

EVALUATION OF THE POWER OF NUTRITION FINDINGS FROM THE MIDLINE ASSESSMENT

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Anitha Sivasankaran, Anu Rangarajan, Dadirai Fundira,
Heather Ingraham, Eline Korenromp, Nadia Carvalho,
and William Winfrey



I. Introduction

Undernutrition is one of the world's most pressing problems, contributing to nearly half of all deaths of children under 5 and causing a loss of billions of dollars to the global economy through diminished productive capacity and health care costs (World Health Organization 2016; World Bank 2017). Despite the prevalence of proven, cost-effective interventions to address undernutrition, efforts to address it face an estimated USD 10.3 billion annual funding gap (Milken Institute 2013). The Power of Nutrition, launched in April 2015, is a partnership of investors and implementers committed to helping children grow to their full potential, ending the cycle of undernutrition, and enabling countries to build strong and prosperous communities. The Power of Nutrition seeks to do this by (1) raising new funds for nutrition, (2) stimulating donor investments through co-financing, (3) investing in ambitious programs that deliver results at scale, and (4) raising the prioritization of nutrition among key institutions and partner countries through commitment of domestic funds. It works towards these objectives by bringing together a network of donors interested in investing in nutrition and by working closely with implementing partners who have deep expertise working with country governments.

In November 2016, Mathematica and its partner, Avenir Health, were contracted by the Children's Investment Fund Foundation (CIFF) on behalf of The Power of Nutrition's board of trustees to conduct an external global evaluation of The Power of Nutrition. The vision was for the global evaluation to assess The Power of Nutrition's impact and influence on the nutrition landscape drawing on findings across The Power of Nutrition's portfolio of donors and investments; provide strategic, real-time feedback and inputs to The Power of Nutrition for monitoring and course correction, if needed; and extract insights and lessons to expand and replicate the model.¹ In 2017, Mathematica conducted a baseline assessment of The Power of Nutrition drawing on rich qualitative information from key stakeholders to document the origin and early vision for The Power of Nutrition, the evolution of its model, the progress around fundraising and investment goals, and early perceptions of its achievements, challenges, and lessons learned.

This report presents findings from the midline assessment, conducted approximately two years after our baseline study, to examine the progress made by The Power of Nutrition toward its key objectives, four years after it was established. In this report, we provide updates on the successes and challenges of The Power of Nutrition's fundraising efforts and new investments, and stakeholders' perceptions about The Power of Nutrition's influence in the nutrition landscape. We also provide an early look at the progress made by The Power of Nutrition's first three investments in improving coverage of key nutrition interventions and outcomes, as well as the extent to which these partner countries prioritize nutrition. The endline assessment, to be conducted in 2023, will examine

¹ The Power of Nutrition and its implementing partners also commission various types of independent evaluations, operations research, and monitoring and evaluation efforts at the country level to track progress in the countries in which it makes investments, which the global evaluation would draw from.

a total of six of The Power of Nutrition's investments (including the first three investments and three additional investments selected to represent its diverse portfolio), in delivering results at scale, as well as the success of their efforts in reinforcing the priority of nutrition in the partner countries.

The rest of this report is organized as follows. Section II provides a brief overview of The Power of Nutrition's approach. Section III outlines the evaluation approach including the key research questions, data sources, and our analysis approach. Section IV summarizes findings from our assessment of The Power of Nutrition's achievements and key learnings with respect to its objectives. Section V summarizes the future priorities and recommendations. The report includes three annexes, which contain our early assessments of The Power of Nutrition's investments in Tanzania, Liberia and Ethiopia.

II. Overview of The Power of Nutrition

The Power of Nutrition is a partnership of investors and implementing partners committed to addressing the current financing shortfall for nutrition and to supporting evidence-based interventions to improve nutrition outcomes. The CIFF and the United Kingdom's Foreign, Commonwealth and Development Office (FCDO), previously Department for International Development (DfID), were the founding funders, and the UBS Optimus Foundation was the first investor. Together, these three organizations provided the initial funding to create The Power of Nutrition. When The Power of Nutrition was first set up, the World Bank and UNICEF were identified as implementing partners. Since then, The Power of Nutrition has expanded the set of implementing partners it works with. The Power of Nutrition's implementing partners work directly or with governments and other entities in countries to implement programs. The Power of Nutrition has four key objectives:

- 1. Raise new funds for nutrition.** The Power of Nutrition seeks to mobilize new sources of funding for nutrition from a largely untapped market of nontraditional donors for nutrition, including the private sector and individuals of high net worth. The Power of Nutrition uses a variety of approaches for fundraising, including organizing events, conducting individual outreach, and leveraging the networks of its staff and board members to target and build relationships with potential investors.
- 2. Co-finance donors' investments.** The Power of Nutrition intends to offer investors the opportunity to multiply their investments fourfold through co-financing. To do this, The Power of Nutrition uses platform funding from its founding donors as well as other platform funding it raises, thus doubling the initial investment. Furthermore, when the funds are invested in specific programs, the implementing partners will provide a second match to the investment, thus quadrupling the initial investment. The World Bank matches The Power of Nutrition's investments by offering International Development Association (IDA) funding for nutrition to countries, on the condition that countries make new IDA allocations to nutrition. UNICEF and other implementing partners mobilize additional new funding, including domestic resources, for nutrition to match the investments.
- 3. Invest in ambitious programs that deliver results at scale.** The Power of Nutrition seeks to invest in evidence-based interventions recommended by the Lancet Series on Maternal and Child Nutrition, the Global Nutrition Report, and Scaling Up Nutrition (SUN). Through these investments, The Power of Nutrition expects to reach an additional 17 million children and 18 million women, protect 600,000 children from stunting, prevent 60,000 deaths among children under 5, and prevent 1.5 million cases of maternal anemia, by investing in.² Box II.1 lists key evidence-based interventions that The Power of Nutrition prioritizes. The Power of Nutrition makes investments in countries with a high prevalence of stunting, working through its implementing partners who bring extensive experience working with governments and nongovernmental programs and systems in eligible countries. When The Power of Nutrition was established, the vision was for it to make investments in 5 to 10 priority countries with a high burden of undernutrition. However, since its inception, as

² The Power of Nutrition's initial goals were to reach 8 million children, reduce the pool of stunted children by 600,000, and prevent 100,000 deaths among children under 5. In June 2018, The Power of Nutrition revised its targets based on LiST modeling by Mathematica and Avenir Health.

of December 2019, The Power of Nutrition had made 12 investments across 11 countries, with several more in the pipeline.

Box II.1. Key nutrition interventions prioritized by The Power of Nutrition

Key evidence-based interventions prioritized by The Power of Nutrition

- Promotion of breastfeeding
- Complementary feeding
- Management and prevention of severe acute malnutrition and moderate acute malnutrition
- Handwashing with soap
- Therapeutic or preventative zinc for diarrhea
- Vitamin A supplementation
- Iron and folic acid or multiple micronutrient supplementation for women of reproductive age
- Multiple micronutrient supplementation for children under 5
- Salt iodization
- Deworming
- Iron fortification of staples

4. Reinforce the prioritization of nutrition among partner countries and key institutions. The Power of Nutrition seeks to reinforce the priority of nutrition in partner countries and key institutions through the funding it offers for nutrition programs and the results that this funding enables. Moreover, although the original model did not involve directly conducting advocacy activities, since late 2019, The Power of Nutrition has expanded its advocacy efforts to raise the priority of nutrition globally and in partner countries.³

III. Overview of the midline assessment

The purpose of the midline assessment is to examine the progress made by The Power of Nutrition since its inception in achieving its key objectives around fundraising and investments, including its successes and challenges. Similar to the baseline report, the midline report draws on rich qualitative interviews conducted with key global stakeholders, including donors and funders, implementing partners, and other bellwether stakeholders, to answer questions around The Power of Nutrition’s successes and challenges related to fundraising as well as making new investments. In addition, for its early investments, we draw on quantitative country-level coverage data provided by the Power of Nutrition, findings from evaluations commissioned by The Power of Nutrition and its implementing partners, and other secondary data, when available, to provide an early look at the likely effects of The Power of Nutrition’s investments in these countries. Because The Power of Nutrition is continuing to make new investments, and it takes time for the investments to roll out at the country level, we have only limited information to assess the effects of The Power of Nutrition in bringing results at scale at the country level at this stage. However, by the time of our endline report in 2023, we anticipate being able to assess impacts at the country level and provide a synthesis for a broader set of investments. Below, we summarize the key research questions we seek to address, followed by the data sources and our analytic approach. We end the section by highlighting some of the limitations of our evaluation.

A. Key research questions

The midline assessment evaluates the progress made by The Power of Nutrition along its key objectives. Specifically, the key research questions (RQs) addressed in this report include:

1. **To what extent has The Power of Nutrition been able to raise new funds and ensure co-financing of investments?**
 - How much new money did The Power of Nutrition mobilize, and from what sources? What are the characteristics of the new money? Has The Power of Nutrition’s approach attracted new and nontraditional donors, particularly from the private sector?

³ In November 2019, The Power of Nutrition hired a Head of N4G Strategy who will focus on aligning The Power of Nutrition with other global organizations like SUN and Gavi and ensure representation on the Standing Together of Nutrition Consortium. In 2020, The Power of Nutrition also hired a Head of Communications and Advocacy to expand focus on advocacy efforts.

- To what extent and how have different implementing partners met co-financing commitments? What constraints, if any, have implementing partners faced in using co-financing?
2. **To what extent has The Power of Nutrition been able to make investments as planned?**
 - What are the characteristics of The Power of Nutrition’s portfolio of investments? How has The Power of Nutrition’s portfolio of investments evolved over time? Why?
 3. **What are emerging findings around the effects of The Power of Nutrition’s early investments?**
 - What progress has been made in improving the coverage, uptake, and utilization of nutrition services and programs in the early investment countries?
 - What are the likely program effects at the beneficiary level in early investment countries, in terms of deaths averted, cases of stunting prevented, and cases of maternal anemia averted?
 4. **What are emerging findings around the extent to which The Power of Nutrition has elevated the priority of nutrition in partner countries and key institutions?**
 - Did The Power of Nutrition contribute to changing the priority of nutrition (for example, the policy environment or the allocation of resources) in the early investment countries? If so, how?
 - Did The Power of Nutrition help key institutions, including the World Bank and UNICEF, realize and maximize strategic ambition in nutrition? How did this happen?

B. Data sources and analytic approach

Our investigation of these questions draws largely on qualitative data gathered from global stakeholders, supplemented by country-level data, from the following data sources:

- **Document review.** We conducted a detailed review of The Power of Nutrition’s fundraising and investment strategy documents, biannual reports, and country investment documents to develop a comprehensive picture of The Power of Nutrition’s strategies and activities. These documents also enabled us to develop targeted and customized protocols for our qualitative interviews.
- **Key stakeholder interviews.** With input from The Power of Nutrition, CIFF, and FCDO, we identified global stakeholders who could provide insights on a range of topics including The Power of Nutrition’s fundraising and investment strategies, engagement with donors, implementing partners and country-level stakeholders, experiences working with The Power of Nutrition, and perceptions on The Power of Nutrition’s achievements to date and its influence in the nutrition landscape. The stakeholders included representatives from founding donors, new donors, potential donors who decided not to invest, implementing partners, country-level stakeholders, The Power of Nutrition’s executive and board members, and external stakeholders from the nutrition community. The broad range of stakeholders we spoke to have been involved with or have observed The Power of Nutrition in different contexts and capacities and provided perspectives from their vantage points. Table III.1 presents broad categories of stakeholders and the perspectives they bring; see Appendix A for a complete list of interviewees.

We developed high-level protocols to guide the qualitative interviews with key stakeholders. Our protocols covered a range of topics, including the stakeholders’ backgrounds and level of engagement with The Power of Nutrition, whether or not donors and potential donors decided to invest in The Power of Nutrition, the process of developing investments with The Power of Nutrition, experiences engaging with The Power of Nutrition, and perceptions of The Power of Nutrition’s achievements, challenges, and future priorities. We tailored our protocols for each interviewee, the person’s role, and the perspective the interviewee would be able to bring. While these protocols provided a useful high-level guide to structure the interviews and capture the key topics we were interested in covering with each respondent, the questions were framed to be open-ended and elicit respondents’ perspectives. Moreover, we allowed for flexibility to shape the interviews to capture the respondents’ perspectives and probe on areas that they highlighted. We also adapted subsequent interviews to probe further on emerging themes and issues. We obtained consent before each interview and

assured respondents that their information would be kept confidential, to facilitate obtaining candid responses and encourage stakeholders to share both positive and less positive views, including areas where they felt The Power of Nutrition could do better.

In total, we conducted 51 interviews by telephone with global stakeholders from July through September 2019. Through these interviews, we also wanted to assess the progress made by The Power of Nutrition, challenges experienced, and any changes in stakeholders' experience with or perceptions of The Power of Nutrition since the baseline assessment (Sivasankaran et al. 2017).

Table III.1. Categories of interviewees (global stakeholders)

Categories of interviewees	Role/perspective ^a	Number of interviews
The Power of Nutrition staff	<ul style="list-style-type: none"> • Chief executive officer • Partnerships and Brands team • Investments team 	5
Board members	<ul style="list-style-type: none"> • Current board members • Members with observer status 	4
Founding donors/investors	<ul style="list-style-type: none"> • CIFF • FCDO • UBS Optimus 	9
Implementing partners	<ul style="list-style-type: none"> • World Bank • UNICEF • Action Against Hunger • CARE • Nutrition International • Save the Children 	15
New donors	<ul style="list-style-type: none"> • Margaret A. Cargill Philanthropies • Jacobs Foundation • Bill and Melinda Gates Foundation • Eleanor Crook Foundation • Department of Foreign Affairs and Trade (Australia) • Asia Philanthropy Circle • TATA Trusts • Bernard van Leer Foundation • Dangote Foundation 	10
Potential donors who decided not to invest	<ul style="list-style-type: none"> • Larry Ellison Foundation • Merck 	2
External stakeholders	<ul style="list-style-type: none"> • Global Alliance for Improved Nutrition (GAIN) • Global Financing Facility (GFF) • Scaling Up Nutrition (SUN) • Results for Development (R4D) 	6

^a Some of the stakeholders we spoke to played multiple roles and were able to provide multiple perspectives. We count these stakeholders under the primary role we focused on for the interview.

- **Country-level program data and evaluations for the three early investments in Ethiopia, Liberia, and Tanzania.** For these countries, we reviewed data reported to The Power of Nutrition by its implementing partners on the coverage of key nutrition interventions in partner countries. The coverage data helped us assess the progress made by The Power of Nutrition's investments towards improving nutrition outcomes. We also reviewed reports from any evaluations commissioned by The Power of Nutrition at the country level to obtain additional insights on the impact and influence of the country programs. Finally, we participated in The Power of Nutrition and the World Bank's mission to Ethiopia. During the visit, we observed meetings between The Power of Nutrition, implementing partners, donors, and government officials, and conducted interviews with key country-level stakeholders using tailored protocols for each respondent to get a broad understanding of the investment, the nutrition landscape in Ethiopia, and whether, when and why policies and

priorities had shifted, and what interests and groups were influencing changes. As with the approach to our interviews with global stakeholders, we obtained consent before each interview and assured respondents that their information would be kept confidential to elicit candid responses. The visit helped us obtain a deeper understanding of The Power of Nutrition's role and influence at the country level.

- **Secondary data.** In addition to the country-level data reported to The Power of Nutrition by its implementing partners, we drew on findings from national surveys such as the Demographic and Health Surveys (DHS) in Ethiopia, Liberia and Tanzania, the Comprehensive Food Security and Nutrition Survey (CFSNS) in Liberia, and the National Nutrition Surveys in Tanzania, where available, to triangulate with the program data reported by country governments and implementing partners.

We used two primary analytic methods to synthesize information generated through the interviews and assess the strength of evidence on various research questions:

Thematic framing. We systematically reviewed and assessed data from documents and qualitative interviews with various stakeholders to identify cross-cutting trends and themes. As themes emerged, we compiled both affirming and contradictory evidence. We produced internal summary memoranda of thematic findings to support the triangulation process.

Data triangulation. We used data triangulation techniques to confirm patterns or findings and identify important discrepancies across the data sources. By triangulating among the data sources, we tested for the strength of and inconsistencies in findings identified through thematic framing. Drawing on the findings from these analyses, we synthesized successes, challenges, and lessons learned related to fundraising, investments, and coordination and communication within the partnership. We critically examined the strength of the evidence supporting these findings, giving considerable weight to consistency across stakeholders' perspectives on The Power of Nutrition's contribution or influence relative to other factors. This approach gives us reasonable confidence in the qualitative findings we report.

In addition, for The Power of Nutrition's early investment countries, we synthesized findings from the program data, country evaluations, and our deep-dive country visit, where available, to obtain a comprehensive understanding of the progress made by The Power of Nutrition at the country level. We also used the Lives Saved Tool (LiST), an epidemiological modeling tool that estimates the impact on mortality of coverage changes of key maternal and child health and nutrition interventions in low- and middle-income countries, to try to estimate the impacts of the program at the country level.⁴ (Please see country assessments for a more detailed description of the approach.)

C. Limitations of the evaluation

The findings from the midline assessment should be interpreted in the context of several contextual and design challenges.

Program data and evaluations at the country level influence the data available for the global evaluation. To understand the impact and influence of The Power of Nutrition's early investments, the global evaluation seeks to assess (1) how well programs were implemented, (2) coverage and uptake of key nutrition services and impacts of the program on outcomes at the beneficiary level, (3) influence of the program on the nutrition programming and funding landscape in the country, and (4) the potential for sustainability of the programs after The Power of Nutrition's investment ends. To do this, as per the original vision, the global evaluation relies largely on coverage data reported by implementing partners as well as the independent program-level evaluations at the country level commissioned by The Power of Nutrition and its implementing partners. However, availability of program and evaluation data—as well as heterogeneity in the type of data collected and evaluation designs—limit the ability of the global evaluation to aggregate findings and attribute impacts to The Power of Nutrition. Of the three early

⁴ LiST uses effect sizes drawn from a wide research-based literature to translate coverage improvements into reductions in mortality risk factors and ensuing reductions in mortality in subsequent years. As part of the pathway to reducing mortality, it also estimates impacts on child growth outcomes, such as stunting and wasting, as well as maternal anemia.

investment countries (Ethiopia, Liberia, and Tanzania), only the Tanzania and Liberia investments have evaluations examining program implementation and achievement, and the scope of these two evaluations and the questions they answer differ greatly, limiting our ability to provide a synthesis at this stage.

The three early investment countries we examine in this midline report differ in terms of context and capacity, making comparisons challenging. The Tanzania and Liberia investments were The Power of Nutrition's first investments with the World Bank and UNICEF, respectively, and were identified at the launch of The Power of Nutrition to demonstrate investments with each of the two original implementing partners. The Tanzania investment was identified as an opportunity to make an initial investment because the World Bank already had a broader maternal and child health program in Tanzania to which the nutrition component could be added. Similarly, UNICEF was making a nutrition investment in Liberia to address child undernutrition and the weakened health system after the Ebola crisis when the Power of Nutrition was being established. In contrast, in Ethiopia, The Power of Nutrition was able to leverage its influence and offer for funding to bring attention to nutrition in a program that was originally not focusing on nutrition. While we can draw out early lessons from examining progress across these three countries, we will be in a better position to do a more systematic comparison across a larger number of investments at endline.

The complex and dynamic global nutrition landscape makes it difficult to attribute observed changes to The Power of Nutrition's investments alone. Several key players in addition to The Power of Nutrition might influence the funding, programming, and priority of nutrition globally and at the country level. Moreover, some of The Power of Nutrition's investments focus on large national programs and systems strengthening. The multiplayer environment makes it challenging to conduct a rigorous impact evaluation that can detect changes in outcomes that can credibly be attributed to The Power of Nutrition alone. Our approach to the evaluation acknowledges the important role of contextual factors. It uses quantitative and qualitative methods to understand the influence and contribution of The Power of Nutrition to improving the coverage and uptake of nutrition interventions, nutrition and health outcomes, funding available for nutrition, and the prioritization of nutrition by partner countries and key institutions.

IV. Key findings

In this section, we discuss the key findings related to The Power of Nutrition's efforts to (1) raise new funding for nutrition and work with implementing partners to ensure co-financing of investments (**RQ 1**), (2) develop a strong portfolio of investments (**RQ 2**), (2) invest in strong programs that deliver results at scale (**RQ 3**), and (3) raise the prioritization of nutrition among partner countries and key institutions (**RQ 4**).

A. Raising new funds for nutrition and ensuring co-financing of investments (RQ 1)

To address **RQ 1**, we begin by describing The Power of Nutrition's key achievements in terms of fundraising and co-financing investments, what has worked well, challenges faced, and lessons learned from its fundraising efforts to date. We then discuss how implementing partners have met co-financing commitments, and any constraints implementing partners have faced in using co-financing.

