Nutrition Thematic Report

January – December 2018

Submitted by
UNICEF West and Central Africa Regional Office

unicef
for every child

Contents

Photo Credit Front page : © UNICEF/UN0238130// Vincent Tremeau, Chad 2018.

Abbreviations and Acronyms

AfDB	African Development Bank
ALN	African Leaders for Nutrition
BEG	Bahr El Gazal
CAR	Central African Republic
CBHW	Community-Based Health Workers
CDC	Centre for Disease Control
CCD	Care for Child Development
CFC	Child-friendly Community
CILSS	Permanent Interstate Committee for Drought Control in the Sahel
CO	Country Office
ECCAS	Economic Community of Central African States
ECD	Early Childhood Development
ECN	Early Child Nutrition
ECHO	European Commission's Humanitarian aid and Civil Protection department
ECOWAS	Economic Community of West African States
GAM	Global Acute Malnutrition
GAVA	Global Alliance for Vitamin A
GIFTS	Girls Iron Folate Tablet Supplementation
FAO	Food and Agriculture Organisation
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immuno-Deficiency Syndrome
HMIS	Health Management Information System
HQ	Headquarter
IASC	Inter-Agency Standing Committee
ICCM	Integrated Community Case Management
IGN	Iodine Global Network
IYCF	Infant and Young Child Feeding
MICS	Multiple Indicator Cluster Survey
NGO	Non-Governmental Organization
NI	Nutrition International
OR	Other Resources
RISING	Regional Initiatives for Sustained Improvements in Nutrition and Growth
RNWG	Regional Nutrition Working Group
RO	Regional Office
FCRN	Food Crisis Prevention Network
RR	Regular Resources
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SDGs	Sustainable Development Goals
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SMC	Seasonal Malaria Chemoprophylaxis
SUN	Scaling-Up Nutrition
UN	United Nations

UNICEF	United Nations Children's Fund
VAS	Vitamin A Supplementation
WAHO	West African Health Organization
WASH	Water, Sanitation and Hygiene
WCAR	West and Central Africa Region
WCARO	West and Central Africa Regional Office
WFP	World Food Program
WHO	World Health organization
WN	Women Nutrition

Executive Summary

Undernutrition is one of the most serious but also most neglected public health and development problems, and its consequences are tragic, yet preventable. Nearly half of all deaths in children under 5 are attributable to undernutrition[1]. Children suffering from malnutrition in the first 1,000 days of their lives (between a woman's pregnancy and her child's second birthday) are victims of a vicious cycle, where poverty, inadequate diet and disease combine to give them the worst possible start in life, trapping individuals and societies in poverty. As the world looks to the Agenda 2030, greater efforts and investments in nutrition are needed to reach the Sustainable Development Goals (SDGs), including SDG 2, which aims to end hunger and all forms of malnutrition by 2030.

The burden of malnutrition across West and Central Africa Region (WCAR) remain unacceptably high, and the progress unacceptably slow. Stunting regional prevalence is declining too slowly while wasting is showing a plateau and still impacts the lives of far too many young children affecting 29 million (accounting for 20 % of stunted children in the world) and 5.8 million children in 2017 respectively[2]. There continues to be a pervasive and an excessively prevalent burden of anemia both in women of reproductive age (49 %) and in pregnant women (54%). While one of the major determinants of stunting in the region is poor Infant and Young Child Feeding (IYCF) practices, these practices are still very low. For instance, exclusive breastfeeding for infants below 6 months and minimum dietary diversity only reached 32.9% and 25.1% respectively in 2018.

UNICEF West and Central Africa Regional Office's (WCARO) presence in 24 countries, multisectoral experience, lead role in the nutrition sector and equity-driven approach make it uniquely positioned to lead progress and get the region on track towards achieving the SDGs. In 2018, the regional office seized the opportunity of the new Strategic Plan (SP) 2018-2021 to renew its commitment towards providing every child with the best start in life. A comprehensive and ambitious agenda have been developed to achieve eight key results for children out of which one focuses on the prevention of stunting: ''*By 2021, 93% (86 million) girls and boys under-five, especially those marginalized and living in humanitarian situations, receive high-impact nutrition services to prevent stunting*''. The choice of stunting reduction as a key result for children and a priority for UNICEF regional office for West and Central Africa was triggered by the insidious nature and the irreversible long terms development and economic consequences of the condition on children and nations. No sustainable results for children can be attained given that stunting is a key marker of development (or lack thereof) that carries significant long-term economic and societal costs. The technical solutions and opportunities exist but they are not yet optimized. The rate and magnitude of this form of malnutrition suggest the need to increase speed and scale of the interventions and investments.

In its first year of the new SP, in 2018, UNICEF WCARO strengthened partnerships, conducted high-level policy advocacy and provided technical assistance to countries involving knowledge generation and capacity development, with a focus on accelerating progress towards the KRC 2 related to reducing stunting. As we know more than ever what policies work, the regional office supported countries in strengthening nutrition multisectoral strategies and plans to translate them into actions. As a result, 13 countries have adopted a multisectoral nutrition plan, including 8 countries that are now equipped with costed plan addressing infant and young child feeding specifically and 10 conducted decentralized monitoring and the central place of adolescent girls widely disseminated in regional fora. Additionally, data on spending for each WHA is critical to better inform policy makers and strengthen strategic investment for nutrition. As such, the regional office developed training

[1] Black, R. E., Victora, C.G., Walker S.P. et al. 'Maternal and child undernutrition and overweight in low-income and middle-income countries' Lancet, vol.382, no.9890, August 2013.

[2] Source:UNICEF/WHO/World Bank group joint child malnutrition estimates, May 2018

package for national budget allocation to nutrition, piloted and supported budget tracking exercises in five countries (Burkina Faso, Guinee, Mali, Mauritania, Togo), to advocate for increased investment in advancing nutrition from all relevant sources, with a focus on domestic resources.

To further kick off the ECN and WN agenda, UNICEF WCARO co-organized 3 strategic regional events with key partners (Alive &Thrive (A&T), Nutrition International (NI), World Health Organization (WHO) and International Baby Food Action Network (IBFAN)) gathering participants from multiple West African countries, sharing technical tools, generating knowledge management, and providing comprehensive guidelines on the promotion, protection and support of breastfeeding. More specifically, the workshops focused on the Code for Marketing of Breastmilk Substitutes, the Baby-Friendly Hospitals Initiative and maternal nutrition, enabling countries to develop action plans for 2019 and roadmaps to enhance these interventions. UNICEF has also initiated the design of a regional communication campaign on breastfeeding “Breastmilk only and no water campaign”, providing Social and Behavioral Change Communications Toolkit with countries aiming to help guide the implementation of this new strategy.

To enhance micronutrient supplementation and food fortification, the regional office has been supporting the country offices to foster and scale up the interventions that aim to reduce micronutrient deficiencies in the region. UNICEF regional office supported national governments to transition the delivery mechanisms from Polio campaigns to integration into routine delivery mechanisms to sustain bi-annual vitamin A supplementation (VAS) in the region. As in other regions of the world, identifying adequate delivery platforms has proven difficult. Although encouraging experiences, such as in Burkina Faso, were put in place, major challenges remain in most countries to ensure consistent VAS with high levels of 2-dose coverage.

In 2018, the total number of children below five years old suffering from SAM was estimated at 6.3 million in the WCA Region. Out of this total, 3.8 million (60%) were in the 9 Sahel countries and 2.1 million (33%) in Central African Republic (CAR), the Republic of Congo (ROC) and the Democratic Republic of Congo (DRC). The total number of children targeted for treatment (defined jointly with National Authorities and partners) was 3.7 million for the whole countries of the region, and 3.4 million for the 12 countries (2.1 million for the 9 Sahel countries and 1.3 million for CAR, DRC and ROC). UNICEF continued to provide financial and technical support to governments and partners. UNICEF has been the primary provider of essential supplies to support the management of SAM. Out of the 3.7 million targeted in the Region, 2.1 million (54%) children affected by SAM were treated across the 21 countries providing IMAM programming, out of which 2.0 million were in the 12 countries. Therefore, care for children with SAM reached 33% of the total number affected and 57% of the target of the whole Region. In the 9 Sahel countries, 1.7 million SAM children were newly admitted (79%) in Nutritional Unit out of 2,1million children targeted, while in the 3 others (CAR, DRC and ROC), 345.227 SAM children were treated out of a target of 1.3 million (25%).

The region kept facing growing humanitarian needs in a context of complex crises and exacerbated chronic vulnerability which required high flexibility, rapidity and efficiency of responses. To best respond to the nutritional crisis that was likely to hit the Sahel countries in 2018, the World Food Program (WFP) and UNICEF decided to work together to address immediate needs as well as longer-term challenges. Both agencies agreed on "priority areas" and developed a joint strategy. This joint approach highlighted the need for programming based on a "multi-sectoral" package of interventions to concomitantly prevent the deterioration of children’s nutritional status before they become SAM while providing treatment in supported heath facilities to those who are already affected by the disease. Finally, in 2018, UNICEF supported three country teams (Nigeria, Mali, and Mauritania) to strengthen national capacities in Nutrition in Emergencies preparedness and response.

The new commitment made towards stunting reduction through the adoption of KRC2 is a great opportunity to accelerate progress, as this commitment represent a collective engagement and responsibility towards achieving concrete results to improve nutrition among women and children in the region. In 2019 by leveraging multiple regional networks and platforms, UNICEF will seek to collaborate with a wide array of partners, including UN agencies, international and national NGOs, academic institutions, civil society and the private sector. UNICEF will make efforts to accelerate the scale up of early childhood and maternal nutrition interventions in the region. To strengthen investment in advancing women and children's nutrition from all relevant sources with a focus on increased domestic resources, UNICEF will also continue, alongside to high-level advocacy, to support budget tracking exercises in five countries.

Flexible funds are urgently needed to support investments in nutrition programming and further enable UNICEF WCARO to lay a solid foundation to achieve KRC2 and better respond to the new dynamic programming environment which is in line with the new SP 2018-2021. UNICEF will also continue to support regional efforts to prioritize nutrition and advocate for national investments in nutrition alongside supporting countries towards progress on SDG targets.

Strategic Context of 2018

Regional trends in malnutrition

Despite the region positive economic growth, the increased attention to undernutrition, and the significant progress made in maintaining high coverage of some key preventive and curative nutrition interventions, malnutrition remains a serious public health and development concern.

The WCAR still faces a complex and multi-faceted nutrition challenges, with the triple burden of stunting, wasting and growing overweight and obesity. The region is also home to other forms of malnutrition, including micronutrients deficiencies. These different, yet interlinked, forms of malnutrition, remain a devastating problem affecting infants, young children, adolescent girls, women and even nations. In 2018, the WCAR region which is home to 11% of the world children, was home to 20% of stunted children and 16% of wasted children.

Stunting rates among under 5 children declined from 41.1% to 33.7% between 2000 and 2017. However, this decline is slow, and the population is growing rapidly resulting in an increase in the absolute number of stunted children from 23 to 29 million between 2000 and 2017 (figure1). The region is not on track to reach the global nutrition target of stunting reduction as the Average Annual Reduction Rate required (5.7%) is not met (figure2) is not reached except for 4 countries (Cote d'Ivoire, Ghana, Liberia and Sao Tome & Principe).

Figure 1: WCAR stunting prevalence vs number of children affected (2000-2017)[3]

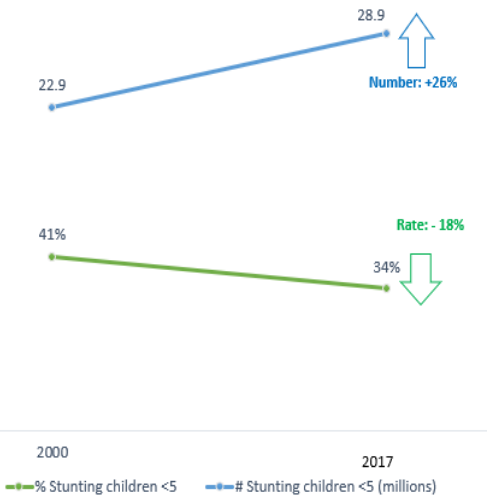
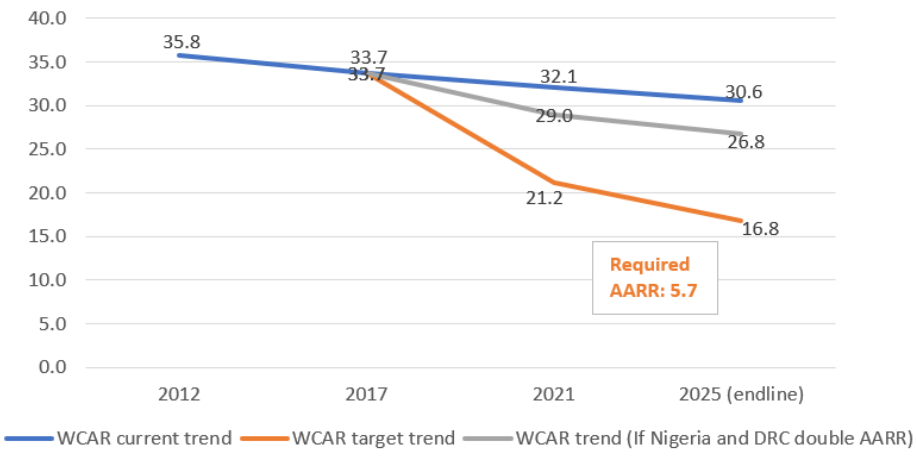


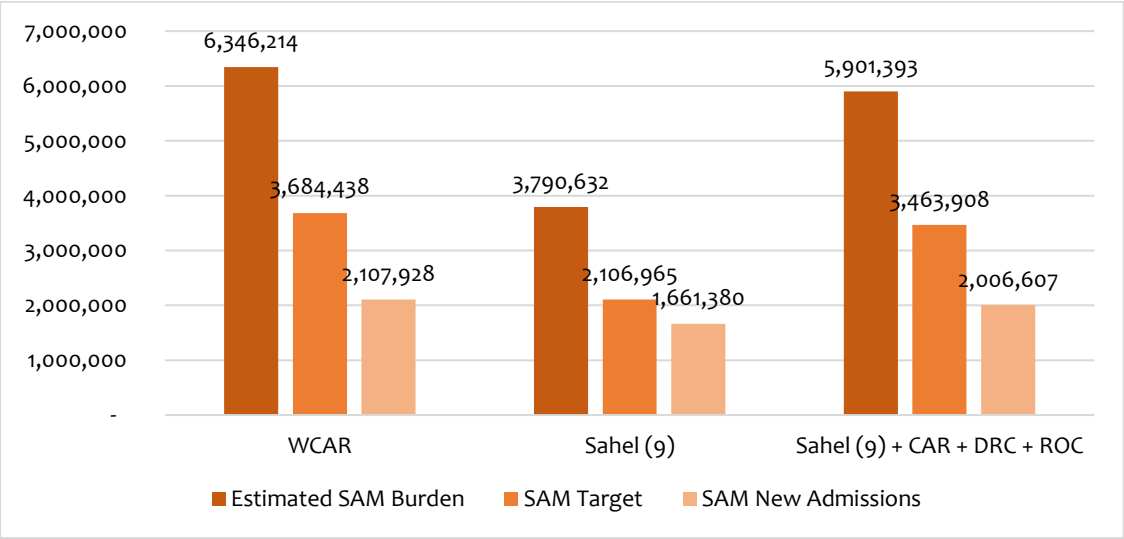
Figure 2: West and Central Africa Region stunting current trend vs target trend (2012-2025)



SAM is also widespread, with a stagnating prevalence and an absolute number of cases which continues to increase (from 3.7 to 6.4 million between 2014 and 2018) (figure 3). 2017 survey results indicated rates of Global Acute Malnutrition (GAM) above 10% in Chad, Mali, Mauritania, and Niger (classified as high level as per the new WHO thresholds). When compared to 2016 results show that SAM rates have increased in Burkina Faso (from 1.4% to 2%), in Chad (from 2.6% to 3.9%), in Mali (from 2.3% to 2.6%), and Mauritania (from 1.5% to 2.3%). However, it is important to note that national level prevalences hide many disparities at sub-national levels, where GAM and SAM rates can be above 15% and 2% respectively (very high level as per the new WHO thresholds).

[3] *Source: UNICEF, WHO, World Bank Group Joint Malnutrition Estimates, May 2018 Edition. UNICEF Annual Results Report 2017 Nutrition.*

Figure 3: SAM Burden vs SAM Target vs SAM New Admissions – 2018

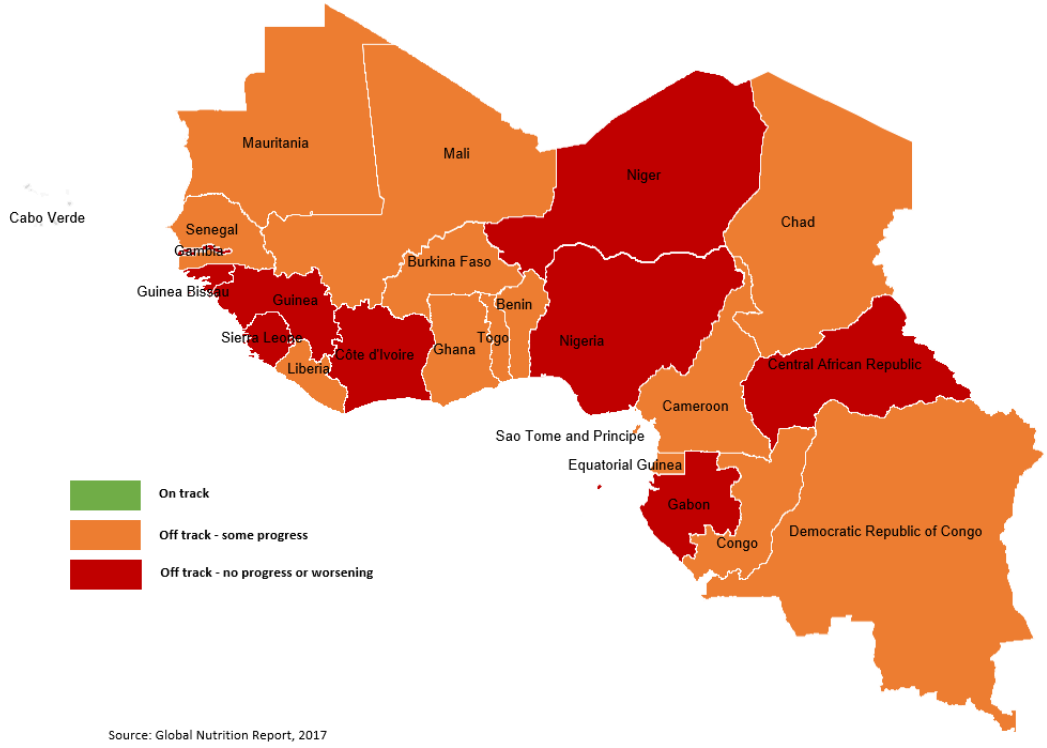


We know that one of the major determinants of stunting in the region is poor infant and young child feeding practices, yet only 13 countries out of 24 (Burkina Faso, Cameroon, Congo, Côte d'Ivoire, DRC, Gambia, Guinea, Guinea-Bissau, Mali, Mauritania, Niger, Sao Tome and Principe and Sierra Leone) are "on course" to reach WHA target by 2025. Evidence also demonstrates that maternal nutritional status is strongly linked to child stunting. The prevalence of anemia in pregnancy in the region is 54%. Given the impact of poor nutrition on maternal health and well-being, as well as the close links between women nutrition and early child nutrition outcomes including stunting, efforts to improve maternal nutrition are also critical in unleashing the developmental potential of countries in the region. While some countries have made some progress te reduce anemia (Benin, Burkina Faso, Camerron, Chad, Congo, DRC, Equatorial Guinea, Ghana, Liberia, Mali, Mauritania, Senegal and Togo)[4] none of the countries in the region are on track to meet the WHA 2 to halve anemia in women of reproductive age by 2025 (figure4). Furthermore, low birth weight prevalence has stagnated above 10% in all West and Central Africa countries except Cape Verde. Finaly, from 2000 to 2016, there has been a slow but steady increase in the prevalence of U5 overweight (3.6 million in 2016).

