

---

---

## Annex 3

# Key Priorities for Action Research in Nutrition: A Proposal

### **Mainstreaming Nutrition in the Development Agenda**

A new programming environment is emerging at the global and country levels. The move from projects to programs, from vertical, disease-specific approaches to sectorwide approaches (SWAps), and budget support are all part of this changing picture. The roles of civil society and the private sector are becoming more important in global health and nutrition. The focus on results has never been higher on the agenda of development partners. These changes call for some adjustments in how the nutrition agenda is furthered. Four key areas of action research are critical in making these adjustments:

- *Mainstreaming nutrition into health, agriculture, rural development, education, and social protection programs.* As outlined in chapter 1, evidence now shows that several of the health and other Millennium Development Goals (MDGs) will not be met without investments in improving nutrition. Some evidence suggests that nutrition education efforts and other demand-side interventions may be necessary but not sufficient to improve outcomes unless these efforts are linked to supply-side interventions such as improved access to health services and micronutrient supplementation and fortification, supplementary feeding, and increased access to cheaper fruits and vegetables for addressing overweight. Programs across many sectors have attempted to include nutrition interventions. Yet very little information is available on how best to do so or which approaches are successful. The Bank-supported development grant for the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) will look at opportunities to include nutrition in maternal

and child health programs. There is a need to review and support similar experiences in other sectors.

- *Guidelines and instruments for assessing institutional capacity.* As outlined in chapter 4, a key constraint on action in nutrition is the institutional arrangements and capacity for nutrition.<sup>11</sup> Many programs are unsuccessful because not enough effort is invested in assessing capacities and in defining capacity needs. Developing guidelines and instruments for assessing institutional capacity and identifying best practices for institutional arrangements in different country scenarios will be critical to helping countries make rational assessments for scaling up programs. Human resource options for nutrition service delivery under different institutional arrangements and their management and fiscal implications need to be researched.
- *Building commitment for nutrition.* How should these commitment-building approaches vary in different country circumstances, and how can international and local stakeholders best partner to strengthen commitment?
- *Costing and financing interventions and service delivery approaches in varied country circumstances.* The Copenhagen Consensus (Behrman, Alderman, and Hoddinott 2004) has shown that nutrition interventions rank very high among other interventions in terms of cost-benefit. While some information is available for costing individual interventions, very little is available on large-scale programs and the levels of investments needed to meet the nutrition MDGs.

## **Strengthening and Fine-Tuning Delivery Mechanism**

- *Exploring the replicability of new delivery mechanisms for nutrition services.* Where government capacities for implementation are limited, countries have explored service delivery through nongovernmental organizations (NGOs), as in Bangladesh. Lessons suggest that this may warrant an alternative capacity for contracting and managing NGOs. In other countries (such as Mexico and Honduras), conditional cash transfers have been used as an opportunity for strengthening the use of health and nutrition services. In the micronutrient sector, public-private partnerships and alliances are being explored. Experience and learning from these innovations needs to be tested in other environments for future adaptation and scaling-up.
- *Research to support a clearer understanding of how far micronutrient supplementation can take us (and for which micronutrients), how long it should be continued under different conditions, and whether fortification or food-based*

*strategies are sufficient.* The efficacy of biofortification and other emerging food-based strategies for micronutrient deficiency control is being explored through initiatives such as the Harvest Plus program. These strategies have immense potential that must be maximized.

- *Cost-effectiveness of food supplementation (linked to nutrition education), and conditions under which costs may outweigh potential benefits.* Food supplementation often consumes 50 percent or more of program budgets. Evidence suggests that to be effective, food supplementation must be linked to nutrition education through growth promotion or other strategies, especially for young children. Yet the evidence is unclear as to what the best targeting mechanisms are and when costs may outweigh benefits.
- *Devise methodologies for forging stakeholder consensus* around results from operations research and monitoring and evaluation as well as the programmatic vision and capacities to fine-tune strategies based on these inputs.

### **Strengthening the Evidence Base:**

- *Evidence-based strategies to prevent and reduce overweight and diet-related noncommunicable diseases (NCDs).* This is a key challenge because it affects both rich and poor countries; these problems contribute substantially to chronic disease and mortality, as well as to economic growth; and reversing overweight offers huge public expenditure savings in both low-income and middle-income countries. The poor in low socioeconomic status countries (gross national product [GNP] less than \$2,500 per capita) may be protected against obesity, but the poor in upper middle-income countries (GNP greater than \$2,500 per capita) are much more prone to obesity.<sup>12</sup> In addition, the Barker hypothesis suggests that fetal food deprivation may result in postnatal programming that predisposes low-birthweight babies to cardiovascular disease and diabetes.<sup>13</sup> Furthermore, in many areas obesity coexists with underweight.<sup>14</sup> However, precise information on the size and scope of the overweight problem as well as the diet-NCD link and tested large-scale interventions on how to address them are still limited. Therefore, the priority here is to find out more about these issues as we move toward scaling up.
- *Efficacy and effectiveness of different nutrition interventions for preventing and mitigating the effect of HIV/AIDS.* These interventions include the role of exclusive breastfeeding in preventing mother-to-child transmission of HIV/AIDS; the role of nutrition in enhancing the effectiveness of anti-retroviral therapy; and the role of food security in mitigating the risk of HIV infection.

- *Linking nutrition data with larger global monitoring initiatives.* Several larger global health and poverty monitoring initiatives (such as the Health Metrics Network) are under development. Development partners and funding agencies are keen to support integrated systems, and it is important that relevant nutrition indicators be included in these initiatives. This will need some research support.
- *Methodologies for evaluating nutrition actions in the context of programmatic approaches such as SWAps and Poverty Reduction Strategy Credits (PRSC)s.* The current evaluation methodologies may need to be adjusted and adapted to these new approaches. In addition, the indicators that are used for assessing progress in nutrition are much harder to apply than those in other sectors. For example, the MDG progress indicator for the education sector is school enrollment rates. The nutrition indicator is underweight rates. While the education indicator is much closer to being a process or output indicator, the nutrition indicator is much more of an impact indicator—and the time frame for achieving an impact in underweight is much longer than that for enrolling children in school. In the choice of indicators, we may be setting nutrition up for higher standards than other sectors. This issue needs some research. In addition, many traditional nutrition evaluations have looked for the benefits of programs across population groups as whole—for example, low-birthweight prevention programs have looked for an impact among all pregnant women. However, emerging research has shown that these benefits may be unequally distributed across different groups (for example, the poorest or the most malnourished may benefit more), or that benefits may be distributed differently across the mother-child dyad under different situations—yet the evaluation methodology used often limits the size and nature of the benefits that can be detected.