5
Accelerating Progress in Nutrition: Next Steps

Chapter 1 outlined why we must invest in nutrition. Chapter 2 detailed the enormous size and the extensive scope of the nutrition problem (both underweight and overweight) at global, regional, and country levels to further strengthen the case for investing in nutrition. Chapter 3 outlined how best to tackle malnutrition. Chapter 4 focused on the challenge of scaling up programs for undernutrition and for micronutrient malnutrition in more countries, incorporating nutrition in rapidly expanding HIV/AIDS initiatives, while starting to address issues of overweight and diet-related noncommunicable diseases (NCDs), where relevant.

This chapter proposes that to accelerate progress in nutrition, development partners, in collaboration with developing countries, need to convene around a common agenda in nutrition and agree to support this agenda through a coordinated, focused set of actions in two areas:

- *Scaling up action in countries by addressing the three key operational challenges: mainstreaming nutrition in country strategies and approaches; reorienting existing large-scale programs to maximize their effects; and building global and national commitment and capacity for enhancing investments in nutrition.*
- *Supporting a coordinated set of priorities for action research and learning-by-doing in mainstreaming nutrition in the development agenda, strengthening and fine-tuning delivery mechanisms, and strengthening the evidence base for investing in nutrition.*

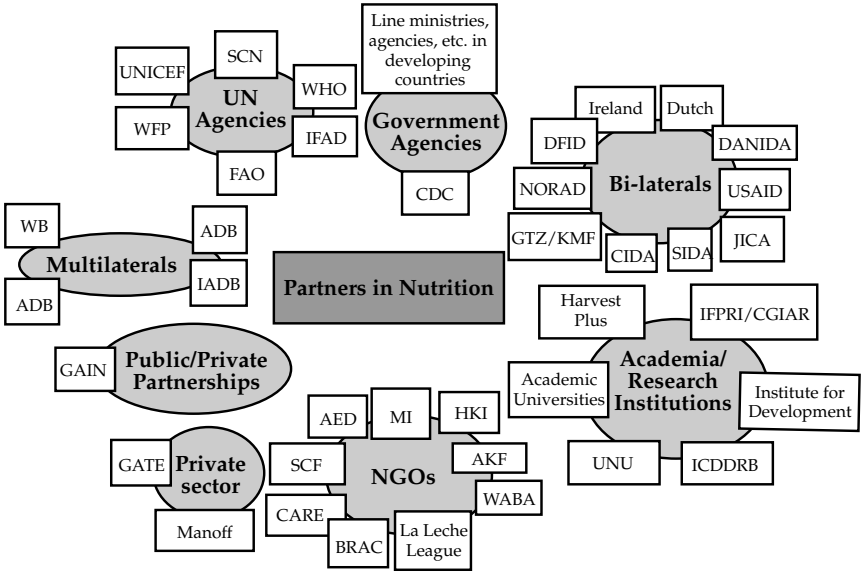
Without this kind of coordinated and focused action by development partners and developing countries, no significant progress in nutrition can be expected and the Millennium Development Goals (MDGs) will continue to be compromised in the countries and among the people who need them the most.

Uniting Development Partners around a Common Nutrition Agenda

Development partners supporting nutrition

The principal development partners that support nutrition at the global or national levels are shown in figure 5.1. Most development partners supporting nutrition focus on food security, agriculture, and rural development, followed by HIV/AIDS and nutrition as part of maternal and child health services (technical annexes 5.1 and 5.2 outline partners' primary focus areas). Addressing micronutrient deficiencies, seizing the window of opportunity to address undernutrition among young children, and controlling overweight and obesity come lower in the current priorities of most partners. Few agencies are working toward mainstreaming nutrition into Poverty Reduction Strategy Credits (PRSCs), Poverty Reduction Strategy Papers (PRSPs), or sectorwide approaches (SWAps), or even across other intersectoral programs such as gender and community-driven development (CDD) programs.

Figure 5.1 Principal development partners supporting nutrition



Most partners support capacity development activities in some form, but much of this effort goes into training nutritionists to be better nutritionists, rather than in orienting key government planning, finance, and economics staff toward nutrition and building commitment and support for nutrition in ministries of finance and planning. Though some agencies are actively building commitment, their efforts are mainly limited to narrow focus areas (such as breastfeeding for the World Alliance for Breastfeeding Action and La Leche League, and micronutrient fortification in selected countries for the Global Alliance for Improving Nutrition [GAIN]). The continuing low level of global interest in general nutrition is evidence that commitment building has been neglected; the fact that many of the agencies reviewed in technical annexes 5.1 and 5.2 have no specific nutrition policies or focus makes it even more evident that nutrition has been marginalized in the development agenda, even by development partners.

