Greater DFID and EC Leadership on Chronic Malnutrition: Opportunities and Constraints

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Commissioned by Save the Children UK

13 April 2007

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ANNEXES

Executive summary

This report assesses the commitment currently demonstrated by DFID and the EC – two of the largest aid agencies – to reducing chronic malnutrition. In doing so the paper reviews the drivers and impediments to changing the status quo. The report was commissioned by Save the Children UK.

The goal of the paper is to give the agencies pause for thought. Do they have common views of what malnutrition is? Do they realise what is at stake in improving nutrition status? Are their assumptions correct as to the priorities they are currently giving malnutrition reduction? Are their assumptions correct about the bigger picture on donor investments in malnutrition? Are there opportunities for sensibly increasing investment? Are there impediments that are not as insurmountable as they at first seem?

The key findings are as follows: Our assessment is that DFID and the EC assign chronic malnutrition a medium level of priority although much of this assessment depends on just how nutrition-friendly the indirect nutrition interventions are. Chronic malnutrition is widely recognised by both DFID and EC as crucial to reducing child mortality, morbidity and in promoting learning in school and economic productivity in the labour market. However, nutrition is seen by the EC and DFID as a supporting investment rather than a foundational one. We identify ten reasons for this.

1. Chronic malnutrition does not fit neatly into the developing country sectoral silos that donor agencies are increasingly linking up with;
2. Chronic malnutrition is seen as everybody's business and nobody's responsibility – there are few institutional champions;
3. Chronic malnutrition has not been seen as linked to the governance agenda, although there are clearly opportunities for it to be;
4. Within DFID and the EC there are few institutional incentives to pay attention to nutrition;
5. International agencies are not seen as capable or willing to support or put pressure on DFID or the EC to do more;
6. Parliamentary bodies have no particular incentive to pressure DFID or the EC on nutrition;
7. Tracking spending flows on nutrition is difficult;
8. Attributing impact on nutrition status of indirect nutrition interventions is difficult;
9. There are some clear direct interventions but these are seen as involving too much or too little behaviour change to be sustainable;
10. The move to direct budget support and SWAPs means these direct nutrition programmes will be underfunded in the absence of champions.

We are optimistic that DFID and the EC could do more on nutrition within the constraints under which they currently operate. In addition, there seem to be several opportunities for SC UK to support DFID and the EC in this regard.

1. Introduction

Chronic malnutrition affects billions of people[1]. In particular, one in three infants in South Asia and sub-Saharan Africa are chronically malnourished. In South Asia the number of children under 5 who are low weight for age or low height for age is steadily declining – albeit with several countries still showing increases – but in sub-Saharan Africa the number is steadily increasing even at the regional level (Annex Figure 1).

As we shall see in the following section, the prevention of chronic malnutrition is vital to mortality and morbidity reduction, to economic productivity, and to the respect and protection of human rights. Yet the prevention of chronic malnutrition tends not to be high on donor or developing country government agendas.

This report explores the reasons for this apparent disconnect. The report was commissioned by Save the Children UK to analyse DFID and the EC in particular. The report uses a number of conceptual approaches to guide data collection from a number of sources to drive the analysis of (1) how DFID and the EC conceptualise chronic malnutrition, (2) the extent to which they currently prioritise addressing it and (3) the factors shaping the policy space in which to shift their priorities on chronic malnutrition.

Section 2 asks why does nutrition matter from intrinsic, instrumental and governance perspectives?

Section 3 describes our methodological approach to analysis and data collection.

Section 4 presents finding on public commitments to, and spending on, chronic malnutrition in DFID and EC headquarters and in section 5 in the six country case-studies. This section draws on policy documents, speeches and multiple sources of budgetary data.

Section 6 presents findings on drivers and impediments shaping DFID and EC's policy space for chronic malnutrition. This section draws on interviews with headquarter and country staff.

Finally, section 7 concludes and makes recommendations for DFID, the EC and Save the Children UK as to what they can do to enhance the profile of chronic malnutrition in the global priorities of DFID and the EC.

2. Why Nutrition Matters

Investments in child nutrition are core to achieving improvements in health and education outcomes and in economic growth[2]. Child malnutrition is responsible for 25-50 percent of all child deaths (Annex Figure 2) and infant

[1] Fifth Report on the World Nutrition Situation (2004), UN's Standing Committee on Nutrition

[2] Improvements to nutrition are core to MDGs in poverty, education, gender equality, child health and maternal mortality and HIV/AIDS.

and maternal malnutrition are leading causes of disease (Annex Figure 3). The economic costs of malnutrition are large (2-8% of GDP lost from iron deficiency anaemia alone, see Annex Figure 4). Economic growth, while crucial for reducing malnutrition will not take care of malnutrition quickly enough – the two are not as tightly wedded as many imagine. Projections in Annex Figure 5 show that by 2015 only 3 out of 12 countries will halve their 1990 malnutrition rates despite projections reliant on 25 years of historically unprecedented income growth. The priority period for investment is while the child is in the womb and up to 18 months of age. Malnutrition losses incurred during this period cannot be retrieved by interventions introduced after the first 18 months of life – they represent losses the child will carry throughout life.[3]

Failure to make the investments in reducing chronic malnutrition is an indictment of the quality of governance. Government exist to provide goods that the market cannot. It exists to promote equity of opportunity between individuals and across generations. Good governance is characterised by a willingness to act, a capacity to act, and an ability to be held accountable for decisions.

Is the government of the population far sighted? If it is, it will invest in preventing the entirely preventable malnutrition suffered by foetuses in the womb and by babies in their first year of life. Of the female babies that survive, the ones that remain malnourished in adolescence are more likely, in turn, to give birth to malnourished babies.

Is the government of the population concerned with equity? If it is, it will note the differential nutrition requirements of men and women and it will address cultural issues often mandating that women eat last and least and are less likely to get clean water and heath care.

Is the government concerned with voice? Children – the ones who suffer first and longest from malnutrition – have little say in decisions that affect their well being. Very young children cannot claim rights and they cannot hold others accountable. Yet when malnutrition is out in the open it can be one of the most articulate measures of collective accountability to children. Is governance concerned with human rights? The combination and duration of deprivations that would be required to actively generate malnutrition is truly horrendous.

Are governments concerned with providing goods that the market cannot? Markets fail to provide financial services that let poor parents invest in their babies today with repayments being financed out of later productivity returns. Markets fail to provide the information to parents about the existence and consequences of the malnourishment of their infants.

Is the organisation of governance responsive to the needs of the population? Nutrition preconditions the success of health and educational investments. Investing in health and education when the population is malnourished is like

[3] Fifth Report on the World Nutrition Situation (2004), UN's Standing Committee on Nutrition

trying to build a tower on fragile foundations. Dealing with health and education will not address issues of malnutrition.

In summary, chronic malnutrition erodes life, health, and productivity. The persistence or worsening of malnutrition trends in a population is a sombre reflection on the quality of how it is governed.

3. Conceptual Approach and Data Collection

We draw on the consensus of a range of conceptual frameworks that have emerged for the analysis of policymaking processes in international development (see for details Brock *et al*., 2001; Court *et al.,* 2005; de Vibe *et al.*, 2002; Keeley and Scoones, 2003; KNOTS, 2006; McGee and Brock, 2001; Stone *et al.,* 2001; Sutton, 1999).

This literature stresses context (e.g. which policy windows are currently open?), messages (e.g. is there a strong set of problem and solution messages to hand?) and connectors (e.g. are there people, organisations and institutions that can play a championing role?).

3.1. Conceptual Approach for Analysing Policy Related to Chronic Malnutrition

The conceptual approach we use has three dimensions which guide our data collection. First, we assess how the agencies and a small but targeted sample of their staff conceptualise chronic malnutrition. Second, we assess the priority they currently give to chronic malnutrition. Third, we evaluate the opportunities and impediments for moving the issue up or down the development agenda.

The way in which chronic malnutrition is conceived should give clues as to the rationale for resource allocation decisions and for understanding the space for changing the priority given to it. For example, if it is seen as a development outcome, indirect efforts to address it may be given priority. If it is seen as a medical condition, certain types of direct interventions might be emphasised. If it is seen primarily as a measure of food shortages then perhaps food policies will be given priority.

To understand the conceptualisation, priorities and the placing of chronic malnutrition on the development agenda, we investigate donor agencies in terms of what they: (a) publicly commit to (by analysing their web sites, speeches and policy publications), (b) spend (by using various data sources) and (c) think (by relying on interviews). Table 1 summarises the approach we take.

Table 1: Our Analytical Approach – Analyst and Donor Perceptions

		Our assessment of donor's perceptions		
		Conceptualisation of chronic malnutrition	Prioritisation of chronic malnutrition	Opportunities for and Impediments to changing the priority
Donors' Stated policy position and personal perceptions of donor staff	What they commit to	Speeches, web sites, policy papers	Speeches, web sites, policy papers	
	What they spend on		CRS and other data	
	What they think	Interviews	Interviews	Interviews

To deepen the analysis of drivers and impediments, we use an approach that we have found useful in understanding how policy spaces emerge. The framework explores the role of context, messages, and connectors in the emergence of policy spaces. The context represents the 'politics and interests'. The messages are the 'policy narrative/discourses'. The connectors are the 'actors and networks'. The framework is best envisaged as a 'menu' or set of prompts of useful questions to pose rather than an encompassing conceptual map. Such policy spaces might be local, regional, national or global. A non-exhaustive list might include:

- *Conceptual spaces* where new ideas can be introduced into the debate and circulated through various media;
- *Bureaucratic and invited spaces* such as PRSPs or other formal policymaker spaces within the government bureaucracy as well as consultations on policy led by government agencies;
- *Popular and practical spaces* such as protests and demonstrations that put pressure on governments or where there is an opportunities for 'witnessing' by policymakers – for example, case studies, study tours and pilot projects (KNOTS 2006: 46).

3.2. Data Collection Methods

Chronic malnutrition interventions and policies tend to be classified as "direct" and "indirect" (see for example Gillespie and Haddad 2003). Direct interventions tend to address the more immediate determinants of chronic malnutrition interventions (such as the quality of individual food intake and the provision of individual health services) while indirect interventions tend to address the intermediate determinants (such as food availability or the quality of water and sanitation). Table 2 provides a mapping of direct and indirect interventions.

Table 2: Direct and Indirect Nutrition Interventions

Direct interventions	Indirect interventions
• Community based nutrition and health services (growth promotion, supplementary feeding) • Breastfeeding counselling • Facility-based nutrition services (treatment of severe malnutrition, 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 • Safe water and sanitation • Legislation on the marketing of breast milk substitutes • Food and agricultural policies to increase supply of safe and healthy food • Food industry development and marketing incentives for developing healthy food • Increasing the incomes of the poor, including micro finance, employment creation • Fiscal and food price policies to increase poor people's purchasing power • Improving the status of women • Reducing women's workload (during pregnancy and post-natally) • Increasing women's formal education • Conditional/unconditional cash transfers • Food aid • National food security • Capacity development

We use these definitions to guide our search for data collection. As Table 1 summarises, we used data from policy documents, publicly available speeches, expenditure data, and individual interviews.

Data collection and analysis was conducted at headquarters and country levels. We can expect more of an emphasis on formulation at headquarter level and more of an emphasis on implementation at the country level. We selected 6 countries, the number determined by the budget of this project. The 6 countries selected were Nigeria, Zimbabwe, Sudan, Bangladesh, Afghanistan, and Ethiopia. They were chosen from the 15 countries in Table 3. From these 15 countries we selected those in which both DFID and EC are active. We removed India, China and South Africa due to the lack of donor influence in these countries. We then took the top two countries from those remaining in each column.

Table 3: Candidate Countries from which the 6 Case-Study Countries were drawn

Top five highest numbers of chronically malnourished children	DFID	EC	Top five where chronic malnutrition trends most off track	DFID	EC	Top five highest levels of chronic malnutrition (all 50% and above)	DFID	EC
India	Y	Y	Zimbabwe	Y	Y	Burundi	N	Y
China	Y	Y	Comoros	N	Y	Afghanistan	Y	Y
Nigeria	Y	Y	South Africa	Y	Y	Yemen	N	N
Bangladesh	Y	Y	Cameroon	N	Y	Ethiopia	Y	Y
Pakistan	Y	Y	Sudan	Y	Y	Nepal	Y	Y

Note: shaded cells represent countries selected

3.2.1. Speeches and Policy Documents

We use "current"[4] key policy documents and speeches that relate primarily to these direct and indirect interventions. We selected the speeches of elected politicians and political appointees (DFID and EC Dev websites – English only) supplemented by press releases and Hansard and the record of the European Parliament.

3.2.2. Expenditure Data

We used multiple sources of expenditure data. For comparison between countries and donors, we have used the DAC Creditor Reporting System (CRS) to analyse spending in the area of nutrition. We have analysed these data for the period 1995-2004 for the following types of intervention:

- Direct nutrition interventions
- Indirect nutrition interventions
- General budget support

The use of the CRS data is problematic. For example:

- Multicountry allocations: When the committed amount of chronic nutrition ODA benefits several countries, no particular country is identified so specific donor-recipient mapping is incomplete. This is relatively common within both the direct and indirect nutrition data and makes country level analysis more difficult. We have dealt with this by supplementing the country level analysis with expenditure data and project information from DFID and EC websites, AiDA at the Development Gateway Foundation, country office interviews and multilateral organisations' websites.

- Multisector projects: If a project that has a primary component which is not relevant to nutrition, but which includes nutrition relevant (both direct and indirect) interventions, it is impossible to know how much of the allocation is assigned to chronic malnutrition and it is also impossible to know how many such projects exist. We have not been able to solve this problem and it is difficult to know the extent to which this affects the accuracy of the data.

- Donor inconsistency in adhering to guidelines: There are specific guidelines for reporting, but these do not seem to be adhered to at all times. For instance, within the "basic nutrition" purpose code we found some emergency assistance funds, which should have been allocated to the purpose code specifically designed for emergency assistance funds. This was rare enough not to bias orders of magnitude or analysis of trends. There is also space for a longer description of the projects, but this

[4] "Current" refers to speeches and records from January 2005 – early on in Hilary Benn's tenure at DFID and just after the European Consensus on development was established. The most recent policy documents on a particular topic are reviewed even if these are published before January 2005.

information is rarely filled in, which means that opportunities for further analysis of the data are lost.

- The CRS dataset does not cover bilateral donor contributions to multilateral agencies. We have tried to map DFID and EC contributions to the World Bank, WFP, FAO, and UNICEF into direct and indirect chronic malnutrition interventions, using resources available on the web sites of DFID and EC and the multilateral agencies, as well as through direct inquiries to the staff of these agencies.

Consequently one has to use the CRS data with care and certainly only in terms of rough orders of magnitude[5].

3.2.3. Interviews

We constructed a list of interviewees to approach based on those working in the divisions with primary responsibility for policy formation in the area of nutrition in DFID and EC Headquarters. In DFID this was the Policy and Research Division. In EC this was the DG Development, Directorates A (development policy: horizontal issues) and B (development policy: thematic issues).[6]

We also included policy implementers. For DFID, this was the Africa Division and CHASE (the Conflict, Humanitarian and Security Department). For the EC this was AIDCO (Europe Aid) and ECHO (EC Humanitarian Office).

We also approached the chair of the relevant parliamentary development committee for both DFID and EC.

In each Division we contacted the Heads of Department and in each Department a senior official. In the DFID Policy and Research Division this translated into each Head of Department and the Head of Professions. In EC DG Development Directorate A and B this meant the Heads of Department and the most relevant Desk Policy Officer in each Department. In both DFID and EC we excluded the IT/media/communications department. The full set of interviewees and anonymous interviews is provided in Annex 3.

In all we approached 5 Heads of Department and 8 Heads of Profession at DFID and 8 Heads of Department and 7 Desk Policy Officers at the EC. In all 12 DFID HQ staff and 10 EC HQ staff were interviewed.

To get further information from those closer to policy implementation, we relied on country office interviews. In each of the 6 countries we contacted the DFID and EC point people for chronic malnutrition – a total of 12 in all.

[5] A more detailed description of the data can be found in Annex 3.
[6] See organograms in Annex 1 (Figures 6 and 7).

4. DFID and EC Headquarters: Public Commitments and Expenditures

We have described what is at stake in terms of improving chronic malnutrition, but what are DFID, the EC and the other bilateral donors publicly committing to do to address chronic malnutrition, what are they spending on it and what are their perceptions about it?

4.1. The Donor Environment: Public Commitments and Expenditures

Table 4 analyses the mission statements and nutrition strategies on the web sites (and key policy documents where readily available) of the top ten bilateral donors of total ODA volume[7] and the European Commission and their conceptualisation of chronic malnutrition[8]. Canada, the Netherlands and the US seem to give undernutrition, food insecurity and hunger the highest priority. The UK and the EC we rate as giving medium priority and the rest of the donors as giving a low priority to these issues, at least based on public statements on websites.

Table 4: Top Ten Bilateral Donors and the EC: Chronic Malnutrition: Conceptualisation and Prioritisation

Country	Conceptualisation	Prioritisation
Canada	Undernutrition[9], hunger, food security	High
France	Hunger, food security	Low
Germany	Not stated	Low
Italy	Not stated	Low
Japan	Not stated	Low
Netherlands	Undernutrition, hunger, food security	High
Spain[10]	N/A	N/A
Sweden	Undernutrition	Low
UK	Undernutrition, hunger, food security	Medium
USA	Undernutrition, hunger, food security	High
EC	Undernutrition, hunger, food security	Medium

Source: Donor websites

Table 5 presents donor policies and interventions by different chronic malnutrition areas activities (direct and indirect). Shaded cells represent an area of policy focus and a tick represents a main area of intervention. This more disaggregated perspective confirms the relative strength of emphasis of the US, the Netherlands, Canada and the UK. The EC fares particularly poorly in this exercise.

[7] Top ten as of 2005: USA, Japan, UK, France, Germany, Netherlands, Canada, Sweden, Italy and Spain (OECD DAC Development Co-operation Report 2005).
[8] This was a relatively brief review and the judgment of conceptualisation is based on first impressions.
[9] Note that "undernutrition" in this table means malnutrition due to lack of calories and micronutrients as opposed to malnutrition due to excess of calories.
[10] The website was not available in English, so we have been unable to determine conceptualisation.

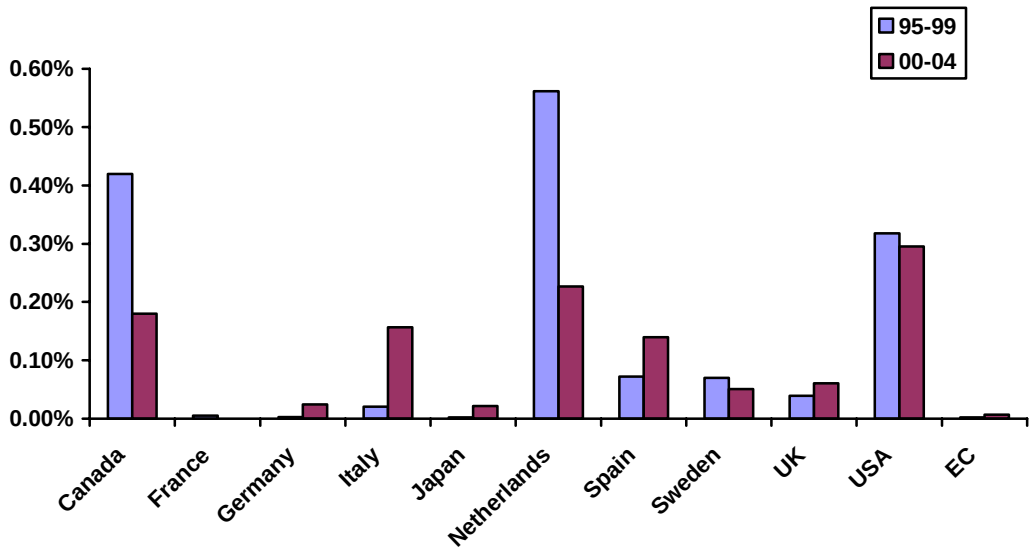
Table 5: Top Ten Bilateral Donors and the EC: Type of Nutrition Activities

		Can	Fra	Ger	Ita	Jap	Net	Spa	Swe	UK	USA	EC
Direct interventions	Community nutrition										✓	
	Micronutrients	✓				✓	✓		✓	✓	✓	
	Women's nutrition			✓				✓			✓	
	Child care /feeding	✓					✓	✓	✓	✓	✓	
	Nutritional surveillance	✓			✓		✓			✓	✓	
	Advocacy	✓		✓			✓		✓			
Indirect interventions	Food aid	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
	Food security	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
	Health & education	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Capacity development	✓		✓			✓	✓			✓	

Source: Donor websites, CRS online, Gillespie & Haddad 2003

Figures 1 and 2 use CRS data to show the percentage of ODA spent on direct and indirect nutrition interventions between 1995 and 2004. In terms of the percent of bilateral ODA allocated to direct nutrition interventions, the Netherlands, Canada and the US do much better than others, although the volumes of aid are all small in relation to total ODA, ranging from less than 0.01% to 0.6% (see Annex Table 1 for further details). Indirect interventions account for a much larger percent of ODA[11] ranging from 2-14%. Here the EC is the lead agency with the highest and fastest growing spend (see Annex Table 2 for further details).

