

NUTRITION AND THE MILLENNIUM DEVELOPMENT GOALS

A KENYAN PERSPECTIVE ON THE ERADICATION OF EXTREME POVERTY AND HUNGER

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Poverty and food insecurity are the twin challenges of the 21st century, alongside issues such as HIV/AIDS, conflicts, and natural disasters. Although many countries have had different strategies to tackle these challenges, the United Nation's Millennium Development Goals (MDGs) provide a united front where eight universal goals must be achieved by the year 2015.

The first part of this paper focuses on the MDGs, what they mean for developing countries and progress in achieving them. The paper goes on to discuss why some countries have made progress, especially in alleviating poverty, and why others have not. The second and third parts of the paper address Kenya's progress in achieving the MDGs, policy implications since independence and achievements since the country endorsed the Millennium Declaration at the Millennium Summit in September 2000. The fourth part provides policy recommendations which Kenya should make a priority to alleviate extreme poverty and hunger and most importantly, towards improved nutrition as a key development input.

What the Millennium Development Goals mean for developing countries

In November 1996, the World Food Summit (WFS) recognized access to and availability of food as a human right, yet hunger has continued to plague the developing world, especially South Asia and Sub-Saharan Africa¹. The Copenhagen Declaration on Social Development indicates that more than one billion people in the world live in abject poverty and most go hungry every day². There has been a variety of efforts to eradicate poverty in developing countries, however, only some countries have improved their living standards. In Sub-Saharan Africa, progress has been slow³.

Firstly, through various poverty reduction strategies, many developing countries have experienced an improved growth in gross domestic product (GDP), increased food production, improved school enrollment, gains in the status of women, improved access to primary health care and clean water, and an enhanced respect for human rights. Yet, Sub-Saharan Africa has not followed these trends. Instead, over the recent decades, several factors such as poverty, civil strife, droughts, diseases such as HIV/AIDS, high population growth, decreasing food production, and, sadly, greed, corruption and indifference amongst leaders have exacerbated the food and nutrition situation in many African countries. In addition, as the SCN reports, Sub-Saharan Africa is the only region in the world where the number and percentages of malnourished children is expected to rise over the next twenty years⁴.

Secondly, in developing countries, and in particular Africa, there is a lack of sustained political commitment as seen by the low per capital spending on nutrition. Thirdly, poverty alleviation strategies have not incorporated nutrition programmes, which reduce hunger faster than poverty alleviation strategies alone⁴.

The WFS acknowledged that the solution to problems of poverty and malnutrition in Africa lies in the empowerment of rural communities through assisting them in identifying and overcoming constraints of participation in developmental processes leading to improved living standards and quality of life¹. The empowerment of rural communities to address the MDGs is the responsibility of concerned governments and communities themselves. Governments, because they have a responsibility in meeting the food and nutrient needs of their people; communities, because they have the power to bring about change in living standards through community-based projects. The community is the key stakeholder in any developmental process. It is disappointing that the majority of people living in poor communities, whose needs the goals are addressing, have no knowledge of the existence of the MDGs. This calls for awareness raising within these countries to enlighten people on the existence of fundamental goals which realize their basic needs.

The potential to achieve the MDGs in developing countries is within reach, however, guidance is needed from international organizations and donor agencies on how to accomplish this as well as support in the ongoing process. Most developing countries are endowed with resources that can be chan-

nelled towards the achievement of the MDGs. The first goal on the eradication of extreme poverty and hunger may be the sole goal that will steer the wheel towards the realization of other equally significant goals. However, successful poverty alleviation strategies cannot be designed without an appropriate understanding of poverty and hunger and the relationship that exists between the two. The vicious circle of poverty breeding malnutrition and in turn malnutrition increasing poverty, is further compounded by the distances women have to travel to access markets, health facilities, water, and firewood; the high numbers of unemployed; and the low education levels and high school drop-out rates.

The introduction of MDGs, therefore, has given developing countries a renewed sense of urgency and has emphasized the importance of poverty eradication and of improving livelihoods; it has also provided a united front whereby countries have come together to achieve common goals as well as a time-frame which is the year 2015.

