AID FOR NUTRITION

Can investments to scale up nutrition actions be accurately tracked?

ACF INTERNATIONAL

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PUBLISHER: Action Against Hunger | ACF International
LEAD AUTHOR: Sandra Mutuma,
s.mutuma@actionagainsthunger.org.uk
CO-AUTHORS: Elodie Fremont, Adebukola Adebayo
COPY EDITOR: Hugh Lort-Phillips
COVER IMAGE: ACF, courtesy of Tine Frank
DESIGN BY: Amanda Grapes

Our mission is to save lives by eliminating hunger through the prevention, detection and treatment of undernutrition, especially during and after emergency situations of conflict, war and natural disaster. From crisis to sustainability, we tackle the underlying causes of undernutrition and its effects. By integrating our programmes with local and national systems we further ensure that short-term interventions become long-term solutions.

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CONTENTS

GLOSSARY

ACF	Action Against Hunger | ACF International (Derived from the French name; Action Contre la Faim)
AECID	Spanish Agency for International Development Cooperation
AFD	French Development Agency
ASDF	Asian Development Fund
BMGF	Bill and Melinda Gates Foundation
CIDA	Canadian International Development Agency
CRS	Creditor Reporting System
CMAM	Community-based Management of Acute Malnutrition
DAC	Development Assistance Committee
DALY	Disease Adjusted Life Years
DFID	Department for International Development
ECHO	European Commission's Humanitarian Aid Office
EDF	European Development Fund
EU	European Union
FAO	Food and Agriculture Organisation of the United Nations
FEWSNET	Famine Early Warning Systems Network
FTS	Financial Tracking System
FY	Financial Year
GAFSP	Global Agriculture and Food Security Programme
GDP	Gross Domestic Product
GNI	Gross National Income
GNP	Gross National Product
IDA	International Development Association
IDS	Institute of Development Studies
IEC	Information Education Communication
IMCI	Integrated Management of Childhood Illness
IYCF	Infant and Young Child Feeding
MAEE	French Ministry of Foreign Affairs
MDGs	Millennium Development Goals
MIC	Multiple Indicator Cluster
MSF	Médecins Sans Frontières
NGO	Non Governmental Organisation
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
REACH	Renewed Efforts Against Child Hunger
SAM	Severe Acute Malnutrition
SSA	Sub-Saharan Africa
SUN	Scaling Up Nutrition
SWAPs	Sector Wide Approaches
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USA	United States of America
WB	World Bank
WFP	United Nations World Food Programme
WHA	World Health Assembly
WHO	World Health Organisation

LIST OF TABLES:

LIST OF FIGURES:

EXECUTIVE SUMMARY

Malnutrition due to undernutrition is particularly important because it has extensive consequences on maternal and child survival, growth and development. When women and children are exposed to undernutrition, particularly during pregnancy and the first two years of a child's life and the problem is not corrected during this time, it has irreversible effects on the ability of children to reach their full genetic growth potential. Their ability to learn and achieve at school and to resist and recover from common childhood illnesses is also jeopardised. If they reach adulthood, they have a reduced capacity to earn as much as others who did not suffer from undernutrition and they are at greater risk of developing non-communicable diseases. In countries trying to achieve the Millennium Development Goals (MDGs), undernutrition can therefore seriously undermine public health and economic development.

For decades, hunger and undernutrition were linked to a lack of calorie intake. Therefore there was an overemphasis on increasing agricultural production and improving food security. But the links to nutrition were often neglected. In recent years nutrition-focused initiatives, such as the Renewed Effort Against Child Hunger and Undernutrition (REACH) initiative and the multi-stakeholder Scaling Up Nutrition (SUN) Movement, have sought to redress the balance.

The aim of this paper is to provide donors, aid recipients and other stakeholders with a detailed analysis of current spending on nutrition and of the adequacy of current aid reporting systems. It also provides recommendations on what can be done to scale up the response to undernutrition effectively. This is especially important for the SUN Movement as it starts to shift its focus from policy to practice. Monitoring and evaluation of progress is dependent on a solid evidence base of the scale of the problem, the extent of efforts to address it and the (cost) effectiveness of these efforts.

This report maps official development assistance (ODA) for tackling undernutrition from key bilateral, multilateral and private donors from 2005 to 2009 through the Organisation for Economic Cooperation and Development's Creditor Reporting System (OECD CRS) database. In so doing, the paper analyses the transparency, quantity (adequacy) and quality (effectiveness) of aid for nutrition. We mapped investments in a key set of nutrition interventions that are proven to have a direct impact on reducing undernutrition. With this information, we tried to answer key questions: is enough money being invested in the right interventions (identified in the 2008 Lancet Series on Maternal and Child Undernutrition) to tackle undernutrition? Is the money being invested at the right time? Are they reaching those most affected by undernutrition?

Our findings are as follows:

The CRS database is problematic to use for detailed tracking of ODA to the nutrition sector due to poor donor reporting practices and limitations with the CRS database itself. This limited our ability to report accurate levels of spending on nutrition. Tracking ODA for nutrition in the CRS database is more accurate when multiple purpose codes are used. Additionally, rather than aggregate analysis of purpose codes, individual analysis of projects in purpose codes increases accuracy. Aggregate analysis of just the 'Basic Nutrition' purpose code can be misleading.

Despite these problems, our detailed analysis of the database showed the following investment trends:

- Investment in nutrition is inadequate. Current investments in proven nutrition interventions account for approximately 1% of the estimated US$11.8 billion required to tackle undernutrition. Disaggregating the data further indicates that investment in direct nutrition interventions is severely inadequate in comparison to indirect nutrition interventions.
- 44% of investments in direct nutrition interventions were allocated to projects to reduce micronutrient deficiencies, 40% to treat malnourished children with special foods and 14% to promote good nutritional practices.
- Comprehensive programmes which deliver the full package of direct nutrition interventions were inadequate (only 2% of funding).
- Nutrition programmes were mainly delivered

through the health sector or in response to humanitarian crises. Few are delivered through development programmes indicating the reactive, short-term and unpredictable nature of aid for nutrition.

- Our data indicates that aid is not necessarily directed to the countries with the highest burden (in terms of caseload) of undernutrition, particularly in the Africa region.
- Fulfilment of individual donor commitments varied widely. Collectively, there was a negative trend indicating that donors failed to deliver 11% of their commitments.

Based on our findings we recommend the following:

1. All bilateral donors and multilateral agencies, particularly ECHO, France, Japan, the WFP and the WHO, and private donors must commit to aid transparency principles by improving their reporting practices to the CRS database. This should include the expediency of donor reporting so that the database is not behind in reporting donor aid activities (it is currently almost 2 years out of date). This will ensure accountability to the electorate who invest in development through their tax contributions and private donations.
2. The DAC Working Party on Statistics must amend the list of nutrition actions within the CRS 'Basic Nutrition' purpose code to ensure that only activities related to nutrition are included and those that are not are reallocated to other purpose codes in the database.
3. All donors and governments who have committed to the Scaling Up Nutrition (SUN) global movement must dramatically increase their investments in direct or nutrition-specific interventions to meet the estimated US$11.8 billion required annually to reduce undernutrition in the worst affected countries.
4. It is crucial that the 13 proven direct nutrition interventions are considered as a minimum nutrition package by donors to mount a robust response to the problem of undernutrition. Therefore there is an obligation for all donors to improve the coordination of their investments so that all direct nutrition actions are fully funded at scale.
5. The links between health and nutrition need to be better understood and supported by donor and recipient governments as well as other stakeholders to facilitate optimal cross-sector working. The contribution that nutrition can make to strengthening health systems needs to be clarified by the WHO and recognised by SUN stakeholders. Furthermore, health system strengthening must incorporate nutrition or be nutrition-sensitive.
6. All donors need to proactively and predictably scale up and target ODA for the treatment and prevention of undernutrition to those at risk in non-emergency as well as emergency contexts, including protracted crises and seasonal hunger, in order to ensure equitable and sustainable access to nutrition services.
7. Therefore, we call for an independent, accurate and comprehensive annual review of donor ODA investments in nutrition in order to keep the paucity of funding for nutrition high on the political agenda until undernutrition rates in the worst affected countries are either significantly reduced or eradicated.

The CRS database has the potential to be a key tool to monitor and evaluate the progress of implementing the SUN Framework and other nutrition focused initiatives which propose the most effective interventions to address undernutrition. Despite the lack of accurate data the trends indicate that investment of ODA in nutrition interventions is woefully inadequate, and that which is being invested, is only delivering some of the direct interventions, to some of those in need, some of the time. This undermines the principles of aid effectiveness. If donors are committed to scaling up nutrition, they must back up their rhetoric with action and provide adequate funds to meet the estimated funding requirement of US$11.8 billion. This report will be followed by a serious evaluation of how this estimated requirement can be met. If these funding levels can indeed be achieved, there would be an ever-greater need for a more robust and standardised system of reporting.

INTRODUCTION

1.INTRODUCTION

1.1 WHAT IS THE PROBLEM AND WHY IS IT SO IMPORTANT?

Malnutrition represents an imbalance between the nutrients the body needs and the nutrients it receives or uses. Thus, the term includes undernutrition (insufficient consumption of calories and/or nutrients) and overnutrition (ingestion of excess calories and/or nutrients). It is particularly important because it has far reaching consequences on overall public health and economic development. Undernutrition encompasses stunting, wasting and deficiencies of essential vitamins and minerals (collectively referred to as micronutrients). Together, these conditions account for 11% of the global burden of disease and child mortality as shown in Table 1.1. They also contribute to chronic disease, disability and poor educational and development outcomes.

The consensus that undernutrition is a globally important public health challenge is growing, particularly in developing countries (Caulfield *et al.*, 2004). Developing countries can lose as much as 3% in Gross Domestic Product (GDP) each year because of losses in productivity (Horton *et al.*, 2010). There are in excess of 3.5 million maternal and child deaths each year related to undernutrition and those most affected are concentrated in 36 developing countries (listed in Annex 1).

Women affected by undernutrition are more likely to bear children with low birth weight, who are in turn more susceptible to disease and premature death. Infants who survive may suffer from limited physical and cognitive development, reduced learning and earning capacity and increased illness and death in later life (UNICEF, 2009). Undernutrition is a devastating violation of a child's right to a standard of living adequate for his or her physical and mental development, and enjoyment of the highest attainable standard of health; as recognised under article 6, paragraph 2, and article 24, paragraph 2 (c), of the Convention on the Rights of the Child. The environment, not genetics, accounts for the differences in child development between the world's regions. The WHO Child Growth Standards demonstrate that children from diverse regions have very similar growth patterns and development potential when their health and nutrition needs are met. States, therefore, have a duty to support the good nutrition of those most likely to be disproportionately affected. They also have a duty to establish food, health and social systems that can ensure each individual's access to sufficient caloric intake and to diverse diets which provide all the micronutrients required (De Schutter, 2011).

TABLE 1.1: THE DISEASE BURDEN AND MORTALITY ASSOCIATED WITH UNDERNUTRITION

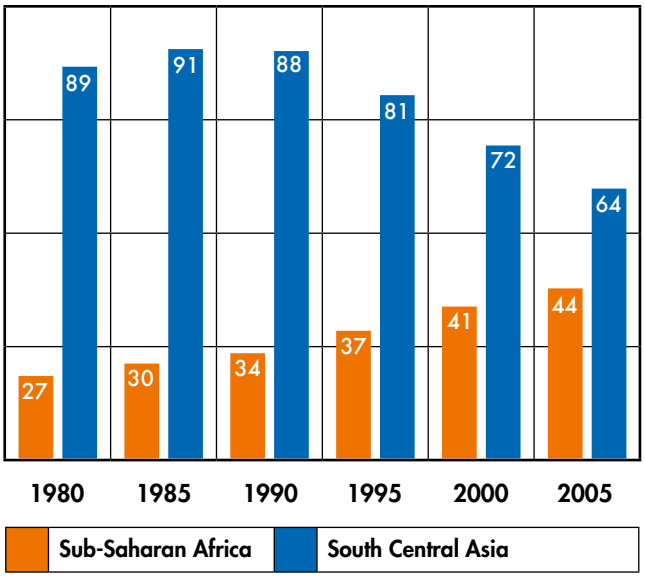
	Deaths	Percentage of deaths in children under 5 years	Disease burden (1 000 DALYs)	Percentage of DALYs in children under 5 years
Wasting	1,509,236	14.6%	64,566	14.2%
Stunting	1,491,188	14.5%	54,912	12.6%
Low birth weight	337,047	3.3%	15,536	3.1%
Vitamin A deficiency	667,771	6.5%	22,668	5.3%
Zinc deficiency	453,207	4.4%	16,342	3.8%
Iron deficiency	20,854	0.2%	2,256	0.5%
Iodine deficiency	3,619	0.03%	2,614	0.6%
TOTAL	4,482,922	43.53%	178,894	40.7%
DALY = Disease Adjusted Life Years				
Source: European Communities 2011, Addressing Undernutrition in external assistance, reference document number 13				

1.2 WHAT PROGRESS HAS BEEN MADE TO TACKLE THE PROBLEM OF UNDERNUTRITION?

More than a decade ago, based on the prevailing efforts of each of the major developing regions, predictions to reduce undernutrition by the year 2020 were mixed. Minimal progress to reduce child undernutrition was expected in sub-Saharan Africa; the prevalence was actually expected to increase. In Latin America and the Caribbean, it was predicted that undernutrition would be practically eliminated although some countries in these regions may retain a high prevalence of malnutrition (Smith and Haddad, 2000). Some of those predictions were accurate. Today, southern Asia and sub-Saharan Africa (SSA) are the regions with the highest prevalences of undernutrition and the rates in SSA are increasing (World Bank, 2006). Scaling up nutrition interventions in the worst affected countries in these regions could lead to the achievement of Millennium Development Goal 1 (MDG 1), to halve severe hunger by 2015, and greatly increase the chances of achieving MDGs 4, 5 and 6 (to reduce child mortality, improve maternal health and combat HIV/AIDS, malaria and other diseases). Major challenges remaining in the achievement of the MDGs include finding sustainable, intersectoral solutions to reduce undernutrition in children and tackling its basic causes which include poverty, lack of education and economic and gender inequality. Nutrition therefore deserves to be a higher priority in national development strategies.

To date, worldwide efforts to improve the nutritional status of those affected have been slow and inconsistent. Without increased investment for nutrition, undernutrition rates will continue to increase in Sub-Saharan Africa and remain high in southern Asia as shown in Figure 1.2.

FIGURE 1.2: CHILD MALNUTRITION (IN MILLIONS) IN SUB-SAHARAN AFRICA AND SOUTH CENTRAL ASIA (SUMNER *ET AL.*, 2007)



1.3 WHAT WILL IT TAKE TO ERADICATE UNDERNUTRITION IN DEVELOPING COUNTRIES?

For almost four decades, efforts to eradicate undernutrition have mostly focused on increasing overall calorie intake through increased agricultural production of staple crops. But emphasis of the links between nutrition and agriculture and of the importance of a diverse diet which provides all essential micronutrients, were often neglected. In addition, the other functions of agriculture — ensuring good incomes for food producers and maintaining ecosystems — have not been addressed (De Schutter, 2011). However, there have been encouraging changes to address this.

Nutrition-focused initiatives and policies have been created which move beyond the traditional focus on low calorie intake:

- In 2008, the FAO, WHO and UNICEF committed to the "Renewed Efforts Against Child Hunger and Undernutrition" (REACH) initiative, which aims to scale up interventions addressing child undernutrition through the coordinated action of United Nations agencies, civil society, donors and the private sector, under country-led plans.
- In the same year, the Malnutrition and Hunger Challenge Paper of the Copenhagen Consensus (Martorell *et al.*, 2008) was published, stating that "achieving goals in primary education, reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases, all depend crucially on nutrition" (Annex 2).
- Evidence also exists which suggests that an

improvement to women's education plays a key role in reducing child undernutrition, compared with other improvements such as health environments, women's status relative to men's, national incomes, democracy and per capita food availability (Smith & Haddad, 2000).

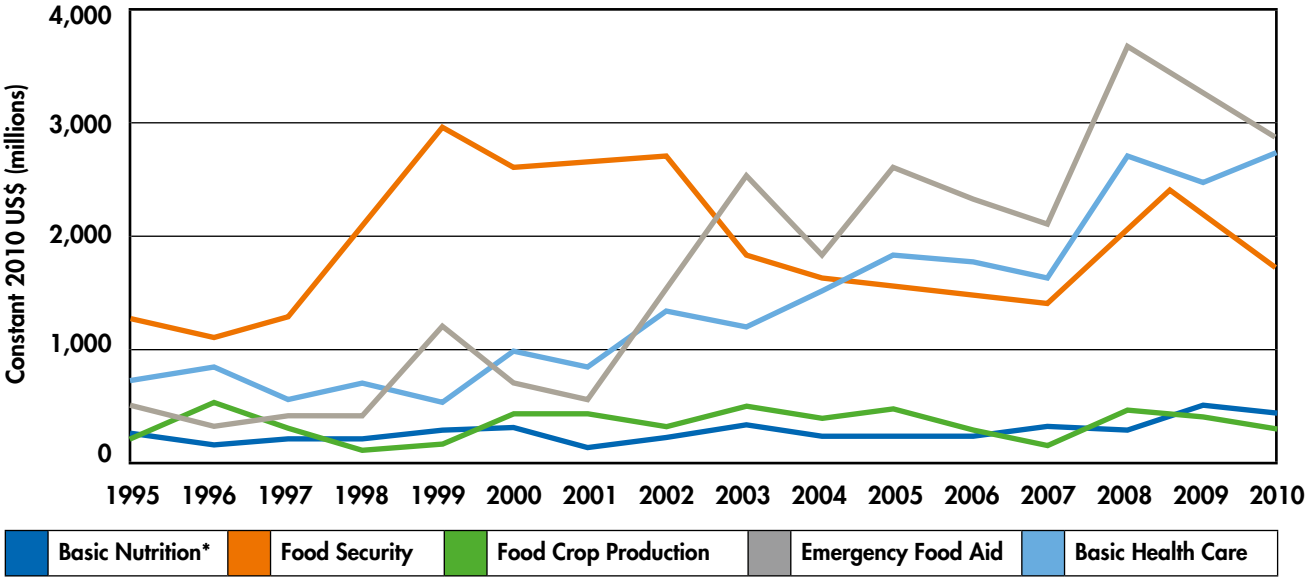
- The United Nations Secretary-General's High-Level Task Force on Food Security has updated the Comprehensive Framework for Action so that it explicitly addresses food and nutrition security with a focus on the links between agriculture, food systems and nutritional outcomes.
- The Muskoka Initiative was endorsed in 2010 by the G8 countries, with the objective of bringing about significant improvements to health systems in developing countries with high burdens of maternal and under-five child mortality. It covers different issues such as basic nutrition, safe water and sanitation.
- Recently, the Lancet Maternal and Child Undernutrition series (Black *et al.*, 2008), followed earlier reports (World Bank, 2006; Ashworth, 2006) to identify interventions which could potentially improve nutrition and health outcomes if implemented at scale in the countries that bear the highest burdens of undernutrition. The Lancet reviewed 45 interventions from the published evidence to identify 13 direct nutrition actions (Annex 3) that have the greatest potential for reducing child mortality and future disease burdens associated with undernutrition (Bhutta *et al*, 2008). Universal coverage with a full package of these proven interventions could prevent a quarter of child deaths, lower the prevalence of stunting by a third and reduce the burden of disease. However, these interventions most effectively prevent irreversible damage when they are administered within the first 1000 days (or 2 years) of a child's life.
- The multi-stakeholder Scaling Up Nutrition (SUN) Movement was launched in 2009 and has gained momentum globally since the presentation of the "SUN Framework for Action" policy document in 2010. This policy advocates for targeted action and investment to improve nutrition for mothers and children in the critical 1000-day period. The Framework proposes a twin track approach to scale up the 13 direct interventions and encourages states to adopt national plans to scale up nutrition through different sectoral policies related to undernutrition (indirect interventions). The Framework relies on the establishment of partnerships between donors, businesses, civil society organisations and governments to incorporate nutrition-sensitive (or indirect) interventions throughout the value chain at country level.

1.4 INVESTMENT TRENDS IN NUTRITION

Financial resources are committed and disbursed on an annual basis to address undernutrition. However, despite the gravity of the short and long-term consequences of maternal and child undernutrition, the amount of nutrition-related aid given to the countries that bear the greatest burden of undernutrition, represents a tiny proportion of the total overseas development assistance (ODA) they receive. Until recently, the global community invested minimal amounts in interventions to combat undernutrition. This is demonstrated in Figure 1.4 which shows the trends in all global ODA from 1995 to 2009. In comparison with other sectors, ODA for basic nutrition has been relatively flat for the past 15 years due to the low status of nutrition in global health and development priorities.

In 2002 the Monterrey Consensus of the International Conference on Financing for Development sought to restore the vital importance of ODA by encouraging member states of the Organisation for Economic Cooperation and Development (OECD) to increase their ODA contributions to 0.7% of gross national product (GNP) by 2015. Countries such as Sweden, Luxembourg and the United Kingdom are well on track to achieving the 0.7% goal and others have already surpassed it. On the other hand, France, Germany and Italy are unlikely to reach the target before 2015. The recent fuel, food and financial crises have seen some large donors reduce or delay the pledges they made for 2010 (UN, 2010).

FIGURE 1.4: TRENDS IN ODA COMMITMENTS TO BASIC NUTRITION AND OTHER SECTORS (SOURCE: OECD DATABASE 2012)



** Basic Nutrition is part of the Health sector*

Prior to the onset of the crises, a number of regions were making progress to halving the proportions of their populations that were undernourished. South-eastern Asia had made steady progress, as had Latin America, the Caribbean and the Far East. However, with real incomes squeezed by the financial downturn and inflation, people were no longer able to access enough, good quality food (Hossain *et al.*, 2010). Nonetheless, an encouraging trend is emerging as investments in nutrition ODA are starting to increase. World leaders are beginning to acknowledge that committing funds to nutrition is one of the most cost-effective investments that can be made to improve maternal and child health as well as to stimulate development in poorer countries (Lie, 2011).

There have been a number of attempts to determine how much ODA is allocated to improving nutrition. An assessment was made of expenditure on nutrition and on general budget support by DFID and the EC, two of the largest aid agencies, for the period 1995 to 2004 (Sumner *et al*. 2007). They found that the proportion of DFID and EC spending on direct nutrition interventions was low compared with indirect interventions and the shift to direct budget support and sector wide approaches (SWAPs), rather than programme support, meant that direct nutrition interventions would be potentially underfunded.

Morris *et al.*, (2008) analysed aggregate amounts of bilateral and multilateral aid in the CRS 'Basic Nutrition' purpose code between 2000 and 2004. The final estimate was that approximately US$250 to US$300 million per year was invested in nutrition.

Meanwhile Médecins Sans Frontières (MSF) analysed nutrition projects which had nutrition as the principal objective (core funding) and projects mixing nutrition objectives with other objectives (mixed funding). MSF's estimates for international funding of nutrition programmes ranged from US$185 million to US$511 million a year between 2004 and 2007. They concluded that US$350 million a year was the most realistic estimate of funding for nutrition for this period (MSF, 2009).

A recent report provided a quantitative analysis of nutrition aid incorporating the 'Basic Nutrition' purpose code of the CRS database in addition to the "Emergency Food Aid" and "Development Food Aid" codes (Coppard & Zubairi, 2011). The analysis was carried out on the committed funding of European donors between 2000 and 2009, with particular focus on the 2005 to 2008 period. Estimated official aid for nutrition was about US$2 billion (ranging from US$1.3 billion to $3.5 billion) in 2009.

1.5 AID EFFECTIVENESS

Aid effectiveness is the extent to which aid is delivered in a way that maximizes its impact on development and achieves value for money. Progress on effectiveness requires both donors and recipients to be more accountable to their taxpayers and to each other, for the development commitments they have made. The Paris Declaration on Aid Effectiveness (OECD, 2005) is founded on five core principles: aid recipients in the development community now need to draft their own national development strategies with their parliaments and electorates (ownership); donors need to support these strategies (alignment) and to work to streamline their efforts in-country (harmonisation); development policies need to have clear goals and progress towards these goals needs to be monitored (results); and donors and recipients alike need to be jointly responsible for achieving these goals (mutual accountability). The Paris Declaration also lays out a practical, action-oriented roadmap to improve the quality of aid and its impact on development (OECD, 2005). However, international aid for nutrition is highly fragmented and there is a lack of prioritisation of direct nutrition activities (Morris *et al*. 2008). In 2009, MSF suggested that much of the nutrition funding gap for nutrition could be reduced by raising extra resources and improving existing food aid funding practices.