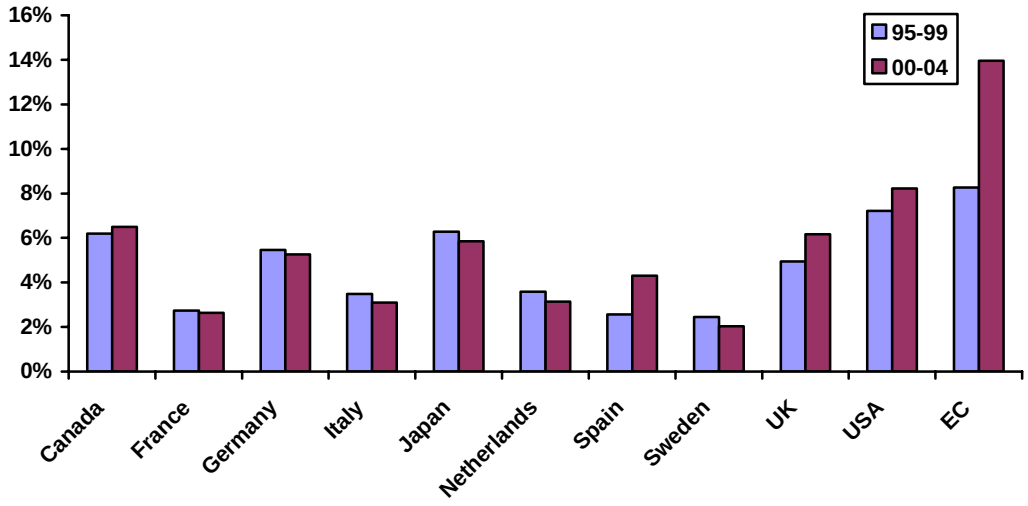
Figure 1: Percentage of Total ODA Spend on Direct Interventions



Source: CRS Online

[11] Indirect interventions include non-emergency food aid.

Figure 2: Percentage of Total ODA Spend on Indirect Interventions



Source: CRS Online

Each of these two perspectives on donor conceptualisation and prioritisation has its own problems, but taken together they suggest that the main bilateral players in the nutrition field (combined direct and indirect) are the Netherlands, USA, Canada and the EC with the UK close behind.

The Netherlands takes a multi-sectoral approach to the explicit improvement of nutritional status and specifically highlights the links between girl's education, improvement of nutritional status and thus increased agricultural output. There is a specific policy document that deals with this approach "Nutrition: interaction of food, health and care" from 1998.

USAID particularly stresses the interdependence between nutritional status, child survival, health, cognitive development, and work capacity and its interventions are focused on micronutrient supplementation and fortification, infant and young child feeding, improvement of household food security and food aid. For such interventions it is stated that locally appropriate, community-based, integrated approaches that build community capacity to monitor and improve children's nutritional status are used. In recent years the USA has, based on these data, been the lead donor on direct nutrition interventions, both in absolute and relative terms. The USA is also one of the lead donors on indirect interventions. Although traditionally much of USAID aid in these areas has been food aid in kind, a majority of this is now monetised (72% in 2002) (FANTA, 2003: 4). One third of all USAID food aid resources is used for health, nutrition and water and sanitation activities.

Canada places high priority on chronic malnutrition within their policy on basic human needs. CIDA's approach is focused on the improvement of household food security, the reduction of micronutrient deficiencies and investing in capacity building for nutrition. Canada's spend in direct interventions is

declining, but is still one of the highest, with an average indirect nutrition spend.

Although chronic malnutrition does not appear to be a priority area for German development cooperation in terms of policy focus, Germany does reportedly have well designed nutrition interventions, particularly working with FAO in Afghanistan (FAO/22/11/06). Japan also has a large indirect nutrition spend, but has nothing much to say on direct nutrition interventions. Apart from these 5 donors and the EC and DFID, the remaining donors – based on the above data – seem to place a low priority on chronic malnutrition.

4.2. DFID: Commitments, Spending and Perceptions

4.2.1. Public Commitments

In terms of public statements we conclude that DFID places a moderate priority on tackling chronic malnutrition. Although it is clear that DFID has a comprehensive understanding of the severity of the problem and how to deal with it – particularly evident in the Eliminating Hunger policy paper (2002) – reducing chronic malnutrition is not a stated DFID priority issue.

Word count analyses of speeches, press releases and key documents as listed in Annex Table 3 show that nutrition is rarely mentioned. The same can be said of DFID's Public Service Agreement (see Annex Box 1). A more detailed analysis of these documents as described in Annex Table 4 confirms initial impressions.

Other political documents, such as the G8 2005 and G8 2006 reports (in which DFID played a prominent role) and "G8 Gleneagles: One Year On" do not refer to chronic malnutrition. The primary focus of the Third White Paper (2006) is on governance and while it does confirm support for a lot of indirect action which can have an impact on nutritional status, including health, women's empowerment, water and sanitation, social protection (with a target of moving 16 million people off emergency relief and onto long-term social protection programmes), microfinance and economic growth, there is no specific chronic malnutrition focus.

Certain DFID sector strategy documents place more importance on chronic malnutrition. The Eliminating Hunger paper (2002) conceptualises malnutrition in terms of the quantity and quality of food access in relation to physiological requirements and ability for the food to be used by the body for growth and development (p. 13) and highlights the potential contribution of nutrition to the achievement of the MDGs (p. 18 & 25). To deal with the problem of food insecurity and chronic malnutrition the document stresses the importance of multi-sectoral indirect interventions that improve education, health, water and sanitation and food security, as well as more direct actions such as promoting good care and feeding practices and improved access to micronutrients (p.8). The document also highlights the significance of nutritional status indicators for monitoring food insecurity and vulnerability (p. 30). It is also stated that DFID should reflect on the role it can play in the nutrition debate, by drawing

on existing work on health, livelihoods, poverty and hunger reduction (p.33). In order to implement this strategy, DFID suggests that better ways of cross-sectoral working are needed to reduce malnutrition and that a focal point for food security and nutrition is created (p. 32). This 2002 document is well-written, but the preceding expectations have not been met.

Other policy documents that include references to malnutrition include the Health strategy 'Better health for poor people' (2000). This document acknowledges the importance of nutritional status (along with other issues such as economic security, education, water and sanitation and broader physical and social environment) for health outcomes and thus prescribes a multi-sectoral approach that includes all these areas (p. 17). The gender strategy 'Poverty Elimination and the Empowerment of Women' (2000) emphasises the links between women's and girls' empowerment and improved nutritional status (p. 16). The paper on social transfers 'Social Transfers and Chronic Poverty' looks at how social transfers can impact on nutrition and have further beneficial consequences, in terms of improved school performance and general health and resistance to HIV/AIDS (p. 13-14).

4.2.2. Spending

This medium-level priority is also evidenced in Figures 1 and 2 by relatively small amounts of bilateral aid spent on direct (7th out of 11) and indirect nutrition interventions (5th out of 11). The low spend on direct nutrition activities is not particularly surprising given the DFID emphasis on multi-sectoral livelihood approaches. On indirect interventions, DFID spends more than an average amount in comparison to the top ten bilateral donors.

On the allocations to multilaterals (Annex Table 5) it is very difficult to establish how much is spent on chronic malnutrition. DFID does not earmark World Bank contributions to specific sectors or activities (DFID/28/11/06), but does earmark some funding for WFP, FAO and UNICEF, although most of DFID multilateral contributions are core funding (DFID/14/12/06). DFID funds UNICEF for some direct nutrition activities[12] and WFP and FAO for some long-term food security interventions (Annex Table 11). None of these allocations seem exceptional in that chronic malnutrition does not seem under or over prioritised given the mandate of the particular multilateral agency.

If the public commitments and spending show a medium priority to reducing levels of chronic malnutrition, what can we say about DFID's human resource expertise on chronic malnutrition? When we asked interviewees how many people in their department or team would identify themselves as "nutrition specialists" most replied that a number of people might have some nutrition expertise but few if any were dedicated "nutrition specialists" (with the exception of the Africa division that has two "nutrition specialists"). While this number seems low, it is worth reflecting on whether we might have generated

[12] We attempted to get precise amounts on this from UNICEF, but staff were unable to help us within our timeframe.

a similar answer had we asked about “education expertise” or “agriculture expertise”. Moreover we cannot place this level of expertise in the context of overall staff levels or in the context of other agency malnutrition expertise levels. Even with these two caveats, the number of nutrition specialists seems very low for an agency committed to reductions in MDGs which can be very effectively attained through improvements in infant nutrition status.

4.2.3. Perceptions

From our HQ interviews with DFID staff (n=12) the modal perception is that chronic malnutrition is a low but rising priority. The low priority assigned by interviewees reflects the general sense that DFID does not see itself as a champion in this area. The sense of upward movement in its priority is interesting and may in part reflect the fact that we as interviewers asked about chronic malnutrition. Interviewees generally saw nutrition as one of many competing poverty issues for DFID albeit one that deserved more attention than it is currently given (with the exception of the economists we spoke to who emphasised this less so). One point made by a number of respondents was that DFID does a lot on nutrition already – directly and indirectly – but it is not necessarily labelled as nutrition and thus it is the invisibility of nutrition that in itself might hinder raising its profile at DFID.

Table 6: Perceptions of DFID HQ Staff on the Priority of Chronic Malnutrition for DFID

	Priority				
	High	Medium	Low	Not sure	Total
Rising	2	1	5	0	8
Stationary	0	0	0	0	0
Falling	0	0	0	0	0
Not Sure	1	1	1	1	4
Total	3	2	6	1	12

From our interviews with DFID country staff (n=6) the perceptions are summarised in Table 7. In Afghanistan and Zimbabwe DFID staff reported chronic malnutrition to be a medium level priority but rising in their country office. In Bangladesh, chronic malnutrition was reported to be a medium-high DFID-Bangladesh priority but whether this was rising or falling was uncertain. In DFID Nigeria the priority was thought to be low and in DFID Ethiopia it was thought to be medium. In both Nigeria and Ethiopia the direction was unclear. In Sudan both the current level of prioritisation and direction was unclear. Of course, all of the above country perceptions should be treated with some caution as they are based on one interview albeit of a senior DFID country staff in the relevant country.

Table 7: Perceptions of DFID Country Staff on the Priority of Chronic Malnutrition for DFID

Priority	Afghanistan	Bangladesh	Ethiopia	Nigeria	Sudan	Zimbabwe
High		x				
Medium	x	x	x			x
Low				x		
Not sure					x	
Rising	x					x
Stationary						
Falling						
Not sure		x	x	x	x	

4.2.4. DFID Summary

DFID seems to have a very good understanding of the nature of the problem of chronic malnutrition and the types of interventions that are needed to deal with it. But it is clear to us that DFID does not see itself a key leader in rallying support from others to address chronic malnutrition. The current focus in DFID is on improving developing country (and donor) governance. As we have argued in section 2 of this report, this governance focus is more than consistent with improvements in nutrition – indeed a persistently high or increasing level of chronic malnutrition in children is one of the most visible indicators of failed governance. The levels of technical capacity in DFID for addressing chronic malnutrition are difficult to assess definitively but they seem low, perhaps reflecting the low levels of spending on direct nutrition interventions. Spending on indirect nutrition activities is just above average for donors. Some multilateral spending to the Rome based UN food agencies is earmarked toward specific nutrition activities in line with the receiving agency's priorities.

4.3. The EC: Commitments, Spending and Perceptions

4.3.1. Public Commitments

The European Commission does not have an explicit focus on chronic malnutrition although food security is one of their main priorities in development cooperation. In speeches and press releases nutrition is only mentioned in terms of crisis, although there are several instances that highlight the EC's new focus on food security as one of the new seven thematic programmes (see Annex Table 3 and 4 and Annex Box 2). 'The European Consensus on development' (2006), which sets out the priorities for EU and EC development cooperation, highlights food security as a priority area and within this the focus is on prevention, on improving the access to food, on the quality of food and on capacity development for food security (p. 13).

Within the food security strategy, framed by two different documents[13], the EC policy is aimed at integrating food availability and access and the prevention of food crises at the centre of poverty reduction strategies. The policy also sees 'hidden hunger' (vitamin and mineral deficiency) and the multidimensional aspects of food insecurity as neglected areas in development cooperation.

The policy prioritises tackling the underlying causes of food insecurity: regionally and nationally; at a household level; and at an individual level, where specific nutrition activities may be undertaken. These include nutrition education, health interventions and income transfers, and should be targeted at the most vulnerable (women and children) (FSBL, p. 9). The EC favours budgetary support and capacity building where appropriate (FSBL, p. 14), but in countries with weak institutional frameworks support is channelled through projects, NGOs or international agencies. The aim is to move away from food aid except in crisis situations (FSBL, p. 16). The health strategy[14] refers to malnutrition as a health condition, but does not specify specific nutritional programmes under health. The gender-nutrition link is not acknowledged in the gender strategy[15].

4.3.2. Spending

The CRS data show that the EC spends very little on direct nutrition activities (Figure 1), explained by a preference for more broad-based food security interventions. However, the food security strategy does highlight the need for some direct activities. The EC has increased the support for indirect activities and the majority of this investment is into food security programmes, with 441 million Euros allocated to the food security budget line in 2006. However, the impact on nutritional status of this type of intervention is notoriously difficult to ascertain. In terms of multilateral aid (Annex Table 5), the EC is moving toward more earmarking of funding (unlike DFID which is moving toward more core funding), but nothing to direct nutrition interventions at the moment. Quite a substantial amount is allocated to indirect projects that could impact on nutritional status, specifically food aid to WFP and food security to FAO, water and sanitation and girl's empowerment to UNICEF and a substantial amount to the World Bank in Ethiopia for funding for the Productive Safety Nets programme.

As before we asked interviewees how many people in their department or team would identify themselves as "nutrition specialists". As with DFID, most EC interviewees replied that a number of people might have some nutrition expertise but few, if any, where dedicated "nutrition specialists" (with the exception of two nutrition experts in the department of Human Development,

[13] Food Aid/Food Security Budget Lines, Programming Document 2005-2006 (FSBL) (DEV/5459/05-EN) and Communication from the Commission to the Council and the European Parliament, Thematic Strategy for Food Security (COMM(2006) 21 final)

[14] Communication from the Commission to the Council and the European Parliament, Health and Poverty Reduction in Developing Countries (COM (2002) 129 final)

[15] Regulation (EC) N° 806/2004 of the European Parliament and of the Council of 21 April 2004, Promoting gender equality in development co-operation

Social Cohesion and Employment and nutrition experts in ECHO working on acute malnutrition issues).

4.3.3. Perceptions

From our interviews with EC HQ (N=10) staff there was a perception that the current prioritisation is high and stationary although the degree of consensus was weaker than at DFID. The reasons given for the high priority included: (a) the EC is one of the highest spenders on food aid, (b) because of the food security budget line, (c) because of the work of ECHO (i.e. nutrition is seen as an emergency issue), and (d) because of the emergence of nutrition in EC documents, like the new seven thematic programmes, which includes the "investing in people" budget line.

Table 8: Perceptions of EC HQ Staff on the Priority of Chronic Malnutrition for the EC

	Priority				
	High	Medium	Low	Not sure	Total
Rising			1	1	2
Stationary	4.5	1	0.5		6
Falling					0
Not Sure		1	1		2
Total	4.5	2	2.5	1	10

Unfortunately, we experienced severe difficulties in getting responses from EC country staff. We were only able to interview EC staff in Ethiopia and Afghanistan. Their perceptions were as follows. In Ethiopia the EC interviewee reported a high level priority given to chronic malnutrition but was uncertain about future changes in priority. In Afghanistan the EC interviewee was not clear about the current level of priority given but felt it was not going to change much in the foreseeable future.

4.3.4. EC Summary:

Spending on direct nutrition programmes is low, both in terms of bilateral and multilateral aid. The increased focus on food security in EC policy papers, speeches and public declarations is a potentially positive development for chronic malnutrition reduction and this is reflected by the high spending on indirect nutrition interventions. Perceptions of the HQ staff interviewed reflect this – there is a sense that the priority given to chronic malnutrition is quite high. However the sparse attention paid to the nature of the links with malnutrition reduction means that the large potential embedded in these developments is at risk of not being realised.[16]

[16] Much of the ECs work on nutrition is through ECHO. We classified ECHO as more focused on acute malnutrition. If ECHO's work reduces acute malnutrition then there is a potential to contribute to reducing chronic malnutrition.

5. DFID and EC in the Six Country Case-Studies: Public Commitments and Expenditures

To get a better sense of how the global priorities, concepts and messages mesh with country level activities, we focused on 6 countries.

5.1. The Nutrition Situation in the Six Countries

Annex Table 12 describes data on underweight (low weight for age) rates and stunting (low height for age) rates for children under 5 years of age in Afghanistan, Bangladesh, Ethiopia, Nigeria, Sudan and Zimbabwe.

In terms of the underweight indicator Afghanistan and Bangladesh are on target to meet the MDG goal 1; Nigeria shows progress, but not enough to meet the MDGs. Ethiopia, Sudan and Zimbabwe are showing no change or are moving away from the goal.

Assuming changes in stunting rates match the changes observed in underweight rates, the number of stunted under fives will increase in Afghanistan by 13% between the survey date and 2015 (despite being on track in terms of % of under fives meeting underweight targets) primarily because of large projected increases in the under five population. The corresponding % increases in Sudan, Zimbabwe, and Ethiopia are 55, 27 and 26. In Bangladesh the number of stunted under fives is projected to fall by 22% between survey date and 2015. In Nigeria, the number of stunted under fives is projected to fall by 9% from survey to 2015 because of modest declines in the percent of under fives that are stunted and the relatively small increases projected in the under five population.

In terms of year on year increases in projected numbers of stunted children, Ethiopia is top with an increase of 111,000 per year, with Bangladesh showing the biggest year on year decline of -142,000.

The costs of failing to strengthen action to address chronic malnutrition are clearly going to be largest in Ethiopia, Sudan and Zimbabwe.

5.2. DFID and EC Approaches to Chronic Malnutrition in the Six Countries[17]

Table 7 has already given us a sense of what DFID country staff perceive to be the level and trajectory of the priority given to chronic malnutrition by their country offices. From reading the DFID CAPs for the 6 countries our conclusions accord with those in Table 7: medium/high priority for Bangladesh and Ethiopia; medium for Zimbabwe, low for Nigeria and Afghanistan and unclear for Sudan. Based on our assessments (as Annex Table 7 shows), the EC documents (typically Country Strategy Papers) give a similar ranking of countries but tend to give a slightly higher priority to chronic malnutrition than

[17] Please see Annex 2 for a further discussion.

do the DFID documents: high for Ethiopia in accordance with country staff interview, high also for Bangladesh and Sudan, medium for Afghanistan, low for Nigeria and unclear for Zimbabwe.

The staff interviews and the document analyses do not, however, correspond to the CRS data in Table 9, which shows absolute investment in direct nutrition interventions. There is no record of any EC investment at all and DFID has spent very little in these countries. This can again be explained in some part by both the EC's and DFID's emphases on more long-term, food security and livelihoods approaches, respectively.

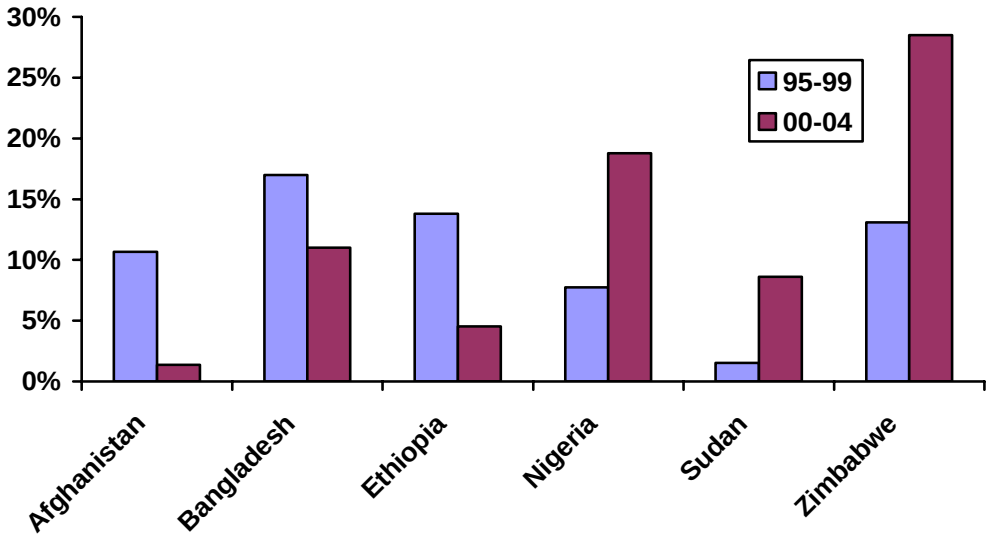
Table 9: Direct Interventions in Case-Study Countries

Millions of USD	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Afghanistan										
DFID	0	0	0	0	0	0	0	0	0	0
EC	0	0	0	0	0	0	0	0	0	0
Bangladesh										
DFID	0.262	0	0	0	0	0.025	0	0	0	0.275
EC	0	0	0	0	0	0	0	0	0	0
Ethiopia										
DFID	0	0	0	0.285	0	0	0.183	1.664	0	0
EC	0	0	0	0	0	0	0	0	0	0
Nigeria										
DFID	0	0	0	0	0	0	0	0	0	0
EC	0	0	0	0	0	0	0	0	0	0
Sudan										
DFID	0	0	0	0	0	0	0	0	0	3.678
EC	0	0	0	0	0	0	0	0	0	0
Zimbabwe										
DFID	0	0	0	0	0	0	0	0	0	0.650
EC	0	0	0	0	0	0	0	0	0	0

Source: CRS Online

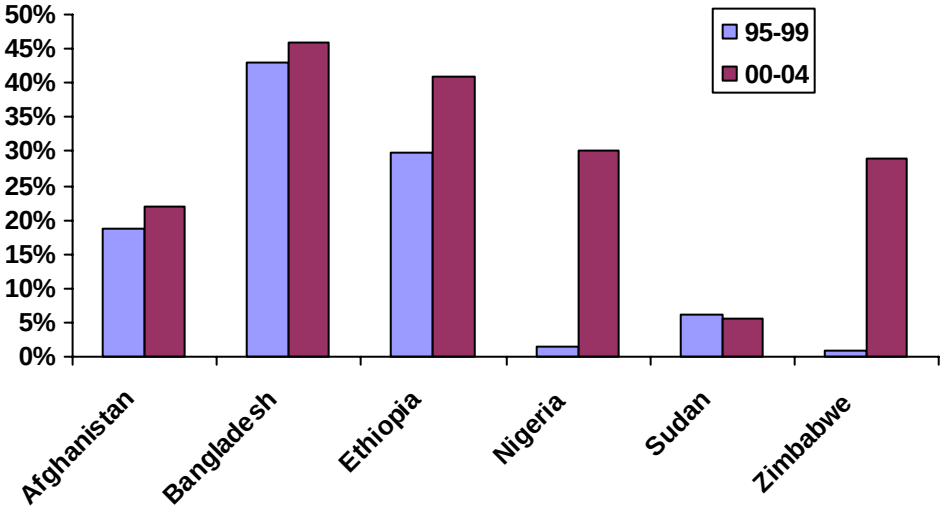
There is also a lack of correspondence between staff interviews and the document analyses with the CRS data in Figures 3 and 4 in terms of percent of ODA to indirect nutrition interventions. This is more troubling and we cannot offer sensible explanations for the difference. We can only recall the reservations and caveats related to the CRS data describe in section 3 and Annex 3 of this report and suggest that we can expect the validity of the CRS data to be even lower at the country level. Hence these numbers need to be further investigated at the country office level if they are to provide answers to commitment to chronic malnutrition. The most likely explanation is that although the interventions we have identified as indirect will have an effect on chronic malnutrition, this may not be the intended purpose of the projects and thus the spend on indirect interventions do not necessarily provide evidence of commitment toward tackling chronic malnutrition.

