

3

Inclusion of Nutrition Issues in ADB Poverty Assessments and Country Strategy and Program Updates



ADB Poverty Assessments¹⁹

ADB has conducted poverty assessments for 24 DMCs, and the SES reviewed all of them to explore the links between poverty and nutrition. The poverty assessments vary in their treatment of nutrition as a development concern. Of the 24 assessments, 22 provide a situational background on nutrition, of which eight present only some general picture of the nutrition situation (e.g., only food consumption information). Undernutrition was stated as a problem in 16 countries, while six countries stated obesity as a growing problem.

The most common immediate causes of malnutrition identified are (i) poor access to safe water source and/or sanitation facility (16 countries), (ii) gender gaps that have caused women to be nutritionally disadvantaged (12 countries), (iii) diet habits and/or changing diets (11 countries), (iv) social exclusion and ethnic tension (5 countries), and (v) inadequate and unbalanced diet (4 countries). The most common underlying causes of malnutrition are (i) high poverty incidence (11 countries), (ii) access and quality problems in primary health care and basic education (6 countries), and (iii) poor governance and neglect of the social sectors (3 countries). Lack of food security, acquired dependencies, low literacy rate, and population movement due to lack of opportunities (3 countries) or war and ethnic strife (2 countries) are other underlying causes given in the documents.

The poverty assessments also analyzed constraints to implementing strong nutrition programs. Such constraints include (i) poor or declining state of health services (11 countries), (ii) lack of poverty and nutrition data (9 countries), (iii) low priority given to health and education in resource allocation (8 countries), (iv) lack of capacity for adequate and appropriate health and nutrition communication (5 countries), (v) weak governance (4 countries), and (vi) absence of mechanisms for well-meaning community participation (4 countries). Other constraints include (i) geophysical factors; (ii) uneven development between the center and the periphery, especially in the Pacific DMCs; (iii) inherent inequality in sociopolitical structures; (iv) low access to mass media; and (v) weak coordination among international

¹⁹ Appendix 7 shows four tables that provide more detailed information on: (i) nutrition and causes of malnutrition in poverty assessments, (ii) immediate causes of malnutrition mentioned in poverty assessments, (iii) constraints to nutrition in poverty assessments, and (iv) the rationale or entry point for nutrition interventions in poverty assessments.

development partners. In Indonesia, threats to the sustainability of nutrition programs were also identified, such as the weakening of community delivery mechanisms like the village health posts (*posyandu*) and the dilution of the sense of urgency for nutrition that may have resulted from decentralization. The same threat possibly applies to Bhutan, Cook Islands, and Pakistan—countries that are also in the process of decentralization.

While the reasons for nutrition interventions vary across countries, the compelling need for these interventions was discussed with a sense of urgency in all of the poverty assessments that the SES reviewed. This sense of urgency is predicated on recognition of a poor or worsening nutrition situation and/or recognition of the enabling factors or opportunities that exist for renewed nutrition drives. In Bangladesh, Indonesia, and Maldives, the need for nutrition interventions was underscored by the high incidence of malnutrition and micronutrient deficiencies. In Samoa, undernutrition is not as great a problem as diet-related diseases that are on the rise. In some DMCs in the Pacific, e.g., the Federated States of Micronesia and the Republic of the Marshall Islands, the nutrition situation has taken on a dual character, that is, both nutrition deprivation and obesity with its accompanying diet-related illnesses exist.

In Cambodia and the Fiji Islands, there is a need for sustained and stronger promotion of breast-feeding behavior. In other countries, such as Bhutan, Cook Islands, Kiribati, Lao People's Democratic Republic, Republic of the Marshall Islands, Federated States of Micronesia, Nepal, Pakistan, Papua New Guinea, Sri Lanka, Tajikistan, Tonga, Tuvalu, and Vanuatu, the rationale for nutrition interventions includes the existence of enabling policy and program environments, such as good governance, decentralization, strong outreach capacity, and high program coverage of the health sector. In Solomon Islands and Sri Lanka, the link between the deprivation of women and high malnutrition was put forward as something that should underpin nutrition programs.

The intergenerational nature of poverty, the culturally determined roles of women in raising a family, and the link between maternal malnutrition and child malnutrition show that investment in women's health and education is a key to achieving good nutrition. In Cambodia, Papua New Guinea, and Solomon Islands poor women have some knowledge of the solutions or mitigating measures to avoid illnesses (e.g., vitamin A supplement, improved access to clean water, malaria prevention through mosquito repellent-impregnated nets). However, they lack the financial and political resources to access the providers of such services. A study in Sri Lanka identified, as the key causes of child malnutrition, poor caring and feeding practices, high

morbidity, and poverty-related factors, such as lack of access to adequate food, adequate housing, clean water, and safe sanitation. The study also identified maternal malnutrition during pregnancy leading to low birth weight as an important causal factor, thereby indicating the paramount need to view child malnutrition in the context of maternal malnutrition. Given the disproportionate number of poor women and the fact that women are generally the child raisers, the Cambodia and Solomon Islands poverty assessments suggest that there is potentially a high return if poverty reduction and mitigation strategies are directed toward women.

