4
Getting to Scale

This chapter focuses on the challenge of scaling up programs for undernutrition and micronutrient malnutrition in more countries, whether on their own, or as is increasingly the case, as part of health, community development, or other sectoral and cross-sectoral initiatives. There are different options in terms of policy choices, institutional arrangements, and financing approaches, and more analysis on which options are appropriate in which country circumstances will be useful. Several countries have already scaled up successfully, and lessons have emerged from their experiences in managing nutrition programs and organizing services, developing approaches for coordinating with development partners and obtaining financing, and finding ways to strengthen commitment and capacity. The key issue facing the international community is not so much how to scale up or what to scale up, but how to strengthen countries' commitment and capacity to do so.

This chapter reviews lessons from the experience of countries that have tried and succeeded, and tried and failed, to scale up nutrition programs. It focuses on options for managing nutrition programs, organizing services, channeling finance and coordinating financiers, and strengthening commitment and capacity.

Managing Nutrition Programs

The international nutrition community has done less analytical work on these four areas mentioned above than on the efficacy and effectiveness of different nutrition interventions (chapters 1 and 3), reflecting a long-standing bias in nutrition research.[1]

Managing nutrition programs in the field

Of the four areas, there is substantial literature only on how large-scale community growth promotion programs are best designed and managed in the field.[2] Two clear lessons emerge from this literature:

- Involving and, as far as possible, empowering communities are key. This means not only consulting communities about the design of nutrition education and using community workers to deliver services (chapter 3), but also mobilizing communities through well-planned communication programs and giving them a role in designing, monitoring, and managing nutrition services. This was attempted in Senegal's first community nutrition project (technical annex 4.1B).
- Successful programs also pay attention to the detailed micro-level design of management systems for targeting program clients; selecting, training, and supervising staff; and monitoring progress. Monitoring processes that focus communities and implementing agencies on outcomes or results are particularly important. India's Tamil Nadu Integrated Nutrition Project (TINP) (see technical annex 4.1C) and Honduras' Atención Integral a la Ni_ez (AIN) (see technical annex 4.1D) programs are examples of paying special attention to the detailed design of management systems.

Managing nutrition programs at the national level

The many sectors and agencies involved in improving nutrition make management difficult. Because nutrition does not naturally fall under a single line ministry, there has been long-standing debate and experiment (see Levinson 2002[3] for a review) about where its institutional home should be. Experience shows both what does not work (technical annex 4.1E) and what can work. In practice, successful nutrition programs have been managed by a variety of line agencies in different countries, with effective oversight from a variety of coordinating or managing bodies: for example, in Burkina Faso, from a National Food Policy Coordinating Committee; in Madagascar, from the Prime Minister's office; in Senegal, from the President's office; and in Honduras, from a ministerial-level body in charge of coordinating foreign-assisted projects. One set of emerging lessons:

- There should be a clear division of responsibilities among implementing institutions.

- Although oversight agencies should not be given implementation responsibilities, they should be able to influence intersectoral resource allocation so they have a way to give implementing agencies an incentive to perform.
- Where the oversight institution is located is less important than that it is at a high level and that it is backed by strong political and bureaucratic commitment.

Thailand managed its national nutrition program, perhaps the world's most successful, along these lines as detailed in box 4.1.

Another clear lesson is that, although oversight and control are important, the best results are obtained when stakeholders cooperate as willing partners, whether in programs involving multiple government agencies, public-private partnerships such as those for food fortification, or programs bringing together multiple development partners or cofinanciers. Progress is being made with technologies for partnership building (see Tennyson 2003 for a recent how-to guide).

