



**Micronutrient Initiative
Five-year Strategic Plan
2008-2013**

**Approved by the Board of Directors of MI
on 13 November 2007**

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Note 1: All figures in this document are expressed in Canadian dollars unless stated otherwise.

Glossary of Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
APC	Additional Person-years of Coverage
CAPC	Cost per Additional Person-year of Coverage
CDC	Centers for Disease Control
CHD	Child Health Day
CIDA	Canadian International Development Agency
DALY	Disability-Adjusted Life-Year
DHS	Demographic and Health Survey
ECHUI	Ending Child Hunger and Under-Nutrition Initiative
EPI	Expanded Program of Immunization
FFI	Flour Fortification Initiative
GAIN	Global Alliance for Improved Nutrition
HIV	Human Immunodeficiency Virus
IACMEG	Inter-Agency Child Mortality Estimation Group
IDA	Iron Deficiency Anaemia
IDRC	International Development Research Centre
IDD	Iodine Deficiency Disorders
MDG	Millennium Development Goal
MI	Micronutrient Initiative
MICS	Multiple Indicator Cluster Survey
NTD	Neural Tube Defects
PMNCH	Partnership for Maternal Newborn and Child Health
PRSP	Poverty Reduction Strategy Paper
USI	Universal Salt Iodization
UNICEF	United Nations Children's Fund
VA	Vitamin A
VAD	Vitamin A Deficiency
VAS	Vitamin A Supplements
VM	Vitamin and Mineral
VMD	Vitamin and Mineral Deficiencies
WFP	World Food Programme
WHO	World Health Organization
ZnS	Zinc Supplements

EXECUTIVE SUMMARY

- i. This Strategic Plan outlines how, over the period 2008-2013, the Micronutrient Initiative (MI) seeks to address its Mission: to develop, implement and monitor solutions for hidden hunger, in partnership with others and with a focus on innovation, cost effectiveness and sustainability. The Plan identifies key program areas where micronutrients have most impact, and outlines the optimal balance of resource use by MI for combating deficiencies of those micronutrients in developing countries, and for maximizing the contributions that it can make to the achievement of the Millennium Development Goals.
- ii. Based on an analysis of the under-nutrition in developing countries that is due to Vitamin and Mineral Deficiencies (VMD), and their impacts on the most vulnerable, the Plan identifies where MI offers comparative advantage in reducing and controlling VMD. It articulates Strategic Goals, and supportive Organizational Goals, and summarizes the approaches needed to achieve them. It outlines MI's role, and identifies opportunities for collaboration with other stakeholders and for leveraging key inputs. Reflecting the large amount of work that still needs to be done to reduce the global burden of micronutrient deficiencies, implementing the Plan will require a steady growth in MI's work and an approximate doubling of its resource base – the better to enable MI to address key gaps.
- iii. MI's main strength as an organization lies in catalyzing the development, and assuring the supply and distribution, of high quality micronutrient products and technologies, while also encouraging commensurate growth in demand for improved, safe and reliable micronutrient intake. With emphasis on meeting the needs of the most vulnerable – who are often the poorest, and include people affected by shocks such as emergencies – and on ensuring that the needs of women and girls are met, MI aims to contribute, in order of priority, to:
 - A. **Improved child survival** – by applying 50% of its efforts to increasing the intake of vitamin A and zinc by children at risk, through: addressing supply constraints, and increasing countries' leadership in assuring access to key supplies on the part of those in need, especially the most vulnerable; improving the integration of vitamin A and zinc supplement delivery into health systems, increasing domestic financing for this by countries, and supporting the coordination of all child survival partners' efforts around this agenda; developing innovative ways of improving long term sustained intake of vitamin A and zinc; and helping countries to develop or improve national action plans to achieve these aims.
 - B. **Improved child development** – by applying 30% of its efforts to increasing the intake of key nutrients by both young children and future mothers, focusing on: improving the adequate iodization of salt and its supply to populations at risk; developing, testing and expanding the distribution of innovative, cost effective ways of improving the iron status of young children; generating new knowledge and evidence to support the wider adoption and use of improved approaches and technologies; helping countries to develop or improve national action plans to achieve these aims; and all the while complementing partners' efforts in reducing and controlling iodine deficiency disorders.
 - C. **Improved health of women** – by applying 20% of its effort to increasing the intake by women of key nutrients, by: furthering the production and utilization of fortified staple foods and condiments with iron and folic acid, including the scale-up of double fortified salt; addressing the supply and adherence constraints that limit iron/folate coverage among women of child bearing age and adolescent girls; contributing to a strengthened knowledge and evidence base about the comparative cost-effectiveness of combinations of interventions for addressing VMD among women and girls; and helping countries to develop or improve national action plans to achieve these aims.
- iv. Success for MI will be a major reduction in the number of people who suffer from the impacts of VMD.

- iv. Reflecting its focus on the most vulnerable, MI will develop a portfolio of interventions that are prioritized in proportion to the level of vulnerability of the individuals/age groups targeted. Within this framework MI will devote about 70% of its efforts to ensuring high coverage of “established” interventions (those proven as cost effective and already implemented extensively in many countries) is maintained, improved, and sustained. MI’s aim ultimately is to help achieve sustained universal coverage, and then to exit from active participation. About 25% of MI’s level of effort will go towards accelerating the adoption and scale-up of ‘transitional’ interventions, which are proven as safe, efficacious and potentially cost-effective, but which are not yet achieving high coverage. MI will retain about 5% of its resources for work in under researched areas which may require a rapid or flexible response. This would include for example continued advocacy by MI for strengthening the evidence base on interactions between under-nutrition and infectious diseases (such as HIV/AIDS and malaria) so as to help generate improved policies, and strategies for safe and cost-effective action.
- v. MI will retain innovation both as a common cross-cutting feature of its programs and as a specific area of program focus, for example developing new technologies to address special needs. MI’s innovative work will differentiate it from other partners as well as provide a strong incentive for staff.
- vi. MI recognizes that it can only achieve its Strategic Goals and, in turn, make significant contributions to the Millennium Development Goals, by integrating all its programs within existing health systems and markets. MI also recognizes that the impact of its work is greatly enhanced by leveraging the resources of partners at all levels: international, national and sub-national. MI will therefore enter into strategic partnerships to expand the resources available for the pursuit of its Mission. The level of inputs provided by MI will be based on the amount of value that MI can add. At least 80% of MI’s level of effort will be devoted to achieving developmental results in countries/regions, while up to 20% may be devoted to achieving enabling results at the global/international level.
- vii. Given the need to use its resources to achieve the greatest possible impacts from reduced VMD and the need to safeguard quality of its programs, MI will concentrate its efforts in regions and countries with the largest numbers of individuals vulnerable to the impacts of VMD. These will include areas with the largest numbers of child deaths. MI will maintain a presence and engage directly in significant programs in a relatively small number of countries or sub-regions with large populations. Where it can achieve impacts, MI will also work in other countries; but generally through other partners.
- viii. MI will develop and maintain a portfolio of programs and a decision-making culture that is based on evidence of impact, cost-effectiveness, safety and sustainability, and will maintain efficient and flexible internal systems that reduce risk while also maintaining the ability to respond rapidly to new opportunities and challenges. In support of this agenda, MI will aim to attract, develop, motivate and retain employees of the highest quality, and to provide a working environment that enables employees to maximize their contribution to the achievement of MI’s goals.
- ix. MI will report and present the results it achieves through a cost-effective marketing and communications function. MI’s communications efforts will be targeted to specific audiences who can support MI’s Mission. MI will in addition seek to support all of its efforts by pursuing four key funding-related objectives: (i) maintaining its current funding relationships; (ii) diversifying its revenue sources; (iii) leveraging significant revenues in addition to its core funding and (iv) leveraging parallel financial inputs for projects from partner organizations. MI aspires to double its current resource base by 2013.
- x. This Plan is designed to be a living document that guides planning and decision-making within MI and helps to communicate the work of MI to key stakeholders. Based on data available as of October 2007, it will be subject to periodic reviews that allow MI to respond to shifts in its operating environment. MI will continue to develop annual Programs of Work and Budgets that will accommodate any needs for shifts in emphasis; and will also track progress towards its Strategic Goals on an annual basis.

I. PURPOSE AND USE OF THE PLAN

1. Following a review of its resource development, partnership and other strategies in October 2006, the Board of the Micronutrient Initiative (MI) requested the MI Executive Management Committee to prepare a new Strategic Plan that articulates the vision, goals and strategic direction for the organization over the next five years. This Strategic Plan, covering the five year period 1 April 2008 - 31 March 2013, has been prepared in response to that direction. It is designed to guide management and staff in the optimal application of MI's human and financial resources to support efforts to eliminate vitamin and mineral deficiencies (VMD). MI will also publish and use the document as a basis for communication with partners about its work.
2. Plan preparation included the development of a situation analysis, based on international micronutrient-related programmatic and research experience as at October 2007, with inputs from desk research, a panel of experts, in-country stakeholder consultations, MI Board members, MI staff, and an evaluation of MI by CIDA in 2006-07. These have taken account of actions being undertaken by others working on maternal, newborn and child health, on ending child hunger and under-nutrition, and on eliminating micronutrient malnutrition. The resulting Plan seeks to respond to the current external environment, to help set future directions for MI, and to identify the work that MI must do to achieve that future.
3. The Plan seeks to confirm the position of micronutrient interventions as essential integral components of wider programmatic approaches that address a number of the Millennium Development Goals. It identifies Strategic Goals of primary importance to MI that are consistent with this positioning, and with the organization's vision and mission. The Plan identifies the key actions needed to achieve these Goals, and requires a challenging but achievable level of growth in MI's resources to enable MI to make a greater contribution over the next five years directly, in addition to leveraging other sources of funds. The Plan also provides a framework within which such an expansion and leveraging of resources will be developed.
4. The Plan recognizes that, even with an expanded resource base for MI, many more resources will be required for MI's Mission and Goals to be fulfilled. The Plan therefore sets out how MI will work with partners jointly to achieve the greatest possible impact, and will prioritize its actions to achieve optimal results. It shows how MI will build on its main strengths as an organization: catalyzing the development, and assuring supplies, of appropriate micronutrient products; helping create an enabling environment that supports the extensive use of cost effective micronutrient interventions; and encouraging the development, largely by others, of sustained demand for micronutrient products and interventions.
5. MI will take a results-based strategic management approach to its work. This will entail (a) ongoing prioritization of its efforts globally and within countries and regions, (b) ongoing assessments of the organization's comparative advantage in taking on tasks independently as opposed to leveraging inputs from others, and (c) reflecting these choices in more detailed annual Programs of Work and Budget. These annual work plans will be prepared and reviewed at the beginning of each financial year, and will include clear specification of the means by which particular goals and objectives are to be achieved, given the resources available, for that given year. Progress towards achieving the objectives will be reviewed on an annual basis.
6. The strategic plan is designed to be a living document. It will be subject to review and changes in response to shifts in the internal or external environments.

