Strengthening Country Commitment to Human Development

Lessons from Nutrition

Richard Heaver
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We all know that good technical and economic design of human development programs is important, but not enough. Programs succeed or fail depending on whether politicians, government officials, and communities back them strongly enough to put in adequate human and financial resources, and on whether they are committed to sustaining high-quality implementation over the years.

But while we talk about commitment, we are not rigorous about assessing and strengthening it. One reason we lack systematic approaches for strengthening commitment is that the skills needed straddle several professional fields—such as communication and social marketing, political and policy analysis, and management and organizational behavior. As far as we know, this book is the first attempt to think systematically through what commitment building in human development takes.

It looks at nutrition because this is the area of human development in which countries and assistance agencies have invested least, even though improving nutrition is critical to achieving the Millennium Development Goals. But though nutrition is the focus of this book, the kinds of approaches it identifies for strengthening commitment to nutrition—finding "champions," systematically building partnerships, carefully designing evidence-based advocacy, motivating staff in implementing organizations and making them accountable—are equally applicable to other areas of human development, and indeed to development programs in general.

Richard Heaver has been with the World Bank as a staff member and consultant since 1981. His work focuses on management and capacity development issues in health, nutrition, and population programs. I hope that his short, practical, accessible book will be read beyond the nutrition community as well as within it, and that it will be followed by systematic efforts to "learn by doing" and to share the lessons learned in strengthening commitment to human development across countries and development partners.

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<tr>
<th>Abbreviation</th>
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<tr>
<td>AED</td>
<td>Academy for Educational Development</td>
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<tr>
<td>BCC</td>
<td>Behavior change communication</td>
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<tr>
<td>BINP</td>
<td>Bangladesh Integrated Nutrition Project</td>
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<td>BMN</td>
<td>Basic minimum needs</td>
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<tr>
<td>CDD</td>
<td>Community-driven development</td>
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<td>GAIN</td>
<td>Global Alliance for Improved Nutrition</td>
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<tr>
<td>GMP</td>
<td>Growth monitoring and promotion</td>
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<tr>
<td>IEC</td>
<td>Information, education, and communication</td>
</tr>
<tr>
<td>INMU</td>
<td>Institute of Nutrition at Mahidol University</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<td>PEM</td>
<td>Protein-energy malnutrition</td>
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<tr>
<td>PRSC</td>
<td>Poverty Reduction Strategy Credit</td>
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<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
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<tr>
<td>TFNC</td>
<td>Tanzania Food and Nutrition Centre</td>
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<tr>
<td>TINP</td>
<td>Tamil Nadu Integrated Nutrition Program</td>
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<tr>
<td>TIPS</td>
<td>Trials of Improved Practices</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>U.S. Agency for International Development</td>
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The world’s political leaders have long recognized that rapid progress against hunger is possible. At the World Food Conference of 1974, they committed themselves to end hunger in a decade. Already then, experts said that the binding constraint was political will. Indeed, in 1963, President Kennedy told delegates to the First World Food Congress, “We have the means, we have the capacity to eliminate hunger from the face of the earth in our lifetime. We need only the will.” Over the last several decades, many reports and conferences on world hunger have concluded with a long list of action areas and a call for more political will. This is not good enough anymore. No report or conference should ever conclude that way again. The analysis should instead continue, explaining what practical steps will be taken—or can be taken—to build the necessary political will.

From “Building Political Will to End Hunger,” a paper prepared for the United Nations Millennium Project Hunger Task Force (Beckmann and Byers 2004)
Executive Summary

Malnutrition remains widespread and serious in more than 80 developing countries. Over a billion people suffer from micronutrient malnutrition, and nearly a third of preschool children in developing countries are stunted by undernutrition. For families, malnutrition has tragic human costs, contributing to 3.4 million unnecessary child deaths a year and preventing those who survive from reaching their full human potential: malnourished children are less intelligent and less able to learn than other children, and they are less productive as adults. For countries, malnutrition imposes a huge economic burden, increasing what they have to spend on health and welfare, while perpetuating poverty by reducing productivity.

Why Strengthening Commitment Is Important

Global leaders have made four recent promises to tackle malnutrition: at the World Food Conference in 1974; through the Convention on the Rights of the Child, signed after the 1991 World Summit for Children; through resolutions adopted at the 1992 International Conference on Nutrition; and through the Millennium Declaration, which committed them to achieve the Millennium Development Goals (MDGs), which include halving malnutrition by 2015 in addition to realizing big reductions in child and maternal deaths and in communicable diseases, which cannot be achieved without tackling malnutrition. Yet even though we have a variety of proven technologies for reducing malnutrition, the problem persists at high levels, especially in Africa and South Asia, and it is actually increasing in many Sub-Saharan African countries. Why?

One reason is that some countries with serious malnutrition problems lack the capacity to design and manage large-scale nutrition programs. Another is that some countries are funding costly programs—like school feeding or poorly targeted food subsidies—intended to improve nutrition, but having little or no impact on it. A third is that some countries, especially in Africa, have been at war and hence unable to focus on development or are so poor that they cannot afford nutrition programs without
massive external assistance. But this is not the full story: most countries with serious malnutrition problems not only invest less in nutrition than they should given the seriousness of the problem but also invest less than they could given their financial and managerial capacity. Weak country commitment to reducing malnutrition is therefore often the immediate constraint to doing more.

Commitment is weak for at least 10 reasons:

• Malnutrition is usually invisible to malnourished families and communities
• Families and governments do not recognize the human and economic costs of malnutrition
• Governments may not know there are faster interventions for combating malnutrition than economic growth and poverty reduction or that nutrition programs need not be prohibitively expensive
• There are multiple organizational stakeholders in nutrition
• There is not always a consensus about how to intervene against malnutrition
• Adequate nutrition is seldom treated as a human right
• The malnourished have little voice
• Some politicians and managers are not interested in whether nutrition programs are implemented well
• Governments sometimes claim they are investing in improving nutrition when they are not
• Lack of commitment to nutrition leads to underinvestment in nutrition, which leads to weak impact, which reinforces lack of commitment.

On the basis of past experience, we can be sure that the MDGs will fail to be achieved, like the international goals before them, unless there is a much more systematic effort to turn conference commitments into real commitment, defined here as “the will to act and to keep on acting until the job is done.” Since reducing malnutrition is both an ethical imperative and central to achieving the important human and economic development goals, strengthening commitment to doing this is one of the most important activities in development. Furthermore, in almost every country, commitment to nutrition can be strengthened: weak commitment should seldom be considered a binding constraint.

What Commitment Building Involves

One dimension of strengthening commitment is getting politicians to commit more money to nutrition. There has been spectacular success with this in the United States, where a coalition of nongovernmental organizations
(NGOs) has persuaded and pressured the government to put an additional billion dollars a year into its domestic nutrition and poverty reduction program. This was done with an annual budget of $7 million—giving a return on the NGOs’ investment of about $150 for every dollar spent. The potential to encourage and pressure developing-country politicians in the same way has not yet been exploited.

But while building the political will to invest is important, many other stakeholders in nutrition need to be brought on board if commitment to implementing quality nutrition programs is to be sustained over the many years it will take to eliminate malnutrition. In developing countries, these stakeholders include parents, communities, people working in NGOs and civil society, program managers and field staff, technical experts in nutrition, and civil servants in a wide range of development ministries. Key international stakeholders include officials in development assistance agencies, politicians who control aid and trade policies, and the voters who influence them.

So commitment building is not just about influencing politicians. It involves influencing staff in a variety of implementing organizations and the general public. This requires three types of skills. First, it requires skills in strategic communication, to put across the message that investing in nutrition benefits everyone, from families to bureaucrats to nations—in other words, that improving nutrition is everybody’s business. Second, it requires skills in partnership building, since action together is more effective, and more sustainable, than action alone. Third, it requires skills in designing and managing implementing organizations, so that they motivate staff to perform and clients to participate.

**What We Know and What We Don’t**

From the experience of several successful nutrition programs, such as those in Bangladesh, Costa Rica, Tanzania, Thailand, and India’s Tamil Nadu State, we know quite a lot about how to strengthen commitment to investment. There are lessons about how to use different types of information and different channels of communication to influence different kinds of stakeholders and how to build partnerships (for example, see box 6.2 on Bangladesh and box 6.3 on Thailand, respectively). The problem is that such lessons from experience have not been systematically collected and applied elsewhere.

With regard to sustaining commitment, we know quite a lot about how to motivate implementers and clients using external incentives, such as information, targets, and milestones for measuring performance (see appendix F). We know less about building on what is called “intrinsic” motivation: espousing and promoting values that are important to
stakeholders and make them feel personally committed to achieving program goals (see box 7.1 for some examples of this). And, because two out of five of these once-successful programs suffered serious setbacks in commitment and one collapsed (see boxes 7.2 and 7.3), we need to learn more about how to keep interest in nutrition alive over the long term (see box 7.4 for some ideas on this).

Missed Opportunities

Investing more in nutrition programs is important. But we are missing an important opportunity if we think of nutrition only as an intervention in health, agriculture, or social protection and not as an outcome measure of development as well. Nutrition is one of the most sensitive overall measures of poverty reduction, where this is defined as improving human development as well as income. Income is an inadequate measure of human development—millions of families that are not poor have malnourished children. Countries could usefully adopt contribution to nutritional status improvement as a criterion for deciding the relative priority of interventions in the various sectors. This would help to improve the usefulness of Poverty Reduction Strategy Papers (PRSPs), which currently do a good job of setting out the wide range of antipoverty interventions, but a poor job of prioritizing the most important.

There is a similar missed opportunity in community-driven development (CDD) programs, where nutrition currently hardly figures. How communities should decide between different development priorities when budgets are limited and how communities should measure the overall outcome of their multisectoral development activities have often proved problematic. As with antipoverty programs at the national level, contribution to nutritional status improvement would be a useful investment criterion and outcome measure for communities. Making nutrition monitoring a routine part of community development programs is also a useful targeting mechanism. It can be used to identify the ultrapoor—often missed by sectoral development programs—for special attention.

Action Required

Commitment building for nutrition needs to move ahead on two tracks: political and operational. The United Nations Millennium Campaign is leading the global effort to mobilize political support to achieve the MDGs. The Millennium Project’s Hunger Task Force is drawing up a plan of action for building political commitment to nutrition. An international coalition of advocacy NGOs called More and Better (more investment, better spent) aims to influence politicians from both the developed and
developing countries to invest more in poverty reduction in developing countries. Nutrition needs to figure prominently in these advocacy efforts.

At the operational level, commitment building needs to be treated by governments, development assistance agencies, and the academic community as a recognized field of professional practice, as important to nutrition as epidemiologic or economic analysis. It needs to be funded as a core development activity, with access to secure sources of funds.

At the country level, nutrition “champions” need to do four things:

- Build local partnerships of individuals and institutions that can influence politicians and implementing agencies to press for larger budgets for nutrition programs; domestic and international financing agencies will only put more money into nutrition if they get financing proposals for it
- Work to get nutritional status accepted as an outcome measure of poverty reduction in PRSPs and CDD programs and to get contribution to nutritional status improvement used as a criterion for prioritizing investment
- Strengthen the capacity of implementing organizations to motivate their staff and to encourage their clients to use nutrition services and play a role in monitoring and managing them
- Identify gaps in their country’s capacity to build commitment to nutrition and seek help to fill them from local institutions, from other developing countries, or from NGOs and development assistance agencies.

Those championing nutrition need help to get nutrition higher on the political, policy, and implementation agendas and keep it there. The urgent needs are for better communication technologies to build commitment, for management technologies to sustain it, as well as for grant finance to cover the costs of commitment building (see table 8.1 on costs).

**What the Development Assistance Community Can Do**

More overseas assistance for nutrition programs is important, but the fact is that what developing countries spend on nutrition will always dwarf foreign assistance. Smaller development assistance agencies may therefore get more bang for their buck from spending small amounts on building and sustaining country commitment to nutrition programs than from financing isolated, small-scale nutrition projects.

The World Bank is in a unique position to help build commitment to nutrition at the operational level, because of its strong commitment to the MDGs, its access to finance and planning agencies, its multisectoral
mandate, and its role in coordinating development assistance. As well as increasing its lending and staffing in nutrition, which are currently inadequate, the Bank should aim to lead in direct advocacy and partnership building for nutrition and also in efforts to help countries to develop their own commitment-building capacity. It should dedicate staff to commitment-building work in nutrition, raise grant finance to help poor countries with the cash costs of commitment building, and test out and disseminate best practices in influencing investment decisions and motivating program implementers.

To be most effective, the World Bank and other development financiers need to partner with institutions with different comparative advantages in nutrition. For example, UNICEF (United Nations Children’s Fund) has technical and communication skills and a substantial network of field offices; the bilateral donors, foundations, and international NGOs could provide grant finance for commitment building; and research organizations could help with “learning-by-doing” action research on best practices. Last but not least, to keep the focus on nutrition, no senior official from any of these institutions should visit a country where nutrition is a problem without asking his or her counterpart, “How are the children growing?”
Introduction

Malnutrition remains widespread and serious in more than 80 developing countries. Over a billion people suffer from micronutrient malnutrition, and 180 million preschool children—nearly a third of all preschoolers in developing countries—are stunted by undernutrition (Gillespie, McLachlan, and Shrimpton 2003). For families, malnutrition has tragic human costs, contributing to 3.4 million unnecessary child deaths a year (World Health Organization 2002). It also prevents those who survive from reaching their full human potential: malnourished children are less intelligent and less able to learn than other children, and they are less productive as adults. For countries, malnutrition is a huge economic burden, increasing what they have to spend on health and welfare, while perpetuating poverty by reducing productivity.

Widespread malnutrition persists, even though the world’s leaders committed themselves to end it at the World Food Conference in 1974. They committed themselves again through the Convention on the Rights of the Child, signed after the 1991 World Summit for Children, and through resolutions adopted at the 1992 International Conference on Nutrition. Already by 1992, considerable experience had accumulated about what works to reduce malnutrition. *Time to Act*, a joint publication of UNICEF (United Nations Children’s Fund) and the World Bank (Gillespie, McLachlan, and Shrimpton 2003), summarizes the fairly rapid impact that can be made by so-called “direct” nutrition programs. The work of the Bellagio Child Survival Study Group confirmed that the impact of several nutrition interventions—notably breast-feeding, complementary feeding, and vitamin A and zinc supplementation—would have a dramatic impact on reducing under-five mortality if taken to scale. Universal breast-feeding, for example, would prevent 1.3 million under-five deaths—13 percent of the total—annually (Jones and others 2003).

If interventions exist that are capable of having a big impact on malnutrition, why does it persist? One reason is that some countries with serious malnutrition problems lack the capacity to design and manage large-scale nutrition programs, and they often have difficulty deciding what nutrition interventions best match their particular contexts. Another
is that some countries are funding costly programs—like school feeding or poorly targeted food subsidies—that are intended to improve nutrition but have little or no impact on it. A third is that some countries, especially in Africa, have been at war and hence unable to focus on development or are so poor that they cannot afford nutrition programs without massive external assistance. But this is not the full story: most countries with serious malnutrition problems not only invest less in nutrition than they should given the seriousness of the problem but also invest less than they could given their financial and managerial capacity.

Weak country commitment is therefore often the immediate constraint to doing more. The gulf between what countries have formally committed to do and what they have actually done shows in:

- Policy statements that prioritize nutrition, while budget requests for nutrition programs do not reflect this priority in practice
- Budgets allocated for nutrition that are much lower than the budgets requested, because nutrition loses in the competition for funding
- Actual spending on nutrition that is much lower than the amount allocated
- Poor-quality implementation of programs, so clients do not benefit as planned.

Global leaders recently made a fourth formal commitment to improving nutrition, by agreeing on the Millennium Development Goals (MDGs). These include halving malnutrition by 2015. They also include big reductions in child and maternal mortality and in communicable diseases, which cannot be achieved without reducing malnutrition. Without a much more systematic effort to turn these commitments into actual investment and effective implementation, we can be sure that the MDGs will fail to be achieved, like the three sets of international goals before them.

This study explores why country commitment to nutrition is often weak and how it might be strengthened more systematically. It is based on experience from successful nutrition programs, which shows that there are underexploited methods for doing this. It aims to help leverage the efforts of professionals who want to see nutrition improved and who have some influence to help make this happen. Its audience is not limited to nutrition specialists. The study is aimed at a wide range of professionals in different disciplines, who may work as civil servants in central or local government, in nongovernmental organizations (NGOs) and civil society, as project or program managers and field staff, as officials in development assistance agencies, or in the research and teaching community.

The study focuses on building commitment at the country level to sanctioning and effectively implementing particular nutrition programs. There
are differences between the approaches useful at the country level and those needed at the global level to build international political commitment to end hunger. This latter form of commitment building—the task taken on by the United Nations Millennium Campaign—is beyond the scope of this study.

This study uses the term strengthening commitment, rather than political will, to underline the point that improving nutrition requires the commitment not just of politicians—although that is extremely important—but of a wide range of professionals as well as communities and parents. As used here, commitment means simply “the will to act and to keep on acting until the job is done.” This definition emphasizes that sustaining commitment over the many years it will take to eliminate malnutrition is as important as building commitment to new investment. Commitment building therefore involves designing and managing implementing organizations so that they motivate staff to perform and clients to participate as well as influencing those who control the allocation of resources.
Why are countries weakly committed to reducing malnutrition? There are 10 possible reasons.

