

Kenya: Linking information to action. Synthesis of coverage assessment findings



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Screening for acute malnutrition in a Kenya

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What we know:

Since August 2010, Kenya has adopted IMAM programming as part of routine health services. Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) surveys are conducted regularly to provide localised, contextual information on IMAM services.

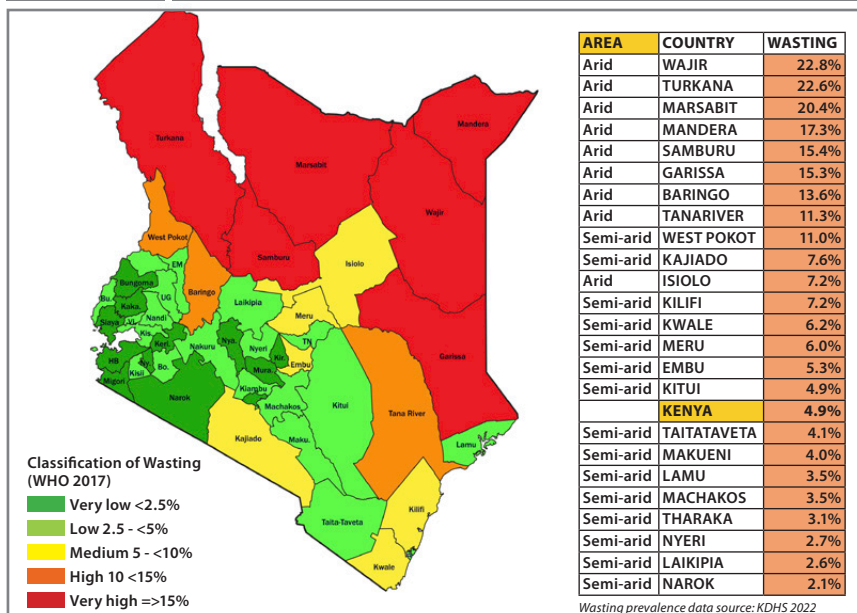
What this adds:

The need to systematically combine SQUEAC survey results to generate all-inclusive recommendations for improving IMAM coverage across the Arid and Semi-Arid Land counties (ASALs) was recognised. This article explores the synthesis of findings from 18 independent surveys. Most IMAM programmes in ASALs have attained coverage above 50% targets, but there is room for improvement. Key barriers and facilitators are explored and recommendations to improve policy, programmes, and coordination are provided.

In Kenya, around 5% of children aged under five years are wasted and about 18% stunted (KNBS, 2022). However, the national prevalence of wasting obscures important sub-national patterns – particularly in the ASALs where wasting is generally more prevalent than the national average (Figure 1). The scale-up of IMAM servic-

es in the ASALs is a key component of Kenya's country roadmap toward achieving and sustaining the Global Action Plan targets on wasting. IMAM is implemented by the Ministry of Health in collaboration with UNICEF, the World Food Programme, and implementing partners as part of the emergency nutrition response in the ASALs.

Figure 1 Wasting prevalence in different Kenyan counties



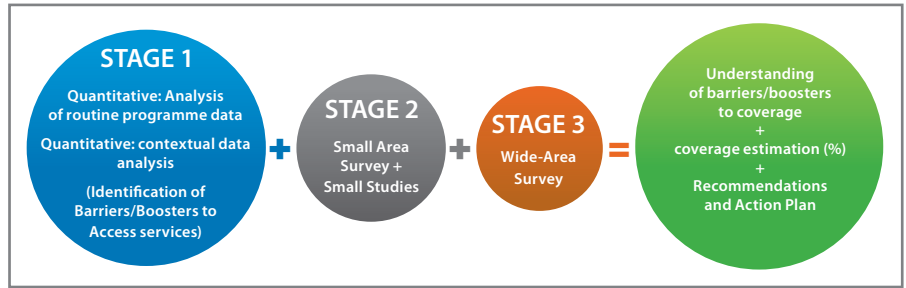
The Kenya Nutrition Information Technical Working Group (NITWG) recognised the need to systematically review localised data, from SQUEAC surveys, to generate all-inclusive recommendations to address key challenges to IMAM coverage across the ASALs. This single, high-level comprehensive outlook could then be used for advocacy, planning, and resource mobilisation, informing the scale-up of IMAM in the ASALs.

Methods

Conducting independent SQUEAC surveys

A total of 18 coverage assessments were conducted between May and July 2023 across 10 ASALs: Turkana, Marsabit, Samburu, West Pokot, Baringo, Isiolo, Tana River, Mandera, Garissa, and Wajir. These assessed Outpatient Therapeutic Programmes (OTPs) and Supplementary Feeding Programmes (SFPs) according to the key steps summarised in Figure 2. In Turkana and Marsabit, six and four separate

Figure 2 Key steps used to conduct SQUEAC surveys in Kenya



surveys were conducted at the sub-county level, respectively. This was due to the geographical expansiveness of these counties.

Synthesis of SQUEAC surveys

We conducted a ‘quasi’ meta-analysis that collated the results of the 18 SQUEAC surveys. First, the single coverage estimates for either

programme (OTP or SFP) were compiled for comparison. From each survey area, coverage barriers and facilitators were collated into an Excel worksheet. Each survey area was allocated a separate worksheet. This was the ‘level one’ analysis of OTP/SFP barriers/facilitators.

In ‘level two’, barriers and facilitators were reviewed and categorised into four general groups: community-level issues, geographical factors, caregiver determinants, and health system issues. The barriers and facilitators that were similar in each of the general groups were further organised into more granular sub-category themes. Sub-categories were then coded in a drop-down menu for ease in enumerating which survey areas reported each sub-category. Our threshold for determining whether a barrier or facilitator (sub-category) was common was that it must have been reported by nine (50%) or more survey areas (counties or sub-counties).

Key informant interviews were also conducted to draw on a broader perspective and to complement county-specific issues. Purposively selected national-level interviewees included: the Ministry of Health National Manager for Emergency Nutrition (n=1), the Ministry of Health Monitoring and Evaluation Manager (1), national staff of implementing partners supporting IMAM (4), the UNICEF Monitoring & Evaluation Specialist (1), the Nutrition Sector Coordinator (1), the UNICEF Emergency Nutrition Specialist (1), nutrition supply chain officers (2), national-level World Food Programme staff (1), the UNICEF Data and Monitoring Nutrition Support Officer (1), and UNICEF Nutrition Specialists at zonal level (2). Guide questions for the key informant interviews were drafted and distributed appropriately across these key informants. This gathered additional information about IMAM coverage that may not have been addressed through the SQUEAC survey methodology alone.

The information collected from key informants was categorised into common themes. These were then triangulated with the synthesised barriers and facilitators to inform the national outlook of issues affecting IMAM programming in Kenya’s ASAL areas (Figure 3).

Results

Programme coverage

There were seven OTP and five SFP survey areas that reported single coverage estimates of less than the 50% minimum standard for rural areas (Figure 4) (Sphere, 2018). When SFP and OTP cov-

