RESILIENT COMMUNITY HEALTH SYSTEMS

LEARNING BRIEF

INTRODUCTION AND RATIONALE

Global evidence supports the importance of investing in strong and resilient community health systems (CHS) to improve and maintain nutrition and health outcomes, and points to some promising systems strengthening approaches. However, even proven approaches are not always easily transferable to different contexts, and prior to USAID Nawiri there was limited evidence from Samburu and Turkana on institutional, structural, and community-level bottlenecks to establishing a more resilient CHS. A research and learning agenda was therefore crafted to investigate factors that affect system functionality, as well as the technical capacity to deliver a consistent, robust, and reliable set of community-level health and nutrition services; analyzing current approaches and tools in light of diverse user needs; and identifying strategic and operational opportunities to strengthen resilience capacities in relation to CHS.

The purpose of this brief is to share key findings and insights from the CHS formative research, as well as from the COVID-19 and droughts responses. These findings have and will continue to shape USAID Nawiri's Phase 2 strategy for the sustainable reduction of persistent global acute malnutrition (P-GAM) in Kenya's risk-prone arid and semi-arid lands. Insights and lessons have already informed key program adaptations, including emergency response actions for the ongoing drought in Samburu and Turkana.

LEARNING JOURNEY

To develop the CHS line of inquiry, in 2020 USAID Nawiri and government teams in Samburu and Turkana constituted a technical working group with strongly embedded principles of collaboration, learning, and adaptation. In consultation with other health system stakeholders, the CHS working group identified three priority evidence gaps, namely 1) the context-specific drivers and barriers of CHS functionality and technical capacity for the prevention, early detection, and treatment of acute malnutrition; 2) how best to adapt technical tools and innovations for identification and tracking of acute malnutrition to the local contexts; and 3) identifying shock-responsive systems adaptations to meet diverse population needs. Initial inquiry methodologies included a desk review of CHS frameworks, stakeholder mapping, and formative research on CHS functionality, with a particular emphasis on understanding facilitators and barriers to community health volunteer (CHV) performance. County-level consultations, dissemination events, validation workshops and meetings of the County Nutrition Technical Working Group were utilized to reflect on findings and gather additional insights. Moreover, despite its initial disruption, the onset of the COVID-19 pandemic presented an opportunity for USAID Nawiri to pivot to a series of action-oriented learning sprints that proved a powerful source of adaptive innovation (see insight n°5 below).

INSIGHTS AND IMPLICATIONS

INSIGHT N°1: Family-led Mid-Upper Arm Circumference (FL-MUAC) and integrated Community Case Management-Community-based Management of Acute Malnutrition (iCCM-CMAM) can strengthen resilience capacities, empowering communities and household members to understand and manage their own health, while simultaneously expanding health and nutrition services to hard-to-reach populations. These approaches are not without challenges however, and USAID Nawiri must continue to critically examine and respond to operational bottlenecks and institutional barriers to scale, at the same time as continuing to innovate, test, and adapt with regard to the early detection and management of acute malnutrition in infants under six months, and vis-a-vis wasted children that only fall under weight-for-height eligibility criteria. (Theory of Change (ToC) reference: SP: 2.2 Outcome 2.2.2.1, 2.2.1.2, Output 2.2.1.3.2)

Prior to 2020, a good deal of evidence existed in relation to FL-MUAC and iCCM-CMAM and their potential to increase coverage of integrated management of acute malnutrition (IMAM) services to hard-to-reach populations. COVID-19 presented an unprecedented, radical imperative to switch to task-shifting approaches whereby CHVs took on more functions to reduce pressure on health facilities and associated transmission risk, while maintaining routine health and nutrition services. As USAID Nawiri rolled out these two approaches and CHVs stepped up to support the gaps in essential service delivery, a welcome effect was that their standing in the community appeared to increase. USAID Nawiri was then able to leverage and expand on this increased social capital by training CHVs to conduct community and household dialogues, in which family members discuss their perceived ability to screen and monitor their children, what they see as possible drivers of malnutrition in the family, and what is within their capacity to change and adapt for better nutrition outcomes. Learning from this experience provided a positive basis for USAID Nawiri's social, structural, and behavior change (SSBC) strategy.

