

International Development Committee

Oral evidence: Extreme poverty and the Sustainable Development Goals, HC 932

Tuesday 26 April 2022

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Members present: Sarah Champion (Chair); Chris Law; Nigel Mills; Kate Osamor; Mr Virendra Sharma.

Questions 125 - 139

Witnesses

I: Dr Githinji Gitahi, Group CEO, Amref Health Africa; Bessie Ndovi, National Co-ordinator, Malawi, Civil Society Organisation Nutrition Alliance.

Examination of witnesses

Witnesses: Dr Githinji Gitahi and Bessie Ndovi.

Q125 **Chair:** Welcome to the International Development Committee's inquiry into extreme poverty and the sustainable development goals. We are very fortunate to be joined by two witnesses in this one-panel session. I will ask them to introduce themselves first before we begin our questions. Dr Gitahi, could you introduce yourself and tell us a little bit about your work, please?

Dr Gitahi: My name is Dr Githinji Gitahi. I am a medical doctor by training, but I am currently working as the global CEO for an Africa-based international NGO called Amref Health Africa, working in about 35 countries in Africa, with about 1,500 staff. We are working in the areas of health and the intersection between healthy communities and health systems. We have been working on this for more than 60 years. That is who we are and what we do every day, working closely with women and girls and Governments in Africa.

Q126 **Chair:** You are the perfect witness for us. Our second and equally appropriate witness is Bessie Ndovi. Could you introduce yourself and say a little bit about your work, please?

Bessie Ndovi: My name is Bessie Ndovi and I am the national co-ordinator for the Civil Society Organisation Nutrition Alliance, abbreviated as CSONA. I am based in Malawi, in Africa. The work programme we do centres on nutrition advocacy: generating accountability for nutrition and making sure that nutrition is prioritised in Government agendas and various strategic documents and policies, as well as budgets; creating general awareness around nutrition in the local masses; and building the capacity of various stakeholders to do with nutrition advocacy, so that nutrition can be placed at the centre of development priorities in the country. Generally, in brief, that is what I do in Malawi.

Q127 **Chair:** Doctor, could I ask you the first question, please? What is the relationship between access to healthcare and the prevalence and persistence of extreme poverty?

Dr Gitahi: If you look at health, education and poverty or wealth, they are completely interconnected and interrelated. The question you are asking is about the relationship between health and extreme poverty. On the one hand, if you look at general economic activity, it is only healthy children who go to school and only healthy adults who work. This means that economic development and productivity, which are tools against poverty, are grossly affected if those two are absent.

For health, there are multiple areas. One is nutrition. You have to look at the journey of life from the beginning, like Bessie has talked about. If you do not have nutrition during pregnancy or after childbirth and during early development, you end up with low-birthweight children and with children who are stunted. These children who are stunted have low



HOUSE OF COMMONS

cognitive ability, which means that, even when they go to school, they are less likely to acquire quality education. That means that, eventually, they end up in poverty, because they cannot produce adequately.

Beyond this is the relationship between health and the cost of health. In the continent of Africa, an inadequate number of people are adequately covered by what we call universal coverage. I will try to give you some figures. If you look at expenditure in dollars per capita, let us say that Africa spends about \$70 per capita on health. In the UK, it would be closer to \$4,000, so we are starting very low. Of that \$70, you would expect that the Government pay half, and the other \$35 would be paid by individuals, out of their pocket, or by partners like yourselves and the UK Government. The portion that individuals pay out of their pocket is significant. If you compare it with the per-capita income of households, it is likely to amount to 3% to 4% of the individual's income. That would be about 1% or less in OECD countries.

This is a major cause of poverty, and individuals are forced to sell their livestock and their land and to give up their savings in order to cover health costs from their pocket. We know that physical space is a problem, and we can discuss that later, but this is the issue. Last year, 15 million people became poor because of health costs in the continent. In a country like Kenya, it is more than a million people. This is a major challenge. It is systemic. It is about nutrition.

The other issue I may have forgotten to mention is reproductive health. If you do not have access to reproductive health services, meaning that adults and girls do not have access to family planning, then adults, girls and boys do not have access to condoms. That means that young girls are likely to get pregnant early. When they get pregnant, you are developing a generation of poverty. They cannot go to school. If your first age of pregnancy is 12, 13, 14 or 15 and you have a child at that point, it means that you cannot go to school and you start a generation of poverty with yourself, with your children and with your dependants. It is a conglomerate of issues—family planning, nutrition and health costs.

Q128 Kate Osamor: I would like to direct my first question to Bessie Ndovi. What impact are you seeing on food security in low-income countries as a result of the war in Ukraine?

