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**Policy Formation in Donor Agencies:
The Case of Nutrition Policy**

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Abstract:

Investments in child nutrition are core to achieving MDGs in poverty, education, gender equality, child health, maternal mortality, HIV/AIDS and to economic productivity. In light of this one would expect nutrition to be high on donor agendas. This article asks what level of prioritization do donors give, in general, to nutrition and what level of prioritization do the UK DFID and EC in particular give. The dynamics of policy formation at DFID and EC are then discussed in greater detail using the study of nutrition policy.

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Johanna Lindstrom

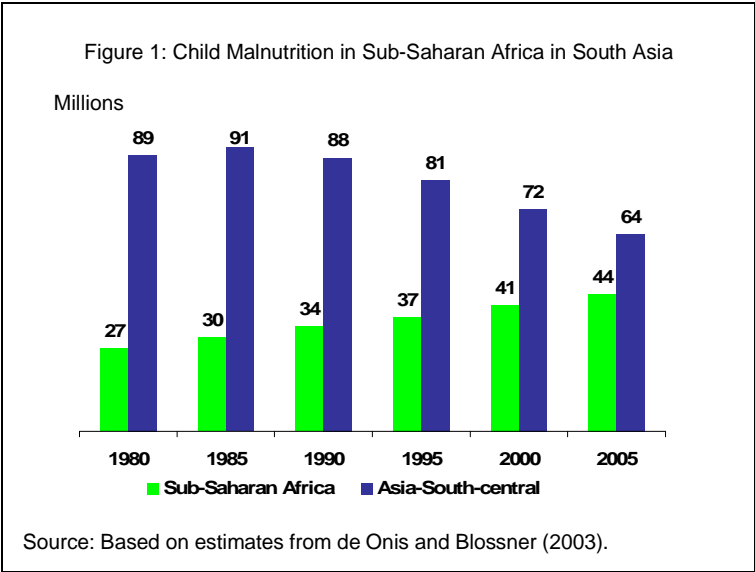
Lawrence Haddadⁱ

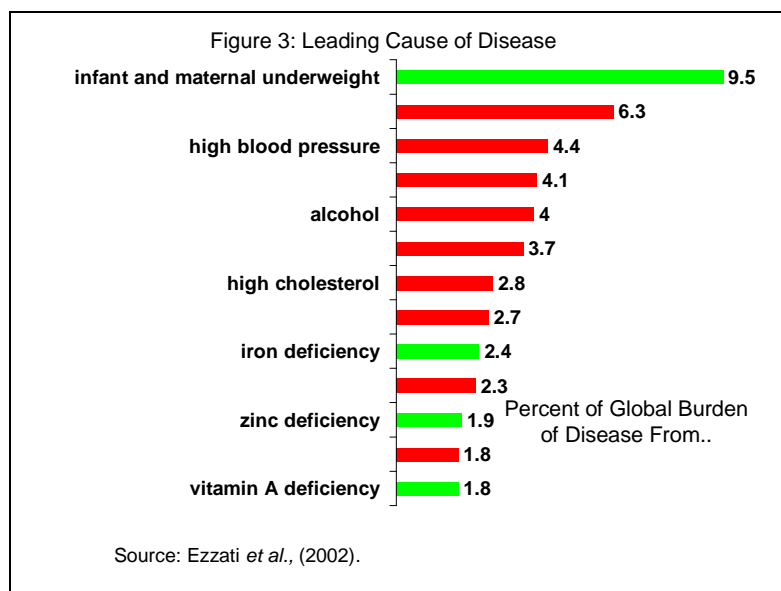
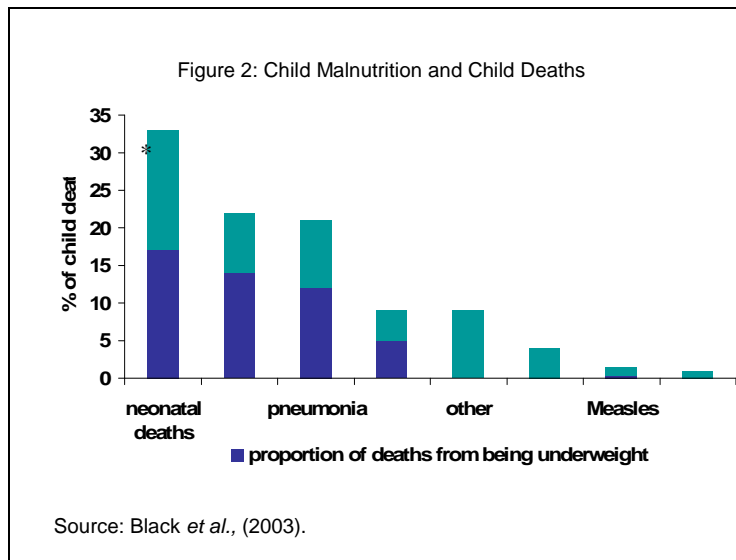
1. INTRODUCTION

Investments in nutrition are core to achieving the MDGs, core to improvements in health and education outcomes and core to economic growth. In light of the above this article discusses the commitment currently demonstrated to nutrition by donors in general and DFID and the EC – two of the largest aid agencies – in particular. This is followed by discussion of the dynamics of policy formation DFID and the EC using nutrition as a case study. Section 2 discusses why nutrition matters to donors. Then, section 3 outlines our conceptual framework and methodology. Section 4 presents finding on public commitments to, and spending on, chronic malnutrition in donors generally and in DFID and EC headquarters in particular. Section 5 discusses the dynamics of policy formation at DFID and EC’s using nutrition policy as a case study. Section 6 concludes.

