Version 2

# REACH

Ending Child Hunger and Undernutrition

# Acting at Scale: Intervention Guide

## Supplementary feeding

February 2009

# Context

**The following document is part of the REACH *Acting at Scale* set of materials**

- The documents' aim is to provide highly condensed information and lessons learned for scaling up REACH-promoted interventions to support field practitioners and other interested parties
- They are intended to become a living set of materials, updated periodically by the REACH Global Interagency Team
- These materials are a first step towards a larger REACH Knowledge Sharing service, which will be developed over time

**The full set of *Acting at Scale* materials includes**

- *An Intervention Summary*
  - An overview document containing key facts for all of the 11 promoted interventions
- *Intervention Guides* for each of the interventions[1]
  - Containing rationale, lessons learned, costs and further resource lists
- *Implementation Case Studies* for each of the interventions[1]
  - Initial set of details and lessons learned from programs implemented at scale
- *Resource Lists*
  - Lists of key documents, organizations and programs at scale
  - Included at the back of each *Intervention Guide* and in Excel spreadsheets available from the REACH Global Interagency Team

**These materials represent a preliminary version, to be validated and refined via additional consultations**

- Prepared in Summer 2008 by the REACH Global Interagency Team, based on inputs from 56 practitioners and experts, as well as extensive desk research
- A revised Version 2 of these documents will be released in late 2008 or early 2009, incorporating feedback from initial recipients

**If you have questions or feedback on these materials, please**

- Contact your local REACH facilitator in Lao or Mauritania, or
- Contact the REACH Interagency Team Coordinator, Denise Costa-Coitinho, at Denise.CostaCoitinho@wfp.org

1. Breastfeeding and complementary feeding have been combined into a single document due to strong linkage in delivery

# Table of contents

# Key messages

**Supplementary feeding is a critical social barrier providing access to nutritious food to at-risk children <5 and P&L women**

- Globally 149M children are underweight
- Delivery is based on prevalence of acute malnutrition, in emergency or non-emergency situations
  - Can be delivered either as blanket or targeted feeding depending on prevalence rates, patterns, & food security situation
  - Wet food rations are not the preferred strategy, except in exceptional circumstances such as camps or extreme insecurity
- Sometimes is augmented or replaced by programs that deliver food in exchange for work or voucher/cash transfers that enable beneficiaries to purchase their own foods on the local economy

**Supplementary feeding provides a delivery channel that can deliver numerous additional interventions**

- Its value to beneficiaries creates a draw that interventions such as exclusive breastfeeding promotion or micronutrient supplements can leverage
- The choice of delivery channel should be based on who has access to the beneficiaries, e.g. in some rural areas the public health system has insufficient outreach
- Community-based approaches are increasingly used in order to reach scale and build local capacity

**Increasing innovation in supplementary food products has increased nutritional benefits**

- Micronutrient-rich, next-generation foods, e.g fortified blended foods are often are employed
- However, benefits of advanced food products should be weighed on a case-by-case basis against opportunities to foster local agricultural production and markets
  - Determine strategy based on availability, quality, cost and sustainability of locally available food

**Logistics are a key cost driver and delivery challenge for supplementary food programs**

- Take-home rations are less costly and easier to implement, but often lead to rations for <5s or P&L women being shared with other family members
  - Can be addressed through education at distribution site and within communities
- Solid, integrated supply chain management is essential for program success
  - Unreliable or insufficient delivery is a key threat to continuous participation of beneficiaries, particularly if they have to walk long distances to distribution points

# Why implement

Preliminary

# Supplementary feeding (SF) is proven to reduce maternal and child undernutrition by increasing access to food

## SF provides an additional ration to vulnerable persons...

**SF is the provision of nutritious rations to targeted individuals that supplement the energy and nutrients missing from the diet**

- Targeted individuals have special nutritional needs, or are moderately malnourished
- The ration provided is additional, and not a substitute for food provided through another distribution channel or purchased

**The purpose of SF is to stabilize or improve the nutritional status of beneficiaries in order to prevent growth failure and malnutrition**

**SF typically is a short-term treatment, generally delivered in relief and recovery situations**

## ...and reduces maternal and child undernutrition

**Maternal supplements of balanced energy and protein improves maternal and child undernutrition in food-insecure contexts**

- Providing supplements to pregnant women of low body-mass index can reduce the risk of small-for-gestational age baby by 32%

**Providing 99% coverage of balanced energy protein supplementation in the 36 priority countries could substantially reduce the burden of disease**

- 7.1M DALYs of children under 36 months could be averted (2.8% of total DALYs lost)
- 2.9% of deaths of children under 36 months could be averted

Source: "Food distribution guidelines." WFP.; Bhutta et. al. "What works? Interventions for maternal and child undernutrition and survival." *The Lancet,* January 2008.

