

The Global Investment Framework for Nutrition

CALCULATING CURRENT DONOR CONTRIBUTIONS TO NUTRITION

November 2016



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Introduction

In April 2016, the World Bank, Results for Development Institute (R4D), and 1,000 Days launched the Global Investment Framework for Nutrition.¹ The World Bank estimated that it would cost an additional \$70 billion globally from 2016-2025 to scale-up a package of nutrition-specific interventions to achieve the World Health Assembly (WHA) targets for stunting, anemia, and exclusive breastfeeding, and to treat severe acute malnutrition. R4D developed a series of financing scenarios for the Global Investment Framework for Nutrition through which the \$70 billion needed can be mobilized through a coordinated effort between donors, governments, and innovative financing mechanisms.² The “Global Solidarity” financing scenario suggests that donors contribute an additional \$25.6 billion on top of current investments between 2016 and 2025 in order to scale up the package of life saving interventions needed to achieve the WHA nutrition targets. This is in addition to contributions by governments and innovative financing mechanisms to close the resource gap.

An assessment of current donor contributions to nutrition was necessary to contextualize the additional amount of donor resources needed to achieve the targets. The following report outlines how current donor contributions to nutrition were estimated to serve as a baseline for the analysis. The methods outlined here are reported in detail in Chapter 8 of “An Investment Framework for Nutrition: Reaching the Global Targets for Stunting, Anemia, Breastfeeding, and Wasting.”

Estimating current donor contributions to nutrition

Estimating ODA for nutrition at the intervention level

Official Development Assistance (ODA) for nutrition was tracked through the Creditor Reporting System (CRS) of the Organization for Economic Co-operation and Development (OECD). The CRS is a standardized reporting system for all OECD donors, and was used for internal consistency across donors.

A qualitative, project-level analysis was conducted for all disbursements in 2013 for the basic nutrition purpose code.³ A keyword search method was conducted for an additional 15 purpose codes to assess aid for nutrition within the health and emergency relief sectors. An objective of this baseline analysis was to align current investments to projected costs *by intervention* (i.e., match current funding for vitamin A supplementation for children to costs for vitamin A supplementation). The methodology is summarized here. Refer to Chapter 8 of “An Investment Framework for Nutrition” for the full methodology, or Annex A of this report for a step-by-step description.⁴

¹ Shekar M, Kakietek J, Eberwein JD, and Walters D. An Investment Framework for Nutrition: Reaching the Global Targets for Stunting, Anemia, Breastfeeding, and Wasting. Washington, DC: The World Bank; 2016.

² D’Alimonte MR, Rogers H, and de Ferranti D. An Investment Framework for Nutrition: Reaching the Global Targets for Stunting, Anemia, Breastfeeding, and Wasting. *Chapter 8: Financing the Global Nutrition Targets*. Washington, DC: The World Bank; 2016.

³ At the time of project-level analysis of the basic nutrition code, 2013 data was the most recently available data.

⁴ D’Alimonte MR, Rogers H, and de Ferranti D. An Investment Framework for Nutrition: Reaching the Global Targets for Stunting, Anemia, Breastfeeding, and Wasting. *Chapter 8: Financing the Global Nutrition Targets*. Washington, DC: The World Bank; 2016.

Basic nutrition: qualitative review of project descriptions

The assessment of the basic nutrition purpose code (12240) was conducted for all basic nutrition disbursements going to the 60 countries with the highest global burdens of stunting, anemia, breastfeeding, and wasting.⁵ Those recipient countries represent 95 percent of the global stunting burden and received about 70 percent of all disbursements to basic nutrition in 2013 (representing 945 unique line items). This generated information on donor-by-donor contributions for nutrition interventions, and an average across all donors (see **Annex Table A1**).

Though the basic nutrition code is commonly used as a proxy for nutrition-specific investments⁶, the project-level analysis found that only 57% of the basic nutrition code can be considered nutrition-specific spending that is aligned with the costed package of interventions. This percentage varies from donor to donor, so each donor's spending was calculated as its total basic nutrition disbursement multiplied by the percentage going towards the nutrition-specific, costed package of intervention.

