AID FOR NUTRITION

Are we on track to meet the needs? 2010 and 2011

ACF INTERNATIONAL

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

ACKNOWLEDGEMENTS

The authors would like to thank all those who spent their valuable time contributing to the development and production of this document in particular: Lilly Frey, Elena Gonzalez, Jean-Michel Grand, Fatima Haase, Ben Hobbs, Christine Kahmann, Elise Rodriguez.

ACF would like to especially thank Anne Peniston, Elizabeth Jordan-Bell and William McCormick from USAID for their assistance in the analysis of USA data that helped us to validate our methodology.

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GLOSSARY

ACF	Action Against Hunger | ACF International (Derived from the French name; Action Contre la Faim)
BMGF	Bill and Melinda Gates Foundation
CRS	Creditor Reporting System
DAC	Development Assistance Committee
ENN	Emergency Nutrition Network
EU	European Union
FAO	Food and Agriculture Organisation of the United Nations
G8	Group of Eight, Forum for the governments of the world's eight wealthiest countries
GNI	Gross National Income
IDA	International Development Association
MDGs	Millennium Development Goals
NGO	Non Governmental Organisation
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
SAM	Severe Acute Malnutrition
SUN	Scaling Up Nutrition
SWAPs	Sector Wide Approaches
UK	United Kingdom
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USA	United States of America
WB	World Bank
WFP	United Nations World Food Programme
WHA	World Health Assembly
WHO	World Health Organisation
ZHC	Zero Hunger Challenge

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EXECUTIVE SUMMARY

Twelve years ago world leaders committed to achieving eight Millennium Development Goals (MDG) by 2015. Four of these MDGs (MDG 1, 4, 5 and 6) are directly linked to good nutrition. Adequate nutrition is essential in early childhood to ensure healthy growth, proper organ formation and function, a strong immune system, and neurological and cognitive development. In the past decade, there has been increasing recognition of the negative impact of undernutrition on child growth and development, public health, productivity and economic growth. Undernutrition, which includes stunting, wasting and micronutrient deficiencies, is widespread in 36 developing countries, predominantly in Africa and Asia. These countries shoulder 90% of the global burden of child undernutrition.

The massive scale of the nutrition crisis means that it is essentially a global public health emergency: 8% of children under-five are wasted and 165 million children under-five are stunted (2011 estimates). Many millions more have vitamin and mineral deficiencies and more still are born with low birth weight due to maternal undernutrition. We know how to treat and prevent these conditions, however the current level of official development assistance (ODA) directed to the provision of appropriate curative and preventive nutrition programmes at a scale that can address the need is inadequate.

However, limited up-to-date and accessible data exists to map the quantity of aid invested in direct nutrition interventions. Such data would enable a baseline of investments to be monitored to assess the progress of the scaling up of nutrition interventions, which stakeholders from national governments, donors and other stakeholders in the Scaling Up Nutrition Movement committed to in 2010. In 2012, ACF reported that the quantity of ODA directed to nutrition interventions for the 2005 to 2009 period was on average US$438 million per year. However direct nutrition interventions (a set of 13 interventions identified by the Lancet medical journal in 2008 as needed to tackle the immediate determinants of undernutrition) received on average just US$73 million per year. This is a fraction of the additional annual investment (US$11.8 billion, estimated by the World Bank in 2010) needed to fund direct nutrition interventions in the 36 countries with the highest burdens of undernutrition.

This report assesses ODA (at 2010 US dollar constant prices) targeted to direct nutrition interventions and overall nutrition interventions by major bilateral, multilateral and private donors. It presents investment trends in nutrition between 2007 and 2011 for all donors, including an assessment of the nutrition aid activities of G8 member states in 2010 and 2011. The analysis maps ODA for nutrition-related programmes reported by key donors to the Organisation for Economic Cooperation and Development's Creditor Reporting System (CRS) database. In so doing, the report analyses the accessibility of information relating to nutrition aid, the levels of aid as a whole and for different types of nutrition interventions, the channel of delivery for these interventions, whether nutrition aid is targeted to the countries most affected by undernutrition and the different between the commitments and disbursements of donors. In addition to updating the main findings of the last report (ACF 2012), this analysis identifies which stakeholders delivered the greatest proportions nutrition aid as well as mapping the nutrition aid activities of G8 member states collectively and individually. This update on the first Aid for Nutrition report will contribute to nutrition advocacy targeted at and by national governments, policy makers and civil society organisations. It will also be a useful source of information for many important nutrition-related events in 2013.

Main findings

- The Basic Nutrition code in the CRS database (code 12240) is problematic to work with as the sole source of nutrition funding data. At least 35% of the projects analysed in the code were not relevant to nutrition and 12% of the projects could not be analysed due to a lack of information. For some donors, such as France and WFP, analysis was hampered by a lack of detailed information. External data sources were therefore used for France and ECHO to

supplement the data from the CRS database.

- Aid to the nutrition sector from all donors analysed amounted to US$598 million in 2009, US$587 million in 2010 and US$612 million in 2011. In all three years, this was equivalent to around 0.8% of overall ODA. This corresponds to an average of US$549 million per annum (2010 constant prices) for the 2007 to 2011 period compared with US$438 million for the 2005 to 2009 period.
- G8 donors increased their funding for direct and indirect nutrition interventions from US$438 million in 2010 to US$573 million in 2011, equivalent to 0.7% of total G8 ODA for 2011.
- Donors collectively (G8, non-G8 and multilateral donors and foundations) contributed US$908 million to nutrition investments in 2011.
- Funding for direct nutrition interventions was US$132 million (0.2% of total ODA) in 2009, US$163 million (0.2% of total ODA) in 2010 and US$222 million (0.3% of total ODA) in 2011. Over the 2007 to 2011 period, an average of US$143 million (0.2% of total ODA) was allocated to direct nutrition interventions annually compared with an average of US$73 million (0.1% of total ODA) over the 2005 to 2009 period.
- Out of the three categories of direct nutrition interventions, the therapeutic feeding of malnourished children with special foods received the biggest increase in funding. Between 2007 and 2011, 49% of funding for direct nutrition interventions was allocated to this category. In the 2005 to 2009 period, the majority of funding (44%) was allocated to increasing the intake of vitamins and minerals.
- However, 40% of funding for direct nutrition interventions were delivered via Humanitarian Aid sector and most of this funding was dedicated to the therapeutic feeding of malnourished children. The majority of direct nutrition interventions (55%) delivered through the Health sector and 4% through Water and Sanitation sector.
- 49% of G8 donor investments in direct nutrition interventions were delivered through the Humanitarian Aid sector and 48% through the Health sector.
- In the 2007 to 2011 period, while aid for indirect nutrition interventions reduced compared to the previous period, it was much still greater than aid for direct nutrition interventions.
- Funding for indirect nutrition interventions was US$466 million in 2009 (0.6% of total ODA), US$425 million (0.5% of total ODA) in 2010 and US$390 million (0.5% of total ODA) in 2011. This represents an annual average of US$407 million or 0.6% of total ODA for the 2007 to 2011 period, increasing from US$365 million (0.5% of total ODA) for the 2005 to 2009 period.
- Nutrition funding to the Africa region increased in the 2007 to 2011 period attracting an average of 62% of total funds. An average of 22% of funding was directed to Asia over the period and funding to the region decreased marginally. Similarly, G8 donors prioritised ODA for nutrition to Africa, investing US$388 million in Africa and US$138 million in Asia in 2011.
- The targeting rates (which indicate what proportion of nutrition funding flows is targeted to the countries most affected by undernutrition) were around 50% for all regions in 2011. While this represents an increase from 40% for Africa in 2009, Asia decreased from 60% in 2009. This is possibly due to India moving from the 2nd largest recipient of nutrition aid in the 2005 to 2009 period, to the 6th largest recipient in the 2007 to 2011 period.
- Overall donors did not deliver on 13.5% of their nutrition funding for the 2007 to 2011 period an increase from the 10% previously reported in the 2005 to 2009 period.
- In 2011, G8 donors did not disburse US$103 million of committed ODA for nutrition.
- Nongovernmental organisations and multilateral UN agencies, such as UNICEF and WFP, were the main implementing partners of ODA for nutrition.

To use the CRS database to track direct nutrition interventions, several purpose codes need to be analysed. It cannot be assumed that the Basic Nutrition code will contain funding which is solely related to

nutrition. The proportion of funding for nutrition as a percentage of total ODA between 2009 and 2011 was consistently about 0.8%. This had increased from 0.6% in 2007 however the increase was inadequate in light of the scale of undernutrition.

This is especially true for direct nutrition interventions. Despite the volume of aid for direct nutrition interventions increasing in 2010 and 2011, funding for direct nutrition interventions as a percentage of total ODA remained unchanged between 2008 and 2010 at 0.2%, only increasing slightly to 0.3% in 2011. The volume of funding directed to both direct and indirect nutrition interventions remains inadequate and it is not increasing fast enough. This is underlined by the finding that the annual average investment for direct nutrition interventions is equivalent to just 1.2% of the estimated additional US$11.8 billion needed per annum to reduce undernutrition. Nonetheless, it is an improvement from the 0.6% recorded in the 2005 to 2009 period.

Furthermore, almost half of the funding for direct nutrition interventions was delivered through short-term Humanitarian Aid, possibly in response to the Horn of Africa crisis in 2011. This also indicates that donors perceive the treatment of acute malnutrition as an intervention which should be provided in response to humanitarian crises, perpetuating the unmet need of the large proportion of acutely malnourished children who live in non-humanitarian contexts.

The increase in funding for direct nutrition interventions was achieved at the expense of funding for indirect nutrition interventions. This suggests that for some donors it was a case of increasing funding for one or the other. However funding needs to increase for both as the different types of interventions reinforce each other.

Aid for nutrition was mainly directed to Africa and Asia the two regions worst affected by undernutrition. However, whereas Asia was the primary recipient of aid in the 2005 to 2009 period, Africa received the greater proportion of funding in the 2007 to 2011 period. This may have been due to the Horn of Africa crisis in 2011 or the decrease in aid to India as a result of its stronger economic development.

The gap between nutrition funds committed and disbursed by donors widened slightly in 2011 which may be a reflection of the lasting impact of the financial crisis. The primary implementing partners of bilateral nutrition aid were UN agencies and NGOs which may hinder long term national governance structures for nutrition.

RECOMMENDATIONS

- The DAC Working Party on Statistics must ensure that all donors provide detailed information in the short and long descriptions of their projects in the CRS database so that the projects in the Basic Nutrition purpose code can be clearly identified as nutrition project. Projects that are not relevant to nutrition should not be recorded under the Basic Nutrition code.
- Improved reporting by donors would support the development of a robust global accountability framework for nutrition investments. This should also be developed for national governments.
- Donors should take bolder steps to increase the amount of ODA for direct and indirect nutrition interventions as these interventions are mutually reinforcing. The G8 member states and other donors should follow the lead of the UK and the EU and fulfil their commitment to increase ODA to 0.7% of GNI in a timely manner and allocate a portion of this to nutrition.
- Donors and national governments need to accelerate the development of innovative financing mechanisms to increase investments in nutrition.
- Increased donor funding for the treatment of acutely malnourished children and for a minimum package of direct nutrition interventions should be continued. However donors should recognise that in order to facilitate the development of national nutrition governance and strengthen national health systems, direct nutrition interventions require long term, sustainable funding.

INTRODUCTION

ACF, courtesy of Hitendra Solanki

1. INTRODUCTION

1.1 BACKGROUND

Twelve years ago world leaders committed to achieving eight Millennium Development Goals (MDG) by 2015. Four of these MDGs (MDG 1, 4, 5 and 6) are directly linked with good nutrition.

But time is running out to achieve these goals in the least developed countries. Malnutrition, specifically undernutrition, includes wasting (acute undernutrition), stunting (chronic undernutrition) and micronutrient (vitamin and mineral) deficiencies. Adequate nutrition is essential in early childhood to ensure healthy growth, proper organ formation and function, a strong immune system, and neurological and cognitive development *(Lancet, 2008)*. In 2011, almost half of under-five child deaths occurred in five countries: India, Nigeria, Democratic Republic of Congo, Pakistan and China *(Levels and trends in child mortality, Report 2012, UNICEF 2012)*. UNICEF further reported that tackling under-five mortality is possible by scaling up the coverage of effective preventive and curative interventions that target the main causes of child deaths (pneumonia, diarrhoea, malaria and undernutrition).

Since the publication of the 2008 Lancet Series on Maternal and Child Undernutrition, nutrition has increasingly been recognised as the foundation for social and economic development. Beyond improved public health outcomes, well-nourished populaces have the ability to attain new skills and to widen their options to get better jobs and lift themselves out of poverty and are well set up to contribute to their national economic growth and human development. Child malnutrition negatively effects cognitive functions and leads to poverty by impeding an individuals' ability to have a productive life.[2]

With three years remaining to achieve the MDGs, national governments and their partners are prioritising nutrition on the global development agenda and political commitments to scale up programmes aimed at reducing child malnutrition have been made. In 2010, the Scale Up Nutrition (SUN) movement[3] was launched. Calling for increased efforts to improve global nutrition, it is employing both indirect nutrition interventions which are preventative in nature, and direct nutrition interventions which include curative or treatment interventions, in the lead up to 2015. The movement brings together government authorities from countries with high burdens of malnutrition, and a global coalition of partners committed to working together to mobilise resources, provide technical support, perform high

TABLE 1.1: UNDERNUTRITION - KEY FACTS AND FIGURES (BASED ON 2011 ESTIMATES[1])

WASTING

- **Globally, an estimated 52 million children under-five years of age, or 8%, were wasted – an 11% decrease from an estimated 58 million in 1990.**
- **Seventy percent of the world's wasted children live in Asia, most in South-Central Asia. These children are at substantial increased risk of severe acute malnutrition and death.**

STUNTING

- **Globally, an estimated 165 million children under-five years of age, or 26%, were stunted — a 35% decrease from an estimated 253 million in 1990.**
- **High prevalence levels of stunting among children under-five years of age in Africa (36%) and Asia (27%) remain a public health problem which is poorly recognized.**
- **More than 90% of the world's stunted children live in Africa and Asia.**
- **Although the prevalence of stunting among children under-five years of age worldwide has decreased since 1990, overall progress is insufficient and millions of children remain at risk.**

[1] Source: © The United Nations Children's Fund, the World Health Organization and the World Bank 2012, Levels and Trends in child malnutrition, UNICEF, WHO, World Bank joint malnutrition [2] Bhutta et al., 2008 What works? Interventions for maternal and child undernutrition and survival. Lancet (371), 417-440 [3] http://www.scalingupnutrition.org/

level advocacy and form innovative partnerships.

In the summer of 2012 the World Health Assembly (WHA) endorsed a comprehensive 13-year implementation plan (2012-2025) to address maternal, infant and child nutrition. The plan aims to assuage the double burden of malnutrition in children, and includes six global nutrition targets to be reached by 2025:

- Reduce by 40% the number of children under age 5 who are stunted
- Achieve a 50% reduction in anaemia in women of reproductive age
- Achieve a 30% reduction of the number of infants born low birth weight
- Ensure that there is no increase in the number of children who are overweight
- Increase to at least 50% the rate of exclusive breastfeeding in the first six months
- Reduce and maintain childhood wasting to less than 5%

Additionally, the United Nations (UN) Secretary General launched the Zero Hunger Challenge (ZHC), for high-level advocacy to advance global efforts on food and nutrition security. It encourages different groups; governments, regional organisations, farmers, businesses, civil society, donors, foundations and the research community — to promote effective policies, increased investments and sustained development that supports hunger reduction. At the 2012 Olympic Games in London, the United Kingdom's Prime Minister hosted the Global Hunger Event on global child undernutrition, which brought together leaders from the developing world, the private sector and international development agencies to spearhead action aimed at cutting the number of stunted children by 25 million before the 2016 Olympic Games in Brazil.

1.2 THE AID FOR NUTRITION REPORTS

In 2012, **ACF International | Action Against Hunger** published a detailed report tracking the commitments and the disbursements of bilateral, multilateral and private foundations for direct and indirect nutrition interventions. The report, entitled ***AID FOR NUTRITION: Can investments to scale up nutrition actions be accurately tracked?*** highlights several issues related to the tracking of global investments in nutrition, namely:

- Average investments in nutrition for the 2005-2009 period were severely inadequate, especially for the proven direct nutrition interventions.
- The majority of funding in direct nutrition interventions over this period was directed to micronutrient supplementation (44 %), followed by treatment of malnourished children with special foods (40%) and interventions to promote good nutritional practices (14%). The remainder was for integrated interventions from all three categories of direct nutrition interventions.
- Nutrition programs were mainly delivered as part of humanitarian response rather than as part of development aid.
- Targeting of aid to high priority countries was poor, particularly in the African region.
- Fulfillment of donor commitments varied widely between donors. Collectively, global donors failed to deliver on 11% of their commitments.
- Tracking aid through the OECD CRS database involved making a lot of assumptions about the data presented particularly for nutrition-sensitive interventions, but also due to poor reporting of some bilateral and multilateral donors which hindered transparency, monitoring and evaluation of the data recorded.

The report includes recommendations on how to address some of these issues. It can be accessed from our website.[4]

This report assesses trends in nutrition investments from 2007 to 2011. The analysis provides an update of global donor aid activities in 2010 and 2011, including the investment patterns of the G8 countries that report to the DAC database.

1.3 WHERE ARE WE IN 2013?

2013 sees the UK assume the one-year Presidency of the G8. The Irish Government's efforts to champion

[4] *http://www.actionagainsthunger.org.uk/resource-centre/online-library/detail/media/aid-for-nutrition-can-investments-to-scale-up-nutrition-actions-be-accurately-tracked/*

an end to hunger and undernutrition have been very successful. In the same vein, the UK Government and the Children's Investment Fund Foundation are following up the Global Hunger event of 2012 with the Nutrition for Growth Event on the 8th June in the lead up to the G8 Summit in Lough Erne, Northern Ireland. It will bring together Heads of State, ministers, corporate and civil society leaders and other prominent stakeholders to agree ambitious new commitments to tackle undernutrition and ultimately, to secure a healthier, more prosperous future for the millions of women, children and families who, with their improved health and productivity, will boost growth and economic development. It is billed as a once in 'a decade opportunity to transform the global work on nutrition and it provides an opportunity for corporations to get behind one of the most critical issues facing children and development'. In the latest budget review the UK Chancellor committed to dedicating 0.7 % GNI to ODA the first G8 country to do so; this is a real opportunity for the UK to increase aid for nutrition dramatically and lead the other donors by example.

Furthermore, hundreds of UK based NGOs launched a huge campaign in January 2013, the Enough Food for Everyone IF campaign, which aims to end hunger and undernutrition in our generation.

The information in this report will support advocacy efforts for various initiatives such as the UK IF Campaign, the *Nutrition for Growth* pre-G8 event and other high level global nutrition events scheduled for 2013 such as the United Nations General Assembly and the post-2015 development framework dialogue. For the consultative post-2015 development framework dialogue, the report can be used for advocacy efforts to increase investment in nutrition interventions as well as to improve tracking of investments at global and national level.

METHODOLOGY

ACF, courtesy of Samuel Hauenstein-Swann

2. METHODOLOGY

2.1 SCOPE OF THE ANALYSIS

The Creditor Reporting System (CRS) Aid Activity database was the primary source of data for this report. For the France and ECHO individual analyses we also used external data.

The CRS database, established by the OECD, is the primary source of data for commitments and disbursements of official development assistance (ODA). It is the most extensive and reliable source of information regarding the aid activities of member countries of the OECD's Development Assistance Committee (DAC), EU institutions, other international organisations and private donors. All financial figures are based on the 2010 constant US dollar rate of inflation.

The analysis maps donor investments trends for nutrition for the period of 2007-2011 for bilateral, multilateral and private foundations. The selected donors are the same as in the 2012 report ***Aid for Nutrition: can investments in nutrition be accurately tracked?*** to enable like for like comparison. Donors included: USA, UK, Canada, Spain, Ireland, Sweden, Norway, EU, UNICEF, IDA and BMGF. Please note that France is not included in the 2007-11 charts because most of the data was rejected due to lack of information over the years. Only the 'basic nutrition' code for 2011 was well reported and contained some indirect interventions which were analysed in the individual analysis. However, this was insufficient to include France with the other donors as the data was not comparable.

The G8 donor investments from 2010 and 2011 only include seven of the eight countries in the G8 because Russia is not a member of the DAC and is thus not required to report its aid activities to the CRS database. Donors included: USA, Canada, UK, France (not included in the compiled results), Germany, Japan and Italy. Although the EU participates in the G8, it was not strictly defined as a G8 country in this assessment because it is a unique supranational organisation and is not a sovereign Member State. However, with the exception of the right to host and chair a summit, the European Union has all the privileges and obligations of membership. The Commission and the Council have all the responsibilities of membership, and what the Presidents of the Commission and the Council endorse at the Summit is politically binding.

Other key aspects of nutrition funding that were examined:

- *The targeting of high-priority recipient countries and regions (refer to ACF's 2012 report **Aid for Nutrition, Can Investments to Scale Up Nutrition Actions be Accurately Tracked?** for a full explanation of the definition of ACF high priority countries ACF 2012)*
- Accountability: as CRS is a statistical tool recording both commitments and disbursements for each project, it enabled us to evaluate which commitments were not honoured and to what extent.
- *Channel of delivery of aid*
- *Allocation of aid to various stakeholders — we also analysed the apportioning of bilateral nutrition aid to various stakeholders for this update.*
- *CRS reporting*: Given the existing problems with the poor quality of data, we were able to quantitatively assess the accuracy of donor reporting

2.2 IDENTIFICATION OF NUTRITION INTERVENTIONS

A key word search was performed to enable us to map direct nutrition interventions in the various purpose codes selected for analysis encompassing health, water and sanitation, food security and humanitarian aid.

Keywords such as 'nutrition', 'hunger' and 'food' were used to ensure that all interventions related to nutrition were selected. This was particularly useful for CRS purpose codes related to nutrition such as 'Basic Health' or 'Basic Drinking Water and Sanitation'.

The keyword search was applied to the title, short description and the long description of the database.

All of the descriptions of the selected interventions were read individually to designate them to a particular category i.e. direct or indirect nutrition interventions.

Nutrition interventions in this report were identified as either:

- **Direct nutrition interventions** are those that address the more immediate determinants of undernutrition (such as the quality of individual dietary intake and the provision of individual health services). For this study we defined direct interventions as those that were included in the Lancet list of direct interventions and were assigned a cost for scale up by the World Bank report *(Horton et al. 2010)*. We further categorised direct nutrition interventions into the three broad themes of the Lancet series, *"promoting good nutritional and hygiene practices", "increasing intake of vitamins and*

TABLE 2.1: DIRECT NUTRITION INTERVENTIONS

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

TABLE 2.2: LIST OF INTERVENTIONS IN THE CRS 'BASIC NUTRITION' PURPOSE CODE

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

minerals" and "supplementary and therapeutic feeding of malnourished children with special foods". This facilitated the mapping of donor priorities per theme within the direct nutrition interventions.

- **Indirect interventions address** underlying determinants of undernutrition such as access to food or the quality of water and water and sanitation.[5] They involve multisectoral approaches, especially in cases where specific pro-nutrition activities were included as part of interventions carried out in other sectors such as health, education and food security. To ensure interventions were indirectly targeted to address undernutrition, we selected cross-sectoral project lines that explicitly included a nutrition objective in the description of activity. For example, the description of a food aid or school feeding programme project line which clearly stated as its objective "to reduce malnutrition in the recipient population" was classified as an indirect nutrition intervention. Also, activities such as nutrition advocacy, nutrition conferences and meetings were classified as indirect nutrition interventions.

In some cases, projects included a mixture of direct and indirect nutrition interventions and it was impossible to establish the share of funds going to each activity. These project lines were classified as indirect interventions.

DONOR SELECTION

Bilateral, multilateral and private donors who have been previously reported as key contributors of ODA to nutrition (refer to Aid for Nutrition: 2012) were selected for analysis in this report. Furthermore, G8 donors who were not analysed in the last report were included in this report.

