Health, wellbeing and nutrition:

Research summary

AFRICAN CITIES RESEARCH CONSORTIUM

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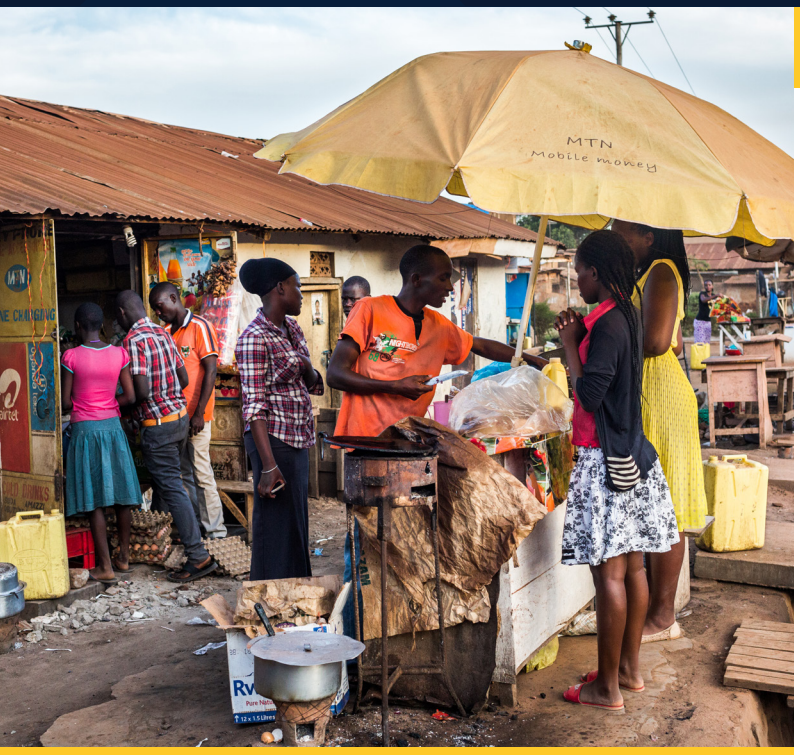


Context

Global food insecurity has increased in recent years as a result of a series of crises and related price hikes. This has taken place against a backdrop of longer-term decline in food quality in many places, which has created a "double burden" of malnutrition, whereby undernutrition and overweight co-exist within individuals, households and at the population level, with long-term societal implications.

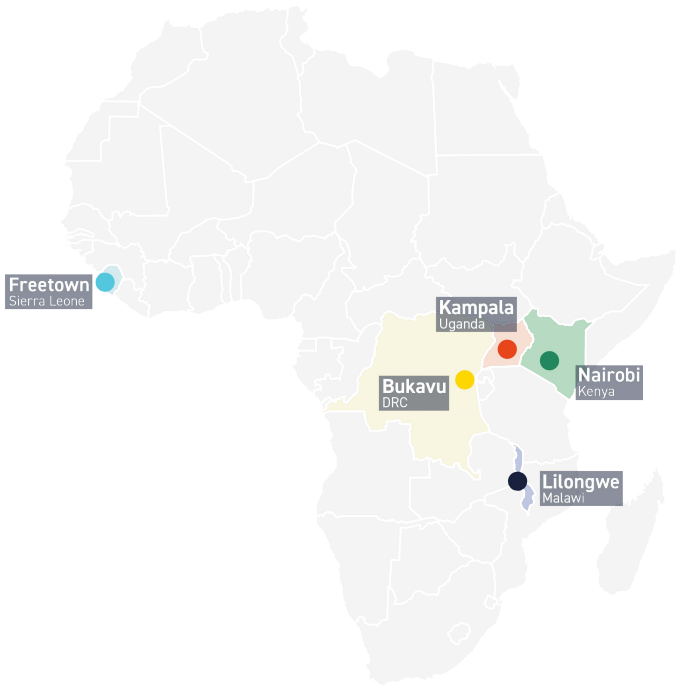
Urban residents rely primarily on purchased food, and are therefore especially vulnerable to increases in the costs of essential, healthy foods. In the African context, moreover, the large proportion of urban populations live in informal, underserviced neighbourhoods, where they are exposed daily to additional risks related to a lack of basic infrastructure and services. Efforts to address food and nutrition insecurity in African urban settings need to take into account how such insecurity may be exacerbated by the various structural constraints specific to urban poverty and informality.

Research approach

Access to healthy diets is essential to wellbeing and good health. We explore the limiting and enabling factors for the uptake of healthy diets in **Bukavu** (Democratic Republic of Congo), **Freetown** (Sierra Leone), **Kampala** (Uganda), **Lilongwe** (Malawi) and **Nairobi** (Kenya), and examine how policymakers, consumers and key actors in the food and health systems engage with the concept of healthy diets. The five city teams used a broadly similar mixed-methods approach to explore the challenges and opportunities shaping residents' dietary practices.