Iodine Deficiency Disorders (IDD) is also a major health problem and have detrimental consequences on newborn, children, adolescent and adults' health and well-being, including pregnancy complications, low birth weight and congenital abnormalities, decreased child survival, mental retardation and impaired cognitive and physical development. Effective control of iodine deficiency by iodine supplementation is still a challenge in WCAR. The Lack of (recent) (sub) nationally representative data for urinary iodine concentration (UIC) is a concern that needs to be addressed to provide an evidence base for the design of future strategic plans and a baseline for monitoring the impact of any revised approach in these areas.

[4] The trends are based on the Micronutrients database. WHO Vitamin and mineral nutrition information system. Geneva: World Health Organization; 2017.

Figure 4: Anemia in women of reproductive age and in pregnant women in West and Central Africa Region – WHA progress



Key Results for Children in West and Central Africa: Renewing commitment to reduce stunting

To address the needs of children, UNICEF WCARO engaged in broad range of nutrition programming, ranging from program to policy level work, prevention to treatment of malnutrition and from development to humanitarian. During 2018, the first year of the Regional Office Management Plan (ROMP) 2018-2021, the WCARO supported the UNICEF Regional Management Team to translate its vision for the KRC into reality. This involved positioning the KRCs, through advocacy and influence at the regional and global levels, as the region's focused response to the manifold deprivations and challenges facing children, and as its strategic contribution towards the SP 2018-2021 and by extension the SDG. The KRCs were put forward as a common agenda for children at all levels of the organization, to federate partners and allies around a focused set of results to catalyze palpable change in the enjoyment of child rights across the region. No sustainable results for children can be attained given that stunting is a key marker of development (or lack thereof) that carries significant long-term economic and societal costs. The technical solutions and opportunities exist but they are not yet optimized. The rate and magnitude of this form of malnutrition suggest the need to increase speed and scale of the interventions and investments. Therefore, KRC 2 has been developed and seeks, by 2021, for 93% (86 million) girls and boys under 5 years in WCA, to receive high impact nutrition services to prevent stunting. A total of 12 countries in the region have committed to implement KRC2. Accelerated stunting reduction requires looking beyond immediate causes of malnutrition to addressing structural causes of children's stunted growth and development. In the context of West and Central Africa, this means engaging more with policy and decision makers, media and considering complex resilience programming that bridges short-term interventions with long-term development programmes including adaptive social protection mechanisms. It also requires systematically addressing gender and the specific needs of adolescent. In view of the previous, KRC 2 will be translated into programming at country level through several strategies:

Strategy 1: Evidence and data as central to UNICEF planning, effective implementation, knowledge management and advocacy: An equity-focused situation analysis on the nutritional status of women and children is the foundation for country level advocacy and nutrition programming. Given that optimal nutrition is the result of both nutrition specific and sensitive inputs, the conceptual framework is used to analyse the potential contribution of sectors beyond Nutrition including Health, WASH, ECD, agriculture, social protection and education. The Regional Office (RO) provides technical support to countries to improve the quality of this analysis.
The Nutrition Section of the Regional Office has developed a guidance note to support country offices in developing an equity-focused Nutrition Situation Analysis. The guidance has three main parts which covers (i) an analysis and review of Nutrition situation and trends, for both prevalence's and numbers with an equity lens; (ii) status of Nutrition programmes in terms of nutrition-specific and –sensitive interventions and their effective coverage, and (iii) a review of the enabling environment (policies, budgets, management and coordination) for Nutrition programming, including of related Nutrition-sensitive sectors.

The Nutrition Section has also developed a bottleneck analysis tool which includes the main nutrition-specific interventions and flexibility to include nutrition-sensitive interventions from other sectors. This tool has been applied in its various iterations at national and/or regional levels in Chad, Cameroon, The Gambia, and Ghana for nutrition-specific interventions. Given that country needs surpass the regional office's current capacity to provide, the regional office has also developed a webinar on vitamin A supplementation bottleneck analysis which has potential to help many countries in this region remotely.

Strategy 2: Improved Governance and accountability and build political commitment and leadership: Limited accountability for nutrition results is noted in the region, despite political commitments and declarations. This is a bottleneck to an enabling environment for policy, strategies, funding, regulations, and economic and public finance decisions, all required to achieve coverage of interventions. To overcome this bottleneck, the RO engaged with civil society and parliamentarians to foster an accountability culture and framework for advocacy, resource mobilization and results monitoring. The workshops were successfully conducted across the region and the materials used are available.

The RO also supports capacity-strengthening of regional bodies (Economic Community of West African States (ECOWAS) and ECCAS eco-systems), African Development Bank Group and related platforms on nutrition leadership; advocacy for including nutrition in their work; and regional policy formulation and implementation. The aim is to provide guidance and support to countries at the political level, within line ministries.

Strategy 3 - Breaking from the past vertical approaches: Through the line ministries to a widened and coherent approach, with the accountability and leadership on the local administrative authority. This implies a community-based multi-sectoral package of interventions – including both supply/service delivery and behaviour and social change and professional community workers' system. This strategy is merged to the Child Friendly Community (CFC) which is progressively being rolled out and has the support from the UNICE top level. This strategy will allow at least 3 important facts:

- Downsize the geographical size of programme to a level that allows an effective management of the programme. Experience shows that progress happens more quickly and frequently into small size countries rather than in larger. Some provinces or States in DRC or Nigeria are larger and more populated than many countries in the region, but do not benefit from an equivalent level of resources to manage the programme
- Accountability and ownership by local administrative or elected authorities and communities as they are closer to the beneficiaries and right owners

- More control on numbers and individual longitudinal follow up from pregnancy to 23 months through delivery and early infancy period

An analysis of the determinants for malnutrition in the region reveals the importance of scaling-up a context-specific package of nutrition-specific and –sensitive interventions in the same geographic areas (geographical convergence) in order to achieve projected reductions in stunting. For instance, in countries where diarrhea and malaria are important contributors to mortality and stunting, nutrition specific interventions need to be accompanied by efforts to prevent and control, and treat diarrhea and malaria, and improve the provision of clean water and sanitation in the same geographic areas and to improve hygiene behaviors. In these settings, treatment of children with severe acute malnutrition must be part of an integrated effort to treat other childhood illnesses such as malaria.

Strategy 4: Engaging with all relevant line ministries and all stakeholders to benefit from nutrition sensitive nutrition contribution: The contribution of many sectors is important to achieving reduction of stunting. Especially achieving accelerated and sustainable reduction required to counterbalance the population growth will not be possible unless all efforts from all relevant sectors are put together. The vertical structure of line ministries in the Government is per se an obstacle to multisectoral convergence, however using the influential power of civil societies, parliamentarians and the SUN Government focal point must be considered by UNICEF to have:

- Nutrition specific results and indicators included in the national policy or strategy document
- Sector specific nutrition sensitive indicators included in the national nutrition programme result framework and monitoring indicators
- Required resources, both financial and human allocated

Strategy 5: Communication for Development, focusing on evidence-based communication for removing the water in under 6-month infant's diet, and improving dietary diversity for older infants and young children: The evidence shows that giving water to infant less than 6 months represents in most countries the main obstacle to high level of exclusive breastfeeding. The recommended approach is therefore to focus the effort to behaviour change communication on strategies that will allow to remove water and fluids in infant diet before the age of 6 months. Similarly, poor intake of animal source food by young children 6-23 months is the main reason for low rate of diet diversity. Communication for development would be helpful in assisting to deliver correct and appropriate and specific messages (messages and activities should be tailored depending on cultural practices and social norm that prevail within the communities) for these 2 feeding practices, so as to achieve the required intensity and using various channels for messaging, dialogue and counselling. This is based on the Alive & Thrive proven model that has demonstrated impact in Ethiopia, Bangladesh and Vietnam[5].

C4D activities should facilitate the adoption of exclusive breastfeeding for up to six months, continued breastfeeding for up to 24 months and improve the dietary diversity of infants and young children at the individual, family and community levels through uptake strategies that mix the use of interpersonal communication, home visits, mothers' groups /care support groups, media channels, community mobilization and advocacy to key influencers to take action and support specific measures to support promotion of exclusive breastfeeding and on the promotion of the campaign "Breastmilk Only, No Water" .

Strategy 6: Innovation: Technology for development to get real-time data, both on supply and demand side, with special focus on strengthening decentralized monitoring**.** Efforts are underway to

[5] A&T's comprehensive, integrated framework for achieving scale consists of four main components: advocacy, interpersonal communication and community mobilization, mass communication and strategic use of data.

develop national Nutrition Information Systems across the countries in the region. Countries are integrating nutrition indicators into routine health information systems and finding ways to collect this information routinely, including the use of technology (e.g. RapidPro, DHIS tracker). Countries are using technology to overcome health system constraints, such as using tablets to report on stock outs of essential commodities such as RUTF and vitamin A. A DHIS2 platform has helped countries organize data from different sources into one platform and generate useful dashboards to visualize data and transform it into information.

However, for most countries, weak routine reporting makes it difficult to monitor nutrition programmes. In addition, most countries lack monitoring frameworks for nutrition. Data exists but is not organized in a way to identify important data gaps/quality. The Nutrition Section has started to work with several Country Offices, including Benin, Burkina Faso and Liberia, to strengthen nutrition information systems in the country, to make sure nutrition information is available and utilized to improve programme planning and performance, and policy development.

Strategic partnership and technical support for nutrition advocacy

Acknowledging the need for a stronger commitment to the new development Agenda, unprecedented partnerships and collaboration are needed to secure a regional nutrition goals. UNICEF WCARO continued strengthening and leading regional partnerships in 2018 to raise awareness, build partnerships and capacities, generate and share evidence for improved nutrition.

UNICEF WCA Regional Director attended the 34th Food Crisis Prevention Network (RPCA) annual meeting where high-level advocacy for nutrition was made. For the first time in the history of the RPCA, the meeting resulted in the preparation and endorsement of a high-level declaration calling for a much stronger commitment to make nutrition a political and financial priority in the Sahel and West Africa. UNICEF has also actively contributed to African Leaders for Nutrition (ALN) and African Development Bank (AfdB)'s effort to develop a regional high-level advocacy tool for nutrition namely the "Score Card".

Using existing coordination bodies, such as the Regional Nutrition Working Group (RNWG), parliamentarian and regional fora (ECOWAS and the Food Crisis Prevention Network (FCPN)), UNICEF has raised awareness on nutrition challenges, lessons learned and transformative approaches to be implemented towards improved nutrition governance and accountability in the region.

Within the framework of this new SP 2018-2021, UNICEF partnered with Bill and Melinda Gates foundation, mainly focusing on ECN and WN. This partnership, ´RISING´ regional Initiatives for sustained improvements in nutrition and growth´ aims to strengthen the organizational and technical leadership of regional platforms and the Regional Economic Commissions (REC) to support the scale up of key evidence-based interventions to improve ECN and WN. To ensure optimal results and accelerate progress, this innovative partnership is mainly implemented through i) strategic advocacy and communication to improve policies, strategies and financing ii) Capacity strengthening, including system strengthening iii) Establishing and strengthening partnerships to improve coordination and synergy and iv) Knowledge management and use of evidence to influence decision making. Within the RISING framework, UNICEF joined forces and leveraged partner's expertise translated through the development of 3 partnerships (One tri-partite Memorandums of Understanding with IFPRI, A&T and 2 Programme Cooperation Agreements with HKI and ACF).

UNICEF remains a recognized partner of Scaling up Nutrition (SUN) movement, through which many countries in West and Central Africa are moving forward in terms of setting up multisectoral platform, policy and legal framework, financing tracking and resource mobilization. As of December 2018, 21

out of 24 WCA countries are signatories of the SUN Movement[6]. Cape Three countries - Cape Verde, Sao Tome and Principe, and Equatorial Guinea are still to join the Movement. UNICEF maintained its collaboration with the Inter-Parliamentary Union (IPU), to advance the momentum of mobilizing parliamentarians for the benefit of nutrition. Parliamentarians are now engaged with an action plan for their commitment in 14 countries which is far above initially expected. Next step will be to go beyond the development of action plan and ensure follow up for implementation.

The No Wasted Lives (NWL) coalition, which was launched in September 2016, has been formed to accelerate collective actions for scaling up access to preventive and curative services for acute malnutrition and support reach 6 million children affected by SAM globally by 2020. The members of the coalition are currently ACF, IRC, Save the Children, CIFF, ECHO, DFID, WFP and UNICEF. With regards to partnership in fragile context, UNICEF and WFP collaborated to elaborate joint analysis and integrated programmatic strategy to address the needs and strengthen the livelihood of women, men and children in the Sahel was developed. This resulted in a joint communication to donors and key stakeholders highlighting priority areas, needs and gaps to address. It is too hasty to attempt to evaluate the results of this UNICEF / WFP joint response plan on the nutritional status of children because impacting prevalence rates GAM (SAM & MAM) is a long-term work, however, it should be noted that this Response Plan has broken down the barrier that existed between prevention interventions and those of treatment in emergency situations. The need to implement multisectoral programming to protect the nutritional status of children upstream of their fall in SAM is now a programmatic approach acquired by nutrition stakeholders and donor partners.

Challenges

Yet progress has been limited, and in certain cases reversed, due to a number of key challenges, some of which are longstanding and others emerging. Crises generated by instability, armed conflict, insecurity and violent extremism, combined with outbreaks of measles, cholera, polio, Ebola and other diseases, continue to affect all too many countries, including the most populated. The deep-rooted nature of gender inequality is illustrated by the classification of 17 WCA countries among the 20 most gender-inequitable countries in the world. This has the effect of circumscribing the rights of girls, depriving whole societies of their potential contribution to development. Demographic growth is proceeding at such a rapid pace that the population of the region is expected to rise from 480 million in 2015 to 708 million in 2030 (48 per cent increase), with an ever-greater proportion concentrated in urban centers. By 2030, nearly 40 per cent of the world's children are expected to be African. While prevalence of certain deprivations has decreased in recent years, the number of children affected by stunting and the number of people practicing open defecation have increased due to demographic growth. Changing climate patterns are exposing ever more children to risks of natural disasters such as drought and floods.

Insufficient funding is another challenge faced. In general, international and domestic resources investments in nutrition, and particularly in stunting reduction, are half of what's require, limiting progress in achieving the WHA and Malabo targets by 2025. For example, funding sources for UNICEF from 2014-2017 were not diversified in the vast majority of the countries. Barriers to formulate and implement actions to reduce stunting include limited capacities at regional and national level; inefficient nutrition governance and insufficient understanding on how to proceed. Although most countries have adopted evidence-based policies to address the main causes of undernutrition, there is low coverage of nutrition-specific interventions, with limited knowledge and capacity to effectively deliver interventions equitably and at scale.

[6] http://scalingupnutrition.org/sun-countries/about-sun-countries/

The lack of technical capacities and leadership of critical regional institutions certainly plays a role in slowing progress to reduce malnutrition. Nutrition is considered a social issue of health programming and is not always addressed by critical stakeholder in the region. For instance, the regional economic bodies (ECOWAS and ECCAS ecosystems) are much more focusing on regional economic integration, financial inclusion, trade and security. They seem more effective in these areas than in nutrition except for WAHO nutrition (WAHO now includes nutrition as one of its priorities. However, the formulation of its first Nutrition strategy started in 2017, meaning that the previous nutrition actions targeting the health sector were fragmented with insufficient support to countries).

Looking forward

On year into UNICEF Global Strategic Plan 2018-2021, UNICEF WCARO has started to put in place an enabling environment at regional level to be on track to meet most of the regional targets in the nutrition outcome area.

In 2019 and beyond, attention will continue to be paid to KRC2 and therefore, significant efforts will further be made to leverage partnerships and galvanize action to make progress on the prevention of stunting into nutrition programming by engaging with a broad range of key stakeholders to raise awareness, build partnerships and capacities, generate and share evidence for improved nutrition governance at all levels.

In 2019 the results of the regional policy and capacity assessments for nutrition will inform UNICEF WCARO on the next steps in strengthening coordination and regional leadership. UNICEF will also contribute to revitalizing of the RNWG through collaborative creation of joint action plans with comprehensive outputs and a special focus on ECN and WN and in synergy with the No Wasted Lives Coalition. Additionally, UNICEF will support the regional assessment of ECOWAS nutrition forum and its organization in collaboration with WAHO as well as the roll-out of nutrition curricula. Finally, with regards to partnership, UNICEF will leverage HKI, ACF, IFPRI and A&T expertise, as well as existing networks (parliamentarians) to strengthen capacities of regional bodies towards a catalytic effect of the RISING investment to move the nutrition agenda forward in the region.

