PRIVATE SECTOR ENGAGEMENT IN NUTRITION

Developing the Business Case

MOMENTUM Country and Global Leadership

AUGUST, 2021

MOMENTUM works alongside governments, local and international private and civil society organizations, and other stakeholders to accelerate improvements in maternal, newborn, and child health services. Building on existing evidence and experience implementing global health programs and interventions, we help foster new ideas, partnerships, and approaches and strengthen the resiliency of health systems.

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ABBREVIATIONS

BF	Breastfeeding
CF	Complementary feeding
CSR	Corporate Social Responsibility
FP	Family Planning
GAIN	Global Alliance for Improved Nutrition
HIC	High-income Country
IFCDC	Infant- and Family-Centered Developmental Care
IYCF	Infant and Young Child Feeding
KMC	Kangaroo Mother Care
LMIC	Low and middle-income country
MNCH	Maternal, Newborn, and Child Health
NS	Nutrient Supplementation
RCT	Randomized Control Trial
RH	Reproductive Health
SME	Small to Medium-sized Enterprise
SSNB	Small and/or Sick Newborns
UNICEF	United Nations International Children's Emergency Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

INTRODUCTION

This document contains findings from a prioritization of private sector engagement modalities and business cases for five priority modalities, which may be explored in future programming.

OVERALL SCOPE

A global nutrition-focused private sector engagement assessment which will inform both future country programming and global/core efforts

OBJECTIVE

Define and prioritize a set of actionable private sector engagement modalities in nutrition

DELIVERABLES

LANDSCAPE OVERVIEW

- Framework of in-scope nutrition interventions
- Overview of gaps in nutrition outcomes and current programming
- Landscape of private sector engagement modalities
- Emerging practices for private sector engagement modalities

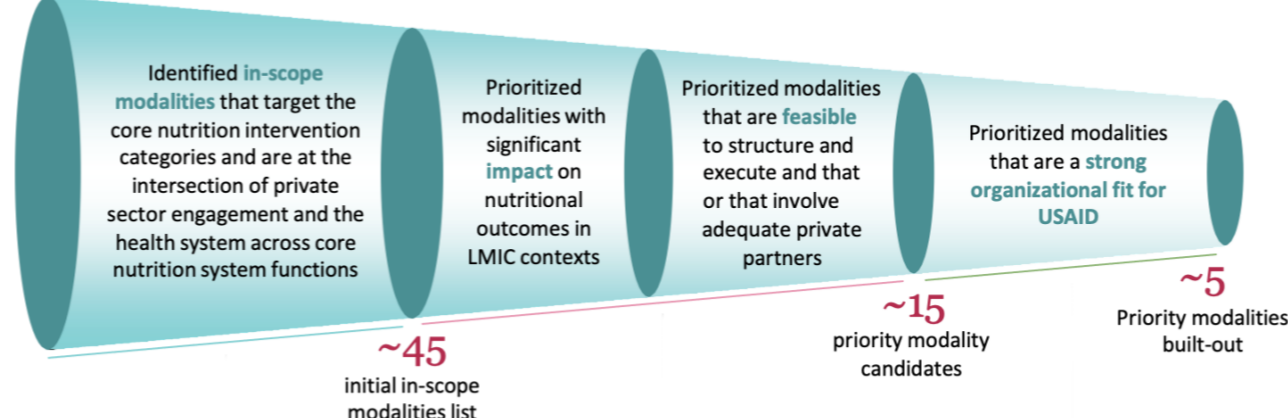
BUSINESS CASE DEVELOPMENT AND IMPLICATIONS

- Prioritization of modalities by:
  - Impact on nutrition outcomes in low and middle-income (LMIC) contexts
  - Feasibility
  - Organizational fit for USAID
- Built-out business cases for five priority modalities, including:
  - Business model considerations
  - Risk and mitigation considerations
  - Key enablers
  - Implications for USAID

OVERALL APPROACH

After identifying ~45 in-scope private sector engagement modalities, USAID prioritized and built-out five modalities based on their impact, feasibility, and organizational fit.

PRIORITIZATION APPROACH



FIVE MODALITIES PRIORITIZED BY USAID

PRIORITIZED MODALITIES:

1. **Employer Policies** (e.g., workplace breastfeeding and childcare)
2. **Traditional Media** (e.g., TV shows, film, radio, and print)
3. **Mother and Family Support Groups**
4. **Counseling Services** (e.g., mobile and facility- based counseling)
   C and D potentially bundled as a maternal care package
5. **Health Worker In-Service Training**

1. EMPLOYER POLICIES

- **Workplace breastfeeding:** Provide lactation rooms and breastfeeding breaks at work
- **Workplace childcare:** Provide/support in-office childcare

RATIONALE FOR PRIORITIZATION

As USAID works to attract more women into the formal workforce in LMIC settings, employer policies on breastfeeding and childcare could lay the groundwork to make the workplace a more accessible place for women.

2. TRADITIONAL MEDIA

Develop/support content for TV shows, movies, radio programs, books, magazines, newspapers, art displays, or posters promoting breastfeeding (BF), complementary feeding (CF) or nutrient supplementation (NS) (e.g., create a show, write/publish baby books).

RATIONALE FOR PRIORITIZATION

Traditional media may offer unique opportunities to reach large cohorts of individuals, model positive nutrition behaviors, and combat negative stigma, particularly for breastfeeding (e.g., work in partnership with the Nigerian film industry could reach huge populations in Nigeria and across many countries in Africa).

3. MOTHER AND FAMILY SUPPORT GROUPS

- **Virtual communities:** Create virtual communities that connect mothers with shared experiences (e.g., social networking service, email/messaging chains)
- **Caregiver support groups:** Develop support groups for partners and other caregivers like grandmothers (e.g., on social media or in a physical space)

RATIONALE FOR PRIORITIZATION

Virtual communities and trainings may have a significant impact on the mothers and families they reach. They also provide a novel mechanism for private sector engagement and can directly address misleading information on social media sites.

4. COUNSELING SERVICES

- **Mobile counseling:** Provide home visits by mobile counselors
- **Facility-based counseling:** Provide counseling services and postnatal care for pregnant/lactating women and families through private pharmacies and private health centers
- **Group classes:** Provide/sponsor group classes for mothers and families

RATIONALE FOR PRIORITIZATION

Counseling services may provide a strong business model to engage private sector players and USAID may be able to build on existing work by the maternal, newborn, and child health (MNCH) team in this space.

***Note:** Mother and family support groups and counseling services potentially bundled as a maternal care package.*

5: HEALTH WORKER IN-SERVICE TRAINING

Host/support focused trainings and capacity building for healthcare workers in prenatal, postnatal, and early childhood interactions to provide information and counseling for pregnant, lactating, and other post-partum women and their families.

RATIONALE FOR PRIORITIZATION

Health worker in-service trainings may offer a unique opportunity to engage with private healthcare systems to train providers to deliver improved nutrition-related care.

BUILT-OUT PRIORITIZED MODALITIES

EMPLOYER POLICY

EXECUTIVE SUMMARY

CONTEXT

Lack of structural supports at work, lack of community supports, and stigma are major drivers of adverse breastfeeding, complementary feeding, and nutrient supplementation behaviors. Thoughtful employer polices to support breastfeeding and childcare (e.g., breastfeeding breaks, lactation rooms, in-office childcare) could have a strong impact on improving nutritional outcomes for employed mothers and their children.

Public policies to support workplace nutrition may serve as a significant enabler in countries where such policies already exist (e.g., Kenya).

DESCRIPTION

Private companies may benefit from being informed of the business case for workplace breastfeeding and childcare policies and from receiving technical assistance from an organization skilled in designing and implementing these policies.

- Non-profit/private organizations may lead advocacy efforts with employers to share evidence of the business case for breastfeeding and childcare polices into the workplace.
- Private companies may contract non-profit/private organizations to help them roll out employer policies.

Multiple levels of technical assistance may be offered, ranging from light-touch to intensive support:

- Light-touch support may include providing private companies with sample policy materials that can be adapted or sharing lists of organizations they can contract (e.g., local contractors who can create lactation spaces) – likely more affordable but requires greater effort for private companies to implement.
- Intensive support may include providing private companies with dedicated, on-site support to directly design and implement workplace policies (e.g., directly set up lactation rooms) – likely requires minimal effort for private companies to implement but costs more.

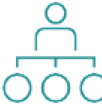
To enable this modality, USAID support can play a role in connecting non-profit/private organizations with expertise and private companies and in scaling demand for these programs by amplifying evidence of the business case. There may be an opportunity to collaborate across USAID bureaus, as this initiative supports women's employment. Further there may be an opportunity to work with organizations already driving such initiatives (e.g., Alive & Thrive, UNICEF)

PRIVATE SECTOR MECHANISM

Private companies are uniquely positioned to implement breastfeeding and childcare policies in the workplace (e.g., farm, factory) for their employees to improve their and their families' nutritional outcomes. Evidence shows that these supports may improve worker productivity, satisfaction, and retention, creating a compelling business case for investment and a strong entry point for private sector activity in nutrition.

EMPLOYER POLICY OVERVIEW

A private/non-profit organization may provide technical assistance to private sector companies that aim to implement policies that support breastfeeding and childcare in the workplace.



1. BUSINESS MODEL

Employers may be incentivized to enact policies to improve employee productivity, increase brand reputation, and enhance corporate social responsibility (CSR).

To be sustainable, employers need to be convinced that implementing employer policies presents a strong business case and be able to afford upfront costs of implementing policies; as a result, larger companies that can absorb costs may be more profitable, while non-profit/donor subsidization may be necessary to reach smaller companies.

Measuring the economic impact when implementing may help strengthen the business case and scale efforts.

2. RISK AND MITIGATION CONSIDERATIONS

Potential risks include:

- Inequitable impact for informal economy
- Inequitable impact for employees in smaller and rural companies that cannot afford to implement employer policies
- Partnership and perception risks, including reputation risks associated with an initiative working with large private companies with extensive public visibility, or companies that fail to follow through on policy intentions

Mitigation strategies that can minimize the likelihood and impact of these risks are outlined in this document.

3. KEY ENABLERS

A few of the main enabling factors that may support implementation are:

- Strong evidence of business case for private employer
- Private employer ability and willingness to pay for technical assistance (TA) and to implement policies
- Non-profit/private organization partner ability to fund research on employer policies (in untested contexts) and their effect on nutritional and financial outcomes
- Existing local/federal public policies or initiatives to support workplace breastfeeding or childcare (e.g., public recognition of employers with policies by local government)

4. WHERE MIGHT USAID SUPPORT

USAID may provide support to:

1. Identify potential partners to promote the evidence base and provide TA and private companies interested in support
2. Support implementation and impact measurement efforts (especially where strong evidence does not already exist), based on archetypes of private sector companies
3. Advocate for expansion of the business model across industries and geographies
4. Support scaling the provision of TA to private companies across industries and geographies

1. BUSINESS MODEL

Non-profit/private organizations could lead advocacy efforts to share evidence of the business model for workplace employer policies and could provide private companies with technical assistance to implement breastfeeding and childcare policies.

TARGET CUSTOMERS/BENEFICIARY

Customer: Medium- to large- scale local companies, especially those that are part of multinational company value chains; potential to also explore small and medium-sized enterprises (SMEs)

Beneficiary: Mothers and caregivers who work in companies where employer policies are implemented

Pain points addressed

- Lack of structural supports at work
- Stigma associated with breastfeeding
- Lack of community support

PRODUCTS AND SERVICES PROVIDED

Advocacy for employers to implement workplace policies focused on breastfeeding and childcare (e.g., lactation rooms in office, time allocated to breastfeeding, in-office childcare) by providing evidence of their economic benefits. Technical assistance to design and implement workplace policies, which may range from light touch support (e.g., providing materials) to more intensive support (e.g., on-site step-by-step instruction).

KEY PARTICIPANTS

PRIVATE COMPANY

Role: Recipient of support to build lactation rooms and breastfeeding breaks at work or provide in-office childcare for their own employees

Incentive:

- Indirect financial: increase employee productivity and satisfaction, decrease absenteeism and sick days
- Indirect: CSR, comply with existing federal/local policy* or their value chain partners' preferences or demands, where applicable

NON-PROFIT/PRIVATE ORGANIZATION

Role: Service provider

- Advocate for adoption of policies by sharing evidence base
- Provide technical assistance

Incentive:

- Direct financial: increase revenue
- Indirect: brand recognition

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* Some countries have existing public policies on workplace nutrition that could serve as a significant enabler

TARGET CUSTOMERS

1. **Large- to medium-scale companies facing pressure from value chain partners** (e.g., a factory that manufactures products for a major retailer that only sells ethically- sourced products)
    - Companies are likely to be willing and able to pay for service themselves; value chain players applying pressure may also be willing to subsidize costs
    - Focus will be on assisting in implementing policy into the workplace; less effort will be necessary to convince the company about the business case because it faces pressure from supply chain partners to implement

2. **Large- to medium-scale, compliance-seeking companies** that face legal pressure from local/federal government to implement workplace policy (e.g., tea plantation in Kenya)
    - Companies are likely to be willing and able to pay for service themselves
    - Focus will be on assisting in implementing policy into the workplace; less effort will be necessary to convince the company about the business case because it faces pressure from government to implement

3. **Large, profit-seeking companies** that might financially benefit from enacting workplace policy
    - Companies are likely to be able to pay for service themselves but may not be initially convinced of the business case
    - Focus will be on sharing evidence to convince company about the financial benefits of workplace policy, and then on assisting in implementing policy

4. **Small- and medium-sized enterprises (SMEs)** that may be unable to pay for technical or policy assistance services
    - Even if there is a longer-term business case to implement policies, SMEs may be unable to afford the upfront cost to pay for services and require subsidization for upfront costs
    - Focus will be on sharing evidence to convince SMEs about the financial benefits of workplace policy, assisting them in implementing policy, and identifying opportunities to subsidize implementation costs

2. RISK AND MITIGATION CONSIDERATIONS

Potential Risk	Potential Likelihood	Potential Impact	Potential Mitigation
Inequitable impact for informal economy: populations who are not formally employed will not benefit directly from employer workplace policies	75%	25%	N/A
Partnership and perception risks, including reputation risks associated with working alongside large companies with extensive public visibility, or companies who fail to follow through on policy intentions	25%	50%	Publish nutritional outcomes of initiatives to create greater accountability Carefully screen private companies, and their past behavior, to minimize likelihood and impact of negative behavior being associated with initiative supported by USAID
Inequitable impact for employees in smaller and more rural companies, which may be unable to afford to implement employer policies	75%	50%	Subsidize upfront costs to implement policies and technical assistance costs for smaller and more rural companies

3. KEY ENABLERS

Key Enabler	Supply Side (Implementation Partner)	Demand Side (Private Company)
Economic	Non-profit/private organization partner ability to fund research on employer policies (in untested contexts) and their effect on nutritional and financial outcomes (Enabler with implications for USAID next)	Existing strong evidence of business case for private employer Private employer ability and willingness to pay for technical assistance and to implement policies (Enabler with implications for USAID next)
Infrastructure & Capabilities	Non-profit/private organization partner capabilities and expertise to provide quality technical assistance	Ability to design policy and follow through with implementation plans
Behavioral	N/A	Genuine buy in by C-suites in private companies
Regulatory	Existing local/federal public policies or initiatives to support workplace breastfeeding or childcare (Enabler with implications for USAID next)	N/A

4. WHERE MIGHT USAID HAVE IMPACT

Phase 1

Identify non- profit/private partners to promote the evidence base and provide TA and private companies interested in support

HYPOTHETICAL USAID INVOLVEMENT

Identify implementation partners who have experience promoting evidence of the business case for workplace breastfeeding and childcare policies and who have capabilities to provide technical assistance

Identify private employers who are likely candidates and connect them with implementation partner to share evidence base for workplace policies

TIMELINE

Short-term: ~6 months to identify implementation partner and interested employers

Phase 2

Support implementation and impact measurement efforts (especially where strong evidence does not already exist, based on company archetypes)

HYPOTHETICAL USAID INVOLVEMENT

Support partner organization in implementing the employer policy program and provide subsidization for initial costs, where necessary – focused on archetyping of companies that will determine likely incentives and e-messaging/support required

Fund evidence-based monitoring and evaluation of nutritional and business impact to strength the business case for future programs (where evidence does not already exist) and to improve program design (e.g., investigate changes in employee productivity and satisfaction)

TIMELINE

Short-term (after Phase 1 is completed): **~2-3 years** to implement program in initial companies and measure impact

Phase 3

Advocate for expansion of the business model across industries and geographies

HYPOTHETICAL USAID INVOLVEMENT

Share evidence-based learnings and proof of business model from monitoring and evaluation efforts to motivate more private companies to implement policies

TIMELINE

Medium-term (after Phase 2 is completed): **2+ years** to share evaluation data

Phase 4

Support scaling the provision of TA to private companies across industries and geographies

HYPOTHETICAL USAID INVOLVEMENT

Support efforts to scale employer policy programs across new industries and geographies

Crowd-in public and non-profit/donor funding resources to support efforts that may require subsidization (e.g., technical assistance for SMEs)

TIMELINE

Medium-term (after Phase 2 is completed): **3+ years** to scale across multiple industries and geographies

For discussion:

- Are there any other teams at USAID or external organizations doing adjacent work that we might partner with to fund or implement?
- What would USAID want to test during the pilot stage?

Potential integration opportunities with other work:

- Organizations that already support these activities (e.g., Alive and Thrive, Scaling Up Nutrition, UNICEF)
- Bureaus in USAID (e.g., Global Health)

TRADITIONAL MEDIA

EXECUTIVE SUMMARY

CONTEXT

Detrimental practices and beliefs due to lack of knowledge of healthy behaviors and stigma are major causes of adverse breastfeeding, complementary feeding, and nutrient supplementation behaviors.

- Media content: traditional media (e.g., film, TV, radio, print) may offer unique opportunities to model positive nutrition behaviors across large cohorts of individuals and to combat negative stigma, particularly for breastfeeding. There may be large scale productions that could reach large LMIC populations (e.g., Nollywood, Bollywood).
- Advertising/branding: There have also been increasing efforts by private sector companies (especially consumer product companies) to incorporate purposeful messaging into their branding and advertising.

DESCRIPTION

A non-profit organization may directly fund a private media partner to develop and share nutritional messaging in media content to shape positive nutritional attitudes and behaviors in target audiences.

- Media content: the media partner would be responsible for integrating nutritional messaging into the script and for production and distribution through traditional channels. Alongside funding the media partner, the non-profit may also guide nutritional messaging in collaboration with key nutrition advocates and subsidize distribution to areas that may not be profitable (e.g., rural, remote populations).
- Advertising/branding: a donor or nonprofit organization would work with a private sector company (or a group of companies) to design purposeful advertising/branding that focuses on pro-nutritional messaging.

Multiple media channels are possible (e.g., film, TV, radio, print); the program will need to identify the most context-appropriate channel to reach target audiences.

There are two approaches to action this program:

- Incorporate nutritional messaging into an existing media production (e.g., adding scenes to an existing TV show) – likely simpler and lower cost if willing partner can be found.
- Develop a new media production from scratch (e.g., creating a new TV show, new branding/ads) – which may be more complex and expensive.

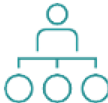
To be successful, companies must be willing and able to collaborate with non-profits to develop and distribute content with nutritional messaging. To enable this modality, USAID support can play a vital role in driving advocacy efforts to explore partnerships and in piloting the model.

PRIVATE SECTOR MECHANISM

Private sector media partners have distinct capabilities that enable them to write, produce, and distribute compelling content that resonates with target populations as they have expertise in media production, control major distribution channels, and have a deep knowledge of their consumers. However, media partners are unlikely[17] to have additive profit through the program, suggesting they will mainly serve in operator roles and need to be funded consistently by non-profits/donors.

TRADITIONAL MEDIA OVERVIEW

A non-profit organization may directly fund a private media partner to develop and share nutritional messaging in media content to shape positive nutritional attitudes and behaviors in target audiences.



1. BUSINESS MODEL

Media content appears unlikely to have additive profit for the private sector through program, suggesting they will need to be funded consistently by a non-profit organization. Purposeful branding / advertising approaches may have greater direct return on investment (ROI).

Key design decisions around target audience, media channel selected, and scope of content being developed may further impact overall cost and ROI in terms of impact.

However, efforts to measure impact in the pilot and to crowd-in additional non-profits and media partners as implementers may help build additional partnerships and scale program – still, the model may require continued subsidization over time.