As with most technical initiatives, however straightforward they appear at first glance, the devil is in the details for both FL-MUAC and ICCM-CMAM. USAID Nawiri has already identified some of the operational bottlenecks and institutional barriers to efficiency and scale up and incorporated these findings into Phase 2 strategies (see insight°2). We will nonetheless continue to interrogate our operational model, aided by

action research designed to generate data on quality of care and nutrition outcomes, while concomitantly providing a framework for further learning on shock-responsive adaptations, shifting resilience capacities and household dynamics. In addition, acutely conscious of our responsibility to "leave no-one behind" and in conjunction with ongoing debates centered on diagnostic tools, simplified protocols, and historically neglected groups, USAID Nawiri will prioritize testing adapted models of ICCM-CMAM for migrating pastoral communities.

INSIGHT N°2: Multiple systemic dysfunctionalities are impeding the ability of CHVs to fulfill their potential as frontline health and nutrition workers and community interlocutors. Though global and national nutrition sector innovations, contextual adaptations, and localized problem solving are all necessary and inherently valuable contributions to CHS strengthening, there also needs to be a collective and coordinated effort to strengthen essential building blocks for system sustainability. (ToC reference: IO 2.2.2 Outcome 2.2.2.1)

Currently CHVs are overstretched and underpaid. Late or non-payment of CHV incentives is a major structural barrier to the functioning and sustainability of the CHS with only a few noticeable exceptions in urban settings (Samburu Central, Turkana Central, Kakuma, and Kalakol). When CHVs are not given the resources they need to perform core tasks, such as delivering paper-based community-based health information system reports to Community Health Assistants (CHAs) and health facilities, they often end up covering this out of pocket and their motivation to continue working naturally wanes. In the above example a further repercussion is delayed submissions, leading to poor data flow and decision-making. Legislation on CHV incentives has already passed in both counties but the regulatory framework is still under development in Samburu and financial coding is causing delays in both counties. Even then operational inefficiencies are likely to result in delayed payments. CHVs are not regarded as mainstream county government staff and hence stipends are requisitioned in line with program processes which are slow and often result in insufficient funds received or their diversion for purposes considered more urgent than CHV payments.

There are also unrealistic time and workload expectations attached to CHVs/CHA. Our research found that many CHVs were essentially doing a full working week and the range of topics and tasks they are responsible for keeps increasing, especially with the instigation of ICCM-CMAM. To bolster the sustainability of the community health system and stay in line with county strategies and action plans, more investment in human resources and clear-sighted workforce planning are urgently required. Efforts to streamline workloads through task prioritization and improved household targeting can help to diminish overload and focus care on those who need it most (based on the right care at the right time). Another mode of prioritization is to utilize available data, as well as local knowledge of season-specific drivers of malnutrition/anticipated peaks in disease burdens, to hone messaging and provide focus for community & household dialogues (i.e., development of some kind of community surge mechanism).

The other major constraint to the system functionality is in the supply chain. Stockouts of Ready-to-Use Therapeutic Food and other medical commodities discourage CHVs from doing case detection and families from seeking care. With increasing coverage through FL-MUAC and ICCM-CMAM comes increasing demand on the supply chain and the system needs to meet this if it is to retain community trust as well as performance targets. ICCM-CMAM in particular requires more complex supply chain management to ensure that there is an adequate flow and tracking of commodities reaching communities and that processes are adept enough to respond to any surges in demands.

At the core of these system dysfunctionalities is the issue of financing. As Hailey et al (2021)[1] point out in their recent Emergency Nutrition Network article, by far the biggest need right now is, "a vision, clear criteria and formalized framework to guide transition from aid to development financing for nutrition in the health system." Both counties recently have developed their County Nutrition Action Plans which is their long-term framework for investing in nutrition that also takes a multi-sectoral approach. USAID Nawiri will focus on working to support operationalization of the plans and integrating the priorities identified in the County Integrated Development Plan and subsequent budget cycles so that they are given priority for resourcing.

