GOVERNMENT OF LIBERIA

NATIONAL NUTRITION POLICY 2019-2024

Monrovia, Liberia – April, 2019

GOVERNMENT OF LIBERIA

NATIONAL NUTRITION POLICY 2019-2024

Monrovia, Liberia – April, 2019

CONTENTS

FOREWORD

In Liberia, chronic malnutrition continues to affect nearly one-third of all children under five. With a stunting prevalence of 35.5 percent (Ministry of Agriculture, 2018), Liberia is among 21 countries with the highest stunting rates worldwide, depriving thousands of children in the country of their full growth and development potential. In the last two decades, Liberia has made some progress towards reducing stunting from 45 percent in 2007 (LISGIS, Ministry of Health and Social Services, National AIDS Control Program, & Macro International, 2008) to 32 percent in 2013 (LISGIS, Ministry of Health and Social Welfare, National AIDS Control Program, & ICF International, 2014). However, the momentum seems to have slowed down since 2008, with stunting prevalence having plateaued and ranging between 35-36 percent in the last decade (Ministry of Agriculture, 2018). Nationally, 4.8 percent of children are thin for their weight (Global Acute Malnutrition/GAM), out of which 3.4 percent are classified as suffering moderate acute malnutrition (MAM) while 1.4 percent are affected by severe acute malnutrition (SAM). Additionally, 15 percent of children are underweight (light for their age), which could reflect short or long-term nutritional issues (Ministry of Agriculture, 2018).

Vitamin A deficiency is also common at 13 percent among children aged 6 to 35 months while the coverage rate of vitamin A supplementation is at 71 percent (Government of Liberia, LISGIS, & UNICEF, 2011). Anemia among Liberian children 6 to 35 months is high at 59 percent. Furthermore, among pregnant women, Anaemia is prevalent at 38 per cent with iron supplementation coverage rate at 68 percent (Government of Liberia et al., 2011). The malnutrition problem in Liberia is now compounded by new dimension of double burden of malnutrition. The prevalence of overweight among women has risen from 15 percent in 2007 to 27 percent in 2013. This puts a huge strain on the fragile health care system that is also grappling with handling other diseases.

undernutrition is responsible for 45 percent of deaths of children younger than 5 years, amounting to 3 million deaths each year (Black et al., 2013). Malnutrition in its entirety leads to compromised cognitive development and physical abilities, making yet another generation less productive than they should be. Not only are the effects of malnutrition felt in childhood but they are far reaching through the life-cycle, forming a cyclical relationship of poverty and malnutrition which is passed from mother to child, across generations. The economic cost of malnutrition is estimated to range from 2 to 3 percent of Gross Domestic Product, to as much as 16 percent in most affected countries (African Union Commission & WFP, 2013). Undernutrition is associated with lower educational achievement, compromised cognitive development during childhood leads to long-term impairment, including increased risk of chronic diseases, as well as lower economic status and productivity during adulthood.

In 2008, the Government of Liberia developed a five-year national nutrition policy to create an enabling environment that facilitated the implementation of nutrition interventions. In 2018, the Ministry, in collaboration with UNICEF and partners commissioned the revision of the National Nutrition Policy (NNP) to update the based on new developments in the field of nutrition, global best practices and to contextualize it appropriately. The NNP has been revised through a process of technical consultation of local technical experts through meetings and workshops, external technical expertise, as well as review of global experiences

and best practices in the area. This revised NNP consolidates the different thematic areas of nutrition into Direct Nutrition Interventions (DNIs) and Sensitive based on the Lancet series of 2013.

The revised policy recommends strategies for achieving our goal of attaining optimal nutrition among Liberian citizens. The policy proposes an emphasis on multi-sectoral approaches to nutrition where all relevant sectors implement interventions in a collaborative manner to address both immediate and underlying determinants of undernutrition. This policy also provides the framework to help government prioritize its nutrition actions in line with our limited human and financial resources. It will also enable us forge new partnerships - between government and key stakeholders (communities, development partners, private sector) - that are critical in addressing the undernutrition problem in the country.

On behalf of the government of Liberia, I wish to thank the United Nations Children's Fund (UNICEF) for providing the technical and financial support for the review and revision of the NNP. I would also like to thank members of the Technical Working Group for their commitment and effort throughout the policy review process.

Hon. Wilhemina S. Jallah MD. MPH, CHES, FLCP

MINISTER

Ministry of Health.

ACKNOWLEDGMENT

This National Nutrition Policy has been reviewed under the leadership of the Ministry of Health (MoH). The Nutrition Division has provided the technical leadership for the review while the Policy Division provided the strategic direction. The United Nations Children's Fund (UNICEF) and the Government of Ireland through the Renewed Efforts Against Child Hunger and Undernutrition (REACH) provided the technical and financial support for the revision. The contributions of both the MoH, UNICEF and the Government of Ireland are deeply appreciated.

Special thanks to the members of the NNP Technical Working Group who provided their technical expertise and experience towards the review of this policy document. The Policy Technical Working Group led the coordination of this entire process and the contributions of each member is acknowledged and appreciated. Technical materials from various sources have been gratefully acknowledged as footnotes wherever they have been quoted.

Hon. Francis N. Kateh, MD, MHA, MPS/HSL, FLCP

Deputy Minister for Health Services, Chief Medical Officer-RL

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
BCG	Bacille Calmette-Guérin vaccine
BFHI	Baby Friendly Hospital Initiative
CHAs	Community Health Assistants
CNS	County Nutrition Supervisor
CRC	Convention on the Rights of the Child
DHS	Demographic Health Survey
DNI	Direct Nutrition Interventions
DPT3	Diphtheria, Pertussis (whooping cough) and Tetanus vaccine
ECE	Early Childhood Education
EPI	Expanded Program of Immunization
EVD	Ebola Virus Disease
GDP	Gross Domestic Product
GOL	Government of Liberia
HFS	Health Facility Survey
HIV	Human Immunodeficiency Virus
IMCI	Integrated Management of Childhood Illnesses
IMAM	Integrated Management of Acute Malnutrition.
LDHS	Liberia Demographic and Health Survey
LIC	Low Income Countries
LISGIS	Liberia Institute for Statistics and Geo-Information Services
MACs	Ministries, Agencies and Commissions
MNP	Multiple Micronutrient Powder
MOH	Ministry of Health
NCC	Nutrition Coordinating Committee
NCDs	Non-Communicable Diseases
NDP	National Development Plans
NER	Net Enrollment Rate
NGOs	Non-Governmental Organizations
NMS	National Micronutrient Survey
NNP	National Nutrition Policy
ORS	Oral Rehydration Solution
PAPD	Pro Poor Agenda for Progress and Development

RCV	Rotavirus Containing Vaccine
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
ROL	Republic of Liberia
SUN	Scaling Up Nutrition
TB	Tuberculosis
UNICEF	United Nations Children's Fund
VAD	Vitamin A Deficiency
WFP	World Food Program
WHO	World Health Organization

1. Introduction

Malnutrition rates in Liberia are among the highest in the world. Globally, undernutrition is responsible for 45% of deaths of children younger than 5 years, amounting to 3 million deaths each year (Black et al., 2013). With a stunting prevalence of 35.5 percent (Ministry of Agriculture, 2018), Liberia is among 21 countries with the highest stunting rates worldwide, depriving thousands of children in the country of their full growth and development potential. Malnutrition in its entirety leads to compromised cognitive development and physical abilities, making yet another generation less productive than they should be. Not only are the effects of malnutrition felt in childhood but they are far reaching through the life-cycle, forming a cyclical relationship of poverty and malnutrition which is passed from mother to child, across generations. The economic cost of malnutrition is estimated to range from 2 to 3 percent of Gross Domestic Product, to as much as 16 percent in most affected countries (African Union Commission & WFP, 2013). Undernutrition is associated with lower educational achievement, duet to compromised cognitive development during childhood and leads to long-term impairment, including increased risk of chronic diseases, as well as lower economic status and productivity during adulthood.

The Government of Liberia recently completed the development of the Pro-Poor Agenda for Prosperity and Development (PAPD) 2018 to 2023, which is the second in the series of National Development Plans (NDP) anticipated under the Liberia Vision 2030 framework. One of the outcome areas under Pillar 1 of the PAPD envisions to achieve, ''Increased access to health, food security, education, and livelihood opportunities for special populations and people with disabilities'' (Government of Liberia, 2018). Under the health docket, the PAPD recognizes the importance of improved nutrition to ensure the health human capital needed for sustained economic growth and poverty reduction. Stunting reduction will therefore be one of the focus areas for the government as exemplified in the PAPD. The revised NNP contains a set of coherent set of goals, objectives, strategies and priority decisions essential for the attainment of optimal nutrition that ultimately contributes to poverty reduction and sustainable human development.

