GLOBAL ACTION PLAN ON CHILD WASTING

A framework for action to accelerate progress in preventing and managing child wasting and the achievement of the Sustainable Development Goals

THE CHALLENGE

In 2015 the world committed to the Sustainable Development Goals (SDGs) including the elimination of malnutrition in all its forms by 2030. To do so, the SDGs incorporated the World Health Assembly targets to reduce the proportion of children suffering from wasting[1] to <5% by 2025 and <3% by 2030[2].

Yet, since these targets were adopted, the proportion of wasted children has remained largely unchanged[3]. Today, an estimated 7.3% (50 million) of all children under five suffer from wasting at any given time[4]. Wasting affects children in virtually every continent on the planet, with the largest number of children suffering from wasting today being found in South Asia.

For much of the past two decades, global efforts to address wasting have primarily focused on providing treatment for wasted children, especially in humanitarian crises. In 2019, an estimated 11 million children received treatment for wasting[5]. Although the coverage of treatment services has steadily increased since 2010, the proportion of wasted children who can access treatment remains unacceptably low with just one in three severely wasted children receiving treatment.

To achieve the SDG targets on wasting and undernutrition, a crucial policy shift is needed, increasing efforts to prevent all forms of malnutrition. There is an urgent need to develop and scale up radically improved solutions addressing the fundamental drivers of malnutrition. The immediate drivers are well known: frequent common childhood illnesses, unhealthy diets. Children in disadvantaged circumstances experience recurrent infections and may not receive the right food at the right time or have increased, but unmet, requirements for essential nutrients due to preventable illnesses; infants born with low birth weight are vulnerable to further growth failure in the first year. The underlying drivers of wasting are, however, complex and vary across seasons, regions and contexts, but include environmental conditions, inadequate or lack of hygiene and sanitation, household food insecurity and lack of age-appropriate caregiver and child interactions. Such conditions are in turn the consequence of inadequate functioning of food, health and other systems, including social protection. Emergencies, outbreaks of communicable diseases and disasters may trigger or aggravate the incidence of child wasting.

A sustainable and positive impact on these determinants and drivers can only be achieved through a combination of sustainable and resilient food systems to ensure access to healthy diets, health services that provide quality universal health coverage with essential nutrition actions throughout the life course, and social protection mechanisms that seek to weed out the worst of inequalities. Prevention efforts can and should be improved, but even then, some children will be affected by wasting. When prevention fails, treatment for wasting becomes essential, and must be made more readily available and accessible to all who need it regardless of the context.

Today, this coherent and coordinated response to prevent and treat child wasting is not a reality. Systems are often dysfunctional, unaligned and not always inclusive. In addition, actors are organized around

[1] The term 'wasting' within this document incorporates severe acute malnutrition (SAM, which includes severe wasting – also known as marasmus, kwashiorkor and marasmus kwashiorkor both with and without the presence of oedema) and moderate acute malnutrition (MAM).
[2] WHO and UNICEF. 2018. *The extension of the 2025 Maternal, Infant and Young Child nutrition targets to 2030*. Discussion paper.
[3] Since 2013, Joint Child Malnutrition Estimates have reported wasting prevalence levels of 8.0% (2013), 7.5% (2014), 7.4% (2015), 7.7% (2016), 7.5% (2017) and 7.3% (2018).
[4] UNICEF, World Health Organization, World Bank Group (2019) Joint Child Malnutrition Estimates (Key Findings, 2019 Edition).
[5] Estimate based on UNICEF reported admissions of children with severe wasting and other forms of acute malnutrition into therapeutic treatment in 2019 (4.9million children) and WFP Annual performance report, 2019 (to be published).

siloed systems such as agriculture, health, social protection and water, hygiene and sanitation rather than coherently and collectively working effectively and efficiently together towards a common goal.
The fragmented response by actors, including the UN system, and the unpredictable nature of current financing for wasting also limits the effectiveness and efficiency of core services to prevent it and treat it. Now, more than ever, there is an urgent need for a more purposeful, systematic, integrated, transparent and accountable collaboration that leverages the collective strengths of all stakeholders – including governments, UN agencies, civil society and the private sector – to more effectively help countries accelerate progress in the forthcoming "decade of action" on the wasting-related SDGs and WHA targets.