Figure 3: Percentage of UK ODA Spend on Indirect Nutrition Interventions



Source: CRS Online

Figure 4: Percentage of EC ODA Spend on Indirect Nutrition Interventions



Source: CRS Online

The correspondence between national government and DFID/EC priorities in chronic malnutrition – as indicated by our assessments of policy documents – is also a vital piece of contextual information to assess donor priorities. If the correspondence is high then a given donor priority is more easily explained. As can be seen in Annex Table 7 the disconnects between levels of priority are not large, perhaps with the Afghanistan documents displaying the most obvious differences in emphasis.

Afghanistan: The Public Nutrition Policy and Strategy shows that the Afghan government has a good understanding of the types of interventions needed although the rest of the PRSP does not really reflect this. For instance,

poverty surveillance could include nutrition surveys and a benchmark for reduced levels of chronic malnutrition could be set. But the three documents do place a relatively high priority on chronic malnutrition, which is reflected within the EC CSP and NIP through the focus on food security and health sector support. The DFID country strategy does not explicitly reflect this priority, although there is potential for chronic malnutrition work to be done through the alternative livelihoods programme area.

Bangladesh: In terms of the interim PRSP objective of human development for the poor, DFID do prioritise maternal mortality reduction and improved access for women and girls to food, water and sanitation. The EC CSP focuses more on supporting the HNPSP, although the DFID document was written before the HNPSP was finalised.

Ethiopia: There is a great deal of consistency between DFID, EC and government documents: agriculture is the number one priority in all. This is entirely defensible, but the failure to realise that some forms of effective agriculture-led industrial development will be more infant nutrition-friendly than others is disappointing.

Nigeria: All the documents place a low prioritisation on nutrition. Drivers and impediments are not mentioned. Neither is there any clear conceptualisation of chronic malnutrition. There is a strong consistency between the EC, DFID and PRSP on economic development and promoting a more efficient and responsive government.

Sudan: There is no PRSP for Sudan due to the political situation although a draft I-PRSP is in circulation with an unclear status. In terms of the correspondence of DFID and EC country plans, the DFID CES places an ambiguous priority on nutrition. Priorities include humanitarian aid and policies for poverty reduction. However, nutrition is only mentioned once. In contrast, the EC CSS places a high priority on nutrition (it is one of the EC's two focal sectors under food security – the other is education). Food security (in all its dimensions) is ranked as the number one priority for future EC-Sudan cooperation and nutrition even has a ‘performance indicator’ (reduction in the under 5 malnutrition rate over 5 years).

Zimbabwe: There is no PRSP for Zimbabwe due to the political situation in the country and there is no DFID CAP or EC CSP for Zimbabwe. On the DFID website, food security and protection of orphans and vulnerable children are stated objectives and through these objectives DFID target the chronically malnourished. DFID also funds a nutritional surveillance project run by UNICEF. The EC also focuses on food security, with a variety of projects, and supports the health sector, but with no particular focus on chronic malnutrition.

6. The Drivers and Impediments Shaping DFID and the EC's Policy Space for Chronic Malnutrition

Our assessment is that DFID and the EC assign chronic malnutrition a medium level of priority – although much of this assessment depends on just how nutrition-friendly the indirect nutrition interventions are.

This section asks the question "what shapes the possibilities for a higher priority?" As such it applies the context-message-connector model described in section 3 to the DFID and EC staff interviews from HQ and from the 6 countries.

6.1. The Context – the Institutional Incentives

DFID and EC staff identified a number of institutional disincentives or obstacles to raising the profile of chronic malnutrition. These relate to the incentives that drive decision-making within the agencies, both domestically and internationally. They fall into three categories: (a) the absence of nutrition indicators in key reporting frameworks; (b) the absence of pressure from key stakeholders and (c) issues relating to the nature of chronic malnutrition.

Absence of nutrition indicators from reporting frameworks: Both DFID and the EC staff raised the importance of the nature of agency reporting requirements for influencing priorities and action. For DFID, the Secretary of State is publicly accountable for the delivery of the PSA 2008 targets. These targets are explicitly linked to the MDGs. For MDG-1 on poverty, the indicator chosen is the dollar a day measure of poverty. If a reporting indicator is in the PSA it cascades down into Director's Delivery Plans (DPPs) and through to country level planning (See Annex Box 1). In reality, the underweight indicator of poverty is a much more reliable guide to changes in poverty levels than the dollar a day measure. Specifically, and unlike the latter, it does not depend on adjusting prices over place and time – always a controversial task. It cannot be reported on an annual basis because it is not collected on an annual basis, although the marginal costs of collecting and analysing underweight data annually in DFID/EC priority countries would be extremely modest. The EC has no PSA equivalent (although it does, of course, have the usual financial reporting requirements), but in a developing country's CSP there is a 'framework of indicators' that are used to assess EC programmes. However, in the CSPs we analysed for our country case studies, there were few nutrition indicators mentioned.

The technical case for increasing the use of nutrition indicators as measures of poverty is strong. The increased use of such indicators would sensitise those who have to monitor and meet targets relating to them. This would likely sensitise actors to the key importance of reducing chronic malnutrition.

Absence of pressure from stakeholders in prioritising chronic malnutrition: The importance of parliamentary oversight of DFID and the EC by the House of Commons Select Committee on International Development and European Parliament Development Committee respectively were raised in interviews. If

these bodies do not emphasise chronic malnutrition, the pressure on DFID and the EC to do so is diminished. Both House of Commons and European Parliament Committees can instigate enquiries and may be triggered to do so. The reports of such committees sometimes get significant press coverage raising their leverage. Additionally parliamentarians can place questions requesting information on what DFID and the EC are doing on an issue particularly so if it relates to a public commitment made by DFID and EC. Civil servants pay attention to the reports of their departments' committees, questions tabled and relevant debates in respective parliaments.

For the EC, the priorities of EU members are important. If an EC member state raises the issue of chronic nutrition the EC could convene a discussion of member states on key issues, actions and priorities for action including improved coordination of action across EU member states.

Many of those interviewed in both DFID and the EC argued that if nutrition was not on the radar of developing country partners, notably in the PRSPs, then they were constrained in what they could or could not do due to the coherence agenda. Further, they said, in a world of direct budget support, how much influence do donors have? Clearly, if PRSPs become more important for informing PSAs, DPPs and CSPs which is likely, the use of underweight indicators in the PRSPs will become more important for influencing DFID and EC activities in chronic malnutrition.

In terms of institutional pressure from international stakeholders, our interviewees saw UNICEF as having many objectives – with efforts to address chronic malnutrition being no higher than many of their other priorities. The interviewees saw FAO as politically weak and not a strong enough partner to enable a higher profile chronic malnutrition agenda.

The nature of chronic malnutrition: Other contextual factors relating to the nature of nutrition itself were raised by DFID and EC staff as impeding their prioritisation of nutrition. A very common response related to the multi-sectoral nature of nutrition. Every sector can affect it, but no sector has the sole responsibility to address it. Further it was noted that chronic malnutrition unlike say, security or HIV/AIDS, is not an issue in rich countries and this hinders donor ability to act on the basis of a strong domestic understanding or constituency on the nature, causes and consequences of the problem. The physiological 'invisibility' of malnutrition was also a common refrain – it is a major contributor to mortality, but it is rarely cited as the cause of death in official documents.

6.2. The Message – Lack of a Simple Story

From our interviews, it was clear that DFID and EC staff do not find the nutrition 'policy narrative' compelling. Most respondents recognised the devastating consequences of chronic malnutrition, but:

Sectoral approaches are not easily applied to the multisectoral causality of chronic malnutrition: The disconnect between the need to support countries

through sector-wide policies and the need to coordinate actions across sectors was seen by many as insurmountable.

Regional prioritisation and targeting is problematic: There is a perception amongst some respondents that the underweight and stunting data at the sub-national levels are weak and hinder regional prioritisation and targeting. Certainly compared to poverty mapping exercises, this is probably true.

The lack of a silver bullet or even a small set of silver bullets: While it was understood that there are some direct nutrition interventions that work well in effectiveness and cost effectiveness terms and are well documented as such, there was a sense that these would have to exist within the much more diffuse indirect nutrition interventions. There was much less of a sense as to how these indirect interventions map into nutrition outcomes. The yearning for a silver bullet solution is somewhat incongruous set against DFID's White Paper emphasis on the often complex politics of the development process.

Lack of attribution: Connected to the previous point, attribution of impacts of a specific intervention is increasingly important in a results-based environment where the delivery of improved outcomes is increasingly stressed.

Conceptual confusion: Our interviewees reported that the chronic/acute malnutrition demarcation is unhelpful as it reinforces the disconnect between the media-driven interest in acute malnutrition and the invisible but more widespread consequences of chronic malnutrition.

No clarity on what constitutes comparative advantage in this area: It was not clear to DFID and EC policymakers why DFID or the EC might have a comparative advantage and the tools to act.

Lack of resonance between the need to address chronic malnutrition and the predominant policy framework: For DFID this is governance. For the EC this is growth and governance. This represents a challenge to the connectors, but one that is far from insurmountable as we have argued in section 2.

6.3. The Connectors – Few, Isolated and Lacking in Visibility

DFID and EC policymakers both reported that often the institutional champions of nutrition are few, isolated and invisible. This was thought to be a reflection of weak institutional incentives and the confused narrative. But it was also thought to be a consequence of nutrition's ambiguous sectoral home, vis-à-vis the sectoral perspectives embodied in SWAPs and Direct Budget Support.

The void left by the lack of a formal institutional champion in DFID has resulted in the formation of an informal virtual nutrition working group within DFID, building on the work of the DFID Africa Hunger Task Force. DFID's new health strategy (yet to be published as of date of writing) will likely help with this, as it will include a draft institutional mapping of where nutrition should sit within DFID. In DFID country offices the role of nutrition champions

has been influential (especially so in Ethiopia and Bangladesh) in promoting nutrition in the country office.

In the EC there seem to be fewer 'connectors' or 'champions' though the vice-chair of the European Parliament Development Committee has a nutrition background. In the context of EC policy coherence debates, as noted above, if one member state and/or the European Parliament Development Committee raised the issue, an EC dialogue on nutrition related issues could be influential, so there seems to be scope for a champion to leverage interest.

Internationally, as noted above, UNICEF is not seen as a strong connector due to its many competing objectives, with nutrition being seen as neither the highest nor the lowest. FAO is viewed as politically weak. In terms of bilaterals, the Dutch and the Norwegians have expressed interest in prioritising nutrition but their ODA levels are such that they cannot be as influential as DFID or the EC.

Table 10 summarises our findings from the interviews.

Table 10: Findings on the Nature of the Policy Space from Interviews with DFID and EC HQ and Country Staff

	Context	Message	Connectors
DFID			
Drivers	MDGs; political pressure – especially from country partners, international system partners; PSA - inclusion of nutrition currently under discussion.	Using 'hunger' term; links to social protection, links to radicalisation, extremism, links to growth; reform of humanitarian response towards chronic malnutrition; identifying nutrition-governance links; links to environment and food impacts of environmental degradation	New DFID virtual working group on nutrition; Africa Hunger TF pushing.
Impediments	Cross-sectoral nature leading to a fragmented/lack of policy coherent approach; lack of country/PRSP interest in nutrition; not in PSA and thus DDPs currently; world of budget support limits possibilities; chronically malnourished not politically important - lack voice; undernutrition does not affect rich countries; no central guidance from DFID HQ: Competing agendas and resources constraints; lack of donor coordination.	Weak policy narrative especially on attribution; lack of a clear cut and compelling case; complexity of message; politics of food aid distorts discussion on nutrition; nutrition message seen as an emergency issue; need to join chronic and acute debates together; lack of country dis-aggregated and trend data, acute malnutrition grabs headlines; chronic malnutrition is also not a very specific indicator (i.e. lots of things can affect it, not just the intervention); weakness in MDG nutrition indicators; lack of country level analysis on subject.	Lack of champion(s) and visible monitoring groups; FAO weak in international system; lack of nutrition people at country level - too expensive to have nutritionists in every country.
EC			
Drivers	MDGs and international policy	--	International partners -

	consensus.		UNICEF and NGOs talking about it more
Impediments	Limited country interest in PRSPs; limited EU member interest; resource competition between various development issues - EC limited to two focal sectors and budget support; EC driven by other priorities - growth/trade; cross-sectoral nature; world of budget support limits; limited EC capacity in terms of personnel.	Lack of nutrition data undermines message; different measures of nutrition – no standard approach; chronic/acute unclear definitions; chronic/acute - we need to break down the wall; not seen as a long term investment;	

7. Conclusions and Recommendations to Improve the DFID and EC Global Role in Reducing Malnutrition

Chronic malnutrition is widely recognised by DFID and EC documents and interviews to have a crucial role to play in reducing child mortality, morbidity and in promoting learning in school and economic productivity in the labour market.

But it is seen by the EC and DFID as a supporting investment rather than a foundational one. This is due to many reasons. First, chronic malnutrition does not fit neatly into the developing country sectoral silos that donor agencies are increasingly linking up with. Second, nutrition is seen as everybody's business and nobody's responsibility – there are few institutional champions. Third, it is not seen as linked to the governance agenda, although there are clearly opportunities for it to be useful for revealing the capacity, accountability and responsiveness of states. Fourth, within DFID and the EC there are few institutional incentives to pay attention to nutrition. Fifth, international agencies are not seen as capable or willing to support or put pressure on DFID or the EC to do more. Sixth, parliamentary bodies have no particular incentive to pressure DFID or the EC on nutrition. Seventh, as the CRS data from the DAC show, tracking spending flows on nutrition is difficult. Eighth, attributing impact on nutrition status of indirect nutrition interventions is also difficult, with little knowledge about what is a nutrition-friendly or unfriendly indirect intervention. Ninth, in the area of direct interventions there are some clear interventions (e.g. breastfeeding promotion, micronutrient supplementation, fortification) but these are seen as involving too much behaviour change (e.g. breastfeeding) or too little (e.g. supplementation) to be sustainable. Finally, the move to direct budget support and SWAPs means these direct nutrition programmes will be underfunded in the absence of nutrition champions.

Despite all of these difficulties, DFID and the EC – based on their public commitments, based on what they spend, and based on what they think – do give medium priority to nutrition. Not as much as some others – Canada, Norway, The Netherlands, and the USA – but more than some others too.

Given their medium interest in nutrition and despite the above contextual, message, and connector related impediments to moving nutrition up the agenda, we are optimistic that DFID and the EC could do more on nutrition within the constraints under which they currently operate. In addition, there seem to be several opportunities for SC UK to support DFID and the EC in this regard. We have classified the opportunities by agency and by context, message and connector.

7.1. DFID

Context

- Link nutrition to the new gender strategy – DFID has been pressured into strengthening its new gender strategy and should be many opportunities to highlight the importance of nutrition for achieving the MDGs in gender equality, health, poverty and education.
- Emphasise nutrition in the new health strategy – as in the previous point, but with a more explicit focus on nutrition.
- Emphasise the difference between 'education for all' and 'learning for all' – the UK's robust investment in the Education For All initiative (see Gordon Brown's recent trip to India) should be framed by the need for an absence of chronic nutrition in early childhood. Going to school will not so easily be converted into learning if the infant population is chronically malnourished.
- Adopt nutrition indicators as complementary poverty outcomes in MDG-1 and PSAs. As indicated, nutrition indicators of poverty are not so susceptible to alternative constructions and are consistent over space and time.
- Use infant nutrition as a measure of Capacity, Accountability and Responsiveness of governments in new DFID country governance ratings promised in WP3. Static or increasing levels of chronic malnutrition in the presence of increasing GDP per capita are evidence of bad governance.
- Make policy links across Whitehall in terms of the new UK Sure Start and new maternity benefits legislation. Learn from domestic UK policies designed to intervene in early childhood and in pregnancy in the UK to protect the child and protect social cohesion.

Message

- Conduct a nutrition audit of current indirect nutrition spending (see best practice Table 13 in Annex). This would essentially be a thematic baseline assessing how nutrition-friendly the current indirect nutrition portfolio is, with follow ups to determine improvements or worsening.
- In CRD, fund some work on generating new cost-effectiveness studies of direct nutrition interventions (the current generation of estimates date from the 1990s).
- Link up with the Gates Foundation on this issue – DFID is looking for complementarities with Gates – this may be one area, documenting experiences from Gates-funded interventions.

- Introduce chronic malnutrition concerns into the various PovNet working groups at the DAC.
- Build malnutrition outcomes into work on safety nets, water, education and health, i.e. embed nutrition indicators into M&E work, for example into the evaluation of the Ethiopian Productive Safety Nets Programme.

Connectors

- Appoint a nutrition champion, preferably someone who can connect nutrition with other departments in DFID and with nutrition focal points in each country office. The appointment of a Chief Scientist has raised the profile of DFID in science and helped it create links with other agencies. The same is needed in early childhood development, with the brief including early childhood nutrition issues. This idea was floated in the Eliminating Hunger but as far as we can tell there has been no follow up.
- Support the UN Standing Committee on Nutrition. This is a highly professional and active Committee that meets once a year and has 9 working groups. The Committee brings together 3 groups: the multilateral agencies (UN, World Bank, CGIAR), the bilateral donors (with the glaring absence of DFID) and civil society (mainly NGOs but also many leading researchers). DFID can play a key role in getting issues of governance onto the table, thereby putting pressure on other bilaterals and multilaterals and civil society to consider how a governance approach might improve their own chronic malnutrition work.
- Set up a Research Programme Consortium on Chronic Malnutrition to link up with the Chronic Poverty Centre and Young Lives. Neither of the latter two research programmes have chronic malnutrition as a core activity. The high levels of chronic malnutrition in DFID priority regions in South Asia and sub-Saharan Africa surely warrant a targeted approach bringing together the sciences and social sciences in a way that embeds them within action on the ground.
- To partner with other organisations to maximise their nutrition investments, e.g. the Ending Child Hunger and Undernutrition Initiative of WFP and UNICEF
- Include nutrition in competency frameworks for at least 2 professional cadres – livelihoods and health.

7.2. EC

Context

- Adopt more nutrition indicators into CSPs. As for DFID, the EC should look to adopt nutrition indicators as complementary poverty outcomes in MDG-1 and the CSPs. As indicated, nutrition indicators of poverty are not so susceptible to alternative constructions and are consistent over space and time.
- Link nutrition to the economic growth (see Annex Figures 4 and 5) and governance (as above) narratives.

- Link up chronic malnutrition work with acute malnutrition work at ECHO – who are already recognising the 'fuzzy' demarcation between the two.

Message

- Conduct a nutrition audit of current indirect nutrition spending (see best practice Table 13 in Annex).
- Fund annual nutrition surveys in high priority EC countries (as for DFID and perhaps in partnership with them).
- Fund additional nutrition research work in Framework 7 (involving nutrition institutes across Europe).
- Introduce chronic malnutrition concerns into the various PovNet working groups at the DAC.
- Adopt the theme of malnutrition/food/hunger in one of the early European Development Reports (EDR) (The EC and some Member States intend to launch a process which will lead to the publication of the first EDR in March 2008. In addition to the annual EDR there will be background papers, seminars and workshops).

Connectors

- Appoint a nutrition champion, preferably someone who can connect nutrition with all the other sectors and EC country focal points.
- Support UN Standing Committee – put pressure on bilaterals and multilaterals and civil society (as with DFID).
- Offer to host the 2008 SCN Conference in Brussels; ask 2-3 European organisations to organise it with the SCN secretariat.

7.3. Save the Children UK

Context

- Lobby to get more nutrition indicators into key institutional reporting requirements.
- Develop a strong dialogue with European Parliament Vice Chair of the Development Committee – perhaps encourage the SCN to invite the VC to give a keynote at the SCN meetings.
- Work with the UK's House of Commons Select Committee on International Development – to ask them to pose questions that would help outline DFID's thinking behind its decision not to prioritise chronic malnutrition issues. As with the European Parliament Committee one can identify those with interest or backgrounds in nutrition as key connectors.
- Identify key backbenchers in the House of Commons and European Parliament who might wish to table written and/or oral parliamentary questions regarding meeting DFID's nutrition commitments, and/or request (adjournment) debates on the subject.
- Review SC UK's own commitments (speeches, spending and thinking) on chronic malnutrition.

