EXPANSION AND SCALE-UP PHASE OF THE SEQOTA DECLARATION:

CONSIDERATIONS FOR AN INVESTMENT PLAN TO ACHIEVE ETHIOPIA'S FOOD AND NUTRITION GOALS

Contents

Abbreviations and Acronyms

AARR	Average Annual Rate of Reduction
BCC	Behavior Change Communication
EDHS	Ethiopian Demographic and Health Survey
FF	Food Fortification
FNA/C	Food and Nutrition Agency /Council
FNCO	Food and Nutrition Coordination Office
FPDU	Federal Program Delivery Unit
FS	Food Supplementation
FSN	Food and Nutrition Strategy
FTC	Farmers Training Center
GMP	Growth Monitoring and Promotion
HEW	Health Extension Workers
HH	Household
ICT	Information Communication Technology
IEC	Information Education Communication
IFS	Iron Folate Supplementation
IYCF	Infant and Young Child Feeding
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
ITN	Insecticide Treated Nets
M&E	Monitoring and Evaluation
MNP	Micronutrient Powder
MUAC	Mid Upper Arm Circumference
NDAs	Nutrition Development Agents
NSA	Nutrition Sensitive Agriculture
NNP II	National Nutrition Plan II
PDU	Program Delivery Unit
PFSA	Poverty and Food Security Alleviation

Abbreviations and Acronyms

PLW	Pregnant and Lactating Women
PSNP	Productive Safety Net Program
RPDU	Regional Program Delivery Unit
SBCC	Social and Behavior Change Communication
SC	Stabilization Center
SD	Seqota Declaration
SSN	Social Safety Net
VAS	Vitamin A Supplementation
WASH	Water, Sanitation, and Hygiene

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Through its Nutrition Technical Assistance Mechanism (NTEAM), Nutrition International shares its expertise globally to support the scale-up of nutrition for the most vulnerable. We believe that knowledge, rigorously obtained and generously shared, is key to effective progress for nutrition.

NTEAM provides timely and coordinated expert technical assistance to countries and agencies. We convene global experts to tackle key nutrition issues and encourage broad use of knowledge by translating technical information and research into accessible guidance, tools, and resources.

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A. OVERVIEW

1. Background

Stunting in Ethiopia is still unacceptably high. Despite the steady decline of stunting over the past twenty years, the rate in children under five was 38% in 2019 and 28% in children under two (with wide regional variation). The Government of Ethiopia (GoE) has designed and implemented several pro-poor policies and strategies across different sectors in the last twenty years focused on multisectoral poverty reduction, food security, increased agricultural production, decentralized health systems, health extension programs, accelerated midlevel health care worker training, girls' and parental education, maternal nutrition status, economic improvement, and a reduction in open defecation and general Water, Hygiene and Sanitation (WASH) practices. Impacts from the implementation of these policies and strategies collectively contributed to the stunting reduction achieved in Ethiopia over the last twenty years.[1] Despite this progress, the gains are insufficient to achieve the country's stunting reduction targets in **either the short term** (the national nutrition plan II NNP II[1] target of reducing stunting in children under five to 26% by 2020) **or long term** (World Health Assembly target of 40% reduction by 2025 and Seqota Declaration target of zero stunting by 2030 in children under two). Gender inequality is highly associated with child malnutrition and child mortality. Women's socio-economic empowerment in terms of access to education, information, media, and income-generating activities is strongly associated with lower rates of childhood stunting and wasting, and women's decision-making power is positively associated with better health status for children.[29]

In July 2015, the Government of Ethiopia exemplified its commitment to nutrition by issuing the Seqota Declaration to eliminate child undernutrition and end stunting in Ethiopia by 2030. The 15-year Seqota Declaration Implementation Plan focuses on delivering high-impact nutrition-specific, nutrition-sensitive, and infrastructure interventions across multiple sectors. Recognizing that ending child malnutrition requires coordinated efforts from all stakeholders, the declaration's implementation plan emphasizes improving adolescent, infant, and maternal nutrition; increasing access to nutrient-rich food all year round, improving access to water and hygienic services; building resilient social protection systems; supporting the economic empowerment of women; and improving access to education, especially for girls. The SD focuses on stunting because it is considered to be the best overall indicator of children's well-being and social inequities globally.

The SD is being implemented in three phases. The Innovation Phase was implemented from 2016 to 2020 to pilot innovative programs in 40 woredas along the Tekeze river basin in Amhara (27 woredas) and Tigray (13 woredas). Amhara and Tigray were targeted for the Innovation Phase because the stunting burden in both regions was consistently above the national average. The Expansion Phase will be implemented between 2021 and 2025 and seeks to expand these innovative pilot programs to additional vulnerable communities. The Scale-up Phase will take place from 2026 through 2030 and will scale these innovations nationally.

[1] NNP II launched in 2016 and covered the period between 2016-2020. Now replaced by FNS (2021-2030).

The SD Innovation Phase (2016 to 2020) included six innovations to catalyze the delivery of SD strategic initiatives to reduce stunting. The Innovation Phase used existing multisectoral structures to implement these innovations based on the "learning by doing" principle.
The six innovations are:

1. Program Delivery Unit (PDU),
2. Data Revolution,
3. Community Labs,
4. Costed Woreda-based Planning (CWBP),
5. Agricultural Innovation and Technology Centers (AITEC), and
6. the First 1000 Days Plus Public Movement.

Based on the evidence from the innovation phase, the SD Expansion and Scale-Up phases aim to end stunting in Ethiopia among children under two years through tested innovative multisectoral coordination and collaboration across sectors, communities, and stakeholders, focusing on high impact nutrition-specific and nutrition-smart interventions and social behavior change communication with special consideration for cross-cutting issues, such as gender mainstreaming, the environment, and integrated community development approaches. The program will focus on 12 regions to[2] improve the nutrition status of children through the implementation of a combination of four clusters of strategic intervention pillars. This investment plan will focus on the strategic objectives of the FNS and the SD expansion and scale-up phases.

2. Approach to development of the investment plan

To achieve the targets of the Seqota Declaration that will enable the achievement of the FNS goals, Ethiopia will need to mobilize the resources required and put them to effective and efficient use. This means that stakeholders involved in developing the plan for the next phases of the Seqota Declaration need to develop a comprehensive investment plan for the FNS that will secure adequate funds for a prioritized package of interventions to maximize the impact of the plan and the resources invested. Each step of the investment plan development should be government-driven, guided by the FNS, and led by the Program Delivery Unit (PDU) team. Hence in preparation for the development of an FNS investment plan series of consultations were conducted by the PDU in collaboration with the technical assistance provider to unpack the main steps needed. These steps are as follows:

Step 1: Define what an investment plan entails in terms of both processes and content

Step 2: Identify What/where the focus of NI- TAN technical assistance should be in the light of existing available data and time constraints. This includes defining the content of the investment plan and how they meet the needs of the PDU in their planning to fund the cost of implementation of the SD roadmap and ultimately the FNS.

[2] Addis Ababa City Administration, Dire Dewa City Administration, Amhara, Afar, Benishangul Gumuz, Gambella , Harari , Oromia, Tigray, SNNPR, Sidama , Somali

Question 3: Define how the PDU intends to use this plan and what the next steps are.

Given the gaps in relevant data needed, for example, there are no data on the cost of the innovation phase interventions (e.g. the top ten interventions) nor the cost of the impact on stunting, wasting mortality rates, etc. (including in the John's Hopkins University impact analysis). To provide this data, will involve months of work on data collection and analysis which is not in the scope of R4D's work but could form the basis for more analysis in future work under the overall FNS investment case development.

The R4D component will therefore focus on three main tasks that will form the foundation for a **government-led** follow-on investment plan aligned with the FNS. The R4D tasks are:

1) Cost the full package of interventions that were developed for the expansion and scale-up phases by the different ministries, departments, and agencies, and the PDU (outlined in the Roadmap).

2) Use the John Hopkins Impact Analysis data and the African Union's Cost of Hunger Ethiopia report to showcase the available evidence of the potential impact of interventions included in the SD expansion and scale-up package.

3) Present the costs for the investment pillars already proposed in the SD Roadmap (around sustaining and creating an enabling environment to improve coverage), to inform conversations between the different ministries, departments, and agencies (MDAs), PDU, and development partners.

The deliverable will provide high-level descriptions of the importance of the investment pillars and their costs and identify considerations for the PDU to inform the dialogue with the MoH to build the necessary data and evidence for developing a sustainable nutrition financing strategy for Ethiopia that will cover both the FNS and SD strategies.

B.STRATEGIC CASE FOR THE INVESTMENT PLAN

1. Context

Stunting and socio-economic progress. Advancing Ethiopia's efforts to reduce stunting is critical to accelerate socio-economic progress and development and improve the health and educational attainment of current and future generations. According to the Cost of Hunger in Africa Report (2013), because of factors associated with undernutrition, Ethiopia loses 17% of GDP each year, which slows down the country's ambition to achieve inclusive growth and become a lower-middle-income country by 2025. If Ethiopia achieves the WHA target of a 40% reduction in the number of stunted children under five by 2025, the cumulative increase in income for the non-stunted workforce would be USD 16 billion from 2035 to 2060 (assuming the workforce is not stunted from the year they enter the labor force to the end).[2] This is partially driven by the significant health and education impact stunting wreaks across generations.

2. Expected results

Based on the evidence from the innovation phase, the SD Expansion and Scale-Up phases aim to end stunting in Ethiopia among children under two years through tested innovative multisectoral coordination and collaboration across sectors, communities, and stakeholders, focusing on high impact nutrition-specific and nutrition-smart interventions and social behavior change communication with special consideration for cross-cutting issues, such as gender mainstreaming, the environment, and integrated community development approaches. The program will focus on 12 regions to[3] improve the nutrition status of children through the implementation of a combination of four clusters of strategic intervention pillars from the FNS and SD. The evidence reviewing[4] Ethiopia's programmatic experience and impact analysis[5] , and the Exemplars in Global Health work[6] indicate that the implementation of high-impact interventions at scale, with increased intensity and coverage (70% coverage), in addition to innovative governance and accountability mechanisms (such as Program Delivery Units (PDUs) and Food and Nutrition Coordination Offices) – will result in a significant reduction in stunting (≥ 3% AARR) and avert deaths in children under five. Hence the following high targets and coverage levels are necessary to achieve the FNS goals.

