Photo: CRS USAID Nawiri /Anthony Nyandiek

USAID Nawiri Learning Brief: Adapted Nutrition Friendly Graduation Pilot

Background

These brief highlights key findings from Nawiri's Adapted Nutrition-Friendly Graduation Approach (ANFGA) Pilot's preliminary baseline survey and routine data collection. The ongoing 1-year pilot, implemented in Cherab and Ngaremara wards of Isiolo County, runs from May 2021 to April 2022.

The Poverty Graduation Approach is a holistic livelihood model designed to address the multi-dimensional needs of ultra-poor households vulnerable to acute malnutrition. It is a fully integrated 5-step suite of interventions, delivered in specific sequence, to help the extreme poor achieve sustainable livelihoods and enhanced nutrition status. The 5 steps include:

(i) Targeting.
(ii) Formation of Business Savings Groups (BSGs.
(iii) Business skills and financial literacy training.
(iv) Provision of small business start-up grants.
(v) Business and BSG mentoring.

The pilot seeks to assess the extent to which the approach is effective in alleviating acute malnutrition in the Kenyan Arid and Semi-Arid Lands (ASALs).

Research questions being explored:

1. To what extent will this model help:
   a) Improve household income, with an associated increase in:
      i. Purchase of nutritious foods
      ii. Consumption of nutritious foods
      iii. Access to health products and services?
   b) Improve knowledge and attitudes around optimal health and nutrition behaviors?
   c) Improve practices in: (i) Minimum Dietary Diversity for children aged 6-23 months, (ii) Minimum Meal Frequency for children aged 6-23 months (iii) preventive health and health seeking behavior and (iv) exclusive breastfeeding for children from 0-6 months old, over the course of 1 year.
   d) Reduce acute malnutrition with regard to the proportion of children malnourished?
2. How cost effective is the Adapted Nutrition-Friendly Graduation Approach?
   a) Which of the two ANFGAs is most cost effective?
   b) What would it cost to scale up the approach in Marsabit and in Isiolo Counties?

Graduation Pilot adapted to Nawiri context

Village Enterprise's 12-month Poverty Graduation Model has been adapted for Nawiri purposes by layering it with 3 complementary interventions:

(i) Provision of unconditional cash transfers (UCTs) for consumption,
(ii) Health and nutrition education and counseling
(iii) Embedding social and behavior change interventions across all components.

The pilot is implemented in 2 arms. Arm 1 interventions include UCTs, poverty graduation, health and nutrition education and counselling and SBC Interventions. Arm 2 interventions include UCTs and poverty graduation only, for comparison purposes.

The selection criteria have also been adapted to prioritize:

(i) HHs with children under the age of 5 (U5s) who are already malnourished.
(ii) HHs with U5s who are at risk of acute malnutrition.
(iii) HHs with relapse cases.
(iv) HHs with Pregnant and Lactating Women (PLW)
(v) Ultra-poor HHs.

Summary Findings and Lessons Learned:

- ***Knowledge, Attitudes and practices for Optimal Health and Nutrition Behaviors:***

The BL findings show 92.99% of Graduation Pilot participants demonstrated knowledge on optimum health and nutrition behaviors, while 49.58% displayed negative attitudes toward the same. Overall, 46.1% of children from 12-59 months old had not been dewormed in the previous 6 months and 39.72% of children 6-59 months old had not received Vit-A supplements in the previous 6 months. 15.11% of the surveyed children U5 had experienced diarrhea and 32.33% had had diarrhea with blood, in the two weeks preceding the survey. 67.67% of children with episodes of diarrhea had not been treated with either Oral Rehydration Therapy (ORT) or Zinc. The percentage of children U5 displaying symptoms of Acute Respiratory Infections (ARI) in the two weeks preceding the survey was 18.52%, of whom 14.72% did not receive any advice or treatment.

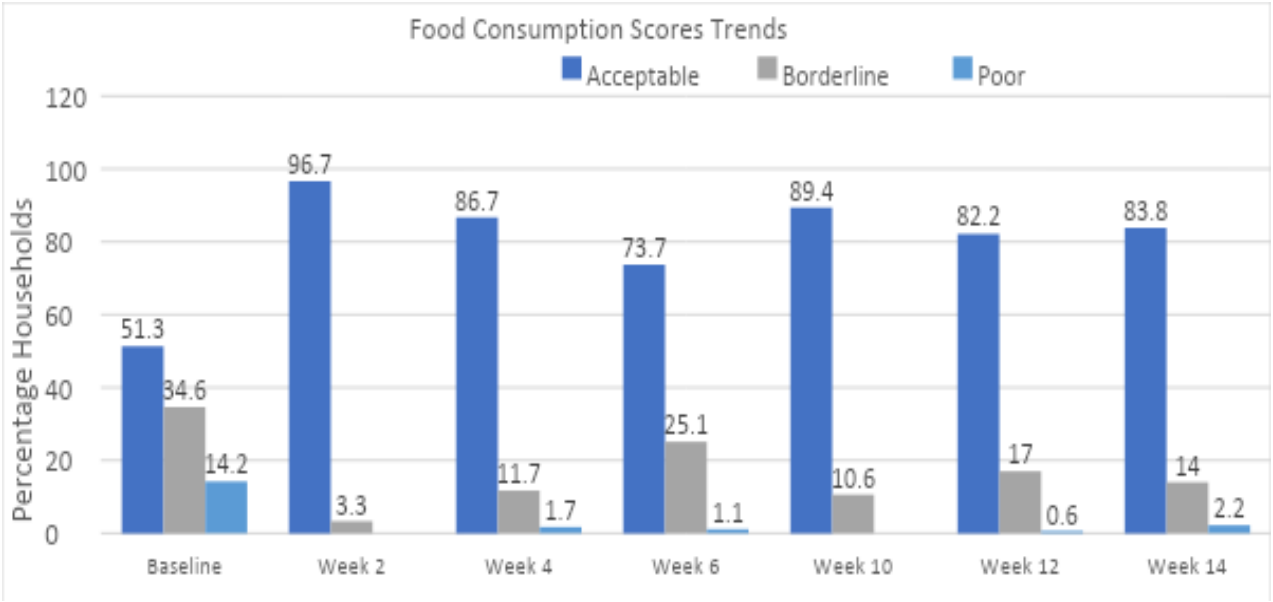
The percentage of children U5 displaying symptoms of Acute Respiratory Infections (ARI) in the two weeks preceding the survey was 18.52%, of whom 14.72% did not receive any advice or treatment. Ideally, related medical advice and/ or treatment should be sought within 24 hours. Of the 85.28% affected who did seek ARI advice and treatment, 43.17% did so after over the recommended 24-hour period, thereby jeopardizing their children's health. The BL survey also showed that 76.67% of children 0-6 months old were exclusively breastfed (against the recommended 100%).

The main hindrances to practicing optimal health-related behaviors include negative attitudes, lack of money to spend on health and nutrition and minimal health service access, given the long distances to health facilities and markets.

- ***Food Security:*** The BL survey shows 51.25% of households having an acceptable food consumption score, while 34.56% and 14.19% demonstrated borderline and poor food consumption scores respectively. The Household Dietary Diversity Scores (HDDS), indicate that HHs in Nawiri pilot areas access and consume an average of 6.04 of the 12 recommended food groups, reflecting average access to diverse foods. Qualitative BL data indicate that the availability of food reserves from the Ramadhan period (April- May 2021) and associated consumption prior to the BL survey, may have contributed to these relatively high scores.

  During implementation, routine ANFGA pilot data shows a significant increase from a BL of 51.3% of HHs achieving an acceptable FCS, to 83.8% over a 4- month period, while 14% of participating HHs (down from 34.6% at BL) and 2.2% (down from 14.2% at BL) achieved borderline and poor FCS' respectively, over 4 months (See Figure 1).

- ***The Household Income and Malnutrition:*** The proportion of U5 children who were wasted at baseline (BL) stood at 18.5%. Graduation Pilot baseline findings show participating HHs average per capita per day income at $0.44, which is below the World Bank defined average of $1.90 for extremely poor and vulnerable HHs. The BL findings also indicate that 100% of wasted children U5 (i.e., 18.5%) were in HHs living below the poverty line. This is corroborated by other Nawiri studies, showing dire lack of income as a main cause of malnutrition in both counties.



Routine Data.

1: Food Consumption Scores Trends

[1] Participatory Epidemiology, SBC formative assessment, and Food Systems Studies.

- ***Minimum Acceptable Diet:*** The BL survey findings show the prevalence of children 6-23 months old with a Minimum Acceptable Diet (MAD) to be 6.38%. At the same time, 90% of the 18.5% wasted children in the 6-23 months old category did not achieve the MAD. Only 17.63% of children 6-23 months old received the Minimum Meal Frequency (MMF) and 37.99% of all children (breastfed and non-breastfed) from 6-23 months old met the Minimum Dietary Diversity for Children (MDD-C). During pilot implementation, routine HH data showed the percentage of children achieving the MAD improving from 6.38% to 51.09% for Arm 1, and to 46.81% for Arm 2 over 4 months. Table 1 below shows trends for both breastfed and non-breastfed children from 6-23 months old.

	Baseline	Week 2	Week 4	Week 6	Week 10	Week 12	Week 14
Breastfed children 6-23 months							
Minimum Dietary Diversity	39.29%	64.63%	70.67%	51.76%	85.39%	77.33%	78.05%
Minimum Meal Frequency	20.36%	47.56%	68.00%	55.29%	71.91%	70.67%	68.29%
MAD	7.14%	31.71%	46.67%	29.41%	66.29%	54.67%	57.32%
Non breastfed children 6-23 months							
Minimum Dietary Diversity	30.61%	42.86%	23.08%	40.00%	100%	47.62%	70%
Minimum Meal Frequency	2.04%	14.29%	15.38%	5.00%	33.33%	23.81%	10%
MAD	2.04%	7.14%	15.38%	5.00%	33.33%	14.29%`	0%
All children 6-23 months							
Minimum Dietary Diversity	37.99%	61.46%	63.64%	49.52%	86.32%	70.83%	77.17%
Minimum Meal Frequency	17.63%	42.71%	60.23%	45.71%	69.47%	60.42%	61.96%
MAD	6.38%	28.13%	42.05%	24.76%	64.21%	45.83%	51.09%

Applying the Findings and Lessons Learned

Key Lessons Learned	Adaptation or implication	Link to the DIP or TOC
100% of HHs with wasted children at BL lived below $0.44 per capita per day. This indicates that ultra-poor HHs are among the most vulnerable population to malnutrition.	Nawiri targeting processes need to prioritize the ultra-poor and Persons Living with Disabilities (PWDs), as they have shown chronic vulnerability in the pilot targeting exercise.	P4, SP 4.3
Limited PWD-responsive strategies for intervening were witnessed through cases of children with physical disabilities being excluded from baseline survey anthropometric measurements, given the lack of guidelines to determine their nutrition status. Similarly, hearing impairment limited the provision of training to targeted PWD HHs.	Nawiri to continue to work with the National Coordinator for PWDs, and county equivalents, to improve interventions for PWDs. Nawiri Business Mentors trained HHs with hearing impairment through written communication. Nawiri will work with County Special Education Department to ensure effective support to PWD participants.	P4, SP 4.3 P3

[2] NB 4 months is a very limited period in terms of seeing the impact of any nutrition and health education, counselling or related SBC, in any context. Over time, however, one can reasonably anticipate seeing greater impact from such initiatives.

Most HHs involved exhibited high knowledge but some negative attitudes and practices towards health and health seeking behavior (not helped by the lack of accessible community-level services in many remote areas, including acute malnutrition hotspots, see 4 below).	Nawiri-SBC to focus on changing HH attitudes toward essential, priority health and nutrition-related practices, supported by contextualized income generation activities alongside support to ensure enhanced and accessible service provision in remote/ malnutrition hotspot locations, to help ensure poor HH access to health and nutrition services.	P1, SP 1.1
Limited access to markets and health services. Access to local suppliers for Graduation Model retail business owners was challenged by high transport costs and minimal linkage efforts. As well, access to reasonably functioning community-level health or nutrition services remains notably limited in many remote parts of Isiolo County.	Nawiri needs to work on strengthening linkages between local suppliers/ private sector actors and graduation retail business owners. System level activities, including sustained work to strengthen health and nutrition service functionality and delivery at community/ front-line levels (especially Health Units) should retain focus on enhancing last mile community access to functional health services and to markets.	P1 SP 1.2 P2 SP 2.1
Improved nutrition practices shown by significant changes in Food Consumption Score and Minimum Acceptable Diet trends, even over a short 4-month period.	The significant improvements witnessed in HHs receiving Arm 1 interventions will continue to inform an evidence-based way forward, including implementation of the full ANFGA package in Marsabit County.	P4 SP 4.3
During the pilot, significant shocks and stresses experienced inevitably affected pilot interventions. These included prolonged drought, COVID-19, regular conflict outbreaks and associated market price fluctuations. This has made Nawiri reassess some initial assumptions and adapt ongoing planning and implementation accordingly.	Nawiri will continue to learn from and adapt to evolving wider contextual factors and shocks that impact on the lives of priority HHs and communities. Moving forward, relevant dimensions of Natural Resource Management (NRM), environmental awareness/ responsiveness and Disaster Risk Reduction (DRR) work will be integrated into Nawiri ANFGA and wider programming.	P3/ All

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