Figure 3 Analysis framework for SQUEAC survey synthesis

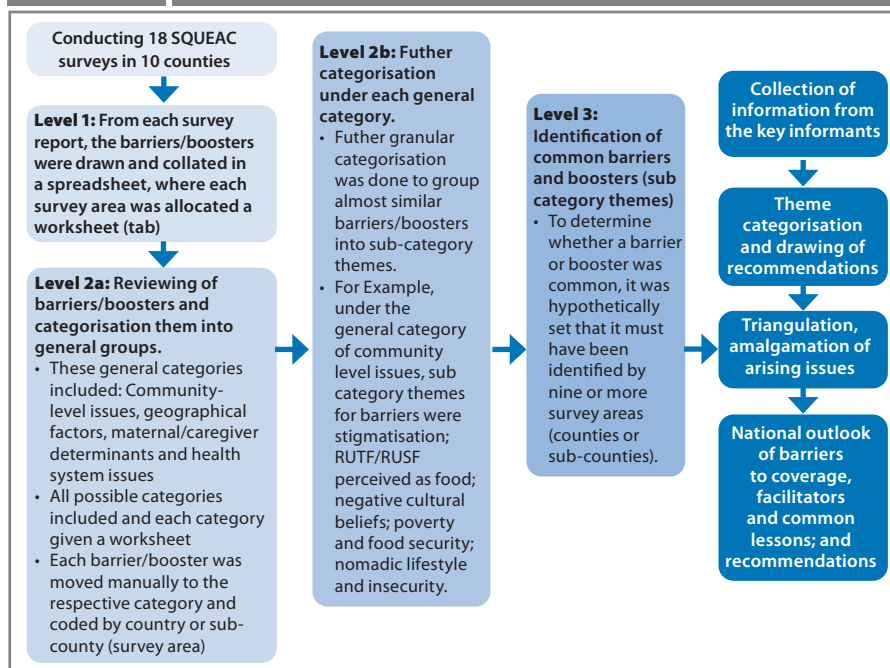
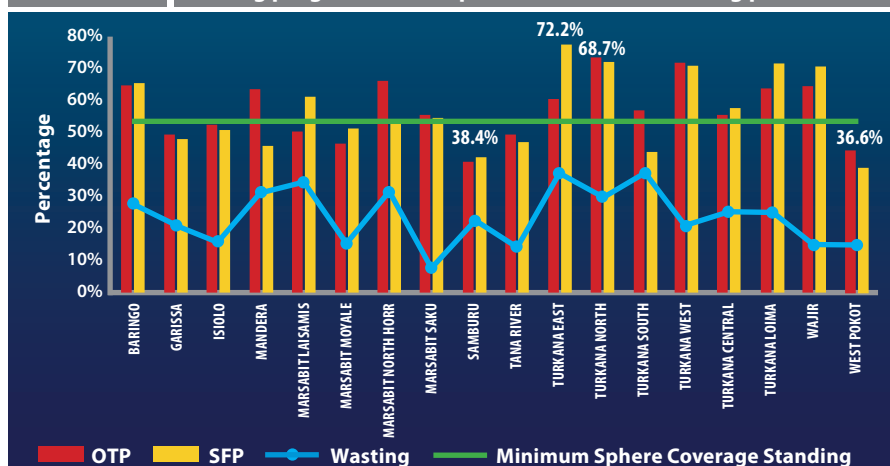


Figure 4 Single coverage estimates for outpatient and supplementary feeding programmes compared to observed wasting prevalence^{a,b}



^a Wasting prevalence was taken from recent Standardised Monitoring and Assessment of Relief and Transitions (SMART) surveys (July 2022 or January 2023).

^b In Turkana and Marsabit counties, sub-counties were assessed separately due to the expansiveness of these areas. Highest and lowest coverages are labelled.

erage and wasting data were merged, and regression analysis performed, a positive relationship was observed – coverage increased in line with increasing wasting rates. Almost two in every three survey areas (64%) with high wasting rates (over 15%) had higher coverage rates (greater than 50%) for both OTP and SFP. From the synthesis, we noted that areas with higher wasting prevalence also had many nutrition partners supporting IMAM programming, thus explaining the higher cov-

erage estimates. However, this did not come into play for areas with high levels of insecurity (such as Samburu and Laisamis).

Common barriers to coverage and treatment

In both OTPs and SFPs, 94% of survey areas reported the sharing of ready-to-use therapeutic food (RUTF) or ready-to-use supplementary food (RUSF) – or exchanging them for money

or food – as a major barrier (Table 1). Similar findings were reported by key informants, who noted nutrition commodity sharing was commonplace. Some caregivers who consumed alcohol would also exchange RUTF for money or alcohol. Maternal workload was also highlighted as a key barrier, as well as poor active case finding and referral. Long distances to health facilities and migration (due to drought or floods) were also important barriers to access.

Table 1 Barriers and facilitators to outpatient and supplementary feeding programme coverage^a