There is a need to ensure that the participants and the target groups own the processes in nutrition and development programs and their intended outcomes; thus, strong local structures for participation are warranted. To avoid wastage of resources, such structures should be better targeted to the poor. The remaining high incidence of malnutrition (undernutrition) in at least 16 of the 24 countries and the growing problem of obesity and lifestyle diseases in at least six countries point to the importance of strong primary health care, where health and nutrition education plays a crucial role.

While the link between nutrition and poverty is obvious in these poverty assessments, and the need for interventions is discussed with intense urgency, only a few of the 24 poverty assessments show a fair level of government spending for health and/or nutrition. In addition, the bulk of the financial resources for health are still devoted to secondary or tertiary care facilities located mainly in urban centers while, on the periphery, there are mothers who cannot even access prenatal and postnatal services or nutrition counseling. In the more resource-challenged DMCs in the Pacific, lessons are learned the hard way, with increased spending for primary health care preceded by prevalence of obesity and related lifestyle diseases, such as diabetes and cardiovascular ailments, alongside the diseases of poverty, such as tuberculosis and malnutrition.

ADB Country Strategy and Program Updates²⁰

Of 33 CSPUs reviewed, 30 include information on nutrition-related situations. Fourteen CSPUs state the immediate and underlying causes of malnutrition, 24 only immediate causes, and 17 only underlying causes. Similar to the poverty assessments, the CSPUs conclude that the most common immediate causes of malnutrition are poor access to safe water and sanitation (23 countries) and gender inequality (13 countries). One country mentions diet habits and inadequate food intake as immediate causes. Poverty was a common underlying cause, and in Sri Lanka war was cited as the underlying cause of poor nutrition, especially among women.

Constraints to a stronger nutrition program are also identified, such as (i) declining quality of primary health care and basic education (16 countries), (ii) poor access to such essential services as health and education (9 countries), (iii) lack of a clear target or consensus for reducing nutrition-based poverty (4 countries), (iv) weak capacity to generate statistics on poverty and nutrition-related information (4 countries), (v) low literacy rate (3 countries), (vi) weak institutional capacities (3 countries), (vii) weak or absence of participatory mechanisms (1 country), and (viii) weak aid coordination (1 country).

The enabling factors for nutrition interventions drawn from the CSPUs are either those that directly address nutrition concerns or those that are only related indirectly, but, nevertheless, can be used in designing and implementing responsive and evidence-based nutrition campaigns. In 13 CSPUs, enabling factors that are proximate to or directly address nutrition problems were identified. These include (i) deliberate government efforts in the fields of nutrition, water, and sanitation; (ii) intersectoral approach addressing the immediate causes of malnutrition; and (iii) presence of several development partners supportive of nutrition. In Sri Lanka, the prospects for peace in the north and east may be considered as a proximate enabling factor for improving the nutrition situation, as years of war have resulted in destruction of water facilities, dislocation, deprivation of the population, and

²⁰ Appendix 8 shows five tables that provide information on: (i) nutrition and causes of malnutrition in CSPUs; (ii) immediate and underlying causes of malnutrition in CSPUs; (iii) constraints to nutrition in CSPUs; (iv) actual or potential enabling factors for strengthening the nutrition drives in various countries mentioned in the CSPUs; and (v) ADB's perspectives, strategies, and activities related to nutrition in DMCs included in the CSPUs.

wastage of resources that would otherwise have been devoted to social sector spending. In 10 countries, the enabling factors identified are those that relate to gender and development, national poverty reduction efforts, free and compulsory basic education, and presence of a strong network of NGOs. The documents also contain information on the current level of priority given by ADB to nutrition interventions (direct impacts) in each country. Nutrition consideration is a priority in many ADB-supported or initiated projects and programs, both within and outside the health and nutrition sector.

In the CSPUs for 12 countries, ADB shows clear and strong support for specific nutrition interventions, such as nutrition education, curbing micronutrient deficiencies, basic nutrition for women, food fortification, and early childhood development. In the other documents, ADB's support for nutrition is either integrated with or treated as spin-offs of support for other sectors, such as livelihood and water resources, health (especially public health programs, such as maternal and child health), education, governance, and gender.