The Lancet Series on Maternal and Child Undernutrition (Morris *et al.*, 2008) arguably provided the definitive list of direct nutrition interventions against which funding could be tracked. Theoretically, this list enables international donor community investments to improve nutrition status in poor countries to be monitored and evaluated more easily. In addition, the World Bank has estimated that US$11.8 billion annually are needed to scale up these proven interventions so that they can be accessible to 100% of the target populations in the 36 countries that carry 90% of the burden of undernutrition (Horton *et al.*, 2010). As the SUN Movement shifts gear from policy to action, in order to support policy and decision making, it is important to monitor and evaluate funding for the scale up of proven nutrition interventions against the estimated requirement. The success of eradicating undernutrition is dependent on a solid evidence base. The primary purpose of this report is to evaluate the current ODA levels for proven direct nutrition interventions to ascertain how much has to be done to advance the scale up of nutrition and to support the policy and decision making of SUN stakeholders.

METHODOLOGY

ACF, courtesy of Tine Frank

2. METHODOLOGY

2.1 SCOPE OF THE STUDY

This study aims to map donor investment trends to nutrition for the 2005 to 2009 period. The Aid Activity (CRS) online database established by the OECD, will be used as the primary source of information as it is the most extensive and reliable tool reporting the aid activities of donors. The database registers information on the purpose of aid using a sector classification system which permits measurement of the share of each sector or category in total aid. There are 26 main sector categories, each of which is broken down to a number of "purpose codes". Each activity can be assigned only one purpose code to avoid double-counting. For activities that span several sectors, either a multi-sector code is used or the code corresponding to the largest component of the activity is chosen.

2.1.1 IDENTIFICATION OF NUTRITION INTERVENTIONS

Nutrition funding can be channelled through diverse programmes in a range of sectors including health, water & sanitation, food security and humanitarian aid. There are three reasons for this:

- The diversity of direct nutrition interventions and indirect nutrition actions;
- The cross-sectoral implementation of some nutrition interventions;
- The variable allocation of interventions to different purpose codes by donors.

A keyword search was performed to enable us to map direct nutrition activities in the various purpose codes (as listed in Table 2.1.1). We tracked funding for nutrition projects to 9 purpose codes which were most likely to contain any of the 13 direct nutrition interventions identified by the Lancet Series (2008) (Annex 4).

Other keywords were added such as 'nutrition', 'hunger' and 'feed' so as to ensure that all interventions related to nutrition were selected. This was particularly useful for categories related to nutrition like 'Basic Health' or 'Basic Drinking Water and Sanitation'. The keyword search was applied to the title, the short description and the long descriptions of the database. All of the descriptions of the electronically selected interventions were read individually. This enabled us to categorise them as follows:

- Direct nutrition interventions;
- Indirect nutrition intervention;
- Rejected as not related to nutrition;
- Rejected due to lack of sufficient information to allocate to a particular code.

Direct nutrition interventions address the more immediate determinants of undernutrition (such as the quality of individual dietary intake and the provision of individual health services). For this study we defined direct interventions as those that were included in the Lancet's list of 13 interventions. We further categorised direct nutrition interventions into the three broad categories: *"promoting good nutritional and hygiene practices"*, *"increasing intake of vitamins and minerals"* and *"therapeutic feeding for malnourished children with special foods"*. This facilitated the mapping of donors' investments in the different categories of direct nutrition interventions.

TABLE 2.1.1: KEYWORDS USED BY THE TYPE OF ACTIVITY

DIRECT NUTRITION INTERVENTIONS	I. PROMOTING GOOD NUTRITIONAL AND HYGIENE PRACTICES
	• Hand washing • Hygiene promotion • Breast feeding
	II. INCREASING INTAKE OF VITAMINS AND MINERALS
	• Micronutrient • Supplement • De-worming • Vitamin
	III. THERAPEUTIC FEEDING FOR MALNOURISHED CHILDREN WITH SPECIAL FOODS
	• Acute malnutrition • Complementary feeding • Therapeutic feeding
TARGETED POPULATION	• Children under five • Pregnant and/or lactating women
OTHER KEY WORDS	• Nutrition • Hunger • Feed

Indirect nutrition interventions address the underlying determinants of undernutrition (such as food availability, the quality of water and water and sanitation). For this study they included multisectoral approaches, particularly in cases where specific pro-nutrition activities were included in interventions carried out in other sectors such as health, education and food security. To ensure that interventions were indirectly targeted to address undernutrition, we selected cross-sectoral project lines that explicitly included a nutrition objective in the activity description. For example, the description of a food aid or school feeding programme project line which clearly stated as its objective "to reduce malnutrition in the recipient population" was classified as an indirect nutrition intervention. Also, activities such as nutrition advocacy and nutrition conferences and meetings, were classified as indirect interventions.

In some cases, projects were a mixture of direct and indirect nutrition interventions and it was impossible to establish the share of funds going to each activity. These project lines were classified as indirect interventions. We judged that it would be preferable to classify these projects as indirect rather than direct; based on a previous report by Sumner *et al.* (2007), our assumption was that the proportion of funding for direct interventions would be very low. Furthermore, nutrition interventions that were categorised as direct actions by other reports (Sumner *et al.*, 2007 and MSF, 2009) but were not included in the list of 13 direct interventions identified by Morris *et al.* (2008), were categorised as indirect interventions. Please refer to Annex 5 for further information.

2.1.2 PROCESS OF DONOR SELECTION

After careful consideration, we decided to include bilateral, multilateral and private donors who had previously been reported as key contributors of ODA to nutrition (Sumner *et al.* 2007; MSF, 2009). The final list was determined by the practical limitations we encountered with the reporting of donor to the CRS. The final list of donors included in the research was:

- Bilateral donors: Canada, the EU, Ireland, Norway, Spain, Sweden, the UK and the USA.
- Multilateral agencies: UNICEF and the IDA (World Bank).
- Private donors: Bill and Melinda Gates Foundation (BMGF), please note that data was available for 2009 and in the 'Basic Nutrition' purpose code only.

2.1.3 OTHER KEY ASPECTS OF NUTRITION FUNDING EXAMINED:

- **The targeting of high-priority recipient countries:** So as to ascertain whether nutrition funding flows were targeted to the countries with the worst rates of undernutition, ACF ranked 15 countries according to their caseloads of stunted and wasted children (Annex 1). These 15 countries were drawn from a list of 36 countries which bear 90% of the world's burden of stunting (Black *et al.* 2008). Some of the countries included were identified as malnutrition hotspots (countries where rates of acute malnutrition were 10% or above) in UNICEF's *State of the World's Children Report* (2011 data). The countries were ranked according to their caseloads of stunted children. A more detailed methodology is available in Annex 1.
- **Accountability:** As the CRS is a statistical tool recording both commitments and disbursements for each project, it enabled us to evaluate to what extent commitments were honoured.

2.2 LIMITATIONS OF THE STUDY

The DAC has 24 member states and it was not possible to analyse all of them in the detail required by this study. As discussed in section 2.1.2, there was a need to select the biggest donors to nutrition. Some key donors were not included in the analysis due to language barriers (the Netherlands) and poor reporting (France, Japan, WFP, FAO and WHO) preventing adequate analysis. In other cases, donors did not provide data to the CRS over the time period of the study. Furthermore, not all donors of nutrition aid report to the CRS. Non-DAC countries are not required to report to the CRS, nor are private donors. Nevertheless, since 2009, data has been available for one non-DAC country, the United Arab Emirates, and

one private donor, the BMGF. Similarly, multilateral agencies only report to the CRS on a voluntary basis and some have not yet taken steps to do so. For those already reporting to the CRS, the availability of data and the quality of reporting is inconsistent.

There is a risk of underestimating the ODA for direct nutrition interventions given that all interventions containing mixed activities (direct and indirect) were classified as indirect nutrition interventions. As explained earlier, this was done as the share of funds for the different activities in mixed projects was unquantifiable.

Indirect nutrition interventions may also be slightly underestimated because our research is based on 9 purpose codes in the CRS database and it is possible that some indirect interventions exist in purpose codes which were not analysed.

2.2.1 LIMITATIONS OF THE OECD CRS DATABASE

Despite being the undisputed tool for tracking official aid flows, the CRS remains insufficient in some respects and is not yet exhaustive.

Firstly, at the beginning of 2012, 2009 was the most recent year available in the database for donor ODA allocations. This delay in reporting has prevented us from presenting a current analysis of ODA trends.

Secondly, the definition and content of purpose codes are unanimously agreed by all DAC member states. However, our analysis revealed some programmes which had been classified incorrectly. Thus, some funds which were allocated to the *'Basic Nutrition'* code were of little relevance to nutrition, while other nutrition funds were allocated to purpose codes unrelated to nutrition. This could be due to a misunderstanding of some purpose codes by donors.

Thirdly, funding flows for some regional programmes were recorded as 'Bilateral Unspecified' and it was difficult to calculate exactly how much was allocated to specific countries. We partially worked around this problem by assuming that the funding patterns would be similar in specific countries. Refer to Annex 1 for further explanation. The database is almost 2 years out of date. As such there is limited transparency and therefore accountability of current donor aid activities.

2.2.2 LIMITATIONS OF DATA COLLECTION AND DONOR REPORTING

Bilateral and multilateral donors are expected to give an accurate account of their ODA flows in line with the guidelines provided by the CRS (OECD, n.d.). However, in some cases, the columns detailing programme descriptions had inadequate descriptions. This lack of information in reporting affected our work in two ways:

Lack of description: A proportion of the data in the database analysed could not be used because there simply was no description about implemented programmes (reporting cells were empty or did not specify the type of services provided). However, this issue did not significantly limit our trend analysis of key donor aid activities.

Bad quality of data: Descriptions of programmes could be short or vague, preventing assessment of their actual objectives and activities. For some programmes, information about recipient countries was incomplete.

In spite of the challenges we faced, our findings indicate that interesting and valuable lessons can be learnt regarding the extent, quality and effectiveness of ODA for nutrition. The results raise questions about the accountability of some key donors who have the mandate to assist those in need. Although our findings are the result of a detailed analysis, for the reasons highlighted already, they provide a conservative estimate of aid for nutrition and should be regarded as an approximate interpretation of the trends. We believe our data can contribute to future research, planning and policy and decision-making for the effective advancement, monitoring and evaluation of scaling up nutrition interventions.

RESULTS

Jason Seagle, Counterpart Images

3. RESULTS

3.0 SUMMARY OF KEY FINDINGS

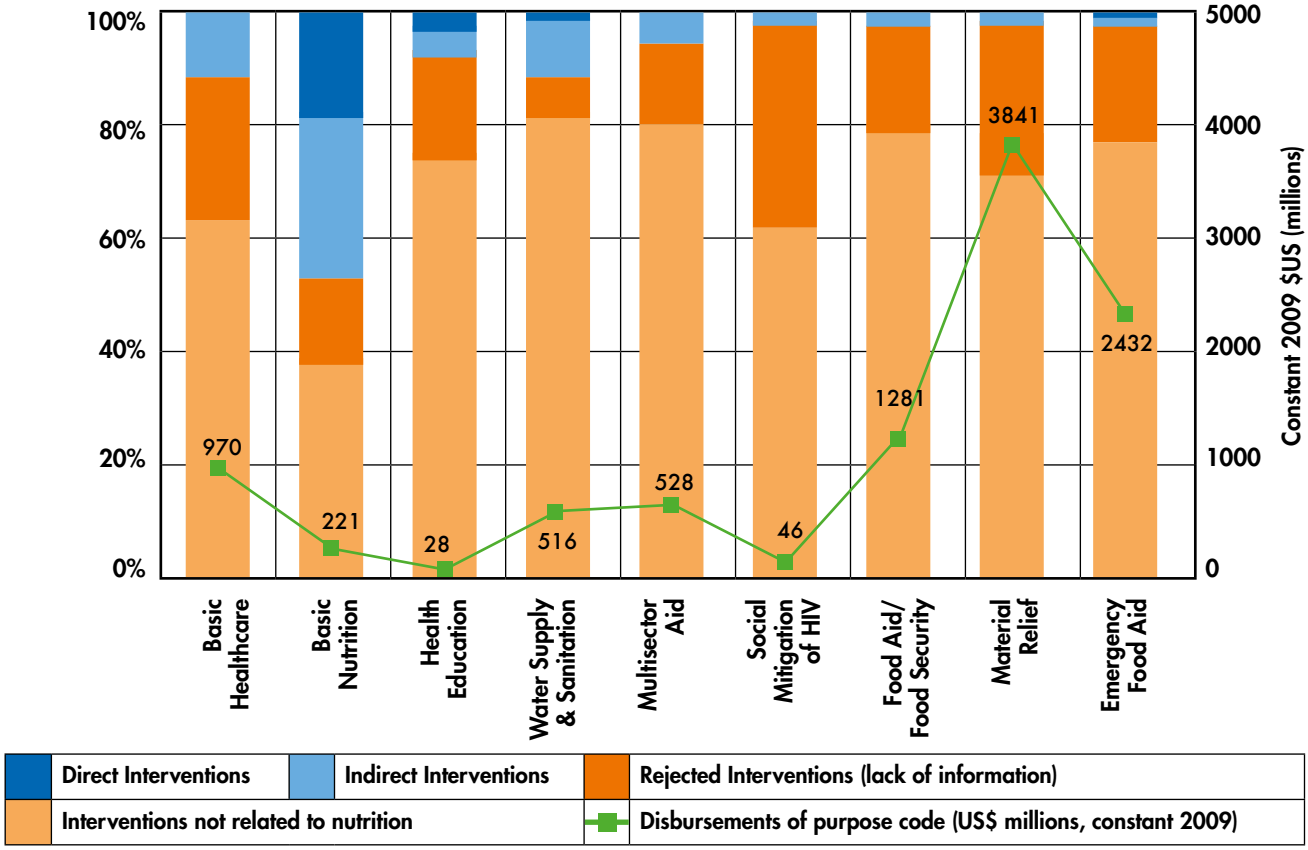
- **Tracking ODA for nutrition in the CRS database is more accurate when multiple purpose codes are used. Additionally, analysis of individual projects rather than aggregate analysis of each purpose code increases accuracy. Aggregate analysis of the 'Basic Nutrition' purpose code only can be misleading.**
- **Poor reporting by key donors to the OECD's CRS database, such as the EU, France, WFP, FAO, WHO and others limits the effectiveness of the CRS as a single source of data for monitoring donor aid activities.**
- **Investment in nutrition is inadequate. Disaggregating the data further indicates that investment in direct nutrition interventions is severely inadequate compared to indirect nutrition interventions.**
- **Almost half of all investments in direct nutrition were to reduce micronutrient deficiencies.**
- **There is inadequate investment in programmes that deliver the full package of direct interventions.**
- **Nutrition activities are mainly delivered through the health sector or in response to humanitarian crises, whilst very little is delivered through the development agenda indicating the reactive, short-term and unpredictable nature of aid for nutrition.**
- **Nutrition interventions are not reaching all of those who require them the most.**
- **Fulfillment of individual donor commitments varied widely. Collectively, there was a general negative trend indicating that donors failed to deliver 11% of their commitments.**

3.1 HOW IS ODA INVESTMENT IN NUTRITION REPORTED IN THE CRS DATABASE?

Figure 3.1A demonstrates that donors use several purpose codes within the CRS database to report funding flows to nutrition. Therefore analysis of multiple purpose codes related to nutrition provides a more accurate picture. Funding to each purpose code analysed differs widely, and 'Basic Nutrition' is one of the purpose codes attracting the least amount of funding (US$221 million) compared to others such as 'Emergency Food Aid' (US$2,432.5 million).

Our findings also show that the case study donors reported most of their aid activities for nutrition under the 'Basic Nutrition' purpose code. However, approximately US$85 million, or 38% of the funds reported in this purpose code, were not related to nutrition. In addition, 14% of funds in the same purpose code were excluded from the analysis due to insufficient information. The other key purpose codes that included the most amount of funding for nutrition interventions were 'Material Relief Assistance and Services' and 'Basic Drinking Water Supply and Services', whilst 'Basic Healthcare' and 'Food Aid/Food Security' contained the least amount of funding. The 'Basic Healthcare' purpose code received US$970 million of funding, but only 10% of this was spent on indirect nutrition interventions. The 'Health Education' code (total amount US$28 million) received the least amount of funding and approximately 3% of this code was allocated to direct nutrition interventions. Meanwhile the 'Emergency Food Aid' code attracted US$2.4 billion and allocated US$68 million to nutrition interventions. 'Material Relief Assistance and Services' received US$3.4 billion of which US$64 million was for nutrition. The 'Food Aid/Food Security' code attracted US$1.3 billion of ODA but only US$23 million was for nutrition. 'Water

FIGURE 3.1A: THE REPORTING OF NUTRITION INTERVENTIONS IN SPECIFIC CRS PURPOSE CODES BY DONORS FROM 2005 TO 2009



Supply and Sanitation' received just over half a billion dollars, a small proportion of which was allocated to direct nutrition interventions (US$4 million). The 'Basic Nutrition' code accounted for 59%, or US$106 million, of the nutrition funding (of which only US$43 million was for direct nutrition) whilst the remainder was distributed to the other purpose codes in varying quantities.

Member states of the DAC voluntarily report their aid activities to the CRS on an annual basis. However, private donors such as the BMGF only started reporting to the CRS in 2009. Furthermore poor reporting by some donors such as France and the WFP prevented their inclusion in the study, or, in the case of the EU, their contribution to nutrition may have been underestimated. In a separate analysis, we supplemented the CRS data for some donors (ECHO[1] and France) with additional data sourced directly from their websites to generate an estimate on nutrition funding for 2009. However, it should be clarified that these figures are from multiple sources whilst the estimate from 2005 to 2009 is from a single source (the CRS database). In total, the estimated investment in nutrition in 2009 was US$878 million. Direct nutrition interventions accounted for US$175 million of this, whilst indirect interventions accounted for US$703 million. Figure 3.1B shows how much different donors allocated to nutrition interventions in 2009.

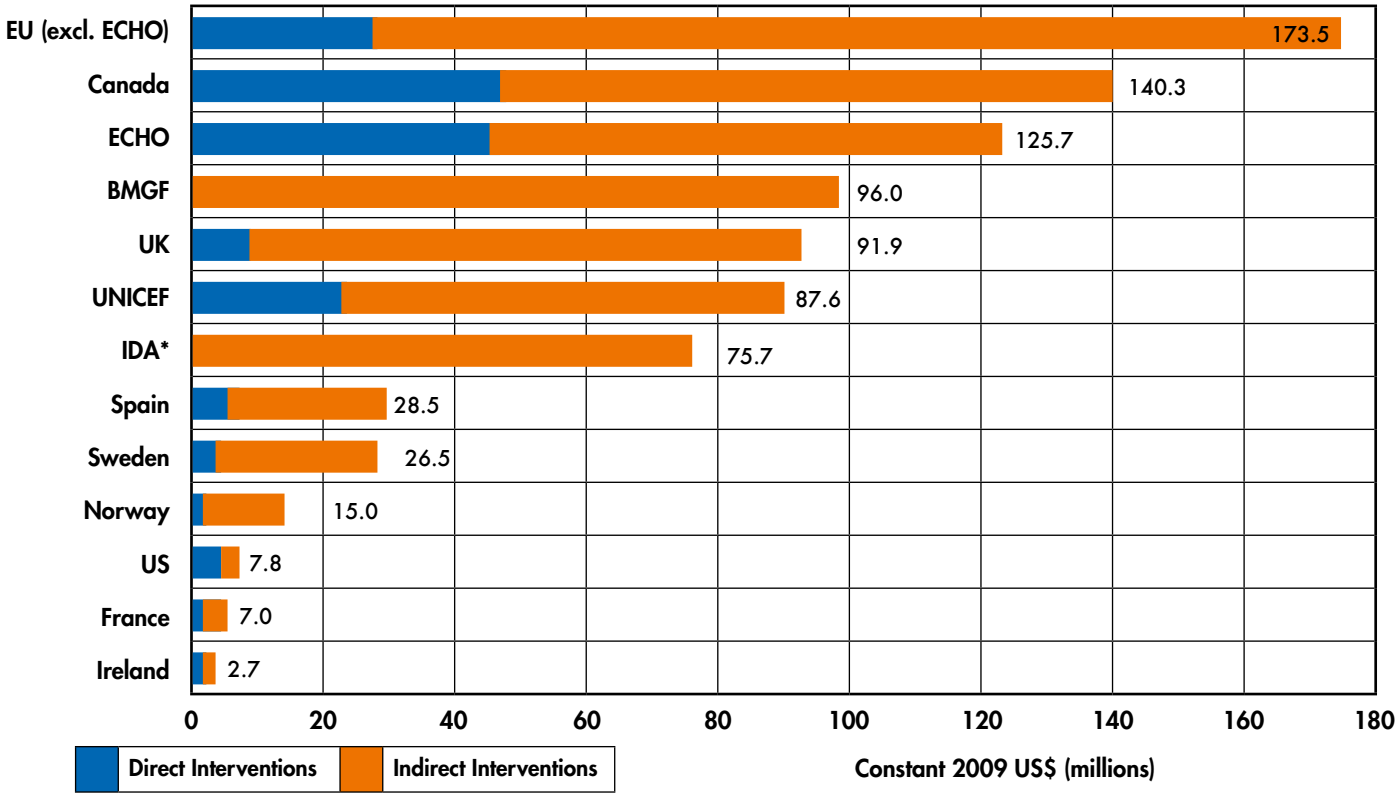
3.2 WHAT ARE THE TRENDS OF DONOR ODA FOR NUTRITION FOR THE 2005 TO 2009 PERIOD?

Ten donors (Canada, the EU, the UK, the IDA, Ireland, the USA, UNICEF, Spain, Sweden and Norway) reported their ODA to the CRS database during the 2005 to 2009 period. This time period enabled a more accurate temporal time analysis.

Figure 3.2 shows the estimated annual average ODA to nutrition interventions in US dollars and as a

[1] *EC (2011) Conventions de financement des operations humanitaires 2004-2008 [online] http://ec.europa.eu/echo/funding/grants_contracts/agreements_fr.htm [Accessed in March 2012]*

FIGURE 3.1B: ESTIMATED ODA FOR NUTRITION INTERVENTIONS PER DONOR IN 2009



** For IDA, no figures were reported in the CRS database for 2009. Therefore an average of ODA for nutrition interventions from 2005-2008 was used.*

percentage of overseas development aid (ODA) for the donors studied. On average, for the 2005 to 2009 period, ODA for nutrition per year totalled US$438 million. ODA for direct nutrition interventions has increased annually from a level of US$20 million in 2005 to $125 million in 2009. However when assessed as a percentage of overall ODA, this represents an increase of 0.03% to 0.2% for the same period, providing an average of US$73 million or 0.1% of overall ODA. This clearly demonstrates how poorly the nutrition sector and more specifically, direct nutrition interventions, have been funded over the years within this sector. Although the volume of ODA for indirect interventions doubled over the same period, their increase as a percentage of overall ODA was relatively flat. Nevertheless, on average, indirect nutrition interventions have consistently attracted more ODA per year (US$365 million or 0.5% of total ODA) compared to direct interventions.

3.2.1 WHAT IS THE DISTRIBUTION OF INVESTMENT BETWEEN THE DIFFERENT DIRECT NUTRITION INTERVENTIONS?

The majority of investment within direct nutrition interventions focused on increasing the intake of micronutrients (44%), either through direct supplementation or food fortification. Following this, 40% of ODA for direct nutrition was allocated to supplementary and therapeutic feeding for undernourished children with special foods.

The category dedicated to promoting good nutritional practices, which encapsulates infant and young child feeding (IYCF) and hygiene, received 14% of the funding for direct nutrition interventions. Disappointingly, only 2% of ODA was allocated to comprehensive programmes that included direct nutrition interventions from all three categories. These came from ODA pledged by the USA. This indicates a disjointed and fragmented approach to tackling undernutrition.

