

NUTRITION: FUNDAMENTAL TO DELIVERING ON THE GFF'S MISSION

OVERVIEW

This paper summarizes the GFF's position on nutrition as fundamental to the health of women, children and adolescents and lays out the argument for its central role in delivering on the GFF's mission of ending preventable maternal, newborn, child and adolescent deaths and improving their health, nutrition, and well-being. The GFF value proposition for nutrition is articulated and lessons learned from the first wave GFF countries are described. Based on the GFF experience in the first 16 countries combined with the epidemiology of the second wave countries, the paper presents a slate of recommended emphases and approaches to the integration of nutrition in the GFF portfolio for the Investors Group's consideration and endorsement.

SUMMARY OF FINDINGS

- Given the pervasive and multi-generational impact of malnutrition, addressing it is central to achieving results for the GFF along the RMNCAH continuum. Undernutrition and poor health in the reproductive and early life periods worsen outcomes for mothers and children alike.
- A recent World Bank analysis estimated the financial resources needed to achieve four key global nutrition targets for which adequate data are available (stunting, anemia, breastfeeding and wasting) is US\$ 70 billion over ten years.
- The GFF contributes to filling this financing gap through its approach to development financing in support of nutrition.
- The value proposition for GFF's support to nutrition includes: 1) the integration of nutrition in strengthened health systems; 2) maximizing impact by reaching the most vulnerable populations; 3) a focus on scale and sustainability through country-driven approaches; 4) increased resources for nutrition through domestic resource mobilization, linking to IDA/IBRD, aligned financing of donor partners at country level as well as within the global nutrition architecture, and the largely untapped potential of the private sector; (5) strengthening country data systems to incorporate nutrition indicators to enable strategic data collection and use.
- Areas of focus going forward include: 1) scaling up cost-effective nutrition-specific interventions; 2) evidence-based interventions for maternal nutrition and expanded implementation-based learning on adolescent nutrition; 3) integrated and multi-sectoral approaches; and 4) "double duty" actions for nutrition.

ACTION REQUIRED

Investors Group's endorsement of the GFF's proposed approach to nutrition in the second wave countries is required.

INTRODUCTION

The vision of the Global Financing Facility (GFF) is to end preventable maternal, newborn, child and adolescent deaths and improve the health, nutrition, and well-being of women, adolescents and children. This vision is guided by the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)¹ which explicitly highlights the challenges and opportunities for achieving progress in reproductive, maternal, neonatal, child, and adolescent health and nutrition (RMNCAH-N). The Strategy recognizes the synergies and interplay between nutrition and health at each life stage including the threat to development that lies in poor nutrition and health and lack of nurturing care including early learning opportunities at the youngest ages.

Burden and consequences of malnutrition

The global burden of malnutrition is staggering: 155 million children are stunted; 52 million children are wasted; 2 billion adults are overweight or obese; 41 million children are overweight; and at least 2 billion individuals suffer from micronutrient deficiencies.² Undernutrition contributes to almost half (45 percent) of all child deaths,³ yet only 0.50% of official development assistance is allocated to addressing undernutrition.⁴ This means that progress on under-five and neonatal mortality (Sustainable Development Goal 3) cannot be achieved without significant investments in maternal, child and adolescent nutrition.

Chronic malnutrition or stunting (low height for age) has far reaching consequences for human capital, with implications for a country's economic and social development.⁵ Early insults to nutrition impact the immune system and physical growth and contribute to potentially irreversible cognitive deficits, predisposing children to health and economic consequences that continue throughout the life course.³ The 1000-day period from conception to 24 months is particularly critical for ensuring adequate nutrition due to the rapid pace of brain development during this time. Furthermore, conditions of growth restriction in utero "program" an increased risk of overweight and chronic diseases later in life.⁶

Nutrition is fundamental to the health of women, children and adolescents

Given the pervasive and multi-generational impact of malnutrition, addressing it is central to achieving results for the GFF along the RMNCAH continuum. Undernutrition and poor health in the reproductive and early life periods worsen outcomes for mothers and children alike. For instance, pregnancy in adolescence halts the growth of the mother and contributes to short stature in adulthood,⁷ which in turn increases her risk for obstetric complications and intra-uterine growth restriction (IUGR) in her offspring. Children who are born with IUGR are typically already stunted at birth, which increases their risk of stunting, morbidity, and mortality throughout early childhood and beyond.³ Similarly, calorie deficits and deficiencies of iron, folic acid, calcium, and iodine in pre-pregnancy and pregnancy contribute to adverse maternal and neonatal outcomes and conditions that hinder adequate RMNCAH and cognitive development.³

Nutrition, women's empowerment and gender equity

Investments to improve the nutritional status of girls, adolescents, and women contribute to improvements in their human capital, which inherently minimizes the cultural constraints that face women and threaten gender equality globally.⁸ Better nourished girls are more likely to be healthier, more likely to stay in school, and to learn more while in school, enabling them to become more productive economically and more empowered to make decisions related to their and their children's health and nutrition.⁸ Over the last 20 years, the global community has narrowed the equity gap between men and women in many areas. However, critical gaps remain, and are highlighted by the continued inequity in

access to, and use of markets, social services, and in the disproportionate burden of mortality faced by women.⁹ For instance, only 15 out of 134 countries met the millennium development goal to reduce maternal mortality by the end of 2015.⁹ Incorporating gender-sensitive nutrition into policies, programs, and health systems is therefore crucial for enhancing women's status and equity, with medium- and long-term benefits that contribute to economic development and sustained human development.⁸

Micronutrient deficiencies

Globally, it is estimated that 18% and 19% of children and pregnant women respectively are iron deficient, with the highest prevalence in Africa and Asia.³ Iron deficiency in pregnancy holds consequences for both the mother and the child, including increased risk of postpartum hemorrhage, maternal mortality, low birthweight, and perinatal and neonatal mortality.³

Other micronutrient deficiencies that are especially relevant to RMNCAH are associated with conditions such as neural tube defects (folic acid), gestational hypertensive disorders (calcium), and pre-term birth (calcium, iodine).³

Overweight and obesity

Contrary to maternal and child undernutrition, the burden of overweight and obesity among both women and children is on the rise globally.³ In Latin America and the Caribbean, close to 60% of women of reproductive age are overweight or obese. In Africa and Asia these numbers are lower, hovering around 30% and 20% respectively, but they are on the rise.³ Despite a lower prevalence of overweight and obesity among children globally, what is most concerning is the rapid speed at which the proportion of overweight children is also increasing. As many African and Asian countries continue in their epidemiologic and nutrition transitions, the threat of overweight and obesity among adults and children alike will require special attention and action.

