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COMMISSION STAFF WORKING DOCUMENT

Third Progress Report on the Commission's Action Plan on Nutrition – April 2017 to March 2018

Contents

Acronyms

DAC	Development Assistance Committee of the OECD
EIP	European External Investment Plan
EU	European Union
EFSD	European Fund for Sustainable Development
FAO	Food and Agriculture Organisation (United Nations)
HANCI	Hunger and Nutrition Commitment Index
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
NGO	Non-governmental organisation
SDG	Sustainable Development Goal
UNICEF	United Nations Children's Fund
WFP	World Food Programme (United Nations)
WHA	World Health Assembly
WHO	World Health Organisation (United Nations)

Key Messages

This third progress report presents highlights of operational developments in the European Union's (EU) external assistance concerned with nutrition and provides updates on progress towards its two commitments in nutrition: to support partner countries in reducing the number of stunted children under the age of five by at least 7 million by 2025 and to ensure the allocation of EUR 3.5 billion between 2014 and 2020 to improve nutrition in developing countries.

The report presents examples of the Commission's nutrition work characterised by a strong gender dimension, aimed at individuals at different stages of the life cycle and applied across sectors. It is anticipated that such cross-cutting approaches will also secure progress in addressing boundaries between different forms of malnutrition.

The Union is on-course to meet its commitment to invest EUR 3.5 billion in nutrition by 2020. In the period 2014 – 2017, total funds committed to nutrition-related actions amounted to nearly EUR 2.5 billion.

Through its assistance programmes, the EU is also contributing to the reduction of stunting. In the 40 partner countries prioritising nutrition[1], the prevalence of stunting has decreased from 39.57% in 2012 to 35.82% in 2017 (see Annex I). The number of children averted from stunting has increased from an estimated 1 million in 2016 to a projected 4.7 million in 2018[2].

The pace of stunting reduction has also accelerated from 1.16% in 2012 to 1.41% in 2017 (see Figure 3), highlighting improvements that were not foreseen when the global nutrition targets were set. Such results have been achieved through the joint efforts of the various actors working in nutrition, both at the national and international levels.

In order to better understand the likely drivers behind the progress in fighting stunting, and as a first step towards assessing the EU's potential contribution to these results, a dashboard has been developed with indicators relevant to nutrition for all partner countries prioritising nutrition (see annex II). These indicate that:

- 36 of the 42 countries (86%) show improvement in their stunting prevalence since 2012.
- All Asian countries and 79% of African countries have seen improvement in stunting prevalence since 2012.
- Across the 42 countries, two of the five context indicators are performing worse than the others, which could have bearing on stunting reduction: limited programme coverage and low ranking in the Hunger and Nutrition Commitment Index (HANCI)[3].

At the Nutrition Seminar held in Brussels in March 2018, European Commissioner Neven Mimica emphasised the need to "explore how we can recalibrate our efforts to ensure that we address all forms of malnutrition and that we continue to contribute to the goal of zero hunger beyond 2020".

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[1] There are 42 partner countries prioritising nutrition, but for the sake of consistent comparability, stunting progress is analysed only for the initial group of 40 (thereby excluding Djibouti and Sudan).

[2] As calculated by the European Commission, using a methodology agreed with WHO, based on data presented in the Global Database on Child Growth and Malnutrition (http://www.who.int/nutgrowthdb/estimates/en/).

[3] Programme coverage is a composite indicator, that combines the estimated coverage of five programmes: treatment of severe acute malnutrition; vitamin A supplementation; under-five year old children with diarrhoea receiving oral rehydration solution; immunisation with DTP3 (diphtheria, tetanus and polio); and iodised salt consumption.
The Hunger and Nutrition Commitment Index (HANCI) ranks governments on their political commitment to tackling hunger and undernutrition.

In that regard, the report indicates that the integration of measures to address multiple forms of malnutrition – such as wasting, anaemia in women and adolescent girls and overweight/obesity – in EU support programmes can contribute to achieve the global stunting reduction target by 2025.

1. Introduction

> *As long as hunger and malnutrition persist, our wider efforts to achieve lasting peace and prosperity for our people and our planet will remain beyond our reach. This is why I insist on keeping quality nutrition high on the political radar – at both the European and global levels.*
>
> Commissioner Neven Mimica, 2018[4]

Background

Since 2016, the Commission has been producing annual progress reports on the implementation of its Action Plan on Nutrition, as demonstrations of the Commission's accountability for its performance in relation to tackling undernutrition. They report on progress with regard to the two key nutrition commitments that underpin the strategic and operational focus of the European Commission's work in nutrition: (i) the 2012 commitment to support partner countries in reducing the number of stunted children under the age of five by at least 7 million by 2025[5], and (ii) the 2013 commitment to ensure the allocation of EUR 3.5 billion between 2014 and 2020 to improve nutrition in developing countries[6].

These two commitments are institutionalised in the EU policy framework on nutrition, which relies on two main documents: the 2013 Commission Communication on Enhancing Maternal and Child Nutrition in External Assistance: An EU Policy Framework[7] (together with the associated Council Conclusions[8]); and the 2014 Commission's Action Plan on Nutrition: Reducing the number of stunted children under five by 7 million by 2025[9] (together with the associated Council Conclusions[10]).

On 27 November 2014, the European Parliament adopted a Resolution on child undernutrition in developing countries[11], calling for nutrition to be prioritised as a development goal by the Commission and EU Member States. Finally, two sets of Council Conclusions were adopted on the first and second progress reports on the Commission's Action Plan on Nutrition[12].

These documents have steered the Commission's action on nutrition, both in partner countries and in international initiatives.

Scope of the third progress report

This third progress report covers the period between April 2017 and March 2018.

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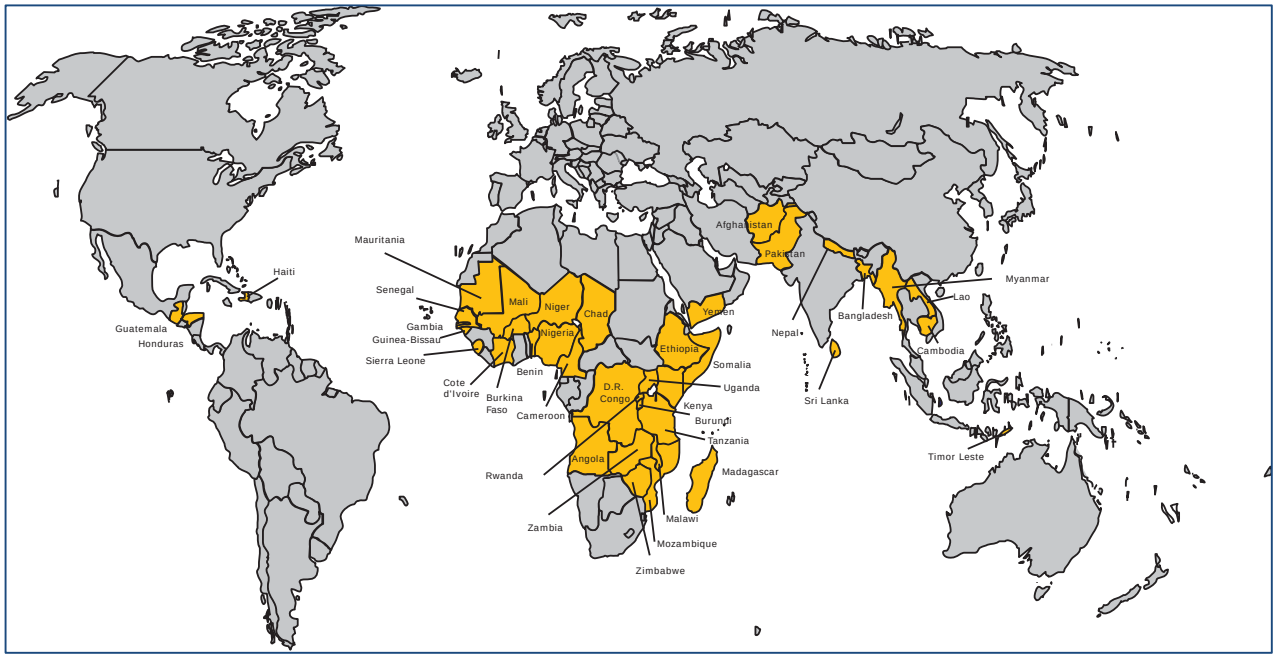
[4] Commissioner Neven Mimica, Nutrition seminar: "The European Commission's Action Plan on Nutrition: Ensuring Quality Implementation", 19 March 2018, Brussels.
[5] http://europa.eu/rapid/press-release_SPEECH-12-575_en.htm
[6] Announced at the Nutrition for Growth (N4G) event in 2013. See the Global N4G Compact and Commitments.
[7] http://ec.europa.eu/europeaid/documents/enhancing_maternal-child_nutrition_in_external_assistance_en.pdf
[8] http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/EN/foraff/137318.pdf
[9] https://ec.europa.eu/europeaid/sites/devco/files/action-plan-nutrition-2015_en.pdf
[10] http://www.consilium.europa.eu/media/24895/146176.pdf
[11] http://www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P8-TA-2014-0072&language=EN&ring=B8-2014-0253
[12] 2016: http://data.consilium.europa.eu/doc/document/ST-10392-2016-INIT/en/pdf and 2017: http://data.consilium.europa.eu/doc/document/ST-10679-2017-INIT/en/pdf

To maximize the impact of the Action Plan on Nutrition, the Commission identified 40 countries of strategic priority for nutrition (Fig.1) because they had a high burden of stunting and had requested support from the Commission to address undernutrition. Progress is reported in reference to this group, for continuity, although Sudan and Djibouti joined in 2017.