1. Improve nutritional status of children under two years

- Overall stunting reduction to almost zero by 2030
- Reduction of stunting in children under two to 14% by 2025 from the current 28% by 2025
- Achieve **≥ 3% AARR** of stunting in children under two between 2021 and 2030

2. Increase coverage and compliance

Agriculture Sector: Improved dairy, poultry & fish production and consumption; Improved production and consumption of nutrient-dense crops and horticulture; Biofortification (maize, potato, bean); Perishable food supply chain standard and directives development; and local food processing (e.g. dried meat powder & egg powder).

Health Sector: Optimum breastfeeding; Minimum acceptable diet, diet diversity and animal source consumption by Infant and Young Child & Pregnant and Lactating Women; and Multiple micronutrient supplementation for pregnant women, vitamin A supplementation.

WASH Sector: Improved latrine and basic handwashing facility for households; improved personal and environmental hygiene; and increased access to improved drinking water.

Education Sector: Increased access to Girls' education; Expansion of model home-grown school feeding program (Ethiopia school meal initiative model); and Student participation in school and family nutrition promotion activities.

Social protection Sector: Pulse transfer to PLW; Fee waiver to all malnourished children; Conditional cash/food transfers to community nutrition champions.

[3] Addis Ababa City Administration, Dire Dewa City Administration, Amhara, Afar, Benishangul Gumuz, Gambella , Harari , Oromia, Tigray, SNNPR, Sidama , Somali

[4] 2021 Synthesized Learnings from the Seqota Declaration Innovation Phase and Evidence on High-Impact Nutrition Interventions: Considerations for the Expansion Phase Roadmap Development. Results for Development

[5] June 2021: Seqota Declaration Innovation Phase- Impact Analysis. Johns Hopkins Bloomberg School of Public Health

[6] Exemplars in Global Health: Stunting Reduction in Ethiopia

Women, Children and Youth Affairs: Supportive social environment for the proper child, PLWs and adolescent girl care and feeding; Male involvement in child nutrition and care.

Road and transport sector: Construction of road to reach the very hard to reach areas

3. Increase timely and quality delivery of routine interventions

Agriculture Sector: Strengthen farmer training centers; Food safety practice; post-harvest loss management; Staple crop diversification; Agriculture workers training on nutrition-sensitive agriculture; Financing facility to actors in the perishable food value chain; and Food market linkages and affordability.

Health Sector: Early identification and treatment of acute malnutrition; Child Growth Monitoring Promotion; Vitamin A Supplementation; Deworming and; Health workers training on nutrition-related services.

WASH Sector: Household and community-based WASH promotion.

Education Sector: Training of teachers on nutrition-sensitive education; and School curriculum revision to adequately incorporate nutrition.

Social protection: Train social safety net staff and social workers on nutrition-sensitive social protection.

Women, children, and youth affairs: Women's social empowerment and gender equity; and child daycare/ECD expansion.

4. Enhance nutrition sensitivity of non-direct cross-sectoral interventions

Agriculture Sector: Large scale irrigation farm; Transform smallholder productivity and income (agricultural inputs, extension services); Natural resource management; Health Sector: Family planning; Child immunization; Antenatal care, post-natal care, & Skilled delivery; Integrated Management of Childhood Illnesses; Malaria prevention and treatment; Strengthening Health Extension Program.

Health Sector: Family planning; Child immunization; Antenatal care, post-natal care, & Skilled delivery; Integrated Management of Childhood Illnesses; Malaria prevention and treatment; Strengthening Health Extension Program.

WASH Sector: Universal access to clean and safe water through large scale water scheme

Education Sector: General school-based nutrition, WASH, and reproductive health

Social Protection: General Productive Safety Net Program; Health care fee waiver to indigents.

Women, Children and Youth Affairs: Labor, time, and energy-saving technology for domestic work; Women economic empowerment

Road and Transport sector: General rural road development and networking.

5. Institutionalized multisectoral nutrition response governance

Multisectoral Coordination and governance: FNCOs, PDUs, Woreda Coordinators; Costed Woreda-based Planning

Human Resource for Nutrition: Career structure and recruitment of sectoral nutrition expert

Data Revolution: Data use culture (Data demand for decision making, analysis, and visualization) and; Performance management and adaptation

Coordination of cross-cutting innovations: Community labs (community participation and ownership; local resource mobilization); The 1000 days public movement mainstreaming and; Expansion of model nutrition smart infrastructure/technologies and innovations across different sectors;

This investment framework document is guided by **the SD Expansion and Scale-Up Phase Roadmap** as well as the Food and Nutrition Strategy**(FNS)**.

3. Rationale and Evidence for the Expansion and Scale-Up Phases and the FNS

In 2021, an impact analysis of the innovation phase of the SD was conducted by the Johns Hopkins University[7] focusing on the impact of agricultural, nutrition, health, social behavior change communication, and WASH interventions – the same interventions that were included in the Seqota Declaration Baseline Report. The Lives Saved Tool (LiST) model was used to estimate changes in the neonatal mortality rate (NNMR), the under-5 mortality rate (U5MR), stunting rate, additional lives saved, and stunting cases averted. The section below describes the main results of the impact evaluation which established the evidence and rationale for investing in the expansion and scale-up phases and the FNS.

Increase in coverage by SD interventions in Tigar and Amhara regions. The innovation phase improved coverage of SD interventions across multiple areas in both Tigray and Amhara regions (refer to Tables 1 & 2). For example, in Tigray, coverage of ANC1 increased from a baseline of 91% to 99%, and Iron and Folic Acid supplementation from 50% to 80%, etc. (refer to table 1). Increased coverage of several SD interventions also contributed to the observed reductions in under-5 mortality in the program area. This contribution was similar in Tigray and Amhara, where only differences in baseline coverage contributed to differences in impact. Agriculture, nutrition, social behavior change communication (SBCC), water, sanitation, and hygiene (WASH) interventions, and improvements in the treatment of sick children accounted for the greatest reductions in mortality. Agricultural interventions resulting in improved coverage of complementary feeding among infants and young children averted the greatest number of child deaths. These agricultural interventions also translated to food supplementation among low BMI women, resulting in improved birth outcomes and reduced child mortality. Increased treatment of diarrhea with ORS and treatment of children with acute malnutrition also accounted for significant reductions in mortality. SBCC to promote breastfeeding was the 4th and 3rd most impactful intervention in Tigray and Amhara respectively. Increased vitamin A supplementation in children was the 6th and 8th most impactful intervention in Tigray and Amhara respectively. Improvements in water sources also contributed to reductions in under-5 mortality.

[7] Johns Hopkins Bloomberg School of Public Health. June 2021: Seqota Declaration Innovation Phase- Impact Analysis.

Table 1. Intervention coverage, change from baseline, and source of indicator change ~ Tigray

Tigray	Baseline	Source of indicator change		Change 2019:2018	Change 2020:2018	2019 Coverage	2020 Coverage
Pregnancy							
ANC1	91.6%	Base * % change ANC1	HMIS	9.7%	19.5%	99.0%	99.0%
ANC4	56.8%	Base * % change ANC4	HMIS	4.7%	9.4%	59.5%	62.1%
IFA	50.0%	Base * % change in IFA 90+	HMIS	31.3%	62.5%	65.6%	81.2%
Food supplement for low BMI women	0.0%	Base + ag intervention coverage	Scorecard	74.6%	74.6%	74.6%	74.6%
Childbirth							
Facility delivery	63.9%	Base * % change SBA at facility	HMIS	1.6%	3.3%	64.9%	66.0%
Breastfeeding							
Promotion of breastfeeding	35.0%	Base + % PLW who participated in Nutrition BCC	Scorecard	31.6%	12.1%	66.6%	47.1%
Preventative							
Complementary feeding (education only)	25.0%	Base + % PLW who participated in Nutrition BCC	Scorecard	31.6%	12.1%	56.6%	37.1%
Complementary feeding (supplemental)	0.0%	Base + ag intervention coverage	Scorecard	74.6%	74.6%	74.6%	74.6%
Vitamin A supplementation	36.2%	Base * % change VAS 6-59 m	HMIS	13.7%	27.5%	41.2%	46.2%
WASH							
Improved sanitation	29.6%	Base + % people to have access to clean and safe water	Scorecard	7.7%	7.0%	37.3%	36.6%
Improved water	72.0%	Base + % people to have access to clean and safe water	Scorecard	7.7%	7.0%	79.7%	79.0%
Water connection in the home	0.7%	Base + % people to have access to clean and safe water	Scorecard	7.7%	7.0%	8.4%	7.7%
Handwashing with soap	0.7%	Base + % people to have access to clean and safe water	Scorecard	7.7%	7.0%	8.4%	7.7%
Safe disposal of stools	29.0%	Base + % people to have access to clean and safe water	Scorecard	7.7%	7.0%	36.7%	36.0%

Curative							
KMC	75.7%	Base * % change SBA at facility	HMIS	1.6%	3.3%	76.9%	78.2%
ORS	30.6%	Base * % change children treated with ORS	HMIS	18.9%	37.7%	36.4%	42.1%
Zinc for diarrhea treatment	10.1%	Base * % change children treated with ORS & zinc	HMIS	22.1%	44.2%	12.3%	14.6%
SAM treatment	33.0%	Base * % change children screened for acute malnutrition	HMIS	26.6%	53.1%	41.8%	50.5%
MAM treatment	20.0%	Base * % change children screened for acute malnutrition	HMIS	26.6%	53.1%	25.3%	30.6%
Household Assumptions							
HH with moderate/severe food insecurity	55.0%	Base * (1-ag intervention coverage)	Scorecard	74.6%	74.6%	14.0%	14.0%

Source: Johns Hopkins Bloomberg School of Public Health. 2021. Seqota Declaration Innovation Phase- Impact Analysis.

