



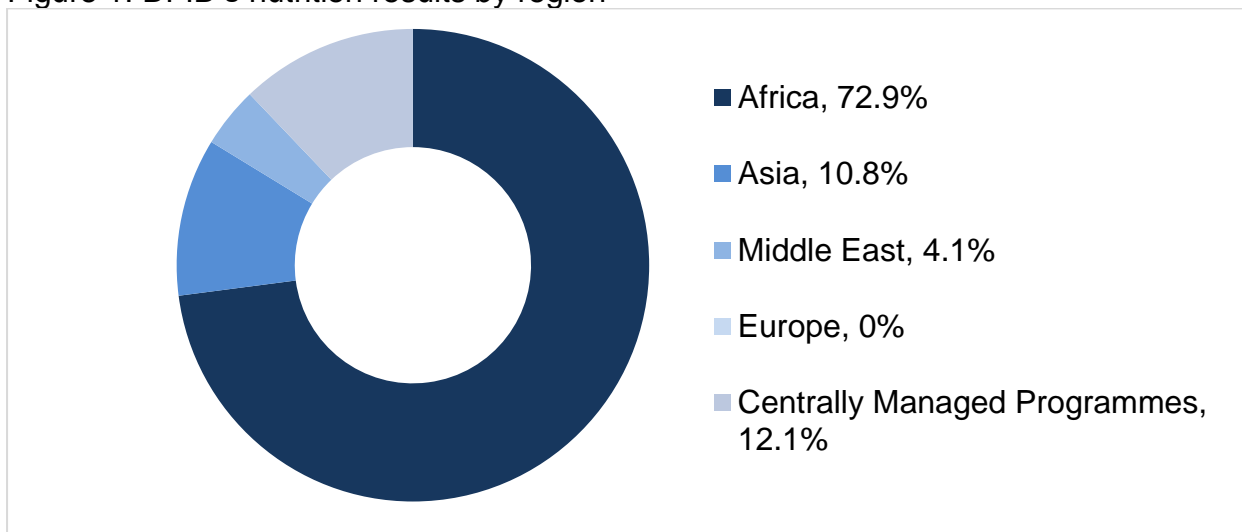
Nutrition

Number of children under 5, women of childbearing age and adolescent girls reached by DFID through nutrition-related interventions.

1. Results:

In 2015-2018 DFID reached 42.1 million children under 5, women of childbearing age and adolescent girls through our nutrition-relevant programmes.

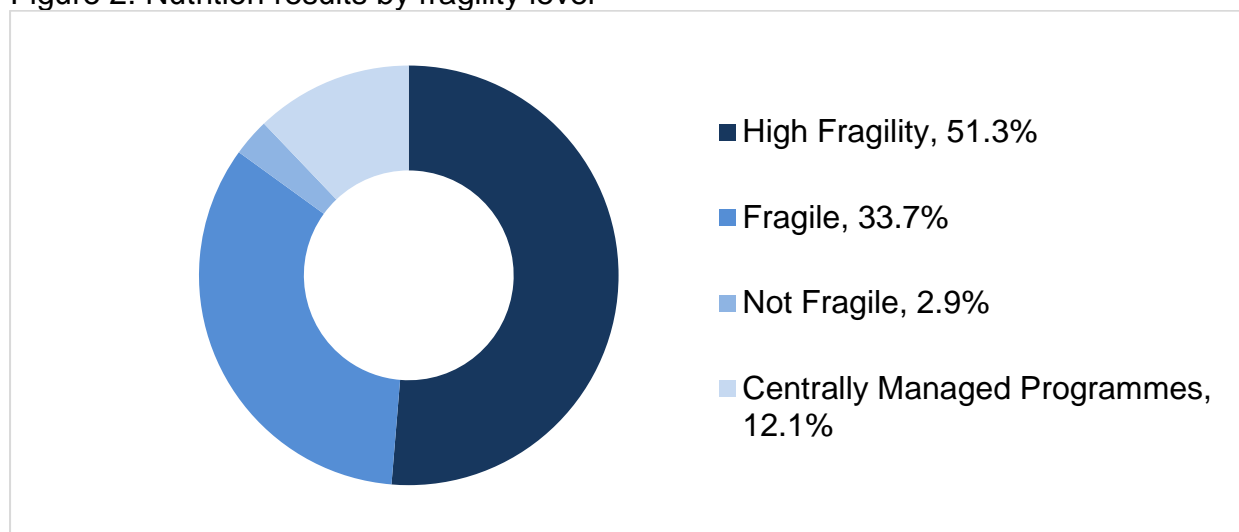
Figure 1: DFID's nutrition results by region



