INTERNATIONAL DEVELOPMENT COMMITTEE INQUIRY – THE UK GOVERNMENT'S WORK ON ACHIEVING SDG2: ZERO HUNGER

ADDITIONAL EVIDENCE SUBMISSION BY THE UNITED KINGDOM COMMITTEE FOR UNICEF (UNICEF UK)

Further to the oral evidence session on January 31, 2024, provided by Grainne Moloney - Senior Advisor, Early Childhood Nutrition, UNICEF, below is additional evidence requested by the Committee:

1. UK Government's long-term investment in Kenya to support the positive results on preventing child stunting and wasting:

1.1 Over the years, DFID/FCDO has supported nutrition interventions in Kenya. DFID supported the Maternal and Child Nutrition Programme II (MCNP II) from June 2018 to December 2020 at a budget of £15 million which paved way for the multi-donor (USAID and others) funded MCNP II across 23 arid and semi-arid counties (ASAL) counties, with DFID directly supporting 13 most vulnerable counties and enabling provision of nutrition supplies for across the remaining ASAL counties. DFID funding was reprogrammed to support delivery of integrated emergency nutrition services in the COVID-19 context, including continuity of essential nutrition services especially in the most affected communities by malnutrition, Communication for Development (C4D) and WASH response actions with a focus on urban slums. The MCNP II shifted to integrated programming within a health system strengthening framework, as well as transitioning to county led implementation. Further, FCDO in contribution to the Horn of Africa drought response supported life-saving nutrition interventions including nutrition commodities up to £2.5 million (2022-2023).

1.2 Some of the key results from the nutrition interventions along the four 2018-2022 MCNP II program outputs (social behaviour change, service delivery, risk informed programming and enabling environment) include:

1.2.1 Six counties increased Government of Kenya (GoK) allocation of funds for nutrition activities.

1.2.2 Six counties transitioned to county-led implementation of at least one MCNP II output.

1.2.3 Eleven counties established multisectoral committees for nutrition.

1.2.4 Twenty-three counties were supported to conduct food and nutrition situation analysis using Integrated Food Security Phase Classification (IPC) protocols during seasonal assessments. Of these, ten priority counties were supported to conduct annual nutrition SMART surveys. The evidence generated informed response planning and decision-making at national and county levels.

1.2.5 Development of 2018-2022 Kenya Nutrition Action Plan (KNAP), KNAP M&E Framework and 13 County Nutrition Action Plans (CNAPs)

1.2.6 Approximately 69% of target health facilities in 10 arid counties were supported to implement Integrated Management of Acute Malnutrition (IMAM) Surge Approach (an early warning-early action) and resulted in building resilience of these health facilities to cope with surges in Malnutrition and provide quality nutrition services.

1.2.7 A total of 692 integrated health and nutrition outreach sites in hard-to-reach areas were supported during the 2019 drought response, contributing the major share of the scaled-up

emergency nutrition response for the 2019 drought (a total of 911 sites out of 1068 functional integrated outreaches)

1.2.8 394,369 primary caregivers of children aged 0-23 months received COVID-19 specific infant and young child feeding counselling through facility and community platforms with an additional 11.6 million people were reached through mass media and technology platforms.

1.2.9 15% of the community units in 13 target counties were supported to implementing Baby Friendly Community Initiative (BFCI); 18% Community Health Volunteers (CHVs) were trained on BFCI; 60% beneficiaries counselled on exclusive breastfeeding.

Longer Term impact of UK Investments in the Nutrition Sector in Kenya

1.2.10 The impact of the UK ODA contributions to Kenya nutrition sector overall has been significant with many of the gains documented in this article which describe the investment across the health system over a 14-year period from 2006 to 2020, which led to a transition of nutrition programming from humanitarian aid to health system strengthening in Kenya.

- https://www.ennonline.net/fex/64/healthsystemstrengtheningkenya ,

1.2.11 In addition to the investment in the health system, there have been impressive results at outcome level with substantial progress in reducing the prevalence of stunting in children under five, from 26% in 2014 to 18% in 2022 as reported in the KDHS 2023. Trends in maternal care also indicate improvements, particularly with respect to delivery by a skilled provider, which rose from 66% in 2014 to 89% in 2022, which also benefited from substantial investments by UK AID ODA to Kenya. Notably on stunting, the prevalence has decreased markedly since 1993, with the greatest decrease between 2008–09 (35%) and 2022 (18%) when UK investments were substantial. Over this same time period, changes in the prevalence of wasting and overweight have been small, although the prevalence of each is at its lowest point since 1993.

