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CASE STUDY 6

# PAKISTAN

## Scaling Up Management of Wasting in Pakistan: A Case Study

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# 1.

# Context

## Context

# Integration of essential nutrition interventions into primary healthcare in Pakistan to prevent and treat wasting[1]

### Overview of child wasting in Pakistan

Child undernutrition remains a public health problem in Pakistan that contributes to high rates of child mortality (currently 74 deaths per 1,000 live births) and impedes national socioeconomic development. Rates of wasting (acute malnutrition) and stunting (chronic malnutrition) in children under five years are extremely high at 17.7% and 40.2% respectively, and around 5.9% of children are concurrently wasted and stunted (Government of Pakistan (GoP), 2018). Pakistan is one of the first countries in the world to adopt national goals in line with the global Sustainable Development Goals (SDGs) to achieve a 40% reduction in stunting and reduce and maintain wasting below 5%. However, progress towards this is slow. Stunting levels have only marginally declined since 2001 (average reduction rate of around 0.4%) and wasting levels have increased (from 12.5% in 1990 to 17.7% in 2018) (GoP, 2018).

Maternal factors play an important role in early infant growth failure in Pakistan. According to the National Nutrition Survey 2018, 14.4% of women in Pakistan are underweight, 42.7% of women are anaemic, and uptake of iron and folic acid (IFA) supplementation is low at 32.9% (GoP, 2018). Infant and young child feeding practices are also suboptimal. Less than half of mothers (45%) practice early initiation of breastfeeding, around half (48%) practice exclusive breastfeeding of infants aged less than six months, one in every three infants age 6-8 months is fed complementary food and only 3.6% of children 6-23 months receive a minimum acceptable diet (GoP, 2018). Food insecurity, another key driver of undernutrition, is also extremely high, with 58% of households estimated to be food insecure (GoP MPDR, 2018).

1 Modified from two Field Exchange field articles in issue 63 by Dr Baseer Khan Achakzai, Eric Alain Ategbo, James Wachihi Kingori, Saba Shuja, Wisal M Khan and Yasir Ihtesham www.ennonline.net/fex/63/pakistanintegrationstoryofchange and Saba Shuja, Eric Alain Ategbo, Yasir Ihtesham and Khawaja Masood Ahmed www.ennonline.net/fex/63/wastingstuntingconnectionpakistan

### Evolution of wasting treatment in Pakistan

Community-based Management of Acute Malnutrition (CMAM) was first implemented in Pakistan in 2005 in response to high levels of child wasting in disaster-prone areas of the country. Between 2005 and 2011, CMAM was implemented as a vertical, standalone, donor-funded emergency programming including response to flash floods and riverine in 2010 and 2011 in Punjab and Sindh provinces. During this period CMAM was implemented by external agencies through available government structures, where possible, coordinated by the Nutrition Cluster.

From 2012, guided by national CMAM guidelines (developed 2010 and updated 2015), the government began driving the scale-up of CMAM in selected emergency and non-emergency districts. This was implemented through provincial nutrition projects (within provincial PC1s)[2] via a separate cadre of staff, supply chain and information management systems, in parallel to the government health system.

From 2018, work began to fully integrate CMAM programming within the routine package of services delivered at primary healthcare level in Pakistan, in the context of the delivery of a 'minimum essential nutrition package'. This included the utilisation of government health workers (Lady Health Workers) for service delivery, integration of nutrition supplies within the health commodities logistics management system and incorporation of nutrition indicators within the Health Management Information System (HMIS). This process of integration is being guided by the Disease Control Priority approach (DCP3) with support from a Technical Group led by the Government of Pakistan (GoP) Ministry of Health, with input from United Nations Children's Fund (UNICEF) and it is also embedded within the strategic framework of the Pakistan Multi-Sectoral Nutrition Strategy (PMNS) 2018-2025 and federal and provincial PC1s 2020-2025.

While coverage of CMAM services remain low in Pakistan (less than 10%) this is an important period of transition towards the mainstreaming of wasting treatment services within primary healthcare services that provides an existing opportunity to rapidly scale-up services towards full coverage.

2 Government development plans

# 2.

# Key Successes

**Success of CMAM as an emergency response:** From 2005 to 2011 the roll-out of CMAM services as part of the emergency response to several disasters in Pakistan averted child deaths and spotlighted the success of the CMAM approach in Pakistan. This was a major driving force in the uptake of CMAM by the Government of Pakistan.

**Initial scale up to high prevalence areas:** From 2012 to 2019, the Government's drive to scale up CMAM services resulted in the establishment of wasting prevention and treatment services in all four provinces of the country (in all districts in Punjab, and many in Sindh, Balochistan and Khyber Pakhtunkhwa). In 2019, overall coverage was around 5%, with 265,000 children treated for severe wasting and 157,000 children treated for moderate wasting countrywide. While this is minimal compared to the needs in-country, it was regarded as a significant step forward for the management of child wasting in Pakistan.

**Drive to mainstream CMAM services into primary health care:** In 2018, the Government endorsed the Astana Declaration on public health revitalisation and subsequently adopted the Disease Control Priority approach (DCP3)[3]. Nutrition partners, including World Bank, UNICEF, World Health Organization (WHO) and World Food Programme (WFP), were able to seize this opportunity to push for the mainstreaming of nutrition services into the primary healthcare system. A 'minimum essential nutrition package' was thus developed for delivery through government primary healthcare facilities that included CMAM services. This is a key success of the process of scale-up to date and provides real potential for higher coverage of services across the country.

**Drive to embed wasting treatment services within stunting reduction strategies:** The integration of the management of child wasting within the Pakistan Multi-Sectoral Nutrition Strategy (PMNS) 2018-2025 and PC1 for 2020-25 (that primarily aims to increase reductions in stunting prevalence) reflects a new understanding of the concurrence of wasting and stunting, and wasting as an important driver of high stunting levels in the country. Embedding wasting prevention and treatment at the heart of stunting reduction strategies promises to provide greater visibility, and opportunity for the resourcing of CMAM services at-scale.

3 http://dcp-3.org/

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# Enablers and barriers to the scaling up of wasting treatment

## Enablers

**Important strategic and guiding frameworks:** An important political impetus for the initial scale-up of CMAM services from 2012 was the development of national CMAM guidelines in 2010. This was driven by the Government of Pakistan, with support from UNICEF, WFP, WHO and non-governmental organisations (NGOs). This provided a much-needed framework to guide future scale-up. The integration of CMAM into provincial level plans (PC1s) 2015-2020 enabled leadership and roll-out of CMAM services at provincial level, which was important in the context of devolved government. Inclusion of wasting treatment and prevention within the Pakistan Multisectoral Nutrition Strategy (PMNS) 2018-2025 has been critical in recent years to put wasting treatment at the heart of the government's stunting reduction strategy. Inclusion of wasting treatment in the federal PC1 for 2020-2025 (targeted to the poorest sections of the population; 35% of the population overall) has also been important in accelerating the potential for higher coverage of treatment services.

**Utilisation of Lady Health Workers (LHWs):** Until recently, CMAM services in Pakistan have been delivered by nutrition assistants at health facility level – a special cadre of staff not on government payroll, recruited as and when needed. Over recent years, work has been taking place to utilise Pakistan's army of community LHWs to boost the nutrition workforce. This approach has been evolving over the last seven years and has now been integrated into the federal PC-1 2020-25 to increase service coverage. Training to support this is currently being cascaded from district-level managers, to facility-based nutrition assistants, to LHWs. In the context of COVID-19, online training modalities are being used. Pre-service training for different health cadres is also being explored.

**Development of a sustainable supply chain:** Local production of lipid-based specialised nutrient supplements (ready-to-use therapeutic food (RUTF) for the treatment of severe wasting, and ready-to-use supplementary food (RUSF)) for the treatment of moderate wasting are now at advanced stages of production and are being used in the implementation of CMAM programming. To sustain local production, the Government has passed a bill for tax exemption on imported raw materials used in RUSF production; efforts are being made to obtain a similar exemption for RUTF production. This will increase the cost-effectiveness of the programme and pipeline sustainability and will enable the expansion of production. Efforts are also underway to include imported multiple micronutrient supplementation (MMS) tablets and sachets in the essential drugs list.

**Integration within the government information system:** For many years, a parallel system of reporting was used for CMAM programming. As part of mainstreaming efforts, nutrition indicators (including those related to CMAM) are now being integrated within the existing District Health Information System (DHIS) to streamline nutrition information and reporting. This will help to inform future scale up efforts.

**Costing and resource allocation:** A cost-effectiveness analysis for the proposed minimum essential nutrition package is being carried out by the Ministry of National Health Services, Regulation and Coordination (MoNHSR&C), with technical support from UNICEF. To support this process, the nutrition section of the MoNHSR&C is developing a nutrition investment case for each of the four provinces (using Optima Nutrition)[4]. The results of this process will be used to inform advocacy for the allocation of the necessary resources to implement CMAM at scale in Pakistan through the primary healthcare system.

## Barriers

**Historical omission of wasting treatment in government strategies:** Historically, wasting was regarded as a short-term problem in Pakistan, limited to emergency settings. CMAM services were therefore implemented as vertical, externally led and funded programmes. The major push towards multi-sectoral programming was to reduce levels of stunting within the country, through the scaling up of multi-sectoral programming as part of the Scaling up Nutrition (SUN) Movement, which also reinforced this siloed thinking and hindered the inclusion of wasting treatment services within government strategies and plans until recently.

**Vertical staff, supply chain and information systems:** Although CMAM services from 2012 across all four provinces have been housed under the same roof of government health facilities, they have been run in parallel to routine health services. CMAM services were implemented by a separate cadre of health staff (nutrition assistants) who were recruited and maintained on a project-basis when resources allowed, making for an unsustainable workforce. In addition, supplies were managed outside of the routine supply chain system and CMAM information was managed outside of the government information system. This led to weaknesses in the information and supply and logistics systems and reliance on short-term funding grants to keep CMAM programmes running, severely limiting both coverage and longer-term sustainability.

**Reliance on short-term, external funding:** In the initial years of CMAM programming in Pakistan, the approach was funded in specific emergency-prone areas as part of the external emergency response. As CMAM was adopted and scaled-up by government (2012-2019) the reliance on short-term external funding remained. For many years this hindered the efficiency and effectiveness of the programme and further scale up.

4 http://optimamodel.com/

# 4.

# Moving forward

**The process of mainstreaming CMAM services into primary healthcare in Pakistan is ongoing. Immediate next steps are to add wasting management to the health function of the Government's Five-Year Plan (2018-23) and National Action Plan (2019-23).**

In addition, a comprehensive national and provincial level nutrition review is to be conducted, to inform the development of a consensus-based national nutrition policy and standardised nutrition programming approach that encompasses all major determinants and manifestations of nutrition. This process is being steered by the MoNHSR&C and Ministry of Planning, Development and Reform (MPD&R), with technical support from UNICEF.

Another key next step is to advocate for the necessary allocation of resources to fund the mainstreaming of CMAM services (within the minimum essential nutrition package delivered through primary healthcare facilities). This will be informed by the costing exercise currently underway by the MoNHSR&C. Training of all necessary cadre of health staff will continue to be rolled out, including LHWs, with priority given to areas of the country at high risk of polio, with particular attention to districts with high burdens of severe wasting. Following this, the approach will be scaled up across the country as a whole.

## References


1. Government of Pakistan, Ministry of National Health Services, Regulations and Coordination, Nutrition Wing (2018) National Nutrition Survey 2018

2. Government of Pakistan and UNICEF (2018). Pakistan National Nutrition Survey 2018. Available from: www.unicef.org/pakistan/reports/national-nutrition-survey-2018-key-findings-report

3. Government of Pakistan Ministry of Planning, Development and Reform (GoP MPDR) (2018) Pakistan multi-sectoral nutrition strategy 2018-2025.