Drawing from the experience in 2018 in the prevention and care of SAM children, UNICEF will work towards a stronger focus on prevention, along with greater investments in interventions that work. This is needed if we want to reverse the trends and achieve the WHA targets of wasting < 3% by 2030. UNICEF will explore different concepts and models to ensure that young children at high risk of acute malnutrition are provided with a preventive package of care. UNICFE WCARO will also make efforts in bridging the humanitarian–development divide is critical to reducing vulnerabilities, managing risks and building resilience.

UNICEF will also continue improving linkages between nutrition, health, water and sanitation, and early childhood development to better address nutrition challenges in the coming year. More efforts will be put to track nutrition investment and ensure that nutrition gather sufficient domestic and international resources to address needs and challenges where they are greatest.

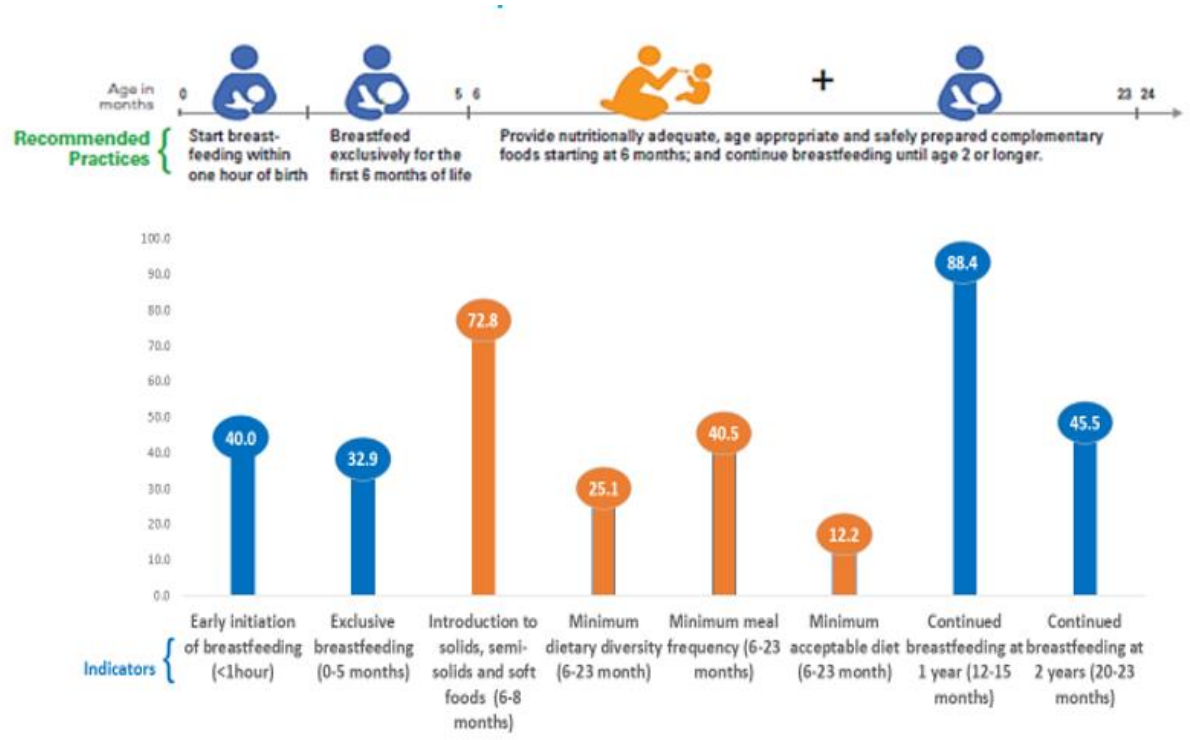
Results by programme Area:

Programme Area 1: Early Childhood Nutrition

UNICEF regional office brings its leadership in nutrition and investments for ensuring optimal ECN and WN to achieve the global nutrition targets and has made significant effort in generating evidence to build capacities and guide maternal and early child nutrition programming in 2018.

Appropriate infant and young child feeding practices are the foundation for good start in life – survival, growth and development. The 1,000 days between a woman's pregnancy and her child's second birthday is a well-recognized window of opportunity when nutrition is essential for brain development, healthy growth and strong immune system. Despite the importance of appropriate infant and young child feeding practices in the 1st 1,000 days, latest data available in the region show that the situation remains challenging. Key indicators are presented in Figure 5. There is an urgent need for enhanced infant and young child feeding programming in the region to ensure child survival and optimal development. Thus, breastfeeding and complementary feeding programming are two key priority for UNICEF in West and Central Africa to reach the 2025 WHA target for stunting.

Figure 5: Infant and Young Child Feeding (IYCF) indicators across the continuum of feeding practices in West and Central Africa in 2018



Protect, promote and support optimal breastfeeding practices

The West and Central Africa Region (WCAR) is the region in the world with the lowest rate of exclusive breastfeeding. While breastfeeding is one of the most effective interventions for child survival, growth and overall healthy development, only 29% of infants (0-5 months) are exclusively breastfed in the region compared with 43% globally (UNICEF, 2016). What is more, increases in exclusive breastfeeding rates have been small in the past ten years. There is still much to do to reach the WHA global exclusive breastfeeding target of at least 50% by 2025.

In 2018, UNICEF regional office has actively engaged into strategic partnerships to make the case for improved infant and young child feeding in the region. As a result, UNICEF has co-organized 3 regional events focusing on breastfeeding and co-designed one regional communication campaign on breastfeeding.

The three strategic regional events were organized in collaboration with A&T, WHO and IBFAN and other partners, generating knowledge and providing comprehensive guidelines on the breastfeeding, and enabling countries to develop action plans for 2019 and beyond. These events were as follows:

- In September 2018, UNICEF, in collaboration with WHO and IBFAN, organized a training course on the International Code of Marketing of Breastmilk Substitutes in Burkina Faso. The purpose of this regional training was to strengthen knowledge of the Code and relevant WHA resolutions and to monitor the implementation of the Code. This training enabled nine countries in the region to develop a national roadmap. This event was crucial to strengthen the positioning of the Code of Marketing of Breastmilk Substitutes in the regional breastfeeding agenda.
- In September 2018, UNICEF, in collaboration with WHO, A&T and WAHO, organized a regional workshop on the theme ''Building Health Systems for optimal Breastfeeding Practices in the ECOWAS Region''. More than 70 participants from nine countries attended this regional event, which complemented the Code training course to strengthen the commitment for the protection and support of breastfeeding at regional and national levels. This workshop was an opportunity to present new evidence and programmatic directions including the guidelines on baby-friendly hospitals initiative. Delegations included representatives from the Ministries of Health and UNICEF, midwives' and pediatricians' associations and members of civil society.
- Lastly, in October 2018, UNICEF catalyzed a regional brainstorming session with key regional partners on the BFHI agenda and it's rolled-out in the region.

In addition to these regional events and technical support to countries, UNICEF has initiated the design of an innovative regional communication campaign on breastfeeding entitled "Breastmilk only and no water campaign" in collaboration with A&T. Indeed, promoting opportunities to change nutrition behaviors of women, girls, families, communities and key influencers is a priority to move the nutrition agenda forward and lessons learned confirm that rapid change is possible if comprehensive SBCC strategies are developed and implemented. In many West and Central African countries, national data indicates that giving plain water in addition to breastmilk in the first six months of life is the main obstacle to improving exclusive breastfeeding rates. This campaign will be rolled-out in 2019 in ECOWAS countries to address this main obstacle.

The regional office also worked with countries offices to help them scale-up IYCF interventions and strengthen national capacities to provide community counselling services, which in turn provide caregivers with the knowledge and skills to improve feeding practices. Community-based counselling is a key pillar of strategic IYCF programmes (see spotlight Burkina Faso).

Aminata breastfeeding her child Fatima. Aminata received nutrition counselling through mother-to-mother support groups in Dori, Burkina Faso 2018.

Spotlight 1: Burkina Faso : Protection, promotion and support of optimal breastfeeding in Burkina Faso

Background: The promotion of optimal breastfeeding is one of the cheapest, most effective and equity-based interventions that have a significant impact on children, women, communities and nations. Indeed, investing in the promotion of optimal breastfeeding could save 7,300 children per year in Burkina Faso (11.6% of mortality under 5 years of age) and reduce diarrhea episodes by 54% and respiratory infections by 32%. In 2012, breastfeeding practices in Burkina Faso were alarming: early initiation of breastfeeding was 29.2% and exclusive breastfeeding 38.2%. To address this problem and help reduce stunting, the Government of Burkina Faso, with the support of partners, adopted a 2013-2025 scaling-up plan to promote IYCF best practices. One of the specific objectives of this plan is to increase the rate of exclusive breastfeeding among children under 6 months of age from 38% in 2012 to at least 80% in 2025.

Strategy and Implementation: This plan, implemented by a multi-stakeholder network (government, civil society, United Nations agencies), consists of several pillars to achieve this objective: (i) Community-Based IYCF, (ii) Multisectoral approach in nutrition, (iii) Mass communication for IYCF practices, (iv) IYCF in health facilities, (v) Strengthening legislation and (vi) IYCF management in fragile contexts (HIV, Ebola, emergencies). It is within this framework that mother-to-mother care groups have been leveraged at community level to implement nutrition counselling, among other interventions. Quality norms have been designed to ensure that women receive adequate counselling: 15 participants counselled by facilitators responsible for a maximum of 50 mothers of children aged 0-23 months and 30 pregnant women. Key community members that can impede changes in social norms work in pairs with facilitators to be sensitized hoping to remove some bottlenecks in optimal IYCF practices.

Results: 217,620 pregnant women and 580,449 breastfeeding women with children under two years of age were enrolled in this scale-up plan through the implementation of 57,000 groups, benefiting from quality optimal breastfeeding counselling. About 6,500 health workers have ANJE counseling skills. Between 2012 and 2018, IYCF's key indicators increased, including early initiation of breastfeeding, the proportion of children who received colostrum, the exclusive breastfeeding increasing from 29.2% to 59.5%, 84.2% to 92.6% and 38.2% to 47.8%[7] respectively.
The experience of Burkina Faso suggests that community level interventions must be targeted as a priority to rapidly improve indicators of optimal breastfeeding as the coverage and quality of health services in developing countries is often very low.

Improved access to and use nutritious, affordable, safe, and sustainable diets for young children

It is widely acknowledged that stunting happens mainly in children between 6 months and 2 years, the complementary feeding period, and that insufficient quantity and inadequate quality of complementary foods, together with poor feeding practices and increased rates of infection during this period are determining factors of stunting. Despite the importance if the complementary feeding period for growth and development, indicators of complementary feeding are suboptimal across countries in the region. 75 % of infants and young children in the region are not receiving a diet with the recommended minimum variety of foods and the limiting factor to be addressed is the consumption of animal source foods.

In this context, UNICEF has prioritized support to countries in the region in accelerating interventions aimed at improving the diets of young children that will contribute to the WCAR Regional priority to reduce stunting. UNICEF intends to conduct a Regional landscape analysis of trends and predictors of young children's diets. This exercise will focus on trends and predictors of complementary feeding as well as the analysis of current policies and strategies, the identification of key bottlenecks and country level lessons learned/good practices and will provide recommendations on potential innovative solutions to enhance programming such as the local production of complementary foods. In addition to the regional landscape analysis of trends and predictors of young children's diets, UNICEF WCARO will conduct a regional analysis focusing on the local production of complementary foods given the potential of this intervention.

This analysis will contribute to better understand current opportunities, gaps and propose solutions towards a better access to nutritious, affordable and safe complementary foods. In 2019, UNICEF WCARO intends to organize a regional consultation *"1st foods: Improved access to and use of nutritious, affordable, safe, and sustainable diets for young children'.* The consultation will bring a spotlight on complementary feeding issues and identify actions to improve diet diversity in young children within the context of ongoing multi-sectoral actions to accelerate stunting reduction. This consultation will build upon the outcomes and recommendations of the two regional landscape exercises.

Micronutrient supplementation

Evidence shows that VAS reduces child deaths by 12–24% when provided every four to six months to children 6–59 months of age, where vitamin A deficiency is a public health problem[8] VAS for preventing morbidity and mortality in children from six months to five years of age, which is the case for 23 out of 24 countries of the WCA region.

[7] National Nutrition Surveys using SMART methodology

[8] Imdad A, Mayo-Wilson E, Herzer K, Bhutta ZA . Vitamin A supplementation for preventing morbidity and mortality in children from six months to five years of age. Cochrane Database of Systematic Reviews 2017, Issue 3. Art. No.: CD008524. DOI:10.1002/14651858.CD008524.pub3.)

The coverage of two-dose VAS in WCA dropped in 2016, from a steady 80% between 2009 and 2015 to 56% in 2016. This drop-in coverage was mainly due to progress on achieving polio eradication, and thus the diminution of polio campaigns that were used as the main platform for delivery of VAS for about 15 years.

Latest VAS two-dose coverage estimates show that, in 20017, out of a total of about 77 million children 6-59 months, 57.5 million received vitamin A supplements in the first semester and 49 million in the second semester. Almost 42 million children, representing merely over half of the children from the region (53%), received appropriate protection from two-dose of vitamin A supplement in the year. Out of the 23 priority countries for vitamin A supplementation, only 8 reached the expected two-dose coverage of 80% in 2017, and another 8 reached less than 25% two-dose coverage. The low coverage threaten progress made in the region to decrease child mortality rate. Following outcomes only cover the 10 Canadian grant countries, for which 2018 are available (but not yet validated). Those countries are: Benin, Burkina Faso, Cameroon, CAR, Chad, Côte d'Ivoire, DR Congo, Guinea, Sierra Leone, and Togo. Only half of the Global Affairs of Canada funded countries (five out of ten) were able to reach a high level two-dose VAS coverage – over 80% of children 6-59 months supplemented with two high-dose vitamin A supplements.

Despite intensive efforts conducted by the ten GAC funded countries to transition from campaign delivery mode to a more sustainable routine system, epidemics have been holding back transition with still lots of campaigns in the region. Burkina Faso is an exciting example of transition to full routine, which has a strong government ownership, and which relies on community-based delivery mechanism (see case study: Burkina Faso Shifting to a cost-effective and efficient strategy for VAS). Benin, Côte d'Ivoire, Guinea, and Democratic Republic of Congo also have developed promising plans for transition to routine that they will need to validate in the coming years.

Spotlight 2: Shifting to a cost-effective and efficient strategy for VAS: a success story form Burkina Faso

Burkina Faso designed and tested a unique delivery mechanism in 2017, which proved very efficient and cost-effective for the two rounds of VAS conducted in 2018.
The institutionalization of VAS delivery was on the radar of the Director of Nutrition, MoH, since 2006 as well as was the strategic reflection around the challenges that had been faced with integration into immunization. The cessation of adequate funding for campaigns highlighted the need for a rapid shift to an innovative approach, while Community Health Workers were put in place nationally in rural areas. This strategy was successfully tested in the second semester of 2017, and used again for the two rounds of 2018, in June and December. The strategy designed was different for rural and urban areas.
In rural area, distribution was done by community-based health workers (CBHW) twice a year, over a period of one month. The MoH decided to institutionalize the community platform by recruiting 17,668 CBHW with a standard of at least two CBHW per village in 8,500 villages. Health activities implemented regularly at community level include treatment of malaria, treatment of diarrhea, treatment of acute respiratory diseases, screening and referral of acute malnutrition, as well as promotion of IYCF and essential family practices. At the end of each semester (June and December), CBHW provide VAS to all the children 6-59 months and deworming to children 12-59 months of their respective catchment areas. The supervision is done by the Chief of health facilities covering the villages.
In urban area, the distribution is done in a campaign mode, door-to-door, by volunteers during a four days' period, twice a year, with support of community volunteers.
The country was able to maintain very high levels of VAS coverage for both semesters at 91.3 % in June 2018 and 99.6% in December 2018.

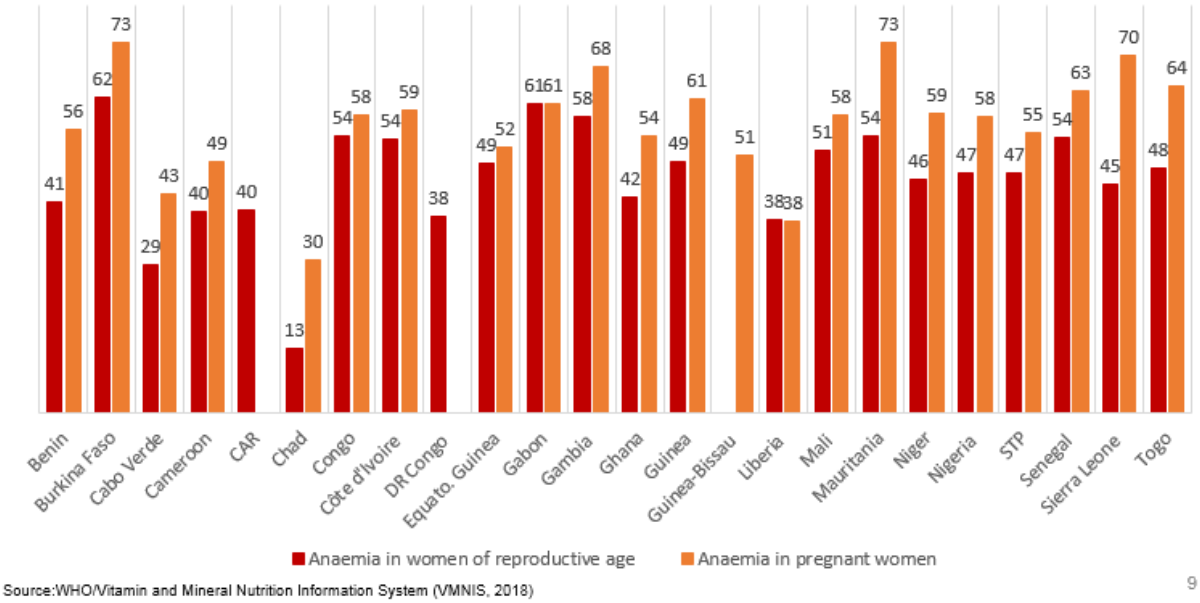
A key achievement in 2018 was that the 2-dose VAS coverage was ensured at high level while the cost of the strategy was limited, and with a very high level of ownership of the activity. The shift of delivery strategy from mass campaigns at national level to routine distribution through the institutionalize community platform in rural area has allowed to reduce the operational costs by more than 50% which is important to sustain this important activity.
The approach and sustainability of the urban strategy are being reviewed, as well as feasible alternative approaches. This will be especially relevant given that most implementation costs are to pay distributors in urban areas. The idea of using the crèche (0-3 years) and daycare (3-6 years) as potential alternatives for distribution are among the options discussed.

