Transitioning nutrition programming from humanitarian aid to health system strengthening in Kenya

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KENYA

What we know: The Arid and Semi-arid Lands (ASALs) of Kenya have experienced 25 years of repeated drought-related emergencies and are dependent on short-term aid for nutrition response.

What this article adds: Since 2006, nutrition partners have combined efforts to transition from ‘aid’ to government led, managed and financed nutrition programming. Impressive gains have been driven by strong central government leadership framed by a health system strengthening approach. Devolution, increased government investment at county level and an obligated requirement to build more resilience in the ASALs have enabled transition. Success factors include developing a common vision for nutrition, inclusive communication and coordination bridging humanitarian and development, securing sufficient human resources, embedding technical assistance into government ministries, improving nutrition information systems, securing longer-term financing and strengthening supply chains. Innovations included the community-based management of acute malnutrition (CMAM) surge approach that significantly increased utilisation/coverage of services. A minimum package of quality nutrition services is now offered every day in health centres. Challenges remain, including a reliance on external technical assistance and difficulties in ensuring long-term funding. A vision, clear criteria and formalised framework are now needed to guide transition from aid to development financing for nutrition in the health system.

Background

From June 2018 to April 2020, Maximising the Quality of Scaling Up Nutrition Plus (MQSUN+) provided technical support to the UK’s Foreign, Commonwealth and Development Office (FCDO), previously the Department for International Development (DFID) and UNICEF in Kenya to analyse progress in the implementation of the Kenya Nutrition Support Transition Programme and to examine the next steps following programme completion in March 2020. Activities included field visits, consultations with stakeholders and technical input to proposals, log-frames and monitoring and evaluation plans.

This article presents observations of successes over the last 14 years and the remaining challenges in transitioning away from aid towards government-led, managed and financed nutrition services within the health system.

Since 1984, large drought-related emergencies have repeatedly affected parts or all of Kenya’s ASALs. Evaluations following...
the 2005-2006, 2008-2009 and 2011 drought responses highlighted recurring issues of late, parallel and weakly coordinated response. Furthermore, associating nutrition programming with drought responses contributed to short-term and intermittent funding and programming. Consequently, there was a need to identify solutions to enable nutrition stakeholders to respond earlier, integrate nutrition-related responses into government systems and identify approaches to improve the coordination of nutrition responses. Subsequent experience showed that establishing strong government-led, health-related nutrition services would result in a better coordinated and timely response in the ASALs.

Nutrition partners, therefore, engaged in a combination of strategies and innovations, starting in 2006 and accelerating between 2012 and 2019 across all six of the World Health Organization (WHO) health systems strengthening (HSS) blocks: leadership and governance, service delivery, human resources, information systems, supply chain and strategic use of financing (WHO 2010).

**Transitioning to a HSS approach**

Three additional important developments in the enabling environment have influenced this transition. Firstly, the 2013 devolution process transferred responsibility for health services to the new county administrative level which, coupled with increased government investment in the most deprived counties of Kenya, resulted in a significant boost to the health system's functioning in the ASALs. The number of government health staff with specific nutrition roles grew and health-related projects increasingly focused on enhancing the service infrastructure. Secondly, Kenya's re-classification in 2014 from a lower-middle-income country resulted in donors beginning to shift financing away from grants for supporting service delivery towards a technical assistance (TA) HSS approach. Thirdly, in 2014-2015, the adoption of the Ending Drought Emergency Common Programme Framework (EDE CPF) obligated the government and its partners to end the cycle of drought responses by building more resilient systems in the ASALs, providing impetus for the health system to lead drought responses.

This article examines key factors that have successfully shaped the transition to date, driven by strong central government leadership and commitment by key partners (UNICEF, the FCDO and other donors) to a systems approach.

