



INTERNATIONAL  
**RESCUE**  
COMMITTEE

# AN UNTAPPED OPPORTUNITY

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SIMPLIFYING AND SCALING WASTING TREATMENT

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# Executive Summary

52 million children under five suffer from wasting at a given time, drastically increasing their risk of death and long-term health and development issues while weakening their immune system and ability to fight off routine illness. Wasting is a neglected public health emergency responsible for nearly 2 million child deaths a year.

A combination of conflict, climate change, and poverty is exacerbating the child wasting crisis and placing more children's lives in danger. Since the outbreak of the COVID-19 pandemic, the number of people requiring humanitarian aid has surged, representing an unprecedented level of displacement and need. Nearly 700 million people globally are undernourished and more than 41 million are on the verge of famine.

Fortunately, we have the evidence and tools to mitigate the worst consequences of the crisis: a highly effective and easy to administer treatment, ready-to-use therapeutic food (RUTF). In the last thirty years, healthcare innovations have greatly expanded the capacity to deliver treatment. First, the invention of RUTF, a shelf-stable, nutrient rich fortified peanut butter paste that can fully recover a child and be administered outside of healthcare settings. Second, the introduction of community-based management of wasting, which enabled outpatient treatment at local clinics and other lower-level health facilities, bringing treatment closer to home. While rapid progress on expanding treatment coverage followed, just 15 years after the adoption of community management, this progress has stalled.

**IF DONORS AND NATIONAL GOVERNMENTS COMMIT AT LEAST**

**\$1 billion per year**

to scale up treatment coverage, we can provide children access to lifesaving care and extend treatment to millions more children.

Only 20% of children who suffer from wasting receive the lifesaving care they need due to a woefully underfunded and uncoordinated system. Moreover, treatment rarely receives the political attention or financial resources it requires among other global food and nutrition priorities. In 2019, approximately \$500 million—a third of all nutrition funding—went to preventing and treating wasting. This relatively small pool of resources represents a missed opportunity for leaders to achieve a tangible victory.

With sufficient resources, wasting treatment can be scaled to reach more children. A growing body

of evidence indicates that innovations that enable scale, a simplified combined protocol, family diagnosis—and treatment delivery by community health workers—are equally effective in recovering children and more cost-effective, offering donors an opportunity to maximize the impact of their dollars.

The persistent treatment gap is a missed opportunity for impact and a moral failing, but can be corrected by mobilizing sustainable and coordinated financing to scale treatment programs. The \$27 billion pledged at the December 2021 Nutrition for Growth (N4G) Summit provides a crucial opportunity to reduce child mortality and ensure that every child can access treatment. If donors and national governments commit at least \$1 billion per year to scale up treatment coverage, we can provide children access to lifesaving care and extend treatment to millions more of children with wasting.<sup>1</sup>

To achieve a vast expansion of treatment coverage, the IRC recommends:

**DONORS SHOULD:**

- Ear-mark a significant allotment of N4G pledges for wasting treatment;
- Invest in wasting at five to ten year timelines, at a minimum;
- Pre-arrange financial mechanisms to surge funding at the warning signs of nutrition-related shocks;
- Align financing with agreed sector-wide goals for both quality and coverage of treatment, against which progress should be transparently, rigorously, and regularly evaluated;
- Scale up results-based funding for treatment, involving the assessment of coverage, quality, and cost-effectiveness integrated within the health system and child survival community strategies;
- Update the 2017 World Bank and R4D Investment Case in consultation and agreement with a diverse and inclusive group of stakeholders to mobilize resources;
- Establish a pooled financing mechanism that feeds into coherent national and regional strategies through a single process; and
- Link financing to a legitimate, inclusive, and effective governance and accountability mechanism that tracks progress against outcomes and directs resources to fill gaps.





*Portrait of Ibrahim Ali, 24 and his baby, Bello Ibrahim, 7 days old, a few hours after his child's naming ceremony at his home in Gwoza, Borno, Nigeria on Wednesday, 22 September 2021.*

#### **THE UN SYSTEM SHOULD:**

- Support the implementation of the Global Action Plan on Child Wasting (GAP) target to scale up wasting coverage by 50% by 2025 and aim to reach 80% coverage by 2030, and establish additional global targets and indicators on treatment coverage; and
- Publish global guidelines that adopt a public health approach to wasting treatment that explicitly prioritizes simplification, decentralization, and scale and endorses evidence-based approaches for scale.

