Policy Brief

No. 34/2023-2024

Thinking Policy Together

NUTRITION BUDGET BRIEF

(2017/18 to 2021/22)

Preface

The nutrition budget brief is among the seven budget briefs that seek to identify the extent to which the needs of children are addressed by the national budget, especially in the social scene. The other six briefs focus on education; health; water, sanitation, and hygiene; social protection; child protection; and national indicators. The brief analyses the size and composition of budget allocations to the interventions aimed at eliminating all forms of malnutrition for the 2017/18 - 2021/22 financial years. The brief is organized as follows: Section 1 - Introduction; Section 2 - Nutrition Overview; Section 3 - Size and Trends in Nutrition Spending; Section 4 - Composition of Nutrition Spending; Section 5 - Financing Sources; Section 6 - Budget Credibility and Execution; and Section 7 - Nutrition Policy and Other Structural Issues.

Key Highlights

(i) **Despite the improved nutrition status, Kenya faces a heavy burden of undernutrition among the population of under-five children with high inequality in outcomes across counties.** The nutrition status in 2022 was such that 18 per cent of the children are stunted, or too short for their age, which is a sign of chronic undernutrition. 10 per cent are underweight, five (5)per cent are wasted and three (3) per cent of children under the age of five (5) are overweight, which is a sign of overnutrition (Kenya Demographic and Health Survey - KDHS, 2022). The country recorded an improvement in the proportion of children under five years who are stunted, wasted, and undernourished between the period 2008 and 2022. There has been a significant reduction in the occurrence of stunting, particularly between 2008/09 (35%) and 2022 (18%). There is a significant disparity in stunting rates among different counties. Kilifi, West Pokot, and Samburu have the highest percentages (37%, 34%, and 31%, respectively), while Kisumu and Garissa have the lowest rates (9% each). Similarly, the country was able to achieve a threshold of below five (5) for wasting. However, it is yet to achieve the threshold of below 10 per cent for stunting as recommended in the National Nutrition M&E Framework. The brief recommends a scale-up of nutrition interventions at the community level.

(ii) **Kenya has shown progress towards achieving the above 90 per cent threshold for the proportion of children exclusively breast feeding in the first six (6) months.** The country has shown an upward trajectory for the period under review in exclusive breast feeding from 2003 to 2022 (from 13% to 60%) (KDHS 2022). At the county level, some of the counties such as Laikipia (96%), Nakuru (92.8%), West Pokot (92.8%), and Makueni (92.0%) have achieved the threshold. However, most counties are still below the national average, with Lamu and Wajir being the poorest at 72.6 per cent and 70.5 per cent, respectively, during the same period (Ministry of Health, 2022).

(iii) **The proportion of newborns with low birth weight has been on an increasing trend at the national level - increasing from 5.1 in 2018/19 to 6.1 in 2021/22** (Ministry of Health, 2022). Among the different causes of low birth weight identified are nutrition, maternal health, and infections. With evidence that nutrition is a key factor contributing to low birth weight, it is then clear that if the country has to address the proportion of low

birth weight among newborns, then the rates of malnutrition among pregnant women and through the life cycle have to be addressed.

(iv) **While budget allocations to nutrition fall short of the financial requirements (at the national and county levels), the sector registered a significant improvement in budget credibility for 2020/21 as compared to 2015/16.** Further, nutrition as a share of the country's GDP was comparatively lower. There is thus a need to continue to advocate for national and county governments to allocate resources aimed at addressing malnutrition, including social safety net programmes and procurement of commodities for the management of acute malnutrition. Among the causes of poor budget credibility are delayed disbursements from the National Treasury, poor planning, and low capacity to spend available resources.

(v) **Multisectoral synergies in the implementation of nutrition programmes and initiatives have improved at all levels**. Within Kenya's school meals initiative, one example of this multisectoral policy agenda has been demonstrated by the convergence of health, education, and agriculture goals. School meals provide an opportunity for increased school enrolment and more consistent attendance, thus addressing education goals and the potential for agriculture leverage by boosting smallholder farmers and thereby bolstering the local economy if foods are sourced locally (World Food Programme - WFP, 2020). School meals provide an opportunity to address several development initiatives (education, health, nutrition, social protection) as an agenda to improve human capital.

(vi) **Vitamin A coverage for children aged 12-59 months remains below the recommended threshold of 95 per cent and above.** Additionally, the counties performed poorly, with most counties registering a coverage of less than 30 per cent for children aged 6-59 months**.** All the counties are yet to achieve the recommended threshold. Marsabit County had the highest coverage at 65 per cent while Nyamira, Mandera, Isiolo, and Meru counties had the lowest coverage, below 20 per cent.

Introduction

This nutrition budget brief examines the allocation of the national budget for 2017/18 to 2021/22 in addressing the nutrition needs of children in Kenya. Given the multifaceted nature of nutrition, the brief assesses the budgetary allocations of various Ministries, Departments, and Agencies (MDAs). The analysis is based on a comprehensive review of budget documents and IFMIS data covering 2017/18 to 2021/22 financial years. Furthermore, the analysis is supplemented by a thorough examination of nutrition-related policies, international reports such as the Cost of Hunger in Africa (COHA), and relevant literature on nutrition.

The number of people faced with hunger globally continues to rise from 618 million in 2019 to 768 million in 2021. Similarly, the number of people unable to afford a nutritious diet increased by 112 million. Almost 3.1 billion people around the world are chronically malnourished. Elimination of all forms of malnutrition (wasting, stunting, underweight, low birth weight, micronutrient deficiencies, overweight, and obesity) features among the top priority areas in Kenya's strategic policy and plans. The Sustainable Development Goal (SDG) two aims to end hunger and all forms of malnutrition, achieve food security, and improve nutrition (SDG Targets 2.1 and 2.2). According to the state of food security and nutrition in the World Report 2022, exclusive breast feeding among infants under six months of age and child stunting were among the key nutrition targets that showed positive progress, while anaemia among women and adult obesity worsened as per the report. The number of undernourished people decreased by 13.2 per cent globally in the last 20 years. However, this alarming rate still calls for stronger efforts to improve food security and nutrition in the continent.

The Malabo Declaration on Accelerated Agricultural Growth and Transformation for Shared Prosperity and Improved Livelihoods targets to eliminate child undernutrition by bringing down stunting to 10 per cent and underweight to five (5) per cent by 2025. Undernutrition has direct negative effects on the education system. For instance, the Cost of Hunger Africa (COHA, 2019) study in Kenya indicated that poor nutrition leads to poor education performance, increased grade repetition, and increased dropouts. In addition, an estimated 17.5 per cent of repetitions were attributed to child undernutrition, due to impaired cognitive abilities and increased incidence of illness leading to reduced class time. Malnutrition has been defined as a state in which the body does not have enough of the required nutrients (undernutrition) or has an excess of the required nutrients (overnutrition). Although Kenya has made significant progress towards addressing malnutrition, the vulnerability to nutrition is still high. The persistent drought since 2017 put a high number of children at risk, particularly in the ASAL counties with an expected worsening situation due to deteriorating food security situation, including reduced milk production and consumption in arid areas.

Kenya has shown limited progress towards achieving the nine diet-related voluntary global non-communicable disease (NCD) targets[1] for 2025[2]. For instance, target seven aims at halting the rise in diabetes and obesity, yet an estimated 13.4 per cent of adult women and 3.6 per cent of adult men are living with obesity (Global Nutrition Report, 2022). Kenya's obesity prevalence is, however, lower than the regional average of 20.7 per cent for women and 9.2 per cent for men. At the same time, diabetes is estimated to affect 7.3 per cent of adult women and 7.0 per cent of adult men.

Nutrition situation was critical in Garissa, Wajir, Mandera, Isiolo, Samburu, Turkana, North Horr and Laisamis sub-counties in Marsabit County and Tiaty in Baringo County. Tana River and West Pokot counties were classified in the serious phase (IPC Phase three), Saku and Moyale sub-counties in Marsabit County were in the alert phase (IPC Phase two), while Kitui was in the acceptable phase. The nutrition situation has deteriorated within the same phase in most counties with rains performing poorly. This has impacted the food security situation negatively, with milk production and consumption declining. This was due to the relatively poor performance of short rains in 2020, and both seasons in 2021, resulting in deteriorating animal body condition.