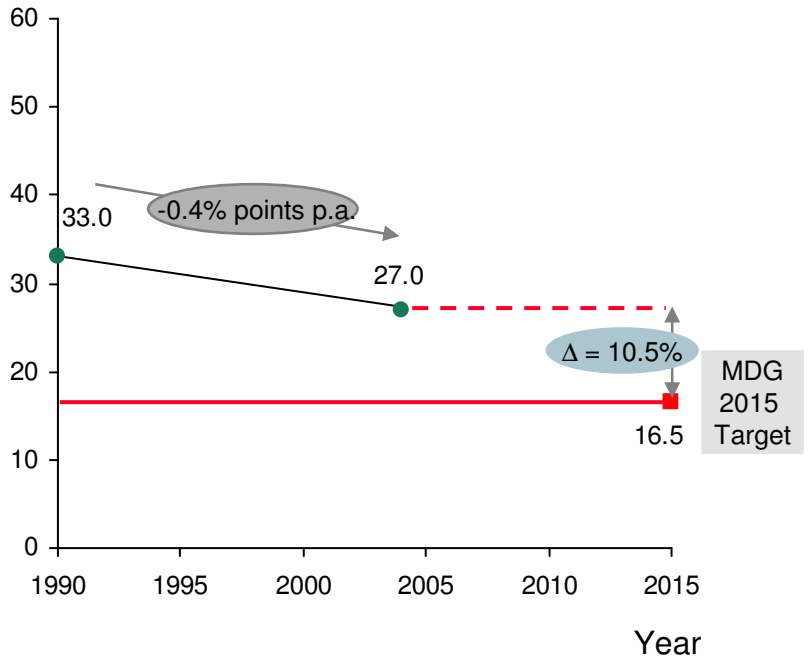
Preliminary

# SF is critical, as progress towards MDG 1, target 2 is moderate

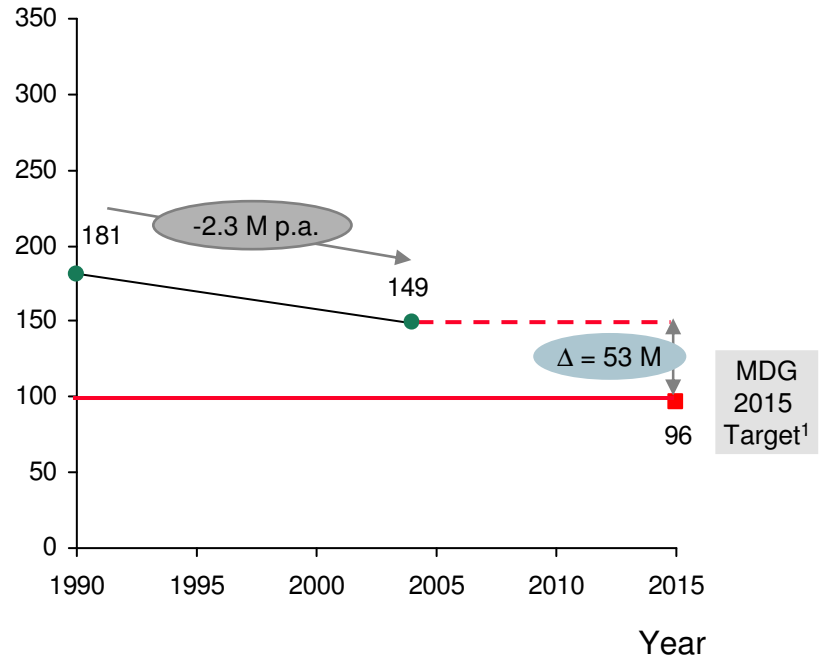
~149M children <5 remain underweight

## Worldwide progress towards MDG1.2

Underweight children (% of total)




Underweight children (M of children)




