Federal Democratic Republic of Ethiopia
Ministry of Health

Tracking Funding for Nutrition in Ethiopia Across Sectors

Ethiopian Fiscal Years 2006 to 2008

(2013/14 to 2015/16)

RESULTS FOR DEVELOPMENT

CIFF CHILDREN'S INVESTMENT FUND FOUNDATION

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Foreword

Significant progress has been made in Ethiopia to improve child and maternal nutrition over the last decade. The Federal Democratic Republic of Ethiopia Ministry of Health (FMoH) is committed to continuing these trends to improve nutrition. This has been demonstrated through the Seqota Declaration to end child undernutrition by 2030, actions and targets set in the National Nutrition Program 2016-2020 (NNPII), and stewardship of the National Nutrition Coordinating Body.

The NNP-II is a multi-sectoral framework to guide sectors and development partners around scaling-up nutrition interventions by setting national nutrition targets and goals for all stakeholders to aspire towards. Information on past and current investments in nutrition is critical to scale-up these interventions in a coordinated manner across partners, assess the resource gap, and set financial targets to be achieved jointly by stakeholders. However, resource data is not readily available across partners, and because nutrition requires a multi-sectoral response, data on nutrition investments across sectors is often not consolidated.

To fill this gap, the FMoH requested collaborative technical support from Results for Development (R4D), with funding provided by the Children's Investment Fund Foundation (CIFF), to track funding for nutrition across sectors. This report identifies funding flows for nutrition across sectors for Ethiopian Fiscal Years 2006 to 2008 (2013/14 to 2015/16). Based on this data, this report identifies a set of programmatic actions to improve Ethiopia's nutrition programming: increase investments in the high-impact, cost-effective interventions to improve nutrition in the NNP-II, and leverage existing nutrition-sensitive investments across sectors. It also recommends improved resource tracking and systems strengthening to ensure nutrition funding data informs decision making and policy-setting on a routine basis. Together, this information will help ensure funding for nutrition is used effectively and efficiently towards maximizing the impact on nutrition outcomes.

The FMoH would use this data and information to inform nutrition planning and priority setting moving forward, and hopes that similar analyses can be conducted on a routine basis to continue to support nutrition governance and coordination.

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From the FMoH, Dr. Ferew Lemma, Senior Advisor to the Minister, and Mr. Birara Melese Yalew, National Nutrition Case Team Coordinator co-developed the methodology, defined the scope—including nutrition interventions, stakeholders, and years to be included—and assisted in the interpretation of findings. Also from the FMoH, Dr. Ephrem Lemango, Director of Maternal and Child Health Directorate, provided feedback on emerging trends in the analysis as well as some context for use in planning. A team from the FMoH Resource Mobilization Directorate, led by Director Dr. Mizan Kiros, and including Ms. Eyerusalem Animut and Mr. Ermias Dessie, co-developed the research design with respect to alignment with Ethiopia's Health Accounts Six (HA VI) exercise by the FMoH for EFY 2006 using the SHA 2011 framework. Thank you to all HA team members who reviewed drafts of this report.

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Glossary of Terms

Bilateral flows: movement of aid from official (government) sources directly to official sources in the recipient country, as defined by the Organization for Economic Co-operation and Development (OECD, n.d.).

Direct nutrition programs: programs where the primary objective is to improve nutrition, such as community based management of acute malnutrition. This is in contrast to broader programs that may integrate nutrition objectives and interventions as one of multiple focus areas—for example, maternal and child health or HIV programs.

Ethiopian Fiscal Year: the period used by the Ethiopian government for accounting and budgeting purposes, ending July 7th of the calendar year (United Nations Statistics Division, n.d.).

Government-managed funds: in this analysis, funding was considered government-managed if it was either: a) reported by the Government; or b) reported by a development partner and the Government was listed as a financing source, recipient, or financing agent for the investment.

Multilateral flows: core contributions from official (government) sources to multilateral agencies where they are then used to fund country programs, some of which are the multilateral agencies' own programs in a beneficiary country (OECD, n.d.).

Nutrition-sensitive: interventions or programs that address the underlying determinants of fetal and child nutrition and development—food security; adequate care giving resources at the maternal, household and community levels; and access to health services and a safe and hygienic environment—and incorporate specific nutrition goals and actions (The Lancet, 2013).

Nutrition-specific: interventions or programs that address the immediate determinants of fetal and child nutrition and development—adequate food and nutrient intake, feeding, caregiving and parenting practices, and low burden of infectious diseases (The Lancet, 2013).

Off-budget: funding from development partners that bypass government management and is used to implement projects directly with non-governmental partners. Funding that is off-budget may still be reported to the government via resource tracking channels and processes led by the government (Collaborative Africa Budget Reform Initiative, 2008).

On-budget: aid is channeled through public systems (i.e., Ministry of Finance and Economic Cooperation) and integrated in budget documents (Collaborative Africa Budget Reform Initiative, 2008).

Nutrition program type: in this analysis, data is categorized under three nutrition program types: non-emergency nutrition-specific programs, non-emergency nutrition-sensitive programs, and emergency-response programs. For brevity, these are referred to in the report simply as nutrition-sensitive, nutrition-specific, and emergency response programs.

Stunting: Stunting is an indicator of chronic malnutrition and is measured by "height-for-age." Stunting occurs when a child is below minus two standard deviations from median height-for-age of the reference population (UNICEF, n.d. a)

Wasting: Wasting is an indicator of acute malnutrition and is measured by "weight-for-height." Wasting occurs when a child is below minus two standard deviations from median weight-for-height of reference population (UNICEF, n.d. a).

Acronym List

AGP:	Agricultural Growth Program
BCC:	Behavior Change Communication
CIFF:	Children's Investment Fund Foundation
CMAM:	Community-based Management of Acute Malnutrition
CRS:	Creditor Reporting System (from OECD)
EDHS:	Ethiopia Demographic & Health Survey
EFY:	Ethiopian Fiscal Year
EPHI:	Ethiopian Public Health Institute
ETB:	Ethiopian Birr
FMHACA:	Food, Medicine and Health Care Administration and Control Authority
FMoH:	Federal Ministry of Health
GDP:	Gross Domestic Product
GMP:	Growth Monitoring and Promotion
GoE:	Government of Ethiopia
HA:	Health Accounts
HABP:	Household Asset Building Program
HEP	Health Extension Program
IEC:	information, education, and communication
INGO:	international non-governmental organization
IHP+:	International Health Partnership
MDG:	Millennium Development Goal
MDGPF:	Millennium Development Goal Performance Fund
MoFEC:	Ministry of Finance and Economic Cooperation
NCD:	non-communicable disease
n.d.:	No date
NDPF:	Nutrition Development Partners Forum
NGO:	non-governmental organization
NNCB:	National Nutrition Coordinating Body
NNP-II:	National Nutrition Program 2016–2020
NNTC:	National Nutrition Technical Committee
NSA:	nutrition-sensitive agriculture
ODA:	Official Development Assistance
OECD:	Organization for Economic Co-operation and Development
PSNP	Productive Safety Net Program
RUTF:	ready-to-use therapeutic food
SHA:	System of Health Accounts
SUN:	Scaling Up Nutrition
UNICEF:	United Nations Children's Fund
UNHCR:	United Nations High Commissioner for Refugees
WFP:	World Food Program

Executive Summary

Ethiopia has made tremendous progress at improving nutrition among women and children across the country, with stunting rates of children under five decreasing from 57 percent in 2000 to 38 percent in 2016 (EDHS, 2016), and the percentage of women with anemia decreasing from 27 percent in 2005 to 23 percent in 2016 (EDHS, 2016). However, rates of chronic and acute malnutrition are still high, with the prevalence of stunting at 38 percent of children under five and the prevalence of wasting hovering at about 10 percent since 2011 (EDHS, 2016).

Note to Readers

Budget and expenditure data presented in this report are for Ethiopian Fiscal Years (EFY) 2006 to 2008, which correspond to Gregorian calendar years 2013/14 to 2015/16. The Ethiopian Fiscal Year is the principal calendar used for the annual budget process. Due to rounding, disaggregated numbers presented within this report may not sum to exact total amounts shown.

In 2015, the Government of Ethiopia launched the Seqota Declaration as a commitment to end child undernutrition in Ethiopia by 2030. The Seqota Declaration builds on and supports implementation of the National Nutrition Program 2016–2020 (NNP-II). The NNP-II is a multi-sectoral nutrition strategy that recommends the scale-up of evidence-based nutrition interventions using a life cycle approach, meaning it focuses on improving nutrition at all stages of the life cycle from young children to adolescent girls to pregnant and lactating women. In this way, the NNP-II aims to improve multi-generational nutrition outcomes and outlines targets to achieve optimal nutrition status for all Ethiopian citizens. The NNP-II serves as a guiding framework for all stakeholders working towards improved nutrition, including government and development partners.

Governance, communication and coordination between ministries and agencies of the NNP-II are supported by the National Nutrition Coordinating Body (NNCB) and the National Nutrition Technical Committee (NNTC). This governance structure enables leaders from across sectors to discuss strategic directions and planning for nutrition programming in Ethiopia. Yet there is currently no routine monitoring system to track funding available from across sectors towards NNP-II objectives, which restricts the level of information available for strategic planning discussions.

Resource tracking for nutrition across sectors generates data on nutrition funding (i.e., budget allocations and expenditures) which can be used to help build the investment case for nutrition and ensure efficient allocation of resources. However, critical information on how much has been invested for nutrition across sectors and stakeholders, where and what has been targeted (i.e., regions, interventions, etc.), and funding compared to costs (i.e., the potential resource gap) is commonly missing in the discussion of scaling-up nutrition programs in Ethiopia.

It is in this context that the Federal Ministry of Health of Ethiopia (FMoH)—Secretariat to the NNCB—requested collaborative technical support from Results for Development (R4D) to map multi-sectoral nutrition investments in Ethiopia, with financial support from the Children's Investment Fund Foundation (CIFF).

This nutrition resource tracking exercise compiled data on nutrition funding available across sectors in Ethiopia, from both public and external sources. The analysis of funding for nutrition presented here—by nutrition program type, funding channels (i.e., financing sources and recipients), off-budget funding and government-managed funds, NNP-II strategic objective area, and regional nutrition burden—provides information on the nutrition financing landscape that is critical for strategic planning and policy development. The findings from this analysis will feed into discussions by the NNCB, the NNTC and the Nutrition Development Partner Forum (NDPF) to support joint planning.

The FMoH Nutrition Case Team and Resource Mobilization Directorate partnered with R4D to map nutrition stakeholders across sectors and collected data on their nutrition investments. This was done in parallel to Ethiopia's Health Accounts Six (HA VI) exercise by the FMoH for EFY 2006 using the SHA 2011 framework. The SHA captures nutrition spending within the health sector, though there is currently no similar mechanism to track and compile off-budget funding for nutrition in other sectors.

This resource tracking exercise collected nutrition budget and expenditure data from fifty-five development partners—including bilateral organizations, multilateral organizations and international non-governmental organizations (INGOs)—and the thirteen government ministries and agencies that were signatories to the NNP-II. Information was disaggregated by region where possible; however, domestic spending by regional bureaus on nutrition was not available at the national level and data collection did not occur in the regions. Funding data for EFY 2006 to 2007 represent reported expenditures, and funding data for EFY 2008 represent budget allocations.

Nutrition funding for nutrition-specific, nutrition-sensitive, and emergency response programs over time

According to this analysis, expenditures to support NNP-II objectives nearly doubled from $181 million in EFY 2006 to $330 million in EFY 2007. By EFY 2008, budget allocations were reported as $455 million, split across nutrition-sensitive programs ($333 million; 73 percent), nutrition in emergency response programs ($68 million; 15 percent), and nutrition-specific programs ($54 million; 12 percent).

The increase in funding was largely driven by investments in nutrition-sensitive programs over time, including the ONE WASH National Program (which began in EFY 2007) and the Productive Safety Net Program-IV (PSNP-IV). In EFY 2008, the PSNP-IV's nutrition-sensitivity was enhanced by a change in program design that tailored the program more towards nutrition outcomes.

Nutrition-specific expenditures increased from $54 million in EFY 2006 to $69 million in 2007, but in EFY 2008, budget allocations were back to $54 million. The data suggests a decline or perhaps a relative flattening of funding for nutrition-specific interventions over the surveyed years. This trend is partly explained by a few large-scale nutrition programs ramping down in EFY 2008—expected renewals in EFY 2009 were not captured because they were not known or committed at the time of data collection. In general, the findings suggest that funding for nutrition-specific programs represents just a small fraction of total annual nutrition investments relative to other investment areas, and that growth has been slow over time.

In EFY 2008, NNP-II strategic objective 4 (*Strengthen implementation of nutrition-sensitive interventions across sectors*) received the greatest budget support ($320 million; 70 percent). This was followed by strategic objectives 1 and 2 (*Improve the nutritional status of women, adolescents, and children*; $92 million, 20 percent), strategic objective 5 (*Improve multi-sectoral nutrition coordination & capacity to implement NNP*; $36 million, 8 percent), and strategic objective 3 (*Improve nutrition services for communicable & non-communicable/lifestyle related diseases;* $7 million, 2 percent).

In EFY 2008, on average, $31 per child under five was budgeted for nutrition programs across sectors, including nutrition-sensitive programs ($22.7 per child under five), nutrition-specific programs ($3.7 per child under five), and emergency response programs ($4.7 per child under five). Globally, the average allocation for nutrition-specific programs from low-income countries was reported as less than $1 per child under five (Shekar et al., 2017).

Sources and channels of nutrition funding

Most funding for nutrition in Ethiopia was contributed by development partners. In EFY 2008, development partners budgeted $405 million for nutrition programming across all sectors, out of a total $455 million from all financing sources.

In the same year, 70 percent of all funding for nutrition was government-managed ($320 million), but this varies by nutrition program type. Of nutrition-sensitive funding, 83 percent was government-managed, primarily driven by large, multi-donor supported programs managed by the Ministry of Finance and Economic Cooperation such as ONE WASH and PSNP-IV. Of nutrition-specific funding, 45 percent was government-managed, along with 30 percent of emergency response funding.

All other funding was off-budget ($135 million), meaning it was not channeled through public systems. Funds may be reported to the government via the FMoH Resource Mobilization Directorate annual budget monitoring assessment, if programs are delivered in the health sector. However, there is not yet a routine mechanism to track and compile off-budget funding for nutrition across sectors to inform planning and priority setting discussions.

Preliminary assessment of regional nutrition funding

Regional analysis was limited by the level of disaggregation reported directly by respondents. Excluding PSNP and ONE WASH, just 47 percent of all budget allocations in EFY 2008 had regional-level disaggregation reported by respondents; for 31 percent of all budget allocations, regions were known but the breakdown by region was estimated based on assumptions that would have further exaggerated any biases. Therefore, it is difficult to draw any confident conclusions in allocations per region.

In EFY 2008, within the 78 percent of total nutrition funding that could be disaggregated by region (either reported directly, 47 percent, or estimated, 31 percent), it appears that total nominal budget allocations for nutrition were highest in Amhara and Oromia, the two most populous regions. Gambella, Harari, Afar, and Somali regions appear to have received the most budget support for nutrition in EFY 2008 relative to their stunting and wasting burden (i.e., high budget allocation per child under five stunted or wasted), noting that most funding in Gambella was directed towards emergency support programs for refugees. Based on a preliminary assessment, there does not seem to be a high level of targeting based on regional nutrition context. However, data limitations of the current regional analysis

exist and point to the need for further research. This is particularly important for the regions with high burdens that have recently experienced an increase in either stunting or wasting prevalence: Dire Dawa, Harari, Amhara, Benishangul-Gumuz, and Gambella (EDHS, 2016).

Key policy recommendations

This multi-sectoral resource tracking exercise leads to important recommendations for nutrition stakeholders and policy makers in Ethiopia. Two programmatic recommendations are made to support scale-up of the NNP-II. Five recommendations for enhanced resource tracking and systems strengthening are made to help promote data-driven nutrition strategy and coordination discussions.

Programmatic recommendations:

- **Increase investments in nutrition-specific activities** in line with the NNP-II for greater impact on nutrition outcomes. Based on available estimates of resource needs in the NNP-II, costs to scale-up nutrition-specific programs in year one were $124 million, while only $54 million was budgeted in EFY 2008. Findings suggest that the potential resource gap for nutrition-specific programming could be as high as $70 million, or 56% of the total estimated need.
- **Systematically enhance the nutrition sensitivity of programs** in agriculture, education, water and sanitation, and social security sectors by leveraging existing resources. For example, adapt program design to include nutrition goals, activities, and indicators. Great progress has been made to make the PSNP more nutrition-sensitive, and a similar approach can be applied more broadly.

Resource tracking and systems strengthening recommendations:

- **Routinely track resources for nutrition across sectors and stakeholders.** This requires a commitment from all stakeholders to report funding flows on a routine basis for planning purposes.
- Convene nutrition stakeholders, including government and development partners, to **build consensus on ways to identify and track nutrition financing data**; and explore ways to systematically track nutrition investments within their own monitoring systems. For example, decide on a set of nutrition financing indicators to report on annually with the appropriate level of granularity to monitor progress and inform policy.
- **Use multi-sectoral nutrition financing data to support allocative decisions** about human resources, capacity building, and programmatic scale-up, and to shape the nutrition governance agenda. Improved coordination of allocative choices can lead to efficiency gains in multi-sectoral program implementation across stakeholders.
- **Invest in systems strengthening and capacity building** so that routine resource tracking across sectors is conducted sustainably through public systems.
- **Promote sustainable, on-budget financing options for nutrition** with monitoring mechanisms that ensure that funds make it to priority interventions.