**A common vision for nutrition**

Prior to 2006, nutrition services were largely provided by non-governmental organisations (NGOs). After the 2006 emergency, nutrition partners began working within government health services. By 2008, a formal Memorandum of Understanding (MoU) between UNICEF and its partner NGOs clarified roles and responsibilities. This was consolidated in a 2009 Partnership Framework between the Ministry of Health (MoH), UNICEF, the World Food Programme (WFP) and their partner NGOs. The framework formalised the common vision for nutrition services, in development since 2007, and included the transition of leadership and governance to the MoH and management of a package of both ‘regular’ and ‘emergency’ nutrition services incorporated into existing health services. In 2008-2009, with the support of UNICEF and other stakeholders, the government adopted integrated management of acute malnutrition (IMAM) protocols and, by 2010, it had institutionalised a package of 11 high-impact nutrition interventions (HiNi), establishing nutrition services as an integral part of the routine health system.

By the time of the 2011 drought, the emergency nutrition response was led by the government, delivered through government services by government staff. While evaluations indicated many improvements, several weaknesses remained, particularly related to the capacity of the health system to respond to a nutrition emergency. This highlighted the need for strengthened government-led, managed and integrated nutrition services and clarification of the government’s leadership in nutrition service delivery in response to emergencies.

Important policy and strategy documents were quickly developed following the 2011 drought, including the National Food and Nutrition Security Policy and the 2012-2017 and 2018-2022 National Nutrition Action Plans, which facilitated the mainstreaming of nutrition budgeting into national development plans. Related County Nutrition Action Plans and Annual Work Plans replicated this at a county level.

Incremental progress in achieving the common vision has continued in a wide variety of ways using a health systems approach (described below). The most significant outstanding issues include the lack of a clear strategy on how to achieve transition in the areas of government leadership and the financing of nutrition services and the nutrition response to emergencies (see conclusions).

**Ensuring continuous and inclusive coordination and communication**

A synthesis paper following the 2005-2006 drought response noted that coordination mechanisms were fragmented with separate structures for drought response and long-term development issues. The paper recommended a coordination mechanism that bridged both relief and development (Longley and Wekesa 2009). The establishment of a MoH-led Nutrition Technical Forum and working groups, which regularly brought together all nutrition partners, at national, then later at county levels (although limited), was a major step in strengthening nutrition coordination and improving communication. These technical groups included a Nutrition Information Technical Working Group, a Nutrition Capacity Working Group, a Maternal, Infant and Young Child Nutrition Technical Working Group and County Nutrition Task Forces (Figure 1). The Nutrition Interagency Coordinating Committee1 has been key in ensuring donor alignment with 2

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1 HiNi adopted in Kenya include breastfeeding promotion; complementary feeding for infants after the age of six months; improved hygiene practices, including handwashing; deworming; supplementation (with vitamin A, zinc for diarrhea management, multiple micronutrients, iron-folic acid for pregnant women), salt iodisation, iron fortification of staple foods; and prevention and treatment of moderate undernutrition and treatment of severe acute malnutrition.

2 The NICC has representation from various agency heads and government line ministries.
government priorities; it now also constitutes the Scaling Up Nutrition (SUN) multi-stakeholder platform. The Nutrition Response Advisory Group, which became the Emergency Nutrition Advisory Committee in 2014, was critical in guiding preparedness and drought response at both national and county levels.

Recent evaluations of the nutrition response to the 2017 drought and 2019 food insecurity crisis credited this coordination system with considerably improving the communication amongst stakeholders, resulting in the nutrition sector being an example to other sectoral responses. Notably, the 2018 Global Nutrition Report stated, “the Kenyan government’s approach presents an example of a country-led approach to resilience. It demonstrates that a stronger development-focused approach can reduce the burden on traditional humanitarian response, benefitting crisis-prone populations” (Development Initiatives 2018).

Human resources for nutrition: Nutrition Support Officers and embedded technical assistance

There has been a progressive increase in the recruitment of nutritionists in most counties since 2013. Since May 2010, donor-funded Nutrition Support Officers (NSOs) have been embedded in the MoH structures at national and ASALs county levels. The NSOs provide TA to County Nutrition Coordinators which has been instrumental in supporting the government and, in 2017, NSOs were seconded to the National Drought Management Authority (NDMA) through this mechanism. Evaluations in 2013 and 2017 noted the importance of NSOs and the role that they have played in establishing effective relationships, systems and processes at national and sub-national levels, as well as influencing resource allocation to ensure an effective response. Given their undoubted success, it is not yet clear how their critical role can be transitioned in a sustainable way.

