UNITED NATIONS
RWANDA

Joint Project Phase III: Effectively Fighting Stunting in Rwanda
Project Proposal Document

Food and Agriculture Organization of the United Nations

unicef

WFP World Food Programme

World Health Organization

Cover Page

Country:	Rwanda
Project Title:	Joint Project Phase III: Effectively Fighting Stunting in Rwanda
Joint Project Outcomes:	1. Strengthened Government capacity in effective and equity-focused policy formulation, strategic planning, coordination, M&E and domestic funds mobilization across different sectors, including WASH, ECD, health, social protection, education and agriculture, along with an increased participation of private sector and civil society actors for sustained nutrition gains. 2. Well-equipped service providers working in health, agriculture, social protection, ECD and education provide quality nutrition-related services to communities contributing to the reduction of malnutrition including stunting in children. 3. Empowered communities in targeted districts improve their nutrition situation through creating better access to and consumption of a variety of nutrient-dense foods, early identification and prevention of cases of malnutrition, decreased risk of infectious and diarrhoeal diseases through improved hygiene and health practices and increased resilience against shocks.
Programme Duration:	4 years
Anticipated start/end dates:	July 2021- June 2025
Fund Management Option(s):	Pooled Funding Modality
Managing or Administrative Agent:	MPTF
Participating UN Agencies:	WFP, FAO, UNICEF, WHO
Available Funds in USD:	Funded Budget SDC & UN contribution: USD 7,073,547 5,316,863 (SDC) 1,756,684 (WFP, FAO, UNICEF & WHO)

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Contents

List of Acronyms

AA	Administrative Agent
CFSVA	Comprehensive Food Security and Vulnerability Analysis
CHW	Community Health Worker(s)
DaO	Delivering as One
DDP	District Development Plan
RDHS	Rwanda Demographic Health Survey
DPEM	District Plan to Eliminate Malnutrition
ECD	Early Childhood Development
EICV	Enquête Intégrale sur les Conditions de Vie des ménages
EKN	Embassy of Kingdom of Netherlands
ENAs	Essential Nutrition Actions
EU	European Union
FAO	Food and Agriculture Organization
FBF	Fortified Blended Food
FDA	Food and Drugs Authority
GMP	Growth Monitoring and Promotion
GoR	Government of Rwanda
HCP	Health Care Provider(s)
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illnesses
JICA	Japan International Cooperation Agency
JMP	Joint Monitoring Programme
LBW	Low Birth Weight
LODA	Local Administrative Entities Development Agency
M&E	Monitoring and Evaluation
MIGEPROF	Ministry of Gender and Family Promotion
MINAGRI	Ministry of Agriculture

MINALOC	Ministry of Local Government
MINEDUC	Ministry of Education
MOH	Ministry of Health
MoU	Memorandum of Understanding
MPTF	Multi-Partner Trust Fund
NCC	National Commission for Children
NCDA	National Child Development Agency
NCDs	Non-Communicable Diseases
NECDP	National Early Childhood Development Programme
NFNCS	National Food and Nutrition Coordination Secretariat
NISR	National Institute of Statistics of Rwanda
NMG	Nutrition, Markets and Gender
NST	National Strategy for Transformation
OH	One Health
PSC	Project Steering Committee
PSTA	Plan Strategique pour la Transformation de l'Agriculture
RAB	Rwanda Agriculture Board
RADA	Rwanda Agricultural Development Authority
RDHS	Rwanda Demographic Health Survey
REACH	Renewed Efforts Against Child Hunger
RICA	Rwanda Institute for Conservation Agriculture
ROHSP	Rwanda One Health Strategic Plan
RSB	Rwanda Standards Board
SAA	Standard Administrative Agreement
SBCC	Social Behaviour Change Communication
SC	Steering Committee
SDC	Swiss Agency for Development and Cooperation
SO	Strategic Objective(s)
SUN	Scaling Up Nutrition (SUN)
TWC	Technical Working Committee
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Sustainable Development Group

UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
WASH	Water, Sanitation and Hygiene
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

Executive Summary

Since 2000, there have been significant declines in stunting prevalence among children under five. From as high as 52% in 2005, stunting prevalence has dropped by 19 percentage points to 33% in the last Rwanda Demographic Health Survey (RDHS) survey in 2019-2020. Nonetheless, stunting remains high and above the public health threshold of severity (30%) according to WHO classification, still far from the national target at 19% to be reached by 2024.

The Government of Rwanda (GoR) recognizes that malnutrition, especially stunting, is a public health issue that requires multi-sectoral and multi-stakeholder interventions and coordination. Elimination of stunting is a high priority for the GoR as witnessed through the integration of nutrition in numerous policies and programmes and through the establishment of National Child Development Agency (NCDA), which is mandated to ensure holistic development of children aged 0-18 years.

Rwanda is one of the eight United Nations pilot countries with a unified multi-agency approach known as Delivering as One (DaO). This emphasizes 'one programme, one budget, one office and one voice' for UN agencies working in the country. The proposed project will be coordinated under the existing "One UN" structure following the UN Nutrition Initiative at country level, which coordinates nutrition interventions in the country through the establishment of the Multi-Partner Trust Fund (MPTF).

The Joint Nutrition Project Phase III aims to support the Government's efforts to reduce stunting in Rwanda with a focus on infants, children, adolescents, and women, and will build on the achievements of Phase I and II, using existing UN and Government structures and mechanisms for management and coordination.

In the context of delivering as One, the participating UN Nutrition agencies, namely UNICEF, WHO, FAO and WFP, will be responsible for the project coordination and technical support to government counterparts. The project will focus on improving the enabling environment for nutrition, improving nutrition services, and empowering communities and households to improve their nutrition situation.

Phase III funds will be managed through the MPTF arrangement, the Rwanda Sustainable Development Fund Terms of Reference. The MPTF is designated to serve as the Administrative Agent (AA) and will act as the administrative interface between the participating UN organizations and the donor(s), in order to facilitate coordination in accordance with the Standard Administrative Agreement (SAA) signed by the MPTF and the Donor.

Background and Context

Today, more than one third of young children worldwide suffer from some form of malnutrition with devastating consequences for health, learning, future earning potential, economic development, resilience, and security. There is strong evidence that eliminating malnutrition in infants and children has multiple benefits [1]. According to the Cost of Hunger in Rwanda study, the annual costs associated with child undernutrition are estimated at 503.6 billion Rwandan francs (RWF), which is equivalent to 11.5% of GDP. Eliminating stunting in Rwanda is therefore a necessary step for inclusive development in the country [2].

Rwanda has made tremendous progress in several areas over the last two decades. Poverty declined from an estimated 58.9% in 2000/2001 to 38.2% in 2016/2017 [3]. According to the 2019/2020 Rwanda Demographic and Health Survey (RDHS), the maternal mortality rate was reduced from 1,071 to 203 per 100,000 live births and the under-five mortality rate from 196 to 45 per 1,000 live births over a period of 20 years from 2000 to 2020.

Similarly, over the past 15 years, there has been significant decline in stunting prevalence among children under five years in Rwanda. From 52% in 2005, stunting prevalence has dropped by 19 percentage points to 33% in 2020. Nonetheless, stunting remains high and above the public health threshold of severity (30%) according to WHO classification, still far from the national target at 19% to be reached by 2024 [4]. Stunting increases with age and affects more boys (37%) than girls (29%). Likewise, children in rural areas are more affected by stunting (36%) compared to urban areas (20%) and the difference in stunting between the lowest (49%) and the highest wealth quintiles (11%) have further increased when comparing with 2014-2015 data.

Wasting levels in children under five have been reducing progressively from 2% in 2015 to 1.1% in 2020, both within acceptable public health thresholds. Specific micronutrient deficiencies such as rickets are being reported by district hospitals, but national data on the micronutrient status in the population is outdated [5]. Still, anaemia among children 6-59 months is persistently high at 36.6% in 2019-20. This figure is close to the public health crisis levels of 40% as per WHO classification. With increasing development and urbanization, Rwanda is experiencing the triple burden of malnutrition[6] with overweight in children under five at 6% in 2020.

The proportion of children receiving a minimum acceptable diet increased slightly from 18% in 2015 to 22% in 2020 while the rate of exclusive breastfeeding in children under age 6 months decreased from 87% in 2015 to 81% in 2020. Timely introduction of complementary feeding measured among children aged 6-8 months, on the other hand, now stands at 79%, a significant improvement from 2015 when this was only 56%.

The situation of nutrition in Rwanda continues to reflect persistent inequalities with risk factors for stunting in children under five in Rwanda including level of education of mothers, number of young children living in the same household, women nutrition and health conditions during pregnancy, birth weight, sex of the child, area of residence (urban/rural), socioeconomic conditions of the family, WASH (including access to basic water and sanitation and hygiene practices) and food security [7].

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[1] Scaling Up Nutrition, 2017

[2] The Cost of Hunger in Rwanda, 2013

[3] Integrated Household Living Condition Survey 5 (EICV 5), National Institute of Statistics of Rwanda, 2018.

[4] National Strategy for Transformation 1 (NST1) and Health Sector Strategic Plan IV (HSSP IV).

[5] A micronutrient survey was included in the 2019-2020 RDHS but results are not yet available.

[6] The triple burden of malnutrition refers to undernutrition, micronutrient deficiencies and overnutrition being prevalent in the same population.

[7] Nutrition, Markets and Gender (NMG) analysis, 2014; Risk Factors Associated with Childhood Stunting in Rwanda: A Secondary Analysis of the 2014 Nutrition, Markets and Gender (NMG) Survey

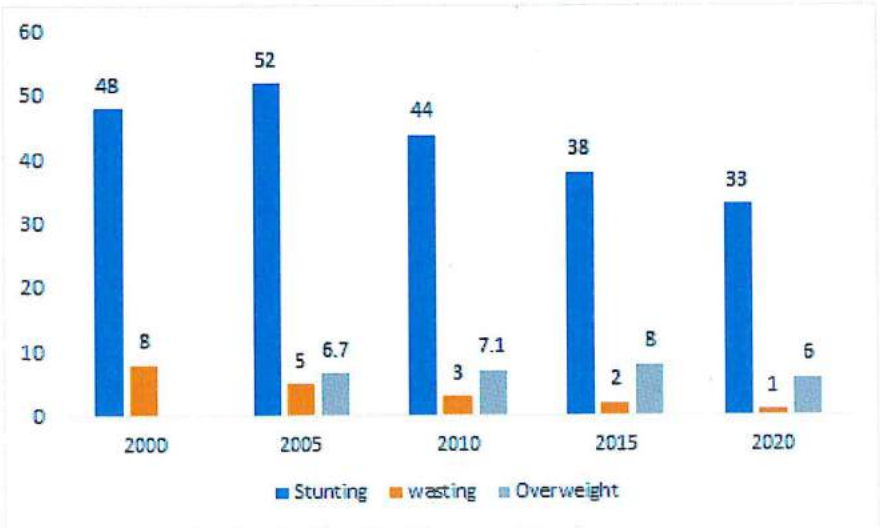

Figure 1: Prevalence of malnutrition in children under 5 years of age (RDHS 2000-2020). Overweight in children is only measured starting 2005.

Nutrition data for older children and adolescents is limited. However, among women of reproductive age (15-49 years), adolescents aged 15-19 years have the poorest nutritional status with 15% compared having anaemia compared to the average of 13% for the 15-49 years age group [8]. Likewise, the prevalence of underweight in the 15-19 years old adolescent girls is three times that of the 15-49 years old women [9]. Malnourished adolescent girls are more likely to grow into malnourished adults with an increased risk of giving birth to low-birth-weight babies, a risk factor for stunting.

This calls for more attention to address nutrition beyond the first 1,000 days (from conception to a child's second birthday). It is important to increase investments for the first 8,000 days (the period from conception through childhood and adolescence) to ensure the realisation of the full developmental potential for each girl and boy. Investments during childhood and adolescence helps to secure the gains of investment in the first 1000 days and enable substantial catch-up from early growth failure.

The need for enhanced focus on adolescent nutrition was echoed by the findings of the Fill the Nutrient Gap analysis conducted in Rwanda in 2019 which showed that the adolescent girl contributed to 31% of the cost of a nutritious diet for a household [10], emphasising the need to address nutrient gaps during adolescence.

The 2018 Comprehensive Food Security and Vulnerability Assessment (CFSVA) reported that 18.7% of Rwanda households are food insecure and 81.3% of households are food secure of which 38.6% are considered to be marginally food secure meaning that they are at a high risk of becoming food insecure. Although food security improved in 18 of 30 districts since the 2015 CFSVA survey, the situation has deteriorated in four districts, namely Kayonza, Ngororero, Kamonyi and Rulindo where food insecurity increased by 22%, 17%, 13% and 9% respectively. Rutsiro district continues to record high levels of food insecurity with 49% of households being food insecure [11].