Health and emergency response sectors: rapid keyword search assessment

A rapid keyword search analysis of 15 purpose codes within the health and emergency response sectors was conducted to assess the extent to which donors were reporting nutrition funding through those codes. Ten out of the 15 purpose codes analyzed were found to contain nutrition funding. These include basic health care (12220), reproductive health (13020), health education (12261), health personnel development (12281), food aid/food security programmes (52010), material relief assistance and services (72010), emergency food aid (72040), relief co-ordination (72050), reconstruction relief and rehabilitation (73010), and disaster prevention and preparedness (74010).

Based on this analysis, it was found that less than 1% to 6% of these codes were related to nutrition (see **Annex Table A2**). The proportions were then applied to each donors' total contributions to the 15 purpose codes, yielding each donors' investments in nutrition as reported by the health and emergency response sectors.

Accounting for donors' nutrition contributions via multilaterals

We estimated the amount of funding for nutrition that is transferred from bilateral donors to multilaterals. For instance, if the United States was contributing to the revenue of WFP, and in turn WFP was conducting work on nutrition, we sought to ensure that the U.S. baseline accounted for the U.S. nutrition contributions as channeled by the WFP. However, this information is not directly available through the CRS and had to be imputed.

The imputation was calculated as follows: 1) we reviewed financial reports of multilaterals to compile information on how much each individual bilateral donor contributes to the eight multilaterals listed in **Annex Table A3**; 2) we compiled data on ODA for nutrition disbursed by multilaterals from the CRS, as described above; and 3) we calculated individual bilateral contributions by multiplying total multilateral funding by the proportion of overall revenue contributed by each bilateral donor. For instance, if a

⁵ Shekar M, Kakietek J, Eberwein JD, and Walters D. An Investment Framework for Nutrition: Reaching the Global Targets for Stunting, Anemia, Breastfeeding, and Wasting. Washington, DC: The World Bank; 2016.

⁶ International Food Policy Research Institute. *Global Nutrition Report 2016. From Promise to Impact: Ending Malnutrition by 2030*. Washington, DC; 2016.

multilateral contributes \$100 million to nutrition, and a particular bilateral donor contributed 5% of that multilateral's revenue, then we would assume that that bilateral donor provided \$5 million in nutrition financing via that multilateral. This method for multilateral imputation has been used in other analyses of foreign aid.⁷

Annex Table A3 includes the list of multilaterals that were included in the imputation analysis, and the sources used to calculate the proportional contributions from bilateral donors. **Annex Table A4** reports the findings. The eight multilaterals were chosen based on reporting basic nutrition funding in 2014 via the OECD CRS database. The nutrition financing for multilaterals was calculated using the relevant nutrition codes in the OECD CRS database, using the methodology described in **Annex A**.

Compilation of total nutrition contributions

Total donor contributions to the nutrition-specific interventions in the costing analysis were calculated by summing the donor's investments from the basic nutrition purpose code, plus the additional nutrition investments as reported through the 15 health and emergency response purpose codes, plus nutrition investments as channeled through multilaterals.

A donor's total nutrition-specific ODA is therefore calculated as:

(Portion of basic nutrition code allocated to nutrition specific interventions)
+ (Nutrition specific financing in the 15 additional health and emergency codes)
+ (Nutrition specific financing as channeled through multilaterals)
= **Donor's total nutrition specific ODA**

Important limitations and considerations for the baseline estimates

1. The OECD Creditor Reporting System database was used for the donor baseline analysis because it could be standardized across all donors. However, a limitation of this is that it may not exactly match donor financial reports because individual donor reporting systems may have different systems for reporting and coding investments. Comparing the two systems would require looking at the various definitions within coding systems and aligning from there.⁸
2. The data has not been officially validated with donor organizations and so should be treated as unofficial estimates.
3. The resource-intensive method to assess donor contributions to nutrition by intervention/activity implies that it will be important to consider a way to revise how ODA for nutrition is coded so that it can be systematically tracked in the future. Recommendations on how monitoring aid for nutrition through the CRS can be improved have been documented elsewhere.⁹

⁷ Oxfam (2015). Syria Crisis Fair Share Analysis 2015. and ACF and IDS. (2012). Aid for Nutrition: Using innovative financing to end undernutrition.