It is in this context that the United Nations Agencies working on the prevention of child wasting have developed this Framework for the Global Action Plan (GAP) on Child Wasting. This Framework identifies four critical outcomes to achieving the SDG targets on child wasting and to improving early detection and treatment for those who need it. Under each of these outcomes, the Framework identifies proven pathways to accelerate the delivery of essential actions and to create a more enabling environment for their success. The goal of this Framework is to provide a common focus to guide individual and collective action to accelerate progress towards the SDGs on child wasting.

This Framework will enable UN agencies to develop a more targeted Roadmap for Action, supporting countries where children are most vulnerable and most affected by wasting to develop concrete, context-specific commitments, targets and actions to accelerate progress and contribute to reaching the global SDG targets. This Framework, and the accompanying Roadmap for Action, will become the Global Action Plan on Child Wasting.

THE APPROACH

Preventing and reducing wasting generally requires that children are born to healthy, well-nourished mothers who receive appropriate antenatal care, and live in households with access to adequate food and care practices as well as to functional quality primary health care services, potable water, safe sanitation and good hygiene. This is especially critical during the first 1000 days window of opportunity from when a child is conceived and through infancy and early childhood but remains vital throughout the entire lifecycle. Healthy children grow into healthy adolescents, adults and parents.

The Framework recognizes **that effective responses to address child wasting must be defined on the basis of stronger evidence of how specific drivers manifest and interplay to increase vulnerability to child wasting across different contexts, populations and seasons**, and how national governments and their partners can mobilize to address these.

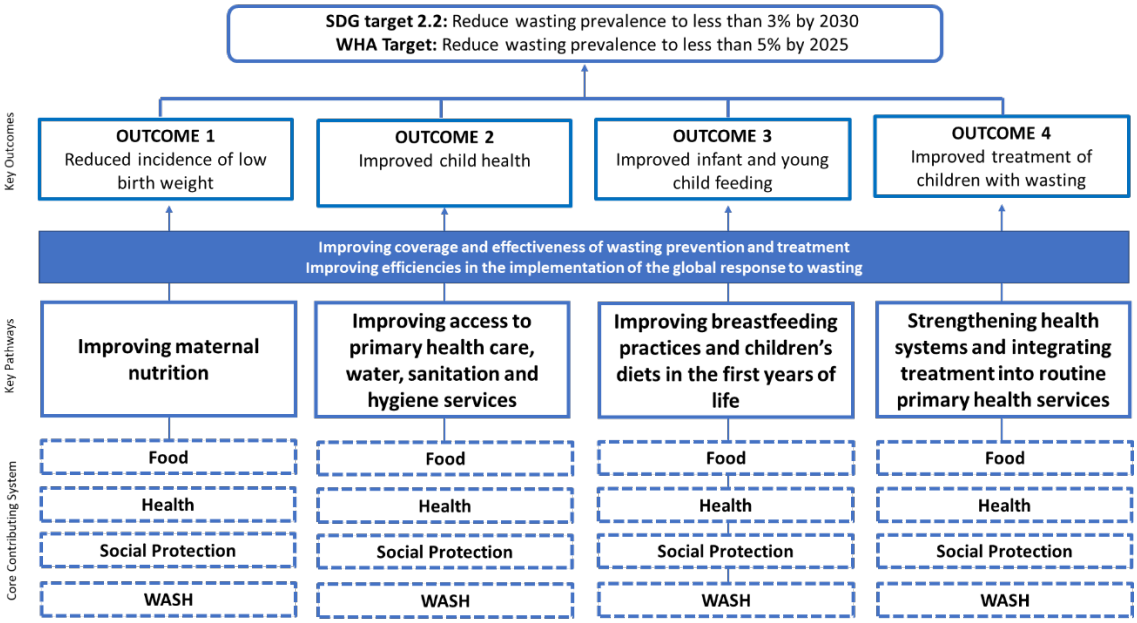
In most contexts, this can be achieved by strengthening **national health, food and social protection systems**. The Framework aims to shift collective focus towards ensuring that these systems are responsive and aligned to deliver healthy diets and sufficient mother and child care- including nutrition interventions. The Framework, however, also recognizes that in many contexts additional support is needed in the form of child and family-centered food assistance, to ensure that families can manage resources and children receive sufficient food, of sufficient quality and quantity to avoid becoming wasted. The goal must be to accelerate the delivery of essential actions to address the immediate determinants of child wasting, whilst aligning actions across multiple systems to simultaneously address underlying drivers that continue to limit our collective ability to protect communities, households and children from wasting.

