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The neglected crisis of undernutrition: DFID's Strategy

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Two years on from the peak prices of the food crisis, as many as a billion people across the world today are in the grip of a hunger crisis.

Undernutrition is evidence of this – and is implicated in the death of more than 100,000 mothers and three million children under five per year. Even when undernutrition does not kill, it undermines opportunities. Some 200 million of tomorrow's adults are today suffering from undernutrition. If they survive, they face physical stunting and reduced mental capacity.

Poor nutrition imperils progress to almost all of the Millennium Development Goals – from maternal mortality to child health, education to gender equality. Good nutrition in the first months of life provides a foundation for future development.

In this, the United Kingdom's first strategy for tackling undernutrition in developing countries, we set out how we will focus our effort where we can achieve the greatest immediate and long term impact. We will ensure that our investments reach the critical period when they can achieve the most – from pre-pregnancy to a child's second birthday.

We will invest in direct interventions such as support for breastfeeding and micronutrient supplementation, which we know are highly cost effective. And we will treat the causes, as well as the symptoms of poor nutrition. So we will work to ensure that families have access to safe drinking water and better sanitation. We will support access to primary health care in order to break the vicious circle of disease and malnutrition; we will empower women and girls; and we will ensure that our investments in social protection and agriculture go further in tackling undernutrition.

This strategy has four objectives. First, we will work with our partners to ensure a more co-ordinated and effective international response to this neglected crisis. We will help to make it a higher political priority, help mobilise more resources where they are needed and ensure that we are collectively monitoring progress at the highest levels.

Second, we will focus our direct support on six countries that collectively account for half of the world's undernourished children under five. We expect to improve the nutrition of at least 12 million children over the next five years – which amounts to 10% of all undernourished children around the world.

Third, we will make sure our investments which have potential to tackle the root causes of the problem, in social protection, agriculture, health, water and sanitation, governance and education, deliver tangible improvements in nutrition.

Fourth, we will invest in research and measuring results so that we can ensure that effective approaches to tackling this problem can be widely adopted.

Working together with our partners, I believe that we can act to save the lives and improve the prospects of a generation of children. By doing so, we can build a better tomorrow for millions of people around the world. This strategy sets out the United Kingdom's contribution towards that great effort.

Douglas Alexander
Secretary of State for International Development

Executive Summary

The problem

Undernutrition is a human disaster on a vast scale. Chronic undernutrition affects one in three children in developing countries. Every year it causes the death of more than three million children and more than 100,000 mothers. Undernutrition cripples the immune system, making children much more susceptible to disease. It increases the risk of anaemia and women dying during pregnancy and childbirth. It prevents proper brain development, which means children are less able to start school when they should, and less able to learn and perform. Adults who were undernourished in childhood earn significantly less and contribute less to economic growth. Undernutrition reduces GDP by at least 2-3%.

The global target of reducing by half the prevalence of underweight children under five years of age by 2015 shows wholly insufficient progress; progress which could be reversed by the economic downturn, the persistence of conflicts and state fragility and the increasing impact of climate change. With less than five years to go to 2015, a massive international effort is required as a matter of urgency. DFID has been supporting nutrition and investing heavily in related sectors but progress has not been fast enough. For these reasons, DFID has decided to increase its focus on nutrition and strengthen its capacity to respond to the ongoing nutrition crisis.

The determinants

Undernutrition arises from complex, multiple and interactive causes. The immediate causes include inadequate dietary intake and disease. Underlying these are causes operating at household and community levels: household food insecurity, inadequate care for women and children, and unhealthy household environments and lack of health services, with income poverty underpinning all three. Ultimately, these factors are determined by the larger political, economic, social and cultural environment. Gender inequalities act at all levels. Gendered power relations are a key factor in decision making within the household and often in ensuring the entitlement of female household members to adequate nutrition. The complex causality calls for a multi-sectoral approach and action at different levels to effectively address undernutrition in the long term.

The response

Delivering an effective multi-sectoral response requires strong co-ordination and leadership at national and international levels. However, national capacity and response are often weak and there is often low political demand for action against undernutrition. Top level leadership is needed to clearly define the roles and responsibilities of each sector necessary to achieve a common goal. Weaknesses of national level systems for nutrition are further compounded by an ineffective international system with weak co-ordination and limited collective action.

In spite of these challenges, evidence shows that improvements in nutrition are attainable. Economic growth is a crucial catalyst for improving nutrition, but on its own it is not enough. Given the major disparities in nutritional status between poor and better off families, inequitable economic growth does little to improve nutrition but economic growth that reaches the poorest can play an important part in the overall response. However, even if growth is equitable, it is not enough to deliver the fast results

required, so investment in direct and indirect approaches must be given equal attention. Proven direct interventions can, if delivered at scale, reduce stunting by a third. These must be supported by indirect interventions to eliminate stunting in the longer term.

Framework for Action

This strategy rests on a set of core principles which commit us to concentrating our resources where we can achieve the greatest short and long term impact. We will focus on reaching pregnant women and children under the age of two in countries with the highest burden of undernutrition, because beyond a child's second birthday the damage from chronic undernutrition cannot be corrected. We will invest in direct interventions which we know achieve high impact at low cost, as well as indirect interventions which tackle underlying causes. And we will pay specific attention to women's power and agency, since gender inequality blocks progress in tackling undernutrition in multiple sectors.

The strategy has four strategic objectives:

1. MOBILISING AND COORDINATING THE INTERNATIONAL RESPONSE. We will work with our partners to secure a more co-ordinated and more effective international response to this neglected crisis. We will help to move this issue up the political agenda, help mobilise more resources where they are needed and monitor progress at the highest levels. In 2010 we will support the development of a Global Action Plan on nutrition to be launched at the MDG Review Summit in September.

2. REACHING 12 MILLION CHILDREN THROUGH PROGRAMMES IN OUR PARTNER COUNTRIES. We will focus our direct support on those six countries that together account for half of the world's undernourished children under five. We are confident that we can improve the nutrition of at least 12 million children over the next five years – 10% of all undernourished children around the world. We will also continue to focus on nutrition in our emergency response work.

3. INVESTING IN MULTIPLE SECTORS TO DELIVER IMPROVED NUTRITION. We will make sure our support for social protection, agriculture, health, water and sanitation, governance and education delivers meaningful improvements in nutrition too. This means, for example, making sure that our support to national health plans leads to more women and children getting the proven low cost interventions such as support for breastfeeding or vitamin and mineral supplements. Or, in social protection, making sure that women receive income support when they most need it over the maternity period.

4. BUILDING EVIDENCE AND DEMONSTRATING RESULTS. We will invest in research and evaluation programmes so that we can measure the impact of our work and make it easier for effective approaches to tackling undernutrition to be widely adopted. We know how to reduce undernutrition by a third, just by scaling up a small set of high impact health services. But the evidence on how to tackle the underlying causes is much less clear. We will address some of these critical gaps in knowledge.

We will monitor the implementation of this strategy on an annual basis and boost our own capacity to deliver it. Undernutrition must be addressed as a priority if DFID is to deliver on its commitment to poverty reduction. The strategy outlines how we will work with others to achieve this.

Glossary

Malnutrition: an abnormal physiological condition caused by deficiencies, excesses or imbalances in energy, protein and/or other nutrients.

Undernutrition: when the body contains lower than normal amounts of one or more nutrients, i.e. deficiencies in macronutrients and/or micronutrients. *'Undernutrition encompasses stunting, wasting and deficiencies of essential vitamins and minerals (collectively referred to as micronutrients).'*[1]

Undernutrition is also indicated by clinical signs (e.g. bilateral oedema, goitre for iodine deficiency) or biochemical indices (e.g. haemoglobin level for iron deficiency anaemia).

Severe Acute Malnutrition (SAM): a weight-for-height measurement of 70% or less below the median or 3 SD or more below the mean international reference values, the presence of bilateral pitting oedema, or a mid-upper arm circumference of less than 115 millimetres in children six – 60 months old.[2]

MDG 1: Millennium Development Goal 1 – to eradicate extreme poverty and hunger – has two associated indicators for its hunger target:

1) **Prevalence of underweight among children under five years of age** measures undernutrition at an individual level. Data compiled by the UN allows comparison across countries.
2) **Proportion of the population below a minimum level of dietary energy consumption** measures hunger and food security, and is measured only at a national level (not at an individual level) through national food balance sheets based on aggregate data on food availability and assumed patterns of food distribution in each country. However, increased aggregate food availability is not synonymous with improving nutrition.

Food security: when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life. **Nutrition security** is achieved when secure access to appropriately nutritious food is coupled with a sanitary environment – alongside adequate health services and care, this ensures a healthy and active life for all household members.

Hunger: is often used to refer in general terms to MDG1 and food insecurity. Acute hunger occurs when lack of food is temporary, and is often caused when shocks such as drought or war affect vulnerable populations. Chronic hunger is a constant or recurrent lack of food and results in underweight and stunted children, and high infant mortality. 'Hidden hunger' is a lack of essential micronutrients in diets.

[1] Black, RE; Allen, LD; A Bhutta, ZG; Caulfield, LE; De Onis, M; Ezzati, M; Mathers, C; Rivera, J, for the Maternal and Child Undernutrition Study Group, 2008, Maternal and child undernutrition: global and regional exposures and health consequences. The Lancet, Vol 371, February 2, 2008.

[2] WHO/UNICEF, 2009, WHO child growth standards and the identification of severe acute malnutrition in infants and children – A Joint Statement by the World Health Organization and the United Nations Children's Fund. Geneva.

The Neglected Crisis of Undernutrition: **DFID's Strategy**

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CHAPTER 1

Introduction

The focus of the strategy is on undernutrition: the most pervasive form of malnutrition to date in the poorest countries, where DFID concentrates the bulk of its assistance.

Tackling undernutrition is core to the Department for International Development's mandate, as nutrition and poverty are closely interrelated. Undernutrition is both a cause and an outcome of poverty.

The global target of reducing by half the prevalence of underweight children under five years of age by 2015 shows wholly insufficient progress. The recent global crises, the growing effects of climate change and the persistence of state fragility threaten to reverse these already meagre achievements.

Undernutrition undermines progress towards other MDGs including maternal health, child mortality and education. Reducing undernutrition contributes to their attainment.

With less than five years to go to 2015, a massive international effort is required as a matter of urgency.

DFID has been supporting nutrition and investing heavily in related sectors, but progress has not been fast enough. For these reasons, DFID has decided to increase its focus on nutrition and strengthen its capacity to respond to the ongoing nutrition crisis.

This document sets out DFID's strategy to tackle undernutrition. It presents a brief overview of the situation and its implications for DFID's role and priorities in nutrition over the coming years.

Child undernutrition encompasses several conditions:

- intrauterine growth restriction resulting in low birth weight*;
- stunting or chronic undernutrition, a chronic restriction of growth in height indicated by a low height-for-age;
- wasting, an acute weight loss indicated by a low weight-for-height, together with bilateral oedema (kwashiorkor) constitute acute undernutrition;
- and less visible micronutrient deficiencies (e.g. iron deficiency anaemia).