USAID Nawiri will provide technical and facilitative support throughout the budget cycle and support the counties with planned Bottleneck Analysis of the CHV incentive legislation. We will also support the ongoing efforts of the national and county governments in digitizing the community-based health information system, including the feasibility of integrating c-stock applications for management of health and nutrition commodities at community level.

INSIGHT N°3: Better integration and communication across the various tiers of the health system, and particularly between primary health facilities and CHS stakeholders, is vital for addressing shortfalls in the care continuum and providing CHVs, Community Health Assistants (CHA) and Community Health Committees (CHC) with the necessary information, feedback and support to successfully carry out their roles. (ToC reference: Outcome 2.2.1.3).

One critical pathway to a resilient CHS is a highly skilled CHV who is integrated into the wider health system by way of a functional two-way feedback mechanism, and who is consistently supported, supervised, and mentored through regular interaction with CHAs. Currently this enabling macro-system is dysfunctional in both regards. First, formal feedback mechanisms among health facility staff, CHAs and CHVs are lacking across most sub-counties and in focus group discussions CHVs shared that the absence of feedback from their supervisors made them feel that their work and contribution to the health sector is ill-acknowledged. This negatively affects CHV morale and inhibits their ability to support continuity of care for community members as they are not kept abreast of the ultimate diagnoses or what follow-up treatment or consultations are required. Secondly, training manuals and guidelines are designed at the national level, with little or no regard for the context, and assume that CHVs are literate. Neither county has a database that includes CHVs' capacity and skills gaps, which is necessary to inform training needs and resource optimization nor is there a supervision toolkit (at national or county level) to standardize and facilitate their work. Moreover, the training curriculum does not include common climatic shocks and stresses or their likely effects, and therefore does not prepare CHAs and CHVs to adapt accordingly. No account is taken of the fact that CHVs' own households are also often affected by shocks and stresses, which can hinder their ability to continue serving their role when it is arguably even more critical.

USAID Nawiri will facilitate the co-creation of more effective referral and feedback procedures. This will be undertaken in close collaboration with county governments and a representative group of health workers, CHAs, and CHVs. Concurrently we will co-design supervisory processes and tools, including for on-the-job coaching of CHVs, designed to encourage confidence, develop practical skills, improve performance, and recognize their efforts. USAID Nawiri will also work with the two counties in

[1] https://www.ennonline.net/fex/64/healthsystemstrengtheningkenya

contextualizing training manuals/curricula and guidelines for ease of content delivery. Different methods will be used to build the capacity of CHVs and transfer skills, including peer-to-peer learning between high and low literate CHVs, use of digital platforms to increase peer and supervisor contact, use of pictorials and videos to deliver content, and continued on-the-job training and mentorship. USAID Nawiri will also facilitate learning exchange. In addition to boosting morale and retention among CHVs, investing in these interlinkages is expected to cultivate community trust in the overall system and encourage health seeking behaviors.

INSIGHT N°4: While there has been some slow but incremental progress in adolescent responsive health services at higher tiers of the health system, the community health system and lower-level health facilities still largely neglects adolescents' diverse health and nutrition needs. (ToC reference: Outcome 2.2.1.1)

Learning in Phase 1 supports the importance of an adolescent-responsive health system to the sustainable reduction of P-GAM in Samburu and Turkana. Recent advances in this regard include the domestication of the National Adolescent and Youth Friendly Services Guidelines (AYFS) by both counties. In terms of implementation to date, the Adolescent Responsive Health Services Assessment undertaken by USAID MOMENTUM found that county, sub-county, and other high-volume facilities do provide a wide range of adolescent health services. Though there are still improvements to be made across those tiers, arguably the biggest limitation in terms of adolescents being able to access services sensitive to their specific needs, is that neither the lower-level public health facilities or the community health systems are adequately designed or equipped for them. Structural barriers alluded to under insight n°2 have an impact on the capacity of these two tiers to offer the full package of AYFS, particularly commodity stockouts and inadequate human resources. At the community level, CHVs are directed to prioritize maternal and child nutrition and health and likewise, the few sporadic community outreaches undertaken predominantly focus on young children and their mothers.

