

Annexe A.1

i. Evaluation context

Despite the progress made, malnutrition remains a major public health and development problem in the world. According to malnutrition estimates (WB / WHO / UNICEF), in 2019, 144 million children were stunted, 47 million were wasted worldwide. In the West and Central Africa region, 29 million children were stunted and 7.3 million children were wasted, i.e. 20% and 16% respectively of global figures.

As part of the Key Results for Children (KRC) initiative of the UNICEF Regional Office for West and Central Africa (WCARO) started in 2018, KRC2 on reducing the delay in growth aims to facilitate the scale-up of nutrition programs that address the structural causes of child stunting and development. Thus, the regional priority nutrition strategies focused on:

- Maternal nutrition including adolescent girls;
- Promoting optimal infant and young child feeding practices with particular emphasis on the promotion, protection and support of breastfeeding, including early latching and exclusive breastfeeding up to 6 months and stimulation early, and complementary feeding of young children (6-23 months)
- Prevention, early detection and management of severe acute malnutrition
- Strengthening the governance framework for nutrition and the nutrition information system

These strategies are based on gender and equity and on a multisectoral and multi-system (Agriculture and food system, Education, Social Protection, Health and WASH) and multi-actor approach at regional, national and decentralized levels. They are also supported by strengthening partnerships at the regional level, with regional institutions (ECOWAS / WAHO, ECCAS), development partners and networks, such as the network of parliamentarians. Particular emphasis is placed on strengthening information systems for nutrition and innovation as well as knowledge management.

Among other initiatives, UNICEF WCARO, in collaboration with country offices and partners, has launched a campaign called "Stronger with Breastmilk Only" aimed at increasing exclusive breastfeeding rates in the region, and the initiative "First foods" with the aim of improving the diet of young children (6-23 months) during the period of complementary feeding. UNICEF also supported the ECOWAS Adolescent Nutrition Forum.

However, WCAR remains in a complex context (insecurity, conflicts, population growth, etc.). This situation is exacerbated by the COVID-19 pandemic, the consequences of which could negatively impact the nutritional situation in the countries of the region.

In this context, it is essential to continue, accelerate and strengthen efforts through synergistic and transformative actions to eradicate malnutrition in all its forms, including the achievement of key result for children number 2 aimed at preventing stunted growth.

Specific National Contexts

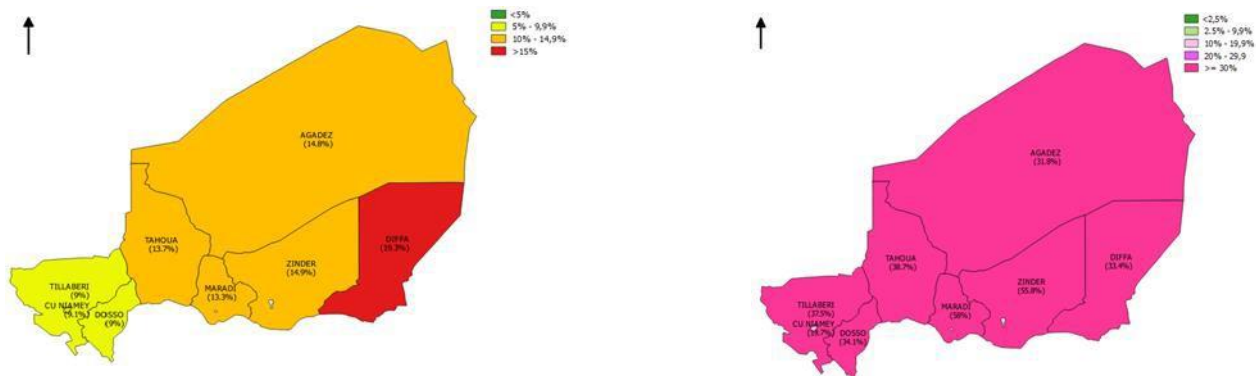
Niger:

Niger is a land locked country covering an area of approximately 1,267,000 km², making it the largest country in West Africa, with over 80% of its land area covered by the Sahara Desert. Estimated at 21.5 million inhabitants in 2018, Niger's population is experiencing rapid growth with an average annual rate of 3.9%. This has resulted in a very young population with those under 25 years of age representing 68% of the overall population and 58% being under 18-years