Programme Area 2: Nutrition of school-age children, adolescents and women

Given the impact of poor nutrition on maternal health and well-being, as well as the close links between maternal nutrition and child nutrition outcomes, efforts to improve maternal nutrition are critical to attaining the Sustainable Development Goal #2 on ending hunger and all forms of malnutrition, and in unleashing the developmental potential of countries in West and Central Africa. Unfortunately, progress on improving maternal nutrition in West and Central Africa has been slow.

The prevalence of anemia in pregnancy in West and Central Africa is 54%, with each of the 24 countries included in the region having a prevalence above the cut off level of severe public health significance (i.e. ≥40%) (figure6). Anemia can increase maternal mortality, and the region faces the highest rates of maternal mortality in the world – where 679 mothers die for every 100,000 live births . For children, the region carries one of the world's highest burden of intrauterine growth restriction in the world, second only to South Asia, as well as a high proportion of child stunting.

Figure 6: Prevalence of anemia in women of reproductive age and in pregnant women in West and Central Africa Region (%)



Source:WHO/Vitamin and Mineral Nutrition Information System (VMNIS, 2018)

9

UNICEF's convening role has contributed to bring a spotlight on maternal nutrition issues in the region and to identify actions to improve women's nutrition and subsequently reduce stunting in children across the region through multisector nutrition programming. The meeting was held in Dakar in

October and allowed 96 participants and 13 countries to come together and exchange regional analyses, expertise and experiences on improving maternal nutrition, while benefiting from technical guidance from recognized international experts on maternal nutrition topics. 10 key actions were identified with the potential to accelerate progress in the nutritional care of women during pregnancy and postpartum.

The need to review existing delivery platforms and explore non-established ones to maximize the opportunities to reach women, including adolescent girls, and families with maternal and early child nutrition interventions was identified as a priority. Noteworthy, considering WCA's large adolescent population coupled with high levels of child marriage, early childbearing and low educational status of women and girls, investments that start early in the life course are identified as crucial to accelerate progress on women nutrition -- by improving adolescents' own nutritional status, reducing the burden of poor maternal nutrition, and stopping the intergenerational cycle of poor child nutrition.

While we still lack behind with regards to nutrition for school-aged children, the new SP 2018-2021 recognizes it is a core component of UNICEF's Global Nutrition Programme and UNICEF WCARO intends to move this agenda forward. Ghana has already committed to work in this area, and the regional office will provide support to Ghana CO and most importantly enhance knowledge management to ensure that good practices and lessons learned serve to others countries in the region to improve nutrition of school-aged children in the region.

Spotlight 3: Ghana's IFA program centered around adolescent girls' health and nutritional needs reduces anemia by 26%

In October 2017, UNICEF supported the Ghana Ministry of Health (MoH) and Education (MoE) to launch the multi-phase national Girls Iron Folate Tablet Supplementation (GIFTS) program to address the high levels of anemia in girls. First program of the kind in the West Africa sub region, GIFTS is designed as an integrated adolescent nutrition and health package delivered through schools and health facilities. Health and nutrition education focused on anemia and malaria prevention, water, hygiene and sanitation (WASH) coupled with Iron Folate (IFA) supplementation is delivered on weekly basis, to girls enrolled in Junior High School, Senior High School, and Technical Education and Vocational Training; and on monthly basis, to out-of-school girls age 10-19 years registered with the Community Health Planning and Services. Prior interventions in Ghana have focused mainly on provision of IFA for pregnant women via healthcare delivery channels, and iron supplementation to children identified as anemic in clinical settings.

An IFA program in this target age group has been recognized as a high potential return on investment for Ghana since anemia is associated with poor growth, reduced concentration and learning ability, physical fitness and work productivity. Providing IFA to adolescent girls, in addition to supporting their own growth and well-being, could confer multiple intergenerational benefits. This is because anemia during pregnancy is associated with low birthweight, perinatal and maternal mortality. Further, folate deficiency is associated with neural tube defects and stillbirths.

The phase I of the program was piloted under the leadership of Ghana Health Service (GHS) and Ghana Education Service (GES) in the period 2017-2019, covering four out of Ghana's ten regions: Brong Ahafo, Northern, Upper East, and Volta; with an estimated adolescent girls' population of over 900,000 combined. Institutional capacity for implementation of GIFTS was strengthened through the development of an operational framework and capacity building of key staff at the regional and district levels (over 4500 teachers and 3000 health workers).

To strengthen the evidence base on the effectiveness of the program and inform national scale up, an impact evaluation using pre-post longitudinal surveys was conducted with technical support from US Centre for Disease Control (CDC) and Emory University. The study found operational fidelity of the IFA program and supply chain in all 60 schools surveyed was high (>90%) and only 6.7% (4 out of 60) of schools had ever missed a weekly IFA distribution due to a stock-out. Baseline anemia prevalence was 25.0% among adolescent girls and was 19.5% at the follow-on survey. After adjustment for student age, this represented a 26% adjusted population prevalence decrease. Further, the study found that the hemoglobin concentrations increased in the surveyed schools. Increases were also recorded in the number of students who have heard of anemia (from 64% at baseline to 90.9%) and IFA (from 27% to 92%), and who mentioned eating dark green leafy vegetables to prevent anemia (21 percentage points).
The Government of Ghana will scale-up of GIFTS to the remaining six regions of Ghana. Phase II will be initiated in 2019 and work to improve the overall efficiency of the program through strengthened communication, increased uptake of IFA among out-of-school girls and engagement of boys through health and nutrition education package.

Programme Area 3: Prevention and Care for children with Severe Acute Malnutrition

Children with SAM need urgent treatment and care to survive. The treatment involves a combination of routine medication, therapeutic foods and individualized care. Most children can be treated by their families, within their own homes and communities, using ready-to-use therapeutic foods (RUTF).

The care of children suffering from SAM is a critical part of UNICEF's work during emergencies and is often associated with populations living in fragile contexts. However, many children suffering from SAM live in non-emergency contexts, in settings characterized by poverty, limited access to nutritious foods and drinking water, poor feeding practices and cyclical infections, and driven by weak health, food and social safety net systems.

Severe acute malnturition remains a serious concern in the region. Prevalence of GAM are not decreasing and the number of children suffering from SAM are increasing (3.7 million in 2017 to 6.3 million in 2018). UNICEF continues to provide financial and technical support to its partners to scale-up access to treatment which is now available in about 40% of health centers in the region. The number of health facilities offering SAM treatment increased the most in the non-Sahel countries (from 7,118 in 2017 to 7,563 in 2018) in 2018. Although 20% of children affected by SAM globally live in WCARO, it is in this region that the greatest number of children with SAM are treated annually (54% of the gobal number treated in 2016 and 45% in 2017). In 2018 a total of 2,107,928 children affected by SAM (57% of the SAM Target) were admitted for treatement across the whole region, including 1.7 million in the Sahel (9 countries). Out of these, about 90% were cured.

Most countries in the region have identified ownership from governments, integration in health systems, sustainable financing, and decentralisation of services as the most critical bottlenecks to sustainable sacle-up and are working with the support of the regional office on developping scale-up plans that address these bottlenecks. In 2018, scale-up plans were developped for 6 countries (Mali, Chad, Niger, Nigeria, DRC, Burkina Faso) which are now being used to guide strategic directions and priority actions. In addtion, UNICEF WCARO provided dedicated support to 5 countries (Burkina Faso, Mali, Chad, Mauritania, CAR) to deepen the bottleneck analsyis and identify country specific bottlenecsk; better understand the causes; and identify context based solutions.

Nigeria, 2018, *A mother feeds her child with Ready-to-Use therapeutic food. UNICEF/UN0260570/Esiebo*

in 2018, many innovative initiatives were implemented to enable early detection and referrals of SAM cases. Burkina Faso, Mali, Mauritania and Niger initiated and/or reinforced the MUAC by Mothers approach to scale-up early detection of SAM children at community level. In addition, MUAC screening was integrated into Seasonal Malaria Chemoprophylaxis (SMC) campaign in 3 countries (Burkina Faso, Mali and Niger). Finally, the Combined Protocol was launched through pilots in Burkina, Mali and Chad.

Although access to treatment at health facility level is increasing slightly each year, inadequate decentralisation at community level is a significant limiting factor to effective coverage. As such, efforts towards strenghening community platforms and models of care that can easily be impelmented by community actors need to accelerate. And, given the growing number of children in need of treatment in a context of limited resources, improving programs performance and effectivness is paramount. With this in mind, UNICEF regional office has been working on developing and implementing new concepts and models that will not only simplify and unify the treatment of acute malnutrition but also improve the coverage, cost effectiveness, quality and continuum of care. UNICEF together with other NWL members (ACF, ECHO, DFID, WFP) and NGO partners (Altima, IRC)

implemented pilot programs using "simplified protocol" to respond to the 2018 Sahel nutrition crisis. This initiative started to build evidence and inform regional and global agenda. Given the growing interest from country teams, implementing partners and donors, UNICEF invested in additional human resources to provide dedicated support to countries interested in piloting or implementing the approach and to lead on evidence generation around new models of care for SAM. An initial regional and global scoping was conducted in 2018, as a first step in identifying a 2019 roadmap. Several countries have already expressed their interest for 2019 including Chad, CAR, Mauritania, DRC.

Spotlight 3: Mali : From Pilot to scale: the case of the integration of child stimulation and play in the management of SAM in Mali

Since 2014 UNICEF in Mali successfully promoted early communication and stimulation as a basic need for child's survival and development. To this effect a cross-sectoral strategy promoting the delivery of care for child development (CCD) services into the nutrition platforms was introduced as an add-on training pilot in Mali. These add-ons introduced into the nutrition care, indoctrinated reinforcing and/or improving primary caregivers' communication and stimulation practices for holistic child development.
The 2014 UNICEF supported CCD pilot was successfully brought to scale with the integration of child stimulation as a basic need for child's survival and development in nutrition interventions. The revised IMAM guideline mandates stimulation and play in the case management of all SAM children. Following the 2017 revised IMAM guidelines, concomitantly, Mali successfully conducted in late 2018 the first pilot training on the CCD enhancement module promoting caring for the caregivers. The next steps are to conduct nationwide training and improve coverage of integrated ECD interventions within the nutrition services. UNICEF in Mali will continue to financially and technically support the Government disseminate and scale-up holistic child development interventions.

Cross-cutting prgramme areas

Knowledge generation, management and exchange

Country-led performance monitoring systems are critical to assessing progress towards WHA targets and to ensure performance monitoring that directly contributes to achieving high coverage of vulnerable populations with evidence-based nutrition services. Having reliable, routine data is critical to understanding where gaps in coverage, access, or equity exist and can be improved with the right investments. Robust routine information systems should not only report quality data to national and international policy makers, but more importantly, generate relevant data that district managers and care providers use in order to make decisions that ultimately lead to sustainable outcomes in the communities served.
In WCARO, major efforts have been undertaken over the past years to improve availability of nutrition information. In 2018, with support from UNICEF, 6 national nutrition surveys (4 SMART, 2 DHS) were implemented. Yet, in 2018, out of 24, a total of 3 countries have no or insufficient data on stunting (Cabo Verde, Equatorial Guinea, Gabon), 3 have no or insufficient data on wasting (Cabo Verde, Equatorial Guinea, Gabon) and 5 have no or insufficient data on exclusive breastfeeding (Cabo Verde, Central African Republic, Equatorial Guinea, Gabon and Liberia).

In addition to nutrition surveys, nutrition information system in most countries includes routine nutrition indicators, which are often not standardized and very limited in number. The recent adoption of DHIS2 in most countries represents an opportunity to revise the list of indicators to be considered in national health information system, including nutrition information. UNICEF has positioned itself as

a proactive partner to support countries in this exercise. More particularly, WCARO-Nutrition Section has contributed to inclusion of relevant and innovative nutrition indicators into the revised national information system of several countries in 2018 (Burkina Faso, Benin, Liberia). In Burkina Faso, a pilot is being conducted in 2 districts where the list of nutrition indicators captured within the national health information system (named ENDOS) was increased. The pilot will run until end of 2019 and will inform a national scale up, planned for 2020. In Benin, nutrition partners including UNICEF, have influenced with success a revision of indicators being captured through the naitonal health system. As a result, the list of nutrition indicators was increased and now covers the 5 nutrition activities implemented in the country (Vitamin A supplementation, management of acute malnutrition, IYCF couselling activities, fortification and Iron Folic Acid suppelemtation). This revised system is yet to be implemented, following final endorsement of local Government, expected mid-year, during a national workshop. Liberia has also also achieved results to strenghten the NIS (see Case study **:** Strengthening Nutrition Information Systems: The Liberia Experience).

UNICEF Regional Office created and launched an e-platform to share documents on lessons, good practices and new knowledge on a integrative nutrition-health intervention, the Child-friendly Community (CFC), which delivers vaccination, vitamin A and deworming services to children under the age of 5 years. The platform has been deployed in five pilot countries (Republic Democratic of Congo, Togo, Chad, Liberia and Congo) to date and will be extended to more countries in WCAR over the next months. This is expected to create an enabled environment for sharing of best practices and lessons learned on use of routine nutrition information for program performance monitoring in WCAR. Extension of this e-platform to more countries and more nutrition services will be a top priority in 2019.

Spotlight 4 : Liberia : Strengthening Nutrition Information Systems: The Liberia Experience

Prior to 2017, the HMIS in Liberia had only two nutrition indicators. At the inception of the nutrition co investment in Liberia, the partners identified the integration of nutrition indicators in the HMIS as a priority the premise being that a lack of it was a serious bottleneck for nutrition programming. This was also a challenge to the mainstreaming nutrition into the health sector since nutrition was viewed as ''an additional'' and a parallel intervention limiting accountability and ownership within the system.

In 2017, in collaboration with the MoH, data collection tools were developed with pre-testing of the tools carried-out in six counties within the public health facilities for three months. The piloting was quickly scaled up to cover the entire country to support data generation for the co investment. Feedback from the pretesting phase and lessons learnt informed the update of data collection tools over time with several iterations prepared before the final versions were agreed upon. As a stop gap measure, a simple Excel-based database was developed and managed by the MoH where data was consolidated monthly, analyzed and feedback provided to respective counties. The initial development and pretesting phase took about 8 months and was marked by multiple field visits, meetings and consultations held with key stakeholders that included the government and implementing partners. The work on development and pretesting of the data collection tools was coordinated by the monitoring and evaluation division of the MoH with UNICEF and the nutrition division providing technical support.

In October 2017, the nutrition reporting formats were integrated into the offline facility level reporting formats of the HMIS. However, the parallel reporting continued since the formats needed to be customized into the District Health Information Systems -2 tool to ensure online reporting. In addition, health workers had to be trained on the new reporting formats before officially reporting through the online system as per existing MoH standard operating procedures. In early 2018, the

nutrition data collection tools and indicators were finally integrated into the DHIS -2 tool. Pre-testing of the online reporting was carried out for over half a year period in select counties with field-based feedback applied in updating the formats.
In the lead up to the full roll out of online reporting, UNICEF in collaboration with the nutrition division updated the Monitoring and Evaluation guide to include the full set of standard nutrition indicators. With funding and technical support from the co investment, the MoH trained health workers (Clinicians and Monitoring and Evaluation staff) across the 15 counties in the county. A total of 559 health workers and County Health Team staff from 158 facilities. The trainings focused on several aspects; a) technical nutrition issues related to the definition and application of the indicators, b) completing the data collection registers/monthly reporting formats c) reporting pathways and d) interpretation of the data.

Following the integration of and reporting of nutrition indicators through the HMIS, a surge in the reporting of nutrition indicators has been observed with 68 percent reporting in December 2018 against 0.3 percent in March 2017. In addition, the following have been observed;

- The integration of nutrition indicators into the HMIS has enhanced the long-term sustainability of the nutrition programme since integration obligates health workers to provide nutrition services routinely and to report on them.
- Catalysed improved accountability among health care providers leading to improved availability of nutrition services.
- Enhanced evidence-based decision making and informed course correction at the local level.
- The DHIS-2 tool has made it easier to analyze the data and to produce dashboards for the nutrition data that are being used for communication and advocacy.

Despite the progress made so far, more needs to be done to ensure the quality and timeliness of reporting. In addition, works needs to be done to support the County Health Teams to integrate nutrition into local level monitoring platforms such as; a) the data validation form, and b) the Join Integrated supportive supervision tool. The foregoing makes up our priorities that the MoH and UNICEF will be addressing during the last year of the co investment.

In 2018, UNICEF WCAR launched the Key Results for Children initiative. There is a total of 11 KRC which reflects UNICEF committement and vision for children in the WCA region; ambitious targets are setted for the period 2018-2021. KRC number 2 (KRC2) is particularly relevant for Nutrition as it seeks, by 2021, for 93% (86 million) girls and boys under 5 years in WCA, especially those marginalized and living in humanitarian situations, to receive high impact nutrition services to prevent stunting.
A total of 12 countries in the region have committed to implement KRC2. In 2018, a result logframe was developed in collaboration with invovled countries to track progresses achieved toward setted targets.
A regional dashbaord was created in 2015 to track admissions and quality of care for SAM programme. The 24 countries in WCA are invited to enter, online, on a monthly basis their results. Informaiton products such as maps and newletters are produced and shared with partners. These surveillance tools allow allow early and improved nutrition humanitarian assistance.

Infant and Young Child Feeding related indicators are usually monitor in large scale national surveys, such as DHS or MICS, which are not implemented every year. In WCA countries, UNICEF is recommending to include these indicators into SMART surveys, in order to increase the frequency of collection. In 2018, 4 countries collected IYCF indicators into their naitonal SMART surveys (Chad, Mauritania, Niger and Burkina Faso).

Spotlight 5 : SAM Bottleneck analysis carried out in 2018 in WCAR countries

In 2018, UNICEF WCARO supported five Bottleneck Analysis in 2018 in four countries at i) national level (Mauritania, Burkina Faso, Mali); (ii) Regional level (Bahr El Gazal in Chad) and (iii) District level (Mongo in chad). The exercise was conducted with the participation of all field nutrition actors (Nutrition Focal Point, doctors and nurses in charge of care), institutional actors (government and United Nations system) and NGOs working in the areas covered by the analysis.

Results revealed that the effective coverage of SAM program is weak in all countries (Mauritania: 57%, Burkina Faso 39%, Southern Regions of Mali 45%, Bahr El Gazal (BEG) Region of Chad 53% except for the Mongo District in Chad 68%). The main bottlenecks identified on the supply side are related to (i) Commodities particularly in Chad in both Guera and Bahr El Gazal regions): RUTF stock out in 82% of health facilities in the Mongo District (65 average days) and 98% in BEG region (30 days of duration).

