ADVOCACY BRIEF

STRENGTHENING HEALTH SYSTEMS FOR ESSENTIAL NUTRITION ACTIONS:

EVIDENCE-BASED RECOMMENDATIONS FROM FRONTLINE HEALTH FACILITIES

From April to July 2024, World Vision conducted an essential nutrition actions (ENA) multi-country survey across 268 health facilities in nine countries – Bangladesh, Ethiopia, Indonesia, Kenya, Mali, Somalia, Tanzania, Uganda, and Venezuela – focusing on areas with the poorest child health and nutrition outcomes. The survey aimed to assess the status of supply chains, workforce competency, and service delivery in alignment with the World Health Organization (WHO) ENA framework.

This brief presents key findings and evidence-based recommendations to strengthen health systems for ENA delivery. Achieving universal ENA coverage requires well-supported health workers with the capacity to deliver services effectively, alongside a robust supply chain that ensures consistent availability of ENA products.

Our survey focused on the three core building blocks of frontline health systems – service delivery, health workforce, and supply chains – and aimed to answer the following three questions.

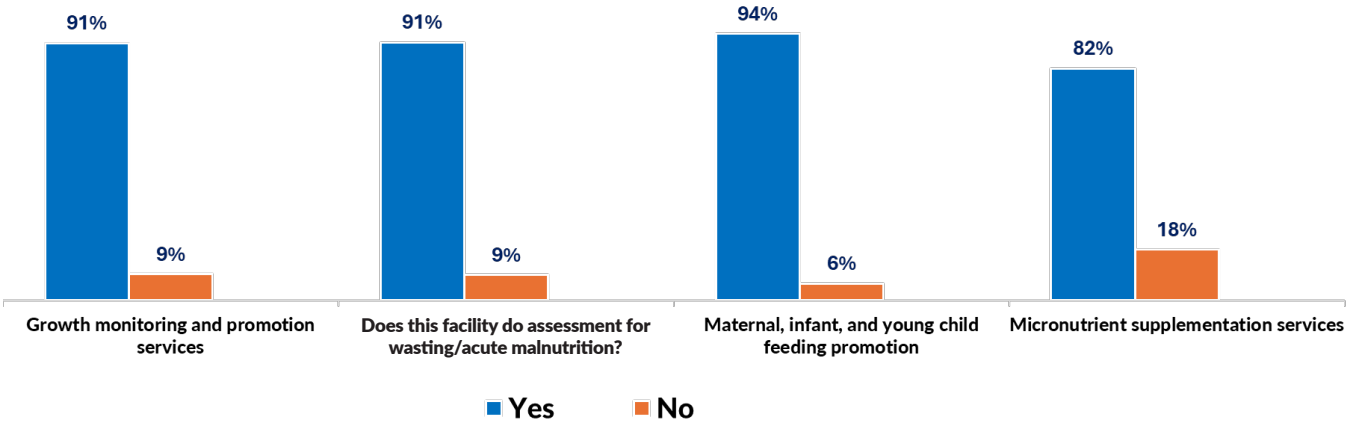
1. **Service delivery:** Are health workers conducting ENA services?
2. **Health workforce:** What capacity (i.e., training, job aids, supportive supervision) do health workers have to deliver ENA?
3. **Supply chains:** Do health centres and health posts in World Vision operational areas have adequate supplies (e.g., anthropometric equipment, mid-upper arm circumference (MUAC) tapes, child health cards, WHO growth charts, micronutrients, therapeutic foods) to effectively deliver and sustain the integration of ENA within the health system in low-resourced settings?

These recommendations are thus limited to that scope and do not cover the other three building blocks (financing, governance, and information systems), despite their interconnectedness. However, addressing the gaps identified by this study will require financial investments and strong government leadership. The long-term benefits of such investments far outweigh initial costs, with an estimated return of US$23 for every US$1 spent, alongside additional Gross Domestic Product (GDP) gains from job creation and increased workforce productivity.[1] According to the WHO, increasing health spending by at least 1% of GDP is within reach for most countries.[2]

I. COMPREHENSIVE SERVICE DELIVERY OF ENA: KEY FINDINGS

The study identified significant gaps in comprehensive ENA service delivery. As illustrated in Figure 1, we found that growth monitoring and assessments for child wasting were unavailable in 9% of health facilities, and 18% of facilities did not offer micronutrient supplementation. On a positive note, maternal, infant, and young child feeding promotion services were available in 93% of facilities. However, these service gaps highlight the need to further optimise ENA delivery within the health system, which plays a critical role in ensuring effective coverage.

Figure 1: Availability of ENA services



Most ENA services are provided through health facilities, with outreach sites contributing only 4% of growth monitoring and 2.5% of screening for wasting. Community health worker (CHW) outreach plays a crucial role in expanding access to ENA services in remote areas. These findings highlight the need for greater decentralisation of service delivery, including CHW-led outreach, to effectively reach communities beyond the existing health system.

The biggest gaps in service delivery were in the treatment of acute malnutrition and micronutrient supplementation.

- Inpatient care for severe acute malnutrition (SAM) with complications consistently ranked among the least provided services, available in only 11% of facilities.
- Outpatient care for SAM without complications was offered by 47% of providers.

[1] Shekar M, Shibata Okamura K, Vilar-Compte M, and Dell'Aira C, eds. Investment Framework for Nutrition 2024. Human Development Perspectives Overview booklet. World Bank, 2024. License: Creative Commons Attribution CC BY 3.0 IGO. https://openknowledge.worldbank.org/server/api/core/bitstreams/4ca9f6a7-c057-4fe4-bcae-0e4539833b4c/content

[2] WHO. Mobilizing ambitious and impactful commitments for mainstreaming nutrition in health systems: nutrition in universal health coverage - global nutrition summit. 2020. License: CC BY- NC-SA 3.0 IGO. https://iris.who.int/bitstream/handle/10665/332221/9789240004252-eng.pdf?sequence=1

- Outpatient moderate acute malnutrition (MAM) service provision was available in only 54% of facilities.
- 99% of facilities did not offer micronutrient powder (MNP) sachets for children with mild to moderate malnutrition, 15% did not provide iron and folic acid supplementation (IFAS) to women, 22% did not provide zinc for child diarrhoeal management, and 18% did not provide vitamin A to children.

Evidence-based recommendations: Service delivery

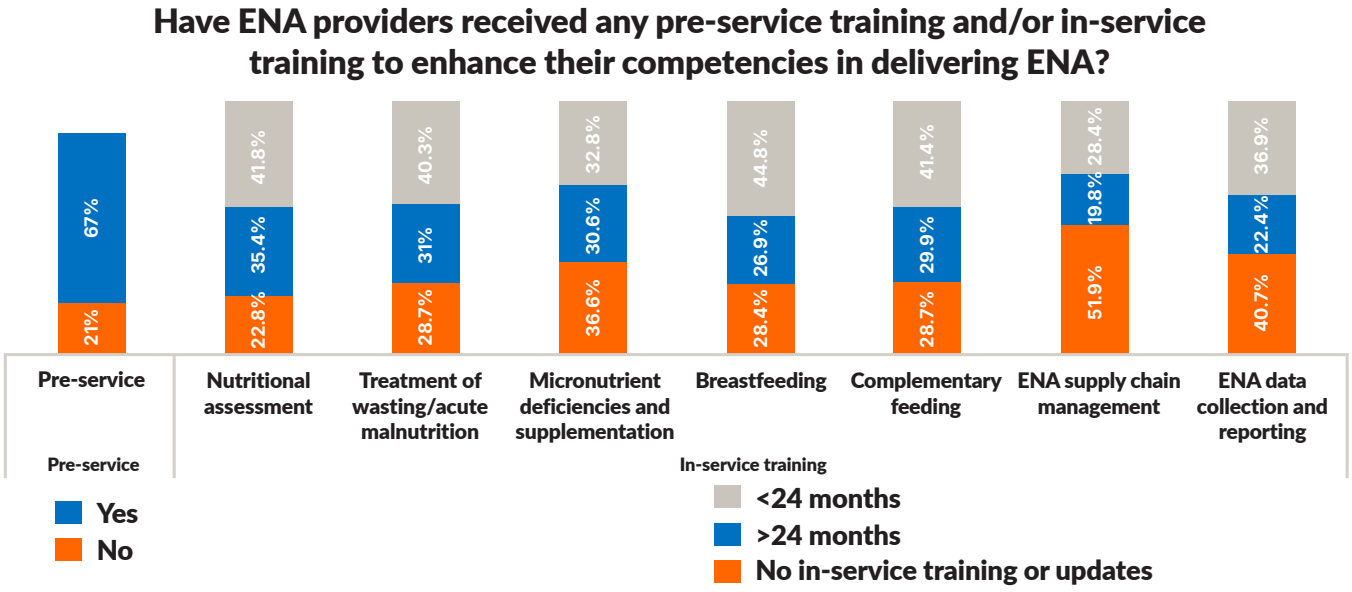
1. **SAM service provision:** Strengthen comprehensive service provision for lifesaving care of severe acute malnutrition in both inpatient and outpatient facilities.
2. **Outreach ENA provision:** Increase the density of CHWs to strengthen the availability of ENA services in outreach sites and extend the reach of health systems to the 'last mile'.
3. **Micronutrient supplementation provision:** Ensure facilities are stocked with essential micronutrients (e.g., vitamin A, zinc, multiple micronutrient supplements (MMS), IFAS, and MNP sachets) and integrate them into routine nutrition programmes.

II. HEALTH WORKFORCE DEVELOPMENT FOR ENA: KEY FINDINGS

Strengthening the health workforce is essential to improving ENA service delivery. Improvements in density of health personnel and ENA training, guidance, and supervision are urgently needed. As illustrated in Figure 2, there are significant gaps in ENA pre-service and in-service training, with the biggest gaps in training for supply chain management, and data collection and reporting. Among healthcare providers surveyed, 21% had never received any pre-service ENA training and 34% had not received any in-service ENA training. Broken down across training categories,

staggering numbers of staff had not received any training at all or had not had refresher trainings in over two years. A key finding is that many providers who lacked pre-service training on ENA also did not receive in-service training, indicating a lack of appropriate training, continual learning, and refreshing of skills. This is concerning regarding the quality-of-service delivery, and without training in data collection and reporting, along with supply chain management, the significant capacity gaps in these areas will not improve.

Figure 2: Pre-service and in-service training



There is also a clear need to improve the consistency of supervision, with 17% of respondents reporting no supervisory visits in the past six months, and 9% reporting they had never received external supervision. For those who did receive supervision, nearly a third received no feedback after the supervisory visit, which is important for professional growth and support. Further, 37% of health facilities had no ENA guidelines or manuals on-site, limiting staff preparedness and quality of care.

The observed violations of the International Code of Marketing of Breast-milk Substitutes (BMS Code) in health facilities are also concerning, with 12% displaying formula marketing or promotional materials, 9% displaying infant formula boxes or cans, and 9% displaying feeding bottles or nipples and teats. BMS Code violations were highest in district hospitals, with an average violation rate of 23%.This highlights the need for more comprehensive health worker training and greater government oversight and leadership in BMS Code enforcement.

Another key finding of the study is that less than half (49%) of healthcare providers felt that caregivers had adequate knowledge and adoption of ENA, indicating a perceived need for improved community nutrition education and social behavioural change. This should be integrated in healthcare worker trainings to support prevention of malnutrition at the household level.

Evidence-based recommendations: Health workforce

1. **Quality job creation:** The Ministry of Health (MOH) must ensure a minimum density of trained and compensated health personnel to respond to nutrition challenges and implement nutrition-related interventions at each service-delivery level.
2. **Comprehensive guidelines and job aids:** The MOH must provide standardised ENA guidelines and job aids at all facility levels, as recommended by WHO, to address existing service delivery gaps and improve staff preparedness.
3. **Comprehensive training requirements:** The MOH must ensure up-to-date ENA content is integrated into pre-service, in-service, and continuing professional development curricula for all healthcare providers. WHO guidance requires that each nutrition topic, including acute malnutrition, adolescent nutrition, growth monitoring and promotion, and breastfeeding, must include a minimum of 20 hours of focused training.
4. **Supportive supervision:** The MOH should implement quarterly supervisory visits to healthcare facilities to monitor ENA service quality, provide mentorship, and support professional growth of healthcare providers.
5. **BMS Code enforcement:** The MOH should enact and enforce comprehensive legislation covering all BMS Code provisions and ensure that healthcare providers are trained and empowered to uphold and enforce this legislation consistently and effectively.
6. **Nutrition education and behavioural change:** The MOH should invest in social behaviour change communication programmes to improve caregiver knowledge of healthy diets, enhance ENA adoption, and foster stronger links between healthcare providers and communities. Caregiver education on ENA practices should be integrated into healthcare provider training programmes to ensure service delivery aligns with community uptake and addresses gaps in nutrition education.

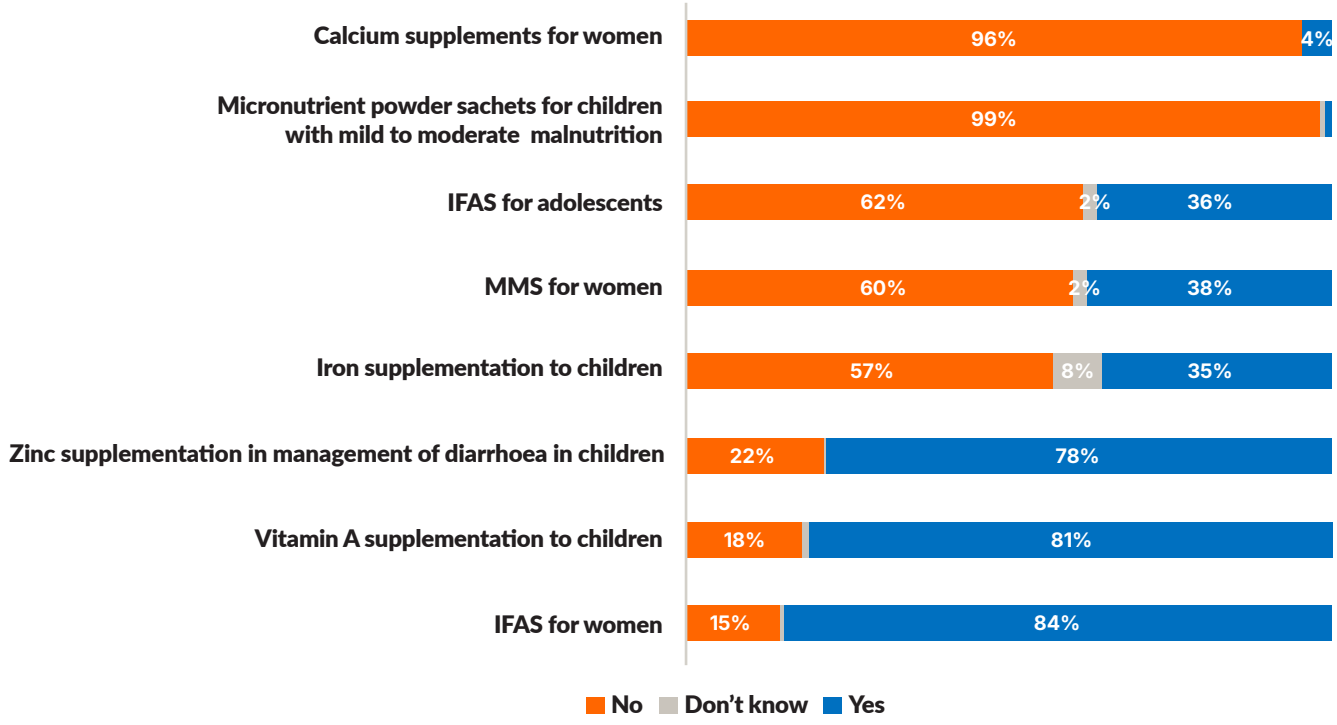
III. NUTRITION SUPPLIES, EQUIPMENT, AND PRODUCTS: KEY FINDINGS

There are many challenges in the management of health supply chains, such as increasing domestic production and managing information, imports, storage, and distribution. The study found that:

- 93% of health facilities rely on the MOH to procure their ENA supplies.
- 1 out of 3 health facilities lacked adequate ENA equipment or available supplies, harming the consistent and quality delivery of ENA services.
- Lifesaving products to treat wasting were not available in health facilities providing MAM and SAM services, with 29% having no ready-to-use therapeutic food (RUTF) and 61% having no ready-to-use supplementary food (RUSF).
- Lack of appropriate storage conditions and inventory management systems raised serious concerns, with 1 of every 4 health facilities not meeting storage standards for essential supplies.
- More than half of healthcare providers did not believe or were unsure that their facility had adequate equipment for ENA service delivery. Perception of inadequate supplies was greater in outpatient facilities and community-level facilities than in-patient facilities and district or regional hospitals.

Availability of micronutrient supplements falls well below universal coverage, as illustrated in Figure 3. Near-total gaps in MNP treatments and calcium supplements are the most serious shortages. Greater than 50% gaps in the availability of IFAS, MMS, and iron supplements indicates neglect of the specific requirements of women, adolescents, and children. There is a clear need to invest in strengthening supply chains and improving the availability of these essential medicines for comprehensive ENA delivery.

Figure 3: Do you provide micronutrient supplementation?



Despite challenges, there are many actions that can be taken immediately to improve the efficiency of supply chains for nutrition products. Greater action is needed from Ministries of Health to improve the functioning and management of supply chains, and the availability of essential medicines to prevent, detect, and treat malnutrition. This need is most urgent for lifesaving medicines like RUTF and RUSF, and micronutrient supplements. Investment is also needed in training for inventory management and minimum storage conditions. This is most pressing in facilities reaching rural communities.

Evidence-based recommendations: Nutrition supply chains

1. **Strengthen supply chains for ENA supplies:** As the primary provider for most health facilities' ENA supplies, the MOH should improve supply chain management to ensure consistent and reliable access to essential medicines and nutrition-related health products. This requires investing in robust supply chains from production to consumption, improving supply chain efficiency, and implementing management systems for information and inventory, with the goal of achieving 100% availability at all facility levels.
2. **Ensure RUTF availability:** The MOH should ensure availability of RUTF in low-level health facilities where treatment is authorised. RUTF is a lifesaving medicine listed on the WHO Essential Medicines List and must be available to the most vulnerable communities.
3. **Improve supply chain management for micronutrients:** The MOH should ensure comprehensive access to micronutrient supplements, improving the availability of and access to calcium, IFAS, MMS, MNP, zinc, and vitamin A, through improved quantification, projection, procurement, storage, and inventory management of these nutrition products.

CONCLUSION

Ministries of Health can take immediate actions to strengthen the health workforce capacity, supply chains, and service delivery of essential nutrition actions. These evidence-based recommendations outline urgent actions that must be prioritised to prevent further losses in GDP, human capital, and lives due to malnutrition:

High-level recommendations to strengthen health systems to comprehensively deliver ENA

These recommendations address the other three health systems building blocks and their inter-linkages with workforce, supply chains, and service delivery.

1. **Strengthen health leadership for nutrition:** The MOH should integrate ENA into the package of essential health services as part of national health plans and universal health coverage roadmaps by 2030.
2. **Increase domestic financing for health and nutrition:** Increase health spending by at least 1% of GDP, with an emphasis on strengthening health workforce, supply chains, and primary healthcare, where most nutrition services are delivered.
3. **Equip health facilities with robust health management information systems:** The MOH should strengthen information systems with innovations and digitalisation, including mobile health technologies.
4. **Enhance data collection and knowledge sharing:** The MOH should ensure reporting on quality of care and service availability for all ENA in the national package of essential health services through household surveys, facility surveys, and administrative systems as appropriate. Policymakers should also establish cross-country knowledge-sharing platforms to facilitate the exchange of successful models and best practices for implementing ENA programmes.
5. **Invest in research and monitoring:** Research and impact evaluations are urgently needed to identify effective interventions to close gaps identified by the study. Country-specific qualitative studies should build on this study's findings to address barriers and develop sustainable, locally tailored solutions.

For more information, please contact:
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