Underweight – a composite measure of both stunting and wasting – is used to assess progress towards the MDG 1 hunger target.

* Low birth weight is also a sign of prematurity

The development of this strategy was guided by recent publications, a review of the evidence *(The neglected crisis of undernutrition: Evidence for Action)*, contributions from a range of DFID departments and public consultation.

The focus of the strategy is on undernutrition: the most pervasive form of malnutrition[3] to date in the poorest countries, where DFID concentrates the bulk of its assistance.

[3] Malnutrition includes both undernutrition and overnutrition.

CHAPTER 2

The problem: an ongoing nutrition crisis

178 million children (one in three) under five years of age are stunted, with short height for their age. Their chronic malnutrition is usually the result of a poor diet and disease over a prolonged period.

2.1 Scale

According to latest estimates:[4]

- 178 million children (one in three) under five years of age are stunted, with short height for their age. Their chronic malnutrition is usually the result of a poor diet and disease over a prolonged period.
- about 55 million children suffer from wasting (acute malnutrition), with low weight for their height. This is equivalent to the total number of children under five years of age in industrialised countries.[5] Nineteen million are severely wasted, usually the result of a severe lack of food and/or disease.
- an estimated 13 million children annually are born underweight due to poor growth in the womb.
- vitamin A deficiency accounts for 6.5% of the deaths of children under five, and 20% of maternal deaths are attributable to iron deficiency anaemia.[6]

This is a human disaster on a vast scale, but concentrated in relatively few countries. In 26 countries levels of stunting exceed 40% (see figure 1). About 80% of the world's stunted children live in 20 countries (see figure 2), and 90% in 36 countries. These are mostly in sub-Saharan Africa and South Asia (see figure 1).

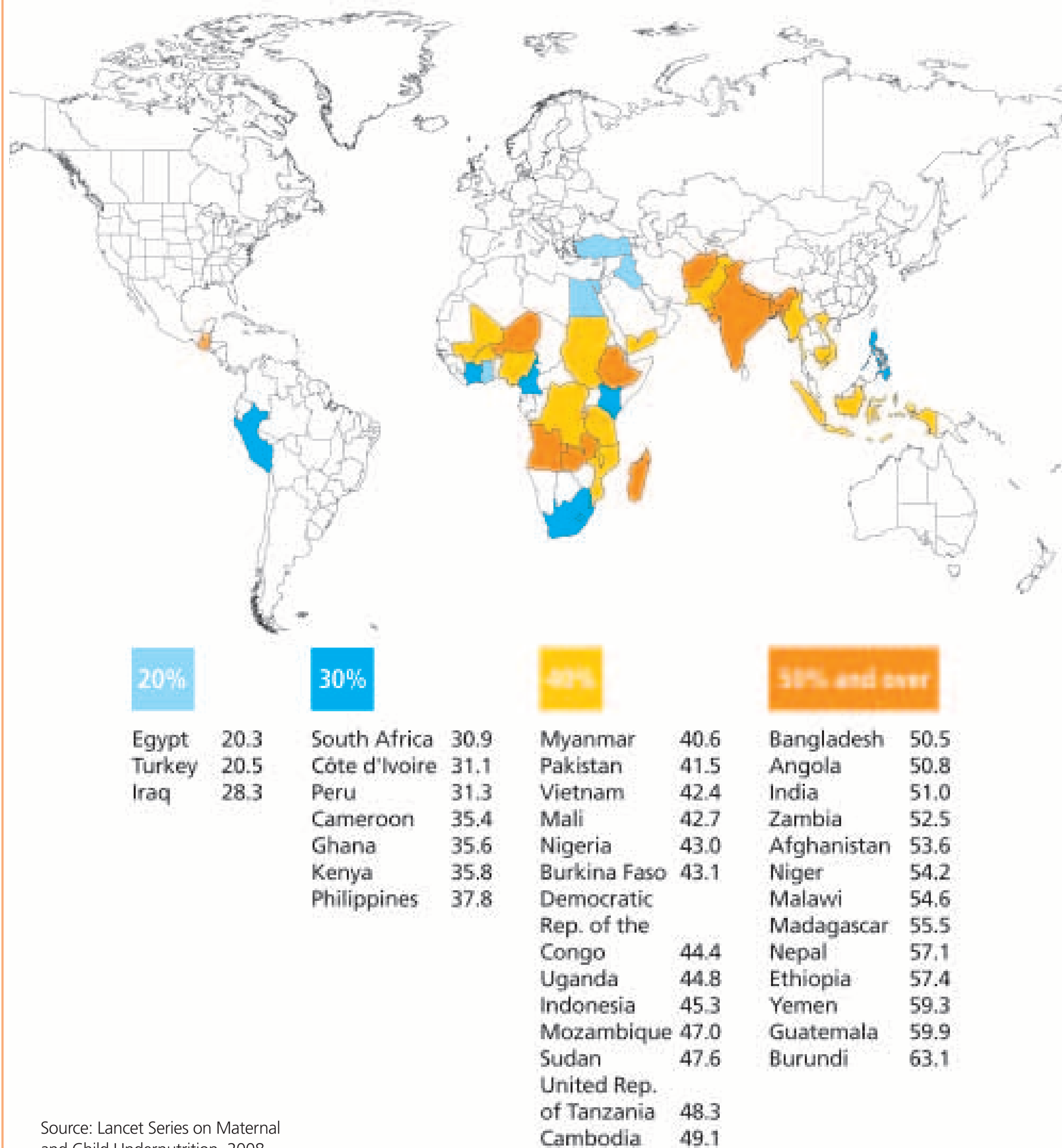
South Asia exhibits the largest number of stunted children worldwide and the highest prevalence and numbers of wasted children. India is home to more than a third of the world's stunted children, with 61.2 million.

[4] Lancet Series on Maternal and Child Undernutrition, 2008 (data from 2005). UNICEF/The Micronutrient Initiative, 2004, Vitamin and mineral deficiency – A global progress report. UN, 2009, The Millennium Goals Report.

[5] According to the UNICEF State of the World's Children 2009 report, there are 54.9 million children under five years of age in industrialised countries.

[6] UNICEF, World Bank, MI, GIN, FFI and USAID, 2009, Investing in the future: a united call to action on vitamin and mineral deficiencies.

Figure 1: Countries with the highest prevalence of childhood stunting.
Countries with ≥ 20% stunting, from among those which in total have 90% of the world's stunted children.



Source: Lancet Series on Maternal and Child Undernutrition, 2008.

Over the last 17 years, the number of underweight children under five in developing countries has decreased from 31% to 26%[7], but this progress leaves the world far short of the hunger target.

The prospect for an improvement is bleak. Even before the food/fuel crisis and the economic downturn, the number of underweight children in Africa was projected to

[7] Fanzo et al, 2009, An Evaluation of Progress Toward the Millennium Development Goal One. Hunger, 2009, Target: A country-level, food and nutrition security perspective.

increase. According to the 2009 Millennium Development Goals (MDG) report "Scant progress on child nutrition is likely to be eroded by high food prices and the state of the global economy."[8]

GUIDING PRINCIPLE:

We will focus our attention where we can achieve the greatest short and long term impact by concentrating on countries which have a high burden of undernutrition. We will prioritise women and children during the period from preconception to two years of age, tackling both acute and chronic undernutrition. We will particularly focus on the poorest and most excluded women and children, since they carry the highest burden of undernutrition.

2.2 Consequences

The costs of undernutrition are pervasive, spanning generations and further deepening poverty.

Undernutrition and survival

More than a third of child deaths worldwide are associated with undernutrition:[9] 3.1 million children under five years,[10] equivalent to the entire population of under fives in England,[11] in 2008. Iron deficiency anaemia and maternal short stature are implicated in one in five maternal deaths.[12]

Undernutrition and health

Undernutrition contributes 35% of the disease burden amongst children under five and 11% of the total global disease burden.[13] In 2004, this disease burden among children under five equated to an estimated 150 million years of healthy lifetime lost, five times that lost to malaria.[14] Early childhood undernutrition increases adult risk of chronic disease if children gain weight rapidly later in childhood and adolescence.[15]

Humanitarian situations and acute malnutrition

Emergencies, whether due to conflict or natural disasters, are often characterised by a high prevalence of acute malnutrition. In the Republic of Congo in 1999 malnutrition was a principle cause of death amongst the displaced and one third of the children in a camp in Brazzaville were suffering from acute malnutrition.[16]

[8] UN, 2009, Millennium Development Goals Report.

[9] Lancet Series on Maternal and Child Undernutrition, 2008.

[10] According to UNICEF, an estimated 8.8 million children under-five died in 2008. Source: 'Press release – Global child mortality continues to drop, UNICEF, 10 September 2009'. Undernutrition is implicated in 35% of these deaths.

[11] 3.1 million in 2008 Source: 'Mid-2008 population estimates; England and Wales; estimated resident population by single year of age and sex, Office for National statistics, 27/08/09'.

[12] Lancet Series on Maternal and Child Undernutrition, 2008.

[13] Estimated by Disability-Adjusted Life Years (DALYs) – a measure of the burden of ill health taking into account reduced life expectancy and quality of life. The number of DALYs lost as a result of disease is calculated by estimating the number of years lost due to premature death plus equivalent years of ill health.

[14] See Table 1, p33 in DFID, 2009, The Neglected Crisis of undernutrition: Evidence for Action.

[15] Victora et al, 2008, The Lancet Series.

[16] Salignon et al, 2000, Health and War in Congo Brazzaville. Lancet Vol 356 Issue 9243.

Undernutrition and HIV and AIDS

The HIV epidemic largely overlaps with populations already experiencing low diet quality and quantity. Under nutrition compounds HIV positive men, women and children's susceptibility to other infections which then worsens their undernutrition.[14]

Undernutrition, women and future generations[17]

Unborn children are at risk of poor growth and low birth weight when their mothers suffer from undernutrition. Closely spaced births and teenage pregnancy can also lead to intrauterine growth restriction. Undernutrition developed in utero may persist until adulthood. Undernourished girls are more likely to become short women who are more likely to give birth to small babies.[18] Undernutrition is perpetuated across generations.

Undernutrition and education

Undernutrition impairs cognitive development, increases the risk of poor school performance[19] and slows down progress towards MDG 2 (Universal Primary Education). For instance, iron deficiency anaemia consistently reduces children's performance on tests of mental abilities.[20]

Undernutrition and productivity

Through the loss of human capital (lasting physical and mental deficits), undernutrition reduces individuals' and societies' productivity and contributes to the perpetuation of poverty. The economic losses attributable to undernutrition can reach 2 – 3% of GDP according to the World Bank.[21]

The crucial window of opportunity

Physical and cognitive damages associated with poor foetal growth and stunting are largely irreversible after the age of two years. There is a crucial window of opportunity – from **pre-pregnancy to 24 months of age** – during which it is critical to ensure that the right conditions are in place for optimal foetal and early childhood growth. It is crucial to prevent accumulated mental and physical losses from becoming permanent and to avoid the long-term consequences of undernutrition.

