February 2018

MAKING THE GFF WORK BETTER FOR NUTRITION

Why we need GFF core & programmatic indicators to cover acute malnutrition

Undernutrition is the underlying cause of nearly half of the under-5 deaths in the world[1]. While stunting is included in the GFF indicators, wasting is not, reflecting an inadequate understanding of nutrition[2]. Wasting and particularly severe acute malnutrition (SAM) used to be seen of as a condition mostly encountered in emergency settings and thus tackled by humanitarian policies and practices[3], while stunting was seen as a development issue[4].

The evidence, however, clearly shows that wasting and stunting coexist in the same contexts, countries and children[5]. Countries like India, with high rates of stunting and wasting existing simultaneously – for instance in the case of India (wasting: 21%, stunting: 38%)[6] or DRC (wasting: 8%; stunting: 21%)[7]. It is therefore urgent to make sure that wasting and particularly severe wasting (severe acute malnutrition) are integrated in the GFF core indicators.

We therefore propose the following two indicators:

Core Indicator	**PREVALENCE OF WASTING**
Programmatic Indicator	**COVERAGE OF SAM TREATMENT**

ACTION AGAINST HUNGER

01/ARGUMENTS IN FAVOUR OF A CORE INDICATOR ON WASTING PREVALENCE

ADDRESSING WASTING WILL CONTRIBUTE TO REACHING THE SDG3 AND REDUCING CHILD MORTALITY

According to the WHO, *" wasting indicates recent and severe weight loss, because a person has not had enough food to eat and/or they have had an infectious disease, such as diarrhoea, which has caused them to lose weight"*[8]. 52 million children under-5 are wasted, and 17 million are severely wasted[9]. Wasting is thus a major health issue, with heightened risk of disease and death for children - wasted children are between 3 and 9 times more likely to die than healthy children. Efforts to improve rates of child survival will plateau without improvements in prevention efforts and an increase in the proportion of wasted children receiving appropriate life-saving treatment. Initiatives aiming to reduce child mortality, such as the GFF, also need to address wasting.

WASTING IS AN SDG TARGET AND INDICATOR AND FALLS WITHIN THE MANDATE OF THE GFF

The SDGs include a target on wasting and an indicator[10]:

- SDG 2.2: By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age.
- Indicator 2.2.2 Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)

Wasting is thus related to the GFF mandate, which is "financing for the Sustainable Development Goals (…) in a (…) way that closes the funding gap for reproductive, maternal, new-born, child and adolescent health and nutrition by 2030."[11]

WASTING IS AN INDICATOR OF THE GLOBAL STRATEGY AND THE 100 CORE HEALTH INDICATORS. It thus fits well with the other GFF indicators

WASTING IS AMONG THE WHO GLOBAL NUTRITION TARGETS

The global nutrition targets have been approved by WHO and Member states; they aim at improving maternal, infant and young child nutrition. The wasting target is: "Reduce and maintain childhood wasting to less than 5% by 2025". The world is not on track to achieve this target in time, and this in turn will impact the realisation of other SDGs related to child health.

02/ARGUMENTS IN FAVOUR OF A PROGRAMMATIC INDICATOR ON THE COVERAGE OF SAM TREATMENT

SAM IS AN OVERLOOKED, LIFE-THREATENING CONDITION which is insufficiently prevented, and therefore requiring urgent treatment. It is, according to UNICEF, *"a major cause of death in children under 5"*[12]. Children with SAM are known to have an increased risk of dying (between 5 and 20 times higher than well-nourished children)[13]. Today, we estimate that at least 17 million children suffer from this disease[14].

LESS THAN 20% OF THE CHILDREN WHO SUFFER FROM SAM ACTUALLY RECEIVE THE TREATMENT THEY NEED[15]. Various reasons account for these low rates, including lack of political attention to malnutrition, lack of investment, poor integration of nutrition services along the continuum of care, weak health systems, stigma associated to the disease in some contexts, etc[16].

THE TREATMENT FOR SAM IS COST-EFFECTIVE: estimates indicate that the treatment of SAM is both cost-effective[17] [18], and comparable to the cost-effectiveness of other child survival interventions[19] [20].

An indicator measuring progress on the rate of children suffering from SAM would contribute significantly to increase attention and action on a neglected health issue with such unacceptable and substantial consequences. Monitoring progress on SAM treatment will thus ensure that investment is cost-effective and truly encompasses the various causes of child mortality.

FOR FOOD.
FOR WATER.
FOR HEALTH.
FOR NUTRITION.
FOR KNOWLEDGE.
FOR CHILDREN.
FOR COMMUNITIES.
FOR EVERYONE.
FOR GOOD.
FOR ACTION.
AGAINST HUNGER.

Contact :
Aurélie du Châtelet
aduchatelet@actioncontrelafaim.org

Action Contre la Faim-France
14/16 Boulevard de Douaumont
75854 Paris cedex 17
France
www.actioncontrelafaim.org

Photo cover : © Kadija Farah pour Action contre la Faim - Somalie
Photo page 2 and 3: © Jean-Luc Luyssen pour Action contre la Faim - Burkina Faso
Photo page 4 : © Sanjit Das - Panos - Népal

1. Black RE, Victora CG, Walker SP, Bhutta ZA, Christian P, de Onis M, Ezzati M, Grantham-McGregor S, Katz J, Martorell R, Uauy R. Maternal and child undernutrition and overweight in low-income and middle-income countries. Maternal and Child Nutrition Study Group. Lancet. 2013 Aug 3; 382(9890):427-451.
2. Tanya Khara & Carmel Dolan. The relationship between wasting and stunting, policy, programming and research implications Technical briefing paper. ENN & USAID July 2014
3. Sphere (2011). The Sphere Project, Humanitarian Charter and Minimum Standards in Humanitarian Response.
4. Khara & Dolan Ibid page 4
5. Khara & Dolan Ibid
6. GNR Nutrition country profile – India 2017
7. GNR Nutrition country profile – DRC 2017
8. WHO Malnutrition factsheet – 2017 http://www.who.int/mediacentre/factsheets/malnutrition/en/
9. Ibid.
10. UNGA, Res 71/313 Global indicator framework for the Sustainable Development Goals and targets of the 2030 Agenda for Sustainable Development 2017
11. GFF Website: https://www.globalfinancingfacility.org/introduction
12. UNICEF – Severe acute malnutrition : https://www.unicef.org/nutrition/index_sam.html
13. WHO, WFP, UNSCN, UNICEF Community-based management of acute malnutrition A Joint Statement 2013
14. Ibid.
15. United Nations Children's Fund. Nutri Dash 2014 global report. New York. UNICEF. 2014.
16. Puett C Guerrero S Barriers to access for severe acute malnutrition treatment services in Pakistan and Ethiopia: a comparative qualitative analysis. 2015 Public Health Nutr. 2015 Jul;18(10):1873-82
17. Wilford R, Golden K, Walker DG. Cost-effectiveness of community-based management of acute malnutrition in Malawi. Health Policy and Planning. 2011; 1-11. Available from: doi:10.1093/heapol/czr017 [Accessed 5 November 2016].
18. Bachmann MO. Cost effectiveness of community-based therapeutic care for children with severe acute malnutrition in Zambia: decision tree model. Cost Effectiveness and Resource Allocation. 2009; 7 (4): 1-9. Available from: doi: 10.1 186/1478-7547-7-2 [Accessed 5 November 2016].
19. Marseille et al. Thresholds for the cost–effectiveness of interventions: alternative approaches. 2014
20. Jamison et al. Priorities in Health. Disease control priority project. World Bank 2006