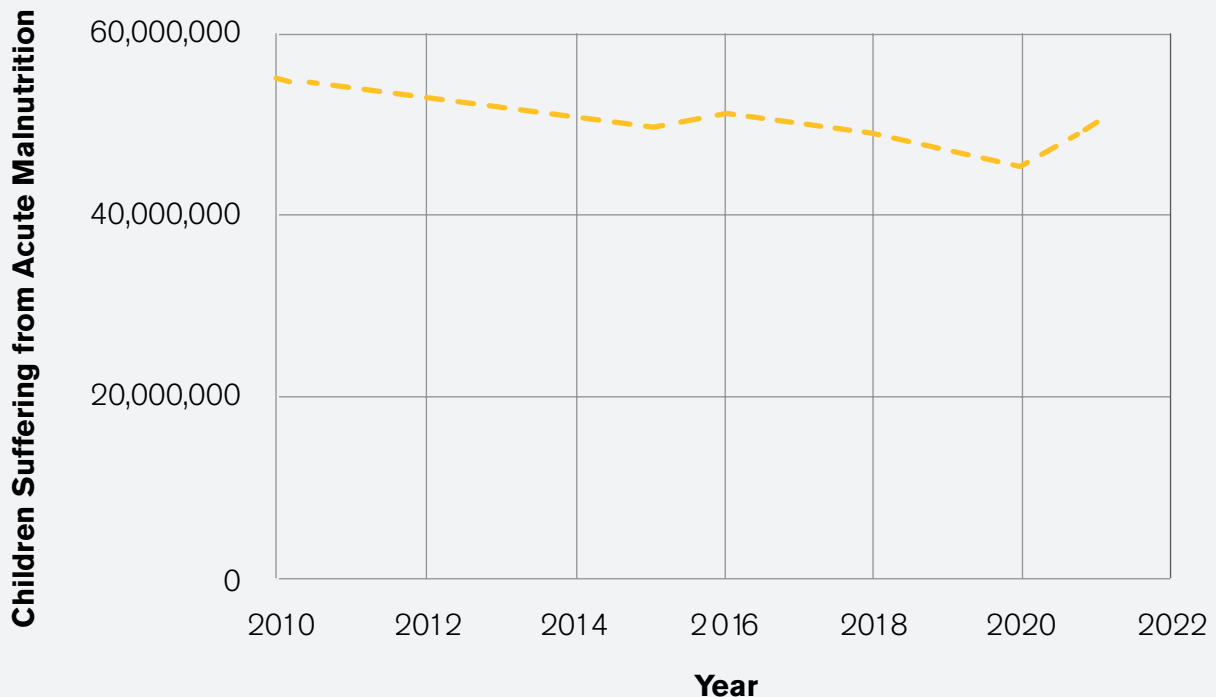
#### **GOVERNMENTS IN COUNTRIES WITH A HIGH BURDEN OF WASTING SHOULD:**

- Adopt a public health approach in national strategies to meet scaling targets that prioritizes effective and efficient delivery strategies;
- Set national level targets and plan processes for subnational and community level outreach to meet treatment targets;
- Work with the health system to implement simplified approaches to wasting treatment. Community-based management of acute malnutrition should incorporate evidence-based simplifications to increase coverage and cost-effectiveness;
- Collect and analyze reliable and disaggregated data on wasting treatment coverage; and
- Develop financial benchmarks for national plans on wasting, devote more funding to wasting treatment coverage in national health budgets, and work with donors to secure the necessary funding to implement them.

# Introduction

Wasting, or acute malnutrition, is the most deadly type of malnutrition.<sup>1</sup> When children do not receive enough nutrition, they may have an unhealthy weight-for-height and become severely underweight. This weakens their immune systems, and erodes their ability to fight off other infections. Children with untreated wasting are also at risk for developmental delays, which have life-long health, physiological, and socio-economic implications.<sup>2</sup> The slow progress on addressing wasting has led to a sustained, yet neglected public health emergency and the deaths of almost 2 million children annually.<sup>3</sup>

## CHILDREN SUFFERING FROM ACUTE MALNUTRITION GLOBALLY



This data was taken from the annual UNICEF-WHO-WB Joint Child Malnutrition Estimates. Given UNICEF's projection that 6.7 million children were at risk for acute malnutrition in 2020, it is estimated that 52 million children in 2020 experienced wasting.



*This picture shows an IRC staff member conducting examinations for a malnourished child, Sarra\*, in Northwest Syria, March 2021.*

UNICEF's projections indicate that the COVID-19 pandemic likely worsened the burden of children with wasting from 45.4 million cases in 2019 to an estimated 52 million cases worldwide in 2020.<sup>4</sup> The quality of data on wasting is poor; however, our best estimates reveal a growing crisis.<sup>5</sup>

Pre-pandemic estimates posit that about 80% of children with wasting lacked access to treatment.<sup>6</sup> In 2019, 36 million children and in 2020, 41 million children were not admitted for potentially lifesaving treatment for wasting.<sup>8</sup> These are conservative estimates and we anticipate better quality data would reveal that we are under-estimating our failure to treat children with wasting.<sup>7</sup>

This is a growing, life-threatening problem. Conflict, climate change, and poverty put more children at risk for wasting, causing the deadly gap in wasting

treatment coverage to grow. Fortunately, treatment for wasting is effective. We have the tools to avoid preventable deaths: successfully scaling treatment coverage to 80% has the potential to reduce the under-five child mortality rate.<sup>9</sup>

Approximately \$500 million, or a third of all nutrition funding, went to wasting programs in 2019. This includes prevention and all other programs in addition to treatment. To close the massive gap in funding needed to scale wasting treatment coverage, at least \$1 billion per year will be needed from both donors and domestic financing.<sup>10</sup> This estimate is based on the 2017 World Bank/R4D's investment case and the costed roadmaps tied to the Global Action Plan on Child Wasting (GAP). With sustainable and coordinated financing and a clear investment framework, this is a tangible and significant opportunity to improve child health and mortality.