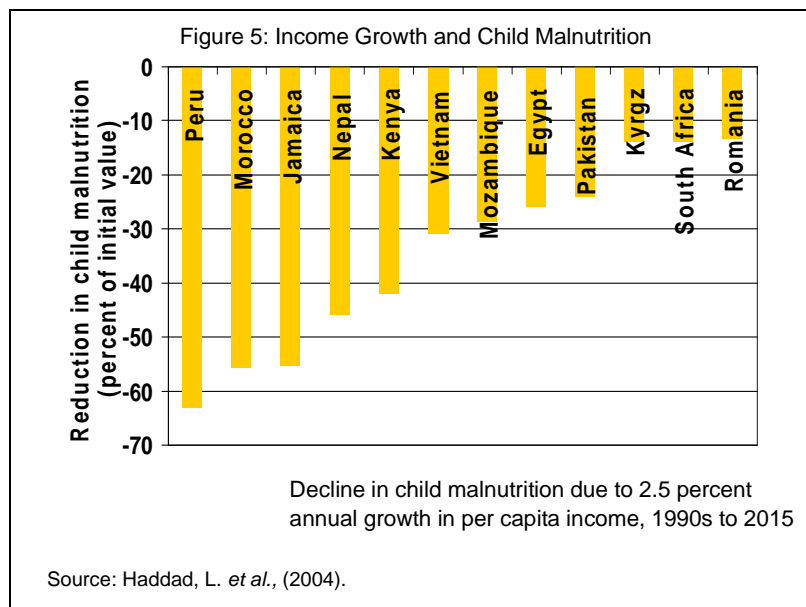
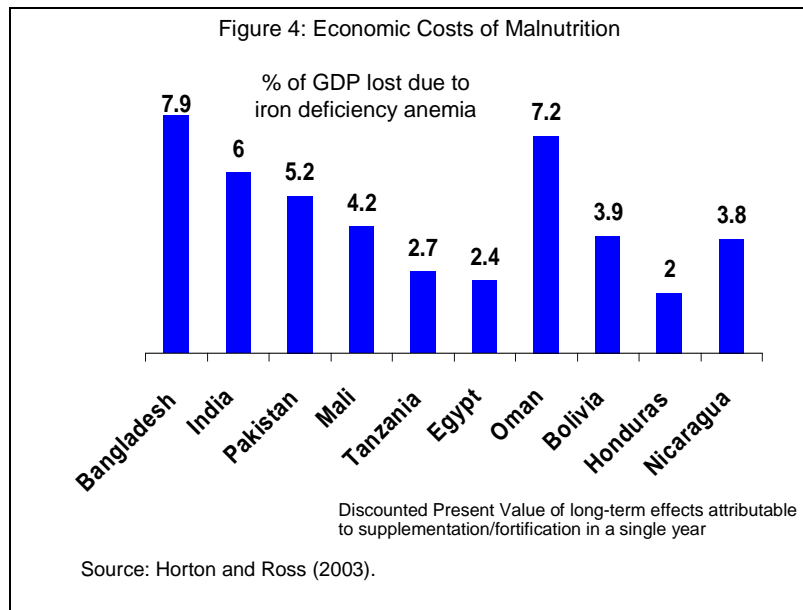
2. WHY NUTRITION MATTERS

Chronic malnutrition affects billions of people. One in three infants in South Asia and sub-Saharan Africa are chronically malnourished. In South Asia the number of children under 5 who are low weight for age or low height for age is steadily declining – albeit with several countries still showing increases – but in sub-Saharan Africa the number is steadily increasing even at the regional level (see figure 1). Child malnutrition is responsible for a half of all child deaths and infant and maternal malnutrition are leading causes of disease (see figure 2). Malnutrition is the leading cause of disease (see figure 3).





The economic costs of malnutrition are large (see figure 4 – iron deficiency anemia alone represents a loss in GDP of 2-8%). Further, economic growth, while crucial for reducing malnutrition will not take care of malnutrition quickly enough – the two are not as tightly wedded as many imagine (see figure 5). Projections show that by 2015 only 3 out of 12 countries will halve their 1990 malnutrition rates despite projections reliant on 25 years of historically unprecedented income growth.

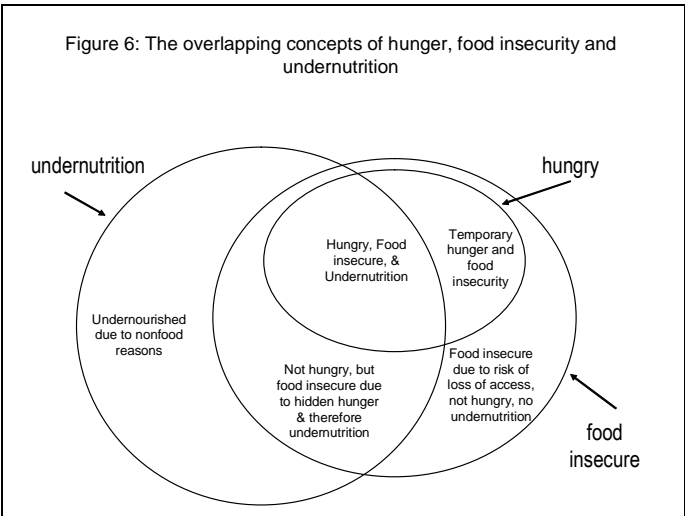


In sum, chronic malnutrition erodes life, health, and productivity and is central to meeting the MDGs. For these reasons it matters to donors.

3. ANALYSING DONOR POLICY AND POLICY FORMATION DYNAMICS

How can we analyse donor policy on nutrition? We draw on the consensus of a range of conceptual frameworks that have emerged for the analysis of policymaking processes in international development (see for details Brock *et al.*, 2001; Court *et al.*, 2005; de Vibe *et al.*, 2002; Gladwell, 2000; Keeley and Scoones, 2003; KNOTS, 2006; McGee and Brock, 2001; Stone *et al.*, 2001; Sutton, 1999). This literature stresses context (e.g. which policy windows

are currently open?), messages or policy narratives (e.g. is there a strong set of problem and solution messages to hand?) and connectors (e.g. are there people, organisations and institutions that can play a championing role?). The conceptual approach we use has three dimensions which guide our data collection. First, we assess how the agencies and a small but targeted sample of their staff conceptualise chronic malnutrition (using figure 6). Second, we assess the priority they currently give to chronic malnutrition. Third, we discuss the dynamics of policy formation at donor agencies using the cases of DFID and EC.



