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Evidencing Policy Decisions

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Policy Brief

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Stunting of Under 5 Children in Kenya

Kenya's overall stunting rate is yet to get to the desired target of 14.7% as stipulated in the Kenya Vision 2030. Stunting rate is higher among poor households in rural areas. Further, there are disparities across counties, varying from a low of 15% to a high of 46%, and therefore nutrition-specific and nutrition-sensitive interventions are required to reduce stunting. It is also necessary to strengthen nutrition services by incorporating nutrition in the County Integrated Development Plans to capture county-specific issues. Furthermore, a governance structure that embraces multi-sectoral actions would address the social determinants of malnutrition. The National Information Platform for Food Security and Nutrition is yet another milestone in strengthening the policy process in addressing stunting. Strengthening centralized data collection with standardization of tools would ensure consistency in tracking nutrition progress.

Introduction

Stunting is the impaired growth and development that children experience from poor nutrition, repeated infection, and inadequate psychosocial stimulation. Stunting before children are 2 years leads to irreversible diminished brain and physical development, poor cognitive outcomes and economic consequences, and reduced productivity at individual, household, and community levels. The Cost of Hunger in Africa-Kenya Report (COHA, 2019) revealed that the total effect of stunting on health, education and productivity was Ksh 373.9 billion (6.9% of GDP) loss due to child undernutrition. The government has put in place various policies to address malnutrition, but the prevalence of stunting is still high. This policy brief seeks to initiate multi-sector dialogue among agencies that have a role in nutrition to analyse data and generate evidence to inform policy and programme interventions focusing on high impact nutrition interventions for reduction of stunting.

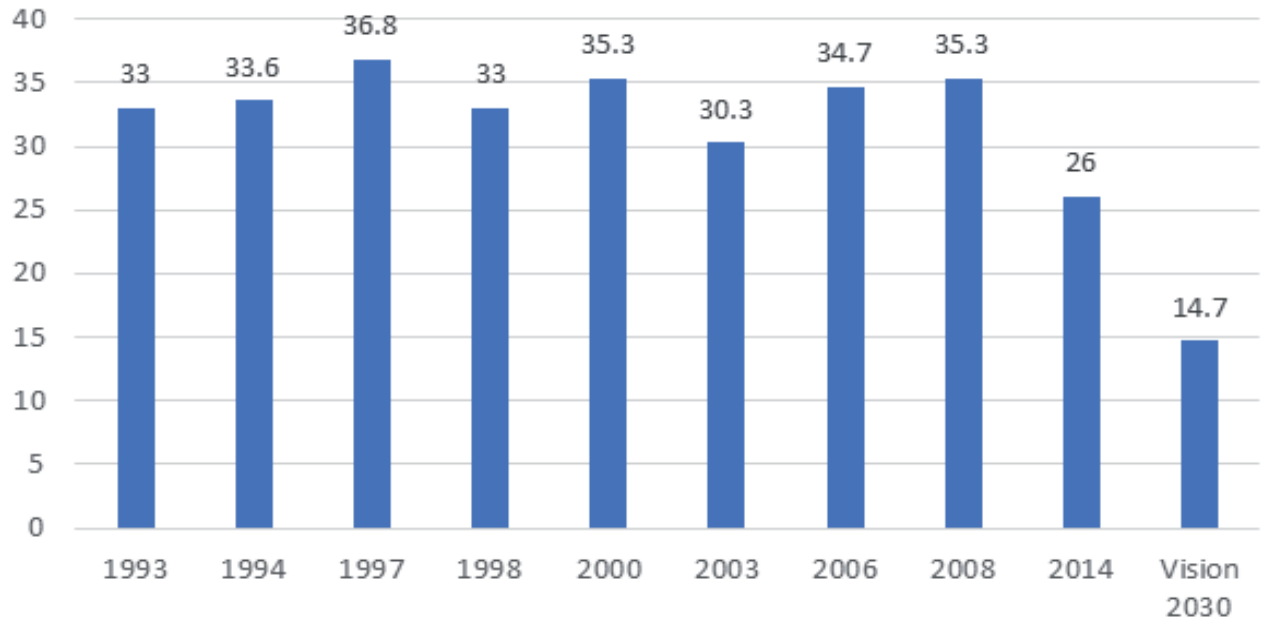
Availability of Data for Analysing Status of Stunting of Under 5 Children