The Framework prioritizes the delivery of these preventative actions in a more coordinated manner, but it also recognizes that their combined effect will come too late for many children who will experience wasting and will require care and treatment. The Framework therefore focuses on identifying concrete actions that will facilitate the integration of early detection and treatment of child wasting into routine primary and community health services, as the most sustainable and effective path to ensuring that all children in need of treatment – today and tomorrow – can access it.

In approaching both prevention and treatment efforts, the Framework recognizes that engaging and empowering communities is and must remain at the heart of our collective efforts. The Framework is designed to be relevant for all populations, including people affected by humanitarian situations due to conflict or natural disasters (e.g. internally displaced persons, asylum-seekers and refugees), migrants, prisoners or people being held in detention, stateless persons, indigenous populations, people living with disabilities, the rural and urban poor and other marginalized groups, as well as specific demographic groups, such as pregnant and lactating women, children under two years of age, adolescent girls and the elderly. The success of our collective efforts on child wasting will depend on our ability to understand and respond to their nutritional vulnerabilities.

THE FRAMEWORK FOR ACTION

The objective of the GAP is to reduce wasting prevalence to less than 5% by the year 2025 and further reduce wasting prevalence to less than 3% by the year 2030.



To achieve this, the GAP will accelerate action towards four key outcomes that will directly contribute to the achievement of the SDG targets on wasting:

1. Reduced incidence of low birth weight
2. Improved child health
3. Improved infant and young child feeding

4. Improved treatment of children with wasting

These four key outcomes described above can be addressed in multiple ways. Building on evidence and programmatic experience from the last few decades, however, the GAP has identified specific effective and cost-effective pathways to achieve them. These four pathways will not be the only approach that will be required, and we anticipate and encourage actions across other complementary pathways. Nevertheless, these pathways will represent the primary focus of our collective response and as such, they provide the key path for identifying operational priorities and our individual commitments towards this Plan.

Finally, in developing and implementing the GAP on Child Wasting, we will be driven by seven common principles.

1. **Promote** government leadership and ownership of prevention and treatment of wasting in all contexts and at all levels.
2. **Re-position** prevention at the center of our collective efforts to reduce the number of children suffering from wasting and increase the efficiency of our collective efforts.
3. **Prioritize** scalable responses that are cost-effective, efficient and designed to be practical and feasible at scale, increasing access to hard-to-reach populations.
4. **Enhance** the life cycle approach to ensure inclusion of adolescents, pregnant women, breastfeeding women, infants 0-5 months and children 6-59 months in prevention, protection and treatment.
5. **Ground** the design of wasting interventions on key present and future factors that impact on wasting, including urbanization, climate change, demographics shifts and increasing inequalities.
6. **Commit** to gender, equality, women's empowerment, community participation and ownership and inclusion of excluded groups and responsiveness to special needs, including populations on the move.
7. **Encourage** iterative action and learning, acting on what we already know and gradually adapting on the basis of emerging evidence and data to ensure maximum effectiveness.

THE STRATEGIC PRIORITIES

The four outcomes list the priority interventions attributed to the most relevant system: health, food, water, hygiene and sanitation, or social protection.

Outcome 1. Reduced low birthweight by improving maternal nutrition

While the prevention of malnutrition is critical for a women's own well-being, a child's nutritional status is closely linked to the nutritional status of the mother before, during and after pregnancy. Poor maternal nutrition impairs fetal development and contributes to low birthweight, subsequent wasting and other forms of malnutrition. Undernourished girls have a greater likelihood of becoming undernourished mothers, who in turn have a greater chance of giving birth to low birthweight babies, perpetuating an intergenerational cycle of malnutrition. This cycle can be compounded further in young mothers, especially adolescent girls who begin childbearing before attaining their own adequate growth and development. Short intervals between pregnancies and having several children may accumulate or exacerbate nutrition deficits, passing these deficiencies on to the children. In regions like South Asia,

where the prevalence of low birth weight[6] and wasting is highest, children are more likely to experience wasting in the first six months of life than at any other phase of their lives.

Evidence suggests that investments in the nutrition of children and adolescents can improve current and future nutrition, while breaking the intergenerational cycle of malnutrition in all its forms. It is therefore crucial that interventions policies, strategies and programmes focus on the prevention of malnutrition in women and adolescent girls before, during and after pregnancy. To effectively reduce the number of children suffering from wasting we must place greater emphasis on strengthening systems to establish a continuum of care for adolescent girls, mothers and their children. There is a need to improve peri-conception care, and care during and after pregnancy.