II. ORGANIZATIONAL DESCRIPTION, VISION AND MISSION

7. The Micronutrient Initiative (MI) was formed in January 1992 out of the pledge of the 1990 World Summit for Children to protect the world's children against malnutrition. It functioned initially as a Secretariat within the International Development Research Centre (IDRC) in Canada to focus the world's attention on the problem of hidden hunger which was not well recognized at that time. MI spent the first 10 years of its existence working with key development assistance agencies, primarily on raising awareness of the problem through advocacy, on expanding the application of known solutions (vitamin A supplementation and salt iodization) and on developing innovative solutions, such as products for children and double-fortified salt, to ensure that micronutrients reached vulnerable populations cost-effectively.
8. At the end of its first 10 years, MI evolved into an independent not-for-profit corporation registered in Canada. It progressively started to shift its emphasis from global advocacy and product development to more direct support at country level. MI focused on scaling-up cost-effective interventions, working in close partnership and in innovative ways with governments, the private sector, UN agencies and civil society. MI's key contributions to global progress over the past 15 years include: providing support for supplies of vitamin A supplements that benefit over 200 million children annually in 70 countries; increasing the production and marketing of iodized salt to reach up to 300 million people in over 10 countries; and supporting the expansion of fortification of staple foods and condiments in over 20 countries.
9. The evolution in its mandate was accompanied by a decentralization of the organization and the establishment and expansion of regional and country offices staffed by skilled professionals recruited locally. Today it is an effective robust organization that advocates at the highest levels for policy and program action on behalf of vulnerable populations, provides technical and financial assistance, secures services, and supports the development, implementation and monitoring of solutions for hidden hunger.

Vision

10. Our vision is of a world free of hidden hunger.

Purpose

11. MI is dedicated to ensuring that the world's most vulnerable - especially women and children - in developing countries get the vitamins and minerals they need to survive and thrive.

Mission

12. To develop, implement and monitor innovative, cost effective and sustainable solutions for hidden hunger, in partnership with others.

III. BACKGROUND AND RATIONALE

13. In a recent publication, *Repositioning Nutrition as Central to Development*, the World Bank (2006) outlined how under-nutrition relates to the Millennium Development Goals (MDGs):

Goal 1: Eradicate extreme poverty and hunger

- Under-nutrition erodes human capital through irreversible and intergenerational effects on cognitive and physical development.

Goal 2: Achieve universal primary education

- Under-nutrition affects the chances that a child will go to school, stay in school, and perform well.

Goal 3: Promote gender equality and empower women

- Anti-female biases in access to food, health, and care resources may result in under-nutrition, possibly reducing women’s access to assets. Addressing under-nutrition empowers women more than men.

Goal 4: Reduce child mortality

- Under-nutrition is directly or indirectly associated with over half of all child deaths and is the main contributor to the burden of disease in the developing world.

Goal 5: Improve maternal health

- Maternal health is compromised by under-nutrition, which is associated with most major risk factors for maternal mortality. Maternal stunting and iron and iodine deficiencies particularly pose serious problems.

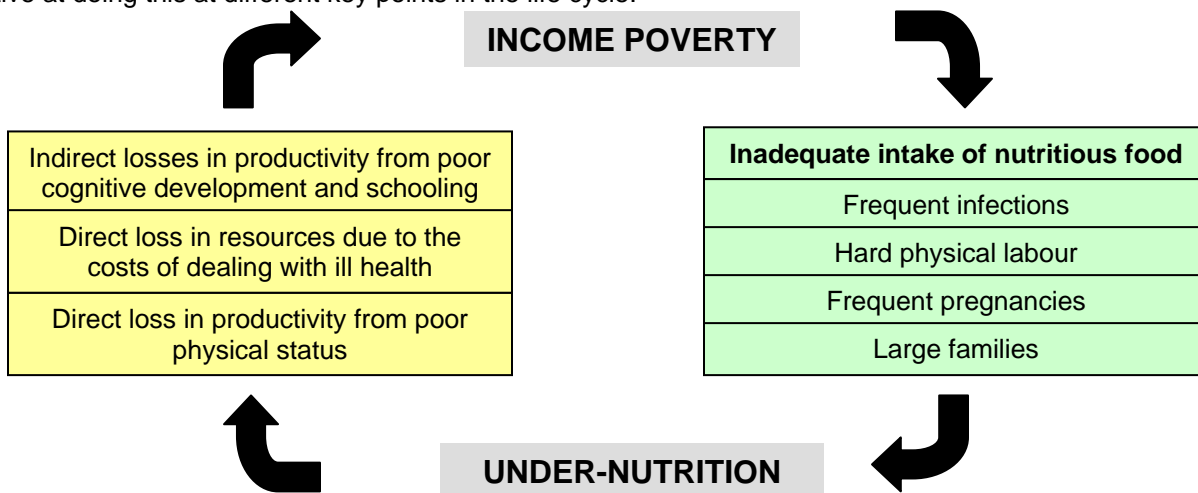
Goal 6: Combat HIV/AIDS, malaria, and other diseases

- Under-nutrition may increase risk of HIV transmission, compromise antiretroviral therapy, and hasten the onset of full-blown AIDS and premature death. It increases the chances of tuberculosis infection, resulting in disease, and it also reduces malarial survival rates.

14. The World Bank (2006) also illustrated how under-nutrition perpetuates the cycle of poverty, as shown in the (adapted) figure below:

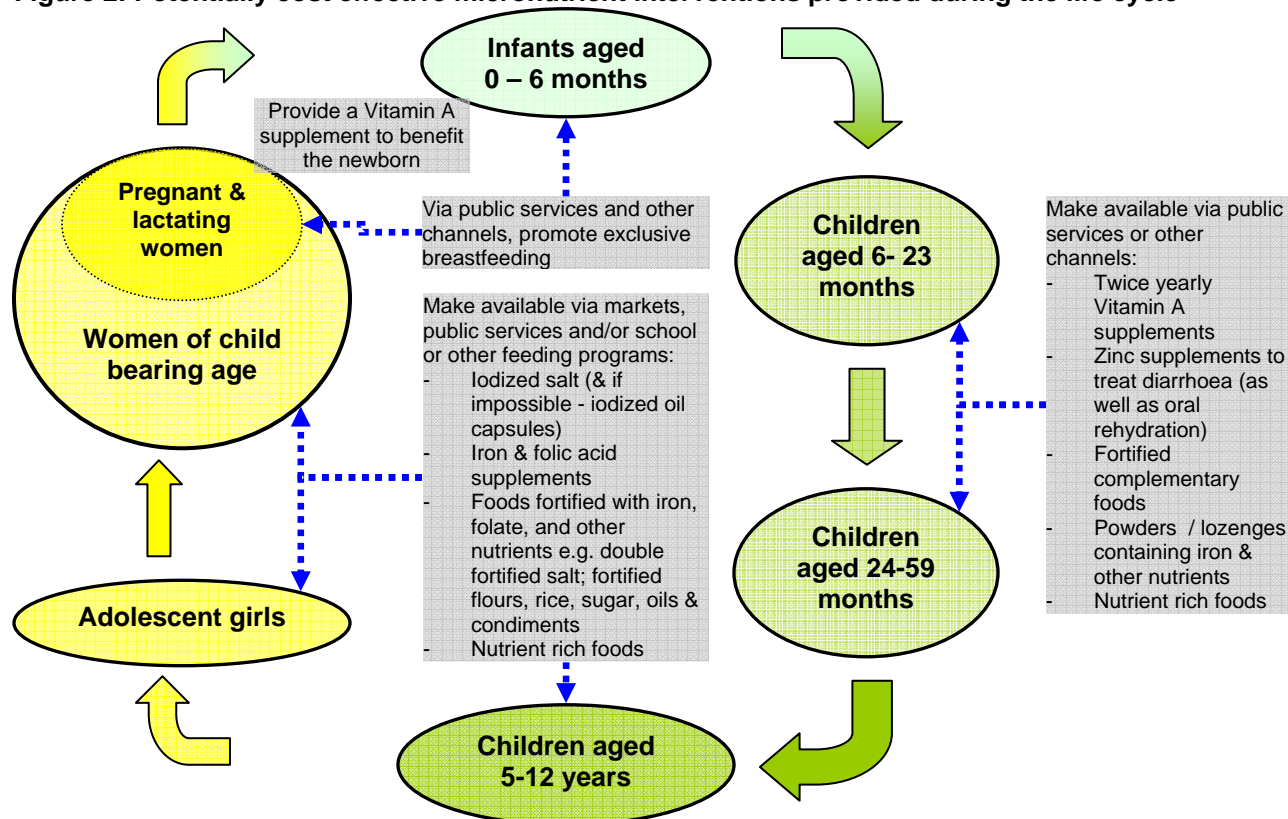
Figure 1: The cycle of poverty and under-nutrition

15. This analysis examines how MI can best contribute to the (MDGs) by improving the intake of essential vitamins and minerals. Several interventions have been shown to be safe, affordable and highly cost effective at doing this at different key points in the life cycle.



Achieving high levels of coverage with these interventions can improve health (by reducing disease and mortality) as well as improving cognitive development, school performance, and physical work capacity. The figure below illustrates some of the interventions considered to be (at least potentially) cost-effective:

Figure 2: Potentially cost effective micronutrient interventions provided during the life cycle



16. MI recognizes that interventions to tackle other determinants of under-nutrition – by acting to reduce infections, increase overall household food security and/or improve care for children and women - can all contribute to improving the micronutrient status of a population. However MI has evaluated its own core strengths alongside those of other actors, and determined that it can add most value by focusing on improving the intake of cost effective micronutrient products that confer direct benefits in terms of child survival, child development and women’s health.