Message

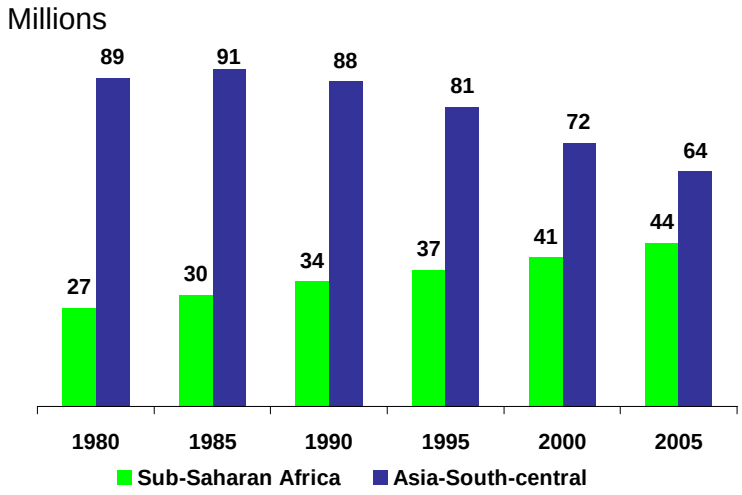
- Develop an accessible slide show with the key nutrition facts showing the scope and consequences of inaction on child malnutrition.
- Link malnutrition to governance and rights language. SC UK has strengths in this area and it should build on them.
- Emphasise that the MDGs which are lagging the most (maternal mortality and child health) are reliant on good infant nutrition and convey this to the International Development Committee.
- Pressure DFID and the EC to undertake a high-profile report on the Economics of Child Undernutrition, similar to the one undertaken by Nick Stern for the UK Treasury on the Economics of Climate Change
- Push for the adoption of the theme of malnutrition/food/hunger in one of the early European Development Reports.
- Push for the respective parliamentary committees to enquire into the nutrition MDGs.

Connectors

- Use the Young Lives programme to connect up to the domestic child poverty agenda of a potential Gordon Brown-Hilary Benn, PM-Deputy PM partnership.
- Ensure chronic malnutrition is embedded in the 2008 Chronic Poverty Report produced by the University of Manchester and ODI.

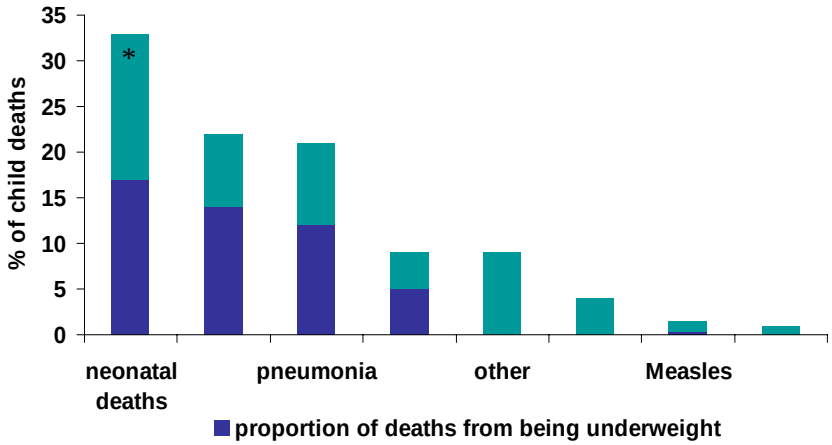
Annex 1: Tables and Figures

Figure 1: Child Malnutrition numbers are Increasing in Sub-Saharan Africa and Still Very High in South Asia



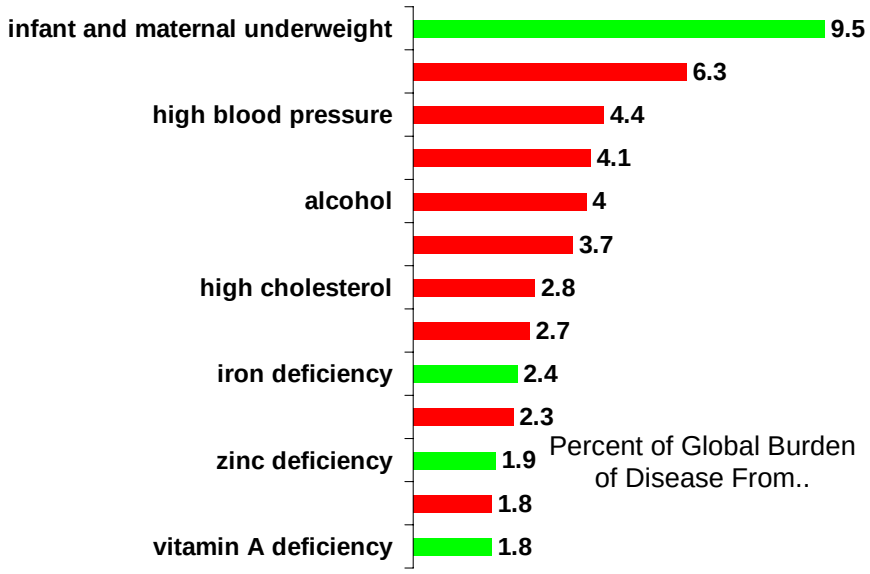
Source: Based on estimates from de Onis and Blossner 2003

Figure 2: Child Malnutrition is Responsible for Half of All Child Deaths



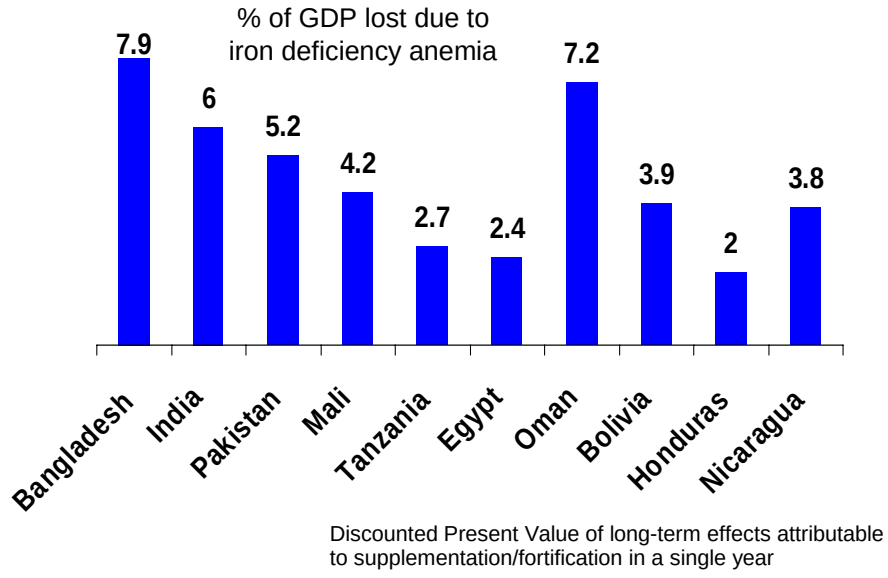
Source: Black RE, Morris SS, Bryce J 2003

Figure 3: Infant and Maternal Malnutrition is Leading Cause of Disease



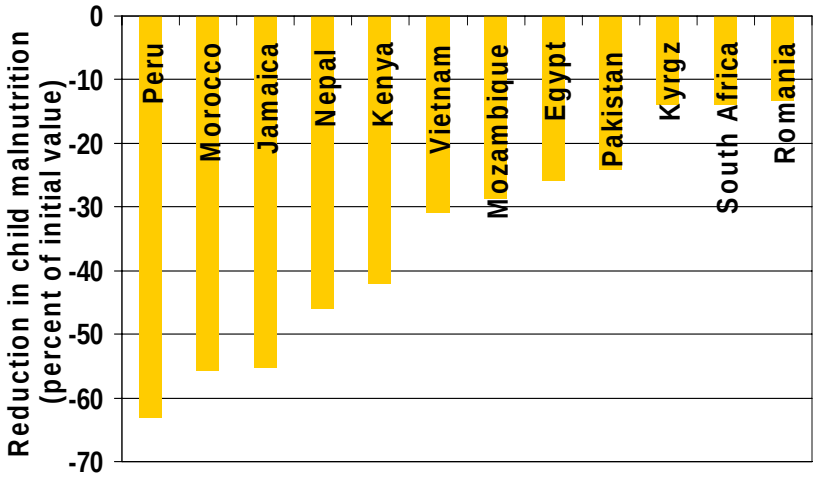
Source: Ezzati et. al. 2002

Figure 4: Economic Costs of Malnutrition are Enormous



Source: Horton and Ross 2003

Figure 5: Income Growth does not Reduce Child Malnutrition Quickly Enough



Decline in child malnutrition due to 2.5 percent annual growth in per capita income, 1990s to 2015

Source: Haddad, L. et. al. 2004.

Figure 6: DFID HQ Organogram

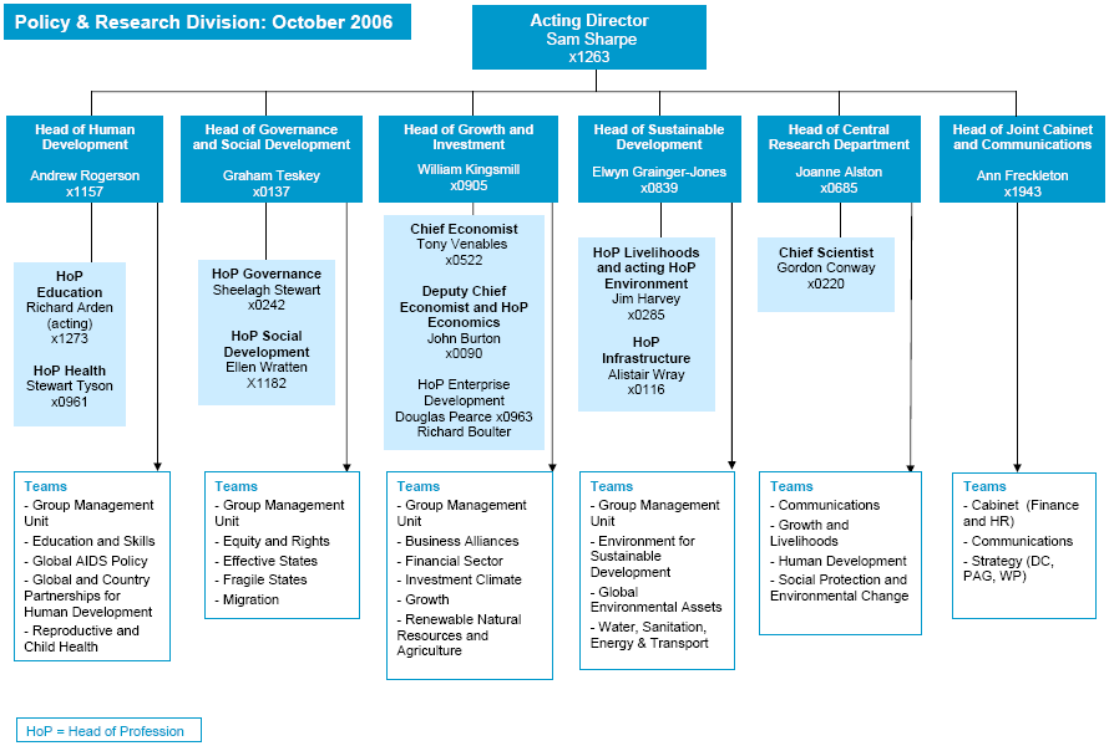


Figure 7: EC HQ Organogram

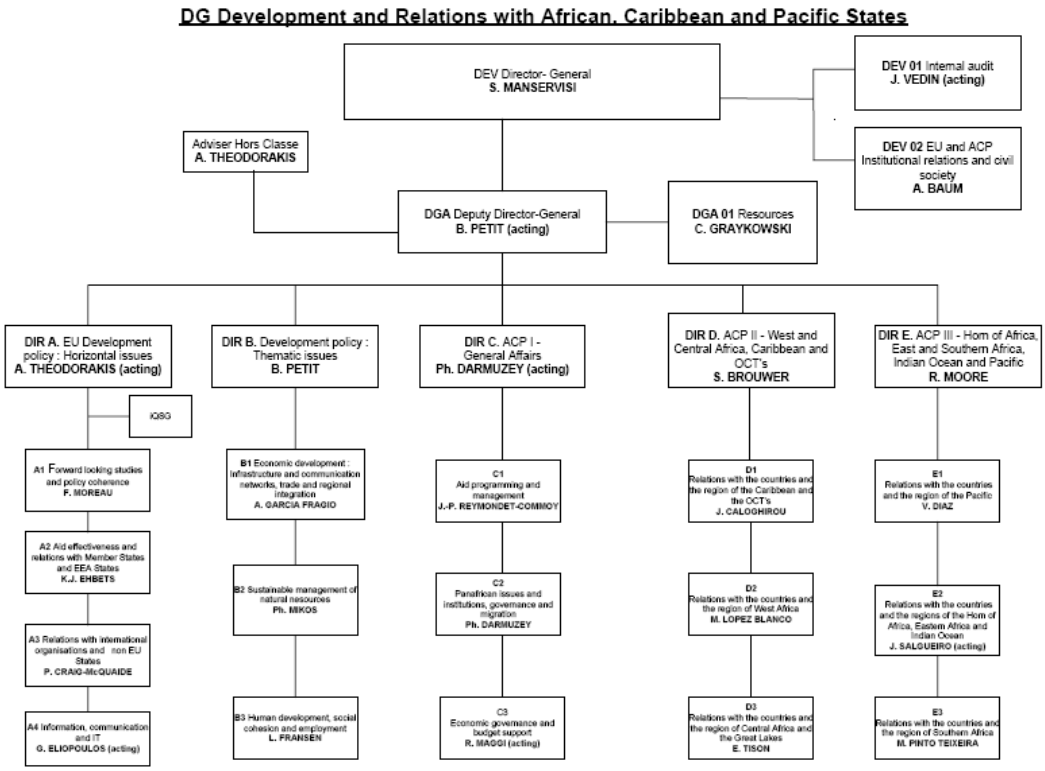


Table 1: Direct Interventions for the Top Ten Bilateral Donors and the EC (Figure 1)

Millions of USD	Can	Fra	Ger	Ita	Jap	Net	Spa	Swe	UK	USA	EC
1995-1999											
Direct ints as % of ODA	0.42%	0.00%	0.00%	0.02%	0.00%	0.56%	0.07%	0.07%	0.04%	0.32%	0.00%
Total direct ints	54.5	2.1	1.3	2.7	1.7	103.8	6.8	7.6	9.2	183.9	1.0
Annual average	10.90	0.42	0.26	0.54	0.34	20.76	1.36	1.52	1.84	36.78	0.20
Total ODA	12993	43067	48189	13375	84654	18487	9415	10870	23695	57827	44322
2000-2004											
Direct ints as % of ODA	0.18%	0.00%	0.02%	0.16%	0.02%	0.23%	0.14%	0.05%	0.06%	0.30%	0.01%
Total direct ints	23.7	0.0	10.9	25.9	16.7	53.1	18.1	5.9	21.1	275.2	3.4
Annual average	4.74	0.00	2.18	5.18	3.34	10.62	3.62	1.18	4.22	55.04	0.68
Total ODA	13208	44218	45319	16512	77763	23406	12993	11617	34751	93136	49780

Table 2: Indirect Interventions for the Top Ten Bilateral Donors and the EC (Figure 2)

Millions of USD	Can	Fra	Ger	Ita	Jap	Net	Spa	Swe	UK	USA	EC
1995-1999											
Indirect ints as % of ODA	6.19%	2.74%	5.46%	3.49%	6.28%	3.59%	2.56%	2.45%	4.94%	7.22%	8.27%
Total indirect ints	804.3	1181.4	2631.7	467.2	5312.6	662.9	241.0	266.3	1170.4	4174.5	3664.6
Annual average	160.86	236.28	526.34	93.44	1062.52	132.58	48.20	53.26	234.08	834.90	732.92
Total ODA	12993	43067	48189	13375	84654	18487	9415	10870	23695	57827	44322
2000-2004											
Indirect ints as % of ODA	6.49%	2.63%	5.25%	3.09%	5.85%	3.14%	4.31%	2.03%	6.16%	8.23%	13.95%
Total indirect ints	857.1	1164.7	2377.5	510.7	4548.5	736.0	559.7	236.0	2141.0	7668.8	6945.2
Annual average	171.42	232.94	475.50	102.14	909.7	147.20	111.94	47.20	428.20	1533.76	1389.04
Total ODA	13208	44218	45319	16512	77763	23406	12993	11617	34751	93136	49780

Table 3: Word Count in Key Speeches, Press Releases and Documents[18]

	Nutrition/ nutritional	Mal-nutrition	Under-nutrition/ nourished	Stunting	Wasting	Under-weight
DFID						
Speeches (from Jan 2005, total number 50)	4	0	0	0	0	0
Press releases (from Jan 2005, total number 197)	4	0	0	0	0	0
Commission for Africa Report, 2005	12	12	2	1	1	1
G8 report 2005	0	0	0	0	0	0
G8 report 2006	0	0	0	0	0	0
HMG G8 Gleneagles: One Year On, 2006	1	0	0	0	0	0
Hansard (from Jan 2005)	5	0	-	0	-	2
White Paper 3, 2006	1	0	0	0	0	0
Eliminating Hunger, 2002	58	28	8	2	2	5
Better health for poor people, 2000	14	2	0	0	0	0
Poverty elimination and the empowerment of women, 2000	1	2	0	0	0	1
Social transfers and chronic poverty, 2005	11	0	0	0	0	1
EC						
Speeches (from Jan 2005, total number 28)[19]	4	0	0	0	0	0
Press releases (from Jan 2005, total number 239)	2	0	0	0	0	0
European parliament (from Jan 2005)	2	0	-	0	-	0
European Consensus on Development, 2006	1	0	0	0	0	0
Cotonou agreement, 2000	1	1	0	0	0	0
Food Aid/Food Security Budget Line, 2005	6	2	5	0	0	1
Health and Poverty Reduction in Developing Countries, 2002	3	8	0	0	0	0
Promoting gender equality in development cooperation, 2004	0	0	0	0	0	0

Sources: DFID, EC, G8 websites

[18] For Hansard and European Parliament only relevant references have been counted. Due to the amount of information, keyword searches on wasting, undernutrition/undernourished were excluded.

[19] A lot of the speeches were in French and not included in the survey.

Table 4: Key documents: Chronic Malnutrition:
Conceptualisation, Prioritisation, Drivers and Impediments

	Conceptualisation	Prioritisation	Drivers	Impediments
DFID				
Speeches (from Jan 2005)	N/A	Low	Better governance, health care, social protection	N/A
Press releases (from Jan 2005)	Hunger	Low	N/A	N/A
Commission for Africa Report, 2005	Food insecurity/ hunger/ undernutrition	Medium	N/A	None noted
G8 report 2005	N/A	Low	N/A	N/A
G8 report 2006	N/A	Low	N/A	N/A
HMG G8 Gleneagles: One Year On, 2006	N/A	Low	N/A	N/A
Hansard (from Jan 2005)	N/A	Low	Microfinance, social transfer	HIV/AIDS
White Paper 3, 2006	N/A	Low	N/A	N/A
Eliminating Hunger, 2002	Food insecurity/ hunger/ undernutrition	Medium-high	Better cross-sectoral working, focal point for food & nutrition	Indicator for MDG1
Better health for poor people, 2000	Undernutrition	Medium	N/A	Multisectoral dimension
Poverty elimination and the empowerment of women, 2000	N/A	Medium	N/A	Gendered dimension of nutrition
Social transfers and chronic poverty, 2005	N/A	Medium	Social transfers	N/A
EC				
Speeches (from Jan 2005)	N/A	Low	N/A	N/A
Press releases (from Jan 2005)	N/A	Low	N/A	N/A
European parliament (from Jan 2005)	N/A	Low	N/A	N/A
European Consensus on Development, 2006	N/A	Low	N/A	N/A
Cotonou agreement, 2000	Food insecurity/ hunger/ undernutrition	Low	N/A	N/A
Food Aid/Food Security Budget Line, 2005	Food insecurity/ hunger/ undernutrition	Medium	N/A	N/A
Health and Poverty Reduction in Developing Countries, 2002	Undernutrition	Low	N/A	N/A
Promoting gender equality in development cooperation, 2004	N/A	N/A	N/A	N/A

Box 1: The MDG Reporting Requirements of DFID

DFID's has a Public Service Agreement (PSA). The PSA sets out a departments aims and objectives and this cascades down to Directors Delivery Plans (DPP) and all country planning. The overall aim DFID's PSA is 'the elimination of poverty in particular through achievement by 2015 of the Millennium Development Goals'. The current PSA sets targets for 2008. The Secretary of State is publicly accountable for the delivery of those targets in the PSA. The DFID Management Board has collective responsibility and directors are individually accountable for their objective/targets. Directors through their delivery plans (DDPS) delegate responsibility to the teams in their department. In short, everyone at DFID is responsible for the delivery of the PSA. The PSA covers 16 African countries (88% of DFID regional aid): Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Nigeria, Rwanda, Sierra Leone, South Africa, Sudan, Tanzania, Uganda, Zambia, and Zimbabwe. The PSA also covers 9 Asian countries (87% regional aid): Afghanistan, Bangladesh, Cambodia, China, India, Indonesia, Nepal, Pakistan and Vietnam. The technical note outlines how each PSA is assessed and measured. There is a special technical note for conflict countries. Each year a full report on PSA progress is published. Joint-departmental PSA are possible (DFID has three currently).

DFID's current PSA (2005-08) does not include nutrition. MDG one is only assessed under the dollar-a-day. DFID's new PSA is currently under discussion. There has been some discussion that it might include the nutrition indicators but the government wants simpler PSA objectives and PSAs are not supposed to capture everything the department does (so qualifiers are not what the treasury wants for example).

Source: DFID website

Box 2: The MDG Reporting Requirements of EC

The EC has no PSA equivalent (although it does have the usual financial reporting requirements) but in a country's EC's CSP there is a 'framework of indicators' that are used to assess the CSP and programmes and EC delegations draw on UN consolidated statistics in their reporting. In the CSPs we analysed there were few nutrition indicators.

CSPs are country-led. There are no rigid requirements for indicators. However, if something major was missing (for example HIV) when reviewed by DG Dev HQ they would raise it with the country staff and ask for attention to appropriate indicators. If one of the EC member state raised the issue of MDG 1 on nutrition the EC could convene a discussion of member states on what are the key themes and what would be better ways of coordinating EU member states action. There could be possibly of a communication on nutrition related issues. This is unlikely to happen without external advocacy or trigger. Non-MDG targets are also worth attention. For example, there is an EC target to get 16 million people off relief and on to safety nets - by implication a chronic malnutrition target.