[8] Rwanda Demographic and Health Survey. 2019-2020
[9] Rwanda Demographic and Health Survey. 2014-2015. (2019-2020 findings yet to be released).
[10] Adolescents contribute the highest percentage of the cost of a nutritious diet for a household.
[11] Comprehensive Food Security and Vulnerability Assessment (CFSVA), 2018

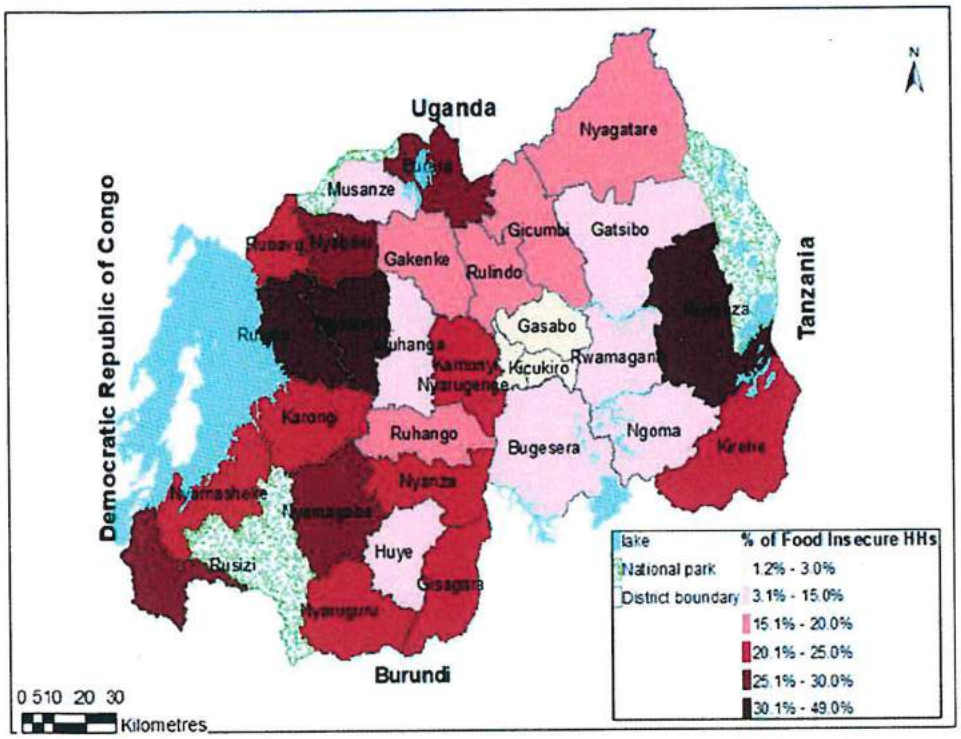

Figure 2: Food security situation in Rwanda (CFSVA 2018)

The COVID-19 pandemic has negatively impacted on the livelihoods of many Rwandan households. Some families have lost their source of income and food prices have been fluctuating since the start of the pandemic. Data collected in June 2020 showed that almost 80% of respondents reported to have had to deplete savings to pay for food, healthcare, or other expenses since February 2020. Likewise, more than 50% of households reported that they have had to reduce food consumption in the past week [12]. The cost of a nutritious diet increased by 12% in rural areas and 15% in urban areas after the onset of the COVID-19 pandemic in Rwanda [13]. Cases of severe wasting in children under five at health facility level as reported through the health information management system (HMIS) increased from around 6,000 in 2019 to around 12,000 in 2020. This is a worrying trend that may be attributed to the impact of COVID-19 on households' food security and livelihoods.

Moreover, the impact of COVID-19 has the potential to negatively impact the food security, health, and nutrition situation in the medium to long term particularly among the most vulnerable households and those in informal sectors, potentially undoing some of the gains made in reducing malnutrition in the country and aggravating existing inequalities.

In addition, global evidence shows that, among cases with COVID-19, those with undernutrition, overweight or non-communicable diseases (NCDs), such as diabetes and hypertension, are at higher risk of developing a severe form of the disease. Up to 40% of COVID-19 related deaths in treatment centres in Rwanda are patients with diabetes. Consequently, preventing malnutrition and NCDs is key to reducing the mortality in cases with severe forms of COVID-19.

[12] Innovations for Poverty Action (IPA), Research for Effective COVID-19 Responses (RECOVR) Survey Analysis, Rwanda, June 2020.
[13] UNHABITAT and WFP, Impact of COVID-19 on Livelihoods, Food Security and Nutrition in East Africa, Urban Focus, August 2020.

➢ Access to Services

Coverage of community growth monitoring and promotion (GMP) [14] is relatively high in Rwanda reaching 87% of children 6-59 months in 2019. Even during the height of the COVID-19 pandemic in 2020, 78 per cent of children aged 6-59 months were reached [15]. However, there are significant disparities in terms of coverage between districts. All health centres and hospitals provide services for the treatment of wasting but recent research shows that economic barriers (e.g. to cover the cost of transportation) may prevent some children from accessing this service [16].

Children 6-59 months are provided with high-dose vitamin A and deworming medication through two annual national campaigns (the Maternal and Child Health weeks) with coverage rates close to 100% in previous years and with 82% of children covered during 2020. The national home-based fortification programme using micronutrient powders (MNP) reached 42% of children aged 6-23 months with at least one pack of MNP during 2020 [17]and the national fortified blended food (FBF) programme targeting pregnant and lactating women and children 6-23 months from the poorest households is currently covering close to 70% of the children targeted for this intervention [18]. At health facility level, screening and treatment of cases with acute malnutrition through existing services such as immunization and Integrated Management of Childhood Illnesses (IMCI) is not systematically done and needs to be strengthened. Follow up of babies with low birth weight in order is also not systematic while it is a key intervention to prevent future stunting and micronutrient deficiencies during infancy and childhood.

Despite improvements in coverage of early childhood development (ECD) programme from 13% to 20% over the past five years, many children are not reached with ECD services. In addition, the introduction of ECD in health facilities is needed to enhance child survival especially among malnourished children. Thirty-seven percent of children aged 36-59 months are not developmentally on track in literacy-numeracy, physical, social-emotional, and learning domains. Likewise, key WASH indicators have improved over the past years, including access to basic sanitation (from 44% in 2000 to 66% in 2017) and access to basic drinking water [19] (from 44% in 2000 to 58% in 2017). However, only 14% of the population have handwashing facilities[20]. A newly concluded ethnographic study on food, feeding and hygiene practices shows that knowledge on child feeding is high, with economic barriers to nutritious food being the main factor related to poor child feeding. However,

knowledge on appropriate hygiene practices (including handwashing and safe disposal of child faeces) remains limited [21].

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[14] During GMP sessions, community health workers (CHW) measure children's weight and plot it against the WHO standard growth curve to detect growth faltering and provide timely advise. The CHW also take the mid-upper arm circumference (MUAC) to detect cases of moderate and severe wasting and make referrals to the nearest health center. They also determine children's stunting status using length mats.

[15] HMIS data on children 6-59 months measured with MUAC tapes by CHWs on a monthly basis during 2020. The annual average is 78% ranching from 65% in March to 85% in July 2020.

[16] Ministry of Health with support from UNICEF, Barriers to accessing health and nutrition services for pregnant women, mothers, newborns and children under five years of age in Rwanda, 2019.

[17] HMIS data from 2020

[18] CHAI coverage survey of the Fortified Blended Food programme, Q4 2019.

[19] Drinking water from an improved source, provided collection time is not more than 30 minutes for a roundtrip including queuing

[20] The Joint Monitoring Programme (JMP) data on WASH indicators, WHO and UNICEF. 2019

[21] Rwanda National Child Development Agency (NCDA) and UNICEF: Food, feeding, handwashing and hygiene norms, beliefs and practices related to maternal, infant and young child feeding in Rwanda: an anthropological study, March 2021.

In Rwanda, the school system provides a cost-effective platform to reach school-aged children and adolescents with a package of nutrition and health services such as deworming, school gardens and nutritious meals to contribute to their nutrition. According to the Ministry of Education, primary school enrollment in 2019 exceeded the target by 39%, mostly because children older than 12 years [22] are still at the primary school level. School children may become good advocates for nutrition through disseminating key nutrition and hygiene messages to household and community members when they are capacitated through school-based activities including school gardens and social and behaviour change communication. However, such activities are currently not implemented at scale in the country. For example, only 41% of primary schools had school gardens as of 2019 and there has not been an increase in this coverage since 2016 [23].

Consequently, there is a need to continue supporting the Government of Rwanda (GoR) to provide integrated quality nutrition services through existing government structures as well as strengthening engagement with other stakeholders, including the private sector, with a focus on promoting nurturing care, early stimulation, complementary feeding, adolescent and maternal nutrition, including improved access to nutritious foods and improved hygiene practices.

- **National policy frameworks, institutional structures and development partners involved in nutrition**

The GoR recognizes that malnutrition, especially stunting, is a public health issue that requires multi-sectoral and multi-stakeholder interventions and strong coordination. This has been prioritised in different national strategies and plans including the National Strategy for Transformation (NST1, 2017-2024), the National Early Childhood Development Programme Strategic Plan (NECDP SP, 2018-2024), the fourth Health Sector Strategic Plan (HSSP IV, 2018-2024), the fourth Agriculture Transformation Strategy (PSTA IV), and the National Social Behaviour Change Communication Strategy for Integrated Early Childhood Development, Nutrition and WASH (2018-2024). A new national Nutrition Policy was finalized in 2020 and is pending Cabinet approval. Finally, the GoR developed a Rwanda One Health Strategic Plan II (ROHSP II) 2019-24 that calls for proactive multi-sectoral and interdisciplinary engagement across the human, animal, and environmental health sectors recognizing their interconnectedness and impact on food security, food safety and nutrition [24].

Strong political will in Rwanda is coupled with adherence to the Paris-Accra Principles on Aid Effectiveness. This is demonstrated by strong government ownership and leadership of the national nutrition agenda, and the request to donors and development partners to support nutrition as a government development priority. Given that Rwanda is a participant in the Scaling Up Nutrition (SUN) initiative, the Government's commitment to combat undernutrition is facilitated within a coordinated multi-sectoral response, which includes both nutrition-sensitive and nutrition-specific activities. To achieve this, the National Food and Nutrition Coordination Secretariat (NFNCS) was established under MINALOC, in July 2016 with the aim to enhance the

[22] The official age range for primary school for Rwanda is 7-12 years. Source: Ministry of Education. 2019 Education Statistics.

[23] Ministry of Education. 2019 Education Statistics. Accessed: https://www.mineduc.gov.rw/publications on 8th May, 2021.

[24] Most of the infectious diseases that are naturally transmitted between vertebrate animals and humans can be transmitted directly by contact with an animal, via contaminated environment, via food or indirectly through bites by arthropod vectors. The diseases caused in humans range from mild and self-limiting (e.g., most cases of toxoplasmosis) to fatal (e.g., Ebola hemorrhagic fever). One Health is a public health approach to reduce the transmission of diseases taking into account the inter-connection between people, animals, plants and their shared environment. One Health issues include zoonotic diseases, antimicrobial resistance, food safety and food security, vector-borne diseases, environmental contamination, and other health threats shared by people, animals, and the environment.

efficiency and coordination of food and nutrition interventions to eliminate all forms of malnutrition in Rwanda including stunting. Recognizing the strong links between nutrition and ECD, the mandate of the coordination secretariat was expanded and the National Early Childhood Development Programme (NECDP) was established under MIGEPROF in the last quarter of 2017. Its mandate was to coordinate all interventions for ECD including nutrition and WASH. In the last quarter of 2020, NECDP merged with the National Commission for Children (NCC) to form the National Child Development Agency (NCDA), further broadening its mandate to ensure holistic development of children aged 0-18 years.

In terms of gender equality and equity, the Government of Rwanda is committed to ensuring equal rights for women and men without prejudice. It is in this context that the Ministry of Family Promotion and Gender (MIGEPROF) was established in 1999. Strong political commitment in Rwanda has resulted in significant positive strides in the promotion of gender equality and women's empowerment. In fact, women's representation in decision-making positions makes Rwanda the world leader in terms of women in Parliament (62% after the 2018 Parliamentary elections). Economically, Rwandan women's labor force participation rate is one of the highest in the world (86%). However, despite the government's efforts to reduce gender disparities, women continue to face inequalities. Women are still responsible for the majority of unpaid housework and childcare, and they generally have limited access to resources, services and household decision making [25]. This hinders Rwandan families from providing adequate childcare including infant and young child feeding practices. Poor nutrition before and during pregnancy, along with the demanding domestic workload for women, (e.g. firewood water collection, sanitation chores, childcare and food preparation) contribute to morbidity and mortality in women as well as malnutrition in infants and young children.