Poverty and hunger in Kenya: post independence policy implications

Since independence, the Kenyan Government has undergone a transition of policies under government control (1963-1979) to liberalized markets (1980 to date)⁷. The control era was marked by government control and participation in agricultural production, marketing and investment activities. The government emphasized self-sufficiency in domestic production of the main food commodities, namely maize, wheat, rice and milk as a means of achieving food security. On the other hand the era of liberalized economy has emphasized the role of market forces in guiding production and marketing of agricultural commodities, with increased private sector involvement and reduced government participation. The mounting debt crisis resulting from the control era triggered the World Bank and International Monetary Fund to push for new policies that limited the state's role by creating enabling environments for individuals and associations to pursue their economic and social objectives⁷.

This shift by Kenya from an era of control to a liberalized economy saw the country move from a food secure to a food insecure nation. Until the late 70s, food security was achieved through domestic production and facilitated by specific policy actions including:

- major land distribution by government to small-scale farmers
- government supported agricultural research that resulted in the release of new high yielding varieties for maize and wheat
- expanded agricultural extension services both in quality and quantity—individual and group farm visits, field demonstrations and whole farm integrated project management (it became expensive in the long-run and targeted only a small group of wealthy farmers)
- increased use of subsidized farm inputs at government-controlled prices
- credit to farmers was made available through the Agricultural Finance Corporation
- producer prices received by farmers were controlled by the government and later deliberately increased as an incentive for farmers to achieve food self-sufficiency
- the marketing of commodities, coordinated by a number of statutory marketing boards, was a booster to agricultural development through the provision of readily accessible markets. Nonetheless, unofficial parallel market outlets for cereals and livestock products existed.

It is worth noting that the above-mentioned policies were centred mainly on agriculture, which was then, and still is today, considered the backbone of the economy. Despite the success of policies in achieving food security in the 60s and 70s (the era of controls), in the 80s, the country was confronted with food shortages and was forced to import maize, wheat and milk in substantial quantities to meet the shortfall⁷.

The food shortfall was attributed to some of the following factors:

- a decline in production due to reduced land available for food crops, resulting from competition by other more profitable commodities
- pricing and marketing inefficiencies
- drought conditions in 1979, 1980 and 1984
- low credit availability and accessibility
- little emphasis and support from the government on traditional, drought resistant food crops such as cassava, sorghum and millet
- concentration of wealth by politically influential individuals, including stretches of under-utilized land

- onset of corruption and mismanagement in public offices
- mismanagement and eventually collapse of food processing and marketing industries such as the Kenya Meat Commission, the Kenya Cooperative Creameries and National Cereals and Produce Board
- the wake of the HIV/AIDS pandemic leading to socio-economic conditions that have affected food production and caused financial instability in the households
- high cost of education and health care leading to low expenditure on food production and purchasing.

With a trend of poor performance in the policy sector for the past decades, there are new efforts to revive the economy, improve food security and eradicate poverty.

The Millennium Development Goals in Kenya

The Kenyan Government endorsed the Millennium Declaration at the Millennium Summit in September 2000. The goals, targets and indicators highlighted in the Summit have given the on-going national frameworks, initiatives and processes a new sense of direction and time frame—the year 2015¹¹.

With a new government in place, Kenya has made progress towards improved governance and renewed donor confidence; however, the challenges facing the nation are still enormous. Poverty remains a constraining factor, and poor health and malnutrition have continued to hinder efforts towards poverty reduction through low productivity and high morbidity and mortality rates. The government has in place various poverty reduction policies and programmes that are designed with the participation of the poor and other stakeholders. At the macro level, these include the National Poverty Eradication Plan (NPEP), the Poverty Reduction Strategy Paper (PRPS), and the Medium Term Expenditure Framework (MTEF). While at micro level, there are specific programmes that address the needs of local communities in various parts of Kenya. With this approach the government expects to reverse the current poverty situation.

While looking at the progress in achieving the MDGs it is important to highlight the strategies the Kenyan Government has adopted to improve human development by 2015 and where nutrition can be incorporated as an input, not just as an outcome.

Goal 1: Eradication of extreme poverty and hunger

NATIONAL POVERTY ERADICATION PLAN AND POVERTY ALLEVIATION

Kenya's population is about 29 million people according to the 1999 census and is projected to grow to 31 million in 2002¹¹. About 56% of the population (that is approximately 16 million people), live below the absolute poverty line, meaning that they are not able to meet their daily basic needs in food, shelter, health, education and related social needs⁸. The NPEP, mentioned above, lists as its main objectives: the reduction of poverty in both rural and urban areas by 50% by 2015; the reduction of gender and geographic disparities, and a healthier, better educated and more productive population. The report on the *Perspectives of the Poor on Anti-Poverty Policies* further reiterates that women and children in general suffer more from intra-household elements of poverty than men, while specific groups such as orphans, single mothers, widows and people with disabilities also suffer disproportionately. The report on the *Geographic Dimensions of Well-being in Kenya*, where poverty mapping has been conducted from district to local levels, clearly documents where the poor are concentrated and the causes of poverty in these regions⁵.