This approach included a review of the literature and secondary data to map the policy landscape and key systems and actors, and to explore patterns of food security and related ill-health, with special attention to their relation to socioeconomic factors (such as income and education) and spatial dimensions (such as residence in under-serviced informal settlements).

Figure 1: Cities covered by the health, wellbeing and nutrition domain research



This was followed by key informant interviews with local and central government, civil society actors, including NGOs and INGOs, local leaders and public and private services providers. Focus group discussions were conducted with communities in informal settlements to gather their insights. These were supplemented by participant observation of operations in food markets and related WASH aspects, existing systems and infrastructure, dietary behaviour in different sites and general living conditions in informal settlements/workplaces. Finally, meetings and validation workshops were held with key stakeholders at different phases of the project.

Key findings

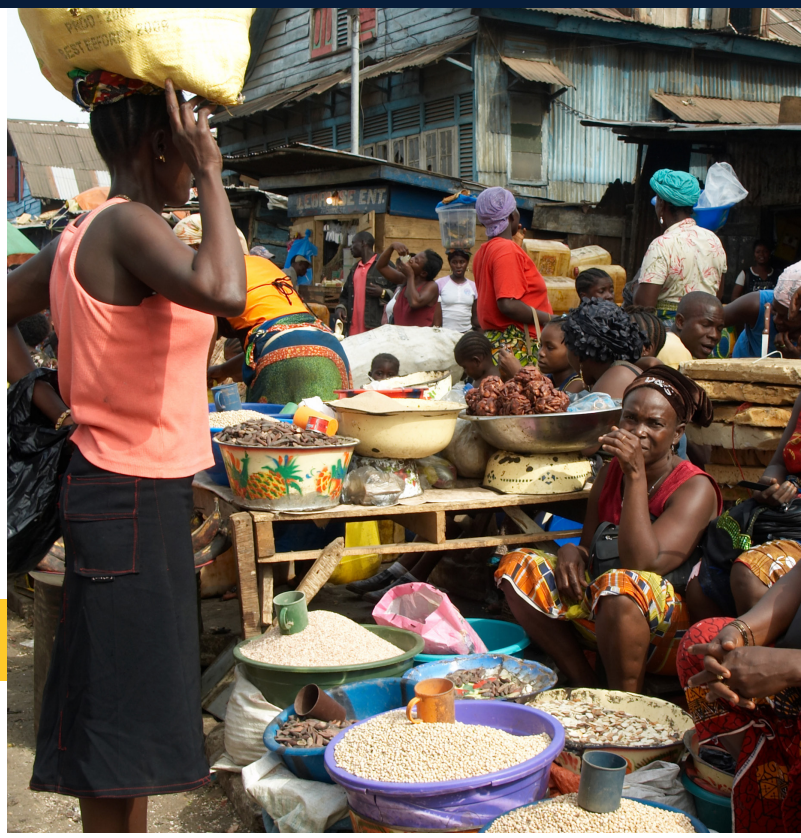
In all five cities, we note an increase in food insecurity and in the incidence of non-communicable diseases (NCDs) related to unhealthy diets, especially diets consisting of ultra-processed, energy-dense but nutrient-poor foodstuffs. While, on average, urban residents are less food-insecure than rural residents, residents of low-income, informal settlements – the majority of the population of all five cities – are likely to be equally if not more food-insecure than their rural counterparts. However, in all cities, with the exception of Nairobi, disaggregated data reflecting the health and nutrition status of residents of different neighbourhoods is limited or non-existent.

We identify a number of income and non-income drivers of food and nutrition insecurity in the five cities, most importantly:

1. **High costs:** Consuming a healthy diet that includes fresh fruit and vegetables is expensive for urban residents who depend on food purchases, and especially so for low-income earners. This is exacerbated by all five countries' dependency on international food markets, increasing their vulnerability to price hikes.

2. **Inadequate access to basic infrastructure and housing:** This results in the pervasive incidence of water- and food-borne illnesses. Access to safe drinking water is a priority for the residents of all five cities.

3. **Expanded access to (energy-dense, nutrient poor) ultra-processed foods, with high levels of salt, sugar and fats:** There is a severe lack of regulation covering food manufacturing processes, distribution and advertising. There are mixed levels of knowledge about healthy diets in the five cities; and even where such knowledge exists, affordability remains a major challenge.