The past five years marked a significant engagement and investment of different stakeholders supporting the government's efforts to eliminate malnutrition through different social cluster ministries and the NCDA. In addition to the United Nations agencies, the main partners include the Swiss Agency for Development and Cooperation (SDC), the US Agency for International Development (USAID), the Embassy of the Kingdom of the Netherlands (EKN), the European Union (EU), the World Bank (WB), and the Japan International Cooperation Agency (JICA) as well as their implementing partners (see annex A). Domestic investment in nutrition have also improved. However, there are still gaps in both geographical coverage and beneficiary coverage of the Essential Nutrition Actions (ENAs). The level of support and coverage of essential nutrition actions varies among districts both in the number of partners supporting the district, the number of ENAs implemented, and the coverage of beneficiaries for these ENAs. Further scale-up, harmonization, and integration are needed to accelerate the reduction of stunting.

- **UN joint contribution towards the elimination of malnutrition in Rwanda: Successes, challenges, and opportunities**

The four main UN agencies working on nutrition in Rwanda (FAO, UNICEF, WFP and WHO) have been working under the framework of the One UN Network for Scaling Up Nutrition (SUN) [26] since 2012 to support the national scale-up nutrition actions as laid out in national plans and strategies related to nutrition. These efforts include supporting the GoR with policy and planning, coordination, advocacy, capacity development, tracking progress and scale-up of both nutrition-sensitive and nutrition specific interventions to enhance impact.

[25] Gender equality strategy UNDP Rwanda (2019-2020)

[26] Currently UN Nutrition, the new UN collaboration platform for nutrition following the recent merger of the UN Network for Scaling Up Nutrition (UNN) and the United Nations System Standing Committee on Nutrition (UNSCN).

In 2013, the One UN Joint Nutrition Project was designed by these four UN Agencies to work together through a multisectoral approach to effectively fight chronic malnutrition in Nyamagabe and Rutsiro districts, which were among the most affected by stunting and poverty, with funding from the Swiss Development Cooperation (SDC). Phase I of this project was implemented between August 2014 and December 2016 and was successful in achieving the target of 30% reduction in anaemia. There was no significant stunting reduction in children under five, however, there was a two-percentage point reduction in stunting in children younger than two years of age, and 4 percentage point reduction in children under 2 years from Ubudehe category 1 and 2 [27] who received the comprehensive package of interventions under the phase I project. The success of the project was due to different factors including the UN agencies comparative advantage, the commitment of all involved parties, community involvement and good leadership at all levels. The best practices and lessons learned from this project inspired GoR's commitment to scale up nationally the micronutrient powder (MNP) programme to all children 6-23 months and the fortified blended food (FBF) programme for children 6-23 months and pregnant and lactating mothers in the poorest Ubudehe categories.

Phase II of the project started in 2017 and will be ending in June 2021. Although this phase encountered some challenges, including several institutional changes in the government structures for nutrition as well as delays in implementation caused by COVID-19 related restrictions, it contributed to strengthening government's capacity and systems to improve nutrition. This includes strengthening the capacity of health, agriculture and education professionals at national and decentralized levels, generating evidence to influence policy, development of the new national nutrition policy and food based dietary guidelines, and successful advocacy for increased government investment in nutrition commodities.

- **Lessons learned from phase I and II informing phase III priorities**

The proposed phase III of the joint UN nutrition project will build on lessons learnt from phases I and II, taking into account the current country context and national priorities by strengthening and contributing to the sustainability of nutrition interventions at national and decentralized levels while striving to mitigate the negative impact of COVID-19 on the nutritional status of the most vulnerable in Rwanda. Lessons learnt from phase I and II are listed below:

Alignment of programmes with the Government's priorities together with advocacy, upstream work and evidence generation is critical for ownership, success, and sustainability. This includes Government's adoption of the provision of micronutrient powders and fortified blended food as key interventions to address stunting and anaemia based on evidence generated through phase I of the joint nutrition project. Phase III of the project will continue to align with government's priorities and support to enhance the enabling environment, produce evidence to inform advocacy for increased and sustained government investment in nutrition, strengthen multi-stakeholder platforms, continue capacity enhancement of government actors and scale up of innovative approaches and packages to address malnutrition and empower community stakeholders.

The role of the private sector in nutrition was not strongly highlighted in Phases I and II though they contribute to improved nutrition outcomes through, for example, the production of nutritious foods. The national Food Systems Summit dialogues convened by the Ministry of Agriculture and Animal Resources underscored the role of private sector in building a resilient nutrition-sensitive food system in Rwanda. Phase III of the joint nutrition project will seek to support on-going efforts to coordinate and harness private sector's support for improved nutrition.

[27] Rwandans are assigned to socioeconomic categories from 1 to 5, with 5 reserved for the wealthiest and 1 the poorest. Ubudehe categories are determined at the community level and are a function of one's income, personal possessions, and general quality of life.

Complementarity and synergy between different sectors are required for a programme to achieve significant and sustainable reduction of malnutrition among the most vulnerable. This includes integration of nutritional care in the national programme for prevention and management of non-communicable diseases, integration of health, nutrition and WASH into school's curriculum, making social projection interventions such as community-based saving groups more nutrition sensitive, and supporting regulators on food safety and private sector food suppliers to reduce the risk of contamination of food stuffs and associated illnesses. Community level activities of Phase III of the project will be implemented in districts with high levels of stunting and food insecurity and ensure geographical convergence with on-going nutrition, food security and resilience programmes to maximise impact on nutrition outcomes.

There is still a need to strengthen the government systems' capacity to implement, coordinate, monitor and evaluate multisectoral nutrition interventions. This includes strengthening planning, budgeting and coordination, including feedback loops between central and decentralized levels, and ensuring adequate nutrition professionals with sufficient capacity for the delivery of quality nutrition services. Phase III of the project will strengthen government capacity in effective and equity-focused planning, budgeting and coordination for nutrition and including supporting the government with prioritizing and mobilizing resources for nutrition interventions with the greatest impact.

Though Phase I of the project included activities on social and behaviour change communication (SBCC), Phase II did not. The GoR and partners have developed the National Social and Behaviour Change Communication Strategy for Integrated Early Childhood Development, Nutrition and WASH (2018-2024). This presents an opportunity for Phase III of the project to deliver an integrated and comprehensive gender-sensitive SBCC package using different approaches to promote priority behaviours for improved nutrition.

The project phase III will ensure complementarity between existing programmes especially at the decentralised level to maximize impact. Collaboration and information sharing mechanisms will be set up and/or strengthened including coordination through existing sector working groups and SUN coordination platforms. Annual meetings with central level counterparts and bi-annual coordination meetings with stakeholders in the two target districts will ensure effective coordination, synergies and integration of project activities.

1. Phase III Project Description

1.1 Development Objectives

Impact The project aims to support the Government of Rwanda's efforts to reduce malnutrition in Rwanda with a focus on infants, children under-five, adolescents, and women and with emphasis on reducing stunting in children.

1.2 Expected Outcomes

Strengthened Government capacity in effective and equity-focused policy formulation, strategic planning, coordination, M&E and domestic funds mobilization across different sectors, including WASH, ECD, health, social protection, education and agriculture, along with an increased participation of private sector and civil society actors for sustained nutrition gains. Well-equipped service providers working in health, agriculture, social protection, ECD and education provide quality nutrition-related services to communities contributing to the reduction of malnutrition including stunting in children.

Empowered communities in targeted districts improve their nutrition situation through creating better access to and consumption of a variety of nutrient-dense foods, early identification and prevention of cases of malnutrition, decreased risk of infectious and diarrhoeal diseases through improved hygiene and health practices and increased resilience against shocks.

1.3 Target Groups and Intervention Districts

- **Target groups:**

Activities under Outcome1, which aim to support an enhanced enabling environment for nutrition including policy coherence, advocacy and coordination, will be implemented at the national level.

Direct beneficiaries: Government staff, private and civil sector actors.

Indirect beneficiaries: The general Rwandan population, especially young children, adolescents and women, who will benefit from the enhanced enabling environment for nutrition.

The majority of activities under outcomes 2 and 3 will be implemented in Rutsiro and Ngororero districts. However, some activities will be implemented in additional districts in line with government's policies and priorities to ensure maximum impact of the project activities.

Direct beneficiaries: Children younger than five, school aged children, adolescent girls and boys and community members and leaders including male and female caregivers of young children, government service providers across health, agriculture, ECD, education and social protection sectors, food safety regulators and private food suppliers.

- **Intervention districts:**

Rutsiro and Ngororero districts have been selected for community level activities in Phase III of the joint nutrition project due to their high poverty rates, poor food security and high prevalence of stunting and anaemia in children under five in order to reach vulnerable populations (See annex B). Data from the Integrated Household Living Condition Survey 5 (EICV 5) shows that both Rutsiro and Ngororero have high poverty rates at 50% and 48%, respectively. Similarly, according to the CFSVA 2018, Rutsiro district has the

highest level of stunting at 54% while that of Ngororero district is 49%, both classified as very high according to WHO classification of malnutrition. In addition, 49% of households in Rutsiro and 41% of households in

Ngororero are food insecure. These are the only two districts in the country with levels of food insecurity above 40% as per the CFSVA 2018 results. About 77% of households in Rutsiro and 64% of households in Ngororero have poor diet diversity and only 7% of children aged 6-23 months in Rutsiro and 8% in Ngororero consume a minimum acceptable diet compared to 22% nationally [28]. Moreover, about 19% of food consumed by households in Rutsiro and 39% in Ngororero come from own production, making it critical to support increased home production and conservation of especially fruits and vegetables for improved dietary diversity. Agricultural support activities will target women-headed households as they are more food insecure than households headed by men (e.g., 62% vs 44% in Rutsiro).

In addition to the districts' poor nutrition and food security situation, both districts have partners working on nutrition, food security, ECD and social protection which is an opportunity for the joint nutrition project phase III to complement ongoing activities thus creating synergies to maximise project results. A rapid assessment of the nature and coverage of ongoing activities supported by existing partners will be undertaken in the first months of the phase III in order to ensure complementarity and avoid duplication. Likewise, the ongoing Comprehensive Food Security and Vulnerability Assessment (CFSVA) will provide updated national and district level data on the nutrition and food security situation, including on the impact of COVID-19 on food availability, accessibility, and consumption. The results are expected in June 2021 coinciding with the release of the RDHS 2019/20 report. A first step of the implementation of the proposed phase III project will therefore be to do a quick assessment of the 2021 CFSVA, the RDHS 2019/20 and other relevant studies to assess the impact of COVID-19 on nutrition and food security. The implementation strategies of the phase III will be sensitive to the findings of the assessment to ensure the project answers to the needs of the population.

1.3 Implementation Strategy

The project will apply several approaches in the implementation of the proposed activities in order to ensure maximum impact while ensuring that the most vulnerable groups are given priority. The following sections are providing details on these approaches:

- **Scaling Up Nutrition (SUN) Movement and One UN Network for SUN:** SUN is a unique global movement founded on the principle that all people have a right to food and good nutrition. The SUN movement recognizes that malnutrition has multiple causes and consequently engages multiple stakeholders to work together to ensure nutrition is reflected in all development efforts and to develop sustainable solutions. In doing so, it unites people from governments, civil society, the United Nations, donors, businesses & research institutions in a collective effort to improve nutrition. Rwanda joined the SUN movement in 2011 with a commitment letter from the Minister of Health. The One UN UN Network for SUN in Rwanda is the joint United Nations facilitation mechanism for nutrition, and acts as a catalyst for scaling up multi-sectoral nutrition activities in the country. The project will be implemented and coordinated by the four UN agencies following existing One UN Network for SUN governance structures and mechanisms. Likewise, the four UN agencies will ensure coordination of the project with other ongoing and future nutrition activities through existing SUN coordination platforms in the country, including the national food, nutrition and WASH technical working group which acts as the joint national government and partner coordination platform for nutrition.

[28] RDHS 2019/20

- **Comparative advantages of the One UN approach:** Prior to the adoption of the "One UN" approach and the establishment of the UN Network for SUN in Rwanda, UN agencies were supporting the GoR's actions to eliminate malnutrition but often with agencies working in silos (fragmented approach) instead of delivering an integrated package of support for nutrition. The adoption of the One UN approach and the establishment of the UN Network for SUN in Rwanda enabled the UN agencies to work together and "Deliver as One" (DaO) by having coordinated actions and combined resources to avoid overlap and duplication, therefore, maximizing impact. It allowed UN agencies to bring their expertise together within a common geographic focus through better planning and prioritization. With this project, the four agencies aim to continue joining their resources and expertise for more efficient and cost-effective support towards the government's efforts to eliminate malnutrition.

