Reflections on the United Nations draft Global Action Plan on wasting

By Steve Collins

Steve Collins is a medical doctor with a doctorate in nutrition. He started working in humanitarian relief in Sudan in 1985, allocating and monitoring general ration distributions in West Darfur. Staying in villages that had been afflicted by famine, he gained first-hand insight into how impoverished communities with high levels of acute malnutrition interact with humanitarian relief.

He spent the 1990s setting up emergency-nutrition interventions in most of the African famines and wars, and researching how to make these programmes more effective. Initially focused on severe adult starvation, his work redefined the limits of human adaptation to starvation, established adult mid-upper arm circumference (MUAC) as a key diagnostic and prognostic tool, and provided the first field evidence of the efficacy of lower-protein rehabilitation diets in the initial phase of treatment of severe acute malnutrition (SAM). He was awarded an MBE in the UK for his work to help secure services to treat adult starvation as a standard element of famine-relief interventions.

Towards the end of the 1990s frustrated by the poor impact, low coverage and social disruption of the therapeutic feeding model for SAM and disillusioned by non-governmental organisation attempts to prevent him publishing data on the negative impact of a therapeutic feeding centre (TFC) intervention he had set up (Field Exchange, 2001), he started Valid International Ltd. Valid pioneered a platform to develop community-based therapeutic care (CTC) (Collins and Khara, 2004). Valid Nutrition was also created as a not-for-profit, social business to manufacture specialised nutritional products using locally grown ingredients in the countries where they are needed. From 2002, he led a collaboration between Valid International and Concern Worldwide that generated data on over 25,000 cases of SAM treated using the new model that was ultimately instrumental in the United Nations adoption of community-based management of acute malnutrition (CMAM) in 2007.

Subsequently, Steve has led Valid International to work with Brixton Health to develop spatial surveying methods such as SQUEAC, RAM and S3M – tools that can better target resources, assess programme coverage and improve accountability. He also led Valid Nutrition’s work to develop and test more efficacious, much lower-cost, plant-based ready-to-use therapeutic food (RUTF) (Bahwere et al, 2017).

His current interests are still focused on improving service delivery at the community-level and developing lower-cost, more effective, plant-based nutritional products. He is working on introducing performance-based incentivisation to improve the effectiveness of community health workers, the use of near-field communication to improve monitoring and accountability, and extending the range of plant-based nutritional products to include different crops and to develop a low cost, plant-based ready-to-use food (RUF) for the treatment of both moderate and severe acute malnutrition.

In July 2019, ENN produced a special edition of Field Exchange (issue 60) on the continuum of care for acute malnutrition. Our editorial identified areas of action we felt were needed to address significant shortcomings that were hampering programming, related to United Nations (UN) institutional arrangements regarding management, supply-chain management of ready-to-use products, and normative guidance. Since then, we have engaged with different stakeholders at multiple levels to highlight these issues and try, as many others are doing, to catalyse progress. A key target has been the eagerly anticipated Global Action Plan (GAP) on Wasting developed by five UN agencies (United Nations Children’s Fund (UNICEF), World Food Programme (WFP), the World Health Organization (WHO), the Food and Agriculture Organization (FAO) and the United Nations High Commission for Refugees (UNHCR)). In February 2020, the draft GAP on wasting was shared for public consultation. As we post this article online/got o print, the final GAP on wasting: a framework for action has been released, and a more targeted Roadmap for Action will follow. Discussions to identify commitments and actions by governments and other key stakeholders will continue throughout 2020, with the aim to release the comprehensive global plan at the Tokyo Nutrition for Growth (TNG) Summit, to be held in December 2020.

Many acted quickly to provide feedback on the GAP on wasting within the very short window for input. Having contributed to several collective initiatives and been party to many, we felt it was important to capture some of these reflections and share them with our readership. Given that 2020 marks 20 years since the birth of community-based management of acute malnutrition (community-based therapeutic care), we felt it most fitting to share GAP reflections from Steve Collins, who conceptualised and then realised the community-based approach that is at the heart of case management of wasting today. An extended biography below is included to contextualise his opinion. Never one to shy away from challenging the status quo, Steve’s reflections provide rich food for thought and debate – your reactions are welcome as letters to the editor (Eds).