The main causes identified are: Non- respect of IMAM Protocol, Misappropriation, sales, Intra-family and community sharing and low performance in supply chain management, (ii) (ii) Human resources (Burkina Faso 20%, Chad and Mauritania 15%): Insufficient numbers, high mobility and poor motivation, staff attribution, poor quality of training, non-respect of protocol, poor supervision. On the demand side the common bottlenecks fund (iii) Initial utilization in Burkina Faso (48%) and Southern Regions of Mali (53% where the program was able to reach around 50% of children instead of the large geographical coverage of SAM care (almost 100% of HF offer SAM services). The mains causes are linked with the weaknesses of community activities supposed to bridge the gap of low geographical access (Burkina Faso: 56% and Mali: 58%) to health care within 5 km radius and (iv) Continuous utilization: The number of defaulters remain high. Indeed, the drop in this determinant in Chad (10% at the level of Bahr El Gazal Region and 13% Mongo District), Mali (7% at the national level and 12% at the level of the northern regions) and Mauritania (11%) compared to the Initial Utilization largely exceeds the threshold values of 5%.
Finally, community activities remain weak in all countries. The higher values in this area in Chad is because the service providers in the Care Centres are at the same time the community actors.

The main causes identified for the low coverage at the level of the enabling environment are related to the funding of therapeutic foods and community activities, the lack or non-application of human resources management policies, weakness in management and coordination between actors and finally the distribution of roles in society with specific tasks for women not always favorable for decision making.
The inexistence, incoherence or lack of data, depending on whether they are directly collected for the purposes of the BNA or extracted from existing databases (DIHS2 or SAM databases), have been a serious constraint to the exercice.
Therefore, the results obtained suggests that scaling up treatment should be accompanied by a significant strengthening of the community strategy and the provision of SAM care by advanced/mobile strategy such as immunization.

Strengthening national policies and plans and increasing domestic ressources

UNICEF has played a key role in fostering partnerships with regional institutions and other core partners around the development of a strategic vision towards stunting reduction. Using existing coordination bodies, such as the Regional Nutrition Working Group, parliamentarian and civil society networks, and regional fora (i.e PREGEC/RPCA, ECOWAS), UNICEF has raised awareness on nutrition challenges, lessons learned and transformative approaches to be implemented towards improved nutrition governance and accountability in WCAR. As a result, key stakeholders are better equipped

to further contribute to improved nutrition programming. As part of this effort, Parliamentarians are now engaged with an action plan for their commitment in 14 countries which is far above initially expected. Next step will be to go beyond the development of action plan and ensure follow up for implementation. WCARO has also developed and expanded its collaboration with strategic partners (AfDB/ALN, BMGF, Muskoka,) academic institutions (IFPRI, IRD) as well as UN agencies and implementing partners (A&T, IBFAN).

WCARO made significant effort in generating evidence to build capacities and guide nutrition programming and has engaged into strategic partnerships to co-organize 3 regional events and one regional technical meeting focusing on women and early child nutrition. UNICEF's convening role has contributed to reach consensus on priority actions to move forward maternal nutrition – with a special focus on the adolescent nutrition and breastfeeding programming.

Annual results are achieved, and it is realistic to expect ROMP 2018-2021 results will be achieved by focusing on the implementation of transformative and innovative strategies of KRC 2. To strengthen investment in advancing women and children's nutrition, UNICEF continued its efforts for high-level advocacy, for instance through providing technical support to improve the design of multisectoral nutrition strategies and to ensure their effective implementation at decentralized level. Alongside women nutrition and the treatment of severe acute malnutrition, the importance of improving young children diets was emphasized as a key priority to address stunting. As a result, a total of 13 countries have multisectoral nutrition plan of which 8 countries (2 countries in 2018, Cameroun and Nigeria) have reported being equipped with costed plans for infant and young child feeding. WCARO has also highly contributed to in-depth analysis of UNICEF's nutrition programmes in key countries, either through the revision of UNICEF's strategic notes or in-country support (i.e. Nigeria, Niger, and DRC).

Accountability and the need for sufficient financial resources for nutrition were emphasized in the 2017 Global Nutrition Report. Thus, there is a great need for countries and partners to determine comprehensive and reliable data on how much funding is going to programmes aiming at fighting malnutrition, and how is that funding distributed across the sectors. This is crucial as well to address funding shortfalls and develop country-specific investment goals. However, tracking nutrition financial resource flows is not straightforward, mostly due to its multisectoriality[9].

In 2018, the regional office provided technical support to five countries (Burkina Faso, Guinea, Mali, Mauritania and Togo). Findings from these exercises show that, despite positive economic growth since 2000, budgets allocated to nutrition remain very low. Estimates range between 0.1% in Guinea to 3% of general government budget in Mauritania. Moreover, most of the financing are engaged in nutrition-sensitive actions. Finally, Guinea has no budget allocation to nutrition-specific activities while Burkina Faso has the highest contribution (14%).

These investments' snapshots highlight the great need for further actions and breakthrough strategy for increased domestic budget for nutrition, especially for nutrition-specific investments. This is critical to make progress towards global nutrition targets as well as to advance nutrition agenda in West and Central Africa. UNICEF is fully committed to this and intends to keep on providing timely support to countries in the area of nutrition financing. Perspectives include among other things, conducting nutrition budget analysis on a regular basis, developing in-country capacity to undertake autonomously nutrition budget analysis, tracking off-budget financing for nutrition, instilling in countries the need for adequate nutrition plan and costing. In this way, and in collaboration with all nutrition stakeholders, we strongly believe in improvement of nutrition landscape and WCAR shortly free from malnutrition.

[9] Picanyol C.Tracking investments on nutrition. 2014. Working Paper – FINAL. SUN Movement. Available on: http://scalingupnutrition.org/wp-content/uploads/2013/02/140120-Tracking-Investments-on-Nutrition.pdf.

Humanitarian Response

Crises in WCAR are increasingly protracted and significantly hamper tackling all forms of malnutrition. In situations of crises arising from conflict, fragility, violence and environmental change there is an urgent need to treat and prevent multiple burdens of malnutrition while also building nutrition resilience to what are often protracted crises. The situation was of great concern in 2018 in the Sahel countries and 11countries needed nutrition humanitarian assistance in the West and Central Africa.
In CAR, the preliminary results of the national nutrition survey conducted in September and October 2018 showed that the situation remains critical with 2.1 per cent of Severe Acute Malnutrition (SAM) prevalence while the Global Acute Malnutrition (GAM) stands at 7.1 per cent. Overall, in 2018, UNICEF and partners admitted 32,232 children suffering from SAM into therapeutic feeding programs. This is the highest number of admissions reported, and a 15 per cent increase compared with 2017.

In DRC, a total of 311,341 SAM children were admitted for treatment, while the target was at 1,3M (24%). UNICEF provided significant support to the National Nutrition (PRONANUT) program to contribute to the overall response of the Ebola Virus Disease (EVD) outbreak in the Eastern part of the country. Thus, UNICEF ensured the sensitization of 1,631 caretakers on appropriate infant and young children feeding practices in emergencies (IYCF -E) in three Ebola treatment centers (Mangina, Beni and Butembo). In addition, UNICEF supported addressing the specific feeding needs of 13 infants under 6 months (separated or orphans) and eight (8) children aged 6 to 23 months. Finally, UNICEF support was critical in providing appropriate diet to almost 90% of EVD patients, which improved overall health and nutritional status of the patients and facilitated their recovery.

In March 2018, the Cadre Harmonise analysis indicated that the proportion of people in crisis or pressure would increase from 38% (7.1 million) in March-May 2018 to 51% (10.6 million) in July-August 2018 in the 17 WCAR countries if no action is taken. This represented about 90% increase compared to the same period in 2017. The situation was alarming in Nigeria with about 5.3 million people in crisis phase, including 235,000 people in emergency in the 3 states of Adamawa, Borno and Yobe. The analysis also highlighted that the food and nutrition emergency could affect Burkina Faso, Cape Verde, Mali, Mauritania, Niger, Senegal and Chad if not immediate actions were taken. Aggravating factors, as shared by the Food Crisis Prevention and Management meeting (PREGEC), included rising food prices, the pastoral crisis, the restriction of population movements across borders, as well as socio-economic crises (strikes and wage arrears) increasingly reported in some countries. As a result, UNICEF increased its preparedness measures, starting by prepositioning supplies, doing a joint analysis and response plan with WFP, strengthening multisectoral interventions (WASH, health and education activities in the most affected communities) and scaling-up early detection of at-risk children to mitigate the impact of SAM.

To best respond to the nutritional crisis that was likely to hit the Sahel countries in 2018, WFP and UNICEF decided to work together to address immediate needs as well as longer-term challenges. Both agencies agreed on "priority areas" and developed a joint strategy. This joint approach highlighted the need for programming based on a "multi-sectoral" package of interventions to concomitantly prevent the deterioration of children's nutritional status before they become SAM while providing treatment in supported heath facilities to those who are already affected by the disease. The Joint Nutrition Response Plan was shared with partners and particularly well received by donors.

Although it may be too soon to assess the impact of this joint approach on the overall nutrition status of children, especially on prevalence of SAM, it is important to note that this joint UNICEF-WFP initiative and response plan facilitated the integration of prevention and treatment in emergency situations. The need to implement multisectoral programming to protect the nutritional status of

children upstream of their fall in SAM is now a programmatic approach acquired by nutrition stakeholders and donor partners.

UNICEF also supported three country teams (Nigeria, Mali, and Mauritania) to strengthen national capacities in Nutrition in Emergencies preparedness and response. This is more than originally planned (i.e. 2). Three workshops were organized at national level and one at sub-national level (in Nigeria). Unlike previous years, the trainings were conducted in countries and were therefore tailored to specific country needs (based on pre-training assessment results). At the end of the training, participants formulated two time bound commitments which were consolidated for further follow-up in 2019.

Finally, UNICEF continued to support countries and governments to implement timely nutrition assessments in emergency situations; to develop countries capacities in implementing Nutrition Surveys in both chronic and rapid onset emergency settings and; to closely monitor the nutrition situation at regional level. As such UNICEF provides monthly and quarterly (situation and program) updates to partners and through the regional coordination platforms which UNICEF co-chair with FAO and WFP.

Financial Analysis

Table 1: 2018 Planned budget by Thematic Sector
Thematic Pool 2: Nutrition
Planned and Funded for the Country Programme 2018 (in US Dollar)

Intermediate Results	**Funding Type[1]**	**Planned Budget[2]**
701-005 Nutrition (Policy, Planning, Advocacy)	RR	-
	ORR	83,650
701-006 Nutrition (Data, Monitoring, KM)	RR	-
	ORR	600,107
Total Budget		**683,757**

[1] RR: Regular Resources, ORR: Other Resources - Regular *(add ORE: Other Resources - Emergency, if applicable)*
[2] Planned budget for ORR *(and ORE, if applicable)* does not include estimated recovery cost (only programmable amounts).
*All e*xpense amounts are provisional and subject to change*

Table 2: Country-level Thematic contributions to thematic pool received in 2018
Thematic Pool 2: Nutrition
Thematic Contributions Received for Thematic Pool 2 by UNICEF WCARO in 2018 (in US Dollars)

Donors	**Grant Number**	**Contribution Amount**	**Programmable Amount***
Global Nutrition	SC149904	391,927	35,863
Global Nutrition	SC189903	700,000	18,964
Total		**1,091927**	**54,827**

*All e*xpense amounts are provisional and subject to change*

Table 3: Expenditures in the Thematic Sector
Thematic Sector 2: Nutrition

Organizational Targets	Expenditure Amount*			
	Other Resources - Emergency	Other Resources - Regular	Regular Resources	All Programme Accounts
21-04 Prevention of stunting and other forms of malnutrition	1,701,754	641,979	105,386	2,449,119
21-05 Treatment of severe acute malnutrition	110,887	108,737	32,180	251,804
Total	**1,812,641**	**750,716**	**137,566**	**2,700,923**

*All *expense amounts are provisional and subject to change*

Table 4: Thematic expenses by Results Area
Thematic Sector 2: Nutrition
The table below shows a breakdown of expenditures of Thematic contributions by results area.

Fund Category	All Programme Accounts
Year	2018
Business Area	WCARO, Senegal - 381R
Prorated Goal Area	21 Survive and Thrive
Donor Class Level2	Thematic

Row Labels	Expense
Other Resources - Emergency	340,345
21-04 Prevention of stunting and other forms of malnutrition	306,043
21-05 Treatment of severe acute malnutrition	34,302
Other Resources - Regular	49,298
21-04 Prevention of stunting and other forms of malnutrition	42,583
21-05 Treatment of severe acute malnutrition	6,716
Grand Total	**389,643**

Table 5: Expenses by Specific Intervention Codes
Thematic Sector 2: Nutrition

Fund Category	All Programme Accounts
Year	2018
Business Area	WCARO, Senegal - 381R
Prorated Goal Area	21 Survive and Thrive
Fund Sub-Category	(Multiple Items)

Row Labels	Expense
21-04 Prevention of stunting and other forms of malnutrition	2,449,119
21-04-01 Breastfeeding protection, promotion and support (including work on Code)	808,880
21-04-07 National multisectoral strategies and plans to prevent stunting (excludes intervention-specific strategies)	34,720
21-04-08 Data, research, evaluation, evidence generation, synthesis,and use for prevention of stunting and other forms of malnutrition	178,432
21-04-99 Technical assistance - Prevention of stunting and other forms of malnutrition	774,241
26-01-01 Country programme process (including UNDAF planning and CCA)	2,723
26-02-08 Programme monitoring	4,477
26-03-01 Advocacy and partnership-building for social behaviour change	2,559
26-03-02 Capacity and skills development for social behaviour change	5,662
26-03-04 Community engagement, participation and accountability	-19
26-03-06 Research, monitoring and evaluation and knowledge management for C4D	234
26-03-07 Strengthening C4D in Government systems including preparedness for humanitarian action	8,936
26-03-99 Technical assistance - Cross - sectoral communication for development	33,779
26-04-01 CO/RO Supply - technical assistance and collaboration in supply chain, procurement of goods and services, and logistics	16
26-05-01 Building evaluation capacity in UNICEF and the UN system	742
26-06-04 Leading advocate	3,192
26-06-06 Supporter engagement	22,479
26-06-08 Emergency preparedness (cross-sectoral)	15,872
26-07-01 Operations support to programme delivery	104,765
27-01-01 HQ and RO technical support to Goal Area 1 Survive and Thrive	-1
27-01-02 HQ and RO technical support to Goal Area 2 Learn	162
27-01-03 HQ and RO technical support to Goal Area 3 Protection from Violence and Exploitation	75
27-01-06 HQ and RO technical support to multiple Goal Areas	49,371
27-01-09 RO advocacy and communication	43,260
27-01-10 RO technical support to countries on Supply/Logistics	21,726
27-01-14 RO planning and quality assurance	134,481
27-02-01 HQ Supply - technical excellence in supply chain, procurement of goods and services, and logistics; including creating healthy markets, supply financing solutions, and sustainablenational supply chain systems	42,983
27-03-02 RO support on humanitarian action to Country Offices	149,723
28-07-02 Management and Operations support from RO	5,650
21-05 Treatment of severe acute malnutrition	251,804
21-05-02 Capacity building for nutrition preparedness and response	150,707
21-05-03 Nutrition humanitarian cluster/humanitarian sector coordination	32,275
26-01-01 Country programme process (including UNDAF planning and CCA)	855
26-02-08 Programme monitoring	1,172
26-03-01 Advocacy and partnership-building for social behaviour change	362
26-03-02 Capacity and skills development for social behaviour change	618
26-03-04 Community engagement, participation and accountability	-6
26-03-06 Research, monitoring and evaluation and knowledge management for C4D	29
26-03-07 Strengthening C4D in Government systems including preparedness for humanitarian action	921
26-03-99 Technical assistance - Cross - sectoral communication for development	3,543
26-04-01 CO/RO Supply - technical assistance and collaboration in supply chain, procurement of goods and services, and logistics	5
26-05-01 Building evaluation capacity in UNICEF and the UN system	233
26-06-04 Leading advocate	620
26-06-06 Supporter engagement	7,062
26-06-08 Emergency preparedness (cross-sectoral)	3,050
26-07-01 Operations support to programme delivery	8,151
27-01-01 HQ and RO technical support to Goal Area 1 Survive and Thrive	-
27-01-02 HQ and RO technical support to Goal Area 2 Learn	16
27-01-03 HQ and RO technical support to Goal Area 3 Protection from Violence and Exploitation	24
27-01-06 HQ and RO technical support to multiple Goal Areas	6,860
27-01-09 RO advocacy and communication	10,843
27-01-10 RO technical support to countries on Supply/Logistics	5,086
27-01-14 RO planning and quality assurance	2,550
27-03-02 RO support on humanitarian action to Country Offices	16,195
28-07-02 Management and Operations support from RO	633
Grand Total	**2,700,923**

Table 6: Planned budget for 2019
Thematic Pool Area 2: Nutrition
Planned Budget and Available Resources for 2019

Intermediate Result	Funding Type	Planned Budget [1]	Funded Budget [1]	Shortfall [2]
701-005 Nutrition (Policy, Planning, Advocacy)	RR	25,000	20,000	5,000
	ORR	334,600	1,011,614	
701-006 Nutrition (Data, Monitoring, KM)	RR	-	-	-
	ORR	2,400,431	1,024,113	1,376,318
Subtotal Regular Ressources		**25,000**	**20,000**	**5,000**
Sub-total Other Resources - Regular		**2,735,031**	**2,035,727**	**1,376,318**
Total for 2019		**2,760,031**	**2,055,727**	**1,381,318**

[1] Planned and Funded budget for ORR *(and ORE, if applicable)* excludes recovery cost. RR plan is based on total RR approved for the Country Programme duration.
[2] Other Resources shortfall represents ORR funding required for the achievements of results in 2019.

Future Workpan

Although in its first year of Strategic Plan 2018-2021, UNICEF has drawn from the experiences of the previous Strategic Plan and new commitments are being made to reduce stunting and wasting in places where needs are the greatest. The choice of stunting as a KRC2 of the RO is a concrete and strong translation of this commitment.

