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USAID Nawiri Learning Brief: Health System Drivers of Acute Malnutrition

Background

Health systems play a significant role in helping achieve lasting positive health and nutrition outcomes, particularly when nutrition interventions are well integrated into health systems. This remains a critical challenge in Isiolo and Marsabit counties, however, particularly given the levels of Persistent Acute Malnutrition (PAM) in both counties. The desk study was conducted to determine the effectiveness of existing nutrition and health systems in both counties, the degree to which they have addressed PAM to date, and to highlight ways forward to strengthen their impact on nutrition in vulnerable communities.

Summary Findings and Lessons Learned

Health system drivers cut across health system building blocks and in Isiolo and Marsabit Counties are exacerbated by historical marginalization, seen in the limited infrastructure, services and social amenities found in many rural locations. Particular challenges include:

- Sub-optimal positioning of nutrition policy in broader development programs fails to unlock resources and support necessary to implement proven interventions. The over dependence on development partners to implement nutrition specific programs is also notable.
- Limited vision and understanding of nutrition related issues, policies and the role of other (non-health) sectors in addressing nutrition, which has mitigated against effective multi-sectoral vision, approaches and planning.
- Inadequate contextualization or roll out of strategies that could yield positive results, particularly in deeply rural areas.

Government resources are generally not prioritized for health and particularly not for nutrition.

- Study Health budgetary allocation goes largely toward recurrent expenditure (especially staff salaries) as opposed to development, leaving minimal funding available to support the setup of facilities or outreach service delivery in remote, high-need areas. Urgent attention needs to be devoted to adequately financing services and improving access in remote parts of both counties. As well, to date neither county has allocated funding to procure life-saving nutrition commodities, which remains donor and partner supported.
- Budgetary allocation to nutrition-specific programs goes largely to staffing and occasionally contingency, leaving other health system pillars (like supplies and service delivery), especially in remote areas including malnutrition hotspots, barely funded. The MoH therefore needs to reconsider health sector resource allocation in light of unmet health and nutrition service needs.

Kenya's ASAL settings suffer disproportionately with regard to inequities in healthcare worker distribution, which adversely impacts ASAL community nutrition status.

- In Marsabit, 87 nutritionists against a target of over 200 currently provide nutrition services across the county. Their spread is notably imbalanced, with the majority located in Saku and Moyale sub-counties where malnutrition rates are lower.
- Isiolo County has a total of 7 nutritionists against a target of 153, an extreme shortfall of 146 officers, with the majority located in the county referral hospital.
- Health service delivery approaches are not adequately contextualized to the ASALs, e.g., some assigned health workers do not speak local languages or appreciate the socio-cultural dynamics and norms of their catchment populations. This impedes their ability to provide optimal services.

The quality and timeliness of nutrition data generated via the health management information system (HMIS) remains limited, constraining its use for effective decision-making.

- Routine data collection happens via the HMIS, but the quality of data remains weak. It is compromised by the sheer number of indicators and volume of data being collected, particularly given the minimal numbers and uneven spread of health information officers across both counties.
- Manual data collection continues to hamper the quality and timely use of data for decision-making.
- Broader nutritional indicators generated from routine surveys (e.g., SMART surveys) often lack disaggregation at and by lower-level administrative units, beyond facilities, which doesn't foster the availability of comprehensive, quality data for effective decision making and programming.

The Community health system functionality is influenced by vast geographical areas and minimal Community Health Volunteer (CHV) renumeration.

- In Isiolo, most of the 703 CHVs are in the more urbanized Isiolo sub-county and lacking in malnutrition hotspots.
- Marsabit's 1,884 CHVs are also questionably imbalanced across the county, leaving notable gaps in some rural malnutrition hotspots. 33.1% of CHVs are in Moyale where malnutrition is not a major concern, with 27% in North Horr and only 21% in Saku and 19% in Laisamis; areas of high need.
- Isiolo has 52 community units (CUs)[1] only 60% of which are functional, largely due to poor/ lack of remuneration for Community Health Volunteers (CHVs).
- Of the 102 Marsabit CHUs, 87 are operational and provide nutritional services, while 9 do not provide nutrition services.
- Remuneration of CHVs remains a critical barrier to the functionality of CUs across both counties, particularly in the last mile acute malnutrition hotspots of Laisamis and North Horr.

Insufficient and poor spatial distribution of health facilities and service arrangements, particularly outside towns, significantly inhibits access to nutritional services - including in malnutrition hotspots.

- Of Isiolo's 71 health facilities, the majority of the 62% owned by government are concentrated in urban settings (non-malnutrition hotspots).
- Of Marsabit's 138 facilities, the bulk of the 68% owned by the government are in the urban hubs of Saku and Moyale.
- Limited opening times (i.e., not full day) make it difficult for many users to access services. In Isiolo this is of particular concern with under 25% open day-long, while Marsabit has a better record at 83% open for full days.

Applying the Findings and Lessons Learned

Key Lessons Learned	Adaptation or implication	Link to the DIP or TOC
• County governments have not given nutrition-related activities adequate attention or prioritization, as long witnessed in limited resource allocation. A similar pattern is evident at community levels. As such, greater focus and priority needs to be given to nutrition as part of the wider development agenda, by communities and county governments, including in related nutrition-specific and multi-sectoral nutrition-sensitive budgetary allocations.	• Introduction of an output to raise nutrition visibility and profile at county level and to promote resource allocation: **Output 2.1.2.7: Nutrition profile at county and community level increased**. Nawiri to strengthen collaborative advocacy efforts for greater resource allocation by the counties. • Nawiri to directly support very weak system pillars, including facilitating service access in very remote areas through government-led outreach services.	P2, Output 2.1.2.7

• Community Health Units are critical to enhancing the coverage of nutrition interventions, including IMAM services, but remain a weak link in health service delivery. Although government owned, the lack of an effective policy and renumeration framework at county level means that CHVs are largely demotivated, leaving CUs dysfunctional.	• Nawiri will support greater county government and community attention to the functionality and quality of service delivery at CUs. Proposed ways forward include: ▪ Prioritizing the capacity development of CHVs and other health workers. ▪ Introducing an output focused explicitly on the functionality of community units (**Output: O 2.1.2.8: Coverage and functionality of CUs improved).** ▪ Adding a programming and support element to improve health and nutrition service access through outreach service provision in hard-to-reach areas, for more vulnerable communities. • Introduction of a new output: **O 2.1.2.9 Quality of community level services improved, to** ensure greater focus on health and nutrition service quality at community levels.	P2, Output: O 2.1.2.8 and O 2.1.2.9
• Context changes: Failed and erratic rainfall patterns in both counties, forcing some communities to move further away from services so further limiting service access and utilization.	• Expand interventions to include nutrition-oriented drought response elements, e.g., by supporting activities like mass screening, outreach support, active case finding and also by increasing vulnerable household visits and support.	P2
• Address the incorrect initial assumption of no major disease outbreaks or epidemics experienced during the project, given COVID-19 realities and their direct impact on health and nutrition service delivery and uptake.	• Plans and interventions refined to be COVID-19 sensitive, including by modifying interventions as necessary in response to the sustained pandemic.	All

See the full Nawiri report on Understanding Nutrition and Health System Drivers of Acute Malnutrition in Arid and Semi-Arid Lands Kenya - Marsabit and Isiolo Counties, Kenya, for all sources cited

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