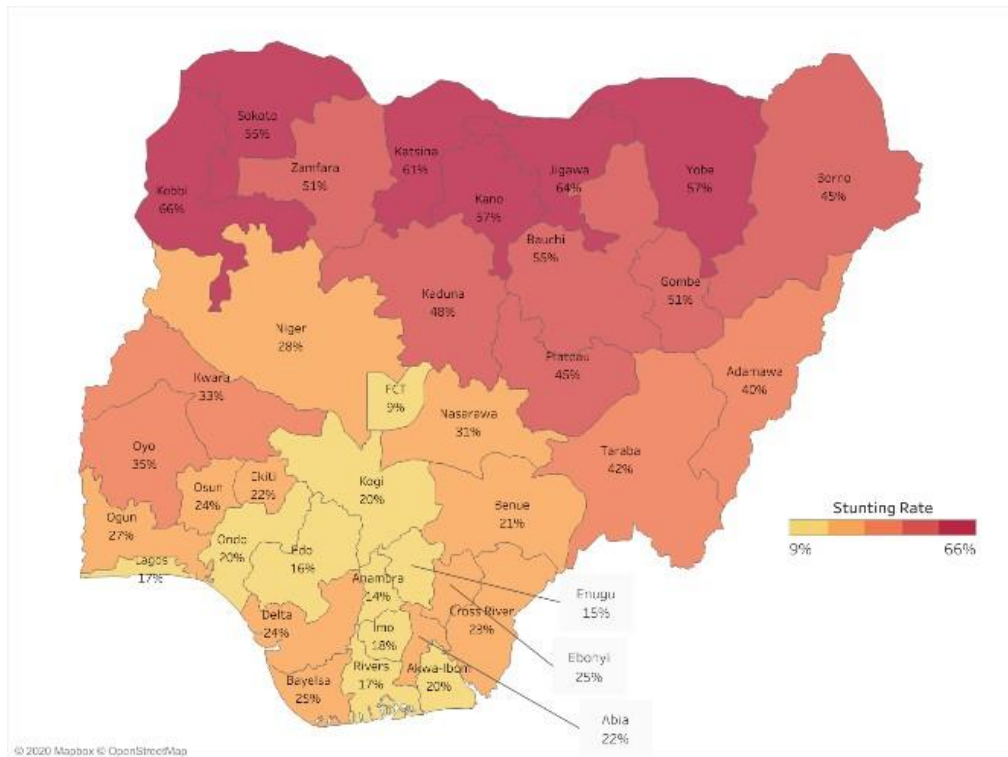
old. The population of Niger remains mostly rural (84%) and illiterate (adult literacy rate is approximately 20%). Rapid population growth presents a major challenge with projections that the population will double in twenty years' time (3.9% per year in 2012) due to high fertility rates (7.6 children per women in 2012). High fertility is associated with large families, high dependency ratios, and low levels of education, all of which are factors that contribute to poverty. The clear majority of Niger's 8.2 million are poor (90% in 2014) and live in rural areas where food insecurity is high (14.5% affected and 32.4% at-risk). In addition, human development indicators are low throughout the country. Niger is regularly affected by severe and adverse weather conditions, for instance recurrent drought in the north western and western areas, where for several years there has been famine and an increase in vulnerability. About 48% of the population are living under the poverty line. Niger is the lowest country in terms of 2018 human development index – 188 out of 188 countries.

Although the infant mortality rate has declined substantially in recent years, it remains high (85/1,000 live births in 2018). Maternal mortality rate is also high (553/100,000 live births) due to poor quality health services, limited access to key health services as well as weakness of the health system in general. Undernutrition represents a serious threat for a large majority of children and trends have remained unchanged since the last decade. A national nutrition survey based on the SMART (Standard Monitoring and Assessment of Relief and Transition) methodology conducted in September-October 2020 showed Global Acute Malnutrition (GAM) rate of 12.7% and Severe Acute Malnutrition (SAM) rate of 2.6%, above the WHO critical thresholds for GAM and SAM.

Stunting is also an issue of great concern in Niger, affecting almost one child in two (45.1%). With this rate, and given its population size, Niger has today one of the highest numbers of stunted children in the Sahel region. Maradi and Zinder, the two most populated regions of the country, are the most affected with rates above 50%.

