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COMMISSION STAFF WORKING DOCUMENT

Fifth Progress Report on the Commission's Action Plan on Nutrition
April 2019 - March 2020

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Acronyms

2FAS	Food Fortification Advisory Service
AARR	Average Annual Rate of Reduction
AGPII	Second Agricultural Growth Programme
APN	Action Plan on Nutrition
C4N	Capacity for Nutrition
CSA	Climate Smart Agriculture
DAC	Development Assistance Committee of the OECD
DEVCO	Directorate-General for International Cooperation and Development
DFID	UK Department for International Development
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
ECHO	Directorate-General for European Civil Protection and Humanitarian Aid Operations
ECOWAS	Economic Community of West African States
EU	European Union
EUR	Euro
FAO	Food and Agriculture Organization (United Nations)
GII	Gender Inequality Index
GIZ	Gesellschaft für Internationale Zusammenarbeit
GDP	Gross Domestic Product
HANCI	Hunger and Nutrition Commitment Index
IFAD	International Fund for Agricultural Development
IRRIGAR	Initiative de Renforcement de la Résilience par l'Irrigation et la Gestion Appropriée des Ressources
JME	Joint Malnutrition Estimates (UNICEF, WHO, World Bank Group)
JRC	Directorate-General Joint Research Centre
IFPRI	International Food Policy Research Institute
KfW	German Development Bank
MDG1c	Millennium Development Goal 1c
MPI	Global Multi-Poverty Index
NCDs	Non-Communicable Diseases
NGOs	Non-governmental Organizations
NIPs	National Indicative Plans
NIPN	National Information Platforms for Nutrition
NRF	Nutrition Research Facility
OECD	Organization for Economic Cooperation and Development
SNNPR	Southern Nations, Nationalities, and Peoples' Region (Ethiopia)
SRCT	Stunting Reduction Calculation Tool
SDGs	Sustainable Development Goals
SETSAN	Secretariat for Food and Nutrition Security (Mozambique)
SUN	Scaling Up Nutrition
WASH	Water, Sanitation and Hygiene
WHA	World Health Assembly
WHO	World Health Organization (United Nations)
WFP	World Food Programme
UN	United Nations
UNICEF	United Nations Children's Fund
UNECA	United Nations Economic Commission for Africa
USAID	United States Agency for International Development

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Key messages

This fifth progress report provides an update on achievements with respect to the European Union's (EU) two ambitious commitments on nutrition: to support partner countries to reduce the number of stunted children under the age of five by at least 7 million by 2025; and to allocate EUR 3.5 billion to nutrition between 2014 and 2020.

The annual resource-tracking exercise presented here confirms that by 2019[1], the EUR 3.5 billion global pledge for nutrition had already been achieved – one year ahead of schedule. In 2018, the latest year for which officially reported data is available, 41 new EU interventions approved had nutrition-relevant components amounting to EUR 546 million. Of this sum, EUR 80 million has been programmed through budget support, more than double the amount committed via budget support in 2017 and confirming partner governments as the largest category of recipients of the EU development funding for nutrition.

With respect to the pledge for stunting reduction, latest estimates indicate that, compared to 2012 when there were 77 million stunted children in the 40 countries prioritising nutrition, in 2019 this number had fallen to 75.4 million. This is due to a reduction in the prevalence of stunting in most of the countries (39 out of 40). If this trend continues, the number of stunted children will fall to 72.3 million by 2025, bringing the number of children averted from stunting since 2012 to 4.7 million. The challenge over the next 5 years will therefore be to accelerate significantly the annual rate of stunting reduction (from 1.35% to 1.82%) so that the 7 million target is achieved.

A degree of caution is required with such projections, since data quality remains a concern in a number of countries with significant implications for the calculation of trends, and with adjustments often made following ongoing scrutiny and the application of internationally agreed standards. An additional challenge is presented by the increasing population and therefore growing number of children in countries prioritising nutrition despite the clear progress being made with reducing stunting prevalence. In African countries prioritising nutrition alone, the under-five population is expected to increase by 34.5 million[2] between 2012 and 2025 compared to an increase of 2.7 million in Asian and Latin American countries prioritising nutrition. Therefore, in order to reach the target of 7 million children averted from stunting the Commission will need to continue investing in effective multi-sectoral nutrition-related actions at country level, supporting partner countries to address the diet, care and health-related problems that cause malnutrition.

This year, the progress report also presents concrete examples showing that investments in nutrition are delivering tangible improvements in the lives of women and children. New insights from multi-sectoral programmes supported by the EU clearly illustrate the changes taking place on the ground. In the case studies (from Ethiopia, Mali, Mozambique and Bangladesh), it is clear that financial resources are being converted into results – whether in terms of breastfeeding, quality of diet, people's resilience or stunting reduction. An additional case study from Guatemala highlights the focus on strengthening country leadership – in particular by ensuring accountability for delivering real change – via support to national information systems for food and nutrition security. Together, these case studies underscore the importance of mainstreaming gender equality in the design and implementation of nutrition-related programmes, as well as the requirement for gender-disaggregated data to ensure evidence based and accountable gender-transformative policies and programmes. Progress with nutrition and the empowerment of women are mutually reinforcing.

The Council Conclusions[3] on last year's progress report provided strategic direction for future priorities. These include ensuring an evidence-based theory of change as a precondition for effective programme design; strengthening the links between nutrition and gender pathways; and supporting communities to build resilience to unforeseen and volatile situations. The latter gains particular

[1] Data for 2019 is preliminary. Final data will be officially available when reported to the OECD DAC in December 2020.

[2] Extracted from the Commission's 'stunting reduction calculation tool' (SRCT) using data from the 2019 revision of the World Population Prospects.

[3] Council Conclusions on the Fourth Progress Report on the Action Plan on Nutrition (14457/19).

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relevance given the recent COVID-19 pandemic, which poses additional risks to the lives and livelihoods of the most vulnerable across the globe, in particular women and children. Further to the public health challenges, the associated socio-economic crisis demonstrates the fragility of the food systems with severe consequences for access to healthy diets and good nutrition.

1. Introduction

Background

Commissioner Jutta Urpilainen has underlined the role of the EU in accelerating implementation of the 2030 Agenda for Sustainable Development[4]. This will be achieved by stronger strategic collegial coordination and by continuing to build international partnerships to ensure the integration of the United Nations (UN) 2030 Agenda for Sustainable and its Sustainable Development Goals (SDGs) across EU policies. The European Green Deal is explicitly anchored in the 2030 Agenda and the SDGs by providing a roadmap to a sustainable and inclusive growth strategy to boost the economy, improve people's health and quality of life and care for environment. Likewise, the EU's Farm to Fork Strategy, unveiled in May 2020 makes the case for a long term vision underpinned by a comprehensive and coherent approach to ensure that food systems are fair, healthy and environmentally friendly. The strategy seeks to heighten awareness of the interrelations between nutrition, healthy diets, ecosystems, supply chains, consumption patterns and planetary boundaries. However, about 135 million people faced food crisis or worse in 2019, the highest in 4 years[5], and the world is off course to meet international nutrition targets[6]. With the onset of the COVID-19 pandemic and as a result of the far reaching socio-economic impacts associated with this crisis, the requirement for a transformative agenda is ever more pressing, underscoring the urgent need for effective investment to end hunger and malnutrition in all its forms. Enhancing sustainability, resilience and capacities at every level in order to provide healthy and nutritious diets for all will be a key condition for achieving a more stable and equitable world.

The fifth progress report demonstrates the Commission's commitment to deliver tangible results for people's lives and accelerate progress towards ending malnutrition, in line with SDG 2[7]. Building on the four previous progress reports[8], this report emphasises again on the two key commitments that underpin the strategic and operational focus of the Commission's work on nutrition within the context of development cooperation and international partnerships: (i) the 2012 commitment to support partner countries to reduce the number of stunted children under the age of five by at least 7 million by 2025[9]; and (ii) the 2013 commitment to ensure the allocation of EUR 3.5 billion between 2014 and 2020 to improve nutrition in partner countries[10].

These two commitments are enshrined in the EU's policy framework on nutrition, which consists of the 2013 Commission Communication on "enhancing maternal and child nutrition in external assistance: an EU policy framework"[11], and the 2014 Action Plan on Nutrition (APN)[12]. Four sets of Council Conclusions have been adopted on the basis of each of the four previous progress reports. Meanwhile, in November 2014 the European Parliament adopted a Resolution on child undernutrition in developing countries[13], calling for nutrition to be prioritised as a development goal by the Commission and EU Member States.

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[4] https://ec.europa.eu/commission/sites/beta-political/files/mission-letter-jutta-urpilainen_en.pdf
[5] Global Report on Food Crisis 2020.
https://docs.wfp.org/api/documents/WFP-0000114546/download/?_ga=2.6932533.602178730.1588588440-1507161033.1587539395
[6] Joint Child Malnutrition Estimates (2020); https://data.unicef.org/resources/jme-report-2020/
[7] SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture.
https://sustainabledevelopment.un.org/sdg2
[8] The first (2016), second (2017), third (2018) and fourth (2019) progress reports can be found at:
https://ec.europa.eu/knowledge4policy/global-food-nutrition-security/action-plan-nutrition_en
[9] http://europa.eu/rapid/press-release_SPEECH-12-575_en.htm
[10] Announced at the Nutrition for Growth event in 2013; https://scalingupnutrition.org/news/an-historic-moment-for-nutrition-nutrition-for-growth-summit-in-london/. This commitment is monitored annually on the basis of the resource tracking methodology agreed by the SUN Donor Network:
http://docs.scalingupnutrition.org/wp-content/uploads/2013/12/RESOURCE_TRACKING_METHODOLOGY_SUN_DONOR_NETWORK.pdf
[11] http://ec.europa.eu/europeaid/documents/enhancing_maternal-child_nutrition_in_external_assistance_en.pdf
[12] Action Plan on Nutrition – Reducing the number of stunted children under five by 7 million by 2025.
https://ec.europa.eu/knowledge4policy/global-food-nutrition-security/action-plan-nutrition_en.
[13] European Parliament resolution of 27 November (2014/2853(RSP)).

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The APN is guided by three mutually-reinforcing strategic priorities for its implementation, which operate at global, regional and country levels. **Strategic Priority One** relates to the strengthening of political commitment and governance for nutrition. Examples under this priority include support to the Scaling Up Nutrition (SUN) Movement and budget support to national governments to establish and reinforce multi-sectoral nutrition coordination mechanisms. From 2019 onwards, the Capacity for Nutrition (C4N) initiative provides an extensive network of international nutrition advisors well placed to respond to demands from EU Delegations and partner countries to strengthen nutrition governance and the performance of national coordination mechanisms for nutrition at various levels. **Strategic Priority Two** boosts actions for nutrition across a range of sectors in countries that have prioritised nutrition in their national and multi-annual indicative plans. In addition to ensuring a clear focus on nutrition across key sectors of programming – including agriculture, social protection, education, health and water, sanitation and hygiene (WASH), expertise is also available to EU delegations, governments and other stakeholders on specific technical issues. The Food Fortification Advisory Service (2FAS) is one example, providing demand-driven support on food fortification within the framework of countries' broader multi-sectoral nutrition strategies to address micronutrient deficiencies. **Strategic Priority Three** focuses on strengthening expertise and the knowledge-base on nutrition as exemplified by the ongoing implementation of the National Information Platforms for Nutrition (NIPN) initiative and the evidence for policy-making provided by the Joint Research Centre (JRC). In addition, the more recently launched Nutrition Research Facility (NRF) will provide specific support to the Commission, EU Member States and partner countries to build and implement robust monitoring and evaluation systems as well as improved knowledge for better programme design. Together with NIPN, the NRF will help to ensure that programmatic evidence, on both emerging nutrition challenges and conditions of success, is generated and translated through active dialogue into policy related decision-making processes.

Since their inception, the 2013 Communication and the APN have guided the Commission's action on nutrition both with specific country partners and internationally. They are strongly aligned with the Agenda 2030 for Sustainable Development (2015) and the new European consensus on development (2017)[14]. Recent Council Conclusions[15] confirm the EU's commitment to addressing all forms of malnutrition while ensuring the sustainable and more equitable transformation of food systems.

Scope of the fifth progress report

The focus of the fifth progress report is on a clear and concise analysis of recent advances regarding the Commission's two international pledges on nutrition. The report includes an in-depth look at selected programmes and how they are transforming resources into results to inform discussions on future nutrition interventions. Section 2 of the report provides an updated overview and analysis of progress on reducing stunting, while Section 3 offers an updated overview of progress with regard to annual financial commitments and disbursements. Section 4 presents evidence from diverse countries and contexts, demonstrating that EU investments in nutrition are making a measurable difference to people's lives – particularly women and children, with a focus on infants, children under five and adolescent girls. These insights are particularly timely for informing policy directions, given the new multi-annual financial programming phase 2021-2027.

Implementation of the APN continues in countries that have prioritised nutrition in their national and multi-annual indicative plans. Forty countries were initially included, with two more added in 2016 at the request of EU Delegations, namely Sudan and Djibouti.

[14] https://www.consilium.europa.eu/media/24004/european-consensus-on-development-2-june-2017-clean_final.pdf
[15] Council Conclusions on the Fourth Progress Report on the Action Plan on Nutrition (14457/19).