Bessie Ndovi: Thank you very much for the question. The war in Ukraine has created some problems not only for us in Malawi but for the rest of Africa and the rest of the world. The first thing that we have seen is an increase in commodities, especially fuel and some gases. This has come about because Ukraine and Russia are the largest producers and exporters of commodities. Now that there are sanctions happening in Russia, and Ukraine is not in a position to export these things, the commodities are being sourced from Asian countries and the Middle East. This has created a scramble for these resources, so commodities have become very expensive.



HOUSE OF COMMONS

For African countries like Malawi, which are already poor and where most people live below the poverty line, it has become very expensive. The transportation of goods and services, and especially food commodities, has become very difficult, to the point that food prices have become very expensive. Quite recently in Malawi, we have seen an increase in fuel prices. About two or three weeks ago, fuel prices increased, and the end result is that everything has gone up, from food commodities to medicines and basic resources at a household level. These have gone up.

We have other countries that rely heavily on wheat as their staple crop. Russia and Ukraine are also the largest producers of wheat. This has made the commodity very expensive and scarce. Countries like Egypt that produce wheat are not able to meet demand for wheat. At the same time, commodities like fertiliser are used in the production of various crops. For us in Africa, especially in Malawi, we produce a lot of maize and other plants that require fertiliser. Right now, fertiliser prices have gone up very high.

The impacts are many, but just to mention a few, food prices have gone up, which has created a big gap in accessing food commodities. In the end, this is causing food insecurity to rise. Malawi is one of the poorest countries. The World Bank placed us below 10 countries that are very poor in the world. Added to this, we are being faced with the issue that is affecting everybody else, which is the war. As such, things have become very difficult for us to access.

We see that ongoing conflict between Ukraine and Russia is, in the long term, going to cause many problems. Instead of reducing malnutrition, we are going to see increasing cases of malnutrition, because food insecurity is on the rise. Babies who are being born now to malnourished mothers are not going to have a safe environment. This is how I see the war affecting us in terms of food security.

Q129 Kate Osamor: In your experience, what is the most effective way to provide relief to the poorest communities when you see these price shocks in terms of food and fuel?

Bessie Ndovi: Usually, from what I have seen happening here at home, subsidies are the way to go, even though they seem to be expensive on the other part. To reach out to the general masses, we need to subsidise certain things. I know that, right now, the Government are subsidising fertilisers. This has been ongoing for some years now. The past two administrations have done fertiliser subsidies, because they saw that the commodity is very important but, at the same time, also very expensive.

Social cash transfers to impoverished communities are another way of cushioning the poor. We can also employ tax waivers and remove levies on certain commodities. Recently, because of the increasing price of fuel, we have seen our Government removing some levies on fuel. Prices have gone up but not to the extent that was expected.



HOUSE OF COMMONS

At the same time, it would be good to encourage locals to increase production and not to depend on importing. We need to increase production and, at the same time, to reduce imports that come into the country.

If we implement these things in complementarity to each other, this would be an effective way of providing some sort of relief, although not in full, to the shocks that may come. As you have rightly put it, it is a shock. It is something that we are not expecting, so we need to have remedies that are there and that will work in the short term as well as, as I was saying, in the long term.

Q130 Kate Osamor: I have another question for you and Dr Gitahi. How does malnutrition in pregnancy and the early years affect the ability of children to grow up healthy and to escape poverty? You have touched on this slightly, but perhaps you could just elaborate a bit.

Bessie Ndovi: Malnutrition affects everybody, but the people who are most vulnerable to malnutrition are women of childbearing age—specifically those who are pregnant or lactating. Children who are born to malnourished mothers usually have low resistance to infections, and the risk of death is quite high on their part as well. The doctor touched on this a little in his introduction.

At the same time, undernourished children are usually at risk of developing low cognitive ability as well as physical impairment. The doctor touched on the issue of stunting, which is usually something to do with brain development. If the brain has not fully developed, it means that the cognitive ability of the children in question is very compromised. This results in high dropout rates, or even high repetition rates, in schools. In the long term, this results in those individuals having low economic opportunities when they become adults later in life. It is a continuum of activities, because one thing leads to another.

At the same time, malnutrition during childhood impacts on the labour force. If you are stunted as a child, the likelihood of you being not as productive to the best of your ability is quite high. This usually also leads to low human productivity. In addition, mortality rates in the workforce become quite high.

At the same time, this exerts pressure on Governments. For example, here in Malawi, all Government hospitals are free of charge. If you go to a hospital, you access free medical services. The same is true for treating malnutrition. Because it is free, it means that everything else is for the Government to handle. If you have lots of children who are malnourished, it becomes an issue. I will give you an example.

Kate Osamor: Bessie, can I bring in Dr Gitahi at this point?

Bessie Ndovi: Yes, sure.

Kate Osamor: Thank you so much. It is only because, as you know, we



are down to the wire with time.

Bessie Ndovi: Yes, I understand.