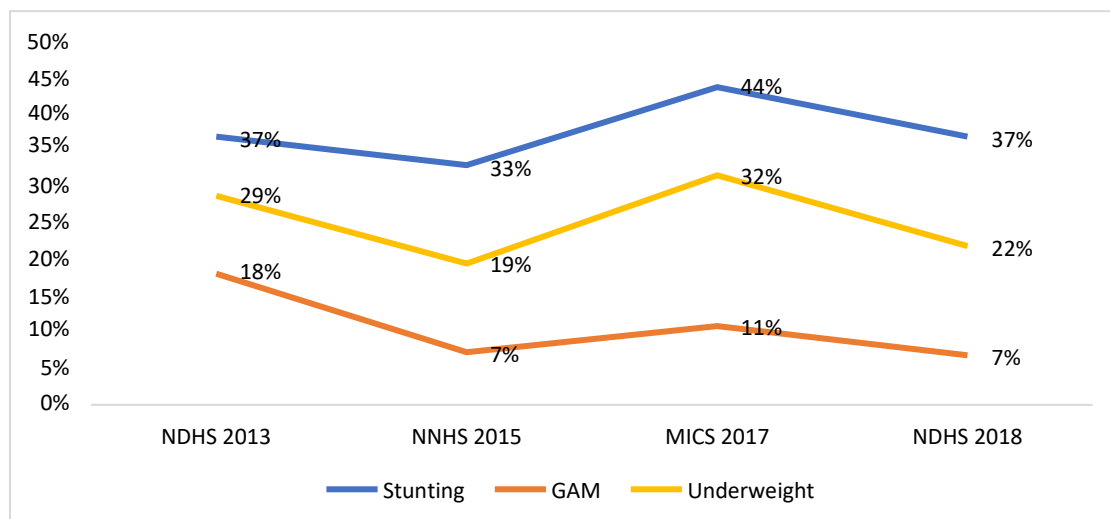


Nigeria : Nigeria has a projected total population size of approximately 200 million with 52 % of this living in urban areas. Despite being almost a middle-income country and the largest economy of the African continent, extreme poverty headcount in 2019 is 50.1 % of the population. Nigeria is a Federation of 36 states and 1 Federal Capital Territory. Each of the 36 states is a semi-autonomous political unit. Each state is subdivided into Local Government Areas (LGAs). There are currently a total of 774 Local Government Areas in Nigeria. Nigeria is home to the second-largest population of stunted children in the world with the highest rates of chronic malnutrition found in the northern part of the country. The 2018 Demographic and Health Survey (NDHS) reported that 37 % of children under-five years old are stunted which translates into over 14 million children. The country contributes about 22% of the total number of stunted children. Only 17% of children 6-23 months receive the minimum acceptable diet, and only 34.5% of children of the same age group meet the minimum dietary diversity to ensure adequate intake of key micronutrients important to ensure optimal growth and survival of children. Also, women of reproductive age have poor nutritional status and suffer micronutrient deficiency especially iron-deficiency anaemia. The 2015 NNHS estimated that 7% of the women of reproductive age surveyed were malnourished and further disaggregation of the data showed that North East and North West had the highest rates in the country. There are geographic disparities within the country regarding the prevalence of stunting as shown below.



Mapping of stunting in Nigeria (NDHS survey 2018)

The trend of malnutrition over the years indicates that to the exception of global acute malnutrition that has slightly decreased since the other indicators (underweight and stunting) have remained almost unchanged.



Trends in anthropometric indices among U5 (2013-2018)

In line with the UNICEF Nigeria 2018-2022 Country Program of Cooperation with the Government of Nigeria, various nutrition sensitive and nutrition-specific interventions are being implemented by the government. Although technical program monitoring visits and analysis of routine data have been used to monitor progress and hence the development of strategies to further improve performances in the KRC#2 indicators, this comprehensive evaluation of the KRC#2 by an external will provide useful information required to achieve more results in stunting reduction in Nigeria. Specifically, an evaluation on nutrition coordination and governance, funding and supplies, human resources,

and demand creation and update of services at the LGA and community level are critical to identifying the barriers and enablers to the achievement of desired KRC#2 results in Nigeria.

Burkina Faso: The current political context is characterized by strong social demand in a country with limited resources. Thus, the recurrence of the socio-political turmoil of 2019 and the coupled elections (presidential and legislative) next November create a climate of tension in a country where the security situation is precarious. Indeed, the security situation is weakened by repeated threats and attacks by terrorist movements and widespread banditry linked to armed attacks in certain localities. Measures are being taken by the authorities in collaboration with the population to improve security. As of September 8 the country had 1,034,609 internally displaced persons (IDPs) due to insecurity. Among them were 231,766 children under the age of 5.

Burkina Faso has an estimated population of 20,244,079 inhabitants with a strong population growth of 3.1% per year (INSD, RGPH projected 2018). This population is composed of 52% women, 24.0% of whom are of childbearing age. The majority of the population is young, 47.6% under 15 years old and 17.8% under five years old. Agriculture, animal husbandry and the mining sector are essentially the driving sectors of the country's development. Burkina Faso ranks 183rd out of 188 countries with a Human Development Index² (HDI) in the "low" category in 2018. The percentage of the population living below the poverty line³ (USD 1.25) is 40.1% at the national level. Although the economic sector is dominated by agriculture, the country is far from ensuring food security and is also constantly confronted with a food safety problem. There is frequently a problem of availability of food resources in addition to poor affordability. This translates into the importation of consumer products such as corn, rice, salt, and oils whose quality control according to the regulations in force remains weak. Some imported products (broths, broiler chickens, etc.) do not meet the nutritional needs of the population but rather their financial value.

The institutional and organizational framework for nutrition is governed by Decree N°2008-003/PRES/PM/MS/MAHRH/MASSN/MEF of January 10, 2008 on the creation, attributions, composition, organization and functioning of the National Council for Consultation on Nutrition (CNCN). This decree defines the actors of the ministerial departments and institutions/organizations involved in nutrition. Nutrition issues are therefore addressed in a multisectoral dynamic in Burkina Faso in order to better address the multifactorial causes of malnutrition. In addition to this consultation framework, there is also the National Food Security Council (CNSA), the National Council for Social Protection (CNPS) and the National Council for Water and Sanitation (CN-EAU) with often the same actors. The institutional anchoring of nutrition did not favor synergy of action and capitalization of actions in this multisectoral context.