17. Specifically, MI feels that it adds most value when
- innovating to improve the **supply and distribution** aspects of micronutrient products such that they are accessible to all those at most risk from VMD, ensuring benefits reach those most vulnerable to VMD, many of whom are likely to be in the lowest socio-economic groups;
 - fostering an **enabling environment** for cost-effective micronutrient products in terms of policy and political commitment that is ‘promotional’ or at least ‘permissive’;¹
 - advocating for **financing** flows to enable timely and adequate provision of cost effective micronutrient products to all those at risk where needs cannot be met via market channels.
 - working in **partnership** with others better able to stimulate sustained demand for appropriate and affordable micronutrient products, and to address other determinants of under-nutrition.

¹ On a spectrum of policy positions that range from: promotional <=> permissive <=> precautionary <=> preventive

18. This assessment of its comparative advantage is reflected in MI's choice of Strategic Goals and the approaches that MI will adopt to achieve them, as outlined in the section that follows.

IV. STRATEGIC GOALS

Program Goals

19. Recognizing under-nutrition as a significant determinant of global poverty that also constrains women's empowerment and limits the productivity and economic growth of nations, MI will work from 2008-2013 to reduce a key element of under-nutrition - vitamin and mineral deficiencies (VMD) – among population groups who are most vulnerable to the impacts of VMD on human health and well-being. In terms of long range development results, MI aims to help achieve three of the Millennium Development Goals (MDGs) particularly. These Goals are, by 2015, to:
- a. MDG4: Reduce Child Mortality
 - b. MDG2: Achieve Universal Primary Education
 - c. MDG5: Improve Maternal Health
- relative to 1990 levels.
20. MI's own Program Goals are rooted in these three MDGs and identify how MI will contribute to them. MI aims:
- A. Child Survival:** To reduce under-five mortality by increasing and sustaining vitamin A and zinc intake
 - B. Child Development:** To improve the cognitive development of, and educational outcomes among, children through increased and sustained intake of iron and iodine
 - C. Women's Health:** To improve the survival and health of women by increasing and sustaining their iron, folic acid and iodine intake and, in turn reducing the consequences of iron deficiency anaemia and of poor pregnancy outcomes.
21. By so doing, MI aims also to contribute indirectly to achieving MDG1 (eradicate extreme poverty and hunger), MDG3 (promote gender equality and empower women) and MDG6 (combat HIV/AIDS, malaria and other diseases).

Organizational Goals

22. To enable it to achieve its Program Goals, MI will also pursue three organizational goals. These are:
- D. Innovating for Large-Scale Impact:** To apply a cutting edge business model that aims to combine innovation, partnership, direct action, and the leveraging of added investments to permit large scale impact on hidden hunger that is cost-effective, safe and integrated sustainably within health systems and markets.
 - E. Investing in People:** To provide a stimulating and rewarding work environment that attracts and retains people of the highest calibre to drive the work of the organization.
 - F. Mobilizing Resources:** To secure diverse and sustained sources of revenue, and to apply them in the most cost-effective manner, while continuing to leverage resources so as to achieve a steady growth in MI's ability to achieve its mission, approximately doubling its annual budget to CDN\$60 million by 2013.

V. MI's PROGRAM GOALS, OBJECTIVES AND APPROACHES

A] CHILD SURVIVAL

Situation Assessment

23. In 2000, the great majority of countries adopted as the 4th Millennium Development Goal: **to reduce, by 2015, the mortality rate among under-five children by two thirds compared to 1990**. Improved child survival can help break the intergenerational cycle of poverty, and so contribute to the reduction of poverty and hunger. Under-nutrition including vitamin and mineral deficiencies (VMD) contributes to 56% of these deaths. 40 countries account for 90% of all child deaths.
24. For child survival programs to save many more children's lives, universal coverage is required, of at least a minimum set of essential interventions. These include, among others, twice yearly preventive supplementation of children under five with high strength vitamin A supplements (VAS), exclusive breastfeeding, treatment of childhood measles with VAS, and treatment of diarrhoeal infection with zinc supplements (ZnS). Increasing intake by children of foods rich in or fortified with vitamin A and/or zinc may also help reduce the risks of morbidity and mortality from these deficiencies.
25. A meta-analysis of several country studies has shown that high dose vitamin A supplements (VAS) can reduce all cause mortality among children aged 6 months to 5 years by 23%. Supplement doses not more than six months apart are currently recommended by WHO for children aged from 6 to 59 months, living in areas with high rates of child mortality, and where vitamin A deficiency is a public health problem. New data is now emerging on the potential benefits of providing vitamin A supplementation to newborns. Evaluations of the safety, feasibility, cost effectiveness and impact of implementing this at scale could lead to an extension of the targeted age range, and possibly to a shift in current program emphasis. It has been estimated that approximately 850,000 infection-related child deaths annually could also be averted by timely treatment of diarrhoea with **zinc supplements** in addition to oral rehydration.
26. Commercial fortification of sugar with vitamin A has been shown to improve children's vitamin A status cost effectively at scale. Although this has yet to be conclusively demonstrated for other approaches, efficacy studies have shown that consuming fortified margarine, flour and lozenges (nutri-candies) can improve children's VA status. Some foods consumed by poor populations in certain areas (red palm oil; orange fleshed sweet potatoes) have been shown to improve vitamin A status. One study has shown consumption of biscuits, made with flour fortified with zinc, can improve zinc status in children.

Twice yearly preventive vitamin A supplementation

27. This is the only micronutrient intervention that is both established as cost effective in terms of improving child survival, and implemented at national scale in many countries. Since 1997-8 MI has played a key role in the achievement of global coverage with two annual doses of almost 60% by 2004, by providing supplies and technical and other support to countries via UNICEF and others. MI also makes available, via UNICEF, vitamin A supplements as part of their response to emergencies, and provides supplies for treatment, via health systems, of children.
28. Progress to date has been achieved and maintained by **integrating** VAS with immunization campaigns or well coordinated events such as Child Health Days, often supported by specific donor funding. However coverage via routine health services remains relatively low where there is no regular outreach to communities. Overall, progress falls short of the universal coverage recognized as essential to save the largest possible number of children's lives.

29. Constraints on universal coverage include limitations in: national policies; political commitment; co-ordination at national and international levels between parallel initiatives to improve child health; social mobilization (especially for caregivers bringing children over 1 year of age to distribution points); and health systems' capacity (especially for results-based planning, supervision, supply chain and other management, forecasting, training and communications). Differing or parallel approaches to coverage assessment and the lack (in many countries) of reliable population data often confuse the picture of coverage achieved. Central buying of high strength vitamin A supplements helps to guarantee and to sustain a reliable supply (as there is no commercial market for them and advance investment costs for suppliers are high). Overall, the lack of adequate sustained financing for regular distribution events remains the greatest constraint to achieving sustained universal coverage with essential child survival interventions. While countries and donors are investing more in health systems, inadequate provision is made for the costs of the regular outreach typically needed for universal coverage, including the 'mopping up' of children missed by scheduled distributions.

Treatment of diarrhoea with zinc supplements

30. This intervention has been shown to be cost effective, but is not yet extensively scaled up. Few countries as yet have policies for the use of zinc supplements for diarrhoeal treatment in addition to oral rehydration. Major constraints include insufficient understanding of the role and importance of zinc and lack of recognition that using zinc supplements can increase the number of lives saved by the use of oral rehydration alone. Very low levels of financing and, in turn, of supply, coupled with limited staff knowledge and training, and unknown levels of demand from, and adherence by, caregivers, all currently stand in the way of more rapid and widespread scaling-up.

Food based approaches

31. These interventions are based on increasing the intake by target groups of foods fortified with, or rich in, nutrients. The challenges involved in these interventions include gaps in the evidence of their cost-effectiveness at large scale (e.g. VA-fortified sugar and the controlled distribution of fortified lozenges as exceptions). Although successful in some settings, sustaining a viable market for VA-fortified sugar can be challenging without sustained public funding. Other constraints on taking these interventions to scale may include limited supplies and financing flows; a lack of promotional policies; and poor awareness and demand.

Strategic Approach to Improving Child Survival

32. MI's Goal is to contribute significantly to reduce under-five mortality by increasing sustained vitamin A and zinc intake. MI's target is to have averted by 2013, a significant number of the deaths of children under five that are currently associated with vitamin A and zinc deficiency. To achieve this MI will focus most attention on countries/regions with the largest numbers of child deaths, working with them directly and through partnerships with others.

33. Specifically, MI will aim to work towards its child survival goal by aiming:

OBJECTIVE	APPROACH - Working in partnership with other actors² where it can add value, MI will achieve this by:
<p>A1. To establish by 2013, in up to 60 countries with the highest child mortality burdens, a clear recognition that vitamin A and zinc supplementation are essential for child survival, evidenced at least in policy documents, and preferably (in at least 10 countries) by adequate recurrent national expenditure on vitamin A and zinc supplementation.</p>	<ul style="list-style-type: none"> (a) continuing international effective, evidence based advocacy as needed to sustain the inclusion of vitamin A and zinc supplementation within integrated approaches to child survival. This would include advocating for <ul style="list-style-type: none"> i. vitamin A supplements to be provided as a preventive measure within an integrated service package (e.g. Child Health Days), and, subject to further evidence and evaluations of safety and cost effectiveness, as part of post natal care; ii. zinc supplements to be used routinely for treating diarrhoea in children alongside oral rehydration, and, subject to further evidence, in treating pneumonia in children; (b) targeting advocacy in at least 10 priority countries (as needed) aimed at achieving the inclusion, in health sector action plans and budgets, of adequate sustained recurrent provision for regular events that reach all communities at least twice yearly with an integrated package of essential interventions that include vitamin A supplements; and for widespread provision of zinc supplements through health systems; (c) continuing to advocate, both internationally, and in high burden countries, for the use of VAS coverage as a performance indicator of service delivery by national health systems - at least for children aged 1-5 years; and (d) providing technical assistance to build national capacity in at least 10 countries for the effective planning, management and monitoring of programs of vitamin A and zinc supplementation.
<p>A2. To improve annually, from 2008 through 2013, the contribution made by vitamin A supplementation to reduced mortality in children under five.</p>	<ul style="list-style-type: none"> (a) Continuing to ensure that countries with high child mortality burdens have timely and adequate supplies of vitamin A supplements available for distribution through appropriate delivery mechanisms by: <ul style="list-style-type: none"> (1) procuring supplies and, by donating them to countries, helping to ensure that distribution events are both planned and implemented; and (2) advocating for the recurrent inclusion of sufficient funding provision within national health budgets to cover the costs of procurement of supplements (linked to A1) – noting that the priority is for national budgets to fully finance distribution costs as commodity costs are a small % of the total delivery cost. (b) Updating situation assessments with the active participation of key stakeholders, and on this basis designing and helping to implement

² Encouraging and supporting coordination between actors via the Global Alliance for Vitamin A, the International Zinc Consultative Group, the "Ending Child Hunger and Under-Nutrition Initiative"; the 10 year strategy to eliminate micronutrient malnutrition, etc.

