, CSOs, business)	Number and type of networks in place	SUN Networks	56/97%
a. UN Network Functionality Index	Country networks scored on the basis of 6 indicators of minimum elements needed for optimal functionality.	UN Network	57/97%
b. SUN Business Network Functionality Index	Country networks scored on the basis of 5 indicators of minimum elements needed for optimal functionality.	SUN Business Network	57/97%
c. SUN Civil Society Network Functionality Index	Country networks scored on the basis of # indicators of minimum elements needed for optimal functionality.	SUN Civil Society Network	57/97%
1.3 Progress in the four SUN Movement processes and related progress markers and evidence	Average total weighted score for each process and overall	SUN Joint Annual Assessment, 2014, 2015, 2016	51/86%
1.4 Existence of WHA targets in nutrition plans[76]	Availability of the 6 WHA targets in plans (U5 child stunting, U5 child wasting, U5 child overweight, low-birth weight, anaemia among women of reproductive age and exclusive breastfeeding for the first six months)	SUN Movement Secretariat & Nutrition International	44/75%
1.5 Existence of NCD targets in nutrition plans	Availability of the 3 nutrition-related NCD targets in plans (overweight/obesity in adults, diabetes, salt intake)	SUN Movement Secretariat & Nutrition International	44/75%

[76] The indicators 1.5 and 1.6 are assessed separately for this Baseline. Included nutrition plans have been reviewed as part of the mapping conducted in 2016. From 2017 onwards, this indicator will be part of the systematic review of the nutrition action plans using the quality checklist.

MEAL Indicator Description	Definition	Data Source(s)	Coverage for SUN Countries (n/%)
1.6 Existence of information systems for nutrition	Each country's Information systems for nutrition index score is based on three groups of indicators: a) government commitment & enabling environment; b) national assessment data; c) national performance monitoring data. Maximum score of 36.	SUN Movement Secretariat & Nutrition International. In 2016, mapping research was undertaken to systematically assess the state of information systems for nutrition across SUN Countries. http://scalingupnutrition.org/share-learn/planning-and-implementation/information-systems-for-nutrition/	59/100%
1.7 Integration of under nutrition in national development plans and economic growth strategies[77]	The indicator assesses to what extent undernutrition and overnutrition features in key multiyear national development and economic growth strategies such as Five-Year Plans, Poverty Reduction Strategy papers, Vision 2020/2030 documents, and so forth. Rank 1–126 for undernutrition and rank 1–116 for overnutrition. 1 is the highest rank of 116 and 126 countries with total of search terms counted divided by number of pages in policy document.	Institute of Development Studies (IDS) 2015. IDS conducted the research for 81 countries on undernutrition, and data for the remaining 45 countries were obtained from: te Lintelo, D. J., L. I. Haddad, R. Lakshman, and K. Gatellier. 2013. The Hunger and Nutrition Commitment Index (HANCI 2012): Measuring the Political Commitment to Reduce Hunger and Undernutrition in Developing Countries. Evidence Report 25. Brighton: IDS. IDS conducted the research for the 116 countries on overnutrition.	56/95%
1.8 Integration of over nutrition in national development plans and economic growth strategies[2]			
1.9 Mobilization of high-level advocates (champions, parliamentarians, media)	Engagement of parliamentarians and media and identification of nutrition champions	SUN Joint Annual Assessment	58/98%
TOTAL: 12 indicators			

[77] This indicator is assessed separately for this Baseline and is based on a study conducted by IDS on all available development plans up to 2015. From 2018 onwards, all plans developed since 2016 will be systematically reviewed by the UN Network for Nutrition (TBC)

List 2: Finance for nutrition

MEAL Indicator Description	Definition	Data Source(s)	Coverage for SUN Countries (n/%)
2.1 National budget spending for nutrition		SUN Movement (based on national budget analysis)	42/71%
a. Budget analysis completeness	A budget analysis is considered complete if it was done + has identified nutrition specific and nutrition sensitive spending + has identified sources of funding + has more than one point in time data		42/71%
b. Budget spending per child U5 for nutrition-specific	The per capita spending is based on the total spending for nutrition-specific divided by the U5 population of the given year		32/54%
c. Percentage budgeted for nutrition-specific spending	Gives the percentage budgeted for nutrition-specific spending out of the total amount identified for nutrition		32/54%
2.2 Donor funding for nutrition (only CRS basic code for nutrition)		OECD (2015 data) InvestininNutrition.org	58/98%
a. Donor spending per stunted child U5 for nutrition	The per capita spending per stunted child is based on the total spending for nutrition (in the CRS basic code) divided by the stunted U5 population based on the stunting prevalence rate in a given year.		58/98%
b. Donor spending per child U5 for high impact interventions	a. The per capita spending is based on the spending for high-impact nutrition interventions by the U5 population of the given year		58/98%
c. Percentage budgeted for nutrition-specific spending	Gives the percentage of nutrition-specific spending out of the total amount identified for nutrition		58/98%
2.3 The agriculture orientation index for government expenditures	Calculated as the ratio of Agriculture Share of Government Expenditures to the Agriculture Share of GDP, where Agriculture refers to the agriculture, forestry, fishing and hunting sector.	SDG Indicators Global Database https://unstats.un.org/sdgs/indicators/database/?indicator=2.a.1	37/63%
TOTAL: 7 indicators			

Note: Costed nutrition high-impact interventions in the Investment Framework for Nutrition include: IYCF counseling, Vitamin A supplementation, SAM treatment, Iron-Folic Acid supplementation, Salt iodization, Food Fortification, maternal micronutrient supplements, provision of complementary food supplements for children 6–23 months living under poverty line, Zinc supplementation

List 3: Interventions and food supply

MEAL Indicator Description	Definition	Data Source(s)	Coverage for SUN Countries (n/%)
3.1 Proportion of health facilities that are Baby Friendly Hospital Initiative (BFHI) certified	Proportion of hospitals and maternity facilities that are designated as a "Baby Friendly" institution	UNICEF NutriDash, PAHO, IBFAN WBTi report	35/59%
3.2 Proportion of children 6–59 months with severe acute malnutrition admitted for treatment	Severe acute malnutrition geographical coverage (from GNR 2015 database)	UNICEF/Coverage Monitoring Network/ACF International. 2012. The State of Global SAM Management Coverage 2012. New York and London.	38/64%
3.3 Proportion of children 6–59 months receiving Vitamin A supplementation	Proportion of 6- to 59-month-olds receiving two high-dose vitamin A supplements in 2015	UNICEF Global Database, October 2017, based on administrative reports from countries. Available from http://data.unicef.org/nutrition/vitamin-a.html	47/80%
3.4 Proportion of pregnant women receiving Iron and Folic Acid supplementation	Percentage of women with a birth in the five years preceding the survey who took iron tablets or syrup (none/ for <60 days to 90+ days/for 90+ days); does not include folic acid	ICF International, 2016. The DHS Program STATcompiler. http://www.statcompiler.com	45/76%
3.5 Number of trained nutrition professionals /100,000 population	Density for each of: • Physicians (includes generalist and specialist medical practitioners) • Nurses (Includes nursing and nursing associate professionals, midwifery and midwifery associate professionals. Does not include traditional midwives)[78]	WHO Global Health Observatory Data Repository 2016. Available from http://apps.who.int/gho/data/node.main.A1444?lang=en	57/97%
3.6 Percentage of households that have iodized salt (>0 ppm)	Percentage of surveyed households which have salt they used for cooking that tested positive (>0ppm) for presence of iodine	UNICEF, Division of Data Research and Policy (2018). UNICEF Global Databases: Percentage of households consuming iodized salt (>0pmm) among all tested households, New York, January 2018. http://data.unicef.org/nutrition/iodine.html	56/95%
3.7 Proportion of children under 5 years old with diarrhea (in last two weeks) receiving oral rehydration salts (ORS) and Zinc	Percentage of children under 5 with diarrhea receiving oral rehydration salts (ORS packets or pre-packaged ORS fluids) and Zinc	UNICEF, Division of Data Research and Policy (2018). UNICEF Global Databases: Diarrhoea treatment: Children with diarrhoea who were given ORS and Zinc, New York, February 2018. (based on MICS, DHS and other national surveys) https://data.unicef.org/topic/child-health/diarrhoeal-disease/	51/86%

[78] Note: data also available for some countries on Community and traditional health workers (Includes community health officers, community health-education workers, family health workers, traditional and complementary medicine practitioners, traditional midwives and related occupations) but this was not captured in the MEAL key indicator due to lower data availability.

MEAL Indicator Description	Definition	Data Source(s)	Coverage for SUN Countries (n/%)
3.8 Proportion of children aged 12–59 months receiving at least one dose of de-worming medication	Percentage of children age 6–59 months given deworming medication in the six months preceding the survey	ICF International, 2016. The DHS Program STATcompiler. http://www.statcompiler.com	47/80%
3.9 Use of insecticide treated nets in children aged 0–5 years	Percentage of children under age 5 who slept under an insecticide-treated mosquito net the night prior to the survey.	UNICEF, Division of Data Research and Policy (2018). UNICEF Global Databases: Malaria: Children under 5 sleeping under an insecticide treated net (ITN) – Percentage, New York, February 2018. (based on MICS, DHS and other national surveys) http://data.unicef.org/topic/child-health/malaria/	46/78%
3.10 Percentage of 1-year-olds who have received the appropriate doses of the recommended vaccines in the national schedule by recommended age	Percentage of surviving infants who received the third dose of DTP containing vaccine (Note: DTP3 coverage is often used as an indicator of how well countries are providing routine immunization services.)	WHO and UNICEF estimates of national routine immunization coverage, 2016 revision (completed July 2017). http://data.unicef.org/child-health/immunization	59/100%
3.11 Proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods	Percentage of women of reproductive age (15–49 years) who are sexually active and who have their need for family planning satisfied with modern methods.	United Nations, Department of Economic and Social Affairs, Population Division (2017). World Contraceptive Use 2017 (POP/DB/CP/Rev2017).	58/98%
3.12 Percentage of calories from non-staples in food supply	Share of dietary energy supply derived from non-staples (%) (3-year average, 2011-2013); staples include cereals, roots and tubers	FAOSTAT data for 2012	53/90%
3.13 Availability of fruits and vegetables (grams)	Total amount of fruit and vegetables and derived products (in grams) available for human consumption during the reference period (expressed in per capita terms)	FAOSTAT data for 2013	53/90%
3.14 Fortified Food Supply	Fortification status of fortifiable food vehicles (including salt, vegetable oil, wheat flour, maize flour, rice, sugar, fish/soy sauce) are classified (sustain, improve, build/expand or N/A) based on information about coverage and compliance.	FFI, GAIN, IGN, MN Forum.	58/98%
3.15 Proportion of the population covered by social protection floors/systems disaggregated by sex, and distinguishing children, the unemployed, the elderly, persons with disabilities, pregnant women, new born, work injury victims, the poor and vulnerable	% of population participating in social protection and labor programs (includes direct and indirect beneficiaries).	World Bank (2017) The Atlas of Social Protection: Indicators of Resilience and Equity (ASPIRE)	41/69%
TOTAL: 15 indicators			