The way in which chronic malnutrition is conceived should give clues as to the rationale for resource allocation decisions and for understanding the space for changing the priority given to it. For example, if it is seen as a development outcome, indirect efforts to address it may be given priority. If it is seen as a medical condition, certain types of direct interventions might be emphasised. If it is seen primarily as a measure of food shortages then perhaps food policies will be given priority. To understand the conceptualisation, priorities and the placing of chronic malnutrition on the development agenda, we investigate donor agencies in terms of what they: (a) publicly commit to (by analysing their web sites, speeches and policy publications), (b) spend (by using various data sources) and (c) think (by relying on interviews). Table 1 summarises the approach we take.

Table 1: Our Analytical Approach – Analyst and Donor Perceptions

Our assessment of donor’s perceptions

		Conceptualisation of chronic malnutrition	Prioritisation of chronic malnutrition	Opportunities for and Impediments to changing the priority
Donors' Stated policy position and personal perceptions of donor staff	What they commit to	Speeches, web sites, policy papers	Speeches, web sites, policy papers	
	What they spend on		OECD DAC Credit Reporting System (CRS) and other data	
	What they think	Interviews	Interviews	Interviews

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

Table 2: Direct and Indirect Nutrition Interventions

Direct interventions	Indirect interventions
<ul style="list-style-type: none"> • Community based nutrition and health services (growth promotion, supplementary feeding) • Breastfeeding counselling • Facility-based nutrition services (treatment of severe malnutrition, antenatal care) • Micronutrient supplementation and fortification • Targeted food aid • IEC/nutrition education/behaviour change programmes • Advocacy on nutrition • Women’s nutrition interventions • Nutritional surveillance 	<ul style="list-style-type: none"> • Primary health services and infectious disease control • Safe water and sanitation • Legislation on the marketing of breast milk substitutes • Food and agricultural policies to increase supply of safe and healthy food • Food industry development and marketing incentives for developing healthy food • Increasing the incomes of the poor, including micro finance, employment creation • Fiscal and food price policies to increase poor people’s purchasing power • Improving the status of women • Reducing women’s workload (during pregnancy and post-natally) • Increasing women’s formal education • Conditional/unconditional cash transfers • Food aid • National food security • Capacity development

We use these definitions to guide our search for data collection. As Table 1 summarises, we used data from policy documents, publicly available speeches, expenditure data, and individual interviews. We used “current” key policy documents and speeches that relate primarily to these direct and indirect interventions. We selected the speeches of elected politicians and political appointees (DFID and EC Dev websites – English only)

supplemented by press releases and Hansard and the record of the European Parliament.ⁱⁱ We used multiple sources of expenditure data. For comparison between countries and donors, we have used the DAC Creditor Reporting System (CRS) to analyse spending in the area of nutrition for the period 1995-2004 for the following types of intervention: Direct nutrition interventions, indirect nutrition interventions and general budget support. The use of the CRS data is not unproblematic. Consequently one has to use the CRS data with care and certainly only in terms of rough orders of magnitude.ⁱⁱⁱ

We also conducted interviews. We constructed a list of interviewees to approach based on those working in the divisions with primary responsibility for policy formation in the area of nutrition in DFID and EC Headquarters. In DFID this was the Policy and Research Division. In EC this was the DG Development, Directorates A (development policy: horizontal issues) and B (development policy: thematic issues). We also included policy implementers. For DFID, this was the Africa Division and CHASE (the Conflict, Humanitarian and Security Department). For the EC this was AIDCO (Europe Aid) and ECHO (EC Humanitarian Office). We also approached the chair of the relevant parliamentary development committee for both DFID and EC. In each Division we contacted the Heads of Department and in each Department a senior official. In the DFID Policy and Research Division this translated into each Head of Department and the Head of Professions. In EC DG Development Directorate A and B this meant the Heads of Department and the most relevant Desk Policy Officer in each Department. In both DFID and EC we excluded the IT/media/communications department. In all we approached 5 Heads of Department and 8 Heads of Profession at DFID and 8 Heads of Department and 7 Desk Policy Officers at the EC. Thus in total 12 DFID HQ staff and 10 EC HQ staff were interviewed.

4. PUBLIC COMMITMENTS TO, AND SPENDING ON, CHRONIC MALNUTRITION IN DFID AND EC

4a. The Donor Environment: Public Commitments and Expenditures

Table 3 analyses the mission statements and nutrition strategies on the web sites (and key policy documents where readily available) of the top ten bilateral donors of total ODA volume^{iv} and the European Commission and their conceptualisation of chronic malnutrition. This was a relatively brief review and the judgment of conceptualisation is based on first impressions. Canada, the Netherlands and the US seem to give undernutrition, food insecurity

and hunger the highest priority. The UK and the EC we rate as giving medium priority and the rest of the donors as giving a low priority to these issues, at least based on public statements on websites.

Table 3: Top Ten Bilateral Donors and the EC: Chronic Malnutrition: Conceptualisation and Prioritisation

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

Source: Donor websites

Notes: “Undernutrition” in this table means malnutrition due to lack of calories and micronutrients as opposed to malnutrition due to excess of calories. The Spanish website was not in English so we have been unable to determine conceptualisation

Table 4 presents donor policies and interventions by different chronic malnutrition areas activities (direct and indirect). Shaded cells represent an area of policy focus and a tick represents a main area of intervention. This more disaggregated perspective confirms the relative strength of emphasis of the US, the Netherlands, Canada and the UK. The EC fares particularly poorly in this exercise.