It is difficult to measure progress and make timely intervention without generating timely data. The latest data available on national prevalence of under 5 stunting in Kenya is the 2014 Kenya Demographic Health Survey (KDHS). The long-time taken (5 to 10 years) between surveys constrains taking timely corrective actions in reversing trends in stunting. In the Kenya Vision 2030, the government targeted to reduce by more than half the stunting rate from 35.3% in 2008 to 14.7% in 2030 (Figure 1). By 2014, with implementation of the first Medium-Term Plan (MTP), a 26% reduction in stunting was achieved, with more children stunting in rural areas (29%) compared to urban areas (20%). Further, the proportion of children receiving minimum acceptable diet (minimum dietary diversity and meal frequency) declined from 39% in 2008 to 21% in 2014. However, it is difficult to tell what was achieved with the second MTP without a recent survey, which would make it difficult to guide the policy direction in the third MTP.

National surveys assess nutrition state of populations by revealing common nutritional problems. Some countries such as Nordic countries (Sweden, Finland, and Denmark) have centralized data on food consumption on European Food Safety Authority (EFSA). The US has National Human and Nutrition Examination Survey (NHNES) and What We Eat In America (WWEIA) surveys that are funded by government. Data from the KDHS is useful for planning for nutrition interventions. The Kenya Integrated Household Budget Survey (KIHBS) data inadequately captures nutrition variables as it does not classify the amounts of food consumed in availing the desired nutrition components. Population census data does not narrow to nutrition-specific indicators that can inform targeted interventions for significant reduction of stunting. National Micronutrient Surveys are done to give a reflection of the state of micronutrient deficiencies in the population. Data from other countries are timely and corrective actions are taken to address malnutrition. Kenya is among countries under the Scaling Up Nutrition movement with Common Results Framework (CRF) in the over-arching nutrition plan to collate, analyse and present information across key sectors and strengthen systems for implementation at the counties. his enables timely analysis, dissemination and use of evidence for nutrition interventions. Best practices evident from these countries is that they have adequate funding by governments to facilitate surveys to inform policy interventions, thus timely interventions are made to reduce the brunt of stunting. In other countries that have reduced stunting, nutrition data is collected by centralized institutions coordinating the sectors that have a role in nutrition. In Kenya, the Kenya National Bureau of Statistics (KNBS) collects, analyses, and disseminates statistical data that include food consumption and food recall surveys to inform nutrition interventions.

Financing nutrition surveys through government national budgets would ensure sustainable facilitation, yielding real-time data for nutrition improvement. This is critical particularly in the context of devolution for standardization of approaches of nutrition interventions, bearing in mind that the state of nutrition in counties contributes to the national state.

Fig.1: Stunting of under 5 children



Source: Computed from Kenya Demographic Health Survey,2014

Focusing on Disparities on Stunting across Various Groups

Households most affected by stunting tend to be the poor in rural areas. For example, the absolute poor have a stunt rate of 34.8% compared to non-absolute poor at 25.9% (Table 1). Further, households that are food poor have a stunt rate of 33.8% compared to non-food poor at 27.3%. Stunting is also higher (in rural, urban, and peri-urban) for female-headed poor households compared to male-headed poor households, and lower for female-headed non-poor compared to male-headed non-poor households.

There is also a strong association between food poverty and stunting for children 6-11 months as complementary foods are introduced at this stage of development (COHA, 2019). At 6-23 months, 59% of children do not consume an adequately diversified diet. Further, those who were stunted as children tend to have lower per capita expenditure and therefore a greater likelihood of living in poverty. The poor also tend to have deprivations in access to safe water and sanitation facilities, which influences stunting.