Figure 1: Map of the Commission 40 partner countries prioritising nutrition



Previous progress has been reported with reference to the three strategic priorities outlined in the Action Plan for Nutrition:

> Strategic Priority 1: Enhance mobilization and political commitment for nutrition
>
> Strategic Priority 2: Scale up actions at country level
>
> Strategic Priority 3: Knowledge for nutrition (strengthening the expertise and knowledge base)

This year, progress will be discussed mainly with reference to the outcomes at the different stages of life, thereby highlighting the improvements the Commission is seeking to make in the lives of individuals – through the life cycle. This speaks particularly to Strategic Priority 2 for scaling up actions at country level. Although the Action Plan on Nutrition has a strong focus on stunting reduction, it can also contribute to improving nutrition beyond stunting in children. Indeed, the experience of the Commission has underscored the importance of tackling all forms of malnutrition using a holistic approach, as recommended by UNICEF, the World Health Organisation and the World Bank:

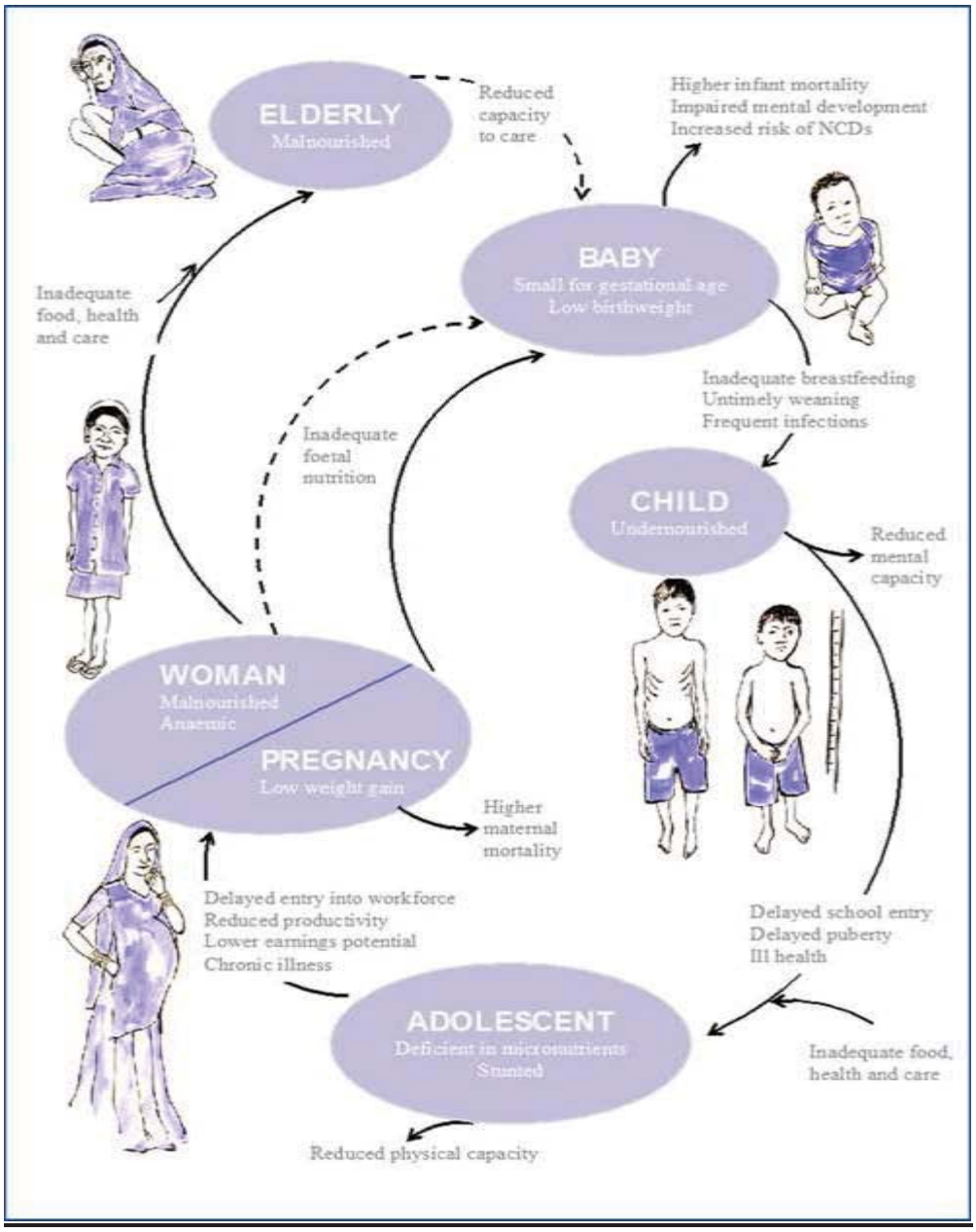
> "While malnutrition can manifest in multiple ways, the path to prevention is virtually identical: adequate maternal nutrition before and during pregnancy and lactation; optimal breastfeeding in the first two years of life; nutritious and safe foods in early childhood; and a healthy environment including access to basic services and opportunities for physical activity. These key ingredients can deliver a world where children are free from all forms of malnutrition."[13]

[13] Levels and Trends in Child Malnutrition. UNICEF/WHO/World Bank Group Joint Child Malnutrition Estimates. Key findings of the 2017 edition. Page 2.

2. Progress in implementing the Action Plan on Nutrition throughout the life cycle

This section relates to the Commission's efforts to scale up actions at country level (strategic priority 2), throughout the life cycle. Figure 2 below shows the inter-linkages in the nutritional well-being of individuals across the different stages of life and across generations.

Figure 2: Nutrition throughout the life cycle[14]



The cycle makes evident the crucial gender dimensions that underpin nutrition, commencing with the nutritional status of women before pregnancy, the potential cross-generational impact of women's nutritional status during pregnancy, through to their role in caring and nurturing children through adulthood and old age. The promotion of gender equality through nutrition-relevant programmes is a strong commitment of the Commission in all operational contexts. In particular, the Commission seeks to "*support and empower women and girls – through a*

http://www.who.int/nutgrowthdb/jme_brochoure2017.pdf?ua=1

[14] Adapted from Nina Seres, for the Administrative Committee on Coordination/Subcommittee on Nutrition ACC/SCN (UN) - appointed Commission on the Nutrition Challenges of the 21st Century.

joint humanitarian-development response - as dynamic agents within their communities, both in terms of advancing nutrition and strengthening resilience"[15].

Evidence of this is seen in the Commission's nutrition-related funding decisions. When analysed according to various 'policy markers' tagged to the objectives of each decision, all[16] nutrition actions in 2016 and 2017 supported by the Commission, for which data is available, are linked to the gender equality marker. These policy markers provide an easily accessible mechanism to monitor whether donor investments are aligned with the development policy objectives of the OECD's Development Assistance Committee (other markers being participation development/good governance; reproductive, maternal, new born and child health; and four Rio Convention markers concerned with climate change).

Another general finding is an apparent maturation in the selection of indicators linked to nutrition programmes. The number of different indicators used in nutrition programmes increased from 80 in 2014 to 232 in 2016. Across all years, indicators on stunting were consistently the most frequently used. However, 2016 saw the use of several indicators for the first time, such as: sex-disaggregated data on exclusive breastfeeding, on social transfers and on food security; indicators on specific micronutrients (iodine, calcium, Vitamins B and D); and indicators on national budget lines - denoting a more thoughtful and tailored approach to monitoring.

Improving nutrition amongst pre-pregnant women

The physical and socio-economic environment in which a child is conceived shapes his or her nutritional trajectory over the months and years ahead. The immediate physical environment is determined by the mother, and her nutritional status at the moment of conception is as important as that during the pregnancy itself. Women can face discrimination in their socio-economic environment. The inequalities faced by rural women, such as limited access to land, credit or technological inputs, can deepen impoverishment and food insecurity, not only for themselves but their households too. Rural women, on average, make up 43% of the agricultural labour force[17], providing an important income for the household. They also tend to be in charge of cooking family meals. "If yields on farms managed by women were raised to the same level as those achieved by men, agricultural output in developing countries would increase by 2.5% to 5%. This could reduce the number of undernourished people in the world by between 12% to 17%"[18].

For these reasons, the Commission is striving to improve the nutritional status of women of reproductive age, including adolescent girls, before pregnancy begins. Indeed, both maternal and paternal nutritional status prior to conception can influence the well-being of future children from embryo to adulthood[19].

Commission activities on nutrition range from budget support programmes (in West Africa for example); improving women's access to land, especially access to irrigated land (such as in Benin and Burkina Faso); to a strong gender approach. In Mali for instance, the Initiative to Reinforce Resilience through Irrigation and the Appropriate Management of Resources (IRRIGAR) seeks to improve women's access to productive assets. It includes a strong behaviour-change component, and support for nutrition-sensitive small-scale irrigation

[15] Remarks by Commissioner Neven Mimica at the Scaling Up Nutrition (SUN) Lead Group annual meeting in New York, 18 September 2017.
[16] 37 out of 45 actions were linked to the gender marker; the remaining 8 had no data.
[17] Because Women Matter, European Commission 2017.
[18] Running out of Time: The reduction of women's work burden in agricultural production, FAO 2015.
[19] Fleming T. et al. Origins of lifetime health around the time of conception: causes and consequences. The Lancet, April 2018. http://dx.doi.org/10.1016/S0140-6736(18)30312-X

activities amongst both women and men. With the strong cooperation of decentralised health and agricultural services, the project aims to diversify food production and consumption (particularly of vegetables and fish) while minimizing the potential adverse effects that can arise from irrigation (such as increased incidence of water-borne diseases and malaria). Several other multi-sectoral resilience projects, such as in Chad, are improving the job opportunities for, and thus the incomes of, women and youth. An illustration of the Commission's support for the empowerment of women is provided in Box A.

Box A: Improving Nutrition Amongst Pre-Pregnant Women: A case example from Pakistan

Pakistan presents some of the poorest nutrition indicators in the world. There is little evidence of progress and a widening gap between the nutritional status of the poor and the better off. In rural Sindh, where stunting amongst children under 5 years of age is at 63%, women face significant gender inequalities - early marriage and pregnancy, high levels of illiteracy and virtually no land ownership - which contribute to the poor nutritional status of their children.

The EU Programme for Improved Nutrition in Sindh (PINS) seeks to empower women (both mothers and mothers-to-be) in leadership roles to tackle these challenges. The six-year programme involves strengthening existing networks of grassroots level organisations (around 30,000 across 10 districts in the province) to play a key role in identifying and acting on communities' priorities. These priorities can range from small scale-infrastructure such as water points, schools and community-led total sanitation, to vocational training for more secure livelihoods, and micro-insurance initiatives. At the same time, empowerment of, and increased income for women leads to greater purchasing power. Coupled with nutrition awareness, this improves the quality of women's diets and, in turn their health, as well as that of their families. Key indicators for PINS focus on women of reproductive age: reduced prevalence of anaemia, improved dietary diversity (measured as minimum dietary diversity in women, MDD-W) and greater access to services. Moreover, the programme focuses particularly on the poorest women.

Supporting optimal growth from conception

The well-being of the growing foetus is intrinsically linked to the well-being of its mother. The early months of life establish a pattern of health that can have lasting impact throughout all stages of life. It is for this reason that two of the 6 global World Health Assembly (WHA) targets agreed in 2012 are directly concerned with this earliest stage: a 50% reduction in anaemia amongst women of reproductive age (from 19% in 2012 to 15% in 2025); and a 30% reduction in low birth weight (from 15% to 10%). Yet, these are also the two targets that have seen virtually no progress[20]. The OECD DAC policy marker for Reproductive, Maternal, New-born and Child Health was linked to the objectives of 32 of the 45 actions committed in 2016 (71%) and 18 of the 29 (62%) 2017 actions.

EU assistance aimed at this stage of life includes projects such as that in Myanmar, where it has contributed to the Livelihoods and Food Security Trust Fund (LIFT). This multi-donor initiative includes nutrition as one of its strategic objectives. Since 2014, cash transfers have been distributed to mothers and children in three areas of the country, to help them buy nutritious food and access health services. In addition, pregnant women and mothers identified how to improve their diets. These inputs led to important benefits: mothers receiving the cash transfers and education had heavier babies compared to mothers who

[20] Francesco Branca, WHO, presenting at the EU Nutrition Seminar, March 2018.

received no cash. Exclusive breastfeeding rates doubled and stunting rates decreased by five percentage points. As a result, the programme has expanded to support more women and children. Another example of the benefit of cash transfers is provided in Box B.

The Commission has been supporting the provision of antenatal health services in a number of countries. In Burkina Faso, for example, it is one aspect of the Budget Support being given to the government for the health sector. This includes the national system for exemption fees, which ensures free health care for pregnant women and children under five. Results are promising, including, for example, the reduction in low birth weight rate from 9.9% in 2015 to 9.4% in 2016.

In Chad, the programme *Sécurité Alimentaire et Nutritionnelle* (SAN) is a multisectoral intervention working through four ministries, that includes a component on improving access to antenatal services for pregnant women in five regions; in Mozambique, the nutrition programme includes improving access and delivery of nutrition and water, sanitation and hygiene (WASH) services, such as the scale up of iron/folate supplementation for pregnant women in two provinces; and several multisectoral resilience projects have incorporated antenatal service provision (in Mali, Burkina Faso, Cameroon and Chad).

Box B: Supporting Optimal Growth from Conception: A case example from Bangladesh

Although Bangladesh has made significant progress since the 1990s, child stunting remains high; around one in three children under five are stunted, with children born to the poorest families being disproportionately affected. Recognising the need to address this challenge head on, and with strategic budget support from the Commission, the Government of Bangladesh has started to implement the ambitious new National Social Security Strategy (NSSS). Until now, only around one third of poor households in Bangladesh had access to any social security.

The Commission's support is specifically intended to strengthen the scaling up of national systems for nutrition-sensitive social security with predictable monthly cash transfers. These are targeted at pregnant women and children under the age of five, living in both rural and urban areas.

For many families in Bangladesh, low and irregular incomes have remained a major constraint to good nutrition – making it difficult to buy nutritious food; and creating an economic burden that often requires pregnant women to engage in physical labour to fill the income gap. Both can influence the birth outcomes. But, by relieving cash constraints, social security can improve nutrition outcomes for both mother and child. As one in five children in Bangladesh are born with a low birth weight, ensuring that a pregnant mother eats a better quality diet presents a significant contribution to the promotion of optimal growth from conception. In the context of Bangladesh, with the Government's strong commitment, the impact on nutrition from support to the NSSS will be further accelerated by the simultaneous investment by the Commission in complementary areas. These include improved access to health services - especially antenatal and delivery services - as well as safe water and sanitation facilities, more resilient livelihoods and evidence based social and behavioural change communications for both women and men in communities across the country.

Managing nutrition in the early years

Malnutrition is a contributing cause of approximately 45% of deaths amongst children under 5, amounting to around 3 million children dying each year.[21] Good nutrition early in life is a critical precondition for optimal growth and development. It is for this reason that improving exclusive breastfeeding is included as one of the six WHA targets: to increase the rate of exclusive breastfeeding in the first 6 months of life from 38% to over 50%.

The Commission has been supporting numerous projects aimed at improving nutrition in the early years. For example, in Senegal, Burkina Faso and Chad, the Commission is supporting projects producing flour enriched with micronutrients aimed specifically at young children. In Burkina Faso, the budget support in health mentioned earlier also includes a component to improve the quality of treatment of severe acute malnutrition in national health structures. Sustainability is being secured through the progressive withdrawal of external support alongside increasing allocations from the national budget for the purchase of ready-to-use therapeutic foods and micronutrient supplements.

In addition, all multi-sectoral resilience programmes in West Africa (in Burkina Faso, Mali, Chad, Cameroon and Senegal) are promoting breastfeeding and securing more diverse diets for children. They are also all aiming to increase immunisation services and improve water and sanitation facilities.

Box C: Managing nutrition in the early years: A case example from Niger

Given the critical importance of good nutrition in early childhood, the Ministry of Health in Niger is leading on the implementation of essential interventions for new-born, infant and young child health and nutrition. Most notably, these include counselling and support for appropriate breastfeeding and complementary feeding; food fortification and micronutrients supplementation; screening for acute malnutrition; increasing access to the treatment and prevention of illnesses such as malaria and diarrhoea and supporting water sanitation and hygiene practices.

With the aim to improve the nutritional status of young children and prevent malnutrition, the EU has been supporting the strategy of the Ministry of Health, including through a project implemented in partnership with UNICEF, health facilities, authorities, communities and NGOs. The project covered 17 communes, with a population of 1.72 million, in the regions of Zinder, Maradi and Tahoua, which have the highest rates of stunting in Niger. Increasing the capacity to deliver the above actions is key to the project. As greater results are achieved when several determinants of malnutrition are tackled in synergy, the Ministry of Hydraulic and the EU Delegation are also investing in improving access to water, sanitation and hygiene in the same communes.

A robust monitoring system was designed to provide data on the programme's effectiveness. After 4 years of implementation, the following results were achieved:

- the proportion of infants 0-5 months exclusively breastfed rose from 21% to 83% between 2014 and 2017;

- the proportion of children 6-23 months receiving a minimum acceptable diet increased from 6% to 28%;

- the coverage of high-impact nutrition specific interventions amongst children under-five improved substantially: the proportion receiving oral rehydration solution with zinc treatment

[21] Black et al, 2013. Maternal and child undernutrition and overweight in low-income and middle-income countries. The Lancet series on maternal and child nutrition; volume 382 (9890), p427-451, August 03, 2013.

for diarrhoea increased from 12% to 71%; the proportion receiving vitamin A supplementation rose from 82% to 99%; and deworming increased from 73% to 99%;

- Over half the children aged 12-36 months were given micronutrient powders (sprinkles) for 6 months a year.

Protecting nutrition through adulthood

As the primary providers for households, adults bear significant burdens in terms of the physical and time demands on them. Although reduced, these burdens tend to continue even into old age. These economic and care-providing roles can run in direct competition with each other, most especially for women. Thus efforts to increase incomes and reduce the time-related burdens are amongst the Commission's priorities to support nutrition in adulthood.

Social transfers can be an effective means to do this, especially when integrated with other measures. For example, specific attention is being given to climate-adaptive agriculture and natural resource management, as part of resilience-building efforts in Cameroon, Chad, Burkina Faso and Mali. Social transfers, mostly cash, have been integrated to provide targeted support to the poorest households. These transfers are often combined with behaviour change communications, assets and skills transfers to maximise their impact on protecting nutrition and creating on- and off-farm productive capacities. More generally, the fisheries and aquaculture sector is crucial to improving food security and human nutrition and has an increasingly important role in the fight against hunger, as evidenced in The State of World Fisheries and Aquaculture 2018[22].

Another approach has been improving incomes, and protecting nutrition, through value chains. Box D describes one such case.

Box D: Managing nutrition through adulthood: A case example from Tanzania

The Agri-Connect programme became operational in early 2018. It aims to generate agricultural wealth by linking smallholder farmers to value chains and markets. At the same time, it seeks better food and nutrition security by improving access, availability, and use of foods by communities in selected regions of Tanzania and Zanzibar.

The programme incorporates several value chains - horticulture, coffee and tea - and will promote improved nutrition through the production of diverse nutritious foods as well as increasing income. This will be achieved through more conducive policies, regulation and financing for smallholders; promotion (through blending) of private sector investment in these commodities; increased market access through the development of road and transport infrastructure; improved awareness amongst smallholders of the value added of producing nutritious crops; and strong emphasis on the empowerment of women to lead small enterprises in these sectors.

In the first stages of the intervention relating to input supply and production, access to inclusive finance will be improved for women and youth. Farming systems will be diversified by introducing legume crops (e.g. pulses), promoting home gardens, and by strengthening farmer field schools. At stages further down the value chains, additional measures will be taken to improve the availability of diverse foods including modified agro-processing to reduce post-harvest losses and improved distribution systems to forge stronger market linkages. All these components will be combined by community nutrition education campaigns. Nutritional changes will be promoted by working with both men and women;

[22] http://www.fao.org/3/I9540EN/i9540en.pdf

however women will be the main direct beneficiaries and key drivers for improved nutrition. Strengthening district nutrition strategies and plans, should ensure better coordination of nutrition activities at the local level.

The impact of this intervention will be measured in terms of jobs created, new enterprises established, income generated, diversification of production and consumption (including dietary diversity in women) and positive nutrition outcomes.

The aquaculture value chain can also contribute to achieving the Sustainable Development Goals – most especially SDG 2 - at both national and regional levels as highlighted in the report on "*Opportunities and challenges for aquaculture in developing countries*"[23].