For over 30 years, efforts to address wasting have focused predominantly on treatment. During that time, however, we have failed to address wasting at a global scale and the coverage of interventions remains extremely low. I agree with the premise behind the UN GAP on wasting that radical change is necessary.

The conclusion that the draft GAP draws from this failure is that we need to change strategy and put prevention at the core of what we do, rather than treatment. To this end, three of the four pathways to impact in this GAP are preventative.

I do not believe that the evidence supports this conclusion. The fact that our interventions have failed to attain an acceptable level of coverage is not, per se, evidence of a flawed strategy. It is merely an observation that we have failed. In my opinion, our collective failure to address
wasting at scale is not primarily a strategic issue, but rather a failure to execute the existing strategy effectively, and it is a severe indictment of the system charged with doing this. This is an implementation failure, wherein donors, national government and the Scaling Up Nutrition (SUN) Movement under-prioritise wasting – and the models, markets, products, funding mechanisms and actors that we use to deliver treatment to wasted children are not fit for purpose and have evolved little in decades. They are wasteful, too expensive, poorly targeted, supply-side orientated and, critically, do not engage the capacity of the private sector at any meaningful scale.

Over the past 20 years, outpatient therapeutic programmes (OTPs) that treat severe acute malnutrition (SAM) as outpatients may have replaced the therapeutic feeding centres (TFCs) that treated them as inpatients, but beyond these (supply-side) tweaks, the core demand-side principles of the original community-based therapy (CTC) model have not been adopted. Current interventions remain overly supply-side driven and fail to overcome the barriers to access and participation that CTC was designed to address. We still engage too little (if at all) with affected communities to ensure that interventions are understandable, acceptable and appropriate for them. The market for nutritional products targeting wasting remains non-transparent and dysfunctional, dominated by a single supplier and single customer that is also the de facto market regulator. For almost 25 years, product development has been minimal, stifled by a UN product specification that, subjected to a strong lobby from those with vested interests in the status quo, has failed to evolve. As a consequence, we still do not produce nutritional products made from locally grown ingredients in the countries where they are needed, thereby missing important opportunities to link prevention to treatment by using ingredient purchase to drive agricultural diversity and improve smallholder incomes.

Prevention is vital; a critical part of any effective model to manage wasting. However, the change to put prevention at the core of the strategy proposed by this draft GAP will not, in my opinion, address the main barriers that have been blocking impact at the global scale we all want to see.

Pathways to delivery and outcomes
The pathways and outcomes identified in the plan are all highly desirable and beneficial. It is clear that multiple technical experts from multiple sectors, each with their own area of expertise and focus, have inputted to the plan. This combination results in a comprehensive list of what we would like to happen, in an ideal world, to end wasting. The key question, however, is whether combining all these individual priority actions into one plan is ‘doable’. Is ‘focusing’ resources on several billion people who require clean water, better sanitation, universal healthcare, improved food systems and more appropriate nutritional behaviours a cost-effective way to help more than 50 million children affected by wasting each year? I do not think it is and I believe that, by casting the net so widely while ignoring key structural issues that undermine implementation, the plan inevitably turns into an unrealistic wish list.

I agree that the prevention of wasting, as well as its treatment, is critical and that there should be a continuum of intervention between SAM, moderate acute malnutrition (MAM) and the prevention of undernutrition in general. However, to maximally impact on wasting in the most cost-effective way possible, I believe that these preventative interventions should be tightly targeted to communities and individuals at the highest risk of wasting, rather than spread homogenously across the developing world, as this plan appears to suggest. We currently reach less than 25% of children with SAM, calculated by prevalence. In reality, this is probably less than 15% if wasting numbers are calculated using incidence, a more appropriate measure for a predominantly acute condition. If we only reach such a small proportion with targeted, nutrition-specific interventions, how can we possibly hope to impact meaningfully on billions of people with the hugely diverse range of interventions included in this plan?

