Developing state capacity to prevent malnutrition in Sierra Leone:

An analysis of development partner support

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The Secure Livelihoods Research Consortium (SLRC) is a six-year project funded by DFID, Irish Aid and the EC. SLRC aims to bridge the gaps in knowledge about:

- When it is appropriate to build secure livelihoods in conflict-affected situations (CAS) in addition to meeting immediate acute needs;
- What building blocks (e.g. humanitarian assistance, social protection, agriculture and basic services) are required in different contexts;
- Who can best deliver building blocks to secure livelihoods in different contexts; and
- How key investments can be better and more predictably supported by effective financing mechanisms.

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Acronyms

ACC	Anti-Corruption Commission
BFHI	Baby-Friendly Hospital Initiative
CAADP	Comprehensive Africa Agriculture Development Programme
CHP	Community Health Post
CHC	Community Health Clinic
CHW	Community Health Worker
COMAHS	College of Medicine and Allied Health Sciences
CMAM	Community based Management of Acute Malnutrition
CSO	Civil Society Organisation
DACO	Development Assistance Coordination Office
DHMT	District Health Management Team
DMO	District Medical Officer
ECDPM	European Centre for Development Policy Management
ECOWAS	Economic Community of West African States
FAO	Food and Agriculture Organisation
GAVI	Global Alliances for Vaccines and Immunisation
GDP	Gross Domestic Product
GoSL	Government of Sierra Leone
HIV	Human Immunodeficiency Virus
HKI	Helen Keller International
HMIS	Health Management Information System
IYCF	Infant and Young Child Feeding
M2M	Mother to Mother
MAFFS	Ministry of Agriculture, Forestry and Food Security
MCH	Maternal and Child Health
MCHP	Maternal and Child Health Post
MDGs	Millennium Development Goals
MEST	Ministry of Education, Science and Technology
MICS	Multiple Indicator Cluster Survey
MoHS	Ministry of Health and Sanitation
MSWGCA	Ministry of Social Welfare, Gender and Children's Affairs
NGO	Non-Governmental Organisation
PHU	Peripheral Health Unit
PRSP	Poverty Reduction Strategy Paper
SCP	Smallholder Commercialisation Investment Programme
SLARI	Sierra Leone Agriculture Research Institute
SLRC	Secure Livelihoods Research Consortium
SUN	Scaling Up Nutrition
TB	Tuberculosis
TBA	Traditional Birth Attendant
UN-REACH	United Nations Renewed Efforts against Child Hunger and Undernutrition
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
WFP	World Food Programme

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Executive summary and recommendations

Malnutrition remains a serious problem in Sierra Leone. In 2009, Sierra Leone was ranked among the five countries with the highest global hunger index score (ACDIVOCA 2011). Of the estimated 1 million children under five in Sierra Leone, 22 per cent are underweight, 44 per cent are stunted or too short for their age; and 8 per cent are wasted or too thin for their height, according to the 2010 Multiple Indicator Cluster Survey. These statistics underline the critical nutrition problems facing the country, problems which persist despite political commitment to tackle malnutrition.

Support to the nutrition sector in Sierra Leone is currently undergoing transition from post-conflict emergency response focused on treating malnutrition to building the capacity of the state to prevent malnutrition (although this transition is not always evident in practice). This shift mirrors broader transitions the country is navigating as it moves further away from its immediate post-conflict moment, in the process becoming increasingly stable. In this context, this report, the first under the Secure Livelihood Research Consortium's two-year Sierra Leone country programme, seeks to understand whether efforts to build state capacity to prevent malnutrition are 'fit for purpose', given the constraints faced and what is known about supporting capacity.

This child has recently been treated for malnutrition, but there are many cases where late referrals put the health and lives of children at risk.

The report argues that in order to comprehensively understand the idea of capacity, we must acknowledge the following characteristics:

1. **Capacity is made up of a set of more specific capabilities.** Support must integrate this breadth of capabilities so that capacity – in the sense of being able to achieve a desired collective purpose – is enhanced.
2. **Capacity is deeply shaped by context.** Capacity is not merely a technical issue determined by an individual's knowledge or an organisation's limitations, but is rather a function of socio-political and historical context.
3. **Capacity is located at multiple and related levels:** agent, organisation and system.
4. **Capacity can be targeted in a number of ways.** Actors can attempt to develop state capability by seeking to effect changes in the following:

- Resources (who has what)
- Skills and knowledge (who knows what)
- Organisation (who can manage what)
- Politics and power (who can get what)
- Incentives (who wants to do what).

Drawing on these conceptual lessons, the report findings indicate that **capacity support focuses on resources and skills and knowledge at the individual and organisation levels,** with the dominant modalities of support being training and provision of resources. While clearly important, this means that **other forms of support that target different kinds of capacity are frequently overlooked**. In part, a continued focus on treatment of malnutrition, rather than its prevention, explains this tendency. In addition, building the skills of individuals and providing resources to assist organisations to function are tangible outputs that can be achieved in short timeframes. Engaging at the other core dimensions of capacity – for instance at the systems level working with issues of politics, power and incentives – is a much longer-term and more amorphous undertaking that does not lend itself to easily measureable results.

There are also **challenges regarding the theories of change** and assumptions implicit within the capacity support that development partners provide. In relation to training, development partners use a 'cascade' model to enable them to reach target beneficiaries in a cost- and time-effective manner. Yet the messages delivered in training courses are diluted as they 'cascade' down the chain, so that the technical knowledge reaching frontline healthcare staff is limited, at best.

Mother-to-Mother Support Groups are relied upon by both the Government of Sierra Leone and development partners as one of the primary structures for preventing malnutrition at the local level. Yet their successful operation and impact depends on a range of assumptions that do not always hold in practice. We find that groups adhere to varying degrees with the model explained by the Freetown-based nutrition community, operating in quite different ways in different communities so that they often achieve only some of their intended outcomes. Finally, Farmer Field Schools are found to be far from institutionalised in practice – in some cases, to the point of not being operational at all. It is apparent that many communities and healthcare staff are unfamiliar with the concept and role of Farmer Field Schools, particularly vis-a-vis food security and nutrition.

A number of **capacity contraints** also exist that need to be addressed if state capacity to prevent malnutrition is to be more comprehensively built. These include:

- Resource constraints:
  - Shortfall of committed funds for the National Food and Nutrition Security Implementation Plan
  - Challenges of disbursement through District Councils
  - Lack of nutrition-related support for ministries playing a more peripheral nutrition role

- Skills and knowledge constraints:
  - Insufficient numbers of staff, especially District Nutritionists
  - Staff often not appropriately qualified in technical skills, data collection for monitoring and reporting or 'soft skills', like communication and negotiation.

- Organisational and management constraints:
  - Coordination challenges
  - Inconsistent reporting by development partners
  - Lack of accurate data from peripheral health units

- Political constraints:
  - Low capacity to build political support for nutrition issues outside immediate community of practice
  - Government not always clearly 'in the driving seat' or able to act independently
  - Focus currently on treating rather than preventing malnutrition

- Incentives constraints
  - Development partner organisational mandates can prevent alignment with government
  - Weak alignment of nutrition policies across government
  - Frontline health staff not incentivised to do community outreach
  - Cultural beliefs can hold greater influence over communities than government healthcare messages.

Our r**ecommendations** based on these findings are set out below. They focus primarily on development partners building a more varied package of capacity development activities that: engages the systemic (as well as the individual and organisational) levels of capacity; and targets political, incentives and management constraints as much as those concerning resources and knowledge. This will likely involve a move away from dominant modalities of support, such as training and provision of resources, towards more flexible engagements that aim to facilitate a political process.

Recommendations for international donors and NGOs

- Consider shifting funding from one-off, spread out trainings for health workers towards more sustained trainings. Also, ensure that technical training is complemented by training in managerial, leadership and communication skills, where appropriate to the role.

- Carefully unpack the assumptions underpinning the successful implementation of cascade training models, Mother-to-Mother Support Groups and Farmer Field Schools; articulate the theories of change behind these interventions and examine if these are realistic and consistent across implementation sites.

- Support the Food and Nutrition Directorate in building political support for the National Food and Nutrition Security Implementation Plan within other ministries – in particular the Ministry of Agriculture, Forestry and Food Security (MAFFS), the Ministry of Education, Science and Technology (MEST) and the Ministry of Social Welfare, Gender and Children's Affairs (MSWGCA) – including by providing greater support to these more peripheral ministries.

- Ensure that programmes clearly align to government-set priorities in the nutrition sector. Where government policies are not immediately clear, conversations should be brokered to clarify.

- Engage government more systematically throughout programme planning, implementation and monitoring, and evaluation cycles. This should include regular meetings throughout programming stages, including at the outset; sharing drafts and relevant information; and jointly discussing evaluation outcomes to feed into programme refinement.

- In keeping with commitments made by donors in the Accra Agenda for Action and the New Deal for Engagement in Fragile States, provide 3–5 year forward estimates of planned contributions to assist government in planning.

- Ensure regular reporting (every 3–6 months), using government's standardised template, to the Food and Nutrition Directorate (in addition to any reporting requirements to DACO).

- Provide the SUN Secretariat and/or the Food and Nutrition Secretariat with a detailed map of all nutrition-related interventions currently being undertaken across the country. This should be updated on an annual basis.

- Commit to regular participation in coordination meetings with staff of an appropriate level of seniority to meaningfully contribute to meetings, beyond updating on programme activities.

- Create flexible contingency funds for unplanned requests from government that can be mobilised quickly on an *ad hoc* basis.

- Diversify forms of capacity support beyond training and providing resources/materials. In particular, consider how support can build capacity in coordination and political support and shift incentives to enable improved prevention of malnutrition capacity. This may require longer-term and more iterative programming approaches that focus on relationship building, rather than on project-to-project cycles.

Recommendations for the Food and Nutrition Directorate/Ministry of Health and Sanitation

- Articulate a clear and coherent vision for prevention of malnutrition in Sierra Leone (based on the National Food and Nutrition Security Implementation Plan) and build support for this across government, in particular within MAFFS, MEST and MSWGCA.
- Design and/or promote a clear reporting system for development partners to share information on their projects with government every 3–6 months.
- Ensure regular coordination with DACO to monitor development partner activities in the nutrition sector.
- Support District Nutritionists in developing District Health Plans by providing senior staff to assist in negotiations with District Health Management Teams (DHMTs) and District Councils.
- Build political support for a higher nutrition budget to enable government to play a stronger lead role in setting the agenda within the nutrition community.
- Actively engage with development partners to design their annual activity plans and ensure that these are clearly linked to the National Food and Nutrition Security Implementation Plan.
- Consider options for increasing numbers of nutrition staff, for instance by providing scholarships for nutritionists who 'repay' government through a set duration of service in the districts.
- Plan as accurately as possible for all expected costs to enable development partners to plan for such costs in their own budgets.

Recommendations for the SUN Secretariat

- Comprehensively map all activities aimed at preventing malnutrition currently being implemented by government and development partners and update on an annual basis.
- Ensure coordination meetings are thoroughly thought through in terms of objectives and what and who are needed to achieve them. This may require creating a hierarchy of coordination meetings: information-sharing meetings requiring junior representation and problem-solving meetings requiring senior representation. Ensure development partners are made aware of such a hierarchy so that they may participate appropriately.
- Work with the Food and Nutrition Directorate to build a clear and coherent vision for a prevention of malnutrition policy and programming in Sierra Leone (based on the National Food and Nutrition Security Implementation Plan) and build support for this across government, in particular within MAFFS, MEST and MSWGCA.

1 Introduction

In the immediate aftermath of Sierra Leone's 11 year civil war, assistance in the nutrition sector largely focused on direct delivery of treatment – an appropriate course of action given the emergency context. This approach endured long into Sierra Leone's post-conflict moment, and only recently have the government and development partners begun to seriously attempt to refocus on the prevention of malnutrition. This is in recognition of the unsustainable nature of externally driven treatment approaches and the need for the Government of Sierra Leone (GoSL) to take the lead in preventing malnutrition. This also reflects of the transition that Sierra Leone has undergone in the last 12 years – from a weak political system with limited resources to a relatively stable democracy (there have been three largely peaceful national elections, including transition to opposition rule in 2007) and a stronger economic base (since 2010 Sierra Leone has achieved a growth rate of above 5 per cent, largely due to growth in the mining sector) (World Bank, 2012). The nutrition community in Sierra Leone is, therefore, at an important juncture, attempting to strike a balance between the ongoing need to save lives through directly implementing treatment programmes, while also shifting attention to the growing GoSL's capacity to prevent the problem of malnutrition in the first place.

Against this backdrop, this study – the first output of a two-year research project under the under the Secure Livelihoods Research Consortium (SLRC) – seeks to capture the nature of capacity support provided by development partners to GoSL, and to better understand the constraints which continue to undermine the capabilities of the state to prevent malnutrition. In doing so, we hope that both GoSL and development partners will gain a clearer picture of the nature of current forms of capacity development and how 'fit for purpose' they are in getting government to a point of self-sustainability in preventing malnutrition.

An entirely government-financed health sector in Sierra Leone is a long-term goal and the short- to medium-term will be characterised by an ongoing aid relationship in which government, civil society and international aid agencies share roles and responsibilities. What is crucial during this time is the extent to which international aid either builds or undermines national capabilities at different levels. Likewise, following more than a decade of international assistance since the end of the civil war, it is important to understand how effectively core state functions are being fulfilled: are the current modes of governance appropriate for effectively and sustainably addressing social and public health problems such as malnutrition? Given that government and development partners in Sierra Leone are currently navigating this challenge, this research is occurring at an important time. We hope that it will contribute ideas for how the nutrition community in Sierra Leone can strengthen capacity to prevent malnutrition.

The report is structured as follows. This introduction continues with a brief discussion of some background to the state of nutrition and the political and social context in Sierra Leone, before setting out the methodology underpinning the study. In section 2, we introduce the idea of capacity in greater depth through a review of key literature to help shape the way we might think about engaging with 'capacity'. Section 3 analyses whether the current model of capacity support that we see being implemented in Sierra Leone is 'fit for purpose'. It does so by examining, first, whether what is being done is appropriate to the context and second, whether it seems to be appropriately targeted (that is, whether there are any gaps and constraints currently being overlooked). Section 4 sets out the conclusions of the research and offers recommendations about how capacity support might be approached in future.