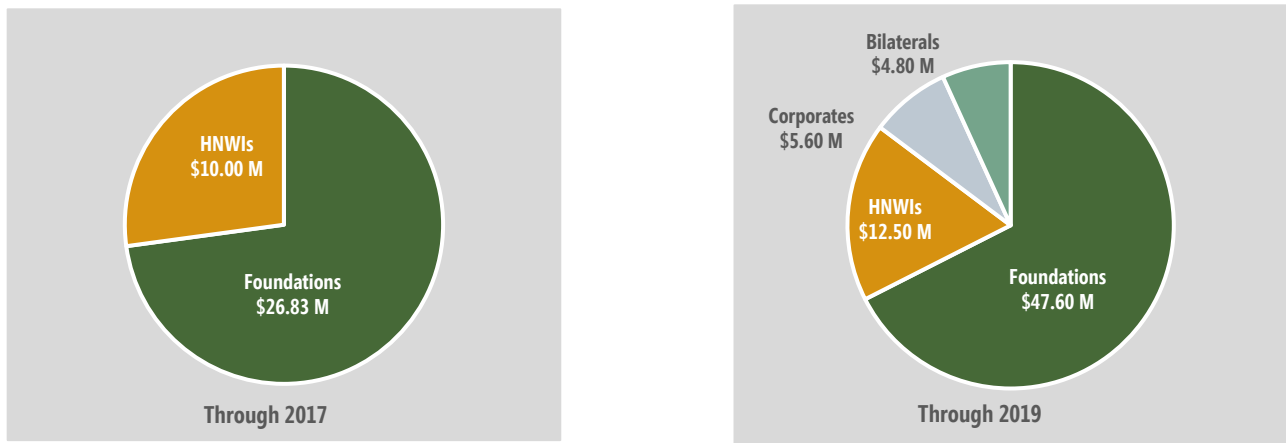
Since its inception, The Power of Nutrition has raised over USD 70 million from a diverse pool of new donors, including new bilateral donors, foundations, corporate donors, and high net worth individuals (HNWIs). However, The Power of Nutrition has not met its fundraising targets in the past two years.

The Power of Nutrition seeks to mobilize USD 1 billion of new financing for nutrition by 2022 through a combination of fundraising and co-financing. As of December 2019, The Power of Nutrition had raised USD 70 million from new investors.⁵ These funds have unlocked additional funds of over USD 65 million through the matched funding from The Power of Nutrition's platform and been matched by nearly USD 300 million in co-financing commitments by implementing partners. It is particularly notable that, of the USD 70 million,

⁵ This does not include the original investments and recent replenishments of the founding donors and investors, CIFF, FCDO, and UBS Optimus Foundation.

approximately USD 18 million is from corporate donors and HNWI's, a segment of the donor landscape that The Power of Nutrition was unable to successfully reach in its early years (Figure IV.1). Given the competitive donor landscape, this is an impressive achievement for a relatively new organization working with a lean team. Even donors who decided not to invest in The Power of Nutrition generally appreciated its model, and typically did not invest because The Power of Nutrition's objectives did not align with their priorities and the sectors in which they wanted to invest. Stakeholders uniformly believe that The Power of Nutrition's most important mandate is to bring new and innovative sources of funding for nutrition, and many believe that The Power of Nutrition has been quite successful in raising money for nutrition.

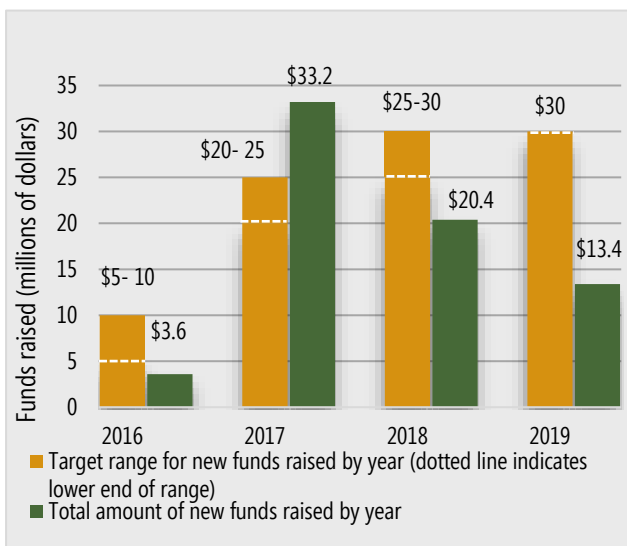
Figure IV.1. Fundraising by type of investor



Source: The Power of Nutrition Fundraising Strategy, June 2019

Despite the strong progress, The Power of Nutrition has not met its fundraising targets in recent years. While The Power of Nutrition exceeded its annual target in 2017, the funds raised in other years were below their respective targets (Figure IV.2). Examining fundraising targets cumulatively, The Power of Nutrition is USD 10 million dollars under the lower end of target range of USD 80 to USD 95 million through the end of 2019 (Figure IV.3). The limited pool of donors interested in nutrition and difficulty in obtaining repeat funding have hindered The Power of Nutrition's success in reaching its ambitious fundraising targets.

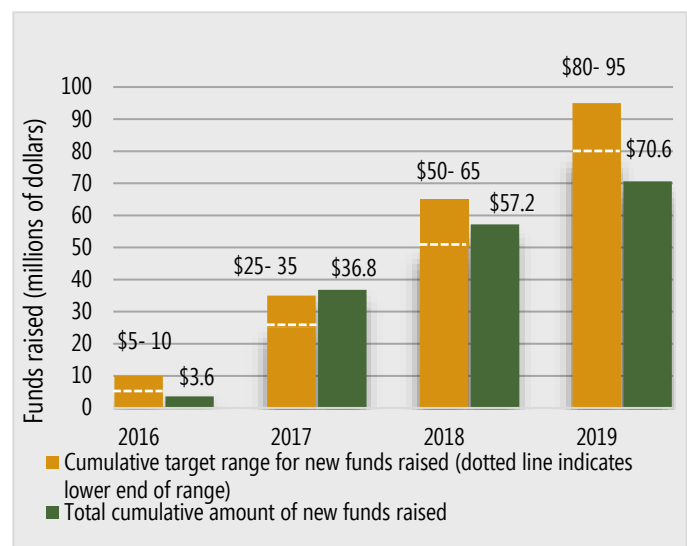
Figure IV.2. Annual targets and new funds raised



Source: The Power of Nutrition Fundraising Strategy, June 2019

Note: The 2018 targets were modified by The Power of Nutrition in the June 2019 Fundraising Strategy document from \$30-40M to \$25-30M.

Figure IV.3. Cumulative targets and new funds raised



The Power of Nutrition has a strong board with a diverse range of expertise; it should now leverage that board to garner broader support.

Over the past two years, The Power of Nutrition has brought on new board members with strong networks in the private sector and in the nutrition community. The executive and board members believe that, along with the support of the technical advisory panel and the newly established finance and audit committee, the new board has the right mix of expertise to support The Power of Nutrition. However, in its early years The Power of Nutrition has not been able to fully engage the board in supporting its fundraising efforts; going forward, The Power of Nutrition should try to leverage board members' networks to bolster those efforts.

Large traditional donors, particularly bilateral donors, value The Power of Nutrition's relationship with the World Bank and its high-level political influence.

Donors are impressed with The Power of Nutrition's ability to influence large World Bank programs and believe that its partnership with The World Bank is an important achievement that The Power of Nutrition should continue to build on and strengthen. The Power of Nutrition is a useful vehicle for traditional donors such as bilaterals because it offers the ability to allocate funds to nutrition-specific interventions and leverage additional funds through the co-financing model, which increases the value of their investment. Although the Global Financing Facility (GFF) may sometimes offer a higher leverage for IDA funds, it does not offer the ability to allocate funds to nutrition, making The Power of Nutrition a more attractive vehicle for leveraging IDA allocations to nutrition. Nevertheless, The Power of Nutrition and GFF have partnered in some countries: The Power of Nutrition leads on the nutrition component and GFF on the broader Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) components.

Some donors value being part of a larger program and the influence it can bring, whereas others, particularly those with a country presence, desire having greater control and closer engagement in the details of the investment.

The ability to aggregate funds by leveraging the match offered by The Power of Nutrition and to potentially influence government programs and policies through World Bank investments is attractive to some donors. However, others, particularly those with a clearly defined program strategy and presence in the country where their funds are being invested, desire greater ability to influence and engage in the program design and implementation. A few donors feel that The Power of Nutrition adds a layer of complexity by being a middleman, and they prefer to work directly with implementing partners. However, the quadruple match offered by investing through The Power of Nutrition attracts all types of donors (including those expressing a desire for greater engagement) and helps align donors to support implementation of nutrition interventions within government health systems rather than invest in multiple fragmented efforts. For new private sector donors and HNWIs, who often do not want to be a "drop in the bucket" of a large program/policy framework and who seek attribution of impact and influence directly to their investment, The Power of Nutrition's investments with international non-governmental organizations (INGOs) could offer more flexibility and attribution while still being aligned with government priorities and plans.

Many donors appreciate the strong monitoring and evaluation (M&E) framework The Power of Nutrition brings; however, donors with a strong learning agenda desire more frequent and detailed reporting.

Several donors were attracted to The Power of Nutrition in part because of its rigorous M&E framework and are satisfied with the level and frequency of its reporting. Some also acknowledged that they might not get as much information as they receive from The Power of Nutrition if they were to make investments directly with large organizations like the World Bank or UNICEF. However, a few donors with an existing portfolio of work in the nutrition sector or a presence in the country/region where the investment was made said that, whereas The Power of Nutrition shares progress reports biannually and obtains donor feedback, interactions between reports can sometimes be limited. These donors indicated that they were interested in understanding the process and learnings from implementation, particularly since investments have long time horizons and impacts on stunting take time. For example, when an investment does not meet its targets, they would like to understand the bottlenecks identified and what plans are in place for course correction. Most donors indicated that they have not

seen the results of the impacts from the investments made so far to know how well the model is working, more regular engagement around key learnings from the investments and any course corrections based on learnings, especially following country visits, could help keep donors engaged and potentially encourage repeat investments from them.

While corporate donors are a potential target for fundraising efforts, sensitivities in the nutrition sector around private sector priorities can limit the opportunities with this sector.

Corporate donors typically have a structured approach and strategy that dictates the sectors and causes in which they will invest, which are typically aligned with the sector they operate in. This strategic focus can limit the pool of corporate donors The Power of Nutrition can reach out to. For instance, The Power of Nutrition cannot obtain funds from some corporate donors in the nutrition sector that would appear to have the most alignment with its work because of sensitivities around these companies' involvement in promoting breastmilk substitutes, as well as ethical considerations of working with industries seen as extractive. Further, The Power of Nutrition has to be careful not to create the perception that it is a vehicle promoting a product or brand, which could affect its reputation. Given these constraints, The Power of Nutrition's corporate partnerships to date are notable, particularly its partnership with Unilever. Through this partnership, The Power of Nutrition and Unilever will support the Government of India's initiative to address undernutrition in the country by promoting handwashing and nutrition for pregnant women and mothers, proven interventions to address undernutrition, through a mobile technology developed by Unilever-Lifebuoy (Unilever's hygiene soap brand).

The Power of Nutrition and UNICEF have made significant progress in improving their relationship and have signed a new partnership agreement that provides more flexibility in co-financing requirements.

The Power of Nutrition and UNICEF had a challenging relationship in the early days because of The Power of Nutrition's restrictions on the sources of funding that UNICEF could use for co-financing. Moreover, The Power of Nutrition requires implementing partners to commit to co-financing the investments when the program is being developed, before obtaining board approval for the program. This sequencing was challenging for UNICEF, which had to identify sources to guarantee co-financing before program approval. However, UNICEF has worked hard to identify sources to co-finance the investments in Liberia and Benin. The Power of Nutrition and UNICEF also developed a three-way partnership agreement between The Power of Nutrition, UNICEF UK, and UNICEF Global, signed in September 2019, that enables the co-financing to be more flexible, including allowing increased domestic resources to count toward co-financing. The engagement and commitment of senior staff from both organizations to work on a new partnership agreement has greatly improved the relationship between the two organizations and has given UNICEF confidence in meeting The Power of Nutrition's co-financing requirements. Some stakeholders also felt the agreement allowing domestic resources is more "equitable" with the agreement The Power of Nutrition has with the World Bank to use IDA funds for co-financing.

INGOs face some challenges with co-financing The Power of Nutrition's investments because of the size of investments, competition within the donor pool, and the long process for developing investments.

New INGO partners are not typically able to co-finance investments of the size The Power of Nutrition makes, which has led some INGOs to partner with each other on investments to share the burden of co-financing. This has made the process of developing investments more resource-intensive, because it requires coordination and negotiation between the INGOs developing the investment together. However, it also lessens fragmentation by aligning INGO programs in support of government priorities. INGO partners that The Power of Nutrition has worked with think there is a need for more clarity and transparency around co-financing criteria and sources. They think The Power of Nutrition should be clearer early in the discussions about the donors investing in the program to avoid duplication in donor outreach and competition between The Power of Nutrition and its INGO partners, which are often trying to raise funds from the same pool of donors. Finally, the long process of investment development can also make it challenging for implementing partners to identify donors to co-finance investments because of uncertainty about when investments will get approved and the timing of some donors' disbursement cycles.

The limited unrestricted funding available, combined with competing stakeholder demands, constrain The Power of Nutrition's flexibility.

Most of the funds The Power of Nutrition has been able to raise are restricted. Moreover, The Power of Nutrition relies on CIFF for most of its operational expenditures, and the second round of funding from CIFF has more restrictions in how it can be used, which constrains The Power of Nutrition's ability to invest in programs up front and sell down investments to new donors. The Power of Nutrition's executive is also accountable to multiple stakeholders, including its board, founding donors, and new donors, and has to balance the needs and priorities of implementing partners and country governments with those of its own donors. Several stakeholders acknowledge that what they perceive as The Power of Nutrition's limited flexibility and bureaucratic processes stem from the competing interests that the executive has to balance. They believe that if The Power of Nutrition had access to unrestricted funding, it might be more nimble and agile. Unrestricted funding would also make it easier for The Power of Nutrition to raise funds, because it could develop investments and sell these investments down to prospective donors, instead of having conversations with donors without a concrete investment to talk about.

B. Developing a strong portfolio of investments (RQ 2)

In this section, we provide an overview of The Power of Nutrition's investment portfolio, stakeholders' perceptions of The Power of Nutrition's value-add, and the process for and approach to developing these investments.

The Power of Nutrition has developed a strong portfolio of diverse investments that respond to country needs.

When The Power of Nutrition was established, the vision was to make time-bound investments in 5 to 10 countries in its first three to four years. The Power of Nutrition has made investments in many more countries than originally envisioned. As of December 2019, The Power of Nutrition had 12 investments across 11 countries that have been approved by The Power of Nutrition board (Table III.1). In addition to these investments, The Power of Nutrition also has a number of investments in the pipeline.⁶

Most of The Power of Nutrition's investments are with the World Bank, which is a strong multilateral partner with the capacity to support implementation at scale. It has also developed investments with UNICEF and, more recently, with new INGO partners such as Save the Children, CARE, Nutrition International, and Action Against Hunger. While all the investments focus on supporting the delivery of key nutrition-specific interventions based on the *Lancet* series on maternal and child nutrition, each investment has been tailored to meet government needs and the state of funding for nutrition in the country. The range of investments include strengthening health systems to deliver nutrition services, multisectoral nutrition programs, technical assistance and operations research to generate evidence for government implementation of nutrition interventions, and efforts to understand and demonstrate models for community-level implementation of nutrition interventions within government health systems.

⁶ As of December 2019, The Power of Nutrition had several programs in the pipeline to present to its board for approval in 2020. These include (1) an investment with UNICEF and The Eleanor Crook Foundation in Niger, (2) the next phase of the program in Liberia that builds on the experience and learning from the current investment, and (3) an investment with the World Bank in Lesotho that focuses on strengthening the country's health system. The Power of Nutrition also has investments in the pipeline in Bangladesh, Malawi, and Zambia that are not yet at the concept note development stage.

Table IV.1. The Power of Nutrition investments

Investment at a glance	Key nutrition interventions included
Tanzania: Strengthening Primary Health Care Results Program (2015-2020)	
Goal: Improve the quality of PHC services nationwide with a focus on maternal, neonatal, and child care services	
<p>Implementing partner: World Bank Co-investment: \$20M The Power of Nutrition; \$24M IDA Total program funding: \$44M within broader \$306M health program Date approved by board: July 2015 Geographic scope: Nationwide Implementation start date: July 2016</p>	<ul style="list-style-type: none"> • Vitamin A distribution to children under 5 • Deworming pills to pregnant women and children • Iron and folic acid (IFA) supplements to pregnant mothers • Improvements in coverage of ANC • Home visits by community health workers on growth monitoring, breastfeeding, complementary feeding, and good nutrition practices
Liberia: Tackling Child Undernutrition in Post-Ebola Liberia (2017–2019) [Phase I]	
Goal: Improve the coverage of and integrate nutrition-specific interventions in the public health system	
<p>Implementing partner: UNICEF Co-investment: \$5M Power of Nutrition; \$4.6M UNICEF UK Total program funding: \$9.6M (includes \$400,000 for M&E) Date approved by board: May 2016 Geographic scope: Nationwide Implementation start date: January 2017</p>	<ul style="list-style-type: none"> • Vitamin A supplementation • Promotion of appropriate breastfeeding and complementary feeding practices among pregnant or lactating women • Multiple micronutrient powder (MNP) supplementation for children 6-23 months • IFA supplementation for pregnant women • Treatment of severe acute malnutrition (SAM)
Ethiopia: Health Sustainable Development Goals Program for Results (2017-2021)	
Goal: Scale up and institutionalize high-impact, evidence-based nutrition interventions nationwide in support of the Government of Ethiopia (GoE) National Nutrition Program II	
<p>Implementing partner: The World Bank Co-investment: \$20M The Power of Nutrition; \$20M IDA Total program funding: \$40M within broader \$230M health program Date approved by board: February 2017 Geographic scope: Nationwide Implementation start date: June 2017</p>	<ul style="list-style-type: none"> • Vitamin A supplementation, including transitioning from campaign to routine delivery • IFA supplementation • Growth monitoring and promotion (GMP) services • Improvements in coverage of ANC
Madagascar: An Integrated Approach to Improving Nutrition Outcomes (2018-2023)	
Goal: Ensure that pregnant women and children under 5 utilize comprehensive health and nutrition services targeting the critical first 1,000 days of infant and young child development	
<p>Implementing partner: World Bank Co-investment: \$10M The Power of Nutrition; \$80M IDA Total program funding: \$90M Date approved by board: October 2017 Geographic scope: 8 regions with stunting prevalence over 50% Implementation start date: April 2018</p>	<ul style="list-style-type: none"> • Breastfeeding promotion and complementary feeding education • ANC and Micronutrient/IFA supplementation in pregnancy • Vitamin A supplementation • Therapeutic zinc with oral rehydration salts (ORS) for treatment of severe diarrhea • Treatment for SAM • Targeted management of moderate acute malnutrition (MAM) • Salt iodization (education/information only) • Fortification of staples (education/information only)
Côte d'Ivoire: Multi-Sectoral Nutrition and Child Development Project (2018-2023)	
Goal: Improve nutrition service delivery at the primary care level and support community mobilization for improving nutrition; enhance the synergy between nutrition interventions across sectors and support implementation of locally designed, decentralized multisectoral approaches to improve nutrition and increase utilization of key services in communities	
<p>Implementing partner: World Bank Co-investment: \$10.4M The Power of Nutrition; \$50M IDA Total program funding: \$60.4M Date approved by board: November 2017 Geographic scope: Regions with the highest stunting burden: North, North East, North West, Center, Center West Implementation start date: May 2018</p>	<ul style="list-style-type: none"> • Promotion of appropriate infant and young child feeding (IYCF) practices, such as exclusive breastfeeding and complementary feeding • Community-based management of acute undernutrition and childhood illnesses • Vitamin A supplementation • Deworming • Treatment of acute diarrhea with ORS and zinc • Micronutrient supplementation for children

- Promoting ANC and Micronutrient/IFA supplementation during pregnancy
- Early Child Development – early stimulation/parenting education

Rwanda: Strengthening Social Protection Project (SSP) and Stunting Prevention and Reduction Project (SPaR) [2018-2022]

Goal: Provide integrated services across the health, nutrition, and social protection sectors to vulnerable populations, with an emphasis on interventions in the first 1,000 days

Implementing partner: World Bank

Co-investment: \$35M The Power of Nutrition; \$66M IDA; \$15M GFF

Total program funding: \$61M for SSP; \$55M for SPaR within broader \$161M program

Date approved by board: December 2017

Geographic scope: 13 districts with high stunting burden

Implementation start date: June 2018

- Promotion of breastfeeding
- Vitamin A Supplementation
- Complementary feeding education
- Multiple micronutrients and balanced energy protein supplementation for pregnant women
- Therapeutic zinc with ORS for diarrhea treatment
- Treatment of MAM and SAM.
- Social-safety nets including cash-transfers

Benin: Improving Children's Nutritional Wellbeing in Benin (2019-2024)

Goal: Support the Government of Benin's national nutrition program to help address systemic weaknesses and improve the supply of quality nutrition services and increase demand in communities

Implementing partner: UNICEF

Co-investment: \$5M The Power of Nutrition; \$5M UNICEF

Total program funding: \$10M

Date approved by board: December 2018

Geographic scope: 3 regions in Benin with extremely high stunting: Alibori, Borgou, Zou

Implementation start date: February 2019

- Early initiation of and exclusive breastfeeding
- Complementary feeding
- IFA supplementation for pregnant women

Nigeria: Bank Executed Trust Fund (BETF) investment to assist the Government of Nigeria in implementing the Accelerating Nutrition Results in Nigeria (ANRiN) program

Goal: Provide the Government of Nigeria with the necessary tools, technical support, and flexibility to strengthen program implementation, innovation, learning, and scale-up of successful elements of the ANRiN project.