Nutrition Overview

Globally, strategic frameworks to support and guide the implementation of the nutrition action plans are in place. Kenya's commitment to address the issues affecting nutrition is demonstrated by the fact that the country is a signatory to several international and regional laws, policies, treaties, and declarations. These include: the Scaling Up Nutrition (SUN) Movement, the World Health Assembly (WHA) 2025 nutrition targets, the Sustainable Development Goals (SDGs), and the United Nations (UN) Decade of Action on Nutrition (2016-2025), the African Regional Nutrition Strategy 2015-2025; and the Comprehensive Africa Agriculture Development Programme, which seeks to mainstream nutrition into National Agriculture Investment Plans. Among the nutrition targets by the World Health Assembly (WHA) 2025 include:

(i) 40 per cent reduction of the number of African children under five years who are stunted by 2025;

(ii) 50 per cent reduction of anaemia in women of childbearing age in Africa by 2025;

(iii) 30 per cent reduction of low birth weight in Africa by 2025;

(iv) No increase in overweight in African children under five years of age by 2025;

(v) Increase exclusive breast feeding rates during the first six months in Africa to at least 50 per cent by 2025; and

(v) Reduce and maintain childhood wasting in Africa to less than five (5) per cent by 2025.

A review of nutrition-related policies, international reports, such as Cost of Hunger in Africa (COHA), and available literature on nutrition further augmented the analysis. Further, budget allocations and expenditures have been used for 2015/16 to 2020/21.

Kenya's commitment to addressing the issues affecting the nutrition of learners is demonstrated by the fact that the country is a signatory to several international and regional laws, policies, treaties, and declarations. The Right to Food is globally anchored in Article 11 of the International Covenant on Economic, Social, and Cultural Rights. The UN 2030 Agenda on Sustainable Development Goals (SDGs 2015); the African Regional Nutrition Strategy 2015-2025; World Health Assembly 2025 nutrition targets; and the African Charter on the Rights and the Welfare of a Child.

At the national level, the Constitution of Kenya (2010), the Medium-Term Plan III and IV, and the Kenya Vision 2030 obligate the government to progressively achieve the right to food for all Kenyans. The Kenya National Food and Nutrition Security Policy (2011) and the National Food and Nutrition Security Policy Implementation Framework 2018-2022 are the overarching regulatory frameworks guiding the multisector engagement for nutrition interventions. The policy provides eight areas of focus to address chronic and acute food insecurity in Kenya. The government has also put in place the Breast Milk Substitutes (Regulation and Control) Act No. 34 (2012), which regulates the marketing and distribution of breast milk substitutes to provide safe and adequate nutrition for infants. This legislation has an implementation framework for securing a breast feeding-friendly workplace environment (2020-2024).

The Food Security Bill, 2017 bestows the responsibility of child nutrition on both national and county governments. Sessional Paper No. 2 of 2014 on the National Social Protection Policy builds on existing initiatives such as school

1 The targets include to: reduce premature mortality due to NCDs by 25 per cent; halt the rise in diabetes and obesity; reduce salt/sodium intake by 30 per cent; reduce the prevalence of high blood pressure/hypertension by 25 per cent; reduce the use of tobacco by 30 per cent; reduce the harmful use of alcohol by 20 per cent; reduce physical inactivity by 15 per cent; increase the coverage of essential NCD medicines and technologies to 80 per cent and increase drug therapy and counselling coverage to 50 per cent.

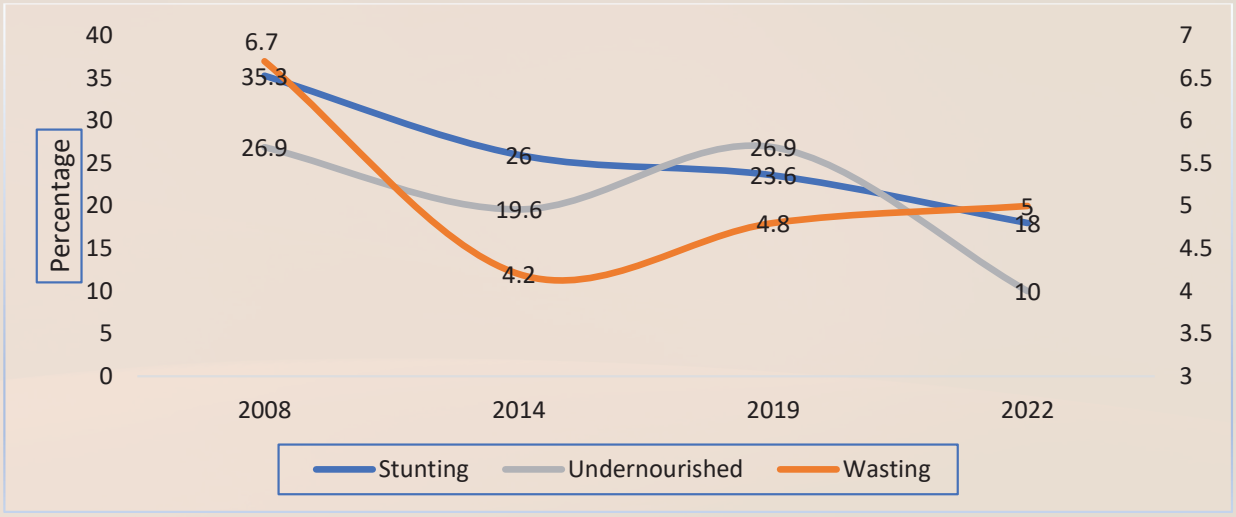
2 Who-gmf-targets-and-indicators-list.pdf

meals programmes to provide meals for those vulnerable to chronic food insecurity. The policy advocates for synergies across sectors that require coordination and support to unleash their most positive outcomes, and supporting training in good nutritional practices, skills transfer, health services, and food distribution during emergencies such as drought and flooding.

Other nutrition strategic frameworks exist at the national level. These include the Kenya Agri-Nutrition Strategy (2020-2024), which strengthens the country's food safety and security; the Kenya Scaling Up Nutrition (SUN) Strategy and SUN Business Network Strategy (2019-2023), which appreciates the role of the private sector in availing nutritious and safe food. The School Health Policy, 2018 recognizes education and health as constitutional rights and views schools as an organized platform providing the opportunity to model and shape national attitudes and values on health. The Kenya Nutrition Monitoring and Evaluation Framework 2018-2022 facilitates progress monitoring of the nutrition action plans as stipulated by the Kenya National Nutrition Action Plan. Despite the existence of these policies and plans, various gaps still prevail in the financing, implementation, monitoring, and evaluation of nutrition activities in the country.

Kenya has made significant progress in reducing acute and chronic undernutrition (Figure 1), but stunting (low height for age) remains high among children under five years. The KDHS 2022 data shows that the prevalence of wasting (weight for height) increased from four (4) per cent in 2014 to five (5) per cent in 2022 while overweight reduced from four (4) per cent to three (3) per cent over the same period. The country was able to achieve a threshold of below five (5) for wasting. However, stunting is still high, affecting 18 per cent of children under five years, which is eight (8) percentage points higher than the recommended average of 10 per cent in the National Nutrition M&E Framework. This is particularly concerning due to its negative impact on children's growth and well-being, and its implications for a country's long-term development. Insufficient practices of feeding infants and young children play a crucial role in contributing to both acute and chronic undernutrition.