*Malnutrition is usually invisible to malnourished families and communities.* Famines appear on television screens because children with wasted limbs arouse viewers’ compassion, but famine is rare. Most protein-energy malnutrition (PEM) around the world is moderate or mild rather than severe, and most affected families do not realize they are suffering from it. Even a health professional may not know if a child has PEM in the absence of a growth chart, because moderately and mildly malnourished children often look healthy. Yet because so many children suffer from it, moderate and mild malnutrition has worse consequences for death and lost productivity than severe malnutrition.

Micronutrient malnutrition is even harder to detect than PEM. While serious micronutrient deficiencies cause night blindness (vitamin A), extreme pallor and lethargy (iron), or goiter (iodine), moderate and mild deficiencies can be detected only by blood tests that most families never get. It is not surprising that families, unaware they are suffering from malnutrition, seek no treatment for it or that communities, unaware they have a malnutrition problem, want schools and roads rather than nutrition services.

*Families and governments do not recognize the human and economic costs of malnutrition.* When a child dies of diarrhea, pneumonia, or malaria, few families realize that malnutrition is often the underlying killer, weakening the immune system and reducing the energy available to fight disease. Many health workers do not know that malnutrition is the underlying cause of more than half of child deaths or that being malnourished as a child makes heart disease and other chronic diseases more likely as an adult. When a child has moderate PEM or micronutrient malnutrition, most families do not realize she is likely to be less intelligent, to do less well in school, and to be less successful as an adult as a result.

As data collection improves, more and more governments understand how bad malnutrition is in their countries, even though more than
20 countries in Sub-Saharan Africa, the only region where malnutrition is not improving, are still without adequate nutrition data (Chhabra and Rokx 2004). But, just as in the case of families, many key government decisionmakers are not aware of malnutrition’s role in high rates of death and disease or the extent to which malnourished populations with lower intelligence quotients, smaller bodies, and reduced energy are less economically productive and competitive, even though there is compelling evidence about this. As a result, nutrition often gets low priority in the competition for public investment.

_Governments may not know there are faster interventions against malnutrition than economic growth and poverty reduction or that nutrition programs need not be prohibitively expensive._ Governments often see malnutrition only as a consequence of poverty rather than as a cause of it as well. If this is how they think, they are likely to see economic growth and poverty reduction as the only ways to tackle malnutrition. Decisionmakers may not know that relying on economic growth and poverty reduction will not solve the malnutrition problem in any foreseeable time frame—for example, of 12 countries studied by Haddad and others (2002), three-quarters would not reach the MDG target of halving child malnutrition by 2015 by relying on economic growth in the absence of nutrition programs. They may not realize that there are faster and usually affordable “direct” interventions against malnutrition, such as micronutrient programs or education programs that improve caring practices for children, or that a combination of interventions reaching the most vulnerable will have the most impact (see World Bank 2003: 39–43).

There are multiple organizational stakeholders in nutrition. Reducing malnutrition involves families and communities; local and provincial governments; ministries of health, education, food, agriculture, fisheries, and livestock; government departments in charge of income, employment generation, and safety net schemes; NGOs; private health care providers; and the food industry. Getting and maintaining support for nutrition programs are difficult tasks, given the number of stakeholders involved. In theory, nutrition is everyone’s business, but because it is rarely the central concern of any one ministry or department, in practice it can become nobody’s business.

_There is not always a consensus about how to intervene against malnutrition._ Opinions about how best to reduce malnutrition can differ, depending on viewpoints about what causes it. People working in agriculture, fisheries, and livestock may see food insecurity as the sole cause of malnutrition and increased food production as a solution. People working in health care may regard malnutrition as a disease and improving the reach and quality of curative health services as the solution. These differences are often as apparent among the development assistance agencies and among
professionals in the international nutrition community as they are among stakeholders in developing countries. These different perspectives reflect more than just differences in where people work; they are rooted in how people are trained to think about malnutrition and its causes. Few decisionmakers have a holistic understanding of malnutrition’s multisectoral causes: food insecurity, poor health, and inadequate care of mothers and children. Governments and development partners are especially likely to underinvest in care-based nutrition programs, since care does not figure prominently in the food- or disease-based models of malnutrition that predominate.²

Adequate nutrition is seldom treated as a human right. This seems surprising at first sight, since no need is more basic and universal than the need to eat. One explanation is that the rights-based approach to development is recent, and nutrition is only beginning to be incorporated into it. Another may be that some governments have little interest in citizens’ rights; if this is the case, articulating nutrition as a human rights issue may generate opposition rather than commitment to action.

The malnourished have little voice. Since malnutrition is the consequence of poor care as well as poverty, malnourished women and children can be found in millions of nonpoor families. Nevertheless, the majority of those suffering from malnutrition are poor. Poor people have less influence on their governments than the better off, because they lack the education, organization, and political power to pursue their interests. Governments that hear little from their citizens about malnutrition, as well as governments that care little about the poor, have little incentive to give high priority to investing in nutrition or implementing nutrition programs well.

Some politicians and managers have goals other than good implementation. When nutrition programs are implemented less well than a country’s managerial capacity should permit, politicians and managers may be pursuing goals other than reducing malnutrition. Politicians may pay attention to more vocal constituencies than the malnourished, they may be preoccupied with rent seeking, or they may simply pay little attention to nutrition because they hear little about it from program managers. Managers, in turn, may be preoccupied with moving paper, with consolidating their position in the bureaucracy, or with seeking rents for themselves or their politicians rather than with making the nutrition program work.

Governments sometimes claim they are improving nutrition when they are not. Governments sometimes back policies—such as subsidizing urban food prices or promoting food production—that are claimed to support nutrition but that often benefit the middle class, better-off farmers, or exporters more than the poor and malnourished. They may be unaware
that the policies they are supporting have little beneficial impact on nutrition—as is sometimes the case with export-oriented agriculture or school feeding. Or, as is often the case with urban food subsidies, they may be consciously satisfying a vocal, politically influential, nearby constituency at the expense of a quieter, weaker, more remote one.

Finally, lack of commitment breeds lack of impact breeds lack of commitment. This mechanism works through multiple vicious circles. Weak commitment leads to underinvestment. Because of this, there are too few trainers for field workers, and the quality of nutrition education and services is poor; hence there is little client demand for services, and worker motivation declines. At a higher level, managers see few prospects in working for a poorly resourced, ineffective program; the better ones jump ship to other opportunities; hence field staff get insufficient supervision, and their motivation and service quality suffer. Up another level, poor program impact convinces policymakers—even those well disposed to nutrition—that malnutrition is too difficult to tackle. They perpetuate the cycle by underinvesting.

These 10 reasons for weak country commitment to nutrition programs divide into three types: lack of awareness or knowledge on the part of different stakeholders; institutional complexity, in terms of multiple stakeholder organizations and actors, resulting in the lack of a “home” for nutrition; and differing political or bureaucratic-political interests.

Countries are not alone; most development assistance agencies are also weakly committed to tackling malnutrition, when judged by their actions rather than their rhetoric. Donor investment in micronutrient programs surged during the 1990s in response to new research showing the very serious consequences of what came to be called “hidden hunger” and the availability of interventions against vitamin A and iodine deficiency that were fairly easy to implement. But success with these interventions was patchy, and it did not extend to iron deficiency or the more difficult and expensive direct nutrition programs aimed at PEM. Indeed, it sometimes displaced funding and staff for the latter.

Overall, the development partners have not been vocal and united in their commitment to addressing malnutrition within the MDG agenda, and signals sent by the development partners that attacking general nutrition is not an investment priority have, in turn, influenced the priority—or lack of it—that countries give to nutrition. As with many countries, one reason the development partners have underinvested in nutrition is the belief that, if they are making a serious effort to fund poverty projects and programs, such as programs for rural development and livelihood creation, they are making a serious effort to reduce malnutrition. But the efforts of most development partners are unbalanced. While most partners finance programs that improve livelihoods
and hence food security, many invest little in maternal and child health. And very few invest in care-based nutrition programs, even though these can have a rapid impact on malnutrition.

Development partners sometimes blame their low investment in nutrition on lack of demand from the countries themselves. This is true at one level: development partners can only finance projects that countries request, and their staffing has to reflect the sectoral balance of their project portfolios. But in some instances development partners have rejected countries’ requests for assistance in nutrition: Indonesia and Nigeria are cases in point for the World Bank. Moreover, when development partners have been strongly committed to action in a sector, they have proved able to generate demand. For example, the Bank generated substantial new lending programs for the environment and for HIV/AIDS in just a few years. This would not have happened had the Bank been reactive rather than proactive.

The development partners are now beginning to realize that the MDGs cannot be achieved without more investment in nutrition. This is a positive sign. At the same time, the recent emphasis on health and social sector reform has sometimes crowded out nutrition, and the increasing use of budget support for entire sectoral programs means that freestanding nutrition projects are likely to become less common, especially in smaller countries. It remains to be seen whether and to what extent the development assistance community will take a proactive approach to generating demand for nutrition investment and whether nutrition will receive appropriate attention in the context of the new range of development financing vehicles.
There is no generally accepted conceptual framework for addressing commitment in nutrition. This is partly because university nutrition faculties lack the range of skills required to address commitment building and, for various reasons, have not worked with other faculties and organizations that do have relevant theories, perspectives, and skills. More fundamentally, it is because governments, universities, and development agencies have not recognized commitment building as a key field of professional practice for improving nutrition, like epidemiologic or economic analysis, even though getting commitment right is as important to a nutrition program’s success as getting its epidemiology or economics right.

Since commitment building is not currently recognized as a field of professional practice, it is important to establish a strong practical and conceptual foundation for it. This task is large, given that commitment building could usefully draw on lessons from a large number of academic literatures, developing principles for applying these lessons in specific contexts. This integration of theory and practice can best be accomplished through collaboration between academia (to cull, organize, and synthesize from the existing literature) and practitioners (to draw out lessons from past experiences and ensure that new tools and guidelines are practical). Written for practitioners, this chapter provides some terms and concepts for use in the interim, until more comprehensive methodological development work can be done.

**Useful Terms**

Although the term *country commitment* is sometimes used, commitment is not monolithic; instead, it differs among individual *stakeholders* and between stakeholder groups (sometimes called *interest groups*). Some stakeholders have more influence than others over the development of policies or the implementation of programs; these are usually called key stakeholders, key actors, or *key players*. Stakeholders have different attitudes or *perspectives*, which depend on their knowledge, beliefs, and interests and which determine their behavior. Key players who are actively
involved in promoting a policy or program are sometimes known as champions or policy entrepreneurs.

Commitment varies over time as well as between stakeholders. This can simply be because governments, and hence policies, change; this is a formal change in commitment. But commitment often varies during the lifetime of a project or program without a formal change in policy. This can be because a program’s champion leaves, because the influence of different organizations grows or declines, or because stakeholders see certain types of activity as more in their interests than others. Sometimes, for example, politicians and bureaucrats are strongly committed to getting new programs through, because they get public credit when they are announced and additional staff and resources when they are sanctioned. But, informally, they may not be committed to high-quality implementation or to monitoring and evaluating results, which bring fewer rewards in terms of recognition or expansion.

Some Relevant Concepts

For practitioners, three professional fields seem especially relevant to developing a practical toolkit for strengthening commitment. This section summarizes their potential uses and the extent to which they have been applied to nutrition commitment building.

Strategic Communication

Several of the reasons for low commitment to nutrition relate to lack of information—on the part of families, communities, and governments—about the extent, consequences, and causes of malnutrition. Communication is therefore a key discipline for commitment building. There is a long history of communication work in nutrition. Information, education, and communication (IEC) activities were systematically designed into nutrition projects from the 1970s onward, evolving into social marketing during the 1980s and behavior change communication (BCC) in the 1990s. The consulting industry has taken the lead in developing new approaches in these areas.

While BCC is highly relevant to commitment building, so far it has mainly involved one-way communication and been applied to changing the behavior of nutrition program clients and service providers. A more recent development in BCC, sometimes called “strategic communication” to distinguish its new focus, emphasizes the importance of two-way (or multifocal) communication among politicians, policymakers, implementers, clients, and civil society, both to elicit stakeholders’ perspectives and to engage them as players in shaping opinions, policies, and programs,
not just as passive targets for behavior modification. Because of this change in perception, strategic communication focuses on the design of participative processes that facilitate communication and lead to action.

The emphasis on action is a key to understanding current approaches. Communication is aimed not just at filling a gap in awareness or knowledge, although this is important, but also at closing the gap between knowledge and action. Some examples of behaviors that strategic communication in nutrition might seek to achieve are given in box 4.1. Stakeholders can only be influenced to act differently on the basis of a good understanding of why they behave as they do today. So strategic communication efforts aimed at action are only as good as the prior work that has been done to learn about stakeholder perspectives and practices and what influences them.

The World Bank’s Development Communication Unit has begun to use strategic communication approaches to enlist the support of policymakers and civil society for economic reform (Cabanero-Verzosa and Mitchell 2002), for the Poverty Reduction Strategy Paper process (Mozammel and Zatlokal 2002), and for community-driven development (Mozammel and Schechter 2003). Strategic communication has great potential for commitment building in nutrition, as its use to build political support for Uganda’s Nutrition and Early Childhood Development Project shows (see box 6.1), but the approach has not yet been widely applied by most countries, or by the development banks, which are the main external financiers of nutrition programs.

**Political Economy and Policy Analysis**

Commitment to reducing malnutrition is weak not only because decision-makers lack information but also because they may not see improving nutrition as promoting political, bureaucratic, or personal interests. There is a large literature on the political economy of development and a small but growing one on the politics of poverty reduction and social sector reform (for example, Moore and Putzel 1999, summarizing 10 papers on this subject; Nelson 2004). But only one book has been written on the political economy of nutrition (Pinstrup-Andersen 1993), and this focuses mainly on food policy and provides no practical guidance for commitment building. An initial paper has been prepared for the Millennium Project’s Hunger Task Force on “Building Political Will to End Hunger” (Beckmann and Byers 2004), and this is to be the beginning of a work program providing practical guidance in this area (see chapter 8).

World Bank staff have written two papers on commitment. One makes the case that so-called country commitment is not monolithic but interest-group based and suggests ways to strengthen commitment for
projects in general (Heaver and Israel 1986). The other evaluates the influence of borrower commitment on the success of structural adjustment programs (Johnson and Wasty 1993).

In the field of nutrition policy analysis, an important contribution has been made by Pelletier (2001, 2003a) in showing how the design and implementation of nutrition programs can be determined by the “rationalities” followed by key stakeholders. He argues that nutrition policymaking and planning have been dominated by what he calls “technical rationality,” focusing on concepts like efficacy and effectiveness, and, to a lesser extent, by “economic rationality.” This has been at the expense of attention to other forms of rationality, such as social, political, or organizational (his list of seven rationalities, and how they influence thinking, is given in appendix A).

He argues, “The most . . . effective . . . policy must take account of the political processes associated with its initiation, acceptance, promotion, implementation, and sustainability. . . . This often involves uncomfortable choices for professionals” (Pelletier 2001: 536). For example, it might be technically rational for professionals to target food assistance tightly on the poor, whereas it might be politically rational to include groups that are not poor, so as not to jeopardize political support for the program. Pelletier develops some broad practical implications from his theoretical analysis. Rather than seeking only technically rational approaches to nutrition improvement, he argues that change advocates need to become flexible policy entrepreneurs, who understand the key actors in the policy process and where they are coming from and have the ability to present proposals for change in a way that will appeal to a diverse range of stakeholders. But Pelletier stops short of guidance about how to apply these important principles in practice.

Organizational Behavior

Chapter 2 suggests that programs sometimes perform poorly because implementers are more committed to pursuing informal goals, such as rent seeking or bureaucratic expansion, than formal program goals. In this context, it is important to understand the following:

- How organizations work and how organizations can be influenced, both from within and from outside
- What motivates individuals and interest groups within organizations and how their motivation can be influenced
- How leadership can be developed
- How networks, coalitions, or partnerships in support of formal goals can be created and expanded.
Organizational behavior has a huge literature on these issues. However, it has been developed mostly by academics working in western management schools and mainly in the context of private sector companies or western government bureaucracies rather than public sector bureaucracies in developing countries. Until very recent efforts by the Global Alliance for Improved Nutrition, the international nutrition community has signally failed to draw on and adapt this rich experience.

In summary, the fields of strategic communication, political and policy analysis, and organizational behavior all offer potential methodologies for helping to strengthen and sustain commitment. They correspond directly to the three types of reasons for weak commitment identified in chapter 1: lack of awareness or knowledge, institutional complexity and managerial capacity, and differing political or bureaucratic-political interests. However, universities and other research organizations have, by and large, failed to work on the practical application of these and many other relevant fields to one of development policy’s most pressing issues: the need to eliminate malnutrition. The chapters that follow deal with assessing and strengthening country commitment, incorporating both some ideas from the literature in the above areas and, more important, experience with what has worked in the field in building support for some of the world’s successful nutrition programs.
Assessing Commitment to Policies and Programs

At present, most countries and donors assess commitment unsystematically and with more focus on formal policy than the perspectives and behavior of key stakeholders. According to a review of the World Bank’s nutrition project portfolio (World Bank 2001: 28),

63 percent of projects cited specific government action including the passing of a bill to facilitate the project prior to approval. . . . More than 50 percent of projects with substantial nutrition components reported some involvement of state or provincial level government, local government, or community-based organizations in project design. . . . However, there is little evidence of in-depth analysis of the political context of projects, with some 76 percent of projects with substantial nutrition components reporting no such analyses. . . . Only two projects, both approved since 1993, analyzed the nature of interest groups’ influence, and three proposed strategies to counter influence and resistance.