List 4: Enacted legislations

MEAL Indicator Description	Definition	Data Source(s)	Coverage for SUN Countries (n/%)
4.1 Country has legislation /regulations fully implementing the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22) and subsequent relevant resolutions adopted by the World Health Assembly	Legal status of the Code in each country	WHO, UNICEF, IBFAN (2016). Marketing of Breast-milk Substitutes: National Implementation of the International Code, Status Report 2016. Geneva: WHO	58/98%
4.2 Country has maternity protection laws or regulations in place in line with the ILO Maternity Protection Convention, 2000 (No. 183) and Recommendation No. 191	Country has ratified International Labor Organization Convention 183 or has passed national legislation in compliance with the three key provisions of the convention (14 weeks of maternity leave, paid at 66% of previous earnings by social security or general revenue). Country has provision for daily nursing breaks on return to work, or a reduction of working time with pay to breastfeed or express breastmilk. Country has provision mandating employers to provide nursing or childcare facilities at or near their workplaces or a reimbursement of childcare costs.	International Labour Organization (ILO), as reported by GNR 2017	56/95%
4.3 Country has legislation on the Constitutional Right to Food	Assessed level of constitutional protection of the right to food (high, medium-high, medium, low)	Food and Agriculture Corporate Document Repository 2003. Recognition of the right to food at the national level. Available from http://www.fao.org/docrep/MEETING/007 /J0574E.HTM#P75_9766	44/75%
4.4 Country has policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, *trans*-fatty acids, free sugars, or salt	Based on Member State responses to the 2017 NCD Country Capacity Survey – considered fully achieved if the country responds “Yes” to the question “Is your country implementing any policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars, or salt?”, and provides supporting documentation.	WHO (2017). Noncommunicable Diseases Progress Monitor, 2017. Geneva: WHO. Available from http://apps.who.int/iris/bitstream/10665/258940/1/9789241513029-eng.pdf?ua=1	53/90%
4.5 Country has legal documentation that has the effect of allowing or mandating food fortification	*Mandatory* = The country has legal documentation that has the effect of mandating fortification of the food vehicle in question with one or more priority micronutrients (Yes/No). *Voluntary* = The country has legal documentation indicating standardized fortification levels of the food vehicle in question, but does not have legal documentation that has the effect of mandating fortification (Yes/No).	FFI, GAIN, IGN, MN Forum. Global Fortification Data Exchange. [Accessed 13 March 2018.] http://www.fortificationdata.org	59/100%

MEAL Indicator Description	Definition	Data Source(s)	Coverage for SUN Countries (n/%)
4.6 Country has legal documentation specifying nutrient levels for fortification	The country has legal documentation indicating standardized fortification levels of the food vehicle in question with one or more priority nutrients (Yes/No)	FFI, GAIN, IGN, MN Forum. Global Fortification Data Exchange. [Accessed 13 March 2018.] http://www.fortificationdata.org	59/100%
TOTAL: 6 indicators			

List 5: Drivers of nutrition (Sustainable Development Goals and others)

MEAL Indicator Description	Definition	Data Source(s)	Coverage for SUN Countries (n/%)
5.1 Prevalence of diarrhea in children under 5 years of age	Percentage of children born in the three years preceding the survey who had diarrhea in the two weeks preceding the survey	ICF International, 2016. The DHS Program STATcompiler. http://www.statcompiler.com UNICEF MICS Country Reports	58/98%
5.2 Proportion of population using safely managed drinking water services	Percentage of the population using at least basic drinking water service (drinking water from an improved source, provided collection time is not more than 30 minutes for a round trip, including queuing)	WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation 2017. Available from https://washdata.org/data	59/100%
5.3 Proportion of population using a safely managed sanitation service [including a hand-washing facility with soap and water]	Percentage of the population using at least a basic sanitation facility (Use of improved facilities that are not shared with other households)	WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation 2017. Available from https://washdata.org/data	59/100%
5.4 Malaria incident cases per 1000 population	Malaria incident cases per 1000 population for the year 2015	SDG Indicators Global Database https://unstats.un.org/sdgs/indicators/database/?indicator=3.3.3	59/100%
5.5 New cases of measles	Reported confirmed measles cases for the year 2016	WHO/UNICEF Joint Reporting on Immunization http://www.who.int/immunization/monitoring_surveillance/burden/vpd/surveillance_type/active/measles_monthlydata/en/	58/98% with reported data
5.6 Number of births during a given reference period to women aged 15–19 years /1000 females (and aged 10–14)	Annual number of births to women aged 15 to 19 per 1,000 women in that age group. (No central source of data was found on births to women aged 10 to 14 years)	United Nations, Department of Economic and Social Affairs, Population Division (2015). 2015 Update for the MDG Database: Adolescent Birth Rate (POP/DB/Fert/A/MDG2015).	59/100%
5.7 Number of new HIV infections per 1,000 uninfected population by age group, sex, and key populations	Number of new HIV infections per 1000 uninfected population for the reference year 2015	WHO GHO http://apps.who.int/gho/data/view.main.57040ALL?lang=en	51/86%
5.8 Tuberculosis incidence per 100,000 population	The estimated number of new and relapse tuberculosis (TB) cases per 100 000 population for the reference year 2016. All forms of TB are included, including cases in people living with HIV.	WHO GHO http://apps.who.int/gho/data/view.main.57040ALL?lang=en	59/100%
5.9 Prevalence of undernourishment	Prevalence of undernourishment (%) (3-year average, 2014–2016); defined by FAO as share of the population that consumes an amount of calories that is insufficient to cover the energy requirement for an active and healthy life (as defined by the minimum dietary energy requirement)	FAO of the United Nations Statistics Division 2015. Food Security / Suite of Food Security Indicators. Available from http://faostat3.fao.org/faostat-gateway/go/to/download/D/FS/E	52/88%

MEAL Indicator Description	Definition	Data Source(s)	Coverage for SUN Countries (n/%)
5.10 Prevalence of moderate or severe food insecurity in the population	Estimated prevalence of moderate or severe food insecurity in the population (reference year 2015) based on the FAO Food Insecurity Experience Scale (Gallup World Poll 2015).	SDG Indicators Global Database. https://unstats.un.org/sdgs/indicators/database/?indicator=2.1.2	15/25%
5.11 Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18	Percentage of women aged 20 to 24 years who were first married or in union before ages 15 and 18	UNICEF Monitoring the situation of women and children Database (March 2018) https://data.unicef.org/topic/child-protection/child-marriage/	58/98%
5.12 Female secondary school enrollment	Total female enrollment in secondary education, in all programs, regardless of age, expressed as a percentage of the female population of official secondary education age. The rate can exceed 100% due to inclusion of overaged/underaged students (early or late school entrance and grade repetition).	UNESCO, World Bank Global Database http://www.uis.unesco.org/DataCentre/Pages/BrowseEducation.aspx https://data.worldbank.org/indicator/SE.SEC.ENRR.FE	55/93%
5.13 Proportion of children 2–14 years old who experienced any violent discipline (psychological aggression and/or physical punishment)	Percentage of children aged 2 to 14 years who experienced any form of violent discipline (physical punishment and/or psychological aggression) within the past month. Psychological aggression refers to the action of shouting, yelling or screaming at a child, as well as calling a child offensive names. Physical (or corporal) punishment is an action intended to cause physical pain or discomfort, but not injuries.	UNICEF Global Database, November 2017, based on DHS, MICS & other nationally representative surveys https://data.unicef.org/topic/child-protection/violence/violent-discipline/	34/58%
5.14 Growth rates of household expenditure and income per capita among the bottom 40% of the population and the total population	Annualized growth in mean household per capita income or consumption for bottom 40% of population and total population	World Bank Global Database of Shared Prosperity http://www.worldbank.org/en/topic/poverty/brief/global-database-of-shared-prosperity	19/32%
5.15 Proportion of urban population living in slums, informal settlement or inadequate housing	Proportion of urban population living in slums. (According to UN-HABITAT, slums are areas where households lack durable housing, sufficient living space, secure tenure, or easy access to safe water or adequate sanitation facilities.)	SDG Indicators Global Database (Nov 2017) https://unstats.un.org/sdgs/indicators/database/?indicator=11.1.1	54/92%
TOTAL: 15 indicators			

List 6: Infant and Young Child Feeding Practices (IYCF) and dietary intakes

MEAL Indicator Description	Definition	Data Source(s)	Coverage for SUN Countries (n/%)
6.1 Exclusive breastfeeding for the first six months	Percentage of infants 0–5 months old who were exclusively breastfed (received only breastmilk during the previous day)	UNICEF Global Database (Jan 2018) http://data.unicef.org/nutrition/iycf.html	58/98%
6.2 Proportion of children born in the last 24 months who were put to the breast within one hour of birth	Percentage of newborns who are put to the breast within one hour of birth.	UNICEF Global Database (Jan 2018) http://data.unicef.org/nutrition/iycf.html	58/98%
6.3 Proportion of children aged 6 to 23 months who Minimum Acceptable Diet (MAD)	Percentage of breastfed children 6–23 months of age who had at least the minimum dietary diversity and the minimum meal frequency during the previous day AND percentage of non-breastfed children 6–23 months of age who received at least 2 milk feedings and had at least the minimum dietary diversity not including milk feeds and the minimum meal frequency during the previous day.	UNICEF Global Database (Jan 2018) http://data.unicef.org/nutrition/iycf.html	46/78%
6.4 Proportion of children aged 6 to 23 months who receive a Minimum Diet Diversity (MDD)	Percentage of children 6-23 months of age who received foods from ≥ 5 (out of 8) food groups1 during the previous day	UNICEF Global Database (Jan 2018) http://data.unicef.org/nutrition/iycf.html	51/86%
6.5 Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day	Mean intake, in grams per day, of fruit and vegetables in persons aged 18+ years for the reference years 1990/ 2005/ 2010	Global Dietary Database (Tufts, Harvard, FAO/WHO GIFT) http://www.globaldietarydatabase.org/country-comparisons.html	58/98%
6.6 Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years.	Mean sodium intake (grams per day) in adults	GNR 2017 dataset, based on Powles et al. (2013) Global, regional and national sodium intakes in 1990 and 2010: a systematic analysis of 24 h urinary sodium excretion and dietary surveys worldwide. BMJ Open; 3:e003733.	59/100%
6.7 Median urinary iodine concentration in children aged 6–12 years	Median urinary iodine concentration (UIC) in the general population, with preference given to studies carried out in school-age children. Data are from the most recent nationally representative survey (2002–2017); Estimates for Niger, South Sudan, Sudan and Zimbabwe are based on sub-national surveys.	Iodine Global Network (2017) Global Scorecard of Iodine Nutrition in 2017 in the general population and in pregnant women. http://www.ign.org/cm_data/IGN_Global_Scorecard_AllPop_and_PW_May2017.pdf	49/83%
6.8 Percentage of the population consuming food that is fortified according to standards	Data on fortification coverage (% uses vehicle, % fortifiable and % fortified) for oil, maize flour and wheat flour	Fortification Assessment Coverage Toolkit (FACT) survey data summarized in Aaron et al. (2017) http://jn.nutrition.org/content/147/5/984S.full	5/8%
TOTAL: 8 indicators			