From 2015 to 2018, Africa was the largest beneficiary of DFID's nutrition-related programmes, with 30.7 million beneficiaries reached. DFID reached 4.5 million beneficiaries in Asia: the majority of whom were in Bangladesh (3.7 million). DFID reached 1.7 million beneficiaries in the Middle East: the majority of whom were in Yemen (1.3 million).

A further 12.1 percent (5.1 million beneficiaries) of DFID's nutrition results were delivered via non-country specific programmes, non-region specific programmes, and multilateral organisation.

Figure 2: Nutrition results by fragility level



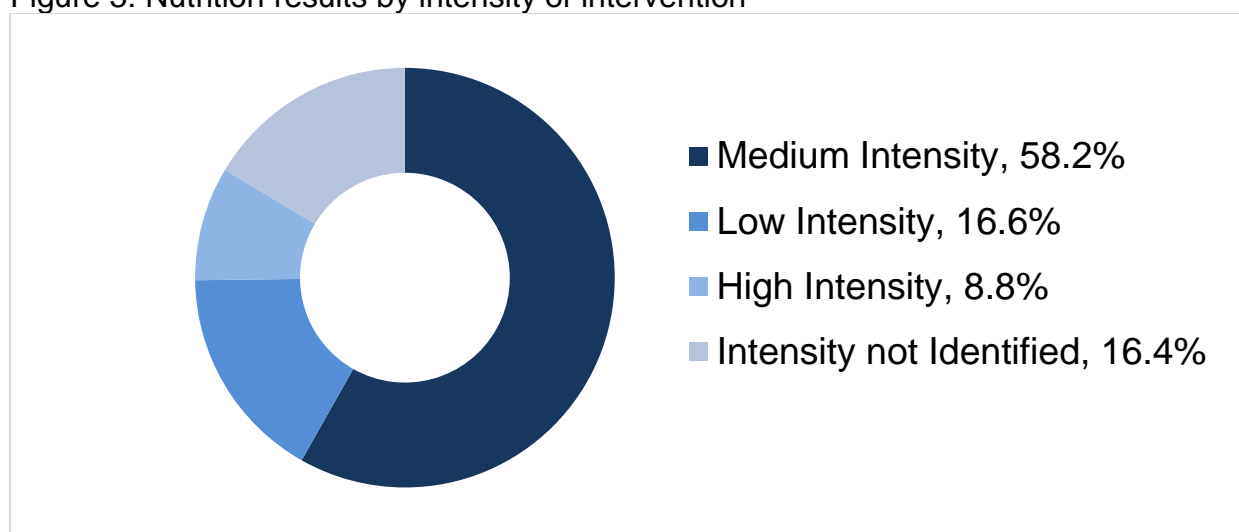
States are considered fragile if they are:

- Fragile states defined based on objective data on state stability from United Nations and the World Bank.
- Neighbouring countries of fragile states and/or part of the three designated regions: Middle East, North Sahara and South Sahara.

DFID produces an [internal listing of fragile states](#) which is used to monitor the UK commitment to focus resources in fragile states. Most of the children under 5, women of childbearing age and adolescent girls reached by DFID's nutrition-related programmes live in fragile states (35.7 million beneficiaries), including 21.6 million beneficiaries living in states with a high level of fragility.