[17] Lancet Series on Maternal and Child Undernutrition, 2008.

[18] Victora et al, 2008, the Lancet series. In India, for example, maternal birth weight is a strong predictor of offspring birth weight, even after adjustment for maternal adult size.

[19] Alderman, H; Hoddinott, J; Kinsey, B, 2006, Long term consequences of early childhood malnutrition. Oxford Economic Papers, 58, 450-474.

[20] Performance was reduced by 0.5 to 1.5 standard deviations in children Source: World Bank, 2006, Repositioning Nutrition as Central to Development – A Strategy for Large-Scale Action. World Bank, Washington DC.

[21] World Bank, 2006, Repositioning Nutrition as Central to Development – A Strategy for Large Scale Action. World Bank, Washington DC.

2.3 The benefits of investing in nutrition

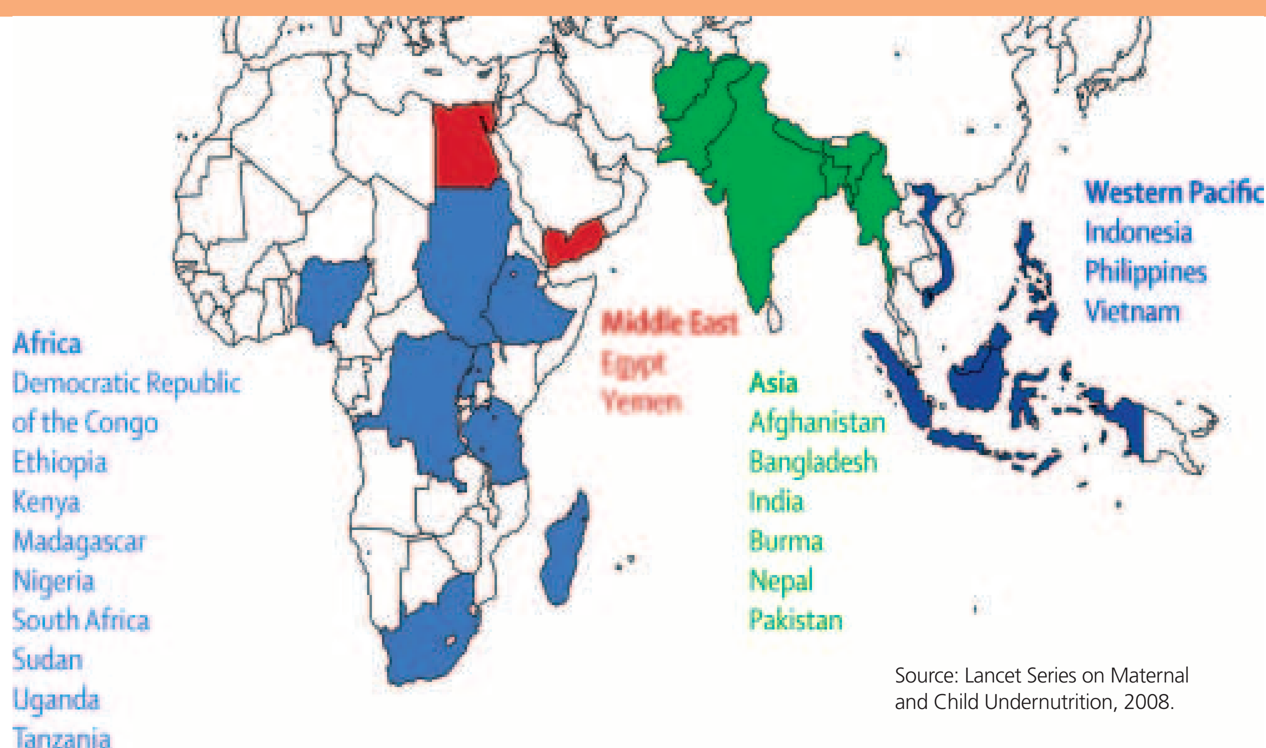
Conversely, sound nutrition can bring profound benefits in terms of survival, health, education, economic growth, poverty reduction and empowerment. It is a foundation for the attainment of the MDGs and an investment in the future. The World Bank reports that, with effective policies to tackle anaemia in women, US$100 million in agricultural productivity over five years could be gained in Sierra Leone.[22]

Economic gains through improvement in nutritional status – the example of the UK

The Nobel Prize Winner in Economics, R.W. Fogel estimated the contribution of improved nutrition/increased food energy intake to the UK's economic growth:

"The combined effect of the increase in dietary energy available to work, and of the increased human efficiency in transforming dietary energy into work output, appears to account for about 50% of the British economic growth since 1790."[23]

Figure 2: The 20 countries with the highest burden of undernutrition.
Countries with stunting prevalence ≥ 20% in children under the age of five years that together account for > 80% of the world's undernourished children. Colour denotes region.



Source: Lancet Series on Maternal and Child Undernutrition, 2008.

[22] Aguaya, VM et al on behalf of the PROFILES study group in Sierra Leone, 2003, Sierra Leone – investing in nutrition to reduce poverty: a call for action Public Health Nutrition: 6(7), 653–657.

[23] Fogel, FW, December 1983, Nobel lecture: Economic growth, population theory and psychology: the bearing of long-term processes on the making of economic policy.

CHAPTER 3

The determinants

The insufficient progress already achieved towards the hunger target could be reversed by the economic downturn, the persistence of conflicts, state fragility and the increasing impact of climate change.

3.1 Immediate, underlying and basic causes

Undernutrition, whether acute or chronic, arises from complex, multiple and interactive causes. Figure 3 illustrates the types of causes and their interactions, at three levels: immediate, underlying and basic.

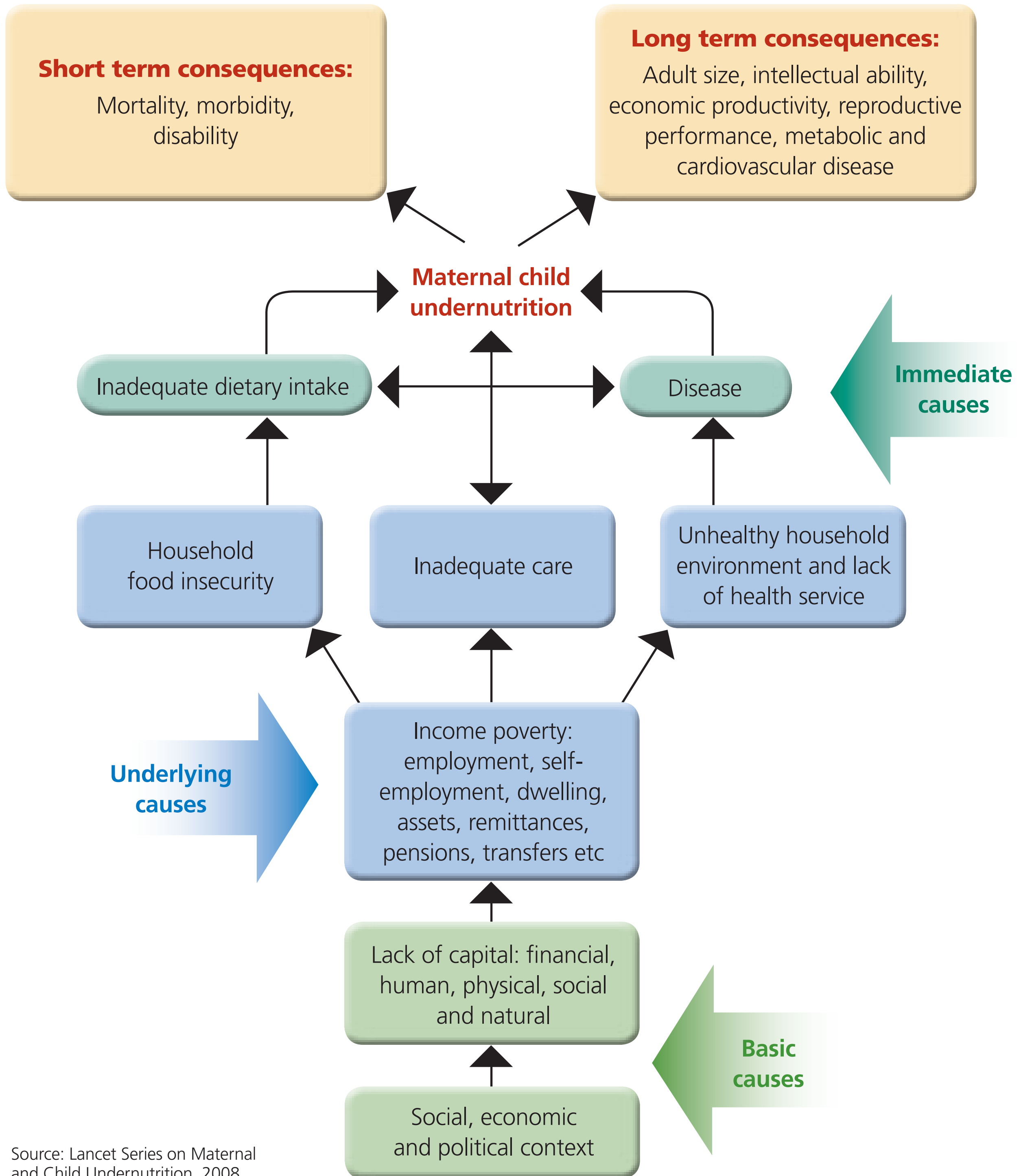
The immediate causes – inadequate dietary intake and disease, including water and sanitation related disease – operate at the individual level. Underlying these are causes operating at household and community levels: household food insecurity, inadequate care for children and women, unhealthy household environment and lack of health services. Income poverty underpins all three. Ultimately, these factors are determined by the larger political, economic, social and cultural environment. Gender inequalities act at all levels. Gendered power relations are a key factor in decision making within the household and often in ensuring the entitlement of female household members (and female headed households) to adequate nutrition.

The complex causality calls for a multi-sectoral approach and action at different levels to address undernutrition effectively in the long term. It calls for national governments and other actors to understand the patterns and particular drivers of chronic and acute undernutrition in any country or area.

GUIDING PRINCIPLE:

We will respond to undernutrition through work in multiple sectors.

Figure 3: Framework of the causes of maternal and child undernutrition and its short term consequences



Source: Lancet Series on Maternal and Child Undernutrition, 2008.

3.2 Challenges of a changing world: economic downturn, conflict/state fragility and climate change

The insufficient progress already achieved towards the hunger target could be reversed by the economic downturn, the persistence of conflicts, state fragility and the increasing impact of climate change.