Table 4: Top Ten Bilateral Donors and the EC: Type of Nutrition Activities

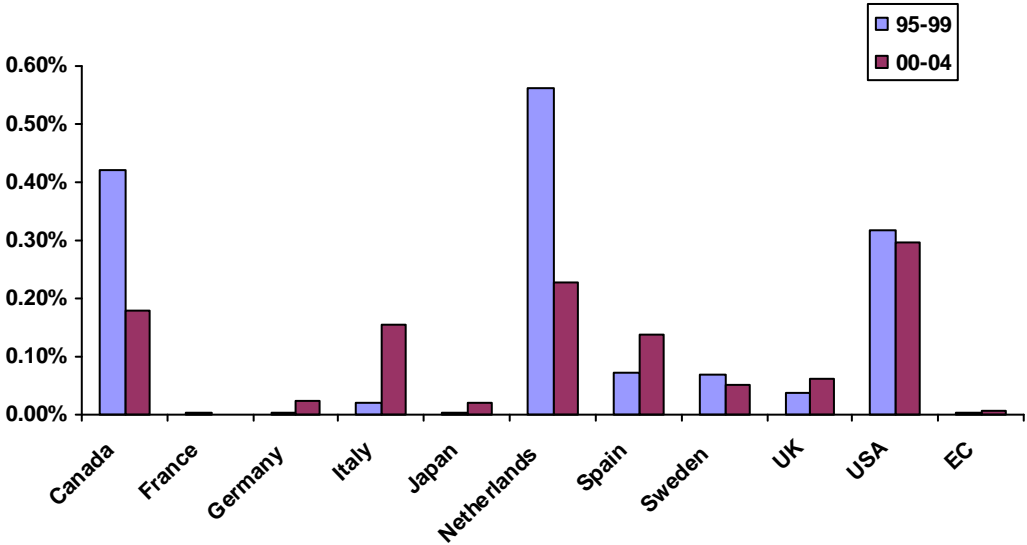
		Can	Fra	Ger	Ita	Jap	Net	Spa	Swe	UK	USA	EC
Direct interventions	Community nutrition										✓	
	Micronutrients	✓				✓	✓		✓	✓	✓	
	Women’s nutrition			✓				✓			✓	
	Child care /feeding	✓					✓	✓	✓	✓	✓	
	Nutritional surveillance	✓			✓		✓			✓	✓	
	Advocacy	✓		✓			✓		✓			
Indirect interventions	Food aid	✓	✓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

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

Figures 7 and 8 use CRS data to show the percentage of ODA spent on direct and indirect nutrition interventions between 1995 and 2004. In terms of the percent of bilateral ODA

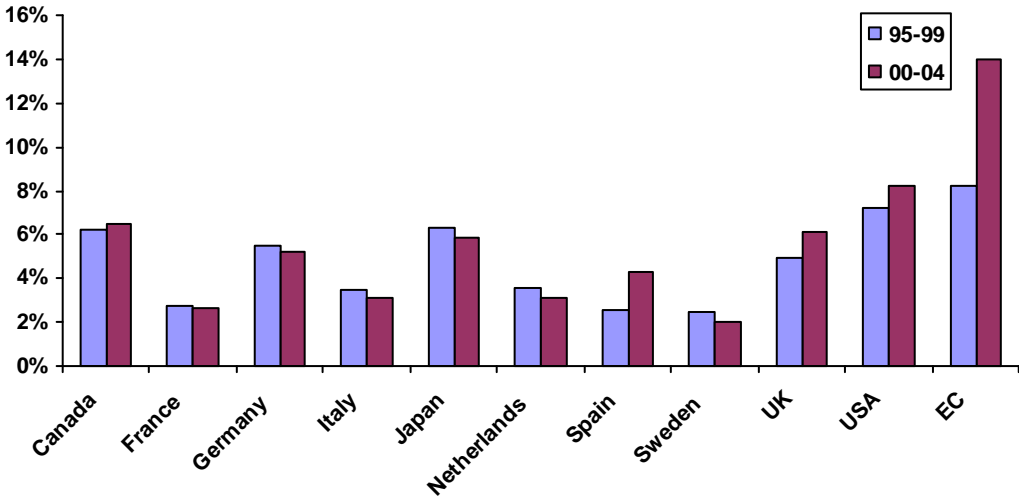
allocated to direct nutrition interventions, the Netherlands, Canada and the US do much better than others, although the volumes of aid are all small in relation to total ODA, ranging from less than 0.01% to 0.6%. Indirect interventions account for a much larger percent of ODA^v ranging from 2-14%. Here the EC is the lead agency with the highest and fastest growing spend.

Figure 7: Percentage of Total ODA Spend on Direct Interventions



Source: CRS Online

Figure 8: Percentage of Total ODA Spend on Indirect Interventions



Source: CRS Online

Each of these two perspectives on donor conceptualisation and prioritisation has its own problems, but taken together they suggest that the main bilateral players in the nutrition field

(combined direct and indirect) are the Netherlands, USA, Canada and the EC with the UK close behind. The Netherlands takes a multi-sectoral approach to the explicit improvement of nutritional status and specifically highlights the links between girl’s education, improvement of nutritional status and thus increased agricultural output. There is a specific policy document that deals with this approach “Nutrition: interaction of food, health and care” from 1998. USAID particularly stresses the interdependence between nutritional status, child survival, health, cognitive development, and work capacity and its interventions are focused on micronutrient supplementation and fortification, infant and young child feeding, improvement of household food security and food aid. For such interventions it is stated that locally appropriate, community-based, integrated approaches that build community capacity to monitor and improve children’s nutritional status are used. In recent years the USA has, based on these data, been the lead donor on direct nutrition interventions, both in absolute and relative terms. The USA is also one of the lead donors on indirect interventions. Although traditionally much of USAID aid in these areas has been food aid in kind, a majority of this is now monetised (72% in 2002) (FANTA, 2003: 4). Canada places high priority on chronic malnutrition within their policy on basic human needs. CIDA’s approach is focused on the improvement of household food security, the reduction of micronutrient deficiencies and investing in capacity building for nutrition. Canada’s spend in direct interventions is declining, but is still one of the highest, with an average indirect nutrition spend. Japan also has a large indirect nutrition spend, but has nothing much to say on direct nutrition interventions. Apart from these donors and the EC and DFID, the remaining donors – based on the above data – seem to place a low priority on chronic malnutrition.