List 7: Nutrition Status

MEAL Indicator Description	Definition	Data Source(s)	Coverage for SUN Countries (n/%)
7.1 Prevalence of low height-for-age <-2 SD in children under five years of age	Percentage of children aged 0–59 months who are below minus two standard deviations from median height-for-age of the WHO Child Growth Standards.	UNICEF-WHO-World Bank: Joint Child Malnutrition Estimates: Levels and Trends (updated December 2017) https://data.unicef.org/topic/nutrition/malnutrition/	59/100%
7.2 Prevalence of infants born <2500 g	Percentage of infants weighing less than 2,500 grams at birth	UNICEF Global Database (updated October 2014) http://data.unicef.org/nutrition/lowbirthweight.html	56/95%
7.3 Prevalence of weight-for-height >2 SD in children under five years of age	Percentage of children aged 0–59 months who are above two standard deviations from median weight-for-height of the WHO Child Growth Standards.	UNICEF-WHO-World Bank: Joint Child Malnutrition Estimates: Levels and Trends (updated December 2017) https://data.unicef.org/topic/nutrition/malnutrition/	59/100%
7.4 Prevalence of weight-for-height < -2SD in children under five years of age	Percentage of children aged 0–59 months who are below minus two standard deviations from median weight-for-height of the WHO Child Growth Standards.	UNICEF-WHO-World Bank: Joint Child Malnutrition Estimates: Levels and Trends (updated December 2017) https://data.unicef.org/topic/nutrition/malnutrition/	59/100%
7.5 Prevalence of haemoglobin <11 g/dL in pregnant women	Percentage of pregnant women with blood haemoglobin concentration <110 g/L (modeled estimate for the year 2016)	WHO Global Health Observatory (2017) Prevalence of anaemia in women. http://apps.who.int/gho/data/view.main.GSWCAH28v	59/100%
7.6 Prevalence of haemoglobin <12 g/dL in non-pregnant women	Percentage of non-pregnant women with blood haemoglobin concentration <120 g/L (modeled estimate for the year 2016)	WHO Global Health Observatory (2017) Prevalence of anaemia in women. http://apps.who.int/gho/data/view.main.GSWCAH28v	59/100%
7.7 Proportion of adult women with low body mass index (BMI)	Percentage of adult women (age 18+ years) who are thin according to BMI (<18.5) (modeled estimate for the year 2016)	NCD Risk Factor Collaboration. (2017). Worldwide trends in body-mass index, underweight, overweight and obesity from 1975 to 2016: a pooled analysis of 2416 population-based measurement studies in 128.9 million children, adolescents, and adults. Lancet, 390 (10113), 2627-2642. http://www.ncdrisc.org/data-downloads.html	58/98%
7.8 Proportion of overweight and obese women aged 18+ years (defined as BMI ≥25 kg/m² for overweight and BMI ≥ 30 kg/m² for obesity)	Percentage of defined population (adults age 18+ years) with a BMI of >25 or a BMI of >30 (modeled estimate for the year 2016)	NCD Risk Factor Collaboration. (2017). Worldwide trends in body-mass index, underweight, overweight and obesity from 1975 to 2016: a pooled analysis of 2416 population-based measurement studies in 128.9 million children, adolescents, and adults. Lancet, 390 (10113), 2627-2642. http://www.ncdrisc.org/data-downloads.html	58/98%

MEAL Indicator Description	Definition	Data Source(s)	Coverage for SUN Countries (n/%)
7.9 Prevalence of overweight and obesity in adolescents (defined according to WHO growth reference for school-aged children and adolescents).	Percentage of adolescent girls aged 10-19 years who are above one and two standard deviations from the median BMI-for-age of the WHO Growth Reference for School-Aged Children and Adolescents (modeled estimate for the year 2016)	NCD Risk Factor Collaboration. (2017). Worldwide trends in body-mass index, underweight, overweight and obesity from 1975 to 2016: a pooled analysis of 2416 population-based measurement studies in 128.9 million children, adolescents, and adults. Lancet, 390 (10113), 2627-2642. http://www.ncdrisc.org/data-downloads.html	58/98%
7.10 Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years (defined as fasting plasma glucose value ≥7.0 mmol/L (126 mg/dl) or on medication for raised blood glucose).	Proportion of adults (age 18+ years) with raised blood glucose (fasting glucose ≥7.0 mmol/L or on medication for raised blood glucose or with a history of diagnosis of diabetes, age-standardized estimate for men and women (modeled estimate for the year 2014)	NCD Risk Factor Collaboration. (2016). Worldwide trends in diabetes since 1980: a pooled analysis of 751 population-based studies with 4.4 million participants. *Lancet, 387*(10027), 1513-1530. http://www.ncdrisc.org/data-downloads.html	58/98%
7.11 Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic BP ≥140 mmHg and/or diastolic BP ≥90 mmHg); and mean systolic BP.	Proportion of adults (age 25+ years) with raised blood pressure: systolic blood pressure ≥140 mm Hg and/or diastolic blood pressure ≥90 or on medication for raised blood pressure (age-standardized estimate) for men and women (modeled estimate for the year 2015)	NCD Risk Factor Collaboration. (2017). Worldwide trends in blood pressure from 1975 to 2015: a pooled analysis of 1479 population-based measurement studies with 19.1 million participants. *Lancet, 389*(10064), 37-55. http://www.ncdrisc.org/data-downloads.html	58/98%
TOTAL: 11 indicators			

List 8: Sustainable Development Goals that are linked to better nutrition

MEAL Indicator Description	Note	Definition	Data Source(s)	Coverage for SUN Countries (n/%)
8.1 Proportion of population below international poverty line disaggregated by sex, age group, employment status, and geographical location (urban/rural)	Nutrition status is linked to individual income	Poverty headcount ratio at $1.90 a day (2011 PPP) = percentage of the population living on less than $1.90 a day at 2011 international prices	World Bank Poverty and Equity Database https://data.worldbank.org/indicator/SI.POV.DDAY (accessed 6 Mar 2018)	58/98%
8.2 Under five mortality rate (deaths per 1000 live births)	LiST estimates the number of deaths averted	Country-specific under-five mortality rate (deaths per 1000 live births) for reference year 2016	UNICEF Global Database updated 19 October 2017 (Estimates generated by the UN Inter-agency Group for Child Mortality Estimation (IGME) in 2017) https://data.unicef.org/topic/child-survival/under-five-mortality/	59/100%
8.3 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory infections	Estimates of deaths attributed to diet-related NCDs. Increasingly significant in LMICs	Total NCD mortality rate (age-standardized mortality rate per 100,000 population), estimates for reference year 2015	WHO Global Health Observatory http://apps.who.int/gho/data/node.main.A860?lang=en	59/100%
8.4 Proportion of children aged 36–59 months who are developmentally on track in at least three of the following domains: literacy-numeracy, physical development, social-emotional development and learning	Nutrition status is linked to cognitive development in young children	Percentage of children aged 36-59 months who are developmentally on track in at least three of the following domains: literacy-numeracy, physical development, social-emotional development and learning	SDG Indicators Global Database https://unstats.un.org/sdgs/indicators/database/?indicator=4.2.1 New data added from MICS reports for Mali (2015), Cote d'Ivoire (2016), Guinea (2016) and Nigeria (2016)	28/47%
8.5 Annual growth rate of real GDP per capita	World Bank estimates on GDP losses due to malnutrition and GDP gains due to improved nutrition	Annual percentage growth rate of GDP per capita based on constant local currency. Aggregates are based on constant 2010 U.S. dollars. Reference year 2016	World Bank (2018) World Development Indicators https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG (accessed 6 Mar 2018)	57/97%
TOTAL: 5 indicators				

Indicators in Progress (not included in the 2016 Baseline)

MEAL Indicator Description	Definition & Status of Data Collection	Data Source(s)	Coverage for SUN Countries (n/%)
List 1: Enabling environment			
Capacity of MSP to coordinate their partners response to identified annual priority action areas in the JAA	Data collected from 2017 JAA Analytical stage	Joint Annual Assessments	
Compliance of partners with the SUN Movement Principles of Engagement	Data collected from 2017 JAA Analytical stage	Joint Annual Assessments	
'Good' quality of new national multi-sectoral, multi-stakeholder action plans/CRF made since the beginning of 2016	Review initiated with published plans shared by SUN Government Focal Points	SUN countries	
SMART-ness of nutrition commitments by Governments and networks / alliances made since the beginning of 2016	Data collected from 2017 JAA Analytical stage	Joint Annual Assessments Potential partnership with the Decade of Action (TBD)	
List 2: Finance			
Financing gap for costed nutrition high-impact interventions	TBD – based on 2015 data	InvestininNutrition.org	
Geographic distribution of resources at sub-national level (linked with mapping of stakeholders and actions)	TBD	UN Network follow up	
Proportion of total government spending on essential services: education, health and social protection	TBD	Reported in GNR using SPEED data	17/29% (SPEED data)
List 3: Interventions and food supply			
Proportion of mothers of children 0–23 months who have received counseling, support or messages on optimal breastfeeding at least once in the last year	Number of mothers of children 0-23 months who received IYCF counseling- based on estimates in 29 countries, over 8.5 million mothers received IYCF counseling in 2015. However, coverage cannot be estimated due to lack of a denominator.	UNICEF NutriDash 2015 data for countries that agreed to share data externally.	29/49%
Proportion of children aged 6–23 months receiving micronutrient powders	Number of children 6-23 months receiving micronutrient powders – based on estimates from 32 SUN countries, over 5 million children 6-23 months received MNPs in 2015. However, coverage cannot be estimated due to lack of a denominator.	UNICEF NutriDash 2015 data for countries that agreed to share data externally.	32/54%
Geographic distribution of core nutrition actions at sub-national level	Data collected from 20 countries with various degree of information on the percent of stakeholders working at sub-national level, nutrition-specific and nutrition-sensitive actions and nutrition actions by sectors.	UN Network	20/34%

MEAL Indicator Description	Definition & Status of Data Collection	Data Source(s)	Coverage for SUN Countries (n/%)
List 6: IYCF and Dietary Intake			
Average amount of food vehicle that is eaten per capita	For wheat flour, maize flour, rice and oil, the data provide estimates of food availability, based on the most recent FAO food balance sheets. For salt, intake data are available for sodium in 2010 (Powles et al., 2013) that can be multiplied by 2.542 to calculate salt intake estimates.	FFI, GAIN, IGN, MN Forum. Global Fortification Data Exchange. [Accessed 07/09/2017] http://www.fortificationdata.org	53/90%
Prevalence of Women of Reproductive Age consuming a Minimum Diet Diversity	Technical working group led by FAO	TBD	

APPENDIX C: ALIGNMENT WITH INTERNATIONALLY AGREED FRAMEWORKS AND MONITORING INITIATIVES

* Maternal, Infant and Young Child Nutrition Monitoring Framework (MIYCF) approved at the 68th World Health Assembly;
† Global Monitoring Framework and Targets for the Prevention and Control of Non-Communicable Diseases approved at the 66th World Health Assembly;
‡ Preliminary file on the provisional proposed tiers for Global SDG Indicators (24 March 2016). A Tier I indicator is conceptually clear, with an established methodology and standards and with data regularly produced by countries.

List 2: Finance for nutrition

List and Indicator description	MIYCF Framework*		NCD Framework†		SDG Framework‡	Other Monitoring Initiatives
	Core	Extended	Target	Indicator		
2.1 National investments for nutrition disaggregated by specific or sensitive, types of programmes, MDAs, sources of funding, allocations expenditures, years						SUN Movement / 2017 GNR
2.2 Total resource flows for development, by recipient and donor countries and type of flow					**SDG 10.b.1** Tier I	SUN Donor Network / 2017 GNR
2.3 The agriculture orientation index for government expenditures					**SDG 2.a.1** Tier I	2017 GNR
2.x Financing gap for costed nutrition high-impact interventions						SUN Movement
2.x Proportion of total government spending on essential services - education, health and social protection					**SDG 1.a.2** Tier III (no methodology and standards established)	2017 GNR
TOTAL: 5 indicators	**0**	**0**	**0**	**0**	**3**	**5**

Note: Costed nutrition high-impact interventions in the Investment Framework for Nutrition include: IYCF counseling, Vitamin A supplementation, SAM treatment, Iron-Folic Acid supplementation, Salt iodization, Food Fortification, maternal micronutrient supplements, provision of complementary food supplements for children 6-23 months living under poverty line, Zinc supplementation