A further 12.1 percent (5.1 million beneficiaries) of DFID's nutrition results were delivered via non-country specific programmes, non-region specific programmes, region specific-programmes, and multilateral organisations.

Figure 3: Nutrition results by intensity of intervention



High, medium and low intensity is defined according to:

- Comprehensiveness of the package reaching the target population
- Whether this package is directly or indirectly targeted to this target population

In all cases, ‘target population’ refers to women of childbearing age (15 to 49 years), children under 5 years and adolescent girls (10 to 19 years). Please refer to the methodology summary, and the published methodology note for more details.

Most of the beneficiaries of DFID nutrition-related programmes received medium intensity intervention (24.5 million beneficiaries). DFID nutrition-related programmes reached 3.6 million beneficiaries with high intensity intervention and 6.9 million beneficiaries with low intensity intervention. Intensity information was not available for 16.4 percent (6.9 million beneficiaries) of DFID’s nutrition results.

Table 1: Change in gender-disaggregated nutrition results between the 2016/17 and 2017/18 reporting period:

Gender	2016/17	2017/18
Female	58%	52%
Male	22%	15%
Not Identified	20%	32%

Of those reached by DFID nutrition-related programs from 2015 to 2018, at least 52 percent (22.4 million) were women and girls. DFID is continuously working with our existing partners towards improving collection of disaggregated dataⁱ. In 2017/18 67 percent of our reported nutrition results were disaggregated by gender. This is a 12 percentage point decrease in data disaggregation by gender between the results reported in 2016/17 and the results reported in 2017/18.

This decrease is driven by a faster increase in results from projects that are unable to disaggregate by gender compared to projects which can provide gender disaggregation. In absolute figures the number of females and males reached has increased compared to last year (Female: from 15.2 million to 22.4 million; Male: from 5.8 million to 6.5 million).

2. Context

Good nutrition plays a key role in child development. Children who are undernourished are more likely to get sick or die. Those who survive suffer impaired physical growth and brain development, which limits educational attainment and lifelong earning potential. Undernutrition remains a major challenge in developing countries including those that face humanitarian crises.

Globally, there are an estimated 151 million children under 5 who are stunted (too short for their age, which can limit brain development) and 51 million who are wasted (low weight for their height, which can increase the risk of death) due to poor nutritionⁱⁱ. The greatest burden of undernutrition falls within Africa and Asia, with almost one in three children in Africa suffering from stunting, and almost one in four children in Asia. Sustainable Development Goal 2 aims to end hunger, achieve food

security and improved nutrition and promote sustainable agriculture, and includes a specific target to end all forms of malnutrition by 2030. The recent pace of change is insufficient to meet this target, and in some countries no progress or a worsening of the situation has been seenⁱⁱⁱ.

Interventions to improve nutrition among children, adolescent girls and women of childbearing age can result in a return on investment of £16 for every £1 spent^{iv}. The 2013 Lancet Commission on Maternal and Child Nutrition recommended the scale-up of a package of ten key interventions to directly address the causes of undernutrition (the so-called nutrition-specific package), based on the available evidence of effectiveness^v. It was estimated that 90% coverage of these interventions could reduce under-five deaths by 15%. However, scale-up of the nutrition-specific package alone will only address 20% of the burden of stunting, given the influence of a range of other factors on child stunting. To address the remaining 80% of the stunting burden, cross-sectoral actions (nutrition-sensitive interventions) are required to address the underlying determinants of undernutrition^{vi}.

3. Methodology summary

DFID's nutrition results data counts the number of beneficiaries within our target groups reached by nutrition relevant interventions. DFID's target groups are children under 5 years of age, adolescent girls (10 – 19 years) and women of childbearing age (15 to 49 years).