Implementing partner: World Bank

Co-investment: \$3.9M The Power of Nutrition

Total program funding: \$3.9M in technical assistance for \$231M ANRiN

Date approved by board: December 2018

Implementation start date: October 2019

- Provision of technical assistance for ANRiN program, which seeks to increase utilization of quality, cost-effective nutrition services for pregnant and lactating women, adolescent girls and children under 5 years of age in select areas of Nigeria

Burkina Faso: Health Services Reinforcement Program (2019-2023)

Goal: Support the Government of Burkina Faso to scale up high-impact nutrition interventions and move from an emergency response approach to a long-term development agenda on nutrition, including building the necessary systems for future investment by the Government of Burkina Faso towards addressing chronic malnutrition

Implementing partner: World Bank

Co-investment: \$10M The Power of Nutrition; \$20M IDA

Total program funding: \$30M within broader \$110M health program

Date approved by board: March 2019

Geographic scope: 6 regions (Boucle du Mouhoun, Centre-Est, Centre-Nord, Centre-Ouest, Nord, and Sud-Ouest) plus Sahel

Implementation start date: Anticipated early 2020

- IFA supplementation for pregnant women
- Vitamin A supplementation for children 6-59 months
- Provision of zinc with ORS
- Provision of micronutrient powders
- Counselling on IYCF and maternal nutrition (including exclusive breastfeeding, complimentary feeding)

Indonesia: Better Investment for Stunting Alleviation (2019-2024)

Goal: Assist provincial governments to use their nutrition resources better, operationalize policies and plans more effectively, and improve management and accountability systems to facilitate the delivery of evidence-based, cost-effective, and sustainable interventions at household and community levels

Implementing partner: Save the Children; Nutrition International

Co-investment: \$5M The Power of Nutrition; \$2.5M Save the Children; \$2.5M Nutrition International

Total program funding: \$10M

Date approved by board: May 2019

Geographic scope: 2 Indonesian provinces with high stunting burden: East Nusa Tenggara, West Java

Implementation start date: August 2019

- Promotion of exclusive breastfeeding, dietary diversity and optimum WASH behaviors
- Vitamin A supplementation
- Treatment of acute diarrhea with ORS and zinc
- IFA for pregnant women and WIFA for adolescent girls

India/Gujarat: Gujarat Nutrition Program (2019-2023)

Goal: Work with the Government of India and the Government of the State of Gujarat to activate and strengthen its nutrition systems and services, with the specific goal of contributing to reductions in children's stunting and severe wasting by improving health, nutrition, and hygiene among pregnant and lactating women and children

Implementing partner: CARE; Action Against Hunger

Co-investment: \$5M The Power of Nutrition; \$2.5M CARE; \$2.5M Action Against Hunger

Total program funding: \$10M

Date approved by board: June 2019

Geographic scope: 2 high-burden districts: Bhavnagar, Sabarkantha

Implementation start date: September 2019

- Treatment of SAM
- Nutrition education and counseling for pregnant women, including promotion of exclusive breastfeeding and complementary feeding
- Deworming for children
- Behavior change
- Counselling for nutrition

India/Maharashtra: Making Nutrition Aspirational for Children and Women (2019-2023)

Goal: Enhance the Government of Maharashtra's capacity to deliver infant and young child nutrition services, provide treatment for SAM, and improve efficiency of nutrition data collection

Implementing partner: UNICEF

Co-investment: \$5M The Power of Nutrition; \$2.5M UNICEF; \$2.5M Government of Maharashtra

Total program funding: \$10

Date approved by board: November 2019

Geographic scope: Statewide

Implementation start date: December 2019

- IFA supplementation
- Vitamin A supplementation
- Deworming
- Nutrition education and counseling to improve feeding and care of children and pregnant women
- Treatment of children with SAM

Source: The Power of Nutrition biannual reports and investment concept notes.

The Power of Nutrition's partnerships with INGOs help diversify its investment portfolio and in-country partners and build evidence on how to deliver scalable interventions at the community level.

When The Power of Nutrition was first established, the World Bank and UNICEF were the only implementing partners. In recent years, The Power of Nutrition has expanded the implementing partners it works with, and signed partnership agreements with INGOs such as Save the Children UK, Nutrition International, CARE UK, and Action Against Hunger. As of December 2019, 2 of The Power of Nutrition's 12 investments are with these new INGO partners. Whereas investments with the World Bank have a large scale and UNICEF is a strong technical partner for governments, INGOs bring expertise in delivering interventions at the local government and community levels. Working with INGOs offers an opportunity to design programs at the sub-national level that align with government plans and can generate evidence for scale-up. The Power of Nutrition will, however, need to manage transaction costs of working with INGOs and draw on its experience with large government programs to ensure that the programs are not disconnected from the government health system. The Indonesia investment is an example of an investment with INGO partners that has been designed with the goal of building evidence to inform government scale-up of nutrition services using an IDA loan from the World Bank. Although this investment was still in early stages at the time of this assessment and it remains to be seen how well it will be able to influence government implementation, stakeholders involved with the intervention consider this a potentially good model for investing.

Most stakeholders and nutrition experts appreciate The Power of Nutrition's focus on delivering evidence-based nutrition-specific interventions, given the need to improve coverage of these interventions and to understand how to deliver them at scale.

Although there is a lot of attention and interest in nutrition-sensitive interventions and multisectoral approaches to delivering nutrition services, most experts considered the evidence base for these interventions relatively weak. Given its focus on impact and scale, it is important for The Power of Nutrition to continue to invest in evidence-based nutrition-specific interventions alongside complementary, strategic investments in health systems strengthening. Coverage of nutrition-specific interventions is still very low in several countries with a high burden of stunting and there is a need for more evidence on how to deliver these interventions at scale and reach the most vulnerable groups. As one of the few organizations focused on investing in these interventions, The Power of Nutrition has an important role to work with countries to solve bottlenecks and identify effective delivery mechanisms at scale.

While maintaining its focus on evidence-based nutrition-specific interventions, The Power of Nutrition has also worked strategically across sectors to invest in nutrition-sensitive interventions. For example, the investment in Côte d'Ivoire includes early childhood development components, and in Rwanda, The Power of Nutrition co-finances a social protection component of the program. Moreover, all its investments work to strengthen the health system to deliver essential health and nutrition interventions. Stakeholders and experts appreciate this flexibility in the model; looking ahead, while continuing to keep its focus on stunting, The Power of Nutrition should continue to consider such adjacent investments such as improving adolescent nutrition or addressing the double burden of stunting and obesity in countries where this is a relevant issue through the promotion of broader good nutrition practices, allowing the country context and need to drive complementary strategic investments.

Some stakeholders believe that there may be opportunities for The Power of Nutrition to make meaningful investments by being flexible with the stunting criteria used to short-list countries.

The Power of Nutrition maintains a list of eligible countries in sub-Saharan Africa and Asia with a stunting prevalence of 30 percent or more and at least 250,000 children stunted.⁷ Some stakeholders believe this could miss countries that have a large problem at a subnational level or a small population that would be screened out based on the absolute magnitude of the cases of stunting. These criteria also do not account for the magnitude of the financing gap in the country. In some cases, The Power of Nutrition's executive and board have responded to this and made exceptions; for example, for the investment in Burkina Faso, they considered subnational levels of stunting even though the national levels met only one of the criteria.

Although the proposal development process continues to be long and resource-intensive, causing some frustration among implementing partners, overall, partners appreciate the commitment of the Investments team to developing strong proposals.

Implementing partners uniformly value the rigor and quality that The Power of Nutrition brings to its investments and appreciate the team's efforts in working with them as a true partner to develop strong proposals. Country offices and technical staff at implementing partners appreciate the efforts of the Investment team, and partners feel they push country teams to develop and implement high-quality programs. Implementing partners also really appreciated the M&E focus of The Power of Nutrition and felt their emphasis on a strong, detailed results framework was a value add and set them apart from other donors. Once an investment is in place, The Power of Nutrition is also committed to working with partners to identify solutions to address bottlenecks and make course corrections. However, partners uniformly noted that the process for developing and receiving approval from the board for an investment is protracted, with some investments taking over two years from initial design to approval. The proposal development process takes time partly because of the variable quality of the initial proposals from partners, but also because The Power of Nutrition has to balance the needs of and input from the various stakeholders to which it is accountable. Some of these challenges are inherent in the complexity of the partnership, but others may be resolved as The Power of Nutrition and implementing partners build their relationship, develop confidence and trust, and gain a better understanding of how each works. Partners thought it would be helpful if The Power of Nutrition shared a common understanding of the review process up front, clarified the roles of different entities, and streamlined the rounds of input and feedback to the extent possible. The Power of Nutrition may also want to consider documenting major decisions and turning points during the negotiation to avoid duplication of comments as the proposal goes through each round of review. Partners noted that The Power of Nutrition has reached out for feedback on templates and processes, and they believe this is a step in the right direction.

⁷ These criteria were updated to in 2020 to include countries with either stunting prevalence of 30 percent or more or at least 250,000 children stunted

Staff turnover has been an issue for The Power of Nutrition, given the importance of cultivating strong relationships with partners.

The Power of Nutrition has a small team with expertise in the development and private sectors. Recently, The Power of Nutrition has had a high rate of turnover in both the Partnerships & Branding (P&B) and Investments teams. This turnover can undo the efforts that have been made in the early years to build relationships. For example, implementing partners appreciate the high quality and caliber of the Investments team members they have worked with so far, and some expressed concern that they have built relationships with specific members of the team and could lose some of the synergies that have come out of working with those members. More broadly, high turnover is typical throughout the development sector and with the donors, partners, and country governments The Power of Nutrition works with, which exacerbates the challenges of building and maintaining relationships.

C. Investing in strong programs that deliver results at scale (RQ 3)

This section summarizes our emerging learnings on the progress made by The Power of Nutrition's first three investments in improving the coverage, uptake, and utilization of nutrition services and programs and the likely effects at the beneficiary level. The investments in Tanzania and Liberia, the first two investments The Power of Nutrition made with each of its original implementing partners (World Bank and UNICEF), are completed or close to completion.⁸ These investments provide a good opportunity to assess the progress made by these early efforts at this midline evaluation. It also helps inform priorities for a potential second phase of investment in Liberia. We also selected to study the investment in Ethiopia as it was the first investment entirely developed by The Power of Nutrition's executive after it was established, and offers an opportunity to understand The Power of Nutrition's role and influence during the design and development of the program and progress made by the investment to date. The Ethiopia investment is now three years into implementation.⁹

The early investments differed in a number of ways, in terms of the process for developing the investments, as well as the country contexts and capacity of the countries' health systems. These countries are also at different stages of programming, with the Liberia investment having completed its first phase, the Tanzania investment ending in 2021 after an extension to the original program period, and the Ethiopia investment just past the midpoint in the investment. These factors make it challenging to directly compare or synthesize findings across the countries; nonetheless, where feasible, we highlight cross-cutting findings and lessons from these country contexts.

The Power of Nutrition's early investments in Ethiopia, Liberia and Tanzania have improved the coverage of key nutrition services in these countries.

Overall, The Power of Nutrition's investments have made considerable progress in delivering nutrition services at scale. The Power of Nutrition's early investments in Ethiopia, Liberia and Tanzania have improved the coverage of key targeted nutrition services, although the programs have missed some of their targets. In Ethiopia, the DHS shows a significant increase in IFA supplementation, a key intervention targeted by the program, in part because of The Power of Nutrition's push to include the intervention in the Performance for Results (PforR) program, which incentivizes the government to achieve targets for selected indicators by tying fund disbursements to those indicators. The proportion of women who consumed any IFA increased from 42 percent in 2016 to 60 percent in 2019 (Ethiopia DHS 2016; mini-DHS 2019). Moreover, the DHS also revealed that the proportion of women who took an adequate dose of iron and folic acid (IFA; 90+ tablets) increased from 5 percent in 2016 to 11 percent in 2019.

In Liberia, the coverage of micronutrient powders (MNP), a new intervention introduced through the investment, improved dramatically during the investment period. The coverage of infant and young child feeding (IYCF) counseling also improved during the investment period. This potentially contributed to improvements in

⁸ The Liberia investment closed in March 2020, after a three month no cost extension from December 2019 to March 2020. The Tanzania program has been extended to 2021.

⁹ The country assessments at the end of the report provide a more in-depth assessment of these investments.

complementary feeding practices. Between 2013 and 2018, the proportions of children who received the appropriate minimum meal frequency (MMF), minimum dietary diversity (MDD), and minimum adequate diet (MAD) increased (LDHS 2013; CFSNS 2018).

In Tanzania, program data and national surveys show that the coverage of vitamin A supplementation for children under 5 and IFA supplementation for pregnant women has improved considerably during the investment period (NNS 2014; DHS 2015-16; NNS 2018). A results-based financing (RBF) component implemented in some regions, which incentivized facility performance through payments based on verified delivery and quality of targeted services, may have contributed to improving the implementation of nutrition interventions. Particularly, the combined effect of RBF payments tied to the delivery of nutrition services at the facility level and incentives for CHWs to accompany women to facilities may have led to increased cooperation between CHWs and health workers at facilities, leading to increased utilization of services, particularly through earlier ANC consultations (Binyaruka et al 2020).

(The country assessments at the end of the report provide in-depth assessments of the investments in Liberia, Ethiopia, and Tanzania.)

The experiences from the early investments highlight some challenges with generating demand for and maintaining the quality of services.

The investment in Ethiopia seeks to transition the provision of vitamin A supplementation and Growth Monitoring and Promotion (GMP) services from campaigns to routine delivery through the health system. However, a challenge for the program has been maintaining the quality of services as they are transitioned. While the transition is important to establish nutrition services within the health system, if the transition happens without adequate support to prepare the health system to provide these services, it could result in lower coverage and uptake of these services. The experience in Ethiopia suggests that more investments and support may be required to improve and maintain the quality of services to sustain coverage gains. The Power of Nutrition and its partners, through an independent joint review mission, have provided guidance and recommendations to the nutrition team in the Ministry of Health (MoH) to support the transition of services. The extent to which the MoH is able to successfully implement these recommendations and ensure quality of services to improve coverage will need to be assessed at the end of the investment. Similarly, in Tanzania, the delivery of vitamin A supplementation is currently primarily through biannual child health and nutrition campaigns conducted by development partners. The government has established a steering committee to lead the transition of delivery of vitamin A supplementation from campaigns to routine services, and it will be important to ensure that coverage can be maintained and improved further during and after transition from delivery through campaigns to routine delivery through the health system.

In Liberia, an independent coverage assessment commissioned by The Power of Nutrition and UNICEF revealed commodity stockouts affected the coverage and uptake of interventions such as vitamin A supplementation and adequate IFA supplementation. On the other hand, a lack of awareness of interventions and their importance for children's health and nutrition were the main causes for low uptake of micronutrient powders and treatment for SAM. These findings indicate a need for programs that generate awareness and demand for nutrition services among mothers and caregivers along with systems strengthening approaches to ensure that the demand can be met by the government health systems.

The early investments demonstrate a need for building the capacity of the local teams to strengthen and ensure sustainability of the investments.

In Ethiopia, the government's nutrition case team has built valuable experience through its participation and engagement in program review missions and technical discussions with the World Bank, The Power of Nutrition, and other partners. The progress achieved by the program to date is in part because of the experience and capacity that staff have developed over time to identify and diagnose issues and translate partners' input to action plans that can strengthen the delivery of nutrition services and to negotiate for increased budget allocations for nutrition programming. However, staff turnover within the MoH and nutrition case team threaten this progress.

In Liberia, the government included key nutrition indicators in the Health Management Information System (HMIS) with support from UNICEF, reflecting the commitment from the government to support monitoring and evaluation of nutrition. Our assessment of the HMIS data highlights inconsistencies between the coverage reported by household surveys and the program data. Stakeholders interviewed as part of an independent assessment of the financing and governance commissioned by The Power of Nutrition and UNICEF felt that joint investment in the HMIS system and the government-wide M&E system could create efficiencies in programming and staff capacity building and facilitate sharing of information across multi-sectoral programs such as nutrition (Connolly and Sesay 2019). Moreover, they noted a lack of trained staff in the nutrition department and lack of support from the government for capacity development programs for nutrition staff more generally. Improving the data quality is a focus area of next phase of the Liberia investment being developed by The Power of Nutrition and UNICEF.

In Tanzania, while there has been increased allocation of domestic budget to nutrition, the midterm review of the 2016-2021 National Multisectoral Nutrition Action Plan showed that there is a large gap between the planned budget and actual expenditure, with over half of the planned investment not released. Investing in building the capacity of the nutrition team for budget tracking and execution could help improve the execution of planned resources. Together, findings from the early investments highlight the need for staff training and capacity building across several areas, including perhaps the development of training materials, as well as program documentation and onboarding materials to ensure newly hired staff can be quickly trained and that overall staff can benefit from continuous quality improvement.

LiST modeling and projections suggest that based on the results achieved to date and targets for future years, the nutrition-specific interventions within the broader health programs being implemented by the World Bank in Ethiopia and Tanzania contributed towards averting nearly 200,000 cases of stunting, more than 11,000 deaths of children under 5, and nearly 500,000 cases of maternal anemia.

Based on progress to date in Ethiopia (as of 2019) and targets for the rest of the investment period (through 2021), impact projections suggest that, if the Ethiopia program meets its targets, the 3 nutrition interventions targeted by the program (IFA supplementation, vitamin A supplementation, and growth monitoring and promotion) could avert nearly 109,000 cases of stunting, over 2,900 deaths of children under 5, and 293,000 cases of maternal anemia. (See Ethiopia assessment for more details on the modeling assumptions. In the endline report, we will update these projections using data on coverage achieved at endline from the DHS and HMIS.) Based on results achieved between July 2015 and June 2020 by the Tanzania program, the nutrition investment is estimated to have averted over 90,000 cases of stunting, nearly 9,000 deaths of children under 5, and over 200,000 cases of maternal anemia. (See Tanzania assessment for more details on the modeling assumptions. In the final endline report, we will update these projections using data from the DHS.) These modeling results should be interpreted in terms of the potential contribution of the nutrition interventions supported by The Power of Nutrition in these programs rather than attribution, given the large number of partners, including the governments, involved in delivering the broad package of health and nutrition interventions.

Due to concerns about the accuracy of the program data available for LiST modeling in Liberia, we are not including results for Liberia.

For the first phase of Liberia investment, which ended in March 2020, our assessment of the HMIS data revealed several inconsistencies between the coverage reported in the program data and findings from household surveys. (See Liberia assessment for our in-depth assessment of the country-level data.) Given these concerns, we will use the Liberia DHS 2019, when available, to model the impacts of the Liberia investment and include impact estimates for the Liberia investment in the endline report.¹⁰

¹⁰ Due to COVID-19 related delays, the Liberia DHS 2019 results were not available at the time of this report.

D. Reinforcing the prioritization of nutrition in partner countries and key institutions (RQ 4)

To address **RQ 3**, we summarize findings about the extent to which The Power of Nutrition’s investments and partnerships have contributed to changing the priority of nutrition and influenced the nutrition landscape across its portfolio of investments and implementing partners. (The country assessments at the end of the report provide a more in-depth assessment of the extent to which The Power of Nutrition has changed the priority of nutrition in its early investment countries.)

In less than five years since its inception, The Power of Nutrition has operationalized a complex model and established itself as a key player in the global nutrition landscape.

Stakeholders uniformly acknowledge The Power of Nutrition’s importance and reputation in the nutrition sector and implementing partners emphasize the importance of partnering with The Power of Nutrition. The Power of Nutrition is seen as a key player and partner (or potential partner) by nearly all the stakeholders and organizations working in the nutrition sector. The Power of Nutrition worked with key development partners like the Bill & Melinda Gates Foundation, 1,000 Days, the SUN Movement, and the World Health Organization to host the Goalkeepers for Nutrition event during the 72nd United Nations General Assembly in 2017, and participates regularly in conferences such as Women Deliver and the Global Nutrition Summit. Stakeholders emphasized that, in the fragmented partner landscape, there was a strong need for key organizations, including The Power of Nutrition, to align their goals and work together to achieve common objectives.

The Power of Nutrition has built a strong relationship and model for working with the World Bank and contributed to the increased prioritization of nutrition within the Bank.

Since its inception, the relationship between The Power of Nutrition and the World Bank has evolved and grown stronger, with both organizations gaining a better understanding of how to work well together. The Power of Nutrition’s partnership with the World Bank brought new money and visibility for nutrition at a time when there wasn’t enough attention to nutrition inside the Bank. Since then, because of the partnership with The Power of Nutrition, as well as other factors, including the focus on a human capital approach at the Bank, nutrition has become a higher priority. The Power of Nutrition’s investments with the World Bank have also brought together donors and partners—particularly from the private sector—and pooled their funds, which might otherwise have been invested in smaller individual programs, to support government implementation of nutrition services at scale.

Some of The Power of Nutrition’s investments have catalyzed dialogue and commitment to nutrition.

In Ethiopia, The Power of Nutrition’s investment brought nutrition into the discussions between the government and the World Bank during negotiations around a larger World Bank PforR program focused on strengthening health systems (which did not include payments linked to achieving nutrition outcomes). By offering grant funding of USD 20 million, the investment led to IDA loan allocations of USD 20 million to nutrition. Further, by linking the disbursement of USD 35 million of the USD 40 million to meeting targets for nutrition outcomes, the investment has led to greater prioritization of nutrition by the MoH and budget allocations for nutrition within the MoH budget. In Tanzania, The Power of Nutrition investment, which was included after the original program was negotiated by the government and the World Bank, brought a nutrition lens to the program, and has opened the possibility of a nutrition-focused program with the government in the next phase. In Liberia, during the period of The Power of Nutrition and UNICEF co-investment, expenditures on nutrition increased significantly; in 2016, before the program began, only 50 percent of the budget allocations for nutrition-specific programs was utilized, but during the investment period, an average of 92 percent of the budget was spent each year. In Benin, a relatively recent investment, UNICEF believes that The Power of Nutrition’s investment has been catalytic and helped leverage other funding for nutrition, which otherwise wasn’t receiving much donor attention.

In countries where the government was already making investments in nutrition, The Power of Nutrition has designed investments that support and strengthen the government’s efforts.