Bilateral donors:

G8 donors: Canada, France (not included in the compiled results), Germany, Italy, Japan, United Kingdom, United States of America, European Union

Non-G8 donors: Ireland, Spain, Sweden, Norway

Multilaterals: UNICEF, IDA (World Bank)

Private donors: Bill and Melinda Gates Foundation (BMGF)

LIMITATIONS OF THE STUDY

Aid for Nutrition: Can investments to scale up nutrition actions be accurately tracked? (ACF, 2012) provided a detailed analysis of the limitations of the study, such as excluding non-DAC Member States, private foundations and multilateral organisations which are under no obligation to report their aid activities. Other limitations included poor reporting by donors (lack of description and bad quality of information provided) and limitations of the OECD CRS database itself. The database is two years behind in its reporting; the 2011 data only became available early in 2013.

[5] *(Horton et al. 2010)*

TABLE 2.3: PURPOSE CODES ANALYSED FOR NUTRITION INTERVENTIONS IN THE CRS DATABASE

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

RESULTS

ACF, courtesy Hitendra Solanki

3. RESULTS

SUMMARY OF KEY FINDINGS

General

- Aid to the nutrition sector increased from US$400m in 2007 to US$598m in 2009, and remained largely constant until 2011 accounting for 0.84% of total ODA in 2011
- Most nutrition interventions were delivered through the health or humanitarian aid sectors
- Overall, donors disbursed more of their commitments in 2010 and 2011 however for the 2007 to 2011 period they failed to deliver 14% of commitments compared with the 2005 to 2009 period.

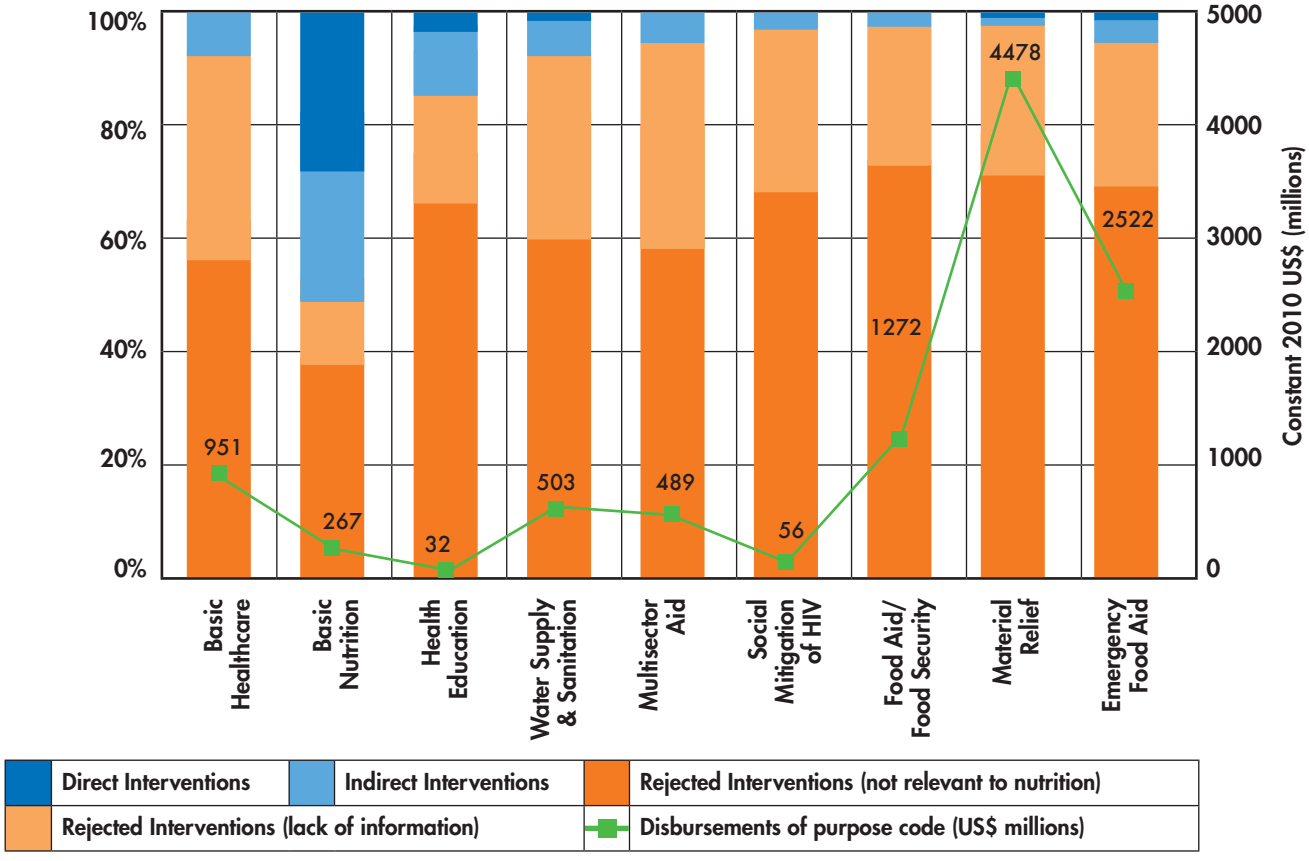
Investment in direct/ indirect interventions

- G8 donors increased their funding for both direct and indirect nutrition interventions in 2010 and 2011.
- Generally, investments in direct nutrition interventions increased at the expense of indirect interventions.
- The increased investment in direct interventions was driven by increased expenditure in the treatment of malnourished children with specialised foods. The other categories of direct nutrition interventions also saw increased investments, however not at the same scale. More donors invested in multiple categories of direct nutrition interventions.

Regional investment

- Africa received more nutrition aid than Asia for the 2007 to 2011 period although this was targeted to only 50% of the high burden countries in Africa.
- Funding for Asia decreased and trends indicate that fewer high burden countries in Asia are receiving nutrition funding.

FIGURE 3.1: THE REPORTING OF NUTRITION INTERVENTIONS IN SPECIFIC CRS PURPOSE CODES BY ALL DONORS FOR 2007-11



3.1 HOW WELL DID DONORS REPORT ODA INVESTMENTS IN NUTRITION IN THE CRS DATABASE?

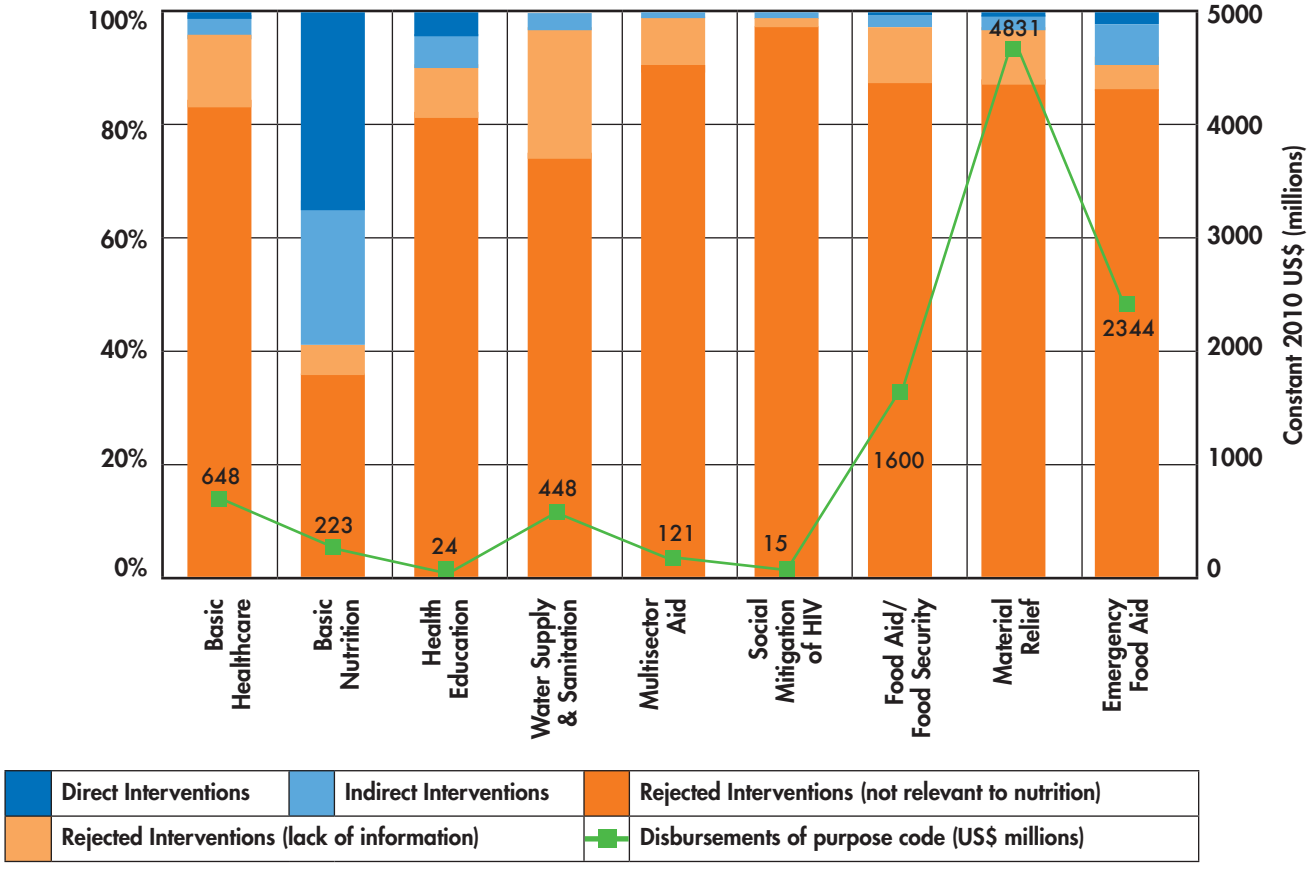
For the 2007 to 2011 period, 28% of the data in the selected purpose codes could not be analysed because the information provided was insufficient to assess the exact nature of the project. In the Basic Nutrition purpose code, where half (52%) of the direct nutrition funding was reported, 12% of the projects could not be analysed due to lack of information, and a further 35% of the purpose code was deemed to be not related to nutrition in line with the methodology used in this report (Figure 3.1). These findings are similar to our original report (researched two years ago) when we found that for the same purpose codes, but particularly the Basic Nutrition code (12240), almost 50% could not be included in the funding for nutrition due to lack of information and the lack of relevance of interventions to nutrition.

The Basic Nutrition code of the CRS database attracted less funding than other codes such as Material Relief, Emergency Food Aid, Food Aid and Food Security, Basic Healthcare, Multisector Aid and Water Supply and Sanitation. This is similar to the analysis of the 2005 to 2009 period, although Basic Nutrition received slightly more funding this time.

The majority of the funding by G8 donors (Canada, the USA, the UK, France (note France not included in the G8 compiled results, however we did analyse as an individual donor in the Annex), Japan, Germany, the EU and Italy — Russia was not included as it is not a member of the DAC) was recorded under the Emergency Food Aid code (Figure 3.2).

Reporting by Canada, the USA, the UK, Germany and Italy was adequate however 42% of Japanese data could not be assessed due to lack of information.

FIGURE 3.2: THE REPORTING OF NUTRITION INTERVENTIONS IN SPECIFIC CRS PURPOSE CODES BY G8 MEMBER STATES IN 2010-11



The reporting trends for all donors for the 2007 to 2011 period and G8 donors in 2010 and 2011 followed a similar pattern as we found nutrition funding in various purpose codes in more or less the same proportions. Only 10% of data reported by G8 donors in 2010 and 2011 and 4% of the Basic Nutrition code could not be analysed. This improvement was attributed to better reporting, not due to differences in the countries studied.

3.2 TREND ANALYSIS OF DONOR INVESTMENT IN ODA FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FOR THE 2007 TO 2011 PERIOD

Investment in nutrition ODA increased from 2007 to 2011 (Figure 3.3). On average US$549 million per annum was invested in nutrition in the 2007 to 2011 period (based on 2010 US$ constant) compared to US$438 million per annum in the 2005 to 2009 period (based on the 2009 US$ constant). Overall, nutrition attracted US$414 million dollars (constant 2010 prices) in 2007, increasing to US$612 million (0.76% of total ODA) in 2009. Thereafter, nutrition ODA remained more or less constant from 2010 to 2011 reaching 0.84% of total ODA in 2011. However, while overall investment remained constant over the period, funding for direct nutrition interventions increased: from (US$132 million) 0.17% of total ODA in 2009 to (US$163 million) 0.21% in 2010 and (US$222 million) 0.3% in 2011. On average, between 2007 and 2011, US$143 million per annum was invested in direct nutrition interventions, representing 0.2% of total ODA. Meanwhile funding for indirect nutrition interventions decreased. Despite this, over the same period, it was more than double the investments in direct nutrition interventions at US$407 million or 0.55% of total ODA per annum. Funding for indirect nutrition interventions decreased from US$466 million in 2009 to US$425 million in 2010 and US$390 million in 2011.

FIGURE 3.3: ODA FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FOR ALL DONORS FROM 2007 TO 2011

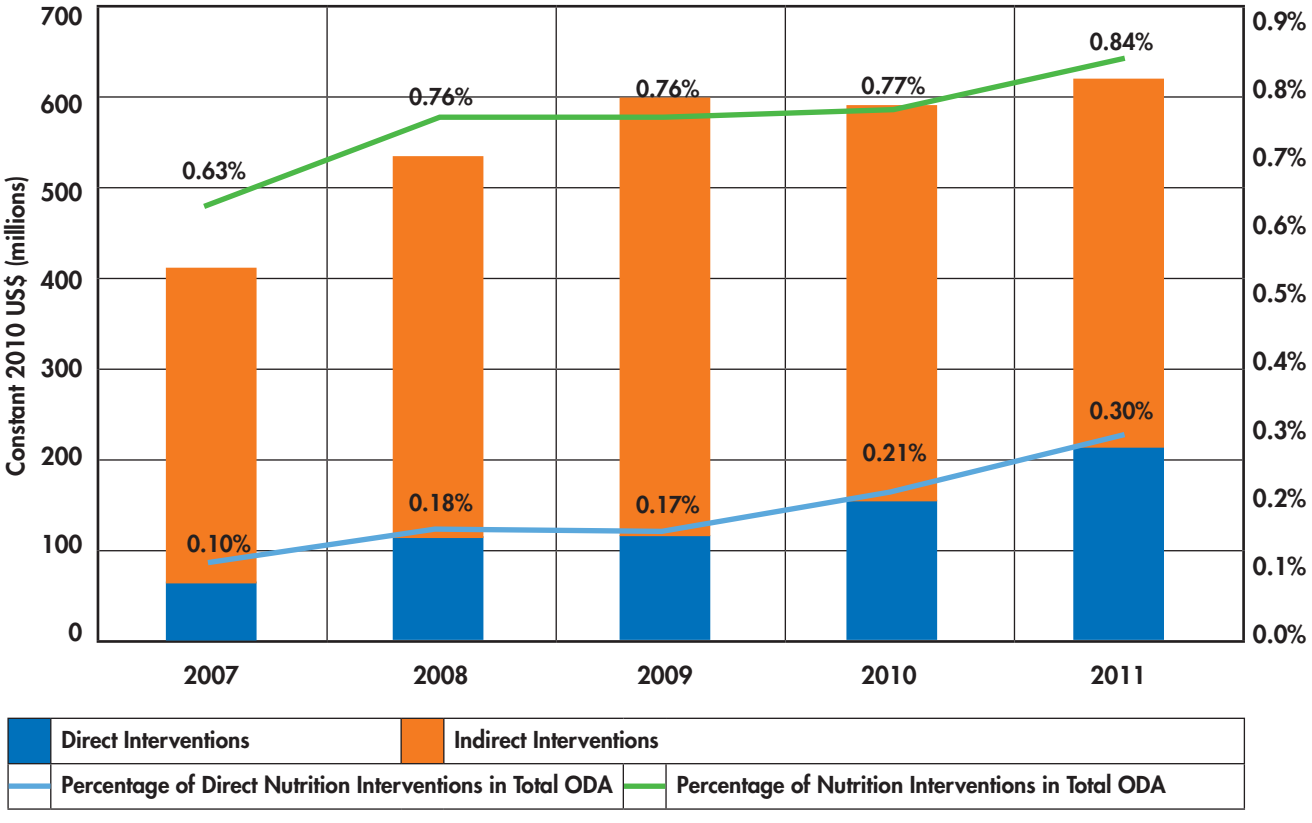


FIGURE 3.4: ODA FROM G8 COUNTRIES FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS IN 2010 AND 2011

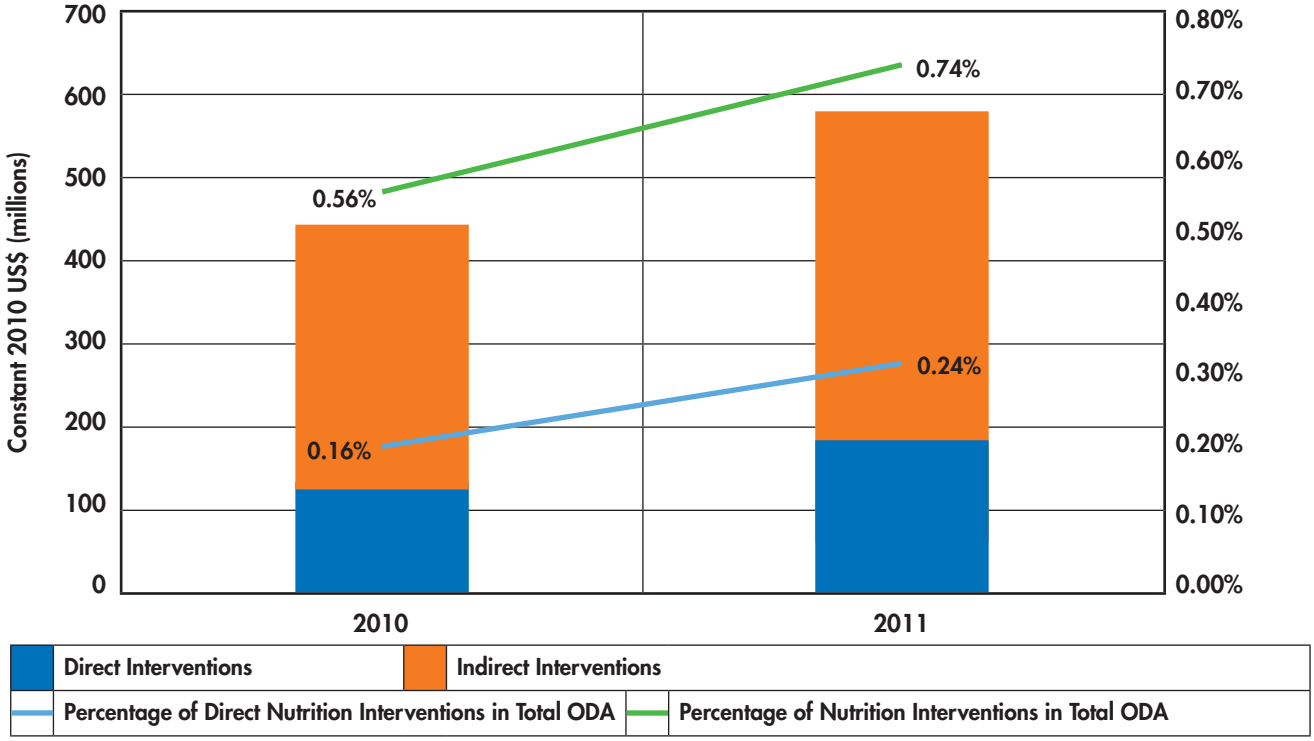
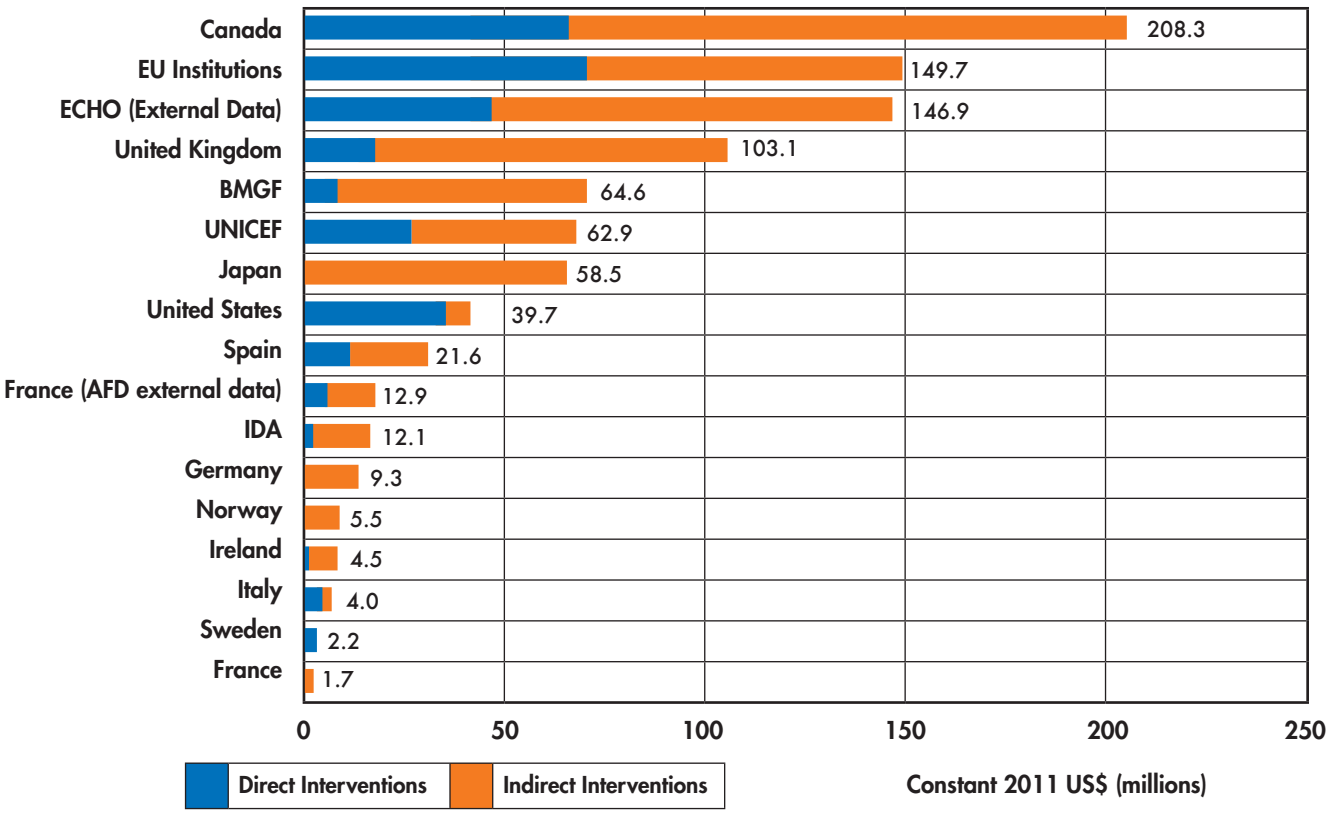


FIGURE 3.5: ODA FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FOR 2011 FOR ALL DONORS



The G8 donors increased their overall funding for nutrition, in terms of volume and proportion of ODA, from 2010 to 2011 (Figure 3.4 on page 23). They increased their overall investment for both direct and indirect nutrition interventions in 2011 to US$573 million (Constant 2010 prices), although this still accounted for only 0.74% of total ODA from G8 donors.

When all donors analysed in this update are considered for 2011 only, they collectively invested, on US$907.7 million in nutrition overall, US$281.3 million for direct nutrition interventions and US$626.3 million for indirect nutrition interventions (Figure 3.5 on page 23).