UNICEF WCARO will work towards a much stronger partnership through leveraging the RISING project and leading the RNWG to enhance collaboration, build leadership and technical capacities of important stakeholders in the region to advocate for and support the scale-up of nutrition programmes. Furthermore, UNICEF will Emergency preparedness with special attention to high risk countries, notably Lake Chad Basin (NE Nigeria, SE Niger, NW Chad), CAR, Mali and Cameroon.

The regional bodies' meetings will be targeted for high-level advocacy events and to prepare and adopt appropriate resolutions. The links between these institutions and country level work will be promoted. To that end, the WCARO senior management and Country Office Representatives could play a critical role in unifying messages and voices within both the United Nations system and regional eco-systems for better-coordinated approach and investments on stunting reduction.

Other priorities on which UNICEF WCARO will focus include but are not limited to:

- Nutrition investments tracking, leveraging domestic resources, and building national capacities, including by working with media and parliamentarians;
- Leveraging opportunities and partnerships for resource mobilisation and scaling-up of nutrition;
- Providing technical support for equity-focused nutrition programming including the development of multi-sectorial nutrition plans to improve child nutrition within the 1,000-day window of opportunity and prevent children nutritional status deterioration;
- Providing technical support for analysis of the fiscal-space and financial tracking of nutrition expenditures;

- Rolling-out of the regional breastfeeding campaign and strengthen the breastfeeding agenda (Code, maternity protection, BFHI);
- Development of a diet diversity agenda for improved children's diets;
- Generating and mobilizing evidence to build capacities and guide nutrition programming, with a focus on women, adolescent nutrition, and diet diversity;
- Providing technical support and guidance to countries to further strengthen food systems, social policy and community systems to be nutrition-sensitive;
- Supporting and maintaining high coverage of VAS in routine for children of 6 to 11 months of age through cost-effective platforms;
- Enhancing programming for Iodine Deficiency Disorders;
- Supporting nutrition information systems for program design and monitoring;
- Supporting the CILLS (Comité Permanent Inter Etats de Lutte contre la Sècheresse dans le Sahel) to improve the quality of the nutrition situation analysis across the region and strengthen the nutrition component of Cadre Harmonise;
- Providing technical support and guidance to countries to strengthen health systems to deliver a package of maternal and early child nutrition interventions including life-saving services for children suffering from SAM at all times (have resilient systems);
- Improving program coverage and effectiveness with the development, piloting and building of evidence of innovative approaches and models of care e.g. adolescent girls nutrition, business model for the local production of complementary foods, simplified protocols, mother MUACs, decentralisation at community level.
-

Expression Of Thanks

UNICEF WCARO and the 24 Country Offices would like to take this opportunity to acknowledge the valuable contributions from various donors through thematic funds and sincerely thank all donors for their commitment to the nutrition of the children in the WCAR. These funds are crucial in supporting activities linked to fulfil women and children's rights.

Case studies

Case study 1

Shifting to a cost-effective and efficient strategy for VAS: A success story from Burkina Faso

Programme Area 1: Early Childhood and Maternal Nutrition

Burkina Faso designed and tested a unique delivery mechanism for Vitamin A supplementation in 2017, which proved very efficient and cost-effective for the two rounds of VAS conducted in 2018. The institutionalization of VAS delivery was on the radar of the Director of Nutrition, MoH, since 2006 as well as was the strategic reflection around the challenges that had been faced with integration into immunization. The cessation of adequate funding for campaigns highlighted the need for a rapid shift to an innovative approach, while Community Health Workers were put in place nationally in rural areas. This strategy was successfully tested in the second semester of 2017, and used again for the two rounds of 2018, in June and December. The strategy designed was different for rural and urban areas.

In rural area, distribution was done by community-based health workers (CBHW) twice a year, over a period of one month. The MoH decided to institutionalize the community platform by recruiting 17,668 CBHW with a standard of at least two CBHW per village in 8,500 villages. Health activities implemented regularly at community level include treatment of malaria, treatment of diarrhoea, treatment of acute respiratory diseases, screening and referral of acute malnutrition, as well as promotion of IYCF and essential family practices. At the end of each semester (June and December), CBHW provide VAS to all the children 6-59 months and deworming to children 12-59 months of their respective catchment areas. The supervision is done by the Chief of health facilities covering the villages.

In urban area, the distribution is done in a campaign mode, door-to-door, by volunteers during a four days' period, twice a year, with support of community volunteers.

The country was able to maintain very high levels of VAS coverage for both semesters at 91.3 % in June 2018 and 99.6% in December 2018.

A key achievement in 2018 was that the 2-dose VAS coverage was ensured at high level while the cost of the strategy was limited, and with a very high level of ownership of the activity. The shift of delivery strategy from mass campaigns at national level to routine distribution through the institutionalize community platform in rural area has allowed to reduce the operational costs by more than 50% which is important to sustain this important activity.

The approach and sustainability of the urban strategy are being reviewed, as well as feasible alternative approaches. This will be especially relevant given that most implementation costs are to pay distributors in urban areas. The idea of using the crèche (0-3 years) and day-care (3-6 years) as potential alternatives for distribution are among the options discussed.

Case study 2

Ghana's IFA program – centred around adolescent girls' health and nutritional needs – reduced anaemia by 26%

Programme Area 2: Nutrition of school-age children, adolescents and women

In October 2017, UNICEF supported the Ghana Ministries of Health (MoH) and Education (MoE) to launch the multi-phase national Girls Iron Folate Tablet Supplementation (GIFTS) program to address the high levels of anaemia in girls. The Demographic Health Survey 2014 indicated that over 40% of adolescent girls 15-19 years suffered from anaemia, which was categorized as a severe problem of public health significance (WHO 2011) with gendered impacts and vulnerabilities, attributed to the neglected nutritional needs of girls in adolescence.

Designing an Iron- Folic Acid (IFA) program for this target age group had been recognized to have a high potential return on investment for Ghana since anaemia is associated with poor growth, reduced concentration and learning ability, physical fitness and work productivity. Providing IFA to adolescent girls, in addition to supporting their own growth and well-being, could confer multiple intergenerational benefits, as anaemia during pregnancy is associated with low birthweight, perinatal and maternal mortality, and folate deficiency is associated with neural tube defects and stillbirths.

Prior interventions in Ghana had focused mainly on provision of IFA for pregnant women via healthcare delivery channels, and iron supplementation to children identified as anaemic in clinical settings. The GIFTS program was instead designed as an integrated nutrition and health package delivered to adolescents through schools and health facilities. Health and nutrition education focused on anaemia and malaria prevention and water, hygiene and sanitation (WASH). Iron- Folic Acid was delivered on a weekly basis to girls enrolled in Junior High School, Senior High School, and Technical Education and Vocational Training; and on monthly basis to out-of-school girls age 10-19 years registered with the Community Health Planning and Services.

The first phase of the program was piloted under the leadership of Ghana Health Service (GHS) and Ghana Education Service (GES) in the period 2017-2019, covering four out of Ghana's ten regions: Brong Ahafo, Northern, Upper East, and Volta; with an estimated adolescent girls' population of over 900,000. Institutional capacity for implementation of GIFTS was strengthened through the development of an operational framework and capacity building of key staff at the regional and district levels (over 4500 teachers and 3000 health workers).

The First Lady of the Republic of Ghana, Mrs. Rebecca Akuffo Addo, launched and championed the GIFTS program, mobilizing institutional and community support across the regions. From the start of the academic year 2017-2018, in-school adolescent girls were given one iron/folic acid tablet by directly observed therapy (DOT) once weekly after meals on a selected day in all eligible schools in the four regions. Out-of-school adolescent girls aged 10-19 years, were given IFA tablet by DOT at the nearest health facility or community outreach event, and the remaining month's supply of IFA tablets has been given to the beneficiary or her guardian to be taken once weekly after meals at home. Adolescent boys and girls equally benefited from the health and nutrition education component in schools. Teachers and school health education program coordinators implement the program in schools whereas health facility staff, primarily community health nurses, implement the program in health facilities. Routine IFA tablets consumed were recorded on a regular basis into the "GIFTS register" in each school by the teacher and in the health facility by the health provider allowing the collation of monitoring data. Regular field monitoring were undertaken by GHS, GES and UNICEF staff.

To strengthen the evidence base on the effectiveness of the program and inform national scale up, an impact evaluation using pre-post longitudinal surveys was conducted with technical support from US Centre for Disease Control and Emory University. The objectives of the evaluation were to examine program implementation fidelity, anaemia and IFA knowledge/awareness, as well as determine changes in anaemia prevalence of among adolescent girls at the end of one year. This in-school program evaluation collected data at both the student and school health teacher/-implementer level in 60 schools selected from the Northern and Volta regions. The baseline survey occurred in September 2017, before the IFA program rollout and at beginning of the academic year. The second survey data was collected in July 2018. All reported estimates of program indicators for students were weighted and accounted for clustering so as to be representative of the adolescent girls' population in the schools in the region at baseline.

The study found operational fidelity of the IFA program and supply chain in all 60 schools surveyed was high (>90%) and only 6.7% (4 out of 60) of schools had ever missed a weekly IFA distribution due to a stock-out. Baseline anaemia prevalence was 25.0% among adolescent girls and was 19.5% at the follow-on survey. After adjustment for student age, this represented a **26% adjusted population prevalence decrease**. The study also found that the haemoglobin concentrations increased in the surveyed schools. Increases were as well recorded in the number of students who had heard of anaemia (from 64% at baseline to 90.9%) and IFA (from 27% to 92%), and who mentioned eating dark green leafy vegetables to prevent anaemia (21%). Around 78.8% school health educators/teacher-respondents recognized the benefits for girls and would recommend the inclusion of boys in future. Around 13.3% of them reported they experienced IFA implementation difficulties from the community, such as misconceptions that the IFA were birth control. Over 71% of the teachers said communication materials (e.g., posters and flyers) would improve the acceptability of the program.

Close routine program monitoring by GHS and GES, identified a similar need for community sensitization to tackle misconceptions. It also identified poorer IFA uptake and compliance rates among out of school girls. Further consultation with out of school girls highlighted that the current approach of IFA service delivery through community events had limited acceptability and reach among the target population. Alternative venues such as market places, mosques and churches were identified as potential platforms for reaching out of school girls.

The Government of Ghana will scale-up the GIFTS program to the remaining six regions of Ghana based on the compelling evidence from the impact evaluation and recommendations from the regional and national stakeholder meetings, which reviewed progress and learning from the implementation of phase I. Phase II will be initiated in 2019 and work to improve the overall efficiency of the program through strengthened communication, increased uptake of IFA among out-of-school girls and engagement of boys through health and nutrition education package.

The experience from the GIFTS program and observations on the diets in schools have demonstrated the need for a much broader approach for improving nutrition of adolescents as well as younger age group (school age children). The GHS and GES have formed a taskforce to work on the enabling environment for improving nutrition of school age children – from preschool through primary school. A landscape analysis on the nutrition situation of school age children is underway and will inform the strategic approach to be adopted in Ghana

The GIFTS program and School Age Nutrition Initiative is being implemented with generous support from the Government of Canada, USAID, Korea International Cooperation Agency (KOICA), Emory University Global Health Institute, Italian Government and the U.S. CDC.

Case study 3

Domestic Investment for Community Management of Acute Malnutrition (CMAM) in Nigeria

Programme Area 3: Prevention and Care for children with Severe Acute Malnutrition

Overview of malnutrition in Nigeria: Nigeria has very high rates of malnutrition that are unevenly spread across the country. Stunting, a measure of chronic malnutrition during the most critical periods of growth and development, and micronutrients deficiencies generates the highest burden. However, wasting a measure of acute malnutrition is equally high in the country. Nutrition indices, especially stunting rates, have not improved since 2008 indicating a long term nutritional problem. The latest National Nutrition and Health Survey (NNHS), conducted in 2018, indicates that 7% of children aged less than 5 years are wasted (with an annual burden of over 2 SAM cases) and 32% are stunted (13.1 million children) are with growth retardation. Percentage of children less than six months who are Exclusively breastfeed is 27%. States with the highest burden of stunting in Nigeria also have highest under-five mortality rates and these states are mostly in the northern part of the country.

Problem statement: UNICEF and other implementing partners with support from donor have made huge investments in improving the nutrition situation of the country over years. However, Nigerian community is still grappling with multiple burdens of malnutrition. Inadequate financing from the government and limited leveraging additional resources from public and private sector for nutrition are hampering progress toward achieving a more robust and cohesive multisectoral nutrition programs targeted at improving the nutrition situation of women and children in Nigeria. The ability to effectively and systematically mobilize domestic resources and efficiently manage them to achieve meaningful results remains a key factor necessary for successful implementation of nutrition programme in Nigeria.

UNICEF Action: Children Investment Funds Foundation (CIFF) one of UNICEF major donor supported the government of Nigeria through UNICEF since 2012 to scale up Community Management of Acute Malnutrition in Nigeria. The main goal of the CIFF-UNICEF "Strengthen and Scale up Community Management of Acute Malnutrition" (SSCMAM) project in Nigeria is to support the Federal Government of Nigeria (FGoN) in continuing, reinforcing and scaling up the existing Community-based Management of Acute Malnutrition (CMAM) programme. This was done by providing support to both service delivery and the leveraging of activities and resources, as well as helping to mainstream the delivery of CMAM as a routine intervention through the public health sector. The advocacy component of the programme had an annual incremental funds target to be mobilized from domestic resources for the CMAM intervention.

To achieve one of the CIFF-UNICEF project goal on domestic resource mobilization, UNICEF developed an advocacy strategy geared towards ensuring that every child with SAM have access to life saving treatment, thrive and survive. One of the main objectives of the UNICEF strategy is to increase domestic financing of ready to use therapeutic foods (RUTF), starting with a low target and increasing the resources so that by the end of 2018 over 60% of RUTF is routinely purchased by the governments of Nigeria. To achieve the domestic financing objectives, state-specific and customized advocacy efforts were combined with a financial incentive was implemented. CIFF committed to match the domestic resources released for Ready to Use Therapeutic Food (RUTF), on a variating ratio as the programme progressed.

UNICEF strategies were centred on continuous engagement of the executives, legislators, traditional and religious leaders, media and CSOs for increased support towards increased funds allocation as well as releases for scaling up implementation of CMAM interventions to improve nutrition outcomes.

UNICEF developed state-specific advocacy materials using evidence-based data, information and success stories highlighted by positive photos of SAM children. Another key strategy was to take political leaders to CMAM facilities, as well as high level meetings to dialogue with relevant stakeholders and secure commitments for CMAM. UNICEF collaborated with CSO and media to sensitize and train them on leverage on its networks to increase reporting on SAM and the call for more domestic financing.

In line with the UNICEF theory of change, the allocations for RUTF were supported by the negotiation of MOUs on RUTF financing, and the process of developing a joint UNICEF-state workplan; alongside fostering a level of political commitment.

Results achieved: These activities secured political commitment and resulted in increased allocation and release of funds for procurement of RUTF in Nigeria. For instance, in 2018, USD 4.50 million in domestic funds was release for the procurement of RUTF. This is a huge increase from USD 3.97 million that was released the previous year and USD 1.2 million that was released in 2016. Cumulative achievement for domestic resources for RUTF procurement was USD 9.67 million (86%) as indicated in the table below.

Year	KPI Target ($) million	Actual ($) million	**Percentage (%)**	No RUTF Procured	Children reached	Live saved
2016	2.7	1.20	**44.4**	25,531.91	29,688	5,641
2017	5.5	3.97	**72.1**	84,468.09	98,219	18,662
2018	3.0	4.50	**150.0**	95,744.68	111,331	21,153
TOTAL	11.2	9.67	**86.3%**	205,744.68	239,238	45,455

Table 1: Domestics Resources KPI for CMAM intervention from 2016 to 2018.

Overall, UNICEF through CIFF support has increased domestic financing for CMAM and has built government awareness and concern for SAM. The UNICEF-CIFF collaboration has been an important trigger/ catalyst in raising the profile of nutrition and mobilizing resources not only for SAM treatment but for nutrition. Relevant Ministries at all levels have dedicated budget lines for nutrition and are allocating a budget each year (although not all allocated funds are released). An environment has been created for sustained investment in nutrition. Starting from a low achievement of 44% in 2016, to a great achievement of 150% in 2018 with UNICEF attaining 86% cumulative achievement of the RUTF domestic financing targets. This result when set against the challenges of the recession and of building political support for a relatively new intervention in Nigeria is quite enormous. In 2017, an ACF publication[10] reported that, beyond Nigeria, only one high SAM-burden country (Malawi) government has purchased RUTF. Previously, domestic investment level was very low, however the CIFF project brought about increased investment by the government. The matched funding modality was a game changer in this process.

Challenges and lessons learnt: The emphasis on advocacy for leveraging domestic resources in the CIFF project has strengthened government awareness/commitment to SAM treatment and to nutrition in general. This was positive for increased budgetary allocation and releases for the CMAM program. Budgetary allocation is an important but not strong commitment for domestic financing in Nigeria, particularly at state level, where there is a history of inflated and unrealistic budgets. Due to this, budget allocation is easier to achieve than actual disbursements. The advocacy strategy gradually shifted from its initial focus on budget allocations, towards a stronger focus on securing releases. The outcomes were greatest where this advocacy was most broad and intense; yet at the same time, the state contexts shaped the intensity of advocacy that was needed and the dynamics that unfolded.

[10] ACF, IMC and Global Health Associates (2017): Financing the sustainable scale-up of CMAM, published by Action Against Hunger, International Medical Corps and Global Health Advocates.

UNICEF's use of data, costed plans and especially emotive evidence of SAM (in photos and facility visits) was instrumental to building political support. Fostering political champions and an alliance among helped UNICEF to trigger funds releases. Civil society and media reporting did help to build the moral imperative to treat SAM.

The programme assumption that 'the RUTF financing targets were feasible despite the recession', might be questioned, however, the recession was certainly a factor that made the target domestic financing difficult. Due to the high cost of CMAM, there is a trend toward prioritising malnutrition prevention among both state and federal governments in Nigeria. Prevention is seen as more affordable than treatment and to tend toward a long-term solution. Despite this, the government has disbursed funds for RUTF and very little for prevention. This seems to evidence the influence of strong UNICEF's advocacy coupled with the matched funding. Increased support for malnutrition prevention is positive outcome of the programme: UNICEF raised awareness of SAM and holistic nutrition interventions as a basis for fostering commitment to CMAM. It is moreover a result of wider development partner and CSO advocacy in Nigeria, which focuses more broadly on 'nutrition' with a growing focus on prevention.