3. Progress in implementing the Action Plan on Nutrition through other strategic priorities

As mentioned earlier, this year's report focuses on the life cycle which is most relevant to Strategic Priority 2: Scale up actions at country level. Progress has also been made in the other two strategic priorities, which will be discussed briefly:

Strategic Priority 1: Enhance mobilisation and political commitment for nutrition

One of the recommendations from last year's Progress Report was that the Commission should "*Leverage the EU's political capital as an agent for change in nutrition, by working in close cooperation with international initiatives*". To this end, two European Commissioners played leading roles in events linked to the Scaling Up Nutrition (SUN) movement and to Nutrition for Growth (an international initiative led by the governments of the United Kingdom, Brazil and Japan, to secure commitments from relevant stakeholders to end malnutrition in all its forms):

Commissioner for International Cooperation and Development, Neven Mimica, addressed the SUN Lead Group at its annual meeting on the margins of the UN General Assembly in September 2017. He highlighted specific concerns, including the detrimental division that persists between development and humanitarian assistance. Nutrition does not abide by such boundaries, and the new EU strategic approach to resilience will help to break down these divisions.

Commissioner for Health and Food Safety, Vytenis Andriukaitis, addressed the Global Nutrition Summit in Milan (linked to Nutrition for Growth, and the first forum of the UN Decade of Action on Nutrition). He drew attention to the continuing need for action across multiple sectors to improve nutrition as well as food security and sustainable agriculture. The new European External Investment Plan (EIP) will unleash EUR 44 billion of new investment for such progress, including in support of agri-business. The EIP will encourage investment in our partner countries in Africa and the neighbourhood region, notably by attracting private resources and applying innovative financing models. This builds on the existing blending activities which combine grant assistance with funding from other sources of finance. Furthermore, the new EFSD Guarantee Fund will make available EUR 1.5 billion in the form

[23] https://europa.eu/capacity4dev/hunger-foodsecurity-nutrition/documents/opportunities-and-challenges-aquaculture-developing-countries
A joint report from the European Commission, French Development Agency (AFD) and the German International Development Agency (GIZ).

of guarantees for investment portfolios of eligible counterparts in 5 thematic windows, including one dedicated to "Sustainable Agriculture, Rural Entrepreneurs and Agribusiness".

During this period the EU-Africa Research and Innovation Partnership on Food and Nutrition Security and Sustainable Agriculture [24] also grew stronger: 12 projects focusing on food/nutrition security and sustainable intensification, supported by Horizon 2020 and the EU pan-African Programme with about EUR 24 million, became operational; the African Union Research Grants programme launched a second call for proposals (EUR 8 million), with particular attention on agriculture and food systems for nutrition; further investments of about EUR 90 million are expected to come from the Horizon 2020 Work Programme 2018-2020.

The Commission has continued to work closely with EU Member States to build synergies and alignment. At the international level, this has included leading the development of a Joint Position Paper on nutrition sensitive agriculture[25], to strengthen the EU and Member State coordination, advocacy and investments at country and global levels.

Strategic Priority 2: Scale up actions at country level

As presented in the introduction of the report, this year, the Progress Report is highlighting the improvements the Commission is seeking to make in the lives of individuals – through the life cycle. Therefore, progresses in implementing the Action Plan on Nutrition throughout the life cycle are described under Chapter 2.

Strategic Priority 3: Knowledge for nutrition (strengthening the expertise and the knowledge-base)

This continues to be an important element in the Commission's contribution to nutrition. One of the most significant developments over the last year concerns progress in the initiative on National Information Platforms for Nutrition [26]. Contracts have been signed in nine countries[27], and work is now focusing on putting together the country teams and to begin operationalizing the platforms.

The Commission has continued to work closely with WHO on tracking progress in stunting at the country and international levels. Furthermore, it has engaged in strategic dialogue with FAO, UNICEF and WFP to explore potential collaboration on nutrition. Following on from the Improved Global Governance for Hunger Reduction programme, the Commission continues to support FAO through the FIRST [28] initiative to strengthen the enabling environment for food and nutrition security and sustainable agriculture in 33 priority countries, and INFORMED[29] which aims to improve the availability of information and evidence-based analysis on food security, nutrition and resilience to support decision-making in selected countries.

Also noteworthy are the investments being made in evaluative research. In order to provide insights into the effectiveness and cost effectiveness of various interventions in addressing undernutrition, the Commission is supporting research linked to programmes in Burkina Faso and Mali. For instance, the evaluative research in Mali is measuring and comparing the effects of different interventions on the resilience of poor households to food and nutrition insecurity

[24] https://ec.europa.eu/research/iscp/index.cfm?pg=africa
[25] Sowing the Seed. How Agriculture can Contribute to Better Nutrition Outcomes: A Joint Position Paper. Draft, January 2018
[26] http://www.nipn-nutrition-platforms.org/
[27] Bangladesh, Burkina Faso, Côte d'Ivoire, Ethiopia, Guatemala, Kenya, Niger, Lao PDR, Uganda and Zambia.
[28] Food and Nutrition Security Impact, Resilience, Sustainability and Transformation.
[29] Information for Nutrition Food Security and Resilience for Decision Making.

and childhood stunting, living in different agro-ecological and security contexts. In addition, as part of its support to addressing micronutrient deficiencies, the Commission is identifying potential topics for an operational research agenda to guide the scale-up of effective and sustainable (national) fortification programmes.

The *Food 2030* initiative continues to promote investments in research and innovation to yield impactful results for nutrition and food systems. Two high-level events have been convened to date[30], helping to galvanise political commitment as well as action.

4. Progress in supporting partner countries to reduce the number of children stunted

Stunting Progress

Focusing on the 40 countries prioritised by the Commission for nutrition, year-by-year progress is seen in three respects:

i) A reduction in the prevalence of stunting from 39.6% in 2012 to 35.8% in 2017 (see Annex 1).

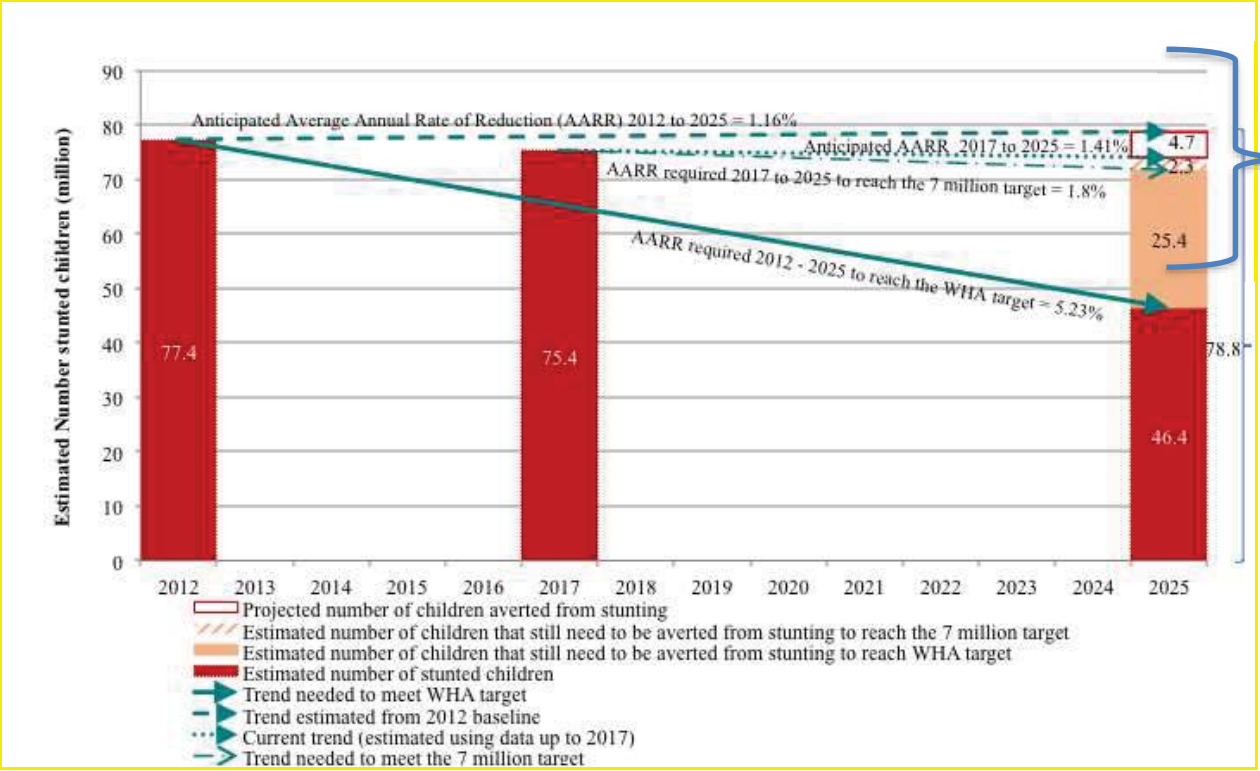
ii) An accelerating pace of stunting reduction from 1.16% in 2012 to 1.41% in 2017 (see Figure 3), reducing the gap to the 1.8% required between 2017 and 2025 to reach the Commission's target of 7 million children averted from stunting.

iii) An increase in the projected number of children averted from stunting by 2025; anticipated as 1 million in 2016 and now predicted at 4.7 million[31] in 2018 (see Figure 3). This demonstrates a doubling in the anticipated number of children averted from stunting compared to last year. Even though this cannot be attributed to the Commission alone - the results have been achieved through the combined efforts of all actors, national and international – it is an encouraging improvement.

[30] In 2016: https://ec.europa.eu/info/events/food-2030-research-and-innovation-tomorrows-nutrition-and-food-systems-2016-oct-12_en
In 2018: http://ec.europa.eu/research/index.cfm?eventcode=3FF3C9E1-AC0B-33A4-C651E86834D63C0D&pg=events

[31] The number of children averted from stunting by 2025, estimated at 4.7 million, is calculated as the difference between the anticipated number of children stunted in 2025 (based on the 2012 baseline and trend), and the anticipated number of children stunted in 2025 (based on 2017 estimates).

Figure 3: Stunting progress in the 40 Countries prioritised by the Commission for Nutrition, showing projected trends to reach the WHA and the Commission's targets by 2025



The country-by-country breakdown of how the above progress has been achieved is presented in Annex I. More detailed graphs, analysing each country's progress towards the WHA target, and any national target they have, are available online:

https://ec.europa.eu/europeaid/nutrition-map_en.

Factors potentially influencing stunting trends

To better understand potential factors that contribute to stunting changes in the 42 partner countries prioritising nutrition, a comprehensive dashboard has been assembled (see Annex II, which includes a full legend and description of the methodology). This presents key indicators relevant to stunting reduction for these countries. The indicators span a simple results chain model along the input-impact pathway, plus relevant contextual indicators:

Inputs:

- Nutrition commitments (2014-2016, EUR millions)

Process/activities:

- Nutrition disbursements (2014-2016, EUR millions)

Outputs:

- Number of women and children benefiting from nutrition programmes (2016-2017)

Outcomes:

- Depth of the food deficit (kcal/capita/day)
- Exclusive breastfeeding of infants < 6 months (%)

Impact:

- Stunting prevalence in children under 5 years of age (%)
- Rate of stunting reduction (%)

Context:

- Programme Coverage (%)
- HANCI Score
- Population Growth (millions)
- Gender Inequality Index
- Global multi-poverty index

All indicators are drawn from data already available (see Annex II for their full description and sources), and were selected based on their links to nutrition and on the frequency with which they are updated.

The dashboard provides a useful indication of where progress has been made in each country as well as where bottlenecks exist that may affect future progress.

The dashboard notably indicates that:

- 36 of the 42 countries prioritising nutrition (86%) are estimated to have improved their stunting prevalence between 2012 and 2017.
- The ten countries affected by conflict[32] show lower overall improvement for both stunting prevalence and rate of stunting reduction compared to non-conflict countries.
- All Asian countries are estimated to have seen improvement in stunting prevalence. This may have been supported by the improvements seen in food security (indicated by the depth of food deficit), gender inequality and multi-dimensional poverty. However, less than half the Asian countries are estimated to have accelerated the pace in stunting reduction, which may be linked to their worse performance, compared to all other countries, in exclusive breastfeeding, programme coverage, and HANCI score.
- 79% African countries are estimated to have seen an improvement in stunting prevalence since 2012. Sahel countries are performing relatively better than other African countries, with 83% of them estimated to have seen an improvement in stunting prevalence between 2012 and 2017. A variety of factors, including progress in some of the contextual indicators, could explain this improvement.
- Out of the 42 countries, 22 are estimated to have improved their performance in at least half of the indicators (5 out of 9) for outcome, impact and context.
- Of the six countries - all African - where the indicator for stunting prevalence has either worsened since 2012 (Angola, Djibouti, and Sudan) or remained static (Burundi, Chad, and The Gambia), four have shown no progress in, or worsened programme coverage[33].
- Across the 42 countries, two of the five context indicators are performing worse than the others which could have bearing on stunting reduction: limited programme coverage and

[32] Afghanistan, Burundi, Chad, DRC, Mali, Myanmar, Nigeria, Somalia, Sudan and Yemen.

[33] Programme coverage is a composite indicator, that combines the estimated coverage of five programmes: treatment of severe acute malnutrition; Vitamin A supplementation; under-five year old children with diarrhoea receiving oral rehydration solution; Immunisation with DTP3 (diphtheria, tetanus and polio); and Iodised salt consumption.

low ranking in the Hunger and Nutrition Commitment Index (HANCI). This is more striking in the case of Asian countries than African.

The individual dashboards for each of the countries are available online (https://ec.europa.eu/europeaid/nutrition-map_en).

5. Progress in ensuring the allocation of EUR 3.5 billion to improve nutrition

Between 2015 and 2016, the nutrition commitments rose from EUR 546.6 million to EUR 1,061.5 million (of which EUR 167.5 million was nutrition specific and EUR 894 million was nutrition sensitive[34]). Nutrition commitments through DEVCO nearly trebled from EUR 309.6 million in 2015 to EUR 893 million in 2016, though preliminary estimates of 2017 nutrition commitments indicate a marked drop, to EUR 343.3 million (see Figure 4). The drop in nutrition commitments indicated for 2017 has to be considered in the context of the 2014-2020 programming cycle. Being over half-way through, 2017 sees a shift in emphasis towards making financial disbursements in line with the financial commitments made earlier in the programming period.

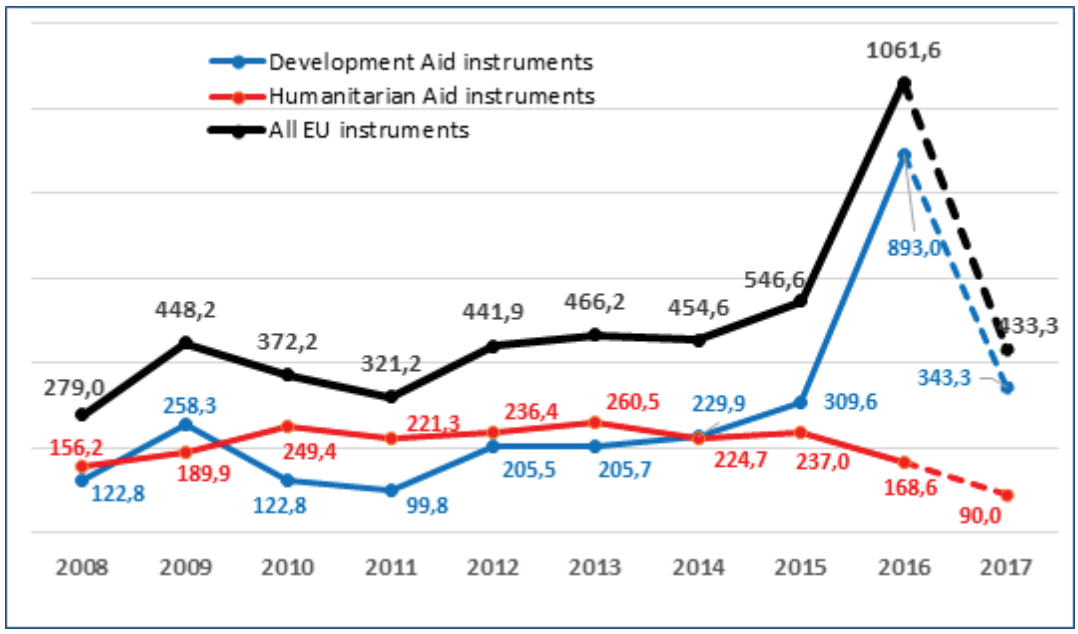
Table 1: Nutrition commitments by category, year and funding source (Euro millions)

Funding Source	Nutrition category	2010	2011	2012	2013	2014	2015	2016	2017 (preliminary)
Commission's development aid instruments	Specific	50.6	1.8	18.7	66.8	33.9	53.0	167.49	68.0
	Dominant	25.2	11.0	25.0	41.1	25.0	18.1	244.45	0
	Partial	46.9	87.1	161.8	97.8	171.0	238.6	481.05	275.34
Subtotal		***122.8***	***99.8***	***205.5***	***205.7***	***229.9***	***309.6***	***892.99***	***343.34***
Commission's humanitarian aid instruments	Specific	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
	Dominant	146.1	51.4	141.5	130.0	91.5	87.5	0.0	0
	Partial	103.3	169.9	94.9	130.5	133.2	149.5	168.59	89.99
Subtotal		***249.4***	***221.3***	***236.4***	***260.5***	***224.7***	***237.0***	***168.59***	***89.99***
TOTAL		**372.2**	**321.2**	**441.9**	**466.2**	**454.6**	**546.6**	**1,061.58**	**433.33**

The large increase in the nutrition commitments through DEVCO in 2016 reflects a number of factors including; increased awareness of the importance of nutrition in the development agenda, the Commission's efforts at national level to engage partner countries in nutrition programmes, and the application of multisectoral approaches which integrate nutrition in different sectors, such as agriculture, social protection, education, water, sanitation and hygiene amongst others.

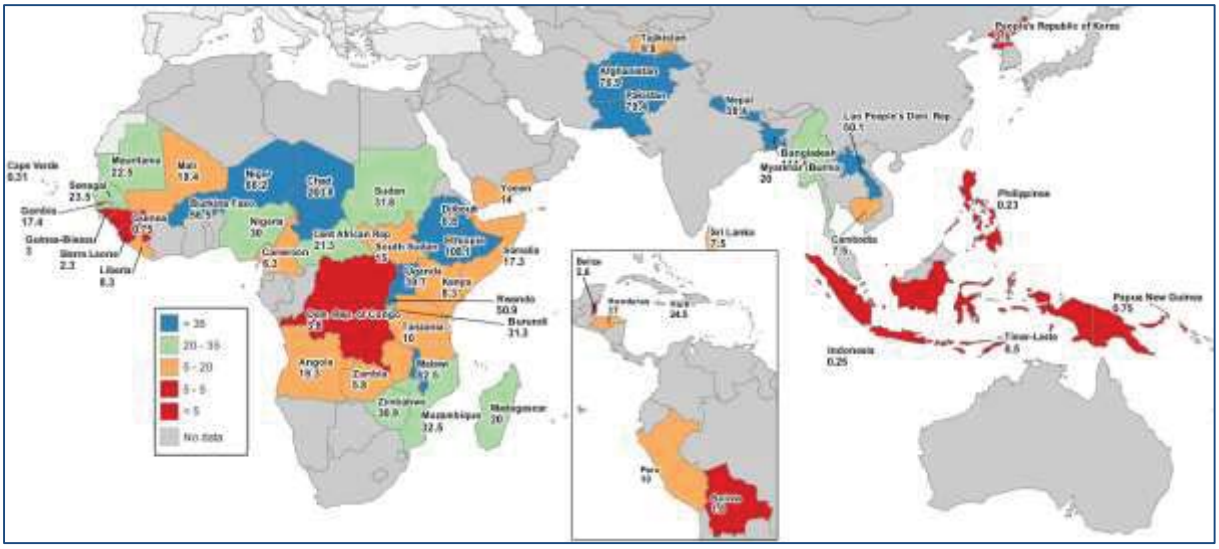
[34] Nutrition-specific commitments are identified by the DAC purpose code 12240 for "basic nutrition". Nutrition-sensitive commitments are identified through a 3-step process, as agreed by the SUN donor network: Step one: Selecting a pool of potentially nutrition-sensitive projects using a combination of DAC codes and key words. Step two: Reviewing these projects individually to determine if they are: Aimed at individuals; and have a significant nutrition objective or nutrition indicator(s); and contribute to explicit nutrition-sensitive outcomes. Step three: Classifying the "intensity" of nutrition-sensitivity into two sub-categories: nutrition-sensitive *dominant* (when the full project (main objective, results, outcomes and indicators) is nutrition-sensitive), or nutrition-sensitive *partial* (when part of the project (one of the objectives, results, outcomes, indicators) is nutrition-sensitive).