Table 1: Association between Poverty and Stunting

Level of stunting; Height for Age<-2SD	Rural	Urban	Peri-urban
Absolute poor	34.8	25.4	24.9
Non-absolute poor	25.9	18.4	21.4
Food poor	33.8	22.8	26.6
Non-food poor	27.3	20.0	21.1
Child poor	34.8	25.4	24.9
Non-child poor	25.9	18.4	21.4
Female-headed poor	34.8	34.7	26.3
Female-headed non-poor	23.2	14.3	18.8
Male-headed Poor	35.1	22.0	22.7
Male-headed non-poor	27.0	19.3	22.3

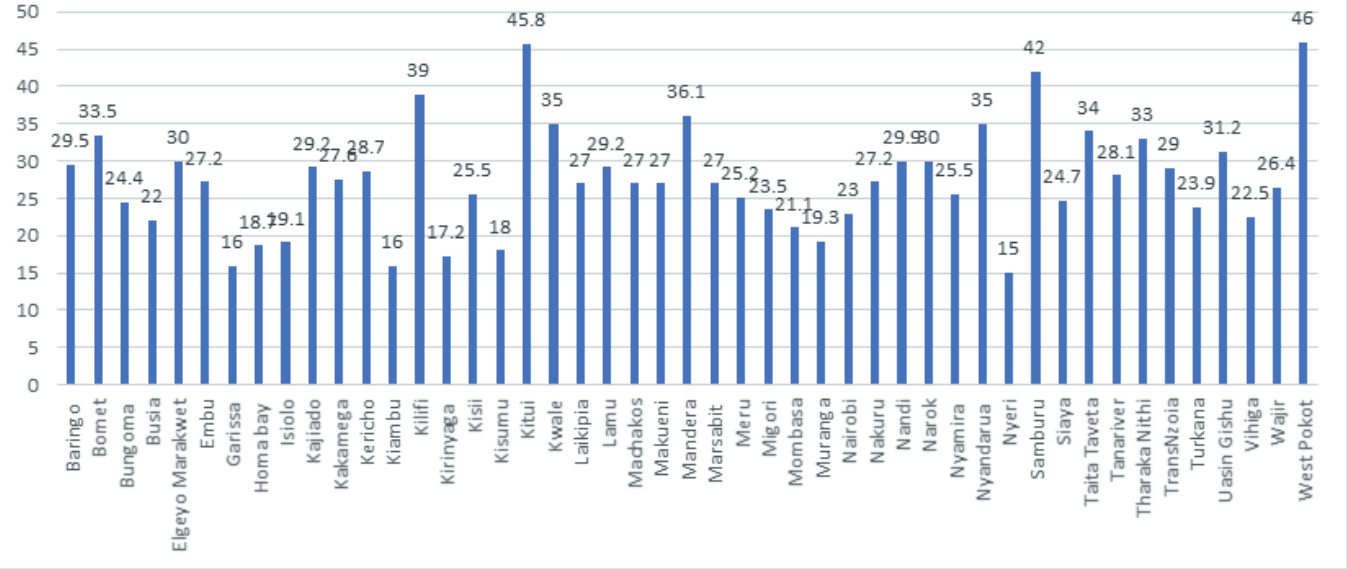
Source: Kenya Integrated Household Budget Survey, 2015/16

Furthermore, there are variations across counties as indicated in Figure 2. Inadequate access to water and sanitation facilities in poor informal and rural areas make children suffer from diarrhoea and, owing to their low incomes, access to healthcare is a challenge and thereby suffer from undernutrition. The causes of undernutrition are multifaceted and interlinked as depicted by various conceptual frameworks on immediate, underlying, and basic causes of malnutrition. Water sanitation and hygiene influences nutrition status through three pathways of diarrhoea, environmental enteric dysfunction, and helminthic infections.