<u>OBJECTIVE</u>	<u>APPROACH - Working in partnership with other actors² where it can add value. MI will achieve this by:</u>
	<p>targeted, timely and cost effective actions to:</p> <ul style="list-style-type: none"> (1) facilitate the sustained integration of the delivery of VAS with at least two other essential interventions (such as immunizations and deworming) through regular contacts with targeted groups during Child Health Days (or similar scheduled distribution events), to maximize the additional coverage achieved in each “semester” (half year period); (2) develop through extenders, or other cost-effective, means, sustainable solutions in priority countries to recurrent supply chain and distribution problems [linked to A1 and A2 (a)]; (3) assure coverage to the most vulnerable who do not present at regular events such as child health weeks; and (4) test, develop and disseminate new knowledge on innovative approaches and technologies for improving coverage, and child survival, rates. (This may include work on the emerging option of neonatal vitamin A supplementation).
<p>A3. To improve annually, from 2008 through 2013, the levels of mortality reduction achieved by improved zinc intake by children under five in up to 10 countries.</p>	<ul style="list-style-type: none"> (a) (in addition to A1) Advocacy for the adoption in priority countries of guidelines and performance indicators relating to the inclusion of zinc supplements as part of the management of childhood diarrhoea; and (b) Advocacy to mobilize support in priority countries and other actions in countries such as: working with local suppliers, as appropriate, to help increase the supply and distribution of zinc supplements of appropriate quality; and establishing approaches to scaling up provision that are cost effective and contribute significantly to mortality reduction.
<p>A4: To accelerate the scale-up of cost-effective means of improving the regular daily intake of VA and zinc by target groups, especially preschool children in up to 10 countries.</p>	<ul style="list-style-type: none"> (a) Advocating for, and, where essential, facilitating, the generation of more extensive evidence on the: <ul style="list-style-type: none"> i. comparative cost effectiveness and cost benefits of differing interventions in relation to child health and survival; and ii. optimal mix of such interventions; (b) Advocating for, and providing value-adding technical assistance to support the scale-up of, an optimal mix of interventions where these are proven to increase VA and/or zinc intake by vulnerable preschool children at scale and to reduce mortality and/or morbidity significantly.

B] CHILD DEVELOPMENT:

Situation Assessment

34. Iodine Deficiency Disorders (IDD) remain a significant public health problem in over 50 countries. Over one and a half billion people worldwide are still not consuming adequately iodized salt and are, as a result, not protected against IDD. The World Health Organization (WHO) has identified iodine deficiency as the world's single most significant cause of cretinism and other forms of preventable brain damage and mental impairment. The most severe impacts of iodine deficiency occur during foetal development and in the first few years of life. It is thus critical to reach women of child bearing age and young children. Given how difficult it is to target these two groups, the global strategy of choice is universal salt iodization (USI). However where iodized salt cannot be made available for a period of a year or more, an alternative is to provide a high dose iodized oil capsule to women of child bearing age.
35. Hunger, under-nutrition and infections continue to make iron deficiency anaemia (IDA) a critical risk factor for cognitive development in early childhood. Iron deficiency in the 6-24 month age group is impairing the mental development of approximately 40-60% of the developing world's children. In the best of circumstances, a breastfed child of normal birth weight, with a mother who is not iron deficient, will have adequate iron for the first six months of life – about half from the breast milk and half from the iron stores inherited from the mother at birth. But when breast milk is complemented with other foods (at about the age of six months) the problem becomes critical. The stores inherited at birth are gone. Continued breastfeeding can still supply about 50% of the iron needed. But the other 50% cannot be provided by the low-density porridges, gruels and mashes that are the usual complementary foods for children across the developing world.
36. As a result, hundreds of millions of children aged 6-24 months are iron deficient, as their diets fail to meet the complex demands of their growing minds and bodies. Bridging this 6-24 month "iron gap" is thus crucial. Because many children 6-24 months will have been missed over the next five years, it is also important during that time to facilitate access to iron-rich foods for children 25-59 months as well as school aged children³.
37. All told, the impacts of IDD and IDA on the cognitive development of affected newborns and young children can put at risk the successful completion of primary schooling for millions of children. In addition, physical and mental development are further affected, and severely, for the 300,000-400,000 infants born worldwide each year with neural tube defects (NTD) or *spina bifida* and anencephaly, associated with a deficiency of folic acid during pregnancy. Incidence ranges from 1-5 per 1000 live births with more than 95% of cases contributed by the first affected pregnancies. Asia accounts for a significant proportion of cases, with 100,000 infants born annually with *spina bifida* or anencephaly in China; while in India the incidence of *spina bifida* ranges from 4-13 per 1000 live births, and that of neural tube defects is 8.2 per 1000 live births. Increased consumption of foods and/or supplements containing folic acid by women of child bearing age is key to addressing this problem.

Iodized Salt

38. Significant progress has been made in recent years in increasing the consumption of adequately iodized salt: as at October 2007, 70% of the world's population were estimated to be doing so. But this also means that 30% of households globally still consume inadequately iodized or non-iodized salt, leaving some 40 million newborns annually unprotected against iodine deficiency disorders. Issues inhibiting sustained universal salt iodization include: production level constraints; problems with the supplies of the inputs required for iodization; weak enforcement of regulations and policy; and inadequate demand on the part of consumers.

³ Source: VMD global progress report, p3

Iodized oil capsules

39. This intervention will be considered by MI only where it can be cost effective. This will usually be where distribution can be undertaken in combination with other health services that reach out to communities – and where there is little or no short term prospect of improving household consumption of iodized salt. Often, opportunities to provide iodized oil capsules to pre-pregnant and pregnant women are constrained by limited access to health services, a lack of awareness among women, a lack of guidelines for health workers, and a lack of supplies and of financing to support procurement and distribution.

Interventions for increasing the intake of iron and other nutrients by pre-school children

40. Access for many children under two to commercially produced fortified complementary foods is often significantly restricted by their socio economic status: many poor households simply cannot afford them, and/or live beyond the range of their distribution. Even in feeding programs for people affected by emergencies, fortified foods suitable for young children may not be available. Iron supplements in the form of syrup or tablets are poorly accepted by consumers, in short supply and often relatively expensive. In areas with endemic malaria, there is also concern about the safety of supplements for children under two. This leaves a number of intervention options for providing iron (and often other nutrients, particularly vitamin A given its important role in iron metabolism):
- 'Sprinkles-type' multiple nutrient powders, containing iron and other nutrients, added by caregivers to children's food daily for sixty days, have been shown to be efficacious in reducing anaemia; however their safety for use in malarial areas is currently uncertain.
 - Multiple nutrient powders added to communal feeding pots (where children are not served food in a separate dish) have been shown to be efficacious and safe in practice.
 - Lozenges / nutri-candies containing iron and other nutrients have been shown to be cost effective at scale for older pre-school children.
 - "Double-fortified" salt (fortified with iron as well as iodine) – of a formulation with demonstrated efficacy – can be added to complementary foods.
 - Lower cost fortified complementary foods can be made available to more people, for example through subsidized market channels.
41. Constraints inhibiting scale up of these interventions include limited sources of supply, inadequate awareness at both governmental and household levels of why iron deficiency among pre-school children matters so much; and safety concerns around supplementation in malaria endemic areas. (The use of supplements or other approaches that deliver high doses of iron to young children in malarial endemic areas are no longer advised in the absence of an effective malaria control program. The MI and its partners presently are reviewing options to determine what can safely be done in these areas.)

Interventions for increasing the intake of iron and other nutrients by mothers

42. Enhancing women's intake of the nutrients which are critical for foetal development and infant growth can improve both their own health and that of their children. This is particularly vital for iodine and folate, the lack of which may have irreversible effects early in pregnancy. But uptake by many women of child bearing age of commercially produced fortified foods is limited by factors such as geographic access and affordability. Even in public feeding programs, including those for people affected by emergencies, the lack of local suppliers of fortified or nutrient rich foods can mean that the nutrient quality of available food is sub-optimal. Coverage with iron and folic acid supplements is limited by the lack of supplies and by low levels of adherence among women (except where there is intensified community based distribution). In many countries, the level of political commitment, and the policies and resources allocated, for tackling iron and other nutrient deficiencies among women are far from adequate.

43. MI therefore considers that their best approach is to help scale up provision of a combination of cost-effective approaches that suit each local situation. These include:
- a. Supporting the development of national strategies or plans to improve the intake by mothers of iron and other key nutrients, and their inclusion in Poverty Reduction Strategy Papers (PRSPs);
 - b. Scaling up the fortification with iron and folate of staple foods such as cereal flours and rice – at commercial and community level to the extent that is feasible and commercially viable;
 - c. Increasing the availability, acceptance and adoption of multi-micronutrient powders by health systems as well as by private sector distributors;
 - d. Transferring the technology to increase the availability, as well as working to increase acceptance and adoption, of salt fortified with iron as well as iodine (DFS) – while also exploring the option of including folic acid in addition.