As with undernutrition, the risk of overweight and obesity in children begins as early as conception: maternal overweight and obesity during pregnancy increases the risk of their offspring's obesity in childhood, adolescence, and early adulthood.³ Maternal obesity also leads to maternal and fetal complications during pregnancy, delivery, and postpartum including increased risk for gestational diabetes, maternal death, hemorrhage, cesarean delivery and infection, delayed or failed breastfeeding, and higher risk of neonatal and infant death.³ Children who are overweight or obese are at risk of elevated cholesterol and blood pressure and type 2 diabetes.³ Longer-term risks include obesity into adulthood, which is associated with many similar health consequences.³

GLOBAL NUTRITION GOALS AND THE CHALLENGES TO ACHIEVE THEM

The recent World Bank publication, *An Investment Framework for Nutrition: Reaching the Global Targets for Stunting, Anemia, Breastfeeding and Wasting*,¹⁰ describes the critical financing gap for achieving four of the six global nutrition targets endorsed by the World Health Assembly in 2012. The targets for stunting, anemia, low birthweight, childhood overweight, breastfeeding and wasting – set for accomplishment by 2025 in support of the SDG 2 (Ending malnutrition in all its forms by 2030) – were proposed to galvanize investments in cost-effective nutrition interventions and accelerate progress toward reducing malnutrition globally.

Challenges to achieving these global nutrition goals include lack of awareness of both the impact of malnutrition and the availability of cost-effective interventions to address it; concomitant low levels of investment in nutrition in nearly all countries (both domestic as well as external financing); the relative

complexity of successfully implementing nutrition programs given their multi-sectoral nature; and lack of knowledge regarding the costs and resources needed for programs designed and implemented at scale.¹⁰

To address the lack of knowledge regarding the financing needs, the World Bank analyses estimate the financial resources needed to achieve the four targets for which adequate data are available (stunting, anemia, breastfeeding and wasting). For the comprehensive package of nutrition-specific interventions based on the 2013 *Lancet* Series on Maternal and Child Nutrition and the 2016 *Lancet* Series on Breastfeeding, an investment of \$70 billion over ten years is needed.¹⁰ For a less ambitious scenario (that will not meet the 2025 targets), an estimated \$2.3 billion per year will support delivery of a limited set of high impact interventions and still yield significant reductions in stunting (50 million less stunted children) and preventable deaths (2.3 million).¹⁰

The GFF contributes to filling this financing gap through its approach to development financing in support of nutrition: supporting domestic resource mobilization to ensure that nutrition is prioritized in national health budgets at a level that is commensurate to its relative contribution to burden of illness; ensuring the allocative efficiency of financing by working with countries to prioritize high impact nutrition issues and cost-effective interventions for Investment Cases including through application of prioritization methodologies such as the One Health, LiST and OPTIMA tools; improving efficiency and reducing duplication and overlaps for implementation by providing a platform for external donor financing alignment, linking catalytic grant financing with IDA/IBRD resources to increase the available envelope for health financing including for nutrition; and catalyzing private sector financing for nutrition.

MAPPING OF GFF-ELIGIBLE COUNTRIES AGAINST THE BURDEN OF MALNUTRITION

To understand the potential impact of the GFF on improved outcomes for nutrition, it is instructive to estimate how much of the burden of child undernutrition is represented by the 67 GFF-eligible countries. The most recent data available indicates that 155 million children are stunted and 52 million are wasted globally.² Using country-specific data on the number of stunted and wasted children in each of the GFF's 67 target countries (including India), we estimate that the GFF will support the countries accounting for 93 and 99 percent of child stunting and wasting, respectively. Persistently underfunded, the fact that the GFF has made nutrition a priority area for investment in the countries that account for nearly all stunted and wasted children globally – in partnership with national governments and development partners – holds tremendous promise for making significant progress on the problem of chronic and acute malnutrition in the early years and its attendant negative impacts on child survival, cognitive development, and later life economic productivity.

NUTRITION IN THE GFF PORTFOLIO

Nutrition in the first wave countries

To date, all GFF country Investment Cases call for increased funding for nutrition with aims to:

- End malnutrition as a cause of maternal and child morbidity and mortality and improve maternal, newborn, infant, young child, and adolescent nutritional status;
- Scale up the coverage, quality and utilization of cost-effective nutrition services, focusing on adolescent girls, pregnant women, lactating women, and children under 5 (especially those aged 0 to 24 months);
- Increase equitable access to nutrition services; and

- Strengthen delivery of nutrition services through performance-based financing (PBF) and other tools.

In the first wave GFF countries,ⁱ country context and Investment Case priorities determine the nutrition interventions selected for implementation. GFF investments support:

- Integrating nutrition into the full continuum of maternal and child health services, focusing on increasing exclusive breastfeeding rates, improving counseling on infant feeding and early stimulation, and the prevention and treatment of maternal and child anemia;
- Building capacity at the community and health facility levels, by training health providers on peer-to-peer counseling on infant and young child feeding (IYCF); better management of moderate and severe acute malnutrition; and the scale up of Kangaroo Mother Care to assist low birth weight babies;
- Providing commodities such as micronutrient supplements, ready-to-use therapeutic foods and deworming medications;
- Increasing the delivery of community-based/outreach services through community health and early childhood development workers;
- Reaching underserved areas by setting up mobile clinics in security challenged settings to deliver health and nutrition services to vulnerable women and children;
- Supporting the Baby-Friendly Hospital Initiative; and
- Working multi-sectorally to address the underlying determinants of undernutrition through nutrition-sensitive approaches in WASH, education and other sectors.

In IDA/IBRD and GFF-supported country investments, nutrition features in ten of the 15 projects that have already gone to the Board, and seven of the eight that are currently under preparation and going to the Board before end of FY18. In eight of the ten operations that have been approved and coded (using the standard World Bank coding system), nutrition activities account for 19 percent of total GFF and IDA/IBRD co-financing. This percentage is anticipated to grow given the inclusion of nutrition activities as new GFF countries continue to prioritize nutrition in their country operations.