In Madagascar, The Power of Nutrition’s investment of USD 10 million to support the government’s long history of commitment to nutrition programming was perceived by country stakeholders as a vote of confidence in the

value of what the government was doing. In Côte d'Ivoire, where there was already commitment from the government to invest in nutrition, The Power of Nutrition's investment contributes to filling a large financing gap in the government's nutrition plan and has brought the private sector in to support the government's efforts. The Power of Nutrition's investment in Indonesia is aligned with government priorities and brings nutrition experts with experience at the grassroots level together to generate evidence that can inform government scale-up of nutrition interventions. Although The Power of Nutrition's investments haven't been as critical to changing the dialogue and prioritization of nutrition in these countries, they have helped validate these countries' work and commitment and strengthened government delivery of nutrition services.

Through its pooled funding model, The Power of Nutrition has been able to unify donors and partners who exist in an otherwise fragmented landscape.

The nutrition sector (and the development sector, more broadly) is highly fragmented, with various donors and partners working on individual projects that are relatively small in scale. The fragmentation in the donor landscape can lead to programs being conducted in isolation without common goals and cooperation, and a waste of resources. By offering an attractive match for their investments, The Power of Nutrition has been successful in bringing some traditional donors and partners who were working independently to align around sustainable government delivery of a common package of interventions in a sustainable way. For example, the investment in Ethiopia brings together key partners such as the Gates Foundation and Nutrition International to invest in and provide technical assistance to government implementation of a set of key nutrition services. This is an important role The Power of Nutrition can play given its reputation and its networks within the nutrition sector.

The Power of Nutrition could benefit from further differentiating its value proposition in countries, particularly countries that are already committed to nutrition.

The Power of Nutrition's investments have been aligned with countries' needs and their commitment to and prioritization of nutrition. Many stakeholders believe The Power of Nutrition has the greatest influence and ability to move the needle in countries where it has changed the dialogue on prioritizing nutrition. For example, as noted, in Ethiopia The Power of Nutrition's investment catalyzed the allocation of IDA funds to nutrition, brought donors together around a package of nutrition interventions and indicators, and has led the government to prioritize and allocate money for nutrition in its budget. However, stakeholders have more mixed perceptions about The Power of Nutrition's value-add in countries like India or Nigeria whose governments are already committed to nutrition and allocate substantial funding to it. Some stakeholders consider The Power of Nutrition a more marginal player in these countries given the abundance of resources already available for nutrition programming and think The Power of Nutrition should focus on other countries where there is lower prioritization of nutrition. Other stakeholders, particularly implementing partners and country-level stakeholders in these countries, believe The Power of Nutrition is still playing an important role filling the gap in funding of nutrition plans and supporting government scale-up of programs by generating evidence that governments are often not willing to invest in. The Power of Nutrition could more clearly define and communicate its value proposition in countries where its role in bringing additional funding may not be as critical, but its ability to bring private-sector donors to the table, decrease fragmentation in the donor landscape, help build government capacity at the subnational level, and build evidence to support government priorities may still be valuable. By differentiating its value proposition in a variety of contexts, The Power of Nutrition may be able to reach and influence a broader set of donors and countries.

V. Future priorities and recommendations

Overall, we find that The Power of Nutrition has made great progress by establishing itself as a key player in the nutrition sector, raising funds for nutrition from a variety of donors, developing strong relationships with its original implementing partners (World Bank and UNICEF), establishing additional partnerships with INGOs, investing in a diverse portfolio of investments with a variety of partners, raising the profile of nutrition in countries where it has made investments, and bringing together development partners in-country to support government programs through its investments. However, The Power of Nutrition operates in a competitive donor landscape with limited unrestricted funding and is accountable to multiple stakeholders in the partnership, which limits its

operational flexibility and leads to some processes that are perceived as bureaucratic by some stakeholders. Despite these challenges, stakeholders generally believe The Power of Nutrition is filling a critical gap in the nutrition sector by bringing private sector money for nutrition, aligning donors and country governments around common priorities, and supporting countries in scaling up evidence-based nutrition-specific interventions.

Below we provide a brief summary of priorities and recommendations for The Power of Nutrition to further its influence and consolidate its role going forward.

With some uncertainty in the amount of funding for and prioritization of nutrition by large donors, The Power of Nutrition has an important role to play in keeping nutrition on the health and development agenda.

Changes in the political environment in countries that are large bilateral donors to nutrition programs, and changes in the priorities of key partners who invest in nutrition, increase uncertainty about the funding available for nutrition globally. Against this broader landscape, stakeholders believe The Power of Nutrition should continue to prioritize stunting and make a strong investment case for investing in nutrition. The Nutrition for Growth Summit offers an important platform for The Power of Nutrition to corral unconventional sources of funding for nutrition. The Power of Nutrition should leverage its partnerships with key organizations in the nutrition landscape to engage in advocacy at the global level and draw attention to nutrition.

Focusing on measuring impacts on stunting, which is an outcome further down the results chain, does not capture The Power of Nutrition's diversity of programs and influence on the nutrition landscape.

The Power of Nutrition's programming has evolved as it has learned more about how to implement evidence-based nutrition interventions at scale. The Power of Nutrition's progress should be assessed against a broader set of indicators, including intermediate nutrition indicators along the pathway to impacts on stunting that can be tracked and measured more easily (for example, breastfeeding, anemia, dietary diversity, etc.), as well as indicators that capture the impact of The Power of Nutrition's investments on improving the capacity of health systems to provide high-quality nutrition services and qualitative measures that track The Power of Nutrition's influence in defragmenting the donor landscape. Although some of these dimensions are difficult to quantify, aggregate, and measure, not considering these dimensions when assessing the progress made by The Power of Nutrition will miss important contributions in these areas. Moreover, a narrow focus on measurable impacts on stunting (which take time to emerge), can risk deprioritizing The Power of Nutrition's efforts in these other areas that are important to strengthening and sustaining the delivery of nutrition services. The Power of Nutrition is working with experts to develop metrics that capture systems-strengthening and capacity-building efforts, and these should be integrated into the results framework used to evaluate The Power of Nutrition's progress.

The Power of Nutrition should improve its communication materials to ensure that prospective partners are not deterred from working with it because of a lack of understanding of its model.

Several stakeholders, including donors (and prospective donors) and organizations doing similar work in the development sector, found The Power of Nutrition's model complex and difficult to understand. This could deter some partners from approaching or working with The Power of Nutrition. The Power of Nutrition would benefit from improving its communication materials, particularly those on co-financing and matching, to help donors and country-level stakeholders understand and leverage the model to make investments in nutrition.

The Power of Nutrition could benefit from tailoring its offerings to match donors' and implementing partners' priorities and clearly communicate the roles of different stakeholders.

Although The Power of Nutrition has succeeded in leveraging some new private-sector money for nutrition, several stakeholders, particularly donors and potential donors, think The Power of Nutrition needs to tailor its value proposition to the needs of different types of donors to remain competitive. Donors can vary in how engaged they want to be with an investment and how important it is for them to be at the table for discussions with partners, depending on how invested they are in a particular country, what other operations they have in country, and what they are looking to get out of the partnership. The same donor can also have different needs across different investments. Some donors think The Power of Nutrition uses a standard approach to fundraising,

focusing on volume rather than analyzing what different donors might be looking for from an investment. Some also think that The Power of Nutrition sometimes offers more than it can promise during the initial outreach to donors, which can lead to donor frustration, when, in reality, there is less flexibility and scope for engagement in the model. Greater partnership between the P&B and Investments team in the early stages of discussions with donors may help set more realistic expectations for donors and inform negotiations with implementing partners. The Power of Nutrition's model of working with implementing partners and aligning with national programs to ensure sustainability limits how much donor engagement it can offer. To facilitate a common understanding among all stakeholders, The Power of Nutrition should communicate up front with donors and implementing partners about what level of engagement is possible (and expected) with each type of investment.

Some donors expressed a need for donor education on investing in nutrition, which The Power of Nutrition could fill.

New and non-traditional donors look to The Power of Nutrition as an entity with experience investing in nutrition that they could leverage and learn from. The Investment team's technical competence and experience are highly regarded by such donors. The Power of Nutrition could be a particularly attractive vehicle for new donors and HNWI's, who could benefit from The Power of Nutrition playing a strategic function for their investments. Engaging the Investment team in conversations with new donors early on could improve donors' understanding and confidence in the relationship.

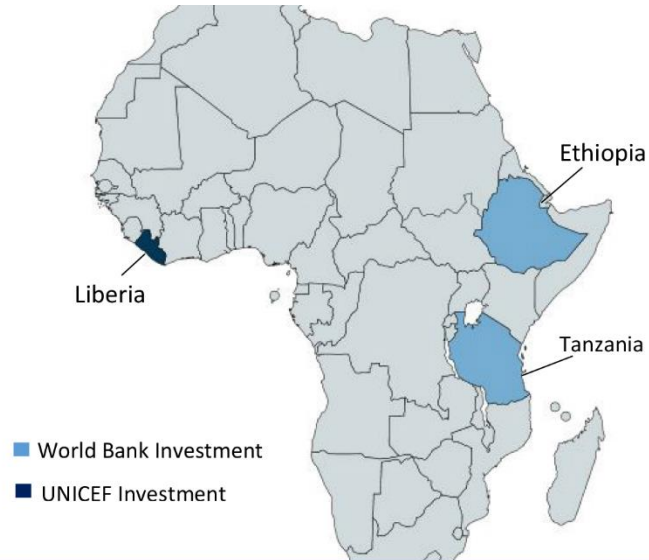
The Power of Nutrition should capture best practices from its portfolio of investments, which could be a useful tool for its own discussions and negotiations and for the broader nutrition community.

The Power of Nutrition has a diverse portfolio of investments—in large-scale government programs with the World Bank and UNICEF, in smaller community-level programs with INGOs, and in operations research with UNICEF, INGOs, and Bank Executed Trust Fund investments with the World Bank. The Power of Nutrition can drive a strong knowledge and learning agenda across this portfolio that captures best practices and lessons learned, and it can feed that knowledge back into the design of new investments (as well as to the broader nutrition field). This will likely be appreciated both by new donors who look to The Power of Nutrition as a key player working with major nutrition sector partners and by implementing partners who value The Power of Nutrition's ability to bring together people with the right expertise for programs. This could also be a valuable resource for negotiations and discussions and give other countries and funders the confidence to pay attention to and invest in nutrition through The Power of Nutrition's platform.

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ASSESSMENT OF THE POWER OF NUTRION'S IMPACT AND INFLUENCE AT THE COUNTRY LEVEL EARLY INVESTMENT COUNTRIES



We assess the impact of The Power of Nutrition's early investments on key targeted outcomes and the contribution of The Power of Nutrition to the nutrition programming and policy landscape in early investment countries. Our assessment of these investments draws on a combination of sources including program documents and data from country programs, independent evaluations, national surveys, and selected deep dive site visits.

ETHIOPIA INVESTMENT PROFILE AND KEY RESULTS

I. Background and context

Ethiopia is home to 90 million people with a rapidly growing population. Although it is one of Africa's poorest countries, Ethiopia has made significant strides in economic growth and human well-being over the past two decades (World Bank 2017). However, despite improvements in nutrition through the delivery of high impact interventions and increased economic growth in recent years, the country still faces serious undernutrition challenges. According to the 2016 Demographic and Health Survey (DHS), 38 percent of children under 5, or about 5.5 million children, are stunted, and 10 percent are wasted, which has significant effects on their cognitive capabilities (Central Statistics Agency [CSA] Ethiopia 2016). Undernutrition has been linked with 16 percent of primary school repetitions (Government of Ethiopia 2013). Moreover, almost one-third of women are malnourished, which contributes to poor birth outcomes and intergenerational cycles of undernutrition (CSA Ethiopia 2016). Undernutrition persists even among the country's wealthiest groups, signaling that the causes stretch beyond poverty and food insecurity. Inadequate food diversity, limited nutrition knowledge, and insufficient access to health, water, and sanitation services contribute to poor health outcomes among infants and young children (The Power of Nutrition Ethiopia Concept Note n.d.).

The Government of Ethiopia (GoE) has demonstrated high level political commitment to ending child under-nutrition. In July 2015, the Seqota Declaration, which pledges to end child undernutrition and stunting in Ethiopia by 2030, was launched by the Deputy Prime Minister and presented by the Minister of Health. The GoE also launched the National Nutrition Plan (NNP) II (2016-2020), which proposes a multisectoral approach to sustain and expand progress in nutrition. However, despite the strong political commitment and prioritization of nutrition, there is a critical financing gap for the implementation of NNP II. The cost of implementation of NNP II was estimated at USD 1.1 billion over the five years of implementation; despite donor support, the estimated financing gap was USD 430 million (The Power of Nutrition Ethiopia Concept Note n.d.).

II. Overview of the program

To support the GoE's goals to reduce undernutrition and stunting, The Power of Nutrition, World Bank, and the Global Financing Facility (GFF) for Every Woman and Every Child Trust Fund are providing USD 230 million of additional funding for the Health Sustainable Development Goals (SDG) Performance for Results (PforR) program (2017-2021). The program supports the SDG Pooled Fund which pools donor money to support the GoE's Health Sector Transformation Plan (2015-2020) through non-earmarked and harmonized support to the sector. The program uses a PforR mechanism that incentivizes the GoE to use its own budget and systems to deliver results in maternal and child health, nutrition, and reductions in key gaps and bottlenecks within the health system by linking payments to the achievement and verification of a set of disbursement linked indicators (DLIs). The program also includes funding for discrete activities related to capacity building, monitoring and evaluation, and operational strengthening through an Investment Project Financing (IPF) vehicle.

Of the USD 230 million, USD 40 million (USD 20 million from The Power of Nutrition and USD 20 million in International Development Association (IDA) funds) have been earmarked for nutrition across the PforR and IPF components. The PforR component (USD 35 million) supports delivery of three nutrition-specific interventions: (1) vitamin A supplementation for children under 5, (2) iron and folic acid (IFA) supplementation for pregnant and lactating women, and (3) Growth Monitoring and Promotion (GMP) for

children under-two.¹¹ The program also incentivizes the government to transition vitamin A supplementation from campaigns to routine services and to transition child health services in emerging regions from enhanced outreach services (EOS) to community health days (CHD). Prior to the program, only 45 percent of children 6 to 59 months were given vitamin A supplements, more than half the women (58 percent) did not take any iron tablets during their most recent pregnancy, and only 5 percent took iron tablets for 90 days or more (Ethiopia DHS 2016). Moreover, although GMP was considered a central platform for delivery of nutrition services, only 38 percent of children were participating in GMP services.

The program incentivizes achievement of targets for 5 nutrition DLIs, which are part of a package of 15 complementary maternal and child health DLIs in the broader program. Table E1 presents the full set of DLIs, including the 5 nutrition-specific DLIs (DLI 10a, DLI 10b, DLI 11, DLI 12a, DLI 12b). Progress against DLIs 10a and 11 are verified through the DHS while the others (DLIs 10b, 12a, and 12b) draw on Health Management Information System (HMIS) data and reporting from the government. An independent verification group, which includes key partners working in Ethiopia such as Nutrition International, Save the Children, UNICEF, Alive and Thrive, and WHO verify the reports from the government for the 3 DLIs that use HMIS data. The group conducts an annual joint review mission (JRM) and draws a mix of quantitative and qualitative data sources to verify results reported and make recommendations. Disbursements against achievement of annual targets for indicators are made to the SDG pooled fund.

Table E1. Disbursement linked Indicators for Performance for Results component

DLI	Description
DLI 1	Skilled Delivery
DLI 2	Children 12-23 months immunized with Pentavalent 3 vaccine
DLI 3	Pregnant women receiving at least 4 antenatal care visits
DLI 4	Contraceptive Prevalence Rate
DLI 5	Health centers reporting HMIS data in time
DLI 6	Development and implementation of Balanced Score Card Approach to assess performance and related institutional incentives
DLI 7	Development and implementation of Annual Rapid Facility Assessment
DLI 8	Transparency of Pharmaceuticals Fund and Supply Agency (PFSA) procurement processes
DLI 9	Introduction of Procurement DLIs developed by Federal Public Procurement Agency at PFSA Automate the PFSA core business fiduciary system PFSA submission of audit reports
DLI 10a	Percent of children 6-59 months receiving vitamin A Supplements
DLI 10b	Percent of woredas in non-emerging regions delivering vitamin A Supplements to children through routine systems (i.e. health facilities)
DLI 11	Percent of pregnant women taking IFA tablets
DLI 12a	Percent of children 0-23 months participating in GMP
DLI 12b	Percent of woredas in emerging regions transitioning from Enhanced Outreach Services to Community Health Days
DLI 13	Percent of PHC facilities having all drugs from the MoH list of essential drugs available Develop and implement postnatal care service directive to improve the quality of postnatal services Improve quality of adolescent health services
DLI 14	Percent of woredas functional Community Based Health Insurance (CBHI) schemes Undertake CBHI schemes review every two years
DLI 15	Devise and implement a mechanism for documenting consultations when communal/ private land is used for construction of health facilities Development and implementation of Health Sector Community Score Card (CSC)

Source: The Power of Nutrition concept note

¹¹ GMP services include targeted counselling to caregivers on appropriate IYCF and childcare practices, referral for follow-up care for illness [e.g., oral rehydration salts (ORS)/zinc for diarrhea] or further treatment as needed (e.g., for SAM), community mobilization and conversations on nutrition issues, and provision of micronutrient powders for home fortification of complementary foods.

The IPF component (USD 5m) supports technical assistance for multi-sector nutrition coordination and operational research to inform course correction. The operational research focuses on how to make GMP more effective, understanding the most effective ways to transition vitamin A supplementation and retain coverage, and the most effective ways to ensure pregnant women collect and consume an adequate dose of IFA.

III. Overview of the assessment

Our assessment seeks to provide an overview of the impact and influence of The Power of Nutrition's investment in Ethiopia. In the absence of a rigorous impact or process evaluation, the findings in this chapter draw on a deep dive country visit conducted in August 2019 and our in-depth review of program documents and country-level data from the HMIS and the Demographic and Health Surveys (DHS). In this section, we describe the key research questions addressed through this assessment, the data sources, and analytic approach used to answer these research questions.

A. Key research questions

We seek to answer the following research questions (RQ):

1. Did The Power of Nutrition's investments in Ethiopia deliver results at scale? In particular, to what extent has the program reached targets for the coverage, uptake, and utilization of nutrition services and programs?
2. What are the likely program effects at beneficiary level, in terms of deaths averted, cases of stunting prevented, and cases of maternal anemia averted?
3. To what extent has The Power of Nutrition contributed to changing the priority of nutrition in Ethiopia?
 - a. Did The Power of Nutrition's investment influence the GoE's attention to and prioritization of key nutrition interventions during the program design and development?
 - b. To what extent and how has The Power of Nutrition's investment influenced the GoE's financial commitments to nutrition programming, policies governing nutrition programming, and the nutrition partner landscape in Ethiopia?

B. Data sources and analytic approach

Our investigation of these research questions draws on a variety of sources including:

- **Deep dive country visit.** Mathematica conducted a one-week country visit to Ethiopia in August 2019. During this visit, we observed meetings between The Power of Nutrition, the World Bank, the Ministry of Health (MoH), and development partners working in the country. We also conducted key informant interviews with country-level stakeholders to shed light on development of the program, key achievements and challenges to date, and stakeholders' perspectives on The Power of Nutrition's contribution to any changes or results. We developed high-level protocols to structure these interviews. The protocols were designed to guide key informants to reflect on the PforR program and the nutrition component broadly based on their experience in their organization and role. Then the questions guided informants to reflect on factors that influenced key focal areas such as the program design, programmatic support, financing for nutrition, partnerships, and outcomes, as well as their independent assessment of the role and influence of various entities, including The Power of Nutrition, in each of these areas. Questions prompted informants to look back and forward to assess past activities and postulate about important future activities that The Power of Nutrition could lead or facilitate. We obtained consent before each interview and assured respondents that their information would be kept confidential to elicit candid responses. This encouraged stakeholders to

share both positive and less positive views, including areas where they felt The Power of Nutrition could do better.

- **Program documents and country-level data.** We reviewed program documents, The Power of Nutrition’s biannual reports, and country-level data reported by the program and implementing partner to The Power of Nutrition to obtain an overall understanding of the investment and progress to date. The country-level data reported to The Power of Nutrition draw on the HMIS, regional administrative reports, and the DHS and mini-DHS findings.¹²

To answer **RQ 1**, we review program documents and data to assess the progress made by the investment towards meeting its targets. We triangulate these findings with insights from the deep dive country visit to shed light on the quality of the nutrition programming and stakeholders’ perceptions on successes and challenges in delivering key targeted nutrition interventions at scale. To answer **RQ 2**, we use DHS data as well as program data to model program impacts on child mortality, stunting, and maternal anemia using the Lives Saved Tools (LiST). LiST is an epidemiological modeling tool which uses effect sizes drawn from a wide research-based literature to translate coverage improvements for key maternal and child health and nutrition interventions in low- and middle-income countries into reductions in mortality risk factors and ensuing reductions in mortality in subsequent years. As part of the pathway to reducing mortality, it also estimates impacts on child growth outcomes, such as stunting and wasting, as well as maternal anemia. Finally, to answer **RQs 3a-b**, we draw on key stakeholder interviews conducted as part of the deep dive site visit. We identified and coded key themes from each interview and triangulated across interviews to confirm and test for consistency in themes and identify discrepancies across interviews. Drawing on the findings from the qualitative analyses, we highlighted key achievements and learnings around The Power of Nutrition’s contribution to changing the priority of nutrition in Ethiopia.