1.1 Methodology

This study is based mainly on qualitative primary research carried out in Sierra Leone between September and October 2013, as well as secondary research in the form of a selective review of key literature. It has also been informed by a weeklong scoping trip in May 2013, the main purpose of which was to make initial contact with potential research partners and map the key stakeholders working on nutrition.

Primary research from September-October 2013 involved two weeks of fieldwork in Freetown and Kambia district, the focus District of the SLRC's Sierra Leone country programme (see map in Annex 1)[1]. The decision to focus on Kambia District was made in collaboration with Focus1000 and our funders, Irish Aid, taking into account the remoteness of the district, severity of malnutrition, extent of war-affectedness and logistical constraints such as terrain and number of chiefdoms. Kambia District has one of the highest rates of acute and moderate malnutrition and food insecurity in the country, and is regarded as a primary source of cholera. Kambia is also yet to fully recover from the devastating health infrastructural damage and emigration of much needed health staff during the civil war.

The main research method involved interviews using semi-structured guide designed to generate information on organisations' malnutrition and capacity building activities, barriers to effective prevention, key areas for improvement and – in Kambia – experiences of malnutrition policy and capacity building activities on the ground. Two or three members of the research team carried out the interviews; a balance of genders and national/international staff were ensured at all times.

Using a purposive sampling strategy, a range of key informants were selected for interview. In Freetown, interviews focused on both the providers and targets of capacity support. The aim was to build an understanding of what the community of practice around nutrition looks like at the national level and how it works. We thus identified individuals within the donor/NGO community who had specific knowledge of their own organisation's capacity building activities around malnutrition. We also met with a broad range of government ministries (health, agriculture, education and social welfare) to ensure that our research captured how capacity development was experienced (or was not) from the perspective of GoSL.

In Kambia District, we were interested in talking to two broad sets of stakeholders. The first included political figures, government and NGO staff in the district capital, Kambia town, who could provide more specific information on malnutrition programming within the district, the local context for prevention, the experience of capacity building and the politics of planning and decision-making. The second set of stakeholders included those working on frontline service delivery who could provide information on the reality of malnutrition work at the local level, interactions with government and NGOs, forms of support received, and key challenges constraining their activities. To cover both stakeholder groups, the research team split, with two researchers based in Kambia town interviewing district-level actors, such as members of the District Council, the District Health Management Team, government ministries, NGO staff and the Paramount Chief. Two other researchers travelled to Kambia's seven chiefdoms to interview staff in the Peripheral Health Units, Mother-to-Mother Support Groups and Farmer Field Schools. In total, 62 interviews were conducted over a two-week period (see list of interviewees in Annex 2).

Analysis and interpretation of interview material was done on an ongoing, iterative basis while in Sierra Leone, as well as in a more consolidated manner in the two weeks following data collection. An analytical framework developed by the SLRC in relation to capacity development helped guide parts of the analysis (SLRC, forthcoming). The framework – which draws heavily on work carried out by the European Centre for Development Policy Management (ECDPM) (see Brinkerhoff, 2007) – was used to disaggregate the broad notion of 'capacity' and to clarify the kinds of support being provided as well as which kinds are not

1 Kambia has been selected as the district focus for the two-year research programme.

1.2 The state of nutrition in Sierra Leone

While malnutrition rates have reduced considerably in Sierra Leone since 2005, malnutrition remains a serious problem in most of the country (Koroma *et al*. 2012: 39). In 2009, Sierra Leone was ranked among the five countries with the highest global hunger index score and among the six most severely affected by and vulnerable to the effects of the global economic crisis by the International Food Policy Research Institute (ACDIVOCA 2011). Of the estimated 1 million children under five in Sierra Leone, 22 per cent are underweight; 44 per cent are stunted or too short for their age, and 8% are wasted or too thin for their height, according to the latest Multiple Indicator Cluster Survey (MICS 2010). Severe acute malnutrition affects 8 per cent of children nationwide. In 2011, the World Food Programme reported that 45% of households in Sierra Leone were food insecure during the wet season (June through September) – with rural areas particularly at risk (ACDIVOCA 2011). While Sierra Leone has made significant progress in the last five years, improving upon its position of having the highest maternal and infant mortality rates in the world, rates remain exceptionally high, with infant mortality at 128 per 1000 and maternal mortality at 857 per 100,000. Malnutrition is an underlying cause of approximately 50 per cent of deaths of children under five (MoHS 2002), attributable to nutritional deficiencies, pneumonia, malaria and diarrhoea (Koroma *et al*. 2012: 39). Table 1 sets out some of Sierra Leone's basic malnutrition indicators.

The nutrition situation in Sierra Leone is dire even in comparison with other sub-Saharan African countries with similar levels of per capita GDP, such as Zimbabwe, the Gambia and Togo (World Bank n.d.). These statistics underline the critical nutrition problems facing the country, problems which exist despite a relatively strong degree of political commitment to tackling malnutrition at the central state level.

Table 1: Nutrition related indicators in Sierra Leone

Indicator	Value	Source
Under weight (calculated by weight for age)	22.0%	MICS4, 2010
Stunting (calculated by height for age)	44.0%	MICS4, 2010
Wasting (calculated by weight for height)	8.0%	MICS4, 2010
Low birth weight	10.0%	MICS4, 2010
Anaemia in children aged less than 5 yrs	82.8%	VAM Survey, 2005
Anaemia in women of child bearing age	75.0%	VAM Survey, 2005
Infant mortality per 1000 live births	128/1000 live births	MICS4, 2010
Child mortality (children under five years)	217/1000	MICS4, 2010
Maternal mortality	857/100,000 births	DHS, 2008

1.3 The political context

The political context in which attempts to reduce malnutrition are undertaken (or not) is centrally important (Gillespie *et al*., 2013). Capacity support must be understood, therefore, within the particular political and social context at play in Sierra Leone.

The Government of Sierra Leone is committed to improving the nutritional status of the population, reflected in the high priority accorded to issues of nutrition and food security in the country's National Development Programmes – including the 2008-10 Poverty Reduction Strategy Paper (PRSP) 'Agenda for Change' and the current PRSP 'Agenda for Prosperity'. GoSL recognises the pivotal role of improved food and nutrition in curbing high maternal and child mortality rates and enhancing the general health and wellbeing of the population. Improved food and nutrition security is also seen as important in accelerating progress towards achieving the Millennium Development Goals (MDGs).

In addition to the formal inclusion of the importance of malnutrition in national development plans, at least two high profile figures have taken up the malnutrition cause. The first lady, Her Excellency Sia Nyama Koroma, has become an advocate for child and maternal nutrition and is a potential resource to draw upon in promoting nutrition-related issues, as demonstrated in her numerous reproductive health programmes already undertaken. To date, however, her influence in relation to malnutrition has not been used to its full potential. Placing the SUN Secretariat in the Office

of the Vice President, Samuel Sam Sumana, has also strengthened the political weight of the Secretariat and lifted it above turf battles between line ministries that might have ensued had it been housed, for instance, in the Ministry of Health and Sanitation. At the launch of the SUN Movement in October 2012, the Vice President declared that SUN would ensure 'decisive action against hunger and malnutrition in Sierra Leone' (WHO, 2012). There are some concerns about potential politicisation of the SUN Secretariat being located within a political office, as well as how it may be affected by internal government politics. However, these concerns seem to be outweighed by the imperative to ensure that the Secretariat has a high profile and good political access and influence.

In addition to these political champions, technocrats working on nutrition issues within GoSL have strengthened their political clout in the last year. The 'Nutrition Unit' was elevated within the Ministry of Health and Sanitation (MoHS) to a 'Food and Nutrition Directorate' in 2013. This means that the Nutrition Manager became a Nutrition Director, with greater access and influence within MoHS. In October 2013, MAFFS was successful in getting a budget line specifically on nutrition approved, which allows them to plan for nutrition-specific interventions; rather than merely as a component of otherwise more agriculture-related activities.

But despite significant progress, GoSL institutions remain susceptible to corruption and investigations are ongoing involving key ministries and offices working on nutrition-related issues. In 2012, investigations were launched into MoHS, with staff accused of misappropriating approximately USD 1m in funds from the Global Alliance for Vaccine Immunisation (GAVI) that had been providing support to the MoHS. The Anti-Corruption Commission (ACC) and High Court of Sierra Leone are conducting ongoing investigations of 29 MoHS staff, who were sacked from government but have not yet been convicted. More recently, in June 2013, the ACC singled out MoHS and MAFFS, along with the Ministry of Local Government and Rural Development, as being particularly vulnerable to corruption due to weak management procedures (Tommy 2013). Such susceptibility to corruption makes capacity development of these institutions both critical (in terms of strengthening oversight and professionalism to ensure corrupt practices do not occur) and risky for development partners working through government systems.

In addition, Sierra Leone is characterised by strong patriarchy and gerontocracy, which means that women and children are generally at the bottom of an inequitable socio-cultural system (Schroven 2006). In relation to nutrition, women and children receive a less protein-rich diet than older men. Moreover, as men tend to control household finances, women can struggle to assert their own spending priorities within the family (Denney and Ibrahim 2012: 8). Mothers are often blamed for unhealthy children, which can discourage them from seeking early treatment. There are also high numbers of teenage mothers in Sierra Leone, who are often not themselves aware of the importance of diet in child development (GoSL, 2013). In rural areas in particular, customary authorities, such as secret societies and 'mammy queens', have traditionally been seen as the repositories of knowledge regarding child birth, rearing and wellbeing, and can have an important influence as a result (Denney and Ibrahim 2012).

2 Making sense of state capacity: What the literature tells us

Drawing on four years of practitioners' shared experiences and reflections, Rick James and Rebecca Wrigley (2007) concluded that capacity development is:

- *confused*, being rarely defined or even translated;
- *contested,* as different stakeholders have different agendas;
- *contextual*, as it differs between contexts and cultures;
- *counteracted*, by an aid system that inhibits capacity development; and
- *complex*, being ultimately about change in human systems.

These reflections highlight the difficult and often esoteric nature of capacity development. Although of profound importance, understanding how state' capacities to deliver effective and equitable services can be strengthened and sustained over time is far from straightforward.

In this section, we introduce the concepts of capacity and capacity development (defined in Box 1), discuss the challenges of strengthening capacity externally; and set out some key features that characterise capacity development, particularly within conflict-affected environments and when multiple international actors are involved. In so doing, we aim to clarify the meaning, breadth and purpose of capacity development, with all of its complexities, before turning to how capacity development is carried out in the nutrition sector in Sierra Leone. The discussion here draws heavily on an analytical framework developed by the SLRC (SLRC, forthcoming). The purpose of that paper is to assist with the complex task of studying capacity and capacity development by sketching out an analytical framework that can be used to

i identify existing gaps in states' capacity to deliver services; and
ii examine how international actors' capacity support programmes work in practice, and assess the extent to which they are fit for purpose in a given context.[2]

By breaking the concept of capacity into its constituent parts, the framework assists in making sense of the capacity support currently being provided, how it is working, and what is being left out. It thus serves as a useful conceptual mechanism for organising and interpreting our empirical material.

2 Our study draws specifically on the 5Cs framework in order to contribute to cross-programme coherence within the SLRC. While other frameworks and approaches are available, advantages of working with the 5Cs framework – both for our own purposes and those of the SLRC more broadly – include: taking a systems approach to the study of capacity which eschews reductionism and embraces complexity (Watson, 2010); enabling an analysis of power and politics vis-à-vis capacity and capacity development (Boesen, 2010); and disaggregating an intangible, fuzzy whole into a set of more accessible constituent parts that act as 'entry points'.

From a review of key contributions to the capacity development literature, we distil four main features that help explain, respectively, what capacity is, what shapes capacity, where capacity is 'located', and how capacity can be externally influenced.

Capacity is made up of constituent parts. One of the central messages to emerge from a five year, multi-country study conducted by the European Centre for Development Policy Management (ECDPM) was that capacity is formed by five specific capabilities (referred to as the '5Cs'). According to Morgan (2006: 8–16), these include:

- *The capability to self-organise and act.* Actors are able to mobilise resources (financial, human, organisational); create space and autonomy for independent action; motivate unwilling or unresponsive partners; and plan, decide, and engage collectively to exercise their other capabilities.
- *The capability to generate development results.* Actors are able to produce substantive outputs and outcomes (for example, health or education services, employment opportunities, justice and rule of law); sustain production over time; and add value for their clients, beneficiaries, citizens, etc.
- *The capability to establish supportive relationships.* Actors can establish and manage linkages, alliances, and/or partnerships with others to leverage resources and actions; build legitimacy in the eyes of key stakeholders; and deal effectively with competition, politics, and power differentials.
- *The capability to adapt and self-renew.* Actors are able to: adapt and modify plans and operations based on monitoring of progress and outcomes; proactively anticipate change and new challenges; and cope with shocks and develop resilience.
- *The capability to achieve coherence.* Actors can: develop shared short and long-term strategies and visions; balance control, flexibility, and consistency; integrate and harmonise plans and actions in complex, multi-actor settings; and cope with cycles of stability and change.

To the degree that the target of capacity development integrates these capabilities, capacity – in the broad sense of being able to achieve a desired collective purpose – is generated and enhanced. Breaking down capacity by using the 5Cs model is useful in the context of the nutrition sector in Sierra Leone, as it unpicks the different kinds of capabilities demanded of the state in dealing with a cross-cutting problem like malnutrition. As will be made clear through this paper, strong overall capacity to prevent malnutrition will likely depend not just on adequate resources or sufficient levels of technical knowledge among frontline health staff, but also upon an extensive set of 'soft' skills for key personnel and the creation of institutional environments that support cross-sector collaboration and constructive negotiations.

Box 1: What does capacity development mean?

Definitions of capacity and capacity development are multiple and contested within the literature. Here, we draw on the widely accepted approach outlined by Simister and Smith (2010):

- *Capacity.* The ability of people, organisations and society as a whole to manage their affairs successfully
- *Organisational capacity.* The capability of an organisation to achieve effectively what its sets out to do
- *Capacity building.* A purposeful, external intervention to strengthen capacity over time
- *Capacity development.* A process whereby people, organisations or society as a whole create, strengthen and maintain capacity over time.