**To reach MDG targets, progress needs to more than double**

1. 2015 MDG1.2 target in absolute figures based on expected 2015 population

Source: mdgs.un.org/unsd/mdg/Host.aspx?Content=Data/Trends.htm; www.unicef.org/about/execboard/index_39942.html; UNICEF "The State Of The World's Children 2007 Report"; REACH analysis

# How to implement at scale

Preliminary

# Key lessons learned about implementing supplementary feeding programs at scale

**Define strategy**

- Consider delivering other interventions to improve maternal and child undernutrition to SF programs
  - Attractiveness of food distribution can increase uptake of other interventions

**Design**

- Select delivery channel based on existing access to beneficiaries
  - E.g. in some rural areas the public health system has very low outreach and should be supplemented with community-based distribution channels
- Augment public channels with community-based approaches to build local capacity and to reach scale
  - E.g. EOS Ethiopia uses Health Extension Workers who screen beneficiaries, distribute food and pass on key nutrition messages
- Determine whether to deliver take-home or on-site rations on a case-by-case basis
  - Take-home rations are less costly and easier to implement, but risks sharing of food at home
- Consider next-generation, fortified supplementary foods to improve nutritional outcomes
- Consider using locally-procured food rather than imports
  - Creates positive economic impact and is more sustainable
  - Must meet quality, cost-competitive and availability criteria

**Implement**

- Invest in integrated supply chain management
  - Unreliable delivery or delivery of insufficient quantities is a key threat to acceptance of programs among beneficiaries, especially if they have to walk long distances to the distribution points

**Monitor, evaluate, refine**

- Foster community accountability to ensure proper delivery if NGO partners are used for distribution
  - E.g. the HNPSP in Bangladesh cooperates with a WB funded social investment program which supports community empowerment, and the establishment of local level institutions
- Engage local community institutions to establish oversight of delivery by service providers- NGO's, health sector, etc
- Both programmatic monitoring and impact evaluations are essential to assess the program's success
  - Programmatic monitoring should survey recovery, death, default and coverage rates ongoing
  - Impact evaluations should periodically survey the nutritional status of the population

Source: Expert interviews; literature review; REACH analysis

# SF programs should be linked with other programs due to its high attractiveness among beneficiaries

## SF's appeal...

**High motivation of target population to participate in SF programs**

- Free food is a strong incentive
- People even are willing to cover long-distances to come to food distribution point

**Continuous provision of food gives a regular contact with the target group**

- Contact frequency every 3 months

**Clearly defined target group**

- Includes the most vulnerable group of P&L women and children <5
- Often ration cards are used for identification and registration

## ... can be used to link to other programs and increase uptake of those

- Breastfeeding and complementary feeding education
- Handwashing education
- Deworming
- Nutrition and cooking education
- Immunization
- Growth monitoring
- Family planning
- Monthly mother checks during pregnancy
- HIV prevention

Source: Expert interviews

# SF is implemented as either blanket or targeted programs

| | Blanket SF | Targeted SF |
|---|---|---|
| **Aim** | **Prevention of widespread malnutrition and related mortality in nutritionally vulnerable groups** | **Prevention of moderately malnourished persons of becoming severely malnourished** |
| **Target groups** | **All members of a specific group in a certain geographic area**<br>• E.g. all children <5<br>• E.g. all P&L women | **Moderately malnourished individuals only**<br>• E.g. malnourished children <5<br>• E.g. children discharged from TFP<br>• E.g. nutritionally vulnerable P&L women |
| **Criteria for selection** | **Very high prevalence of acute malnutrition**<br>• Malnutrition rate[1] >15%<br>• Malnutrition rate 10-15% in presence of aggravating factors[2]<br><br>**Season, food ration availability, other alternatives** | **High prevalence of acute malnutrition**<br>• Malnutrition rate[1] 10-15%<br>• Malnutrition rate 5-10% in presence of aggravating factors[2]<br><br>**Season, food ration availability, other alternatives** |

1. Malnutrition rate = proportion of children (6 months to 5 years) who are below 80% weight-for-height or below -2 z-score weight-for-height
2. Aggravating factors are: general ration below the mean energy requirements; epidemic of measles or whooping cough; high prevalence of respiratory or diarrhoeal diseases

