7 MEETING THE NEED: FINANCING TO ATTAIN TARGETS

COMMITMENT WITHOUT FUNDING REPRESENTS UNFULFILLED GOOD INTENTIONS. IF NUTRITION-PROMOTING ACTIONS ARE TO BE IMPLEMENTED AND TARGETS MET, they need to be financed. Financing for nutrition comes from governments (domestic), from international sources—the bilateral and multilateral aid agencies and foundations that make up the "donor" community—and from people themselves.

We know that investing in scaling up nutrition interventions is a high-impact, high-return proposition. The *Global Nutrition Report 2014* estimated a benefit-cost ratio of 16:1 and the *Global Nutrition Report 2015* summarized new estimates that show a compound rate of return from nutrition investments of greater than 10 percent. We also know that the costs of nutrition-related noncommunicable diseases (NCDs) are very high: for example, Popkin et al. (2006) estimate that for China the costs of obesity and obesity-related dietary and physical activity patterns will increase from 3.58 percent to 8.73 percent of gross national product from 2000 to 2025.

This chapter outlines how much it will cost to scale up interventions and accelerate improvements in nutrition—and how well governments and donors are doing in meeting that challenge. In doing so we identify ways in which governments and donors can increase and most effectively allocate resources to support action on nutrition. The chapter also provides civil society with data to help it hold governments and donors more accountable for financing actions to accelerate nutrition improvements.

The first part of the chapter deals with the spending levels needed to attain targets related to undernutrition and breastfeeding. It presents analyses that answer the following questions: How much will be needed to finance direct nutrition interventions to meet the World Health Assembly (WHA) targets on stunting, wasting, exclusive breastfeeding (EBF), and anemia by 2025? Who has to step up, and how will the resources be raised? The analysis shows that

governments and donors—together—need to increase their investments in nutrition several times over if the highest-burden countries are to reach the WHA goals.

Next, we conclude that there is significant room for governments to increase their allocations to nutrition. We show that governments are allocating 2.09 percent of their expenditures to nutrition. This compares with 33 percent of government expenditure in Asia and Africa allocated to four sectors: agriculture, education, health, and social protection (we do not have comparable data for water, sanitation, and hygiene [WASH]). These sectors are the reservoirs that nutrition must draw on. We show that 24

KEY FINDINGS

This chapter outlines how well governments and donors are doing in meeting nutrition financing needs, and what it will cost to meet the challenge that malnutrition poses.

- Scaling up nutrition investments is still a high-impact, high-return proposition, with a benefit-cost ratio of 16:1 and a compound rate of return of more than 10 percent (IFPRI 2014, 2015a).
- The costs of neglecting nutrition are high, causing economic losses of 10 percent of gross domestic product. In China, the gross national product losses due to obesity are likely to double from 4 percent in 2000 to 9 percent in 2025. In low-income countries, 54 percent of the cost of cardiovascular disease is met from household expenses.
- There is a strong case for tracking financial resources and investments in nutrition: it leads to a far greater focus on results and helps make the case for additional investment.
- Current funding levels do not meet the needs:
  - The 10-year funding gap to meet 2025 milestones for stunting, severe acute malnutrition, breastfeeding, and anemia is US$70 billion.
  - Analysis of 24 low- and middle-income governments' spending shows the mean allocation to nutrition at 2.1 percent, compared with 33 percent to agriculture, education, health, and social protection.
  - Noncommunicable diseases (NCDs), many of which are linked to nutrition, cause 49.8 percent of death and disability in low- and middle-income countries. But less than 2 percent of donor health spending goes to NCDs per year ($611 million in 2014). And nutrition-related NCDs received only $50 million of donor funding in 2014, compared with nearly $1 billion spent on nutrition-specific interventions.
  - Donor allocations to all nutrition-specific interventions are stagnating at $1 billion, although their allocations to nutrition via other sectors are increasing.
- Governments and donors must triple their commitments to nutrition to meet these critical milestones, with annual spending increases of $3.7 billion and $2.6 billion, respectively.
- Significant opportunities exist to increase nutrition spending: governments can make the 33 percent they spend on agriculture, education, social protection, and health work harder for nutrition by including nutrition targets in their plans and by tracking impact.
- Reporting on nutrition spending is patchy, at best. Government spending data on nutrition-related NCDs and obesity are fragmented across multiple departments and often bundled in with non-nutrition items. The Organization for Economic Co-operation and Development's Development Assistance Committee does not monitor donor nutrition-sensitive spending or nutrition-related NCD spending. Governments and donors do not always take consistent approaches to tracking their nutrition spending.

governments are already drawing on these sectors, but the flow to nutrition is, at present, a trickle.

We show that while donors have stepped up impressively for undernutrition interventions over the last 10 years, their momentum on nutrition-specific spending—such as breastfeeding promotion, the promotion of improved infant and young child feeding, micronutrient supplementation and fortification, and therapeutic feeding for severe acute malnutrition (SAM)—has stalled. We point out that spending on these items has plateaued while major donors such as the United States, the United Kingdom, and Japan have seen significant declines in their disbursements to nutrition-specific interventions. In addition, 13 of the 28 Organization for Economic Co-operation and Development (OECD) donors continue to shun nutrition-specific interventions by allocating less than US$1 million[1] to them. Donor nutrition-sensitive disbursements to combat undernutrition in areas such as agriculture, social protection, education, WASH, and women's empowerment are increasing, although the reporting remains patchy and therefore difficult to analyze.

Finally, and for the first time in the *Global Nutrition Report*, we begin to assemble a picture of funding for nutrition-related NCD actions. Data sources are fragmented and not well tailored to assessing government or donor spending on such actions. Governments, donors, and researchers have a great deal more work to do to identify spending on actions to prevent and control nutrition-related NCDs.

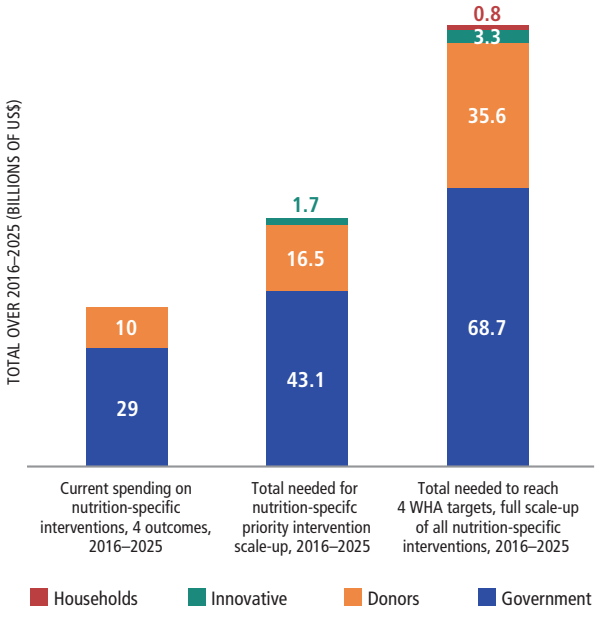
COSTING AND RESOURCING OF DIRECT INTERVENTIONS TO MEET GLOBAL MATERNAL AND CHILD NUTRITION TARGETS

The *Global Nutrition Report 2015* summarized a preliminary analysis from the World Bank and the Results for Development Institute (R4D) on the cost of scaling up nutrition-specific interventions in 37 high-burden countries to meet the 2025 stunting targets. Since that work in mid-2015, the World Bank and R4D teams have refined their stunting analysis and added similar analyses for three further targets—under-5 severe acute malnutrition,[2] anemia in women of reproductive age, and exclusive breastfeeding—this time for all low- and middle-income countries.[3]

The teams estimate that current spending on nutrition-specific interventions to address stunting, severe acute malnutrition, exclusive breastfeeding, and women's anemia is $3.9 billion a year: $2.9 billion from government sources and $1 billion from donors. If this level is maintained over the coming decade, a total of $39 billion will be invested in the key intervention package (Figure 7.1). To meet the four targets, however, this amount will have to increase by nearly $70 billion. This represents a near tripling of the current spending over this 10-year period to a total of $108 billion (Figure 7.1). Governments will need to mobilize an average of $3.9 billion more per year, and donors an additional $2.6 billion annually over the next 10 years to meet the targets. This would increase current government funding by a factor of 2.3 over the 10-year period and current donor funding by a factor of 3.6. The middle bar of Figure 7.1 provides estimates for scaling up a subset of interventions[4] (see Shekar et al. 2016). These multiples for the full scale-up are in line with previous estimates on stunting from the World Bank and R4D team, reported in the *Global Nutrition Report 2015*.

Are these increases in nutrition-specific investment levels feasible in an era when economic growth is slowing and official development assistance levels are plateauing? Donors have already quadrupled their spending on nutrition-specific interventions over the past 10 years, though

FIGURE 7.1 Financing levels and sources to meet stunting, severe acute malnutrition, anemia, and exclusive breastfeeding goals for all low- and middle-income countries by 2025



Source: Authors, based on data in Shekar et al. (2016).

Note: Examples of innovative financing mechanisms include the Power of Nutrition (see www.powerofnutrition.org) and the Global Financing Facility in support of Every Woman, Every Child (see www.globalfinancingfacility.org). *Global Nutrition Report 2015* reported on these mechanisms.

admittedly from a very low base. Will they be willing to expand at this more demanding pace?

To make a convincing argument for additional investment, several things need to happen. First, there needs to be an engaging articulation of the lives saved and the benefit-cost ratios of scaling up direct nutrition interventions (see the median benefit-cost ratio of 16:1 reported for 40 countries in the *Global Nutrition Report 2014)*. Second, the total cost needs to be broken down into "bite-sized" pieces that are more politically feasible for domestic and international investors to commit to (hence the "priority intervention" scenario, middle column, Figure 7.1). Third, a timeline needs to be articulated for a schedule of payments that reflects different stakeholders' ability to invest. And fourth, the circle of investors needs to be expanded.