The Nutrition Policy will complement the National Health Policy and the Food Security and Nutrition Strategy which are supportive of public action to improve nutrition. Maternal and young child undernutrition will be addressed by accelerating the scale up Direct Nutrition Interventions (DNIs) with a view of improving population coverage. The DNIs are a set of 10 proven nutrition interventions that address the immediate causes of undernutrition. The emerging problems of obesity and diet related communicable diseases will be tackled through a combination of nutrition and health education and actions to promote health, diet and lifestyle changes.

In addition to the application of DNIs, the policy proposes a strong advocacy approach to ensure the implementation of Nutrition Sensitive interventions across the relevant sectors. “In addition to nutrition-specific interventions, acceleration of progress in nutrition will also require increases in the nutritional outcomes of effective, large-scale, nutrition-sensitive development programs” (Black et al., 2013). Nutrition-sensitive programs address some key underlying determinants of nutrition that include; poverty, food insecurity, and scarcity of access to adequate care resources.

The implementation of nutrition sensitive interventions can help enhance the effectiveness, coverage, and scale of nutrition-specific interventions. Focus will be on the implementation of nutrition sensitive interventions in the following sectors: Agriculture, social protection, education as well as Water Sanitation and Hygiene. Targeted agricultural programs will be reinforced because they have an important role in support of livelihoods, food security, diet quality, women's empowerment, and complement global efforts to stimulate agricultural productivity Agricultural programs can increase producer incomes at the same time protecting consumers from high food prices. To enhance impact, agricultural programs will also incorporate strong social behavior change communications strategies and a gender equity focus that is evidence based. Thoughtful actions shall be taken to enhance the nutrition-sensitivity of programs by improving targeting; using conditions; integrating strong nutrition goals and actions; and focusing on improving women's physical and mental health, nutrition, time allocation and empowerment.

The operationalization of the national nutrition policy will rely on a joint collaborative framework across sectors. This framework will emphasize on institutionalization of nutrition actions to ensure sustainability and the implementation of interventions that are supportive of optimal nutrition outcomes. An appropriate multi-sectoral mechanism will be established for effective coordination.

1.1 Country Context

Liberia has a population estimate of 4.2 million people with a growth rate of 2.1 percent (LISGIS, 2017). The land area comprises 110,080 square km and lies on the Western coast of Africa; bordered on the West by Sierra Leone, on the East by Côte d'Ivoire, on the North by Guinea and on the South by the Atlantic Ocean.

The terrain consists of coastal beaches and mangroves, fading into semi-deciduous shrubs and wooded hills that transitions into the interior dense tropical rainforest and highland plateaus. The climate is tropical with a wet season from May to October and a dry season from November to April. The average annual rainfall is 5,200 mm and average temperature ranges from 22 degrees Celsius to 27 degrees Celsius (Abeodu Bowen Jones, Petterson, & Holsoe, 2019).

Liberia has a young populace with 62.6 individuals younger than 25 years (LISGIS et al., 2008). Reproductive age women (15-49 years) make up 23 percent of the women total population that is more than half of the country's population. Life expectancy at birth is estimated at 62 years, while the total fertility rate is 4.7 children per mother (LISGIS, 2017). Early childbearing has changed very little over the years, with teenage pregnancy posing a health risk to both young mothers and their infants. Thirty percent of women aged 15 to 19 years, have already begun bearing children. The fraction is higher among rural adolescents compared with their urban counterparts (LISGIS, 2017).

The national average household size is 4.3 persons; and ranges from 3.7 to 4.9 persons per household in Gbarpolu county (Northwest region) to 4.9 in Maryland (Southeastern region) respectively. At the current growth rate, the population increases by approximately 382 persons daily or by 139,000 per year (LISGIS, 2017). Liberia is among the top six countries where life expectancy increased the most over the past decade.

1.2 Situation Anaysis

1.2.1 Education

Education is not readily available and accessible for all. Progress has been made in increasing school enrollment; but Primary Net Enrollment Rate (NER) in Liberia is 46 percent (Ministry of Education, 2016); significantly lower than other Low Income Countries (LIC) in Sub-Saharan Africa (78 percent) (World Bank Group & UNESCO Institute for Statistics, 2017). Moreover, approximately 85 percent of primary students and 75 percent of children in Early Childhood Education (ECE) are overage for their grade levels (Ministry of Education, 2016) On a more positive note, NER was even for male and female students across all academic levels; but nearly two thirds (61.5 percent) of schools do not have a library. Media centers with computers are virtually non-existent or nonfunctional. Only 58 percent of schools have latrine facilities segregated for boys and girls (Ministry of Education, 2016).

To get the maximum return on investment in human capital, efforts should start in the early years of life. Early childhood is a critical developmental window when a child's abilities or disabilities can be identified to aid further development. Early Childhood Development (ECD) encompasses all aspects of children's development including cognitive, social, emotional and physical abilities and cuts across several sectors including: education, health and nutrition, protection. In 2015, 13 percent of children aged 0-4 years were enrolled in ECD programs. Children in urban areas (19 percent) were more likely to receive ECD education services than children in rural areas (9.8 percent) (Ministry of Education, 2016).

1.2.2 Health, Water and Environmental Sanitation

Over the past decade, enormous progress has been made in the Health Sector. Significant gains were made in improving performance on major Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) indicators. RMNCAH services are now available across the 15 counties. Skilled birth attendant is now 11.8 per 10,000 populations from 4 per 1000 in 2006; while infant mortality is now 54 per 1,000 live births, compared to 71 deaths per 1,000 live births in 2007 (LISGIS et al., 2014). Infant mortality declined from 71 deaths per 1,000 live births to 54 deaths per 1,000 live births; neonatal mortality decreased from 32 to 26, and under-five mortality also decrease from 110 to 94 deaths per 1,000 live births between 2007 and 2013 (LISGIS et al., 2014).

Contraceptive prevalence increased among currently married women from 10.3 in 2007 to 19.1 percent in 2013 and among sexually active un-married women from 23.1 in 2007 to 34.6 in 2013 (LISGIS et al., 2014). Teenage pregnancy still stands at 31 percent demanding a differentiated approach to adolescent health service. Population access to healthcare within 5KM or 1-hour walk is 71 percent--up from 41 percent in 2008 (LISGIS et al., 2014).

Community Health Assistants (CHA's) are delivering an integrated and standardized package of health services; which includes curative, preventive, promotive, rehabilitative and palliative services, to households located more than one-hour walk (more than 5km) from the nearest health facility. Households located within 5km of a health facility are receiving tailored package of services delivered by other community cadres. To date, 80 percent or 3,200 of the overall targeted 4,000 CHAs have been recruited, trained, and deployed in 13 counties. The CHA program is a promising approach that can potentially change the narrative around health care delivery in Liberia.

Communicable Diseases: Malaria is endemic and the entire population is at risk of the disease. Children under five and pregnant women are the most affected groups. According to data from the Health Facility Survey (HFS, 2013) malaria accounted for 42 percent of outpatient department attendance and 39 percent of in-patient deaths. The total number of cases reported between 2016 and 2017, however, has fallen by nearly 29 percent from 1,517,115 to 1,069,880. TB case notification improved by 24 percent in 2015; thus, placing the overall notification at 7,119 (56%) of all expected TB cases) at the end of 2016. Liberia TB treatment success rate has increased from 68 percent in 2015 to 76 percent in 2016.

The LDHS 2013 estimates the national HIV prevalence rate among sexually-active adults (15-49 years) to be 2.1 percent, with variations based on sex, age range, geography, and socio-economic status (LISGIS et al., 2014). Leprosy is still a public health concern, with prevalence (3.61/10000) above the World Health Organization (WHO) threshold.

Prevalence of other Neglected Tropical Diseases (NTD) remains very high. Mass Drug Administration for the elimination and control is ongoing in all counties for Onchocerciasis and Soil transmitted helminths. Mass Drug Administration is ongoing in 13 counties except for Bomi and Gbarpolu. Mass Drug Administration is ongoing in 13 counties except for Rivercess and Grand Kru.