These definitions draw a distinction between capacity building and capacity development, where the former refers to an external intervention to strengthen the capacity of a domestic organisation. Capacity development is the process one would hope capacity building would then feed into and support. Given that we are interested in deep and sustained improvements in capacity over time, in this report we generally talk in terms of 'capacity development' and 'capacity support'.

Capacity is deeply shaped by context. Capacity is not merely a technical issue determined by an individual's knowledge or an organisation's limitations, but is rather a function of socio-political and historical context. Understanding the role of context requires recognising the depth of factors that shape capacity at different levels. Barma *et al* (n.d.), for instance, conclude that three major categories of factors help explain why some organisations work and others do not: inner institutional/organisational workings; the external operational environment; and the broader socio-political and historical context. The central implication is that capacity is both a technical and political problem: staffing policies and skill enhancement courses that affect inner-organisational workings might be important, but so too is the way in which decisions to invest in state capacity are undertaken (the nature of power and politics). Unfortunately, the political dimensions of capacity development are harder to address and more resistant to external intervention than the relatively straightforward technical issues of boosting resources or improving knowledge (see Figure 1).

A deep understanding of capacity that engages with the broader political context also highlights the importance of both formal and informal institutions. While formal characteristics may define the form of state structures, for example, the actual way in which things are done may be heavily influenced by informal norms and processes (Barma et al, n.d.). This phenomenon can manifest in the form of hybrid service delivery – or plural health systems, as observed in Sierra Leone (Scott *et al*., 2013) – indicating that services are often not provided in a purely state-centric manner. Acknowledging this informal nature of governance means seeing what is really there – in terms of service delivery modalities, state capacity and the ways in which governance plays out on an everyday basis– rather than assuming that things work (or ought to work) in a pre-determined way (Boege *et al*., 2008). Understanding how issues of inequality play out at this informal level is particularly important, as 'formal equality' encapsulated in national legislation, for instance, can belie deeply experienced inequalities on a day-to-day basis. Capacity development processes thus need to be attuned to the 'actually existing' nature of governance in particular contexts. While this may seem obvious, capacity development has not always been designed or implemented in ways that take context seriously (Pritchett *et al*. 2012; Andrews 2013).

Making sense of state capacity to prevent malnutrition in Sierra Leone therefore demands an appreciation of the country's experience as a state in transition[3]. While some good progress has been made over the past decade in improving development outcomes, the state – in some senses, at least – continues to be heavily influenced by its emergency phase in the 1990s and early 2000s. The health system we observe today, for example, is crowded with international and national development partners (Donnelly, 2011). Achieving coherence in such a highly populated environment requires a particular sort of capacity, one that goes beyond simply being able to deliver frontline services. Nutrition issues have also vied for political support with host of other priorities – such as basic security and revitalising a collapsed economy (Donnelly, 2011). The influence of patrimonial norms and networks that still characterises Sierra Leonean politics (although it is changing in some quarters) further reinforces the need to consider how personalised relationships between key individuals mediates decisions within the political marketplace, and how this favours some groups over others (with women, for instance, often being disadvantaged) (de Waal, 2009; Meyer 2007).

Capacity is 'located' at multiple levels. Broadly speaking, capacity can exist at three different levels of what Pritchett *et al*. (2012) call an 'ecological space': agents (leaders, managers and front-line staff); organisations (firms, NGOs, and line ministries); and systems (the broader administrative and political apparatus under whose jurisdiction the activity falls, as well as cross-organisational processes of governance such as procurement systems and delivery chains). For example, the District Health Management Teams (DHMTs) found in each district in Sierra Leone can themselves be understood as organisations. Through these organisations, decisions concerning health in the district are made and resources disbursed to lower-level health structures. The DHMTs are, in turn, made up of sets of agents, including the District Medical Officer and the District Nutritionist – the individual capabilities of these personnel influence, in part, the broader functional capacity of the DHMT. As one example, the capability of the District Medical Officer to establish supportive relationships outside the DHMT may have important implications for how much leverage the organisation has in decision-making processes at the District Council level. Finally, the DHMT not only forms part of the broader health system in Sierra Leone, but is also governed by rules and procedures (both formal and informal) that cut across organisations – such as how budgets and annual plans are designed and signed off, or the financial mechanisms that move resources between different organisations.

Importantly, these three levels are related. The actions of agents, for example, are mediated by the norms, procedures and mandates of the organisations in which they work. Yet, despite these interrelations, capacity is not developed in a linear fashion (that is, developing the capacity of agents does not necessarily translate into higher aggregate capacity at the organisation or systems levels).

Capacity can be targeted in a number of ways. As mentioned, capacity has both technical and political dimensions, and support can be targeted at different areas. Specifically, the extent to which a particular capability can be referred to as strong depends on the 'right' mix of factors or conditions being in place. Drawing on the findings of the ECDPM study, we can identify five broad dimensions which seem to matter for the strength of capabilities and capacities, and which can be targeted by policy interventions (see also Figure 1).

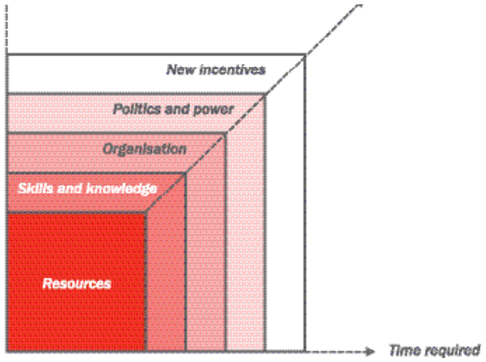
3 While some have recently made the case for Sierra Leone to now be recognized as a 'non-fragile' state – encouraged, no doubt, by the fact that the country's UN Peacebuilding Mission, UNIPSIL, is expected to withdraw by 31 March 2014 – there appears little agreement that such a reclassification is appropriate given the country's ongoing security and development challenges (see Jesperson, 2013). For examples of those suggesting a rethinking of the 'fragile state' label, see http://www.un.org/apps/news/story.asp?NewsID=43522#.UosmjydYUmt and http://awoko.org/2012/12/14/sierra-leone-no-morefragile-butlow-income-state%E2%80%99/

- *Resources* (who has what). Interventions designed to increase resources might focus on budget support or provision of equipment.
- *Skills and knowledge* (who knows what). Interventions designed to enhance skills and knowledge might focus on training, technical assistance or technology transfer.
- *Organisation* (who can manage what). Interventions designed to strengthen organisation might focus on restructuring, civil service reform or decentralisation. [4]
- *Politics and power* (who can get what). Interventions designed to address politics and power might focus on legislative strengthening, community empowerment or civil society advocacy development.
- *Incentives* (who wants to do what). Interventions designed to realign incentives might focus on sectoral policy reforms, improving the rule of law or strengthening accountability structures.

Capacity building programmes often focus on addressing the first two or three targets listed above – resources, skills and knowledge, and organisation. This is partly because focusing on these technical and more tangible targets is simpler, more in line with donor reporting requirements and is more easily measured to demonstrate results. As we will see in the following sections, much of the capacity support being provided to the GoSL follows this pattern, with an emphasis on transferring skills and knowledge through training various kinds of health workers.

However, without changes in the enabling environment encapsulated in the political and incentive categories, increased resources and better skills are unlikely to be enough to develop sustained state capacity. What is needed, therefore, is for capacity development practitioners to recognise which mix of targets needs to be addressed in a particular context. Those designing capacity building programmes should consider how power relations shape who has what, knows what, manages what, can get what and wants what – and which groups of people may need to be empowered to alter existing capacities.

Figure 1: Targets of capacity development by degree of difficulty, time and magnitude of change



Source: Brinkerhoff, 2007 adapted from Fowler, 1997

The literature cited above refines our understanding of what capacity is, what shapes it and where it can be located. A comprehensive approach to capacity recognises that it is a broad concept that is deeply shaped by socio-political context, that is located at multiple levels and that can be targeted in different ways. Failure to engage with this breadth of capacity development can mean that interventions are narrow (focusing only on some aspects of what constitutes capacity development), shallow (unconnected to the deeper political context that shapes capacity) and limited (engaging with only some of the repositories of capacity). Capacity development can take a wide variety of forms, which can focus on different targets with differing degrees of engagement with the political context. Below, Box 2 sets out some examples of forms of capacity development that are useful to keep in mind as we turn to examine the forms of support making up the nutrition sector in Sierra Leone.

Box 2: Examples of capacity support

- Paying the salaries of staff in line Ministries / funding new positions
- Providing materials, such as logistical equipment (modes of transport), technical equipment (anthropometric measurement tools) and training equipment (counselling cards)
- Training staff at different levels of government in various topics / issues, such as screening and sensitisation methods, data analysis, management and leadership, and so on
- Introducing new technologies and practices (for example, in relation to agricultural production and diversification)
- Improving coordination mechanisms
- Creating space for all relevant stakeholders to contribute to planning and implementation
- Reforming organisational systems and changing organisational cultures
- Strengthening accountability, for example through designing clear and more harmonised reporting structures and procedures
- Reforming the systems and processes of the provider of capacity development so as to lessen the burden (for instance in applying for funds, reporting, etc.) of the target of capacity development.

Source: adapted from Heaver, 2000 in Gillespie, 2001: 24

4 The SLRC framework refers to 'organisation' as 'management' when conceptualising targets to avoid mixing up terminology.

3 Is the current model fit for purpose?

3.1 An assessment of modes of capacity support in the nutrition sector

A range of development partners, both domestic and international, are supporting the state in working towards better nutrition outcomes in Sierra Leone. For those unfamiliar with the structures, roles and responsibilities of the Government of Sierra Leone and development partners responsible for preventing malnutrition, further information is provided in Annex 3. In this section, we set out the way(s) in which these players are working to prevent malnutrition, with an emphasis on how international development partners are seeking to strengthen the capacity of the state, and some of the possible assumptions implicit in this support.

The table in Annex 4 sets out the key international development partners working in the nutrition sector in Sierra Leone (although the list might not be comprehensive) and the kinds of capacity support they are currently providing, based on semi-structured interviews with staff at these organisations. Given the diversity of forms that capacity development can take, we asked about the kinds of support being provided, using prompts and examples of support if necessary. The table does not offer a comprehensive inventory of all capacity support activities being carried out to prevent malnutrition. Nor does it provide an historical overview of this activity. What it aims to do is capture the essence of partners' current support, providing the basis for analysing dominant and missing modalities.

As can be seen from the table in Annex 4, capacity support by development partners mostly targets individuals and organisations (primarily the MoHS, DHMTs and Mother-to-Mother Support Groups). Training focused on skills and knowledge gaps is clearly the dominant modality of capacity support, as well as provision of resources. Drawing on the discussion and framework introduced earlier in this section, Figure 2 illustrates these characteristics of current capacity support interventions and highlights what is being overlooked. The remainder of this section examines these and other aspects of the dominant approaches that emerge from the table in Annex 4.

Figure 2: What does capacity support to the state look like in Sierra Leone's nutrition sector?

It is clear from the table in Annex 4 that much is being done by a range of actors to address the problem of malnutrition in Sierra Leone. But is the activity appropriate given the nature of the problem at hand? We set out to answer this question. Our focus asks whether what is being done – what the current model looks like and how it functions – is fit for purpose given the nature of the challenges and persistent capability gaps. We aim to answer this question by: (1) analysing the patterns and trends in how development partners are currently providing capacity support; (2) questioning the assumptions embedded within the dominant modes of engagement; and (3) exploring the specific constraints and capability gaps that continue to undermine the overall capacity of the state to prevent malnutrition. In the final section, we sketch out what this means for how capacity support might be provided in future.

3.2 Analysing the dominant modes of capacity support

Drawing on the table in Annex 4, we identify three key characteristics of capacity support. First, much of the programming remains focused on treatment rather than prevention. Second, capacity support overwhelmingly targets skills and knowledge through training and provision of resources. Third, individual and organisation levels are the most commonly engaged, with a resulting lack of emphasis on the system level.

Treatment over prevention. Interviews with both development partners and GoSL revealed that the nutrition community in Sierra Leone is shifting from focusing primarily on treatment of malnutrition to prevention. In part, this reflects the transition that Sierra Leone is undergoing more broadly from a post-conflict country to a more stable low-income country and the concomitant shift from emergency response to sustainable development on the part of development partners. In the interests of sustainability, development partners indicate that they are shifting operations to focus more on prevention of malnutrition. However, as the table in Annex 4 demonstrates, the majority of assistance from development partners still focuses primarily on treatment. This continued focus on malnutrition treatment initiatives becomes more accentuated the closer one gets to communities, with DHMTs and Peripheral Health Units (PHUs) almost solely focused on treatment, rather than prevention. When PHU staff in Kambia were asked about their roles, they routinely replied that they were responsible for Community-Based Management of Acute Malnutrition (CMAM). Only on further questioning did they mention Infant and Young Child Feeding (IYCF) practices and, rarer still, community awareness about nutrition issues. It is only recently that IYCF has become part of the role of PHUs. To date, the continued focus on treatment reflects a division of labour at the local level, where PHUs focus their resources on treatment, while prevention activities are essentially outsourced to Mother-to-Mother Support Groups and Community Health Workers. In any case, the discursive focus on prevention so tangible and widespread at the national level does has not yet altered the focus at the PHU level. This may change as PHU staff are trained in IYCF practices as part of the 6-Month Contact Point programme being implemented by Helen Keller International. However the Mother-to-Mother Support Groups and Community Health Workers will continue to have primary responsibility for prevention activities.

The difficulty of operationalising commitments to shift from a treatment to prevention focus is explained in part by the fact that it is not possible to stop treatment work because this would result in loss of life. When cases of malnutrition are diagnosed, they must be treated. 'Shifting' to prevention, therefore, is not so much about reallocating resources, at least in the short term, as it is about allocating more resources to nutrition work so that treatment can continue while prevention capacity is built. In the longer term, increased prevention capacity will mean reductions in spending

on treatment of malnutrition are possible, but in the interim period (the short- to medium-term) a shift to prevention is only possible with increased nutrition budgets. Until such increased funding is available, it will remain difficult for development partners to step up their support to prevent malnutrition, as they will remain committed to the priority of saving lives through treatment.