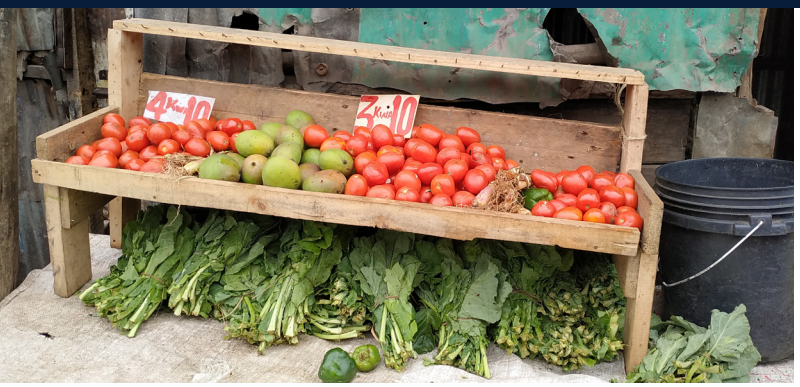


4. **Exclusion of important actors:** Informal food vendors provide affordable essential nourishment in poor neighbourhoods, yet suffer regular harassment and discrimination. They are either neglected or actively harassed, although they typically pay business taxes to the municipality, as well as bribes. Large commercial food importers and manufacturers wield greater influence on national policymakers to resist regulating unhealthy food environments.

5. **Control by powerful elites:** Both the food distribution system and the increasingly privatised health system are highly profitable and, as such, they are controlled by powerful elites, who also have strong links with policymakers. The result is a profit-driven vicious cycle, whereby unhealthy diets have become a major driver of ill-health, which in turn requires curative treatment for those who can least afford it.

Implications for urban reform

Growing global attention on tackling malnutrition provides impetus for domestic policymakers to elevate food and nutrition as an urban priority to be addressed locally. In all five cities, there are several programmes and initiatives aiming to improve access to staple foods and public healthcare. Support for such programmes is recurrently promised in election campaigns (often with commitments to providing state subsidies). However, such programmes invariably compete for scarce resources and have limited success – that is, if they actually get implemented.



These shortcomings in nutritional health policy and programming can be addressed through the following approaches:

- **Coordinating governmental action:** Siloed technocratic approaches must be replaced with coordinated governance, recognising cities' frontline roles. There need to be clearly designated mandates plus financing to promote healthy diets, making connections across related mandates like water, food markets and planning. There must also be a focus not just on the quantity, but also the quality, of food available, which has been somewhat disregarded in policy debates and initiatives.

- **Shaping behaviours and markets:** While city governments cannot do much to rein in price hikes linked to global events, they can run successful awareness campaigns – engaging community healthcare workers – and contribute to modifying consumer preferences and behaviours. They can also act on distribution, by lowering business taxes for food retailers and recognising and supporting the role of street vendors as key providers of food to low-income consumers, for example, by upgrading informal food vendors' rights and facilities. This requires addressing political interests, power imbalances that marginalise low-income urban residents, and commercial sectors promoting ultra-processed foods.

- **Mobilising healthcare services:** Primary healthcare services – including access to supplementary and therapeutic foods for malnourished children, and access to family planning – remain important entry points for addressing and preventing malnutrition in low-income communities, with community health workers sometimes acting as a critical link to services. Universal healthcare, community health worker and emergent non-communicable disease strategies may continue to offer strategic points for multi-sectoral collaboration on improving healthy diets. Youth development and adolescent health policy strategies are another point of potential policy and multisectoral convergence, since resources and support for preventing adolescent pregnancy and supporting adolescent parents are important in breaking intergenerational cycles of poor nutrition and ill-health.

- **Promoting effective advocacy:** Finally, substantial barriers will persist if wider systemic change is not secured. Sustained advocacy and activism are vital amidst wider political, climate and food pricing crises that magnify diet-health challenges. Within cities, concentrated efforts can seed gradual broader transformation, if backed by political will and resources. Civil society is an active player in all five cities examined here; however, it needs to form wider reform coalitions with local and national governments, community organisations and the private sector – the last of which comprises both formal and informal, small-, medium- and large-scale actors. The evidence from Nairobi indicates the effectiveness of combined top-down and bottom-up pressure for reform, involving wider coalitions spanning government, businesses, civil society and communities pushing a shared agenda.

About this summary

This is a summary of a Working Paper, written by the African Cities Research Consortium (ACRC) health, wellbeing and nutrition domain leads: Cecilia Tacoli, Rachel Tolhurst and Paul Currie.

Read the full paper

Photo information (by order of appearance):
1. Street food vendor in Kampala, Uganda - emretopdemir / iStock; 2. Food market in Freetown, Sierra Leone - Abenaa / iStock; 3. Fruit and vegetable stall in Nairobi, Kenya - Sam Owuor.

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