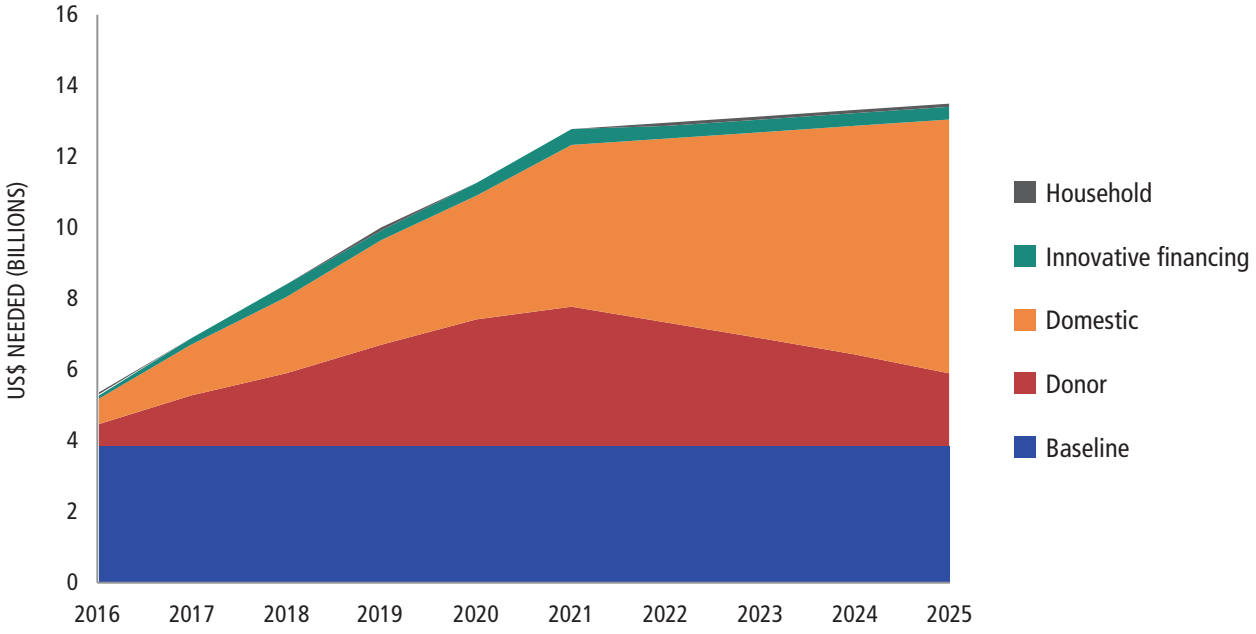
To make the step up in funding more feasible, the World Bank and R4D authors propose a time line with a schedule of payments that, they argue, reflects ability to invest. This is the "global solidarity" scenario for funding (Figure 7.2). Donor increases would be front-loaded, with the bulk of government domestic increases occurring in the second half of the 10-year period.

The *Global Nutrition Report* strongly endorses the conclusions of the analysis of the World Bank and R4D team. Further details of their work are summarized in Shekar et al. (2016).

COUNTRY DOMESTIC NUTRITION BUDGET ALLOCATIONS

In the *Global Nutrition Report 2015* we presented data from 14 countries that had estimated their domestic allocations to both nutrition-specific and nutrition-sensitive actions.[5] Each of those countries derived and applied its own nutrition weights to various line items in its government budget. This section applies the mean weights for those 14 countries to 8 new countries.[6] Two additional countries, Peru and Guatemala, provided their actual nutrition budget allocations. Thus, we have 24 country-level estimates of domestic allocations to nutrition.[7] Figure 7.3 presents the nutrition allocations as a percentage of general (total) government expenditures. The estimates range from 0.06 to 9.23 percent of general government expenditures. The mean nutrition allocation across the 24 countries is 2.1 percent.

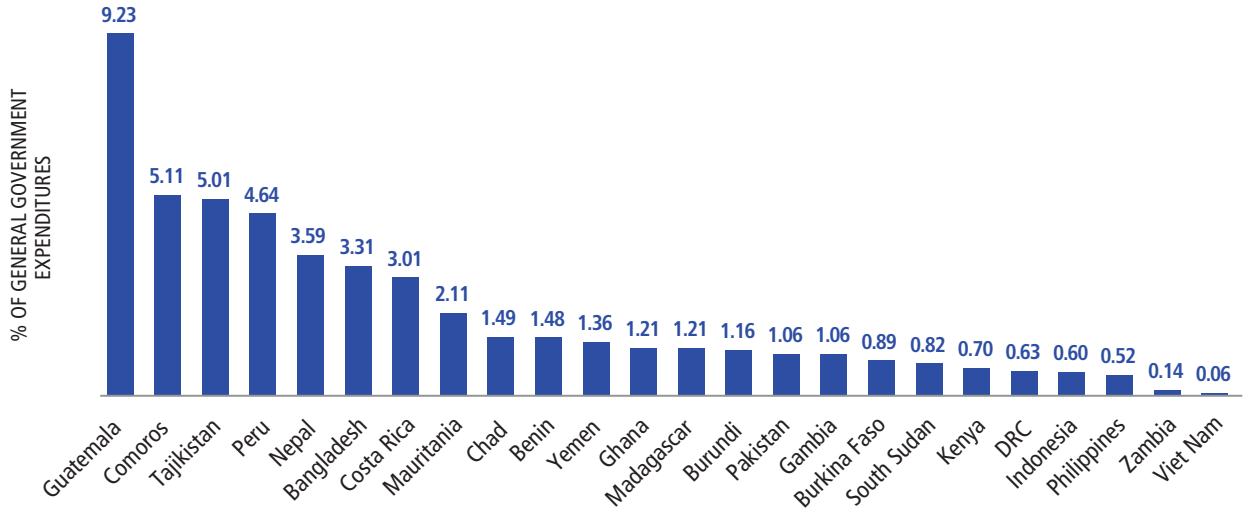
FIGURE 7.2 Additional investments required to achieve "global solidarity" scenario for all low- and middle-income countries, 2016–2025



Source: Shekar et al. (2016).

Note: Dollar amounts represent the additional investments over baseline required from different stakeholders to achieve the 2025 global nutrition targets for stunting, severe acute malnutrition, anemia, and exclusive breastfeeding in the "global solidarity" scenario for the full scale-up in all low- and middle-income countries.

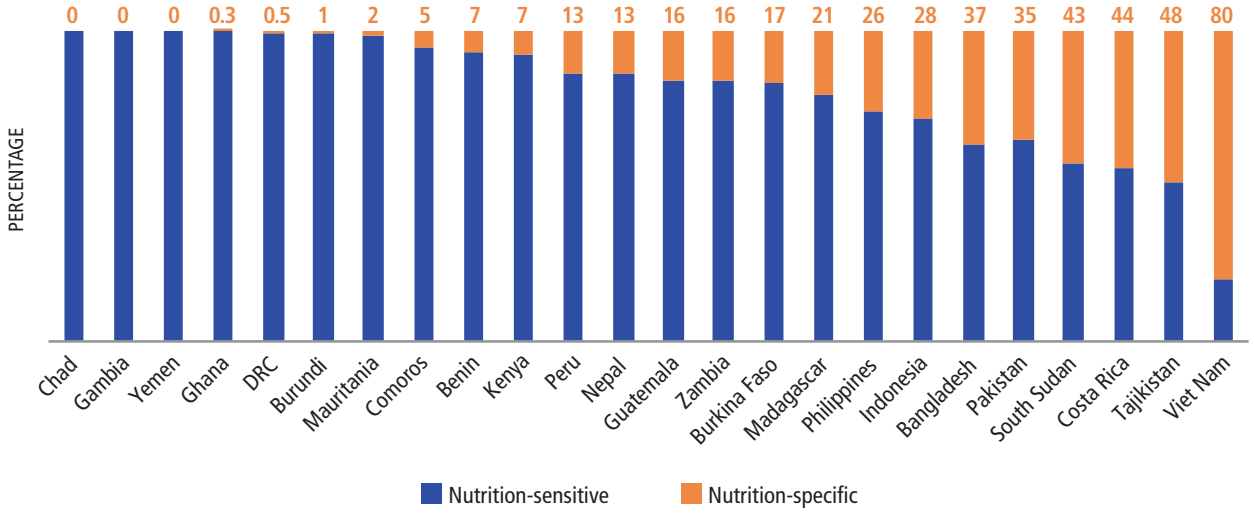
FIGURE 7.3 Budget allocations to nutrition-specific and nutrition-sensitive interventions, 24 countries



Source: Authors, based on data in Greener et al. (2016).

Note: DRC = Democratic Republic of the Congo.

FIGURE 7.4 Nutrition-specific and nutrition-sensitive budget allocations, 24 countries



Source: Authors, based on data in Greener et al. (2016).

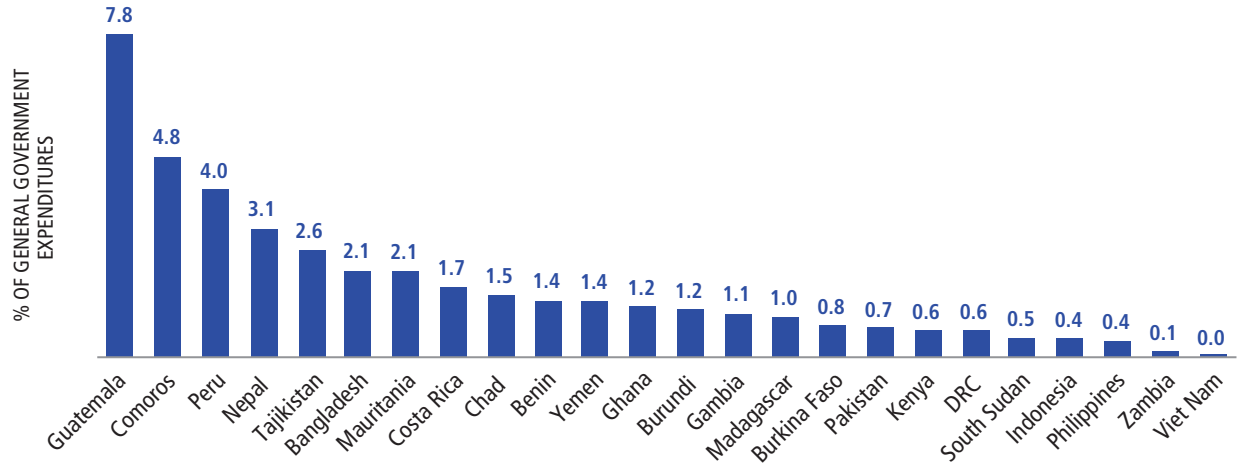
Note: DRC = Democratic Republic of the Congo.