Source: "Food and nutrition handbook." WFP. "Food distribution guidelines." WFP

# Delivery channel selection generally driven by existing access to beneficiaries

| Typical delivery channels | How-to | Strengths | Lessons learned |
|---|---|---|---|
| **Public health system**<br>• Clinics, hospitals or health outposts<br>• Mostly dry-feeding | • Analyze staff capacity to assure that capacity needed for food distribution does not affect delivery of health services<br>• Provide training | • Low incremental cost<br>• Sustainable as capacity is built<br>• Attractiveness of food increases uptake of other health services<br>• Good targeting of P&L women | • As bandwidth commonly is low, use staff to train others for food distribution<br>• If coverage/outreach is low, supplement with community channels, especially in rural areas |
| **Community**<br>• Distribution by select community members, often women<br>• Usually dry-feeding | • Identify capable NGOs to manage the program and provide continuous delivery<br>• Select appropriate storage facilities, e.g. schools<br>• Train community workers to assure high quality nutrition messages | • Low cost<br>• Potentially high coverage<br>• Sustainable as local capacity is built | • Assure that continuous supply can be managed, especially in rural areas Use trusted community persons to deliver food, e.g. educated women<br>• Consider involving local farmers for food production<br>• Motivate volunteers through ongoing training |
| **UN facilities**<br>• E.g. WFP feeding centers or refugee camps<br>• Dry or as wet-feeding | • Select sites where a gap exists between need and existing gov't, NGO access<br>• Engage gov't and/or communities in order to build local capacity | • Rapidly scalable as coordination requirements are low<br>– Important in emergencies<br>• Often offer outreach to rural areas | • Include steps to foster gov't and possibly NGO capacity |

Source: Expert interviews; REACH analysis

# Community-based approaches are commonly used to build local capacity and to reach scale

## Traditional facility-based distribution may be insufficient to meet demand

**Outreach of public health infrastructure is often limited**
- Especially in rural areas
- Particularly in countries with weak government systems

**Set-up of additional distribution centers is costly and time-consuming**
- New distribution centers have to built/refurbished and staffed
- Identifying suitable locations is a long process

**Using UN facilities is not sustainable**
- E.g. feeding centers are set-up during emergencies but international aid partners often reduce their involvement later
- Often non-local staff is used that moves on, therefore no local capacity is built

**Acceptance among beneficiaries is sometimes low**
- Often no community involvement, e.g. farmers are not involved in food supply
- No local volunteers/workers provide or cook food, give cooking and nutrition education

## Example: EOS Ethiopia reaches high coverage through involvement of community women

**Selected community women, called Food Distribution Agents (FDAs) are recruited from the local community**
- Health Extension Workers screen beneficiaries and assign ration cards to eligible children and P&L women
- Distribute food to beneficiaries every 3 months in a local food distribution center, e.g. town halls, schools, cooperative shops
- Pass on key nutrition messages in small groups using provided education materials

**Several benefits to leveraging FDAs**
- Distribution points are very decentralized, easing beneficiaries' access
- Community involvement in screening increases coverage
- Community sensitization prior to distribution increases awareness of distribution
- Nutrition messages are trusted
  - Adapted to the local culture and context
  - Are delivered by a trusted, credible source
- Builds local capacity and empowers women

Source: Expert interviews; "Enhanced Outreach Strategy. Activity implementation manual." WFP, 2006

# Need to select between take-home or on-site feeding based on local context

| | Take-home (aka "dry-feeding") | On-site (aka "wet-feeding) |
|---|---|---|
| **Description** | • Provision of food to beneficiaries for take home<br>• Usually provided weekly or bi-weekly | • Provision of cooked meals to beneficiaries on-site<br>• Usually provided daily or several times a week |
| **Assessment** – **Cost** | + Less costly than wet-feeding | − More costly than dry-feeding |
| **Assessment** – **Coverage** | + Higher coverage as no on-site preparation is needed | − Lower coverage due to need for staff and equipment to prepare food |
| **Assessment** – **Targeting** | − Food shared at home with others, therefore extra quantities have to be given | + Control over food amount each beneficiaries consumes |
| **Assessment** – **Quality** | − No control over food preparations | + Control over preparation, e.g., using safe water, adding multimicronutrients |
| **Assessment** – **Integrations of other interventions** | + Provision of food can be made conditional to education interventions | + Beneficiaries spend time on-site which can be used for education interventions |
| **When used** | • Common in most situations<br>• Used when delivery facility capacity is low | • If no other food sources exist and rations are likely to be shared with the family at home<br>• Conflict areas with high insecurity<br>• Areas with lack of water or firewood, complicating home preparation of meals<br>• If there are many unaccompanied children<br>• In refugee camps and for school feeding |

**Some NGOs advocate an approach where beneficiaries select between dry- or wet-feeding**

Source: Expert interviews; "Food and nutrition handbook." WFP

# New SF products are emerging to increase micronutrient concentration

| | Traditional SF | Ready to Use SF Next-generation |
|---|---|---|
| **Examples** | • Corn-Soya blend (CSB)<br>• Wheat-Soya blend (WSB)<br>• Wheat flour<br>• Sugar<br>• Cooking oil | • Micronutrient-rich fortified food blends<br>– E.g. DSM's fortified rice pellets<br>• Next generation CSB with higher micronutrient content<br>• Multimicronutrients, e.g. Sprinkles, MixMe<br>– For on-site fortification of supplementary foods<br>– For home fortification |
| **Description** | • Generally cost-effective for providing energy, proteins, fat and some micronutrients<br>• But often fail to meet full micronutrient requirements of the target populations | • Meet the full micronutrient requirements of target populations<br>– Especially children < 2 who need extra animal proteins<br>• But more expensive to provide |

**The types of food distributed also must be culturally accepted**

Source: Expert interviews, literature review

# Local food is an alternative to imported food

## Quality, cost and availability need to be considered

### Guidance for selecting imported or local foods

- Always a case-by-case decision
- Often local and imported foods are used in combination
- If the economics make sense, local food is preferable due to
  - Potential value to growing the local economy
  - Higher degree of long-term sustainability
- Local food is only an option if it meets desired quality, is cost-competitive and consistenly available

### Criteria for evaluating local or imported food source options

| | |
|---|---|
| **Quality** | • Nutritional value<br>• Shelf-life<br>• Quality of packaging<br>• Ongoing, reliable quality assurance systems |
| **Cost** | • Material costs (including discounts for bulk purchase)<br>• Logistics costs and tariffs<br>• Expected waste<br>• Overhead costs for coordination |
| **Availability** | • Reliability of on-time delivery<br>• Stringency of import restrictions<br>• In crisis situations, local foods often are unavailable |
| **Sustainability** | • Long-term supplier development potential |

Source: Expert interviews

# Critical to maintain strong, integrated supply chain management

| | Sourcing and delivery | Storage | Distribution |
|---|---|---|---|
| **Supply chain** |  |  | Identification of beneficiaries<br>• Beneficiary lists<br>• Ration cards<br>  Wet-feeding<br>  Dry-feeding |
| **Common causes for failure** | • No availability of commodities<br>• Irregular or unreliable supply<br>– E.g. due to bad road conditions or unreliable partners<br>• Low outreach to inaccessible regions<br>• Loss of food<br>– E.g. theft or poor storage | • Low quality of storage<br>• Insecure storage facilities<br>• E.g. theft<br>• Inadequate quantities on storage to fulfill beneficiaries' demand<br>• Insufficient shelf life of food | • Leakage due to poor targeting<br>• Inappropriate timing and duration of feeding<br>• Distribution points badly accessible for beneficiaries<br>• Lack of counseling on the need to feed children<br>– High intra-household sharing of the ration or sale of the ration |

Source: Expert interviews; Allen, et al. "What Works? A Review of the Efficacy and Effectiveness of Nutrition Interventions." 2001

# Community engagement can improve delivery accountability

**Traditional supervision methods can be limited...**

**Monitoring of program activities through forms filled out by distribution agents**

- Manipulation of data in the forms is easy

**Supervision of program activities through program staff**

- As supervision is usually announced delivery is carried correctly in front of supervisors
- Beneficiaries often do not report misbehavior as they are afraid of personal consequences when they blame others, especially respected community persons

**...but community accountability and self-control approaches may be more promising**

**Improved information of the community**

- Billboards or leaflets at the distribution center that inform beneficiaries of interventions they are entitled to
- Information sessions that explain the expected service

**Accountability via an empowered community**

- Giving communities the responsibility to self-monitor operations
- E.g. Government of Bangladesh's Health, Nutrition and Population Sector Program (HNPSP), funded by the World Bank
  - Community engagement is crucial for day to day quality service delivery and supervision.
  - Cooperation was established with the Social Investment Program Project (SIPP), a program to empower communities to take ownership their development, e.g. road building, well digging and other income generating activities
  - HNPSP utilized the SIPP community structures to help manage the supplementary feeding programs

Source: Expert interviews

# Both programmatic monitoring and impact evaluations are essential to assess the program's success

## Programmatic monitoring helps to maintain high operational performance

**Feeding center staff should continuously monitor and report key programmatic indicators and benchmark them with Sphere standards**

| | Target | Alarm rate |
|---|---|---|
| • Recovery rate | > 70 % | < 50 % |
| • Death rate | < 3 % | > 10 % |
| • Defaulting rate | < 15 % | > 30 % |
| • Coverage rate | > 50 % (rural)<br>> 70 % (urban)<br>> 90 % (camps) | |

## Impact evaluations are needed to assess program impact and coverage

**Periodically nutrition surveys of the population should be carried out to survey improvements in the nutritional status**

- Number of moderately malnourished children
- Number severely malnourished children

**Improvements in the nutritional status are not automatically due to the supplementary feeding program**

- Other confounding factors such as improved overall food security and health situation have to be taken into account

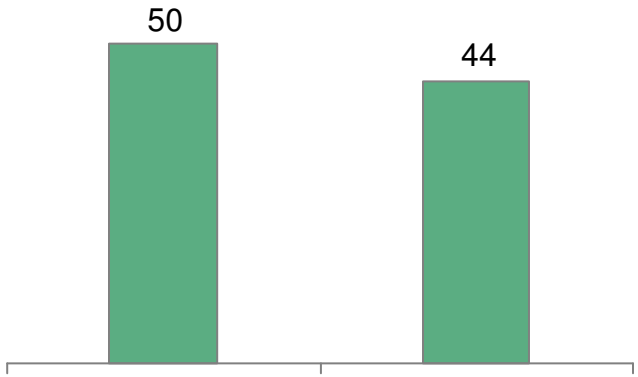
Source: "Food and nutrition handbook." WFP

# What it costs

# Maternal SF programs costs ~$ 50 per beneficiary annually

**A typical 660 kcals ration including delivery costs ~ $50**

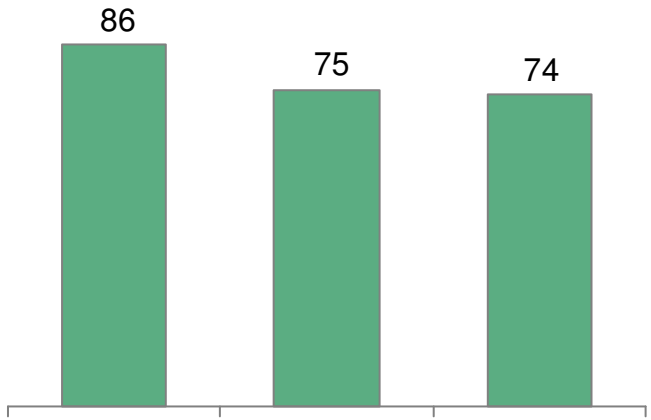
Cost of 660 kcals / person / day annually (USD)




Ration standardized to 660 kcal per day

**A typical 1,000 kcal ration including delivery costs ~ $75**

Cost of 1,000 kcals / person / day annually (USD)



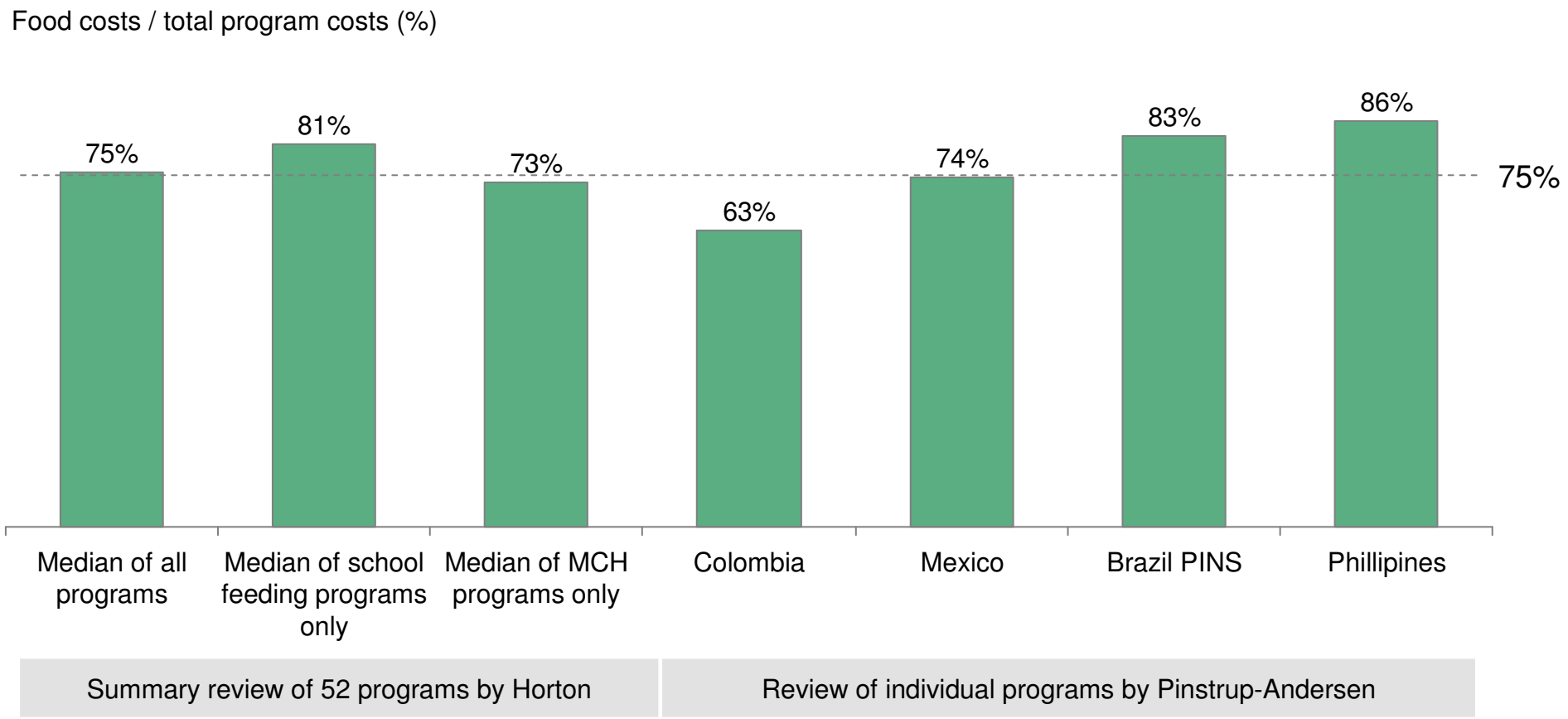

Ration standardized to 1,000 kcal per day

**Source**

**Some next-generation foods can be more expensive**

Source: "World Hunger Series 2007. Hunger and health." WFP, 2007.; internal WFP analysis; "Cost analysis of feeding and food subsidy programmes." Horton, 1993

# Food costs comprise ~75% of SF program costs




Source: "Cost analysis of feeding and food subsidy programmes." Horton, 1993.; "Assuring food security and adequate nutrition for the poor." Pinstrup-Andersen, 1988

# Where to go for further information

# Key reference materials: Supplementary feeding

## Normative guidance

- "Manual on the management of nutrition in major emergencies." WHO, 2000

## Operational guidance

- "Guidelines for selective feeding programmes in emergency situations." UNHCR/WFP, 1999[1]
- "Supplementary feeding for mothers and children: Operational guidelines." WFP, 1998
- "Infant and young child feeding in emergencies. Operational guidance for emergency relief staff & programme managers." IFE core group, 2007
- "Handbook for emergencies." UNHCR, 1999
- "Field guide on rapid nutritional assessment in emergencies." WHO/EMRO, 1995
- "Nutrition guidelines." MSF, 1995 (not available)
- "Food scarcity and famine-assessment and response." Oxfam, 1992
- "Food distribution guidelines." WFP
- "Food and nutrition handbook." WFP
- "Emergency field operations pocketbook" WFP, 2002