Box 4.1 How Thailand managed its National Nutrition Program

Thailand had no agency in charge of nutrition. The National Nutrition Program's overall direction was set by a National Nutrition Committee, chaired by the Deputy Prime Minister, on which the line agencies in the program were represented. The Committee was served by a small secretariat, headed by the Deputy Secretary-General of the National Economic and Social Development Board (NESDB, Thailand's planning ministry) and housed initially in the NESDB and later in the health ministry.
The program was set out in an annual national food and nutrition plan, allocations to which were controlled by the NESDB, based on line agencies' performance. The Ministries of Health, Interior, Agriculture, and Education helped draw up their parts of the plan and control its implementation, so they were motivated to perform. The Permanent Secretaries of the four ministries met once a month to coordinate their work. Thus in Thailand, it is less appropriate to speak of one multisectoral national nutrition program than of a set of nutrition programs in different sectors, run by different agencies.

Source: Heaver and Kachondam (2002).

Where we need to know more

Key areas for further work:

- Best-practice case studies of how countries have organized multisectoral nutrition program management and partnership building at central and field levels, and action research on how partnership approaches are best organized and managed in different country circumstances.
- Best-practice case studies of monitoring processes that focus policy makers, implementers, and communities on outcomes and results.

Organizing Services

Because nutrition is not a sector, but contributes to the activities and outcomes in a variety of sectors, nutrition services need to be integrated into existing sectoral programs and build on existing institutional capacity. Using existing capacity is particularly important if nutrition programs are to scale up in Sub-Saharan Africa and other environments where financial and managerial resources are limited.

Fostering public-private partnerships

Countries are increasingly using institutional resources outside government. Food fortification programs harness the institutional capacity of the commercial private sector for production and marketing, while the government's role is usually to build awareness, monitor, and regulate. The Micronutrient Initiative (MI), the United Nations Children's Fund (UNICEF), and the World Bank have had successful experience in assisting governments in this area, especially with salt iodization. A new international nongovernmental organization (NGO), the Global Alliance for Improving Nutrition, has been created to help foster partnerships for food fortification. Similarly, a new Network for Sustained Elimination of Iodine Deficiency is emerging from the Micronutrient Initiative—although questions remain about whether approaches that deal with single nutrients are the best way forward.

Experience from these initiatives is still emerging, and the potential of such public-private partnerships is only beginning to be exploited. In each country, there is a need to identify ways in which the food industry can be involved in designing and supporting implementation of the national nutrition strategy. This means developing a multisectoral alliance in each country between industry, the national government, international agencies, expert groups, and other players to work on specific issues relating to technology; food processing and marketing; standards; quality assurance; product

certification; social communications and demand creation; and monitoring and evaluation.

As well as working with the commercial private sector, governments are increasingly working through partnerships that use the institutional capacity of NGOs for growth promotion as well as micronutrient programs—as in 1993 in Madagascar, in 1995 in Senegal and Bangladesh, and more recently in Honduras and Uganda. Contracting with NGOs poses a management challenge for governments: NGOs have to be overseen, so developing adequate procurement, performance monitoring, and accounting capacity in government is essential. But NGOs have proved flexible and many of them, especially locally based ones, are highly motivated and skilled at mobilizing local communities. And because they are employed on a contract basis, they can be phased out once malnutrition rates decline—an exit strategy that is very difficult to implement in programs that rely on government field staff.

Mainstreaming nutrition into sectoral programs and projects

However, most countries lack a strong network of NGOs and need to organize growth promotion services through government agencies. Integrating these services into existing health and child development programs is one logical option. The World Health Organization (WHO) and UNICEF recently commissioned an exhaustive review of more than 700 studies to determine what combination of interventions would have the most impact on child growth and development.[4] Of the 12 interventions this review came up with (see technical annex 4.2A), 5 were in nutrition and 7 in health and hygiene, illustrating why it makes sense to build nutrition interventions into health services (the 12th was in cognitive and social development in early childhood). These 12 interventions now form the core of the Community-Integrated Management of Childhood Illnesses (IMCI) initiative championed by UNICEF and WHO.