Figure 7.4 breaks the estimated nutrition allocations down into nutrition-specific[8] and nutrition-sensitive shares. Most of the domestic budget allocations to nutrition identified by the countries relate to nutrition-sensitive interventions (1.7 percent of general government expenditures for sensitive and 0.4 percent for specific). The dominance of the nutrition-sensitive category reinforces the importance of underlying drivers as highlighted in the previous chapter.

Figure 7.5 shows the estimated domestic budget allocation of each of the 24 countries to nutrition-sensitive interventions as a percentage of general government expenditures. This measure ranges from 0.01 to 7.78 percent. The mean nutrition-sensitive allocation as a percentage of general government expenditures across the 24 countries is 1.7 percent.

That is a small percentage relative to the shares of the sectors from which most of these line items are drawn.[9] For example, in 2011 the Bangladesh government spent 37

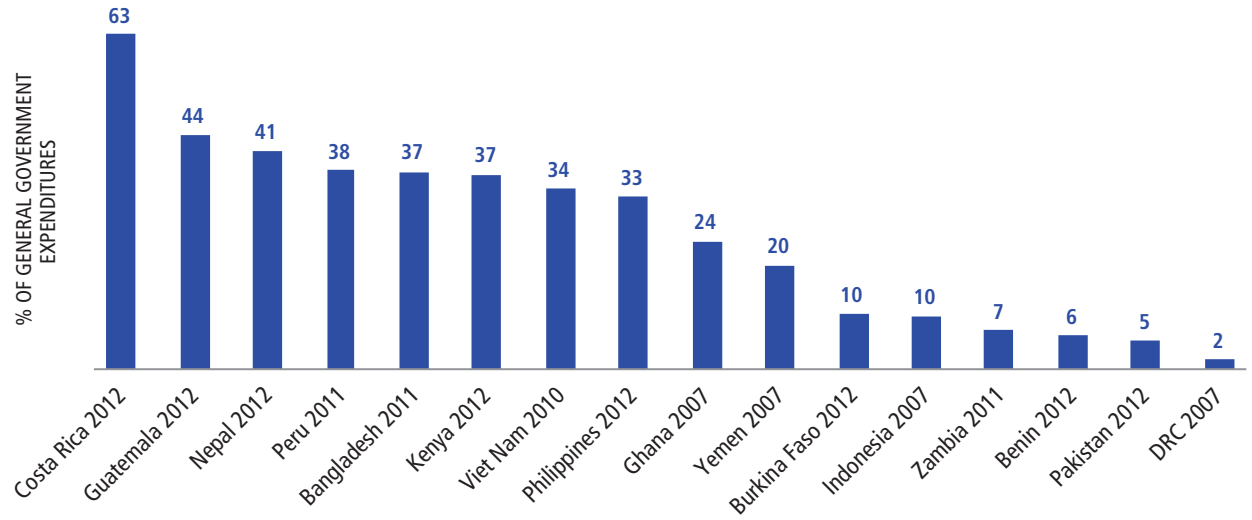
FIGURE 7.5 Estimated budget allocations to nutrition-sensitive interventions, 24 countries



Source: Authors, based on data in Greener et al. (2016).

Note: DRC = Democratic Republic of the Congo.

FIGURE 7.6 Budget allocations to nutrition-relevant sectors, 16 countries



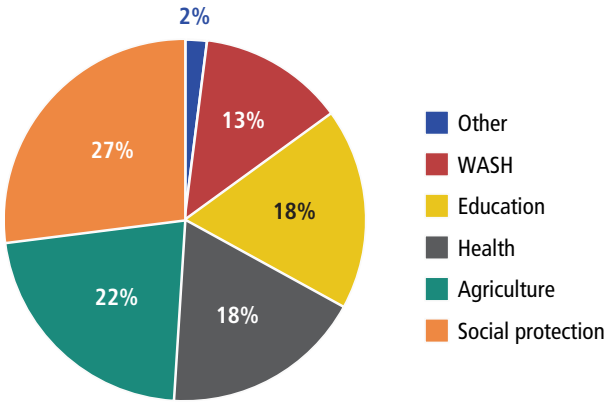
Source: Authors, based on SPEED database (IFPRI 2015b).

Notes: Sectors are agriculture, education, health, and social protection. Data for water, sanitation, and hygiene are not available. DRC = Democratic Republic of the Congo.

percent of its general budget expenditures on agriculture, health, education, and social protection (Figure 7.6). On the other hand, it allocated 2.1 percent of its total budget to nutrition-sensitive interventions (Figure 7.5).

Figure 7.7 shows the nutrition-sensitive breakdown by sector across the 24 countries. The social protection sector accounts for the highest share of nutrition-sensitive allocations, followed by agriculture, health, and education. The *Global Nutrition Report 2014* highlighted the large amounts of resources allocated by governments to social protection and pointed out the opportunity for using it to advance nutrition. The *Global Nutrition Report 2015* provided examples of how Bangladesh and Ethiopia were making their social protection financing work harder for nutrition. Chapter 6 of the *Global Nutrition Report 2016* has panels on WASH and education that provide new and clear guidance on how to embed nutrition more firmly in those sectors.

FIGURE 7.7 Share of nutrition-sensitive allocations from each sector, 24 countries



Source: Authors, based on data in Greener et al. (2016). Data are from the same 24 countries covered in Figures 7.3, 7.4, and 7.5.

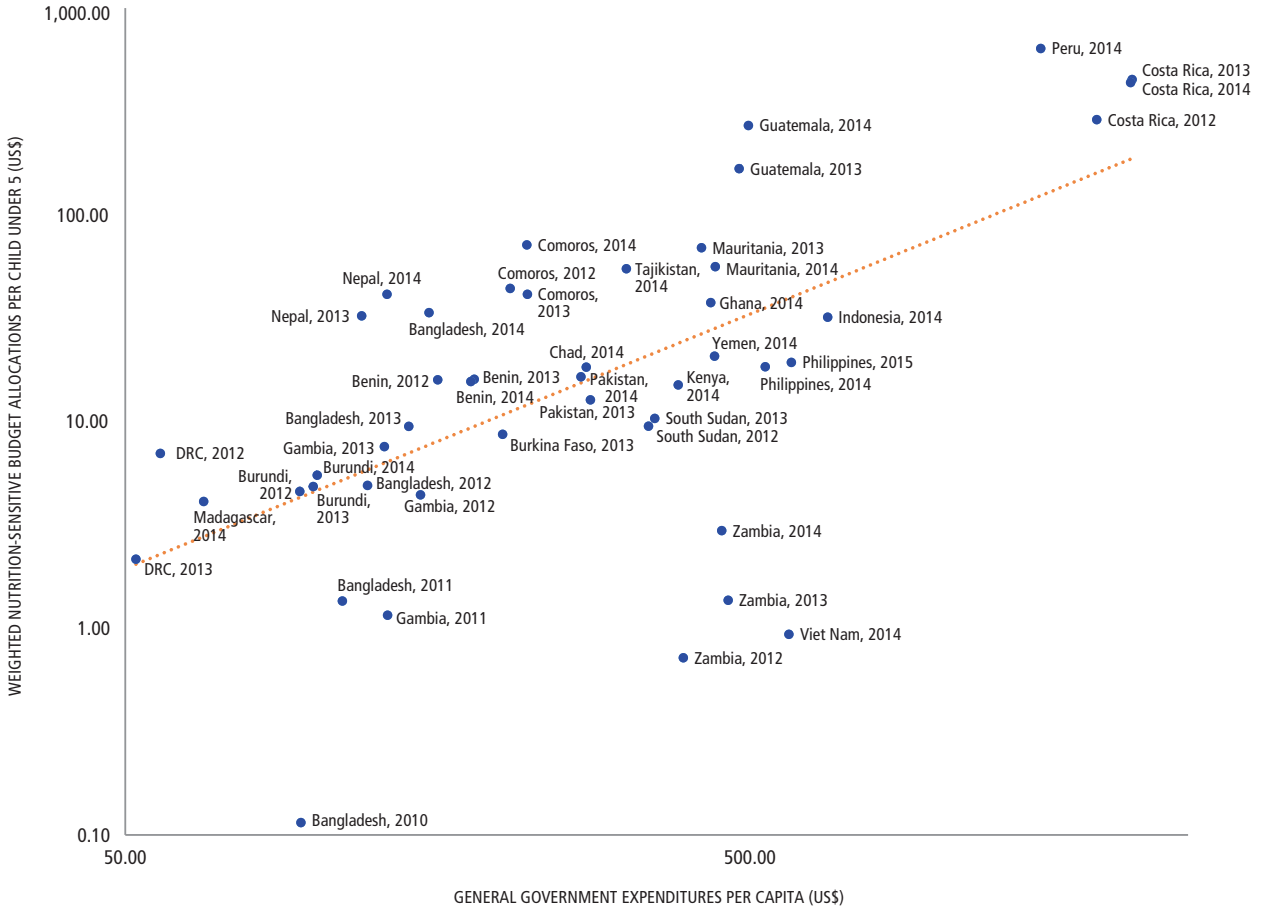
Note: WASH = water, sanitation, and hygiene.

NUTRITION-SENSITIVE ALLOCATIONS PER CHILD UNDER 5 ARE CORRELATED WITH OVERALL GOVERNMENT EXPENDITURES PER CAPITA — BUT THERE ARE SIGNIFICANT OFF-TREND EXAMPLES

Figure 7.8 shows that nutrition-sensitive budget allocations, normalized on a per-child-under-age-5 basis, are positively correlated with per capita general government expenditures. As the line of best fit shows, countries with larger overall government spending (typically countries with higher incomes) allocate more nutrition-sensitive resources per child under 5.