The poor benefit from social safety net programmes where they can access food and money. Orphaned and vulnerable children are supported to access food and money for acquisition of basic needs that they require. There have been efforts to automate and develop a database of beneficiaries of the social safety net for efficiency for their protection. Among the initiatives to reduce child undernutrition include nutrition education for mothers. This education is integrated in maternal child health services, and through community units where women are

educated during visits to homes and public meetings. The poor access this during community engagements, but with health security issues posed by the current COVID-19 pandemic, more options of integrated nutrition information systems would avail electronic messages if people were empowered economically to access phones and internet.

Fig.2: County Stunting Rates in 2014



Source: Kenya Demographic Health Survey ,2014

In addition, there is need for enhanced interventions to fortify commonly consumed staple foods with vitamin A and iron and folic acid supplementation for pregnant mothers to promote improved nutrition. Fortification started in 2012 but access to fortified foods by households with low incomes in rural and urban informal areas has been inadequate. There have been efforts to reach out to small scale retail millers to fortify their flour, but they need to be organized into formal groups through which they can be trained and assisted to obtain premixes and dossiers at low costs to increase access to fortified foods. The poor have disproportionate access to fortified foods due to high prices, and lack of knowledge on foods for making appropriate food choices that promote good nutrition.

At county level, some counties such as Baringo, Nyamira, Murang'a, Tharaka Nithi, Marsabit, Kajiado, Turkana, Isiolo, Kitui, and Makueni have done well in domesticating the Kenya Nutrition Action Plans by developing their County Nutrition Action Plans. Others such as Baringo and Makueni have included nutrition services in their County Integrated Development Plans (CIDPs), which would help sustain nutrition investments. Counties such as Nairobi, Kirinyaga and Kisii are yet to develop their nutrition action plans. The key issues in the Nutrition Action Plans include reduction of the prevalence of stunting by 40% among children below 5 years from 26% in 2018 to 17% in 2022. This would significantly reduce the brunt of stunting. Other initiatives that are complementary is the increase of rate of exclusive breast feeding in the first 6 months by 20% and above from 61% in 2018 to 75% in 2022.The CIDPs bring nutrition issues to visibility for consistent and co-ordinated implementation of nutrition interventions. The plans have monitoring and evaluation frameworks and key result areas with categorized activities for implementation. The activities are costed, and mechanisms of funding indicated for synergy and coordination.

Adequately Planning and Budgeting for Nutrition

Planning and budgeting are key in delivery of nutrition interventions to curb stunting. The share of national health budget that includes nutrition allocation has averaged below the Abuja Declaration target of 15% of total annual budget. The Kenya Nutrition Action Plan (KNAP) targets to have the proportion of health budgets spent on nutrition increased from 2% to 8% by 2022. Further, some policies in health, agriculture and education sectors have been aligned to ensure funding of nutrition activities. These include the Kenya Health Policy Framework of 1994, the National School Health Strategic Implementation Plan 2011-2015, and the Agricultural Sector Development Strategy 2010-20.

The level of budgets is still low and has not met the thresholds to which the country has committed. There are gaps in planning, as some of the funds are off-budget expenditures not reflected in the overall national budgets. Data for co-ordinated planning for nutrition interventions is critical for synergy by all nutrition actors. The Abuja Declaration of spending 15% of GDP on health has not been met and, consequently, the budgets on nutrition are low. The countries that met the Abuja Declaration are Ethiopia, Gambia and Malawi, having surpassed the target of spending on health. However high-income countries have incommensurately allocated health resources. Countries' economies vary and thus of importance is whether the difference in allocation has resulted in real progress on health indicators, making people healthier and prosperous. Sufficient measures to equally distribute wealth and invest in social sectors by enacting appropriate policies would improve health systems. Malawi has demonstrated this by interventions of improved Reproductive Maternal Neonatal Child and Adolescent Health and nutrition services through strengthened linkages between primary health facilities and communities, particularly in rural areas. This has been complemented by initiatives to bridge the gender inequalities and increase household food production and improved incomes by households.