Strategic Approach to Improving Child Development

44. MI's Goal is to increase the intake of iron, folic acid and iodine during foetal and early childhood development and so improve cognitive development and educational outcomes among children. In support of this, MI aims over 2008-2013 to contribute to:
- a. Achieving and sustaining universal consumption of adequately iodized salt (supplementing with iodized oil only where essential), focusing especially on countries at most risk of IDD, so as to reduce the number of newborns of both sexes who are unprotected from IDD and the risk of impaired brain development;
 - b. Scaling up cost-effective interventions that directly benefit pre-school children (especially those aged 6-24 months) and to lesser extent primary school children, and adolescent girls;
 - c. Scaling up cost-effective interventions that improve the intake by women of child bearing age of other key nutrients, such as iron and folate, that impact indirectly on child development (see also the section below on women's health).

MI will focus particularly on the most vulnerable groups, such as those from lower socio-economic groups, the marginalized and populations affected by emergencies. Specifically, MI aims:

OBJECTIVE	APPROACH - Working in partnership with other actors where it can add value, MI will achieve this by:
<p>B1. To increase the proportion and number of individuals in developing countries who consume adequately iodized salt on a sustained basis.</p>	<p>(a) developing the capacity of the private sector in targeted countries for increased overall production and marketing of adequately iodized salt for human consumption. The focus will be on countries with large volumes of inadequately iodized salt that are produced for either domestic consumption (reflected as low household consumption) or for export, especially where consumers live in areas with higher prevalence of IDD. This is expected to involve intensive efforts to locate, map and engage with salt producers (especially small-scale); installation of adequate equipment, training and quality assurance; supporting the procurement and distribution of potassium iodate, consumables and spares; and helping develop and embed sustainable business models;</p> <p>(b) advocating for improvements in the proportion of salt in processed staple foods and condiments that is adequately iodized;</p> <p>(c) providing technical assistance to facilitate the increased use of adequately iodized salt in processed foods where it can be achieved cost-effectively;</p> <p>(d) supporting the provision of iodized oil capsules to women of child bearing age in high burden areas where adequately iodized salt cannot feasibly be made available within two years;</p> <p>(e) fostering coordination between all partners' efforts via the Network for the Sustained Elimination of Iodine Deficiency Disorders, and by coordinating its work with that undertaken by partner organizations on advocacy, demand creation, etc.</p>

<u>OBJECTIVE</u>	<u>APPROACH - Working in partnership with other actors where it can add value, MI will achieve this by:</u>
	(f) advocating for regular tracking of household coverage , while also working in countries as needed to strengthen sustained monitoring and regulatory processes and actions to address any 'backsliding' that is detected among producers;
B2. To institutionalize, in at least 10 countries with high levels of childhood anaemia, interventions that safely and cost-effectively improve the intake of iron by young children aged 6-24 months, and confer on them adequate protection from iron deficiency anaemia.	(a) advocating for, and facilitating, the adoption and scale up of innovative technologies that are proven to be safe and efficacious <i>via</i> existing commercial and public distribution channels. Examples of these technologies may include: micronutrient powders (<i>vita-shakti</i> ; <i>buddhi shakti</i> and 'sprinkles-like' products); low-cost fortified complementary foods; double-fortified salt; fortified lozenges; etc. Channels would include targeted food subsidy or distribution mechanisms, capable of providing effective coverage particularly of children from the two lowest socio-economic strata. (b) advocating for, and advising on, the inclusion, in PRSPs and other plans, of regular tracking of anaemia among children aged 1-5 years; and advocating for, and, where essential, facilitating the generation of, more extensive evidence on the (i) comparative cost effectiveness and cost benefits for young children of differing combinations of interventions; and (ii) optimal mix of interventions in given settings
B3. Institutionalizing, in up to 10 countries, interventions that safely and cost-effectively improve by 2013 the intake of iron and folic acid by women of child bearing age at levels sufficient to confer benefits to foetal and childhood development. [See also C2]	(a) facilitating the wider adoption and provision of key products (that are proven to be safe, efficacious and effective) at scale via existing commercial and public distribution channels. Examples of such technologies may include: iron & folic acid supplements; cereals or other staple foods fortified with iron and folic acid; multi-micronutrient powders (<i>vita-shakti</i> ; <i>buddhi shakti</i> ; etc.); fortified lozenges; double fortified salt etc. (b) facilitating as needed the generation of more extensive evidence on the (i) comparative cost effectiveness and cost benefits for women of child bearing age of differing (combinations of) interventions; and (ii) optimal mix of such interventions in given settings and building this into national plans and policies
B4: Integrating a wider range of cost effective micronutrient interventions within emergency response & other targeted public feeding operations , initially via their inclusion in policies and guidelines at international, regional and national levels; and the inclusion in these operations of appropriate coverage indicators. [See also C3]	(a) advocating for, and providing technical assistance where needed to support, the integration of key micronutrient interventions into international and national level policies and guidelines; (b) providing technical assistance to facilitate the evaluation and adoption of appropriate new technologies (such as <i>vita shakti</i>); (c) where there is a clear need based on safety, efficacy, cost, availability or effectiveness, further developing and testing innovations in technologies that can provide improved micronutrient intake to displaced populations at scale; and (d) undertaking, when emergencies occur and MI can add value, situation assessments to identify missed opportunities with respect to improving micronutrient intake, and by initiating or leveraging programming to reduce these gaps.

C] WOMEN'S HEALTH

Situation Assessment

45. The prevalence and effects of micronutrient deficiencies reflect broader biases against women in access to food and basic services. Ensuring that women and children get the micronutrients they need for survival and health can contribute indirectly to improved gender equality and to the empowerment of women (MDG3). Ensuring that women have an adequate intake of key micronutrients (including VA, iron, iodine, and folic acid) can impact directly and beneficially on the health of their children, and help break the intergenerational cycle of under-nutrition. Likewise, doing more to fulfil the daily needs for vitamins and minerals of the poorest and most vulnerable women can help to contribute to reducing poverty and hunger (MDG1).
46. The impact of iron deficiency on women tends to be greater than that on men, reducing their potential to participate in social and economic activity and to escape poverty. Iron deficiency contributes to maternal mortality (in cases of severe anaemia) and morbidity, and is associated with decreased productive capacity in both genders. Of the 2 billion people estimated by WHO to be affected globally by iron deficiency anaemia (IDA), women of child bearing age (especially those who are pregnant and/or in populations displaced as a result of emergencies) are particularly vulnerable. Increasing attention is also being focused on the micronutrient deficiencies of adolescent girls and the importance of improving pre-pregnancy nutritional status and iron stores.

Interventions for women and adolescent girls

47. No single intervention can however provide a broad based solution for all. A combination of complementary and locally appropriate approaches is needed. These include:
- a. **Iron and folic acid supplements** for pregnant women. Although well established as safe and efficacious, constraints on their cost effectiveness at scale include limited: political commitment and financing; supplies; and availability through public distribution channels. Even where available, poor adherence can limit effective coverage, although this can be improved in some settings by using intensive community-based distribution.
 - b. **Fortified staple foods and condiments.** Commercial scale fortification of centrally processed foods is gaining ground. However constraints on the effective coverage of people most at risk include low levels of financial and geographic access for people in marginalized groups and from lower socio-economic groups. Even where adequate amounts are consumed, there may be issues with efficacy, as a result of the sub-optimal bio-availability of nutrients in cases where the type and/or composition of fortificants used are not appropriate, do not take account of local dietary factors, or when intake of other key nutrients that play a role in iron metabolism are insufficient. This means that, while cereals fortified with iron and folic acid can be expected to provide some protection to consumers in higher socio-economic groups who consume adequate amounts, others may not derive the same level of benefit. Double fortified salt (DFS, containing iron as well as iodine) offers, in time, the potential to reach entire populations, including lower socio-economic groups. But DFS needs much wider recognition, championship and adoption to achieve extensive scale-up and to fulfil its potential.
 - c. **Championship** of improved nutrition as a maternal health issue among policy and decision makers, and higher levels of explicit financial provision to address iron deficiency anaemia among women and girls, are both essential. Both are major gaps in most countries.
 - d. Improved **monitoring** of effective coverage especially among the groups most vulnerable to VMD, and the **evaluation** of the effectiveness of, interventions are both needed to guide countries on the best choices of approach to be taken; and on what works locally.

Strategic Approach to Improving Women’s Health

48. MI's Goal is to increase women’s intake of iron and other nutrients essential for their improved survival, health and productivity. In support of this, MI aims by 2013 primarily to contribute to a reduction in the burden of iron deficiency anaemia among women of reproductive age in up to 10 priority target countries/regions. To do so, MI will build on its experience over recent years of scaling up the fortification of cereals in several countries (including work on fortified rice in India) of using multi-nutrient powders to improve intake in feeding programs, of improving coverage with supplements, and of developing and establishing the efficacy, acceptability and initial scaling up of double fortified salt. Specifically MI will aim to:

<u>OBJECTIVE</u>	<u>APPROACH - Working in partnership with other actors where it can add value, MI will achieve this by:</u>
<p>C1. To establish by 2013, in up to 10 priority countries with high burdens of maternal anaemia, sustained commitment in the country to improving the intake of iron (as well as of other nutrients) by women (as well as men), evidenced at least in policy documents, and preferably via sustained annual public sector expenditures, and via routine fortification of key foods by local industries.</p>	<p>(a) advocating for, and facilitating where essential the generation of more extensive evidence on the:</p> <ul style="list-style-type: none"> i. comparative cost effectiveness and cost benefits for women of child bearing age of differing (combinations of) interventions to improve their intake of iron (and other key nutrients); ii. optimal mix of interventions in given settings iii. understanding of linkages between better nutrition and gender equity. <p>(b) targeting advocacy in at least 10 priority countries as needed aimed at achieving the (i) inclusion, in health sector action plans and budgets, of sustained recurrent provision for cost-effective approaches for meeting the nutrient intake needs of women of child bearing age and adolescent girls – including funds for increased supplies, and counselling to improve adherence with iron and folic acid supplements at antenatal contacts; and (ii) the mandatory fortification of key foods, such as flour, rice, salt and condiments, with iron & other nutrients, and its regulation;</p> <p>(c) advocating internationally and nationally as required for regular tracking of the prevalence of iron and folic acid deficiencies and other key VMD among women of child bearing age; and</p> <p>(d) where essential to sustaining high coverage, providing technical assistance to develop national plans and strategies to reduce VMD, including relevant elements of PRSPs.</p>
<p>C2. To institutionalise, in up to 10 priority countries, the provision, and utilization at high rates of adherence, by women of child bearing age and adolescent girls, of appropriate combinations of products rich in iron and other nutrients (such as folic acid). [See also B3]</p>	<p>(a) providing technical assistance to build the capacity of local food producers (including salt processors re double fortified salt) to produce and market foods fortified with iron (and other nutrients) that are proven to be safe, efficacious and cost effective at scale for women of child bearing age, especially those in the two lowest income quintiles; and</p> <p>(b) where essential to program success, providing technical or other forms of assistance to achieve improvements in the local supply and distribution of iron and folic acid supplements to women of child bearing age and adolescent girls, and to encourage actions to secure higher levels of adherence.</p>
<p>C3: As per B4</p>	<p>(a) As per B4</p>