- **Good governance mainstreaming strategy:** Good governance will be promoted through all project components by ensuring close collaboration with local and central government structures from planning to implementation and monitoring. This will include integration of project interventions into government annual work plans, including the district plans for elimination of malnutrition (DPEM), joint field visits with UN agencies, central and decentralized government to assess progress of activities in the two focus districts and aligning monitoring and reporting of project activities to government routine reporting systems. In addition, the project will strengthen national and decentralized capacities in planning, budgeting, implementation and monitoring of nutrition interventions through building central and district level capacity on results-based management and public financial management tools and approaches. Finally, the collaboration with the Rwanda Women Parliamentarian Forum will strengthen parliamentarian oversight of national nutrition policies and programmes, including analysis of national budget allocations and executions, for improved accountability.

  At community and household level, the project will promote good governance through implementation of community-based savings and lending groups which includes capacity building on accounting and improved planning of household expenses. To improve responsible management of agriculture and livestock assets, a control and accountability mechanism will be put in place whereby each beneficiary household will sign a performance contract with the local authority at sector level on optimal utilization of received assets to make sure that activities contribute to addressing household food and nutrition insecurity. Finally, the support to the implementation of the child scorecard, a tool to facilitate individual monitoring and follow up of nutrition status and access to services, will enhance accountability of public service providers.

- **Gender mainstreaming strategy:** There is still a need for more concerted efforts to address social norms and culture rooted stereotypes that perpetuate gender inequalities in Rwanda through awareness raising and dialogues. Gender, like good governance, is a cross cutting issue across all project components and will be fully taken into consideration in view of the empirical evidence that malnutrition in mothers, especially those who are pregnant or breastfeeding, can set up a cycle of deprivation that increases the likelihood of low birth weight, child mortality, disease, poor classroom performance and low work productivity. Ensuring good nutrition is the joint responsibility of all family members, including men and boys. Hence, the project will ensure that project interventions will pay particular attention to ensuring equal participation of women and, when relevant, adolescent girls in all community level activities, including community-based savings and lending groups which will promote their economic empowerment. Also, the involvement of women, men, girls and boys in nutrition will be promoted throughout the project interventions including through SBCC activities aiming to build their commitment to improving the nutrition and health of mothers and children and increase their participation in childcare. Schools will be used as an entry point to sensitize girls and boys on the importance of nutrition and associated gender issues and will facilitate that they knowledgeable and empowered to ensure good nutrition for themselves and their future families.

Finally, gender-sensitive methodologies such as the Gender Action Learning System [29] will be used wherever possible and project reporting will use gender-disaggregated data whenever possible.

Leaving No One Behind (LNOB) is a UN value which is crucial to the realisation of the sustainable development goals (SDGs). This is a principle that aims to ensure that the most vulnerable including women, youth, adolescents and children (especially girls) are empowered and benefit from increased social and economic opportunities. This project will contribute to inclusivity of the most vulnerable in the design and implementation of activities.

[29] FAO, IFAD, WFP: Gender Transformative Approaches for Food Security and Nutrition. Good Practice. Gender Action Learning System. 2020.

2. Theory of Change

a) Summary

The Joint Project will strengthen strategies and policies aiming at reducing stunting by supporting an enabling environment to improve nutrition outcomes at all levels, enhance service delivery for improved nutrition by strengthening inter-sectoral capacity for addressing malnutrition and nutrition-related non-communicable diseases in the context of COVID-19 and other possible future shocks and strengthen community empowerment and resilience to improve their nutrition status and capacity to identify, prevent and manage stunting.

IF the SUN Network, schools, health care providers, partners and community members are capacitated to prevent and manage nutrition related issues,

IF the project beneficiaries adopt good nutrition practices,

IF on-going efforts to coordinate and harness private sector's support for improved nutrition are supported,

IF the UN joint approach on nutrition is continued to assist the Government of Rwanda to accelerate the scale up of, quality and sustainability of food and nutrition actions,

IF there are no major changes in government counterpart structures and priorities,

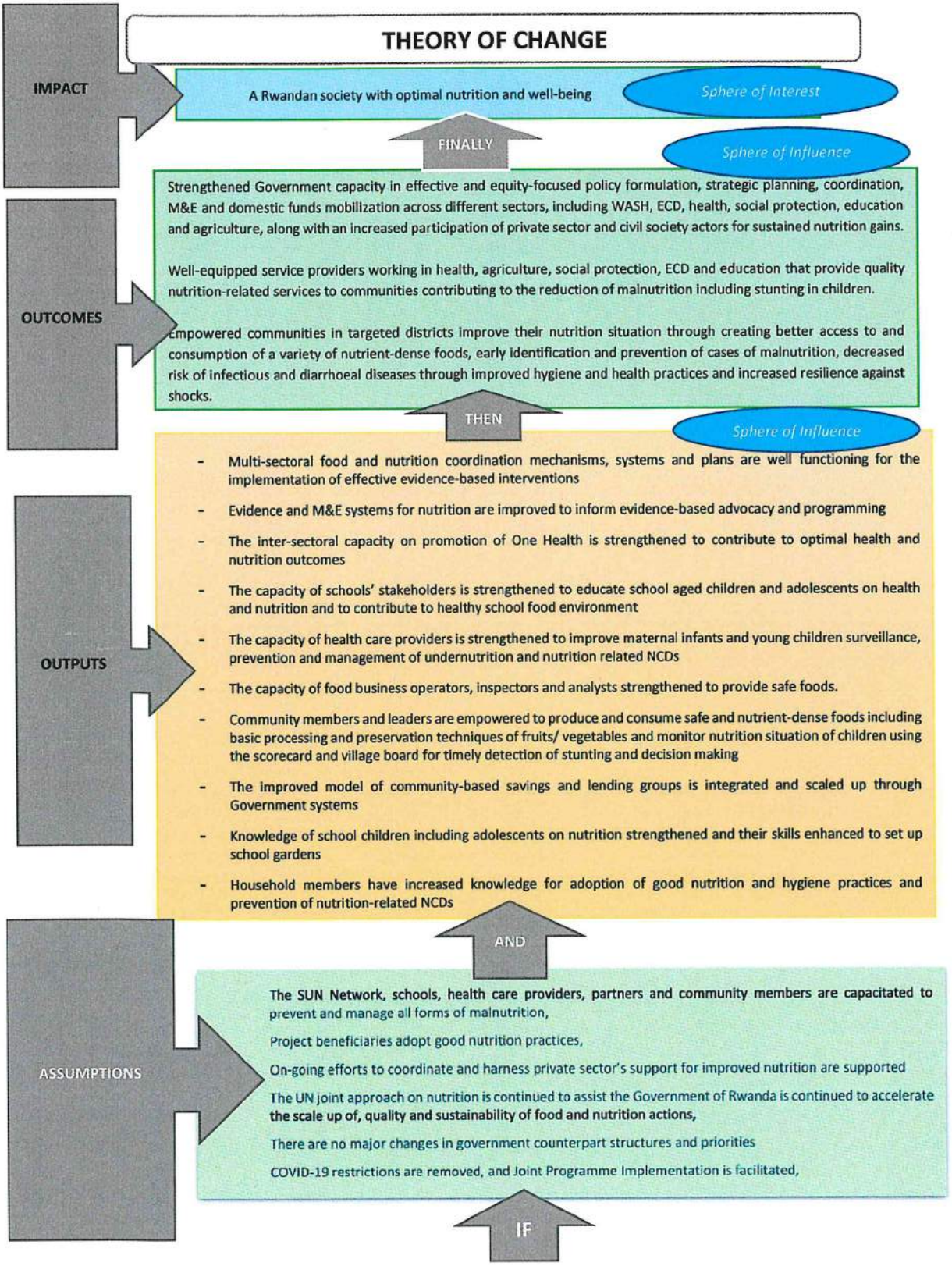
IF COVID-19 restrictions are removed, and Joint Programme Implementation is facilitated,

THEN, Multi-sectoral food and nutrition coordination mechanisms systems and plans are well functioning with equipped Private sector, SUN Network, schools, health care providers, community members and leaders informed by evidence-based advocacy and programming (Outputs 1-10);

LEADING TO strengthened Government capacity in effective and equity-focused policy formulation, strategic planning, coordination (Outcome 1); well-equipped service providers (Outcome 2); and empowered communities in targeted districts (Outcome 3);

WHICH WILL RESULT IN a Rwandan society with optimal nutrition and well-being (Impact).

Theory of Change schematic



3.Proposed interventions

The JP interventions build upon already implemented interventions in phase I & II. The project objectives are in line with the government priorities in reducing stunting. The UN would like to contribute to the government's efforts through the following:

Outcome 1: Strengthened Government capacity in effective and equity-focused policy formulation, strategic planning, coordination, M&E and domestic funds mobilization across different sectors, including WASH, ECD, health, social protection, education and agriculture, along with an increased participation of private sector and civil society actors for sustained nutrition gains.

Output 1.1: Multi-sectoral food and nutrition coordination mechanisms, systems and plans are well functioning for the implementation of effective evidence-based interventions

Output 1.2: Evidence and M&E systems for nutrition are improved to inform evidence-based advocacy and programming

Intervention areas:

Strengthen existing national coordination platforms, including SUN networks and technical working groups, as well as strengthening private sector's participation in nutrition through the establishment of SUN Business Network to enhance multi-sectoral collaboration, accountability, and synergies.

Provide support to the NCDA and to District Plans to Eliminate Malnutrition (DPEM) committees to ensure integrated and effective planning, budgeting, implementation, and monitoring of national and district plans to ensure prioritization of high-impact evidence-based interventions and effective use of resources.

Conduct analysis of government's investment in nutrition to assess gaps to support evidence-based advocacy for increased investment in nutrition including continued collaboration with the Parliamentarian's network for SUN.

Improve the evidence base for nutrition, including nutrition surveillance building on existing systems and mechanisms, and documenting best practices and lessons learned

Activities:

1.1. UN Network for SUN facilitation to support the various multi-sectoral coordination platforms (TWGs, SUN Government platform and focal point, etc.)

1.2. Support the establishment of the SUN Business Network in Rwanda to maximize private sector contribution to improving nutrition (including. development of strategy, terms of reference, action plan, awareness campaign, workshops/roundtable discussions operationalization of secretariat).

1.3. Support capacity building using an evidence-based, integrated and mentorship approach to strengthen use of results-based management and public financial management tools for improved planning, budgeting, implementation and monitoring of national and district nutrition plan

1.4. Strengthen collaboration with the Rwanda Women Parliamentary Forum (FFRP), also known as the Parliament network for SUN, to support parliamentary oversight of multisectoral nutrition policies, programmes and budgets for improved impact, including supporting in-depth analysis of the national budget to inform advocacy for nutrition

1.5. Support monitoring and evaluation of the improved nutrition-sensitive community-based savings and lending groups and the peer-to-peer support model for improved nutrition practices (see activity under SO 3) to assess impact on households' food and nutrition security and resilience

1.6. Conduct a survey of the nutrition services provided in the Integrated Management of Childhood Illnesses, immunization and NCDs services at health center level (baseline and end-line, survey representative of all districts) and a cohort study of babies born with LBW (mid-term and end-line)

1.7. Carry out a gap analysis of the food safety system among key line ministries using a holistic approach (One Health)

1.8. Conduct baseline and end line surveys for the project's impact evaluation

1.9. Produce and disseminate joint communication materials about the project

Outcome 2: Well-equipped service providers working in health, agriculture, social protection, ECD and education that provide quality nutrition-related services to communities contributing to the reduction of malnutrition including stunting in children.

Output 2.1: The inter-sectoral capacity on promotion of One Health is strengthened to contribute to optimal health and nutrition outcomes

Output 2.2: The capacity of schools stakeholders is strengthened to educate school aged children and adolescents on health and nutrition and to contribute to healthy school food environment

Output 2.3: The capacity of health care providers is strengthened to improve maternal infants and young children surveillance, prevention and management of undernutrition and nutrition related NCDs

Output 2.4: The capacity of food business operators, inspectors and analysts strengthened to provide safe foods.

Intervention areas:

Strengthen inter-sectoral capacity on promotion of One Health to contribute to optimal health and nutrition outcomes.

Strengthen the capacity of care providers through the health, ECD, education and agriculture systems to identify, prevent and manage malnutrition

Strengthen the capacity of health care providers on nutritional care for prevention and management of nutrition related Non-Communicable Diseases

Strengthen the capacity of food suppliers and regulators on food safety to reduce the risk of contamination of food stuffs and associated illnesses.