Nutrition landscape in second-wave GFF countries

This section presents a brief mapping of the disease burden in the 10 second-wave GFF countries,ⁱⁱ which, along with a synthesis of first-wave country experience, builds the foundation for recommendations for priority GFF nutrition activities.

- The mean prevalence of child **stunting** in the ten second wave countries is 36 percent, which ranges from 22 percent in Haiti to 49 percent in Madagascar.¹¹
- **Vitamin A deficiency** among children is particularly problematic in the African countries, with prevalence of low serum retinol (<70umol/L) ranging from 38 percent in Rwanda to 65 percent in the Central African Republic.¹²
- **Anemia** (much of which is due to iron deficiency), on the other hand, is more prevalent in children in the Asian countries of Afghanistan (42 percent), Cambodia (42 percent), and Indonesia (64 percent), though still quite high (>40 percent) in some of the African countries including Madagascar (44 percent) and Rwanda (53 percent).¹²

ⁱ Bangladesh, Cameroon, the Democratic Republic of the Congo (DRC), Ethiopia, Guatemala, Guinea, Liberia, Kenya, Mozambique, Myanmar, Nigeria, Senegal, Sierra Leone, Tanzania, Uganda, and Vietnam.

ⁱⁱ Afghanistan, Burkina Faso, Cambodia, Central African Republic, Cote d'Ivoire, Haiti, Indonesia, Madagascar, Malawi, and Rwanda.

- Although data for iodine deficiency is not available, **consumption of adequately iodized salt** is concerning as it remains below 65 percent in all second-wave countries, except in Rwanda where it stands at 87 percent.¹¹ Haiti and Afghanistan are particularly concerning, with only 3 percent and 20 percent of children, respectively, consuming adequately iodized salt.¹¹

Poor IYCF practices contribute to the high prevalence of stunting and micronutrient deficiencies reported above. In the ten second wave countries, key IYCF indicators such as **exclusive breastfeeding** in children <6 months of age is, on average, below 50 percent, while the proportion of children who achieve a **minimum acceptable diet**ⁱⁱⁱ is below 20 percent in the African and Latin American countries for which there are data (Burkina Faso, Cote d'Ivoire, Haiti, Malawi, and Rwanda) and below 40 percent in Cambodia and Indonesia.¹¹

The rising threat of **overweight and obesity** is alarming: in Indonesia, 12 percent of children are overweight, and in Rwanda, the prevalence is 8 percent.¹¹ In the remaining eight countries, the prevalence of overweight remains below 6 percent for children. Among women, the prevalence is much higher with figures over 20% for overweight and obesity in all countries except Cambodia (18%) and Madagascar (15%) and as high as 36% in Haiti. Given global trends in both adult and child overweight, combined with what is known about the importance of optimum growth in the first 1,000 days of life for the prevention of overweight in childhood and later in life,³ the GFF has an opportunity to help countries to incorporate **double duty actions**¹³ which can simultaneously address the risk of undernutrition and overweight (see below).

GLOBAL FINANCING FACILITY VALUE PROPOSITION FOR NUTRITION

Given its broad focus on RMNCAH and nutrition, the GFF is well-placed to support programming that addresses the nutritional needs of vulnerable populations along the life course continuum (see Figure 1). Evidence-based **nutrition-specific** actions are integrated in programs delivering key health services at critical points along the life cycle with a strong focus on the 1000-day window of opportunity between pregnancy and 24 months of age. The GFF's parallel emphasis on strengthening health systems, expanding access to universal health care, and on health financing reforms underpin the effective delivery of nutrition-specific interventions, while also sustainably growing the financing envelope for nutrition.

The GFF also supports **nutrition-sensitive** interventions to address the basic and underlying causes of malnutrition that include both health sector programming (e.g., family planning for birth spacing and prevention and treatment of maternal infections, both of which contribute to reduced risk of LBW and later childhood stunting) and other sectors such as social protection and WASH (e.g., conditional cash transfer programs to keep adolescent girls in school; increased availability/accessibility of latrines and clean water to decrease exposure to fecal contamination leading to diarrheal disease).

ⁱⁱⁱ A minimum acceptable diet is a composite indicator of feeding frequency and dietary diversity. A child who achieves a minimum acceptable diet is fed the minimum number of times per day (2 times for breastfed children 6-8 months, 3 times for breastfed children 9-24 months, and 4 times for non-breastfed children 6-24 months) and a minimum number of food groups per day (4).