Non-Communicable Diseases: Liberia has only one psychiatrist, no doctoral level psychologists, and few social workers (Saxena et al., 2014). Liberia needs over 1,000 mental health professionals. WHO estimates that Liberia needs 427 trained psychiatric nurses (9.5 for every 100,000 population). There is one psychiatric referral hospital and 4 Wellness Units. Cancer remains a serious issue. Only two (2) public and one (1) private facility are currently screening for cancer. There is little or no access to chemotherapy and radiotherapy, thus rendering cancer treatment services very inadequate. Eye health is available but at a high cost in Monrovia. Outside of Monrovia limited eye care is available at a few secondary hospitals - Ganta, Phebe, Zwedru, Fishtown, Harper, Barclayville and Greenville.

Immunization: Immunization services existed in Liberia since 1978, preventing 6 childhood diseases (measles, diphtheria, pertussis, polio, TB and tetanus). To date, new antigens have been added into routine immunization program. The antigens are Yellow Fever - 2007; Pentavalent Vaccine - 2009 replacing DPT; Pneumococcal Conjugate Vaccine - 2014; Rotavirus Containing Vaccine RCV - 2016; and Human Papillomavirus Vaccine has been piloted in Bong and Nimba Counties, while Inactivated Polio Vaccine, IPV was introduced in 2017.

Health care Management: The current situation is characterized by inadequate health financing, underdeveloped health services infrastructure, a shortage of both human resources for health and essential medical supplies and limited administrative and managerial competence. These restrict health service delivery and coverage. Therefore, equity and access to quality health care remains limited. High out-of-pocket, expenditure (42 percent) on health care especially, among low income earners, generally signifies a lack of financial risk protection against catastrophic health risks for the poor (Ministry of Health and Social Welfare and Health Systems 20/20 Project, 2011).

Water Sanitation and Hygiene: Access to and the use of improved sources of drinking water has improved. Access to drinking water is estimated at around 73 percent and access to sanitation is estimated at 17 percent. About 15 percent of the population has access to sanitation and hygiene. In the rural areas open defecation is still the most widespread method of feces disposal with as many as 85 percent households still practicing open defecation. Only 6 percent of the rural population currently have access to improved sanitation. It is estimated that each year, Liberia loses USD 17.5 million due to the poor sanitation; the poorest quintile of the population is almost 7 times more likely to practice open defecation than the wealthiest (Water and Sanitation Program, 2012).

Additionally, large disparities exist across the country. There are inequalities in coverage. The 2015 MDG targets for access to improved drinking water sources and improved sanitation are 79 percent and 63 percent respectively. The targets for rural areas were 67 percent access to improved water sources and 52 percent access to improved sanitation. An estimated 35 percent of existing clinics and schools lack adequate access to water and sanitation facilities while formal solid waste management services are only available in Monrovia (Ministry of Health, 2012).

1.2.3 Food Security and the Economy

Access to food by most Liberians is constrained by "high poverty rates" (Water and Sanitation Program, 2012), "an under-performing labor market", (LISGIS, 2017) and poor road conditions particularly in rural communities. In 2015, food expenditures accounted for over 65 percent of total household spending by a quarter of households in the country, while 41 percent of households did not have food or money to buy food the week before the Emergency Food Security Assessment (Liberia Food Security Cluster, 2015). "Agricultural productivity is low, leading to a deficit in the domestic requirements of staple foods, which is subsidized by rice importation (65 percent). Two out of every three households (34 percent) lack access to farmland. Households in Lofa have the most access to farmland (67 percent), followed by Rivercess (61 percent), Nimba and River Gee (58 percent) and Grand Gedeh (55 percent). Liberia imports more than 60 percent of its staple food thus making population vulnerable to food insecurity and malnutrition in times of price increase and fluctuation on the world market" (LISGIS et al., 2014).

Access to food is also a function of household income, which largely depends on employment. Employment in Liberia is low. The 2010 Labour Force Survey reports that 68 percent of employed Liberians work in the informal sector without regular wages or benefits. Agriculture employs 67 percent of the labour force, but the proportion of rural households with access to agricultural land is 73 percent (Ministry of Agriculture, 2013). Those unable to access food through their own production or income-generating employment would be expected to resort to social safety nets, but these options are limited because of dwindling donor assistance and diminishing government fiscal space.

The Human Development Index (HDI) increased by 10.6 percent between 2000 and 2015. The Gross National Income (GNI) per capita rose by 8.4 percent from 1990 to 2015 (UNDP, 2018). Nevertheless, Liberia remains in the low human development category and absolute poverty is on the rise in 5 of the 6 national statistical regions. Historical GDP growth has

been volatile. Per capita GDP increased from about US$ 1,270 in the 1960s to US$1,680 in the 1970s and sharply declined to below US$1,400 in the 1980s. Liberia experienced the worst decline, to less than US$115, during the civil war in the mid-1990s. From 1995 onward, the GDP improved and progressively increased to growth rates of 11 to 14 percent from 2007 (Government of Liberia, 2018).

The gains produced by GDP growth have not been universally felt nor are they sustainable. The outcomes produced by large investments inflow over the last 12 years show marginal reductions in key indicators of disparity and deprivation among the population and geographic regions. When inequality measurements are introduced, the 2016 adjusted HDI show losses of 33.4 percent due to inequality in the distribution of the basic indicators of development. The average loss for Sub-Saharan Africa is 32.2 percent over the same period (UNDP, 2018). As the 181st of the 189 countries on the 2017 human development index, Liberia ranks as the 8th lowest. On the inequality adjusted and the gender HDI, Liberia ranks as the 8th lowest and is among the 10 most unequal countries (UNDP, 2018).

1.2.4 Nutrition Situation

Malnutrition continues to be a major public health problem in Liberia, exacerbated by poverty, food insecurity, poor dietary practices, low literacy levels and poor access to basic social services. The most vulnerable groups include women and children, the elderly, people living with HIV/AIDS and tuberculosis patients.