2. RISK AND MITIGATION CONSIDERATIONS

Potential risks include:

- Partnership and perception risks, including reputation risks associated with an initiative with extensive public visibility (especially if focusing on a branding / advertising strategy)
- Inequitable impact for remote and rural poor populations

Mitigation strategies that can minimize the likelihood and impact of these risks are outlined in this document.

3. KEY ENABLERS

A few of the main enabling factors that may support implementation are:

- Willingness of private sector companies to collaborate with non- profit and include nutritional messaging in media
- Consumer access to different channels of media
- Capability of media partners to develop, market, and distribute content

4. WHERE MIGHT USAID SUPPORT

USAID may provide support to:

1. Drive advocacy efforts to identify private companies and non- profit nutrition partners to design the program
2. Fund pilot to test model, and identify opportunities to scale

1. BUSINESS MODEL

The business case is unlikely to be sustainable through private sector engagement alone as a media partner's main incentive to integrate nutrition messaging into a media production may be non-profit funding.

TARGET CUSTOMERS/BENEFICIARY

Mothers, child caregivers, and children who are either higher- and lower- income and who live in urban or remote, rural settings

Family members and communities who influence nutrition practices

Pain points addressed

- Detrimental practices and beliefs by mothers, caregivers, and the public due to lack of knowledge of BF, CF, and NS
- Stigma associated with BF

PRODUCTS AND SERVICES PROVIDED

Nutritional content included in traditional media production, and distributed widely to reach relevant target beneficiaries

KEY DESIGN CHOICES

- What is the most appropriate media channel? (e.g., film, TV, radio, print)
- What is the scope of content being developed? (e.g., adding a scene to media that has been greenlit, developing new media from scratch)

KEY PARTICIPANTS

MEDIA CONTENT APPROACH: MEDIA PARTNER

(e.g., Bollywood production studio, local radio station)

Role:

- Integrate nutritional messaging into plot/script (e.g., integrate scene highlighting exclusive breastfeeding into script)
- Filming/editing
- Marketing
- Distribution through traditional channels

Incentive:

- Direct financial: Grants (from non-profit)
- Indirect financial: Expanded funding opportunities (e.g., grants, tax-deductible donations, and other tax benefits)
- Indirect: CSR

BRANDING / AD APPROACH: PRIVATE COMPANY / GROUP OF COMPANIES

Role:

- Develop branding approach and consumer targeting strategy
- Roll out strategy

Incentive:

- Indirect: Increased financial returns from improved branding strategy and improved public relations

NON-PROFIT ORGANIZATIONS*

(focused on nutrition)

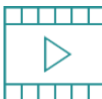
Role:

- Oversee nutritional messaging: guiding nutritional message (e.g., exclusive breastfeeding) to be included in media production in collaboration with key nutrition advocates (e.g., GAIN, A&T, and Ministry of Health)
- Funder: directly fund production; contract/subsidize distribution to areas that may not be profitable (e.g., rural poor populations)

Incentive:

- Direct: Mission
- Indirect: Organizational awareness/publicity

WHAT IS THE MOST APPROPRIATE MEDIA CHANNEL?



FILM

Potential benefits:

- Greater capabilities and global reach of film industry: a film produced with major film industries (e.g., Bollywood, Nollywood, or Cinema of Indonesia) may enable higher quality content, greater popularity, and global distribution channels
- Greater screening flexibility: a film produced may be exhibited through many different channels, including a theater, a TV channel, or personal home viewing (e.g., DVD, download, streaming)

Potential challenges:

- More resource intensive: production of feature-length films may be more resource-intensive than TV or radio
- Greater need to develop a relevant audience: a standalone film (not a sequel) may require heavy marketing to procure viewers, making it hard to predict if the film will be popular amongst the target audience
- Limited reach for populations without access to television or internet

* Private sector players with CSR objectives may also player funder roles

TELEVISION (TV)

Potential benefits:

- Existing targeted viewership: a TV show (or ads) currently airing may be more likely to have a dedicated audience with known demographics, making it easier to ensure that new content with nutritional messages will be received by a relevant audience
- Opportunities for recurrent messaging: a TV show may enable more frequent, consistent nutritional health messaging compared to a single film, ensuring messages are not just a flash in the pan

Potential challenges:

- Limited reach for populations without access to television or internet

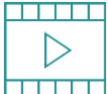
RADIO

Potential benefits:

- **Greater access for under-resourced communities:** a radio show (or ads) may be more accessible than film and TV in lower-income communities with limited digital connectivity
- **Less resource intensive:** production of a radio show may be less expertise than film and TV, which require video production and editing

Potential challenges:

- **Messaging may be less powerful:** without moving visual imagery, radio shows may be less effective at demonstrating techniques or images that improve nutritional behaviors (e.g., breastfeeding)
- **More local audience:** a radio show may have a smaller marketing budget and more localized reach compared to TV shows and films



PRINT

Potential benefits:

- Greater availability: print media may be more accessible than film and TV in communities with limited digital connectivity

Potential challenges:

- **Messaging may be less powerful:** without moving visual imagery, print may be less effective at demonstrating techniques or images that improve nutritional behaviors (e.g., breastfeeding)
- **Less accessible in areas with lower literacy rates**

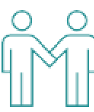
Implications

A non-profit may select the most effective channel based on the reach and demographics of the audience they aim to target.

Appropriate channels may vary depending on a target audience's country of residence, culture, income level, literacy, and level of urbanization, among other attributes.

Some channels may already have an established viewership (e.g., a TV show currently airing) or be more likely to have a broad reach (e.g., a film produced by a major film industry).

WHAT IS THE SCOPE OF CONTENT BEING DEVELOPED?



JOIN EXISTING PRODUCTION

A non-profit may partner with a media partner to incorporate nutritional messaging into an existing media production (e.g., adding one or more breastfeeding scenes to an existing movie script or TV show)

Potential benefits:

- **More affordable and faster production time:** minimal investment of time and resources is necessary to include nutritional messaging in an existing production as most costs will be covered by the product company; main costs in a program to include nutritional content may be advocacy to encourage companies to adopt messaging
- **Higher quality and larger audience:** joining an existing production may help ensure nutrition messaging is subtle and effective but also reaches a broader audience

Potential challenges:

- **Less autonomy:** joining an existing media production may require tradeoffs in influence over the overall media script/screenplay and in editing the final product as the non-profit would have limited control over production

START FROM SCRATCH

A non-profit may independently coordinate the complete development of a new media production and include nutritional messaging in it (e.g., writing a script for a new movie with breastfeeding as a major theme or creating a new TV show)

Potential benefits:

- **Greater autonomy:** building a media production from scratch may provide greater control over content development, overall themes, and other production decisions

Potential challenges:

- **Higher** cost: non-profit may have a much higher out-of-pocket cost because they may have to fund more components of content production
- **Lower quality content:** developing a production from scratch may prove challenging for a non- profit as they may lack the expertise possessed by a private film production team to produce high quality content, market the film to appropriate consumers, and build an audience

Implications

Joining an existing production can be efficient and affordable if media partner is willing to incorporate nutrition messaging into its storyline.

Building a production from scratch may be required to ensure greater control or if relevant media companies are not willing to partner on existing projects.

2. RISK AND MITIGATION CONSIDERATIONS

Potential risk	Potential Likelihood	Potential Impact	Potential Mitigation
Partnership and perception risks: Media partner may develop other content or participate in behaviors that are inconsistent with USAID's mission; additionally, there may be reputational risks associated with an initiative that could have extensive public visibility. This challenge may be especially salient for the branding/advertising approach	50%	50%	• Carefully screen potential private partners, and their past content and behavior, to minimize likelihood and impact of negative behavior being associated with initiative supported by USAID • For a branding/ advertising strategy, consider focusing on non-food companies (where there might be fewer direct conflicts) or group branding strategies
Inequitable impact for remote and rural poor populations: It may be more challenging for traditional media to reach under-resourced populations (e.g., lower-income, rural) that have limited access to internet, TV, cinema, etc.	50%	50%	• Identify context-appropriate channels in specific regions. • Consider subsidizing channel distribution if a channel exists but is not directly profitable

3. KEY ENABLERS

Key enabler	Supply Side	Demand side
Economic	Distributor (e.g., movie theater, streaming service, television station) willingness to pay production studio for rights to screen content (e.g., confidence in expected viewership)	Consumer willingness to pay for content (e.g., paying for a movie ticket or access to TV channel) Sufficient market size within chosen channel of media content (e.g., sufficient demand for television series in targeted geography)
Infrastructure & Capabilities	Capabilities of media partners within specific regions to develop and market content (e.g., Nollywood, Bollywood) Capabilities of media partners to distribute content to rural and urban regions (e.g., ability to distribute print media to rural poor regions) (Enablers with implications for USAID next)	Consumer access to different channels of media (e.g., access to cinema, TV stations, or radio) (Enablers with implications for USAID next)
Behavioral	Media partner willingness to collaborate with non-profit and include nutritional messaging content in media (Enablers with implications for USAID next)	Cultural acceptance of taking lessons from media (e.g., some cultures may be less motivated to change behaviors based on media messaging)
Regulatory	Government-mandated laws around what may be included in media content (e.g., breastfeeding may be illegal to screen in some countries)	N/A

4. WHERE MIGHT USAID HAVE IMPACT

Phase 1

Drive advocacy efforts to identify private and non- profit nutrition partners to design the program

HYPOTHETICAL USAID INVOLVEMENT

Identify relevant private sector partners and nutrition-focused non-profit partners to collaborate on designing pilot program

Develop and fund partners to design the pilot program, including conducting customer segmentation of the target population, identifying the most appropriate channels (film, TV, radio, or print) to reach target audiences, determining the scope of content being created (e.g., a single scene, a new production), and developing nutrition messaging content

TIMELINE

Short-term: ~6 months to identify partners and design program

Phase 2

Fund pilot to test model and identify opportunities to scale

HYPOTHETICAL USAID INVOLVEMENT

Fund pilot implementation to include nutritional messaging in content

Subsidize distribution efforts to ensure media equitably reaches target population, where necessary

Sponsor evaluation of nutritional and business impact to build a case for further private sector engagement

Share impact evaluations to crowd-in additional non-profit and media production companies as implementers, and **support efforts to scale media productions with nutrition messages** to new geographies

TIMELINE

Medium-term (after Phase 1 is completed): **3+ years** to scale non- profit and media partner collaborations across geographies

FOR DISCUSSION

- Are there any other teams at USAID or external organizations doing adjacent work that we might partner with to fund or implement?
- What would USAID want to test during the pilot stage?
- Would USAID be interested in an approach that may require continued subsidization/funding over time?

POTENTIAL INTEGRATION OPPORTUNITIES WITH OTHER WORK

- "Shaina" the feature length film (USAID project)
- USAID Community Health Radio Program (Zambia)
- Bollywood/Nollywood production companies
- Global Girl Effect (Yegna's TV drama)

MOTHER & FAMILY SUPPORT GROUPS[*]

EXECUTIVE SUMMARY

CONTEXT

Detrimental practices and beliefs due to lack of knowledge of healthy behaviors and stigma are major drivers of adverse breastfeeding, complementary feeding, and nutrient supplementation behaviors. Furthermore, family members, especially fathers and grandmothers, have a very strong influence on mothers' practices and beliefs.

Facilitated support groups can be developed for mothers or family members with similar experiences (e.g., fathers) to provide encouragement, emotional support, and timely information (e.g., nutrition education, feeding techniques). Alongside formal group sessions, support groups may also provide mothers or family members with more personalized one-on-one support/"sponsors" (e.g., which may be provided by a non-profit or corporation). Support groups may be a strong mechanism to improve nutritional practices and reduce stigma.

USAID has significant experiences supporting women's support groups; new interventions could be explored to strategically build on existing work by introducing new components that might add additional impact opportunities (e.g., assessing impact for nutrition components specifically, exploring digital strategies, exploring bundling with counseling services, developing scale-up models or guidance for setting up new models) – otherwise, this modality may be less additive.

DESCRIPTION

A healthcare facility can offer support groups for mothers and their families to attract greater patient volumes and sales of ancillary services. Although a business case is possible, it may be limited to higher income populations; thus, significant subsidization from a non-profit/donor or corporation may be necessary.

- Private healthcare facilities could host support groups moderated by healthcare workers that are trained in nutrition practices to provide high-quality sessions.[†] Providers may be incentivized to provide trainings to increase patient engagement with the healthcare system, which could subsequently increase ancillary service line utilization.
- Healthcare providers may wish to offer this service as part of a broader bundled care package with other services (e.g., counseling[‡]) for a fee. This method would enable cross- subsidization of services to partially or fully cover costs of support groups. It may also provide opportunities to reinforce nutrition education shared with patients (e.g., feeding techniques), improving overall care quality. This type of bundling may only be viable for higher-income groups.
- Support groups services could also theoretically be offered for free but indirect financial benefits of offering this service may not cover its costs.

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[*] This modality may be bundled with counseling services in a broader maternal care package.
[†] This modality may be integrated with health worker in-service trainings as moderators will be need to be appropriately trained to host support groups
[‡] This modality may be integrated with counseling services as support groups are likely to be included as part of a larger, bundled care package

Multiple mediums may be offered (a hybrid approach is also possible):

- In person sessions – likely most engaging and effective to drive greater patient volumes, but more costly and limited in scale.
- Virtual synchronous – likely still engaging but technology barriers may limit reach.
- Digital asynchronous – likely greater flexibility for support group members and easiest to scale but may be less engaging and technology barriers may limit reach.

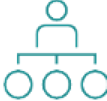
To enable this modality, USAID support can play a vital role in driving uptake by piloting a bundled care model, subsidizing services provided, and measuring impact.

PRIVATE SECTOR MECHANISM

The private sector may not be uniquely capable of providing support group services; however, in countries where significant populations receive MNCH services through the private sector, it may be worth engaging to ensure extended reach of these services. Additionally, if bundling support group offerings with other services can provide a meaningful business case, there can be a unique role for the private sector to sustain this offering. However, it is unclear if healthcare systems will experience additive profits by providing these sessions, which suggests programs may need financial support provided by non-profits/donors.

MOTHER & FAMILY SUPPORT GROUPS OVERVIEW

A healthcare system may provide support group sessions to generate positive nutritional attitudes and behaviors in family groups and to attract greater patient volumes and sales of ancillary services.



1. BUSINESS MODEL

Private health systems may provide support groups as part of a bundled care package with other services (e.g., counseling). Private health systems may alternatively offer support groups for free because they believe they will increase sales of ancillary service lines that will cover their costs. If these models are not profitable, programs may require non- profit/donor subsidization.

Overall cost and ROI in terms of impact may also be affected by key design decisions around healthcare and non-profit/donor partners, target populations, support-group medium, and session cost.

2. RISK AND MITIGATION CONSIDERATIONS

Potential risks include:

- Inequitable impact for remote and rural poor populations
- Privacy concerns
- Misinformation risk

Mitigation strategies that can minimize the likelihood and impact of these risks are outlined in the document

3. KEY ENABLERS

A few of the main enabling factors that may support implementation are:

- Mother & family ability and willingness to pay for support group sessions
- Mother & family access to adequate technology and transportation needed to join sessions
- Capability of healthcare systems to deliver and moderate support groups

4. WHERE MIGHT USAID SUPPORT

USAID may provide support to:

1. Identify private healthcare systems interested in providing bundled care (e.g., support groups alongside counseling services) and potential non- profit/donor partners
2. Fund bundled care pilot and support impact measurement
3. Advocate for expansion of the business model across geographies
4. Support scaling the provision of the bundled care program across geographies

Note: modality could be less additive if deemed duplicative with existing USAID programs

1. BUSINESS MODEL

The business case for healthcare facilities providing support groups may be limited (e.g., to higher income populations) regardless of design choices and will likely require significant subsidization.

TARGET CUSTOMERS/BENEFICIARY

Mothers and caregivers who are either higher- or lower-income and who live in urban or remote, rural settings.

Pain points addressed

- Detrimental practices and beliefs by mothers, caregivers, and the public due to lack of knowledge of BF, CF, and NS
- Stigma associated with BF
- Lack of social, emotional, and community support
- Difficulty implementing breastfeeding practices at home

PRODUCTS AND SERVICES PROVIDED

Facilitated support groups may be moderated by healthcare workers and provide mothers or family members with peer-to-peer support and information on positive behaviors. Sessions may also crowd in additional service utilization for health systems (especially through bundled care packages) and may increase patient satisfaction and referrals.

Alongside formal group sessions, support groups may also provide mothers or family members with more personalized one-on-one support (e.g., from a non-profit or corporate sponsor).

KEY DESIGN CHOICES

- Will sessions be free or will attendees be charged?
- How are sessions provided? (e.g., digitally, in-person, hybrid)

KEY PARTICIPANTS

PRIVATE HEALTHCARE FACILITY

Role: Service provider

- Use in-house staff and space to provide support groups on-site and/or online

Incentive:

- Indirect financial: Increase sales of ancillary services (e.g., other post-natal/pediatric care); increase quality of care; increase retention and referrals
- Indirect: Increase patient satisfaction; increase brand awareness

PUBLIC/NON-PROFIT ORGANIZATION

Role: Funder

- Subsidize services for under-resourced populations (e.g., lower-income, rural, non-insured)

Incentive:

- Direct: Mission

DELIVERY MODELS

IN-PERSON ATTENDANCE

Potential benefits:

- **Higher quality engagement:** in-person attendance is more likely to create a participatory environment and allow for more meaningful peer-peer connections and real- time feedback
- **Higher facility patient flow:** in-person sessions could be more likely to increase patient flow through health facilities and potentially increase service line utilization or product sales

Potential challenges:

- **Transportation barriers:** communities that are farther away from where sessions are offered (e.g., rural and remote populations) could have a more challenging time attending sessions

ASYNCHRONOUS DIGITAL ATTENDANCE

Support groups may be provided through WhatsApp communities, SMS messaging groups, live chatrooms, etc.

Potential benefits:

- **Convenience for participants:** compared to synchronous virtual and in-person session, asynchronous sessions offer more flexible involvement as participants can message at their leisure and do not need to join sessions at specific times

Potential challenges:

- **Lower quality engagement:** participation in support groups may be less engaging if they are performed asynchronously
- **Some technological barriers to access:** access to requisite hardware and network connectivity may be challenging in under-resourced communities

SYNCHRONOUS VIRTUAL ATTENDANCE

Support groups may be provided using virtual, live- streaming technology

Potential benefits:

- **High quality engagement:** compared to asynchronous sessions, virtual sessions may be more likely to create meaningful peer-peer connections and real-time feedback as participants are interacting live and on video

Potential challenges:

- **Significant technological barrier to access:** videoconferencing requires access to high-speed internet and requisite hardware, which may be challenging in under-resourced communities

Implications

In-person sessions may offer higher quality engagement and may be more likely to drive increased patient flow in private healthcare facilities than online sessions.

BUSINESS MODELS

FREE SESSIONS

Potential benefits:

- **Lower financial barrier to access,** particularly for under-resourced attendees

Potential challenges:

- **Unclear revenue potential:** without charging for support groups, a revenue mechanism may be less sustainable (it seems unlikely that sessions will crowd-in sufficient utilization of ancillary services to cover the sessions' costs)

CHARGE FOR SESSIONS AS PART OF A BUNDLED SERVICE

Potential benefits:

- **Opportunity to raise revenues and reduce costs:** charging patients for sessions as part of a bundled package may provide a direct revenue opportunity for healthcare facilities; providing a bundle of services may also enable cross-subsidization of services
- **Potential higher quality care:** providing multiple care services may enable reinforcement of positive nutrition practices for patients through multiple touchpoints, improving overall care quality (e.g., feeding techniques demonstrated in counseling sessions may be discussed in support groups)
- **Participants who can afford to pay for bundled services may have greater incentive to attend support groups** if they paid for them

Potential challenges:

- **Limited willingness and ability to pay – and therefore lower overall attendance:** charging for sessions may create a barrier to access for under-resourced families (who are unable to pay)

Implications

It is unclear if there is a sustainable business case and either model must be tested and validated:

Charging for support group sessions as part of a bundled service may provide higher quality care and direct revenue, but access is likely limited to higher-income populations.

If charging for bundled care services proves to be an unsustainable model or support group services are aimed at lower- resourced populations, a free model may be more likely and may require non-profit/ donor subsidization.