List 3: Interventions and food supply

Indicator description	Sector	MIYCF Framework		NCD Framework		SDG	Other Monitoring Initiatives
		Core	Extended	Target	Indicator		
3.1 Proportion of health facilities that are Baby Friendly Hospital Initiative (BFHI) certified	HEALTH						GNR NutriDash
3.x Proportion of mothers of children 0-23 months who have received counselling, support or messages on optimal breastfeeding at least once in the last year	HEALTH	Reporting delayed till 2018					Nutridash
3.2 Proportion of children 6-59 months with severe acute malnutrition admitted for treatment	HEALTH						NutriDash / No Wasted Lives Initiative / Coverage Monitoring Network / 2015 GNR
3.3 Proportion of children 6-59 months receiving Vitamin A supplementation	HEALTH						2017 GNR
3.4 Proportion of pregnant women receiving Iron and Folic Acid supplementation	HEALTH	Reporting delayed till 2018					
3.x Proportion of children aged 6-23 months receiving micronutrient powders	HEALTH						NutriDash
3.5 Number of trained nutrition professionals /100,000 population	HEALTH	Reporting delayed till 2018				Or consider **SDG 3.c.1** Health worker density Tier I	2017 GNR (only health workers)
3.6 Percentage of households that have iodized salt (>15 ppm)	HEALTH						2017 GNR
3.7 Proportion of children under 5 years old with diarrhea (in last two weeks) receiving oral rehydration salts (ORS packets or pre-packaged ORS fluids)	HEALTH						2017 GNR

Indicator description	Sector	MIYCF Framework		NCD Framework		SDG	Other Monitoring Initiatives
		Core	Extended	Target	Indicator		
3.8 Proportion of children aged 12-59 months receiving at least one dose of de-worming medication	HEALTH						NutriDash
3.9 Use of insecticide treated nets in children aged 0-5 years	HEALTH						
3.10 Percentage of 1-year-olds who have received the appropriate doses of the recommended vaccines in the national schedule by recommended age	HEALTH						
3.11 Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods	HEALTH					**SDG 3.7.1** Tier I	EWEC / 2017 GNR
3.12 Percentage of calories from non-staples[79] in food supply	FOOD SYSTEM						2017 GNR
3.13 Availability of fruits and vegetables (grams)	FOOD SYSTEM						2017 GNR
3.14 Fortified Food Supply	FOOD SYSTEM						GAIN/FFI/MNF
3.15 Proportion of the population covered by social protection floors/systems disaggregated by sex, and distinguishing children, the unemployed, the elderly, persons with disabilities, pregnant women, new born, work injury victims, the poor and vulnerable	SOCIAL PROTECTION					**SDG 1.3.1** Tier II	
3.x Geographic distribution of core nutrition actions at sub-national level							Stakeholder and Action Mapping
TOTAL: 18 indicators		**5**	**7**	**0**	**0**	**3**	**13**

[79] Staples include cereals, tubers and starches.

List 4: Enacted legislations

Indicator descriptions	MIYCN Framework		NCD Framework		SDG	Other Monitoring Initiatives
	Core set	Extended set	Target	Indicator		
4.1 Country has legislation /regulations fully implementing the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22) and subsequent relevant resolutions adopted by the World Health Assembly						2017 GNR
4.2 Country has maternity protection laws or regulations in place in line with the ILO Maternity Protection Convention, 2000 (No. 183) and Recommendation No. 191						2017 GNR
4.3 Country has legislation on the Constitutional Right to Food						2017 GNR
4.4 Country has policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, *trans*-fatty acids, free sugars, or salt						2016 GNR
4.5 Country has legal documentation that has the effect of allowing or mandating food fortification (Y/N)						Global Fortification Data Exchange / 2015 GNR / Iodine Global Network
4.6 Country has legal documentation specifying nutrient levels for fortification (Y/N)						Global Fortification Data Exchange
TOTAL: 6 indicators	**2**	**1**	**0**	**1**	**0**	**5**

List 5: Drivers of nutrition (Sustainable Development Goals and others)

Indicators	Sector	MIYCN Framework		SDG Framework	Other Monitoring Initiatives
		Core set of indicators	Extended set of indicators		
5.1 Prevalence of diarrhoea in children under 5 years of age	WASH				
5.2 Proportion of population using safely managed drinking water services	WASH			**SDG 6.1.1** Tier I	Every Woman Every Child / GNR
5.3 Proportion of population using a safely managed sanitation service [including a hand-washing facility with soap and water]	WASH			**SDG 6.2.1** Tier I	Every Woman Every Child / GNR
5.4 Malaria incident cases per 1000 population	HEALTH			**SDG 3.3.3** Tier I	
5.5 New cases of measles	HEALTH				
5.6 Number of births during a given reference period to women aged 15-19 years /1000 females (and aged 10-14)	HEALTH			**SDG 3.7.2** Tier I TBC	Every Woman Every Child / GNR
5.7 Number of new HIV infections per 1,000 uninfected population by age group, sex, and key populations	HEALTH			**SDG 3.3.1** Tier I	
5.8 Tuberculosis incidence per 1,000 population	HEALTH			**SDG 3.3.2** Tier I	
5.9 Prevalence of undernourishment	FOOD SYSTEMS			**SDG 2.1.1** Tier I	2017 GNR
5.10 Prevalence of moderate or severe food insecurity in the population	FOOD SYSTEMS			**SDG 2.1.2** Tier I	2017 GNR

Indicators	Sector	MIYCN Framework		SDG Framework	Other Monitoring Initiatives
		Core set of indicators	Extended set of indicators		
5.11 Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18	GENDER			**SDG 5.3.1** Tier I	Every Woman Every Child / 2017 GNR
5.12 Female secondary school enrollment	EDUCATION			Or consider **SDG 4.5.1** Tier I female/male parity index)	2017 GNR
5.13 Proportion of children 2-14 years old who experienced any violent discipline (psychological aggression and/or physical punishment)				**SDG 16.2.1** Tier II	ECDAN (Early Child Devt Action Network) Adjusted to 1-4 years
5.14 Growth rates of household expenditure and income per capita among the bottom 40% of the population and the total population	Poverty / Social Protection			**SDG 10.1.1** Tier I	
5.15 Proportion of urban population living in slums, informal settlement or inadequate housing	Poverty / Social Protection			**SDG 11.1.1** Tier I	2017 GNR
TOTAL: 15 indicators		**4**	**2**	**13**	**9**

List 6: Infant and Young Child Feeding Practices (IYCF) and dietary intakes

Indicator description	MIYCN Framework		NCD Framework		SDG	Other Monitoring Initiatives
	Core set	Extended set	Target	Indicator		
6.1 Exclusive breastfeeding for the first six months	WHA Target					2017 GNR
6.2 Proportion of children born in the last 24 months who were put to the breast within one hour of birth						2017 GNR
6.3 Proportion of children aged 6 to 23 months who Minimum Acceptable Diet (MAD)	Reporting delayed till 2018					2017 GNR
6.4 Proportion of children aged 6 to 23 months who receive a Minimum Diet Diversity (MDD)						2017 GNR
6.5 Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day						
6.6 Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years.						2017 GNR
6.7 Median urinary iodine concentration in children aged 6-12 years						2017 GNR
6.x Average amount of food vehicle that is eaten per capita (*suggested by GAIN, FFI, IGN and MNF)*		Percentage of households *consuming* iron-fortified wheat flour products				Global Fortification Data Exchange
6.8 Percentage of the population consuming food that is fortified according to standards (*suggested by GAIN, FFI, IGN and MNF)*						Global Fortification Data Exchange
TOTAL: 9 indicators	**2**	**3**	**1**	**1**	**0**	**7**

List 7: Nutrition Status

Indicator description	WHA Global Nutrition Target	MIYNF	NCD Target	SDG	Other Monitoring Initiatives
7.1 Prevalence of low height-for-age <-2 SD in children under five years of age	Childhood Stunting			**SDG 2.2** (2.2.1) Tier I	2017 GNR
7.2 Prevalence of infants born < 2500 g	Low birth Weight				2017 GNR
7.3 Prevalence of weight-for-height >2 SD in children under five years of age	Childhood overweight			**SDG 2.2** (2.2.2) Tier I	2017 GNR
7.4 Prevalence of weight-for-height < -2SD in children under five years of age	Childhood wasting			**SDG 2.2** (2.2.2) Tier I	2017 GNR
7.5 Prevalence of haemoglobin <11 g/dL in pregnant women	Anaemia in women of reproductive age				2017 GNR
7.6 Prevalence of haemoglobin <12 g/dL in non-pregnant women	Anaemia in women of reproductive age				2017 GNR
7.7 Proportion of women aged 15–49 years with low body mass index (BMI)					2017 GNR
7.8 Proportion of overweight and obese women aged 18+ years (defined as BMI ≥25 kg/m² for overweight and BMI ≥ 30 kg/m² for obesity)			Obesity		2017 GNR
7.9 Prevalence of overweight and obesity in adolescents aged 10-19 years (defined according to the WHO growth reference for school-aged children and adolescents, overweight - one SD BMI for age and sex, obese - two SD BMI for age and sex).			Obesity		2017 GNR
7.10 Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years (defined as fasting plasma glucose value ≥7.0 mmol/L (126 mg/dl) or on medication for raised blood glucose).			Diabetes		2017 GNR
7.11 Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic BP ≥140 mmHg and/or diastolic BP ≥90 mmHg); and mean systolic BP.			Raised blood pressure		2017 GNR
TOTAL: 11 indicators	**6**	**9**	**4**	**3**	**11**

List 8: Sustainable Development Goals that are linked to better nutrition

Indicator description	Note	MIYCNF Frame work*	NCD Framework†	SDG Framework‡	Other Monitoring Initiatives
8.1 Proportion of population below international poverty line disaggregated by sex, age group, employment status, and geographical location (urban/rural)	Nutrition status is linked to individual income			**SDG 1.1.1** Tier I	2017 GNR
8.2 Under five mortality rate (deaths per 1000 live births)	LiST estimates the number of deaths averted			**SDG 3.2.1** Tier I	2017 GNR
8.3 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory infections	Estimates of deaths attributed to diet-related NCDs. Increasingly significant in LMICs			**SDG 3.4.1** Tier II (agreed methodology but limited data availability)	WHO NCD Monitoring Framework 2017 GNR
8.4 Proportion of children aged 36-59 months who are developmentally on track in at least three of the following domains: literacy-numeracy, physical development, social-emotional development and learning	Nutrition status is linked to cognitive development in young children			**SDG 4.2.1** Tier II (no agreed methodology and no data yet)	ECDAN (Early Child Devt Action Network)
8.5 Annual growth rate of real GDP per capita	World Bank estimates on GDP losses due to malnutrition and on GDP gains due to improved nutrition			**SDG 8.1.1** Tier I	2017 GNR
TOTAL: 5 indicators		**0**	**0**	**5**	**5**

APPENDIX D: LIST OF SUN COUNTRIES AND CHARACTERISTICS FOR ANALYSIS

SUN Group	Region and Country	Year Joined SUN	INFORM Humanitarian Risk Level	World Bank Country Income Classification
	Latin America/Caribbean Region (N=5)			
2010–11	Guatemala	2010	High	Lower-middle
	Peru	2010	Medium	Upper-middle
2012–14	Costa Rica	2014	Low	Upper-middle
	El Salvador	2012	High	Lower-middle
	Haiti	2012	Very High	Low
	West/Central Africa Region (N=21)			
2010–11	Benin	2011	Medium	Low
	Burkina Faso	2011	High	Low
	Gambia	2011	Medium	Low
	Ghana	2011	Medium	Lower-middle
	Mali	2011	High	Low
	Mauritania	2011	High	Lower-middle
	Niger	2011	Very High	Low
	Senegal	2011	Medium	Low
2012–14	Cameroon	2013	High	Lower-middle
	Chad	2013	Very High	Low
	Congo	2013	High	Lower-middle
	Côte d'Ivoire	2013	High	Lower-middle
	Democratic Republic of Congo (DRC)	2013	Very High	Low
	Guinea	2013	High	Low
	Guinea-Bissau	2014	High	Low
	Liberia	2014	High	Low
	Nigeria	2013	High	Lower-middle
	Sierra Leone	2012	High	Low
	Togo	2014	Medium	Low
2015–17	Central African Republic (CAR)	2017	Very High	Low
	Gabon	2017	Medium	Upper-middle