VI. MI's ORGANIZATIONAL GOALS, OBJECTIVES AND APPROACHES

D] INNOVATING FOR LARGE SCALE IMPACT

49. MI will continue to apply a cutting edge business model that aims to combine innovation, partnership, direct action and the leveraging of added investments to permit large scale impact on hidden hunger that is cost-effective, safe and integrated sustainably within health systems and markets. This business model is grounded in a number of principles that govern the way MI will approach the achievement of its Strategic Goals. These include:

- D1: Evidence-Based Decision Making and Results Based Management
- D2: Prioritization and Targeting for Optimal Impact
- D3: Innovation
- D4: Leveraging, Integration and Partnership
- D5: Marketing and Communications

D1: Evidence-Based Decision-Making and Results Based Management

Safety and Efficacy

50. MI will exercise stewardship relating to the safety, and to the cost-effectiveness of new and existing VMD control measures, and will develop a portfolio of programs and a decision-making culture within the organization that is firmly rooted in **evidence of safety, impact, cost-effectiveness, and sustainability**. MI will achieve this in part by utilizing an advisory Panel of Experts to help assess systematically the programmatic implications of new evidence on the safety or cost-effectiveness of micronutrient interventions and to assure the safety and technical quality of MI programs; and through the ongoing professional development of in-house staff.

51. MI will pay special attention to the relationship between micronutrient deficiencies and infectious diseases and the ways in which nutritional status can affect immune function. MI acknowledges that major gaps remain in the evidence base regarding the optimal means of utilizing micronutrients in the prevention, treatment and mitigation of the impact of major infectious diseases, and, at the same time, regarding the optimal means of reducing micronutrient deficiencies in the presence of infectious disease. The problem of addressing iron deficiency anaemia in malaria endemic areas, raised in discussion of the Child Development goal, requires immediate attention. Additionally, optimal programmatic approaches in addressing micronutrient deficiencies in populations with high proportions of HIV positive individuals require further investigation, as do links between tuberculosis (with and without HIV) and micronutrient deficiencies. This would include exploring how best to address the impact of zinc deficiency on pneumonia rates, malaria and illness among HIV positive children.

52. The constraints inhibiting progress in this area are substantial; however to the extent possible MI will:

- a. Lobby for the mobilization of resources for addressing gaps in the evidence; and, subject to adequate financing and evidence, for the field testing and evaluation of innovative approaches to address these challenges;
- b. Seek to improve programmatic linkages between infectious disease control programs and micronutrient deficiency control programs, and to generate new evidence of the scope for linking health interventions to deal with infections and VMD.

Results Based Management

53. MI will use a results-based management approach to planning, managing, monitoring and evaluating its operations. This will involve comparing actual with expected performance on a regular basis, and adjusting operations to take account of variances and lessons learned. To facilitate this, MI will measure and monitor progress regularly against key performance indicators in five key areas:
- a. **Benefits for target groups** – each year, as a result of MI inputs:
 - Annual # of child deaths averted (or the best available proxy)
 - Annual # of cognitive impairments averted (or the best available proxy)
 - Annual # of women who no longer suffer from moderate and severe anaemia (or the best available proxy)
 - b. **Integration and Sustainability** – each year, as a result of MI inputs:
 - # of countries with adequate VMD control measures in national plans or strategies (including PRSPs) as a direct result of MI inputs
 - The extent to which the total effective coverage achieved by countries is dependent on MI inputs
 - c. **Leveraging and Efficiency** – each year:
 - MI cost (\$) per target group benefit generated
 - % variance from projections of MI disbursements
 - d. **Demand for MI services** – each year
 - Revenue realized by MI each year, by source
 - Value of inputs provided by MI as perceived by partners in annual surveys
 - e. **Stakeholder and Partner Satisfaction**
 - Retention rate of staff
 - % of stakeholders at least 'satisfied' with MI performance in annual surveys
54. MI recognizes that its contributions to the Millennium Development and Strategic Goals cannot be measured directly. MI will therefore adopt and use internationally recognized best practice and data for estimating the outcomes and impacts of its work. In support of this, MI will continue to lead the monitoring, assessment and data working group of the 10-year strategy to end micronutrient malnutrition being developed jointly with other agencies involved in micronutrient programming. MI will maintain a platform of user-friendly knowledge, data and evidence that can be used to generate targeted advocacy and evidence-based programmatic decision-making.
55. When measuring progress, MI considers interventions in two categories. In the case of interventions for which large scale⁴ cost-effectiveness **is not** already adequately demonstrated, MI may contribute to, or facilitate, assessments of the effectiveness of an intervention by means of representative sample surveys in the country/ies concerned. These will assess its costs and effectiveness in reducing one or more deficiencies in a representative sample of targeted beneficiaries using baseline and endline studies with accepted biological markers, and appropriate process indicators to monitor relevant variables. As well as impacts on health outcomes, these may include some or all of the following:
- acceptability to targeted beneficiaries (size; taste; colour; presentation and packaging)
 - awareness and/or perceptions among targeted beneficiaries of benefits and risks
 - capacity for sustained production/procurement (including commercial viability)
 - extent of distribution and/or market reach that realistically can be achieved and sustained
 - local product storage, handling and cooking conditions
 - financial and non-financial costs of access for targeted beneficiaries
56. In the case of interventions for which cost-effectiveness at large scale **is** already demonstrated and accepted for an intervention, MI will assess progress in terms of the **effective coverage** that is

⁴ Large scale is defined as serving >50,000 beneficiaries

attributable to a given MI program. This will be done using a composite indicator that incorporates the most relevant variables: the additional person-years of coverage (APC)⁵ generated over a stated period. This 'effective coverage' – measured in APC – is calculated from the percentage of a target group at risk who are expected to consume a specified % of the estimated average requirement (EAR) of a nutrient over a required period of time, discounted by known risk factors and the estimated extent to which the increase in effective coverage is attributable to MI's intervention. To achieve this:

- a. changes in coverage will be assessed using independently collected representative sample survey data wherever practicable and affordable
- b. modelled or administrative estimates will be made (where surveys are impractical or unavailable), using methodologies that are internally consistent within MI, and externally consistent with other comparable assessments. (As and when survey results become available, MI will reassess administrative estimates as needed).

57. MI will seek to **lead by example in terms of evaluating the outcomes and impact of its efforts**, and using these to improve its programming. This process will start at the design stage, with MI ensuring that its investments are designed so as to allow effective monitoring and evaluation. For example:

- a. At the **input** level MI will track the quantity and quality of goods (e.g. potassium iodate; VA capsules; equipment) and of services provided by MI, and their timeliness.
- b. At the **output** level, MI will track the additional annual production or provision of micronutrient products (such as iodized salt) achieved with the support of MI.
- c. At the level of **immediate outcomes**, MI will use APC to project the outcomes expected from a program or intervention, and to update ongoing assessments of progress made against those expected outcomes. MI will also use the cost per additional person year of coverage (CAPC) to help compare the relative cost-effectiveness of different interventions. Whenever improved data become available, MI's results for any given period may be restated and adjusted in line with newer information.
- d. MI will also continue to evaluate its projects in terms of their impact on health and/or development outcomes.

D2: Prioritization and Targeting for Optimal Impact

Prioritizing The Most Vulnerable

58. The main target groups for MI are determined in accordance with their comparative vulnerability to VMD and its effects on their survival and health. On the basis of the situation analyses above, MI will therefore focus particularly on **newborns** and **children** (especially pre-school) of both sexes, **and women**. Within these age groups, MI also recognizes that people with heightened food (and other forms of) insecurity (e.g. people affected and/or displaced by emergencies; low income groups, and particularly the poorest of the poor) are the most susceptible to VMD. Multiple constraints inhibit efforts to increase coverage among these **vulnerable groups**, including access to, and affordability of, foods with adequate nutritional value. Where these groups are being reached successfully, MI will work to **integrate** innovative and high impact micronutrient technologies into well targeted and pro-poor programming, to leverage larger scale and more inclusive coverage of these groups. MI believes that the incorporation of such technologies across relevant sectors (agriculture; education; food security; health; and rural livelihoods) can be facilitated and enhanced by well placed advocacy and technical assistance inputs.

⁵ Additional Person-Years of Coverage is a measure of the additional benefit conferred on individuals at risk of a Vitamin or Mineral (VM) Deficiency. It is the additional Q% of the RDA of a vitamin or mineral which is bio-available to U individuals in at-risk group(s) during a given period of time Y (in years) as a result of an MI intervention. "Additional" means additional to what would have happened in the absence of MI intervention.

59. MI will seek, in up to 10 priority countries, to integrate actions to control and reduce VMD within national Poverty Reduction Strategy Papers (PRSP) and within pro-poor elements of (health and other) sector action plans; and to promote the inclusion of relevant nutritional indicators in protocols for monitoring PRSP progress. This will involve MI in:
- advocating for (and facilitating) the generation of more evidence on the comparative cost effectiveness and cost benefits for the most vulnerable of differing (combinations of) options for improving nutrient intake; and on the optimal mix of interventions to use in targeted pro-poor programs;
 - advocating to increase the inclusion of an optimal mix of interventions, within policies, plans and guidelines, along with suitable monitoring protocols (this could include the distribution of fortified foods – such as flour, rice, salt, oil, etc – through subsidized distribution channels, and the use of lozenges, micronutrient powders and fortified foods in targeted community, school, and therapeutic feeding programs);
 - advocating in up to 10 priority countries as needed for the inclusion of sustained recurrent provision of an optimal mix of interventions in budgets for PRSPs, sector action plans, and/or targeted or pro-poor programs; and
 - where essential to achieving and sustaining universal coverage, providing technical assistance to help the country to develop appropriate strategies.
60. Keeping in mind the critical importance of reaching the “**hard to reach**”, MI will develop a portfolio of programs with interventions prioritized proportionate to the level of vulnerability of the individuals/age groups targeted. The table below illustrates the main target groups for interventions supported by MI.

