EuropeAid

Enhancing EC's contribution to address Maternal and Child undernutrition and its causes

Concept note

January 2009

EUROPEAN COMMISSION

Paper published in January 2009

The present document was developed under the leadership of AIDO E6, following the EC seminar "Enhancing EC's contribution to address maternal and child undernutrition and its causes" held in Brussels from 7 to 8 May 2008. Comments are welcomed and can be addressed to the following e-mail address: *EuropeAid-E6-natural-resources@ec.europa.eu*

The aim of this paper is to present the way forward for the EC in nutrition and it should not be considered as an official document.

Contents

I. INTRODUCTION - 1 -

II. WHY NUTRITION SHOULD BE HIGHER ON THE POLITICAL AGENDA OF THE EU AND MEMBER STATES? - 2 -

CONSEQUENCES OF UNDERNUTRITION - 2 -
UNDERNUTRITION A REFLECTION OF POOR GOVERNANCE AND HUMAN RIGHTS VIOLATIONS - 2 -
UNDERNUTRITION AND WORLD FOOD PRICES FLUCTUATION - 3 -

III. THE NATURE OF UNDERNUTRITION AND IMPLICATIONS - 4 -

IV. EU ADDED VALUE WITHIN THE CURRENT DONOR ENVIRONMENT - 6 -

KEY CHARACTERISTICS OF THE DONOR ENVIRONMENT - 6 -
EC'S POSITIONING, STRENGTHS AND COMPARATIVE ADVANTAGE - 7 -

V. INTERNAL PRIORITIES FOR ACTIONS - 8 -

VI. PRIORITIES FOR ACTION IN PARTNERSHIP/ COLLABORATION WITH OTHERS - 10 -

ANNEXES - 12 -

ANNEX 1: ACRONYMS - 13 -
ANNEX 2: GLOSSARY - 14 -
ANNEX 3: THE 36 COUNTRIES WITH CHILDHOOD STUNTING PREVALENCE ≥ 20% COVERING 90% OF THE 178 MILLION GLOBALLY ESTIMATED NUMBER OF STUNTED CHILDREN - 15 -
ANNEX 4: FRAMEWORK OF THE RELATIONS BETWEEN POVERTY, FOOD INSECURITY, AND OTHER UNDERLYING AND IMMEDIATE CAUSES TO MATERNAL AND CHILD UNDERNUTRITION AND ITS SHORT-TERM AND LONG-TERM CONSEQUENCES - 16 -
ANNEX 5: INTERVENTIONS WITH DEMONSTRATED IMPACT ON MATERNAL AND CHILD UNDERNUTRITION AMONGST 'TRADITIONAL' NUTRITION PROGRAMMES - 17 -
ANNEX 6: PRIORITIES FOR ACTIONS ACCORDING TO THE COPENHAGEN CONSENSUS 2008 CHALLENGE PAPER - 18 -

I. Introduction

The European Commission is in the process of reviewing its involvement in the field of nutrition in developing countries[1].

This initiative was first triggered by the EC's desire to maximise the impact of its resources on food security and nutrition and better support progress towards the first MDG target: halving, between 1990 and 2015, the proportion of people who suffer from hunger. Secondly, it was prompted by the awareness that 'structural' malnutrition, and specifically chronic malnutrition, has largely been overlooked and does not frequently feature among development priorities. Thirdly, the EC wishes to better coordinate responses to malnutrition during emergencies and post-crisis actions and hence strengthen LRRD (Linking Relief Rehabilitation and Development) in order to properly tackle malnutrition.

The revision process leading up to this paper has included a background paper and the seminar *'Enhancing EC's contribution to address Maternal and Child Undernutrition and its causes'* which was held by EuropeAid in May 2008[2].
The scope of this paper (and the process leading up to it) is restricted to one form of malnutrition[3]: undernutrition[4] (see annex 2:

glossary). The focus on maternal and child undernutrition reflects the scale of the issue among these groups and its consequences on mortality, morbidity and development.

This paper draws on the outcomes/recommendations of the seminar and recent publications[5]. It is primarily intended for EC staff at headquarter and in delegations. It is also meant to inform other stakeholders in nutrition and contribute to better coordination and complementarities.

This paper suggests a way forward for the EC to prioritise nutrition and to develop a nutrition strategy/operational plan.

The first section presents key reasons why nutrition should be higher on the political agenda of the EU and its member states. The second reviews the nature of undernutrition and the implications for actions. The third section provides a brief overview of the donor environment in nutrition and related areas and highlights the EC's strength and comparative advantage. The fourth and fifth sections suggest next steps: actions for EC internal implementation and activities to be undertaken in partnership/collaboration with others.

1 The EC has undertaken a similar process on the topic: 'Entitlement and access to food: systems of social transfers to fight extreme poverty'. The concurrent development of both concept notes facilitated the convergence of the two processes and enables the EC to take advantage of social transfers to reduce undernutrition.

2 It brought together nutrition experts and EC staff to advise the EC on priorities, strategy and responses to tackle undernutrition.