Tangible outputs over deeper change. As Figure 2 suggests, in general, capacity support activities are designed to increase 'resources' and 'skills and knowledge' (with some exceptions). Recalling Figure 1 in section 2, activities focusing on these targets tend to be the most straightforward, generally cheaper and less time-consuming than those associated with addressing incentives or politics and power. There is an obvious demand for support which targets 'resources' and 'skills and knowledge' in the nutrition sector in Sierra Leone, with building basic technical capacity, particularly among PHU staff and community health workers, regularly cited as a priority area in interviews across government and development partner stakeholders.[5] However, it is not clear whether these kinds of investments, on their own, will lead to sustained, deep improvements in state capacity.

Indeed, what emerges clearly from the table in Annex 4 is the frequency with which training appears as a form of capacity support. This suggests not only the dominance of this particular modality among development partners but also the tendency for capacity development to target 'skills and knowledge' almost exclusively through training. The interviews were illustrative: respondents, when asked about the forms of capacity support provided to government, tended to immediately cite training (as opposed to any other kinds of support provided), indicating that this is how capacity development is often framed and understood. The words of Potter and Brough (2004: 336) seem fitting: 'Too often [capacity building] becomes merely a euphemism referring to little more than training.' This point was not lost on many development partners and MoHS staff interviewed, but it did not appear to be transformed into programming.

As Leppo (2001: 9) points out, 'The need for training and skill development are normally accepted as necessary in any change for improving systems, but there is much less recognition of the fact that trained personnel will be effectively utilised only in organisational settings with certain characteristics.' In other words, the knowledge and skill-sets of individuals matters, but so too does the institutional environment in which they act and interact. As discussed in section 2, this institutional setting is multi-dimensional, comprising both policy and legal frameworks, as well as informal social norms that determine the ways in which things are done. Such a consideration was largely absent from our discussions in Freetown and Kambia, although it was alluded to on a few occasions. Conversations in Kambia, for example, hinted at the way in which socially embedded attitudes towards birthing practices and intra-household food distribution affect the capacity of health workers to prevent malnutrition in the local community. This speaks to the influence of patriarchy and gerontocracy in disadvantaging women and children, as well as the strength of cultural food taboos that discourage children from eating protein. In institutional contexts like this, equipping staff with the right technical know-how may not be sufficient to generate deeper change. Instead, what is arguably needed is a more ambitious attempt to reconfigure the gendered power structures that allow such attitudes and practices to persist within the system as a whole. This is a less straightforward and much more long-term task.

Individual and organisation over system. Capacity development focuses overwhelmingly on the individual and organisational levels. Relatively little engagement was apparent at the system level both in the sense of processes, such as procurement and delivery chains, and the broader enabling environment in which organisations and the individuals that constitute them operate within. In part, such a focus can be explained by the tangibility of individuals and organisations that make for more straightforward logical frameworks, measurability and demonstrable results. Moreover, strengthening the capacity of individuals and even organisations has a more immediate timeframe in which results can be expected. Engaging at the 'systems' level is less straightforward, as it potentially entails organisational restructuring and fundamental changes in the way organisations work within a system. It is a long-term process, the results of which cannot easily be anticipated. Indeed, our sense emerging from the interviews was less that stakeholders failed to recognise the importance of building capacity in these strategic ways, but more that doing so was simply much harder and therefore less common. This problem is compounded by a lack of clarity among those working in the sector regarding viable options and approaches for systemic change; although some interviewees identified a need for more harmonised system-wide surveillance and reporting processes, relatively little else was mentioned (particularly in relation to improving vertical linkages within the system). Examples of systemic capacity building from the literature include a focus on generating system-wide political commitment to preventing malnutrition, implementing effective system-wide reporting systems and creating work environments which help to retain staff (for example, by ensuring timely remuneration) (Pelletier *et al*. 2012).

Focusing on strengthening the capacities of individuals and organisations is also less overtly political than working at the system level to alter incentives and power relations. This becomes significantly more messy and long-term than training individuals and providing materials and resources for an organization to fulfil its mandate. What is more, given that current donor discourse emphasises the centrality of country ownership and ensuring that government is 'in the driving seat', engaging in the kinds of political reforms that capacity building of systems entails can appear more interventionist than good practice principles advocate. The danger is that a desire or necessity to conform to such good-practice principles undermines the ability of development partners to engage in the kind of 'deep' (that is, institutional or systemic) capacity building necessary to genuinely and sustainably build capacity.

These three trends highlight that the nature of capacity support currently being provided by development partners represents just a fraction of possible targets, levels and approaches. There are opportunities to extend capacity support to take account of other layers and components of the multiple factors that shape capacity.

3.3 Questioning the assumptions of what is being done

Our previous discussion of the dominant trends in capacity support helps highlight the kinds of activities that are not being implemented. But, as the following examples demonstrate, challenges also exist regarding the theories of change and assumptions implicit within the capacity support that development partners do provide.

A number of interventions emerged from interviews as relatively common across development partners, including training, and engagement with the Mother-to-Mother (M2M) Support Groups and Farmer Field Schools. Each of these interventions is based on some kind of theory of change, whether explicit or implicit, that is in turn based on a number of assumptions. In this section, we attempt to tease out the theory of change and implicit assumptions embedded within these three key interventions, demonstrating that the assumptions they are based upon do not always hold. This is not to suggest that current capacity support is necessarily ineffective – rather it suggests that the mechanisms for delivery that development partners rely upon do not always operate in the manner assumed, or with the intended effect.

Training. As mentioned above, we observed that much capacity support is provided as training to improve the skills and knowledge of individuals at various levels of the nutrition and food security system. In addition, training almost uniformly shared two similarities: a focus on technical skills; and the transmission of knowledge through a 'cascade' model. These features are based on certain assumptions about skills needed and how to transfer knowledge that our research indicates do not necessarily hold in practice.

The logic underpinning training programmes runs crudely as follows: identify capacity gaps; identify personnel whose low capacities are the cause of these gaps; provide them with knowledge, information and skills necessary to address their own capacity deficits; reinsert them back into the system whereupon the gaps will be filled and the situation improved. This seems a sensible fix to problems of low capacity, and one that can be implemented with relative ease. However, whether staff are trained or not risks missing the point if more basic requirements for doing the job (such as being paid on time, having access to supplies such as Ready to Use Therapeutic Food (RUTF) or corn-soya blend, as well as vehicles and fuel) are not in place. Increased knowledge can only be put to use if it is deployed in an appropriately equipped and incentivised environment. Moreover, technical know-how is not the only set of skills required for good nutrition work. The cross-cutting, multi-sectoral nature of nutrition, demanding cross-government action means that a high degree of coordination is required. The challenge of getting nutrition-related issues onto the agenda (and budget) in a conflict-affected, low income country setting where multiple priorities compete requires significant influencing and negotiation skills. The oversight of approximately 100 PHUs per district means that a high degree of management expertise is also required. These capacity needs make the simple focus on technical practices involved in nutrition work particularly problematic.

Thinking about the 5Cs model introduced in section 2, it is apparent that improving the capabilities of key personnel to, for example, 'establish supportive relationships' and 'achieve coherence', is of similar necessity to building technical skills (Morgan 2006: 8-16). Drawing on systematic review findings, Gillespie et al (2013) conclude that:

> ***Human and organizational capacity need to encompass not only nutrition know-how, but also a set of soft-power skills to operate effectively across boundaries and disciplines, such as leadership for alliance building and networking, communication of the case of collaboration, leveraging of resources, and being able to convey evidence clearly to those in power.***

This is consistent with comments from the Food and Nutrition Directorate that training in managerial, leadership and

5 Of course, the demand for training may be high partly due to the financial benefits associated with participation.

communication skills is often deprioritised and that training focuses overwhelmingly on technical skills so that staff may have required technical knowledge, but not the social or managerial skills to share it and influence others.

To reach the 1,228 PHUs across the country, development partners use a training system known as 'cascade training' that allows them to reach the target beneficiaries in a cost- and time-effective manner. A relatively small group of individuals are trained initially, who then become 'master trainers' responsible for passing on the skills and knowledge acquired in the original training to a larger group. Members of this group may then also train others, and so on. Cascade training models can be cost-effective methods of disseminating key information among large groups, but they operate on the assumption that information (both amount and quality) survives throughout the various levels to which it is cascaded, which our research suggests does not always hold in practice. While supportive supervision by DHMTs can help identify and address gaps in training, if the model of training is itself deficient, then the gaps being identified are not necessarily filled.

The biggest problem appears to be that the quality of training diminishes at each level, meaning that the last to receive it (frontline healthcare staff) receive significantly diluted or flawed information. This was apparent, for instance, in the Mother-to-Mother Support Groups (see below), who receive training from a combination of NGOs, PHU staff and community health workers. The trainings reportedly include information about antenatal visits, exclusive breastfeeding, complementary feeding, nutritious diet and food diversification, as well as basic hygiene. However, the lead mothers we spoke with in Kambia spoke almost solely about exclusive breastfeeding and it was not clear on further questioning whether any information is being provided beyond this.

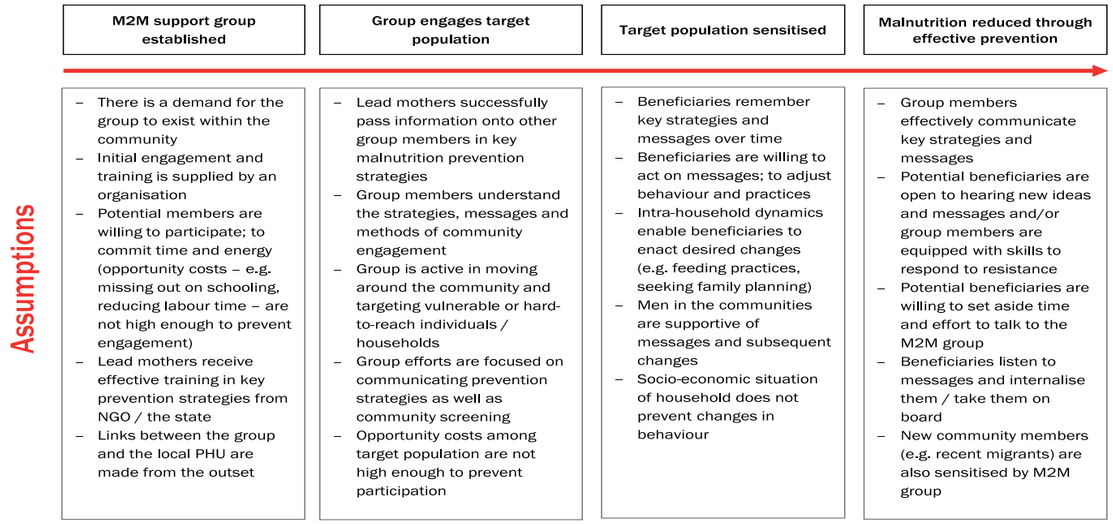
Mother-to-Mother (M2M) Support Groups. The M2M Support Groups are described by development partners and the MoHS in Freetown as groups of up to 15 women. Members learn about a broad range of child nutrition-related issues and practices (including exclusive breastfeeding, complementary feeding, diversified and nutritious diets, home gardening, cooking practices and hygiene) via trainings, activities, demonstrations and discussions and provide social support to each other. The broad objectives are to facilitate optimal IYCF practices within communities, and to promote the uptake of routine preventive services at PHUs through community mobilisation and sensitisation. In theory, each group is headed by a lead mother,[6] who has responsibility for convening the group and passing on knowledge to the other members. This is initially acquired through a training course run by NGOs or MoHS staff. Members of the group then share the knowledge received from the lead mother with other members of the community who may not be part of the group.

Our research suggests that both GoSL and development partners consider the M2M Support Groups to be one of – if not the – primary structure for sensitisation on nutrition at the community level in Sierra Leone. Currently, M2M Support Groups are present in only 18 per cent of the country, although there are plans to increase this to 50 per cent in 2014. They are seen to constitute a key mechanism through which malnutrition can be prevented, and they are one of the main ways hard-to-reach households are targeted. Their role becomes particularly pronounced when the constraints around effective outreach that PHU staff work within are considered. Although phases of outreach activity are planned into the schedules of PHU staff, our research suggests that in reality this work is made difficult by logistical challenges. Staff are expected to travel sometimes-considerable distances without motorised transport, and even where motorbikes are available, a lack of fuel limits their use. There is a seasonal dimension to outreach too, with this kind of activity becoming more problematic during the rainy season when roads can become impassable.

Thus, M2M Support Groups exist to fill an important gap in service delivery. Yet despite the considerable trust placed in the groups, their successful operation and impact depends on a range of assumptions. Given the centrality of the M2M Support Groups in many development partners' activities to prevent malnutrition, we have attempted to sketch in below in Figure 3 the rudimentary theory of change that seems to underpin them. The boxes running across the top of the figure represent the steps leading to a successful outcome. The longer, dashed boxes beneath describe the assumptions that must hold for each to step to be realised.

6 We spoke to eight M2M Support Groups at least one in each chiefdom. However, some groups are headed up by more than one lead mother, meaning that in some interviews we spoke to two lead mothers simultaneously.

Figure 3: Rudimentary theory of change underpinning the effectiveness of M2M support groups



Our research suggests that not all of these assumptions hold true. Indeed, interviews in each of Kambia's seven chiefdoms suggest that M2M Support Groups may adhere to varying degrees to the model explained by the Freetown-based nutrition community. In practice, we found groups operating in quite different ways in different communities. For instance, there appeared to be clear variations in how closely linked the M2M Support Groups were to the PHUs. In some cases, the relationships seemed strong, with regular interactions between the groups and PHU staff, as well as use of the facility for group meetings. However, in other instances the groups were essentially disconnected from the PHUs. In one chiefdom, neither the PHU staff nor the lead mother we interviewed knew the other personally, and it was clear that very little in the way of coordination or information sharing between the two was being done. There also appeared to be variations between the different M2M Support Groups in terms of both structure and remit. For example, while some groups had more than one lead mother, some lead mothers did not have a M2M Support Group as such, instead appearing to conduct outreach at the PHU and in households in the community. Further, in one chiefdom, the distinction between the M2M Support Group and the local Farmer Field School was blurred to the point of being non-existent. Formed of what appeared to be the same members, there was little sign of a clear division of labour between the two groups. Further, in contrast to other M2M Support Groups, this group met on an ad hoc basis. What these brief insights illustrate is that, in practice, the M2M Support Groups operate in a less uniform and structured way than is suggested by the model understood in Freetown or even the district capital. This suggests both a need for more monitoring and supportive supervision, as well as more flexible theories of change that adapt to ensure that implicit assumptions reflect reality.