⁸ The purpose code 12240 for basic nutrition is defined as "Direct feeding programmes (maternal feeding, breastfeeding and weaning foods, child feeding, school feeding); determination of micro-nutrient deficiencies; provision of vitamin A, iodine, iron, etc.; monitoring of nutritional status; nutrition and food hygiene education; household food security."

⁹ Results for Development (2016). Tracking Funding for Nutrition: Improving how aid for nutrition is reported and monitored.

4. The segmentation of the basic nutrition code presented in **Annex Table A1** represents a first approximation of each donor's nutrition-specific portfolio based on the above-mentioned CRS purpose codes, and should be supplemented with individual donor reporting when possible for tailored, donor-specific analyses.
5. While the total disbursement for the additional health and emergency response codes is donor-specific, the percentage of funds from these codes that are allocated towards nutrition is not. Rather, it is a general assumption applied across donors based on 2013 and 2014 project descriptions and does not account for variability across donors.
6. Due to the two-year lag in CRS reporting and the resource-intensive method to extract intervention-level data, it is not possible to determine whether intervention or recipient country donor prioritization has changed between 2013 and 2014. All 2014 figures are based off of the intervention and recipient country donor prioritization as calculated in the analysis of 2013 data, since this was the most recent data at the time of analysis. Future work to track these resources year-on-year (or at least every two years) is needed for the purposes of monitoring and accountability.
7. Annex A contains further details on the methodology of segmenting the OECD purpose codes into different nutrition interventions.

Annex: Step-by-step methodology for estimating current donor contributions to nutrition

Intervention segmentation of basic nutrition code (12240)

1. In order to break down total nutrition financing to determine how much of it is invested in nutrition-specific interventions, we conducted an analysis of 2013 CRS project description files for 60 countries with the highest global burden of stunting, wasting, and anemia, as well as low breastfeeding rates. For all 60 recipient countries, we reviewed all projects in the CRS that received disbursements coded as 12240 for basic nutrition. We downloaded project description files from the CRS and categorized disbursements by intervention project type based on their project title and short and long descriptions.
2. When not enough detail was available through project descriptions, the categorization process was supplemented with desk research.
3. For projects that funded multiple interventions, we split disbursements proportional to their relative cost across the interventions (as estimated by the World Bank). For a project with multiple interventions, we applied the fraction of one intervention's cost relative to the cost of all interventions included in the project to the full project disbursement to estimate how much of the disbursement can be allocated to each intervention.
4. Capacity building and nutrition-sensitive investments included in the basic nutrition code: If capacity building was included with other interventions of a particular project, 25% of the total disbursement went to capacity building. If nutrition-sensitive interventions were included with other interventions of a particular project, 60% of the total disbursement went to the bucket of nutrition-sensitive financing. The remaining disbursement was then split according to relative costs of the other included interventions. If the only interventions included in a particular project were capacity building and one or more nutrition-sensitive interventions, the disbursement was split equally (50%/50%) between capacity building and nutrition-sensitive.
5. Research & development (R&D): Projects that only described a R&D nutrition intervention, with no other interventions, were deemed R&D and 100% of the total disbursement went to R&D. If R&D was only a small mention within a larger project description, no disbursement went to R&D and the total disbursement was split among the other included interventions. This likely results in an underestimate of total R&D. When tied to other interventions rather than as a stand-alone investment, it is more likely to be operational research.
6. We summed the amount of nutrition ODA attributed to the costed package of interventions in order to estimate nutrition-specific funding for stunting, wasting, anemia, and exclusive breastfeeding from the basic nutrition code for each donor. Since this analysis was only conducted for the year 2013, we assumed the segmentation (i.e., proportional spending by intervention) is maintained for 2013 onwards for the purposes of this analysis. In reality, it is likely to change year on year.
7. Austria, New Zealand, Norway, Poland, Slovak Republic, Slovenia, and Switzerland did not have sufficient 2013 data to determine each of these donor's financing segmentation. For these donors missing data, we applied the average 2013 OECD-DAC donor funding contributions to the costed package of interventions as a share of total basic nutrition disbursement to each donor's 2013 and 2014 nutrition disbursement.

Additional health codes

1. Project descriptions for all sectors and purpose codes were downloaded in November 2015. After conversations with the Scaling Up Nutrition Donor Network, desk research,^{10,11} and quick assessment of potentially relevant project codes, additional health purpose codes were selected for assessment: basic health care, reproductive health, health education, health personnel development, infectious disease, and personnel development for population & reproductive health.
2. From the data downloaded, long descriptions for projects were either not available or did not significantly supplement the project titles or short descriptions. For this reason, we only assessed project titles and short descriptions.
3. We conducted a “nutrition” keyword search within the project titles and short descriptions of the additional health codes. We assessed the number of projects and associated disbursements that included mention of the word nutrition, and compared it to the total number of projects and total disbursement in the relevant health code.
4. From analysis, we determined that basic health care, reproductive health, health education, and health personnel development had enough nutrition context (above 1% of frequency of projects with “nutrition” and above 1% of disbursements going to projects with “nutrition”) to be considered.
5. For each code under consideration, we calculated the sum of disbursements of projects with “nutrition” in the short descriptions as a percentage of the total disbursements of the projects under the health code.
6. We assumed this percentage stayed the same across all countries and donors, and applied this percentage to the total 2013 disbursement of each donor to estimate individual donor contributions.
7. A rapid assessment of project descriptions led to determining the interventions assumed to be included in the relevant health code. Using the same weighting method as explained under the segmentation element of the basic nutrition code analysis, we split the “nutrition disbursement” across the interventions assumed to be included in the health code.
8. This analysis was rerun, following the same methods as above, for the 2014 data recently added to the CRS database for purpose codes 12220, 12261, 12281, and 13020.

Wasting treatment funding from emergency codes

1. A similar methodology for the additional health codes was applied to emergency and food aid codes. A keyword search of “nutrition”, “CMAM”, and “RUTF” was conducted across the 2014 project descriptions (downloaded in January 2016, n=15,052) for the following purpose codes: general budget support-related aid (51010), food aid/food security programmes (52010), import support (53030 and 53040), material relief assistance and services (72010), emergency food aid (72040), relief co-ordination (72050), reconstruction relief and rehabilitation (73010), and disaster prevention and preparedness (74010).
2. No mention of the keywords was found in 51010, 53030, or 54040, so these codes were removed from the rest of the analysis.

¹⁰ ACF International. Aid for Nutrition: Can Investments to Scale Up Nutrition Actions Be Accurately Tracked?; 2012.

¹¹ ACF International. Aid for Nutrition: Improving Tracking and Accountability for More Impact; 2014.

3. For each code under consideration, we calculated the sum of disbursements of projects with keywords in the short descriptions as a percentage of the total disbursements of the projects under the purpose code.
4. We assumed this percentage stayed the same across all countries and donors, and applied this percentage to the total 2014 disbursement of each donor.
5. We attributed all additional funding found to treatment of severe acute malnutrition (SAM), the wasting intervention included in the analysis.

Limitation: While the total disbursement for health, emergency, and food aid codes is donor-specific, the percentage applied for first approximation of funding from codes going towards nutrition is not. Rather, it is a general assumption applied across donors based on 2013 and 2014 project descriptions and does not account for variability across donors.

Note: The agriculture sector code (311) was also analyzed. No additional financing for food fortification was found within this code.

Annex Table 1: Segmentation of basic nutrition (12240) disbursements in 2013 by donor and intervention/activity

