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STRENGTHENING CAPACITY TO IMPROVE NUTRITION

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ABSTRACT

A major premise of this paper is that the failure—or limited achievements—of many large-scale nutrition programs is very often a function of insufficient sustainable capacities within communities and organizations responsible for implementing them.

Following a brief review of the various rationales for an intensified focus on capacity and capacity development, the paper examines the linkages between nutrition programming and capacity development processes before proposing a new approach to assessing, analyzing, and developing capacity. The ensuing sections then focus in more detail on the ingredients and influences of capacity at the levels of the community, program management, supporting institutions, and the government. Finally, the implications of a more proactive focus on strengthening nutrition capacity for donor modes of operation and support priorities are discussed.

A fundamental premise, as enshrined in major international conventions and declarations, is that adequate nutrition is a human right. In order to operationalize a truly human-rights-based approach to nutrition action—whether policy or programs, a fundamental first step is to assess capacity. The rights approach demands an active involvement of “beneficiaries” in processes to improve nutrition. Nutrition-vulnerable individuals, households, and communities are no longer objects of welfare transfers, but rather subjects whose capabilities are ultimately the foundations of sustainable progress.

There are several key recommendations for donor policy and practice that emerge. First, donors need to provide more support for capacity assessment and development, operational research, and the building of policy-research-training-program networks. A concrete, rights-based programming process demands a focus on individuals as subjects—not objects—and thus on their inherent capacity. Inclusion of stakeholders in the process of preparing a project or program—right from the initial problem assessment to the design of appropriate actions—is one of the most important capacity development tools. Such a redefinition of the role of “recipients” demands, in turn, a fundamental redefinition on the part of donors of the key concepts of planning, performance, speed, and quality.

With regard to planning, the traditional project cycle is predicated on the assumption that solutions to known problems can be fully determined at the outset and that projects can be fully designed and costed in advance and successfully implemented to a fixed timetable. This approach is clearly ill-adapted to a learning-by-doing approach that is the foundation of true capacity development. Performance needs to be considered

more with respect to the degree to which the donor is slowly becoming redundant as local capacities develop, while speed should be understood in terms of capacity development, not the processing of donor finance. Quality relates not only to the customary performance standards set by the donor, but crucially to such process factors as the degree of active local ownership of the project.

At the level of donor capacity, such a realignment of procedures will necessitate shifts in the incentive environment. The monitoring of staff performance needs to be related more explicitly to contributions to capacity development, not just to disbursing loans and generating traditional project outputs. Finally, donors need to attach greater priority to encouraging and supporting the monitoring and evaluation of both capacity development and program performance, so as to better know what works where and to disseminate success stories more widely.

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1. INTRODUCTION

Capacity Building is a risky, murky, messy business with unpredictable and unquantifiable outcomes, uncertain methodologies, contested objectives, many unintended consequences, little credit to its champions and long time lags.

Morgan (1997)

The failure, or limited achievements, of many large-scale nutrition programs is very often a function of insufficient sustainable capacities within communities and organizations responsible for implementing them. The principles behind successful community-driven nutrition programming in Asia have been described in an earlier Regional Technical Assistance (RETA) project (Tontisirin and Gillespie 1999), where a dual programming model was adopted—namely direct action in the form of community-based nutrition programs, backed up by supportive or enabling sectoral policy and programs. This paper starts by summarizing these findings as a basis for moving on to consider issues of capacity and institutional development as pertaining to such a model.

First, the definitions of *capacity* and *capacity development* are considered, followed by a review of the various rationales for an intensified focus on this area. The linkages between the programming and capacity development processes are then outlined, before an approach to assessing, analyzing, and developing capacity is put forward. The ensuing sections then focus in more detail on the ingredients and influences of capacity at the levels of the community, program management, supporting institutions, and the government. Finally, the implications of a more proactive focus on strengthening nutrition capacity for donor modes of operation and support priorities are discussed.

A fundamental premise, as enshrined in major international conventions and declarations, is that adequate nutrition is a human right. In order to operationalize a truly human-rights based approach to nutrition action (whether policy or programs), a fundamental first step is to assess capacity. The rights approach demands an active involvement of “beneficiaries” in processes to improve nutrition. Nutrition-vulnerable individuals, households, and communities are no longer objects of welfare transfers, but rather subjects whose capabilities are ultimately the foundations of sustainable progress.

The reader will notice that in many sections the discussion of such issues as capacity-strengthening and institutional development is not specifically focused on nutrition. This is because many of the requirements in these areas are generic to a variety

of social development concerns. The need for change from a nutrition perspective, however, is particularly pronounced, largely because malnutrition is so multifaceted, that is, its causation and sustainable remedies cut across classic sectoral divides. This is particularly true of general, as opposed to micronutrient, malnutrition (hitherto known as protein-energy malnutrition). The capacity to reduce malnutrition thus relates indirectly to the capacities to successfully undertake various activities that may have several nonnutritional benefits.

Second, there are few studies of capacity or institutions deriving from a nutrition perspective from which to draw relevant findings. Indeed this represents a gaping hole in nutrition-relevant research globally, albeit one that is increasingly recognized. Some work is underway at the level of academic capacity building, supported by the IUNS and United Nations University (UNU), but little on explicit capacity development for community nutrition programming. The approach of considering the type of programs that are appropriate with respect to problem and context often does not extend into supporting institutional structures. Even if the “Triple A” cycle of assessment-analysis-action (see Figure 2) is carried out appropriately and a resource analysis is undertaken, other essential elements of capacity are often not investigated (Pelletier 2000; Jonsson, Pelletier, and Shrimpton 1998). This paper suggests a process for systematically and comprehensively analyzing capacity.

The main intended audience for this paper comprises program planners and managers, nutrition specialists, and donors concerned with improving the long-term impact of country-level nutrition support.

2. COMMUNITY-BASED NUTRITION PROGRAM MANAGEMENT PRINCIPLES

The following sections expand on work that was undertaken in the ADB-UNICEF RETA 5671, with particular regard to the paper “Linking Community-Based Programs and Service Delivery for Improving Maternal and Child Nutrition” by Tontisirin and Gillespie (1999). This paper described the ingredients and the dynamics of successful community-based nutrition programs, including social mobilization strategies, project planning and design, management structures, implementation mechanisms, issues of monitoring, sustainability, replicability, and the nature of supportive policy. The main findings of this paper are summarized in this section.

Progress in nutrition programming has been made where community-based programs are linked operationally to service delivery structures, which are often village-based primary health care outlets. Government employees at such levels may be oriented to act as facilitators of nutrition-relevant actions that are coordinated and managed by community-based mobilizers, who are often volunteers selected by local communities. The mobilizer-facilitator nexus (see Figure 1) should be supported and managed by a series of organizational structures from grassroots to national levels, and underpinned by broad-based social mobilization, advocacy, and other communication strategies. Thailand has led the way in Asia with regard to such community-government partnerships.

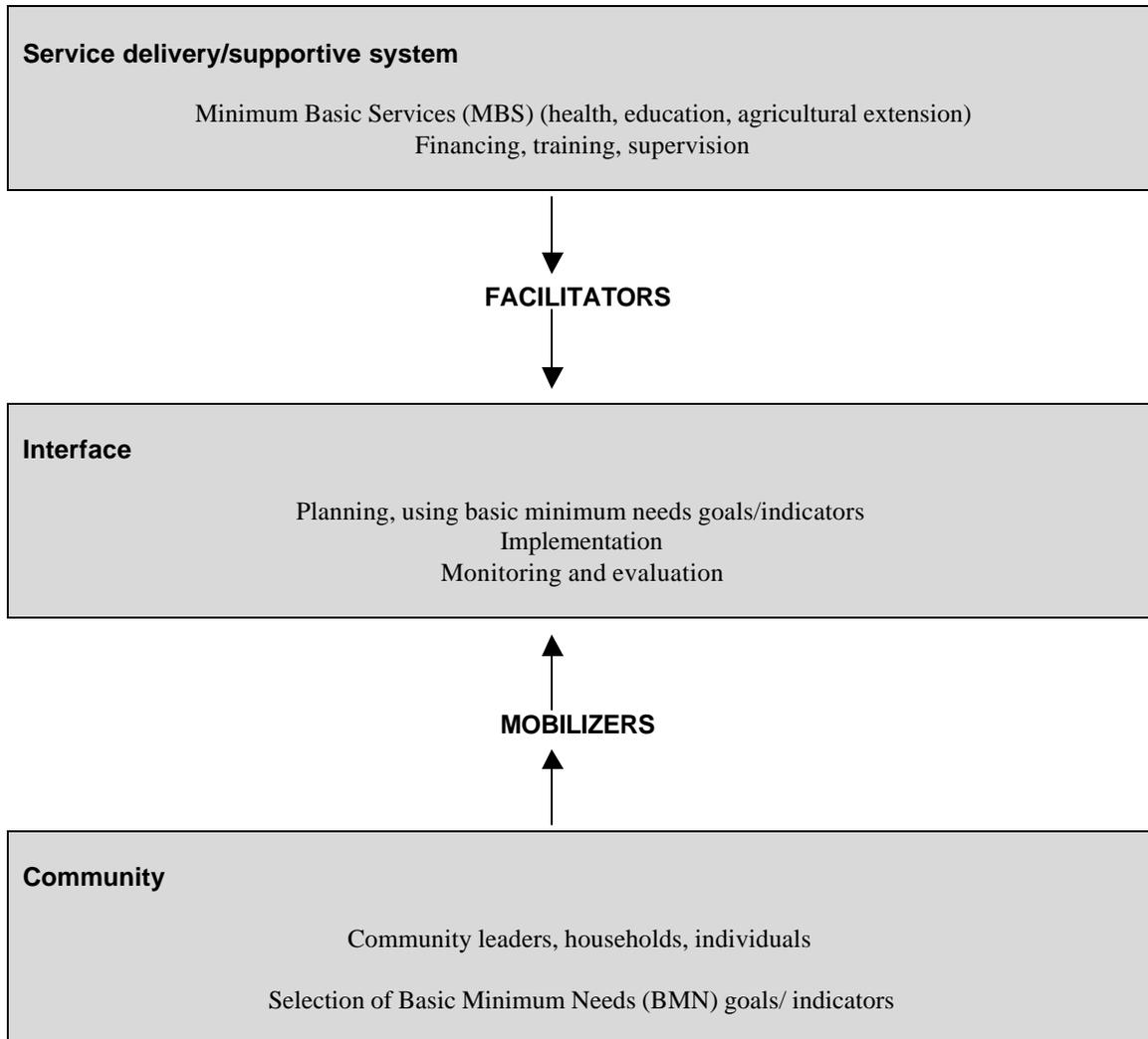
The menu from which relevant actions are chosen and around which community-based programs are developed (as also described in Allen and Gillespie 2000) tends to include the following:

- For young children: growth monitoring and promotion, promotion of breastfeeding and appropriate complementary feeding practices, disease management, micronutrient supplementation, deworming, and possibly targeted food supplementation.
- For women: ante-natal and post-natal care for women including tetanus toxoid immunization, micronutrient supplementation, food supplementation during pregnancy, malaria chemoprophylaxis in endemic areas, and reproductive health education.

The appropriate mix of actions and how they are to be implemented and phased in will depend on the nature of the problems, their causes, and the feasibility (including capacity) and cost-effectiveness of different strategies. Locally-selected indicators may be used by mobilizers and facilitators, both for planning and monitoring.

At national or state levels, enabling policies and programs are needed that explicitly consider the nature and causes of the malnutrition problem and thus the type of sectoral policy modifications that may result in improved outcomes (or at the very least will not exacerbate the problem). Policymaking should in a sense be more bottom-up than in the past, with a greater emphasis on what can be learned from community-based success and how best to enable and accelerate it. This does not imply the exclusion of top-down, centrally derived solutions that may have a role in certain situations (see Section 10).

Figure 1: Community-based nutrition operational nexus



Source: Tontisirin and Gillespie (1999).

Overall, the type of generic lessons to be learned from past experience with community-based nutrition programming (see Box 1) relate more to the approaches adopted than to what was actually done—more how than what. Both process and outcome orientations have merit over different time spans, but for maximal long-term sustainable impact they need to be integrated. Ownership is fundamental to success, with respect to both means and ends. Tools such as the Triple A cycle and the conceptual framework (see Annex 1) are extremely useful in making the process and outcomes explicit to all stakeholders, thus improving communication and fostering ownership.

Box 1: Key success factors in community-based nutrition programs in Asia

Contextual Success Factors

- Political commitment at all levels of society is considered essential for social mobilization at the start of the program or project and for future sustainability. The integration of nutritional goals in development programs in general is a clear manifestation of genuine awareness and political commitment.
- A culture where people, particularly women, are involved in decisionmaking, is a prerequisite for people's participation and the creation of articulate bottom-up demands. A high level of literacy, especially among women, is also associated strongly with participation and organizational capabilities.
- Community organizations, e.g., women's groups, people's NGOs, credit associations, youth clubs or peasant associations, along with good infrastructure for the delivery of basic services, including committed and capable staff.
- Charismatic community leaders who can mobilize and motivate people to do more for themselves in a genuine self-reliant way.
- The parallel implementation of poverty-reducing programs, particularly those integrated with nutrition-oriented programs/projects.

Program Success Factors

- The creation of awareness of the high prevalence, serious consequences and causes of malnutrition, including the hierarchy of immediate, underlying and basic causes, and the need to address causes at all three levels.
- The initiation, promotion, and support of a process whereby individuals and communities participate in assessing the nutrition problem and decide how to use their own and outside resources for actions.
- Clear identification and definition of time-bound goals (targets) at all levels of the program/project. Young children from birth up to 2-3 years, pregnant and lactating women, and adolescent girls are normally the focus.
- The identification and support of facilitators and community mobilizers, providing a sense of joint ownership of the program/project by the community and government.
- Good management of the program/project, including effective leadership, training and supervision of facilitators and mobilizers, an appropriate balance between top-down and bottom-up actions, and effective community-based monitoring.
- The involvement of local NGOs, who often provided excellent facilitators as well as culturally-relevant training. They were usually accountable to the community, which facilitated sustainability.

Source: Jonsson (1997).

3. WHAT IS CAPACITY AND CAPACITY DEVELOPMENT?

Capacity is complex, both conceptually and operationally. It is also a fairly nebulous concept; often invoked—usually as a reason for failure—yet rarely analyzed. Capacity has been defined as:

- “The combination of people, institutions, and practices that permits countries to achieve their development goals” (World Bank 1996).
- “The ability of individuals, organizations, or societies to set and implement development objectives on a sustainable basis” (Schacter 2000).
- “The ability to take collective action to achieve desired results” (Matta 2000).
- “The ability to perform fair and competent analysis and deliberation about the situation, with appropriate forms of participation, so that resulting decisions and actions will be both effective in meeting specified goals and appropriate in the larger context. This ability has technical as well as normative (ethical) and political aspects” (Pelletier 2000).
- The ability of individuals and organizations or organizational units to perform functions effectively, efficiently, and sustainably (UNDP 2000). This definition implies that capacity is not a passive state but part of a continuing process and that human resources are central to capacity development. The overall context within which organizations undertake their functions are also key considerations in capacity development.
- Capacity is the power of something—a system, an organization, or a person—to perform or produce. Capability, a closely allied term, can be seen as synonymous with capacity, or simply as undeveloped or unused capacity (UNDP 2000).

Capacity for nutrition is here defined simply as the ability to assess and analyze the problem of malnutrition and design, implement, manage, and monitor appropriate actions. Thus defined, capacity is the product of many interrelated factors at different levels of social organization—household, community, subnational, and national. Linkages are both vertical and horizontal, and usually two-way. Community capacity, for example, can be strengthened or diminished by subnational and national government actions and policies.

Individual capacities, understood in terms of skills and aptitudes (acquired and augmented through training) are a necessary but not sufficient part of the capacity

equation. Understanding how individual capacities are harnessed and translated into organizational capacities raises the question of incentive frameworks and the supportiveness of the wider organizational environment.

Organizational capacity¹ is likewise influenced not only by internal structures, systems, and procedures, but by the collective capabilities of its staff and by external factors in the wider institutional environment, such as the policy framework, and other political, economic, and cultural factors. These may constrain or support performance and influence issues of organizational credibility and legitimacy.

Inevitably, as focus shifts from the individual level to societal levels, questions of capacity and how to address them become more complex and interrelated.

CAPACITY DEVELOPMENT

Capacity development, or capacity building, has been defined as:

- “The process by which individuals, organizations, institutions, and societies develop abilities (individually and collectively) to perform functions, solve problems, and set and achieve objectives” (UNDP 1997).
- “The growth of formal organizational relationships and abilities, i.e., those changes in organizational behavior, values, skills, and relationships that lead to the improved abilities of groups and organizations to carry out functions and achieve desired outcomes over time” (Morgan 1997).
- “A continuous process by which individuals, groups, institutions, organizations, and societies enhance their abilities to identify and meet development challenges in a sustainable manner” (Land 1999).
- “The process by which individuals, groups, organizations, institutions, and societies increase their abilities to: i) perform core functions, solve problems, [and] define and achieve objectives; and ii) understand and deal with their

¹ The term “organization” is defined as “the rational coordination of activities by a group of individuals with the aim of achieving a common purpose” (taken from Schein 1979). Organizations thus include community-based organizations, NGOs, local and national governments, and international organizations. Nutrition support institutions, e.g., national nutrition institutes, are one type of organization (discussed later). Berg (1993) writes “organizations form part of the fabric of institutions but are not institutions themselves. ...Institutional development means more than just structural or functional changes of an organization. It involves fundamental social change, the transformation of patterns of behavior....”

development needs in a broad context and in a sustainable manner”² (OECD Development Assistance Committee (DAC) 1999).

Capacity development is distinct from institutional development. Institutions may be viewed both as aggregations of organizations—examples of which may include government and banking—or as subsystems within a broader system (e.g., government within broader society). The capacity to do something may require the development of several different institutions.

The notion of capacity is inextricably linked to change and the management of change at different levels. Increasingly, broader capacity initiatives address transformational change (e.g., in such programs as those dealing with governance, decentralization, public sector reform, etc.) in contrast to programs that address gradual or incremental change.

Recognition of capacity development as process carries implications in particular for the roles performed, and approaches used by external agencies such as the ADB in working with local organizations. Issues of ownership, commitment, and leadership are central to this notion of capacity as process.

UNICEF considers capacity building to be an inappropriate term in most cases, as capacity is not created *de novo*—it always exists in some form (UNICEF 1999). It may, however, require realigning or strengthening. Capacity development or capacity strengthening are UNICEF’s—as well as this paper’s—preferred terms.

CAPACITY GAPS

Different types of capacity gap have been identified. Matta (2000) refers to the chasm that separates the view of what “should be done” from “the client’s ability and motivation to do it” as the Type-I Capacity Gap, i.e., “what we think is right for you” versus “what you are willing and able to do.” This, he suggests, was particularly prevalent up to the early 1990s. Following a much greater emphasis on client participation and partnership, this gap is increasingly being bridged. But a second type of capacity gap is emerging as external experts and their clients move into more of a

² This definition goes on to define core capacities of an organization, or community, or sector (or system) as consisting of defining, analyzing the environment or overall system, identifying needs and/or key issues, formulating strategies to respond to or meet needs, devising or implementing actions; assembling and using resources effectively and sustainably, monitoring performance, ensuring feedback, and adjusting courses of action to meet objectives, and finally acquiring new knowledge and skills to meet evolving challenges.

partnership mode. It is the gap between what the clients and development experts jointly aspire for, and the capacity in the client country to move from vision to reality—to drive, manage, and sustain the changes required to make the journey from current reality to aspirations. This Type-II Capacity Gap is possibly a more pernicious mutation of the Type-I Capacity Gap. It breeds frustration without giving either development experts or clients the outlet of blaming each other, or the relief of a ready recipe for corrective action.

4. WHY IS CAPACITY IMPORTANT?

The following are several key elements of a justification for an intensified focus on capacity.

CAPACITY AND HUMAN RIGHTS

Human development expresses itself in human capabilities. In the 1996 Human Development Report, UNDP defines the three most important human capabilities as (1) capability to be well-nourished and healthy, (2) capability for healthy reproduction, and (3) capability to be educated and knowledgeable (UNDP 1996).

The failure of economic growth approaches on their own to build human capabilities has opened the door for more normative arguments in development (ACC/SCN-IFPRI 2000). The United Nations has a normative foundation that is explicitly expressed both in the UN Charter and the Universal Declaration of Human Rights. In his launch of the UN reform in 1997, the Secretary General stated clearly that all major UN activities should be undertaken in a human rights perspective. Many UN agencies, particularly the United Nations Development Programme (UNDP), the United Nations Fund for Population Activities (UNFPA), the Office of the United Nations High Commissioner for Refugees (UNHCR), and the United Nations Children’s Fund (UNICEF), have started a process of operationalizing a “human rights approach” to development (see Section 5).

At least in the case of children, adequate nutrition is enshrined as a human right in the Convention on the Rights of the Child, a convention ratified by all countries except the United States and Somalia. The principle of the “best interest of the child” ensures that adequate nutrition is one of the rights of the child.