3 Malnutrition encompasses both undernutrition and obesity/over-consumption of specific nutrients. The obesity epidemic and diet-related chronic non-communicable diseases are spreading quickly and consitute major public health/public nutrition issues. They should be included at a later stage of the process.

4 'Undernutrition includes a wide array of effects including:
intrauterine growth restriction resulting in low birthweight;,
underweight, a reflection of low weight-for-age;
stunting, a chronic restriction of growth in height indicated by a low height-for-age;
wasting, an acute weight loss indicated by a low weight-for-height;
and less visible micronutrient deficiencies.' Lancet Series summary, 08

5 Predominantly the 'Lancet Series – Maternal and Child Undernutrition', 2008 referred to in this document as the 'Lancet Series 08' and 'Greater DFID and EC Leadership on Chronic Malnutrition: Opportunities and Constraints', Institute of Development Studies, 2007.

II. Why nutrition should be higher on the political agenda of the EU and member states?

Consequences of undernutrition

Child and maternal undernutrition (see box 1) causes tremendous devastation in developing countries with far reaching and pervasive negative consequences beyond its terrible death toll.

Undernutrition is estimated[6] to be responsible for **3.5 million child deaths per year[7],** 35% of the disease burden amongst children under 5 years and 11% of total global Disability Adjusted Life Years[8]**.** Iron deficiency anaemia is responsible for at least 20% of maternal mortality (estimated at 115,000 deaths/year).

Undernutrition compromises physical and cognitive development which in turn lowers individuals' and societies' economic potential and contributes to the perpetuation of poverty. The **economic costs of malnutrition are estimated at 2 to 3% of GDP and 10% of lifetime earnings**[9]. **Tackling undernutrition is therefore critical to poverty reduction and needs to be an integral part of the EC's growth promotion strategy.**

The outcomes of undernutrition (death, illness, impaired physical and mental development) **undermine progress towards several MDGs**, not just the first one but also MDG 4 (reduction in infant mortality) and MDG 5 (reduction in maternal mortality). Undernutrition impedes directly or indirectly on primary education, reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases.

Undernutrition a reflection of poor governance and human rights violations

Ensuring good nutrition is a matter of international law conveyed by several international declarations and human rights instruments: '*States parties must take appropriate measures to reduce infant and child mortality and to combat disease and malnutrition'*[10]*.*

Undernutrition has to been linked to the governance agenda as *'the persistence or worsening of malnutrition trends in a population is a sombre reflection on the quality of how it is governed'. 'Failure to make the investments in reducing chronic malnutrition is an indictment of the quality of governance. (SC UK, IDS, 2007)'* Governance failure is particularly striking in places where economic growth is strong but undernutrition is persistent.

6 Lancet Series, 2008, data from 2005

7 In comparison, about 9 million people were killed during the 4 years of the First World War. The death toll of the 1994 Rwandan genocide was estimated at 800,000. 881.000 child deaths are attributable to malaria per year (WHO, 2008).

8 DALY: an indicator developed for the calculation of disease burden which quantifies, in a single indicator, time lost due to premature death with time lived with disability

9 'Repositioning Nutrition as Central to Development - A Strategy for Large-Scale Action', World Bank, 2006

10 Article 24 of the Convention on the Right of the Child

Undernutrition and world food prices fluctuation

Rising world food prices reveals pre-existing problems and adds an unprecedented challenge for nutrition. Reduced purchasing power will further weaken households' access to an adequate diet and ability to care for their children. Actions are needed to offset the negative impact of rising food prices and prevent a rise of undernutrition both in rural and urban settings. Yet, recent discussions on the international architecture in response to rising food prices (e.g. Global Partnership on Agriculture and Food) have overlooked malnutrition.

Reasons for addressing undernutrition are compelling and yet too little has been achieved.

Box 1: levels and trends of undernutrition – key points

- Latest estimates[11] report that there are 13 million children born annually with Intrauterine Growth Restriction, **55 million children under 5 years wasted and 178 million stunted**.

- Between 40 and 50% of pregnant women and preschool children suffer from iron deficiency anaemia worldwide[12].
- About 40% of children are growing up with insufficient vitamin A[13].
- About 15% of people in developing countries lack adequate iodine[14].

- The reduction of underweight (from 32% to 27% between 1990 and 2006)[15] is considerably lower than what is needed in order to reach the MDG 1 target (halving, between 1990 and 2015, the proportion of children under five who are underweight).

- The regions worst affected by undernutrition are South Central Asia and Sub-Saharan Africa. **About 80% of the world's stunted children live in 20 countries and 90% in 36 countries** (see annex 3).

- **In Sub-Saharan Africa**, although the prevalence of underweight appears to have dropped (32% in 1990 to 28% in 2006)[16], **the number of underweight children is on the increase** (29 million in 1990 to 37 million in 2003)[17]. Between 2005 and 2015, an additional 3.7 million underweight children is expected[18].
- In South Asia, both the prevalence (54% in 1990 to 46% in 2006[19]) and the number (88 million in 1990 and an estimated 64 million in 2005[20]) are declining.

