EXECUTIVE SUMMARY

Integrating Early Detection and Treatment of Child Wasting into Routine Primary Health Care Services

A RESOURCE GUIDE TO SUPPORT NATIONAL PLANNING

The Global Action Plan for Child Wasting (GAP) is a framework to accelerate the prevention and management of child wasting to achieve the Sustainable Development Goals. This Guide offers an easy-to-follow process for governments to identify integration actions that can help achieve programme goals for the early detection and treatment of child wasting within routine primary health care services while moving toward universal health coverage (UHC). **Services to prevent child wasting are required alongside early detection and treatment across the food system, health, social protection, and WASH systems.**

Problem

Efforts to prevent and treat wasting have accelerated over the last 20 years but wasting remains a massive public health problem in many countries, and too many children are left untreated.

45%
of child deaths are linked to malnutrition

45M
children are wasted

only
1 in 3
get treatment

Solution

Integration can help countries achieve programme goals for the early detection and treatment of child wasting. This means embedding vertical services into broader child health programmes or systems and increasing responsibility on the part of national governments while reducing reliance on external support.

Programme goals

Increase coverage and equity of services

Reduce costs and increase efficiency

Increase sustainability (programmatic and financial)

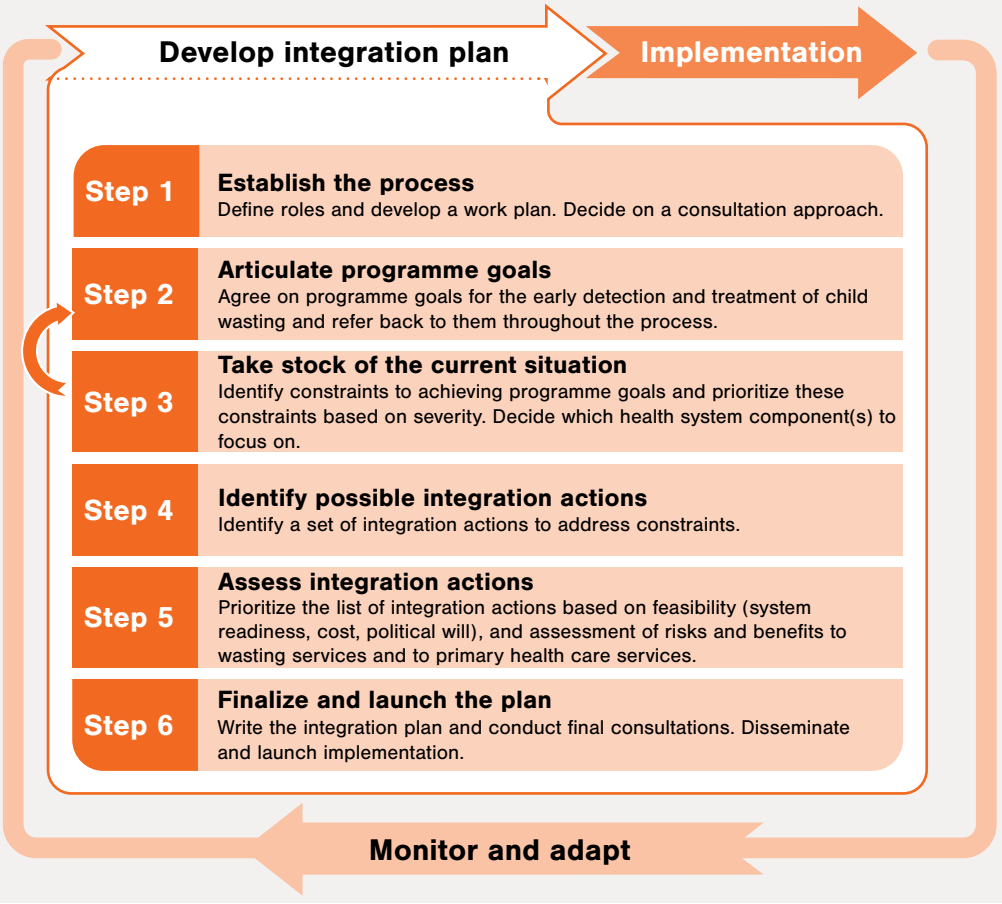
However, this may not always be the case. Integration must be carefully assessed based on feasibility, risks, and benefits.

Process

Many forms of integration are possible. So, how can national policymakers and planners decide whether integration will work for their country, and in what form?

The 6-step process to develop an integration plan is a way for health sector decision-makers to prioritize integration actions that will work in their context. This process is iterative: plans are set, implementation begins, progress is monitored, and plans are adapted as needed based on lessons learned and successes.

The Resource Guide focuses on the integration of early detection and treatment of child wasting into routine primary health care as a starting point (including nutritional assessment or screening, referral, and treatment, which are referred to collectively as "wasting services" in this document). **The approach can be adapted to include prevention, although this requires consensus on the package of preventative services and assessment of feasibility, risks, and benefits for each sector.** Similarly, many countries are considering or testing programme adaptations to simplify wasting service delivery, which, if proven to be successful should be considered with an integration lens.