Outcome 1. By 2025, reduce low birthweight by 30%		
System	**Our Priorities**	
Health	1.1	Increase the number of infants born safely at health facilities having received appropriate antenatal care support [7]
	1.2	Scale up services to provide iron and folic acid supplements to women of reproductive age, particularly those who go through a pregnancy. In populations with a high prevalence of nutritional deficiencies provide services to give multiple micronutrient supplements to pregnant women that include iron and folic acid
	1.3	Prevent adolescent pregnancies by supporting country efforts to prohibit marriage before the age of 18 years and increase the use of contraception
	1.4	In undernourished populations, establish programmes of balanced energy and protein supplementation in pregnant mothers in Antenatal Care services
Food	1.5	Strengthen food value chains that aim to increase the accessibility and affordability of sustainable healthy diets for women of reproductive age (minimum diet diversity with an emphasis on animal source foods, pulses, fruits and vegetables and fortified foods as needed)
	1.6	Improve the design of micronutrient fortification programmes through food fortification of common staple foods (wheat or maize flour, rice, condiments) Include biofortification of staple crops using conventional breeding techniques as part of food security and resilience agricultural strategies to improve diets of vulnerable rural communities that rely heavily on few staples
	1.7	Improve the design of food assistance programmes on the basis of the specific nutritional needs of adolescents, pregnant and breastfeeding women and girls
	1.8	Strengthen institutional procurement as part of national and/or large-scale programmes (e.g. school meals, cash and vouchers, food assistance)
Social Protection	1.9	Improve the use of school platforms to support efforts to reach adolescent girls with school feeding and education/messaging around nutrition and reproductive health
	1.10	Align nutrition and social protection policies, strategies and programmes to leverage social protection systems to more effectively contribute to nutrition results for vulnerable adolescent girls and women

[6] UNICEF-WHO Low birthweight estimates, 2019

[7] WHO Recommendations on antenatal care for a positive pregnancy experience. Geneva, 2016. https://apps.who.int/iris/bitstream/handle/10665/250796/9789241549912-eng.pdf;jsessionid=3E683A7957BA562D8F0826278EE0FDBC?sequence=1

Outcome 2. Improved child health by improving access to primary health care, water, sanitation and hygiene services and enhanced food safety

Despite improvements, millions of people globally lack adequate water, sanitation and hygiene services. In 2017, 785 million people lacked basic drinking water services, including 144 million people who are dependent on surface water. Globally, 2 billion people still do not have access to basic sanitation facilities such as private toilets or improved latrines and nearly three quarters of the population in least developed countries lack handwashing facilities with soap and water[8].

An unhealthy environment and poor water, sanitation and hygiene (WASH) services increases the risk of diarrhea, malaria, acute respiratory and other infections, particularly amongst children. Lack of access to WASH may affect a child's wellbeing in many ways (e.g. via diarrheal diseases, intestinal parasite infections and environmental enteropathy) but its impact on these children is always significant. In 2016, inadequate water, sanitation and hygiene were responsible for 297,000 deaths among children under five in low- and middle- income countries, representing 5.3% of all deaths in this age group[9]. Today, children under five years of age bear 40% of the foodborne disease burden. To reduce the number of children suffering from wasting, availability and access to WASH services of adequate quality must be increased.

Improved access to primary health care including in protracted crises and fragile settings, is equally essential to ensure that childhood illnesses, which are closely associated with wasting can be prevented and addressed early and growing efforts towards Universal Health Coverage (UHC) provide a unique opportunity to accelerate progress in this regard. As countries implement their national health plans and UHC roadmaps, their journeys are marked by incremental expansions across three dimensions: expanding the population that has access to health care; expanding the package of quality health services and essential health services in fragile and conflict affected settings; and reducing out of pocket payments, such as user fees, which currently push 100 million people into poverty each year. To reduce the number of children suffering from wasting, UHC efforts must be accelerated.

[8] WHO/UNICEF 2019. Progress on household drinking-water, sanitation and hygiene 2000-2017. Special focus on inequalities. New York: United Nations Children's Fund (UNICEF) and World Health Organization (WHO).
[9] WHO 2019. Safer water, better health.