11 Lancet Series, 2008, data from 2005

12 Ibid

13 'Vitamin and mineral deficiency – A global progress report', UNICEF, The Micronutrient Initiative, 2004

14 Ibid

15 'Progress for Children - A World Fit for Children - Statistical Review' – N° 6, UNICEF, Dec. 2007

16 Ibid

17 'The Millenium Development Goal Report', UN, 2005.

18 'Everybody's business, nobody's responsibility', SC UK, 2007 - Data available for 40 countries.

19 Ibid

20 Presentation Haddad L., IDS, 2007 (based on estimates from De Onis and Blossner 2003)

III. The nature of undernutrition and implications

Undernutrition encompasses several conditions (e.g. stunting, wasting, anaemia, etc...) and each of these is usually the result of a combination of factors as illustrated by the UNICEF causal model (see annex 4). Given the complex interplay of factors, **preventing/ addressing undernutrition in the long term requires acting concomitantly on several determinants and different levels of causes** (immediate, underlying and basic causes).

There is a set of generic interventions – **addressing immediate causes** - with proven effectiveness that should be prioritised. Recommendations from the Lancet Series 08 and the 'Copenhagen consensus 2008 challenge paper' are presented in annexes 5 and 6.

For example, the Lancet Series 08 conclude that *'Of the reviewed interventions, breastfeeding promotion, appropriate complementary feeding, supplementation with vitamin A and zinc, and appropriate management of severe acute malnutrition showed the most promise for reducing child deaths and future disease burden related to undernutrition.'*

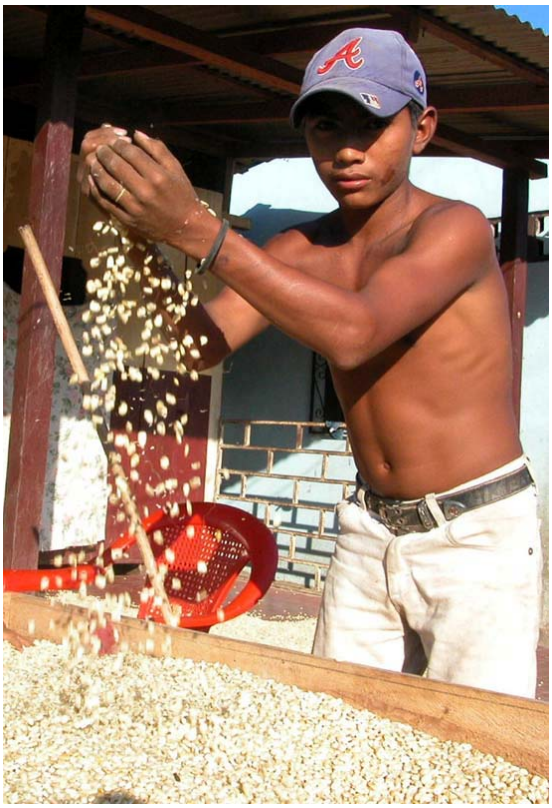
Box 2: crucial window of opportunity

Physical and mental damages associated with poor foetal growth and stunting are largely irreversible after two years. Moreover, undernutrition passes from one generation to the next as maternal undernutrition increases the risk of low birth weight leading to the inter-generational cycle of undernutrition.

It is therefore critical to ensure the right conditions are there **6 months before and during the pregnancy and the first two years of life of a child** in order to avert the adverse and pervasive effects of stunting.

The authors estimate that *'universal coverage with the full package of proven interventions at observed levels of programme effectiveness could prevent about one-quarter of child deaths under 36 months of age and reduce the prevalence of stunting at 36 months by about one-third'* in the 36 worst affected countries.

Therefore, a further reduction of undernutrition prevalence in a sustainable manner is also dependent upon **addressing underlying and basic causes**. Actions such as land reforms, safety-nets/social transfers, primary health care, empowerment of women, education, agriculture/agro-biodiversity, livestock and water programmes should be more systematically aligned behind nutrition objectives and designed to improve nutritional outcomes.



The pre-requisites to achieve a substantial and lasting reduction in undernutrition prevalence (multi-sectoral approach, long-term perspective and prioritising the window of opportunity) call for **a set of conditions at country level**:

- political commitment and government leadership
- adequate and sustained financial resources
- adequate technical, strategic and management capacity
- appropriate institutional arrangements, strategic frameworks and coordination mechanisms bringing together the relevant stakeholders,
- implementation at scale of the right actions and effectively reaching those in need.

The above would be greatly enhanced by a clearer international leadership and a better coordination of the international community in nutrition.

IV. EU added value within the current donor environment

Key characteristics of the donor environment

Overall investment in nutrition is characterised by:

1) **Questionable prioritisation of available resources** both in geographic terms and type of actions funded

The geographical allocation of resources reflects a variety of agendas rather than a prioritisation of countries with a high burden of undernutrition. For example, between 2000 and 2004, *'Emergency food aid went principally to just six countries: Ethiopia, Sudan, Afghanistan, Angola, Iraq, and North Korea, a clearly politicised distribution'*[21].