FIGURE 3.2: ODA FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2005 TO 2009

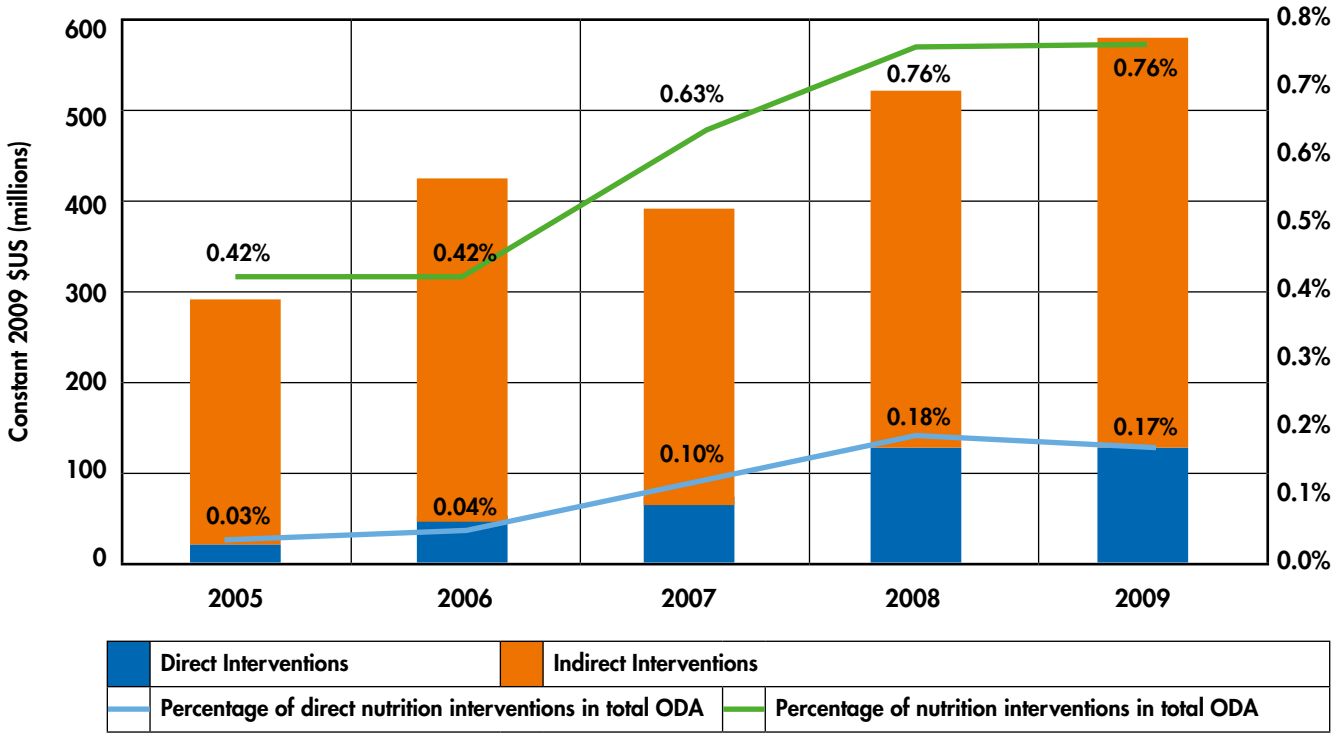
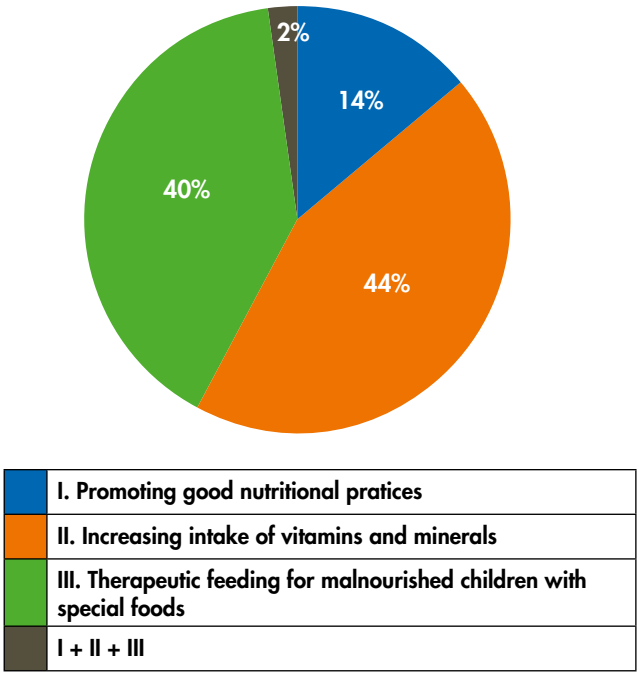


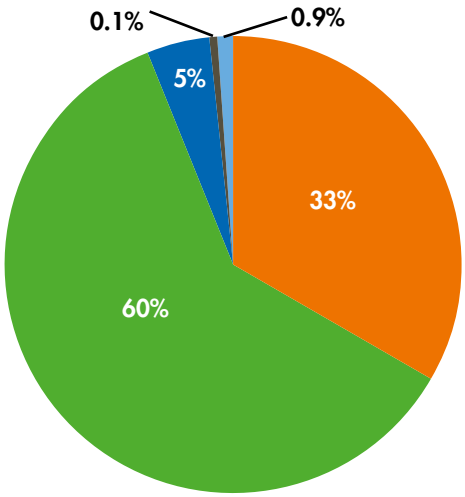
FIGURE 3.2.1: PROPORTION OF ODA TO THE DIFFERENT CATEGORIES OF DIRECT NUTRITION INTERVENTIONS



3.3 SECTOR OF DELIVERY FOR NUTRITION INTERVENTIONS

As shown in Figure 3.3A, direct nutrition interventions were most frequently implemented through the health sector (61%) and as humanitarian aid (33%). They were also implemented through water and sanitation programmes (5%) or as development food aid (1%). Similarly, Figure 3.3B shows that indirect nutrition interventions were implemented through the health sector and as humanitarian aid (44% and 29% respectively), although the proportions were slightly reduced. The proportion of indirect nutrition delivered through development food aid and water and sanitation programmes was higher (6% and 14% respectively) and 25% were delivered through social infrastructure and services.

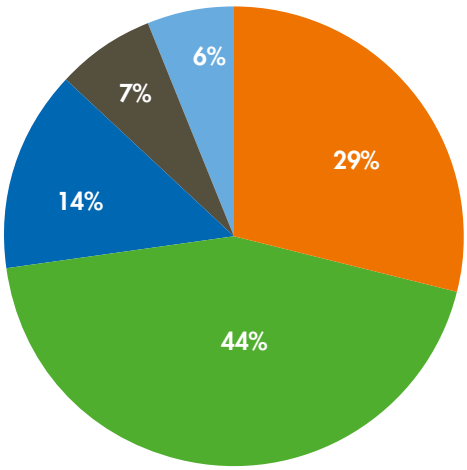
FIGURE 3.3A: SECTORS* OF IMPLEMENTATION FOR DIRECT NUTRITION INTERVENTIONS



Humanitarian Aid
Health
Water & Sanitation
Social Infrastructure & Services
Commodity Aid and General Programme Assistance

** Sectors were classified according to the CRS database (see Annex 4).*

FIGURE 3.3B: SECTORS OF IMPLEMENTATION FOR INDIRECT NUTRITION INTERVENTIONS



Humanitarian Aid
Health
Water & Sanitation
Social Infrastructure & Services
Commodity Aid and General Programme Assistance

3.4 WHO ARE THE DONOR NUTRITION CHAMPIONS?

The top donor to invest in direct nutrition interventions over the 2005 to 2009 period, independent of total ODA, was Canada followed in descending order by UNICEF, the European Union Institutions, the UK, the USA, Spain, Ireland, Norway and Sweden. For indirect nutrition interventions, Canada and the EU were joint leaders, followed by the IDA, which invested all of its contributions in indirect interventions. UNICEF and the UK jointly trailed the IDA, followed by the USA, Spain, Norway and Ireland.

However, as shown in Figure 3.1B, for the 2009 data the order of the top donors changes as it used various sources of data (in addition to the CRS database) and includes other donors.

3.5 IS ODA FOR NUTRITION GOING TO THE REGIONS WHERE IT IS NEEDED THE MOST?

Funding trends for nutrition for the two regions worst affected by undernutrition in the world are summarised in Figure 3.5. In Africa, the volume of funding for nutrition activities increased steadily from 2005 to 2009. Funding trends in Asia decreased from US$152 million in 2005 to US$112 million in 2009. Other regions such as the Americas and Oceania received minimal funding in this period and some interventions were not specified to any particular region or country. The top 5 high priority countries (out of 15) ranked by ACF according to their caseloads of stunting are India, Indonesia, Nigeria, Bangladesh and Pakistan. When we assessed the quantity of funds disbursed to high priority countries (see Annex 1 for the full list), the trend analysis indicated that almost half of the ODA for nutrition in the Africa region was delivered to those countries which were lower on the priority list. However, the majority of ODA for nutrition in Asia was targeted to higher priority countries. Table 3.5 details the top 15 recipients of ODA for nutrition.

Our data indicates that Bangladesh attracted 12% of the funding for nutrition but that it only has the 4th highest caseload, whilst India, which has the highest caseload, received less than Bangladesh. Out of the 15 top recipient countries, only 6 are included in the list of high priority countries.

FIGURE 3.5: PROPORTION OF ODA FOR THE REGIONS WORST AFFECTED BY UNDERNUTRITION

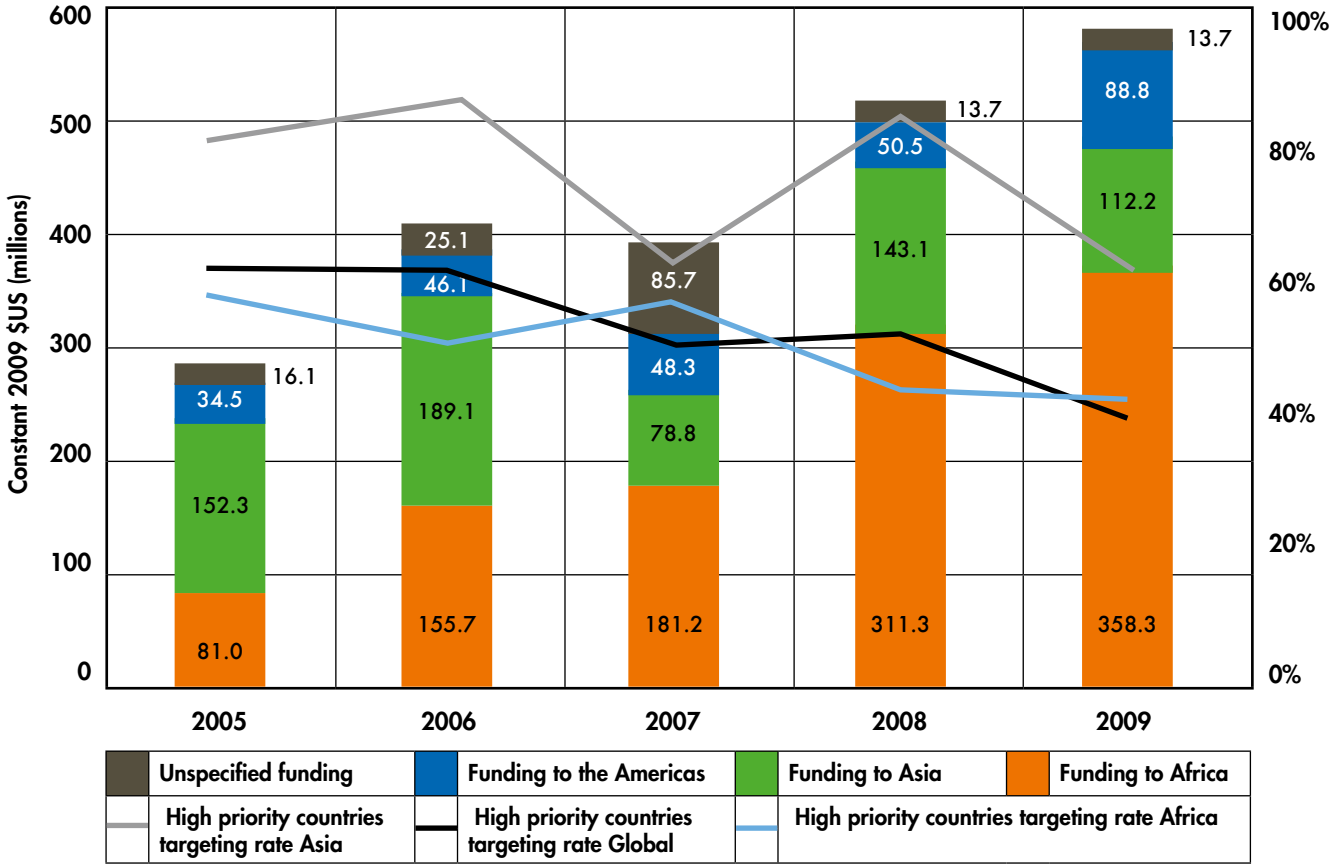


TABLE 3.5: LIST OF TOP ODA RECIPIENT COUNTRIES

	Recipient	Average annual funding for nutrition from 2005-2009 (Constant 2009 US$ millions)	Percentage of total nutrition funding	Rank (caseload of stunted children)*
1	Bangladesh	53.7	12%	4
2	India	33.4	8%	1
3	Sudan	31.5	7%	13
4	Ethiopia	27.5	6%	6
5	Somalia	17.4	4%	NR
6	Niger	11.0	3%	22
7	Kenya	9.9	2%	16
8	Guatemala	9.8	2%	27
9	Peru	8.4	2%	32
10	Congo Dem.Rep	8.3	2%	7
11	Afghanistan	7.6	1%	10
12	Honduras	7.0	1%	NR
13	Ghana	6.4	1%	29
14	Haiti	6.4	1%	NR
15	Uganda	6.2	1%	12

** Rank of caseloads of stunted children in the Lancet's list of 36 High Burden Countries (2008).*

3.6 ACCOUNTABILITY

It was possible to analyse to what extent donors fulfilled their promises (commitments) against what they actually paid out (disbursements) in ODA. The general trend saw an increase in ODA commitments and disbursements over the 2005 to 2009 period. However, as shown in figure 3.6A, from 2009, donor adherence to commitments of aid for nutrition decreased.

Between 2005 and 2009, Figure 3.6B indicates that the percentage difference between donor commitments and disbursements was collectively negative (-11%), meaning that donors broke their promises and did not deliver on a tenth of their collective pledges. However, when considered individually there was greater variation. This indicates the volatility and unpredictability of bilateral aid which make it impossible for recipient countries to develop long-term national policies to tackle undernutrition.

FIGURE 3.6A: DIFFERENCE BETWEEN COMMITMENTS AND DISBURSEMENTS OVER TIME

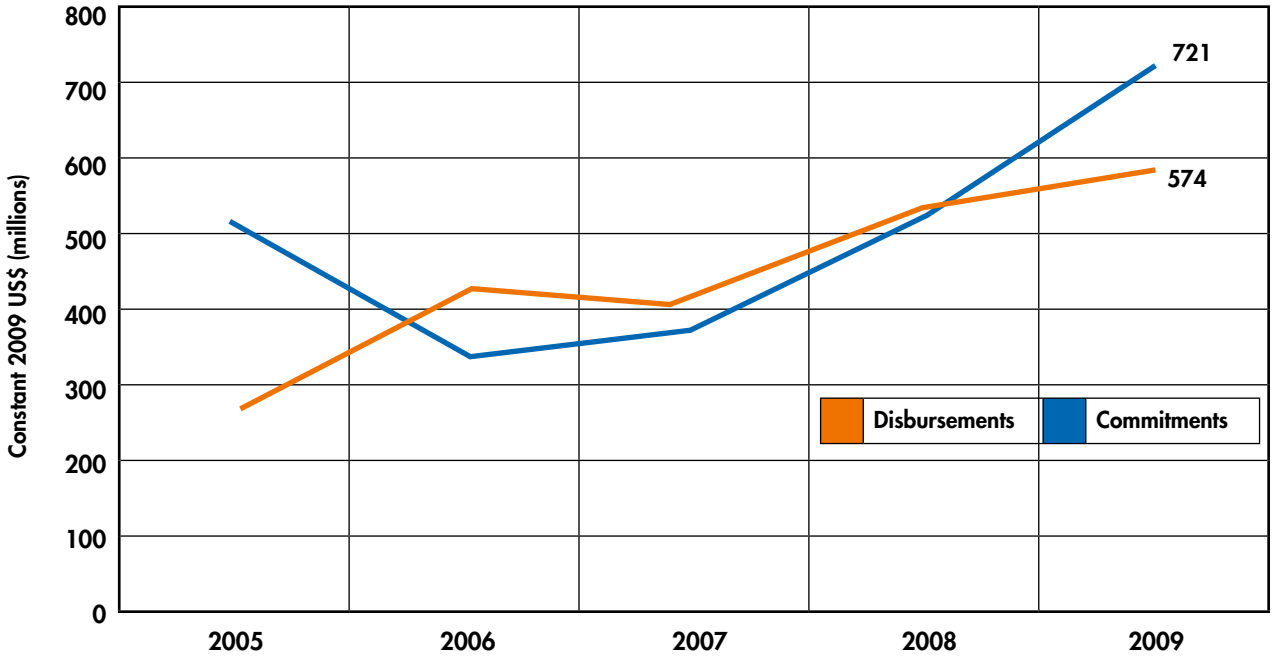
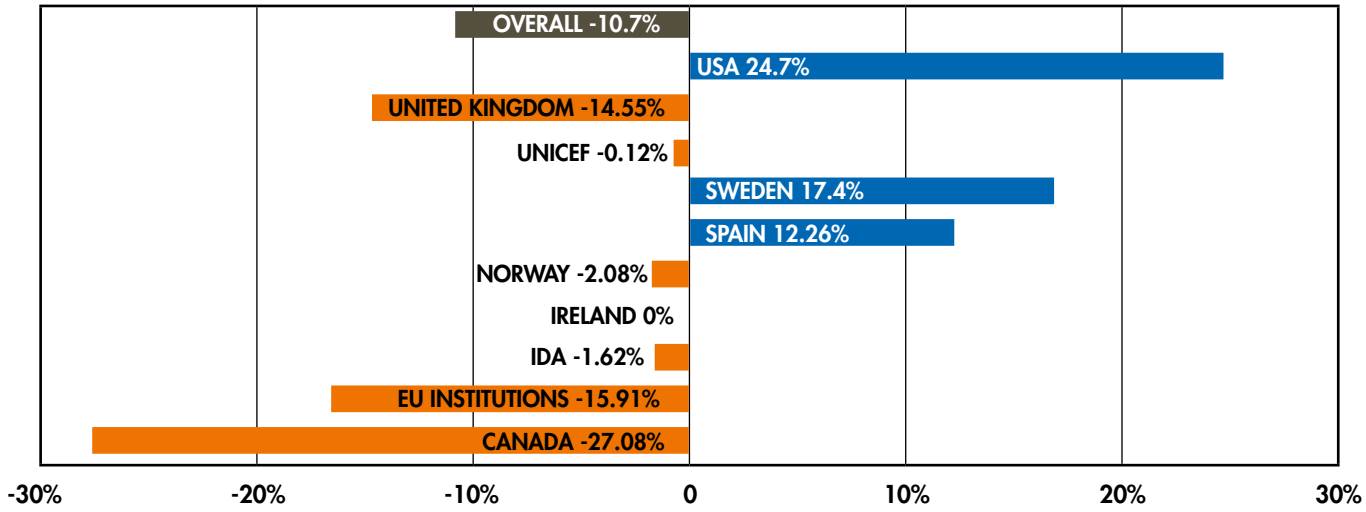
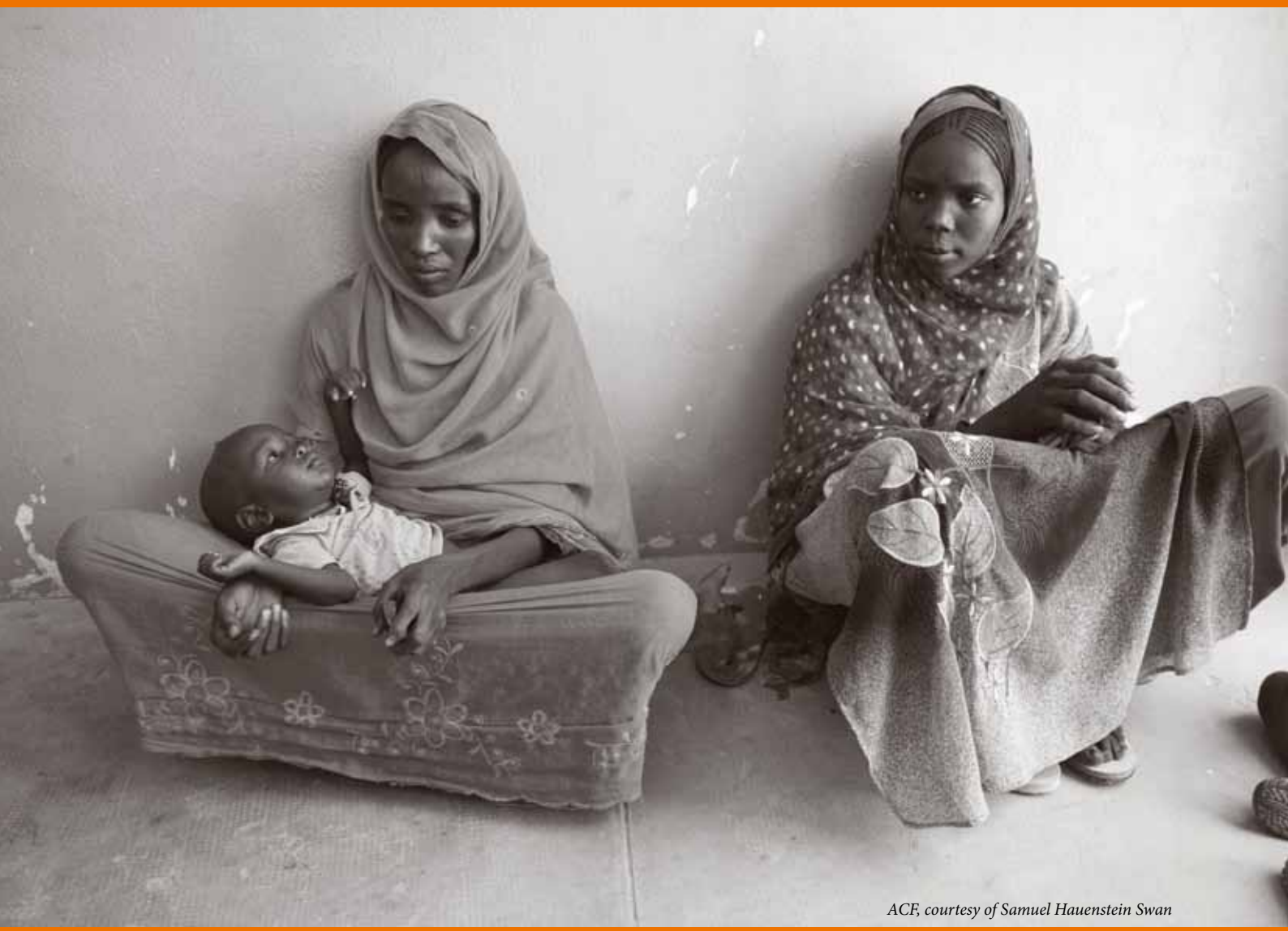


FIGURE 3.6B: PERCENTAGE DIFFERENCE BETWEEN COMMITMENTS AND DISBURSEMENTS PER DONOR STUDIED



DISCUSSION



ACF, courtesy of Samuel Hauenstein Swan

4. DISCUSSION

4.1 LIMITATIONS OF MAPPING AID FOR NUTRITION IN THE CRS DATABASE

Tracking a discrete set of direct nutrition interventions in the CRS database is very difficult, as reported by others who have attempted this exercise previously (Sumner *et al*. 2007, Morris *et al*. 2008, MSF 2009, Coppard *et al*. 2011). Nutrition mapping is approached by researchers in one of two ways: Morris *et al*. (2008) and Coppard and Zubairi (2011) analysed aggregated sector codes for 'Basic Nutrition' and other purpose codes. Sumner *et al*. (2007) and MSF (2009) undertook a detailed analysis of the CRS database project line by project line using multiple purpose codes and categorised projects as either direct or indirect interventions. Our aim was to map funding for the 13 proven, cost-effective direct nutrition interventions (Morris *et al*., 2008; Horton *et al*., 2010). However we encountered barriers which risk limiting the transparency of aid from donors and the accuracy of estimating ODA invested in nutrition.