1. Introduction

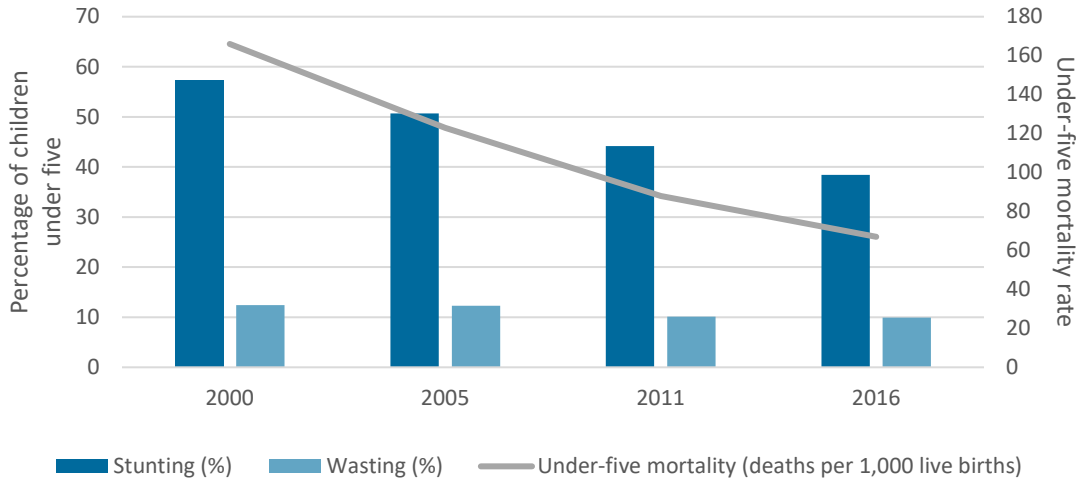
1.1. Nutrition context in Ethiopia

Ethiopia has experienced impressive improvements in child health and nutrition over the last two decades. Between the years 2000 and 2016 (roughly, EFY 1993 to EFY 2009), the prevalence of stunting declined by 33 percent and under-five mortality decreased 2.5-fold (**Figure 1**) (EDHS, 2016). This significant decline in stunting rates is markedly more accelerated than in other African countries, which averaged a decrease of 19 percent over the same period (UNICEF, World Health Organization, and World Bank Group, 2017). In addition to improvements in child nutrition, anemia rates in Ethiopia have been improving, with the percentage of women with anemia decreasing from 27 in 2005 to 23 percent in 2016 (EDHS, 2016).

Ethiopia's gains in child health and nutrition are to be applauded. However, rates of chronic malnutrition are still high, with the prevalence of stunting at 38 percent of children under five and the prevalence of wasting hovering at about 10 percent since 2011 (EDHS, 2016). These rates are higher than the regional Africa average of 31 percent stunting prevalence and 7 percent wasting prevalence (UNICEF, World Health Organization, and World Bank Group, 2017). Improvements in nutrition are necessary for child health, as nutritional deficiencies are among the five greatest causes of death among children under five in Ethiopia (IHME, 2015).

Table 1 presents stunting and wasting prevalence by region based on the most recent national DHS data. Four regions have stunting burdens with very high severity (over 40 percent prevalence among children under five) and two regions have wasting burdens with very high severity (over 15 percent prevalence among children under five). In Afar, both stunting and wasting burdens are very high.

Figure 1: Improving health and nutrition indicators in Ethiopia (2000–2016)



Source: EDHS 2000–2016. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ICF International, 2016.

Table 1: Stunting and wasting prevalence by region (2016, percent of children under five)

Region	Stunting burden severity (%)	Wasting burden severity (%)
Amhara	Very high (46.3%)	High (9.8%)
Benishangul-Gumuz	Very high (42.7%)	High (11.5%)
Afar	Very high (41.1%)	Very high (17.7%)
Dire Dawa	Very high (40.2%)	High (9.7%)
Tigray	High (39.3%)	High (11.1%)
SNNPR	High (38.6%)	Medium (6.0%)
Oromia	High (36.5%)	High (10.6%)
Harari	High (32.0%)	High (10.7%)
Somali	Medium (27.4%)	Very high (22.7%)
Gambella	Medium (23.5%)	High (14.1%)
Addis Ababa	Low (14.6%)	Low (3.5%)
National average	**High (38.4%)**	**High (9.9%)**

Sources: EDHS 2016; WHO classification for assessing severity of malnutrition by prevalence ranges among children under 5 years of age.

NOTE: Threshold was applied to rounded prevalence numbers (i.e., 9.8% rounded to 10%, as high severity). Legend, defining the severity grades for stunting and wasting by WHO:

Severity	Stunting threshold	Wasting threshold
Very high	Equal to or over 40%	Equal to or over 15%
High	30-39%	10-14%
Medium	20-29%	5-9%
Low	Less than 20%	Less than 5%

Child nutrition has improved in many regions over time, including Somali and Afar—the two regions with the highest wasting rates. **Annex B** shows the change in stunting and wasting prevalence by region between 2014 and 2016 (Gregorian).

Somali experienced the largest reduction in stunting compared to all other regions between 2014 and 2016, where stunting rates declined from 37 percent to 27 percent (25 percent decline). Wasting also improved, where rates declined from 28 percent in 2014 to 23 percent in 2016 (17 percent decline).

Afar experienced the largest decline in wasting compared to all other regions between 2014 and 2015, where wasting rates declined from 25 percent to 18 percent (28 percent decline). Stunting also improved, where rates declined from 46 percent to 41 percent (11 percent decline).

Although malnutrition rates in Afar and Somali remain at a very high severity, reductions in stunting and wasting are moving in the right direction. However, five regions experienced an increase in stunting prevalence between 2014 and 2016 (**Annex B**): Dire Dawa, Harari, Amhara, Benishangul-Gumuz and Gambella. Four regions experienced an increase in wasting prevalence between 2014 and 2016: Harari, Oromia, Amhara, and Addis Ababa. Strikingly, Harari and Amhara experienced an increase in both stunting and wasting over the two-year period.

National strategy discussions require information on regional nutrition indicators to monitor context. As important to these discussions is information on what is currently being done to improve nutrition (i.e., coverage of programs and interventions) and funding being channeled to support nutrition programs. However, as discussed in the following sections, there are data gaps to compiling this information from across sectors.

1.2. Ethiopia's commitment to ending undernutrition

Improving the nutritional status of citizens has the enormous potential to save lives as well as strong potential for economic gains and productivity. The 2013 Cost of Hunger in Africa study in Ethiopia estimated that malnutrition cost the economy $4.8 billion USD (55.5 billion ETB) in 2009 from absenteeism, reduced physical capacity, and increased health care costs, representing 16.5 percent of Gross Domestic Product (GDP) (World Food Programme, 2013). Conversely, investing in nutrition can have a massive return on investment—compared to other global health interventions, nutrition interventions are consistently named as highly cost-effective by the Copenhagen Consensus (Copenhagen Consensus, 2014). Studies by the World Bank in the Democratic Republic of Congo, Mali, and Nigeria show that stunting reduction interventions could generate a 13 to 18 percent return on investment (Shekar et al., 2015a; Shekar et al., 2015b; Shekar et al., 2015c).

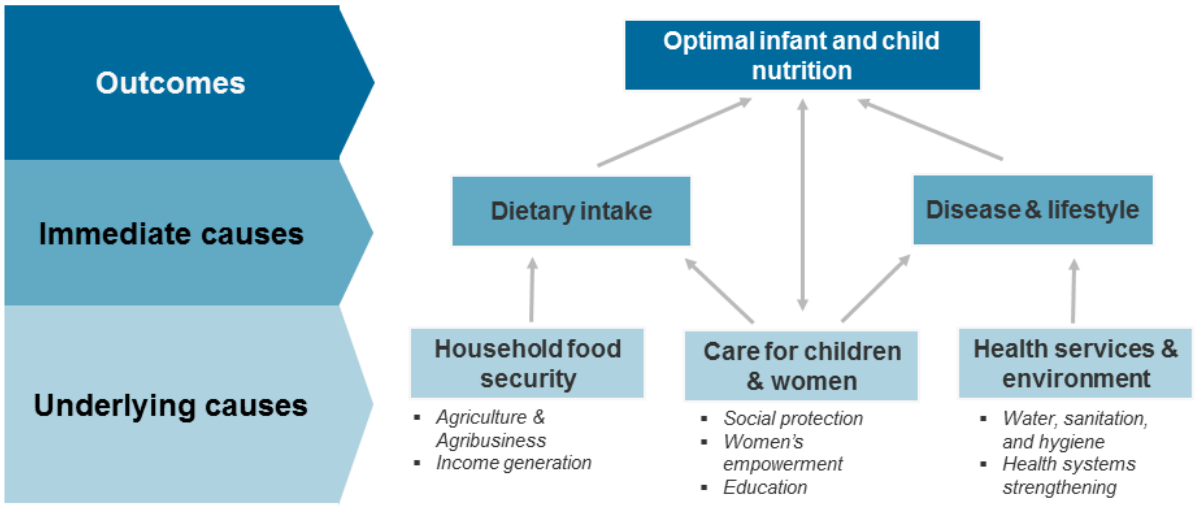
The Government of Ethiopia made a strong commitment to end undernutrition by 2030 through the Seqota Declaration. The Seqota Declaration builds on and supports implementation of the National Nutrition Program 2016–2020 (NNP-II), which is a multi-sectoral strategy with a life cycle approach to improving maternal and child nutrition. The NNP-II sets national goals, objectives, and targets for nutrition and outlines a set of evidence-based interventions to achieve those targets.

The NNP-II recommends scaling-up direct, nutrition-*specific* interventions, which are interventions that address the immediate causes of nutrition and child development—such as micronutrient supplementation and fortification; the treatment and management of acute malnutrition; counseling mothers on optimal infant and young child feeding behaviors; and breastfeeding promotion (**Figure 2**) (UNICEF, 2008). In parallel, the NNP-II recommends the scale-up of nutrition-*sensitive* programs across sectors, which are interventions that address the underlying causes of nutrition and child development—such as food security and dietary diversity; social protection; adequate caregiving resources at the maternal, household and community levels; health and nutrition education; access to health services; and access to clean water and a safe and hygienic (Federal Democratic Republic of Ethiopia, 2016). Incorporating nutrition goals and actions into existing programs across sectors could enhance the nutrition sensitivity of the program and the overall likelihood of improving nutrition outcomes (Ruel et al., 2013).

A multi-sectoral approach is necessary to improve nutrition in all its forms. To this end, thirteen Ethiopian government ministries and agencies are signatories to the NNP-II.[1] Governance, communication, and coordination between ministries are supported by the National Nutrition Coordinating Body (NNCB) and the National Nutrition Technical Committee (NNTC). This governance structure is in place for sectors to discuss strategic directions and planning for nutrition programming in Ethiopia.

Despite astounding achievements in nutrition and clear commitment to a multi-sectoral approach to nutrition programming, the Government of Ethiopia does not yet have adequate data on nutrition funding (i.e., budgets and expenditures) across all sectors and stakeholders. This information is critical for policy and planning to ensure optimal allocation of funds towards NNP-II objectives. Currently, there is no mechanism to gather and consolidate nutrition funding data across sectors, and a lack of information on off-budget nutrition programs, especially those outside of the health sector. Equally, a comprehensive map of nutrition stakeholders working across sectors on interventions in line with the NNP-II is not updated routinely.

Figure 2: UNICEF Conceptual Framework for nutrition showing a multi-sectoral approach



Source: Adapted from UNICEF Conceptual Framework (2008). Retrieved from http://www.unicef.org/nutrition/training/2.5/4.html

[1] Ministry of Health (MoH); Ministry of Agriculture and Natural Resources (MoANR); Ministry of Water, Irrigation, and Electricity (MoWIE); Ministry of Education (MoE); Ministry of Industry (MoI); Ministry of Finance & Economic Cooperation (MoFEC); Ministry of Livestock and Fishery Resource Development (MoLFR); Ministry of Trade (MoT); Ministry of Women and Children Affairs (MoWCA); Ministry of Labour & Social Affairs (MoLSA); Ministry of Youth and Sport (MoYS); National Disaster Risk Management Coordination Commission (NDRMCC); and the Federal Government Communication Affairs Office.

1.3. Purpose of this nutrition resource tracking exercise

Key Questions:

1. *What are the historical trends in nutrition funding, by intervention area, and what can we expect moving forward?*
2. *How much was spent on high impact, nutrition-specific programs?*
3. *How much was spent on nutrition within multi-sectoral nutrition-sensitive programs?*
4. *Were investments targeted towards NNP-II objectives?*

In order to describe the financing landscape for nutrition in Ethiopia, the Federal Ministry of Health, acting as Secretariat of the NNCB and NNTC, requested collaborative technical support from Results for Development (R4D) to track multi-sectoral nutrition investments in Ethiopia, with financial support from the Children's Investment Fund Foundation (CIFF). This resource tracking effort was done in parallel with Ethiopia's Health Accounts Six (HA VI) exercise by the FMoH for EFY 2006—which tracked health expenditures using the SHA 2011 framework—and expanded upon it to capture nutrition investments across sectors at the intervention level. The scope was to track funding associated with interventions that are meant to improve nutrition for women, children and adolescent girls in Ethiopia, based on the NNP-II framework.

The overarching objective of this work was to generate information to support policy development, planning and allocative decisions for nutrition across all stakeholders and sectors in Ethiopia. Information on the financing landscape for nutrition can help improve joint planning with and among development partners and the Government of Ethiopia; it can enhance advocacy and resource mobilization efforts for nutrition; and it can improve allocative efficiencies by targeting funding to the highest impact interventions to areas most in need.

This report documents previous and ongoing nutrition resource tracking efforts in Ethiopia, describes the approach undertaken in the current exercise to capture nutrition funding information across sectors, presents the findings from the analysis, and discusses policy recommendations to improve the tracking and targeting of nutrition funding in Ethiopia in line with government priorities.

2. Resource tracking in Ethiopia

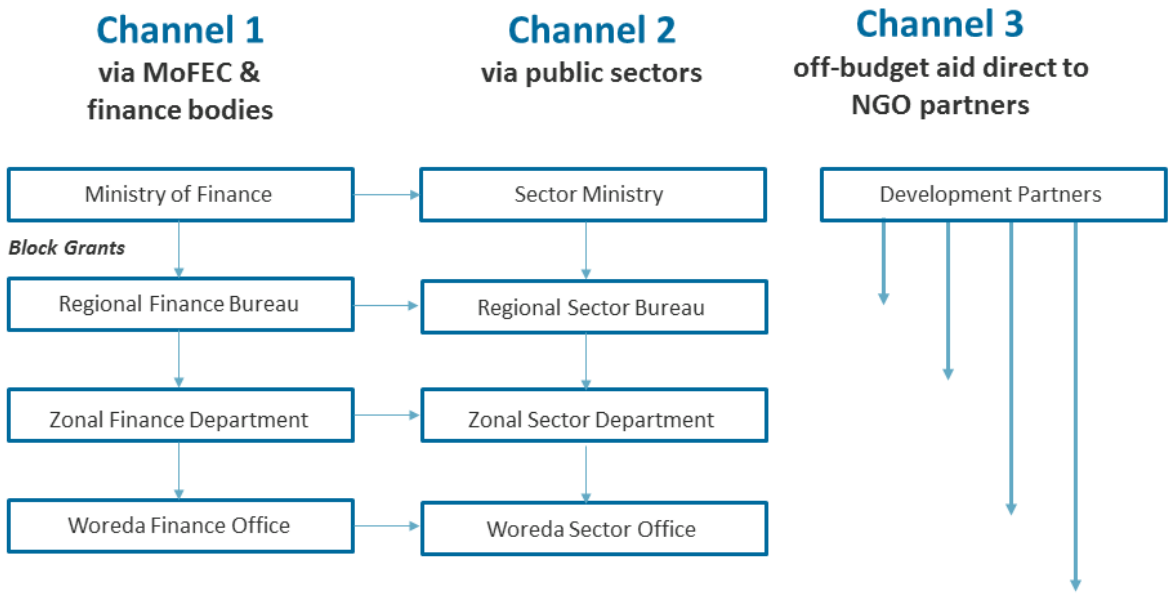
2.1. Funding aid modalities

Ethiopia's Health Sector Development Program IV (2010/11 to 2014/15) identifies three aid modalities through which funding can be channeled by development partners: via the Ministry of Finance and Economic Cooperation (Channel 1), via sectoral line ministries (Channel 2), or directly to non-governmental organizations (NGOs) without government management (Channel 3) (Federal Democratic Republic of Ethiopia, 2010). Each channel is described in **Table 2** (Alemu, 2009; International Health Partnership, 2013; Prizzon and Rogerson, 2013). Given that Ethiopia is a federal state, these aid modalities also exist at all subnational levels, including the federal, regional, zonal and woreda levels, as illustrated in **Figure 3**.

Table 2: Description of funding channels in Ethiopia

Funding channel	Description	Examples	Implications for aid coordination
Channel 1	Funding flows are channeled through the Ministry of Finance and Economic Cooperation (MoFEC), including its regional, zonal and woreda-level subdivisions. Channel 1 funding can be categorized as **1A** (non-earmarked) and **1B** (earmarked).	» Direct budget support from a donor **(Channel 1A)** » PSNP and ONE WASH programs **(Channel 1B)**	On-budget and managed by the government.
Channel 2	Public sector budget support and block grants. Development partners bypass MoFEC and instead disburse funds directly to sector ministries, e.g., the Ministry of Health, including its regional, zonal or woreda-level subdivisions. Channel 2 funding can be categorized as **2A** (non-earmarked) or **2B** (earmarked).	» Millennium Development Goal (MDG) Pooled Fund within the FMoH **(Channel 2A)** (IHP+, 2015) » Funding from UNICEF to the FMoH for specific program implementation **(Channel 2B)**	Investments are government-managed, and sector ministries report funding flows to MoFEC. However, there may be risk for inconsistent reporting between sectors.
Channel 3 (off-budget)	Funding that is outside of the government financial management system. Development partners implement projects directly with non-governmental partners (i.e., funding is channeled from development partners directly to NGOs).	» Development partner funding channeled directly to a local NGO for implementation » USAID's direct funding to international and local NGOs for the PSNP-IV, outside of the pooled funding mechanism managed by MoFEC	These investments are considered off-budget. In these cases, the government may have visibility into the use of funds, but only when they are reported directly by partners through public reporting systems. This is often done sectorally.

Figure 3: Funding channels in Ethiopia



Source: Figure adapted from Development Cooperation Ireland. 2005. *Aid Modalities in Ethiopia.*

The Government's preferred aid modalities are through either Channel 1 or Channel 2—sector budget support and block grant (Federal Democratic Republic of Ethiopia Ministry of Health, 2015; IHP+, 2015). In 2007, Ethiopia joined the International Health Partnership (IHP+), now known as IHP for Universal Health Coverage (UHC) 2030, which is an initiative to translate the Paris Declaration on Aid Effectiveness into practice in the health sector. In Ethiopia, IHP+ signatories, which included the Ministry of Health, Ministry of Finance, and thirteen development partners (IHP+, n.d.), committed to support a single country-led national health strategy moving towards the use of public systems (UHC 2030, 2017). Adherence to a one-plan, one-budget structure involves development partners sharing information about plans and budgets with the government, and monitoring commitments according to jointly agreed indicators.