Each country needs to drive its own investment agenda and hence should lead the repositioning of nutrition in the development agenda that is proposed in this report. When countries request help in nutrition, the role of development partners is to respond, first by helping countries develop a shared vision and consensus on what needs to be done, how, and by whom, and then by providing financial and other assistance. Nevertheless, in chapter 4 we argued that much of the failure to scale up action in nutrition results from a lack of sustained government commitment to action and hence low demand for assistance in nutrition. In this situation, the role of the development partners must extend beyond responding when requested to do so by governments, to using their combined resources for analysis, advocacy, and capacity building to encourage and influence governments to put nutrition higher on the agenda wherever it is holding back achievement of the MDGs, poverty reduction, and human capital formation. This role can be fulfilled only if the development partners share a common view of the malnutrition problem and broad strategies to address it and speak with a common voice (box 5.1).

Building a shared vision and consensus on actions does not imply that there should be no discussion or dissenting voices or new research. Instead, we propose that the approach to cooperation and consensus should differ in the political and programmatic realms. In the political realm, key development partners must forge a consensus on the "big picture" issues that drive and sustain political commitment to investing in nutrition at global and national levels. In the programming realm, partners must institute a culture of inquiry that derives from action research, monitoring, and evaluation—and that drives stakeholders at all levels to continuously reorient and fine-tune programs and investment strategies to maximize impact, within the framework of a broad strategic consensus.[1] Although previous

efforts at uniting development partners have not always been successful, we hope that this distinction between the political and the programmatic realms will help lay the groundwork for successful consensus building as nutrition is repositioned at the center of the development agenda.

Box 5.1 Lessons for nutrition from HIV/AIDS

Some lack of focused interest and support for nutrition may derive from the disadvantages inherent in multisectoral problems and solutions, but successful examples from HIV/AIDS may offer lessons for scaling up nutrition efforts. The Multicountry HIV/AIDS Program (MAP) was jump-started by the World Bank committing $1 billion in little more than three years and creating an enabling environment for major inputs from other partners. This happened because Bank leaders spoke out forcefully and regularly so the issue became a "must" on national agendas, and dedicated Bank funds and staff provided consistent support, and a mechanism supported by the Bank coordinated the relevant partners (primarily UN agencies through the Joint United Nations Programme on HIV/AIDS [UNAIDS]). Such a potential mechanism exists for nutrition through the United Nations' Standing Committee on Nutrition (SCN)—but for the SCN to play a coordination role would require major changes in its mandate. Other more operational mechanisms may need to be explored.

Further lessons are embodied in the MAP interim review undertaken in 2004. It identified eight critical MAP elements that provide a simple framework—one that could apply to future efforts in nutrition:

- Government commitment and governance, particularly the role of national leadership (in nutrition this is embodied in resolving institutional and commitment-building issues).
- National HIV/AIDS strategies and frameworks linked to resource allocation (National Plans of Action for Nutrition have been largely theoretical, unlinked to national resources, and divorced from assessments of national capacities).
- The multisectoral approach, including but not limited to the health sector.
- Community engagement (may need to be considered in a review of human resources for nutrition at community levels, among other issues).
- Strengthened monitoring and evaluation.
- Donor collaboration and coordination.
- Bank instruments—and the links from MAP projects to programmatic loans and health sector investments.
- Implementation experience.

Three Key Operational Challenges to Scaling Up

To more effectively address the malnutrition challenge, actions must be scaled up. To do so, three key operational issues must be addressed. They are to mainstream nutrition interventions into programs (rather than projects) in health, agriculture, and other sectors; to reorient some existing large-scale nutrition investments that are not achieving the desired effect; and to build the commitment and capacity required to underpin the scaling-up and reorientation needed. Some tools to help development partners decide on priorities for scaled-up action follow this discussion.

Mainstreaming nutrition in country strategies and program approaches

As outlined in chapter 4, a new programming environment is emerging globally and nationally. The move from projects to programs, from financing and implementing vertical disease-specific projects to SWAps and budget support, as well as a reinvigorated focus on multisectoral action, poverty reduction, and equity issues, are all part of this new environment. The roles of civil society and the private sector are becoming more important. The focus on results has never been higher on the agenda of both development partners and developing countries. These changes call for new approaches in taking the nutrition agenda forward, especially in the following areas.

Repositioning nutrition appropriately in country development strategies. Countries need to recognize that nutrition is not a consumption issue; nor is it primarily a question of welfare. Strategic nutrition investments can contribute to human capital formation and can thereby drive economic growth. Nutrition is an integral part of the first MDG, which aims to reduce poverty and hunger. While many countries are on track in reducing income poverty, most are not on track in improving nonincome poverty (malnutrition and hunger). Without direct investments in nutrition, they will continue to be off track not only on the first MDG, but also on the health, HIV/AIDS, education, and gender MDGs (chapters 1 and 2). This critical recognition is the most important issue in repositioning nutrition in country development strategies and within the agendas of development partners.