IV. Key findings

In this section, we synthesize findings from our assessment around the role and influence of The Power of Nutrition’s investment on the following key areas: (1) coverage, uptake, and utilization of nutrition services and programs (**RQ 1**), (2) impacts on beneficiary level nutrition outcomes (**RQ 2**), (3) program design and development (**RQ 3a**), and (4) government commitment to and prioritization of nutrition (**RQ 3b**).

A. Coverage, uptake, and utilization of nutrition services and programs (RQ 1)

As of December 2019, the program exceeded targets for 3 of the 5 nutrition DLIs, but missed targets for the remaining 2. Challenges with the quality of services, particularly as the GoE transitions nutrition services from nutrition campaigns to routine delivery through the health system, will need to be addressed for the program to meet targets for the next year.

Table 2 shows the coverage of key indicators compared with what was targeted at the start of the program. As seen in Table E2, the program exceeded targets for the transition of vitamin A to routine systems in non-emerging regions (DLI 10b), consumption of IFA tablets by pregnant women (DLI 11), and transition of GMP from EOS to CHDs in emerging regions (DLI 12b). However, the program failed to meet its targets for coverage of vitamin A supplementation (DLI 10a) and coverage of GMP (DLI 12a). Assessments conducted by the JRM indicate potential gaps in the quality of these services, particularly as these services were transitioned into routine systems and integrated within the health system. Below we

¹² The DHS 2016 was conducted before the program and provides a baseline for nutrition outcomes indicators. The mini-DHS conducted in 2019 provides a midline. The next DHS, scheduled for 2021, when available, could serve as an endline for nutrition outcomes and indicators.

discuss the progress to date and quality of each of the three key nutrition interventions prioritized by the program.

- **Vitamin A supplementation.** The coverage of vitamin A supplementation for children 6-59 months could not be measured in the mini-DHS 2019.¹³ However, the coverage of vitamin A supplementation for children 6-35 months captured in the mini-DHS 2019 suggested that the program had not made enough progress to meet the 2018 target (Table E2). The independent JRM conducted in November 2018 highlighted that while the government had conducted trainings for the transition of vitamin A supplementation to routine systems, the health systems were not equipped to provide quality services. The JRM identified key quality criteria for the transition and provided recommendations for the program. The JRM in December 2019 evaluated the progress made by the program based on its recommendations, and found that while the program had transitioned all woredas to routine systems (exceeding the 2019 target for DLI 10b), there were remaining issues with community sensitization on the importance of vitamin A supplementation and challenges with stockouts, which should have been addressed during the transition. These issues likely resulted in the program missing its target for the coverage of vitamin A supplementation, and if they remain unaddressed could affect further progress in providing these services.
- **GMP.** Despite an overall upward trend in participation in GMP, the program missed the 2017, 2018, and 2019 targets for DLI 12a (Table E2). Moreover, there has been great disparity in coverage across the different regions, with the coverage in 2019 ranging from 18 percent in Harari to 95 percent in Dire Dawa, and two regions showing a decrease in coverage from 2018. However, the program exceeded targets for DLI 12b, with 80 percent of woredas in emerging regions reported to have been transitioned from EOS to CHDs. Similar to the transition of vitamin A supplementation, findings from the JRM in December 2019 suggest that while efforts have been made to address quality issues identified during the November 2018 JRM, there continue to be some challenges in the quality of services after the transition. These include workload and capacity constraints for health workers, lack of equipment at health posts, need for training for health center staff to provide these services, and challenges with registration and recording of services. These issues raise concern that the intervention will not be able to meet future targets unless the government takes immediate action to address the issues identified and improve quality of GMP services, particularly in woredas that have transitioned from EOS to CHDs.
- **IFA supplementation.** The mini-DHS in 2019 shows that program exceeded the 2018 target for IFA supplementation which is based on any IFA supplementation (Table E2). Further, the DHS reveals that the proportion of women who took 90+ IFA tablets also increased from 5 percent in 2016 to 11 percent in 2019, suggesting better than anticipated performance in the delivery of this intervention (mini-DHS 2019). Country-level stakeholders noted that the addition of indicators to track IFA supplementation to the HMIS had facilitated close monitoring of progress. This allowed the nutrition team to take actions to course correct when the HMIS data indicated that they may be off track from achieving the target. The nutrition team has also been able to access SDG pooled funds for the procurement of IFA to meet the projected needs based on forecasts at the facility level. Following the success of the program in delivering IFA supplementation and The Power of Nutrition's recommendation to the World Bank, the GoE has agreed to add another DLI to incentivize improving the coverage of pregnant women taking IFA for 90+ days (which was approved in February 2020 following the midterm review). This is notable given the GoE was initially hesitant to include any DLIs

¹³ The age group that was surveyed in the mini-DHS 2019 was 6-35 months and not the standard 6-59 months due to a change in the agency that conducts the DHS.

for IFA supplementation during the program development phase. However, the mini-DHS 2010 reveals large disparities in the results across regions, with coverage of any IFA supplementation ranging from 19 percent in Somali (a drop from 28 percent in 2016) to 85 percent in Tigray (mini-DHS 2019). The program should try to address these disparities across regions.

Table E2. Program progress against targets for nutrition DLIs

Disbursement Linked Indicator	Baseline (2016)	Y1 Target (2017)	Y1 Result (2017)	Y2 Target (2018)	Y2 Result (2018)	Y3 Target (2019)	Y3 Result (2019)
DLI 10a. Percent of children 6-59 months receiving vitamin A supplements ¹	45%	N/A	N/A	49%	47% ⁴	N/A	Next reporting in 2021
DLI 10b. Percent of woredas in non-emerging regions delivering vitamin A supplements to children through routine systems (i.e. health facilities rather than campaigns) ²	48%	50%	63%	55%	69%	60%	100%
DLI 11. Percent of pregnant women taking IFA tablets ¹	42%	N/A		46%	60% ⁵	N/A	Next reporting in 2021
DLI 12a. Percent of children 0-23 months participating in GMP ³	38% ⁶	44%	42%	50%	44%	56%	53.5%
DLI 12b. Percent of woredas in emerging regions transitioning from EOS campaigns to CHDs ²	0%	10%	19%	20%	26%	35%	80%

Source: The Power of Nutrition Biannual Report July 2019-December 2019

¹ This indicator is tracked using the DHS or mini-DHS

² This indicator is tracked using regional administrative reports

³ This indicator is tracked using the HMIS

⁴ The Ethiopia Mini-DHS 2019 measured vitamin A supplementation coverage among children 6-35 months and not the standard age group of 6-59 months. The next full DHS is scheduled for early 2021, which will provide progress against this indicator.

⁵ This indicator is recorded as any consumption of IFA tablets in pregnancy from the DHS. The Ethiopia Health Data Analysis Platform (EHDAP) data report 836,103 pregnant women received IFA tablets in pregnancy in 2017-2018 and 2,390,569 pregnant women received IFA tablets in pregnancy between 2018-2019.

⁶ The baseline and targets for GMP were revised to reflect the inclusion of 150 woredas that were supported under ClIFF nutrition investment in Ethiopia

Overall, the alignment around three key nutrition services and DLIs for these services has allowed the nutrition team to focus its efforts on achieving targets for these services. Moreover, since these services and DLIs are sentinel indicators for delivery of other nutrition services in Ethiopia, the focus on these indicators is aligned with the GoE's NNP II.

B. Impacts on beneficiary level nutrition outcomes (RQ 2)

Results from the LiST modelling suggest that based on the results achieved to date and targets for future years, the program could avert nearly 109,000 cases of stunting, over 2,900 deaths of children under 5, and 293,000 cases of maternal anemia.

We used the LiST to model the impacts of the package of nutrition interventions implemented as part of the program. The modeling draws primarily on national-level intervention coverage trends observed across the DHS 2011, 2014, 2016, and mini-DHS 2019 for IFA supplementation and vitamin A supplementation (Appendix Table E1). Given the importance of GMP services and a platform for delivery

of nutrition interventions including IYCF counseling, we used the results and targets for GMP from the HMIS as a proxy indicator for education of mothers on complementary feeding (without supplemental feeding). Similarly, we assumed that the GMP services must have contributed to improving the promotion of age-appropriate breastfeeding, and thus the prevalence of breastfeeding. We used the DHS 2016 and mini-DHS 2019 data on exclusive breastfeeding rates to model the impacts of promotion of breastfeeding.

For 2020-2021 (the remaining duration of the investment), for which results are not yet available, we assumed that over 2020-2021, the program will achieve and maintain its coverage targets for IFA supplementation, vitamin A supplementation and GMP. Based on the progress to date and targets for the rest of the investment period, by 2021, the investment would avert almost 109,000 cases of stunting (driven by complementary feeding education), over 2,900 deaths of children under 5 (driven by vitamin A supplementation), and 293,000 cases of maternal anemia (driven by IFA supplementation).¹⁴ Given that The Power of Nutrition support is part of a broader maternal and child health program package being implemented by the GoE and other partners, the estimated health and nutrition effects should be generally interpreted in terms of contribution rather than attribution.

C. Program design and development stage (RQ 3a)

Country level stakeholders and implementing partners uniformly agreed that The Power of Nutrition's funding was critical to including a nutrition component and allocating IDA funds to nutrition as part of the Health SDG PforR program in Ethiopia.

From 2008 to 2013, the World Bank supported a USD 30 million Ethiopia Nutrition Project which implemented community-based nutrition activities through the Health Extension Program (World Bank 2019). Once the project ended, there was a gap in resources available for nutrition, with no specific budget allocated for nutrition from the MoH. Nutrition programming relied on support from various development partners working in Ethiopia.

The Power of Nutrition was interested in developing an investment in Ethiopia because one of its new donors had expressed interest in funding a program in Ethiopia. This provided an opportunity to leverage The Power of Nutrition's funding to include a nutrition component in the Health SDG PforR program that was being negotiated between the World Bank and the GoE. Prior to The Power of Nutrition's involvement, the program was focused on maternal and child health, and the GoE was reluctant to invest IDA loans in nutrition. However, The Power of Nutrition's grant money that would match IDA loans from the World Bank one-for-one incentivized the GoE to consider including nutrition as part of the broader Health SDG PforR program. The World Bank and country stakeholders uniformly highlighted that in the absence of The Power of Nutrition's funding, there would not have been a nutrition component in the program. Moreover, The Power of Nutrition's funding (along with similar funding from GFF) contributed to increasing the overall envelop for the program and led to the allocation of additional IDA funds, which might have otherwise gone to infrastructure projects, towards a health and nutrition program.

The Power of Nutrition also conducted extensive negotiations between the GoE, the World Bank to represent the priorities of the various stakeholders and get alignment on the DLIs to be included for nutrition.

Stakeholders emphasized that The Power of Nutrition's funding was critical to convincing the GoE and the World Bank to include 5 DLIs for nutrition. Because of the amount of resources (USD 40 million) that The Power of Nutrition and IDA match had brought for nutrition, The Power of Nutrition was able to negotiate with the GoE and the World Bank to include more DLIs than they would have otherwise considered for

¹⁴ We will update these findings using coverage data from the DHS 2021 in the endline report.

nutrition. Some stakeholders also felt that The Power of Nutrition's negotiations had also pushed the government to include challenging DLIs (for example, IFA supplementation, which had been historically low in Ethiopia) and set ambitious targets for the government to achieve.

There were a few key issues presented by the different stakeholders involved that required extensive negotiations:

- **GMP.** First, the government was keen to include GMP as one of the DLIs. The Power of Nutrition's due diligence, however, highlighted a divergence in opinion within the international nutrition community around GMP, driven in part by quality concerns around GMP measurement. However, country-level stakeholders and technical experts working in Ethiopia considered GMP to be the central platform for contact between trained health workers and caregivers for the transmission of nutrition education to promote Infant and Young Child Feeding (IYCF) practices and build demand for nutrition services. Ultimately, two DLIs (DLIs 12a and 12b) were included for GMP. To address The Power of Nutrition's concerns about quality, it was decided that the IPF component would include operations research to understand what works for GMP and how to improve the quality of GMP.
- **IFA supplementation.** The Power of Nutrition wanted to include a DLI for IFA supplementation. The standard indicator used for this is consumption of 90+ IFA tablets. However, because IFA supplementation had been poor in Ethiopia because of supply issues, the government was reluctant to tie disbursements to IFA. Ultimately, one DLI (DLI 11) capturing any IFA supplementation for pregnant women was included in the program, considering the government's concerns around potential measurement challenges associated with the standard indicator of consumption of 90+ IFA tablets.¹⁵

Overall, the extensive negotiations resulted in a strong program that reflected country priorities and represented the priorities and concerns of the key stakeholders.

The Power of Nutrition negotiated to allocate IDA funds for technical assistance and operations research to improve the quality of nutrition services.

Since the disbursements under the PforR component of the program are largely based on coverage of services rather than quality, some stakeholders felt there was a need for technical assistance and operations research to improve the quality of services. Moreover, the coverage targets would not be achieved without sufficient quality of services. For example, transitioning the delivery of vitamin A supplementation from campaigns to routine systems (i.e. at facilities) and transitioning GMP from enhanced outreach services to community health days requires that the health system can integrate nutrition services and maintain quality. If the transition is not done effectively and the quality of services available through the health system is poor, caregivers may not seek these services, which would ultimately lower coverage of these services. The Power of Nutrition's grant funding allowed the inclusion of technical assistance and operations research activities under the IPF component. Initially, the GoE did not want to invest any of the IDA loans towards technical assistance and operations research activities and wanted to use The Power of Nutrition's grant to support the USD 5 million IPF component. The Power of Nutrition, however, successfully negotiated to split the IPF component equally with the GoE to make sure that the government would be invested in the activities conducted under the IPF component. Although this was a challenging negotiation, ultimately program stakeholders, including staff from the MoH are relying on the IPF component to provide insights on challenges faced in reaching targets and to help address them and improve the quality of services. The technical assistance and operations research will be

¹⁵ Following the strong performance of the program in delivering IFA supplementation and The Power of Nutrition's recommendation to the World Bank after the midterm review, the GoE agreed to add another DLI to incentivize improving the coverage of pregnant women taking IFA for 90+ days.

provided by UNICEF under a contract agreement between the MoH and UNICEF developed as part of the program.

D. Government commitment to and prioritization of nutrition (RQ 3b)

The program has led to increased allocation of government budget to nutrition and increased prioritization of nutrition. This is attributed largely to having USD 35 million in disbursements linked to 5 nutrition-specific indicators.

Before the program, the nutrition team struggled to obtain funds for nutrition, with country stakeholders reporting that they received less than 10 million Ethiopian Birr (approximately, USD 300,000) for implementation. However, since the PforR program started, the nutrition team has been more empowered to make a case to the MoH for budget allocations for nutrition since USD 35 million in disbursements from the program are tied to the achievement of nutrition-specific DLIs. In the last 3 years, country stakeholders report large increases in the amount of funding the team has been able to get for nutrition. Moreover, since the program started, the MoH has also allocated a regular budget from the SDG Pooled Fund for the procurement of IFA tablets for pregnant women.

To ensure sustained progress, the MoH will need to build the capacity of the nutrition team.

The MoH and nutrition team have experienced significant turnover since the program began. The nutrition team has built experience and capacity over the course of the program by participating in program review missions and engaging in technical discussions with the World Bank, The Power of Nutrition, and other partners. The team has also built the confidence to negotiate with the MoH for the allocation of resources from the SDG Pooled Fund to nutrition. The progress achieved by the program to date is in part because of the experience and capacity that staff have developed over time to strengthen the delivery of nutrition services within the health system. However, the staff turnover within the MoH and nutrition team and the long time taken to fill vacancies could setback this progress while new staff are recruited and brought up to speed.

The GoE has made efforts to strengthen the tracking of nutrition services by including nutrition indicators within the HMIS.

The negotiations during the program development phase also led to the addition of 4 nutrition indicators to the HMIS, including indicators to track IFA supplementation and GMP for children under 2. The inclusion of these indicators in the HMIS and transition to the national district health information system (DHIS) 2, a web-based platform, since 2018 has facilitated tracking of services at the facility level and easy identification of outliers and incomplete data. As discussed earlier, the HMIS data helped the government track and diagnose issues with IFA supplementation early on and course correct resulting in impressive progress on this intervention.

The PforR program is designed such that the funds for achieving results flow to the federal level, which may result in a lack of incentives at the regional level, the level that is responsible for program implementation.

Ethiopia has a decentralized federal structure of administration in which the responsibility for health and nutrition policy is shared between the Federal MoH, regional health bureaus, and *woreda* health offices. For the program to succeed in achieving targeted results, it is important that there is buy-in at the regional and *woreda* levels for the plans made at the federal level. Large disparities across regions in program achievement suggest that the MoH will need to work with the regional and *woreda* levels to present data, identify challenges and bottlenecks, and align on an action plan to address issues.

The Power of Nutrition’s pooled funding model brings together donors to jointly support the GoE’s priorities for nutrition.

The donor landscape in Ethiopia is highly fragmented with partners supporting the GoE in providing nutrition services through several individual projects. The Power of Nutrition’s investment pools funds from several donors towards a program implemented by the GoE to strengthen delivery of key nutrition services prioritized by the government within the broader health system. By bringing focus and attention to these core interventions (and associated DLIs), the program aligns partners around a common set of priorities and facilitates the government and partners working together to achieve the targets. Moreover, by bringing together partners with a deep footprint in Ethiopia, such as Nutrition International and UNICEF, the investment offers an opportunity to leverage these partners’ extensive experience and learnings from their work in the country to inform government delivery of nutrition services. The Power of Nutrition actively engages with the World Bank, MoH, and nutrition case team to flag issues and improve the coverage and quality of interventions during its review missions in country, drawing on input from country partners to inform its recommendations. For partners, the opportunity to invest in a large World Bank program with the GoE, improves their ability to engage with the government and the World Bank.

The Power of Nutrition and World Bank have also created an informal donor group that conducts the JRM to provide independent verification of the progress reported by the government. The input from the JRM as well as from supervisory missions conducted by The Power of Nutrition and its partners has stimulated conversations between partners, the World Bank, UNICEF, and the MoH, and provided a platform for sharing information and learnings to come up with a coordinated response to address issues identified.

While overall, there has been a push to defragment the partner landscape, some country partners felt that the program could engage more with them and leverage their local expertise. For some partners, there was a disconnect between the headquarters and country offices, with input on the program design and development coming from headquarters without involvement of the country office. Country office stakeholders felt they had not been engaged during the design and development of the program components and were sometimes not fully aligned with the program priorities and approach.

Although there is high level political and financial commitment to the multisectoral coordination to address undernutrition and stunting, the GoE needs to provide clear guidance on how these efforts will be coordinated.

Under the IPF component, the nutrition team has also conducted work at the policy level, and recently developed a National Food and Nutrition Policy for Ethiopia. This policy establishes a legal and institutional framework to improve food and nutrition security outcomes through coordination of nutrition-sensitive and nutrition-specific interventions across sector ministries. At the same time, the GoE renewed its commitment to the Seqota declaration, which seeks to end child undernutrition and stunting in Ethiopia by 2030, with high level engagement from the Deputy Prime Minister and ministers across sectors. The IPF component of the Health SDG PforR program supports roll out of multi-sector efforts piloted in 2 regions under the Seqota declaration to other regions. While such high-level commitment and cross-sector coordination to eliminate undernutrition and stunting is promising, with multiple agencies focusing on nutrition, it will be important for GoE to provide guidance on the exact structure and technical coordination body responsible for coordinating the efforts across sectors.

V. Summary

Overall, the investment has made significant progress towards achieving key targeted nutrition outcomes. However, there remain quality issues, particularly as services transition from campaigns to routine delivery through the health system. The World Bank’s PforR model and The Power of Nutrition’s pooled funding

approach and matched funding model have raised the prioritization of nutrition by the MoH and contributed to defragmenting the partner landscape. The GoE has demonstrated high level political commitment and will to reduce undernutrition and stunting through multisectoral approaches. The GoE will need to provide guidance to coordinate cross-sector efforts to achieve its goals.

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Appendix Table E1: Ethiopia LiST Modeling Results

Interventions		DHS		Mini-DHS		Power of Nutrition target		LiST representation				Beneficiaries 2017-21 (LiST)	Averted cases (2017-2021):		
		2016	2019	2020	2021	2016	2019	2020	2021	2016	2019		2020	2021	Stunting
IFA Supplementation	Coverage: Target				66%	42%	60%	60%	60%		9,285,024				293,035
	Coverage: Result	42%	60%												
Vitamin A Supplementation	Coverage: Target			53%		45%	47%	53%	53%		33,211,226	5,406	646		
	Coverage: Result	45%	47%												
Complementary Feeding, Education (GMP)	Coverage: Target			62%	65%	38%	54%	62%	65%		8,416,968	102,875	1,709		
	Coverage: Result	38%	54%												
Promotion of Breastfeeding (GMP)	Coverage of BF promotion					58%	61%	63%	64%		9,791,937	588	637		
	Prevalence	58%	59%			58%	59%	59%	59%						
TOTAL												108,869	2,992	293,035	

LIBERIA INVESTMENT PROFILE AND KEY RESULTS

I. Background and context

Liberia has historically been among the world's poorest countries, and even as of 2019, ranked 176 of 189 on the United Nations Development Program's Human Development Index (United Nations Development Program 2019). Decades of conflict and civil wars have led to negative impacts on the country's economy and overall development. Liberia's healthcare delivery system is among the poorest in the world, contributing to high rates of malnutrition, and childhood mortality. Before the Ebola outbreak in 2014, the country showed some early signs of improvement. By 2012, Liberia achieved the Millennium Development Goal of reducing the under 5 mortality rate by one-third (Streifel 2015). However, undernutrition indicators still remained dangerously high. In 2013, nearly one-third of children under 5 were stunted, and the prevalence of anemia among this population was more than 60 percent (Liberia Institute of Statistics and Geo-Information Services 2013). The Ebola outbreak of 2014 worsened nutrition practices and outcomes, constrained an already overwhelmed health system, contributed to a lack of confidence in the health system, and diverted government and international donor funds originally intended for nutrition activities towards the immediate Ebola concerns, creating a nutrition funding gap in the country (The Power of Nutrition Investment Summary n.d.). To address these issues, The Power of Nutrition and UNICEF committed to support the Government of Liberia's (GoL) efforts to implement the National Nutrition Plan and tackle childhood undernutrition in the post-Ebola period. In this chapter, we provide an overview of the investment and results achieved to date.