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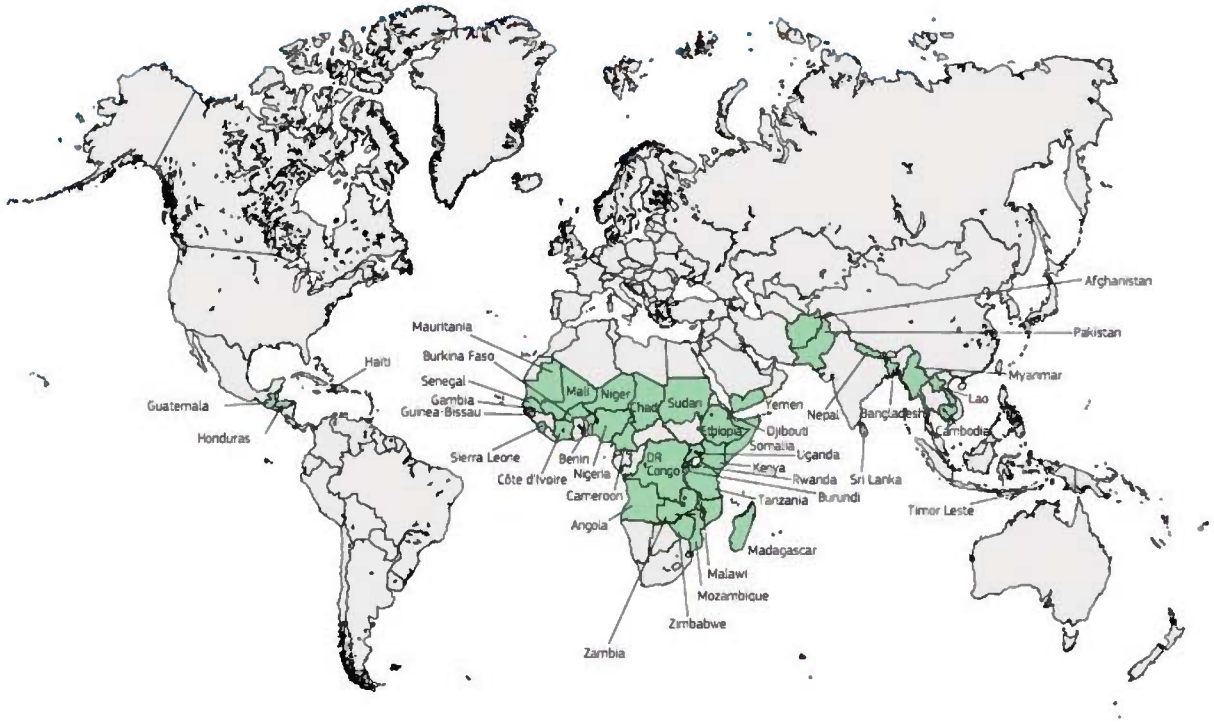
Figure 1: Partner countries that prioritised nutrition in their cooperation with the EU



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

Stunting is the result of chronic undernutrition in-utero and early childhood. Children suffering from stunting may never reach their full potential height or cognitive abilities. Later in life, they are also more likely to be at risk of overweight and obesity than children of normal height, and in turn, may be more susceptible to the negative implications of these conditions on their overall health and well-being[16]. Furthermore, there is increasing evidence on the linkage between stunting and wasting which together are implicated in the deaths of almost two million children each year[17]. If a stunted child goes on to become moderately wasted, the risk of death can be as great as that faced by a severely wasted child, while children who survive repeated episodes of wasting are more likely to become stunted[18,19].

This section presents an analysis of data from the Commission's 'stunting reduction calculation tool' (SRCT)[20], developed in 2014-15 in collaboration with the World Health Organization (WHO)[21,22].

Stunting trends

Since the first progress report, analysis of results on stunting has focused on the original group of 40 countries that prioritised nutrition in their cooperation with the EU (Figure 1)[23]. Based on current trends, the latest estimates indicate that the projected number of children averted from stunting from 2012 to 2025 will be 4.7 million in these 40 countries. This means that 4.7 million children who would otherwise have suffered from stunting over the period will have achieved normal growth. This estimate is lower than the 4.9 million reported last year mainly as a result of retrospective adjustments to country survey data on the basis of international standards[24]. However, population growth continues to present a major challenge for reducing the absolute number of stunted children. Indeed, the positive trend of stunting prevalence is being offset by the growing number of children (estimated increase of 34.5 million in African countries prioritising nutrition alone).

[16] https://data.unicef.org/topic/nutrition/child-nutrition/
[17] https://archpublichealth.biomedcentral.com/articles/10.1186/s13690-018-0277-1
[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6669055/ and https://www.ennonline.net/resources/wastmetaanalysis
[19] https://bmjopen.bmj.com/content/bmjopen/10/2/e033148.full.pdf
[20] The methodology for this tool can be found here: https://ec.europa.eu/international-partnerships/system/files/ec-srct-method-300319_en.pdf
[21] This collaboration was the basis for the WHO tool that is available online at: https://www.who.int/nutrition/trackingtool/en/
[22] The SRCT uses a longer time horizon than the tool currently used by the WHO. This Progress Report continues to use the SRCT to ensure consistency across reporting years.
[23] The two additional countries that were added from 2016 onwards are not included in this section's analysis to facilitate comparison of trends and changes over time, but are included in the analyses presented in other sections.
[24] While the number is in fact slightly lower, this is not because the situation has worsened (indeed the AARR has increased) but is rather due to a recently undertaken, and as yet incomplete, recalculation by the JME on the basis of the retrospective quality checking and standardisation of national surveys which has involved 21 changes in 16 countries; and 1 survey being removed.

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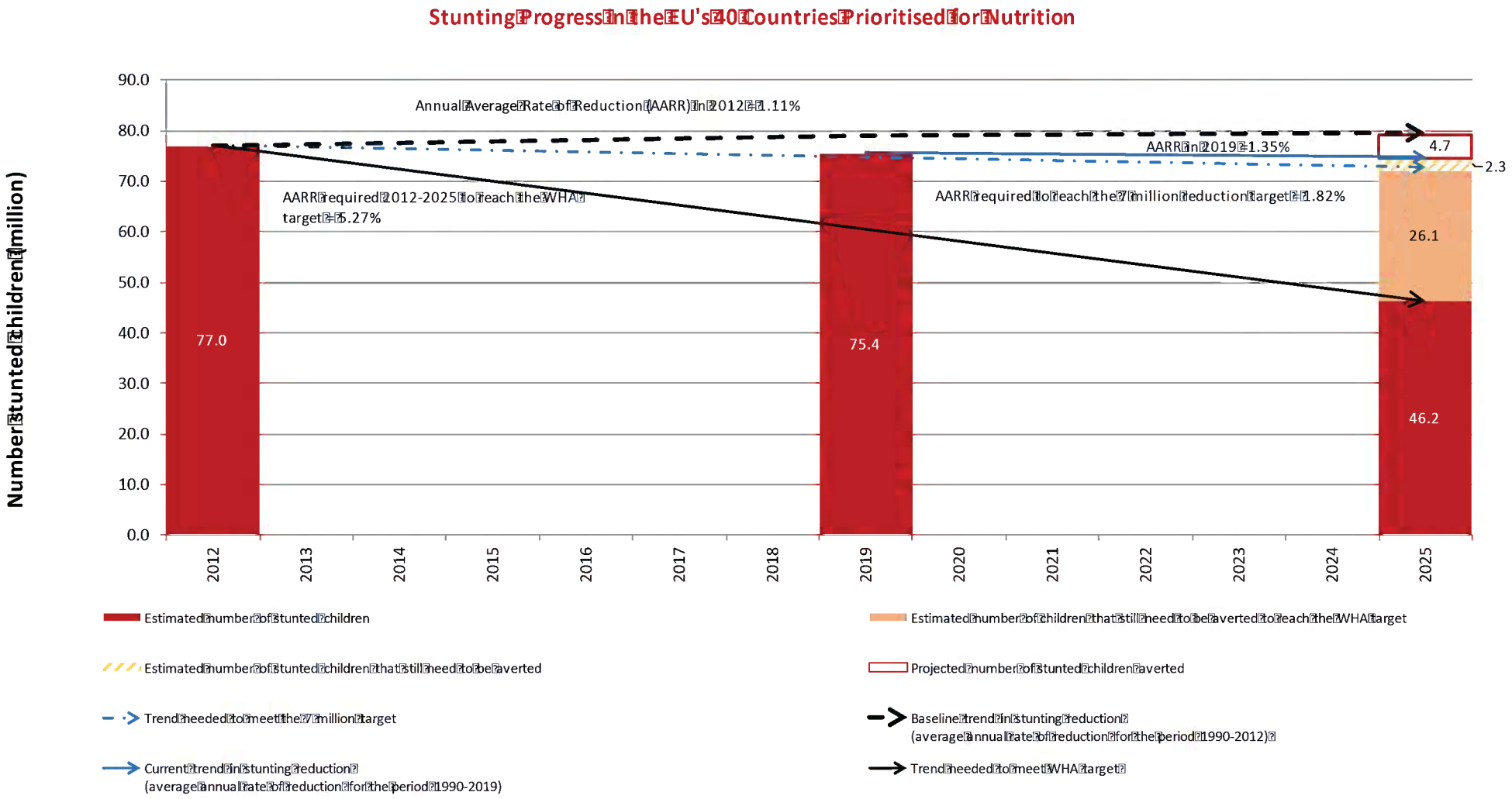
Figure 2: Stunting progress in partner countries prioritising nutrition, showing projected trends to reach World Health Assembly[25] and Commission targets by 2025



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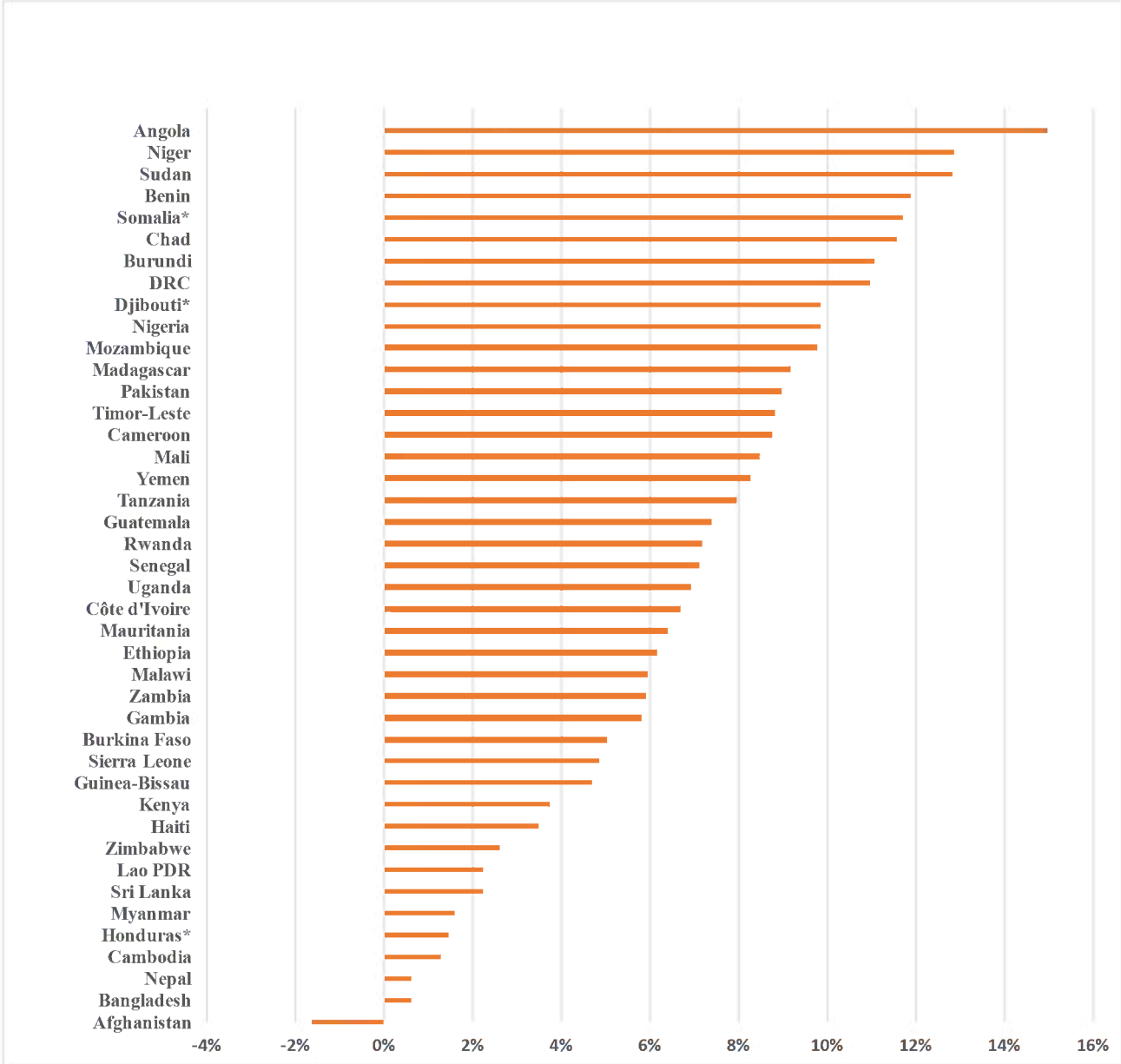
[25] The World Health Assembly is the decision-making body of WHO.

The annual average rate of reduction (AARR) stands at 1.35% as compared to 1.32% last year. The key conclusion of the trend analysis remains that the pace of reduction will need to increase significantly (to 1.82% across the 40 countries) to achieve the target of 7 million children averted from stunting by 2025. The fastest rate of stunting reduction was found in Mauritania (3.2%) and the slowest in Chad (0%) and Sudan (0.02%). More investment in data quality and national information systems at country level is needed to better analyse causes underlying child stunting and to understand why it is that some countries are performing better than others.

Considered as a group, the 40 countries remain off track to achieve the World Health Assembly (WHA) 40% stunting reduction target. This outcome reflects the global situation: the world as a whole is not yet on track to achieve this global target for stunting[26]. Figure 2 shows a breakdown by country of the gap between the pace of stunting reduction and that needed to achieve the target, based on the SRCT.

Figure 3: The difference between the current rate of stunting reduction and that required to meet the WHA target by 2025 (AARR%) using SRCT criteria[27]



* Countries with no data after 2012 (differences between baseline AARR and required AARR)

[26] Global Nutrition Report 2018.
[27] For all 42 countries prioritising nutrition in their cooperation with the EU.

The only country on track to achieve the WHA stunting target is Afghanistan. On the basis of the agreed methodology for assessing progress towards stunting reduction[28], all other countries (with data) are off-track. Of these, 35 have made some progress since the 2012 baseline while 3 (Yemen, Timor Leste and Sudan) have made no progress or are worsening. A stunting profile for all 42 countries is given in Annex 1[29].

A closer look at the regional level provides valuable insights. The prevalence of stunting continues to fall since the 2012 baseline in every region. The most significant decline – 6.1 percentage points – is in Asia. As there has been a relatively low increase in the population of children under five in countries prioritising nutrition in Asia (the population of under five children is even decreasing in 5 out of the 10 Asian countries prioritising nutrition[30]), the number of stunted children in this region alone has fallen by around 2.8 million since 2012. However, in countries prioritising nutrition in Africa, the reduction of stunting prevalence since the 2012 baseline – by 3.6 percentage points – has been somewhat masked by the notable increase in the population of children under five since the 2012 baseline (an increase of 18.6 million[31]). As a result, and despite the reduction of stunting prevalence, the number of stunted children in countries prioritising nutrition has risen by 1.8 million between 2012 and 2019. As Figure 3 shows, of the top 10 countries closest to potentially meeting the WHA target (according to current data), only two are African namely Zimbabwe and Kenya.

While average stunting prevalence remains slightly higher in countries in Asia (36%), than in Africa (34.5%) or Latin America (32.3%), it varies considerably across the 42 countries, ranging from 54% in Burundi to 14% in Sri Lanka. National figures can also mask significant inequalities within countries. The prevalence of stunting among children in vulnerable groups, for example among the chronically poor or in indigenous communities where many families struggle to afford a healthy diet and to ensure adequate care for infants and young children, is generally much higher than in the country as a whole. This highlights the extent to which child stunting is largely driven by structural inequalities relating to factors including income, gender and access to safe drinking water and basic health facilities. Addressing the cause of these inequalities is key to accelerating the rate of stunting reduction.