Many evaluations have rightfully cautioned that intervention strategies must be context-specific,[2] so we do not subscribe to a prescriptive approach. Each country's strategy and actions for improving nutrition will look different. In particular, each country needs to find a balance of interventions in food, health, and caring practices that is appropriate to its situation—in terms of the type and seriousness of malnutrition, where past nutrition investments have gone, and the country's commitment and capacity to act. (See figure 5.2 for a practical tool for helping countries make policy choices

for investing in nutrition, and box 5.2 for some specific suggestions about priorities when commitment or capacity are weak.) We do not propose a global "one size fits all" approach to addressing malnutrition; however, we do recommend that when developing national or regional strategies, countries and their development partners pay special attention to the following efforts:

- Focusing strategies and actions on the poor to address the nonincome aspects of poverty reduction that are closely linked to human development and human capital formation.
- Focusing interventions on the window of opportunity—conception through the first two years of life—because this is when irreparable damage occurs.
- Improving mother- and child-caring practices to reduce the incidence of low birthweight, and to improve infant-feeding practices, including exclusive breastfeeding and appropriate and timely complementary feeding, because many countries and development partners have neglected to invest in such programs.
- Scaling up micronutrient programs because of their widespread prevalence, effect on productivity, affordability, and extraordinarily high benefit-cost ratios.
- Building on the country capacities developed through micronutrient programming to extend actions to community-based nutrition programs.
- Working to improve nutrition not only through health, but also through appropriate actions in agriculture, rural development, water supply and sanitation, gender, social protection, education, and CDD.[3]
- Strengthening investments in the short routes to improving nutrition, yet maintaining a balance between the short and the long routes.
- Integrating appropriately designed and balanced nutrition actions in country assistance strategies, SWAps in multiple sectors, MAPs, and PRSPs.

Development partners can assist by:

- Helping countries identify appropriate institutional arrangements for policy development, cost-effectiveness and affordability analysis, and investment planning.
- Providing technical assistance and capacity-building support in these areas if needed.

Accelerating the move from project to more coordinated program approaches. Multisectoral PRSPs, PRSCs, and SWAps offer an opportunity to mainstream and scale up nutrition. Development partners can help countries take advantage of this opportunity by moving from financing

Box 5.2 What to do when

Financial capacity is weak:

- Vitamin and mineral supplementation (vitamin A, iodine, iron).
- Food fortification.
- Immunization.
- Oral rehydration therapy.
- Deworming.
- Community-Integration Management of Childhood Illnesses (IMCI), including nutrition.
- Growth promotion, if it can be added to an existing outreach system.

Managerial capacity is weak:

- Immunization and oral rehydration therapy.
- Vitamin A supplementation as an add-on to immunization.
- Food fortification (provided there is a manageable number of food manufacturers).
- Growth promotion, if it can be added to an existing outreach system.
- Leverage scarce government capacity by:
  - Contracting services out to NGOs, if available
  - Using community organizations to deliver services.

Commitment is weak:

- Reduce risk by choosing just one or two interventions in one or two government departments where champions can be found.
- Start with interventions that are relatively cheap and easy to manage, such as vitamin A and iodine supplementation.
- Pilot interventions in a small area, where speedy, commitment-boosting results can be assured without government spending too much money.
- Invest in analysis and evidence-based advocacy to strengthen country commitment rather than in donor-driven projects that will not be sustained without country ownership.

Source: Excerpt from technical annex 5.4.

small-scale, donor-driven projects to partnering in large-scale, country-driven programs; by agreeing on how each agency can best support developing country governments in terms of its comparative advantage in financing, technical expertise, or presence; and by reducing the government's aid management burden through common procurement, accounting, and reporting

procedures. This is beginning to happen in some countries, showing that it can be done:

- In Bangladesh through the recently approved Health, Nutrition, and Population Sector Program (HNPSP), 13 donors have agreed to pool their funds for a SWAp—of which a substantial proportion will go to nutrition. Nutrition is also a key element of the draft PRSP in Bangladesh. All this builds on experience gained through previous traditional projects—the Bangladesh Integrated Nutrition Project (BINP) and the National Nutrition Project.
- In Madagascar, nutrition is being mainstreamed and scaled up through the PRSC, building on experience from the SEECALINE project.
- In Ethiopia, the government is developing a national nutrition strategy with coordinated support from several partners (The United Nations Children's Fund [UNICEF], the Canadian International Development Agency [CIDA], the U.S. Agency for International Development [USAID], the International Food Policy Research Institute, the World Bank, and others). The strategy, which was a condition to be met before the next PRSC, can provide a focus for coordinated donor support in the country and could be resourced from the next PRSC as well as from coordinated donor resources for different elements.