2. RISK AND MITIGATION CONSIDERATIONS

Potential risk	Potential Likelihood	Potential Impact	Potential Mitigation
Inequitable impact for remote and rural poor populations: It may be challenging for under- resourced and remote communities to access digital and virtual sessions due to technology barriers; they may also face transportation barriers that may make it difficult to access in-person sessions	75%	50%	• Provide subsidization for travel to and from in- person sessions or for technology required for under-resourced populations
Privacy concerns: digital and patient privacy concerns may be raised if patients are discussing personal health information during in-person and online support groups	25%	50%	• When online, only use secure platforms and minimize patient identifiers that are shared. • In-person, ensure attendees sign a pledge to not discuss group discussion outside of sessions
Misinformation risk: peer information sharing can result in spread of misinformation across mothers and families	50%	75%	• Provide facilitators to ensure quality of information shared • Bundle with counseling modality so that mothers and families are provided correct information that can be brought to group sessions

3. KEY ENABLERS

Key enabler	Supply Side	Demand side
Economic	Healthcare facility provision of existing/new ancillary services that may be increasingly utilized with increased patient traffic	Mother & family willingness and ability to pay for support groups (Enablers with implications for USAID next)
Infrastructure & Capabilities	Healthcare facility capability to deliver facilitated support groups and moderate sessions Healthcare facility capability to offer and develop support group services on virtual/digital platforms (Enablers with implications for USAID next) Healthcare facility capability to offer physical space for in- person support groups	Mother and family ability to access digital/virtual platforms Mother and family ability to travel to locations where in-person sessions are offered (Enablers with implications for USAID next)
Behavioral	N/A	Mother & family willingness to engage in support groups using digital/virtual platforms Cultural acceptability to share personal or sensitive information amongst strangers
Regulatory	Government regulation that protects patient privacy on digital/virtual platforms and within in-person support groups Additional mechanisms to protect patient privacy on in-person sessions (e.g., communal agreements and/or pledges)	Adherence to rules protecting information shared in group sessions

4. WHERE MIGHT USAID HAVE IMPACT

Phase 1

Identify partners and design pilot program that builds on existing knowledge

HYPOTHETICAL USAID INVOLVEMENT

Identify relevant private sector healthcare system partners and non-profit/donor partners to collaborate on designing a bundled care pilot program (including support groups, counseling services, and other services)

Fund healthcare system partner(s) to design the broader bundled care program, especially exploring opportunities to improve on current models: exploring digital strategies, exploring bundling with counseling services, developing scale-up models and guidance for setting up new models (e.g., optimizing messaging strategies for different target populations, identifying best practices emerging from COVID-19 experiences)

Ensure appropriate training for counselors and support group moderators by providing in-service training opportunities (detailed out in health worker in-service training modality)

TIMELINE

Short-term: ~<6months to identify healthcare system partners and design bundled care program strategy

Phase 2

Fund pilot and support impact measurement

HYPOTHETICAL USAID INVOLVEMENT

Fund bundled care program pilot implementation by healthcare system partners

Subsidize efforts alongside non-profit to ensure equitable reach for rural and under-resourced populations, where necessary

Fund evidence-based monitoring and evaluation of nutritional and business impact to build the business case for future programs and to improve program design (e.g., investigate improvements in quality of care; measure costs of care before and after intervention; measure patient volumes and sales of ancillary services)

TIMELINE

Medium-term (after Phase 1 is completed): **~1-2 years** to run and measure pilot

Phase 3

Advocate for expansion of the business model across geographies

HYPOTHETICAL USAID INVOLVEMENT

Share evidence-based learnings and proof of business model from monitoring and evaluation efforts to crowd-in additional healthcare facilities interested in providing bundled care

TIMELINE

Medium-term (after Phase 2 is completed): **2+ years** to share evaluation data

Phase 4

Support scaling the provision of the bundled care program across geographies

HYPOTHETICAL USAID INVOLVEMENT

Support efforts to scale support program created with implementing partners across existing healthcare system networks and to new geographies

Crowd-in public and non-profit/donor funding resources to support further efforts by healthcare systems that may have significant impact (e.g., technology and transportation for under-resourced populations)

TIMELINE

Medium-term (after Phase 3 is completed): **2+ years** to scale program across geographies

FOR DISCUSSION

- Are there any other teams at USAID or external organizations doing adjacent work that we might partner with to fund or implement?
- What would USAID want to test during the pilot stage?

POTENTIAL INTEGRATION OPPORTUNITIES WITH OTHER WORK

- USAID's Title II MCHN programs (e.g., Mother's Club, Hearth Sessions)
- Integration with work in other modalities (e.g., health worker in-service trainings, counseling services)
- Center for Innovation and Impact (USAID) – may want to explore existing USAID work with accelerators

COUNSELING SERVICES*

EXECUTIVE SUMMARY

CONTEXT

Detrimental practices and beliefs, breastfeeding anxiety, and poor postnatal care adherence are major drivers of adverse BF, CF, and NS behaviors in mother and caregivers. Counseling services can offer support to mothers and caregivers during a potentially stressful time by sharing information (e.g., feeding techniques), answering questions, and helping troubleshoot breastfeeding problems, improving nutrition behaviors.

DESCRIPTION

Healthcare facilities (and potentially private pharmacies) may provide counseling services for new mothers and caregivers to attract greater patient volumes through a new revenue channel and to increase sales of ancillary products and services. Although a business case is possible, it may be limited to higher income populations; thus, significant subsidization from a non-profit/donor may be necessary.

- Healthcare facilities or pharmacies could provide counseling services delivered by healthcare workers (e.g., doctors, nurses, pharmacists) that are trained in nutrition practices to provide high-quality care.[†] Pharmacies and healthcare facilities may provide services to attract greater patient volumes and increase ancillary sales.
- Healthcare facilities or pharmacies may wish to offer this service as part of a broader bundled care package with other services (e.g., support groups[‡]) for a fee. This method would enable cross-subsidization of services to partially cover costs of counseling services. It may also provide opportunities to reinforce nutrition education shared with patients (e.g., feeding techniques), improving overall care quality. This type of bundling may only be viable for higher-income groups.
- Counseling services could also theoretically be offered separately for a fee but there may be very limited willingness to pay, and the indirect financial benefits of offering this service may not cover its costs.

There are two main delivery models:

- Facility-based counseling (individually or in groups) – more likely to be profitable as there are no transportation costs and services provided on-site may increase sales of ancillary products and services through increased patient volumes (for healthcare facilities) and foot traffic (for pharmacies).
  - Group sessions are most likely to be profitable as counselors can provide services to multiple patients at once.
- Mobile counseling – least likely to be profitable as facilities may need to pay for transportation to homes in remote areas and services are less likely to crowd-in ancillary sales.

PRIVATE SECTOR MECHANISM

The private sector may not be uniquely capable of providing counseling services; however, in countries where significant populations receive MNCH services or pharmaceutical products through the private sector, it may be worth engaging to ensure extended reach of these services. Additionally, if bundling counseling

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[*] This modality may be bundled with counseling services in a broader maternal care package.
[†] This modality may be integrated with health worker in-service trainings as moderators will need to be appropriately trained to host support groups
[‡] This modality may be integrated with mother and family support groups as counseling services are likely to be included as part of a larger, bundled care package

services with other services can provide a meaningful business case, there can be a unique role for the private sector to sustain this offering. However, it is unclear if healthcare facilities and pharmacies will experience additive profits by providing these sessions, which suggests programs may need financial support provided by non-profits/donors.

COUNSELING SERVICES OVERVIEW

Private pharmacies and healthcare facilities may provide mobile and on-site counseling services for new mothers and caregivers in order to attract greater patient volumes through a new revenue channel and increase sales of ancillary products and services.

1. BUSINESS MODEL

To be sustainable, private pharmacies and healthcare facilities may need to identify enough patients who are willing & able to buy counseling services to cover costs; the business case is stronger if providing this service also crowds in sales of other ancillary products and services (e.g., BF/CF/NS products; other postnatal care).

As a result, urban & higher- income populations may be more profitable, and rural & lower- income populations may require alternative solutions to offset profitability concerns (e.g., public subsidy).

2. RISK AND MITIGATION CONSIDERATIONS

Potential risks include:

- Promotion of inappropriate or unsanctioned products
- Overpromotion of sanctioned products
- Inequitable impact for remote and rural poor populations
- Poor quality counseling
- Initiation of negative practices once funding ends

Mitigation strategies that can minimize the likelihood and impact of these risks are outlined in the document.

3. KEY ENABLERS

A few of the main enabling factors that may support implementation are:

- Private pharmacy/healthcare facility ability and willingness to provide counseling services
- Trainings on best practices for counselors to ensure high quality care
- New mother/caregiver ability and willingness to pay for counseling services

4. WHERE MIGHT USAID SUPPORT

USAID may provide support to:

1. Fund a pilot with a few implementing partners
2. Share and advocate for the expansion of the business model across geographies
3. Support scaling the provision of counseling services across geographies

1. BUSINESS MODEL

Private pharmacies and healthcare facilities may provide mobile and on-site counseling services for new mothers and caregivers to attract greater patient volumes through a new revenue channel and to increase sales of ancillary products and services

TARGET CUSTOMERS/BENEFICIARY

Mothers and caregivers (e.g., family members) that are both higher- and lower- income and that live in urban and remote, rural settings

Pain points addressed

- Detrimental practices and beliefs by mothers and the public due to lack of knowledge of BF, CF, and NS
- Mothers feeling anxious or pain when breastfeeding
- Limited awareness and uptake of postnatal visits, often driven by cost and in places with home deliveries

PRODUCTS AND SERVICES PROVIDED

- Mobile counseling focused on remote settings
- Facility-based counseling (individual and group) focused on urban settings

KEY PARTICIPANTS

PRIVATE PHARMACIES

Role: Service provider

- Contract/hire independent counselors to provide facility-based or mobile counseling services
- Provide space for counseling on-site

Incentive:

- Direct financial: Add counseling services as a new sales channel
- Indirect financial: Increase sales of ancillary products (e.g., BF/CF/NS products in stores or carried by mobile counselors)
- Indirect: Increase brand awareness

HEALTHCARE FACILITIES

Role: Service provider

- Use in-house counselors to provide facility-based or mobile counseling services, likely as part of a bundled post-natal care package
- Provide space for counseling on-site

Incentive:

- Direct financial: Broaden catchment area of counseling services
- Indirect financial: Increase sales of ancillary services (e.g., other postnatal/pediatric care)
- Indirect: Increase brand awareness

INDEPENDENT COUNSELORS

Role: Service provider

- Provide facility-based or mobile counseling services for private pharmacies

Incentive:

- Direct financial: Add private pharmacies as a new sales channel

PUBLIC/NON-PROFIT PLAYER

Role: Funder

- Subsidize counseling services that may not be profitable, including counseling services for lower-income populations and mobile counseling for remote rural populations

MAJOR COST DRIVERS

- **Personnel costs** (the principal cost may be paying counselors for providing services; personnel costs may be particularly high per patient for individual counseling sessions and mobile counseling sessions, compared to group counseling sessions)
- **Space/set-up cost** (some opportunity cost of space and set- up needed to host sessions)
- **Transportation for mobile counseling** (costs may be significant for mobile counselors to reach remote populations)
- **Training costs** (some cost to train counselors to provide quality care – detailed out in "health worker in-service training" modality)
- **Marketing costs** (minimal costs may be required to market the counseling services to raise awareness of the offering)

POTENTIAL REVENUE DRIVERS

CHARGE PATIENTS FOR COUNSELING SERVICES

Potential revenue drivers

- **Willingness and ability to pay:** Providing counseling services may be profitable if enough patients may be willing and able to pay for them to cover their costs; patients may be more likely to be willing to pay for these services as part of a bundled post-natal care package
- **Crowd-in ancillary sales:** Providing counseling services may crowd-in sales of other ancillary products and services to improve overall profitability
- **Covered by insurance:** Public or private health insurance providers may cover the cost of the counseling services

IMPLICATIONS

- Willingness and ability to pay is likely limited to higher-income and insured populations
  - Group sessions in urban and higher- income populations may be profitable
  - Other groups may not be profitable without cross-subsidization
- Counseling services could be offered as part of a bundled post-natal care package

PROVIDE COUNSELING SERVICES TO PATIENTS FOR FREE; COST COVERED BY PUBLIC/NON- PROFIT PLAYER

Potential revenue drivers

- **Publicly-funded:** Private pharmacies/health facilities may be funded by a public/non-profit player (e.g., donors or government through a public private partnership) to cover the cost of the services
- **Crowd-in ancillary sales:** Providing counseling services may crowd-in sales of other ancillary products and services
- **Supported by manufacturer:** Private pharmacies/health facilities may be funded, in part, by a BF/CF/NS product manufacturer to promote delivery of their product

IMPLICATIONS

- External public or nonprofit funding may be required especially in rural, lower-income, or non-insured populations
- External public or nonprofit funding may be required indefinitely, or at least until incomes increase sufficiently
- Need for caution around any product sponsorship associated with the program

2. RISK AND MITIGATION CONSIDERATIONS

Potential risk	Potential likelihood	Potential impact	Potential mitigation
Promotion of inappropriate or unsanctioned products: Partnered private pharmacies or healthcare facilities may promote inappropriate products that negatively influence nutritional outcomes (e.g., formula from a company violating the International Code of Marketing of Breast-milk Substitutes).	50%	75%	• Design counseling services program with quality assurance mechanisms that check in on activities to ensure inappropriate products are not being promoted • Ensure breastmilk substitute companies are not funding counseling services programs and partnered private pharmacies or healthcare facilities are not receiving funding from these companies
Overpromotion of sanctioned products: Partnered private pharmacies or healthcare facilities may overpromote otherwise sanctioned products that can negatively influence nutritional outcomes (e.g., overpromotion of a high-margin commercial formula; early promotion of a CF product).	50%	75%	• Share information with counselors in private pharmacies and healthcare facilities on which products may be harmful if introduced too soon or introduced to patients who do not need them (note the suggested mitigation mechanism is unlikely to tackle purposeful bad behavior, which will be difficult to track and counter)
Inequitable impact for remote and rural poor populations: Private pharmacies and healthcare facilities may disproportionately target mothers/caregivers in urban areas or with relatively higher incomes given their greater potential profitability. This may limit access to counseling resources for under-resourced populations (e.g., lower- income, rural), who may be harder to reach and have less ability to pay.	75%	50%	• Provide targeted, external subsidies for mobile counseling sessions and transportation of mobile counselors to remote communities • Encourage bundling of mobile counseling with sales of sanctioned products (see risk above to ensure products are appropriate)
Poor quality counseling: Counselors may unintentionally deliver inappropriate counseling care to mothers/caregivers that harms nutritional outcomes (e.g., a counselor may support early introduction of water to a baby or early introduction of formula).	50%	100%	• Provide trainings on best practices for counselors in private pharmacies and healthcare facilities • Design counseling services program with quality assurance mechanisms that monitor counseling quality and flag issues
Initiation of negative practices once funding ends: Once funding ends, partnered private pharmacies and healthcare facilities, or affiliated counselors, may start promoting unsanctioned products given they will no longer have incentives to refrain (e.g., counselors may begin promoting formula that violates International Code of Marketing of Breast-milk Substitutes).	75%	75%	• Include a stipulation in contracts that bind the partnered private pharmacies and healthcare facilities to continue to refrain from promoting unsanctioned products • Include a stipulation in initial contracts that creates financial penalties for future noncompliance

3. KEY ENABLERS

Key enabler	Supply Side	Demand side
Economic	Private pharmacy/healthcare facility willingness to pay counselors to provide counseling services (e.g., belief in demand for service; belief sales will increase ancillary product/service sales) Private pharmacy/healthcare facility ability to pay counselors to provide counseling services (Enablers with implications for USAID next) Health insurance reimbursement of counseling services	New mother/caregiver willingness to pay for counseling services (e.g., perceived value of service) New mother/caregiver ability to pay for counseling services (Enablers with implications for USAID next) Sufficient market size and population density of new mothers/caregivers (especially in urban settings, which may be more profitable)
Infrastructure & Capabilities	Trainings on best practices for counselors to ensure high quality care (Enablers with implications for USAID next) Transportation infrastructure for mobile counselors (e.g., reliable roads; minimal traffic; employer-hired transit; public transit; ride-sharing services) Capabilities of existing private pharmacies and healthcare facilities (e.g., ability to identify high quality counselors in the area; ability to host sessions on-site) Scale of private pharmacy and healthcare facility networks	Transportation infrastructure for mothers/caregivers to access facility-based counseling (e.g., reliable roads; minimal traffic; public transit; ride-sharing services)
Behavioral	Positive staff cultural behaviors or beliefs (e.g., belief that breastfeeding is healthier than commercial substitutes; belief that counseling services are important)	Positive patient cultural behaviors or beliefs (e.g., belief that breastfeeding is healthier than commercial substitutes; belief that counseling services are important) Trust for and positive perceptions of private counselors, pharmacies, and healthcare facilities Limited stigma against breastfeeding
Regulatory	Lactation counseling/consultant certification required (e.g., International Board Certified Lactation Consultant)	N/A

4. WHERE MIGHT USAID HAVE IMPACT

Phase 1

Fund pilot counseling services with a few implementing partners (private pharmacy and healthcare

POTENTIAL USAID INVOLVEMENT

Sponsor pilot counseling programs – likely as part of a bundled care program in order to test and validate the business model for private pharmacies and health facilities (bundled care may include support groups detailed out in "mother and family support groups" modality)

Design programs so counseling services are initially free or highly subsidized for new mothers/caregivers to raise awareness and generate demand for services

Provide trainings for counselors on best practices to ensure they are equipped to provide quality care (detailed out in "health worker in-service training" modality)

Fund third-party organization to conduct evidence-based monitoring and evaluation and develop market research to build the business case for further private sector engagement and to improve program design

TIMELINE

Short-term: ~2-3 years to implement pilot programs and collect evaluation data

Phase 2

Share and advocate for the expansion of business model across geographies

POTENTIAL USAID INVOLVEMENT

Share evidence-based learnings and proof of business model from monitoring and evaluation efforts to crowd-in additional private pharmacies and healthcare facilities as potential implementers

TIMELINE

Short-term (after Phase 1 is completed): **~1 year** to share business cases and advocate for expansion

Phase 3

Support scaling the provision of counseling services across geographies

HYPOTHETICAL USAID INVOLVEMENT

Support efforts to scale counseling service programs created with implementing partners across existing networks and to new geographies

Crowd-in public and non-profit funding resources to support efforts that may be less profitable but have significant impact on under-resourced populations (e.g., counseling services for lower-income or remote populations)

TIMELINE

Medium-term (after Phase 1 is completed): **3+ years** to scale provision of counseling services across geographies

For discussion:

- Are there any other teams at USAID or external organizations doing adjacent work that we might partner with to fund or implement?
- What would USAID want to test during the pilot stage?

Potential integration opportunities with other work:

- Advancing Nutrition (Kyrgyz Republic)
- Innovation Lab for Nutrition (Malawi)
- Innovation Catalyst in MCGL *(currently in development)*
- Frontier Health Markets *(upcoming)* or potential follow on to Sustaining Health Outcomes through the Private Sector (SHOPS) Plus
- Global Development Alliance (GDA) Annual Program Statement (APS)
- Stars in Global Health – Grand Challenges Canada

DOUBLE CLICK: COUNSELING SERVICES CASE STUDIES FROM PRIOR USAID WORK

ADVANCING NUTRITION (KYRGYZ REPUBLIC)

USAID collaborated with the Kyrgyz government, village health committees, district-level health centers, and other nutrition stakeholders to improve the nutritional status of women of reproductive age and children under 5 years old by providing counseling services to strengthen positive nutrition knowledge, attitudes, and practices.

Program outcomes:

- After receiving training, healthcare workers and volunteers delivered counseling services on anemia, nutrition, and maternal health:
  - Healthcare Workers: 379 healthcare workers conducted ~10,000 consultations in Q1 of 2021.
  - Volunteers: 2,315 trained community volunteers delivered counseling to over 52,000 community members over 2 years.
- Detailed manuals on how to instruct healthcare worker and volunteers to deliver nutrition counseling were developed by USAID for the trainings.

Takeaways:

- Both healthcare workers and volunteers demonstrated a willingness and ability to be trained and to provide counseling services, which may serve as a positive indicator for future programs.
- USAID has training materials on counseling services, which may be re- purposed in the future.

INNOVATION LAB FOR NUTRITION (MALAWI)

USAID collaborated with the Malawi government, Lilongwe University, and Tufts University to develop a postgraduate dietetics degree program. Follow establishment of the degree program, USAID continued working with the Malawi government to employ graduated dietitians to provide counseling in both public and private healthcare facilities.

Program outcomes:

- USAID supported the Malawi government to establish 27 dietitian positions offering counseling services across tertiary hospitals in Malawi.
  - For example, Kamuzu Central Hospital is an 800-bed, tertiary referral hospital that hired 4 dieticians to improve the quality of their clinical services.

