

## UNICEF PNG Country Programme Strategy Notes - Nutrition

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**Nutrition Outcome:** By 2022, children under five, adolescent girls and women, adopt improved nutrition and care practices and increase utilization of nutrition-specific and nutrition sensitive services, especially in the most disadvantaged and marginalized communities.

## 1. Introduction

This strategy note, as part of development of UNICEF-PNG Country Programme 2018-2022, is a forward looking, evidence based and equity-focused document building on the CP 2012-2017. It aims to guide UNICEF PNG's support to nutrition for the next five years. During this period, UNICEF-PNG will primarily focus on building capacity of the most deprived provinces to improve both nutrition-specific and nutrition-sensitive interventions and programmes.

PNG is the only country in the Asia-Pacific region that achieved none of the targets of the MDGs. The country has one of the most complex and costly operating environments in the world, with a diverse geographic, social and cultural landscape, characterised by remote, isolated and hard-to-reach areas. PNG also has one of the worst nutrition situations globally– with the highest rate of stunting in East Asia and the Pacific region - a staggering 50% - and 4<sup>th</sup> highest in the world. A stunted child has lowered IQ, completes less schooling and earns less as an adult, leading to overall economic losses for the country – up to 11% of GDP.

The program advances the implementation of UNDAF outcomes for PNG in the area of Inclusive Human Development & Equitable Services<sup>1</sup>, which includes a specific indicator on stunting. It is aligned to national development priorities, particularly those expressed in the national multi-sectoral National Nutrition Policy 2016–2026, approved by the National Executive Council (NEC). UNICEF supported the development of the new Nutrition Policy, and the establishment of a multi-sectoral coordination mechanism for providing strategic guidance to and monitoring to of the implementation of nutrition programmes by the all concerned sectors. PNG also obtained membership of Scaling-Up Nutrition (SUN) global movement as the 57<sup>th</sup> member in April 2016.

<sup>1</sup> By 2022, people in PNG especially the most marginalized and vulnerable have enhanced and sustained utilization of quality and equitable basic social services, food security and social protection.

Through the current Country Programme, UNICEF-PNG supported the strengthening of national capacity to provide essential nutrition-specific services including for the management of severe acute malnutrition; promotion of infant and young child feeding, micro-nutrient supplementation and food fortification. Partnerships with churches, NGOs and civil society have expanded to take forward the delivery of nutrition-specific services, although much remains to be done to achieve a high level of coverage of nutrition services. The development of a costed multi-sectoral Strategic Action Plan (SAP) is in progress – to enable policies and resources to be leveraged from all concerned sectors for implementation of both nutrition-sensitive and nutrition-specific interventions. Responding to UNICEF's advocacy, for the first time, the government, allocated US\$1 million additional budget for nutrition in 2016 and further national funding is expected in 2017 and beyond.

This Strategy Note outlines the theory of change for the Nutrition Outcome, describing the expected changes in lives of Papua New Guineans – aimed at equitable reduction of malnutrition, including interventions for adolescent and maternal nutrition, Infant and Young Child Feeding (IYCF), micro-nutrient supplementation, food fortification including Universal Salt Iodization (USI) and treatment of acute malnutrition. The nutrition outcome is closely linked to progress in Health, water, sanitation and hygiene, Education, and Child Protection. The specific intervention areas that directly contribute to the nutrition outcome are access to healthcare, safe water and sanitation, promotion of hygiene, prevention of violence against children and early childhood development (ECD) interventions, in particular, early learning and early stimulation. The nutrition outcome is also strongly linked to other sectors such as agriculture and food security, livelihood and income generation, and social protection.

In PNG, the coverage of interventions that address the determinants of nutrition is very low. According to NDOH 2015 Report, only 39 percent infants were immunized against measles, and only 20 percent of children 6–59 months received two doses of vitamin A. The UN Joint Monitoring Programme Report 2015 estimated that only 40 percent of households had access to safe water and 19 percent to sanitation.

Access to healthcare by children, adolescent girls, pregnant and lactating women is critical for preventing and controlling chronic diseases and infections that affect child growth and development. The worse the water, sanitation and hygiene situation in a country, the higher are the chances of a child experiencing diarrhoea, pneumonia, worm infestation and damaged intestinal villi (environmental enteropathy), which can prevent absorption of nutrients leading to poor growth and development.

The nutrition outcome has both a direct and an indirect strong correlation with the cross-cutting issues of gender equality, communication for development, ECD, disabilities, disaster risk reduction (DRR), and humanitarian action.

Feeding and caring practices, specifically, related to food habit and feeding practices during pregnancy, pre-lacteal feeding of new-borns and maternal care, rest and recreation are significantly influenced by gender stereotypes and disparities. Studies have demonstrated that low intra-household bargaining power and decision-making of women affects child health and nutrition (Richards E, Theobald S, et al 2012), and this is particularly relevant to PNG.

Communication for development, addresses the knowledge, awareness and action of both the duty bearers and the rights holders towards improved feeding and caring practices, including the consumption of nutritious food at the minimum required frequency and quantity. Although women may have knowledge about nutrition, they may not be able to apply positive practices if traditional beliefs and customs, including those related to gender relations, are not changed.

The Strategy Note has been developed in consultation with government partners, civil society organizations and UNICEF regional and country technical teams. The proposed Nutrition outcome area was discussed at the 18 November consultation meeting hosted by the Department of National Planning and Monitoring and attended by all relevant line Ministries. UNICEF also examined its added value in the context of the UNDAF, to complement the work of other UN agencies towards SDG Goal No. 2, to end hunger and all forms of malnutrition by 2030. UNICEF will specifically contribute to SDG target 2.2, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons, in both development and humanitarian situations. Similar targets are included in PNG's Infant and Young Child Feeding (IYCF) Policy, 2014 and the multi-sectoral National Nutrition Policy 2016-2026 Objectives 3, 4 & 7.

To contribute to the reduction of these forms of malnutrition, it is intended to work in partnership with a wide range of National Departments and Ministries implementing nutrition-sensitive interventions, and with UN partners, including WHO, UNDP, FAO, UNAIDS, UNFPA, UN Women, IOM as well as I/NGOs, faith based organizations; civil society organizations, the academia and private sector. Associating these partners to a common result requires strategic coordination, outside the health sector.

## 2. Prioritized issues and areas

The following issues in Nutrition have been prioritised based on the situation analysis of children and women in PNG that highlighted the state of food and nutrition security and a prioritisation exercise using a “five filter” analysis.

**Child Malnutrition:** According to Health Income and Expenditure Survey (HIES) 2009/2010, almost half of the children under-five in PNG were detected as stunted (only 3 other countries in the world have a prevalence of this magnitude), 27 per cent were underweight and an unacceptably high 14.3 per cent were wasted. At the same time, 14 per cent of children under-five were found to be overweight, meaning there is an important double burden of malnutrition in PNG. It has the highest rates of all dimensions of child malnutrition in the region and is off-track on all the global nutrition targets. If untreated, Severe Acute Malnutrition (SAM) results in an increased risk of death of up to 12 times (Olofin et al 2013), compared to non-malnourished children, while 12 per cent of overall childhood mortality is attributable to wasting (Lancet 2013). PNG has one of the highest under-five mortality rate (U5MR) in the Pacific Region. The UN IGME estimated the under-five mortality of PNG at 57 per 1000 live births in 2015. According to 2015 administrative reports, 14 per cent of the children admitted in health facilities in PNG were due to severe acute malnutrition and 27 per cent of all registered children's deaths in 2015 were related to severe acute malnutrition.

**Poor Adolescent and Maternal Nutrition:** The poor nutritional status of adolescent girls, pregnant and lactating women affects the intrauterine developmental process. In PNG, the nutritional situation of adolescents is very poor due to traditional beliefs and practices, inadequate access to nutritional information and access to adolescent-friendly services. According to DHS 2006, adolescent girls (15-19 years) adolescent fertility rate stands at 65 births per 1,000 women of child bearing age, the 5th highest among the countries in the Pacific region (excluding Australia and New Zealand). The nutritional status of women is inextricably linked to the birth weight of their children and subsequently to child survival. Of all mothers, adolescent mothers are more likely to have preterm births. In PNG, 8 per cent of babies born each year have low birth weight (LBW), which has been linked to maternal under-nutrition and anaemia among other causes. Teenage pregnancy in PNG is estimated to be around 13 per cent, almost 16 per cent of women gave birth to their first child before reaching 18 years; 3.6 per cent of

adolescent girls have below normal body mass index (BMI), and almost 34 per cent of adolescent girls aged 15–19 years have anaemia (PNG DHS 2006).

The gender programmatic review of UNICEF conducted in May 2016 highlighted that gender norms and roles significantly affect the access to proper feeding, care and nutritional support by the adolescent girls and women. Women's status in the household and community is linked to the health and nutritional status of their children, including stunting. Pregnant women's diet and nutrition is not a priority at the household level in PNG, and they have minimal access to financial resources to invest in preventative measures that may reduce their burden and improve family health. While the lack of gender-sensitive arrangements in health facilities is a major barrier, male involvement in child feeding and care seeking is low in most provinces. Poor breastfeeding and complementary feeding practices are often associated with taboos, beliefs, food preparation methods, diversity of food available, timing of introduction of new food, quantities, qualities, and frequencies of feeding that can differ between ethnic groups.

There are widespread disparities in nutritional status of children and in accessing essential nutrition services by different socio-economic groups of people in PNG. As per NDOH 2015 report based on health facility data, child under-weight was 4.5 times higher in Milne Bay province (36%) compared to National Capital District (NCD) province (8%); and the low birth weight (LBW) was estimated at as high as 13% in Madang province compared to only 4% in Simbu province. Nutritional deficits for those in the poorest families are worse than the other quintiles. However, even among the richest quintile, stunting remains very high at 36%. There is little variation in prevalence of wasting.

**Poor Infant and Young Child Feeding (IYCF) practices:** There is limited information on infant and young child feeding in PNG, however, the Household Income and Expenditure Survey (HIES) 2010 determined that rates of exclusive breastfeeding for the first six months of life – one of the most important measures to ensuring infant and young child survival – was 36.6%, a reduction from the DHS 2006 reported figure of 56% of infants 0-5 months exclusively breastfed. The National Department of Health (NDOH) showed that 28.8% of mothers do not give colostrum to their babies, and more than half of the babies surveyed were introduced to solid food before 4 months of age; and that the complementary feeding is often not appropriate—as solid food is introduced to young infants too early (before 6 months) or too late (even after 9 months) and is given in inadequate frequencies and quantities. Families are also being influenced by the availability of infant formulas or breastmilk substitutes, which are being sold in shops freely. Infant and young child feeding practices are heavily influenced by cultural beliefs which dictate colostrum not to be fed as its "dirty pus from the body;" Many husbands/partners encourage women to stop breastfeeding as there are cultural taboos related to sex with breastfeeding women; violence against women is high and may affect lactation.

**Micronutrient Deficiencies:** The children and women of child-bearing age in PNG suffer from high rates of micronutrient deficiencies. In PNG, the Southern and Momase regions are the most affected with micronutrient deficiency. Highland Region is equally affected with Iodine deficiency. Although there is no recent data, the PNG National Nutrition Survey (NNS) 2005 estimated that the anaemia prevalence among children 6 to 59 months were 49 per cent and 27 per cent of them having Iron deficiency anaemia. The prevalence of anaemia among women of child bearing age (15–49 years) in PNG was estimated to be 35 per cent with 19.5 per cent of iron deficiency anaemia. Vitamin A deficiency with inflammation at 25.6 per cent among children 6 to 59 months remains a severe micronutrient problem affecting children's sight and general immune system. Iron fortification of food both commercial and in-home fortification (e.g. using multiple micronutrient powders) for infants and young children should be explored to reduce the prevalence of Iron deficiency anaemia. This should be accompanied by infection control interventions such as Water Sanitation and Hygiene (WASH) interventions, malaria control and deworming, among others.

Almost 30 per cent non-pregnant women have urine iodine less than the standard measure, indicating low iodine associated with severe mental retardation, low school performance and high school dropout (PNG NNS 2005). Although a Pure Food Standard amendment was made mandatory in 1995 that all salt imported into the country should be iodized with Potassium iodate and iodine content at 30 ppm and despite the PNG Food Sanitation Regulations 2007 which establish the iodine content of Table salt at not less than 30ppm, in the Southern Region, 23.9% salt was inadequately iodised.

**Nutrition in Emergencies (NiE):** The poor nutritional status of children in PNG in “normal” situation is already at critical thresholds as defined by WHO crisis classification, yet, the situation may worsen during emergencies. Papua New Guinea is located in the Pacific Ring of Fire, one of the most hazard-prone regions in the world. The most common natural hazards that affect the country are landslides, cyclones, earthquakes, tsunamis, floods and flash floods, tidal surges, drought, forest fires and volcanic eruptions. In 2015, Papua New Guinea was severely affected by heavy rains in March causing an estimated \$36 million in damages to infrastructure and agriculture, followed mid-2015, by drought and frost caused by the El Niño phenomenon. These events seriously disrupted food production and livelihoods and led to widespread food and water shortages. Government estimated that more than 2.7 million people in the country were affected by drought and over 700,000 people lived in areas where food production had been severely affected. Approximately 480,000 of these people faced critical food shortages. UNICEF PNG responded to the humanitarian situation with support from UN Central Emergency Response Fund (CERF). A total of 680 children 6–59 months (against a target of 530 children), received SAM treatment in 4 Local Level Governments (LLGs) under 3 districts of Enga and Hela provinces severely affected by El-Niño. A total of 18,467 children under-fives received IYCF and MNP supplement in the four LLGs of those two provinces.

**Nutrition Systems Building:** In Papua New Guinea, nutrition programming, especially through a multi-sectoral approach, is a new concept. Even though country is suffering from the double burden of malnutrition with very high rates of both under-nutrition and overweight, malnutrition is yet to be perceived a developmental concern by Government managers and policy makers. With UNICEF support, the government has developed the multi-sectoral national nutrition policy 2016–2026 recently approved by the National Economic Council (NEC). However, translating this policy into strategic operational plans incorporating essential nutrition actions is yet to begin.

UNICEF supported the conceptualization and establishment of a high-level interim inter-departmental coordination mechanism co-chaired by the Secretaries of the Department of Health (NDOH) and the Department of National Planning and Monitoring (DNPM). However, this mechanism is not yet able to provide policy and strategic guidance to concerned sectors to promote integrated programming for both nutrition-specific and nutrition-sensitive interventions. Nutrition is still perceived to be a health problem, and there is no separate budget line for nutrition in the government multi-year national development plan. There is no organization and management structure for nutrition in any of the concerned ministries and departments of the government. The situation is even worse at the provincial government level where there are no nutrition professionals. The country has no nutrition curriculum which could train the necessary human resources for nutrition management and service delivery.

### 3. Theory of Change for Programme Components

The Theory of Change (ToC) for Nutrition describes the expected changes in the lives of children in PNG at different levels of the hierarchy of results (impact, outcome, output) explaining the logical assumptions, risks and their mitigation measures to achieve the outcome (expected changes), which if achieved, would be significantly contributing to achieve the results at the impact level, which is the improved nutritional status of children and women in target areas with reduced rates of stunting, wasting, underweight and overweight. UNICEF PNG will focus on three key outputs specified below, which are the necessary

conditions to bring the desired changes, required during the country programme cycle to achieve the Nutrition outcome. These outputs specifically address the bottlenecks and the determinants related to the enabling environment, supply and demand.

**Impact:** At the impact level, the overall change expected is the **equitable reduction of child malnutrition**, which will contribute to the multi-sectoral National Nutrition Policy 2016–2026 goals, National Health Plan (NHP) 2011–2020 goals and the Sustainable Development Goals 2 (End hunger, achieve food security and improved nutrition and promote sustainable agriculture), 3 (Ensure health and well-being for all at all ages) and 10 (reduce inequality).

The theory of change is that:

- **if** children under five, adolescent girls and women of reproductive age equitably access and utilize evidence-based high-impact nutrition-sensitive and nutrition-specific interventions with adoption of feeding, caring and care-seeking practices, especially among disadvantaged and vulnerable populations in most deprived provinces/districts...

**Then** the nutritional status of children and women, especially the most marginalised and disadvantaged, would improve.

The government of PNG is committed to achieve SDGs 2, 3 and 10 as reflected with setting the food and nutrition security goals and targets in various development plans and sector-specific strategies, notably, the Vision 2050, National Health Plans 2011-2020, and multi-sectoral National Nutrition Policy 2016–2026. The relevant impact indicators and targets that the UNICEF Nutrition programme will contribute to addressing in pursuit of the progressive fulfilment of these national and international commitments are:

- Prevalence of child stunting (Baseline: 46 percent (2010) / Target: 42 percent (2022)
- Prevalence of child wasting (Baseline: 14 percent (2010); Target: 10 percent (2022)
- Prevalence of child underweight (Baseline: 13.8 percent (2010); Target: 10 percent (2022)

For the outcome level change to be achieved – there are several preconditions or intermediate outcomes that must be achieved. First, the **enabling environment** should be in place with relevant policies, strategies, mechanisms, plans and guidelines/protocols and allocation of funds to support the implementation of evidence-based high impact Nutrition-sensitive and Nutrition-specific interventions. Second, the necessary **supplies** of human resources, essential nutrients, equipment, and infrastructure through the provisions of nutrition systems building integrated into health systems strengthening support should be improved both at health facility and community level. Finally, the **demand** for quality nutrition services must be increased with improved knowledge, attitude and practices of appropriate timely adoption of key caring, feeding practices by the community and family.

**Following this logic**, the outcome level theory of change for nutrition states that:

- **if** multi-sectoral political commitment and approaches are in place to support prioritized and integrated package of both nutrition-sensitive and nutrition-specific interventions with an equity focus,
- **if** Departments of Health, Agriculture and Livestock, other implementing partners at national and sub-national level, including non-state actors, have increased capacity and accountability in evidence-based planning, budgeting and regulating the scaling up of high-impact nutrition-sensitive and nutrition-specific interventions and monitoring the results with equity, and
- **if** national systems of harmonized procurement, logistics and supply chain management are strengthened for delivery of equitable and quality essential nutrition services, and

- *if* government workers in nutrition related sectors (health, agriculture, and others) have increased capacity to deliver nutrition services according to standards at all times, and
- *if* national and sub national level institutions and front-line government and non-government workers have improved capacity to reach more vulnerable populations with quality nutrition services, and
- *if* Department of Health and other partners at national and sub-national level, including non-state actors, have improved capacity to integrate nutrition interventions in primary health care for children, adolescent girls and women with sustainable approaches at scale, and
- *if* caregivers, family members, communities and institutions have increased knowledge and skills to practice appropriate feeding, caring and care-seeking practices during critical periods of growth and development and to demand quality nutrition services, and
- *if* the government health sector plans, standards and legislation are evidence-based, adequately resourced, effectively implemented, enforced and monitored at national and sub-national levels...

**Then** children, adolescent girls and women would have improved feeding, care and care-seeking practices and increased utilization of nutrition-specific and nutrition sensitive services, especially in the most disadvantaged and marginalized communities.

In summary, The TOC Nutrition (Diagram 1) at output level explains

- 1) *if* appropriate policies and strategies on nutrition-sensitive and nutrition-specific interventions are in place and, the managers and front-line workers of concerned sectors (Health, Agriculture, and others) at all levels are fully equipped with required knowledge and skills to deliver them, and
- 2) *if* health facilities and systems are fully equipped with necessary nutrition supplies, human resources for nutrition including community nutrition workers, and
- 3) *if* mothers and caregivers are given timely information and knowledge...

**Then** the capacities of the duty bearers (nutrition managers and workers) on planning, budgeting, regulating, coordinating, delivering, monitoring and reporting the nutrition services would be sufficient to reach every child, specifically identifying and reaching the most vulnerable children, and ensure that service delivery mechanisms are inclusive, child-centred, gender-sensitive and risk-informed; as well as the knowledge and awareness of duty holders (mothers, caregivers, family and community members) to demand for quality services would improve.

The UNICEF nutrition programme will contain the following three outputs that would contribute to achieving the planned outcome.

**Output-1: National and provincial governments have improved capacity to formulate policy and strategy, plan, budget, manage and coordinate multi-sectoral nutrition-specific and nutrition-sensitive interventions for the most vulnerable and disadvantaged children, adolescents and women, including during emergencies.**

Rationale for focusing on this output: Integrated nutrition security services in Papua New Guinea are severely constrained by a poor enabling environment of inadequate policy frameworks for implementing integrated nutrition-sensitive and nutrition-specific interventions (multi-sectoral Nutrition Strategic Action Plan is in preparation now), poor understanding of nutrition (considered to be a health problem), absence of a functioning inter-sectoral coordination mechanism, inadequate real-time credible data, and lack of regulatory standards at all levels. There is no separate budget line for nutrition in provincial government plans nor in any of the concerned sectoral ministries budgets at national and sub-national level other than health. Declining trends of investment in health sector both from domestic resources and international

development affect implementation of nutrition-sensitive interventions by NDOH. The per capita public health expenditure is still low (3.6% of GDP in 2012) and overseas development assistance for health declined by 18 per cent from 2015 to 2016. Challenges remain in translating political commitment at national level into concrete plans and budgets at provincial level; in finding synergies and coordination among the various initiatives (both within the health sector, and between health and other sectors); in ensuring that evidence-based planning and real-time monitoring take place at all levels, with adequate attention to equity and age/sex disaggregated analysis of data.

Therefore, the theory of change for this output states that:

- **if** health managers at national, provincial and district levels can do the costing, budgeting and planning guided by the policy frameworks and standards for implementation and scale up of high impact nutrition-sensitive interventions, and
- **if** technical support is provided for capacity gap analysis, interventions planning and development of investment case at provincial government level for mobilizing and leveraging resources for integrated nutrition security services, and
- **if** evidence of good practices is generated and documented on prioritising, packaging and implementing integrated nutrition-sensitive and nutrition-specific interventions, and
- **if** the government at national and provincial level is supported to lead intra- and inter-departmental collaboration and coordination along with non-public partners, including in emergency preparedness and response, and
- **if** credible information management systems are developed and data is routinely analysed and used at national and sub-national levels to inform approaches and interventions at scale...

**Then** the Departments of Health, Agriculture and Livestock, Infrastructure (Water Supply & Sanitation) and other sectors at national and sub-national level, including non-state actors, would have increased capacity and accountability in evidence-based policy, planning and budgeting for implementation and scaling up of high-impact nutrition-sensitive and nutrition-specific interventions as well as monitoring results with equity.

UNICEF, will provide technical advice on planning, budgeting, monitoring and identification of capacity gaps; help to coordinate stakeholders; and leverage resources from other partners including civil society and private sector.

#### **Risks and assumptions:**

- The economic downturn that resulted in decreased national budget in 2016 remains a big risk to investment in nutrition;
- Some effort has already been made by the CO to advocate for nutrition, several sectors and other stakeholders have started to gain interest, however, the ongoing 2017 elections activities can result in shifting political priorities, thus, requires a stronger than usual advocacy to elevate nutrition as a new national priority;
- Technical capacity necessary for nutrition programming at all levels remains low (lack of institutional accountability, high vacancy rates and absenteeism, low motivation) and these pose risks for achievement of the outcome;

However, the CO assumes that:

- The inter-ministerial coordination for multi-sectoral interventions will greatly improve;
- That other UN agencies contribute to the UNDAF outputs including FAO for food security and livelihoods; WHO for issues related to overweight while UNICEF concentrates on underweight; and that, UNFPA addresses high fertility that threatens national planning efforts.



**Output-2: National and provincial health authorities have improved capacity and necessary supplies to ensure the delivery of nutrition-specific interventions, including severe acute malnutrition (SAM) management, infant and young child feeding, micronutrient supplementation and maternal nutrition services, to prevent excess morbidity and mortality among girls, boys and women, including during emergencies.**

Rationale for focusing on this output: Papua New Guinea is one of the few countries in the East Asia-Pacific region that suffers from very high rate of acute malnutrition. The country is prone to various natural disasters and is ranked 54th among the countries most exposed to multiple hazards according to the World Bank's natural disaster hotspot study. In 2016, PNG experienced several earthquakes, volcanic eruptions, severe flooding throughout many parts of the country, and drought and frost conditions as a result of a continuing El Niño weather pattern. During 2015 and 2016, the country faced severe drought brought on by the El-Niño event resulted in almost complete failure of staple food crops in the Highland regions. Natural disasters affect infrastructure, agriculture, health, nutrition, and community livelihoods that leads to widespread food and nutrition insecurity. Results from a screening programme in a hospital in Hela province in 2015 run by Médecins Sans Frontières (MSF) showed an average 46 per cent of children with moderate acute malnutrition (MAM) and 5 per cent with severe acute malnutrition (SAM) during the period of weeks 37-44 in 2015.

Therefore, the theory of change for this output states that:

- **if** technical support is provided to assess and build national and sub-national capacity for emergency preparedness and response for NiE intervention including the development of SOPs and guidelines on cluster coordination mechanism, and
  - **if** the NDOH is supported to develop guidelines, protocols and tools for facility- and community-based implementation of NiE interventions including SAM management services, and
  - **if** national and sub-national team (in UNICEF selected provinces) are equipped with knowledge, skills and resources to provide training to improve quality facility and community based nutrition care, in emergencies and non-emergency settings, and
  - **if** advocacy results in increased government financing for essential nutrients and commodities, and
  - **if** provincial and district health managers can identify and address bottlenecks to deliver nutrition interventions in hard-to-reach LLGs (Local Level Governments) of the most deprived provinces/districts, and
  - **if** there is strong accountability for quality facility and community-based nutrition care, through sustained supportive supervision and monitoring systems, and
  - **if** referral systems are established/ strengthened for emergency and non-emergency settings, and
  - **if** local level partnerships are strengthened and expanded to address gaps in delivering essential commodities and services to populations in hard to reach areas;
- then** national and sub-national health care providers and institutions have improved capacity and necessary supplies to ensure the delivery of nutrition-specific interventions, including severe acute malnutrition (SAM) management, infant and young child feeding, micronutrient supplementation and maternal nutrition services including during emergencies.

#### **Risks and assumptions:**

Major risks include:

- Many provinces have not included nutrition within their list of high priorities and resources are not yet allocated to support key nutrition interventions;
- Shortage of trained human resources, high turn-over of trained staff, poor status of equipment, huge delays in supply distribution and funds disbursements, a poorly structured health system and poor management capacity at district and provincial levels.

- Poor information flow is also a risk, exacerbated by low or delayed reporting rates, and poor quality routine data. It is assumed that, the national information system will improve, in all sectors, and at all levels of data collection and reporting.

**Output-3: Male and female caregivers and families, especially the most vulnerable and disadvantaged, have improved knowledge of appropriate feeding and caring practices for women, adolescent girls, infants and young children and to seek quality health and nutrition services, including in emergencies.**

Rationale for focusing on this output: Papua New Guinea is known to have unique socio-cultural settings, social and ethnic diversity, and deep-rooted cultural traditions considered to be the major obstacles to appropriate feeding, caring practices, and timely care-seeking. PNG hardly benefitted from the adoption and use of modern communication technologies including the Communication for Development (C4D) technologies and strategies. Remoteness and difficulties of access severely limit the opportunities of community members and target beneficiaries, especially children, adolescent girls and women, to access information and services on the importance of life-saving care-seeking behaviours and caring practices.

Therefore, the theory of change for this output states that:

- **if** technical support is provided to improve C4D strategies, coordination and interventions on nutrition, especially focused to marginalised communities, and
- **if** community participation and engagement for demand creation and for addressing various barriers to access/utilize nutrition services is fostered, and
- **if** evidence-based, innovative and gender-sensitive C4D interventions are supported, to empower mothers/caregivers to adopt appropriate feeding, child-care and care-seeking practices and fathers and other family members to support them and
- **if** evidence-based C4D interventions use multi-layer communication channels that address cultural, social and gender norms related to food and nutrition, and the feeding behaviours, and
- **if** the capacity of frontline workers and local level partners is strengthened to deliver appropriate messages through effective C4D approaches...

**Then** male and female mothers, family members, communities and institutions, particularly in selected most deprived provinces, would have increased knowledge and skills to practice appropriate feeding and caring for children and timely care-seeking from the health facilities and health workers during critical periods of growth and development, and to demand quality nutrition services, including in emergencies.

Capacity development at all levels (government, civil society and community) is a feature of UNICEF's work on C4D. Cross-sectoral linkages, particularly among Health-Nutrition-WASH, Nutrition-ECCE, and Nutrition-Child Protection will be ensured to support coherent and consistent messages to strategically targeted groups who can function as change agents. In hard to reach and vulnerable areas, where coverage is very low and there are gaps in outreach and community mobilization, UNICEF will work with local partners to support service delivery of C4D and social and behavioural changes. Innovative communication tools will also be explored to reach target audiences and monitor changes in knowledge and practices.

#### **Risks and assumptions:**

- Entrenched social norms and cultural practices in feeding, hygiene and care can pose risks for the realisation of this output;
- Behaviour change messages related to health and hygiene will be ineffective if water and sanitation access does not scale up in parallel.

However, it assumed that:

- Families, authorities and institutions are open to receive behavior change messages related to adolescent and maternal nutrition as well as IYCF and WASH practices;
- Minimum capacities are in place and functional and that central and local authorities can manage service delivery for nutrition outcomes and C4D;
- Partnerships, coalitions and movements for changing nutrition behaviors are formed and sustained.

### ***Strategic Approaches and Interventions:***

UNICEF PNG collaborates and coordinates with a wide range of national and international development partners to complement its support to the National and the Provincial Government Authorities to implement its programme in Nutrition. Through the Delivering as One initiative, the UN advocates with the Government to uphold its international commitments (embodied within Human-Rights Based conventions and the 2030 Development Agenda), which promote equitable and inclusive human development. This includes ensuring a comprehensive and dynamic set of global norms, policies and standards on human rights, gender equality and women's empowerment is in place. Other UN agencies equally contribute to the UNDAF outputs including FAO for food security and livelihoods; WHO addresses issues related to overweight while UNICEF concentrates on underweight; and UNFPA addresses high fertility that threatens national planning efforts. WFP does not have an office in PNG but did recently participate in emergency response activities.

UNICEF PNG will capitalise on its comparative advantages to provide high-level technical and advocacy support for policy formulation and leveraging resources; to develop counterpart and partners' capacity to improve service delivery, coverage, and quality of nutrition services; to generate community demand for quality services; to generate evidence to improve knowledge management and scale up innovations; to strengthen capacities in evidence-based planning and monitoring of results and quality, both at national and provincial levels.

The programme will apply the following implementation strategies to address key barriers and bottlenecks towards achieving the expected results:

- scaling-up risk-informed, area-based programming targeting the most disadvantaged children;
  - Programme convergence to deliver an integrated package of both nutrition-specific and nutrition-sensitive interventions through promoting multi-sectoral approach with critical sectors (Health, WASH, Education, Protection); and
  - Integration of cross-cutting strategies (Advocacy, C4D, M&E, Innovation and Knowledge Management and Disaster Risks Reduction- DRR).
- **Evidence Generation, Policy Dialogue and Advocacy:** Evidence generation will be enhanced by supporting assessments, surveys, and formative research such as Nutrition SMART survey, Demographic and Health Survey (DHS), assessment of community-based Integrated Management of Acute Malnutrition (IMAM), and formative studies and assessment on the operationalisation of a basic package of nutrition-specific and nutrition-sensitive interventions to generate new ideas, information and evidence to influence policies and programming. Formative research on social and gender norms, socio-cultural practices and spheres of influence on maternal and child nutrition and trials of improved practices will also be supported to inform more effective communication for development approaches. The programme will continue with policy dialogue and advocacy to promote the multi-sectoral approach to programming for nutrition as part of PNG's in-country roll-out of SUN movement.

- **Capacity Development:** Government-led capacity building initiatives will be supported, with special emphasis on strengthening longer-term institutional capacity to plan and implement programme through integrated, multi-sectoral approaches. Capacity building support will be expanded to develop implementation protocols and guidelines on IMAM, community-based nutrition care, and integrated Nutrition-WASH programme linkages. Equity-focused programming with particular focus to community-based skills-mix, project and financial planning and management, quality assurance, supervision and monitoring, mentoring and reporting aligned with Results Based Management (RBM) principles will be given special emphasis. Capacity building approaches will be reviewed to design and support effective approaches that would be effective in removing key bottlenecks identified through analysis at district and Local Government Level.
- **Partnerships:** The programme will further expand and strengthen partnerships with NGOs, FBOs, civil society organisations and the private sector. The programme will continue to expand and strengthen its collaborative efforts with UN system, donors, institutions/universities, women group, youth and students, and professional associations. Partnerships with NGOs and FBOs will be strengthened to introduce and scale-up the community-based nutrition interventions focused on early identification and referral of malnourished children for treatment, communication and social mobilisation on promoting infant and young child feeding practices and household level follow-up on the progress monitoring and reporting. Partnership with academic institutions and professional association will be maximised to promote and institutionalise longer-term capacity building on nutrition through the introduction of pre-service education and training.
- **Innovation:** The Nutrition programme will continue to support innovation, such as further expanding the use of Rapid-Pro platform and piloting new approaches to reach children and women with life-saving message on key feeding and caring practices. The programme will improve service delivery technologies and approaches, data and evidence-based programming, community-based platforms and avenues, and innovation of e-reporting and referral systems for management of severe acute malnutrition linked to integrated Community Case Management (iCCM) of common childhood illnesses.
- **Service Delivery:** UNICEF will continue to support the government and other implementing partners (NGOs, Churches) with selected supply, cash and services to facilitate the delivery of essential nutrition services. UNICEF's assistance will focus on the sustainable approach of service delivery capitalising the already established mechanisms of GoPNG and to explore new approaches to sustain the service delivery gains so far as well as to scale-up critical interventions for the children in the most disadvantaged and vulnerable communities. During the next country programme, UNICEF PNG will simultaneously focus on developing GoPNG's capacity towards a transition of government's ability to take full responsibility for service delivery, especially in terms of provision of Government budgets and in the areas of equity-focused programme planning, supply chain management, and supportive supervision and monitoring.
- **Integration and Cross-sectoral Linkages:** The Nutrition programme will strengthen strategic linkages with other components of the country programme towards achieving survival, growth and cognitive development goals. Strengthening linkages with WASH programme will contribute to reducing stunting and wasting through increased provision of safe water, sanitation, hand washing and hygiene practices. Linking with Health programme is critical for ensuring large scale, quality treatment of acute malnutrition, and the promotion of appropriate feeding, care-seeking, and nutritional management of tuberculosis, HIV and AIDS, and other chronic infections of children. Fully institutionalizing IYCF, micronutrient supplementation and maternal nutrition services in the health system also requires that

various aspects of the health system are strengthened overall, such as health worker availability and capacity, supply and information management, adequate budgets, etc. Linkages with the ECD will promote early stimulation while formal education programme will encourage school based nutrition education. It is also proposed to outsource specialists to deliver a standalone curriculum on nutrition that would contribute to strengthening human resources. Strategic linkages will also capitalize on advocacy initiatives raising the profile of nutrition to obtain increased Government and donor investment, and with C4D activities on social mobilization, community education and community-based nutrition services, feeding and caring practices.

- **South-South & Triangular Cooperation:** UNICEF PNG will support the NDOH to establish South-South cooperation to exchange of ideas, good practices and capacity building on community nutrition, including for longer-term nutrition capacity building through pre-service education on nutrition. Only six of 22 provinces have nutritionists that support public health nutrition interventions. Thus, to address the overwhelming gap in pre-service training in the country, tripartite cooperation between external Universities, PNG government and UNICEF, will be initiated, drawing on the opportunities available through the Scaling up Nutrition (SUN) movement.
- **Emergency preparedness, humanitarian action and humanitarian-development nexus:** Based on the experience of implementing El-Nino emergency responses with management of SAM integrated with IYCF, the programme will integrate Nutrition in Emergencies (NiE) responses in the next country programme. SAM management will be an important intervention package planned and delivered routinely thus building nutrition systems capacity to prepare, respond and report, both in humanitarian and non-humanitarian situations. WASH and Nutrition joint planning and implementation in emergencies will be pursued.

Diagram-1: Theory of Change (TOC) Nutrition



	<ul style="list-style-type: none"> <li>Technology and innovation - provision of gadgets</li> </ul>	
Dem and	<ul style="list-style-type: none"> <li>Behaviour change among mothers/care givers/families to accept and practice appropriate maternal and child feeding and caring behaviours; Behaviour change of the duty-bearers focused to front-line service-providers.</li> </ul>	

#### 4. Results Structure (Outputs and Outcomes, and the Associated Indicators) (1 page)

SDG Goals/Targets (SDG-2): End hunger, achieve food security and improved nutrition and promote sustainable agriculture

2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons

*indicators:*

2.2.1 Prevalence of stunting (height for age  $<-2$  standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age;

2.2.2 Prevalence of malnutrition (weight for height  $>+2$  or  $<-2$  standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight))

National Development Goals:

- **Policy Objective 1:** Strengthen nutrition governance, coordination, communication, partnerships and research to effectively plan, implement, monitor and evaluate nutrition activities across sectors
- **Policy Objective 2:** Improve nutrition capacity including pre-service training, cross sector in-service training, supportive supervision, work force development, career structures and operational resources
- **Policy Objective 3:** Implement interventions to prevent, control and treat under nutrition, including low birth weight, stunting, wasting and underweight.
- **Policy Objective 4:** Strengthen interventions to prevent and control micronutrient deficiencies including iron deficiency, vitamin A deficiency, iodine deficiency and other micronutrients.
- **Policy Objective 5:** Implement interventions to prevent and control over nutrition mainly overweight and obesity to reduce the risk of lifestyle related diseases
- **Policy Objective 6:** Strengthen interventions to prevent and control malnutrition among vulnerable groups people living with HIV, TB patients, those mental illness and disabilities, and institutionalized populations
- **Policy Objective 7:** Strengthen interventions that protect resilience and support recovery of households from the impact of nutrition emergencies and other vulnerabilities

UNDAF Outcome Area: By 2022, people in PNG especially the most marginalised and vulnerable, have enhanced & sustained utilization of quality and equitable services, food security & social protection

UNICEF's Outcome statement: By 2022, children under 5, adolescent girls and women, adopt improved nutrition and care practices and increase utilization of nutrition-specific and nutrition sensitive services, especially in the most disadvantaged and marginalized communities.

Outcome level indicators:

- 1) Proportion of infants aged 0-5 months who are exclusively breastfed [ B: 36 per cent (2010); T: 60 per cent (2022)]

2) No. of provincial hospitals providing SAM treatment of SPHERE standards [B: 0 (2016); T: 19 (2022)] 3) Proportion of children 6-59 months who received 2 doses of vitamin A (B: 22 per cent (2015); T: 70 per cent)		
<b>Output Statement #1 (EE):</b> National and provincial governments have improved capacity to formulate policy and strategy, plan, budget, manage and coordinate multi-sectoral nutrition-specific and nutrition-sensitive interventions for the most vulnerable and disadvantaged children, adolescents and women, including during emergencies.	<b>Output Statement #2 (supply):</b> National and provincial health authorities have improved capacity and necessary supplies to ensure the delivery of nutrition-specific interventions, including severe acute malnutrition (SAM) management, infant and young child feeding, micronutrient supplementation and maternal nutrition services, to prevent excess morbidity and mortality among girls, boys and women, including during emergencies	<b>Output Statement #3 (demand):</b> Male and female caregivers and families, especially the most vulnerable and disadvantaged, have improved knowledge of appropriate feeding and caring practices for women, adolescent girls, infants and young children and to seek quality health and nutrition services including in emergencies.
Output level indicators	Output level indicators	Output level indicators
Costed multi-sectoral national nutrition Strategic Action Plan (SAP) 2017–2021 endorsed by the government (B: 0; T: 1)	Emergency Preparedness Plan for nutrition developed and in place in selected provinces (B: 0; T: 6)	Adoption of the International Code on Marketing of Breastmilk substitutes as legislation by PNG, with a designated body carrying out going monitoring and translated to the population. (B:0 T:1)
Number of provinces with costed cross sectoral Nutrition Action plans (B: 0; T: 6)	Number and percentage of hospitals and health facilities in UNICEF focus provinces equipped with at least one trained staff and have supplies to implement nutrition specific services (SAM management, maternal nutrition, adolescent nutrition, micronutrient supplementation and IYCF counselling services. (B: 0/0; T: /80 per cent).	Country has an endorsed training curriculum on 'infant and young child feeding' that includes training on 'early childhood stimulation and development' for community workers/health service providers for outreach and disseminated. (B:0, T:1)
Number of provinces with budget allocation for nutrition (B: 0; T: 6).	UNICEF-targeted children in selected provinces aged 6-59 months with SAM in humanitarian situations admitted to SAM programmes and recover (B: X; T: 75 per cent)	Number and percent of LLGs in UNICEF selected provinces have at least one trained community health workers on promotion of adolescent, maternal nutrition and



		IYCF practices. (B: 0/0, T: /75 per cent).
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## 5. Monitoring Outputs and Demonstrating UNICEF's Contribution to Outcomes

UNICEF will monitor progress towards the achievement of output results and demonstrate its contribution to the achievement of the Outcome result. Progress towards planned results will be monitored using the indicators contained in the results matrix. In monitoring progress, UNICEF will focus strategically on analysing and addressing barriers and bottlenecks to the achievement of results. This reflects mainstreamed principles of the UNICEF Monitoring Results for Equity System. Monitoring initiatives will benefit from lessons learned and expertise from UNICEF global and other UNICEF country offices on innovations to develop systematic, real-time approaches for key nutrition indicators.

The programme will also build on partnership within United Nations agencies, civil society, private sector and Government to strengthen national monitoring and evaluation systems. The Office will work with the relevant national line Ministries such as National Department of Health, National Department of Education, National Department for Agriculture and Livestock, and Community Development and Religion to effectively monitor progress towards national and international goals and to track inequities using timely and relevant data. There will be a focus on improving data on nutrition, firstly for the national health information system (NHIS) and subsequently other sectors, towards a multi-sectoral shared data capture and reporting system, all of which are underdeveloped at present. This should reduce the data collection and reporting burden, since the proposed outcome indicators will be monitored through national data systems. Multi-sectoral approach of implementing towards nutrition outcome in PNG should also be evaluated and the evaluation should be planned with both budget and baselines. Periodic surveys, studies and research on key issues will be prioritized and additional research will be undertaken as needed to provide more in-depth analysis on key issues. The CO proposes to leverage resources by tapping into other partner surveys and building in targeted indicators given the high cost of implementation in PNG.

Outcome Statement:	By 2022, children under 5, adolescent girls and women, adopt improved nutrition and care practices and increase utilization of nutrition-specific and nutrition sensitive services, especially in the most disadvantaged and marginalized communities.		
Outcome Indicators	Baseline	Means of verification	Details
Proportion of infants exclusively breastfed up to 6 months in selected provinces [B: 36 per cent (2015); T: 80%]	Baseline will be established using the new DHS data available in late 2017.	DHS and/or Household Income and Expenditure Survey (HIES)	Frequency of data would be a challenge as next DHS may only occur after 5 years. HIES survey may be conducted depending on WB's support available.
No. of provincial hospitals providing SAM treatment of SPHERE standards [B: 0 (2016); Target:19]	Baseline will be established using the hospital and health centre based in-patient and out-patient admission data annually	Hospital based admission data annually analysed and reported by the PNG Paediatric Society	Frequency and timing of data is a challenge since it doesn't coincide with UNICEF reporting and there is no mid-year data

	analysed and reported by the PNG Paediatric Society		available from PNG Paediatric Society.
Proportion of children 6-59 months who received 2 vitamin A doses (B: 22% (2015); T: 80%)	NDOH Statistical Annual Performance Report (SAPR) of 2016 available in mid-2017.	NDOH Statistical Annual Performance Report (SAPR).	Reporting wouldn't be synchronised with UNICEF annual reporting cycle since SPAR data available almost after one year. Quality of data would also be a concern.
Output #1 Statement:	National and provincial governments have improved capacity to formulate policy and strategy, plan, budget, manage and coordinate multi-sectoral nutrition-specific and nutrition-sensitive interventions for the most vulnerable and disadvantaged children, adolescents and women, including during emergencies.		
Costed multi-sectoral national nutrition Strategic Action Plan (SAP) 2017–2021 endorsed by the government (B: 0; T: 1)	Since the measurement of this indicator is a Text document, baseline will be established after verifying the availability of the document with NDOH	The Nutrition SAP endorsed by the National Economic Council (NEC).	
Number of provinces with costed cross sectoral Nutrition Action plans (B: 0; T: 6)	Will be established after verifying with NDOH and PHA on the current status	NDOH and PHA Annual Report	
Number of provinces with budget allocation for nutrition (B: 0; T: 6).	There are fragmented data capture modalities for HIS. Will be established after verifying with NDOH, other sectors and PHA.	PHA Quarterly and Annual Report	
Output #2 Statement: National and provincial health authorities have improved capacity and necessary supplies to ensure the delivery of nutrition-specific interventions, including severe acute malnutrition (SAM) management, infant and young child feeding, micronutrient supplementation and maternal nutrition services, to prevent excess morbidity and mortality among girls, boys and women, including during emergencies			

Emergency Preparedness Plan for nutrition in UNICEF selected provinces developed and in place (B: 0; T: 6)	Baseline will be established after verifying the availability of the document with PHAs/PHOs.	NDOH and PHA Annual Report	
Number and percentage of hospitals and health facilities in selected provinces equipped with at least one trained staff and have supplies to implement nutrition specific services (SAM management, maternal nutrition, adolescent nutrition, micronutrient supplementation and IYCF counselling services. (B: 0/0; T: /80 per cent).	Will be established after verifying with PHAs/PHOs on current status.	NDOH and PHA Annual Report	
In selected provinces, children aged 6-59 months with SAM in humanitarian situations admitted to SAM programmes and recover (B:X; T: 75 per cent)	Baseline will be established based on the province-wise estimation of SAM children using the 2016/17 DHS data on SAM prevalence	NiE interventions implementation report and Annual Report of PHA/PHOs	Regular and timely collection and compiling the data by the PHA/PHO; and the authenticity of data.
Output #3 Statement:	Male and female caregivers and families, especially the most vulnerable and disadvantaged, have improved knowledge of appropriate feeding and caring practices for women, adolescent girls, infants and young children and to seek quality health and nutrition services, including in emergencies.		
Adoption of the International Code on Marketing of Breastmilk substitutes as legislation by PNG, with a designated body carrying out going monitoring and translated to the population. (B:0 T:1)	There is a baby feeds and supplies Act endorsed in the 70s that is proposed for overhaul and replaced by the International Code on Marketing of Breastmilk substitutes	National Executive Council (NEC) records of approved laws and regulations and National Health Board reports of regulatory monitoring.	

Country has an endorsed training curriculum on 'infant and young child feeding' that includes training on 'early childhood stimulation and development' for community workers/health service providers for outreach and disseminated. (B:0, T:1)	The baseline records show that the country is currently developing the training package for infant and young child feeding' that includes training on 'early childhood stimulation and development' for community workers/health service providers for outreach. This must be submitted to Curriculum review board at the department of health for approval and endorsement will be subsequently sought from government.	NDoH/PHA/PHO Quarterly and Annual Report	Regular and timely collection and compiling the data by the NDoH/PHA/PHO; and the authenticity of data
Number and percent of LLGs in selected provinces which have at least one trained community health workers on promotion of adolescent, maternal and IYCF practices. (B: 0/0, T: ??/75%).	Using the project implementation report supported by UNICEF.	PHA/PHO report on the implementation of the project.	Regular and timely collection and compiling the data by the PHA/PHO; and the authenticity of data

UNICEF will also contribute to the following efforts in the nutrition sector:

UNICEF contributions to <b><u>national household surveys and/or census</u></b> for this Outcome area:	UNICEF is currently supporting the on-going DHS that has incorporated key nutrition related outcome indicators. The preliminary data will be available in late 2017.
UNICEF's contributions to strengthening <b><u>national monitoring systems</u></b>	UNICEF Nutrition programme will support the NDOH and PHA/PHO to train and advocate to include some of the critical indicators in the regular performance reporting. UNICEF will also support to review and explore inclusion of some of the demand side indicators in the Rapid-Pro to collect data directly from users on their knowledge and awareness.
<b><u>Studies/profiles or research projects</u></b>	In collaboration with partners (e.g. WHO, FAO, NGOs), UNICEF will support a Nutrition SMART survey, assessment of community-based Integrated Management of Acute Malnutrition (IMAM), and

	formative studies and assessment on the operationalisation of a basic package of nutrition-specific and nutrition-sensitive interventions to generate data.
<b>Evaluations</b> that will be influential in this sector – that UNICEF or partners are planning:	In collaboration with partners, UNICEF will support the evaluation of community-based Integrated Management of Acute Malnutrition (IMAM).
<b>Sector review processes</b> and/or critical multi-stakeholder consultations	UNICEF will be actively engaged and contribute to the mid-year and annual joint Government-DP summit with UN system, donors, NGOs and other partners. UNICEF will support to organise multi-stakeholder consultations on developing the Nutrition Strategic Action Plan, its costing and budgeting, ensuring equity and coverage of nutrition services.
Data in emergencies	UNICEF is the cluster lead. UNICEF will actively work with NDOH, WHO, FAO, WFP and NGOs to strengthen cluster coordination mechanism and support to improve reporting on critical HPM indicators.

## 6. Resource Requirements<sup>2</sup>

Given the significant scale of nutrition challenges faced by PNG, and subsequent negative impact that will continue unless malnutrition is reversed, the CO requires substantial resources and additional staffing. The Australian government (DFAT) offers the highest contribution towards nutrition service delivery, directly to UNICEF. The proposed programme will leverage resources from responsible government sectors. PNG funds, up to 10M Kina is given to legislators, each, annually, and funds are spent at the discretion of the individual. This is an area UNICEF can potentially leverage to contribute to the nutrition outcome. In addition, there is a need to negotiate with major new bilateral funding opportunities in programming areas in which UNICEF has a clear comparative advantage to contribute to reversing malnutrition.

UNICEF's current country staffing requires an urgent boost. UNICEF Nutrition capacity in PNG currently rests with one international programme (IP) staff member (P3), and most recently, National officer (NoB) charged with managing inputs to the design of Nutrition activities. The scope and detail of work required in planning, budgeting, resource mobilisation, supporting, analysing, monitoring and reporting on nutrition activities requires additional staff members, both IPs and national staff.

Management strategy <sup>3</sup>	This outcome area can be best managed as an independent programme section led by a Chief (P4).
Staffing structure envisioned	Major change is envisioned if a separate section is established. The Programme would be implemented by a team of 6 staff led by an International Professional (P4) – the Chief Nutrition, supported by

<sup>2</sup> Note that the Country Office Management Plan including office structure is currently under discussion. Elements included in this Strategy Note are indicative

<sup>3</sup> Note that the Country Office Management Plan including office structure is currently under discussion. Elements included in this Strategy Note are indicative

	one professional at P-3/NOC level (Nutrition Specialist - IMAM), one national professional at NO-B level (Nutrition Officer) and one Programme Assistant (PA). The Programme will also require support from the Communication for Development (C4D) section.
Special services/technical expertise	Technical experts (consultants) support will be required to support UNICEF and NDOH to design and conduct listed assessment, surveys, and evaluation.

## Financial Resources:

Nutrition -	RR	OR	Potential for ORE (not included in ceiling)
Nutrition - Total	1,000,000	9,000,000	5,000,000
Output 1 (EE)	0	1,866,896	
Output 2 (Supply)	0	1,568,778	
Output 3 (Demand)	0	334,99	
PA	133,982	0	0
Total planned expenditure on payroll (36% of ceiling)	133,982	3,469,173	

## Resource Mobilisation Opportunities:

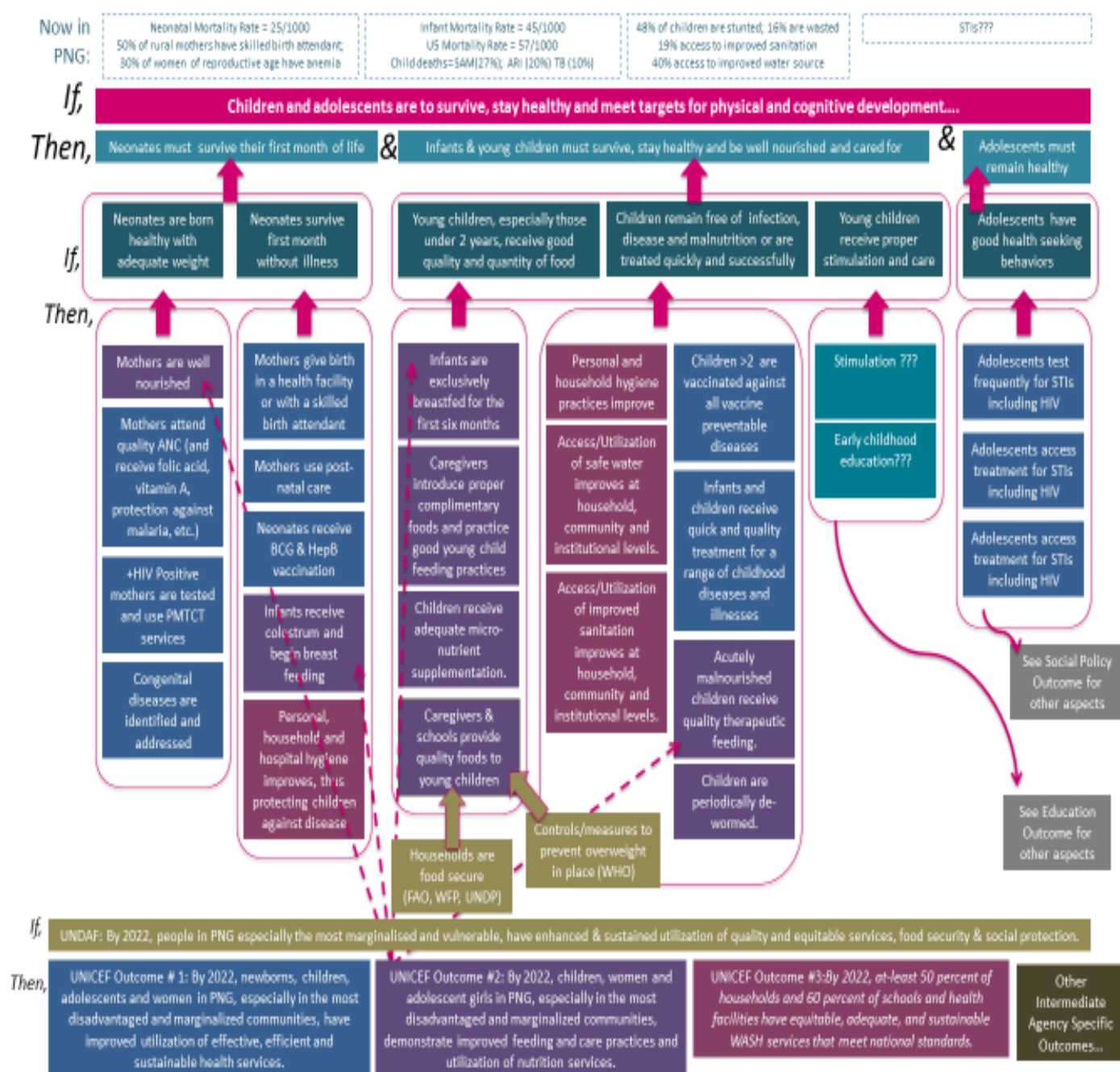
Main donors to the last CP	DFAT (Australia), Hong Kong NatCom, Govt. of Papua New Guinea DFAT is likely to support the CP in 2017.
UN Common Fund for mobilisation of resources	The efforts of mobilising funds will further be expanded through UN joint programming with FAO and WHO under the new UNDAF.
Soft or firm pledges from donors for the new CP	At this point, there is not yet any pledge from any donors, nor through the UN common fund. There are evolving partnerships under discussion with the government of South Korea while discussions continue with DFAT, the only bilateral donor for Nutrition programme under current CP.
Major global programme partnerships and development partners	PNG's membership of global SUN movement could provide opportunities of exploring and accessing international technical and materials support facilitated by SUN secretariat.
Private sector resource mobilisation (Natcoms, Corporates, Foundations, etc.)	The French NatCom has pledged for three years (2017–2019), US\$ 300,000 each year. There are also potentials of continuing support from UK Nat Com, and new opportunity from Australia NatCom. Potentials of engaging with Oil Search Limited (OSL), a major private sector partner in PNG could be engaged through their CSR charity initiative, Oil Search Foundation (OSF).

## 7. External Risks and Planned Responses

Risk Category	Specific Threat	Mitigation Measures
From Impact to Outcome	<ul style="list-style-type: none"> <li>• Though there is increased interest in nutrition at national level, general perception that malnutrition is not a problem that exists in PNG.</li> <li>• Economic downturn recently resulted in decreased national budget, this is a big risk that affects declining investment in health, subsequently, in nutrition;</li> <li>• Advocacy has been done to 'win' some managers and politicians, however, the upcoming 2017 elections can result in shifting political priorities;</li> <li>• Technical capacity at all levels is lacking (no nutrition curriculum is running, there is lack of institutional accountability, high vacancy rates and absenteeism, low motivation) and these pose risks for achievement of the outcome;</li> <li>• A history of poor donor interest since nutrition has not been consistently funded within PNG;</li> <li>• The low existing capacity is overwhelmed by humanitarian crises.</li> </ul>	<ul style="list-style-type: none"> <li>• There is need for stronger and widened advocacy to achieve elevation of nutrition on new agenda; with an improved Inter-ministerial coordination for multi-sectoral interventions improves;</li> <li>• Improved leveraging of resources and partnerships with better engagement of donors and other development partners;</li> <li>• Strengthened government capacity on and integrated early warning system and resilience that considers nutrition.</li> </ul>
From Outcome to Output	<ul style="list-style-type: none"> <li>• Entrenched social norms and cultural practices in feeding, hygiene and care can pose risks for attainment of outcome by all partners;</li> <li>• Inadequate capacity of implementing partners;</li> <li>• Inadequate tools, guidelines and policies to implement nutrition programme; critically poor information flow is also a risk,</li> </ul>	<ul style="list-style-type: none"> <li>• Developed capacity of national partners to design and implement strategies that address socio-cultural norms impacting nutrition;</li> <li>• Strategically prioritise and promote institutional approach of longer-term capacity building – devoting to pre-service human resource contribution;</li> <li>• Improve/update nutrition programme technical and</li> </ul>

	<p>exacerbated by low reporting rates, poor quality routine data and delayed reporting with a lack of global indicators in PNG's administrative reports;</p> <ul style="list-style-type: none"> <li>• Unclear resource mapping and allocation.</li> <li>• Limited implementing partners in nutrition to reach the un-reached vulnerable communities.</li> </ul>	<p>implementation tools, guidelines and policies e.g. the code of marketing breast milk substitutes;</p> <ul style="list-style-type: none"> <li>• Improve government's capacity on evidence-based costing, budgeting and allocating resources</li> <li>• Establish and expand strategic partnerships with NGOs and private sectors for nutrition programming.</li> </ul>
From Output to Interventions	<ul style="list-style-type: none"> <li>• Behaviour change messages related to nutrition, health and hygiene will be ineffective if water and sanitation access does not scale up in parallel.</li> <li>• Almost no provinces have included nutrition within their list of high priorities and resources are not yet allocated to support key nutrition interventions. Provincial nutrition posts remain vacant, with uneven nutrition structures across the 22 provinces, moreover, there is either a critically aging or high attrition of nutrition staff, where they exist;</li> <li>• Government and partner resources not sufficient for nutrition supplies to reach where they are needed;</li> <li>• Caregivers may lack resources to carry out certain practices (e.g. access to facilities for care of malnourished child)</li> <li>• Some populations may have no or limited access to Government and other not for profit facilities and critical services through which nutrition interventions can be delivered;</li> <li>• The high cost and delays in procurement and distribution of nutrition supplies, in both development and humanitarian situations affect results.</li> </ul>	<ul style="list-style-type: none"> <li>• Families, authorities and institutions are open to receive behaviour change messages related to IYCF &amp; WASH practices;</li> <li>• Minimum capacities in place and functional central &amp; local authorities that can manage service delivery and C4D;</li> <li>• Partnerships, coalitions and movements for changing behaviours are formed, sustained, committed and common results messages developed, delivered and monitored;</li> <li>• Sustained good working relationship with govt., partners and all stake holders;</li> <li>• Improved advocacy and negotiation effective at technical level to avoid bureaucracy of centralised governance;</li> <li>• Integrated and improved planning and monitoring in relation to procurement and distribution of supplies;</li> <li>• Strengthened government capacity on HACT compliance;</li> <li>• Enhanced field monitoring and support</li> </ul>





Annex-2: UNICEF CP 2018–2022 Results Structure for Nutrition