While overall the pace of stunting reduction across all 40 countries remains slower than expected, evidence from EU-supported programmes demonstrates that they are improving nutrition, with tangible positive impacts on the lives of women and children. Insights into these impacts, such as improved quality of diets as well as enhanced childcare practices, are presented in Section 4.

Factors associated with stunting reduction

The third progress report introduced a dashboard (see Annex 2) for all 42 partner countries that have prioritised nutrition, with 17 indicators to track progress[32]. The dashboard shows the evolution of national-level data from a 2012 baseline. The dashboard, which is updated annually, is designed to present data on child stunting trends based on multiple factors in countries prioritising nutrition and aims to inform country level analysis and policy dialogue. It adopts a traffic light (dot) system to show improvement (green), no change (yellow) or deterioration (red), while the colour of cells categorises the position of each country relative to others. Associations between indicators cannot be used to infer causality in a given context. In addition, it is important to distinguish between the

[28] WHO & UNICEF 2017 https://globalnutritionreport.org/reports/global-nutrition-report-2018/appendix-1-assessing-country-progress-against-global-targets-a-note-on-methodology/#note-source-942014c6-3.

[29] Annex 1 provides data for all 42 countries as opposed to the 40 original countries prioritising nutrition. Individual country graphs are available online at https://ec.europa.eu/international-partnerships/topics/fostering-better-nutrition_en

[30] Extracted from the Commission's 'stunting reduction calculation tool' (SRCT) using data from the 2019 revision of the World Population Prospects.

[31] Between 2019 and 2025 the population of children under five in Africa is expected to rise by another 16.5 million.

[32] Individual country dashboards are available online at: https://ec.europa.eu/international-partnerships/topics/fostering-better-nutrition_en

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direction of trends compared to the baseline for a given country[33]. This year's dashboard reveals the following:

- Stunting prevalence has declined in all countries except for Angola, Sudan, Benin and Djibouti, where it has increased, and Chad, where there has been no change.
- Ten countries affected by conflict[34] have seen both a lower reduction in stunting and a slower rate of improvement regarding stunting compared to countries not affected by conflict. The same countries also show a poorer performance in terms of income inequality.
- The prevalence of wasting[35] has increased in four countries (Yemen, Sudan, Mauritania and Lao PDR)[36]. Of these, Sudan has also seen an increase in prevalence of stunting.
- Rates of exclusive breast feeding[37] have improved in 26 countries and worsened in 8 countries, with Chad and Yemen seeing the worst performance.
- 80% of countries[38] have seen an improvement in the following indicators: delivery in a health facility; Gender Inequality Index[39]; Global Multi-dimensional Poverty Index[40]; and improved drinking water.
- Less than half of the countries have seen an improvement with respect to the Hunger and Nutrition Commitment Index[41] (HANCI); and income inequality.
- For most of the countries where there has been no decline in either multi-dimensional poverty or income inequality, the rate of stunting has also not declined.
- The two countries where access to health care has deteriorated have also performed poorly in the rate of stunting reduction (Benin and Nigeria).

[33] For example, while data from Zambia indicates a deterioration in exclusive breastfeeding compared to the 2012 baseline, the country is among the top three performing countries for this indicator, with a rate of almost 70%.
[34] Afghanistan, Burundi, Chad, Democratic Republic of Congo (DRC), Mali, Myanmar, Nigeria, Somalia, Sudan and Yemen.
[35] Wasting is a life-threatening condition attributable to poor nutrient intake and/or disease. Characterised by a rapid deterioration in nutritional status over a short period of time, children suffering from wasting have weakened immunity, increasing their risk of death due to greater frequency and severity of common infection, particularly when severe.
[36] Data trends for child wasting must be interpreted with caution as there can be significant fluctuations in wasting by season and year to year.
[37] Feeding infants nothing but breastmilk for the first six months of life, exclusive breastfeeding, is the safest and healthiest option for children everywhere and has great potential to save lives.
[38] Countries with data: delivery in a health facility (n=38); Gender Inequality Index (n=34); Global Multi-dimensional Poverty Index (n=35); and, improved drinking water (n=27).
[39] http://hdr.undp.org/en/content/gender-inequality-index
[40] https://ophi.org.uk/multidimensional-poverty-index/
[41] http://www.hancindex.org/

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

'One year ahead of schedule, the European Union has already achieved its EUR 3.5 billion global pledge for nutrition'

Financial commitments to nutrition in 2018

In 2018[42], 41 new EU nutrition-related financing decisions[43] were approved. The total amount committed[44] to nutrition was EUR 546.4 million[45], of which EUR 100.6 million was nutrition-specific and EUR 445.7 million was nutrition-sensitive; EUR 320.2 million was financed by development aid instruments and EUR 226.2 by humanitarian aid instruments[46].

Financial commitments to nutrition since 2014

Taking into account the 2018 data on nutrition commitments together with a preliminary analysis of 2019 nutrition commitments (EUR 594.3 million), total nutrition commitments in the period 2014 to 2019 currently amount to almost EUR 3.8 billion (see Table 1). This means that the Commission's pledge of committing EUR 3.5 billion towards nutrition in the period 2014-2020 has achieved one year ahead of schedule.

Table 1: Nutrition commitments 2014-2019 by category and funding source *(million EUR)*

	Development aid instruments				Humanitarian aid instruments			Total EU
	Nutrition-specific	Nutrition-sensitive		Sub-total	Nutrition-sensitive		Sub-total	
		Dominant	Partial		Dominant	Partial		
2014	33.9	25.0	171.0	**229.9**	91.5	133.2	**224.7**	**454.6**
2015	53.0	18.1	238.6	**309.6**	87.5	149.5	**237.0**	**546.6**
2016	167.5	244.5	481.0	**893**	0.0	168.6	**168.6**	**1061.6**
2017	60.0	0.0	316.3	**376.3**	0.0	190.3	**190.3**	**566.6**
2018	100.6	0.0	219.5	**320.2**	0.0	226.2	**226.2**	**546.4**
2019*	218.9	38.5	126.7	**384.1**	0.0	210.1	**210.1**	**594.3**
Total	633.9	326.0	1 553.2	**2 513.0**	179.0	1 077.9	**1 256.9**	**3 770.0**

* Data for 2019 is preliminary. It will be reported to the OECD DAC in December 2020.

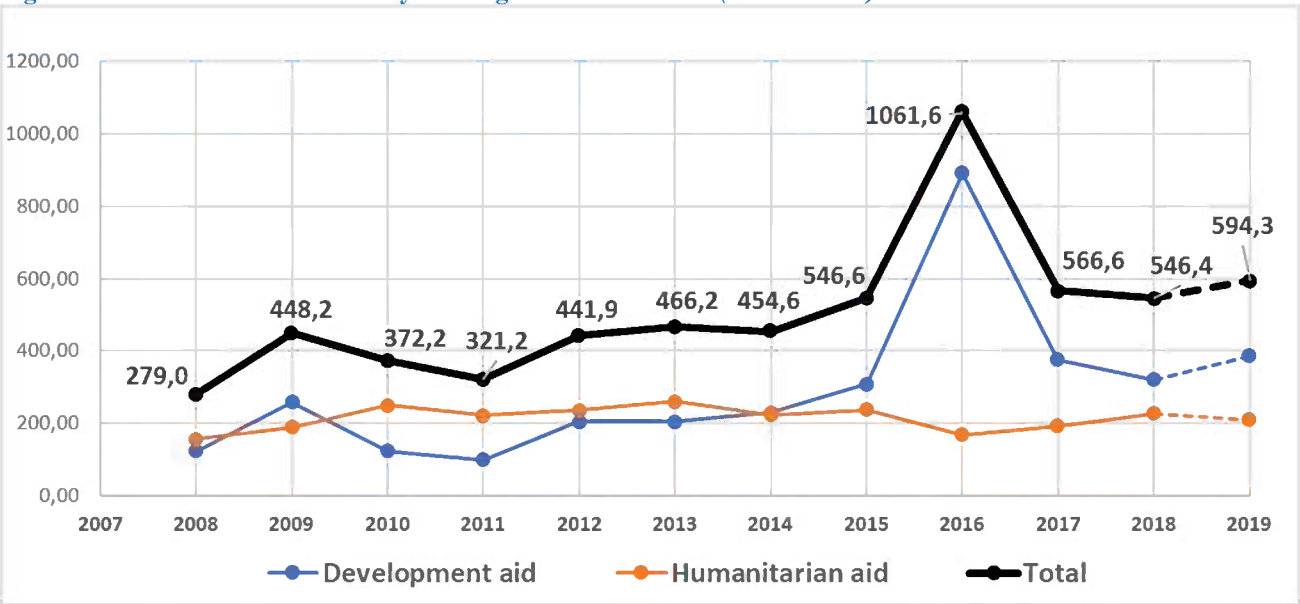
Between 2014 and 2019, nutrition-specific commitments amounted to EUR 633.9 million, while nutrition-sensitive commitments exceeded EUR 3.1 billion.

Efforts in the current funding cycle (2014-2020) to boost nutrition programming in EU international cooperation and development resulted in an upward trend in nutrition commitments compared to the previous programming period (2007-2013) (see Figure 4). Based on data available for 2008-2019, the average nutrition commitment in the previous funding period was EUR 388.1 million per year,

[42] 2018 is the latest year for which official data is available on the OECD DAC Creditor Reporting System. Preliminary data for 2019, not yet reported to OECD DAC, is included to calculate total Commission commitment for the period 2014-2019.
[43] Comprising 25 development aid decisions, 10 humanitarian aid decisions and 6 EU trust fund decisions.
[44] The Commission defines a commitment as a 'legal obligation to spend money that is signed in a given financial year' while 'the amounts are not necessarily paid out in the same year but may be spent over several financial years'.
[45] Nutrition commitments the previous year totalled EUR 566.6 million.
[46] The Commission applies the methodology of the SUN Donor Network for nutrition resource tracking. For development aid, nutrition-specific actions address the symptoms and immediate determinants of malnutrition (coded 12240 Basic Nutrition under Health in the OECD DAC reporting system) and 100% of the amount of such actions is recorded as a nutrition commitment. Nutrition-sensitive actions generally address more underlying determinants and basic causes meeting three criteria (intention to improve nutrition for women or adolescent girls or children; having a significant nutrition objective or indicator; and contributing to explicit nutrition-sensitive outcomes and expected results), and either 100% or 25% of the amount of the action is recorded as a nutrition commitment depending on whether the full project or part of the project has been identified as nutrition sensitive according to the above criteria. Note: since all humanitarian aid has a separate DAC code, it cannot therefore be classified as nutrition specific by the SUN methodology, but the methodology is nevertheless applied to determine whether nutrition is 'dominant' or 'partial' in a given action.

compared with EUR 628.4 million per year in the current funding period. This represents an increase of 62%.

Figure 4: Nutrition commitments by funding source 2008-2019 *(million EUR)*



Nutrition disbursements, 2014-2018

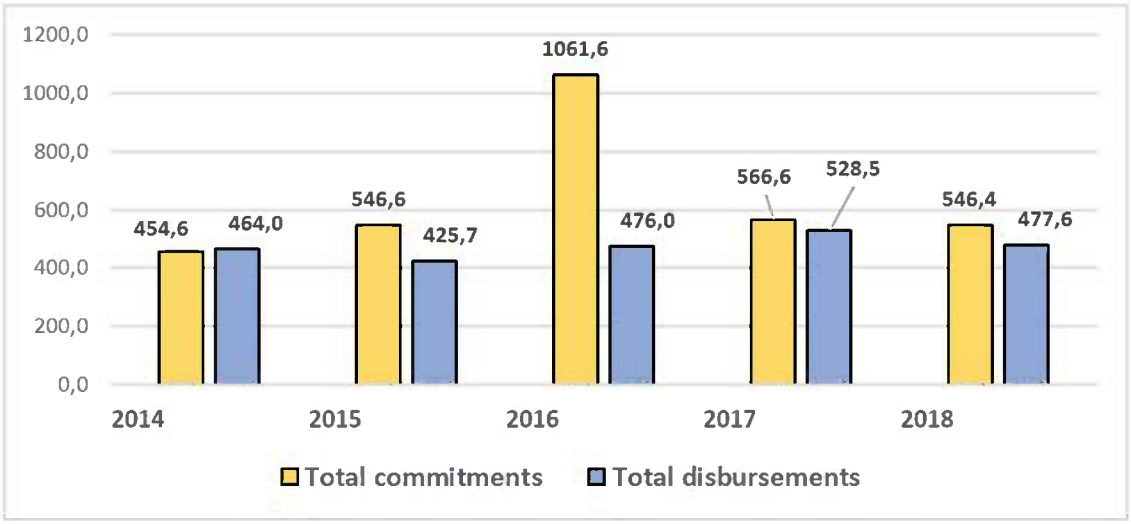
While nutrition commitments constitute the legal decision to fund an action, nutrition disbursements are the actual expenditures related to previous commitments. Disbursements thus give a more accurate representation of implementation. In 2018, Commission nutrition disbursements totalled EUR 477.6 million (see Table 2). Of this, EUR 45.3 million was nutrition-specific and EUR 432.3 million was nutrition-sensitive. The sum was disbursed via both EU development cooperation and humanitarian aid instruments: EUR 290.6 million was disbursed through development cooperation instruments and just under EUR 187 million through humanitarian instruments. Total nutrition disbursements in 2014-2018 were EUR 2 371.7 million.

Table 2: Nutrition disbursements, 2014-2018 (*million EUR*)

	Development aid instruments				Humanitarian aid instruments			Total EU
	Nutrition-specific	Nutrition-sensitive		Subtotal	Nutrition- sensitive		Subtotal	
		Dominant	Partial		Dominant	Partial		
2014	33.7	26.6	103.3	**163.6**	130.3	170.1	**300.4**	**464.0**
2015	43.5	14.6	114.3	**172.4**	119.5	133.8	**253.3**	**425.7**
2016	26.9	15.1	226.2	**268.2**	30.1	177.8	**207.8**	**476.0**
2017	50.7	36.4	242.9	**329.9**	2.8	195.8	**198.6**	**528.5**
2018	45.3	28.8	216.5	**290.6**	0.1	186.9	**187.0**	**477.6**
Total	200.1	121.5	903.1	**1 224.7**	282.8	864.2	**1 147.1**	**2 371.7**

As expected, annual nutrition disbursements are less than commitments over the last 5 years, reflecting the time-lag between commitment and implementation during which disbursements can be spread out over a period of several years as well as due to time taken in the contracting, mobilisation and inception process (see Figure 5).