Outpatient Therapeutic Feeding Programme			Supplementary Feeding Programme		
Commonly reported barriers	Survey areas	%	Commonly reported barriers	Survey areas	%
RUTF sharing or exchange for money or food	17	94%	RUSF sharing or exchange for money or food	17	94%
Poor active case findings and referral system	15	83%	Challenges with HCWs	16	89%
Challenges with CHVs	15	83%	Long distance from health facility	16	89%
Maternal workload	14	78%	Maternal workload	15	83%
Long distance from health facility	13	72%	Poor active case finding and referral	15	83%
Poor knowledge on causes and treatment of severe wasting	12	67%	Migration due to drought and floods	15	83%
Negative cultural beliefs, practices, and myths	12	67%	Challenges with the CHVs	14	78%
Migration due to drought and floods	12	67%	RUSF and other commodity stockouts	14	78%
Poverty and food insecurity	11	61%	Stigmatisation of households with moderate child wasting	13	72%
Stigmatisation of households with severe child wasting	10	56%	Poverty and food insecurity	12	67%
Poor documentation/records	9	50%	Maternal knowledge and perceptions	12	67%
Nomadic lifestyle and insecurity	8	44%	Poor knowledge on causes and treatment of moderate wasting	11	61%
Poor health seeking behaviours	8	44%	Negative cultural beliefs, practices, and myths	10	56%
Alcoholism	8	44%	Poor health seeking behaviours	10	56%
Challenges with HCWs	8	44%	Nomadic lifestyle and insecurity	9	50%
RUTF and other commodity stockouts	8	44%	Poor or impassable roads	9	50%
RUTF is perceived as food	7	39%	RUSF perceived as food	8	44%
Limited defaulter tracing and follow-up	7	39%	Limited defaulter tracing and follow-up	7	39%
Maternal knowledge and perceptions	6	33%	Poor documentation/records	7	39%
Commonly reported facilitators	Survey areas	%	Commonly reported facilitators	Survey areas	%
Awareness on causes and treatment of severe wasting	18	100%	Awareness of and limited stigma regarding moderate wasting	18	100%
Health Care Worker capacity to implement IMAM	18	100%	Active case finding and referrals	18	100%
RUTF and other supplies available (no stockouts)	17	94%	HCW capacity to implement IMAM	17	94%
Positive health seeking behaviours	16	89%	Collaboration between HCWs, CHVs, communities, and leaders	16	89%
Community Health Volunteer capacity to implement IMAM	16	89%	Active outreach services and mass screening	16	89%
Active case finding	14	78%	CHV capacity to implement IMAM	15	83%
Support supervision and programme review	14	78%	Family led MUAC and self-referral	15	83%
Family led MUAC and self-referral	13	72%	Positive health seeking behaviours	13	72%
Active outreach services	13	72%	RUSF supplies available (no stockouts)	13	72%
Stakeholder support and coordination	12	67%	Stakeholder support and coordination	12	67%
Collaboration between HCWs and CHVs	10	56%	Defaulter tracing mechanisms	11	61%
OTP services available at health facilities	9	50%	Support supervision and programme review	11	61%
Availability of screening, referral and reporting tools	9	50%	SFP services available (at various service points)	10	56%
Active community and leader's involvement	8	44%	Availability of equipment	7	39%
Defaulter tracing mechanisms	8	44%	Proximity to health facilities	6	33%
Recognition of role of CHVs	6	33%			

^a Only commonly reported barriers / facilitators have been shown here (i.e. those reported in six or more survey areas)
 RUTF/RUSF = Ready-to-use therapeutic/supplementary food; CHV = Community Health Volunteer; HCW = Health Care Worker;
 MUAC = Mid-upper arm circumference

Kenya's community health strategy was launched in 2006 to improve community access to healthcare. Since then, most counties have adopted it – including all the survey areas featured in this article. However, continued challenges were observed in regard to the community health strategy. In some areas, there were no community health volunteers (CHVs). Where they existed, numbers were often not adequate to support in active case finding, defaulter tracing, and referral. Some CHVs had capacity gaps, as was reported by a partner staff key informant.

“Knowledge of IMAM by CHVs has enhanced screening and active case finding in the community. However, a good number of CHVs have not been trained on IMAM due to limited resources.”

– Key informant, nutrition partner

Demotivation, due to a lack of or a delayed stipend, was commonly reported for CHVs across the survey areas. We also observed that a barrier may have a geographical aspect due to geopolitical and sociocultural similarities. An example is maternal alcoholism, which was reported in Turkana Central, Turkana South, Turkana West, Samburu, West Pokot, Baringo, Laikipia, and North Horr. These areas border each other, and this finding calls for inter-county collaboration in addressing the challenge.

Common facilitators of coverage

Most health systems facilitators were common across the survey areas for both OTPs and SFPs. These included HCWs and CHVs' availability and their capacity to provide IMAM services, active case finding, active outreaches, and mass screening exercises. Also important were no stock-out of nutrition commodities, provision of supportive supervision and programme reviews. All the surveyed areas indicated awareness of the causes and treatment of severe and moderate wasting as a key community-level facilitator.

Common maternal/caregiver facilitators identified were positive health seeking behaviour, training caregivers to identify early signs of malnutrition in their children using MUAC (“Family-led MUAC”) and self-referral. Only Turkana North reported availability of active mother support groups as a facilitator.