Through the NPEP and the PRSP, the government has put in place the Economic Recovery Strategy for Wealth and Employment Creation (2003-2007)¹⁵ to revive the ailing economy as well as create jobs. Some of the specific objectives include creating 500,000 jobs annually, reducing the poverty level by at least 5% from the current 56.8% level, achieving a high GDP growth rate (rising from an estimated 1.1% in 2002 to 7% in 2006), containing the average annual inflation rate to below 5% and increasing domestic savings to enable higher levels of investment for sustainable development.

NATIONAL FOOD POLICY AND FOOD SECURITY

A selected policy area identified by the report on the *Perspectives of the Poor on Anti-Poverty Policies* is food security. The picture that emerges in the study is one of declining food security and changing consumption patterns, limited extension services, low quality farm inputs and high cost of foodstuffs. However, as stated in the National Food Policy, food security should have top priority since no meaningful development in the economic, social or cultural spheres is possible without it⁹. Food insecurity reduces the quality of life through malnutrition and poor health as a result of infections; infections lead

Table 1

INDICATOR (children underfive)	Year		
	1990	2000	2015
Prevalence of underweight (weight-for-age)	32.52	33.12	16.26
Prevalence of stunting (height-for-age)	6.17	6.6	3.09
Prevalence of wasting (weight-for-height)	22.5	22.1	11.05

Source: Millennium Development Goals Progress Report for Kenya, 2003

to low productivity and low income, thus reducing expenditures for medical services and education. This is evident in the latest report by Kenya Demographic Health Survey (KDHS), which indicates that the steady rise in the death of children is one of the clearest indicators of a drop in the quality of life in Kenya over the past 20 years¹⁰. KDHS indicates that between 1989 and 2003 the infant mortality rate increased by 30%. This is a rise from 60 deaths per 1000 live births in 1989 to 78 deaths per 1000 births in 2003. The child mortality for the same period also increased by 30% from 89 deaths per 1000 births in 1989 to 114 deaths per 1000 births in 2003. Causes of death have been identified to be malnutrition, morbidity, and impaired mental and physical development.

In Kenya, malnutrition remains high according to the *Millennium Development Goals Progress Report for Kenya*¹¹. Table 1 below gives the current prevalence of protein-energy malnutrition among children underfive, based on the 1998 KDHS survey. By 2015, it is projected that there will be a decrease in the prevalence of malnutrition due to the efforts in place to improve food security.

Agriculture, livestock and fishing are major productive sectors identified for investment towards economic recovery as well as provision of food, both in the productive and marginal lands (arid and semi-arid areas). The government has also proposed to eliminate vitamin A deficiency in underfive year olds by 2005 through the production and consumption of nutritious foods, especially those locally produced.

GOOD GOVERNANCE AND DEMOCRACY

The year 2003 can be termed as the year of rebirth for Kenya. The new coalition government has put in place new policies to rejuvenate the ailing economy and improve livelihoods, thus signaling political will. This, together with the new policies will go a long way in achieving the MDGs. What we hope for is continued transparent and accountable governance. Further, the *Millennium Development Goals Progress Report for Kenya*¹¹ indicates that the current government has demonstrated renewed commitment to reducing the high levels of poverty and hunger through the existing initiatives mentioned above and the Economic Recovery Strategy for Wealth and Employment Creation for 2003-2007, as well as its commitment to the New Partnership for Africa's Development (NEPAD) principles which is linked to national planning, poverty reduction and economic recovery.