Activities:

2.1. Provide technical support to operationalize One Health platforms including One Health Secretariat and Technical Working Groups engaged in planning, implementation, communication, advocacy and M&E of One Health Strategic Plan

2.2. Develop or revise regulatory standards and guidelines on food safety using One Health approach

2.3. Training and supervision of primary and secondary school teachers on health and nutrition (4 districts per year)

2.4. Capacity building (Training, supervision and provision of tools) of health care providers from health centers (IMCI and Immunization officers) on growth monitoring, identification of cases with acute malnutrition, counselling for feeding, management of acute malnutrition and introduction for Child Development (CCD) in health facilities (all districts)

2.5. Capacity building of health care providers at health center and community level for follow up of Low Birth Weight (LBW) babies up to the age of 2 years with growth monitoring, micronutrient supplementation and counselling to mothers/caretakers: trainings, supervision and supply chain follow up (2 selected districts)

2.6. Strengthen the capacity of district and health centre nutritionists and data managers to improve nutrition data quality gaps, use of the national nutrition app and facilitate analysis of nutrition data (antenatal, postnatal and child) to ensure timely detection and management of malnutrition

2.7. Train school stakeholders on nutrition and food safety to contribute to healthy school food environment.

2.8. Capacity building (Supportive supervision) of health care providers at health center and community level to sensitize families on healthy diet and nutritional care for prevention and management of nutrition related NCDs (all districts)

2.9. Train food business operators (e.g., local manufacturers, wholesalers, distributors and retailers) on complying with food quality and safety standards to prevent food-borne diseases

2.10. Train major media practitioners on reporting issues affecting food safety and promote community education to prevent COVID-19 and food-borne diseases among the general population of Rwanda

2.11. Train primary producers, food handlers, food inspectors and analysts on One Health approach

Outcome 3: Empowered communities in targeted districts improve their nutrition situation through creating better access to and consumption of a variety of nutrient-dense foods, early identification and prevention of cases of malnutrition, decreased risk of infectious and diarrhoeal diseases through improved hygiene and health practices and increased resilience against shocks.

Output 3.1: Community members and leaders are empowered to produce and consume safe and nutrient-dense foods including basic processing and preservation techniques of fruits/ vegetables and monitor nutrition situation of children using the scorecard and village board for timely detection of stunting and decision making

Output 3.2: The improved model of community-based savings and lending groups is integrated and scaled up through Government systems

Output 3.3: Knowledge of school children including adolescents on nutrition strengthened and their skills enhanced to set up school gardens

Output 3.4: Household members have increased knowledge for adoption of good nutrition and hygiene practices and prevention of nutrition-related NCDs.

Intervention areas:

Support improved local production of nutrient-dense foods among poor and vulnerable households that are land constrained (such as kitchen gardens, community nurseries, fruits trees, and small livestock) as well as small scale food processing (e.g. vegetable and fruit drying).

Support the scale up of nutrition-sensitive interventions including the improved model of community-based savings and lending groups to strengthen households' nutrition resilience in the context of COVID-19.

Support NCDA to scale up the "stunting-free village" model which aims to address stunting using the child scorecard to monitor and track nutrition indicators at individual and community levels to facilitate data-driven decisions.[30]

Support to improve the nutrition status of school-aged children and adolescents by enhancing nutrition knowledge of parents and school children and empower community members to become nutrition champions.

Promote social and behaviour change communication (SBCC) at community level to address malnutrition and nutrition-related non-communicable diseases (NCDs) through increased awareness and promotion of good practices including WASH, early stimulation of children, improved family diet and child feeding practices.

Activities:

3.1. Support establishment of community and homestead vegetable gardens including innovative approach such as using community vegetable nurseries to guarantee a sustainable seeds production of locally vegetable varieties for the homestead gardens, and support production of high protein rich leguminous crops such as soybeans

3.2. Support production of biofortified crops (e.g. High iron beans, vitamin A rich sweet potatoes and promote the planting of at least three fruit trees at household level

3.3. Support increased access to animal source proteins including eggs through homestead poultry rearing and adopt an innovative agroforestry practice to improve local production of food through promoting multipurpose plants (e.g., high-protein fodder boosting milk yields in animals, soil fertility for increased crop yields, environment protection and eco-friendly)

3.4. Provide capacity on basic food processing and preservation techniques/ tools to tackle seasonality food shortage and enhance nutritional value

3.5. Support the scale up of the improved nutrition-sensitive community-based savings and lending groups model through integration into government systems

3.6. Support NCDA to train district stakeholders and roll out the stunting-free village model including the child scorecard

3.7. Conduct school-based nutrition sensitization activities including the development of Information, Education and Communication (IEC) materials to improve nutrition awareness, and empower adolescents through positive life skills sessions and support the setting up of school gardens

[30] The "stunting-free village" model developed jointly by the UN, government and other partners has been adopted by NCDA as a model to contribute to accelerated reduction in stunting in the country.

3.8. Train parent committees, district, sector, cell and village leadership on nutrition of school-aged and adolescent children at the community level

3.9. Support to scale-up through government systems of the peer-to-peer support model for improved nutrition practices through integration into government systems

3.10. Provide technical support to implement the multisectoral plan of Rwanda Food-Based Dietary Guidelines at community level

3.11. Conduct formative research in Rutsiro and Ngororero districts to inform the conduct of gender-sensitive SBCC activities to promote adoption of good nutrition and hygiene practices using interpersonal, media (particularly mid-sized and print) and community mobilization approaches

3.12. Support awareness campaign with communication tools targeting communities to prevent nutrition-related non-communicable diseases

4. Sustainability

- **Government Commitment**

The GoR recognizes that malnutrition is a public health concern. Thus, nutrition is a priority across multiple national policies, plans and strategies. The GoR's commitment to the nutrition agenda is further demonstrated by the creation of the NCDA to coordinate nutrition as well as heightened awareness among donors on the importance of nutrition in development. The adoption of district level planning and coordination for nutrition further demonstrates this commitment. Annual District Plans for Elimination of Malnutrition (DPEM) are developed with support from the NCDA. Furthermore, specific nutrition interventions are occasionally included in performance contracts for District Mayors which demonstrates the GoR's commitment to ensure full participation by district authorities in the fight against malnutrition. However, there is still a need to improve linkages between the DPEM and the District Development Plans as well as central level planning and policy documents. The project will include specific activities to strengthen these linkages and thereby improve coordination, budgeting, implementation and monitoring of nutrition interventions.

- **UN Agencies Commitment**

The UN Nutrition Network in Rwanda has built-in qualities that provides enabling conditions for sustainability. Commitment to the project is secured by an MOU between the four founding UN agencies (UNICEF, WFP, WHO and FAO) as a way forward for the UN delivering as One to support scaling up nutrition by coordinating actions and combining resources to avoid overlap, duplications and promote optimal results. Project funds will be managed through a Multi-Partner Trust Fund arrangement, following the United Nations Sustainable Development Group (UNDG) structure, which will enable donors to contribute finances to this joint project. The Multi-Partner Trust Fund arrangement ensures systematic review and alignment of the allocations with the strategic development framework of the country and approved national priorities enshrined in the UN Development Assistance Framework.

5. Organization, Management and Administration

5.1 Project Duration

The project will be implemented over a period of 4 years (July 2021- June 2025) in Rutsiro and Ngororero Districts.

5.2 Project Governance, Management and Coordination

The JP represents a winning coalition bringing together the comparative strengths of multiple UN organizations under the critical leadership of the Government of Rwanda. It will take existing partnership arrangements between the GoR, the UN to a higher level, and is poised to draw in other pivotal actors in the Nutrition space as well as private sector actors.

The RCO will coordinate and oversee the JP while the four PUNOs will be responsible for its implementation. In order to ensure an integrated approach towards implementation and effective coordination, the PUNOs have developed a joint work plan (see Annex) and designated a lead agency (WFP) for as the joint project lead. On the GoR side, MIGEPROF will be the primary government lead on the project, while the Ministry of Local Government, Ministry of Health and other ministries and institutions will be involved in accordance with the joint work plan activities. Government ministries and institutions will play a key role in implementation and participate in decision-making.

The project will use existing UN structures and mechanisms for management and coordination, that were used during phases I & II of the project. The four participating UN organizations (FAO, UNICEF, WFP, and WHO) will be responsible for project coordination and implementation in collaboration with the NCDA and the DPEM committees at district level.

Specifically, for project management, a **Steering committee** (SC) is the governing body of the JP which is responsible for making decisions under the management of the project through dialogue and consensus. The committee will convene on bi-annual basis informed by progress against annual work plans. The committee will be chaired by NCDA, and co-chaired by the WFP. The Steering Committee (SC) will provide overall strategic direction for the project. The Steering Committee will comprise the heads of agencies of the four participating UN agencies, the donor and the Government.

Reporting to the steering committee, a Technical committee (TC) composed of experts from line ministries and PUNOs chaired by UNICEF, will support day to day running of the project and coordination with the government. It will ensure adequate quality control of the activities as listed out in the annual work plan. The TC will also hold joint coordination meetings with the intervention districts twice a year. Both the SC and TC will be supported by a UN Nutrition National Facilitator who will support the secretariat, ensure project coordination and support reporting. The Steering Committee will meet semi-annually and on ad-hoc basis as needed and make decisions through consensus. Decisions of the Steering Committee shall be duly recorded.

A High-Level Joint Review Committee will be established to ensure close collaboration with government counterparts and will comprise of high-level staff from the NCDA, participating UN agencies and the donor. It will meet once a year and on ad-hoc basis as required. Additionally, a Technical Joint Review Committee will be set up comprised of technical focal points from the NCDA, participating social cluster ministries and UN agencies. It will meet annually and on ad-hoc basis in advance of the High-Level Joint Review Committee meetings. Identified issues will be duly recorded and presented to the High-Level Joint Review Committee for decision making.

5.3 Implementing Partners

The project will be implemented by the social cluster ministries (including Ministries of Health, Agriculture, Gender and Family Promotion, Education, Local Government) at central, district and community levels with support from four UN agencies (FAO, UNICEF, WFP and WHO).

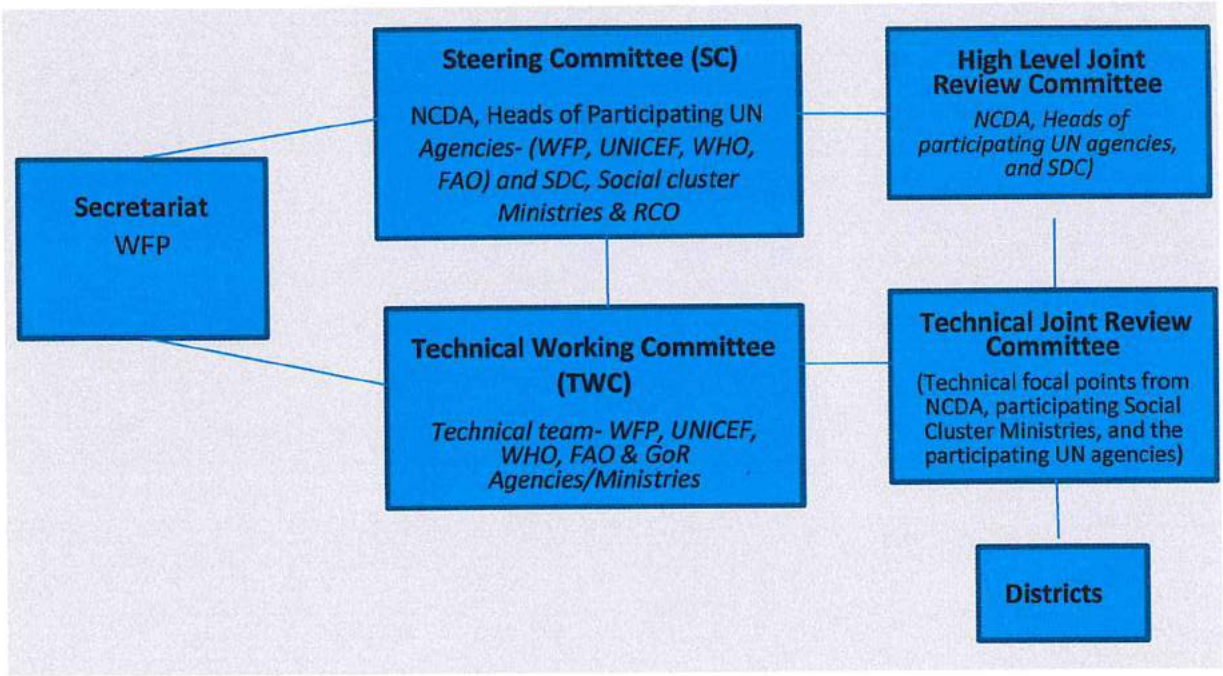


Figure 3: Project Management Set-Up

- **Role of the UN Resident Coordinator's Office**

The Resident Coordinator will strengthen authority and leadership of this joint project by providing strategic guidance, advocacy to implement the programme. The Resident Coordinator Office will ensure that operational activities for development are focused on advancing sustainable development and that communication and advocacy are jointly done to achieve the SDGs in a way that leaves no one behind and ensures respect for and protection of, human rights and gender equality. The Resident Coordinator's Office (RCO) will ensure alignment between the Cooperation Framework result framework and the Joint project. RCO will also be responsible for the quality assurance of the project as well as coordinating timely reporting of the results including support in data and financial aspects, results management and reporting to account for the Cooperation Framework.