Operational priorities and commitments
The plan is, in my opinion, predicated on an unrealistic assessment of the capacity of the existing public-sector system to intervene. It is not realistic for a ‘Global Action Plan to Address Wasting’ to expect the current system to cover such a broad and diverse range of nutrition-sensitive and nutrition-specific interventions – from strengthening national food systems world-wide to improving water provision and sanitation for billions of people, improving road infrastructure and social protection system (and there’s more) that together target billions of people, plus providing wasting treatment for all who need it. Although all are important, taken together and without the mechanisms to target communities at the highest risk of wasting, they merely represent a wish list, rather than a plan to address wasting. A plan that includes everything for everybody ceases to be an action plan for wasting. How would a plan to address stunting, or even a global plan to address excess child mortality and morbidity, differ? By trying to do everything across such wide-ranging populations, we risk throwing the baby out with the bathwater and ultimately failing to implement even relatively focused actions specifically targeting wasted children themselves, effectively. Instead of fundamentally changing the strategy and massively broadening the range of interventions, I believe that we should focus on fixing what is manifestly wrong with the way we intervene, the coalitions of stakeholders with whom we engage and the products we use. For example, this means:

• Improving the targeting of interventions so that a greater proportion of the limited resources that are available reach those at highest risk of wasting.
• Improving the impact and cost-effectiveness of existing community-based intervention by increasing the focus on improving access and demand, ensuring that treatment and preventative action are integrated and developing performance-based, last-mile delivery solutions.
• Creating mechanisms whereby the private sector can engage at scale in the treatment and prevention of wasting in a way that ensures that commercial interests are aligned with the interests of low-income consumers and maximises the comparative advantages of public and private sector actors.
• Shaping the market for nutritional products to treat and prevent wasting by facilitating true competition and transparent standards and regulation.
• Ensuring that guidelines and specifications for nutritional products serve to maximise competition and value for money and do not arbitrarily restrict innovation.
• Better connect treatment with food security and resilience by truly facilitating the production of nutritional products at scale in developing countries, using locally grown ingredients selected to help drive agricultural diversity and resilience to changing climates.
• Providing low-income consumers with the choice of effective, attractive and affordable nutritional products that provide essential nutrients through retail channels, and supporting this by using the core competencies of the public-sector system to help such people make informed choices, ensure appropriate marketing and transfer subsidies to those who cannot afford them.

Research agenda
I find much of the research agenda in the GAP abstract overly academic; as such, I believe that it will not be effective in focusing research resources on the main issues limiting coverage, impact and cost-effectiveness. Its focus is on the aetiology, measurement and pathophysiology of wasting and on further refining clinical management; they are not the research questions that will deliver maximum ‘bang for our buck’ in improving the delivery and impact of intervention. By contrast, there are far fewer research questions concerned with service delivery and critical practical issues are omitted.

Some of the research ideas also appear to contradict the premises underlying the GAP. For example, the premise of GAP pathway 1 is that “It is crucial that intervention policies, strategies and programmes focus on the prevention of malnutrition in women and adolescent girls before, during and after pregnancy.” However, the first two specific research questions imply that we do not yet know the main pre-pregnancy and maternal factors that predispose a child to wasting. If this is the case, then surely it is premature to include addressing these issues as a core element in the GAP? If, on the other hand, this pathway is understood well enough to
warrant being included as a key impact pathway, why is further research in this area a priority and how will that help with the radical transformation of the system that is required?

