

PROCEEDINGS OF THE NUTRITION SOCIETY

*The Summer Meeting of the Nutrition Society was held at the University of Southampton on
2–5 August 1994*

**Symposium on
'Investing in nutrition: maximizing returns'**

Nutrition in overseas aid: the investors' perspective

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The aim of the present paper is to explain the current priorities for Overseas Development Administration (ODA) support to developing countries, the main criteria by which proposals are judged and the sort of outcomes that are expected from our investments. I have concentrated in particular on describing how nutrition interventions might be planned as part of broader investment in health care systems in the poorest countries of the world.

Like many development agencies ODA has come under increasing scrutiny in recent years. We are expected to develop and support interventions which are technically sound, of good quality and which are likely to have the greatest impact on poor people. At a time when resources are scarce and budgets constrained, maximizing the return from our investments is a major pre-occupation. Government health care budgets average about US \$10 per person per year in the developing world: in over forty countries less than this sum is available. This compares with the budget of the UK National Health Service of approximately £600 (US \$900) per person per year; a 100-fold difference. Last year's *World Development Report 1993: Investing in Health* (World Bank, 1993) suggests that a minimum package of essential and curative health care costs about US \$13 per person per year. In order to provide such services, resources must be managed as efficiently as possible; in practice most developing countries do not make best use of either their financial or human resources.

The estimate of US \$13 per person per year assumes that resources are equitably distributed between primary, secondary and tertiary health care systems. This is seldom the case as, despite promotion of the concept of primary health care over the last decade, many Ministries of Health allocate a disproportionate share of the health budgets to hospital-based health care systems. These have particularly high recurrent cost requirements. It is not unusual for a teaching hospital, based in a capital city and serving less than 10% of the total population, to consume more than 50% of the recurrent budget for health. As a result little money is left over for preventive programmes, which include most nutrition interventions.

Recognizing these problems ODA has attempted to identify some of the underlying issues which affect the way in which health care services are provided, in order to change the way in which governments plan and deliver their health services. ODA is trying to facilitate this by supporting the process of health sector reform. While this process will vary from country to country it will typically include the following:

1. development and promulgation of health policies that relate care to need and define priorities for spending;
2. definition of nationwide standards for health care with clearly specified outcomes;
3. use of cost-effective interventions;
4. separation of policy and financing from service delivery (referred to as the purchaser-provider split in the UK);
5. systems for monitoring and auditing the quality of care;
6. attempts to link remuneration and promotion to performance;
7. rationalizing the work force so that the proportion of expenditure on staff salaries is reduced and adequate allowances made for maintenance and the purchase of essential drugs and equipment;
8. examining options for introducing user charges and establishing exemption systems to protect the poor.

Such a reform process can be tortuous and may create widespread resentment amongst both the general public and health care providers. However, given the current state of health care in many parts of sub-Saharan Africa where I spend much of my time, there is no alternative. While in general most Ministries of Health remain well staffed, in fact many are overstaffed, salaries are low and may not be paid for months on end. Health facilities commonly lack basic equipment in working order, buildings are maintained little, if at all, and essential drugs may be scarce or completely absent. Staff morale is low, with many health workers resorting to private practice or charging for health services that the government has deemed to be 'free'. Under such circumstances it is hardly surprising that only 20–30% of the population in rural areas make use of government health facilities in many of these countries. Church and voluntary agency health services provide health care for significant numbers of people in most developing countries. The traditional sector is often well patronized. However, many poor people are forced to do without any recognized type of health care.

At this point I would like to describe the priority objectives for the Overseas Development Administration (Foreign and Commonwealth Office, 1994). These overarching objectives are to:

1. promote economic liberalization;
2. enhance productive capacity;
3. encourage good government;
4. help implement poverty reduction strategies;
5. promote human development, including better education and health, and children by choice;
6. improve the status of women;
7. help tackle environmental problems.