The Lancet Series 08 estimated that total funding for basic nutrition interventions per annum from 2000 to 2005 did not exceed US$250-300 million[22]. Over the same period, funding for food aid/food security amounted to US$1.375billion while US$5.7billion was allocated to HIV/AID per annum. According to the Lancet, there are no more DALYS lost to HIV than to maternal and child undernutrition.

2) **Under-funding of basic nutrition**[23]

If all of the US$250-300 million *'were allocated with perfect targeting to the 20 countries accounting for 80% of all stunted children, then each of the roughly 130 million infants younger than 2 years living in these countries could benefit from an investment of just over $2 a year, which is far less than the $5–10 per child that effective large-scale community nutrition programmes are estimated to cost.'*

Relatively few donor governments substantially support basic nutrition. Both the IDS analysis (which estimated the investments made by governments and the EC to tackle stunting) and the Lancet series 2008 showed that the USA is the largest donor government for basic nutrition followed by the Netherlands, Canada and the UK.

3) **Indirect**[24] **investments which are too rarely aligned behind nutrition objectives and designed to improve nutritional outcomes**

Indirect investments have the potential to prevent/reduce undernutrition through addressing its underlying and basic causes. However, they seldom have specific and stated nutrition objectives and they are not necessarily designed to maximise nutritional outcomes. Consequently, there is no guarantee that they have an impact on undernutrition and if they do, it is rarely measured.

4) **Insufficient investment in supporting strategies/enabling environment such as capacity building, integration in PRSPs and coordination**

A World Bank analysis – which did not include the EC – reviewed donors' investment in areas such as mainstreaming nutrition in PRSPs, monitoring/evaluation. It concluded that:

- Most of the effort in capacity development *'goes into training nutritionists to be better nutritionists rather than in orienting key government planning, finance, and economics staff toward nutrition and building commitment and support for nutrition in ministries of finance and planning*.'
- Few of the donors reviewed invested in monitoring/evaluation, commitment building and mainstreaming nutrition into PRSPs and sectorwide approaches. This reflects the low level of interest in nutrition and its lack of prioritisation in development agendas.

21 Lancet series 2008

22 Including the World Bank and Gates Foundation's contributions

23 Also referred to as direct interventions in the literature, e.g. breastfeeding counselling, targeted food aid, micronutrient supplementation

24 E.g. support to agriculture, food security, health system, education, governance

EC's positioning, strengths and comparative advantage

The EC could give a higher strategic priority to combating undernutrition overall as it already does in emergency contexts. Interventions in basic nutrition tend to fall under the remit of the health sector which is not always a priority area for the EC[25]. Current EC's instruments and their procedures restrict the ability to operate on a contiguum despite the recognised need to link relief to rehabilitation and development.
Nevertheless, the EC has a distinctive set of strengths to build on to enhance its contribution to addressing child and maternal undernutrition and its causes.

1) The EC is **the source of large resource flows with a high profile in indirect interventions** which have the potential to address underlying causes of undernutrition

Between 2000 and 2004, the EC was the second largest donor for development food aid/food security assistance[26]. According to IDS, the EC ranked first on indirect investments made by governments and the EC which could help tackle stunting. For instance, its substantial investments in research, agriculture, social protection and the more recent allocations to offset world food price rises could have a significant impact on undernutrition prevalence.

2) It is **involved in both development and humanitarian aid**. The latter – through **ECHO - gives a high priority to acute malnutrition**

Of DG ECHO's spending in 2008, to date almost €350m went on food[27] and nutrition. In line with previous years, more than €60m were provided for direct support to the prevention and treatment of acute malnutrition, or almost 10% of ECHO's budget. Within that, priority goes to community-based approaches and management of malnutrition in health institutions. In addition to the latter ECHO also supported broader packages of interventions aimed at reducing acute malnutrition through a better understanding of the situation (nutritional surveys/ surveillance, early warning systems and food and livelihoods assessments), through the reduction of food and livelihood insecurity (e.g. through cash-based interventions, food aid and food security interventions) as well as though a significant support to mitigating measures with support to health, water and sanitation or education of mothers (feeding practices) projects.

3) It has **significant influencing potential**

- The EC has significant country and regional presence (118 delegations) in low and middle income countries in comparison with other donors. It considers political dialogue as a key dimension of its cooperation. Therefore, it has the potential to exercise political leverage to get undernutrition higher on political and development agendas in aid recipient countries.
- It can influence EU Member States policies to mobilise more support for nutrition within the EU.

The combination of these strengths places the EC in a unique position to :

- exercise more leadership in nutrition amongst (poorly coordinated) EU actors with a view to attaining clear global leadership
- increase its commitment/contribution to tackle undernutrition, and
- have a major impact on progress towards MDGs 1, 4 and 5

[25] Lancet Series 2008 and IDS 2007 (ranking 10 out of 11 donor governments and EC reviewed)

[26] After the USA, according to the Lancet series 2008

[27] According to the Lancet series 2008, the EC was the second largest donor for emergency food aid after the USA between 2000 and 2004.