Figure 5: Nutrition commitments and disbursements by year *(million EUR)*

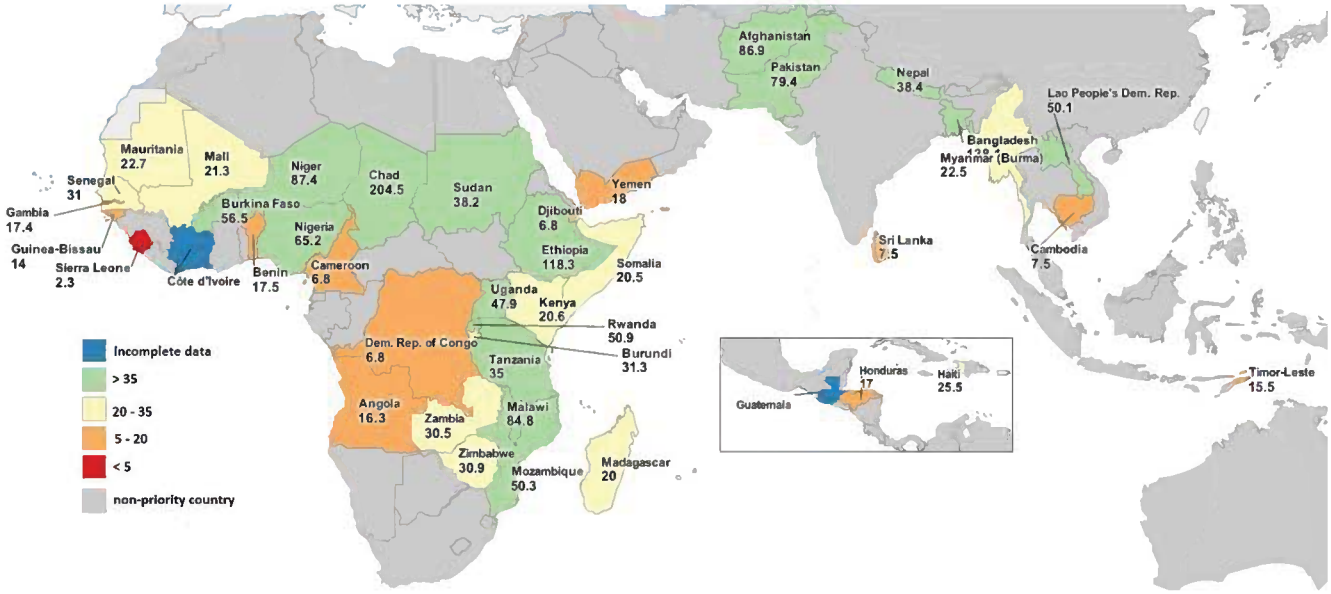


Geographical distribution of development cooperation nutrition commitments

Nutrition commitments financed through development cooperation instruments are targeted at 42 countries that have a high burden of stunting and have prioritised nutrition in their national indicative plans (NIPs). The regional breakdown of commitments in 2014-2018 shows that sub-Saharan Africa was the major beneficiary, with 70% of the total, followed by South and Central Asia, 22%.

For all of the 42 countries prioritising nutrition in their NIPs, financial commitments to nutrition have been made (see Figure 6).

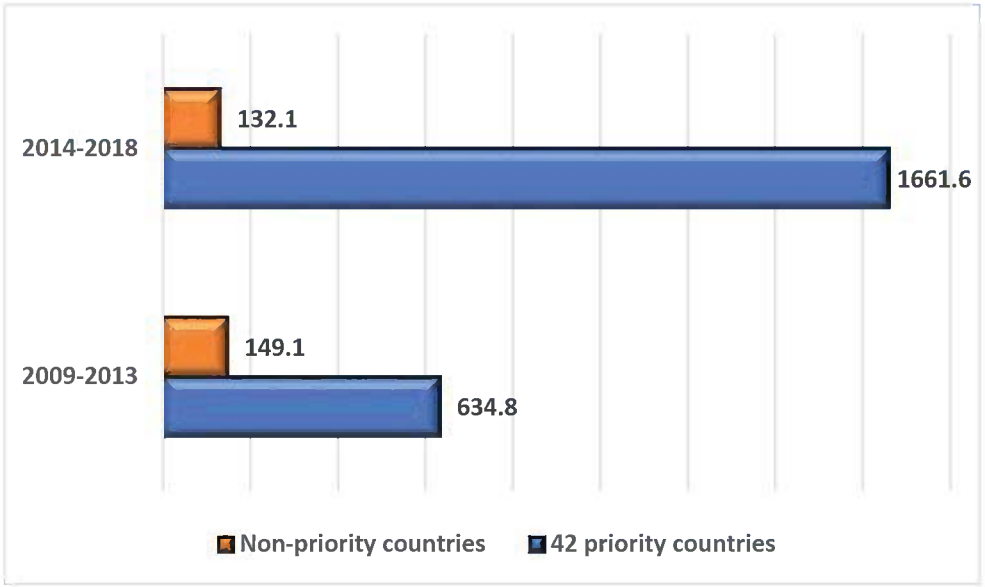
Figure 6: Total development aid nutrition commitments 2014-2018 *(million EUR)*



Note: Map data excludes some regional, global and policy/research/information commitments in 2014-2018 that could not be disaggregated by beneficiary country at this stage, amounting to EUR 335.28 million (15.7% of the total).

Based on the country-level disaggregated data, EU development cooperation nutrition commitments to the 42 countries prioritising nutrition accounted for 93% of all nutrition commitments through development cooperation in 2014-2018, the remaining 7% going to countries that did not prioritise nutrition (Figure 7). Commitments totalled EUR 1 661.58 million, compared with EUR 634.81 million in the previous 5 year period, an increase of EUR 1 billion.

Figure 7: Development aid nutrition commitments to countries prioritising nutrition before and after 2014 ***(million EUR)***



Note: Data excludes some regional, global and policy/research/information commitments that could not be broken down by beneficiary country at this stage, amounting to EUR 443.44 million (14.7% of the total) for 2009-2018.

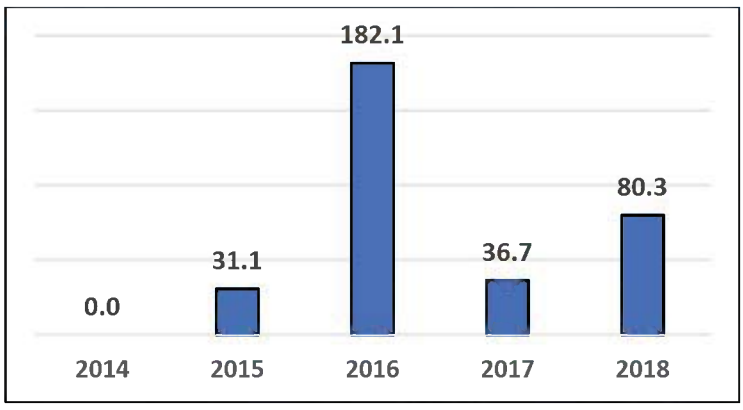
Budget support for nutrition

Since 2014, the Commission has acknowledged that budget support can offer an efficient means to scale up nutrition support, by promoting a government-led, accountable and inclusive approach to service delivery across multiple sectors.

Budget support assists a government in delivering on its multi-sectorial nutrition policy or plans, which most EU partner countries already have, or to enhance nutrition-related outcomes of sectoral policies, for example agriculture, social protection, education, health and governance, among others, while also improving public financial management.

New budget support actions were approved in 2018[47] for Bangladesh, Niger, Senegal, Tanzania and Timor Leste, with nutrition components totalling EUR 80.3 million, up from EUR 36.7 million in 2017 (see Figure 8). From 2014 to 2018, the EU invested a total of EUR 330.2 million in budget support for nutrition-related actions in 15 countries.

Figure 8: Nutrition commitments through budget support, 2014-2018 ***(million EUR)***



[47] Analysis of nutrition commitments for 2019 is not available because data is still preliminary.

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Partnerships for nutrition

Partnerships with other actors, whether for scaling up nutrition investments through leveraging co-financing or for multi-stakeholder collaboration around implementation of nutrition actions, are an important feature of the Commission's APN.

Beyond direct funding, EU development cooperation support for nutrition was worth EUR 320.2 million in 2018 and leveraged an additional EUR 115.6 million in co-financing from other donors. From 2014 to 2018, co-financing added EUR 1.2 billion to the EUR 2.1 billion EU development cooperation support for nutrition.

In 2018, and largely due to the scale of budget support arrangements, partner governments were the largest category of recipients of EU development aid funding for nutrition. Other recipients were UN agencies, EU Member State agencies and public and private sector organizations and NGOs (see Figure 9).

Figure 9: Development aid nutrition commitments by implementing partner category, 2014-2018 ***(million EUR)***

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4. Improvements in the lives of women and children – from resources to results

The APN considers the first 1 000 days of life critical to preventing malnutrition and its consequences. The Commission therefore focuses on improving the nutrition of women and children, including adolescent girls and infants, in addition to fostering growth from the earliest stage of life by addressing maternal malnutrition.

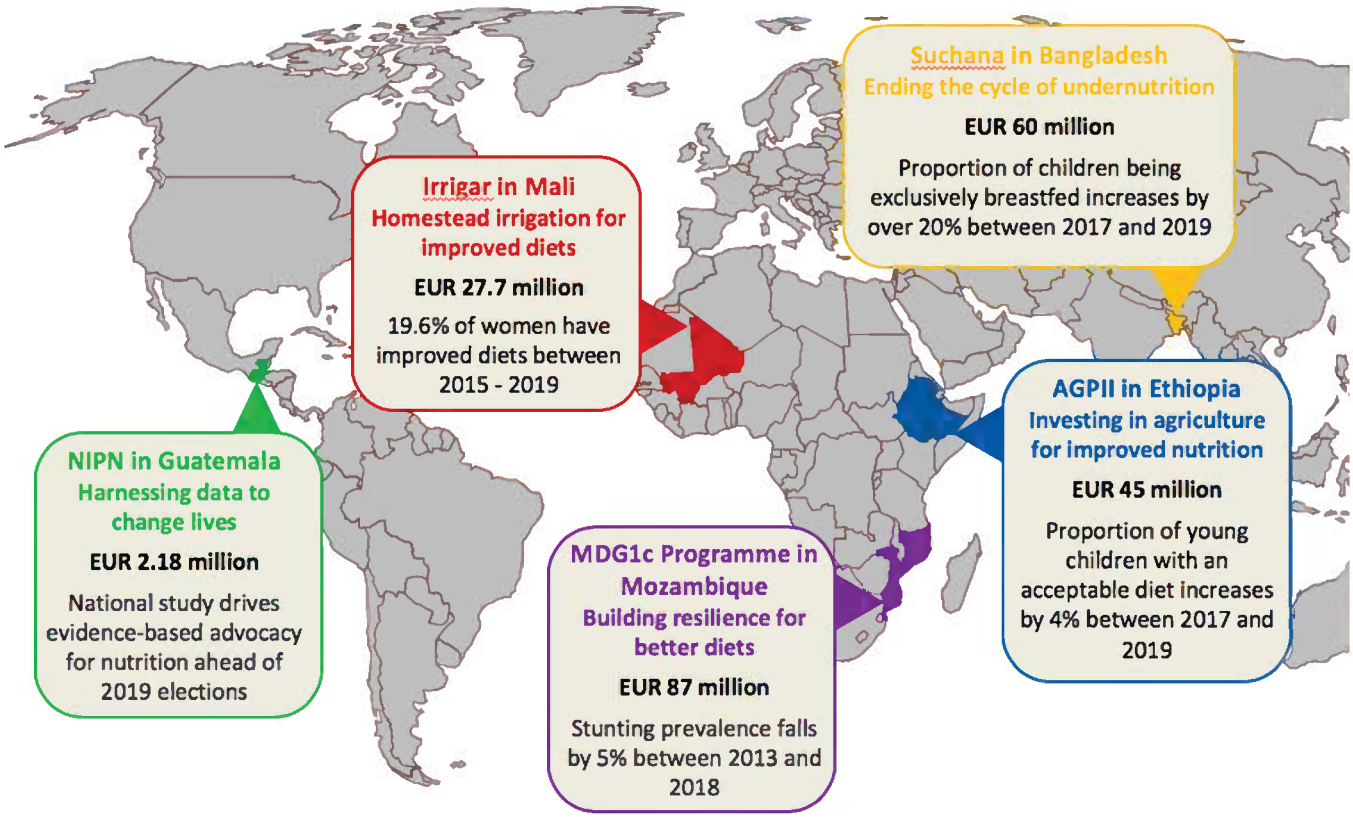
This section of the report presents the growing body of evidence showing improvements to the lives of women and children as a result of EU support for nutrition.

Tackling malnutrition effectively requires many sectors to be mobilised. This can be challenging to implement at scale, as sustained progress depends on the strengthening of national coordination mechanisms and capacity development at all levels. Additionally, it can take several years for progress – whether in terms of women's empowerment, increased incomes, improvement in basic services or adequate basic hygiene – to deliver lasting and sufficient shifts in the quality of diets and nutritional outcomes.

The Commission's commitment to support partner countries to accelerate the reduction of child stunting has been accompanied by efforts to boost accountability mechanisms in the design of programmes. Monitoring and evaluation systems have been reinforced to understand and measure the results obtained.

The case studies presented in this section, from Ethiopia, Mali, Mozambique and Bangladesh, represent a range of country contexts to show how resources are being transformed into results. They demonstrate measurable improvements in the lives of women and children, whether in terms of breastfeeding, dietary quality, household resilience, food security or stunting reduction. An additional case study from Guatemala highlights the Commission's focus on strengthening country ownership – in particular by ensuring accountability for delivering real change – via support to the effective management of national information systems.

Figure 10: From resources to results – evidence from 5 illustrative programmes



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AGPII: Harnessing agricultural investments to improve the diets of women and children in Ethiopia

Malnutrition in Ethiopia. Ethiopia has set ambitious targets to reduce malnutrition and has made considerable progress on reducing stunting among children under five. However, stunting is still very common (38%): over 6 million children are affected by stunting and 1 in 10 suffer from wasting. Only 7% of children aged 6 to 23 months get a minimum acceptable diet[48]. One in 4 adult women are anaemic. At the same time the number of overweight and obese children and adults continues to rise. Malnutrition continues to undermine national development efforts: the cost of undernutrition has been estimated at 16.5% of annual GDP[49].

Second agricultural growth programme (2015-2020). AGPII is a EUR 418 million flagship programme implemented by the Ethiopian government within the framework of its second national nutrition programme (NNPII). AGPII is supported by multiple donors[50] including the EU (EUR 45 m) along with Member States, Spain and the Netherlands. The goal of AGPII is to contribute to sustainable agricultural transformation while improving the food and nutrition security situation of vulnerable groups. The programme focuses on areas of considerable agricultural potential in seven regional states[51] with high stunting prevalence. More than 20 million smallholder farmers are expected to benefit from the intervention while 1.6 million smallholders (40% of them women) are direct beneficiaries. The programme components include public support services for agriculture, agricultural research, small-scale irrigation, agriculture marketing and value chain promotion. EU support includes a EUR 5 million complementary action designed to accelerate the provision of nutrition training and promotion of nutrition-sensitive technologies to farmers. This component also develops nutrition-related capacities for the delivery of public services across agriculture, education and health sectors. Overall, AGPII reinforces the focus of the NNPII on tackling the underlying causes of malnutrition via a multi-sectoral approach[52].