The question may be asked: 'where does nutrition come into all this?' Nutrition interventions are capable of enhancing the productive capacity (addressing the problems of Fe and I deficiency), reducing poverty in particular through promoting increased food security at national, community and household level; improving health through general improvements in nutritional status and by addressing the interaction between nutrition and infections. The status of women can be improved by involving them in the planning and delivery of health and nutrition interventions, and by raising the general level of education, including their understanding of basic nutrition, so that they may feed themselves and their children better.

The total ODA budget for the financial year 1993–4 was £2.1 billion. This is disbursed through a range of channels, including bilateral (government to government), multi-lateral (through the United Nations (UN), European Community or Development Banks), emergency aid (of which the significant proportion is food aid), through non-governmental organizations and support for research. About 55% of this total is disbursed directly through bilateral channels, the balance in the form of multilateral aid. Approximately £100 million per year of the bilateral aid is spent on health and population aid, almost 10% of the total budget. Slightly more than this is spent on emergency programmes. To this should be added ODA's contributions to the UN Agencies, notably World Health Organization, UN International Children's Emergency Fund (UNICEF), UNFPA and World Food Programme, which total about £40 million per year.

For our support to health and population programmes in developing countries four themes have been identified (Overseas Development Administration, 1992). These are:

1. strengthening health service management and supporting the process of health sector reform;
2. enabling women (and men) to have children by choice, by providing better access to good-quality family planning services and reproductive health care;
3. effective control of malaria, tuberculosis and acquired immune deficiency syndrome (AIDS);
4. improving the quality and relevance of available health services in emergency situations.

Recently at a meeting in Brussels member states of the European Union and the European Commission endorsed this approach to development in the health sector. Discussions with my colleagues in the Education and Natural Resources Sectors indicate that they too are focusing on much the same issues. Twenty countries have been identified as priorities for ODA support to the health sector. These are: Kenya, Uganda and Tanzania; Ghana, The Gambia and Nigeria; Namibia, South Africa, Zimbabwe, Zambia and Malawi, Pakistan, Bangladesh, India, Nepal and Cambodia; Russia, Kazakhstan, Kurdistan and Peru. In addition, ODA support health and population programmes in thirty to forty other countries. When appraising a project ODA seeks to achieve a number of objectives. These include: (a) maximizing the return for a given investment; (b) improving the efficiency with which existing resources, primarily financial and human, are managed; (c) minimizing risk.

Like most development agencies ODA is increasingly concerned with identifying the risks associated with given interventions, clearly identifying them and taking explicit steps to minimize them.

Any project proposal should contain a clear statement of objectives, a precise account of the financial and human resources to be invested in the programme and, most importantly, measurable outcomes. A typical project to support the process of health-sector reform, which has been developed by ODA in the last 2 years, is in Ghana. Over a 3-year period (and almost certainly beyond that) ODA will be providing a total of £12 million to the Ministry of Health to: strengthen financial management systems, improve human resource development to make better use of existing staff, strengthen the policy and planning capacity of the Ministry, support the establishment of district and sub-district health teams to extend the coverage of quality primary health care programmes, supply health equipment to health centres and district hospitals

throughout the country in the context of a rational equipment supply operation and maintenance system, and strengthen transport operation systems.

We believe that by adopting such an approach Ministries of Health will be able to better plan and deliver a wide range of services which best address the morbidity and mortality patterns at national or local level and reflect the level of resources which are available. Clearly in many parts of the developing world such programmes would include nutrition interventions, such as growth monitoring and promotion, promoting exclusive breast feeding and controlling Fe, I and vitamin A deficiencies. ODA often collaborates with other development agencies, notably the World Bank and the European Community (17% of whose aid budget is paid for by ODA). Under such projects, ODA expertise is often used to complement World Bank and European Community capital investments.

Over the next few years resources will continue to be scarce and competition for limited budgets, whether from donors or from developing countries, will become more intensive. By demonstrating sound management of human and financial resources, value for money and the achievement of clearly-defined objectives according to an agreed upon work plan, those who are involved in the planning and management of nutrition interventions will maximize their chances of gaining support from whatever source.

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