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USAID Nawiri Learning Brief: Adapted IMAM Surge Pilot

Background

The Integrated Management of Acute Malnutrition (IMAM) Surge approach complements routine IMAM services by supporting all level health teams to better anticipate, prepare for and manage increased acute malnutrition (AM) service demand. Since Kenya's first IMAM Surge pilot in 2012, the approach has been scaled-up across the Arid and Semi-Arid Land (ASAL) counties and introduced in 12 African countries. Learning from related experience has informed the Nawiri pilot: (i) the expansion of IMAM/ health surge by exploring its potential to be applied in a more holistic way; to better manage key childhood illness services as well as those for acute malnutrition by supporting health teams to better anticipate, prepare for and manage increased demand for key curative services for children, and (ii) using IMAM Surge data to inform community action. The pilot started in April 2021 and remains ongoing until April 2022.

Summary Findings and Lessons Learned

Adapted IMAM Surge pilot set up

- The participatory set up process involved sub-county community health focal persons, nutrition officers, facility in-charges and community representatives within the catchment area. This fostered collective ownership, paving the way for strengthened community- health facility linkages and collective responsibility regarding implementing the adapted IMAM surge.
- Preventive actions proposed by communities engaged included infection prevention, enhancing individual hygiene, timely health seeking behavior and treating drinking water. Handwashing, selling of livestock for income and food when necessary, establishing kitchen gardens where water allows and using long lasting, insecticide treated mosquito nets, were also prioritized. Community Health Volunteer (CHV) priorities in both counties included screening and early referrals, the provision of water treatment chemicals, promoting latrine construction and promoting kitchen gardens in communities with access to permanent water sources.

- Diseases selected for inclusion in the health surge depended on what the facilities involved felt were the main local drivers of seasonal child and maternal morbidity, which included diarrhea, Upper Respiratory Tract Infections (UTRI) and malaria, in both counties.

Health worker perceptions on the adapted IMAM Surge

- In-depth interview findings showed that facility in-charges see the adapted IMAM Surge approach as having the potential to strengthen community engagement.
- The adapted IMAM Surge empowers community and facility staff to use data to help address malnutrition, e.g., by supporting communities to think and plan ahead on what to expect within the month. The pilot does not, however, support communities with resources to initiate related action, which would foster the uptake of action points.

Adapted IMAM Surge pilot implementation

- Success in implementing the community component has largely depended on the proactivity of CHVs involved. The functionality of Community Units (CUs) remains critical to adapted IMAM Surge success, CUs being the main link between community health services and health facilities.
- Community health worker capacity to identify malnutrition directly impacts community health referrals and nutrition service uptake.
- Health surge components focused on disease prevention and expanding health system capacity, including human resources, medical supplies and non-medical commodities, for enhanced IMAM services, increased access and improved service quality.
- Frequent/ prolonged IMAM commodity stock outs directly lead to poor health and nutrition-seeking behavior in these communities.
- IMAM service coverage remains low across both counties, below acceptable global standards. See Table 1 for IMAM coverage across the four sub-counties involved (Marsabit and Isiolo County SQUEAC Surveys, 2021).

Impact on health and nutrition service delivery

- Facilities implementing community screening contributed to higher admissions to nutrition OTP and SFP programs, compared to the previous year. Scale up action led to expanded service provision through integrated outreach, with more participants reached. From May to November 2020, 3,457 children were admitted to the IMAM programs, versus 4,882 admitted in the same period in 2021 (DHIS, Marsabit County); an increase of 1,425 children, of which 607 directly resulted from mass screening activities conducted as part of the IMAM Surge pilot.
- The uptake of various preventive actions varied, e.g., handwashing, water treatment and CHV screening were readily taken up, but others relating to improved livestock management have experienced low uptake. This highlights the need for greater consultation and collective decision making, as well as for the integration of related SBC initiatives.
- Facilities' initiation of preventive actions has contributed to better treatment outcomes for OTP clients, potentially due to earlier admissions to the nutrition program. Admissions into OTP and SFP programs have generally been comparable to those in the previous year, despite the severe 2021 drought, indicating IMAM Surge contributions to lower admissions in sites implementing preventive action.
- The health surge has had a positive impact on scaling up action at system levels. In Dukana health facility, for example, the system was able to respond to high cases of Upper Respiratory Tract Infections (URTIs) by repositioning essential drugs from Kalacha sub-county referral hospital.