Reorienting existing large-scale investments to maximize impact

While most countries have failed to mount large-scale programs to improve nutrition, some have made substantial investments whose effects are less than they could be. This usually happens because the quality of implementation is poor, or because there is a mismatch between the causes of malnutrition and the priorities of the programs to address it, as outlined in chapter 4. In many cases, even where the need to change design and strategy is recognized, bureaucratic and political resistance to change often makes programs more inflexible than they need to be.

Improving implementation quality. Poor implementation quality can have a variety of causes: implementation capacity in general may be weak; some specific aspects of program management such as worker training may be weak; or—a design problem—the intensity of resource use for training and supervision, or the ratio of field staff to population, may not be enough to allow quality services; and monitoring and evaluation may not focus on this issue (chapter 4). In addition, program experience suggests that bureaucratic, professional, and political resistance to change has been underestimated. Development partners can help by:

- Giving more attention to and financial and technical assistance for improving program design, monitoring, evaluation, and management.

- Providing technical support for cost-effectiveness analysis to identify issues of intensity of resource use and providing finance for resolving them.
- Providing coordinated support and guidance on overcoming bureaucratic and political resistance to change in program strategies and design.

Addressing mismatches between causes and interventions. Three common mismatches between needs and design, outlined in chapter 3, are the "food-first" mismatch, wherein countries spend large resources on food or feeding programs when the problem lies elsewhere; the age-targeting mismatch, wherein countries invest in older children, when most malnutrition happens at younger ages; and the poverty-targeting mismatch, wherein programs fail to target malnutrition in the poorest areas, either by design or by faulty targeting. Such mismatches must be fixed if any effect is to be expected from several existing large-scale nutrition programs. Similarly, as PRSPs become important policy tools, attention must be paid to ensuring that the strategies and actions proposed in country PRSPs match the epidemiology of malnutrition in that country. Development partners can help by supporting policy analysis that identifies mismatches (see, for example, Gragnolati and others forthcoming and Shekar and Lee 2005) and with technical support and financing to help countries reorient their investments more productively.

Building commitment and capacity

Scaling up nutrition programs in countries that have underinvested and reorienting ineffective programs in countries that have invested requires strong commitment and specific institutional capacities. These two efforts also require a very specific investment in skills for building consensus among stakeholders at global and national levels.

Building commitment. Commitment building takes place in a largely unsystematic way rather than being treated as a recognized field of professional practice as important to nutrition as epidemiologic or economic analysis. It needs to be professionalized, drawing on skills from the fields of strategic communication, political and policy analysis, and organizational behavior.[4] Well-informed nutrition champions need to work systematically to:

- Build local partnerships of individuals and institutions that can influence politicians, implementing agencies, and development partners to press for increased budgets for the right kinds of nutrition investments because development partners can put more money into nutrition only if countries demand it.
- Identify gaps in the country's capacity to build commitment to improving nutrition and seek help to fill those gaps from local institutions, other

developing countries, or nongovernmental organizations (NGOs) and other development partners.

Systematic commitment-building activities can cost several hundred thousand dollars per country,[5] costs that are largely incurred before government or donor finance is available for the resulting programs or reforms. Development partners could help countries cover these costs by raising a grant fund that countries can draw on to pay for technical assistance and the upstream costs of building commitment and stakeholder consensus. To advance the state-of-the-art, they could help develop best practices and document them in a toolkit.

Building capacity. Evaluation shows that several aspects of institutional capacity building have received little attention (chapter 4). Countries need to focus more on increasing accountability to managers and clients, on improving governance, and on other measures that give implementers stronger incentives to perform. While many capacities can be strengthened during program implementation, countries need to focus also on developing capacities required before major programs are scaled up or reoriented, such as the capacities to:

- Systematically strengthen commitment.
- Analyze the relative cost-effectiveness of nutrition investments and service delivery approaches.
- Identify appropriate institutional arrangements through careful analysis of the best implementation arrangements and their fiscal and political implications.
- Develop evaluation plans and carry out quality baseline studies needed for evaluation.

Development partners could support this agenda by developing guidelines for assessing and strengthening institutional capacity, and by providing funding and technical assistance in these areas where it is needed.

Where to Focus Actions against Malnutrition

Prioritizing countries for nutrition actions

Many countries deserve priority action, given the scale of their malnutrition problems. But epidemiological considerations are only one of four key criteria for determining investment priorities across countries. The three remaining criteria are commitment, capacity, readiness for action, and to some extent, population size.