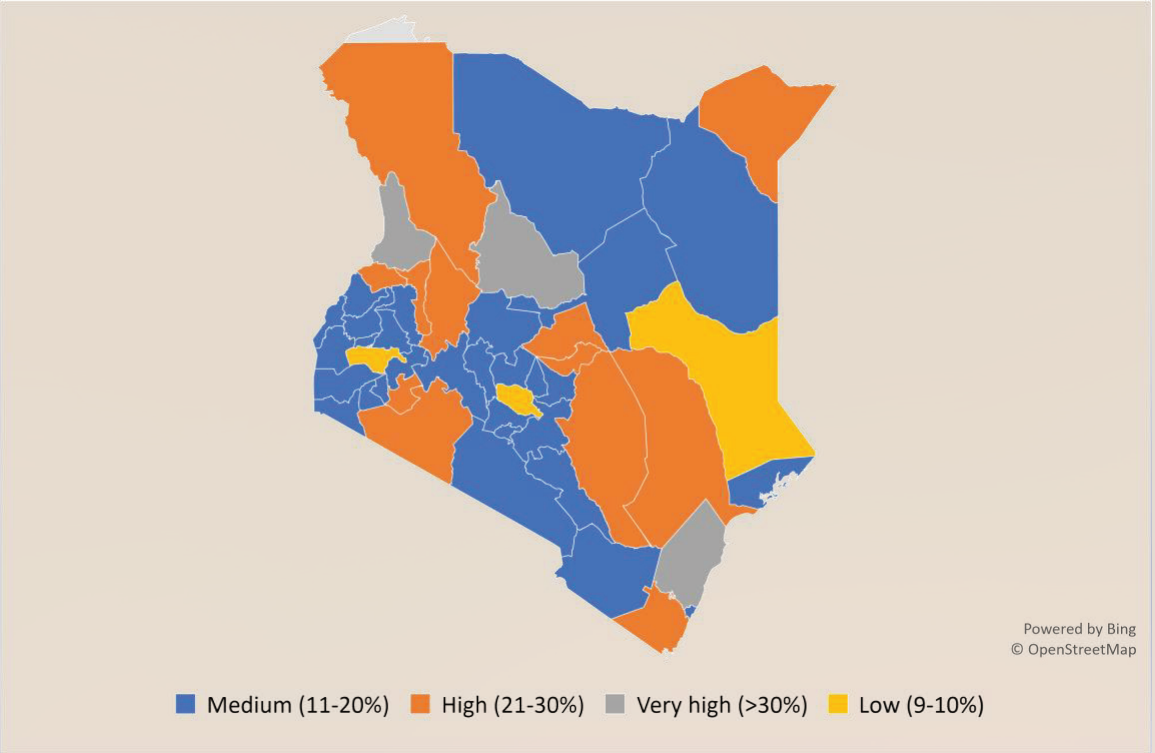
Figure 1: Children under five years who are wasted, stunted, and undernourished (percentage)



Data Source: KDHS (Various)

There is also a considerable rural/urban disparity in stunting levels among children under the age of five. For instance, stunting is higher among children in rural areas (20%) compared to children in urban areas (12%). When compared across counties, there are wide variations (Figure 2). Kilifi, West Pokot, and Samburu have the highest percentages (37%, 34%, and 31%, respectively), while Kisumu and Garissa have the lowest rates (9% each).

Figure 2: Percentage of children under the age of five who are stunted by county



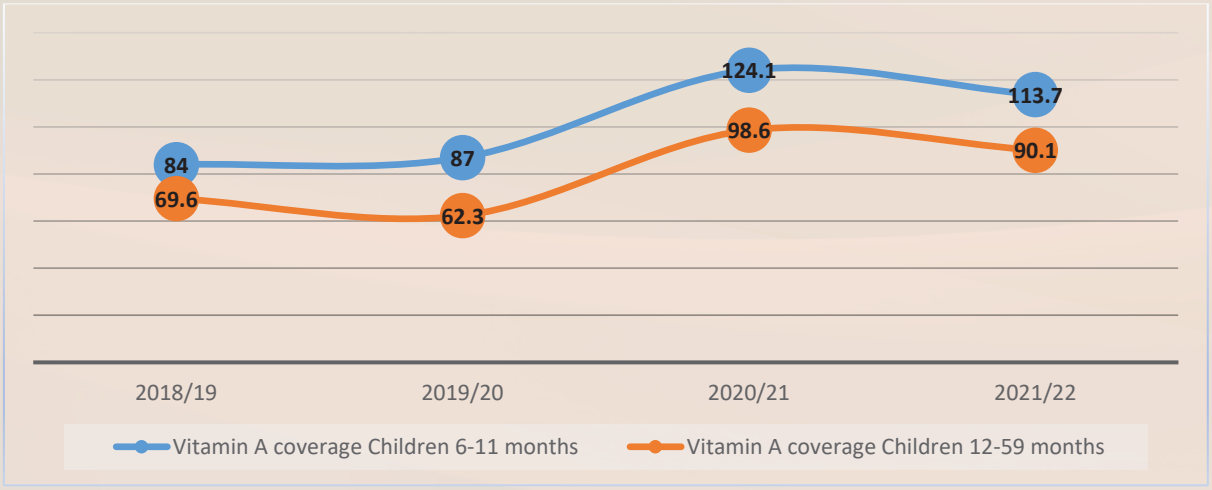
Data source: KDHS, 2022

***See Annex Table 1 for detailed information*

Furthermore, the 2022 KDHS results revealed worsening indicators related to child diet, with a high prevalence of micronutrient deficiencies (hidden hunger), vitamin A deficiency, and anaemia rates particularly being high. Poor feeding practices among children in Kenya contribute to malnutrition. As of 2022, only 30.8 per cent of children (aged 6-23 months) consumed food that meets the minimum acceptable diet demonstrating a dire need for a coordinated effort on sustainable food system transformation and multisystem approach to improve children's diets.

On a positive note, it is highly encouraging that the government has achieved a significant reduction in Vitamin A deficiency. Between 2018 and 2022, the proportion of children aged 6-11 months and 12-59 months supplemented with Vitamin A nationally increased significantly as evidenced in Figure 3. However, Vitamin A coverage for children aged 12-59 months is still below the recommended threshold of 95 per cent and above.

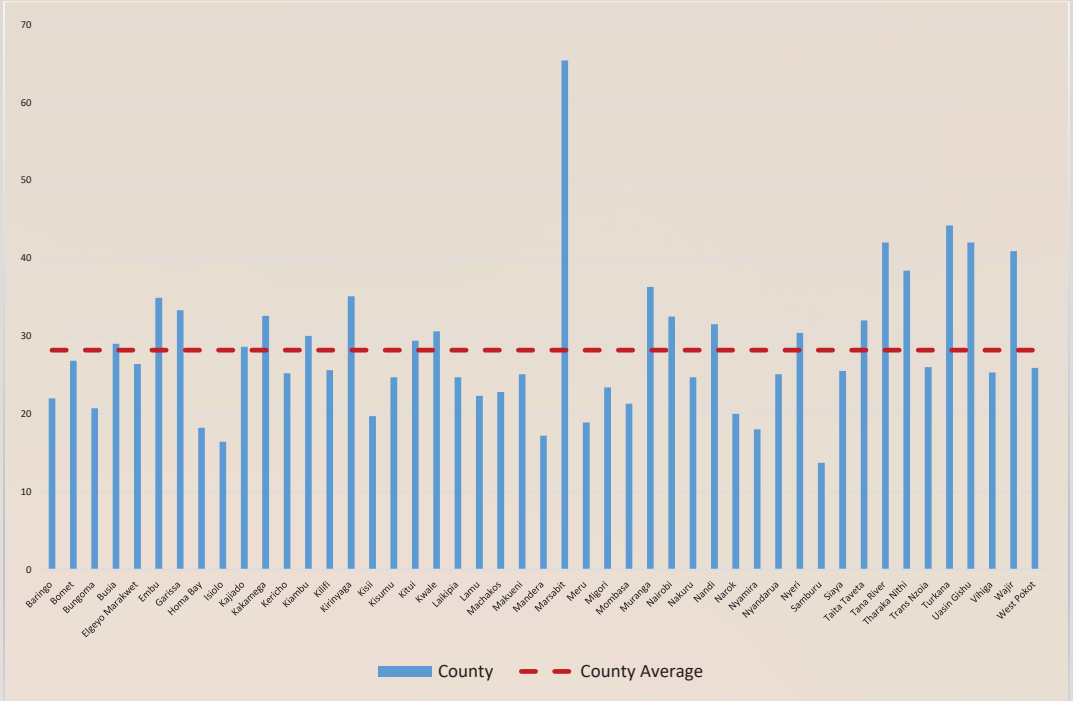
Figure 3: National Vitamin A coverage for children aged 6-11 months and 12-59 months (2018/19-2021/22)



Data source: Ministry of Health (2022)

In contrast with the Vitamin A coverage status at the national level, the counties performed poorly, with most counties registering a coverage of less than 30 per cent for children aged 6-59 months as demonstrated in Figure 4**.** All the counties are yet to achieve the recommended threshold. Marsabit County had the highest coverage at 65 per cent while Nyamira, Mandera, Isiolo, and Meru had the lowest coverage, below 20 per cent.