1.3 The FCDO support contributed to reducing hunger – SDG2 – in Kenya by:

1.3.1. Supporting communities to practice better nutrition through interventions such as social behaviour change communication.

1.3.2 Strengthening health systems capacity to deliver quality multisectoral nutrition services including in far flung areas.

1.3.3 Supporting early warning and early action to mitigate the effects of drought and other shocks on food and nutrition security through evidence informed contingency planning and response while implementing resilience building interventions.

1.3.4 Strengthening an enabling environment including development of multi-sectoral food and nutrition security plans, nutrition action plans that define the key multisectoral actions that need be undertaken to address malnutrition at national and county levels, development of M&E frameworks that prioritize indicators to track Kenya's commitments to addressing hunger and malnutrition.

1.3.5 Facilitating domestic resources for ending child wasting by collaboratively establishing the Child Nutrition Fund - Match Window in 2021 with UNICEF, CIFF and BMGF.

1.4 The Kenyan Government's support to the UNICEF-led Child Nutrition Fund and upcoming opportunities:

1.4.1 The Kenyan Government has efficiently leveraged the CNF Match Window, allocating over $200,000 in 2022 for the acquisition of ready-to-use therapeutic food (RUTF). This strategic move has effectively doubled the available funds for this critical life-saving commodity, allowing for the provision of life-saving treatment to more than 7,000 children. The current scenario presents an ongoing opportunity to expand the funds matched by Kenya throughout this year and in subsequent periods.

1.4.2 The CNF is actively identifying and capitalizing on additional opportunities within the Kenyan context. Areas for potential collaboration include the increase of domestic resources allocated to nutrition supplies and services through the Match Window. Furthermore, there is a focus on providing support to programs dedicated to the prevention and treatment of child wasting, including women's nutrition.

1.4.3 The overarching goal of the Child Nutrition Fund is to collaborate with the Kenyan government in scaling up services for the prevention and treatment of child wasting. By doing so, the aim is to reach by 2030 the ambitious annual target of over 9 million Kenyan women and children with these essential programmes at a cost of $75 million USD (£59 million) per year. This strategic partnership underscores a commitment to addressing crucial nutrition challenges and achieving significant milestones in ending child wasting.

2. IMPACT OF ODA CUTS ON UNICEF INDONESIA WASTING PROGRAMMING, 2020 – 2023:

2.1 Tackling wasting in Indonesia - Indonesia, despite being categorised as an upper middle-income country, has the second highest number of children under five affected by severe wasting in the world. Notably, one in twelve Indonesian children under five is estimated to be wasted, with stark differences between provinces ranging from 11.9% in Maluku to 2.8% in Bali. UNICEF's Child Wasting and Innovation Programme (CWIP) has been supporting the Government of Indonesia to improve prevention, early detection, and treatment of child wasting.

In partnership with the Government, UNICEF has been supporting policies to address child wasting through the National Strategy for Accelerating Stunting Reduction (documented in a joint UNICEF and Government publication in Emergency Nutrition Network's (ENN) Field Exchange Publication, Issue 62, in April 2022). These collaborative efforts have included child wasting awareness campaigns, including via online digital platforms, reaching over 12 million people with key messages. UNICEF introduced multiple innovations to facilitate programme scale-up. This included developing and using an online digital platform chatbot (through WhatsApp) to counsel parents and caregivers of children with wasting. A significant milestone was achieved in which the Ministry of Health (MoH) has taken steps to adopt the Chatbot and embedded it in the MoH website to reach a wider audience.

2.2. As a result of the ODA cuts and coupled with the redirection of the Indonesian government budget to the COVID-19 pandemic response, there was a sudden funding gap to maintain integration of IMAM services in the health system. The capacity building of healthcare workers was either cancelled or moved online where possible. This delayed the scaling up process of the IMAM programme with less health facilities providing IMAM services as it typically would be and affected the quality of care. Furthermore, this caused delays in the implementation of the local production of local RUTF. Consequently, severely wasted children were at risk of receiving non-standardized therapy and a lower quality of care in the field due to a disruption in the RUTF supply. Also, there was a lack of

adequate supervision and monitoring of IMAM implementation to ensure quality and continuity of services due to reduced capacity of healthcare workers.

2.3. In terms of the specific regions affected, UNICEF supports the government to expand IMAM services throughout the country, with a particular focus on seven highly affected provinces namely Aceh, Central Java, East Java, East Nusa Tenggara (NTT), West Nusa Tenggara (NTB), Papua, and West Papua. However, with the recent division of the Papua provinces into six new provinces has presented a significant challenge in terms of adequate resources needed to fully implement the IMAM programme in relation to the needs in the provinces.