Takeaways:

- Hospitals may have incentives to employ nutrition counselors to improve quality of care delivered to patients and to reduce future healthcare costs.
- Universities may be a good mechanism for training the private sector on counseling

Overall Takeaway

Existing USAID programs may be a strong source for operational learnings and further investigation of these models may yield additional insights.

HEALTH WORKER IN-SERVICE TRAINING

EXECUTIVE SUMMARY

CONTEXT

Lack of quality, trained healthcare workers on BF, CF, and NS topics are a major driver of poor nutrition outcomes. In-service trainings may offer a unique opportunity to train healthcare providers to deliver improved nutrition-related care.

DESCRIPTION

A training organization (e.g., a specialized training institution or a training service of a health provider) may administer approved, in-service trainings on positive BF, NS, and CF behaviors to healthcare providers to improve quality of care.

- The training organization may provide in-service trainings for healthcare providers and charge providers for their services. Nutrition trainings may be provided individually or integrated into a broader, bundled training curriculum.
- For rural and under-resourced providers, non-profit/donor subsidization may be necessary to cover costs (e.g., cost of training, transportation).

Multiple learning mediums are possible, and the training organization will need to identify the most context-appropriate medium(s):

- In-person synchronous trainings – likely most engaging and effective for trainees, but more costly and limited in scale
- Virtual synchronous – likely still engaging for trainees and easier to scale, but technology barriers may limit reach
- Digital asynchronous – likely easiest to scale, but may be less engaging and technology barriers may limit reach

There are two approaches the training organization may take to deliver trainings:

- Directly deliver trainings to healthcare providers – likely helps maintain consistent training quality but may be limited in reach
- Utilize a "train the trainer" model and train some healthcare providers on how to train other providers – likely enables greater reach and may cause inconsistent quality

PRIVATE SECTOR MECHANISM

In-service training can be profitable if the training organization (a public, non-profit, academic, or private organization – e.g., an in-service vocational training social enterprise) is sufficiently paid by public and private healthcare providers (hospital systems and individual providers) to administer trainings. Private healthcare providers may be willing and able to pay for trainings if there is strong evidence that they improve patient care quality and employee productivity. Rural or under-resourced providers that have trouble accessing services may require non-profit/donor subsidization.

HEALTH WORKER IN-SERVICE TRAINING OVERVIEW

A training organization may train public and private healthcare providers on best practices for breastfeeding, complementary feeding, and nutrition supplementation to improve the quality of care that healthcare providers deliver to patients.

1. BUSINESS MODEL

To be sustainable, public and private healthcare providers may need to be willing & able to pay the training organizations to provide in- service training.

As a result, providers affiliated with larger healthcare systems that can absorb additional costs and providers in urban areas may be more profitable; non-profit/donor subsidization may be necessary to reach independent healthcare providers and providers working in rural areas.

Opportunities for standardization (that balance local needs) can provide an option for efficient scale- up that improves the business model.

2. RISK AND MITIGATION CONSIDERATIONS

Potential risks include:

- Inequitable impact for smaller providers that cannot afford training
- Inequitable impact for remote and rural poor populations
- Poor or inconsistent quality trainings
- Conflict of interest of training organization

Mitigation strategies that can minimize the likelihood and impact of these risks are outlined in the document.

3. KEY ENABLERS

A few of the main enabling factors that may support implementation are:

- Healthcare provider (healthcare systems and individual providers) willingness to pay for training services
- Training accreditation required to work in maternal or child health and/or partake in other donor-funded programs (e.g., counseling services)
- Provider access to adequate technology and transportation needed to receive trainings

4. WHERE MIGHT USAID SUPPORT

USAID may provide support to:

1. Identify training organization partner(s) to design the program
2. Help local agency explore training accreditation/ certification options (e.g., with the Ministry of Health)
3. Implement program and advocate for the expansion of the business model across geographies
4. Support scaling the provision of trainings across geographies

1. BUSINESS MODEL

A training organization may be a public, non-profit, academic, or private organization; private healthcare providers may pay for the training service to improve patient care quality and employee productivity.

TARGET CUSTOMERS/BENEFICIARY

Healthcare workers and the patients they serve

Pain points addressed

- Lack of quality training for healthcare workers
- Lack of quality staff support to mothers on breastfeeding during pregnancy touchpoints and birth
- Trained healthcare workers are scarce

SERVICES PROVIDED

Healthcare worker trainings that improve delivery of counseling and care related to breastfeeding, complementary feeding, and/or nutrition supplementation to mothers and children <5; nutrition trainings may be provided individually or integrated into a broader, bundled training curriculum.

KEY DESIGN CHOICES

- What is the approach to scale trainings? (e.g., does the training organization exclusively conduct trainings, or do they teach others, such as private providers, how to train?)
- How are trainings provided? (e.g., digitally, in-person, hybrid)

KEY PARTICIPANTS

TRAINING ORGANIZATION*

Role: Trainer

- Provide trainings to healthcare workers across multiple providers

Incentive:

- Direct financial: Increase revenue
- Indirect: Organizational/ institutional recognition

PUBLIC AND PRIVATE HEALTHCARE PROVIDERS

Including hospital systems & individual providers

Role:

- Receive training for staff
- May fund and host training on-site

Incentive:

- Indirect financial:
  - Increase service provision and quality
  - Increase employee productivity and satisfaction
- Indirect: Brand recognition

* Could be a public, non-profit, or academic organization, or a private healthcare provider or in-service vocational training organization

PUBLIC AND PRIVATE HEALTHCARE PROVIDERS

Role: Funder

- Subsidize services for less profitable populations (e.g., smaller or rural providers)

Incentive:

- Direct: Mission

WHAT IS THE APPROACH TO SCALE TRAININGS?

DIRECT TRAINING

Training organization may provide trainings directly to healthcare providers (e.g., through on-site training or digital/virtual)

Potential benefits:

- **More standardized trainings:** a single organization providing trainings is more likely to provide consistent training quality and to be held accountable for quality

Potential challenges:

- **Smaller catchment area:** it may be logistically challenging for a single organization to reach all interested healthcare providers across geographies

"TRAIN THE TRAINER" HUB AND SPOKE MODEL

A training organization may train a group of healthcare providers on how to train other healthcare providers (in addition to the actual in- service training)

Potential benefits:

- **Broader reach and faster dissemination:** training local providers to be trainers may facilitate greater access to trainings for more remote providers, and may enable a greater volume of providers to be trained at once
- **Tailored trainings:** local trainers may be better able to customize the curriculum to the local context
- **Continuous learning:** local trainers may also be able to reinforce learnings for trainees on the job

Potential challenges:

- **Inconsistent training quality:** "train the trainer" model may result in inconsistent training quality at the local level
- **Potential conflict of interest:** a local healthcare provider delivering trainings may face difficulty convincing competitors (other providers) to be trained by them or may be reluctant to provide the training

Implications

A direct training model may maintain consistent training quality but be limited in reach.

HOW ARE TRAININGS PROVIDED?

IN-PERSON SYNCHRONOUS[*] TRAININGS

Trainees will be taught by live instructors in-person

Potential benefits:

- **Physical observation and feedback:** observing and providing feedback on techniques related to feeding may be more effective (e.g., demonstrating appropriate latching techniques) and trainees may be overall more engaged in-person
- **Less technology barriers:** communities without access to technology may have greater access to in- person trainings (assuming travel is subsidized)

Potential challenges:

- **More costly:** scaling in-person trainings may be more expensive given greater travel and personnel costs and limited potential class sizes
- **Inequitable access:** trainees in rural, remote communities may have less access to in-person trainings

VIRTUAL SYNCHRONOUS[*] TRAININGS

Trainees will be taught by live instructors virtually (e.g., through videoconferencing)

Potential benefits:

- **Real-time feedback:** trainees may be able to ask questions and receive answers live
- **Less costly:** virtual trainings may be less expensive than providing trainings in-person (as traveling costs may be much lower and class sizes may be larger)

Potential challenges:

- **Greater technology barrier:** trainees may require higher internet bandwidth and other necessary technology to access virtual trainings

DIGITAL ASYNCHRONOUS[†] TRAININGS

Trainees may be able to complete educational modules on their own schedule

Potential benefits:

- **More efficient expansion:** digital asynchronous training may allow for more rapid distribution of trainings for communities with technology access and may enable more trainees to be trained at once
- **Less costly**: after the initial cost of creating the digital training platform, distributing digital trainings may be less expensive than providing trainings in- person (as traveling costs and personnel costs may be much lower)

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[*] Synchronous trainings enable trainees to engage with training materials at the same time as their peers; they are guided by live instructors (either in-person or virtually)

[†] Asynchronous trainings enable trainees to learn on their own schedule as they can access training materials at any time; they do not require a live instructor

Potential challenges:

- **Greater technology barrier:** trainees may require necessary technology to access digital trainings (e.g., rural, lower-income communities)
- **Limited feedback:** asynchronous, digital trainings may prevent trainees from receiving helpful, timely feedback and may be less engaging than live instruction

Implications

In-person synchronous training may be more engaging but is more resource-intensive and harder to scale.

Virtual and digital training may be less expensive and enable greater reach, but technology barriers may limit access.

Hybrid models may be more engaging and enable broader reach; regardless of what model is chosen, trainers may want to explore how novel digital approaches can be leveraged in training.

2. RISK AND MITIGATION CONSIDERATIONS

Potential risk	Potential likelihood	Potential impact	Potential mitigation
Inequitable impact for rural, remote healthcare providers: trainings may be more likely to target providers in high-density urban areas, limiting access for rural providers	50%	50%	• Provide subsidies for rural and remote providers to travel to training locations • Consider employing “hub and spoke” model and train a few rural providers to provide trainings in remote areas
Inequitable impact for healthcare providers who are unable to afford training: under-resourced and independent healthcare providers may have less ability to pay for trainings or to take time off work	75%	50%	• Provide subsidies to cover the cost of training for healthcare providers who are otherwise unable to afford them and/or to opportunity cover the cost of their time
Poor or inconsistent quality trainings: trainers may deliver low-quality, inappropriate, or inconsistent training content rural), who may be harder to reach and have less ability to pay.	25%	75%	• Ensure training material alignment with approved medical society best practice and all trainers are well-qualified to deliver trainings • Collect anonymous evaluations of trainers from healthcare providers following sessions • Design program with quality assurance mechanisms that monitor quality of trainings and flag issues • Ensure breastmilk substitute companies are not funding training programs and partner organizations

Potential risk	Potential likelihood	Potential impact	Potential mitigation
Real or perceived conflict of interest: if private sector institutions (especially providers of nutrition- or food-related products) fund or directly provide trainings, there may be a (real or perceived) conflict of interest around their intentions	75%	50%	• Work only with training providers (and funders) that would avoid these conflict challenges (e.g., training institutions or training arms of health providers)

3. KEY ENABLERS

Key enabler	Supply Side	Demand side
Economic	Willingness for trained healthcare provider to provide training to competitors (e.g., other providers)	Healthcare provider (healthcare systems and individual providers) willingness to pay for training (e.g., existing demand for in-service trainings, perceived value of training, belief that training will improve overall quality of care) Training accreditation required to take part in other donor-funded programs (e.g., counseling services program) (Enablers with implications for USAID next) Sufficient market size and population density of providers (especially in urban settings, which may be more profitable)
Infrastructure & Capabilities	Capabilities of training organization (e.g., ability to identify qualified trainers; ability to identify space in a community center or health center to host training sessions)	Provider access to adequate technology needed to receive training (e.g., connectivity to engage in digital trainings) Transportation infrastructure for providers to access in-person trainings (e.g., reliable roads; minimal traffic; public transit; ride-sharing services) (Enablers with implications for USAID next)
Behavioral	Ability of training organization to deliver trainings that are adapted to local contexts in which the trainings are provided	Positive healthcare provider attitudes (e.g., openness to being trained, desire to learn, openness to learning online) Trust for training organization and trainers Calls for better-trained providers (e.g., complaints by patients about lack of provider knowledge, growing demand for providers to have capabilities for new services)
Regulatory	N/A	Training accreditation required for healthcare providers working in maternal or child health (Enablers with implications for USAID next)

4. WHERE MIGHT USAID HAVE IMPACT

Phase 1

Identify training organization partner(s) to design the program

POTENTIAL USAID INVOLVEMENT

Identify relevant training organization(s) with strong capabilities in health worker in-service trainings to design the training program

Fund training partner(s) to design the health worker in-service training program, including determining the most appropriate learning methodology (e.g., in-person, virtual, hybrid) for target populations, building the delivery strategy ("train the trainer" or direct training model), and assessing if trainings should be delivered individually or integrated into a broader training curriculum

TIMELINE

Short-term: ~<6months to identify organization and determine training strategy

Phase 2

Help local agency explore training accreditation/ certification options

POTENTIAL USAID INVOLVEMENT

Support a local agency in exploring training accreditation/certification options for healthcare providers working in maternal and child health (e.g., explore supporting medical associations or local government agencies, like the Ministry of Health, in making the training part of the process to renew licenses or to be certified to provide services)

TIMELINE

Short-term (as Phase 1 is being completed): **~1-2 year** to explore accreditation options

Phase 3

Implement program and advocate for the expansion of the business model across geographies

HYPOTHETICAL USAID INVOLVEMENT

Support training organization in implementing the training program and provide subsidization for under-resourced healthcare providers

Fund evidence-based monitoring and evaluation of nutritional and business impact to build the business case for future programs and to improve program design (e.g., investigate improvements in quality of care; measure costs of care for cohorts of patients before and after training intervention)

Share evidence-based learnings and proof of business model from monitoring and evaluation efforts to crowd-in additional healthcare providers interested in trainings

TIMELINE

Short-term (after Phase 1 is completed): **~2-3 years** to implement program and share evaluation data

Phase 4

Support scaling the provision of trainings across geographies

POTENTIAL USAID INVOLVEMENT

Support efforts to scale training programs created with implementing partners across existing networks and to new geographies

Crowd-in public and non-profit/donor funding resources to support further efforts that may have significant impact (e.g., trainings and transportation for under-resourced healthcare providers)

TIMELINE

Medium-term (after Phase 4 is completed): **3+ years** to scale trainings across geographies

For discussion:

- Are there any other teams at USAID or external organizations doing adjacent work that we might partner with to fund or implement?
- What would USAID want to test during the pilot stage? (e.g., business model, marketing approaches)

Potential integration opportunities with other work:

- Advancing Nutrition: Handbooks on training health workers/ volunteers on nutrition (USAID work)
- Jacaranda Health (EmONC Mentorship Program)
- Helping Babies Breathe (USAID work)
- Existing vocational training organizations (e.g., Tech Mahindra Foundation, Labornet Private Limited)

IMPACT AND FEASIBILITY ASSESSMENTS FOR ALL MODALITIES

RUBRIC USED FOR SCORING MODALITIES

IMPACT

Degree of impact is defined as the degree the modality addresses major barriers to nutrition interventions.

Level of confidence is driven by maturity of the evidence base

DEGREE OF IMPACT ON NUTRITION INTERVENTIONS

Score	Description
3	**Strong impact on nutrition interventions:** (e.g., breastfeeding, complementary feeding, nutrient supplementation) **for under-resourced populations** (e.g., rural communities, informal economy)
2	Strong impact on nutritional interventions for well- resourced populations, or some impact on nutritional interventions for under-resourced populations
1	Weak impact on nutrition interventions

LEVEL OF CONFIDENCE IN SCORE

Score	Description
3	Strong and translatable experimental/ longitudinal study across multiple low- and middle-income country contexts
2	Strong experimental/longitudinal study in high-income country contexts
1	Emerging anecdotal evidence or limited qualitative, correlational data, or strong health-related proxy evidence
N/A	No existing robust evidence base, or weak proxy evidence

Compelling modalities that are yet to be tested broadly in practice (i.e., with low confidence scores) were considered

FEASIBILITY

ATTRACTIVENESS OF BUSINESS MODEL

Score	Description
3	Strong, sustainable business case with clear, **well-defined financial incentives**
2	Significant non-financial incentives and/or potential, less- defined financial incentives
1	Business case with no clear, substantial incentives

DIFFERENTIATED CAPABILITY, EXPERTISE, OR ASSETS

Score	Description
3	**Private sector action required** to provide a differentiated capability, expertise, or asset (e.g., IP, private data, etc.)
2	Private sector action helpful but not critical; some public/social sector capabilities in place today (e.g., at lower efficiency)
1	Private sector action does not provide a differentiated capability, expertise, or asset

EASE OF IMPLEMENTATION AND SCALE

Score	Description
3	**Limited partners** required to achieve impact, **clear opportunities to scale**, and straightforward logistical set up
2	Multiple partners required to achieve scale and somewhat complex set up required
1	Many highly fragmented partners required with limited opportunities to scale and complex set up required

Compelling modalities that score high on some feasibility metrics but low on others were considered, as these levers can compensate for one another

DETAILED IMPACT ASSESSMENTS

ADVOCACY FOR PRIVATE SECTOR PRACTICES

Private sector engagement modalities evaluated against degree of impact and strength of evidence base

EMPLOYER POLICIES

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
1. Parental leave: Provide maternity and paternity leave and flexible options (e.g., part time or remote work options)	2	3

SUMMARY

Maternity and paternity leave policies may have a strong impact on nutrition interventions for resourced populations that are working in the formal economy (e.g., part-time or full-time workers in farms, factories, etc.).

Robust evidence that maternity and paternity leave improves breastfeeding outcomes in LMIC settings.

- Across 20 LMICs, a longitudinal trial identified that every additional month of paid maternity was associated with 7.9 fewer infant deaths per 1,000 live births, a 13% relative reduction.[1]
- Across 38 LMICs, a 1-month increase in duration of paid maternity leave was associated with 7.4% increase in prevalence of early initiation of BF, 5.9% increase in exclusive BF, and 2.2 month increase in BF duration.[2]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
2. Workplace breastfeeding: Provide lactation rooms and breastfeeding breaks at work	2	3

SUMMARY

Lactation rooms and breaks may have a strong impact on nutrition interventions for resourced populations that are working in the formal economy in structured, physical workplace environments.

Robust evidence that workplace lactation supports improve breastfeeding outcomes in LIMC settings.

- Across high-, middle-, and low-income country settings, a systematic review of workplace lactation support services suggested these supports increase rates of BF initiation, duration, and exclusivity amongst working mothers.[3]
- In Kenya, implementation of BF rooms and breaks on an agricultural farm was associated with 4x increase in prevalence of exclusive BF amongst mothers.[4]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
3. Workplace childcare: Provide/support in- office childcare	2	1

SUMMARY

In-office childcare may have a strong impact on nutrition interventions for resourced populations that are working in the formal economy in structured, physical workplace environments.

Limited qualitative evidence that onsite childcare improves breastfeeding outcomes in high-income country (HIC) settings, however further investigation into LMIC settings is necessary.

- In the U.S., when childcare was located on site, women were more successful at continuing to breastfeed after work.[5]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
4. Subsidized nutritional products: Provide subsidies or partner to provide preferred rates for employees for childcare, healthcare, BF equipment, counseling, diet diversity support, etc.	2	2

SUMMARY

Provisions or subsidies for BF equipment, childcare, diet diversity support, and other products and services may have a strong impact on nutrition interventions for resourced populations that are working in the formal economy (e.g., part-time or full-time workers in farms, factories, etc.).

Robust evidence that employer provision of lactation support improves breastfeeding outcomes in HIC settings and limited evidence that employer-provided nutritional supplements improved health outcomes in LMIC settings.

- In the U.S, women with access to breast pumps, professional lactation support, and time to express milk had longer durations of BF than the average working woman (57.8% vs 36.2% at 6 months).[6]
- In Bangladesh, a pilot program that provided fortified meals and iron-folic acid supplements decreased the prevalence of anemia in female factory workers.[7]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
5. Workplace-provided counseling: Sponsor counseling services or health messaging apps for direct employees or cooperative members	2	1

SUMMARY

Counseling or health messaging for employees may have a strong impact on nutrition interventions for resourced populations that are working in the formal economy (e.g., part-time or full-time workers in farms, factories, etc.).

Counseling or health messaging for employees may have a strong impact on nutrition interventions for resourced populations that are working in the formal economy (e.g., part-time or full-time workers in farms, factories, etc.).

Emerging anecdotal evidence that employer-sponsored counseling services improve breastfeeding outcomes.

- In Kenya, at the Kericho Tea plantation, mothers that reported they received work-sponsored counseling services were associated with having improved breastfeeding knowledge and skills.[8]

ADHERENCE TO PUBLIC POLICIES

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
6. Organizational policy adherence: Adhere to existing international and national policies, including the International Code of Marketing of Breastmilk Substitutes (ICBMS)	3	3

SUMMARY

Adherence to the ICMBS may have a strong impact on nutrition interventions for under-resourced populations by preventing commercial milk manufacturers from illegally influencing formula purchasing and distribution behaviors for urban and rural poor populations.