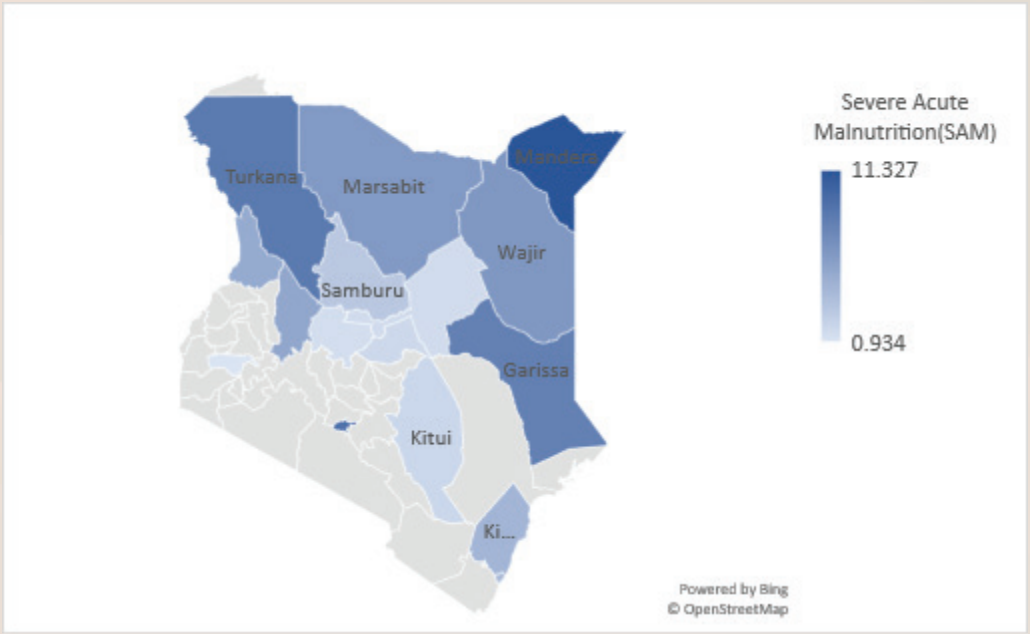
Figure 4: County Vitamin A coverage for children aged 6-59 Months, 2021/22



Data source: Ministry of Health (2022)

The lack of adequate nutrients over a long period leads to growth failure in children. Undernourished children are at higher risk of anaemia, diarrhoea, and respiratory infections. These additional cases of illness are costly to the health system and families. In the same period, 4.2 per cent of the children were affected by acute malnutrition, which concerns a rapid deterioration in the nutritional status over a short period.

Figure 5: Estimated caseloads of children 6-59 months requiring treatment for acute malnutrition ('000')

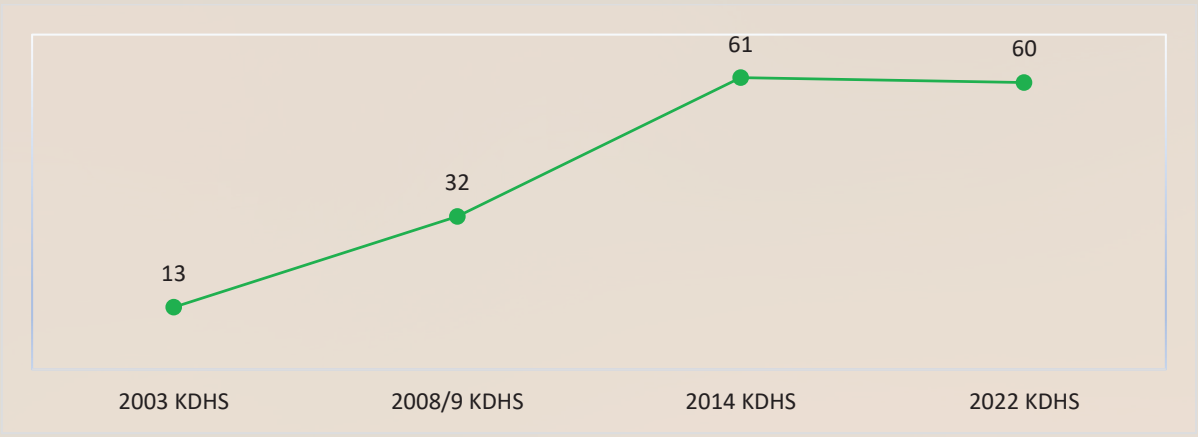


Data source: Government IFMIS data (2017/18 to 2021/22)

**See Annex Table 2 for detailed data*

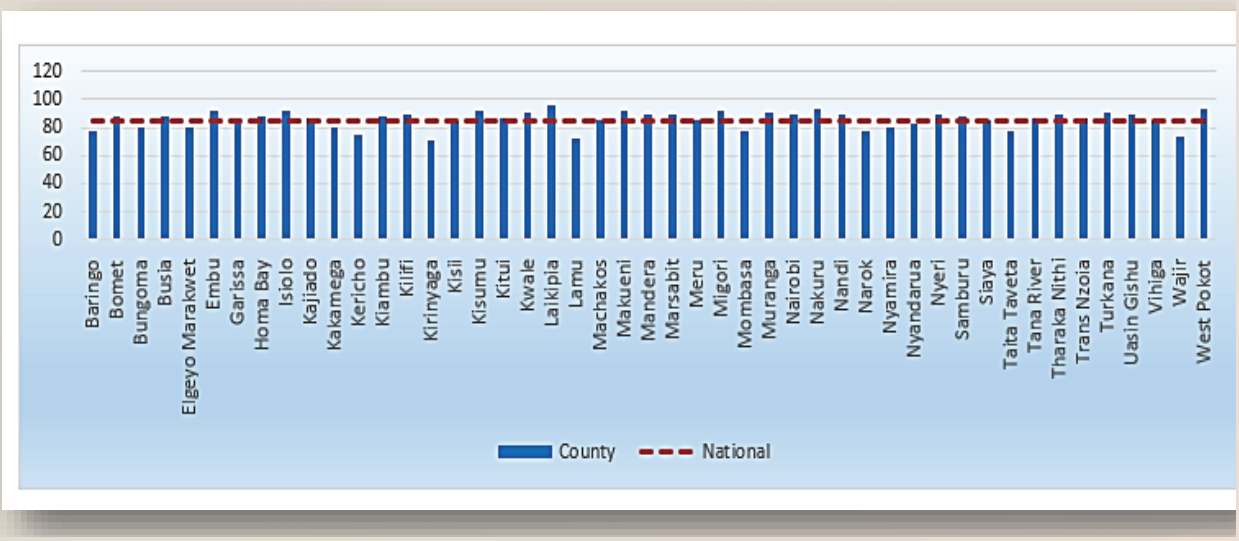
Kenya is on the course of achieving the >90 per cent threshold for the proportion of children exclusively breast feeding in the first six months as shown in Figure 6. The country has shown an upward trajectory in exclusive breast feeding from 13 per cent in 2003 to 60 per cent in 2022 (KDHS, 2022). At the county level, some of the counties such as Laikipia (96%), Nakuru (92.8%), West Pokot (92.8%), and Makueni (92%) have achieved the threshold. However, most counties are still below the national average, with Lamu and Wajir performing the poorest at 72.6 per cent and 70.5 per cent, respectively, during the same period (Ministry of Health, 2022), as shown in Figure 7.

Figure 6: Proportion of infants less than six months old on exclusive breastfeeding



Data source: KDHS (Various)

Figure 7: Infants less than six months old on exclusive breast feeding, percentage 2021/22



Data source: Ministry of Health (2022)

Nutrition-related diseases such as low birth weight and malnutrition are among the top ten leading causes of under-five admissions to health facilities for the period between 2018 and 2020. Nutrition thus remains a key area of focus, since it impacts various sectors such as health as shown in Table 1.