Figure 4: The Commission's nutrition commitments 2010 to 2017 (Euro, millions) [35]



Note: data for 2017 are preliminary estimates, not yet officially reported to the OECD DAC.

Figure 5: Map of total nutrition commitments through DEVCO, 2014-2017 (Euro, millions)



As shown in Figure 6, the share of funding channelled through the EU institutions, such as regional trust funds[36] increased markedly in 2016 and 2017 compared to 2014 and 2015, in line with the Paris Declaration principle of harmonisation and transaction costs reduction.

Figure 6: Nutrition commitments through DEVCO, by implementing partner,[37] 2014-2017, (Euro)

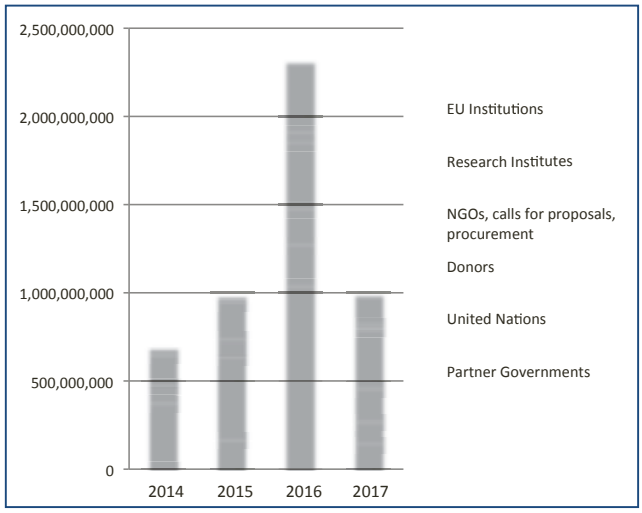
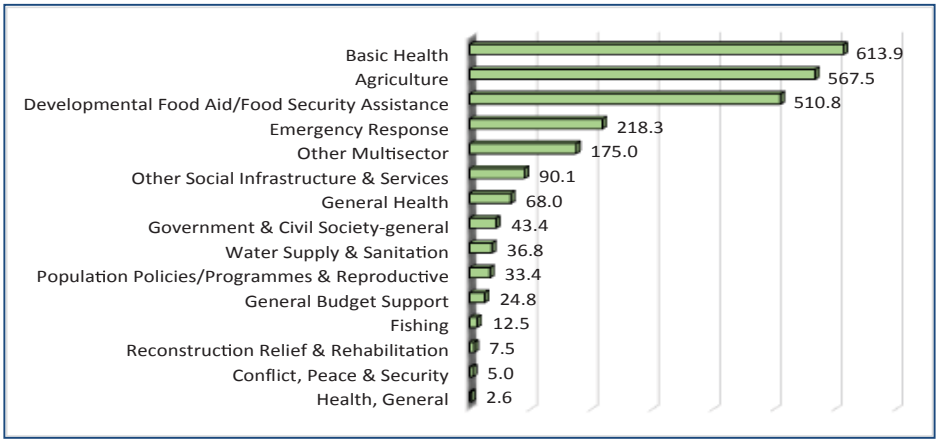


Figure 7 shows the sectors concerned by Commission nutrition commitments, which mainly focussed on basic health, agriculture, and developmental food aid/food security assistance in 2010-2017.

Figure 7: Nutrition commitments through DEVCO, by sector, 2010-2017 (Euro, millions)



[36] The Trust Fund for North Africa; Trust Fund for the Sahel and Lake Chad; Trust Fund for Horn of Africa; and Trust Fund for Central African Republic (Bêkou). For 2017, 10 EU Trust Fund Programmes are nutrition-sensitive for an amount of EUR 49.2 million.

[37] Note: these figures are for the whole financial commitment, not just the nutrition component, as it is not possible to allocate the specific funding going to each partner within a commitment. In addition, the categories are not entirely comparable across the years: 'NGOs, calls for proposals, procurement' includes for 2016 and 2017 budget lines for audit, evaluation, communication and visibility; 2016 and 2017 include DEVCO funding to ECHO (under EU Institutions).

Budget support has become an increasingly important implementation modality for nutrition. In 2016, total budget support that included a nutrition component amounted to EUR 737 million - up from EUR 131 million in 2015. Such budget support involves financial transfers from the Commission to the partner country's budget, along with policy dialogue, performance evaluation and capacity development. It is based on close partnership and mutual accountability. Budget support may involve several ministries (for example agriculture, health, education, hydraulics, family, economy and finance). For nutrition security, in particular, an inter-sectoral approach is vital.

Overall, with Commission commitments amounting to nearly EUR 2.5 billion in 2014-2017, the EU is on track to deliver on its commitment to dedicate EUR 3.5 billion to nutrition in 2014-2020.

6. Conclusions

Analysis of overall progress

At current predicted trends, the number of additional children averted from stunting in the Commission's 40 partner countries prioritising nutrition is expected to reach 4.7 million by 2025. Even though this could not be attributed only to the Commission's investments and actions that support efforts at country level, the financial and programming evidence presented in this report demonstrates that the Commission has substantially contributed to this improvement. Thus, the anticipated stunting burden in the 40 partner countries indicates a gap of 2.3 million children required to achieve the target of 7 million children averted from stunting. Given the year-on-year acceleration of progress seen since 2016, bridging this gap is possible.

The time-line for achievement of the financial commitment is tighter. Taking account of the preliminary results for 2017, the Commission has 3 years left to commit the EUR 1 billion needed to bring the cumulative total to the EUR 3.5 billion target by 2020. Achieving this commitment will demonstrate the Commission's intent to go against the global tide whereby global spending by donors on undernutrition, as a proportion of official development assistance, is dropping[38].

Key issues for the European Commission

Assessing the Impact of the Commission's Investments

To date, the Commission has evidenced progress with respect to its nutrition commitments by:

The amount of support it gives (financial commitments to nutrition);

The types of support it gives (increasing proportion of nutrition-sensitive commitments, and, within that, an increasing proportion of programmes designed with a close attention to nutrition (nutrition-sensitive dominant rather than partial);

The comprehensiveness of the support it gives (actions that span the strategic priorities of the Commission's Action Plan on Nutrition); and

The overall stunting progress being made in countries.

The Commission has wanted to go further than this, and has invested substantial effort over the last year or so, to examine more rigorously its contribution to the impact on reducing

[38] Global Nutrition Report, 2017, citing trends between 2014 and 2015.

stunting. It has worked closely with the World Health Organisation, Ghent University as well as other international experts, drawing on lessons learnt, to explore possible options.

Whilst it cannot estimate the number of children averted from stunting through its programmes alone, the Commission is taking steps to analyse how its assistance is contributing towards changes in stunting, by taking account of other factors that may have influenced this. The dashboard presented above, documenting the chain from input to impact through activities, outputs and outcomes, is the first step towards this. It is anticipated that this will be followed by:

Further multi-level analyses, using dynamic regression techniques, to develop a classification of countries relating to stunting and its causes and to inform the choice of the most appropriate multi-sectoral approaches that might be effective in reducing stunting. The results from these analyses will be used to guide further operational research to generate more evidence and reduce knowledge gaps. This will substantiate the Commission's efforts to move towards more plausible assessment of its contribution to tackling stunting both globally and at country levels.

In addition, such multi-level analyses could also be undertaken with respect to other forms of malnutrition - and the co-occurrence of different forms - that have sufficient data to allow dynamic regression techniques to be applied. These would provide further insights into all forms of malnutrition and the Commission's plausible contribution towards tackling them.

All the preceding analyses will inform investments in longer-term operational research at country level. These would, in turn, lead to better understanding of the dynamics of the changes in stunting and the specific influence Union-funded programmes have had.

Together, these efforts will provide more rigorous analysis and assessment of the Commission's contribution towards the changes seen in stunting, and thereby strengthen its accountability for its use of public funds and for its commitments, although it will not allow the Commission to estimate the number of children averted from stunting through the Commission's investments and programmes alone. Such new insights will be presented in the next year's Progress Report.

Positioning of the Commission's nutrition work

With approximately one third of the world's population suffering from at least one form of malnutrition, combatting malnutrition in all its forms presents one of the greatest global challenges. The Sustainable Development Goals, and most especially SDG 2, which defines global aspirations to eliminate all forms of malnutrition by 2030, are laudable. Yet, overall progress is slow and uneven. The Commission is fully aware of the complexity of the task to improve nutrition, and has learned critical lessons over the last few years from its work, such as the importance of strong partnership with national governments addressing undernutrition as a national concern, and supporting their national strategies and plans accordingly; the value of doing so through coordinated efforts with other development partners, civil society organisations and the private sector, so as to create alignment and synergies; and the importance of strategic and geographic focus in the Commission's nutrition work. Only by grasping malnutrition as a developmental challenge – in terms of human health, social equity and economic security – can meaningful progress be made. For the EU, and as underscored in the 2017 European Consensus, the 2030 SDG Agenda provides an opportunity to embed nutrition at the heart of development.

"We have known for some time that actions delivered through the 'nutrition sector' alone can only go so far. For example, delivering the 10 interventions

that address stunting directly would only reduce stunting globally by 20%. The SDGs are telling us loud and clear: we must deliver multiple goals through shared action. Nutrition is part of that shared action"[39].

Achieving the European Union's Commitments

1. To achieve the European Union's financial commitment by 2020

The Union is well placed to achieve the EUR 3.5 billion target committed to in 2013. It will be critical that funding available continues to be programmed with nutrition sensitivity and that funding possibilities are fully capitalised upon.

The Mid-Term Review of the status of spending under the National Indicative Programmes of the 11th European Development Fund indicates that up to EUR 2.3 billion are remaining within focal sectors that are related to nutrition, in the 40 partner countries. Ten countries are highlighted as having the highest potential financial contribution to make to nutrition (Afghanistan, Bangladesh, Chad, Cameroon, Ethiopia, Mozambique, Myanmar, Pakistan, Tanzania and Zambia).

In addition, the Commission will continue to help leverage additional funds from other sources, advocating for the mobilisation of global and domestic resources.

2. To achieve the European Union's stunting commitment by 2025

Evidencing direct attribution of stunting changes to the Union's investments and programmes is not feasible in a pragmatic and cost-effective manner. The Commission is analysing progress in stunting reduction and evidencing the mechanisms through which its financial commitments and programmes are likely to have contributed to bring these changes about. Since 2016, the estimated number of additional children averted from stunting has increased from 1 million to 4.7 million. There is scope to accelerate stunting improvements by integrating measures to address multiple forms of malnutrition in individual programmes, such as wasting, anaemia in women and adolescent girls and overweight/obesity. This need not imply more resources, but rather more attention to achieving nutrition outcomes in the design of interventions coupled with rigorous monitoring and evaluation processes. This includes breaking the divide between humanitarian and development support on wasting and stunting.

Furthermore, it requires that nutrition is constantly at the core of the development policy dialogue with partner countries as well as collaboration through joint programming with other development partners, especially EU Member States, which would have the additional benefit of integrating nutrition across the humanitarian-development nexus.

One of the measures well suited to tackling both undernutrition and overweight/obesity is support to the protection and promotion of exclusive breastfeeding in the first 6 months of life. There is evidence to suggest that 823,000 deaths in children under five could be avoided

[39] Global Nutrition Report, 2017.
The 10 nutrition-specific interventions, identified by the Lancet 2013 series are: 1. Maternal multiple micronutrient supplements to all; 2. Calcium supplementation to mothers at risk of low intake; 3. Maternal balanced energy protein supplements as needed; 4. Universal salt iodisation; 5. Promotion of early and exclusive breastfeeding for 6 months and continued breastfeeding for up to 24 months; 6. Appropriate complementary feeding education in food secure populations and additional complementary food supplements in food insecure populations; 7. Vitamin A supplementation between 6 and 59 months age; 8. Preventive zinc supplements between 12 and 59 months of age; 9. Management of moderate acute malnutrition; and 10. Management of severe acute malnutrition.
See table 2: http://www.thelancet.com/pb/assets/raw/Lancet/stories/series/nutrition-eng.pdf

each year (or 13.8% of deaths amongst children under 2 years of age) if almost every mother breastfed her babies[40].

3. Securing continued progress

Another measure concerns the Commission's comparative advantage in nutrition-sensitive programming, together with nutrition-specific interventions, where appropriate. The Commission will continue to generate and consolidate evidence on the impact of the array of nutrition-sensitive interventions by not only strengthening programme monitoring and evaluation, but also by investing in operational and implementation research to provide such evidence of effectiveness, as well as strengthening capacities at country level.

[40] Victoria, C. et al, 2016. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *The Lancet*, Vol. 387 January 30, 2016.

ANNEX I: Stunting situation in the 40 countries prioritising nutrition from 2012 to 2025[41]

40 Countries prioritising nutrition	Baseline prevalence of stunting in 2012 (estimated in 2018)	Number of children stunted in 2012 (estimated in 2018)	Number of children projected to be stunted in 2017 (based on 2012 baseline and trend) A	Prevalence of stunting in 2017 (estimated in 2018)	Number of children stunted in 2017 (estimated in 2018) B	Number of children projected to be stunted in 2025 (based on 2012 baseline and trend) C	Number of children projected to be stunted in 2025 (estimated in 2018) D	Estimated number of children averted from stunting 2012-2017 A-B	Estimated number of children averted from stunting 2012- 2025 C-D
Total	**39.57%**	77,368,840	78,373,373	**35.82%**	75,388,542	78,772,043		**2,984,830**	**4,710,585**
Africa	38.87%	50,847,246	53,263,673	35.26%	51,111,805	56,285,697	52,798,664	2,151,868	3,487,034
Angola	20.78%	997,404	798,813	30.78%	1,662,162	559,697	1,625,340	-863,349	-1,065,642
Benin	47.37%	775,385	916,344	35.99%	651,147	1,174,889	712,739	265,198	462,149
Burkina Faso	34.87%	1,041,394	1,065,115	29.55%	969,868	1,099,462	954,406	95,247	145,056
Burundi	59.21%	1,012,058	1,161,339	59.49%	1,161,339	1,361,733	1,361,733	No stunting data since 2012	
Cameroon	33.96%	1,205,695	1,278,091	32.09%	1,238,967	1,366,462	1,307,376	39,124	59,086
Chad	38.98%	943,236	1,022,625	38.82%	1,058,213	1,120,391	1,179,154	-35,588	-58,762
Côte d'Ivoire	37.73%	1,325,052	1,594,656	31.12%	1,228,113	2,064,883	1,442,876	366,543	622,007
DRC	42.68%	5,532,414	6,064,117	41.03%	6,091,000	6,668,075	6,711,465	-26,882	-43,390
Ethiopia	43.49%	6,191,645	5,988,710	37.98%	5,835,447	5,356,042	5,161,327	153,262	194,715
Gambia	22.33%	73,077	73,339	22.00%	80,945	69,953	80,913	-7,606	-10,960
Guinea-Bissau	28.62%	77,256	77,318	26.19%	77,254	72,765	72,668	64	96
Kenya	37.37%	2,579,077	2,627,219	30.80%	2,186,096	2,866,721	2,226,152	441,122	640,569
Madagascar	47.91%	1,690,366	1,754,749	45.61%	1,754,749	1,900,694	1,900,694	No stunting data since 2012	
Malawi	48.74%	1,377,947	1,394,613	41.45%	1,229,409	1,566,874	1,305,800	165,204	261,074
Mali	31.38%	971,777	1,007,614	27.63%	938,141	1,087,733	985,696	69,473	102,037
Mauritania	24.65%	147,035	140,720	22.64%	151,050	123,205	135,826	-10,331	-12,621
Mozambique	41.21%	1,872,612	1,911,465	37.87%	1,911,465	1,956,614	1,956,614	No stunting data since 2012	
Niger	44.86%	1,645,274	1,778,519	41.90%	1,829,582	1,997,957	2,087,821	-51,063	-89,864
Nigeria	38.24%	11,128,984	11,726,803	33.73%	10,921,703	12,227,291	11,065,738	805,100	1,161,553
Rwanda	44.82%	763,407	753,214	39.43%	689,593	730,404	644,595	63,621	85,809
Senegal	17.80%	412,295	402,412	16.75%	432,874	359,248	396,166	-30,462	-36,918
Sierra Leone	40.59%	453,688	467,092	35.10%	403,620	498,613	409,278	63,472	89,335
Somalia	30.38%	731,456	796,096	29.64%	796,096	930,845	930,845	No stunting data since 2012	
Uganda	34.66%	2,420,973	2,530,072	30.60%	2,412,032	2,667,765	2,495,884	118,040	171,881
Utd. Rep. of Tanzania	39.11%	3,400,613	3,600,952	34.65%	3,417,797	3,786,287	3,513,704	183,155	272,582
Zambia	48.67%	1,250,522	1,410,663	41.84%	1,208,607	1,704,721	1,373,503	202,056	331,218
Zimbabwe	35.02%	826,606	921,004	30.39%	774,535	966,372	760,351	146,469	206,021
Asia	41.44%	25,078,771	23,732,234	37.37%	22,893,042	21,230,184	19,997,569	839,192	1,232,616
Afghanistan	57.15%	2,993,726	3,056,649	44.82%	2,362,576	3,287,648	2,240,355	694,073	1,047,293
Bangladesh	40.07%	6,197,449	5,335,742	34.73%	5,268,072	4,066,212	3,995,132	67,670	71,080
Cambodia	36.80%	644,100	568,125	30.75%	543,094	444,597	415,424	25,031	29,173
Lao PDR	43.65%	344,716	316,216	41.42%	316,216	281,445	281,445	No stunting data since 2012	
Myanmar	31.81%	1,483,738	1,243,568	28.04%	1,268,579	976,092	1,003,663	-25,011	-27,571
Nepal	39.92%	1,205,498	936,705	34.33%	942,414	725,970	732,422	-5,710	-6,452
Pakistan	41.67%	9,924,398	9,949,051	39.60%	9,949,051	9,186,758	9,186,758	No stunting data since 2012	
Sri Lanka	15.26%	266,065	206,517	13.11%	206,517	146,197	146,197	No stunting data since 2012	
Timor-Leste	56.80%	112,967	120,196	51.00%	106,107	138,076	112,758	14,089	25,318
Yemen	49.84%	1,906,115	1,999,466	46.92%	1,930,416	1,977,189	1,883,413	69,050	93,776
Latin America	34.63%	1,442,823	1,377,466	32.75%	1,383,696	1,256,161	1,265,226	-6,230	-9,065
Guatemala	47.32%	915,950	925,126	45.66%	931,356	890,612	899,676	-6,230	-9,065
Haiti	22.84%	286,215	247,558	20.09%	247,558	198,196	198,196	No stunting data since 2012	
Honduras	24.63%	240,658	204,782	21.49%	204,782	167,354	167,354	No stunting data since 2012	

[41] Figures are based on calculations by the Commission, using a methodology agreed with WHO, based on data presented in the Global Database on Child Growth and Malnutrition. All estimates use the latest (2017) demographic data published by World Population Prospects of the UN.