V. Internal priorities for actions

This section presents actions for EC internal implementation. Those in section 5 are to be undertaken in partnership/collaboration with others.

1) More impact on nutrition can be achieved by **applying a nutrition lens** to existing programmes and adjusting them accordingly:

- focusing on the most effective interventions according to context,
- adding nutrition indicators,
- improving targeting (e.g. children under two years and pregnant women),
- reducing risks of negative impacts,
- better integrating nutrition within areas/sectors such as agriculture/rural development, social transfers and the recent funding allocations to offset world food price rise

The EC will also consider:

- including a nutrition situation analysis in annual Country Technical Papers and ensuring nutrition features in subsequent guidelines
- adding nutrition objectives/programmes into new calls for proposals and applying a nutrition lens when designing the calls.

Countries with a high burden of undernutrition should be priorities.

2) **Under LRRD**, overcome the barriers that prevent better cooperation between development and emergency:

- Emergency relief and development should be seen as contiguous and complementary rather than successive links in a chain
- ECHO and Delegations should begin dialoguing at the planning stage with a right to provide input into each other's work. There should be joint programmes with shared monitoring.

3) **Better integration of nutrition in EC's relevant policies and inclusion of nutrition indicators in reporting frameworks** (e.g. underweight as an indicator for MDG1).

The use of nutrition indicators to report progress is important in areas such as food security, safety nets and social protection, governance, water and sanitation and health.

4) **Sensitisation of EC staff** and increasing expertise in public nutrition

Outside of ECHO, nutrition expertise is scarce within the EC. Providing guidance papers (e.g. similar to the 'Environmental integration handbook') and sensitising staff across sectors and at all levels could be a first step towards strengthening competence. The development and implementation of a comprehensive nutrition strategy (see below) will require more expertise in public nutrition within the EC.

5) **Develop a full strategy/ operational plan in time for the revision of the 10th EDF**

The EC's actions in nutrition need to be quickly guided by a comprehensive strategy/operational plan so that they are not simply disconnected opportunistic actions operating on a small scale. Moreover, a strategy/operational plan will:

- provide the necessary framework to maximise impact on nutrition by aligning resources from relevant areas - such as poverty reduction, agriculture, social protection and economic development - behind nutrition objectives
- facilitate synergy, an integrated approach and an effective collaboration between the relevant sectors of the EC as well as with partners
- provide coherence, structure and incentives to address undernutrition
- ensure nutrition is given a high strategic priority.

6) **Research priorities to guide the development of the EC nutrition strategy/operational plan:**

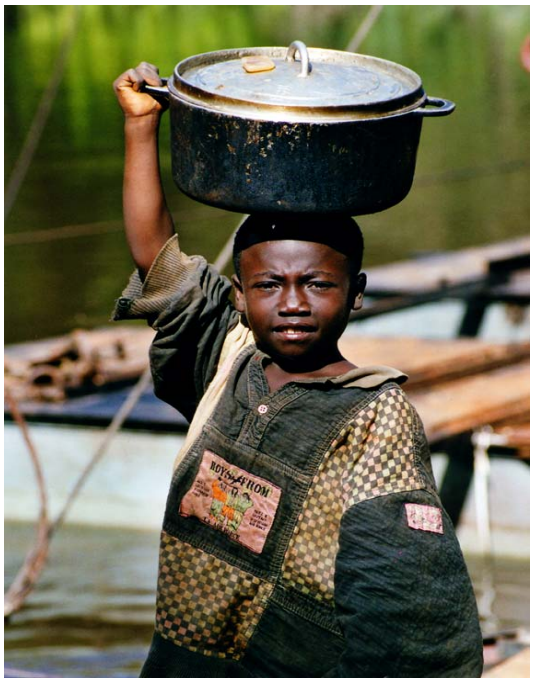
- conducting a review of EC's **direct and indirect nutrition spending** .
- This will enable the EC to understand what is being spent on nutrition, the impact it has and draw recommendations on how to make future spending more nutrition-friendly. The review could act as a thematic baseline to monitor progress.
- It will start with an internal inventory to capitalise on experience. Such a review will be the opportunity to gain a better understanding of the effect of EC's substantial investments in indirect interventions (e.g. agriculture, rural development, food security and social transfers) on nutrition and its causes (strengthening the evidence base).
- Measuring the **effectiveness of different aid mechanisms** (e.g. budget support, project aid) to address undernutrition. This could be linked to a governance agenda, reviewing institutional set up and aid modalities.

7) Identifying **nutrition champions/ focal points** and **institutional arrangements** within the EC bringing together DGDeV, ECHO, AIDCO, RELEX and the delegations to implement the strategy.

Because undernutrition does not fall automatically under one sector, it does not get prioritised (except in emergencies) or as IDS put it, it is ***'everybody's business and nobody's responsibilities'.***

The identification of nutrition champions/focal points at key levels (delegations, unit heads, directorates, etc…) will help a broad mobilisation to move forward and maintain a nutrition agenda.