Table 1: Leading causes of under-five admissions in health facilities, 2018 - 2020

Condition	2018	2019	2020
Pneumonia	23,935	21,383	15,127
Low birth weight	9,727	9,263	3,066
Confirmed malaria	9,304	11,321	11,787
Birth asphyxia and birth trauma	8,862	8,465	5,737
Diarrhoea diseases	8,393	8,875	n/a

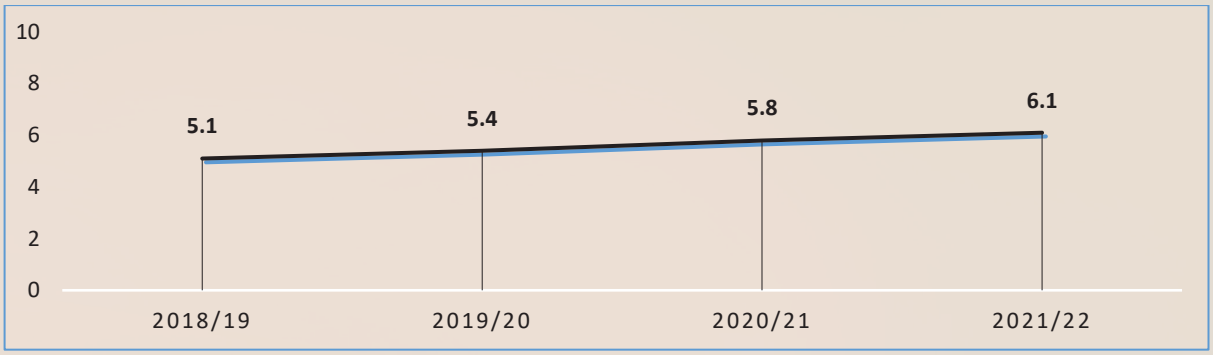
Condition	2018	2019	2020
Congenital malformations, deformations, and chromosomal abnormalities	2,379	1,818	n/a
Meningitis	2,147	1,777	n/a
Anaemia	2,115	2,187	n/a
Malnutrition	1,876	2,086	n/a
Low respiratory infections	1,609	n/a	n/a
Sepsis	n/a	1,599	9,209
Febrile	n/a	n/a	2,543

Data source: Ministry of Health 2021

** n/a: Data not available*

The proportion of newborns with low birth weight has been on an increasing trend at the national level. The proportion increased from 5.1 in 2018/19 to 6.1 in the 2021/22 financial year (Figure 8). Among the causes of low birth weight are nutrition, maternal health, and infections. The country needs to ensure that the nutrition aspect is not neglected in addressing the issue of low birth weight, hence reversing the upward trend.

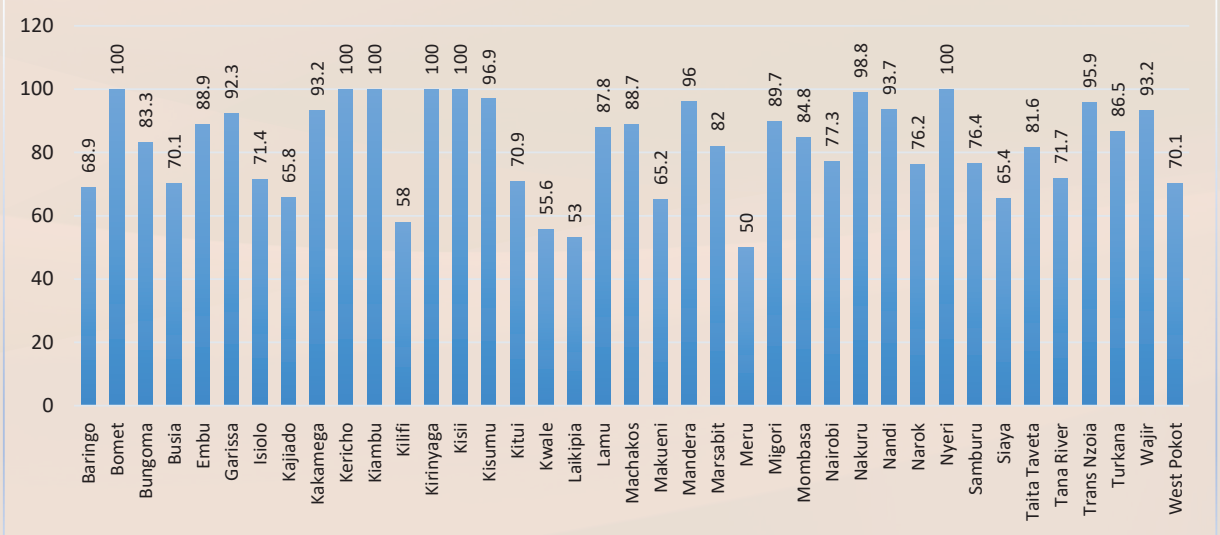
Figure 8: Proportion of newborns with low birth weight (<2500g), 2018/19-2021/22



Data source: Ministry of Health (2022)

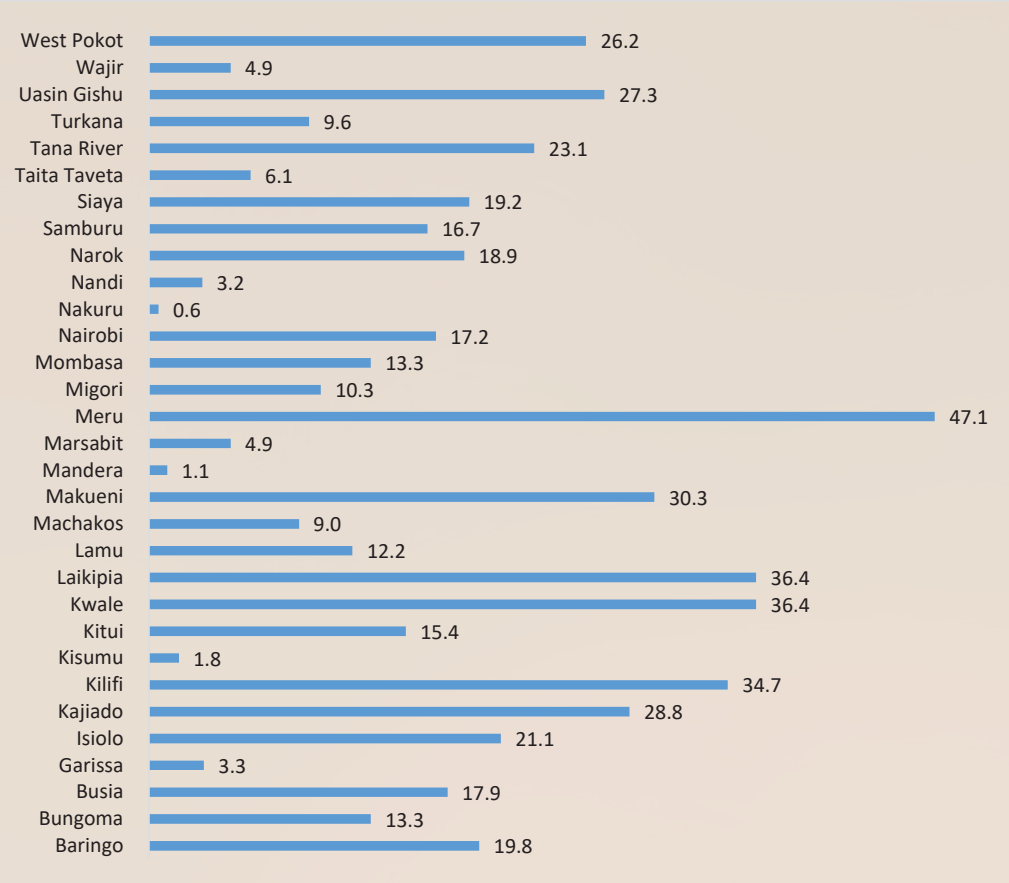
All counties reported an Out-patient Therapeutic Programme (OTP) recovery rate of over 50 per cent for children 6-59 months with severe acute malnutrition for 2021/22 as shown in Figure 9. Counties such as Bomet, Kericho, Kiambu, Kirinyaga, Kisii, and Nyeri had a recovery rate of 100 per cent. Counties that registered a low recovery rate such as Kilifi, Laikipia, and Meru had high default rates as illustrated in Figure 10.

Figure 9: OTP recovery rate for children 6-59 months with severe acute malnutrition, 2021/22



Data source: Ministry of Health (2022)

Figure 10: OTP default rate for children 6-59 months with severe acute malnutrition, 2021/22



Data source: Ministry of Health (2022)

Poor dietary intake, prevailing drought in the Eastern and Horn of Africa, food insecurity, low household incomes, poor childcare practices, poor sanitation, and limited supply of health and WASH services are among the underlying causes of acute malnutrition in Kenya. With reduced milk production and consumption, which forms the main diet for children in arid areas, malnutrition sets in. Recurrent and unusual shocks such as flooding reported due to the back flow of Lake Turkana, interruption of regular operations and livelihood by the rising Turkwel Dam, desert locust invasion in several counties, security incidences, for example, in Baringo County, and COVID-19-related impacts, especially in urban centres where livelihoods were most affected exacerbated the malnutrition problem. Basic causes such as low literacy levels, poor infrastructure, and poverty that slow down recovery from the recurrent shocks increased exposure of the communities, especially in arid areas, to rapid deterioration of the nutrition situation during the projection period.