Outcome 2. By 2030, achieve universal health coverage, including access to quality essential health-care services for all		
System	**Our Priorities**	
Health	2.1	Increase access and coverage of essential interventions[10] for promotion of child health and wellbeing, caregiver mental health, and prevention and treatment of common childhood illnesses close to where children live
	2.2	Provide tailored and coordinated country support to strengthen health systems for primary health care by generating evidence; country prioritization, planning and budgeting; mobilization of financing and health workforce development to improve coverage and equity, including in fragile and vulnerable settings
	2.3	Integrate Essential Nutrition Actions[11] into the package of health services as part of national health plans and UHC roadmaps, ensuring access for those most left behind including in crises and emergencies
	2.4	Strengthen and expand services for the early detection of growth faltering and continuum of care for low-birth weight infants including preterm births
Food	2.5	Reduce contamination of crops in farms, enhance food safety in markets and improve food storage and food handling at household level (food hygiene), with a focus on complementary and supplementary foods for young children
Water, Sanitation, and Hygiene	2.6	Increase the implementation of joint nutrition and WASH programmes and increase the coverage of handwashing facilities and WASH services (safe water and sanitation)
	2.7	Promote the provision of soap and relevant WASH services through all food assistance platforms

[10] WHO. Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health. Geneva, 2012
[11] Essential Nutrition Actions- mainstreaming nutrition through the life-course. Geneva, 2019
https://apps.who.int/iris/bitstream/handle/10665/326261/9789241515856-eng.pdf?ua=1 (see actions for women of reproductive age and infants and young children

Outcome 3. Improved infant and young child feeding by improving breastfeeding practices and children's diets in the first years of life

Adequate caring and feeding practices are crucial for child wellbeing. Ensuring that children have access to an adequate and diverse diet in the first years of life is critical and demands sustainable and resilient food systems that can deliver these diets. Feeding habits are equally critical and promoting, protecting and supporting appropriate Infant and young child feeding (IYCF) practices - exclusive breastfeeding during the first six months, followed by continued breastfeeding with adequate complementary feeding up to two years - is essential to protect children from growth faltering and wasting. Therefore, policies, programmes and strategies that support breastfeeding as a norm, support children's right to a healthy diet, including access to diverse, nutritious, safe and age-appropriate foods should be promoted.

In contexts characterized by limited availability of or access to nutritious food, the inclusion of child-centered food assistance may be warranted. This may include the provision of prevention rations of specialized nutritious food or cash-based transfers. The appropriate use of these interventions should be closely monitored, and the use of specialized products should be discontinued as soon as the situation allows to encourage the shift to more appropriate and sustainable home food diets.

Outcome 3. By 2025, the rate of exclusive breastfeeding in the first 6 months will increase up to at least 50% and at least 40% of children between 6-23 months consume a minimum diet diversity with an emphasis on animal source foods, pulses, fruits and vegetables		
System	**Our Priorities**	
Health	3.1	Increase early initiation and exclusive breastfeeding rates and adequate complementary feeding and hygiene practices and eliminate harmful effects of inappropriate marketing of breast-milk substitutes and processed foods, high in added sugar, salt and trans fats
	3.2	Support the systematic implementation of the Nurturing Care Framework to ensure that children are developmentally on track in health, learning and psychosocial wellbeing. Include kangaroo mother care for small and sick neonates
	3.3	Promote that age-appropriate Infant and Young Child feeding and care practices and caregiver mental health are systematically integrated in routine maternal and child health care services, including in community-based services
Food	3.4	Strengthen food value chains that aim to improve the availability and affordability of healthy and nutritious diets, for all vulnerable groups at all times, including animal source foods, pulses, fruits and vegetables biofortified crops (using conventional crop breeding methods) and fortified complementary food, when needed
	3.5	Improve analysis, decision-making and response as well as the design of interventions to improve the diets and nutritional status of populations
	3.6	Strengthen storage capacity, transport infrastructure and post-harvest loss management, including distribution of and training on post-harvest loss siloes as well as minimal processing to improve household food access to healthy and nutritious diets at all times
	3.7	Improve the design of micronutrient fortification programmes through food fortification of common staple foods (wheat or maize flour, rice, condiments). Include biofortification of staple crops using conventional breeding techniques as part of food security and resilience agricultural strategies to improve diets of vulnerable rural communities that rely heavily on few staples