Tangible results in the lives of women and children. AGPII closely monitors the links between agriculture and nutrition outcomes along the dietary pathways of women and children. Improving complementary feeding of children aged 6 to 23 months has been identified as a crucial pathway to prevent stunting in Ethiopia[53]. While very few Ethiopian children get a minimum acceptable diet and the diet of most mothers is inadequate, the programme has already led to significant changes between 2017 and 2019. Children in the regions of intervention are now consuming more pulses, grains, roots, tubers, fruits, vegetables and animal and milk products than previously[54]. Data from the outset of the programme showed that in female-headed households surveyed no young children were getting an acceptable diet. As a result of AGPII this is beginning to change.

Outcomes[55]	2017	2019
Children's diet in male-headed households	5.4%	9.3%
Children's diet in female-headed households	0%	6.7%
Women's diet	17.9%	30%
Household diet	65%	84%

Realising human potential. Ethiopia's NNPII adopts the lifecycle approach with a particular emphasis on the crucial period of pregnancy and the first 2 years of life (first 1 000 days) during which good nutrition and healthy growth deliver lasting benefits throughout life. AGPII is playing a fundamental role in raising awareness of the contribution that nutrition-sensitive agriculture and food systems play in achieving this goal. However, addressing the overlapping inequalities of wealth and gender remains a challenge. AGPII therefore focuses on rural households with access to limited resources and specifically ensures the inclusion of women farmers. Support is explicitly provided to build the capacity, representation and financing of women in agriculture through a transformative approach. Attention is given to ensuring that the workload of women is not exacerbated through access to relevant information, labour-saving technologies and regular gender impact evaluations.

Tackling climate and environmental challenges. Ethiopia is especially vulnerable to climate change. AGPII is therefore committed to mainstreaming climate smart agriculture (CSA) approaches across the entire programme, thereby providing an important contribution to Ethiopia's climate resilient green economy strategy. The programme also includes the establishment of a climate advisory service across the agricultural extension system to promote CSA technologies while supporting improved conservation and management of the natural resources upon which farmers and pastoralists depend.

[48] Ethiopia Demographic and Health Survey 2016.
[49] The Social and Economic Impact of Child Undernutrition in Ethiopia, UNECA/WFP 2013.
[50] The principal donor is the World Bank (USD 350 million), along with the EU, USAID, Canada, Spain and the Netherlands.
[51] Amhara, Oromia, SNNPR, Tigray, Benshangul-Gumuz, Gambella and Harar as well as Dire Dawa city administration.
[52] This follows a narrower focus during the first phase to address the more immediate causes and treatment of malnutrition.
[53] Baye, K., IFPRI 2019.
[54] Kuma, T., Changes in household and children's dietary diversity in AGP intervention areas, Policy Studies Institute, December 2019.
[55] The Policy Studies Institute AGPII Impact Evaluation Report, May 2019, has applied internationally recognised indicators: for children's diet, the Minimum Acceptable Diet 6-23 months; for women's diet, the Dietary Diversity Score for pregnant women; for household diet, the Household Dietary Diversity Score.

IRRIGAR: Homestead irrigation improves diets in Mali for women and children

Malnutrition in Mali. One million children under five are affected by stunting in Mali (more than one in four)[56] and the number of stunted children is not expected to fall in the coming years. Mali is therefore currently not on track to meet the international target for stunting[57]. At the same time, other forms of malnutrition also persist. More than one in eight children suffer from wasting. Only 9% of children aged 6-23 months old eat even a minimally acceptable diet. In recent years, the prevalence of overweight and obesity in women has almost doubled[58], while half of women have anaemia. The double burden of malnutrition[59] results from many factors, often rooted in widespread multi-dimensional poverty. The economic cost of undernutrition in Mali is estimated to be 4% of GDP[60]. National efforts to tackle malnutrition have largely focused on strengthening health services, but it is increasingly recognised that a multi-pronged approach with a strong focus on agriculture is required.

IRRIGAR[61] (2014-2019). IRRIGAR was a EUR 27.7 million programme funded by the EU[62], and implemented by GIZ, KfW and decentralised state services. The programme aimed to contribute to improving food security and nutrition by increasing and diversifying agricultural production. Located in several regions[63], the focus was on establishing small-scale irrigation and pond structures for fish farming. Poor farmers (both women and men) received support to use this infrastructure efficiently, for both household consumption and sales through local markets. To maximise the impact on people's nutrition, educational materials were developed and disseminated in collaboration with local health actors. As a result, people have become more aware of the risks associated with malnutrition and the importance of ensuring a more diverse and healthy diet and food hygiene. A community dynamic has emerged through the creation of local level nutrition action groups. Both the second phase of IRRIGAR, jointly funded by the EU and Germany, and an anticipated third phase, will ensure continued progress in the two regions of Sikasso and Koulikoro.

Tangible results in the lives of women and children. IRRIGAR set up a robust monitoring and evaluation system to ensure that the situation at the end of the programme could be compared with that at the start. Data collected in 2019 now confirms a marked improvement in the dietary diversity of both mothers and young children as well as in household food security compared to the baseline situation of 2015. Sales of agricultural and market garden products had increased while household expenditure on health is more regular. There has also been an improvement in mothers' attendance at ante-natal check-ups, an increase in exclusive breastfeeding and a more frequent preparation of nutritious recipes for children than was previously the case.

Outcomes[64]	2015	2019
Household food security	53.6%	93%
Mothers' diet	2.3%	21.9%
Children's diet:		
6-23 months	10.4%	17%
24-59 months	11.4%	23.9%
Exclusive breastfeeding	33.8%	39.9%

Realising human potential. In Mali, the poorest children are three times more likely to be affected by stunting as those from better-off families. Nutrition inequalities can have short- and long-term consequences, such as poor health, delays in early child development and underperformance at school. The IRRIGAR programme ensured support for disadvantaged women and men in the creation of mechanisms for local community engagement in rural areas: 121 food and nutrition security community action groups with the involvement of local mayors. Gender considerations were central to the programme, which promoted the participation of men as well as women, facilitated women's access to irrigated land and ensured gender disaggregated data in the design of monitoring and evaluation systems. Working with local radio stations to produce and broadcast informational programmes also helped raise to public awareness of nutrition and food hygiene as well as ensuring dissemination of messages in four local languages for maximum outreach.

Tackling climate and environmental challenges. Already subject to frequent droughts, Mali is highly vulnerable to climate change, which is expected to increase local temperatures, rainfall variability and the magnitude of extreme weather events. Climate-related changes are already being felt and are leading to a steady, southwards shift of agricultural activities to areas where population density is higher and the risk of conflict greater. The investments in small scale infrastructure associated with IRRIGAR play a key role in helping to mitigate drought risks and create new income opportunities. Reduced levels of outward migration have also been reported in the areas covered. Sensitivity to conflict with respect to the management of scarce water resources to preserve social cohesion has been central to IRRIGAR's effectiveness.

[56] Stunting prevalence is 27% (Mali DHS, 2018).
[57] World Health Assembly target to reduce the number of stunted children by 40% by 2025.
[58] Prevalence of overweight and obesity in women 15-49 years: DHS-2001: 15%, DHS-2018: 28%.
[59] The double burden of malnutrition is characterised by the coexistence of undernutrition (including micronutrient deficiencies) and overweight and obesity.
[60] Cost of Hunger in Mali, 2018.
[61] IRRIGAR: Initiative de Renforcement de la Résilience par l'Irrigation et la Gestion Appropriée des Ressources.
[62] IRRIGAR is a subcomponent of a larger programme, PASSIP (Programme d'Appui au Sous-Secteur de l'Irrigation de Proximité), co-funded by the EU and the Department of Global Affairs Canada, which supports the National Small Scale Irrigation Programme.
[63] Inner delta of Niger, the Dogon country and regions of Koulikoro and Sikasso.
[64] Evaluation finale du volet sécurité alimentaire et nutritionnelle du PASSIP dans les régions de Koulikoro, Sikasso, Mopti et Tombouctou. The evaluation applied internationally recognised indicators: for household food security, the Food Consumption Score; for mother's diet, the Dietary Diversity Score for Women; for children's diet, the Minimum Dietary Diversity.

Suchana: Ending the cycle of undernutrition in Bangladesh

Malnutrition in Bangladesh. While Bangladesh could potentially still meet the global target, child stunting remains highly prevalent (31%) and its decline is slowing down[65]. One in 10 of the poorest children also suffer from wasting – associated with weakened immunity and increased risk of death. At the same time, and with 40% of adult women anaemic, overweight and obesity continue to rise at national level. Undernutrition comes with high social and economic costs, which disproportionately affect the poorest households. Globally, nutrition-related factors are estimated to contribute to about 45% of deaths in children under-5 years of age[66]. Undernutrition has lifelong consequences: by undermining a child's physical and cognitive development, it can lead to long-term reduction in productivity and a greater risk of chronic diseases later in life. The economic cost of undernutrition is estimated to exceed USD 1 billion per year in Bangladesh[67].

***Suchana* (2016-2022).** *Suchana* is a EUR 53.8 million programme jointly supported by the EU and the UK Department for International Development (DFID). It aims to significantly reduce the incidence of stunting in children under two in two districts of Sylhet Division (which has the highest stunting and wasting prevalence, as well as the worst levels of gender inequality in Bangladesh). The programme's multi-sectoral approach focuses on tackling undernutrition within the critical 1 000 days from conception until children reach their second birthday. This involves working closely with seven ministries to strengthen delivery systems and improve people's access to key nutrition-related services as well as directly empowering women and men through support to income-generating activities, homestead gardening and awareness about health and nutrition. At the same time, *Suchana* is harnessing evidence of progress to catalyse support from government and other stakeholders to scale up a multi-sectoral approach and improve nutrition governance across the country. Core programme targets include:

- Livelihood diversification and increased income for 1.3 million people;
- Empowering 68 000 adolescent girls from poor households to extend school attendance and so to delay marriage;
- Delivering improved nutrition services through the health system to a quarter of a million rural families.

To ensure that nutritionally vulnerable households and individuals are better able to absorb climatic, health and economic shocks, a key component of the programme focuses on increasing access to government social protection schemes, including maternity allowance[68]. *Suchana* is implemented by a consortium of national and international NGOs led by Save the Children.

Tangible results in the lives of women and children. *Suchana* has been designed to boost knowledge and evidence and so promote commitment and momentum for change. Halfway through implementation, annual surveys confirm significant improvement compared to the baseline. Household food insecurity has more than halved, while women's dietary diversity has almost doubled. There has been a substantial increase in the number of children aged 6-23 months getting a minimally acceptable diet. Furthermore, the rate of exclusive breastfeeding has increased by almost 20%.

Outcomes[69]	2017	2018	2019
Food insecurity	85.9%	59.4%	38%
Women's diet	26.7%	42%	52%
Children's diet	10.4%	13.5%	17%
Exclusive breastfeeding	63.9%	75.6%	83%
Women's empowerment	17.3%	57.9%	67%

Realising human potential. Access to adequate nutritious food is a fundamental human right and provides the foundation for healthy individuals and societies. *Suchana* reinforces Bangladesh's national plan of action for nutrition by demonstrating that efforts to improve the nutrition of women and children should be understood as an investment in realising human potential, rather than a cost. Using a rights-based and gender-transformative strategy, *Suchana* positions women's political, social and economic empowerment centre-stage: for example, by supporting women to establish village savings and loan groups to strengthen their decision-making in the household, while at the same time ensuring men's participation in education and counselling sessions on maternal and child nutrition.

Tackling climate and environmental challenges. Bangladesh is uniquely vulnerable to climate change, with two-thirds of the country less than five metres above sea level. In 2017, severe flooding was experienced across the intervention area. *Suchana* has taken concrete steps to support beneficiaries to adopt climate-resilient livelihoods and disaster preparedness practices to increase resilience to shocks and stresses. Interventions include production diversification, eco-friendly cropping patterns and climate-smart cultivation techniques. Early warning systems have been introduced to help beneficiaries to get information and knowledge on short-term/rapid climatic hazards (such as cyclones, floods and storms), as well as long-term/slow hazards (such as drought and long-term climate change).

[65] Bangladesh Demographic Health Survey (2018).
[66] WHO (2019); https://www.who.int/news-room/fact-sheets/detail/children-reducing-mortality
[67] Howlader S. R. et al (2012).
[68] The EU also supports the Government of Bangladesh (via budget support) to scale up national coverage of maternity allowance and child benefit. A programme reorientation is enabling the provision of income support to garment workers who have lost their livelihoods as a result of the Covid-19 outbreak in the country.
[69] Internationally recognised indicators used: for food insecurity, the Household Food Insecurity Access Scale; for women's diet, the Minimum Dietary Diversity for Women; for children's diet, the Minimum Acceptable Diet; for women's empowerment, a composite indicator for intra-household decision-making.

The MDG1c programme: building resilience for better diets in Mozambique

Malnutrition in Mozambique. Mozambique's strong economic performance has not been accompanied by a significant reduction in malnutrition. At 43%, the national prevalence of child stunting remains very high[70]. With more than 2 million stunted children, Mozambique is off-track to meet global nutrition targets on stunting, and children from the poorest households are disproportionately affected. At the same time anaemia affects almost 7 out of 10 children and more than half of women, while overweight and obesity is increasing across all groups[1]. The causes of malnutrition are multi-faceted and include poor diets, inadequate childcare, inability to access a quality education and health services, unsafe water and sanitation, gender inequalities and persistent multi-dimensional poverty. Malnutrition – in all its forms – comes with unacceptably high, yet preventable, human, social and economic costs. Mozambique loses over 10.9% GDP each year to child stunting alone, equivalent to USD 1.6 billion[71].

***Accelerate progress towards MDG1c in Mozambique* (2013-2019).** This EUR 87 million[72] programme was funded under the EU MDG1c initiative to reduce hunger and undernutrition in areas with high agricultural potential but poor nutrition[73]. Adopting a holistic approach, the programme's aims included improving agricultural and fisheries production to increase access to food and improving the nutrition status of vulnerable groups and low income households, with a focus on women and young children. Interventions included strengthening value chains in the agricultural and fisheries sectors, farmer field schools, e-vouchers, home gardens, food fortification, strengthening market information systems and nutrition education (including social behaviour change). Covering six ministries, the action was designed to reinforce existing national programmes and implementation brought together three UN agencies: IFAD, FAO and WFP. Crucially, programme coordination and monitoring were in the hands of the government's technical secretariat for food and nutrition security (SETSAN). As identified by a 2015 midterm review, achieving a multi-sectoral approach to address nutrition at scale can be challenging. Key lessons learned have included the importance of adapting the programme to local contexts, strengthening nutrition governance and developing nutrition-related capacities of service providers at every level.