4.1.1 POOR DONOR REPORTING

Limited or missing information for projects reported in the analysed purpose codes of the CRS database hampered analysis. We were unable to analyse 22% of the projects in the study due to a lack of adequate information. Furthermore, donors were inconsistent in adhering to existing CRS reporting guidelines. Some donors such as ECHO, the WFP, the WHO, France, the Netherlands and Japan could not be analysed at all due to a lack of sufficient information. Also, when donors allocated ODA to several countries, recipient countries were not specified and were lumped into a region (e.g. Africa or Asia). Sometimes, neither the country nor the region was specified, impeding aid mapping. Our findings support the findings of other researchers (Sumner *et al*., 2007; Morris *et al*., 2008; MSF, 2009; Coppard and Zubairi 2011).

All bilateral donors and multilateral agencies, particularly ECHO, France, Japan, the WFP and the WHO, and private donors must commit to aid transparency principles by improving their reporting practices to the CRS database. This should include the expediency of donor reporting so that the database is not behind in reporting donor aid activities (it is currently almost 2 years out of date). This will ensure accountability to the electorate who invest in development through their tax contributions and private donations and ensure that the scale up of nutrition can be tracked effectively.

4.1.2 LACK OF RELEVANCE OF SOME INTERVENTIONS IN THE 'BASIC NUTRITION' PURPOSE CODE

'Basic Nutrition' is the purpose code dedicated to nutrition funding in the CRS database. The interventions included in this purpose code are listed in Annex 6. However we did not include 38% of the projects detailed in this code because they were not related to nutrition. Interventions included in the 'Basic Nutrition' code such as growth monitoring, household food security and school feeding, have not been proven to have an impact on reducing undernutrition (Bryce & Coitinho 2008). For example, by including 'household food security' in this purpose code, the CRS suggests that this intervention has a direct impact on nutrition. The achievement of household food security does not necessarily lead to improvements in the nutritional status of all household members.

Activities to determine nutritional and micronutrient status are also included in the purpose code. These are not direct interventions as such but intend to measure the prevalence of undernutrition.

Our findings demonstrate that aggregate analysis of this and other codes can be misleading and overestimate ODA for nutrition. Although the code attracted US$221 million for the period of 2005 to 2009, interventions related to nutrition amounted to US$106 million, less than 50% of total funding reported in that code.

The DAC Working Party on Statistics must amend the list of nutrition actions within the CRS 'Basic Nutrition' purpose code to ensure that only activities related to nutrition are included and those that are not are reallocated to other purpose codes in the database.

4.1.3 NUTRITION AID ACTIVITIES ARE REPORTED IN SEVERAL PURPOSE CODES

An accurate and detailed mapping of aid for nutrition was conducted by analysing each project within specific purpose codes and categorising it as a direct or indirect nutrition intervention. The importance of including purpose codes other than 'Basic Nutrition' in this analysis was evident when we found that 40% of direct nutrition funding was reported in other purpose codes. Donors use several purpose codes to report aid activities in nutrition. Nutrition, particularly direct nutrition, made up a small proportion of these codes, accounting for less than 3% of the codes that received more than a billion dollars such as 'Emergency Food Aid'. 'Basic Health Care', 'Emergency Food Aid', 'Material Relief Assistance and Services', 'Water Supply and Sanitation', 'Multisector Aid' and 'Food Aid/Food Security' are also important purpose codes for mapping aid for nutrition.

The issues highlighted limit the transparency of donor aid activities. Failure to address these limitations adequately will undermine the aims of the CRS which are to be the main source of information on the sectoral and geographical distribution of aid, to report the terms and conditions of bilateral and multilateral aid and to provide quality assurance of data comparability. Furthermore, these issues limit the additional aims of the database to respond to the needs of aid agencies for country and sector programming and analysis and to act as a tool for monitoring policy implementation.

4.2 IS THE MONEY INVESTED IN NUTRITION SUFFICIENT TO ADDRESS THE ESTIMATED NEEDS?

From 2005 to 2009, donor investments to tackle undernutrition varied. Our research found that in this period, an annual average of US$438 million (disbursements, constant 2009) was invested in nutrition. This amounts to just **under 4%** (**or 8%** if the estimate is increased by an arbitrary figure of 50% to compensate for the donors that were not included in this report) of the estimated need. However, it is shocking to see that funding for proven direct interventions amounts to **0.6%** (**or** US$ 73.3 million, annual average, 2009 constant) of the estimated US$11.8 billion needed each year to prevent and treat undernutrition (Horton *et al.*, 2010). The data shows how much more needs to be done to scale up investment in nutrition interventions. Our estimate of US$438 million for overall nutrition related interventions was comparable to previous estimates determined using a similar methodology.

When considering the estimates made by other researchers, it is important to note that MSF's (2009) list of direct nutrition interventions is broader and more comparable to the list of Sumner *et al.* (2007) than that of the 13 proven interventions identified by Morris *et al.* (2008). Annex 5 shows the differences in interventions included in the reports cited in Table 4.2. In comparison with the MSF (2009) estimate of ODA for direct nutrition interventions, our lower estimate is partially explained by the broader list of interventions included in their 'core' or direct actions category. Coppard and Zubairi (2011) had the highest estimate for 2009 however this may have been an overestimate due to the issues raised in

TABLE 4.2 ESTIMATES OF ODA FOR NUTRITION REPORTED BY DIFFERENT RESEARCHERS

Research	Period studied	Direct Interventions (US$ millions)	Percentage of estimated need	Direct and Indirect Interventions (US$, millions)	Total
ACF (2011)	2005 to 2009	73	0.6%	364	438
	2009	175	1%	703	878
Coppard & Zubairi (2011)	2009	511*	6%	-	511
MSF (2009)	2004 to 2007	114	1%	539	539
Morris *et al.* (2008)	2000 to 2004	269*	2%	-	269

** Based on aggregate analysis of the 'Basic Nutrition' purpose code.*

Sections 4.1.1, 4.1.2 and 4.1.3. It is undeniable that the food and economic crises have increased aid for nutrition in recent years. However nutrition spending has been consistently low, averaging less than 0.3% of total ODA over the last decade, which is much lower in comparison to other sectors. We acknowledge that this analysis tells only part of the story as it does not include investments in nutrition by developing countries, non-OECD countries and other private donors.

Despite the problems with the CRS database, the data that is accessible suggests that investment in nutrition as a sector remains severely inadequate and is particularly dire for the evidence-based direct nutrition interventions in light of the estimated needs. Against the current trend of severe budget cuts and competing priorities, scaling up proven, cost-effective nutrition interventions would contribute to aid effectiveness and accelerate achievement of the MDGs.

All donors and governments who have committed to the Scaling Up Nutrition (SUN) global movement must dramatically increase their investments in direct or nutrition-specific interventions to meet the estimated US$11.8 billion required annually to reduce undernutrition in the worst affected countries.

In 2010, net ODA from OECD DAC member states reached a record level of US$128.7 billion, representing 0.32% of their combined gross national income (GNI) (Fifth High Level Dialogue on Financing for Development, 2011). However, the net ODA/GNI ratios of most large donors were below the United Nations target of 0.7%. Moreover, the G8 member states (the UK, the USA, Canada, Japan, France, Italy, Germany and Russia) did not deliver on their Gleneagles promise to increase aid to Africa by US$25 billion (2004 constant prices).

ACF has commissioned the Institute of Development Studies (IDS) to propose various ways in which the funding gap can be closed to ensure that all proven direct nutrition interventions are delivered at scale. A follow up report to make the case for funding the SUN fully and equitably will be released in 2012.

4.3 HOW IS FUNDING DISTRIBUTED BETWEEN DIRECT AND INDIRECT NUTRITION INTERVENTIONS?

The SUN Framework (2010) supports both nutrition-specific (direct) and nutrition-sensitive (indirect) interventions. Direct interventions tend to address the more immediate determinants of undernutrition, such as the quality of individual food intake and the provision of individual health services (Sumner *et al.*, 2007). Our findings indicate that investment in direct nutrition interventions is low, accounting for just **0.1% of total ODA.** This was dwarfed by investment in indirect nutrition interventions which are 0.5% of total ODA. These findings support the findings of Sumner *et al.* (2007) who reported that donor investment in direct interventions ranged from 0.01% to 0.6% for the 2000 to 2004 period. It is debatable whether an ideal balance exists between investments in direct and indirect nutrition interventions.

4.4 HOW IS FUNDING DISTRIBUTED BETWEEN DIFFERENT DIRECT NUTRITION INTERVENTIONS?

The three main categories of the evidence-based direct interventions to prevent and treat undernutrition include increasing the intake of vitamins and minerals, providing therapeutic feeding for malnourished children with special foods and promoting good nutritional practices. Assessing how ODA is distributed between these interventions could highlight which areas need improvement and provide indications of the effectiveness of ODA investments in nutrition. (See Figure 3.2.1 on page 21).

4.4.1 INCREASING INTAKE OF VITAMINS AND MINERALS

Programmes to increase the intake of micronutrients commanded 44%, or almost half, of all direct nutrition funding. This is unsurprising given that the influential Copenhagen Consensus included increasing micronutrient intake, such as Vitamin A and zinc supplements for children, as one of the top ten solutions to end undernutrition. Indeed, vitamins and minerals are low in price, small in size and easy to integrate into existing child health programmes. For instance, as part of the WHO IMCI strategy, children suffering from severe acute malnutrition or severe

anaemia routinely receive a dose of Vitamin A. In many countries, vitamin A and deworming treatments are distributed biannually through outreach services as part of integrated approaches that deliver high-impact, low-cost, child survival interventions.

4.4.2 THERAPEUTIC FEEDING FOR MALNOURISHED CHILDREN WITH SPECIAL FOODS

Therapeutic and supplementary feeding interventions with special foods accounted for 40% of all investment in direct nutrition. Of the 13 interventions, the scaling up of therapeutic feeding for children suffering from acute malnutrition with special foods is the most expensive, requiring an estimated US$6.3 billion annually. Despite the cost, the treatment of acute malnutrition is a priority intervention as it saves the lives of children. Also, the cost-effectiveness ratio of treating severely malnourished children with therapeutic foods is comparable to other programmes perceived to be less expensive. The cost-effectiveness ratio of US$42 per DALY (disability adjusted life year) for treating SAM is within the general range of cost-effectiveness ratios estimated for other priority child healthcare interventions (Wilfred *et al.*, 2011). These include community or facility-based case management of lower acute respiratory infections (US$39), integrated management of childhood illness (US$38), universal salt iodization (US$34–36) and iron fortification (US$66–70).

Traditionally, supplementary or therapeutic feeding of acutely malnourished children has been implemented in response to emergencies. As such, these programmes tend to suffer from a stop-start donor funding approach, where the programme is funded and initiated when the prevalence of acute malnutrition exceeds pre-determined thresholds and then phased out when the prevalence decreases. However, in the past decade, the community-based approach for the management of acute malnutrition (CMAM) has been accepted as a key approach for tackling acute malnutrition and is one of the key direct interventions prioritised for scale up. Although 55 countries have implemented CMAM, many are pilot programmes which started in response to an emergency, such as in Ethiopia and Malawi; two countries that have now scaled up CMAM nationally (UNICEF/Valid, 2011). As national scale up takes hold and expands, investments in these programmes should increase.

4.4.3 PROMOTING GOOD NUTRITIONAL PRACTICES

Promoting good nutritional practices, which encapsulates infant and young child feeding (IYCF) and good hygiene, received 15% of the funding for direct nutrition interventions. It includes the promotion of breastfeeding, appropriate complementary feeding practices (excluding the provision of food) and proper hygiene, specifically hand-washing. A new resolution on Infant and Young Child Nutrition (WHA 63.23) highlighted that "the improvement of exclusive breastfeeding practices, adequate and timely complementary feeding, along with continued breastfeeding for up to two years or beyond, could save annually the lives of 1.5 million children under five years of age."

4.4.4 FUNDING FOR COMPREHENSIVE NUTRITION PROGRAMMES

Our data indicates a piecemeal approach by donors regarding the direct interventions they invest in. Only 2% of funding was invested in programmes that incorporate interventions from all three categories of proven direct interventions. This funding came from one donor only, the USA. However, it is a practice that should be adopted by all stakeholders committed to the scaling up of nutrition.

It is crucial that the 13 proven direct nutrition interventions are considered as a minimum nutrition package by donors to mount a robust response to the problem of undernutrition. Therefore there is an obligation for all donors to improve the coordination of their investments so that all direct nutrition actions are fully funded at scale.

It is important that member states of the DAC invest fully in the right direct nutrition interventions, prioritising them above others that are either not proven or have been shown to not have a direct effect on undernutrition (Bryce & Cointinho, 2008). Failure to do so will undermine aid effectiveness

and deliver disappointing results in the fight against undernutrition.

4.5 TREATMENT AND PREVENTION OF UNDERNUTRITION ACROSS SECTORS

Our data demonstrates that the health sector is one of the frontline sectors for treating and preventing undernutrition in development and humanitarian contexts. In both contexts the health sector is the main channel of delivery for direct nutrition interventions (61%) and indirect interventions (44%).

Health and nutrition are closely linked. Stunting, an indicator of chronic undernutrition, was associated with an increased incidence of malaria among a group of HIV-infected and uninfected young children living in an area of high malaria transmission intensity (Arinaitwe & Gasasira, 2012). However, poorly functioning health infrastructures and a lack of health workers who are able to recognise and treat undernutrition, will slow down the integration of evidence-based nutrition interventions such as CMAM into health policies and into the minimum basic package of healthcare for women and children.

It has also been shown that health system determinants associated with lower IMR (infant mortality rate) include, but are not limited to, higher physician density and more sustainable access to water and sanitation (Muldoon, Galway, *et al.*, 2011). This highlights the need for a multisectoral approach to tackle the problem of undernutrition.

The links between health and nutrition need to be better understood and supported by donor and recipient governments as well as other stakeholders to facilitate optimal cross-sector working. The contribution that nutrition can make to strengthening health systems needs to be clarified by the WHO and recognised by SUN stakeholders. Furthermore, health system strengthening must incorporate nutrition or be nutrition-sensitive.

4.6 ARE NUTRITION INTERVENTIONS ACCESSIBLE TO THOSE WHO NEED THEM MOST?

ACF's mapping of ODA investments indicate that investment in nutrition is more reactive and related to emergency response than it is proactive and part of the development agenda. 'Humanitarian Aid' accounted for 33% of ODA for direct nutrition interventions, whilst 'Development Aid' accounted for only 1%. This approach is not conducive to saving lives and averting short and long term illness, neither is it cost-effective or sustainable.

We found that there was a poor match between where aid was going and where it was needed most. However, most of the top recipients of ODA for nutrition include countries that are listed in the 36 countries with the highest burdens of stunted children. For example, out of the top 15 recipients of ODA for nutrition, the largest recipient was Bangladesh, which has the 4th largest caseload of stunted children in the world, whilst India, which has the largest caseload, received less than Bangladesh. Sudan and Ethiopia, which were the 3rd and 4th largest recipients of ODA respectively, are ranked as having the 13th and 6th largest caseloads of stunted children respectively. Meanwhile, the countries that have the 2nd and 3rd largest caseloads of stunted children (Indonesia and Nigeria respectively), did not even make it onto the list of top 15 countries to receive ODA for nutrition. This could be due to a number of factors including geopolitical preferences by donors, weak political will to invest in or prioritise nutrition at national level or weak capacity of government to mount a response. Coppard and Zubairi (2011) also reported that basic nutrition aid does not clearly reflect the need; they found that countries with 90% of all stunted children received just 57% of financing by DAC member states for the 'Basic Nutrition' purpose code, although sub-Saharan Africa was clearly a donor priority.

All donors need to proactively and predictably scale up and target ODA for the treatment and prevention of undernutrition to those at risk in non-emergency as well as emergency contexts, including protracted crises and seasonal hunger, in

order to ensure equitable and sustainable access to nutrition services.

4.7 WHO ARE THE TOP NUTRITION DONORS?

Through our research we found that the top donors to nutrition varied depending on whether programmes included direct or indirect nutrition interventions. For direct interventions, Canada, the EU, the UK, the USA, Spain, Norway, Sweden and Ireland, in that order, were the top bilateral donors and UNICEF was the top donor of the multilateral organisations. A previous report for the period of 2000 to 2004 listed the USA, Canada, Spain, the UK, Sweden and the EU as the top bilateral donors and UNICEF and the IDA as the top multilateral donors (Sumner *et al.*, 2007). However, our ranking was only based on data included in the OECD DAC database and on a narrower list of interventions. MSF (2009) ranked donors based on information gathered directly from the donors as well as from the OECD. It ranked the EU first, followed by the World Bank, Canada, the US, UNICEF, the Bill and Melinda Gates Foundation, the UK, Spain, the Asian Development Fund (AsDF) and finally Norway for the period of 2004 to 2007. Our analysis of funding flows to nutrition for 2009 also confirms the EU as the biggest donor to nutrition.

Coppard and Zubairi (2011) reported the top donors to nutrition, by analysing both bilateral and multilateral contributions to basic nutrition (i.e. 'Basic Nutrition' aid delivered indirectly through donor country core contributions to multilateral agencies). Their findings matched ours for 2009. Top donors in terms of volume were reported as Canada, the EU, Japan, the UK and UNICEF, while in terms of bilateral and imputed multilateral contributions, Canada was again the top donor, followed by Japan, the UK, Germany and France. The differences in donor investment in direct or indirect nutrition interventions are dependent on the level of priority a donor assigns to direct nutrition interventions.

Sumner *et al.*, (2007) reported that in many cases the donor's perception of nutrition affects their contribution to the sector. If nutrition is deemed to be a supporting investment rather than a foundational one, then it is assigned a lower priority. This occurs particularly in cases where there are no institutions or parliamentary bodies to prioritise nutrition in the country or institution or where it is difficult for donors to track funding flows or attribute impact to nutrition status. Our data clearly shows that although many donors may be committed to scaling up nutrition, they are usually more focused on indirect rather than direct nutrition interventions. Individual donor case studies examining donor investment patterns are presented at the end of this report in Annex 7.

Therefore, we call for an independent, accurate and comprehensive annual review of the quantity and quality of donor ODA investments in nutrition in order to keep the paucity of funding for nutrition high on the political agenda until undernutrition rates in the worst affected countries are either significantly reduced or eradicated.

CONCLUSION AND FUTURE WORK

ACF, courtesy of Hitendra Solanki

5.1 CONCLUSION

Tracking aid for nutrition is difficult and complicated. It forces researchers to make many assumptions that risk either under or overestimating how much ODA is invested in nutrition. Our findings confirm the urgent need to reform the CRS established mechanism for tracking ODA and to standardise the reporting practices of donors. In addition, in the interests of transparency and accountability, the 'Basic Nutrition' purpose code should be reformed so that it only includes activities directly related to the treatment and prevention of undernutrition. If nothing changes, the SUN Framework is at risk of being operationalised in darkness and its progress not being evaluated effectively or indeed fairly. Given the scale of the problem, it is essential to build a solid evidence base to evaluate progress towards the scale up of nutrition funding, to inform policy and decision making and to ensure that donors and recipients adhere to the principles of aid effectiveness.

In spite of the limitations we faced, our findings indicate that aid for nutrition is severely inadequate against the estimated US$11.8 billion needed to tackle undernutrition. In particular, the direct nutrition interventions that have been proven to work and to be cost-effective received, on average, just 0.1% of total ODA from 2005 to 2009. There have been encouraging signs of increases in ODA for nutrition in recent years in the wake of the triple F (food, fuel and financial) crises, but the increases suggest a reactive rather than a proactive approach to investing in nutrition. Greater prioritisation of the treatment and prevention of acute undernutrition is needed on the development agenda. Multisectoral approaches to tackle undernutrition should not be limited to indirect nutrition interventions, and should include direct nutrition interventions. Along with the WASH sector, the health sector is a key sector for the implementation of nutrition interventions and needs to be better prepared to take on the challenge of tackling undernutrition effectively.

The SUN Framework, and other nutrition focused initiatives, offer the most promising platforms to tackle one of the largest public health and development priorities of our time. Given the collective evidence of this and previous reports, the estimated US$11.8 billion needed to tackle undernutrition is urgently required. However, our findings suggest that current investments in a discrete set of direct nutrition interventions are not only inadequate, but are only succeeding to provide some of the interventions to some of those in need, some of the time. This, of course, undermines the aid effectiveness agenda which most governments claim to be a part of. If the estimated investment of US$11.8 billion can indeed be achieved, our recommendation to develop robust and standardised reporting through the existing OECD CRS database is all the more relevant for all stakeholders. The CRS database has the potential to be an incredibly useful reference source for all ODA for nutrition. With adequate, up-to-date information, it would enable full comparisons to be made between donors, sectors and recipients. However, for this potential to be realised, the issues we identify need to be resolved.

Many stakeholders, including bilateral, multilateral, private donors and others have endorsed the Scaling Up Nutrition Framework. It is therefore crucial for all stakeholders to be able to monitor and evaluate progress of the SUN. Holding governments accountable for commitments to eradicate undernutrition will be difficult without a comprehensive annual review of progress of the SUN. Accurate monitoring and evaluation of the quantity and quality of investments by independent observers is therefore crucial.

5.2 FUTURE WORK

1. ACF will commission a follow up report by the Institute of Development Studies (IDS) to examine and propose how the estimated funding requirements to deliver direct nutrition interventions at scale can be adequately achieved. The report will be completed in 2012.
2. ACF aims to produce an update of the estimated ODA for nutrition for 2010 for some of the key donors to nutrition.
3. ACF proposes to work with other key stakeholders in nutrition to advocate for the member states of the DAC to review the OECD CRS 'Basic Nutrition' purpose code to ensure it only includes interventions related to nutrition.
4. ACF will commission an independent observer to monitor and evaluate ODA for a discrete set of proven, cost-effective nutrition interventions annually, subject to adequate funding resources.
5. ACF aims to advocate to donors in each of the countries where they have headquarters to allocate a specific budget for the scale up of nutrition.
6. Nutrition investments should also be tracked in the future so that national governments can be monitored and held accountable for the commitments they have made to scale up nutrition. Although the OECD data provides ample information about commitments and disbursements from donors to developing countries, there is no established methodology or framework for tracking spending associated with nutrition programmes in low and middle-income countries.
7. Finally, ACF will endeavor to work with our colleagues in different sectors and our partners to make the case that undernutrition should be eradicated holistically through direct and indirect interventions and to establish best practices for indirect interventions in the Food Security, Health and Water and Sanitation sectors.