Beyond recession and lack of commitment another challenge experienced in the domestic resource mobilization is the unpredictable budget cycle in Nigeria. The budget cycle is not in sync with the calendar year. Most times the budget cycle commences from May/June and ends the same month the previous year. This affected release of funds and judicious utilization of released funds to scale up live saving nutrition interventions. To overcome this, UNICEF commenced early advocacy and pursued very intensive advocacy, targeting key stakeholders at each stage of the disbursement process.

Way forward: Following this success story, UNICEF will leverage on the high momentum for nutrition in Nigeria and strengthen engagement with actors and non-state actors who will support the advocacy and maintain commitment through political stakeholders: traditional leaders, civil society and media (especially in the states). UNICEF will support the wider Nigerian nutrition community to develop a more aligned understanding and message that will balance nutrition treatment and prevention financing.

Case study 4

Setting up and development of the National Multisectoral Information Platform for Nutrition in Côte d'Ivoire: a good opportunity to nurture the multisectorality in Nutrition and advance the Nutrition agenda

Cross-cutting Programme Area

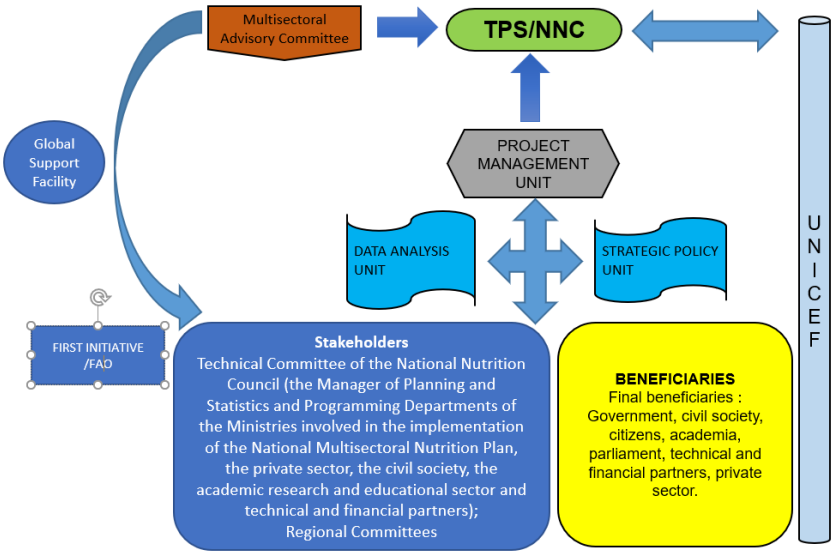
Background: The government of Côte d'Ivoire has joined in 2013 the Scaling Up Nutrition (SUN) movement. Over the last past five years, there has been high level commitments to nutrition in Côte d'Ivoire, with the establishment of the National Nutrition Council (NNC) and the Technical Permanent Secretariat (TPS) at the Prime minister's office in July 2014, the establishment of the nutrition working group of technical and financial partners bringing together the United Nations agencies, donors and international NGOs chaired by UNICEF and co-chaired by the African Development Bank, the adoption of the National Nutrition Policy in June 2015 and of the National Multisectoral Nutrition Plan – NMNP (2016-2020) in May 2016.

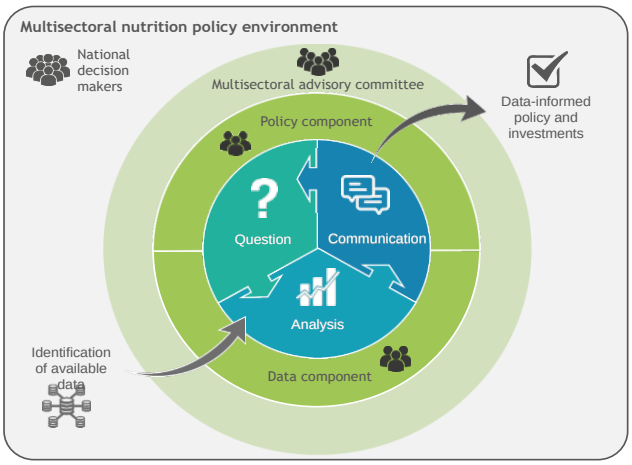
Despite the significant upstream achievements, there is an urgent need to scale up the implementation of both nutrition-specific and nutrition-sensitive interventions included in the NMNP 2016-2020 especially those that promote malnutrition prevention targeting the first 1,000 days and based on Behavioural Change Communication and community engagement.

Since 2017, the government with the support of UNICEF have negotiated the setting up of the global initiative of the National Information Platforms for Nutrition (NIPN) funded by the European Commission's Directorate General for Cooperation and Development and supported by the United Kingdom Department for International Development and the Bill & Melinda Gates Foundation.

This initiative aims at supporting countries to strengthen their multisectoral information systems for nutrition and to improve data analyses in order to better inform strategic decisions and improve nutrition programming. The National Multisectoral Information Platform for Nutrition (NMIPN) in Côte d'Ivoire aims also at facilitating the multisectoral and multi-stakeholder dialogue on nutrition.

The project of the NMIPN led by the Technical Permanent Secretariat of the National Nutrition Council started in 2018 with support from UNICEF and is in line with the seventh strategic axis of the National Multisectoral Nutrition Plan. More specifically, the expected results of this project are: (i) Nutrition information management stakeholders have increased capacity to operationalize and maintain the NMIPN; (ii) Stakeholders are able to use NMIPN results to influence, guide and improve the implementation of PNMN 2016-2020 as well as to better orientate strategic decisions ().
Figure).
Figure 1. The organizational scheme of the National Multisectoral Information Platform for Nutrition in Côte d'Ivoire with stakeholders





Operational cycle of the National Multisectoral Information Platforms for Nutrition

The process can be summarized in three essential steps:

1. Formulation of questions related to government priorities.
2. Data analysis to inform questions.
3. Communication of results to targeted decision-makers.

Ongoing Results: Data analysis began with the identification of 147 key indicators defined through the common monitoring and evaluation framework of the National Multisectoral Nutrition Plan. Data mapping is well underway through the finalization of the dashboard of nutrition-specific and nutrition-sensitive indicators which will serve for the question formulation process. In the long term, distinct types of data are going to be collected: situational, programmatic coming from various sectors, investment tracking (domestic and other resources), legislative, etc.). Regarding the nutrition situation and its trends, UNICEF is supporting specific analysis in order to let data do the talking (analysis of malnutrition determinants with MICS 2016 data, Analysis of Benefits of Breastfeeding, Modelling stunting in LiST).

Challenges and Lesson Learned:

- **Partnership**: UNICEF is providing a technical and financial (through four-years EU funds) day-to-day support to the Technical Permanent Secretariat of the National Nutrition Council allowing to ensure the smooth running of the project. A Global Support Facility (GSF) team based in Montpelier (France) has been created to support each country to develop its NIPN and to coordinate the technical support and capacity building required.
- **Ownership supporting by an optimal anchorage**: The NMIPN is integrated into the national multisectoral nutrition coordination structure with an anchorage in the Prime Minister (cf. Technical Permanent Secretariat of the National Nutrition Council) allowing to facilitate the

centralization of data coming from all involved sectors and various sources and the effective involvement of sectoral ministries through the consideration of their interests.

- **Quality, availability and use of data**: The quality of data for which each sectoral ministry is responsible is particularly critical for programmatic data. However, there is a specific need to improve quality and organization of data in some ministries that have more a project culture than a program culture. Some difficulties could be related to data storage (maintenance, server protection). There is globally an increasing recognition of data availability and use to better monitor program progresses: With the NMIPN, the slogan ***"No data, no real project"*** can be translated into ***"No multisectoral data in nutrition, no multisectorality in nutrition"***.
- **Sustainability**: The members of the project management unit housed within the offices of the Permanent Technical Secretariat have been recruited by the government of Côte d'Ivoire allowing to maintain and operate this platform after the end of the project. This is a strong commitment from the government of Côte d'Ivoire regarding ownership for planning, monitoring and knowledge management.
- **Nurture and support the multisectoral approach in Nutrition**: The National Multisectoral Information Platform for Nutrition (NMIPN) in Côte d'Ivoire should (i) monitor the implementation of the nutrition-specific and nutrition-sensitive interventions through programmatic date availability and use, (ii) follow progress of key nutrition indicators, (iii) facilitate the multisectoral and multi-stakeholder dialogue on nutrition, (iv) estimate trends in nutrition investments (both domestic and other resources).

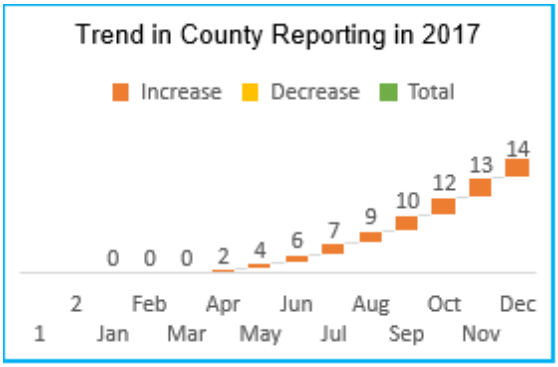
Case study 5

Strengthening Nutrition Information Systems: Experience from Liberia

Cross-cutting Programme Area

A well-functioning health management information system (HMIS) ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status. Prior to 2017, the HMIS in Liberia had only two nutrition indicators. At the inception of the nutrition co investment in Liberia, the partners identified the integration of nutrition indicators in the HMIS as a priority; the premise being that a lack of it was a serious bottleneck for nutrition programming since it made it difficult to track progress. This was also a challenge to mainstreaming nutrition into the health sector since nutrition was viewed as ''an additional'' and a parallel intervention limiting accountability and ownership within the system.

The work started in early 2017 where a full set of standard nutrition indicators was agreed upon with the Ministry of Health (MoH). In collaboration with the MoH, data collection tools were developed with pre-testing of the tools done in six counties within the public health facilities for three months. The piloting was quickly scaled up to cover the entire country to support data generation for the co investment. Feedback from the pretesting phase and lessons learnt informed the update of data collection tools over time with several iterations prepared before the final versions were agreed upon. As a stop gap measure, a simple Excel-based database was developed and managed by the MoH where data was consolidated monthly, analysed and feedback provided to respective counties. The initial development and pre-testing phase took about eight months and was marked by multiple field visits, meetings and consultations held with key stakeholders that included the government and implementing partners. The work on development and pre-testing of the data collection tools was coordinated by the monitoring and evaluation division of the MoH with UNICEF and the nutrition division providing technical support.



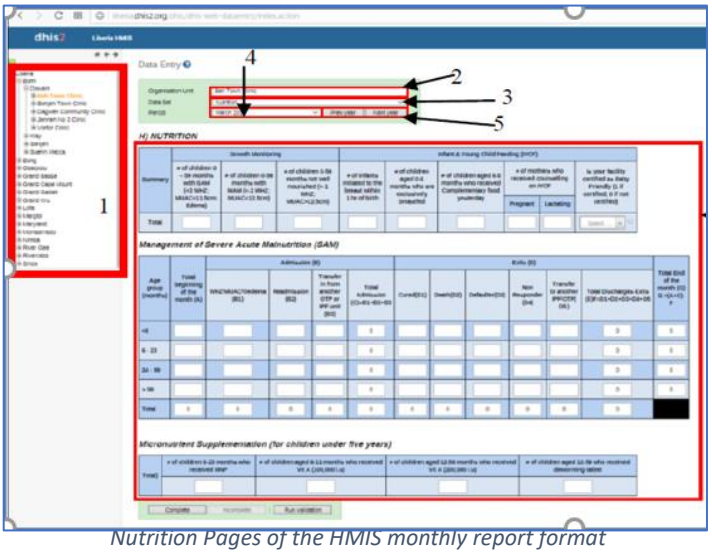
Graph showing progress in county level reporting of nutrition intervention in 2017

In October 2017, the nutrition reporting formats were integrated into the offline facility level reporting formats of the HMIS. However, the parallel reporting continued since the formats needed to be customized into the District Health Information Systems -2 tool to ensure online reporting. In addition, health workers had to be trained on the new reporting formats before officially reporting through the online system as per existing MoH standard operating procedures. In early 2018, the nutrition data collection tools and indicators were finally integrated into the DHIS -2 tool. Pre-testing of the online reporting was carried out for over half a year period in select counties with field-based feedback applied in updating the formats.

In the lead up to the full roll out of online reporting, UNICEF in collaboration with the nutrition division updated the Monitoring and Evaluation guide to include the full set of standard nutrition indicators. With funding and technical support from the co investment, the MoH trained health workers (Clinicians and Monitoring and Evaluation staff) across the 15 counties in the county. A total of 559 health workers and County Health Team staff from 158 facilities received training. The trainings focused on several aspects: a) technical nutrition issues related to the definition and application of the indicators, b) completing the data collection registers/monthly reporting formats c) reporting pathways and d) interpretation of the data.

Following the integration of and reporting of nutrition indicators through the HMIS, a surge in the reporting of nutrition indicators has been observed with 68 percent reporting in December 2018 against 0.3 percent in March 2017. In addition, the following have been observed;

- The integration of nutrition indicators into the HMIS has enhanced the long-term sustainability of the nutrition programme since integration obligates health workers to provide nutrition services routinely and to report on them.
- Catalysed improved accountability among health care providers leading to improved availability of nutrition services.
- Enhanced evidence-based decision making and informed course correction at the local level.
- The DHIS-2 tool has made it easier to analyse the data and to produce dashboards for the nutrition data that are being used for communication and advocacy.



Nutrition Pages of the HMIS monthly report format

Nutrition Reporting format integrated in the DHIS-2 tool

Despite the progress made so far, more needs to be done to ensure the quality and timeliness of reporting. In addition, works needs to be done to support the County Health Teams to integrate nutrition into local level monitoring platforms such as; a) the data validation form, and b) the Join Integrated supportive supervision tool (JISS). The foregoing makes up our priorities that the MoH and UNICEF will be addressing during the last year of the co investment.

Case study 6

Systematization of nutrition surveillance mechanism in Mauritania's emergency response

Cross-cutting Programme Area

Issue/Background: Mauritania faces structural crisis of malnutrition, often aggravated by various shocks. A nutrition survey using SMART methods was conducted during the lean season of 2017. It showed a degradation of the nutritional status among children 6-59 months age. In 2018, an estimated 32,000 children under 5 years were estimated to be in need for treatment for SAM[11]. In addition, Projections of the "Cadre Harmonisé" (West Africa's version of the Integrated Food Security Phase Classification) indicated that over 602,000 people would be in a critical food insecurity situation during the lean season in 2018 – which was projected as much more severe than the average, and expected to start much earlier than normal (in some areas, possibly as early as February rather than June).

In order to assist the most vulnerable population, an integrated emergency response plan was developed. Priority actions identified for nutrition assistance were: (i) ensuring an appropriate supply of therapeutic inputs in line with targets for the management of severe cases of acute malnutrition nationally; (ii) intensifying a package of curative and preventive nutrition activities targeting children under five years, pregnant and lactating women in the 21-nutritional emergency Moughataas according to the 2017 SMART survey (global malnutrition> 15% and/or severe cases> 2%); and (iii) contributing to create an enabling environment to strengthen resilience among vulnerable communities based on a multi-sectoral approach and on coordination.

To mitigate the impact of the lean season in any department countrywide, a national surveillance mechanism was systematized. This mechanism consisted of: (i) ensuring access of quality screening of acute malnutrition twice yearly using mass campaign countrywide, with integration of VAS and deworming, (ii) conducting the national nutrition survey using SMART methodology during the lean season; and (iii) conducting a real-time monitoring to identify the origin of severe cases of acute malnutrition using RapidPro platform.

Key Results: The systematization of a nutrition surveillance mechanism during the 2018 Mauritania's emergency response led to screen almost 500,000 children twice a year, which represents 87% of the children aged 6-59 months of the country. This permitted to refer 2,241 children with severe acute malnutrition (SAM) for appropriate treatment. Over 560,000 children aged 6-59 months were also supplemented with vitamin A during two rounds, representing a 88% coverage. A bit less than 500,000 children aged 12-59 months benefited from de-worming tablets as part of the anaemia integrated control approach, representing a coverage of 86%.

The 2018 SMART survey showed that the national nutrition situation was still serious with 11.6% of GAM and 2.3% of SAM; 23 districts out of 55 are in nutrition emergency (GAM>15% and/or SAM >2%). Through intersectoral group[12] (nutrition/food security), the SMART 2018 results were presented, discussed and priority actions identified for the ongoing nutrition response and preparedness for the 2019 humanitarian response plan. The Ministry of Health had also received funding and technical support from UNICEF to hold regional restitution[13] of the key 2018 SMART survey results in eight

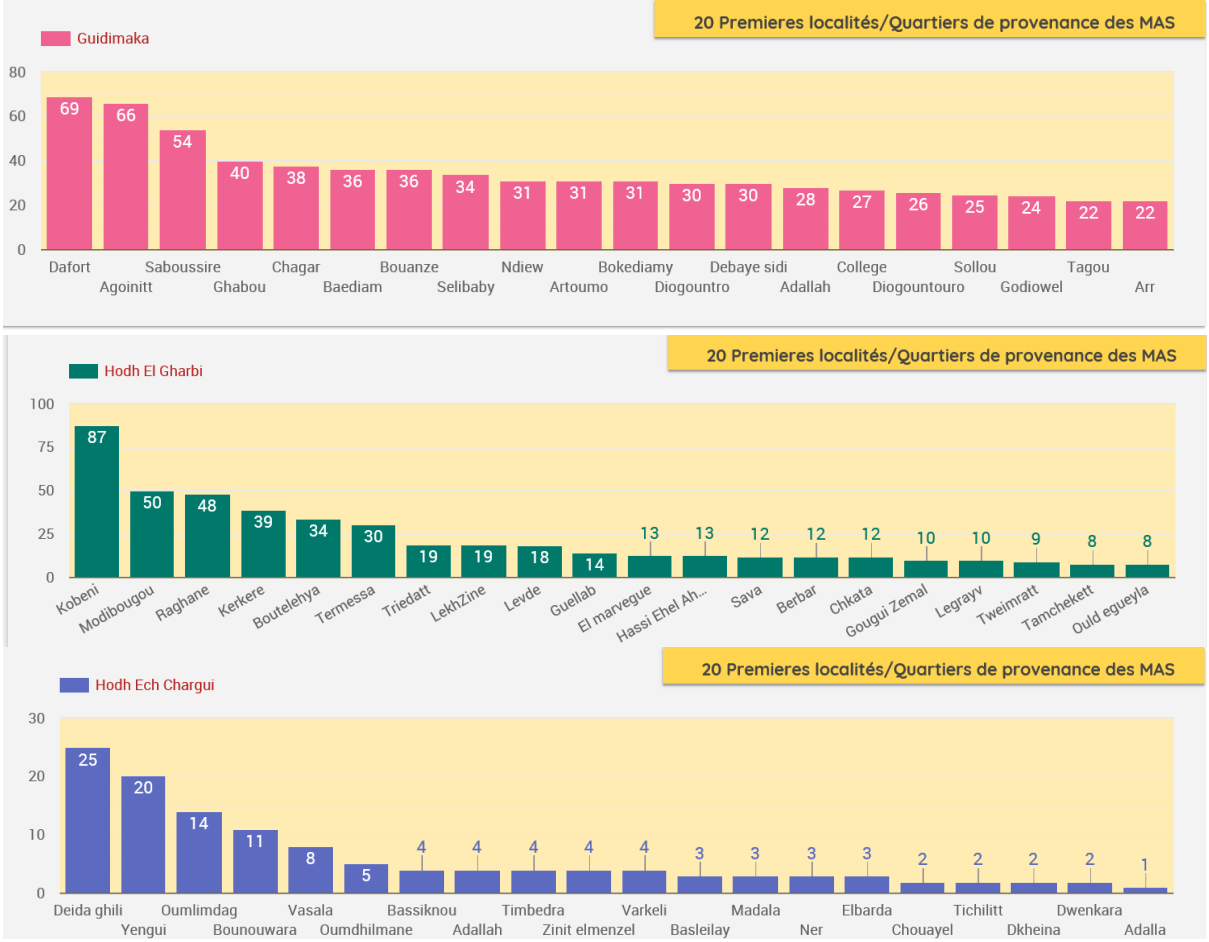
[11] Government of Mauritania Ministry of Health, Nutrition SMART Survey, August 2017; and Word Food Programme Mauritania, Food Security Monitoring Survey, November 2017.