SUN Group	Region and Country	Year Joined SUN	INFORM Humanitarian Risk Level	World Bank Country Income Classification
	East/Southern Africa (N=19)			
2010–11	Ethiopia	2010	High	Low
	Malawi	2011	Medium	Low
	Mozambique	2011	High	Low
	Namibia	2011	Medium	Upper-middle
	Rwanda	2011	High	Low
	Uganda	2011	High	Low
	Tanzania	2011	High	Low
	Zambia	2010	Medium	Lower-middle
	Zimbabwe	2011	High	Low
2012–14	Burundi	2013	High	Low
	Comoros	2013	Medium	Low
	Kenya	2012	High	Lower-middle
	Lesotho	2014	Medium	Lower-middle
	Madagascar	2012	High	Low
	Somalia	2014	Very High	Low
	South Sudan	2013	Very High	Low
	Swaziland	2013	Medium	Lower-middle
2015–17	Botswana	2015	Low	Upper-middle
	Sudan	2015	Very High	Lower-middle
	West/Central Asia Region (N=3)			
2010–11	Kyrgyzstan	2011	Medium	Lower-middle
2012–14	Tajikistan	2013	Medium	Lower-middle
	Yemen	2012	Very High	Lower-middle
	South/SE Asia Region (N=11)			
2010–11	Bangladesh	2010	High	Lower-middle
	Indonesia	2011	Medium	Lower-middle
	Lao PDR	2011	Medium	Lower-middle
	Nepal	2011	High	Low
2012–14	Cambodia	2014	Medium	Lower-middle
	Myanmar	2013	Very High	Lower-middle
	Pakistan	2013	Very High	Lower-middle
	Philippines	2014	Medium	Lower-middle
	Sri Lanka	2012	Medium	Lower-middle
	Viet Nam	2014	Medium	Lower-middle
2015–17	Papua New Guinea (PNG)	2016	High	Lower-middle

APPENDIX E: LIMITATIONS

Although the selection of MEAL indicators was guided by the requirement of a publicly available source of data, not all data sources have been immediately available and not all indicators have broad coverage across all SUN countries.

Indicators with no data currently available – This includes the following indicators:

- **List 2: Finance for nutrition –** Data on finance gaps will be available for 2018 with a focus on a minimum package of high-impact interventions.
- **List 3: Interventions –** Although NutriDash data is available on the number of beneficiaries of IYCF counseling and micronutrient powder interventions for some SUN countries, no data are available to calculate coverage estimates in these countries.

Indicators with low data coverage –The following indicators have lower than desired availability for SUN countries and therefore any summary measures that include these indicators should be interpreted with caution.

- **Very low data coverage** (<50% of SUN countries have data) – moderate/severe food insecurity (FIES), household income growth, early child development status, geographic distribution of actions at sub-national level (UN Network), per capita intake of fortified foods (only 5 countries)
- **Low data coverage** (only 50–74% of SUN countries have data) – budget analysis (nutrition –specific), baby-friendly hospital initiative coverage, severe acute malnutrition treatment coverage, social protection programme coverage, child exposure to violent discipline

There are also recognized limitations in the range of indicators identified in specific areas of great relevance and interest to nutrition. These include the food system, human resources/capacity and finance.

- **Food system** – very few indicators were found that provided valid and standardized methods of assessing food supply and food consumption across SUN countries. These are currently limited to indicators based on household consumption survey data, which provide rough estimates of food availability. Efforts to capture country progress in food system legislation (e.g. policies to reduce the impact on children of marketing of foods and beverages high in fat, sugar or salt) were constrained by limited variation in the data provided by countries on this topic.
- **Human resources/capacity** – although the MEAL framework sought to identify a data source to assess the number of trained nutrition professionals in each country, no data was found and therefore the density of physicians and nurses was used in its place.
- **Finance** – Significant efforts are going into tracking of allocations with significant variance across countries. Estimates on finance data gaps for high-impact interventions should be available for 2018 based on an updated analysis of donor funding using the Credit Reporting System (Results for Development). Estimates of actual expenditures are only available for a handful of countries. Finally, estimates on nutrition-sensitive allocations are too heterogeneous across countries and appear to respond to different assumptions and priorities. More work is foreseen in 2018.

APPENDIX F: INDIVIDUAL COUNTRY SCORES FOR THE NETWORK FUNCTIONALITY INDICES

UN Network Functionality Index

TABLE 121: INDIVIDUAL COUNTRY SCORES FOR THE UN NETWORK FUNCTIONALITY INDEX

Country	Functionality Index Score*	Chair(s) Nominated	3+ Focal Points	Work Plan Developed	Reporting Exercise Completed	UN Nutrition Inventory	UN Network Strategy/ Agenda
Bangladesh	4	0	1	0	1	1	1
Benin	3	0	1	0	1	1	0
Botswana	0	0	0	0	0	0	0
Burkina Faso	6	1	1	1	1	1	1
Burundi	2	1	1	0	0	0	0
Cambodia	2	1	1	0	0	0	0
Cameroon	1	1	0	0	0	0	0
Chad	5	1	1	1	1	1	0
Comoros	4	1	1	1	1	0	0
Congo	4	1	1	0	1	0	1
Costa Rica	2	0	1	0	1	0	0
Côte d'Ivoire	6	1	1	1	1	1	1
DRC	6	1	1	1	1	1	1
El Salvador	2	0	1	0	1	0	0
Ethiopia	2	0	1	0	1	0	0
Gambia	4	1	1	1	1	0	0
Ghana	2	0	1	0	1	0	0
Guatemala	3	1	1	0	1	0	0
Guinea	4	1	1	0	1	1	0
Guinea-Bissau	3	1	1	0	1	0	0
Haiti	4	1	1	0	1	1	0
Indonesia	4	1	1	1	1	0	0
Kenya	5	1	1	1	1	1	0
Kyrgyzstan	6	1	1	1	1	1	1
Lao PDR	4	1	1	1	1	0	0
Lesotho	4	1	1	1	1	0	0
Liberia	2	0	1	0	1	0	0
Madagascar	4	1	1	1	1	0	0
Malawi	5	1	1	1	1	0	1

Country	Functionality Index Score*	Chair(s) Nominated	3+ Focal Points	Work Plan Developed	Reporting Exercise Completed	UN Nutrition Inventory	UN Network Strategy/ Agenda
Mali	5	1	1	1	1	1	0
Mauritania	4	1	1	1	1	0	0
Mozambique	6	1	1	1	1	1	1
Myanmar	5	1	1	1	1	1	0
Namibia	3	1	1	0	1	0	0
Nepal	3	1	1	0	1	0	0
Niger	3	1	1	0	1	0	0
Nigeria	0	0	0	0	0	0	0
Pakistan	6	1	1	1	1	1	1
Papua New Guinea	2	0	1	0	1	0	0
Peru	1	0	1	0	0	0	0
Philippines	4	1	1	0	1	1	0
Rwanda	5	1	1	1	1	1	0
Senegal	4	1	1	0	1	1	0
Sierra Leone	3	1	1	0	1	0	0
Somalia	3	1	1	0	1	0	0
South Sudan	2	1	1	0	0	0	0
Sri Lanka	2	0	1	0	1	0	0
Sudan	5	1	1	0	1	1	1
Swaziland	1	0	1	0	0	0	0
Tajikistan	3	1	1	0	1	0	0
Tanzania	4	1	1	1	1	0	0
Togo	2	0	1	0	1	0	0
Uganda	3	0	1	1	1	0	0
Vietnam	2	1	1	0	0	0	0
Yemen	2	0	1	0	1	0	0
Zambia	6	1	1	1	1	1	1
Zimbabwe	4	1	1	1	1	0	0

***Level of set up:** Advanced (Score 5) | In progress (Scores 3-4) | Early stages (Scores 1-2) | Non-functioning (Score 0)

SUN Business Network (SBN) Functionality Index

TABLE 122: INDIVIDUAL COUNTRY SCORES FOR THE SUN BUSINESS NETWORK FUNCTIONALITY INDEX

Country	Functionality Index Score*	Network established/ being established	Coordinator appointed (FT/PT)	SBN's strategy developed and aligned to national nutrition plans	SBN's action plan in place	Funding secured for at least the first semester in 2017*
Bangladesh	1	1	0	0	0	0
Benin	0	0	0	0	0	0
Botswana	0	0	0	0	0	0
Burkina Faso	0	0	0	0	0	0
Burundi	0	0	0	0	0	0
Cambodia	1	1	0	0	0	0
Cameroon	2	1	0	0	1	0
Chad	0	0	0	0	0	0
Comoros	0	0	0	0	0	0
Congo	0	0	0	0	0	0
Costa Rica	0	0	0	0	0	0
Côte d'Ivoire	0	0	0	0	0	0
DRC	0	0	0	0	0	0
El Salvador	1	1	0	0	0	0
Ethiopia	4	1	1	1	1	0
Gambia	0	0	0	0	0	0
Ghana	0	0	0	0	0	0
Guatemala	4	1	0	1	1	1
Guinea	0	0	0	0	0	0
Guinea-Bissau	0	0	0	0	0	0
Haiti	0	0	0	0	0	0
Indonesia	5	1	1	1	1	1
Kenya	3	1	0	1	1	0
Kyrgyzstan	3	1	1	0	1	0
Lao PDR	2	1	0	0	0	1
Lesotho	0	0	0	0	0	0
Liberia	0	0	0	0	0	0
Madagascar	0	0	0	0	0	0
Malawi	1	1	0	0	0	0
Mali	0	0	0	0	0	0
Mauritania	0	0	0	0	0	0
Mozambique	5	1	1	1	1	1
Myanmar	0	0	0	0	0	0
Namibia	0	0	0	0	0	0

Country	Functionality Index Score*	Network established/ being established	Coordinator appointed (FT/PT)	SBN's strategy developed and aligned to national nutrition plans	SBN's action plan in place	Funding secured for at least the first semester in 2017*
Nepal	0	0	0	0	0	0
Niger	3	1	1	0	0	1
Nigeria	5	1	1	1	1	1
Pakistan	5	1	1	1	1	1
Papua New Guinea	0	0	0	0	0	0
Peru	0	0	0	0	0	0
Philippines	0	0	0	0	0	0
Rwanda	0	0	0	0	0	0
Senegal	0	0	0	0	0	0
Sierra Leone	0	0	0	0	0	0
Somalia	0	0	0	0	0	0
South Sudan	0	0	0	0	0	0
Sri Lanka	0	0	0	0	0	0
Sudan	0	0	0	0	0	0
Swaziland	0	0	0	0	0	0
Tajikistan	1	1	0	0	0	0
Tanzania	5	1	1	1	1	1
Togo	0	0	0	0	0	0
Uganda	0	0	0	0	0	0
Vietnam	0	0	0	0	0	0
Yemen	0	0	0	0	0	0
Zambia	5	1	1	1	1	1
Zimbabwe	2	1	1	0	0	0

***Level of set up:** Advanced (Score 5) | In progress (Scores 3-4) | Early stages (Scores 1-2) | None (Score 0)

SUN Civil Society Network (CSN) Functionality Index

TABLE 123: INDIVIDUAL COUNTRY SCORES FOR THE SUN CIVIL SOCIETY NETWORK FUNCTIONALITY INDEX

Country	Functionality Index Score*	Alliance established	Steering group/ executive committee in place	Sub-national/ decentralised coordination structure in place	Funding secured for at least the first semester in 2017	MSP engagement
Bangladesh	5	1	1	1	1	1
Benin	4	1	1	1	0	1
Botswana	0	0	0	0	0	0
Burkina Faso	4	1	1	1	0	1
Burundi	3	1	1	1	0	0
Cambodia	3	1	1	0	0	1
Cameroon	1	1	0	0	0	0
Chad	5	1	1	1	1	1
Comoros	0	0	0	0	0	0
Congo	0	0	0	0	0	0
Costa Rica	0	0	0	0	0	0
Cote d'Ivoire	3	1	1	0	0	1
DRC	3	1	1	0	0	1
El Salvador	4	1	1	1	0	1
Ethiopia	2	1	0	0	0	1
Gambia	0	0	0	0	0	0
Ghana	3	1	1	0	0	1
Guatemala	3	1	1	0	0	1
Guinea	3	1	1	1	0	0
Guinea-Bissau	0	0	0	0	0	0
Haiti	0	0	0	0	0	0
Indonesia	1	1	0	0	0	0
Kenya	4	1	1	1	0	1
Kyrgyzstan	4	1	1	1	0	1
Lao PDR	4	1	1	0	1	1
Lesotho	0	0	0	0	0	0
Liberia	3	1	1	0	0	1
Madagascar	4	1	1	1	0	1
Malawi	4	1	1	0	1	1
Mali	4	1	1	1	0	1
Mauritania	4	1	1	1	0	1
Mozambique	3	1	0	1	0	1
Myanmar	4	1	1	0	1	1
Namibia	0	0	0	0	0	0
Nepal	5	1	1	1	1	1