Goals 2 and 3: Achieving universal primary education and the promotion of gender equality and the empowerment of women

Education is a key determinant of earnings and an important exit strategy from poverty. It improves people's ability to take advantage of the opportunities that can improve their well being and to participate more in the community and markets. The education level of mothers significantly affects the health and nutritional status of household members. On the other hand, poverty and lack of food tend to hamper efforts to provide education. Children from poor families drop out of school in search of employment to contribute to the family income, while those who opt to stay in school have low levels of concentration due to hunger pangs and poor performance. Maternal malnutrition leads to impaired infant growth due to poor nutrition during foetal life, whereas foetal and infant undernutrition affects children's school enrollment, educational attainment, cognitive ability and lifetime earnings. Micronutrient deficiency, especially iodine deficiency, has a spectrum of effects on growth and development, particularly mental. Prevention will therefore result in improved quality of life, productivity, and educability of children and adults.

To achieve the goal of universal primary education, the government has in place the policy of free primary education. This is aimed at reversing the trends of low enrollment and high drop-out rates. Table 2 indicates that the government aims to achieve 100% enrollment by the year 2015.

According to the *Millennium Development Progress Report for Kenya*¹¹ the government's policy of free primary education will substantially contribute towards attaining the second MDG of universal access to primary education by the year 2015. The current and recent unsatisfactory performances of the pri-

Table 2

INDICATOR	YEAR		
	1990	2000	2015
Net enrollment rate in primary education	80.0	73.7	100
Proportion of pupils starting grade 1 who reach grade 5	63	81	100

Source: MDG Progress Report for Kenya 2003

primary school system are often linked to Kenya's previous cost-sharing policy and differential geographic access to educational facilities, staffing problems and mismanagement of education resources. The major challenges facing the universal primary education initiative include:

financing the infrastructure expansion and human resource

regional disparities in access whereby low enrollment in some areas is closely linked to the nomadic lifestyle of its local population

high wastage rates, repetition and drop-out rates, and low transition are exacerbated by poverty and HIV/AIDS pandemic

reducing child labour which has been identified as one of the factors explaining declining enrollment rates in primary school in Kenya.

In an effort to close educational achievement gaps between regions and economic classes, the government has invested in four key programmes/activities. These include the children's bill, which provides the framework for enforcing universal primary education in the country and became an Act of Parliament in 2002; the school feeding programme that targets the arid and semi-arid lands; the textbook fund; and the bursary fund to enable the poor to further their education.

The third MDG promotes gender equality and empowerment of women. The goal targets the elimination of gender disparity in primary and secondary education preferably by 2005, and at all levels of education, no later than 2015. *Kenya's Millennium Development Goals Progress Report* indicates that although female to male ratio in primary and secondary school is almost equal, there is a major gap in enrollment in tertiary institutions. However, the enrollment ratio in mid-level tertiary institutions increased from 22.5% in 1998/1999 to 44.2% in 2001/2002. Factors such as premarital pregnancy and early marriage may determine the low progression of women from secondary to tertiary institutions; however, the choice of school subjects and females' poor performance at the end of their secondary schooling influences their engagement in the job market. Results of final secondary school examinations show that girls perform better than boys in languages, while boys consistently perform better than girls in all science subjects.

To promote gender equality, there is a national gender and development policy that has been approved but needs implementation. Other than attaining education, women need to take up leadership positions to influence decisions affecting household accessibility to basic needs such as water, food and shelter. This is also supported by the gender dimensions of the New Partnership for Africa's Development (NEPAD)¹⁴, which emphasize women's participation in macro-economic debates as well as those taking up political positions. Kenya continues to perform dismally in the participation of women in politics. There has been an increase in the number of women members of parliament from a mere five in 1990 to 18 in 2002/2003 (8% of the total parliamentary membership). In terms of leadership positions only seven women serve as Government Ministers as compared to 44 positions held by men.

The involvement of women in non-agricultural wage employment is quite low. The annual economic survey data on wage employment in the modern sector for 1999-2001 reports women's participation around 30%. A review of data on civil service employees shows that women made up 24.3% in September 2002, with a majority concentrated in the lower level job groups, whereas few occupied decision-making positions in the civil service.

The MDGs Progress Report reiterates that the government has committed itself to mainstreaming gender issues in its legislations, policies and programmes. It is also a signatory to international conventions and treaties on women's rights and empowerment.

Goals 4 and 5: reduce child mortality and improve maternal health

Maternal malnutrition causes intrauterine growth retardation (IUGR), and low birth weight. Due to



Table 3

INDICATOR	YEAR		
	1990	2000	2015
Underfive mortality rate	98.9	111.5	33.0
Infant mortality rate	67.7	73.7	24.0
Measles	48	76.1	100

Source: MDG Progress Report for Kenya 2003

this, children have a higher risk of dying in infancy. Survivors of IUGR are unlikely to catch up significantly on this lost growth and more likely to experience developmental deficits. Underweight children tend to have severe illnesses (eg, diarrhoea and pneumonia) due to compromised immune systems. Therefore, nutrition is an important component in ensuring a healthy population through proper maternal and child nutrition.