Countries above the line allocate more to nutrition-sensitive actions than we would expect based on their overall government expenditure. Countries below the line allocate less than we would expect. There are wide variations around this line, however. For example, Zambia and Guatemala allocated similar amounts of total government resources per person (the horizontal axis), but Guatemala allocated much higher levels of nutrition-sensitive funding per child under 5 (the vertical axis).[10]

FIGURE 7.8 Relationship between nutrition-sensitive weighted budget allocations per child under age 5 and general government expenditures per capita



Source: Greener et al. (2016).

Note: Countries appear more than once depending on how many years of budget data are available.

PANEL 7.1 GUATEMALA AND PERU: TIMELY ACCESS TO FINANCIAL DATA MAKES A DIFFERENCE IN ACTUAL SPENDING AND SPURS ACCOUNTABILITY AT ALL LEVELS

PAOLA VICTORIA, ARIELA LUNA, JOSÉ VELÁSQUEZ, ROMMY RÍOS, GERMÁN GONZÁLEZ, WILLIAM KNECHTEL, VAGN MIKKELSEN, AND PATRIZIA FRACASSI

Guatemala and Peru have put in place advanced integrated financial management information systems with public access to daily updated budget and other management data.

In Guatemala, expenditure tracking is consolidated in monthly reports prepared by the Secretariat of Food Security and Nutrition (SESAN), with data extracted from the Integrated Government Accounting System (SICOIN) managed by the Ministry of Public Finance. Guatemala has embarked on a results-based management program, and has developed a publicly accessible tracking system specifically to monitor the Zero Hunger Pact Plan[1] interventions. Its tracking system enables the monitoring of progress by institution, program, and municipality. It also allows other stakeholders to promote accountability. For example, a private-sector initiative—Mejoremos Guate ("We will improve Guatemala")—undertook a detailed monitoring exercise of service delivery to prevent chronic malnutrition. So far, four monitoring exercises have been undertaken, informing the ministry in charge of implementation results.

In Peru, expenditure tracking is through a publicly available electronic portal—Consulta Amigable—managed by the Ministry of Economy and Finance. The Ministry of Social Development and Inclusion consolidates data for the social programs. The Ministry of Economy and Finance prepares a monthly report on financial execution for all budget programs. A red alert is issued for executing entities/products with a low execution rate. Recently, an attempt to improve financial tracking vis-à-vis progress in service delivery was carried out. Ministries worked with regional and local governments as well as civil society to generate data on service delivery (for example, growth control, vaccination scheme, micronutrient supplementation, human resource capacity, and so forth), which were then related to financial execution to understand if this was a key bottleneck to scale up.[2]

The regular tracking in both countries reveals that Guatemala's actual expenditures are lower than planned allocations, while Peru's actual expenditures are higher than planned allocations. The significantly higher spending in Peru is because releases take place every month based on results. For this reason, Peru's actual spending is 26 percent higher than initial allocations that are planned on an annual basis, but 12 percent lower than modified allocations that occur once or twice per year when required.

Transparent and regular access to data allows for results-based releases of resources and the timely correction of low implementation rates as well as increased accountability of ministries to local governments, civil society organizations, and the families for whom these investments are meant.

We include this analysis here because it is possible that this association may form the basis for a benchmark on nutrition-sensitive budget allocations. For example, the line of best fit might be interpreted in a larger data set as the average level of nutrition-sensitive allocation for a country of a particular income level. Total nutrition allocations could also be benchmarked in this way. More work needs to be done to develop these benchmarks.

THE PROCESS OF COLLECTING NUTRITION BUDGET ALLOCATION DATA HELPS COUNTRY CHAMPIONS INFLUENCE CHANGE

In general, as reported by Scaling Up Nutrition (SUN) government focal points, the process of tracking budgets increases dialogue between ministries, departments, and agencies within governments about the need to invest in nutrition (Scaling Up Nutrition 2015). Peru and Guatemala are two of the better-known examples of countries with budget-driven planning processes. Panel 7.1 elaborates on how those countries use nutrition budgets to ensure effective implementation.

Perhaps less well known are the experiences from South Asia, and therefore we provide examples from Pakistan and Bangladesh as well as a very recent example from India.

The Pakistan government's analysis of budget data brought up two main findings. First, the Benazir Income Support Program accounts for almost 50 percent of the analyzed budget (with $985 million allocated per year). This is an unconditional cash transfer to poor households. The Pakistan government is engaging partners to improve

PANEL 7.2 BUDGETING FOR NUTRITION IN INDIA

SUMAN CHAKRABARTI, PURNIMA MENON, AND SUBRAT DAS

Several points are worth noting from the Indian budget of 2015–2016 released in February 2016.

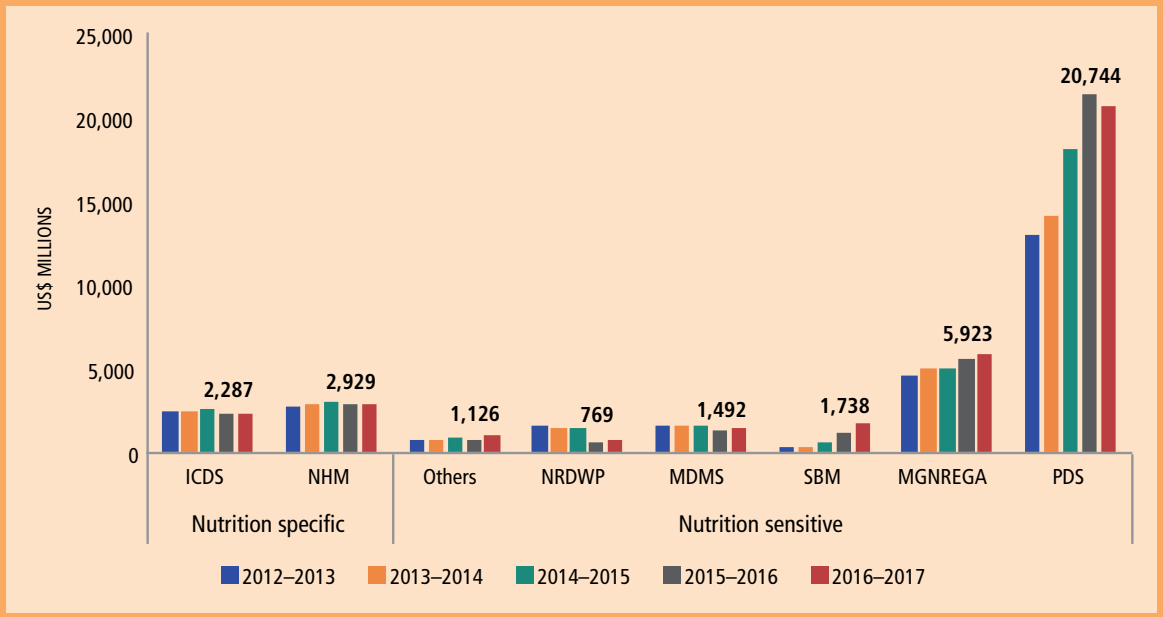
First, in 2016, the Indian government, at the central level, allocated approximately US$5.3 billion in total to nutrition-specific programs such as the Integrated Child Development Services Scheme and the National Health Mission. It allocated $31.6 billion in total to several programs aimed at improving the underlying determinants of nutrition, such as the Public Distribution System (PDS), which focuses on food security, the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), which focuses on livelihood security in rural areas, and the Swachh Bharat Mission, which is focused on sanitation.

Second, although a large amount of money is committed to nutrition-specific interventions, it falls $700 million short of the $6 billion per year Menon, McDonald, and Chakrabarti (2015) estimate is needed. The Indian government could meet this independently assessed target by increasing the budget 13 percent.

Third, programs such as the PDS (food subsidy) and MGNREGA (employment security) that target underlying determinants account for about 70 percent of India's expenditure on nutrition. Such allocations, and those available from the central government for the sanitation mission, can help create more supportive home environments for improved nutrition, if well implemented. For all these programs, the onus of strengthening centrally sponsored government schemes by reducing inefficiencies, improving targeting, and ensuring greater convergence of the schemes lies with the state governments.

Finally, due to changes in the country's fiscal architecture, there are now opportunities for states to increase their commitment to nutrition and allocate additional state financing. But there is a risk that states may not prioritize nutrition. Guidelines for prioritizing and allocating financing available from the central government could help strengthen nutrition-financing efforts at the state level as well.

BUDGET ALLOCATIONS TO NUTRITION-RELATED PROGRAMS IN INDIA, 2015–2016



Source: Authors, based on data in CBGA (2016a).

Notes: US$1 = INR 65. Figures for 2016–2017 are budget estimates. ICDS = Integrated Child Development Services Scheme; NHM = National Health Mission; NRDWP = National Rural Drinking Water Programme; MDM = Mid-day Meal Scheme; SBM = Swachh Bharat Mission; MGNREGA = Mahatma Gandhi National Rural Employment Guarantee Act, PDS = Public Distribution System (food subsidy). "Others" includes National Creche Scheme for Children of Working Mothers, Indira Gandhi Matritva Sahayog Yojana, Scheme for Empowerment of Adolescent Girls, National Mission for Oilseeds and Oil Palm, National Mission for Sustainable Agriculture, National Food Security Mission, and National Rural Livelihood Mission.

PANEL 7.3 GLOBAL PARTNERS HARMONIZE TECHNICAL SUPPORT ON BUDGET ANALYSIS

ALEXIS D'AGOSTINO, AMANDA POMEROY-STEVENS, CLARA PICANYOL, MARY D'ALIMONTE, PATRIZIA FRACASSI, SASHA LAMSTEIN, HILARY ROGERS, AND SHAN SOE-LIN

The 2014 *Global Nutrition Report* emphasized the need for sufficient financial resources for nutrition and pointed out the requisite by countries to be able to track their domestic nutrition spending. A year later, 30 countries were able to report preliminary estimates of national budget shares for nutrition in the 2015 *Global Nutrition Report*.