4b. DFID: Commitments, Spending and Perceptions

Although it is clear that DFID has a comprehensive understanding of the severity of the problem and how to deal with it – particularly evident in the Eliminating Hunger policy paper (2002) and the new Health Strategy (2007) – reducing chronic malnutrition is not a stated DFID priority issue in its own right. Word count analyses of speeches, press releases and key documents as listed in Table 5 show that nutrition is rarely mentioned in speeches and press releases. The same can be said of DFID’s Public Service Agreement.^{vi}

Table 5: Nutrition Word Count in Key DFID Speeches, Press Releases and Documents

Speeches, Press	Conceptual-	Word Counts
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Releases and Documents	isation of chronic malnutrition	Nutrition / nutritional	Mal-nutrition	Under-nutrition/nourished	Stunting	Wasting	Under-weight
Speeches (from Jan 2005, total number 51)	N/A	4	2	0	0	0	0
Press releases (from Jan 2005, total number 198)	Hunger	4	0	0	0	0	0
Commission for Africa Report, 2005	Food insecurity/hunger/undernutrition	12	12	2	1	1	1
G8 report 2005	N/A	0	0	0	0	0	0
G8 report 2006	N/A	0	0	0	0	0	0
HMG G8 Gleneagles: One Year On, 2006	N/A	1	0	0	0	0	0
Hansard (from Jan 2005)	N/A	5	0	-	0	-	2
White Paper 3, 2006	N/A	1	0	0	0	0	0
Eliminating Hunger, 2002	Food insecurity/hunger/undernutrition	58	28	8	2	2	5
Better health for poor people, 2000	Undernutrition	14	2	0	0	0	0
Poverty elimination and the empowerment of women, 2000	N/A	1	2	0	0	0	1
Social transfers and chronic poverty, 2005	N/A	11	0	0	0	0	1
Working together for better health, 2007	Food insecurity/hunger/undernutrition	14	8	1	0	0	1
Working together for better health: evidence for action, 2007	Food insecurity/hunger/undernutrition	9	5	1	1	0	0

Note: For Hansard only relevant references have been counted. Due to the amount of information, keyword searches on wasting, undernutrition/undernourished were excluded.

Key policy documents documents, such as the G8 2005 and G8 2006 reports (in which DFID played a prominent role) and “G8 Gleneagles: One Year On” make limited reference to chronic malnutrition. The primary focus of the Third White Paper (2006) is on governance and while it does confirm support for a lot of indirect action which can have an impact on nutritional status, including health, women’s empowerment, water and sanitation, social protection (with a target of moving 16 million people off emergency relief and onto long-term social protection programmes), microfinance and economic growth, there is no specific chronic malnutrition focus. Certain DFID sector strategy documents place more importance

on chronic malnutrition. The Eliminating Hunger paper (2002) conceptualises malnutrition in terms of the quantity and quality of food access in relation to physiological requirements and ability for the food to be used by the body for growth and development (p. 13) and highlights the potential contribution of nutrition to the achievement of the MDGs (p. 18 & 25). To deal with the problem of food insecurity and chronic malnutrition the document stresses the importance of multi-sectoral indirect interventions that improve education, health, water and sanitation and food security as well as more direct actions such as promoting good care and feeding practices and improved access to micronutrients (p.8). The document also highlights the significance of nutritional status indicators for monitoring food insecurity and vulnerability (p. 30). It is also stated that DFID should reflect on the role it can play in the nutrition debate, by drawing on existing work on health, livelihoods, poverty and hunger reduction (p.33). In order to implement this strategy, DFID suggests that better ways of cross-sectoral working are needed to reduce malnutrition and that a focal point for food security and nutrition is created (p. 32).

The gender strategy 'Poverty Elimination and the Empowerment of Women' (2000) emphasizes the links between women's and girls' empowerment and improved nutritional status (p. 16). The paper on social transfers 'Social Transfers and Chronic Poverty' looks at how social transfers can impact on nutrition and have further beneficial consequences, in terms of improved school performance and general health and resistance to HIV/AIDS (p. 13-14).

The (2000) Health strategy 'Better health for poor people' acknowledged the importance of nutritional status (along with other issues such as economic security, education, water and sanitation and broader physical and social environment) for health outcomes and thus prescribes a multi-sectoral approach that includes all these areas (p. 17).

However, it is in the recently released, 2007 Health Strategy (written whilst we conducted interviews for our research here) there is much more of a focus on nutrition. This is particularly evident under the section titled 'Priority 2: Working Together: Expanding Access To Basic Services'. One of the priority objectives is promotion of good nutrition. Another is to improve the health of mothers and children (p.40). Within these priorities both direct and indirect interventions are prescribed, noting that a lot of the interventions that improve nutrition take place outside the health sector. The critical role of nutrition in child health and development, maternal health and prevention of non-communicable diseases as well as for people living with HIV and AIDS is also recognized (p. 43) and DFID states that it will ensure that investments in other sectors (including water and sanitation, food security and

nutrition, education, environment, and social protection) will lead to maximum health gains (p. 44). The accompanying document ‘Evidence for action’ also has a section on the importance on tackling malnutrition for to achieve better health outcomes (p. 11).

This medium-level priority is also evidenced in Figures 7 and 8 by relatively small amounts of bilateral aid spent on direct (7th out of 11) and indirect nutrition interventions (5th out of 11). The low spend on direct nutrition activities is not particularly surprising given the DFID emphasis on multi-sectoral livelihood approaches. On indirect interventions, DFID spends more than an average amount in comparison to the top ten bilateral donors. What about DFID multilateral spending on chronic malnutrition? On the allocations to multilaterals (Table 6) it is very difficult to establish how much is spent on chronic malnutrition.

Table 6: DFID’s Contributions to Multilateral Agencies in 2005

	According to donor	According to UN agency	Earmarked funds	Nutrition spend by agency
UNICEF	£32,428,000	Total: \$159,228,000 Excl. emergency: \$98,086,00	Some, but details not available	\$128,278,031 (unable to split in direct and indirect)
WFP	£5,001,000 (all of WFP excl. emergency food aid)	\$114,263,605	Yes	\$258,884,000 (unable to split in direct and indirect)
FAO	£4,805,000	N/A	Direct: N/A Indirect: \$11,200,798	Direct: \$19,617,000 Indirect: \$32,035,000
World Bank (IDA)	£271,175,000	N/A	No	\$731,000,000 (unable to split in direct and indirect)
EC	£916,857,000	N/A	Some earmarked, but nothing for nutrition.	See rest of report

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

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

DFID does not earmark World Bank contributions to specific sectors or activities (DFID/28/11/06), but does earmark some funding for WFP, FAO and UNICEF, although most of DFID multilateral contributions are core funding (DFID/14/12/06). DFID funds UNICEF for some direct nutrition activities and WFP and FAO for some long-term food security interventions. None of these allocations seem exceptional in that chronic malnutrition does not seem under or over prioritised given the mandate of the particular multilateral agency.