Tangible results in the lives of women and children. An evaluation of the *MDG1c* programme confirmed a measurable improvement in the food security, diet and nutritional status of children as compared to control groups who did not benefit from the programme[74]. In particular, the share of food-insecure households was halved, thereby increasing resilience to shocks; the diversity of children's diets improved, as did the diets of women and adolescent girls[75], and the prevalence of child stunting fell by 5 percentage points at district level. A particularly important finding was that the gains in food and nutrition security were much higher for households reached by the greatest range of interventions.

Outcomes[76]	2013	2018
Stunting	45%	40%
Food insecurity	31%	16%
Coping strategy index	45%	20%
Exclusive breastfeeding	27%	54%
Children's diet	30%	35%

Realising human potential. Malnutrition on the scale found in Mozambique has long term negative consequences in terms of poor health, low levels of child development and reduced productivity leading to lower incomes. Social and economic inequalities between men and women can exacerbate poor nutrition while good nutrition and gender equality are mutually reinforcing. The programme set out to address gender inequalities with a number of interventions (such as farmer field schools for women and men, mothers' care groups, and women's savings groups) to ensure positive effects on women's empowerment. One women's savings group in Barue (Beira corridor) saw women start up successful businesses with the additional income allowing families to improve or build a new house or afford a better education for their children. As a result, the programme has contributed directly to breaking the cycle of deprivation connected to maternal disadvantage and malnutrition

Tackling climate and environmental challenges. Mozambique is one of the countries most vulnerable to natural disasters and climate change and in recent years has faced repeated emergencies. The severe El Niño drought in 2016, followed by two cyclones in 2019, caused widespread damage to already vulnerable livelihoods and further deterioration of food insecurity. During the humanitarian and early recovery response period, e-vouchers developed and institutionalised by the *MDG1c* programme worked effectively to distribute assets to affected populations. Communities were able to become more resilient by having better knowledge on how to prevent disease, improved crop production during the lean season and periods of crisis, and the building of community assets such as irrigation schemes, water harvesting systems and roads.

[70] Mozambique DHS 2011; SETSAN Baseline Study 2013.
[71] The Cost of Hunger in Africa (COHA) Mozambique study 2017.
[72] EU support EUR 77.3 million including EUR 10 million top-up following El Niño emergency in 2016.
[73] The programme's geographical focus is on the Beira and Nacala corridors (76 districts in 10 provinces).
[74] SETSAN (2018) *Endline Study* (district level) and *Impact Evaluation* (community level) of MDG1c programme in Mozambique. Note: limitations of the *Endline Study* do not allow to attribute impact only to MDG1c while there is a greater level of confidence with the *Impact Evaluation*.
[75] Evaluation of IFAD/PROMER agricultural marketing interventions showed the Minimum Dietary Diversity for Women indicator improved both for women (from 28% to 40%) and adolescent girls (from 55% to 68%) between 2017 and 2018.
[76] Internationally recognised indicators used: for food insecurity, the Food Consumption Score; for coping strategy index, the Reduced Coping Strategy Index; for children's diet, the Minimum Dietary Diversity.

National Information Platforms for Nutrition: Using data to accelerate change in people's lives

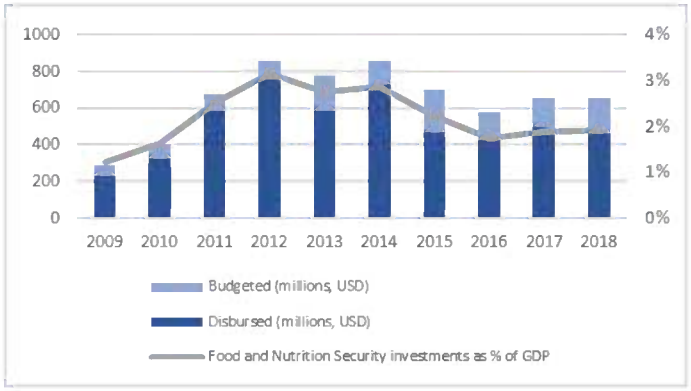
Malnutrition in Guatemala. With almost half of all children under five stunted[77], Guatemala is not on track to reduce the number of stunted children by 40% in line with the international target for 2025. Among indigenous communities, more than 7 out of 10 children are stunted, highlighting the persistence of serious inequalities. At the same time, Guatemala also faces a rapid rise in adult obesity with rates among women doubling in two decades – and tripled among indigenous women – leading to an acceleration of non-communicable diseases (NCDs). These different forms of malnutrition often coexist in individuals, households and populations and the existence of households with a stunted child and an overweight mother is a growing problem in the country. Evidence shows undernutrition in early stages of life is an important risk factor for obesity and NCD in adulthood[78]. The generally worsening quality of diets coupled with persistent barriers in access to basic services and gender inequalities are key contributors to this double burden of malnutrition. Recurrent natural disasters exacerbate vulnerabilities and destabilise rural livelihoods. Undernutrition alone has been estimated to cost Guatemala at least 11% of its GDP[79].

Guatemala's information platform on nutrition. A Commission global initiative[80] to support countries committed to tackling malnutrition, NIPN aims to strengthen the management of national nutrition information systems and improve the analysis of data to better inform inclusive policies and planning. NIPN thus inspires a shift from policy to implementation. In Guatemala, the NIPN[81] was launched in 2017 and is hosted by the Secretariat of Food and Nutrition Security[82]. A key focus has been on accelerating progress with implementing the multi-sectoral national strategy for the prevention of chronic malnutrition (2016-2020).

Results of NIPN Guatemala. The NIPN in Guatemala conducted a national study to analyse the country's progress on the basis of four multi-sectoral nutrition strategies from 2006 to 2020 and ahead of the 2019 elections. The study confirmed that stunting is declining far too slowly: on current trends almost 2 out of every 5 children will still be stunted by 2030. The study analysed in detail budget allocations and expenditures across priority sectors and over time in order to identify potential issues. A number of key insights were established:

1. Over the years, the strategies have progressively narrowed in terms of targeting fewer areas, more restricted age groups and a smaller of number of interventions.
2. Funding and human resources have often not matched the ambitious commitments made. Public investments in food and nutrition security were found to have actually decreased since 2012, meaning that coverage targets could not be met.

Figure 11: Government of Guatemala annual operational plans for national investments in food and nutrition security (2009-2018)



3. There has been a greater focus on and budget allocation towards addressing immediate causes via nutrition-specific interventions, falling mostly in the remit of health, as compared to addressing more basic structural causes such as multi-dimensional poverty and gender inequality.
4. Beyond the health sector, capacities to actually make effective use of resources were very limited, particularly at more local levels, and monitoring systems were weak.

Overall, this unprecedented national exercise concluded that more needed to be done in order to transform the multi-sectoral approach from policy into practice. Accordingly, NIPN was integrated within a municipal information system and is now operational as a pilot initiative[83]. Local authorities are already employing the tool to support better planning and monitoring of municipal interventions for vulnerable households.

Realising human potential. Stunting is associated with poor cognitive and educational outcomes while a stunted child is also at risk of developing obesity and NCDs later in life. The elimination of child stunting is therefore crucial to realise the basic rights of all children and catalyse national development. Seizing the opportunity of the 2019 elections, NIPN contributed to high-level advocacy efforts to maintain nutrition as a top political priority. Guatemala must address the structural drivers of malnutrition with adequate investment and service provision in order to unlock the human potential of disadvantaged populations, especially indigenous communities. To this end, the new government has recently approved its new strategy, the 'great national crusade for nutrition' (2020-2024).

Tackling climate and environmental challenges. Guatemala is among the nations deemed most vulnerable to the effects of climate change. Recent studies show a clear link between climate variability, food and nutrition insecurity and migration, increasingly perceived by poor people as their only option. The establishment of NIPN in Guatemala supports national stakeholders to gear up to address such challenges, by ensuring better information systems and strong data analysis that speaks to the most pressing of policy priorities.

[77] Guatemala DHS 2014/15; Global Nutrition Report 2018.
[78] Maternal and child nutrition, Lancet 2013.
[79] ECLAC/WFP 2004.
[80] Also supported by DFID and the Bill & Melinda Gates Foundation.
[81] Supported by the EU with a budget of € 2.75 million for 3.5 years.
[82] Technical assistance is being provided by the Research and Higher Education Centre for Tropical Agronomy (CATIE).
[83] Municipality of Momostenango in the Department of Totonicapán.

5. Conclusions

Progress towards the EU's commitments

The report confirms that the Commission's 2013 financial pledge of EUR 3.5 billion for nutrition-related programmes in the period 2014-2019 has already been achieved a year ahead of schedule.

The prevalence of stunting has declined in 37 countries prioritising nutrition. On current predicted trends, the number of children who will have been averted from stunting in 40 partner countries between 2012 and 2025 is 4.7 million. To achieve the target of averting 7 million children from stunting, the average annual rate of reduction in these countries will need to increase from 1.35% to 1.82%. In order to further accelerate the reduction of stunting, the EU will need to continue directly engaging with governments in partner countries to scale up nutrition related investments. This becomes even more urgent given the economic fallout of COVID-19. Although the medium-longer impact of the pandemic is still a major unknown, it could especially threaten people suffering from hunger or malnourishment, in particular undernourished children.

While the ongoing reduction in stunting prevalence cannot be attributed entirely to the EU's investments, the financial achievements coupled with the strong evidence of results in the lives of women and children through nutrition related programmes testify to the importance of the EU's contribution in tackling malnutrition and underscores the continued relevance of the pledge to meet the 2025 target[84].

Key insights from progress

Seven years since its publication, the APN's core strategic objectives continue to be highly relevant. Detailed insights at programme level confirm that strengthening governance, scaling up actions through national systems and investing in knowledge for nutrition can bring real change at multiple levels. The increasing use of budget support modalities for nutrition is potentially accelerating the efficiency of investments in national capacities and systems. Building on this experience, opportunities exist to ensure multi-sectoral nutrition outcomes from all budget support operations. In the education sector for instance, this may involve agreeing national targets for the provision of safe drinking water, good sanitation and hygiene in schools as well as integrating nutrition awareness into teacher training and curriculum development.

The case studies presented in this report highlight the message that a rights-based, multi-sectoral and locally adapted approach to nutrition can have a profound impact on people's lives. By increasing income, improving access to basic services and supporting the transformation of gender relations, concrete changes are manifested in more diverse and nutritious diets, improved care practices, women's empowerment and ultimately, better nutritional status – including stunting reduction.

Ongoing and emerging challenges

The global outbreak of COVID-19 is disrupting food systems - including humanitarian supply chains - around the world, often with unduly negative impacts, in particular for women, adolescent girls and children. This pandemic, reinforces the growing recognition that good nutrition and healthy diets are crucial to build and maintain a strong immune system, thereby ensuring that people are better able to fight disease.

[84] Child stunting is linked to other forms of malnutrition. For instance, the evidence shows that undernutrition early in life can increase the risk of overweight and noncommunicable diseases such as diabetes and heart disease later in life https://www.who.int/nutrition/double-burden-malnutrition/en/.

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It has been estimated that the economic fallout from the global pandemic could increase global poverty by half a billion people, or 8% of the total human population[85]. Those regions and countries of the world having the highest numbers of poor people are precisely those with the majority of the world's stunted children. Even within countries, socio-economic inequalities continue to present a daunting challenge for policies focused on tackling malnutrition. This is reflected in the disproportionately high incidence of stunting among children from the poorest and most excluded segments of society.

Moreover, the climate crisis - with rising carbon emissions propelling a dangerous increase in global temperatures, greater climate variability and more frequent extreme weather events – continues to pose a potentially even more daunting range of threats to economies and the prospect of reducing inequalities, ensuring sustainable food systems and healthy diets and improving people's health.

Pressure from demographic growth – particularly in Sub-Saharan Africa – also means that improvements in stunting prevalence do not immediately translate into a reduction in the number of stunted children. Additionally, in a quarter of the countries prioritising nutrition in their cooperation with the EU, protracted conflict is associated with lower improvement in stunting prevalence. This underlines the need to create stronger synergies between humanitarian assistance and longer-term development efforts for nutrition.

The multiple and reinforcing socio-economic impacts of such crises and the resulting disruption of food systems place, invariably, the greatest burden on fragile developing countries, where the interaction of hunger, malnutrition and infectious diseases already constitutes a leading cause of morbidity and mortality. At the same time the global obesity epidemic continues to accelerate[86].

Against this backdrop of heightened vulnerability it is clear that the protection and promotion of good nutrition - especially for the poor and most vulnerable, and with increased attention to the territorial differences across regions in terms of how challenges evolve and impact - is at the core of a policy driven approach to EU cooperation. Ending malnutrition is fundamental to achieving sustainable planetary well-being[87].

Looking forward

The Commission continues to make use of up-to-date and publicly-available nutrition country profiles to support EU Delegations to work with national stakeholders in better understanding and prioritising the specific challenges currently experienced and anticipated at national and local levels. The profiles identify country-specific opportunities for nutrition mainstreaming across sectors and ensure that fresh data and analysis are available to inform ongoing policy dialogue with the EU.

The Commission's strategic engagement with international initiatives also continues to add value – including support to NIPN and the SUN Movement, in addition to ongoing participation in the Committee on World Food Security[88] – in particular regarding the development of the Voluntary Guidelines for Food Systems and Nutrition. Such engagement is expected to contribute to rendering food systems more sustainable and nutrition-sensitive, and to promoting secure access to safe, diverse and healthy diets for all.

In the face of daunting global challenges, including COVID-19, people and environment must remain at the core of food systems transformation. At the same time, these challenges may provide

[85] The UNU/WIDER Working Paper (April 2020) estimates an outcome of a 400-600 million persons increase in global poverty given a scenario in which per capita consumption contracts by 20%. The study also estimates poverty increases for mitigated contractions of 10% and 5% and shows the impacts on poverty by region, as well as globally.
https://www.wider.unu.edu/news/press-release-covid-19-fallout-could-push-half-billion-people-poverty-developing-countries

[86] https://www.nature.com/articles/s41586-019-1171-x. In low and middle income countries the prevalence of overweight and obesity now appears to be increasing at the same rate or faster in rural areas than in cities.

[87] https://www.thelancet.com/commissions/global-syndemic

[88] The Committee on World Food Security is an international and intergovernmental platform for stakeholders to work towards ensuring food security and good nutrition for all. The Committee reports to the UN General Assembly through the Economic and Social Council and to FAO Conference.

new and more resilient ways to tackle hunger and malnutrition. Supporting efforts to better understand the actual impact of COVID-19 on nutrition outcomes in diverse contexts and on different vulnerable populations, thereby anchoring policymaking in evidence on the ground, undoubtedly presents an immediate priority at country level.