INTERVENTIONS	Infants aged 0 – 5 months		Children aged 6 – 59 months		Children aged from 5 to 12 years		Adolescent girls	Women of child bearing age
	Female	Male	Female	Male	Female	Male		
Vitamin A supplements	✓ (TBC)	✓ (TBC)	✓	✓				
Iodized salt	✓ (via mothers)	✓ (via mothers)	✓	✓	✓	✓	✓	✓
Micronutrient powders ⁶			✓	✓			✓	✓
Fortified cereals & oil			✓	✓	✓	✓	✓	✓
Double fortified salt	✓ (via mothers)	✓ (via mothers)	✓	✓	✓	✓	✓	✓
Multi-nutrient lozenges			✓	✓			✓	
Zinc supplements			✓	✓				
Orange-Fleshed Sweet Potatoes			✓	✓				✓

Advancing Gender Equality and Women’s Empowerment

61. All of MI’s programs are expected to benefit women, more than men, both directly and indirectly. MI recognizes the importance of ensuring equity of access to interventions supported by MI. MI will use participatory approaches in key programming stages and give special emphasis to the needs of women and girls throughout. This will include (a) conducting participatory stakeholder and gender analyses to inform program design and inception; (b) conducting participatory monitoring of MI programs, including gender based monitoring; and (c) conducting participatory evaluations of MI programs, including gender based evaluation.

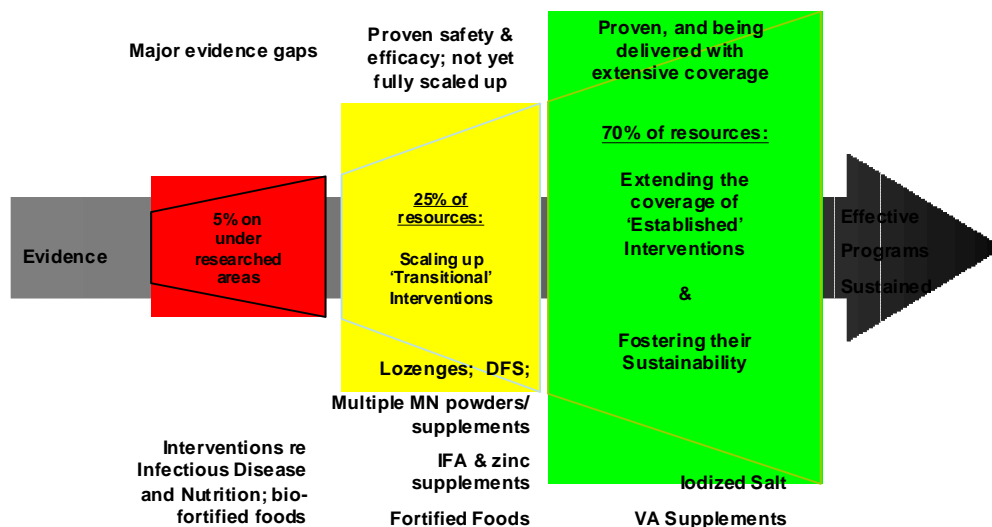
⁶ Such as *vita shakti*, *bhuddi shakti*, *anuka*, *Sprinkles™* etc

62. MI also recognizes the importance of strengthening the participation of women in decision-making and will use every effort to identify and include women leaders when identifying and supporting champions and change agents in high burden countries.

Choice of Interventions

63. MI will work with governments and other partners, including the private sector, UN agencies and NGOs, to select and /or develop innovative, cost-effective and appropriate technologies, delivery mechanisms and strategies that enhance the coverage, effectiveness and sustainability of VMD control programs; and where found to be safe and more cost-effective than existing solutions, to work to scale them up. This will involve
- a. conducting relevant situation analyses and/or surveys, to identify gaps in provision or other needs that lend themselves to improvement through innovation;
 - b. working with partners to develop the solutions best able to meet these gaps or needs;
 - c. testing the products carefully;
 - d. convening expert consultations, where needed to facilitate scaling up; and
 - e. initiating efforts directly or indirectly, where found to be safe and potentially sustainable, to scale up distribution and coverage of target groups via public and/or private sector channels, with concurrent efforts to assure adequacy of supply and procurement.
64. MI recognizes that interventions beyond supplementation and fortification can be used to improve nutrient intake and to reduce the loss of key nutrients. MI will take these into account in its advocacy and in program planning, and will partner as appropriate with others who have comparative advantages in these areas. However MI does not plan to become more directly involved in actions such as:
- a. the promotion of exclusive breastfeeding;
 - b. the control of parasitic infections;
 - c. projects that focus exclusively on the creation of household level awareness and demand;
 - d. the selective breeding and/or genetic modification of crops;
 - e. addressing chronic diseases etc
65. MI recognizes that different micronutrient products, and the interventions needed to deliver them, are at different stages of development, and will seek to strike an optimal balance of investment between them, devoting:
- a. **approximately 70%** of its efforts and resources to ensuring that extensive coverage is improved for interventions that are proven and **established** internationally as safe and cost effective at scale, and ultimately that universal coverage is achieved and **sustained**;
 - b. **approximately 25%** of its efforts and resources to accelerating the adoption and scale-up of **transitional** interventions, that are proven to be safe, efficacious and potentially cost-effective and affordable, but are not yet achieving high coverage; and
 - c. **approximately 5%** of its efforts and resources on fostering the generation of key evidence in critical **under researched** areas and stimulating action that could lead to more cost-effective interventions.

Figure 3: Prioritizing Interventions



Geographic Focus

66. MI has assessed where the needs are greatest, and where it believes it can add most value. MI recognizes that it can achieve the best results overall if it focuses on fewer areas with larger populations (countries; sub-regions; Indian States) rather than a large number of small ones. MI's greatest efforts will thus be made in countries or regions with the largest numbers of deficient individuals or deficiency-related health burdens. MI will establish and maintain a presence in a few **countries** both to maximize the sustainable impact of MI's resources and to safeguard the quality of its programs. MI will also work in other countries through other partners, where it makes sense.

67. MI **will focus at least 80% of its efforts and expenditures on achieving results within its priority countries and regions, and up to 20% on achieving results at an international level.** Some higher risk countries with smaller populations, for example in Africa, may need to be supported as sub-regional groups; others with large populations at higher risk in localized areas may need to be supported on a sub-national basis, e.g. Indian States. In so doing, MI recognizes that it will not be possible to address all program areas in each priority country or region, and may need to adjust the balance of activities on an ongoing basis. With respect to the choice of priority countries and regions, MI will invest where as many as possible of the following criteria are met:

- a. the size of the populations at risk from VMD and their impacts (particularly on the mortality and morbidity of children under five and on anaemia in women) is the greatest;
- b. MI has a history, local knowledge, key contacts, and scope to achieve results;
- c. MI can help to fill gaps in the extent to which other partners are meeting the country's needs;
- d. MI has the potential to mobilize (additional) resources to help achieve results, with manageable levels of risk;
- e. there are both the needs, and the opportunities, for support from MI to address more than one deficiency;
- f. a country has a larger role and influence on regional policies and programs; and
- g. there is a good likelihood of success

68. MI will also consider other factors with respect to how and where it will invest. The:
- a. need to **integrate** micronutrient provision optimally into health systems, and/or into the local markets for foods or other relevant products;
 - b. need to **tailor** its activities, within the limits of other priorities, in ways that respond to country and regional needs and to stated priorities in these geographic areas;
 - c. scope for **partnering** in each of its priority undertakings with governments, international donor organizations, private organizations and/or other key stakeholders;
 - d. need to **communicate** clearly its larger goals (in part to generate partnerships), its activities and the success of these activities in terms of coverage and impact;
 - e. comparative **rate of return**, in terms of coverage and impact benefits, on (MI's) investment;
 - f. potential **sustainability** of its actions, and the scope for MI to exit over time; and
 - g. extent to which MI can effectively address more than one strategic goal.

Financial Resource Allocation

69. Overall, in the period 2008-2013 MI aims to devote:
- a. **approximately 50%** of its efforts and resources to **Child Survival (Goal A)**;
 - b. **approximately 30%** of its effort and resources to **Child Development (Goal B)**;
 - c. **approximately 20%** of its effort and resources to **Women's Health (Goal C)**
70. MI recognizes that specific approaches or actions may address more than one Goal. In these cases MI will integrate such overlapping approaches into the interventions specified each year in MI's annual operational plans.

D3: Innovation

71. MI's innovative work differentiates it from other partners and provides a strong incentive to attract and retain highly qualified staff. Innovation will remain a cross-cutting feature of MI's core programs, and will also be a specific area of MI's work.
72. MI's work in this area will focus on both **product innovation** and **process innovation**. MI will work on improvements in existing products, as well as on new technologies, so as to address the needs of the most vulnerable groups more cost-effectively. In terms of process innovations, MI will work on innovative strategies, channels, delivery mechanisms and opportunities for achieving universal coverage of groups at risk in a sustainable way. MI will in particular continue to develop innovative ways of reaching the "hard to reach". MI will also seek innovative ways of scaling up the use of proven products that are not yet achieving their potential in terms of coverage.