Improved nutrition information systems

Nutrition information systems (NIS) have transitioned from gathering and analysing information before and during drought emergencies to becoming the basis on which the health system manages all nutrition services. After 2006, parallel NGO and United Nations (UN) reporting systems and nutrition surveys were gradually integrated under the leadership of UNICEF and were formalised in the 2008 Memorandum of Understanding (MoU) and 2009 Framework Agreement. Early in the transition, challenges included the use of non-standard indicators, duplicative and inconsistent data collection mechanisms and inconsistent results (Maina-Gathigi et al., 2017). Recommendations from a 2013 NIS evaluation led to the rationalisation of indicators and processes used at the district/sub-county level, the alignment of anthropometric data to global standards and widespread capacity strengthening of nutrition and nutrition-related information systems, including the NDMA early warning system. These improvements in the NIS were credited to “strong government leadership and commitment from all stakeholders, the building of institutional capacities and structures” (Maina-Gathigi et al., 2017).

Capacity strengthening involved investment in increased specialist NIS staff at UNICEF and at the MoH and embedded TA within the MoH, regular data clinics led by the MoH and facilitated by the Center for Disease Control & Prevention (CDC) with close attention to on-the-job training of health facility, sub-county and county staff and others, often supported by NGOs.

The value of a strengthened NIS became evident in the nutrition response to the 2016-2017 drought emergency. Following early warning reports in July 2016 (Famine Early Warning Systems Network 2016) describing a worse-than-expected projected harvest, the MoH and its nutrition partners began to adapt activities to respond and new funds were allocated to nutrition programming (the Centre for Humanitarian Change and the Global Emergency Group 2018). This nutrition response began up to six months ahead of other sectors.

Regular programme monitoring has also seen significant improvements in terms of timeliness, completeness and quality of the reporting. Focus is now shifting to capacity strengthening of the District Health Information System 2 (DHIS2) system with a nutrition lens.

Longer-term financing

During the 2011 drought it became apparent that multi-year funding was required to ensure better programming for drought response and the maintenance of high-quality services before, during and after a drought. Since 2012, donors have funded the multi-year UNICEF Maternal and Child Nutrition Programmes (MCNP)s through a mix of multi-year humanitarian and development funds with a gradual shift to higher proportions from development envelopes, making supplementary emergency funds available during drought years. This longer-term view has allowed programmes to strengthen health system-related nutrition services. County MoH annual work plans increasingly include funding provisions for health system-related nutrition services. At the end of 2019, UNICEF reported that four out of 13 priority counties had increased funding allocated to nutrition in the fiscal year and two further counties had allocated funding for the first time. Despite this, there are still many steps to take to achieve the financing goals of the common vision, including incorporating nutrition financing in County Integrated Development Plans, financing nutrition supplies and MoH integration into emerging disaster risk financing mechanisms and county level contingency budgeting.

The NDMA also introduced a government-managed Drought Contingency Fund, used for the first time in July 2014. By October 2016, health and nutrition services benefited from this fund. However, government financing systems for a response to drought, especially for health, are still weak in terms of timeliness and identifying hotspots. In 2019, National Government Emergency Response Funds were allocated to nutrition services and, in a few counties, recently established County Contingency Funds were allocated to nutrition services as part of the response, although transparency regarding amounts and expenditure is weak (Fornæm et al., 2020).

Supply chain strengthening

Since 2011, IMAM supplies have been included in the essential medicines list, thereby facilitating government procurement, management and monitoring. This was followed by the inclusion of supply chain quality and management in the 2012-2017 National Nutrition Action Plan. Standard operating procedures were developed to improve coordination which increased transparency and enabled a quicker response to fluctuations in supply and demand. The government-led Commodity Steering Committee ensured commitment and stakeholder engagement.

In 2017, nutrition partners increased their focus on supply systems strengthening, building the capacity of county teams to scale up the logistics management information system (LMIS), leading to a measurable improvement in management and reporting. UNICEF reported that stock-outs decreased from an estimated 25% in January 2017 to 8% at the end of 2017.7 Ready-to-use therapeutic food (RUTF) supplies remain significantly dependent on donor funding and there is an urgent need to prioritise sustainable financing of supplies within the common vision.