- **Administrative Arrangements**

The funds will be channeled through the Rwanda Sustainable Development Fund and shall be administered by Multi- Partner Trust Fund (MPTF) Office, as Administrative Agent (AA), on behalf of the Participating UN Organisations and the Resident Coordinator as agreed with the Government. This will be administered in accordance with Regulations and Rules, and a Memorandum of Understanding signed by the Participating Organizations and the MPTF Office.

The MPTF as the designated AA will enter into funding agreement "Standard Administrative Arrangement with the donor" using pass through fund management with SDC and will receive contributions on behalf of all participating UN organizations. The AA will also develop and sign a Memorandum of Understanding (MoU) with Participating UN Organizations, which will stipulate the terms, conditions, and procedures for any transfer of funds. Following UNDG Joint Programming guidelines, the MoU will stipulate that the implementing UN agencies will manage the funds according to their own rules and regulations and will be solely and fully accountable for the use of those resources. Upon instructions from the Steering Committee, the AA will disburse the funds timely to the various UN organizations concerned as per approved project work plan and budget and MoU with participating UN agencies. The AA is accountable for financial and narrative reporting to the donor on the basis of consolidated reports submitted by the participating UN agencies in accordance with the Standard Administrative Agreement.

WFP will act as the lead agency with understanding that the participating UN agencies assume full programmatic and financial accountability for the funds disbursed to them by the AA. WFP will lead on the preparation of the narrative reports to the MPTF and the donor.

- **Financial Management and reporting**

The implementing UN organizations have set-up a Multi-Partner Trust Fund (MPTF) where all funds contributed by the donor will be deposited for the purpose of the implementation of the project. The AA shall disburse the funds to the participating UN agencies in accordance with instructions from the Steering Committee (SC), in line with the budget set forth in the project document, as amended from time by the SC. The disbursement will consist of direct and indirect costs as set out in the SAA. Each participating UN organization shall establish a separate account or fund under its financial regulations and rules for the receipt and administration of the funds disbursed to it by the AA for the joint project. That account shall be administered by each participating UN organization in accordance with its own regulations, rules, directives and procedures, including those relating to interest.

Full details on financial arrangements and reporting will be elaborated in the MOU between the AA and the participating UN agencies, as well as in the SAA between the AA and the donor.

6. Project Cost

The overall cost of the project will be US$7,073,547 of which US$ 5,316,863 will be funded by the Swiss Agency for Development and Cooperation (SDC) and US$1,756,684. UN contributions essentially covers the proportionate costs of staff time utilized in providing technical support and coordination of project activities. The UN will continue to explore funding opportunities to complement funds from SDC. The table below presents the repartition of the SDC contribution per agency.

Table 1: Budget allocation by agency[31]

Agency	Programme cost (USD)	Indirect Support Cost /ISC (7%) (USD)	Total SDC contribution (USD)	UN contribution (USD)	Total cost (USD)
UNICEF	1,225,980	85,819	1,311,799	706,242	2,018,041
FAO	1,090,000	76,300	1,166,300	330,000	1,496,300
WHO	1,145,000	80,150	1,225,150	215,920	1,441,070
WFP	1,458,360	102,085	1,560,445	504,522	2,064,967
Administrative Agent's Fee (1%)			53,169		53,169
TOTAL	**4,919,340**	**344,354**	**5,316,863**	**1,756,684**	**7,073,547**

NB: At least 20% of the total SDC contribution for programme cost for each participating agency will be implemented by local organizations.

[31] UN rate for the CHF4,950,000 is USD 5,316,863

Table 2: Budget Allocations for Each Activity

Outcomes	Intervention areas	Activities	Lead Agency	SDC Contribution ($)	Associated UN agencies	GoR partners
Outcome 1	Strengthen existing national coordination platforms, including SUN networks and technical working groups, as well as strengthening private sector's participation in nutrition through the establishment of SUN Business Network to enhance multi-sectoral collaboration, accountability, and synergies	1.1. UN Network for SUN facilitation to support the various multi-sectoral coordination platforms (TWGs, SUN Government platform and focal point, etc)	WFP	241,791	UNICEF, WHO, FAO	NCDA, MoH, MINAGRI
		1.2. Support the establishment of the SUN Business Network in Rwanda to private sector contribution to improving nutrition (including. development of strategy, terms of reference, action plan, awareness campaign, workshops/roundtable discussions operationalization of secretariat).	WFP	78,534	UNICEF, WHO, FAO	NCDA, Rwanda FDA, Private Sector Federation, Sight and Life
	Provide support to the NCDA and to District Plans to Eliminate Malnutrition (DPEM) committees to ensure integrated and effective planning, budgeting, implementation, and monitoring of national and district plans to ensure prioritization of high-impact evidence-based interventions and effective use of resources.	1.3. Support capacity building using an evidence-based, integrated and mentorship approach to strengthen use of results-based management and public financial management tools for improved planning, budgeting, implementation and monitoring of national and district nutrition plans	UNICEF	154,000	WFP, FAO, WHO	NCDA, MINALOC, LODA, RMI

	Promote increased government commitment for nutrition through strengthened collaboration with the Parliament network for SUN including conducting analysis of government's investment in nutrition-to support evidence-based decision making	1.4. Strengthen collaboration with the Rwanda Women Parliamentary Forum (FFRP), also known as the Parliament network for SUN, to support parliamentary oversight of multisectoral nutrition policies, programmes and budgets for improved impact, including supporting in-depth analysis of the national budget to inform advocacy for nutrition	UNICEF	255,600	FAO	FFRP, NCDA, MINECOFIN
	Improve the evidence base for nutrition, including nutrition monitoring systems, building on existing structures, and through documenting best practices and lessons learned	1.5. Support monitoring and evaluation of the improved nutrition-sensitive community-based savings and lending groups and the peer-to-peer support model for improved nutrition practices (see activity under SO 3) to assess impact on households' food and nutrition security and resilience	UNICEF	114,390	WFP, WHO, FAO	MINALOC, LODA, NCDA, RBC, Local NGO
		1.6. Conduct a survey of the nutrition services provided in the Integrated-Management of Childhood Illnesses, immunization and NCDs services at health center level (baseline and end-line, survey representative of all districts) and a cohort study of babies born with LBW (mid-term and end-line)	WHO	100,000	UNICEF	RBC/MCCH division, NCDA
		1.7. Carry out a gap analysis of the food safety system among key line ministries using a holistic approach (One Health)	FAO	20,000	WHO	MINAGRI, MINISANTE, MoE, RSB, Rwanda FDA

		1.8. Conduct baseline and endline surveys for the project's impact evaluation	WHO	100,000	FAO, UNICEF and WFP	NCDA/MIGEPROF, MINISANTE, MINAGRI, MoE MINALOC
		1.9. Produce and disseminate joint communication materials about the project	UNICEF	40,000	FAO, WFP and WHO	NCDA/MIGEPROF, MINISANTE, MINAGRI, MoE MINALOC
Outcome 2	Strengthen inter-sectoral capacity on promotion of One Health to contribute to optimal health and nutrition outcomes	2.1. Provide technical support to operationalize One Health platforms including One Health Secretariat and Technical Working Groups engaged in planning, implementation, communication, advocacy and M&E of One Health Strategic Plan	FAO	90,000	WHO	MINAGRI, MINISANTE, MoE
		2.2. Develop or revise regulatory standards and guidelines on food safety using One Health approach	FAO	20,000	WHO	MINAGRI, MINISANTE, MoE,RSB, Rwanda FDA
	Strengthen the capacity of care providers through the health, ECD, education and agriculture systems to identify, prevent and manage cases with malnutrition	2.3. Training and supervision of primary and secondary school teachers on health and nutrition (4 districts per year)	WHO	200,000	UNICEF, WFP, FAO	MINEDUC
		2. 4.Capacity building (Training, supervision and provision of tools) of health care providers from health centers (IMCI and Immunization officers) on growth monitoring, identification of cases with acute malnutrition, counselling for	WHO	250,000	UNICEF	RBC/MCCH division and NCDA

		feeding, management of acute malnutrition and introduction of Care for Child Development (CCD) in health facilities (all districts)				
		2.5. Capacity building of health care providers at health center and community level for follow up of Low Birth Weight (LBW) babies up to the age of 2 years with growth monitoring, micronutrient supplementation and counselling to mothers/caretakers: trainings, supervision and supply chain follow up (2 selected districts)	WHO	185,000	UNICEF	RBC/MCCH division and NCDA
		2.6. Strengthen the capacity of district and health centre nutritionists and data managers to improve nutrition data quality gaps, use of the national nutrition app and facilitate analysis of nutrition data (antenatal, postnatal and child) to ensure timely detection and management of malnutrition	WFP	40,000	UNICEF, WHO	NCDA, RBC
		2.7. Train school stakeholders on nutrition and food safety to contribute to healthy school food environment.	WFP	30,000	WHO, FAO	MINEDUC, NCDA
	Strengthen the capacity of health care providers on nutritional care for prevention and management of Non-Communicable Diseases	2.8. Capacity building (Supportive supervision) of health care providers at health center and community level to sensitize families on healthy diet and nutritional care for prevention and management of nutrition-related NCDs (all districts)	WHO	230,000	UNICEF	
	Strengthen the capacity of food suppliers and regulators on food safety to reduce the risk of	2.9. Train food business operators (e.g., local manufacturers, wholesalers, distributors and retailers) on complying with food quality and	FAO	450,000	WHO	

	contamination of food stuffs and associated illnesses.	safety standards to prevent food-borne diseases				
		2.10. Train major media practitioners on reporting issues affecting food safety and promote community education to prevent COVID-19 and food-borne diseases among the general population of Rwanda	FAO	25,000	WHO	Rwanda FDA, MINISANTE, MINAGRI, RICA
		2.11. Train primary producers, food handlers, food inspectors and analysts on One Health approach	FAO	40,000	WHO	MINAGRI, Rwanda FDA, RSB, RICA
Outcome 3	Support improved local production of nutrient-dense foods among poor and vulnerable households that are land constrained (such as kitchen gardens, community nurseries, fruits trees, and small livestock) as well as small scale food processing (e.g. vegetable and fruit drying).	3.1. Support establishment of community and homestead vegetable gardens including innovative approach such as using community vegetable nurseries to guarantee a sustainable seeds production of locally vegetable varieties for the homestead gardens, and support production of high protein rich leguminous crops such as soybeans	FAO	200,000	UNICEF	MINAGRI, Districts
		3.2. Support production of biofortified crops (e.g. High iron rich beans, vitamin A rich sweet potatoes and promote the planting of at least three fruit trees at household level	FAO	100,000	WFP	
		3.3. Support increased access to animal source proteins including eggs through homestead poultry rearing and adopt an innovative agroforestry practice to improve local production of food through promoting	FAO	300,000	UNICEF, WFP	MINAGRI, Districts

		multipurpose plants (e.g. high-protein fodder boosting milk yields in animals, soil fertility for increased crop yields, environment protection and eco-friendly)				
		3.4. Provide capacity on basic food processing and preservation techniques/ tools to tackle seasonality food shortage and enhance nutritional value	FAO	150,000	UNICEF	MINAGRI, RAB, NCDA
	Support the scale up of nutrition-sensitive interventions including the improved model of community-based savings and lending groups to strengthen households' nutrition resilience in the context of COVID-19	3.5. Support the scale up of the improved nutrition-sensitive community-based savings and lending groups model through integration into government systems	UNICEF	325,995	FAO	MINALOC, LODA, NCDA NGO
	Support NCDA to scale up the "stunting-free village" model which aims to address stunting using the child scorecard to monitor and track nutrition indicators at individual and community levels to facilitate data-driven decisions	3.6. Support NCDA to train district stakeholders and roll out the stunting-free village model including the child scorecard	WFP	238,035	UNICEF, WHO, FAO	NCDA, district authorities
	Support to improve the nutrition status of school-aged children and adolescents by enhancing nutrition knowledge of parents and school children and empower community members to become nutrition champions	3.7. Conduct school-based nutrition sensitization activities including the development of Information, Education and Communication (IEC) materials to improve nutrition awareness, and empower adolescents through positive life skills sessions and support the setting up of school gardens	WFP	330,000	UNICEF WHO	MINEDUC, NCDA, RBC