Mainstreaming nutrition into health services. Progress is being made in integrating nutrition interventions into health services through several initiatives. One is the WHO and UNICEF–assisted IMCI program, which has made considerable progress in integrating nutrition interventions into health services at hospitals and clinics. The next step, applying IMCI to services at the community level, is at the pilot stage in several countries. Another initiative is Essential Nutrition Actions, developed by USAID and being implemented by governments and NGOs in several countries. It sets a framework for identifying entry points and tools for integrating essential nutrition actions in policy, health, and community programs. In the Basic Support for Institutionalizing Child Survival (BASICS) projects,

nutrition activities are being incorporated into the routine work of health personnel (technical annex 4.2B). Micronutrient supplementation programs have also successfully mainstreamed nutrition through health.

Mainstreaming nutrition into community development programs. But integrating nutrition into health services is not the only option. A complementary opportunity, little exploited so far, is to integrate nutrition into the community-driven development (CDD) programs that are scaling up rapidly in Africa and elsewhere,[5] rather than duplicate institutions for mobilizing and empowering communities in each sector. Integrating nutrition into CDD programs poses risks as well as opportunities,[6] especially the risk that when empowered to choose their own development priorities, communities may opt for investments in infrastructure rather than nutrition. But incorporating nutrition into community development has three potential advantages:

- Growth monitoring data can help communities define their problems and monitor their progress, as in the World Bank–supported Sri Lanka Poverty Alleviation Project.[7] In Thailand, growth monitoring data lead the list of community development indicators that are displayed in every village (technical annex 4.1F).
- Growth monitoring data can help CDD programs target their interventions in different sectors to the families for which they will do most good.
- CDD programs that finance investments in agriculture, income generation, gender, and social protection can help integrate and balance short

Box 4.2 Assessment, analysis, and action: The "Triple A" process

The Triple A process was developed in Tanzania's Iringa district and then replicated in several other districts, with assistance from UNICEF. Community workers used child growth monitoring to assess the nutrition situation, identifying families in which there was actual malnutrition and families in which a child's growth was faltering and malnutrition needed to be prevented. They then worked with the family to analyze the possible causes: ill health, poor child-care practices, food insecurity, or some combination. Working with the family and with local government organizations, they drew up a tailor-made plan of action to help the family. Depending on the cause of malnutrition, the intervention might be counseling, referral to the health service, or participation in a livelihood creation, microcredit, or social protection program to improve food security.

Source: UNICEF (1990).

route and long route approaches to improving nutrition at the local level. A practical process for achieving this was developed in the 1980s in Tanzania (box 4.2).

Where we need to know more

- Cultural traditions favoring community service vary, as do the amount of time and energy women have. Where are paid community workers likely to be more effective than volunteers?
- What can be done to build and strengthen the trust of governments to give communities and NGOs more responsibility and accountability for identifying and addressing their development problems, with only selective external help?
- While the potential exists for early childhood development programs to improve nutrition, there has been mixed experience with delivering nutrition services through them.[8] How could such programs be designed to make the most impact on nutrition?

Channeling Finance and Coordinating Financiers

Many countries with serious undernutrition problems need external assistance to help them scale up nutrition services. Whether nutrition actions are sustained and institutionalized depends critically on what vehicles and approaches are chosen for financing them.

Projects

Traditional projects are ideal vehicles for testing delivery strategies before scaling up and have also proved well suited to developing capacity—especially, in the World Bank's experience, when improving nutrition is the primary goal of a substantial project, as in Bank-financed projects in Bangladesh, Honduras, Madagascar, Senegal, and Tamil Nadu.[9] Among their advantages: enough money was spent on nutrition to make an impact; enough technical resources could be put in for effective systems development and learning-by-doing; and managers had a strong incentive to focus on nutrition outcomes because they were the primary project goal. Large-scale projects with an emphasis on capacity building are therefore likely to continue to have a role to play.

But many countries are implementing large numbers of small-scale projects in nutrition, often following different intervention strategies, inadequately evaluated, and overlapping geographically in some areas while leaving big gaps in coverage in others. They leave communities poorly

served and governments not knowing which project strategies are most effective. Scarce government management capacity is wasted administering many small-scale efforts and dealing with different donor procurement and reporting requirements. And multiple small-scale projects, flying different donor flags, encourage divided loyalties that make it difficult for government and civil society to build commitment to a national effort to control malnutrition. These major disadvantages suggest that small-scale project approaches are part of the problem rather than part of the solution and should give way to larger-scale approaches and financing.

Sector-wide programmatic approaches

Some countries have made progress toward national nutrition strategies through voluntary coordination efforts. Madagascar, for example, has a voluntary nutrition coordinating group that brings together more than 70 project agencies,[10] reducing project overlaps and harmonizing the nutrition messages sent to communities. Other governments—India is an example—have taken stronger control, enforcing a single community nutrition program model. In the India model, however, the potential programmatic synergies between the reproductive and child health and micronutrient programs (managed by the Health Ministry) and the nutrition program (Integrated Child Development Services Scheme, ICDS, managed by the Social Welfare Ministry) have not been maximized. A third and increasingly widely used option is for traditional projects to give way to program financing, where governments and all development partners cofinance branches of a common national program or vision, rather than small-scale, time-bound projects.

This kind of sectorwide approach (SWAp) is now being adopted in Bangladesh (box 4.3). This should make it easier to sustain and scale up the nutrition program—and to avoid the outcome in Tanzania, where the approach developed by the initially successful Iringa project (see box 0.2) has all but collapsed because the project had no line agency sponsor and its financing was never incorporated into the regular government budget.[11]

Sector-wide programs work best when governments have tested intervention strategies and have developed capacity in procurement, financial management, monitoring, and evaluation—one reason why traditional capacity-building projects still have a place in many countries. Sound monitoring is especially important to the success of sector-wide programs because many of them aim to disburse on the basis of whether output and outcome targets are reached. Linking disbursements to performance creates powerful incentives for managers and workers—but only if the

Box 4.3 Institutionalizing nutrition in Bangladesh: From project to program

Bangladesh's first large-scale nutrition investment was the Bangladesh Integrated Nutrition Project (BINP), a traditional project financed by a $65 million World Bank credit, which expanded a community nutrition intervention piloted by the Bangladesh Rural Advancement Committee (BRAC), a major local NGO. The project focused on improving maternal knowledge and child-care and feeding practices, identified as key causes of undernutrition. The initial investment (1995–2000) was followed up with another investment of $92 million through the National Nutrition Program (2002–6). Financing for scaling up this community nutrition effort has recently been incorporated into Bangladesh's national Health, Nutrition, and Population Sector Program (HNPSP), which will support the government's Health Sector Investment Plan, which includes nutrition (2005–10). The HNPSP is financed by the Government of Bangladesh, with support from 13 development partners, 8 of which (the Canadian International Development Agency [CIDA], the U.K. Department for International Development [DFID], the European Commission [EC], the German Development Bank [KfW], The Netherlands, the Swedish International Development Agency [SIDA], the United Nations Fund for Population Activities [UNFPA], and the World Bank, collectively referred to as the "pooling development partners") will contribute $760 million to a common pool of resources to the government of Bangladesh provided through the World Bank. The SWAp will use common procurement and disbursement procedures and a common monitoring and evaluation system, thereby reducing transaction costs for the government. Other development partners in Bangladesh (including UNICEF, the U.S. Agency for International Development [USAID], WHO, the German Agency for Technical Assistance [GTZ], and the Japanese International Co-operation Agency [JICA], the "non-pooling development partners") will also finance the investment plan, albeit through parallel financing mechanisms. Thus, nutrition will now be financed and managed as part of an enduring government program rather than as a time-bound project. There will be a stronger focus on results: disbursements will be linked to performance, and good performance will be rewarded with extra funds from the pooled financiers. In addition, nutrition is considered key among the six pillars of Bangladesh's Poverty Reduction Strategy Paper (PRSP), thereby further institutionalizing nutrition in the country's development agenda.

Source: Pelletier, Shekar and Du (forthcoming), and World Bank staff.

monitoring system is trusted to reflect reality and if it provides results that feed into the planning and budget process in a timely way.