Q131 **Kate Osamor:** The bell will ring for us soon and we will have to go and vote. Dr Gitahi, what kinds of programmes would you say have the biggest impact on reducing the risks that Bessie has been speaking about?

Dr Gitahi: We tend to look at nutrition or malnutrition as multidimensional, because a lot of children who are malnourished will also be living in environments where there is what we call structural violence: they are poor, there is no water or sanitation, they are not going to school—it is a multidimensional issue.

What we have done is to say, “We need to address the first thousand days,” because that is really what is most critical for childhood development. Those first thousand days start by taking care of maternal health. Pregnant mothers need to be taken care of, so maternal health investment by your Government and others is a critical part of that intervention, and for domestic resources as well, in terms of ensuring that mothers are given access to antenatal services.

That means that there should be access to health services, which is linked to universal health coverage. That means that they do not have to worry about who pays for their antenatal visit, for their iron or for their folic acid when they go to the clinic. That is a critical part of taking care of this issue of malnutrition in the first thousand days. Then, of course, breastfeeding is critical, as are, finally, school feeding programmes and the fortification of food.

Q132 **Mr Sharma:** Bessie, do you think there is enough focus by donor countries on agriculture and climate adaptation?

Bessie Ndovi: I would not say yes or no, because most of my work focuses on nutrition advocacy and things to do with nutrition, but I have worked in the Ministry of Agriculture before. Right now, the general mood is focusing more on food systems, climate change and climate adaptability. In terms of the donors that are present in Malawi now, including the EU, GIZ and USIP, the tone now is shifting more towards climate change and improving the food system. I would say that there is focus, but maybe not enough, from donor countries when it comes to issues to do with food security and climate adaptation. That would be my response to your question.

Q133 **Mr Sharma:** Are agriculture programmes and climate finance well targeted to help the poorest?

Bessie Ndovi: To an extent, yes. Going back to the explanation that I gave about the issue of fertiliser subsidy, that programme targets the poorest of the poor. They have access to farm inputs like fertilisers and a certain amount of kgs of seed. The targeting that has been there in the



past is that they need to have access to a staple crop like maize, and they also need to have access to a legume crop like soybeans or groundnuts. In that regard, because we also get some funding cushioning from donor countries, I would say that the programmes are targeted enough towards the poor, but because a lot of Malawians are poor, it is not enough to reach out to everybody. At least I know that the poorest of the poor are targeted for such interventions to do with agriculture.

Q134 Mr Sharma: My next question is to both of you, but you choose who wants to go first. We have heard in a previous evidence session that donor countries should focus on scaling up what works in tackling extreme poverty, rather than spreading ODA too thinly. What should the FCDO focus on to have the most impact on the poorest communities?

Dr Gitahi: I can start and attempt to answer that question. If you look at poverty, you need to look at multi-year programming. You need to look at something that intervenes at a structural level. What we see is that women and girls are at the centre of tackling extreme poverty in many of these communities, even related to agriculture and climate change adaptation, as Bessie was saying.

The first thing that we need to do is to focus and to ask women and girls what really is needed for them. One of them is water. The issue of water and sanitation stops young girls from going to school. Secondly, it increases the chance of child mortality, because mothers have to take care of their children. There is no water, so the children are dying of diarrhoea or pneumonia.

The next thing is family planning. The role of family planning in addressing poverty has not been addressed properly, and that is another area that the FCDO should focus on—sexual and reproductive health and rights, and reproductive services—so that young adolescent girls can access family planning. That stops early teenage pregnancies, which is one of the biggest challenges in terms of creating intergenerational poverty. That would be my immediate response, but I would be happy to hear from Bessie.

Bessie Ndovi: I agree with you, doctor. It is good to continue with interventions that are already working, because we have evidence that these interventions do work. Then there is also a danger, in a sense, in doing things that you are already comfortable with, in that you become too comfortable and it becomes business as usual. We are living in a world where research is ongoing. There is new data coming in every day and new evidence being generated every other day, so it would also be good to have new things on the board, because, if we do not try them now, when are we going to start?

I would respond by saying, let us try both. Let us continue with what is already working, but if we have new data and evidence that we have gathered and generated, let us also roll with that. The world is changing every day. As the doctor said, we need to also focus on sanitation,



HOUSE OF COMMONS

because these are things that are affecting women and girls largely. Yes, let us do that, but let us also focus on other new aspects that we have evidence and data on and that we think can work. Only by trying will we know that these things are working, but without neglecting what is already there on the ground and being implemented. I thought that I should add that.

Q135 Mr Sharma: How important is it that funding is predictable and long-term when looking at health and nutrition programmes?