	3.8	Support the integration of livelihood dynamics and seasonality in the design and delivery of emergency and resilience building programmes countries to meet the nutritional needs of children in situations of acute food insecurity
Social Protection	3.9	Improve access to age-appropriate nutritious, affordable and sustainable foods through social protection transfers (cash or in kind) targeting at risk children and women

Outcome 4. Improved treatment of children with wasting by strengthening health systems and integrating treatment into routine primary health services

Over the last decade, significant improvements have been made in the capacity to effectively treat children with wasting. Since the introduction of outpatient treatment for wasting in 2007[12], treatment services to address severe wasting have been integrated into the national health system of over 70 countries around the world. Yet, the proportion of children with wasting in need of therapeutic treatment who receive it is still low, with an estimated 2 out of every 3 children with severe wasting still not accessing the care they need.

To address this, key action is needed to make treatment of wasting a routine part of primary and community health care, by leveraging and integrating into existing platforms at a facility level (Integrated Management of Childhood Illnesses) and at a community-level (including Integrated Community Case Management). Making the treatment of child wasting routinely available and accessible to all those who need it will require targeted actions across several components of the health system, including health workforce, financing, governance and service delivery. It will also require modifications to ensure that health services treat children with wasting until they achieve full recovery from the condition, and that key commodities (e.g. Ready to Use Therapeutic Food) are routinely available and managed as part of national health systems. In contexts where these systems are fragile, additional complementary action will be needed to increase the capacity of caregivers to seek care and to ensure and to offer those living in hard-to-reach areas equitable access to the care they need.

Outcome 4. By 2025, we will increase by 50% the coverage of treatment services for children with wasting		
System	**Our Priorities**	
Health	4.1	Strengthen the integration of early detection and treatment for wasting as part of routine primary and community health care services and ensure referral systems are in place for appropriate management of wasting in children
	4.2	Increase the capacity of community health workers to identify and, whenever possible, treat children with uncomplicated wasting and monitor their nutritional rehabilitation in the home
	4.3	Adopt programmatic solutions that will improve the cost-effectiveness of early detection and treatment of child wasting
	4.4	Strengthen national health information systems to regularly monitor and report wasting and wasting-related data to support and inform the implementation of national services for its effective prevention and treatment

[12] World Health Organisation, World Food Programme/United Nations System Standing Committee on Nutrition/The United Nations Children's Fund. Community-based management of severe malnutrition: a joint statement. May 2007

	4.5	Empower caregivers to monitor the healthy growth of their children using low-literacy/numeracy anthropometric tools
	4.6	Support the inclusion of Ready to Use Therapeutic Foods (RUTFs) into the Model Essential Medicine List by identifying/developing an appropriate category for this commodity and taking into account country level assessments on benefits versus potential harms
Food	4.7	Streamline supply chain systems for the delivery of key commodities for the treatment of child wasting
	4.8	Ensure the safety and quality standards of locally produced specialized nutritious food required for the treatment of child wasting, through improved collaboration with the private sector
	4.9	Support efforts to prevent and reduce aflatoxin and other toxins in therapeutic foods
Social Protection	4.10	Support government shock responsive social protection in areas with food insecurity giving a safety net transfer to families with at-risk children

THE RESEARCH AGENDA

To support the delivery of impactful actions for the prevention and treatment of child wasting, policy and practice will need to be reviewed and updated to reflect the latest evidence. Over the course of 2019, WHO and its partners have identified evidence gaps which will require additional operational and scientific research. This is based on initial technical consultations and builds on the wealth of existing research priorities that were outlined by WHO and other initiatives to identify research priorities for wasting. This Agenda will be further detailed in consultation with key stakeholders at global, regional, and country level to identify specific evidence needs to support operational delivery at scale and global normative guidance.

The timelines for the initiation and implementation of research to produce sufficient evidence in the areas identified in this Research Agenda will vary. Some areas and questions will be more advanced or closer to having evidence sufficient to support operational and normative guidance actions in the short-term. Other areas and questions will require more time to fully address, and the availability of comprehensive evidence and associated policy-changes may go beyond 2025.

Over the next five years, WHO with the support of other UN agencies, will coordinate and oversee the generation of new evidence to address these gaps and accelerate the process to update global normative guidance and country-level guidance for the prevention and treatment of child wasting. In doing so, WHO will collaborate with national governments, academics, donors and other stakeholders to regularly update the global community on key emerging evidence and their wider implication for policy and practice.