Through IHP+, Ethiopia has assessed opportunities for, and obstacles to, having development assistance for health on-budget and channeled through government systems (IHP+ Results, 2014; IHP+ Results, 2016). Increasing on-budget support can help build capacity of public systems. However, a 2016 IHP+ Monitoring Report cited a series of limitations to increasing on-budget assistance, as identified by development partners, including: weak coordination and monitoring of Channel 2 funds by MoFEC; absence of sufficient financing mechanisms within the FMoH, particularly for the nutrition program; the policy of some development partners to require a set proportion of funding to be directed to non-governmental implementing agencies; Ethiopia's use of a different calendar year; unpredictability of the exact funding basket of some development partners; and the lack of a transparent national budget with partners, against which all players report routinely and which is publicly available (IHP+ Results, 2016).

2.2. Mechanisms to track off-budget funding for nutrition in Ethiopia to date

Without a consolidated financial database of all nutrition budget allocations and expenditures across sectors, capturing off-budget (or Channel 3) development assistance requires data collection. To date, there are three examples of efforts to track nutrition funding from development partners, as listed below. The current analysis builds on these efforts by capturing data with a higher degree of disaggregation across sectors, and including on- and off-budget support.

i. Nutrition Stakeholder Mapping, 2013–2015

In 2014, an analysis led by the FMoH, with technical support from Renewed Efforts Against Child Hunger and undernutrition (REACH), produced a Nutrition Stakeholder Mapping, 2013–2015 (Federal Ministry of Health and REACH, 2014). The aims of the study were to identify and document stakeholder activities in nutrition programming in order to assess gaps and overlaps in intervention coverage. Data on program coverage and funding (budget allocations only) were captured through an Excel-based survey tool. Results from the study accounted for 40 organizations that were involved in nutrition in Ethiopia between 2013 and 2015, including 32 organizations with active nutrition programs. However, it was noted in the limitations that some organizations—especially those that were only implementing nutrition-sensitive interventions—were not covered by the mapping exercise. For this reason, this exercise likely underestimated funding and potential gaps in funding for nutrition-sensitive programs.

Other countries in the REACH partnership have undertook a nutrition stakeholder mapping to collect budgetary information using this method, including Tanzania and Uganda (WHO, 2014). All countries have reported similar challenges regarding limited access to financial data by nutrition intervention (WHO, 2014).

ii. FMoH Annual Resource Mapping

The FMoH Resource Mobilization Directorate conducts an annual resource mapping exercise using the Clinton Health Access Initiative (CHAI) Resource Mapping Tool. This exercise captures annual development partner health program budget allocations aligned with the five-year Health Sector Transformation Plan (HSTP).[2] The information from this routine mapping exercise is used to produce a gap analysis, meant to identify and utilize all possible sources of financing and helps ensure a continuous flow of health program funding. In 2016, additional intervention-level details on nutrition budget allocations were included in this exercise.

This exercise is valuable for planning and coordination, though it is limited to only capturing budget information (i.e., intended commitments that may, or may not have, been disbursed and spent). In EFY 2007, 40 percent of the annual health sector budget was under-disbursed (IHP+ Results, 2016). As such, budget allocation information alone may be an overestimate of funding available in the health sector. According to the FMoH, the main reasons for under-disbursement of funds in the health sector included: some development partners disbursing less than what was pledged or budgeted; delayed receipt of funding from development partners; and discrepancies in budget versus actual spending, especially for capital expenses (IHP+ Results, 2016).

[2] Respondents include development partners working in the health sector only.

For the purpose of tracking funding for nutrition, this resource mapping exercise is limited by scope, as it does not include information on nutrition spending by development partners outside of the health sector. These contributions are important for planning, given the multi-sectoral nature of nutrition programming.

iii. Nutrition expenditures through the System of Health Accounts

In 2016, Ethiopia conducted its Sixth Health Accounts exercise using the System of Health Accounts (SHA 2011) framework to track expenditures within the health sector for EFY 2006 (OECD, Eurostat, WHO, 2011). Based on the SHA 2011 framework, health expenditures can be analyzed by beneficiary characteristics such as age and gender, type of disease or condition, socioeconomic status, etc. Within the SHA 2011 framework, considerable work has been done in recent years to estimate health expenditures by type of disease or condition by classifying them under the following categories: infectious and parasitic diseases (DIS.1), reproductive health (DIS.2), nutritional deficiencies (DIS.3), non-communicable diseases (DIS.4), injuries (DIS.5), and non-disease specific (DIS.6).[3]

Within the health sector, nutrition interventions can be delivered through direct nutrition programs (i.e., where the primary objective of the program is to improve nutrition, such as community based management of acute malnutrition), or integrated through wider maternal and child health programs or infectious disease programs (e.g., nutrition interventions included as part of antenatal care and reproductive health, or nutrition interventions included as part of HIV treatment programs). This distinction between direct nutrition programs and integrated nutrition programs is important for resource tracking within the SHA framework, as described below.

To avoid double counting, the SHA only allows for one disease code to be applied to each transaction. Therefore, in practice, the code for nutritional deficiencies (DIS.3) mainly captures expenditures for direct nutrition interventions as stand-alone programs versus expenditures for nutrition interventions integrated within wider maternal and child health or other programs. Integrated programs are likely given the predominant disease code (i.e., for reproductive health or infectious disease, etc.).

To capture those nutrition expenditures that cut across disease codes (i.e., integrated programs), a healthcare function classification for nutrition can be applied. The “nutritional information, education, and communication (IEC)” code, known as (HC.6.1.2), exists in the SHA coding framework for this purpose.

A limitation of the SHA coding framework is that nutrition interventions that are integrated into wider disease programs can be aggregated into their respective, non-nutrition, disease codes (i.e., reproductive health, infectious disease, etc.), and, if not captured by the nutrition IEC healthcare classification code, they are not counted as nutrition spending. For example, a preventative intervention such as prophylactic zinc for the prevention of diarrhea may be more naturally coded under the disease code for infectious diseases, rather than nutritional deficiencies. Given that zinc provision is not an IEC activity (and is therefore not captured by the only other nutrition code, HC.6.1.2), the investment is not coded as nutrition and the activity is lost in aggregation during data analysis.

[3] Note that sub-categories exist within each of these disease categories.

The SHA coding framework enables the SHA to be internally consistent and comparable, while also avoiding double counting. However, it likely underestimates nutrition spending by missing nutrition expenditures integrated into broader health programs. In addition, it does not capture nutrition spending outside of the health sector,[4] which this exercise found to be a substantial contribution to total nutrition spending.

[4] In the analysis of health accounts (HA) the aim is to track all health expenditures from all entities. The guiding principle to account spending as within the health sector is based on the primary purpose of the particular investment, regardless of who spent it across all sectors. If the nutrition expenditure is considered a health investment, it should be captured in HA analysis whether it is outside of the health sector or not. However, many nutrition-sensitive investments are typically not considered a health investment; rather, investment in support of the enabling environment for nutrition.

3. Methodology

3.1. Scope and definitions

This multi-sectoral resource tracking exercise aimed to collect on- and off-budget funding data (budget allocations and expenditures) for all nutrition activities in Ethiopia within the NNP-II, including both public revenue and external sources of funding. Private sector contributions to nutrition were not collected, nor were out-of-pocket payments individual persons might have made for their nutritional needs. Data collection for these sources was outside the scope of this exercise and assessment of contributions from these sources to nutrition will draw from the forthcoming Ethiopia Health Accounts VI report. The scope and methodology of this exercise were designed with guidance and leadership from the FMoH.

Respondents were asked to report funding data (i.e., budgets and expenditures) in Ethiopian Fiscal Years (EFY) (**Table 3**). Data collected for EFY 2006 and 2007 represent expenditures; and data collected for EFY 2008 represent budget allocations.[5] Data collection took place towards the end of EFY 2008 when expenditure data was still unavailable for that fiscal year. Data on *both* expenditures and budgets were not collected for any given year due to the substantial increase in reporting burden associated with collecting both data points for every year. Because both data points were not collected for a given year, a comparison on what was budgeted versus what was spent (i.e., utilization rates) cannot be made.

Table 3: Ethiopian Fiscal Year calendar

Ethiopian Fiscal Year (EFY)	Corresponding Gregorian Year
2006	8 July 2013–July 7 2014
2007	8 July 2014–July 7 2015
2008	8 July 2015–July 7 2016

[5] Participants were asked to report budget allocations for EFY 2008-2010. However, most respondents did not provide budget data for EFY 2009 and 2010, making those data years incomplete; as such, results presented here are only for EFY 2006–2008. Compared to EFY 2008, 23% fewer organizations reported budget data for EFY 2009, and 62% fewer organizations reported budget data for EFY 2010. The challenge of development partners not being able to submit onward-looking plans for available funding for three years has been previously documented in the health sector (UHC 2030, 2017).

Nutrition program types included nutrition-specific, nutrition-sensitive, and emergency response programs for nutrition.

Inclusion criteria for nutrition-sensitive programing was adopted from the Scaling Up Nutrition (SUN) Donor Network methodology (SUN Movement, 2013). To be nutrition-sensitive, the actions must have fulfilled **all** of the following criteria:

A. The actions must intend to improve nutrition for women or adolescent girls or children. This does not necessarily entail targeting only to women or children because actions targeted at households, communities or nations can also be designed to result in improved nutrition for women and children. It entails, though, an intention to achieve results and measure them at the level of women, adolescent girls or children.

AND

B. The project has a significant nutrition objective **OR** nutrition indicator(s); the objective must go beyond just mentioning nutrition and aim to take action(s) to improve nutrition.

AND

C. The project must contribute to nutrition-sensitive outcomes, which are explicit in the project design through activities, indicators and specifically the expected results themselves.

For nutrition-sensitive programs, this resource tracking exercise aimed to quantify investments towards discrete nutrition activities and components built within the program. Like other global and country-level analyses (Fracassi and Picanyol, 2016; SPRING 2015), this exercise aimed to capture the proportion of the program that can be considered nutrition to avoid overestimation of nutrition funding across sectors.[6] For example, an agriculture extension program that includes a capacity building component to train Agriculture Development Agents on food-based nutrition would be considered nutrition-sensitive; investments towards the nutrition capacity building component would be included in this resource tracking exercise rather than total program funding. As described below, if financial records did not have data on budget or expenditures by that particular component, it was approximated by program managers based on guidance from data collectors.

3.2.Stakeholders that participated in the exercise

A list of nutrition stakeholders in Ethiopia was compiled that included donor institutions, non-governmental implementing agencies, and government ministries that invest in nutrition across sectors. Core background documents were reviewed, including the FMoH and REACH Nutrition Stakeholder Mapping 2013–15, the Transform Nutrition Ethiopia Stakeholder Mapping Report 2015, and UNICEF's Situation Analysis of the Nutrition Sector in Ethiopia 2000–2015 (Federal Ministry of Health and REACH, 2014; Transform Nutrition, 2015; Federal Ministry of Health et al., 2016). This list was triangulated with any additional development partners that reported disbursements or commitments to Ethiopia for nutrition through the Organisation for Economic Co-operation and Development (OECD) Creditor Reporting System or the NGO Aid Map database. This list of stakeholders was validated with the FMoH Nutrition Case Team and senior advisors.

[6] Scaling Up Nutrition Movement guidelines on country budget analysis refer to this step as applying a 'weight': "attribute a percentage of the allocated budget to nutrition [based on] a judgement call by national experts" (Fracassi and Picanyol, 2016).

All government ministries and agencies that were signatories to the NNP-II and were implementing or planned to implement nutrition programs at the time of data collection were included: the Ministry of Health (MoH); Ministry of Agriculture and Natural Resources (MoANR); Ministry of Water, Irrigation, and Electricity (MoWIE); Ministry of Education (MoE); Ministry of Industry (MoI); Ministry of Finance & Economic Cooperation (MoFEC); Ministry of Livestock and Fishery Resources Development (MoLFR); Ministry of Trade (MoT); Ministry of Women and Children Affairs (MoWCA); Ministry of Labour & Social Affairs (MoLSA); Ministry of Youth and Sport (MoYS); National Disaster Risk Management Coordination Commission (NDRMCC); and the Federal Government Communication Affairs Office.

3.3. Data collection and data management

This resource tracking exercise was aligned with Ethiopia's sixth Health Accounts (HA VI) exercise which employed the SHA 2011 framework, led by the Resource Mobilization Directorate of the FMoH.[7] At the inception phase of this work, data collection for the HA VI was underway to track EFY 2006 expenditures in the health sector. The HA VI Excel-based survey tool was adapted to capture more detailed information for nutrition. Because the nutrition exercise goes beyond the health sector, the changes made to the SHA survey tool drew inspiration from National AIDS Spending Assessment (NASA) guidelines and tools, which also capture information beyond the health sector (UNAIDS, n.d.; Federal HIV/AIDS Prevention and Control Office, 2013).

Data were collected through interviews with respondents from participating institutions in the stakeholder list mentioned above. The exercise garnered a high response rate from development partners. Of the 82 donors and implementing agencies requested to participate,[8] 55 organizations (67 percent) reported data on nutrition investments and 14 organizations (17 percent) reported no investments in nutrition (**Table 4**). The remaining 13 organizations (16 percent) did not respond to the survey. All 13 NNP-II government signatories responded to the survey. Seven ministries and agencies (54 percent) provided funding data; other ministries reported forthcoming plans but were not able to provide nutrition funding data. See **Annex A** for a list of all participating organizations and institutions.

Interviewers used a structured Excel-based questionnaire with mostly close-ended questions to collect data. Respondents were asked to 1) identify any interventions their institution supports financially from a list of nutrition-specific and nutrition-sensitive interventions based on the NNP-II (**Annex C**); and 2) report budget allocation and expenditure data for all identified interventions within the surveyed years. A trained data collection team based in Addis Ababa visited participating institutions and provided guidance to respondents on how to report funding data when no discrete budget line for nutrition was available.

[7] Public contributions to nutrition from the health sector drew from the HA IV analysis.

[8] These 82 stakeholders represent a complete list of stakeholders that invest in nutrition that the MOH is aware of based on previous stakeholder assessments (as indicated above in section 3.2). The aim was to get as close to a census as possible, however it is possible that some stakeholders are missing from the list if not captured by the above-mentioned sources.

Completed surveys were quality checked to ensure consistency and completeness. The data collection team followed up with participants to resolve any missing data or ambiguities, as needed. All data was compiled and consolidated in a master database. Investments between donor institutions and implementing organizations were matched to re-create full financial transactions, to prevent double-counting and to ensure the matching investment was only counted once. When a matching transaction was found, the information reported by the implementing partner was used, under the assumption that the implementing partner is closer to the point of service delivery and is therefore more likely to have accurate and detailed data on how the funds were used.[9] Bilateral flows to multilateral organizations were also matched. Double-counting between bilateral and multilateral flows was avoided by only including multilateral-reported investment data when the original source could not be identified (i.e., multilateral-reported investment data were treated as their total "universe" of funding).[10]

Stakeholders reviewed and validated summary profiles of how their investments had been captured in the consolidated dataset prior to finalizing the analysis. Revisions were made where necessary.

Table 4: Development partner response rates

Type of institution	Reported investments in nutrition, N (%)	Reported no investments in nutrition, N (%)	No response, N (%)	Total, N (%)
Donors (bilaterals, multilaterals, and foundations)	21 (60%)	10 (29%)	4 (11%)	35 (100%)
Implementing agencies	34 (72%)	4 (9%)	9 (19%)	47 (100%)
Total N (%)	55 (67%)	14 (17%)	13 (16%)	82 (100%)

NOTE: Percentages are reported as row percentages. See **Annex A** for a list of all participating organizations and institutions.

[9] We assumed this to be true for both budget and expenditure data.

[10] Due to the pooled financing structure of some multilaterals where contributions are aggregated together (i.e., the sources not identified), it was not always possible to identify cases of double-counting. A conservative approach was taken by only including multilateral-reported data for matched transactions.

3.4. Exchange rates

Data is reported in United States Dollars (USD). All reported currencies were standardized to USD and Ethiopian Birr (ETB). The end period mid-market exchange rates as reported by the National Bank of Ethiopia's 2015/2016 annual report were used (**Table 5**). Inflation adjustments were not applied to the nominal figures.

Table 5: USD exchange rates

	EFY 2006	EFY 2007	EFY 2008
Ethiopian Birr (ETB)	0.051	0.048	0.046
Canadian Dollar (CAD)	0.935	0.809	0.770
Great British Pound (GBP)	1.702	1.570	1.343
Euro (EUR)	1.362	1.111	1.108
Japanese Yen (JPY)	0.010	0.008	0.010
US Dollar (USD)	1	1	1

Source: National Bank of Ethiopia's 2015/2016 annual report.

4. Results

4.1. Funding for nutrition across sectors by program type and intervention, all sources

All figures and tables show data for EFY 2006 and 2007 as reported expenditures and for EFY 2008 as budget allocations.

Between EFY 2006 and 2007, total expenditures for nutrition programs across sectors increased from $181 million to $330 million, including combined government and development partner contributions (**Figure 4**). By EFY 2008, annual budget allocations for nutrition were reported as $455 million. Most of this nearly three-fold increase over three years was due to two national programs supporting the enabling environment for nutrition. First, the ONE WASH National Program, which promotes good hygienic practices that are critical to nutritional status, began in EFY 2007 (**Box 1**). Second, programmatic changes to the Productive Safety Net Program (PSNP-IV) in EFY 2008 made it more nutrition-sensitive by including pulses in the food/cash transfer component to promote dietary diversity and by encouraging PSNP-IV beneficiaries to attend behavior change communication sessions delivered through the Health Extension Program. These changes led to a significant increase in the amount considered as nutrition funding over the study period (**Box 2**).