# Humanitarian Crises, COVID-19, and Malnutrition



Communities, ministries of health, donors, the humanitarian sector, and the UN system must be ready to respond to wasting at a steady state and whenever cases surge, particularly in fragile contexts and conflict-affected settings. Persistently high rates of hunger and food insecurity in recent years have been caused by rising conflict, the worsening climate crisis, and deepening inequality, amidst global shocks like the COVID-19 pandemic. Since the outbreak of COVID-19, the number of people requiring humanitarian aid has surged 63%, leading to record numbers of displacement and people in need. The increasing humanitarian burden produces horrific consequences.<sup>11</sup> Approximately 690 million people are undernourished globally, more than 41 million people are on the verge of famine (IPC Phase 4: Emergency),<sup>12</sup> and, in many cases, hunger is used as a weapon of war.<sup>13</sup>

Crises have become more protracted, and a state of near-permanent crisis is becoming the new normal for millions worldwide. According to the UN FAO, “conflict is a major threat to food security and nutrition and the leading cause of global food crises...More than half of the people who are undernourished and almost 80% of stunted children live in countries struggling with some form of conflict, violence or fragility.”<sup>14</sup> In the

last two years, we have witnessed the Russian invasion of Ukraine; a war between Azerbaijan and Armenia; the Taliban seizing control of Afghanistan; political and economic turmoil in Venezuela; escalating conflict in Tigray, Ethiopia; an armed coup in Myanmar; rising political tension and renewed violence in Somalia; and continued conflict and an ebola outbreak in the DRC.<sup>15</sup> Additionally, protracted crises such as the war in Yemen, militant activity in northeast Nigeria, violence and insecurity in South Sudan, civil war in Syria, and conflict in Sudan continue to expose millions to food insecurity and hunger. With the exceptions of Russia, Azerbaijan, and Armenia, all of these countries have seen a rise in rates of wasting since 2019.

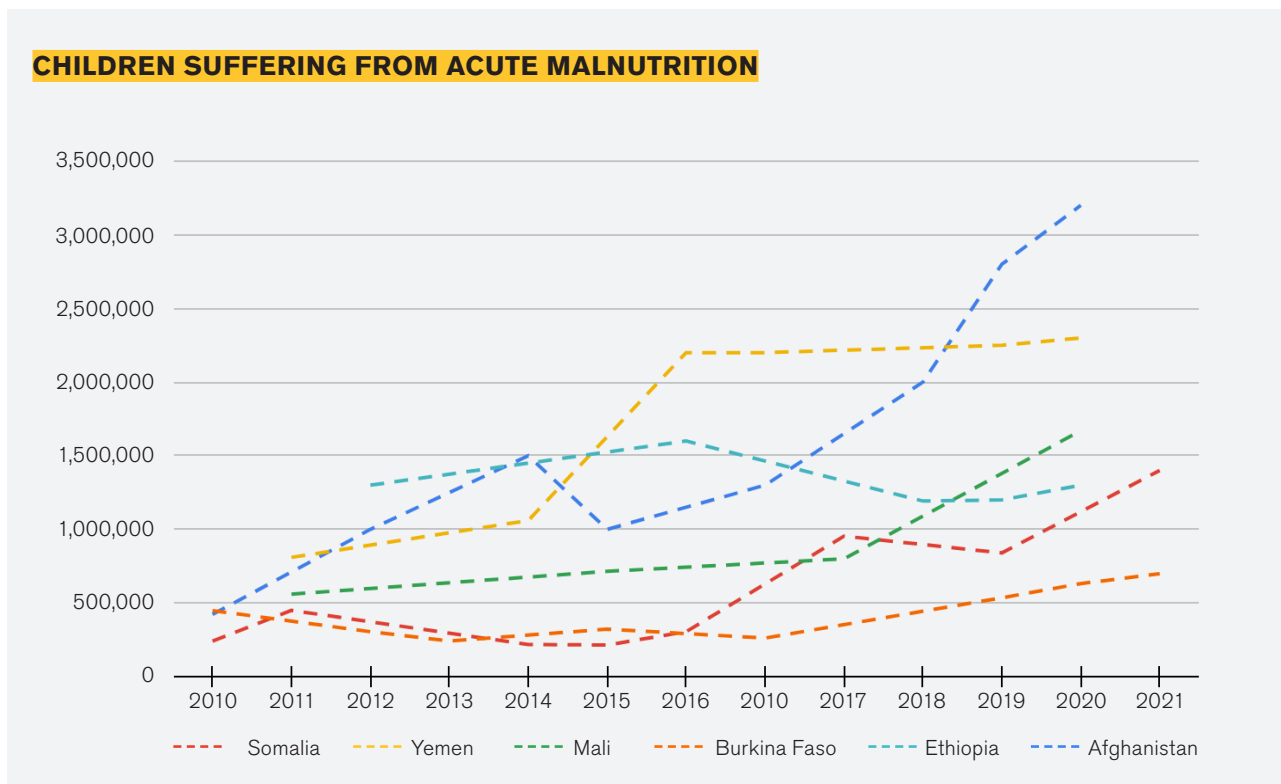
The worsening climate crisis, in tandem with the pandemic, has driven increases in global hunger and contributes to the high rates of all forms of malnutrition.<sup>16</sup> This is particularly severe when shocks of conflict and climate change overlap, such as locust plagues in Sudan, cyclones in Mozambique, extreme weather in Afghanistan, droughts in the Sahel region, and climate shocks in the Northern Triangle. East Africa is currently experiencing its worst drought in more than 40 years; 40-55 million people in the region require humanitarian food and nutrition assistance while more than 14 million people, almost half of which are children, face severe hunger.<sup>17</sup> Conflict-affected areas of the region have been categorized as IPC Phase 4—an emergency declaration one step away from famine.<sup>18</sup>