Table 1: IMAM coverage across Nawiri IMAM Surge sub-counties

Marsabit County		Isiolo County	
OTP	SFP	OTP	SFP
Laisamis 51.4% ¹	Laisamis 48.4%	Merti 25.7%	Merti 24%
North Horr 54.8%	North Horr 51.4%	Garbatulla 32.9%	Garbatulla 29.7%

As shown in the table above, coverage was found to be below SPHERE recommended standards of 50% for rural areas (across the 3 Isiolo County facilities), while in Marsabit coverage was only slightly above the 50% threshold, with the exception of SFP in Laisamis (at 48.4%). Specific barriers and boosters identified in the study are outlined in Table 2 below.

Table 2: Other key boosters and barriers to IMAM coverage

Boosters	Barriers and Challenges
<ul style="list-style-type: none"> • Present and active CHVs • Availability of Moderate Acute Malnutrition (MAM) services. • Strong collaboration between various stakeholders in MAM. treatment and service provision • Family MUAC - The majority of caregivers are able to recognize malnutrition. • Community awareness of the IMAM program. • Related Social Behavior Change (SBC) initiatives. • Collaboration between facility staff and CHVs. • External partner support 	<ul style="list-style-type: none"> • High caregiver workloads hinder their ability to routinely take malnourished children for SAM/ MAM treatment. • Lack of/ limited access to health services due to far distances, poor infrastructure, transport costs and limited or no outreach services. • COVID-19 related challenges • Impact of the recent extensive drought (2020/ 2021), during and following three failed rainy seasons.

¹ I.e., only 54% of malnourished children were enrolled in the nutrition program at baseline

Applying the Findings and Lessons Learned

Key Lessons Learned	Adaptation or implication	Link to the DIP or TOC
<p>1. Community Health Units (CHUs) are critical to enhancing health and nutrition intervention coverage, including IMAM and the management of child illnesses. However, they remain a weak link in health service delivery due to several factors, including limited capacity and lack of incentives.</p>	<p>1. Nawiri seeks to heighten county government and community focus on the functionality and quality of service delivery at CHUs. Proposed related TOC refinements include²:</p> <ul style="list-style-type: none"> ○ Prioritize the capacity development of CHVs and health workers. ○ Introduce an output to enhance focus on the functionality of CUs (Output: O 2.1.2.8: Coverage and functionality of CUs improved). ○ Add a programming and support element to improve health and nutrition service access through outreach services in hard-to-reach areas. <p>Introduction of a new output: O 2.1.2.9: Quality of community level services improved. This output will ensure greater focus on health and nutrition service quality at community levels.</p>	<p>P2, Output: O 2.1.2.8 and O 2.1.2.9</p>
<p>2. CHU effectiveness directly affects community IMAM Surge related actions, including prevention and mass screening. Admissions increased whenever CHVs received incentives from implementing partners, as well as during supported mass community screening. Social protection safety net support, like cash transfers to program participants through the the HSNP, NDMA³ and Nawiri Drought Emergency Response, have also boosted program visibility, identification, attendance and CHV morale.</p>	<p>2. Support counties to fast track CHS Bill operationalization and finalize critical decisions on a viable CHV incentive mechanism. 2022 election related issues risk severely delaying the Bill implementation.</p>	<p>LLO 3.1.2.1 Output: O 2.1.2.8</p>

² They are “proposed” for now, as the pilot remains ongoing. As appropriate, further unpacking of the implications of findings will take place as the pilot progresses and ends.

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³ Kenya's Health Safety Net Program (HSNP) and the National Drought Management Authority (NDMA)

<p>3. Knowledge of existing, effective nutrition/ IMAM Surge services greatly influences service uptake by the catchment population.</p>	<p>3. Most community participants reported learning from CHVs about the IMAM services available in local health facilities which encouraged them to seek services, especially when drought strikes. Related SBC communication needs strengthening.</p>	<p>SP 2.1 Key Research Area 3: What are the barriers to promoting more effective health systems and integrating nutrition, from stakeholder / community and gender perspectives?</p>
<p>4. Frequent/ prolonged IMAM commodity stockouts directly undermine services and lead to poor nutrition service seeking behavior in communities, as evidenced by participants from Nawiri Graduation model areas.</p>	<p>4. MOH and partners who support nutrition treatment commodities should cushion IMAM facilities against prolonged stockouts. Commodity contingency and emergency pre-positioning plans and action need to be strengthened.</p>	<p>SP 2.1 Key Research Area 3: What are the barriers to promoting more effective health systems and integrating nutrition, from stakeholder / community and gender perspectives?</p>
<p>5. Timely triggering of community and health system actions is key to ensuring timely responses are put in place by the county government and communities respectively.</p>	<p>5. Investment in technology, to complement quick information sharing. E.g., exploring the feasibility of a simple phone future app which is easy to use and can be adopted by the health facility and CHS focal points for bilateral information sharing, whenever the surge threshold has been met.</p>	<p>P2, Output: 2.1.2.8 and Output 2.1.2.9</p>

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