The MoH, UNICEF and the Kenya Medical Supplies Authority (KEMSA) jointly monitor progress and sign off quarterly on agreed key performance indicators.

Innovations in nutrition health systems

Community-based management of acute malnutrition surge approach

North-western and north-eastern Kenya are part particularly vulnerable to droughts. Consequently, a resilient health system is essential. The CMAM/IMAM surge approach, developed by Concern Worldwide and partners, helps the health system to prepare for, detect and respond to peaks in demand for nutrition services by setting thresholds for caseloads based on health facility capacity to provide quality nutrition services, monitoring caseloads against these thresholds and triggering surge support when thresholds are reached. In 2016, the government adopted the approach and initiated rollout to the ASALs counties. As analysis of the 2019 drought response emerges, there are indications that the approach contributed to the timeliness of the response, as 63% of health facilities in 10 counties offering IMAM now implement the

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7 Between 2010 and 2014, provincial/district nutrition officers were funded by the US Agency for International Development (USAID); 16 NSOs were recruited to support 28 counties, 10 of which were in the ASALs. From 2014 to date, UNICEF NSOs were funded by OFD, USAID and internal funds and recently also supported by World Bank funds through the NICHE project

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Data from UNICEF reporting, internal communication
approach. Building on this success, there is potential for the surge model to be extended to other community health interventions.

Outreach services
Given the sparse population and long distances to health facilities in the ASALs, outreach services were critical but costly. Consequently, the government relied on donor resources for funding outreaches. Two innovations have considerably increased the effectiveness and coverage of outreach services. Firstly, the integration of a basic package of health and nutrition services led to reduced duplication of outreach interventions. Secondly, county outreach deployment plans, in use since 2016, have successfully used evidence from nutrition services and local contextual knowledge to prioritise malnutrition hotspots and inform the timing of scale-up. This approach was used extensively in 2017 and 2019 and is credited with a significant increase in the utilisation and coverage of services. The challenge of sparse populations in large geographical areas means that externally funded and expensive mechanisms to achieve universal health coverage (UHC) is unlikely to ever be sustainable. Incorporating alternative approaches into UHC, such as integrated Community Case Management (iCCM)-IMAM and task shifting to community levels, is likely to be the next challenge for the transition process.

Community capacity to provide and receive nutrition services
Since the rollout of the Community Health Strategy (CHS) in 2006 (Kenya Ministry of Health 2006), civil society actors and faith-based organisations (FBOs) have complemented the government’s efforts to roll out the CHS including by establishing and supporting/facilitating community units, aiming to empower communities to manage their own health. Capacity building of the Community Health Extension Workers (who are employees of the MoH) and Community Health Volunteers (CHVs) to deliver nutrition services has mainly taken place through partners (UNICEF, NGOs and FBOs). During the 2011 emergency response, CHS enhanced service delivery at the facility level by establishing links to community-level structures. As a result, by 2017 improved early detection, identification and referral of acute malnutrition was noted (Figure 2). The new Community Health Policy 2020-2030 aims to streamline the implementation of the CHS, clarifying leadership, coordination structures and the appropriate level of human resources required. In several counties, legislation clarifying issues related to the sustainability of the CHS including incentives to CHVs has been passed or is in progress. Despite the crucial nature of the community health system, the CHS still experiences weaknesses, including how to sustainably incentivise CHVs.

Indications of progress in nutrition services
The steps outlined above contributed to an increase in admissions for children with severe wasting rising from 21,658 in 2009 to 87,622 in 2019 (Figure 3). Despite the increase in admissions, recovery rates remained relatively unchanged with cure rates of 81% in 2019 (Figure 4). These figures are notable given the shifts from NGO driven to government owned services and three droughts occurring within this timeframe.