Farmer Field Schools. An important intervention attempting to link nutrition and food security is the Farmer Field Schools. These schools were initially set up by MAFFS with support from FAO to improve farmer productivity in growing staple crops, like rice and cassava. More recently, the potential for Farmer Field Schools to improve nutrition has been recognised, and an emphasis on training farmers in growing more nutritious and diversified crops has emerged. In addition, efforts have been made to link farmers up with markets so they can profit from selling their produce, thus providing the farmers with an income with which to purchase a more varied diet. The Farmer Field Schools proved the most difficult aspect of programming to research as finding operational schools in Kambia was difficult. On a number of occasions, particular Farmer Field Schools indicated to us by MAFFS in Kambia were not operational or could not be located; community members had not heard of them. In several cases, farmers involved in Farmer Field Schools reported having been operational in the past but that funding had dried up, and MAFFS and development partner staff had not visited for up to ten months. There was genuine interest among farmers we met in either revitalising, or simply starting, Farmer Field Schools, but this was by far the least institutionalised of the programmes we examined. In general, the concept of Farmer Field Schools was not clearly known or understood by respondents. This was quite surprising given that the impression from development partners and GoSL in Freetown is that the Farmer Field Schools

are active throughout the country. Some Farmer Field Schools may well be active, particularly in other districts where they have received more sustained support, but they are certainly not operating nationwide and there is ample room for capacity support for them.

3.4 Persistent gaps in state capacity to prevent malnutrition

Alongside mapping the kinds of capacity support provided by development partners in the nutrition sector, our research examined state capacity gaps and constraints, as articulated by MoHS, MAFFS, MEST and MSWGCA at national, district and community level. We set these out below, organising them by way of the different dimensions of capacity identified in section 2: resources, skills and knowledge, organisation, politics and power, and incentives. Subsequently, in the final section, we point to ways in which capacity support can better connect with these existing gaps.

Resource constraints

Although much capacity support in the nutrition sector is already being directed towards boosting resources, there are still gaps in this area. Perhaps the most obvious relates to **financial constraints**. Indeed, our research suggests that the GoSL operates with three funding gaps.

First, as part of the National Food and Nutrition Security Implementation Plan, GoSL outlined a four-year budget. However, following government and development partner pledges, a 50-80 per cent shortfall remains. Part of the shortfall is explained by the fact that development partners have only committed funds to year one of the budget – due to their own funding cycles. However, this clearly limits the ability of government to plan for implementation of a complex strategy that involves multiple government ministries at national and district levels, development partners and private sector representatives.

Second, since the Local Government Act (2004) and ongoing decentralisation efforts, government funding of the DHMTs and PHUs has been dispersed through the District Councils. This adds another layer of bureaucracy and politics to funding cycles, and many interviewees reported delays in receiving their budgets from government and that the entire agreed budget amount was rarely received. In some cases, it was reported that DHMTs received their first budget allocation of 2013 in June – five months late. Budget tracking by a network of NGOs reveals large discrepancies between budgets reportedly dispersed by District Councils and amounts that DHMTs and PHUs acknowledge receipt of (Save the Children *et al.* 2012).

Third, government ministries that do not play a direct nutrition role, such as MEST and MSWGCA, receive virtually no funding for nutrition-related activities. This inhibits a whole-of-government response to the challenge of preventing malnutrition and does little to encourage cross-ministry coordination. Interviewees bemoaned the lack of action or participation in coordination mechanisms on the part of these ministries. However, if they receive no capacity support to define and assert their role in nutrition, then a retreat to conventional siloes of expertise is not surprising: it is hard to build commitment and engagement from these ministries if there is no budget to pay for people's time. Within the Ministry of Education, for example, the Home Economics Unit has a degree of responsibility for promoting nutrition within national education curricula. But the Unit is staffed by a single person, with little or no authority to deliberate on nutrition policy issues. This makes it difficult to encourage sustained engagement between the Unit and wider nutrition-related activities. Home Economics is also perceived to be a feminine subject area and is less prioritised than more technical disciplines such as nutrition or food security.

Skills and knowledge constraints

Persistent problems relate to both the **numbers and quality of relevant staff**. Across stakeholder groups, our interviews found that overwhelmingly people felt that a quantitative increase in existing activity, as well as a qualitative improvement in technical knowledge, was needed to prevent malnutrition. This seemed to take precedence over fundamental changes to how things are done. For example, we were consistently told about the need to increase the number of M2M Support Groups at the community level or to employ additional District Nutritionists. However, while straightforward increases in human resources are likely to be important, at least in the short-term, it is questionable whether these investments will generate the kinds of deep and sustained improvements in state capacity needed to prevent malnutrition in the county. In addition, it will be important to pay to look closely at how current prevention models are actually working in practice, and to ask whether they are achieving as expected to.

Aside from constraints on the quantity of staff, there are also concerns that certain **key personnel currently do not possess the requisite knowledge** regarding nutrition. Most of those we spoke to felt that technical capacity at the community level and within the PHUs is currently inadequate. The obvious response might be to increase the transfer of skills and knowledge to staff through effective trainings. However, as we have discussed already, placing too much emphasis on training alone and too much faith in cascade training models may be problematic. High levels of PHU staff turnover – arguably a result of broader structural problems that trainings alone cannot address – do not help, as incoming staff have not received the necessary training.

Another skills and knowledge constraint that emerged as significant is **surveillance and reporting**. While part of the problem stems from a lack of standardised monitoring procedures within the system as a whole, there are also concerns about weak reporting capacity among PHU staff at the community level. For example, reports from the PHUs, usually received late, often contain missing or inaccurate data, meaning that District Nutritionists and Monitoring and Evaluation Officers must verify the information by phone or in person.

Staff at peripheral health units in rural Sierra Leone are on the frontline of dealing with manlutrition. But how can the capacities of the state be developed to help them in this challenging task?

Organisational and management constraints

Interviewees at the national level regularly cited **coordination problems** as a pressing challenge. As discussed above, multiple actors work in the nutrition sector, and effective solutions to widespread malnutrition require cross-cutting responses that, by definition, demand collective action from a range of stakeholders. The need for good coordination has not been neglected in Sierra Leone. At the national level, a variety of meetings regularly take place, the purpose of which are to promote coordination, particularly among development partners. However, there are concerns around how effective the current coordination mechanisms are.

There is confusion about the specific aims of the various meetings and working groups and the content of the meetings is often not as useful as it could be. For example, one NGO interviewee noted, 'We don't know exactly who is doing what, who is part of what meeting', and there were concerns about the additional pressure that coordination meetings place on already busy schedules. However, the general sense seems to be that while the meetings and working groups are not problematic in and of themselves, in practice they may not be as productive as they might be. Currently, coordination meetings are spaces for providing updates within the community of practice and give agencies the opportunity to let others know what they are doing. While important, a focus on information sharing does not leave much room for other important and potentially more transformative tasks, such as collective problem solving or joint planning – tasks that require 'putting heads together', as one NGO interviewee called it. A related issue is who participates, and with how much consistency. Meetings designed to reach solutions to complex problems may demand the attendance of different kinds of people than meetings designed to simply share information.

Part of the problem here may be leadership. Although it the MoHS – the key nutrition actor on the government side – has strengthened considerably over the last decade, arguing that the ministry is squarely in the driving seat would be disingenuous. The Food and Nutrition Directorate is demonstrating encouraging leadership, but it nonetheless continues to face obstacles to managing partners, activities and resources. Here we see some of the legacies of conflict shaping current governance capacities, with the state finding itself confronted with a still weak health system and a multiplicity of partners – that they still largely rely on– to organise. As one donor representative remarked, 'This is the reality of post-war'. It will take time for the ministry, and the Food and Nutrition Directorate in particular, to reach a stage where it is capable of managing and coordinating stakeholders. There are signs that progress continues to be made, but space may exist for development partners to realign some of their support to focus more rigorously on enhancing the capability of the Food and Nutrition Directorate to 'balance diversity and coherence' (see Brinkerhoff, 2007).

Government-led coordination and management is also

made more complicated by **data and reporting constraints**. Given the multiple actors operating within the nutrition arena, some coherence miht be expected around monitoring and information. However, due to a lack of awareness of or use of a standardised reporting system by development partners (the reasons appear to be mixed), most partners appear either to adopt their own procedures or harmonise their own reporting methods with some key donors, such as UNICEF. This makes is difficult for the Food and Nutrition Directorate to have a coherent sense of what is going on within the nutrition sector at any given time.

Data problems, particularly at community levels, were routine, with reports from PHUs often containing inaccurate or missing data. High staff turnover and a subsequent lack of training in reporting do not help, but concerns about intentional misreporting were also raised. The piloting and gradual implementation of new technologies for monitoring and reporting at community level – such as the M-Health system used by Helen Keller International – are welcome steps towards improving the quality and timeliness of data collection and sharing. But it would be short-sighted to view technological fixes as a complete solution to this problem.

Political constraints

At the national level, there is an almost tangible sense that momentum for taking action on malnutrition is building. This is due in particular to impressive demonstrations of commitment from the Food and Nutrition Directorate. As one NGO interviewee said, 'The commitment of the government is there – you can feel it.' An atmosphere of enthusiasm surrounds the recently established SUN movement; many of those we spoke to feel positive about its future impact. But the extent to which SUN – together with the MoHS – is able to galvanise **broad support and engagement** across a range of stakeholders remains to be seen. As Gillespie *et al*. (2013: 14) note, 'If nutrition is to be embedded into broader development processes, the nutrition community needs to actively forge alliances with those for whom malnutrition reduction is not a top priority and to do this in a politically aware manner.' Effective collective action will thus depend on the capabilities of key nutrition players to engage other stakeholders and attract support. Specifically, enhancing the capability of MoHS, the Food and Nutrition Directorate and SUN will be important to 'motivate unwilling or unresponsive partners', to 'establish and manage linkages, alliances and partnerships with others to leverage resources and actions', and to 'deal effectively with competition, politics and power differentials' (Brinkerhoff, 2007).

Additionally, such capabilities are required not just at the national level, but further down also. It is clear from our research in Kambia that competing priorities within both the DHMT and the District Council are squeezing out nutrition, with consequences for funding and programming. Greater resources could usefully be channelled towards brokering and supporting conversations about planning and budgeting both across government departments and between the national and district levels.

In particular, it will be interesting to observe how the role and function of the SUN Secretariat evolves. While most interviewees felt generally positive about the movement, many were quick to point out that the next steps are key. As one interviewee noted, 'Everything is moving and that is very good, but it is sometimes moving too fast.' In light of these concerns, setting time and resources aside to do the hard work of building relations and forging coalitions of political support across different line ministries and development partners makes a lot of sense. Some steps have already been taken, such as the designation of a SUN focal person in major line ministries. However, the extent to which these focal persons carry weight and are capable of making decisions within their respective organisations is not clear.

In addition to the above, questions remain over who is setting the agenda and 'sitting in the driving seat' when it comes to developing policy, mobilising resources and managing activity. It is apparent from our research that while the nutrition community in Sierra Leone cooperates to a high degree and is characterised by a strongly held shared goal, working to one agreed plan is still a challenge. While one development partner interviewed told us that 'our work plan is the ministry's work plan', government representatives indicated that this does not always hold true in practice and that, in reality, 'he who holds the pipe plays the tune'. This speaks to how the political capacity of the government nutrition sector to set the agenda is limited by weak financial capacity, which makes it reliant on development partners who have other organisational agendas. Interviews with government also revealed a sense that often development partners set the priorities because of their expertise in the area. In the past, and particularly in the immediate post-conflict setting, the government struggled to articulate a clear agenda. Who sets plans and to what extent these plans align, is an ongoing negotiation in Sierra Leone. While the MoHS increasingly has the technical capacity, particularly at senior and ministerial levels, to articulate priorities in the nutrition sector, government still lacks the capacity to operate independently on preventing malnutrition more broadly. We see this explicitly in the number of development partners continuing to operate within the nutrition arena and the funds that donors continue to supply. But we see it implicitly too, in the (informal) workings of the nutrition community– with a government employee noting, for instance, 'In practice, it is partners who set the agenda.' At the district level, District Nutritionists draw heavily on a close and critical network of NGO personnel to deliver nutrition services and even to do their jobs (transport to conduct monitoring, for instance, is often provided by local partners rather than by government). An indisputable characteristic of Sierra Leone's nutrition sector is that the state still struggles to assert its agenda amid more strongly capacitated development partners that work alongside it; but there are also issues of ensuring that development partners give government the space to set the agenda.

Incentives constraints

Some of the issues already discussed in this section – such as the challenges associated with getting nutrition to be prioritised by 'non-traditional' ministries and individuals – could arguably also be framed as incentives constraints. So too could the continued focus on t**reating rather than preventing malnutrition**. In some ways, the hesitancy to make a substantive shift is perhaps understandable, particularly given the additional funding that would be required to increase prevention at the same time as maintaining present levels of treatment.

The situation is further complicated, however, by the **organisational mandates and incentive structures** of development partners, who often find themselves trying to balance what is essentially a humanitarian imperative to save lives with the demand for longer-term engagement in strengthening health systems (see Brinkerhoff, 2010). Indeed, not only is the former a more comfortable and traditional focus for many agencies, it is also more straightforward. Engaging in institution building and systems strengthening is a messy, non-linear and profoundly political process, and it is much harder to demonstrate results in this kind of work. One donor interviewee mentioned such challenges: 'Building systems is very, very time consuming … there are no silver bullets or short cuts.' What makes malnutrition prevention particularly complex is that appropriate solutions demand the engagement of multiple actors, whose priorities and interests may not necessarily align. Thus, it is not simply a case of whether development partners are aligning with the government. In many instances, the more relevant question might be *who* exactly within government is an agency aligning with, and why. In circumstances where alignment between ministries may not exist, or where it is weak, there may be a particular need for high level political leadership to generate coherence. One of the key messages to emerge from GoSL's experience of providing free healthcare is how important it is to get big, influential political players on side, both within the executive and within line ministries (Donnelly 2011).