A matrix for prioritizing nutrition actions (figure 5.2) has two purposes:

- First, the matrix uses available epidemiological data to make the case that the malnutrition problem is pervasive in many countries and should therefore be an impetus for action; countries with the highest malnutrition rates in each region should be prioritized for action, followed by those with lower rates.
- Second, the matrix suggests that the response should be tailored to the magnitude and the nature of the problem. For example, where problems of underweight or stunting are overwhelming, that should be the focus of action. Where the undernutrition problem is confined to micronutrient deficiencies, those should be the focus for action. Where undernutrition issues are large and the overweight problem is emerging, actions must be targeted to both, without compromising investments in either. For overweight it may be best to scale up slowly, starting with only a few countries, to allow fine-tuning of strategies and approaches.

The detailed methods for identifying priority countries for support are outlined in technical annex 5.5. More details on regional and national epidemiology are included in technical annex 5.6.

Priority countries for nutrition actions

Three categories of countries are identified in figure 5.2, based on this classification:

- Category A: Countries that have either underweight or stunting rates greater than 20 percent.
- Category B: Countries that have either vitamin A deficiency greater than 10 percent or iron deficiency anemia prevalence greater than 20 percent.
- Category C: Countries that have an emerging overweight problem.

The matrix shows that undernutrition (both macro- and micronutrient deficiencies) and overweight are significant public health problems in most developing countries: 80 of 126 countries for which we had data fall in category A, and all 80 countries with micronutrient data fall in category B; 63 countries have both macro- and micronutrient deficiency problems (overlap between categories A and B). In about half the countries with overweight data, more than 3 percent of children are overweight (category C), and about 40 percent of these countries have both underweight and overweight problems (overlap between categories A and C), suggesting that

both ends of the malnutrition spectrum (underweight and overweight) coexist in many developing countries.

Almost all the countries in the Middle East and North Africa, as expected, have both macro- and micronutrient deficiency problems that require interventions. It is also evident that overweight among children is fast becoming a public health problem even though absolute levels are still considerably low compared with the magnitude of the undernutrition problem. About one-third of the countries with overweight data have overweight prevalence rates higher than 3 percent among preschool children.

In East Asia and the Pacific, more than 70 percent of countries with data have underweight or stunting problems. Countries such as Indonesia and Mongolia carry the double burden of undernutrition and overweight problems, and the overweight problem is emerging in China.

Prevalence of undernutrition is much lower in Europe and Central Asia, but a quarter of the countries still have a stunting problem. Uzbekistan and Albania also show more than 10 percent wasting. Unsurprisingly, overweight is common; two-thirds of countries with data have an overweight problem. Besides vitamin A deficiency and iron deficiency anemia, iodine deficiency disorders (IDD) of public health significance are found in two-thirds of countries with data.

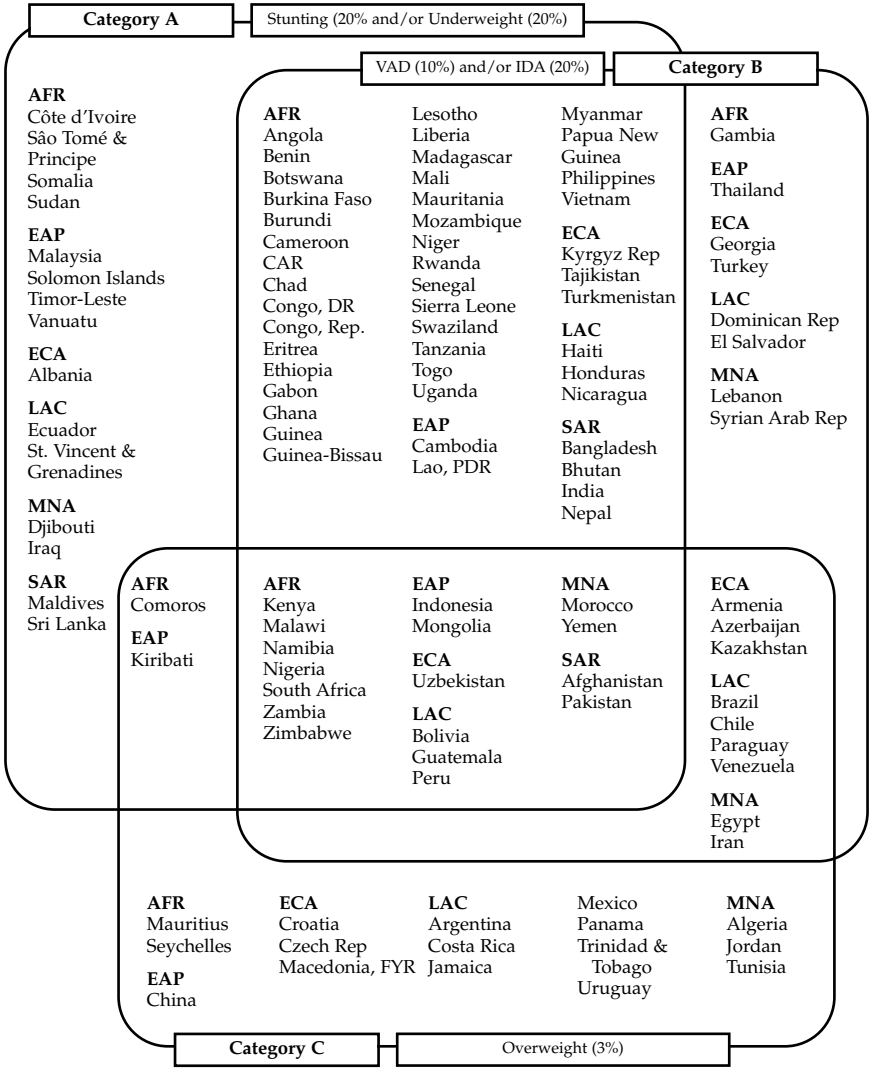
Countries in the Middle East and North Africa have a similar malnutrition profile to those in Latin America and the Caribbean. Although underweight is very limited (primarily to the Republic of Yemen), about one-third of the countries have stunting, and Djibouti has a concurrent problem of wasting. Overweight is of particular concern in the Middle East and North Africa; in all seven countries with data, more than 3 percent of children are overweight. Prevalence of overweight is higher than 5 percent in Algeria, Egypt, Jordan, and Morocco. And the high prevalence of both macro- and micronutrient deficiency in Yemen calls for immediate attention.