| Donor | Proportion of donor funding examined | Unspecified funding (% of total) | Intervention/Activity Segmentation | | | | | | | | | | | | | Total (%) | |
|--------------------|--------------------------------------|----------------------------------|---|-------------------------------------|-----------------|---------------------|---------------------------|------------------|---------------|--|---------------------|------------------------|------------------------------|---------------------------|--------------------------|-------------|------|
| | | | Infant and young child nutrition counseling (%) | Treatment of acute malnutrition (%) | Supplementation | | | | | Provision of complementary foods and BEP (%) | Salt iodization (%) | Food fortification (%) | Research and development (%) | Systems Strengthening (%) | Nutrition -Sensitive (%) | | |
| | | | | | Deworming (%) | Iron-folic acid (%) | Micronutrient Powders (%) | Zinc and ORS (%) | Vitamin A (%) | | | | | | | | |
| AsDB Special Funds | 81% | 0% | 8.1% | 0.0% | 0.0% | 1.4% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 4.4% | 0.0% | 23.1% | 63.0% | 100% |
| Australia | 96% | 0% | 12.8% | 44.5% | 0.0% | 2.1% | 3.6% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 7.2% | 0.0% | 27.7% | 2.0% | 100% |
| Belgium | 59% | 41% | 8.6% | 60.9% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 2.2% | 0.0% | 26.3% | 2.0% | 100% |
| BMGF | 51% | 42% | 48.4% | 0.0% | 0.7% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.2% | 12.1% | 35.4% | 2.6% | 0.6% | 100% |
| Canada | 37% | 0% | 13.4% | 9.6% | 0.0% | 0.8% | 0.1% | 0.1% | 0.4% | 4.2% | 0.1% | 1.9% | 1.6% | 11.1% | 56.6% | 100% | |
| Czech Republic | 100% | 0% | 16.7% | 58.3% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 25.0% | 0.0% | 100% |
| Denmark | 100% | 0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 100.0% | 0.0% | 100% |
| EU Institutions | 29% | 0% | 19.5% | 0.6% | 0.1% | 4.0% | 0.0% | 8.1% | 6.1% | 0.0% | 0.5% | 0.0% | 0.0% | 0.0% | 15.4% | 45.8% | 100% |
| Finland | 75% | 4% | 14.8% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 2.0% | 0.0% | 83.2% | 100% |
| France | 30% | 69% | 1.1% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 36.6% | 0.0% | 3.1% | 0.0% | 54.0% | 5.0% | 100% | |
| Germany | 96% | 0% | 14.3% | 49.0% | 1.8% | 2.4% | 0.0% | 25.0% | 3.6% | 0.0% | 0.0% | 0.0% | 0.1% | 0.3% | 3.4% | 100% | |
| Iceland | 100% | 0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 100.0% | 100% | |
| IDA | 89% | 0% | 19.2% | 10.5% | 0.0% | 0.3% | 0.1% | 2.2% | 1.5% | 0.0% | 0.1% | 0.0% | 0.0% | 30.9% | 35.2% | 100% | |
| IDB Sp.Fund | 19% | 0% | 22.2% | 77.5% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.3% | 0.0% | 100% |
| Ireland | 81% | 17% | 6.2% | 9.6% | 0.3% | 0.6% | 0.6% | 3.7% | 0.9% | 16.4% | 1.7% | 27.7% | 11.7% | 4.4% | 16.2% | 100% | |
| Italy | 87% | 0% | 0.0% | 3.8% | 0.0% | 0.0% | 0.3% | 0.0% | 0.0% | 0.0% | 0.0% | 0.7% | 0.0% | 3.3% | 91.8% | 100% | |
| Japan | 95% | 0% | 7.4% | 15.7% | 0.1% | 0.4% | 0.2% | 8.1% | 0.3% | 12.2% | 0.0% | 0.0% | 0.0% | 6.1% | 49.6% | 100% | |
| Korea | 64% | 0% | 38.6% | 6.7% | 0.0% | 2.4% | 0.0% | 0.0% | 3.7% | 7.1% | 0.0% | 1.0% | 0.0% | 8.0% | 32.4% | 100% | |
| Luxembourg | 10% | 0% | 15.9% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 84.1% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 100% |
| Netherlands | 32% | 13% | 39.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 25.4% | 0.0% | 13.0% | 22.6% | 100% | |
| Portugal | 54% | 0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 50.0% | 50.0% | 100% | |
| Spain | 38% | 0% | 9.5% | 31.7% | 0.0% | 0.3% | 0.0% | 0.4% | 0.4% | 1.6% | 0.0% | 0.0% | 0.1% | 0.1% | 55.9% | 100% | |
| Sweden | 73% | 27% | 9.0% | 31.4% | 1.2% | 1.5% | 2.6% | 16.0% | 2.3% | 0.0% | 1.2% | 9.8% | 0.0% | 25.0% | 0.0% | 100% | |
| UNDP | 55% | 0% | 3.3% | 0.0% | 0.0% | 0.0% | 0.7% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 52.8% | 43.3% | 100% | |
| UNICEF | 89% | 0% | 10.7% | 20.7% | 1.2% | 0.7% | 0.7% | 4.6% | 2.3% | 6.2% | 0.5% | 1.5% | 0.0% | 42.7% | 8.3% | 100% | |
| United Kingdom | 89% | 6% | 7.9% | 34.3% | 2.0% | 0.2% | 3.9% | 1.6% | 3.5% | 1.6% | 0.7% | 1.9% | 0.8% | 13.6% | 28.2% | 100% | |
| United States | 68% | 10% | 11.0% | 5.5% | 0.1% | 0.5% | 0.2% | 0.4% | 0.5% | 3.1% | 0.0% | 2.2% | 0.0% | 6.6% | 70.1% | 100% | |
| WFP | 51% | 0% | 11.6% | 0.0% | 0.1% | 0.2% | 0.3% | 1.8% | 0.3% | 5.7% | 0.1% | 0.5% | 0.0% | 40.1% | 39.3% | 100% | |
| WHO | 16% | 25% | 23.7% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 21.7% | 54.5% | 100% | |
| Average | 66% | 8% | 14% | 15% | 1% | 1% | 1% | 4% | 1% | 4% | 0% | 3% | 3% | 13% | 42% | 100% | |