D4: Leveraging, Integration and Partnerships

73. MI will work to enable the delivery of micronutrients efficiently to the largest possible number of vulnerable individuals with a minimal level of effort. MI recognizes that the greatest impact will be achieved by **leveraging the resources of its partners**. MI will thus enter into **strategic partnerships to expand the resource base** required to advance its Mission. MI will therefore also undertake all of its programming with the active participation of other key partners, and will integrate all its programming into existing health systems and local markets. MI will apply most effort in areas where the shortfall between the risk of, and the extent of protection against, VM deficiencies is the greatest.
74. In respect of its actions in priority countries, MI will partner as appropriate with governments; NGOs; development assistance agencies and programs; the private sector; the research community; the media and other stakeholder groups at all stages of programming, from planning through to evaluation. Partnership building will be a high priority at all levels within the organization. The MI Board of Directors

will play a key role in supporting the development and stewardship of partnerships at all levels. Key partnerships include those with:

- a. **National Governments:** MI will continue to work in close collaboration with national governments at national levels as a trusted, expert and objective partner to help develop policy, and to design and implement programs that are cost-effective, sustainable and respond to National plans.
- b. **Multilateral Agencies:** MI will work with key development assistance agencies including UNICEF, WFP, WHO, The World Bank and regional development banks to help integrate micronutrients within broader health and nutrition initiatives. This cooperation will include:
 1. High level advocacy among key policy and decision makers in support of MI's efforts to improve vitamin and mineral intake by the most vulnerable groups;
 2. Support to the planning and implementation of national programs including procurement and distribution support, financing, training, monitoring and evaluation;
 3. Integration of cost-effective micronutrient interventions within the scope of national budgets, supported by lending programs, pooled and other grant funding and debt relief in high burden countries; and
 4. Working closely (and acting as Secretariat when necessary and called upon) with several agencies in thematic partnerships such as the 10-year strategy to eliminate micronutrient malnutrition, the Global Alliance for Vitamin A, the Iodine Network and the Flour Fortification Initiative, the Partnership for Maternal, Newborn and Child Health, and the Ending Child Hunger and Under-Nutrition Initiative.
- c. **Bilateral Agencies:** The Canadian Government, through the Canadian International Development Agency (CIDA) has been MI's lead sponsor since its inception. MI will continue to work closely in support of Canada's development assistance objectives and will also pursue other bilateral relationships. In addition MI will continue to work actively with US bodies (including USAID and the US Centers for Disease Control) as well as with other bilateral agencies to improve linkages with their national, regional and sectoral priorities.
- d. **Non-Governmental Organizations:** MI will continue to work with the non-governmental organization (NGO) community in the implementation and delivery of its programs. MI works with international, national and local NGOs. NGOs are integral to ensuring the high quality field level support required to deliver MI programs.
- e. **Private Foundations:** MI will seek support from private foundations to expand its funding base in order to fulfill its Mission. MI will link its partnerships to meet the mutual objectives of both the foundations and MI.
- f. **Private Sector:** The private sector is an immense resource in terms of solving problems and implementing solutions that can deliver micronutrients to people on a sustainable basis. It has the technical, marketing and financial capacity to develop, distribute and promote products and services. MI will build on its long experience working with the private sector in advocacy, technology development and testing, commercialization and partnerships. MI will work at various levels ranging from large multinational corporations to national and local industrial businesses. MI will partner with the private sector to support mutual interests that may be commercial and/or philanthropic.

- g. **Global Alliance for Improved Nutrition (GAIN):** GAIN engages with several of the above groups with a focus on infant and young child feeding, food fortification, and building business alliances for food fortification. MI will work to strengthen linkages with GAIN at all levels.
- h. **Research Agencies and Networks:** MI endeavours to apply, and to translate into action the latest science for the benefit of the most vulnerable. MI is leading efforts to monitor and synthesize all ongoing research in the field of VMD in terms of understanding the problems and assessing the impact and effectiveness of interventions. MI aims to rapidly adapt and transfer successful experiences globally. MI will maintain close links with leading researchers, research organizations and networks internationally. MI will also encourage the development of local research capacity through activities that will include mentoring and other collaborative arrangements.
- i. **Media:** MI will develop and maintain links with strategic media locally, nationally and globally to support advocacy efforts in the field of VMD and effect behaviour change at the community level.

75. MI will also participate actively in global efforts to improve the quality and utilization of data on the prevalence of the major micronutrient deficiencies; on the coverage of interventions addressing them; and on the impacts of these interventions in terms of health and/or functional consequences.

D5: Marketing and Communications

76. MI will present the results achieved and progress made by MI through a cost-effective marketing and communications function. MI's communications efforts will be targeted to specific audiences who can support our mandate. Resource levels invested in communications will be balanced with resources required for other aspects of MI's work (e.g. program delivery). MI will update, improve and maintain a well-targeted communications strategy to support all areas of its work that will include:

- a. **Program communications**, including advocacy to key target audiences, where MI will:
 - Continue its policy of giving credit and visibility to countries for successful programs. MI recognizes that the self-imposed lower visibility has costs, such as lesser awareness of MI's contributions by potential resource providers. MI has concluded from experience that, more important than publicity for MI, is the sense of accomplishment by countries, the strengthened ownership of programs, and the improved chances for sustainability that accrue as a result
 - Disseminate program results and lessons learned from outcomes to target audiences.
 - Seek to act as a focal point to improve the coordination and the availability of key data on micronutrients, building on its role as Secretariat for the *Iodine Network* and for the *Global Alliance for Vitamin A*, on its role as Chair of the *10 Year Strategy Working Group on Monitoring Assessment and Data*, and on its links with the *Micronutrient Working Group of the UN Standing Committee on Nutrition* among others.
 - Integrate communications objectives and behavioural change outcomes within program planning, monitoring, implementation and evaluation, as deemed appropriate.
- b. **Corporate communications**, where MI will:
 - Use the communication of program and other results to underpin all partnership and resource development efforts, with a view to both raising donors' understanding of the importance of addressing VMD in a major way, and their appreciation of MI's role and unique potential to make very significant contributions to overcome them.

- Ensure regular effective communication with all its stakeholders, and the appropriate recognition of the support that is provided to MI by its stakeholders including its Board and its financial sponsors.
- c. **Internal communications**, where MI will:
- Promote and facilitate ongoing feedback and learning on the part of all MI staff across the world so that all employees are well informed about MI's operations, achievements, priorities and activities. This will be achieved, in part, through the establishment of an intranet accessible to all staff, regular internal news bulletins, and other communications tools that aim to empower staff, improve efficiency, and enhance morale. Opportunities will be created for staff to share knowledge and key learning.

Risk Management

77. MI will use internal processes to manage in an efficient manner that reduces risk while maintaining the flexibility that has given MI a competitive edge. One of the aspects that differentiate MI from other organizations working to alleviate micronutrient malnutrition is that MI's systems enable its staff to respond nimbly to address bottlenecks. MI will integrate risk assessment into project design, appraisal, monitoring and evaluation procedures while, at the same time, encouraging innovative approaches capable of taking advantage of new windows of opportunity.

E] INVESTING IN PEOPLE

78. Staffing accounts for a significant component of MI's operating budget. Accordingly, MI will adopt a strategic corporate approach in the management of its people. A strategic focus on human resource management will align MI's productive culture and organizational structure with its business strategy to ensure that MI achieves its objectives.
79. MI's future success depends significantly upon the skills, energy and commitment of its people. Consequently, MI will seek to attract, develop, motivate and retain employees of the highest quality and provide a working environment that will enable employees to maximize their contribution to the achievement of MI's goals. Challenges in this regard include the articulation and pursuance of both programmatic and personnel policies that are consistent, clear and transparent (these also requiring effective internal communications systems); the development and maintenance of reward systems that are both equitable and competitive and of opportunities for continued professional development; and means to maintain organizational memory within the staff by maintaining low turnover rates for MI employees. To help achieve its human resource management objectives, MI will:
- a. Develop and apply throughout the organization a Human Resource framework of clear and consistent global policies that is accessible, understood and transparent to MI employees;
 - b. Establish and maintain human resource policies and tools that cover all aspects relating to employment, pay and performance, benefits, employee relations and health and safety policies;
 - c. Ensure that each employee has a fair and equitable salary, with terms and conditions assessed by the same criteria across the organization;
 - d. Maintain pay and performance policies that includes global pay principles, job evaluations, job performance management and pay range structures;
 - e. Develop and sustain a workplace which values, recognizes and rewards the contributions of employees to MI's success;
 - f. Enhance the performance management and reward systems to effectively identify and reward high performance by employees and to communicate and celebrate significant achievements of employees, regional units and MI as an organization;
 - g. Develop, implement and continually improve strategies to attract, motivate and retain employees which will:

- reduce the impact of a loss of institutional knowledge and history from MI's workforce;
- reduce turnover of key employees with less than 3 years service; and
- promote MI as an employer of choice in order to attract talented and highly qualified employees.

80. MI will use such means as creating opportunities for the professional development of staff, further developing the employee training programs, encouraging innovation and creativity among employees to improve how MI conducts business and provides program services, and by implementing an annual staff survey to help in identifying employee issues in need of attention.

81. MI will enhance internal communication between MI's regional, country and head offices so that all employees are well informed about MI's operations, achievements and activities. This will be achieved in part, by establishment of an intranet accessible to all staff, and the regular posting of internal news bulletins, and other communications tools for empowering staff, improving efficiency, and enhancing morale.

F] MOBILIZING RESOURCES

82. MI aims to secure diverse and sustained sources of revenue, and to apply them in the most cost-effective manner while continuing to leverage resources so as to advance MI's Mission and to achieve a steady growth in MI activities, approximately doubling its annual budget to CDN\$60 million by 2013. With this in mind, MI will work to achieve four key related resource development objectives: (a) maintaining its current funding relationships; (b) diversifying its revenue sources; (c) leveraging significant revenues in addition to core funding, and; (d) leveraging parallel financial inputs for projects from partner organizations.

- a. MI's funding sources provide the financial foundation for work that is carried out to achieve its Mission. Maintaining current relationships requires continued and expanded program delivery with a primary focus on coverage and cost-effectiveness plus timely, responsive and quality-assured reporting.
- b. Diversification of revenue sources requires the identification of new donors likely to be receptive to MI's comparative advantages, and the effective marketing of these strengths as competitive in terms of value returns and key performance criteria.
- c. Leveraging financial inputs from others requires programmatic credibility plus the development/maintenance of positive relationships with donors, governments, the private sector, UN agencies and civil society organizations.

83. This strategic plan will require MI to approximately double its revenue, incrementally, over the five year period 2008-2013. MI will support a strengthened resource development function by marketing and communications efforts that target specific audiences. MI will maintain and steward current funding relationships. MI will diversify its revenue sources, carefully matching prospective donors with programs. New revenue streams will include bilateral and multilateral agencies, the private sector, individuals and foundations as well as national governments.