

EXECUTIVE SUMMARY

This special evaluation study (SES) reviewed and analyzed current and future nutrition and food fortification related issues. It also explored whether the links with malnutrition are included and examined in the Asian Development Bank's (ADB's) poverty assessments conducted in 24 developing member countries (DMCs), as well as 33 of ADB's country strategy and program updates (CSPUs). From 1985 until July 2004, ADB financed 31 regional technical assistance projects (RETA) related to health, nutrition, population, and early child development (HNP-ECD) for a total of \$32.8 million. Beginning in January 1996, ADB approved five RETAs directly related to enhancing nutrition conditions and setting the stage for ADB interventions in food fortification in 16 DMCs, totaling \$11.7 million, out of which \$8.8 million was financed by the Japan Fund for Poverty Reduction (JFPR). The SES evaluated all of the RETAs on nutrition and food fortification, except technical assistance (TA) 9052-REG on Sustainable Food Fortification, which was recently approved and not implemented during the SES.

The SES ratings of the RETAs were successful for a project on Reducing Child Malnutrition in Eight Asian Countries (TA 5671-REG) and a Regional Study of Nutrition Trends, Policies and Strategies in Asia and the Pacific (TA 5824-REG) as compared to the technical assistance completion report ratings of generally successful and highly successful. The preliminary ratings for the ongoing RETAs, which are almost completed, are satisfactory for the Regional Initiative to Eliminate Micronutrient Malnutrition in Asia through Public-Private Partnership (TA 5944-REG) and highly satisfactory for the project on Asian Countries in Transition for Improving Nutrition for Poor Mothers and Children (TA 9005-REG). The strengths and weaknesses of RETAs as a modality in addressing nutrition issues and initiatives were explored and discussed in the SES. Key issues, lessons, inputs, and recommendations on strategic choices and priorities for future ADB operations in nutrition are also provided.

Nutrition is integral to the first Millennium Development Goal (MDG) on hunger and poverty. It is also instrumental in the efforts to achieve other MDGs, particularly those related to improvements in primary education enrollment and attainment, gender equity, child mortality, maternal health, and the ability to combat disease. Malnutrition is a multigenerational issue, because fetal development during gestation is influenced by maternal nutrition status. Women who were malnourished as infants are more likely to give birth to malnourished babies, and malnourished children have lower resistance to infection, thus making them more likely to die from childhood ailments. Those who survive are prone to frequent illnesses that worsen their nutrition status, trapping them in recurring sickness and faltering growth. Hence infant malnutrition, especially for girls, plays an important role in perpetuating poverty and malnutrition across generations.

The prevalence of low birth weight is strongly associated with the undernutrition of mothers. Sixty percent of women in South Asia, and 40% of women in Southeast Asia, are underweight, and it is estimated that about 50% of all growth retardation during gestation in rural developing countries is attributed to small maternal size at conception. Low birth weight is one of the main reasons why children are underweight. The consequences include increased morbidity and mortality risks, poor neuro-developmental outcomes, reduced strength and work capacity, and increased risk of chronic diseases in adulthood. Moreover, iodine deficiency disorders (IDD) can seriously damage the brain, slowing mental responses and impairing intelligence levels. Even moderate IDD can decrease the IQ level by 10 to 20 points, thus children with IDD suffer most; they are slower and less intelligent, resulting in poor attainment in school. As adults they are weaker, less productive, and earn lower incomes. Reducing infant

malnutrition, especially in girls, weakens one of the strongest links in the intergenerational transmission of poverty.

The Asia and Pacific region is currently facing a double burden of disease due to the nutrition transition, which accompanies development and urbanization. Therefore, in addition to the old problems caused by undernutrition, new problems arise due to the epidemiological transition, from endemic deficiency and infectious diseases, toward diet-related (overnutrition) chronic diseases, such as ischemic heart disease, diabetes, obesity, hypertension, stroke, and certain cancers.

There is great debate concerning whether nutrition and food are the responsibility of the government (a public good), or the domain of the consumer (a private good). It appears that this question is also a function of consumer demand for good nutrition, which in turn is a function of education and of cultural practices. Among consumers with adequate information for making appropriate dietary decisions, the responsibility of the government decreases to ensuring that updated information continues to be disseminated to them. In areas where the capacity of the consumer is weak, usually due to low education attainment, the government needs to play a stronger role in improving nutrition and education.

In general, the start-up cost for food fortification is relatively inexpensive for related industries. Recurrent costs such as setting up product monitoring and quality assurance of fortification programs within the government are often ignored. While most development partners seem eager to help set up fortification projects, they seem less inclined to ensure that these projects consistently turn out high-quality products that are valued by the consumer, hence are sustainable, and that the government and consumer groups have the capacity to monitor and enforce uniformity of quality products across processed food products, and processed and nonprocessed imported food.

