

Child wasting in South Asia

Unravelling the conundrum and areas for action

November 2020



In partnership with the United Nations International Children's Fund Regional Office South Asia (UNICEF ROSA) team, ENN produced a special edition of *Field Exchange* (issue 63) in October 2020 that focused on child wasting in South Asia. Together, we aimed to increase the understanding of child wasting in South Asia and identify the challenges and opportunities to support advocacy efforts and inform policy, programme and research priorities.

This brief has been prepared by the Field Exchange Team to summarise highlights from the edition. We share some of the critical issues identified by contributors that underpin insufficient attention and action on wasting management in the region,¹ provide a snapshot of opportunities and challenges reflected in articles, and share regionally identified priority actions.²

The problem

Conservative estimates of the prevalence of child wasting in South Asia are huge – 25.1 million wasted children (14.8%) of whom 7.7 million (4.5%) are severely wasted – twice as high as in sub-Saharan Africa (UNICEF, WHO & World Bank, 2020). Yet this has not sparked sufficient regional or global action – only 5% of wasted children, most of whom live in development settings and middle-income countries, receive the treatment that they need.

Unravelling the conundrum

Wasting and stunting divide

Siloed approaches to tackling wasting and stunting and the prioritisation of stunting prevention efforts in South Asia have fuelled the neglect of the wasting problem. But this should not be so as wasting and stunting share many of the same causes, may be present in the same children and both have severe consequences for child survival, growth and development. In addition, evidence on the relationship between wasting and stunting suggests that failure to address wasting likely contributes to the persistently high rates of stunting in South Asia.

"Short, thin, anaemic and young" characterises maternal malnutrition

The highest levels of wasting in South Asia occur at birth and in the first three months of life. It is estimated that, on average, one in four (27%) births in the region are low birth weight (LBW) and these infants are more likely to be born wasted and/or stunted and/or underweight, more likely to experience wasting and stunting in childhood, and are at higher risk of death than normal birth weight infants.³

Women who are undernourished and in poor health, along with adolescent girls, are more likely to give birth to babies with LBW (Salam et al, 2016). As one in five women in South Asia are too thin, one in ten have short stature and multiple micronutrients among women persist (Goudet et al, 2018), maternal undernutrition has been identified as a key

driver of the high child wasting caseloads in South Asia (UNICEF, WHO, World Bank, 2020).

The coverage of maternal iron and folic acid (IFA) supplementation is low in most countries despite decades of implementation and this hinders efforts to improve maternal and foetal nutrition, health and survival. Furthermore, countries have not adopted multiple micronutrient supplementation (MMS) during pregnancy, despite clear evidence that multiple micronutrient deficiencies are the norm and that MMS improves foetal growth.⁴ More evidence is needed on effective maternal nutrition interventions at scale in different settings.⁵

Status and barriers to scaled up treatment

There is still a long way to go to scale up wasting treatment in South Asian countries. Many wasted children are not identified in the region, active screening at community level is rare and mid-upper arm circumference (MUAC) is not widely used. There are currently no national programmes to treat severely wasted children at community-level in Bangladesh, India and Sri Lanka, although we identified some examples of state-wide programmes being scaled up in India.⁶ Several articles state there are insufficient domestic resources allocated to child wasting and, like in many other regions, regional staff describe that little development funding invested in this problem. For example, progress in

¹ See FEX 63 [editorial](#) and views articles: [South Asia and child wasting – unravelling the conundrum](#) and [Improving maternal nutrition in South Asia and interview with Victor Aguayo, UNICEF Chief of Nutrition](#)

² Full details of these opportunities and many more are detailed in [Field Exchange 63](#)

³ See FEX 63 summaries of research by [Mertens et al \(2020a\)](#), [Mertens et al \(2020b\)](#) and [Benjamin-Chung et al \(2020\)](#)

⁴ See <https://micronutrientforum.org/goalkeepers/mms-stakeholder-alignment-consultation/> and FEX 63 research article [Possible role for multiple micronutrient supplementation in pregnancy](#)

⁵ See FEX 63 article [Improving maternal nutrition in South Asia](#)

⁶ See FEX 63 article [Community management of acute malnutrition in Rajasthan, India](#)

embedding wasting treatment into the health system in Afghanistan is hindered by reliance on short-term emergency funds and considerable funding shortfalls. There are significant challenges to estimating costs of scale up; lack of clarity on how much scale up will cost hampers financial planning and commitments of governments and donors.