Out of the 30 countries, 16 carried out the data gathering themselves, 10 were supported by the *Global Nutrition Report* secretariat, two got support from the Results for Development Institute (R4D), and two were supported by the USAID-funded SPRING project. The work culminated in April 2015 with four regional budget analysis workshops supported by UNICEF on behalf of the United Nations Network for the Scaling Up Nutrition (SUN) Movement.

At those workshops, the countries requested that technical support be accelerated in a number of areas, including these:

1. Provide guidance to standardize the categorization of "nutrition-specific" and "nutrition-sensitive" interventions.
2. Develop recommendations on how to identify allocations for personnel and how to deal with subnational government finances.
3. Develop options to harmonize the "weighting" of the interventions, especially the nutrition-sensitive ones.
4. Provide recommendations on the next steps—in particular,
   a. how to use the results of the Budget Analysis Exercise for advocacy and communication;
   b. how to track actual expenditures;
   c. how to track off-budget allocations and expenditures; and
   d. how to link the financial tracking with planning and resource mobilization.

A group of global technical experts convened by the SUN Movement Secretariat and including SPRING and R4D is working to provide further guidance to researchers, donors, and government agencies responsible for analyzing nutrition financing (allocations and/or expenditures). This joint effort should move the topic of nutrition financing forward by answering key questions identified with estimating and tracking nutrition budget and expenditures.

the design of the program so that it can respond to the nutritional needs of women and children. Second, the analysis revealed a significant variation among the provinces in the ratio between nutrition-specific and nutrition-sensitive allocations, as well as the relative contributions made by each sector. This shows that even within a country, different regions make different decisions on resource allocations to improve nutrition outcomes, and there is potential for peer learning between subnational governments.

The government of Bangladesh uses a financial database that is based on the 2012 Country Investment Plan. An analysis of the actual versus planned spending in 2014 revealed that, on average, 81 percent of allocations directed toward nutrition-specific interventions were actually spent compared with 48 percent of allocations directed toward nutrition-sensitive actions. The agriculture sector receives the highest share of domestic funding. The government is updating the national plan of action, which is expected to influence the sectoral budgetary allocations to nutrition and, especially, the actual spending in the coming years.

The Indian government released its 2015–2016 budget in February 2016. Despite the lack of mention of any explicit commitments to nutrition in the budget speech by the finance minister, an analysis of the budget (Panel 7.2) through a nutrition lens by the Centre for Budget and Governance Accountability in India reveals several insights about how the government of India is investing in areas that could support nutrition. The panel shows that the budget allocation to nutrition is not increasing, is short of what is needed, and is dominated by interventions at the underlying level (such as the Public Distribution System), which have to be well designed, with an intent to improve nutrition, if they are to be effective.

An important overall conclusion from observing the process of estimating country nutrition budget allocations is that the process opens debate on how some programs might be improved to have a larger impact on nutrition out-

comes. Once the initial setup is completed and the process annualizes, it can become an inspiration for other countries, including high-income countries, many of which cannot report nutrition budgets.

Finally, it should be noted that the process of estimating funding gaps, such as in the foregoing discussion, requires solid estimates of current government spending. Domestic budget analysis has come a long way since 2014, but it still has a ways to go before methods are harmonized. Panel 7.3 describes the process of harmonization currently under way.

As more nutrition spending data become available, studies will be needed to analyze the impacts of budget/funding allocations on levels/changes in program coverage and nutrition status. While there is plenty of evidence on the costs and nutrition-outcome impacts of raising nutrition-specific coverage rates (for example, Bhutta et al. 2013; IFPRI 2014), we know of no studies that link actual nutrition spending with rates of nutrition progress.

DONOR SPENDING

This section analyzes official donor spending on actions to reduce undernutrition (nutrition specific and sensitive) and nutrition-related NCDs.[11]

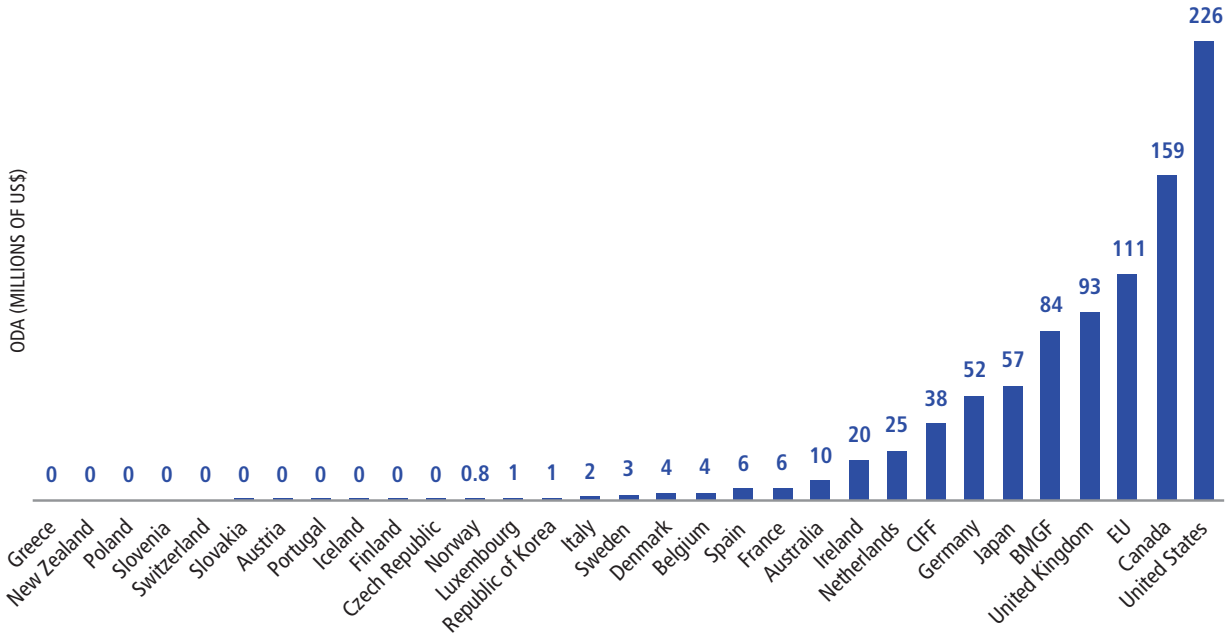
UNDERNUTRITION ACTIONS

Nutrition-specific spending

Using the latest donor data from the Creditor Reporting System (CRS),[12] Figure 7.9 shows the official development assistance (ODA) spending levels in 2014 for the 28 OECD bilateral agencies, the European Union, and two foundations—the Bill & Melinda Gates Foundation (BMGF) and the Children's Investment Fund Foundation (CIFF). The 31 donors spent a total of $900 million on nutrition-specific interventions (for example, breastfeeding promotion, infant and young child feeding, and vitamin A supplementation). The top five donors (United States, Canada, European Union, United Kingdom, and BMGF) provided most financing (75 percent of the total). Only 11 of the 31 donors allocated more than $10 million. As in 2013, 13 donors spent less than $1 million on nutrition-specific interventions. An additional $10 million from each of the 20 donors who currently spend less than $10 million on nutrition-specific interventions would add $200 million per year to nutrition-specific disbursements, an increase of 22 percent on the total.

Trends show that ODA disbursements to nutrition-specific interventions have plateaued. Between 2013 and

FIGURE 7.9 Nutrition-specific spending by donors, 2014



Source: Authors, based on reported disbursements under CRS code 12440.

Note: Dollar amounts are in current prices and rounded to the nearest whole number. ODA = official development assistance; CIFF = Children's Investment Fund Foundation; BMGF = Bill & Melinda Gates Foundation.

2014, total global ODA spending (minus BMGF and CIFF) on nutrition-specific interventions decreased by 1 percent: down $12 million—from $949 million in 2013 to $937 million in 2014. This fall in spending breaks a pattern of annual increases initiated in 2011 (Figure 7.10). Despite the slight decrease, global nutrition-specific ODA spending as a proportion of total ODA spending remains steady at 0.57 percent—representing an all-time high.

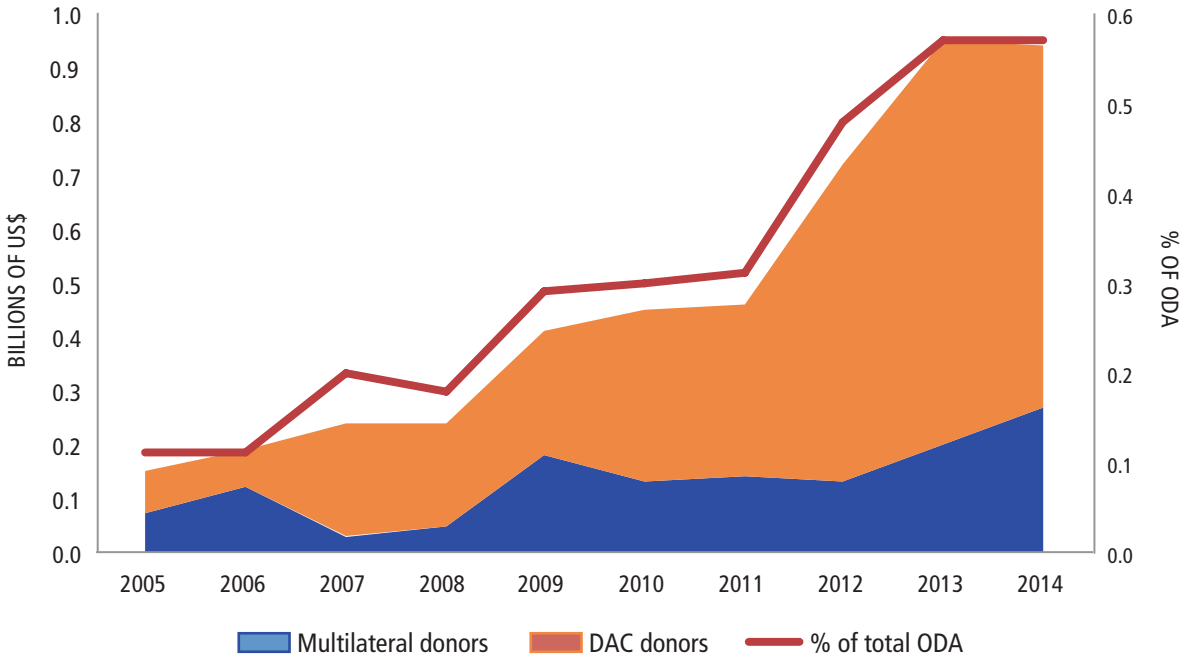
Ten of the 28 OECD country donors reported decreased spending in 2014 ($77 million in total). This includes four of the top five[13] OECD donors: the United States, Canada, the United Kingdom, and Japan (Figure 7.11). Multilateral donors' cumulative spending did, however, increase significantly, by $63 million. While six multilateral donors decreased their spending, several major multilaterals increased theirs by significant amounts. The overall increase was a result of greater spending from the European Union ($69 million) and the World Bank (International Development Association, $29 million). For the first time since 2009, some spending was reported by non–Development Assistance Committee (DAC) donors. Kuwait and the UAE reported spending of $0.9 million and $0.8 million, respectively.