Fortification has been promoted as the most cost effective nutrition intervention. However, in most areas, the majority of the population at high risk of micronutrient malnutrition, i.e., the poor, rarely consume processed foods suitable for fortification. While fortification holds great promise in improving regional nutrition status, it has to be combined with the development of other important household food security and community nutrition initiatives.

Poverty reduction and strengthening of health care systems alone cannot solve micronutrient deficiency problems. Among other things, micronutrient deficiency is due to the hidden property of the micronutrient content of foods. Consumers do not automatically demand micronutrient-rich foods with increased income. Hence, food and agricultural policies need to watch over the quantity and quality of food supply, and promote the production, marketing, and consumption of micronutrient-rich foods. Safety-net programs, including refugee feeding, must also respond to the total nutrition needs of target groups, and not be limited to calorie needs only. Therefore, close collaboration between the public and private sector, as well as civil society, is essential.

The ADB poverty assessments of 24 DMCs and 33 CSPUs identify poor access to a safe water source, sanitation facility, and gender inequality, as the most frequent immediate causes of malnutrition. Poverty is identified as a common underlying cause. The major constraints to implementing nutrition programs observed both poverty assessments and CSPUs are (i) poor access to essential services, such as health and education, and declining state of health services, as well as the low resource allocations given to these sectors; and (ii) lack of poverty and nutrition data. While the reasons for nutrition interventions vary across countries,

the compelling need for these interventions was discussed with a sense of urgency in all the poverty assessments that were reviewed. However, only a few of the 24 poverty assessments show a reasonably fair level of government spending for health and/or nutrition.

In 13 CSPUs, factors that were identified as proximate to or directly address nutrition problems include (i) deliberate government efforts with regard to nutrition, water, and sanitation; (ii) intersectoral approaches addressing the immediate causes of malnutrition; and (iii) the presence of multiple development partners supportive of nutrition. In 10 other CSPUs, 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 nongovernment organizations (NGOs). 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 child development. In 19 of these documents, ADB's support for nutrition is either integrated within or treated as spin-offs of support for other sectors, such as livelihood and water resources, maternal and child health, education, governance (linked to decentralization), and gender.

Improving the monitoring and risk management capacity of the participating DMCs in TA 9005-REG has allowed their governments to make quick managerial decisions that enable increased coverage and focus on delivery of fortified foods consumed by the poor. Identifying new technologies, and facilitating transfer of these technologies to governments, NGOs, food industries, and consumer groups—thus facilitating resources and synergies of the public-private sector and civil society—are some of the strengths of this RETA in aiming to ensure successful and sustainable fortification programs. ADB also has the capacity to play the role of a catalyst in nutrition and food fortification, as demonstrated by (i) TA 5944-REG, where DMCs have received support from various development partners to implement their country investment plans for food fortification developed by the RETA, and (ii) TA 9005-REG in mobilizing other development partner assistance for nutrition and food fortification in Asian countries in transition.

A modified (hybrid) modality RETA/TA, with clear and simpler processing and administrative procedures, which allows small investments for pilot projects and equipment, etc., seems better suited to enhance the effectiveness of technical assistance and produce sustainable impact than just consultants' inputs, and a series of meetings and workshops offered by the current technical assistance modality. This type of modified modality is provided by JFPR-funded assistance, such as TA 9005-REG. However, although this preferred modality could indeed offer greater possibilities for a good outcome, particularly with the inclusion of small investments, its cumbersome administration often discourages its use.

Meetings and workshops are useful for defining issues. However, integrating effective nutrition policy components into overall development plans can best be done as country-specific activities. While the results of consensus building at the regional level using RETAs does not always “trickle down” to national decision makers, particularly in countries where budgetary authority has been decentralized, they are good forums for advocacy and raising awareness.

The SES recommendations include the following:

- (i) ADB should include costs that are often ignored, such as costs related to supporting quality assurance and standardization when designing a food fortification intervention and in calculating the cost effectiveness of the intervention.
- (ii) Modified (hybrid) modality RETA/TA that allows small investment components appears to have potential in enhancing effectiveness and ensuring sustainable impact of ADB RETA/TA, which will also enable optimum utilization of the Eighth Replenishment of the Asian Development Fund (ADF IX) grants for TA. ADB should further explore the possibility of this modified (hybrid) modality for its RETA/TA in ADB's ongoing effort to restructure its TA operations.
- (iii) ADB RETAs should build ownership by tailoring nutrition interventions to local social conditions.
- (iv) The findings and outputs of the nutrition-related RETAs, and lessons from other ADB nutrition-related operations, could be useful inputs for a nutrition section that should be incorporated into the updated ADB Policy for the Health Sector or the integrated Health, Nutrition and Population Strategy planned for 2006.
- (v) ADB should continue playing the role of a catalyst in nutrition development efforts in the region.
- (vi) Holistic solutions in poverty reduction that will correct underlying risks for poor nutrition should be promoted by supporting complementary activities for improved nutrition and empowerment of women in ADB operations.

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