Table 2. Intervention coverage, change from baseline, and source of indicator change ~ Amhara

Amhara	Baseline	Source of indicator change		Change 2019:2018	Change 2020:2018	2019 Coverage	2020 Coverage
Pregnancy							
ANC1	72.2%	Base * % change ANC1	HMIS	9.7%	19.5%	79.3%	86.3%
ANC4	36.2%	Base * % change ANC4	HMIS	4.7%	9.4%	37.9%	39.6%
IFA	40.1%	Base * % change in IFA 90+	HMIS	31.3%	62.5%	52.6%	65.1%
Food supplement for low BMI women	0.0%	Base + ag intervention coverage	Scorecard	74.6%	74.6%	74.6%	74.6%
Childbirth							
Facility delivery	47.2%	Base * % change SBA at facility	HMIS	1.6%	3.3%	48.0%	48.7%
Breastfeeding							
Promotion of breastfeeding	35.0%	Base + % PLW who participated in Nutrition BCC	Scorecard	31.6%	12.1%	66.6%	47.1%
Preventative							
Complementary feeding (education only)	25.0%	Base + % PLW who participated in Nutrition BCC	Scorecard	31.6%	12.1%	56.6%	37.1%
Complementary feeding (supplemental)	0.0%	Base + ag intervention coverage	Scorecard	74.6%	74.6%	74.6%	74.6%
Vitamin A supplementation	36.8%	Base * % change VAS 6-59 m	HMIS	13.7%	27.5%	41.8%	46.9%

WASH							
Improved sanitation	55.4%	Base + % people to have access to clean and safe water	Scorecard	7.7%	7.0%	63.1%	62.4%
Improved water	72.0%	Base + % people to have access to clean and safe water	Scorecard	7.7%	7.0%	79.7%	79.0%
Water connection in the home	7.0%	Base + % people to have access to clean and safe water	Scorecard	7.7%	7.0%	14.7%	14.0%
Handwashing with soap	0.7%	Base + % people to have access to clean and safe water	Scorecard	7.7%	7.0%	8.4%	7.7%
Safe disposal of stools	34.4%	Base + % people to have access to clean and safe water	Scorecard	7.7%	7.0%	42.1%	41.4%
Curative							
KMC	71.8%	Base * % change SBA at facility	HMIS	1.6%	3.3%	73.0%	74.2%
ORS	35.7%	Base * % change children treated with ORS	HMIS	18.9%	37.7%	42.4%	49.2%
Zinc for diarrhea treatment	6.1%	Base * % change children treated with ORS & zinc	HMIS	22.1%	44.2%	7.4%	8.8%
SAM treatment	33.0%	Base * % change children screened for acute malnutrition	HMIS	26.6%	53.1%	41.8%	50.5%
MAM treatment	20.0%	Base * % change children screened for acute malnutrition	HMIS	26.6%	53.1%	25.3%	30.6%
Household Assumptions							
HH with moderate/severe food insecurity	61.0%	Base * (1-ag intervention coverage)	Scorecard	74.6%	74.6%	7.8%	7.8%

Source: Johns Hopkins Bloomberg School of Public Health. 2021. Seqota Declaration Innovation Phase- Impact Analysis.

Impact of SD interventions on stunting averted and deaths in Tigray and Amhara. The impact analysis indicates in the year 2021, the SD interventions are expected to reduce NNMR by 1.9% in Tigray and 2% in Amhara (Table 1). We expect a greater reduction in under-5 mortality, resulting in a 6.6% reduction in Tigray and a 6.7% reduction in Amhara in 2021. By 2023, we expect the intervention scale-up in 2019 and 2020 to result in a 10.5% absolute reduction or a 26.4% relative reduction in stunting in Tigray. A similar 11.8% absolute reduction of 22.8% relative reduction in stunting in Amhara is also anticipated. By the year 2021, the SD will prevent almost 400 child deaths in Tigray and Amhara annually.

Table 3. Impact of Seqota Declaration on mortality and stunting rates in Tigray and Amhara

		2018	2019	2020	2021	2022	2023
Tigray		%	%	%	%	%	%
NNMR	Seqota implementation	20.82	20.54	20.46	20.42	20.42	20.42
	Reference (no intervention)	20.82	20.81	20.81	20.81	20.81	20.81
U5MR	Seqota	41.56	39.27	38.58	38.24	38.14	38.1
	Reference	41.56	41.21	40.98	40.93	40.94	40.92
Stunting Rate	Seqota	39.71	36.73	34.66	32.31	30.05	29.42
	Reference	39.71	39.79	39.91	39.97	40	39.95
Amhara							
NNMR	Seqota	25.11	24.73	24.69	24.61	24.61	24.61
	Reference	25.11	25.1	25.1	25.1	25.09	25.09
U5MR	Seqota	46.88	44.22	43.53	43.1	43.01	42.96
	Reference	46.88	46.5	46.27	46.21	46.22	46.2
Stunting Rate	Seqota	51.05	47.68	45.56	43.06	40.58	39.88
	Reference	51.05	51.26	51.5	51.64	51.71	51.65

Source: Johns Hopkins Bloomberg School of Public Health. 2021. Seqota Declaration Innovation Phase- Impact Analysis.

Top ten interventions accounting for stunting cases averted. The SD impact analysis identified the top ten interventions or risk factors that accounted for the significant reductions in child stunting (Table 3) and in the table, the findings also show under 5 lives saved by these interventions. Increased complementary feeding was the primary driver of stunting reductions, accounting for over 90% of the stunting cases averted. Vitamin A supplementation, improved water source, food supplementation for low BMI women, improved sanitation, improved breastfeeding practices due to promotion, and increased handwashing also contributed to reductions in stunting. It is noteworthy to state that the health impact of most of the nutrition-sensitive interventions in the SD has not yet been measured (globally and country-level), however, the evidence in Ethiopia and globally indicate that these ten high impact interventions are low cost and better value for money when implemented across the 4 intervention pillars (refer to the summary of interventions under the 4 pillars in boxes 1-4).

Table 4. Interventions accounting for stunting cases averted (0-59 months) each year

	2018	2019	2020	2021	2022	2023
Tigray						
1. Appropriate complementary feeding	0	9,564	16,534	25,014	33,259	35,311
2. Vitamin A supplementation	0	126	458	527	613	632
3. Improved water	0	234	405	509	606	627
4. Water connection in the home	0	148	255	320	381	395
5. Food supplementation for low BMI women	0	124	295	311	405	424
6. Improved sanitation	0	97	167	210	250	258
7. Age-appropriate breastfeeding practices	0	55	45	139	183	193
8. Hand washing with soap	0	41	71	89	106	109
9. Rotavirus vaccine	0	0	4	6	5	5
10. Maternal age and birth order	0	0	3	5	9	10
Amhara						
1. Appropriate complementary feeding	0	9,723	16,196	23,956	31,321	32,677
2. Vitamin A supplementation	0	106	389	443	510	517
3. Improved water	0	209	355	441	519	528
4. Food supplementation for low BMI women	0	136	289	303	382	392
5. Water connection in the home	0	132	224	278	327	332
6. Improved sanitation	0	89	151	188	221	225
7. Age-appropriate breastfeeding practices	0	65	52	151	193	200
8. Hand washing with soap	0	36	62	77	90	92
9. Rotavirus vaccine	0	0	4	6	5	5
10. Maternal age and birth order	0	0	3	5	9	10

Source: Johns Hopkins Bloomberg School of Public Health. 2021. Seqota Declaration Innovation Phase- Impact Analysis.

Table 5. Top 10 interventions accounting for lives saved (0-59 m) each year

	2018	2019	2020	2021	2022	2023
Tigray						
1. Complementary feeding (via reduction in stunting)	0	27	36	45	54	56
2. Complementary feeding (via reduction in wasting)	0	31	31	32	32	32
3. ORS for treatment of diarrhea	0	13	26	25	25	25
4. Age-appropriate breastfeeding practices	0	20	8	21	21	21
5. Treatment for moderate acute malnutrition	0	7	16	16	16	16
6. Vitamin A supplementation	0	5	11	11	11	11
7. Treatment for severe acute malnutrition	0	5	10	10	10	10
8. Improved water	0	8	7	8	8	8
9. Food supplementation for low BMI women	0	7	8	8	8	8
10. Water connection in the home	0	5	5	5	5	5
Amhara						
1. Complementary feeding (via reduction in stunting)	0	26	33	41	48	49
2. Complementary feeding (via reduction in wasting)	0	34	34	34	34	33
3. Age-appropriate breastfeeding practices	0	26	10	26	26	26
4. ORS for treatment of diarrhea	0	13	26	25	25	24
5. Treatment for moderate acute malnutrition	0	7	17	17	16	16
6. Treatment for severe acute malnutrition	0	6	10	10	10	10
7. Food supplementation for low BMI women	0	8	8	9	9	9
8. Vitamin A supplementation	0	4	9	9	9	9
9. Improved water	0	7	6	7	7	7
10. Water connection in the home	0	4	4	4	4	4

Source: Johns Hopkins Bloomberg School of Public Health. 2021. Seqota Declaration Innovation Phase- Impact Analysis.

By the end of 2030, the expected targets to be reached by the SD investment are indicated in table 6.

Table 6. Expected reach of SD by 2030

Expected targets to reach	Expansion Phase (#)	Scale-up Phase (#)	Total (#)
Woredas	700	350	1,050
Population	77,000,000	38,500,000	115,500,000
Households	16,739,130	8,369,565	25,108,696
Pregnant and Lactating Women	17,453,333	8,726,667	26,180,000
Children under two years of age	18,456,900	9,228,450	27,685,350
Children under five years of age	20,751,500	10,375,750	31,127,250
Agriculture Extension Workers trained on nutrition sensitive agriculture	42,000	21,000	63,000
Model farmers / pastoralist training centers established and used as a showcase to expand diverse, nutrient rich and safe food production and consumption	2,100	1,050	3,150
Health Extension Workers trained on nutrition smart health interventions	42,000	21,000	63,000
Safe drinking water schemes constructed	4,500	1,500	6,000
Odorless pit latrine constructed and used as a show case to expand to wider geographies	14,000	7,000	21,000
Teachers, education experts, parent teacher association members trained on overall school based nutrition smart interventions	56,000	28,000	84,000
Model home-grown school feeding program (Ethiopian School Meal Initiative/ESMI/ centers established and used as a showcase for expansion	25	25	50
Social safety net and social workers trained on nutrition sensitive social safety net	14,892	7,446	22,338
Model community mobile daycare centers for preschool-age children established used as a showcase to expand to wider geographies	520	300	820
Sector Food and Nutrition Experts recruited and trained on nutrition smart interventions	3,565	1,815	5,380
Woreda Food and Nutrition Coordinators recruited and trained on multisectoral nutrition coordination, planning, and monitoring	700	350	1,050
Woredas with UNISE multisectoral nutrition data system	700	350	1,050
Kebeles with YAZMI technology for multisectoral nutrition data system	15,400	7,700	23,100

Source: MOH Conversion Factor [8]

The SD PDU worked in collaboration with sectoral stakeholders to set these targets using the MOH Conversion Factor among others including the following target calculations:

- The proportion of U5 Children from total population: 14.59%;
- Infant 0-12 months: 3.09%;
- Under 2 Children / 0-23 months proportion: 7.99%;
-Age 3-5 years proportion: 6.60%; and
- PW proportion: 3.40%

As mention in this document, the woredas were selected with sectoral stakeholders based on stunting rates and the population of the primary target groups affected.