Clear leadership and institutional arrangements which bring together the several bodies within the EC are a pre-requisite to a successful implementation of the strategy. In the case of the EC, DG ECHO has a clear mandate for nutrition in emergencies. It is less clear which body takes over the leadership and brings together the different sectors in development contexts. The EC considers conducting an internal situation analysis reviewing internal systems, structures, decision-making procedures and capacity. This could be linked to the research on the effectiveness of the different aid mechanisms (see above).



VI. Priorities for action in partnership/ collaboration with others

1) For the EC to place a greater emphasis/priority on nutrition it requires **political commitment at member state and European parliamentary committee levels**.

In order to obtain such a political commitment, one needs to exercise leverage on EU member states, the European parliament and commissioners. For example, undernutrition could be included as a priority of the forthcoming EU presidencies (Czech Republic, Sweden). Alternatively, an EU member state or a European parliamentary committee could call for greater priority to be given to undernutrition (raising the issue of the attainment of MDG 1). '*The EC could then 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 possibility of a communication on nutrition related issues.'(IDS, 2007)*

2) Promote **better integration of nutrition at country level in development agendas, national poverty reduction and relevant sector plans**

Linked to the above, the EC could play a role in revitalising political dialogue on nutrition and putting nutrition on the agenda of central and decentralised governments. For instance, the EC could support better and/or further integration of nutrition in PRSPs as they offer the necessary multi-sectoral framework to tackle undernutrition. Additionally, nutrition should be integrated in the EC 4-years Country Strategy Papers and EDF negotiations (National Indicative Programme, budget allocations, mid-term review and indicators).

Through its food security budget line, the EC has experience of multi-sectoral coordination and complex institutional arrangements at country level. It could apply its experience to the nutrition arena.

3) Support capacity building in nutrition:

- to enhance the ability of a broad set of actors (e.g. managers, decision-makers, other sector specialists) to address undernutrition
- to increase the pool of nutritionists competent in both structural and transitory issues

4) Linking nutrition to the governance agenda

'… there are clearly opportunities for it (nutrition) *to be useful for revealing the capacity, accountability and responsiveness of states'(IDS, 2007).* For example, nutrition could be included in the EC political dialogue with aid recipient countries particularly during budget support negotiations.

5) Strengthening involvement in the **management of acute malnutrition[28](ECHO)**

- promote free access to treatment of severe acute malnutrition as part of the health package
- support the reform in the management of acute malnutrition with the introduction of the new WHO growth charts (e.g. through capacity building)
- health system strengthening and ensuring a continuum of quality care between emergency and development
- support community-based treatment of acute malnutrition
- support the development of frameworks/processes to set standards and regulate international accreditation of new fortified and nutrient-rich products aimed at addressing acute malnutrition

[28] Acute malnutrition encompasses wasting and/or the presence of nutritional oedema

- encourage synergies between development and emergency actors to ensure adequate prevention and treatment of moderate acute malnutrition

6) Consider **pilot countries** initially to test a comprehensive approach

The following criteria will be considered to select countries: willingness of the EC delegation to engage in the pilot, countries with a high burden of undernutrition, and presence of partners (government and/or UN) willing to embark on such a process and with the political will to address undernutrition.

7) Foster a better coordination of the international community

The international nutrition system – made up of international and donor organisations, academia, civil society, and the private sector - is 'fragmented and dysfunctional'29. The EC will contribute to foster greater leadership and coordination within the international community through supporting the Standing Committee on Nutrition.

Greater coordination and cooperation with other donors is needed to ensure a fairer aid allocation that covers the spectrum of actions required to address undernutrition and its causes. For instance, the EC could build on and co-finance initiatives with key other stakeholders involved in nutrition including EU member States, the World Bank or new private actors (i.e. Gates Foundation)

8) Positioning the EC strategically within the donor environment, to help ensure **increased investment for nutrition**, more harmonised and fairer allocation of resources

Conducting a donor mapping (if on-going donor reviews are not sufficient) to gain a better understanding of what others are doing in nutrition could help EC positioning.

In addition to its current strengths (indirect investments and humanitarian aid), the EC should consider addressing some of the shortfalls in international funding for nutrition. Some of the options are:

- increasing investment in basic nutrition for actions that have proven to be effective
- additional investments to ensure actions reach or target those in need (e.g. children under two years, women during and before pregnancy, the poorest children).
- increasing investment in countries with a high burden of undernutrition.

Linked to the above, further research could be considered on the barriers and solutions to scale up effective interventions, measure the impact of pre-maternal interventions on infant nutritional status and mortality for example.

The EC will explore opportunities within its instruments, innovative approaches (e.g. social benchmarking attached to infrastructure programmes) and ensure budgets are nutrition-friendly.

The scope of the strategy/operational plan could encompass malnutrition broadly rather than focus on undernutrition solely.