Human rights express relationships between subjects with claims or rights and objects with duties or obligations. Essentially, human rights are the relationships between claimholders and duty-bearers (ACC/SCN 1999). Bearers have a duty to respect, protect, facilitate, and fulfill the rights of the claimholders. Bearers and claimants may be the international community, national and local governments, NGOs, communities, families, households, and parents.

One of the most significant paradigm shifts embodied in a human rights approach is that people who are poor are no longer seen as passive recipients of transfers, but rather as subjects of their own actions. This shift not only justifies but *implicitly demands a focus on capacity*, because the performance of duties relating to human rights depends on capacities. Any duty-bearer, whether it be an individual or a national government, cannot be held accountable for the realization of a particular human right unless the capacity exists for duty to be carried out. A fundamental purpose of development cooperation should thus be to improve the capacity or capability (including responsibility, motivation, authority, and resources) of the duty-bearer to meet various obligations. These obligations may be concretized as goals, subscribed to by such duty-bearers as national governments.

CAPACITY AND GOVERNANCE

Alongside this emerging rights paradigm, emphasis on “good governance” is increasing (World Bank 2000). Governance may be defined as the norms, traditions, and institutions through which a country exercises authority for the common good. It includes the processes for selecting, monitoring, and replacing those in authority; the capacity of government to manage its resources and implement sound policies; and the respect that citizens and the state have for the institutions that govern economic and social interactions among them. Governments, as mentioned, represent high-level duty-bearers with fundamental obligations to respect, protect, facilitate, and fulfill the rights of populations to adequate nutrition.

In this era of devolution and rolling back the state, it should be remembered that government remains a critical duty-bearer from a rights perspective. There are certain functions that cannot be adequately accomplished by the private sector or civil society. The private sector may be efficient, but it is not always equitable. NGOs may be more equitable, but they are ultimately accountable to their boards, not those they serve. Government, however, is in principle accountable directly to the people. Good

governance means a government that recognizes its obligations and duties and acts accordingly.

Considerations of governance and human rights both throw the spotlight on capabilities and capacity and the institutions that mediate the capacity-action link.

CAPACITY AND DECENTRALIZATION

Decentralization or “scaling down” essentially refers to the ceding of authority, resources, and capacity to lower levels—or more specifically, the enabling, supporting, or facilitating function whereby the central government scales down its own role, adopting modes of functioning that allow local communities and organizations to build conceptual, operational, and institutional capacities.

There are many examples of the benefits of decentralization such as improved project relevance and performance (including quality and sustainability) and increased efficiency, accountability, and transparency, as discussed in Section 10. In practice, however, mechanisms to ensure sufficient local capacity and accountability have to be present as well. Decentralization processes thus need to be accompanied by adequate support and safeguards from the center.

As decentralization progresses, a central challenge for nutrition programs is finding a balance of approaches. It is not simply a choice between top-down and bottom-up approaches—both are needed. Governments need to scale down to allow programs to scale up and achieve large-scale impact. For effective community-government partnerships to be forged, there is a need for increased advocacy on the part of the center, and increased capacity-strengthening for local governments to undertake new functions usually involving an increased integration of activities.

CAPACITY AND SOCIAL CAPITAL

Social capital essentially refers to the ability of individuals to secure benefits as a result of membership in social networks or other social structures. The *World Development Report* (2000) of the World Bank provides examples, from a poverty perspective, that illustrate how social networks and organizations are key assets in the portfolio of resources drawn on by the poor to manage risk and opportunity.

Distinguishing different types of social capital helps to throw light on important relationships between and within communities that condition their capacity. At the micro and meso levels, the strong ties among family members, neighbors, and close friends can be referred to as “bonding” social capital. The weak ties connecting individuals to work colleagues, fellow members of religious or civic organizations, and business associates can be referred to as “bridging” social capital, which implies horizontal connections to people with similar economic status and political power. “Linking” social capital, on the other hand, refers to vertical ties between the poor and people in positions of influence in formal organizations, such as the state. This model of social capital enables us to capture a vitally important additional feature of life in poor communities, namely, that its members are usually excluded—by discrimination or lack of resources—from places where major decisions regarding their welfare are made.

Many case studies in the *World Development Report* (2000) have shown that social capital is an important ingredient of community capacity, which not only enhances project sustainability, but provides the energy for successfully scaling up programs.

CAPACITY, PARTICIPATION, AND SUSTAINABILITY

Participation is not possible without capacity, and sustainability in community-based programs is not possible without participation. Participation is not merely desirable in nutrition programming, it is a fundamental right—both a necessary outcome and a necessary aspect of the process.

Sustainability is conventionally defined as the durability of positive results, but of course it is more than this. For nutrition programs to make a difference in the long term, sustainability of positive outcomes and positive processes is crucial. Programs may deliver services that improve nutrition, and it will be important that such services and benefits continue—at least so long as they remain relevant, effective, and efficient compared to other options. But the long-term aim should be to facilitate or strengthen community-based nutrition-improving processes.

It is thus ultimately the sustainability *of the process*, not the program *per se* that is most important, with the link between the two being community ownership (see Section 8). Program sustainability is thus merely a milestone along the road to process sustainability.

Program sustainability has been characterized as having the following ingredients, many of which relate to capacity: (1) the stability and strength of support of a program

from key stakeholders (including the community, local and national government, and other external agencies), (2) the coverage, intensity, targeting, quality, and effectiveness of actions, (3) the status and condition of program infrastructure, the systems for its maintenance, and the adequacy of the operating budget, and finally (4) long-term institutional capacity, including the capacity and mandate of operating agencies, the stability of staff and budget of operating agency, adequacy of coordination between agencies and between community organizations and beneficiaries, and the flexibility and capacity to adapt the project to changing circumstances (Valdez and Bamberger 1994).

CAPACITY AND PROJECT PERFORMANCE

Capacity constraints are one of the major reasons for poor project performance. A recent review of World Bank Implementation Completion Reports (ICRs) has shown that only 18 percent of World Bank-assisted HNP projects completed between 1991 and 1998 were rated by the Bank's Operations Evaluation Department (OED) as having substantially achieved their institutional objectives (Johnston and Stout 1999). The most frequently cited constraint with regard to project design (with 44 percent ICRs) was "poor assessment of capacity."

The World Bank-UNICEF joint nutrition assessment has confirmed that, in most countries, it is neither the lack of good interventions nor financial constraints that are the main barrier to project performance as much as it is management problems related to limited local capacity to implement what is planned and budgeted (Gillespie 2000).

The World Bank's 1999 annual report suggests that low-income countries are suffering a "silent crisis" of poverty and destitution that is "deeply rooted in capacity constraints." And several World Bank evaluations indicate that project success is influenced in large part by the degree of project ownership and the fit between a project's design and the capacity of the clients to implement change. The more complex the project design, the more it strains local implementation capacity. Yet the pressing need to deal with long-term systemic issues that require complex and highly intensive outside assistance often leads development professionals to design projects and programs that are beyond the capacity of client countries to absorb, implement, and sustain. This can lead to a vicious circle of effort and frustration on the part of both donors and their clients—all working hard to implement complex and much-needed change, without experiencing success commensurate with their efforts (Matta 2000).

Donors have been guilty of contributing to a “cozy accommodation with dependency” (World Bank 1996) on the part of developing country governments. The recent interest in capacity development represents a new awareness that past approaches—focusing on the quantity rather than the quality of assistance and geared more to the internal agenda of the donor than the recipient country’s need to build capacity to plan and manage its own affairs—have underperformed badly. Talk about capacity-strengthening signals recognition that the *process* of development assistance needs to be radically changed so that results on the ground, and the way such results are achieved, take precedence over “moving money.”

5. NUTRITION PROGRAMMING AND CAPACITY DEVELOPMENT

A focus on capacity is fundamental to a rights-based approach to nutrition programming that emphasizes the achievement of outcomes through sustainable processes. A major challenge for the nutrition community is how to operationalize rights-based principles in nutrition programming. The 1999 SCN Symposium in Geneva on human rights and nutrition made some progress in this regard (ACC/SCN 1999), and UNICEF is leading the international community in further articulating practical steps in human rights-based programming.

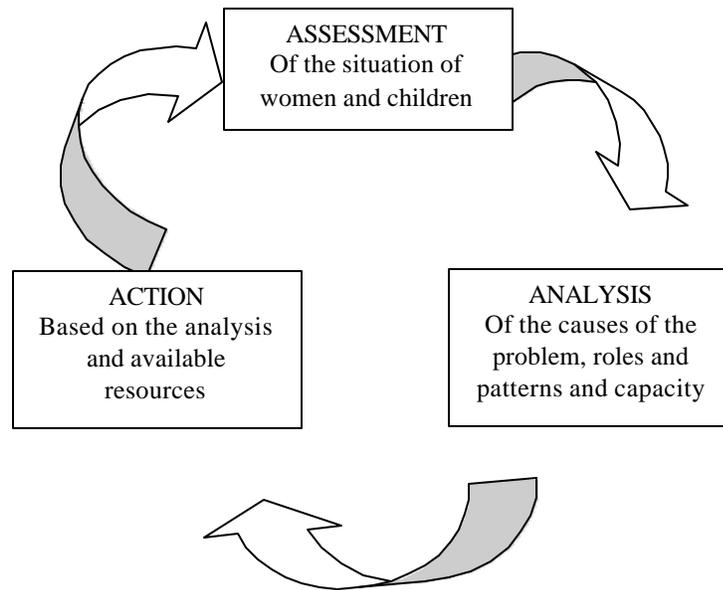
The shift from the traditional basic needs-based approach to a rights-based approach will change programming by

- changing the process through which action is undertaken, as shown in the programming steps described below;
- demanding a focus on disparity reduction or “reaching the unreached” rather than an increase in average well-being of the population;
- viewing participation as not merely desirable in nutrition programming, but as a fundamental right;
- demanding attention to causes of malnutrition *at all levels*, including basic or structural causes; and
- changing the rationale for promoting the realization of human rights should derive to the concern for justice and solidarity rather than benevolence and charity.

The following are seven essential steps in an iterative and fully participatory process for rights-based, capacity-developing nutrition programming (UNICEF 1999).

This is basically an elaboration of the Triple A cycle of Assessment-Analysis-Action (see Figure 2), in which the analysis is deepened to focus on roles and patterns of duty-bearers or stakeholders and their capacities (Stages 3 and 4 below, discussed in detail in Section 6).

Figure 2: Expanded Triple A Cycle



ASSESSMENT

1. *Assessment of the problem* to describe the nature of the malnutrition problem and the individuals or groups whose rights to adequate nutrition are being violated. This will also result in the identification of a list of rights that are being violated or at risk of being violated.

ANALYSIS

2. *Causality and vulnerability analysis* to identify the major causes of these rights violations. This should be done in a fully participatory way using the conceptual framework (see Annex 1), starting from the top and moving downwards. It is essential to include an analysis of basic or structural causes.

3. *Role or pattern analysis* to understand who is responsible and accountable (i.e., the duty-bearers) at different levels in society.
4. *Capacity analysis* to investigate the elements and influences of capacity (as per the matrix in Figure 3), followed by a mapping of the gaps in different key capacities for each duty-bearer identified in step 3.

ACTION

5. *Identifying candidate strategies and actions* that aim to fill these gaps. The following are common strategies and their effects at different stages in the Triple A:

<i>Strategy</i>	<i>Objective</i>
Advocacy and social mobilization	Strengthen overall process
Information systems	Improve assessment
Education	Improve analysis
Training	Improve action
Service delivery	Improve action

These strategies have their effect through the mobilizer-facilitator interface (see Figure 1).

6. *Prioritizing and selecting actions*, including use of cost-effectiveness analysis (which is as important in a rights-based approach as it is in a basic-needs approach). While human rights cannot be prioritized, the options for action can and should be prioritized on the basis of the outputs of the foregoing analysis. In other words, priority actions should be those that are most relevant and appropriate with respect to the nature of the problem and its causes and within the confines of resources and capacity.

REASSESSMENT

7. *Monitoring*: A human rights approach implies accountability of those with duties or obligations. Both the obligations of conduct/effort and the obligation of result must be constantly checked. This requires monitoring at all levels of society and the use of the information for the design of new actions to respect, protect, facilitate, and fulfill human rights.

It is important to recognize that the “action” stage does not necessarily relate solely to projects or programs, but encompasses steps in the formulation of policy.

Such a programming process, if followed in this way, would itself strengthen capacity for nutrition-relevant Triple A processes—a proactive “learning-by-doing” approach to capacity development that may be adopted in parallel with more conventional and specific capacity development initiatives (see Section 7).

Matta (2000) argues for such an approach in calling for “capacity building through results.” Engaging key actors in a series of rapid results initiatives, he suggests, would immediately involve them in an action-learning process. The experience of pursuing and achieving these results could then be leveraged to build self-confidence, commitment, and stronger capacity to make change happen on a broader scale.

6. ANALYZING ROLES, PATTERNS, AND CAPACITY

ROLE AND PATTERN ANALYSIS

The purpose of a role and pattern analysis is to arrive through a participatory analysis at the most crucial claim-duty relationships for each set of rights violations. A role analysis is similar to a stakeholder analysis.³ Parents tend to be first-line duty-bearers whose rights themselves may, however, be violated by duties not having been performed at higher levels. At the next level above the household, community mobilizers, if they exist, are accountable. In this way a map of accountability (see Box 2) may be developed showing the roles and patterns of duty-bearers from households up to national governments.

Tools for role and pattern analysis include stakeholder mapping, using flow diagrams that chart the power or influence of different groups or organizations, and tools such as participatory rural appraisal (PRA) and others, described in Annex 2. Individual circumstances will dictate which would be the most effective. Care must be taken to avoid covering so large a “stakeholder” group that the capacity process gets bogged down.

³ A stakeholder is any individual or entity that is involved, directly or indirectly, in any stage in the program including the ultimate beneficiaries. A stakeholder analysis determines who is or should be involved, the nature of their involvement (role, responsibilities, accountabilities; direct or indirect involvement), and magnitude of involvement (e.g., full or part-time, specific activities only).

Box 2: Roles and patterns at different levels

It is not only the direct care provider (in most cases the mother) who is responsible for ensuring adequate nutritional status for the child. Others in the household, the family at large, the community, institutions such as health centers, and local and central governments also have roles to play. In most cases,

- It is the role of the direct care provider to fulfill the right of the child to adequate nutrition through feeding, providing adequate care, and making adequate use of available resources.
- The role of the household is to facilitate the direct care provider in her task by ensuring a conducive environment for adequate care. In cases where the primary care provider is not able to take up her duties (e.g., because she is ill), the household is responsible for taking over her roles.
- It is the role of the community to facilitate and respect the roles of both the family and the direct care provider in ensuring adequate child nutrition.
- The primary role of the local and central government is to respect and protect the right to nutrition and to facilitate the efforts made by communities, households, and care providers by ensuring adequate services such as health care.
- The role of regional governing bodies is to advocate for adequate attention to nutrition by member states and to support their activities.
- The role of agencies both at the country and regional level is to advocate for adequate action by the other duty-bearers and support their actions.

Equally important is the range of tools for building stakeholder consensus through the use of participative workshops to build coalitions of stakeholders in support of nutrition improvement. This is a fundamental stage of the early project preparation process by many external agencies. UNICEF conducts consensus-building Triple A workshops, usually two done consecutively, with the assessment and analysis stages separated from the action deliberations.

CAPACITY ASSESSMENT AND ANALYSIS

Capacity assessment is a structured and analytical process whereby the various ingredients and influences of capacity are assessed within a broader systems context.

Capacity assessments can be carried out as “one-off” types of initiatives—sometimes referred to as capacity mapping—for the purposes of assessing requirements, determining feasibility or supporting research, or they can be carried out as part of the programming process. The type of assessment depends very much both on the objectives

and nature of the initiative, and on the entry point to be made. The important thing to remember is that capacity assessments can and should be carried out on a continuous or ongoing basis, as the Triple A cycle iterates.

While capacity requirements may differ with respect to what needs to be done (the objective), it is possible to identify in broad categories the common elements or ingredients of capacity as well as the generic factors and conditions affecting it. It is thus possible to be more specific about what is achievable in attempting to build or strengthen capacity. Concrete, intermediate capacity-related objectives may thus be set, and indicators determined, which will facilitate the monitoring and evaluation of progress.

The proposed framework in Figure 3, adapted from Alley (1999), is an analysis tool that relates the types of ingredients and influences of capacity to different levels—from the individual level (e.g., the direct caregiver) to the level of national governmental capacity. The level of “program” has been included to illustrate how the program (in this case, a community-driven program) should be seen as filling gaps in capacity at the community level. The capacity of the program itself is influenced by supporting structures including nutrition support institutions (represented by the level “institutional”) and governments.

Elements of Capacity

These are the ingredients—which apply at all levels in society—though the proportions and relative importance will always vary.

1. *Authority*: For each group or organization, it is important to understand who has the authority to act on behalf of nutritionally vulnerable individuals—formally and informally. Laws, traditions, and culture determine such legitimacy.
2. *Responsibility*: This is easily understood within organizations as the structured distribution of critical functions and tasks among members/employees. Yet division of labor is also an ingredient of capacities in communities and households. Analysis of critical functions for a given goal most often forces us to look at the arrangement of those functions outside the scope of one organization or community, looking instead at existing or potential networks. This broader systems view permits us to look at the distribution of roles and responsibilities at different levels of social organization.

Figure 3: Capacity analysis matrix

			Levels at which capacity exists				
			Individual	Family	Community	Program	“Institutional”
Factors influencing capacity	Dynamics of change	+					
		-					
	Institutional norms & practices	+					
		-					
	Links & relationships	+					
		-					
Elements of capacity	Authority	+	←—————→				
		-					
	Responsibility	+					
		-					
	Motivation	+					
		-					
	Leadership	+					
		-					
	Systems	+					
		-					
	Resources	+					
		-					
Communication	+						
	-						
Product of capacity	Performance/achievements	+					
		-					

Source: Adapted from Alley (1999).

3. *Motivation*: Patterns of behavior of different stakeholders are guided by incentives, attitudes, and values. Incentives include income, indirect economic benefits, and the recognition and status that individuals within an organization or group receive or perceive as the result of a given action. Within organizations they would also include training or learning opportunities for staff. Attitudes and values are held by individuals and can also form an organizational or community identity. There is clearly a link between institutional norms and practices at each level of social organization, from individual to national.

There is also a process by which subgroups or organizations may strive, and ultimately succeed, to influence institutional norms at different levels of social organization. The relationship is two-way. For example, attitudes toward malnourished children at the level of the community, through community leaders, can influence the behavior of families.

4. *Leadership*. This is an issue again at all levels. Leadership need not be understood as one individual leader or as formally recognized leaders, but can also be related to

leadership provided by some form of “governance system” such as an executive board or a governing council. Leadership is also important among organizations, to ensure that one body can take on the role to convoke, coordinate, and lead common planning. Even for individuals, finding leadership somewhere is often a key to finding an outlet for skills, motivation, etc.

5. *Systems*: This refers to systems for planning, decisionmaking, coordination, implementation, management, monitoring, evaluation, learning (including training), operational research, etc. The capacity of any individual, community, or organization to achieve something is shaped by the way in which they accomplish three basic functions—to perceive and analyze their context, to analyze and resolve problems internally and externally, and to learn from what they have already done as well as from the experience of others. Essentially these are Triple A cycles.
6. *Resources*: These include the quantity, quality, control, and use of human resources (including skills, knowledge, time), financial, material, organizational, technological, and information resources.
7. *Communication*. Communication is the means through which resources are put to work or mobilized for a particular objective. It links key actors to functional networks that are able to address critical issues. Communication ensures agreement on the nature of the malnutrition problem, its causes, and the way resources are going to be harnessed or mobilized to address it. Communication is essential for participation. Moving from individuals to larger systems and organizations, communication becomes increasingly crucial and complex.

These elements may also be divided into “hard” and “soft” elements. The hard elements refer to obvious things like personal skills, functions, structures, systems, and to factors such as equipment, infrastructure, and financial resources. The soft elements refer to less easily definable and quantifiable factors, e.g., incentive, motivational, and demand factors of a material, cultural, or social nature. For personnel, this may refer to financial, career, and professional incentives, or more widely to questions of attitude and mind-set. At the organizational level, this can refer to aspects of policy, legitimacy, norms, and values as well as to wider questions of governance (Box 3).

Box 3: Examples of common issues emerging from a capacity analysis

There are several reasons why duty-bearers are not fulfilling their roles to ensure adequate child nutrition. These reasons have to do with assumption of responsibility and leadership, motivation, access to human, organizational, and financial resources, and the authority the duty-bearer requires to be able to play his (or her) role. Duty-bearers often lack the capacity to undertake and support effective Triple A processes and communicate effectively within communities. Because they often lack responsibility/commitment, authority, and resources, duty-bearers often fail, and the child's right to adequate nutrition is not fulfilled.

At the level of the *care provider*, in most cases the mother, factors such as inadequate information and skills about health, nutrition, and childcare contribute to inadequate child nutrition. The situation is often worsened by the unavailability of needed inputs such as clean water, nearby clinics or hospitals, or lack of money to buy adequate food and make use of existing health care facilities. But even in cases where the resources are available, they might not be accessible for the care provider due to cultural/gender divisions of responsibilities and authority within the household and community.