What next?

The synthesis of findings from the independent surveys, together with the consolidation of insights from key informants, highlight actions to be considered to scale up IMAM across Kenya's ASALs.

Policy and strategy considerations

Developing and implementing a national strategy for peace, security, development, and humanitarian operations, as well as tackling poverty and infrastructural challenges, all remain important. Poverty and childhood malnutrition are interlinked – and they are mediated by inadequate diets, lower education, poorer living standards, and limited access to healthcare fa-

cilities and appropriate water, sanitation, and hygiene. This clearly articulates the need for policies and guidelines that prioritise overall poverty and malnutrition reduction.

Kenya has chosen the primary healthcare system to deliver universal health coverage. A ‘community health strategy’ has been given prominence in all the survey areas. However, challenges to full strategy implementation still exist, as only two counties are reported to be giving CHVs a monthly stipend. There is a need for county governments to collaborate with partners to develop and implement community health acts. These acts will provide a legal basis for counties to allocate funds for remuneration and provide adequate supervision of CHVs. This will result in CHVs who are better motivated, better equipped, and who are accountable when providing health services at community level.

Programmatic issues

Across 18 independent SQUEAC surveys, with a few exceptions (Turkana East, Turkana Loima, and Wajir), the OTP was found to perform better in both coverage and outcome indicators than the SFP. This is despite both programmes being implemented jointly in all the survey areas. This calls for further analysis to understand the associations and unique factors that could be causing this difference.

Maternal workload was highlighted as a key caregiver barrier. Programming should be designed to encompass male involvement in childcare activities and not purely focus on mothers and children. Counties and partners could also support establishing peer-to-peer support groups for fathers at community level, which have been proven to positively influence child feeding practices (Bogale et al, 2022; Atuman et al, 2023). Fathers can be involved in financial and resource support, as well as social and physical support, such as shared responsibility for the nutritional wellbeing and health of the child. A study in Ethiopia found that, for children aged 6–23 months, dietary diversity in the household increased by 13.7% when fathers were involved in infant and young child feeding (Gebremedhin et al, 2017).

Community engagement, sensitisation, and mobilisation clearly remain as barriers to increasing coverage for both OTPs and SFPs. Addressing these issues will be central to achieving greater coverage in IMAM programmes. As well as developing guidelines and strategy documents, it is critical for counties and partners to allocate resources for improved community engagement.

The sharing and commodification of RUTF/RUSF was a major barrier. This directly affects programme outcomes, increasing both length of stay and non-response in a programme. Ultimately, children who remain wasted remain at heightened risk of mortality and morbidity associated with malnutrition. Such practices also increase the cost of programmes. To curb this, it is critical to link households with malnourished children who have exited as ‘cured’ from IMAM programmes to social safety net schemes. However, in this analysis, only two survey zones reported the availability of social safety net pro-

grammes as a facilitator. National and county governments, and partners, must scale up social safety net and poverty alleviation programmes that integrate nutrition.

The adequacy and availability of nutrition supplies was a key facilitator leading to the success of the IMAM programme. Although the supply chain is government led, procurement is heavily supported by donors. Advocacy efforts should continue at both the national and county levels for resource allocation to cover nutrition supplies and for ring-fencing finances to protect any allocated funding for this task.

Coordination actions

Several coordination mechanisms for nutrition exist in the country at national level, providing opportunities for collaboration and to strengthen partnerships between the Ministry of Health and nutrition stakeholders. These include the Nutrition Technical Forum, ENAC, and NIT-WG. Counties could establish such coordination structures for inter-county information sharing and collaboration, seeking to address common barriers and documenting best working practices.

Conclusion

This systematic synthesis of findings from 18 SQUEAC surveys highlighted that most IMAM programmes in ASALs have attained OTP and SFP single coverage above 50% but there is room for improvement and a need to sustain the gains already made. OTP was noted to perform better compared to SFP.

The identified common barriers and facilitators, and additional key observations, provide relevant information for policy, advocacy, and programmatic efforts to scale up the management of wasting across the ASALs. Moreover, the synthesis diagnoses the need for inter-county collaboration in tackling specific barriers, given their geographical spread. Ultimately, systems need to be strengthened to prevent children from becoming wasted in the first place. Poverty alleviation, stronger community systems, and gender equity (all advocated for above) will not only reduce barriers to increasing treatment coverage but also promote prevention.

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