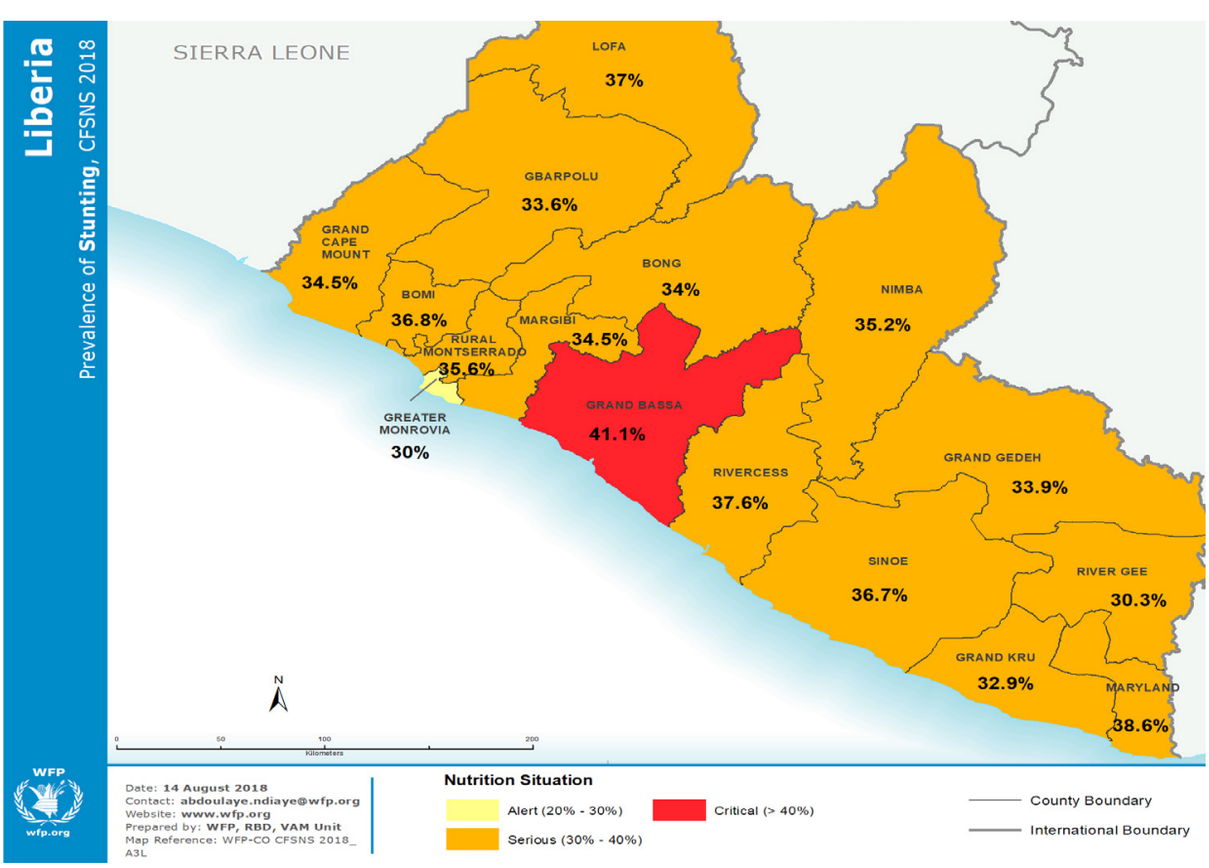


Figure 1. 0 Prevalence of stunting across counties in Liberia, 2018

One of the major factors inhibiting the healthy development of children in Liberia is the high prevalence of stunting. Stunting rates increase gradually with age and peak at 42 per cent for children aged 36-47 months (LISGIS et al., 2014). The highest increase is seen between the ages of 6 and 24 months with the prevalence of stunting more than doubling from 17 to 37 percent. Stunting levels vary little by residence; by county, Grand Bassa has the highest prevalence (41 percent) while the rates are not significantly different across the rest of the counties (30 – 39 per cent). This indicates that the rate of stunting is very high across the country (Ministry of Agriculture, 2018) as defined by the WHO-UNICEF threshold of ≥30 per cent. The prevalence of stunting and wasting are inversely correlated with wealth quintile (LISGIS et al., 2014), with children in the highest wealth quintile less likely to suffer from malnutrition than those in lower wealth quintiles. Proportions of stunting, wasting and underweight are higher among children reported as very small and small at birth than among children reported as average or larger at birth. In addition, the prevalence of stunting, wasting and underweight is higher among children born to underweight mothers than among those born to normal-weight or overweight mothers.

In the last two decades, Liberia has made some progress towards reducing stunting among children under the age of five years, with a reduction of 9 percentage points from 2000 to 2008, from 45 to 36.1 per cent (Ministry of Agriculture, 2018). However, the momentum slowed in the last decade with stunting prevalence having plateaued near 36 per cent, meaning that more than one third of all children under five—some 263,000 children as of 2018—are stunted. This has long-term consequences for their survival and development because of the effects of stunting on brain development and learning performance and, ultimately, on adults' health and productivity, and its strong association with increased morbidity and mortality.

Vitamin A deficiency is common at 13 percent among children aged 6 to 35 months (Government of Liberia et al., 2011). Anemia among Liberian children 6 to 35 months. Furthermore, among pregnant women, Anaemia is prevalent at 38 per cent (Government of Liberia et al., 2011).

Some 8 percent of pregnant women are undernourished. Almost all pregnant women have deficiencies in trace elements such as iodine and iron; 38 percent of pregnant women suffer from anemia. Only 21 percent took iron tablets for the recommended period and only 58 percent took deworming medication (LISGIS et al., 2014). One in four women and fewer than 1 in 10 men are overweight or obese. Malaria during pregnancy is a major contributor to low birth weight, maternal anemia, infant mortality, spontaneous abortion and stillbirth. The mother's nutritional status, including anemia, affects the health of her baby. Proportions of stunting, wasting, and underweight are higher among children reported as very small and small at birth than among children reported as average or larger at birth. The prevalence of stunting, wasting, and underweight is higher among children born to underweight mothers than among those born to normal-weight or overweight mothers.

Nutrition mainstreaming is at its nascent stages hence the coverage of nutrition interventions as well as essential nutrition practices among the communities are low. In addition, there are gaps in terms of key policies, legislations and institutional capacities that could support the realization of optimal nutrition outcomes. To address the foregoing, there is need for a greater focus on; i) scaling up proven direct nutrition interventions through the health

sector, ii) institutionalization through better data gathering, analysis and planning iii) Community nutrition interventions to raise demand and uptake of nutrition services and appropriate nutrition practices and behaviors.

The determinants of stunting in Liberia are wide ranging but include the following; poor child care and feeding practices (leading to inadequate food intake), poor maternal nutrition especially among adolescent (LISGIS et al., 2014) mothers (leading to fetal growth retardation and low birth weight); and preventable diseases including malaria, diarrhoea and pneumonia. For instance, only 51 per cent of infants aged 0-5 months are exclusively breastfed and the diets of only 11 per cent of children aged 6-23 months meet the recommended minimum acceptable diets (Ministry of Agriculture, 2018). These factors are compounded by the weak implementation of the policies, legislation and guidelines.

An estimated 18 percent of Liberians are food insecure and 2 percent are severely food insecure (Liberia Food Security Cluster, 2015). This means that households end up consuming foods that are inadequate in quantity and quality. Children are more sensitive to short-term food shortages and this pushes them into malnutrition.

Malnutrition rates vary by area of residence; by county, Grand Bassa has the highest prevalence of stunting (41 percent) and underweight (16.3 percent), and Greater Montserrado has the highest prevalence of wasting (6.3 percent). The prevalence of stunting, wasting, and underweight is inversely correlated with wealth quintile. Children in the highest wealth quintile are less likely to suffer from malnutrition than those in lower wealth quintiles. The prevalence of overweight children varies little by background characteristics.

2. Policy Development Process

In revising the NNP, consultations were held with key stakeholders and technical experts at national level especially members of the Technical Working Group. Reference was made to the Pro-Poor Agenda for Prosperity and Development (PAPD) to ensure alignment with government priorities for the coming period. During the implementation of this policy, the GoL will make adjustments as needed to align with the evolving context and policy environment. However, the overall thrust of the NNP is expected to remain the same, given its focus on meeting basic needs and improving nutrition outcomes among the population.

3. Policy Foundations

The Liberia National Nutrition Policy is founded on the following mission, vision, goal, objectives and guiding principles.

3.1 Mission

To scale up the coverage, accessibility and utilization by individuals and communities of nutrition specific and sensitive interventions that prevent stunting and other manifestation of malnutrition.

3.2 Vision

To achieve optimal nutritional status for all Liberians through the implementation of both nutrition specific and sensitive interventions across sectors.

3.3 Goal

Accelerate stunting reduction interventions/initiatives with an aim to achieve a stunting prevalence of 22 percent by 2023.

3.4 Objectives

This policy is geared towards achieving the following objectives:

1. To ensure improved access to and utilization of a comprehensive package of proven Direct Nutrition Interventions (DNI) and nutrition specific interventions.
2. To shape positively the enabling environment essential for the attainment of positive nutrition outcomes (nutrition policies, guidelines, laws and legislations, influence policies of other sectors to have a nutrition lens).
3. To improve awareness and practices of positive nutrition behaviors essential for the attainment of optimal nutrition status (demand creation).
4. To strengthen the coordination, monitoring and evaluation of multi-sectoral nutrition interventions.

4. Guiding Principles

The National Nutrition Policy is guided by the following principles:

4.1. Nutrition as a Universal Human Right

Article 6 of the Convention on the Rights of the Child (CRC) states that "children have the right to live and governments should ensure that children survive and develop healthily". The Convention places a high value on the children's right to survival and states that children have the right to good quality health care, to safe drinking water, nutritious food, a clean and safe environment, and information to help them stay healthy (United Nations General Assembly, 1989). As a signatory to the universal human rights laws, the Government of Liberia acknowledges the moral and legal imperative for the right to food, centered on human dignity, needs, and interests. The government recognizes the role of nutrition as a precondition for sustainable social, economic and human development and is committed to invest adequate resources, capacity and political capital to promote and protect the right to nutrition.

4.2 Political Will and Awareness of the Importance of Nutrition at all Levels

Firm political commitment to address the problem of malnutrition as a development priority is contingent on the recognition of the role of nutrition in human development and poverty reduction. The lack of awareness of nutrition issues among the major economic and social policy decision makers has hampered the progress of improving nutrition at all levels in Liberia. The nutrition policy will seek to raise the awareness of policy and decision makers at all levels, on the importance of nutrition as central to development. Public awareness of nutrition issues is also low, thus generating little demand for improved nutrition-related services as well as safe and high quality foods.

4.3 Adequate Financial Resources

To achieve the objective of nutrition well-being, it is essential that adequate financial resources be provided for the effective implementation of programs. the Government will put in budgetary allotment focus on nutrition specific interventions that achieve maximum nutrition outcome at minimal cost. This will include interventions that are not only affordable but also manageable within the context of a constrained fiscal space and institutional framework. The MoH will increase awareness and sensitization on nutrition program and scale up 10 direct nutrition interventions across the life cycle. In the interim, the Ministry will identify and implement quick wins for nutrition such as taking up warehousing of nutrition supplies, inclusion of nutrition supplies in the essential medical list among others.

4.4 Coordination

Multi sectoral approaches to nutrition: The determinants of malnutrition cut across different sectors, which calls for the implementation of multi sectoral approaches to nutrition if meaningful shifts in stunting reduction are to be achieved. Nutrition-sensitive interventions and programs address key underlying determinants of nutrition such as poverty, food insecurity, WASH services and scarcity of care resources. The implementation of nutrition sensitive interventions at scale can therefore help enhance the effectiveness, coverage, and scale of nutrition-specific interventions.

The government remains committed to ensuring effective coordination across sectors through regular meetings of the national nutrition committee and the Scaling Up Nutrition (SUN) movement multi-stakeholder platform. County level coordination mechanisms and forums shall be supported to ensure synergy and program implementation at sub national level. In emergency contexts, the global nutrition cluster approach will be adopted to improve coordination among relevant stakeholders and actors.

4.5 Decentralization

The Government of Liberia has adopted a policy of decentralization within the public service structure as a means of increasing efficiency in public service provision in response to local needs and de-concentrating management responsibilities at the central level. The implementation of the policy will draw on frameworks that government is putting in place for consultation, prioritization, and planning at district and county levels and will see county authorities equipped to assume responsibility for delivery of nutrition services, with the central level focusing on policy development, resource mobilization and allocation, planning, setting of standards and regulations.

4.6. Community Participation and Involvement

A people-focused approach for nutrition improvement acknowledges the fact that people's knowledge, practice and opinions are important driving forces for social change. Community participation is a prerequisite for addressing the immediate and underlying causes of malnutrition. Community engagement will be guided by the government framework, multi-sectoral policies and approaches with relevant community stakeholders. Special effort will be made to ensure the participation of all people, particularly the poor and marginalized, in all stages of planning and implementation of community-based interventions in order

to foster ownership and empowerment. Community actors will also be engaged in the identification and response to perceived community needs for improved nutrition and long-term sustainability.

4.7 Prioritize the most Nutritionally Vulnerable

In Liberia, infants, children under five years, school age children, adolescents as well as pregnant and lactating women are among the most nutritionally vulnerable. Other groups that are at risk include the elderly and people living with HIV/AIDS, TB and victims of disasters and emergencies. Priority will be given to protecting and promoting nutritional well-being of these vulnerable groups. Within the country, malnutrition varies little by geography and therefore focus will be on supporting the entire country to improve prevailing malnutrition rates. This will call for holistic programming to address undernutrition across counties within the framework of other development policies and programs.

4.8 Focus on Women

The role of women in Liberia as food providers and caregivers gives them a fundamental control over health and nutritional well-being at the household level. As individuals, and in accordance with Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women, to which Liberia is signatory, women are also entitled to adequate nutrition. Optimal maternal nutrition is important, firstly to ensure good pregnancy outcomes considering stunting starts intrauterine, and secondly to break the intergenerational cycle of malnutrition. Special attention will therefore be given to women of child bearing age to allow for equitable access to high impact nutrition interventions, education, economic opportunities, and increased access to reproductive health services.

4.9 Focus on Nutrition of School Age Children and Adolescents

The importance of adolescence nutrition cannot be over emphasized. Adolescents are the future parents hence good nutrition is essential to avoid the intergenerational cycle of malnutrition. Despite the critical nutrition needs for adolescents, there are no nutrition programs targeting this age group in Liberia. Facility based delivery of nutrition services is not effective in reaching adolescents hence need for new approaches at school and community level specifically targeting them. There is need to develop package for nutrition services for adolescents and to ensure its implementation at appropriate contact points. The consequences of malnutrition among school age children and its impact on future nutrition and health outcomes is well documented. Children spend more time in school than they do at home. Schools can provide an important opportunity for prevention as they provide the most effective way of reaching large number of people including youth, school administration, families and community members.

4.10 Adequate and Skilled Human Resources

Adequate and qualified human resources are necessary to plan, manage and evaluate appropriate activities, as well as provide services. Liberia lacks a critical mass of skilled personnel in relevant disciplines, particularly, food and nutrition specialists. Nutrition is new for the majority of health workers in Liberia, hence, the capacity of health workers around nutrition is limited.

A productive and motivated healthcare workforce that is fit-for-purpose will be a government priority under this policy. A long-term capacity development plan coherent with sectoral human resource policies that involves both pre-service and in-service approaches to strengthen the capacity of health care providers will be adopted. Curriculum for health training institutions shall be revised or updated to include the latest development in nutrition to ensure that graduates possess solid skills and competencies to enable them deliver quality nutrition services. Appropriate Nutrition education shall also be included in the primary, junior, senior high schools and university curriculum.

4.11. Evidence-based Planning

Choosing appropriate options that are locally appropriate and effective is critical to meeting nutritional objectives. An evidence-based approach to planning will be adopted that involves the use of the best available up-to-date evidence/data to guide informed decision making to develop and implement effective, nutrition programs and policies. This approach requires the integration of nutrition indicators into health and other sectoral information systems (e.g. DHIS2). The regular collection and reporting of nutrition indicators through existing information systems will support nutrition programming by:

a) Ensuring evidence-based decision making
b) Enabling the tracking of progress in the implementation of nutrition services
c) Informing timely course correction
d) Instilling accountability among duty bearers to provide nutrition service.

Additionally, being attentive to the most recent developments in the nutrition field, supported by locally generated research, evaluation and epidemiological information is essential to ensure that the most effective nutrition approaches and interventions are implemented. Information will be pursued in a pragmatic way making maximum use of global recommendations and contextually adaptable information.

5. Policy Orientation

The NNP was originally developed in October 2008 alongside the National Health Policy and Plan 2007-2011. Overall, the policy has provided the thrust and focus in nutrition since then and its revision has been deemed necessary to ensure its relevance and responsiveness to current contexts. Lessons learned and experiences during the implementation of the policy have informed the revision of the policy. In addition, new developments and evidence in nutrition have since come up and the national context has evolved since then. Consequently, the 2019 version of the NNP has considered the aforementioned developments and considerations.

6. Policy Priority Areas

The National Nutrition Policy covers the following priority areas:

6.1 Mainstreaming Nutrition into the Public Health Sector (Nutrition Service Delivery)

Scale up the coverage of DNIs to 90 percent by 2023 through mainstreaming of nutrition service delivery into the public health sector.

Objectives:

a) To improve the coverage of Infant and Young Child Feeding Interventions (promotion of adolescent and preconception nutrition, promotion of optimum breastfeeding, promotion of appropriate complementary feeding).

b) To improve the coverage of micronutrient prevention interventions (Iron Folic Acid supplementation for pregnant mothers, support for food fortification (salt iodization and fortification of staple foods), multiple micronutrient powder (MNP) supplementation for children aged 6-23 months, Vitamin A supplementation, De-worming of children aged 12-59 months).

c) To increase the coverage of acute malnutrition treatment and management through community outreach.

d) To strengthen institutional capacities essential for the provision of quality nutrition services.

Strategies:

a) Develop the capacity of health care providers to have the skills and competencies required for the provision of quality nutrition services.

b) Integrate cross-sectoral linkages to ensure that DNIs are provided routinely within the public health care system and mainstreamed in other sectors.

c) Adopt community health initiatives to roll out nutrition services at the community level.

d) Demand creation for nutrition services in order to increase awareness regarding the availability and the importance of these services.

e) To adopt, develop, enforce standards and regulations that enhance nutrition in Liberia.

6.2 Scaling Up Nutrition Sensitive Interventions

Ensure nutrition sensitive interventions implementation through an integrated nutrition targets, goals and actions across the sector of the SUN platform.

Objectives:

a) To enhance the nutrition-sensitivity of programs by improving targeting; using conditions and integrating strong nutrition goals and actions (social safety nets, education, agriculture, WASH, etc).

b) To integrate nutrition indicators into sector information systems to ensure tracking or progress and evidence-based decision-making.

c) To reach adolescent girls with pre-conception nutrition interventions through schools and home/community-based platforms.

d) To reach school going children with DNIs at schools.

Strategies:

a) Deploy community-based delivery platforms since they have evidence for scaling up the coverage of nutrition interventions in hard to reach populations through demand creation and household service delivery.

b) Create diverse platforms to improve awareness on and uptake of positive nutrition behaviors and interventions.

c) Integrate nutrition goals and actions into nutrition sensitive programs at planning and design stages.

d) Strengthen information systems to ensure the integration, tracking of progress, analysis and the use of the information for decision-making.

e) Focus on equity, nutrition needs for school going children, adolescents and improving women's physical and mental health, nutrition, time allocation and empowerment.

f) Emphasize on reaching adolescent girls during preconception through school-linked conditions and interventions or home-based platforms.

g) Develop a national strategy on stunting reduction.

6.3 Nutrition Governance

Strengthen the enabling environment to improve the nutritional outcomes through the identification and closure of gaps in policies, laws and legislation.

Objectives:

a) To incorporate clear nutrition goals into national development plans, sectoral policies/plans, programs and projects.

b) To increase awareness of policy makers on the importance of nutrition for sustainable development and poverty reduction.

Strategies:

a) Advocate to improve awareness among decision makers on the role of nutrition in national development and how sectors can work together to achieve desirable change.

b) Advocate for gradual increase of financial allocations for nutrition by the government.

c) Conduct capacity building to strengthen technical capacity for nutrition program implementation, policy analysis, development and monitoring of their implementation at all levels.

d) Integrate nutrition goals into national development plans, sectoral policies/plans, programs and projects.

e) Enshrine policy implementation and monitoring at all levels.

f) Evidence generation, policy dialogue and advocacy, knowledge management.

6.4 Improving Household Food Security

Enhance investments in agricultural production to achieve household food security.

Objectives:

a) To ensure adequate agricultural production, stable and sufficient supply and utilization of a diversity of safe foods of high nutritional value.

b) To ensure accessibility and affordability of diverse/nutritious food nationwide.

Strategies:

a) Enhance access to agriculture inputs, incentives, credit, markets, factors of production and other essential services to enhance agricultural production.

b) Adopt appropriate technologies for the production, processing and handling of agricultural products.

c) Advocate for strategies to maintain predictable and stable food imports including cost reduction measures and establishment of strategic food reserve mechanisms.

d) Establish and promote joint public-private sector partnership initiatives for improved handling and storage, food processing, preservation and value-added marketing.

6.5 Consumer Protection through Food Safety, Standards and Quality Control

Safeguard consumers' protection through the enhancement, awareness, adoption and enforcement of food safety standards and quality control.

Objectives:

a) To raise awareness on consumer rights as well as on the dangers of unsafe and sub-standard quality food.

b) To formulate, adopt, monitor and enforce food quality and safety standards.

Strategies:

a) Sensitize and inform the public and key decision makers on the importance of food quality and safety.

b) Review, update and/or formulate legislation, guidelines, standards and codes of practice on food quality and safety.

c) Strengthen institutional capacity to ensure the monitoring and enforcement of food, sanitary and phytosanitary standards.

d) Consumer education, protection and put in place systems for consumers to express grievances and make suggestions for improvements in food safety.

6.6 Promoting Appropriate Diets and Lifestyles

Minimize the extent and magnitude of chronic diet related non-communicable diseases through the promotion of appropriate diets and lifestyles.

Objectives:

a) To contribute to the prevention of diet-related non-communicable diseases.

b) To contribute to good health and quality of life of individuals with diet-related non-communicable diseases.

Strategies:

a) Create awareness on appropriate dietary practices and lifestyles essential for the prevention of NCDs particularly targeting groups most at risk.

b) Incorporate information on food safety, food preparation and healthy diet and lifestyles into the curricula of school children, and for the training of health professionals and agriculture extension workers.

c) Build the capacity of health workers and other relevant individuals on the prevention of NCDs.

d) Encourage the formation of pressure groups such as anti-smoking, anti-drug and anti-alcohol abuse groups, to enhance capacity to combat the problems.

e) Advocate for the development of guidelines on management of NCDs and the establishment of fitness and recreational facilities targeting children and high-risk groups throughout the country.

6.7 Nutrition Information Systems

Preserve a functional nutrition information system that enables the measurement of changes in nutritional status, helps track progress and supports evidence-based decision making.

Objectives:

a) To measure the trends/evolution of nutrition status of the vulnerable segments of the population to inform programing.

b) To enable the tracking of progress towards targets that informs timely course correction.

c) To generate information that will inform evidence decision making and prioritization of program actions.

Strategies:

a) Integrate and assimilate standard nutrition indicators into sectoral information systems with a priority for HMIS.

b) Systematize regular review and bottleneck analysis to ensure the utilization of data for decision-making. Capacity building of health care providers and staff of relevant government sectors on the collection, analysis and utilization of nutrition information.

c) Strengthen existing systems and capacity to collect, analyze, report and monitor nutrition situations.

6.8 Social Behavior Change Communication for Nutrition

Improve and promote the adoption of positive attitudes and behaviors for improved nutrition for health and sustainable development.

Objectives:

a) To develop a social behavior change communication strategy.

b) To improve awareness of and uptake of positive nutrition behaviors and interventions.

Strategies:

a) Develop a social behavior change communication strategy to increase knowledge and promote positive nutrition behaviors.

b) Model community-based communication initiatives such as the engagement of Community Health Assistants (CHAs) to raise awareness and support caregivers at household level.

c) Develop and standardize nutrition messages and communication materials.
d) Engage nutrition champions (influential personalities) in awareness-raising initiatives to influence populations.
e) Partner with mass media in disseminating nutrition messages.
f) Develop the capacity of community and facility-based service providers on essential skills and competencies in nutrition counseling.
g) Engage in dialogue with local communities to improve nutrition.

6.9 Nutrition for School Age Children and Adolescents

Develop and deliver programs focusing on improving the nutrition status of school going children and adolescents at school and community levels.

Objectives:

a) To develop packages of nutrition services for school going children and adolescents.
b) To support the implementation of nutrition programs for school going children and adolescents.

Strategies:

a) Develop a package of nutrition interventions and operational guidelines appropriate for children and adolescents.
b) Adopt community and school based platforms for the delivery of nutrition services for school age children and adolescents.
c) Integrate nutrition into school curriculum.

6.10 Emergency Preparedness and Response

Improve resilience to all forms of hazards, emergency response capability and migrate to climate change-sensitive development processes.

Objectives:

a) To ensure adequate emergency preparedness actions are in place to reduce delays in
b) response times and in effect adverse impacts of an emergency.
c) To ensure adequate capacities within government and stakeholders on emergency preparedness and response.

Strategies:

a) Solidify systems of relevant government institutions to ensure emergency preparedness and response.
b) Establish contingency planning and prepositioning of emergency supplies.
c) Strengthen health and nutrition surveillance, emergency preparedness and response to effectively detect and respond to public health threats.
d) Improve Disaster Risk Reduction, by strengthening disaster Management Committees at national, county, district and clan levels (decentralizing).
e) Enhance an effective and functional institutional system for Disaster Risk Management, enhance risk identification mechanisms; preparedness, emergency

response and recovery; improve information and knowledge management and vulnerability factors.

f) Strengthen community preparedness, response, and recovery for natural and man-made disasters/outbreaks through national emergency response and recovery strategy.

6.11. Partnerships and Coordination for Nutrition

Establish a functional multi-sectoral coordination mechanism for nutrition at the national and sub-national levels.

Objectives:

a) To strengthen partnerships and coordination to enhance the impact of programing for nutrition.

b) To ensure a unity of purpose by all nutrition stakeholders through a common vision and set of priorities.

c) To improve service delivery and optimum use of available human and financial resources.

d) To facilitate information sharing.

e) To enable periodic review and re-planning based on monitoring and evaluation results.

f) To enable appropriate and timely attention to emerging nutrition issues, such as non-communicable diseases and food safety issues.

Strategies:

a) Develop clear terms of reference and separation of duties for the different coordination mechanisms.

b) Earmark regular and fixed meeting dates in advance.

c) Assign the SUN focal persons at an appropriate level/office within government with convening powers.

6.12 Improve Nutrition Outcomes of Poor Children and Adolescents through Social Services

Develop and implement a social cash transfer program focusing on improving the nutrition status of children and adolescents at the community level.

Objectives:

a) To develop packages of social cash transfer services for vulnerable children and adolescents.

b) To support the implementation of cash transfer programs for vulnerable children and adolescents.