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7. ANNEXES

CONTENTS

ANNEX 1: LIST OF 36 HIGH-BURDEN COUNTRIES

The ACF list of 15 high-priority countries was established by selecting countries which had the highest case-loads of stunted children (taken from the list of 36 High Burden Countries identified in the Lancet (2008)) along with a high prevalence (≥10%) of wasting in children under 5 (taken from UNICEF[1]). The countries were then ranked according to the caseloads of stunted children. The 15 high-priority countries are highlighted in orange in the table below:

	COUNTRIES	NUMBER OF CHILDREN UNDER FIVE SUFFERING FROM STUNTING (THOUSANDS)	CHILDHOOD STUNTING PREVALENCE[3] (%)	BURDEN OF STUNTING (% OF NUMBER OF STUNTED CHILDREN OF WORLDWIDE TOTAL)	CHILDHOOD WASTING PREVALENCE[2] (%)
1	India	61,206	51.0	34%	20
2	Indonesia	9,772	45.3	5%	14
3	Nigeria	9,571	43.0	5%	11
4	Bangladesh	8,787	50.5	5%	17
5	Pakistan	8,763	41.5	5%	14
6	Ethiopia	7,498	57.4	4%	12
7	Democratic Republic of the Congo	4,977	44.4	3%	10
8	Philippines	3,730	37.8	2%	7
9	Viêt Nam	3,375	42.4	2%	NR
10	Afghanistan	2,967	53.6	2%	9
11	United Republic of Tanzania	2,920	48.3	2%	4
12	Uganda	2,675	44.8	1%	6
13	Sudan	2,483	47.6	1%	16
14	Yemen	2,175	59.3	1%	15
15	Nepal	2,078	57.1	1%	13
16	Kenya	2,054	35.8	1%	7
17	Myanmar	1,891	40.6	1%	11
18	Egypt	1,813	20.3	1%	7
19	Madagascar	1,724	55.5	1%	13
20	South Africa	1,616	30.9	1%	0
21	Mozambique	1,547	47.0	1%	NR
22	Niger	1,545	54.2	1%	12
23	Angola	1,511	30.8	1%	8
24	Turkey	1,479	20.5	1%	1
25	Malawi	1,278	54.6	1%	4
26	Iraq	1,223	28.3	1%	6
27	Guatemala	1,210	59.9	1%	NR
28	Mali	1,111	42.7	1%	15
29	Ghana	1,104	35.6	1%	9
30	Burkina Faso	1,060	43.1	1%	11

[1] [2] Source: UNICEF (2011) The state of the world's children - Adolescence: An age of opportunity [online] http://www.unicef.org/sowc2011/statistics.php [3] Source: EC (2009) Enhancing EC's contribution to address Maternal and Child undernutrition and its causes: Concept note [online] http://ec.europa.eu/europeaid/infopoint/publications/europeaid/documents/183a_conceptnote_undernutrition_en.pdf

31	Zambia	1,056	52.5	1%	5
32	Peru	938	31.3	1%	1
33	Cambodia	901	49.1	1%	9
34	Cameroon	868	35.4	0%	7
35	Côte d'Ivoire	863	31.1	0%	8
36	Burundi	837	63.1	0%	NR
	32 other countries	17,845	<20	10%	
	TOTAL	178,451		100%	
	total 36 HBC	160,606	44.064	90%	
	total ACF 15 HBC	124,641	48.880	70%	

Methodology for the calculation of the proportion of funding targeting high-priority countries in cases where no country was specified

To assess if nutrition funding was targeting the countries with the greatest needs, we calculated the proportion of funding targeting the high-priority countries out of the overall nutrition funding.

Donors do not always specify the name of the recipient country and often report some projects as "Bilateral Unspecified" or they mention simply the name of the region for regional programmes. In these cases, we assumed that this unspecified funding followed the same pattern of country targeting than for the funding that went to specified countries. For 'Bilateral Unspecified' projects, ratios were calculated for each year and each donor. Regional programmes were differentiated by calculating a ratio for the Asian region and for the African region. No ratios were calculated for the Americas, Oceania and Europe, as these regions contain no countries on the high-priority list.

For each donor and each year, three types of ratios were calculated:

The general unspecified ratio, to be applied to 'Bilateral, Unspecified' funding:

$$\frac{\Sigma\, D\,[\text{High-priority recipient countries}]}{\Sigma\, D\,[\text{recipient countries}]} \times 100$$

The African ratio, to be applied to African regional funding:

$$\frac{\Sigma\, D\,[\text{High-priority African recipient countries}]}{\Sigma\, D\,[\text{African recipient countries}]} \times 100$$

The Asian ratio, to be applied to Asian regional funding:

$$\frac{\Sigma\, D\,[\text{High-priority Asian recipient countries}]}{\Sigma\, D\,[\text{Asian recipient countries}]} \times 100$$

For example: if Canada spent US$100 million in nutrition interventions in 2008, of which 10 million was marked as 'Bilateral, Unspecified' and 45 million was dedicated to high-priority countries, then the general unspecified ratio is 50%. We therefore assume that 50 million (45+10*0.5) targeted high-priority countries, or 50% of Canadian funding in 2008.

ANNEX 2: THE COPENHAGEN CONSENSUS (2008)

RANK	SOLUTION	CHALLENGE
1	Micronutrient supplements for children (vitamin A and zinc)	Malnutrition
2	The Doha development agenda	Trade
3	Micronutrient fortification (iron and salt iodization)	Malnutrition
4	Expanded immunization coverage for children	Diseases
5	Biofortification	Malnutrition
6	Deworming and other nutrition programs at school	Malnutrition and Education
7	Lowering the price of schooling	Education
8	Increase and improve girl's schooling	Women
9	Community-based nutrition promotion	Malnutrition
10	Provide support for women's reproductive role	Women

ANNEX 3: INTERVENTIONS INCLUDED / EXCLUDED FROM THE COSTING EXERCISE OF *SCALING UP NUTRITION: WHAT WILL IT COST?* (HORTON *ET AL.* 2010)

INTERVENTIONS INCLUDED IN HORTON ET AL. 2010	INTERVENTIONS INCLUDED IN THE LANCET SERIES 2008	DIFFERENCES BETWEEN THE TWO PUBLICATIONS
Behaviour change interventions		
Breastfeeding promotion	Breastfeeding promotion	No deviation
Promotion of appropriate and timely complementary feeding (does not include provision of complementary foods)	Behaviour change communication for improved complementary feeding	No deviation
Promotion of handwashing	Promotion of handwashing / hygiene interventions	No deviation
Micronutrients and deworming interventions		
Vitamin A supplements	Vitamin A supplementation or fortification	Only vitamin A supplementation
Therapeutic zinc supplements for management of diarrhoea	Therapeutic zinc in management of diarrhoea	No deviation
Provision of micronutrient powders (sachets or crushable tablets) to children under two years of age	Not included	Micronutrient powders added as an evidence-based strategy to reduce anaemia; international expert meeting occurred after Lancet publication
Deworming	Deworming included only under specific situational contexts	No deviation
Iron-folic acid supplements for pregnant women	Maternal iron-folate supplements; and maternal multiple micronutrient (MMS) supplements	Only iron-folate supplements are costed here for two reasons. First, mothers will receive only one of the two interventions, not both; second, there are no available costs for MMS and delivery platforms as the two are identical
Iron fortification of staple foods	Iron fortification recommended only in specific situational contexts	Given the high prevalence of iron deficiency anaemia and low costs of iron fortification, a wider application is justified
Salt iodization	Universal salt iodization	No deviation
Iodized oil capsules	Maternal iodine supplements	No deviation
Complementary and therapeutic feeding interventions		
Prevention or treatment of moderately malnourished children from 6–23 months of age using complementary foods	Not included	Added here based on recent research and humanitarian imperative
Treatment of severe acute malnutrition using a community-based management of acute malnutrition	Treatment of SAM	Community management of treatment added on the basis of new evidence from MSF

ANNEX 4: THE SELECTED PURPOSE CODES OF THE CRS DATABASE

PURPOSE CODE	PURPOSE CODE NAME	CODE DESCRIPTION
120 HEALTH		
12220	Basic health care	Basic and primary health care programmes; paramedical and nursing care programmes; supply of drugs, medicines and vaccines related to basic health care.
12240	Basic nutrition	Direct feeding programmes (maternal feeding, breastfeeding and weaning foods, child feeding, school feeding); determination of micro-nutrient deficiencies; provision of vitamin A, iodine, iron etc.; monitoring of nutritional status; nutrition and food hygiene education; household food security.
12261	Health education	Information, education and training of the population for improving health knowledge and practices; public health and awareness campaigns; promotion of improved personal hygiene practices, including use of sanitation facilities and handwashing with soap.
140 WATER AND SANITATION		
14030	Basic drinking water supply and basic sanitation	Programmes where components according to 14031 and 14032 cannot be identified. When components are known, they should individually be reported under their respective purpose codes: water supply [14031], sanitation [14032], and hygiene [12261].
160 OTHER SOCIAL INFRASTRUCTURE AND SERVICES		
16050	Multisector aid for basic social services	Basic social services are defined to include basic education, basic health, basic nutrition, population/reproductive health and basic drinking water supply and basic sanitation.
16064	Social mitigation of HIV	Special programmes to address the consequences of HIV/AIDS, e.g. social, legal and economic assistance to people living with HIV/AIDS including food security and employment; support to vulnerable groups and children orphaned by HIV/AIDS; human rights of HIV/AIDS affected people.
500 COMMODITY AID AND GENERAL PROGRAMME ASSISTANCE		
52010	Food aid/Food security programmes	Supply of edible human food under national or international programmes including transport costs; cash payments made for food supplies; project food aid and food aid for market sales when benefiting sector not specified; excluding emergency food aid.
700 HUMANITARIAN AID		
72010	Material relief assistance and services	Shelter, water, sanitation and health services, supply of medicines and other non-food relief items; assistance to refugees and internally displaced people in developing countries other than for food (72040) or protection (72050).
72040	Emergency food aid	Food aid normally for general free distribution or special supplementary feeding programmes; short-term relief to targeted population groups affected by emergency situations. Excludes non-emergency food security assistance programmes/food aid (52010).

ANNEX 5: LIST OF ACTIVITIES CONSIDERED TO BE DIRECT NUTRITION INTERVENTIONS BY VARIOUS RESEARCHERS (2007-2012)

STUDIES	PERIOD	DEFINITION OF NUTRITION	
		List of Direct/Core/nutrition-specific interventions	List of Indirect/Mixed/nutrition-sensitive interventions
ACF, 2012	2005-09	• Breastfeeding • Complementary feeding for infants after 6 months • Improved hygiene practices • Periodic Vitamin A supplements • Therapeutic Zinc supplements for diarrhoea management • Multiple micronutrient powders • De-worming drugs for children (to reduce losses of nutrients) • Iron-folic acid supplementation for pregnant women to prevent and treat anaemia • Iodized oil capsules where iodized salt is unavailable • Salt iodization • Iron fortification of staple foods • Prevention or treatment for moderate undernutrition • Treatment of severe undernutrition with ready to use therapeutic foods	
COPPARD & ZUBAIRI, 2011	1996-2009		Basic Nutrition (OECD CRS database): • Direct feeding programmes • Micronutrient assessments and provision • Nutrition monitoring and education • Household food security.
LANCET, 2008	2000-2004		Basic Nutrition (OECD CRS database, Nov 2011): • Direct feeding programmes, • Micronutrient assessments and provision, • Nutrition monitoring and education, • Household food security
MSF, 2008	2004-2007	Any nutrition activity or project which includes a nutrition objective, including any activity whose title and description shows nutrition as a single objective. Also inclusive of the direct interventions of the Sumner et al. (2007) below.	Any interventions which correspond to nutrition activities and another type of activity e.g. other health objectives, food security and hygiene
SUMNER *ET AL.*, 2007	1995-1999; 2000-2004	• Community based nutrition and health services (growth promotion, supplementary feeding) • Breastfeeding counselling • Facility-based nutrition services (treatment of severe undernutrition , antenatal care) • Micronutrient supplementation and fortification • Targeted food aid IEC/nutrition education/behaviour change programmes • Advocacy on nutrition • Women's nutrition interventions • Nutritional surveillance	Primary health services and infectious disease control

ANNEX 6: LIST OF INTERVENTIONS IN THE CRS 'BASIC NUTRITION' PURPOSE CODE

	LANCET/SUN FRAMEWORK INTERVENTIONS	CRS 'BASIC NUTRITION' INTERVENTIONS
I. BEHAVIOUR CHANGE INTERVENTIONS	1. Breastfeeding promotion and support 2. Complementary feeding promotion 3. Handwashing with soap and promotion of hygiene behaviors	Breastfeeding Weaning foods Nutrition and food hygiene education
II. MICRONUTRIENT AND DEWORMING INTERVENTIONS	4. Vitamin A supplementation 5. Therapeutic zinc supplements 6. Multiple micronutrient powders 7. Deworming 8. Iron-folic acid supplements for pregnant women 9. Iron fortification of staples 10. Salt iodization 11. Iodine supplements	Provision of vitamin A, iodine, iron etc.
III. COMPLEMENTARY AND THERAPEUTIC FEEDING INTERVENTIONS	12. Prevention or treatment of moderate malnutrition in children 6–23 months of age 13. Treatment of severe acute malnutrition	Child feeding School feeding Maternal feeding
OTHER		Household food security Monitoring of nutritional status Determination of micro-nutrient deficiencies

ANNEX 7: INDIVIDUAL DONOR ANALYSES

THE BILL AND MELINDA GATES FOUNDATION

A SHORT REVIEW OF THE BILL AND MELINDA GATES FOUNDATION NUTRITION STRATEGY

The Bill and Melinda Gates Foundation (BMGF) is committed to ensuring that children have the nutrition they need for a healthy start to life. The Foundation takes particular interest in research and development of new products and tools to ensure adequate nutrition for women and children; this includes developing new approaches for addressing undernutrition within the first two years of life. The Foundation relies on its partners to deliver nutrition interventions around the world, particularly in sub-Saharan Africa and south Asia, where the burden of undernutrition is greatest. Moreover, they investigate ways in which these interventions can be replicated and scaled up to improve nutrition.

Are financial investments in nutrition sufficient to address the estimated needs?

This report analysed the BMGF's grants for 2009, which, at the time of data collection, was the only year it had reported to the OECD CRS database. The Foundation spent US$96 million on nutrition interventions in 2009 — all of which were on indirect nutrition interventions. Most of the nutrition activities carried out were in research and development which was in line with their nutrition strategy. Moreover, their spending on nutrition amounted to 5.2% of their total grants for that year. No funds were spent on direct nutrition interventions — this is understandable as the foundation's main focus is on advocacy, research and development to improve undernutrition.

How is funding distributed between direct and indirect nutrition interventions?

In 2009, 100% of the Foundation's funding was channelled through the health sector.

Are nutrition interventions accessible to those who need them most?

69% of the Foundation's funding in 2009 was classified as 'Bilateral Unspecified'. It was thus almost impossible to conduct an analysis which would show if funds were targeted at countries with high caseloads of undernutrition.

Reporting and transparency

Within the analysed purpose codes, activities involving nutrition interventions were reported only under the 'Basic Health' sector as part of the 'Basic Nutrition' purpose code. Descriptions of nutrition activities were detailed and clear and no projects were rejected for lack of information. Approximately 99% of all project lines reported were related to nutrition.

Key recommendations

- Prioritise and fund strategies that directly diagnose and treat undernutrition.
- Increase the share of nutrition grants in their total annual grant in a bid to scale up nutrition financing.
- Improve the identification of recipient countries in grants reported to the CRS to increase transparency and accountability to ensure their nutrition policy (of focusing on high burden countries in Africa and south Asia) matches their action.

CANADA

A SHORT REVIEW OF CANADA'S NUTRITION STRATEGY

Between 2005 and 2009, Canada was the 10th largest donor of ODA worldwide, pledging on average US$2.6 billion annually, (equating to 0.3% of its GNI) through CIDA, the Canadian International Development Agency (CIDA n.d a).

Over the years, Canada has been recognised for its commitment to eradicating hunger by improving food security. It aims to provide "more flexible, predictable and needs-based funding to meet the emergency and long-term food and nutrition needs of the most vulnerable and higher-risk populations" (CIDA n.d b) through emergency food aid, social safety nets and nutrition interventions. Nutrition is part of the food security strategy. It is therefore mainly addressed through the 'micronutrient supplementation' component of the strategy which also includes dietary diversification, fortification of staple foods and school feeding programmes.

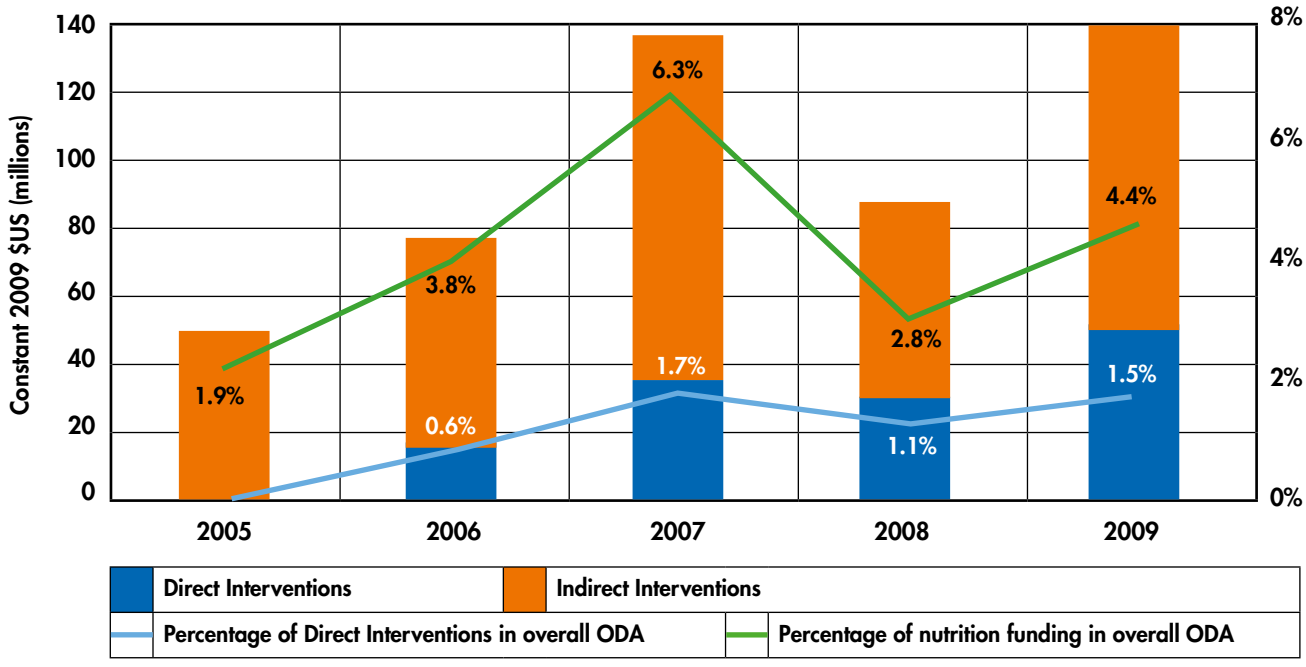
Nutrition is also a component of the Canadian 'Maternal, Newborn and Child Health Strategy' (CIDA 2011). In addition to micronutrient supplementation, the strategy recommends the promotion of breastfeeding, infant and young child feeding practices and the provision of ready-to-use therapeutic foods.

Micronutrient interventions are mainly implemented through the Micronutrient Initiative, an organisation emanating from CIDA, whose significance increased following the Muskoka Maternal and Child Health initiative which was championed by Canada (Micronutrient Initiative, 2012). Canada claims to have provided more than 75% the developing world's needs of vitamin A in 2008 through this initiative.

ARE FINANCIAL INVESTMENTS IN NUTRITION SUFFICIENT TO ADDRESS THE ESTIMATED NEEDS?

Between 2005 and 2009, CIDA spent on average US$26 million annually on direct nutrition interventions and US$71.4 million on indirect nutrition interventions, which together represent 3.8% of Canada's overall ODA in this period. With the exception of 2008, CIDA's funding for nutrition consistently increased over the same period, particularly in direct nutrition interventions. In 2009, Canada's nutrition funding made up more than a third of global nutrition funding — the highest of all bilateral donors.

ODA FROM CANADA FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2005 TO 2009

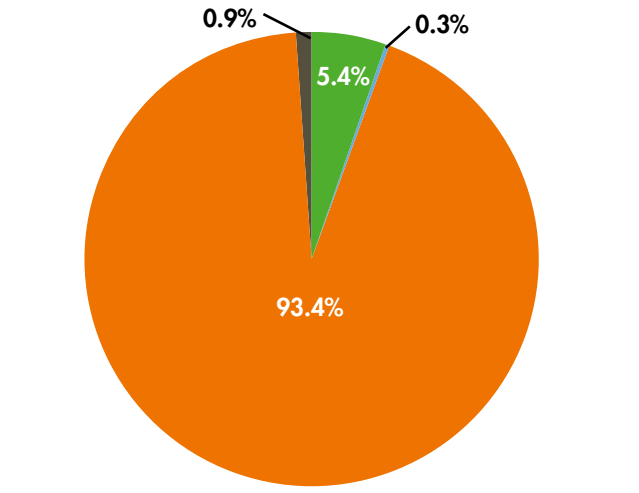


HOW IS FUNDING DISTRIBUTED BETWEEN DIRECT AND INDIRECT NUTRITION INTERVENTIONS?

Direct Interventions

In 2009, Canada was the top donor of ODA for nutrition (including both bilateral and multilateral donors) and allocated a large proportion to direct interventions, specifically to micronutrient and deworming interventions. In the studied period, funding almost exclusively focused on micronutrient and deworming interventions (93%) whilst only 5.4% of interventions focused on the treatment of severe or moderate acute malnutrition. Behavior change interventions were also poorly funded. Almost all of the direct interventions were found in the 'Basic Nutrition' purpose code, which demonstrated a good understanding and use of the purpose code in the CRS database. However only 5% of the 'Development Food Aid' code had a nutrition component; this sector should have been one of CIDA's main channels for delivering nutrition funding. Therefore it is likely that the reported food security initiatives do not contain enough nutritional objectives (or indicators).

CANADA'S DISTRIBUTION OF DIRECT INTERVENTIONS



Indirect Interventions

The main proportion funding for indirect interventions was channeled through the humanitarian aid sector (62%) followed by the health sector (26%) and the water and sanitation sector (10%). It is surprising to note that only 2% of development food aid initiatives had a nutrition component, especially considering that much of Canada's nutrition funding is channeled through its food security strategy.

ARE NUTRITION INTERVENTIONS ACCESSIBLE TO THOSE WHO NEED THEM MOST?

Over the whole period, Canada invested 55% of its nutrition funding in Africa, 23% in Asia and 9% in the Americas (13% was unspecified). In 2009, only 20% of this funding targeted the most vulnerable countries. This rate has decreased from an average of 40% in 2005.

Only two of the top five recipient counties are included in ACF's list of high priority countries. This is likely to change in the next few years, as Canada has redesigned its zone of interest and plans to spend 80% of its funding in 20 countries, selected according to "their real needs, their capacity to benefit from aid and their alignment with Canadian foreign policy priorities" (CIDA 2009). 10 countries (5 of which are in ACF's list of our high priority countries) have been selected to receive funding through the "Maternal, Newborn and Child Health Strategy" and so will receive more direct nutrition interventions. The countries include Haiti, Afghanistan, Bangladesh, Ethiopia, Mali, Mozambique, Sudan, Malawi, Nigeria and Tanzania.

REPORTING AND TRANSPARENCY

20% of the analysed projects in the database were rejected because they did not provide enough information. Although project descriptions of Canadian projects were detailed, they frequently did not contain the exact nature of implemented activities. However Canada also did well to report most of their programmes in both English and French, improving transparency.

TOP RECIPIENT COUNTRIES FOR CANADA				
	Recipient	Average annual funding for nutrition from 2005-2009 (Constant 2009 US$ millions)	Percentage of total nutrition funding	Rank (caseload of stunted children)*
1	Sudan	13.3	14%	13
2	Afghanistan	5.1	5%	10
3	Iraq	5.1	5%	26
4	Haiti	3.9	4%	NR
5	Ethiopia	3	3%	6

Almost all direct interventions were found in the 'Basic Nutrition' purpose code and 63% of funding in this code was actually classified under our definition of nutrition funding which demonstrates appropriate use of the 'Basic Nutrition' code.

Nevertheless, in spite of the policy convergence of nutrition interventions and food security initiatives to tackle hunger, it was clear that Canada's projects under the 'Food Aid Development' purpose code did not have significant nutrition objectives or activities. Only 5% of the projects in the code were linked to nutrition, whilst indirect nutrition funding was found in most of the other purpose codes analysed. The share of indirect nutrition funding varied from 16.7% to 40.9% depending on the purpose code. It is extremely disappointing that Canada is cutting its overseas aid spending and presenting this action as an exercise in accountability. Reneging on its commitment to increase ODA to 0.7% of GNI demonstrates a lack of accountability and is against the Paris and Accra Agenda for Aid Effectiveness.