Economic slowdowns are a third leading cause of hunger, food insecurity, and malnutrition.<sup>19 20</sup> The growing poverty rate and deepening inequality exacerbate the rates of hunger and malnutrition, which is particularly dangerous for children. In 2020, the number of children living in multidimensional poverty escalated to an estimated 1.2 billion,<sup>21</sup> increasing their risk of malnutrition. This is deeply concerning as undernutrition, inclusive of wasting, is linked to approximately 45% of deaths among children under five years of age.<sup>22</sup>

Most severely affected are communities that suffer from the overlapping burdens

described above. As reflected in the graph, the burden of wasting in children under five has been increasing in Afghanistan, Burkina Faso, Ethiopia, Mali, Somalia, and Yemen since before the pandemic. Notably, more than 3 million children in Afghanistan under the age of five suffered from wasting in 2021, and approximately 1 million children are at risk of dying from severe wasting without access to prompt treatment.<sup>23</sup>

As long as global crises continue, impacted children will face the risk of wasting.



*Given the lack of consistent quality data, individual country statistics in this chart were pulled from different sources including UNICEF and WFP situation reports, the UNICEF-WHO-WB Joint Child Malnutrition Estimates, Integrated Food Security Phase Classification reports, and other reliable sources.*



James from IRC takes care of Peter, help by his mother Abang, at home in Northern Bahr El Ghazal, South Sudan, Saturday, October 16, 2021.

# Contextualizing Wasting Treatment in Global Health

The global community has been working to address child wasting for decades. Despite numerous commitments, however, wasting continues to be a public health emergency. **Approximately 37 million children have died from severe wasting in the last 25 years.**<sup>24</sup> In 2000, the global community set the Millenium Development Goals. These goals, including the goal on reduction of poverty and hunger, were not met.

Though the Millenium Development Goals were not achieved, substantial progress was made in expanding treatment coverage during this time. This progress was made possible by two key innovations: the invention of ready-to-use therapeutic food (RUTF) and the adoption of community-based management of wasting. RUTF, invented in 1996, is a nutrient rich fortified peanut butter paste fed to children in daily doses. Over a few months, a child can fully recover. Community-based management of wasting enabled outpatient treatment with RUTF, allowing children to recover at home rather than in inpatient therapeutic feeding centers often located far from remote



*IRC training parents and care-takers in diagnosing acute malnutrition and administering treatment for acute malnutrition. Niger, July, 2021.*

communities with high burdens of wasting. Once community-based management was formally adopted as a best practice by the WHO, UNICEF, and World Food Programme in 2007, rapid progress was made as more children were able to access care. Just 15 years later, this progress has slowed and, “the proportion of wasted children who can access treatment remains unacceptably low with just one in three severely wasted children receiving treatment.”<sup>25</sup>

During the World Health Assembly (WHA) in 2012, Member States endorsed the resolution WHA 65.6, which set forth an implementation plan on maternal, infant, and young child nutrition, and established six global nutrition targets to be met by 2025. The target on wasting is to, “reduce and maintain childhood wasting to less than 5%.”<sup>26</sup> With only three years to go until the deadline, huge gaps remain on wasting treatment coverage.

In 2015, the global community, again, set goals to advance peace and prosperity—the Sustainable Development Goals (SDGs), intended to be met by 2030. Even before the onset of the COVID-19 pandemic, the targets on hunger and nutrition were very off-track. Given the socio-economic hardship of the pandemic, decades of progress on poverty, hunger, and health have been reversed.

Building on SDG 3: Ensure healthy lives and promote well-being for all at all ages, the UN General Assembly approved on the Political Declaration of Universal Health Coverage in 2019,<sup>27</sup> in which UN Member States agreed that each person should have access to the highest attainable standard of healthcare. However, wasting treatment has been left out: it is often not included as part of universal health care efforts and is not integrated into health systems as a basic service.