Although only one country in Latin America and the Caribbean region (Guatemala) shows an underweight prevalence of more then 20 percent, one-third of the countries have a problem with stunting. Vitamin A deficiency and iron deficiency anemia are also common, although the prevalence of IDD is relatively low. Overweight is pervasive in seven countries—Argentina, Bolivia, Chile, Costa Rica, Jamaica, Peru, and Uruguay—with rates of more than 5 percent.

Figure 2.12 and Maps 1.1–1.4 give additional regional and country information.

Although in South Asia overweight is currently limited to two countries, Afghanistan and Pakistan, undernutrition is incomparably high in all countries in the region; even Sri Lanka, with an under-five mortality rate of less than 20 per 1,000 live births, has about 30 percent underweight and 20 percent stunting. All countries in South Asia also have extremely high rates of vitamin A deficiency and iron deficiency anemia.

Figure 5.2 Typology and magnitude of malnutrition in World Bank regions and countries



Source: WHO (2004); UNICEF and MI (2004b); De Onis and Blossner (2000).
Note: IDA = iron deficiency anemia only; VAD = vitamin A deficiency only; S = stunting only; U = underweight only; (S) = stunting with no underweight data; (U) = underweight with no stunting data; Δ = wasting; π = total goiter rate greater than 20 percent. All countries with only macronutrient deficiency do not have micronutrient information. ™ = no overweight data. AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MNA = Middle East and North Africa; SAR = South Asia.

Implications for action

Decisions to prioritize nutrition actions in regions and countries must be based on two criteria:

- The nature and magnitude of the nutrition problem in the region or country, as identified in the prioritization matrix.
- Country capacity, commitment, and readiness for nutrition actions, including institutional arrangements for nutrition.

Where the need is great, but capacity and commitment are low, investing in building commitment and capacity and identifying an appropriate institutional home for nutrition may be the first priority, perhaps through the vehicle of a traditional project. Where the need is high and there is some experience, commitment, and capacity for implementing nutrition actions, efforts may be best directed at scaling up pilot interventions through newer approaches and instruments, such as SWAps and PRSCs. For countries that fall in the middle of this continuum, a carefully balanced approach may be called for.

Supporting a Focused Action Research Agenda in Nutrition

Though some technical challenges remain (especially in overweight and in links between nutrition and NCDs and nutrition and HIV), there is broad consensus in the international nutrition community on many technical approaches for improving nutrition.[6] The emerging research challenges are therefore not so much technical or academic as operational, and so need to be pursued through learning-by-doing in the real world in three areas:

- Mainstreaming nutrition in the development agenda.
- Strengthening nutrition service delivery.
- Continuing to build the evidence base for how to tackle some forms of malnutrition operationally.

Research in the last area is needed to meet the rapidly growing challenge of overweight and obesity and the links between nutrition and HIV, as well as low birthweight reduction where operational experience is insufficient to scale up with confidence.