DFID's commitments:

- We will work to ensure that social protection systems are in place to help the millions of vulnerable people who cannot produce or buy enough food to feed themselves and their families.
- We will also support improved social protection programmes in places at risk of malnutrition or food shortages.[26]

The combined effect of the food and fuel price crisis and the following economic downturn have inevitably resulted in an increase in the severity and incidence of poverty and a rise of undernutrition. States' ability to deliver services and household purchasing power have been affected. The World Bank estimates that the fuel and food price crisis alone has pushed as many as 130 – 155 million more into poverty and hunger.[24] By mid-2009, The UN Food and Agriculture Organization (FAO) estimated that the number of people suffering from hunger had exceeded one billion.[25]

State fragility results in reduced access to basic services and increased threats to life. The burden of disease, mortality and undernutrition borne by fragile states is high. Emergency situations, caused by conflict or natural disasters, are often characterised by a high prevalence of acute malnutrition and micronutrient deficiencies. Globally, more than a third of stunted children live in fragile countries. Renewed efforts to address undernutrition in these contexts are required.

GUIDING PRINCIPLE:

Where appropriate, we will help to bridge the gap between humanitarian assistance and long term development systems, to maximise progress in tackling chronic and acute undernutrition.

Overall, levels of hunger are expected to decline over the coming 50 to 70 years as a result of socio-economic development. But **climate change** is projected to reduce progress. The proportion of people made hungry by climate change is likely to increase with the higher frequency and severity of extreme weather events, flooding and drought. These undermine already precarious livelihoods, creating greater poverty and undernutrition. By 2050, the number of people at risk of hunger because of climate change will be 10 to 20% higher than it would have been in the absence of climate change.[27]

[24] The World Bank, 2009, Global Economic Prospects 2009 – Commodities at the Crossroads.
[25] More people than ever are victims of hunger, FAO, 15/06/09.
[26] DFID, July 2009, Eliminating World Poverty: Building our Common Future.
[27] World Food Programme, 2009, Climate change and hunger: responding to the challenge.

CHAPTER 4

The response

Economic growth is a crucial catalyst for improving nutrition, but on its own it is not enough.

4.1 The necessary interventions

Improvements in rates of undernutrition are attainable and vital to sustain economic growth. Economic growth is a crucial catalyst for improving nutrition, but on its own it is not enough. Given the major disparities in nutritional status between poor and better off families, inequitable economic growth does little to improve nutrition.

> The rapid gains in nutrition made by Vietnam in the 1990s are attributed half to its balanced economic growth and half to deliberate improvements in direct and indirect nutrition investments.[28]

Equitable growth that reaches the poorest can play an important part in the overall response. However, even if growth is equitable, it is not enough to deliver the fast results required, so investment in direct and indirect approaches must be given equal attention.

4.1.1 Direct responses to undernutrition

Direct interventions are usually targeted at the immediate causes – inadequate dietary intake and disease – and poor caring practices. The review of evidence conducted for the 2008 Lancet series on Maternal and Child Undernutrition focused mainly on direct interventions and recommends a set of actions with proven effectiveness (see Table 1).

Table 1: Direct interventions with demonstrated effectiveness on maternal and child undernutrition[29]

Maternal and birth outcomes	Newborn babies	Infants and young children
Iron folate supplementation Maternal supplements of multiple micronutrients Maternal iodine through iodisation of salt Maternal calcium supplementation Interventions to reduce tobacco consumption or indoor air pollution	Promotion of breastfeeding (individual and group counselling)	Promotion of breastfeeding (individual and group counselling) Behaviour change communication for improved complementary feeding for infants* Zinc supplementation Zinc in management of diarrhoea Vitamin A fortification or supplementation Universal salt iodisation Hand washing or hygiene interventions Treatment of Severe Acute Malnutrition

*In food-insecure populations additional food supplements might be necessary

[28] O' Donnel, O; Lopez Nicolas, A; Van Doorslaer, E, 2009, Growing richer and taller: Explaining change in the distribution of child nutritional status during Vietnam's economic boom. Journal of Development Economics. Vol 88, Issue 1, pp 45-48.

[29] Lancet series on Maternal and Child Undernutrition, 2008.

Of the interventions reviewed, breastfeeding promotion, complementary feeding, vitamin A and zinc supplementation and management of severe acute malnutrition showed most promise for reducing child deaths and the future disease burden related to undernutrition.[30]

The Copenhagen Consensus Initiative found that the development intervention with the highest benefit to cost ratio is the provision of micronutrients supplements (vitamin A and zinc) to children in developing countries.[31]

The authors of the 2008 nutrition Lancet series estimate that universal coverage with the full package of proven interventions "could prevent about one quarter of child deaths under 36 months of age and reduce the prevalence of stunting at 36 months by about one third." Such levels of improvement, according to the Lancet,[32] would result in "averting some 60 million DALYs [disability-adjusted life years]" in the 36 countries with 90% of stunted children under five.

These interventions are highly cost effective: Table 2 shows that it costs some US$3-70 per year of healthy life saved for a range of proven direct nutritional interventions. This compares with US$11 for bed nets and US$922 anti-retroviral therapy for HIV/AIDS. However, there remains a significant funding gap, despite the cost effectiveness of these interventions.[33]

Breastfeeding: increasing the chance of survival and healthy development

Breastfeeding has been shown to protect from diseases, promote healthy child development and reduce mortality in newborns and young children. Exclusively breastfeeding in the first six months of a child's life is one of the most effective ways to ensure health and survival. This can be particularly important during humanitarian crises.

For instance, DFID-funded research in Ghana showed that 22% of newborn deaths could be prevented by starting to breastfeed them within the first hour of birth. Four million babies in the developing world die each year in the first month of life.[34]

WHO estimates that "a lack of exclusive breastfeeding during the first six months of life contributes to over a million avoidable child deaths each year."[35]

[30] These lists of interventions are indicative and should be revised in light of future research findings.
[31] Horton S et al, 2008, Copenhagen Consensus 2008 Challenge Paper – Hunger and Malnutrition.
[32] Lancet, 2008. Estimates vary for this figure with a range of 30-60 million DALYs.
[33] Horton S et al, 2009, World Bank 2009, Scaling up Nutrition: What will it cost?
[34] DFID Research Strategy, 2008-13.
[35] WHO, July 2009, 10 facts on breastfeeding.

Table 2: Cost effectiveness of direct nutrition interventions[36]

Condition	Intervention	Cost-effectiveness (US$) per DALY averted
Nutrition	Promotion of breastfeeding	3-11
	Zinc in management of diarrhoea	73
	Vitamin A fortification	33-35
	Vitamin A supplementation	6-12
	Universal salt iodisation	34-36
	Iron fortification	66-70
	Hygiene promotion	3
	Treatment of Severe Acute Malnutrition (example of Zambia)	(41)[37]
Example child health & nutrition package	***Sustained child health & nutrition programme*** that can include prenatal care, women's health & nutrition, breastfeeding promotion, complementary feeding, micronutrient supplementation, supplementary feeding with local supplies etc (mix depends on local capacity/conditions)	225
Other health interventions	Traditional Expanded Programme on Immunisation (EPI)	7
	Case management of mild to very severe lower respiratory infections	398
	Family planning programmes	117
	HIV peer education programmes for high risk groups	37
	Anti-retroviral therapy for HIV/AIDS	922 (sub-Saharan Af)
	Insecticide-treated bed nets for malaria prevention	11 (sub-Saharan Af)
	Directly observed short-course therapy for tuberculosis in endemic areas[38]	5-50

[36] Jamison, TJ et al, 2006, Disease Control Priorities in Developing Countries.

[37] Bachmann, M, 2009, Cost Effectiveness of Community Therapeutic Care for Children with Severe Acute Malnutrition in Lusaka, Zambia.

[38] For all regions excluding Eastern and Central Europe.

4.1.2 Indirect responses that tackle the economic, political, social and cultural causes of undernutrition

Although substantial, the contribution of direct interventions will be insufficient. Two thirds of stunting will not be addressed through these interventions. Indeed the direct interventions are estimated to avert 60 million DALYs yet 150 million are attributable to undernutrition. If we are to achieve a long lasting difference, it is imperative to simultaneously focus on indirect interventions that are intended to address underlying and basic causes.

These can be:

- social transfers and other **social protection measures** that provide effective and predictable support to poor and vulnerable families and tackle social exclusion.
- **food security and agricultural interventions** that increase families' access to a balanced, affordable diet.
- **primary and maternal and child health care** including interventions that prevent and treat health related causes and consequences of chronic acute undernutrition.
- programmes that ensure poor families have access to **clean and safe drinking water and improved sanitation and hygiene**.
- education, especially **girls' education** which has proven impacts on the better care and survival of their children.
- trade reforms, **women's empowerment** (see box right), increased equity and improved governance that address the basic causes of undernutrition.

For example, there is growing evidence that social transfers can significantly contribute to reducing undernutrition, not just for the transfer recipient, but also for other household members. Through addressing the financial and material determinants of undernutrition, they can have an impact on the key underlying causes: increasing access to food, dietary diversity, health care and education.

Example of impact of an indirect intervention: social transfers

South Africa Old Age Pension and Child Support Grant
Research data shows that receipt of the unconditional child support grant in South Africa increases the height of children who receive it by 3.5cm, if it is received in their early years. The old age pension increases the height of girls who are living with pension recipients by over two centimetres (Aguero et al, 2009). There are gendered differences in the sharing of pensions, with a greater proportion of women's pensions being spent on food, and women's pensions showing particular improvement in the height and weight of girls (Duflo, 2003).

Nicaragua Red de Proteccion Social
As part of this social protection scheme, households received a cash transfer conditional on using preventive health care and education services. In a country where stunting affects nearly a fifth of children under five, the levels of stunting for those benefiting from the scheme were 5% lower than for those not benefiting.[39]

[39] Maluccio, J, et al, IFPRI, 2004, Impact evaluation of a conditional cash transfer program: the Nicaraguan Red de Proteccion Social.

There is less evidence overall about the effectiveness of indirect interventions, compared to direct. This is because, first, these interventions rarely have a stated nutrition objective and hence are not evaluated by this criterion. Second, it is difficult to ascertain their impact on undernutrition when they are preventative or when a complex causal pathway is involved. Therefore there is a need to expand the evidence base for these actions, which should be more systematically designed and combined to improve nutrition outcomes.

Women and girls at the heart of the solution

Nutrition is intricately linked to women's biological, economic and socially constructed gender roles. Lifting the economic, political, social and cultural barriers that prevent women and girls from fulfilling their potential and tackling undernutrition are mutually reinforcing goals.

Improving women's nutritional status has a multiplier effect. It benefits women's and young children's nutritional status and that of the next generation.

Women are the main care providers during the first two years of life, a crucial period for a child's nutrition and development. Ensuring women have the means and time to breastfeed and provide adequate care is essential to the reduction of undernutrition. Women also often make a major contribution to household food security.

Children's nutritional status is negatively affected by women's low status when they "tend to have weaker control over household resources, tighter time constraints, less access to information and health services, poorer mental health, and lower self-esteem."[40] Gender-balanced access to opportunities and control over resources benefit the nutritional status of the entire family as well as empowering women within their households and communities.