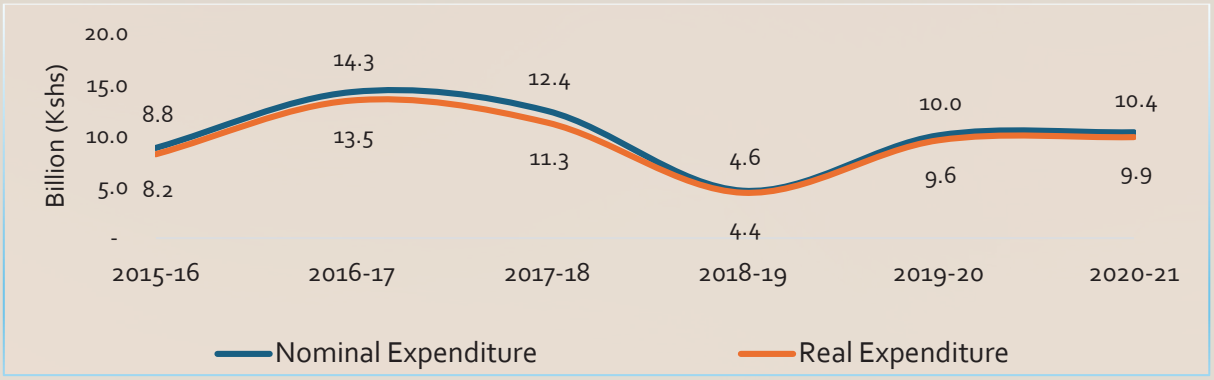
These are risks related to dietary composition and weight levels. The combined risk is less than the sum of individual risks because individuals can be exposed to multiple risks, but mortality is ascribed to one risk and cause. 'All risk factors' includes all deaths associated with dietary composition (that is, diets low in fruits, diets low in vegetables, diets low in whole grains, diets high in processed meat, diets high in red meat, and diets high in sugary drinks) and all deaths associated with weight levels (that is, underweight, overweight, obese).

Size and Trends in Nutrition Spending

Funding is not proportional to the burden of malnutrition. Government spending on nutrition decreased from Ksh 14.3 billion in 2016/17 to Ksh 10.4 billion in 2020/21 as shown in Figure 11. However, when compared to the previous year, there was an increment of four (4) per cent. It is worth noting that there was a substantive budget cut spending on nutrition in 2018/19. Real nutrition expenditure witnessed the same trend. The economic downturn triggered by the COVID-19 pandemic, combined with emerging issues such as the Ukraine - Russia war, disruption in food and health systems, and prices, threatens to increase malnutrition significantly. Estimated nutrition-specific financing needs for select maternal, infant, and young child global targets have not been met. This calls for nutrition-sensitive needs towards the full scope of SDG two targets.

At 0.5 per cent of the total budget in 2020/21, Kenya's spending on nutrition lags behind the regional average of about 1.7 per cent. The World Bank developed an investment framework on financing for meeting the World Health Assembly nutrition targets by 2025. Based on the framework, countries would require an average of US$ 7 billion every year from 2016 to 2025 for financing nutrition-sensitive activities. In Kenya, the nominal expenditure on nutrition increased from Ksh 8.8 billion in 2015/16 to 10.4 billion in 2020/21.

Figure 11: Total nutrition spending in nominal and real terms

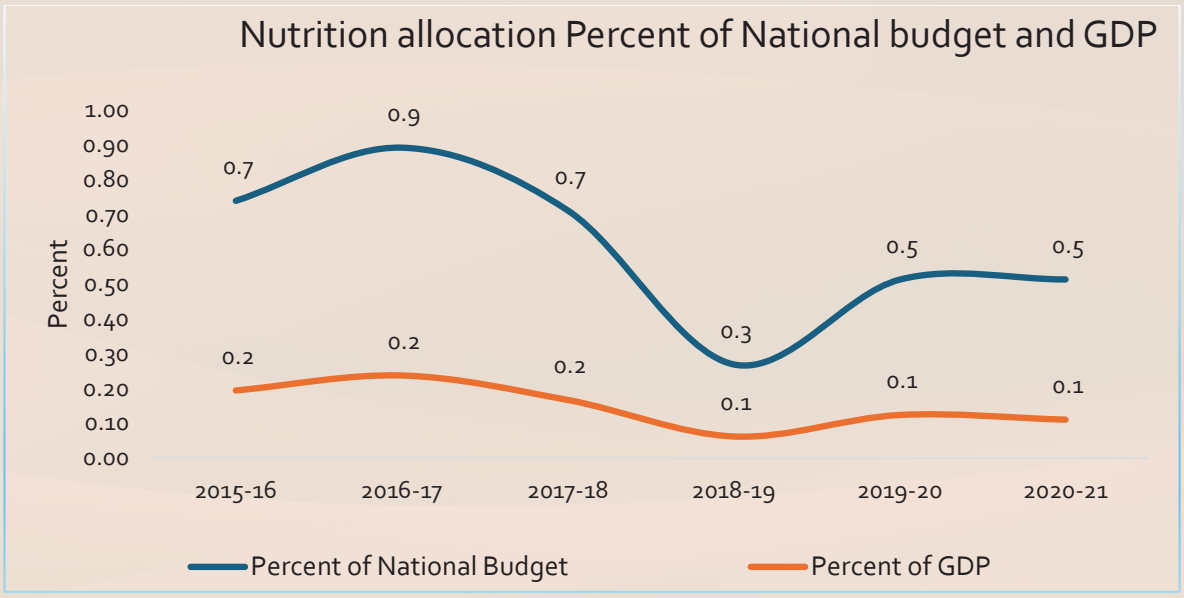


Data source: Government IFMIS data (2015/16 to 2020/21)

Government investment in nutrition goes a long way in the achievement of nutrition objectives such as the promotion of sound nutrition and health habits that promote healthy diets and lifestyles to prevent obesity and lifestyle diseases (FAO, 2019). These investments, when complemented with nutrition-sensitive investments, will bring us close to achieving targets on stunting, maternal anaemia, breast feeding, and childhood wasting. Funding for nutrition from the national budget has been steady in the last two years. Of the total national budget, only an average of 0.5 per cent was allocated to nutrition in the 2019/20 and 2021/21 financial years.

Kenya's spending on nutrition as a share of her GDP is significantly lower when compared to other sectors. The nutrition sector budget allocation compared to the national GDP dropped from 0.2 per cent (from 2015/16–2017/18) to 0.1 per cent in 2020/21. These estimates underestimate the nutrition-specific financing investments needed to tackle malnutrition to its full extent.

Figure 12: Nutrition allocation per cent of national budget and GDP



Data source: Government IFMIS data (FY 2015/16 to 2020/21)

Composition of Nutrition Spending

An analytical model proposed by the Lancet Maternal and Child Nutrition relates to under five (5) malnutrition comprising three pillars of nutrition-specific interventions, nutrition-sensitive interventions, and an enabling policy environment.

Most identifiable nutrition budgets are spent by the Ministry of Agriculture, which dominates aggregate sector spending. Nearly three-quarters (83%) of nutrition resources are spent through the Ministry of Agriculture, nine (9) per cent through the Ministry of Health and eight (8) per cent through the Ministry of Education. Table 2 shows the most recent weighted budget expenditure as a percentage by thematic sector related to nutrition. The key sectors with high percentages are food security at 34 per cent; livestock at 15 per cent and fisheries at 11 per cent and basic healthcare at nine (9) per cent in the financial year 2020/21. Most existing nutrition budget lines increased compared to the previous year save for fisheries, rural development, and basic healthcare. This may potentially affect the delivery of some nutrition-specific interventions.