Since Burkina Faso joined the SUN movement in 2011, the actors are organized into functional networks (Government, Civil Society, United Nations, Donors, Private Sector and Academia) whose common goal is to support the government in strengthening nutrition in the development agenda through the effective animation of the multisectoral platform, advocacy for high-level political commitment and sustainable financing. The technical and financial partners working in the field of nutrition have set up a consultation platform (PTF nutrition) with sub-groups: (i) Integrated Management of Acute Malnutrition (PCIMA); (ii) Infant and Young Child Feeding (ANJE); (iii) food security; (iv) Advocacy and communication; (v) Health and nutrition; (vi) Health and nutrition education; (vii) Health and education.

In order to improve governance in nutrition and the coordination and monitoring of the multisectoral nutrition policy, the anchoring of the CNCN was improved with the creation in 2017 of the Technical Secretariat in charge of improving food and nutrition for mothers and children (STAN) which now ensures the strategic steering of the CNCN and the focal point of the SUN movement.

The main laws governing nutrition in Burkina Faso are : The law N°028-2008/AN of May 13, 2008 on the labor code in its articles 1, art.145-148 guarantees maternity leave and the right to rest for breastfeeding when resuming service; Law N°049-2005/AN of 21 December 2005 on reproductive health in its article 7 guarantees the health of the child, in particular neonatal care/child surveillance; vaccination, growth monitoring and child nutrition; and Law N°23/94/ADP of 19 May 1994 on the Public Health Code in its articles 3, 9, 11-15, s.19-22, s.23-25, art.33-43 emphasizes the protection and promotion of good food and nutritional conditions; the decree on the marketing of breast-milk substitutes is currently being revised.

Nutrition programs in Burkina Faso primarily target children aged 0-59 months (0-23 months for the current evaluation) and pregnant and lactating women. Significant progress has been made in the fight against malnutrition in all its forms in Burkina Faso over the last decade. Indeed, chronic malnutrition has increased from 35.1% in 2009 to 25.4% in 2019

(national nutrition survey SMART) in Burkina Faso. In 2018, approximately 902,253 children under 5 years of age are affected by stunting. In addition, maternal and child undernutrition in Burkina Faso represent serious public health problems. In fact, 16% of women of childbearing age have a body mass index of less than 18.5 kg/m².

With regard to micronutrient deficiencies, the 2014 ENIAB survey found a high prevalence of anemia among women of childbearing age (61.9%) and pregnant women (72.3%). It should be noted that the prevalence of anemia among children aged 6-59 months is also very high according to the 2010 DHS (83.4%). According to the WHO classification, anemia in all population groups in Burkina Faso is a serious public health problem.

In the area of breastfeeding practices, at the national level, the rate of initiation of breastfeeding in the first hour after birth has increased from 29.2% (2012) to 59.5% (2018), the rate of exclusive breastfeeding has increased from 38% in 2012 to 59% in 2018.

With respect to complementary feeding, in Burkina Faso only 17.4% of children aged 6 to 23 months have a minimum acceptable diet and 24.2% have a minimum acceptable dietary diversification, i.e. they consume at least 4 food groups. These indicators related to complementary feeding have not changed much over the last ten years.

In view of this worrying nutritional situation, the Government of Burkina Faso is implementing specific and nutrition-sensitive interventions. As part of the specific nutrition interventions, the Ministry of Health has developed a plan to scale up infant and young child feeding interventions in 2012 for the period 2013 to 2025. The goal of the plan was to contribute to a 40% reduction in stunting among children aged 0-59 months and a reduction in infant and child mortality in Burkina Faso by 2025 by relying on the following main strategic axes:

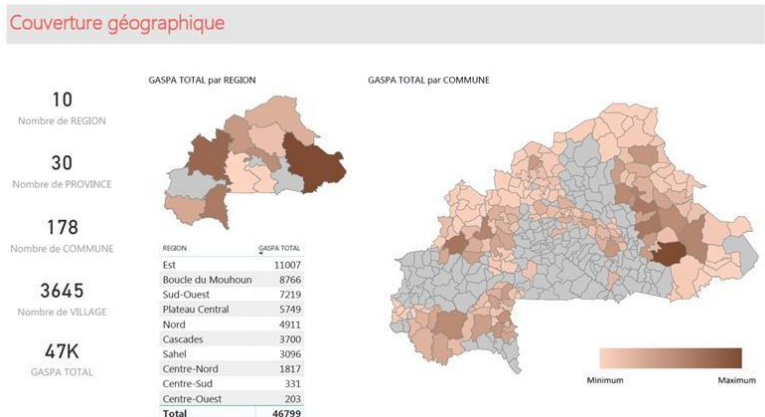
- Strengthening the quality and coverage of ANJE's community-based interventions to promote best practices.
- The creation at the community level of an environment conducive to the protection and promotion of ANJE's best practices.
- The implementation at the national level of a communication plan to support community activities.
- Support for the protection and promotion of ANJE's best practices at the level of health structures.
- Strengthening the implementation of the International Code of Marketing of Breast Milk Substitutes.
- Strengthening skills for the management of ANJE in difficult situations (HIV, emergencies).