From our HQ interviews with DFID staff (=12) the modal perception is that chronic malnutrition is a low but rising priority. The low priority assigned by interviewees reflects the

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

4c. The EC: Commitments, Spending and Perceptions

The European Commission does not have an explicit focus on chronic malnutrition although food security is one of their main priorities in development cooperation. In speeches and press releases nutrition is only mentioned in terms of crisis, although there are several instances that highlight the EC’s new focus on food security as one of the new seven thematic programmes.^{vii} (see table 7).

Table 7: Nutrition Word Count in Key EC Speeches, Press Releases and Documents

Speeches, Press Releases and Documents	Conceptualisation of chronic malnutrition	Word Counts					
		Nutrition / nutritional	Mal-nutrition	Under-nutrition/nourished	Stunting	Wasting	Under-weight
Speeches (from Jan 2005, total number 28)	N/A	4	0	0	0	0	0
Press releases (from Jan 2005, total number 239)	N/A	2	0	0	0	0	0
European parliament (from Jan 2005)	N/A	2	0	-	0	-	0
European Consensus on Development, 2006	N/A	1	0	0	0	0	0
Cotonou agreement, 2000	Food insecurity/hunger/undernutrition	1	1	0	0	0	0
Food Aid/Food Security Budget Line, 2005	Food insecurity/hunger/undernutrition	6	2	5	0	0	1
Health and Poverty Reduction in Developing Countries, 2002	Undernutrition	3	8	0	0	0	0
Promoting gender	N/A	0	0	0	0	0	0

equality in development cooperation, 2004							
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Notes: A lot of the speeches were in French and not included in the survey. For the European Parliament only relevant references have been counted. Due to the amount of information, keyword searches on wasting, undernutrition/undernourished were excluded.

‘The European Consensus on development’ (2006), which sets out the priorities for EU and EC development cooperation, highlights food security as a priority area and within this the focus is on prevention, on improving the access to food, on the quality of food and on capacity development for food security (p. 13). Within the food security strategy, framed by two different documents^{viii}, the EC policy is aimed at integrating food availability and access and the prevention of food crises at the centre of poverty reduction strategies. The policy also sees ‘hidden hunger’ (vitamin and mineral deficiency) and the multidimensional aspects of food insecurity as neglected areas in development cooperation. The policy prioritises tackling the underlying causes of food insecurity: regionally and nationally; at a household level; and at an individual level, where specific nutrition activities may be undertaken. These include nutrition education, health interventions and income transfers, and should be targeted at the most vulnerable (women and children) (FSBL, p. 9). The EC favours budgetary support and capacity building where appropriate (FSBL, p. 14), but in countries with weak institutional frameworks support is channelled through projects, NGOs or international agencies. The aim is to move away from food aid except in crisis situations (FSBL, p. 16). The health strategy^{ix} refers to malnutrition as a health condition, but does not specify specific nutritional programmes under health. The gender-nutrition link is not acknowledged in the gender strategy^x.

The CRS data show that the EC spends very little on direct nutrition activities (Figure 7), explained by a preference for more broad-based food security interventions. However, the food security strategy does highlight the need for some direct activities. The EC has increased the support for indirect activities and the majority of this investment is into food security programmes, with 441 million Euros allocated to the food security budget line in 2006. However, the impact on nutritional status of this type of intervention is notoriously difficult to ascertain. In terms of multilateral aid (Table 8), the EC is moving toward more earmarking of funding (unlike DFID which is moving toward more core funding), but nothing to direct nutrition interventions at the moment. Quite a substantial amount is allocated to indirect projects that could impact on nutritional status, specifically food aid to WFP and food security to FAO, water and sanitation and girl’s empowerment to UNICEF.

Table 8: Contributions to Multilateral Agencies in 2005

	According to donor	According to UN agency	Earmarked funds	Nutrition spend by agency
UNICEF	€73,180,000	Total: \$27,844,213 (incl. emergency funding)	Direct: N/A Indirect: €43,133,614	\$128,278,031 (unable to split in direct and indirect)
WFP	€180,590,000	\$263,940,274	Yes	\$258,884,000 (unable to split in direct and indirect)
FAO	€29,960,000	N/A	Direct: N/A Indirect: €14,163,040	Direct: \$19,617,000 Indirect: \$32,035,000
World Bank Group	€515,623,570	N/A	Direct: N/A Indirect: €99,665,000	\$731,000,000 (unable to split in direct and indirect)

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

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

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

5. THE DYNAMICS OF DFID AND EC’S NUTRITION POLICY.

This section asks the question “what shapes the possibilities for a higher priority to chronic malnutrition?” As such it applies the context-message-connector model described earlier to the DFID and EC staff interviews.

5a. The Context

DFID and EC staff identified a number of institutional disincentives or obstacles to raising the profile of chronic malnutrition. These relate to the incentives that drive decision-making within the agencies, both domestically and internationally. They fall into three categories: (a)

the absence of nutrition indicators in key reporting frameworks; (b) the absence of pressure from key stakeholders and (c) issues relating to the nature of chronic malnutrition.

Both DFID and the EC staff raised the importance of the nature of agency reporting requirements for influencing priorities and action. For DFID, the Secretary of State is publicly accountable for the delivery of the PSA 2008 targets. These targets are explicitly linked to the MDGs. For MDG-1 on poverty, the indicator chosen is the dollar a day measure of poverty. If a reporting indicator is in the PSA it cascades down into Director's Delivery Plans (DPPs) and through to country level planning (See footnote ix). In reality, we would argue that the underweight indicator of poverty is a much more reliable guide to changes in poverty levels than the dollar a day measure. Specifically, and unlike the latter, it does not depend on adjusting prices over place and time – always a controversial task. It cannot be reported on an annual basis because it is not collected on an annual basis, although the marginal costs of collecting and analysing underweight data annually in DFID/EC priority countries would be extremely modest. The EC has no PSA equivalent (although it does, of course, have the usual financial reporting requirements), but in a developing country's CSP there is a 'framework of indicators' that are used to assess EC programmes. The technical case for increasing the use of nutrition indicators as measures of poverty is strong. The increased use of such indicators would sensitise those who have to monitor and meet targets relating to them. This would likely sensitise actors to the key importance of reducing chronic malnutrition.