Dr Gitahi: I could talk about that for several days, but we do not have those days. Let me just collapse my many days into two minutes. I run an organisation that spends money from bilateral and multilateral donors like yourselves, and the biggest challenge is project-based financing. The money comes in. You start a programme, you discover new things, you research and you get new data. The data is not always quantitative; it is also lived experiences, hearing from the communities, seeing them, and seeing what is and is not working. Then the project ends. The next donor comes and says, "We want to focus our money on something different," and there is no incremental value.

My only answer here is, please let us work on long-term programming, so that we can adapt, learn, adapt, learn and adapt for a long time. It is better to have a small amount over a long time than a huge amount for just three or four years, because you do not actually gain incremental value.

Bessie Ndovi: A good example would be Covid, because Covid came in and everything else stopped. Most donors channelled their funding towards Covid response activities, which was okay, but what I noted was that a lot of programmes suffered because the focus was more on Covid relief. Even some of the funds that were being released by some donors were more focused on Covid response, so I do agree with what the doctor said.

They may be small programmes, but they have to be long-term. You have a programme that is running for five years, you discover new things along the way and you want to change the approach to the programme, but you are not allowed to, because you are in an agreement with the donor that says, "No, this is what we agreed to do. These are the outputs that we put out there. These are the things that you are supposed to do, so let us not go outside of what we have agreed."

In the end, you miss out on new opportunities or new ways of doing things, so it would be good to have small, focused projects running for a longer time, so that you are able to see the impact at the end of the period that has been set out. I do agree with what the doctor has said.

Q136 Mr Sharma: Have programmes that you have both worked with been affected by cuts to UK aid?



HOUSE OF COMMONS

Dr Gitahi: Yes, they have. The programmes that have been affected are largely water and sanitation programmes and, secondly, the area around health workers' training and sexual reproductive health and rights. We have had to take cuts. The other programme that has been affected is the programme that we call adaptation for people living with disabilities. We bring innovation for people living with disabilities, discovering new tools for them and applying them, and that was cut.

Bessie Ndovi: For CSONA, not directly, but as a country, yes, we have been hit hard by the cut in UK aid. For example, the withdrawal of UK aid has increased inefficiencies in the distribution of antiretroviral drugs for people living with HIV and AIDS. This has put a great amount of pressure on the Government in terms of bridging the gap that has been created by such a cut.

At the same time, UK aid was supporting several sexual reproductive health and family planning programmes, so we are likely to have a lot of teenage pregnancies coming in now, because of limited access to these family planning services.

At the same time, there have been a few organisations that have had to let go of people, and people have lost their jobs, because of the sudden cut in UK aid. As a country, we have felt it, we are feeling it, and I am sure we will continue to feel it, because we do not have enough funds to cover the gaps that have been created because of such cuts.

Q137 **Mr Sharma:** Very briefly, do you think that those cuts adequately considered the impact on poverty reduction?

Dr Gitahi: The answer is no, they did not. The answer is a clear no. There needs to be a mutual partnership between the FCDO and the countries in which it works. That means that, even before the cuts, there should have been conversations to discuss repurposing, moving or concentrating. The cuts did not consider the needs of those people who are living in extreme poverty.

Bessie Ndovi: No, they did not.

Q138 **Chair:** Doctor, I have one follow-up question. In terms of the projects that you were talking about, was the funding completely cut to end the project, or was it just reduced?

Dr Gitahi: In some instances it was cut; in some instances, it was reduced. There were multiple projects, so it depended on where the focus and priority moved to. If you need me to write a one-pager on what happened to each programme and send it to you, I could do that in the next three days.

Chair: That would be really helpful. Thank you very much.

Q139 **Chris Law:** As we hear repeatedly on this Committee these days about the appalling cuts and what the impact has been, it is really helpful to



HOUSE OF COMMONS

hear about it again today, albeit that it is painful, as I understand, for yourselves and those you serve. The question I want to ask goes back to universal healthcare—something that I am passionate about. I want to ask Dr Gitahi what role universal health coverage could play in tackling extreme poverty.

Dr Gitahi: One of the biggest expenses for households, especially those that are extremely poor, is health. There is food, education and health, and many times they have to make a choice between education and health. There is data that shows how families move when they have a sick person. If you look at a household over time, if somebody is sick, everybody stops working. Even when there are two people contributing to the household income, they all stop working and start collecting money from social support and from communities.

Universal health coverage would be the shock absorber for families, so that they can save. They can be healthy, they can access family planning commodities, they can access nutrition, and when somebody is sick they do not have to dispose of their savings or to sell their land or their livestock in order to be able to pay. Universal health coverage is a creator of wealth for communities.

Chair: Doctor, Bessie, I am afraid that we are going to have to stop the Committee session. We have another vote coming. There are still a couple of questions that we would like to ask you. If it is okay, we would like to write to you and get your answers that way, because we really do want to have you on record. It has been incredibly useful having you here. I am really sorry about the disruption with the votes. We try to organise sessions so that it does not happen, but sometimes it does happen. Thank you for being patient.