The map presented shows the areas where ANJE's interventions are underway. Detailed data by region will be available.

The implementation of ANJE interventions is affected by the current security context. In some villages, it is increasingly difficult to bring people together for all promotional or community mobilization activities (cine-debats, fora theaters, GASPA animations). The insecurity causing population displacements, pregnant and nursing women who are members of displaced GASPA do not necessarily find these groups in the areas where they are resettled because the

program is not yet at scale. In addition, it is feared that as living conditions deteriorate, breastfeeding and feeding practices will deteriorate. The COVID-19 pandemic has also led to some changes in the implementation of activities because the number of people to be gathered for certain activities such as training and GASPA activities has been reduced.

KRC 2 has been identified as one of the priorities of the UNICEF Burkina Faso office. Since the start of the implementation of the ANJE Scale-up Plan on which Burkina Faso's KRC 2 strategy is aligned, no evaluation has ever been conducted to document its relevance to reducing stunting prevalence in a sustainable manner. In addition to this, a number of initiatives such as the planning and implementation of joint interventions (WAH-Nut, Nutrition-ECD, or the UN Agencies' Joint Project for the Prevention of Stunting Sot or have been implemented to accelerate progress toward achieving



KRCs. Having reached this level, it is relevant for the country office to monitor whether the strategies chosen are the right ones or need to be improved.

Liberia : The 2019-20 Liberia Demographic and Health Survey (LDHS)¹⁹ result show that 30 per cent children under age 5 are stunted while 10 per cent are severely stunted. The stunting prevalence can be classified as ‘very high’ based on the WHO-UNICEF threshold of ≥ 30 per cent. Stunting rates are spatially distributed across the county with geographical variations. For instance, children residing in urban areas are less likely to be stunted than those living in rural areas (25 per cent and 35 per cent, respectively). Additionally, stunting is lower in the South-Central region (25 per cent) than in the other regions (33-34 per cent). Among the counties, the prevalence of stunting is highest in River Cess (41 per cent) and lowest in Montserrado (21per cent) again indicating the urban rural disparities. The prevalence of stunting decreases with increasing mothers’ education and household wealth showing an inverse correlation. Children from educated mothers and those from the highest wealth quintile are less likely to suffer from stunting. Stunting has long-term consequences for children’s survival and development because of the effects of stunting on brain development, learning performance and, ultimately, on adults’ health and productivity, and its strong association with increased morbidity and mortality.

Three per cent of Liberian children are wasted, and 1 per cent are severely wasted (-3 SD). There is no variation in wasting between based on area of residence with children in both urban and rural areas being wasted at 3 per cent each. Also, wasting is similar among boys (4 per cent) and girls (3 per cent). Unlike with stunting, there is no clear relationship between the prevalence of wasting and mother’s education; however, wasting increases with increasing wealth status before dropping among children in the highest wealth quintile.

With regards to underweight, the 2019-2020 demographic and health survey showed that 11% of Liberian children are underweight, with 3per cent classified as severely underweight. The proportion of underweight children varies by residence, with 13 per cent of children in rural areas and 9 per cent in urban areas being underweight. By region, the proportion of children who are underweight ranges from 9 per cent in North Central to 16 per cent in North Western. The proportion of children who are underweight is highest in River Cess County (20 per cent) and lowest in River Gee County (7 per cent).

A trend analysis of anthropometric data in the 2013 and 2019-20 LDHS surveys shows that stunting, wasting, and underweight have improved in the last seven years. Over this period, stunting prevalence took a downward trend moving from 32 to 30 per cent, wasting decreased from 6 to 3 per cent while the proportion of underweight children decreased from 15 to 11 per cent. Additionally, both surveys show that stunting prevalence in Liberia varies with age with the highest increase recorded among children withinthe complementary feeding age of 6-23 months. In the 2019-2020 LDHS, the prevalence of stunting increases gradually from around 13 per cent among children aged 6-8 months and peaks at 31 per cent among children 18-23 months.

Micronutrient deficiencies appear to be of public health concern in Liberia. Overall, 45 per cent of women of childbearing age are anemic; 23 per cent are mildly anemic, 21 per cent are moderately anaemic while 1 per cent are severely anaemic. The prevalence of anemia is higher among adolescent girls within the age range of 15-19 years (55 per cent) than among women in the other age groups (40-44 per cent).