Not all household members have enough interest in children's issues, including childcare and nutrition issues. Often fathers do not think they have a role other than providing resources for food. It is often household members other than the immediate care provider, who have authority over resources, health seeking behavior, and other issues directly affecting childcare and nutrition. Limited knowledge and skills as well as cultural and religious practices have a direct impact on the care and nutritional status of the child.

At *family and community levels*, resources are not always mobilized in favor of, nor priority given to, health or nutrition.

In many cases, *organizations* such as extension services and clinics are not able to provide adequate assistance as a result of a lack of financial resources, inadequate training, low prioritization of child and maternal nutrition, and limited motivation and leadership.

At *district and national levels*, there is limited attention given to nutrition policies and projects. When there is a focus on nutrition, it is on the health or food security aspects, with little attention given to care aspects. Most policymakers and implementers at district and national levels have little knowledge of the importance of nutrition and of actions proven successful in improving it. Even if they are aware, child nutrition is often given low priority. The sectoral organization of government is not always conducive to the promotion of nutrition as a multisectoral area that cannot be covered by one ministry or department. The capacity to monitor and evaluate nutrition interventions and nutritional effects of other interventions is also limited. Where this is done, analysis is not always fed into future action—the Triple A process is broken.

Factors Influencing Capacity

There are number of factors that influence capacity at all levels. These can be grouped as follows (though all are interrelated):

1. *Institutional norms and practices*: These are the “rules of the game” that guide interactions in the social, political, and economic spheres. They include formal norms (legislation, policy, established governmental structures that govern relations and distribution of power from central to local levels) as well as informal norms (customs and traditions, including age and gender roles, structures of entitlements (e.g., kinship, clientelism, etc.). In addition, widely accepted “common practice” also influences capacities.
2. *Dynamics of change*: Capacity must be understood within a context of change. This context is shaped by fast changing events—political, social and economic—and slower changing institutional norms and practices with ripple effects across all spheres and all levels of social organization—from global to family.
3. *Links and relationships*: Across levels of social organization and within levels—i.e., horizontal and vertical—the network of relations among organizations and individuals also influences capacity (see Section 4). This includes relationships among individuals and organizations with common or competing goals and interests. These are naturally shaped by institutional norms and practices but can be built, strengthened, or reoriented. Capacity to reduce malnutrition must be understood in the context of some form of mapping of allies, adversaries and groups and individuals who could be mobilized (this is the role and pattern analysis).

Finally, capacity must be analyzed in terms of a specific objective—in this case, malnutrition reduction. It is also important to consider that the outcome of capacity development itself—achievement of an objective—is both a measure of and a contributor to that capacity (hence the two-way arrow). For example, achieving certain measures for reducing malnutrition contributes to certain values in the community and strengthens the credibility of leaders speaking out in favor of nutrition. Capacity outcomes are thus inputs into future nutrition improvement processes.

In sum, all the factors outlined above may be considered as representing “entry points” for capacity development interventions at any level from the household up to national or international levels.

The analysis of capacity should ideally start at the household and community level and be progressively broadened (UNDP (2000) refers to this broadening as “zooming out”). The framework can also be represented as intersecting checklists to

guide information gathering and analysis so as to understand better whether and how the factors above contribute to or limit capacity to achieve a certain goal.

Following a discussion of capacity development strategy formulation in Section 7 below, specific issues regarding capacity at the levels of “program,” “institutional” and “government” are discussed in detail in the remaining sections of this paper, in addition to considering another level—that of donor capacity to assist in filling gaps in capacity at lower levels.

7. FORMULATING CAPACITY DEVELOPMENT STRATEGIES

Once capacity has been assessed and analyzed, strategies for developing it may be formulated. It is necessary to consider what to do, how and when to do it, how to monitor and evaluate progress, who should guide and supervise the process, and what techniques should be used.

What to do, in terms of measurable objectives and actions, will emerge from the analysis of which capacities and whose capacities need strengthening (role, pattern, and capacity analysis). In all cases, emphasis would be given to *utilizing existing capacities* and to developing new capacities only where they are needed.

The wide range of options for *how* to do capacity development includes the following: adding staff, adding physical and financial inputs, providing training and technical assistance, introducing new technologies, changing coordination mechanisms, giving particular stakeholders increased 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, changing incentives, providing information, and increasing accountability (Heaver 2000). In general, the first three options are by far the most common, and perhaps overemphasized in relation to the other options.

Given that the capacity to strengthen capacity is itself limited, and that capacity development takes time, deciding *when* to act is as important as what to do. Capacity development activities should be phased and sequenced in the light of

- the seriousness of the capacity constraints,
- the willingness and ability to strengthen capacity,
- the time that specific capacity development activities take,

- the implications the feasible rate of capacity improvement has for scaling up,
- how program support can be tailored to support scaling up and capacity development that makes sense in a particular context.

With regard to the last issue, a particular concern is how to reconcile the long time frame of many capacity-development activities with the short duration of most projects.

A capacity initiative that may require limited change within only one or two entities may be seen as one of incremental change. As capacity initiative impacts and change affect greater numbers of individuals and greater numbers of entities, then the initiative becomes more transformational. This also applies to the dimensions of capacity within individuals and entities—the more that are impacted, the greater the transformational nature. There are no hard and fast rules to classify an envisaged program as one of either transformational or incremental change. In simple terms, if an envisaged future situation is seen to be *very* different from the way it is today (at all levels), then the capacity initiative is likely one of transformational change.

A recent World Bank review found that

the lack of clarity regarding objectives of organizational capacity-strengthening has contributed to a complete absence—until very recently—of any indicators of organizational capacity or performance. ICRs [Implementation Completion Reports] tend to assert that capacity was built in a given organization because workshops were attended, staff were trained, and computers were provided. This focus on inputs also contributes to a lack of attention to proper sequencing, which is often essential to achieving results (Johnston and Stout 1999).

Such weakness in *monitoring progress* in capacity-building activities is partly a consequence of poorly defined capacity development objectives, but also relates to the difficulty of finding measures of what are often qualitative changes. Examples of appropriate monitoring indicators are needed.

The matrix in Figure 3 may be used to generate relevant capacity development indicators. These should be designed and managed by local stakeholders (to avoid making them into a form of conditionality) primarily to manage capacity-development performance and as a part of the process of capacity development itself. The other two uses of indicators—part of the donor reporting and accountability system and shaping the

contractual relationships with executing agencies—should supplement but not supplant the first two to avoid draining ownership and commitment away from local stakeholders.

Rough operational guidelines for the design of capacity indicators are provided by Morgan (1997). Using common sense and some simplification, improving their diagnostic value, focusing their use for project management, building on country commitment, experimenting to find the right indicators, and retaining flexibility to adjust as circumstances require are some of the main recommendations.

Finally, consideration needs to be given to *who* will guide and supervise capacity development, and *how*. While the ultimate responsibility for capacity development lies with senior-sector managers, they are likely to need the help of a unit or network that can provide specialist skills in capacity development, and in which the capacity to build capacity can be institutionalized independently of the tenure of sector managers. The success of any capacity development program also depends on the processes used to manage change. The skillful and participatory use of tools for role and pattern analysis and participation is likely to be critical here.

What will determine the success of the capacity assessment, and subsequent capacity development initiative? The following list of success factors in Box 4 is based on extensive UNDP and other international experience in development programs, technical cooperation, and capacity development.

8. PROGRAM MANAGEMENT CAPACITY

The architecture of community-driven nutrition programs run through community-government partnerships, as depicted in Figure 1, has been described by Tontisirin and Gillespie (1999). This section moves on to consider four of the most critical aspects of the capacity to implement and manage such programs: the capacity for community empowerment, the capacities of mobilizers and facilitators, and the capacity to generate and use information for management.

CAPACITY FOR COMMUNITY EMPOWERMENT

Community participation, involvement, empowerment, and ownership are all terms used to describe the role of communities in nutrition improvement. Community participation has been defined as having three main elements: the sharing of power and

Box 4: Success factors in UNDP capacity development initiatives

- *Visible Leadership*: meaningful commitment and *ownership* (and “*political will*”) at political and senior bureaucratic levels, sustained throughout the process.
- *Organization-wide and participative*: highly consultative, with meaningful involvement of all affected parties or stakeholders.
- *Open and transparent*: the process itself is open, with no hidden agendas, and decisionmaking is transparent. In some situations, external consultants may help facilitate this process and assure independence and objectivity.
- *Awareness and understanding*: all affected parties/stakeholders are aware of and understand the development or capacity initiative, the implied changes and capacity needs; requires strong internal and external communications; public relations.
- *General buy-in and acceptance*: understanding generates buy-in and acceptance; critical mass of commitment; resistance is managed.
- *Appropriate methodologies*: for program and project management; tools and techniques adapted to the local situation and needs; measures of performance established (results, outputs, outcomes); allowance for early successes and pilots; ongoing monitoring and evaluation.
- *Clear set of objectives and priorities*: built into project/program plans; incremental and phased; available resources appropriate to workload.
- *Clear management accountabilities*: transparent processes and decisionmaking; open dialogues; explicit responsibilities and accountabilities set.
- *Sufficient time and resources*: committed availability of financial, information, and human resources to plan, develop, implement the capacity initiative; strong managerial resources.

Source: UNDP (2000).

resources, deliberate efforts by social groups to control their own destinies, and the opening up of opportunities from below (Dillon and Steifel 1987; Ghai 1988). But the concept has often been abused as a way of co-opting local people to undertake certain tasks cheaply, so as to further goals set by external programmers. In such approaches, community participation in implementation was usually not matched with decisionmaking power or control over the use of resources. *Community-based* clearly does not equate with *community-driven*. Consequently, there was little sustainability. Active (or proactive) community participation should thus be differentiated from passive (or coerced) participation. Table 1 differentiates the various forms of participation.

Table 1: The participatory continuum

Mode of participation	Involvement of local people	Relationship of research or action to local people
Co-option	Token representatives are chosen but with no real input or power.	ON local people
Compliance	Tasks are assigned with incentives; outsiders decide the agenda and direct the process.	FOR local people
Consultation	Local opinions are asked; outsiders analyze and decide on the course of action.	FOR/WITH local people
Cooperation	Local people work together with outsiders to determine local priorities; responsibility remains with outsiders for directing the process.	WITH local people
Co-learning	Local people and outsiders share their knowledge and understanding to create new understanding and work together to form action plans, with outsider facilitation.	WITH/BY local people
Collective action	Local people set their own agenda and mobilize to carry it out in the absence of outsider initiators and facilitators.	BY local people

Source: Adapted from Pretty (1995) in Cornwall (1996).

Communities are not conveniently homogeneous. There are often several communities in any one village or urban slum, with divides along socioeconomic, cultural, or religious lines, and there are even divisions within households where the less powerful household members, e.g., women and children, may not as readily benefit from a given intervention.

In addressing malnutrition, there is no substitute for assessment and analysis done with the full and active participation of the families most threatened by nutritional problems and most familiar with their effects and causes. In the long run, active community participation is essential for real community-based nutrition programming to succeed and sustain itself. It routinely emerges as a key success factor in many reviews of nutrition programs (e.g., Gillespie, Mason, and Martorell 1996; Jennings et al. 1991).

Not only does active community involvement make sense with regard to efficiency, effectiveness, and sustainability (Bamberger 1988), it is also an imperative from a human rights perspective (see Section 4). Nutrition is a human right. In order for households and communities to carry out their duties toward nutritionally vulnerable individuals such as children, they must be recognized as key actors rather than as passive beneficiaries.

Fostering empowerment, however, takes time and requires substantial investment of human and financial resources, including mobilizers and facilitators, as discussed in

Section 8. The potential for successful empowerment varies significantly from country to country, depending on the political and administrative culture of government, and the degree to which local community cultures already encourage participation. Table 2, taken from Shrimpton (1995), illustrates how qualitative data on aspects of community involvement can be organized to measure the degree to which a program empowers local communities.

Community capacity is determined by the degree of empowerment in the particular sociopolitical context, the type and appropriateness of local organizational structures used to promote participation or empowerment (including community mobilizers, women's groups, and community management committees), focusing particularly on whether they are representative of the local community (rather than dominated by community elites); whether they have clearly defined roles (and a plan to empower them further); how they relate to existing structures of local government, local traditional, or religious authority, and the community organizations of other development programs.

Capacity for empowerment relates also to the processes used to empower those working in the community-level structures, including experience with the Triple A process or other participatory tools; use of management information systems at the local level to empower local people to take management action (see section on program management below); and use of rewards and incentives (financial and nonfinancial) to encourage community involvement.

Strategies for *initiating* and *expanding* the empowerment process include those that have been used to bring politicians and bureaucrats at different levels on board in support of participation or empowerment; what blend of government and NGO resources has been used to foster participation, and the comparative advantage that each brought; what strategy was used to scale up empowerment efforts, and whether there is a clear strategy for developing the actual capacity to foster community empowerment.

Genuine decentralization (when both authority and money are given to lower levels) opens the door for greater community participation and empowerment (for further discussion, see Section 10). The design of nutrition programs needs to be appropriate to the level of decentralization in the country, taking full advantage of whatever legal and budgetary flexibility is available. For preexisting nutrition programs, there needs to be a strategy to progressively increase decentralized management of the program in line with broader plans to decentralize government.

Table 2: A tool for measuring community participation in community nutrition projects

Indicator	Ranks				
	Nothing/narrow	Restricted/small	Mean/fair	Open/good	Wide/excellent
Needs assessment/ action choice	None.	Done by outsiders with no VHC ^a involvement.	Assessment by outsiders and discussed with VHC whose interests considered.	Community does assessment and outsider helps in analysis and action choice.	Community does assessment/analyzes/ acts on choice.
Organization	Imposed with no active community/organizational support.	Imposed but some activity, or limited community organization links.	VHC-imposed but becomes very active.	Uses existing community organizations.	Existing community organizations involved and controlling activities.
Leadership	One-sided organizational support dominated by elite or health staff.	CW ^b working independently of social interest groups or community support structure.	Organizational support functioning under leadership of independent CW.	VHC or organizational support active, taking initiative together with CW.	Organizational support fully represents variety of interests in community and controls community worker.
Training	Little or no training of CW or in unfamiliar language.	Lengthy preservice training of CW in remote institution with no inservice training.	Preservice CW training in local institution with little inservice training.	Short local preservice CW training followed by regular inservice training outsiders.	Short local CW preservice training, plus regular inservice training through supportive local supervisor/trainers.
Resource mobilization	No resource contribution by community. No fees for services. CW externally financed.	Fees for services, no fund-raising. VHC has no control over money collected. CW externally paid.	Community fundraising and fees paid but no VHC control of expenditure. CW voluntary.	Occasional community fundraising but no fees; VHC controls allocation of money. CW voluntary.	VHC raises funds, collects fees, and controls allocation of money, pays CW.
Management	Induced by health staff, CW supervised by health staff.	CW manages independently with some involvement of VHC. Supervision by health staff.	VHC self-managed without control of CW activities.	VHC self-managed and involved in supervision of CW.	CW responsible to and actively supervised by VHC
Orientation of actions	No clear objectives, no targeting, curative.	Process-oriented objectives, no targeting, curative more than preventive.	Impact-oriented objectives but no targeting and more curative than preventive.	Impact-oriented objective, VHC interventions targeted to at-risk groups, but more curative than preventive.	Impact-oriented objectives, CW interventions targeted at at-risk groups. Preventive and curative.
Monitoring evaluation/ information exchange	No IS ^c , or information used locally. Nobody aware of problem dimension or program progress.	Information sent to outsiders who are aware of problem dimension and program progress, but no feedback to VHC.	IS used for routine daily activities/decision-making by CW, who is aware of dimension of process and program progress.	VHC receives information necessary for decision-making from CW. VHC aware of problem, program progress/benefits.	VHC disseminates information so that community is aware of problems program and progress/benefits.

Source: Shrimpton (1995).

^a VHC = village health committee.

^b CW = community worker.

^c IS = information system.

Decentralization gives local governments and communities greater power to decide their own investment priorities, which may not include nutrition, or which may be to fund cost-ineffective but politically attractive interventions in nutrition (e.g., food supplementation rather than growth promotion). Nutrition, per se, is rarely high on the list of community priorities, and often not on the list at all.

Managers can achieve a focus on national nutrition priorities by *influencing* local governments and communities without imposing top-down *control*, including such approaches as advocacy and training to help local governments and communities recognize the seriousness of malnutrition, and hence give it greater investment priority; nationally-funded technical support and supervision to complement, but not supplant, local governments' administrative supervision; and matching grants to encourage local governments and communities to invest in nutrition interventions.

It usually is possible to convince communities that community-based programs, utilizing local, trained community workers would be in their interest. Information indicating the relative mortality risks of well-nourished young children compared with those of even moderately malnourished children has been used effectively in community mobilization efforts. Communities also are likely to recognize that the community-based worker, although labeled a nutrition worker, will also be providing, right in the community, health-related services that otherwise would require travel of some distance to a primary care facility.

CAPACITY AND PERFORMANCE OF THE COMMUNITY MOBILIZER

Community mobilizers are usually respected members of the community, most often volunteers or at least not remunerated from outside. The Thailand success (see Box 5) was crucially dependent on the use of such village-based volunteers, who were well-respected women chosen from within and by the communities who then mobilized support and developed self-help systems within these communities.

The capacity and performance of a community mobilizer depends to a large extent on her role, the way her job is organized, the resources available (e.g., time, skills, knowledge) and the type of incentives and rewards for performing well.

Box 5: Mobilizers and facilitators in Thailand

In Thailand, it is common for a cluster of 10 to 20 households to depend on one or two well-respected individuals for guidance or assistance in emergencies. Such individuals were selected by the communities themselves as community health nutrition volunteers (CHNVs) or *mobilizers*, and given appropriate training. Mobilizers served to link service delivery with the communities and to foster local community-based nutrition initiatives. Mobilizers were individuals, preferably women, with qualities of leadership and commitment who were capable of instilling confidence in community members and encouraging their involvement. A ratio of one mobilizer to 10–20 households was considered optimal for maximizing program effectiveness.

While mobilizers did not receive any cash incentives or salary, they benefited from free medical services for themselves and their families and organized visits to other communities. Recognition was also given in the form of volunteer badges, uniforms, certificates, and awards for meritorious performance.

Training of CHNVs was a pivotal element of successful programming. An initial training of about two weeks was given, wherein theoretical and practical aspects of basic nutrition and health facts were inculcated, including emphasis on the importance of antenatal and postnatal care, maternal and childcare practices, birth spacing, breastfeeding, immunization, complementary feeding, growth monitoring and promotion, etc. Communication skills were instilled to foster adequate care and nutrition of women and children as well as to motivate self-help activities of local community members, particularly women's groups.

On-the-spot refresher training and monitoring of specific activities was then undertaken every one to two months, and the CHNVs were motivated to strengthen supportive links between themselves and the community on nutrition activities. Communities were encouraged over time to take increasing responsibility for influencing growth of their own children, using simple, attractive growth charts.

The success of the CHNV system depended largely on supervision at all levels, especially at the community level. Supervision was oriented toward support, rather than policing, including on-the-spot training, problem-solving, motivation, legitimization, and the sharing of technical and managerial information between facilitators and mobilizers. Interpersonal supervision on a regular basis was found to be most effective, along with periodic monthly or bimonthly review meetings of mobilizers and facilitators. Additional methods of supervision included communication through meetings, social events, and distance supervision through printed media.

Based on the functions and tasks set, impact indicators were tracked and evaluation collectively undertaken leading to recommendations for improvement. Evaluation was seen as an ongoing process that included both qualitative and quantitative indicators.

Source: Tontisirin and Gillespie (1999).

Role and Organization

It is critically important to clearly specify what the community worker should do. Is she a nutrition worker, or is she a dual-purpose (e.g., nutrition and health) or even multipurpose (e.g., nutrition, health, and early childhood development) worker?

Combining services can be justified in terms of increased efficiency, and it is also sometimes advocated on the grounds of synergy gains—although, in fact, synergy can just as well be achieved by the *coordinated* provision of services by more than one worker (see below), as by the *integrated* provision of the same services by a single worker.

Provision of primary health and micronutrient supplementation services are a relatively manageable combination, since the latter take little time. It is less clear whether it is appropriate for a single worker to be responsible for the provision of both primary health services and growth monitoring and promotion, given the substantial time requirements for both. Similarly, the combination of growth promotion and preschool education is not only very time-consuming, but also involves a different client group (4–6 year olds, as opposed to the 0–2 or 0–3 year olds on which growth promotion focuses). On the basis of experience with programs in India, such as the Integrated Child Development Services (ICDS), this combination is not recommended.

Since decisions to combine service provision may be political in nature and hard to reverse on technical grounds, it may be necessary to consider how changes to existing multipurpose worker programs might be made to make them more manageable and more effective, either by reducing the total number of tasks of a given worker, or by improving the worker-household ratio to the point where each worker has enough time to carry out each task well.

For workers whose job is exclusively nutrition, job design needs to consider three sets of issues: the time requirements for individual tasks; the way work routines are organized; and the way nutrition workers cooperate with health workers covering their service area.

There are different ways of handling these issues including leaving it up to the worker, increasing efficiency by providing certain services on a group basis, supplemented by home visits to those not attending group meetings, and/or leveraging the efforts of workers by involving community members in providing certain services.