The importance of parliamentary oversight of DFID and the EC by the House of Commons Select Committee on International Development and European Parliament Development Committee respectively were raised in interviews. If these bodies do not emphasise chronic malnutrition, the pressure on DFID and the EC to do so is diminished. Both House of Commons and European Parliament Committees can instigate enquiries and may be triggered to do so. The reports of such committees sometimes get significant press coverage raising their leverage. Additionally parliamentarians can place questions requesting information on what DFID and the EC are doing on an issue particularly so if it relates to a public commitment made by DFID and EC. Civil servants pay attention to the reports of their departments' committees, questions tabled and relevant debates in respective parliaments. For the EC, the priorities of EU members are important. If an EC member state raises the issue of chronic nutrition the EC could convene a discussion of member states on key issues, actions and priorities for action including improved coordination of action across EU member states. Many of those interviewed in both DFID and the EC argued that if nutrition was not on the radar of developing country partners, notably in the PRSPs, then they were constrained in

what they could or could not do due to the coherence agenda. Further, they said, in a world of direct budget support, how much influence do donors have? Clearly, if PRSPs become more important for informing PSAs, DPPs and CSPs which is likely, the use of underweight indicators in the PRSPs will become more important for influencing DFID and EC activities in chronic malnutrition. In terms of institutional pressure from international stakeholders, our interviewees saw UNICEF as having many objectives – with efforts to address chronic malnutrition being no higher than many of their other priorities. The interviewees saw FAO as politically weak and not a strong enough partner to enable a higher profile chronic malnutrition agenda.

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

5b. The Policy Narrative

From our interviews, it was clear that DFID and EC staff do not find the nutrition ‘policy narrative’ compelling. Most respondents recognised the devastating consequences of chronic malnutrition, but sectoral approaches are not easily applied to the multisectoral causality of chronic malnutrition: The disconnect between the need to support countries through sector-wide policies and the need to coordinate actions across sectors was seen by many as insurmountable.

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

There is a lack of a ‘silver bullet’ or even a small set of silver bullets: While it was understood that there are some direct nutrition interventions that work well in effectiveness and cost effectiveness terms and are well documented as such, there was a sense that these

would have to exist within the much more diffuse indirect nutrition interventions. There was much less of a sense as to how these indirect interventions map into nutrition outcomes. The yearning for a silver bullet solution is somewhat incongruous set against DFID's White Paper emphasis on the often complex politics of the development process. Connected to this point, attribution of impacts of a specific intervention is increasingly important in a results-based environment where the delivery of improved outcomes is increasingly stressed.

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

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

There is a lack of resonance between the need to address chronic malnutrition and the predominant policy framework: For DFID this is governance. For the EC this is growth and governance. This represents a challenge to the connectors, but one that is far from insurmountable.

5c. The Connectors

DFID and EC policymakers both reported that often the institutional champions of nutrition are few, isolated and invisible. This was thought to be a reflection of weak institutional incentives and the confused policy narrative. But it was also thought to be a consequence of nutrition's ambiguous sectoral home, vis-à-vis the sectoral perspectives embodied in SWAPs and Direct Budget Support. The void left by the lack of a formal institutional champion in DFID has resulted in the formation of an informal virtual nutrition working group within DFID, building on the work of the DFID Africa Hunger Task Force. DFID's new health strategy will likely help with this, as it includes a draft institutional mapping of where nutrition should sit within DFID. In DFID country offices the role of nutrition champions has been influential (especially so in Ethiopia and Bangladesh) in promoting nutrition in the country office. In the EC there seem to be fewer 'connectors' or 'champions' (though the vice-chair of the European Parliament Development Committee has a nutrition background). In the context of EC policy coherence debates, as noted above, if one member state and/or the European Parliament Development Committee raised the issue, an EC dialogue on nutrition

related issues could be influential, so there seems to be scope for a champion to leverage interest. Internationally, as noted above, UNICEF is not seen as a strong connector due to its many competing objectives, with nutrition being seen as neither the highest nor the lowest. FAO is viewed as politically weak. In terms of bilaterals, the Dutch and the Norwegians have expressed interest in prioritising nutrition but their ODA levels are such that they cannot be as influential as DFID or the EC. Table 9 summarises our findings from the interviews.

Table 9: Findings on the Nature of the Policy Space from Interviews with DFID and EC

	Context	Message	Connectors
<i>DFID</i>			
Drivers of policy change	MDGs; political pressure – especially from country partners, international system partners; PSA - inclusion of nutrition currently under discussion.	Using 'hunger' term; links to social protection, links to radicalisation, extremism, links to growth; reform of humanitarian response towards chronic malnutrition; identifying nutrition-governance links; links to environment and food impacts of environmental degradation	New DFID virtual working group on nutrition; Africa Hunger TF pushing.
Impediments to policy change	Cross-sectoral nature leading to a fragmented/lack of policy coherent approach; lack of country/PRSP interest in nutrition; not in PSA and thus DDPs currently; world of budget support limits possibilities; chronically malnourished not politically important - lack voice; undernutrition does not affect rich countries; no central guidance from DFID HQ; Competing agendas and resources constraints; lack of donor coordination.	Weak policy narrative especially on attribution; lack of a clear cut and compelling case; complexity of message; politics of food aid distorts discussion on nutrition; nutrition message seen as an emergency issue; need to join chronic and acute debates together; lack of country disaggregated and trend data, acute malnutrition grabs headlines; chronic malnutrition is also not a very specific indicator (i.e. lots of things can affect it, not just the intervention); weakness in MDG nutrition indicators; lack of country level analysis on subject.	Lack of champion(s) and visible monitoring groups; FAO weak in international system; lack of nutrition people at country level - too expensive to have nutritionists in every country.
<i>EC</i>			
Drivers of policy change	MDGs and international policy consensus.		International partners - UNICEF and NGOs talking about it more
Impediments to policy change	Limited country interest in PRSPs; limited EU member interest; resource competition between various development issues - EC limited to two focal sectors and budget support; EC driven by other priorities - growth/trade; cross-sectoral nature; world	Lack of nutrition data undermines message; different measures of nutrition – no standard approach; chronic/acute unclear definitions; chronic/acute - we need to break down the wall; not seen as a long term investment;	

	of budget support limits; limited EC capacity in terms of personnel.		
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6. CONCLUSIONS