[12] Intersectoral group: Nutrition group led by UNICEF and Food Security group led by WFP

[13] http://fr.ami.mr/Depeche-47710.html; http://fr.ami.mr/Depeche-47724.html

emergency regions. This was an opportunity to support discussions with sub-national nutrition stakeholders on factors contributing to malnutrition and identify priority actions to be implemented at regional level. Factors contributing to malnutrition were: (i) immediate causes of acute malnutrition – poor practices of infant and young child feeding and childhood diseases (diarrhoea, malaria, acute respiratory infection); (ii) underlying cause of acute malnutrition – food insecurity, mis-understanding of appropriate feeding practices, low access to health care and sanitation, poor practice of hygiene, gender issues, under-protected children from divorced parents, (iii) root-causes of acute malnutrition - rainfall deficit, soil depletion, structural issues of health, agriculture/livestock sectors. Immediate actions to undertake in 2019 were identified as: (i) to strengthen multisectoral coordination at regional level; (ii) to scale-up optimal infant and young child feeding practices promotion at health facilities and communities level; (iii) to create enable environment for optimal nutrition, health care, hygiene and sanitation access using child focus intervention through multisectoral approach.

Real time monitoring to identify the geographical origin of SAM cases was conducted in three regions (Guidimakha, Hodh El Gharbi, Hodh Ech Chargui). It allowed to identify the hot spots of SAM cases (top 20 localities) as shown in the graphics below. Early corrective actions could be undertake, which included pre-proposing stocks of RUTF close to the hot spots of SAM, and intensifying early screening of acute malnutrition by community health workers and mothers/caregivers, along with promotion of optimal IYCF practices.



Lesson Learned: Systematizing surveillance mechanism eased decision making including reviewing ongoing emergency response, undertaking earlier corrective actions, prioritizing zones, preparedness

action for 2019 emergency plan. It also helped catalyse multisectoral coordination at decentralized level. Including a surveillance mechanism as part of the humanitarian response to monitor the evolution of the nutritional situation at national level was a major success.

Surveillance mechanism pointed out the chronic vulnerabilities of eight regions that required to combine emergency and development actions using child focus programming. However, raising development funding proved to be a major obstacle. Activities related to surveillance mechanism were entirely financed by external emergency donors.

Moving Forward: As part of the implementation of longer-term strong nutrition surveillance system in Mauritania, UNICEF will pursue capacity building on nutrition surveillance. Advocacy will be undertaken for domestic financial resource mobilization to support minimum package of nutrition surveillance activities: a SMART survey; two mass campaigns screening of acute malnutrition; real time monitoring of SAM case origins in the seven chronic vulnerable regions combined with sentinel sites approach implementation in these regions. As part of multisectoral coordination, it should be important to explore whether some nutrition surveillance activities could be integrated within existing food security surveillance system.

The nutritional surveillance mechanism was supported by funding opportunities from CERF, USAID OFDA and FFP, and ECHO.

Case study 7

Multi-stakeholder advocacy to leverage domestic investment and nutrition governance to support the implementation of the multisectoral action plan for food and nutrition in Chad

Cross-cutting Programme Area

Background: Despite significant progress in recent years (under-five mortality rate has dropped by 53%, and maternal mortality has fallen by 44% since 1990[14]), Chad still holds the second highest maternal mortality rate in the world (856 deaths per 100,000 live births) and ranks as the 6th highest country for infant mortality with 87 deaths per 1,000 live births[15]. The main direct causes of mortality of under-five children in Chad are preventable diseases. Malaria (20.4%), pneumonia (15.7%) and diarrhoea (13.5%) are the top causes, while malnutrition, micronutrient deficiencies and poor child care such as sub-optimal infant feeding practices contribute to at least a third of these deaths. According to the last nutrition SMART survey carried out in August 2018[16], to assess the magnitude of the different forms of malnutrition, the rate of GAM was as high as 13.5% (just below WHO emergency threshold of 15%) while chronic malnutrition stands at 31.9% (below WHO critical threshold of 40%). In addition, 65.6% of under-five children and 43.6% of women aged 15–49 years were anaemic. Exclusive breastfeeding is low at 17.7% and VAS reaches only 64.3% of children 6–59 months.

In response, significant efforts have been made to improve the institutional framework for nutrition and the implementation of a multi-sectoral and multi-stakeholder platform for nutrition governance with the implementation of the National Council for Food and Nutrition under the leadership of the Prime Minister and the Technical Committee for Food and Nutrition[17]. However, in early 2018, the country has adopted the fourth Republic and the office of Prime Minister was cancelled. As a result, the high-level coordination and governance was no longer functional. Besides, interventions focus only on the short-term emergency response with no clear link to the development program and exclusively depend on external support from donors and partners.

In order to engage the government on addressing child under nutrition, UNICEF as the leading agency on nutrition support the Ministry of health to finalize the multi-sectoral action plan on food and nutrition 2017 – 2025 and engage multi-stakeholder advocacy activities to support its implementation. However, the plan remains underfunded and the instruments of its operationalization have not been put in place.

Action points and Results: In order to reinforce nutrition governance and financial commitment especially for the implementation of the multisectoral food and nutrition action plan, UNICEF developed partnership with the parliamentarians' network for nutrition to carry out advocacy activities toward the national authorities. To ensure that the parliamentarians have the required knowledge to relay appropriate nutrition messages, a training session was conducted at the national assembly and booklet summarizing the key messages was developed

Photo 1: MPs training session on nutrition

[14] Enquête Démographique et de Santé et à Indicateurs Multiples au Tchad (EDS-MICS) 2014-2015

[15] Enquête Démographique et de Santé et à Indicateurs Multiples au Tchad (EDS-MICS) 2014-2015

[16] Ministère de la Santé Publique : Enquête Nationale de Nutrition, SMART 2018

[17] They are the technical bodies for the coordination of the implementation of nutrition interventions. This entity is represented at the decentralized level by a provincial committee under the leadership of the Governor

in close collaboration with Directorate of food and nutrition at the MoH. Additionally, UNICEF supported the parliamentarians to conduct two meetings with line ministers that are members of the multisectoral platform to advocate for governance and the creation of budget lines for sensitive and specific nutrition interventions.

In July 2018, the UN network for SUN invited the Coordinator of the global Scaling Up Nutrition (SUN) Movement, on official visit in chad. She met with senior government officials, including the President of the Republic and members of the government in charge of sectors related to nutrition. She also met with all stakeholders in the nutrition sector, including key donors such European Union. This visit was an opportunity to engage the government on investing in both specific and sensitive nutrition interventions while exchanging on challenges and opportunities to reinforce the bridge between emergency and development program on nutrition related interventions.

Photo 2: Gerda Verburg, Coordinator of the global Scaling Up Nutrition on official visit to Chad

In August 2018, following the publication of the nutrition SMART survey results showing an alarming level of malnutrition, a meeting was organised with the Minister of Health, UN agencies, donors and stakeholders in the nutrition sector to present the findings and agree on a response plan. An advocacy meeting was then held with the President to advocate on three main points: The transfer of the National Council for Food and Nutrition to the Office of the President; Provide funding to support the scale up of multi-sectoral action plan on food and nutrition; and the adoption of the decree of the national code of marketing of breastmilk substitutes. The President agreed to set the National Council under the lead of the Office of the President and a first meeting was held to approve its annual action plan. The multi-sectoral action plan on food and nutrition for 2019 was finalized and will be submitted for the President's approval and allocation of resources for the first year of implementation. The decree on the national code of breastmilk substitutes was enacted submitted to the parliament for adoption. In February, 10 provincial coordinators of the multisectoral coordination platform were appointed to office of the Governors to support the coordination at the decentralized level. A meeting co-organized by the government and UN system on the nexus Humanitarian and development will be held in March 2019 to reinforce the integration of the emergency response and the development agenda.

Moving Forward: In partnership with the Directorate of food and Nutrition, UNICEF is monitoring the adoption of the code of breastmilk substitutes and the allocation of the budget line for nutrition. Partnership with the journalists' network for nutrition is being established to support the mass communication strategy for a countrywide dissemination of key messages. The MPs will conduct a caravan to 9 provinces to maintain the advocacy and communication activities at the decentralized level. With the implementation of aforementioned actions and the scale up of the multisectoral action plan, it is expected that Chad will make a significant move toward achieving the WHA and the SDG targets by 2025 with a decrease of stunting rate from 31.9% to 20% [18], wasting rate from 13.5% to 5% and increase the breastfeeding rate (from15 to 30%).

Lessons learnt: With regard to process and the achievement of these results, the importance of the joint advocacy activities and the necessity to work and collaborate beyond the usual nutrition sector cannot be stressed enough. The involvement of various actors and the adoption of different communication and advocacy was instrumental in the achievement of such result.

[18] The Average Annual Reduction Rate of stunting in 2018 reached 4.9%.

Using evidence-based information was also a key for success. Advocacy materials were based on concrete results of various studies and surveys carried out in Chad and the neighbouring countries, giving adequate weight to the information shared.

The senior government officials are sensitive to the detrimental consequences of undernutrition and its impact on the country as a whole due to malnutrition and are committed to continuing to work with UNICEF and other partners.

Case study 8

Rapid Scale up of Emergency Nutrition Response in North East Nigeria

Cross-cutting Programme Area

Situation overview: Since 2009, large parts of North Eastern states have been severely affected by the Boko Haram protracted insurgency. At the peak of the crisis, between 2015 to early 2017, up to 10.5 million people across the lake chad basin (North East Nigeria, Chad, Cameroon and Niger) were denied access to essential basic services including food, water, health services, shelter, etc.…). Insecurity has been hampering the resumption of normal life, leaving conflict-affected families dependent exclusively on humanitarian assistance for survival.

In Borno, Yobe and Adamawa states; the ongoing crisis has left around 7.1 million people including 4.2 million children, exposed to extreme hardship conditions. The Boko Haram conflict insurgency has triggered 1.9 million internally displaced persons (IDPs) across those 3 states.) (OCHA, 2018). And because military forces strictly restricted IDPs' movement; they can't engage in livelihood activities therefore remain in dire need of urgent life-saving humanitarian assistance. Very little resources within host communities also got stretched therefore, the vast majority of IDPs and their host communities are almost entirely dependent on humanitarian interventions for the basic needs of life.
Problem statement: At the beginning of 2017, an estimated 449,235 children under five were on urgent need for treatment of severe acute malnutrition (SAM). The Nutrition Sector had targeted to reach 314,557 (70% of the total burden), with UNICEF targeting 220,190 (70% of the total sector target). In is worth noting that, even before the onset of the current crisis, malnutrition has been a significant challenge in northern states of Nigeria. This has been attributable to several factors including food insecurity, traditional beliefs, illiteracy, inadequate availability of basic social services and poor health seeking habits.

Even without the prevailing challenges, targeting that number of children for SAM treatment could be an ambitious endeavour. In North-Eastern Nigeria the greater proportion of government infrastructure including health facilities, that should have supported such a large-scale response were either destroyed or were not functional due to lack of resources including human and financial. Health workers were clearly not enthusiastic to risk their lives working in many highly insecure areas of the states. Though a handful of health workers were ready to take the risk, many of them lacked the required skills to support the response. The Nigerian government's capacity to respond to the nutrition emergency was therefore severely compromised. All challenges abovementioned occurred at a point of time when even international non-governmental organizations were not too willing to implement their activities outside of a few secure main towns and cities.
UNICEF response: UNICEF, as last resort provider, led the SAM treatment response in collaboration with the State Primary Health Care Development Agencies of Borno, Yobe and Adamawa states. Key pillar of the response plan was to improve access to nutrition services through a very strong community mobilization component using all existing community platforms such as nutrition mobilizers, traditional and religious leaders for sensitization and primary health care centres. Strategies used to achieve that included:

- Strengthened community mobilization for early detection, treatment and prevention of malnutrition**.** Monthly screening took place; and a total of 1.5 million children under 5 years were screened for SAM, by a network of 3,508 Community Nutrition Mobilizers (CNMs).
- Establishment of 3,058 community-based mother support groups (MSGs) to support sensitization around optimal infant and young child feeding practices, appropriate use of ready to use therapeutic food and multiple micro-nutrient powder supplementation.
- Integration of treatment of acute malnutrition, IYCF counselling and micro-nutrient supplementation in 389 fixed government health facilities across the 3 states. Furthermore,

49 outreach sites were established; and 49 mobile nutrition teams deployed in hard to reach areas to optimize access to appropriate life-saving nutrition services.
Establishment of the WhatsApp group for timely and regular communication, information and action sharing.

To maximize impact, additional strategies were included a) mapping of high malnutrition burden pockets and entry points for IDPs for quick a timely response, b) integration of health, WASH and child protection into the nutrition programming; and c) strengthened monitoring and supportive supervision.

Achievements: A total of **233,996** children with severe acute malnutrition were admitted to the 517 static and mobile nutrition treatment sites across the 3 states. This represented over 100% and 76% of the UNICEF's original target and the total sector target; respectively. Cure rate (94.3%); defaulter (4.1%), non-responder (1.4%) and death (0.2%); were all above the Minimum SPHERE standards. IYCF counselling services were provided to 206,547 pregnant and lactating women as well as children caregivers, whilst 232,463 children aged 6-23 were provided micronutrient powder supplements.

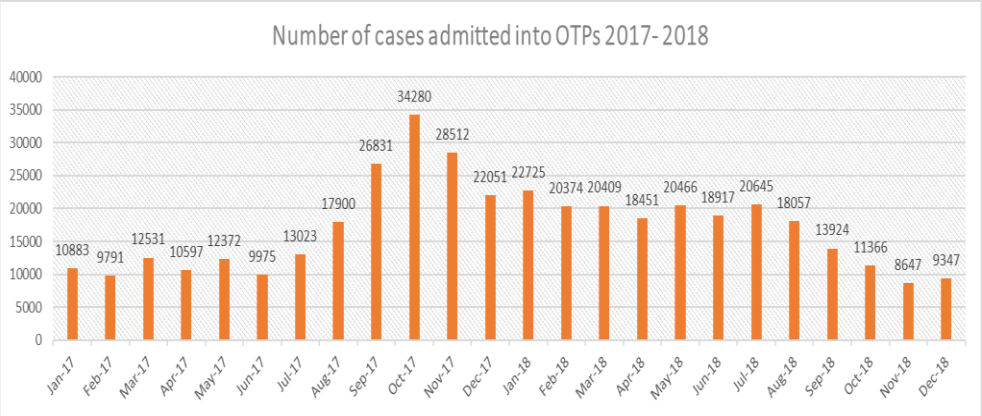


Figure 1: Monthly admissions into SAM treatment centres across Borno and Yobe States in 2017 and 2018

The chart above indicates increased admission of SAM children after massive scale up of nutrition program in Jun-Jul 2017 and gradually stable and decreasing trend due to intensive community mobilization and sensitization efforts for the prevention of malnutrition. In the beginning of 2017 also, admission of SAM children looks low due to inadequate community mobilization and availability of nutrition service sites.

Challenges and lessons learnt: Major obstacles to early case detection and timely access to nutrition service provision included1) illiteracy; 2) traditional beliefs that influence health seeking behaviours pattern; 3) frequent staff turnover and 4) absenteeism of staff at the service provision points. Furthermore, delivery of community mobilization activities, program monitoring, and supplies were challenged by the volatile and unpredictable security situation.

It is widely acclaimed that despite the unique and structural challenges the North-Eastern Nigerian context presents, UNICEF made progress in improving the nutrition situation thereby saved lives of vulnerable people. This was, partly, made possible through the 2017-2018 momentum for scaling up SAM treatment services. Implementation of the following strategies were critical for the progress achieved in the nutrition programme - this included:

- Building the programme on existing community structures (CNMs, MSG).
- Timely and periodic data analysis (target versus achievement), with feedback provided to programme staff, helps in identifying and addressing gaps; as well as adapting activities.
- Adoption of context specific solutions to address challenges related to supply chain management to prevent supplies stock-out.
- Use of social media (WhatsApp in this case) can enhance programme effectiveness.

Way forward: With the required structures at community and facility levels for implementation of the integrated nutrition package in emergency and early recovery settings across the 3 states now firmly established, it is important that coverage is maintained whilst efforts now shift to a continuous improvement in the quality of delivery. This changing strategy will include focusing on effective monitoring at all levels of implementation. And provision of quality and robust supportive supervision.

UNICEF will therefore continue working with the Nutrition in Emergency Sector Working Group, INGO partners, State Ministries of Health and other relevant authorities to ensure that this is achieved. This will however require that UNICEF maintains the level of support currently provided to partners while deliberately ensuring gradual and smooth transfer of ownership of the programs to government authorities.