Figure 4: Nutrition funding in Ethiopia by program type/intervention from public and development partner sources across sectors
(EFY 2006–2008, USD millions)

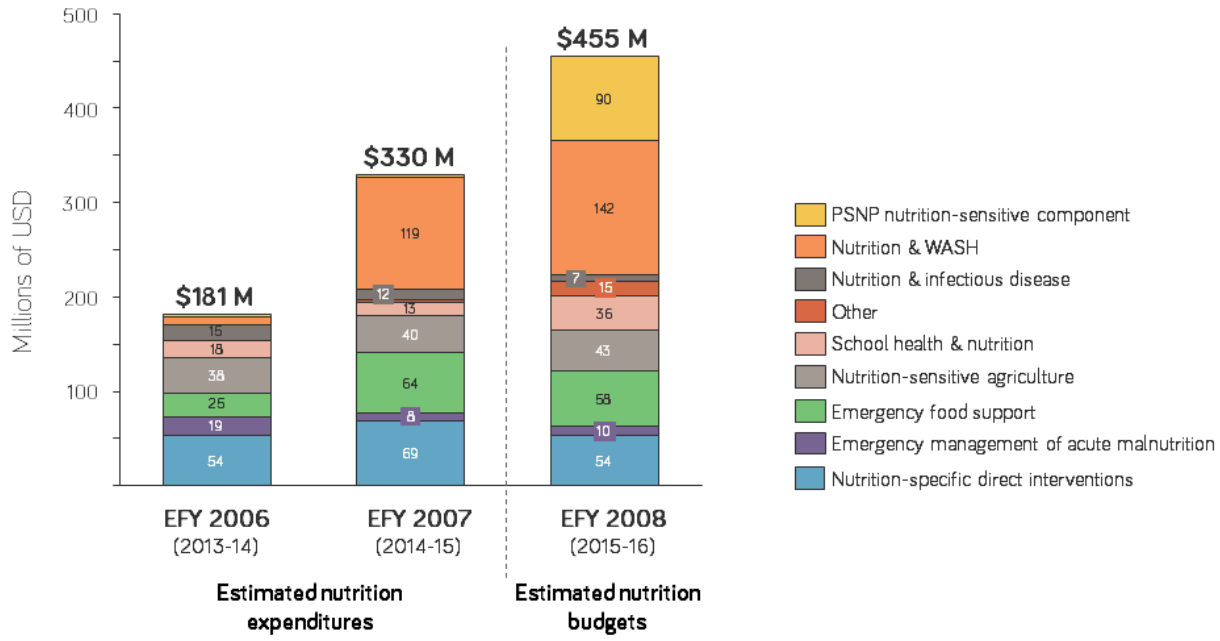


Table 6 shows the breakdown of nutrition funding by nutrition-sensitive, nutrition-specific, and emergency response program types across years.

In aggregate, expenditures for nutrition-sensitive programs grew from $84 million in EFY 2006 to $189 million in EFY 2007 (126 percent increase), and budget allocations were reported as $333 million for EFY 2008 (**Table 6**). The increase between EFY 2006 and 2007 is mainly due to the ONE WASH program, but also includes a modest increase in nutrition-sensitive agriculture, which grew from $38 million to $40 million (5 percent increase).

Some nutrition-sensitive programs saw a decrease in funding over the period. Expenditures for nutrition within infectious disease programs (i.e., community-based nutrition assessment, counseling and support [NACS] services for people living with HIV and other infectious diseases) decreased from $15 million in EFY 2006 to $12 million in EFY 2007 (24 percent decrease). Expenditures for school health and nutrition (including school feeding) decreased from $18 million in EFY 2006 to $13 million in EFY 2007 (25 percent decrease); however, budget allocations for this intervention were planned as $36 million in EFY 2008. In EFY 2008, the Government of Ethiopia budgeted for enhanced funding support to the school feeding program in response to the drought crisis that year (Humanitarian Response, 2017),[11] contributing to this increase in funding support to school health and nutrition.

Total nutrition expenditures directed towards emergency response programs—including emergency food support and emergency management of acute malnutrition—grew from $44 million in EFY 2006 to $72 million in EFY 2007 (64 percent increase).

Expenditures for direct, nutrition-specific programs grew from $54 million in EFY 2006 to $69 million in EFY 2007 (28 percent increase). Within nutrition-specific expenditures, funding for the management of acute malnutrition represented 24 percent of total expenditures in EFY 2006 and 26 percent in EFY 2007. In EFY 2008, budget allocations for all nutrition-specific interventions were reported as $54 million (22 percent lower than EFY 2007 expenditures). Given the nature of this exercise, a one-to-one comparison between EFY 2007 and 2008 cannot be made because the years represent different data points (expenditures and budgets, respectively); however, the trend indicates a potential reduction in the amount of funding for these programs. In general, nutrition-specific investments make up a relatively small proportion of total annual funding for nutrition.

[11] As of December 2016, the Government of Ethiopia allocated more than $735 million to respond to the drought crisis out of a total of $1 billion raised from all sources for all sectors (including agriculture, food support, WASH, etc.), as reported by the 2017 Ethiopia Humanitarian Requirements Document.

Table 6: Nutrition funding in Ethiopia by program type and intervention from public and development partner sources across sectors
(EFY 2006–2008, USD millions)

	Expenditures		Budgets
Activity	**EFY 2006**	**EFY 2007**	**EFY 2008**
Nutrition-sensitive	**$83.6**	**$188.7**	**$333.1**
Nutrition & Water, hygiene & sanitation (WASH)	$8.5	$118.7	$142.2
PSNP nutrition component	$3.1	$2.9	$89.7
Promotion of nutrition-sensitive agriculture and food security	$37.9	$39.7	$43.0
School health & nutrition	$17.6	$13.3	$36.4
Other nutrition-sensitive	$1.0	$2.5	$14.7
Nutrition & infectious diseases	$15.4	$11.6	$7.0
Emergency response	**$43.8**	**$71.7**	**$68.3**
Emergency assistance (food support and resources)	$25.1	$63.9	$58.4
Management of acute malnutrition (emergency)	$18.7	$7.8	$9.9
Nutrition-specific	**$54.1**	**$69.4**	**$53.7**
Capacity building for nutrition	$8.7	$20.8	$18.8
Behavior change communication (BCC) & breastfeeding promotion	$7.9	$8.2	$11.0
Research, knowledge management and data for decision making	$16.6	$14.1	$9.0
Management of acute malnutrition (non-emergency)	$13.2	$17.8	$6.8
Micronutrients	$4.5	$5.7	$3.4
Support for the implementation of multi-sectoral nutrition actions at national and sub national levels	$1.7	$1.8	$2.0
Growth monitoring and promotion (GMP)	$0.8	$0.4	$1.4
Advocacy for nutrition	$0.7	$0.4	$1.1
Integrated package of nutrition interventions	$0.1	$0.1	$0.4
Nutrition & lifestyle/chronic diseases	$0.0	<$0.01	$0.0
Grand Total	**$181.5**	**$329.7**	**$455.1**

NOTE: Interventions are sorted in descending order based on EFY 2008 budget allocations. Due to rounding, numbers presented within the table may not sum to the total amounts shown.

Table 7 reports nutrition funding per child under five across years surveyed for the three program types. In EFY 2008, the most recent year, average budget allocations for nutrition-specific programs was $4 per child under five; for nutrition-sensitive programs $23 per child under five; and for emergency response programs $5 per child under five. In total, this amounts to $31 per child under five budgeted for all nutrition investments included in the NNP-II in EFY 2008. Globally, the average allocation for nutrition-specific programs across low-income countries was reported as less than $1 per child under five (Shekar et al., 2017).

Table 7: National average nutrition funding per child under five (EFY 2006–2008, USD per child under five)

	Expenditures		Budgets
	EFY 2006	EFY 2007	EFY 2008
Nutrition-sensitive	**$5.8**	**$13.0**	**$22.7**
ONE WASH	-	$7.7	$8.7
PSNP nutrition-sensitive	$0.2	$0.2	$6.1
All other nutrition-sensitive	$5.6	$5.1	$7.9
Emergency response	**$3.1**	**$4.9**	**$4.7**
Nutrition-specific	**$3.8**	**$4.8**	**$3.7**
Total	**$12.6**	**$22.7**	**$31.1**

NOTE: Child under-five population figures were compiled from the UN World Population Prospects. The total population of children under five in Ethiopia was estimated to be 13,913,648 in 2010 and 14,601,687 in 2015, as reported by the UN World Population Prospects: The 2015 Revision. Linear growth of this population was assumed between 2010 and 2015 to estimate the population of children under five in 2013 and 2014.

Box 1: The ONE WASH National Program: Enhancing the enabling environment for nutrition

Background and objectives of the program

The ONE WASH National Program was launched in 2013 and aims to increase access to water supply and sanitation in rural and urban areas of Ethiopia, in line with the targets outlined in the Growth and Transformation Plan 2010–2015 for access to safe water supply (Federal Democratic Republic of Ethiopia, 2013). The program seeks to promote good hygienic practices, such as handwashing, which is key to improved nutrition outcomes (International Food Policy Research Institute, 2016).

Financing and implementation

Development partners contribute to the ONE WASH program through a multi-donor pooled fund, known as the Consolidated WASH Account, which is managed by the Ministry of Finance and Economic Cooperation. The program is implemented by the National WASH Coordination Office, as well as by relevant line ministries at the federal and regional levels, including the Ministry of Water, Irrigation, and Electricity, the Ministry of Health, and the Ministry of Education (Federal Democratic Republic of Ethiopia, 2013).

Regional targeting

In order to reduce regional disparities and promote equity, funds are targeted to areas with low access to safe water and sanitation, as established by the National WASH Inventory (Federal Democratic Republic of Ethiopia, 2013; UNICEF, n.d. b). In addition, funds are also targeted to "hot spot" woredas with acute water and sanitation needs. At the inception of the ONE WASH program, "hot spot" woredas were mainly concentrated in eastern regions receiving humanitarian assistance, as well as near the border with Sudan in Benishangul-Gumuz (Federal Democratic Republic of Ethiopia, 2013).

What was included in this analysis

Government respondents reported that the ONE WASH program meets the nutrition-sensitive inclusion criteria described in the methodology of this resource tracking exercise. As a result, the entire ONE WASH expenditure and budget was included in this exercise.

The financing mechanism of the ONE WASH program may serve as a model for future research on multi-sectoral nutrition aid modalities as it demonstrates a structure of multi-sectoral financial monitoring in Ethiopia.

Box 2: Quantifying nutrition-sensitive components of the Productive Safety Net Program (PSNP)

Background and objectives of the PSNP

The Productive Safety Net Program (PSNP) was first launched in January 2005 (EFY 1997) with the goal of improving household food security, strengthening household and community resilience to shocks, and tackling Ethiopia's dependence on food aid (Devereux et al., 2008). When it was first launched, the PSNP targeted approximately five million chronically food-insecure people living in 262 woredas (Devereux et al., 2008). As of 2015 (Gregorian), the PSNP covers approximately eight million beneficiaries across 318 woredas (MoANR Food Security Coordination Directorate, 2015). While components of the PSNP have shifted over time, at the core of the program is its safety net cash and food transfer to food-insecure beneficiaries. The PSNP has improved household food security in the country (Berhane et al., 2013; Berhane et al., 2017).

The current fourth phase of the program (PSNP-IV) was designed to be more nutrition-sensitive than previous phases (World Bank, 2014). This section describes how that was accomplished, and estimates funding towards the nutrition-sensitive components across years EFY 2006 to 2008.

The three PSNP-IV beneficiary groups

- **Public Works beneficiaries:** qualifying households with adult labor capacity receive cash/food transfers for six months of the year on the condition of working on public works projects, such as community road construction or small-scale irrigation (Ministry of Agriculture, 2014).
- **Direct Support beneficiaries:** vulnerable households that have low labor capacity receive transfers unconditionally for twelve months of the year (Ministry of Agriculture, 2014).
- **Temporary Direct Support beneficiaries:** Public Works beneficiaries who are pregnant and/or lactating women and/or guardians of malnourished children transition to a new beneficiary group for PSNP-IV, Temporary Direct Support, where they receive transfers unconditionally for six months of the year (Ministry of Agriculture, 2014).

Cash/food transfers for PSNP-IV

Safety net transfers are equivalent to 15kg of cereals and 4kg of pulses per month per beneficiary, received either as a food transfer or the cash equivalent. The inclusion of pulses in the cash/food transfer is new to PSNP-IV and, as a significant source of fiber, iron, and vitamins (Mudryj et al., 2012), helps improve the dietary diversity of PSNP beneficiaries. Food transfers of the program meet the internationally accepted standard energy requirement (World Bank, 2016b).

Conditionality

Public Works beneficiaries must complete five days of public works activities per month of transfer entitlement to receive a food/cash transfer. As of PSNP-IV, behavior change communication (BCC) sessions delivered through the Health Extension Program have become part of the public works conditionality. Public Works beneficiaries must attend six BCC sessions per year, which are counted as two public works days (out of the 30 public works days each year). BCC sessions cover topics including gender and social development, maternal health, breastfeeding, complementary feeding, WASH, nutrition-sensitive agriculture, and savings and income generation. The BCC sessions targeted to Public Works beneficiaries are guided by the gender and social development provisions of the PSNP, which

were developed by the MoH and MoANR. Direct Support beneficiaries are also encouraged to attend BCC sessions and utilize other health and nutrition services delivered through the Health Extension Program, though it is a soft conditionality for them and non-attendance would not result in a deduction in transfer entitlement (World Bank, 2014).

Financing and implementation

The PSNP is implemented by the Government of Ethiopia with support from development partners. Development partner resources are channeled to the National Bank of Ethiopia or through a multi-development partner trust fund. Funds from development partner accounts are then channeled to a PSNP pooled fund managed by MoFEC. MoFEC then transfers funds for implementation to the Regional Bureau of Finance and other designated federal accounts (World Bank, 2016b; Van Domelen and Coll-Black, 2012). The World Food Programme and USAID provide in-kind contributions to the program.

Targeting

PSNP-IV uses a community-based targeting methodology that considers two factors for eligibility into the program: food insecurity and household income. Kebele food security and household poverty indices are used by woreda and kebele community task forces to determine and validate household eligibility (World Bank, 2014).

What was included in this nutrition resource tracking analysis

This nutrition resource tracking exercise aimed to capture funding for nutrition activities within the total food/cash transfer component of the PSNP. The PSNP Donor Coordination Team provided expenditure and beneficiary data for the total food and cash transfer component of the program across EFYs 2006 to 2008.[12] This data was used to approximate funding allocations for nutrition, as described below.

Figure 5 shows annual expenditures for the food/cash transfer component of the PSNP and what was counted as nutrition spending during EFY 2006 and 2007, when PSNP-III was active, and EFY 2008, when PSNP-IV (the current fourth phase) began. Annual food/cash transfer amounts represent approximately 80 percent of total annual program expenditures.[13]

For PSNP-III, transfers targeted to pregnant and lactating women were considered by this exercise to be relevant to nutrition. In EFY 2006 and 2007, about $2 million per year from the PSNP pooled fund was spent on in-kind and cash transfers specifically to pregnant and lactating women within the Direct Support beneficiary group.[14] An additional $1 million per year was contributed directly from the United States to NGO providers of nutrition-sensitive PSNP activities (non-government-managed).

[12] Data on cash transfers and in-kind transfers procured by the Government of Ethiopia was taken from PSNP Interim Financial Reports for EFY 2006–2008 and from the annual work plan for EFY 2009. Cash transfer values included the transfers to beneficiaries made through the PSNP's contingency budgets and risk financing. The value of in-kind transfers contributed by USAID and World Food Programme (WFP) was monetized using a price per metric ton estimated from the average market price, plus transportation and logistics costs for EFY 2006 and 2007 (PSNP-III). For EFY 2008 and 2009 (PSNP-IV), the value of in-kind transfers was directly accounted for in WFP's budget, and USAID provided a recommended price per metric ton. The number of Public Works and Direct Support beneficiaries was taken from the annual work plans of the respective years.

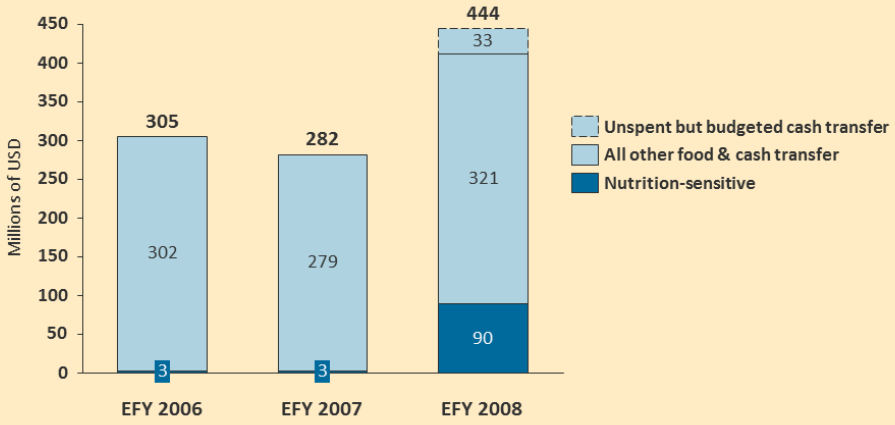
[13] Approximation by the PSNP Donor Coordination Team.

[14] Proportion of pregnant and lactating women among PSNP beneficiaries in EFY 2006 and 2007 was assumed to be equal to the ratio of Temporary Direct Support beneficiaries to total beneficiaries in EFY 2008.

In EFY 2008, PSNP-IV became more nutrition-sensitive, as compared to previous years, by introducing pulses to the food/cash transfer and BCC days as part of the program. The total nutrition component was considered as the sum of three parts: 1) the in-kind or cash equivalent of pulse transfers to any beneficiary group, 2) the in-kind or cash equivalent of cereal transfers to Temporary Direct Support beneficiaries (i.e., pregnant and lactating women),[15] and 3) funding linked with the addition of BCC days. Given the conditionality of BCC days attendance for Public Works beneficiaries to receive a food/cash transfer, the funding linked with the addition of BCC days was calculated as one-fifteenth of the cash equivalent of cereal transfers to Public Works beneficiaries.[16] In EFY 2008, $88 million was spent on these nutrition components through the PSNP pooled fund (21 percent of the total food/cash transfer expenditures). An additional $2 million was contributed outside of the pooled fund from development partners to government ($1 million) and NGO providers ($1 million) of nutrition-sensitive PSNP activities. In total, $90 million in EFY 2008 was counted as nutrition-sensitive funding within PSNP-IV.[17]

Because the PSNP is a dynamic program, expenditures for EFY 2008 were used instead of budget allocations; this approach was recommended during consultations with the PSNP Donor Coordination Team.

Figure 5: PSNP funding for food/cash transfers over time, and estimated funding associated with nutrition-sensitive activities within the program (EFY 2006–2008, USD millions)



NOTE: In EFY 2008, of the $90 million in nutrition-sensitive contributions, $2 million flowed outside of the PSNP pooled fund from development partners to government ($1 million) and NGO providers ($1 million).

Source: Analysis by the PSNP Donor Coordination Team.

[15] Pulses transfers, regardless of recipient, were considered a nutrition activity because of the high nutritional value of pulses. However, cereal transfers, which are of lower nutritional value, were only considered a nutrition activity when provided to nutrition target groups such as pregnant and lactating women, and malnourished children.

[16] This calculation was used because, out of 30 conditional public works days each year, two days are comprised of attendance at BCC sessions. There do not appear to be administrative costs associated with the linkage to BCC days. This calculation does not account for the cost of implementing BCC sessions, but rather the amount of investment leveraged to incentivize a nutrition intervention. As mentioned above, 100% of contributions for pulses was counted as nutrition-sensitive.