Pulling together the knowledge gaps identified earlier in the report suggests a set of action research priorities for discussion (table 5.1). Ensuring a strategic link and a synergy between the global research agenda and the global programmatic agenda—so that each drives the other—is critical for

Table 5.1 Suggested priorities for action research in nutrition

Theme	*Key action research issues*
Mainstreaming nutrition in the development agenda	• Mainstreaming nutrition into sector programs and PRSPs/PRSCs—how this can best be operationalized in different country circumstances. • How best to strengthen commitment to nutrition, build stakeholder consensus, and overcome resistance to change in different country circumstances. • How best to assess and build institutional capacity for nutrition policy analysis and investment planning at the country level. • Costing, financing, and institutional options for nutrition service delivery, including human resource options for nutrition services.
Strengthening and fine-tuning service delivery mechanisms	• Exploring replicability of new service delivery mechanisms in different resource-poor settings: conditional cash transfers, NGO service delivery, public-private partnerships for micronutrients, and so on. • Micronutrients: the complementary role for supplementation, fortification, and food-based strategies (including the efficacy and effectiveness of emerging technologies for food-based approaches such as biofortification). • Targeting and cost-effectiveness of food supplementation linked to nutrition education and growth promotion to maximize the effect on the mother-child dyad.
Further strengthening the evidence base for what works operationally	• Evidence-based strategies to prevent and reduce overweight and diet-related NCDs. • Efficacy and effectiveness of nutrition interventions in HIV programs, such as the role of exclusive breastfeeding in preventing mother-to-child transmission in developing countries; the role of food security in preventing HIV; and the role of nutrition in enhancing the effectiveness of antiretroviral therapy. • Linking nutrition data with larger global monitoring initiatives such as the Health Metrics Network and other MDG and poverty monitoring initiatives, such as the national sample surveys, Multiple-Indicator Cluster Surveys, Demographic and Health Surveys, and Living Standards Measurement Surveys. • Methodologies for evaluating nutrition in the context of programmatic approaches (SWAps and PRSCs); fine-tuning the indicators—are we setting higher standards for nutrition than for other sectors?

Note: For details, see annex 3.

future investments in nutrition to succeed. Development partners could help countries pursue these priorities by providing funds and technical assistance for designing the action research and documenting, evaluating, and disseminating results. Further details on suggested action research priorities appear in annex 3.

The Gaps between Identified Needs and Development Partners' Focus

The development community, and the world as a whole, has consistently failed to address malnutrition over the past decades. The consequences of failure to act on what has been long known about how malnutrition undermines economic growth and perpetuates poverty are now evident in the slow progress toward the MDGs. The unequivocal choice now is between acting on what has been known for so long or continuing to fail.

Few development partners have clear nutrition policies or strategies. The main gaps between the operational needs for scaling up and the focus of development partners lie in four areas:

- Mainstreaming undernutrition and micronutrient programs, as well as integrating nutrition into HIV/AIDS programs.
- Identifying strategies for addressing the emerging epidemic of obesity and building the evidence base for the link between early undernutrition and later susceptibility to NCDs, as well as diet-related NCDs.
- Building commitment.
- Identifying workable institutional arrangements for, and developing institutional capacity in promoting, managing, monitoring, and evaluating large-scale nutrition actions.

The World Bank is the largest investor in global nutrition, with many other investments in its portfolio that can improve nutrition more generally. However, it will take several decades for many of its investments to improve nutrition adequately. Given the magnitude of the problem (chapter 2), the Bank's investments in direct interventions (short route) are extremely small—not more than 3.8 percent of its lending for human development and less than 0.7 percent of Bank-wide lending in 2000–4.

Currently, only 36 Bank-supported investments include some direct support for nutrition. The Bank's total investment is $662 million, spread across Health, Nutrition, and Population (22 investments); Agriculture and Rural Development (5); Education (4); Social Protection (3); and Transport (2 emergency rehabilitation projects). Most of these investments are less than $10 million and only nine have somewhat more substantive (albeit modest) investments in Argentina, Bangladesh, Eritrea, India and its state of Andhra

Pradesh, Iran, Madagascar, Senegal, and Uganda. Yet undernutrition is serious in more than 80 developing countries. The gap between the need and the level of investment, paralleled in the efforts of other development partners, is indeed very large.

Next Steps

The next steps address the gaps between current focus and identified needs in scaling up nutrition actions at global and country levels.

At the global level, the development community needs to unite in explicitly recognizing the role of malnutrition as an underlying cause of mortality, morbidity, and slow economic growth in countries, and to agree on five next steps:

- Coordinating efforts to strengthen commitment, consensus, and funding for nutrition within global and country-level partnerships such as the Child Survival Partnership, the Partnership for Safe Motherhood and Neonatal Health, the New Partnership for Africa's Development (NEPAD), GAIN, SCN, the Micronutrient Initiative (MI), national and global alliances, and public-private partnerships.
- Agreeing on broad strategic priorities for the next decade (such as the three operational priorities and three research themes proposed above) and applying their comparative advantage to each area.
- Agreeing on priority countries for investing in nutrition and for mainstreaming and scaling up nutrition programs (see figure 5.2, figure 2.2, and maps 1–4).
- Agreeing on priority countries for testing systematic approaches to mainstreaming nutrition, building commitment and capacity, and reducing overweight and obesity.
- Making a collective effort to switch financing from small-scale projects to large-scale programs, except where small projects with strong monitoring and evaluation components are required to pilot-test interventions and delivery systems.

In addition, the grant development agencies and foundations need to work together to make funding available at global and national levels to promote and finance the country commitment and capacity-building activities needed before large-scale investments or program reforms are made. Development partners should also encourage well-designed action research on large-scale nutrition programs and more systematic monitoring and evaluation so we can learn from this research and share the resulting knowledge internationally. The World Bank has recently committed to support the International Centre for Diarrhoeal Disease Research, Bangladesh

(ICDDR,B) through a small catalytic development grant ($3.6 million) that will allow ICDDR,B to undertake such activities. Development partners need to strategize together to see how this model can be a catalyst for additional investments to empower other global and regional agencies to play a similar stepped-up role.

At the country level, the development community needs to agree on four next steps:

- In all countries with micronutrient deficiencies, develop a national strategy for micronutrients, finance it, and scale up micronutrient programs to nationwide coverage within five years. An important caveat: while we strongly endorse the need to take the micronutrients agenda to completion, it must not crowd out the need for attention to general undernutrition, as has been the experience in several countries and agencies over the past decade.
- In all countries with undernutrition and overweight problems, in the medium or shorter term:
  - Identify and support at least five to ten countries with large nutrition problems where development partners collectively work toward mainstreaming nutrition into SWAps, Multi-country AIDS Projects (MAPs), and PRSCs (as in Bangladesh and in Madagascar). Where countries have little experience with such investments, nutrition projects may be the first step toward building capacity.
  - Identify and support at least three to five countries where existing large-scale investments can be reoriented to maximize impact. In these countries, provide constructive and coordinated technical support to reorient program design and strengthen implementation quality.
  - Identify and support at least three to five countries where nutrition issues loom large, but where limited investment is available (as in Ethiopia). In these countries, invest in building commitment and provide technical support to develop coordinated strategies that can then be financed through complementary resources from development partners.[7]

The challenge—especially in low-income developing countries—will be to take the unfinished micronutrient agenda to completion and slowly introduce attention and tested strategies to address the overweight agenda, without crowding out attention, capacity, and funding for the most important undernutrition agenda. Initial estimates suggest that the costs for addressing the micronutrient agenda in Africa will be approximately $235 million a year. Costs for other regions and for other aspects of the nutrition agenda have yet to be estimated. Other gross estimates are much larger,

($750 million for global costs for two doses of Vitamin A supplementation per year; between $1 billion and $1.5 billion for global salt iodization, including $800 million to $1.2 billion leveraged from the private sector; and several billion dollars for community nutrition programs).[8] A more detailed costing exercise is being conducted by the World Bank to come up with realistic figures.

One way to prioritize the selection of these countries and actions is to use the tools outlined here and in technical annexes 5.4, 5.5, and 5.6, while considering country capacity, commitment, and readiness for action. The balance between long and short route interventions (identified in chapter 3) will be critical. The agenda proposed here needs to be debated, modified, agreed on, funded, and acted on in concert by development partners through a process of consultation and dissemination.

Notes

1. Pelletier, Shekar, and Du (forthcoming).

2. Pelletier, Shekar, and Du (forthcoming); Habicht, Victora, and Vaughan (1999).

3. Most development partners share the health sector bias. In UNICEF, USAID, and the World Bank, for example, nutrition is managed by the agencies' health bureaus. Of 36 current World Bank-supported projects that include nutrition, 22 are in the health sector, the other 14 in agriculture and rural development (5), education (4), social protection (3) and transport (2) (from April 2005 Portfolio review).

4. Heaver (2005b).

5. Heaver (2005b).

6. *Lancet* series on child survival (2004).

7. In doing this, several steps may be involved:

- Helping countries identify the local causes of malnutrition, and malnutrition's importance compared with other development constraints.
- Helping with practical tools for deciding how to invest (see technical annex 5.4).
- Helping develop a national intervention strategy and a matching action research program.
- Putting in place the public expenditure reorientation needed to finance the strategy.
- Agreeing on a cofinancing strategy that makes best use of each development partner's comparative advantages (technical support, financing, monitoring and evaluation, and on-the ground presence).

8. Hunt (2005).