		3.8. Train parent committees, district, sector, cell and village leadership on nutrition of school-aged and adolescent children at the community level	WFP	50,000	UNICEF WHO	MINEDUC, NCDA, District Authorities
	Promote social and behaviour change communication (SBCC) at community level to address malnutrition and related non-communicable diseases (NCDs) through increased awareness and promotion of good practices including WASH, early stimulation of children and improved child feeding practices.	3.9. Support to scale-up through government systems of the peer-to-peer support model for improved nutrition practices through integration into government systems	UNICEF	335,995	WFP, WHO	NCDA, RBC, NGO
		3.10. Provide technical support to implement the multisectoral plan of Rwanda Food-Based Dietary Guidelines at community level	FAO	100,000	WHO, UNICEF, WFP	MINAGRI, NCDA
		3.11. Conduct formative research in Rutsiro and Ngororero districts to inform the conduct of gender-sensitive SBCC activities to promote adoption of good nutrition and hygiene practices using interpersonal, media (particularly mid-sized and print) and community mobilisation approaches	WFP	450,000	UNICEF	NCDA, District Authorities
		3.12. Support awareness campaign with communication tools targeting communities to prevent nutrition-related non-communicable diseases	WHO	80,000	UNICEF, WFP	RBC/NCD division
TOTAL **cluding 1%** **fee and 7%** **ISC)**				**5,316,863**		

7. Monitoring and Evaluation

- **M&E Plan**: The four UN agencies will adopt a harmonized M&E plan for the project. The frequency of data collection will be based on the project's logical framework. Robust monitoring of all interventions will be done, both as a way of coordinating on-going activities and to identify bottlenecks and track progress and results. All M&E data will be disaggregated by sex and age wherever possible, with the aim of mainstreaming gender and women empowerment. In addition, the data will be assessed relative to the project's targeting mechanism. The project M&E logical framework defines the causal relationship between outputs, outcomes, and impact of the project. Outputs are tracked through activity monitoring, while outcome level results are determined through surveys which measure the reduction in prevalence of stunting and micronutrient deficiencies among pregnant and lactating women, and children less than two years of age, in supported communities. Project progress reports, secondary data, surveys, meetings' minutes, training reports, and project evaluation reports will be the main sources of project data collection. There will be efforts to establish information collection and consolidation mechanisms within the context of already existing systems and government staff capacities, roles, and responsibilities.
- **Baseline and end line surveys:** The project will carry out a survey in the targeted districts at the beginning of the project to obtain baseline values of the indicators in the logframe. The baseline results will be the basis for comparison for outcome and output reporting. A mid-term review will be conducted using secondary data. An end line survey will be carried out by the end of the project cycle, to assess the project's impact.
- **The Comprehensive Food Security and Vulnerability Assessment (CFSVA):** The Comprehensive Food Security and Vulnerability Assessment is done every 3 years. It aims to analyse the food security, nutrition and vulnerability conditions of population groups and communities in the country, and to provide information to actors focusing on food and nutrition insecurity. It also provides district-level food security and nutrition situation. The 2021 CFSVA is currently ongoing and may serve as baseline for the project and the next CFSVA, which is planned for 2024, may serve as the end line to assess the impact of the project.
- **Crop Assessment**: The Ministry of Agriculture and Animal Resources (MINAGRI) in collaboration with Rwanda Agriculture Board (RAB)/Rwanda Agricultural Development Authority (RADA), the National Institute of Statistics of Rwanda (NISR), and WFP, regularly organizes a crop assessment survey for each agricultural season. The assessment provides users with statistics on the area food crops are planted, yield and crop production, and food security status in terms of energy coverage (Kcal/capita/day).
- **Rwanda Demographic Health Survey (RDHS):** The Demographic and Health Survey is designed to provide data for monitoring the population and health situation in Rwanda. The objective of the survey is to provide up-to-date information on fertility, family planning, childhood mortality, nutrition, maternal and child health, domestic violence, malaria, maternal mortality, awareness and behaviour regarding HIV/AIDS, HIV prevalence, malaria prevalence, and anaemia prevalence. The survey is conducted every 5 years. The last RDHS survey was done in 2019-20 with the final report expected in June 2021.
- **Reporting System:** Each participating UN organization covering the area of intervention will ensure output monitoring in close collaboration with the partner government institution. With their respective government partners, UN agencies will provide a progress report quarterly and these reports will be consolidated by the Technical Working Committee (TWC) using a common reporting format based on the approved annual work plan and budget. The TWC will ensure the preparation of a consolidated annual project report (narrative and financial), which will be submitted to the Project Steering Committee for submission to the donor and the UN Country Team in accordance with the MOU reporting requirement. Reporting requirements will be in accordance with agreed reporting schedules as per MOU and Standard Administrative Arrangement.

8. Communication

The project will produce and disseminate joint communication materials, including a documentary, human interest stories with video, social media posts and high-quality photographs.

9. Risk monitoring and management

Identified risks to the achievements of the project's objectives are shown in below table:

Table 3: Risk analysis matrix

Contextual risks			
Main identified risks related to the intervention	**Probability of incidence (Low, Medium, High)**	**Impact**	**Mitigation**
Additional COVID-19 restrictions	Medium	Delays in project implementation due to measures put in place to minimize COVID-19	Regular consultation with government counterparts and the donor to find solutions to emerging challenges and explore possible alternative ways of implementing activities that are affected Accelerating the implementation of the project's activities where possible.
Changes in government counterpart structures and priorities	Medium	Delays in project implementation due to re-focusing of government priorities and availability for implementation Decreased commitment of local authorities and communities to fully implement various project activities Decreased likelihood for sustainability of project gains and scaling up	
Institutional risks			
Main identified risks related to the intervention	**Probability of incidence (Low, Medium, High)**	**Impact**	**Mitigation**

Discontinuity of the UN joint approach to nutrition to assist the GOR to accelerate the scale up of, quality and sustainability of food and nutrition actions	Low	The UN coordination for nutrition may not be sustained	The One UN joint approach to nutrition has key elements for improved sustainability: 1. An MOU between the four participating UN agencies (FAO, UNICEF, WFP, and WHO) securing inter-agency collaboration 2. The approach is country-led and country-specific 3. The approach acts as a catalyst to integrate complementary skills and activities 4. Nutrition is a priority in the UNDAF, which ensures continued focus on nutrition actions
Programmatic risks			
Main identified risks related to the intervention	**Probability of incidence (Low, Medium, High)**	**Impact**	**Mitigation**
Task overload and limited capacity of district and national technicians	Medium	Project activities implementation might be delayed	The project will invest in building the capacity of national and district counterparts and ensure that technical assistance and other inputs will be provided timely
Limited capacity of project beneficiaries to adopt good nutrition practices due to competing priorities and limited means	Medium	Inadequate participation of directly targeted groups, decreased effectiveness of project interventions	The project will include tailored social and behaviour change communication interventions, which will support efforts to create a supportive enabling environment and individually oriented behaviour change activities at community level to adopt optimal maternal and child nutrition practices. Also, the community-based savings groups will help vulnerable households to better manage their income and access credits which will

			facilitate improved financial access to e.g. nutritious food.
Limited funds to fully support the needs	Medium	Limited coverage Limited effectiveness of joint nutrition intervention package	UN agencies will continue exploring opportunities to engage more donors and development partners in supporting the project interventions, including through fundraising.

10. Annexes

Annex A: Key nutrition stakeholders in Rwanda

Stakeholder	Project name	Duration	Implementing partner (s)	Project aim/ key intervention areas	Districts
SDC	Effectively fighting chronic malnutrition in Rwanda	2017-2021	FAO, UNICEF, WFP, WHO	Aims to contribute to the government's efforts to effectively fight against stunting in Rwanda.	National level
	Nutrition in secondary cities	2021-2025	Swiss TPH, Sight and Life, Syngenta	Aims to contribute to improved nutrition among consumers, including the most vulnerable ones, living in the urban, peri-urban and rural areas.	Rubavu and Rusizi
USAID	Hinga Weze	2017-2022	CNFA	Aims to sustainably increase smallholder farmers' income, improve the nutritional status of women and children, and increase the resilience of Rwanda's agricultural and food systems to a changing climate	Bugesera, Gatsibo, Kayonza, Ngoma, Karongi, Ngororero, Nyabihu, Nyamasheke, Rutsiro and Nyamagabe
	Orora Wihaze	2019-2024	Land O Lakes	Aims to sustainably increase the availability of, access to, and consumption of animal-source foods (ASF) through development of a profitable market.	Burera, Gakenke, Nyamagabe, Nyamasheke, Rutsiro, Ngororero, Kayonza and Ngoma
	INECD activity	2021-2026	TBD	Aims to promote nurturing and responsive care practices, especially in the areas of health, functioning,	Kayonza, Ngoma, Nyabihu, Ruhango, Nyanza, Kicukiro, Nyarugenge,

				nutrition, and early childhood development (ECD) for caregivers and children	Rwamagana, Rutsiro and Rubavu
EKN	Accelerating Stunting Reduction Among under two Children in Rwanda		UNICEF and its IPs	Aims to harness the power of integrated programming for nutrition and ECD to ensure that children in Rwanda reach their full developmental potential	Nyamagabe, Ngororero, Rutsiro, Gakenke, Burera, Rubavu, Nyaruguru, Karongi, Gicumbi, Nyamasheke, Gatsibo, Rusizi, Nyagatare and Musanze
	HortInvest	2017-2021	SNV	Aims to increase farmers' incomes, grow the relative contribution of the horticultural sector to the regional economy, and improve the food and nutrition security of the targeted households.	Ngororero, Rutsiro, Rubavu, Muhanga, Kicukiro, Nyabihu and Karongi
EU	Budget support and technical assistance		Government (MINAGRI)	Aims to support government programmes to improve nutrition among rural communities, expand the number of food-secure households, make farmers more efficient in cropping patterns and land use, and extend the irrigation network to cover more households	National level
World Bank	SPRP	2018-2023	Government (MoH and NCDA)	Aims to support the government to adopt and implement a bold, new national strategy to improve the visibility of stunting in Rwanda, and to deliver harmonized behaviour change messages across various platforms	Nyabihu, Ngororero, Karongi, Rubavu, Rutsiro, Rusizi, Nyamagabe, Huye, Nyaruguru, Ruhango, Gakenke, Kayonza, and Bugesera
	SAIP	2018-2023	Government (MINAGRI)	Aims to increase agricultural productivity, market access, and food security of the targeted	Rulindo, Rwamagana, Karongi, Rutsiro, Kayonza, Nyanza,

				beneficiaries in the project intervention areas.	Gatsibo, and Nyabihu
	NSDS	2018-2023	Government (LODA)	Aims to address the demand and supply side constraints to chronic malnutrition	Nyabihu, Ngororero, Karongi, Rubavu, Rutsiro, Rusizi, Nyamagabe, Huye, Nyaruguru, Ruhango, Gakenke, Kayonza, and Bugesera
JICA	Sector Policy Loan for Nutrition Improvement through Agriculture Transformation		Government (MINAGRI)	Aims to assist Rwanda's effort to tackle malnutrition in Rwanda	-

Annex B: District analysis

District	Stunting level (CVSVA 2018)	Stunting level score	Food insecurity (CFSVA 2018)	Food insecurity score*	Poverty rates (EICV5)	Poverty rates score	Total score	Stakeholders
Rutsiro	54%	3	49%	3	50%	3	9	USAID, EKN, WB
Nyabihu	53%	3	26%	1	47%	3	7	USAID, EKN, WB
Rubavu	50%	3	22%	1	36%	2	6	SDC, USAID, EKN, WB
Burera	49%	3	30%	2	50%	3	8	USAID, EKN
Ngororero	48%	3	41%	2	48%	3	8	USAID, EKN, WB
Nyaruguru	48%	3	24%	1	52%	3	7	EKN, WB
Nyamagabe	43%	2	30%	2	49%	3	7	USAID, EKN, WB
Kayonza	42%	2	33%	2	27%	1	5	USAID, WB
Nyamasheke	42%	2	21%	1	69%	4	7	USAID, EKN
Rulindo	42%	2	17%	1	54%	3	6	WB
Gakenke	41%	2	15%	1	34%	2	5	USAID, EKN, WB
Gicumbi	38%	2	17%	1	35%	2	5	EKN
Gisagara	38%	2	24%	1	56%	3	6	-
Gatsibo	37%	2	10%	1	42%	2	5	USAID, EKN, WB
Musanze	37%	2	11%	1	41%	2	5	EKN
Ngoma	37%	2	13%	1	38%	2	5	USAID
Karongi	35%	2	25%	1	53%	3	6	USAID, EKN, WB
Rusizi	35%	2	25%	1	34%	2	5	SDC, EKN, WB
Huye	33%	2	14%	1	40%	2	5	WB
Nyanza	33%	2	20%	1	47%	3	6	USAID, WB
Kamonyi	32%	2	23%	1	22%	1	4	-
Kirehe	32%	2	23%	1	45%	3	6	-
Muhanga	32%	2	13%	1	33%	2	5	EKN
Rwamagana	31%	2	12%	1	19%	1	4	USAID, WB
Ruhango	30%	2	18%	1	38%	2	5	USAID, WB
Nyagatare	29%	1	17%	1	45%	3	5	EKN
Bugesera	25%	1	9%	1	40%	2	4	USAID, WB
Gasabo	14%	1	2%	1	16%	1	3	-
Nyarugenge	13%	1	1%	1	12%	1	3	USAID
Kicukiro	12%	1	3%	1	11%	1	3	USAID, EKN