Finally, we can identify a series of **incentives constraints at the local level** regarding attitudes, preferences and behaviours in the PHUs as well as within communities. The activity of clinic staff includes conducting **outreach with surrounding villages**. Outreach involves both identifying and referring of cases of malnutrition, as well as sensitising communities through education and messaging. Interviews with PHU staff suggest that, in reality, there is little incentive to do this work. Some villages in the PHU catchment areas are located several miles away, and staff are often not provided with motorised vehicles to travel to and from the various communities (even when they are, fuel is often not provided). These logistical issues are compounded in the rainy season, when roads become difficult to negotiate. Further, PHU staff lack incentives to undertake outreach as, in practice, this role is shared with M2M Support Groups and Community Health Workers (CHWs). The division of labour between these actors is ill-defined and often overlapping. In particular, only a vague sense of the role of CHWs exists in many places, with a particular lack of clarity surrounding reporting procedures and management structures. While having all these actors involved in community outreach is no doubt intended to fill gaps and ensure that *someone* is undertaking this task, in practice sharing the tasks between multiple actors seems to actually deter many from taking it seriously.

Attitudes and practices of communities, particularly in relation to diet, distribution of food within the household, clinic attendance and childbearing can also undermine malnutrition prevention. There are concerns around how cultural beliefs regarding the signs and symptoms of malnutrition confound an understanding of the condition, why it happens, and how (and where) it can be treated. These **attitudes and practices are highly gendered**. Stories about the best food going to the 'man of the house' were common (although not universal) in Kambia, as were food taboos that generally resulted in children not being fed protein. Also common were reports about how embedded sexual expectations of women often result in dangerously close spacing between births, which then increases the likelihood of early weaning (a contributor to malnutrition in infants). In other instances, we were told that some men discourage clinic attendance of their children, realising its importance only at the later stages of malnutrition. The Valid International SLEAC study reported a similar finding regarding delayed clinic attendance: 'Health clinic staff reported that they believe most mothers with SAM [severe acute malnutrition] children still come late to the clinic because of the social stigma attached to the condition' (Guevarra, 2011: 20). By this time, however, it is sometimes too late, and as one PHU staff remarked, 'We don't have magic in our clinics.' Arguably, the incentives of local health workers to try to alter these kinds of problematic social dynamics are not there.

4 Conclusion: Reconnecting capacity support with state capabilities

Our research reveals a remarkably committed and cooperative community of practice around nutrition issues in Sierra Leone and a genuine sense of momentum to prevent malnutrition in the country. This is promising in that the technical commitment is in place for strengthening the government's capacity to prevent malnutrition. Yet the methods being employed by development partners to build this capacity appear to be fairly homogenous. They tend to focus overwhelmingly on the transfer of resources, skills and knowledge at the individual and organisational levels. What we see, therefore, is a major emphasis on training of government staff in the health sector; provision of equipment and materials to clinics; and creation of new local-level prevention structures, such as M2M Support Groups. This is perhaps unsurprising, given that it is relatively straightforward to deliver these forms of support, as they are more easily measurable and less politically difficult. But as the nutrition community in Sierra Leone is aware, it is not enough to assume that capacities have been built as long as workshops were attended, staff were trained and equipment was provided (Johnston and Stout, 1999).

This paper points to two main problems with the present state of capacity support. First, what is being done represents just a fraction of the possible modalities that could be used to develop capacities. Second, it is not clear whether current capacity building approaches are working as expected – primarily because they are based on assumptions that our research suggests do not always hold in practice. This does not mean that capacity building is not working – but rather that it might not be working in quite the way that development partners and government expect.

Our research suggests that persistent constraints in various domains – resources, skills and knowledge, organisational, political and around incentives – are undermining state capabilities to prevent malnutrition. In setting these out, we hope this paper will be a jumping off point for government and development partners to discuss how these constraints can be addressed. Some initial ideas for doing so are set out in this conclusion, and will be refined through later stages of the SLRC Sierra Leone country programme.

Alignment

It is apparent from our research that while the nutrition community in Sierra Leone cooperates to a high degree and is characterised by a strongly held shared goal, there are still challenges of working to one agreed plan. While one development partner interviewed told us that 'our work plan is the ministry's work plan', government representatives also indicated that this does not always hold true in practice and that, in reality, 'he who holds the pipe plays the tune'. In order for government to take on more of an agenda setting role, GoSL needs to commit to funding more than simply the salaries of staff (and even here, a number of development partners, including UNICEF and the WFP, cover the salaries of key nutrition staff), leaving the remaining costs to be covered by development partners, so that they can be seen to demonstrate leadership and commitment. This is particularly important given the emphasis on sustainable prevention of malnutrition – which in the long-term means significantly greater government contributions. In 2010, the MoHS reported that

> ***Government is struggling against enormous hurdles to improve the macro-economic situation in Sierra Leone and is committed to meeting the Abuja target of 15% of the national budget to be allocated to the health sector.***
> (MoHS 2010: 15)

In 2012, the health sector received 7.4 per cent of the national budget (Save the Children *et al.* 2012: 3). Moreover, the 2010 MoHS report goes on to note that, even if the 15 per cent target can be met, this will be 'grossly insufficient' to finance effective implementation of the basic package of essential health services (2010: 15). Thus, if prevention of malnutrition is to be seriously prioritised, then the GoSL must commit higher levels of funding to the issue – even though it is clear that development partners will be relied upon for some time to come. As government steps up, development partners in turn need to take more of a backseat and allow the increasingly capacitated government to set the agenda. This may be a rough transition, particularly given that development partners will still play a crucial role in delivering nutrition-related services but will – at the same time – need to accept less of a leadership role in doing so.

Alignment to government plans can be particularly challenging, given that development partners must also adhere to their own global and regional organisational strategies. Balancing differences in organizational and government priorities can place development partners in a difficult situation. One interviewee noted that total alignment is rarely possible: 'the most you can do is create synergies [between government and development partner plans].'

Further, for development partners to align to government plans, government agencies must themselves be aligned or, in some cases, even have a nutrition policy to align to. While the MoHS has a very clear nutrition policy, other government ministries lack a clear policy or plan and a lack of coherence between MoHS, MAFFS, MEST and MSWGCA was reported. Although the Food and Nutrition Security Implementation Plan is intended to provide the cross-government strategy for addressing malnutrition, this is not always internalised or owned by individual ministries, who may not be familiar with what the Implementation Plan implies for their own ministry. As a result, the first step in improving alignment is for government to develop a more coherent approach *that is understood by all*, that can assist development partners by providing a clear sense of what they should be aligning to.

Joint Planning

Interviews revealed a diverse set of planning practices: some development partners plan internally; some converse with other partners or government counterparts, but largely devise their own programmes that are then shared with government; and others liaise closely with government in developing their activities. Most government representatives, at both national and district levels, however, indicated that they did not feel well consulted in the planning processes of most development partners. This suggests some degree of breakdown of communication (or practice) whereby development partners feel they are consulting but government does not feel consulted.

To address this disconnect, development partners must engage government more consistently and systematically throughout programme planning, implementation and monitoring and evaluation cycles. This should include regular meetings throughout programming stages (including, importantly, at the outset so that government does not have the sense that decisions have already been made that they are simply being informed of), sharing of drafts and relevant information and joint discussion of evaluation outcomes so that this can feed into programme refinement. This may require that development partners alter their planning and budgeting practices – for instance by prioritising the government's financial calendar, not that of donors, and channelling support through a single funding mechanism rather than fragmented funding streams (which was found to be a crucial ingredient for improving nutrition governance in a six-country study) (Mejía Acosta and Fanzo, 2012). While this can present some budgeting difficulties, the priority must be improving government capacity to prevent malnutrition, not donor reporting. Development partners should provide government with 3–5 year forward estimates of their contributions so that government is able to plan accordingly, in keeping with commitments made by donors in the Accra Agenda for Action and the New Deal for Engagement in Fragile States.

Reporting

Connected to issues of alignment, standardised reporting (and adherence to it) would help ensure that government

has a clear picture of what is going on in the nutrition sector and streamline development partner communication with government. Currently, reporting appears somewhat haphazard, with different partners reporting in their own formats with varying levels of regularity. In some cases, development partners appear to have better reporting relationships with the Development Assistance Coordination Office (DACO) in the Ministry of Finance than with the relevant line ministry. Improved reporting could be facilitated by using a *pro forma* reporting template that gets submitting reports to one individual in the Food and Nutrition Directorate or SUN Secretariat on a regular basis (for instance, every 3–6 months). This would help to build institutional memory and management capacity within government, and facilitate record keeping regarding what programmes have been implemented, where and with what results.

Coordination

While a number some coordination mechanisms exist currently at both the technical and political levels, there still appear to be information asymmetries that need to be overcome. This means having agreed communication channels that are consistently used. Clarity regarding the respective roles of the SUN and Food and Nutrition Secretariats will be particularly important. No central database currently exists to capture all nutrition-related work in the country. An attempt to aggregate all this information was made during the UN REACH (Renewed Efforts Against Child Hunger and Undernutrition) programme, but has not been updated since around 2011. Clearly, having effective coordination is not possible until there is a shared sense of all the activities going on within the sector. Mapping these activities and making this information accessible to stakeholders should be a priority of the SUN Secretariat. It is also incumbent on development partners to ensure that GoSL has a thorough understanding of their various programmes.

Sustained training

Our research revealed both the absolute necessity of training and the problematic nature of the way that it is currently carried out. One of our interviewees put this challenge most eloquently: 'Training, training, training, training, training – how much training does one person need?!' A number of interviewees suggested that rather than short, scattered trainings throughout the year that can result in disparate learning, investing in sustained trainings that consolidate courses and topics into a more comprehensive package would be better. This would also alleviate the problems of multiple development partners all running their own training courses and health sector staff being routinely called away from their jobs for training. It was suggested that a 1–3 month training course for all District Nutritionists, for instance, would help to ensure consistency of knowledge across the cohort and allow sufficient time to ensure that the knowledge shared is clearly understood and able to be applied. Suggestions were that such training could be done overseas through institutions such as the London School of Hygiene and Tropical Medicine, or that staff from such institutions could conduct the training in Freetown. The immediate problem raised by longer-term training is that this leaves a gap in frontline delivery staff. This would be perhaps most pronounced for District Nutritionists, as there is just one per district. As a result, conducting such longer-term training would not be possible until a second nutritionist was available. One way to approach this would be to conduct the longer-term training course for new nutrition graduates who would then be sent to each district so that the incumbent District Nutritionist could then also undertake the longer-term training. To attract nutritionists to work in the districts, GoSL could consider offering university scholarships that would be repaid by 2–3 years of government service in the districts.

Alternative forms of capacity support

In the words of one government interviewee, 'capacity building is a broad thing – it's not just [about training].' This report has aimed to demonstrate first and foremost development partners can assist in a multitude of ways in building the capacity of GoSL to prevent malnutrition. What is taking place currently is just a small part of what is possible. Some alternative forms of capacity support are relatively straightforward additions to current approaches, while others will require greater changes to development partner operating procedures.

One area where support could be provided in a relatively straightforward and immediate way is providing District Nutritionists with greater political support in negotiating District Health Plans. It was apparent from interviews that District Nutritionists struggle to ensure that their priorities withstand negotiations within both the DHMT and District Council. Currently, junior District Nutritionists fight this battle alone and a relatively easy 'quick-win' would be to ensure the presence of a senior member of the Food and Nutrition Secretariat attends, or at least, weighs in on, district planning processes to increase the likelihood of nutrition-related priorities being included in District Health Plans.

Flexible contingency funds need to be created so that unplanned requests from government can be mobilised quickly on an *ad hoc* basis. Very few organisations we met had such a facility and this poses challenges for government in accessing funds in the short-term. This can be particularly important at the district level, where government funding is often delayed or falls short of agreed budgets. Unlike government expenditure, development partner funding does not have to pass through District Councils and can thus ease funding gaps or shortfalls while government budget mechanisms are strengthened. Of course, government should also aim to plan as accurately as possible for all expected costs to enable development partners to plan for such costs.

To engage more extensively with the various forms of capacity support available, however, development partners also need to reorient programming away from project-oriented approaches and towards sustained engagement. The focus here should be on building key political relationships in an iterative manner that positions partners for taking opportunities as and when they arise. Sustained partnerships can help to build momentum and sustain capacities, alleviating the disjointed and inconsistent support that project-to-project funding cycles can result in, with recipients being uncertain about how long funding will last, thus skewing incentives towards short-term considerations. As David Nabarro of the global SUN Movement Secretariat has pointed out, research 'explicitly shows that the solution to malnutrition relies on a collective effort in which all stakeholders – governments, academia, civil society, UN system organisations, foundations, development banks, and businesses – carry out specific roles in ensuring that interventions are delivered equitably and at scale' (Nabarro, 2013: 666). Similarly, Gillespie *et al*. (2013: 559) draw on the empirical work of Mejía Acosta and Fanzo (2012) to make the point that nutrition success stories – such as those in Brazil, Peru, Thailand and Vietnam – tend to have 'strong and effective networks of national nutrition leaders at their core'. Part of task, they argue, is to forge strong alliances across government, particularly drawing in weakly engaged departments, and with civil society and the private sector. Key partners that could be engaged to a much greater degree in this process include District Councils, District Medical Officers and Paramount Chiefs, all of whom we found to be relatively unengaged in nutrition discussions. Peripheral ministries, such as MAFFS, MEST and MSWGCA, could also be engaged in a more sustained manner to ensure that conversations are not stop-start and happen only when a seemingly relevant activity involving them emerges, but rather are part of a broader political process that aims to align get all the key players.