The level of budgets to counties for nutrition-specific and sensitive interventions are spread across sectors, with roles on nutrition. County budget allocation on nutrition in the financial year 2017-18 in millions Kenya shillings varied across counties as follows: Marsabit 440, Kajiado 286, Homa Bay 174, Murang'a 170, Isiolo 134, Kiambu 126, Nyandarua 124 and Makueni 102.5, among other counties. The allocation was not reflective of the brunt of malnutrition in some non-arid and semi-arid counties which had high allocations. County level budgets are not reflective of the costed activities in the County Nutrition Action Plans. There are activities that are in the Plans for which county governments mobilize funds to execute. Each county is autonomous in planning for nutrition budgets and execution, thus there are variations in prioritization of nutrition interventions across counties. Partner preference of counties to implement nutrition intervention are guided by surveys/assessments of nutrition status, but the tools used are not standardized, and there is no proper coordination of the exercise for consistency.

The role of community units such as village health committees is significant in strengthening nutrition awareness and linking malnourished cases to health care services. This has come out even more clearly in the context of COVID-19 strategy of managing patients at home. The gap is the training and retention of members of the committee for consistent follow up of nutrition interventions at the community level. There is high turnover on village health committee workers since there are no incentives for retention. The gaps on village health committees are on incentives to be motivated for continuity of service delivery, thus minimizing on the high turnover by these critical primary care workers.

There are areas not addressed by the existing policy frameworks, and these include advocacy, social mobilization, and communication. Policies drive the agenda of government, and developing plans that are funded for social mobilization and communication with respective audiences ensure sustainable reduction of stunting. Advocacy and social mobilization are critical components of uptake of nutrition services. Social behaviour change to adoption of healthy diets can be attained through continuous nutrition education integrated in learning institutions and community

engagement initiatives. All immediate and underlying causes of malnutrition are behavioural and are influenced by the behaviours of individuals. People can change behaviours to improve nutrition outcomes especially when the environment in which they live and work support changes. Nutrition is influenced by behaviours of other actors that include private sector and policy makers who collectively, directly or indirectly influence childcare and feeding practices, household food security, and household environment and health care services (USAID, 2017). Behaviour change interventions need to be integrated into design of nutrition interventions to instil a healthy eating culture among the population for sustainable uptake of nutrition services. The workforce will be prepared to offer responsive healthcare services because their capacities are enhanced through training.

Conclusion and Policy Recommendations

Stunting requires interventions that are designed to address its key drivers for attainment of sustainable development. Malnutrition is multifaceted and interlinked, hence the need for multi-sector approach in nutrition interventions. Water sanitation and hygiene influences nutrition status through three pathways of diarrhoea, environmental enteric dysfunction, and helminthic infections. There are disparities in status of nutrition across counties, with inadequate nutrition budgets that are not a reflection of the burden of stunting in the respective counties. Funding of national surveys requires to be factored in national budgets and standardization of data collection tools and methods ensured for real-time generation of evidence for use in nutrition interventions for sustainable nutrition improvement. Investment by countries in the social sectors and the health system will sustainably reduce the brunt of stunting.

In this regard, the following are policy recommendations:

- Strengthening nutrition financing and investments by all nutrition actors.
- Including nutrition in the County Integrated Development Plans for sustainable interventions.
- All counties to have in place their own County Nutrition Action Plans to help focus on county-specific issues.
- Strengthening community units to promote nutrition initiatives.
- Strengthening centralized funding for nutritional surveys for timely information for nutrition interventions.

Further reading

1. COHA (2019), The cost of hunger in Africa, social and economic impact of child undernutrition, Kenya.
2. KDHS (2014), Kenya Demographic Health Survey
3. World Bank (2018), Malawi systematic country diagnostic: Bringing the cycle of low growth and slow poverty reduction.
4. USAID (2017), Moving nutrition social and behaviour change forward: Lessons from the SPRING project.

About NIPFN Project

The National Information Platform for Food Security and Nutrition (NIPFN) is a country-led and country-owned platform, to facilitate multi-sectoral and multi-stakeholder dialogue on nutrition. The Kenya National Bureau of Statistics (KNBS) and the Kenya Institute for Public Policy Research and Analysis (KIPPRA) are the two State Corporations mandated by the Government of Kenya to implement the project.

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