There was a reduction in infant and child mortality in Kenya during the 1960-1990 period. From more than 190 deaths per 1,000 live births in the 60s, the underfive mortality rate decreased to less than 100 deaths per 1,000 live births in the 90s. It is reported that this substantial reduction was, to a large extent, made possible through the control of malaria, tuberculosis, measles, cholera and other highly communicable diseases. For the last decade, Kenya has experienced an increase in infant and child mortality. KDHS reports that today at least 12% of children born alive do not reach age five. This is attributed to a high incidence of child malnutrition, poverty, the HIV/AIDS pandemic, acute respiratory infections, malaria and diarrhoea, and the low quality of health facilities and services.

Similarly, the infant mortality rate decreased in the period 1960-1990 from 100 deaths per 1,000 live births to about 60 deaths per 1,000 live births. In the last decade it has increased to 73 in 2000 (Table 3). It is worth noting that although tremendous progress had been made in the reduction of infant and child morbidity and mortality, which is mostly attributed to the significant improvement in the general immunization status of children, the gains made in child health have in recent years been adversely affected by the HIV/AIDS pandemic.

Referring to Figure 1 (next page), it is worth noting that there is a wide geographic disparity of under-five mortality across the regions due to social and economic factors. Although current and reliable sources of data are still lacking on regional differentials in maternal mortality, the KDHS 1998 estimates the maternal mortality ratio at 590 maternal deaths per 100,000 live births. The fifth MDG, which aims at reducing the maternal mortality ratio by three-quarters, between 1990 and 2015, remains a challenge for Kenya. Direct obstetric causes that need to be addressed have been identified such as haemorrhage, sepsis, complications arising from unsafe/induced abortions, eclampsia, and obstructed labour. Other causes include malaria, TB, anaemia, and HIV/AIDS. On a positive note, Kenya has experienced a dramatic decline on total fertility rate from 5.4 in 1993 to 4.4 in 1998¹¹.

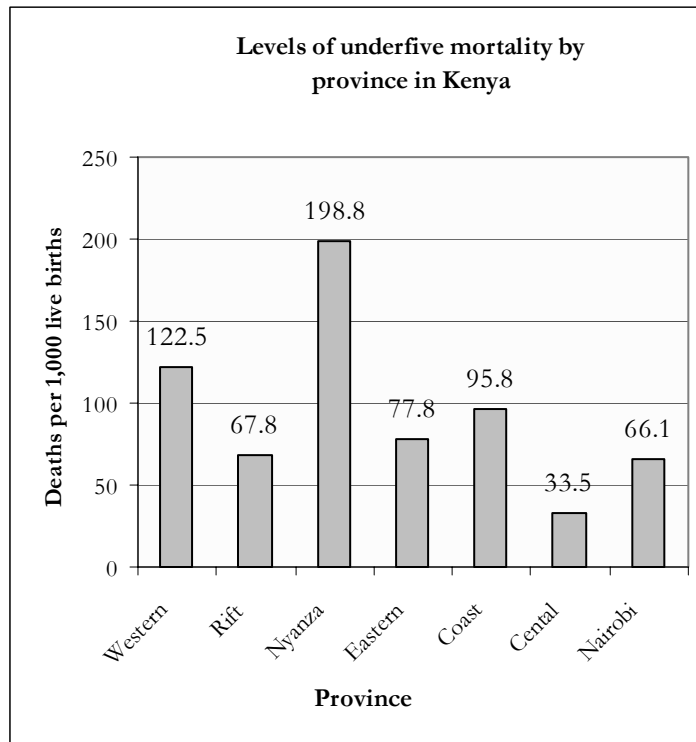
Besides the disease burden affecting child and maternal morbidity and mortality, the poor performance of the economy together with demographic pressures have affected the overall delivery of health services in Kenya. However, in an effort to improve the health status of Kenyans, the government, through the Ministry of Health, has set up several programmes that are currently supporting components of reproductive health. These include Kenya's expanded programme on immunization, control of diarrhoeal diseases and acute respiratory infections, nutrition, sexually transmitted infections and HIV/AIDS. There is also the Safe Motherhood Initiative, whose key components include family planning, antenatal care, safe delivery and essential obstetric care.