Since little systematic assessment of commitment in nutrition has taken place, this chapter is based less on program experience than those that follow. Readers are requested to bring examples of systematic assessments of commitment to the World Bank’s attention.

Who Should Assess Commitment and How?

Country and development assistance agency policy entrepreneurs can assess the commitment of key players during their policy dialogue. The commitment of key players is best assessed in one-on-one meetings, where openness is more likely. However, since decisionmakers may only partially reveal their motives and interests, what they say needs to be compared with what they do and cross-checked against the views of local people familiar with the informal interests of key stakeholders. Who is corrupt, for example, is usually well known.
Assessing the commitment of broader stakeholder groups, such as local government leaders and clients, is best done by consultants with qualitative research skills. “Narrow and deep” approaches, like structured interviews and focus groups, are likely to be more useful than “broad and shallow” surveys of knowledge, attitude, and practice, even if they do not yield statistically valid results. Client assessments need to relate to the choice of policy or program design at issue. Some past World Bank–financed social assessments have asked standard sociological questions rather than specific program-related ones about felt needs, access to services, and experience dealing with service providers. Policy entrepreneurs and program designers should therefore help researchers to design the content of such studies.

Identifying Key Players

The range of nutrition stakeholders is large. Appendix B lists about 60 types of stakeholders and is probably not complete. This long list needs to be reduced to a more manageable number of key players—a process sometimes called stakeholder mapping—whose commitment needs to be assessed. Three types of stakeholders are important: decisionmakers, influencers, and clients.

Decisionmakers include senior civil servants, politicians, and, in the case of food fortification, leaders of the food-processing industry. Key civil servants are:

- The heads of the relevant line ministries (for example, health, agriculture)
- The heads of the implementing departments and the finance and planning units in these ministries
- The heads of the relevant units in the finance ministry and the planning ministry.

Key political decisionmakers are the ministers in charge of the relevant line agencies and, if the policy change or program is big enough, the prime minister and the finance and planning ministers. If a reform has to be passed through a national parliament, the commitment of leading members of major political parties also needs to be assessed. In a devolved system where local governments determine spending priorities, the commitment of a sample of local government leaders should be assessed.

People without formal power, but who influence decisionmakers, may also be key players. They often include:

- Spouses or close relatives of heads of state or influential politicians
- Leading nutrition specialists, whether individual academics or representatives of professional bodies, such as a national nutrition council or nutrition institute
• Senior line agency staff who represent interest groups in the bureaucracy, such as doctors or the cadre of extension workers
• Development partner representatives
• Leaders of NGOs active in nutrition, health, or poverty reduction
• Religious leaders
• Individuals in the media (print, radio, and television)
• The winners and losers from a policy reform (for example, winning and losing consumer groups where a food subsidy is to be retargeted).

Clients are all too often unable to influence what programs they get and how they are designed. But experience shows that clients frequently fail to participate in nutrition programs that their designers thought were appropriate for them. Clients’ perspectives should therefore be established from the outset, and listening to clients from the outset sends decisionmakers the message that nutrition programs need to be client-centered if they are going to work. Appendix C, on the Trials of Improved Practices (TIPS) approach, which has been used in more than a dozen countries, illustrates how formative research for nutrition programs can be designed to ensure that proposed changes are acceptable to clients and can be implemented.

Assessing Perspectives

The knowledge, beliefs, motives, and interests of stakeholders together determine their perspectives and behavior. Key players in different parts of the government may have widely different knowledge and beliefs about the following:

• The extent of PEM and micronutrient malnutrition
• Who suffers most from it (age, sex, location, jobs)
• The causes of malnutrition
• The consequences of malnutrition
• How improving nutrition contributes to development goals
• The different ways to intervene against malnutrition
• The relative cost-effectiveness of different interventions in different circumstances.

The knowledge and beliefs of key players are one determinant of their perspectives on the importance of investing in nutrition and which types of intervention to support. Their perspectives are also influenced by a wide variety of motives and interests (some of which may be conflicting):

• Improve the humanitarian condition of poor people
• Give poor people more rights
• Foster national pride (if malnutrition is a source of shame, this can motivate action to reduce malnutrition or to hide it)
• See the country prosper economically and compete internationally
• Expand the part of the bureaucracy to which they belong
• Improve their personal position in the bureaucracy or that of family members
• Look good in the eyes of the public (again, this can motivate action either to reduce malnutrition or to hide it)
• Accumulate votes and political power
• Enrich themselves or their families through rent seeking or nepotism.

An attempt should be made to assess the interests of key players, although this is harder than assessing their knowledge and beliefs.

Assessing Behavior

The acid test of commitment is what stakeholders do rather than what they know, believe, or say. Box 4.1 suggests a dozen indicators of behavior, all signs of commitment.

Box 4.1 A Dozen Behaviors That Signal Commitment to Nutrition

• Politicians emphasize the need to tackle malnutrition in their speeches
• Government sponsors public campaigns to raise awareness about the causes and consequences of malnutrition and about the benefits of investing in nutrition
• Governments hold workshops within and between departments to explain how improving nutrition is central to achieving their development goals, and stakeholder departments collaborate on implementation
• Commitments to international goals (such as the MDGs) are translated into national policies for nutrition
• Nutrition policies are translated into specific national and regional targets
• Targets are translated into concrete investment plans and budgets, and donor support is sought where necessary
• The size of the budget request for nutrition reflects its priority in policy statements
• The budget actually sanctioned for nutrition is close to the budget requested
• What is actually spent on nutrition is close to the budget sanctioned
• The coverage and quality of different nutrition interventions relate to what has been spent
• Politicians regularly review the performance of nutrition programs
• Senior civil servants regularly review the performance of nutrition programs.
The biggest problem in assessing commitment is that, while the presence of these behaviors signals commitment, the absence of some of them does not necessarily signal the lack of it. In particular, small budget allocations may reflect poverty rather than lack of priority, and low spending against budget, low coverage, and poor service quality can be the consequence of weak implementation capacity as well as weak commitment. This suggests the usefulness of consultants specializing in finance, procurement, disbursement, and management capacity, since these specialists can help to sort out the relative influence of weak commitment and weak financial and

Box 4.2 The Philippines in the Early 1990s: Signs of Low Commitment to PEM Reduction

The following signs of low commitment in knowledge, beliefs, and behaviors in the Philippines are taken from Heaver (2004).

Knowledge and beliefs

- PEM was not viewed as a serious problem, because the reference standard used in the Philippines measured prevalence at 11 percent, compared with 33 percent by the international reference standard.
- Child survival was the priority of the Department of Health, but policymakers had little awareness about the importance of PEM as an underlying cause of child deaths.
- Outside the Department of Health, poverty and food insecurity were seen as more important causes of malnutrition than caring practices.
- There were unsettled debates about intervention strategies, for example, with regard to whether growth monitoring and promotion were more important than livelihood creation, whether growth monitoring and promotion programs should be staffed by paid or volunteer workers, and whether food supplementation was cost-effective.

Behaviors

- Nutrition was given low priority in the intersectoral plan allocations of the National Economic and Development Authority (the planning ministry).
- Nutrition education was only 5 percent of the 1993–98 National Nutrition Plan budget, compared with 51 percent for food security and 44 percent for micronutrients.
- Less than a third of the budget requested in the National Nutrition Plan was sanctioned.
- Multiple nutrition activities were undertaken in the field, but with different strategies and limited coverage.
managerial capacity. But because of these confounding factors, assessing commitment is difficult and inevitably involves subjective judgment.

**Putting It Together**

Box 4.2 uses the Philippines as a case to summarize how the various elements of a commitment assessment can come together. At the end of the 1970s, PEM rates in the Philippines and Thailand were comparable at around 30 percent of children under five. By the late 1990s, PEM prevalence remained the same or a little higher in the Philippines but had decreased to less than 15 percent in Thailand. The relatively poor performance in the Philippines was partly the legacy of the long Marcos dictatorship, which gave little priority to poverty reduction or social sector investment. But by the mid-1990s, two successor democratic governments had had considerable success with child survival and micronutrient supplementation programs. Why did PEM reduction lag behind?

Today, and partly due to its lack of commitment to reducing PEM in the 1990s, the Philippines remains an outlier in the relationship between its income per head, which is that of a middle-income East Asian country, and its malnutrition rate, which is comparable to that of a low-income Sub-Saharan African country.
5
Commitment and Strategic Choices

One use of the results of a commitment assessment is to design systematic ways to strengthen and sustain commitment. The bulk of this study (chapters 6 through 8) suggests ideas for how to do this. But commitment is not strengthened overnight. In addition to using assessments of commitment as the basis for designing measures to build commitment, governments and donors also need to take their results into account as they decide what kind of investment to make in nutrition and on what scale. This chapter looks at how judgments about commitment are relevant to strategic choices about whether to invest in broad poverty reduction programs or in more focused interventions, whether to promote projects or programs, and whether to carry out operational research, analysis, or partnership building before attempting to scale up.

Broad or Narrow?

Costa Rica and Thailand are well known in the international public health community for their successful health and nutrition programs. Their success in reducing malnutrition is due not just to what they did in primary health care but also to the fact that their primary health programs were part of much broader poverty reduction programs. Costa Rica, for example, invested heavily in modernizing agricultural and industrial technology and in water and sanitation, and its spending on health was part of a broader agenda of social reform (Muñoz and Scrimshaw 1995). Thailand funded a multisectoral rural development program that was heavily targeted on the poorest districts in the poorest provinces (Heaver and Kachondam 2002).

Multisectoral programs are the most effective way to tackle malnutrition. This is not surprising, given that nutrition has been shown to be affected by economic growth; the availability of water, sanitation, and primary health care; food security; the level of mothers’ education; and child-caring practices. But developing multisectoral poverty reduction programs takes sustained commitment over at least a decade, in addition
to money and managerial capacity. Building such commitment is a key development challenge and is now being pursued by more than 50 countries that are in the process of producing Poverty Reduction Strategy Papers and related investment programs. The hope is that more countries will join this process.

Nevertheless, countries start with very different levels of commitment to reducing poverty in general and malnutrition in particular. It is therefore important for governments and assistance agencies to assess the level of commitment to poverty reduction before they make strategic choices about how best to tackle malnutrition. It is worth noting that Costa Rica and Thailand were able to sustain their commitment to reducing poverty over a prolonged period, because this was seen as central to the political survival of both governments—a far from usual situation (see box 5.1).

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**Box 5.1 What Costa Rica and Thailand Had in Common**

Costa Rica suffered a damaging civil war in 1948, after which the losing Communist Party was made illegal and its leaders exiled. The National Liberal Party, formed from the factions that won the civil war, governed the country from the 1950s through the 1970s, an unusually long period of continuity. President Figueres, who led the government after the civil war (and was president again from 1970 to 1974, when Costa Rica’s primary health care drive began) saw poverty reduction and social reform as a necessity if further civil conflict, and possibly revolution, were to be avoided (Muñoz and Scrimshaw 1995). He took an unprecedented decision to abolish the army. This decision both demonstrated and sealed the government’s political commitment to social reform. With the option of military repression gone, satisfying the electorate through economic and social development was the government’s only means of staying in power.

When Thailand became interested in nutrition in the 1960s, the government was a military dictatorship worried that the country might become another domino in the spread of communism (Heaver and Kachondam 2002). The leadership was conscious that economic disparity was a breeding ground for insurgency and that Thailand’s poorest region lay just across the Mekong River from communist Indo-China. In the late 1970s, Thailand’s national security strategy shifted from containing insurgency through military means to winning hearts and minds through systematic rural development. As part of the shift from containment to inclusion, amnesty was offered to political activists, many of whom rejoined the mainstream and put their energies into social development. Some joined NGOs working in disadvantaged regions. Hundreds of young doctors opted to serve in uncomfortable provincial postings and became a key resource for the nutrition program. Promoted to senior positions in the health ministry, some of these doctors helped to preserve the ethos of the nutrition program into the 1990s.
The ideal way to reduce malnutrition is for countries to invest in multisectoral poverty reduction programs, and strengthening commitment to such programs is everywhere a priority. However, building commitment to programs with multiple agency stakeholders is difficult and time-consuming. In the short run, while the commitment and capacity to undertake a broader effort is being built up, it may be prudent for some countries to put most of their investment in nutrition into one or two narrow programs, run by one or two government departments. Narrower programs with a limited number of implementing agencies can make it easier both to develop managerial capacity and to finance expansion to national coverage; they also simplify the task of sustaining commitment. And succeeding with one or two narrower programs helps to build confidence to take on bigger challenges.

India’s Tamil Nadu State chose this route when it designed the Tamil Nadu Integrated Nutrition Program (TINP) at the end of the 1970s. The government decided to focus on childcare practices because its research showed that, while there was a broad relationship between income and nutritional status, malnourished children were also found in many families that had more than enough income for an adequate diet (see box 5.2). Changing traditional child-rearing behaviors was seen as the key to improving nutrition.

Tamil Nadu’s decision may be appropriate for other governments, where constraints in commitment, financing, or managerial capacity

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**Box 5.2 The Tamil Nadu Integrated Nutrition Program: A Focused Intervention**

TINP was designed following a detailed analysis of nutritional status, the consumption aspects of nutrition, food production and processing, and the relationship between income and employment growth and nutrition in the state (Heaver 2003). The study led to the identification of a complex, multisectoral project, with components for growth monitoring, behavioral change, food supplementation, health care, food production, and food processing. In the course of project preparation, this broad menu of activities was reduced to a more limited focus on promoting child growth by improving mothers’ childcare practices and improving maternal and child health services. A limited range of services was chosen because these were likely to be the most cost-effective and more manageable than a “Christmas-tree” project. But the focus on two key activities and two implementing agencies (social welfare and health) also made it easier to sustain commitment to the program.
make it infeasible to invest in large-scale efforts to tackle malnutrition on all fronts. While investment priorities should vary from country to country, depending on the local epidemiology of nutrition and on where past investment has gone, most countries have invested much more in improving food security and access to health care than in improving breast-feeding, weaning, and other childcare practices. Given that investment is necessary in each part of the food-health-care triad that contributes to good nutrition (UNICEF 1990), redressing the balance by investing more in the care-related activities is now essential (a case argued in more detail in Pelletier 2003b).

Program or Project?

The decision whether to combat malnutrition through a single national nutrition program or a variety of smaller projects is also a strategic choice in which considerations of commitment should play a part. Although TINP was nominally a project, it was rapidly scaled up and, by the end of its second phase, had expanded to cover 80 percent of the state, with nutrition centers in more than 20,000 villages; it was effectively a program. It was the result of a conscious government decision to create a single program to replace the 25 small-scale nutrition projects that had hitherto been operating in Tamil Nadu, with little effect on reducing malnutrition. Costa Rica and Thailand also developed nationwide programs following a single strategy.

The rapid scaling-up strategy followed by these governments, all of which successfully reduced malnutrition, contrasts with the situation elsewhere, where the norm is often a large number of small-scale projects, with limited geographic coverage, with different intervention strategies, and targeting different population groups—often not those at the highest risk of malnutrition. This situation arises partly because governments lack the commitment and capacity to tackle malnutrition on a large scale: domestic NGOs and foreign development assistance agencies move in to fill the gap as best they can. But multiple projects are a cause as well as a consequence of low commitment: they create a variety of vested interests that make it difficult to unite government, civil society, and the donor community around malnutrition reduction.

India has avoided this problem by creating a nationwide nutrition and child development program (the Integrated Child Development Service), into which TINP has been absorbed. Development assistance agencies participate only on condition that they buy into the national program. The opposite situation obtains in most of Sub-Saharan Africa, where donors sometimes provide the majority of the development budget for health and nutrition. Projects are mushrooming in an environment where
governments have very limited capacity to manage them. Few countries are taking serious steps to deal with this problem: Madagascar is one. Madagascar’s interagency nutrition coordinating committee has more than 70 institutional members and is working with increasing success to rationalize a situation in which some villages have been getting more than one nutrition intervention from different agencies, while some have been getting none (see Heaver 2004).

While governments should take the lead in moving the donors from project to program financing, the United Nations Development Programme (UNDP) and the World Bank can play an important supporting role, as aid coordinators, in fostering donor commitment to national nutrition programs. It is possible to move from project to program support even in countries where the development budget is dominated by foreign aid, as shown by the successful efforts of the government of Bangladesh, working with the donor community, to channel the majority of health and nutrition assistance through national programs rather than bilateral projects. Bangladesh’s National Nutrition Program is cofinanced by the government, the Bank, and two bilateral donors and is implemented by the government and a variety of local and foreign NGOs, all following a common strategy (see Heaver 2004).

Trial or Scale?