II. Overview of the program

The Power of Nutrition and UNICEF committed USD 9.2 million to fund a three-year program supporting nutrition activities in Liberia, with additional in-kind support of USD 3.2 million from the GoL. The program, which seeks to improve the coverage of nutrition-specific interventions across the country, was implemented across 15 counties in Liberia from January 2017 to March 2020. Before the Liberia-specific Contribution Agreement was signed in December 2016, UNICEF was already funding implementation in 10 counties in the country. Upon signature of the Contribution Agreement, the co-investment became operational, and The Power of Nutrition and UNICEF started contributing to the national program covering all 15 counties.

Prior to the program, nutrition interventions had largely been implemented as standalone parallel programs, and there was commitment from the government to mainstream nutrition programming. Moreover, there was a strong need to build the capacity of health workers to deliver nutrition services and strengthen nutrition information systems. To address these issues, the program supported the implementation of the following nutrition-specific interventions: (1) promotion of appropriate breastfeeding and complementary feeding practices among pregnant or lactating women; (2) vitamin A supplementation for children 6-59 months; (3) multiple micronutrient powder (MNP) supplementation for children 6-23 months; and, (4) iron and folic acid (IFA) supplementation for pregnant women; and (5) treatment of severe acute malnutrition (SAM) for children 6-59 months. In addition, the program also provided complementary and support activities, including procurement and the distribution of nutrition commodities, community mobilization aimed at raising awareness and creating demand for nutrition services, capacity building of health workers on key nutrition topics and nutrition information systems, establishment of a robust nutrition information system that is integrated in the national HMIS, and advocacy to the GoL to fulfil its USD 3.2m Nutrition for Growth commitment and to support regular coordination and program review initiatives (Table L1). Program activities are implemented by the GoL, UNICEF, and key nutrition stakeholders in the country.

Table L1: Focus areas and program activities

Focus Areas	
Nutrition-related activities	<ul style="list-style-type: none">• Managing, procuring, and distributing nutrition commodities, including:<ul style="list-style-type: none">○ ready-to-use therapeutic foods (RUTF) for children 0-59 months with SAM○ micronutrient powders (MNP) for children 6-23 months○ IFA supplements for pregnant women• Creating awareness and demand for nutrition services among mothers through:<ul style="list-style-type: none">○ Community mobilization using community meetings, radio messages, and dissemination of information, education and communication (IEC) materials○ Multi-media campaigns/SMS technology for education on MNP, IFA, vitamin A, infant and young child feeding, treatment of SAM.
Health system strengthening	<ul style="list-style-type: none">• Strengthening the capacity of health workers on nutrition topics• Establishing a robust nutrition information system integrated within the HMIS• Strengthening supervision, data collection, monitoring, reporting and evaluation through UNICEF monitoring and technical assistance to NGOs
Advocacy activities	<ul style="list-style-type: none">• Technical assistance to GoL to develop national nutrition policies• Advocacy with GoL to fulfill their financial commitments to nutrition

Source: UNICEF Liberia Program Description; UNICEF Liberia Executive Summary

III. Overview of the assessment

Our assessment seeks to provide an overview of the impact and influence of The Power of Nutrition and UNICEF co-investment in Liberia. In the absence of a rigorous impact evaluation or deep dive country visit, the findings in this chapter draw on our in-depth review of program documents and data, independent assessments of the program commissioned by The Power of Nutrition and UNICEF, and secondary data sources such as national surveys conducted during the investment period. In this section, we describe the key research questions addressed through this assessment, and the data sources and analytic approach used to answer these research questions.

A. Key research questions

We seek to answer the following research questions (RQ):

1. To what extent has The Power of Nutrition and UNICEF co-investments in Liberia delivered results at scale?
 - a. What data and evidence are available to assess the coverage, uptake, and utilization of nutrition services and programs? How reliable are these data sources?
2. What results have the program achieved at beneficiary level, in terms of deaths averted, cases of stunting prevented, and cases of maternal anemia averted?
3. To what extent and how has the prioritization of nutrition by the GoL evolved during the investment period? Has the program increased government ownership of nutrition programming and policies? To what extent has co-investment contributed to changing the priority of nutrition in Liberia?

B. Data sources and analytic approach

Our investigation of these research questions draws on a variety of sources including:

- **Program documents and data.** We reviewed program documents, The Power of Nutrition's biannual reports, and program data from the Health Management Information System (HMIS) reported by the country program and implementing partner to The Power of Nutrition to obtain an overall understanding of the co-investment and progress to date.

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- **Independent assessments of the program commissioned by The Power of Nutrition and UNICEF.** The Power of Nutrition and UNICEF commissioned two independent evaluations of the program to assess program coverage and government financing and sustainability:
 - **Assessment of coverage of direct nutrition interventions.** Valid International conducted two rounds of coverage surveys in 2 of the 15 program counties, Grand Bassa and Montserrado (Greater Monrovia). These counties were selected to represent an urban and a rural county. Moreover, Montserrado county was selected because it is the most populous county in the country and home to nearly one-third of the country's population, with most of this population living in Greater Monrovia District (Liberia Census 2008). Grand Bassa was selected because it had the highest stunting rate at the time of the survey. Data were collected in September 2018 and September 2019, approximately 1.5 years and 2.5 years after the program started. The surveys capture the need for and coverage of treatment of SAM in children 6 and 59 months, vitamin A supplementation, MNP supplementation, IFA supplementation, and infant and young child feeding (IYCF) counselling. It also explores barriers to uptake of nutrition services. Although the limited geographic scope and lack of a baseline somewhat limit the usefulness of the assessment in understanding the impact of the program, the findings from the surveys provide useful insights on coverage and quality of the nutrition services provided by the program and gaps in nutrition programming in the two counties.
 - **Assessment of government financing and sustainability of nutrition programming.** Valid International conducted a comprehensive review of the GoL's financial commitments to nutrition (budget and expenditures) and governance of nutrition programming (ownership of new or existing policies related to nutrition-specific interventions) drawing on both qualitative and quantitative data. The assessment of financial commitments included a review of budget commitments and expenditures for 10 nutrition-specific interventions, quantitative analysis and estimates of financial commitments, and stakeholder interviews to augment the financial analysis. This mixed-methods approach is particularly important because the economy was contracting during the investment period, and budget analysis alone would not give a clear picture of the government commitment to nutrition. The governance assessment also involved a desk review of all existing or new policy documents or strategy documents developed during the investment period, a review of monitoring and evaluation, including the HMIS, and interviews with key stakeholders.
 - **Secondary data sources.** In addition to program data and the coverage surveys, we draw on findings from national surveys such as the Liberia Demographic and Health Surveys (LDHS) and the Comprehensive Food Security and Nutrition Surveys (CFSNS). The LDHS 2013 was conducted before the program and provides a baseline for nutrition outcomes indicators. The LDHS 2019 was underway at the time of this draft, and findings from the LDHS 2019 could not be included in the review, but when available, could serve as an endline for nutrition outcomes and indicators. The CFSNS, implemented by the GoL with support from humanitarian and development partners, collected data from March to May 2018, which provides a midline for nutrition outcomes and indicators.¹⁶ The CFSNS surveys provide both national and county-level estimates.

To answer **RQ 1** around levels of coverage, uptake, and utilization of nutrition services, we begin with an in-depth review and comparison of the coverage of nutrition services reported in the program data,

¹⁶ The CFSNS is a national assessment that is undertaken periodically to inform the food security, health and nutrition status of the population. Prior to 2018, the survey was conducted in 2012, 2010, 2008, and 2006. Ebola Outbreak in 2014/2015 led to a long gap between the 2012 survey and the 2018 survey. The partners in the food security and nutrition sector/cluster involved include UN agencies, International Non-Governmental Organizations (INGOs), USAID, EU, etc.

national surveys, and coverage assessment. The program data provide the most comprehensive set of indicators to examine progress made by the program in improving coverage of targeted nutrition-specific interventions during each year of investment period (2017-2019). For indicators available in the national surveys (particularly CFSNS), we triangulated the reports across these data sources to assess validity and quality of the data reported by the program. For other interventions, we triangulate between coverage reported in the program data and the independent coverage assessments. Since Montserrado and Grand Bassa counties together account for nearly 40 percent of the total population in Liberia, and the CFSNS data suggest that estimates for these two counties are similar to national estimates, we expect the coverage surveys provide a reasonable benchmark for comparison. (A complete list of data sources and indicators is provided in Appendix Table L1.) To answer **RQ 2** around the beneficiary-level effects of the program, we look at changes in national data over time where available. When the LDHS 2019 is available, we will model program impacts on child mortality, stunting, and maternal anemia using the Lives Saved Tools (LiST). Finally, to answer **RQ 3** on the prioritization of nutrition by the GoL, we draw on the findings from the assessment of government financing and sustainability of nutrition programming commissioned by The Power of Nutrition and UNICEF.

IV. Key findings

In this section, we synthesize findings from our assessment around the following key areas: (1) the coverage, uptake, and utilization of nutrition services and programs (**RQ 1**), (2) impacts on beneficiary level nutrition outcomes (**RQ 2**), and (3) the GoL's commitment to, prioritization, and ownership of nutrition programming (**RQ 3**).

A. Coverage, uptake and utilization of nutrition services and programs (RQ 1)

Patterns of changes in the coverage data, as well as differences between the coverage reported in the program data, and the CFSNS and the independent coverage assessments, highlight potential measurement issues that should be taken into account when interpreting the program achievements.

Where comparable data are available across sources, our comparison of indicators suggest that the program data (from the HMIS) typically report higher levels of coverage compared to both the CFSNS and coverage assessments. Below we describe the findings for each of the key nutrition-specific interventions targeted by the program and try to reconcile differences between the data sources to obtain a better understanding of the coverage, uptake, and utilization of key nutrition services.

The CFSNS 2018 reports on coverage of vitamin A supplementation in children under 5 and MNP distribution through household surveys conducted between March and May 2018. The program data tracks these indicators all year through the HMIS. Since the CFSNS 2018 surveys were conducted from March to May 2018 while the program data cover the entire year, we compare the estimates from the CFSNS to the program data reported for both 2018 and 2017. We also compare the program data to county-level results generated by both the CFSNS and the independent coverage surveys conducted in 2018.

- **Vitamin A supplementation.** The program data for 2017 and 2018 indicate that the program reached more than the projected number of beneficiaries for vitamin A supplementation (126 and 123 percent for 2017 and 2018, respectively (Table L2). The Power of Nutrition biannual report notes that there were issues with targeting children in the 6 to 59-month age range for vitamin A supplementation, resulting in some children 5 and older, who are outside the target age range, receiving supplementation. The targeting issue inflates the numbers from the program data in the early years. In 2019, the program improved its targeting to reach children in the correct age group

with supplementation. However, due to a funding constraint, the program prioritized providing the second dose of vitamin A in 5 out of the 15 counties. The combined impact of the improved targeting and funding shortage is a dramatic drop in coverage reported in the program data, from 820,140 children in the targeted age group reached in 2018 to 420,589 (or 62 percent of the population in need) in 2019.

The CFSNS reports a much lower coverage of 71 percent in 2018 (which is up from 60 percent in LDHS 2013). Additionally, the independent coverage surveys estimate the coverage in the two counties to be considerably lower than the over-100 percent coverage reported by the program data nationally, also suggesting that it is unlikely the program reached its target of 96 percent for 2018.¹⁷ These issues highlight potential concerns with the quality of program data, particularly in the first two years of the program.¹⁸

Table L2: Comparison of coverage estimates across program data, CFSNS, and independent coverage surveys

	National			Greater Monrovia			Grand Bassa			
	Program data			CFSNS	Coverage Assessment ¹		CFSNS	Coverage Assessment ¹		CFSNS
	2017	2018	2019	2018	2018	2019	2018	2018	2019	2018
Proportion children 6-59 months who received 2 doses of vitamin A supplementation in calendar year ²	126%	123%	62%	71%	82%	78%	72%	84%	82%	70%
Proportion of children 6-23 months who received MNPs	30%	88%	92%	16%	13%	43%	14%	1%	37%	15%

Source: Program data reported by the GoL and UNICEF to The Power of Nutrition, CSFNS 2018, Coverage assessment report

¹ Independent coverage surveys conducted by Valid International

² CFSNS reports the proportion of children 6-59 months have received vitamin A supplement. The coverage assessment reports the proportion of children 6-59 months have received vitamin A supplementation in the past 6 months

N/A: data not reported for the indicator

- MNP supplementation.** For MNP supplementation, the program data suggest that there was 88 percent coverage of the target population (children 6 to 23 months) in 2018, nearly tripling from the coverage reported in 2017 and exceeding the program target (60 percent) for 2018. In contrast, the CFSNS 2018 reports that only 16 percent of children 6-23 months received MNP supplements (Table L2). Since data collection for CFSNS was conducted from March to May 2018 while the program data cover the entire year, we also compared the results in CFSNS 2018 to the program data for 2017. The coverage reported in the program data for 2017 (30 percent) is still nearly double the coverage reported by the CFSNS. Discussions with stakeholders suggest two potential explanations for these differences. First, since the program data report the distribution of supplements from the HMIS, the program data may overstate coverage because it cannot verify if children consumed the MNP supplements distributed. Second, stakeholders noted that MNP supplementation was a relatively new

¹⁷ The independent coverage survey conducted in 2018 in Greater Monrovia and Grand Bassa reported slightly larger estimates of vitamin A coverage compared to the estimates by county from the CFSNS 2018 (Table 2), but these differences could be due to differences in the timing of data collection for the CFSNS (March to May 2018) and the coverage assessment survey (September 2018).

¹⁸ The LDHS 2019, when available, will report coverage levels in 2019 which can be compared to the program data in 2019.

activity, and several activities to build awareness about MNP supplementation were conducted in 2018, which might explain the large increase by the end of 2018.

For Greater Monrovia and Grand Bassa, the coverage surveys show an improvement in MNP supplementation between 2018 and 2019 (Table L2). However, the coverage levels reported in the two counties for 2018 and 2019 are much lower than the program data nationally, indicating that it is likely that the program data are overstating the coverage. One potential reason for the lower coverage of MNPs in the 2019 coverage assessment may be due to fact that while the survey intended to show the survey respondent the two types of MNP's that were being distributed by the health system, the teams were not able to source one of the MNP's – the one more commonly distributed – prior to the data collection, so households may not have reported having received or bought the MNP.

The CFSNS 2018 does not report data on coverage of community-based management of acute malnutrition (CMAM), IFA supplementation, or IYCF counseling, and the program data and the coverage assessment which report coverage of these interventions have different geographical scope and samples, which limit our ability to compare these indicators across the surveys. However, we provide a qualitative assessment of the levels and trends reported in the program data.

- **Treatment of SAM.** We find large disparities in the trend for CMAM coverage between the program data and independent coverage surveys. The program data report that the proportion of children under 5 reached with treatment for SAM increased from 48 percent in 2017 to 54 percent in 2018 and 69 percent in 2019 (Table L3). The coverage assessment on the other hand reported a large drop in treatment of SAM from 55 percent in 2018 to 27 percent in 2019 in Greater Monrovia and a smaller drop from 18 percent in 2018 to 14 percent in 2019 in Grand Bassa (Table L3). One possible explanation for the higher rates of treatment reported in the program data could be that the screening and case finding effectiveness is poor, resulting in a large number of undetected cases of SAM, which aren't counted in the denominator when calculating the treatment coverage. This explanation is consistent with findings from the independent coverage assessment. The coverage surveys independently assessed the prevalence of acute undernutrition using middle upper arm circumference (MUAC) criteria as well as the prevalence of screening, case-finding effectiveness, and treatment of SAM. The coverage surveys report extremely low rates of screening coverage (3 percent in 2019 in both counties) and case-finding effectiveness for CMAM (14 percent in Greater Monrovia and 6 percent in Grand Bassa in 2019), suggesting that most cases of SAM might go undetected by health workers. As a result, we expect the program data likely overstates the treatment rates.
- **IFA supplementation.** The program data reports IFA supplementation for women who are currently pregnant while the coverage survey reports the coverage of IFA supplementation for mothers of children 6 to 59 months during their most recent pregnancy. The difference in the indicator and sample represented by the indicator limits our ability to compare these sources. Overall, the program data show a decrease in the proportion of pregnant women who received IFA supplements for 180 days from 88 percent in 2017 to 84 percent in 2018 and 70 percent in 2019 (Table L3). This could be a result of stockouts, with 758 facilities reporting stockouts in the availability of IFA in 2019. Consistent with the trend over time observed in the program data, the coverage assessment finds that the proportion of mothers who reported consuming IFA tablets for 90 days or more dropped from 2018 to 2019 in both Greater Monrovia and Grand Bassa, likely also reflecting stockouts (Table L3).
- **IYCF counseling.** The program data reports the proportion of pregnant women who received IFA tablets for 180 days reached with counselling on appropriate IYCF as a proxy indicator for promotion

of breastfeeding and complementary feeding education.¹⁹ This indicator likely underreports the IYCF coverage since it does not include women who may have received IYCF counseling but not received IFA tablets for 180 days. The program data reveal an increase in the coverage during the investment period from 31 percent in 2017 to 62 percent in 2018 and 68 percent in 2019. The coverage assessment reports the proportion of women with children 6 to 59 months who attended IYCF counseling. Given the difference in the indicator, the coverage levels in the program data cannot be compared to those in the coverage assessment; however, the coverage assessment reveal a similar upward trend in coverage of IYCF counseling.

Table L3: Comparison of coverage estimates across program data and independent coverage surveys

	National			Greater Monrovia		Grand Bassa	
	Program data			Coverage Assessment ¹		Coverage Assessment ¹	
	2017	2018	2019	2018	2019	2018	2019
Proportion of children aged 0-59 months reached with treatment for SAM	48%	54%	69%	55%	27%	18%	13%
Proportion of pregnant women who received IFA supplements for 180 days	88%	84%	70%	N/A	N/A	N/A	N/A
Proportion of mothers of children 6-59 who consumed IFA (for at least 90 days) during most recent pregnancy	N/A	N/A	N/A	33%	30%	43%	38%
Proportion of pregnant women who received IFA for 180 days reached with counselling on appropriate IYCF	31%	62%	68%	N/A	N/A	N/A	N/A
Proportion of mothers of children 6-59 who attended IYCF counseling	N/A	N/A	N/A	77%	87%	78%	82%

Source: Program data reported by the GoL and UNICEF to The Power of Nutrition, Coverage assessment report

¹ Independent coverage survey conducted by Valid International

N/A: data not reported for the indicator

Lack of awareness on program availability, knowledge of how the program works, and its importance for children’s health and nutrition were the main causes for low uptake of programs, particularly for MNP supplementation and CMAM. On the other hand, stock outs were the main reason for low uptake of vitamin A and IFA supplementation.

The coverage assessment reports that in 2019, 51 percent of mothers of children 6 to 23 months in Great Monrovia and 57 percent in Grand Bassa had not heard about MNP. Among mothers whose children did not receive MNP supplementation, 15 percent in Greater Monrovia and 40 percent in Grand Bassa reported they didn’t participate because their child didn’t need the supplement. Similarly, approximately 20 percent of mother/caregivers did not know about the CMAM program and hence did not seek treatment for their children in both Greater Monrovia and Grand Bassa.

On the other hand, access and availability of vitamin A supplements are the main reasons reported for children not receiving the supplement in both Greater Monrovia and Grand Bassa. Similarly, for IFA supplementation, of the few women who did not receive any IFA supplements, availability of IFA tablets at

¹⁹ The program relies on LDHS 2019 for data on breastfeeding and complementary feeding practices.

the clinics or hospital was the main reason reported. Limited availability of IFA is also consistent with the high-level coverage of any consumption of IFA, but lower levels of sustained consumption of 90+ IFA tablets.

The coverage assessments report high levels of coverage of IYCF counselling, with 90 percent of mothers of children 6 to 59 months in Greater Monrovia and 85 percent in Grand Bassa reporting having attended IYCF counseling. Among those who did not receive IYCF counseling, inconvenient timing of IYCF counselling and lack of interest in IYCF counselling were reported as reasons for not receiving counseling.

B. Impacts on beneficiary level nutrition outcomes (RQ 2)

Complementary feeding practices improved between 2013 and 2018; however, exclusive breastfeeding dropped slightly during this period.

Between 2013 and 2018, the proportion of children who received the appropriate minimum meal frequency (MMF) increased from 30 percent to 61 percent, minimum dietary diversity (MDD) increased from 11 percent to 23 percent, and minimum adequate diet (MAD) increased from 4 percent to 11 percent (LDHS 2013, CFSNS 2018).²⁰ This suggests improved infant feeding practices which could reflect the improvements in coverage of IYCF counseling reported in the program data. On the other hand, exclusive breastfeeding dropped slightly during this period, from 55 percent to 51 percent (LDHS 2013, CFSNS 2018). However, during the Ebola outbreak, exclusive breastfeeding decreased, as the virus could be transmitted through breast milk (The Power of Nutrition Investment Summary n.d.). So it is possible that exclusive breastfeeding was lower in the post-Ebola period when the program started than reported in the LDHS 2013.