Chronic malnutrition is widely recognised by DFID and EC documents and interviews to have a crucial role to play in reducing child mortality, morbidity and in promoting learning in school and economic productivity in the labour market. But it is seen by the EC and DFID as a supporting investment rather than a foundational one. This is due to many reasons. First, chronic malnutrition does not fit neatly into the developing country sectoral silos that donor agencies are increasingly linking up with. Second, nutrition is seen as everybody’s business and nobody’s responsibility – there are few institutional champions. Third, it is not seen as linked to the governance agenda, although there are clearly opportunities for it to be useful for revealing the capacity, accountability and responsiveness of states. Fourth, within DFID and the EC there are few institutional incentives to pay attention to nutrition. Fifth, international agencies are not seen as capable or willing to support or put pressure on DFID or the EC to do more. Sixth, parliamentary bodies have no particular incentive to pressure DFID or the EC on nutrition. Seventh, as the CRS data from the DAC show, tracking spending flows on nutrition is difficult. Eighth, attributing impact on nutrition status of indirect nutrition interventions is also difficult, with little knowledge about what is a nutrition-friendly or unfriendly indirect intervention. Ninth, in the area of direct interventions there are some clear interventions (e.g. breastfeeding promotion, micronutrient supplementation, fortification) but these are seen as involving too much behaviour change (e.g. breastfeeding) or too little (e.g. supplementation) to be sustainable. Finally, the move to direct budget support and SWAPs means these direct nutrition programmes will be underfunded in the absence of nutrition champions. Despite all of these difficulties, DFID and the EC – based on their public commitments, based on what they spend, and based on what they think – do give significant priority to nutrition. Not as much as some others – Canada, The Netherlands, and the USA – but more than some others too. Given their interest in nutrition and despite the above contextual, message, and connector related impediments to moving nutrition up the agenda, we are optimistic that DFID and the EC could do more on nutrition within the constraints under which they currently operate.

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NOTES

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ⁱⁱ “Current” refers to speeches and records from January 2005—early on in Hilary Benn’s tenure at DFID and just after the European Consensus on development was established. The most recent policy documents on a particular topic are reviewed even if these are published before January 2005.

ⁱⁱⁱ We have identified four problems with CRS data. First, multicountry allocations: When the committed amount of chronic nutrition ODA benefits several countries, no particular country is identified so specific donor-recipient mapping is incomplete. This is relatively common within both the direct and indirect nutrition data and makes country level analysis more difficult. We have dealt with this by supplementing the country level analysis with expenditure data and project information from DFID and EC websites, AiDA at the Development Gateway Foundation, country office interviews and multilateral organisations’ websites. Second, multisector projects: If a project that has a primary component which is not relevant to nutrition, but which includes nutrition relevant (both direct and indirect) interventions, it is impossible to know how much of the allocation is assigned to chronic malnutrition and it is also impossible to know how many such projects exist. We have not been able to solve this problem and it is difficult to know the extent to which this affects the accuracy of the data. Third, donor inconsistency in adhering to guidelines: There are specific guidelines for reporting, but these do not seem to be adhered to at all times. For instance, within the “basic nutrition” purpose code we found some emergency assistance funds, which should have been allocated to the purpose code specifically designed for emergency assistance funds. This was rare enough not to bias orders of magnitude or analysis of trends. There is also space for a longer description of the projects, but this information is rarely filled in, which means that opportunities for further analysis of the data are lost. Fourth, the CRS dataset does not cover bilateral donor contributions to multilateral agencies.

^{iv} Top ten as of 2005: USA, Japan, UK, France, Germany, Netherlands, Canada, Sweden, Italy and Spain (OECD DAC Development Co-operation Report 2005).

^v Indirect interventions include non-emergency food aid.

^{vi} DFID’s Public Service Agreement (PSA) sets out a departments aims and objectives and this cascades down to Directors Delivery Plans (DPP) and all country planning. The overall aim DFID’s PSA is ‘the elimination of poverty in particular through achievement by 2015 of the Millennium Development Goals’. The current PSA sets targets for 2008. The Secretary of State is publicly accountable for the delivery of those targets in the PSA. The DFID Management Board has collective responsibility and directors are individually accountable for their objective/targets. Directors through their delivery plans (DDPS) delegate responsibility to the teams in their department. In short, everyone at DFID is responsible for the delivery of the PSA. The PSA covers 16 African countries. The PSA also covers 9 Asian countries. There is a special technical note for conflict countries. Each year a full report on PSA progress is published. Joint-departmental PSA are possible (DFID has three currently). DFID’s current PSA (2005-08) does not include nutrition. MDG one is only assessed under the dollar-a-day. DFID’s new PSA is currently under discussion.

^{vii} The EC has no PSA equivalent (although it does have the usual financial reporting requirements) but in a country’s EC’s CSP there is a ‘framework of indicators’ that are used to assess the CSP and programmes and EC delegations draw on UN consolidated statistics in their reporting. In the CSPs we analysed there were few nutrition indicators. CSPs are country-led. There are no rigid requirements for indicators. However, if something major was missing (for example HIV) when reviewed by DG Dev HQ they would raise it with the country staff and ask for attention to appropriate indicators. Non-MDG targets are also worth attention. For example, there is an EC target to get 16 million people off relief and on to safety nets - by implication a chronic malnutrition target.

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

^{ix} Communication from the Commission to the Council and the European Parliament, Health and Poverty Reduction in Developing Countries (COM (2002) 129 final).

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