Country	Functionality Index Score*	Alliance established	Steering group/ executive committee in place	Sub-national/ decentralised coordination structure in place	Funding secured for at least the first semester in 2017	MSP engagement
Niger	4	1	1	1	0	1
Nigeria	3	1	1	1	0	0
Pakistan	4	1	1	0	1	1
Papua New Guinea	0	0	0	0	0	0
Peru	3	1	1	0	0	1
Philippines	2	1	1	0	0	0
Rwanda	5	1	1	1	1	1
Senegal	5	1	1	1	1	1
Sierra Leone	5	1	1	1	1	1
Somalia	0	0	0	0	0	0
South Sudan	1	1	0	0	0	0
Sri Lanka	4	1	1	1	0	1
Sudan	0	0	0	0	0	0
Swaziland	0	0	0	0	0	0
Tajikistan	0	0	0	0	0	0
Tanzania	5	1	1	1	1	1
Togo	3	1	1	0	0	1
Uganda	3	1	1	0	0	1
Vietnam	0	0	0	0	0	0
Yemen	0	0	0	0	0	0
Zambia	4	1	1	1	0	1
Zimbabwe	4	1	1	1	0	1

***Level of set up:** Advanced (Score 5) | In progress (Scores 3-4) | Early stages (Scores 1-2) | None (Score 0)

APPENDIX G: DETAILED RESULTS OF THE INFORMATION SYSTEMS FOR NUTRITION INDEX

The following sections provide more detailed results for each of the three components within the Information Systems for Nutrition Index.

GOVERNMENT COMMITMENT & ENABLING ENVIRONMENT

The first component, Government Commitment & Enabling Environment, seeks to summarize the extent to which a country has established a governance mechanism to prioritize, collect, access and use data and information on nutrition.

POLICY & PLANNING DOCUMENTS

A Common Results Framework that includes a Monitoring and Evaluation Framework is useful for clearly articulating the specific nutrition data to be gathered from multiple sources in order to inform multi-sectoral responses. By 2016, while 44 of 59 SUN countries have developed a Common Results Framework (at least in draft form), only 22 of these have an agreed Monitoring and Evaluation framework as part of those documents. Higher income countries were more likely to have existing Monitoring & Evaluation framework documents compared to low-income countries (Table 1).

About three quarters (43 of 59) of SUN countries report having conducted at least once a budget analysis that reviews allocations for nutrition in the national budget and helps to identify gaps and support resource mobilization for nutrition.

TRACKING GLOBAL TARGETS

Inclusion of the World Health Assembly (WHA) global targets for improving maternal, infant and young child nutrition within SUN country policies and strategies is imperative for assessing progress toward these targets. Only 10 of 59 countries mention all six WHA targets within their current policies (Table 1). Few SUN countries track the three nutrition-specific NCD targets (overweight/obesity in adults, diabetes in adults and salt/sodium intake) within their national policies and strategies either.

Low- and lower middle-income SUN countries are more likely to include targets related to undernutrition (stunting, wasting and anaemia) as well as exclusive breastfeeding in their policies/strategies compared to upper middle-income countries.

INSTITUTIONALIZATION & COORDINATION OF INFORMATION SYSTEMS

Research on the degree of institutionalization of information systems for nutrition in SUN countries revealed evidence of a designated coordinating department or ministry for nutrition information in 25 SUN countries; coordinating bodies were more common in higher income countries. A central repository for nutrition data and reports that facilitates sharing information across sectors and programmes was found in 21 countries, with 16 of these repositories being publicly accessible (i.e. available to the public online). However, many of the most recent documents in these repositories were several years old, suggesting poor timeliness of information sharing.

A total of 36 SUN countries have conducted some form of stakeholder mapping. SUN countries in the Africa regions tend to score lower on institutionalization indicators but over half of countries have conducted some form of stakeholder mapping. SUN countries that joined the SUN Movement in 2010–11 have higher scores for all institutionalization and coordination indicators compared to those that joined later.

TABLE 124: PROPORTION OF SUN COUNTRIES WITH A COMMITMENT TO TRACKING NUTRITION INFORMATION

Sub-components and indicators		All SUN countries, % (n/N)	Country Income Classification		
			Low, % (n/N)	Lower middle, % (n/N)	Upper middle, % (n/N)
POLICY AND PLANNING DOCUMENTS					
	Common results framework	75 (44/59)	82 (23/38)	65 (17/26)	80 (4/5)
	Monitoring & evaluation framework	38 (22/58)	29 (8/28)	44 (11/25)	60 (3/5)
	Budget exercise completed	77 (43/56)	72 (18/25)	81 (21/26)	80 (4/5)
TRACKING GLOBAL TARGETS					
WHA	Stunting in children <5 years	64 (28/44)	64(14/22)	67 (12/18)	50 (2/4)
	Anemia in women of reproductive age	57 (25/44)	50 (11/22)	72 (13/18)	25 (1/4)
	Birth weight in newborns	46 (20/44)	45 (10/22)	44 (8/18)	50 (2/4)
	Overweight in children <5 years	32 (14/44)	23 (5/22)	50 (9/18)	0 (0/4)
	Exclusive breastfeeding in children <6 months	66 (29/44)	64 (14/22)	72 (13/18)	50 (2/4)
	Acute malnutrition in children <5 years	50 (22/44)	59 (13/22)	50 (9/18)	0 (0/4)
NCD	Overweight/Obese in adults	30 (13/44)	18 (4/22)	44 (8/18)	0 (0/4)
	Diabetes in adults	5 (2/44)	9 (2/22)	0(0/18)	0 (0/4)
	Salt/sodium intake	5 (2/44)	5 (1/22)	6 (1/18)	0 (0/4)
INSTITUTIONALIZATION AND COORDINATION					
	Government coordinating body	44 (25/57)	36 (10/28)	48 (13/25)	75 (3/4)
	Central repository for data	36 (21/59)	36 (10/28)	38 (10/26)	20 (1/5)
	Data is publicly accessible	27 (16/59)	18 (5/28)	38 (10/26)	20 (1/5)
	Stakeholder mapping Completed	61 (36/59)	68 (19/28)	62 (16/26)	20 (1/5)

NATIONAL ASSESSMENT DATA

The second component, National Assessment Data, looks at what types of national surveys and surveillance systems are being used to provide an overall picture of the nutrition situation across the country.

The majority of SUN countries (46/59) have conducted the DHS and 29 have conducted the MICS within the past five years. Sixteen countries in sub-Saharan Africa and Haiti have recently conducted a national-level SMART survey, with many of these countries now using this

methodology to assess nutrition indicators on an annual basis. None of the SUN countries in the other regions have conducted this type of national nutrition survey, based on our data sources.

Twenty-six (26) SUN countries have collected data at a national scale specifically on micronutrients in the past 10 years, including those that have used the Fortification Assessment Coverage Toolkit (FACT) developed by GAIN. Household-level food consumption data is broadly available, with 58 SUN countries having conducted some form of a Household Consumption and Expenditure Survey; 53 have data collected within the past five years. Based on the information found on WFP's website[80], 45 countries have some form of food security or vulnerability assessment mapping within the past five years.

TABLE 125: PROPORTION OF SUN COUNTRIES WITH NATIONAL SURVEYS BY REGION

Type of survey	Latin America/ Caribbean (N=5)	West/ Central Africa (N=21)	East/ Southern Africa (N=19)	West/ Central Asia (N=3)	South/ Southeast Asia (N=11)	Overall (N=59)
Any national demographic & health survey (<5 y)	100 (5)	100 (21)	89 (17)	100 (3)	100 (11)	97 (57)
Micronutrient/ Fortification survey (<10 y)	20 (1)	33 (7)	(37 (7)	67 (2)	82 (9)	44 (26)
HCES (<5 y)	100 (5)	76 (16)	95 (18)	100 (3)	100 (11)	89 (53)
Food security, vulnerability mapping assessment (<5 y)	40 (2)	90 (19)	84 (16)	100 (3)	45 (5)	76 (45)

NATIONAL PERFORMANCE MONITORING DATA

The third component, National Performance Monitoring Data, focuses on the systems in place to routinely monitor coverage of services and programmes in various sectors for accurate progress tracking and prioritization of future efforts.

NUTRITION-SPECIFIC INTERVENTIONS AND PROGRAMMES

Based on the data found, several key nutrition interventions are delivered through health facilities and tracked through the health management information system (HMIS). Information on nutrition programme-based monitoring data was available from global partners, including UNICEF for vitamin A supplementation and GAIN for food fortification.

[80] The WFP manages a "one stop shop" website (http://vam.wfp.org/) with country-specific food security analysis information and reports from the most recent emergency and market assessments, baseline studies, and Monitoring, Updates and Bulletins on Food Security and Markets.

SECTORAL PLATFORMS RELEVANT FOR NUTRITION

Management information systems are established for most sectors relevant for nutrition. All SUN countries have health management information systems (HMIS) and most of these track key nutrition indicators. In the agriculture and food sector, FAO data show that 49 countries have a designated government institution or other organization that conducts regular food price monitoring. Education Management Information Systems (EMIS) were identified in 55 SUN countries. WASH data collection and use for decision-making was found in 49 SUN countries (92% of countries with data)[81]. Based on recent social protection programme country assessments,[82] 31 SUN countries had established or emerging safety net systems in place by 2010–11 but most information systems needed strengthening. In 28 SUN countries, there was either no adequate national safety net system in place or information systems were absent.

[81] Based on the UN Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS); no data for 6 SUN countries.
[82] Monchuk 2014; ADB 2015 (no data available for Guinea-Bissau and Kyrgyzstan)

APPENDIX H: UN NETWORK STAKEHOLDER AND NUTRITION ACTION MAPPING TOOL – MYANMAR EXAMPLE

The UN Network Stakeholder and Nutrition Action Mapping tool collects and collates data (who is doing what, where, and when) related to implementation of nutrition-specific and sensitive interventions by partner, including geographic location and delivery platform. The mapping also estimates geographic and population delivery coverage of nutrition actions utilizing data available in country. Data is typically presented per country, disaggregated to sub-administrative level. The following provides an example of the results based on the Myanmar country profile.