KEY RECOMMENDATIONS

- Canada should approach the treatment and prevention of undernutrition in a holistic manner that addresses all 13 proven and cost-effective direct nutrition interventions.
- Canada should better direct its overseas aid to the most vulnerable countries so that the worst affected populations can access vital nutrition services.
- Canada should be held accountable for delivering on its promise to increase its ODA to 0.7% of GNI.
- Canada should improve its reporting on development food aid to clearly identify the nutrition objectives in its multisector projects such as food security.

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** Rank of caseloads of stunted children in the Lancet's list of 36 High Burden Countries (2008).*

EUROPEAN UNION INSTITUTIONS

A SHORT REVIEW OF THE EUROPEAN UNION'S NUTRITION STRATEGY

On average, The European Union (EU) has pledged US$12 billion a year of ODA. Nutrition funding is delivered through two organisations of the European Commission (EC):

- Europeaid is in charge of the implementation of external aid for the EU and is financed by the EU regular budget and the European Development Fund (EDF). The latter is the main instrument for delivering aid for development.
- The European Commission Humanitarian Office (ECHO) has the mandate to provide emergency relief to victims of conflicts or disasters.

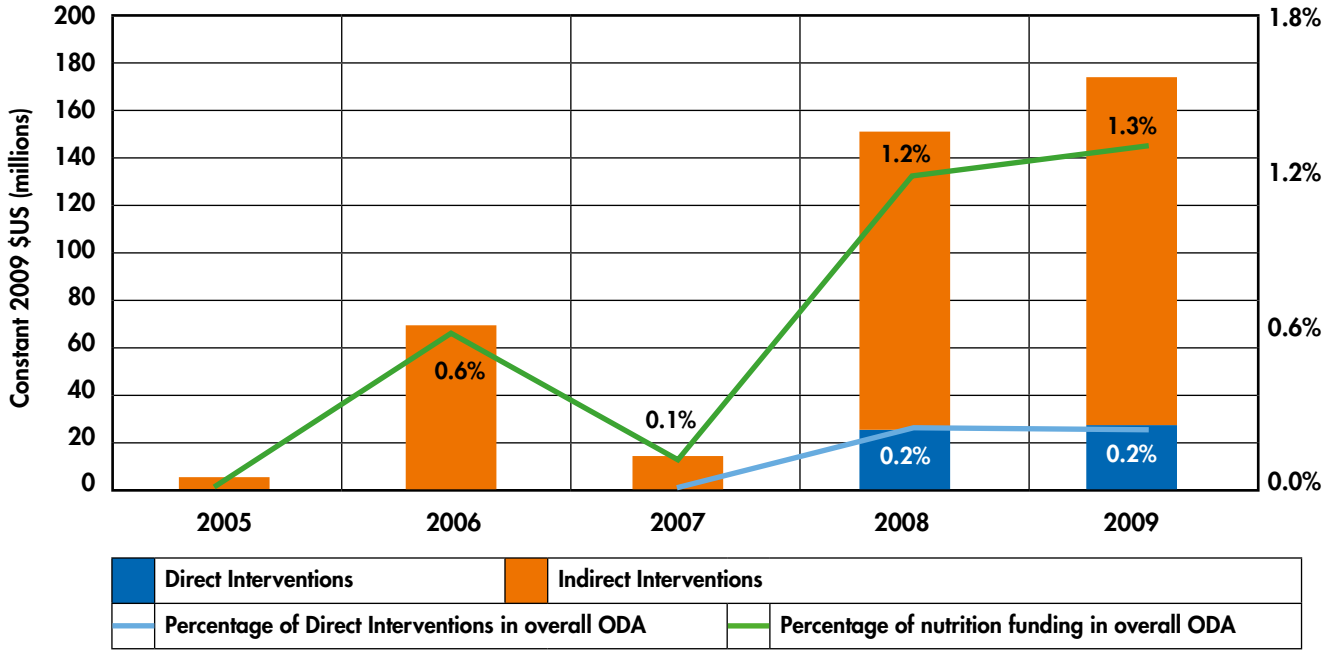
In 2009, Europeaid launched a concept note on nutrition reaffirming the importance of long-term projects (such as safety nets, primary health care, women's empowerment, education, agriculture, livestock and water programmes) with nutrition objectives to address the underlying causes of undernutrition. It also highlighted the importance of implementing direct nutrition interventions to address the immediate causes of undernutrition. For 2007-2013, nutrition was mainly addressed through a food security lens, particularly through the Food Facility initiative, which was implemented in 2009-2011 in response to soaring food prices.

ARE FINANCIAL INVESTMENTS IN NUTRITION SUFFICIENT TO ADDRESS THE ESTIMATED NEEDS?

Between 2005 and 2009, EU institutions invested on average US$10 million annually in direct nutrition interventions and US$71.7 million in indirect nutrition interventions, representing 0.7% of the EU's total ODA. Nevertheless, as ECHO projects could not be analysed within the CRS database, a separate analysis of ECHO projects for 2009 was made which revealed that ECHO contributed US$47.4 million to direct nutrition and US$78.3 million to indirect nutrition interventions. If the figures from the CRS database and ECHO's website are combined for 2009, the European Union invested almost US$300 million in nutrition, or 2.3% of its overall ODA.

Our data suggests that the EU started to increase its investment in nutrition from 2008, which is likely to have been in response to the food crisis. European nutrition funding was especially low in 2005 and between 2005 and 2007 the EU did not invest in any direct nutrition interventions.

ODA FROM THE EU INSTITUTIONS (EXCL. ECHO) FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2005 TO 2009

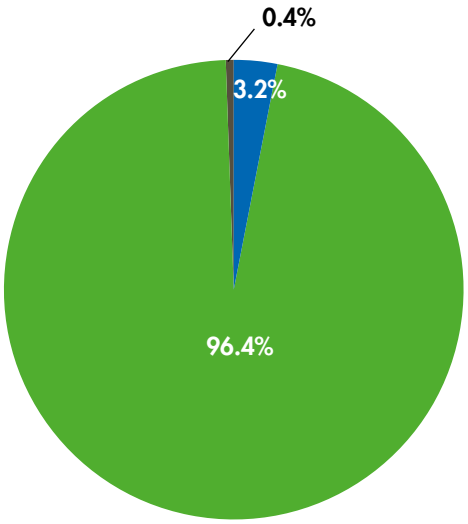


HOW IS FUNDING DISTRIBUTED BETWEEN DIRECT AND INDIRECT NUTRITION INTERVENTIONS?

Direct Interventions

Over the course of 2008 and 2009, when the EU Institutions did invest in direct nutrition interventions, they invested 96% of funding in the therapeutic feeding of undernourished children with special foods. The analysis of ECHO's direct interventions supports these findings as almost all of ECHO's direct funding was focused on the treatment of SAM.

THE EU'S DISTRIBUTION OF DIRECT INTERVENTIONS



I. Promoting good nutritional pratices
II. Increasing intake of vitamins and minerals
III. Therapeutic feeding for malnourished children with special foods
III. + I.

Indirect Interventions

The majority of funding for indirect interventions was allocated through the humanitarian aid sector (62%) while health (28%) and water and sanitation (10%) were allocated less. The same analysis could not be done on ECHO's funding but given ECHO's mandate, we can assume that most of these projects would have been funded through the humanitarian aid sector.

ARE NUTRITION INTERVENTIONS ACCESSIBLE TO THOSE WHO NEED THEM MOST?

For 2005 to 2009, the EU institutions (excluding ECHO) invested 53% of nutrition funding in Africa, 31% in Asia and 15% in the Americas (1% was unspecified). 57% of funding targeted high priority countries dropping to 33% in 2009. However, in the same year, 42% of ECHO's funding targeted high priority countries.

REPORTING AND TRANSPARENCY

For the period studied (2005 to 2009), about half of the data in the CRS purpose codes studied could not be analysed because of a lack of information adequately describing the projects. This is partly due to poor reporting as the projects reported in the database by ECHO only included a budget code in the project descriptions. Consequently, 93% (or US$370 million annually) of the 'Emergency Food Aid' code was rejected from the analysis. Nonetheless it remained the code in which the highest volume of nutrition interventions were identified (US$23.5 million each year), whereas US$20.9 million were identified in the 'Basic Healthcare' purpose code and US$12.1 million were reported in the 'Basic Nutrition' purpose code. A significant proportion (more than 40%) of projects in the 'Food aid/Food security' purpose code were rejected due to lack of information.

With regards to the 'Basic Healthcare' purpose code, 93% of its projects could be analysed, of which almost 100% were identified as being related to nutrition. The majority of these projects were classified as indirect interventions.

Direct nutrition funding was almost exclusively (94%) found in the humanitarian aid purpose codes, namely in 'Material Relief' and 'Emergency Food aid'. Overall, a little over half of the EU Institutions' funding declared to the CRS was able to be analysed in line with the study's criteria. This is largely as a result of the poor reporting of ECHO to the CRS.

TOP RECIPIENT COUNTRIES FOR THE EU									
EU INSTITUTIONS (WITHOUT ECHO)						ECHO (2009 ONLY)			
	Recipient	Average annual funding for nutrition from 2005-2009 (Constant 2009 US$ millions)	Percentage of total nutrition funding	Rank (caseload of stunted children)*		Recipient	Annual funding for nutrition for 2009 (Constant 2009 US$ millions)	Percentage of total nutrition funding	Rank (caseload of stunted children)*
1	Bangladesh	21.6	26%	4	1	Sudan	20.8	17%	13
2	Ethiopia	7.7	9%	6	2	Kenya	17.4	14%	16
3	Peru	7	9%	32	3	Ethiopia	12.8	10%	6
4	Sudan	5.5	6%	13	4	Somalia	8.5	7%	NR
5	Kenya	3.8	5%	16	5	Niger	7.1	6%	22

KEY RECOMMENDATIONS

- ECHO must improve its reporting to the CRS database and correctly fill description columns to highlight the contribution of projects to nutrition goals and to aid transparency and accuracy of mapping funding for nutrition.
- The EU must scale up its investment in all direct nutrition interventions in non-humanitarian contexts in a more sustainable and predictable manner to advance the fight against undernutrition and to help achieve the MDGs which are related to hunger and to maternal and child health.

** Rank of caseloads of stunted children in the Lancet's list of 36 High Burden Countries (2008).*

FRANCE

A SHORT REVIEW OF FRANCE'S NUTRITION STRATEGY

French Official Development Assistance is delivered through several agencies. The two most important are the Ministry of Foreign Affairs (MAEE) and the French Development Agency (AFD, which is under the supervision of the MAEE). These two bodies both endeavour to improve nutrition in developing countries. In fact, the French Development Agency is a development bank and the central agency for French aid (AFD, 2012a); it focuses on areas which are not directly related to nutrition (Agriculture, Education, Water, Environment, Capacity Building and Health), which integrate few or no nutritional components. The MAEE actions focus on humanitarian interventions, governance and global food security. Fighting against undernutrition is an integral part of French food aid policy and is therefore primarily seen as a short-term approach in immediate response to crises.

In 2011, France issued its first policy document on nutrition which places the prevention and treatment of undernutrition in a broader context; on the one hand, it addresses the strengthening of national efforts to tackle undernutrition and on the other, it promotes stronger international mobilisation. The direct nutrition actions recommended by the Lancet (2008) are at the centre of this strategy, as are the integration of nutrition objectives in other sectors (water and sanitation, health, education and food security). The actions should be supported by private partnerships set up by the AFD to support the production of food and nutrition supplements as well as the mobilisation of technical expertise and research capabilities in the fight against undernutrition (MAEE, 2011). The MAEE will guarantee the success of this strategy through the coordination of different actors (MAEE, 2011).

THE TWO PILLARS OF THE FRENCH NUTRITION STRATEGY (MAEE, 2011)

1. Help countries detect, prevent and treat malnutrition in women of childbearing age and children under two years:

1.1.Strengthen human and institutional capacities;
1.2. Support information systems to improve the quality of information for decision making;
1.3.Sustain operations for the prevention and treatment of maternal and child malnutrition;
1.4. Support research and development, build and develop the results.

2. Contribute to a more effective international mobilisation against malnutrition:

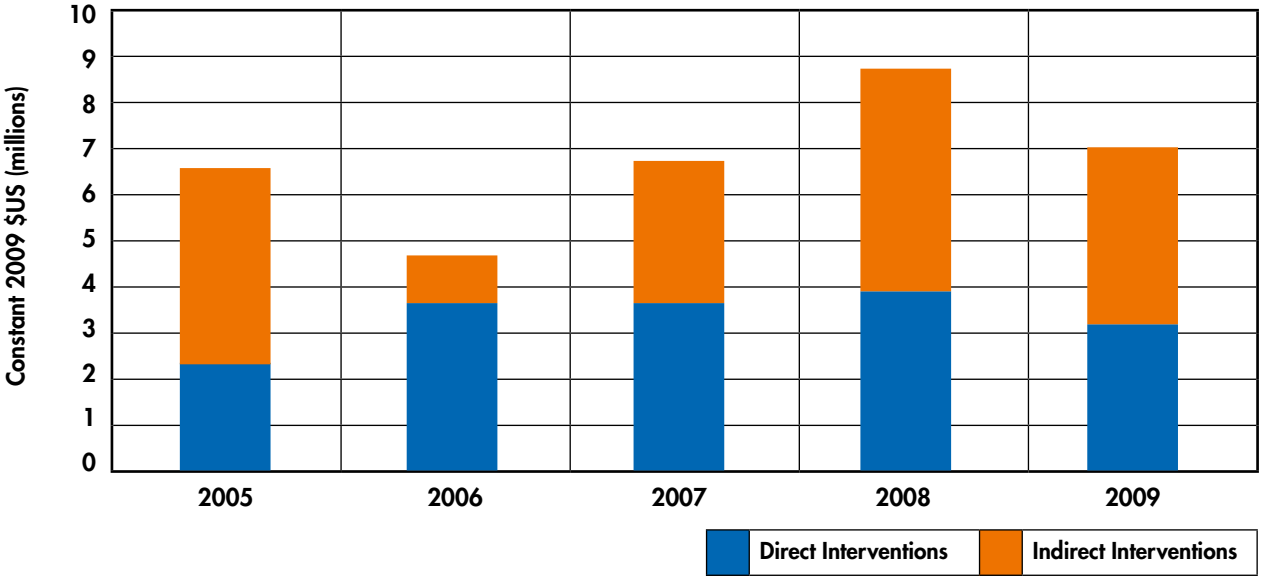
2.1. Strengthen strategies, governance and financing of the fight against malnutrition globally;
2.2. Increase the mobilisation of European partners for nutrition;
2.3. Support research and international intelligence on emerging issues

ARE FINANCIAL INVESTMENTS IN NUTRITION SUFFICIENT TO ADDRESS THE ESTIMATED NEEDS?

Between 2005 and 2009, France was the fourth largest bilateral donor of ODA spending on average US$9.3 billion each year. This represents 0.33% of France's GNI each year, which is well below the target of 0.7% set by the OECD member states in 2002. Quality descriptions of programmes reported by France were few and far between and where available, were too poor to include in the analysis; therefore information was requested from the MAEE directly. Two documents were provided: a table presenting AFD's nutrition portfolio and a balance sheet of food aid programmes from 2005 to 2009.

AFD projects were excluded from the analysis due to the nature of allocated funds (funding for entire, multi-annual projects rather than annual disbursements), the grant date and the inadequacy of descriptions making these projects incomparable to those in the CRS. In addition, the project list did not include multisectoral programmes including water and sanitation, education and food security which have an indirect impact on nutrition. The assessment of the MAEE contribution to nutrition was made by analysing food aid programmes. Direct and indirect nutrition interventions averaged US$3.4 million and $US3.3 million per year respectively for 2005 to 2009. It is important to note that this is an incomplete assessment of France's contribution to nutrition.

ODA FROM FRANCE FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2005 TO 2009 (SOURCE OF RAW DATA: DIRECT COMMUNICATION WITH THE FRENCH GOVERNMENT)



Overall nutrition funding has increased slightly since 2005, although the level of funding for direct interventions has not increased since 2006.

HOW IS FUNDING DISTRIBUTED BETWEEN DIRECT AND INDIRECT NUTRITION INTERVENTIONS?

From 2005 to 2010, France reported US$10.5 million (or US$2.1 million per year on average) to the 'Basic Nutrition' purpose code.

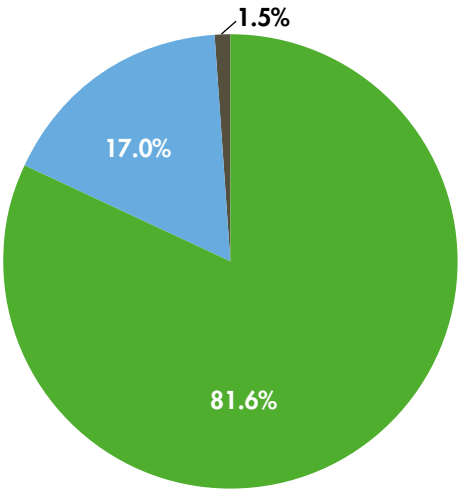
Direct Interventions

Interventions under 'Food Aid' programmes focused predominantly on the treatment of undernutrition, but also included other direct nutrition activities such as behaviour change interventions (17%) and increasing micronutrient intake and deworming (1%).

Indirect Interventions

AFD interventions were mainly delivered through the health and water and sanitation sectors, but it was difficult to determine whether these programmes were either direct or indirect programmes.

FRANCE'S DISTRIBUTION OF DIRECT INTERVENTIONS



I. Promoting good nutritional pratices
II. Increasing intake of vitamins and minerals
III. Therapeutic feeding for malnourished children with special foods
II. + III.
III. + I.

TOP RECIPIENT COUNTRIES FOR FRANCE				
	Recipient	Average annual funding for nutrition from 2005-2009 (Constant 2009 US$ millions)	Percentage of total nutrition funding	Rank (caseload of stunted children)*
1	Ethiopia	1.4	21%	6
2	Somalia	1.3	18%	NR
3	Madagascar	1.1	16%	19
4	Chad	0.7	9%	NR
5	Niger	0.5	7%	22

ARE NUTRITION INTERVENTIONS ACCESSIBLE TO THOSE WHO NEED THEM MOST?

Between 2005 and 2009, just under 50% of France's interventions in nutrition targeted ACF's high-priority countries (see Annex 1). It must also be noted that almost all ODA for nutrition was allocated to Africa (93%) while Asia only accounted for 3% of investments in nutrition and the Americas, 4%. Furthermore, aid is concentrated on a few African countries. The top five recipient countries account for 71% of funding for nutrition, three of which are considered by ACF to be high priority countries.

These results are not surprising given that the Priority Solidarity Zone (PSZ) implemented by France (MAEE, 2012) consists mainly of sub-Saharan African countries. The 2011 nutrition strategy shows that 20 countries in this area are part of the 36 High Burden Countries identified by the Lancet and will therefore be given priority in the coming years. In addition, different multisectoral approaches will also be undertaken in different countries: agriculture and food security in Afghanistan, Cambodia, Cameroon, Ghana, Madagascar, Vietnam and Yemen; water and sanitation in Burundi, Ethiopia, Ghana, Kenya, Mali, Niger and Tanzania; and health in Cambodia, Cameroon, Madagascar, Mozambique, Niger, Nigeria, and the Democratic Republic of the Congo.

REPORTING AND TRANSPARENCY

However, the poor project descriptions in all of the selected purpose codes prevented us from commenting on their relevance to nutrition. Detailed mapping of funding for nutrition from the French Government could not be undertaken using the CRS database. This was due to poor reporting by them to the selected purpose codes. France therefore has failed to adhere to aid transparency principles.

KEY RECOMMENDATION

- France must improve the transparency of its aid activities for its electorate and for other stakeholders committed to the scaling up of nutrition to ensure better donor coordination, more predictable funding and better accountability to the recipients of its ODA. This will also allow quality standards for reporting to be met and comparison with other DAC countries to be made. Failure to improve its reporting practices as soon as possible means that AFD will fail to achieve its stated commitment to maintain a policy of transparency (AFD, 2012b) which will enable the public to be better informed of funded projects through a project database (AFD, 2012c).

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** Rank of caseloads of stunted children in the Lancet's list of 36 High Burden Countries (2008).*

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IDA (WORLD BANK)

A SHORT REVIEW OF IDA'S NUTRITION STRATEGY

The International Development Association (IDA) is "The World Bank's Fund for the Poorest". The World Bank's charter is to help those in the greatest need. The Bank's commitment to achieving the MDGs focuses on three health strategies: expanding access to reproductive health, scaling up support for early childhood nutrition and the prevention of HIV/AIDS and other communicable diseases (World Bank, 2012). In the last decade, an annual average of US$825 million has been lent to developing countries by the IDA for health, nutrition and population (HNP) initiatives. During the fiscal period of 2005 to 2010, IDA's total investment in HNP initiatives was US$5.6 billion. Of this, nutrition was allocated the lowest share, representing 5% of the fund, while over 30% of the fund was allocated to health system strengthening (IDA, 2010).

IDA's main approach to achieve the HNP strategy is through results-based financing which involves using financial incentives to reward the delivery of verified health outputs or outcomes. Other approaches include the mainstreaming of multisectoral interventions (based on the inter-dependence of other key sectors with the health sector) and improved monitoring and evaluation of health innovations and programmes.

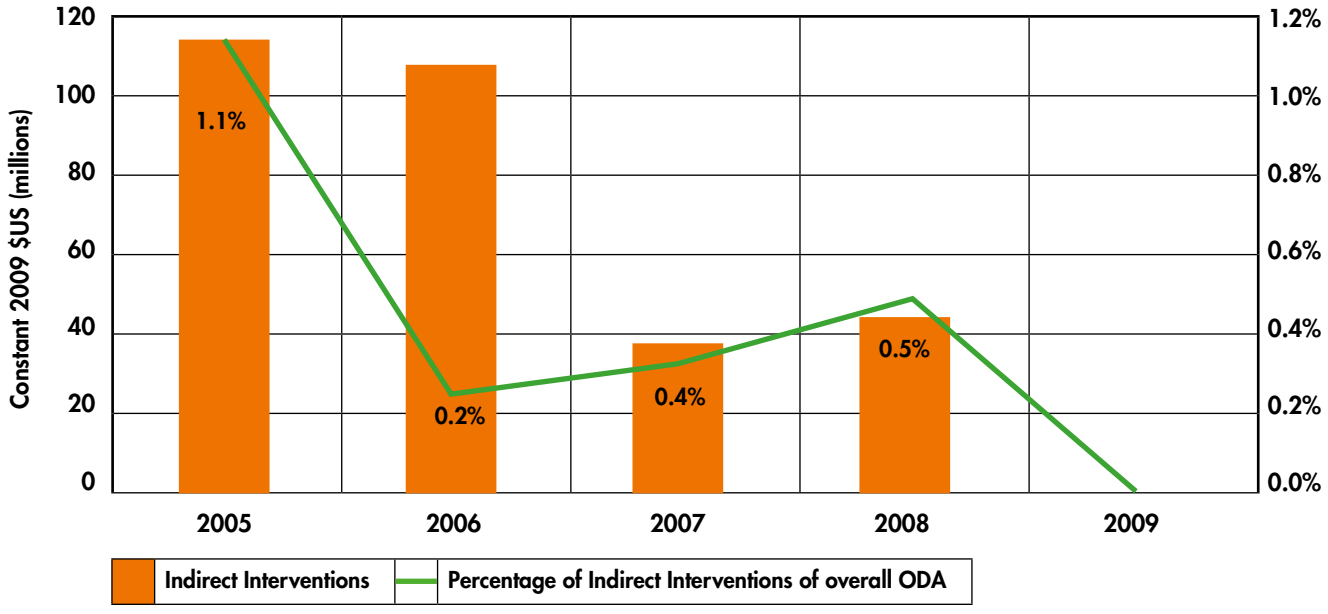
ARE THE FINANCIAL INVESTMENTS IN NUTRITION SUFFICIENT TO ADDRESS THE ESTIMATED NEEDS?

Our analysis found that the IDA invested a total of US$302.8 million in nutrition between 2005 and 2010, representing 0.4% of the IDA's total annual ODA. All of this was invested in indirect nutrition interventions. During this period funding was found to be quite inconsistent, falling drastically between 2006 and 2007 and rising again in 2008. In 2009, according to the CRS website, no funds were allocated to nutrition by IDA, although this may be due to a reporting error.