This does require less of a preoccupation with tangible, measureable results and indicators and a greater focus on facilitating a political process. Work by Booth (2012) and others (Andrews, 2013; Tavakoli *et al*., 2012; 2013) provides clues for how partner strategies might be legitimately realigned towards approaches that centre on facilitation, brokering and iterative problem-solving. Research from five countries suggests activities of this nature may be particularly important in a sector like nutrition, where collaborative problem-solving methods are required to address differing professional views (Pelletier *et al*., 2012). This kind of political engagement can seem quite amorphous, given the lack of specific inputs and outputs, but engaging in such a way better positions development partners to work at the level of politics and incentives, which is currently being overlooked by most capacity development support.

Of course, developing the capacities of a state emerging from civil war in a context where much of the country experiences food insecurity for one third of the year was never going to be a straightforward or purely technical task. One the one hand, as Sierra Leone continues to transition out of its 'post-conflict' phase, the government will be expected to take greater responsibility and leadership for service delivery functions and, as this happens, a rebalancing will need to occur as the government takes the driving seat and development partners adjust to playing a more supportive, backseat role. On the other hand, government is still a long way from being able to achieve self-reliance in preventing malnutrition and, given the lives at stake, development partners continue to be absolutely central. During this transition phase, therefore, capacity building is critical and finding ways to best support it is more important than ever.

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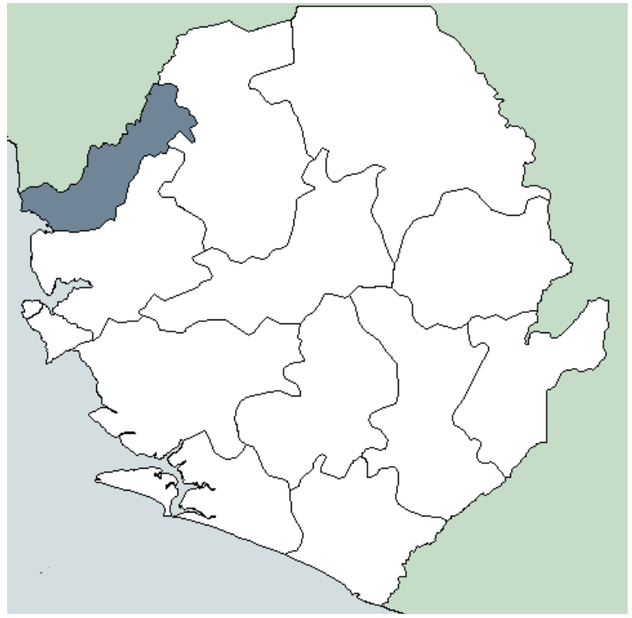
Annexes

Annex 1: Map of Sierra Leone with Kambia District highlighted



Annex 2: List of interviewees

Freetown

Bangura, Allieu – National Technical Coordinator for Health, World Vision
Barics, Kelly and Kamara, Isatou – Country Programme Manager and Food for Peace Specialist, USAID
Benga-Dé, Elisabeth and Nshimirimana, Pascale, Sustainable Nutrition and Agriculture Promotion (SNAP)
Butao, Ruth and Kanu, Philip – Chief Technical Advisor and National Coordinator, Food and Nutrition Security and Right to Food, FAO
Dyson, Meredith – Health Programme Manager, Catholic Relief Services
Foh, Mohammed and SUN Secretariat staff – SUN Secretariat, Office of the Vice President
Hodges, Mary and Sesay, Fatmata – Country Director and Nutrition Programme Manager, Helen Keller International
Kallon, Mustafa and Owen, Katherine – GOAL
Kerr, Heather – Country Director, Save the Children
Koroma, Mariatu – Home Economics Unit, Ministry of Education, Science and Training
Makavore, Alfred – Technical Coordinator, CARE
Mansaray, Zainab – World Food Programme
Molloy, Paula – Irish Embassy
Moninger, Jochen – Country Representative, Welt Hunger Hilfe
Pratt, Samuel – Focus1000
Pyne-Bailey, Solade – Nutrition Directorate, Ministry of Health and Sanitation
Robert, Emily – Health and Nutrition Coordinator, ACF
Sawi, Foday – Deputy Minister of Health and Sanitation, Ministry of Health and Sanitation
Shamin, Aminatta – Director, Nutrition Directorate, Ministry of Health and Sanitation
Sheriff, Abuja – Ministry of Agriculture, Forestry and Food Security
Sinnah, Joseph – Acting Chief Social Development Officer, Ministry of Social Welfare
Swaray, Mustafa – Livelihoods Programme Officer, Trocaire
Wolman, Yaron – Chief of Child Survival and Development, UNICEF
Yankson, Hannah – Nutrition Officer, World Health Organisation
Zombo, Mariama – Food and Nutrition Manager, Plan

Kambia

Chairman, Deputy Chairman and Chief Administrator – Kambia District Council
Director – Community Action for the Welfare of Children (CAWEC)
District Manager – Action Aid
District Medical Officer – DHMT
District Nutritionist – DHMT
Extension Supervisor – Ministry of Agriculture, Forestry and Food Security
Food Aid Manager – Plan
Medical Superintendent – Kambia District Hospital
Monitoring and Evaluation Officer – DHMT
Nutrition Focal Point – DHMT
Paramount Chief – Magbwema Chiefdom
Probation Officer in Charge of Child Welfare – Ministry of Social Welfare, Gender and Children's Affairs
Programme Manager for Integrated Community Case Management – ABC Development
Project Nutritionist – Community Action for the Welfare of Children (CAWEC)
Senior Inspector of Schools – Ministry of Education, Science and Training

Peripheral Health Units, Mother-to-Mother Support Groups and Farmer Field Schools
CHC worker, Kukuna CHC, Bramaia Chiefdom, Kambia District
Midwife, Kukuna CHC, Bramaia Chiefdom, Kambia District
CHC worker, Madina CHC, Tonka Limba Chiefdom, Kambia District
CHP worker (MCH aide), Kassirie CHP, Samu Chiefdom, Kambia District
MCHP worker (MCH aide), Magbengbeh MCHP, Gbileh Dixon Chiefdom, Kambia District
CHC worker (MCH aide), Mambolo CHC, Mambolo Chiefdom, Kambia District
Community Health Officer at CHC, Barmoi Munu CHC, Masungbala Chiefdom, Kambia District
CHP worker, Bamoi Luma CHP, Magbwema Chiefdom, Kambia District

Two lead mothers of local Mother-to-Mother Support Group, Kukuna, Bramaia Chiefdom, Kambia District
Two lead mothers of local Mother-to-Mother Support Group, Madina, Tonka Limba Chiefdom, Kambia District
Two lead mothers of two separate local Mother-to-Mother Support Groups, Kassirie, Samu Chiefdom, Kambia District
Lead mother of local Mother-to-Mother Support Group, Royale, Gbileh Dixon Chiefdom, Kambia District
Two lead mothers of two separate local Mother-to-Mother Support Groups, Matiti, Mambolo Chiefdom, Kambia District
Lead mother of local Mother-to-Mother Support Group, Masungbala Chiefdom, Kambia District
Lead mother of Mother-to-Mother Support Group, Masorie, Magbwema Chiefdom, Kambia District

Supervisor of Farmer Field School, Madina, Tonka Limba Chiefdom, Kambia District
Chairman of Farmer Field School, Kassirie, Samu Chiefdom, Kambia District
Chairman of Farmer Field School, Royale, Gbileh Dixon Chiefdom, Kambia District
Facilitator of Farmer Field School, Mambolo Chiefdom, Kambia District
Chairman of local agricultural community-based organisation, Barmoi Munu, Masungbala Chiefdom, Kambia District
High school staff, Masorie, Magbwema Chiefdom, Kambia District
Chairman of Farmer Field School, Sabenty, Magbwema Chiefdom, Kambia District

Annex 3: Structures, roles and responsibilities for preventing malnutrition in Sierra Leone

The state

Several government ministries and agencies are involved in implementing the GoSL's plans to prevent malnutrition and a number of policies provide the framework. These are set out below, providing a snapshot of the institutional scope for prevention of malnutrition.Ministry of Health and Sanitation (MoHS)

With support from government and partners, the Directorate of Food and Nutrition coordinates all nutrition activities in the country. It is the responsibility of the Directorate to

- plan, develop policies and advocate for scaling up nutrition interventions nationwide;
- mobilise and allocate resources;
- support capacity building for health staff and partners for preventive and curative services;
- support operational research and document best practices and lessons learnt for wider dissemination; and
- support the development of the Health Management Information system (HMIS).

Ministry of Agriculture, Forestry and Food Security (MAFFS)

MAFFs conducts training to build the capacity of small-scale farmers and women in improved methods of farming to increase yields and quality of traditionally local products such as roots, tubers, legumes and pulses. Farmer field schools are established in all districts to conduct these trainings, often with development partner support. The schools are considered an important method of preventing malnutrition at the local level, not just through helping farmers to boost agricultural production and link up more effectively with markets, but also through the promotion of better diets and feeding behaviours. Through collaboration with the Food and Agriculture Organisation (FAO), MAFFS builds the capacity of farmers in processing and preserving products to reduce post- harvest loss and improve overall food availability.

Ministry of Education, Science and Technology (MEST)

MEST, in collaboration with the National Directorate of Food and Nutrition, is responsible for the development of syllabi for primary, secondary and tertiary institutions. The Home Economics Unit within MEST supervises the teaching of nutrition courses in selected schools and colleges nationally. MEST ensures that relevant knowledge required for a particular career area is included in the training curricula of relevant training institutions. It is the responsibility of the Food and Nutrition Directorate to ensure that course content on nutrition is accurately disseminated at all levels.

All national training institutions fall under MEST. Training of health personnel in medicine, nursing, community health, environmental hygiene, pharmaceutical sciences and other allied health disciplines is done through the College of Medicine and Allied Health Sciences (COMAHS), which is under the University of Sierra Leone. Njala University offers training in nutrition, public health, and environmental sciences.

Ministry of Social Welfare, Gender and Children's Affairs (MSWGCA)

The mandate of MSWGCA in relation to nutrition involves caring for women, children and vulnerable groups. This is effectively coordinated through Local Councils to whom power has been devolved for managing of nutrition interventions in public state institutions such as remand homes and prisons. MSWGCA seeks to empower women through advocacy about prevention of malnutrition through Community Awareness Advocacy Groups. It also acts as a focal point in National Nutrition Technical Committee meetings. MSWGCA also takes responsibility for abandoned and malnourished babies and ensures their referral to Therapeutic Feeding Centres. More broadly, the MSWGCA advocates for gender mainstreaming across all policy areas and ministries.

The table below summarises the roles and responsibilities of the various national bodies involved in delivering the National Food and Nutrition Policy.

Table 2: Summary of Roles and Responsibilities in improving nutrition

Ministry/Partners	Role and responsibility
MoHS	Finalise policy/strategy document on IYCF
	Adapt and adopt the code on marketing of breast milk substitutes and monitor its implementation
	Adapt guidelines on standards for the Baby-Friendly Hospital Initiative (BFHI)
	Train health workers on BFHI
	Coordinate the development of IYCF promotion materials and disseminate
	Provide technical support to the private sector in food fortification standards
	Map and manage the construction of Birth Waiting Homes
	Review national protocol on management of acute malnutrition and implement CMAM
	Conduct training of trainers on WHO growth standards for assessment of nutritional status
	Provide tools and equipment for assessment of nutritional status
	Conduct twice yearly micronutrient supplementation (Vitamin A, deworming, iron folate)
	Sensitise on iodised salt consumption
	Conduct nutrition education
Consumer Watch Protection Agency	Monitor the implementation of the code on marketing of breast milk substitutes
	Monitor consumption of iodised salt
	Conduct sensitisation on micronutrients and food fortification
Ministry of Trade (Standards Bureau)	Develop standards for compliance with the code on marketing of breast milk substitutes
	Develop and monitor standards for compliance of micronutrient fortification for essential products
Universities/SLARI	Review nutrition and food security curricula for higher learning institutions to include IYCF and CMAM
	Conduct research on essential food products to increase yield
	Advise on how to add value during food processing and preservation
	Undertake operational research on complementary feeding and implement recommendations
MEST	Support curricula development and approve content for primary schools, secondary schools and tertiary institutions
	Conduct nutrition education in schools and colleges

Ministry/Partners	Role and responsibility
MAFFS	Contribute in the development of food-based IYCF promotion materials
	Produce food for nutrition security
	Establish and train Farmer Field Schools in increased food production
	Disseminate nutrition promotion materials through agricultural channels
Ministry of Information	Disseminate nutrition promotion materials
MSWGCA	Mobilise the community to manage birth waiting homes
	Review labour laws for maternity leave and establish community mechanisms for women care practice
	Monitor and supervise Local Councils for prevention and management of malnutrition
	Facilitate adoption of orphans
Ministry of Justice	Reinforce the code and laws on importation, distribution and consumption of food
Ministry of Lands and Environment	Provide land for food production
	Coordinate construction of birth waiting homes in urban areas
Ministry of Local Authorities	Provide land for construction of birth waiting homes in rural areas
UNICEF, FAO, WFP, WHO	Mobilise the community to manage birth waiting homes
	Review labour laws for maternity leave and establish community mechanisms for women care practice
	Monitor and supervise Local Councils for prevention and management of malnutrition
	Facilitate adoption of orphans
NGOs	Advocacy, capacity development and technical support
	IYCF and CMAM implementation
	Community mobilisation
	Dissemination of messages

Source: Adapted from National Food and Nutrition Policy 2012)