Goal 6: Combating HIV/AIDS, malaria and other diseases

HIV/AIDS has become one of the major public health challenges facing Kenya today and has been declared a national disaster. In the wake of HIV/AIDS, mortality and morbidity rates have increased, with a wide gender disparity in prevalences (women are more likely to be HIV positive than men)¹⁰. The disease is characterized by wasting, diarrhoea and other opportunistic infections. Nutrition is particularly important in the management of the disease, especially in prolonging life and delaying the progression to full-blown AIDS. Nutrition management centres provide personal individual nutrition support to counteract the severe wasting and malnutrition characteristic of the disease. On the other hand, pregnant women are particularly prone to severe complicated forms of malaria due to their reduced immunity levels. Moreover, malaria in pregnancy is a major cause of anaemia and low birth weight.

Malaria, HIV/AIDS and tuberculosis are at the top of the development agenda for Kenya, and there

Figure 1



Source: KDHS 1998

has been increased political and resource commitment by the government combined with an increase in donor support to fight these diseases. There has also been a steady rise in the number of people infected by the HIV virus. The *MDGs Progress Report for Kenya* indicates that the national HIV prevalence rate doubled from 5.1% to 10.4% between 1990 and 1995 and peaked at 13.4% in 2000 before declining to 10.6% in 2002. Urban areas are more devastated by AIDS than rural areas, although prevalence rates in rural areas are growing more rapidly than in the urban areas. In 2002, prevalence rates were 12.9% in urban areas and 7.7% in rural areas. Younger women in particular are more vulnerable than men. For instance, among 20-24 year olds, about 40% and 15% of women and men, respectively, were infected.

The major HIV/AIDS challenges facing the government are the provision of free or cheap anti-retroviral drugs (ARVs); controlling the spread of the disease by reducing the number of people newly infected; provision of voluntary counselling and testing in the rural areas; behaviour and attitude change; and tackling the problem of rising numbers of children orphaned by the disease as well as the promotion of home-based care and support for people living with HIV/AIDS.

On the other hand, 70% of the total population is at risk of malarial infection. The *MDGs Progress Report for Kenya* indicates that every year, about 34,000 children underfive years of age are estimated to die of illnesses related to malaria, roughly 93 per day. Throughout the country, malaria accounts for about one-third of outpatient clinic visits. The case fatalities in the country are attributed to highland malaria. In response to the huge disease burden and renewed international efforts of Roll Back Malaria, the government has developed a National Malaria Strategy with a main objective of reducing the level of malaria illness and death in Kenya by 30% by the year 2006 and maintain the level of improved control to 2010. Key interventions in place to tackle malaria include providing malaria prevention and treatment to pregnant women, promoting the use of insecticide treated nets and other vector control measures, and improving malaria epidemic preparedness and response.

Policy recommendations

Besides highlighting Kenya's progress in achieving the MDGs, it is important to remember that much more has to be done before Kenya can break out of the poverty trap. In as much as efforts put in place by the Kenyan Government are bearing fruit, as seen in the high enrollment in primary school and recarpeting of major roads, there is a need to concentrate on other services that are crucial to improving livelihoods, such as water and sanitation, as well as direct nutrition interventions and capacity building. These have been incorporated into community-based programmes, which already exist in most parts of the country but need scaling up. Women groups run most of the community-based projects, such as the income generating activities. Since in most cases women do not own land and there-