ANNEX II: Country Dashboard

	Inputs	Process/Activiti	Outputs	Outcomes				Impact				Context									
	DEVCO Nutrition Commitments 2014-2016 (EUR millions)	DEVCO Nutrition Disbursements 2014-2016 (EUR millions)	No. of women + children benefiting from DEVCO nutrition assistance (2016-2017)	Depth of the food deficit (kcal/capita/day)		Exclusive breastfeeding of infants < 6 months (%)		Stunting Prevalence in children under 5 years of age		Rate of stunting reduction (%)		Programme Coverage (mean %)		HANCI Score		Population Growth (millions)		Gender Inequality Index (range 0 to 1)		Global multi-poverty index (range 0 to 1)	
				3-year average 2014-2016	Change since 2012 baseline	Most recent data	Change since 2012 baseline	2017 Estimate	Change since 2012 baseline	2017 Estimate	Change since 2012 baseline	Most recent data (2016)	Change since 2012 baseline	Most recent data	Change since 2012 baseline	Most recent data (2016)	Change since 2012 baseline	Most recent data (2015)	Change since 2012 baseline	Most recent data	Change since 2012 baseline
AFRICA																					
Angola	-	0.17	-	89		-	-	30.8		2.60		32.2		85		3.37		-	-	0.2592	
Benin	-	-	-	67		41.4		36.0		0.64		71.9		169		2.76		0.613		-	-
Burkina Faso	56.50	26.75	32,259	159		50.1		29.6		2.01		68.7		207		2.92		0.615		-	-
Burundi	7.50	5.55	-	-	-	-	-	59.5		-	-	67.0		149		3.14		0.474		-	-
Cameroon	6.25	3.04	-	50		28.2		32.1		0.67		70.8		124		2.61		0.568		-	-
Chad	201.25	25.34	36,667	246		0.3		38.8		0.55		60.8		105	-	3.11		0.695	-	0.5521	
Côte d'Ivoire	-	-	-	113		-	-	31.1		-0.15		46.6		185		2.51		0.672		-	-
DRC	3.75	9.84	-	-	-	47.6		41.0		0.85		59.9		150		3.28		0.663		0.4009	
Djibouti	-	0.43	-	96		-	-	33.7		-	-	69.6		-	-	1.60		-	-	-	-
Ethiopia	90.38	58.99	-	201		-	-	38.0		2.31		54.7		163		2.50		0.499		0.5058	
Gambia	12.25	1.88	-	69		46.8		22.0		1.67		42.7		199		3.03		0.641		0.3226	
Guinea-Bissau	3.00	7.61	-	204		52.5		26.2		1.75		61.2		77		2.52		-	-	0.3708	
Kenya	4.50	7.73	-	120		61.4		30.8		1.05		72.9		221		2.56		0.565		0.1874	
Madagascar	0.00	3.01	-	306		41.9		45.6		-	-	53.0		222		2.69		-	-	-	-
Malawi	70.00	3.16	-	179		61.2		41.4		1.41		67.2		233		2.90		0.614		0.2506	
Mali	18.39	37.64	-	24		-	-	27.6		1.44		40.4		179		2.97		0.689		-	-
Mauritania	11.25	7.76	2,682	35		-	-	22.6		2.75		55.3		116		2.80		0.627		-	-
Mozambique	32.50	8.40	-	192		41.0		37.9		-	-	57.2		162		2.88		0.574		-	-
Niger	53.67	51.08	729,006	67		-	-	41.9		1.72		60.0		157		3.83		0.695		-	-
Nigeria	25.03	14.43	466,529	48		17.4		33.7		1.44		60.7		115		2.62		-	-	0.3027	
Rwanda	50.00	30.84	-	321		87.3		39.4		1.25		78.4		204		2.45		0.383		0.2587	
Senegal	23.53	21.20	-	71		33.3		16.8		2.33		61.5		183		2.86		0.521		0.2956	
Sierra Leone	2.25	3.95	43,672	228		32.0		35.1		0.63		54.0		140		2.18		0.650		0.4645	
Somalia	17.25	8.21	230	-	-	-	-	29.6		-	-	22.2		-	-	2.90		-	-	-	-
Sudan	19.00	9.87	-	184		55.4		36.7		0.03		46.1		75		2.38		0.575		0.2866	
Tanzania	10.00	-	-	237		59.2		34.7		1.64		71.4		212		3.09		0.544		0.2843	
Uganda	34.70	1.64	-	284		-	-	30.6		1.75		56.7		151		3.29		0.522		-	-
Zambia	5.75	11.99	-	378		72.5		41.8		0.70		73.0		163		3.00		0.526		0.2815	
Zimbabwe	25.71	20.62	-	356		47.8		30.4		0.20		59.8		150	-	2.34		0.540		0.1520	
ASIA																					
Afghanistan	76.88	24.59	-	145		43.3	-	44.8		1.27		56.6		100		2.69		0.667		0.2953	
Bangladesh	100.14	7.14	-	107		55.3		34.7		2.63		48.3		185		1.08		0.520		0.1958	
Cambodia	7.50	0.76	-	108		65.2		30.8		2.93		51.3		133		1.56		0.479		0.1464	
Lao PDR	50.12	0.54	113	124		-	-	41.4		-	-	71.0		-	-	1.41		0.468		-	-
Myanmar	20.00	18.06	-	121		-	-	28.0		2.78		78.7		88		0.91		0.374		0.1342	
Nepal	28.43	6.88	-	54		56.9		34.3		3.06		60.0		205		1.13		0.497		0.1749	
Pakistan	19.37	10.22	89,634	151		37.7		39.6		-	-	55.1		138		2.00		0.546		-	-
Sri Lanka	7.50	-	-	195		-	-	13.1		-	-	65.0		-	-	1.12		0.386		-	-
Timor-Leste	0.50	8.20	-	180		62.3		51.0		0.63		56.8		-	-	2.21		-	-	-	-
Yemen	14.00	9.37	82,794	201		10.3		46.9		0.67		30.2		87		2.45		0.767		0.2357	
LATIN AMERICA																					
Guatemala	-	2.18	-	104		53.2		45.7		0.80		62.0		226		2.01		0.494		0.1131	
Haiti	18.00	8.88	-	468		-	-	20.1		-	-	35.1		-	-	1.26		0.593		-	-
Honduras	15.00	4.02	-	109		-	-	21.5		-	-	84.3		-	-	1.68		0.461		-	-

LEGEND

For each indicator the 42 countries were divided into three groups of 14 countries (top, middle and bottom) according to data from 2012, the baseline year. The same cut-offs were then applied to assess the status of the most recent data for each indicator:

Green: comparable performance to the top group of 2012
Orange: comparable performance to the middle group of 2012
Red: comparable performance to the bottom group of 2012

In addition, the change in each indicator (since 2012) is illustrated by a traffic light signal. Green indicates a notable improvement, red a notable deterioration, while orange denotes no or 'limited' change, calculated by subtracting the minimum value from the maximum value for each indicator, and then dividing by the number of countries.

	There has been an improvement since 2012
	There has been no or limited change since 2012
	There has been a deterioration since 2012

Indicator	Source	Comments
Nutrition commitments through DEVCO 2014-2016	European Commission	DEVCO figures, as reported to the OECD DAC in December 2017
Nutrition disbursements through DEVCO 2014-2016	European Commission	DEVCO figures, as reported to the OECD DAC in December 2017
N° women and children benefiting from EU nutrition assistance	European Commission	Internal indicator
Depth of food deficit	FAO statistical database (FAOSTAT)	The depth of food deficit is the difference between the average dietary energy consumption of undernourished people and the average dietary energy requirement, multiplied by the estimated number of undernourished people. denotes 0 ± 3.8 kcal/capita/day

Indicator	Source	Comments
Exclusive breastfeeding of infants less than 6 months	Global Nutrition Report (http://www.globalnutritionreport.org/the-data/dataset-and-metadata/)	Baseline is the data available for 2012 or the closest year before 2012. The latest available data varies between countries from 2013 to 2015. ● denotes 0 ± 1.6 %
Stunting prevalence children < 5 years	World Health Organisation (http://www.who.int/nutgrowthdb/estimates/en/)	● denotes 0 ± 0.53 %
Rate of stunting reduction	European Commission	Data was obtained through the 'stunting reduction calculation tool' developed by the European Commission and the World Health Organisation. Note: Minus numbers denote an increasing prevalence ● denotes 0 ± 0.19 %
Programme Coverage	Global Nutrition Report 2017: http://www.globalnutritionreport.org/the-data/dataset-and-metadata/	This indicator is a combination of the estimated coverage of 5 programmes: treatment of severe acute malnutrition; Vitamin A supplementation; under-five year old children with diarrhoea receiving oral rehydration therapy; Immunisation with DTP3 (diphtheria, tetanus and polio); and Iodised salt consumption If countries do not have coverage data for all 5 programmes, then the average is calculated from the coverage data available. The mean is calculated based on data available in 2017 (from the GNR 2017 database). ●

Indicator	Source	Comments
		denotes 0 ± 1.1 %
Hunger and Nutrition Commitment Index (HANCI)	HANCI 2012: (Table 4.5 p.57) https://opendocs.ids.ac.uk/opendocs/bitstream/handle/123456789/2955/ER25%20Final%20Online.pdf?sequence=1_source=hanci HANCI 2014: (Table 3.2 p.17) https://opendocs.ids.ac.uk/opendocs/bitstream/handle/123456789/7072/ER150_TheHungerandNutritionCommitmentIndexHANCI2014.pdf?sequence=1 HANCI Africa 2016: (p. 2) http://africa.hancindex.org/wp-content/uploads/sites/2/2017/01/HANCI-InfoMap_English_web.pdf	HANCI measures the political commitment of countries to reduce hunger and undernutrition in their populations. The latest available data varies between countries: 2016 for African countries and 2014 for non-African countries. denotes 0 ± 4.5 %
Population Growth	World Bank (https://data.worldbank.org/indicator/SP.POP.GROW)	The latest population estimates are used, from World Population Prospects (WPP) 2017 denotes 0 ± 0.2 %
Gender Inequality Index (GII)	United Nations Development Programme (http://hdr.undp.org/en/content/gender-inequality-index-gii http://hdr.undp.org/en/data)	The GII measures gender inequalities in 3 aspects of human development: - reproductive health, measured by maternal mortality ratio and adolescent birth rates; - empowerment, measured by proportion of parliamentary seats occupied by females and proportion of adult females and males aged 25 years and older with at least some secondary education; and - economic status, expressed as labour market participation and measured by labour force participation rate of female

Indicator	Source	Comments
		and male populations aged 15 years and older. It ranges from 0, where women and men fare equally, to 1, where one gender fares as poorly as possible in all measured dimensions. ● denotes 0 ± 0.0025 %
Global multi-poverty index (MPI)	Oxford Poverty and Human Development Initiative (http://ophi.org.uk/multidimensional-poverty-index/global-mpi-2017/mpi-data/)	The MPI is an internationally comparable measure of acute poverty for over 100 developing countries. It captures the multiple deprivations that each poor person faces at the same time with respect to education, health and living standards. The MPI reflects both the proportion of people in a population who are multidimensionally poor; and the intensity of poverty (the average percentage of deprivations each poor person experiences at the same time). It relies on two main datasets: the Demographic and Health Survey (DHS), and the Multiple Indicators Cluster Survey (MICS). Baseline is the data available for 2012 or the closest year before 2012. The latest available data varies between countries from 2013 to 2016. ● denotes 0 ± 0.01 %