Since nutrition and health services are complementary, efficiency and effectiveness gains can be made by planning work routines based on nutrition and health

worker cooperation, e.g., joint training for nutrition and health workers, emphasizing the commonality of goals, clear and appropriate division of labor, piggybacking nutrition services on group meetings organized by health workers (e.g., micronutrient supplementation and IEC at immunization days), joint identification of high-risk individuals in need of both nutrition and health services, and joint field visits to offer combined services (e.g., growth monitoring combined with health checkup).

Incentives and Rewards

The relative cost-effectiveness and local feasibility of using all-volunteer workers versus paying workers from the community is a major issue, and one that is context-specific.

A study of the feasibility of using noncompensated community health volunteers, drawing from examples from Botswana, Colombia, and Sri Lanka, concluded that large-scale community volunteer programs will be characterized by high attrition rates and low activity levels and will only be sustainable under particular enabling conditions (Walt, Perera, and Heggenhougen 1989). On the other hand, the most successful example of effective community volunteers is Thailand (see Box 5). The following are some conditions that favor voluntarism (Walt, Perera, and Heggenhougen 1989):

- Where there are substantial numbers of young, relatively well-educated men and women in rural areas, for whom further training or employment opportunities are lacking;
- Where the religious or ethical value of serving others through voluntary work is a strong cultural force;
- Where traditional, often authoritarian, structures underlie expectations of voluntarism;
- Where political commitment, sometimes under adverse conditions, unites and stimulates voluntary effort.

Other incentives include performance-linked rewards such as certificates, plaques, stars, designing systems for recognition by the local community, initiating competition

between service areas, based on comparison of performance statistics, and rewarding performance through promotion.

Recruitment and Training

Commonly used criteria for selection of community mobilizers can be divided into four categories:

1. *Residence*: A mobilizer who is a local resident of the community and is known by members of the community is considered to be a key factor for sustainability. It promotes community ownership, provides an opportunity to build indigenous capacity, and reduces the risk of attrition.
2. *Gender*: Some programs, because they target largely women of childbearing age, include criteria relating to gender, showing a preference for female mobilizers.
3. *Educational level*: Community mobilizers will be expected to carry out a host of tasks, such as community animation, information transfer, and record keeping. Such tasks require certain skills and capacities that require a basic level of education.
4. *Personality traits* such as honesty, good organizational skills, high motivation, patience, and flexibility are important but often neglected criteria for selection of community mobilizers. Such criteria are especially important where local workers are voluntary or are paid a token amount in cash or kind.

Other important capacity issues include the length and content of preservice and inservice training (especially the balance between technical and operational training, and training on work routines, communications techniques (IEC), management information systems (MIS), and community mobilization); and the process and methodology used for training (especially the opportunities which workers have to practice skills, whether through role-play or working in field practice areas).

Programs for training community workers should have two main components: (1) content (the “what” of nutrition) akin to a toolbox of methods, and (2) problem-solving (the “how to” processes of nutrition-relevant Triple A), or how to use the tools. The latter is often underplayed.

A training plan for community mobilizers should specify who will be trained, in what, by whom, how, and for how long. The focus should be on raising awareness of the importance of nutrition, of community involvement and gender; on knowledge and understanding of malnutrition, its causes, and the role of different stakeholders; and on key skills for participatory assessment (see Annex 2), program design, mobilization, counseling, implementation, monitoring, and evaluation.

With regard to the design of training strategies, a key difference exists between institution-based training, in which fieldworkers are sent for training in relatively large batches by training specialists, and field-based training, in which workers are trained by their own supervisors. The former has the advantage of exposing workers to professional trainers; allows countries to diffuse a standard approach to service delivery; and allows workers to meet staff from other regions and learn from their experiences (if the training is structured appropriately). Learning from success is a relatively efficient way of learning, and options for exposing workers to model programs should be considered. Distance learning, too, may be an option.

But institution-based training can cost too much to be frequent, and can promote standardization at the cost of responsiveness to changing program needs over time or in different geographic areas. Field-based training has the advantage that workers are trained by their own supervisors, who know their strengths and weaknesses, as well as the performance of the program and the needs of local communities. Training can therefore be tailored to each worker's needs. The relative cost-effectiveness of these two approaches is unknown.

Other specific issues regarding the management of training include the system adopted for carrying out training needs assessments, and how best to manage the development of a cadre of professional trainers (including different approaches for training of trainers; incentives and career development for trainers; and linkages between trainers and the field program).

CAPACITY AND PERFORMANCE OF THE FACILITATOR (OR SUPERVISOR)

Facilitators are usually paid frontline primary health care workers, NGO employees, or even staff from universities or other institutions of learning who may support, supervise, or train mobilizers. They normally do not live in the community but visit frequently; they know the local language and are familiar and positive to the local culture.

It is the relationship between facilitators and community mobilizers that determines the extent to which outside support can become catalytic and empowering, rather than creating a new dependency that cannot be sustained. The facilitator channels the outside support to the community through community mobilizers, while the mobilizer internalizes this support in such a way that community processes are strengthened and accelerated (Jonsson 1997).

Role and Organization

Issues with regard to the structure and field practices of facilitators include the ratio of facilitators to mobilizers; the design of supervisors' work routines, in particular time spent in the field and the frequency and length of interactions with community members and workers; and how supervisors make use of information locally available from the MIS and directly from the community (Table 3).

Facilitators should not train mobilizers in what to do, but rather strive to empower them. Supervision in community nutrition programs needs to become more focused on supporting community-based workers rather than on "policing," which requires both participatory training methods and a power shift from outside supporters to facilitators and the mobilizers. Outside support channeled through facilitators includes advocacy, information, education, training, and direct service delivery.

Quality Assurance

Facilitators should aim to ensure the quality of nutrition services through use of service standards and protocols, which define what is a quality service. Direct observation of service provision should be viewed as important as the checking of records, incorporation of key quality indicators into the MIS, and complementing supervision of the technical quality of services with feedback from community members on friendliness, timeliness, and convenience.

Recruitment and Training

Capacity issues with regard to recruitment and training of supervisors or facilitators include pre-recruitment qualifications and experience (high academic

Table 3: Roles and responsibilities of mobilizers and facilitators in proposed nutrition investment plans of the ADB-UNICEF RETA 5671

Country	Mobilizer	Facilitator
Bangladesh	Conduct monthly growth monitoring and promotion, micronutrient supplementation (iron, vitamin A); nutrition and health counseling and referral.	Support and supervise mobilizers
Cambodia	Promote home-based care; utilization of health services including growth monitoring, promotion of food safety and hygiene; promotion of appropriate feeding practices; deworming and micronutrient supplementation; Integrated Management of Childhood Illness (IMCI).	Ensure that mobilizers have adequate capacity to promote household-level activities
India	Village-based <i>anganwadi</i> workers (AWWs) of the Integrated Child Development Services (ICDS) program are the closest existing approximation of a mobilizer, but at 1 per 200 households, they are overstretched. Community volunteers are thus proposed as additional resources in the investment plan. AWWs provide six services to 0–6 year-old children and mothers: supplementary feeding; immunization; health check-ups and referral; health and nutrition education to adult women; and preschool education to 3–6 year-olds.	ICDS Supervisors at block-level supervise AWWs through regular on-site support and monthly review meetings. AWWs also link with Auxiliary Nurse Midwives (ANMs) for health-related activities.
Pakistan	Community Health Nutrition Volunteers (CHNVs) and <i>dais</i> (traditional birth attendants) aim to provide the missing link between health care outlets and the users of such services. They will undertake tasks relating to maternal care, child growth monitoring and promotion, and counseling mothers on infant feeding and care, birth spacing, hygiene and sanitation, etc.	Lady Health Workers (LHWs) deliver primary health care and nutrition services including community organization, disease-control, and prevention, maternal and child nutrition and health care, personal and family hygiene.
Sri Lanka	Social mobilization through women's group formation; nutrition and health counseling, promotion of health service utilization; participation in community development plan preparation; quarterly evaluation meetings, integration of nutrition-relevant activities within poverty alleviation program.	External facilitators are staff of the Divisional Secretariat offices, including managers of the poverty alleviation program (<i>Samurdhi</i>). MOH staff provide additional technical support.
Viet Nam	Register young children and pregnant women; mobilize pregnant women for ante-natal care; undertake nutrition counseling; growth monitoring and promotion; compile monthly report; participate in monthly meetings.	Draft commune Plan of Action; act as a secretary to Commune Steering Committee; assist in work of mobilizers; organize monthly review meetings with mobilizers; report regularly to district level.

Source: Tontisirin and Gillespie (1999).

requirements may attract higher social status, urbanized supervisors who dislike living in villages and have difficulty in communicating with clients and fieldworkers); the length and content of preservice and inservice training (especially the balance between technical, managerial, IEC, MIS, and community mobilization); and the process and methodology used for training, especially the methods used to reorient supervisors from existing cultural behaviors.

CAPACITY TO GENERATE AND USE INFORMATION FOR PROGRAM MANAGEMENT

Solving nutrition problems requires improved management of resources at all levels of society. The provision of information and its systematic use is an essential part of any resource management and decisionmaking process.

The design of a strategy for generating and using nutrition-relevant information should start by considering factors that influence decisionmaking processes. A main aim should be to strengthen the interaction between individual and institutional decisionmaking processes for the improvement of nutrition and to rationalize and enhance the use of information to improve nutrition-related decisions at all levels of society.

Nutrition information *systems* should be considered subsets of an overall nutrition information *strategy*, which broadly specifies the means through which information gets translated into action. Nutrition information systems are essentially variations of the Triple A cycle (Jonsson, Pelletier, and Shrimpton 1998), with the following specific objectives and broader goals (Table 4).

Table 4: Goals and objectives of nutrition information systems

Objective of system	Goal of information system		
	Improved targeting of resources	Improved use of existing resources	Improved availability and access to resources
Growth monitoring and promotion	X	X	
Program design	X	X	
Program management		X	
Policymaking	X	X	X
Surveillance/early warning	X	X	X

Growth monitoring and promotion, program design, and MISs are described here (as they aim to maximize the use of existing resources for nutrition improvement), while systems for policymaking and surveillance are covered in the following section on institutional capacity as they apply at a policy level.

Growth Monitoring and Promotion

Growth monitoring and promotion (GMP) (or more appropriately referred to as “growth promotion”) is a specific communications approach aimed at behavioral change, through making the impact of preventive actions visible to families and to others in the community and health services. Through monthly weighing of a child and plotting the weight on a growth chart, adequate or inadequate changes in weight can be revealed, discussed, and used to reinforce positive practices, motivate changes in harmful ones, reward and sustain new behaviors, and target nutrition and health advice and services to particular individuals, households, and communities (see Allen and Gillespie 2000).

Growth monitoring is effective only when the information is actually used in this way, hence the switch to the term “growth promotion,” which is the ultimate objective. It is usually only effective when carried out at the community-level by community mobilizers (e.g., trained mothers, adolescent girls) who can weigh accurately, understand and interpret growth, and use the information in counseling or in advocating for more community resources for nutrition. Its *raison d’être* is one of prevention, through identifying growth faltering early on.

In 1990, UNICEF conducted a multicountry evaluation using a common protocol that viewed GMP programs as an effort to incorporate a Triple A cycle into existing decisionmaking processes at household and community levels (Pearson 1995). The main findings were as follows:

- GMP has been viewed as an objective in its own right, rather than an important tool to facilitate a process. Weighing and plotting technologies have often been disseminated (for assessment) without proper attention or support to the other components of the GMP-based Triple A cycle (analysis of causes, communication with decisionmakers, linkage to action).
- The weakest stages of GMP have been analysis and action. Analysis has been impaired by the lack of a well-understood conceptual framework to guide the

search for causes and solutions and often by the lack of time for the health worker to conduct the analysis with the child's caretaker. This problem is particularly acute in clinic settings, where time is short and action is limited to what can be done in the clinic (e.g., supplementary feeding), actions that may be inappropriate for the causes of malnutrition in every child.

- Most GMP programs have not forged effective links with the individuals and institutions that control resources for action. The separation of clinics from relevant community institutions and decisionmakers is a particularly acute problem.
- The successful introduction of a “new” Triple A cycle—in the form of GMP—requires a significant effort to sensitize household or community decisionmakers to the existence of a broad social problem, to relate it to familiar aspects of life that concern them (including consequences of illness and death), and finally to mobilize a demand for the information and action that can be derived from GMP.

Transmitting data from GMP to higher administrative levels often has a negative impact on their use at lower levels. This is partly because of the time required to make use of the data, but also, and equally important, because transmitting data elsewhere gives the impression that the data—indeed, the entire exercise—are for “someone else” at the higher levels that receive the data. In any event, GMP data are seldom used at higher levels, except for monitoring attendance, and are seldom communicated back to the communities. Best practice guidelines for GMP are provided in Allen and Gillespie (2000).

Information for Program Design

This involves consideration of coverage, intensity, targeting, and program content. Coverage relates to the percentage of the at-risk population participating in the program, while targeting concerns the degree to which this coverage is oriented toward the most needy among those who are able to respond. The issue of intensity concerns how much resources are used per participant, either expressed financially or with regard to population and worker ratios, e.g., number of children per community-level worker or mobilizer, number of facilitators or supervisors per mobilizer.

Coverage, targeting, and intensity require straightforward results from a few measurements, although usually requiring a large sample. Deciding program content, however, requires more advanced analysis, including small-scale but in-depth studies (Mock and Mason 2000). Indicators appropriate to program design may be grouped into the categories of outcome, process, and context. Outcomes refer to population level changes in behavior and health/nutrition status, usually the immediate causes and consequences within the UNICEF conceptual framework (see Annex 1). Processes refer to the host of program-related activities such as coverage, targeting, intensity, and quality of services, etc. These indicators track the efficacy and efficiency of transforming inputs to outputs. Finally, context indicators reflect basic and underlying causes that may not be directly targeted by country programs, but which represent either important constraints or mediating influences on the results of country programs.

Information for Program Management and Quality Assurance

Program management requires regular data on the process of program implementation—hence *management information systems*—data that are usually derived from routine program monitoring data collection. Measuring outcomes over time using growth-monitoring data is a high priority, but should only be promoted when it is first useful as part of the community-based actions.

Program management information does not generate evaluation of impact (meaning net effect attributable to program activities). Impact evaluation (and cost effectiveness analysis) entails more complex and less common evaluation research, typically involving probability surveys and comparison groups. Evaluation research is discussed later.

Much has been written about best practices in program monitoring, most notably Levinson et al. (1998). As mentioned earlier in this section, one prevalent problem is that monitoring systems are often mainly designed to serve the information needs of senior managers, thus reinforcing a top-down, rather than bottom-up, community-based management system. The drive for more and better information for management often leads to more data being collected and sent upwards than is usable by managers, delays in processing data and providing feedback to the field, too much fieldworker time spent on recording and reporting, and marginalization of fieldworkers, supervisors, and local communities as primary information users.

An MIS is essentially a system of collecting, analyzing, and using key monitoring data to improve the management and ultimately effectiveness of a program (see Tontisirin and Gillespie 1999; Mock and Mason 2000). The two main principles for the use of information for action are first, to collect the minimum, feasible amount of data required to inform and improve decisions leading to action, and second, maximize the use of data at the level they are collected. An MIS should specify the

- purpose of data collection—who needs to know what to do what,
- type, quantity, and quality of data to be collected, by whom and how frequently,
- level of aggregation required (e.g., regions, communities, households),
- type of minimum analysis to be carried out at each level,
- types of action envisaged on the basis of such analysis, at each level,
- means of transmitting such data, to whom, and how frequently,
- types of feedback (including qualitative) to those responsible for these actions,
- system to be adopted for data validation and data quality improvement,
- communities' role in monitoring and in targeting at-risk households,
- role of qualitative information, and means of collection and analysis,
- indicators that are valid, reliable, sensitive, feasible as well as acceptable to beneficiaries.

Box 6: An Indonesian nutrition MIS

In Indonesia, the UPGK program used a system known as "SKDN," where S is the number of children under-five; K, the number with growth charts; D, the number who have attended a weighing session, and been weighed; and N, the number who have gained weight. Each *posyandu* (or community health post) examined and reported its coverage at first contact (K/S); participation in weighing (D/S); and outcome (N/S). Monitoring of the participation in weighing (D/S) was considered a measurable indicator of community participation. Such information could be provided on a community growth chart so that the community is aware of and involved in the progress made. This system fell into disuse during the 1990s. Recognition of its unrealized potential for targeting poverty alleviation efforts following the late 1990s financial crisis has led to recent efforts to revive it.

A simple, streamlined MIS should be constructed as part of the initial program design process to monitor performance (see Annex 3 for an example of a core monitoring proforma). A simple guideline matrix linking options for action with different types of information could be drawn up including all levels from community to central government. This might include the specification of “trigger points” or critical thresholds for action with respect to certain indicators.

Qualitative “soft” monitoring should be incorporated in the system through periodic social assessments or PRAs (see Annex 2), e.g., using focus-group sessions—to provide valuable qualitative information to supplement quantitative data, and highlight possible operational research priorities. There will be a particular need for information about caregivers’ changing perceptions and behaviors, and the quality of worker/caregiver interactions, especially with regard to community mobilization and IEC. Typically, such information, if gathered at all, has been collected as part of infrequent evaluation exercises; yet, if behavioral change and community empowerment are key objectives of community nutrition programs, qualitative monitoring of progress in these areas is as important as quantitative monitoring of input and output indicators. Sentinel sites may be used for such monitoring with periodic rotation to ensure that they are not changed by the monitoring process itself.

The MIS is fundamentally a program quality assurance tool. The findings of whatever analysis is undertaken at more central levels should be promptly fed back in a clear format to lower levels. Such analyses could compare performance in different project areas, which, in turn, permits (1) workers to see how they are doing relative to others; (2) managers to use competition between project areas as a performance incentive; and (3) supervisors and higher-level managers to practice management by exception. But for the MIS to improve program quality, its own quality needs to be taken into account. Simple data quality control checks should be incorporated in the training of MIS managers at different levels.

One overriding lesson from successful community nutrition programs is that detailed planning of micro-level management is key to their success. Box 8 illustrates this with no less than 20 micro-level management interventions that contributed to the performance of one of the more successful World Bank-assisted projects, the first Tamil Nadu Integrated Nutrition Project (TINP-1). The Implementation Completion Report for this project stressed that there was no magic bullet: it was the attention to detail, the combination of micro-level interventions, and their mutually reinforcing effect that were important.

Box 7: Data for decision-making in the Philippines' Early Childhood Development Project

Information systems can be used to identify populations to be targeted for assistance, assist in decisionmaking about the nature of services required, support advocacy to create demand and local ownership for nutrition programs, and provide the basis for assessing impact and sustainability.

The Philippine Early Childhood Development Project provides an excellent example of an integrated information system that effectively uses microcomputer-based information technologies at the subnational level. Enabling conditions include decentralized resource management to local governments and a ten-year investment program for childhood development that mandated the development of local programs.

Census data and agency service statistics were combined to rank municipalities according to the severity of the problems facing children (e.g., high population ratios for each school, health facility, or daycare center, or high rates of malnutrition and school dropout) and the number of children needing targeted services in health, nutrition, and early education. One-hundred-seventy municipalities (11 percent) were targeted in three regions in southern Philippines. These areas represented over half of the nation's at-risk children.

Local cost sharing was an element of the national program, and fiscal data on municipalities were used to develop a set of sliding scale cost-sharing rules. Each municipal plan is tailored to the children's health, nutrition, and educational profile. Unless the mayor and municipal council agree to balance all the needs of children and provide appropriate integrated services, national subsidies will not be forthcoming and the municipality will not participate.

The third important use of information is for advocacy, social mobilization, and local empowerment. Several methods of data analysis and presentation link nutrition, health, and developmental indicators. These include community data boards relating minimum basic needs to child development; creation of community plans for accessing child development funding; and integrated planning and budgeting that links resource use to development outcomes.

The vertically integrated system permits the Council for the Welfare of Children (CWC) to identify problem areas in reaching program goals. From the village captain to the CWC Director and the President's Cabinet Office, data are the key to planning, managing, and sustaining a highly devolved program that is viewed as a model for accountable governance for children. Microcomputer-based software enhances the decision-support qualities of the information system by permitting easy integration of outcome, process, and context data and easy to interpret graphical output.

Source: Mock and Mason (2000).

Box 8: The importance of micro-level design in the first Tamil Nadu Integrated Nutrition Program

Community empowerment

Women's, children's, and adolescent girls' working groups were created in every village. Women's groups were formed prior to the introduction of services, and had clearly defined roles in community advocacy and communications. Community growth charts were displayed at each Community Nutrition Center (CNC), to help communities understand the nutrition situation. All Community Nutrition Workers (CNWs) had to be from the village, and resident in the village, so that they were part of the community.

Mobilizer capacity

Though a minimum educational qualification was required, equal weight in recruitment was attached to selecting CNWs who were both poor and had well nourished children—since these women would already have key childcare skills.

Enough time to do professional Growth Monitoring and Promotion was ensured by focusing the CNW on the 0–3 age group where malnutrition was concentrated; paying CNWs for putting in a minimum six-hour day; and having women's group volunteers support the CNW (each women's group member was responsible for mobilizing and supporting about 10 households in her area).