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RESULTS FOR DEVELOPMENT

Integration must be a health sector priority and the process of integration must be led by country governments. Government health and nutrition teams must own the process of integrating wasting services into routine primary health care services. Support is needed from partners, including donors to fund systems strengthening efforts, NGOs to provide technical support during programme transitions, and research institutions to generate evidence to monitor the integration process.

The feasibility, risks, and benefits of integration must be considered across all essential health and nutrition services. Integrating too quickly or where there is low capacity can overwhelm the health system and reduce the quality of essential health and nutrition services. In these cases, broader efforts to strengthen the health system may be necessary first. Assessment of risks and benefits—to the delivery of wasting services and to primary health care services—is necessary when deciding whether to pursue further integration and in what form.

Many forms of integration are possible across components of the health system. Countries are at different stages of embedding wasting services into the health system and assuming responsibility for the delivery of services while reducing reliance on external support. In many cases, the current state of integration is different across heath system components: leadership and governance, service delivery, health workforce, information systems, sustainable financing, and supply chain for ready-to-use therapeutic foods (RUTFs). Countries also differ in the extent of integration within the emergency preparedness and resilience of wasting services, a theme that cuts across health system components. Integration is not all or nothing but a process: many kinds of partial integration may be appropriate, and further integration can take place across the entire health system or within components sequentially. Some countries may decide to focus on one or several health system components when developing their integration plan.

The Resource Guide to Support National Planning provides resources for health sector decision-makers. For each health system component, the Guide reviews common constraints to achieving programme goals for the early detection and treatment of child wasting and presents a set of integration actions that could help address constraints. These are summarized in the following section and should be considered a starting point—the list of programme constraints is not exhaustive and does not differentiate between minor and critical constraints, and not all integration actions presented here will be relevant or feasible in all cases. Health sector decision-makers will need to decide which actions—or a bundle of integration actions across health sector components—are relevant by going through the 6 steps in the process. This experience will in turn generate lessons learned that can further improve the process across countries.

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> **"Good health and sustainable development are not possible without good nutrition, and UHC is not possible without integrating nutrition actions into national health plans and UHC roadmaps."**
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> — WORLD HEALTH ORGANIZATION, 2020

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	CONSTRAINT		POTENTIAL INTEGRATION ACTIONS TO ADDRESS CONSTRAINTS
Leadership and Governance	**Inadequate prioritization of and accountability for wasting services within the health sector**	**LG.1.**	Ensure adequate consideration of wasting services within health sector strategies and plans (operational and financial) including expected impact on health outcomes
		LG.2.	Ensure adequate consideration of wasting services within health workforce capacity development strategies and plans
		LG.3.	Include wasting indicators within health sector monitoring and evaluation frameworks and develop a coordination group for nutrition information
		LG.4.	Ensure adequate consideration of wasting services within annual budgeting processes, including RUTF and operational costs
		LG.5.	Include wasting services in an essential package of health services as part of the approach to UHC
		LG.6.	Engage civil society and local governments in the implementation of and advocacy for wasting services and mobilize communities to ensure that services respond to local demand, to promote accountability, and to leverage local resources
	Uncertain sustainability of wasting services	**LG.7.**	Develop multi-stakeholder plans to transition the implementation of wasting services from external partners to the health sector, when capacities exist
		LG.8.EP.	Ensure adequate consideration of wasting services within national and subnational emergency response plans (e.g., for droughts, climate change mitigation, etc.) ⚠
Service Delivery	**Limited success of community outreach efforts to identify child wasting**	**SD.1.**	Include nutritional screening in additional community health programmes, e.g., iCCM, growth monitoring, or mobile health outreach programmes
		SD.2.	Include caregiver/family education on the identification of wasting, risks, and where to go for help in additional health programmes, e.g., maternal health services, family planning, and growth monitoring
	Low treatment coverage at the facility level	**SD.3.**	Increase geographic coverage by providing wasting treatment (outpatient and/or inpatient) in additional facilities when deemed cost-effective based on burden and other factors
		SD.4.	Include nutritional screening in additional facility-level health programmes, e.g., immunization, HIV, and other infectious disease programmes
		SD.5.	Strengthen coordination and referral links within and between all levels of care across health and nutrition services
	Limited ability to respond to surges in child wasting	**SD.6.EP**	Develop protocols and build the capacity of health facilities to respond to predictable and unpredictable surges in child wasting (e.g., the CMAM Surge Approach). ⚠
Health Workforce	**Missed programme opportunities due to siloed management of health services**	**HW.1.**	Ensure that nutrition representatives are included in health prioritization discussions during annual and routine planning (at all levels of government: national, subnational, and local)
	Limited capacity of health staff to deliver wasting services	**HW.2.**	Add wasting services to the job descriptions and task lists of health workers at the facility and community levels
		HW.3.	Incorporate wasting services in national pre-service trainings and academic curricula for health workers (e.g. medical and nursing schools, community extension workers' curricula)
		HW.4.	Incorporate wasting services into in-service trainings for health workers at the facility and community levels
		HW.5.	Ensure that management teams are trained to support health workers who deliver wasting services at the facility and community levels (e.g., training in routine performance monitoring, supportive supervision, task-sharing guidelines for wasting and health services, and standard operating procedures)
		HW.6.	Transition training and capacity-building efforts for wasting services from external partners to national health sector training plans, with support from academic institutions for pre-service training
		HW.7.EP.	Develop emergency response plans to ensure adequate workforce coverage to deliver wasting services during emergencies (e.g., through temporary staff deployment and re-arrangement) ⚠