The prevalence of anaemia is 52 per cent among pregnant women indicating their high likelihood to suffer from anaemia than their breastfeeding (48 per cent) and non-breastfeeding/non-pregnant (43 per cent) counterparts. Women living in rural areas (47 per cent) are more likely to be anaemic than those living in urban areas (43 per cent). By region, the prevalence of anaemia ranges from 37 per cent in North Central to 52 per cent in North Western. By county, the prevalence is highest in Grand Bassa (59 per cent) and lowest in Nimba and Lofa (35 per cent each). There are no clear

¹⁹ The 2019-2020 LDHS is yet to be published. The Government launched the Key Indicator Report in mid May 2020.

patterns in anaemia prevalence according to education or wealth.

The main challenge in addressing stunting in the country has been limited implementation of multi sectoral approaches to nutrition. Multi sectoral approaches to nutrition requires the simultaneous implementation of both nutrition specific and sensitive interventions to address holistically the problem of undernutrition. The forgoing is supported by several studies that have been done by Civil Society Organisations in the form of Nutrition Causal Analysis as well as barrier analysis that highlighted the need to strengthen multisectoral approaches. Overall lessons learned during the implementation of phase one of the nutrition programme will inform a strategic shift in programmes aimed at addressing stunting in the country going forward. Implementation experience has indicated that there is need for a greater focus on further scaling up proven nutrition interventions through the health sector towards universal coverage, strengthening nutrition-sensitive efforts, focusing more on maternal, first foods and adolescent nutrition and strengthening systems through better policies, data gathering, analysis, and planning. This will involve scaling up nutrition interventions beyond health facilities to the community level to increase chances of attaining universal coverage, focus on maternal and adolescent nutrition as well as efforts to improve young child diets. A lot of effort is also required to support nutrition sensitive sectors to implement their interventions at scale to enhance their contribution to aggregate nutrition outcomes. To achieve results at national level, both nutrition specific and nutrition sensitive interventions must be cohesive and be delivered at scale

Programme Overview : UNICEF and The Power of Nutrition are partnering to support the government of Liberia towards meeting its aggressive goal of reducing stunting from 32% in 2018 to 22% by 2023. The proposed programme will support the implementation of the government's National Nutrition Policy, which was reviewed and approved in 2019. The proposed three-year (2020-2023) US\$10million programme will build on the foundation laid in Phase One of the programme (2017-2019), in which significant progress was made in strengthening the health system to deliver high-impact interventions at scale. Re-establishing a strong health care delivery system has been critical, as it has enabled the national scale-up and the uptake of high-impact nutrition specific interventions in Liberia, following the Ebola Virus Disease (EVD) outbreak in which uptake of health -and the limited scope of nutrition services- considerably dropped. Since 2017, UNICEF has supported the government to mainstream and scale-up 10 high-impact nutrition interventions to 80% of health facilities; embed the 10 interventions within the government health system; and strengthen the delivery capacity of health workers, which has created a pathway for sustainability of nutrition programme delivery in the country. The programme has achieved most of its key targets and has enabled over 1 million children to access age-specific nutrition interventions and over 500,000 pregnant and lactating women to access essential nutrition services². Through reviewing nutrition policies and guidelines, strengthening the capacity of the Ministry of Health (MoH) to plan and implement programmes, and advocating for a stronger government commitment to nutrition, the programme has strengthened the nutrition enabling environment. This will in turn allow a stronger policy, financing and governance environment moving forward. Another lever to improve the policy environment and programme implementation was the integration of nutrition indicators into the health management information system (HMIS), which has enhanced the implementation of policies and will enable informed decision making in programme planning, implementation and monitoring. Through its work, UNICEF has established itself as a key implementing and funding partner and a critical technical assistance provider for both the government and other development partners. This has positioned UNICEF in a much stronger position to strategically drive nutrition policy, programme implementation and the financing landscape in Liberia.

The proposed Phase Two three-year programme will build on the current gains and momentum and the success and key lessons learnt during the implementation of Phase One, with an overall aim of accelerating the reduction of stunting in Liberia. This will be achieved through strengthening both curative and preventive nutrition specific

interventions within health facilities; strengthening social behavior change and communication to create demand for services, enhancing behavior change to increase effectiveness of interventions; and further scaling preventative services to the community level to achieve universal coverage of nutrition services. Phase Two will also pilot and scale high-impact interventions that specifically target adolescent girls -who are currently unable to access nutrition interventions but comprise 38% of pregnant women- and enhance complementary feeding practices among children in the 6-24 months age group. Research will be done to better understand the barriers to effective consumption of micronutrient supplementation, which will inform programme implementation and the messaging and intensity of counselling and education provided. To build on UNICEF's increasing influence in Liberia, UNICEF will seek to further drive the nutrition landscape in Liberia through strengthening policy, governance structures, financing and improving data-based decision making.

Phase Two of the programme is estimated to reach 1.3million additional women and children and reduce the prevalence of stunting by 3 percent relative rate of reduction per annum, from 36 percent in 2018 to 32.85 percent by 2023³.