[17] Note that a total of $89 million (99%) is considered government-managed, including contributions from the pooled fund plus direct support to the government.

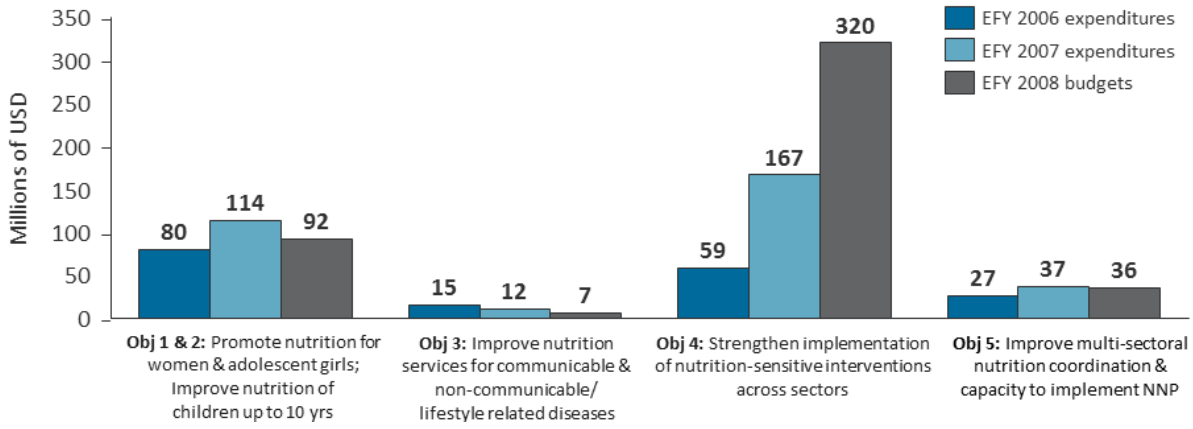
4.2.Total funding for nutrition by NNP-II strategic objective area

Importantly, this analysis also coded all nutrition funding in Ethiopia according to the strategic objective areas of the NNP-II. This allows for analysis on stakeholder alignment to key interventions proposed by the national guiding policy.

Figure 6 shows the total amount of nutrition funding per NNP-II strategic objective area. For the purposes of this analysis, strategic objective 1 (*Improve the nutritional status of women and adolescent girls*) and strategic objective 2 (*Improve the nutritional status of children*) were merged together as many nutrition interventions targeting mothers and children are delivered as one program, and financing for each target group could not be disaggregated.

Refer to **Annex C** for a list of interventions included in the analysis with the corresponding NNP-II strategic objective, and **Table 6** for corresponding investments.

Figure 6: Funding for nutrition by NNP-II strategic objective area
(EFY 2006–2008; USD millions)



In EFY 2006, $80 million was spent on programs within **strategic objective areas 1 and 2** (44 percent of total annual expenditures), which increased in nominal amounts to $114 million in EFY 2007, but was reduced proportionally to other objective areas to 35 percent of total annual expenditures. In EFY 2008, the budget allocations were reported as $92 million (only 20 percent of total annual budget allocations). Forty development partners contributed financially to these objectives across all years.

Strategic objective 3 (*Improve nutrition services for communicable & non-communicable/lifestyle related diseases*) has the least number of stakeholders (seven development partners) compared to all others, and received the smallest shares of annual funding. It is also the only strategic objective with funding consistently declining over time—in EFY 2006, $15 million was spent (8 percent of total annual expenditures), which decreased to $12 million in EFY 2007 (4 percent of total annual expenditures). Budget allocations were $7 million in EFY 2008 for this objective (just 2 percent of total annual budget allocations).

Strategic objective 4 (*Strengthen implementation of nutrition-sensitive interventions across sectors*) experienced the largest increase in investments over time—notably because of the PSNP and ONE WASH programs. In EFY 2006, $59 million was spent within this objective area (33 percent of total annual expenditures), which increased nearly 3-fold to $167 million in EFY 2007 (51 percent of total annual expenditures). By EFY 2008, budget allocations for this objective were reported as $320 million (70 percent of total annual budget allocations). Strategic objective 4 also has the highest number of development partners contributing to it, with 44 stakeholders contributing financially to the objective area across all years.

Finally, for **strategic objective 5** (*Improve multi-sectoral nutrition coordination & capacity to implement NNP*), $27 million was spent in EFY 2006 (15 percent of total annual expenditures), which increased slightly to $37 million in EFY 2007 (11 percent of total annual expenditures). In EFY 2008, budget allocations for Objective 5 were $36 million (8 percent of total annual budget allocations). Thirty-one stakeholders were investing in this objective across all years.

The NNP-II reports a preliminary estimation of what it would cost to implement the plan at full scale-up: a resource need of $147 million in year one (2016), comprised of $124 million towards nutrition-specific interventions and $24 million towards nutrition-sensitive interventions. However, nutrition-sensitive costs were likely underestimated, as indicated by a resource need closer to $60 million for year-one implementation of the Seqota Declaration in agriculture, WASH, and education sectors.[18] By year five (2020), total NNP-II costs rise to $306 million. Costs are not presented by NNP-II strategic objective area.

The preliminary cost estimates reported in the NNP-II were compared with budget allocations compiled through this resource tracking exercise to contextualize historic funding with what more might be needed. However, it is difficult to assess the resource need required on top of the current funding since neither costs by program/intervention type nor by strategic objective were available to be aligned with the financing data presented here (making it difficult to ensure appropriate comparisons are made). A rough comparison of year one total nutrition-specific costs with EFY 2008 allocations to nutrition-specific programs point to a potential $70 million resource gap.

[18] A preliminary costing exercise of the Seqota Declaration estimated it would cost $211 million to fund implementation of Phase 1 2016-2018, made up of $30 million from the health sector, $3 million from agriculture, $108 from WASH, and $70 million from education. Here, nutrition-sensitive costs for year one were approximated by summing costs for agriculture, WASH and education and dividing evenly across the three years. A more extensive costing analysis of the Seqota Declaration is expected to be forthcoming.

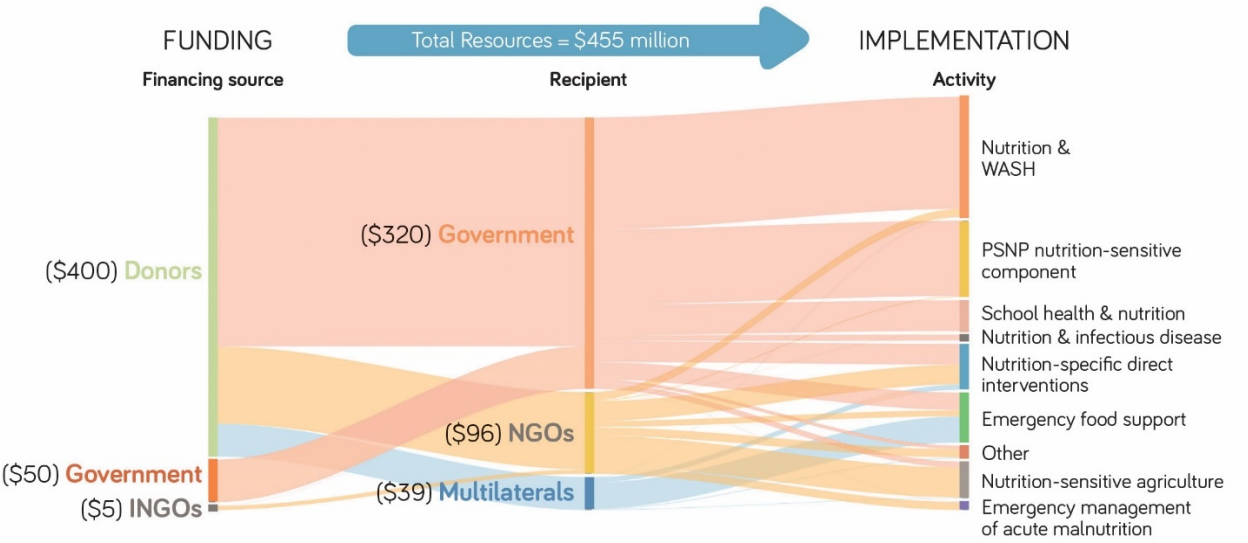
4.3. Nutrition funding flows in EFY 2008: financing sources, recipients and activities

Figure 7 illustrates a funding channel map for nutrition, showing how funding flows from the financing source (i.e., donors, government, or non-governmental organizations), to the recipient (i.e., implementing agency), and finally to the nutrition activity being implemented for the most recent year, EFY 2008. The amount of budget allocations flowing from financing source to recipient to activity is illustrated by the proportional thickness of the bars (i.e., colored bars represent funding flows).

Within the total $455 million budgeted to nutrition in EFY 2008, the largest contributions came from donor sources ($400 million, 88 percent), followed by the Government of Ethiopia ($50 million, 11 percent), and, finally, some amounts from international non-governmental organizations (INGOs) ($5 million, 1 percent).[19] **Annex D** reports the nutrition interventions funded by each financing source.

In EFY 2008, the Government of Ethiopia[20] was budgeted to receive $320 million in allocations for nutrition, meaning 70 percent of all nutrition budget allocations for that year were government-managed (represented by the orange funding flows in **Figure 7**). Of the remaining funds in EFY 2008, $96 million (21 percent) was budgeted for implementing NGOs, and $39 million (9 percent) went to multilateral organizations such as UNICEF, UNHCR and WFP to implement programs. These off-budget investments are represented by the yellow and blue funding flows in **Figure 7**, respectively.

Figure 7: Funding channel map illustrating financial flows for nutrition from the financing source to recipient and to activity implemented (EFY 2008, USD millions)



NOTE: color corresponds to the recipient/implementing organization; thickness of the lines is proportional to annual budget allocations for EFY 2008. Total nutrition budget allocation in EFY 2008 was reported as $455 million.

[19] INGO funds that do not originate from development partners typically comprise of philanthropic contributions.
[20] Representing any sector, including Ministry of Finance and Economic Cooperation and line ministries (**Annex A**).

Within the $320 million in nutrition budget allocations received by the Government of Ethiopia in EFY 2008, 80% went to three investment areas: nutrition-sensitive WASH programs ($132 million; 41 percent),[21] nutrition-sensitive components of PSNP-IV ($89 million; 28 percent),[22] and school health and nutrition programs ($36 million; 11 percent). The remaining 20% of nutrition budget allocations managed by the government in EFY 2008 went towards nutrition-specific programs, emergency food support, nutrition and infectious diseases, nutrition-sensitive agriculture and all other nutrition programs. See **Annex E** for a detailed intervention breakdown.

The $96 million for nutrition received by INGOs in EFY 2008 (off-budget) was directed to the promotion of nutrition-sensitive agriculture ($35 million, 37 percent), nutrition-specific interventions ($23 million, 24 percent), nutrition-sensitive WASH ($10 million, 10 percent), and all other nutrition programs, receiving $28 million in total. See **Annex E** for a detailed intervention breakdown.

The $39 million for nutrition received by multilateral organizations such as UNICEF, UNHCR and WFP in EFY 2008 (off-budget) was directed to emergency food support ($31 million, 79 percent), nutrition-specific direction interventions ($6 million, 15 percent), and all other nutrition programs, receiving $2 million in total.

Annex E describes the type of nutrition activities implemented by the Government of Ethiopia, NGOs and multilateral organizations and reports what is included in the "other" categories.

4.4. Government-managed and off-budget funds for nutrition

All funding flowing through the Government of Ethiopia is considered here as government-managed.[23] Conversely, funding channeled from development partners directly to non-government implementing partners is considered off-budget, or Channel 3, as described in the "Funding aid modalities" section above. Off-budget investments may be reported to the government by development partners via routine public reporting systems, such as through the annual FMoH resource mapping exercise that compiles data on development partner budget allocations in the health sector. However, there is no routine monitoring system to consolidate data for nutrition from across sectors.

Figure 8 shows the proportion of government-managed and off-budget funding for all nutrition funding and disaggregated by program type (nutrition-sensitive, nutrition-specific, and emergency response programs).

In total, in EFY 2006, 52 percent of all nutrition expenditures were government-managed ($94 million), which increased to 63 percent in EFY 2007 ($206 million). In EFY 2008, 70 percent of total nutrition budget allocations were government-managed ($320 million), whereas the remaining 30 percent was off-budget ($135 million). As described below, the increase in funding that was government-managed over the years was primarily due to the increase in nutrition-sensitive funding.

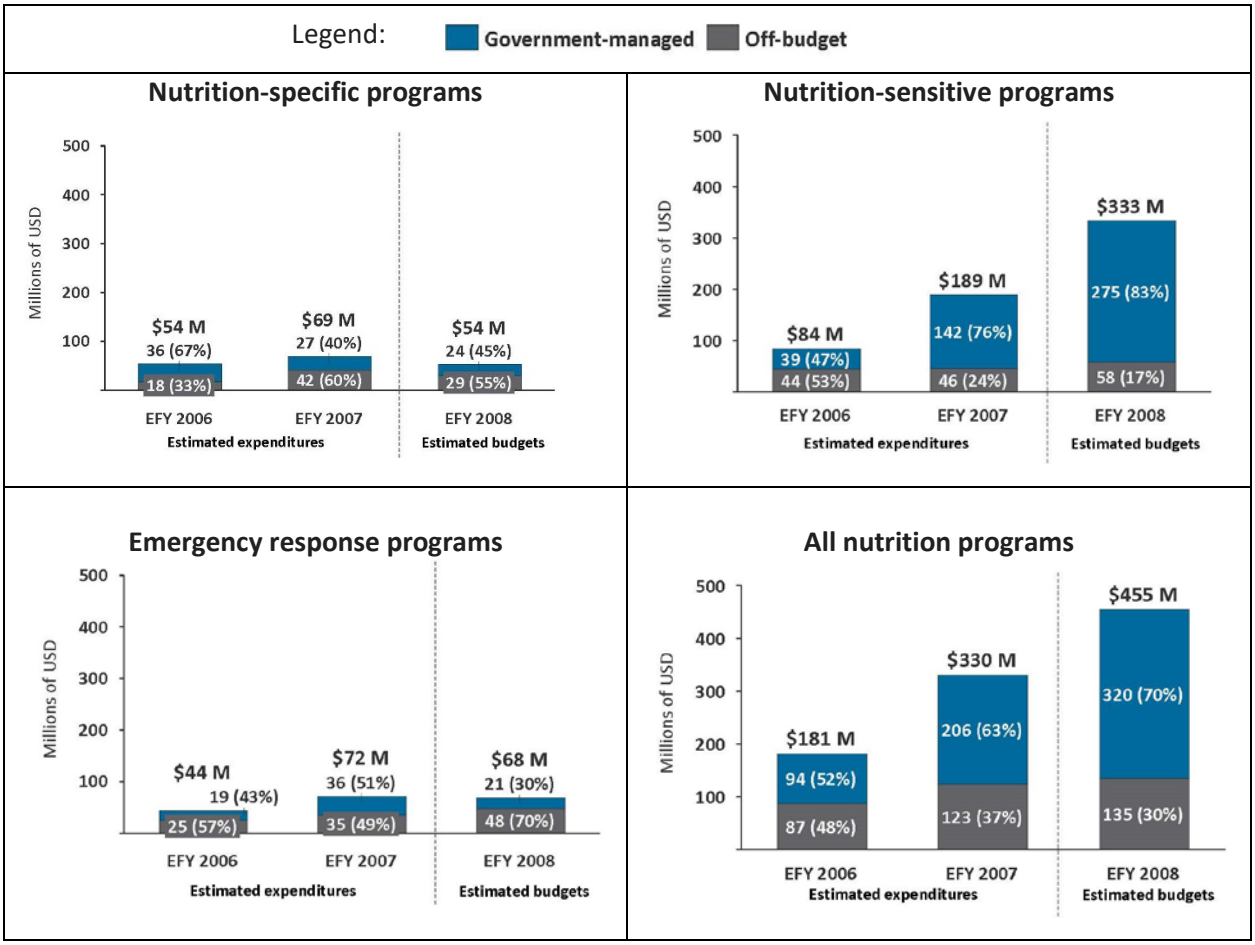
[21] This includes $127 million contributed for the ONE WASH program.
[22] As mentioned in **Box 2** for PSNP, in EFY 2008, of the $90 million in nutrition-sensitive contributions of the program, 99% was government-managed and 1% flowed directly from development partners to NGO providers.
[23] Government-managed funding is defined here as any investment that was either: a) reported by the Government; or b) reported by a development partner and the Government was listed as a financing source, recipient or financing agent for the investment.

Notable differences in the management of funds exist between nutrition-specific, nutrition-sensitive, and emergency response program types, as shown in **Figure 8**. Most nutrition-sensitive investments were channeled through public systems—47 percent of expenditures in EFY 2006 ($39 million) and 76 percent of expenditures in EFY 2007 ($142 million) were government-managed, and the remainder were off-budget. In EFY 2008, 83 percent of nutrition-sensitive programs were government-managed ($275 million). This increase can be primarily attributed to ONE WASH and PSNP, which have multi-donor-supported pooled funding mechanisms managed by the Ministry of Finance and Economic Cooperation (see **Box 1** and **Box 2**).

In comparison, for nutrition-specific investments, 67 percent of expenditures in EFY 2006 ($36 million) and 40 percent of expenditures in EFY 2007 ($27 million) were government-managed, and the remainder were off-budget. In EFY 2008, 45 percent of nutrition-specific programs were government-managed ($24 million).

For emergency response programs, 43 percent of expenditures in EFY 2006 (19 million) and 51 percent of expenditures in EFY 2007 ($36 million) were government-managed, and the remainder were off-budget. In EFY 2008, 30 percent of emergency response programs were government-managed ($21 million).

Figure 8: Proportion of funding for nutrition programs that are government-managed versus off-budget (EFY 2006–2008, USD millions)



4.5. Funding for nutrition by region

Almost all regions require focused financial support for nutrition programming—10 out of 11 regions have high or very high burdens of stunting and/or wasting, as classified by the WHO (refer to **Table 1** in the Introduction section). This section looks at nutrition budget allocations by region in EFY 2008 and compares budget allocations with regional stunting burden.

Data on regional allocations were reported by respondents at the national/federal level; data collection at the regional level to capture public funding channeled to regions and woredas and subsequently allocated to nutrition services was not within the scope of this exercise. As indicated below, this likely means that results presented here underestimate regional-level funding.

Annex B shows wasting and stunting prevalence data by region for context.

Data availability by region and limitations

In EFY 2008, excluding PSNP and the ONE WASH National Program, 10 percent of all budget allocations went towards programming at the national/federal level; 47 percent could be disaggregated at the regional level; 31 percent had regions which were known (i.e., reported in data collection), but the breakdown by region was estimated based on assumptions that may have further exaggerated any biases; and 11 percent of budget allocations had unknown geographic allocations (**Table 8**).