Recognizing the ongoing challenges, in 2020, the UN produced a Global Action Plan on Child Wasting (GAP), which is a framework for action to accelerate progress in preventing and managing child wasting and achieving the Sustainable Development Goals.<sup>28</sup> Objective four of the GAP is improved treatment of children with wasting by strengthening health systems and integrating treatment into routine primary health services. Its stated aim is to increase the coverage of treatment services for children with wasting by 50% by 2025. As part of this process, 23 countries with high burdens of wasting developed Country Operational Roadmaps, which were rolled out in November 2021.<sup>29</sup> This is an important step; however, to be realized it will require intensive planning, resourcing, implementation, and monitoring. There is limited data on treatment coverage and few benchmarks to measure progress.

Despite these efforts, expanding treatment coverage of child wasting has been neglected in comparison with other global health priorities such as HIV and routine immunizations. As of June 2020, 75% of patients with HIV are accessing antiretrovirals, up from 25% coverage in 2010.<sup>30</sup> Similarly, global immunization coverage rose from approximately 20% in 1980 to 80% in 2000.<sup>31</sup> In comparison to providing a life-long daily dose of antiretrovirals to every HIV positive person or maintaining global cold supply chains and training medical personnel to reach every person with routine immunizations, providing wasting treatment is relatively manageable.

Since the onset of the pandemic in January 2020, about 6.25 million people have died of COVID-19, 1.6 million people have died of HIV-related causes, and 5 million children under age 5 have died of wasting. HIV was declared an epidemic in 1981, and about 36.3 million people have died from AIDS-related illnesses since. In the same time-frame, at least 82 million children have died of wasting. Wasting is a public health emergency with a devastating impact on child mortality and well-being. Unlike COVID-19, wealthy people do not die of wasting. Unlike HIV, a high burden of wasting has not been prevalent in high-income countries. Inequity is central when we consider who is exposed to wasting, who can access treatment for wasting, and which areas of nutrition and health are prioritized for financing. The reality is deaths due to wasting are happening among the youngest children in low-income countries. Wasting is an 'invisible crisis,' as most children with wasting are too young to even speak, let alone advocate and organize. Equity needs to be at the heart of efforts to expand wasting treatment.

The successes in expanding coverage of routine immunization and HIV/AIDS antiretrovirals indicates the capacity of the global community to mobilize and achieve significant health gains. Scaling up funding for addressing wasting treatment coverage can enable a similar trajectory. What's more, we already know of efficacious, evidence-based, and cost-effective approaches to treating wasting.



# Wasting Treatment Efficacy



With concerted effort from governments, UN agencies, and INGOs, and with dedicated financing, we can successfully scale proven health interventions to expand treatment coverage. Unlike many other health interventions, uncomplicated wasting treatment can be administered by non-medical professionals, like community health workers. Screening can be conducted by caretakers, RUTF products are heat-stable and have long shelf-lives, and treatment can be delivered at the community level.<sup>32</sup>

Simplified approaches are simplifications to treatment protocols and programs that seek “to increase the efficiency, effectiveness, coverage, and quality of programmes” for children with wasting.<sup>33</sup> A growing body of evidence indicates that simplified approaches to wasting treatment are as effective as traditional approaches.<sup>34 35</sup> They are particularly useful in emergency settings, areas with limited humanitarian access, and places with supply chain difficulties.<sup>36 37</sup>

A range of simplified and decentralized approaches have been designed and tested, including:

- Low-literacy resources for community-based management of wasting;
- Family or caregiver screening and referral;
- Diagnosis and treatment of wasting by community health workers;
- Combining the treatment of severe and moderate acute malnutrition into one program, supply chain, and delivery-points;
- Utilizing RUTF for all wasting treatment (vs RUSF or other products for moderate acute malnutrition (MAM));
- Using middle upper arm circumference (MUAC) or oedema to determine admissions and discharge;
- Simplifying the dosage protocol of RUTF, based on MUAC; and
- Reducing the dosage of RUTF for children with wasting as they recover.<sup>38</sup>

Each simplification has been proven effective, and the various simplifications can be combined and selected as it best fits a given context.

Simplified and decentralized approaches have been proven effective in reaching children who currently lack access to diagnostic services or treatment centers. Community management of services, including community-based management of acute malnutrition, or CMAM, is particularly useful in expanding services to children in under-served and under-resourced settings.<sup>39</sup> Delivery can be further decentralized by using low literacy tools for treatment and patient monitoring. When parents and community health workers are trained in detection and management of wasting, children are able to receive treatment closer to home.<sup>40</sup> This not only increases the likelihood of sustained access to services during crises, but it is also cost-effective.<sup>42</sup>

Modeling indicates that scaled up treatment programs produce better value for money: the more children we treat, the cheaper treatment will be per child.<sup>42</sup> Research findings by organizations including Action Against Hunger, ALIMA, IRC, and UNICEF have indicated that simplified approaches use fewer resources and enhance cost-effectiveness.<sup>41</sup> This means that donor dollars could reach more children without sacrificing the efficacy of treatment programs, if simplified approaches are used. Allocating more donor dollars to the treatment of wasting is therefore a cost-effective and impactful way to improve the health and child mortality outcomes for millions worldwide.

### **INVESTMENT CASE SUMMARY:**

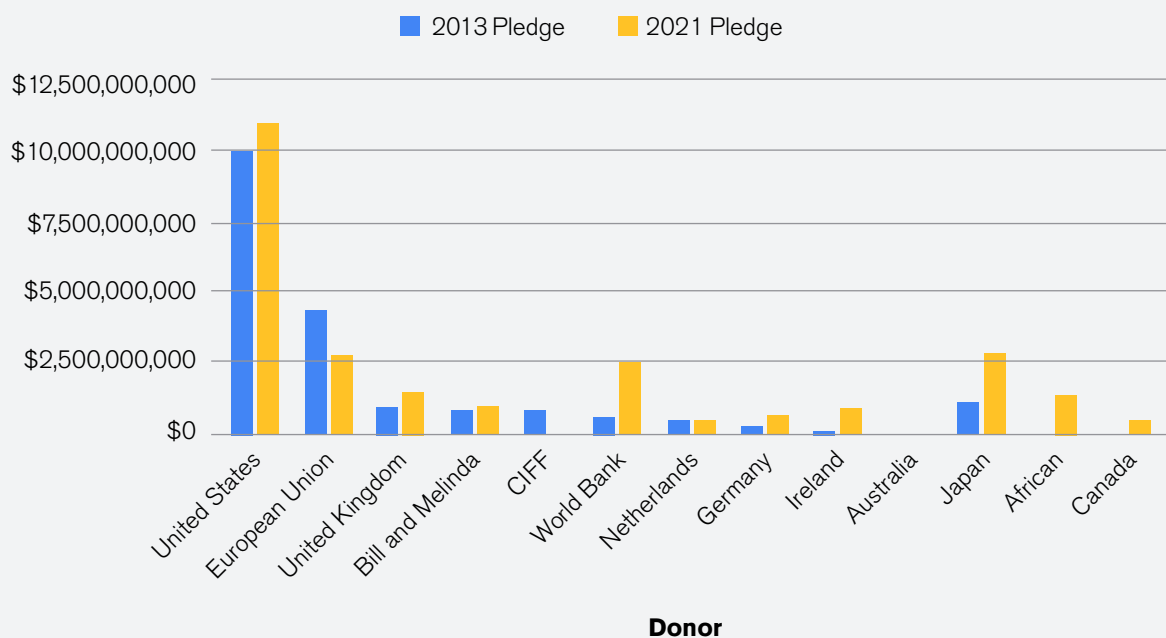
Results for Development and the World Bank estimated that \$9.1 billion would be needed over 10 years to increase treatment coverage of severe acute malnutrition to 90% averting 860,000 deaths. It should be noted; however, that outsized impacts could be achieved with just a fraction of that financing. Specifically, 49% mortality reductions could be achieved by targeting just 25% of that figure (2.3 billion) to sub-Saharan African countries over the next 10 years. These outsized gains are reflected in cost benefit ratios which the World Bank authors estimate to be roughly six times as high in sub-Saharan Africa as in South Asia and East Asia Pacific regions.

# The Opportunity of Emerging Funding

Given the immense need, donors have increasingly deemed wasting, though rarely treatment, a priority issue in health and nutrition. Donor disbursements to wasting increased between 2015 and 2019 by 18% each year, rising from \$258 million to \$507 million.<sup>43</sup> This is promising, but insufficient and not proportional to the scale of the problem. A recent investment case from Results for Development (R4D), in partnership with the World Bank and the Bill and Melinda Gates Foundation, projected that it will cost \$9.1 billion to meet the World Health Assembly (WHA) nutrition targets on wasting by 2025 (10 years from the time of publication).<sup>44</sup> Donors should scale up their pledges to close the funding gap required to meet the WHA targets in time.

At the Tokyo Nutrition for Growth (N4G) Summit, held 7-8 December 2021, donors and governments pledged more than \$27 billion to address the global malnutrition and hunger crisis. Governments also

## 2013 AND 2021 N4G SUMMIT PLEDGES



made broad commitments to increase national budgets allocated to nutrition.<sup>45</sup> Overall, 394 commitments were made linked to the three core areas of health, food, and resilience.<sup>46</sup> **This is a record number of commitments, and most pledges remain un-earmarked and open-ended, creating an opportunity to organize funding in an effective and coordinated manner.**

There is an opportunity for donors to commit a significant portion of this financing towards expanding treatment coverage for children experiencing wasting. Considering the R4D Investment Case on wasting, dedicating 1/3 of the pledges made at the 2021 N4G Summit to the treatment of wasting has the potential to increase coverage of severe acute malnutrition among children under age five by 50%.<sup>47</sup> Distributing this funding over the next 10 years could scale treatment to reach approximately 91 million children suffering from severe acute malnutrition in low- and middle-income countries. This equates to about \$110 per child in Africa and \$90 per child in South Asia.<sup>48</sup>

Donors should work alongside governments of countries that suffer from a high burden of wasting to financially support the expansion of wasting treatment. While many governments made commitments to reducing the instance of wasting in their respective countries, there is a notable gap in commitments to expanding coverage of wasting treatment.<sup>49</sup> Financing prevention and treatment of wasting are both extremely important.

The Tokyo N4G Summit witnessed a new wave of both financial and policy commitments to tackle wasting specifically. Many governments and donors pledged funding to tackle malnutrition in all its

Country	Stated Commitments at N4G to:	
	Reducing Prevalence of Wasting	Increasing Treatment Coverage of Wasting
Bangladesh	X	X
Benin	X	
Burkina Faso	X	
Burundi	X	
Chad	X	
Cote D'Ivoire	X	
DRC	X	
Egypt	X	
El Salvador	X	
Ethiopia	X	X
Guatemala	X	
Guinea	X	
Honduras	X	
Indonesia	X	
Kenya	X	X
Mali	X	X
Niger	X	X
Nigeria	X	X
Pakistan	X	X
Somalia	X	
South Sudan	X	X
Thailand	X	
Yemen	X	X

forms, which includes wasting. However, the US, Bangladesh, Canada, Ireland, and UNICEF explicitly pledged funding to improve wasting treatment. The United States—who pledged a total of \$11 billion—included the prevention and management of wasting in children under five as one of the top six priorities in its 2021-2026 global nutrition strategy.<sup>50</sup> Ireland committed to supporting innovative approaches for the prevention and treatment of wasting for children aged 0-6 months.<sup>51</sup> The Government of Bangladesh committed to expanding and investing in community-based nutrition services, especially infant and

young child feeding (IYCF) and community-based management of wasting.<sup>52</sup> Dedicated national efforts to implement simplified approaches have the potential to increase access to treatment for children suffering from wasting. The Government of Canada pledged CAD\$520 million (\$408 million) “for nutrition-specific investments over the next five years to address wasting and the underlying determinants of malnutrition.”<sup>53</sup> UNICEF also pledged to mobilize an additional \$800 million in 2022 to accelerate global efforts for the prevention, early detection, and treatment of child wasting as part of the agenda on the Global Action Plan on Child Wasting.<sup>54</sup>

It is encouraging to see some governments committing to expand treatment of wasting, but given the scope of the crisis, a broader cohort of dedicated donor support is needed. These commitments are significant, though they provide an opportunity rather than a cohesive strategy.

The \$27 billion committed at the N4G Summit, as well as additional funds committed to nutrition in 2021 and 2022, can make a significant impact on children’s health and mortality through national health systems. Donors and governments can maximize impact for their money by committing a significant allotment of funding to address wasting, with a portion dedicated to expanding wasting treatment coverage.



# Financing Wasting Treatment at Scale



Investing in wasting treatment is not only a moral imperative and cost-effective way to achieve humanitarian impacts, it is also an untapped political opportunity. An effective investment approach that drives wasting treatment to scale offers a chance to point to a very clear and compelling outcome on a relatively short timeline: millions of children cured of wasting.

The status quo approach to funding has not resulted in improved coverage of wasting treatment. As discussed above, the percentage of wasted children receiving treatment has been stalled at 20% for nearly a decade. Current funding for wasting treatment is too often fragmented, reactive, and unaccountable to both sector wide goals and the clients it is meant to serve. These structural issues are preventing donor contributions and other nutrition financing from achieving the maximum impacts.

At present, financing for wasting treatment is a patchwork of sources, recipients, geographic foci, timelines, targets, and metrics. This approach results in gaps, overlaps, and significant inefficiencies. Individual donors each bear the full management and transaction costs for the funds they contribute. Worse still, national and frontline implementers have to report against multiple funding streams with different indicators on different timelines—at an opportunity cost to actual service delivery.

In addition to being uncoordinated, more than 54% of financing for wasting comes through humanitarian channels in response to an acute crisis.<sup>55</sup> Humanitarian financing is intended to address time-limited and unpredictable needs. It is,

by design, short-term, unpredictable, and reactive. Yet, while the number of children affected by wasting might vary predictably by season and less predictably in response to conflict or disaster, wasting is a constant threat in high burden contexts. To achieve and sustain high coverage, treatment programs must ramp up over time, serving predictably large numbers of children at steady state. They must also have the capacity to surge above steady state, quickly in response to unpredictable crises. In turn, operating such a program requires resources that are predictable and sustained over time and that can surge quickly in an emergency. Reactive funding risks arriving months into a crisis, flowing into treatment programs with limited absorptive capacity.

A third and final shortcoming is that current funding is not organized around a sector-wide goal nor is there systematic accountability for progress toward agreed outcomes. There has been no overarching treatment goal—in terms of quality or coverage—to which the patchwork of financing streams, projects, and strategies align. In turn, measurement of progress is inconsistent and there is no mechanism for identifying gaps in progress and ensuring remedial action.

Closing the coverage gap in wasting treatment requires not just earmarking funds but channeling them through the **right structure, at the right time, under the right governance**. Specifically we argue that:

- Funding streams should be pooled, feeding into coherent national and regional strategies through a single process. Pooling funds could enable

economies of scale and negotiating power that can be used to reduce the costs of both ready-to-use therapeutic-food (RUTF) and the health systems needed to deliver it. It could also reduce transaction and management costs.

- To both build delivery systems and allow them to surge in times of crisis, financing should be reliable at a steady state and able to ramp up quickly at the first warning signs of nutrition-related shocks. The pooled fund should aim to make investments over five to ten year timelines, at a minimum. Ensuring that children have sustainable access to treatment for wasting takes long-term planning, coordination, and resourcing. For instance, long-term financing could enable a sustained pre-stock of RUTF before a lean season. Communities, governments, and health systems are more likely to be able to respond immediately when unexpected shocks occur if long-term funding is in place.
- Financing should align with an agreed sector-wide goal for quality, cost-effectiveness, and treatment coverage. Progress toward that goal should be transparently, rigorously, and regularly evaluated. Results should be reviewed by an inclusive, legitimate, and effective governance and accountability body with the ability to reward performance and remediate gaps. Governance arrangements must include a meaningful role for implementing regions and countries, and client groups must be included and empowered to make decisions. Evaluating the speed and equity of progress will require investment in reliable disaggregated data.

# Recommendations

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Currently, a low percentage of children with wasting are accessing treatment, leading to almost 2 million child deaths annually. A vast expansion of treatment coverage is within reach. Donors can finance the scaling up of well-researched simplified approaches to reach children in places that are currently unreached. It is scalable and cost-efficient. We cannot let this opportunity pass. To this end, the IRC recommends:



## **DONORS SHOULD:**

- Ear-mark a significant allotment of N4G pledges for wasting treatment;
- Invest in wasting at five to ten year timelines, at a minimum;
- Pre-arrange financial mechanisms to surge funding at the warning signs of nutrition-related shocks;
- Align financing with a agreed sector-wide goals for both quality and coverage of treatment, against which progress should be transparently, rigorously, and regularly evaluated;
- Scale up results-based funding for treatment, involving the assessment of coverage, quality, and cost-effectiveness integrated within the health system and child survival community strategies;
- Update the 2017 World Bank and R4D Investment Case in consultation and agreement with a diverse and inclusive group of stakeholders to mobilize resources;
- Establish a pooled financing mechanism that feeds into coherent national and regional strategies through a single process; and
- Link financing to a legitimate, inclusive, and effective governance and accountability mechanism that tracks progress against outcomes and directs resources to fill gaps.



## **THE UN SYSTEM SHOULD:**

- Support the implementation of the GAP target to scale up wasting coverage by 50% by 2025 and aim to reach 80% coverage by 2030, and establish additional global targets and indicators on treatment coverage; and
- Publish global guidelines that adopt a public health approach to wasting treatment that explicitly prioritizes simplification, decentralization, and scale and endorses evidence-based approaches for scale.



## **GOVERNMENTS IN COUNTRIES WITH A HIGH BURDEN OF WASTING SHOULD:**

- Adopt a public health approach in national strategies to meet scaling targets that prioritizes effective and efficient delivery strategies;
- Set national level targets and plan processes for subnational and community level outreach to meet treatment targets;
- Work with the health system to implement simplified approaches to wasting treatment. Community-based management of acute malnutrition should incorporate evidence-based simplifications to increase coverage and cost-effectiveness;
- Collect and analyze reliable and disaggregated data on wasting treatment coverage; and
- Develop financial benchmarks for national plans on wasting, devote more funding to wasting treatment coverage in national health budgets, and work with donors to secure the necessary funding to implement them.

# Endnotes



1. [https://www.who.int/health-topics/malnutrition#tab=tab\\_1](https://www.who.int/health-topics/malnutrition#tab=tab_1)
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3. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8050919/#:~:text=Children%20with%20severe%20acute%20malnutrition%20are%20nearly%2012%20times%20more,due%20to%20severe%20acute%20malnutrition.>
4. <https://www.unicef.org/press-releases/unicef-additional-67-million-children-under-5-could-suffer-wasting-year-due-covid-19> Given UNICEF's projection that 6.7 million children were at risk for acute malnutrition in 2020, it is estimated that 52 million children in 2020 experienced wasting.
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7. <https://www.actionagainsthunger.org/publication/2021/08/state-evidence-2021-modifications-aiming-optimize-acute-malnutrition-management>
8. <https://acutemalnutrition.org/en/countries>
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10. The World Bank, in partnership with R4D, estimated that \$9.1B would be needed to scale wasting treatment over 10 years to reach 90% of children in need. However, this analysis also notes that outsized gains could be achieved with just a fraction of that investment. Specifically, a 50% reduction in mortality from wasting could be achieved by investing just 25% of the total amount (about \$2.3B over 10 years) in Sub-Saharan Africa. Further, in 2021, UNICEF released a country-level cost estimate in line with its Global Action Plan on Wasting. The combined cost estimate for wasting treatment across the 23 participating countries was \$946M annually. This total was costed against country generated targets for wasting coverage largely expressed in percentage

increase, rather than absolute, terms. Considering the limitations of insufficient data, limited lives saved modeling, and varied estimates, IRC estimates that \$1 billion annually is needed to scale up treatment coverage to reach all children in need. However, more research and analysis is needed.

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