Output 1: Gaps in laws, policies, strategies and guidelines are identified, closed and progressively implemented and monitored in line with international norms and standards.

i. Phase 1 Achievements

At the upstream level, the investment influenced and catalyzed notable improvements in the enabling environment for nutrition in the country. Progress has been made in addressing barriers in the broad area of enabling environment for nutrition with the programme contributing in shaping positively the enabling environment for nutrition in Liberia as follows:

- **Strengthening of nutrition information systems.** UNICEF supported the integration of fourteen standard nutrition indicators into the Health Management Information Systems (HMIS). This involved consultations to agree on the indicators, development of data collection tools, design of reporting formats and piloting as the first phase in 2017 and part of 2018. In the second phase, the programme supported the integration of the data collection and reporting formats into the HMIS and the online DHIS-2 tools of the MoH. The tracking and monitoring of nutrition service delivery has enhanced accountability among health care providers by catalyzing them to provide and report on nutrition services (What gets measured gets done).
- **Nutrition coordination:** The Scaling Up Nutrition (SUN) movement country team membership was activated in the first quarter of 2017 and has been functional since then. In October 2018, the government appointed a coordinator for the SUN following intense advocacy by UNICEF. Presently, the SUN Focal Point is hosted by the MoH and has led the establishment of the SUN secretariat.
- **The National Multisectoral Costed Plan of Action for Nutrition (NMCPAN):** Following the validation of the National Nutrition Policy (NNP), the programme has been supporting the development of the NMCPAN for Liberia. The SUN movement is leading this piece of work and is bringing together all sectors to agree on their contribution to stunting reduction in the country.
- **Nutrition content has been included in the Nursing and Mid Wifery Curriculum.** UNICEF supported the nursing board and the Ministry of Health in the revision and updating of the nursing and mid wifery curriculum. As a result, nutrition content features in detail in the new curriculum. The application of the new curriculum will equip entry level graduate nurses and mid wives with knowledge, skills and competencies in nutrition as they join the health sector.
- **Inclusion of stunting reduction as a priority in the Government's Pro Poor Agenda for Prosperity and Development (PAPD).** This is the first time that nutrition has been included a priority in the national

development agenda in Liberia.

- **National Nutrition Policy (NNP) reviewed, updated and under implementation:** In 2018, the MoH led the process and delivered a revised NNP. The NNP includes new evidence in nutrition and broadens nutrition interventions beyond the health sector proposing a broader multisectoral approach to address stunting in the country. In addition to nutrition specific interventions that are implemented through the MoH, the NNP proposes the implementation of nutrition sensitive interventions across the relevant systems of agriculture, education and social protection. The updated NNP is also aligned to the PAPD.
- **Nutrition Sensitive Liberia Social Safety Net (LSSN) programme:** UNICEF influenced the shift towards making the Liberia Social Safety Net (LSSN) programme nutrition sensitive. Through advocacy and engagement with the key stakeholders i.e Ministry of Gender Children and Social Protection and the World Bank, nutrition accompanying measures have been included as part of the cash transfer programmes in the country. The co investment has also supported the development of a Hand Book for Nutrition Sensitive Accompanying Measures for the LSSN.
- **Inclusion of nutrition indicators in the Liberia Social Safety Net (LSSN) programme:** three standard nutrition indicators have been included in the M and E handbook of the LSSN to enable tracking of progress in nutrition practices and outcomes. The indicators are:
 - Percentage of children under five who are stunted (to be measured half yearly).
 - Percentage of primary caregivers of children aged 0-23 months who received counselling on Maternal Infant and Young Child Nutrition (MIYCN).
 - Percentage of children aged 6-23 months fed a minimum number of food groups.

ii. Phase 2 Priorities

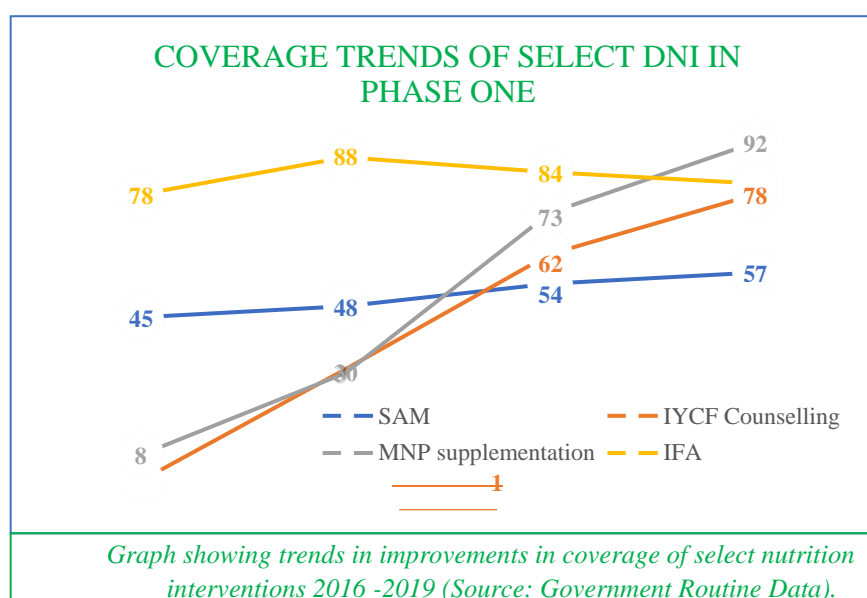
- Support the development of the costed multisectoral plan of action for nutrition in Liberia.
- Further strengthen individual and institutional capacities around nutrition information system that is integrated in the HMIS.
- Develop nutrition data collection and reporting materials for nutrition sensitive sectors and seek possibilities of operability with the HMIS at the MoH.
- The programme will also undertake operational research to better understand delivery approaches that are being effective and understand key barriers to service utilization and uptake.