3.3 WHO ARE THE DONOR NUTRITION CHAMPIONS FOR THE PERIOD OF 2007 TO 2011?

Of the donors analysed, those who invested the most in nutrition were (starting with the biggest):

Bilateral donors: Canada, the EU, the UK, the USA and Spain (unchanged from the 2005 to 2009 period);

FIGURE 3.6: AVERAGE ODA FOR NUTRITION INTERVENTIONS FOR ALL DONORS BETWEEN 2007 AND 2011

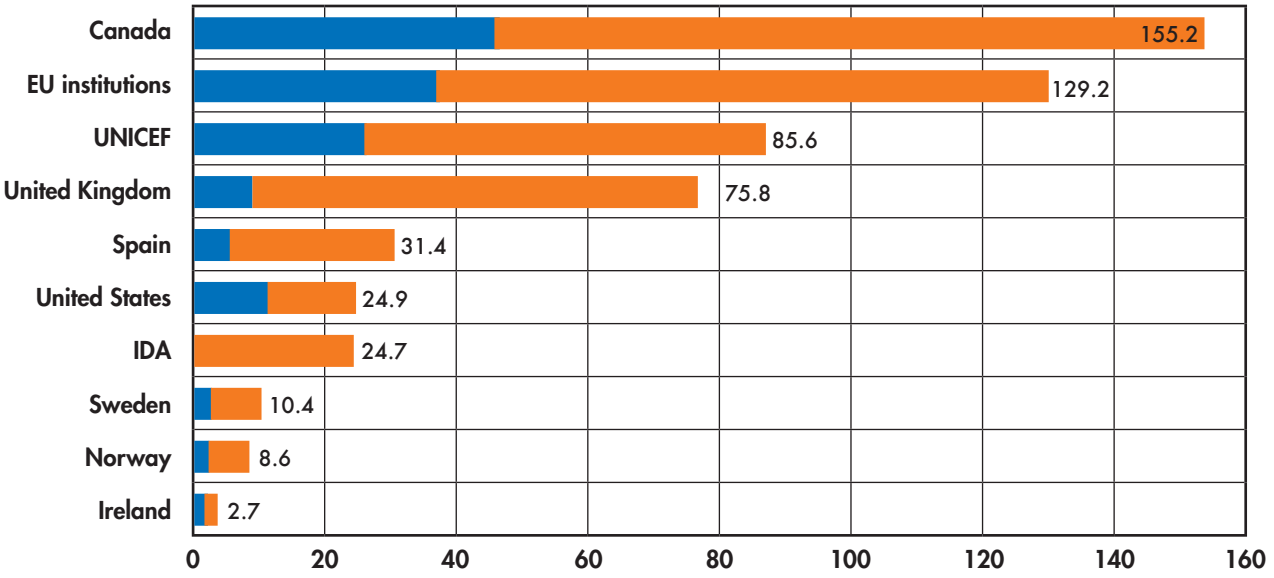
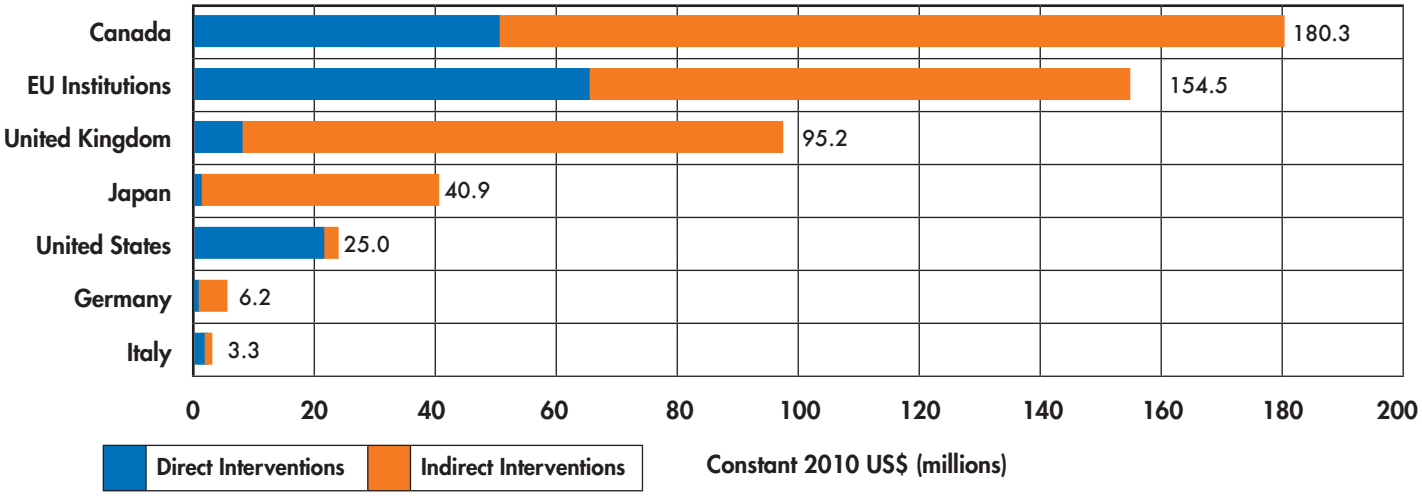


FIGURE 3.7: AVERAGE ODA FOR NUTRITION INTERVENTIONS FOR G8 COUNTRIES FOR 2010 TO 2011 PERIOD



Multilateral donors: UNICEF and IDA.
Together, Canada, the EU, UNICEF and the UK accounted for 81% of the nutrition funding, and on average these donors invested slightly more than a quarter (27%) of their nutrition ODA on nutrition-specific interventions. For the top three, this increased to 30%. Although the USA was not one of the top four bilateral donors in terms of volume of nutrition ODA, they invested 45% of their expenditure on nutrition on direct nutrition interventions (Figure 3.6).

For the G8 donors (Figure 3.7), Canada, the EU Institutions, the UK and Japan were the greatest investors in nutrition, however the United States, the EU Institutions and Italy invested the most in direct nutrition interventions. The investment trends for Germany, Japan and the UK indicated that they preferred funding indirect nutrition interventions rather than direct nutrition interventions.

3.4 WHAT IS THE DISTRIBUTION OF ODA INVESTMENTS BETWEEN THE VARIOUS CATEGORIES OF DIRECT NUTRITION INTERVENTIONS?

Between 2007 and 2011, just under half (49%) of direct nutrition funding was spent on therapeutic feeding for malnourished children with specialised food products (Figure 3.8). In the 2005 to 2009 period this figure was just 40% which shows that there was an increase in funding for this category of interventions in 2010 and 2011. Meanwhile the proportion of investment directed towards increasing intake of vitamins and minerals had diminished slightly from 44% (2005 to 2009) to 34% (2007 to 2011). Interventions to promote good nutritional practices also received a reduced proportion of funding from 14% (2005 to 2009) to 9% (2007 to 2011), whilst the proportion of funding directed towards interventions that incorporate all three categories of direct interventions increased from 2% (2005 to 2009) to 8% (2007-2011).

Investments for all three categories of direct nutrition interventions in terms of volume increased but the increase was greatest for the therapeutic feeding of malnourished children with special foods, which almost doubled in the latter period of 2007 to 2011

FIGURE 3.8: PROPORTION OF ODA TO THE DIFFERENT CATEGORIES OF DIRECT NUTRITION INTERVENTIONS FOR ALL DONORS FOR THE 2007 TO 2011 PERIOD

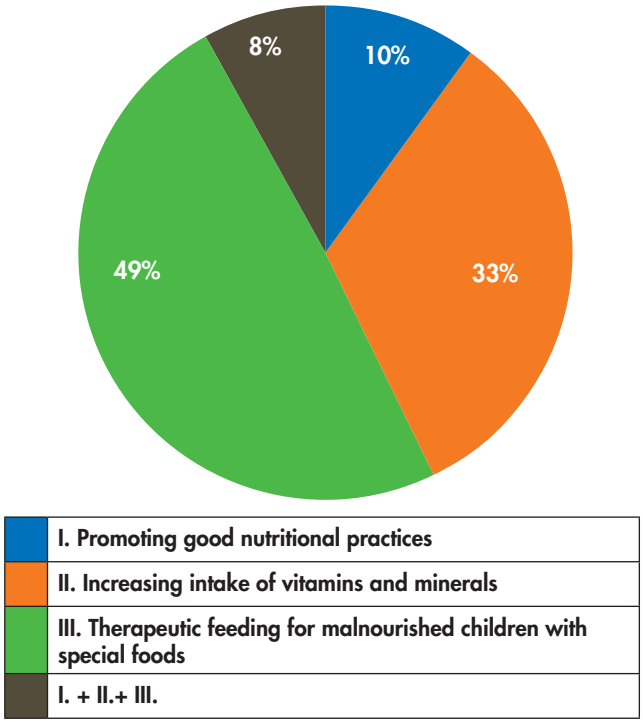


FIGURE 3.9: PROPORTION OF ODA TO THE DIFFERENT CATEGORIES OF DIRECT NUTRITION INTERVENTIONS FOR G8 COUNTRIES FOR THE 2010 TO 2011 PERIOD

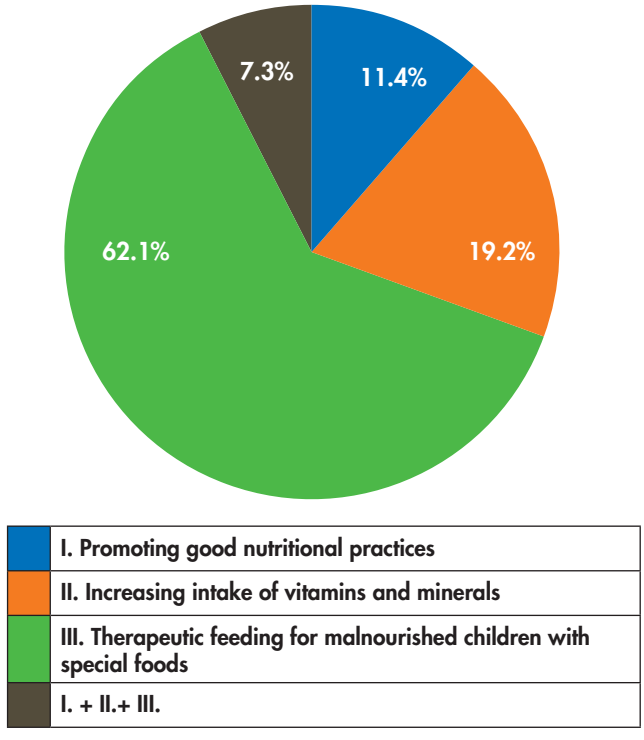


FIGURE 3.10: COMPARISON OF VOLUME AND PROPORTIONS OF ODA DISTRIBUTED TO THE DIFFERENT CATEGORIES OF DIRECT NUTRITION INTERVENTIONS BETWEEN THE PERIODS OF 2005-2009 AND 2007-2011 FOR ALL DONORS

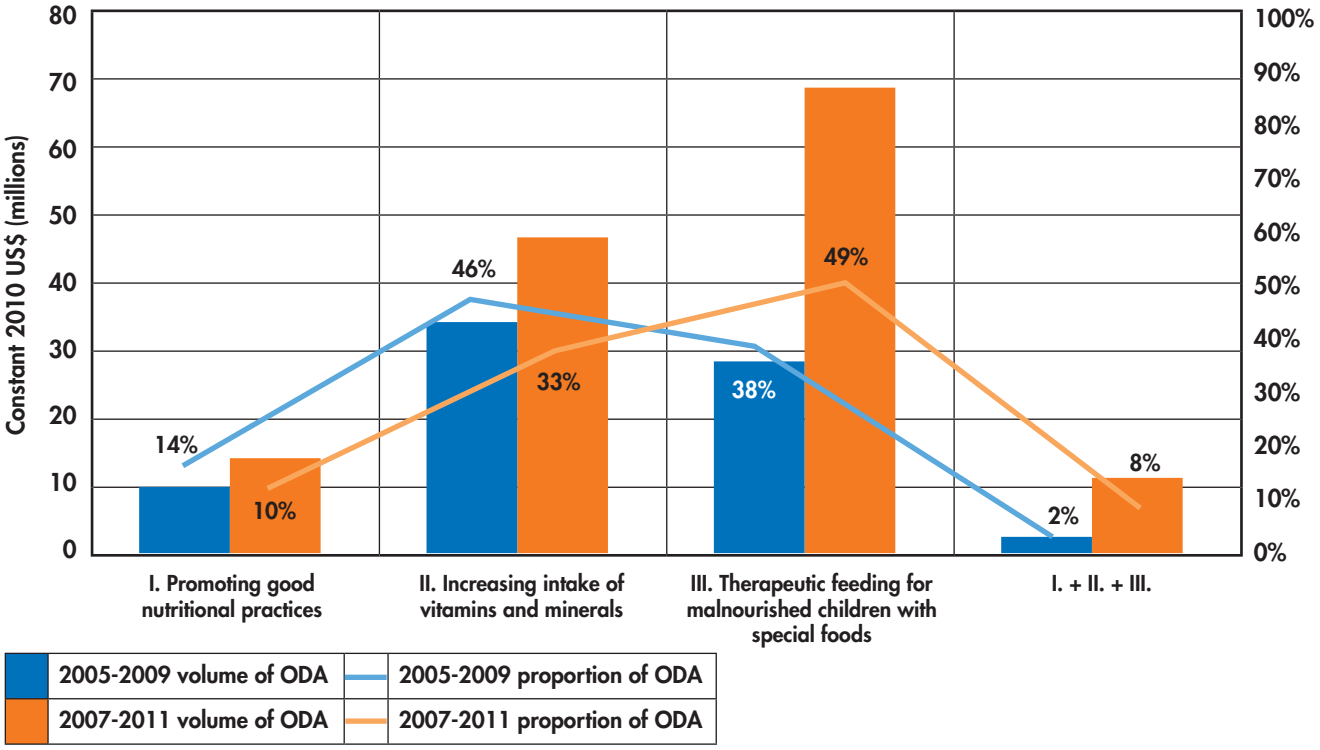


FIGURE 3.11: SECTORS OF IMPLEMENTATION FOR DIRECT NUTRITION INTERVENTIONS FOR ALL DONORS FOR THE 2007 TO 2011 PERIOD

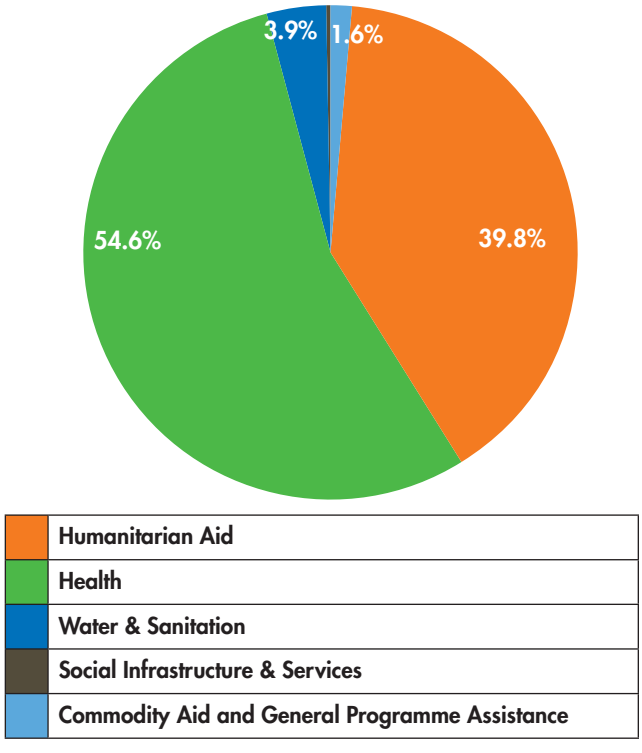
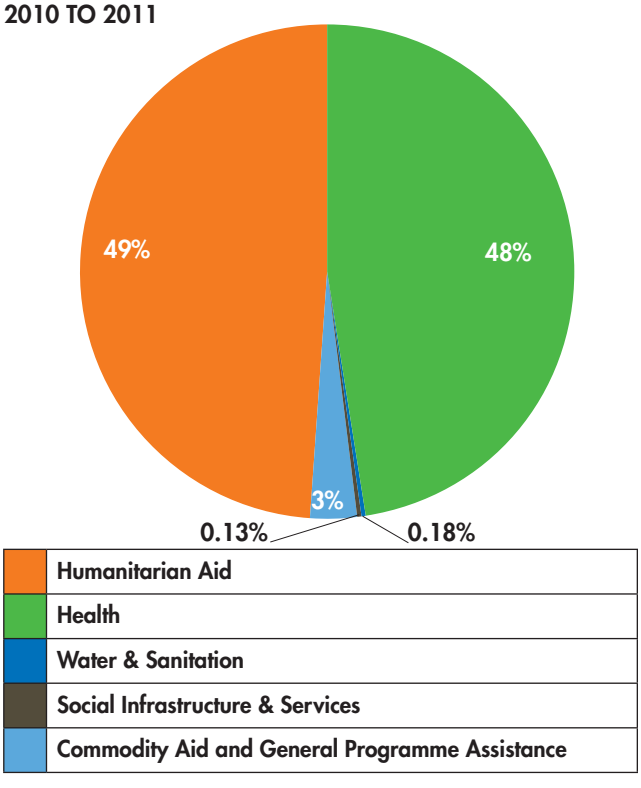


FIGURE 3.12: SECTORS OF IMPLEMENTATION FOR DIRECT NUTRITION INTERVENTIONS FOR G8 FUNDING FOR 2010 TO 2011



(Figure 3.10 on page 26). Funding was not necessarily displaced from the other categories of direct nutrition interventions, it simply did not increase at the same rate. Furthermore, a welcome trend is emerging of donors investing in a comprehensive package of direct interventions, rather than polarising their investments into one category of direct nutrition intervention. In the previous report, the USA was the only donor to invest in a package all three types of direct interventions, but in 2010 and 2011, other donors such as Spain, Canada and France also started to provide a combination of direct nutrition interventions involving at least two categories of direct nutrition interventions.

G8 donors also proportionally invested more in direct nutrition interventions in the 2010 to 2011 period (Figure 3.9 on page 25). Overall they invested 62.1% in therapeutic feeding for malnourished children with specialised foods, 19.2% in bolstering the intake of vitamins and minerals, 11.4% in interventions to promote good nutritional practices and almost 7.3% in programmes that included all three categories.

3.5 SECTORS OF DELIVERY FOR NUTRITION INTERVENTIONS

Direct Interventions: The majority (55%) of funding for direct nutrition interventions was delivered through the health sector (Figure 3.11 on page 26). There are two main reasons for this. Firstly, the Basic Nutrition (12240) code in the CRS database falls under "Health", secondly interventions such as the therapeutic feeding of malnourished children are provided through the health sector in many countries. 40% of funding for direct interventions was delivered through "Humanitarian Aid" and most of the funding in this sector was dedicated to the treatment of acute malnutrition in emergency contexts. As the promotion of hand washing and hygienic practices is often coupled with schemes in this sector, a further 4% was delivered through "Water and Sanitation" and 1% through "Commodity Aid and General Programme Assistance" (which corresponds with Food security programmes). Please note that "Social Infrastructure & Services" accounted for 0.18% of funding but this is not clearly visible on the chart.

FIGURE 3.13: SECTORS OF IMPLEMENTATION FOR INDIRECT NUTRITION INTERVENTIONS FOR ALL DONORS FOR THE 2007 TO 2011 PERIOD

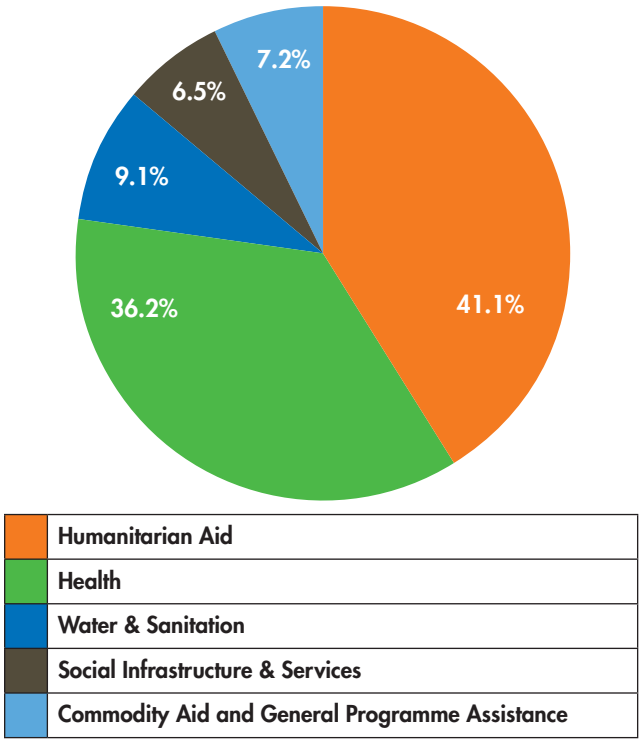
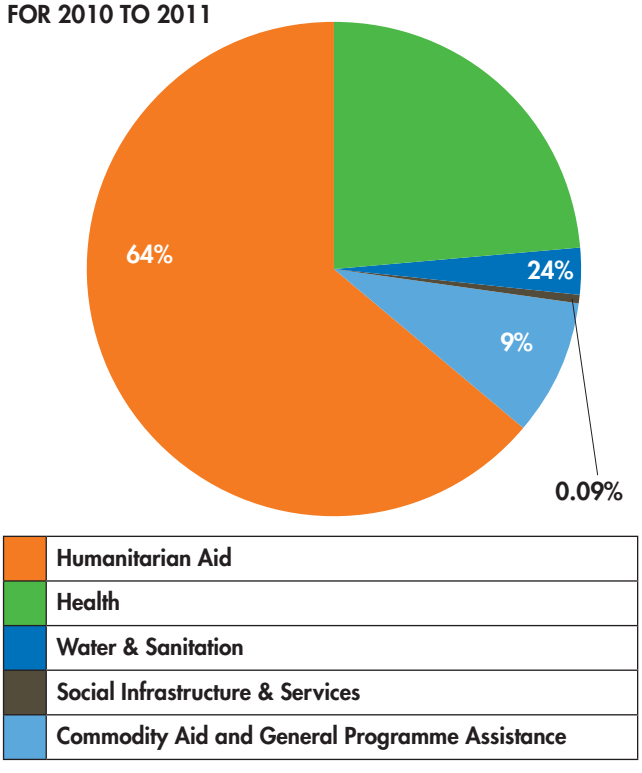


FIGURE 3.14: SECTORS OF IMPLEMENTATION FOR INDIRECT NUTRITION INTERVENTIONS FOR G8 FUNDING FOR 2010 TO 2011



Investments by G8 donors were more or less equally distributed through "Humanitarian Aid" (49%) and "Health" (48%), whilst only 3% of G8 funding was distributed through "Commodity Aid and General Programme Assistance" (Figure 3.12 on page 26).

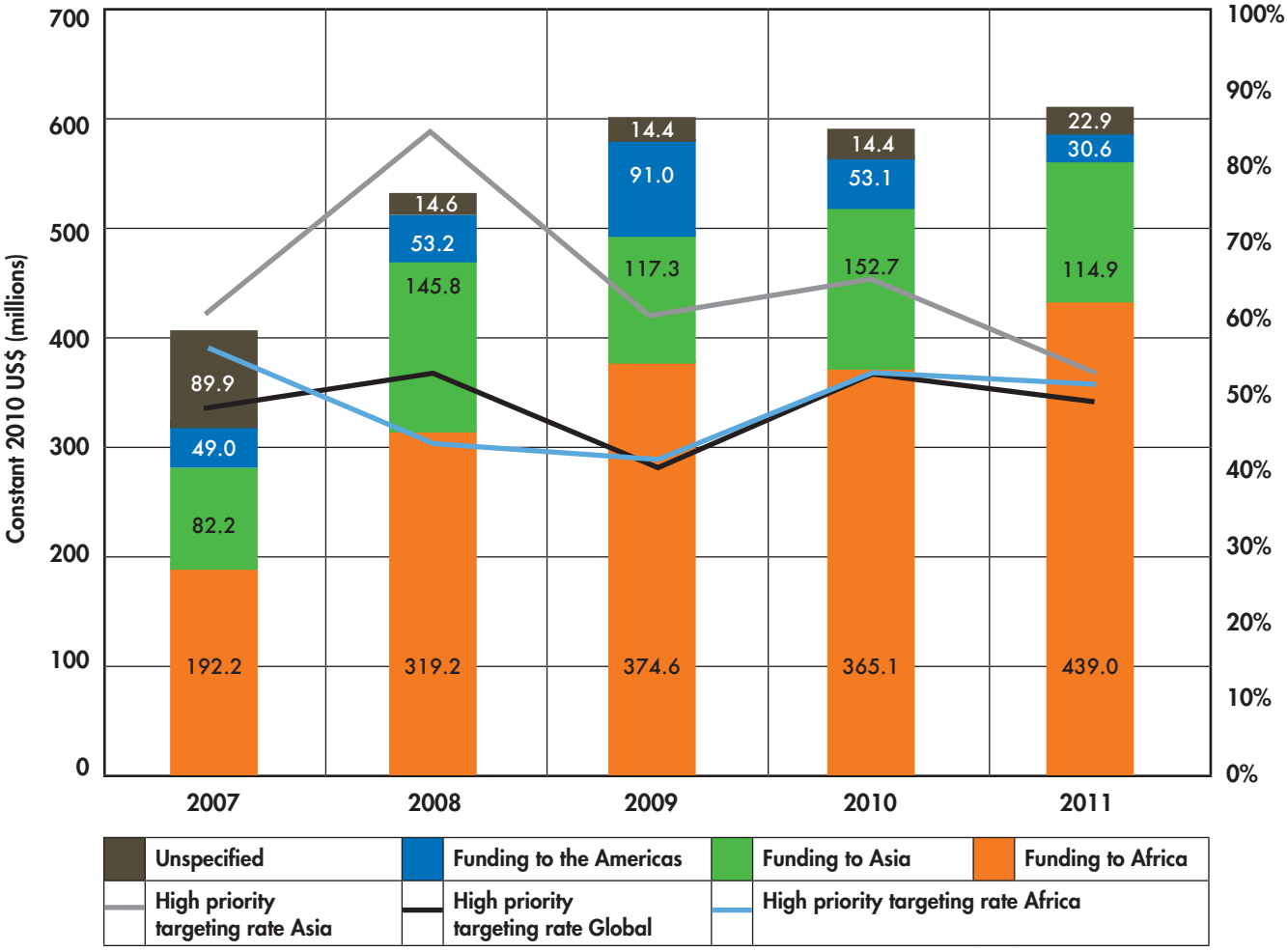
Indirect Interventions: Forty-one percent of funding for indirect interventions, a big increase from 29% in the 2005 to 2009 period, was delivered as part of "Humanitarian Aid", mainly because emergency response often includes nutrition activities and other activities which aim to restore access to basic services and goods (Figure 3.13 on page 27). The remainder of investments for indirect nutrition interventions were delivered as part of "Health" (36% compared with 44% previously reported by ACF in 2012). "Water and Sanitation" also decreased from the 14 % to 9% while "Social Infrastructure and Services" remained unchanged at 7%.