Programs in multiple sectors

Development financing is also moving away from traditional sectoral projects to multisectoral program financing. More than 50 poor countries have now developed PRSPs, with priorities often financed through multisectoral Poverty Reduction Strategy Credits (PRSCs). A recent review[12] of PRSPs in 40 countries where malnutrition is serious concludes that although most PRSPs mention nutrition issues, they seldom effectively integrate nutrition into strategy. Malnutrition[13] is frequently referred to in definitions of poverty, and nutrition is also often discussed as part of the poverty analyses. Twenty-eight countries used at least one nutrition indicator[14] to measure nonincome poverty; indictors for macronutrient deficiencies such as underweight, stunting, and wasting are most commonly used (even though the technical terms used are not always clear). Six countries also used the United Nations Development Programme's human poverty index, which includes the proportion of underweight children as an indicator of deprivation in a decent standard of living. However, few of these countries follow up with appropriate actions. For example:

- While more than 70 percent of the PRSPs identified malnutrition as a development problem, only 35 percent allocated budget resources for specific nutrition activities. This suggests that nutrition can potentially fit well in multisectoral policy initiatives such as PRSPs; however, because of limited commitment and limited capacity for planning and implementing nutrition actions in countries, it rarely gets funded.
- Many PRSPs identified specific nutrition actions, but they often did not correspond to the type of malnutrition problem. As mentioned in chapter 3, 40 percent of the 38 countries had a micronutrient deficiency problem, but their PRSPs mentioned no activities to address it. By contrast, most countries suggested additional actions to increase food production even when food was not necessarily the limiting factor in improving nutrition in those countries.
- Nutrition actions were rarely prioritized and sequenced on the basis of institutional and financial capacity analysis, or their importance compared with other development needs. Countries with limited development budgets have so far seldom used the PRSP process to face up to the trade-off that doing more in nutrition may mean doing less in other, lower-priority areas.

PRSCs, along with SWAps and CDD programs, are emerging as the dominant approaches to development in smaller, poorer countries, where limited management capacity makes financing development through a smaller number of sectorwide or multisectoral efforts sensible. Integrating nutrition into these vehicles is a challenge now being addressed in countries such as Honduras, Madagascar, and Mauritania, which are scaling up successful nutrition efforts by moving from traditional project to financing through budget support or PRSCs. This experience is too new to have been evaluated; however, an evaluation process must be put in place now, so that lessons can be learned in the near future.

Initial experience suggests that PRSCs may offer a very promising avenue for mainstreaming multisectoral nutrition actions in countries that have already invested substantially in nutrition, and where capacities have been developed through large-scale investment programs. They may be less useful where country commitment to and capacity in nutrition are weak. The dilemma is that while such countries do not have the capacity to implement large numbers of individual projects and need to explore multisectoral alternatives, making nutrition a small part of a multisectoral program may be tantamount to sidelining it. In such cases, where commitment and capacity for nutrition are weak and yet it may have been included in the PRSPs/PRSCs, several options need to be systematically explored and documented:

- A phased approach, beginning with a standard investment project or projects in nutrition to build capacity, followed by mainstreaming in a PRSC.
- Ensuring that nutrition activities get appropriate attention in PRSCs by giving them clear objectives and progress indicators, and by incorporating processes for progress monitoring by a variety of stakeholders—politicians, government departments, program clients, and the media.
- Complementing a nutrition component of such a PRSC with an additional technical assistance project for nutrition capacity building.

Where we need to know more

More work is needed to document country experience with:

- How to integrate nutrition better into health and other sectoral programs and into PRSPs, PRSCs, SWAps, and other new financing and coordinating approaches, while paying adequate attention to the details of behavioral change communication, management, and accountability that are critical for the success of nutrition activities.
- How best to test and evaluate new strategies and develop management capacity in countries where development financing has moved from a project to a program approach.