* Scoring: 1 = Less than 30, 2= 30-45, 3= 45-60, 4= above 60

Annex C: Project Results Framework

Hierarchy of Objectives Strategy of Intervention	Key Indicators	Baseline	Target	Data Sources Means of Verification
Impact (Project Goal)	***Impact Indicators***			
To support the Government's efforts to reduce stunting in Rwanda with a focus on infants, children, adolescents, and women.	• Stunting in children younger than five (U5) • Minimum Acceptable Diet (MAD) • Minimum Dietary Diversity for Women of Reproductive Age (MDD-W) • Percentage of households with adequate food consumption score	• Stunting U5: Rutsiro: 54%, Ngorero: 48% • MAD in infants and children 6 to 23 months: 22% (DHS 2019-20)* • MDD-W: 28%* (CFSVA 2018) • Percentage of households with adequate food consumption [32]: Rutsiro: 37%, Ngororero district: 51% * Baseline data for Rutsiro and Ngororero districts will be available through the baseline survey	1,5 percentage points increase per year for all four impact indicators in the interventio n districts	Baseline and endline surveys
Outcome 1: Strengthened Government capacity in effective and equity-focused policy formulation, strategic planning, coordination, M&E and domestic funds mobilization across different sectors, including WASH, ECD, health, social protection, education and agriculture, along with an increased participation of private sector and civil society actors for sustained nutrition gains.				

[32] Food consumption is based on the food consumption score which compute the number of food groups consumed in a week (diversity) and how often in a week they are consumed (frequency).

Intervention area	Hierarchy of Objectives Strategy of Intervention	Key Indicators	Baseline	Target	Data Sources Means of Verification
Strengthen existing national coordination platforms, including SUN networks and technical working groups, as well as strengthening private sector's participation in nutrition through the establishment of SUN Business Network to enhance multi-sectoral collaboration, accountability, and synergies	*Output 1.1:* Multi-sectoral food and nutrition coordination mechanisms, systems and plans are well functioning for the implementation of effective evidence-based interventions	TOR for the food, nutrition and WASH coordination meetings are revised and adopted to ensure a well-functioning coordination platform	No	Yes	Meeting reports
		Number of SUN country team meetings organised	Once per year	Twice a year	Meeting reports
		Number of SUN Business Network member convenings (meetings/events) Number of tools/guidance documents/best practices disseminated to businesses	0 0	2 1	Meeting/Events reports Final versions of the tools/guidance documents

Provide support to the NCDA and to District Plans to Eliminate Malnutrition (DPEM) committees to ensure integrated and effective planning, budgeting, implementation, and monitoring of national and district plans to ensure prioritization of high-impact evidence-based interventions and effective use of resources		District Plans for the Elimination of Malnutrition (DPEM) in the two priority districts are clearly linked with other relevant plans (such as the district development plan (DDP) and are developed using RBM and PFM tools	No	Yes	DPEM and DDP
		NCDA has capacity to guide central and district nutrition actors on the use of RBM and PFM for improved planning for nutrition	No	Yes	Training and mentorship reports
Promote increased government commitment for nutrition through strengthened collaboration with the Parliament network for SUN including conducting analysis of government's investment in nutrition to support evidence-based decision making		The SUN Parliament Network carries out annual budget reviews for nutrition to assess and address gaps	No	Yes	Nutrition budget analysis report

Improve the evidence base for nutrition, including nutrition monitoring systems, building on existing structures, and through documenting best practices and lessons learned	*Output 1.2:* Evidence and M&E systems for nutrition are improved to inform evidence-based advocacy and programming	Assessment of nutrition services within IMCI and immunization services conducted at baseline and endline; cohort study of stunting in babies born with Low Birth Weight conducted at mid-term and endline Gap analysis of the food safety system among key line ministries conducted	Baseline assessment conducted No	Mid-term and end-line surveys conducted Yes	Survey reports finalised Gap analysis report
		% of children under two years reached with the child scorecard	TBC	80% in Rutsiro and Ngororero districts	Monthly nutrition situation reports for village, cell, sector and district levels
		Regular reports are produced on the community-based savings groups and peer-to-peer support through government routine systems to allow for programme monitoring and adjustments	No 0	Yes 2	LODA monitoring reports Study reports

		Number of studies to inform the community-based savings and lending group peer-to-peer support groups programming are carried out			
		Baseline and endline surveys carried out timely with good quality data	0	Baseline survey carried out at year 1 Endline survey carried out at year 4	Baseline survey report Endline survey report
		Joint communication materials timely produced and disseminated	0	2 human interest stories At least 5 social media posts At least 50 high quality photos every year	Communication materials produced and disseminated
Outcome 2: Well-equipped service providers working in health, agriculture, social protection, ECD and education that provide quality nutrition-related services to communities contributing to the reduction of malnutrition including stunting in children.					
Intervention area	**Hierarchy of Objectives** **Strategy of Intervention**	**Key Indicators**	**Baseline**	**Target**	**Data Sources Means of Verification**
Strengthen inter-sectoral capacity on promotion of One Health to contribute to	*Output 2.1:* The inter-sectoral capacity on promotion of One Health is	The One Health Secretariat established and operational Up-to-date regulatory	No	Yes	Meeting reports

optimal health and nutrition outcomes	strengthened to contribute to optimal health and nutrition outcomes	standards and guidelines on food safety using One Health approach are available	No	Yes	Standards and reports
Strengthen the capacity of care providers through the health, ECD, education and agriculture systems to identify, prevent and manage cases with malnutrition	*Output 2.2:* The capacity of schools is strengthened to educate school aged children and adolescents on health and nutrition and to contribute to healthy school food environment	Average number of training sessions targeting primary and secondary schools' students on health and nutrition Number of training sessions for headteachers, teachers, cooks, storekeepers, and parents' committees on nutrition and food safety % of schools with improved food safety, handling and storage practices	0 0 0%	Once per week per class 1 per year 80%	Reports from Ministry of Education Training reports Monitoring reports
	Output 2.3: The capacity of health care providers is strengthened to improve maternal infants and young children surveillance, prevention and management of undernutrition	% of children under five with severe acute malnutrition who received outpatient treatment % of children under five with severe acute malnutrition and medical complications	TBC TBC Baseline assessment	80% 60 % Twice the % from baseline survey	CFSVA 2021 Assessment of nutrition services through IMCI and immunization services

	and nutrition related NCDs	identified at health centre level and referred for inpatient care % of caretakers attending either IMCI or immunization services who received counselling for feeding			Assessment of nutrition services through IMCI and immunization services
		% of Low-Birth-Weight babies being stunted at 2 years of age.	Mid-term survey in two districts	Twice less from baseline	Cohort study of LBW babies at mid-term and end term
		% of health centres in the two districts with good quality of nutrition data reported to HMIS and NCDA Monitoring Information System (MIS)	TBC	70% of health centres	NCDA MIS and HMIS reports
Strengthen the capacity of health care providers on nutritional care for prevention and management of nutrition-related Non-Communicable Diseases		Number of counselling sessions to patients on nutrition provided by Health care providers working in Non-Communicable Diseases (NCDs) services	Baseline assessment	Twice more than baseline assessment	Assessment of nutrition services with NCD services at health center level
Strengthen the capacity of food suppliers and regulators on food safety to reduce the risk of	*Output 2.4*: The capacity of food business operators, inspectors and analysts strengthened	% of food suppliers compliant with Rwanda FDA guidelines on registration and	0%	100%	Reports of trainings; Rwanda FDA progress reports

contamination of food stuffs and associated illnesses.	to provide safe foods.	licensing of food premises Inter-sectoral roles and responsibilities on national food control systems are in place and mainstreamed across sectors strategies Number of media professionals trained on communicating Food safety related issues	No 0	Yes 100	Progress reports Training reports
Outcome 3: Empowered communities in targeted districts improve their nutrition situation through creating better access to and consumption of a variety of nutrient-dense foods, early identification and prevention of cases of malnutrition, decreased risk of infectious and diarrhoeal diseases through improved hygiene and health practices and increased resilience against shocks.					
Intervention area	**Hierarchy of Objectives** **Strategy of Intervention**	**Key Indicators**	**Baseline**	**Target**	**Data Sources Means of Verification**
Support improved local production of nutrient-dense foods among poor and vulnerable households that are land constrained (such as kitchen gardens, community nurseries, fruits trees, and small livestock) as well as small scale food	Output 3.1: Community members and leaders are empowered to produce and consume safe and nutrient-dense foods including basic processing and preservation techniques of fruits/ vegetables and monitor nutrition situation of	% of targeted vulnerable households with access to nutrient dense foods (e.g. vegetables, animal-sourced foods and biofortified foods) % of targeted households trained on basic techniques on vegetable and	Baseline assessment Baseline assessment	100% 100%	Progress reports Progress reports

processing (e.g. vegetable and fruit drying).	children using the scorecard and village board for timely detection of stunting and decision making	fruit processing and preservation			
Support NCDA to scale up the "stunting-free village" model which aims to address stunting using the child scorecard to monitor and track nutrition indicators at individual and community levels to facilitate data-driven decisions		% of community health workers and village leaders in Rutsiro and Ngororero districts trained on the child scorecard Number of community health workers and village leader meetings to discuss the nutrition situation in Rutsiro and Ngororero districts to inform decision making	Baseline assessment Baseline assessment	90% Once a quarter	Training reports Quarterly monitoring reports
Support the scale up of nutrition-sensitive interventions including the improved model of community-based savings and lending groups to strengthen households' nutrition resilience in the	*Output 3.2:* The improved model of community-based savings and lending groups is integrated and scaled up through Government systems	The nutrition-sensitive community-based savings and lending groups model is scaled up nationally through existing government systems % of villages in the two target districts with active nutrition-sensitive	No 0%	Yes 80%	LODA monitoring reports LODA monitoring reports

context of COVID-19		community-based savings and lending groups			
Support to improve the nutrition status of school-aged children and adolescents by enhancing nutrition knowledge of parents and school children and empower community members to become nutrition champions	*Output 3.3:* Knowledge of school children including adolescents on nutrition strengthened and their skills enhanced to set up school gardens	% of targeted primary schools in Rutsiro and Ngororero districts with school gardens set-up and maintained	Baseline assessment	100% of targeted schools	Monitoring reports
		% of school children in targeted primary schools in Rutsiro and Ngororero districts who can recall hearing or seeing at least 60% of the promoted messages	Baseline assessment	80%	
		% of parents' committees, district, sector, cell and village leaders trained on nutrition in Rutsiro and Ngororero districts	0	50%	Monitoring reports

Promote social and behaviour change communication (SBCC) at community level to address malnutrition and related non-communicable diseases (NCDs) through increased awareness and promotion of good practices including WASH, early stimulation of children and improved child feeding practices.	*Output 3.4:* Household members have increased knowledge for adoption of good nutrition and hygiene practices and prevention of nutrition-related NCDs	% of households in targeted districts reached by interpersonal SBCC approaches	0%	30% of households with children U5	Monitoring reports
		% of households in targeted districts exposed to SBCC approaches using media (mid-sized, traditional media, mobile technology)	0%	50% of households with children U5	Monitoring reports
		SBCC strategy informed by findings of formative research in Rutsiro and Ngororero districts available	No	Yes	Formative research report
		Peer-to-peer support modelled scaled up country-wide through existing government systems	No	Yes	Monitoring reports
		% of villages in the two target districts with active peer-to-peer support groups	0%	80%	Monitoring reports
		% of villages who received IEC materials or radio messages on healthy diet	0%	30%	Reports of supervision from RBC communication division

		for prevention of nutrition related NCDs disseminated			