Who are the key stakeholders? What are their roles? (1/2)

	Core Nutrition Action	Responsible Ministry	Technical assistance	Field implementer	Funder
IYCF	Promotion of infant & young child feeding (IYCF)	**MOHS, MOBA, MSWRR** *DOPH, DSW, GAD, HEB, NNC*	Plan, SCI, UNICEF, WFP, WVI	ACF, CMMCS, DOPH, KBC, Malteser, MHAA, MNMA, PCI, SCI, WCM, WHH, WVI	3MDG, BMZ, EU, GAC, GFFO, JICA, LIFT, OFDA, Plan, SCD, TEAR, UNICEF, WFP, WVI
IYCF	Provide child health checks, including Growth Monitoring Practices (GMP)	**MOE, MOHS, MSWRR** *DOPH, DSW, NNC*	ETWG-ECCD, IRC, Plan, UNICEF, WFP, WVI	ACF, CMMCS, DOPH, GOLD, IRC, KBC, KMSS, Malteser, MBC, MHAA, MPSWA, NNC, PC, PTZA, WCM, WVI	3MDG, BMZ, ECHO, EU, FWAB-Japan, GAC, GFFO, Government, JICA, LIFT, MEC, MFH, Plan, SDC, SV, TEAR, UNICEF, WFP, WVI
Micronutrient supple. & fortification	Provide Vitamin A supplementation	**MOHS** *DOPH, NNC*	IRC, SCI, UNICEF	CHDN, DOPH, IRC, SCI	3MDG, NI, OFDA, UNICEF
Micronutrient supple. & fortification	Provide Iron / folate supplementation	**MOHS** *NNC*	IRC, SCI, UNICEF	CHDN, IRC, DOPH, NNC, SCI, WCM	3MDG, Diakonia, Government, OFDA, UNICEF
Micronutrient supple. & fortification	Carry out / support salt iodization	**MOHS, MONREC** *NNC*	UNICEF	Department of Mining	Government
Micronutrient supple. & fortification	Carry out / support rice fortification (with iron, folic acid, B1, A)	**MOHS, MOALI** *NNC*	PATH, UNICEF, WFP	PATH, PSI	LIFT
Mgmt. of Malnut.	Provide therapeutic and supplementary feeding as part of integrated management of acute malnutrition (IMAM)	**MOHS** *DOPH, NNC*	ACF, MHAA, SCI, UNICEF, WFP	ACF, AGE, CDN, CMMCS, IRC, KMSS, Malteser, MHAA, MHDO, NNC, PC, Plan, SCI	CIAA, DFID, ECHO, EU, GAC, JICA, MHF, OFDA, SDC, SIDA, SV, UNICEF
Disease prevention & management	Provide deworming tablets	**MOHS** *NNC*	SCI, UNICEF	DOPH, NNC, SCI	Government, OFDA, UNICEF
Disease prevention & management	Provide diarrhea treatment ORS / Zinc	**MOHS**	IRC, PSI, WVI	DOPH, IRC, KMSS, PSI, SQH, WVI	3MDG, ECHO, MHF, SV, WVI
Disease prevention & management	Provide antenatal care visits, including counselling on optimal nutrition practices	**MOHS, MSWRR** *HEB, RH*	HEB, IRC, Jhpiego, MSI, PSI, SCI, UNICEF, WHO, WVI	CHDN, DOPH, GOLD, IRC, KMSS, MPSWA, NNC, SCI, WVI	3MDG, ECHO, FWAB-Japan, Government, LIFT, MHF, OFDA, SV, UNFPA, UNICEF, USAID, WVI
Disease prevention & management	Provide post-natal care visits during post-partum period	**MOHS** *RH*	IRC, Jhpiego, MSI, PSI, SCI, UNICEF, WHO, WVI	CHDN, DOPH, IRC, KMSS, NNC, SCI, WVI	3MDG, ECHO, Government, MHF, OFDA, SV, UNFPA, UNICEF, WVI
Nut. Edu.	Provide nutrition and healthy lifestyle education for adolescents	**MOHS, MOE** *DOPH, HEB*	SCI, TWDC, UNFPA	DOPH, GOLD, HEB, SCI, UNICEF	FWAB-Japan, OFDA, UNFPA, UNICEF

REACH 1

Who are the key stakeholders? What are their roles? (2/2)

	Core Nutrition Action	Responsible Ministry	Technical assistance	Field implementer	Funder
Nut. Edu.	Promotion of health, nutrition and hygiene activities	**MOBA, MOE, MOHS**	UNICEF	DBE, DEPRT, GOLD, WHH	BMZ, FWAB-Japan, Government
WASH	Promotion of safe hygienic environment and hygiene education	**MOBA, MOE, MOHS, MSWRR** *DOPH, DSW, RRD*	AVSI, ETWG-ECCD, Plan, UNICEF, WFP	AVSI, CMMCS, DBE, DEPRT, GOLD, IRC, KBC, MOE, MOM, MSDA, NBS, PTZA, WCM, WHH	AVSI, BMGF, BMZ, DFAT, ECHO, FWAB-Japan, GFFO, Government, JICA, LIFT, MEC, Plan, SV, TEAR, Tearfund
	Provide materials / construct infrastructure and BCC for hand washing	**MOBA, MOE, MOHS** *DOPH, HEB*	HEB, Plan	CMMCS, DOPH, IRC, KBC,WCM, WHH	BMGF, BMZ, EU, GFFO, LIFT, SV, Plan, TEAR, Tearfund, UNICEF
	Provide materials / construct infrastructure and BCC for improved sanitation	**MOBA, MOC, MOE, MOHS, MSWRR, Wa SAR** *DOPH, DSW, DWS*	Plan, UNICEF, WFP	CMMCS, DBE, DEPRT, IRC, KBC, NCV, WCM WFP, WHH	BMGF, BMZ, EU, GFFO, Government, LIFT, Plan, SV, TEAR, Tearfund, WFP
Social Protection	Provide nutritious school feeding combined with nutrition education	**MOALI, MOE, MOHS, MSWRR** *DLBV, RRD*	AVSI, WFP	AVSI, DBE, DEPRT, DLBV, DSW, GOLD, MOE, MOM, MSDA, NBS	AVSI, DFAT, FWAB-Japan, Government, JICA, WFP
	Provide nutrition sensitive social safety net actions	**MOBA, MOHS, MSWRR** *DOPH, DRD, DSW, GAD, RRD*	DSW, GAD, SPPRG, WFP	ACRD, ACTED, AGE, ALARM, AYO, CDN, DOPH, GAD, GREEN, IRC, KMSS, MEET, MHDO, MNMA, NCV, OISCA, Partners, Plan, REAM, RRD, SCI, SPPRG, WVI	BMGF, EU, Government, LIFT, JICA, GAC, SDC, SIDA, The Global Fund, USAID, WFP
Food & Agriculture	Nutrition-sensitive agriculture activities, such as crop diversification	**MOALI**	Cornell	MIID	LIFT
	Ensure food safety through measuring all hazardous contaminants in foods	**MOALI**	N/A	DOA	Government
	Safe food storage, postharvest facilities, and processing facilities along the value chain	**MOALI**	N/A	DOA, DOF, MCU	Government
Rural Development	Alternative income generation activities	**MOALI, MSWRR** *DRD, DCOOP, RRD*	DCOOP, DRD, DSW, MOE, Private Sector, SPPRG, SSID, TWDC	AVSI, DCOOP, DRD, DSW, GRET, IRC, Plan, WCM, WHH	Diakonia, EXIM Bank, EU, Government, LIFT, Plan
	Enhance household food security with activities such as small scale horticulture	**MOALI, MOHS, MSWRR** *DRD, DOA, DOPH, RRD*	AVSI, DOA, Golden Plain, LIFT, Plan, TdH	AVSI, CMMCS, DOA, Golden Plain, GRET, IRC, KBC, MPSWA, TdH, WCM, WHH	BMZ, ENI, GIZ, GFFO, Government, HelpAged, LIFT, Plan
	Enhance household food security with activities such as small scale fishery and livestock	**MOALI, MSWRR** *DLBV, DOF*	DLBV, World Fish	DLVB, GRET, NAG, Pact, WHH	Government, LIFT

Overview of coverage of core nutrition actions at the national level (1/2)

	Core Nutrition Action	# of states/regions covered	Target Group	% of target population covered	Delivery Mechanisms
IYCF	Promotion of infant & young child feeding (IYCF)	10/15	Children 0-23m	3.2%	Media, Assistance organizations, Health system, Community, Mass campaigns
	Provide child health checks, including Growth Monitoring Practices (GMP)	15/15	Children 0-59m	1.5%	Community, Health system, Assistance organizations, Mass campaigns
			Pregnant women	1.0%	
Micronutrient supple. & fortification	Provide Vitamin A supplementation *(Population coverage data presented is from DHS 2015-16)*	15/15	Children 6-59m	54.4%	Health system, Mass campaigns
			Post-partum women	35.2%	
	Provide Iron / folate supplementation	15/15	Women 15-49 years	63.2%	Community, Health system
	Carry out / support salt iodization	15/15	Entire population	92.4%	Health system, Private sector, Social services
	Carry out / support rice fortification (with iron, folic acid, B1, A)	5/15	Entire population	0.1%	Private sector, Social services
Mgmt. of Malnut.	Provide therapeutic and supplementary feeding as part of integrated management of acute malnutrition (IMAM)	15/15	Children 6-59m with MAM	8.4%	Community, Health system, Assistance organizations, Mass campaigns
			Children 0-59m with SAM	12.5%	
Disease prevention & management	Provide deworming tablets	15/15	Children 2-9yrs	80.4%	Community, Health system, Mass campaigns
			Pregnant women	80.9%	
	Provide diarrhea treatment ORS / Zinc	15/15	Children 0-59m with diarrhea	2.7%	Health system, Community
	Provide antenatal care visits, including counselling on optimal nutrition practices	15/15	Pregnant women	2.1%	Health system, Community, Assistance organizations
	Provide post-natal care visits during post-partum period	15/15	Post-partum women	1.5%	Health system, Community
Nut. Edu.	Provide nutrition and healthy lifestyle education for adolescents	10/15	Adolescents 10-19yrs	0.1%	Schools, Community, Assistance organizations

≤25% >25% - ≤50% >50% - ≤75% >75%

REACH 3

Overview of coverage of core nutrition actions at the national level (2/2)

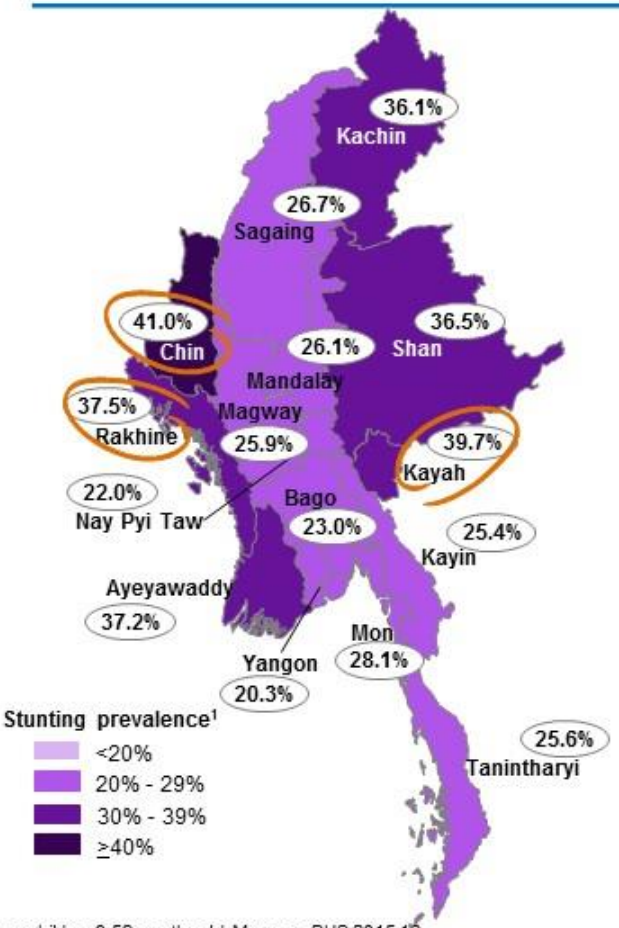
	Core Nutrition Action	# of states/regions covered	Target Group	% of target population covered	Delivery Mechanisms
Nut. Edu.	Promotion of health, nutrition and hygiene activities	15/15	Children 3-4yrs	4.6%	Schools, Community, Assistance organizations
			Children 5-9yrs	95.2%	
			Adolescents 10-19yrs	72.9%	
WASH	Promotion of safe hygienic environment and hygiene education	15/15	Entire population	16.8%	Schools, Mass campaigns, Health system, Community, Assistance organizations
	Provide materials / construct infrastructure and BCC for hand washing	7/15	Entire population	0.1%	Health system, Community, Schools, Mass campaigns, Assistance organizations
	Provide materials / construct infrastructure and BCC for improved sanitation	15/15	Entire population	16.2%	Assistance organizations, Schools, Community, Mass campaigns, Health system
Social Protection	Provide nutritious school feeding combined with nutrition education	15/15	Children 3-4yrs	1.6%	Schools, Community, Assistance organizations
			Children 5-9yrs	6.4%	
	Provide nutrition sensitive social safety net actions	15/15	Entire population	3.2%	Government, Community, Assistance organizations, Health system
Food & Agriculture	Nutrition-sensitive agriculture activities, such as crop diversification	1/15	Entire population	<0.1%	Agriculture sector
	Ensure food safety through measuring all hazardous contaminants in foods	Centralized at national level	Entire population	Not available	Agriculture sector
	Safe food storage, postharvest facilities, and processing facilities along the value chain	15/15	Entire population	18.0%	Agriculture sector, Assistance organizations
Rural Development	Alternative income generation activities	15/15	Households	28.9%	Government, Assistance organizations, Community
	Enhance household food security with activities such as small scale horticulture	15/15	Working age population	4.1%	Agriculture sector, Assistance organizations, Community, Mass campaigns
	Enhance household food security with activities such as small scale fishery and livestock	14/15	Working age population	<0.1%	Assistance organizations, Agriculture sector, Community