[29] Lancet series 2008

Annexes

Annex 1: acronyms

AIDCO: EuropeAid Cooperation Office
DAC: Development Assistance Committee
DALY: Disability Adjusted Life years
DfID: Department for International Development (UK)
DG Dev: Directorate General for Development
DG ECHO: Directorate General European Commission Humanitarian Office
EC: European Commission
EDF: European Development Fund
EU: European Union
GDP: Gross Domestic Product
IDS: Institute of Development Studies
LRRD: Linking Relief Rehabilitation and Development
MDG: Millenium Development Goal
OECD: Organisation for Economic Cooperation and Development
PRSP: Poverty Reduction Strategy Paper
RUTF: Ready To Use Therapeutic Food
SCN: Standing Committee on Nutrition
SC UK: Save the Children UK
UNICEF: United Nations Children's Fund
WHO: World Health Organisation

Annex 2: glossary

Acute malnutrition	Low weight-for-height (see wasting below) and/or bilateral oedema
Chronic malnutrition	See stunting
Disability Adjusted Life Year (DALY)	An indicator developed for the calculation of disease burden which quantifies, in a single indicator, time lost due to premature death with time lived with disability
Low birthweight (LBW)	Defined as a body weight at birth of less than 2500 grams
Malnutrition	Malnutrition encompasses both undernutrition and obesity/over-consumption of specific nutrients.
Micronutrients	Vitamins and minerals
MUAC	Mid-Upper-Arm Circumference is used by some as an indicator of acute malnutrition (mostly in emergencies). It is a predictor of risk of death when below 110 mm in children aged 12 (or 6) – 59 months. It can also be indicative of acute malnutrition.
Stunting:	Low height-for-age. It refers to shortness that is a deficit of linear growth which has failed to reach genetic potential as a result of poor diet and disease. Stunting is defined as a height-for-age index < - 2 Z-scores of the median of the international reference population. Severe stunting is defined as a height-for-age index < - 3 Z-scores below the median of the international reference population.
Undernutrition	Intrauterine growth restriction resulting in low birthweight; underweight; stunting; wasting; and less visible micronutrient deficiencies.
Underweight	Low weight-for-age and a composite of stunting and wasting. Underweight is defined as a weight-for-age index < - 2 Z-scores of the median of the international reference population. Severe underweight is defined as a weight-for-age index < - 3 Z-scores below the median of the international reference population.
Wasting	Low weight-for-height. It is usually the result of a severe process (lack of food and/or disease) that has produced a substantial weight loss. Wasting is defined as a weight-for-height index < - 2 Z-scores of the median of the international reference population. Severe wasting is defined as a weight-for-height index < - 3 Z-scores below the median of the international reference population.

Annex 3: the 36 countries with childhood stunting prevalence ≥ 20% covering 90% of the 178 million globally estimated number of stunted children

(Source: Lancet Series 08)

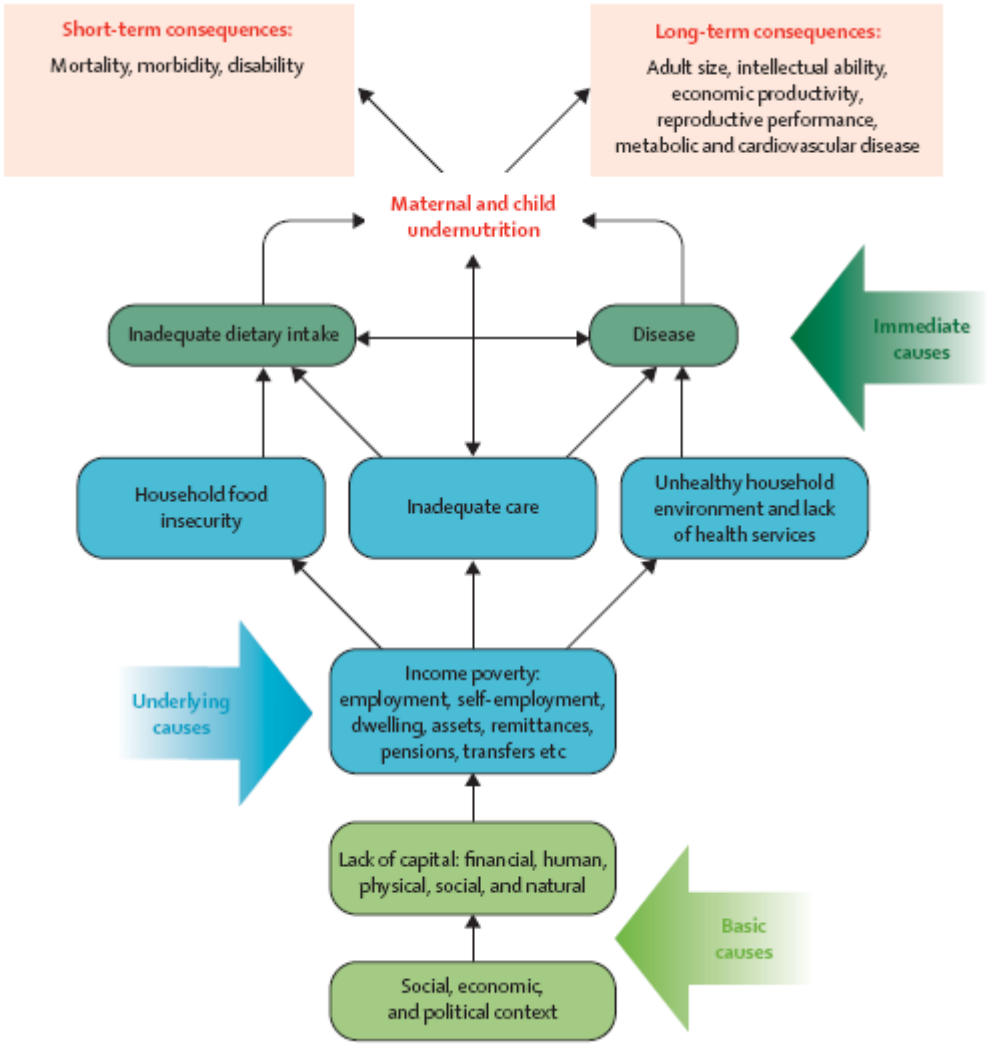
Country[30]	% stunted[31]	Numbers < 5 years stunted in millions
India	51.0	61,206
Indonesia	45.3	9,772
Nigeria	43.0	9,571
Bangladesh	50.5	8,787
Pakistan	41.5	8,763
Ethiopia	57.4	7,498
Democratic Republic of the Congo (the)	44.4	4,977
Philippines (the)	37.8	3,730
Viet Nam	42.4	3,375
Afghanistan	53.6	2,967
United Republic of Tanzania (the)	48.3	2,920
Uganda	44.8	2,675
Sudan (the)	47.6	2,483
Yemen	59.3	2,175
Nepal	57.1	2,078
Kenya	35.8	2,054
Myanmar	40.6	1,891
Egypt	20.3	1,813
Madagascar	55.5	1,724
South Africa	30.9	1,616
Mozambique	47.0	1,547
Niger (the)	54.2	1,545
Angola	30.8	1,511
Turkey	20.5	1,479
Malawi	54.6	1,278
Iraq	28.3	1,223
Guatemala	59.9	1,210
Mali	42.7	1,111
Ghana	35.6	1,104
Burkina Faso	43.1	1,060
Zambia	52.5	1,056
Peru	31.3	938
Cambodia	49.1	901
Cameroon	35.4	868
Côte d'Ivoire	31.1	863
Burundi	63.1	837