Few countries are so committed to nutrition—or so well off and so well endowed with managerial capacity—that they can fund all of the direct nutrition interventions on a national scale in the short run. Nor is this necessarily a desirable aim, given that nutrition interventions vary in their cost and effectiveness. Strategic choices about the order in which to move different interventions to scale can have important implications for commitment, bearing in mind that it is crucial for initial investments in nutrition to be successful if governments are to commit to subsequent interventions.

From this perspective, for example, vitamin A supplementation can be a good candidate for early scaling up because the chances of success are high (see box 5.3). By contrast, although iron supplementation is fairly cheap and its efficacy as an intervention against anemia is proven, the effectiveness of iron supplementation programs has been very uneven—partly because of logistical difficulties in distributing the tablets and partly because of the challenge of providing pregnant women with the counseling needed to convince them to take a daily supplement. Testing distribution and promotion arrangements may be preferable to going to scale and failing, thereby casting doubt on the effectiveness of investing in nutrition.
Box 5.3 Vitamin A as a Useful Early Intervention

Vitamin A is a useful intervention for building commitment because it

- Is a relatively cheap intervention
- Is relatively easy to manage because children need supplementation only once in six months
- Can be delivered by health outreach workers when immunizations are given
- Has a big impact on child mortality, which gives health workers an incentive to help with it
- Stops night blindness and xerophthalmia, conditions more visible to villagers than a drop in deaths due to measles or other infectious diseases.

The positive cost-benefit ratio of child growth monitoring and promotion (GMP) makes it a proven intervention. It has been the core of successful nutrition programs in Costa Rica, Tamil Nadu, Thailand, and, more recently, Bangladesh and Honduras. Nevertheless, GMP is a much more costly and management-intensive intervention than micronutrient supplementation, and in some countries there is still controversy about whether it should be implemented by volunteers or paid workers at the village level and about how much, if any, investment should be put into expensive food supplements for children and pregnant women. Where such controversies exist, small-scale trials to decide what works best may be better than moving immediately to scale and risking failure or widespread criticism that government resources are being wasted.

The strategic choice between trial and scale is, of course, closely related to the strategic choice about project versus program. Small- to medium-scale projects are ideally suited to testing new approaches, since they offer controlled conditions where supervision and evaluation are relatively easy; indeed, it can be argued that the only real justification for a project, as opposed to a program, is in situations where strategies need to be tested before being scaled up.

But the systematic use of projects for this purpose remains the exception rather than the rule. In the Philippines, for example, which has had little success in reducing general malnutrition, the World Bank and UNICEF are financing different approaches to GMP. One uses paid and one uses unpaid village workers, but their projects are in different, unmatched areas, and no comparative evaluation was designed before implementation began. The result is likely to be continuing uncertainty
about which approach is most cost-effective, further delaying a consensus about what works—an outcome that will do little to strengthen national commitment to reducing general malnutrition.

**Investment or Analysis and Partnership Building?**

In summary, if commitment to poverty reduction is broad based, malnutrition can best be tackled as part of a multisectoral program. If commitment to broad-based poverty reduction will take time to build up or if financial and managerial capacity is weak, investing in a narrower, high-impact program, such as one to improve childcare practices, may be more appropriate in the short run. Where there is uncertainty or controversy about what is cost-effective or how to implement an intervention, it is better to invest in well-evaluated operational research projects than in a large-scale program. Last in the hierarchy of strategic choices is the decision not to invest at all in a particular intervention rather than to press ahead with a project or program that donors may be committed to, but that the government does not fully own.

Not investing in a particular intervention need not mean failing to act. A variety of analytical and partnership-building activities, explored in the next chapter, can be undertaken to build commitment to future investment. Both governments and the development banks find it difficult to commit staff time or find grant funds for such purposes, unless a project is immediately in the offing. Partnering governments and the banks with institutions that have grant finance for partnership-building activities—in effect, forging partnerships for partnership building—is an important part of strengthening the capacity for commitment building, as explored in chapter 8.
This chapter begins by summarizing some lessons from how commitment to successful nutrition programs has been built in the past by champions and “policy entrepreneurs” who created effective partnerships supportive of nutrition. It then examines three new opportunities for strengthening commitment to nutrition, which are presented by the Millennium Development Goals, by the Poverty Reduction Strategy Paper and community-driven development processes, and by the extraordinarily successful experience in the United States with lobbying government to do more in nutrition.

Champions, Policy Entrepreneurs, and Supporters

Successful nutrition initiatives need national champions, who will build coalitions of interest in nutrition and steer policies and programs through the planning and clearance process in an entrepreneurial way. Nutrition programs were championed by a finance secretary in Tamil Nadu and by a senior official in the planning ministry in Indonesia. Such champions have the advantage of controlling resources and of not being aligned with a particular sector. But the partnership-building skills of champions are more important than their location: two of Thailand’s three nutrition champions were from the health sector, and one was from agriculture (a combination that helped to build commitment to Thailand’s multisectoral nutrition program); these two sectors convinced the finance and planning ministries of the importance of investing in nutrition.

Political as well as bureaucratic champions are crucial when the project or program is big enough to need sanction by parliament or congress. In Uganda, for example, the minister of planning and economic development led preparation of a child development project in which nutrition was an important element. He created a parliamentary advocacy committee to build and sustain political commitment to the project, using technical assistance in strategic communication (see box 6.1). President Lula has personally led the commitment-building process in Brazil since 2002,
through a “Zero Hunger” citizen’s movement involving government, parastatal organizations, private industry, and civil society (for a case on this, see Beckmann and Byers 2004).

While important, political champions cannot substitute for champions in the bureaucracy; in fact, most successful nutrition programs have been initiated and sustained by civil service champions rather than politicians. Where changes of government are frequent—the case in most countries—a program initiated by and strongly associated with one political party may get weak commitment from its successor. Civil servant champions usually outlast governments and therefore have a key role in sustaining commitment, if necessary by “remarketing” nutrition in ways that coincide with the policies and interests of new governments. Costa Rica, where politicians initiated the program and were the driving force in sustaining the bureaucracy’s commitment, may be the exception that proves the rule, since Costa Rica was governed by the same party for decades.

Effective champions need strong leadership, political, communication, and partnership-building skills. They need to be senior enough to have the ear of heads of ministries. They need to stay in place long enough to build a constituency for nutrition that will outlast their time in office. Above all, they need to be country nationals rather than officials of development assistance agencies; nutrition interventions championed by donors seldom outlast the availability of project funds. Donors may, however, have an unexploited role in identifying potential champions and helping to develop their leadership and partnership-building skills.

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Box 6.1 Helping Political Champions: The Uganda Child Development Project

According to Elmendorf and others (2003: 25),

Members of the Advocacy Committee participated in a communication planning workshop. . . . At this workshop parliamentarians were also given on-camera training to provide real-time and hands-on practice on how to communicate to media and other stakeholders about the project. As the project got under way, key members of parliament were also invited to visit Kenya’s Early Childhood Development Project as a way of gaining information about what makes projects successful. Throughout project implementation, parliamentarians were given updates on the status of communications activities and feedback from the field. Audiotapes of key messages about the project were given to parliamentarians to enable them to keep abreast of activities.
GAIN—the Global Alliance for Improved Nutrition—is making this its business. It has drafted a “Partnering Toolbook” and is examining how UNDP’s experience in leadership development could be adapted and applied to nutrition.

Pelletier (personal communication) has suggested that it may be useful to import from the policy literature the distinction between champions, entrepreneurs, and supporters. Champions are high-level people such as politicians and top civil servants who control or directly influence policies and who choose to make nutrition (or other causes) an important and visible part of their agenda. Entrepreneurs are more likely to be mid-level civil servants, NGO members, or academics who do not directly make policy. Many of those committed to nutrition may see themselves as playing an entrepreneurial role, even if they are not in a position to champion in the above sense. To illustrate the distinction: an important function of entrepreneurs is to identify, cultivate, and support the champions. The third category consists of a larger number of supporters of nutrition, also from the mid-level civil service, NGOs, and academia, who may contribute to the nutrition cause in various ways but are not engaged in strategizing, coalition building, and other activities characteristic of policy entrepreneurs, as described in the literature (Haass 1999; Kingdon 1995; Mintrom 2000).

Entrepreneurs and supporters are neither clear-cut nor static categories: supporters may act as entrepreneurs at certain times, on certain issues, and in certain situations. However, experience suggests that sustained efforts to build commitment to nutrition at the national level or within specific organizations can benefit from having a few individuals or organizations play an entrepreneurial role in a more continuous fashion (see, for example, Heaver and Kachondam 2002; Milio 1990).

Building Partnerships for Nutrition

Commitment is fragile when it depends on individual champions. Policy entrepreneurs therefore need to create networks or partnerships of nutrition champions and supporters across the concerned agencies and among NGOs and civil society. Partnerships supportive of nutrition can be built in several ways.

Analytical work assessing the causes and consequences of malnutrition and appropriate intervention strategies can help to create partnerships of common understanding if the work is designed in a participative way. For example, although the Tamil Nadu nutrition study (the basis for designing TINP, described in box 5.2) was financed by the U.S. Agency for International Development, it involved 12 Indian nutrition professionals as well as foreign technical assistance. This helped to forge a common
vision of the state’s nutrition problems and possible solutions in the technical community. The study was overseen by a government committee, consisting of the secretaries in charge of the key development ministries, which did the same at the top levels of the civil service. By contrast, studies managed by foreign consultants may result in competent analysis, but little commitment building.

Cross-departmental seminars and training can offer an opportunity to promote a broad, multisectoral view of the causes of malnutrition and the need for balanced investment in food, health, and care. Bringing staff from different agencies together for discussion and training also helps to develop a common vision of nutrition problems and solutions across the government, and it creates informal networks that facilitate interagency coordination in program design and implementation. Seeing training as a tool for changing perspectives, identifying common agendas, and building partnerships as well as for transferring knowledge and skills has implications for the design of training goals and the selection of participants, the frequency and length of training, and the techniques and even venues used.

The strategic use of information can be directed to a wide range of purposes, for example, to:

- Increase knowledge about the extent, causes, and consequences of malnutrition
- Challenge existing assumptions and beliefs
- Convince about the benefits of investing in nutrition
- Inform about the range of successful nutrition interventions
- Appeal to the interests of a particular audience.

Both the type of information and the channel through which it is conveyed need to be tailored to the consumer (see box 6.2). Some further examples of the use of PROFILES for advocacy purposes are given in appendix D.

Advocacy to the general public needs to appeal to widely shared interests, such as peoples’ common concern for the welfare of children. In contrast, advocacy to professionals needs to be based on hard data, carefully tailored to the argument being made. For example, making the case for care-based nutrition interventions—an especially important job since these, unlike health and food security interventions, often have no line agency constituency—requires data on:

- Malnutrition prevalence by income group (the presence of malnutrition in families with enough money for food shows that care, not just food security, is an issue)
- The concentration of malnutrition in children from birth to two years of age
The small amount of additional food needed by children this age (together these data show that most poor families can afford the food needed to nourish their children properly, indicating that caring practices, not food security, are the key constraint).

Evidence-based advocacy requires good data on nutrition and on household income and expenditures. This underlines the importance of investing in data collection, especially in the 22 African countries, together making up 35 percent of Sub-Saharan Africa’s population, which currently have inadequate data on trends in nutritional status (Chhabra and Rokx 2004).

Appropriate financing and management arrangements are an important means of formalizing partnerships once built. National nutrition investment plans not only formalize financial commitments but also can help to give nutrition visibility and standing. The process of preparing them can itself be a partnership-building tool, if it is done jointly by the finance and

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**Box 6.2 Matching the Type and Channel of Information to the Consumer in Advocacy for Bangladesh’s Integrated Nutrition Project (BINP)**

PROFILES is a program for calculating the benefits from improving nutrition in terms of the following:

- Reductions in mortality and disease
- Increases in productivity and wages gained
- Reductions in spending on social sector programs.

The program was used to demonstrate the enormous human, economic, and financial benefits of reducing malnutrition in Bangladesh and was an important factor in convincing senior finance and planning officials to invest in BINP (Heaver 2004). Officials particularly appreciated the program’s high-tech simulation facility, which allowed them to see instantly the implications for the economy of different levels of achievement in improving nutrition.

By contrast, for lay audiences, a short film was made documenting the implementation of a small, NGO-run pilot of the proposed service delivery intervention. Better than a project proposal could, it conveyed both the stark human dimensions of malnutrition in the villages and how within a year or two trained and empowered village women could run an effective growth monitoring and promotion program. While appealing to all audiences, it was especially effective in engaging the interest of the prime minister and other key politicians.
planning ministries and the line agencies concerned. But when it comes to program management, a substantial literature on the failure of multisectoral nutrition programs in the 1970s and 1980s (for example, Field 1985; Levinson 1995; Pines 1982) suggests that, while finance and planning ministries should control the planning process, they should not try to manage implementation.

The same experience also suggests that multisectoral programs should not be managed by a single line agency: for example, if the program management unit is in the health ministry, agriculture’s commitment may be weak; if it is in agriculture, it may lose the support of health. Commitment to implementation is strongest when each line agency owns and manages the particular program for which it is responsible. This leads to an important distinction regarding commitment: from a planning and financing perspective, there is a single, multisectoral nutrition program, but from an implementation perspective, there is a series of programs run by different agencies.

The different approaches to partnership building need to be combined and sequenced in ways that will vary from country to country. Box 6.3

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**Box 6.3 Making Nutrition Everybody’s Business: Sequenced Partnership Building in Thailand**

Thailand’s three nutrition champions built up a broader group of “friends of nutrition” across the government by sending key staff from the planning ministry and line agencies for overseas nutrition training together and through follow-up seminars that combined staff from different government departments (see Heaver and Kachondam 2002). They convinced senior managers in the finance and planning ministries that putting money into nutrition was an investment rather than a social welfare expenditure, since it would make Thailand more stable, productive, and competitive. They enlisted the support of the private sector to finance a much-repeated television ad, showing children in the northeast who were so poor that they were reduced to eating earth to fill their stomachs. There was a nationwide sense of shame that this could happen in Thailand. A national nutrition committee, chaired by the deputy prime minister and with representatives from all concerned line agencies, helped to raise the profile of nutrition. Although annual financial allocations are controlled by the planning ministry, each line agency is responsible for managing its contribution to the multisector program, and so each feels that nutrition is its business. The military government began to see the advantages of a multisectoral rural development program for national stability and security (box 5.1) as well as for economic development. Once commitment had been built up in central government, seminars for provincial governors helped to bring regional governments into the partnership.
shows how Thailand’s policy entrepreneurs built commitment to nutrition as part of a multisectoral poverty reduction program, through a process combining most of the above tools in a carefully orchestrated sequence. Systematic commitment building involving multiple agencies and levels of government takes years rather than months. This underlines the importance of making strategic choices about the phasing of investment in different nutrition interventions, according to the rate at which commitment, financial capacity, and managerial capacity can be built up (chapter 5).

Using the MDGs to Make Nutrition Everybody’s Business

The Millennium Development Goals provide one of three underexploited new opportunities to build commitment to investing more in nutrition. Having committed themselves formally to the MDGs, some governments and development assistance agencies are gradually realigning their spending to focus on investment that contributes most to meeting the MDG targets. The first of these targets is to halve hunger among children under five. In a world that practiced zero-based budgeting, this would put malnutrition reduction high among governments’ investment priorities. But there is a long way to go before this happens, partly because high, fixed salary costs everywhere limit the reallocable, discretionary budget and partly because powerful government departments are often able to protect their financial turf.

But investing in nutrition is not only relevant to the first MDG target, it also helps to achieve several other MDG targets: for example, reducing child and maternal mortality and noncommunicable disease, increasing school enrollment, and eliminating gender disparity in schools (see appendix E for a fuller list of ways in which investing in nutrition contributes to achieving the MDGs). As investment priorities are rethought in the context of the MDGs, the message that needs to reach government departments is that investment in nutrition is not money lost to a competing department, but investment in achieving each department’s own goals. The latest strategic communication technologies need to be used to sell the idea that improving nutrition is everybody’s business. This can be accomplished by (a) presenting quantified evidence about the benefits to various interest groups (see box 6.4 for some examples) and (b) finding the best channels of communication and processes to put this evidence across.

Repositioning Nutrition in PRSPs, PRSCs, and CDD

Poverty Reduction Strategy Papers (PRSPs) and Credits (PRSCs, at the national level) and community-driven development programs (CDD programs, at the community level) will increasingly be the vehicles for
deciding the priorities for investment in poverty reduction. Yet nutrition has been getting marginal attention in most PRSPs, PRSCs, and CDD programs (see Shekar and others 2004). These important instruments for allocating development resources present a second underexploited opportunity for building commitment to nutrition investment.

Nutrition partnership-building efforts, including strategic communication campaigns to promote the benefits of investing in nutrition to a wide variety of interest groups, ideally need to take place before PRSP negotiations begin:

**Box 6.4 How Investing in Nutrition Helps Government Departments to Achieve Their Own Goals**

Malnutrition underlies more than half of child deaths and is linked to an increased likelihood of dying from diet-related, noncommunicable diseases in later life (Pelletier and others 1995; World Health Organization 2003). Among young children 45 percent of measles deaths, 52 percent of pneumonia deaths, 57 percent of malaria deaths, and 61 percent of diarrhea deaths are attributable to malnutrition; among adults, at least 10 percent of maternal mortality is attributable to iron deficiency (Caulfield and others 2004; World Health Organization 2002). So improving nutrition is central to achieving the goals of health ministries.