Table 5: Contributions to Multilateral Agencies in 2005[20]

	According to donor	According to UN agency	Earmarked funds	Nutrition spend by agency
DFID				
UNICEF	£32,428,000	Total: $159,228,000 Excl. emergency: $98,086,00	Some, but details not available	$128,278,031 (unable to split in direct and indirect)
WFP	£5,001,000 (all of WFP excl. emergency food aid)	$114,263,605	Yes – see examples in Table 11	$258,884,000 (unable to split in direct and indirect)
FAO	£4,805,000	N/A	Direct: N/A Indirect: $11,200,798[21]	Direct: $19,617,000 Indirect: $32,035,000
World Bank (IDA)	£271,175,000	N/A	No	$731,000,000 (unable to split in direct and indirect)
EC	£916,857,000	N/A	Some earmarked, but nothing for nutrition.	See rest of report
EC				
UNICEF	€73,180,000	Total: $27,844,213 (incl. emergency funding)	Direct: N/A Indirect: €43,133,614[22]	$128,278,031 (unable to split in direct and indirect)
WFP	€180,590,000	$263,940,274	Yes – see examples in Table 11	$258,884,000 (unable to split in direct and indirect)
FAO	€29,960,000	N/A	Direct: N/A Indirect: €14,163,040[23]	Direct: $19,617,000 Indirect: $32,035,000
World Bank Group	€515,623,570	N/A	Direct: N/A Indirect: €99,665,000[24]	$731,000,000 (unable to split in direct and indirect)

Sources: DFID, EC, UNICEF, WFP, FAO websites, direct contact with DFID, FAO, World Bank and UNICEF staff.

[20] Due to different reporting requirements and availability of data, all data is not from the calendar year. This information has been difficult to find for DFID. The EC produces an annual report which lists all multilateral contributions, but DFID referred us to the different agencies for data. FAO staff provided information about DFID contributions. UNICEF staff provided nutrition expenditure data, but were unable to collate information about DFID contributions in time. World Bank staff provided nutrition expenditure data.

[21] Mainly toward food security in Zimbabwe and alternative livelihoods in Afghanistan.

[22] Mainly toward water supply and sanitation and adolescent girls empowerment.

[23] Mainly toward food security programmes.

[24] More than half of this was toward Productive Safety Net Programme in Ethiopia

Table 6: Case-Study Countries: Word Count in key Documents

	Nutrition/ nutritional	Mal-nutrition	Under-nutrition/ nourished	Stunting	Wasting	Under-weight
Afghanistan						
DFID Strategy	0	0	0	0	0	0
EC CSP	5	1	0	0	0	0
PRSP	14	8	0	0	0	1
PNPS	60	69	0	6	5	5
NDF	7	7	0	0	0	0
Bangladesh						
DFID CAP	8	4	0	0	0	1
EC CSP	16	9	0	0	0	2
PRSP	151	42	0	7	3	12
Ethiopia						
DFID CAP 2003	0	2	0	2	0	0
EC CSP	3	4	0	0	0	0
PRSP	15	6	0	15	10	0
Nigeria						
DFID CAS	0	0	1	0	0	1
EC CSSIP	0	0	0	0	0	0
PRSP	3	1	0	0	0	1
Sudan						
DFID CAS	0	1	0	0	0	0
EC CSSIP	8	4	0	0	0	0
PRSP	-	-	-	-	-	-
Zimbabwe						
DFID CAP	-	-	-	-	-	-
EC CSP	-	-	-	-	-	-
PRSP	-	-	-	-	-	-

Table 7: Key Documents Related to Chronic Malnutrition in the Six Countries: Conceptualisation and Prioritisation

	Conceptualisation	Prioritisation
Afghanistan		
DFID	N/A	Low
EC	Food security	Medium
PRSP	Food security/ undernutrition	Medium
PNPS	Food security/hunger/ undernutrition	High
NDF	Food security/ undernutrition	Medium
Bangladesh		
DFID CAP	Undernutrition	Medium, high for girls
EC CSP	Undernutrition/ food security	High
PRSP	Undernutrition	High
Ethiopia		
DFID CAP 2003	Undernutrition	High
EC CSP	Food security	High
PRSP	Undernutrition	Medium
Nigeria		
DFID	N/A	Low
EC	N/A	Low

PRSP	N/A	Low
Sudan		
DFID	N/A	Unclear
EC	Food security	High
PRSP	-	-
Zimbabwe		
DFID	Food security	Medium
EC	N/A	Unclear
PRSP	-	-

Table 8: Total ODA to Case-Study Countries

Millions of USD	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Afghanistan										
DFID	15.9	12.4	12.5	11.7	5.6	17.0	48.8	167.7	112.9	224.0
EC	27.2	83.1	40.8	50.1	44.7	26.9	113.7	319.4	324.3	308.2
Bangladesh										
DFID	112.6	103.5	93.3	126.0	133.1	138.5	171.4	130.5	313.2	260.1
EC	141.3	122.3	76.6	132.3	276.0	49.4	141.1	40.7	169.6	44.7
Ethiopia										
DFID	62.1	28.4	28.6	16.5	15.3	15.2	38.0	56.0	72.0	147.1
EC	61.3	81.5	170.0	542.1	23.1	122.2	94.5	272.1	110.2	210.9
Nigeria										
DFID	16.3	16.3	18.6	22.0	26.6	30.7	45.2	53.5	48.8	126.1
EC	-22.8	-26.4	-38.7	-42.8	26.1	94.3	95.3	12.6	26.5	369.0
Sudan										
DFID	16.8	14.6	13.4	39.2	16.7	7.7	13.7	17.3	37.8	116.6
EC	36.0	8.5	27.7	101.6	6.0	103.9	28.8	22.9	49.4	143.0
Zimbabwe										
DFID	69.9	39.3	33.0	56.3	37.3	30.4	25.5	37.5	67.8	49.7
EC	35.6	31.1	-5.7	32.1	28.3	63.4	47.3	41.2	20.7	38.3

Source: CRS Online

Table 9: General Budget Support to Case-Study Countries

Millions of USD	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Afghanistan										
DFID	0	0	0	0	0	0	0	24.42	0	36.64
EC	0	0	0	0	0	0	0	0	0	0
Bangladesh										
DFID	0	0	0	0	0	0	11.90	0	0	0
EC	0	0	0	0	0	0	0	0	0	0
Ethiopia										
DFID	22.96	0	0	0	0	0	0	0	18.77	36.64
EC	18.03	2.89	0	104.9	0	6.60	33.92	56.82	0	118.1
Nigeria										
DFID	0	0	0	0	0	0	0	0	0	0
EC	0	0	0	0	0	0	0	0	0	0
Sudan										
DFID	0	0	0	0	0	0	0	0	0	0
EC	10.16	3.03	0	0	0	71.50	0	0	0	5.20

Zimbabwe										
DFID	34.44	0	0	0	0	0	0	0	0	0
EC	7.06	18.99	0	0	0	3.42	0	0	0	0.08

Source: CRS Online

Table 10: Indirect Interventions in Case-Study Countries

Millions of USD	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Afghanistan										
DFID	6.20	0	0	0	0	0	0	1.92	0.98	4.99
EC	0	7.37	7.91	6.24	24.17	2.28	7.10	92.47	61.47	76.48
Bangladesh										
DFID	6.21	7.79	12.07	20.57	49.59	65.12	2.68	4.75	13.13	21.21
EC	45.26	68.27	54.24	39.92	112.35	65.82	98.93	2.01	14.06	24.85
Ethiopia										
DFID	13.63	0.69	0	0.04	6.45	0.95	0.87	2.86	2.80	7.38
EC	40.37	30.48	54.22	87.79	48.59	114.43	98.43	62.43	19.47	37.47
Nigeria										
DFID	4.26	0.30	0.99	0.80	1.38	20.42	2.98	29.00	4.42	(0.29) [25]
EC	0.45	0	0.14	0.99	0	77.15	85.29	0.68	16.32	0
Sudan										
DFID	0.99	0	0.54	0	0	0	0	0	0	16.62
EC	1.38	2.60	0.96	5.40	0.63	8.21	5.27	2.40	3.81	0
Zimbabwe										
DFID	0.63	0.76	19.61	9.79	0.10	2.61	8.02	36.54	12.92	0
EC	0	0.68	0.24	0.10	0	27.34	0	32.99	0.99	0.04

Source: CRS Online

[25] This number has been manually calculated due to the fact that the CRS data contained an anomaly. The original figure was $183,580,000, but $183,217,000 of this is for UN MDG support. This should not have been entered for Nigeria as the DAC total ODA does not include this figure.

Table 11: Recent Direct and Indirect Nutrition Projects in Case-Study Countries

Funder	Agency	Title	Short description	Time	Budget
Afghanistan					
DFID	GoA	Food security and surveillance (NRVA)	The proposed national surveillance system focuses on monitoring changes in food security in selected sentinel sites, and on analysing the information within a livelihoods framework	2003-2004	£536,586
DFID	IOM	Cash for work	The International Organization for Migration (IOM) proposes to establish, in close coordination with the Government of Afghanistan, DFID, and national and international organizations, the Community Stabilization Initiative (CSI) to target vulnerable groups with labour-intensive, cash-for-work and other projects.	2004-2005	£3,000,000
DFID		Microfinance Support Initiative	MISFA is a national microfinance programme which supports delivery of credit and other financial services to the poor, particularly women.	2004-2008	£3,000,000
DFID	GoA	National Emergency Employment Programme (NEEP)	This project creates minimum wage employment through labour-based public works.	2005	£18,000,000
DFID	FAO	Development of Sustainable Agricultural Livelihoods in Eastern Hazarajat		2003-2007	$5,992,655
DFID	FAO	Alternative Agricultural Livelihoods Programme	To reduce dependency on poppy cultivation by increasing on and off farm income generation opportunities in poppy growing areas.	2004-2007	£3,750,000
EC	NGOs	Implementation of BPHS	Basic Package of Health Services	2002-2004	€33,000,000
EC	GoA	National Risk and Vulnerability Assessment	Support to NRVA	?	?
EC		Horticulture – perennial crops	Major horticultural programme which includes cultivation of dried fruits, due to their high calorific value	2005-2010	€12,500,000
EC		Capacity Building of central level MoPH	Technical Assistance for external coordination and policy and planning; training in health management and surveys	2002-2004	€3,000,000
EC	NGOs	Food security/aid	Various food security and food aid projects, including projects that distribute seed, specifically targeting women and aiming at improving the diet of the most vulnerable / poorest in the project areas.	2002-2007	$65,000,000
EC (with other donors)	FAO	Special Programme for Food Security (SPFS) in Afghanistan	Preparatory Phase for Community-Based Food Production Capacity Building	2003-2007	$694,355 (total budget)
EC	FAO	Support to the Food, Agriculture and Animal Husbandry Information Management and Policy Unit (FAAHM)	Support in developing an agricultural statistics and market information system – Phase II	2006-2009	$3,841,339
EC	FAO	Strengthening National Seed Production Capacity		2003-2006	$6,911,607

		in Afghanistan			
Bangladesh					
DFID	GoB (WB)	Health, Nutrition and Population Sector Programme	This programme includes a specific nutrition component, a continuation of BINP and NNP.	2006-2011	£100,000,000
DFID		Rural livelihoods programme	To improve livelihood security of men and women living in 221,375 poor and vulnerable rural households in Bangladesh	2003-2005	£6,993,518
DFID	PASS	Nutrition Policy and Practice	To increase use of evidence-based approaches in developing and implementing relevant national programmes to reduce malnutrition in Bangladesh. It seems that this project started, the design phase was conducted by PASS, but according to PASS, due to resources constraints at DFID-B, it closed early.	2005-2011	£150,000
DFID		Support to Arsenic Mitigation	Addressing the arsenic crisis in Bangladesh, particularly for the poor, through improved knowledge, awareness and delivery mechanisms, including support to the Government Arsenic Policy Support Unit	2002-2005	£1,000,000
DFID		Adv Sustainable Env Health	Sustainable improvement in hygiene behaviour and reduction in exposure to water and environmental sanitation risks for whole, poor rural and urban communities in challenging geographical , socio economic and technical contexts	2003-2009	£15,575,000
DFID		Chars livelihoods programme	To develop new partnerships and approaches which provide improved livelihood security and opportunities for extremely poor women, men and children Char dwellers (approximately 1 million) in the five districts of the Northern Jamuna.	2002-2010	£50,000,000
DFID		Maternal Mortality Reduction	Increased demand for and utilisation of maternal health services provided by a range of quality assured health providers	2004-2010	£50,000,000
DFID (11.68%of budget)	WFP	Bangladesh country programme	To enhance the development, implementation and effectiveness of food security policies and food aid programmes	2001-2006	£10,000,000 (total budget $191,000,00)
DFID	UNICEF	Rural Hygiene, Sanitation & Water Supply	Reduce the mortality and morbidity due to diarrhoea and other water borne diseases		£27,250,000
EC	WFP	Food Security for VGD - women and their dependants (FSVGD)	Support to the Vulnerable Group Development (VGD) Programme in seven north-western districts with the objective of improving sustainably the food security of women belonging to the extreme poor category.	2001-2006	€35,600,000
EC	GoB	Health, Nutrition and Population Sector Programme	Sector-wide programme to improve the health and family status, especially among the most vulnerable groups, including women, children and the poor.	1998-2003	€70,000,000
EC	IIRD	Food Security through Sustainable Income Uplift and Poverty Eradication	The objective is to reduce overall poverty in four districts. Sustainable income will be ensured among target families to meet annual food needs. There will be two main indicators to measuring the achievement of the project purpose: 7,200 families will achieve a sustainable income level for meeting their annual food needs (2,122 kcal/ pppd) and among hard-core poor families at least 2,400 families will increase the food	1999-2003	€2,625,000

			intake (more than 1,804 kcal/pppd).		
EC	CARE GoB	Rural Maintenance Programme (RMP III)	The Rural Maintenance Programme (RMP) is aiming to contribute to poverty alleviation in rural Bangladesh by providing medium-term employment and life management skill training to some 41,000 destitute women.	2002-2005	€17,500,000
EC	CARE	Support to Vulnerable Food Insecure Farmers, CARE LIFE NOPEST Phase II	This project aims at building capacity of food deficit households (who are primarily dependent upon farming to maintain livelihood) on increasing, diversifying and sustaining farm production in an environment friendly manner.	2001-2003	€4,000,000
Ethiopia					
DFID	GoE	Ethiopia: Support to a national safety net	The safety net will provide cash and some food transfers to households identified by their community as chronically food insecure. As far as possible, transfers will be linked to employment in public works designed to reduce vulnerability.	2005-2007	£80,000,000
DFID	GoE	Productive Safety Net Programme	To improve the efficiency and productivity of transfers to food insecure households, reducing household vulnerability, improving resilience and promoting sustainable community development.	2005-2007	£43,000,000
DFID (with other donors)		Protection of Basic Services	This will ensure that poor people continue to have access to the basic services they need (specifically, education, health, agriculture, water and sanitation services).	2006-2007	£97,000,000
DFID (1.26% of budget	WFP	Ethiopia Country Programme	This programme consists of school feeding 9%, MERET (Managing environmental resources to enable transitions to more sustainable livelihoods) 83% and support to households affected by HIV/AIDS 8%.	2003-2006	$89,000,000 (total budget)
EC	GoE (WB)	Productive Safety Net programme	To improve the efficiency and productivity of transfers to food insecure households, reducing household vulnerability, improving resilience and promoting sustainable community development.	2005	$59,200,000
EC	NGOs	Various micro-projects in the area of food security		2001-2006	€7,800,000
EC	GoE	Food Security Programme 2002	General Budget Support in favour of food security	2003-2005	€22,000,000
EC	WaterAid	Tsegede Armacho water supply sanitation and Hygiene promotion project (TSA – WSSH)	The overall objective of the Project is to increase access to potable water and improve health and sanitation.	2002-2005	€1,064,639
EC	Local govt	Various integrated food security programmes	The overall objective of the programme is to improve the livelihood of the food insecure populations, through increasing and diversifying income opportunities.	1999-2005	€21,000,000
EC	UNICEF/ WFP	EOS (Enhanced Outreach Strategy for Nutrition)	This project is aimed at reducing the mortality rate of mothers and children and increasing access to health care for the target group and providing supplementary food.	2005	£7,000,000
EC (4.97% of budget)	WFP	Enabling Livelihood Protection and Promotion	This programme is aimed a reducing food insecurity amongst 5-6 million chronically food insecure Ethiopians.	2005-2007	$784,000,000 (total budget)
EC (not	FAO	Special Programme for Food Security – Ethiopia		1996-2006	$1,317,885

known how much)					
EC	FAO	Food Security Programme Phase II – Account 1 & 3		2006-2008	$9,809,300 & $1,372,823 (global allocation)
Nigeria					
DFID		Urban and Small Town Water and Sanitation Jigawa	Improve the sustainable delivery of current water supply and sanitation services to the urban and peri-urban poor	2004-2005	£1,500,000
DFID		Partnership for Transforming Health Systems (PATHS)	The aim of this project is to bring about sustainable health benefits for the poor by addressing the deep-seated systemic constraints to effective health service delivery. There is an explicit focus on areas that will have maximum impact on reducing child and maternal mortality.	2002-2007	£39,000,000
DFID	UNICEF	FGN/UNICEF Water and Environmental Sanitation	To facilitate replicable, sustainable, demand-responsive water and environmental service delivery	2003-2010	£15,000,000
EC	NGOs	Various micro-projects	Small community projects in the areas of water and sanitation, health centres, schools and transport	2001-2008	€63,000,000
EC	GoN	Small towns water supply and sanitation programme	Access to the supply of potable water and decent sanitation is very low in most small towns with a population between 5,000 and 20,000 people.	2003-2008	€15,000,000
EC	WaterAid	Universal Access to Water and Sanitation	To contribute to poverty reduction through increasing access to sustainable water, sanitation and hygiene promotion services to the rural and urban poor of Nigeria.	2005-2007	€550,000
EC	NOVIB/ OXFAM	Integrated Sexual and Reproductive Health & Service Delivery in Northern Nigeria	To improve the quality of life of young people and women of reproductive age through an expanded scope and coverage of an integrated sexuality education, Reproductive Health services and HIV/AIDS programmes in Northern Nigeria.	2006-2009	€1,800,000
EC	Concern	Cross River State Water and Sanitation project	Improved health of rural poor population through reduction of water-borne and environmentally communicable diseases in 4 LGAs within the Northern and Central Senatorial Districts of Cross River State.	2006-2011	€712,280,000
Sudan					
DFID		Goal South Sudan Health and Nutrition	To improve the health status of the community served by Goal with the provision of health care services and facilities	2004-2006	£1,260,000
DFID	NGOs	Basic Services Fund	Fund for NGOs working on basic health, education and water and sanitation.	2006-2007	£17,000,000
EC		Various food security programmes		2002-2006	€4,700,000
EC	FAO	Food Security Programme Phase II – Account 1 & 3		2006-2008	$9,809,300 & $1,372,823 (global allocation)

Zimbabwe					
DFID	CARE, OXFAM & SC	Emergency agricultural recovery for vulnerable households	To assist the recovery of agricultural production and increase access to food through the distribution of essential sees, fertilizer and advice	2004	£4,010,000
DFID	NGOs	Protracted Relief Programme (PRP)	The goal of this programme is to reduce extreme poverty and the proportion of people who suffer from hunger in Zimbabwe. The programme's purpose is to improve food security and the livelihoods of more than 1.5 million people in Zimbabwe, particularly households affected by AIDS	2004-2007	£30,500,000
DFID	UNICEF	Orphans and Vulnerable Children Response Programme	To ensure an effective coordinated and integrated national response to meet the immediate and medium-term needs of OVCs in Zimbabwe through contributions to UNICEF	2005-2010	£25,000,000 (DFID portion)
DFID	UNICEF	Nutrition surveillance	This provides technical input into the PRP.	?	£300,000/year
DFID	FAO	Improved Food Security and Production of Vulnerable Households in Zimbabwe		2004-2007	$2,036,359
EC		Food security/food aid	Various food security projects	2002-2007	$21,000,000
EC	MoH	Health sector support		2001-	$29,554,003
EC	FAO	Food Security Programme Phase II – Account 1 & 3		2006-2008	$9,809,300 & $1,372,823 (global allocation)

Sources: DFID, EC, WFP, UNICEF, FAO websites, AiDA, CRS Online and Country Office interviews

Table 12: Compilation of Total Number of Chronically Malnourished under the Age of Five

	under 5 population in 2000	under 5 population in 2015	Year of survey	age range	% moderate and severe stunting	Annual rate of reduction in underweight rate 1990-2004	On track to meet MDG Underweight target?	predicted stunting rate in 2015 (simple extrapolation)	number of stunted children at latest survey date	number of stunted children in 2015	% change in number of stunted children from survey to 2015	annual change in number of stunted under 5s	2015 minus the year of survey (years)	cumulative factor (years)	sum of (stunting-years) from survey year to 2015
Afghanistan	4,561,000	7,426,000	2003.5	6-59 months	54	3.1	yes	37.6	2,462,940	2,791,722	13	28,590	11.5	66	30,210,732
Bangladesh	16,852,000	18,057,000	2004	0-59 months	43	2.8	yes	31.5	7,246,360	5,681,238	-22	-142,284	11	66	70,319,227
Ethiopia	12,096,000	15,069,000	2000	0-59 months	52	-0.1	no change or getting worse	52.8	6,289,920	7,954,245	26	110,955	15	110	106,553,847
Nigeria	20,588,000	24,429,000	2003	0-59	38	2.2	progress, but insufficient	29.1	7,823,440	7,108,133	-9	-59,609	12	78	89,231,784
Sudan	5,000,001	5,415,000	2000	0-59 months	43	-2.4	no change or getting worse	61.4	2,150,000	3,323,275	55	78,218	15	11	33,110,408
Zimbabwe	1,799,000	1,777,000	1999	0-59 months	27	-1.6	no change or getting worse	34.8	485,730	618,515	27	8,299	16	126	8,817,365