⚠ *Emergency preparedness and resilience integration actions*

	CONSTRAINT		POTENTIAL INTEGRATION ACTIONS TO ADDRESS CONSTRAINTS	
Information Systems	**Limited data availability to monitor and adapt programmes**		IS.1.	Collect priority wasting indicators *for treatment* within existing government-managed health information systems (e.g. DHIS), including integrated data collection tools. Consider the following core set: new admissions, in-treatment, died, recovered, defaulted, non-recovered/non-response, relapse, early discharge, and late discharge
			IS.2.	Collect priority wasting indicators *for screening* within existing government-managed health information systems, including integrated data collection tools
			IS.3.	Train data personnel on nutrition, and/or, where appropriate, embed nutrition data experts in national or subnational HMIS and statistics departments to help liaise with and train programme teams (nutrition and health), troubleshoot data quality queries, and participate in relevant data/ indicator review processes
	Limited access to and use of wasting data in health sector decision-making		IS.4.	Compile, analyze, and communicate wasting and health data together in a user-friendly format across facility and community sources (e.g., using data visualization tools such as dashboards or scorecards to interpret trends in service delivery and burden)
			IS.5.	Ensure that wasting data is routinely available to decision-makers who are planning the delivery of health and wasting services at all levels of government (national, subnational, and local)
			IS.6.	Build evidence for the prioritization of wasting services and ensure that it is available to health sector decision-makers at key milestones to advocate for wasting services
			IS.7.EP.	Strengthen linkages between early warning systems and health information systems to help predict and more quickly detect surges in child wasting and mount a rapid emergency response ⚠
Sustainable Financing	**Insufficient funding**	Revenue raising	SF.1.	Increase domestic resource allocation to wasting services by ensuring adequate prioritization in health sector budgets commensurate with need (donors may provide incentives through co-financing agreements or matching schemes)
			SF.2.	Mobilize new domestic resources for wasting services to gain a net increase in overall health sector funding (e.g., through tax reform or innovative financing mechanisms)
			SF.3.	Increase donor funding for longer-term system strengthening, shifting away from shorter-term humanitarian funding for wasting services
			SF.4.	Increase domestic contribution to wasting services by using concessional loans and grants (e.g., from the World Bank and regional development banks)
	Unsustainable, fragmented, and inefficient funding	Pooling	SF.5.	Shift from off-budget, external funding to donor funding channeled through government budgets and financial systems
		Public financial management	SF.6.	Include costed plans for wasting services within the annual health planning and budgeting process
			SF.7.	Track on- and off-budget funding for wasting services in accordance with targets established in national plans
			SF.8. EP	Ensure that costed emergency response plans for wasting services are included in subnational health plans and local budgets ⚠
			SF.9. EP	Review processes for quickly reallocating funding to respond to surges in child wasting and develop an emergency funding plan ⚠
		Strategic purchasing	SF.10.	Clearly specify and define the provision of wasting services in the existing national insurance benefit package
			SF.11.	Review provider payment mechanisms (e.g., fee-for service, capitation) to identify ways to incentivize provision of wasting services
			SF.12.	Leverage performance-based financing to incentivize wasting services
			SF.13.	Explore demand-side incentives (e.g., household conditional cash transfers and vouchers) to incentivize wasting services
RUTF Supply	Limited availability of RUTF (stockouts)	**Under-prioritization of RUTF as an essential commodity**	RS.1.	Include RUTF in national prioritization processes for essential commodities (e.g., national essential medicines list)
			RS.2.	Include RUTF in existing national and subnational budgeting and planning processes for essential commodities
			RS.3.	Include RUTF in national procurement management processes alongside other essential commodities, including services contracted by the government
		Inefficient RUTF supply chain and weak last-mile distribution	RS.4.	Transfer the management of RUTF storage and distribution to the national supply chain according to readiness at each level of the system (national, subnational, local), including services contracted by the government
			RS.5.	Use RUTF inventory and consumption data to plan for needs (demand forecasting) and coordinate the distribution of RUTF to health facilities with existing schedules for other essential commodities when appropriate
			RS.6.	Budget for last-mile distribution in subnational plans, including transportation costs and buffer stock positioning
		Limited ability to predict and plan for RUTF needs at subnational and health facility levels	RS.7.	Include RUTF in the national logistics management information system (LMIS) that is used to forecast and communicate commodity needs across all levels of the supply chain
			RS.8.	Ensure that RUTF stock is managed by staff who are trained in logistics and inventory management at the subnational level (e.g., pharmacists, logistics managers, etc.)
			RS.9.EP	Develop emergency response plans to ensure the availability of RUTF during surges in child wasting (e.g., buffer stock and funds designated for emergency transport) ⚠

⚠ *Emergency preparedness and resilience integration actions*