≤25% >25% - ≤50% >50% - ≤75% >75%

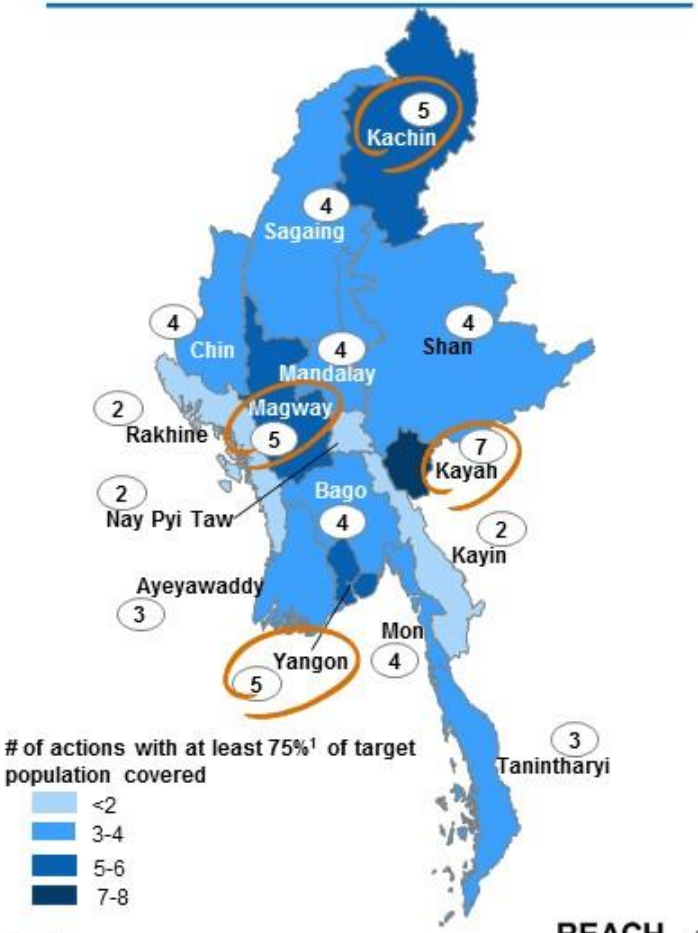
REACH 4

What is regional stunting prevalence? What is the action intensity per region?

The prevalence of stunting among children under 5 years in Chin, Kayah and Rakhine states



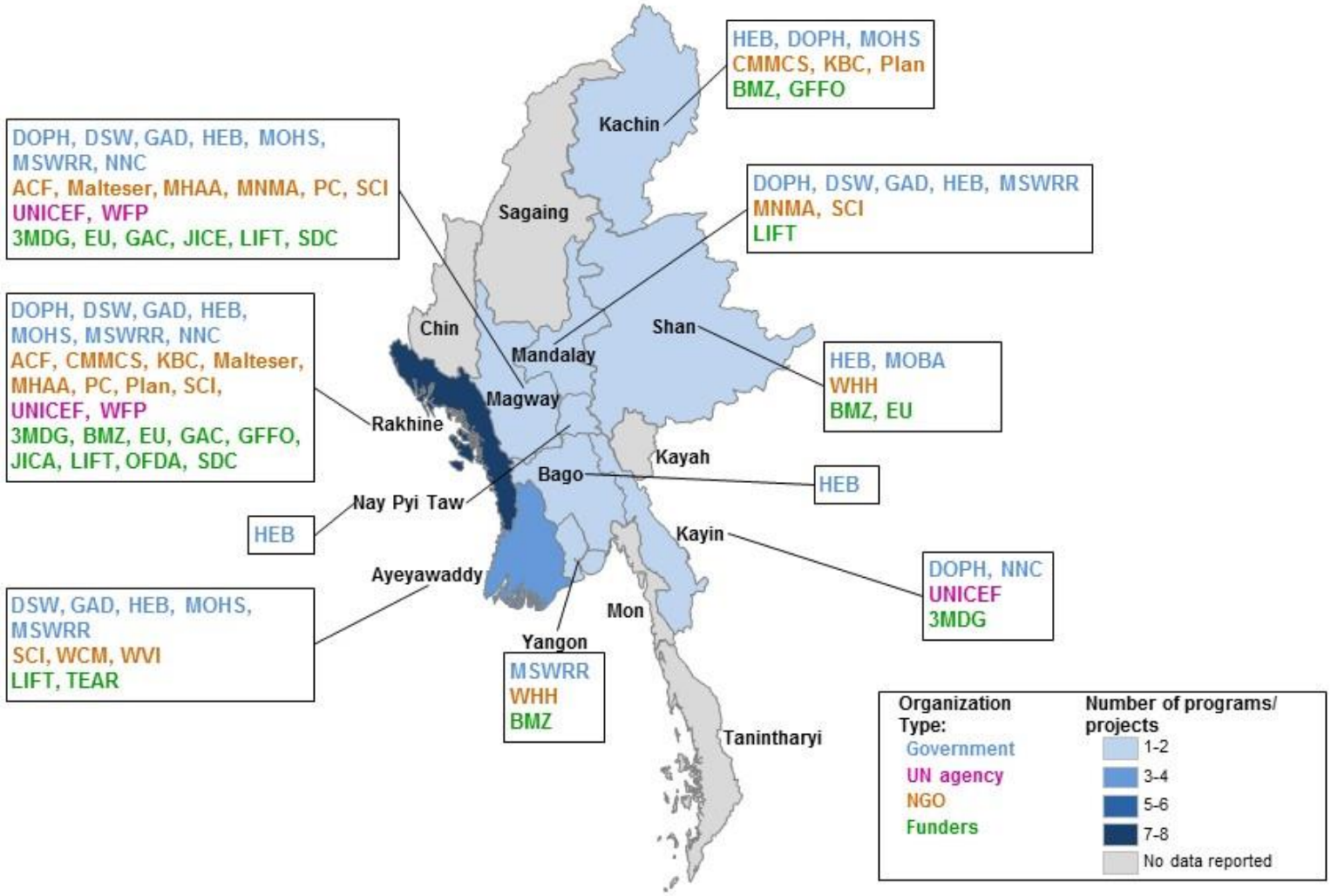
However, the states/regions with the most actions reaching ≥80% of the target population differ, except for Kayah State



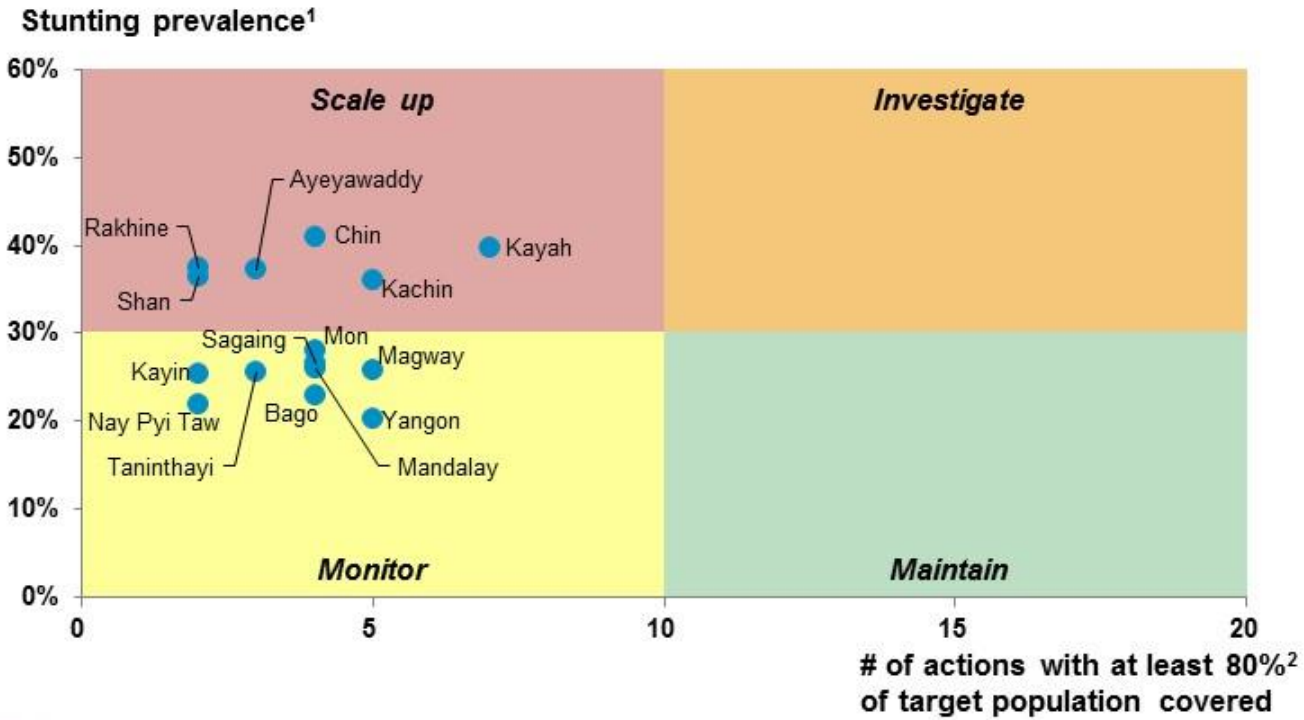
[1]Among children 0-59 months old, Myanmar DHS 2015-16
[2]This number is a country-defined level based on the results of the stakeholder mapping to highlight disparities in action coverage

REACH 6

Government and stakeholders supporting the promotion of infant & young child feeding for children 0-23 months



Which regions are not adressed adequately?



Scale up	nutrition situation is critical with low coverage of target populations
Investigate	nutrition situation is critical with adequate coverage of target populations
Monitor	nutrition situation is not critical with low coverage of target populations
Maintain	nutrition situation is not critical with adequate coverage of target populations

[1]Among children 0-59 months old, Myanmar DHS 2015-16
[2]This number is a country-defined level based on the results of the stakeholder mapping to highlight disparities in action coverage

REACH 7


Scaling Up
NUTRITION
ENGAGE • INSPIRE • INVEST


NUTRITION
INTERNATIONAL
Nourish Life


UKaid
from the British people