Nutrition relevant interventions include:

- Nutrition-specific interventions, which directly address undernutrition (e.g. nutrient supplementation for women and children, support for infant and young child feeding or treatment for acute malnutrition) *and*
- Nutrition-sensitive interventions, which address factors that contribute to undernutrition (e.g. providing access to safely managed water and sanitation to prevent diarrhoeal disease, which contributes to undernutrition) *and*
- Hunger-sensitive interventions, which aim to address food insecurity (e.g. by improving the quantity and diversity of food available to households).

Individual beneficiaries may receive more than one type of nutrition relevant intervention (e.g. nutrient supplementation and access to safely managed water and sanitation), but should only be counted once. We also classify the intensity of the reach of our nutrition programmes based on how comprehensive the package of interventions provided, and whether our priority population are directly targeted or not.

- High intensity reach includes those directly targeted with both a nutrition-specific and a nutrition-sensitive or hunger-sensitive programme.
- Medium intensity reach includes those directly targeted with only a nutrition-specific or a nutrition-sensitive programme (or a hunger-sensitive programme with integrated nutrition-sensitive behaviour change activities).
- Low intensity reach includes those indirectly targeted with a nutrition-sensitive intervention.

As interventions often support individuals for multiple years, our methodology ensures we don't count the same individuals multiple times. Where we have access

to data on unique beneficiaries, we calculate the total (cumulative) number of beneficiaries reached over time. Where this is not available, we use “peak year” results from each country (i.e. the maximum number of beneficiaries reached within a year during the period 2015/2016 – 2019/2020).

There have been no changes to [the methodology](#) since the 2016 data release.

4. Data sources

The information on results is collected from DFID country offices, central DFID departments and multilateral institutions. Given the breadth of intervention types which can be included in the nutrition results, the data used comes from a range of different sources.

In some cases, partner country government management information systems, or individual programme monitoring data are used to provide information on beneficiaries receiving interventions. Where this level of information on beneficiaries is unavailable, data are derived from other sources, such as representative household surveys. In some cases, assumptions are required to estimate the reach of specific interventions (see data quality notes below).

5. Data quality notes

Given the range of data sources used, the accuracy of the results data varies and is subject to the quality of the underlying data source. In many cases DFID uses data collected by others (e.g. partner country governments, international organisations) and therefore DFID has limited control over the quality of the data.

As noted above, assumptions may be used to estimate the reach of interventions in some cases. For example, in programmes which are indirectly targeting our priority population groups, there may be no data available on programme reach, requiring estimation of beneficiary numbers (e.g. the reach of mass media nutritional education campaigns). Assumptions may also be used to avoid double counting where there is overlap of different interventions within a specific geographical area, or to estimate the number of beneficiaries within our target population groups, where an intervention has a broader reach (e.g. using demographic data to estimate the proportion of the population reached that are under 5 years, adolescent girls or women of childbearing age).

Statistics Advisers in DFID undertake quality assurance of the results data and attempt to minimise the source of any errors although there is a risk that errors may still exist. Reported results for 2017/2018 may change following provision of more up to date information.

ⁱ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582315/Data-disaggregation-action-plan-Jan-2017.pdf

ⁱⁱ UNICEF/WHO/World Bank Group. 2018. Joint Child Malnutrition Estimates 2018 edition. New York. Available at: <https://data.unicef.org/resources/jme/>

iii Development Initiatives. 2017. Global Nutrition Report 2017: Nourishing the SDGs. Bristol: Development Initiatives. Available at: https://www.globalnutritionreport.org/files/2017/11/Report_2017.pdf

iv Hoddinott J. 2016. Global Panel on Agriculture and Food Systems for Nutrition Working Paper: The economics of reducing malnutrition in Sub-Saharan Africa. Available at: http://glopan.org/sites/default/files/Global_Panel_Working_Paper.pdf

v Bhutta ZA *et al.* 2013. Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? *The Lancet*, Volume 382, Issue 9890, 452 - 477

vi Ruel MT *et al.* 2013. Nutrition-sensitive interventions and programmes: how can they help to accelerate progress in improving maternal and child nutrition? *The Lancet*, Volume 382, Issue 9891, 536 - 551