Sources: UNICEF Childinfo.org, World Population Prospects: The 2004 Revision Population Database
Note: Assume rate of decline in stunting=decline in rate of underweight

Table 13: Best Practice Guidelines on Making Indirect Nutrition Interventions more Nutrition-Friendly

Area of Indirect Nutrition Interventions	What to do to make policy more nutrition-friendly	How to do it
Household Food Security and livelihoods promotion	Targeting	Ensure that investment to improve livelihoods are designed to reach the poorest including those who are net consumers and not net producers and those who are labour poor
	Make agriculture more productive in ways that are consistent with improved nutrition	Increase investment in agricultural research, particularly that which is sensitive to poverty and nutrition impacts, drawing in particular on community knowledge and preferences Encourage the development of plant breeding methods that improve the nutrition content of staples Encourage the development of agriculture-communications-health partnerships that improve the impact of food-based interventions
	Make income generation programs more pro-poor and malnourished	Encourage community-based ownership of interventions Ensure that women are not excluded and participation is consistent with needs for child care Conduct more evidence based evaluations of impact
	Social protection and safety nets	Use nutrition indicators to measure progress Inform the design by analysing the minimum cost of a healthy diet Design packages which include cash and other services such as free health care, micronutrient supplementation/home fortification, child care facilities which can support better child nutrition Ensure families with children under 2 are explicitly included Ensure any special provision needed for pregnant and breastfeeding women to maximise their time for maternal and child care
	Improve the monitoring of food insecurity	Strengthen the capacity of countries to collect and use information on food access Create food insecurity and malnutrition maps for planning and advocacy
Care Provision to Women and Infants	Strengthen the role of women in society and in home	Monitor extent to which gender asymmetries are embedded in law & custom Change and enforce laws to eliminate gender inequalities in access to information and other assets Develop gender-based budgets by government department Recruit more women within organizations that allocate resources Encourage the enrolment of girls in school through incentives Conduct gender reviews of program designs to ensure that women are not excluded, particularly at the community level In some cases deliberately target program resources to women Design safety nets that are targeted to the needs of female-headed households with young children Involve women in the design of interventions Invest in female literacy programmes
Health, Water and Sanitation	Health systems	Remove user fees for health services Invest in systems and services which reach and treat children with common infections Support the treatment of acute malnutrition according to international protocols
	Strengthen the quality of service delivery	Increase the demand for services by increasing their quality Higher salaries; better training for employees More authority to health clinic heads Better and more transparent monitoring of performance of clinics More accountability to local community
	Integrate nutrition into the delivery of other health services	Better training of doctors in nutrition issues and best practices Learn from the integrated management of child illness (IMCI) initiative; More baby-friendly hospitals, clinics, professionals Ensure the International Code of Marketing of Breastmilk Substitutes is adopted as law, is monitored and enforced

	Improve access to water in sufficient quantity and quality	Develop water user groups that have high levels of participation from community user groups with a strong representation from women
	Improve access to good quality sanitation	Give community greater say in selection of community infrastructure Develop demand for improved dwelling-specific sanitation through communication programs; Develop more effective solutions for the hygienic disposal of waste

Table 14: Total spend on chronic malnutrition, excluding contributions direct to civil society[26]

	EC	DFID	EC	DFID	EC	DFID
	GBP (millions)	GBP (millions)	Euros (millions)	Euros (millions)	USD (millions)	USD (millions)
Bilateral spend[27] (see Tables 1 & 2)						
direct spend annual average 2000-4	0.350101	2.172684	0.511009	3.171262	0.680000	4.220000
indirect spend annual average 2000-4	715.152800	220.460483	1043.841335	321.785449	1389.040000	428.200000
Multilateral spend 2005 (see Table 5)[28]						
UNICEF	29.551529	32.428000	43.133614	47.331909	57.397900	62.984580
WFP[29]	123.725098	58.829074[30]	180.590000	85.867271	240.311113	114.263605
FAO	9.703298	5.766776	14.163000	8.417186	18.846704	11.200798
WB	68.282086	24.676925	99.665000	36.018440	132.624216	47.929745
EC		169.343488		247.173755		328.914163
TOTAL ANNUAL SPEND (dir, indir and multilat)	946.764912	513.677429	1381.903958	749.765271	1838.899933	997.712891
	GBP	GBP	Euros	Euros	USD	USD
TOTAL ANNUAL SPEND per malnourished child (146 million)	6.48	3.52	9.47	5.14	12.60	6.83
TOTAL DAILY SPEND per malnourished child		0.0096	0.0259			

[26] Exchange rates calculated using http://www.x-rates.com/calculator.html; March 2007
[27] This does not include bilateral emergency spending including emergency food aid.
[28] Contributions according to the donor are taken unless earmarked fund are specifically cited. For agencies which work on multiple sectors (i.e. EC and WB) a proportion of the total amount was taken as follows: For World Bank total IDA is 7-9 billion per year. WB spend 731 million on nutrition – i.e. 9.14% of total IDA – this proportion is applied to DFID commitment. Total percentage of EC ODA (bilateral plus multilateral, excluding emergency food aid) which goes on nutrition is 18.47%, this proportion was applied to DFID commitment. Total UNICEF spend is included as it was not possible to delineate spending on nutrition specifically.
[29] These amounts include total commitments to WFP including for emergency food aid
[30] WFP (rather than DFID) reports (http://www.wfp.org/appeals/wfp_donors/2005.asp?section=3&sub_section=4) are used here to ensure that the figure include emergency food aid and is therefore comparable to the EC figure.

Annex 2: A Description of the Extent to which DfID and EC Play a Part in Tackling Chronic Malnutrition in the Case-Study Countries

Afghanistan

DFID

Strategy

DFID has not yet developed a long-term strategy for Afghanistan (last CSP out in 2003, but is now out of date and not even available on DFID's website. This has been postponed to 2006 so that it could be developed in line with Afghanistan National Development Strategy (ANDS). Instead there is an interim strategy (2005), which sets out the priorities and spending plans for 2005/6. This document places a very low priority on chronic malnutrition. The UK focus is not on progress toward to the MDGs in the short term and the strategy does not prioritise UK involvement in the provision of basic services at all (section 3.3). The focus is on stabilisation for Afghanistan to be able work on achieving the MDGs in the longer term. The DFID programme has three focal areas: i) livelihoods; ii) economic management and aid effectiveness; iii) state-building (section 3.4).

Spending and projects

The CRS data shows that DFID not did fund any direct nutrition activities in Afghanistan between 1995 and 2004 and spending on indirect interventions reduced from 10% of ODA in 1995 to 1999 to less than 2% in 2000 to 2004 (Figure 3). Since 2004 (last period for CRS data) DFID has also increasingly supported the Government of Afghanistan (GoA) directly through budget support, with £35million forecast spend for 2005/06, as well as providing technical assistance to the GoA (Annex 2 of DFID strategy). Looking at specific relevant projects (Annex Table 11), DFID funded the National Risk and Vulnerability Assessment (NRVA). This survey includes food availability assessment, but it is not a nutritional survey[31]. DFID also funds various cash-for-work programmes, mostly through the GoA. These are not specifically designed to impact on nutrition (CT6/13/12/06). FAO works with DFID in Afghanistan on two livelihoods programmes, but these are also not designed specifically with nutrition in mind (FAO/22/11/06). While there is no evidence of a specific focus on nutrition, there may be indirect impacts on nutrition within the livelihoods programme area, but with a focus on alternative livelihoods this is not self-evident, since it targets people that already make a living through drug production. However, a portion of this programme will be on farmers that for some reason (self-restraint or eradication) have stopped growing poppy, so there the indirect affect on nutrition will probably be greater for these individuals.

EC

Strategy

[31] http://www.mrrd.gov.af/vau/NRVA_2003.htm

The EC Country Strategy Paper and National Indicative Programme was published in 2003, before the Afghanistan Interim PRSP, has been developed in line with the Afghanistan National Development Framework from 2002 (see below). This document places a relatively low priority specifically on chronic malnutrition, but a high priority on food security. Food security and rural development (€100million for period 03/04) is one of the four key areas for EC development cooperation with Afghanistan. The others are capacity building (€15million), economic infrastructure (€90million) and health (€15million) (CSP, p.2).

Spending and projects

The CRS data shows that the EC not did fund any direct nutrition activities in Afghanistan between 1995 and 2004, but spending on indirect interventions is very high and increasing (Figure 4). Within this a lot of support is provided to government ministries, including support for livelihoods and food security surveillance systems (including the NRVA)[32], employment creation, rural recovery and food security support (NIP, p. 5). Within health, the EC provides sector support to the Basic Package of Health Services, which includes a nutrition component. EC also funds various seed distribution projects through NGOs and horticultural programme focused on dried fruit cultivation (CT7/13/12/06). Multilateral programmes supported by EC in Afghanistan include various food and agricultural programmes implemented by FAO (Annex Table 11). The aim of the EC programme is to move toward sector wide approaches, but if there is a lack of government capacity, EC implements projects through NGOs (NIP, p. 15).

PRSP

The Afghan I-PRSP is from May 2006 and therefore DFID and EC has not yet formalised their responses to this, we have also reviewed two other nutrition relevant documents for Afghanistan (see below). The Afghan I-PRSP (Afghan National Development Strategy, 2006) gives a medium priority to nutrition. The severity of the problem is highlighted and the multiplicity of factors that contribute to improved nutrition are acknowledges, including, health interventions, improved food security programmes aimed a reducing infant and maternal malnutrition and nutrition education (p. 143). The I-PRSP also highlights the problem of lack of data for all poverty indicators (p. 47). However, even though the health and nutrition section describes nutritional deficiencies it does not include a strategy for dealing with these. The BPHS (Basic Package of Health Services) should cover nutrition interventions, but this is not stated explicitly in the I-PRSP and there is not benchmark for improved nutrition. The relevant benchmarks are the aim of hunger reduction of 5% per year by 2010; increased food security within agricultural development, economic growth, extension of water supply and sanitation and women's empowerment (Annex I).

Public Nutrition Policy and Strategy (PNPS): 2003-2006

The PRSP sections on nutrition are based on this report from 2003, which has a very advanced conceptualisation of malnutrition and a good strategy for

[32] http://www.mrrd.gov.af/vau/NRVA_2005.htm

dealing with the problem. This is written by the Ministry of Health and it uses the UNICEF conceptual model of the causes of malnutrition (p.4). It highlights the absolute importance of maternal nutritional status and the cycle of malnutrition that this causes and concludes that only comprehensive public health and food security interventions that address the underlying causes targeted toward specifically women will succeed. Innovative, context-specific and integrated programmes are needed (p. 8). The right to food and nutrition highlighted and the positive outcomes of improved nutrition acknowledged (p.10). Main interventions will be through the BPHS, but MOH will collaborate with other ministries (to integrate nutrition into food security programmes), donors, UN agencies, NGOs, private sector and researchers for a fully integrated approach (p. 21-22).

National Development Framework April 2002

The national development framework was adopted by the interim administration and it sets up a development strategy and sets up policies and priorities for the future. This document places a medium priority on chronic malnutrition. Within the health sector, there is specific focus on tackling malnutrition through food fortification (with WFP), basic package of oils and pulses for humanitarian assistance where there is up-to-date information about malnutrition, mobilise donor and practitioner community to assess nutrition situation and direct actions (p. 22). Within livelihoods and social protection, there is specific focus on cash or food-for-work programmes, depending on the cash and food availability situation (p. 23), although the nutritional component of these is not discussed.

Consistency between EC-DFID-PRSP

The Public Nutrition Policy and Strategy provides shows that the Afghani government has a good understanding of the types of interventions needed although the PRSP does not really reflect this. For instance, poverty surveillance could include nutrition surveys and a benchmark for reduced levels of chronic malnutrition could be set. But the three documents place a relatively high priority on chronic malnutrition, which is reflected within the EC CSP and NIP, through the focus on food security and health sector support. The DFID strategy does not reflect this priority, although some good work is done through the alternative livelihoods programme area.

Bangladesh

DFID

Strategy

The document distinguishes well between income poverty and nutrition poverty and highlights the male-female differences in nutrition outcomes. The report also recognises the links between malnutrition and 2/3 of under five deaths.

Spending and projects

DFID has funded some direct nutrition interventions in Bangladesh over the period 1995-2004, but this accounts for a very small part of UK ODA to

Bangladesh and this is going down (Table 9). Spending on indirect interventions is also going down according to CRS. However, looking at recent project data (Annex Table 11), DFID does fund some good longer term projects, such as the Chars livelihoods programme and a large project aimed at improving maternal health. DFID will also invest £100 into the HNPSP over the next five years and this includes a specific nutrition component. DFID funds a UNICEF water supply and sanitation programme and just over 11% of the WFP Bangladesh country programme.

EC

Strategy
The report highlights EC priorities as human development and export promotion and diversification. Within human development nutrition is one of 6 areas highlighted. The EC is committed to supporting the Health, Nutrition and Population Sector Programme (HNPSP).

Spending and projects
The EC have not been investing in any direct nutrition activities in Bangladesh in the last ten years, but a large part of their programme was in support of indirect activities (about 20%) (Figure 4). Recent indirect activities include sector wide support for the HNPSP and support for the Rural Maintenance Programme and the Vulnerable Food Insecure Farmers Programme, both run by CARE (Annex Table 11).

PRSP
While nutrition is listed as a "critical development challenge" and number 2 in an 8 point Strategic Agenda, one does not get a strong feel for a comprehensive policy. The National Nutrition Policy is a rather narrow set of initiatives and the report is not convincing in demonstrating the capacity for coordination with other nutrition initiatives such as the Vulnerable Group Development and the Food for Education. Hopefully this will happen through the HNPSP. The initial NNP has received very mixed reviews in terms of coverage and level of support and the PRSP does not reflect on these.

Consistency between PRSP-DFID-EC
In terms of the interim PRS objective of human development for the poor, DFID prioritise maternal mortality reduction and improved access for women and girls to food, water and sanitation. The EC focus more on supporting the HNPSP, although the DFID document was written before the HNPSP was finalised.

Ethiopia

DFID

Strategy
DFID is offering the country technical cooperation in 3 key areas and food security is one of these along with education and capacity development of government and civil society. The overall thrust of the food security technical

cooperation will be to support the move from shorter term food aid solutions to longer term solutions. Engagement includes social protection for chronically poor to enable them to enter the development process. Reducing the vulnerability of Pastoralists is also key. Other key activities: helping to implement the Governments rural travel and transport programme and monitoring and evaluating the World Bank funded Food Security Project. Malnutrition mentioned twice – first to demonstrate progress in human development indicators between 1995/6 and 1999/2000 survey data and second in the MDG target table. Nutrition not mentioned further.

Spending and projects

CRS shows that DFID has spent some funds on direct nutrition activities and this spending was quite big in 2002 (Table 9). Indirect spending is however much lower and going down. In part this can be explained by DFID reverting to direct budget support (Annex Table 9), but this stopped in 2005. Recent projects show that DFID provides a substantial amount to the Productive Safety Net Programme and runs, in partnership with other donors, the Protection of Basic Services programme (Annex Table 11).

EC

Strategy

Malnutrition is mentioned exclusively under food security. Transport, Capacity Development and Food Security are the 3 priority EC areas. The EC is focused on moving from dependence on food aid to supporting more sustainable internal solutions and reserving food aid for acute emergencies. This could mean support for a whole range of things. Some mentioned: microfinance, employment guarantee schemes, improved agricultural production and marketing and livestock development.

Spending and projects

CRS shows that the EC has provided a substantial amount of their total ODA toward direct budget support in Ethiopia (Annex Table 9), much of which is in favour of food security, and indirect interventions also amount to a substantial part of the budget (41% 2000-2004) (Figure 4). More recent information shows that the EC focus a lot of their support on so called micro-
projects in the area of food security implemented through NGOs or through local government agencies. The EC also fund the PSNP and last year they put £7m into the UNICEF EOS (Enhanced Outreach Strategy for Nutrition). The EC work with WFP on the Enabling Livelihood Protection and Promotion programme and with FAO on their Special Programme for Food Security (Annex Table 11).

PRSP

Agriculture-Led Industrial Development (ADLI) is the key instrument to generate growth in income and food. Stunting is used as an indicator of long-term food insecurity, but nutrition is classified as a health problem, and is also seen as part of emergency response. Nutrition is atomised – split between agriculture, health and emergencies, with little attention paid to it in any of the

areas. It is mentioned more as a welfare indicator rather than as an area of focus.

Consistency between EC-DFID-PRSP
There is a great deal of consistency – agriculture is the number one priority. This is entirely defensible, but the failure to realise that some forms of effective agriculture-led industrial development will be more infant nutrition-friendly than others is disappointing.

Nigeria

DFID

Strategy
The DFID CAS (2004-08 signed Dec. 2004) places a low priority on nutrition issues. It notes that 29% of children are underweight (p. 6) in referring to the MDG target. It notes that (p. 7) the proportion of undernourished children is significantly higher in the North, and across Nigeria child mortality rates have fallen more slowly than in any other African country (citing as reference: Child mortality has fallen by 10% since 1960 compared with a least developed country average of over 40% - Children's and Women's Rights in Nigeria: A Wake Up Call, National Planning Commission and UNICEF, 2001). DFID's budget allocation is two-third to 'empowering people to demand reform and building a social contract'. The remainder is split between improving public expenditure management and promoting sustainable pro-poor growth (p. 16-18). The document is vague on what these will actually entail.

Spending and projects
CRS shows no direct nutrition spending, but indirect investment has been rising (Figure 3). Indirect ongoing projects include Urban and Small Town Water and Sanitation Jigawa and the PATHS programme in the health sector. DFID also works with UNICEF in the area of water and sanitation, but there is very little in terms of direct and indirect nutrition programmes (Annex Table 11).

EC

Strategy
The EC CSS/IP (2001-07 signed July 2002 and March 2005 addendum following the mid term review) places a low priority on nutrition issues. The EC has two focal sectors in Nigeria – water/sanitation and state and local institutional and economic reform. Programmes outside the focal sectors relate to immunisation – polio and human rights/capacity building of state and non-state actors. The section on poverty (p. 16-17) does not mention nutrition even within the context of the MDGs.

Spending and projects
The EC do not appear to invest into direct nutrition activities in Nigeria, although indirect activities are a large part of EC ODA (Figure 4). In Nigeria the focus is also on various micro-projects, implemented through NGOs, in

the area of water and sanitation, health, education and transport. Nutrition focus is not evident in any of these. The EC also funds water and sanitations in partnership with the government and Concern (Annex Table 11).

PRSP

The PRSP (signed in Dec 2005) notes that 30% of children under 5 years are underweight (p. 30). The document notes the right to nutrition (p. xv and p. 28). The message from the President also notes nutrition under 'measuring quality of life' (p. 29). Children have a special section that mentions nutrition in passing (p. 46). Overall the PRSP emphasises the macroeconomic framework (chapter 1), empowering people (chapter 2), promoting the private sector (chapter 3) and promoting a more efficient and responsive government (chapter 4).

Consistency between EC-DFID-PRSP

All the documents place a low prioritisation on nutrition. Drivers and impediments are not mentioned. Neither is there any clear conceptualisation of chronic malnutrition. There is a strong consistency between the EC, DFID and PRSP on economic development and promoting a more efficient and responsive government.

Sudan

DFID

Strategy

DFID has a Country Engagement Strategy rather than a Country Assistance Strategy because of the political situation in Sudan. The DFID CES (undated lifespan and undated signing) places an ambiguous priority on nutrition. Priorities are (p. 14) humanitarian aid; assist in peace process; support for effective public administration and development/implementation of policies for poverty reduction. However, in spite of the humanitarian aid and poverty reduction focus, nutrition is on mentioned once - high rates of widespread malnutrition are noted (p. 17). Most of DFID's involvement is through third parties (p. 12). For example, 2002-4 - £9.6m to INGOs, £8.5m for ICRC; £7.8m for UNICEF; £7.5m for WFP; £3m for UNDP - all for humanitarian aid. A further £4m was given for UN mine clearance and £0.4m to UNDP for HIV/AIDS (p. 12).

Spending and projects

CRS shows that DFID spent a large amount of money on nutrition activities in 2004 (Table 9), but looking more closely at the data, this was in fact emergency funding and should not have been classified under this purpose code. Indirect investment has been rising, but is not a substantial amount of the budget (Figure 3). In terms of indirect projects, DFID funds the £17m, 'Basic Services Fund' for 2006-7 covering South Sudan and health, education and water and sanitation, implemented by NGOs. DFID also funds a specific health and nutrition project in Southern Sudan (Annex Table 11).

EC

Strategy

The EC CSS (2005-2007 - unsigned and undated) places a high priority on nutrition. The EC's two focal sectors are food security and education. The document notes that malnutrition is linked to conflict (p. 10), sustainable livelihoods (p. 19) and child development (p. 27) and is liable to sudden increases caused by drought-related food emergencies (p. 10). Further that data is incredibly weak and there has been no progress towards the MDGs including nutrition targets (p. 10). Food security (in all its dimensions) is ranked as the number one priority for future EC-Sudan cooperation (p. 43-4). ECHO's operations are listed (p. 40). One 'performance indicator' is (p. 31) reduction in the under 5 malnutrition rate over 5 years to be verified through 'nutrition surveys/UNICEF and UNICEF MIC analysis. The percentage of under 5s wasted is disaggregated by region (p. 37).

Spending and projects

CRS does not show any spending on direct nutrition projects in Sudan and indirect spending is not significant (Figure 4). It seems like most interventions are emergency projects through ECHO at the moment and there is not much spending on long term food security programmes (Annex Table 11)[33].

PRSP

There is no Sudan PRSP because of the political situation in the country. However, a pre-interim PRSP draft has been circulated but the status (and source) of this document is unclear.

Zimbabwe

DFID

Strategy

There is not CAP for Zimbabwe, due to the fact that DFID does not work directly with the government. All projects in Zimbabwe are implemented through other agencies. On the DFID website, it is stated that the main priorities for DFID in Zimbabwe are HIV/AIDS, food security and orphans and vulnerable children. The food security budget is mainly delivered through the Protracted Relief Programme, which targets the poorest and most vulnerable people in Zimbabwe by increasing their access to seeds and fertilisers, nutrition gardens and safe water, so DFID places a medium priority on chronic malnutrition in Zimbabwe[34].