Given concerns about the accuracy of the program data we do not use these data to estimate impacts at the beneficiary level.

The goal of Liberia investment was to reduce the prevalence of stunting from 32 percent to 28 percent. With a population of approximately 715,000 children under 5, this translates to reducing the number of children under 5 who are stunted by approximately 28,600 (USAID 2018). Given concerns about the validity of the coverage reported by the program data, we do not use these data to model impacts of the program on stunting, mortality, and maternal anemia. We will use data from the LDHS 2019, when available, to model the beneficiary-level impacts.

C. Government commitment to, prioritization, and ownership of nutrition programming (RQ 3)

In addition to supporting the implementation of nutrition-specific interventions, the co-investment also supported health systems strengthening and advocacy activities to: (1) strengthen the capacity of health workers on nutrition topics, (2) establish a robust nutrition information system integrated within the HMIS, (3) strengthen supervision, data collection, monitoring, reporting, and evaluation through UNICEF monitoring and technical assistance to NGOs, (4) provide technical assistance to the GoL to develop national nutrition policies section, and (5) advocate with the GoL to fulfill their financial commitments to nutrition (Table L1). In this section, we draw on findings from the independent assessment of government financing and sustainability of nutrition programming commissioned by The Power of Nutrition and UNICEF to assess the extent to which and how the government commitment to, prioritization and ownership of nutrition changed during the investment period, and how The Power of Nutrition and UNICEF contributed to these changes.

²⁰ These data can be compared to the findings from the LDHS 2019, when available.

Lack of trained nutrition personnel and inadequate on the job training to support the implementation of nutrition programs in Liberia present a challenge for scaling interventions.

Stakeholders interviewed as part of the government assessment highlighted the lack of trained staff in the nutrition department and lack of support from the government for capacity development programs for nutrition staff (Connolly and Sesay 2019). There was consensus that there was a shortage of staff to deliver both nutrition-specific and nutrition-sensitive programs. They also noted that although there are a limited number of nutritionists, with one stakeholder estimating only 5 available in the country, people working in other sectors could be trained to implement nutrition programs.

The GoL has also made some progress in establishing and strengthening tracking of nutrition indicators within the HMIS.

With support from UNICEF, the GoL included key nutrition indicators into the MoH's HMIS, reflecting the commitment from GoL to support monitoring and evaluation of nutrition. These include indicators for IYCF counselling, micronutrient supplementation (IFA, vitamin A, and MNP supplementation), growth monitoring, and treatment of severe acute malnutrition. However, as discussed in Section IV.A, the quality of these data is inconsistent. These inconsistencies highlight an opportunity for strengthening training around monitoring and evaluation. Improving the data quality is a focus area of Phase II of the Liberia investment being developed by The Power of Nutrition and UNICEF.

The Liberian government has made significant progress in providing a coherent policy and legal framework for nutrition. During the investment period, UNICEF and other partners supported the GoL in updating and harmonizing key policy and legal frameworks for nutrition, which were previous fragmented and outdated.

In 2019, the Nutrition Division under the Ministry of Health (MoH), with support from The Power of Nutrition/UNICEF co-investment as well as other donors and implementing partners, updated and validated the 2019-2024 National Nutrition Policy document. In addition, several other policy documents have been updated, published, or are in process, including the public health law, a school health and nutrition strategy through the Ministry of Education, a multisectoral national nutrition implementation plan through the MoH, and a Zero Hunger Strategic Plan and common reporting framework. The GoL also took steps to promote breastfeeding by developing regulations for the marketing of breastmilk substitutes and to promote fortification by establishing the National Fortification Alliance to regulate fortification (Scaling up Nutrition Report, 2018).

The GoL has also shown an increased commitment and prioritization of nutrition through the development and prioritization of several strategic initiatives and inclusion of nutrition actions into these key strategic plans. However, the GoL continues to rely largely on its partners for nutrition planning and budgeting.

In 2017, the GoL conducted a Zero Hunger strategic (Government of Liberia, 2017) review which identified key gaps in nutrition implementation and helped map government strategic plans and responses. The Pro-poor Agenda for Prosperity and Development (PAPD) developed in 2018 includes malnutrition as one of the eight essential health targets. In addition to these strategic plans, the GoL has continued to be committed to the Scaling up Nutrition (SUN) initiative. The Liberian government first joined the SUN movement in 2014, and in 2018, established a Multi-Stakeholder Platform (MSP) which provides structure for actors from different economic sectors and government departments to work together to address common goals (Scaling up Nutrition, 2014). The MSP platform in Liberia has expanded to involve new line ministries for better coordination of nutrition activities and has championed the increased involvement of Parliamentarians and other decision makers in ongoing advocacy efforts for nutrition. Under the banner of *A Promise Renewed*, Liberia also signed a pledge committing to take action to address child mortality

and integrated nutrition into the vision to improve child survival by 2035 (UNICEF, 2015). Since signing the pledge, Liberia has continued to keep track of childhood health and nutrition indicators, including key nutrition indicators tracked by The Power of Nutrition. Finally, during the investment period, the GoL, with support from UNICEF, The Power of Nutrition, and other partners prioritized national surveys to track key nutrition indicators, including the CFSNS, which was conducted in 2018, and the LDHS which is currently underway.

Despite the GoL's commitment to nutrition, it relies on its partners to help drive the nutrition agenda. The Power of Nutrition's recent biannual report indicates that the GoL, with support from UNICEF plans to develop a costed nutrition plan. UNICEF with the nutrition team at the MoH develops the annual budget that identifies the interventions to be included and costed. There is a need for the GoL to take more ownership in identifying priorities aligned with its strategic plans and work with partners to achieve the goals. While the government developed the draft NNP 2019-2024, it does not have a costed strategic plan to provide guidance on the amount of funding required to implement the policy in its entirety to date.

Although there was little change in budget allocations to nutrition-specific interventions, higher rates of spending from the budget allocated to nutrition during the investment period suggest improved commitment to the implementation of nutrition programs. However, there is a need for greater budget allocation in the future and improved tracking of nutrition spending.

The budget analysis conducted as part of the government financing and sustainability assessment showed only a slight increase in the nutrition-specific budget allocations during the investment period. However, this should be interpreted in the context of a decline in GDP growth in the post-Ebola era, which potentially constrained the GoL's ability to increase budget allocations. Moreover, the analysis suggests that even though budget allocations showed little change, expenditures increased by 236 percent between 2016 and 2019. In 2016, only 50 percent of the budget allocations for nutrition-specific programs was utilized, and the 2016 expenditures were estimated at USD 258,000. However, the budget and expenditure analysis found that an average of 92 percent of the budget was spent each year during the investment period, resulting in a total three-year actual expenditure of USD 1.4 million.

The review of budgets and other documents conducted as part of the assessment indicated that budget commitments for nutrition activities post 2019 are lower than previous levels. In addition, there is no coordinated effort to track budgets or expenditure for nutrition. The assessment revealed that there is no specific budget line for nutrition in the country's budget with nutrition-specific interventions implemented alongside nutrition-sensitive interventions implemented by key ministries and agencies. The nutrition-specific interventions are integrated into the primary health care approach in the Essential Package of Health Services (EPHS) of Liberia, and the budget for EPHS does not disaggregate individual budget lines and map it to the delivery of nutrition-specific interventions. The resource mapping exercise that is conducted annually by the planning department at the MoH to track health financing accounts and expenditures needs to be strengthened to include a specific focus on nutrition interventions, which is currently missing.

V. Recommendations for Phase II of Liberia investment

The Power of Nutrition is developing the next phase of the program in Liberia, which it seeks to present to its board for approval in 2020. Given this opportunity to build on the experience and lessons learned from the current effort, we provide some recommendations:

- **Further investments in improving the quality of HMIS data.** The large inconsistencies between the program data which draw on the HMIS and the findings from household surveys suggest that there is a need to invest in strengthening the HMIS and capacity for monitoring and evaluation. Further

investments in probing and cross-referencing data report across different sources may help obtain more accurate estimates of program coverage.

- **Prioritize community programs and actions to improve demand for nutrition services.** The coverage assessment indicates that a lack of awareness and understanding of the importance of nutrition to overall health and well-being at the community level potentially affects demand and uptake of some nutrition services. The next phase of the investment should emphasize and prioritize creating awareness and demand for nutrition services among mothers through more focused community level actions.
- **Strengthen capacity building:** The government financing and sustainability highlight that there is a need to improve human resource capacity for nutrition planning, programming, and nutrition financing. Capacity building and actions around development and implementation of a more coordinated effort to track budgets or expenditures for nutrition should be a priority for the next phase of the investment.

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Appendix Table L1: Complete list of data sources and indicators/information reviewed

Data source	Organization	Geographic coverage	Years captured	Relevant Indicators/information included
Program data (collected through the HMIS)	GoL	Nation wide	2017 2018 2019	Proportion of children 6-59 months who received 2 doses of vitamin A supplements Proportion of children 6-23 months who received MNPs Proportion of children aged 0-59 months reached with treatment for SAM Proportion of pregnant women who received IFA supplements Proportion of pregnant women who received IFA for 180 days reached with counselling on appropriate IYCF
Comprehensive Food Security and Nutrition Survey (CFSNS)	GoL	Nationwide-includes data by county	2018	Proportion of children 6-59 months who received vitamin A supplements Proportion of children 6-23 months who received micronutrient powders (MNPs) Proportion of children 0–5 months exclusively breastfed Proportion of infants 6–11 months of age who received solid, semi-solid or soft foods Proportion of children 6–23 months receiving minimum meal frequency Proportion of children 6–23 months receiving minimum dietary diversity Proportion of children 6–23 months receiving minimum acceptable diet Prevalence of stunting among children under 5 years (0–59 months) Prevalence of underweight among children under 5 years (0–59 months) Prevalence of wasting among children under 5 years (0–59 months) Prevalence of severe acute malnutrition among children under 5 years (0–59 months)
Demographic Health Survey (DHS)	GoL	Nationwide-includes data by county	DHS-2013 DHS-2019 (in progress, not included)	Proportion of children 6-59 months who received vitamin A supplements Proportion of children 6-23 months who received micronutrient powders (MNPs) Proportion of children 0–5 months exclusively breastfed Proportion of children 4–5 months exclusively breastfed Proportion of early initiation of breastfeeding (i.e., put to the breast within 1 hour of birth) Proportion of continued breastfeeding at 2 years Proportion of infants 6–8 months of age who received solid, semi-solid or soft foods. Proportion of children 6–23 months receiving minimum meal frequency Proportion of children 6–23 months receiving minimum dietary diversity Proportion of children 6–23 months receiving minimum acceptable diet

Data source	Organization	Geographic coverage	Years captured	Relevant Indicators/information included
Coverage Survey (CS)	Valid International	Two counties Grand Bassa and Montserrado (Greater Monrovia)	2018 2019	<ul style="list-style-type: none"> Prevalence of stunting among children under 5 years (0–59 months) Prevalence of underweight among children under 5 years (0–59 months) Prevalence of wasting among children under 5 years (0–59 months) Prevalence of severe acute malnutrition among children under 5 years (0–59 months) Prevalence of stunting among children under 5 years (0–59 months) Prevalence of wasting among children under 5 years (0–59 months) Prevalence of severe acute malnutrition among children under 5 years (0–59 months) Proportion of children 6-59 months who received vitamin A supplements Proportion of children 6-23 months who received micronutrient powders (MNPs) Proportion of children aged 0-59 months reached with treatment for Severe Acute Malnutrition (SAM) Proportion of pregnant women who received any IFA supplements Proportion of pregnant women who consumed IFA (for at least 90 days)
Government financing and sustainability assessment	Valid International	Nation wide	2017-2019	<ul style="list-style-type: none"> GoL budgets and spending reports GoL policies around nutrition

TANZANIA INVESTMENT PROFILE AND KEY RESULTS

I. Background and context

Tanzania has sustained relatively high economic growth, averaging about 7 percent a year over the last decade. Also, poverty dropped significantly to an estimated 26 percent in 2018 in mainland Tanzania using the USD 1.90 per day global poverty line (World Bank 2020). However, despite the steady improvements in economic growth, malnutrition in Tanzania remains high. One of every three children in Tanzania under 5 is physically and cognitively stunted (UNICEF 2015), which translates to over 2.7 million children that are more likely to have lower IQs and drop out of school.

The Government of Tanzania (GoT) has demonstrated its commitment to improving nutrition through a number of key global and regional commitments. These include the government joining the Scaling Up Nutrition (SUN) Movement in 2011, committing to the New Alliance for Food Security and Nutrition in 2012, and pledging to reduce mortality among children under 5 to 20 or fewer deaths per 1000 live births by 2035. However, despite these commitments, the country's health system faces a number of challenges that pose barriers to meeting its goals. The Tanzanian health system suffers from shortages and uneven distribution of health care workers. Health facilities have little accountability for their performance, which contributes to poor quality of care and stark regional variation in nutrition indicators (The Power of Nutrition Investment Summary 2016; World Bank 2015). Addressing key deficiencies in the Tanzanian health system is necessary to sustain and expand progress toward meeting key nutrition goals, including reducing stunting (The Power of Nutrition Investment Summary 2016).

II. Overview of the program

In 2015, The Power of Nutrition partnered with the World Bank to support the USD306 million Strengthening Primary Health Care for Results Program, which seeks to strengthen primary health care (PHC) services nationwide in Tanzania, with a focus on improving reproductive, maternal, neonatal, child health, and nutrition (RMNCHN) outcomes. The program uses a Performance for Results mechanism to incentivize the government at all levels (national, regional, local, health facility, and community) to reduce maternal and neonatal mortality by improving the performance of health workers, redistributing skilled PHC workers, increasing the availability of essential medications and commodities in PHC facilities, and increasing the coverage and improving the quality of maternal, neonatal, and child health services. It includes a results-based financing (RBF) component, implemented in nine regions, which pays PHC facilities based on verified delivery and quality of essential RMNCHN services, including community services.

The Power of Nutrition's investment of USD20 million, matched by a USD24 million International Development Association allocation, seeks to strengthen the nutrition component of the program. The combined USD44 million co-investment finances incentives to improve the delivery and quality of evidence-based nutrition-specific interventions, including vitamin A supplementation for children under 5, deworming, iron and folic acid (IFA) supplementation for pregnant women, and provision of health and nutrition education through community health workers (CHWs) on key topics such as growth monitoring, complementary feeding, and breastfeeding. The investment benefits from complementary investments in the broader program that seek to improve performance along a wider set of nutrition-sensitive interventions such as immunization, family planning, and malaria prophylaxis. The co-investment provides financial incentives directly to health facilities in nine priority regions where the RBF component is being implemented as well as to all local government authorities (LGAs) throughout the country for the successful delivery of quality nutrition interventions.

Specifically, the investment incentivizes the achievement of nutrition-specific targets for two of the seven disbursement linked indicators (DLIs) in the broader program, DLI 3 and DLI 4, which incentivize facility and LGA performance, respectively (Table 1). Half of The Power of Nutrition investment is used to provide performance-based payments to facilities in the nine priority regions to effectively deliver two nutrition-specific interventions (vitamin A supplementation for children under 5 and household visits by a CHW to deliver nutrition education). The Power of Nutrition’s investment does not pay for the delivery of these interventions, but it provides a small fee for each completed intervention, and funds are disbursed quarterly, contingent on the successful achievement of targets, performance on a health facility quality assessment (to ensure quality of services), and independent verification for a random subset of facilities. The other half of the investment provides incentives to LGAs to deliver vitamin A supplementation for children of ages 12 to 59 months and IFA supplementation for pregnant mothers. As with the disbursement of funds to facilities, the investment does not pay for the direct delivery of the intervention at the LGA level, but instead provides a fee based on a “Balanced Scorecard” for each LGA that is used to assess progress of the LGA toward service delivery and quality targets. The score is based on a weighted performance of the LGA on delivering a set of 12 interventions, including the 2 nutrition-specific interventions, and targets are set based on the baseline and performance during the previous year.

Table 1: Disbursement linked indicators for Performance for Results component

Disbursement linked indicators (DLIs)	Description
DLI 1	A robust system-level framework for the program
DLI 2	Institutional strengthening at all levels (national, regional, local government authority, and facilities)
DLI 3	Facility performance
DLI 4	Local government performance (i.e., Council Health Management Team)
DLI 5	Regional performance (i.e., Regional Health Management Team)
DLI 6	National performance (i.e., Ministry of Health and Social Welfare, Ministry of Finance & Prime Minister’s Office – Regional Administration and Local Government)
DLI 7	Capacity building at all levels

Source: The Power of Nutrition concept note

III. Overview of the assessment

This assessment seeks to provide an overview of the impact and influence of The Power of Nutrition’s investment in Tanzania. The findings draw on our review of program documents provided by The Power of Nutrition, program data from the GoT’s Health Management Information System (HMIS), the Demographic and Health Surveys (DHS), and the National Nutrition Surveys (NNS). In this section, we describe the key research questions addressed through this assessment, the data sources, and the analytic approach used to answer these research questions.

A. Key research questions

We seek to answer the following research questions (RQs):

1. To what extent has The Power of Nutrition’s investment in Tanzania delivered results at scale? To what extent has the program reached targets for the coverage, uptake, and utilization of nutrition services and programs?
2. What results has the program achieved at the beneficiary level, in terms of deaths averted, cases of stunting prevented, and cases of maternal anemia averted?
3. To what extent and how has The Power of Nutrition’s investment influenced the GoT’s financial commitments to nutrition programming, policies governing nutrition programming, and the nutrition partner landscape in Tanzania?

B. Data sources and analytic approach

Our investigation of these research questions draws on a variety of sources, including the following:

- **Program documents and data.** To obtain an overall understanding of the investment and progress to date, we reviewed program documents that include The Power of Nutrition’s investment documents and biannual reports, and reviewed program data reported by the implementing partner to The Power of Nutrition. The program data reported to The Power of Nutrition draw on the HMIS, regional administrative reports, as well as the DHS and the NNS. In addition, we also draw directly from the most recent rounds of the DHS and NNS.²¹
- **Secondary data sources.** We also reviewed secondary data sources that included the independent evaluation of the RBF component conducted by a team of researchers from the London School of Hygiene and Tropical Medicine, Ifakara Health Institute, and CHR Michelsen Institute; the midterm review of the 2016–2021 National Multisectoral Nutrition Action Plan (NMNAP); the nutrition public expenditure review (PER); and relevant nutrition policy documents that describe the GoT’s commitment to nutrition during the investment period.

To answer **RQ 1**, we reviewed program documents and data as well as national surveys (DHS 2015–16; NNS 2014 and 2018) to assess the progress made by the investment toward meeting its targets and improving coverage of key targeted nutrition services in the country. We triangulate these findings with insights from the independent evaluation of the RBF model and the NMNAP that highlight the successes and challenges in delivering the key targeted nutrition interventions and the extent to which the RBF component influenced delivery of nutrition services. To answer **RQ 2**, we used program data to model impacts on child mortality, stunting, and maternal anemia using the Lives Saved Tools (LiST). LiST is an epidemiological modeling tool that uses effect sizes drawn from a wide research-based literature to translate coverage improvements for key maternal and child health and nutrition interventions in low- and middle-income countries into reductions in mortality risk factors and ensuing reductions in mortality in subsequent years. As part of the pathway to reducing mortality, LiST also estimates impacts on child growth outcomes, such as stunting and wasting, as well as maternal anemia. For **RQ 3**, we draw on the review of The Power of Nutrition biannual reports, an Oxford Policy Management report on Nutrition Public Expenditure in Mainland Tanzania and Zanzibar, World Bank program documents, and the midterm review of the 2016–2021 NMNAP as well as other nutrition policy documents to draw insights on the level of prioritization of nutrition within the GoT during the investment period.²²

IV. Key findings

In this section, we synthesize findings from our assessment of the progress made by The Power of Nutrition’s investment in Tanzania in the following key areas: (1) coverage, uptake, and utilization of nutrition services and programs (**RQ 1**); (2) impacts on beneficiary-level nutrition outcomes (**RQ 2**); and (3) government commitment to and prioritization of nutrition (**RQ 3**).

A. Coverage, uptake, and utilization of nutrition services and programs (RQ1)

Although we primarily draw on program data to assess progress to date in improving coverage of key nutrition services, we also compared findings from program data to national coverage of nutrition

²¹ The Tanzania DHS initially planned to be conducted in 2020 has been delayed due to COVID-19 and was therefore unavailable for the assessment.

²² In the absence of a deep-dive visit to learn more about the program’s influence from country-level stakeholders, our ability to answer RQ 3 is limited to publicly available reports and information.

interventions reported in the NNS conducted in 2018. We found differences between the coverage reported in the program data and the national surveys, highlighting potential measurement issues that should be taken into account when interpreting the results. Where comparable data are available across sources, we describe the findings for each indicator and try to reconcile differences between the data sources to obtain a better understanding of the coverage, uptake, and utilization of key nutrition services.

In the five years since the program started, the program has generally met or exceeded targets against several key indicators that measure the quality of health services, including delivery of key nutrition services targeted by the program.

To measure progress on achievement of the local government performance indicator (DLI 4), the program reports on six key indicators that measure the quality of PHC services and are relevant for nutrition (Table 2). Two of these indicators are directly related to the delivery of nutrition services (IFA supplementation for pregnant women and vitamin A supplementation for children 12–59 months of age), whereas the other four indicators measure the continuous availability of medicine in facilities, quality of facilities based on a star-based rating system, number of pregnant women attending antenatal care (ANC) visits, and number of ANC attendees receiving intermittent malaria treatment. Below we discuss progress made by the program toward achieving targets for the nutrition-specific indicators.