In order to reduce undernutrition, there must be:

- greater prioritisation of women and adolescent girls in nutrition and health policies (e.g. maternal and reproductive health policies) and education policies that improve female access to education. The link between girls' education and smaller, healthier families is well established.
- economic empowerment of women as they are more likely to spend their earnings on food for the family.
- gender sensitive social protection policies (e.g. measures to reduce pressure on women to contribute economically to the household during the later stages of pregnancy and while breastfeeding, and to provide child care to enable women to work).

[40] Smith et al/IFPRI, 2003, The importance of women's status for child nutrition in developing countries.

Women and girls at the heart of the solution *(continued)*

- access to a range of family planning methods which allow women to choose when and how many children they have. According to UNICEF, "teenagers who give birth when their own bodies have yet to finish growing also have a greater risk of bearing underweight babies".[41]
- gender sensitive economic policies (e.g. agricultural policies to enhance nutrition outcomes and to promote greater equality of access by women farmers and food producers to land, credit and farm inputs).
- legal frameworks which protect women's rights (e.g. land inheritance rights).
- increased participation and representation of women in decision making at all levels of the political and public arena.

GUIDING PRINCIPLE:

Throughout our work in nutrition we will pay specific attention to women's power and agency, since gender inequality blocks progress in tackling undernutrition in multiple sectors.

[41] http://www.childinfo.org/low_birthweight.html.

4.2 Challenges of implementing the response at national level

National capacity and response are often weak in countries with a high burden of undernutrition. Acknowledging the extent of the nutrition problem is a prerequisite to effective action. There is low political demand for action against undernutrition. Some 13 of the 20 countries that account for 80% of the world's undernourished children deem nutrition to be a low priority.[42]

Leadership and strategic capacity are essential ingredients for advancing the national nutrition agenda. An effective multi-sectoral approach requires clear delineation of the roles and responsibilities of each sector in order to achieve a common goal. Multi-sectoral work does not necessarily require that sectors work together at all levels, but in some instances joint action will enhance results, particularly when services are well integrated at user level.

Effective cross sector and inter-ministerial working remains a challenge due to divergent policy agendas, limited incentives for co-operation and limited technical and managerial capacity to deliver on nutrition. Federalism adds to the complexity. In countries such as Nigeria, India and Pakistan, 'joining up' necessitates effective working together across different tiers of government and multiple ministries.

An effective response requires:

- managerial and technical capacity;
- an information base relevant to decision making;
- adequate and sustained financial resources;
- implementation at scale of the right actions and effectively reaching those in need;
- active participation of communities, where the voices of traditionally excluded people are heard.

Weaknesses of national level systems for nutrition are further compounded by an ineffective international system that must be addressed.

4.3 Challenges of the international response

Lack of progress on nutrition is also a governance failure at international level. The international system is made of a poorly co-ordinated "constellation of institutions" that has been described as "a loose collection of entities that are focused largely on their own survival without an overriding logic or plan behind the division of responsibilities among them. As such, their roles and activities sometimes overlap, sometimes compete, and often reveal gaps".[43] Nutrition has been described as "an administrative and institutional orphan".[44] There is a need to establish strong leadership, coherence and clear allocation of responsibilities across the international system.

Action on nutrition tends to be narrowly defined and confined to three dimensions: behaviour change, reduction of micronutrient deficiencies and treatment of acute malnutrition. Action is marginalised within nutrition-relevant fields (health, food security, agriculture and broader poverty/development) and international initiatives and partnerships.

[42] Bryce et al, 2008, Maternal and child undernutrition: effective action at national level, (article 4, Lancet 371:510-26).

[43] Centre for Global Development, 2008, Review of the global nutrition ecosystem.

[44] Hunger Task Force, 2008, Report to the Government of Ireland.

A body, system and agreed framework are needed to facilitate the collaboration and contribution of relevant sectors, actors and international initiatives. More systematic reporting against nutrition indicators, as well as the use of nutrition outcomes as a key measure of programme success across sectors, are needed for nutrition to gain higher priority.

The international system is a means to an end: enabling developing countries to address undernutrition. Yet it does not effectively support national level action.

First, funding for nutrition is insufficient (particularly for direct interventions and for enabling strategies), mostly short term and sometimes poorly prioritised (geographically and thematically). Between 2000 to 2007, Official Development Assistance commitments for basic nutrition remained below £250 million per annum, in spite of very high investments in the health sector. The World Bank[45] estimates that an additional £6.18 billion per year would be needed to scale up 13 direct interventions[46] in the 36 worst affected countries. This could potentially prevent about 1.1 million deaths and 30 million cases of stunting among children under five years of age, in addition to averting 30 million DALYs lost per year.

GUIDING PRINCIPLE:

We will seek to make existing resources being channelled towards health systems and services, food security and agricultural production, social protection, water and sanitation more effective at reducing undernutrition, and address resource gaps where they exist.

Second, even in humanitarian situations, where undernutrition has traditionally been more visible and prioritised, "emergency response systems are fragmentary"[47]. Third, fluctuating priorities, inconsistent guidance and a lack of respect for locally generated solutions hinder effective support. Finally, the existing system does not enable developing countries affected by high levels of undernutrition to be heard in decision making on international policy and practice matters that are meant to help them.

A reform of the global nutrition system is needed to mobilise more resources and provide effective support at country level. This should happen in full consultation with nations with a high burden of undernutrition.

[45] World Bank, 2009, Scaling Up Nutrition: What will it cost?, Horton S et al.

[46] The 13 interventions fall under three broad categories: behaviour change communication, micronutrients and deworming interventions and complementary and therapeutic feeding.

[47] Lancet Series on Maternal and Child Undernutrition, 2008.

4.4 What DFID brings to the response

Undernutrition must be addressed as a priority if DFID is to deliver on its commitment to poverty reduction. We are well placed to make a difference.

DFID is involved in policy and programmes in fields that are essential to the sustainable reduction of undernutrition including health, food security, social protection, education and water/sanitation. We have done important cross-cutting work on gender and governance. Our expertise in working cross-sectorally under a poverty framework is highly relevant to nutrition.

DFID bilateral and multilateral spending in 2008/9 on sectors that relate to nutrition:

- Health: £959m
- Education: £711m
- Food & Agriculture: £378m
- Humanitarian: £317m
- Water & Sanitation: £134m
- Social Protection: £122m

Recent DFID high level commitments that relate to nutrition.[48]

- a White Paper commitment to continue to spend half of future UK direct support to developing countries on public services;
- £6 billion on health systems between 2009-2015;
- commitment to reach 50 million vulnerable people through support to social protection systems, including £200 million on social protection that will reach children vulnerable to HIV/AIDS;
- £8.5 billion on education between 2006-2015;
- £1.1 billion share of the global response to the food crisis.

DFID has a strong presence in many of the high burden areas – 14 of the 22 countries worst affected by undernutrition are DFID's priority countries.[49] We work across the range of contexts (humanitarian, development, fragile countries) where undernutrition is prevalent. We provide flexible resources suited to the various circumstances: directly to countries (general/sector budget), or to non-state actors (grants to NGOs, multilateral agencies and civil society groups).

[48] DFID White Paper, 2009, Eliminating World Poverty: Building our Common Future. Achieving Universal Access/ AIDS strategy 2008.

[49] DFID's priority countries are DRC, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Sierra Leone, Sudan, Tanzania, Uganda, Zambia, Zimbabwe, Afghanistan, Bangladesh, India, Nepal, Pakistan, Cambodia, Vietnam and Yemen.

GUIDING PRINCIPLE:

We will uphold the principles of aid effectiveness agreed in the Paris Declaration and Accra Agenda for Action.

Due to our decentralised structure and commitment to the aid effectiveness agenda,[50] DFID is ideally placed to support partner country priorities and country-led responses to build sustainable national systems that respond to and prevent undernutrition.

DFID has a significant potential influence with a range of stakeholders – including the UN family, the World Bank, other donors such as the EC and its partner countries in Asia and Africa – to move the international nutrition agenda forward.

Our substantial support to research, particularly health and agricultural research, and our commitment to building evidence, mean that DFID is well positioned to make a significant contribution to the nutrition research agenda.

[50] DFID promotes aid effectiveness in line with the five principles of the 2005 Paris Declaration on Aid Effectiveness: ownership, alignment, harmonisation, managing for results and mutual accountability.

Examples of DFID funded research

1. DFID co-funded the IDS Bulletin: "Lifting the curse: overcoming persistent undernutrition in India", a collection of papers investigating the Indian paradox of persistent undernutrition amid macro-economic growth. The research suggests concrete steps to redesign the Government's main programme to address undernutrition (the Integrated Child Development Scheme) and ways for the state and civil society to improve the governance of nutrition.[51]

2. The transformation of mungbean from a marginal to a major crop in Asia has boosted nutrition for poor and anaemic women and children, improved soil fertility, and provided poor farmers with a new income opportunity. DFID's investment of £450,000 between 1997 and 2004 funded research to identify the best early maturing mungbean lines that were resistant to yellow mosaic virus and get them into use in the rice-wheat cropping system in the Indo-Gangetic plains of South Asia. This led to a 28-55% improvement in incomes of small farmers, and improved the nutrition of 1.5 million anaemic children through greater availability of iron and protein in diets. Improved varieties are now grown on almost three million hectares of land across in Pakistan, Thailand, China, Bangladesh and Myanmar, and iron content is almost double that of traditional varieties.[52]

[51] IDS Bulletin, Volume 40, Number 4, July 2009.

[52] DFID, January 2009, Case Study of collaboration with the World Vegetable Centre, Counting on Beans: Mungbean improvement in Asia.