Work routines were designed to make the most efficient use of time, and to provide services that maximized participation. Growth monitoring was combined with counseling by the CNW, and a health check-up by the local health worker. It was done at group sessions, to make efficient use of workers' time, and always on the last three days of each month. Supplementation was done at the nutrition center early morning, when a) more mothers were available to bring their children, and b) there was less likelihood of the supplement substituting for a main meal. Taking food home was discouraged because of sharing, and because it reduced mothers' participation at the CNC. Each afternoon CNWs systematically visited the homes of those who didn't come for weighing and feeding as well as those whose children were not growing adequately. A referral slip was used to track referral of severely malnourished children and children who failed to gain weight over several weeks, and feed back diagnoses.

All CNW training, both preservice and inservice, was carried out at the block level, thus allowing Community Nutrition Instructresses (CNIs) (see below) to tailor training to local needs and workers' strengths and weaknesses.

Facilitator capacity

There was one first-level supervisor for every 12–15 CNWs. There was a second-level supervisor/trainer, the Community Nutrition Instructress (CNI), for each population of 60 thousand clients. All CNIs were trained at a single Home Science college in the state, which allowed the program to maintain consistency and quality.

Program monitoring

Monitoring information was displayed at the community nutrition center and updated monthly; it therefore served local needs as well as management needs. Monitoring information was processed rapidly enough for program managers to have a detailed picture of performance area by area within a month of raw data reporting by fieldworkers. This allowed managers to rapidly identify areas for corrective action.

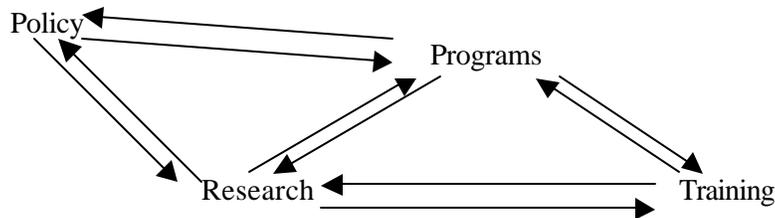
Source: Heaver (2000); Gillespie and Naidu (1997); Gillespie and Measham (1998).

9. INSTITUTIONAL CAPACITY

Malnutrition is one outcome of social, economic, and political processes and their interactions with each other. These interactions are mediated through a range of formal and informal institutions (as shown in Annex 1) that are critical to understanding malnutrition and to formulating strategies to reduce it (UNICEF 1990).

Nutrition program support institutions are defined here as those that aim to contribute to nutrition improvement through supporting processes of assessment, analysis, and action at any level from the community to the national. Such activities may include information gathering and compilation, data analysis, research, training, policymaking, advocacy, program design, implementation, management, monitoring, evaluation, and funding. These activities are, or should be, interrelated, as depicted in Figure 4, with funding being required to do any and all of it.⁴

Figure 4: Relationships between different institutional functions



Note: “Programs” here covers design, management, implementation, monitoring, and evaluation. “Policy” covers specific nutrition policies and those policies that, while they will affect nutrition outcomes, are not specifically nutritional. There are many other influences on policy—beyond those relating to research and program experience—as described later.

This definition encompasses government institutions as well as external nutrition support institutions. Generally, in countries where there are reasonably successful programs there is a duality between the various functions of support to programs and those relating to implementation and management, as shown in Table 5 below. Though

⁴ This is an extension of the more common triangle linking programs, research and training—thus including the important area of policy.

countries differ significantly, external or parastatal institutions usually provide the type of support services discussed in this section—relating to training, research, monitoring, and evaluation. The issues of political commitment, policy development, advocacy, and the strategic management of the nutrition “sector” are discussed in the next section, as they relate more directly to governmental capacity. It is nonetheless recognized that responsibilities and functions often overlap between these two levels and are in any case strongly situation-specific. Moreover, the *linkages* between these two types of institutions, and indeed communications and networking between institutions in general, are a fundamental aspect of national capacity that is often weak.

Table 5: Examples of institutional involvement in nutrition in Asia

Country	Support function	Operational function
India	National Institute of Nutrition (NIN), involved in research, training, advocacy and nutrition outcome monitoring through the NNMB.	Dept. of Women and Child Development in the Ministry of Human Resource Development (ICDS). Nodal state directorates housed in Women and Child Development, Welfare or Health.
Indonesia	BAPPENAS, Centre for Research and Development for Nutrition (Bogor). Also Schools for Nutrition (high-school training) and the Academy of Nutrition (undergraduate training).	Nutrition Directorate, MOH Community volunteers in <i>posyandus</i> (integrated community health posts), established by PKK (women's organizations)
Thailand	Nutrition Division in Department of Health with technical, logistic and supervisory role (coordinates information systems and conducts operational research). Institute of Nutrition at Mahidol University (INMU)	Different sectors (incl MOPH, MOA, MOE)

Source: Gillespie et al. (1996).

Institutional arrangements for nutrition in Asia and elsewhere can be seen in relation to the extent of nutrition programs—where programs are extensive, resources are more readily available for institutions—although the relevance, quality, and timeliness of work differ (see, for example, Box 9). In many countries (with or without programs), one or more focal institutions for nutrition policy, monitoring, etc. are well established (e.g., the National Institute of Nutrition (NIN) in India), often with university or research institution links (e.g., Institute of Nutrition at Mahidol University in Thailand, Centre for

Research and Development in Nutrition in Bogor, Indonesia). In other cases, this role is taken on by government departments, commissions, etc.

Box 9: Institutional capacity for nutrition in India

India's institutional capacity in nutrition began to decline in the 1970s and today is deplorably weak. Until then, India had a vibrant and internationally-renowned set of nutrition institutions. The National Institute of Nutrition (NIN) was at the forefront of research and training in nutrition science for the country, and internationally. Nutrition activities were well developed in agricultural universities, colleges of home science, some medical colleges, and in national institutes such as the All-India Institute of Public Health and Hygiene in Calcutta.

India needs to recognize this gap openly, and provide the resources to build institutions capable of dealing with its vast and varied malnutrition problems. The ultimate goal must be to ensure that there is sufficient capacity to undertake the policymaking, program design, implementation, training, monitoring, and research tasks required to address malnutrition in the country. There is a pressing need to document the nutritional situation, study its determinants and consequences, design appropriate interventions, and manage their implementation within the context of twenty-first century science and political economy. There is also urgent need to train people, from village-level workers to medical specialists and policymakers, and greatly expand public awareness of malnutrition through communications and education. Institutions are needed in every major state of the country, as nutrition problem identification and program responses must be region-specific.

Rebuilding capacity should begin by mapping existing institutions and their capabilities and measuring these against what is needed to revitalize nutrition efforts. To understand both the quantitative dimensions and qualitative nature of the rebuilding required, it would be necessary to carry out needs assessments of key institutions and an overall human resource planning exercise. Beyond this, a phased approach should be adopted to increasing the size and number of institutions and bringing about qualitative improvements in existing ones.

Source: Measham and Chatterjee (1999).

Program-specific support functions of institutions—including issues of program coverage, targeting, design, management, and implementation—have already been covered in three papers of the earlier RETA 5671 (Tontisirin and Gillespie 1999; Mock and Mason 2000; Mason et al. 1999).

INSTITUTIONAL CAPACITY ANALYSIS

The quality of nutrition-relevant institutional analysis is generally fairly poor. In the World Bank's 1999 review, Bank project designs were found paradoxically to be the most complex—with a greater number of components and organizational units—in

countries with weak institutional capacity (Johnston and Stout 1999). A main recommendation was for the Bank to seek to establish appropriate tools, guidelines, and training programs for institutional and stakeholder analysis in health, nutrition and population. This should include strengthening analytic work on major institutional challenges and providing flexible support to task teams facing difficult institutional problems.

Line agencies involved in nutrition are often dependent on external support institutions for help in specialist areas. External program support institutions will continue to play an important role in nutrition for a variety of reasons, such as: lack of staff or expertise in the line agencies; the need for objectivity and independence (especially for research and evaluation); because specialist institutions can develop a reservoir of unique expertise through their experience in serving multiple clients; or because independent agencies can offer better financial incentives than government, or have less bureaucratic ways of doing business, and hence can perform better (Heaver 2000).

Nutrition program support institutions can also fail to respond to the needs of the line agencies managing nutrition programs for a variety of reasons, including having different agendas and priorities; not being up to date with the latest techniques; doing poor quality work due to poor management, under-qualified or poorly trained technical staff, or inadequate incentives; or consistently providing services too late to meet program needs.

The key issue is how nutrition program managers can get the services they want, when by definition they are not in control of the support institutions. There are two different kinds of strategies, which can be used separately or in combination.

- Exerting more direct control, whether through getting representation on the governing board of the support institution, developing improved contractual arrangements (including better planning and monitoring), or providing funding for the institutional strengthening of the support institution (through staff training, technical assistance, performance incentives, or reform of management systems and procedures).
- Building *alternative* capacity, whether through building internal capacity for the particular function within the line agency or using competitive contracting to stimulate the development of additional capacity in the public, NGO, or private

sectors—which may in turn necessitate developing the line agency’s capacity to procure, manage, monitor, and evaluate such services.

In order to build a picture of an effective support institution, it is useful to outline some principles and better practices with regard to some of the main functions of such institutions. This is done in the following sections, where the key institutional functions of training, research, evaluation, and surveillance are described. Advocacy and policy development are other key functions of nutrition support institutions, but these are described in the following section on government capacity, as they relate directly to policy and resource allocation for nutrition.

TRAINING

Interdisciplinary knowledge and intersectoral action have come to be recognized as important strategies for improving nutrition, given its multifaceted causation. Disciplinary knowledge is essential for characterizing the prevalence, distribution, causes, and consequences of nutrition problems and for developing and testing potential interventions. But it is not sufficient for generating effective and sustainable solutions, on account of four main limitations (Pelletier 1997): pragmatic (it oversimplifies complex realities to fit within sectoral boundaries); epistemological (it omits nondisciplinary knowledge); instrumental (it does not motivate relevant groups to take appropriate action, as it usually does not include them in analysis); normative (it is unable to make value judgments that are essential in decisionmaking).

The realization of the need for a shift in the way nutrition is conceived, investigated, and taught led to the emergence in the mid-1990s of a movement among academics and practitioners that was labeled *public nutrition*, and defined as being “concerned with improving nutrition in populations in both poor and industrialized countries, linking with community and public health nutrition and complementary disciplines” (Mason et al. 1996) and including the type of activities shown in Box 10 below.

The key to an effective public nutrition practitioner, at whatever level, is the ability to seek out and integrate knowledge from diverse sources, being guided by the particular characteristics of a given problem and the ecological, social, economic, political, and institutional context within which it occurs (Pelletier 1997). The construct of “public nutrition” should facilitate the development of better practice to improve the

well-being of all populations and to develop the training and research to support that practice (Habicht 1999).

Box 10: Public nutrition

Public nutrition is proposed to include the following activities:

1. Understanding and raising awareness of the nature, causes and consequences of nutrition problems in society,
2. Epidemiology, including monitoring, surveillance and evaluation,
3. Nutritional requirements and dietary guidelines for populations,
4. Programs and interventions: their design, planning, management and evaluation,
5. Community nutrition and community-based programs,
6. Public education, especially nutrition education for behavioral change,
7. Timely warning, prevention, and mitigation of emergencies, including use of emergency food aid,
8. Advocacy and linkage with, for example, population and environmental concerns,
9. Public policies relevant to nutrition in several sectors, for example, economic development, health, agriculture, and education.

Source: Mason et al. 1996.

There is a large mismatch between discipline-based training and the actual needs of such problem-oriented public nutrition practitioners. Discipline-based universities are similar to many national governments in their sectoral perceptions of nutrition problems and potential solutions. Structures, incentives, and reward systems propagate such thinking. Knowledge is compartmentalized and individuals are encouraged to think “within the box,” with specialization having more prestige than generalization. This mismatch is most apparent to anyone working at the community level, where the complexity and inter-relatedness of problems and the imperative to involve all interested parties and institutions is clear.

As a result, nondisciplinary knowledge tends to be ignored. At a community level, such gaps in thinking and approaches to action are revealed in conflicts and dilemmas. For example, there is the conflict over women’s time. Increasing her labor participation might bring greater household (or even female) income, but what of the effects on young childcare? Extra-disciplinary consequences are usually not anticipated. Another example is the educational specialist who believes that better communication and education is the

answer—an approach predicated on the assumption that resources will be adequate for whatever is prescribed and that individuals in communities share the same priorities. In many cases neither is true.

In order to include relevant nondisciplinary knowledge in the Triple A process, it is essential to involve, directly and actively, all interested and affected parties in all phases of the cycle. This is the substantive utility of a participatory approach. In addition, there are instrumental advantages—it is far more likely that the solutions that emerge from such a consultative process will be adopted and implemented by those who have participated along the way. Community ownership is not related only to the final action, but to the whole Triple A process. A final advantage is that value judgments are implicit in participatory processes. Many important decisions in Triple A will be based on normative considerations. Scientific analysis may help to characterize the distributional aspects in order to assist decisionmaking but the decisions will ultimately require normative judgment. Technical analysis should thus be linked with deliberation (reflecting interests and values) in the Triple A. This will automatically be included in participatory processes.

More attention is needed in training public nutrition practitioners on rights-based rationales and approaches to programming, social systems, policy advocacy, and the political economy of nutrition, i.e., the influences on nutrition of economics, political and social institutions and ideas, and the values, perceptions, and priorities of decisionmakers.

The type of content of public nutrition training is illustrated in Box 11 and further details of such an approach are provided in Pelletier (1997).

RESEARCH

The vast bulk of malnutrition research focuses on questions of why, who, where, and to some extent what—as opposed to *how* questions, which are often the most critical impediment to program effectiveness (Berg 1991). In an analysis of abstracts for the 1997 IUNS Congress, only 10 percent were found to have focused on the basic causes of malnutrition, and only 10 percent on underlying causes (Beaudry 1999). There are other biases, such as the age-old equation of nutrition with food.

Following Berg's provocative "nutrition malpractice" thesis, a feasibility study commissioned by the Rockefeller Foundation in 1992 provided several structural alternatives including an International Center for Nutrition Research and Training, an International Nutrition Research and Training Fund housed at an international agency and

regional initiatives. A subsequent workshop at Bellagio opted for a regional action alternative and proposed a series of national assessments of constraints to program effectiveness as a first step (IDRC-ACC/SCN 1995).

Box 11: Curriculum and educational content for public nutrition training

Applied research skills: Epidemiology; survey and field study design; data handling, analysis, and interpretation; application to community needs assessment; program monitoring and evaluation; qualitative and quantitative methods.

Communications and advocacy skills: Ability to write and speak persuasively; identify an audience and communicate ideas at the appropriate level; advocate for a point of view; train and work effectively with staff.

Program management and administration: Management and administrative skills as relevant to service delivery, NGO, government, and international agency settings; personnel management; new management techniques. Techniques for conducting situation analyses; program design processes, including planning, budgeting, implementation, operations, monitoring, and evaluation.

Nutrition science: Basic concepts of nutrition science: human nutrition, physiology, and diseases of nutrition and malnutrition; food and dietary composition; assessment of nutritional status in community settings.

Nutrition policies and programs: Case study of successful and failed experience of policy and program interventions, with a study of their rationale and context; how to select policy interventions from a range of possible options.

Social science concepts: An understanding of the underlying economic and social conditions as related to nutrition and food security; an understanding of behavior and its social, cultural, and psychological determinants.

Fieldwork, internship, and practica: The application of training to nutrition problems in field settings.

Source: Rogers (1990).

Many of the concerns voiced in the section on training pertain to research as well. Researchers and managers need to develop a culture of inquiry into dynamics of societal causes and the mechanics of effective programming. Better collaboration is needed between research and implementing institutions through networking, communications, and strengthening the program-policy-research-training networks.

Within the broader scope of applied research, operational research forms a subset that is directly program-driven. Operational research needs should be determined on the basis of the problems with project implementation that are identified over time by in-built

management information systems. Examples include the most cost-effective systems for targeting, supervision, service delivery, etc. Qualitative monitoring in particular should reveal priority research needs. Research should be simple, timely and participatory.

One recurring question is what is the role, if any, of supplementary feeding in community-based nutrition programs? This is particularly important given the highly political aspect of food distribution and its high economic and opportunity costs. Supplementary feeding typically takes about half the budget in food costs, plus large amounts of staff time. The availability of the supplementary food may crowd out other crucial aspects of the program such as counseling. Even if it is effective in closing nutrient gaps in nutritionally vulnerable individuals, there remains a question of its cost-effectiveness and sustainability relative to other interventions. Best practices in supplementary feeding are discussed in Allen and Gillespie (2000).

The following represents the 1994 Bellagio Conference consensus on key characteristics of an operationally-oriented research approach (IDRC-ACC/SCN 1995). Such an approach should

- be national program driven and owned,
- develop and reorient research capacity in a sustainable manner in developing countries using existing institutions,
- raise the status of program research done in developing countries,
- promote community involvement in posing research questions and identifying solutions,
- institute peer-review of the research process at appropriate levels,
- be open to the utilization of a diverse range of existing research capabilities, strengths and disciplines,
- create a culture of inquiry and self-accountability at all levels, and
- promote the development and use of rapid and reliable methods.

Evaluative Research

Evaluative research is a key element of research in public nutrition. Program evaluation is a subset of operational research, as the findings should be used to improve

programs, whether it be the program being evaluated or others. Evaluation is simply the application of social science research techniques to one particular kind of question: whether a particular intervention does or does not work, and why. The “why” question in evaluation research thus relates to the “how” question of nutrition programming (Rogers 1999).

The significant absence of evaluation research on the impact of large-scale nutrition-oriented programs has been highlighted elsewhere (Mason et al. 1999; Allen and Gillespie 2000). Case studies of successful programs should be carried out and widely disseminated. A proportion of the project budget should be set aside for these investigations.

An evaluation essentially comprises a description of what happened (in relation to what was intended to happen), an analysis of why/how it did or did not happen, and finally a prescription, in the form of recommendations, on what to do next. Description and analysis focus on inputs, outputs, processes, outcomes, and impact. The questions to be answered by an evaluation may include those related to effectiveness, efficiency, impact, relevance, and sustainability.

We need to know what works and why. And we need to know why programs fail—whether due to inappropriate strategies, inadequate resources, low coverage, poor targeting, or insufficient intensity of resources (Box 12). We may find that

- the strategy works, but scarce resources preclude wide coverage and hence national targets cannot be achieved;
- the strategy works, but scarce resources are spread too thinly, diluting actual inputs to the point where achievement may be compromised;
- the strategy works, and the inputs are adequate, but institutional constraints limit the speed of implementation;
- there is not a workable strategy to deal with the particular problem.

In order to choose an appropriate design for an evaluation, it is first necessary to answer the following questions:

- Why is the program being evaluated?
- Who will make decisions on the basis of the evaluation findings?

- What type of decisions?

Box 12: The challenge for nutrition program evaluations

It may be more difficult in nutrition to demonstrate the full range of beneficial outcomes than it is with other interventions—for example immunization—but it is critical to demonstrating success and thus generating interest and resources for sustained nutrition-relevant action. Nutrition evaluation may pose a particular challenge for several reasons:

- because of nutrition's very nature as an outcome of myriad, interacting processes in society,
- because of the marked site-specificity of these causative processes—each new nutrition project is thus breaking new ground,
- because a central objective of many nutrition programs is to change human behavior,
- because the type of benefits that may accrue from nutrition improvement are multidimensional in nature, level, and timing,
- because many of the common nutrition outcome indicators, based on anthropometry, are proxy indicators which, albeit quite sensitive, are not specific to the causes of malnutrition nor the benefits from alleviating it.

Whether an evaluation is complex or simple, it should be rigorous in relating evaluation design to decisions. A useful two-dimensional framework for deciding on an appropriate design has recently been proposed (Habicht, Victora, and Vaughan 1999). The first axis concerns the indicators of interest: whether these refer to provision or utilization of services, coverage, or impact measures. The second axis refers to the type of inference to be made: whether this is a statement of adequacy, plausibility, or probability. This relates to the question of how confident decisionmakers need to be that any observed effects (both in terms of performance and impact) are due to an intervention. The difficulties of assessing impact are discussed in Annex 4. In addition to the above framework, other factors affect the choice of an evaluation design, including the efficacy of the intervention, the field of knowledge, timing and costs.

While anthropometry provides the main outcome indicators for evaluations, it should nonetheless be remembered that it does not encompass other effects or benefits of improved nutrition such as increased activity and exploration of the child and cognitive skills. Severely underweight children are most likely to respond to nutrition interventions with improved growth, but moderately underweight children are more likely to respond with increased activity, greater disease resistance, and possibly improved cognitive development. These outcomes are important, albeit very difficult to measure.

Nevertheless, following the principle of “plausible inference,” it is well known that for a given anthropometric improvement, certain other benefits are likely to be achieved, e.g., relating to cognitive development, productivity, mortality, etc., as these have already been demonstrated in longitudinal studies (e.g., the meta-analysis that conclusively established the contribution of child malnutrition to child mortality [Pelletier et al 1994]).