Data for 2014 show that nutrition-specific spending from all donors was directed to at least 116 different countries. Spending is, however, largely concentrated in 12 selected countries. They are, in order of highest to lowest, Ethiopia, Yemen, Mali, Mozambique, Bangladesh, Rwanda, Malawi, Niger, India, Senegal, Kenya, and Tanzania. They received more than half (51 percent) of all disbursements in 2014.[14] Ethiopia received 8 percent of country-allocable disbursements, the most of any country.

Nutrition-sensitive spending

Based on data the donors reported to the *Global Nutrition Report*, it appears that nutrition-sensitive spending (disbursements) has increased substantially in the aftermath of the 2013 Nutrition for Growth Summit. But it is difficult to tell. Table 7.1 presents the data and caveats. The missing full time series for four of the largest donors (the United States, the World Bank, the European Union, and Canada) makes the construction of meaningful overall time series impossible. Nevertheless, looking across the rows of Table 7.1, one sees upward trends between 2010 and 2014 for nearly all donors in the nutrition-sensitive category, which is encouraging. And as Chapter 6 has suggested, the scope to increase this source of funding for nutrition remains significant.

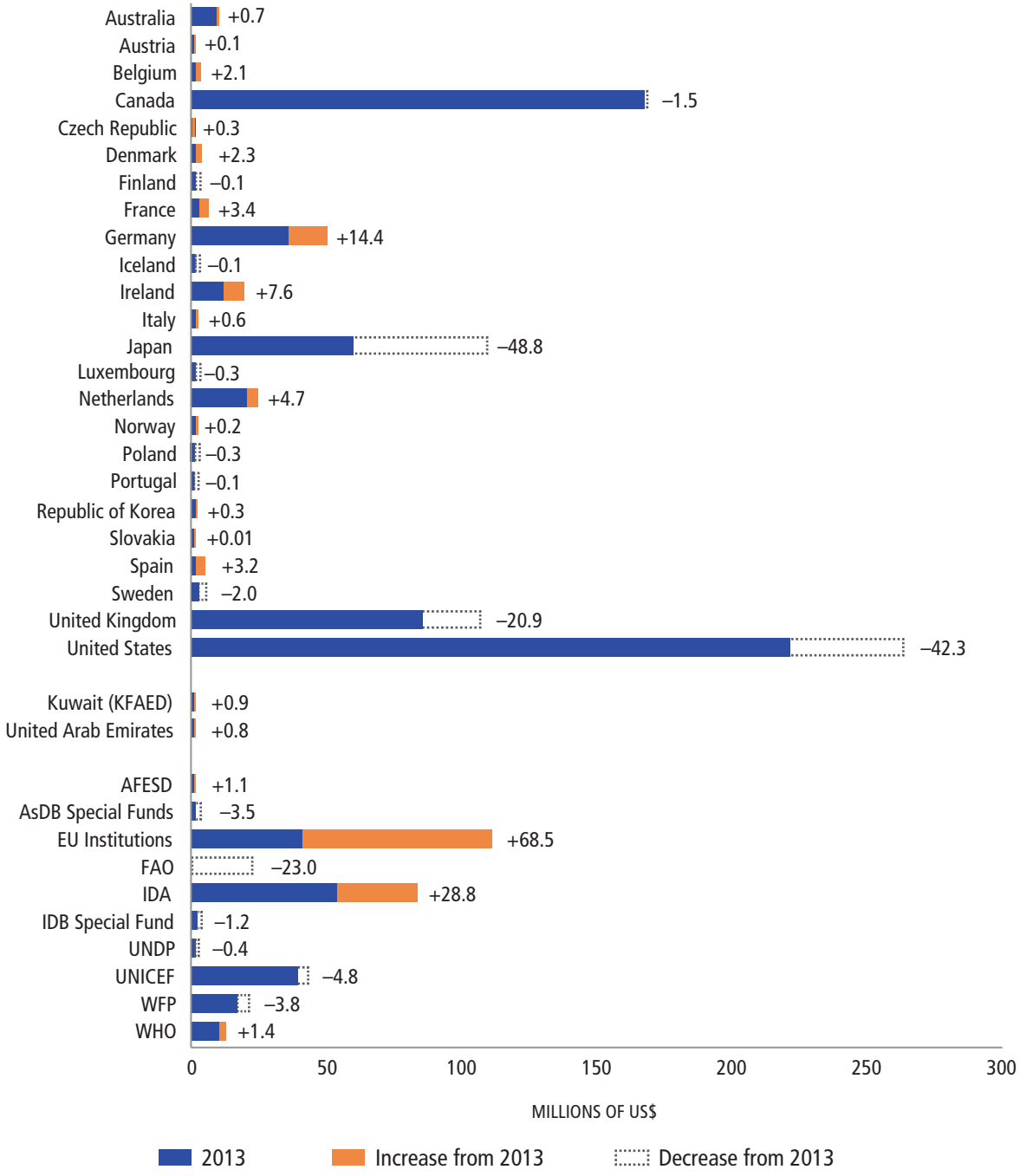
FIGURE 7.10 Donor ODA spending on nutrition-specific interventions, 2005–2014



Source: Development Initiatives, based on OECD (2016a).

Note: Amounts are gross disbursements in constant 2013 prices. DAC = Development Assistance Committee; ODA = official development assistance.

FIGURE 7.11 Changes in nutrition-specific spending by country donors and multilateral donors, 2013–2014



Source: Development Initiatives, based on OECD (2016a).

Note: Amounts are based on gross disbursements in constant 2013 prices. KFAED = Kuwait Fund for Arab Economic Development; AFESD = Arab Fund for Economic and Social Development; AsDB = Asian Development Bank; FAO = Food and Agriculture Organization of the United Nations; IDA = International Development Association; IDB = Inter-American Development Bank; UNDP = United Nations Development Programme; WFP = World Food Programme; WHO = World Health Organization.

TABLE 7.1 Nutrition disbursements reported to the 2014–2016 *Global Nutrition Reports*, 13 donors (thousands of US$)

Donor	Nutrition-specific 2010 disbursements	Nutrition-specific 2012 disbursements	Nutrition-specific 2013 disbursements	Nutrition-specific 2014 disbursements
Australia	6,672	16,516	NR	20,857
Canada[a]	98,846	205,463	169,350	159,300
EU[b]	50,889	8	54,352	44,680
France	2,895	3,852	2,606	6,005
Germany	2,987	2,719	35,666	50,572
Ireland	7,691	7,565	10,776	19,154
Netherlands	2,661	4,007	20,216	25,025
Switzerland	0	0	0	0
United Kingdom	39,860	63,127	105,000	87,000
United States[c]	8,820	229,353	311,106	263,240
BMGF	50,060	80,610	83,534	61,700
CIFF	980	5,481	37,482	26,750
World Bank[d]	61,160	21,873	NR	NR
Total of 13 donors	333,521	640,574	NA	NA
Donor	**Nutrition-sensitive 2010 disbursements**	**Nutrition-sensitive 2012 disbursements**	**Nutrition-sensitive 2013 disbursements**	**Nutrition-sensitive 2014 disbursements**
Australia	49,903	114,553	NR	87,598
Canada[a]	80,179	90,171	NR	998,304
EU[b]	392,563	309,209	315,419	570,890
France	23,003	27,141	33,599	NR
Germany	18,856	29,139	20,642	51,547
Ireland	34,806	45,412	48,326	56,154
Netherlands	2,484	20,160	21,616	18,274
Switzerland	21,099	28,800	29,160	26,501
United Kingdom	302,215	412,737	734,700	780,500
United States[c]	NR	1,857,716	2,206,759	2,619,923
BMGF	12,320	34,860	43,500	29,200
CIFF	0	0	854	154
World BankB[d]	NR	NR	NR	NR
Total of 13 donors	NA	NA	NA	NA
Donor	**Total 2010 disbursements**	**Total 2012 disbursements**	**Total 2013 disbursements**	**Total 2014 disbursements**
Australia	56,575	131,069	NR	108,455
Canada[a]	179,025	295,634	NA	1,157,604
EU[b]	443,452	309,217	369,771	615,570
France	25,898	30,993	36,205	NA
Germany	21,843	31,858	56,308	102,119
Ireland	42,497	52,977	59,102	75,308
Netherlands	5,145	24,167	41,832	43,299
Switzerland	21,099	28,800	29,160	26,501
United Kingdom	342,075	475,864	839,700	867,500
United States[c]	NR	2,087,069	2,517,865	2,883,163
BMGF	62,380	115,470	127,034	90,900
CIFF	980	5,481	38,336	26,904
World Bank[d]	61,160	21,873	680,000	1,627,000
Total of 13 donors	NA	3,610,472	NA	NA

Source: Authors, based on data provided by the donors.