Although the draft GAP identifies the fact that the global system achieves only very low coverage, the research agenda fails to focus on this critical factor limiting impact. When the vast majority of wasted children receive no treatment at all, research into improving the clinical efficacy of treatment regimens that already offer ‘per protocol’ recovery rates in excess of 90%, or further refining the relative sensitivity and specificity of anthropometric assessment, are missing the point. The research agenda must acknowledge that extremely low coverage is the main factor limiting impact and answer the question: “How do we deliver support to the greatest numbers of children in the most cost-effective manner possible?” For example:

- How can we identify and target clustered phenomena such as wasting more cost-efficiently through wide-area and small-area spatial surveying tools?
- How can we incentivise community-based workers to case-find, treat and follow up causes of wasting to increase coverage and reduce diversion and non-compliance, and how do we sustain these incentive systems over the longer term?
- How do we move away from treatment programmes largely financed and implemented by short-term humanitarian donors and implementing partners, especially in fragile protracted-crisis contexts?
- How do we combine the ability of the public sector to target wasting and transfer entitlements to those affected with the ability of the private sector to manufacture, move and deliver products and services at scale, in a way that maximises the competitive advantages of each and ensures that the poorest and most vulnerable are not excluded and are protected from commercial exploitation?

The underlying challenge

I believe that our failure to address wasting is symptomatic of a profound misconception at the heart of the aid and development industry. We misconceive our industry as something primarily benevolent; the ‘charity sector’ supplying ‘aid’ to ‘beneficiaries’ and we fund it by selling this misconception to the public and hence to politicians. The facts are, however, very different. Those suffering from wasting have rights enshrined in international law that we have a duty to fulfil. They are not passive recipients of our benevolence but active clients who must juggle multiple priorities, constraints and opportunities.

This misconception is profoundly damaging, because it focuses our attention on ourselves, our motives and our strategies, rather than the needs, rights and realities of our clients. It cements a supply-side, central-planning mentality at the industry’s core. It perpetuates renumeration systems related to process and control of resources rather than to outcomes and impact, wherein those at the centre receive large, often tax-free salaries, while those who actually deliver products and services to our clients receive very little – and are often even expected to work as volunteers. It incentivises excessive investment in agency profile that discourages transparency and undermines innovation. It also sees profit as distasteful, precluding meaningful engagement with the private sector.¹

To change this requires radically different ways of working. In particular, it requires profound collaboration between government, the public sector and the private sector, where each plays to their respective strengths and does not engage in activities for which they are ill suited, even if this means forgoing control of resources and profile. In almost all other walks of life, it is the private sector that delivers goods and services to people, and we must leverage its scale, capability and capacity to do this along the entire chain of service delivery, up to and including last-mile delivery to those suffering from wasting. The public sector should focus on ensuring that the services delivered meet the needs of those affected by wasting by improving targeting, transferring entitlements to ensure equitable coverage, with nobody left behind, and imposing ethical standards to prevent exploitation. The research agenda must inform us on how best to achieve this collaboration.

Enacting this change will not be easy. There are vested interests perpetuating the status quo and threats posed by increased private-sector involvement, given its history of promoting poor nutrition and exploitation. However, with sufficient will, I am sure that these vested interests can be challenged and the threats addressed. The bottom line is that, after more than 30 years of failing to reach the vast majority of those affected by wasting, we really have no choice but to fundamentally change how we go about things.

Conclusion

History has shown that the aid and development industry, working with government, is not able to deliver effective services to wasted children at scale. Our response to this failure should be to fundamentally change how services are delivered to ensure that those who need them, receive them. The GAP represents an important opportunity to kickstart the profound changes needed and to set an ambitious research agenda to inform and guide the change process. However, by ignoring the massive implementation failures at the heart of the system and instead focusing on shifting the strategy towards more generalised prevention, the draft GAP fails to grasp this opportunity.

¹ This is reflected in the draft GAP where, out of 34 desired outcomes, the private sector is confined to just two which represent a niche involvement in standards for specialised nutritious products or abstract aspirations to improve food value chains. No research question is included that looks at how better to engage the massive resources, capabilities and capacities that the private sector has to offer.

References