This pandemic has strikingly brought to light the need to transform unsustainable food systems. It underlines the relevance for the Commission's Green Deal, and Farm to Fork Strategy in particular, to actively contribute to the realisation of a greener future, in which sustainable and resilient food systems play an essential role.

Understanding that malnutrition represents the tangible manifestation of inequalities is key to ensuring a systematic approach to mainstream the reduction of inequalities across EU development cooperation. Maintaining a strong focus on nutrition outcomes by following a multi-sectoral approach will be essential to accelerate stunting reduction and the overarching commitment to eradicate poverty and achieve sustainable development by 2030. Good nutrition matters more than ever before.

Annex 1: Stunting in children under 5 in the 42 countries prioritising nutrition

42 countries by region	Baseline % children stunted, 2012 (2020 estimate)	Baseline number of children stunted in 2012, millions (2020 estimate)	% stunted, 2019 (2020 estimate)	Number stunted, 2019, millions (2020 estimate)	Estimated no. of children averted from stunting 2012-2019 (*millions*)	Estimated no. of children who will be stunted if WHA target is met by 2025 (*m*)	Estimated no. of children who will be averted from stunting if WHA target is met by 2025 (2019-2025) (*millions*)
Total	***39.2%***	***78.833***	***34.9%***	***77.692***	**1.141**	**47.300**	30.392
Africa	**38.1%**	***51.637***	**34.5%**	***53.444***	**-1.807**	**30.982**	**22.462**
Angola	20.9%	***1.002***	29.3%	***1.660***	**-0.658**	**0.601**	**1.059**
Benin	30.5%	***0.499***	32.2%	***0.604***	**-0.105**	**0.299**	**0.305**
Burkina Faso	34.9%	***1.042***	26.0%	***0.887***	**0.155**	**0.625**	**0.262**
Burundi	55.5%	***0.945***	54.1%	***1.092***	**-0.147**	**0.567**	**0.525**
Cameroon	35.7%	***1.292***	31.5%	***1.277***	**0.015**	**0.775**	**0.502**
Chad	38.9%	***0.955***	38.4%	***1.103***	**-0.148**	**0.573**	**0.530**
Côte d'Ivoire	35.3%	***1.220***	26.8%	***1.084***	**0.136**	**0.732**	**0.352**
DRC	42.6%	***5.524***	40.3%	***6.253***	**-0.729**	**3.314**	**2.938**
Djibouti	32.1%	***0.030***	33.3%	***0.033***	**-0.004**	**0.018**	**0.015**
Ethiopia	43.5%	***6.383***	36.5%	***6.037***	**0.346**	**3.830**	**2.207**
Gambia	21.7%	***0.073***	17.1%	***0.069***	**0.005**	**0.044**	**0.024**
Guinea-Bissau	37.1%	***0.100***	28.0%	***0.084***	**0.015**	**0.060**	**0.025**
Kenya	35.7%	***2.505***	27.8%	***1.951***	**0.554**	**1.503**	**0.448**
Madagascar	48.7%	***1.717***	43.7%	***1.757***	**-0.040**	**1.030**	**0.727**
Malawi	48.5%	***1.325***	39.4%	***1.132***	**0.193**	**0.795**	**0.337**
Mali	29.4%	***0.909***	26.6%	***0.940***	**-0.031**	**0.545**	**0.395**
Mauritania	24.4%	***0.143***	21.0%	***0.143***	**0.000**	**0.086**	**0.057**
Mozambique	41.1%	***1.786***	38.3%	***1.934***	**-0.148**	**1.071**	**0.862**
Niger	45.1%	***1.663***	42.7%	***1.984***	**-0.322**	**0.998**	**0.987**
Nigeria	37.2%	***10.828***	35.1%	***11.742***	**-0.914**	**6.497**	**5.245**
Rwanda	46.0%	***0.751***	39.1%	***0.723***	**0.028**	**0.451**	**0.272**
Senegal	19.0%	***0.435***	16.9%	***0.436***	**-0.001**	**0.261**	**0.175**
Sierra Leone	41.5%	***0.449***	32.5%	***0.373***	**0.076**	**0.269**	**0.104**
Somalia	30.4%	***0.719***	29.3%	***0.806***	**-0.086**	**0.432**	**0.374**
Sudan	32.2%	***1.831***	36.8%	***2.296***	**-0.465**	**1.099**	**1.198**
Tanzania	34.3%	***2.251***	29.2%	***2.247***	**0.004**	**1.350**	**0.896**
Uganda	39.1%	***3.231***	33.0%	***3.142***	**0.089**	**1.938**	**1.204**
Zambia	49.4%	***1.278***	37.0%	***1.073***	**0.205**	**0.767**	**0.306**
Zimbabwe	35.3%	***0.754***	27.3%	***0.584***	**0.170**	**0.453**	**0.131**
Asia	**42.1%**	***25.678***	**36.0%**	***22.847***	**2.831**	**15.407**	**7.440**
Afghanistan	67.1%	***3.631***	38.1%	***2.148***	**1.483**	**2.178**	**-0.030**
Bangladesh	39.4%	***5.878***	31.7%	***4.565***	**1.313**	**3.527**	**1.038**
Cambodia	36.0%	***0.631***	28.6%	***0.509***	**0.122**	**0.378**	**0.131**
Lao PDR	43.8%	***0.349***	34.5%	***0.274***	**0.075**	**0.209**	**0.065**
Myanmar	32.5%	***1.536***	26.9%	***1.213***	**0.323**	**0.922**	**0.291**
Nepal	39.9%	***1.170***	32.4%	***0.876***	**0.294**	**0.702**	**0.174**
Pakistan	41.1%	***10.168***	39.6%	***10.958***	**-0.790**	**6.101**	**4.857**
Sri Lanka	15.2%	***0.268***	13.9%	***0.233***	**0.035**	**0.161**	**0.072**
Timor-Leste	58.7%	***0.091***	52.7%	***0.092***	**-0.001**	**0.055**	**0.037**
Yemen	52.0%	***1.957***	48.3%	***1.979***	**-0.022**	**1.174**	**0.805**
Latin America	**35.9%**	***1.517***	**32.3%**	***1.401***	**0.116**	**0.910**	**0.490**
Guatemala	50.8%	***0.983***	46.5%	***0.955***	**0.028**	**0.590**	**0.365**
Haiti	23.0%	***0.292***	20.1%	***0.255***	**0.037**	**0.175**	**0.080**
Honduras	23.7%	***0.242***	18.8%	***0.190***	**0.051**	**0.145**	**0.883**

Annex 2: Country dashboard of nutrition-relevant indicators

Country	Inputs	Process/ Activities	Outputs	Outcomes									Impact					
	DEVCO Nutrition Commitments 2014-2018 (EUR millions)	DEVCO Nutrition Disbursements 2014-2018 (EUR millions)	Number of women & children reached by DEVCO nutrition assistance (2016-2018)	Global Food Security Index			Exclusive breastfeeding of infants < 6 months (%)			Wasting Prevalence in children under 5 years of age (%)			Stunting Prevalence in children under 5 years of age (%)			Rate of Stunting reduction (%)		
				2012	2019	Change since 2012 baseline	Data of the closest year to the 2012 baseline	Most recent data	Change since 2012 baseline	Data of the closest year to the 2012 baseline	Most recent data	Change since 2012 baseline	2012 baseline (as estimated in 2019)	2019 Estimate	Change since 2012 baseline	2012 baseline (as estimated in 2019)	Estimated in 2019)	Change since 2012 baseline
Afghanistan	86.88	70.93	-	-	-	-	43.1	57.5		9.5	5.1		67.1	38.1		-1.6	1.9	
Angola	16.25	4.27	-	35.8	45.5		-	37.4	-	8.2	4.9		20.9	29.3		6.5	2.6	
Bangladesh	138.06	36.70	35,451	42.6	53.2		55.9	55.3		15.7	8.4		39.4	31.7		2.8	2.9	
Benin	17.50	5.91	-	36.0	51.0		32.5	41.4		9.0	5.0		30.5	32.2		1.5	0.8	
Burkina Faso	56.50	53.54	57,623	33.2	50.1		38.2	47.8		10.7	8.4		34.9	26.0		1.0	2.3	
Burundi	31.25	12.11	-	29.1	34.3		69.3	82.3		6.0	5.1		55.5	54.1		1.0	0.7	
Cambodia	7.50	2.12	6,405	38.4	49.4		72.8	65.2		11.0	9.7		36.0	28.6		2.8	3.0	
Cameroon	6.75	6.15	-	40.2	49.9		19.9	28.0		5.7	4.3		35.7	31.5		-0.2	0.5	
Chad	204.50	48.46	51,754	30.9	36.9		3.2	0.1		16.3	13.3		38.9	38.4		0.7	0.5	
Côte d'Ivoire	-	0.51	-	42.0	52.3		11.8	23.1		7.6	6.1		35.3	26.8		-0.1	1.4	
Democratic Republic of The Congo	6.75	13.88	-	26.5	35.7		36.4	47.3		8.5	8.1		42.6	40.3		0.9	0.8	
Djibouti	6.75	1.73	-	-	-	-	12.4	-	-	21.5	-	-	32.1	33.3		-0.5	-0.5	
Ethiopia	118.33	94.20	46,196	39.4	49.2		52.0	56.5		9.8	7.2		43.5	36.5		2.2	2.3	
Gambia	17.39	15.23	43,821	-	-	-	33.1	46.8		9.5	6.1		21.7	17.1		2.5	2.9	
Guatemala	-	2.18	3,186,235	49.1	60.6		49.6	53.2		1.0	0.8		50.8	46.5		0.4	0.7	
Guinea-Bissau	14.00	12.69	-	-	-	-	38.3	52.5		5.9	6.0		37.1	28.0		0.1	1.8	
Haiti	25.49	20.02	-	31.0	43.3		39.3	39.9		5.1	3.7		23.0	20.1		2.5	2.3	
Honduras	17.00	9.17	11,210	49.7	58.0		30.7	-	-	1.4	-	-	23.7	18.8		3.2	3.2	
Kenya	20.59	16.75	534,566	43.7	50.7		31.9	61.4		6.9	4.2		35.7	27.8		0.7	1.6	
Lao People's Democratic Republic	50.12	14.31	1,142	37.3	49.1		39.7	44.4		5.9	9.0		43.8	34.5		1.0	1.8	
Madagascar	20.00	5.36	-	33.6	37.9		50.1	41.9		7.5	6.4		48.7	43.7		0.9	1.1	
Malawi	84.75	25.69	3,117	33.5	42.4		69.0	59.4		4.0	1.3		48.5	39.4		0.9	1.6	
Mali	21.27	57.02	184,712	40.6	54.4		20.2	40.4		8.9	9.0		29.4	26.6		2.4	2.0	
Mauritania	22.70	12.76	3,282	-	-	-	26.7	40.3		11.6	14.8		24.4	21.0		3.8	3.2	
Mozambique	50.25	27.60	-	34.2	41.4		40.0	41.0		6.1	4.4		41.1	38.3		1.7	1.5	
Myanmar	22.50	28.22	146,938	39.3	57.0		23.6	51.2		7.9	6.6		32.5	26.9		2.8	2.7	
Nepal	38.43	18.27	12,216	42.0	56.4		69.6	65.2		11.2	9.6		39.9	32.4		3.1	3.0	
Niger	87.37	82.79	1,560,520	33.0	49.6		23.3	-	-	18.2	10.1		45.1	42.7		0.6	0.7	
Nigeria	65.18	39.03	3,640,460	37.7	48.4		14.7	28.7		10.2	6.8		37.2	35.1		1.1	1.0	
Pakistan	79.37	35.06	89,634	46.6	56.8		37.7	47.5		14.8	7.1		41.1	39.6		0.7	0.7	
Rwanda	50.92	54.34	-	37.4	48.2		83.8	86.9		2.4	2.1		46.0	39.1		0.6	1.2	
Senegal	31.03	29.26	939,494	35.8	54.5		37.5	42.1		8.7	8.1		19.0	16.9		2.6	2.3	
Sierra Leone	2.25	4.17	43,672	34.4	39.0		31.4	47.2		8.5	5.4		41.5	32.5		-0.3	1.1	
Somalia	20.50	17.70	230	-	-	-	5.3	-	-	14.3	-	-	30.4	29.3		0.5	0.5	
Sri Lanka	7.50	3.60	1,210	53.5	60.8		75.8	82.0		21.3	15.1		15.2	13.9		3.1	2.4	
Sudan	38.22	20.40	102	34.4	45.7		41.0	54.6		15.4	16.3		32.2	36.8		2.9	0.0	
Timor-Leste	15.50	9.86	-	-	-	-	62.3	50.2		18.9	9.9		58.7	52.7		-0.6	0.4	
Uganda	47.85	15.01	-	41.8	46.2		62.3	65.5		4.2	3.5		34.3	29.2		1.9	2.0	
United Republic of Tanzania	35.00	2.98	-	37.1	47.6		48.7	59.0		6.2	3.5		39.1	33.0		1.4	1.7	
Yemen	18.00	26.28	231,383	36.1	35.6		11.5	9.7		13.3	16.4		52.0	48.3		0.1	0.4	
Zambia	30.50	14.75	-	34.1	44.4		72.0	69.9		6.2	4.2		49.4	37.0		0.3	1.5	
Zimbabwe	30.88	36.02	6,600	-	-	-	31.3	47.1		3.2	2.9		35.3	27.3		-0.8	0.9	

Note:

Data excludes some regional, global and policy/research/information **commitments** during 2014-2018 that could not be disaggregated by beneficiary country at this stage, amounting to EUR 335.28 m (15.7% of the total).

Data excludes some regional, global and policy/research/information **disbursements** during 2014-2018 that could not be disaggregated by beneficiary country at this stage, amounting to EUR 121.69 m (9.9% of the total).