Spending and projects

CRS shows that DFID only invested in direct nutrition activities in 2004 (Table 9), but has spent quite a large proportion of aid on indirect activities since 2000 (Figure 3). DFID works with UNICEF on a nutrition surveillance project in Zimbabwe and this provides input into the Protracted Relief Programme, which is implemented by NGOs. Other projects include working with FAO to

[33] Project information in Sudan for EC operations is not readily available due to the fact that the EC do not have a delegation there.

[34] http://www.dfid.gov.uk/countries/africa/zimbabwe.asp

improve food security and production and with UNICEF on Orphans and Vulnerable Children (Annex Table 11).

EC

Strategy

There is a draft CSP for Zimbabwe, but due to the fact that this has not been agreed with the government of Zimbabwe or signed, it is not available online. The CSP process started in 2000 and was agreed by both parties in 2001, but relations deteriorated and all cooperation with the government was suspended in 2002. The EC however still continue operations in the country, but all financial support for projects is suspended apart support for those that are in direct support of the population[35].

Spending and investment

The CRS data shows no direct interventions, but quite a large proportion of ODA is dedicated to activities that may impact indirectly on nutrition (Figure 4). The EC support the health sector in Zimbabwe, although there are no specific nutrition projects in this portfolio. Food security is a priority and there are some projects ongoing, but specific project details are not available (Annex Table 11). There is no evidence of a specific nutrition focus within these two sectors.

PRSP

There is no PRSP for Zimbabwe, due to the political situation in the country. The IMF has excluded the country and no PRSP process has been started.

[35] http://www.delzwe.cec.eu.int/en/index.htm

Annex 3: CRS data

Our sample

To be able to compare donors and countries, we have used data on ODA which comes from the OECD Creditor Reporting System (CRS) On-line Database of Aid Activities. This system uses internationally recognised reporting requirements to be used for donor comparison.

As recommended by DAC, the data is based on commitments, rather than disbursements of ODA (please see below CRS user's guide for details). It is important to note that commitments logged in the database may often be commitments for multi-year programmes (with disbursements in years following the commitment year). This means that data can vary year from year, so when looking at trends we have looked at the data is periods over five years. We have mostly looked at data over the period 1995 to 2004. Unfortunately, data for 2005 is not yet available for all donors on the system.

All ODA figures are stated in constant 2004 US dollars, which is recommended by DAC for time series analysis.

We looked at 4 areas of CRS data relevant to chronic malnutrition:

1. Direct nutrition interventions (DAC purpose code: basic nutrition, 12240) closely corresponding to the short term project activities in the Terms of Reference. Defined as: *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.*
2. Indirect nutrition interventions. These were chosen to closely correspond to the longer term interventions described in the Terms of Reference. We chose to look at: *Basic health care (12220), infectious disease control (12250), reproductive health care (13020), water supply and sanitation – large systems (14020), basic drinking water supply and basic sanitation (14030), Women's equality organisations and institutions (15164), Multisector aid for basic social services (16050), Informal/semi-formal financial Intermediaries (24040), Food crop production (31161), Agricultural research (31182), Food aid/Food security programmes (52010).* The case can be made for looking at other areas as well, but we wanted to try to be as specific as possible.
3. Direct budget support to see if low investment into nutrition activities were to do with resources being directed directly to governments. Purpose code: General budget support (51010)

Issues with the data

The use of this data has not been unproblematic and there are many issues that need to be spelt out:

1. When the committed amount of ODA benefits several recipients, no particular country is identified. This means that a certain amount of relevant data may be lost when looking at specific countries. For instance, querying the amount spent on basic nutrition in Bangladesh by DFID will leave out money allocated to basic nutrition, but to LDCs in general. This may include nutrition activities in Bangladesh.
2. When a project has two (or more) main components, the smaller of which is relevant to this study, the donor allocates either a multisector code or the code of the main component of the project. This means that the relevant data will not be captured. In this instance, when comparing indirect and direct nutrition interventions, the distinction is blurred, due to the fact that there may well be direct nutrition activities within the indirect data. However, this may balance out, with indirect data within the direct data as well.
3. When looking more closely at the data, it is also clear that there is a problem with reporting by donors. There are specific guidelines for reporting, but these do not seem to be adhered to at all times. For instance, within the basic nutrition sector certain we found some emergency assistance funds, but these should be allocated to the relevant emergency assistance purpose codes. There is also space for a longer description of the projects, but this information is rarely filled in, which means that an opportunity for further analysis of the data is lost. Instances of data inputting errors have also been found.

So, there are several problems with the data capturing all investment into nutrition activities and perhaps trying to use this data, which is specified by sector, is completely the wrong way of going about looking at nutrition which is not easily located within a sector. However, this has been a useful exercise. We think that although the data is not perfect, it is generally difficult to find accurate data on ODA, and the data has given us some indication of nutrition spending. DAC acknowledges a lot of these problems, but says that the *"CRS is the only practical method of standardising reporting on a basis that permits valid donor comparisons and that is not likely to bias analyses of trends and orders of magnitude"*. We have therefore used the data, but not relied on it too much for our analysis, but more to confirm indications from our policy analysis and interviews. We have also used data directly from DFID and EC, AiDA and multilateral agencies for relevant recent projects. We have however not attempted to compare this data.

Guidelines for use of the CRS data[36]

The objective of the CRS Aid Activity database is to provide a set of readily available basic data that enables analysis on where aid goes, what purposes it serves and what policies it aims to implement, on a comparable basis for all DAC members. The aid activity data come from donors, including the 22 member countries of the OECD's Development Assistance Committee (DAC), the European Commission and other international organisations. The data are part of DAC members' official statistical reporting to the OECD.

[36] From http://www.oecd.org/document/49/0,2340,en_2649_34469_32234801_1_1_1_1,00.html

The Aid Activity database covers DAC Members' bilateral ODA/OA i.e.:

- activities undertaken directly with an aid recipient or with national and international non-governmental organisations active in development; and
- promotion of development awareness and other development-related spending in the donor country (e.g. debt reorganisation, administrative costs).

DAC Members' multilateral aid i.e. contributions to the regular budgets of the multilateral institutions is excluded. These data are available in the aggregated DAC statistics. Aid activities financed from the multilateral institutions' regular budgets are referred to as "multilateral outflows". The Aid Activity database includes those of the World Bank, the regional development banks and some UN agencies. Projects executed by multilateral institutions or non-governmental organisations on behalf of DAC Members are classified as bilateral aid (since it is the donor country that effectively controls the use of the funds.)

The implementation of an aid activity can go on for several years. Data on the amounts disbursed each year are available at the activity level for some, but not all, donors. Consequently, most analyses have to be undertaken on a commitment basis. Total commitments per year comprise new undertakings entered into in the year in question (regardless of when disbursements are expected) and additions to agreements made in earlier years.

Each activity has only one recipient. (This is to avoid double-counting when summing up activities in different ways.) Activities that benefit several recipients are classified by continent or sub-continent (e.g. Africa, Sub-Saharan Africa). The category "developing countries, unspecified" is used if an activity benefits several regions.

The Aid Activity database registers information on the purpose of aid using a sector classification specifically developed to track aid flows and to permit measuring the share of each sector or other purpose category in total aid. All in all, there are 26 main sector/purpose categories, each of which is defined through a number of "purpose codes". Each activity can be assigned only one purpose code. (This is to avoid double-counting when summing up activities in different ways.) For activities cutting across several sectors, either a multi-sector code or the code corresponding to the largest component of the activity is used. The data obtained using the method of a single purpose code may differ slightly from those provided by donors' internal systems that allow an activity be assigned to more than one sector. However, at present it is the only practical method of standardising reporting on a basis that permits valid donor comparisons. It is not likely to bias analyses of trends and orders of magnitude.

<u>Recommendations</u>

For this review we used the DAC Creditor Reporting System to analyse nutrition expenditure by donors. As previously explained there are several problems with the use of this data and we have had supplement it with data

from other sources. Potentially, CRS could be incredibly useful and become a one-stop-shop for all data on ODA. This would allow for proper comparisons between donors, sectors and recipients, which would ensure increased transparency and accountability in the development sector. However, for this potential to be realised, a few issues need to be resolved:

- Donor reporting need to be improved. The reporting requirements should be more strictly enforced by DAC and donors should make more of an effort to adhere to them. DFID is reported working on this.
- For analysis of multisector issues such as nutrition, the CRS reporting guidelines could be made more consistent. A decision should be made to either identify them under a multisector code or under the code of the primary component.

Annex 4: A compilation of all interview summaries

List of interviewees

DFID

Andrew Rogerson
HoD Human Development
Elwyn Grainger-Jones
HoD Sustainable Development
Emma Spicer
Deputy HoD Central Research Dept
Richard Arden
HoP Education
Ellen Wratten
HoP Social Development
Jim Harvey
HoP Livelihoods and HoP Environment
Alastair Wray
HoP Infrastructure
Stewart Tyson
HoP Health
Tony Venables
Chief Economist
Stephen Kidd
Head of Social Protection
Jo Raisin
Head of Africa Hunger TF
Saul Morris
Statistician

EC

Philippe Mikos
Dir, Sustain Man Nat Res (B2), DG DEV
Peter Craig-McQuaide
Dir, Relations with international orgs (A3), DG DEV
Laura Garagnani
Policy Desk Officer, SMNR (B2), DG DEV
Juan Garay Amores
Policy Desk Officer, Human Dev Soc Coh Emp (B3), DG DEV
Neil Squires
Policy Desk Officer, HDSCE (B3), DG DEV
Walter Seidel
Policy Desk Officer, HDSCE (E3), AIDCO
Simeon Moutaftchieff
Policy Desk Officer, SMNR (E6), AIDCO
Max Van Den Berg
Vice-Chair of the Dev't Committee of EP (MEP)
Nanna Skau

Policy Officer, Food Aid and Health, ECHO
Brian O'Neill
Head of West Africa, Carib + Pacific, ECHO

SCN

Arne Oshaug
Chair, SCN

Country interviews

Jonathan Patrick
Humanitarian Advisor, DFID-Sudan
Peter Hawkins
Head of Human Development, DFID-Nigeria
Tim Robertson
Livelihoods Adviser, DFID-Ethiopia
Paolo Curradi
Head of Rural Development and Food Security Section, EC-Ethiopia
Rachel Yates
Deputy Head Programmes and Social Development Adviser, DFID-Zimbabwe
Anthea Kerr
Livelihoods Adviser, DFID-Afghanistan
Elisabeth Rousset
Deputy Head of Operations Section, EC-Afghanistan
Ali Forder
Health and Population Adviser
DFID-Bangladesh

Others spoken to

Andrew Long
Social Development Advisor, CRD, DFID
Sarah Cooke
Multilaterals, DFID
Ben Green
WHO liaison, DFID
Carl Kalapesi
Economic Adviser, International Financial Institutions Department, DFID
Sandra Baldwin
Multilateral liaison, DFID
Vic Heard
Rome Office, DFID
Florence Egal
FAO representative to SCN
Richard Trenchard
Project Analyst, TCOT
Ian Darnton-Hill

Acting Chief, Nutrition Section, Senior Adviser, Child Survival and Nutrition, UNICEF
Julia Krasevec
UNICEF
Rekiya Adamu-Atta
UNICEF
Meera Shekar
Senior Nutrition Adviser, World Bank
Cécile Sangaré
Statistician, OECD

Declined interview

Malcolm Bruce
Chair, House of Commons, International Development Select Committee
Klaas Ehbets
Dir, Aid effectiveness, DG DEV
A. Theodorakis
Dir, EU development policy - horizontal issues, DG DEV
F. Moreau
Dir. Forward looking studies and policy coherence, DG DEV
Lieve Fransen
Dir, HDSCE, DG DEV
Bernard Petit
Dir, development policy - thematic issues, DG DEV
Antonio Garcio Fragio
Dir, Economic development, DG DEV
Gordon Conway
Chief Scientist, DFID
Graham Teskey
HoD Governance and Social Development, DFID
Sheelagh Stewart
HoP Governance, DFID
Joanne Alston
HoD CRD, DFID

Compilation of all interview summaries

DFID1

- Conceptualisation of chronic malnutrition – Impairment of potential to achieve life; access to tools/resources but also handicap society has to pay for.

- Prioritisation of chronic malnutrition – Not enough, in sense not visible enough, not instrumental enough in objectives or accountable/monitorable targets. Lack of visibility across DFID. Lack of champion contributes to this. Going up from low base. Could be due to MDGs are phrased – i.e. MDG1 – have to scratch quite hard to find the

hunger indicators under income. Current draft of health strategy talks about cross-sectoral linkages says need for anchor for nutrition urgently. No specific non-health looking at nutrition. People dealing with health consequences of chronic malnutrition. PSA – process of reformulation – fewer PSA and now dept strategic objectives.

- Drivers/impediments – Lack of a clear story relating outcomes to policy and programme inputs – a clear log frame people could use. Because health is a product of multiple policy and sectoral inputs attribution is quite difficult to measure. You can see the problem but to chart out how your logical framework on how your contribution counts and to what extent should you be accountable for it is difficult. Who can take credit if improves? Also subject to lags and unintended effects. As measure of effectiveness of country programme or office people uneasy about pursuing. People don't know enough about what works, what doesn't work and why. Not enough success stories. It's all too complicated. Not enough impact data. No list of the five most important things to do. Absence of coherent stories or coherent policy narrative – confusion of development lessons on nutrition. Lack of visible internal monitoring groups. Lack of internal group. Because multi-sectoral difficult to clear across organisations.

DFID2

- Conceptualisation of chronic malnutrition – Not enough calories and diversity of nutrition to lead a healthy and productive life and develop as a child.

- Prioritisation of chronic malnutrition – I am not best placed to answer this.

- Drivers/impediments – I can't really comment on nutrition.

DFID3

- Conceptualisation of chronic malnutrition - Images from TV in 1980s such as Michael Burke. Wasting, malnutrition stats.

- Prioritisation of chronic malnutrition – Low but improving

- Drivers/impediments:
    - The cross-cutting nature of issue – whose responsibility is it?
    - Articulation of a clear cut and compelling case and why we have the tools to do so. Why DFID as a development agency? I think those things are coming together now.
    - PSA negotiated between DFID and treasury – may be an issue of what we can easily count.
    - Lack of country interest and lack of PRSP interest.

DFID4

- Conceptualisation of chronic malnutrition – Because of famine or extreme lack of basic nutrients children don't have strength to concentrate or even get to school.

- Prioritisation of chronic malnutrition – Medium

- Drivers/impediments – fragmented approach – lack of policy coherence; ministries ad-hoc response to crises in many countries. Lack of long term or holistic approaches. Lack of linking nutrition to other things other than health.

DFID5

- Conceptualisation of chronic malnutrition – On-going in its nature. Debate at DFID over food security versus livelihoods more broadly and social protection, right to income, etc. I'd come at it from a wider perspective than food security. But also, issue of culture and beliefs.

- Prioritisation of chronic malnutrition – In Africa there's a TF – so a group there pushing but only one I know of. Nutrition policy paper forthcoming and a virtual group established in DFID.

- Drivers/impediments – Political pressure – outside pressures especially from country partners and international system partners; new evidence – more profound that thought would be a driver; PSA and joint-PSAs drivers.

DFID6

- Conceptualisation of chronic malnutrition – Undernutrition and hunger, food insecurity - non-food reasons, productive side, macro and micro, dealing with vulnerability and make a living.

- Prioritisation of chronic malnutrition – Medium and rising. Not always labelled malnutrition/undernutrition.

- Drivers/impediments – Drivers – Africa Hunger Task Team pushing; 2002 hunger strategy paper was important. MDG 1 (hunger target) not talked about a lot. Current PSA discussion on whether hunger target should feature in next PSA. Ought logically to be there but Treasury want simpler, cross-departmental (where appropriate) PSA objectives with verifiable targets - and PSAs not meant to capture everything. Lot of work with FAO on nutrition indicators and MDGs. No support from FAO or other FAO members to go further on this. Non-MDG targets worth remembering. We do have an EU target to get 16 million off emergency relief and on to long-term social protection programmes - by implication a chronic malnutrition target. Mix of health and livelihoods issues – cross-sectoral nature – falls between cracks - not only at DFID. New health target strategy paper on its way. Health

strategy recommending virtual network or champions for nutrition. Politics of food aid distorts whole discussion on nutrition. Especially so with imagery used in media; and e.g. supply-led proposals for school feeding. Note: The '16 million target' for the transition from relief cited in the White Paper III has its roots in the EU Africa strategy. This committed the EU member states to take 8 million chronically food insecure out of emergency relief and place them under safety nets by 2009. The WP III doubled this commitment to 16 million recognising that 8 million already fell under the umbrella of the Ethiopia Productive Safety Net Programme (PSNP) and that a further predictable caseload of 8 million were evident throughout Africa.

DFID7

- Conceptualisation of chronic malnutrition – Stunting, inability to function properly.

- Prioritisation of chronic malnutrition – Explicitly not high but DFID gives a high priority to excluded areas and groups and those in rural and urban suffering – so these are likely the chronically poor and chronically malnourished. Rising as a priority.

- Drivers/impediments – MDGs context; lack of champions especially important in country offices; PSA and cascading down – i.e. have something explicit in directors delivery plans (DDPs). Weak political strength of FAO.

DFID8

- Currently writing the draft health strategy for DFID. Due out for consultation in 3-4 weeks. The strategy will stress a need to return to a more health systems approach – thinking hard about how vertical Global Funds and calls for universality of coverage with targets can undermine the health systems in place by externally prioritising certain diseases over others. It will also stress the need to coordinate donor approaches in health.

- The consultation process that underpins the new strategy stressed the need to pay attention to undernutrition and chronic diseases related to nutrition, such as diabetes, hypertension, some forms of cancer and coronary heart disease.

- The new strategy would reflect the need to do more on nutrition. Noted that nutrition is a difficult issue to deal with as it is cross-sectoral (it has no natural home) and does not have as strong a set of champions as HIV/AIDS (e.g. there is no equivalent for nutrition to UNAIDS, even UNICEF has many different priorities).

- The message that the nutrition community sends out is not as simple as some others, e.g. it is difficult to say to DFID country offices, "if you do X it will have an Y percent effect on poverty reduction"

- In the past 5 years nutrition has been overshadowed by the communicable disease agenda (HIV/AIDS, Malaria, TB)

- DFID is certainly having a positive impact on nutrition through its work in health, water/san, social protection, women's empowerment and agriculture, social protection, education, but acknowledged that these are not being viewed through nor coordinated via a nutrition lens and if they were they may possibly have a greater nutrition impact with little discernable impact on other objectives.

- There will likely be an RPC call in undernutrition in the next round of DFID research funding.

- DFID cannot do much on nutrition in a country like Tanzania where 85% of DfID resources go into direct budget support if the government does not prioritise nutrition.

- The Norwegian prime minister has approached Gordon Brown to jointly lead a more consolidated approach to MDGs 4 and 5 (child mortality and maternal mortality). Again noted that MDGs drive everything they do.

- If UNICEF is an effective champion for child nutrition in, say Malawi, then DFID-Malawi would be hard pressed not to invest. Stressed the need for an effective demand, and in that spirit he welcomed SC UK's challenge function, although he thought we and SCF are pushing on an open door.

DFID9

- Conceptualisation of chronic malnutrition – Chronic malnutrition is self explanatory. Part of package associated with Poverty. I visited Malawi recently and saw chronic malnutrition as part of drought and poverty.

- Prioritisation of chronic malnutrition – It’s there but not explicitly discussed.

- Drivers/impediments – PSA.

DFID10

- Conceptualisation of chronic malnutrition – Not enough to eat. Social protection is an important part of this.

- Prioritisation of chronic malnutrition – High but perhaps not explicit. High priority to social protection is indicative. Lot of work in Africa

division on moving people from relief to longer term social protection programmes. So, reasonably high profile if not yet financially. Commitments in white paper regarding finance. Rising but not always explicitly labelled as nutrition.

- Drivers/impediments – Drivers – using 'hunger' term has been a strong driver in Africa; linking to social protection is a key driver; make links to radicalisation, extremism, social unrest. Links to growth agenda important – lower productivity, exclusion from job market, less entrepreneurs, etc. linking to broaden base of growth. Poor schools performance due to chronic malnutrition and growth effects. Governance links tenuous. And reform of humanitarian response towards chronic malnutrition too. Impediments – if not country-led DFID finds it increasingly difficult – country dialogues are important – need to get it on radar of country partners; those who are chronically malnourished not politically important due to lack of voice is an impediment.

DFID11

- Conceptualisation of chronic malnutrition – Undernutrition/hunger/food insecurity

- Prioritisation of chronic malnutrition – Low but rising – because nutrition is addressed as an emergency issue but changing – becoming a development issue. Need to join debates on hunger and chronic malnutrition together.

- Drivers/impediments – PSA – because directors feels they have to deliver so PSA important. If not in PSA no DDP at country level. DFID hasn't disaggregated MDG 1 to nutrition indicator tracking. Lack of prioritisation for many governments – hardly on government radars. DFID not seen to have a comparative advantage.

DFID 12

- The case that nutrition matters for the MDGs was widely understood within DFID. That could be marginally improved on (e.g. how many billions of $ are underutilised in education programmes due to poor learning in school).

- The real issues are:
    - political (undernutrition does not affect rich countries; and it is not going to rapidly deteriorate any time soon)
    - institutional (despite the presence of good multidisciplinary policy division teams at DFID there is no obvious place for cross-sectoral work like nutrition, and even less so in a world dominated by sector-wide approaches and direct budget support)
    - lack of a local champion

- how to link nutrition to the current White Paper theme of making governance work for the poor

- And even strong DFID policy imperatives translate unpredictably into DFID country programme activities.

- Was positive about a number of issues:
  - Nutrition will be in the health strategy at DFID.
  - the cross-team working group has yielded (a) a draft institutional analysis of where nutrition could be best placed within DFID. We and (b) the India country office has begun doing more nutrition work.
  - DFID could be the leader in dealing with malnutrition due to its strong interdisciplinarity. The Dutch could be strong allies.