Box 4.4 Five steps toward integrating nutrition in country PRSPs

Step 1: Determine whether the country has a nutrition problem of public health significance (see annex 1 or technical annex 5.6 for a list of countries):

- If yes, a strong rationale for including nutrition issues in the PRSP exists.
- If yes, develop a case for prioritizing nutrition over other sectors in the country PRSP.
- If not, prioritize other sectors and see if and how nutrition issues fit.

Step 2: If nutrition issues are important:

- Review the size and nature of the nutrition problem (see annex 1 for basic information).
- Using levels of malnutrition estimated in annex 1, calculate estimated productivity losses attributable to malnutrition (both undernutrition and overweight), and analyze cost-benefit of addressing malnutrition.[a]

Step 3: Identify the (possible) causes of malnutrition:

- This information may be available in country.
- If not, commission some analytical work—Demographic Household Survey data are usually a good source for these analyses; also check for other data sets such as Multiple Indicator Cluster Surveys and Living Standards Measurement Surveys.[a]

Step 4: Set up working groups to:

- Identify appropriate objectives for nutrition in the country.[a]
- Select strategies and actions that will respond to the size and nature of the nutrition problem.[a]
- Prioritize proposed actions so they match the epidemiology of the problem and the country capacity.
- Lay out appropriate institutional arrangements for supporting the implementation of nutrition activities across sectors.[a]
- Identify monitoring and evaluation arrangements and capacity development plans.[a]

Step 5: Allocate reasonable funds and resource them through subsequent PRSCs:

- Support implementation.
- Strengthen capacity and implementation through a learning-by-doing approach.

Source: Excerpts from Shekar and Lee (2005).

a. These steps can be built into the PRSP/PRSC implementation process; however, consider laying out these steps in the PRSP.

- A related question (addressed in chapter 3) is to explore the opportunities for scaling up nutrition actions/interventions through Multicountry AIDS Projects (MAPs) and other large-scale AIDS initiatives such as the President's Emergency Plan for AIDS Relief (PEPFAR).

Strengthening Commitment and Capacity

If short route nutrition interventions have high benefit-cost ratios and many of them are quite affordable (chapter 1), why have most countries failed to scale them up—and why have most development assistance agencies put few resources into them? The key constraints appear to be weak commitment and capacity. Of the two, commitment is the binding constraint, since the precondition for developing capacity is commitment to do so.

Strengthening commitment

Country commitment to combating malnutrition can be weak for a variety of reasons (box 4.5). A recent report[15] suggests ways to assess commitment and reviews how some countries with successful nutrition programs built the commitment to scale up. One or a few champions of nutrition—people with the ear of policy makers and capable of carrying out evidence-based advocacy—built partnerships of individuals and institutions that can influence politicians and implementing agencies to press for increased budgets for nutrition programs. They did this by convincing others that improving nutrition was essential to achieving their own goals—whether political stability, national security, developing education, industry or agriculture, or international competitiveness.

Effective communication is the key to building commitment. In Bangladesh, a PROFILES analysis (Academy for Educational Development [AED] process for nutrition advocacy, box 4.6) helped convince financial decision makers of the importance of investing in nutrition. A film from a pilot project, showing children suffering from malnutrition and how village women could run an effective growth promotion program for them, helped bring key politicians on board. In Uganda, politicians promoted the Early Childhood Development and Nutrition project through a specially created Parliamentary Advocacy Committee, and were given on-camera training in how to communicate to the media about the project.[16] These experiences show how important it is to use different communication strategies to win the support of different stakeholders.