[8] Proportion of U5 Children from total population: 14.59%; Infant 0-12 months: 3.09%; U2 Children / 0-23 months proportion: 7.99%; Age 3-5 years proportion: 6.60%; PW proportion: 3.40%

C. THE INVESTMENT INTERVENTION PILLARS

The evidence reviewing[9] Ethiopia's programmatic experience and impact analysis[10], and the Exemplars in Global Health work[11] indicate that the implementation of high-impact interventions at scale, with increased intensity and coverage (70% coverage), in addition to innovative governance and accountability mechanisms (such as Program Delivery Units (PDUs) and Food and Nutrition Coordination Offices) – will result in a significant reduction in stunting (≥3% AARR) and avert deaths in children under five.

What are the proposed feasible investment pillars? Based on this evidence, the high-impact interventions proposed for SD Expansion and Scale-up Phases[12] are categorized into the f**our strategic investment pillars**[13] depending on their current coverage status and complexity of the associated barriers for low coverage, availability of existing platforms, and their potential contribution to creating an enabling environment for enhanced implementation and impact of cross-sectoral interventions. These are categorized as lifting, backstopping, leveraging, and enabling pillars (see details in the Seqota Declaration Expansion and Scale-Up Phase Roadmap).

Pillar 1: Increase coverage and compliance

The **"lifting"** investment Pillar aims to raise the coverage and/or compliance of high-impact direct nutrition interventions across different sectors where current coverage is considered low, and which need an innovative or highly intensive implementation to meet the minimum 70% coverage requirement. The SD PDUs and Food and Nutrition Coordination Office (FNCOs) will demonstrate direct responsibility and accountability to improve coverage and compliance of these interventions through strong resource mobilization, and facilitation of their implementation at scale, in close collaboration with the implementing sectors. The six innovations tested during the Innovation Phase are: 1) Program Delivery Unit (PDU), 2) Data Revolution, 3) Community Labs, 4) Costed Woreda-based Planning (CWBP), 5)Agricultural Innovation and Technology Centers (AITEC), and 6) the First 1000 Days Plus Public Movement – these can be excellent drivers of interventions in this category.

[9] 2021 Synthesized Learnings from the Seqota Declaration Innovation Phase and Evidence on High-Impact Nutrition Interventions: Considerations for the Expansion Phase Roadmap Development. Results for Development
[10] June 2021: Seqota Declaration Innovation Phase- Impact Analysis. Johns Hopkins Bloomberg School of Public Health
[11] Exemplars in Global Health: Stunting Reduction in Ethiopia
July 2021. Seqota Declaration costed Roadmap for Expansion and Scale up Phases 2021 – 2030

[13] **The SD PDU and govt stakeholders grouped interventions under 4 strategic pillars (which they called "strategic investment options") - according to existing entry points/opportunities in each sector. This makes it easier for sectors to set targets within their own sectors to render implementation more achievable**

Box 1: Summary of interventions under Pillar 1

Sector	Interventions: Pillar 1
Agriculture	- Improved dairy, poultry & fish production and consumption - Improved production and consumption of nutrient-dense horticulture - Biofortification of staple crops (maize, potato, bean) - Local food processing (e.g. dried meat powder & egg powder) - Perishable food supply chain standard and directives development - Construction of roads to the very hard to reach areas
Health	- Optimum breastfeeding - Minimum acceptable diet, diet diversity, and animal source consumption by Infant and Young Child & Pregnant and Lactating Women - Multiple micronutrient supplementation for pregnant women - Vitamin A Supplementation
WASH	- Improved latrine and basic handwashing facility for households - Increased access to improved drinking water sources
Education	- Girls' education - Expansion of model home-grown school feeding program (Ethiopia school meal initiative model) - Student participation in school and family nutrition promotion activities
Social Protection	- Pulse transfer to PLW - Fee waiver to all malnourished children - Conditional cash/food transfers to community nutrition champions
Women, Children & Youth Affairs	- A supportive social environment for the proper child, PLW, and adolescent girl care and feeding - Male involvement in child nutrition and care

Pillar 2: Increase timely and quality delivery of routine interventions

The **"backstopping"** investment pillar aims to ensure timely and quality delivery of high-impact nutrition interventions that would be routinely planned, implemented, monitored, and evaluated by the associated implementing sectors. The SD PDUs and FNCOs will support sectors through technical assistance to ensure interventions are being planned and financed directly by the relevant sectors. Although sectors will be responsible for financing these interventions, the SD PDUs and FNCOs can assist in costing, resource mapping, and resource mobilization strategies. Lastly, the SD coordination office could provide sector-specific technical assistance (TA) related to the design and delivery of specific interventions based on the sectoral TA needs.

Box 2: Summary of interventions under Pillar 2

Sector	Interventions: Pillar 2
Agriculture	- Strengthen men and women farmer training centers - Food safety practice - Post-harvest loss - Staple crop diversification - Agriculture male and female workers training on nutrition-sensitive agriculture - Financing facility to men and women actors in the perishable food value chain - Food market linkages and affordability - Target women farmers, pregnant and lactation women including poor and vulnerable households
Health	- Early identification and treatment of acute malnutrition - Child Growth Monitoring Promotion - Vitamin A Supplementation - Deworming - Health workers training on nutrition-related services
WASH	- Household and community-based WASH promotion
Education	- Training of teachers on nutrition-sensitive education - School curriculum revision to adequately incorporate nutrition
Social Protection	- Train social safety net staff and social workers on nutrition-sensitive social protection
Women, Children & Youth Affairs	- Women's social empowerment and gender equity - Child daycare/ECD expansion

Pillar 3: Enhance nutrition sensitivity of nondirect cross-sectoral interventions

The **"leveraging"** investment pillar aims to enhance the nutrition sensitivity of routine or cross-cutting sectoral interventions that have been identified as high-impact interventions in reducing stunting. The SD PDUs and FNCOs will provide light-touch support to respective sectors through developing and sharing technical guidance on mainstreaming nutrition across these interventions. High coverage of interventions in this category is critical to enhancing their contribution to reducing stunting, and FPDU and FNCOs will regularly analyze and track their coverage and advocate with relevant sectors to improve and maintain the coverage of the intervention above the 70% requirement. Since these interventions are already routine and have well-established financing mechanisms, the SD will only be responsible for any additional funding for the sensitization support.

Box 3: Summary of interventions under Pillar 3

Sector	Interventions: Pillar 3
Agriculture	- Large scale irrigation farm - Transform smallholder productivity and income (agricultural inputs, extension services) - Natural resource management - General rural road development and networking
Health	- Family planning - Child immunization - Antenatal care, Post-natal care, & Skilled delivery - Integrated Management of Childhood Illnesses - Malaria prevention and treatment - Strengthening Health Extension Program
WASH	- Universal access to clean and safe water through large scale water scheme - Improved latrine and basic handwashing facility for households
Education	- General school-based nutrition, WASH, and reproductive health promotion and services
Social Protection	- General Productive Safety Net Program - Health care fee waiver to indigents
Women, Children & Youth Affairs	- Labor, time, and energy-saving technology for domestic work - Women economic empowerment

Pillar 4: Institutionalised multisectoral nutrition response governance

The **"enabling"** investment Pillar aims to support and adapt the multisectoral nutrition response governance innovations tested during the Innovation Phase (refer to table 4). The SD will expand and institutionalize the innovations across different administrative structures to facilitate an enabling ecosystem for the delivery of nutrition-smart interventions. These innovations include the Program Delivery Unit/Coordination Office, the Nutrition Human Resource, Data Revolution, the Costed Woreda-based Planning, and the Community Lab. The SD PDUs and FNCOs will be responsible for financing, planning, implementing, monitoring, and evaluating the ongoing governance interventions in close collaboration with relevant sectors.

Box 4: Summary of interventions under Pillar 4

Sector	Interventions: Pillar 4
Enabling Ecosystem	**- Fostering Political Commitment and Leadership** **- Multisectoral Coordination and governance** - FNCOs, PDUs, Woreda Coordinators **- Human Resource for Nutrition** - Career structure and recruitment of sectoral nutrition experts **- Costed Woreda-based Planning** - Nutrition resource tracking and budget gap analysis; resource mobilization at all levels; efficiency improvement and allocative decision **- Data Revolution** - Data use culture (data demand for decision making, analysis, and visualization) - Performance management and adaptation o Web based data system o KPI manual tracking and rating (Scorecard) o Collaborative review and learning - Baseline and Evaluation including annual outcome monitoring **- Coordination of cross cutting innovations** - Community labs (community participation and ownership; local resource mobilization) - The 1000 days public movement mainstreaming - Expansion of model nutrition-smart infrastructures / technologies and innovations across different sectors

What is the government's capacity to scale up? Are the proposed interventions likely to strengthen capacity sustainably? The GoE has invested considerable effort to develop national, regional, district, and community level extension workers and structures that could deliver the interventions within the agriculture, health, WASH, social protection, women, children, and youth affairs, and education sectors as well as the governance mechanisms needed to support them.

Capacity building of agriculture sector staff, farmers, and pastoralists will be ensured through the strengthening of farmer training centers, training of Agriculture Extension Workers (AEWs) on proper delivery of the nutrition-sensitive agriculture interventions, and on use of nutrition corners for a demonstration that promotes the production, food safety, cooking, and consumption of diverse food. The current farmer training centers will be further strengthened with display rooms for nutrient-rich seeds; cooking demonstration corners; and food preservation demonstration corners (dried vegetables, bottling technologies, etc.). Technical assistance support will be given to the Ministry of Agriculture to assess and fill the capacity-building needs including AEWs, woreda supervisors, and food and nutrition focal persons at the regional and federal levels on nutrition-sensitive agriculture. The SD will use coaching and mentoring support through the deployment of TA providers on different nutrition-sensitive agriculture technical areas including on how to use community lab for improved nutrition-sensitive agriculture practice and organize targeted face-to-face training to agriculture sector staff at all levels.

The SD will support the health sector to undertake periodic capacity building needs and gaps of the primary health care (PHC) and health extension package (HEP) on nutrition and assist in updating existing training materials and organizing capacity building training for HEWs and nutrition focal persons. The SD will leverage the ongoing advocacy effort for career structure development and deploy nutrition experts for nutrition-sensitive implementing sectors at all levels (federal, region, zone, and woreda level) to overcome the current barrier of the insufficient workforce for proper and timely planning, implementation, and monitoring of sectoral nutrition interventions.

Deployment and capacity building of the woreda food and nutrition coordinators will be facilitated to ensure they play a lead role in the coordination, planning, monitoring, and reporting of multisectoral nutrition response activities at the woreda and kebele levels, and to catalyze the vertical coordination between woreda and regions.

For the first 200 woredas, the regional government will lead the entire process and allocate resources similar to the Innovation Phase for effective implementation and generation of learning and the federal government will provide technical and capacity-building support to ensure that the regions effectively launch and building the capacity of the regions and city administrations. When the expansion is conducted in additional woredas, the regions will be able to have the required capacity to provide leadership in resource mobilization and implementation while the federal government provides support for the 1:1 match to ensure that the regions can include more vulnerable woredas in the Expansion Phase.

What is the likely impact on gender and geographical inequalities? The SD approaches and activities have been tailored to ensure they meet diverse needs including gender, different geographical, social, religious, and cultural circumstances. An important goal of the SD is to enhance gender mainstreaming of the program at all levels in all the program components. Gender inequality is highly associated with child malnutrition and child mortality. Women's socio-economic empowerment in terms of access to education, information, media, and income-generating activities is strongly associated with lower rates of childhood stunting and wasting, and women's decision-making power is positively associated with better health status for children.29 Men's dietary knowledge strongly contributes to maternal and childhood dietary diversity.30 Labor-saving technologies play an important role in promoting gender equality and women's empowerment (FAO 2015). The gender mainstreaming efforts will among others target women farmers, pregnant and lactation women and women, poor and vulnerable households, indigenous communities, fragile and conflict-affected communities, and adolescent girls.

As one of the cost-effective and high-impact interventions that lead to a longstanding reduction of stunting, the SD will implement key interventions at scale to address critical barriers to universal access to girl's education and their retention in school. These include improving enrollment of girls; sustainable supply of sanitary and other educational materials; gender-sensitive toilets in schools and supply of safe drinking water.

Ethiopia has filled about 71% of the gender disparities in the economic, education, health, and political environment in 2020 (UN gender gap report). The SD will support the Ministry of Women, Children, and Youth Affairs to keep this momentum by enhancing women empowerment initiatives. Some of these are activities will focus on community-based forums to address women's access to and control over resources and decision making; couple communication, husbands' support to achieve female empowerment, leverage the ongoing efforts to improve microfinance access to poor rural women, leverage the ongoing efforts to expand design and marketing of labor-saving technologies for household work, behavior change, and communication messages through local mass media and community discussion platforms on food taboo, harmful traditional practices including gender-based violence and fathers' involvement in child care and feeding.

The SD will also continue to strengthen advocacy workshops and training of women and youth to address gender-based violence and inequalities and promote women's access to and control over resources. Female-headed households will be supported to have business skills and financial facilities to engage in Income Generating Activities (IGAs). Mobile daycare centers were also established in selected kebeles to allow mothers to engage in the Productive Safety Net Program (PSNP) and other tasks outside the home

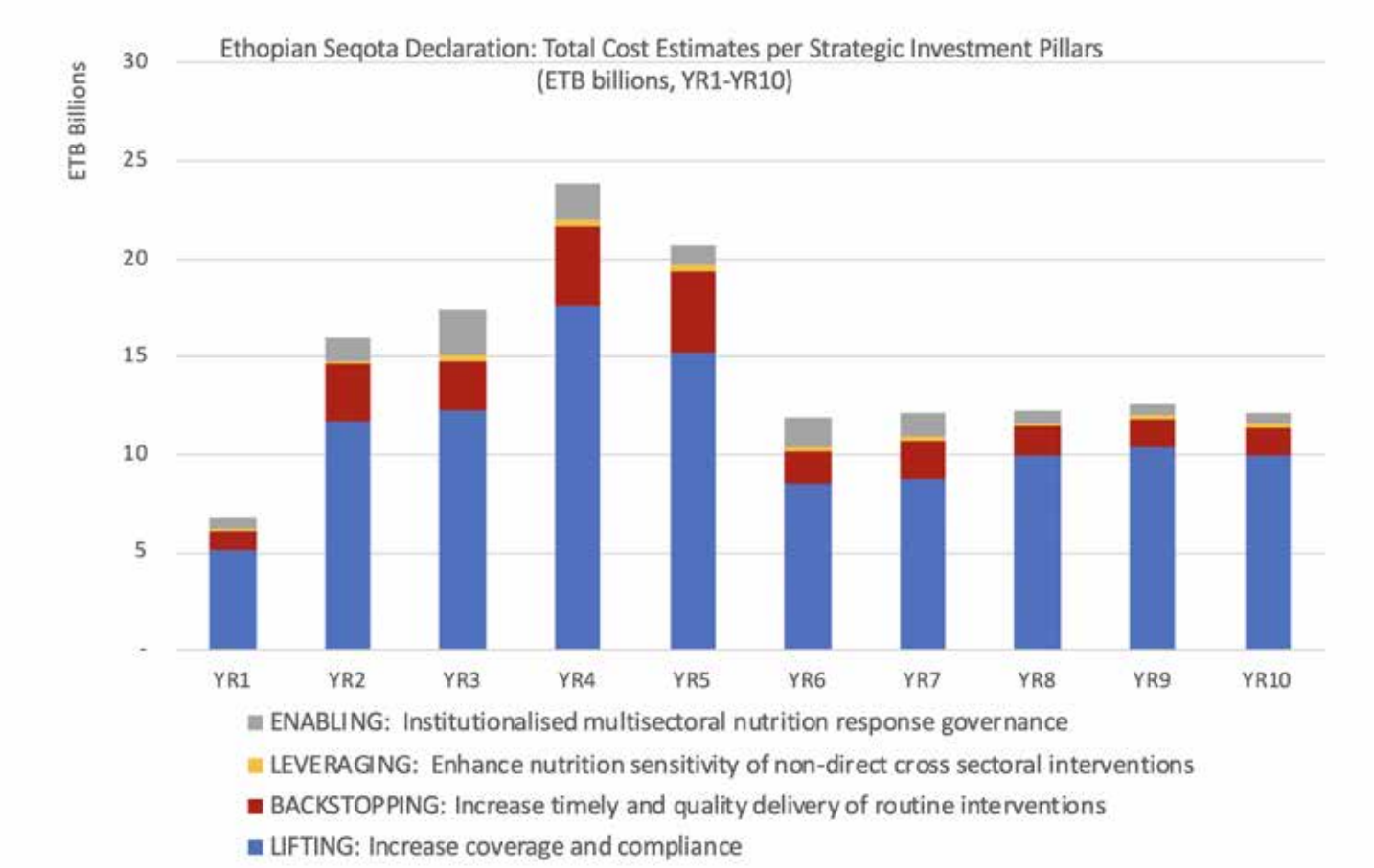
D. COSTS OF THE INTERVENTION PILLARS

The SD Expansion and Scale-Up Phases, as outlined in the roadmap, were costed by applying an ingredient-based costing approach, but within a results-based framework, from the perspective of the service provider (the different sectors)[14]. The costs include the expected targets to be reached (refer to table 4) and were categorized according to the 4 strategic intervention Pillars. The cost estimates are based on the activities designed to reach the result areas under each Pillar, and their targeted annual coverage rates, as well as their implementation details (ingredients, frequencies, quantities), all defined by the sectoral task teams involved in developing the SD Roadmap (refer to the SD Expansion and Scale-Up Phases Roadmap for details of the costing).

Figure 1 below presents a summary of the estimated SD costs, per strategic intervention pillar, overall increasing in the Expansion Phase from ETB 6.8 billion in year 1 to almost ETB 24 billion by the fourth year. Thereafter, the Scale-Up phase is expected to require around ETB 12 billion per annum.

[14] Costed Seqota Declaration Roadmap for Expansion and Scale up phases. 2021-2030

Figure 1: Estimated costs of each Investment Pillar (YRS 1-10, ETB billions)



Source: Based on activity-based costings of the SD work plans of each sector.

Figure 1 indicates that the first (lifting) strategic Investment Pillar, which aims to increase coverage and compliance, would require the largest share (75%) of the resources. Investment Pillars 2 and 4 (backstopping and enabling) require much smaller portions of the resources, 16% and 8% respectively while Pillar 3 (leveraging) could require the least amount (1%) of resources. The annual cost details of the Investment Pillars, are provided below for each of their **Result Areas**, in Tables 4a and 4b and for each of the **Strategic Objectives** provided in Tables 5a and 5b.

Table 4a: Investment Pillars Annual Costs per Result Area – EXPANSION PHASE (YRS 1-5, ETB)