Pathways to impact: how the GFF improves nutrition outcomes

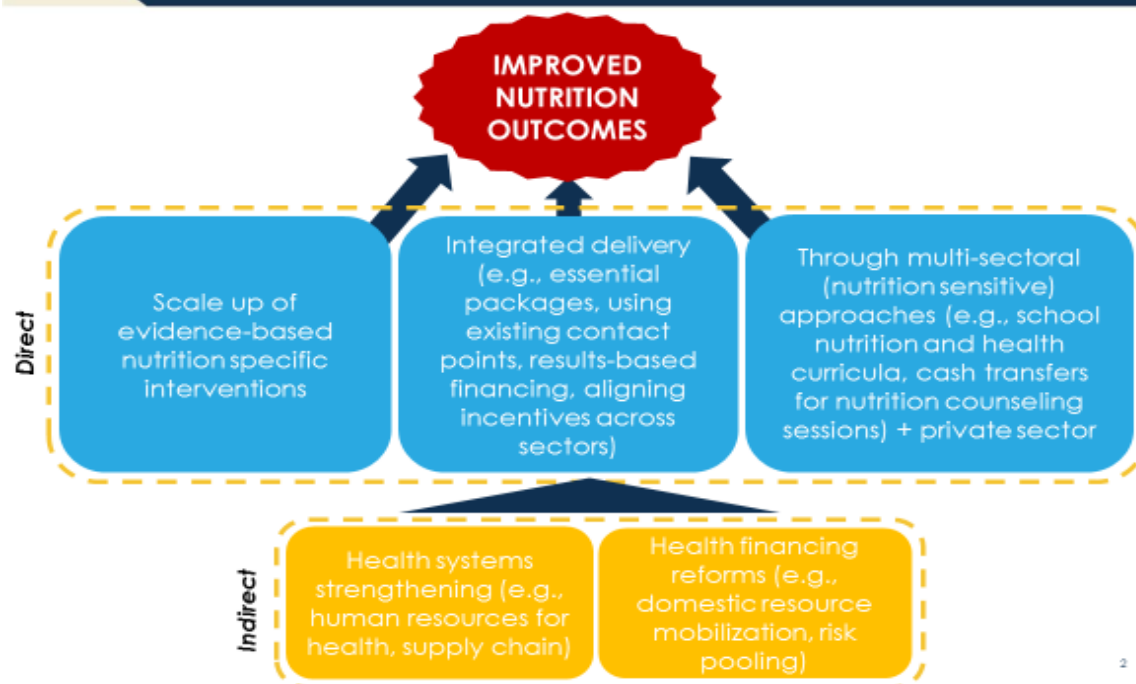


Figure 1 How the GFF works to improve nutrition outcomes

Integrating nutrition in strengthened health systems

Nutrition and health are indivisible: malnutrition is a form of poor health and all diseases increase nutritional needs.⁴ Embedding evidence-based nutrition-specific interventions in strengthened health systems is a compelling feature of the GFF model and addresses a key shortcoming of vertical nutrition programs that fail in part due to the inability of weak health systems to deliver either quality health or nutrition services. Strengthened health systems and the delivery of quality health services are prerequisites for improved nutrition outcomes. And the effective delivery of quality nutrition services cannot happen without the backbone of a well-functioning, adequately financed health system including the needed human resources for service delivery at all levels, with a particular focus on front-line public health facilities and community workers/platforms. Contact points for integrated delivery of nutrition services include adolescent health and nutrition programs, antenatal, intrapartum and post-natal care, and during well- and sick child visits. Other types of activities included under health system strengthening that are relevant to nutrition include, for example, supply chain management and logistics to ensure adequate stock and availability of key nutrition commodities such as ready-to-use therapeutic foods and micronutrient supplements. Nutrition-specific interventions delivered through public health systems feature in virtually every Investment Case and IDA/IBRD/GFF Trust Fund-supported project across the GFF portfolio.

Maximizing impact by reaching the most vulnerable

A critical aspect of the prioritization process for the GFF Investment Case is equity analysis, to enable the most vulnerable to benefit from health and nutrition services. While poverty is only one of the determinants of malnutrition, most countries have levels of malnutrition that are approximately twice as

high in households of the lowest two income quintiles than the wealthier households. Yet, it is often the poorest households which cannot access nutrition services and products, either in public systems or on the market. Specific groups are often particularly vulnerable to malnutrition either because of the specific demands of that stage of the life (e.g., pregnant adolescent girls) or due to social exclusion (e.g., specific ethnic groups), socially constructed gender roles (e.g. women of reproductive age) or geographic cycle isolation.

The equity analysis which is a core element of the Investment Case enables resources to be targeted to these beneficiaries who are all too often missed. The focus on community-based approaches within the GFF also lends itself well to enabling countries to reach the most vulnerable. Furthermore, the GFF's use of a gender equity lens applied to the challenge of improving nutrition helps to ensure that the most disadvantaged and vulnerable women and children are identified and their nutritional needs are prioritized. The gender equity emphasis in the GFF is evidenced by: the use of gender and intersectional analysis of health determinants in Investment Case development and program planning to support prioritization; the use of data disaggregation by sex and age; the push to strengthen CRVS to contribute to reductions in child marriage, early childbearing and malnutrition associated with adolescent pregnancy; working coherently across the continuum of care from birth through the reproductive years; and engaging with men and boys to lay the foundation for maximum uptake of nutrition information by adolescents prior to starting child bearing and child rearing.

Focus on scale and sustainability through country-driven approaches

The GFF offers a pathway to sustainably financed nutrition programming implemented at scale in countries with high burdens of malnutrition among women, children and adolescents. The GFF model is predicated on country-driven selection of national nutrition priorities for which multiple sources of financing are then brought together in a synergistic way to support quality nutrition services delivered equitably and at scale to a country's population. The focus on going to scale and sustainable financing are major contributions of the GFF to achieving SDG 2 (Ending malnutrition in all its forms). The four-pronged strategy to increase financing for health and nutrition includes: 1) increased domestic resources for health, 2) IDA/IBRD financing, 3) better aligned external financing and 4) harnessing the potential of private sector resources. The GFF offers technical resources and capacity building support to the health financing reform agenda of every GFF country, helping to guarantee that nutrition – integrated into a functioning health system that is focused on eventual achievement of UHC – will be sustained for the long-haul.

Domestic resource mobilization

Mobilizing additional domestic resources for health and nutrition and obtaining more results from existing domestic resources are key features of the GFF approach. For nutrition, increasing domestic on-budget allocations is a crucial piece of the global nutrition financing gap puzzle.¹⁰ The GFF works with countries to address domestic resource mobilization (DRM) through 1) identifying additional sources of sustainable resources for nutrition; 2) increasing the prioritization of nutrition and health in the national budget; and 3) increasing nutrition and health-specific revenues from (for example) taxes on tobacco and sugar-sweetened beverages.

Examples of successful DRM for nutrition in the first 16 countries come from Mozambique, Tanzania and Guatemala, among others. In Mozambique, Disbursement Linked Indicators (DLIs) have been agreed with the government that maintain and then later increase the percentage of total domestic government expenditure allocated to health and nutrition as well as a DLI that specifically increases the coverage of target populations with nutrition services. The approach to DRM in Tanzania also relies on holding the

government accountable for increasing the share of health and nutrition in the total budget through a DLI. In Guatemala, the GFF investment provides the government with financing for a large nutrition project through a performance-based buy-down of the IBRD interest and loan charges; the resources that are freed up from the debt payments will then be matched with domestic resources for reinvestment in a conditional cash transfer program that promotes health visits for children and pregnant women, thus contributing to improving health-related determinants of undernutrition in addition to the nutrition-specific focus of the main IBRD project.