Outstanding questions and insufficient country-specific evidence around ready-to-use therapeutic food (RUTF) or equivalent formulations in the region stifles policy and programming across the region. RUTF is sanctioned by government for use in just three countries (Afghanistan, Pakistan and Nepal) where community-based management is available, introduced through humanitarian programming. Barriers to wider national endorsement of RUTF relate to financial costs, cultural acceptance of the product and the availability of local alternatives in existing services.

Opportunities to combat child wasting in South Asia

The UNICEF-led development of country-led Road Maps for **Action for the UN Global Action Plan (GAP) on Child Wasting and Phase 3.0 of the Scaling up Nutrition (SUN) Movement** offer great opportunities to connect wasting prevention and treatment and converge wasting and stunting agendas and actions at regional and country levels. Experiences from Pakistan and Afghanistan describe early political will, policy frameworks and programming opportunities to do so. Prevention has been agreed in Afghanistan as critical to reduce caseloads, which has been catalysed by the unsustainable costs of treatment; action plans are being led by government framed within the GAP on Child Wasting RoadMap development.

Innovative programming in Mumbai, Bangladesh and Indonesia provides workable examples of integrated **maternal nutrition and health** programming.

Progress on community-based treatment of wasting in Nepal, Pakistan, Afghanistan and India (Bihar) all began as emergency responses dependent on humanitarian funds. In Nepal, **government leadership** and the allocation of **domestic resources** to **wasting treatment** have been critical in the transition from humanitarian dependence. In Pakistan, community-based treatment is now reflected in public health policy as part of an essential package of interventions committed under Universal Health Coverage that is being costed to inform phased rollout.

There are also good examples of states in India that are on a pathway to the scale up of child wasting management, enabled by strong, early government leadership to **embed services into existing systems, government agendas and commitments**. The success of a government-funded programme in India will depend on a robust management information system, a trained healthcare workforce, a strong reporting mechanism and significant resources and supply-chain management for RUTF or equivalents.

Important **research** continues in Bangladesh⁷ and India on **RUTF or equivalents** using locally available ingredients that can be used in wasting treatment services.

Streamlined care plans at in-patient and out-patient levels are being explored or used in India and Afghanistan.

Simplified approaches to wasting treatment in the region include reduced dosage RUTF schedules in Afghanistan, the use of MUAC in Cox's Bazar in Bangladesh and India as an adaptation to COVID-19 and the use of **weight-for-age z-score (WAZ)** to identify both infants and children for in-patient wasting treatment. Since WAZ identifies children concurrently wasted and stunted, LBW infants and infants under six months of age at higher mortality risk and is measured in growth monitoring programmes throughout the region, this presents an important opportunity to identify children 'at risk' and to facilitate continuity of care between services.

Reimagined care for wasted children in South Asia and beyond

Effective management of child wasting requires enhanced, targeted, timely and preventive actions across the life cycle and across a spectrum of child risk. We must prevent a child's nutrition status from deteriorating in the first place, prevent the decline of more at risk children and urgently act to care for those at greatest risk to prevent death. The earlier the intervention, the lower the cost of treatment per child; a 'win-win' in both financial and human terms.

Maternal undernutrition and ill-health, LBW and poor early infant growth experiences are fundamental to the burden, causes and consequences of both immediate and subsequent growth faltering in the region. The burden of child wasting is arguably a marker of the neglect of women's nutrition and health; child undernutrition is part of the collateral damage.

Priorities for policy, programme and research action in South Asia

The **development community should pay proportionate attention to South Asia** in terms of technical assistance and funding to unravel the most pressing challenges on wasting management. This includes leveraging the global health as well as nutrition communities. A crucial step in leveraging financial resources for wasting prevention and treatment is to understand the costs involved.

Changing our narrative to one that focuses on 'risk' rather than 'body-size' is needed to help break down silos between wasting and stunting, between humanitarian and development actors and to generate clearer, simpler advocacy messages for non-technical decision-makers and influencers (ENN, 2020; Kerac et al, 2020).

Preventive actions should be positioned at the centre of national efforts to reduce the number of wasted children.