2.4 As a result of the funding cuts, expanding operations between the health and WASH sectors and even to maintain the existing partnerships become difficult given the restricted resources required for programming.

2.5. The impact of UK ODA on health systems strengthening in Indonesia was particularly impactful as it enabled UNICEF to provide technical and advocacy support to the government of Indonesia (GoI) to scale IMAM within the existing health system to:

2.5.1 Institutionalize IMAM services in the primary health centres and a wide range of community-based platforms, including the monthly community health outposts (Posyandu), early childhood development centres, and mother support groups. Notably, substantial efforts have been made to support the government in enhancing the screening and referral of child wasting by continuing to integrate mid-upper arm circumference (MUAC) measurement into routine primary health care and community services nationally.

2.5.2 Incorporate child wasting screening and treatment data into national information system on health and nutrition and support the rollout.

2.5.3 Strengthen the supply chain of RUTF to support treatment of severely wasted children through evidence-based study on the acceptability and efficacy of local RUTF, development of national standard and procurement plan, and ongoing development of government regulation on local RUTF.

3. OVERALL IMPACT OF ODA CUTS ON UNICEF ROGRAMMING:

3.1 The UK is an important partner for UNICEF, providing core resources for children, or flexible funding. Completely flexible funding is a vital source of income for use across the organisation, which supports effective and efficient financing of our work, and is distributed across the organisation and country offices using an equitable criteria and an evidence based approach. After basic annual allocation of USD 850,000 per country office, additional core resources is allocated based on three key criteria; under-five mortality rate, gross national income per capita, and child population size. Each country team then allocates funds according to their nationally agreed-upon, rights based country programme, which itself is developed in partnership with government and under the umbrella of the United Nations in country and SDG targets therein.

3.2 Where a donor specifies a direction or use of funds, or in other words contributes restricted funding, this funding does not fall into the core resources allocation and UNICEF is unable therefore to focus the spend solely on greatest need for children as identified in the Country Programme document (CPD). In extraordinary circumstances, should UNICEF identify sufficient need, funding can only be redirected upon request to and approval by the donor and after the associated investment and administration in realising changes agreed. Flexible core funding, conversely, guided by our CPDs supports strengthened and highly responsive humanitarian action, underpins our capacity to innovate

for children, facilitates our work to strengthen systems over the long term, and helps us reach children and families in chronic cycles of poverty and crises which do not make the international news.

3.3. In 2018-2022 the UK was the second largest donor to UNICEF for multi-year core resources, donating a total of 154 million USD. This kind of contribution has demonstrable value for two reasons: first the funding can be directed at greatest need. Second, over multiple years it offers predictability and supports sustainable adaptive programming. Other Governments providing flexible multi-year funding at this level are Sweden, Switzerland and the Netherlands. Other resource partners offering core resources either support in single-years, or at a level less than 100m over multiple years. The UK sets a great example in this space and should continue to do so.

3.4. On 8 June 2021, UNICEF released a Press Release to convey that the FCDO pauses and reductions to earmarked contributions were negatively impacting UNICEF programming at the local, regional and global level, including:

3.4.1. UNICEF's global water and sanitation programme, through which over 2.6 million people have gained access to basic sanitation services and more than 330 schools and health care facilities gained access to water and sanitation facilities;

3.4.2. UNICEF's global programme to prevent, detect and treat child wasting which is on track to deliver essential nutrition support for at least 6 million children by 2025 in nine countries with high levels of child wasting and periodic exposure to climate shocks;

3.4.3. UNICEF's programme in Syria which in 2020 reached 3.1 million people with water services, more than 2.6 million children with polio vaccines, over 166,000 people with gender-based violence support, nearly 390,000 children with warm clothes to survive cold temperatures, and more than 17,000 children with treatment for severe acute malnutrition.

3.5. In our single-year resource revenue record however, the UK does not fall into the top 30 for 2022 for core resources for children, whereas Sweden, Switzerland and the Netherlands fall into our top 15 for single-year core resources as well as our top 4 for multi-year core resources. Multiple million USD of valuable and impactful contribution made by the UK to UNICEF work for children in a single year in 2022 was through funds restricted to countries, thematic areas, or specific projects. As a result our potential to reach the most vulnerable children and families equitably cannot be realised in full and in part our work towards equitably meeting the SDGs including SDG2 is compromised.