IDA and IBRD

Linking operationally with IDA/IBRD investments provides a range of advantages and opportunities for nutrition including through the World Bank Group's focus on multi-sectoral investing in children's early years (see below). Bank-implemented studies provide technical and operational knowledge that is integrated into the GFF grant-supported nutrition programs. For example, the series of analytic studies of economic efficiency and the economic impact of investing in nutrition in several of the GFF African countries (Cote d'Ivoire, DRC, Kenya, Madagascar, Nigeria, and Uganda) and cost-effectiveness analysis to support country planning and prioritization of nutrition investments in Afghanistan and Bangladesh are practical benefits of linking to IDA and IBRD.

By co-financing World Bank Group projects, instruments such as results-based financing (RBF) for nutrition and drilling down on key operational issues affecting delivery of nutrition services including community-based service delivery platforms such as growth monitoring and promotion contribute important operational learning and concrete outcomes for nutrition implemented through GFF-supported investments. Experimentation and evaluation of different approaches to address key operational effectiveness questions, for example, in the Rwanda IDA/GFF health and social protection projects, related to improving the performance of front line health workers further illustrates the advantages of linking to IDA/IBRD for strengthened nutrition outcomes.

Aligned financing and fit within the global nutrition architecture

In addition to strengthening alignment and harmonizing financing of prioritized nutrition interventions through the GFF engagement process in a country, the GFF maximizes its investments in nutrition by engaging in partnerships and collaboration with a broad range of global stakeholders as well. These include:

- **Scaling Up Nutrition (SUN):** This global movement is a country-led initiative to achieve a world free from malnutrition through (1) country-level action, (2) scale-up of evidence-based interventions, and (3) use of a multi-sectoral approach. Four SUN networks coordinate business, government, donor, and civil society contributions under a collective agenda, and member countries—currently there are 60—appoint government focal points from Prime Ministers' offices, food and nutrition councils, relevant line ministries, or other high-level stations and organize around SUN multi-stakeholder country platforms. To date, **all countries in which GFF is investing are also part of the SUN movement**, and have thus committed to nutrition as a priority investment and policy area. Exploring potential synergies and linkages between the SUN networks, country platforms, and focal points and the GFF multi-stakeholder country platforms has the potential for important knowledge sharing and technical capacity building; strengthened nutrition technical content; and enhanced implementation of the Investment Cases, particularly through private sector involvement, civil society feedback, and NGO coordination. The SUN process usually leads to the

development of costed national strategies for nutrition. These strategies are all too often not fully financed and the GFF can help mobilize financing for their implementation.

- **Power of Nutrition (PON):** The Power of Nutrition is an innovative financing mechanism focused on scaling up a comprehensive package of high-impact interventions to improve child nutrition, complementing the work of the GFF by tapping uniquely different private and non-traditional donors to help close the global nutrition financing gap. The GFF co-finances IDA projects or technical assistance with the Power of Nutrition Trust Fund in high burden countries including Tanzania, Ethiopia, Nigeria and Rwanda. Partnerships between the GFF and PON are also being explored in Madagascar and Côte d'Ivoire, which recently became GFF recipients.
- **Early Childhood Development Action Network (ECDAN):** Launched by UNICEF and the World Bank in 2016, this network seeks to advance progress toward achieving the Sustainable Development Goals for early childhood development including health and nutrition. Several of the second wave GFF countries (e.g., Malawi, Rwanda, Indonesia) feature investments in young child nutrition, health and early stimulation/early learning in the IDA/GFF-supported projects.
- **Regional initiatives** such as the Initiative for Food and Nutrition Security in Africa (IFNA) with its focus on several GFF countries including Senegal, Burkina Faso, Kenya, Malawi, Mozambique, Madagascar, Nigeria and Ethiopia offer the potential to complement GFF-supported country-led efforts to address determinants of poor nutrition through other sectors, including, importantly, agriculture.

Engaging the private sector for nutrition impact

The Global Financing Facility uses the flexibility of its trust fund and the expertise of its facility partners to draw in the private sector to help countries achieve RMNCAH-N outcomes. The GFF's equity-driven approach to private sector engagement is built around facilitating and emphasizing the importance of policy and planning processes that reflect a mixed health/nutrition systems approach in GFF countries, and by supporting specific mechanisms at the global, regional and country levels to best leverage private sector resources, capacity and innovation for RMNCAH-N.¹⁴

For the nutrition agenda, there are challenges to partnering with private sector companies that actively oppose national policies and legislation to restrict food and beverage marketing, including breast milk substitutes and the Code on the Marketing of Breast Milk Substitutes as well as the marketing of foods to infants and children and the labeling of unhealthy processed foods. At times, such company practices are incompatible with national health and nutrition aims. And while it is important to leverage the opportunities that the private sector provides, it is also critical to ensure a principle of avoiding harm. The GFF can act as a neutral broker between the public and private sector through its country platform. This is critical because meeting SDG and WHA nutrition targets without private sector strengths, including its technical expertise and capacity for logistics, branding, finances, and ability to reach remote populations, will be difficult.

Keeping the main pathways for GFF private sector engagement in mind (i.e., developing innovative financing mechanisms to catalyze private sector capital for nutrition, facilitating partnerships between private sector entities and countries, and leveraging the private sector to deliver on nutrition objectives in Investment Cases), there are potentially several types of opportunities for engaging with the private sector on nutrition in the GFF platform:

- **Private sector financing mechanisms** (including but not limited to policy instruments). For example, through its partnership with the International Finance Corporation (IFC) at the World

Bank Group, the GFF is also able to broker financing to de-risk private sector investment (e.g., advance purchase guarantees).

- **Working with private health providers** to provide accurate nutrition information to patients/clients and delivery of quality nutrition services. The GFF engages with private health facilities in several countries through performance-based financing; in recent years this has increased the focus on nutrition through, for example, including more nutrition advice and services during the ante-natal visit. The GFF also encourages countries to consider innovative results-based implementation modalities such as the performance-based contracting of nutrition services in Nigeria.
- **Supporting private food millers/manufacturers to fortify staple foods and salt with micronutrients** through partnerships between country governments and the private sector. This is a highly effective strategy to address micronutrient malnutrition at scale.
- **Partnering with food and beverage companies** to increase availability and lower costs of nutritious foods and improve nutrition profiles of other consumables (e.g., reduce sugar, salt, fats; increase micronutrients).
- **Working with information and communications technology** companies to improve access to data and actionable information, including public information campaigns. Often these innovations are developed as pilots and tested at a relatively small scale. The GFF can bring the financing to integrate these innovations into broader national data and information systems for nutrition.
- **Engaging with employers** to offer workplace health and nutrition wellness programs and to support key policies like maternity leave, creches, breastfeeding breaks and lactations rooms.

Strengthening of data systems to support high quality implementation of nutrition interventions

Strengthening of data systems is critical to measuring the success of health and nutrition programs, as well as to achieving equitable implementation of interventions and targeting of the most vulnerable groups, a priority area for the GFF. The global nutrition community is heavily reliant on nutrition data that are collected by population-based surveys conducted relatively infrequently (every 3-5 years), which makes accountability for scale-up, quality of implementation, and data-driven course correction difficult.

To address the shortage of robust, actionable data on coverage of nutrition interventions, and limited and inconsistent inclusion of nutrition indicators in routine health information systems, an important role for the GFF engagement in-country is to strengthen country data systems. This focus ensures that M&E frameworks for the Investment Cases (ICs) adequately reflect the priority issues featured in the ICs (including nutrition); that data quality improvement is an ongoing activity; and that all indicators for which data are collected are used, and used effectively. In addition to capacity building for data quality and analysis, the GFF process aims to strengthen information systems at all levels/for multiple purposes (e.g., routine administrative data collection systems, periodic facility, patient and household surveys, electronic medical records) to achieve sustained and ongoing improvements in quality service delivery and coverage for positive change in MNCA health and nutrition outcomes. Data systems for nutrition often require specialized attention as part of the overall health information system.

At the implementation level, the GFF's leveraging of IDA and IBRD funding further supports the delivery of high quality interventions using innovative financing mechanisms, such as performance-based financing and the use of disbursement-linked indicators (DLI). In Mozambique, for example, project financing is linked not only to the scale-up of a package of nutrition interventions to high-burden districts using DLIs,

but also to their high-quality implementation.^{iv} Similarly, in Guatemala, DLIs are tied to behavioral indicators that are dependent on high quality implementation of program activities, including SBCC for improved breastfeeding practices and full compliance with health co-responsibilities of the conditional cash transfer program. In Bangladesh and Burkina Faso, the GFF is collaborating with the BMGF to integrate nutrition coverage measurement into administrative data and survey or surveillance systems to ensure that information relevant to nutrition service delivery DLIs is available.

ANTICIPATED AREAS OF FOCUS GOING FORWARD

Given the nutrition epidemiology of the second wave countries in combination with lessons learned from first-wave countries, the GFF proposes to focus on the following areas going forward:

1. Scaling up cost-effective nutrition-specific interventions
2. Maternal and adolescent nutrition
3. Integrated and multi-sectoral approach
4. “Double Duty” actions for nutrition

Scaling up cost-effective nutrition-specific interventions

At the outset of the GFF engagement in a country, the country-led Investment Cases for RMNACH-N are developed. This process identifies the priority issues and interventions as well as approaches to health financing reform that will chart a course toward achievement of the SDGs and sustainable UHC. For nutrition, the *Lancet* Nutrition Interventions Review Group and the Maternal and Child Nutrition Study group (2013) identified a set of evidence-based nutrition specific interventions throughout the life course that will contribute to reductions in child stunting, maternal and child anemia and other conditions of malnutrition. Interventions target adolescence, pregnancy, infancy and childhood, and include, among others, preconception care and delay of first pregnancy, micronutrient supplementation, exclusive breastfeeding and optimal complementary feeding, and disease prevention and treatment. All too often the coverage of these interventions is much lower than the evidence of their cost effectiveness and affordability would warrant. The Investment Case prioritization process has been signaling this to GFF countries and partners and has generated greater focus on nutrition.

Maternal and adolescent nutrition

The intergenerational cycle of undernutrition often begins before conception and continues in pregnancy, with a mother who is undernourished (low BMI and/or short stature), and whose intrauterine environment in turn produces a small or low birth weight child who is at a far higher risk of mortality in the neonatal period or later infancy.¹⁵ Among those who survive, children who experience intra-uterine growth restriction are unlikely to significantly catch up on this lost growth, and are at greater risk of growth faltering and developmental deficits throughout childhood.¹⁵ The *Lancet* 2013 Series on Maternal and Child Nutrition brought added attention to the need to address the determinants of undernutrition prior to the start of pregnancy, intervening with girls earlier in the life cycle during adolescence. There is also still much to be done to improve nutrition during pregnancy in GFF countries, in alignment with the WHO’s new antenatal care (ANC) guidelines,¹⁶ which include: regular weight monitoring; balanced protein energy supplements; diverse home diets and physical activity counseling; IFA supplementation; calcium supplementation where needed; and screening for undernutrition and food support.

^{iv} High quality implementation will be measured by a third party external evaluator using a checklist that outlines minimum standards of implementation quality.

Given the evidence that demonstrates an increased risk of adverse maternal, neonatal, and infant outcomes among first time mothers who are less than 18 years old, this paper calls for a stronger focus on adolescent nutrition and health in second-wave countries. In countries where adolescent pregnancy is high (Afghanistan, Central African Republic, Cote d'Ivoire, Madagascar, and Malawi), for example, interventions that promote the delay of marriage and/or first pregnancy, and/or that support the scale-up of implementation of the new ANC guidelines, should be prioritized for both health and nutrition impacts. These might include innovative approaches such as cash transfers or subsidization of secondary schools to keep girls in school and increase age of marriage as well as SRHR education and FP services targeting adolescents to prevent or delay pregnancy for indirect but sustainable impacts on stunting reduction.¹⁷

Adolescent nutrition has been prioritized in several first-wave GFF countries, from which early approaches and lessons can be taken:

- In **Bangladesh**, where about 50 percent of girls are married before the age of 18 years and one third bear children as adolescents, the *Transforming Secondary Education* project (USD 10 million GFF investment) addresses critical issues influencing dropout rates among adolescent girls. Activities include health within the school curriculum and the provision of health services using the school as the platform for service delivery. The program is anticipated to delay girls' age at marriage and subsequently the timing of their first birth. Key activities cover incentives to female students in grades 9-12 from economically disadvantaged areas; provision of separate functional toilets for girls and menstrual hygiene with disposal facilities at schools; health curricula including sexual and reproductive health, gender equity, good nutrition and physical activity; teacher training, awareness raising, and peer counseling; nutrition services for girl students to address underweight and anemia; and improved linkages between schools and local health services.
- In the **DRC**, to address the key determinants of stunting among children, the project will begin interventions as early as adolescence, for example increasing access to family planning services and behavior change counseling among adolescent girls to promote the delay of first pregnancy.
- In **Nigeria**, part of the GFF's work is focused on the Northeastern states where adolescent pregnancy and child undernutrition are highest, providing fortified foods and supplements to adolescent girls. A new GFF-co-financed nutrition project in Nigeria in 12 high-burden States will also include specific targeting of adolescent girls and their children.