CHAPTER 5

Framework for action

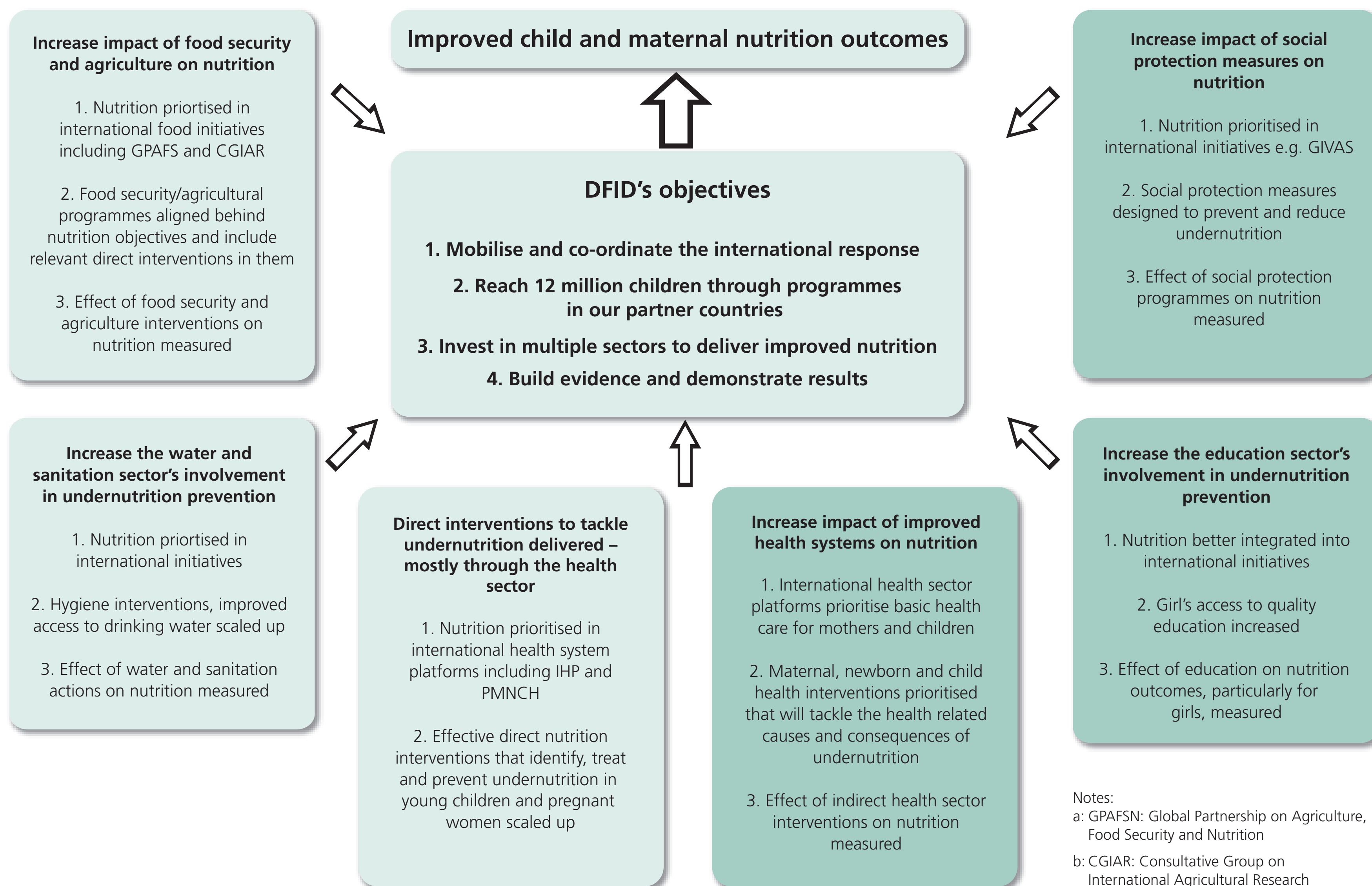
Our common goal is to eradicate poverty and hunger and to halve the prevalence of underweight children under five years of age by 2015. From 2010, we will monitor the nutrition indicator as part of our Public Service Agreement reporting.

Our common goal is to eradicate poverty and hunger and to halve the prevalence of underweight children under five years of age by 2015. From 2010, we will monitor the nutrition indicator as part of our Public Service Agreement reporting.

We will have five guiding principles for our work on undernutrition:

1. To focus on achieving the greatest short and long term impact by concentrating on countries with a high burden of undernutrition, prioritising women and children during the period from preconception to two years old and tackling both acute and chronic undernutrition. We will particularly focus on the poorest and most excluded women and children, who carry the highest burden of undernutrition.
2. To respond to undernutrition through work in multiple sectors (see Figure 4).
3. To uphold the principles of aid effectiveness agreed in the Paris Declaration and Accra Agenda for Action which are also expressed in the International Health Partnership and the Five Rome Principles for Sustainable Global Food Security.
4. To seek the increased effectiveness of existing resources being channelled towards health systems and services, food security and agricultural production, social protection, water and sanitation so that they better reduce undernutrition, addressing resource gaps where they exist. Where appropriate we will help to bridge the gap between humanitarian assistance and long term development systems, to maximise progress in tackling chronic and acute undernutrition.
5. Throughout our work in nutrition, pay specific attention to women's power and agency, since gender inequality blocks progress in tackling undernutrition in multiple sectors.

Figure 4



To progress towards our goal and implement this multi-sectoral approach, DFID will pursue four objectives:

1. **Building international support, co-ordination and coherence for global action on nutrition.** We will help co-ordinate efforts to strengthen commitment, coherence and funding for nutrition. DFID will do this within global, regional and national partnerships, initiatives and strategies.
2. **Identifying partners, building support and scaling up programmes in partner countries** in order to make direct impact on nutritional outcomes (through direct and/or indirect interventions).
3. **Ensuring our investments in multiple sectors deliver improved nutrition** by making explicit links to improved nutrition in programme design, monitoring and evaluation.
4. **Building evidence, demonstrating results:** we will strengthen the links between evidence, policy, results and impact, through country evaluations and investments in operational research.

5.1 Objective 1: Building international support, coordination and coherence for action on nutrition globally

5.1.1 Global partnerships and initiatives

We believe that greater global mobilisation and more effective international support are needed to achieve a significant reduction in undernutrition.

We will:

- support the development of a high level consensus on nutrition that clearly communicates the problem and how it should be tackled through a multi-sectoral approach. It will establish policy coherence in nutrition and provide a framework for harmonised action by the main actors. This consensus will be an important milestone signalling a dramatic acceleration of progress towards achieving nutrition targets, and should be a major focus for the Millennium Review Summit in September 2010. We will support the role of the UN Special Representative on Food Security and Nutrition in this initiative.
- support additional efforts to raise the political profile of, and momentum for nutrition among heads of state, exploring the best mechanisms to achieve this with our partners. We will specifically facilitate the involvement of countries with a high burden of undernutrition in this effort.
- push to improve governance on nutrition, in particular the improvement of UN and World Bank co-ordination at international level.

- explore options for plugging gaps in information collection, analysis and reporting as this is a critical ingredient for stimulating and monitoring progress. Specifically we will seek to improve the diagnostics of undernutrition at national level and the availability of nutritional outcome data to pick up the effects of global and local shocks.
- continue to work with others to attain MDG 1 by 2015. We will also support efforts to improve reporting of progress on nutrition indicators by monitoring policy commitments, budgets, coverage of key services and nutritional outcomes. We will engage in the debate to promote the adoption of a new post-MDG framework suited to the nutrition challenges of a changing world.

5.1.2 Institutional relationships

Recognition of the nutrition challenge is increasing among international agencies. We will capitalise on this momentum and work closely with others for progress.

The **EU** is building its capacity to tackle undernutrition. Through it, the UK has an opportunity to operate on a broader scale. It can increase its influence in global debates and make an extra impact on nutrition beyond that which we could achieve by ourselves. We will:

- contribute to EU relevant strategies/policy development, with a focus on their nutrition, food security, social protection and health strategies, so that its strategic framework is designed to maximise nutrition outcomes and funding prioritises nutritional outcomes.
- push the EC to report on nutrition indicators, i.e. the inclusion of nutrition indicators in National Indicative Programmes in high burden countries.
- support the EC's role in convening member states on nutrition.

Because of its mandate and broad country presence, the **UN** is an important partner in nutrition. Specifically, we will work with UNICEF, WFP, FAO and WHO, who each have a mandate in nutrition.

We will:

- push for UN coherence, more effective responses to undernutrition that move beyond multi-agency projects, co-ordination of UN agencies around a single common framework, and delivering as One United Nations.
- ensure UNICEF scales up direct nutrition actions and develops harmonised, integrated, evidence-based policies and practice.
- ensure WHO does more to provide normative standards and frameworks to support governments in the efforts to tackle undernutrition.
- support WFP to enhance the nutritional impact of food assistance (food transfers, cash transfers and vouchers) notably in emergencies, particularly for women and young children.

The **World Bank** is an important player, with its long term commitment to tackling undernutrition and its substantial investments in poverty alleviation and social protection. It has the potential to mobilise relevant sectors for the reduction of undernutrition and maximise its impact. We will push to secure more support for nutrition from key units within the World Bank. We will encourage joined up working on a shared nutrition agenda, increased capacity and increased effectiveness.

To continually improve our policies and practice, we will seek partnerships with civil society and non-governmental organisations who have a proven track record in nutrition. We will form partnerships with organisations who are able to fill evidence gaps in the effort to tackle undernutrition. We will also support civil society to mobilise more effectively in order to advocate for improved nutrition.

5.2 Objective 2: Identifying partners, building support and scaling up programmes in partner countries

We aim to reach at least 12 million children under five through our direct support to multi-sectoral strategies and programmes for nutrition. This accounts for 10% of those who are underweight globally.

5.2.1 In at least six targeted high burden countries (Bangladesh, Ethiopia, India, Nepal, Nigeria and Zimbabwe)

We will adopt a multi-sectoral approach to tackling undernutrition. These countries account for more than 50% of all underweight children under five years old. We will support improved governance at the national level to deliver nutrition results and a multi-sectoral, whole government response to the problem. There is a weak track record in developing multi-sectoral plans for tackling undernutrition. We will learn from past mistakes and build on success stories. Fast progress requires presenting the problem so that it captures the attention of political elites and civil society, with strong leadership from the top. We will expand our use of political analysis to do this.

To start with, at country level we will develop nutrition action plans that support national priorities and frameworks, and support the development of a multi sectoral approach at national and state level where this doesn't exist. DFID India has audited the nutrition

contribution of its various programmes, setting up a nutrition policy team to tackle undernutriution. We will publish a strategy in 2010 (see box) and will scale up its health and nutrition spend with an additional £110 million between now and 2015 to tackle child undernutrition in the states of Madhya Pradesh and Orissa, where one out of every two children is malnourished. This will ensure that the sector support includes nutrition and has reduction in underweight as a key goal (MDG 1). Strategies or action plans will be published in Nepal and Bangladesh in 2010. Zimbabwe, Nigeria and Ethiopia will develop plans, building on and, where feasible, expanding existing investments.

We will then strengthen existing programmes to increase and measure their impact on nutrition, including in response to the economic downturn and in the event of other shocks (e.g. natural disaster, food crisis or the longer term impact of AIDS).

DFID Bangladesh will continue to work with the Government and relevant partners to develop a joined up, multi-sectoral response to undernutrition.

In particular, DFID Bangladesh will:

- protect people's lives and livelihoods and build their resilience against natural disasters such as floods and cyclones;
- support improvements in food security and nutrition for the extreme poor.

In Nepal, DFID will work with country partners to develop work to date and ensure a clear focus on nutrition outcomes in the new national health sector programme. We will dedicate specific advisory capacity to support this.

In Ethiopia, DFID will continue to support the Productive Safety Net Programme. This provides cash and food to chronically food insecure households and is supporting a pilot to improve nutrition. We will also continue to support the Health Extension Programme, which includes a focus on community and household level nutrition interventions.

In Zimbabwe we will support a harmonised multi-sector effort to tackle undernutrition in a manner that responds to the national context of fragility and high HIV prevalence. We will:

- strengthen our current programmes (health, livelihoods, food security, water and sanitation) to increase and measure impact on nutrition for pregnant and lactating women and children under two years.
- assess the potential for additional high impact programmes.

Planning for nutrition in a country affected by climate change

DFID's hunger and poverty targets in Bangladesh for the 2009 – 14 period are.[53]

- 6.5 million people will have been lifted out of extreme poverty.
- Monga (seasonal hunger) will have been eliminated by 2015 and acute malnutrition reduced.