Workers who are small in stature because of childhood malnutrition or who suffer from iron deficiency are less productive than healthy workers. Anemia-related losses in economic productivity in Bangladesh, India, and Pakistan amount to an estimated $4.5 billion annually (Galloway 2003). So improving nutrition helps to achieve the goals of agriculture and industry ministries.

Children who do not suffer from PEM have a better attendance rate in school. An improvement of 0.5 standard deviation in nutrition increases school initiation by 19 percent for Pakistani girls, and a 0.6 standard deviation increase in the stature of malnourished children increases completed schooling by nearly 12 months in the Philippines (Alderman and others 2001; Glewwe, Jacoby, and King 2000). Eliminating iodine deficiency can increase the intelligence quotient by 13 points, making children better learners in school and, when they become adults, making them better able to compete for fast-growing service industry jobs that demand brain rather than muscle power (Grantham-McGregor, Fernald, and Sethuraman 1999). So improving nutrition is central to achieving the goals of education and industry ministries.

The PRSP Process

Nutrition partnership-building efforts, including strategic communication campaigns to promote the benefits of investing in nutrition to a wide variety of interest groups, ideally need to take place before PRSP negotiations begin:
they improve the chances that nutrition interventions will get the investment they merit given their potential contribution to achieving the MDGs. To be effective in influencing the PRSP process, initial nutrition partnerships built within the government need to be extended beyond the government to civil society and to development assistance agencies, since these are important partners in the PRSP process.

Wherever nutrition advocacy and partnership building have already led to an appreciation that nutrition interventions are essential to reducing poverty and achieving the MDGs, an important further step could be taken—this time in terms of reshaping the PRSP process itself. Nutrition is not simply a series of interventions, meaning an input to poverty reduction; rather, improved nutritional status, like income, is also an outcome measure of poverty reduction activities across all sectors. It can be argued that nutritional status is a more sensitive measure of poverty reduction than income, because it reflects the distribution of resources within households to vulnerable family members and the application of increased government revenues to vulnerable groups, capturing choices that lead to real improvements in well-being, not just higher income. As a sensitive measure of progress in poverty reduction, nutritional improvement could become a useful organizing principle for the PRSP process.

This would mean reversing current thinking. Instead of nutrition being seen as a development activity competing for resources, the various sectoral investment possibilities would be reviewed and prioritized in light of their relative contribution to nutritional improvement. The latest review of PRSPs points out that most PRSPs do a good job of setting out the wide range of interventions for reducing poverty (the average PRSP is now 190 pages long!), but a less good job of prioritizing them (International Monetary Fund and World Bank 2003). They fail in one of the main functions of PRSPs: to provide guidance about what priorities the resulting poverty reduction sector credits should fund. Thus contribution to nutritional status improvement could become a valid criterion for PRSP partners to decide on the relative priority of interventions in the various sectors.

The CDD Process

Similar arguments can be made for community-driven development. In the early stages of developing programs, the focus was primarily on designing processes for community empowerment. But as CDD scales up and becomes more expensive, increasing attention will have to be paid to helping communities choose interventions that are most cost-effective in reducing poverty. Contribution to nutritional status improvement could become a valid criterion for communities to decide on the relative priority of interventions in the various sectors. Another problem facing CDD,
as a multisectoral activity, has been the difficulty of finding good overall measures of progress, an increasing concern as the focus on development outcomes sharpens. Using PEM status as an overall outcome measure for CDD could help to overcome this problem.

National nutrition surveys have no validity at the community level, and nutritional status varies greatly among communities. Therefore, if nutritional impact is to be used either as a criterion for choosing investments or as a measure of development outcomes, child growth monitoring will need to become a standard part of CDD programs. One reason that nutrition has been neglected in CDD programs in favor of investment in roads, farming, water, and sanitation is that it is often invisible to communities (chapter 2). Knowing how their own children are growing will help communities to give appropriate weight to nutrition as they decide what to invest in.

Another reason for investing in growth monitoring programs is that they offer a means for CDD programs to target the poorest. Although not all the malnourished are poor, most of the poorest are malnourished. Community-based nutrition monitoring can identify marginal groups in society who are otherwise invisible and not reached by sector programs. Community nutrition programs offer a way to identify those at highest risk and, after assessing the cause of malnutrition in each family, to target appropriate interventions on them: education in improved caring practices, health care, water and sanitation, livelihood creation, or safety nets.

**Using NGO–Civil Society Partnerships to Lobby Governments**

In developing countries, most initiatives to invest in nutrition have originated within government or through donor advocacy. There has been little pressure to do more from domestic constituencies outside government. But in the United States, NGOs have been very successful in getting the government to increase the nutrition budget and spend it more efficiently (see box 6.5). Learning from and applying this experience presents a third underexploited opportunity for building commitment in developing countries.

Most nutrition NGOs in developing countries focus on service delivery rather than advocacy. While they often succeed in making a big difference to peoples’ lives in a small geographic area, they may be missing an opportunity to make a much larger impact, by influencing what governments do with their greater resources. Partnerships between developing-country and international NGOs could help local NGOs to strengthen their lobbying skills and form networks, together with local universities, research institutes, media persons, and civic associations, for this purpose.
Documenting existing models of this and designing improved ones are an important area for action research. Particular issues that need to be explored are what core staffing is required for such networks to be effective and how they can be sustainably financed.
7
Sustaining Commitment through Implementation

The lesson from experience is that commitment to nutrition programs is fragile and constantly assaulted as governments, policies, priorities, and key actors change over time. Undertaking systematic efforts to sustain commitment through implementation is therefore as important as building initial commitment to investment. Of the large-scale nutrition programs that, at one time or another, have been held up as models to emulate, only two—those of Costa Rica and Thailand—have sustained good performance over the long run (15 years plus), perhaps because these two governments saw poverty reduction as intrinsic first to their survival and then to their competitiveness (box 5.1). Elsewhere, model programs have declined in quality (as in Tamil Nadu from the mid-1990s), collapsed (as in Tanzania in the late 1990s), or faltered (as in Bangladesh since 2002). This chapter looks first at some lessons from success and then at some lessons from situations where commitment weakened.

Lessons from Success: Keeping Stakeholders Motivated

Organizational behavior distinguishes between two types of motivation: intrinsic, stemming from personal goals and values, and extrinsic, stemming from external incentives and pressures to perform. Promoting a human rights–based approach to development, for example, appeals to an intrinsic motivating value; promoting an outcome-based approach to development, based on accountability for meeting goals such as the MDGs, is an example of extrinsic motivation. Ideally, programs should motivate stakeholders both ways: by espousing and promoting values important to stakeholders, so they feel personally committed to achieving program goals, and by promoting accountability, through setting targets, monitoring performance, and rewarding achievement.
Intrinsic Motivation

When it comes to implementing nutrition programs, little systematic work has been done on how to tap into and build on peoples’ intrinsic motivation, despite the fact that the idea of improving nutrition is in many ways intrinsically motivating. Nutrition programs are an obvious opportunity to pursue the rights-based approach to development—having enough to eat is clearly a basic right—but so far this opportunity has not been taken. Outside Thailand’s nutrition program, which consciously sought to create an ethos of community self-reliance and mutual support in the context of traditional values, no systematic efforts have been made to tap into peoples’ intrinsic desires, among others, to:

- See their children survive, be healthy, and succeed in school and work
- See their family, community, or country defeat the shame of poverty and malnutrition
- Feel part of the community
- Fulfill religious and cultural traditions to help others
- Work as part of a team with people whose values they share
- Be self-reliant rather than dependent on others.

Box 7.1 gives 10 examples of how some successful nutrition programs have appealed to peoples’ personal, cultural, or community values, even though most had no systematic plan for doing this.

We do not know nearly enough about how to unleash peoples’ positive energies by appealing to their intrinsic motivation or, conversely, how to counter the apathy of social groups not concerned about malnutrition. Future action research should explore this systematically, using formative research to look at the motives and values of each key player or interest group and to see how nutrition programs can be designed to appeal to positive values, counter negative ones, and harness active participation. The approaches for doing this, and the prospects for success, are likely to be culture-specific. The examples in box 7.1 suggest half a dozen more specific lessons that action research might explore in different country conditions:

- Strategic communication should not just impart information or encourage dialogue but also seek to stir up feelings and appeal to values that make people reject the persistence of hunger and want to act to improve nutrition.
- Nutrition programs should encourage people to participate as a fulfillment of community responsibilities, religious duties, or cultural values, not just as employees. Given the importance of religion in many
Box 7.1 Nutrition Programs Can Build on Traditional or Universal Values and Promote Empowering New Ones

Some successful nutrition programs have appealed to peoples’ personal, cultural, or community values, even though most had no systematic plan for doing this:

- Bangladesh, Costa Rica, Tamil Nadu State (India), Tanzania, and Thailand relied on local workers, motivated by the contribution they made to—and the respect they got from—their local community.
- In Thailand community workers were motivated by ancient Buddhist traditions of compassion for the suffering and duty to help the community.
- TINP formed three separate “working groups” of women, adolescents, and children in each village to receive and help with IEC; being part of a group of their peers helped to motivate clients (and meeting people in groups rather than individually saved workers time).
- In TINP supervision was supportive rather than inspectional, focusing on individual on-the-job training to deal with implementation problems. This made workers feel personally valued and gave them an opportunity to grow professionally.
- In Tanzania local people’s self-reliance was built by having them assess their own nutrition problems, analyze their causes, and decide how to act (the “Triple A” process), rather than by having outsiders from the government decide what was best for them.
- Bangladesh, Tamil Nadu State, Tanzania, and Thailand all encouraged communities to monitor the program’s performance in their village, increasing their control and self-reliance.
- TINP recruited community workers who were poor yet had well-nourished children, showing other poor people that poverty was not a bar to improving their condition.
- In Brazil social movements taught that poverty and hunger were not the natural order of things; the church’s liberation theology encouraged the poor to stand up for themselves.
- Thailand motivated the nation through a BCC campaign that made Thais feel ashamed that serious malnutrition persisted in their country.
- In Brazil the Citizens’ Action against Hunger and for Life Campaign encouraged all Brazilians to do something about hunger in their communities, making people feel an empowered part of a national movement.
countries, working with religious leaders to achieve this may be a particularly productive avenue to explore.6

• Workers and clients are more motivated if they feel part of a group of their local peers, or an enterprise greater than themselves, such as a national citizen’s movement.

• Communities should diagnose their own problems, provide their own nutrition workers, and monitor their own performance, if they are to become more self-reliant and able to sustain the program over the long run.

• Workers should be hired and fired by, and report to, their local community, because this promotes community self-reliance and empowerment.

• Supervision and training should make workers feel part of a team, be problem-solving rather than correctional, and offer opportunities for personal and professional growth.

Extrinsic Motivation

There is more program experience with how to sustain commitment to program implementation through extrinsic motivation. There are nine common ways to motivate clients, field workers, and managers; a little more detail on each is given in appendix F. While none of them is innovative in itself, most programs do just a few of these things: the most successful programs do many of these things together, so their effects are mutually reinforcing. TINP is perhaps the best example of a management system designed to do this (Heaver 2003):

1. Provide clients with information about the extent of malnutrition
2. Provide clients with information about the adverse consequences of malnutrition and the benefits of intervening
3. Provide clients with convenient services
4. Provide clients with cash transfers or food
5. Give clients information about program performance
6. Pay village workers
7. Give village workers feedback about performance and focus management and supervisory attention on low-performing units or areas
8. Use participative micro planning to motivate workers and managers
9. Monitor service quality as well as the achievement of quantitative targets.
TINP began in 1979. By the mid-1990s it covered a population of more than 30 million and had been evaluated as contributing to a decline in malnutrition “unprecedented in other parts of India and elsewhere in the world where large-scale nutrition interventions have been implemented” (World Bank 1994). But following a change of political leadership and program management after the election of a new state government in the mid-1990s, there was—at least as the World Bank perceived it—a sharp decline in understanding of the program’s principles, commitment to its implementation, and integrity in handling its finances. Box 7.2 summarizes some of the signs and consequences of reduced commitment at that time.

Eventually, the Bank’s project staff identified a clear contravention of the Bank’s procurement rules, a “misprocurement” was declared, and the Bank canceled the amount of the concerned contract from its loan. The project manager was transferred, and a new management team slowly

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**Box 7.2 TINP: Signs and Consequences of Faltering Commitment**

According to Heaver (2003), the following signs and consequences of faltering commitment were evident in the Tamil Nadu Integrated Nutrition Program:

- The Bank received allegations, which it thought credible, of corruption in procuring food supplements, drugs, and equipment and in recruiting community workers in some areas.
- There were complaints about the quality of food supplements reaching the villages.
- Several thousand faulty scales and low-quality cooking utensils were procured and had to be replaced.
- Lack of supportive supervision by top managers led to lower morale among field staff.
- The quality of field training and supervision and the proportion of children being regularly weighed and supplemented declined.
- Managers seemed unconcerned about increasing variations in performance between districts.
- Managers were preoccupied with expanding the program into new areas at the expense of maintaining and improving quality in existing areas.
- Some managers in the program office resigned, unwilling to accept the declining standards.
began to restore the program’s quality standards. But these never fully recovered, and Tamil Nadu’s performance in community nutrition remains below par for southern India.

The TINP story raises important questions. Participative planning, performance monitoring, and quality control are tools that can help top program managers to sustain the commitment of managers down the line. But what if top management itself is not strongly committed to program implementation? When the commitment of top managers falters, even the tightest of management systems quickly starts to disintegrate. The question, Who manages the managers? is seldom addressed systematically when the institutional arrangements for nutrition programs are designed.

During the 1980s, Tanzania was famous for its Iringa Program, which developed the food-health-care framework for nutrition improvement in wide use around the world today. Community nutrition seemed institutionalized. But by the end of the 1990s, the program had all but collapsed. Box 7.3 gives some reasons why.

Box 7.3 Tanzania’s PEM Program: When Push Came to Shove

According to Heaver (2004) and Levinson and Dolan (2000), Tanzania’s Iringa Program failed to be sustained for a number of reasons:

- The economic crisis in the 1990s meant severe government budget cutbacks, and community volunteers, struggling to survive, had little time for nutrition work.
- Responding to the budget crisis, the government focused on health sector reform; Tanzania was spending almost twice as much per head on health as neighboring Kenya, with less effect on fertility, mortality, and disease.
- PEM prevention got little attention in the reform. What money there was for nutrition went mainly to micronutrients and integrated management of childhood illness; none of the Health Sector Plan of Action’s 36 “key performance indicators” related to nutrition; only one of the 98 activities in the Plan of Action for District-Level Services related to community nutrition.
- Reforms also affected Tanzania’s Food and Nutrition Centre (TFNC), which had previously managed community nutrition. An 80 percent cut in TFNC’s budget made regular field supervision impossible, while a new, government-wide emphasis on decentralization required TFNC to find a new role in policy advice, research, and quality control rather than implementation. Faced with the need to become financially self-sufficient, TFNC began to focus on micronutrient malnutrition, where it was easier to get donor finance.
This case suggests that commitment to community-driven PEM reduction was never as well entrenched as was thought back in 1993, when a history of the Tanzania program was entitled *We Will Never Go Back* (UNICEF 1993). It is at times of financial crisis that governments and donors reveal their true commitments. When the crisis hit, the UNICEF staff who had provided much of the impetus for Iringa had moved on, Swedish government support for nutrition had ended, the World Bank was preoccupied with health sector reform, other donors had switched their interest from PEM to micronutrient malnutrition, the government had to slash spending, and no political voice spoke up for community nutrition. There was no explicit decision to dismantle the PEM program: attention to it was simply displaced by the priority given to other issues.

The experience in these two programs is not exceptional. Faltering commitment during implementation is the norm rather than the exception for nutrition programs, suggesting that no single group of stakeholders can be relied on to sustain commitment over the long run. Top managers change, and their successors pursue informal goals different from those of the program; key players in donor offices move on; the donor community switches its attention to the latest development bandwagon; a new political party comes to power; governments are preoccupied with crisis management; and the voice of clients is seldom strong enough to be heard.

The implication is that nutrition programs, and broader poverty reduction programs, need to be made accountable to multiple external stakeholders. Then, if the commitment of one stakeholder group is lost, others can try to keep the program on track. Key stakeholder groups include program managers, politicians, heads of finance and planning agencies, nutrition institutes, NGOs, religious leaders, the media, clients, and the general public.

Little consideration has been given to how to make nutrition programs externally accountable, let alone accountable to multiple external stakeholders. Various issues need to be explored for each of the key stakeholder groups:

- What structures and processes might be used to involve external stakeholders in program oversight, whether individually or together?
- What quantitative and qualitative information on performance should flow to each type of stakeholder, through what channels?
- What influence or authority should they have over the program, under what circumstances?

Of particular importance, and particularly neglected by both domestic and donor policy entrepreneurs, is the question of how to keep nutrition
high on politicians' agendas. Box 7.4 offers some ideas that might be tested through action research.