IFA supplementation for pregnant women: For IFA supplementation, the program reports IFA supplementation during ANC visits. The proportion of pregnant women obtaining four or more ANC visits increased from 35 percent at baseline (2014) to 80 percent in the most recent reporting period (July 2019–June 2020), and the percentage of ANC visits where adequate IFA is distributed similarly increased from 57 percent at baseline to 84 percent in the most recent reporting period. The program exceeded its yearly targets for this indicator in three out of the five program years, including the two most recent years (July 2018–June 2019 and July 2019–June 2020). This was achieved after a USD3.3 million procurement of new stock and buffer stock in 2018 following missed targets in the two previous years (July 2016–June 2017 and July 2017–June 2018), indicating that the program was able to course correct and improve delivery of IFA supplementation during ANC visits. The percentage increase translates to 6.4 million pregnant women receiving IFA supplements.

IFA coverage reported in national surveys showed small consistent improvements from 2014 to 2018. The proportion of pregnant women taking IFA supplements increased from 18 percent in the NNS 2014 to 21 percent in the DHS 2015–16, and to 29 percent in the NNS 2018. The levels reported in the program data cannot be compared directly to the levels in the survey data because the surveys report coverage of IFA supplementation among all women who self-reported a pregnancy, whereas the program data estimate the coverage of IFA supplementation within the subset of women attending ANC. Moreover, the much lower levels in the survey data may in part reflect the five-year recall period in the survey, which included a period of stock-out.

Vitamin A supplementation for children under 5: The proportion of children 12–59 months of age receiving at least one dose of vitamin A in the previous year increased from 63 percent at baseline to 100 percent in the most recent reporting period. Overall, the program has consistently met or exceeded targets for this indicator each year and has reported 100 percent coverage in the last three reporting periods. National surveys, however, show lower coverage of vitamin A supplementation, although they show a sharp increase in coverage from 41 percent in the DHS 2015–16 to 64 percent in the NNS 2018. This difference in coverage levels between the survey data and program data is possibly due to underestimation of the target population in the program data obtained from the HMIS as well as poor recall in the survey data. Moreover, the delivery of this intervention is currently primarily through biannual child health and nutrition campaigns, conducted by development partners. The government has established a steering committee to lead the transition of delivery of vitamin A supplementation from campaigns to routine services, and it will be

important to maintain and improve coverage during and after transition from delivery through campaigns to routine delivery through the health system.

Table 2: Key performance indicators (DLI 4)

DLI 4 Key performance indicators		Baseline (2014)	Year 1: (July 2015- June 2016)	Year 2: (July 2016- June 2017)	Year 3: (July 2017- June 2018)	Year 4: (July 2018- June 2019)	Year 5: (July 2019- June 2020)
Percentage of ANC visits where adequate IFA is distributed	Target	--	60	70	68	46	79
	Achieved	57	66	65	43	76	84
Percentage of children 12-59 months receiving at least one dose of vitamin A supplementation in the last year	Target	--	72	74	76	78	90
	Achieved	63	72	100	100	100	100
Percentage of pregnant women attending four or more ANC visits	Target	--	38	42	46	50	68
	Achieved	35	38	42	46	64	80
Percentage of ANC attendees receiving at least two doses of intermittent preventative treatment for malaria	Target	--	37	41	53	57	85
	Achieved	34	57	60	66	81	87
Percentage of PHC facilities with a rating of three stars or higher	Target	--	4	9	n.a.	29	50
	Achieved	n.a.	1	2	22	19	No data ^a
Percentage of PHC facilities with continuous availability of 10 tracer medicines in the past year	Target	--	35	50	65	87	100
	Achieved	30	45	60	82	96	96

Source: The Power of Nutrition Biannual Report

DLI = disbursement linked indicator; IFA = iron and folic acid; ANC = antenatal care; PHC = primary health care; n.a. =not available .

^a Not measured due to delays related to COVID-19.

Findings from an independent evaluation of the RBF component of the program suggest that the RBF component significantly increased service utilization for maternal and child health services, including nutrition services. The evaluation used a quasi-experimental design to evaluate the impact of the RBF component of the program, which incentivizes facility performance through payments based on verified delivery and quality of targeted services. In addition to the RBF component, in 2017, Tanzania introduced a second financing mechanism, Direct Health Facility Financing of Health Basket Funds (HBF-DHFF). This mechanism provides direct financing to health facilities through direct transfer of health-sector basket funds from the central government to health facilities' bank accounts to increase the facilities' autonomy. The evaluation used the phased rollout of the RBF component, which started in 2016 in the intervention area, Mwanza, and in 2019 in the comparison area, Mara, to examine the impact of RBF. Implementation of HBF-DHFF nationwide began in early 2018. Using data from 2016 to 2020 in the Mwanza and Mara regions, the study examines the impact of RBF by comparing RBF in Mwanza to no financing component in Mara between 2016 and 2017 and comparing RBF along with HBF-DHFF in Mwanza to HBF-DHFF in Mara between 2018 and 2019.

The findings from the evaluation suggest that the RBF component contributed to positive results in intervention area, Mwanza, including a reduction in the prevalence of stunting from 34 percent in 2014 to 26 percent in 2018. However, because several other health- and nutrition-related programs were

implemented along with RBF, it is not possible to attribute the change in stunting to RBF alone. Evidence from the evaluation suggests that the financial incentives provided through RBF for the implementation of interventions at the facility level and the performance monitoring and verification visits likely contributed to improving the implementation of nutrition interventions. RBF was perceived by facility in-charges as having a significant impact on nutrition by reducing shortages of nutritional supplements and increasing the frequency of CHWs bringing women and children for visits to facilities, particularly for ANC visits. The combined effect of RBF payments tied to the delivery of nutrition services at the facility level and incentives for CHWs to accompany women to facilities may have led to increased cooperation between CHWs and health workers at facilities, leading to increased use of services, particularly through earlier ANC consultations. However, although incentives provided for CHWs may have resulted in more household visits, there is no evidence that RBF resulted in improvements in the provision of nutrition counseling by CHWs during these visits, possibly because CHWs did not have incentives linked specifically to delivering nutrition messages. Some delays in RBF payments were reported during the evaluation period due to delays in the verification of results as well as additional reporting requirements from the Ministry of Finance and Planning. However, the evaluation did not find any evidence of impacts of the delayed RBF payments on the uptake of services.

B. Impacts on beneficiary-level nutrition outcomes (RQ 2)

LiST modeling based on service delivery results achieved through June 2020 estimates that the nutrition interventions supported by the investment have averted more than 90,000 cases of stunting, almost 9,000 deaths of child under 5, and more than 200,000 cases of maternal anemia. However, these estimates include interpretations about how reported service delivery results translate into effective beneficiary coverage, and they should be considered as semi-quantitative indications rather than as precise numbers.

We used LiST to estimate the expected impact of four nutrition interventions (IFA supplementation, vitamin A supplementation, promotion of breastfeeding, and promotion of complementary feeding)²³ implemented as part of the program on child mortality, stunting, and maternal anemia cases. The modeling draws primarily on service delivery results reported by the program for the period from July 2015 to June 2020 and the pre-program year 2014. (Appendix Table T1).²⁴

For IFA supplementation, as discussed earlier, the program reports the number of ANC visits where IFA was provided rather than the number of pregnant women covered. Because the program also reports on the number of pregnant women receiving four or more ANC visits, we assume that the proportional coverage of pregnant women with IFA supplementation was the same as that of ANC visits, but this inference is uncertain, especially given the much lower levels of IFA coverage for pregnant women indicated in the national survey data from 2014, 2015-2016, and 2018. For vitamin A supplementation, we use the national, program-reported coverage, which was nearly universal in every year from 2016.²⁵

For counseling of mothers on breastfeeding and complementary feeding, no intervention-specific targets or results were reported by the program. We interpreted targets and data on coverage of CHW visits to households to reflect coverage with breastfeeding and complementary feeding counseling. Specifically, to convert CHW visits into years of effective counseling, we applied recommended numbers of visits assumed

²³ The impact modeling estimates do not include impacts of deworming of pregnant women and children under 5 because LiST, per consensus among international experts, does not assume a stunting or mortality impact for these interventions.

²⁴ Program estimates were obtained from The Power of Nutrition biannual report for January 1 through June 30, 2020.

²⁵ As discussed earlier, findings from the NNS 2018 show lower coverage of vitamin A supplementation (64 percent). Therefore, the program and survey results need to be reviewed once results from the DHS, expected to be conducted in 2021, are available.

as global defaults in the LiST model for costing purposes (three visits per year for infant and young child feeding (IYCF) and six visits for breastfeeding).

Based on these assumptions, the nutrition investment, to date, is estimated to have averted 90,096 cases of stunting (driven by complementary feeding education and vitamin A supplementation), 8,664 deaths of children under 5 (driven by vitamin A supplementation), and 217,517 cases of maternal anemia (driven by maternal iron supplementation). Because The Power of Nutrition's investment is part of a broader package of health interventions being implemented by the GoT and other partners, there are likely additional impacts beyond those of the four nutrition-specific interventions modeled. Moreover, these results should be interpreted in terms of contribution rather than attribution.

The coverage improvements in breastfeeding and complementary feeding education through CHW visits and resulting impacts in LiST are supported in part by survey data indicating improvements in behavioral outcomes for some IYCF practices.

For breastfeeding, the interpretation of CHW household visits as adequate breastfeeding counseling is supported by an observed increase in the prevalence of exclusive breastfeeding among infants ages 0 to 5 months, from 41 percent in the NNS 2014 to 58 percent in the NNS 2018. Timely initiation of breastfeeding within the first hour was 54 percent, which was slightly higher than in 2014 (51 percent). In contrast, between the NNS 2014 and the NNS 2018, the percent of children ages 0 to 23 months reported to have ever been breastfed was stable or even slightly fell, from 98 percent to 97 percent.

Complementary feeding indicators, on the other hand, showed more mixed results. There was no improvement, or possibly even a worsening, in the proportion of children who had timely introduction of complementary food (90 percent in 2014 and 87 percent in 2018), possibly because of the already high levels at baseline. However, a coverage increase in IYCF counseling was indirectly supported by an increase in minimum dietary diversity (receiving foods from four or more food groups in the past 24 hours) of children ages 6 to 23 months, from 25 percent in 2014 to 35 percent in 2018. Similarly, the proportion of children ages 6 to 23 months who received solid, semisolid, or soft foods the minimum number of times or more was 57 percent in 2018, which was much higher than in the DHS 2015–2016 (40 percent), although it was lower than in 2014 (66 percent).

Results from national surveys also show small reductions in stunting among children under 5 from 2014 to 2018 and a sharp decline in anemia rates among pregnant women from 2015–2016 to 2018. Although Tanzania achieved or surpassed the World Health Assembly (WHA) midterm targets for stunting, acute malnutrition, and maternal anemia, it is not on track to meeting the 2025 stunting target because of rapid population growth.

Data from the national surveys show a small but consistent decline in stunting prevalence among children under five, from 35 percent in the NNS 2014 to 34 percent in the DHS 2015–16 and 32 percent in the NNS 2018. This observed reduction is somewhat larger than that estimated by the LiST model, from 37.3 percent of children ages 0 to 59 months in 2014 to 36.6 percent in 2018.²⁶ Although an overall 3 percentage point decline in stunting is encouraging, the remaining stunting prevalence still leaves more than 3 million children under 5 stunted in Tanzania in 2018, and above the threshold of “very high stunting prevalence” (≥ 30 percent) according to the 2018 UNICEF-WHO classification.

Anemia prevalence among pregnant women declined significantly from 45 percent in 2015–16 to 29 percent in 2018. These results appear to be as expected in view of The Power of Nutrition and World Bank

²⁶ The larger reduction in stunting prevalence reflected in the survey data may in part reflect the impacts of a broad set of health interventions compared to the LiST estimates which modelled the effect of the four nutrition-specific interventions supported by the program.

investment that incentivized IFA supplementation for pregnant women, suggesting that the increased IFA coverage may have contributed to reducing maternal anemia.

The midterm review of the NMNAP conducted April–September 2019 showed that out of the nine WHA targets, four indicators (stunting, acute malnutrition, maternal anemia, and prevalence of overweight children under 5) achieved or surpassed the NMNAP midterm targets, one was delayed, and four could not be assessed during the midterm review because the data on these were not available at the time of the review. Although stunting achieved the midterm target of 32 percent in 2018, rapid population growth in Tanzania suggests that the number of stunted children under 5 increased from 2.7 million to 3 million and hence the country is not on track for meeting the 2025 WHA target for stunting set at a 40 percent reduction in the absolute number of stunted children under 5.

C. Government commitment to and prioritization of nutrition (RQ 3)

Results in this section are based on secondary data sources examining the GoT's budgets, spending, and policy commitments around nutrition. Without being able to obtain primary data through a deep dive or interviews with key country-level stakeholders, we were unable to determine the contribution of The Power of Nutrition to improving government commitment to and prioritization of nutrition. This section therefore highlights key changes in the GoT's commitment to and prioritization of nutrition that coincide with the investment period.

Between 2019–20 and 2020–21, there was an increase in domestic resource allocation for nutrition and a decline in development partners' contribution to nutrition. Despite improvements in domestic budget allocations for nutrition, budget execution remains a significant constraint to nutrition public expenditures.

A review of LGA nutrition plans and budgets for the 2020–21 financial year conducted by the Ministry of Local Government showed that 81 percent of the annual nutrition budget is from domestic sources and has increased from USD3.9 million in 2019–20 to USD5.1 million in 2020–21. This increase in local resource allocation for nutrition has been attributed to several factors, including increased political commitment, increased advocacy from nutrition champions among members of parliament, improved capacity building and planning at the regional and council levels, and improvements in the government's planning and reporting system (The Power of Nutrition biannual report January–June 2020). However, contribution from development partners during this period decreased from USD3 million to USD1.2 million, with the completion of some key projects that did not receive additional funding.

Although there are improvements in domestic budget allocations for nutrition, the midterm review of the NMNAP budget showed that there is a large gap between the planned budget and actual expenditure, with more than half of the planned investment not released. In 2019, only 40 percent of the budget for the midterm review period was mobilized and mainly funded by development partners, especially for nutrition-specific interventions. Budget analysis per Key Results Areas provided additional insights on budget execution, showing a varying trend for nutrition-sensitive and nutrition-specific interventions. Nutrition-sensitive budgets performed above average, whereas nutrition-specific and information system budgets were below average in budget execution. This is partly because the budget execution for nutrition-sensitive and nutrition-specific interventions is issued and approved differently. The last nutrition PER conducted in 2016 also highlighted a lack of information on funds released and funds made available for nutrition, and even where the information is available, it is very limited making it unclear if the failure of nutrition budget execution was a result of inadequate funding, or of the failure of implementing agencies to absorb funds provided. (Oxford Policy Management, PER report 2018). Information is particularly scarce for district-level funding and budgets. To ensure improvements in budget execution and tracking of budget data, the GoT will need to strengthen and build the capacity of the nutrition team.

The GoT has shown an increased commitment to and prioritization of nutrition through the development and prioritization of several strategic initiatives and policies, and the inclusion of nutrition actions into these key strategic plans during the investment period.

The GoT developed the NMNAP, which covers a five-year period between 2016–17 and 2020–21 and is the current costed implementation plan for the updated Tanzania Food and Nutrition policy, which outlines strategies and guidelines for the strengthening of implementation, monitoring, and evaluation of nutrition in Tanzania. Tanzania is also a signatory to commitments at the regional and global levels linked to the improvement of nutrition. Tanzania has been a member of the SUN Movement since 2011 and continues to strengthen nutrition efforts in the country as part of its SUN commitments. The GoT has also committed to achieving the Sustainable Development Goals, the WHA Nutrition Targets 2025, and the WHO Global Noncommunicable Disease Targets 2025.

V. Summary

Overall, the investment in Tanzania contributed to significant progress toward achieving key targeted nutrition outcomes. However, differences between the coverage estimated from the program data and the national surveys between 2014 and 2018 highlight potential measurement issues in the program data that preclude a precise quantitative assessment of program achievements and health impact. Nevertheless, the program has made positive contributions to strengthening the coverage of key nutrition services. The funding model has also helped bring together partners to prioritize and fund key nutrition activities. There is high-level political commitment from the GoT to prioritize nutrition, as is evidenced by key policies, strategic documents, and budget priorities for nutrition over the last few years. There is, however, still a need for the GoT and partners to invest in capacity building to strengthen budget execution at both the national and local levels.

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Appendix Table T1: Tanzania LiST Modeling Results

Interventions		NSS	DHS	NSS	Power of Nutrition targets					LiST Representation					Beneficiaries	Averted cases (2015-2020)			
		2014	2016	2018	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2014	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2015-2020	Stunting	Child deaths	Maternal Anemia
ANC visits where IFA was distributed*	Coverage: Target				60%	70%	68%	46%	79%										
	Coverage: Result				66.3%	65%	76%	76%	84%										
Pregnant women who received >=4 ANC visits	Coverage: Target				38%	42%	46%	50%	68%										
	Coverage: Result				38%	42%	46%	64%	80%										
Women who consumed >= IFA tablets during pregnancy	Coverage: Target				60%	70%	68%	46%	79%										
	Coverage: Result	17.5%	21.4%	29%	66%	65%	76%	76%	84%	40.5%	46.5%	44.9%	51.7%	51.3%	56%	2037872			217517
Vitamin A supplementation	Coverage: Target																		
	Coverage: Result	72.6%	41.2%	64%	72%	100%	100%	100%	100%	53%	61%	84%	84%	83%	82%	13280758	44092	7453	
Complementary child feeding education	Coverage: Target																		
	Coverage: Result									0%	0.2%	1.9%	17.6%	16.6%	26%	1030524	45401	532	
Promotion of breastfeeding	Coverage: Target																		
	Coverage: Result									0%	0.7%	0.7%	6.3%	5.9%	9%	514066	604	679	
4 interventions																	90096	8664	217517
Beneficiaries: Children <5 years																13280758			
Beneficiaries: Mothers & pregnant women																2037872			

Appendix A: List of Interviewees by Category

The Power of Nutrition staff

1. Martin Short (Chief Executive Officer)
2. Mavis Owusu-Gyamfi (Director, Head of Investments)
3. Sarah Dunn (Director, Head of Partnerships & Brands)
4. Michelle Thompson (Director, Partnerships & Brands team)
5. Andrew Davidson

The Power of Nutrition board members

6. Jonathan Brinsden (current member)
7. David Bull (current member)
8. Siobhan Crowley (current member; CIFF)
9. Claire Moran (current observing member; FCDO)

Representatives from founding donors/investors

10. Sufia Askari (CIFF)
11. Maria Guerra (CIFF)
12. Sarah Gibson (CIFF)
13. Anna Hakobyan (CIFF)
14. Abigail Perry (FCDO)
15. Kachi Okorie (FCDO)
16. Anna Morgan (FCDO)
17. Marissa Leffler (UBS Optimus)
18. John Soleanico (UBS Optimus)

Implementing partners

19. Meera Shekar (World Bank)
20. Lisa Shireen Saldanha (World Bank)
21. Michelle Mehta (World Bank)
22. Menno Mulder-Sibanda (World Bank)
23. Victor Aguayo (UNICEF)
24. Oren Schlein (UNICEF)
25. Edward King (UNICEF)
26. Oscar Serrano Oria (UNICEF)
27. Juliet Parker (Action Against Hunger)

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28. Sri Srivivekanandarajah (CARE)
 29. Thomas Schaetzel (CARE)
 30. Emily Measures (Nutrition International)
 31. Alison Greig (Nutrition International)
 32. Judith Nihorimbere (Nutrition International)
 33. Gillian Bath (Save the Children)

Representatives from new donors

34. Anna Madsen (Margaret A. Cargill Philanthropies)
35. Fabio Segura (Jacobs Foundation)
36. Nemat Hajeebhoy (Gates Foundation)
37. Nicki Connell (Eleanor Crook Foundation)
38. Katty Dani (DFAT)
39. Kate Smith (DFAT)
40. Taila Mueller (Asia Philanthropy Circle)
41. Rajan Sankar (TATA Trusts)
42. Andrea Torres (Bernard van Leer Foundation)
43. Francis Aminu (Dangote Foundation)

Representatives from potential donors who did not invest

44. Fabian Chessell (Larry Ellison Foundation)
45. Mark Allen (Merck)

External stakeholders

46. Steve Godfrey (GAIN)
47. Leslie Elder (GFF)
48. Julie Ruel Bergeron (GFF)
49. Jean Sebastien Kouassi (SUN)
50. Edwyn Shiell (SUN)
51. Jack Clift (R4D)

Appendix B: Glossary

Children's Investment Fund Foundation (CIFF)
Comprehensive Food Security and Nutrition Survey (CFSNS)
Demographic and Health Surveys (DHS)
Department for International Development (DfID)
disbursement linked indicators (DLI)
Foreign, Commonwealth & Development Office (FCDO)
Global Financing Facility (GFF)
Government of Ethiopia (GoE)
Government of Liberia (GoL)
Growth Monitoring and Promotion (GMP)
Health Management Information System (HMIS)
Health Sustainable Development Goals (SDG)
high net worth individuals (HNWIs)
International Development Association (IDA)
international non-governmental organization (INGO)
Investment Project Financing (IPF)
joint review mission (JRM)
Liberia Demographic and Health Surveys (LDHS)
Lives Saved Tool (LiST),
micronutrient powders (MNP)
minimum adequate diet (MAD)
minimum dietary diversity (MDD)
minimum meal frequency (MMF)
Ministry of Health (MoH)
monitoring and evaluation (M&E)
National Nutrition Plan (NNP)
Performance for Results (PforR)
Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH-N)
research questions (RQs)
Scaling Up Nutrition (SUN)