An evaluation may also consider the relevance or appropriateness of the project—particularly for a long-standing project in a rapidly changing environment. Are the objectives still relevant? Is the approach taken still appropriate for combating the current causes of malnutrition in the project area? Do the assumptions that underlie program design remain valid? A project’s objectives after a few years of implementation may be considered to have been too ambitious—particularly if unforeseen changes have occurred in the conditions. If so, the evaluation must make a judgment about the actual progress made with respect to what is considered to have been feasible. One of the key differences between monitoring and evaluation is that evaluation, unlike monitoring, may question program goals and hence judge relevance. Evaluations should also look to the future, and consider issues of sustainability (see Section 4).

Quantitative data are measurable, reliable, comparable, and objective, and as such are useful for answering “what” questions. But they are less helpful in addressing “why” or “how.” Evaluations should delve deeper into the dynamics of the program, including qualitative aspects such as how household-level behaviors have changed. Answers to such questions can point to what needs to be done to improve the content or methods of communications promoting behavior change, so as to improve home-based care for nutrition.

Qualitative data may promote a more holistic and deeper understanding of underlying dynamic processes behind changes in outcomes. Qualitative methods are flexible and may be used in more free-flowing, open-ended inquiries with local people. Improvisation is possible to further explore new lines of inquiry. Qualitative methods particularly lend themselves to participation of key stakeholders. They enable a rapport to be established where local people’s knowledge is respected and they provide insights into the diversity of real life in communities through techniques such as social mapping and ranking (see Annex 2). Feelings, attitudes, beliefs, motives, and behaviors may all be revealed using qualitative approaches. Essentially, the work of anthropology is “telescoped” with such methods, as its essential tasks are performed in a shorter time.

Finally, another important consideration relates to the way success is communicated, internalized, and ultimately used to generate more success. There is often a gap in evaluation planning, which results in many evaluation reports gathering dust on bureaucrats' shelves. In any evaluation, it is simply not enough to carry out a survey, measure changes in a few indicators, and draw conclusions on the degree of programmatic success. The *use* of evaluations should not be separated from their actual implementation. This requires consideration of a variety of communication strategies and methods for disseminating lessons to those who can best apply them—from the communities involved to national-level policy-makers (see Box 13).

Box 13: Evaluating development effectiveness: Lessons from the World Bank

The changing global economy and the Comprehensive Development Framework suggest several principles for evaluating development effectiveness. Evaluation should focus on results, and this depends on accurate tracking of progress toward development goals, with a clear focus on poverty reduction and growth. Tracking development outcomes should comply with the comprehensive development agenda agreed by the government and its partners.

As the focus of the development effort moves from projects to the higher plane of country programs, so must the evaluation process. Resources and skills should be invested in developing appropriate indicators and information systems. The current preoccupation with project performance and evaluation should be complemented by a sectoral and countrywide focus. Public sector reform needs to include building the evaluation capacity of countries.

Development effectiveness should be evaluated in terms of shared objectives, joint responsibility for outcomes, reciprocal obligations to achieve results, and distinct accountability for performance. In particular, donors and governments should team up to involve civil society and the private sector in monitoring and evaluation, and to help all stakeholders acquire the needed skills and attitudes. Participatory monitoring and evaluation hold significant promise for social learning and managing for results.

Evaluation should be informed by the global perspective of the International Development Goals endorsed by the development community. Far from implying rigid, top-down global planning, this two-way link means adapting the international goals to country conditions and priorities and enhancing partnerships at all levels.

Source: The World Bank (1999).

Nutrition Surveillance for Early Warning and Crisis Management

Nutritional surveillance for crisis management is a process of monitoring, analysis, and interpretation of indicators and causal factors in order to make appropriate decisions resulting in improvements in the nutritional status of a population. A general principle of a nutrition surveillance system is that it should be simple, user-driven, based on existing institutional structures, and have the commitment of relevant decisionmakers for information use in planning and policy design. Tracking the deviations in implementing nutritional surveillance systems from these criteria helps to reorient activities toward the ultimate goal of informed nutrition decisions.

Many monitoring systems continue to be heavily donor-driven and remain dependent on external aid and technical assistance (Quinn and Kennedy 1994). The lack of evaluation of how well these systems are performing has been frequently suggested as one reason for such low sustainability. The situation in Asian developing countries is typical of this problem. Usually, two types of evaluations are necessary: first, evaluating the performance of the nutritional surveillance systems in terms of the quality of information generated and in terms of their success in meeting information needs; and second, evaluating the impact of the resultant information in influencing policy decisions.

Assessing nutritional surveillance systems is perhaps more aptly viewed as a cyclical process. Several criteria are used to evaluate the performance of these monitoring systems. A fundamental factor that determines the sustainability of nutritional surveillance systems is how user-driven are the objectives for which information is generated. This reflects the nature and the extent of the operational linkages between the surveillance system and its user organizations (Tucker et al. 1989). The quality of data and the speed with which they are generated is determined by the simplicity of the instruments used for gathering information. The existing use of infrastructure for collecting and compiling information has proved to be more successful than creating new institutional structures for the purposes of nutritional surveillance for crisis management. In addition to the existing institutions, the capacity for data collection, processing, analysis, and interpretation is necessary for the continuous generation of information for program interventions.

It is also important to compare the cost of information generation to the benefits attained in terms of changed program impacts, although it is generally agreed that such benefits are not readily quantifiable. One approach could be to document the use of information from nutritional surveillance systems for various programming purposes on a case-by-case basis and to estimate the costs saved over information generation in the

absence of a comprehensive surveillance system. For example, a part of information collected by the nutritional surveillance systems could be used by donor agencies in their planning exercises, which otherwise would involve additional resources for data collection. These benefits are in addition to the information benefits for which the surveillance system was originally intended. Information gathered by the nutritional surveillance systems may also be used by nongovernmental and donor agencies for their planning and programming purposes, providing easy access to such data. Most often the use of data collected through monitoring however is restricted to government agencies due to its sensitive nature. Even in the case of data collected through NGO-run nutritional surveillance systems, the sharing of data with others remains a contentious issue (HKI 1999). Transparency in the use and sharing of data would enable faster response to shocks.

Institutional development as part of the nutritional surveillance is important for ensuring that information is generated from the data and that it is used in decisionmaking. Past experiences in nutrition surveillance systems indicate that there is a tendency toward using short-term technical assistance in generating data from the field. Even with long-term projects, such as the ones implemented by external agencies, adequate resources have not been devoted to developing institutional and human capacity to sustain surveillance systems. This has resulted in low quality and decreased frequency in outputs from the surveillance systems following the end of the technical assistance (UNICEF 1992). In the interest of showing quick results, nutritional surveillance systems have often not placed adequate emphasis on institutional development. To the extent that surveillance systems include the development of institutions involved in nutrition decision-making as a long-run objective, they are likely to be more successful and sustainable.

Monitoring the use of information in designing intervention programs and evaluating its impact on policy decisions is important for identifying new channels for information dissemination. Assessing surveillance systems for their effectiveness in influencing crisis management programs is useful as an instrument to gain resources and support for sustaining the systems. Monitoring and evaluation of the impact of surveillance systems in influencing policy decisions requires continuous follow up of the flow of information and documentation of the use of information at various stages of decisionmaking. The benefits of such documentation, however, outweigh the time and cost involved. Such information is also useful for getting the attention of donors and governments and for receiving their continued support.

10. GOVERNMENT CAPACITY

In this section, some of the most important aspects of capacity at the governmental level are described, including the capacity to analyze, build, and sustain political commitment to reducing malnutrition, and the capacity for effective advocacy and policy development. The capacity for effective strategic management of the nutrition “sector” is discussed from a new perspective. Finally the implications for nutrition of the accelerating processes of decentralization of government functions for nutrition are reviewed.

POLITICAL COMMITMENT

Building the capacity to analyze and increase commitment is as important a capacity-development intervention as building the capacity to deliver services (Heaver 2000).

Malnutrition is largely invisible and therefore commitment to combat it is generally weak. Parents of malnourished children often do not know they are malnourished, because mild and moderate underweight and subclinical vitamin deficiencies are not apparent to the eye. Politicians and planners often underallocate resources to nutrition, because they do not see the damage that malnutrition does to health, educability, and productivity. And since malnutrition is seldom an immediate cause of death, and better nutrition is less obviously linked to doing well in life than is going to a good school, parents and communities are more likely to demand health care and education than nutrition services. This lack of demand means that many governments can get away with underinvestment in nutrition.

The fact that nutrition programs are often run by line agencies for whom nutrition is a secondary concern is another reason for weak commitment. Improving nutrition is not seen as a primary goal by many agriculture ministries, who remain preoccupied with production rather than consumption. Food fortification is never a central concern of ministries of industry. And even in health, which is crucially dependent on good nutrition, the links between better nutrition and lower mortality and disease rates are often poorly understood. The priorities of health ministries are often set by medical specialists, who focus more on the disease control programs in which they were trained than on the community nutrition programs that should be their natural complement.

Education about the extent and seriousness of malnutrition and about the impact on health and productivity of improving nutrition usually, but not always, leads to increased action to improve nutrition (see Box 14). There are many examples of countries that are aware of their serious malnutrition problem, but that have not invested adequate skills and resources to deal with it. Sometimes this is because they lack the will to tackle the problem, sometimes it is because they lack the ability, due to financial or capacity constraints. Because the solutions are different in each case, it is crucial to distinguish to what degree poor nutrition program performance is due to lack of understanding, lack of commitment, or lack of capacity.

Analyzing Commitment

At the country level, commitment to nutrition can be shown by various actions, including the development of policies (see section on Policy Development below), the enactment and enforcement of laws to combat malnutrition; the dissemination of information about the extent and seriousness of malnutrition; the financing of nutrition service delivery and community empowerment programs; and the prioritization of support to systems of monitoring and evaluation.

But country commitment is something of a myth. A systematic analysis of commitment requires identifying the various interest or stakeholder groups actually or potentially involved in nutrition, assessing their power or influence, analyzing their attitudes and behavior, and seeing what influences underlie them. As mentioned, the range of potential stakeholders needs to be mapped as part of the role and pattern analysis, and key influencers (whose commitment must be ensured through the development of specific strategies) need to be identified.

Building Commitment

Building commitment among different stakeholder groups can involve a variety of approaches and tools, depending on the degree of control or influence that change agents may have over the particular group, where the particular bottlenecks lie, and the power or influence of the group itself. Where an interest group's power is considerable, and change agents' degree of influence is low—as is often the case with politicians, for example—orientation, advocacy, and publicity may be the only tools available. Where change agents can exercise a higher degree of control—over community workers, for example— incentives such as pay, promotion, rewards, and recognition can be used. Where

commitment needs to be built in external organizations, measures to reward increased cooperation may include providing additional funding, entering into performance contracts, or developing improved monitoring systems (Heaver 2000).

Sustaining Commitment

Once commitment has been generated, different strategies may be appropriate in the short and long term to sustain it. In the short run, change agents may need develop a process for systematically orienting and educating new stakeholders moving into key government positions. But in the medium and long run, sustained bottom-up demand for quality services from organized community groups is the best way to maintain the commitment of both policymakers and service providers. Empowering households and communities to know their rights, understand their needs, and participate in program monitoring and management is therefore an important tool for building and sustaining commitment.

ADVOCACY

Advocacy, like social mobilization, is a communication strategy fundamentally geared to building commitment, which may be concretized in changes made to nonnutritional policies, sectors, and resource allocation. Advocacy goes to the heart of the Triple A programming process, shown in Figure 2, literally in that it is also designed to highlight the ethical imperative of acting to reduce malnutrition.

Through demonstrating the potential or actual effects of non-nutritional policies on nutrition outcomes, exploiting a range of opportunities through different strategies, nutrition advocates may succeed in influencing and changing existing policies. In the last two decades, nutrition outcomes have increasingly been used as a measure of the degree of equity of development processes. Nutrition advocates can build on this growing awareness and seek leverage to further influence nutrition-improving processes and actions.

In reality, the process of policymaking is more complex than that outlined in the standard linear model whereby policy is primarily modified on the basis of new information about the problem or its possible solutions. The various types of events of processes that may actually precipitate or catalyze such policy change are shown in Box 14 (Sutton 1999). These change events—which are possible entry points for advocacy—

Box 14: Policy change factors

Policy change happens when...

New Research/Data

- A ground-breaking piece of research is completed that defines a problem and clarifies appropriate courses of action to remedy it.
- A development problem is analyzed in a scientific, technical way, producing tangible data that offer something concrete to act on.
- The publication of research happens at a time when a policymaking organization is interested in the issue being researched.

Networking

- There are good links between and within agencies whereby lessons learned from practical experience can be shared and acted upon.
- There are good connections between interested parties such as aid organizations, the research community, and government, making a network through which ideas are exchanged and thoughts clarified about possible policy directions.
- There is a dominant epistemic community, a particularly influential group that has close links with policymakers, and forces an issue onto the agenda and shapes policymaking.

Authority/Influence

- A person in authority has a particular interest in a certain issue and as a result those around him/her are influenced to work on it and develop policy in that area.
- Events are timed in such a way that a person who is particularly interested in pushing forward an agenda is working at a time when a powerful political authority has reason to be interested in the same agenda.
- Policymaking and implementing bodies have sufficient authority to push a new policy through even if it is not widely supported.

Simplification

- A development problem is turned into a “story” that simplifies it and sets out an agenda for action.
- A dominant discourse or way of thinking becomes established that makes clear certain priorities, thereby simplifying a situation and providing guidance toward certain policy directions.
- A situation develops which is represented in a widely accepted scenario or narrative as a ‘crisis’, requiring rapid and dramatic action to avoid catastrophe.
- There is a code of conduct or best practice regarding a particular issue, creating guidelines as to how to act.

Organizational Opportunities/Change

- There is a general consensus within an organization or wider network (which may include the general public) that change is needed, a new policy direction is required, and that old strategies are not working as well as they could.
- An organization and the individuals within it are open-minded and consider it important to adapt to new ideas from the external world, rather than seeing these as a threat.
- An organization fosters innovation. People are encouraged to develop new ways of doing things and are confident their ideas will be considered with an open mind by others.
- There is an individual or a group of people who have an idea for a new policy direction. These “change agents” carry the idea forward, explaining it to others and building a consensus toward the new position.
- There is a network of people around the change agents who respond to them and help them carry the process forward.
- An organization has a sufficiently flexible organizational structure to enable the development of new groups or units, which will be effective in seeing a policy change through.
- Resources within an organization exist, or can be gathered, to respond to a new way of working.
- There is the required motivation and energy to use and mobilize these resources to achieve the goals of a policy innovation.

Source: Sutton (1999).

are not mutually exclusive, and any one policy innovation will include some and not others. Some are good motivations for change, others may not be.

There are certain critical contextual factors that need to be taken into account when designing an advocacy strategy, such as the following.

Perception and Understanding of Malnutrition

People's perceptions are governed in part by their personal conceptual frameworks that relate certain problems to likely causes, and ultimately to a course of action. Nutrition has tended in the past to be compartmentalized either as a food or a health problem. As a means of communicating the multifaceted nature of the malnutrition, UNICEF has successfully pioneered the food-health-care conceptual framework shown in Annex 1 and disseminated it as a tool for assessing and analyzing nutrition situations and designing appropriate actions (UNICEF 1990). The portrayal of malnutrition as having many potential causes should be framed in a way that will not stymie action, but rather promote a better awareness of multiple sectoral opportunities that may be seized to combat it.

Demand for Information

Demand for relevant information may increase if the nutrition problem begins to be perceived in a different way, particularly if a potential information user expects certain new benefits to result from acting on information. For example, a mother who becomes aware that her child's growth is faltering may then learn through counseling that it is possible individually and/or with other individuals to do something about it. An improved understanding of either the causes or the consequences of malnutrition can lead to such changes in perception.

Ways to increase demand may also be determined by carrying out a "decision audit" to see what type of information would be needed to improve decisionmaking at different levels of nutrition-relevant sectors, as well as how it should be presented and disseminated. The design of the information system, being more demand-driven, becomes more action-oriented. Information should be functionally disaggregated so as to guide decisionmakers (see Section 8).

Demand may also be augmented through building accountability into nutrition-relevant actions, perhaps through the formulation of a national nutrition policy (see

Section 10 on Policy Development below) that clearly articulates different sectoral roles—and thus each sector's share of responsibility for a portion of the problem. Accountability may also derive from the use of certain nutrition outcome indicators to monitor nonnutritional policies and programs and the dissemination of the results.

Overall, perceptions of the nutrition problem and demand for nutritional outcome information are relatively low in Asia and the Pacific. At all levels of organization, outcome information is not consistently available and nutrition objectives are usually not a part of performance criteria for policymakers, program managers, or caregivers. In order to mainstream nutritional considerations at the national level, advocacy activities utilizing tools such as PROFILES should be utilized to generate political support for country programs. Where possible, influential agencies, both domestic and international, should advocate the incorporation of nutritional indicators into national development plans and monitoring and evaluation systems. In designing country programs, nutritional outcomes—both general and micronutrient outcomes—should be a part of performance evaluation schemes for program managers.

Public advocacy should focus on the extent and severity of the malnutrition problem, its costs to the individual and the society, the low level of resources going into nutrition (as compared to the military, for example) while cost-effective options for action exist, and the fact that adequate nutrition is a fundamental human right enshrined in conventions ratified by governments.

The types of information systems that may be used for advocacy or problem sensitization include large-scale population-based surveys of nutrition outcomes. These are really essential to demonstrate that a problem actually exists, how severe it is, and where it is concentrated. Nationally representative data that include maternal and child anthropometry, biochemical indicators (vitamin A, iodine, and anemia), as well as intermediate outcome and key contextual factors, should be collected, preferably within five-year intervals. To the extent possible, these efforts should be synchronized across countries to permit comparability. Capacity for information management is a clear capacity development priority within the region.

Motivation of Decisionmakers

Information needs to be presented in such a way that it motivates people and promotes appropriate action. It thus links again to the need to create a demand (see above) and also create an expectation of success. Motivational theory recognizes the

importance of expectations of outcomes in motivating and sustaining action. The range of benefits including fundamental ethical concerns and economic rationale need highlighting. The decisionmaker should be presented first with the most negative outcomes, before being shown that solutions are feasible (including success stories), often with multiple benefits, and finally that s/he has the power to achieve at least part of the solution. The decisionmaker needs to be adequately furnished with the necessary arguments for taking action, in the context of peer group dialogue. Information systems should be designed so as to give regular ongoing feedback on the results of actions taken—to reinforce accountability for successes and failures at all levels, and to continue to motivate.

Political Economy of Nutrition

Information does not exist in a vacuum and actions are not purely determined by information (see Box 14). Powerful political and economic objectives may conflict and possibly outweigh nutrition considerations. Nutrition may remain relatively marginalized. Greater political weight needs to be attached to the concept of malnutrition to counter its compartmentalization as a scientific problem to be dealt with by "nutritionists" alone. This will require better nutrition advocacy skills training of public nutrition practitioners, and a better grasp of political economy and the human rights and economic dimensions to nutrition policy and programming.

SOCIAL MOBILIZATION

Social mobilization is the process of bringing together all feasible social partners or stakeholders to determine felt-need, raise demand for and sustain progress toward a particular development objective, in this case, malnutrition reduction. It involves enlisting the participation of such actors—including institutions, communities, and social and religious groups—in identifying, raising, and managing human, economic, and organizational resources to increase and strengthen participation in nutrition-relevant activities. Through social mobilization, the pursuit of common goals and objectives becomes progressively rooted in the community's conscience, thus ensuring sustainability.

While the emphasis in community-based programming will be on community mobilization to foster a growing sense of ownership, social mobilization does not only

apply to communities. The mobilization of strategic allies is also a very important tool to help create a supportive environment for change.

The social mobilization component of the Bangladesh Integrated Nutrition Program (BINP) is one example. This involves various nutrition committees in village, ward, union, and thana levels who follow the Triple A approach at each level as they focus attention on malnutrition, its causes, and its local solutions. Through local community-government partnerships, mobilization and participation is promoted and supported at each level. A continuous interaction and feedback operates between the service providers and recipients through mobilizers. The social mobilization also strengthens local organization and enrolls the broader community to work for nutrition.

Advocacy was key to building commitment in Bangladesh. After several years of inaction on a national program, the BINP project was finally approved by a Minister of Finance on the basis of a "profiles" exercise specifying the likely losses in national productivity resulting from nutritional stunting.

POLICY DEVELOPMENT

One approach to institutionalize a broader role for nutritional considerations in a country's development process has historically been through the formulation of a national nutrition policy.

A nutrition policy is usually considered as comprising a coherent set of principles, objectives, priorities, and decisions adopted by a government *and implemented* by its institutions as an integral part of its national development plans. It is essential to take the approach that "policy is what it does" (Schaffer 1984) in order to avoid the possibility of implementation being seen as something separate. In the past, where implementation was not seen as part-and-parcel of the policy process, accountability was reduced or absent and policies often either failed (e.g., in Thailand in the late 1970s) or continued to exist only on paper (e.g., in India in the mid-1990s).

As with community-based nutrition programming, the process approach has been found to be very important in policymaking. National nutrition policy should never be prepared *de novo*. It should emerge from a consensus-building approach that will take time and usually involve political compromises. The actual process of drawing up a policy through involving different sectors in a dialogue on nutrition may often be prolonged but it may serve to raise an awareness, or "nutritional literacy" among different sectors. The development of viable policy will be an ongoing struggle along two axes—

vertical and horizontal—between central and peripheral levels, and between different sectoral levels. It is a process, not only of raising nutritional literacy, but of bargaining and compromise, which takes time.

Consider the cases of Zimbabwe and Tanzania. In Zimbabwe, the evolution of nutrition programs, with their district-based interministerial management teams spearheaded the development of a national nutrition policy—in a bottom-up rather than top-down fashion. According to Tagwireyi, Jayne, and Lenneiy (1992),

the multifaceted dimensions of the nutrition problem and how it demanded intersectoral action was not understood by policymakers. The painfully slow process of creating awareness toward comprehensive action was necessary. But a policy document without the requisite level of understanding would be no more than a document. Policy development is itself a gradual process incorporating lessons learned in struggling with solving the problems of malnutrition in the local context.

Similarly, in Tanzania, the division between the process and implementation was viewed as arbitrary in the sense that implementation of the policy was going hand in glove with its development—the process of assessment, analysis, and action continuing despite the absence of a formal declaration of the policy. The mobilizing effect of the process was more important than the elaboration of the document. The delay in the declaration of the policy was seen by the focal nutrition institute, the TFNC, as "a blessing in disguise," as it kept the policy on the agenda of many high level bodies until a critical mass of awareness and opinion was mobilized (Kavishe 1993).

Nutrition policy needs to be grounded in operational realities. In the fourth National Economic and Social Development Plan (NESDP) in Thailand from 1977 to 1981, nutrition planning was largely top-down and overseen by a multisectoral national coordinating body, with little emphasis on community participation. Implementation of programs presented major problems. Lessons were learnt, and in the fifth NESDP (1982–86), the incorporation of nutrition objectives into overall developmental goals was found to improve intersectoral efforts, both at central and community levels. The nutrition policy became rooted in the Poverty Alleviation Plan and a greater emphasis was placed on effective resource allocations through targeting and the integration of micro-level program implementation with macro-level policy (described in Tontisirin and Gillespie 1999).

In sum, the means may be as important as the ends with respect to policy. The process, sometimes prolonged, of building collaboration between sectors and between community organizations and local or central government, is essential. This results not only in a better policy design but also better policy implementation.

As national decentralization processes continue (see section on Scaling Up/Down below), the impetus for formulating a policy is increasingly likely to come from community-levels where the particular needs for extra resources from the center are better understood, as was the case with Zimbabwe. At the central level, it is increasingly understood that a multicausal problem does not necessitate a multisectoral centrally-controlled approach for its control, as discussed in the next section.

STRATEGIC MANAGEMENT OF THE NUTRITION “SECTOR”

Strategic management may be defined as an approach whereby organizations define their overall character and mission, their longer-term objectives or goals, the activities they undertake and the strategies they adopt, including how they allocate resources. The approach is comprehensive and far-reaching, integrating and addressing all dimensions of capacity at all levels.

While there is consensus in the nutrition community that nutrition lacks an institutional base, with consequences for political support and funding, the institutionalization debate has taken different forms during particular historical contexts and with particular sets of actors. Because of nutrition’s multisectoral nature, a view that prevailed in the 1970s was that nutrition should be managed by multisectoral units in ministries of planning. These units however often had little impact, since they had little influence over the line agencies, which were the only institutions with the field staff and other resources to mount large scale nutrition programs.

As the weaknesses of multisectoral nutrition units became apparent, the pendulum swung back, and in the more isolationist period of the 1980s and 90s, the focus shifted to debates over a food versus health and community orientation and on the balance of science and practice, both with important implications for institutionalization. In many countries the “home” for nutrition moved to one of the line agencies of government: whether this was the ministry of health or agriculture depended largely on whether nutrition was more strongly championed by health and care stakeholders, or by food stakeholders. This approach, too, has had its problems, since single-line ministries seldom understand or are committed to the full range of nutrition activities; have little

control over other agencies implementing other parts of the national nutrition strategy; and are not in a strong political position (and may have little political incentive) to secure resources from ministries of planning and finance for other line agencies' programs.

It has recently been suggested (Levinson 2000) that a third opportunity to establish meaningful institutionalization and purpose may be provided at present by new goal oriented strategic thinking in development agencies, as manifest by the World Bank's new Comprehensive Development Framework (see Box 10), UNDP's "Multiple Dimensions of Human Development" approach, and the new United Nations Development Assistance Framework (UNDAF). This may offer another chance for nutrition to become integrated into the development process, and for nutrition interventions to become part of a larger arsenal of development inputs addressing the same objectives, this time at the behest not of nutrition advocates alone but of governments and development agencies themselves.

But what does this mean in practice? Perhaps we have been asking the wrong question in focusing on where "nutrition" is located. The fact is that the implementation of national nutrition strategies everywhere involves several ministries, each of which needs to be responsible for and committed to its activities. In any one country, there is usually a network of nutrition programs run by different agencies and local governments.

An alternative approach would be to redefine the issue as being *how* best to manage the nutrition sector, rather than *where* best to manage it (Heaver 2000). This would open the door for a wider range of pragmatic solutions. With regard to the strategic management of policymaking and resource allocation, several stakeholder groups are involved: technical nutrition specialists with specialist knowledge of nutrition and efficacy of possible solutions; national and local level politicians promoting some mixture of their constituents' and their own interests; and finance, planning, and implementing agencies, all with limited budgets and multiple activities competing for resources with nutrition. Seen from this perspective, the issue is not so much who is in charge of nutrition, but how to bring these different stakeholders together to build consensus in a participatory way, and the means to feed performance results of different programs into decisions about resource allocation.

SCALING UP / SCALING DOWN

One reason for breaking away from thinking in terms of top-down versus bottom-up development is to avoid two fallacies about assisting the poor. The first is the paternalistic fallacy: the belief that planners, technicians, and experts possess all the knowledge, wisdom, and virtue needed to achieve development and that the poor should be responsible and grateful beneficiaries. Similarly mistaken is the populist fallacy that the poor themselves possess all that is needed for their own advancement, that they can do entirely without bureaucrats and technocrats. While there are some impressive self-help examples and enclaves, those regional and national programmes that benefit the poor on a significant scale have been concurrent mutual endeavours from above and below.

Source: Uphoff 1988

The allocation of public resources—whether health and nutrition or otherwise—is decentralizing rapidly in many institutions throughout the world. Decentralization is here defined as the ceding of power from the central government to a local government or agency with the central government retaining some measure of oversight over the decisions of the decentralized body.

There are many examples of the benefits of decentralization such as improved project relevance and performance (including quality and sustainability) and increased efficiency, accountability, and transparency (World Bank 2000). The movement of authority and accountability closer to the intended beneficiaries of an initiative—poor communities, for example—is likely to strengthen the incentives to use public funds more effectively and to facilitate the generation of complementary private funds.

In practice, however, mechanisms to ensure sufficient local capacity and accountability have to be present as well. Communities also have embedded power structures and in the absence of transparency and accountability mechanisms, local elite groups can appropriate funds. Moreover, if local communities are to compete for central funds, the better equipped, more cohesive, and less excluded communities will capture them. Communities that are unable to organize proposals or less likely to be noticed by central authorities will lose out. There are other potential problems with decentralization including the restrictions due to fiscal austerity; the inability of mechanisms to allow demands to be included in national objectives and strategies; the lack of sufficient authority and/or resources to match the delegation of responsibilities; the lack of mechanisms to generate own resources for the cofunding of programs; duplication of effort between local and central government; the persistence of a paternalistic approach toward the most vulnerable sectors; and the replication at local level of the

compartmentalization of public service functions at central level (FAO 2000). Decentralization processes thus need to be accompanied by adequate support and safeguards from the center.

In such an era of progressive decentralization, a central challenge for nutrition programs is finding a balance of approaches that work. The nature of community-government partnerships has been described (Tontisirin and Gillespie 1999) but how can the grassroots and the center be brought together effectively? What balance of top-down (or center-derived) versus bottom-up (community-derived) planning and action is optimal for nutrition?

First, it is important to restate experience—as described by Uphoff above—that suggests it is not an either/or question. Both top-down and bottom-up approaches are potentially relevant, appropriate, and complementary. In practice, a shift toward a more bottom-up or decentralized approach to nutrition programming is often required to redress past imbalances in which the center traditionally assumed control of most critical structures and functions. Nonetheless, there are some nutrition-relevant actions that can be appropriately formulated at higher levels, using wide and more top-down application of appropriate strategies and technologies, based on the best scientific knowledge, e.g., salt iodization or immunization. Legislation is another top-down strategy. The challenge then is how to integrate these two approaches for maximal long-term impact on nutrition.

Two promising approaches in World Bank-supported projects, as described in World Bank (1999) are

- An adaptive learning process that starts small and combines top-down direction with bottom-up experimentation and learning. This shifts the emphasis from up-front analysis and detailed design toward developing flexible solutions, building local capacity, and relying on social processes and monitoring systems for adaptation and learning during implementation.
- Sequencing. One way out of the excessive complexity of projects and programs is to sequence interventions within a long-term strategy that builds on past learning. Such sequencing can start by piloting comprehensive approaches at the local level, then scaling them up as part of a long-term process of capacity building and decentralization.

The strengthening of community-government partnerships (see Figure 1) essentially implies two processes (Uvin 1999)—scaling up from communities and scaling down from more central levels, usually the government.

Scaling Down

Scaling down essentially refers to a decentralization of authority, resources, and capacity—or more specifically, the enabling, supporting, or facilitating function whereby the government scales down its own role, adopting modes of functioning that allow local communities and organizations to build conceptual, operational, and institutional capacities. It implies a need for “management by withdrawal,” co-adaptation, responsiveness, flexibility—to provide the space for community organizations to learn, grow, initiate, and scale up. It usually involves the creation of smaller, more participatory projects, with more in-built flexibility, greater local ownership and sustainability.

Such a convergence of government and community will require changes in administrative culture. The causes of malnutrition are multifaceted and often interrelated. Multifaceted and interconnected activities work better at the village level than at higher organizational levels as people’s lives naturally comprise such diversity. Decentralization thus increases the potential for intersectoral action that can maximize impacts on nutrition outcomes. It is only when attempts are made to interface the diverse community-level realities with the sectoral interests of governments, agencies, and even NGOs, that problems often emerge. The multifaceted nature of malnutrition is often viewed as a problem rather than a blessing precisely because it is bureaucratically and politically inconvenient. But the onus should be on the center to better align its systems with grassroots realities if scaling down is ever to reap rewards—not on resource-poor villagers to adapt to sectoral fragmentation. As described later, this calls for more flexible, area-based programming.

“Scaling down” has been promoted in recent years through the following types of processes:

- erosion of legitimacy of the state⁵ and the rise of civil society, particularly NGOs,

⁵ Although government remains a critical duty-bearer that should be held accountable to the people it serves.

- NGO pressure brought to bear upon governments, bilateral and multilateral institutions,
- financial crises that force the need to tap new resources (favors disengagement, privatization, and community self-help),
- information technological revolution freeing up and reducing cost of information access.

Box 15: Decentralizing India's Integrated Child Development Services (ICDS) program

To achieve community ownership, ICDS must first devolve responsibility to the states, to adapt the basic model to their particular problems and needs, and to take full charge of program management. In addition to the Government of India's announced intention to devolve centrally-sponsored schemes to the states, and ICDS's efforts to decentralize training, the emergence of *panchayati raj* institutions, charged with major responsibility for the social sectors and growing in capability, make decentralization to communities more feasible now than ever before. Below the state level, decentralized management could, in principle, be achieved by many routes: delegating the implementation of ICDS to the private sector and/or NGOs; setting up societies at the district or block levels; and/or devolving responsibility to the district, block and village *panchayats*. Neither the private sector nor NGOs offer a viable option, mainly due to the massive scale of services demanded by the size of the malnutrition problem. NGO efforts can complement ICDS in important ways, notably by experimenting and disseminating information about innovations that work.

Source: Measham and Chatterjee (1999).

Case studies indicate that the limited capacity of panchayats (village development committees) for planning has prevented them from taking up responsibility of self governance endowed by recent constitutional amendments. Also, without their own resource base, they depend on income transfers from State and Central Governments under various developmental programs with little flexibility for innovation. Despite these constraints, the panchayat raj system has demonstrated that it can bring about better inter-sectoral coordination and more transparency in selection of beneficiaries under poverty alleviation programs. The major constraint, however, is the poor familiarity of most of the panchayat members with the on-going health and nutrition programs.

Source: RETA 5671 country summary.

All this has led to decentralization of government structures and increased grassroots (including NGO) participation. In the 1990s, 40 percent of World Bank programs had NGO involvement. Other international agencies have developed consultative mechanisms that increasingly involve NGOs from developing countries. NGO pressure on World Bank has led to participatory social assessments.

Decentralization will necessitate parallel institutional changes and costs to reorient health and nutrition bureaucracies—hitherto used to managing centrally controlled programs—to become technical assistants and influencers of nutrition programs run by others.

Scaling Up

Scaling up is the process by which community-based organizations expand their impact and enter into relations with more central administrative levels, e.g., the government. There are four important aspects of scaling up:

- *Quantitative*: when a program or organization expands its size through increasing its membership base or its constituency, its geographical working area and/or its budget.
- *Functional*: an expansion of the number and type of activities, or increasing integration within other programs.
- *Political*: moving, for example, from service delivery to empowerment and attempting to address basic structural causes, including addressing policy.
- *Organizational*: increasing organizational strength so as to improve effectiveness, efficiency, and sustainability of benefits they provide to their members, e.g., financially (self-financing), institutionally (links with other actors, public or private), and by improving internal management capacity.

“Scaling up” has been conventionally equated with expansion in scale or “replicability,” the condition that a program can be applied in another geographic setting (regional, national, or international). The issue is usually raised by donors who would like to copy certain positive aspects of a program or project elsewhere, with the common expectation that such a copy be implemented at a substantially lower cost, and often more quickly.

Just as the initial choice of action in any situation is very much linked to that situation or context, so should replicability *not* be seen as the transfer of a prepackaged set of inputs. Rather it should relate to a process that identifies and supports the technical

interventions, with the choice of action always deriving from an understanding of the nature and causes of the problem and the capacity available to address it.

Processes are thus more replicable than projects or programs. In this sense, for improved nutrition, the most important element to adapt is the elaborated approach to the Triple-A cycle and support for it. Early community and district level involvement helps to assure replicability.

Thus, the enduring question of how to go to scale may be missing the point to some degree. Where successful community-based nutrition projects have accelerated nationwide, governments have usually changed their policies (i.e., scaled down) in ways that have triggered the emergence of appropriate community-based initiatives elsewhere. This is a truly bottom-up approach to policy, where the micro informs the macro, where policy levers are used to create conditions—that is, the essential contextual factors—for community-based initiatives to emerge, grow, and mushroom across the country. Capacity is one of these contextual factors and capacity development must accompany scaling-up processes. International agencies should be prepared to learn from and to support such processes, as described in the final section.

One key lesson for practitioners and policymakers that emerges from experiences reviewed in the World Development Report 2000 is the importance of using existing forms of social capital in poor communities as a basis for scaling up the efforts of local community-level organizations (World Bank 2000).

11. IMPLICATIONS FOR DONOR POLICY AND PRACTICE

Donor agencies often appear to have a nutrition strategy in search of a problem. A global agenda is established at headquarters and passed on to country offices for implementation as a package. Any deviation from the package is quite difficult and is not encouraged. ...There appears to be reluctance to adapt the strategy to suit local conditions, even when it is painfully obvious that this should occur, or to change the package completely if the perceived priority by nationals is different.

Tagwireyi (1994)

The themes discussed here have several implications for nutrition investors at all levels (including governments and donors).

First, donors themselves need to promote relevant scaling-up and scaling-down processes and provide more support for capacity assessment and development, operational research, and the building of policy-research-training-program networks.

Tools and methodologies are needed for governments and project staff to systematically undertake institutional capacity assessment, analysis, and development. Much is context-specific and much will come from learning “on the job.” While there are seldom generalizable, “right” answers, there is need to start with a generic but adaptable methodology based on the theory and practice of capacity development as it applies to nutrition and related disciplines. Donors need to consider capacity development as a serious discipline, and invest in developing professional skills in this area.

In doing this, past experience with policy and program support could be reviewed to see how capacity assessment and strategy development was approached, and what issues from operational experience should be incorporated to further develop the methodology. The methodology could be applied in future efforts, further refining it. This would permit guidelines to be developed for staff, covering not only the methodology, but also how to apply it, how long it takes, how much it costs, and what technical assistance resources are available.

Governments and donors may not welcome the idea of community-based organizations with multiple roles because these do not fit bureaucratic incentives nor the increasingly specialized funding sources for which they may be competing. But donors need to play their part in the support of community organizations to undertake a range of activities as decided locally. Communities should not be artificially “sectoralized.”

Second, the rights-base for nutrition-relevant actions should provide guidance, in its emphasis on duties and obligations at different levels in society. A concrete rights-based programming process involving seven clear steps now exists. This demands a focus on such individuals as subjects, not objects, and thus on their inherent capacity. Inclusion of stakeholders in the process of preparing a project or program—right from the initial problem assessment to the design of appropriate actions—is one of the most important capacity development tools. Such a redefinition of the role of “recipients,” demands in turn a fundamental redefinition on the part of donors of the key concepts of planning, performance, speed, and quality.

With regard to *planning*, the traditional project cycle implies a linear progression from problem identification to project preparation, appraisal, implementation, supervision, and evaluation. It assumes that solutions to known problems can be fully determined at the outset and that projects can be fully designed and costed in advance and successfully implemented to a fixed timetable. This approach is clearly ill-adapted to a learning-by-doing approach that is the foundation of true capacity development. But there are signs of positive change. For example, the World Bank in 1998 introduced an

“adaptable program loan” based on mutually agreed long-term development goals without predetermining the means.

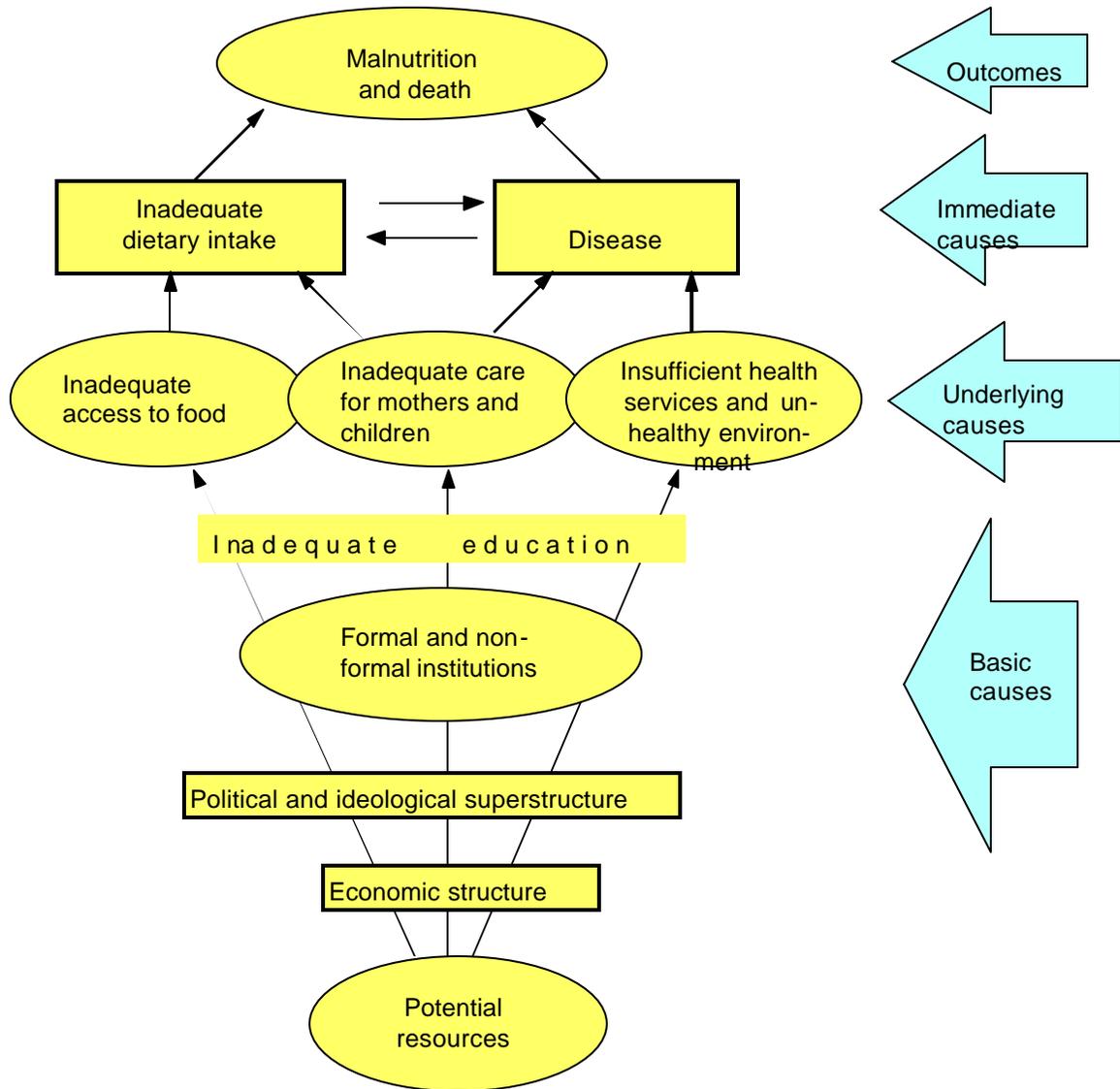
Performance needs to be considered more with respect to the degree to which the donor is slowly becoming redundant as local capacities develop. Capacity development indicators are required to measure such dimensions of performance. *Speed* should be understood in terms of capacity development, not the processing of donor finance. There is a need for longer-term support and patience if sustainable processes to be strengthened. Time horizons of a decade or more (as opposed to the current 3–5 year project cycles) are needed to build the required capacities at different levels (as has been done recently in Bangladesh's National Nutrition Program—a 12-year time horizon). As part of this, the bureaucratic drive to try something new even when the old problems are still being solved should be kept in check. Such “gratuitous innovation” (Mason 2000), driven by bureaucratic imperatives to keep trying new things even when there is no new technology, insight, or indeed new problem dictating this, is pernicious to sustained work. Frequent priority shifts and institutional reorganizations are also anathema to sustained attention to deep-rooted problems such as malnutrition.

Finally, *quality* relates not only to the customary performance standards set by the donor, but crucially to such process factors as the degree of active local ownership of the project.

At the level of donor capacity, such a realignment of procedures will necessitate shifts in the incentive environment. The monitoring of staff performance needs to be related more explicitly to contributions to capacity development, not just to disbursing loans and generating traditional project outputs. Recruitment and training practices for new staff will need to change, and in-house orientations for existing staff take place. “Software” development needs to be prioritized over hardware delivery.

Finally, donors need to attach greater priority to encouraging and supporting the monitoring and evaluation of both capacity development and program performance, so as to better know what works, where and to disseminate success stories more widely. We need to know more about the applicability of different kinds of indicators to different kinds of functions for different types of organizations at varying stages of their evolution. Donors should also periodically evaluate themselves from a capacity development perspective. A self-assessment checklist of key questions for this purpose is provided in Annex 5.

ANNEX 1: CONCEPTUAL FRAMEWORK FOR THE CAUSES OF MALNUTRITION IN SOCIETY



Source: UNICEF, 1990

ANNEX 2: QUALITATIVE DATA COLLECTION METHODOLOGIES

Methods for the collection of qualitative data for roles and pattern analysis include the following:

- **RRA**, or Rapid Rural Appraisal, was part of the first generation of qualitative approaches, that emerged in the 1970s as a reaction against the biases inherent in the timing and mode of data collection through large-scale surveys (UNHCR 1982, Pacey 1981). RRA aimed to rapidly generate key data based on visits which were often seasonally timed to coincide with the most vulnerable time of the year for communities.
- **KAP**, or Knowledge-Attitude-Practice, surveys are designed to elicit exactly those three behavioral aspects. For behavioral change to occur, the KAP needs to change in sequence. There are obstacles to such change at each step. Knowledge is most directly linked with learning and education but may be blocked by difficulties in bridging conceptual barriers. Attitude change may be blocked for political, emotional, or religious reasons having nothing to do with nutrition. Finally, despite changes in knowledge and attitude, behavioral change may be thwarted because of the pressure to conform—either from the household, community, or because of a lack of capacity or resources to act differently. KAP surveys may reveal where blocks may occur in this sequence.
- **RAP**, or Rapid Assessment Procedures, were developed in the early 1980s to obtain timely, relevant, and useful information in a cost-effective way (Scrimshaw and Hurtado 1987, Cervinskaskas and Young 1990). RAP may be used for the collection of qualitative or quantitative data through informal interviews, focus-group sessions etc. RAP data are rich and contextualized, but as such they cannot be generalized from.
- **PLA/PRA**. Beyond qualitative data collection, other approaches have been adopted to understand nutrition and other development situations. These may be referred to as Participatory Learning and Action (PLA). Participatory rural appraisal (PRA) is one of these. PRA seeks not to *collect* data so much as to facilitate or catalyze local people's own assessment and analysis. Through witnessing such discussions, as an observer (not an interrogator), much can be learned—about relevance, acceptability, and real needs. PRA requires a role

reversal, or as Robert Chambers has put it “passing the stick.” It is usually highly visual, based on mapping and the drawing of diagrams and matrices on the ground to facilitate full participation and consensus-building. PRA thus extends the concept of rapid assessment methodology beyond data collection into analysis, planning, and action. Successful applications have included charting seasonality of malnutrition as it affects different groups in a village, mapping households in a village with respect to locally-derived poverty variables, and charting maternal and child nutrition practices over generations to analyze continuity and change (Chambers 1990).

- The *Social Capital Assessment Tool: A Methodology for Operationalizing Cross-Cultural Measures of Social Capital* is a field-tested set of indicators and methodologies that measures levels of social capital in communities designated for project implementation. The SCAT is useful for determining baseline levels of social capital and monitoring progress over the course of project implementation (Dongier 2000).
- **Beneficiary Assessment (BA)** is a consultative methodology used to assess beneficiary perceptions to projects or policies. Groups of beneficiaries can be consulted to ascertain their views and priorities.
- **Social Assessment** provides a way to identify stakeholder subgroups among the poor and assess what may need to be done to promote their full participation in a project.

Ultimately, both qualitative and quantitative data need to be used together in a complementary fashion. For example, quantitative data may point to widespread problems with participation in growth monitoring and promotion (GMP) followed by qualitative data revealing that this is often related to the caregiver not having sufficient time to bring the child for weighing. The prescription here would be for more mobility and flexibility in the GMP activities.

Participatory assessment tools

Semi-structured interviews—these are informal open-ended interviews with individuals in a community, using a checklist as an initial guide.

Direct observation—keeping your eyes open to cross-check findings and to open up other lines of inquiry.

Wealth-ranking—ranking households in a community with respect to local people’s own assessment of relative value, not measures imposed by outsiders.

Timelines—chronological sequencing of events.

Activity profiles—time allocation through the day or week, at different seasons.

Venn diagrams (or “chapatti” diagrams)—to illustrate local people’s perception of the interactions between people, institutions etc.

Social mapping—to show spatial relationships between people and resources in a community. Maps may be drawn by community members in a participatory fashion on the ground using locally-available materials.

Transect walks—a relaxed walk through a village or community with local informants to provide an opportunity for observation and relevant questions.

Seasonal calendars—constructed by local people to indicate the seasonality in factors that may affect nutrition including agricultural workload, morbidity peaks, etc.

Stories, case studies—as illustration of the full dynamics and to give life to the data. Case studies can help answer “why” or “how” type questions—e.g., why did this group not get involved in the program, “how” did the program achieve this effect in this village?

Shared presentations and feedback sessions—where the findings are shared with respondents.

Source: Adapted from Young and Jaspars (1995) and Dongier (2000).

ANNEX 3: MODEL MONITORING PROFORMA

The following is one example of a typical core proforma for monitoring a community-based nutrition program—in this case, one that includes supplementary feeding.

OUTCOMES

These outcome indicators are relevant for quarterly monitoring and for evaluation purposes. The primary outcome indicator for *monthly* monitoring purposes is the percentage of young children growing adequately.

1. Nutritional and growth status

1.1 Monthly monitoring outcome indicator

Number of eligible* (targeted) children weighed that month (A)

Number who are growing adequately** (B)

% growing children (B/A)

1.2 Quarterly monitoring and periodic evaluation indicators

Number of babies born during previous three months (A)

Number of babies weighed within ten days of birth (B)

% birth weight coverage (B/A)

Number of babies with birth weight less than 2.5 kg (C)

% low birth weight incidence (C/B)

Number of eligible* children weighed (D)

Number above -2 SDs weight-for-age (E)

% normal or mildly underweight (E/D)

Number of normal or mildly underweight children (E) who are growth faltering** (F)

% normal or mildly underweight children who are growth faltering (F/E)

Number between -2SDs and -3 SDs weight-for-age (G)

% moderately underweight (G/D)

Number below -3 SDs weight-for-age (H)

% severely underweight (H/D)

2. Nutrition behavior change:

Qualitative measures of actual behavior change by beneficiaries and the quality of workers' antenatal, postnatal and young child counseling need to be employed to track these outcomes. This may be done quarterly and during evaluations. Perceptions of both beneficiaries and workers regarding growth and nutrition, relevant child health, care and feeding practices as well as the objectives and design of the program.

Notes: * eligibility to be defined at the targeting stage; most likely all 0-24 month old children will be eligible for weighing, whilst 6-24 month olds who qualify anthropometrically will be eligible for feeding. ** "growing adequately" is the inverse of growth faltering.

OUTPUTS (monthly)

3 Pregnant women

Number of total pregnant women in target population (A)

Number of registered pregnant women (B)

% total registration (B/A)

Number pregnant women newly registered (C)

Number registered before 20th week (D)

% early registration (D/C)

Number registered pregnant women receiving regular check-ups, incl. counseling (E)

% ante-natal coverage (E/B)

Number registered pregnant women receiving supplementary foods (F)

% supplementary feeding coverage (F/B)

4 Lactating women

Number of registered lactating women (A)

Number of registered lactating women receiving supplementary foods (B)

% supplementary feeding coverage (B/A)

Number of birth deliveries (C)

Number of mothers receiving first post-natal consultation (D)

% post-natal coverage (D/C)

Number of mothers receiving child nutrition counseling (E)

% child nutrition counseling coverage (E/outcomeF + outcomeG + outcomeH)

5 Children

Number of eligible children in target population (A)

Number weighed (B)

% weighing coverage (B/A)

Number of weighed eligible children receiving supplementary foods (C)

% supplementary feeding coverage (C/B)

Number of 12-23 month old children (D)

Number of 12-23 month old children who are fully immunized (E)

% full immunization coverage (E/D)

INPUTS (monthly)

6 Food Movements

Stocks remaining at the end of preceding period (quarter)

Quantity received during this period

Losses

Quantity available for distribution

Quantity distributed to beneficiaries:

- Pregnant women

- Nursing mothers

- Children

- Total

Remaining stocks

7 Personnel

Training courses conducted

Timely basic and refresher training?

Joint training: community workers with clinic workers?
supervisors with front-line workers?

Site of training? Hands-on fieldwork?

Content and style of training?

Evaluation of training?

8 Equipment and materials available

Weighing scales

Growth charts

Educational material

Posters

Counseling aids

Monitoring proforma

**

Data should be collected by community mobilizers from growth charts, ration cards and registers. Simple monthly monitoring reports should be shared with supervisors at regular meetings, where progress is discussed and problems addressed. Monthly reports should then be aggregated into quarterly reports at supervisory level and combined with the quarterly outcome monitoring reports. These consolidated summary reports should then be sent on to higher administrative levels every quarter, with a description of relevant actions taken on the basis of their findings, as well as requested support from these higher levels, if required. In addition, community workers can chart essential indicator ratios in graphic form on community charts every quarter and initiate periodic focus group discussions on their findings.

ANNEX 4: MEASURING IMPACT AND ADEQUACY OF COMMUNITY NUTRITION PROGRAMS

MEASURING IMPACT

The impact of the program is essentially the *net* effect on the status of beneficiaries resulting from the project. There are different dimensions to impact:

- type (positive or negative),
- quantity (degree of change in status attributable to the project),
- quality,
- time (short or long term),
- level (micro, meso or macro),
- intent (intended or unintended).

As well as net effect, impact may also refer to the degree of achievement of overall development objectives via the direct project outcomes.

Providing the intervention is known to be effective, then its *impact* will ultimately be determined by its coverage. For example, if we measured the drop in underweight prevalence of children who attended a supplementary feeding center—this is effectiveness of the intervention only, as it says nothing about the situation of those who do not attend. In order to examine the impact of the intervention on this population, it would be necessary to measure the change in a group of children who are representative of the whole target community, not just the attenders. It is quite possible to have an effective intervention that has little impact, if its coverage is low.

But coverage is not the only limiting factor. Despite high coverage, impact may be limited by the poor *quality* of implementation. To keep track of quality other relevant process indicators are needed. For example, if we consider a health worker who is expected to make regular visits to the homes of severely malnourished children for counseling, coverage may refer to the percentage of eligible households she actually visits, while a quality measure would need to take some account what was actually discussed and recommended in the counseling process.

Is the determination of impact actually feasible?

The gold standard for proving impact of an intervention (i.e., that a certain effect is caused by the intervention) is the double-blind, randomized, placebo-controlled design. This basically randomly distributes confounding factors among recipients of program services and non-recipients without either the program functionaries or recipients knowing who is, and who is not, receiving the services.

Such a design is the stock in trade of a small-scale *efficacy* trial—essentially evaluative research which aims to demonstrate that certain interventions under given conditions will have an effect. Proven efficacy represents the potential for success. But it clearly does not equate with operational effectiveness or true impact in a large-scale real-world environment in which programs are conceived and implemented.

So can impact ever be realistically assessed in the real world? The very fact that it can never be known what the situation in a particular community would have been had the intervention not been initiated suggests not. But pragmatic compromises can be made. It is possible to get closer to determining the net effect of a program through a “before/after, with/without” type of study design. This would require a solid baseline carried out before the project was initiated. The project area would be “matched” as far as possible with another non-project or control area and the baseline would cover both areas. At the time of evaluation, a survey is carried out in both areas to enable comparison with the baseline. The rate of nutrition improvement in the project area is compared with the rate of change in nonproject areas. If the former is significantly greater than the latter, then the project can be said to be *associated* with a beneficial quantifiable outcome.

Strictly speaking, this is not impact. Moreover it is very difficult to achieve such a design, for the following reasons:

- it is probably impossible to match areas at baseline (“with/without” or “case/control”) so as to eliminate confounding factors or threats to validity;
- it may be unethical to try to do so if this means withholding a critically-needed service for the sake of such a study;
- the “control” group may become affected by the project activities in the neighboring project area during implementation. This has been referred to as a “leakage” or a “spillover effect.”

In the latter case, there may thus be a conflict between the overall project goal (which may be “to improve child nutrition”) and the objectives of the evaluation which aims at determining impact. If the leakage happens to result in non-project populations becoming empowered and/or adopting practices that improve nutrition, this surely is ultimately a good thing and not something to be prevented, notwithstanding the difficulties it imposes on impact determination.

In general, attribution of impact becomes increasingly difficult the longer the assumed linkage between the intervention and the desired outcome. For example, assessing the degree of impact of a shift in cropping patterns on child nutrition will be harder than assessing the impact of exclusive breastfeeding promotion.

Measuring Adequacy

But how important is it to measure actual impact? Will a measurement of adequacy suffice? Adequacy of a program refers to a judgment made about its process and *gross* outcome. If the program is functioning as planned (process) and the change in nutritional status is in the right direction and considered large enough (gross outcome), then the program may be considered to be “adequate”. Adequacy evaluations require a clear definition of the target group and a clear definition of an “adequate” process and an “adequate” gross outcome.

Adequacy of an outcome may be specified with respect to a minimum acceptable level of an indicator, below which the program is deemed “unsuccessful” or “inadequate”. This level may be related to quantities expressed in the project objectives e.g. if the project only succeeds in raising the annual percentage point underweight prevalence reduction by < 1 percent, this may be deemed inadequate. Comparisons should be made between the changes in the project area and those achieved in the past without the program (the secular trend) or in other areas. The effect of the project-related processes on its outcomes may however be swamped by some sudden or unforeseen factor, e.g., war, drought. In such a case, “adequacy” may need to be redefined in relation to such events. National goals may be other adequacy benchmarks—for example, the goals specified in National Plans of Action for Nutrition, drawn up following the 1992 International Conference on Nutrition (ICN).

Adequacy of process. Conventionally, success means a good outcome while process is equated with service delivery. But process is being increasingly viewed as more than service delivery. It relates to the means through which changes are occurring

in people's capabilities and behaviors. One process indicator in the conventional sense might be "numbers of health workers trained." A process indicator in the newer sense might relate to the quality of counseling undertaken by these trainees. An emphasis is increasingly being placed on the process of empowering communities to improve their nutritional status beyond the confines of the program. Participation, ownership, empowerment and consequently sustainability are important aspects of such a process.

"Success" in community-based nutrition programming has been defined as: "A process which appropriately alters nutrition factors that positively affect human health and quality of life of individuals in a target community through active participation of local players; the process is resilient and can be adapted to changing conditions in order to maintain or foster nutritional changes over the long term" (Smitasiri 1998).

Ultimately therefore success requires a good outcome to be achieved through a sustainable process. Evaluations should also be able to identify the processes within a successful program and how these were brought about—"success processes" as well as success factors. These processes should of course be pre-defined as outputs of the program. All too often, however, the outputs are purely delivery-oriented, based only on quantity and not quality. In order to root the concept of sustainability in a project, outputs should include those that are more capability-oriented, e.g., changes in behaviors, community mobilization.

ANNEX 5: TOOL FOR DONOR SELF-ASSESSMENT IN CAPACITY DEVELOPMENT

INTRODUCTION

The DAC Informal Network on Institutional and Capacity Development (I/CD Network) has developed a practical tool that assists donor agencies to make a "self-assessment" of their progress in implementing partnership and capacity development principles. The self-assessment is aimed at reform-minded agencies and staff concerned with integrating capacity development into their day-to-day operations and improving their performance in this field.

The self-assessment makes a link between, on the one hand, agencies' internal policies and practices and, on the other, the impact of these in the field. As far as possible, impact may be disaggregated along the lines of social groupings, gender and geographic areas. Users are encouraged to adapt the self-assessment as and where necessary. Questions may be reworded, expanded, or omitted. Users may also provide brief illustrations (examples, cases).

Five major questions are asked:

1. Does the aid agency have a clear *strategy* to promote and integrate capacity development into day-to-day operations?
2. To what extent has the agency adapted its *interventions* and *processes* to fit with the requirements of capacity development?
3. To what extent has the agency adapted its administrative *procedures* to fit the requirements of capacity development?
4. What *incentives for change* have been introduced to promote and integrate capacity development into day-to-day operations?
5. To what extent has the agency developed mechanisms to measure *impact*, and what *results* have been recorded?

STRATEGY

What is your agency's understanding of the concept of capacity development?

To what extent has this concept been accepted in your agency?

How does your agency orient its staff regarding capacity development?

To what extent is capacity development an integral part of your agency's operations, and how is it translated into, for example, country-specific strategies for capacity development, sectoral/thematic strategies, and projects and programs?

What resources and what types of resources (e.g., funds, number of staff, specific projects), are devoted to capacity development within your agency?

In which ways has your agency changed its modes of delivery?

PROCESS

What mechanisms does your agency apply to make realistic assessments of local conditions and capacities, e.g., contextual and/or capacity analyses?:

- Is this institutionalized through external appraisal?
- Does your agency have facilities for counterpart organizations to undertake a self-assessment?
- Do you include in this analysis the existing national development programs and the programs of other donor agencies?

In which ways are stakeholders involved in shaping the design and implementing a program and agreeing upon the contribution of all actors concerned?

What facilities does your agency apply to allow adjustments in the course of the implementation of a cooperation agreement? For example,

- flexible funding arrangements,
- delegated authority,
- monitoring in place,

- long-term commitment,
- ability to accept setbacks.

PROCEDURES

Is capacity development a vital element in your agency's appraisal (decisionmaking and evaluation, etc.) procedures?

To what extent have the responsibilities on your head office been delegated in line with capacity development requirements in developing countries? For example, what types of decisions can be made at recipient country level?

To what extent is there flexibility within the annual budget cycle of your organization, and what options does your agency have for long-term financial commitments?

INCENTIVES TO CHANGE

What changes have taken place in your agency's human resources policies to include capacity development requirements?:

- recruitment policies and criteria,
- job descriptions (including profile for staff dealing with capacity development) and evaluations,
- promotion policies,
- adequate training opportunities.

In what specific ways does your agency promote cooperation between its various disciplines and departments?

Does your agency provide tools/instruments to deal with capacity development to

- counterpart organizations (e.g., self assessments)?
- own staff?
- contracted consultants?

To what extent are these tools/instruments adequate and user-friendly?

What methods do you apply to strengthen the institutional memory of your agency?

- Collecting best practices?
- Network of professionals within your organization?
- Making resources available for briefing and debriefing, etc.?

IMPACT ASSESSMENT OF CAPACITY DEVELOPMENT INTERVENTIONS

What kind of mechanisms does your agency apply to measure the impact of your capacity development interventions, and do these operate both at the central and field office/embassy level?

What kind of indicators is used to measure capacity development processes and outcomes (e.g., internal measurement of organizational efficiency versus external measurement of effectiveness and impact)? To what extent do these indicators allow for disaggregation of impact along the lines of social groupings, gender, geographic areas and administrative levels (central/local government, NGOs)?

What impact have you actually made in the field of capacity development and do you record this impact (e.g., at the project/program, sectoral or system wide-level)?

To what extent do the results of impact assessment feed back into your policies and practices (e.g., have they resulted in/contributed to changes in the organizational set up of your agency, or to the introduction of new modes of cooperation)?

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