Annex Table 2: Summary of purpose codes included in the analysis

| Purpose code | Purpose code name | Total disbursements in 2013 (USD millions) | Screening method used | Percent of projects screened under the purpose code using the related method | Percent of disbursements found to be aligned with the costed package of interventions |
|--------------|--|--|------------------------------|--|---|
| 12240 | Basic nutrition | 946 | Project-level categorization | 70 (<i>n</i> = 945) | 57.1%* |
| 12220 | Basic health care | 3,217 | Key word search | 100 | 0.9% |
| 12250 | Infectious disease control | 1,369 | Key word search | 100 | <0.01% |
| 12261 | Health education | 167 | Key word search | 100 | 1.5% |
| 12281 | Health personnel development | 107 | Key word search | 100 | 2.4% |
| 13020 | Reproductive health care | 1,678 | Key word search | 100 | 5.7% |
| 13081 | Personnel development for population & reproductive health | 68 | Key word search | 100 | 0.0% |
| 51010 | General budget support-related aid | 9,629 | Key word search | 100 | 0.0% |
| 52010 | Food aid/food security programmes | 1,290 | Key word search | 100 | 2.0% |
| 53030 | Import support (capital goods) | 315 | Key word search | 100 | 0.0% |
| 53040 | Import support (commodities) | 58 | Key word search | 100 | 0.0% |
| 72010 | Material relief assistance and services | 7,405 | Key word search | 100 | 1.2% |
| 72040 | Emergency food aid | 3,835 | Key word search | 100 | 5.3% |
| 72050 | Relief co-ordination; protection and support services | 835 | Key word search | 100 | 0.5% |
| 73010 | Reconstruction relief and rehabilitation | 625 | Key word search | 100 | 0.04% |
| 74010 | Disaster prevention and Preparedness | 1,017 | Key word search | 100 | 0.2% |

* Remaining disbursements within the basic nutrition code went towards interventions not included in the costed package of interventions (including deworming and salt iodization), nutrition-sensitive interventions such as school feeding, and unspecified disbursements.