But there is more to strengthening commitment than good communication, as shown by Thailand's experience developing its community nutrition program (technical annex 4.1G), and China's developing its salt fortification program (technical annex 4.1H). Also important in varying

Box 4.5 Ten reasons for weak commitment to nutrition programs

- Malnutrition is usually invisible to malnourished families and communities.
- Families and governments do not recognize the human and economic costs of malnutrition.
- Governments may not know there are faster interventions for combating malnutrition than economic growth and poverty reduction or that nutrition programs are affordable.
- Because there are multiple organizational stakeholders in nutrition, it can fall between the cracks.
- There is not always a consensus about how to intervene against malnutrition.
- Adequate nutrition is seldom treated as a human right.
- The malnourished have little voice.
- Some politicians and managers do not care whether programs are well implemented.
- Governments sometimes claim they are investing in improving nutrition when the programs they are financing have little effect on it (for example, school feeding).
- A vicious circle: lack of commitment to nutrition leads to underinvestment in nutrition, which leads to weak impact, which reinforces lack of commitment since governments believe nutrition programs do not work.

Source: Abridged from Heaver (2005b).

degrees in different country circumstances are building informal constituencies in the civil service and in civil society, as well as with industry where appropriate; management arrangements that provide incentives for implementers; appropriate choices of financing vehicles; effective performance monitoring; policy environments conducive to reform; strong legislative and regulatory frameworks; and support from external development partners working together. Efforts to organize civil society in support of nutrition are particularly critical. Thailand's success in mobilizing civil society helps explain how it sustained commitment to its nutrition program for more than 25 years. By contrast, in Bangladesh, Tamil Nadu, and Tanzania, there has been little public pressure to keep initially successful programs on track when government or development partner commitment has faltered.

Box 4.6 PROFILES

PROFILES is a computer-based program for calculating the benefits from improving nutrition in terms of mortality and disease reduction, increased productivity and wages gained, and reductions in spending on social sector programs. Financial decision makers particularly appreciate the program's simulation facility, which allows them to instantly see the implications for the economy of different levels of achievement in improving nutrition.

PROFILES estimates the far-reaching consequences of malnutrition, assessing the short- and long-range benefits of combating nutritional deficiencies, and helps in communicating these findings to decision makers. Over the past 10 years, PROFILES has been used in 25 countries (Bangladesh, Ethiopia, Ghana, Guatemala, India, Russia, and Gaza, to name a few) and a recent evaluation of PROFILES shows that it is an effective tool for:

- Raising awareness about nutrition, promoting coalitions in support of nutrition, and building consensus that nutrition is a priority.
- Building capacity and developing the leadership skills of nutrition advocates.
- Promoting more comprehensive nutrition strategies, leveraging new resources for nutrition, and better targeting existing resources.

In Ghana, for example, a team of nutrition and health professionals from various government ministries, universities, and NGOs used PROFILES to estimate that 5,500 infants were dying per year as a result of suboptimal breastfeeding practices. The use of PROFILES with other initiatives helped nutrition advocates address poor infant feeding practices and helped mobilize the government to include breastfeeding and nutrition programs among its top five child survival priorities, as well as make it the top priority of the Ghana Vision 2020 health sector strategy. For further details, see www.aedprofiles.org.

Source: Excerpt from AED (2003).

Strengthening capacity

The literature on strengthening management and implementation capacity in nutrition is limited.[17] This section develops just two themes among many needing attention in this field—the usefulness of distinguishing between capacities that can be built during implementation and capacities that need to be developed before scaling up, and the need to pay greater attention to issues of governance as part of capacity building.

When and how to build capacity. Most countries that develop successful nutrition programs do not wait to build capacity before scaling up. After short pilot activities to develop effective strategies (a year in the case of Tamil Nadu and Bangladesh), they expand rapidly. Thailand mobilized half a million volunteers in just a few years. The nutrition champions knew they needed to move fast to take advantage of political commitment—a need that must be balanced against the risks of too rapid expansion, which can jeopardize funding and commitment if the program fails to deliver results.

With this trade-off in mind, Matta, Ashkenas, and Rischard (2000) are developing an approach called "building capacity through results," in which systematic capacity building is built into the implementation process. Program implementation is broken down into steps; an analysis is made of what capacities, and whose, need to be developed to achieve the next step; and capacity development activities are limited to only those needed to achieve the next step. This approach means that capacity development automatically responds to operational needs, and managers have an incentive to focus on it because each capacity-building activity produces an immediate, tangible, improved outcome—unlike traditional institutional development activities, which are often disconnected from operations and given low priority.[18]

This approach can be systematically used to build capacities in community mobilization, field-level training, and supervision during program implementation. However, a small number of key capacities are needed before programs expand. In addition to strengthening procurement and financial management capacity (now usually routinely included), up-front attention is required to the capacities for:

- Communicating effectively, which is critical for strengthening the commitment of development partners, governments, and civil societies to nutrition, in turn a precondition for increasing investment.
- Analyzing the relative cost-effectiveness of nutrition programs and service delivery approaches, key to ensuring the right investment decisions are made.
- Carrying out quality baseline studies, so countries can evaluate down the line how well their investment has paid off.

The need for more attention to issues of governance and corruption. A review of institutional development interventions in a sample of World Bank–assisted health and nutrition projects in Africa[19] found that their focus was mainly on three or four of ten possible types of intervention: adding staff and physical and financial inputs; providing training and technical assistance; introducing new technologies; and changing coordination mechanisms. The shortage of trained human resources, especially in

Sub-Saharan Africa, means that traditional, training-oriented, capacity development interventions will remain important. But equally salient in both Africa and South Asia, where malnutrition is concentrated, are problems of weak governance and corruption.[120]

To address these issues, governments and development partners may need to focus more on six capacity development interventions that this study found to be less widely implemented:

- Increasing particular stakeholders' voice in planning and implementation.
- Altering the balance between public and private sectors in service delivery.
- Reforming specific organizational systems.
- Changing or enforcing laws, rules, or regulations.
- Changing attitudes, values, organizational cultures, or incentives and disincentives.
- Providing information and increasing accountability.

Recent work on education in Africa points to high returns from improvements in the governance of social services in countries where corruption is institutionalized.[21]

Where we need to know more

The priority needs are for:

- Practical methodologies for assessing and strengthening commitment and institutional capacity.
- Case studies of successful attempts to assess and strengthen commitment and capacity, and to deal with problems of poor governance and corruption.

Notes

1. Berg (1992).

2. Jennings and others (1991); Gillespie, Mason, and Martorell (1996); ACC/SCN (1997); Jonsson (1997); Hunt and Quibria (1999); Tontsirin and Gillespie (1999); Allen and Gillespie (2001); Heaver (2002).

3. A summary of this paper can be found in Gillespie, McLachlan, and Shrimpton (2003).

4. Hill, Kirkwood, and Edmond (2004).

5. Gillespie (2004).

6. Heaver (2003b).

7. World Bank (1998); Ranatunga (2000).

8. Heaver (2005a).

9. Heaver (2005a).

10. Rokx (2000).

11. Dolan and Levinson (2000); a summary of this paper can be found in Gillespie, McLachlan, and Shrimpton (2003).

12. Shekar and Lee (2005).

13. Not only the explicit term "malnutrition" and its indicators stunting and underweight, but also implicit terms such as "food insecurity," "insufficient food," and "hunger" are used in definitions of poverty.

14. One of the most commonly used income poverty indicators, percentage of food-poor is the proportion of households whose annual per capita expenditure is not enough to buy a basket of food products that ensures the minimum energy requirement.

15. Heaver (2005b).

16. Elmendorf and others (2005).

17. For a tentative conceptual framework for assessing and strengthening capacity in nutrition, see Gillespie (2001); for a discussion of issues in nutrition management and capacity development, see Heaver (2002).

18. Johnston and Stout (1999).

19. Orbach and Nkojo (1999).

20. For example, at different times and in different places, World Bank–supported nutrition programs have suffered from attempts by program managers to use political influence to hire NGOs and community workers who do not meet program recruitment criteria; demand kickbacks for contracts, for recruitment, or for promptly processing expenditure claims; fix the bid prices of supplementary food and medicines; and supply low-quality weighing scales or food, permitting contractors to finance kickbacks from the excess profits.

21. Reinikka and Svensson (2004).