Output 2: Proven direct nutrition interventions are accessible at facility and community levels and are utilized by children under five, adolescents and women of childbearing age both in development and humanitarian conditions.

i. Phase 1 Achievements

- **Comprehensive package of nutrition services is now provided in health care facilities across the country:** The package of nutrition services was expanded from three to ten with most of these services (seven) now provided routinely in public health facilities. Presently, the following Direct Nutrition Interventions (DNIs) are provided routinely in majority of public health care facilities across the country; i) Counselling on appropriate adolescent and maternal nutrition, ii) Iron Folic Acid supplementation for pregnant mothers, iii) Promotion & support for optimum breastfeeding, iv) Multiple micronutrient Powder (MNP) supplementation for children 6-23 months old, v) Promotion of appropriate complementary feeding vi) Deworming, vii) Care for children with Severe Acute Malnutrition (SAM), viii) Vitamin A supplementation.

- **Nutrition services have been embedded into the public health care system fostering sustainability:** DNIs are now provided in over 80 per cent of all public health facilities from baselines of about 30 percent. The embedding of nutrition services into the public health care system was very successful in improving access, availability and coverage of the same to the population. The integration of nutrition services into the health care system has also increased the profile of nutrition and health care providers now consider nutrition services as part of the package of health care services that they must provide.
- **Significant improvements in coverage of DNIs has been achieved:** The programme was monitored through the MoH run Health Management Information Systems (HMIS) and the online District Health System.
- **Social Return on Investment for the programme has been enhanced several folds:** The programme



originally targeted to support nutrition services in 10 counties only. However, following a change in strategy, improved efficiencies in programming and economies of scale, nutrition services are now provided in all the 15 counties in Liberia greatly increasing the social return on investment. With nutrition services provided routinely across the country, accessibility and availability has significantly improved as has the profile of nutrition generally.

ii. Phase 2 Priorities

- **Community nutrition:** Taking nutrition services to the community level through the Community Health Assistants initiative. The proposed package of services to be provided by CHAs include MNP supplementation, Vitamin A supplementation, deworming, IYCF counselling.
- **Cash transfers for nutrition:** Leverage on the Liberia Social Safety Net (LSSN) program to influence and support first food. Design and fund raise for UNICEF supported cash transfers for nutrition programme focusing on intervening within the first two years of children's lives. About USD 500,000 funding from the thematic fund has been received to finance a proof of concept on operational study this.
- **Adolescent Nutrition programming:** Pilot and roll out the adolescent nutrition programme at community level and in schools. Consultations have been completed with relevant Government ministries and departments for the roll out of the programme has been completed. A study protocol to pilot the adolescent nutrition programme has been developed that will provide evidence and inform the

nationwide roll out of the programme. Some USD 2.5 million has been provided by the Irish Aid to finance this component for three years (April 2020 – March 2023).

- **Nutrition for school age children:** This is a new programme area that needs to be rolled out too. Discussions and agreement on how to go about this have been completed with the Ministry of Education.
- **Transitioning Vitamin-A supplementation and deworming into the health care facility level.** Until 2019, the two interventions have been provided through national polio campaigns. The government strategy has changed recently necessitating the embedding of the two services within the health care facilities. As at July 2020, adequate supplies of the Vitamin A capsules and deworming tablets enough to cover for a full year have been distributed to all the 15 counties.

Output 3: Parents, adolescents, women of childbearing age, caregivers and communities understand and practice appropriate nutrition behaviours and know where and how to avail of nutrition services.

Phase 1 Achievements : Over 80% of the population were reached with messaging on nutrition through standard nutrition messages developed and validated by the Ministry of Health. All counties reached with nutrition related posters on exclusive breastfeeding, micronutrients, complementary feeding etc. Over 10,000 posters distributed.

Phase 2 Priorities : Activities will focus on Social Behaviour Change Communication (SBCC) Strategy and the process of developing a national SBCC strategy will be initiated. The strategy is deemed essential to guide a shift in demand creation and awareness raising in the country. It is planned to develop a nationwide stunting reduction campaign based on the SBCC and engage nutrition champions to speak on importance of nutrition.