Notes: NR = no response to our request for the data. NA = not applicable (meaningful totals cannot be calculated owing to missing data or data produced using a methodology other than the Scaling Up Nutrition Donor Network Methodology). Data are not in constant prices. Finally, most donors report in US dollars, and where they do not, we use an annual average market exchange rate from the period reported on (https://www.irs.gov/Individuals/International-Taxpayers/Yearly-Average-Currency-Exchange-Rates). BMGF = Bill & Melinda Gates Foundation. CIFF = Children's Investment Fund Foundation.

[a] The Canadian government's nutrition-sensitive component for 2014 is calculated in a different way from that of other countries. The method used is available by inquiring here: https://www.international.gc.ca/department-ministere/form_contact-formulaire_contacter.aspx?lang=eng.

[b] At the Nutrition for Growth Summit, the EU committed 3.5 billion euros for nutrition interventions between 2014 and 2020. A commitment corresponds to a legally binding financial agreement between the European Union and a partner. The disbursement figures reported by the European Union are the total amounts contracted in respect of commitments. Further disbursements of funds are made according to a schedule of disbursements outlined in individual contracts, progress in implementation, and rate of use of the funds by the partner.

[c] The US government's nutrition-sensitive component is calculated in a different way from that of other countries (see Panel 7.4).

[d] The World Bank reports that its 2013 total disbursement number covers two fiscal years (2013 and 2014) and its 2014 total disbursement number also covers two fiscal years (2014 and 2015); thus it is not appropriate to add $680 million and $1,627 million because doing so would result in double counting.

PANEL 7.4 DONORS' METHODS FOR ESTIMATING NUTRITION-SENSITIVE SPENDING MATTERS

LAWRENCE HADDAD AND JORDAN BEECHER

As in 2015, this *Global Nutrition Report* reports nutrition-sensitive spending from donors using the Scaling Up Nutrition (SUN) Donor Network methodology, with the exception of the United States, which reports nutrition-sensitive spending using a less resource-intensive method.[1] What difference does methodology make? To answer this question, we applied the US methodology to the other N4G donors and then compared the levels of nutrition-sensitive spending generated by both methods and the donor rankings that each set of estimates generates. The results are presented in the table below.

The US government methodology inflates the nutrition-sensitive disbursement estimates for all donors. The inflation is substantial for some donors—the allocations of Germany and the Netherlands are inflated by a factor of 10. The rankings are also significantly altered. While the top two nutrition-sensitive donors in the table remain the same (United Kingdom and Australia), the five countries below change positions significantly.

Methodology matters. Given that the SUN methodology is more refined than the US methodology, we recommend that all countries use the SUN methodology for reporting on nutrition-sensitive disbursements.

WHAT DIFFERENCE DOES METHODOLOGY MAKE TO NUTRITION-SENSITIVE DISBURSEMENTS?

Country	Rank	Nutrition-sensitive disbursements, 2013 (US$ millions) SUN DONOR NETWORK METHOD		Country	Rank	Nutrition-sensitive disbursements, 2013 (US$ millions) US GOVERNMENT METHOD
United Kingdom	1	734.7		United Kingdom	1	949.0
Australia	2	74.7		Australia	2	224.4
Ireland	3	48.3		Germany	3	210.6
France	4	33.6		Netherlands	4	204.9
Switzerland	5	29.2		Switzerland	5	181.1
Netherlands	6	21.6		France	6	78.6
Germany	7	20.6		Ireland	7	37.2

Source: Analysis undertaken by Jordan Beecher at Development Initiatives.

Note: Table includes countries that reported nutrition-sensitive spending using the SUN donor methodology in the *Global Nutrition Report 2015*. The United States cannot be included in the comparison as it did not report nutrition-sensitive spending using the SUN donor methodology in the 2015 *Global Nutrition Report*.

In addition to the patchy reporting from some donors, the donors need to solve a methodological issue pertaining to the estimation of nutrition-sensitive spending (Panel 7.4).

NUTRITION-RELATED NCD ACTIONS

Chapter 2 reminded us that estimated rates of adult overweight, obesity, and high blood sugar are increasing in nearly every country. The economic costs of these nutrition-related NCDs are high: obesity treatment alone consumes 2 to 20 percent of health care expenses (IFPRI 2015a). Despite significant adverse economic impacts, there is little published information about the financing directed to prevent and control nutrition-related NCDs.

Here we draw on new information from the World Health Organization (WHO), the Institute for Health Metrics and Evaluation (IHME), and the OECD/DAC database to present the best available data. We first provide information about sources of funding for all NCDs for selected low-income countries, followed by the most recent information about donor funding for NCDs. We then offer a new analysis of nutrition-related funding within this category.

Country sources of funding for NCDs

There are three main payers for health services: households themselves paying out of pocket (directly or through private insurance); governments paying directly (general

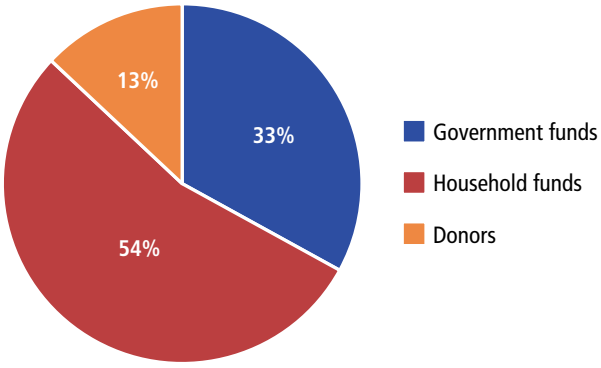
government revenues via taxation on unhealthy products); or through public insurance schemes, the private sector, and donors. The mix of payment sources varies substantially by disease or health issue, and by country income.

Because there is limited government funding, and unlike many other areas of health, much of the burden of NCDs is borne by households themselves through out-of-pocket expenditures. For example, a recent systematic review of the global impact of NCDs on household income (Jaspers et al. 2015) found that cardiovascular disease (CVD) patients in India spent 30 percent of their annual family income on direct CVD health care, where the mean out-of-pocket cost per hospitalization increased from $364 in 1995 to $575 in 2004. The authors also found that in India the risk of impoverishment due to CVD was 37 percent greater than for communicable diseases. The same review reports that "14.3% of high-income families in China experienced some form of household income loss due to cardiovascular disease (CVD) hospitalization, rising to 26.3% in India, to 63.5% in Tanzania, and to 67.5% in Argentina" (Jaspers et al. 2015, 170).

Recent WHO data from a sample of low-income countries show that more than half of current spending for the treatment of CVD is out of pocket from patients and their households, 33 percent is from domestic governments (but only drawing on ministries of health accounts), and 13 percent is from donors (Figure 7.12).

In higher-income countries, out-of-pocket spending on NCDs is less common (WHO 2014c). Government financing for NCDs also varies substantially across countries. In high- and middle-income countries, government financing of NCD prevention and control often exceeds financing for other health needs, since NCDs are the main health burden. But governments in low- and lower-middle-income countries have, to date, allocated very little to NCD prevention and control, including for nutrition-related needs (WHO 2015b). While half of all countries now have costed NCD plans (see WHO 2012a, fig. 4), few countries actually track government expenditures across the entire budget. To better understand the totality of government spending on NCDs and the nutrition-related component, it will be essential to undertake NCD public expenditure reviews. This will promote the efficiency, effectiveness, and accountability of such spending.

FIGURE 7.12 Sources of expenditures on cardiovascular diseases, average of eight low-income countries



Source: Authors, based on country health accounts reports posted on the World Health Organization's Global Health Expenditure Database (WHO 2016w).

Notes: The countries included are Benin, Burkina Faso, Burundi, Cambodia, Democratic Republic of the Congo, Niger, Togo, and United Republic of Tanzania. Three types of health expenditures are added to derive the national health account figures. These are earmarked expenditures (for example, TB control program spending, drugs, and specific commodities); shared expenditures (such as salaries) distributed among diseases using utilization information; and proportionately distribution of nondirectly allocatable expenditures such as central administration of health (for example, minister of health salary). This creates a standard way to allocate shared expenditures for all diseases, ensures internally consistent estimates, and minimizes multiple parallel data collection initiatives at the country level that are labor intensive.

Donor funding for all NCDs

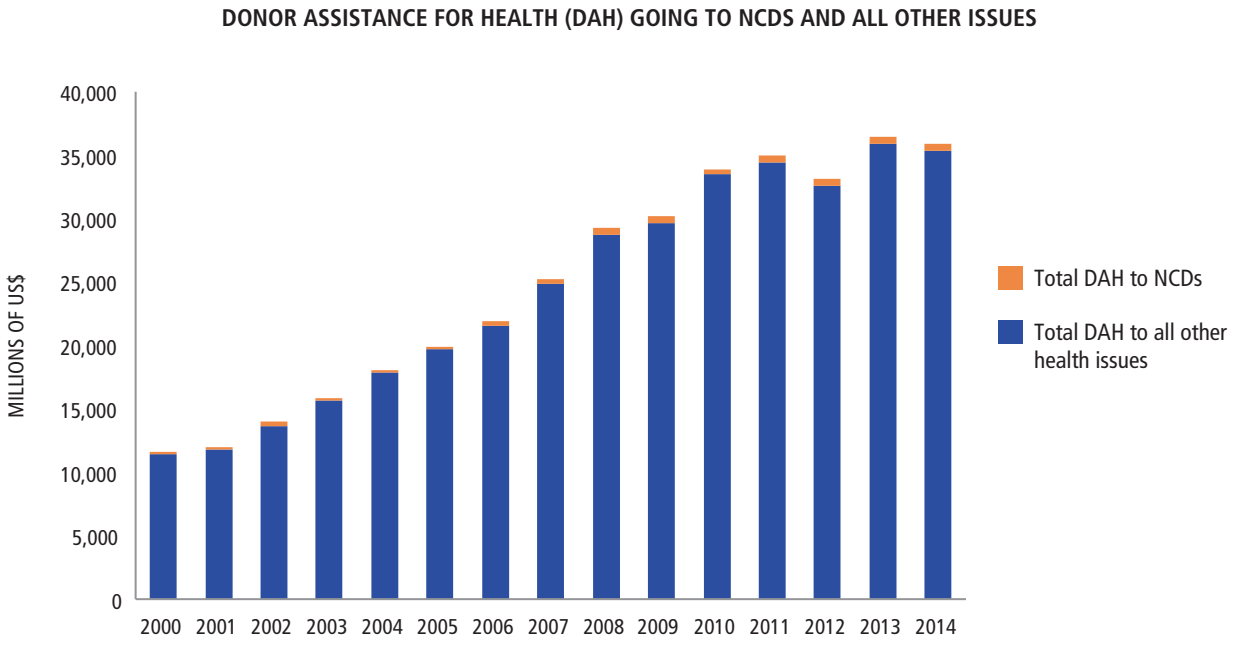
Donor funding can be an important catalyst for national NCD funding, but it should not substitute for a national response. As we will see in this section, donor funding for NCDs is low. Dain (2015, 924) notes that "NCDs—namely cancer, cardiovascular disease, chronic respiratory diseases, and diabetes—cause 49.8% of death and disability in low-income and middle-income countries." In fact, a recent analysis concluded that nongovernmental organizations collectively provided more aid for NCDs than bilateral donors, and almost as much as multilateral organizations (Nugent and Feigl 2010).