Strong evidence in Kenya and correlational evidence globally that regulatory action may incentivize the private sector to adhere to public policy and, in turn, improve breastfeeding outcomes.

- In Kenya, implementation and adherence to the free maternity service policy was associated with 89%, 97%, and 98% increases in prenatal care visits, health facility deliveries, and live births, respectively.[9]
- In Vietnam, the government adopted part of the ICMBS code into law in 2006. In 2014, the government passed additional legislation to limit advertising and stipulating proper labeling. Between 2006 and 2014, the rate of exclusive BF increased from 16.9% to 24.3%.[10]
- An international literature review identified that inappropriate marketing is widespread and the research team recommends that stricter regulatory frameworks and compliance enforcement are needed to counter the impacts of global formula marketing.[11]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
7. Healthcare worker policy adherence: Require healthcare professionals working in health facilities to pledge to not inappropriately market formula in their offices & to counter misconceptions about infant and young child feeding behaviors	**1**	**N/A**

SUMMARY

Requiring healthcare workers to take a pledge may have very weak impact on nutrition interventions given limited accountability and enforceability mechanisms.

Weak proxy evidence that pledges can influence the behavior of healthcare workers to improve health service delivery outcomes, but further investigation into their ability to influence nutritional outcomes is necessary.

- In Bihar, India, a motivational pledge (amongst other interventions) with the goal to improve health worker motivation and performance was associated with improved teamwork and equitable service delivery.[12]

LOBBYING FOR POLICY CHANGES

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
8. Campaigns opposing unethical advertising: Join/support campaigns calling out organizations conducting illegal or misleading advertising or formula messaging	**2**	**1**

SUMMARY

Media campaigns may have some impact on nutrition interventions for under-resourced populations if the external pressure prompts direct legal or corporate-behavior action against illegal advertising and messaging for urban and rural poor populations.

Strong health related proxy evidence that advocacy campaigns positively influence nutritional outcomes but further investigation into their direct impact is necessary. Non-health proxy evidence that media campaigns can influence political behavior in HIC settings.

- In Southeast Asia, a contribution analysis study demonstrated the contribution of advocacy efforts carried out by Alive & Thrive (and partners) in improving infant and young child feeding policies.[13]
- In the U.S., a randomized control trial found when political mobilization messages were delivered to 61 million Facebook users, the messages directly influenced real world voting behaviors, and the effect of social transmission was greater than the direct effect of messages themselves.[14]

Modality	**Degree of impact on nutrition interventions**	**Level of confidence in impact score**
9. Advocate for nutrition labeling: Add nutrition labeling to baby foods being sold (which sets an example and applies pressure on other companies to follow)	1	1

SUMMARY

Adding labeling to baby foods may have very weak impact on nutrition interventions given limited consumer knowledge and may have no impact on nutrition interventions for illiterate populations.

Strong health related proxy evidence that advocacy campaigns positively influence nutritional outcomes but further investigation into their direct impact is necessary.

- In the U.S., a review found that warning labels (high sugar, fat, etc.) were the most successful front of package label strategy to help shoppers identify what foods were healthy vs. not healthy.[15]

BEHAVIOR CHANGE

TECH-ENABLED HEALTH MESSAGING

Modality	**Degree of impact on nutrition interventions**	**Level of confidence in impact score**
10. Health messaging service: Build/support health information messaging service (e.g., share regular, tailored nutrition text reminders; build health app to include nutrition information messages)	3	3

SUMMARY

Health information messaging may have (an increasingly) strong impact on nutrition interventions for under-resourced population due to increasing access to SMS technology in both urban and rural poor populations.

Robust data across LMICs that health information messaging has impact on nutrition interventions.

- In Kenya, weekly SMS messages, including educational and motivational content covering antenatal care and infant health, yielded higher postpartum exclusive breastfeeding rates (~73%) compared to controls (~57%).[16]
- Text messaging between pregnant Kenyan mothers and a breastfeeding counselor providing breastfeeding education encouraged mothers to contact counselors more quickly after giving birth.[17]
- In Kenya, cell phone-based counselling approaches can be at least as effective in supporting exclusive breastfeeding as peer support groups and facility-based approaches.[18]
- In Iran, SMS text messages to pregnant women yielded higher rates of iron supplement compliance compared to the control group (94% vs 66%).[19]
- In Australia, weekly automated text messaging on breastfeeding for postpartum women improved the duration of exclusive breastfeeding compared to controls.[20]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
11. Educational game: Build/support educational game (e.g., where a player has to make health decisions while pregnant and raising a child)	1	1

SUMMARY

Educational games may have weak impact on nutrition interventions given their dubious effectiveness in influencing long-term behaviors.

Anecdotal evidence that educational games can improve nutritional outcomes. More rigorous research is necessary to determine if games may improve nutritional outcomes.

- One study in the United States suggests building an online antenatal BF education game is feasible but the study yielded no significant differences in breastfeeding self-efficacy and intention between the intervention group and control.[22]
- In Nepal, mothers experienced statistically significant knowledge gains in maternal and neonatal health after utilizing a mobile educational game.[23]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
12. Health video library for patients: Build/ sponsor health video library reference app (with videos answering questions about BF, CF, and NS)	2	N/A

SUMMARY

A health video library reference app may have some impact on nutritional health interventions for under-resourced populations where urban and rural poor populations have adequate access to mobile technology and connectivity that can support videos.

Weak anecdotal health-related proxy evidence that video libraries can positively influence healthy behaviors in HIC settings, however further research is necessary to determine if a health video library may improve nutritional outcomes in LMICs.

- In the United States, an initiative had health practitioners role model best practices to deliver evidence-based healthcare through live action videos for other practitioners. Participants reported the videos provided valuable feedback and stimulated self-directed learning.[6]

TRADITIONAL MEDIA (TV, RADIO, MOVIES)

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
13. Traditional media: Develop/support content for TV shows, movies, radio programs, books, magazines, newspapers, art displays, or posters promoting BF, CF or NS (e.g., create a show, write/publish baby books)	3	2

SUMMARY

Traditional media may have a strong impact on nutrition interventions for under-resourced populations because it can easily penetrate urban and rural poor populations and is widely accessible.

Strong correlational data across several LMICs that people who watch traditional media sources delivering educational message are more likely to engage in healthy behaviors. However, strong evidence does not exist on whether traditional media directly motivates those behaviors.

- In Nepal, mothers who met minimum dietary diversity for their children age 6 months to 5 years were 1.5 times as likely to have listened to the USAID-supported radio show Bhanchhin Aama.[24]
- In South Africa, an analysis of a population who viewed Scandal, a television soap opera designed to delivery financial education, found that those who watched the show had significantly higher financial knowledge of issues highlighted in the soap opera story line.[25]
- Across India's 100 poorest districts, the rate of early initiation of breastfeeding increased from 20% in 2007 to 37% in 2011. Aguayo, et al suggest that strategic mass media communication, alongside other strategies, may have contributed to this increase.[26]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
14. Nutrition demonstrations: Host nutrition demonstrations in stores or at events	2	N/A

SUMMARY

Hosting nutrition demonstrations may have some impact on nutrition interventions for those who attend them, but they are limited in reach and unlikely to have impact on under-resourced populations in rural communities.

Weak proxy evidence that a nutrition demonstration in a store or event can improve health outcomes.

- In a high-income setting, when subjects were offered an average of four healthier food alternatives to four categories of food they chose, on average subjects swapped out one food product. This suggests that there may be some consumer openness to buying healthier food choices when presented with new products but there is still very limited evidence of effectiveness.[27]

EMPLOYEE EDUCATION

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
15. Employee education: Build/support educational game (e.g., where a player has to make health decisions while pregnant and raising a child)	1	1

SUMMARY

Employee education may have very weak impact on nutrition interventions given their limited scope and likelihood to influence long-term nutrition behaviors. Limited impact would be for resourced populations that are working in the formal economy (e.g., part-time or full-time workers in farms, factories, etc.).

Strong health-related proxy evidence across HICs and LMICs that education provided in the workplace may improve nutritional and health outcomes of employees, however further research on pre- and post-natal mothers in LMIC settings is necessary to solidify potential impact on nutrition interventions in these environments.

- In Kenya, Tanzania, and India, female supply chain workers in tea farming communities were selected and trained to deliver behavior change messages on healthy diets within their communities. This was associated with an improvement in female worker's dietary diversity.[29]
- In Iran, a randomized control trial was performed to provide petrochemical workers with educational on healthy nutrition over 3 months. This was associated with significant improvements in nutritional knowledge, dietary intake and fasting blood sugar.[28]
- In the U.S, a controlled longitudinal trial revealed that placement of informational nutrition sheets near food products in a company canteen was effective in significantly changing behavioral determinants towards eating less fat.[30]

VIRTUAL COMMUNICATIONS AND NETWORKING

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
16. Virtual communities: Create/support virtual communities that connect mothers with shared experiences (e.g., social networking service, email or messaging chains)	3	3

SUMMARY

Virtual communities may have a strong impact on nutrition interventions for under-resourced populations due to increasing access of phones, SMS technology, and connectivity in urban and rural poor populations.

Robust evidence that virtual communities may have impact on improving breastfeeding outcomes for mothers.

- In Nigeria, a randomized control trial revealed that women who formed cell phone groups (voice and text messages) were more likely to have exclusively breast fed (Odds Ratio=5.6) compared to the control group.[32]
- In the U.K., 65% of breastfeeding mothers who engaged in an online breastfeeding social support group cited that the primary reason for using the group was "informational support."[33]
- In the U.S., amongst African American mothers who participated in BF support groups on Facebook, a cross-sectional study identified these groups may positively influence BF norms and extend BF duration.[34]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
17. Webinars: Host/sponsor virtual webinars on positive nutrition behaviors	2	1

SUMMARY

Webinars may have a strong impact on nutrition interventions in resourced populations where there is strong access to video- conferencing materials and connectivity that can support video streaming. They are less likely to have impact on under-resourced rural populations with more limited connectivity.

Strong health-related proxy evidence that virtual webinars can influence positive behaviors in LMICs.

- In Kosovo, weekly webinars were thought to have been a helpful tool to train ~1000 volunteers and mental health professionals providing psychosocial services.[35]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
18. Social media influencers: Sponsor social media influencers posting photos and videos (e.g., moms sharing personal challenges; tips on how to BF or CF and what products to use; importance of pre- and post-natal nutrition iron/folate supplementation	**2**	**1**

SUMMARY

Social media influencers may have strong impact on nutrition interventions in resourced populations where there is strong access to connectivity that can support video streaming. They are less likely to have impact on under-resourced rural populations with more limited connectivity.

Strong health-related proxy evidence suggests that sponsored social media influencers may positively influence health behaviors. However the evidence is mixed and further investigation on their impact on maternal and child outcomes in LMIC settings is necessary.

- In the Netherlands, an observational study found that when social media influencers establish a strong connection with their followers, this may lead to higher healthy food brand attitude and purchase intention. This suggests influencers can promote healthy foods as a public health measure.[36]
- In the U.K., a randomized control trial revealed that children who viewed influencers with unhealthy snacks had significantly increased intake of unhealthy snacks, however influencers with healthy snacks did not affect snack intake.[37]
- In the U.S., ecological studies show a correlation between social media HPV vaccine sentiment and state-level HPV coverage, suggesting social media messaging may influence health behaviors.[38]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
19. Sponsored social media posts: Sponsor posts that promote positive nutrition behaviors	**2**	**1**

SUMMARY

Sponsored posts may have very weak impact on nutrition interventions, particularly on under-resourced rural populations with more limited connectivity and illiterate populations.

No existing robust evidence base that sponsored posts may improve nutrition outcomes.

ENGAGEMENT OF COMMUNITY AND FAMILY INFLUENCERS

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
20. Caregiver support groups: Develop support groups for partners and other caregivers like grandmothers (e.g., on social media or in a physical space)	3	3
21. Family member trainings: Host/sponsor community discussions, trainings, or Q&A sessions with healthcare professionals for family members	3	3

SUMMARY

Partner support groups and community trainings may have a strong impact on nutrition interventions for under-resourced populations given the strong influence family members have on a mothers' decision-making and given their capability to reach both urban and rural poor populations in LMICs.

Robust data across several LMICs that partner and caregiver support and training can improve breastfeeding outcomes.

- In Vietnam, when fathers received BF education and counseling, their children were ~4x more likely to exclusively BF at 6 months.[40]
- In rural Vietnam, mothers were 3.52 times more likely to exclusively breastfeed when their grandmothers had a feeding preference for exclusive breast feeding.[41]
- In Senegal, when grandmothers received education to promote infant feeding practices, the percent of grandmothers who advised mothers to attempt breastfeeding during the 1st hour after birth doubled (46% to 98%) and the percent of grandmothers who advised mothers to breastfeed for 5 months more than tripled (26% to 94%).[42]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
22. Pledges: Create pledges by family members (e.g., new grandmothers' pledge to support mothers with BF, fathers' pledge to feed young children diverse foods)	2	1

SUMMARY

Pledges may have some impact on nutritional interventions for under-resourced populations because they can easily be distributed and taken across urban and rural poor settings, however the extent of their effectiveness is dubious without substantial accountability mechanisms.

Strong health-related proxy evidence that pledges, alongside other interventions, may be able to influence healthy behaviors. However, further research is necessary to isolate the impact of pledges and to investigate their specific impact on nutrition outcomes.

- In India, children (<5-13) who experienced community events, education, and a pledge, had 37% prevalence of handwashing with soap compared to 6% in the control group.[43]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
23. Breastfeeding dolls: Sell/support breastfeeding dolls in childcare centers	1	N/A

SUMMARY

Breastfeeding dolls may have weak impact on nutrition interventions given their dubious effectiveness in influencing long-term behaviors.

There is no robust evidence and further research is necessary to determine if breastfeeding dolls in childcare centers can improve breastfeeding outcomes.

- In the U.S., exposure to a professionally mediated peer support group for mothers for breastfeeding (including but not limited to dolls) was associated with longer duration of exclusive breastfeeding compared to control group.[44]

TOOLS TO TRACK IMPACT OF INITIATIVES, MOTHER SENTIMENT, ETC.

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
24. Mother and family behavioral survey: Build/sponsor tools that evaluate mother and family-member nutrition sentiment, know-how, and likelihood to engage in desired behaviors (e.g., sending out surveys or feedback forms, scraping social media)	1	1

SUMMARY

Tools to evaluate mother and family-member sentiment may have very weak impact on nutrition interventions given the challenges with translating data and information acquired into actionable initiatives. Information collected would also likely be disproportionately focused on urban populations that are easier to reach.

Correlational evidence that tools may effectively evaluate initiatives promoting nutrition intervention behaviors (and therefore may promote effective initiatives addressing the nutrition interventions).

- In Uganda, Living Goods performed a phone survey to find that those who used their program demonstrated a 13% improvement in breastfeeding knowledge compared to the control.[31]

SUPPLY CHAIN

PRIVATE DISTRIBUTORS TO HEALTH SYSTEM OUTLETS

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
25. Existing channels: Add new products to existing channels that currently do not support them to distribute more affordable, accessible, and effective products	3	3

SUMMARY

Engaging alternative channels may have a strong impact on nutrition interventions for under-resourced populations by increasing access to cost-effective products, particularly in rural communities.

Robust evidence that employing alternative channels to distribute more cost-effective products to women in LMIC settings can influence positive nutritional outcomes.

- In Malawi, a randomized control trial revealed that a more cost-effective and locally produced milk-free soya, maize, and sorghum ready-to-use therapeutic food (RUTF) was as efficacious in treating severe acute malnutrition in children 6-59 months as was standard peanut and milk RUTF.[45]
- In Bangladesh, a quasi-experimental study revealed that bundling fortified rice with iron-folic acid supplements for the lunches of female garment factory workers was associated with a reduction in anemia compared to control groups.[46]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
26. Direct selling systems: Distribute affordable and accessible BF, CF, and NS products through direct selling systems (e.g., independent or employed agents selling door-to-door)	2	3

SUMMARY

Distributing products through direct selling systems may have strong impact on nutritional interventions for resourced populations but limited impact on under-resourced populations given the challenges of door-to-door distribution and inventory management in rural communities.

Robust evidence that the practice of direct distribution of nutritional products or services can influence positive nutritional outcomes and strong health-related proxy evidence that improving efficiency of distribution can improve coverage of health products.

- In Uganda, a RCT found that Living Goods' door-to-door Community Health Promoters (who sell medicines, fortified foods, and supplements) program reduced under-5 child mortality by 27% compared to the comparison group.[47]
- Among several Sub-Saharan African villages, a microplanning model (a salesperson-based accessibility algorithm that determines the optimal door-to-door itinerary for a walking community health worker) was associated with up to a 63% improvement in seasonal malaria coverage and may have broader applicability to other community health programs.[48]

SERVICE DELIVERY

COUNSELING THROUGH PHARMACIES, HEALTH CENTERS, AND MOBILE COUNSELORS

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
27. Mobile counseling: Provide/sponsor home visits by mobile counselors	3	3

SUMMARY

Mobile counselor home visits may have a strong impact on nutrition interventions for under-resourced populations because they can deliver quality care across LMIC settings, including rural poor populations.

Robust evidence that the use of mobile counselors may positively influence maternal breastfeeding outcomes in LMICs.

- Across many LMICs, a systematic review revealed that mothers who receive home visits by community health workers have a higher likelihood to initiate early BF (Odds Ratio=1.8), breastfeed exclusively (Odds Ratio 3.33), and have children who are 7% less likely to be underweight compared to the control group.[49]
- In Thailand, mobile counselors who performed home-visits to deliver information about BF, CF, and food diversity drove a 23% increase in exclusive BF and a 85% increase in adequate dietary diversity.[50]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
28. Facility-based counseling: Provide/sponsor counseling services and post-natal care for pregnant/lactating women and families through private pharmacies and private health centers	2	3

SUMMARY

Counseling services delivered through private centers may have strong impact on nutritional interventions for resourced populations as centers are often located in urban (or adjacent) settings and may pose challenges to access for rural poor populations.

Robust evidence that delivering counseling services through private healthcare delivery institutions may positively influence nutrition outcomes.

- In Bangladesh, a longitudinal study found that mothers who received nutrition counseling during pre-natal visits had children who gained more weight and had a higher birthweight than the control group. 75.4% of mothers who received nutrition counseling-initiated BF within 1 hour of birth, compared to only 34.5% for the control group.[51]
- In the U.S., a public-private prenatal care model was implemented amongst a low-income population in Georgia and resulted in a “low birthweight rate” (% of births < 2500g) of 8.9%, which is 1.1% lower than the CDC reported rate in Georgia in 2019.[52]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
29. Group classes: Provide/sponsor group classes for mothers and families	3	2

SUMMARY

Group classes may have some impact on nutrition interventions in under-resourced populations because they can be implemented across urban and rural poor settings.

Robust evidence in HIC settings that group classes for mothers improve breastfeeding outcomes and strong health-related proxy evidence that they promote behaviors that indirectly influence infant health outcomes. However, further investigation of group classes in LMIC settings is important to understand direct impact on nutrition interventions.

- In the U.S., mothers who attended Baby Café (informational lactation support group), were found to have higher rates of exclusive BF and longer BF duration than national rates in the U.S.[53]
- In Kenya and Nigeria, a randomized control trial identified that group antenatal care (ANC) was associated with higher facility-based infant delivery rates, higher proportions of women receiving quality ANC, and higher frequency of ANC visits compared to women who receive individual ANC.[54]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
30. Remote health counseling app: Build/support remote health counseling app (e.g., telehealth app, chatbot, etc.)	2	2

SUMMARY

Telehealth counseling apps may have a strong impact on nutrition interventions in resourced populations where there is strong access to video-conferencing materials and connectively that can support video streaming. They are less likely to have impact on under-resourced rural populations with more limited connectivity.

Robust evidence in HIC settings that telehealth counseling and monitoring improve breastfeeding outcomes and strong health- related proxy evidence that they effectively promote better diabetes care. However, further investigation of telemedicine counseling in LMIC settings is important to understand direct impact on nutrition interventions.

- In the U.S., a randomized control trial suggested that using web-based monitoring system for breastfeeding was associated with higher rates of exclusive breastfeeding compared to the control group.[55]
- Across several LMICs, a review of several randomized control trials found that using telemedicine to deliver diabetes care was associated with lower serum glycated hemoglobin (HbA1c) levels, lower fasting blood sugar, and higher adherence to treatment.[56]

SALES THROUGH PHARMACIES AND POST-NATAL COUNSELORS

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
31. Product sales through pharmacies and counselors: Supporting BF, CF, and NS product sales through pharmacies and post-natal counselors (e.g., nutrient supplements, breast pumps, pasteurization kits, nipple covers, bras, pillows)	2	1

SUMMARY

Sales through private pharmacies and channels may have a strong impact on nutrition interventions for resourced populations as existing private pharmacies and channels are likely located in urban (or adjacent) settings and may pose challenges to access and cost for rural poor populations.

Strong health-related proxy evidence that utilizing private, drug-dispensing organizations to deliver products can promote positive health outcomes. However, further investigation of private distribution of BF, CF, or NS products through pharmacies is important to understand impact on nutrition interventions.

- In Tanzania, a pilot study identified that if private, accredited drug-dispensing organizations are trained on how to deliver rapid diagnostic malaria tests (RDT), then the parasite-based diagnosis rate increased from 19% to 74% compared to the control group, which improved from 3% to 18% over the same period.[57]

SUPPORT FOR BF IN PRIVATELY-OWNED PUBLIC SPACES

(e.g., lactation rooms in markets, religious centers, parks, community centers)

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
32. Public lactation rooms: Build/ support permanent and mobile lactation rooms in public spaces (e.g., markets, religious centers, parks, community centers)	2	1

SUMMARY

Building lactation rooms may have a strong impact on nutrition interventions for resourced populations in urban areas with heavy foot traffic.

Anecdotal evidence that building lactation rooms in public spaces in LMICs impacts health outcomes. Similarly, strong proxy evidence that building lactation rooms in workplace settings impacts health outcomes. Further investigation of the impact of building lactation rooms in public spaces is important understand impact on nutrition interventions.

- Robust data across HICs and LMICs that workplace lactation support services (especially providing a lactation space and providing breastfeeding breaks) increased rates of BF initiation, duration, and exclusivity among working mothers.[58]
- In China, in light of COVID-19 and other infectious disease, occupational research recommend that mothers do not breastfeed in public toilets and that “efforts should be put into improving the design of public lactation rooms” with adequate privacy and ventilation.[59]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
33. Lactation room locator app: Build/sponsor health app to locate public lactation rooms	1	1

SUMMARY

Lactation room apps may have very weak impact on nutrition interventions for resourced populations in urban areas given the apps' value is dependent on the presence of existing public lactation rooms.

Anecdotal evidence that developing an app to locate public lactation rooms impacts breastfeeding outcomes.

- In Thailand, an evaluation of the MoomMae app (designed to support breastfeeding women) found it encouraged BF on demand, supported the establishment of BF support groups, and raised public awareness about BF.[60]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
34. Nursing covers: Provide nursing covers in public spaces (e.g., markets, religious centers, parks, community centers)	1	N/A

SUMMARY

Sponsored nursing covers may have a very weak impact on nutrition interventions for resourced populations in urban areas with heavy foot traffic.

There is no robust evidence that sponsored nursing covers in public spaces have a positive impact on nutrition outcomes.

IN-SERVICE TRAINING/SKILL ENHANCEMENT

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
35. Health worker in-service training: Host/support focused trainings and capacity building for healthcare workers in pre-natal, post-natal, and early childhood interactions to provide information and counseling for pregnant, lactating, and other post-partum women and their families	3	3

SUMMARY

Health worker training may have strong impact on nutrition interventions for under-resourced populations where healthcare workers are able to reach urban and rural poor communities.

Robust data across LMICs that training healthcare workers on breastfeeding improves breastfeeding outcomes.

- In South Sudan, after healthcare workers completed the UNICEF/WHO Baby Friendly Hospital Initiative training, the prevalence of early initiation of BF increased from 48% to 91%, the colostrum (initial milk released) discard rate decreased from 8% to 3%, and pre-lacteal feeds (food given before breast milk arrives) decreased from 17% to 2%.[61]
- In Bihar India, the initiation of a 10-day training program on breastfeeding for healthcare workers was associated with mothers being significantly more likely to breastfeed early (78% vs 17%) and not use pre-lacteal feeds (58% vs 3%) compared to the control group.[62]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
36. Civil society organization training: Host/sponsor focused training for civil society organizations (e.g., women's groups) and volunteers to provide counselling and support to mothers and families	2	2

SUMMARY

Civil society organization training may have some impact on nutritional interventions for under-resourced populations where organizations and volunteers are able to reach urban and rural poor communities.

Robust data in Nigeria that training community volunteers to provide counseling to mothers may improve exclusive breastfeeding.

- In Nigeria, the rate of intention by mothers to exclusively BF increased from 30% to 60% after they were provided counseling by community female volunteers who were trained in nutrition, breastfeeding, and counseling.[63]

TOOLS TO TRACK SERVICE PROVISION QUALITY, QUANTITY, EFFECTIVENESS, ETC.

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
37. Service and product provision tracker: Develop health information management systems and health center accountability systems to track provision of services and products (e.g., Vitamin A supplements) to young children	2	1

SUMMARY

Developing health information management systems to track provision of services and products may have some impact on nutrition interventions for under-resourced rural population, where care delivery may be fragmented and harder to monitor. However, impact may be limited given challenges with translating data into actionable initiatives, and information collected would likely be disproportionately focused on urban populations that are easier to reach.

There is no robust evidence that health information management systems can positively impact nutrition outcomes. However, strong health-related proxy evidence suggests that tracking the provision of services and products through heath information management systems can positively impact health outcomes.

- In Zimbabwe, RapidPro, an open-source software that can collect nutrition data via SMS, was implemented into 655 health facilities and significantly reduced the frequency of reported stock-outs for ready to use therapeutic foods.[65]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
38. Provider survey: Build/sponsor tools that evaluate and share provider sentiment, know-how and likelihood to engage in desired behaviors	1	1

SUMMARY

Tools to evaluate provider sentiment or know-how may have very weak impact on nutrition interventions given the challenges with translating data and information acquired into actionable initiatives. Information collected would also likely be disproportionately focused on urban populations that are easier to reach.

There is no robust evidence that building tools to evaluate provider sentiment and know-how can positively impact nutrition outcomes. However, strong health-related proxy strategies employed to combat COVID-19 may provide promising new models.

- In the U.S., the US Pharmacopeia launched a survey to better understand the attitudes, beliefs, and practices of healthcare workers in LMICs around the COVID-19 vaccine, PPE, and treatments. Researchers say the survey will provide critical information that can be used to design further interventions to prevent and treat COVID-19 in LMICS.[67]

APPS FOR SERVICE PROVIDERS

(e.g., how-to guides, scheduling, patient data storage)

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
39. Remote patient monitoring and support: Build/sponsor patient eHealth management app (to enable patients to remotely share nutrition challenges and ask questions, and for providers/ counselors to monitor patients and provide support)	2	3

SUMMARY

eHealth management apps may have some impact on nutrition interventions for under-resourced populations due to increasing access to phones and connectivity in urban and rural poor populations. However, depending on the use cases of the app, they may be less likely to have impact on under-resourced rural populations with limited connectivity.

Robust evidence that electronic health management services can positively influence breastfeeding outcomes in LMICs.

- In Zanzibar, a RCT suggested that connecting pregnant mothers with mobile phone text-messages and vouchers with health education and routine prenatal care appointment reminders was associated with an increase in prenatal care attendance (Odds Ratio=2.39).[68]
- In Malaysia, telephone lactation counseling was effective in increasing the rate of exclusive BF amongst mothers for the first month postpartum.[69]
- In Australia, a RCT comparing face-to-face father breastfeeding classes to a breastfeeding app designed for fathers (Milk Man) found that there was no significant difference in breastfeeding self-efficacy in mothers.[70]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
40. Electronic health records: Build/sponsor nutrition health provider app (to capture and store patient data, schedule appointments, etc.)	2	1

SUMMARY

Nutrition health provider apps may have some impact on nutritional interventions for under-resourced populations due to increasing access to phones and connectivity in urban and rural poor populations. However, depending on the use cases of the app, they may be less likely to have impact on under-resourced rural populations with limited connectivity.

Limited qualitative data that electronic health management services can positively influence service provision in LMICs.

- In Thailand, an observational study showed that using mobile technology to generate prenatal care schedule dates that can be combined with healthcare facility records was associated with increased rate of on-time prenatal care visit.[71]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
41. Provider transportation: Support provider logistics for home visits by hosting service for providers in existing ride-sharing app (e.g., with preferred or monthly rates, regular scheduled rides and shorter wait times)	2	1

SUMMARY

Ride-share apps for providers may have some impact on nutrition interventions for under-resourced populations because they can help connect providers to deliver care to more rural populations. However, access may still be limited for very remote rural populations or for populations living in areas without an existing ride-sharing service.

There is no robust evidence that using ridesharing to support provider home-visits improves nutrition outcomes. However, strong health-related proxy evidence that transportation strategies for patients appear to improve maternal care.

- In rural Mali, a community cost-sharing maternity transportation system for basic and emergency maternal care decreased obstetric mortality rates ~50%.[72]
- In Uganda, travel vouchers were used to provide mothers with transportation to delivery facilities. This was associated with a 258% increase in number of deliveries that occurred in a healthcare facility.[73]
- In India, the introduction of a national ambulance service for mothers was associated with an increase in institutional infant deliveries and was found to have the largest impact in rural communitites.[74]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
42. Video reference library for providers: Build/sponsor health video library reference app (with videos to help providers diagnose and treat malnutrition and to help counselors provide BF support and engage family)	2	2

SUMMARY

A health video library reference app may have some effect on nutrition interventions for under-resourced populations if healthcare workers who deliver care in rural poor communities have adequate access to these resources (e.g., through pre-loaded phones with videos on them in areas with low connectivity where streaming video is not possible).

Robust evidence in HIC settings suggests that video-based teaching can help trainees learn medical skills as well as in-person trainings, however the application to nutrition outcomes in LIMCs has not been investigated.

- In the U.S., a RCT showed that a video-based ultrasound technique course for medical students was found to be equivalent in mean test scores compared to students who received in-person instruction.[75]
- In the U.S. tele-present supervision was as effective as in-person supervision in teaching medical students to perform tracheal intubation.[76]

Modality	Degree of impact on nutrition interventions	Level of confidence in impact score
43. Virtual provider community: Create/support virtual communities for counselors to connect and share nutrition counseling emerging practices	**2**	**1**

SUMMARY

Virtual communities for counselors may have some impact on nutrition interventions for under-resourced populations due to increasing access to phones, SMS technology, and connectivity in urban and rural poor populations.

There is no robust evidence that virtual counselor communities have an impact on improving nutrition outcomes in LMIC settings. However, strong health-related proxy evidence shows that promoting mobile communication between care providers can improve service provision.

- In Malawi, when community health workers were given cellphone to communicate with one another and other healthcare resources, the local hospital doubled the capacity of their tuberculosis treatment program.[77]

DETAILED FEASIBILITY ASSESSMENTS

ADVOCACY FOR PRIVATE SECTOR PRACTICES

Private sector engagement modalities evaluated against attractiveness of business model, capabilities, and ease of implementation and scale

EMPLOYER POLICIES

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
1. Parental leave: Provide maternity and paternity leave and flexible options (e.g., part time or remote work options)	2	2	1
2. Workplace breastfeeding: Provide lactation rooms and breastfeeding breaks at work	2	2	1
3. Workplace childcare: Provide/support in-office childcare	2	2	1
4. Subsidized nutritional products: Provide subsidies or partner to provide preferred rates for employees for childcare, healthcare, BF equipment, counseling, diet diversity support, etc.	2	2	1
5. Workplace-provided counseling: Sponsor counseling services or health messaging apps for direct employees or cooperative members	2	2	1

SUMMARY

Family-friendly policies (e.g., paid leave, flexible options, and childcare) enable firms to attract and retain talent (and avoid turnover costs, which average one-fifth an employee's salary). Workplace programs promoting BF, CF, and NS among employees (e.g., lactation rooms, childcare, counseling, subsidies) may mitigate lost productivity and absenteeism by decreasing absences associated with caring for a sick child, promoting earlier return from maternity leave, and increasing retention of female employees.

Public sector can pass legislation requiring maternity/paternity leave, lactation rooms/BF breaks, or childcare but reforms may take time and require an enabling political climate. Similarly, the public sector could provide direct subsidies and counseling services to constituents, but they would require significant public spending and strong political will. Thus, there is a unique role for private sector employers to play in providing services to employees.

Structuring an initiative around enacting employer policy changes would require interacting with and influencing many highly fragmented partners (employers) across industries and would provide limited opportunities to scale efficiently.

ADHERENCE TO PUBLIC POLICIES

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
6. Organizational policy adherence: Adhere to existing international and national policies, including the International Code of Marketing of Breastmilk Substitutes (ICBMS)	1	2	1

SUMMARY

Financial case unclear. A private commercial breastmilk substitute manufacturer may adhere to the Code to establish itself as an industry leader, attract positive media attention and brand recognition, and pressure other substitute manufacturers to follow suit. However, it is possible that by drawing attention to sudden adherence, a company may inevitably also draw unwanted attention to its prior lack of adherence. Additionally, there are substantial financial incentives for formula manufacturers to continue breaking the Code.

Public sector can pass legislation requiring adherence to the Code but reforms may take time and require an enabling political climate and strong enforcement mechanisms. Thus, there may be a unique role for breastmilk substitute companies to change their activity directly as they are the primary organizations that are not currently adhering the Code.

Structuring an initiative around adherence to the Code would require interacting with and influencing multiple partners (formula manufacturers) and would provide limited opportunities to succeed or scale without significant external media and regulatory pressure.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
7. Healthcare worker policy adherence: Require healthcare professionals working in health facilities to pledge to not inappropriately market formula in their offices & to counter misconceptions about infant and young child feeding behaviors	1	2	1

SUMMARY

Financial case unclear. Private health facilities may require providers take a pledge as a preventive health measure to improve the quality of their maternal and child care and as a way to build their external brand. However, without regulatory or media pressure, incentives are overall weak for health facilities to require their health professionals take a pledge or to monitor their behavior.

If public regulations and enforcement are not in place, private health facility activity may be required to mandate their employees adhere to the Code and counter bad behaviors. In public health systems, enforcement of the Code may be possible without private sector intervention.

Structuring an initiative around health facility pledges would require interacting with and influencing fragmented private health facilities and would provide limited opportunities to succeed or scale without significant external media and regulatory pressure.

LOBBYING FOR POLICY CHANGES

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
8. Campaigns opposing unethical advertising: Join/support campaigns calling out organizations conducting illegal or misleading advertising or formula messaging	2	1	1

SUMMARY

Financial case unclear. BF delivery tool product manufacturers (e.g. pump manufacturers) may be incentivized to join or support campaigns that "call out" formula manufacturers that are non-adherent to the Code to draw attention to the negative health outcomes of formula feeding and to convince more mothers to BF and purchase BF-related products, indirectly increasing demand. Alternatively, formula manufacturers who do adhere to the Code may be incentivized to join or support efforts to call out formula manufacturers who don't adhere to improve their competitive positioning and diminish their competitors' brands.

Private sector activity is not required to call out the private sector as public and social sector players could lead campaigns to do so.

Structuring an initiative around campaigns to call out illegal advertising would require interacting with and influencing multiple partners (formula manufacturers). However, success and scale is dependent on raising awareness and may prove difficult without significant external media and regulatory pressure.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
9. Advocate for nutrition labeling: Add nutrition labeling to baby foods being sold (which sets an example and applies pressure on other companies to follow)	1	2	1

SUMMARY

Baby food manufacturers may add nutrition labeling to their products to establish themselves as industry leaders, to attract positive media attention and brand recognition, and to pressure other baby food manufacturers to follow suit. However, it is possible that by adding labeling, a company may also draw unwanted attention from the media for the nutritional value of its products. Therefore, there may be substantial financial incentives for baby food manufacturers to keep nutrition labeling off their products, particularly if their products are not healthy.

Public sector can pass legislation requiring nutrition labeling on baby foods being sold but reforms may take time and require an enabling political climate and strong enforcement mechanisms. Thus, there may be a unique role for private sector manufacturers to change their activity directly and proactively add appropriate nutrition labeling to their products.

Structuring an initiative to add nutrition labeling to products may require interacting with and influencing multiple partners (formula manufacturers) in each geography to pressure other manufacturers to follow. However, success and scale is dependent on raising awareness and may prove difficult without significant external media and regulatory pressure.

BEHAVIOR CHANGE

TECH-ENABLED HEALTH MESSAGING

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
10. Health messaging service: Build/support health information messaging service (e.g., share regular, tailored nutrition text reminders; build health app to include nutrition information messages)	1	3	3

SUMMARY

Financial case unclear. Theoretically telecom companies may be financially incentivized to provide targeted nutrition messaging as a marketing tool to crowd in subscribers to use other services; but it is unlikely to lead to significant shifts in consumer behavior. Nonfinancial incentives for telecom companies may include engaging with customers to collect further insights and providing brand recognition.

Given their marketing capabilities and deep knowledge of mobile user behavior, private telecom providers may be best suited to develop compelling, targeted messages that resonates with different population segments and to deliver those messages through existing communications channels.

Existing health information services have straightforward structures requiring private players to create content and distribute it. Scaling to other geographies would likely require partnering with additional telecom providers.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
11. Educational game: Build/support educational game (e.g., where a player has to make health decisions while pregnant and raising a child)	1	3	2

SUMMARY

A game-developer may realize financial gain by selling a game on an app store or earn money though advertising revenues. However, sales are conditional on willingness/ability to pay and it seems unlikely there will be multiple individuals in LMIC contexts that may purchase the game.

Private sector game development companies may be required to design, build, test, and release a compelling game that resonates with target population segments as they have expertise in video game development, control major distribution channels, and have a deep knowledge of their consumers.

Developing a video game requires multiple players to design a game, build it, & distribute it. Scaling to mobile populations is straightforward on existing app stores.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
12. Health video library for patients: Build/sponsor health video library reference app (with videos answering questions about BF, CF, and NS)	2	2	2

SUMMARY

Private sector players could sell a health video library directly to employers, who could provide the service to cooperative members or employees as part of a broader employer-sponsored program. They could also sell it directly to mothers as an individual or bundled service to realize financial gain. However, sales are conditional on willingness/ability to pay.

Private sector players may be best suited to build and distribute a health video library reference app for providers as they may have greater capabilities and expertise in producing and distributing compelling content that is tailored to relevant population segments (e.g., mothers, fathers).

Developing a health video library requires multiple players to develop content, produce the videos, and distribute them. Scaling to mobile populations is straightforward on existing app stores.

TRADITIONAL MEDIA (TV, RADIO, MOVIES)

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
13. Traditional media: Develop/support content for TV shows, movies, radio programs, books, magazines, newspapers, art displays, or posters promoting BF, CF or NS (e.g., create a show, write/publish baby books)	2	3	2

SUMMARY

Financial case unclear. Media production company could be funded by a BF/CF/NS product company for indirect marketing/ product placement (e.g., breast pump company sponsoring a scene where a woman pumps). Alternatively, a media production company could be funded by a public/non-profit player (e.g., donors or government) through a PPP to share nutritional content.

Private sector media production companies may be required to write, produce, and distribute compelling content (e.g., TV shows, movies, books, etc.) that resonates with target populations as they have expertise in multimedia production, control many major distribution channels (e.g., TV channels, streaming platforms, theaters, etc.) and have a deep knowledge of their consumers.

Developing media content may require multiple players (often public and private) to develop content and distribute it. Scaling opportunities vary based on platform: Major production companies (e.g., TV shows, movies) have straightforward existing scaling structures in place with global reach. Local media production efforts (e.g., radio, books, art displays) would likely require working with many fragmented partners across geographies.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
14. Nutrition demonstrations: Host nutrition demonstrations in stores or at events	2	2	1

SUMMARY

BF/CF/NS product companies could share nutritional information and demonstrations in stores and at events to market and sell their products. Doing so may be directly profitable and enables them to directly engage with customers to build their brand.

Given their marketing capabilities and deep knowledge of their customers, private product companies may be best suited to develop and give compelling demonstrations with targeted messages that resonate with different population segments. They may also be uniquely able to deliver those messages in private areas where they know target populations congregate, including stores and private events.

Nutrition demonstrations are straightforward to implement (with minimal players needed to provide the space, perform the demonstration, and advertise) but have very limited opportunities to scale efficiently.

EMPLOYEE EDUCATION

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
15. Employee education: Support employee education in nutrition (e.g., host presentations; fund email nudges)	2	2	1

SUMMARY

Improved employee education on nutrition may lead to improved employee health, which could lead to greater job productivity, decreased absenteeism, greater job satisfaction, and greater staff retention. Possible employers may include companies in the garment or agricultural industry.