Strategic Investment Pillars and their Result Areas			EXPANSION PHASE COSTS ETB					
			YR1	YR2	YR3	YR4	YR5	Total Expansion Phase costs (ETB)
LIFTING: Increase coverage and compliance	Result 1.1.1	Improved production of poultry and poultry	287 010 048	287 010 048	1 004 535 168	1 004 535 168	1 004 535 168	3 587 625 600
	Result 1.1.2	Improved production of dairy products	173 383 680	185 763 680	619 222 880	619 222 880	616 882 880	2 214 476 000
	Result 1.1.3	Improved production of fish and fish products	600 000	2 844 000	2 370 000	2 370 000	2 370 000	10 554 000
	Result 1.1.4	Improved production and market availability of of nutrient rich fruits and vegetables	1 941 800 592	5 775 401 776	3 883 601 184	7 767 202 368	7 767 202 368	27 135 208 290
	Result 1.1.5	Improved production of diversified staple crops, including bio-fortified crops (e.g.	636 308 800	1 907 926 400	1 273 117 600	2 542 235 200	2 542 235 200	8 901 823 200
	Result 1.5.1	Enhanced education and promotion of consumption of diverse and nutrient rich	474 000	80 617 120	80 617 120	81 417 120	79 017 120	322 142 480
	Result 1.5.2	Improved access to locally processed nutrient rich foods	-	90 229 400	90 229 400	135 344 100	-	315 802 900
	Result 1.5.3	dried meatpowder and egg podwer processing and marketing supported	-	4 290 959	141 824 146	140 700 000	140 700 000	427 515 105
	Result 2.1	Improved feeding practices of infant and young children, and pregnant and lactating	75 284 863	55 256 398	202 087 039	146 367 160	146 367 160	625 362 619
	Result 2.2	Enhanced essential nutrition services in under five children and pregnant women	7 388 836	9 572 289	300 000	170 073 621	170 073 621	357 408 368
	Result 2.3	Strengthened capacity of primary health care/ health extension program on nutrition	10 209 600	10 209 600	30 628 800	20 419 200	-	71 467 200
	Result 3.1	Increased access to improved clean and safe water source by households	833 087 010	833 087 010	1 569 767 558	1 569 767 558	833 087 010	5 638 796 146
	Result 3.2	Increased access to improved latrine and handwashing facilities by households	202 297 590	1 416 083 130	1 618 380 720	1 618 380 720	809 190 360	5 664 332 520
	Result 4.1	Enhanced girl's education	784 974 502	800 350 102	1 339 807 518	1 528 834 527	989 377 111	5 443 343 761
	Result 4.2	Increased number of schools with home grown school feeding programs	16 550 005	25 850 005	16 550 005	16 550 005	16 550 005	92 050 027
	Result 4.3	Improved student participation in school and family nutrition promotion activities	76 702 456	76 702 456	219 319 712	153 404 912	10 787 656	536 917 193
	Result 5.1	Increased coverage of children and pregnant and lactating women that benefit from social	7 325 791	7 325 791	7 325 791	-	-	21 977 372
	Result 6.2	Improved social environment for the appropriate child and maternal feeding and	600 000	94 487 120	82 137 120	82 137 120	82 137 120	341 498 480
	Result 7.1	Improved food market value chain system and infrastructure	20 300 000	22 324 146	20 300 000	20 300 000	20 300 000	103 524 146
	LIFTING total		**5 074 297 774**	**11 685 331 430**	**12 202 121 760**	**17 619 261 660**	**15 230 812 781**	**61 811 825 406**
BACKSTOPPING: Increase timely and quality delivery of routine interventions	Result 1.3.1	Improved post harvest management practices of households	779 868 800	2 278 348 800	1 569 947 200	3 037 798 400	3 088 846 400	10 754 809 600
	Result 1.4.1	Enhanced capacity of agriculture sector staff and farmers/pastoralist training centers on nutrition sensitive agriculture	808 975	241 989 600	229 989 600	244 984 400	107 497 400	825 269 975
	Result 2.2	Enhanced essential nutrition services in under five children and pregnant women	1 680 000	9 549 312	3 750 000	-	-	14 979 312
	Result 3.3	Improved awareness on personal hygiene, household, and environmental sanitation	87 826 920	87 646 920	96 276 720	96 276 720	87 646 920	455 674 200
	Result 4.4	Leveraged ongoing nutrition service and promotion efforts in schools	29 989 600	30 904 485	90 138 806	59 979 200	-	211 012 091
	Result 5.1	Increased coverage of children and pregnant and lactating women that benefit from social safety net programs	5 110 965	5 110 965	14 143 425	9 627 195	-	33 992 549
	Result 6.1	Improved female decision-making power, and access to and control over resources	32 428 895	32 428 895	104 343 895	104 343 895	104 343 895	377 889 477
	Result 6.2	Improved social environment for the appropriate child and maternal feeding and caring practice	53 662 895	253 662 895	304 332 195	303 775 395	553 775 395	1 469 208 777
	Result 7.1	Improved food market value chain system and infrastructure	-	54 341 791	157 818 895	157 818 895	157 818 895	527 798 477
	BACKSTOPPING total		**991 377 050**	**2 993 983 664**	**2 570 740 737**	**4 014 604 101**	**4 099 928 906**	**14 670 634 458**
LEVERAGING: Enhance nutrition sensitivity of non-direct cross sectoral interventions	Result 1.6.1	Strengthened advocacy for nutrition sensitivity of routine agriculture	2 965 005	2 965 005	2 965 005	2 965 005	2 965 005	14 825 027
	Result 2.4	Strengthened advocacy and support for improved coverage of routine high impact [illegible]	2 965 005	2 965 005	2 965 005	2 965 005	2 965 005	14 825 027
	Result 4.4	Leveraged ongoing nutrition service and promotion efforts in schools	-	10 210 786	-	10 210 786	-	20 421 571
	Result 5.1	Increased coverage of children and pregnant and lactating women that benefit from social	2 700 000	2 700 000	2 700 000	2 700 000	2 700 000	13 500 000
	Result 6.1	Improved female decision-making power, and access to and control over resources	98 325 781	98 325 781	314 070 781	314 070 781	314 070 781	1 138 863 905
	Result 7.1	Improved food market value chain system and infrastructure	5 850 000	-	5 850 000	-	-	11 700 000
	LEVERAGING total		**112 805 792**	**117 166 577**	**328 550 792**	**332 911 577**	**322 700 792**	**1 214 135 529**
ENABLING: Institutionalised multisectoral nutrition response governance	Result 8.1	Increased political commitment and leadership for stunting reduction	4 572 743	3 137 033	4 865 553	3 802 653	3 137 033	19 515 013
	Result 8.2	Strengthened multisectoral nutrition response coordination at all levels	146 286 412	148 432 748	316 966 698	327 618 948	327 618 948	1 266 923 756
	Result 8.3	Strengthened human resource capacity for nutrition at all levels	1 569 225	65 469 225	213 900 000	213 900 000	213 900 000	708 738 450
	Result 8.4	Expanded and strengthened costed woreda-based planning	26 757 353	21 403 783	48 146 443	40 628 933	38 380 228	175 316 739
	Result 8.5	Expanded and strengthened data revolution at all levels	441 961 293	870 587 785	1 729 060 852	1 311 540 226	467 304 077	4 804 074 233
	Result 8.6	Improved coordination of key cross cutting nutrition activities	5 860 633	10 833 793	5 860 633	10 833 793	5 860 633	39 249 483
	ENABLING total		**627 007 659**	**1 119 864 366**	**2 318 800 179**	**1 908 324 552**	**1 056 200 919**	**7 013 817 674**
Total Seqota Declaration costs (ETB)			**6 805 488 274**	**15 916 346 037**	**17 420 213 468**	**23 875 101 890**	**20 709 643 397**	**84 710 413 067**
Total Seqota Declaration costs (USD)			**$ 213 885 308**	**$ 500 224 588**	**$ 547 488 669**	**$ 750 355 200**	**$ 650 870 044**	**$ 2 662 309 012**

Table 4b: Investment Pillar Annual Costs per Result Area – SCALE-UP PHASE (YRS 6-10, ETB)

Strategic Investment Pillars and their Result Areas			SCALE-UP PHASE COSTS ETB					
			YR6	YR7	YR8	YR9	YR10	Total Scale-Up Costs (ETB)
LIFTING: Increase coverage and compliance	Result 1.1.1	Improved production of poultry and poultry	501 461 376	501 461 376	501 461 376	501 461 376	501 461 376	2 507 306 880
	Result 1.1.2	Improved production of dairy products	309 061 440	309 061 440	307 891 440	307 891 440	307 891 440	1 541 797 200
	Result 1.1.3	Improved production of fish and fish products	600 000	1 244 250	1 244 250	1 244 250	1 244 250	5 577 000
	Result 1.1.4	Improved production and market availability of of nutrient rich fruits and vegetables	2 126 316 819	2 816 700 888	3 257 601 184	3 741 700 888	3 741 700 888	15 684 020 667
	Result 1.1.5	Improved production of diversified staple crops, including bio-fortified crops (e.g.	890 932 320	890 932 320	889 932 320	889 432 320	889 432 320	4 450 661 600
	Result 1.5.1	Enhanced education and promotion of consumption of diverse and nutrient rich	80 291 120	81 017 120	79 017 120	79 017 120	79 017 120	398 359 600
	Result 1.5.2	Improved access to locally processed nutrient rich foods	-	45 114 700	45 114 700	45 114 700	22 557 350	157 901 450
	Result 1.5.3	dried meatpowder and egg podwer processing and marketing supported	-	-	-	-	-	-
	Result 2.1	Improved feeding practices of infant and young children, and pregnant and lactating	127 230 381	76 209 660	76 209 660	76 209 660	76 209 660	432 069 021
	Result 2.2	Enhanced essential nutrition services in under five children and pregnant women	2 110 970 266	2 110 970 266	2 954 838 373	2 954 838 373	2 954 838 373	13 086 455 651
	Result 2.3	Strengthened capacity of primary health care / health extension program on nutrition	25 524 000	10 209 600	-	-	-	35 733 600
	Result 3.1	Increased access to improved clean and safe water source by households	833 087 010	833 087 010	533 087 010	98 000 000	98 000 000	2 395 261 031
	Result 3.2	Increased access to improved latrine and handwashing facilities by households	404 595 180	404 595 180	809 190 360	809 190 360	404 595 180	2 832 166 260
	Result 4.1	Enhanced girl's education	788 320 311	412 077 403	371 620 003	734 377 111	734 377 111	3 040 771 941
	Result 4.2	Increased number of schools with home grown school feeding programs	16 550 005	16 550 005	16 550 005	16 550 005	16 550 005	82 750 027
	Result 4.3	Improved student participation in school and family nutrition promotion activities	137 223 428	102 917 571	-	-	-	240 140 999
	Result 5.1	Increased coverage of children and pregnant and lactating women that benefit from social	7 325 791	7 325 791	7 325 791	-	-	21 977 372
	Result 6.2	Improved social environment for the appropriate child and maternal feeding and	95 087 120	82 137 120	82 137 120	82 137 120	82 137 120	423 635 600
	Result 7.1	Improved food market value chain system and infrastructure	20 300 000	20 300 000	20 300 000	20 300 000	20 300 000	101 500 000
	LIFTING total		**8 474 876 568**	**8 721 911 701**	**9 953 520 713**	**10 357 464 724**	**9 930 312 194**	**47 438 085 899**
BACKSTOPPING: Increase timely and quality delivery of routine interventions	Result 1.3.1	Improved post harvest management practices of households	1 098 963 040	1 063 229 440	1 098 963 040	1 063 229 440	1 098 963 040	5 423 348 000
	Result 1.4.1	Enhanced capacity of agriculture sector staff and farmers/pastoralist training centers on nutrition sensitive agriculture	23 246 100	114 994 800	114 994 800	114 994 800	64 994 800	433 225 300
	Result 2.2	Enhanced essential nutrition services in under five children and pregnant women	12 354 312	-	-	-	-	12 354 312
	Result 3.3	Improved awareness on personal hygiene, household, and environmental sanitation	83 512 020	85 489 470	87 646 920	87 646 920	87 646 920	431 942 250
	Result 4.4	Leveraged ongoing nutrition service and promotion efforts in schools	59 979 200	44 984 400	-	-	-	104 963 600
	Result 5.1	Increased coverage of children and pregnant and lactating women that benefit from social safety net programs	5 110 965	11 885 310	-	-	-	16 996 275
	Result 6.1	Improved female decision-making power, and access to and control over resources	54 003 395	54 003 395	54 003 395	54 003 395	54 003 395	270 016 977
	Result 6.2	Improved social environment for the appropriate child and maternal feeding and caring practice	289 298 445	538 741 645	38 741 645	38 741 645	38 741 645	944 265 027
	Result 7.1	Improved food market value chain system and infrastructure	87 166 291	81 228 395	81 228 395	81 228 395	81 228 395	412 079 872
	BACKSTOPPING total		**1 713 633 768**	**1 994 556 856**	**1 475 578 196**	**1 439 844 596**	**1 425 578 196**	**8 049 191 613**
LEVERAGING: Enhance nutrition sensitivity of non-direct cross sectoral interventions	Result 1.6.1	Strengthened advocacy for nutrition sensitivity of routine agriculture	2 965 005	2 965 005	2 965 005	2 965 005	2 965 005	14 825 027
	Result 2.4	Strengthened advocacy and support for improved coverage of routine high impact [illegible] health sector interventions	2 965 005	2 965 005	2 965 005	2 965 005	2 965 005	14 825 027
	Result 4.4	Leveraged ongoing nutrition service and promotion efforts in schools	10 210 786	-	10 210 786	-	10 210 786	30 632 357
	Result 5.1	Increased coverage of children and pregnant and lactating women that benefit from social	2 700 000	2 700 000	2 700 000	2 700 000	2 700 000	13 500 000
	Result 6.1	Improved female decision-making power, and access to and control over resources	163 049 281	163 049 281	163 049 281	163 049 281	163 049 281	815 246 405
	Result 7.1	Improved food market value chain system and infrastructure	5 850 000	-	5 850 000	-	-	11 700 000
	LEVERAGING total		**187 740 077**	**171 679 292**	**187 740 077**	**171 679 292**	**181 890 077**	**900 728 814**
ENABLING: Institutionalised multisectoral nutrition response/governance	Result 8.1	Increased political commitment and leadership for stunting reduction	5 011 958	3 137 033	3 137 033	3 626 967	3 137 033	18 050 022
	Result 8.2	Strengthened multisectoral nutrition response coordination at all levels	183 471 858	188 813 869	188 813 869	188 813 869	188 813 869	938 727 335
	Result 8.3	Strengthened human resource capacity for nutrition at all levels	108 900 000	108 900 000	108 900 000	108 900 000	108 900 000	544 500 000
	Result 8.4	Expanded and strengthened costed woreda-based planning	35 456 662	27 171 328	24 916 292	24 916 292	24 916 292	137 376 864
	Result 8.5	Expanded and strengthened data revolution at all levels	1 165 353 144	924 419 915	273 531 013	273 531 013	305 331 042	2 942 166 128
	Result 8.6	Improved coordination of key cross cutting nutrition activities	10 833 793	5 860 633	10 833 793	5 860 633	5 860 633	39 249 483
	ENABLING total		**1 509 027 414**	**1 258 302 777**	**610 131 999**	**605 648 773**	**636 958 868**	**4 620 069 832**
Total Seqota Declaration costs (ETB)			**11 885 277 828**	**12 146 450 626**	**12 226 970 985**	**12 574 637 384**	**12 174 739 335**	**61 008 076 158**
Total Seqota Declaration costs (USD)			**$ 373 534 742**	**$ 381 742 973**	**$ 384 273 596**	**$ 395 200 179**	**$ 382 632 041**	**$ 1 917 383 531**

Table 5a: Investment Pillar Annual Costs per Strategic Objective – EXPANSION PHASE (YRS 1-5, ETB)

Strategic Investment Pillars & their Strategic Objectives		EXPANSION PHASE COSTS ETB					
		YR1	YR2	YR3	YR4	YR5	Total Expansion Phase costs
LIFTING: Increase coverage and compliance	S.Obj1 Agriculture:	3 039 577 120	8 334 083 384	7 095 517 498	12 293 026 836	12 152 942 736	42 915 147 575
	S.Obj2 Health:	92 883 299	75 038 287	233 015 839	336 859 981	316 440 781	1 054 238 187
	S.Obj3 Water & Sanitation:	1 035 384 600	2 249 170 140	3 188 148 278	3 188 148 278	1 642 277 370	11 303 128 666
	S.Obj4 Education:	878 226 964	902 902 563	1 575 677 235	1 698 789 445	1 016 714 773	6 072 310 980
	S.Obj5 Social Protection:	7 325 791	7 325 791	7 325 791	-	-	21 977 372
	S.Obj6 Women Children & Youth:	600 000	94 487 120	82 137 120	82 137 120	82 137 120	341 498 480
	S.Obj7 Transport:	20 300 000	22 324 146	20 300 000	20 300 000	20 300 000	103 524 146
	S.Obj8 Governance:	-	-	-	-	-	-
	LIFTING total	**5 074 297 774**	**11 685 331 430**	**12 202 121 760**	**17 619 261 660**	**15 230 812 781**	**61 811 825 406**
BACKSTOPPING: Increase timely and quality delivery of routine interventions	S.Obj1 Agriculture:	780 677 775	2 520 338 400	1 799 936 800	3 282 782 800	3 196 343 800	11 580 079 575
	S.Obj2 Health:	1 680 000	9 549 312	3 750 000	-	-	14 979 312
	S.Obj3 Water & Sanitation:	87 826 920	87 646 920	96 276 720	96 276 720	87 646 920	455 674 200
	S.Obj4 Education:	29 989 600	30 904 485	90 138 806	59 979 200	-	211 012 091
	S.Obj5 Social Protection:	5 110 965	5 110 965	14 143 425	9 627 195	-	33 992 549
	S.Obj6 Women Children & Youth:	86 091 791	286 091 791	408 676 091	408 119 291	658 119 291	1 847 098 254
	S.Obj7 Transport:	-	54 341 791	157 818 895	157 818 895	157 818 895	527 798 477
	S.Obj8 Governance:	-	-	-	-	-	-
	BKSTOPPING total	**991 377 050**	**2 993 983 664**	**2 570 740 737**	**4 014 604 101**	**4 099 928 906**	**14 670 634 458**
LEVERAGING: Enhance nutrition sensitivity of non-direct cross sectoral interventions	S.Obj1 Agriculture:	2 965 005	2 965 005	2 965 005	2 965 005	2 965 005	14 825 027
	S.Obj2 Health:	2 965 005	2 965 005	2 965 005	2 965 005	2 965 005	14 825 027
	S.Obj3 Water & Sanitation:	-	-	-	-	-	-
	S.Obj4 Education:	-	10 210 786	-	10 210 786	-	20 421 571
	S.Obj5 Social Protection:	2 700 000	2 700 000	2 700 000	2 700 000	2 700 000	13 500 000
	S.Obj6 Women Children & Youth:	98 325 781	98 325 781	314 070 781	314 070 781	314 070 781	1 138 863 905
	S.Obj7 Transport:	5 850 000	-	5 850 000	-	-	11 700 000
	S.Obj8 Governance:	-	-	-	-	-	-
	LEVERAGING total	**112 805 792**	**117 166 577**	**328 550 792**	**332 911 577**	**322 700 792**	**1 214 135 529**
ENABLING: Institutionalised multisectoral nutrition response	S.Obj8 Governance:	627 007 659	1 119 864 366	2 318 800 179	1 908 324 552	1 056 200 919	7 013 817 674
	ENABLING total	**627 007 659**	**1 119 864 366**	**2 318 800 179**	**1 908 324 552**	**1 056 200 919**	**7 013 817 674**
Total Seqota Declaration costs (ETB)		**6 805 488 274**	**15 916 346 037**	**17 420 213 468**	**23 875 101 890**	**20 709 643 397**	**84 710 413 067**
Total Seqota Declaration costs (USD)		**$ 213 885 308**	**$ 500 224 588**	**$ 547 488 669**	**$ 750 355 200**	**$ 650 870 044**	**$ 2 662 309 012**

Table 5b: Investment Pillar Annual Costs per Strategic Objective – SCALE-UP PHASE (YRS 6-10, ETB)

Strategic Investment Pillars & their Strategic Objectives		SCALE-UP PHASE COSTS ETB					
		YR6	YR7	YR8	YR9	YR10	Total Scale-Up Costs (ETB)
LIFTING: Increase coverage and compliance	S.Obj1 Agriculture:	3 908 663 075	4 645 532 094	5 082 262 390	5 565 862 094	5 543 304 744	24 745 624 397
	S.Obj2 Health:	2 263 724 648	2 197 389 526	3 031 048 033	3 031 048 033	3 031 048 033	13 554 258 272
	S.Obj3 Water & Sanitation:	1 237 682 190	1 237 682 190	1 342 277 370	907 190 360	502 595 180	5 227 427 291
	S.Obj4 Education:	942 093 745	531 544 980	388 170 009	750 927 117	750 927 117	3 363 662 967
	S.Obj5 Social Protection:	7 325 791	7 325 791	7 325 791	-	-	21 977 372
	S.Obj6 Women Children & Youth:	95 087 120	82 137 120	82 137 120	82 137 120	82 137 120	423 635 600
	S.Obj7 Transport:	20 300 000	20 300 000	20 300 000	20 300 000	20 300 000	101 500 000
	S.Obj8 Governance:	-	-	-	-	-	-
	LIFTING total	**8 474 876 568**	**8 721 911 701**	**9 953 520 713**	**10 357 464 724**	**9 930 312 194**	**47 438 085 899**
BACKSTOPPING: Increase timely and quality delivery of routine interventions	S.Obj1 Agriculture:	1 122 209 140	1 178 224 240	1 213 957 840	1 178 224 240	1 163 957 840	5 856 573 300
	S.Obj2 Health:	12 354 312	-	-	-	-	12 354 312
	S.Obj3 Water & Sanitation:	83 512 020	85 489 470	87 646 920	87 646 920	87 646 920	431 942 250
	S.Obj4 Education:	59 979 200	44 984 400	-	-	-	104 963 600
	S.Obj5 Social Protection:	5 110 965	11 885 310	-	-	-	16 996 275
	S.Obj6 Women Children & Youth:	343 301 841	592 745 041	92 745 041	92 745 041	92 745 041	1 214 282 004
	S.Obj7 Transport:	87 166 291	81 228 395	81 228 395	81 228 395	81 228 395	412 079 872
	S.Obj8 Governance:	-	-	-	-	-	-
	BKSTOPPING total	**1 713 633 768**	**1 994 556 856**	**1 475 578 196**	**1 439 844 596**	**1 425 578 196**	**8 049 191 613**
LEVERAGING: Enhance nutrition sensitivity of non-direct cross sectoral interventions	S.Obj1 Agriculture:	2 965 005	2 965 005	2 965 005	2 965 005	2 965 005	14 825 027
	S.Obj2 Health:	2 965 005	2 965 005	2 965 005	2 965 005	2 965 005	14 825 027
	S.Obj3 Water & Sanitation:	-	-	-	-	-	-
	S.Obj4 Education:	10 210 786	-	10 210 786	-	10 210 786	30 632 357
	S.Obj5 Social Protection:	2 700 000	2 700 000	2 700 000	2 700 000	2 700 000	13 500 000
	S.Obj6 Women Children & Youth:	163 049 281	163 049 281	163 049 281	163 049 281	163 049 281	815 246 405
	S.Obj7 Transport:	5 850 000	-	5 850 000	-	-	11 700 000
	S.Obj8 Governance:	-	-	-	-	-	-
	LEVERAGING total	**187 740 077**	**171 679 292**	**187 740 077**	**171 679 292**	**181 890 077**	**900 728 814**
ENABLING: Institutionalised multisectoral nutrition response	S.Obj8 Governance:	1 509 027 414	1 258 302 777	610 131 999	605 648 773	636 958 868	4 620 069 832
	ENABLING total	**1 509 027 414**	**1 258 302 777**	**610 131 999**	**605 648 773**	**636 958 868**	**4 620 069 832**
Total Seqota Declaration costs (ETB)		**11 885 277 828**	**12 146 450 626**	**12 226 970 985**	**12 574 637 384**	**12 174 739 335**	**61 008 076 158**
Total Seqota Declaration costs (USD)		**$ 373 534 742**	**$ 381 742 973**	**$ 384 273 596**	**$ 395 200 179**	**$ 382 632 041**	**$ 1 917 383 531**

E. THEORY OF CHANGE FOR COMBINING THE FOUR PILLARS

The theory of change is based on evidence of proven nutrition interventions and adapted proven innovations that are known to work in Ethiopia, which were tested during the SD innovation stage (refer to Annex 1 for Theory of Change).

Assumptions. Informed with the programmatic experiences in the SD Innovation Phase and global and national evidence review, the goal and high-impact interventions for the SD Expansion and Scale-up Phases are proposed based on the following key assumptions:

- Stunting continues as the main outcome of the SD expansion and Scale-up Phases with 28% stunting prevalence in under two children (mini-EDHS 2019) as a baseline.
- The Government of Ethiopia sustains its commitment to acting at scale both in financing and implementing high-impact interventions in the expanded geographies to end stunting in under two children by 2030.
- A threshold of minimum 70% implementation coverage for high-impact interventions to achieve the required annual average stunting reduction rate of ≥3% to end stunting in under two children by 2030

F. MONITORING AND FINANCING

How are these costs going to be financed? For the first 200 woredas in the expansion phase, the regional government will lead the entire process and allocate resources similar to the Innovation Phase for effective implementation and generation of learning and the federal government will provide technical and capacity-building support to ensure that the regions effectively launching and building the capacity of the regions and city administrations.

When the SD moves into additional woredas in the Expansion Phase, the regions would have acquired the required capacity to provide leadership in resource mobilization and implementation while the federal government provides support for the 1:1 match to ensure that more vulnerable woredas are supported. Hence the Expansion Phase woredas will primarily be financed by the government. Both federal and regional governments will contribute their part to the successful implementation of the expansion phase investment plan. Moreover, resources will be mobilized from the development partners, financial institutions, and donors to complement the government commitment. The community will also contribute resources that are available locally including labor and locally available resources.

How will government track the SD resources? The SD PDU will track resources at all levels and institutionalize a continuous resource mobilization plan which includes the following activities:

- SD Resource tracking indicators included in performance monitoring
- Quarterly financial tracking
- Woreda level plans and budget tracking and analysis
- Quarterly and annual reviews

How will progress and results be monitored, measured, and evaluated?

Performance Management:
One of the key roles of the PDU is performance management. Annual key performance management indicators will be set for the respective sectors and development partners. This tool will serve as a dashboard to assess the progress of sectors and partners' plan at federal and regional levels. The PDU will be responsible for tracking the performance management indicators and following up with respective sectors and development partners to identify bottlenecks for areas that are not progressing well or draw lessons where there is high performance. The federal PDU will use a web-based performance management tool, called Unified Nutrition Information System for Ethiopia (UNISE) which will provide access for all the partners to upload their targets as well as their results. The web-based platform will reveal the overall SD performance and scorecards at woreda, zonal, regional and federal levels with possible disaggregation by sector or strategic initiatives.

Performance Review:
Monthly Performance Review: At kebele and woreda levels, monthly performance review meetings will be conducted under the leadership of the woreda and kebele administrators respectively. They will be responsible for convening the performance reviews and sharing the performance reports with zonal and regional government structures. The federal PDU will also conduct quarterly review meetings with the implementing sectors and development partners at the federal level. Regional PDUs will do the same at the regional level. In addition, federal and regional PDUs will conduct joint quarterly review meetings and will share the outcomes with the respective political leaders who are championing efforts around the Seqota Declaration.

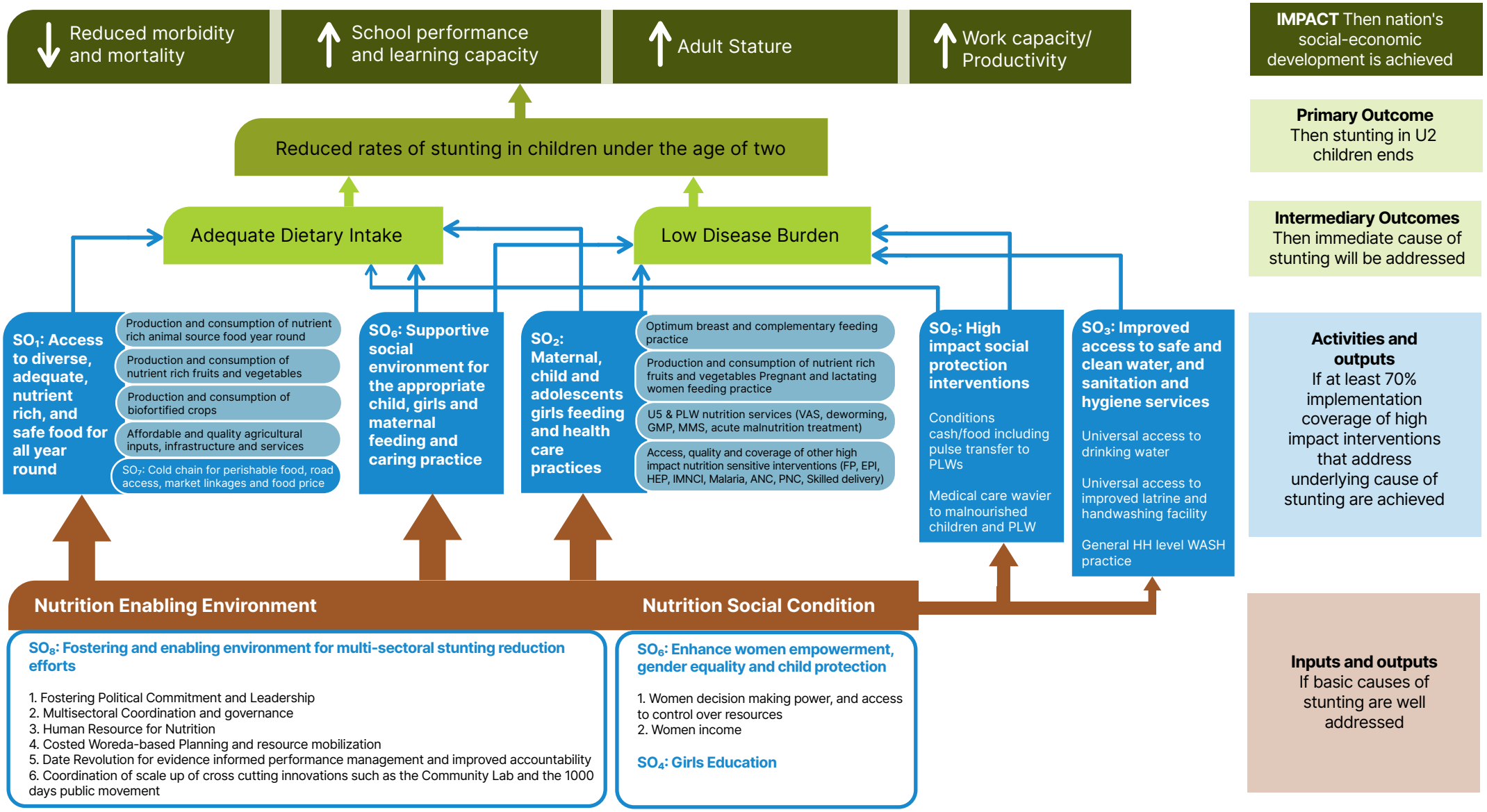
Biannual and Annual Performance Review: Biannual and annual review meetings will be held at the regional level under the leadership of the Regional Presidents. After completing the regional review meetings, joint bi-annual and annual review meetings will be held in collaboration with the federal PDU. These meetings will be chaired by the Deputy Prime Minister. The annual targets and performances of the respective sectors will be assessed based on the annual performance targets.

G. CONCLUSION

Investing in nutrition and reducing childhood stunting has well-known benefits and cost-savings to society. The interventions designed to achieve the SD and FNS goals will require significant resources and large funding gaps are anticipated. The GoE will mobilize resources, strategically target the available resources at the most impactful interventions and ensure their efficient use for optimal results. It will be essential to carefully track the use of resources and monitor their outputs and impact, to inform the strategic allocation of resources towards the pillars of the SD, and to ultimately contribute to the achievement of the FNS.

The importance of **tracking budget and expenditure data** needs to be fully understood by the concerned parties such as development partners, the woredas and implementing partners to obtain accurate and complete data for a meaningful analysis.

ANNEX 1: THEORY OF CHANGE



EXPANSION AND SCALE-UP PHASE OF THE SEQOTA DECLARATION:

CONSIDERATIONS FOR AN INVESTMENT PLAN TO ACHIEVE ETHIOPIA'S FOOD AND NUTRITION GOALS