<table>
<thead>
<tr>
<th>County</th>
<th>Mapped sites Sept 2019 (#)</th>
<th>Operational outreach sites July 2019</th>
<th>Operational outreach sites Sept 2019</th>
<th>Increase (%)</th>
<th>Current gap (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baringo (East Pokot)</td>
<td>109</td>
<td>26</td>
<td>91</td>
<td>65</td>
<td>18</td>
</tr>
<tr>
<td>Garissa</td>
<td>280</td>
<td>21</td>
<td>81</td>
<td>60</td>
<td>199</td>
</tr>
<tr>
<td>Isiolo</td>
<td>82</td>
<td>10</td>
<td>20</td>
<td>10</td>
<td>50%</td>
</tr>
<tr>
<td>Kilifi</td>
<td>66</td>
<td>20</td>
<td>22</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Mandera</td>
<td>194</td>
<td>77</td>
<td>140</td>
<td>63</td>
<td>45%</td>
</tr>
<tr>
<td>Marsabit</td>
<td>172</td>
<td>72</td>
<td>92</td>
<td>20</td>
<td>22%</td>
</tr>
<tr>
<td>Samburu</td>
<td>71</td>
<td>14</td>
<td>31</td>
<td>17</td>
<td>55%</td>
</tr>
<tr>
<td>Tana River</td>
<td>63</td>
<td>25</td>
<td>44</td>
<td>19</td>
<td>43%</td>
</tr>
<tr>
<td>Turkana</td>
<td>195</td>
<td>66</td>
<td>185</td>
<td>119</td>
<td>64%</td>
</tr>
<tr>
<td>Wajir</td>
<td>120</td>
<td>12</td>
<td>42</td>
<td>30</td>
<td>71%</td>
</tr>
<tr>
<td>West Pokot</td>
<td>102</td>
<td>14</td>
<td>18</td>
<td>4</td>
<td>22%</td>
</tr>
<tr>
<td>Total</td>
<td>1454</td>
<td>357</td>
<td>766</td>
<td>409</td>
<td>53%</td>
</tr>
</tbody>
</table>

Source: UNICEF Kenya 2020

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**Figure 2** North and North Eastern Kenya outreach sites by donor support, map as of 18 December 2019

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Field Article

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Moving forward and building on the successes

The last 14 years of nutrition programming in Kenya have seen considerable progress, moving from a parallel UN and NGO ‘emergency’ approach to a government-led and managed nutrition service within the health system. A minimum package of nutrition services is now offered every day in health centres and nutrition services are no longer seen as emergency-related interventions. These transitions have gone some way to achieving the objectives of the EDE CPF and the common vision for nutrition formalised in 2009:

- Integrating a holistic package of nutrition services into the health system
- Using a HSS approach to support the government (national and county) to provide high-quality health and nutrition services.
- Using the HSS approach to integrate emergency responses into government-led and managed health systems.

This process has had synergistic benefits for ‘regular’ nutrition services as well as the nutrition drought response. Weaknesses in responses prior to 2011, i.e. parallel programming, late response, poor coordination and intermittent services, have now, to a great extent, been addressed but the question of financing remains. A faster transition from donor support to government-financed systems is now urgent. This transition will also mean a reduction in external TA, necessitating a strategy to ensure sustainability of the capacities the IA has successfully strengthened. There is a need to further embed nutrition in the health system within the national and county financing vision/strategy and disbursement.

A recent analysis of how countries have transitioned away from aid concludes, “Usually, countries do not have a strategy to address potential challenges and plan ahead for the transition from aid” (Engen and Prizzon 2019). It recommends, “Both recipient countries and donors should identify priorities and develop a strategy for managing the transition away from aid”. Learning from the last 13 years suggests that a common vision and coordination structure, together with strong UNICEF and donor support, was fundamental for the successful steps taken to date in the transition. There is now an urgent need for Kenya’s nutrition partners to build on these successes, developing and implementing a clear, criteria-based transition away from aid to development financing for nutrition in the health system and formalising this refreshed transition vision in a MoU or similar framework.

Building on successes, priorities for the next five years include refreshing the common vision for health system-based nutrition services transitioning away from aid to develop financing, embedding the financing of nutrition services into government-led financing of the health system, most immediately the financing of specialist nutrition products and ensuring that the health systems can better respond to the forecast increase in climate shocks related to climate change. Finally, sustained reductions in the prevalence of undernutrition in the ASALs will not be achieved without addressing all of the drivers of undernutrition across all sectors of people’s livelihoods.

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References