Public sector can sponsor educational behavior change campaigns on nutrition but reforms may take time, may not reach all individuals, and may require an enabling political climate. Employees may also have greater conviction in messaging coming from their employers than from broader government-sponsored campaigns. Thus, there may be a unique role for private sector employers to play in providing nutrition education directly to their employees.

Structuring an initiative around employee education would require interacting with and influencing many highly fragmented partners (employers) across industries and would provide limited opportunities to scale efficiently.

VIRTUAL COMMUNICATIONS AND NETWORKING

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
16. Virtual communities: Create/support virtual communities that connect mothers with shared experiences (e.g., social networking service, email or messaging chains)	2	2	3

SUMMARY

Financial case unclear. BF/CF/NS product companies or private health providers may fund virtual communities and market them alongside products or services to engage with customers and to provide brand recognition. Alternatively, social media marketing companies could be sponsored by a public/non- profit player (e.g., donors or government) through a PPP to raise awareness of virtual communities or to manage virtual communities and disseminate nutritional content produced by public/non-profit players.

Given their marketing capabilities and deep knowledge of consumer behavior, private companies may be best suited to develop compelling, targeted messages that resonates with mothers and to deliver those messages through existing communications channels (e.g., social media platforms, SMS messaging chain) to relevant population segments.

Limited partners required to achieve impact, clear opportunities to scale online across geographies, and straightforward logistical set up on existing social media platforms. PPP partnerships may include public/non-profit players to fund initiatives and private sector media companies to market them.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
17. Webinars: Host/sponsor virtual webinars on positive nutrition behaviors	2	2	3

SUMMARY

Financial case unclear. BF/CF/NS product or health system service providers may host/sponsor virtual webinars on positive nutrition behavior to market products and services, to engage with customers, and to provide brand recognition (e.g., BF pump company may provide webinars on positive breastfeeding behaviors and also mention using BF pumps as supports).

Given their marketing capabilities and deep knowledge of consumer behavior, private companies may be best suited to perform compelling demonstrations with targeted messages that resonates with mothers and to deliver those messages through webinars to relevant population segments.

Virtual webinars are straightforward to implement (with minimal players needed to present the information and advertise) and have clear opportunities to scale online across geographies with connectivity to stream videos.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
18. Social media influencers: Sponsor social media influencers posting photos and videos (e.g., moms sharing personal challenges; tips on how to BF or CF and what products to use; importance of pre- and post-natal nutrition iron/folate supplementation	2	2	2

SUMMARY

Financial case unclear. BF/CF/NS product companies or private health providers may sponsor influencers to market their products and services, indirectly engage with customers, and provide brand recognition. Alternatively, influencers could be sponsored by a public/non-profit player (e.g., donors or government) through a PPP to raise awareness of positive nutrition behaviors.

Private companies may be more experienced working with social media influencers and have more expertise on how to make content go viral to increase reach. Similarly, given their marketing capabilities and deep knowledge of consumer behavior, private companies may be best suited to develop compelling, targeted content that resonates with relevant populations.

Straightforward set up with large potential reach and clear opportunities to scale. However, initiative may require interacting with and monitoring many highly fragmented individuals (influencers) across geographies.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
19. Sponsored social media posts: Sponsor posts that promote positive nutrition behaviors	2	2	3

SUMMARY

Financial case unclear. BF/CF/NS product or health system service providers may share sponsored posts that promote positive nutrition behaviors to market products and services, to engage with customers, and to provide brand recognition (e.g., BF pump company may provide sponsored post on positive breastfeeding behavior with mention of BF pumps as supports).

Private companies may be more experienced in online advertising techniques and more expertise on how to make content go viral to increase reach. Similarly, given their marketing capabilities and deep knowledge of consumer behavior, private companies may be best suited to develop compelling, targeted content that resonates with relevant populations and to target those populations on social media.

Sponsored posts are straightforward to implement (with minimal players needed to build and distribute messages) and have clear opportunities to scale online across geographies on existing social media platforms.

ENGAGEMENT OF COMMUNITY AND FAMILY INFLUENCERS

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
20. Caregiver support groups: Develop support groups for partners and other caregivers like grandmothers (e.g., on social media or in a physical space)	2	2	3

SUMMARY

Financial case unclear. BF/CF/NS product companies may fund support groups online and market them alongside products to engage with customers and provide brand recognition. They may also fund and host support group efforts in person to attract customers to locations that sell their products. Alternatively, private health providers may fund support group efforts online and market them alongside their services as a preventive health measure to improve the quality of their maternal and child care. They may also fund and host support group efforts in person to attract more patient volume to locations that provide ancillary services. Alternatively, a public/non-profit player (e.g., donors or government) may fund private sector marketing efforts to raise awareness of support groups or fund an organization to run the support group through a PPP.

Private sector activity is not required to develop support groups. But given their marketing capabilities and deep knowledge of consumer behavior, private companies may be best suited to amplify awareness of support groups and reach relevant population segments through compelling, targeted messaging in their existing communications channels (e.g., traditional and social media platforms).

For a virtual support group, there are limited partners required to achieve impact, clear opportunities to scale online across geographies, and straightforward logistical set up on existing social media platforms. PPP partnerships may include public/non-profit players to host, fund, and market the support group. An in-person support group may require more partners to provide a physical space and host support groups to scale across geographies but would have a very clear logistical set up.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
21. Family member trainings: Host/sponsor community discussions, trainings, or Q&A sessions with healthcare professionals for family members	2	2	2

SUMMARY

Financial case unclear. BF/CF/NS product companies family member trainings and market them alongside products to engage with customers and provide brand recognition. They may also fund and host trainings to attract customers to locations that sell their products. Alternatively, private health providers may fund family member trainings and market them alongside their services as a preventive health measure to improve the quality of their maternal and child care. They may also fund and host trainings in person to attract more patient volume to locations that provide ancillary services. Alternatively, training companies could be sponsored by a public/non-profit player (e.g., donors or government) through a PPP.

Private sector activity is not required to engage family members in sessions. But given their marketing capabilities and deep knowledge of consumer behavior, private companies may be best suited to amplify awareness of trainings and reach relevant population segments through compelling, targeted messaging in their existing communications channels (e.g., traditional and social media platforms). Private sector may also be able to provide incentive for family members to attend (e.g., discounts).

Family member trainings are straightforward to implement within a single business but scaling more broadly across geographies would require interacting with multiple partners.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
22. Pledges: Create pledges by family members (e.g., new grandmothers' pledge to support mothers with BF, fathers' pledge to feed young children diverse foods)	2	2	3

SUMMARY

BF/CF/NS product companies may build, market, or fund a pledge campaign to engage with customers and to provide brand recognition. Alternatively, private health providers may fund a pledge campaign as a preventive health measure to improve the quality of their maternal and child care. Alternatively, a public/non-profit player (e.g., donors or government) may fund private sector marketing efforts to raise awareness of a pledge campaign. Comparing the different business models, a collaboration between public and private sector players would likely provide greater legitimacy and popularity around the campaign.

Private companies may be more experienced in online advertising techniques and have more expertise on how to make a pledge go viral to increase reach. Similarly, given their marketing capabilities and deep knowledge of consumer behavior, private companies may be best suited to develop compelling, targeted content that resonates with relevant populations and to target those populations on existing communication channels.

A pledge campaign may be straightforward to set up and would likely involve public or non-profit players and minimal private sector players.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
23. Breastfeeding dolls: Sell/support breastfeeding dolls in childcare centers	1	3	2

SUMMARY

Financial case unclear. Breastfeeding doll manufacturers may distribute dolls to childcare centers to increase sales and penetrate new markets, however additional sales are conditional on existence of buyers, demand for products, and willingness/ability to pay. It is unlikely there will be multiple childcare providers in LMIC contexts that may purchase the dolls.

Private sector players currently produce and sell breastfeeding dolls internationally as a tool to train students and providers. Thus, private sector expertise and capability in manufacturing and distribution may be required to build and deliver dolls efficiency.

Distributing breastfeeding dolls through new customer channels would likely be straightforward to set up but would require existing manufacturers (minimal players) to expand their distribution channels.

TOOLS TO TRACK IMPACT OF INITIATIVES, MOTHER SENTIMENT, ETC.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
24. Mother and family behavioral survey: Build/sponsor tools that evaluate and share mother and family-member nutrition sentiment, know-how, and likelihood to engage in desired behaviors (e.g., sending out surveys or feedback forms, scraping social media)	1	2	2

SUMMARY

Financial case unclear. BF/CF/NS product companies or private health providers may develop or fund surveys to develop customer insights but would likely have few incentives to share results. Alternatively, a public/non-profit player (e.g., donors or government) may fund a survey company or telecom provider to poll consumers to track impact of initiatives or guide future funding decisions.

Given their expertise in collecting consumer insights, private sector product companies or providers may be helpful to amplify reach, effectiveness, and efficiency of polling efforts, but would not be critical to distribute surveys. Similarly, telecom companies may be helpful to widely distribute virtual surveys rapidly, but would not be critical.

For a private product or service provider company, sending out and collecting survey results online would be fairly straightforward and require minimal players, though convincing populations to take surveys may prove challenging. Alternatively, the initiative may involve a public-private collaboration with survey companies or telecom providers who have the ability to poll large populations. Scaling these may be possible with limited partners because minimal infrastructure is required to reach across geographies online. However, if surveys are completed in person, limited opportunities to scale efficiently given necessary coordination with fragmented surveyors in each geography.

SUPPLY CHAIN

PRIVATE DISTRIBUTORS TO HEALTH SYSTEM OUTLETS

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
25. Existing channels: Add new products to existing channels that currently do not support them to distribute more affordable, accessible, and effective products	3	2	2

SUMMARY

Private manufacturing companies may pay logistics or distribution companies to add new products to existing supply chains if manufacturers are able to penetrate new markets.

In many countries, BF/CF/NS product supply chains are private sector-led so private sector activity may be helpful to add new products to existing channels. However, private sector activity is not necessary as public sector supply chains may also provide these products in some countries and could be more likely to target remote populations.

Potential to scale highly dependent on fragmentation of distributors and potential reach of partners. However, once partners are identified, implementation is straightforward to add a new product to existing supply chain channels.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
26. Direct selling systems: Distribute affordable and accessible BF, CF, and NS products through direct selling systems (e.g., independent or employed agents selling door- to-door)	2	2	2

SUMMARY

Financial case unclear. Distribution of BF/CF/NS products through direct selling systems may increase sales by penetrating new markets. However, additional sales are conditional on willingness/ability to pay and may be weighed against additional costs of selling door-to-door.

In many countries, BF/CF/NS product supply chains are private sector-led so private sector activity may be helpful to effectively employ direct selling systems. However, private sector activity is not necessary as public sector supply chains may also provide these products in some countries and could be more likely to target remote populations.

Limited opportunities to scale efficiently given necessary recruitment and coordination with fragmented independent agents selling door-to-door in each geography. However, examples exist of multinational companies successfully scaling direct selling systems across geographies, including a model of female employees engaging in door-to-door product sales across rural villages.

SERVICE DELIVERY

COUNSELING THROUGH PHARMACIES, HEALTH CENTERS, AND MOBILE COUNSELORS

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
27. Mobile counseling: Provide/sponsor home visits by mobile counselors	3	2	2

SUMMARY

Private healthcare facilities/groups may directly provide home visits by mobile counselors to realize financial gain by increasing access to counseling services, broadening catchment area, and increasing patient volumes (which may also increase volumes for ancillary services, such as deliveries and c-sections). Alternatively, private mobile counselors could be contracted by a public/non-profit player (e.g., donors or government) through a PPP or by a private healthcare facility/group to provide the service. Alternatively, a BF/CF/NS product manufacturer may fund mobile counseling services to promote delivery of their product (e.g., counselors could provide samples of CF/NS products or demonstrate use of BF delivery tools).

Private sector activity would be helpful to provide home visits by private mobile counselors, but is not necessary as public healthcare facilities and counselors could also provide these services.

Mobile counseling services may be straightforward to implement (with private healthcare facilities/groups providing services directly) but opportunities to scale depend on the fragmentation of existing health systems.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
28. Facility-based counseling: Provide/sponsor counseling services and post-natal care for pregnant/lactating women and families through private pharmacies and private health centers	3	2	2

SUMMARY

Private pharmacies and healthcare centers may provide counseling services and post-natal care to realize financial gain. Alongside being profitable, providing counseling services and post-natal care may enable pharmacies and health centers to directly engage with customers to build their brand, which may indirectly increase revenues for ancillary products and services, such as deliveries and c-sections in health centers and healthcare products in pharmacies.

Private sector activity could be helpful to provide counseling services and post-natal care through private pharmacies and health centers, but is not necessary as public pharmacies and health centers could also provide these services.

Counseling services and post-natal care services through pharmacies and health centers may be straightforward to implement (with those entities providing services directly) but opportunities to scale depend on the fragmentation of existing health systems.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
29. Group classes: Provide/sponsor group classes for mothers and families	3	2	2

SUMMARY

Private pharmacies and healthcare centers may provide group classes for mothers and families to realize financial. These classes may be more profitable than individual counseling services as group classes can reach multiple consumers at once. Alongside being profitable, providing group classes may enable pharmacies and health centers to directly engage with customers to build their brand, which may indirectly increase revenues for ancillary products and services, such as deliveries and c-sections in health centers and healthcare products in pharmacies.

Private sector activity may be helpful to provide group classes through private pharmacies and health centers, but is not necessary as public pharmacies and health centers could also provide these services.

Group classes through pharmacies and health centers could be straightforward to implement (with those entities providing services directly) but opportunities to scale depend on the fragmentation of existing health systems.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
30. Breastfeeding dolls: Build/support remote health counseling app (e.g., telehealth app, chatbot, etc.)	2	3	2

SUMMARY

Financial case unclear. Private health facilities/groups may sponsor app development for use in-house (or could license it out to other players) to realize later financial gain by delivering more cost-effective, quality care and to achieve brand recognition to draw greater patient volumes. Alternatively, private app developers could be sponsored by a public/non-profit player (e.g., donors or government) through a PPP to build a remote health counseling app to be used by public and private healthcare providers to deliver care.

Private sector activity may be required to design and develop a high-quality app with relevant technology that works across multiple context-appropriate platforms (e.g., SMS, voice messaging, videoconferencing) because private sector players are more likely to have deep capabilities and expertise in app development.

Building a remote health counseling app may require multiple partners (public and private) to fund the app technology, develop it, and integrate it into existing healthcare systems. Once built, scaling to mobile populations could be straightforward on existing app stores (or through partnerships with telecom providers to send SMS messages) but may require integration with existing health information systems.

SALES THROUGH PHARMACIES AND POST-NATAL COUNSELORS

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
31. Product sales through pharmacies and counselors: Supporting BF, CF, and NS product sales through pharmacies and post-natal counselors (e.g., nutrient supplements, breast pumps, pasteurization kits, nipple covers, bras, pillows)	3	2	2

SUMMARY

Private pharmacies and post-natal counselors in healthcare centers may sell BF/CF/NS products to increase sale volumes. Alongside being profitable, providing products may indirectly increase revenues for other healthcare products in pharmacies by attracting customers to the stores. Alternatively, BF/CF/NS product companies may sell products to post-natal counselors at preferred rates for them to resell to their patients in order to establish an initial point of contact with customers through their trusted providers. Alternatively, a public/non-profit player (e.g., donors or government) could subsidize the costs of BF/CF/NS products for private pharmacies and post-natal counselors through a PPP to generate demand for products and promote positive behaviors.

Private sector activity may be helpful to provide sales through pharmacies and health centers, but is not necessary as public pharmacies and health centers could also provide these products.

Selling products through private pharmacies and counselors is straightforward to implement but opportunities to scale may be limited as the landscape of private pharmacies is likely highly fragmented. An initiative to structure a PPP to subsidize the cost of BF/CF/NS products (especially those already being sold) would be straightforward to implement and may leverage existing supply chain channels.

SUPPORT FOR BF IN PRIVATELY-OWNED PUBLIC SPACES

(e.g., lactation rooms in markets, religious centers, parks, community centers)

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
32. Public lactation rooms: Build/support permanent and mobile lactation rooms in public spaces (e.g., markets, religious centers, parks, community centers)	2	2	1

SUMMARY

BF/CF/NS product companies may sponsor building free-to-use lactation rooms with advertisements for the company to engage with customers and provide brand recognition. Alternatively, local businesses may build permanent or temporary lactation rooms in high traffic areas to encourage mothers to remain in retail spaces for longer periods of time.

Private sector activity is not necessary to build lactation rooms in public spaces, unless those spaces are privately owned (e.g., religious center).

Building lactation rooms would require interacting with and influencing many highly fragmented partners (employers) to fund and build them and would provide limited opportunities to scale efficiently, particularly in rural areas.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
33. Lactation room locator app: Build/sponsor health app to locate public lactation rooms	2	3	1

SUMMARY

BF delivery tool product companies may sponsor developing a lactation room locator app as a tool to market their products, engage with customers, and provide brand recognition. Alternatively, an existing web mapping platform may develop a lactation room locator feature on their existing app as a tool to engage with customers and provide brand recognition. Alternatively, private app developers may also be sponsored by a public/non-profit player (e.g., donors or government) through a PPP to build a lactation room locator app to be used in public spaces.

Private sector activity would be required to design and develop a high-quality app with GIS technology.

Building a lactation room locator app may require multiple partners (public and private) to fund the app technology, develop it, and integrate it into the local geography. Once built, scaling to mobile populations is likely straightforward on existing app stores but initial useability of app may be limited and depend on input from app users and local businesses on where public lactation rooms are located.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
34. Nursing covers: Provide nursing covers in public spaces (e.g., markets, religious centers, parks, community centers)	1	1	1

SUMMARY

BF delivery product retailers could rent nursing covers to mothers in public spaces. However, the service likely may not be profitable given sanitary concerns around sharing items soiled with saliva or breastmilk.

Private sector activity is not necessary to provide nursing covers in public spaces and they may be provided by a non-profit organization who can manage a subsidized service.

Providing nursing covers would require interacting with and influencing many highly fragmented partners at the local level to distribute covers and would provide limited opportunities to scale efficiently.

IN-SERVICE TRAINING/SKILL ENHANCEMENT

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
35. Health worker in-service training: Host/support focused trainings and capacity building for healthcare workers in pre- natal, post-natal, and early childhood interactions to provide information and counseling for pregnant, lactating, and other post- partum women and their families	3	2	3

SUMMARY

Private healthcare facilities/groups may directly provide training for its providers; in doing so, they may realize financial gain by delivering more cost-effective, quality care and may also achieve brand recognition (e.g., “Centers of Excellence” status) to draw greater patient volumes. Alternatively, training companies could be sponsored by a public/non-profit player (e.g., donors or government) through a PPP or could be sponsored by a private healthcare facility/group to provide the service. Alternatively, a BF/CF/NS product manufacturer may sponsor broader BF/CF/NS trainings for external public and private healthcare workers to promote delivery of their product.

Private sector activity may be helpful to train private health facilities/groups’ staff and improve quality of care, but is not necessary as public health facilities/groups could also undergo training and improve their care quality.

Scaling opportunities would depend on the fragmentation of existing health systems. Private healthcare facilities only require collaboration with the organization providing training. Similarly, manufacturers providing trainings would only require collaboration with public or private healthcare facilities/groups involved in pre-natal and post-natal interactions.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
36. Civil society organization training: Host/sponsor focused training for civil society organizations (e.g., women's groups) and volunteers to provide counselling and support to mothers and families	1	2	2

SUMMARY

Financial case unclear. Companies who aid efforts to train civil society organizations through funding, service provision, or other supports may receive strong brand recognition. Alternatively, training companies could be sponsored by a public/non-profit player (e.g., donors or government) through a PPP.

Private sector may be helpful to rapidly and efficiently distribute training services to civil society organizations across different resource levels and geographies.

Trainings would require interacting with multiple partners (civil society organizations) across geographies to achieve scale and may require PPP structures to provide funding.

TOOLS TO TRACK SERVICE PROVISION QUALITY, QUANTITY, EFFECTIVENESS, ETC.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
37. Service and product provision tracker: Develop health information management systems and health center accountability systems to track provision of services and products (e.g., Vitamin A supplements) to young children	1	2	2

SUMMARY

Private health facilities/groups may develop or fund health information management systems to track provision of services and products to develop insights on patient and provider behavior and to improve care quality. But providers would likely have few incentives to share results. Alternatively, NS product companies may fund systems to track provision of their products (e.g., Vitamin A supplements) but would similarly likely have few incentives to share results. Alternatively, a public/non-profit player (e.g., donors or government) may fund a private company to build an information management system and to integrate it into existing health systems in order to more effectively track provision of services and products to patients across geographies.