**A Final Lesson**

Systematic measures to make nutrition programs externally accountable are best taken at the time of project or program design. It is much harder to fix commitment problems during implementation than to prevent them at the time of planning a new initiative, when decisionmakers are engaged, there is more openness to new strategies and institutional structures, and discretionary funds are available.
Commitment building takes information, skills, money, and the capacity to manage the process. Countries start out differently endowed with each of these resources. Some may need only to mobilize and organize existing resources; others may need help. Arguably, now that we have strong research showing the benefits of improving nutrition and proven ways of intervening, building the professional capacity to strengthen commitment to act is the activity with the single highest return to effort in nutrition—both for countries and for the international nutrition community.

**Strengthening Country Capacity for Commitment Building**

Countries need to mobilize the resources to build commitment, and they need to consider how to manage the commitment-building process.

**Resource Requirements**

A variety of *information* is needed for commitment building, including:

- Levels of and trends in malnutrition for different geographic areas, income levels, and risk groups
- The knowledge and beliefs that politicians, bureaucrats, clients, and others in civil society have about the causes and consequences of malnutrition and the priority they give to tackling it
- Commitment-building messages about the benefits of reducing malnutrition, tailored to different stakeholder groups
- The kinds of nutrition interventions that work best in different circumstances and their cost.

Key *skills* are also needed:

- Formative research skills (for example, structured interviews, focus groups, TIPS)
• Quantitative and qualitative data analysis skills
• Skills in modeling (for example, PROFILES)
• Skills in networking, building partnerships, and designing participative processes
• Communication skills, including skills in developing strategies and messages; in undertaking advocacy to key policymakers in finance, planning, health, and other key sectoral agencies; and in packaging messages for different channels, including interpersonal communication, print media, television, radio, and film
• Skills in designing intrinsic and extrinsic incentives for political and bureaucratic champions, implementers, and clients to stay supportive of and engaged with the program.

The costs of commitment building will vary greatly from country to country. Table 8.1 presents some order of magnitude costs for different

**Table 8.1 Cost of Commitment-Building Activities**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Cost (U.S. dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Running a commitment-building unit or team within government (annual cost)</td>
<td>100,000–150,000</td>
</tr>
<tr>
<td>Running an NGO network (annual cost)</td>
<td>25,000–50,000</td>
</tr>
<tr>
<td>Formative research to find out what clients, implementers, and other stakeholders think and want</td>
<td>25,000–60,000</td>
</tr>
<tr>
<td>Training in communication for key players</td>
<td>10,000</td>
</tr>
<tr>
<td>A film on malnutrition and how to tackle it</td>
<td>10,000</td>
</tr>
<tr>
<td>Television ad and other media communication campaigns</td>
<td>100,000–200,000</td>
</tr>
<tr>
<td>Technical assistance to</td>
<td></td>
</tr>
<tr>
<td>Conduct a PROFILES simulation (see appendix D for details)</td>
<td>50,000</td>
</tr>
<tr>
<td>Prepare a strategic communication strategy for influencing different stakeholders</td>
<td>5,000–30,000</td>
</tr>
<tr>
<td>Develop and pretest messages for different stakeholders</td>
<td>10,000</td>
</tr>
<tr>
<td>Help a local NGO network to develop its lobbying skills</td>
<td>30,000</td>
</tr>
</tbody>
</table>

a. Includes salaries for two or three staff and costs of travel; running orientations, seminars, workshops, and training; producing materials; organizing press conferences, receptions, and site visits for orientation and publicity purposes; commissioning reports and analyses from experts; arranging for key players to visit successful programs overseas, attend international meetings, and travel for other strategic purposes.
commitment-building activities. The range of costs for formative research and strategic communication work reflects the fact that some countries may need to seek foreign assistance to design research and communication strategy and develop messages, on top of the local costs of conducting research, producing films, or paying for ad campaigns. In addition, some poor countries (22 in Sub-Saharan Africa, according to Chhabra and Rokx 2004) lack adequate data on the prevalence of or trends in malnutrition. Surveys to establish the basic information needed for evidence-based nutrition advocacy could add an additional $50,000 to $500,000, depending on the gaps in the data and whether foreign assistance is required to fill them.

The message is that, even setting the costs of nutrition surveys aside, a systematic commitment-building program is likely to cost on the order of several hundred thousand dollars per country. Moreover, (a) while some of the costs are one-time start-up costs, others are recurrent, if commitment to programs is to be sustained over the long run, and (b) the costs do not include the costs of the kind of organization and management interventions discussed in appendix F for motivating clients and service providers. While this magnitude of costs may be fairly easy to finance as part of a large-scale project or program, it can be more difficult to raise before a project or program is sanctioned, which is when commitment-building activities are first needed.

How to finance up-front costs for commitment building is therefore a major issue for countries and development assistance agencies to address. Although these costs are significant, they are small compared with the costs of programs. They are a necessary investment in sustainability, and they can be sourced from a variety of grant mechanisms. The issue is not one of feasibility, so much as of developing appropriate, innovative financing mechanisms.

**Management of the Commitment-Building Process**

Commitment-building does not need to wait while capacity is developed. All countries have significant resources that can be mobilized for this purpose, and one of the initial tasks of a champion or policy entrepreneur is to do this. Nutrition champions often develop an informal network of skilled persons in statistical institutes, university departments, NGOs, and radio and television, and they also forge contacts with private companies, which may have better skills than government in communications and advertising and may also be prepared to finance the costs of ad campaigns, as they did in Thailand, as a service to the public.

But there is a limit to what can be achieved by suasion and by informal networks. Systematic commitment building ideally requires a small core
staff to oversee the development and implementation of strategy and to contract the skills required for specific tasks; this, in turn, requires a budget and systems for procurement and accounting—in short, a small “nutrition marketing unit.” Because commitment building historically has not been managed professionally, we have little experience with how to design such units or where to situate them—another task for action research.

Zimbabwe’s experience suggests that there can be disadvantages to establishing a unit with multisectoral advocacy responsibilities under a line agency (Tagwireyi and Greiner 1994):

> Although the mandate given to the Department of National Nutrition was sufficiently broad to tackle the problems of malnutrition holistically, the parent Ministry of Health did not always understand or appreciate the intersectoral aspects of this mandate. . . . The health sector could only allow a staffing complement that fell within acceptable Health Ministry norms. . . . At the same time, the advocacy efforts of the department have resulted in increasing requests for technical support from other sectors, which threatens to overwhelm the capacity of this small unit.

While different structures and processes are likely to be appropriate in different countries, Thailand overcame this problem by creating an Institute of Nutrition at Mahidol University (INMU), which one of the country’s three nutrition policy entrepreneurs moved to head. The institute was closely linked to government (for many years its director chaired the technical committee that drew up the planning ministry’s five-year plan for food and nutrition), but not beholden to it. Overseen by a committee headed by the university president, INMU had both academic freedom and administrative freedom from the government bureaucracy. It was ideally placed to provide technical expertise to any line agency that requested it. It also used its nutrition training mandate to bring staff from different sectors together, helping to build commitment to a multisectoral approach to improving nutrition (Heaver and Kachondam 2002).

### Deploying and Strengthening the International Nutrition Community’s Capacity for Country Commitment Building

While key players in developing countries should lead country commitment building, the international nutrition community can do much to help. The initial process should be a learning-by-doing one, in which best practices in commitment building are developed in a few countries and then disseminated more broadly. Since different institutions in the
international community have different capacities, they need to consider how best to support capacity building by working together in a partnership to which each would contribute according to its comparative advantage. The following sections set out some roles that different actors are playing or might play.

**Political Commitment Building**

The United Nations Millennium Campaign is leading the global effort to mobilize political support to achieve the MDGs. Two of the Millennium Campaign’s 10 task forces—the Hunger Task Force and the Maternal and Child Health Task Force—specifically address nutrition. The Hunger Task Force has produced an interim report with a preliminary work plan for creating political support and action for achieving the MDG on hunger alleviation (Hunger Task Force 2003: ch. 6). By the end of 2004, it aimed to have a detailed plan of action for political commitment building, based on lessons learned from other efforts and covering operational priorities, organizational and financing structures, roles and responsibilities, and specific political mobilization strategies for hunger hot spots in Africa and Asia.

The advocacy NGOs in the United States have had significant success in lobbying their government to put more money into nutrition (box 6.5). The U.S. Alliance to End Hunger works with these NGOs and others to build the political will to make nutrition a higher priority for elected officials. The United Nations food agencies have begun an effort to identify or initiate national alliances against hunger and to link them together into an International Alliance against Hunger. They have initiated or identified such alliances in 50 countries so far.

A group of NGOs from around the world has come together in a parallel NGO campaign called “More and Better.” They have agreed to push together to meet the MDGs on hunger and poverty, focusing on more and better development assistance for agriculture, rural development, and food (see their Web site: www.moreandbetter.org). The International Alliance, together with the related More and Better Campaign, will give antihunger activists around the world information about what people in other countries are doing to build political will to overcome hunger. The challenge is to ensure that these initiatives focus attention on strategies that directly address malnutrition among young children.

**Operational Commitment Building**

The World Bank is the leading international financier of nutrition programs, having lent more than $1.5 billion for these, and is currently considering
whether to substantially increase its assistance. The Bank (and the regional
development banks) could potentially play a leading role in commitment
building. The World Bank’s commitment to the MDGs, its multisectoral
mandate, its access to politicians and to finance and planning ministers, its
role as leader of aid consortia, and its intellectual leadership in the PRSP
and CDD processes together give it a unique comparative advantage in
nutrition. Working as a development partner with governments, the Bank’s
role potentially complements that of international and national NGOs
lobbying from outside government.

However, to be effective, the Bank needs first to demonstrate its own
commitment by putting nutrition closer to the center of its policy dialogue
with countries and increasing its nutrition lending and staffing from
current low levels. The Bank is already actively using strategic communi-
cation methods in some of its work. It now needs to apply these system-
atically to nutrition, first, to communicate directly to governments the
message that investing in nutrition is central to achieving the MDGs and,
second, to help key players in developing countries to strengthen their
capacity to build and sustain commitment. While the consulting industry
could provide technical assistance with this, the Bank needs to dedicate
staff to commitment-building work for nutrition and should raise and
channel funding for technical assistance and the cash costs of commit-
tment building, which many poor countries cannot afford (table 8.1).

Such funding should be on a grant basis. Grant financiers, such as the
bilateral development assistance agencies, the Rockefeller, Ford, and Gates
foundations, and a variety of international NGOs, could have a major role
to play in covering the costs of technical assistance and commitment
building. The funds that the international community can provide for nu-
trition intervention programs will always be a small proportion of what de-
veloping-country governments contribute. The international community’s
grant resources for nutrition are therefore better spent on “pump-priming”
support for strengthening country commitment and capacity than on
financing small-scale nutrition intervention projects themselves.

The UN Sub-Committee on Nutrition is the United Nations’ coordinating
body for nutrition. It has a mandate for advocacy and commitment build-
ing, which has not been adequately fulfilled to date. It has recently de-
cided to devote more resources to its advocacy work—in particular, to get
key nutrition messages to global bodies and international forums—and to
encourage countries and development assistance agencies to give appro-
priate weight to nutrition, as they consider how investment priorities
should change to meet the MDGs.

UNICEF has been a strong supporter of nutrition in the past, although
its interest has waned in recent years. Its access to political leaders and its
close relationship with human development agencies in many countries
makes UNICEF well placed to contribute to nutrition advocacy. Its grant
financing and its network of field offices, many with specialist nutrition and communication staff, also position it well to help strengthen countries’ commitment-building capacity. Should both institutions commit themselves to tackle malnutrition, there potentially is a strong complementarity between UNICEF, which cannot fund large-scale interventions but has up-front grant funds and technical assistance capacity, and the World Bank, which has substantial loan funds to finance nutrition programs, but no up-front grant finance to help prepare them.

GAIN, the Global Alliance for Improved Nutrition, sees commitment building and capacity building for this purpose as core activities. Although new, it is already developing methodologies for this (see chapter 6), and, although its focus is on food fortification, the approaches it is developing are relevant to commitment building for nutrition in general. GAIN is strongly interested in partnering with other institutions in the international community as well as in developing countries.

Universities and research institutes, such as the International Food Policy Research Institute, are also potentially important partners in the capacity-building process, as designers, monitors, and documenters of action research projects in the many areas where there is more to learn about commitment building (see chapter 9 for a summary of these). Universities and research institutes need to work in partnership with development assistance agencies, like GAIN, UNICEF, and the World Bank, which can give them access to governments. They also need to build their own capacity in the areas of communication, policy and political analysis, and management capacity development if they wish to position themselves to make a significant contribution to increasing commitment to eliminating malnutrition.

The development assistance community will need to invest more time and effort in building consensus about how best to reduce malnutrition if it is to unite in successful partnerships for country commitment building. It would be particularly useful if agencies could, through dialogue, move to closer agreement on issues such as (a) the appropriate balance among health, food security, and care-related nutrition interventions in different country circumstances, (b) the conditions in which nutrition programs are best implemented by paid or volunteer workers, and (c) the place of nutrition in health and social sector reform and in sectorwide approaches. Differing viewpoints among agencies on these issues currently hamper the development of consensus on national nutrition strategies in a number of countries.
Various technologies are capable of substantially reducing malnutrition. Weak commitment—in developing-country governments and in the development partner community—is the most significant reason why not enough is being invested in them. Since reducing malnutrition is both an ethical imperative and central to achieving the MDGs, strengthening commitment to this is one of the most important activities in development. In almost every country, this can be done: weak commitment should seldom be seen as a binding constraint.

Currently, commitment building takes place in a largely unsystematic way rather than being treated as a recognized field of professional practice, as important to nutrition as epidemiologic or economic analysis. This needs to change. Commitment building needs to be professionalized, drawing in particular on the fields of strategic communication, political and policy analysis, and organizational behavior that seem most relevant to dealing with the three main causes of weak commitment identified here: lack of awareness or knowledge on the part of different stakeholders; institutional complexity, in terms of multiple stakeholder organizations and actors; and differing political or bureaucratic-political interests. Commitment building needs to be funded as a core development activity, with access to secure sources of funds.

Strengthening politicians’ commitment to nutrition—strengthening political will—is key to moving away from “business as usual” to an order of magnitude increase in nutrition investment. But strengthening the commitment of many other actors—from senior bureaucrats and civil society opinion leaders to communities and parents—is just as important, if commitment to implementing nutrition programs is to be sustained over the long run.

Commitment building is therefore not just about deciding to invest but also about making sure that people in implementing organizations and local communities stay committed to an endeavor that will take many years. So commitment building is not just about advocacy but also about
building partnerships and developing management capacity, particularly in the areas of leadership, motivation, and incentives.

All countries have significant resources for commitment building, and there are many ideas from successful past experience on how to go about it. Countries should move ahead with this urgent task, while building further capacity. Nevertheless, there are substantial gaps in our knowledge. Countries could usefully partner with the international nutrition community to develop best practices through learning-by-doing, especially in the following areas:

- Developing improved practical approaches for assessing commitment
- Tailoring information about the causes and consequences of malnutrition, and the need to act, so that the message appeals to different stakeholder groups
- Finding ways to make politicians feel that improving nutrition wins votes
- Learning how to unleash peoples’ energies by appealing to their values, not just by providing them with incentives to perform
- Exploring how to make nutrition programs accountable to multiple external stakeholders in order to reduce the chances of faltering commitment
- Seeing what organizational structures and processes are best for managing commitment building and how they can be financed.

Last, while all countries should seek to build commitment to multisectoral poverty reduction programs as the best way of reducing malnutrition, doing so takes time. While commitment to broad-based nutrition action is being built, it can sometimes be prudent in the short run to invest in more limited activities managed by one or two agencies, where commitment exists or can be readily strengthened, and to focus on “easier” interventions, where success will encourage the government to do more.

Country nutrition champions and policy entrepreneurs should make use of appropriate communication and management technologies to do four things:

- Build local partnerships of individuals and institutions who can influence politicians and implementing agencies to press for increased budgets for nutrition programs: domestic and international financing agencies can only put more money into nutrition if they get financing proposals for it
- Work to get nutritional status accepted as an outcome measure of poverty reduction in PRSPs and CDD programs and to get contribution
to nutritional status improvement used as a criterion for prioritizing investment

• Strengthen the capacity of implementing organizations to motivate their staff and to encourage their clients to use nutrition services and play a role in monitoring and managing them

• Identify gaps in the country’s capacity to build commitment to nutrition and seek help to fill them from local institutions, from other developing countries, or from NGOs and development assistance agencies.

The Millennium Campaign and the coalitions of advocacy NGOs are drawing up systematic plans to build political will to invest in nutrition by lobbying political leaders. The other potential international champions of nutrition—the World Bank and UNICEF—are currently not significant advocates for nutrition. They should make nutrition advocacy, as a moral imperative and human rights issue and as a key to achieving the MDGs, a routine and central part of the way they do business. For example, no senior official should visit a country that has a nutrition problem without asking his or her counterpart, “How are the children growing?”

As the main international financier of nutrition, and because improving nutrition is key to its core mandates of poverty reduction and human development, the World Bank should aim to lead, not only in direct advocacy but also in helping countries to develop their commitment-building capacity. It should dedicate staff for nutrition commitment building, develop and document best practices in the form of a “toolkit” for commitment building, and raise and manage a grant assistance fund that countries can draw on to pay for technical assistance and the cash costs of “up-front” commitment building.