The breadth of activities targeting adolescent girls—including those that go beyond the health sector—present promising examples of how adolescent nutrition can be addressed in second-wave countries through a variety of nutrition-specific and nutrition-sensitive approaches.

Integrated and multi-sectoral approaches

As early as 1990, UNICEF outlined the major determinants of maternal and child undernutrition in a framework that highlighted immediate, underlying, and basic causes of undernutrition.¹⁸ Basic causes of undernutrition comprise the financial, sociocultural, economic, and political context that contributes to inequitable access to health and social services, which in turn contribute to underlying causes of undernutrition such as household food insecurity, poor feeding and care practices, and unhealthy living environments. Underlying causes contribute directly to the immediate causes of undernutrition, which include inadequate dietary intake and disease. While nutrition-specific interventions that address “immediate causes” of malnutrition are typically delivered through the health sector, the activities that

address “underlying” and “basic” causes are rooted in many other sectors: water and sanitation, social protection, governance and trade, agriculture, and others.

Multi-sectoral approaches are a hallmark of the GFF, so the continued implementation of both nutrition specific and nutrition sensitive activities through or in collaboration with various sectors beyond health, will be a priority as the GFF tackles new challenges in new contexts. The complexities of implementing a multi-sectoral approach led the World Bank to recommend **plan multi-sectorally, implement sectorally and evaluate multi-sectorally**. This concept has been taken on in many first-wave GFF countries, such as Bangladesh, Cameroon, Guatemala, and Liberia, where multi-sectoral approaches address key determinants of preventable death and disability among women, children, and adolescents. In Bangladesh GFF resources support both a health project and an education project. In other first wave countries, GFF funds are channeled through the health sector, with collaboration and involvement by other sectors such as social protection (Cameroon), water, sanitation and hygiene (Guatemala), and education (Liberia).

- In **Cameroon**, the GFF investment leverages project experience in the **health and social protection** sectors to provide targeted cash transfers, linked to education outcomes and outreach from nutrition services as well as life skills coaching for adolescents. These transfers are complemented by improved health service delivery and health system performance overall. The use of **social safety nets** constitutes an important investment in the nutrition and health of vulnerable families.
- *Creceer Sano* in **Guatemala** addresses the lack of improved sanitation services and low access to safe drinking water in rural areas to address the link between poor **WASH** and child malnutrition, illness, and even death. The program incorporates behavior change communication on hygiene as well as infrastructure work on small water and sanitation systems, water filters for households and strengthened water quality monitoring systems in collaboration with Guatemala’s Municipal Development Councils. By targeting largely rural areas and those with higher indigenous populations, *Creceer Sano* is likely to reach those with the least access to these inputs.

Second-wave countries such as Rwanda and Indonesia are also championing the multisectoral approach for nutrition. **Rwanda**, a rapidly moving second wave GFF country and one that is committed to the WB Investing in the Early Years initiative (see below), is addressing the multi-sectoral determinants of comprehensive young child health and development through the geographical convergence of three projects in social protection, health, and agriculture. With GFF resources allocated to both the social protection and health projects, there are major opportunities to learn from this transformational approach to development.

The health project focuses on achieving reductions in child stunting through health and nutrition service delivery innovations including revamping the community health worker platform and testing new models that foster sustainability (e.g., improved training curriculum, enhanced mentorship and supervision of CHWs, novel interactive technologies for monitoring and tracking children and women, and payment of performance incentives); promoting results-based service delivery approaches and implementation of national-scale state of the art mass media and behavior change campaigns to shift the needle on key determinants of stunting.

In parallel, the conditional cash transfers delivered through the social protection project will incentivize the poorest households to utilize key health and nutrition services (antenatal and postnatal care and regular height monitoring and growth promotion sessions) and provide demand-side incentives to reinforce the supply side performance incentives delivered through the health program. Gender and nutrition-sensitive public works and community capacity building for parents/caregivers also feature in the social protection project.

This innovative model of project and sectoral integration and coordination is mirrored in the alignment of financiers and country-level actors. The Power of Nutrition is also co-financing the IDA health and social protection projects and as a SUN country since 2011, the Rwanda SUN activities, coordinated by the Ministry of Health and USAID, also focus on policy and programming to prevent and reduce stunting for clear alignment around the national health and nutrition priorities for RMNCAH-N.

Another example of multi-sectoral engagement in a second-wave country comes from **Indonesia**. In 2017 the Government of Indonesia launched a high-profile, ambitious national strategy to accelerate stunting reduction in four years (2018-2022). The US\$12.5 billion *Stunting Reduction Acceleration Strategy* (SRAS) acknowledges that stunting is at crisis levels and proposes a high level political leadership approach to strengthen the execution of existing multi-sectoral programs and drive convergence of nutrition-specific and nutrition-sensitive service delivery.

The GFF TF grant supports the new multi-sectoral nutrition project (US\$400 million) that uses Pay for Results (PforR) lending instruments to enhance the focus on results of the SRAS program. The PforR will incentivize the government to address management problems using existing resources more effectively, plug key intervention gaps as well as drive performance from the center of government and stimulate bottom-up demand. The GFF TF grant aims to improve the quality of PforR implementation with specific focus on supporting the financing reforms for enhancing the results-orientation of intergovernmental fiscal transfers and strengthening the monitoring, evaluation and learning agenda. The multi-sectoral nutrition project, delivering on nutrition outcomes through health, social protection, education, and WASH, will support the government program through six policy instruments.^v

Double duty actions

Double duty actions accompany the concept of the **double burden of malnutrition**, or the coexistence of undernutrition and overnutrition (e.g., overweight and micronutrient deficiency), in the same individuals households and communities.¹⁹ According to the 2016 Global Nutrition Report, the prevalence of stunting among under-5s, anemia among women of reproductive age, and overweight/obesity in women are concurrently above WHO public health risk levels in 20 countries.⁴ And, while under-5 stunting worldwide has been falling in absolute terms since 1990, the opposite is true for overweight.