Figure 7.13 provides the most recent estimates of development assistance for all health issues and for NCDs specifically. Development assistance going to all health issues other than NCDs has increased significantly since 2000, whereas the small percentage of health-related development assistance to NCDs has increased only slowly, reaching 1.7 percent in 2014, or $611 million (Dieleman et al. 2014). It is important to note that nutrition-related conditions are just one component of NCDs.

Donor funding for nutrition-related NCDs

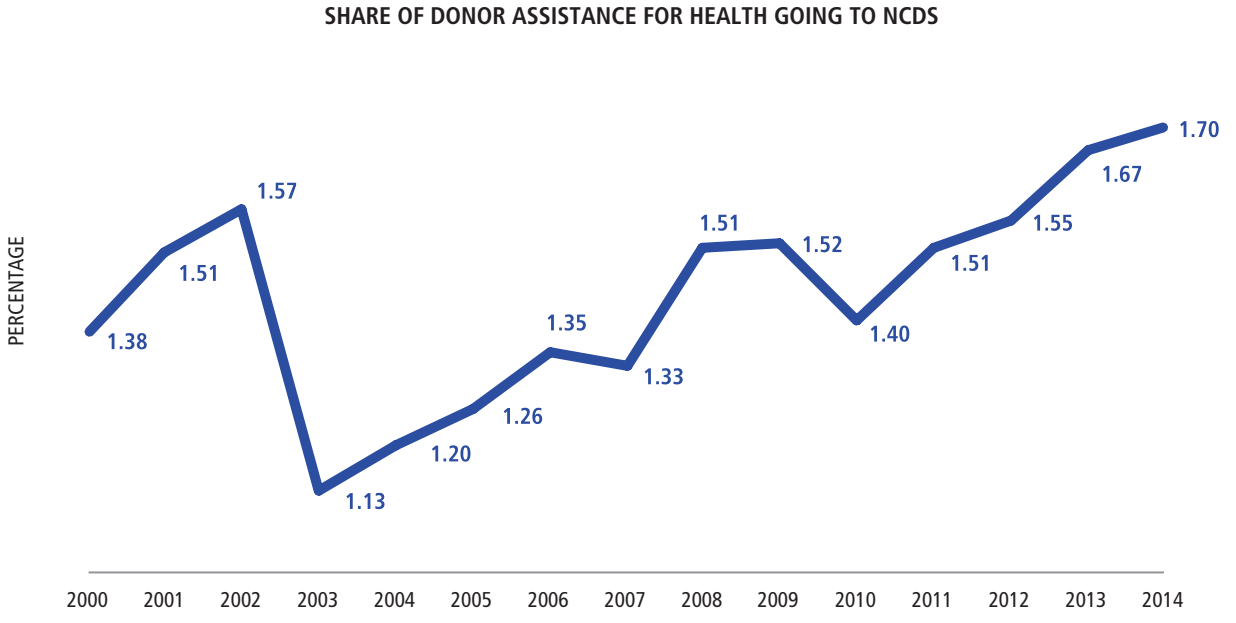
As we noted, IHME estimates that donors allocated $611 million (or 1.7 percent of all development health

FIGURE 7.13 Donor assistance for all health issues and for NCDs, 2000–2014



Source: Authors, based on data from IHME data described in Dieleman et al. (2014).

Note: The "other health issues" make up seven focus areas: HIV/AIDS; malaria; tuberculosis; health-sector support; maternal, newborn, and child health; tobacco use prevention and control; and other.



Source: Authors, based on data from IHME data described in Dieleman et al. (2014).

assistance) to NCDs in 2014. However, not all of that was allocated to nutrition-related NCDs, and not all nutrition-related NCD allocations are found in the health sector.

Here we make a start on analyzing data on official development assistance (ODA) to nutrition-related NCDs. At present there is no Creditor Reporting System code to track ODA to NCDs.[15] While discussions are under way for an improved NCD tracking system through the CRS, it will still combine funding for all forms of NCDs rather than allocations just to the nutrition-related aspects of NCDs—unhealthy diet, obesity, and the disease outcomes themselves. The ability to track NCD-related donor expenditures is about efficiency and effectiveness, but it is also about accountability. To begin to address this gap, we performed a search of the entire CRS dataset to identify any activities relating to nutrition-related NCDs and to produce an estimate of nutrition-related NCD funding in the year 2014.[16]

Of the 441 records originally identified through the word searches, 153 were deemed relevant based on a review of the reported information. These 153 activities have associated total spending of $49.1 million (in ODA disbursements) and commitments equal to $44.7 million. This represents a tiny fraction of the total ODA disbursement of $135.2 billion in 2014 (OECD 2015) and 5 percent of OECD DAC spending on nutrition-specific interventions (Figure 7.9).

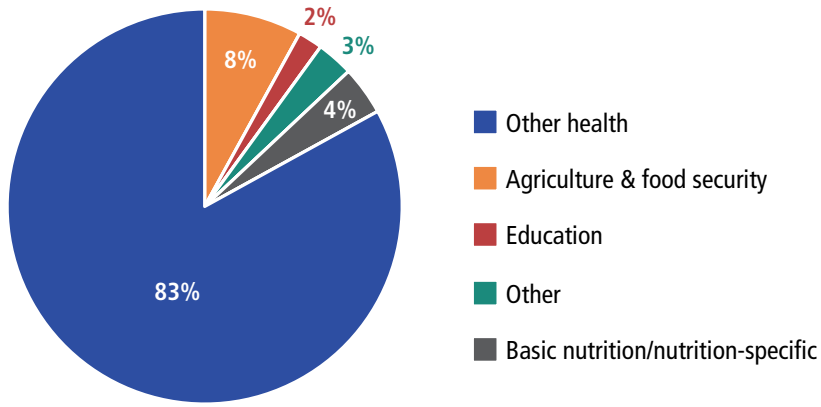
The top donors of these funds were the United States and Australia, disbursing $14.3 million and $13.5 million, respectively. These funds were disbursed to at least 55 different countries. The top recipients were Kenya and Fiji, receiving $14.8 million and $7.9 million, respectively. The majority of records (86 percent of disbursements) were reported under the health sector, $2.1 million of which was disbursed to projects under the "basic nutrition" purpose code, the proxy for nutrition-specific spending. Other NCD-related spending was identified among projects that related to agriculture and food security and education (Figure 7.14).

The mismatch between donor assistance going to health and the burden of disease is well known (Dieleman et al. 2014). Based on this comparison, donor funding directed toward NCDs is extremely underpowered, even for low-income countries. In the short term, nutrition champions need to find ways of embedding nutrition-related NCD programs within areas that are currently donor priorities. One example is the growing emphasis on the integration of NCDs with primary health care (Pettigrew et al. 2015).

CALLS TO ACTION

1. **Increase budgetary allocations to nutrition-specific programs.** In line with analyses reported in Chapter 7, governments and donors must triple their allocations to high-impact interventions that address stunting, wasting, anemia, and exclusive breastfeeding over the 2016–2025 period to meet global targets.

FIGURE 7.14 ODA spending on nutrition-related NCDs, by sector, 2014



Source: Development Initiatives, based on OECD (2016a).

Note: Amounts based on gross official development assistance disbursements in 2014.

2. **Increase budgetary allocations to obesity and nutrition-related noncommunicable diseases.** The funding of obesity and nutrition-related noncommunicable disease policy and interventions represents a small fraction of spending of government budgets and international aid. Governments should cost their national noncommunicable disease plans as they develop them, and funders should support these plans.
3. **Expand the share of sectoral budgets that aim to improve nutritional status.** Governments, civil society, and development agencies need to step up their efforts to make a larger percentage of budgets in agriculture, education, the food system, health systems, social protection, and WASH work more directly for all forms of nutrition. These budgets are large, yet a small fraction of them factor nutrition explicitly into their aims. An essential first step is to set a baseline and a SMART spending target in each sector. Countries that have led the way on nutrition budgeting could set the example again by reporting on such targets in the 2017 *Global Nutrition Report*.
4. **All actors must track their complete nutrition spending more consistently.** Donors, given their catalytic role and relatively strong capacity, need to report commitments to—and disbursements of—nutrition-specific financing. They should also report nutrition-sensitive commitments and disbursements—from the broader development and social sectors that affect nutrition—every year, using the same methodology, starting with the 2017 *Global Nutrition Report*.
5. **Make the Creditor Reporting System codes work better for nutrition accountability.** By the 2020 N4G Summit, the Organization for Economic Co-operation and Development's Development Assistance Committee's database should develop codes for aid spending on nutrition-sensitive undernutrition projects and on nutrition-related noncommunicable disease projects.