[53] DFID, 2009-14, Country plan, Development in Bangladesh.

DFID India: a multi-sectoral approach to undernutrition

DFID India's approach to tackling undernutrition includes:

- advocacy for and completion of multi-sectoral State strategies for nutrition in the high burden states. With 60% of under fives undernourished, Madhya Pradesh has, with DFID support, developed a strategy which will be endorsed by the Chief Minister and monitored regularly.
- livelihood and inclusive growth programmes which address the economic determinants of undernutrition in the poorer states – for example, by increasing household income. DFID has helped a million people move out of poverty in Andrah Pradesh since 2000.
- support to the Health Sector to include the provision of nutrition interventions for treatment and prevention, including through the central Government of India's National Rural Health Mission.
- encouraging better collaboration of the health, nutrition and water and sanitation departments – including new sector support to all three relevant ministries in Bihar and provision of joined-up technical assistance at national level. In the last two years DFID has helped ten million slum dwellers get access to water and sanitation, a key cause of undernutrition.
- support to the national gender equality and women's empowerment programmes which aim to increase women's role in local Government and improve their access to basic services and economic opportunities.
- technical inputs to improve the design and impact assessment of the national Integrated Child Development Scheme.
- new support to the national flagship programme for universalising elementary education, with a particular focus on girls' education. DFID has helped 1.2 million girls go to primary school.
- a new DFID cross-sectoral nutrition policy team to support advocacy with the Government of India – to translate lessons learnt at the state level about service delivery, fund the generation of new evidence and lobby for inclusion of evidence-based approaches in new national policies.

To take forward our work on nutrition governance in South Asia we will work with the World Bank and other partners in the region, developing the South Asia Regional Food Security and Nutrition Initiative (SAFSNI). This initiative will promote leadership and accountability for nutrition outcomes in countries across the region. The focus will be on issues such as food production and distribution, social protection and health. SAFSNI will commission research to fill evidence gaps – crucial for framing the problem to political leaders. SAFSNI will support mechanisms for linking evidence to policy decisions more effectively and provide a forum for lesson learning and exchange between a diverse group of countries. Gender will be an important focus of this initiative. In addition to mainstreaming gender in all aspects of the programme, additional support will be provided through the South Asia Gender Policy Fund for initiatives that address barriers to nutrition at household and community level.

5.2.2 In all other high burden, DFID priority countries (DRC, Kenya, Sudan, Tanzania, Uganda, Afghanistan, Pakistan, Vietnam and Yemen)

We will include nutritional indicators in our country results frameworks, or will seek to deliver improved nutrition through investments in at least one sector. Seventy per cent of the world's underweight children live in these countries combined with our targeted countries above.

For example, in Sudan and DRC, we will ensure that our humanitarian investments make a real impact on the prevention and treatment of acute undernutrition. In Afghanistan we will include nutrition outcomes in our new agricultural production programme. In Kenya, nutritional outcomes are monitored in our social protection investments.

5.2.3 In emergencies

We will continue to play a part in responding to situations where women and children are experiencing high rates of acute malnutrition, to save lives and reduce suffering. We will do so by drawing on local and external capacity (where local capacity is insufficient). In 2008/9, DFID spent over £15 million on emergency nutrition in Africa, and it will remain a core element of our overall humanitarian response.

Having the right skills and systems in place is often a barrier to scaling up an emergency programme. We will invest in increasing capacity for nutrition in countries prone to emergencies. We will do this through our commitment to:

- allocate at least 50% of all new bilateral aid to fragile and conflict affected states. In particular we will support investment in nutrition services in fragile states where citizens deem these to be expected state functions.
- invest 10% of humanitarian response funding in helping to prepare for future crises.

We will continue to invest in strengthening the evidence base for humanitarian action, improving coherence in needs assessment initiatives and improving integration of information to benefit consistency and quality. We will continue to support UNICEF to implement the Nutrition Information Project for the Horn of Africa. We will also support efforts to include nutritional measurements in food security information systems where they exist, including feeding this information into the Integrated Food Security Phase Classification. Through our support to NGOs on evidence and needs assessment during humanitarian response, we will promote improved methods for measuring and monitoring nutritional outcomes. Through our support to UNICEF as nutrition cluster lead, we will help to ensure that the cluster is an effective channel for good quality information.

We will work with the European Commission (DG ECHO) to ensure that, in emergencies, direct and indirect responses to acute undernutrition are prioritised, and that more nutrition needs are met. We will support humanitarian actors to prevent acute undernutrition and achieve Sphere minimum standards for programme coverage.[54] We will continue to support WFP to strengthen the nutritional impact of its food assistance and help UNICEF and the nutrition cluster to fill any critical gaps in the nutrition response, such as infant and young child feeding support for women and young children.

Because chronic undernutrition is often very high preceding an emergency, our response to the acute situation must maximise impacts on stunting. We will also seek to make certain that approaches for tackling the chronic problem are strengthened as a result of the humanitarian response through building better connections with longer term development work.

5.3 Objective 3: Ensuring our investments in multiple sectors deliver improved nutrition

Investments in many sectors improve undernutrition, but we will ensure these investments work harder to reduce the problem. This means we will need to adjust our work in these sectors to maximise nutrition results.

5.3.1 Health, particularly maternal, newborn and child health

Coverage of some of the high-impact low-cost nutrition interventions which must be delivered through the health system is still very low. We will work to expand access to these interventions through our work with government and multilateral partners to strengthen health systems.

Our 2007 Health Strategy 'Working Together for Better Health' sets out how we help countries to build and strengthen their national health systems to deliver integrated, quality basic health services. This includes working with them to:

- put sound national policies in place, along with the necessary institutions, to ensure that priority programmes are implemented effectively;
- invest in human resources for health through comprehensive approaches to workforce planning; recruitment, deployment and retention; training; and maximising staff efficiency;
- strengthen national health information systems to improve data collection and management to make detailed monitoring and reporting of trends and results possible;
- secure reliable supplies of safe, effective and affordable essential medicines and diagnostics;
- improve management of health services , including the effective regulation of non-state health service providers.

The International Health Partnership (IHP+) seeks to mobilise all donors behind countries' own health plans and to provide the predictable, long-term aid commitments that are needed to make them work.

[54] The Sphere project is a voluntary initiative to improve the quality of assistance to people affected by disaster and improve the accountability of states and humanitarian agencies to their constituents, donors and the affected populations. It has developed a humanitarian charter and minimum standards in humanitarian response.

DFID will work through this systems approach to increase access to critical nutrition interventions, specifically the:

- prioritisation of adolescent girls, pregnant women and children under the age of two. Services need to be delivered in a manner which maximises uptake by these target groups and by the poorest and most marginalised.
- integration of vertical nutrition projects into health systems with a focus on maintaining or increasing coverage levels
- development of capacity and skills in nutrition in the health workforce. Nutrition needs to be a core element of in-service training for health professionals.
- improvements in the reach and effectiveness of community-based services. Treatment of severe acute undernutrition and support for breastfeeding require considerable capacity at very local level to deliver effective services.
- inclusion of relevant nutrition inputs in essential drug packages. Ready to use Therapeutic Foods and micronutrient supplements, particularly therapeutic zinc, should all be included.
- engagement with the private sector on the development and use of nutritional products.

We will also encourage the inclusion of nutritional outcomes and coverage of critical services in common monitoring and evaluation frameworks for the health sector.

5.3.2 Food security and agriculture

Food insecurity is a major cause of undernutrition, yet it is common for efforts to tackle food insecurity to focus on reducing poverty and promoting economic growth and agricultural production, rather than on reducing undernutrition.

The main vehicles for ensuring investments tackle undernutrition are provided by:

- the L'Aquila food security initiative which committed US$22 billion (2009-2012) and the 2009 Declaration of the World Summit on Food Security with its five 'Rome Principles' (recognising the nutritional dimension is integral to the concept of food security);
- the Global Partnership on Agriculture, Food security and Nutrition;
- the development of national strategies for agriculture and food security, including the compacts developed by African countries under the Comprehensive Africa Agriculture Development Programme (CAADP). We will work with partners to ensure the third pillar of CAADP's Framework for Action on Food Security is well reflected in national strategies.

DFID will promote approaches to addressing food insecurity which maximise nutrition results, specifically:

- focusing on consumption as well as production. Agriculture strategies which increase poor people's access to nutritious foods including non staple foods or bio-fortified crops are likely to deliver stronger nutritional results. This may be through increasing subsistence production, through increasing incomes or through reducing prices by increasing market availability. Given that the poorest families are net purchasers of food, strategies to increase access to food are paramount.
- ensuring nutrition education is delivered to farmers, alongside production information, has been shown to consistently increase nutritional impact on their families.[55] Increasing the power of women as economic agents in agricultural development is particularly important. This is due to their huge impact as stewards of food security and health for young children. Strategies must take women's time and resource constraints into account and where possible reduce them.
- investing in agricultural research to help identify approaches that can tackle undernutrition.

We will make the reduction of hunger and undernutrition a central objective of our support to agriculture and food security.

5.3.3 Social transfers

DFID aims to help build social protection systems to reach 50 million people in over 20 countries between 2009 and 2012. Many of these families will receive social transfers, which are non-contributory, regular and predictable, in cash or kind, including public works programmes. Expenditure surveys find that poor households spend most of their transfer on food. Regardless of the type of social transfer programme, household food spending and consumption consistently increases, as does the nutritional value of the food consumed.[56]

[55] World Bank, 2007, From agriculture to nutrition. Pathways, synergies and outcomes.

[56] Samson, Dr M; Kaniki, Dr S; Van Niekerk, I and Mac Quene, K of the Economic Policy Research Institute (EPRI), for DFID, 2007, Social Transfers Evidence Base, Synthesis Document: The Social and Economic Impact of Cash Transfers.

In some countries, receipt of cash transfers is conditional on households undertaking certain actions such as making their children attend school or having health check-ups. Evidence from Latin America shows that conditional cash transfer programmes can have a large impact on the nutritional status of children, though the reasons are not well understood (i.e. whether its through the transfer itself, accompanying food or micronutrient supplements, or complementary health services or women's empowerment). Unconditional cash transfer programmes in South Africa have also been shown to have positive impacts on nutrition.

Social transfer programmes are recognised to be an extremely important intervention for improving nutrition because they target the poorest groups, provide inputs which have potential to tackle the immediate and underlying causes of undernutrition and can achieve high levels of coverage. The design elements which maximise nutritional results are not well known, though the following are likely to be important:

- the size of the transfer;
- the extent to which pregnant women and young children are targeted;
- the type and quality of the transfer – food, cash or vouchers. The quality aspect of food transfers, including whether the food is fortified or specifically designed for young children, is also likely to be significant;
- whether the programme helps to empower women by requiring them to be the recipients of the transfer;
- whether or not conditions are attached to the transfer – these could both enhance or reduce the value of the transfer. Conditions that require women to work in receipt of the transfer may take them away from nutritionally important child care. Conditions which require attendance at nutrition education sessions may enhance the transfer value. Telling recipients about the intended purpose of the transfer may also be important;
- The quantity and quality of complementary services available may be significant, particularly health services but also child care, agriculture and community-based services. These may help to empower women and provide opportunities for information sharing and learning.

We will strengthen the design and monitoring of five social transfer programmes in order to maximise nutritional results.

5.3.4 Water, sanitation and hygiene

Water, sanitation and hygiene measures all have a significant impact on diarrhoea, dysentery and intestinal parasites. This in turn improves nutritional status. Tropical Enteropathy has also recently been identified as a water and sanitation related contributor to undernutrition that requires further investigation.[57] Environmental factors are estimated to account for half of the infectious disease burden triggered by undernutrition. Recent evidence shows that hygiene interventions (handwashing, water quality treatment, sanitation and health education) can reduce stunting at 36 months by 2-4%.[58]

[57] Humphrey, J, 2009, Child undernutrition, tropical enteropathy, toilets, and handwashing. Lancet 2009; 374: 1032–35.

[58] Bhutta, Z, 2008, What works? Interventions for maternal and child undernutrition and survival. Lancet 2008;. Vol 371. February 2, 2008.

In addition to the direct health benefits, improved water supplies in particular may free up time, money and energy (physical energy as well as fuel used for boiling water). This often directly benefits women and children.

In the design of water, sanitation and hygiene programmes, the correlation between the absence of services and undernutrition should be assessed. The impacts of environmental health programmes can potentially be increased if they target areas with high rates of undernutrition, and if communities with large numbers of undernourished children can be reached. Community engagement through programmes, such as the Community Led Total Sanitation Campaign, provides a potential entry point for other nutrition-related interventions. Also, collaborative relationships between government Ministries with responsibilities for health, water and sanitation can be developed.

DFID will monitor nutritional outcomes of water, sanitation and hygiene investments in at least three of our six targeted high burden countries. We will do this through our collaboration with partners such as UNICEF and the World Bank. In these countries we will uphold approaches that improve the effects of investments in multiple sectors, including environmental health, to deliver greater impact on undernutrition. This will enhance understanding of the critical role that water and sanitation plays in reducing undernutrition. In particular it will enhance the right investment to maximise nutrition results (e.g. the balance between health promotion and engineering solutions) in different settings (e.g. rural and urban). In turn, this could help make a stronger case for investment in water and sanitation – a sector which has been chronically under-funded globally.

International water and sanitation initiatives such as the Global Framework for Action, the EU Water Initiative and the Water Supply and Sanitation Collaborative Council's Global Sanitation Fund, are seeking to increase the coverage of safe water and improved sanitation coverage. DFID will continue to engage with these initiatives. Sanitation is one of the most off-track MDGs and increased progress is expected to impact positively on rates of undernutrition.

5.3.5 Education, especially for girls

Undernutrition *in utero* and the early years of life has a direct impact on cognitive development. When nutritional deficiencies are severe, growth processes in all areas of the brain are affected. This can result in delayed school enrolment, school absenteeism, poor performance and early drop-out. Improving the diets of school age children can help keep children in school and can improve their performance, but these interventions are often too late to tackle the irreversible effects of stunting on development. We will tackle undernutrition during pregnancy and in infancy to provide a critical foundation for DFID's education strategy.

Likewise, DFID's investments in education will help to tackle long term undernutrition. Women who were school-educated are much more likely to be able to protect their children from undernutrition. We will continue to prioritise efforts toward a basic, quality education for all, particularly for girls. Through our £8.5 billion commitment to education we will prioritise fragile and conflict affected states and all of the six countries targeted for nutrition. We are aiming to create a virtuous circle between better education and mothers who in turn can raise better nourished and educated children.

5.3.6 Governance

Improving governance for nutrition is a critical element of the overall response. Successful models for delivering a multi-sectoral response are needed, as are strategies for overcoming weak capacity in delivery of programmes and services at sub-national level. Donor and UN agencies also need to be better co-ordinated.

Civil society is rarely sufficiently mobilised on nutrition, and yet maternal and child undernutrition is of direct concern to women's groups, farmers networks, unions and many others. The result is that upward demand for improved efforts to address undernutrition is rare. This has knock-on impacts on the attention given to nutrition by decision makers and the extent to which governments are held accountable for progress. Civil society also plays a role in providing services where governments are unable or unwilling to do so. Civil society and the private sector play a role in helping to change social and cultural norms at the very local level. Shifting these norms is important for tackling gender inequality and social exclusion – a major contributor to the undernutrition problem and also for changing behaviours which affect nutrition such as feeding practices and health seeking behaviour.

In our target countries we will include, where relevant, initiatives to improve governance on nutrition. We will prioritise work with civil society partners in nutrition, using our central and country-level funding instruments, to support service delivery and advocacy at the global, regional and country levels.

5.4 Objective 4: Building evidence, demonstrating results

5.4.1 New policy knowledge and evidence

There are considerable evidence gaps which need to be filled to meet the nutrition challenge. Questions include:

- which interventions are the most cost effective, beyond those direct nutrition services typically delivered through the health system? We know that if direct nutrition interventions are delivered at scale, they will only reduce stunting by one third. We need to understand which interventions should be prioritised for tackling the underlying and basic causes of undernutrition. There are also some evidence gaps on direct approaches including the best approaches to treat and prevent moderate acute malnutrition.
- how interventions should be best delivered at scale, including delivery through national systems, optimal governance arrangements, and operationalising a multi-sectoral approach.
- future challenges to nutrition, including the impact of climate change, global shocks, including high food prices and the effects of population growth and urbanisation.

We will work closely with others to fill these evidence gaps by using a combination of research and programme monitoring and evaluation.

We will continue to invest considerable resources in nutrition-related agricultural research. Our agricultural research spending of £80 million per year includes support to CGIAR's mega-programme on "Improvement in the nutritional value of food and diets." DFID will continue to finance research into the diversification and biofortification of crops to improved nutritional outcomes. In addition, we will design a nutrition research programme (Research Programme Consortia) which takes explicit account of the multi-sectoral nature of nutrition (e.g. governance, political economy) and looks at the importance, effectiveness and value for money of different indirect interventions.

We will use our humanitarian research funds to support innovation in approaches to tackling undernutrition in crisis settings. We will also ensure nutrition research needs are integrated into a further four new research programmes and will form action research partnerships with expert NGOs.

We will also strengthen our programme monitoring and evaluation on nutrition. In targeted countries, we will audit existing programmes' likely effect on nutrition. The results will act as a baseline against which to strengthen investments in nutrition. Making sure that programmes are designed to support nutritional monitoring, via a range of nutritional indicators and evaluating nutritional results will be a central element of our aim to make our investments in multiple sectors deliver improved nutrition.

We will guarantee that nutrition is a key theme in our major sectoral evaluations in health, social protection and food security. We will ensure that new decentralised programme evaluations in DFID include studies directly on nutrition where appropriate and/or consider this issue fully in relation to other programmes.

We will use our influence on new initiatives that fund high quality impact evaluations, such as the International Initiative on Impact Evaluation (3IE), to ensure the inclusion of nutrition. We will promote better evidence gathering by international organisations such as the UN agencies.

5.4.2 Linking evidence to policy

We believe that greater emphasis should be placed on making research results accessible to policy makers and practitioners to inform their decisions. We also believe that policy decisions should only be made on a sound understanding and application of the evidence.

We will work with others to ensure that research priorities highlighted by policy makers inform our commitments. We will systematically plan the dissemination of research and programme evidence using a variety of communication channels to promote accessibility and use of findings for policy decisions.

5.5 Delivering the strategy

We will achieve these results in nutrition by boosting our own capacity in the field. We have created a global network of nutrition leaders, with capacity at central and country level and coming from different sectoral backgrounds, who will lead the implementation of the strategy.

As a result of re-orienting our spending in multiple sectors, we expect to see significant increases in our spending coded to nutrition, whether this be through the agriculture, social protection, water and sanitation or health sectors. We will publish these figures annually (2010-2015) as part of our review of progress in implementing this strategy.[59]

We will monitor implementation of this strategy on an annual basis. The Development Committee will take stock of progress against the strategy in 2011 and 2013.

[59] It should be noted that increased nutrition spend will only be evident in OECD-DAC figures if the nutrition component is the majority element of the programme costs.

Annex 1: List of abbreviations

BCR	Benefit cost ratio
CGIAR	Consultative Group for International Agricultural Research
DAC	Development Assistance Committee
DALY	Disability Adjusted Life Year
DFID	Department for International Development
EC	European Commission
ECHO	European Commission Humanitarian Office
FAO	Food and Agriculture Organisation
GDP	Gross Domestic Product
GIVAS	Global Impact and Vulnerability Alert System
GPAFS	Global Partnership for Agriculture and Food Security
HIV	Human Immunodeficiency Virus
IDS	Institute of Development Studies
IFPRI	International Food Policy Research Institute
MDG	Millennium Development Goal
NGO	Non Governmental Organisation
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
ORS	Oral Rehydration Salts
PSA	Public Service Agreements
PRSP	Poverty Reduction Strategy Paper
RUTF	Ready to Use Therapeutic Foods
SAM	Severe Acute Malnutrition [Undernutrition]
SAFSNI	South Asia Food Security and Nutrition Initiative
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WFP	World Food Programme

What is Development?
Why is the UK Government involved?
What is DFID?

International development is about helping people fight poverty.

This means people in rich and poor countries working together to settle conflicts, increase opportunities for trade, tackle climate change, improve people's health and their chance to get an education.

It means helping governments in developing countries put their own plans into action. It means agreeing debt relief, working with international institutions that co-ordinate support, and working with non-government organisations and charities to give communities a chance to find their own ways out of poverty.

Getting rid of poverty will make for a better world for everybody.

Nearly a billion people, one in six of the world's population, live in extreme poverty. This means they live on less than US$1 a day. Ten million children die before their fifth birthday, most of them from preventable diseases. More than 113 million children in developing countries do not go to school.

In a world of growing wealth, such levels of human suffering and wasted potential are not only morally wrong, they are also against our own interests.

We are closer to people in developing countries than ever before. We trade more and more with people in poor countries, and many of the problems which affect us – conflict, international crime, refugees, the trade in illegal drugs and the spread of diseases – are caused or made worse by poverty in developing countries.

In the last ten years Britain has more than trebled its spending on aid to nearly £7 billion a year. We are now the fourth largest donor in the world.

DFID, the Department for International Development, is the part of the UK Government that manages Britain's aid to poor countries and works to get rid of extreme poverty.

We work towards achieving the Millennium Development Goals - a set of targets agreed by the United Nations to halve global poverty by 2015.

DFID works in partnership with governments, civil society, the private sector and others. It also works with multilateral institutions, including the World Bank, United Nations agencies and the European Commission.

DFID works directly in over 150 countries worldwide. Its headquarters are in London and East Kilbride, near Glasgow.

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