Given the constrained resources available globally for addressing malnutrition, the idea of implementing interventions that simultaneously address the drivers¹³ of undernutrition and overweight/obesity – **double duty actions** – is highly appealing. WHO highlights the following potential candidates for double duty actions: maternal nutrition and antenatal care programs; protection and promotion of exclusive breastfeeding; actions to improve IYCF practices to ensure optimal nutrition in the early years; school food and nutrition policies and programs to reach (for example) adolescents both for their own health and nutrition status as well as future parents and caregivers; and marketing regulations that protect young children from foods and beverages that can contribute either to undernutrition (e.g., breastmilk substitutes) or overweight (e.g., high fat/ sugar snack foods).¹³ Clearly these are not new actions, but rather, are now understood to offer the potential for integrated solutions to multiple issues of malnutrition that face vulnerable populations in GFF-eligible countries.

^v (i) Annual Stunting Leadership Summits; (ii) Results-Based Convergence Planning and Budgeting; (iii) Results-Based Intergovernmental Fiscal Transfers; (iv) Multi-Sectoral Technical Support; (v) Multi-Sectoral Human Development Workers (HDW); and (vi) Data for Evidence-Based Program Management.

It will be important for the GFF to highlight the significant potential of nutrition-specific actions, social policies (e.g., marketing of breastmilk substitutes, paid maternity leave and improving female access to education) and health system strengthening (e.g., strong primary care and UHC to ensure comprehensive prevention and treatment of undernutrition and overweight/obesity) to governments as they undertake the development of prioritized Investment Cases for RMNCAH-N. The double duty concept can be an effective advocacy tool and helps to shape the discussion of technical efficiency for nutrition actions.

LINK TO THE RESULTS AGENDA

What is GFF monitoring?

The GFF aims to achieve results in three domains: 1) Ending preventable MNCA deaths and improving MNCA health and nutrition status; 2) increasing the total volume of financing for RMNCAH-N; and 3) preventing impoverishment in the case of illness. Data is collected and used at three levels: **global**, to ensure accountability to those affected by RMNCH-N outcomes as well as to those providing resources; **country**, to assess effectiveness of RMNCAH-N programs and to identify areas for real time course correction; and **Investment Case**, to guide the planning, coordination, and implementation of the RMNCAH-N response. The approach to reporting and monitoring results for the GFF is embedded within the monitoring framework of the Global Strategy to ensure close correspondence with the overall reporting process for the SDGs. This alignment is intended to minimize the monitoring and reporting burden by countries and to highlight the fact that reporting for the GFF should be closely connected with national systems rather than treated as “project” reporting. For nutrition, the core impact level indicator required for all GFF countries is **Prevalence of stunting among children under 5 years of age**.

Improvements in health impact will take time to measure and therefore measurement of changes in coverage of key interventions across the RMNCAH continuum will be important to assess the progress GFF countries are making to reaching their health and nutrition impact targets. The selection of indicators will depend on the priorities outlined in the Investment Case. Examples of nutrition-specific and nutrition-sensitive indicators included in Investment Case results frameworks follow:

- Proportion of infants who were breastfed within the first hour of birth
- Percentage of children aged 6–59 months who receive Vitamin A supplementation
- Prevalence of anemia in women aged 15-49
- Prevalence of stunting in children under-5 years of age
- Prevalence of wasting in children under-5 years of age
- Percentage of children with diarrhea receiving ORS (under-5 years)
- Percentage of children fully immunized
- Proportion of children with suspected pneumonia taken to an appropriate health provider

Additional indicators cover exclusive breastfeeding under 6 months and at 6 months, adequate complementary feeding including dietary diversity, meal frequency, WASH interventions, and so forth.

Health and nutrition impacts of GFF investments and replenishment

The GFF replenishment was launched in September 2017 and aims to raise US\$2 billion by fall 2018 to enable the GFF to expand country operations to an eventual total of 67 eligible countries by 2030. If achieved, the opportunity for impact through evidence-based nutrition interventions scaled up in GFF countries is large: Shekar et al (2016) estimates a return of between \$4 and \$35 for every dollar invested

in a package of nutrition specific interventions. The package of interventions includes: (1) improving nutrition for pregnant mothers; (2) iron and folic acid supplementation for non-pregnant women; (3) improving IYCF practices, including breastfeeding; (4) staple food fortification; (5) pro-breastfeeding social policies and national breastfeeding promotion campaigns; and (6) improving child nutrition, including micronutrient supplementation. Returns on investment of nutrition interventions can also be thought of in terms of its contribution to GDP per capita, which has been estimated somewhere between 4 and 11%.¹⁰

To provide more specific impacts of investments (including the GFF) on morbidity (stunting) and mortality in the 67 GFF-eligible countries and from 2018-2030, the GFF commissioned work on modeling the health impact of the three following scenarios:

- Impact of a 'full' package of RMNCAH-N interventions
- Impact of the full package of RMNCAH without nutrition interventions
- Impact of a nutrition only package of interventions

The purpose of this exercise is not only to quantify the GFF's activities in terms of lives saved and morbidity (cases of stunting) averted, but also to unpack the potential trade-offs of investing in vertical, as opposed to integrated programming. Specifically, what are the potential gains of investing in a comprehensive RMNCAH-N package, as the GFF prioritizes, as opposed to investing in nutrition or health alone. Although implementation of the nutrition or health interventions only packages can have a remarkable impact on newborn and child deaths in particular, the differences in magnitude of impact and cost-effectiveness of implementing a full package of RMNCAH-N as opposed to nutrition-only or health-only interventions once again highlights the value add of the GFF as a non-vertical programming entity. That is, the GFF's emphasis on the scale-up of a full package of RMNCAH-N, as opposed to nutrition or health only, yields higher returns on investment and improved outcomes among women and children.

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