Private sector activity may be helpful to design and develop effective health information management system technologies as they are more likely to have capabilities and expertise in building information management software systems and in collecting, analyzing, and disseminating health data.

Developing a health information management system requires multiple players to fund the technology, develop it, and integrate it into existing healthcare systems. Scaling opportunities would depend on the fragmentation of existing health systems.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
38. Provider survey: Build/sponsor tools that evaluate and share provider sentiment, know-how and likelihood to engage in desired behaviors	1	2	2

SUMMARY

Private health facilities/groups may develop or fund surveys for their employees to develop insights on provider behavior and create targeted trainings to improve care quality. But providers would likely have few incentives to share results. Alternatively, BF/CF/NS product companies may develop or fund surveys to develop provider insights but would similarly likely have few incentives to share results. Alternatively, a public/non-profit player (e.g., donors or government) may fund a private company to survey providers to track impact of initiatives or guide future funding decisions.

Given their expertise in collecting consumer insights, private sector companies may be helpful to amplify reach, effectiveness, and efficiency of surveys efforts.

Sending out and collecting survey results would be fairly straightforward but scaling opportunities would depend on the fragmentation of existing health systems.

APPS FOR SERVICE PROVIDERS

(e.g., how-to guides, scheduling, patient data storage)

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
39. Remote patient monitoring and support: Build/sponsor patient eHealth management app (to enable patients to remotely share nutrition challenges and ask questions, and for providers/ counselors to monitor patients and provide support)	2	3	2
40. Electronic health records: Build/sponsor nutrition health provider app (to capture and store patient data, schedule appointments, etc.)	2	3	2

SUMMARY

Financial case unclear. Private health facilities/groups may sponsor app development for use in-house to realize later financial gain by delivering more cost-effective, quality care and to achieve brand recognition to draw greater patient volumes. Alternatively, private app developers could be sponsored by a public/non-profit player (e.g., donors or government) through a PPP to develop an app to be used by public and private healthcare providers.

Private sector activity may be required as they are more likely to have deep capabilities and expertise necessary to design and develop a high-quality, multi-functional app with technology that works across multiple context-appropriate platforms (e.g., SMS, voice messaging, videoconferencing).

Developing an app requires multiple players (often public and private) to fund the app technology, develop it, and integrate it into existing healthcare systems. Scaling to mobile populations is likely straightforward on existing app stores but may require some integration with existing health information systems.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
41. Provider transportation: Support provider logistics for home visits by hosting service for providers in existing ride- sharing app (e.g., with preferred or monthly rates, regular scheduled rides and shorter wait times)	2	3	2

SUMMARY

Financial case unclear. Private health systems may directly sponsor ride-sharing efforts (partner with ride-sharing services) to support home visits by providers to expand their service reach and increase patient volumes. Alternatively, private ride-sharing services could be sponsored by a public/non-profit player (e.g., donors or government) through a PPP to support home visits by public and private providers to deliver care in rural populations.

Private sector ride-sharing companies may be required to deliver services as they own their private platforms and may already have significant reach through a large driver population. They can also use their economies of scale to bring costs down and structure special rates for providers.

Existing ride-sharing services have straightforward payment structures and would likely require minimal logistical set up to integrate preferred rates and priority pick-ups for healthcare providers. Scaling to other geographies would likely require partnering with additional local ride-sharing providers.

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
42. Video reference library for providers: Build/sponsor health video library reference app (with videos to help providers diagnose and treat malnutrition and to help counselors provide BF support and engage family)	2	3	2

SUMMARY

Financial case unclear. Private health facilities/groups may sponsor health video development for use in- house to realize later financial gain by delivering more cost-effective, quality care. Alternatively, private app developers could develop and sell the health video library directly to private healthcare facilities/groups, who could provide the service to employees to deliver more cost-effective, quality care. Alternatively, private app developers could be sponsored by a public/non-profit player (e.g., donors or government) through a PPP to develop the health video library app for use by public and private healthcare providers.

Private sector players may be best suited to build and distribute a health video library reference app for providers as they may have greater capabilities and expertise in developing compelling content that is tailored to relevant provider population segments.

Developing a health video library requires limited players. However, scaling opportunities may depend on the fragmentation of existing health systems as fragmented systems may require interacting with and influencing many partners (private health facilities/groups).

Modality	Attractiveness of business model	Differentiated capability, expertise, or assets	Level of confidence in impact score
42. Video reference library for providers: Build/sponsor health video library reference app (with videos to help providers diagnose and treat malnutrition and to help counselors provide BF support and engage family)	**2**	**3**	**2**

SUMMARY

Financial case unclear. BF/CF/NS product companies may fund virtual provider communities and market them alongside products to engage with counselors and to provide brand recognition. Alternatively, private health facilities/groups may sponsor communities within their facilities to promote knowledge- sharing and connectivity between employees. This may lead to improved quality of care, productivity, and employee happiness and, in turn, lower turnover, however benefits are likely hard to measure.

Private sector is not required to create provider communities for counselors. But given their marketing capabilities and deep knowledge of consumer behavior, private companies may be best suited to amplify awareness of provider community and reach relevant population segments through compelling, targeted messaging in their existing communications channels (e.g., traditional and social media platforms).

Set up is straightforward on existing virtual platforms. However, scaling opportunities may depend on the fragmentation of existing health systems as fragmented systems may require interacting with and influencing many partners (private health facilities/groups) to engage providers in the virtual community.

APPENDIX

SUMMARIZED INTERVIEW INSIGHTS*

The prioritized modalities are compelling, and SUN, Alive & Thrive, and GAIN are actively working in these spaces:

- **SUN and Alive & Thrive use workplace nutrition programming as an entry point for engagement with the private sector**, including employer policy programs focused on workplace lactation supports, maternity leave, and access to nutritious foods.
  - Alive & Thrive mainly provides technical assistance for multinational industry leaders in the garment industry.
  - SUN is working on initiating these practices in SMEs (as these have already been a focus for big businesses).
  - GAIN cited the value of these programs but cautioned they require third-party evaluations to validate their impact.
- **Behavior change: Traditional media is often donor-supported, and messaging is typically broad** because populations are often not large and dense enough to warrant messaging for specific groups. **Social media is increasingly compelling** and SUN, Alive & Thrive, and GAIN all actively use it. **Alive and Thrive and GAIN use health information messaging** through WhatsApp or SMS but are unclear on evidence to date for it. **CCP focuses on building long-term brands and utilizes multiple channels** (e.g., TV, radio, WhatsApp) **to reinforce messages.**
- **Lactation counseling services could be profitable as a reimbursable healthcare service.** Alive & Thrive is pushing private healthcare providers to provide lactation services by saying it will draw in patients to utilize ancillary services. They are also working with breastfeeding associations and governments to generate demand for these services and to advocate for their reimbursement.

Concerns were raised about risks when engaging the private sector to improve nutrition outcomes, including concerns with:

- Aligning with private sector companies promoting specific products in any way that looks like an endorsement.
- Inadvertently supporting private sector companies that are using CSR initiatives to get a seat at the policy-making table.
- Having inequitable impact on urban cities compared to rural, remote areas.

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* Source: Interviews with GAIN, SUN, UNICEF, Alive & Thrive, Abt Associates, World Bank Global Financing Facility, and Johns Hopkins Center for Communication Programs

INTERVIEWS TO DATE

GAIN (6/1/2021): **Christina Nyhus Dhillon**, lead of Workforce Nutrition Program

- **Our current modality categories all feel compelling** and are largely in line with the Access to Nutrition Index.
  - **Advocacy for private sector practices – pressure for external evaluations could help:** There is a big role for private sector players to lead, but well-intentioned companies with workforce nutrition programs often evaluate them internally, making it difficult to validate their impact. There is an opportunity to apply pressure for open, third-party evaluations to enable greater transparency and trust.
  - **Behavioral change – SMS messaging and social media are compelling ideas with limited evidence:** GAIN does a lot of health information SMS messaging work, which has significant reach but lacks evidence on its effectiveness. Similarly, GAIN is working to involve adolescents in social media work but is unclear on evidence to date.
  - **Supply chain idea** *[out of scope]***:** A novel distribution opportunity could involve bringing supply chains of nutritious foods closer to remote agricultural or factory settings and setting up nutrition shops to improve worker nutrition and boost sales.[2] Up-front costs of shifting supply chains are a bigger barrier than sustaining them, suggesting initial investment may enable long-term models. GAIN is still collecting data on these programs' effectiveness.
- **Business incentives for the private sector to improve workforce nutrition may be rooted in productivity gains** created by less absenteeism, fewer sick days, improved job satisfaction, and greater staff retention. Beyond direct business incentives, there are also strong incentives to increase brand reputation, CSR, access to different players, or supplier loyalty (note: this may be market-dependent, unclear how impactful for LMIC-based companies.

UNICEF (6/3/2021): **Nita Dalmiya,** Maternal Nutrition Specialist; **Grainne Moloney,** Senior Advisor for Early Childhood Nutrition; **Kathy Shats**, Legal specialist

- **Concern about risks when engaging the private sector to improve nutrition outcomes**, particularly in behavior change and advocacy.
  - Even CSR initiatives are sometimes pursued by corporations in order to get a seat at the policy-making table
  - The most effective way to get positive outcomes is to keep corporations out of the policy-making table and to pass strong regulations for health, complementary foods, and substitutes. Much of UNICEF's work is focused on helping governments pass these laws. *[Out of scope]*
  - The private sector can play operator roles to minimize the impact of misaligned incentives, and their activities should be closely regulated by government.

Alive & Thrive/FHI 360 (6/7/2021): **Sandy Remancus**, Project Director; **Toby Stillman** & **Donna McCarraher**, co-leads of nutrition component of Momentum Suite (MPHD)

- **Alive & Thrive/FHI 360 is actively working with private sector players across many of our modality categories** and finds them compelling.
  - **Advocacy for private sector practices – A&T uses the workplace as an entry point for private sector activity:** A&T provides TA for multinational garment industry leaders in S.E. Asia to create more nutrition-focused workplaces (through creating workplace lactation rooms and employer policies for maternity leave & BF breaks). Corporations are incentivized by having an "ethically sourced" label and productivity gains.
  - **Behavior change – Traditional mass media initiatives are often donor-supported and are challenging to coordinate with local government. Traditional media is also becomingly less relevant as social media becomes increasingly important.** Commercial breast milk manufacturers are masters at social media marketing and have been creating campaigns and sponsoring influencers to promote their products. Keeping up with their efforts may prove challenging.
  - **Behavior change – A&T is early in its work on tech-enabled health messaging:** In Nigeria, A&T utilized WhatsApp messaging to communicate with partners/husbands and mothers and is evaluating the results. They are also actively thinking about engaging telecom companies and app developer but have made little progress there.
  - **Service delivery – Lactation counseling services could be profitable as a reimbursable healthcare service:** In Jordan, A&T is pushing private healthcare providers to provide lactation services, with a business case that those services will draw in more patients to utilize the provider for other ancillary services (e.g., deliveries, c- section) In conjunction, A&T is working with organic campaigns (e.g. BF associations) and the MOH to generate demand for these services and advocate for their reimbursement by insurance companies.
  - **Concern about aligning with private sector companies promoting specific products** in any way that looks like an endorsement.

SUN Business Network (6/9/2021): **Emily Heneghan; Maired Petersen; Jean-Sebastian Kouassi; and Ritta Sabbas Shine**

- **SUN Business Network's work is focused on engaging business and aligning them with national nutrition goals around CF and BF.** It has strong networks in Sub-Saharan Africa (esp. East Africa) and South Asia. It focuses it support on SMEs because it aims to engage the private sector not as a donor but as a long-term sustainable investor.
- **SUN Business Network works closely with GAIN, WFP, and the Global Alliance program across our modality categories:**
  - **Advocacy for private sector practices – SUN uses workplace nutrition as an entry point for private sector activity:** Workforce nutrition practices has been a big focus for larger businesses and SUN is working on initiating practices in SMEs as well (including nutritious foods in the workplace; lactation supports; securing BF rights).
  - **Advocacy for private sector practices – SUN worked on an initiative using nutrition labeling to generate demand for healthy foods:** Zambia released a government-led "healthy diets logo" in conjunction with TV ads, radio ads, and social media posts to generate consumer demand for the logos. Businesses were pressured to get the logo to prove their products were healthy. The initiative was donor-funded and government-led. A private sector marketing firm with a development-focused arm created the ads and the messages were developed by a technical team with a range of stakeholders from SUN, government, and private sector to ensure messages were appropriate.

- **Behavioral change – SUN uses traditional and social media and employee education to promote nutritional messages on healthy diets:** Many of SUN's member businesses have been creatively engaging with customers on social media and messaging to mothers on how to use specific products, especially CF products (e.g., sharing recipes). GAIN and SUN are looking to develop a suite of digital marketing tools that SMEs can use in the future. SUN also noted that in most countries, the population is not large and dense enough to profitably focus traditional media messaging on specific groups (with few exceptions, like Nigeria), so messaging is typically broad in scope.
- **Supply chain – Last mile distribution to access nutritious products and services in rural and hard-to-reach populations:** SUN is supporting SME partnerships between producers and distributors to produce and distribute local foods to more remote markets, especially in Mozambique and Nigeria.
- **R&D practice to identify innovation in local food systems** *[out of scope]***:** Two years ago, SUN organized a global pitch competition to link innovative SMEs working on food solutions to investors and TA. The model has since been replicated by SUN teams at the country level (e.g., Kenya, Ethiopia, and Bangladesh).

- **Reflections on CF market:** The CF market has large players and many fragmented smaller players that struggle to compete. An idea was raised *[out of scope]* to have centralized resources accessible to smaller players to promote economies of scale (e.g. a centralized manufacturing plant or centralized labeling/packaging).
- **Concerns:**
  - National work and networks are often focused on urban cities and SUN is looking to expand into more regionalized approaches.
  - Smaller CF products players sometimes forget about exclusive BF and have questionable marketing practices but all have been quick to fix their approach when issues are raised.

Abt Associates (6/9/2021): **Alysha Beyer** and **Lisa Nichols**

- **Abt is working in partnership with public and private sector players across our functions but in slightly different modality categories:**
  - **Advocacy for private sector practices – Abt emphasized the value of engaging pharmacy and healthcare associations in advocacy efforts** as their power and influence has grown significantly in the past decade.
  - **Behavior change idea:** An opportunity to influence provider behavior to recommend more nutritious products could be a detailing strategy where private sector players go to healthcare providers on a regular basis to educate them about a specific nutrition product or service (like the pharmaceutical industry historically).
  - **Supply chain – Abt's SHOPS Plus project has done a lot of work to improve distribution and delivery of health products by engaging public sector supply chain.**
  - **Supply chain – Abt is exploring using community health workers and mobile direct selling models.** – The SUN Movement has identified interesting opportunities to form communities to sell products (e.g., a health worker cadre can become promoters and sellers of fortified or supplemental foods in the community).
  - **Supply chain idea** *[out of scope]*: A novel opportunity to decrease costs of products could involve working with ecommerce providers (e.g., ecommerce pharmacies) to get products directly to consumers or retailers to shorten the supply chain.

- **Service delivery – Abt is working with digital technology innovators in LMICs to use websites and apps to market and provide access to pharmaceutical products.**
- **Service delivery idea** *[out of scope]*: An opportunity could involve subsidizing products to crowd out a bad product or to instigate demand. Evidence in Kenya shows that public sector products going into the private sector that are fully subsidized help instigate demand and private sector interest in providing those products. Abt also suggested exploring blended finance and direct investment options. It mentioned it is working to fertilize seed companies in Bangladesh to instigate that market.

World Bank Global Financing Facility (6/30): **Leslie Elder**, Nutrition Specialist; **Julie Bergeron**; and **Sneha Kanneganti**

- **GFF's private sector work is focused on three pathways**, none of which are directly relevant to our modalities:
  - **Innovative financing** *[out of scope]***:** focused on production, manufacturing and supply chain of nutrition projects (e.g., develop more local production of foods)
  - **Partnerships:** focused on supply chain where companies can share expertise on logistics; GFF has not done any work here in the nutrition space
  - **Helping governments support private facilities in delivering health services:** focused on convening public and private health sector to improve service delivery – but minimal work focused on nutrition

- **GFF is working with Alive & Thrive across our modality categories, but its nutrition work is focused on the public sector:**
  - **Advocacy for private sector practices – GFF emphasized the potential value of engaging federations in private sector advocacy efforts**, as they are the main counterpart to government to have dialogue on policy issues. (E.g., many East African countries (e.g., Kenya, Uganda, Tanzania) have long-standing federations that feed into a broader African federation umbrella. Federations also often have subgroups for specific stakeholders, including groups for midwives, NGOs, etc.)
  - **Behavior change and service delivery – GFF is working on promoting counseling and behavior change activities in the public sector** (e.g., a project in Cambodia is focused both on training frontline public healthcare workers on quality counseling and on creating mass media campaigns. Alive & Thrive was consulted for the project design.)

Johns Hopkins Center for Communication Programs (7/7/2021): **Frederick Rariewa**, Marketing and Private Sector Partnerships Lead

- **CCP's behavior change private sector engagement work is focused on building long-term brands as a public good:**
  - For example, in 2004, CCP produced the "Good Life" brand in Uganda, which is still used by local NGOs today. The brand included a national media campaign (TV and radio) sharing values of health, family, and success. Private sector players, including Toyota and Unilever, joined the campaign because they saw those values as being aligned with their brand. The brand was so successful that it was adopted in Ghana and has been used by the MOH for over 10 years. FHI 360 also uses the brand.
  - Similarly, in Madagascar, CCP brought the MOH to a Branding 101 workshop, where the MOH determined the name of the brand, and CCP then helped them develop it. CCP shared the brand with the private sector and a telecom group loved it and wanted to finance it. CCP is currently determining hat legal structure they might use to share the brand so it can remain a public good but receive private financing.
- Reflections on what makes a behavior change program effective:
  - A major pitfall of public health behavior change campaigns is focusing on functional benefits instead of emotional benefits. Feelings are much more influential on behavior. (E.g., instead of saying, "Wash your hands to prevent germs," a campaign is better framed around saying, "Wash your hands so you can protect and care for your family.")
  - Consumers are bombarded by many different messages through different fragmented channels (E.g., WhatsApp, radio, TV, print, etc.). Having a campaign that utilizes many channels is important to reinforce messaging, and branding helps customers integrate the messages across platforms.

POTENTIAL NEXT STEPS

WHERE TO GO FROM HERE?

How might modalities be further prioritized for future efforts?

CONSIDERATIONS DISCUSSED:

What kind of roles does USAID envision themselves playing?

(e.g., provide catalytic funding, broker relationships, drive scale-up, advocacy)

How is USAID thinking about where to focus? See perspective on next slide

What kind of impact does USAID most want to have?

1. Scaling proven models and/or leveraging ongoing work versus proving new models (in LMICs)
2. Prioritizing sustainable private sector-funded models versus those requiring long- term subsidization
3. Shorter timeline to impact versus longer investment

Therefore, which modalities are most compelling for USAID to explore further, and how?

For example:

- Opportunities for country buy-ins and field engagement within MOMENTUM suite of awards (MOMENTUM only, other MOMENTUM awards like MPHD)
- Opportunities for engagement outside of MOMENTUM suite of awards

THEREFORE, WHAT MODALITIES MIGHT BE FURTHER EXPLORED NEXT YEAR?

Note: *scores are relative to other models in this short-list and thus may be somewhat different (i.e., more nuanced) than the scoring in the earlier part of the deliverable*

	1. Ability to prove new models (for LMICs)	2. More sustainable private sector-funded models	3. Having shorter timeline to impact
A. Employer Policies (e.g., workplace breastfeeding, childcare)	**50%** True for some industries/geographies	**50%** Clear business case for many policies/industries; to be proven for others	**75%** Some partners already exist who could be leveraged
B. Traditional Media (e.g., TV shows, film, radio, and print)	**25%** May be true in some cases but extensive experience already	**25%** Media forms other than ads likely require ongoing subsidy	**50%** Some content could be developed quickly
C. Mother and Family Support Groups **D. Counseling Services** (Potentially bundled as a maternal care package)	**50%** Some experiences exist but many models to explore (e.g., digital, bundling, nutrition-focused)	**50%** Sustainable business case would need to be proven; may be possible in some circumstances	**50%** Pilots may be developed rapidly; scale could take more time
E. Health Worker In-Service Training	**50%** Some experiences exist but many models to explore (e.g., digital, nutrition-focused programs)	**50%** Sustainable business case would need to be proven; may be possible in some circumstances	**75%** Some partners already exist who could be leveraged/built up

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