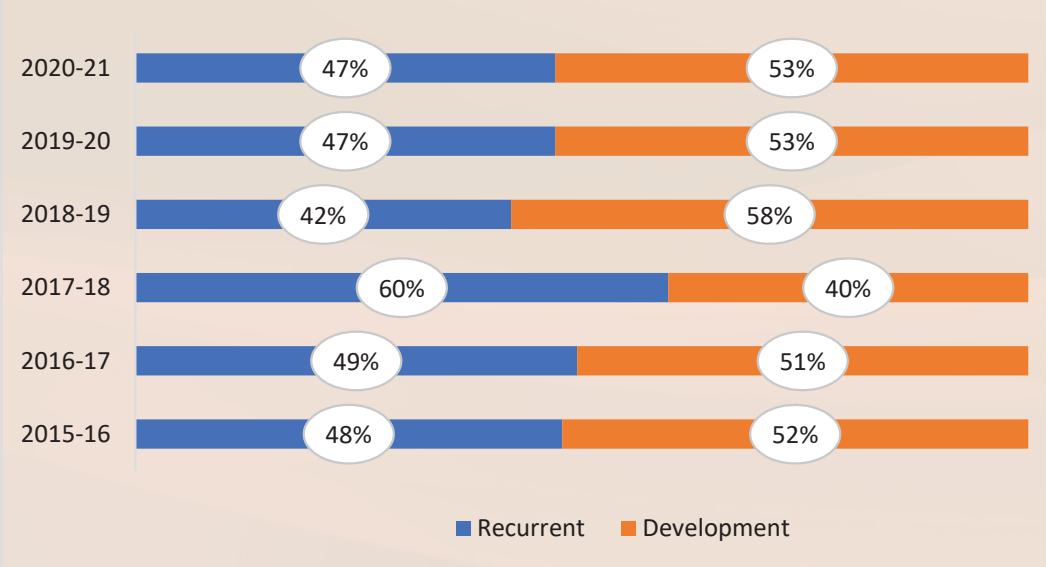
Table 2: Nutrition-related expenditures by program (%)

Budget lines (Expenditure)	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Agriculture production (generic)	5.0	7.5	10.3	6.5	7.7	8.3
Agriculture services	6.1	4.2	5.8	19.0	6.8	7.0
Fisheries	19.2	12.5	8.3	8.8	12.3	10.8
Food safety	2.5	3.4	4.8	7.5	4.1	4.5
Food security	22.4	34.5	42.9	11.1	31.7	33.7
Livestock	11.4	14.0	12.5	27.8	14.6	15.2
Rural development	5.4	2.3	2.5	8.2	3.7	3.4
Early child development	1.6	1.3	1.6	3.3	1.7	1.7
School health, nutrition, and meals	5.2	5.8	9.3	0.7	6.1	6.4
Basic healthcare	21.1	14.5	2.0	7.1	11.2	9.1
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total (millions)	8,820.5	14,281.7	12,443.9	4,640.1	10,046.6	10,353.1

Data source: Government IFMIS data (2015/16 to 2020/21)

Slightly above 50 per cent of the total nutrition budget is spent for development projects (Figure 13). These include the roll-out of nutrition-enhancing interventions such as deworming and vitamin supplementation.

Figure 13: Proportion of recurrent and development spending



Data source: Government IFMIS data (2015/16 to 2020/21

Under the nutrition functional classification budget, subsidies, grants, the acquisition of non-financial assets and use of goods and services shares averaged 34 per cent, 29 per cent, and 24 per cent, respectively, during the review period (Table 3).

Table 3: Proportion of expenditure by economic classification (%)

Expenditure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Compensation of employees	15.8	9.5	13.6	27.0	13.2	13.2
Use of goods and services	15.4	20.9	31.4	25.1	24.1	24.1
Interest payments	0.1	0.0	-	0.4	0.1	0.1
Subsidies and grants	48.3	45.2	19.2	10.8	33.4	33.4
Social benefits	0.0	0.0	0.1	0.0	0.0	0.0
Acquisition of non- financial assets	20.3	24.3	35.7	36.6	29.3	29.3
Total (%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total (Ksh millions)	8,820.5	14,281.7	12,443.9	4,640.1	10,046.6	10,353.1

Data source: Government IFMIS data (2015/16 to 2020/21)

Financing Nutrition

On average, Ksh 12.8 billion is allocated to nutrition programmes from various sources. The main nutrition funding sources in Kenya were from the government averaging 81 per cent, grants (3%), appropriation in aid (11%) and loans (5%), over time the sources of resources have not been consistent as presented in Table 4.

Table 4: Funding sources

Budget	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	Average
Domestic resources %	73.1	77.9	82.3	88.2	83.7	83.7	80.6
Grants %	7.3	4.5	1.2	0.0	2.9	2.9	3.5
AIA %	14.5	13.8	11.1	3.8	8.9	8.9	11.0
Loans %	5.1	3.8	4.8	8.0	4.4	4.4	4.7
Total %	100%	100%	100%	100%	100%	100%	100%
Total	**13,019.2**	**18,156.5**	**14,216.8**	**5,757.0**	**12,787.4**	12,729.4	12,777.7

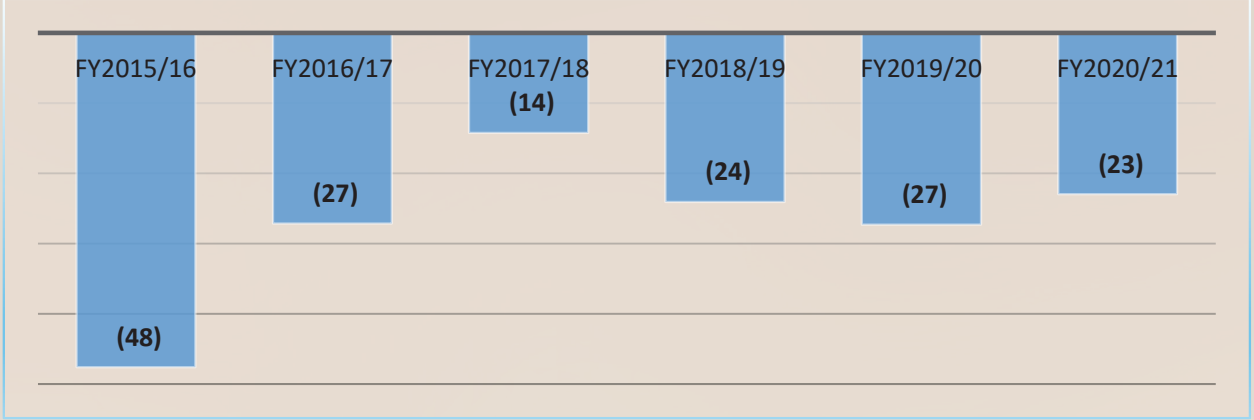
Data source: Government IFMIS data (FY 2015/16 to 2020/21)

Country preparedness and response to new and emerging pandemics such as COVID-19 have put immense pressure on the health system with limited resources. This calls for strengthening nutrition as part of the universal health coverage agenda. There is also a need to ensure timely contingency and response planning for early action and to mitigate the effects of the projected worsening drought situation and food shortage on nutrition.

Budget Credibility

While budget credibility is still poor, the sector registered a significant improvement in relation to budget credibility for 2020/21 as compared to 2015/16. One of the major causes of poor performance is delayed disbursements from the National Treasury. Additionally, some poor planning and low capacity to spend available resources can lead to poor budget credibility. Assessing deviation from approved estimates by administrative units can help to identify areas of weakness, although a much more comprehensive analysis is required to understand both the causes and remedial actions.

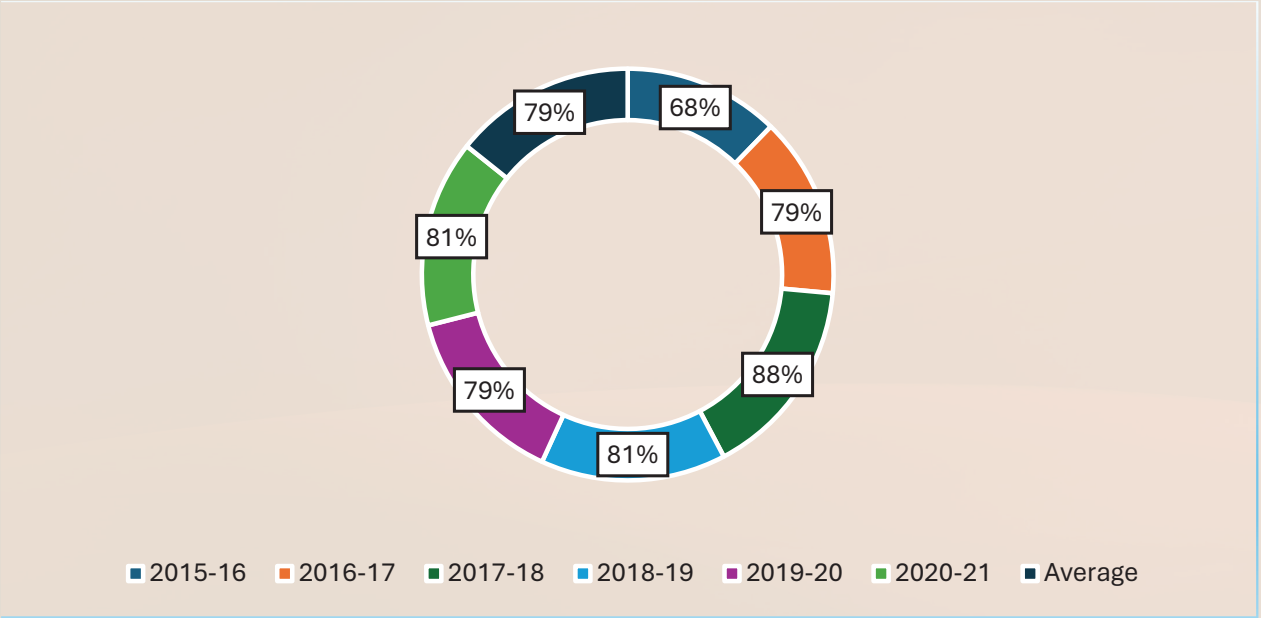
Figure 14: Nutrition budget credibility (2015/16-2020/21)



Data source: Government IFMIS data (2015/16 to 2020/21)

The sector had a fairly good absorption rate, averaging 79 per cent over the review period. For specific financial years 2015/16 to 2020/21, the absorption rate was 68 per cent and 81 per cent, respectively. During the review period, the nutrition programmes were characterized by large deviations between approved budgets and actual spending, which reflect on budget credibility. The trends in absorption rate show improvement over the years.