Strategies:

a) Develop a package of nutrition cash transfer interventions and appropriate operational guidelines for vulnerable children and adolescents.

b) Implement community-based platforms for the delivery of nutrition cash transfer services for vulnerable children and adolescents.

c) Integrate cash transfer programs to provide income support to vulnerable groups to improve health and nutrition of children in targeted households.

7. Roles and Responsibilities

The core sector responsible for the provision of nutrition related services to address the immediate causes of malnutrition is the Ministry of Health. The section responsible for the health sector nutrition program is the Nutrition Division at the Ministry of Health. The Nutrition Division will liaise with relevant stakeholder /line ministries to implement nutrition activities in the county.

7.1 Organization and Functions

Nutrition programs will be organized and integrated with other services provided at the three levels of the health service delivery system- central, county and community levels.

7.1.1 The MoH Nutrition Division

The central level shall coordinate and regulate all nutrition activities in the health sector. Its functions shall include:

a) Conduct analysis of the nutrition situation in country including epidemiological data, program activities, requirements for human resources development and research in consultation with Health Management Evaluation Research Unit (HMER).

b) Advocate for nutrition and nutrition related programs at all levels.

c) Assume leadership and coordination of nutrition activities within the health sector.

d) Conception and formulation of nutrition policies and plans of action, protocols and guidelines within the health sector along with the Policy and Planning Department.

e) Conception, formulation and integration of nutrition goals and objectives within development policies and plans across relevant sectors.

f) Integration of the Direct Nutrition Interventions into the public health services including timely availability of materials and supplies.

g) Roll out and support National Nutrition Information within the HMIS (surveillance, tracking of implementation and evaluation).

h) Prevention and control of diet-related non-communicable diseases.

i) Conduct capacity building to ensure that service providers attain the relevant skills and competencies to enable them provide nutrition services that meet norms and standards promulgated from time to time.

j) Conduct operations research to test innovative approaches for improving effectiveness and efficiency of nutrition programs and interventions.

k) Regular monitoring and evaluation of nutrition programs and interventions.

l) Advocate for the introduction of nutrition courses in pre-service curriculum.

m) Advocate for capacity building including correspondent related courses.

7.1.2 County Nutrition Supervisor

The County Nutrition Supervisor shall coordinate and regulate all nutrition activities in the county. The County Nutrition Supervisor functions shall include:

a) Develop county level plans of action for nutrition, based on the national nutrition policy and action plan.
b) Facilitate the integration of nutrition services into public health and other sectors at county level.
c) Facilitate information gathering for nutrition data analysis and ensure utilization for decision making at county and community level.
d) Support capacity building of service providers at county, district and community levels.
e) Ensure inter-sectoral action and collaboration in nutrition at the county level.
f) Monitor and supervise county and district level community-based nutrition related activities.

7.1.3 District Nutrition Supervisor

The District Nutrition Supervisor shall coordinate and regulate all nutrition activities in the district. The District Nutrition Supervisor functions shall include:

a) Develop district level plans of action for nutrition that will align with county level plan of action for nutrition intervention.
b) Facilitate the integration and collaboration of nutrition services into public health and other sectors at district level.
c) Facilitate information gathering for nutrition and ensure data verification at district level.
d) Support capacity building of service providers at district and community level.
e) Monitor and supervise district level and community-based nutrition related activities in collaboration with Community Health Services Supervisor.

7.1.4 Community Health Assistant

As per the National Community Health Policy, Community Health Assistant and other community health cadres shall perform the following functions in the community related to nutrition interventions:

a) Participate in needs assessment and planning for community-based nutrition interventions.
b) Conduct routine community- based nutrition screening (MUAC and Edema) and referral of severely malnourished children.
c) Support implementation of community-based communication activities and interventions to address nutritional problems.
d) Support community- based delivery of select DNIs such as Vitamin A supplementation, deworming during campaigns and micro nutrient powder distribution routinely.
e) Recording and reporting of nutrition interventions provided at community level.

7.2 Nutrition Directorate

The minimum of trained personnel required to run the nutrition program shall be as follows:

7.2.1 Central Level:

a) Nutrition Director
b) Assistant Nutrition Director
c) Integrated Management of Acute Malnutrition (IMAM) Coordinator
d) Assistant IMAM Coordinator
e) Infant and Young Child Feeding (IYCF) Coordinator
f) Assistant IYCF Coordinator
g) Micronutrient Coordinator
h) Data Manager
i) Administrative Finance Officer
j) Research and Surveillance
k) Logistician
l) Driver

7.2.2 County Level:

County Nutrition Supervisor (CNS)

There is need to have a minimum one CNS assigned to support nutrition programming on full time basis if marked progress is to be expected. Having dedicated nutrition personnel at sub national level through partners has been shown to accelerate progress in nutrition service delivery in Liberia. Programmatic data has shown that counties where NGOs have deployed dedicated human resource for nutrition have performed better than those without.

7.2.3 District Level:

District Nutrition Supervisor (DNS)

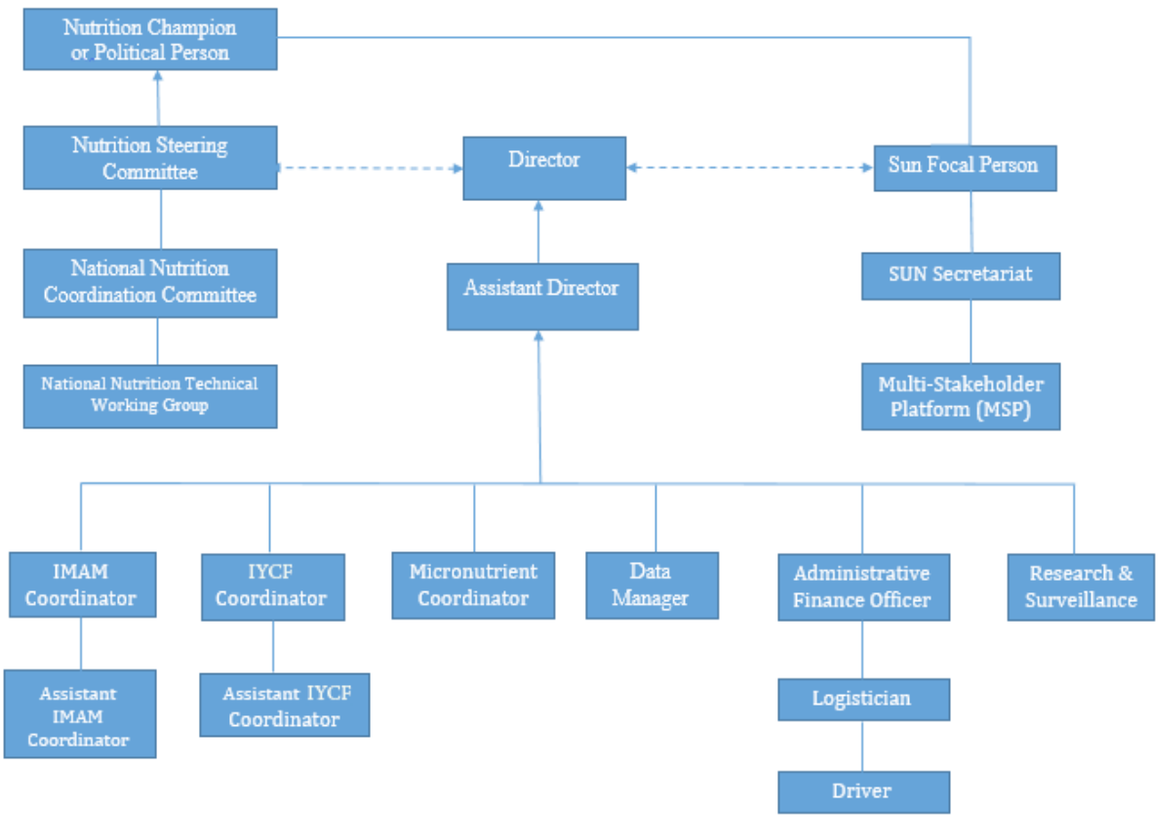
There is need to have the DNS assigned to support nutrition program on a full time basis if noticeable progress is to be expected.

7.2.4 Community Level:

Community Health Assistants (CHAs)

Community Health Assistants and other community health cadres will be the front-line nutrition service providers at the community level. The CHAs and other community health cadres will be expected to provide a select number of nutrition services as identified in their terms of reference.

7.3 Nutrition Division Organogram



8. Implementation Arrangement, Monitoring and Evaluation

Timely, relevant and accurate nutrition information is essential for the development, implementation, monitoring and evaluation of effective policies and programs to improve nutrition and to provide early warning of impending nutritional emergencies and for ongoing program management.