Table 4

Democracy and good governance Political will and commitment Anti-corruption strategies (transparency and accountability)	
Major policy sectors	
Existing policies	Proposed new policies centred on nutrition as a foundation for development
Health <ul style="list-style-type: none"> • more clinics and dispensaries opened • free drugs in government hospitals • more VCT centres opened 	<ul style="list-style-type: none"> • private and mission hospitals to offer free ARVs for HIV/AIDS patients • nutrient supplements for HIV/AIDS patients • families affected by HIV/AIDS to be put under a welfare scheme, especially given food provision • promote consumption of indigenous foods for health maintenance
Education <ul style="list-style-type: none"> • free primary education 	<ul style="list-style-type: none"> • free adult education (targeting women) • reduce cost of secondary and tertiary education to allow more money allocated for food in households • expand school feeding in arid regions
Agriculture <ul style="list-style-type: none"> • food policy-advocates for increased production and distribution of food • liberalized markets 	<ul style="list-style-type: none"> • rehabilitation of marginal lands • afforestation of deforested lands • adopt of low-cost food policy for arid regions • promote production and consumption of indigenous foods
Land reforms <ul style="list-style-type: none"> • reclaiming public land that had been grabbed by individuals 	<ul style="list-style-type: none"> • prevent further subdivision of land to small, low yielding pieces • government land that is not being utilized to be leased out to farmers
Infrastructure <ul style="list-style-type: none"> • road reconstruction and building of bypasses 	<ul style="list-style-type: none"> • construction of rural access roads throughout the country to facilitate accessibility and availability of food to households • construction of more silos to boost food storage

fore cannot use it as collateral to obtain loans, the government needs to intervene by setting aside funds to support these projects that compliment the household income and eventually translate into increased food purchases and meeting the health, nutritional and educational needs of the children.

The new policies ought to be centred on the fact that nutrition is a key component of development (Table 4). The government should take a leading role in planning for the future food and nutritional needs of its people.

- Since food production has not matched population increase and dietary requirements, unproductive land should be rehabilitated and underutilized productive land should be maximised through irrigation, land conservation and afforestation.
- New land policies should favour land consolidation rather than further land division by parents into small portions for their children resulting in limited productivity. Optimization of available resources is vital, and the government needs to ensure water availability in the dry lands for irrigation, livestock as well as domestic use.
- Incentives, such as farm subsidies, may have to be provided to farmers whose productivity levels have declined.
- Cooperatives need to be created by farmers, to serve as channels through which the governments can reach the farmer.

- The government needs to take full control of the demand and supply of food, right from farm production to marketing of the food (going back to the era of controls).
- By adopting a low cost-food policy, the government will ensure that food is not only available but also affordable for the poor and those on marginal lands.

If food production targets population needs and individual dietary requirements, household food security will improve as the nutritional status improves, people's health will also improve, and child mortality rates will decrease with improvements in maternal health. Other policies are equally as important.

- Policies are needed that recognize and strengthen the role of women in food production and procurement through financial support and the improvement of working conditions.
- Education policies in developing countries need to embrace the principle of basic education for all. A policy of free primary education has been adopted in Kenya, however the government must allocate resources to also fund adult education, especially that of women.
- Women are key to household food security and educating them empowers them to influence decisions affecting food availability and accessibility to all household members.
- The high cost of education at the secondary and tertiary levels still constraints households' budgets and reduces available expenditure for food and other needs. Education policy and adequate remuneration of all stakeholders in the educational system needs to be examined.

Community-based projects should be supported as instruments of poverty reduction, especially income generation as well as the nutrition intervention strategies such as school feeding programmes. Renewed political commitment translated into funding and the provision of essential services provides support mechanisms to ensure the success of these community projects. David Beckmann, President of Bread for the World, sums it up well when he says that nutrition programmes reduce hunger faster than poverty alleviation programmes in general⁴.

Because the central role of agriculture in generating employment and income, policies aimed at increasing agricultural production and productivity are essential for improving household food security and nutrition⁶. However, it is necessary, but not sufficient, in halving the numbers of the poor and hungry by 2015. Therefore, it is important to look at policies that will ensure affordable and accessible education and health as well as promote new technologies such as biotechnology that may in the long-run provide the ultimate answer to food insecurity in the region.

Conclusion

Nutrition is an excellent investment. Improved nutrition empowers individuals as well as communities. In doing so it fuels the development process that leads to poverty reduction¹³. The UN has provided leadership through the MDGs, other intergovernmental organizations have the responsibility of following this lead by providing a framework for the process, while states and governments must provide a stable political environment, the will and the commitment to achieve them. Democracy and good governance build the bridge leading to the realization of the MDGs. Good governance and democracy open up channels for dialogue, peace, transparency, accountability, donor support, policy reforms and more respect for human rights. As for civil society organizations, they have an important role to play by putting in place checks and balance to ensure that the MDGs are achieved.

However, let us take nutrition seriously as an input and foundation for development rather than just an outcome, by adopting policies and strategies that integrate it into agriculture, health, infrastructure, education and other major sectors, and by supporting community-based projects that have achieving better health and nutrition as a core objective.

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