Annex Table 3: Sources used for multilateral imputation

| Multilateral | Source used to calculate the proportional contributions from bilateral donors |
|--------------------------------------|---|
| Asian Development Bank Special Funds | OECD Creditor Reporting System database, "Members' total use of the multilateral system." Data downloaded in February 2016. |
| European Union | OECD Creditor Reporting System database, "Members' total use of the multilateral system." Data downloaded in February 2016. |
| IDA | OECD Creditor Reporting System database, "Members' total use of the multilateral system." Data downloaded in February 2016. |
| IDB Special Fund | OECD Creditor Reporting System database, "Members' total use of the multilateral system." Data downloaded in February 2016. |
| UNDP | <p>"Top Contributing Donors." http://open.undp.org/#top-donors/total (main source used)</p> <p>"UNDP Funding Compendium 2014." http://www.undp.org/content/dam/undp/library/corporate/Partnerships/UNDP-BERA-Funding-Compendium-2015.pdf</p> <p>"Contributors to Core Resources." http://www.undp.org/content/undp/en/home/ourwork/funding/top-contributors/top-donors/ (2015 data used where 2014 data was unavailable)</p> |
| UNICEF | <p>"UNICEF Compendium of Resource Partner Contributions 2014."</p> <p>http://www.unicef.org/publicpartnerships/files/UNICEF_Compndium_of_Resource_Partner_Contributions_2014.pdf</p> |
| World Food Programme | "Contributions to WFP in 2014." http://www.wfp.org/funding/year/2014 |
| World Health Organization | <p><i>Assessed Contributions:</i> "World Health Organization Assessed Contribution Status Report, as at 31 December 2014." http://www.who.int/about/resources_planning/AC_Status_Report_2014.pdf?ua=1</p> <p>Half of assessed contributions are collected in USD, and half are collected in CHF. A historical 2014 exchange rate from Oanda was applied for the CHF contributions. Only contributions that were actually received by WHO are included.</p> <p><i>Voluntary Contributions:</i> "Annex to the Financial Report for the year ended 31 December 2014: Voluntary contributions by fund and by contributor." http://www.who.int/about/resources_planning/AnnexA68_inf1-en.pdf?ua=1</p> <p>Includes voluntary core and specified contributions, as well as contributions to the fiduciary funds for the Partnership for Maternal, Newborn, and Child Health and the UN System Standing Committee on Nutrition</p> |

Annex Table 4: Percent of total multilateral revenue contributed by the top 11 bilateral donors

| | | Multilateral (recipient of funds) | | | | | | | |
|----------------------------|----------------|-----------------------------------|--------------|--------------|-------------|------------------|--------------|--------------|--------------------|
| | | WFP | EU | WHO | IDA | IDB Special Fund | UNICEF | UNDP | AsDB Special Funds |
| Donor (source of funds) | Australia | 2.0% | 0.0% | 4.4% | 0.8% | 0.0% | 2.6% | 0.9% | 6.0% |
| | Canada | 6.3% | 0.0% | 6.7% | 5.0% | 0.0% | 3.9% | 1.2% | 2.4% |
| | France | 0.4% | 17.3% | 2.9% | 6.5% | 0.1% | 1.6% | 0.4% | 1.7% |
| | Germany | 5.4% | 21.1% | 5.7% | 7.9% | 0.0% | 5.6% | 3.0% | 4.1% |
| | Ireland | 0.4% | 1.0% | 0.3% | 0.2% | 0.0% | 0.6% | 0.3% | 0.0% |
| | Italy | 0.6% | 12.2% | 1.8% | 4.1% | 0.0% | 1.1% | 0.1% | 2.5% |
| | Japan | 2.8% | 0.0% | 5.7% | 11.7% | 1.3% | 5.7% | 8.1% | 20.2% |
| | Netherlands | 1.6% | 4.8% | 1.9% | 0.8% | 0.0% | 4.0% | 2.2% | 0.0% |
| | Sweden | 1.7% | 3.0% | 3.1% | 4.3% | 0.0% | 4.9% | 3.3% | 0.0% |
| | United Kingdom | 7.3% | 14.1% | 12.2% | 30.0% | 0.0% | 11.2% | 3.9% | 4.5% |
| | United States | 40.3% | 0.0% | 26.7% | 15.1% | 6.3% | 18.2% | 10.5% | 9.2% |
| Total | 68.9% | 73.5% | 71.4% | 86.3% | 7.8% | 59.6% | 34.0% | 50.5% | |

Note: Table includes column percentages.

Source: Outlined in Annex Table A3