Presently, adolescents and youth have few, if any, opportunities to influence the development, dissemination, and monitoring of policies and guidelines that impact their lives. The Kenya Community Health Strategy does envisage youth representation among CHV cadres and on Community Health Committees, however while many CHVs in Samburu and Turkana are indeed themselves young mothers, representation on CHCs and Health Facility Management Committees lags behind. The USAID MOMENTUM assessment found that few adolescents were able to demonstrate awareness of their health rights and did not attend community dialogues which are a core platform for helping to set community health agendas.

In partnership with USAID MOMENTUM, USAID Nawiri will work across all health system blocks to improve the design and delivery of adolescent-responsive health and nutrition services. Specifically, USAID Nawiri will support the two counties to implement their action plan priorities, including the co-design of activities aimed at enhancing the interface between health workers and adolescent clients, improving the accessibility of contraceptives, and supporting the meaningful involvement of adolescents and youth in holding the system accountable for the delivery of health services that meet their needs, year-round and during shocks.

INSIGHT N°5: The learning sprints initiated in response to COVID-19 were invaluable tools for fostering partnership, agile thinking, and adaptive management. (ToC reference: SP 2.2 linked to SP 4.3; Outcome, 2.2.2.1)

In 2020-21, while USAID Nawiri was immersed in Phase 1 research, a number of severe shocks and stresses affected Samburu and Turkana, including the COVID-19 pandemic, floods, locusts, and drought. USAID Nawiri's COVID-19 response involved supporting the health system to avail basic services to vulnerable populations, thereby mitigating the ripple effects of the pandemic on health and nutrition outcomes. This included adaptations to CHV training and supervision, iCCM-CMAM service integration and expeditious scale up of family-led MUAC. These and other COVID-19 response actions were analyzed in pause and reflect sessions, which helped to tease out learnings and adaptations for improved action. This process, characterized as 'learning sprints', later evolved into a more formalized county learning and quality improvement committee, wherein county government teams, USAID Nawiri, and other stakeholders collaborate to rapidly test, analyze, and endorse promising adaptations.

CONCLUSIONS & PRIORITY AREAS FOR ONGOING LEARNING

Findings and insights derived from the CHS research and learning agenda have already informed USAID Nawiri's approach to CHS strengthening. Specifically, we are working on facilitating strong linkages between the CHS and other community structures; developing and reinforcing feedback mechanisms between CHVs, CHAs, and other levels of the health system; and implementing strategies to increase CHV motivation and improve their skills in detecting, treating, and referring children with acute malnutrition through training, supportive supervision, and increased social support. Learnings from implementation in an initial cohort of 30 community units will be used to expand activities to other units in the counties and USAID Nawiri will continue to work with the county government and other stakeholders to document learnings and adapt to further improve CHS functionality. Furthermore, USAID will strengthen the IMAM surge by instituting community surge through adapted community dialogue and action, while learning how such community surge action will improve IMAM surge utility as a risk-informed early action model for health systems.

Priority Areas for continued learning include:

1. Consolidating learning from the COVID-19 response on the scale up of FL-MUAC and iCCM. Additional iterative learning will be generated through the CLA on the effectiveness of the two interventions in the face of shock and stresses.
2. Whether multi-sector information sharing at village level - via an adapted community dialogue model – actually enhances risk informed and early action in those communities, in addition to improving accountability from duty bearers at county and sub-county level.
3. Collaboration, Learning, and Adaptation as a facilitative tool for strengthening CHS resilience capacities.

CONTACT:

Hussein Noor Abdille, Chief of Party
Email: habdille@mercycorps.org
Cellphone: +254 721 4975 43 | skype husseinoor

This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents of this report are the responsibility of Mercy Corps recipient of cooperative agreement no. 72DFFP19CA00003 and do not necessarily reflect the views of USAID or the United States Government. Nawiri is a consortium of: