



# NUTRITION WITHIN THE HEALTH SYSTEM

## Moving Towards Universal Health Coverage

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### Box 1. Key messages of this brief

- Each country is at a different place on the path towards achieving [universal health coverage](#), and the World Health Organization notes that such coverage would be incomplete without nutrition services.
- Nutrition is fundamental to health, and other health areas have a reciprocal relationship with it. Other illnesses drive malnutrition, and malnutrition drives other forms of ill health and—ultimately—mortality.
- The health system is a key channel to deliver nutrition-specific interventions (those addressing dietary and health factors that drive nutrition), which should be provided whenever the system reaches an individual.
- Ensuring nutrition's full inclusion within health services offers benefits at intermediate (e.g. coverage) and outcome levels (e.g. reduced malnutrition). It can also reduce costs and increase effectiveness and scale.
- In defining the services to be universally covered, countries should consider [essential nutrition actions](#) alongside other health services, in light of the needs and resources available and the common platforms.

### Universal health coverage

Universal health coverage is a critical objective for achieving the Sustainable Development Goals (SDGs) for health and well-being; partnerships and institutions; and addressing hunger, poverty and inequity. Likewise, the SDGs reinforce universal health coverage (UHC); as countries develop, they will be better able to consistently deliver health care. Attaining UHC means that everyone can access needed health services, of sufficient quality to be effective, and without financial hardship. Equity, quality and financial protection are the three objectives of UHC ([Figure 1](#)) (World Health Organization [WHO] 2019c).

Ensuring UHC means offering all health care categories that individuals and communities need—whether promotive, preventive, curative, rehabilitative or palliative. Of course, being able to afford UHC means prioritising some services over others. Policymakers and implementers will need to consider—within their context—which actions to prioritise in order to ensure the health system equitably and cost-effectively delivers. This brief shares a perspective on a type of health service that needs to be universally covered: nutrition.

Figure 1. The three objectives of universal health coverage.



Source: WHO 2019b.

## Prioritising nutrition as an integral part of health

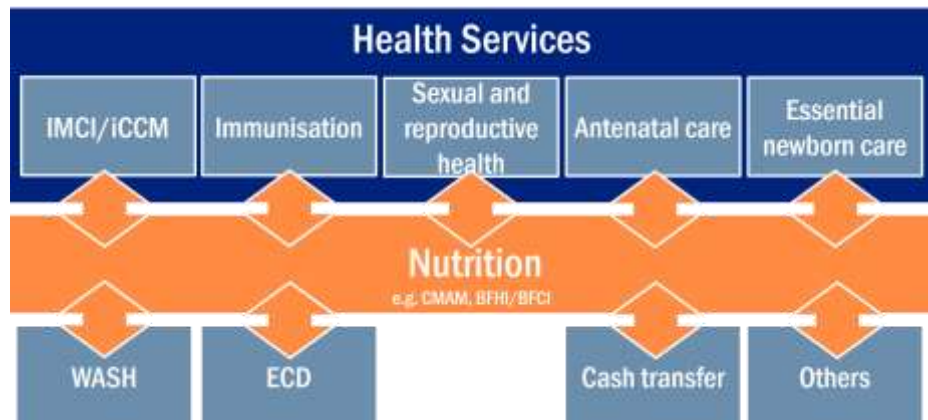
This brief defines [nutrition's inclusion in health](#) as the extent of adoption and eventual assimilation of nutrition-specific interventions into the health system's key building blocks: service delivery, health workforce, governance, financing, supplies and technology and information systems (WHO 2007). At heart, successful inclusion means that nutrition is a part of ongoing, regular health care, and that health is thought of holistically, with an individual being offered all appropriate services at each contact with the health system.

Figure 2 presents various health sector and other platforms through which individuals are served and may receive nutrition interventions. Key platforms include antenatal care (WHO 2016); Baby-Friendly Hospital or Community Initiatives—BFHI/BFCI (United Nations Children's Fund and WHO 2018; Ministry of Health Kenya 2016); essential newborn care (WHO 2010); Community Management of Acute Malnutrition—CMAM (Food and Nutrition Technical Assistance III Project 2018); Integrated Management of Childhood Illness—IMCI (WHO 2014); immunisation; and reproductive health.

These platforms deliver several nutrition services—to one degree or another, though there are other nutrition services they could better cover (Box 2) (WHO 2020).

Furthermore, these platforms do not reach the elderly, young adolescents and perhaps other populations contemplated in the essential nutrition actions (ENAs) (WHO 2019a). Therefore, other mechanisms will need support. Furthermore, though many high-impact nutrition interventions are primarily delivered through the health system, scaling up coverage within, rather than across, sectoral or sub-sectoral areas is counterproductive (Bhutta et al. 2013). It is important that other sectors, such as agriculture, and other areas of health, such as reproductive health, also incorporate nutrition.

Figure 2. Considering nutrition as a part of health and other platforms.



Abbreviations: BFHI/BFCI, Baby-Friendly Hospital or Community Initiatives; CMAM, Community Management of Acute Malnutrition; ECD, early childhood development; IMCI/iCCM, Integrated Management of Childhood Illness/Integrated Community Case Management; WASH, water, sanitation and hygiene.

## Box 2. The essential nutrition actions

Essential nutrition actions are nutrition-related interventions recommended by WHO to prevent disease and reduce mortality (Afshin et al. 2019; Maternal and Child Nutrition Study Group 2013; WHO 2019a). They occur at all levels of the health system (WHO 2019b) and can be categorised as follows:

- Monitor and assess child growth
- Support optimal infant and young child feeding
- Treat acute malnutrition
- Provide micronutrient supplements
- Provide anthelmintic drugs
- Provide nutritional care for special populations and illnesses
- Create a healthy food environment

As indicated above, many ENAs are delivered through the aforementioned platforms. However, there are several that are not yet fully covered, but which it would make sense to include within these platforms.

Platform	ENAs intended for all contexts, which could also be covered by that platform
BFHI/BFCI	<ul style="list-style-type: none"> <li>• Ensure optimal timing of umbilical cord clamping.</li> <li>• Enable kangaroo mother care for low-birthweight infants.</li> <li>• Promote positive newborn feeding practices and address care of infants, including optimal feeding of low- and very low-birthweight infants.</li> </ul>
CMAM	<ul style="list-style-type: none"> <li>• Identify infants under 6 months of age with severe acute malnutrition.</li> </ul>
IMCI	<ul style="list-style-type: none"> <li>• Create a healthy food environment that enables people to adopt and maintain healthy dietary practices.</li> <li>• Develop a management plan for overweight children under 5 presenting at primary health care facilities.</li> </ul>

Given the commonalities (e.g. goals, target groups and implementers), pursuing ways to ensure proper coverage of nutrition within health platforms and vice-versa can reduce delivery and opportunity costs and increase effectiveness. Other benefits include—with the literature demonstrating the key nutrition outcomes (**Box 3**):

- Progress towards the achievement of targets (e.g. coverage, quality and outcomes).
- Increased scale, as multiple services are provided during each contact.
- Improved patient satisfaction (due to better care and lower direct and indirect costs to consumers).
- Reduced costs to the system (as well-nourished children are less likely to become ill).

On the other hand, possible downsides to ensuring nutrition is fully embraced by health systems include reliance on a system that might already be weak or inaccessible; health professionals being overloaded; lack of nutrition skills; and poor-quality services and, as a result, poor outcomes (Bush and Keylock 2018). To achieve the promised benefits, these issues would need to be addressed. Nevertheless, competing demands can leave health providers insufficient time to offer services, such as counselling on infant and young child feeding and nutritional care for pregnant women. The failure to offer these services has human and economic costs (Shekar et al. 2016).

### Box 3. Outcomes from inclusion of nutrition as a part of health

Incorporating nutrition as a part of the health system can have positive impacts at intermediate (e.g. quality care) and outcome (e.g. wasting) levels. In IMCI programmes, there were improvements in correct pneumonia treatment and classification of very low weight, care seeking for danger signs and infant mortality (Arifeen et al. 2009; Mazumder et al. 2014; Schellenberg et al. 2004; Bryce et al. 2005; Bhandari et al. 2012). Nutrition-inclusive immunisation programmes saw improvements in early initiation of breastfeeding and indication of higher exclusive breastfeeding rates, higher vitamin A coverage and/or lower night blindness (Baqui et al. 2008; Hodges et al. 2015; Klemm et al. 1996). Integrated delivery of cash transfers saw improved recovery and reduced relapse of acutely malnourished children, weight, underweight, wasting and body mass index (Grellety et al. 2017). Another programme saw wasting and/or stunting reduced in children whose families received cash transfers or food vouchers (Fenn et al. 2017).

Other programmes saw improvements in antenatal/postnatal visit coverage, health facility delivery, vitamin A and paediatric iron supplementation, use of supplementary foods, early initiation of breastfeeding and/or exclusive breastfeeding (Fagerli et al. 2017; Nguyen et al. 2017; Singh et al. 2017). There were also non-significant but potentially positive trends on similar nutrition-sensitive and -specific outcomes (e.g. anthropometric). Unfortunately, none of the included programmes offered data for proper gender equity analysis (Salam, Das, and Bhutta 2019).

## Accelerating nutrition towards universal health coverage

Positioning nutrition as integral to health will require adjustments. However, it is a vital type of promotive, preventive, curative, rehabilitative and palliative health service, and so these adjustments are needed to make it fully part of the services provided in the regular course of health care, rather than side-lined as a separate concern. We must make a start, for “[no country can achieve universal health coverage ... without investing in essential nutrition actions](#)” (WHO 2019b). As health systems look to accelerate their efforts towards UHC, nutrition cannot be left behind.

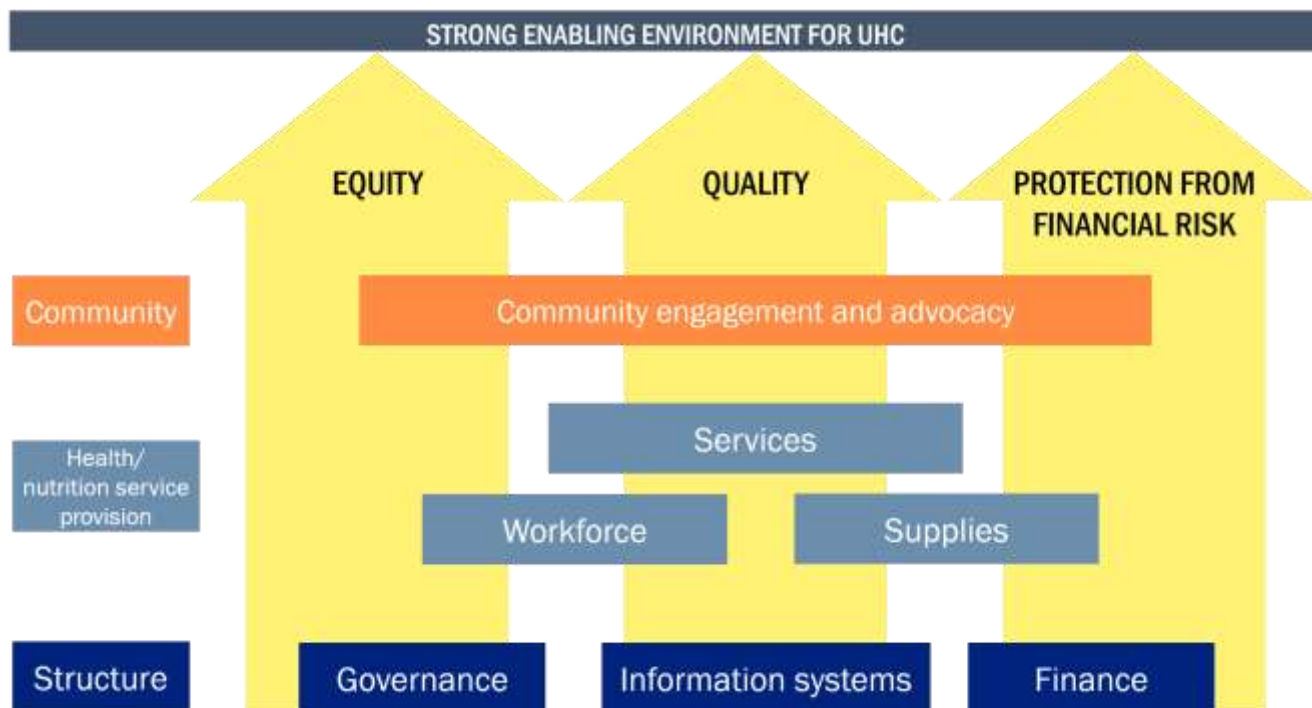
Of course, it cannot be expected that health systems fully include all nutrition-related actions immediately, and that all ENAs will ultimately be prioritised within health systems. Plans for including ENAs in the vision for UHC must be tailored to each context. The ability to take this on may depend on how well a health system is functioning and where a context is along the humanitarian-development spectrum. It also depends on where nutrition fits within existing national priorities and available resources, including from where revenues are generated, how services are purchased and how service delivery and governance (e.g. devolution) are organised (Mathauer et al. 2019).

First, countries would do well to prioritise the ENAs that will be cost-effective and impactful for their most vulnerable populations. Several of the ENAs are highly impactful and/or cost-effective and are proposed for inclusion in an Essential Universal Health Coverage package (Watkins et al. 2017). Those include immediate skin-to-skin contact at birth, detection and management of severe acute malnutrition, breastfeeding and complementary feeding counselling, provision of vitamin A and zinc to children, provision of iron folate to pregnant women, food supplementation for pregnant women in vulnerable populations and moderately acutely malnourished children, and provision of anthelmintic drugs.

However, rather than simply uptake that package, or try to cover all of the ENAs, policymakers should consider that UHC is meant to provide for a basic health system, in which services will be prioritised and new interventions will be added over time as more resources are made available. “Countries are encouraged to prioritise health interventions that are both cost-effective and serve the poorest and most vulnerable groups first, so that no one is left behind” (WHO 2019b). They should reflect on the context-specific causes of malnutrition (for example, is malaria the driver of anaemia rather than the oft-assumed iron deficiency) and the interventions appropriate for

their national or subnational contexts; for example, some ENAs are meant for all contexts and some are targeted to specific contexts (WHO 2019a). To achieve UHC, policymakers also would need to look at which services are important for and to those who have challenges with physical or financial access (WHO 2019b).

**Figure 3. Contributions of the universal health coverage objectives and health system building blocks to an enabling environment for universal health coverage.**



Abbreviation: UHC, universal health coverage.

Once the specific ENAs are prioritised, to ensure they are effectively included in these systems, governments may take certain measures to establish the enabling environment. **Figure 3** illustrates the relationship between the three objectives of UHC, the six building blocks of health systems—and the inclusion of a seventh building block, community—as a basis for creating a strong enabling environment for providing nutrition services as an integral part of health care within UHC. The three UHC objectives—equity, quality and financial risk—underlie the health systems building blocks and must each be considered during planning and operationalisation. The building blocks are shown by organisational level: structural, service provision and community.

**Equity** means that everyone who needs nutrition services—not only those who can afford them—should be able to access and obtain these services. Governance should be accomplished through involving consumers throughout public policymaking processes. It should also ensure that planning for UHC considers national nutrition plans (WHO 2019b). Equity-focused information systems would include indicators to track whether and how marginalised and other vulnerable groups are covered by services (WHO 2019b). It should also include them in considering and making decisions about those data. Equity-focused financing would see greater allocation of domestic resources to nutrition services in the national health system and improvements in subnational budgeting and expenditure tracking (WHO 2019b).

At the service provision level, equity would see a diverse workforce that represents the entire population and understands the diverse barriers that consumers face. Equity-focused supplies would see the provisioning of nutrition-related goods to in-need populations in a fair and consistent manner. Equity-focused services would then see populations served based on need, with an eye towards vulnerable or marginalised groups (WHO 2019b).

Equity in the community engagement and advocacy building block would see communities involved in the planning and operationalisation of UHC, with an eye towards their diverse nutrition-related needs.

**Quality** refers to the objective that the services be good enough to improve the nutrition of those receiving them. At the structural level, quality would see the inclusion of nutrition-related actions as part of national health systems and UHC roadmaps; rigorous data collection to provide early warning of nutrition emergencies alongside capacity to use such information for decision-making; and transparency in financial tracking and reporting (WHO 2019b). This emphasises that the system is designed to be effective, safe and people centred.

At the level of service provision, quality includes a nutrition-skilled workforce that receives integrated supportive supervision and mentoring to further build their capacity to deliver the breadth and depth of integrated essential nutrition care. Actions to support procurement of good-quality supplies would ensure that essential, quality-assured nutrition-related health products are included in national essential medicines lists. The services provided would place the recipient of care first and foremost and be sensitive to their needs (WHO 2019b). Quality at the community level would see thorough engagement of local groups and persons so those who will be offered the services are involved in their development and implementation, to ensure quality.

**Protection against financial risk** refers to the objective of ensuring that people are not put at risk financially when they access nutrition services. At the structural level, this involves policies and oversight to ensure the cost of services are not an undue burden upon the population and that expenditures are tracked and reported transparently.

Achievement of this objective at the structural level will feed into nutrition service provision, and see people capable of seeking and receiving care at minimal personal expense, or at a cost that is manageable within their financial situation. Actions should ensure that essential, quality-assured nutrition-related health products are affordable and accessible (WHO 2019b). Protection against financial risk at the community level would see the costs of services at local health care centres adjusted to the financial realities of consumers, and potentially the power of communities to negotiate and fix costs that may be different from those at the national level. Such protections would provide for the development of the community and for the betterment of local economies.

## Moving forward

As countries continue to forge their paths towards UHC, it will be essential to position nutrition as a core component of good health and well-being. The artificial differentiation between nutrition and health care endangers the fulfilment of UHC. As discussed, nutrition is an integral part of health and, with many existing similarities in the provision of care, should be included in the operationalisation of UHC. As countries examine just how to achieve UHC, they should look towards the building blocks of their health systems and communities, through the lens of the UHC objectives. Ensuring that each UHC objective is achieved in each building block will pave the way towards healthier, more financially secure populations. Operationalising UHC will be no easy feat, but ensuring that nutrition is positioned as an integral component, provided equitably, with quality and minimising financial risk, will ensure that more comprehensive care is provided to all.

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## About MQSUN+

MQSUN+ provides technical assistance and knowledge services to the UK Government's Foreign, Commonwealth and Development Office (FCDO) and the SUN Movement Secretariat to improve the quality of nutrition-specific and nutrition-sensitive programmes. MQSUN+ services are resourced by a consortium of five nonstate organisations leading in the field of nutrition: PATH (lead), Aga Khan University, DAI Global Health, Development Initiatives and NutritionWorks.

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