The majority of nutrition funding from G8 donors for indirect nutrition interventions, 64%, was channelled through "Humanitarian Aid", followed by 24% through "Health", 9% through "Commodity Aid and General Programme Assistance" and only 3% through "Water and Sanitation" (Figure 3.14 on page 27).

3.6 IS ODA FOR NUTRITION BEING DIRECTED TO THE WORST AFFECTED REGIONS?

For the 2007 to 2011 period, 62% of ODA for nutrition on average was directed to Africa, whilst 22% and 10% were directed to Asia and the Americas respectively (Figure 3.15). In 2007, the volume of nutrition ODA directed to unspecified regions was at its highest

FIGURE 3.15: PROPORTION OF ODA FOR THE REGIONS MOST AFFECTED BY UNDERNUTRITION FROM ALL DONORS



before decreasing from 2008 to 2010, although there was a slight increase in 2011. Funding targeted towards unspecified regions was at similar low levels in 2005 and 2006

During the 2007 to 2011 period, funding flows of nutrition ODA to Africa increased steadily, the biggest increase taking place in 2008. Funding then decreased in 2010 to US$365 million followed by an increase in 2011 to US$439 million — the largest investment in the region in the five year period. Even though Bangladesh was the second highest recipient of nutrition aid in the 2007 to 2011 period, seven of the top ten recipients of nutrition aid were African countries (Table 3.1). Africa received more funding for nutrition overall however the targeting of high priority African countries according to stunting and wasting (as defined in ACF 2012) was just 50% (although this represents an improvement from 2009 when the figure was around 40%). Although Asia received less funding than Africa, the targeting of high burden Asian countries has been consistently better than for Africa since 2005 and was, at slightly over 80%, best in 2008. Since 2008, this figure has gradually decreased to just under 50% in 2011, very close to the targeting rate in the Africa region. While

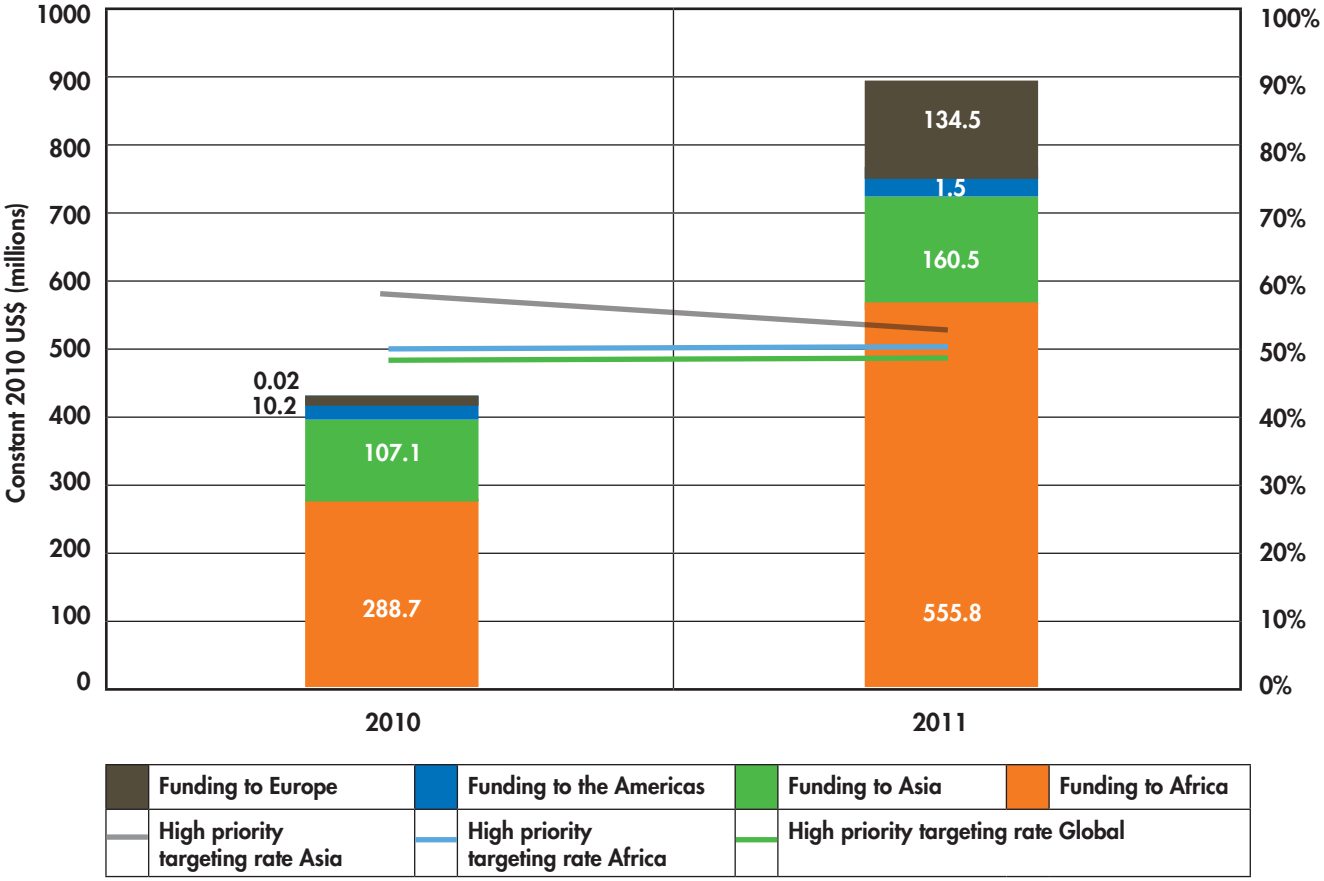
TABLE 3.1: LIST OF TOP ODA RECIPIENT COUNTRIES FOR 2007-2011 FOR ALL DONORS

Ranking (2005-2009 ranking in brackets)	Recipient	Average annual funding for nutrition from 2007-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1 (4)	Ethiopia	50.2	9%
2 (1)	Bangladesh	35.8	7%
3 (3)	Sudan	27.2	5%
4 (6)	Niger	25.3	5%
5 (5)	Somalia	22.7	4%
6 (2)	India	18.1	3%
7 (10)	Congo, Dem.Rep	17.3	3%
8 (7)	Kenya	16.0	3%
9 (14)	Haiti	15.6	3%
10 (n/a)	Chad	12.2	2%
11 (n/a)	Pakistan	11.1	2%
12 (n/a)	Mali	11.0	2%
13 (n/a)	Burkina Faso	10.4	2%
14 (11)	Afghanistan	9.3	2%
15 (9)	Peru	8.9	2%

TABLE 3.2: LIST OF TOP FIVE RECIPIENT COUNTRIES FOR 2010-2011 FOR G8 COUNTRIES

Ranking	Recipient	Average annual funding for nutrition from 2010-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1	Ethiopia	24.0	12%
2	Niger	15.6	8%
3	Bangladesh	7.9	4%
4	Afghanistan	9.2	5%
5	Chad	8.6	4%

FIGURE 3.16: VOLUMES OF ODA DELIVERED TO THE REGIONS WORST AFFECTED BY UNDERNUTRITION IN 2010 AND 2011 BY G8 MEMBER STATES



India was the second biggest recipient of nutrition aid for the 2005 to 2009 period, it did not make it into the top five recipients for nutrition ODA for the 2007 to 2011 period (Table 3.1: List of top ODA for nutrition recipient countries on page 29).

From 2010 to 2011, the volume of aid distributed to the Africa region by G8 donors increased from US$289 million to US$388 million (Figure 3.16). While funding to Asia also grew, compared to Africa the increase was much smaller increasing from US$107 million in 2010 to US$138 million in 2011. However, the targeting of aid to high burden countries in Africa remained unchanged at 50% in 2010 and 2011 and the targeting of aid to high burden countries in Asia decreased from nearly 60% in 2010 to just above 50% in 2011.

3.7 ACCOUNTABILITY

Prior to 2006, the extent to which donors met their promised investments (commitments) compared to what they actually delivered (disbursements) was poor (Figure 3.17). By 2007, commitments and disbursements were beginning to converge however by 2009 the gap had widened again and was at its greatest in 2010. By 2011 the gap had narrowed again, with an overall gap of US$100 million between commitments and disbursements.

The commitments and disbursements of G8 donors improved between 2010 and 2011, although there was still a difference of US$117 million (constant 2010 prices) between commitments and disbursements in 2011.

FIGURE 3.17: DIFFERENCE BETWEEN COMMITMENTS AND DDISBURSEMENTS FOR ALL DONORS OVER TIME

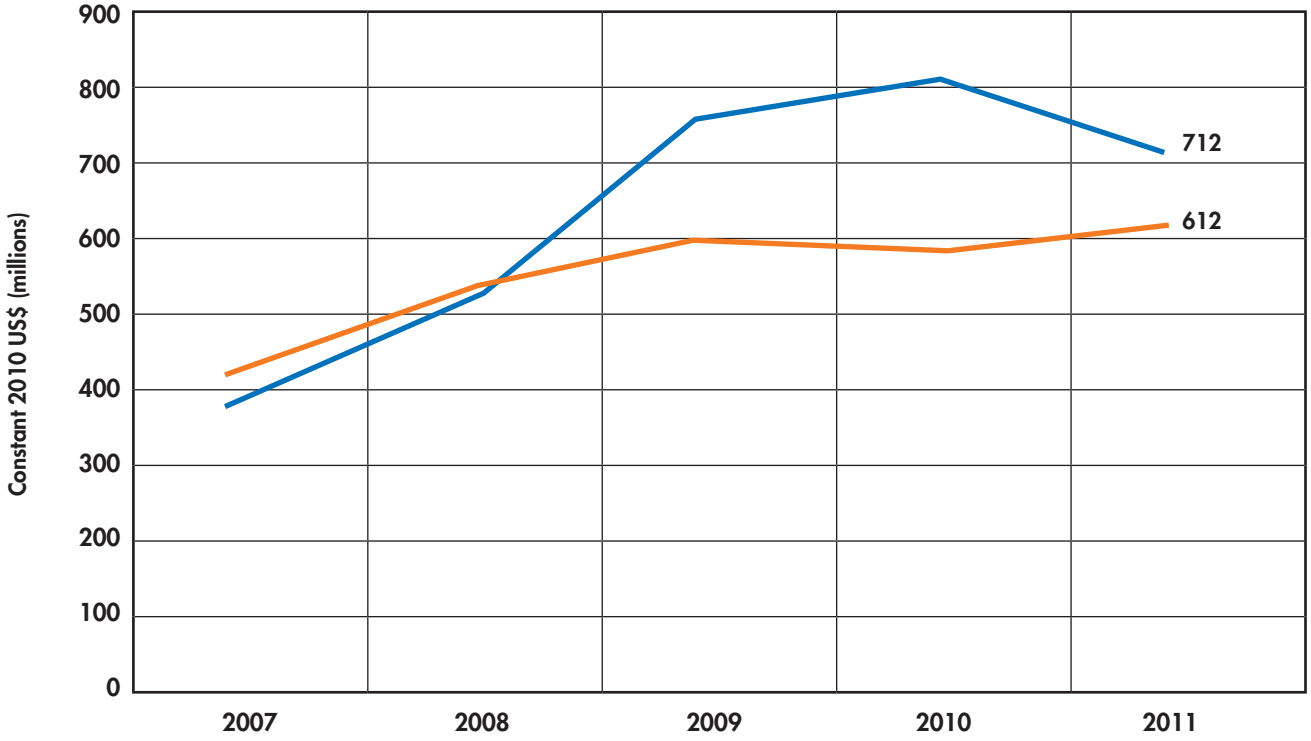


FIGURE 3.18: COMMITMENTS AND DISBURSEMENTS OF G8 COUNTRIES IN 2010 AND 2011

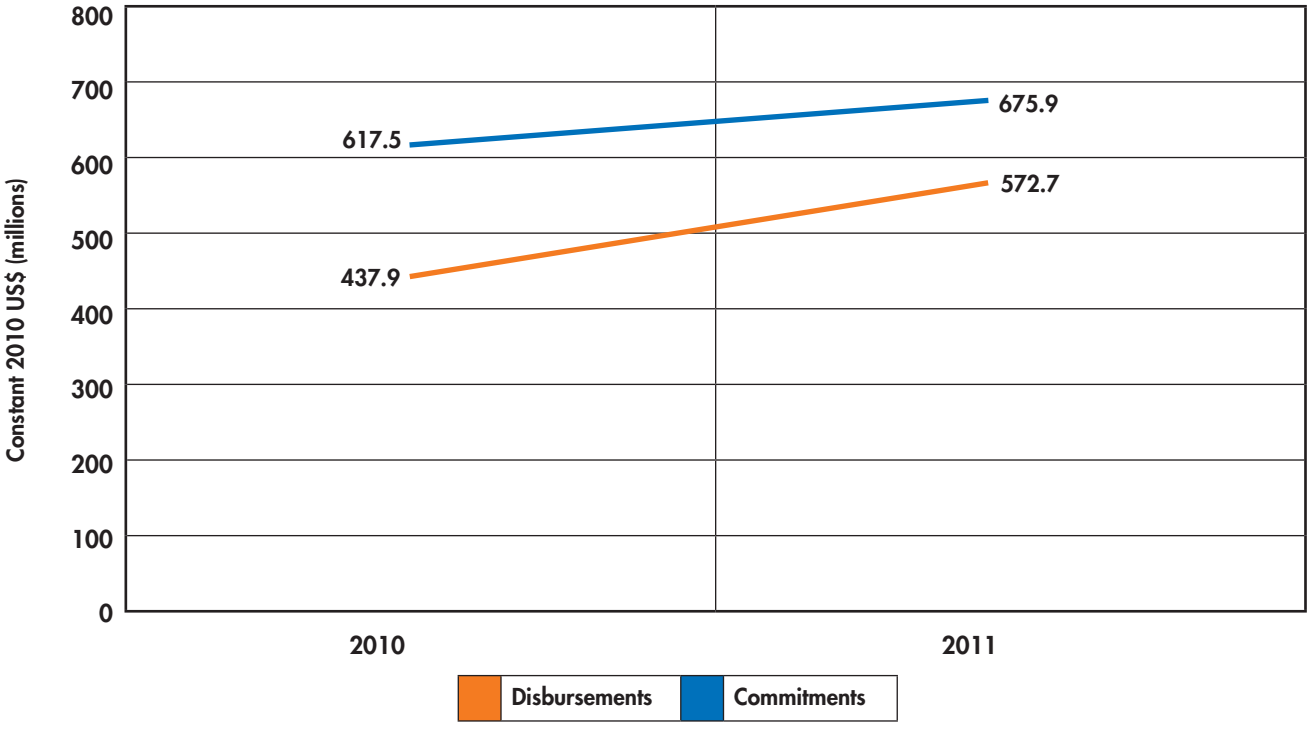


FIGURE 3.19: PERCENTAGE DIFFERENCE BETWEEN COMMITMENTS AND DISBURSEMENTS PER DONOR STUDIED AND OVERALL

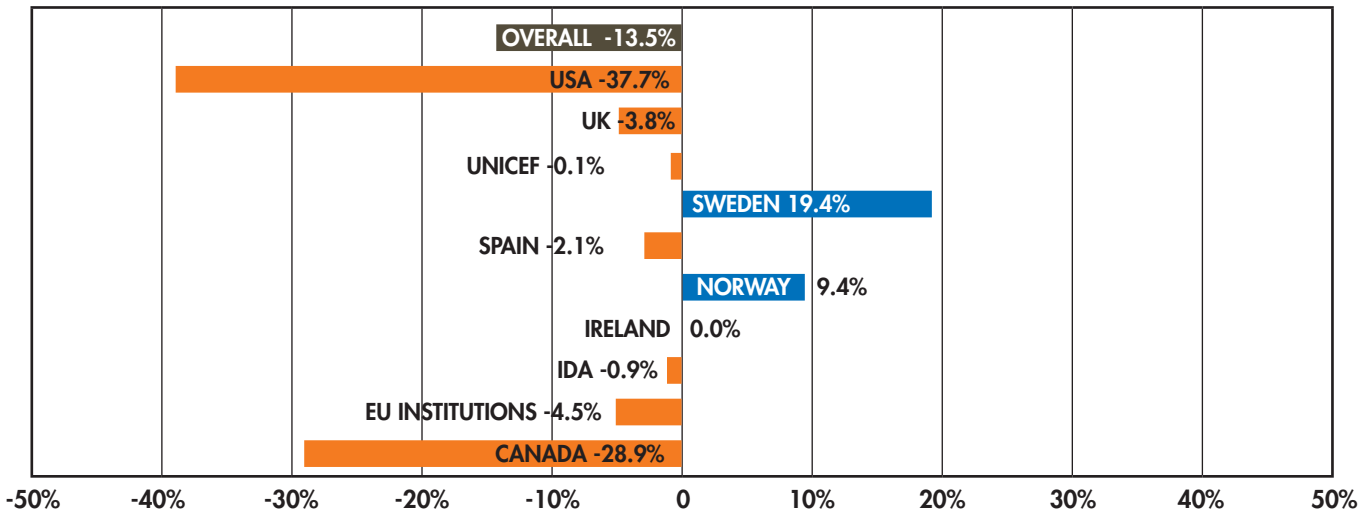
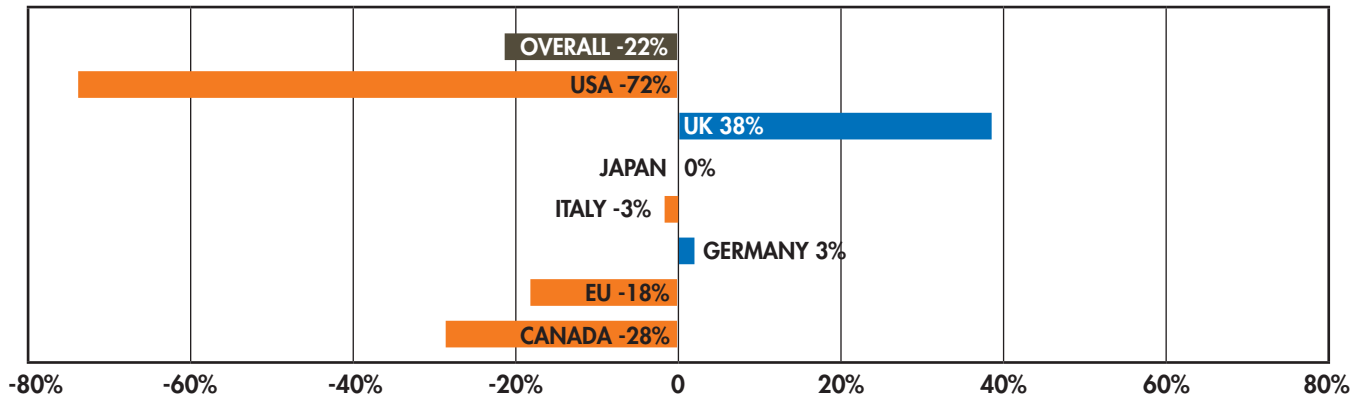


FIGURE 3.20: PERCENTAGE DIFFERENCE BETWEEN COMMITMENTS AND DISBURSEMENTS OF G8 COUNTRIES IN 2010 AND 2011



3.8 BILATERAL FUNDING DISBURSED THROUGH VARIOUS STAKEHOLDERS

Outside of their annual contributions to the core budgets of multilateral agencies, bilateral donors chose to deliver 43% of their funding for nutrition through multilateral agencies for the 2007 to 2011 period. Most of this was to UNICEF and WFP, both of which received 10% each, or almost a quarter of this 43% share. Another 20% went through 'unspecified multilateral agencies' and the remaining proportion was directed through IBRD (2%), WB group (0.76%), FAO (0.59%) and UNHCR and WHO. 37% of bilateral aid was delivered through non-governmental organisations (NGOs) such as ACF. A further 7% was delivered through the Public Sector and 10% through unspecified stakeholders.

Unsurprisingly, a similar pattern was observed for the G8 donors, although, at 40%, NGOs received slightly more. For G8 donors alone, the share for multilateral agencies such as UNICEF and WFP was greater than for all donors analysed during the 2007 to 2011 period. This can be attributed to the improved quality of reporting in 2010 and 2011.

FIGURE 3.21: PERCENTAGE OF NUTRITION FUNDING FOR ALL DONORS DELIVERED THROUGH DIFFERENT STAKEHOLDERS

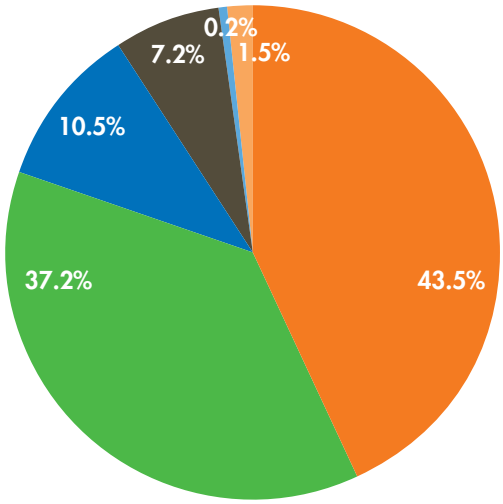
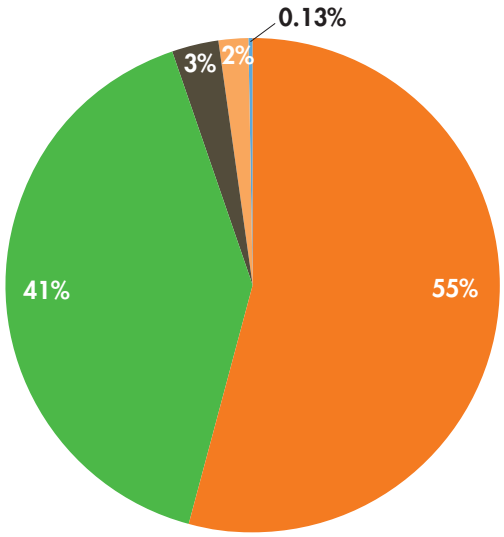


FIGURE 3.22: PERCENTAGE OF NUTRITION FUNDING FOR G8 DONORS DELIVERED PER SECTOR



	Multilateral agencies
	NGO's
	Non-Specified
	Public Sector
	Public/Private Partnership
	Other

DISCUSSION

ACF, courtesy of Samuel Hauenstein-Swann

4. DISCUSSION

4.1 LIMITATIONS OF MAPPING NUTRITION AID IN THE CRS DATABASE:

Tracking a discrete set of direct nutrition interventions in the CRS database remains difficult, more difficult for some donors than others. It would be greatly assisted if all donors that report to the database adhered to a minimum standard of reporting. This would aid rather than hinder the transparency of donor aid activities in the nutrition sector.

Various stakeholders in developing and donor nations need to access up-to-date information about nutrition aid. The governments of developing nations need the information to plan and manage their resources effectively, whilst citizens in developing countries and donor countries need the information to hold their governments to account for the disbursement of committed resources.[6] Accurate, timely and detailed reporting of aid activities can also contribute to lesson learning and policy development.

With the advent of the SUN Movement[7] and the growing recognition that to rid the world of the scourge that is undernutrition more financial resources are needed to scale up direct and indirect nutrition interventions. It is essential that a robust accountability framework for investments in nutrition is in place. For the SUN Movement, an accountability framework would:

- Provide accurate/credible information for mutual accountability (transparency)
- Report on projects related to nutrition in a consistent manner

Poor donor reporting: The Basic Nutrition purpose code (12240) is the code most used by donors to report direct nutrition interventions. However even in this code, 12% of the projects could not be analysed due to lack of information, and a further 35% of the code was deemed to be unrelated to nutrition in line with the methodology of this report. Assessing the total investments in the Basic Nutrition purpose code rather than on a project by project basis can therefore lead to an overestimation of aid allocated to nutrition by up to 50%. Some donors, such as France and Japan, were consistently poor with their reporting although for France there were signs of improvement in 2010 and 2011. Some multilateral agencies, such as WFP, consistently fail to provide detailed information on their projects making it very difficult to track any direct nutrition interventions they may have invested in.

ACF reiterates its call for improved reporting by donors to provide sufficient detail in the short and long descriptions of the nutrition projects or programmes they fund.

Furthermore, the DAC Working Party on Statistics must amend the aid activities reported in the Basic Nutrition purpose code to include only those projects which are directly related to nutrition.

Until the above changes are implemented, it is recommended that other purpose codes beyond the Basic Nutrition purpose code are analysed to keep track of other nutrition related programmes. We acknowledge that one of the limitations of this analysis is that it did not include purpose codes related to agriculture which may have contained more nutrition investments. This will be addressed in subsequent analyses.

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

In 2010, the World Bank estimated that an additional US$11.8 billion should be invested annually in direct nutrition interventions. But it did not put forward an estimate for funding required for indirect nutrition interventions (Horton *et al.* 2010). On average, nutrition investments averaged US$438 million per year over the 2005 to 2009 period. For the 2007 to 2011 period, investments averaged US$549 million per year; an increase of US$111 million. The funding allocated to nutrition in 2010 and 2011 (US$588 and US$612 respectively) remained more or less constant from 2009, when it was US$598 million. It was interesting to observe that although the funds allocated to overall nutrition interventions remained relatively constant between 2009 and 2011, the money allocated to direct nutrition interventions increased from US$132 in 2009, US$163 in 2010 and to US$222

[6] *International Aid Transparency Initiative (IATI) http://www.aidtransparency.net/*

[7] *http://www.scalingupnutrition.org/*

million in 2011. This trend of increased funding for direct nutrition interventions is most welcome and overdue and should be considered as the start of a long term trend of increased investments in direct nutrition interventions that should be built upon year by year until undernutrition is eradicated.

The average annual investment of US$143 million in direct nutrition interventions between 2007 and 2011, represented just 0.2% per year of total ODA. Furthermore, when one considers that this represents just 1.2% of the additional US$11.8 billion per year which is needed for direct nutrition interventions, it is clear current investments are vastly inadequate and that reaching this goal will require a marathon effort rather than a series of sprints. Nevertheless, it is an improvement from the 2005 to 2009 period when only 0.6% (or an annual average of US$73.3 million, 2009 constant prices) was allocated to direct nutrition interventions. Although this increase is an improvement, it is not on a scale large or fast enough to meet MDGs 1, 4, 5 and 6 in the worst affected countries by 2015.

Both domestic and global donors will need to be more committed, ambitious and innovative in their funding in order to rid the world of undernutrition. ACF's publication Aid for Nutrition: Using Innovative Financing To End Undernutrition (2012),[8] suggests various mechanisms that could be employed by donor and recipient governments to raise funds to combat undernutrition beyond the ODA of traditional donors. However, this does not mean that donor governments should shirk their responsibility of delivering on their promise of increasing ODA to 0.7% of GNI, delivery of which would raise a significant amount of money for public goods such as nutrition. G8 donor governments should increase their ODA to meet this target and should earmark nutrition programmes for additional investment. The UK should be highly commended on their commitment to deliver 0.7% of their GNI from 2014 onwards to ODA — the first of the G8 member states to do so. Nutrition should certainly be one of the sectors that benefits from the fulfilment of this promise and the UK has an opportunity to lead its G8 peers by example. Furthermore, the EU has reported that it will be on track to deliver 0.7% of its GNI to ODA by 2015. However this may be hampered by the fact that some member states have cut their aid contributions drastically in response to the economic and financial crisis (Aidwatch, 2013).[9]

Key message: The increase in funding for direct nutrition interventions is welcomed, but more needs to be done by G8 countries in the near future to deliver 0.7% of their GNI to ODA. Both donor and domestic governments need to earmark funds for nutrition programmes. Innovative financing mechanisms should also be developed to achieve the estimated funding needs for nutrition.

4.3 TREND ANALYSIS OF THE DISTRIBUTION OF FUNDING OF DIRECT AND INDIRECT NUTRITION INTERVENTIONS:

The Scaling Up Nutrition Movement advocates for the scale up of both direct and indirect nutrition interventions. The analysis in this report indicates that since 2009, there has been a general increase in funding for direct nutrition interventions, matched by a corresponding decrease in funding for indirect nutrition interventions. This suggests that donors tend to prioritise one in favour of the other rather than funding both types of interventions. Adequate funding for both types of interventions is required because they address different things. Direct nutrition interventions have a direct impact on an individual's health and nutrition status and in some cases save lives, while indirect nutrition interventions set out to improve the wider quality of life. Further research is required to determine what the ideal balance of investments for these two types of interventions is. However, we do know there is a significant gap between what current investments in direct nutrition interventions are and what they need to be and so this is a good starting point. Direct and indirect nutrition interventions reinforce each other and scaling up investments in each is important.

In 2010 and 2011, there were changes in the proportions of funds directed towards the different categories of direct nutrition interventions. In the 2005 to 2009 period, interventions to increase the

[8] *http://www.actionagainsthunger.org.uk/resource-centre/online-library/detail/media/aid-for-nutrition-using-innovative-financing-to-end-undernutrition-1/*
[9] *http://aidwatch.concordeurope.org/*

intake of vitamins and minerals was the category to receive the majority of funding (44%) for direct nutrition interventions, followed by the therapeutic feeding for malnourished children with special foods (40%) and the promotion of good nutritional practices (15%). However, for the 2007 to 2011 period, a greater proportion of the funding was allocated to the therapeutic feeding of malnourished children (49%), whilst increasing the intake of vitamins and minerals decreased to 34% and promoting good nutritional practices decreased to 9%. These changes were driven by the large increase in funding for the therapeutic feeding of malnourished children category. Funding for the other two categories of direct nutrition interventions also increased, however not at the same scale as the therapeutic feeding of children.

Furthermore, funding for nutrition programmes which incorporated all three categories of direct nutrition interventions increased from 2% in the 2005 to 2009 period to 8% in the 2007 to 2011 period. In the earlier period the USA was the primary donor country to fund these integrated programmes. Between 2007 and 2011, the USA increased its funding for integrated programming and other donors such as Canada, Spain, Italy and the EU also started to fund such programmes. This trend of increased funding for programmes which incorporate the minimum package of interventions and provide a holistic response to undernutrition should be welcomed and encouraged. This is not to say that we are encouraging all donors to provide the minimum package of direct nutrition interventions all the time. The minimum package of interventions is welcome whether it is provided as one package by a single donor to a specific country or as coordinated funding from a collective of donors to a specific country.

Key message: The increase in funding for the minimum package of direct nutrition interventions is welcome and should be continued.

4.4 SECTORS OF IMPLEMENTATION FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS

The majority of funding for direct nutrition interventions was channelled through the CRS database's "Health" sector (55%) in the 2007 to 2011 period — a slight decrease from the 2005 to 2009 period. A high percentage of nutrition funding was recorded under the "Health" sector as it includes the Basic Nutrition (12440) purpose code. Forty percent of funding for direct nutrition interventions was channelled through the "Humanitarian Aid" sector — a slight increase from 33% in the earlier period. The majority of nutrition funding in the "Humanitarian Aid" sector was allocated to the therapeutic feeding of malnourished children in emergency contexts. This suggests that the general donor perception is that acute malnutrition is a problem in emergency contexts only. However, the majority of acutely malnourished children live in countries not considered to be part of the humanitarian context, whereas about half the funding for the treatment of acutely malnourished children with special foods is from humanitarian aid. This leaves important gaps in funding the treatment of acutely malnourished children in development contexts. The Emergency Nutrition Network (ENN, 2012) also reported that the treatment of acutely malnourished children is usually financed by humanitarian aid. The ENN views funding delivered through humanitarian aid as short term, unpredictable funding which does little to build national nutrition governance and strengthen national health systems. Furthermore UN agencies and implementing partners are the main recipients of humanitarian aid rather than national governments. This preference for UN agencies and their implementing partners remains even in development contexts (ENN, 2012).[10] Direct nutrition interventions were also delivered through "Water and Sanitation" (4%) at similar levels to the 2005 to 2009 period (5%) and the proportion of funding for direct interventions delivered through "Commodity Aid and General Programme Assistance" was unchanged at 0.9% for both the 2005 to 2009 and 2007 to 2011 periods.

The proportion of indirect nutrition interventions channelled through the "Health" and "Humanitarian

10

Aid" sectors followed the same trend as direct nutrition interventions. However, for the 2007 to 2011 period, a greater proportion of funding for indirect nutrition interventions was channelled through "Water and Sanitation", "Commodity Aid and General Programme Assistance" and "Social Infrastructure and Services" compared with direct nutrition interventions.

Key message: Longer term sustainable funding is required for direct nutrition interventions to facilitate the development of national nutrition governance and strengthen national health systems, particularly for the treatment of acutely malnourished children with special foods as the risk of death for these children in development contexts is the same as in emergency contexts.

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

Funding for the Africa region increased steadily from 2007 (US$192 million) until 2009 (US$375 million) before decreasing in 2010 (US$365 million) and increasing again in 2011 (US$439 million). For the same period the Asia region had more variable funding trends, with increases and decreases in funding. Asia's funding increased from US$82 million in 2007 to US$146 million in 2008, before dipping to US$117.3 million in 2009. Thereafter, it increased to US$153 million in 2010 and decreased to US$115 million in 2011. Other regions such as the Americas and Unspecified regions received much lower quantities of funding compared to Africa and Asia.

Africa received the majority of nutrition funding in terms of volume and percentage in the 2007 to 2011 period. The targeting of funds to African countries worst affected by undernutrition also showed some improvement. In 2009 the targeting rate was just under 40%, but it increased to around 50% in 2010 and 2011, this may have been due to the Horn of Africa crisis in 2011. However, the trend for Asia was more variable. The targeting rate in the region increased from 60% in 2009 to around 65% in 2010, but decreased to just over 50% in 2011. This is reflected in the list of top recipient countries. India was the second largest recipient of nutrition aid for the 2005 to 2009 period and in the 2007 to 2011 period it had dropped to 6th, this may have been a result of its stronger economic development. As India has the highest burden of undernutrition in the world, a decrease in its funding will have a significant impact on the targeting rate for Asia. Four of the top five recipients of nutrition aid were African countries, with Bangladesh being the only Asian country. Readers who are interested in the ranking should refer to the previous publication (ACF 2012) for further explanation.

4.6 ACCOUNTABILITY

Over the course of 2009 and 2010, the difference between the overall commitments and disbursements of all donors was generally large however in 2011, donors honour more of their commitments and the difference became smaller. In 2011, there was a difference of US$100 million between committed and disbursed funds. Overall, donors did not deliver on 13.5% of their commitments during the 2007 to 2011 period, compared with 10.7% during the 2005 to 2009 period, which shows an overall decrease in the tendency of donors to adhere to their commitments for nutrition aid. However, trends vary considerably for individual donors reflecting the variable responses by individual donors as they adjusted their ODA budgets in the wake of the economic and financial crisis. However, it also highlights how nutrition aid for recipient countries can be very unpredictable and can possibly hinder their ability to implement long-term national policies in a sustainable manner.

4.7 DISBURSING BILATERAL FUNDING THROUGH VARIOUS STAKEHOLDERS

The majority of ODA for nutrition was delivered through multilateral agencies (55%), followed by non-governmental organisations with smaller amounts being delivered through public-private partnerships such as GAIN, the Public Sector and others. The Emergency Nutrition Network (ENN) suggests that the preference for multilateral agencies and non-governmental agencies rather than national governments in both humanitarian and development contexts is incompatible with efforts to strengthening national nutrition governance or health systems (ENN, 2012).

4.8 RECOMMENDATIONS

- The DAC Working Party on Statistics must ensure that all donors provide detailed information in the short and long descriptions of their projects in the CRS database so that the projects in the Basic Nutrition purpose code can be clearly identified as nutrition project. Projects that are not relevant to nutrition should not be recorded under the Basic Nutrition code.
- Improved reporting by donors would support the development of a robust global accountability framework for nutrition investments. This should also be developed for national governments.
- Donors should take bolder steps to increase the amount of ODA for direct and indirect nutrition interventions as these interventions are mutually reinforcing. The G8 member states and other donors should follow the lead of the UK and the EU and fulfil their commitment to increase ODA to 0.7% of GNI in a timely manner and allocate a portion of this to nutrition.
- Donors and national governments need to accelerate the development of innovative financing mechanisms to increase investments in nutrition.
- Increased donor funding for the treatment of acutely malnourished children and for a minimum package of direct nutrition interventions should be continued. However donors should recognise that in order to facilitate the development of national nutrition governance and strengthen national health systems, direct nutrition interventions require long term, sustainable funding.

CONCLUSION

ACF, courtesy of Samuel Hauenstein-Swann

CONCLUSION

Tracking the quantity of aid distributed to nutrition interventions can be difficult and complicated. Interpreting the results relies on numerous assumptions and great care. Nevertheless, since the first Aid for Nutrition report (ACF 2012) was researched and written, there have been some improvements by donors in their efforts to provide more detailed reporting in the CRS database. As such, in this report, it was possible to analyse the aid activities of additional donors in 2010 and 2011. However there remains much room for improvement.

The minor increases in nutrition funding observed during the 2007 to 2011 period indicate that nutrition programmes are still given very low priority by many donors, particularly in development contexts. The rate of increase in aid for nutrition is too slow for the worst affected countries to achieve MDGS 1,4,5 and 6 by 2015 or indeed the WHA global targets to reduce the double burden of malnutrition by 2025. Strong advocacy to and by national governments and other stakeholders involved in combatting undernutrition is required to maintain recent trends which have seen an increase in investments in direct nutrition interventions.

In Africa and Asia the targeting of nutrition funding to the countries with the highest burdens of undernutrition should be improved so that 100% of the worst affected countries receive assistance to curb undernutrition rates rather than the 50% that currently do. Furthermore, the tendency of donors to use multilateral agencies and non-governmental organisations as their preferred implementing partners, may not support the realisation of the costed nutrition plans which have been drafted by the governments of high burden countries. The aim of these plans is to strengthen national nutrition governance and health systems and too much reliance on external support may not result in long-term, sustainable change. However the fact that donors continue to rely on multilateral agencies and NGOs to deliver nutrition interventions reflects the huge capacity gaps that exist in the affected countries to deal with the problem themselves.

6. ANNEX

CONTENTS

A1 BILL AND MELINDA GATES FOUNDATION (BMGF)

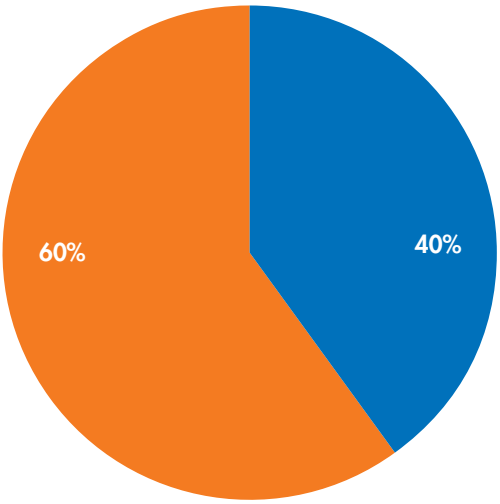
HOW MUCH IS BEING INVESTED IN NUTRITION BY BMGF?

The BMGF began voluntarily reporting their aid activities to the OECD CRS database in 2009. In 2009, the Foundation had disbursed US$96 million for indirect nutrition interventions only. In 2011 however, there was a decrease in the total amount to US$41.2 million. Although the majority of funding was allocated to indirect interventions, there was a small amount of money, US$3.6 million allocated to direct interventions as well. There was an increase in funding allocated to nutrition in 2011 (US$US64.6 million), although the total amount failed to reach the 2009 level of investment. The level of investment for direct nutrition interventions in 2011 also showed an increase (US$ 4.9 million) albeit a small one.

HOW IS FUNDING DISTRIBUTED BETWEEN DIRECT AND INDIRECT NUTRITION INTERVENTIONS?

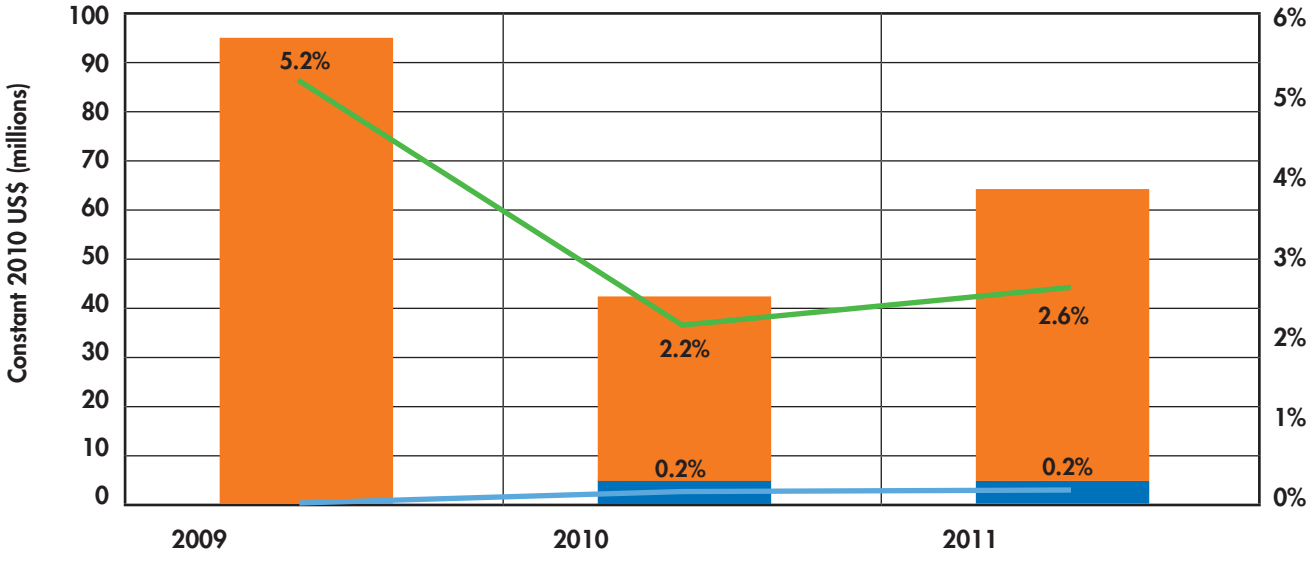
The chart below indicates that the BMGF 's funding was mainly for indirect nutrition interventions rather

BMGF'S DISTRIBUTION OF DIRECT INTERVENTIONS



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

ODA FROM THE BMGF FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2009 TO 2011



Direct Interventions	Indirect Interventions
Percentage of Direct Nutrition Interventions in Overall ODA	Percentage of Nutrition Interventions in Total ODA

than direct nutrition interventions although in 2010 and 2011 there were some investments for direct nutrition observed. In 2009, all BMGF investment was for indirect nutrition interventions. The Foundation allocated a significant proportion of money towards two main categories of direct nutrition interventions promoting good nutritional practices (40%) and increasing the intake of vitamins and minerals (60%).

Funding for direct interventions was mainly channelled through the Health sector and to a lesser extent the Water and Sanitation sectors. This pattern was repeated for indirect interventions although the Health sector delivered the biggest proportion of indirect nutrition interventions and less so the Water and Sanitation sector.

ARE RESOURCES FOR NUTRITION BEING TARGETED TO THOSE WHO NEED THEM MOST?

Since 2009, the BMGF decreased its funding for nutrition in Africa from US$18.41 million to US$8.91 million in 2010. Funding levels increased in 2011 to US$16.09 million.

There was an increase in BMGF funding for nutrition in Asia, increasing from US$ 0.18, 18.23 and 22.09 million in 2009, 2010 and 2011 respectively.
The Table below demonstrates that countries in Asia particularly India and Bangladesh were the top recipients of aid for nutrition from the BMGF and Ethiopia was the only African country in the top five recipients of BMGF funding for nutrition.

However, greater volumes of funding were allocated to regions that were 'Unspecified' US$ 65.65, 11.62 and 25.09 million in 2009, 2010 and 2011 respectively. Meaning that it is not clear where 51% of the nutrition funding was allocated for the period of 2009 to 2011 (69% in 2009, 28 % in 2010 and 39% in 2011). Compared with other donors, this proportion of unspecified funding is quite large.

ACCOUNTABILITY

In 2009, BMGF disbursements (US$ 94.70 million) were slightly lower than commitments (US$96.18). Disbursements were almost double (US$ 41.17 million) that of the commitments made (US$24.80 millions) in 2010, but in 2011 disbursements were lower than commitments (US$64.63 million).

TOP RECIPIENT COUNTRIES FOR THE BMGF

Ranking	Recipient	Average annual funding for nutrition from 2009-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1	India	11.2	5%
2	Bangladesh	9.5	4%
3	Myanmar	7.5	3%
4	Ethiopia	6.3	3%
5	Vietnam	5.8	2%

A2 CANADA

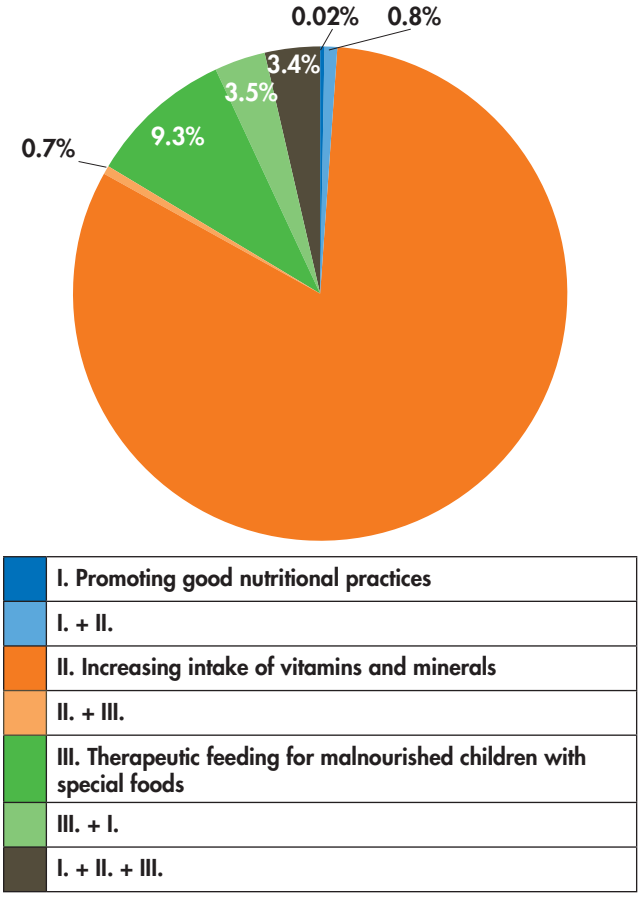
HOW MUCH IS BEING INVESTED IN NUTRITION BY CANADA?

ODA directed to nutrition by Canada decreased from US$159.9 million in 2009 to US$152.2 million in 2010 before increasing to US$ 208.3million in 2011. This represents 4.4, 3.8 and 5.4% of total ODA for each year respectively.

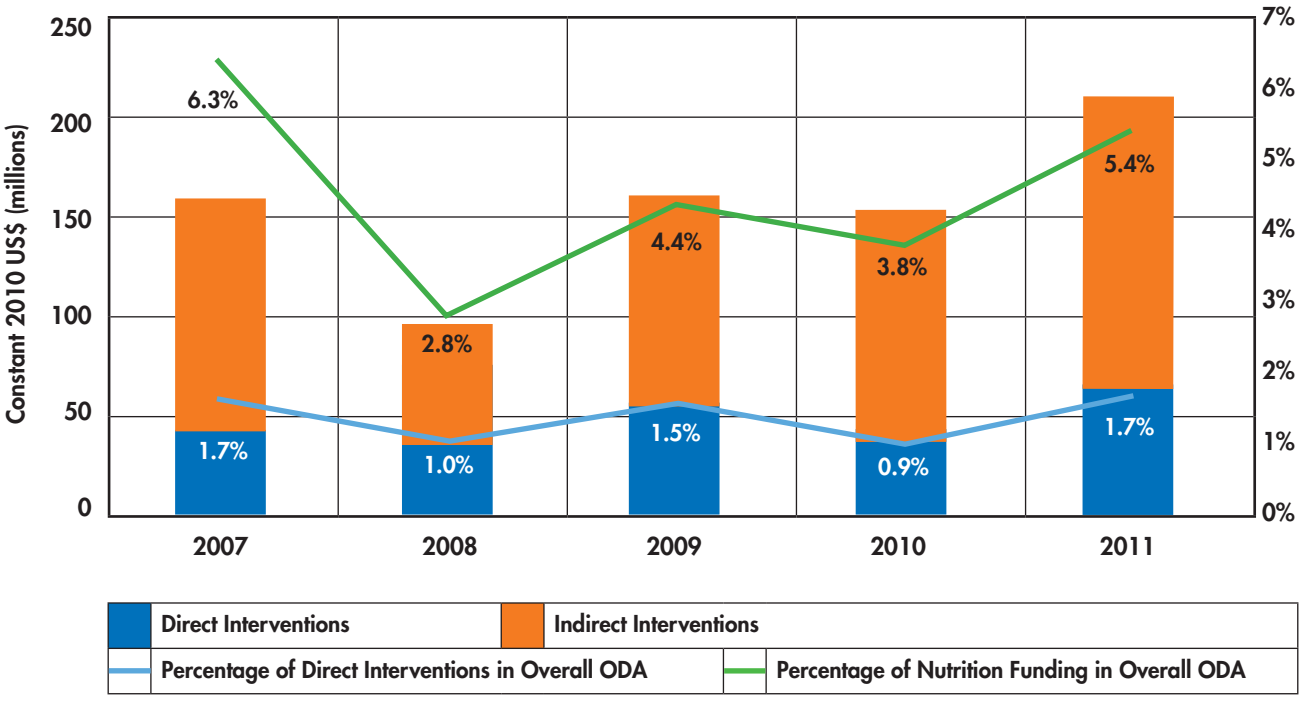
HOW IS FUNDING DISTRIBUTED BETWEEN DIRECT AND INDIRECT NUTRITION INTERVENTIONS?

The majority of funding for nutrition was directed to indirect nutrition interventions when compared with direct nutrition interventions. In 2009 US$55.2 million was directed to direct nutrition interventions whilst almost double US$104.8 million was directed to indirect nutrition interventions. In 2010, direct nutrition interventions were allocated 0.9% of nutrition funding whilst indirect interventions received 2.9% of total ODA. This proportion was maintained in 2011 although the proportion for direct nutrition interventions had increased to 1.7% of total ODA (US$67.5 million) that for indirect interventions had increased to 3.6% of total ODA or US$140.8 million. Together nutrition interventions accounted for 4% of total ODA in 2010 and 5% of total ODA in 2011.

CANADA'S DISTRIBUTION OF DIRECT INTERVENTIONS



ODA FROM CANADA FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2010 TO 2011



Canada funded direct interventions from all three categories of direct interventions, although the promotion of good nutritional practices was usually delivered in combination with other direct nutrition interventions such as increasing the intake of vitamins and minerals and the therapeutic feeding of malnourished children with special foods. Increasing the intake of vitamins and minerals tended to be funded as a standalone intervention and to fund therapeutic feeding of malnourished children in combination with other direct interventions. For the period of 2005 to 2009, increasing the intake of vitamins and minerals received 93.4% of all funding for direct nutrition interventions, for the 2007 to 2011 period this decreased to 82.2% and the proportion of funding for therapeutic feeding increased from 5.4% to 9.3% for the same period. Furthermore, there was an increase from 1.2% to 8.4% for funding of direct nutrition funding interventions combining two or more direct nutrition interventions. The combination to receive the most funding was a package of interventions from all three categories of direct interventions (3.4%) and those combining promoting good nutritional practices with increasing the intake of vitamins and minerals (3.5%).

Direct nutrition interventions were mainly channelled through the Health sector (42.7million) and less so through the Humanitarian Aid (4.3 million) and Commodity Aid and General Programme Assistance (0.3 million) sector. Indirect interventions were mainly channelled through Humanitarian Aid (64.2 million) followed by the Health sector (36.8 million), Commodity Aid and General Programme Assistance (5.4 million), Water and Sanitation (1.4 million) and Social Infrastructure and Services (0.1 million).

ARE RESOURCES FOR NUTRITION BEING TARGETED TO THOSE WHO NEED THEM MOST?

Canada invested a significant amount of funding to Africa from 2009 to 2011 although the funding was variable, from a 2009 funding level of US$112.26 million, it decreased in 2010 to US$90.24 million, followed by an increase to US$142 million in 2011. Although Asia received less funding in volume compared to Africa funding allocated to Asia increased from US$28.61 million in 2009 to US$39.37 and 47.37 million in 2010 and 2011 respectively.

Amongst the top 5 recipient countries for aid in nutrition were Ethiopia and Sudan in the lead but Pakistan was the only country from Asia to make the list in 5th position.

ACCOUNTABILITY

Disbursements were lower than commitments US$159.93 compared to 283.59 million in 2009 however the reverse was true in 2010. Commitments were much lower than the preceding year at US$80.38 million however, disbursements were higher and almost similar to the previous year at US$ 152.24 million. In 2011 however, disbursements (US$208.33 million) were almost 50% lower than commitments (US$418.09 million).

The majority of funding was allocated to NGOs and multilateral agencies.

TOP RECIPIENT COUNTRIES FOR CANADA

Ranking (2005-2009 ranking in brackets)	Recipient	Average annual funding for nutrition from 2007-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1 (5)	Ethiopia	11.9	8%
2 (1)	Sudan	11.3	8%
3 (4)	Haiti	8.7	6%
4 (n/a)	Somalia	5.1	3%
5 (n/a)	Pakistan	5.0	3%

A3 EUROPEAN UNION (EU) INSTITUTIONS

HOW MUCH IS BEING INVESTED IN NUTRITION BY THE EU?

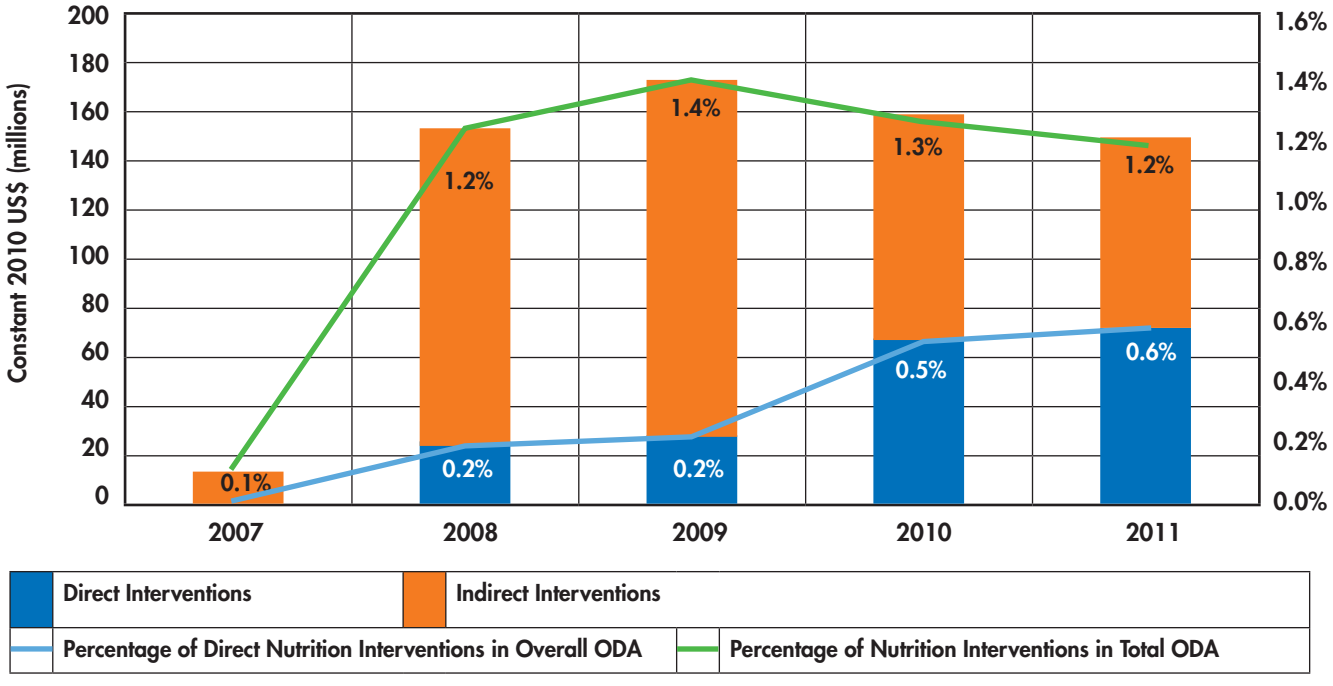
Funding for nutrition from EU institutions (excluding ECHO) decreased from 2009 to 2011, from US$173.5 in 2009 to 159.3 and 149.7 million in 2010 and 2011 respectively. ECHO funding for nutrition was US$120.8, 117 and 146.9 million in 2009, 2010 and 2011 respectively.

Although overall funding for nutrition decreased between 2009 and 2011, funding for direct nutrition interventions has increased, especially between 2009 and 2010, from US$27 million or 0.2% of total ODA in 2009 to 67.9 million or 0.5% of total ODA in 2010. The increase in 2011 was less steep at US$71.2 million or 0.6% of total ODA. ECHO had a more variable trend marked by an initial decrease in funding for direct nutrition interventions from US$45.4 million or (0.34% of total ODA) in 2009 to US$20 million (0.16% of total ODA) in 2010 and increased to US$46.4 million (0.39% of total ODA) in 2011. Please be aware that the % of total ODA for ECHO was calculated as follows: ECHO funding (from external data) divided by overall ODA (from CRS, so the same as for EU Institutions). EU institutions funding (using the CRS database) for indirect interventions was US$146.6 and 91.4 million in 2009 and 2010 respectively, except in 2011 when funding for direct interventions exceeded those for indirect interventions at US$78.5 million. ECHO funding for indirect nutrition interventions was consistently greater than that for direct interventions at US$75.4, 97 and 100.5 million in 2009, 2010 and 2011 respectively.

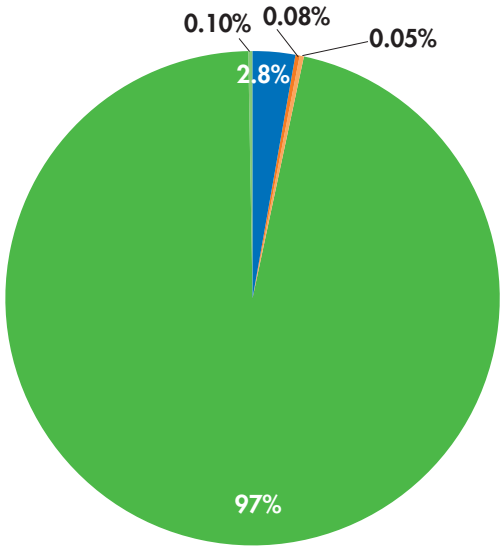
HOW IS FUNDING DISTRIBUTED WITHIN THE DIRECT NUTRITION INTERVENTIONS?

With respect to direct nutrition interventions, the EU prioritised the therapeutic feeding of malnourished children with special foods, this category received 97% of all funding for direct nutrition interventions, a slight increase from 96% in the 2005 to 2009 period.The proportion of funding for promoting good nutritional practices was slightly reduced at 2.8% compared with 3.2% for 2005 to 2009. Some funding was invested in a combination of various direct nutrition interventions such as therapeutic feeding with promoting good nutritional practices (0.1%) or increasing the intake of vitamins and minerals with therapeutic feeding interventions (0.05%). ECHO mainly funded therapeutic feeding programmes

ODA FROM EU INSTITUTIONS FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2007 TO 2011



THE EU INSTITUTIONS DISTRIBUTION OF DIRECT INTERVENTIONS



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

(98%), with a smaller amount being assigned to the promotion of good nutritional practices (1%) as single interventions, with a small amount (1%) being allocated to a combination of all 3 interventions.

The EU primarily channelled direct nutrition interventions through Humanitarian Aid, followed by the Health sector, Commodity Aid and General Programme Assistance and Water and Sanitation in that order. Indirect interventions were also delivered in similar proportions in the same sectors.

ARE RESOURCES FOR NUTRITION BEING TARGETED TO THOSE WHO NEED THEM MOST?

Africa was the main recipient of EU funding for nutrition; US$105.1, 132.06 and 120.28 million in 2009, 2010 and 2011 respectively. Although there was an initial increase in 2010 followed by a decrease in funding in 2011, Africa still remained the leading recipient when compared with Asia. Asia received US$14.45, 18.94 and 23.92 million in 2009, 2010 and 2011 respectively, orders of funding that are much lower than for Africa. ECHO followed the same pattern and mainly funded Africa (US$103.24 in 2009, 98.97 in 2010, and 125.76 million in 2011) compared with Asia (US$11.57 in 2009, 9.65 in 2010 and 14.15 million in 2011).

The prioritisation of funding for Africa is reflected in the table showing that the top 5 recipient countries for the EU institutions included 4 African countries while Bangladesh was the only recipient from Asia, whilst the top 5 recipients for ECHO funding were all from Africa. The order of countries in the list has changed, for the EU, Niger rose to the top spot as the primary recipient of aid, but it didn't make the list in the analysis for 2005 to 2009, similarly, Peru failed to make the list in this analysis. In the ECHO list of top recipients, Chad was displaced by Ethiopia.

ACCOUNTABILITY

There has been some variability in the fulfilment of commitments. In 2009, disbursements (US$173.54 million) were greater than commitments (US$139.55 million), whilst in 2010 and 2011 the reverse was true. In 2010 and 2011, commitments were US$373.9 and 2.36 million respectively, whilst disbursements were US$159.28 and 149.69 million respectively.

Stakeholders such as NGOS (42%) and UN agencies (38%) such as UNICEF and WFP were the main recipients of EU funding and as well as the Public Sector (18%) as defined by the OECD. 55% of ECHO nutrtition funding was implemented through NGOs whilst 45% was channelled through UN agencies.

TOP RECIPIENT COUNTRIES FOR THE EU INSTITUTIONS			
EU INSTITUTIONS (WITHOUT ECHO)			
Ranking (2005-2009 ranking in brackets)	Recipient	Average annual funding for nutrition from 2007-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1 (n/a)	Niger	15.0	12%
2 (1)	Bangladesh	14.0	11%
3 (4)	Sudan	9.5	7%
4 (2)	Ethiopia	8.5	7%
5 (n/a)	Kenya	7.4	6%
ECHO (2009-2011 ONLY)			
Ranking (2009 ranking in brackets)	Recipient	Average annual funding for nutrition from 2009-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1 (5)	Niger	21.6	17%
2 (2)	Kenya	14.9	12%
3 (1)	Sudan	10.8	8%
4 (4)	Somalia	9.3	7%
5 (n/a)	Chad	8.5	7%

A4 FRANCE

Sources of data external to the CRS database were used to analyse France's ODA activities as reporting to the CRS database was difficult to analyse due to poor reporting, especially in the humanitarian aid codes. In 2011, 100% of Emergency Food Aid, 99% of Food Aid/Food Security and 87% of Material Relief could not be analysed because the description of projects were not detailed enough to assess their purpose. French nutrition funding was therefore addressed through its Programmed Food Assistance (Aide Alimentaire Programmée), even if it is a partial and underestimated assessment of the French nutrition funding. In 2011, some nutrition related interventions identified in the Basic Nutrition and Food Security CRS codes will be detailed further.

HOW MUCH IS BEING INVESTED IN NUTRITION BY FRANCE?

As part of the Programmed Food Assistance, France invested US$ 7.3, 15.9 and 12.9 million in 2009, 2010 and 2011 in nutrition, showing an overall increasing trend in aid for nutrition especially in 2010, although this was followed by a decrease, it remained in excess of the 2009 ODA level.

Funding for direct nutrition interventions also increased in 2010 to US$7.6 million following the trend of an increase in nutrition overall, but this was followed by a decrease in 2011 to US$4.6 million although levels still remained higher than those in 2009 (US$3.3 million).

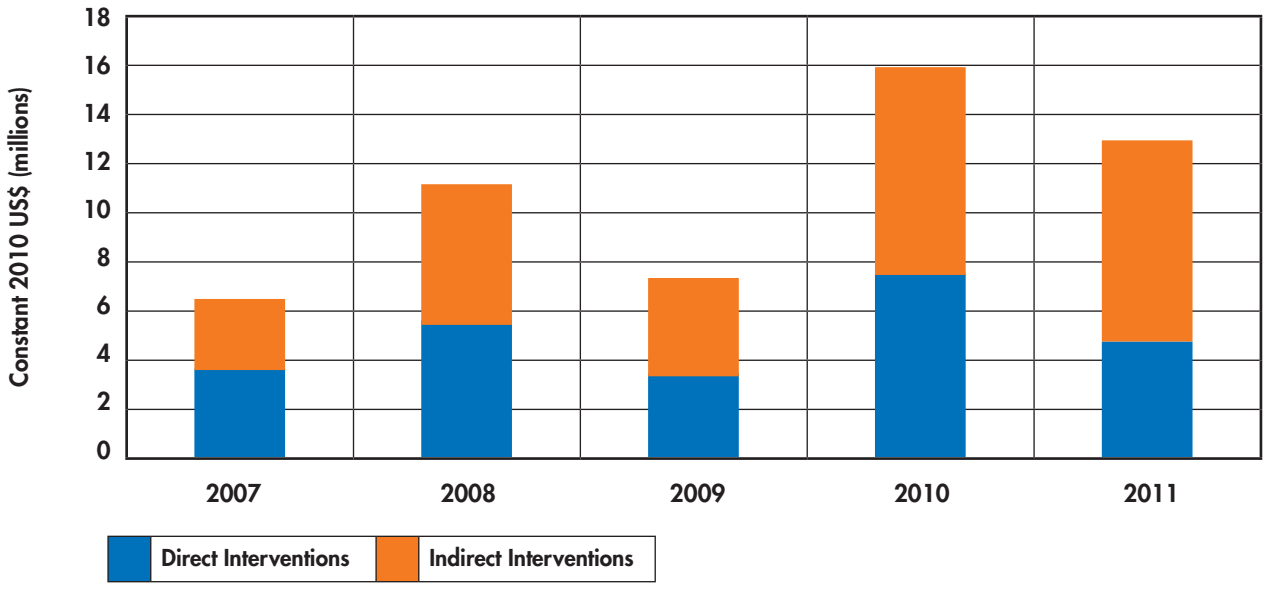
Funding for indirect nutrition interventions doubled from US$ 4.1 in 2009 to 8.3 million in 2010 and decreased slightly to US$8.2 million in 2011, indicating that funding for direct nutrition interventions was more susceptible to adjustment in comparison with indirect interventions.

In 2011, US1.2 million of the $1.7 million of funding for indirect nutrition interventions was identified mainly in the Basic Nutrition code of the CRS database.

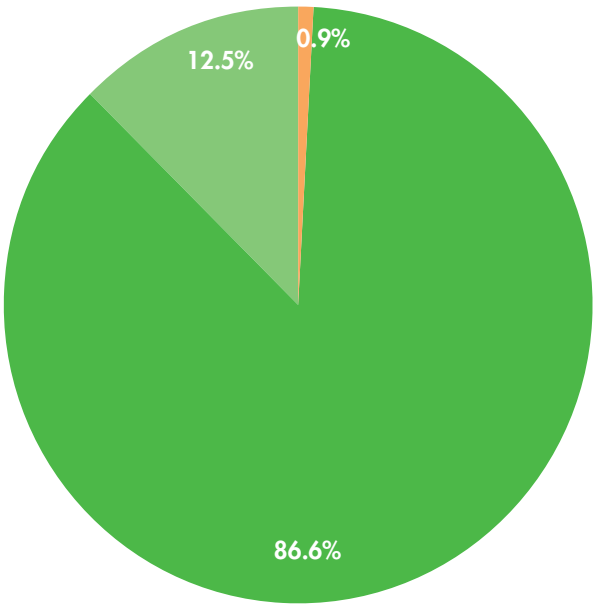
HOW IS FUNDING DISTRIBUTED WITHIN THE DIRECT NUTRITION INTERVENTIONS?

A large proportion of funding for direct nutrition interventions was allocated to interventions for the therapeutic feeding of malnourished children with special foods (87%). 12% was allocated to a combination of interventions that included the therapeutic feeding of malnourished children and promoting good nutritional practices and the remaining 1% of funding was directed to interventions combining the increase the intake vitamins and minerals with the therapeutic

ODA FROM FRANCE FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2007 TO 2011



FRANCE'S DISTRIBUTION OF DIRECT INTERVENTIONS



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

feeding of malnourished children. For 2005 to 2009, the proportion of funding for therapeutic feeding was slightly lower than the current figure of 81.6% and the combined interventions of therapeutic feeding for malnourished children with promoting good nutritional practices received 17%, slightly higher than the present 12%. The combined interventions to increase vitamin and mineral intake with the therapeutic feeding of malnourished children received 1.5% compared with 1% for the period of 2005 to 2009.

The delivery channels for nutrition interventions could not be assessed because the French data source was external to the CRS database.

ARE RESOURCES FOR NUTRITION BEING TARGETED TO THOSE WHO NEED THEM MOST?

Africa was the primary recipient of nutrition aid from France. Aid increased steeply from US$7.31 to 11.66 million in 2010 and slightly increased to US11.69 million in 2011.

The top 5 recipient countries were all countries from Africa and were mostly from the Francophone regions.

On the other hand, Asia was not a recipient of any ODA for nutrition from France in 2009, but this changed in 2010 when Asia received US$1.72 in 2010 and US$1.19 million in 2011 respectively although the funding is quite minimal relative to the funds received by Africa.

ACCOUNTABILITY

It was impossible to compare commitments to disbursements as the most reliable data for France's aid activities was obtained from external sources and therefore we cannot comment any further.

TOP RECIPIENT COUNTRIES FOR FRANCE

Ranking (2005-2009 ranking in brackets)	Recipient	Average annual funding for nutrition from 2009-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1 (4)	Chad	2.1	19%
2 (3)	Madagascar	1.5	14%
3 (1)	Ethiopia	1.2	11%
4 (2)	Somalia	1.1	10%
5 (5)	Niger	0.6	5%

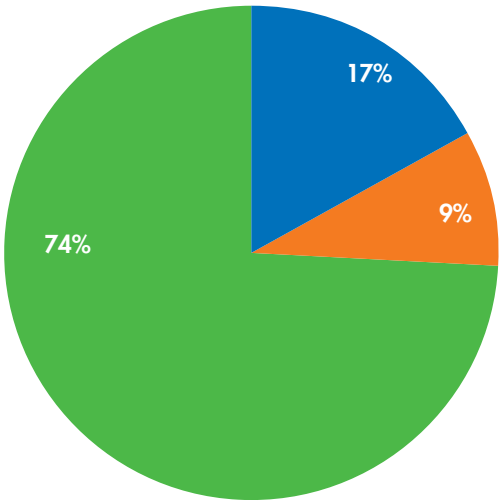
A5 GERMANY

HOW MUCH IS BEING INVESTED IN NUTRITION BY GERMANY?