- Is the Policy Division the best place for nutrition? Other places could be CHASE (humanitarian) or the UN/multilateral section of DFID

EC1

- Conceptualisation of chronic malnutrition - Insufficient quality/quantity of food. Recurrent.

- Prioritisation of chronic malnutrition – Medium to high. Because of the food security budget line. Now food aid/emergency aid is moving to ECHO. We're focusing medium-long term and more on the chronic scenarios than the acute.

- Drivers/impediments – Impediments – limited prioritisation from countries. MDGs - EC has implicit reporting on MDGs in the CASs.

EC2

- Conceptualisation of chronic malnutrition – Insufficient calories

- Prioritisation of chronic malnutrition – Part of poverty mission and MDGs but not very high in development aid. Likely to be rising due to international development consensus.

- Drivers/impediments – Impediments – competition between various issues; limited country interest. Drivers – international policy agenda on MDGs and public interest.

EC3

- Conceptualisation of chronic malnutrition – A result of poverty and inequality. Imbalances access to food. And cultural practices.

- Prioritisation of chronic malnutrition – Medium. DG Dev growth focused and trade/regional integration. Concerning the second issue I would not

be pessimistic, actually nutrition features much more now than in the past in EC documents, like the new thematic programmes for example. Definitely, food security more broadly is not the top priority.

- Drivers/impediments – Impediments - cross-sectoral nature; media. I don't think there are any nutritionists in the EC. Possibly in ECHO.

EC4

- Conceptualisation of chronic malnutrition – Low calorific intake

- Prioritisation of chronic malnutrition – Low, because of shift to budget funding

- Drivers/impediments – Impediments – lack of EC capacity in personnel; lack of nutrition data

EC5

- Conceptualisation of chronic malnutrition - Lack of protein/energy intake leading to stunting.

- Prioritisation of chronic malnutrition – Probably not enough. No clear policy instrument. EC commission resources limited. Not particular high priority to social sector. Tendency to focus on health and diseases. Nutrition comes into child and maternal mortality and HIV in terms of responses but marginal rather than main issue. Taken into account rather than main stream. Focus food security. 95% defined by countries themselves. New thematic programme gives opportunity for more strategic work between bits of the EC. Investing in people budget line but resources limited.

- Drivers/impediments – One issue is what EU members states can do. EC could do with more policy coherence. If one of member state raised issue – MDG 1 on nutrition – EC could convene discussion of member states on what are the key themes and are their better ways of coordinating EU member states action. There could be possibly of a communication on nutrition related issues. Wouldn't be more resources as programmed at country level. More a question of capturing increase in EU financing to 0.7% GNI to be spent on nutrition. Some of this spent on nutrition need coherent view from Member States that this should be a priority. Not happen without external advocacy/trigger rather than driven from with the EC. Thus impediment is EC responds to country-led demands from member states; 2 focal sectors in each country plus budget support so if nutrition not prioritised at country level won't filter through. Currently no programme level guidance as no request. Require UN agencies to be more effective advocates and demanding country support for this.

The EC responds to country led demands and to Member State pressure - rather than country led demand from member states (the countries make demands themselves to the delegations – but there is also the possibility of the EU member states working collectively at the country level to help ensure that country identified demands are covered by the donors working in a cooperative way – the EC could work with the member states on joint programming to ensure that issues such as nutrition do not get neglected, for example if all donors choose to focus on health, at the expense of investing in nutrition. In addition, the member states can apply pressure in Brussels – through prompting technical dialogue to prioritise nutrition – or through views expressed in council and through the Parliament, which also help to shape central policy development.

EC6

- Conceptualisation of chronic malnutrition – Low calorific intake. We stress the links between nutrition and infection. Measured by stunting.

- Prioritisation of chronic malnutrition – There is no objective measure of high/low prioritisation but it is an integral part of EC business. Well establish priority.

- Drivers/impediments – Impediments – cross-sectoral nature

EC 7

- Conceptualisation of chronic malnutrition - Low calorific intake.

- Prioritisation of chronic malnutrition – Has always been on the agenda because of food security budget line and programmes. Perhaps not a specific focus on chronic malnutrition explicitly.

- Drivers/impediments – Drivers - MDGs

EC 8

- Conceptualisation of chronic malnutrition – Food security/hunger/undernutrition - non-food items.

- Prioritisation of chronic malnutrition – High – EC is global number one (ECHO); expressed more as food aid; Netherlands has integrated acute-chronic programmes. Rising? No, same.

- Drivers/impediments – Impediments - lack of country partners putting on agenda; expertise nutrition requires not always available.

EC9

- Conceptualisation of chronic malnutrition – ECHO handles food aid. It is needs based. Malnutrition to us is transitory/humanitarian/WFP definition. Chronic malnutrition relates to food security measures. DG Dev does food security.

- Prioritisation of chronic malnutrition – It's rising because international partners talking more about malnutrition rates especially UNICEF and WFP but NGOs too.

- Drivers/impediments – Impediments – chronic/acute unclear definitions – media usually influential; different measures of nutrition – no standard approach.

- Other info – ECHO recently set up a unit on food aid. From 2007 this unit will handle emergency food aid. From 2007 change in ECHO from block grants to UNICEF and others to more earmarked approach to focus on refugees and under five children. We have specifically mentioned to WFP that we would earmark in their programmes (trying to avoid financing development activities as they are often placed within their emergency programmes (EMOPs) and protracted relief and recovery operations (PRRO). We have not given the earmarking message to UNICEF – but only WFP. The earmarked approach is to target better the most vulnerable populations (the refugees and children under five are considered to be some of the most vulnerable populations in ECHO's strategy).

EC10

- Conceptualisation of chronic malnutrition – Open question difference between chronic-acute malnutrition.

- Prioritisation of chronic malnutrition – High/stationary

- Drivers/impediments – One impediment is chronic/acute demarcation - we need to break down the wall; talk to each other on both sides of the fence. Cross-sectoral nature makes more complex. Cultural barriers to nutrition one of the biggest problem.

SCN1

- Conceptualisation of chronic malnutrition – The standard UN food-care-health definition, but applied to stunting of under 2's.

- Prioritisation of chronic malnutrition by bilateral donors at the SCN – Medium, but declining in last 2-4 years. There is a feeling that this decline is happening because the bilateral representatives who come to the SCN are able to link their home bilateral policy frameworks to nutrition. The newer generation is less able to do this due to the lack of

degrees that train nutrition people who are embedded in the broader development picture. New graduate programmes have been introduced in the US and the Nordics and hopefully the new graduates will begin to champion nutrition within arenas where it requires some creativity to engage.

- Drivers/impediments – Impediments: inability of the nutrition community to connect with policy frameworks used in bilaterals. The UK's new White paper which talks about governance and the capacity to deliver, accountability and responsiveness could be a driver: the nutrition community in the UK could engage with accountability (annual nutrition surveys would be a very effective and credible way of naming and shaming governments); and the capacity and responsiveness language is the language of human rights and the nutrition community has made strong contributions to the rights debates. In Norway the development ministers are worried about nation building and peacekeeping – and there are some opportunities to bring nutrition in terms of human capital, civil and political rights, the treatment of captives, the use of starvation as a weapon. Combating malnutrition requires a sophisticated approach which conflicts with the need to spend 30m a year in safety nets. We know the stories about good nutrition reducing mortality, morbidity and raising productivity and learning, but the real issue is the need to spend through line ministries, even in humanitarian spends, and here the issue is the lack of institutional home. Drivers: Using chronic malnutrition as an indicator of progress in things like safety nets might be useful, but need to recognise that chronic malnutrition is also not a very specific indicator (i.e. lots of things can affect it, not just the intervention).

CT1

- Conceptualisation – Several years. Underlying causes. Acute programmes contribute to chronic malnutrition work.

- Prioritisation of chronic malnutrition – Difficult to say. Indirect approach - More a livelihoods approach. Difficult to say if up or down.

- Drivers and impediments – We don’t look through it from a chronic malnutrition lens necessarily. Looking through other lenses.

- Other – Examples of the best and worst investments in nutrition over the last 5 years – Best – those that seek to understand chronic malnutrition and cross-sectoral issues. Number of programmes on health care and child rearing issues. Least – supplementary feeding programmes – a number of which have been wound up. Therapeutic feeding programmes questioned. What do you think DFID could do to improve their role in reducing malnutrition? – Linking/closer engagement with relevant people in London. More thoughtful approach to chronic malnutrition – GAM and SAM rates dominate currently – not yet gone beyond but good understanding in DFID of these issues. Poor

understanding of chronic malnutrition outside of nutrition sector amongst other donors.

CT 2

- Conceptualisation - Common occurrence; food security
- Prioritisation of chronic malnutrition – Low – because economic not food security perspective – income poverty based. Up or down - difficult to say.
- Drivers and impediments – Drivers – more balanced perspectives on poverty need to broaden to include environment and food impacts of environmental degradation. Impediments – lack of data and lack of analysis on subject – look at immunisation and HIV data and thus impact; and malnutrition doesn't kill directly – other things – malaria for example can say how many people died, etc.
- Other – examples of the best and worst investments in nutrition over the last 5 years by DFID? Nothing done. What do you think DFID could do to improve their role in reducing malnutrition? 4-5 years time there will have to due to seriousness of chronic malnutrition in the north.

CT3

- Conceptualisation of chronic malnutrition – Cumulative lack of food and sanitation. Something that is unacceptable, even though considered "normal" in certain provinces of Ethiopia by certain countries. Focus not particularly age specific, but more region-specific.
- Prioritisation of chronic malnutrition – Medium, but buried in 3 strategic priorities of DFID/Ethiopia: Investing in basic services; improving capacity to deliver; and safety nets. It comes into all 3, but not many people in the office will be talking about "chronic malnutrition". They have engaged with debates on the National Nutrition Programme, designed by World Bank and UNICEF in conjunction with GoE, but DFID remains unconvinced about its overreliance on "one programme to deal with all malnutrition issues" and concerns about its design. DFID does not finance it for these reasons, but also because they are driven by "which government system allows the greatest spend". He is the point person on nutrition even though not a nutritionist. The one nutritionist on staff is working on HIV/AIDS issues.
- Drivers/impediments – Impediments – combating malnutrition requires a sophisticated approach which conflicts with the need to spend 30m a year in safety nets. We know the stories about good nutrition reducing mortality, morbidity and raising productivity and learning, but the real issue is the need to spend through line ministries, even in humanitarian spends, and here the issue is the lack of institutional home. Drivers - using chronic malnutrition as an indicator of progress in things like

safety nets might be useful, but need to recognise that chronic malnutrition is also not a very specific indicator (i.e. lots of things can affect it, not just the intervention).

CT4

- Conceptualisation – Within the 0-59 age group. Both a food and health determinants (but nothing about role of care). Seemed keen to label as a health responsibility. Was convinced I was only really interested in health aspects of nutrition. Focuses on food security although is the liaison point on nutrition too. No confusion with acute emergency response. Health person at EC does not work on nutrition.

- Priority to chronic malnutrition – Depends. If framed broadly, then high priority from EC through (a) productive safety net programme that EC supports. On this I asked why there was not a nutrition focus in the cash transfer element as in Progresa, and he said that the GoE did not want the conditionality. Said there were teething problems with the programme (targeting, capacity building, financial management, but that these were being worked out), and (b) through investments in rural infrastructure and rural development (service delivery). If more traditionally focused (according to his definition) then there was the opportunitistic investment by the EC – they had some end of year money left over last year and they put £7m into the UNICEF EOS (Enhanced Outreach Strategy for nutrition – one-shot set of interventions aimed at preschoolers and pregnant and lactating women, screening on nutrition status, vitamin supplementation, medical activities). He did wonder about the sustainability of the EOS and how the GoE would fund it if UNICEF pulled out (although the EOS is cited as his nutrition success story, even though the WFP evaluation of it – the EOS uses WFP rations – will not be finalised until January).

- Drivers/impediments – Nutrition programming not seen as a long term investment – sustainability seems like a key issue. Again noted the productive safety net was protecting asset deterioration. Did not make the connection in terms of the similarities with the UNICEF intervention (protecting human capital, capital that could be irreversibly compromised). Also said lots of other priorities could claim credibly for higher attention from the EC – but budgets limited, even when large, and others are doing nutrition, and in any case, the EC is responding to the PRSP.

CT5

- Conceptualisation of chronic malnutrition – Height-for-age – stunting - linked to wider issues of long-term food insecurity and chronic poverty.

- Prioritisation of chronic malnutrition – When talking about malnutrition - more of a focus on acute malnutrition – grabs headlines. Less focus on chronic malnutrition – lack of reliable data. There is progress on this,

with the move from food aid to long term food security. In DFID Zimbabwe the prioritisation is going up. Good work with UNICEF on nutritional surveillance looking at basic causes of malnutrition – not just food availability but water supply sanitation, health (including HIV and AIDS) and poverty reduction programmes. Linking up with experts on nutrition. Nutritionist skill set undervalued in general. [DFID Zim: Medium and rising; DFID HQ: Appears to be low]

- Drivers/impediments – No central guidance (that DFID-Zim are aware of) from DFID HQ on chronic malnutrition – good things are happening at DFID Zimbabwe – mostly due to nutritionist in the office there before and move from narrow humanitarian to broader livelihoods and social protection approach to tackling chronic poverty. Good would be a resource centre of experts – e.g. drawing on expertise of organisations such as IDS/Save if we decided to outsource expertise. Also need to link up with nutritional expertise in country to develop joint approaches e.g. UNICEF. Too expensive to have nutritionists in every country office, particularly with 5% cuts on running costs and headcount constraints. Another driver for nutrition mainstreaming is to look at linkages between nutrition and other programmes of support e.g. treatment for people living with AIDS and support for vulnerable children.

- Other info:
  - Best example: Nutrition surveillance: £300k/year to UNICEF working with MoH (country ownership) – cost effective and creates data for further analysis of problem. Also – positive shift away from supplementary feeding to long term livelihoods support programmes – these are also more cost effective (the cost of growing instead of giving maize as food aid is much lower).
  - DFID has comparative advantage in the areas of social protection and livelihoods expertise - flexible toolkit (with cash transfers etc) to move from crisis situations to more long-term poverty reduction programmes. Not as inflexible as USAID that does more on acute malnutrition via food aid and ECHO with one year work programmes.
  - DFID Zimbabwe funds part of a nutritionist in UNICEF and can access expertise that way.

CT6

- Conceptualisation of chronic malnutrition – Looks at it from the livelihoods perspective.

- Prioritisation of chronic malnutrition – In DfID Afghanistan: medium and rising slowly. Aware of problem, but not level and degree due to insufficient data – this will change with the NRVA and EC food security assessment – includes nutrition surveillance – not released yet. Focus has moved from counter narcotics to more focus on food security and malnutrition – gradual process, but rising in importance. This

development is wider than DFID Afghanistan – also in GoA – more focus on what is going on with people, use of nutrition indicators.

- Drivers/impediments – Competing agendas and resources constraints, there is only a limited budget and malnutrition is not that high on list of priorities in a highly politicised aid environment. Also donor coordination – EC do a lot on food security. Lack of accurate data is impediment – the data coming soon from the EC food security assessment can drive issue higher up agenda.

- Other info:
  - Best example: EC food security assessment and nutrition surveillance – data very important. DFID bilateral NGO programmes – moved quickly from humanitarian aid to long term development programmes. Worst – some cash for work programmes make assumptions about outcomes – but not sure if they are successful in targeting chronically malnourished.
  - Need to decide if DFID should do more on chronic malnutrition – need to make this assessment of programme. Need to decide what comparative advantage is, perhaps not doing more on food security, due to EC role. Comparative advantage may be to continue with dialogue with GoA (£50million budget support/year) – help assess government policy, in line with new data – this will probably happen.
  - No nutrition specialist at DFID Afghanistan (DFID does not do work in health in the country), no such role as nutrition adviser at DFID – would call on statistician in DFID Pakistan when needed (for data analysis) or buy in consultants for specific needs.

CT 7

- Conceptualisation of chronic malnutrition – Chronic malnutrition is an unbalance between energy intake and energy output created by either a chronic insufficient availability of food, an unbalanced diet e.g. for cultural reasons or maybe a disease affecting the general processing of the intake affecting mainly children and elderly, and in generally persons with bad physical state.

- Prioritisation of chronic malnutrition – EC supports the Basic Package of Health Services which includes a part on public nutrition -including chronic malnutrition. EC supports also a food aid and a food security programme in Afghanistan which includes interventions targeting women and aiming at improving the diet of the most vulnerable / poorest in the project areas (sent table with examples of food security project – distribution of vegetable seeds). Since the issue is also linked to the rural development of a country, I inform you that EC supports a major horticulture programme namely for dried fruits known for their high caloric value. The prioritisation remains the same.

- Drivers/impediments – There is no profile to raise, nutrition issues are simply part of our support to the health programme as designed by the Ministry. Nutrition is also part of the food aid programmes of EC.

- Other info:
  - Best examples: Not being a specialist, I just think that kitchen gardens are a good initiative. I am not sure if this is the best. Worst: Distribution of food massively might create dependent behaviours, distortions of markets. I have no particular example of EC bad investments.
  - What do you think EC could do to improve their role in reducing malnutrition? – EC will continue to support the Health programme since it is the best way of preventing malnutrition linked to bad food behaviours (weaning etc.). It allows also for its national coverage a greater access than punctual actions.

CT8

- Conceptualisation of chronic malnutrition – DFID defines malnutrition as an abnormal physiological condition caused by deficiencies, excesses or imbalances in energy, protein and /or other nutrients. Nutritional status is determined by many factors including health status, household food security, household and community practices, environmental factors, education. Malnutrition and hunger are, of course, inextricably linked to poverty and vulnerability. Lack of food security in Bangladesh relates predominantly to issues relating to access and utilisation of food. DFID recognises that improved nutrition has a role in the pursuit of the MDG goals on primary education, gender equality, child mortality, maternal health, and combating disease. As well as to achieving MDGs 1 (eradicating extreme poverty and hunger) and 7 (ensure environmental sustainability).

- Prioritisation of chronic malnutrition – Medium to high. As one of the 'off track' MDG targets and the links between nutrition and poverty and vulnerability this is a priority area for DFID B. One of the key results areas of our emerging Country Assistance Plan for Bangladesh focuses on reducing extreme poverty and vulnerability. Within this we will have a target of ending seasonal hunger. In the health sector, the national nutrition programme is being brought under the Health, Nutrition and Population Sector Programme which DFID supports. Whilst DFID B does not sit on the MoHFW led Nutrition Working Group (in line with commitments on aid effectiveness, different development partners take the lead and represent other consortium members in thematic areas), we are following progress on this carefully. The prioritisation is about right, but DFID B plans to develop a position paper on food security and nutrition that lays out our thinking, current and planned involvement in food security and nutrition.

- Drivers/impediments – Drivers in Bangladesh include the availability of very good data on the trends in nutrition status in recent years.

Impediments include the various many actors and institutions (with varying degrees of capacity) that need to be involved in improving nutrition and food security.

- Other info:
  - Best example – Using the Expanded Programme of Immunisation has been a successful mechanism in Bangladesh for distribution of Vitamin A. Recent MoHFW data suggests that 85% of children (9-59 months) had received vitamin-A capsules in the preceding 6 months.
  - Staff working on nutrition issues and nutrition specialists – In the DFID B office people across the teams work directly or indirectly on nutrition issues including in the areas of health, education, livelihoods and reducing extreme poverty. There are no nutrition specialists in the office.

Annex 5: List of Abbreviations/Acronyms

ACP	African, Caribbean and Pacific Countries
AIDCO	EuropeAid Co-Operation Office
ANDS	Afghanistan National Development Strategy
BPHS	Basic Package of Health Services
CAP	Country Assistance Plan (DFID)
CES	Country Engagement Strategy (DFID)
CGIAR	Consultative Group for International Agricultural Research
CHASE	Conflict, Humanitarian and Security Department (DFID)
CIDA	Canadian International Development Agency
CRD	Central Research Department (DFID)
CRS	Creditor Reporting System (DAC)
CSP	Country Strategy Paper (EC)
CSS/IP	Country Support Strategy and Indicative Programme (EC)
DAC	Development Assistance Committee (OECD)
DDP	Director's Delivery Plan (EC)
DFID	Department for International Development, UK
DG Dev	Directorate-General for Development (EC)
EC	European Commission
ECHO	European Commission's Humanitarian Aid Office
EOS	Enhanced Outreach Strategy for Nutrition
EU	European Union
FANTA	Food and Nutrition Technical Assistance Project
FAO	Food and Agriculture Organization of the United Nations
G8	Group of 8 (Canada, France, Germany, Italy, Japan, Russia, the United Kingdom and the United States)
GoA	Government of Afghanistan
GoB	Government of Bangladesh
GoE	Government of Ethiopia
GoN	Government of Nigeria
HNPSP	Health, Nutrition and Population Sector Programme
HoD	Head of Department
HoP	Head of Profession
ICRC	International Committee of the Red Cross
IDS	Institute of Development Studies
IEC	Information Education Communication
INGO	International Non-Governmental Organisation
I-PRSP	Interim Poverty Reduction Strategy Paper
KNOTS	Knowledge, Technology and Society Team at IDS
LDC	Least Developed Country
MDGs	Millennium Development Goals
MIC	Multiple Indicator Cluster
MoH	Ministry of Health
MoPH	Ministry of Public Health
NGO	Non-Governmental Organisation
NIP	National Indicative Programme (EC)
NNP	National Nutrition Policy
ODA	Overseas Development Assistance
OECD	Organisation for Economic Cooperation and Development

PATHS	Partnership for Transforming Health Systems
PNPS	Public Nutrition Policy and Strategy
PRSP	Poverty Reduction Strategy Paper
PSNP	Productive Safety Net Programme
PSA	Public Service Agreement (UK)
SCN	United Nation System Standing Committee on Nutrition
SC UK	Save the Children UK
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WB	World Bank
WFP	United Nations World Food Programme

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