HOW IS FUNDING DISTRIBUTED BETWEEN DIRECT AND INDIRECT NUTRITION INTERVENTIONS?

Over the analysed period, the IDA prioritised its nutrition funding to indirect nutrition interventions rather than to direct nutrition interventions. Within the indirect interventions, more funds were allocated to activities involving the provision of micronutrients than any other nutrition-specific intervention. These funds were only channelled through two sectors and tended to be loans rather than grants. The IDA's nutrition funding was mainly channelled through the health and water and sanitation sectors, with the health sector receiving the highest share (68%). This is consistent with the agency's HNP strategy.

ODA FROM THE IDA FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2005 TO 2009



TOP RECIPIENT COUNTRIES FOR IDA				
	Recipient	Average annual funding for nutrition from 2005-2009 (Constant 2009 US$ millions)	Percentage of total nutrition funding	Rank (caseload of stunted children)*
1	India	27.7	46%	1
2	Bangladesh	13.8	23%	4
3	Ethiopia	3.8	6%	6
4	Ghana	2.7	4%	29
5	Madagascar	2	3%	19

ARE NUTRITION INTERVENTIONS ACCESSIBLE TO THOSE WHO NEED THEM MOST?

During the period studied the IDA allocated 74% of its funds to Asia and 25% to Africa. India received the largest share of ODA and out of the five biggest recipients of the IDA's aid for nutrition, four were in ACF's list of 15 high priority countries.

REPORTING AND TRANSPARENCY?

Despite there being sufficient information to analyse all of the IDA project lines in the CRS database, more than half the interventions reported in the 'Basic Nutrition' purpose code were not related to nutrition. However 20% of the funds in 'Basic Health Care' and 27.4% of those in 'Water Supply and Sanitation' were related to nutrition.

KEY RECOMMENDATIONS

- As a key participant of the SUN Framework, the IDA should also invest in direct nutrition interventions which diagnose and treat undernutrition.
- The IDA should ensure a balanced allocation of funds between all of the 13 nutrition interventions within the three categories of proven direct nutrition interventions which include: behaviour change interventions, micronutrient and deworming interventions and therapeutic feeding interventions.
- The IDA should disburse more funding for nutrition through grants rather than loans especially for the poorest high burden countries.
- The targeting of high priority, high burden countries needs to improve, particularly in the Africa region.
- Reporting to the OECD CRS database should include clearer and more adequate descriptions of activities.

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** Rank of caseloads of stunted children in the Lancet's list of 36 High Burden Countries (2008).*

SPAIN

A SHORT REVIEW OF SPAIN'S NUTRITION STRATEGY

Spain was the 7th largest donor of ODA, contributing on average US$3.8 billion per year between 2005 and 2009. This was delivered through the Spanish Agency of International Development Cooperation (AECID) which is part of the Ministry of Foreign Affairs and Cooperation (MFAC). Autonomous communities also contributed to a large proportion of cooperation funding.

For the 2005 to 2009 period, Spain regarded the lack of access to food as the main cause of hunger and malnutrition, with poverty and inequality also playing important roles. Thus, in recent years, Spain has focused its efforts to tackle hunger on humanitarian aid and food aid (MFAC, 2007). The Strategy for the Fight Against Hunger (SFAH) was developed to help strengthen and guide AECID in the achievement of these objectives. The SFAH was developed based on analyses of the regulatory, institutional and theoretical frameworks in place at national and international levels.

The Spanish Cooperation considers rural development in a broad sense, using both territorial and multisectoral aspects to formulate its own strategies to ensure food and nutrition security. In the Third Master Plan (2009-2012), actions in this sector form part of the overall objective of "contributing to making the human right to food a reality and improving living conditions and the food security of rural and urban populations". The focus on the right to food includes elements of food security related to the availability, access, stability and biological utilization of food, taking into account human dignity and cultural acceptability. In this way, citizens become individuals with rights rather than anonymous groups which receive assistance. Thus, AECID promotes food as a human right, supports public policies and institutions which can achieve more equitable distribution of, and access, to resources and services and favours the inclusion of the most vulnerable populations. This can be seen in its food security actions which aim to strengthen nutrition in five strategic areas:

1. Improve access to adequate quantities of nutritious food for populations which are vulnerable and subject to discrimination (with a particular focus on hidden hunger);
2. Promote sustainable production systems;
3. Improve access to resources and services and create localised bases for socio-economic development;
4. Promotion, coordination and articulation of public agricultural policies;
5. Strengthen the capacity and coordination of Spanish Cooperation.

Rural development is the self-sustaining, balanced revitalization of rural areas, taking into account the economic, social and environmental potential of communities, by means of a regional policy and integrated implementation at the community level (Quintana 1999. Spanish Cooperation Strategy to Fight against Hunger). For AECID, rural development and the fight against hunger are priority action areas. AECID is committed to cooperation in agriculture, rural development and food and nutrition security in the countries with which it cooperates, to contribute to making the human right to food a reality.

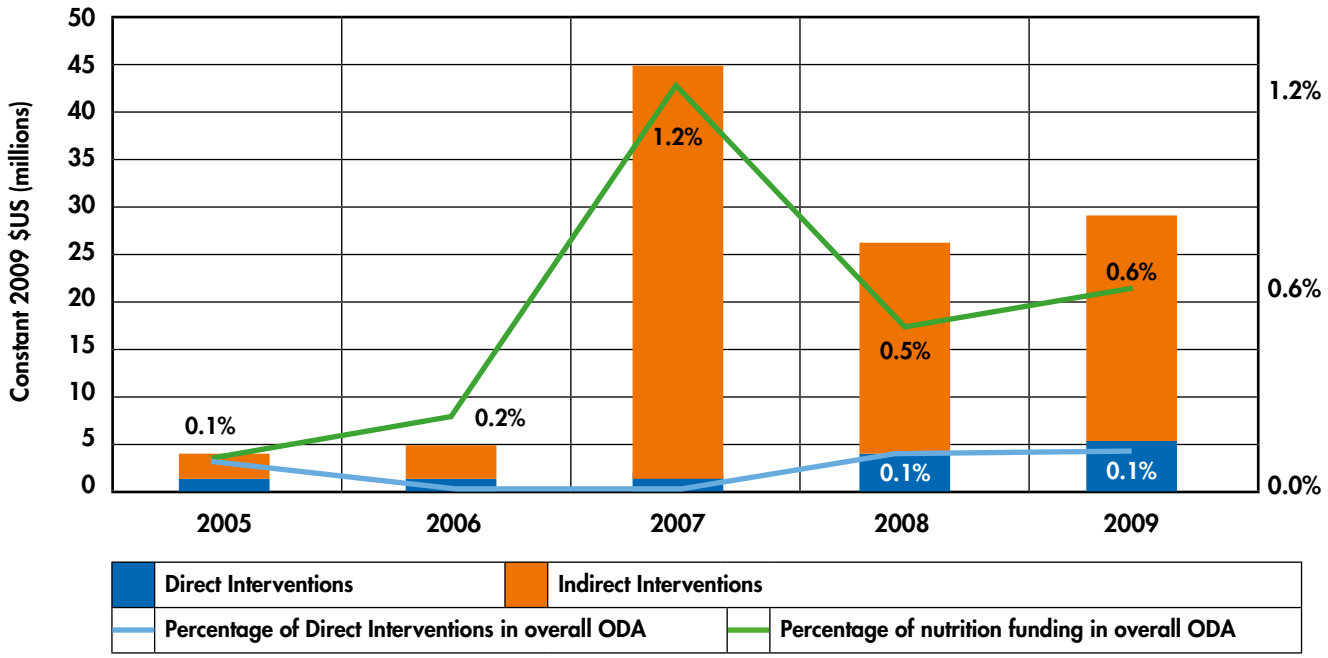
For 2010-2012, AECID reaffirmed its commitment to nutrition in the plan 'Director de la Cooperacion Espanola 2009-2012' and in a new strategy paper in which 2 strategic lines are emphasised (see table on the right, source: AECID, 2012).

ARE FINANCIAL INVESTMENTS IN NUTRITION SUFFICIENT TO ADDRESS THE ESTIMATED NEEDS?

Between 2005 and 2009, Spain spent on average US$2.7 million annually on direct nutrition interventions and US$18.9 million on indirect nutrition interventions, representing 0.6% of its overall ODA. In 2007, the volume of nutrition funding increased significantly to 1.2% of overall ODA following a sudden increase in funding of indirect nutrition interventions. Spain was the fourth largest bilateral donor over the 2005 to 2009 period. It made efforts to strengthen its commitment to nutrition by preparing strategy papers and increasing its nutrition funding. However funding for nutrition remains insufficient to

1. ACCESS TO DECENT AND ADEQUATE FOOD FOR THE MOST VULNERABLE POPULATIONS	
DIRECT ACTIONS	Prevention and treatment of infantile acute malnutrition (promotion of breastfeeding and complementary feeding practices; food supplementation and fortification; treatment of severe acute malnutrition with ready-to-use food in line with national health systems)
	Prevention and treatment of chronic malnutrition (Diversification of production and food intake to address micronutrient deficiencies; Nutrition education; School feeding programmes)
	Prevention of malnutrition in women and mothers: women empowerment to facilitate their access and control to food resources; Promotion of supplementation of iron, zinc and folic acid during pregnancy and lactation; Nutrition education
INDIRECT ACTIONS	Support to food safety nets aimed at ensuring adequate food
	Promotion of access to safe water and basic sanitation
2. SUPPORT FOR GOVERNANCE OF FOOD SECURITY AND NUTRITION	
	Support of worldwide governance initiatives of food security and nutrition
	Incorporation of nutrition as a transversal outcome into related sectors such as food security, health, education and humanitarian action
	Strengthening regional and local governance by developing and implementing regional strategies for food and nutrition and development of national nutrition policies

ODA FROM SPAIN FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2005 TO 2009



meet current needs. Considering the country's nutrition strategy for 2010-2012, it is likely that Spanish contributions to nutrition will increase and diversify, both for direct and indirect interventions.

HOW IS FUNDING DISTRIBUTED BETWEEN DIRECT AND INDIRECT NUTRITION INTERVENTIONS?

Direct Interventions

Spain almost exclusively dedicated its funding for direct nutrition interventions to the treatment of acute malnutrition whilst behavior change interventions and micronutrient and deworming interventions received minimal funding.

Indirect Interventions

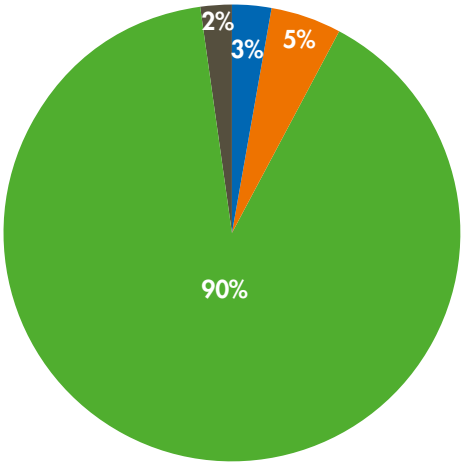
Indirect interventions were mainly implemented through food aid programmes (43%) as part of Spain's food security strategy. The Health (24%), Social infrastructures and services (10%) and Water and Sanitation (8%) sectors also received some nutrition investment. 15% of nutrition funding was disbursed though humanitarian aid programmes. This distribution of funding for nutrition shows a good integration of nutrition outcomes in other sectors. It was planned that both direct and indirect interventions would be funded in 2010-2012, mainly through the food security strategy, but also through health, education and water and sanitation programmes.

ARE NUTRITION INTERVENTIONS ACCESSIBLE TO THOSE WHO NEED THEM MOST?

Over the whole period, Spain invested 33% of its nutrition funding in Africa, 8% in Asia and 23% in the Americas (36% was unspecified). Only 33.8% of this funding targeted the most vulnerable countries in 2005-2009. This rate remained constant over the period analysed.

Given that Spain implemented the majority of its nutrition interventions through food security programmes, it chose to prioritise countries for which food insecurity permanently affected development. However these priorities were flexible and varied depending on the occurrence of crises, such as that which affected Niger in 2005.

SPAIN'S DISTRIBUTION OF DIRECT INTERVENTIONS



	I. Promoting good nutritional pratices
	II. Increasing intake of vitamins and minerals
	III. Therapeutic feeding for malnourished children with special foods
	II. + III.
	III. + I.

Thus, Spanish geographical priorities covered a large range of countries (11 in Latin America, 24 in Africa and 6 in Asia) which benefitted from both direct and indirect interventions. In order to diffuse its aid efforts, Spain defined its geographical targets in line with its food security strategy across a large number of countries.

REPORTING AND TRANSPARENCY

Only 12.7% of Spain's analysed funding were rejected due to a lack of information. In the 'Basic Nutrition' purpose code, however, this rate increased to 31%, which partly explains why this purpose code contained just 20.5% of Spain's nutrition funding (6% of direct and 14.5% of indirect funding). The 'Development Food aid' purpose code accounted for the majority (63.5%) of funds for indirect interventions. Spain's reporting to the CRS database was quite good in comparison to others. However, 'Food aid / Development Food Aid', one of the most important purpose codes which is likely to have contained numerous indirect interventions, had poorly reported projects which prevented better monitoring of Spain's contribution to nutrition.

TOP RECIPIENT COUNTRIES SPAIN				
	Recipient	Average annual funding for nutrition from 2005-2009 (Constant 2009 US$ millions)	Percentage of total nutrition funding	Rank (caseload of stunted children)*
1	Niger	1.9	9%	22
2	Peru	1.3	6%	32
3	Mali	1	5%	28
4	Ethiopia	0.8	4%	6
5	Bolivia	0.7	3%	NR

KEY RECOMMENDATIONS

- Spain should maintain its efforts in the future and aim to further increase its nutrition funding.
- Spain should define a list of priority recipient countries, which are more closely related to where nutrition needs are greatest.
- Spain needs to make more of an effort to improve the reporting of project descriptions in order to better track indirect nutrition funding, especially in food security programmes. This will be all the more crucial for 2010-2012 as Spain has planned to develop nutrition as a transversal outcome of education, health and water and sanitation programmes.

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** Rank of caseloads of stunted children in the Lancet's list of 36 High Burden Countries (2008).*

THE UNITED KINGDOM

A SHORT REVIEW OF THE UK'S NUTRITION STRATEGY

The United Kingdom's (UK) development aid is delivered through the Department for International Development (DFID). Between 2005 and 2009, the UK was the fifth biggest bilateral contributor to global ODA and spent, on average, nearly US$7 billion dollars annually. Having succeeded in delivering 0.56% of its GNI to aid in 2010, the UK is well on track to reaching the target of contributing 0.7% of GNI to aid by 2015. In fact it intends to achieve this by 2013.

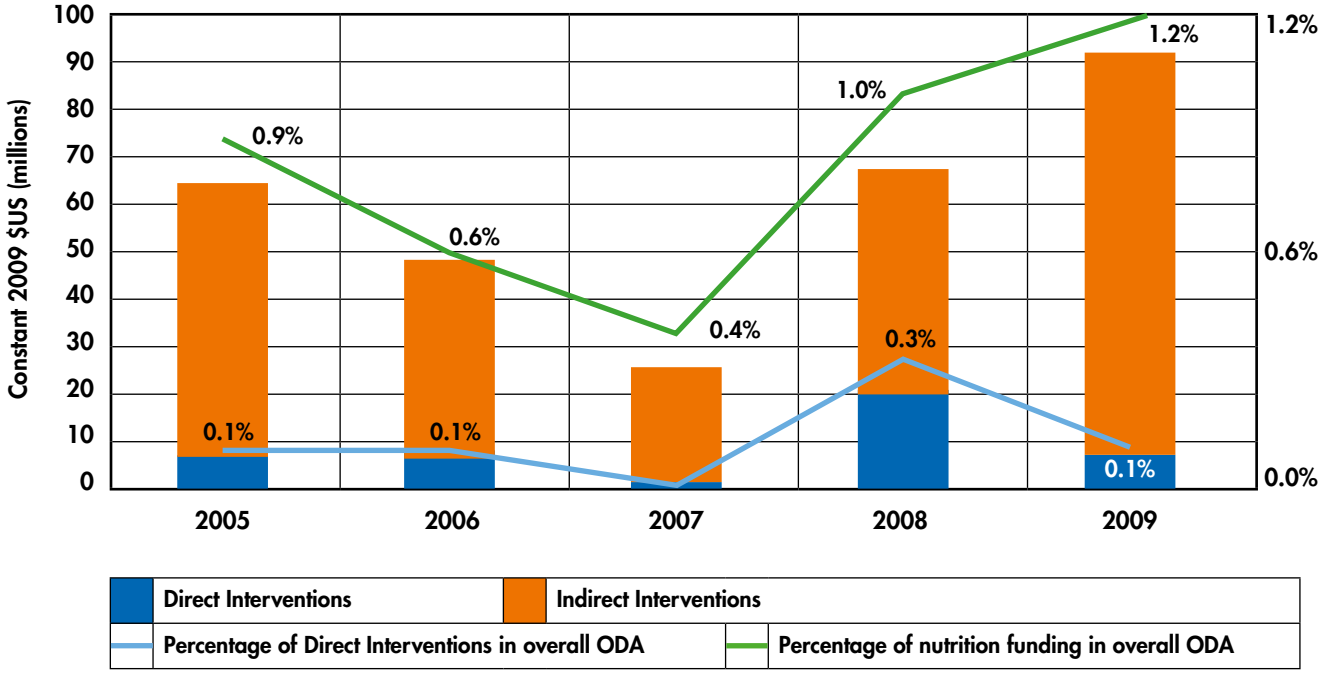
Currently, nutrition is one of DFID's eight key issues which encompass: education; health; economic growth and the private sector; governance and conflict; climate and environment; water and sanitation; food and nutrition; and humanitarian disasters and emergencies (DFID, 2002). As an organisation DFID has historically been reluctant to formalise a strategic commitment to nutrition until a report by an influential think tank — the Institute of Development Studies — on the lack of nutrition focus by DFID and the onset of the global food price crisis, led DFID to set up a formal task team. This eventually led to the launch of DFID's first nutrition strategy in early 2010: 'The neglected crisis of undernutrition' (DFID, 2010). In 2011, under a new coalition government, DFID released a new 'strategy': 'Scaling Up Nutrition. The UK's position paper on undernutrition', which sets out how DFID will help more than 6 million people out of extreme poverty, stop 20 million children from going hungry and ensure another 4 million people have enough food to eat throughout the year (DFID, 2011). It will do this by:

- Targeting adolescent girls and pregnant women and children under the age of five with nutrition specific interventions;
- Delivering greater impact through programmes across multiple sectors ("nutrition-sensitive development");
- Building a more effective international response.

DFID will also focus on building partnerships in target countries, internationally, and with the private sector in order to increase global efforts to tackle undernutrition during the critical '1,000 days window'.

Furthermore the coalition government is an active supporter of the global Scaling Up Nutrition (SUN)

ODA FROM THE UK FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2005 TO 2009



movement and states that it will scale up programmes where there will be 'fast and sustainable impact'.

As part of DFID's efforts to build an effective global response to tackle undernutrition, it is supporting the development of a distance-learning course called 'Programming for Nutrition Outcomes', to be launched in 2012.

Although the UK Government has reiterated its commitment to dedicating 0.7% of GNI to ODA, at the time of writing there was no official budget line for nutrition.

ARE FINANCIAL INVESTMENTS IN NUTRITION SUFFICIENT TO ADDRESS THE ESTIMATED NEEDS?

From 2005 to 2009, DFID invested an annual average of US$8.4 million in direct nutrition interventions and US$51 million in indirect nutrition interventions, representing on average 0.8% of the UK's overall ODA. However, nutrition funding over the five years of the study was inconsistent.

With the exception of 2008, indirect nutrition interventions represented more than three quarters of nutrition funding, which is in line with DFID's cross-sectoral implementation of nutrition aid.

HOW IS FUNDING DISTRIBUTED BETWEEN DIRECT AND INDIRECT NUTRITION INTERVENTIONS?

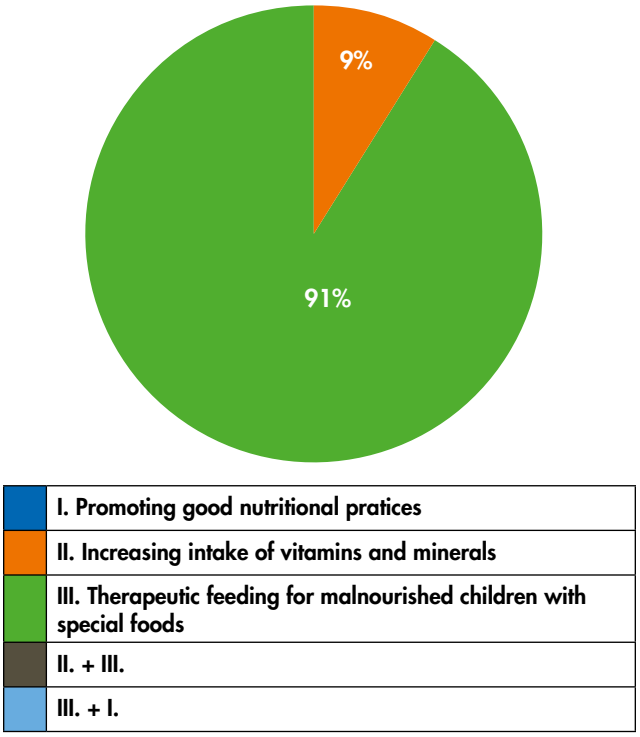
Direct Interventions

Data from the CRS indicates that DFID invests a lot of money in the treatment of acute malnutrition (91% of its direct funding to nutrition). However investment in 'Micronutrient and Deworming interventions' is negligible and no funding was recorded for behaviour change interventions. The share of direct nutrition funding is quite low compared to indirect funding. As a consequence, nutrition funding is mainly allocated through emergency responses. This goes some way to explain the inconsistency of UK nutrition funding over the years of the study.

Indirect Interventions

The UK is the second largest bilateral donor to nutrition but a large proportion of the funds are invested

THE UK'S DISTRIBUTION OF DIRECT INTERVENTIONS



in indirect nutrition interventions, as the UK favours incorporating nutrition funding in cross-sectoral interventions (such as food security, health and water & sanitation interventions). The scope of future analyses will certainly be even broader given that the UK now plans to include gender empowerment as a sector through which nutrition actions are delivered.

ARE NUTRITION INTERVENTIONS ACCESSIBLE TO THOSE WHO NEED THEM MOST?

During the study period, DFID allocated most of its nutrition funding to Africa (62%) and Asia (35%) and 60% of nutrition funding targeted countries included in the Lancet's 2008 list of countries suffering from a high burden of stunting. However with the top three recipient countries benefitting from 64% of the total funds, this funding was highly concentrated on a few countries.

Only two out of the top five recipient countries are included in ACF's list of high priority countries. However this should change in the coming years as the new nutrition strategy will focus on six countries: Bangladesh, Ethiopia, India, Nepal, Nigeria and

TOP RECIPIENT COUNTRIES FOR THE UK				
	Recipient	Average annual funding for nutrition from 2005-2009 (Constant 2009 US$ millions)	Percentage of total nutrition funding	Rank (caseload of stunted children)*
1	Bangladesh	15.7	27%	4
2	Sudan	11.3	19%	13
3	Somalia	10.5	18%	NR
4	Kenya	2.4	4%	16
5	Eritrea	2.2	4%	NR

Zimbabwe — five of which are ranked in ACF's list of 15 high priority countries. In these countries, a multisectoral approach will be undertaken to tackle nutrition. Moreover, DFID will continue its nutrition programmes in other high burden countries (DRC, Kenya, Sudan, Tanzania, Uganda, Afghanistan, Pakistan, Vietnam and Yemen).

REPORTING AND TRANSPARENCY

The UK's reporting to the CRS is commendable as only 18% of projects presented in the selected purpose codes were unable to be analysed due to a lack of information — a significantly lower percentage than other donors.

A huge proportion of direct interventions were reported in the 'Emergency Food Aid' purpose code. However it appears that the UK did not use the 'Basic Nutrition' purpose code as much as it should have done: only 30% of the projects reported in this code were dedicated to improving nutrition (through direct and indirect interventions), 9% of which were for direct interventions. It is crucial to note this as DFID has expressed its desire to ensure that there is an increase in the number of the UK's projects reported in the 'Basic Nutrition' code so as to track and monitor its spending on nutrition and to evaluate the progress of its strategy. It plans to publish these figures annually (from 2010 to 2015) in a review.