Several additional considerations to the regional data apply:

1. Regionally disaggregated funding data for PSNP's nutrition components were not collected and thus not shown here, as indicated in the Figures and Tables below.
2. ONE WASH contributions were excluded from this regional sub-analysis because the program is designed to target areas with low access to safe water and sanitation, and nutrition burden is not an allocation factor (**Box 1**). This is indicated in the Figures and Tables below.
3. Data on block grants from the federal government to regional bureaus were not compiled, because disaggregated information on nutrition spending within block grants was not available from MoFEC. Such information would have required further analysis through regional data collection. Public sector contributions were included if directly reported through data collection.[24]

[24] The only sector to provide regional data was the Federal Ministry of Education for the School Feeding program.

4. Lack of regional block grant data has implications primarily for nutrition interventions delivered at the regional level through the Health Extension Program. As part of the Health Extension Program package of sixteen preventive and basic curative services, funding associated with two service areas can be considered as nutrition spending (World Bank, 2013). Allocations to line-ministries that were subsequently transferred to the regional level for implementation of the Health Extension Program were captured by this exercise and represent a portion of the domestic nutrition spending at the regional level. However, the total value of the nutrition spending through the Health Extension Program, primarily as health extension worker salaries to deliver nutrition services, may be underestimated, perhaps by as much as $3.6 million a year (Bilal et al., 2011).[25]
5. Child under-five population figures were compiled from the UN World Population Prospects as described in **Table 7**. Regional proportions were compiled from the most recent 2007 census (Gregorian year) conducted by the Central Statistical Agency. Limitations to the regional and child under five population data have implications for indicators of nutrition funding per child under five. Indicators of funding per child under five are shown here to map funding by nutrition outcomes (indicators for stunting and wasting are for child under five populations), though, it is important to note that nutrition interventions/programs may benefit women, adolescents, and households.
6. Not all data that was reported by development partners could be disaggregated by region. However, the majority of funding across each year could be disaggregated at the regional level either through direct reporting or estimation of regional breakdown (72 percent in EFY 2006, 76 percent in EFY 2007, and 78 percent in EFY 2008, as shown in **Table 8**). For projects implemented across multiple regions, where regions were identified but the percentage breakdown was not indicated, the project disbursement was assumed to be split across regions in proportion to the total amount that each region received compared to each other, as indicated by reported data (i.e., regional targeting was predicted by the subset of data that was directly reported).[26] This approach may have exaggerated regional biases in the analysis.

[25] One study approximates Health Extension Program salaries as $143 million over five years (Bilal et al., 2011), which is roughly $28.6 million per year. The nutrition portion may be estimated as 12.5% of these annual contributions (2 nutrition interventions out of the package of 16), which amounts to approximately $3.6 million.

[26] For transactions that identified Gambella as a regional recipient but were not emergency-based, assumptions excluded funding for emergency response as this would have highly biased the investment upward. Refer to **Figure 10** to support this.

Table 8: Amount of nutrition funding disaggregated by geographic allocation, *excluding PSNP and ONE WASH* (EFY 2006–2008, USD millions, % of total funding for that year)

	EFY 2006	EFY 2007	EFY 2008
Regionally targeted	$128.3 (72%)	$163.6 (76%)	$186.5 (78%)
Regional breakdown reported directly	*$45.8 (26%)*	*$72.2 (34%)*	*$112.2 (47%)*
Regional breakdown estimated	*$82.5 (46%)*	*$91.4 (43%)*	*$74.3 (31%)*
National/Federal level	$37.1 (21%)	$38.8 (18%)	$24.4 (10%)
Unknown/Other	$13.0 (7%)	$12.4 (6%)	$27.1 (11%)
Total	**$178.4 (100%)**	**$214.8 (100%)**	**$238.0 (100%)**

NOTE: PSNP and ONE WASH funds are excluded from the table above. Regional breakdown was estimated when the identity of regions was known, but the split was not directly reported; assumptions of regional split drew from data that was reported directly. Percentages are reported as column percentages.

Budget allocations by region, EFY 2008

Figure 9 shows the breakdown of total nutrition budget allocations by region in EFY 2008 for all programs excluding PSNP and ONE WASH, broken down by emergency versus non-emergency funding. **Figure 9** also shows the amount budgeted per child under five (yellow secondary axis), also excluding PSNP and ONE WASH.[27]

In EFY 2008, within the 78 percent of total nutrition funding that were disaggregated by region (either reported directly or estimated), excluding PSNP and ONE WASH, total budget allocations were largest in Amhara ($49 million), Oromia ($43 million), and Gambella ($26 million). Total allocations appear to be driven by population size (i.e., the most populous regions have the most absolute budget support).

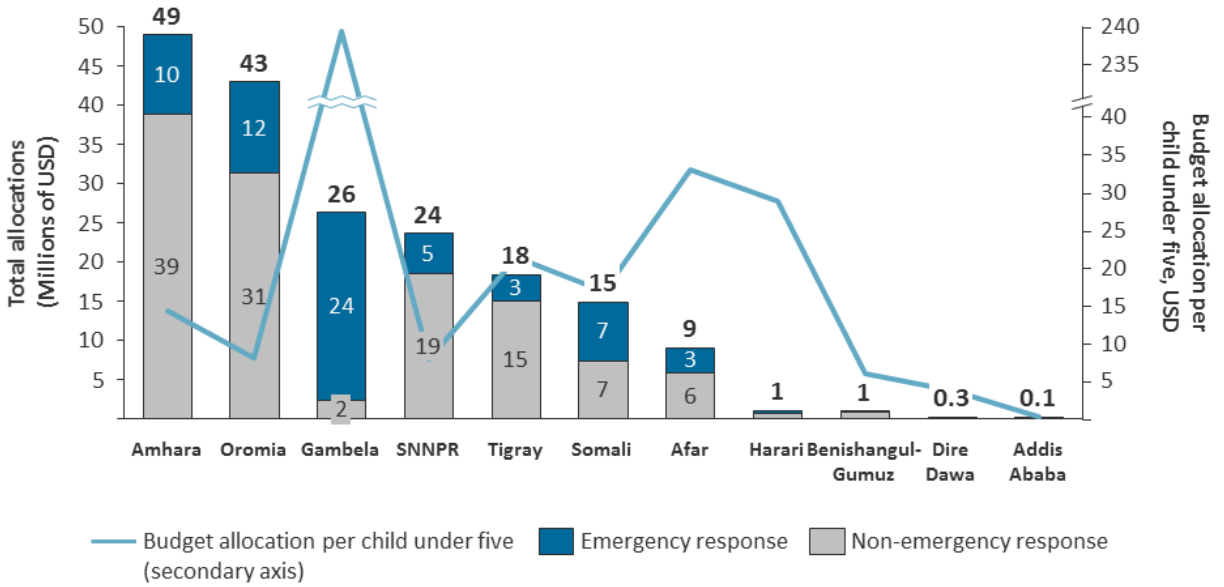
Regional breakdowns by program types—emergency response, non-emergency nutrition-specific and non-emergency nutrition-sensitive—are presented in **Annex F**.

Gambella is a likely outlier in this dataset. In EFY 2008, $239 in nutrition funding was budgeted per child under five in Gambella, which is seven times more than the next highest region (Afar, at $33 per child under five). As shown in **Figure 9**, most funding in Gambella was budgeted for emergency response; the main target population was people living in refugee camps. As this likely would have skewed these results, an estimate of the refugee population was added to calculate budget per child under five.[28]

[27]The total population of children under five in Ethiopia was estimated to be 13,913,648 in 2010 and 14,601,687 in 2015, as reported by the *UN World Population Prospects: The 2015 Revision*. Linear growth of this population was assumed between 2010 and 2015 to estimate the population of children under five in 2013 and 2014. This was divided proportionally across regions based on the regional population breakdown in the most recent 2007 census (Gregorian year) conducted by the Central Statistical Agency.

[28] Most budget allocations in Gambella in EFY 2008 went towards emergency response programs targeted to refugee populations. Because the refugee population is likely not included in census population data (i.e., the denominator for the budget allocation per child-under-five indicator), estimates of the under-five refugee population in Gambella (25,173 in EFY 2006, 44,156 in EFY 2007, and 49,570 in EFY 2008) were added to the denominator of total child-under-five population using data from UNHCR's Information Sharing Portal on the South Sudan situation in the Gambella region of Ethiopia (downloaded May 12, 2017).

Figure 9: Nutrition budget allocations by region, *excluding PSNP and ONE WASH* (EFY 2008, USD millions)

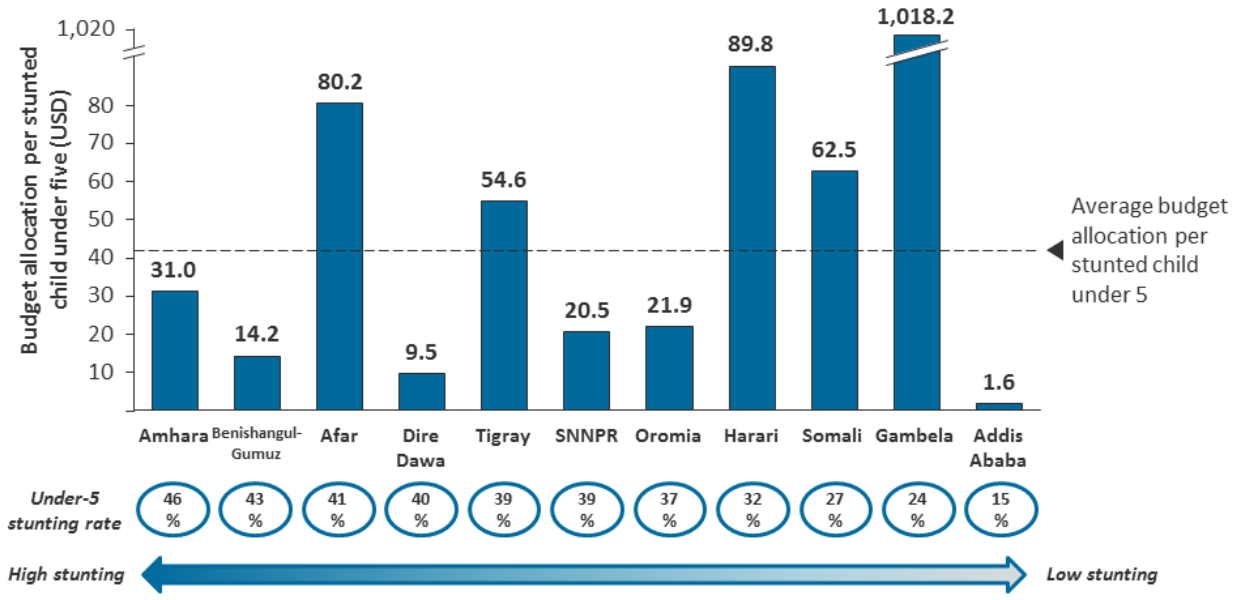


NOTE: This figure does not include PSNP and ONE WASH spending, nor the 10 percent of funding in EFY 2008 that was budgeted for national/federal-level programs nor the 11 percent where geographic targeting was unknown/other. Regional breakdown was estimated for 40 percent of the total $186.5 million shown here (**Table 8**). Excluding PSNP and ONE WASH, the national average in EFY 2008 was $16 per child under five (**Table 7**).

Figure 10 shows nutrition budget allocations per stunted child under five by region in EFY 2008. Gambella (24 percent stunting), Harari (32 percent stunting), and Afar (41 percent stunting) received the most budget support relative to their child under five stunting population. Oromia, SNNPR, Benishangul-Gumuz, Dire Dawa, Amhara and Addis Ababa are all under the national average of $43 budgeted per stunted child under five in EFY 2008. Budget allocations per stunted child under five are low in Addis Ababa, likely because of the relatively low stunting burden compared with other areas.

Future targeting may consider prioritizing investments to regions with high burden that recently experienced an increase in either stunting or wasting prevalence: Dire Dawa, Harari, Amhara, Benishangul-Gumuz, and Gambella (**Annex B**).

Figure 10: Budget allocation for nutrition per stunted child under five, by region, *excluding PSNP and ONE WASH programs* (EFY 2008, USD)



NOTE: This figure does not include PSNP and ONE WASH spending, nor the 10 percent of funding in EFY 2008 that was budgeted for national/federal-level programs nor the 11 percent where geographic targeting was unknown/other. Regional breakdown was estimated for 40 percent of the total $186.5 million shown here (**Table 8**). Excluding PSNP and ONE WASH, the national average budget allocation is $43 per stunted child under five. Source for stunting burden statistics: EDHS 2016.

5. Discussion

This section discusses programmatic considerations that emerge from the findings, considerations for future nutrition resource tracking efforts, lessons learned, and, finally, summarizes the main points into key policy messages to support nutrition planning and priority setting through resource tracking and systems strengthening.

5.1. Programmatic considerations: Nutrition funding in line with NNP-II

The NNP-II incorporates evidence-based recommendations to support the scale-up of high-impact nutrition-specific interventions that are commonly delivered through the health sector (Bhutta et al., 2013). In addition, the NNP-II recommends the scale-up of nutrition-sensitive investments across sectors—meaning the incorporation of nutrition objectives, indicators and activities within existing programs to make them more likely to improve nutrition outcomes (Ruel et al., 2013).

Between EFY 2006 and 2007, expenditures for nutrition-sensitive programming more than doubled. NNP-II strategic objective 4 (*strengthen implementation of nutrition-sensitive interventions across sectors*) by far received the most financial support compared to other objective areas (see **Figure 6**). The rise in funding for nutrition-sensitive programming suggests programs across sectors have increasingly incorporated nutrition activities and components. Prioritizing nutrition during project design is critical to ensure program resources are leveraged to achieve the maximum impact on nutrition (Ruel et al., 2013; Alderman et al., 2014; Alderman, 2016).

In some cases, adaptations to program design to become more nutrition-sensitive may not require additional program funding; rather, existing funding can be leveraged to add or enhance a nutrition focus. For example, programmatic changes between PSNP-III and PSNP-IV to make the program more nutrition-sensitive were successfully built into broader program design. In the case of PSNP-IV (see **Box 2**), the linkage with the Health Extension Program to increase coverage of nutrition and health education (via behavior change communication sessions) for PSNP-IV beneficiaries did not have significant cost implications; rather, resources were utilized to maximize the potential benefit of a linkage with the Health Extension Program to enhance health and nutrition outcomes. Through programmatic changes, the PSNP-IV became more nutrition-sensitive, and more funding was attributed to nutrition compared to PSNP-III. Future research can assess the cost differential for multi-sectoral programs to become more nutrition-sensitive by leveraging existing resources.

In comparison to NNP-II strategic objective 4, spending towards NNP-II strategic objectives 1 and 2 (*improve the nutritional status of women, adolescent girls, and children*) did not have similar growth. (see **Figure 6**). Funding for nutrition-specific programs—which make up most of NNP-II objectives 1 and 2—represents a small fraction of total annual investments relative to other investment areas, and growth has been slow over time.

In the context of rising expenditures overall, it is important to note that expenditures for NNP-II strategic objective 3 (*improve nutrition services for communicable & non-communicable/lifestyle related diseases*) declined across years, and expenditures for strategic objective 5 (*improve multi-sectoral nutrition coordination & capacity to implement NNP*) seemed to have flatlined, relative to other investments (see **Figure 6**). The findings indicate a need to strengthen planning for NNP-II objectives 3 and 5, and raise a question whether these objectives are being prioritized appropriately across stakeholders.

The NNP-II includes a preliminary cost component, where it was estimated that the scale-up of nutrition interventions outlined in the plan would require an investment of $147 million in year one (2016), rising to $306 million in year five (2020). A comparison of year one nutrition-specific costs ($124 million) with EFY 2008 nutrition-specific budget allocations ($54 million) points to a potential resource gap of $70 million and a significant resource requirement (2.3-fold increase). However, this represents a preliminary resource gap approximation. Cost categories were not presented by NNP-II objective area or by intervention, which made it difficult to compare cost estimates with appropriately matched financing data (this is expanded upon in section 5.3 on lessons learned).

In summary, the analysis points to two programmatic recommendations: increase investments in nutrition-specific programs and continue to find ways to enhance existing investments across sectors to make them more nutrition-sensitive. To put this call for increased investment into context, relative to total Official Development Assistance (ODA) in Ethiopia, all multi-sectoral nutrition contributions from development partners represented only 5 percent of total ODA in EFY 2006 and 10 percent of total ODA in EFY 2007.[29] Nutrition-specific investments represented a much smaller share of total aid at approximately 2 percent of total annual ODA in Ethiopia. This perhaps indicates room for development partners to increase prioritization of nutrition within their overall financing envelope (i.e., mobilize more resources or leverage existing resources). Nevertheless, continued analysis on costs and potential financing scenarios for stakeholders is needed to dive deeper on what more can be done.

5.2. Considerations for nutrition resource tracking and systems strengthening

Two considerations emerge from the analysis that point to the need for routine resource tracking for nutrition. First, the analysis shows that a high proportion of certain types of nutrition funding is off-budget—especially nutrition-specific programming—meaning public systems may have limited visibility into nutrition funding flows for planning purposes. Second, nutrition investments towards the NNP-II are indeed multi-sectoral, but there is currently no mechanism to consolidate information on funding flows for nutrition from across sectors. Even when sectoral reporting mechanisms exist, this information may not be collected within each sector in the same way; and multi-sectoral funding for nutrition data is not consolidated, nor mapped to NNP-II progress. Because the NNP-II framing document is multi-sectoral, it requires a resource tracking component to track and monitor funding aligned with NNP-II objectives across sectors.

[29] Data on total Official Development Assistance was extracted from the OECD Creditor Reporting System (CRS) on April 12, 2017. Note that the CRS reports use Gregorian calendar years, so percentages represent an estimated annual indicator (i.e., EFY annual expenditure divided by Gregorian annual disbursement of total ODA from the CRS).

The FMoH has routine reporting structures to compile off-budget development partner funding data within the health sector for planning purposes. However, there is currently no system in place to track and compile data from across sectors. This limits the ability to execute multi-sectoral nutrition planning without duplication of resources, raises questions around fragmentation in budgeting and planning of service delivery, and, in turn, limits the ability to leverage opportunities for cross-sectoral gains in efficiency. In addition, even if resources are external, having multi-sectoral nutrition funding data routinely reported and consolidated through public reporting mechanisms is important to build public sector capacity and support their coordinated planning.