30 The 20 countries with childhood stunting prevalence ≥ 20% covering 80% of the 178 million globally estimated number of stunted children are presented in the grey shaded part of the table.

31 Based on the WHO Child Growth Standards. Data from 2005. For Afghanistan, Cote d'Ivoire, Philippines, South Africa, Turkey and Viet Nam the prevalence of stunting based on WHO Child Growth Standards was derived using a conversion factor.

Annex 4: Framework of the relations between poverty, food insecurity, and other underlying and immediate causes to maternal and child undernutrition and its short-term and long-term consequences

(Source: Lancet Series, 2008)



Annex 5: Interventions with demonstrated impact on maternal and child undernutrition amongst 'traditional' nutrition programmes

(Lancet Series 08)

Actions with sufficient evidence of effectiveness and feasibility to recommend implementation in all 36 countries[32]	Actions with evidence of effectiveness and feasibility for implementation in specific situational contexts
Maternal and birth outcomes	
Iron folate supplementation	Maternal supplements of balanced energy and protein
Maternal supplements of multiple micronutrients	Maternal iodine supplements
Maternal iodine through iodisation of salt	Maternal deworming in pregnancy
Maternal calcium supplementation	Intermittent preventive treatment for malaria
Interventions to reduce tobacco consumption or indoor air pollution	Insecticide-treated bednets
Newborn babies	
Promotion of breastfeeding (individual and group counselling)	Neonatal vitamin A supplementation
	Delayed cord clamping
Infants and children	
Promotion of breastfeeding (individual and group counselling)	Conditional cash transfer programmes (with nutritional education)
Behaviour change communication for improved complementary feeding*	
Zinc supplementation	Deworming
Zinc in management of diarrhoea	Iron fortification and supplementation programmes
Vitamin A fortification or supplementation	Insecticide-treated bednets
Universal salt iodisation	
Handwashing or hygiene interventions	
Treatment of severe acute malnutrition	

*Additional food supplements in food-insecure populations.

32 The 36 countries with childhood stunting prevalence ≥ 20% covering 90% of the 178 million globally estimated number of stunted children.

Annex 6: priorities for actions according to the Copenhagen consensus 2008 challenge paper

Based on cost-benefit and cost-effectiveness analysis, the paper determined the following priorities:

- Universal Salt Iodization, zinc and vitamin A supplementation and iron and folate fortification of staples
- baby-friendly practices for promotion of breastfeeding
- anthelminths (deworming)

According to the authors, *'All these potential solutions are highly cost-effective, but tackle only a modest proportion of undernutrition'*. '*… only a quarter to a third of undernutrition can be removed by micronutrient interventions and education.' 'To achieve a further reduction beyond this, one would have to consider broader programs such as food or cash transfers, enhancing the status of women, etc.'*