The UK has also made efforts to improve the accountability and transparency of its aid over the years. Therefore the majority of project descriptions, representing 82% of the money spent in the analysed purpose codes, were usable for our analysis. However, reporting to the CRS would be greatly improved with longer project descriptions (NB: these descriptions now exist in DFID's on-line database of interventions). It might also be the case that many of the direct nutrition interventions were reported in the humanitarian response purpose codes because the treatment of acute malnutrition could be considered a response to implement during emergencies.

KEY RECOMMENDATIONS

- DFID should increase funding for nutrition in a predictable manner so as to aid the development of long-term programmes.
- DFID should invest more ODA in the treatment of undernutrition in non-humanitarian contexts, in programmes which promote good nutritional practices and in micronutrient and deworming programmes in order to deliver a more rounded approach to tackling undernutrition.
- DFID should improve the targeting of its funding to high priority countries and investment in each high priority country should be in line with its caseload of undernutrition.
- DFID needs to improve the descriptions of projects reported in the CRS database and the reporting of its direct nutrition interventions in the 'Basic Nutrition' purpose code in order to improve the tracking of all nutrition interventions.

** Rank of caseloads of stunted children in the Lancet's list of 36 High Burden Countries (2008).*

SOURCES

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USA

A SHORT REVIEW OF THE USA'S NUTRITION STRATEGY

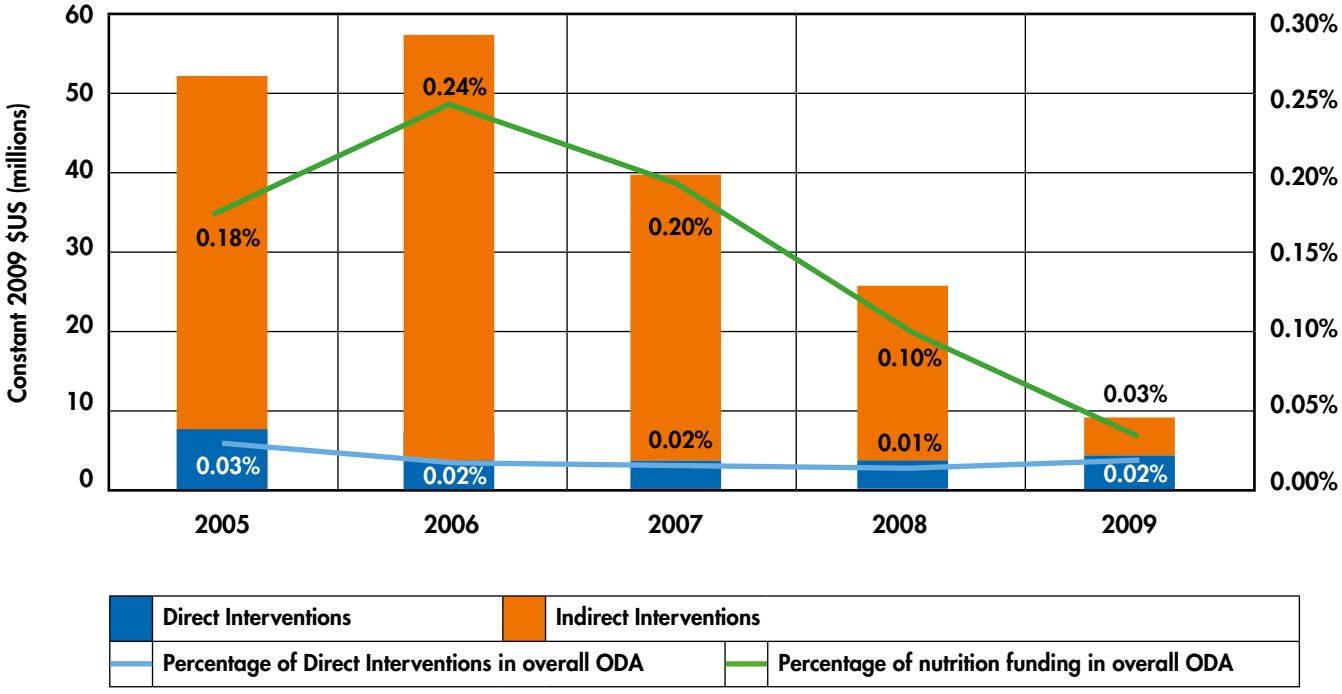
The United States spent an annual average of US$24.6 billion on development aid over the study period making them the biggest contributor to ODA in volume. The US Agency for International Development (USAID), which delivers the USA's ODA, views nutrition as "one of the most cost-effective strategies for development" (USAID, 2012a). Progress in child survival and disease control has long been, and remains, a priority for USAID. The agency aims to reduce under five mortality, maternal mortality and child undernutrition by targeting 30 priority countries which account for 50% of infant, child and maternal deaths worldwide.

USAID aims to deliver high-impact, proven interventions at scale and to strengthen the essential elements of health systems. Collaborative partnerships with UN agencies, private and public sectors, host country governments, cooperating agencies, foundations and civil society organisations are a key component of USAID's work to combat global hunger and undernutrition. USAID's donor partners include the Global Alliance for Improved Nutrition (GAIN), the Micronutrient Initiative, Sight and Life, UNICEF, the US Centre for Disease Control and Prevention (CDC) and WHO. The Agency also funds a number of other initiatives and projects including: A2Z: The USAID Micronutrient and Child Blindness Project; Food and Nutrition Technical Assistance II Project (FANTA-2); the Infant and Young Child Nutrition Project; the Point-of-use Water Disinfection and Zinc Project; and the Famine Early Warning Systems Network (FEWSNET).

The agency invests in nutrition in four main areas:

- Reduce micronutrient deficiencies through Vitamin A supplementation, anaemia programmes for women and children and fortification of staple foods and condiments.
- Prevent undernutrition through maternal, infant and young child nutrition programmes that support exclusive breastfeeding and improve feeding practices and intake of micronutrients (vitamin A, iodine and iron).
- Strengthen programmes at the community level to manage undernutrition (USAID pioneered CMAM in early 2000) (USAID, 2005). In 2009, USAID committed to investing US$30 million

ODA FROM THE USA FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2005 TO 2009



annually in these programmes (USAID, 2009a).

- Improve nutritional outcomes through integrated nutritional care and support for people living with HIV and improve nutritional outcomes in food security programmes (USAID, 2009b) and humanitarian assistance (USAID, 2003).

Recently, USAID expressed its interest to maximize synergies with other sectors such as agriculture and social protection (Prayes and Egan, 2011). According to the *Foreign Assistance Dashboard* (USAID, 2003), US$220 million were planned to be spent on nutrition programmes in 2010, US$177 million in 2011 and US$225 million in 2012. USAID is committed to health research programmes (USAID, 2012c), which incorporate nutrition as a major component and it published a paper on the state of global undernutrition in 2010 (USAID, 2010).

ARE FINANCIAL INVESTMENTS IN NUTRITION SUFFICIENT TO ADDRESS THE ESTIMATED NEEDS?

Between 2005 and 2009, USAID spent an average of US$4.5 million annually on direct nutrition interventions and nearly US$32 million on indirect nutrition interventions; however, these are comparatively small figures when considering the country's overall ODA. In volume, USA is the highest donor of ODA. However, its ODA only makes up 0.21% of its GNI — still a long way from the 0.7% target for 2015. Moreover, the USA allocated less than 0.1% of its overall ODA to nutrition.

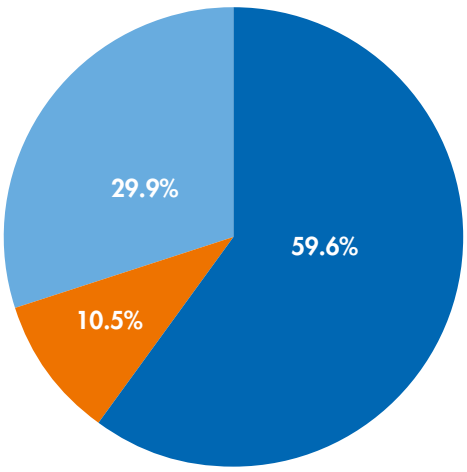
It is also worth noting the sharp decrease in nutrition funding over the years. For example, direct nutrition funding decreased by 45% between 2005 and 2009 and indirect nutrition funding decreased by 92%. These reductions are largely due to the reduction in the size of projects: in 2005, on average, each nutrition project received US$0.6 million. However by 2009, this figure had reduced to US$0.1 million. Within this period, funding for direct nutrition interventions represented 12% of overall ODA nutrition funding.

HOW IS FUNDING FOR NUTRITION DISTRIBUTED BETWEEN DIRECT AND INDIRECT INTERVENTIONS?

Direct Interventions

The majority of the USA's funding for direct nutrition interventions were allocated to 'behavior change interventions'. This was largely due to the huge contributions it made to breastfeeding and complementary feeding programmes which were part of its 'maternal, infant and young child nutrition programmes'. Micronutrient interventions were also implemented in line with its nutrition policy. Nearly a third of direct funding supported projects addressed all three of the thematic areas recommended by the Lancet Series on Maternal and Child Undernutrition (2008). This is commendable as the USA is the only country to have invested in such projects. These types of programmes started in 2007 and their size increased over time until they represented the only direct interventions funded in 2009 (US$0.2 million in 2007, US$2.3 in 2008 and US$4.2 in 2009). They were mainly implemented through NGO's and targeted countries which were almost exclusively in Africa.

THE USA'S DISTRIBUTION OF DIRECT INTERVENTIONS



I. Promoting good nutritional pratices
II. Increasing intake of vitamins and minerals
III. Therapeutic feeding for malnourished children with special foods
II. + III.
I. + II. + III.

However, as a proportion of overall ODA, the level of nutrition funding from the USA remains critically low (on average 0.6% of overall ODA between 2005 and 2009). Although USAID has committed to spending US$200 million annually on nutrition between 2010 and 2012, it is not clear how this money will be invested.

Indirect Interventions

USAID funds most of its nutrition programmes through the health sector (98%). This is largely due to the fact that its nutrition strategy is part of its development health policy. Humanitarian aid, water and sanitation and social protection do not appear to be priority sectors for USAID's delivery of nutrition interventions so it is not surprising that they are absent from the analysis. However this is not the case for the food security sector as it is the most suitable delivery vehicle for nutrition interventions from the USA.

Nutrition is viewed as a health component of the USAID nutrition strategy. However a lack of sufficient detail in some of the project descriptions may have failed to identify indirect nutrition interventions in which did not have nutrition as the main outcome. This is particularly relevant in food security and humanitarian aid projects, in which USAID claims to have objectives to improve nutrition outcomes.

ARE NUTRITION INTERVENTIONS ACCESSIBLE TO THOSE WHO NEED IT MOST?

On average, only 4% of nutrition funding per year from the USA targeted high-priority, high burden countries between 2005 and 2009. 68% of funding was dedicated to the Americas region, in which there are no high-priority countries and only 2 of the Lancet's (2008) 36 high burden countries — Guatemala and Peru. Guatemala was the biggest recipient of US nutrition funding, however Peru received nothing between 2005 and 2009 (13% of the funding was allocated to Africa, 1% to Asia and the rest was unspecified). The US nutrition strategy aims to target "30 priority countries that account for 50% of infant, child and maternal deaths" (USAID, 2003).

REPORTING AND TRANSPARENCY

USAID is conscious of the necessity to improve the transparency of its aid activities for its citizens. This was witnessed in 2009 when Barack Obama signed the Memorandum on Transparency and Open Government (Barack Obama, 2012).

With only 1.3% of the interventions rejected due to lack of information, reporting was adequate and clear although descriptions were sometimes too concise. Funding for direct nutrition interventions was mainly reported in the 'Basic Nutrition' purpose code while indirect interventions were predominantly reported in the 'Basic Health Care' purpose code.

KEY RECOMMENDATIONS

- USAID should reverse the drastic reduction of funding for nutrition interventions and predictably scale up funding in order to achieve its stated aims to reduce maternal and child mortality and undernutrition in children under-five.
- USAID must scale up its funding for holistic, direct nutrition programming which includes interventions which promote good nutritional practices, increase vitamin and mineral intake and which involve the treatment of acute malnutrition with therapeutic foods.
- The US Government should protect its ODA budget so that the USA can honour its commitments for nutrition funding from 2010 to 2012.
- USAID should honour its commitment to target the 36 high burden countries (The Lancet, 2008) which account for 50% of infant, child and maternal deaths worldwide rather than those which serve its strategic interests.
- USAID should improve its project descriptions in the CRS to facilitate the tracking of nutrition funding.

TOP RECIPIENT COUNTRIES FOR THE USA				
	Recipient	Average annual funding for nutrition from 2005-2009 (Constant 2009 US$ millions)	Percentage of total nutrition funding	Rank (caseload of stunted children)*
1	Guatemala	6.9	19%	27
2	America, regional	5.7	15%	NR
3	Honduras	4.7	13%	NR
4	Nicaragua	3.9	11%	NR
5	Dominican Rep	2.7	8%	NR

SOURCES:

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** Rank of caseloads of stunted children in the Lancet's list of 36 High Burden Countries (2008).*

UNICEF

A SHORT REVIEW OF UNICEF'S NUTRITION STRATEGY

A joint health and nutrition strategy for 2006-2015 (UNICEF, 2006) was approved by the UNICEF executive board in January 2006. This strategy aims to leverage policies, legislation, plans and budgets through enhanced knowledge and evidence and to translate these into accelerated action.

UNICEF's commitment to scaling up nutrition revolves around four key programme areas (UNICEF, 2012):

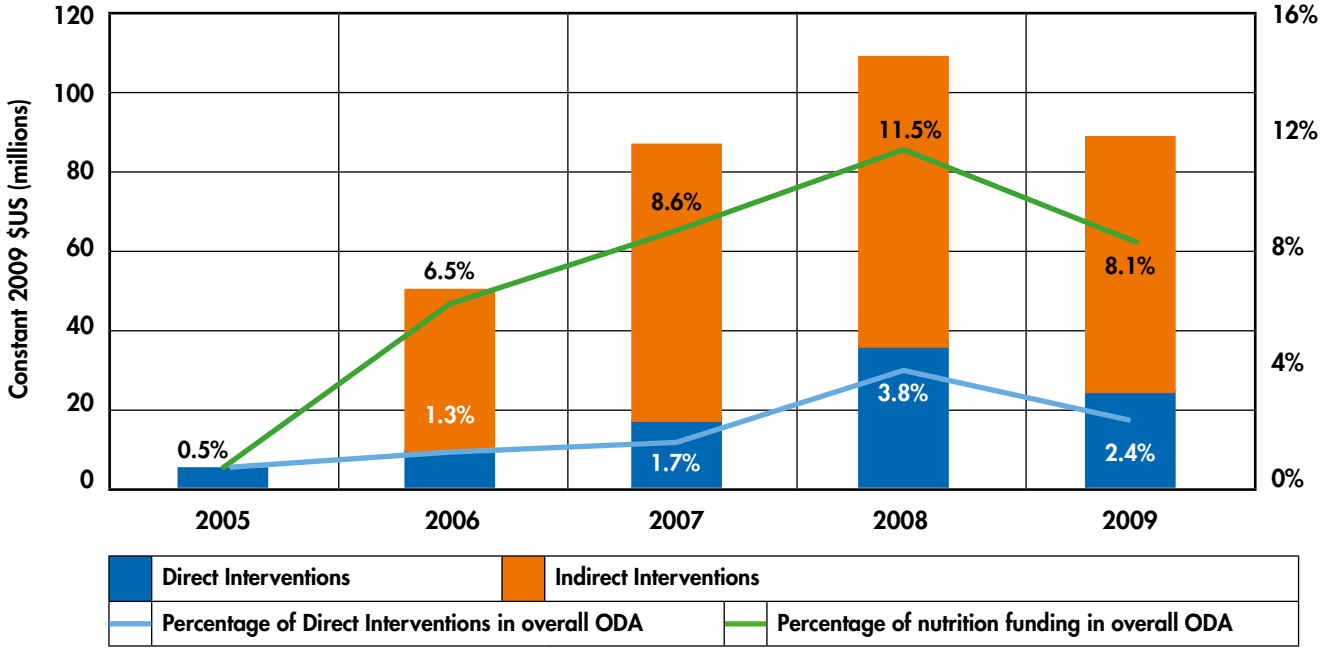
- Infant and young child feeding: For optimal child growth and development, UNICEF supports early initiation of breast milk within the first hour of birth with exclusive breastfeeding for the first six months of life. This should be followed by the provision of safe and nutritionally adequate complementary food at home and continued breastfeeding for up to two years.
- Micronutrients: UNICEF supports governments and various public and private groups in the provision of iron, iodine and vitamin A supplements, particularly to children aged 6-59 months and to pregnant and lactating women.
- Nutrition security in emergencies: This programme area aims to prevent maternal and child deaths during emergencies through support for breastfeeding, therapeutic and supplementary feeding, provision of essential micronutrients and feeding of orphans.
- Nutrition and HIV/AIDS: UNICEF's nutritional response to HIV/AIDS victims includes helping infected mothers make informed decisions on infant-feeding, supporting the nutritional needs of children living with HIV and caring for children who are orphaned and vulnerable as a result of HIV.

It is estimated UNICEF will spend approximately US$736 million per annum on health and nutrition programmes during the period covered by the joint health and nutrition strategy.

ARE FINANCIAL INVESTMENTS IN NUTRITION SUFFICIENT TO ADDRESS THE ESTIMATED NEEDS?

For the period of 2005 to 2009, UNICEF's total estimated funding for nutrition amounted to an annual average of US$68.1million. This represents 7.2% of UNICEF's total annual aid expenditure. The largest amount of aid for nutrition was invested in 2008, when 11.5% of its ODA was allocated to nutrition interventions.

ODA FROM UNICEF FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2005 TO 2009



However, considering the organisation's commitment to addressing child and maternal nutrition programmes as a key focus area, the average share of nutrition funding as a percentage of UNICEF's total ODA was very low (4.4%) over the period analysed.

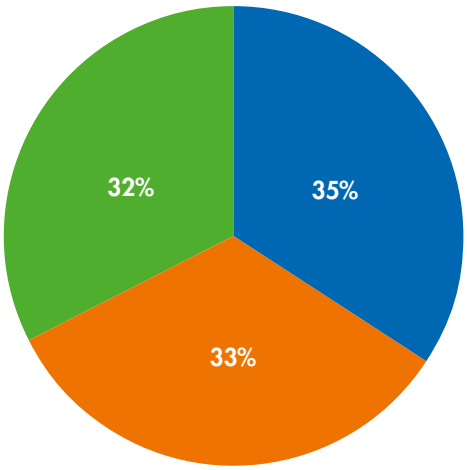
HOW IS FUNDING DISTRIBUTED BETWEEN DIRECT AND INDIRECT NUTRITION INTERVENTIONS?

Direct Interventions

Nutrition-specific or direct interventions received 45%, or approximately US$31 million, of UNICEF's total funding for nutrition. Funding for direct nutrition interventions increased steadily between 2005 and 2008, however in 2009 funding levels for both direct and indirect nutrition interventions decreased.

As shown by the chart, UNICEF has equally disbursed its funding to the three categories of direct nutrition interventions which is in line with its policy. It has therefore provided a rounded response to addressing the problem of undernutrition.

UNICEF'S DISTRIBUTION OF DIRECT INTERVENTIONS



	I. Promoting good nutritional pratices
	II. Increasing intake of vitamins and minerals
	III. Therapeutic feeding for malnourished children with special foods
	II. + III.
	III. + I.

Indirect Interventions

Like the other donors studied in this report, UNICEF invested more money in indirect nutrition interventions than direct nutrition interventions. Throughout the period studied, indirect interventions received two times more funding that direct interventions. This was to be expected, as UNICEF delivered most of its interventions through multiple sectors. More than half of their aid was delivered through the Health sector, 32% through Social infrastructures and services, 11% through Humanitarian aid and 8% through water and sanitation programmes. However, no funding for nutrition interventions was channelled through Development food aid, indicating UNICEF's focus on ensuring nutrition security during emergencies.

ARE NUTRITION INTERVENTIONS ACCESSIBLE TO THOSE WHO NEED THEM MOST?

During the 2005 to 2009 period, about 54% of UNICEF's funding to nutrition was targeted at countries with a high prevalence of stunting. Africa received 72% of the funding, whilst Asia received 25%.

Ethiopia was the country to receive the largest share of funding. The five countries that received the most funding from UNICEF are all present in ACF's list of high priority countries although the countries with the largest caseloads of stunting (India and Nigeria) did not receive the largest amount of funds.

REPORTING AND TRANSPARENCY

We found that UNICEF's reporting to the OECD CRS was done adequately and in sufficient detail for our study. Only 5% of the projects could not be analysed due to insufficient information. Also, reporting to the 'Basic Nutrition' purpose code contained a high percentage (92%) of activities that incorporated nutrition interventions – only 3% of the interventions described in this purpose code were not related to nutrition.

TOP RECIPIENT COUNTRIES FOR UNICEF				
	Recipient	Average annual funding for nutrition from 2005-2009 (Constant 2009 US$ millions)	Percentage of total nutrition funding	Rank (caseload of stunted children)*
1	Ethiopia	9.4	14%	6
2	India	4.3	6%	1
3	Nigeria	3.9	6%	3
4	Congo Dem Rep	3	5%	7
5	Madagascar	2.5	4%	19

KEY RECOMMENDATIONS

As stated in the joint health and nutrition strategy, UNICEF committed to "assist countries in identifying and filling gaps in financial support needed to implement their health and nutrition policies and plans" (UNICEF, 2006) and projected to spend an annual average of $736 million on this component between 2006 and 2015. However findings from our analysis suggest that this is a long way from being achieved by the organisation. We therefore recommend that:

- As the normative agency for implementing nutrition interventions, UNICEF should increase its funding for nutrition-specific, evidence-based interventions in line with its own annual projections for 2006 to 2015.
- UNICEF should acknowledge that nutrition security is also a key aspect of development by scaling up the funds it allocates to nutrition through Development Food Aid and other sectors in non-emergency contexts.
- UNICEF must clearly allocate funding to nutrition within its joint Health and Nutrition strategy, ensuring that its commitments to nutrition funding are set out in a predictable and sustainable manner. This would enable the organisation to more readily monitor, evaluate and remain accountable to their commitment to improve maternal and child nutrition and to achieve MDG1 by 2015.
- UNICEF should commit to prioritising the countries with the largest caseloads of stunting to ensure that nutrition programmes are accessible to those who have the greatest need.

SOURCES:

- UNICEF (2006) Joint Health and Nutrition Strategy for 2006-2015 [online] *http://www.unicef.org/about/execboard/files/06-8_health_and_nutrition_final_ODS.pdf* [Accessed on December 2011]
- UNICEF (2012) Nutrition [online] *http://www.unicef.org/nutrition/index_4050.html* [Accessed on March 2012]

** Rank of caseloads of stunted children in the Lancet's list of 36 High Burden Countries (2008).*

Action Against Hunger – UK
First Floor, Rear Premises, 161-163 Greenwich High Road
London, SE10 8JA T: +44 (0)20 8293 6190 F: +44 (0)20 8858 8372
E: info@actionagainsthunger.org.uk www.actionagainsthunger.org.uk

Action Contre La Faim – France
4 rue Niepce / 75662 Paris Cedex 14
T:+33 (0)1 43 35 88 88 F:+33 (0)1 43 35 88 00
www.actioncontrelafaim.org

Accion Contra el Hambre – Spain
C/Caracas, 6, 1º, 28010 Madrid
T: +34 91 391 53 00 F: +34 91 391 53 01
www.accioncontraelhambre.org

Action Contre la Faim – Canada
1150, boulevard St-Joseph est, Bureau 302, Montréal, QC, H2J 1L5
T: (514) 279-4876 F: (514) 279-5136
www.actioncontrelafaim.ca

Action Against Hunger – USA
247 West 37th Street, 10th Floor, New York, NY, USA 10018
T: +1 (212) 967-7800 Toll free: +1 (877) 777-1420
F: +1 (212) 967-5480 www.actionagainsthunger.org