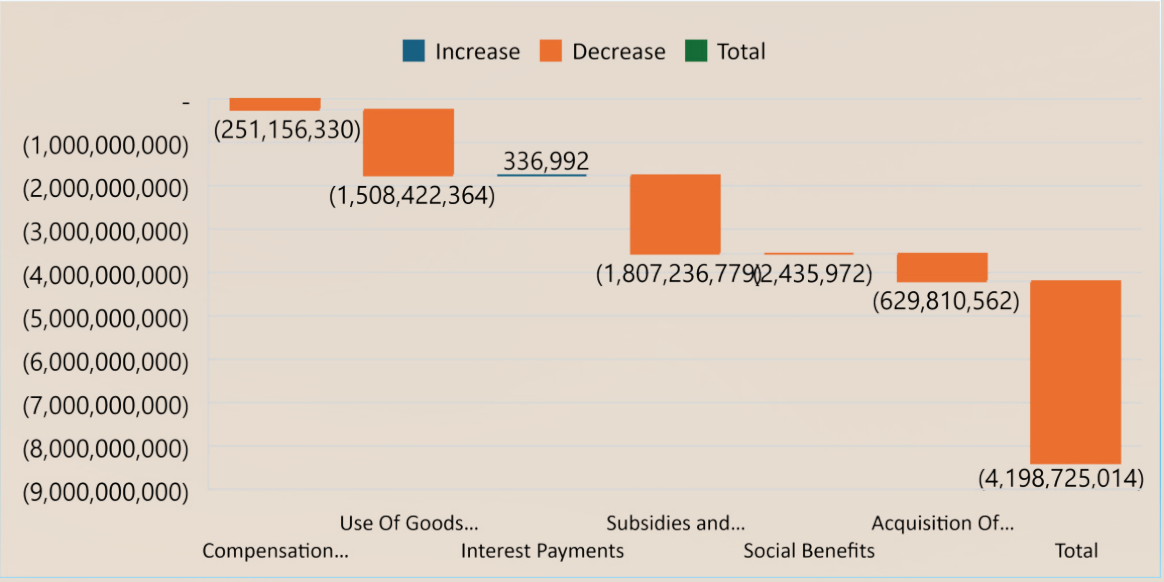
Figure 15: Absorption rate



Data source: Government IFMIS data (FY 2015/16 to 2020/21)

The credibility of nutrition spending under-performance on all economic classifications is presented in Figure 16. Higher under-spending of the investment budget is observed during 2015/16 and 2017/18 (Figure 16). Goods and services were also under-purchased, amounting to an average of 14 per cent rate over the 2013/14-2017/18 period.

Figure 16: Budget credibility by economic classification for 2015/16 to 2020/21



Data source: Government IFMIS data (FY 2015/16 to 2020/21)

Implementation Strategy of Key Issues

The following strategies are proposed to address the policy issues emerging from the foregoing analysis.

Table 5: Proposed strategies to address the emerging policy issues

Issue	Recommendation	Action (responsibility)	Timelines
Nutrition financing	Parties involved need to focus on the proper utilization of their budgets to aid in improving the key nutrition indicators that are performing below par.	National Treasury, Ministry of Health, Ministry of Agriculture, Ministry of Education, County governments	Continuous
Stunting	Need to prioritize/increase funding towards nutrition-specific programmes, including nutrition education and counselling to promote intake of proper diet.	National Treasury, Ministry of Health, Ministry of Agriculture, Ministry of Education, County governments	Continuous
Malnutrition	Need to prioritize/increase funding towards nutrition-specific programmes, including nutrition education and counselling to promote intake of proper diet.	National Treasury, Ministry of Health, Ministry of Agriculture, Ministry of Education, County governments	Continuous
Budget credibility	Assess deviation from approved estimates by administrative units to help identify areas of weakness for better effectiveness and efficiency in the utilization of funds.	National Treasury, Ministry of Health, Ministry of Agriculture, Ministry of Education, County governments	Continuous

ANNEX

Annex Table 1: Stunting in children by county

County	Percentage of children under the age of five who are stunted
Mombasa	14
Kwale	23
Kilifi	37
Tana River	21
Lamu	16
Taita Taveta	19
Garissa	9
Wajir	12
Mandera	21
Marsabit	19
Isiolo	14
Meru	25
Tharaka-Nithi	21
Embu	20
Kitui	25
Machakos	16
Makueni	20
Nyandarua	18
Nyeri	13
Kirinyaga	11
Murang'a	10
Kiambu	15
Turkana	23
West Pokot	34
Samburu	31
Trans Nzoia	21
Uasin Gishu	14
Elgeyo Marakwet	22
Nandi	15
Baringo	21
Laikipia	13
Nakuru	19
Narok	22
Kajiado	14
Kericho	19
Bomet	22
Kakamega	12
Vihiga	17
Bungoma	19
Busia	15
Siaya	19
Kisumu	9
Homa Bay	13
Migori	15
Kisii	16
Nyamira	14
Nairobi City	11

Annex Table 2: The proportion of children 6-59 months with Severe Acute Malnutrition (SAM) who recovered while on treatment in the OTP program (OTP Default rate - Nutrition)

County	2018/19	2019/20	2020/21	2021/22
Baringo	73.2	72.6	71.9	68.9
Bomet	96.1	100	100	100
Bungoma	96.7	94.7	96.5	83.3
Busia	89.3	72.2	78.9	70.1
Embu	73.7	78.2	79.1	88.9
Garissa	87.7	93.4	94.2	92.3
Isiolo	76.2	69.4	78	71.4
Kajiado	47	60.4	54.2	65.8
Kakamega	87.2	70.4	83.7	93.2
Kericho	100	100	98.4	100
Kiambu	100	100	100	100
Kilifi	57.2	63.1	58.6	58
Kirinyaga	100	100	100	100
Kisii	95.1	99.8	97.6	100
Kisumu	94.8	89.9	88.1	96.9
Kitui	71.9	74.5	55.3	70.9
Kwale	61.8	59.3	60.1	55.6
Laikipia	44.7	68.9	53.1	53
Lamu	52.4	69.3	68.2	87.8
Machakos	80	82.8	82.1	88.7
Makueni	64.1	67.4	70.4	65.2
Mandera	89.2	94.6	95.4	96
Marsabit	74.4	68.8	68.1	82
Meru	80.4	58	38	50
Migori	95.5	96.2	99.7	89.7
Mombasa	71.8	56.4	70	84.8
Nairobi	67.9	19.5	75.3	77.3
Nakuru	85.3	99.7	99.3	98.8
Nandi	95.9	95.7	93.1	93.7
Narok	59.7	72.2	64.9	76.2
Nyeri	97.6	80.7	100	100
Samburu	72	74.7	83	76.4
Siaya	50	100	100	65.4
Taita Taveta	63.4	80	62.4	81.6
Tana River	80.8	71.1	70.7	71.7
Trans Nzoia	94.5	100	83.2	95.9
Turkana	85.5	88.4	86	86.5
Wajir	94.9	95.5	91	93.2
West Pokot	60.2	74.9	73.9	70.1

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KIPPRA Policy Briefs are aimed at a wide dissemination of the Institute's policy research findings. The findings are expected to stimulate discussion and also build capacity in the public policy making process in Kenya.

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