A 2016 Ethiopia Public Expenditure Review (World Bank, 2016a) conducted by the World Bank recommended improving the alignment of government and development partner strategies at the operational level. The review found that harmonizing external assistance under the "One Plan, One Budget, One Report" philosophy has been helpful in ensuring coordination among and between development partners. Improved alignment could involve, for example, channeling aid through a multi-donor pooled funding mechanism such as the Millennium Development Goal Performance Fund (MDGPF) managed by the Ministry of Health, or routinizing development partners' annual reporting through the FMoH resource mapping exercise (World Bank, 2016a).

The recommendations in the 2016 Ethiopia Public Expenditure Review raise a question around the utility of a multi-donor, multi-sectoral pooled fund for nutrition. Based on experiences in universal health coverage, an important driver of development partner contributions to a multi-donor fund will likely include having a transparent financing mechanism to track and monitor funding linked with nutrition (UHC 2030, 2017). Therefore, securing buy-in for such a fund would likely require a sufficient resource tracking mechanism to ensure that funds are used for priority nutrition interventions (refer to section 2.1 Funding Aid Modalities for other considerations raised by development partners in Ethiopia related to on-budget funding) (IHP+ Results, 2016).

Further research into a multi-donor, multi-sectoral pooled fund for nutrition could draw from the Consolidated WASH Account (see **Box 2**). This account consolidates development partner contributions to the ONE WASH National Program in one account managed by MoFEC, which then administers funds across line ministries. Governmental implementing agencies for the ONE WASH program benefit from this arrangement because it increases implementers' level of financial control and accountability, reduces complexity in financial reporting and reduces transaction costs (Federal Democratic Republic of Ethiopia, 2011).

5.3. Lessons learned for future nutrition resource tracking exercises

This analysis builds on a series of resource tracking exercises previously conducted by the Government of Ethiopia. The multi-sectoral approach used here made it possible to track nutrition funding for nutrition-sensitive components, which are critical components to the NNP-II and often represent large investments.

Moving forward, lessons learned from this analysis can be used to establish a routine Government-led multi-sectoral nutrition resource tracking system. This way, funding data (i.e., expenditures and/or budgets) generated on a routine basis can be used to track progress towards the NNP-II. Methods used in this exercise could be refined and adapted to better capture the nutrition financing landscape in a policy- and goal-oriented manner. Some lessons learned are listed below:

» **Assess the appropriate level of granularity to inform policy.** This exercise attempted to disaggregate funding data to the lowest intervention level possible to align with the NNP-II. Some participants reported difficulty in providing disaggregated data because nutrition interventions are often integrated within wider programs without their own budget line; in these instances, the nutrition component was approximated based on discussion with program staff. Future resource tracking work can consider the maximum and minimum levels of programmatic and financial disaggregation required for policy needs in order to minimize reporting burden and maximize data quality and timely reporting. For example, a minimum reporting standard might be to report funding by NNP-II objective area, or to report based on broader intervention categories than what is shown in **Annex C** (i.e., micronutrient supplementation would include iron, folic acid, zinc, but financial reporting would not necessarily go down to the micronutrient level etc.). The main point here is to develop a nutrition intervention taxonomy that aligns well with the national plan (i.e., to be able to compare with cost categories in the NNP-II) and that it is feasible for stakeholders to report on systematically. It is critical for all stakeholders to participate in decision-making on these choices.[30]

» **Train managers of nutrition-sensitive programs on a standard approach to identify and quantify nutrition-sensitive investments that are integrated into larger programs.** Identifying nutrition-sensitive programs and quantifying the amount of funding that has been committed to, or indirectly benefits, nutrition is essential to monitor alignment within the NNP-II framework. However, the ability to monitor and report these investments within most development partner financial systems remains weak and is not standardized. The approach used here to quantify nutrition-sensitive investments benefited from and built on the Scaling Up Nutrition (SUN) Movement and other partners' efforts to develop guidelines for nutrition budget analysis and resource tracking (Fracassi and Picanyol, 2016; SPRING, 2015). Similar to the SUN experience, collecting data on nutrition-sensitive funding often required approximation by program managers because they had no other systematic way to account for nutrition investments within broad, multi-faceted programs. Guidance on how to report these investments was provided to participants by the research team, with multiple iterations when needed. In the future, it might be valuable to hold a workshop with program managers to ensure reporting guidelines are clear, and, importantly, program managers understand the importance of tracking and monitoring funding for nutrition within their programs as contributions towards the NNP-II.

[30] Note that for HIV resource tracking, the taxonomy and classifications used in the National AIDS Spending Assessment (NASA) guidelines and tools took several years and feedback from many countries to complete (UNAIDS, n.d.; Federal HIV/AIDS Prevention and Control Office, 2013).

» **For most organizations, headquarters staff in Addis can provide only limited data on regional level expenditures.** The regional analysis presented here represents an initial exploration with a relatively small subset of overall funding by region, collected at the national level. It was often the case that the requested level of programmatic disaggregation (i.e., by intervention) complicated the ability to also report by region. Future analysis is needed to assess funding flows to regions and regional implementation of funds, and will require refined coding of the implementers' spending by geographical identifier. Based on interviews conducted in this work, collecting data at the sub-national level is necessary to get a complete picture of funding flows in a region.

» **A cost analysis with disaggregated cost categories by NNP-II objectives is needed to track and monitor funding against financial benchmarks.** A detailed cost analysis would help contextualize the nutrition financing landscape by indicating the magnitude of resources needed by program and strategic objective—while the NNP-II includes a costing component, it is not disaggregated by NNP-II objective area. Cost categories should align with the NNP-II and financing categories presented here—or categories otherwise agreed upon based on discussions of the appropriate level of granularity— to track and monitor progress. If tracked routinely, funding data could be compared with resource needs annually to indicate gaps and priority areas. This could support data-driven joint planning discussions between government and development partners.

At the global level, lessons learned from this exercise can be shared with the nutrition community to further develop and refine global guidelines for resource tracking for nutrition.[31]

Data limitations of the current study should be taken into consideration. First, nutrition activities and interventions are often integrated within wider programs and may not have their own budget line. In these cases, approximations on how much was dedicated to nutrition were made by program staff based on activities within programs, where they might have either under- or over-estimated the shares for nutrition. Next, some transactions may not have been matched due to limited detail in project descriptions. In the case of multilateral organizations where financing sources could not be identified due to aggregated pooled funding, a conservative approach was taken to avoid double counting. Also, many development partners do not track and report funding using the Ethiopian Fiscal Year calendar, so approximations were made by respondents according to program months as necessary.

Finally, due to data and resource limitations, funding data at the regional level is incomplete. Of funding data reported by development partners, only a portion was disaggregated to the regional level; and some data could only be disaggregated by applying assumptions. In addition, data on nutrition allocations within block grants from the Federal Government to Regional Bureaus were not compiled as this required regional data collection (whereas data collection occurred at federal level). Based on trends in government health expenditure overall, regional and woreda level contributions for nutrition could be significant (World Bank, 2016a). Therefore, the regional comparisons provided here have a high degree of uncertainty and conclusive comments cannot be made.

[31] At the time of writing, the SUN Movement Secretariat was developing an updated guideline on budget analysis for nutrition for SUN countries (forthcoming), with contributions from R4D. Also refer to Fracassi and Picanyol, 2016.

5.4. Key policy messages

This multi-sectoral resource tracking exercise leads to important programmatic and resource tracking-related recommendations for nutrition stakeholders and policy makers in Ethiopia. The goal of these recommendations is to improve coordination and collaboration across stakeholders (government, donors, and implementing partners), which in turn will improve optimal allocative choices and efficiency in spending for nutrition. As such, these recommendations should be discussed further in an open, multi-stakeholder forum.

Programmatic recommendations:

- **Increase investments in nutrition-specific activities in line with the NNP-II for greater impact on nutrition outcomes.** Investments in nutrition-specific interventions—high-impact nutrition interventions aimed at improving the immediate causes of nutrition and development—are required to achieve the targets outlined in the NNP-II. Based on available estimates of resource needs in the NNP-II, there is a potential resource gap of $70 million for year one scale-up of the plan.

- **Systematically enhance the nutrition sensitivity of programs in agriculture, education, and water and sanitation sectors by leveraging existing resources.** Large-scale programs across sectors can become more nutrition-sensitive by adapting program design to include nutrition goals, activities, and indicators. Great progress has been made to make the PSNP more nutrition-sensitive, and a similar approach can be applied more broadly.

Resource tracking and systems strengthening recommendations:

- **Routinely track resources for nutrition across sectors. This requires a commitment from all stakeholders to report funding flows on a routine basis for planning purposes.** Given that a large portion of development assistance for nutrition is off-budget—especially for nutrition-specific programs—and there is no mechanism to compile data from across sectors, a routine resource tracking system is needed to monitor progress made towards the NNP-II and to identify resource gaps or potential overlaps in funding.

- **Convene nutrition stakeholders, including government and development partners, to build consensus on ways to identify and track nutrition data; and explore ways to systematically track nutrition investments within their own monitoring systems.** Stakeholders are encouraged to decide collectively on the minimum level of disaggregation of nutrition funding data needed to monitor progress and inform policy. Development partners are encouraged to track nutrition funding within their own financial monitoring systems to streamline reporting and also use nutrition funding data for internal planning purposes.

- **Use multi-sectoral nutrition financing data to support allocative decisions about human resources, capacity building, and programmatic scale-up, and to shape the nutrition governance agenda.** If captured routinely, funding data can feed into strategic planning discussions by the National Nutrition Coordinating Body, National Nutrition Technical Committee, and Nutrition Development Partner Forum. Improved coordination of allocative choices can lead to efficiency gains in multi-sectoral program implementation across stakeholders.

» **Invest in systems strengthening and capacity building so that routine nutrition resource tracking across sectors is conducted through public systems.** For a routine resource tracking system to be sustainable, it should be led and developed by the government so that information can feed into the national budget and planning cycle. This requires investment by development partners in improved public finance and reporting systems, and the civil service's capacity to manage these systems.

» **Promote sustainable, on-budget financing options for nutrition with monitoring mechanisms to ensure that funds are used for priority interventions.** The ONE WASH National Program and the PSNP pooled funds represent important mechanisms to reduce fragmented efforts, reduce duplication and improve efficiencies within their respective programs. Considerations for on-budget support for nutrition programs should be explored.

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Annex A: Respondent organizations and institutions

Government ministries and agencies

Ministries and agencies that reported investments:

1. Ministry of Agriculture and Natural Resources
2. Ministry of Education
3. Ministry of Health (including EPHI and FMHACA)
4. Ministry of Labour and Social Affairs
5. Ministry of Water, Irrigation and Energy
6. Ministry of Women and Children Affairs
7. Administration of Refugees and Returnees Agency

Ministries and agencies with forthcoming plans:

8. Ministry of Finance and Economic Cooperation
9. Ministry of Industry
10. Ministry of Livestock and Fishery Resource Development
11. Ministry of Trade
12. Ministry of Youth and Sport
13. National Disaster Risk Management Coordination Commission
14. Federal Government Communication Affairs Office

Donor institutions (bilaterals, multilaterals and foundations)

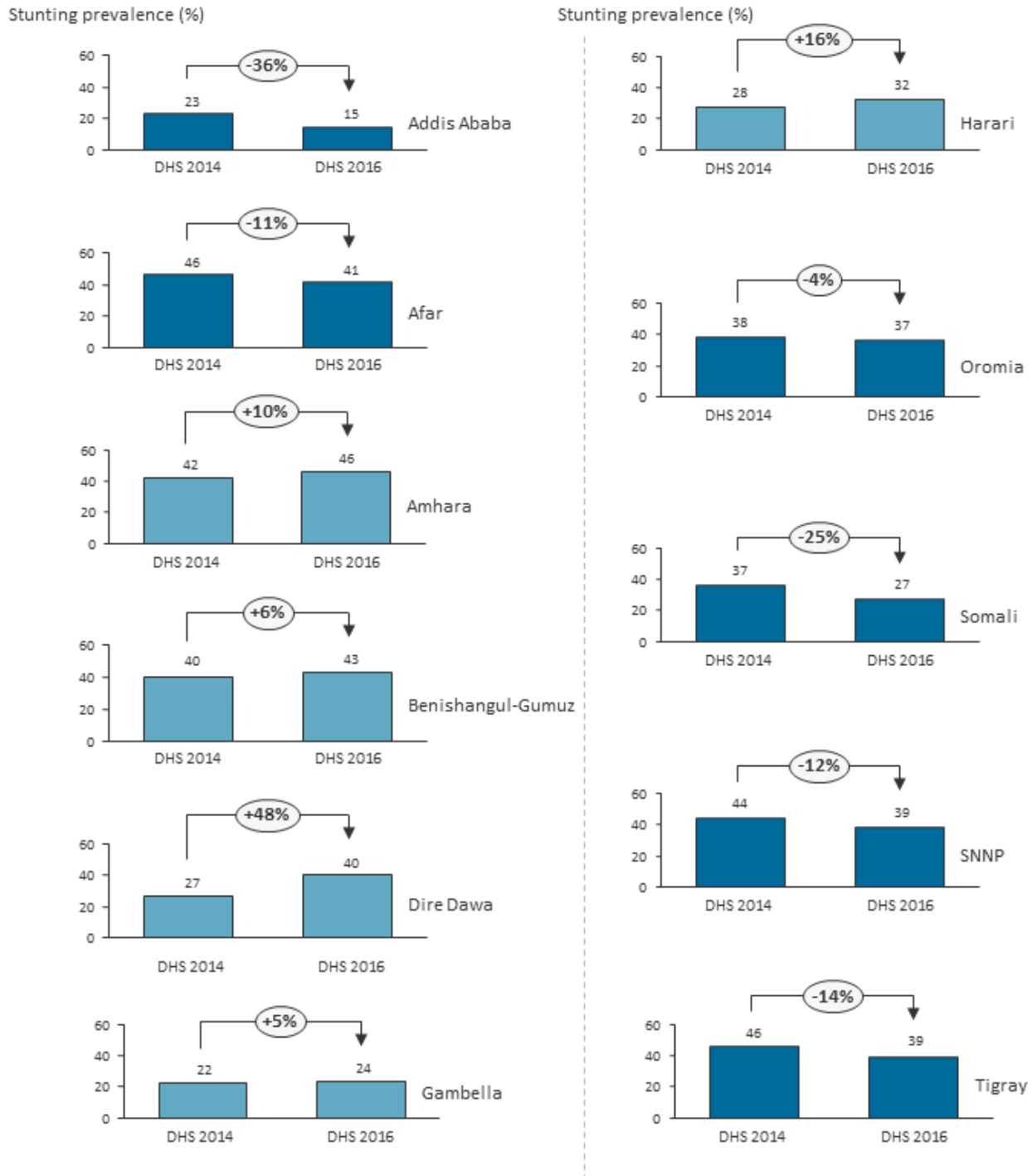
1. Austria
2. Bill & Melinda Gates Foundation (BMGF)
3. Children's Investment Fund Foundation (CIFF)
4. Department for International Development (DFID)
5. European Union (EU)
6. European Commission Humanitarian Aid (ECHO)
7. Food and Agricultural Organization of the United Nations (FAO)
8. France
9. German Corporation for International Cooperation(GIZ)
10. Global Affairs Canada (GAC)
11. Irish Aid
12. Italy
13. Japan International Cooperation Agency (JICA)
14. Netherlands
15. Spain
16. Sweden
17. United States Agency for International Development (USAID)
18. United Nations Children's Fund (UNICEF)
19. United Nations High Commissioner for Refugees (UNHCR)
20. World Food Programme (WFP)
21. World Health Organization (WHO)

Implementing partners

1. Agricultural Cooperative Development International/Volunteers in overseas Cooperative Assistance (ACDI/VOCA)
2. Action Against Hunger (ACF)
3. Adventist Development and Relief Agency (ADRA)
4. Alive & Thrive
5. Amref Health Africa (AMREF)
6. Cooperative and Assistance for Relief Everywhere (CARE)
7. Clinton Health Access Initiative (CHAI)
8. Child Fund
9. Christian Child Fund International
10. Cultivating New Frontiers in Agriculture (CNFA)
11. Concern Worldwide
12. Catholic Relief Services (CRS)
13. Ethiopian Civil Society Health Forum
14. Ethiopian Strategy Support Program
15. Family Health International (FHI 360)
16. Food for the Hungry
17. Global Alliance for Improved Nutrition (GAIN)
18. GOAL
19. International Food Policy Research Institute (IFPRI)
20. International Medical Corps (IMC)
21. International Rescue Committee (IRC)
22. Islamic Relief
23. Mercy Corps
24. Micronutrient Initiative
25. Médecins Sans Frontières France (MSF)
26. Médicos Sin Fronteras Spain (MSF)
27. Management Sciences for Health (MSH)
28. PATH
29. Plan International
30. Population Services International (PSI)
31. Save the Children
32. Self Help Africa
33. Source of Hope Foundation
34. ZOA Ethiopia

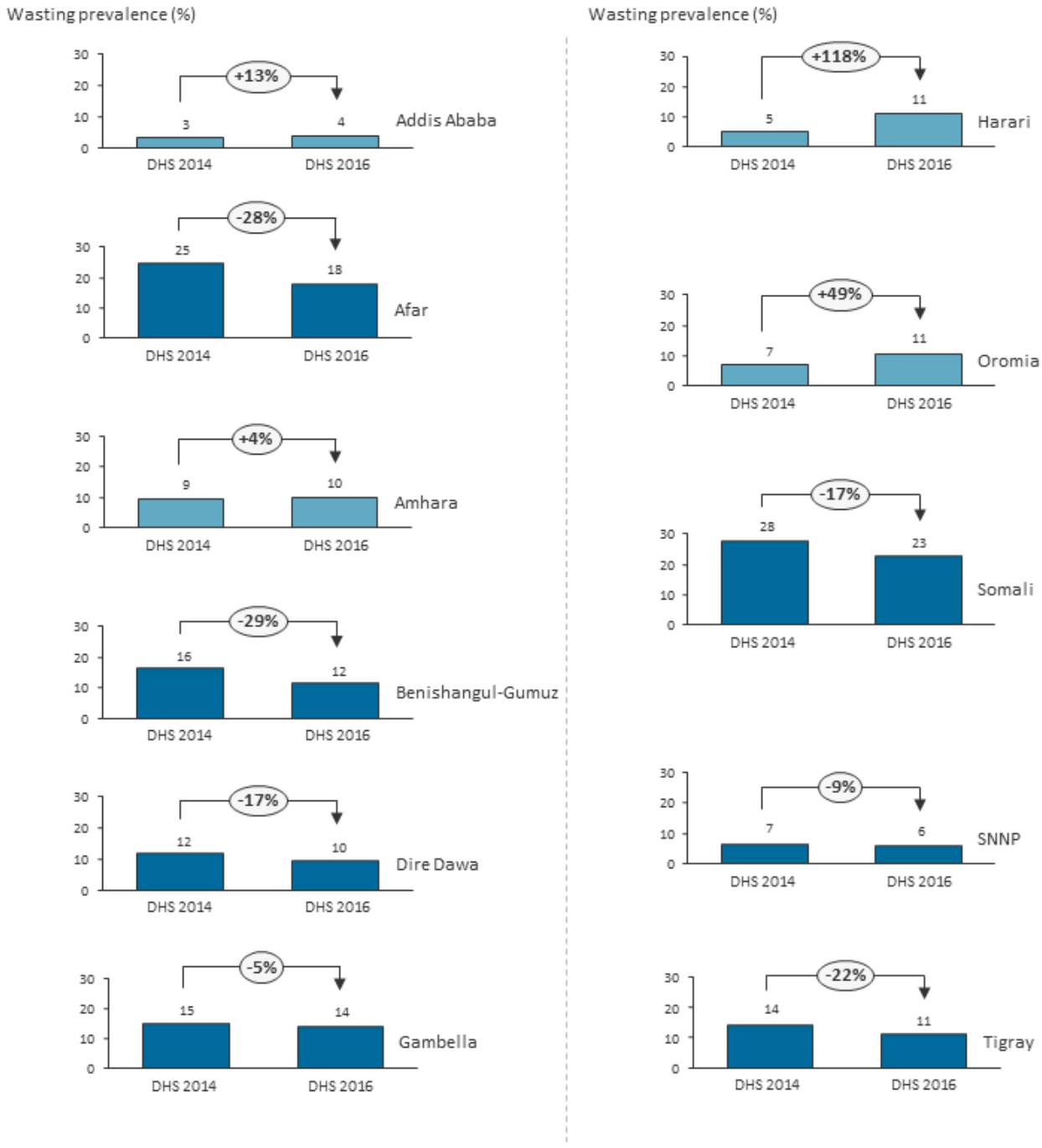
Annex B: Change in stunting and wasting by region between 2014 and 2016 (Gregorian years)

Change in Stunting Prevalence Among Children Under Five by Region Between 2014 and 2016



Source: EDHS 2014-2016

Change in Wasting Prevalence Among Children Under Five by Region Between 2014 and 2016



Source: EDHS 2014-2016

Annex C: Interventions included in the analysis in line with NNP-II

Nutrition Intervention Category	Nutrition Intervention	Program Type *	National Nutrition Plan II Objective Area
Advocacy for nutrition	Advocacy for nutrition	Specific	Strategic objective 5: Improve multi-sectoral nutrition coordination and capacity to implement NNP
Behavior change communication (BCC) for nutrition	Media strategies for BCC	Specific	Strategic objectives 1 & 2: Promotion of nutrition for women and adolescent girls; Improve the nutritional status of children from birth up to 10 years
	Nutrition counseling	Specific	Strategic objectives 1 & 2: Promotion of nutrition for women and adolescent girls; Improve the nutritional status of children from birth up to 10 years
	Other BCC	Specific	Strategic objectives 1 & 2: Promotion of nutrition for women and adolescent girls; Improve the nutritional status of children from birth up to 10 years
Breastfeeding promotion (policy)	Baby friendly hospital initiative (BFHI)	Specific	Strategic objectives 1 & 2: Promotion of nutrition for women and adolescent girls; Improve the nutritional status of children from birth up to 10 years
	Breastfeeding promotion (policy)	Specific	Strategic objectives 1 & 2: Promotion of nutrition for women and adolescent girls; Improve the nutritional status of children from birth up to 10 years
Capacity building for nutrition	Capacity building for nutrition	Specific	Strategic objective 5: Improve multi-sectoral nutrition coordination and capacity to implement NNP
	Nutrition trainings for staff (can be health workers or any other nutrition-sensitive sector)	Specific	Strategic objective 5: Improve multi-sectoral nutrition coordination and capacity to implement NNP
Emergency assistance (food support and resources)	Emergency assistance (food support and resources)	Emergency	Strategic objectives 1 & 2: Promotion of nutrition for women and adolescent girls; Improve the nutritional status of children from birth up to 10 years
Growth monitoring and promotion (GMP)	Growth monitoring and promotion (GMP)	Specific	Strategic objective 2: Improve the nutritional status of children from birth up to 10 years
Integrated package of nutrition interventions	Integrated package of nutrition interventions	Specific	Strategic objectives 1 & 2: Promotion of nutrition for women and adolescent girls; Improve the nutritional status of children from birth up to 10 years

Management of acute malnutrition	Local production of complementary and therapeutic food	Specific	Strategic objective 2: Improve the nutritional status of children from birth up to 10 years
	Management of acute malnutrition (general)**	Specific	Strategic objective 2: Improve the nutritional status of children from birth up to 10 years
	Management of moderate acute malnutrition**	Specific	Strategic objective 2: Improve the nutritional status of children from birth up to 10 years
	Management of severe acute malnutrition (outpatient-level)**	Specific	Strategic objective 2: Improve the nutritional status of children from birth up to 10 years
	Management of severe acute malnutrition (stabilization center-level)**	Specific	Strategic objective 2: Improve the nutritional status of children from birth up to 10 years
Micronutrients	Iron and folic acid supplementation	Specific	Strategic objective 1: Promotion of nutrition for women and adolescent girls
	Micronutrients (general)	Specific	Strategic objectives 1 & 2: Promotion of nutrition for women and adolescent girls; Improve the nutritional status of children from birth up to 10 years
	Multiple micronutrient powder (point-of-use fortification)	Specific	Strategic objectives 1 & 2: Promotion of nutrition for women and adolescent girls; Improve the nutritional status of children from birth up to 10 years
	Multiple micronutrients supplementation	Specific	Strategic objectives 1 & 2: Promotion of nutrition for women and adolescent girls; Improve the nutritional status of children from birth up to 10 years
	Other food fortification	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
	Salt iodization	Sensitive	Strategic objectives 1 & 2: Promotion of nutrition for women and adolescent girls; Improve the nutritional status of children from birth up to 10 years
	Vitamin A supplementation	Specific	Strategic objective 2: Improve the nutritional status of children from birth up to 10 years
	Wheat flour fortification	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
	Zinc and/or ORS for diarrhea management	Specific	Strategic objective 2: Improve the nutritional status of children from birth up to 10 years

Nutrition & infectious diseases	Counseling and nutritional support for people with chronic infections (i.e., HIV+ cases, TB, malaria)	Sensitive	Strategic objective 3: Improve the delivery of nutrition services for communicable and non-communicable / lifestyle related diseases
	Deworming (non-school based)	Sensitive	Strategic objective 3: Improve the delivery of nutrition services for communicable and non-communicable / lifestyle related diseases
	Other nutrition & infectious diseases	Sensitive	Strategic objective 3: Improve the delivery of nutrition services for communicable and non-communicable / lifestyle related diseases
Nutrition & lifestyle/chronic diseases	Dietary goals and food-based dietary guidelines for the purpose of preventing NCDs	Specific	Strategic objective 3: Improve the delivery of nutrition services for communicable and non-communicable / lifestyle related diseases
Nutrition & Water, hygiene & sanitation (WASH)	Other nutrition & Water, hygiene & sanitation (WASH)	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
	Promotion of improved hygiene practices	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
	Provision of safe water (e.g., through ONEWASH program)	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
Other nutrition-sensitive	Other nutrition-sensitive	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors

Promotion of nutrition-sensitive agriculture and food security	Biofortification	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
	Food diversification	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
	Food safety	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
	Other promotion of nutrition-sensitive agriculture and food security	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
	Post-harvest processing	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
	Promotion of household food security (not through PSNP/HABP)	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
	Promotion of household food security via the Household Asset Building Program (HABP)	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
	Promotion of household food security via the Productive Safety Net Program (PSNP) food/cash transfer	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
Research, knowledge management and data for decision making	Evaluation of nutrition programs	Specific	Strategic objective 5: Improve multi-sectoral nutrition coordination and capacity to implement NNP
	Nutrition information systems	Specific	Strategic objective 5: Improve multi-sectoral nutrition coordination and capacity to implement NNP
	Nutrition research and development	Specific	Strategic objective 5: Improve multi-sectoral nutrition coordination and capacity to implement NNP
	Other research, knowledge management and data for decision making	Specific	Strategic objective 5: Improve multi-sectoral nutrition coordination and capacity to implement NNP
School health & nutrition	Deworming (school-based)	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
	Other school health & nutrition	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
	School feeding program (including home-grown school feeding)	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors
	School gardening	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors

Support for the implementation of multi-sectoral nutrition actions at national and sub national levels	Support for the implementation of multi-sectoral nutrition actions at national and subnational levels	Sensitive	Strategic objective 5: Improve multi-sectoral nutrition coordination and capacity to implement NNP
Women's empowerment & nutrition	Women's empowerment & nutrition	Sensitive	Strategic objective 4: Strengthen implementation of nutrition-sensitive interventions across sectors

NOTE:

*The specific vs. sensitive classifications shown in this table represent the assignment given in most cases of that intervention. Certain transactions were assigned types contrary to what is indicated based on self-reported classifications and project descriptions.

**Transactions under the management of acute malnutrition category were coded as part of the emergency response program type when project descriptions explicitly indicate that it was implemented in an emergency context; otherwise, non-emergency management of acute malnutrition was coded as nutrition-specific.

Annex D: Funding by financing source and intervention (EFY 2006–2008, USD millions)

	Estimated expenditures		Estimated budgets
Type of funding source	**EFY 2006**	**EFY 2007**	**EFY 2008**
Donor organizations (Bilateral, Multilateral, and Foundations)	**168.7**	**319.6**	**400.0**
Nutrition & Water, hygiene & sanitation (WASH)	8.4	118.5	142.2
PSNP nutrition component	3.1	2.9	72.2
Emergency assistance (food support and resources)	24.6	62.7	56.0
Promotion of nutrition-sensitive agriculture and food security	36.9	38.3	42.8
Capacity building for nutrition	8.6	20.4	18.6
Other	1.0	2.5	14.6
Behavior change communication (BCC) & breastfeeding promotion	7.8	7.8	10.1
Management of acute malnutrition (emergency)	16.4	6.8	9.1
Research, knowledge management and data for decision making	16.5	13.5	8.8
Nutrition & infectious diseases	15.4	11.6	7.0
Management of acute malnutrition (non-emergency)	12.4	17.1	6.3
School health & nutrition	11.9	11.0	6.0
Micronutrients	4.1	5.7	3.3
Growth monitoring and promotion (GMP)	0.8	0.4	1.4
Advocacy for nutrition	0.7	0.4	1.1
Integrated package of nutrition interventions	0.1	-	0.4
Support for the implementation of multi-sectoral nutrition actions	-	0.1	0.1
Government	**5.6**	**4.8**	**49.9**
School health & nutrition	3.9	2.3	30.2
PSNP nutrition component	-	-	17.5
Support for the implementation of multi-sectoral nutrition actions	1.7	1.8	1.9
Research, knowledge management and data for decision making	0.03	0.5	0.2
Micronutrients	-	-	0.1
Promotion nutrition-sensitive agriculture and food security	0.1	0.1	0.05
Other	0.001	0.01	0.01
Capacity building for nutrition	-	0.03	-
Behavior change communication (BCC) & breastfeeding promotion	-	0.005	-

Nutrition & lifestyle/chronic diseases	-	0.01	-
Nutrition & Water, hygiene & sanitation (WASH)	-	0.05	-
INGOs	**7.1**	**5.3**	**5.2**
Emergency assistance (food support and resources)	0.5	1.2	2.4
Behavior change communication (BCC) & breastfeeding promotion	0.01	0.3	0.9
Management of acute malnutrition (emergency)	2.3	1.0	0.8
Management of acute malnutrition (non-emergency)	0.7	0.7	0.5
School health & nutrition	1.9	0.01	0.2
Capacity building for nutrition	0.1	0.4	0.2
Promotion of nutrition-sensitive agriculture and food security	0.9	1.3	0.1
Other	-	-	0.1
Research, knowledge management and data for decision making	0.1	0.1	0.1
Nutrition & Water, hygiene & sanitation (WASH)	0.1	0.1	0.04
Growth monitoring and promotion (GMP)	0.003	0.003	-
Micronutrients	0.3	-	-
Integrated package of nutrition interventions	-	0.1	-
Nutrition & infectious diseases	0.01	0.04	-
Grand Total	**181.5**	**329.7**	**455.1**

NOTE: categories are sorted in descending order based on EFY 2008.

Annex E: Funding by implementing organization and intervention (EFY 2006–2008, USD millions)

	Estimated expenditures		Estimated budgets
Type of implementing organization	**EFY 2006**	**EFY 2007**	**EFY 2008**
Government	**94.2**	**206.4**	**320.0**
Nutrition & Water, hygiene & sanitation (WASH)	2.1	112.3	132.1
PSNP nutrition component	2.1	1.9	88.8
School health & nutrition	17.4	12.8	36.1
Emergency assistance (food support and resources)	18.8	36.0	20.4
Capacity building for nutrition	6.6	8.6	9.7
Nutrition & infectious diseases	6.7	6.5	7.0
Promotion of nutrition-sensitive agriculture and food security	10.6	8.3	6.9
Research, knowledge management and data for decision making	14.3	11.0	4.4
Other	0.3	0.6	4.0
Behavior change communication (BCC) & breastfeeding promotion	0.1	0.8	3.8
Support for the implementation of multi-sectoral nutrition actions	1.7	1.8	1.9
Growth monitoring and promotion (GMP)	0.8	0.4	1.3
Management of acute malnutrition (non-emergency)	11.5	0.5	1.2
Micronutrients	0.9	4.4	1.0
Advocacy for nutrition	0.2	-	0.8
Integrated package of nutrition interventions	0.1	-	0.3
Management of acute malnutrition (emergency)	0.1	0.4	0.3
Nutrition & lifestyle/chronic diseases	-	0.01	-
NGOs	**64.1**	**60.6**	**96.3**
Promotion of nutrition-sensitive agriculture and food security	23.1	27.0	35.5
Other	0.8	1.8	9.9
Nutrition & Water, hygiene & sanitation (WASH)	2.9	2.8	9.6
Management of acute malnutrition (emergency)	18.6	7.4	9.6
Capacity building for nutrition	0.8	8.0	7.7
Emergency assistance (food support and resources)	3.8	2.5	7.2
Behavior change communication (BCC) & breastfeeding promotion	3.5	2.8	6.9
Research, knowledge management and data for decision making	2.4	2.8	4.5
Micronutrients	1.8	1.1	1.9

Management of acute malnutrition (non-emergency)	1.6	2.4	1.8
PSNP nutrition component	1.0	0.9	1.0
School health & nutrition	0.2	0.5	0.3
Advocacy for nutrition	0.5	0.4	0.3
Support for the implementation of multi-sectoral nutrition actions	-	-	0.1
Growth monitoring and promotion (GMP)	0.003	0.003	0.1
Integrated package of nutrition interventions	0.01	0.1	0.04
Nutrition & infectious diseases	3.1	0.04	-
Multilateral and bilateral donor organizations	**23.2**	**62.7**	**38.8**
Emergency assistance (food support and resources)	2.5	25.3	30.8
Management of acute malnutrition (non-emergency)	-	15.0	3.7
Capacity building for nutrition	1.3	4.2	1.3
Other	-	0.1	0.8
Promotion of nutrition-sensitive agriculture and food security	4.2	4.3	0.6
Nutrition & Water, hygiene & sanitation (WASH)	3.6	3.6	0.5
Micronutrients	1.7	0.3	0.5
Behavior change communication (BCC) & breastfeeding promotion	4.2	4.6	0.3
Research, knowledge management and data for decision making	-	0.3	0.1
Management of acute malnutrition (emergency)	-	-	0.04
Nutrition & infectious diseases	5.6	5.1	-
Support for the implementation of multi-sectoral nutrition actions	-	0.1	-
Grand Total	**181.5**	**329.7**	**455.1**

NOTE: categories are sorted in descending order based on EFY 2008.

Annex F: Regional data—funding by region and nutrition program type (EFY 2008, USD millions)

Region	EFY 2008 Nutrition-sensitive budget	EFY 2008 Nutrition-specific budget	EFY 2008 Emergency response budget	EFY 2008 total nutrition budget
Amhara	$27.1 (55.5%)	$11.6 (23.7%)	$10.2 (20.8%)	$48.9 (100%)
Oromia	$25.5 (59.4%)	$5.7 (13.4%)	$11.7 (27.2%)	$42.9 (100%)
Gambella	$0.8 (3.0%)	$1.6 (5.9%)	$24.0 (91.0%)	$26.3 (100%)
SNNPR	$13.9 (58.9%)	$4.6 (19.4%)	$5.1 (21.7%)	$23.6 (100%)
Tigray	$11.9 (64.8%)	$3.2 (17.2%)	$3.3 (18.0%)	$18.3 (100%)
Somali	$5.0 (33.6%)	$2.4 (16.1%)	$7.5 (50.3%)	$14.9 (100%)
Afar	$3.7 (40.9%)	$2.1 (23.1%)	$3.3 (36.0%)	$9.1 (100%)
Harari	$0.2 (19.2%)	$0.4 (40.5%)	$0.4 (40.3%)	$1.0 (100%)
Benishangul-Gumuz	$0.1 (14.2%)	$0.7 (74.0%)	$0.1 (11.8%)	$0.9 (100%)
Dire Dawa	$0.2 (90.5%)	$0.02 (9.5%)	$0.0 (0.0%)	$0.3 (100%)
Addis Ababa	$0.01 (5.1%)	$0.1 (60.2%)	$0.04 (34.6%)	$0.1 (100%)
National	$9.7 (39.8%)	$14.6 (59.9%)	$0.1 (0.3%)	$24.4 (100%)
Multiple regions/other	$12.2 (74.2%)	$4.1 (24.7%)	$0.2 (1.1%)	$16.4 (100%)
Unknown	$5.5 (51.3%)	$2.7 (25.6%)	$2.5 (23.1%)	$10.7 (100%)
Grand Total	**$115.9 (48.7%)**	**$53.7 (22.6%)**	**$68.3 (28.7%)**	**$238.0 (100%)**

NOTE: All figures are presented as USD millions for EFY 2008 budget allocations. This table presents all data that could be disaggregated, excluding the PSNP and ONE WASH programs (see **Table 8**). Percentages are reported as row percentages (i.e., share of total region's funding).

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RESULTS FOR DEVELOPMENT

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