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Country	Context													
	Delivery in health facility (%)			HANCI Score			Population Growth (millions)			Gender Inequality Index (Range 0 to 1)			Global multi-poverty Index (Range 0 to 1)		
	2012 baseline	Most recent data	Change since 2012 baseline	2012 baseline	Most recent data (2017)	Change since 2012 baseline	2012 baseline	Most recent data (2019)	Change since 2012 baseline	2012 baseline	Most recent data (2019)	Change since 2012 baseline	Data of the closest year to the 2012 baseline	Most recent data	Change since 2012 baseline
Afghanistan	35.8	48.1		104	81		3.41	2.38		0.644	0.575		0.353	0.272	
Angola	45.8	45.6		80	103		3.60	3.28		-	0.578	-	0.452	0.282	
Bangladesh	31.0	37.4		189	158		1.15	1.05		0.569	0.536		0.253	0.198	
Benin	86.9	83.9		147	136		2.80	2.73		0.626	0.613		0.307	0.368	
Burkina Faso	66.3	82.2		198	175		3.00	2.87		0.609	0.612		0.519	-	-
Burundi	78.2	83.9		86	142		3.16	3.17		0.539	0.520		0.454	0.403	
Cambodia	61.4	83.2		175	148		1.63	1.49		0.484	0.474		0.212	0.170	
Cameroon	61.2	61.3		122	136		2.73	2.61		0.616	0.566		0.248	0.243	
Chad	15.8	21.7		-	105	-	3.37	3.02		-	0.701	-	0.554	0.533	
Côte d'Ivoire	57.4	69.8		132	150		2.44	2.55		0.667	0.657		0.310	0.236	
Democratic Republic of the Congo	74.9	79.9		76	128		3.34	3.23		0.674	0.655		0.392	0.389	
Djibouti	86.7	-	-	-	-	-	1.68	1.56		-	-	-	0.170	-	-
Ethiopia	9.9	26.2		160	135		2.83	2.62		0.569	0.508		0.564	0.489	
Gambia	55.7	62.6		201	199		3.03	2.95		0.657	0.620		0.324	0.286	
Guatemala	63.1	65.0		240	245		2.13	1.95		0.517	0.492		0.127	0.134	
Guinea-Bissau	41.4	44.0		74	78		2.65	2.49		-	-	-	0.462	0.372	
Haiti	35.9	39.4		-	-	-	1.48	1.27		0.621	0.620		0.231	0.200	
Honduras	82.7	-	-	-	-	-	1.87	1.67		0.513	0.479		0.159	0.090	
Kenya	42.6	61.2		114	185		2.66	2.31		0.606	0.545		0.229	0.178	
Lao People's Democratic Republic	37.5	64.5		-	-	-	1.52	1.55		0.495	0.463		0.211	0.108	
Madagascar	35.3	37.9		213	203		2.73	2.67		-	-	-	0.453	-	-
Malawi	73.2	91.0		222	213		2.86	2.64		0.615	0.615		0.334	0.243	
Mali	55.5	66.8		177	174		2.95	3.01		0.674	0.676		0.457	0.457	
Mauritania	64.5	69.3		101	144		2.95	2.78		0.647	0.620		0.285	0.261	
Mozambique	54.8	-	-	186	121		2.75	2.91		0.590	0.569		0.411	-	-
Myanmar	36.2	37.1		89	115		0.83	0.61		0.507	0.459		0.154	0.176	
Nepal	35.3	57.4		175	216		-0.19	1.65		0.516	0.476		0.217	0.148	
Niger	29.8	58.8		162	163		3.90	3.82		0.679	0.647		0.590	-	-
Nigeria	45.1	39.4		135	103		2.68	2.59		-	-	-	0.240	0.291	
Pakistan	41.0	66.2		147	187		2.13	2.06		0.563	0.547		0.228	0.198	
Rwanda	68.9	90.7		179	185		2.46	2.64		0.435	0.412		0.350	0.259	
Senegal	71.0	78.2		172	169		2.79	2.78		0.550	0.523		0.332	0.288	
Sierra Leone	50.1	76.7		147	121		2.25	2.14		0.660	0.644		0.388	0.297	
Somalia	9.4	-	-	-	-	-	2.70	2.83		-	-	-	0.514	-	-
Sri Lanka	98.2	99.5		-	-	-	0.13	1.05		0.400	0.380		0.021	-	-
Sudan	20.5	27.7		92	119		2.36	2.39		0.612	0.560		0.321	0.279	
Timor-Leste	22.1	49.0		-	-	-	1.77	1.97		-	-	-	0.360	0.210	
Uganda	57.4	73.4		173	149		3.18	3.72		0.552	0.531		0.367	0.269	
United Republic of Tanzania	50.2	62.6		201	191		2.97	2.98		0.558	0.539		0.332	0.273	
Yemen	23.5	29.8		97	81		2.76	2.36		0.826	0.834		0.283	0.241	
Zambia	45.0	67.4		176	144		3.10	2.91		0.588	0.540		0.328	0.261	
Zimbabwe	65.1	77.0		-	150	-	1.70	1.41		0.567	0.525		0.172	0.137	

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Country	Context														
	Urbanisation			DPT3 coverage			Gini coefficient			Access to improved drinking water (%)			Primary education (% women)		
	2012 baseline	Most recent data (2019)	Change since 2012 baseline	2012 baseline	Most recent data (2018)	Change since 2012 baseline	Data of the closest year to the 2012 baseline	Most recent data	Change since 2012 baseline	Data of the closest year to the 2012 baseline	Most recent data	Change since 2012 baseline	Data of the closest year to the 2012 baseline	Most recent data	Change since 2012 baseline
Afghanistan	24.16	25.75		67.0	66.0		-	-	-	-	65.3	-	-	2.0	-
Angola	61.27	66.18		52.0	59.0		42.7	-	-	48.7	52.3		2.8	6.0	
Bangladesh	31.99	37.41		94.0	98.0		32.1	32.4		98.5	97.6		11.6	11.1	
Benin	44.13	47.86		80.0	76.0		43.4	47.8		78.4	71.2		4.1	1.6	
Burkina Faso	25.77	29.98		90.0	91.0		39.8	35.3		77.0	80.7		3.4	3.6	
Burundi	11.19	13.37		96.0	90.0		33.4	38.6		79.2	82.9		13.9	13.5	
Cambodia	21.04	23.81		90.0	92.0		-	-	-	32.5	65.2		8.1	8.0	
Cameroon	52.77	56.97		85.0	79.0		42.8	46.6		70.8	-	-	14.4	-	-
Chad	22.14	23.28		40.0	41.0		43.3	-	-	35.8	55.3		1.8	4.9	
Côte d'Ivoire	48.17	51.24		82.0	82.0		43.2	41.5		78.3	-	-	9.0	-	-
Democratic Republic of the Congo	41.08	45.05		75.0	81.0		42.1	-	-	46.2	48.7		7.1	8.4	
Djibouti	77.14	77.92		81.0	84.0		45.1	41.6		-	-	-	-	-	-
Ethiopia	18.16	21.23		62.0	72.0		33.2	35.0		53.7	64.8		4.0	3.2	
Gambia	57.11	61.93		98.0	93.0		43.6	35.9		91.0	-	-	5.5	-	-
Guatemala	49.00	51.44		96.0	86.0		54.6	48.3		85.5	57.3		14.5	17.3	
Guinea-Bissau	40.91	43.78		87.0	88.0		50.7	-	-	-	-	-	-	-	-
Haiti	49.48	56.19		66.0	64.0		41.1	-	-	64.8	74.0		4.6	8.8	
Honduras	53.20	57.73		98.0	90.0		56.1	50.5		89.8	-	-	27.1	-	-
Kenya	24.38	27.51		94.0	92.0		48.5	40.8		63.5	75.1		26.9	33.6	
Lao People's Democratic Republic	31.26	35.65		79.0	68.0		36.4	-	-	-	-	-	-	-	-
Madagascar	33.23	37.86		70.0	75.0		42.6	-	-	37.2	43.8		10.0	12.9	
Malawi	15.81	17.17		96.0	92.0		45.5	44.7		80.7	86.2		10.7	10.5	
Mali	37.60	43.14		65.0	71.0		33.0	-	-	66.0	68.7		2.2	3.8	
Mauritania	48.40	54.51		80.0	81.0		35.7	32.6		63.1	-	-	8.6	-	-
Mozambique	32.85	36.53		76.0	80.0		45.6	54.0		51.0	63.8		7.3	8.3	
Myanmar	29.27	30.85		84.0	91.0		-	38.1	-	-	80.2	-	-	18.0	-
Nepal	17.46	20.15		90.0	91.0		32.8	-	-	91.6	94.6		5.5	5.5	
Niger	16.21	16.52		71.0	79.0		31.5	34.3		67.0	-	-	1.6	-	-
Nigeria	45.25	51.16		42.0	57.0		43.0	-	-	53.6	63.0		12.1	10.1	
Pakistan	35.41	36.91		64.0	75.0		30.9	33.5		93.4	94.6		10.0	11.1	
Rwanda	16.94	17.31		98.0	97.0		47.2	43.7		73.8	78.5		13.9	17.9	
Senegal	44.60	47.65		91.0	81.0		40.3	-	-	76.0	81.0		3.7	2.6	
Sierra Leone	39.64	42.48		91.0	90.0		34.0	-	-	60.6	70.1		3.4	2.8	
Somalia	41.56	45.55		42.0	42.0		-	-	-	-	-	-	-	-	-
Sri Lanka	18.20	18.59		99.0	99.0		39.2	39.8		-	-	-	-	-	-
Sudan	33.35	34.94		92.0	93.0		35.4	-	-	-	-	-	-	-	-
Timor-Leste	28.43	30.95		83.0	83.0		27.8	28.7		63.3	78.6		8.9	6.5	
Uganda	20.42	24.36		83.0	93.0		41.0	42.8		70.3	78.3		11.3	12.8	
United Republic of Tanzania	29.49	34.50		92.0	98.0		37.8	-	-	58.7	63.3		52.1	47.4	
Yemen	32.96	37.27		67.0	65.0		34.7	36.7		58.8	-	-	-	-	-
Zambia	40.35	44.07		78.0	90.0		55.6	57.1		41.1	64.5		19.0	16.1	
Zimbabwe	32.83	32.21		95.0	89.0		43.2	-	-	78.7	78.1		16.6	14.5	

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Dashboard legend

For the 18 outcome/impact/context indicators in the dashboard, two colour-coded analyses of progress are presented:

- Firstly, cell colours show how the latest data fits according to the thresholds established for the 2012 baselines for each indicator. These baseline thresholds divided the countries into three groups of equal size, so that for all indicators, 33% of countries fell into the 'best' green category; 33% were in the 'middle' amber category; and 33% in the 'worst' red category. The latest data was then compared to these baseline thresholds to assess progress (described as 'shifts' in the analysis below).
- Secondly, a circular traffic light is used to show whether the indicator has improved (green), worsened (red), or remains unchanged (amber), compared to its baseline value.

Thresholds were defined for each indicator for the baseline year, which divided the countries up into 3 groups of equal size. These same thresholds have been applied to the relevant indicator to assess the status of the most recent data:

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Green: data falls within the top of the 2012 groups		There has been an improvement since the baseline
Orange: data falls within the middle of the 2012 groups		There has been no or limited improvement since the baseline
Red: data falls within the bottom of the 2012 groups		There has been a deterioration since the baseline

In addition, the change in each indicator since the 2012 baseline is illustrated by a separate traffic light signal. The amber signal 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. This provides a range around zero for each indicator.

Indicator	Source	Comments
DEVCO Nutrition Commitments 2014-2018	DEVCO Unit C1; Nutrition Advisory Service Resource Tracking Team	DEVCO figures, as reported to the OECD DAC up to December 2018
DEVCO Nutrition Disbursements 2014-2018	DEVCO Unit C1; Nutrition Advisory Service Resource Tracking Team	DEVCO figures, as reported to the OECD DAC up to December 2018
Number of women and children benefiting from DEVCO nutrition assistance	DEVCO Unit 05 (Results and Business Processes)	EU corporate result indicator for nutrition. It includes EU-funded interventions that either ended between July 2013 and June 2018 or were ongoing at time of project selection (June 2018)
Global Food Security Index	The Economist Intelligence Unit	The 2019 Global Food Security Index provides a worldwide perspective on which countries are most and least vulnerable to food insecurity and how resource risks increase vulnerability. The index considers affordability, availability and quality & safety. The scale is normalised from 1-100 where 100 = most favourable. denotes 0 ± 0.37
Exclusive breastfeeding of infants under 6 months	UNICEF: https://data.unicef.org/topic/nutrition/infant-and-young-child-feeding/	Baseline is the data available for 2012 or the closest year before 2012. The latest available data varies between countries, from 2013 to 2018. denotes 0 ± 1.12%
Wasting prevalence children < 5 years	Joint malnutrition estimates (JME 2020)	denotes 0 ± 0.31%
Estimated stunting prevalence children < 5 years	DEVCO Unit C1 Nutrition Advisory Service, applying the 'stunting reduction calculation tool' developed with WHO (linear estimates)	denotes 0 ± 0.89%
Rate of stunting reduction	DEVCO Unit C1 Nutrition Advisory Service, applying the 'stunting reduction calculation tool' developed with WHO	Note: Minus numbers denote a decreasing trend in stunting rate denotes 0 ± 0.02%
Delivery in a health facility	UNICEF 2019 https://data.unicef.org/wp-content/uploads/2018/02/Maternal-and-Newborn-Health-Coverage-Database-2019-Nov14.xlsx	Percentage of births delivered in a health facility. The indicator refers to women who had a live birth in a recent time period, generally 2 years for MICS and 5 years for DHS. denotes 0 ± 0.91%
HANCI Hunger and Nutrition Commitment Index	Institute of Development Studies: 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 2017: Data direct from IDS	The HANCI measures the political commitment of countries to reduce hunger and undernutrition in their populations. The latest available data varies between countries is 2017. Higher scores indicate a better commitment. denotes 0 ± 4.12%
Population growth	https://data.worldbank.org/indicator/SP.POP.GROW	Annual population growth rate for year. The latest population estimates are used. denotes 0 ± 0.07%
GII Gender Inequality Index	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

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Indicator	Source	Comments
		secondary education; and - economic status, expressed as labour market participation and measured by labour force participation rate of female 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 ± 0.002%
Global Multi-Poverty Index (MPI)	Oxford Poverty & Human Development Initiative: https://ophi.org.uk/multidimensional-poverty-index/global-mpi-2019/ (winter 2017-8 update) The MPI relies on two main datasets: the demographic and health survey (DHS), and the multiple indicators cluster survey (MICS).	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 multi-dimensionally poor; and the intensity of poverty (the average percentage of deprivations each poor person experiences at the same time). Baseline is the data available for 2012 or the closest year before 2012. The latest available data varies between countries from 2013 to 2018. denotes 0 ± 0.007%
Urbanisation	World urbanisation prospects UN population division https://population.un.org/wup/Download/	Based on an individual country's definition of urban. Annual Percentage of Population at Mid-Year Residing in Urban Areas by region, sub-region and country, 1950-2050 denotes 0 ± 0.17%
GINI coefficient	World development indicators latest update 31/01/2019 https://data.worldbank.org/indicator/SI.POV.GINI?	The Gini index measures the extent to which the distribution of income (or, in some cases, consumption expenditure) among individuals or households within an economy deviates from a perfectly equal distribution. A Gini index of 0 represents perfect equality, while an index of 100 implies perfect inequality. denotes 0 ± 0.70
DPT3 coverage	World Health Organization: https://www.who.int/gho/immunization/dtp3/en/	The percentage of children receiving the final dose (DPT3) is a vital gauge of how well countries are providing immunisation coverage for their children (2019 data). denotes 0 ± 0.62%
Improved drinking water	DHS data. Statcompiler https://statcompiler.com/en/	The percentage of households using improved water source. denotes 0 ± 2.30%
Women's primary education	DHS data. Statcompiler https://statcompiler.com/en/	The percentage of women who had completed primary school. denotes 0 ± 0.44%

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