⁷ Visit <https://www.icddrb.org/> under research



© UNICEF/UNI194346/Kaur

Greater priority must be given in South Asia to improving the **nutritional and health care of women** before and during pregnancy for their own health and wellbeing and to prevent LBW, to strengthening the support provided for LBW infants and their mothers at facility and community level including and beyond the immediate postnatal period, to improving breastfeeding and complementary feeding practices in the first two years of life and to identifying and referring children who become wasted. Identified actions to prevent and treat wasting must be embedded in multi-sector nutrition strategies, policies and plans, including those identified in country-specific Roadmaps for Action as part of the operationalisation of the **GAP on Child Wasting: Framework for Action**.⁸

We must **strengthen the integration of wasting management into the health system across a continuum of care**. All wasted children are at risk but some are more at risk than others; further evidence on how to stratify risk is needed to inform how wasted children are best managed within and beyond the health system. For some countries, integration must begin with policy consensus on evidence-based approaches to treat wasting at community level.

Health systems play a primary role in delivering nutrition interventions. In all contexts, interventions to prevent and treat wasting should be considered as part of the essential healthcare package and be appropriately reflected in policies, plans, budgets, health workers' pre-service training, supply-chain management and health management information systems.

While action on prevention is essential, access to treatment remains paramount. When children become wasted, it is essential that they are **identified and treated early** to prevent severe and long-lasting outcomes. This is best achieved through a combination of community-based treatment for those without medical complications and facility-based treatment for those with medical complications. Ensuring **continuity of care** between treatment services across the health system is essential to securing the best child outcomes.

Connecting wasting and stunting agendas and actions is critical as reflected in a landmark **regional Call to Action** to guide policy and programming action to **reduce child wasting** in 2017.⁹ Convergent actions by the food, social protection and water and sanitation systems are needed to improve the access of vulnerable households to safe, nutritious and affordable diets and the capacity of caregivers to care for their children during the crucial early years.

Finally, we need to **build the evidence base on the epidemiology (causes, distribution and outcomes) of wasting in South Asia and on effective models of care across a prevention and treatment continuum that includes risk stratification**. There is an urgent need to convene the academic community to build a stronger evidence base that can objectively inform policies and programmes to treat severe wasting in South Asia and to inform global normative guidance. **Implementation research** is needed to examine the effectiveness of alternative models and innovative approaches to care for wasted children that build on existing systems and service-delivery platforms and which have genuine potential for scale. Open forums are necessary to discuss the evidence and its interpretation and to drive **consensus-based and evidence-driven** policy and programme decisions.

Commitment to continued learning

We still have much to learn about how to deliver services that treat and prevent child wasting; all actions should be coupled with knowledge generation to ensure a continual cycle of learning. South Asia offers a wealth of capacity and opportunities to think and do things differently and to help to drive innovative approaches that can and should inform policies and programmes to prevent and treat wasting in South Asian countries and globally.

This technical brief was developed by Field Exchange Editors and draws significantly on views shared by the UNICEF ROSA team in the Field Exchange 63 edition.

⁸ See FEX 63 views article **UN Global Action Plan (GAP) Framework for Child Wasting and the Asia and Pacific Region**. Note these estimates are based on prevalence only and do not account for incidence or projected increases due to COVID-19 pandemic.

⁹ See in FEX 63 **Report of the South Asia 'Stop stunting: No time to Waste' conference**

References

- ENN. (2020). Wasting in the wider context of undernutrition: An ENN position paper.
- Salam, R. A., Faqqah, A., Sajjad, N., Lassi, Z. S., Das, J. K., Kaufman, M., & Bhutta, Z. A. (2016). Improving Adolescent Sexual and Reproductive Health: A Systematic Review of Potential Interventions. *The Journal of adolescent health* : official publication of the Society for Adolescent Medicine, 59(4S), S11–S28.
- Kerac M, McGrath M, Connell N, et al (2020). 'Severe malnutrition': thinking deeply, communicating simply. *BMJ Global Health* 2020;5:e003023.
- United Nations Children's Fund (UNICEF), World Health Organization, International Bank for Reconstruction and Development/The World Bank. *Levels and trends in child malnutrition: Key Findings of the 2020 Edition of the Joint Child Malnutrition Estimates*. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO