CMAM 2021

22-25 March

VIRTUAL CONFERENCE

SCALE PAPER

INTEGRATION OF SEVERE WASTING SERVICES INTO HEALTH SYSTEMS

Preparing for Scale

CONCERN worldwide

Irish Aid
An Roinn Gnóthaí Eachtracha agus Trádála
Department of Foreign Affairs and Trade

Integration of severe wasting services into health systems: summary of key points for going to scale

CONCEPT

Further integration of services for the management of severe wasting into public health systems, especially at community and primary care levels. This should be the aim even in fragile contexts because it is the only real pathway to achieving meaningful scale.

Recognise that innovative financing mechanisms will be needed to help governments shoulder the costs of wasting services.

CURRENT SCALE

70 countries have community based management of child wasting reflected in national policies, but functional integration is only partially achieved.

PRACTICAL CONSIDERATIONS FOR SCALE UP

Health sector implementation strategies and protocols must be reviewed to identify where and how specific adaptations are needed to integrate severe wasting (particularly IMCI and iCCM and Child Health Days). Inclusion of severe wasting management into broad health policies is a first step but not enough.

A number of global guides on how to integrate severe wasting into health systems exist or will soon be published. These offer a useful starting point for country level guidance.

Procurement and transport of RUTF is a central challenge due to its cost and bulkiness. A phased plan will likely be needed to integrate this responsibility into fragile government health systems. Adding RUTF to the Essential Medicines List in high burden countries may facilitate integration.

Wasting management tasks should be integrated into the standard roles and responsibilities of all health workers that have contact with children at facility and community level as well as pre-service and on-the-job training strategies.

Supervisions systems and tools and health information management systems (HMIS) are also key points for integration.

Integration of tasks related to the screening and referral of wasted children into community-health systems must avoid adding to the current workload of overstretched community-health workers/ volunteers. Family MUAC offers significant potential to help strike this balance.

Accurate costing of all inputs required for the management of severe wasting, including RUTF, at different levels of service coverage is critical to the integration process. Innovative financing mechanisms that can more efficiently fund wasting services from within the health system are needed.

CRITICAL NEXT STEPS

Analyse existing health systems and support functions to identify opportunities for integration of the management of severe wasting at community and primary health care levels.

Establish accurate costs for managing severe wasting, and calculate the potential cost-savings resulting from integration actions identified in the above analysis.

Map where funding for the management severe wasting is coming from and how it is being.

Identify a focal point within the Ministry of Health who can lead the integration of severe wasting.

Work together to develop more innovative, long-term financing mechanisms for wasting services within health development funds.

Support financial modelling of longer term costs and cost-savings to be gained by integrating services for the management of wasting through government health funding.

This document is a summary of group work conducted during the CMAM 2021 conference in March 2021. The conference did not provide adequate time for lengthy discussions of these important topics, and therefore this document represents a starting point to refine discussions on bringing key adaptations and approaches to wasting management to scale. Concern is immensely grateful to all practitioners who took the time and interest to contribute to this document.

Mother Munira (28) with her 18 month old daughter Malika being seen by a Banadir Hospital Doctor. Malika became malnourished from acute diarrhoea. Somalia.

Photography: Gavin Douglas/Concern Worldwide

Brief Description

The scaling up of services for the management of child wasting has been ongoing since the advent of Community Management of Acute Malnutrition (CMAM) in the early 2000s, but progress to shift from vertical specialised CMAM programmes to integration in public health services has been slow. This paper focuses on the integration of resources and actions to manage *severe* wasting and nutritional oedema in children - including detection, referral, treatment and follow up - into the functions of public health systems.[1] The aim of integration is to improve and sustain access to and uptake of quality wasting services and improving reach and efficiency with resources that are often limited. Integration is not a goal in itself. The ultimate aim of integrating severe wasting services is to improve child survival and development, and integration is a means to this end. We must pursue integration with a holistic view of the health system and the full package of essential child and maternal health services – not just those for the management of severe wasting - in each context.

In many countries, services for severe wasting are often run in parallel to other child health services – delivered only on certain days, by certain staff or in certain locations within or sometimes outside the main health facility. Successful integration of severe wasting services will ensure there are no missed opportunities to screen, refer and treat any wasted child encountered at any point of contact in the health system. It will also put families at the centre – reducing time and out of pocket expenses incurred by attending different services for different purposes.

The six WHO health system building blocks offer a useful framework for analysis on where integration needs to happen: 1) governance and leadership 2) financing 3) health workforce 4) service delivery 5) supplies and 6) health information systems. However, true integration will require in-depth analysis of the specific health system functions and processes that fall within and across these building blocks. It will also require strong analysis of community health systems, health system responsiveness to shocks and changing need, and equity – issues that are not always well captured by the basic six building blocks.[2] Integration must be led by the higher levels of each government's health system - not just nutrition actors, non-govermmental organisations and civil society entities – or it is not likely to be successful.

1 Some consider the management of wasting to include the above plus prevention of wasting. This brief and the working group that contributed to its content was asked to specifically focus on the above aspects and only on severe wasting (and nutritional oedema). Note, wherever the term wasting is used, it refers to both wasting and nutritional oedema.

2 The Maintains project provides a useful model for understanding the attributes of a shock-responsive health system by Newton-Lewis et al, Maintains Working Paper: What is a Shock-Responsive Health System?, June 2020 (model on p2)

Where and when to integrate

There was agreement in the CMAM conference working group that integration of services for severe wasting into public health policies and specific care protocols should be the goal in almost all contexts with a high burden of severe wasting - including fragile contexts. Delivery through public health services, particularly at the primary and community level is the only way to achieve economies of scale and to sustain access to services for severe wasting over time. However, in many high burden contexts the existing health services and infrastructures are still inadequate to achieve this. Several important risks/trade offs, therefore, must be considered before any government decides to accelerate integration of severe wasting services. The first risk is that the quality of services to manage severe wasting may decline if not sufficiently resourced. While this is a risk, it is important to consider the potential gains in coverage that integration offers for services users and families.

The second, and often overlooked, risk is that the quality of other services of equal or greater public health importance will suffer. Decisions on the pace of integration must therefore consider the relative burden and mortality risk of severe wasting vis-a-vis other child and maternal illnesses in each context. It must also consider the relative costs (and ideally cost effectiveness) of delivering preventative and curative services for each priority illness and how integrating severe wasting services may negatively (or positively) affect those other vital services considering the capacity of a given health system. The working group also agreed that integrating the management of moderate wasting within government health system is likely to overburden the majority of health systems in fragile contexts and will need to be decided on a country-by-country basis.

Where and when to integrate

Clearer criteria for making the decision of when and where to integrate services for moderate and severe wasting are needed. However, three priority areas of integration include:

- *Colocation*: services for severe wasting should be delivered within primary care facilities on the same day as child health consultations and postnatal care (i.e. every day) to meet children's holistic health needs and ensure treatments can be started the same day;
- *Integration into protocols for infant and child health services at facility level*. Screening and treatment protocols should be such integrated into all curative and preventative service protocols, including Integrated Management of Newborn and Child Illness (IMNCI) and postnatal service protocols
- *Integration into community-level services*. All community-based service providers should know, as a minimum, how to screen, refer, health check, and monitor progress of severely wasted children; CHW-led treatment of severe wasting is highly desirable where capacity and support exists.

Ultimately, each Ministries of Health in these high-burden contexts will have to decide the appropriate pace and approach to integrating wasting services based on the public health priorities and the specific costs for those services at facility and community level in their context. It is possible for governments to pursue functional integration while still being supported on the financing side via more integrated bilateral or pooled funding approaches with donors – see Finance section below.

Direct, emergency provision of nutrition (and health) services by non-governmental actors may still be required during exceptional crises or in some locations where the government is simply unable to provide adequate services, but this must be a strategy of last resort. In all scenarios, humanitarian partners should seek opportunities to integrate wasting services into whatever health system exists – preparedness measures should include exactly this type of analysis. The CMAM Surge approach can help build more resilient, shock-responsive health systems by helping governments and supporting partners prepare for fluctuating caseloads and identify when certain actions or external support may be needed during at different times of the year and what form they should take.

Evidence

A recent systematic review assessing the impact of integrating nutrition services into health systems on key health outcomes, including coverage of nutrition services, uptake of other health services, child mortality, child morbidity, or cost-efficiency.[3] Evidence of impact for integration of services for wasting management were particularly sparse. However, integration of other nutrition-specific interventions into community and primary health care approaches such as integrated management of childhood illness (IMCI), integrated community case management (ICCM), child health days and vaccination, showed a positive effect on some nutrition and health outcomes, including early initiation of breastfeeding, care seeking for children with danger signs, and underweight.[4] The systematic review did conclude, however, that 'there is much potential for integrating nutrition interventions into health and related programmes to ensure adequate, efficient service delivery and impact on nutrition and non-nutrition outcomes." Considerable operational experience also suggests integration of management of wasting into health systems has the potential to yield benefits in terms of coverage and cost-efficiencies. However, there is very limited evidence on how to do this well and which integration approaches are the most effective at optimising child health and nutrition outcomes and cost-efficiency. There are, however, some emerging frameworks for assessing and tracking the level of integration of wasting services, and a recent report by ENN offers a stakeholder perspective on barriers and enablers. [5] [6] Finally, a forthcoming UNICEF wasting integration guide developed in partnership with Results for Development (R4D) will also outline key steps and tools for this process.[7]

3 Salam, R.A., Das, J.K. & Bhutta, Z.A. 2018. Integrating nutrition into health systems: What evidence advocates. Matern Child Nutr, 2019, 15(S1):e12738.

4 Ibid

5 Deconinck et al. 2016. Integrating acute malnutrition interventions into national health systems: lessons from Niger. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-2903-6

6 Akwanyi, B., James, P., Lelijveld, N., and Mates, E. Scale up of severe wasting within the health system: A stakeholder perspective on current progress. ENN March 2021. https://www.ennonline.net/scaleupseverewastinghealthsystem

7 The guide is being funded by the Eleanor Crook Foundation and Child Investment Fund Foundation. For more on R4D's work see https://r4d.org/projects/strengthening-systems-for-the-treatment-of-acute-malnutrition/

Practical considerations for scaling up the adaptation/approach

Efforts to integrate wasting management into health systems over the last 20 years have yielded a number of practical considerations for countries wanting to take this further.

- **Policies.** Community based management of severe wasting is reflected in the health policies of more than 70 high-burden countries, and it is officially part of the essential health package for children in a large number. However, in order for integration and scale up of severe wasting services within health systems to succeed, governments and supporting partners must identify where and how existing implementation strategies, protocols, and standard operating procedures must be changed to include severe wasting. Key services include IMCI, iCCM, vaccination, Child Health Days, post-natal care for at-risk children under-six months and health promotion. A clear action plan for those adaptations then needs to be carried out.
- Effective detection and referral of severely wasted children rely on clear government strategies and support for community-level health services. Unfortunately, these services are often weak and/or underfunded, and all actors must be careful not to overburden community health workers further. Their workloads, expectations and links with facilities and other parts of the health system must be fully understood before adding any tasks related to severe wasting. The Family MUAC approach has significant potential to help strike this balance.

High-level leadership and political commitment within the Ministry of Health (not just led by the nutrition department) and close coordination between and within ministries is critical to meaningful integration. NGOs, the UN and donor agencies must also better align and integrate their agendas for health and nutrition and ensure detection, referral, treatment and follow up of wasting is integrated into global health guidelines and the package for Universal Health Care (UCH).

Practical considerations for scaling up the adaptation/approach

- **Guidance and tools.** Guidance and tools on how to more effectively integrate wasting services need to be highly contextualised to the health systems in each country. In some countries, guidance may even need to be adapted to specific zones in the country as there can be different health structures and strategies. The global guide currently under development by UNICEF and R4D may be a useful starting point, but it will need to be rapidly adapted based on a strong analysis of the specific health system functions in each country.

Any guidance will also be most effective if embedded within a broader health system strengthening guide or tool so integrating nutrition becomes part of that ongoing process. Action Against Hunger's guide on Health System Strengthening: from Diagnosis to Planning can help governments and particularly supporting partners identify bottlenecks in health service delivery, including services for severe wasting.[8] The Universal Health Care Compendium, which is a database of health services and inter-sectoral interventions, could help identify key points for integration.

- **Supply chain.** The main supply chain issue is RUTF, given its cost and bulkiness to transport. Integrating the financing, procurement, and delivery of RUTF into government health systems is likely to prove one of the biggest challenges and will require a detailed analysis of each government's financial resources, budgeting processes, and medical procurement and distribution systems. Governments already have systems and tools to finance, procure and deliver other health commodities, which may already or should be the focus of broader health system strengthening efforts.

8 ACF, 2017 https://knowledgeagainsthunger.org/technical/health-system-strengthening-from-diagnosis-to-planning/

Practical considerations for scaling up the adaptation/approach

Undoubtedly, integration of RUTF into these systems (and into any broader health supply chain strengthening efforts) will need to be phased in gradually in fragile contexts, where these systems may already be weak. Adding RUTF to the Essential Medicines List in each country has generally helped facilitate procurement via national supply systems, although with a few caveats (see Promising Practices, below).[9] [10]An important first step is to build capacity to estimate the costs of RUTF procurement and delivery, including the 'last mile' to health facilities. Country-specific tools adapted to the systems for supply chain management in each country will most certainly be needed.

A second important step is to map out how those RUTF and other wasting management costs should be incorporated into national and sub-national budgets and planning processes in the correct format and at the right time. There is a huge role for UNICEF, WFP, other UN agencies and donors to play in supporting governments to do this supply chain analysis and develop a clear and realistic plan to strengthen government supply chains and empower the government to gradually take on this responsibility. The Country Roadmaps on Wasting being developed to achieve the Global Action Plan on Wasting may be an important opportunity to do this (see Finance section, below).

Note, other commodities that will need to be procured include MUAC bands, weighing scales and height boards, inpatient therapeutic milks and a limited number of inpatient feeding supplies that may not be on routine procurement lists. Essential medicines to treat underlying illnesses among severely wasted children in inpatient and outpatient facilities should be already procured via normal government procurement channels for child health, though these systems may need strengthening. The supply of MUAC bands required will depend on the screening strategy in each country; where Family MUAC is being implemented, the needs are likely to be at least 50 fold what it might be if only health workers and community health agents were screening.

9 Du Chatelet A, et al. Process and impact of integration of ready-to-use therapeutic foods in national essential medicines lists in In: WHO technical consultation: Nutrition-related health products and the World Health Organization Model List of Essential Medicines – practical considerations and feasibility. Geneva, Switzerland, 20–21 September 2018, Geneva, World Health Organization, 2019 https://cdn.who.int/media/docs/default-source/nutritionlibrary/publications/nutrition-related-health-products-and-the-world-health-organization-model-list-of-essential-medicines-practical-considerations-and-feasibility/lem-du-chatelet-et-al-2019.pdf?sfvrsn=46b0880b_4

10 Emergency Nutrition Network. 2019. Nutrition and Health Integration: A Rapid Review of Published and Grey Literature. https://www.ennonline.net/resources/nutritionandhealthintegration

Practical considerations for scaling up the adaptation/approach

- **Workforce.** It is important that relevant and clear tasks associated with detection, referral, treatment and follow up of wasting are integrated into the responsibilities and job descriptions of all formal health workers that may come in contact with a child at risk of acute malnutrition at community or facility level. However, all of this must be done with a full understanding of the current expectations and workload of those staff, how they link with the other parts of the health system, and the time and skills required for any additional wasting-related task the health worker is being asked to do. The aim is identify efficient ways to incorporate wasting management tasks into the routines of key staff, rather than just adding to a list. Compromises will likely need to be made. The specific tasks to integrate will depend on the function of the staff cadre, but critical are all clinical staff (e.g. nurses, medical officers) who diagnose, treat or provide preventative services for children under-five.

Community health worker responsibilities should, at a minimum, include screening and referral of wasted children via MUAC and oedema and follow-up via home visits, but, in some contexts, may also include treatment of wasting.[11] The expectations of other less formal community health agents who work on more of a voluntary basis should also be reviewed to include, where feasible, MUAC/ oedema screening, referral and follow up of wasted children, in coordination with the role of the more formal CHWs. All revised responsibilities will require initial and refresher training, supervision and provision of the necessary supplies, see below.

Finally, there is a need to broaden the skills of the nutrition 'workforce' within the non-governmental humanitarian and development sector to promote broader health system analysis and strengthening. This may be achieved in part by integrating health and nutrition teams/experts and by building the capacity of nutrition staff within NGOs, the UN and donor agencies on health system functions and the practicalities of integration within the broader child health agenda. The should include targeting the most vulnerable children and at risk mothers/ infants to provide targeted support for prevention.

11 See the companion brief: Preparing for Scale: CHW-led wasting treatment for more on this.

Practical considerations for scaling up the adaptation/approach

- **Capacity strengthening and supervision.** Pre-service training for formal health workers should include practical training on how to perform the specific tasks assigned to them to detect and treat wasting as they deliver their routine health services. Training on severe wasting should be one component or module within the wider pre-service health curriculum for each cadre of staff. In-service and on the job training will certainly be needed, but to the degree possible, it should be part of broader trainings planned on child health. Supervision tools for child health services must include essential prompts to review services for wasting. Regular capacity assessments for health staff should include aspects of wasting treatment to identify need for additional training and support. CHWs treating wasting in the community should have direct contact (at least via telephone) with health facility staff for support, particularly for complicated cases.

- **Information management.** Data on child wasting services, including admissions, recovery/ default/ death/ non-response rates must be collected and reported on as an integral part of government health information management systems (HMIS). In many countries, the CMAM reporting system remains completely or partially parallel to the HMIS. There are often multiple systems to manage and report on wasting treatment data that are led by the government, NGOs and/or the Nutrition Cluster, which wastes time and resources. The current wasting data being collected in each country and by whom and how it is being collected should be reviewed as part of the broader health systems analysis outlined above. Reporting formats and systems for data entry, aggregation and analysis at all levels, but should align roughly with those used for sick-child consultations. Only data that the government has the capacity to analyse and use for decision making should be collected. More detailed CMAM indicators such as length of stay and weight gain, which are included in the Sphere Guideline are generally not appropriate for integrated monitoring via HMIS. Several countries have quite successfully integrated core wasting treatment data into their HMIS, including Kenya Ethiopia, and Niger. Additional information on the prevalence of wasting and the coverage of wasting services via periodic population-based surveys are also important to understand the burden and reach of services, but should be integrated into government-led surveys.

Practical considerations for scaling up the adaptation/approach

- **Finance.** Efforts to integrate the financing of wasting management costs into government health budgets and financing mechanisms must recognise that these costs have a long history of being covered by more parallel, emergency funding mechanisms, and thus will need strong and consistent advocacy from the donor community. As mentioned above, a critical first step is to accurately cost all the supplies and identify where and when these costs need to be fed into existing budgeting and planning process at all levels. Accurately estimating and integrating costs for additional in-service training should be relatively straight forward as it may be a matter of adding an additional day to existing training budget lines. Pre-service curricula are likely to cost more and their funding will likely come from different streams. Financing RUTF will likely require a phased plan for gradual uptake of severe wasting costs into domestic budgets in fragile contexts, with regular review of what is feasible. The CMAM Costing Tool from FANTA may be useful for the initial costing step, but estimates will need to be adapted to the realities of context, as will the process of actually integrating them into in-country budgeting and planning processes.

Donors will need to coordinate extremely closely and transparently with each other and with the governments directing health services. All donors should be seeking innovative funding mechanisms to provide longer term health funding opportunities and explore the potential for bilateral or pooled funding that combines government and donor funds but encourages integration at all other levels of the health system. Governments in fragile contexts tend not to prioritise health budgets and the majority of health budgets that are allocated are used primarily to cover the costs of the health workforce. Thus, integration of costs for severe wasting services into domestic health budgets will need to be gradual. Governments and other stakeholders must advocate for these innovative financing mechanisms and for the global nutrition community to continue to clearly estimate and reduce the costs associated with managing severe wasting within the primary health package, including the cost of RUTF. The OneHealth Costing Tool could be useful to link strategic objectives and targets of disease control and prevention programmes to the required investments in health systems.

Promising practices

A number of promising practices have supported the integration of severe wasting services into health systems to date:

- **Long-term roadmaps to enable governments to manage wasting including RUTF.** The government of Niger in coordination with supporting partners have developed a ten year roadmap (2020 – 2029) known as the 'Feiulle de route' to gradually take on the management of wasting, including full management of RUTF. Uganda is currently piloting government-led RUTF supply chain management in the West Nile region with a plan to scale up.
- **CMAM Surge.** In Kenya, CMAM Surge (known as 'IMAM Surge') is an official strategy of the Kenyan government to help health facility and Sub-county & County Health Management Teams in the Arid and Semi Arid Lands of Kenya to better anticipate, prepare for and respond to seasonal peaks in wasting admissions from within the health system. For more information see this Field Exchange Article *Implementing the IMAM (CMAM) Surge approach – experience from Kenya*.
- **Adding RUTF to the national Essential Medicines List.** A number of countries have done this and it has generally made it easier to procure and manage RUTF via their existing medical supply chains. There may be some disadvantages of RUTF being categorised as a medical product when trying to expand CHW-led wasting treatment as CHWs in many countries are not allowed to prescribe or dispense medicines. On balance, however, this seems to facilitate integration.
- **Innovative, multi-donor financing models for long term funding via the health system.** The Global Financing Facility has been used for broad health sector funding and could be explored to fund services for the management of wasting via government health systems, including RUTF supply.

Critical next steps

The further integration of services for the management of severe wasting into health systems will require an enormous, coordinated effort, but is seen as the only path to achieving scale and coverage over the medium to long term. Critical next steps are outlined below.

To go to scale, *individual countries* should:

- **Analyse the specific health system services and support functions in detail** to determine what specific tasks and aspects of wasting management must be integrated and where in each context. While the six broad health system building blocks offer a framework, the analysis will need to go much deeper to pinpoint how specific policies, guidelines, capacity building and logistics, finance and information systems must be adapted and how. The forthcoming UNICEF wasting integration guide could support this analysis, but the diagnosis will need to be highly context specific, identifying specific gaps, practical actions and realistic objectives.
- **Establish accurate costs for managing severe wasting, including not only RUTF costs but all those suggested through the above analysis.** The current FANTA CMAM Costing guidelines can help with the initial costing step, but more tools and support will be required to guide the process of integrating those costs into in-country budgeting and planning processes.
- **Map where funding for the management severe wasting is coming from and how it could be harmonised and efficiencies improved**. It may not be possible for all governments with a high burden of wasting to take on full fiscal responsibility for the management of wasting. Alternative, bi-lateral arrangements with donors or a group of donors may be possible (see below). Mapping the funding streams and processes for severe wasting services is an essential first step to those discussions.
- **Identify a focal point within the Ministry of Health and ideally within the department responsible for child health who can lead the integration of severe wasting services into the health system,** including the analysis and identification of specific actions. This focal point would also have the role of building and presenting the case for integrating severe wasting services to other health workers and decision makers**.**

Critical next steps

To support scale at a broader level, ***regional and global partners*** should:

- **Work together to develop more innovative, long-term financing mechanisms to fund services for the management of wasting through government health system funding.** This should include RUTF and build on the experience of mechanisms like the Global Financing Facility already used for primary health care initiatives.
- **Support financial modeling of longer term costs and cost-efficiencies/ effectiveness to be gained by integrating** wasting services into government systems.

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