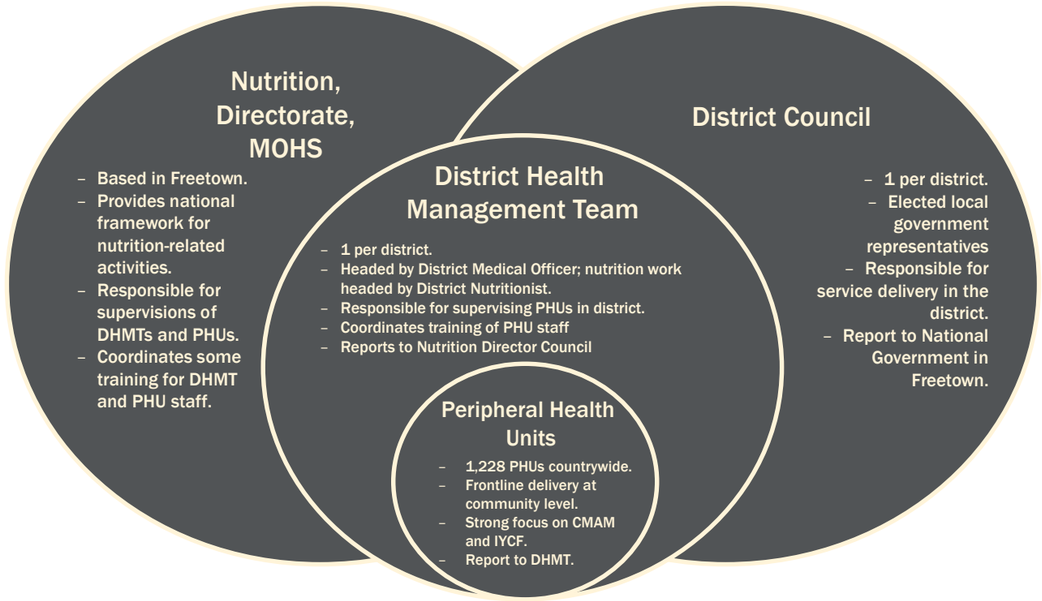
Scaling Up Nutrition (SUN) Secretariat

In addition to the main government ministries outlined above, one important recent addition to the nutrition arena is the Scaling Up Nutrition (SUN) Movement. SUN is a global movement designed to strengthen and coordinate nutrition-related activities at the country level by bringing together a range of stakeholders, including government, civil society, donors and the private sector. The SUN Movement in Sierra Leone was launched in October 2012. A national secretariat has been established in the Office of the Vice President, giving the SUN more political weight than it would have had if located in a line ministry. This SUN Movement comprises all relevant government ministries, departments and agencies, UN agencies and donors, civil society organisations and private sector entities involved in combating the challenges of malnutrition and food insecurity through a harmonised approach. The SUN Civil Society Platform was launched in 2013, comprising a wide range of civil society organisations including market women associations, youth leagues, associations of bike riders and fishermen, NGOs and other community-based groups. FOCUS 1000 and Helen Keller International (HKI) co-chair the SUN Civil Society Platform, and are leading the task of mobilising community-based efforts for the coordination of nutritional interventions and resources.

Key structures at the district and community levels

Nutrition structures in Sierra Leone exist at the national, district and community levels. The figure below depicts these structures.

Figure 4: Nutrition Structures in Sierra Leone



Peripheral Health Units (PHUs) are the frontline healthcare delivery mechanism at the community level. There are 1,228 PHUs across Sierra Leone (Turay, 2013); however these include three 'levels' of PHU. The level of PHU is determined by the resident staff expertise, its location and size of the population to be served: in descending order these are Community Health Clinics (CHC), Community Health Posts (CHPs) and Maternal and Child Health Posts (MCHPs). PHUs are monitored by District Health Management Teams (DHMTs) that are present in each of Sierra Leone's 13 districts (12 provincial districts and the Western Area Rural). The DHMTs have responsibility for all health related matters in the district and are led by the District Medical Officer (DMO) with a District Nutritionist leading on nutrition-related matters. Only since 2013 has a nutritionist resided in every district in Sierra Leone (in 2009 there were just four nutritionists for the districts) (Lowman 2013).

The DHMTs have reporting relationships with both the Food and Nutrition Directorate within the MoHS in Freetown, from which they derive technical support and policy guidance, as well as the relevant District Council, from which they receive their government-allocated budget and agree district health plans. While the Food and Nutrition Directorate, the District Health Management Teams, and Peripheral Health Units directly focus on health and nutrition-related activities, the District Councils are political and administrative bodies through which district-level service delivery decisions are made. Sierra Leone's nutrition structures and the ways in which they relate are set out below.

While the relationship between PHUs and DHMTs seems relatively straightforward on paper, it is not necessarily problem-free in practice. For example, clinic staff sometimes use the DHMT supervision visits to put in requests for additional trainings or materials, such as equipment that would facilitate community outreach activities.17 However, where requests have not been met with a tangible response – a common story that emerged from our fieldwork in Kambia District, and perhaps not a surprising one given persistent resource constraints at the district level – staff appear to have become frustrated, doubtful that anything will eventually follow. This in turn has possible impacts on the motivation and incentives of clinic staff to stay in their job or to do it effectively. On the other hand, and in other ways, the relationship also creates frustration among DHMT staff. We see this particularly in relation to data collection and surveillance. PHU reports received by DHMT are said to often contain mistakes or data is missing, meaning that someone – usually the Monitoring and Evaluation Officer or District Nutritionist – must travel to the clinic to go through the reports with them. In districts with multiple health facilities and difficult terrain, this is not a straightforward task. Data collection problems are compounded by high levels of clinic staff turnover, which creates situations where PHUs are staffed by individuals who may not have received training in recording and monitoring procedures. Possibly related to reporting issues such as these is the problem of therapeutic drug and feeding supplies running out in PHUs – again, a common story. However, it is not clear whether insufficient supply is caused more by low staff capacity to record accurate data or the maldistribution of supplies once they have been received.

Nutrition activities in Sierra Leone are supposed to coalesce around a series of key policies and plans. The following box summarises the most important of these.

7 Outreach should be considered particularly important in light of findings from a 2011 report by Valid International (Guevarra, 2011) which examined programme access and coverage under Sierra Leone's National Community-Based Management of Acute Malnutrition (CMAM) programme. The report found that the majority of severe acute malnutrition cases identified by the study were not covered by a treatment programme; in 68% of these cases, the most critical barrier to coverage was identified as lack of knowledge about the programme. An accompanying Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) study in Western Area found that a low level of awareness of treatment programmes was closely related to weak mobilisation of community-based health workers, whose responsibility it should be to raise awareness within communities and conduct active case finding.

Box 3: A summary of the key nutrition policies of the Government of Sierra Leone

National Food and Nutrition Security Policy, 2012-2016

The government, with support of development partners, has developed the National Food and Nutrition Security Policy to provide guidance and comprehensive strategies to address the problems of nutrition and food security in the country. The policy reflects the complex nature of the causes of malnutrition, the need for multi-sectorial collaboration across government and involving different stakeholders to address them. The vision of the National Nutrition Policy is 'A healthy and well-nourished population with communities and families well informed and empowered to take appropriate action on their food and nutrition situation.'

National Food and Nutrition Security Implementation Plan, 2013-2017

A national implementation plan and budget have been developed by stakeholders to translate the goals, objectives and strategies articulated in the National Food and Nutrition Security Policy into implementable priority projects and activities. The implementation plan covers five years from 2013–2017, and its objective is, by 2017, to increase food production and consumption scores by 80 percent and 25 percent respectively, and reduce malnutrition rates among infants and young children by 30 percent. It involves a wide range of government ministries, departments and agencies and will draw on the support of UN Agencies and national and international NGOs. The Plan aims to improve the health and wellbeing of the population with special emphasis on the nutritional status of young children and pregnant and lactating mothers.

Reproductive and Child Health Strategy Plan

MoHS has developed the Reproductive and Child Health Strategic Plan in collaboration with key international partners and UN agencies. The prevention and management of malnutrition is one its key components. The aim of the malnutrition component is to improve the nutritional status of infants and children under five to ensure their survival, growth and development.

Free Health Care Initiative (FHCI)

In 2010 the government introduced the Free Health Care Initiative to increase access to basic health services for pregnant women, lactating mothers and children under five. Although the initiative has not been fully evaluated, it has indicated positive progress in improving access to health care for vulnerable populations.

Smallholder Commercialisation Investment Programme

The Ministry of Agriculture, Forestry and Food Security (MAFFS) has developed the Smallholder Commercialisation Investment Programme (SCP) under the Comprehensive Africa Agriculture Development Programme (CAADP) initiative. The SCP has six components that include: (1) smallholder production intensification, diversification, value addition and marketing; (2) small scale irrigation development; (3) market access expansion through feeder road rehabilitation; (4) smallholder access to rural financial services; (5) strengthening social protection, food security, and productive social safety nets; and (6) SCP planning, coordination, monitoring and evaluation. Component (1) and (5) have a direct impact on nutrition while the other components have an indirect impact on nutrition.

Annex 4: Table of capacity support provided to GoSL to prevent malnutrition

Table 3: Capacity support provided to GoSL to prevent malnutrition

Organisation[8]	Type of capacity support	Details	Recipient of support	Target level of support
Action Contre la Faim (ACF)	Training	On-the-job training on CMAM for DHMT	DHMT	Individual
	Technical support	Supporting screening by PHUs and CHWs	M2M Support Groups	Organisation
	Resources/supplies	Training on database management for DHMTs	CHWs	
		Support for M2M Groups	PHU staff	
		Supporting micro-nutrient survey and review of surveillance system.	Food and Nutrition Directorate	
CARE	Training	'Window of Opportunity' programme to promote IYCF finished in 2012.	M2M Support Groups	Individual
	Resources/supplies	At PHU level, provided equipment and promotional materials, training and counselling	TBAs	Organisation
		Established M2M Support Groups and trained DHMT to supervise	PHU staff	System
			District Council	
			Koinadugu and Tonkolili districts	
Catholic Relief Services (CRS)	Training	Training of PHUs in screening, sensitisation and CMAM	M2M Support Groups	Individual
	Resources/supplies	Some supportive supervision	CHWs	Organisation
	Supportive supervision	Support to M2M groups through training and provision of materials for backyard gardens	PHU staff	
			Kailahun (9 out of 15 chiefdoms	
Food and Agriculture Organisation (FAO)	Resources/supplies	Mainstreaming nutrition into smallholder agriculture (recruiting nutrition expert to be placed in MAFFS; training); national early warning system	National-level staff within MAFFS	Individual
	Payment of government salaries	Development of food-based dietary guidelines and nutrition modules for Farmer Field Schools	District Councils (helping to integrate nutrition into planning)	Organisation
	Technical support		Civil Society Organisation (CSOs)	System
	Training			
GOAL	Training	CMAM and IYCF support to 19 PHUs in Western Area	PHU staff	Individual
	Resources/supplies	Training of CHWs through cascade model in IYCF	CHWs	Organisation
		Support government campaigns on basis of demand	Nutrition Directorate	
		Supporting micronutrient survey		
		Provision of vehicle and modem to Food and Nutrition Directorate		
Helen Keller International (HKI)	Supportive supervision	Technical support integrating vitamin A supplementation into routine health services	National and district-level staff within the MoHS	Individual
	Technical support	Production and provision of training materials and research		Organisation
	Research	Assistance with nutrition planning at national and district-levels; development of protocols and fortification standards		System
		Supporting monitoring through development of M-Health to allow health staff to record and transmit data by smart phones		

8 This table is not exhaustive. It includes information about capacity development activities related specifically to nutrition and food security as provided to us by representatives of these core development partners in Sierra Leone. These organisations may provide other forms of capacity development not captured here and some organisations providing capacity development might have been unintentionally excluded from this list.

Organisation	Type of capacity support	Details	Recipient of support	Target level of support
Plan	Resources/supplies	Food aid in partnership with WFP	Lactating mothers, people living with TB and HIV and children in four districts (Port Loko, Kambia, Kenema and Moyamba)	Individual
	Supportive supervision	Supplementary and school feeding programmes		
		Monitoring of PHUs		
		Financial support to MoHS and SUN to hold meetings		
		Supporting micronutrient survey		
SNAP	Training	Promoting behaviour change through training and equipping M2M Support Groups	M2M Support Groups and PHUs in 18 chiefdoms across four districts: Bonthe, Tonkolili, Koinadugu, Kailahun	Individual
	Resources/supplies	Distribution of food supplementation (blanket rations in lean season)		Organisation
	Supportive supervision	Food and cooking demonstrations		
		Promotion of family planning		
		CMAM training for PHU staff		
Trocaire	Training	Funding recently secured for initial nutrition work	Makeni and Kambia	Individual
	Resources/supplies	Will involve training farmers and raising awareness about food and diet diversity, and reviewing government policies		Organisation
UNICEF	Training	Support to CMAM on nationwide basis	At national level: MoHS, SUN Secretariat and key stakeholders	Individual
	Resources/supplies	Prevention support at national level (provision of promotional materials; assistance for revising of nursing school curriculum; funding events)		Organisation
	Paying government staff salaries	Prevention support at district-level (IYCF cascade training and supportive supervision of PHUs in four districts)	At district level (Moyamba, Kenema, Pujehun, Kambia): DHMT and PHU staff and MCH Aide schools	System
		Paying salaries of eight District Nutritionists and staff in Food and Nutrition Directorate		
Welt Hunger Hilfe	Training	Training of MAFFS and agriculture extension workers	MAFFS	Individual
	Technical support	Focus on building capacity of CSOs	CSOs	Organisation
		Reviewing government policies and providing advice		
World Food Programme (WFP)	Secondment of staff member to Food and Nutrition Directorate	Secondment of WFP staff member to MoHS for two years to oversee pilot prevention project	Fortified micro-nutrient food provision in 9 districts	Individual
		Provision of fortified micro-nutrient food through PHUs	School feeding in 12 districts	
	Training	Training in sensitisation and clinical practices	Under-two feeding in Moyamba	
	Resources/supplies	School feeding and under-two feeding programmes	M2M Support Groups	
		Training of M2M Support Groups and MCH Aides	MCH Aides	
World Health Organisation (WHO)	Training	Training on nutrition surveillance and data analysis	National and district level MoHS staff	Individual
	Technical support	Provision of logistical equipment and materials		Organisation
	Resources/supplies	Technical inputs into nutrition planning and reviews		
		Review of nutrition curriculum		
World Vision	Training	Training on screening and sensitisation at community level	Food and Nutrition Directorate and MAFFS	Individual
	Resources/supplies	Provision of materials for outreach, seeds for backyard gardens, drugs to PHUs for CMAM, malaria, deworming and iron folate	Bo, Pujehun, Bonthe, Kono: M2M Support Groups, CHWs, DHMTs	Organisation
		Logistical support and equipment for national campaigns and processes	SUN Secretariat	

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