A simple but efficient nutrition surveillance system for generating timely and relevant information for program planning and decision-making shall be developed with appropriate mechanisms for flow of information from community to central levels. Comprehensive nutrition surveys will be conducted as required. For more efficient use of resources, a multi-sectoral coordinated approach to nutrition monitoring will be adopted.

A set of standard nutrition indicators will be developed to monitor progress of implementation of the actions plan developed based on this policy. These indicators are largely aligned to the national nutrition policy, PAPD, Sectoral M&E plans and the SDGs. The GoL will continue to engage in strategic partnerships with the development partners, donors and private sector to support the generation of high-quality, reliable evidence to report against the outcome indicators. Results will be monitored progressivley, giving priority to monitoring of activity implementation, removal of bottlenecks and progress towards period targets. The MoH will undertake regular reviews of the nutrition program and shall seek to strengthen the feedback mechanism to progressively improve program implementation.

The nutrition division will continue to work with National Nutrition Coordination Committee

and the Scaling Up Nutrition (SUN) movement at the central level and other coordination forums at the subnational level to undertake regular planning and review of the nutrition program. Both forums are led by the government and are geared towards better coordination and an enhanced enabling environment for nutrition programing.

The MoH will integrate nutrition indicators into the Health Management Information systems (HMIS), reporting formats and registers/ledger to enable the routine reporting of data. Capacity building shall be provided to health workers to enable them to collect data and report regularly. The availability of up to date data on nutrition will support policymaking and planning, promote a culture of informed decision-making, and buttress the monitoring of indicators at all administrative levels.

9. Policy Enabling Environment

9.1 Legal Framework

This policy shall be draw from and be guided by relevant global as well as national legal instruments and focus area. Globally, the policy is anchored and draws upon the following instruments, the Universal Declaration of Human Rights, Sustainable Development Goal II and the 1989 Convention of the Rights of the Child. Nationally, the NNP will be guided and aligns with the PAPD Liberia Rising 2030 (Vision 2030), the Zero Hunger Strategic Review, the National Food Security and Nutrition Strategy 2015, the Children's Law of 2011 and the Public Health Law of Liberia. In the event any of the provisions of the NNP are in conflict with any provision/s of any of the said national/global instruments, the provisions of the subject parent instrument will prevail.

9.2 Regulation

The nutrition division under the MoH, may promulgate regulations for the effective implementation of this policy, provided that such regulations shall not impair the spirit and intent of this policy and are in line with relevant legal instruments.

9.3 Enforcement

The Nutrition Division, in conjunction with the policy planning, monitoring and evaluation department, and the Office of General Counsel (OGC), shall monitor and enforce the provisions of this policy. The Ministry of Health will promote the monitoring and enforcement of this policy in line with existing national laws, regulations and other policies. Modalities shall be established to ensure compliance with existing Nutrition legislations, regulations, policies, standard operating procedures, protocols and guidelines.

10. Risks and Assumptions

10.1 Risks

a) A possible outbreak of a public health epidemic like Ebola that leads to overwhelming of the government systems

b) Natural disasters (drought, floods)

c) Political insecurity

d) Disease outbreaks
e) General inflation
f) Increased demand for social services especially in urban areas

10.2 Assumptions

a) That the policy shall serve as the main agenda and will provide the main thrust for nutrition programing in the country.
b) Government ownership and commitment for nutrition is sustained.
c) No major humanitarian situation that overwhelms the health sector and other relevant sectors.
d) The government deploys adequate numbers of health workers and service providers.
e) A favorable political environment prevails and that fiscal allocations for nutrition are made and honored.
f) The National Community Health Assistant Program is sustained to ensure that nutrition and health services are available and accessible to communities in remote areas.
g) Advocacy efforts towards strengthening the policy architecture is successful.
h) All stakeholders are committed and proactively collaborate to advance the nutrition agenda through the existing coordination mechanisms.

REFERENCES

Abeodu Bowen Jones, Petterson, D. R., & Holsoe, S. E. (2019). Introduction and Quick Facts: Republic of Liberia. In *Encyclopedia Britannica*. Retrieved from https://www.britannica.com/place/Liberia

African Union Commission, & WFP. (2013). *The Cost of Hunger in Ethiopia: Implications for the Growth and Transformation of Ethiopia: The Social and Economic Impact of Child Undernutrition in Ethiopia*. Addis Ababa, Ethiopia. Retrieved from https://reliefweb.int/sites/reliefweb.int/files/resources/FINAL Ethiopia - COHA Summary Report June 28.pdf

Black, R. E., Alderman, H., Bhutta, Z. A., Gillespie, S., Haddad, L., Horton, S., et al. (2013). Maternal and child nutrition: building momentum for impact. *The Lancet*, *382*(9890), 372–375. https://doi.org/10.1016/s0140-6736(13)60988-5

Government of Liberia. (2018). *Pro-Poor Agenda for Prosperity and Development (PAPD)* (Vol. 231). Monrovia. Retrieved from https://www.theperspective.org/2018/Revised_PAPD.pdf

Government of Liberia, LISGIS, & UNICEF. (2011). *Liberia National Micronutrient Survey, 2011*. Monrovia, Liberia.

Liberia Food Security Cluster. (2015). *Liberia Food Security Assessment (LFSA)*. Monrovia. Retrieved from https://reliefweb.int/sites/reliefweb.int/files/resources/Liberia Food Security Assessment- Draft Summarised Report of Pre-liminary findings.pdf

LISGIS. (2017). *Liberia Household Income and Expenditure Survey 2016*. Monrovia.

LISGIS, Ministry of Health and Social Services, National AIDS Control Program, & Macro International. (2008). Liberia Demographic and Health Survey, (LDHS), 2007. Monrovia, Liberia. Retrieved from https://dhsprogram.com/pubs/pdf/fr201/fr201.pdf

LISGIS, Ministry of Health and Social Welfare, National AIDS Control Program, & ICF International. (2014). *Liberia Demographic and Health Survey, (LDHS), 2013*. Monrovia. Retrieved from https://dhsprogram.com/pubs/pdf/FR291/FR291.pdf

Ministry of Agriculture. (2013). Liberia Comprehensive Food Secutiy and Nutrition Survey, 2013, (June).

Ministry of Agriculture. (2018). *Comprehensive Food Security and Nutrition Survey (CFSNS), 2018*. Monrovia.

Ministry of Education. (2016). *Liberia Education Statistics Report 2015-16*. Monrovia, Liberia.

Ministry of Health. (2012). *Liberia Water Supply, Sanitation and Hygiene: WASH Sector Investment Plan, 2012-2017*. Monrovia, Liberia.

Ministry of Health and Social Welfare and Health Systems 20/20 Project. (2011). *Liberia's Second-Round National health Accounts: Part 1: Institutional Health Spending 2009/10*. Bethesda, MD. Retrieved from www.healthsystems2020.org

Saxena, S., Lora, A., van Ommeren, M., Barrett, T., Morris, J., & Saraceno, B. (2014). WHO's

Assessment Instrument for Mental Health Systems: Collecting Essential Information for Policy and Service Delivery. *Psychiatric Services*, *58*(6), 816–821. https://doi.org/10.1176/ps.2007.58.6.816

UNDP. (2018). Human Development Reports: Human Development Index (1990-2017). Retrieved June 24, 2019, from http://hdr.undp.org/en/data

United Nations General Assembly. (1989). *Convention on the Rights of the Child, 20 November 1989*. *Annual review of population law* (Vol. 16). Retrieved from https://www.ohchr.org/documents/professionalinterest/crc.pdf

Water and Sanitation Program. (2012). *Economic Impacts of Poor Sanitation in Africa* (No. 1) (Vol. 68124). Retrieved from http://documents.worldbank.org/curated/en/420721468270024637/pdf/681240WSP0ESI000Box367907B00PUBLIC0.pdf

World Bank Group, & UNESCO Institute for Statistics. (2017). Sub Sahara Africa Net Primary School Enrollment Rate. Retrieved September 24, 2018, from https://data.worldbank.org/indicator/SE.PRM.NENR? locations= ZG-Z

THE POWER OF nutrition

unicef | for every child

Irish Aid
Rialtas na hÉireann
Government of Ireland

REACH
ACCELERATING THE SCALE-UP OF FOOD AND NUTRITION ACTIONS

Scaling Up NUTRITION
UN Network