Grant donors interested in nutrition—whether official agencies or foundations—do not have the resources to finance direct intervention programs at scale. They should therefore put their money into “pump-priming” commitment-building efforts that can have a huge return on investment, in terms of getting governments to allocate more of their own resources for nutrition and to seek additional development assistance for it.

Universities and research institutes active in nutrition should partner with countries and development assistance agencies, like GAIN, UNICEF, and the World Bank, to develop best practices in commitment building. They also need to build their own capacity in the areas of communication, political analysis, and management capacity development, if they want to make a significant contribution to increasing commitment.

The international nutrition community will need to invest more time and effort in building consensus about how best to reduce malnutrition, if it is
to unite in successful partnerships for country commitment building. Differing viewpoints among agencies currently hamper the development of consensus on national nutrition strategies in a number of countries. The differences include issues such as (a) the appropriate balance among health, food security, and care-related nutrition interventions in different country circumstances, (b) whether nutrition workers should be paid workers or volunteers, and (c) the place of nutrition in reform and sector-wide adjustment programs.
Appendix A
Forms of Rationality Underlying Public Policy

Table A.1 Rationality, Key Focus, and Key Concepts of Public Policy

<table>
<thead>
<tr>
<th>Rationality</th>
<th>Key focus</th>
<th>Key concepts or elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical</td>
<td>Causal analysis</td>
<td>Cause-effect relationships and mechanisms, dose-response, exposure, objectivity, uncertainty, methodology</td>
</tr>
<tr>
<td></td>
<td>Intervention analysis</td>
<td>Efficacy, effectiveness, coverage, targeting, quality, technical efficiency, unintended consequences</td>
</tr>
<tr>
<td>Economic</td>
<td>Allocative efficiency</td>
<td>Opportunity costs, incentives, self-interest, social welfare, consumer sovereignty, marginality, public and private goods, net social costs-benefits, externalities, information failures, market failures, government failures</td>
</tr>
<tr>
<td>Social, normative</td>
<td>Equity, ethics, democracy</td>
<td>Fairness, distributive justice, rights, duties, obligations, autonomy, beneficence, lack of maleficence, participation, consent, legitimacy, accountability, sovereignty</td>
</tr>
<tr>
<td>Political</td>
<td>Social allocation, freedom, power</td>
<td>Sovereignty, participation, resources, groups, identities, alliances, interests, values, compromise, reciprocity, ideologies, rules, norms, institutions</td>
</tr>
</tbody>
</table>

(Table continues on the following page.)
Table A.1 (continued)

<table>
<thead>
<tr>
<th>Rationality</th>
<th>Key focus</th>
<th>Key concepts or elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative, organizational</td>
<td>Performance, risk</td>
<td>Routines, rules, authority,</td>
</tr>
<tr>
<td></td>
<td>avoidance, survival,</td>
<td>jurisdiction, discretion,</td>
</tr>
<tr>
<td></td>
<td>expansion, control,</td>
<td>professionalism, expertise,</td>
</tr>
<tr>
<td></td>
<td>reputation</td>
<td>planning, management, political pressures, timing, opportunism,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>coping, negotiation, context, interests, beliefs,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>culture</td>
</tr>
<tr>
<td>Legal</td>
<td>Conformity</td>
<td>Laws, rules, precedents, rights, enforcement, contestation, due process</td>
</tr>
<tr>
<td>Multiple, integrative</td>
<td>Effective, appropriate</td>
<td>Wisdom, judgment, justice,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>dignity, fairness, and competence in analysis, deliberation, and participation; legitimate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>representation of public values and interests</td>
</tr>
</tbody>
</table>

# Appendix B

## Potential Stakeholders in Nutrition Programs

### Table B.1 Stakeholder Groups and Their Members

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual clients</td>
<td>Mothers, children</td>
</tr>
<tr>
<td>Local-level influencers</td>
<td>Fathers, in-laws, politicians, elders, religious leaders, schoolteachers</td>
</tr>
<tr>
<td>Local-level groups</td>
<td>Mothers’ groups, peoples’ organizations, NGOs, occupational groups, caste or class groups, groups of people living near each other</td>
</tr>
<tr>
<td>Local-level workers</td>
<td>Health extension workers, social welfare extension workers, agricultural extension workers, ration shop employees</td>
</tr>
<tr>
<td>Local-level planners</td>
<td>Planning officers, statisticians, doctors, other sectoral planners</td>
</tr>
<tr>
<td>Regional planners(^a)</td>
<td>Planning officers, sectoral planners</td>
</tr>
<tr>
<td>Central planners, bureaucrats, regulators, technical experts</td>
<td>Planning ministry, finance ministry, health ministry, social welfare ministry, agriculture ministry, food ministry, food regulation ministry, law ministry, water and sanitation ministry, interior and local government ministry, nutrition institutes, policy analysis institutes, data collection and evaluation agencies</td>
</tr>
<tr>
<td>Central-level influencers</td>
<td>Prime minister, minister of finance, minister of planning, minister of health, minister of agriculture, minister of social welfare, minister of water and sanitation, minister of interior, local government, parliament, congress, parliamentary and congressional committees, individual politicians with special interests, NGOs, newspapers, television, radio, Internet, celebrities</td>
</tr>
</tbody>
</table>

(Table continues on the following page.)
Table B.1 (continued)

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food industry</td>
<td>Manufacturers, processors, advertisers</td>
</tr>
<tr>
<td>International</td>
<td>Development banks, bilateral development assistance agencies, United Nations technical assistance agencies, universities and research institutes, foundations, international NGOs, national legislatures, developing-country ministries of agriculture, food, and trade, World Trade Organization and other trade organizations, farmers’ unions</td>
</tr>
</tbody>
</table>

a. Depending on the system, politicians and planners may be important stakeholders at one or more levels (for example, regional, provincial, and municipal).
Appendix C
A Client-Centered Formative Research Approach: Trials of Improved Practices (TIPS)

Inappropriate breast-feeding and weaning practices are the most significant immediate cause of protein-energy malnutrition. The success of a PEM program therefore depends critically on how far mothers are prepared to change the way they feed their children. It follows that understanding this should be a core part of the program design process. But all too often, nutrition education messages are based on theoretical notions about correct feeding practices, without testing what practices are acceptable to families, in light of the foods that are locally available and their cost and in light of families’ taste and cooking preferences, beliefs, and cultural traditions.

It is not uncommon for more design effort to go into the support aspects of nutrition programs—training, supervision, and management information systems, for example—than into the design of key behavioral changes at the household level that will directly determine the program’s success or failure. The TIPS process sets out to fill this common gap in program design by providing a systematic procedure for finding out how children are currently fed and in what ways traditional feeding practices are inappropriate, for testing different alternatives, and for working with representative client families to be sure that proposed changes are feasible. TIPS has been used in a wide variety of countries, including Cameroon, Eritrea, the Gambia, Ghana, Niger, Nigeria, Senegal, Swaziland, Tanzania, and Uganda in Africa; India, Indonesia, and Pakistan in Asia; and Bolivia, Ecuador, El Salvador, and Honduras in Latin America, so there is a substantial reservoir of positive experience with it.

The TIPS process begins with a review of all available research in the country on feeding and eating practices and of previous project and program experience with changing behavioral practices. But the core of TIPS is actually trying out possible program interventions with sample client households. Ideally, the process takes place over a two-week period, with three visits for each family in the sample.
On the first visit, researchers ask mothers to do a detailed dietary recall of what they feed their children, both when they are well and when they are ill. They also discuss with mothers why they follow the practices they do. This helps researchers to draw up a list of problem practices after the initial visit, gain some initial insight into which practices are likely to be resistant to change, and prepare a set of alternative practices that are likely to have better nutritional results.

On the second visit, one or two days after the first, the researchers explain to mothers why some of their existing practices are inappropriate, offer some alternatives, and get mothers’ reactions to them. A key feature of this second visit is that mothers are not told what to do: the purpose of the meeting is to negotiate a set of revised feeding practices that will be better from a nutritional standpoint and that mothers are prepared to try out.

The third visit takes place after mothers have had time to try what was agreed, five to eight days after the second visit. It provides invaluable information about which new practices are feasible and acceptable and which are not. It often leads to changes in the agreed set of new practices, for further trial. Researchers learn from the process not only what practices are feasible but also why families resist adopting particular new practices and what arguments and messages are most successful in helping them to overcome these resistances—invaluable information for the design of behavior change communication messages that will later be communicated on a program-wide scale by field workers.

Two things make it feasible to incorporate TIPS as a routine part of the design of all nutrition behavior change programs. First, the procedure is relatively straightforward, and a how-to manual based on a great deal of field experience is available (Dickin, Griffiths, and Piwoz 1997): because of this, TIPS can be implemented by field researchers who do not have prior training in qualitative research methodologies. Second, it has been found that trials with relatively small samples, often of less than 50 families, can yield findings that are valid for entire populations, providing the families are carefully chosen to represent the local diversity of feeding practices. This, in turn, means that a TIPS research activity in three diverse country settings can usually be completed in two to four months, for a cost ranging from $8 to $30,000 (information on time frame and cost from Marcia Griffiths, president of Manoff Group, personal communication).
Appendix D

Using PROFILES Simulations as an Advocacy Tool to Promote Investment in Nutrition

PROFILES, developed by the Academy for Educational Development (AED), a Washington-based international organization, is a computer simulation tool used for policy analysis and advocacy. PROFILES projects the functional consequences of poor nutrition on mortality, morbidity, worker productivity, mental development, and fertility and estimates the economic benefits that can be realized through nutrition programs. It is designed to assist countries in making economic, social, and health-related arguments for investing in nutrition. To date, more than 25 countries have participated in national-level PROFILES training, while several others have taken part in regional training. Many institutions and governments are using PROFILES in nutrition advocacy, including efforts to convince policymakers that nutrition should be a crucial component of national poverty reduction strategies because it addresses the roots of poverty in poor human capital formation.

The computer simulations are used as part of a participative process, involving key stakeholders involved in decisions about investment in nutrition, human development, and poverty reduction. The simulations offer the opportunity for interactive participation, in which stakeholders can vary assumptions about the coverage and effectiveness of interventions and see the impact on human development and the economy (for an interactive example of how the technology can be applied to underweight and anemia control programs, see “PROFILES calculators” at www.aedprofiles.org). The computer simulations are normally run as part of a broader participative planning process, which can include some or all of the following (Stiefel 2002):

- Situational analysis
- Community nutrition assessment
- Spreadsheet vulnerability indicators, including benefit-cost analysis
- Nutrition policy and program assessment
• Capacity-building plan
• Policy brief
• Nutrition strategy
• Advocacy nutrition action plan matrix, including resource mobilization plan
• PowerPoint communication presentation.

How Has PROFILES Been Used?

Helen Stiefel, AED PROFILES coordinator, provided the following examples (personal communication).

In *Bangladesh*, PROFILES was first used in 1993 by the Ministry of Health, UNICEF, and the World Bank to highlight the tremendous nutrition problems faced by the country and the social and economic benefits that would result from reducing these problems (box 6.2).

In *the Philippines* in 1994, the Asian Development Bank and the Department of Health requested a PROFILES cost-benefit analysis to promote their iron and iodine supplementation programs. Using conservative assumptions, PROFILES showed a cost-benefit ratio of 1.8 to 1 and 7.8 to 1 for the iron and the iodine supplementation interventions, respectively.

In *Togo* in 1999, PROFILES simulations showed that reducing stunting could increase the wage earnings of agricultural workers by $42 million over eight years. If no nutrition intervention were put in place to address stunting, productivity losses would be an estimated $134 million over eight years. The Togo analysis brought the problems of child malnutrition to the attention of the health minister and was instrumental in generating a proposal to UNICEF for a new household food security initiative.

In *Ghana* in 2001, following the PROFILES analysis, nutrition became the top priority of the Ghana Vision 2020 health sector strategy.

In *China* in 2001, two innovations were added to the standard PROFILES simulations. Projections for iron deficiency anemia were calculated for adults (men and women) and for children, instead of only for women of reproductive age, as in the past. Also for the first time, the implications of malnutrition for noncommunicable diseases, including diabetes and hypertension, were analyzed. Both sets of calculations were done for different regions and for urban and rural areas. This highlighted big disparities between urban and rural environments and between provinces, an important policy issue.

In *Benin* in 2004, PROFILES simulations with a multisectoral group including agriculturists, nutritionists, economists, teachers, and statisticians focused particularly on the benefits of reducing iron deficiency anemia, which affects 68 percent of women of reproductive age there. The analysis
showed that reducing anemia could increase the wages earned by reproductive-age women over the next 10 years from about $636 million to about $805 million, an increase of 26 percent, and that, for each dollar invested in reducing anemia in women, there is a productivity gain of $9.

**Opportunities and Issues**

Aside from its existing use to highlight the benefits of investing in nutrition for ministries of health and to finance and planning agencies, PROFILES has unexploited potential as a participative planning tool in the context of the PRSP process. AED has detailed the possible uses of PROFILES for this in a draft paper (Stiefel 2002), obtainable from hstiefel@aed.org.

The results of PROFILES simulations vary dramatically, depending on the assumptions made about outcome responses to different nutrition interventions and on the quality of the nutrition data fed into the model. Some input-outcome responses are estimated based on data from research studies in a small number of countries, which may or may not be replicable in other country environments. One challenge is to convince nutrition specialists in major funding agencies, such as the World Bank, that the model’s results are robust and reliable in a variety of country circumstances.

**What Does PROFILES Cost?**

The cost of implementing a full PROFILES process is around $50,000, including the costs of foreign technical assistance. AED has found that technical assistance is required to help:

- Design the participative planning process
- Review the quality and appropriateness of local nutrition and demographic data that need to be entered into the model
- Decide which simulations are most appropriate to country circumstances
- Review what input-outcome assumptions are appropriate to country circumstances
- Develop a communication strategy and messages based on the results of the simulations.
## Appendix E

**Contribution of Improved Nutrition to the MDGs**

### Table E.1 Contribution of Improved Nutrition to the Millennium Development Goals

<table>
<thead>
<tr>
<th>Goal</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eradicate extreme poverty and hunger</td>
<td>Undernutrition erodes human capital, reduces resilience to shocks, and reduces productivity (through effects on physical and mental capacity). Early child undernutrition is partially irreversible and intergenerational, with consequences for adult health, including an increased risk of chronic disease.</td>
</tr>
<tr>
<td>2. Achieve universal primary education</td>
<td>Undernutrition reduces cognitive function. Undernourished children are less likely to enroll in school or enroll later than other children. Current hunger and undernutrition reduce school performance. Iodine and iron are critical for cognitive development. Undernutrition may disable (vitamin A and blindness; iodine deficiency and impaired mental development).</td>
</tr>
<tr>
<td>3. Promote gender equality and empower women</td>
<td>Gender inequality increases the risk of female undernutrition, which erodes human capital and reduces women’s access to assets. Better-nourished girls are more likely to stay in school.</td>
</tr>
<tr>
<td>4. Reduce child mortality</td>
<td>Undernutrition is directly or indirectly associated with more than 50 percent of all child mortality. Undernutrition is a significant contributor to childhood infections, which exacerbate child mortality in the developing world. Micronutrients are key to child survival (particularly vitamin A and zinc). Breast-feeding and appropriate and timely complementary feeding are key to child survival.</td>
</tr>
</tbody>
</table>
5. Improve maternal health

Undernutrition and anti-female bias in allocations of food, health, and care compromise maternal health. Undernutrition is associated with many of the major risk factors for maternal mortality. Stunting increases the risk of cephalopelvic disproportion and obstructed labor. Deficiencies of several micronutrients (iron, vitamin A, folate, iodine, calcium) are associated with complications during pregnancy.

6. Combat HIV/AIDS, malaria, and other diseases

Undernutrition hastens the onset of AIDS among HIV-positive individuals. Undernutrition may compromise efficacy and safety of treatments for the AIDS-related virus and weaken the resistance to opportunistic infections. Undernutrition reduces malaria and diarrhea survival rates. Different forms of undernutrition (both undernutrition and overnutrition) are important risk factors for diet-related chronic disease.

Source: Reproduced, with permission, from Sethuraman and others (2004, table 3).

<table>
<thead>
<tr>
<th>Goal</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Improve maternal health</td>
<td>Undernutrition and anti-female bias in allocations of food, health, and care compromise maternal health. Undernutrition is associated with many of the major risk factors for maternal mortality. Stunting increases the risk of cephalopelvic disproportion and obstructed labor. Deficiencies of several micronutrients (iron, vitamin A, folate, iodine, calcium) are associated with complications during pregnancy.</td>
</tr>
<tr>
<td>6. Combat HIV/AIDS, malaria, and other</td>
<td>Undernutrition hastens the onset of AIDS among HIV-positive individuals. Undernutrition may compromise efficacy and safety of treatments for the AIDS-related virus and weaken the resistance to opportunistic infections. Undernutrition reduces malaria and diarrhea survival rates. Different forms of undernutrition (both undernutrition and overnutrition) are important risk factors for diet-related chronic disease.</td>
</tr>
<tr>
<td>diseases</td>
<td></td>
</tr>
</tbody>
</table>
Appendix F
Sustaining Commitment to Program Implementation through Extrinsic Motivation

Extrinsic motivation, which stems from external incentives and pressures to perform, can help to sustain commitment to the implementation of nutrition programs. The following paragraphs present some techniques for motivating clients, workers, and managers.

*Provide clients with information about the extent of malnutrition.* Clients will only demand nutrition services if they know they are malnourished. Since malnutrition typically rises and falls at different times of the year, monthly growth monitoring is the only way for clients to know the extent of malnutrition in their local area.

*Provide clients with information about the adverse consequences of malnutrition and the benefits of intervening.* Clients are more likely to use nutrition services if they understand the serious consequences of malnutrition and the benefits to them of reducing it. The kind of messages about benefits to the economy that should be developed for decisionmakers (chapter 7) are not appropriate for clients, and action research is needed on how to adapt these messages to families and communities.

*Provide clients with convenient services.* Poor people have little time to spare after working and fetching water. As an incentive to use nutrition services, the infrastructure network needs to be dense enough for community nutrition centers or weighing posts to be available in every village or for regular outreach visits to all families at risk of malnutrition.

*Provide clients with cash transfers or food.* Mexico’s Progresa program provides poor clients with cash transfers on condition that they bring their children for regular growth monitoring and health checkups. The provision of food supplements in PEM programs is controversial, from a technical and financial perspective. But there is little doubt that providing food encourages clients to participate, as it has in Bangladesh, Costa Rica, Tamil Nadu, and Thailand.
Give clients information about program performance. Posting growth monitoring data publicly in each village, as in Bangladesh, Tamil Nadu, and Thailand, is a simple but powerful tool, sending the message that the program is accountable to local people, not just to program managers. Appendix G shows the information about progress in meeting basic needs that is publicly displayed in Thai villages; nutrition information plays a prominent part.

Pay village workers. Some successful programs, like Thailand’s, have relied on volunteers; others, like TINP, have paid their community workers small honorariums. Volunteers cannot spare much time, so many are needed to provide convenient services—one for every 10–20 households in some programs. By contrast, TINP’s paid workers could put in five or six hours a day, making it possible for one worker to cover 200–300 households. The smaller number of field staff made it possible to give them intensive supervision and training, which helped to motivate them (box 7.1).

Give village workers and managers feedback about performance. Most monitoring systems collect too much information and send it up the management system, where it is processed slowly (if at all) and is used to inform senior managers rather than motivate field managers and field workers. But local information can be locally processed, locally displayed, and used to motivate local action, as in Thailand. In the best-managed programs, it has proved possible to aggregate performance information for the entire program and get feedback down to the bottom of the system within a month of the data being generated. For a village or district to know how it is performing relative to other areas is an important motivator. Appendix H, on TINP, shows (a) the performance information that was locally processed and displayed at community nutrition centers, (b) the key indicators that were processed centrally for each nutrition center on a monthly basis, and (c) the performance trigger points that project managers used to alert low-performing centers. Identifying and focusing on low-performing units or areas in this kind of “management by exception” approach makes the best use of scarce management skills.

Use participative micro planning to motivate workers and managers. Too often, nutrition programs have had broad, overly ambitious impact objectives and failed to translate them into feasible plans for individual workers and managers, related to inputs and outputs over specific time periods. Workers and managers can be motivated by having them participate in setting their own goals, by having them make a public commitment to achieving them, and by making sure that the planning time frame is short enough for the worker or manager to get rapid, motivating feedback about performance (Matta, Ashkenas, and Rischard 2002).
Monitor service quality not just achievement of quantitative targets. This can be facilitated by incorporating quality indicators into service protocols, so technical quality can be monitored, and through periodic surveys of the quality of provider-client interactions, preferably by an independent organization with professional skills in formative research. There is relatively little experience with systematic approaches to quality management in nutrition programs, and this is another priority area for action research.
Appendix G
Keeping Communities Informed about Progress in Meeting Basic Needs: Thailand’s Village Information System

Four government ministries (health, agriculture, education, and interior), led by the Ministry of Public Health, jointly developed the basic minimum needs (BMN) system. The system was piloted in Korat Province in the northeast and then picked up by the National Economic and Social Development Board, Thailand’s planning ministry, and implemented nationwide. The 32 BMN indicators are divided into eight groups, as shown in table G.1.

Table G.1 BMN Indicators in Thailand’s Village Information System, by Group

<table>
<thead>
<tr>
<th>Group</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate food and nutrition</td>
<td>1. Proper nutrition surveillance is conducted from birth to five years, and no moderate and severe PEM is found.</td>
</tr>
<tr>
<td></td>
<td>2. Schoolchildren receive adequate food for nutritional requirements.</td>
</tr>
<tr>
<td></td>
<td>3. Pregnant women receive adequate and proper food and deliver newborn babies with birthweight not less than 3,000 grams.</td>
</tr>
<tr>
<td>Proper housing and environment</td>
<td>4. The house will last at least five years.</td>
</tr>
<tr>
<td></td>
<td>5. Housing and the environment are hygienic and in order.</td>
</tr>
<tr>
<td></td>
<td>6. The household possesses a hygienic latrine.</td>
</tr>
<tr>
<td></td>
<td>7. Adequate clean drinking water is available all year round.</td>
</tr>
</tbody>
</table>

(Table continues on the following page.)
<table>
<thead>
<tr>
<th>Group</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate basic health and education services</td>
<td>8. Infants under one year receive BCG, DPT, OPV, and measles vaccine.</td>
</tr>
<tr>
<td></td>
<td>9. All children receive primary education.</td>
</tr>
<tr>
<td></td>
<td>10. Primary schoolchildren are immunized with BCG, DPT, and typhoid vaccine.</td>
</tr>
<tr>
<td></td>
<td>11. Citizens 14–50 years old are literate.</td>
</tr>
<tr>
<td></td>
<td>12. Monthly education and information are offered in health care, occupation, and other important areas for the family.</td>
</tr>
<tr>
<td></td>
<td>13. Antenatal services are adequate.</td>
</tr>
<tr>
<td></td>
<td>14. Delivery and postpartum services are adequate.</td>
</tr>
<tr>
<td>Security and safety of life and property</td>
<td>15. People and properties are secure.</td>
</tr>
<tr>
<td>Efficiency in the family’s food production</td>
<td>16. Families grow alternative crops or soil production crops.</td>
</tr>
<tr>
<td></td>
<td>17. Families use fertilizers to increase yields.</td>
</tr>
<tr>
<td></td>
<td>18. Families employ prevention and control of pests in plants.</td>
</tr>
<tr>
<td></td>
<td>20. Families grow proper genetic plants and raise proper genetic animals.</td>
</tr>
<tr>
<td>Family planning</td>
<td>21. There are no more than two children per family, and family planning services are adequate.</td>
</tr>
<tr>
<td>People’s participation in community development</td>
<td>22. Each family is a member of self-help activities.</td>
</tr>
<tr>
<td></td>
<td>23. The village is involved in self-development activities.</td>
</tr>
<tr>
<td></td>
<td>24. Public properties are cared for.</td>
</tr>
<tr>
<td></td>
<td>25. Culture is cared for and promoted.</td>
</tr>
<tr>
<td></td>
<td>26. Natural resources are preserved.</td>
</tr>
<tr>
<td></td>
<td>27. People are active in voting.</td>
</tr>
<tr>
<td></td>
<td>28. The village committee is able to plan and implement projects.</td>
</tr>
<tr>
<td>Spiritual or ethical development</td>
<td>29. Family members are cooperative and helpful in the village.</td>
</tr>
<tr>
<td></td>
<td>30. Family members are involved in religious practices once a month.</td>
</tr>
</tbody>
</table>
Family members do not gamble and are not addicted to alcohol or other drugs.

The family’s standard of living and expenses are moderate.

Table G.1 (continued)

<table>
<thead>
<tr>
<th>Group</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>31.</td>
<td>Family members do not gamble and are not addicted to alcohol or other drugs.</td>
</tr>
<tr>
<td>32.</td>
<td>The family’s standard of living and expenses are moderate.</td>
</tr>
</tbody>
</table>

a. BCG, vaccine for tuberculosis; DPT, vaccine for diphtheria, pertussis, and tetanus; OPV, vaccine for oral polio.
Appendix H
Using Monitoring Information as a Motivator: The Tamil Nadu Integrated Nutrition Project

The following information is publicly displayed at TINP’s Community Nutrition Centers (World Bank 1990):

- Population of area
- Number of children 0–3 years of age
- Number of children 0–3 weighed last month
- Number of children enrolled for feeding
- Number of children coming for feeding
- Number with grade-three and grade-four malnutrition
- Number graduated out of severe malnutrition
- Number of children losing or with static weight
- Number of children under special observation
- Number coming into the feeding program
- Number of children graduating from supplementary feeding last month
- Number of children relapsing into supplementary feeding this month
- Number of mothers receiving antenatal care.

In addition, the TINP Project Coordination Office prepares the following key indicators on a monthly basis (Shekar 1991):

- Number of children 6–36 months as a percentage of the total population
- Number of children 6–36 months newly entered into the program as a percentage of the number of children 6–36 months
- Number of children 6–36 months weighed as a percentage of the number of children 6–36 months
- Number of children eligible for feeding as a percentage of the number of children 6–36 months weighed
- Number of children 6–24 months in normal and first-grade malnutrition as a percentage of the total number of children 6–24 months weighed
• Number of children 25–36 months in normal and first-grade malnutrition as a percentage of the total number of children 25–36 months weighed
• Number of children 6–36 months in normal and first-grade malnutrition as a percentage of the total number of children 6–36 months weighed
• Number of children 6–24 months in grade-two malnutrition as a percentage of the total number of children 6–24 months weighed
• Number of children 25–36 months in grade-two malnutrition as a percentage of the total number of children 25–36 months weighed
• Number of children 6–36 months in grade-two malnutrition as a percentage of the total number of children 6–36 months weighed
• Number of children 6–24 months in grade-three and grade-four malnutrition as a percentage of the total number of children 6–24 months weighed
• Number of children 25–36 months in grade-three and grade-four malnutrition as a percentage of the total number of children 25–36 months weighed
• Number of children 6–36 months in grade-three and grade-four malnutrition as a percentage of the total number of children 6–36 months weighed
• Number of children receiving food supplement as a percentage of the number of children 6–36 months
• Number of children receiving food supplement in current month as a percentage of the number of children eligible for supplement in the previous month
• Number of children entering feeding for the first time as a percentage of the total number of children weighed
• Number of children under feeding for more than three months as a percentage of the total number of children under feeding
• Number of children under feeding for more than six months as a percentage of the total number of children under feeding
• Number of children graduated in 90 days as a percentage of the number of children fed in the last three months
• Number of children graduated in 120 days as a percentage of the number of children fed in the last four months
• Number of children graduated in 150 days as a percentage of the number of children fed in the last five months
• Number of children graduated in 180 days as a percentage of the number of children fed in the last six months
• Total number of children graduated as a percentage of the total number of children in feeding minus the number of children under feeding in the first and second month
• Number of cases of first relapse as a percentage of the number of cases graduated during the last six months
• Number of cases of second relapse as a percentage of the number of cases graduated during the last six months
• Number of total cases of relapse as a percentage of the number of cases graduated during the last six months
• Number of children absent for five days or more as a percentage of the number of children receiving food supplement
• Number of pregnant women entering feeding in the third trimester as a percentage of the number of pregnant women in the third trimester
• Number of pregnant and nursing women receiving supplement as a percentage of the number of pregnant women in the third trimester and nursing women in the first four months
• Number of women absent for five days or more as a percentage of the number of women receiving food supplement
• Number of children less than three years old given vitamin A as a percentage of the number of children less than three years old
• Number of children less than three years old dewormed as a percentage of the number of children less than three years old
• Number of diarrhea cases treated by community nutrition workers as a percentage of the number of children affected by diarrhea
• Number of children affected by diarrhea as a percentage of the number of children 6–36 months
• Number of diarrhea cases referred to multipurpose health workers as a percentage of the number of cases treated by community nutrition workers
• Number of dropout cases as a percentage of the number of children under feeding during the quarter.

Table H.1 presents the information on inputs and outputs that triggers intervention by the TINP Coordination Office.

Table H.1 Trigger Points for Intervention by the TINP Coordination Office

<table>
<thead>
<tr>
<th>Information reported</th>
<th>Action initiated&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of project inputs</td>
<td></td>
</tr>
<tr>
<td>Coverage for weighing (6–36 months)</td>
<td>&lt;80</td>
</tr>
<tr>
<td>Coverage for feeding (6–36 months)</td>
<td>&lt;20</td>
</tr>
<tr>
<td>Coverage of pregnant or lactating women (feeding)</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Number of pregnant or lactating women entering feeding each month</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Vitamin A prophylaxis (last six months)</td>
<td>&lt;30</td>
</tr>
</tbody>
</table>
### Table H.1 (continued)

<table>
<thead>
<tr>
<th>Information reported</th>
<th>Action initiated^a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deworming drug (last month)</td>
<td>&lt;40</td>
</tr>
<tr>
<td><strong>Quality of project outputs</strong></td>
<td></td>
</tr>
<tr>
<td>Number of grade-three and grade-four malnutrition (6–36 months)</td>
<td>&gt;10</td>
</tr>
<tr>
<td>Number entering feeding per month</td>
<td>&lt;2</td>
</tr>
<tr>
<td>Number fed more than three months</td>
<td>&gt;40</td>
</tr>
<tr>
<td>Number fed more than six months</td>
<td>&gt;20</td>
</tr>
<tr>
<td>Number graduated in 90 days</td>
<td>&lt;50</td>
</tr>
<tr>
<td>Total number graduated</td>
<td>&lt;30</td>
</tr>
<tr>
<td>Number relapsed in the last month as a percentage of the number graduated in the last six months</td>
<td>&gt;3</td>
</tr>
</tbody>
</table>

^a. Remedial action notices issued if percentage is greater or less than the number indicated.

Notes

1. Direct nutrition programs include (a) three types of micronutrient programs—micronutrient supplementation, mainly with vitamin A, iron, and iodine; efforts to get people to grow and eat more micronutrient-rich foods; and fortification of commercially produced food with micronutrients—and (b) growth promotion programs, which usually include growth monitoring, health and nutrition education, plus some combination of basic health care, food supplementation, and food security or safety net interventions.

2. Care-based nutrition programs are targeted mainly to pregnant and lactating women and very young children; they focus on growth monitoring, nutrition education, and improved caring practices, such as exclusive breast-feeding and the right amount and type of weaning foods.

3. For example, in a comprehensive textbook on public policy, Parsons (1995) identifies political science, sociology, organizational theory, economics, psychology, and management as some of the social sciences that have contributed to our understanding of decisionmaking, which is only one element of the policy process. He also identifies five major approaches to decisionmaking that crosscut or overlap with these social sciences: power, rationality, public choice, institutional, and informational and psychological. The proliferation of disciplines, subdisciplines, and schools of thought on public policy has created a highly fragmented body of knowledge about the policy process.

4. A Geneva-based organization created in 2002 to coordinate and finance global food fortification efforts.

5. The Philippines considered—but wisely avoided—promoting its fortified vitamin rice as FVR—the initials of the then president. Bangladesh wisely called its PEM intervention BNP (the Bangladesh Integrated Nutrition Project), rather than BNP, at a time when the Bangladesh National Party was in power.

6. For example, UNICEF sponsored a multimedia religious effort in Indonesia at one point, including singling out and highlighting portions of the Koran that dealt with nutrition and helping those in need and suggesting topics for mullahs to raise with their congregations.

7. This quote is from a mother commenting on the program’s day care arrangements; that it was picked up as the title of a report on the program as a whole suggests something of the optimism of the time.

8. As distinguished from food aid, where the World Food Program and the United States are the main financiers.
9. TINP’s unique approach to supplementation helped to gain widespread community support. Cheaper than previous, untargeted feeding programs, it supplemented only about 25 percent of client children each day (because children entered into supplementation only when they were malnourished and left when they improved). But by supplementing 75 percent of client children at different times, it increased the program’s acceptability to communities.
The word “processed” describes informally produced works that may not be commonly available through libraries.


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Malnutrition persists in most developing countries. It contributes to the deaths of 3.4 million children annually and reduces the intelligence, health, and productivity of those who survive. Nutrition programs—indeed all human development programs—succeed or fail depending in part on the commitment of politicians, bureaucrats, and communities to properly implement them, both initially and over the long term.

Technical, economic, and organizational issues get the lion’s share of attention in designing nutrition and other human development programs. But the success of such programs often depends on two variables: whether countries back them with adequate financing and whether countries sustain a commitment to high-quality implementation. This book argues that assessing and strengthening country commitment should therefore become a new field of systematic professional practice. This new field requires expertise in political and policy analysis, organizational behavior, and strategic communication.

Focusing on a variety of country programs in nutrition—both successful and failed—the book describes practical ways to assess and strengthen commitment and outlines an agenda for “learning by doing.” In addition to political will, programs need to build support and commitment across government and civil society, from local leaders to parents. To sustain that commitment, organizational structures and processes must be designed to motivate communities and officials over the 15 to 20 years it takes to successfully implement a national nutrition program.

This book will especially appeal to those in the fields of nutrition, public health, community and economic development, and political science.