## Training materials

- N/A

1. Proposal to the IASC Nutrition Cluster was already submitted to update these guidelines

# Organizations: Supplementary feeding (I)

| | Organization | Description | Key activities |
|---|---|---|---|
| Multilateral | **World Food Program**<br>• www.wfp.org | • UN Nations food emergency program | • Implementation, e.g. school feeding, food-for-work<br>• Development of guidelines<br>• Advocacy |
| | **World Bank**<br>• www.worldbank.org | • International development bank | • Funding<br>• Advocacy |
| | **FAO**<br>• www.fao.org | • United Nations food and agriculture program | • Technical guidance for foods |
| | **UNHCR**<br>• www.unhcr.org | • UN refugee agency | • Development of guidelines<br>• Coordination of supplementary feeding in refugee situations |
| | **UNICEF**<br>• www.unicef.org | • United Nations Childrens Fund | • Implements supplementary feeding programs<br>• Advocacy |
| Bilateral | **USAID – Food for Peace**<br>• www.usaid.gov/our_work/humanitarian_assistance/ffp/ | • The United States development agency's food program | • Makes commodity donations to cooperating partners |

# Organizations: Supplementary feeding (II)

| | Organization | Description | Key activities |
|---|---|---|---|
| NGOs | **CARE**<br>• www.care.org | • Humanitarian organization fighting global poverty with focus on women | • Implementation of supplementary feeding programs or food-for-work programs |
| | **World Vision**<br>• www.wvi.org | • Christian relief, development and advocacy organization dedicated to working with children, and families | • Implementation of supplementary feeding in emergencies |
| | **Catholic Relief Service**<br>• www.catholicrelief.org | • Official international relief and development agency of the U.S. Catholic community | • Implementation of supplementary feeding in emergencies |
| | **Lutheran World Relief**<br>• www.lwr.org | • Faith-based humanitarian organization working in 35 countries to help people grow food, improve health, strengthen communities, end conflict, build livelihoods and recover from disasters | • Implementation of supplementary feeding in emergencies |

# Organizations: Supplementary feeding (III)

| | Organization | Description | Key activities |
|---|---|---|---|
| NGOs (cont'd) | **Food for the Hungry**<br>• www.fh.org | • International faith-based organization providing emergency relief and long-term development aid | • Provides supplementary food in emergency situations, e.g. Darfur |
| | **Caritas**<br>• www.caritas.org | • Catholic humanitarian organization working in emergencies, sustainable development and peace building | • Implements supplementary feeding programs, e.g. in Eritrea |
| | **Food Security Network**<br>• www.foodsecuritynetwork.org | • Resource center and site for food security program designers and implementers supported by USAID and maintained by Food for the Hungry<br>• Successor of Food Aid Management | • Sharing of success stories and program updates from the field<br>• Provision of the latest technical papers and reports<br>• Linking to other materials and relevant sites<br>• Posting of meeting notices, training events and other joint-forums serving the food security community |

# Scaled-up programs: Supplementary feeding

| Name/country | Implementing partners | Other information |
|---|---|---|
| Enhanced Outreach Strategy, Ethiopia[1] | Ministry of Health, UNICEF, WFP | • ~6.6M children under five screened in 2006: ~475K admitted to supplementary feeding<br>• ~0.9M P&L women screened in 2006: ~300K admitted to supplementary feeding<br>• Integrated delivery with other MCH interventions<br>• Coverage of ~50% of the country with a population of ~37M |
| Integrated Child Development Services, India | Government, UNICEF | • World's largest ongoing supplementary feeding sustained for about 30 years<br>• Implemented through communities including delivery of various interventions<br>• India-wide, about 25% of the children <6 years are enrolled in the program |
| National Nutrition Program, Bangladesh[1] | Ministry of Health, World Bank, various local NGOs | • Supplementary food provided through women community nutrition promoters in 105 sub-districts |
| Supplementary feeding and health and nutrition education, Ghana | WFP | • Scale up of supplementary feeding and other child health interventions |
| PCCN – Brazil (National Programme for the Control of Nutritional Deficiencies) | Ministry of Health, state and municipal health authorities | • Take away ration of milk and soya bean oil distributed to moderately malnourished children 6 to 59 months of age.<br>• Integrated delivery with other MCH interventions<br>• 850K children assisted in 1186 least developed municipalities<br>• Transformed into a cash-transfer program after impact evaluation |

1. Initial case study provided

# Appendix: experts consulted

# Experts consulted during preparation of this document

| Name | Organization and title | Area of expertise |
|---|---|---|
| Lynn Brown | World Bank, Food Policy Specialist | Implementation |
| Sylvie Chamois<br>Selamawit Negash<br>Jakob Mikkelsen | UNICEF, EOS Ethiopia | Implementation |