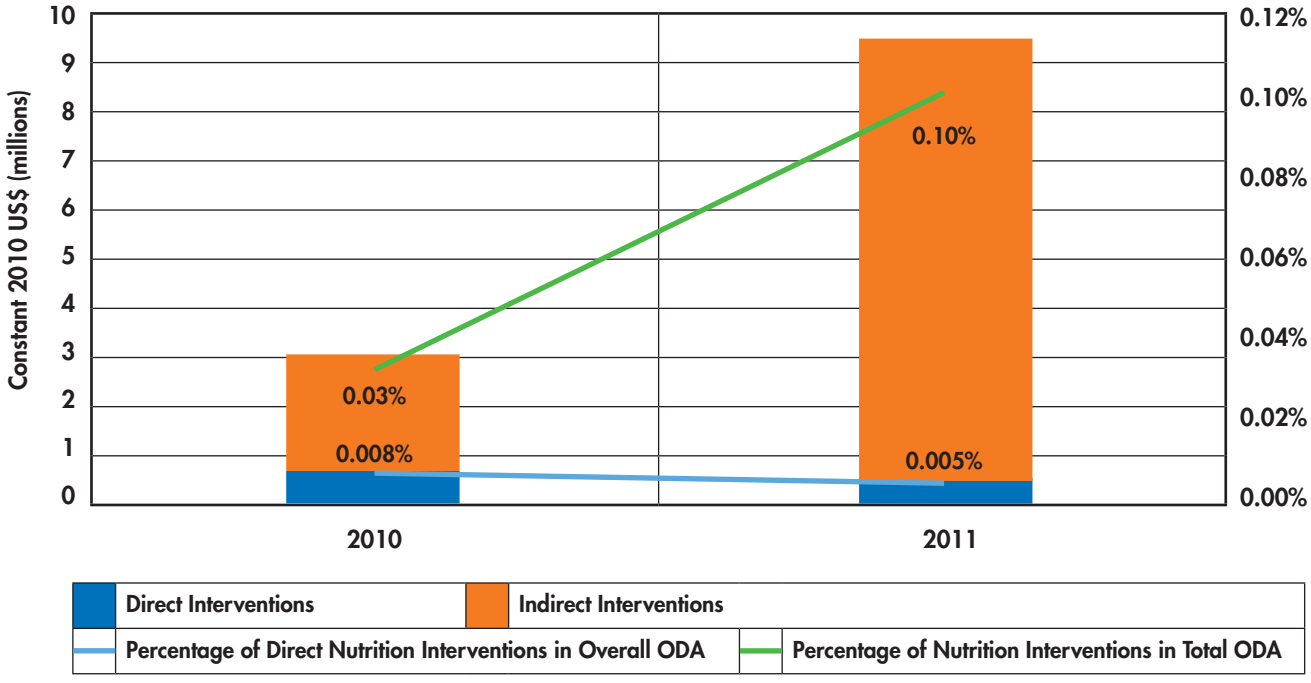
Funding for nutrition trebled from US$3 million in 2010 to 9.3 million in 2011. This represented 0.03% and 0.1% of total ODA for 2010 and 2011 respectively.

Germany allocated 0.7 million (0.01% of total ODA) to direct nutrition interventions in 2010 and 0.5 million (0.01% of total ODA) in 2011. There was a slight decrease in volume but the proportion of aid for direct nutrition interventions was unchanged.
The investment for indirect nutrition interventions outweighed that for direct nutrition interventions. Indirect nutrition interventions received on average 0.06% of total ODA compared with 0.01% for direct nutrition interventions. Whilst aid for direct nutrition decreased in volume in 2011, aid for indirect interventions increased from US$2.3 to 8.8 million in 2010 and 2011 respectively, representing 0.02 and 0.09% of total ODA for 2010 and 2011 respectively.

GERMANY'S DISTRIBUTION OF DIRECT INTERVENTIONS



ODA FROM GERMANY FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2010 TO 2011



HOW IS FUNDING DISTRIBUTED WITHIN THE DIRECT NUTRITION INTERVENTIONS?

Within the direct nutrition interventions, the largest share of funding (74%) was for the therapeutic feeding of malnourished children, followed by the promotion of good nutritional practices (17%) and 9% of the funding for direct interventions was for increasing the intake of vitamins and minerals.

Direct interventions were equally channelled through the Health sector and Humanitarian Aid, although the Health sector was more popular channel compared with Humanitarian Aid. The reverse is true for indirect nutrition interventions as they were primarily channelled through Humanitarian Aid.

ARE RESOURCES FOR NUTRITION BEING TARGETED TO THOSE WHO NEED THEM MOST?

Asia was the main recipient of German ODA in 2010 and 2011. In 2010, Asia received US$1.94 million and this increased to US$5.72 million in 2011. Africa was lagging behind in 2010 at US$ 0.44 million and in 2011 at US$1.41 million, in spite of aid for nutrition increasing in 2011. This trend is shown in the list of Top 5 country recipients, where South Sudan was the only country to just make it onto the list.

ACCOUNTABILITY

In 2010, disbursements (US$2.98 million) were less than commitments (US$3.28 million) whilst in 2011, the reverse was observed disbursements (US$9.33 million) were more than commitments (US$8.70).

Non-governmental organisations and the UN agency WFP were the main recipients of German funding.

TOP RECIPIENT COUNTRIES FOR GERMANY

Ranking	Recipient	Average annual funding for nutrition from 2007-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1	Afghanistan	2.6	43%
2	Sri Lanka	0.4	7%
3	Cambodia	0.4	6%
4	Pakistan	0.2	3%
5	South Sudan	0.2	3%

A6 INTERNATIONAL DEVELOPMENT ASSOCIATION (IDA)

The International Development Association (IDA) provides interest-free loans called credits and grants to governments. The IDA focuses exclusively on the world's poorest countries. This institution is part of a larger body known as the World Bank Group.

HOW MUCH IS BEING INVESTED IN NUTRITION BY THE IDA?

The IDA invested US$ 27.9 million for nutrition interventions in 2010 but this decreased by more than 50% in 2011 to US$12.1 million. These values are much lower than previous aid activities in nutrition in 2007 and 2008 that were US$39.4 and 44.2 million respectively. However there was apparently no aid to nutrition reported to the CRS database in 2009 at all.

In 2007, 2008 and 2010 all funding was directed to indirect nutrition interventions but in 2011 the IDA directed US$0.8 million to direct nutrition interventions, a small proportion compared with the US$11.3 million allocated to indirect nutrition interventions for the same year.

HOW IS FUNDING DISTRIBUTED WITHIN THE DIRECT NUTRITION INTERVENTIONS?

The funds allocated to direct nutrition interventions were primarily for the therapeutic feeding of malnourished children. The promotion of good nutritional practices and increasing the intake of vitamins and minerals were invested in as combined interventions.

Direct nutrition interventions were only delivered through the Health sector, whilst indirect interventions were delivered through the Health sector primarily, followed by the Water and Sanitation sector and less so through Social Infrastructure and Services.

ARE RESOURCES FOR NUTRITION BEING TARGETED TO THOSE WHO NEED THEM MOST?

In 2010, Africa was the leading recipient of IDA funding for nutrition. It received US$13.93 million compared with the slightly lower US$10.59 received by Asia. The difference between the two regions increased greatly in 2011 as Africa received $8.92 million compared to $0.54 million for Asia. Indeed, India was the leading recipient in the list of top 5 recipient countries for IDA funding as shown in the table. It was also the only country from Asia on the list.

ACCOUNTABILITY

In 2010, disbursements (US$27.88 million) were nearly half that of commitments (US$54.74), however in 2011 disbursements were US$12.14 but there was no record for commitments. As the IDA provides interest-free loans—or credits— and grants to governments it is difficult to interpret this data. It may also be that disbursement in 2011 may be catching up to 2010 commitments or some other reason

TOP RECIPIENT COUNTRIES FOR THE IDA

Ranking (2005-2009 ranking in brackets)	Recipient	Average annual funding for nutrition from 2007-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1 (1)	India	7.4	30%
2 (3)	Ethiopia	2.7	11%
3 (n/a)	Senegal	2.0	8%
4 (2)	Bangladesh	1.6	6%
5 (n/a)	Malawi	1.3	5%

A7 ITALY

HOW MUCH IS BEING INVESTED IN NUTRITION BY THE ITALY?

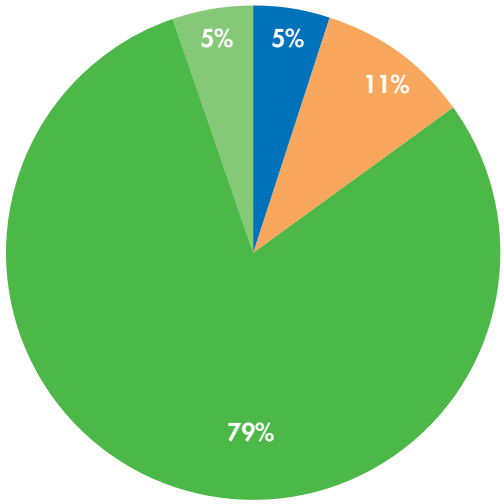
Italy increased its funding for nutrition, almost doubling it from the 2010 level of US$ 2.4 to 4 million in 2011.

The increase in funding for nutrition was mainly driven by a large increase in funding for direct nutrition interventions. Funding for direct interventions increased from US$ 0.8 million (0.09% of total ODA) in 2010 to US$3.1 million (0.16% of total ODA) in 2011. The opposite trend was observed for indirect nutrition interventions, whose funding decreased between 2010 and 2011, from US$1.5 (0.16% of total ODA) to 0.9 million (0.05% of total ODA) respectively.

HOW IS FUNDING DISTRIBUTED WITHIN THE DIRECT NUTRITION INTERVENTIONS?

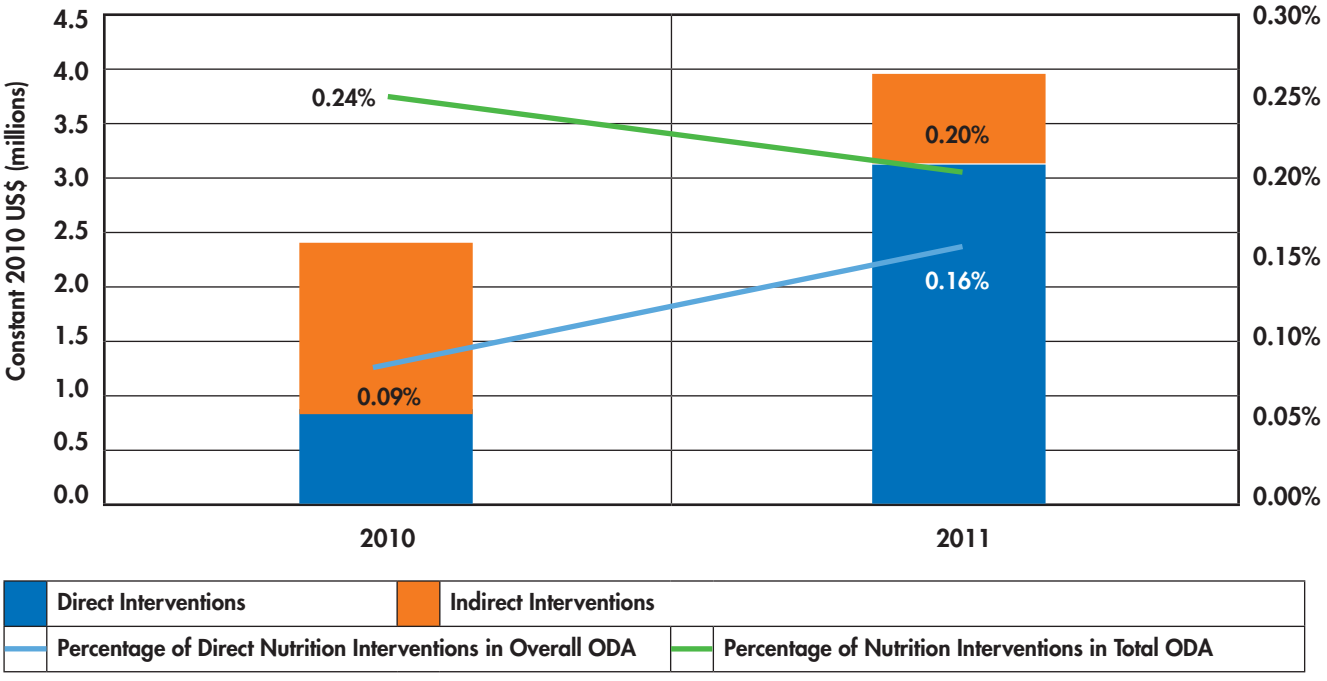
Seventy-nine percent of direct nutrition funding was assigned to the therapeutic feeding of malnourished children with special foods, 5% was assigned to the promotion of good nutritional practices. Furthermore, Italy funded combined programmes that included the increasing the intake of vitamins and minerals with

ITALY'S DISTRIBUTION OF DIRECT INTERVENTIONS



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

ODA FROM ITALY FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2010 TO 2011



therapeutic feeding of malnourished children (11%). The other combination funded was the combination of therapeutic feeding with the promotion of good nutritional practices (5%).

Direct nutrition interventions were channelled through the Humanitarian Aid sector, followed by the Health sector. The Water and Sanitation sector was the least preferred for direct nutrition interventions. Indirect nutrition interventions were almost equally delivered as part of Humanitarian Aid and Health.

ARE RESOURCES FOR NUTRITION BEING TARGETED TO THOSE WHO NEED THEM MOST?

Africa was the main recipient of Italian aid for nutrition in 2010 and 2011, receiving US$1.4 million in 2010 which increased to US$ 2.98 million in 2011. Somalia, Malawi and Sudan were some of the top 5 recipients for aid for nutrition from Italy.

Asia did not receive any aid for nutrition in 2010 but did receive a small amount of aid, US$0.89 million in 2011.

ACCOUNTABILITY

At US$2.38 million, disbursements were lower than commitments US$3.51 million in 2010. However in 2011 the reverse was observed as disbursements were US$3.96 million compared with commitments worth US$3.31 million.

Stakeholders who were custodians of Italian ODA were mainly non-governmental organisations, the Public Sector, followed by UNICEF and WFP.

TOP RECIPIENT COUNTRIES FOR ITALY

Ranking	Recipient	Average annual funding for nutrition from 2007-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1	Somalia	1.3	41%
2	Guatemala	0.4	12%
3	West Bank & Gaza Strip	0.2	6%
4	Malawi	0.2	6%
5	Sudan	0.2	5%

A8 JAPAN

HOW MUCH IS BEING INVESTED IN NUTRITION BY JAPAN?

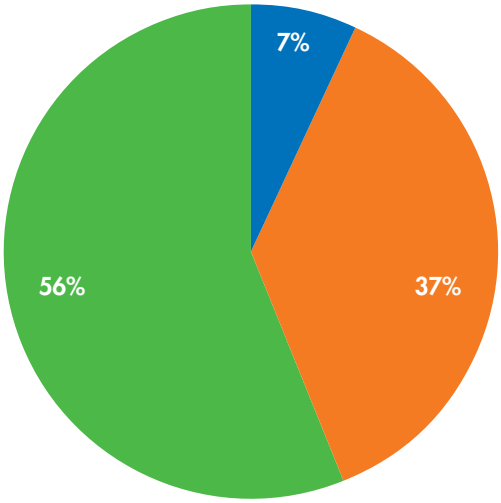
Japan invested US$23.2 million (0.15% of total ODA) in nutrition in 2010 and this more than doubled in 2011 to US$58.5 million (0.4% of total ODA).

Although Japan directed a small amount of funding to direct nutrition interventions US$3.3 million (0.02% of total ODA) in 2010, there was no funding for direct nutrition interventions in 2011 when all funding was directed to indirect nutrition interventions (US$58.5 million or 0.4% of total ODA).

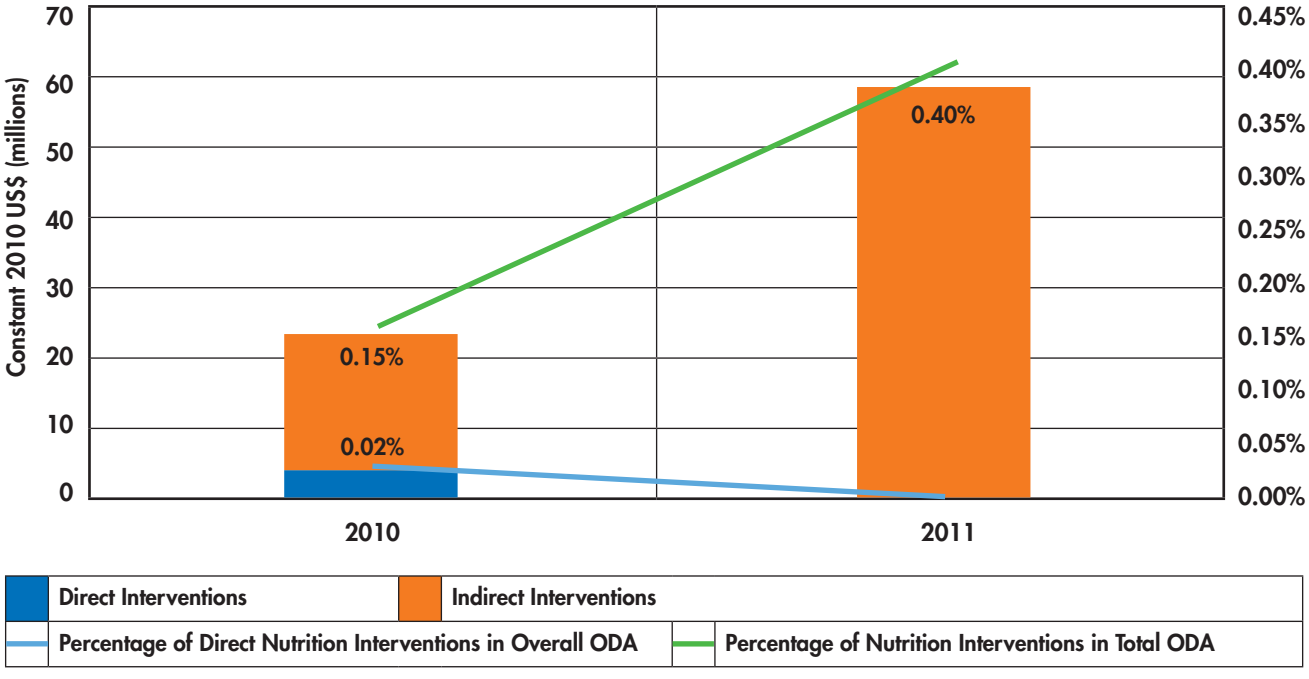
HOW IS FUNDING DISTRIBUTED WITHIN THE DIRECT NUTRITION INTERVENTIONS?

Therapeutic feeding of malnourished children received the largest proportion (56%) of direct nutrition funding followed by interventions to increase the intake of vitamins and minerals (37%) and promoting good nutritional practices (7%).

JAPAN'S DISTRIBUTION OF DIRECT INTERVENTIONS



ODA FROM JAPAN FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2010 TO 2011



Direct nutrition interventions were mainly delivered through the Health sector and indirect nutrition interventions were primarily delivered as part of Humanitarian Aid and to a lesser extent as part of Health.

ARE RESOURCES FOR NUTRITION BEING TARGETED TO THOSE WHO NEED THEM MOST?

In 2010, Africa was the main recipient of aid for nutrition (US$22.72 million) compared with Asia (US$ 0.52 million). However the reverse was true in 2011 when Asia received more aid for nutrition (US$37.02 million) in contrast to Africa (US$ 21.41 million). Afghanistan was the top recipient of aid followed by four countries from Africa.

ACCOUNTABILITY

Disbursements and commitments in 2010 and 2011 were identical US$23.24 in 2010 and 58.48 million in 2011.

Aid for nutrition was delivered through WFP mainly, followed by UNICEF and finally NGOs.

TOP RECIPIENT COUNTRIES FOR JAPAN

Ranking	Recipient	Average annual funding for nutrition from 2007-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1	Afghanistan	18.5	45%
2	Sudan	6.7	17%
3	Chad	3.7	9%
4	Kenya	3.1	7%
5	Uganda	2.3	6%

A9 SPAIN

HOW MUCH IS BEING INVESTED IN NUTRITION BY SPAIN?

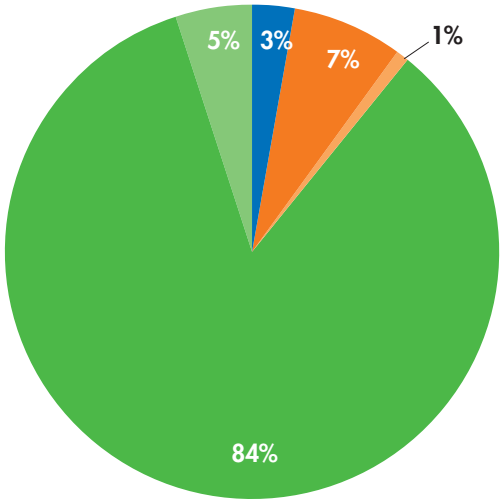
Aid for nutrition increased from US$27.2 million in 2009 to US$40.6 million in 2010 but the level of aid decreased to its lowest level of US$21.6 in 2011 for the 2007 to 2011 period.

Although the increase in overall funding for nutrition in 2010 subsequently decreased in 2011, the decrease in 2011 was primarily due to cuts in funding for indirect nutrition interventions. Nonetheless, a steady increase in funding for direct nutrition interventions was observed from 2009 (US$5.1 million or 0.1% of total ODA) to US$8.2 million (0.2% of total ODA) in 2010 and US$8.7 million (0.4% of total ODA) in 2011.

HOW IS FUNDING DISTRIBUTED WITHIN THE DIRECT NUTRITION INTERVENTIONS?

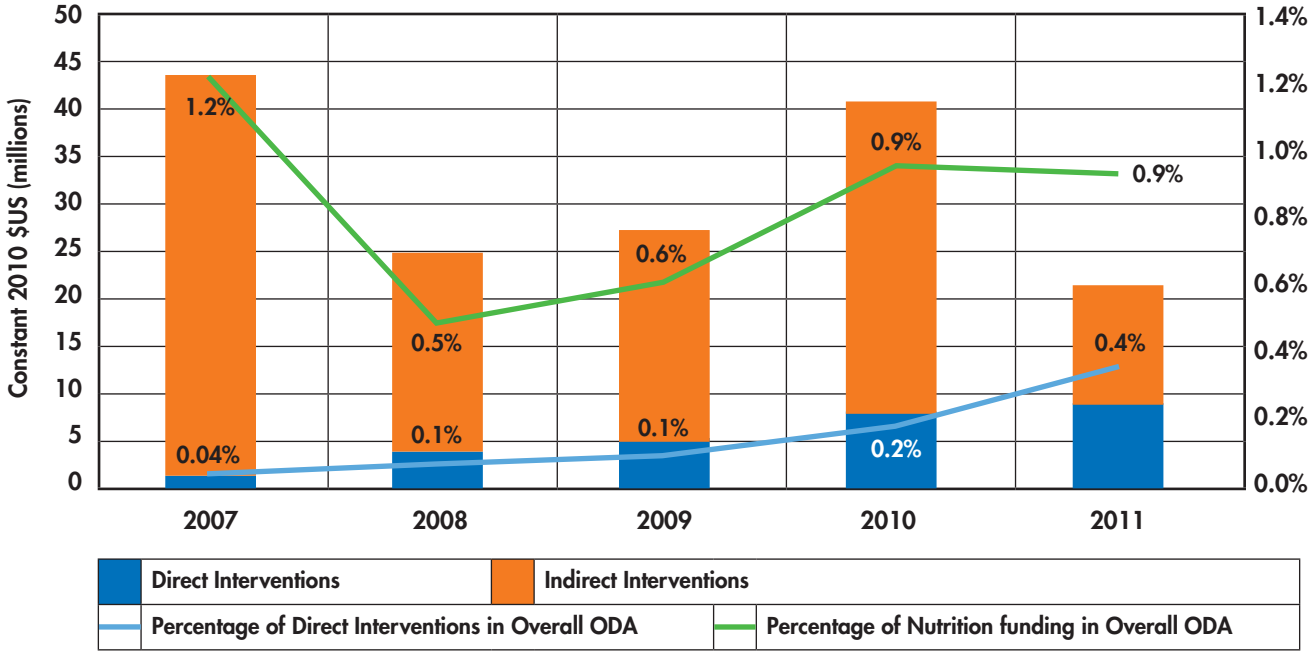
Eighty-four percent of direct nutrition funding was for therapeutic feeding of malnourished children, 7% was allocated to increasing the intake of vitamins and minerals and 3% was for promoting good nutritional practices. Interventions that combined increasing the intake of vitamins and minerals with therapeutic feeding received 1% of direct nutrition funding

SPAIN'S DISTRIBUTION OF DIRECT INTERVENTIONS



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

ODA FROM SPAIN FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2007 TO 2011



and those that combined therapeutic feeding with promoting good nutritional practices received 5% of funding for direct nutrition interventions.

Humanitarian Aid was the main conduit for direct nutrition interventions followed by the Health sector. Indirect nutrition interventions were delivered in a more diverse manner and were present in a variety of sectors, the main being Humanitarian Aid, followed by Commodity Aid and General Programme Assistance, Health, Social Infrastructure and Services and Water and Sanitation in that order.

ARE RESOURCES FOR NUTRITION BEING TARGETED TO THOSE WHO NEED THEM MOST?

Spain prioritised Africa for aid for nutrition consistently for the 2007 to 2011 period although since 2009, there have been small variations in funding levels for Africa since 2009 US$14.47, 12.98 (2010) and 13.16 (2011) million. The amount of funding Asia received has been consistently low since 2009 US$1.73, 6.68 (2010) and 1.31 (2011) million although a relatively large increase was observed in 2010. The top 5 recipient countries for aid for nutrition included Haiti, Niger, Peru, Bolivia and Ethiopia.

ACCOUNTABILITY

Commitments (US$23.69 million) in 2009 were lower than disbursements (US$27.23 million), in 2010 commitments (US$57.78 million) also failed to match disbursements (US$40.59 million) but in 2011 the commitments (US$19.07 million) were lower than disbursements (US$21.65 million).

The majority of ODA for nutrition was awarded to NGOs, followed by UNICEF and the Public Sector

TOP RECIPIENT COUNTRIES FOR SPAIN

Ranking (2005-2009 ranking in brackets)	Recipient	Average annual funding for nutrition from 2007-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1 (4)	Haiti	3.3	10%
2 (3)	Niger	2.9	9%
3 (1)	Peru	1.8	6%
4 (2)	Bolivia	1.5	5%
5 (5)	Ethiopia	1.4	5%

A10 UNITED KINGDOM (UK)

HOW MUCH IS BEING INVESTED IN NUTRITION BY THE UK?

For the 2007 to 2011 period, investment in aid for nutrition was highest in 2011 at US$103 million (1.2% of total ODA). In 2009, aid for nutrition was US$93.4 million (1.2% of total ODA) and it decreased to US$87.3 million (1% of total ODA) in 2010.

The variation in aid for nutrition was driven by variations in aid for indirect nutrition interventions. Aid for indirect interventions contracted from US$87.1 million in 2009 to US$79.4 million in 2010 before it increased to US$92.3 million in 2011.

Aid for direct nutrition interventions was at its greatest in 2008, accounting for 0.3% of total ODA but this decreased to 0.08% of total ODA in 2009 and has been increasing in small increments to 0.09% in 2010 and 0.13% of total ODA in 2011. This represents US$6.4, 7.9 and 10.8 million in 2009, 2010 and 2011 respectively and is 50% less than the US$20.9 million invested in 2008.

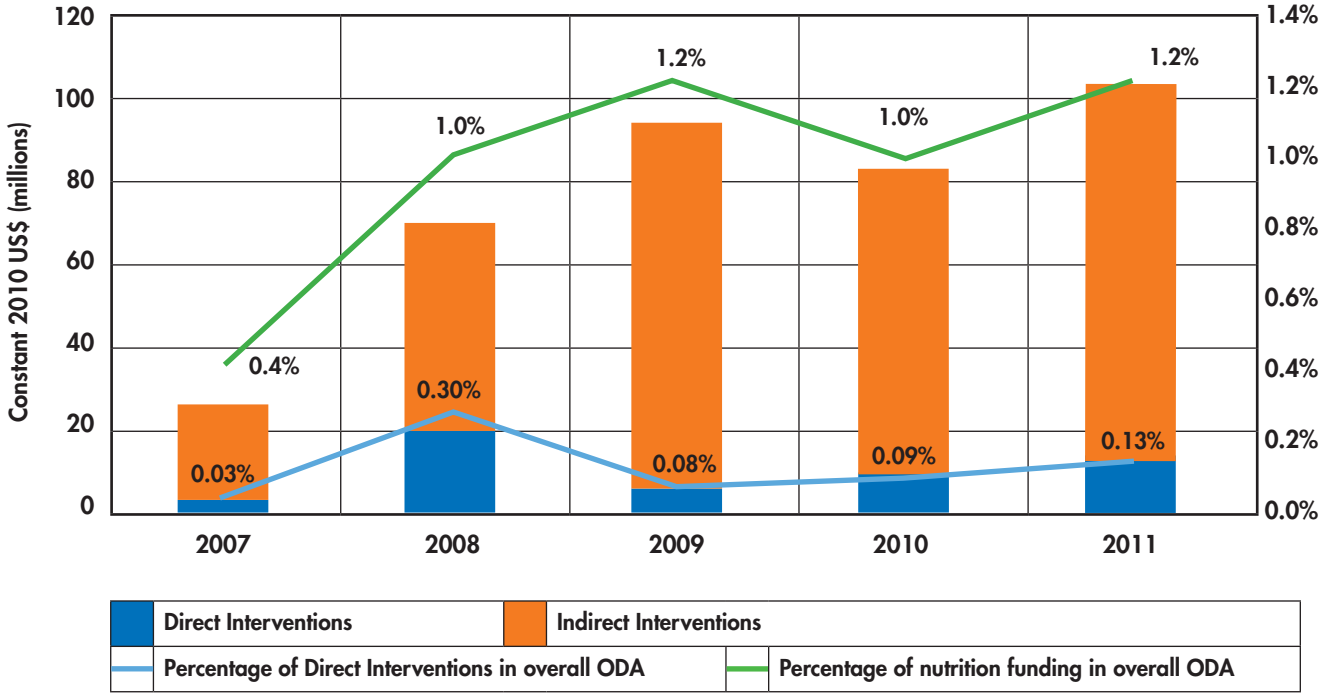
HOW IS FUNDING DISTRIBUTED WITHIN THE DIRECT NUTRITION INTERVENTIONS?

Ninety-five percent of direct nutrition funding was allocated to the therapeutic feeding of malnourished children, a slight increase observed for this period compared to the 2005 to 2009 period when it was 91%. Funding for increasing the intake of vitamins and minerals accounted for 4% of all direct nutrition funding, a 50% reduction from the 9% observed for 2005 to 2009. Interventions to promote good nutritional practices accounted for 1% of direct nutrition funding but represented a 100% increase from the investments for the 2005 to 2009 period as this category of intervention did not receive any funding at all during that period.

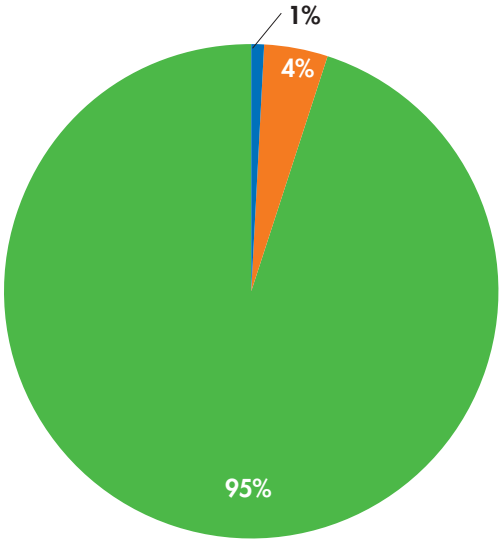
The majority of direct nutrition funding was delivered as part of Humanitarian Aid, and in lesser amounts as part of Health, Water and Sanitation and Commodity Aid and General Programme Assistance.

Funding for indirect nutrition interventions was part of Humanitarian Aid mainly, as well as part of Health and Water and Sanitation and less so Commodity Aid and General Programme Assistance.

ODA FROM THE UK FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2007 TO 2011



THE UK'S DISTRIBUTION OF DIRECT INTERVENTIONS



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

ARE RESOURCES FOR NUTRITION BEING TARGETED TO THOSE WHO NEED THEM MOST?

In 2009 aid for nutrition was similar for Africa (US$46.33 million) and Asia (US$43.88 million), whilst in 2010 Asia received slightly more funding (US$44.38 million) than Africa (US$36.43 million). In 2011 this was reversed and Africa was the leading recipient of aid for nutrition (US$84.63 million) compared with Asia (US$17.66 million). Nonetheless, Bangladesh and India were the first and 4th top recipients of aid for nutrition, the three remaining spots were filled by countries in Africa.

ACCOUNTABILITY

Aid commitments of US$178.33 million were much greater than disbursements of US$93.43 million in 2009 however commitments in 2010 were lower US$56.56 million than disbursements for the same year of US$87.32 million. Disbursements (US$103.13) continued to exceed commitments (US$ 81.94 million) in 2011. This means that for the period of 2007 to 2011, the UK defaulted on only 3.8% of their commitments, however if only 2010 and 2011 are considered the UK exceeded its commitments by 38%.

UK aid for nutrition was delivered through various stakeholders, the main recipients of which were NGOs, WFP, Non-specified multilateral agencies, UNICEF, Public Sector.

TOP RECIPIENT COUNTRIES FOR THE UK			
Ranking (2005-2009 ranking in brackets)	Recipient	Average annual funding for nutrition from 2007-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1 (1)	Bangladesh	15.7	21%
2 (n/a)	Ethiopia	13.1	17%
3 (3)	Somalia	8.2	11%
4 (n/a)	India	5.5	7%
5 (2)	Sudan	3.5	5%

A11 UNITED STATES OF AMERICA (USA)

HOW MUCH IS BEING INVESTED IN NUTRITION BY THE USA?

Aid for nutrition has been on average US$24.9 million per year for the 2007 to 2011 period. In 2009, aid for nutrition was at its lowest at US$7.9 million (0.03% of total ODA), before increasing to US$10.2 million ((0.04% total ODA) in 2010, followed by a further increase to US$39.7 million (0.14% of total ODA) in 2011.

Indirect nutrition intervention funding decreased from US$3.6 million (0.01% of total ODA) in 2009 to US$2.1 million (0.01% of total ODA) in 2010 followed by a slight increase to US$3.6 million (0.01% of total ODA) in 2011. The proportion of funding for indirect nutrition interventions was stable from 2009 to 2011.

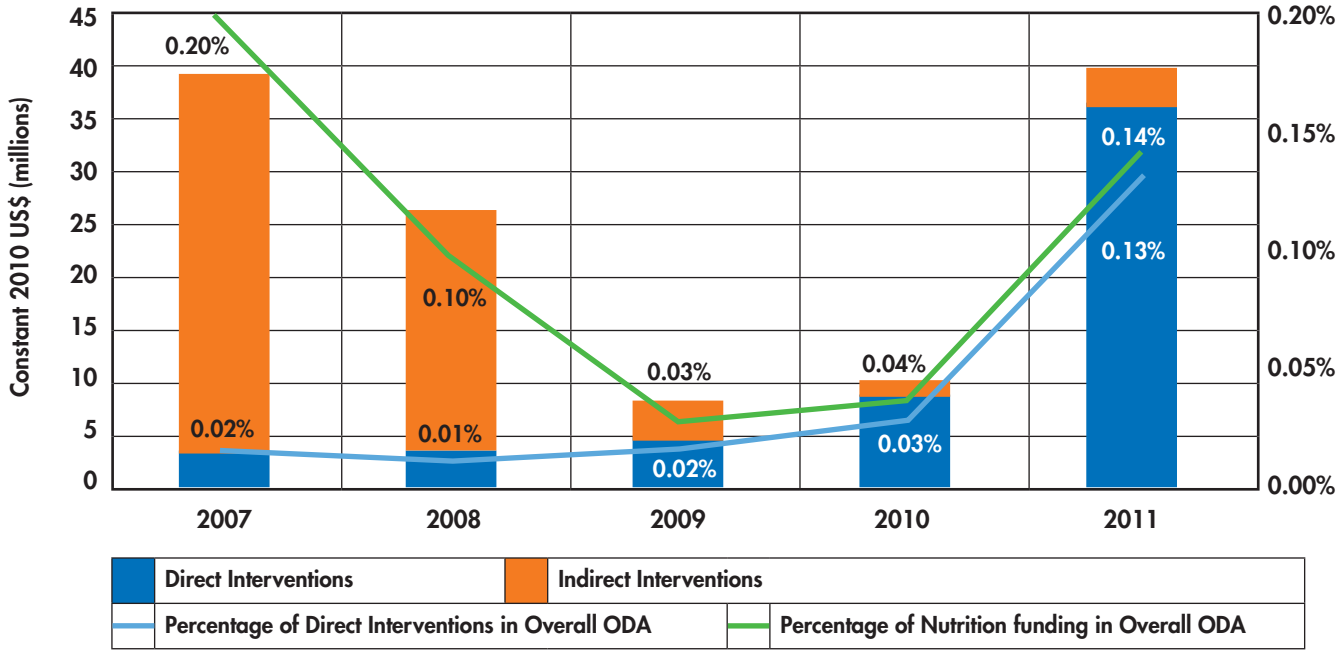
Funding for direct nutrition interventions steadily increased from 0.02% of total ODA in 2009 to 0.03% in 2010 followed by a further sharp increase to 0.13% in 2011.

HOW IS FUNDING DISTRIBUTED WITHIN THE DIRECT NUTRITION INTERVENTIONS?

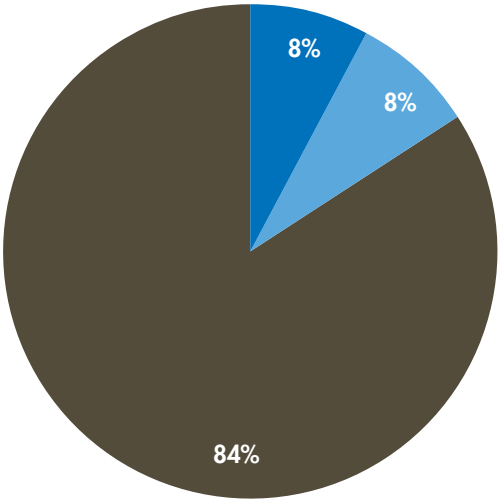
The majority (84%) of the USA's funding for direct nutrition interventions was allocated to programmes combining interventions from all three categories of direct interventions: promoting good nutritional practices, increasing the intake of vitamins and minerals and therapeutic feeding of malnourished children. This minimum package was recommended by the Lancet 2008 Series on Maternal and Child Undernutrition. This level of funding for such a combined minimum package of interventions represents more than double the funding for similar programmes by USAID in 2005 to 2009 (29.9%). Less funding (8%) was also invested in programmes combining the promotion of good nutritional practices with increasing the intake of vitamins and minerals. A similar proportion of funding (8%) was directed to interventions promoting good nutritional practices as a stand-alone programme.

The Health sector was the main channel of delivery for direct nutrition interventions, whilst indirect interventions were also mainly delivered through Health, in addition to Water and Sanitation and Humanitarian Aid.

ODA FROM THE UNITED STATES FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2007 TO 2011



THE USA'S DISTRIBUTION OF DIRECT INTERVENTIONS



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

ARE RESOURCES FOR NUTRITION BEING TARGETED TO THOSE WHO NEED THEM MOST?

Aid for nutrition was mainly directed to Africa, providing US$5.4, 5.16 and 15.61 million in 2009, 2010 and 2011 respectively. In contrast Asia received US$0.3, 1.97 and 4.94 million for 2009, 2010 and 2011 respectively.

The top 5 recipient countries for aid for nutrition included countries from Latin America, Asia and Africa as shown in the table.

ACCOUNTABILITY

Since 2009, the USA's commitments have consistently exceeded disbursements in 2009; commitments were US$8.53 whereas disbursements were US$7.93 million. In 2010, commitments were US$76.57 but disbursements were US$10.17 million and in 2011, commitments were US$102.99 whilst disbursements were US$39.75 million.

According to the aid activity recorded in the CRS database, the USA did not deliver 37.7% of their commitments for the 2007 to 2011 period. For 2010 to 2011, the USA did not deliver on 72% of their commitments.

Aid for nutrition was distributed through a wide range of stakeholders including NGOs, Non-specified agents, Non-specified multilateral agencies, the UN, UNICEF, Public Sector and the World Bank Group.

TOP RECIPIENT COUNTRIES FOR THE USA

Ranking (2005-2009 ranking in brackets)	Recipient	Average annual funding for nutrition from 2007-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1 (1)	Guatemala	4.1	16%
2 (4)	Nicaragua	2.1	8%
3 (3)	Honduras	2.0	8%
4 (n/a)	India	1.0	4%
5 (n/a)	Mali	0.8	3%

A12 UNICEF

HOW MUCH IS BEING INVESTED IN NUTRITION BY UNICEF?

UNICEF investments for nutrition were variable for the 2007 to 2011 period. In 2009 US$88.4 million was invested, decreasing to $79.1 million in 2010 with a further decrease to $62.9 million. This represented 8.1, 7.5 and 6.1% of total ODA in 2009, 2010 and 2011 respectively.

The decreasing trend in the volume and proportion of aid for nutrition was mainly facilitated by decreasing funding for indirect nutrition interventions from US$62.3 to 50.1 to 39.4 million in 2009, 2010 and 2011 respectively. This was the equivalent of 5.7, 4.8 and 3.8% of total ODA for 2009, 2010 and 2011 respectively. However, funding for direct nutrition interventions remained largely stable at US$26.1 (2.4% of total ODA), 29 (2.8% of total ODA) and 23.5 (2.3% of total ODA) million in 2009, 2010 and 2011 respectively.

HOW IS FUNDING DISTRIBUTED WITHIN THE DIRECT NUTRITION INTERVENTIONS?

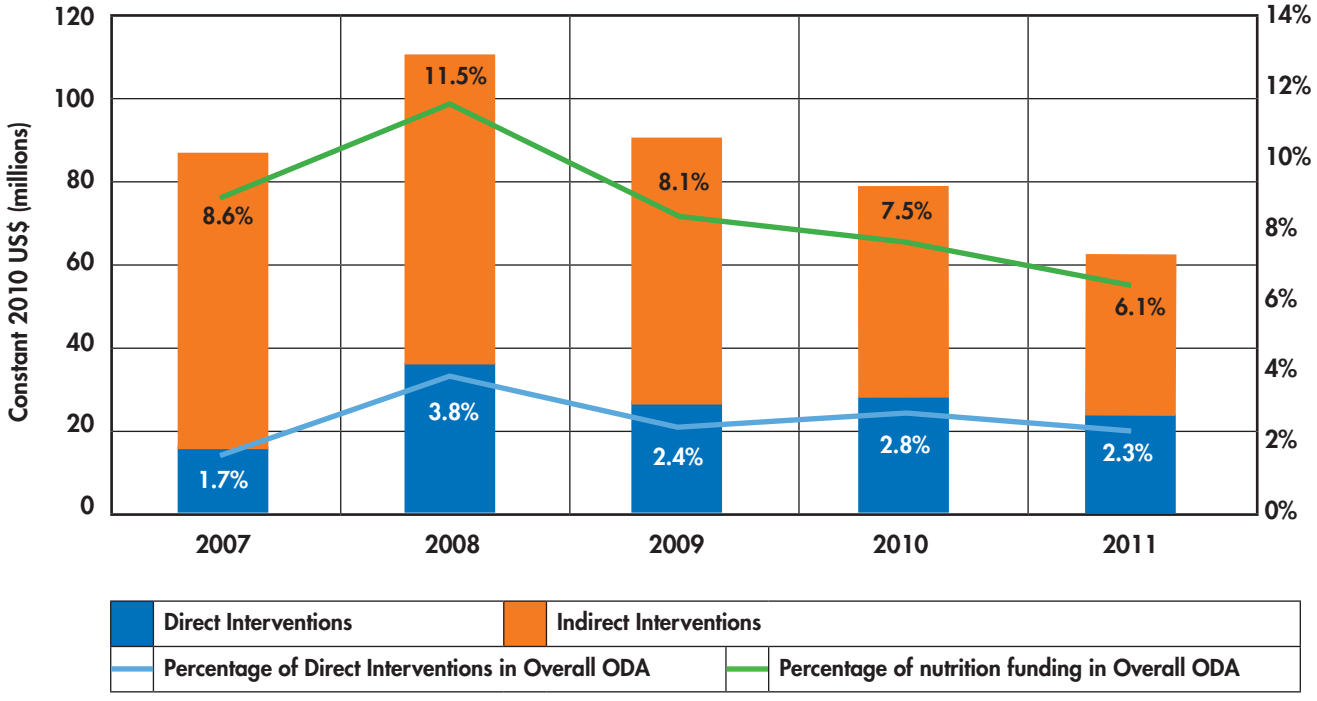
UNICEF directed funding to direct nutrition interventions leading with therapeutic feeding for malnourished children (40%), followed by the promotion of good nutritional practices (36%) and increasing the intake of vitamins and minerals (24%). This almost equal apportioning of funding between the three categories of direct nutrition interventions is very similar to the 2005 to 2009 analysis of UNICEF's aid activities.

Direct nutrition interventions were mainly channelled through Health and lesser but almost equal amounts of funding were channelled through Water and Sanitation and Humanitarian Aid. Indirect nutrition interventions were mainly channelled through Health, Social Infrastructure and Services, Humanitarian Aid and Water and Sanitation in decreasing order of funding.

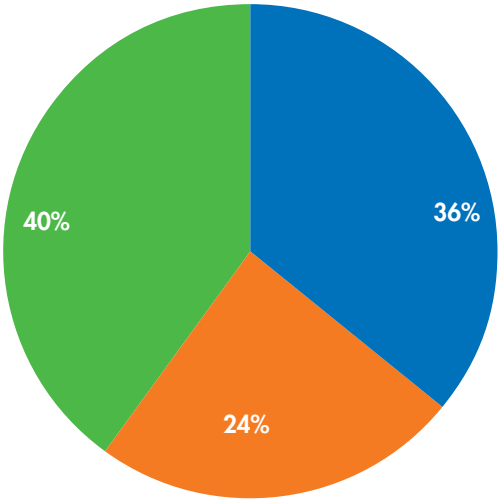
ARE RESOURCES FOR NUTRITION BEING TARGETED TO THOSE WHO NEED THEM MOST?

During the 2007 to 2011 period, an estimated US$64.44 million of UNICEF funding was targeted to

ODA FROM UNICEF FOR DIRECT AND INDIRECT NUTRITION INTERVENTIONS FROM 2007 TO 2011



UNICEF'S DISTRIBUTION OF DIRECT INTERVENTIONS



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

Africa, whilst Asia received US$19.1 million. Funding targeted to Africa decreased to US$60.19 million in 2010 and US$49.81 million in 2011. Funding for Asia also decreased from the 2009 level of US$20.36 to US$17.17 million in 2010 and US$12.12 million in 2011.

Four of the top 5 recipients of aid for nutrition are in Africa.

ACCOUNTABILITY

UNICEF commitments were closely matched with disbursements and for the period of 2007 to 2011, UNICEF did not deliver on 0.1% of their commitments. Commitments in 2009, 2010 and 2011 were US$88.67, 79.12 and 62.94 million respectively, whilst disbursements were US$88.43, 79.12 and 62.94 million. The trend is for decreasing funding for nutrition, although it should be noted that UNICEF's funding will be significantly dependent on aid from donors.

TOP RECIPIENT COUNTRIES FOR UNICEF

Ranking (2005-2009 ranking in brackets)	Recipient	Average annual funding for nutrition from 2007-2011 (Constant 2010 US$ millions)	Percentage of total nutrition funding
1 (1)	Ethiopia	11.4	13%
2 (3)	Nigeria	5.4	6%
3 (4)	Congo, Dem.Rep	4.5	5%
4 (2)	India	4.1	5%
5 (n/a)	Niger	3.1	4%

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