Research Priorities

Objectives	Global Action	Regional/Country Action	Research areas and Specific questions
Ensure updated guidelines reflecting the latest evidence on: I. Approaches for identification and risk characterization of children with wasting before and during treatment II. Management of infants and children with wasting III. Prevention of wasting in infants and children	Refine research questions Support research proposal development and implementation Mobilise research funding Synthesise evidence and guideline processes	Research teams conduct clinical research Implementation research jointly undertaken by academic and programme teams Operational research embedded into programmes and data collected to inform and optimise local service delivery	<u>Risk stratification, screening and monitoring</u> Which anthropometric and non-anthropometric measures or combinations of measures among children with wasting best predict the risk of mortality, serious morbidity or longer term adverse outcome? Which measures, or combination of measures of children with wasting best predict immediate response to treatment(s) and sustained recovery after treatment? What community and environmental factors (e.g. prevalence food insecurity, seasonality, health system quality and coverage, humanitarian emergencies) best characterise populations to inform appropriate wasting prevention strategies in children? What is the best metric for monitoring the effectiveness of programmes to prevent wasting and to achieve sustained functional recovery among children identified with wasting? <u>Management</u> What interventions (nutrition specific or sensitive) are most cost-effective for achieving sustained nutritional and functional recovery of children with moderate wasting according to risk stratification? Should treatment approaches of children with severe and moderate wasting - accounting for differences in metabolic and other physiological functions/needs - be similar in order to achieve full nutritional and functional recovery? Can milk-free/amino-acid enriched RUTF formulas achieve comparable/improved recovery outcomes and/or at a reduced cost than traditional RUTF formulations? What other formulation considerations (pulses, emulsifiers, etc.) affect cost and effectiveness of products for treatment? Can using pulses improve the gut function and nutrient absorption in children affected by wasting and exposed to environmental enteric disorder? Under what circumstances can community health workers provide appropriate and safe care for children with wasting?

			<u>Prevention</u> What is the effect of a pre-pregnancy and pregnancy maternal health intervention on the prevention of low birth weight?
			What is the effect of an integrated package of care for LBW infants in reducing stunting, wasting and underweight in the first 2 years of life?
			What is the impact of interventions for managing growth failure among infants less than 6 months of age on the risk of wasting between 6-24 months?
			In populations where children are at risk of wasting, what programmatic approaches, according to population context, are most effective at improving quality complementary feeding?

Operational Research Priorities (treatment of wasting)

Operational Research Questions
What are health workforce requirements for the management of childhood wasting according to setting?
How can early detection and treatment of child wasting be integrated into primary health services effectively, efficiently, while ensuring quality of care?
How can the coverage of treatment services delivered as part of primary health services be increased in a sustainable manner?
How can community health workers be more directly involved in finding, treating and following- up children with uncomplicated wasting in the communities?
What are the most effective and cost-effective models for integration of diagnosis and treatment into decentralized, community-based platforms?
Which measures, or combination of measures, best predict immediate response to treatment(s), risk of relapse and sustained recovery during, and after treatment, and can also be used for monitoring programme delivery?
What are the most effective (low-literacy/numeracy anthropometric) tools for use by community members, including caregivers and community health workers to diagnose wasting.
How can existing interventions (e.g. growth monitoring, IMCI) better detect and support children 0-59 months of age who are failing to thrive?
How can the cost-effectiveness of treatment services delivered as part of primary health services be improved?
What is the most effective and cost-effective dosage of RUFs to ensure optimum treatment and recovery outcomes?
How can key commodities for the treatment of child wasting be integrated into national supply chain systems effectively and efficiently?

OUR APPROACH TO IMPROVED COORDINATION & IMPLEMENTATION OF THE PLAN

The principal measure of success of the Global Action Plan will be the progress made towards achieving World Health Assembly and Sustainable Development Goals related to child wasting. But all agencies recognize that our success in supporting the achievement of these targets will in turn depend on our ability to improve when, where and – most importantly - how we work together in supporting national governments and their partners on the ground.

To-date, the design of the Global Action Plan has been primarily driven by our efforts to harness the UN Agencies individual and collective visions and strategies in a more effective, efficient and impactful manner and to do so in way that improves coordination and accountability amongst UN agencies. The priorities listed in this Framework reflect this new, more coordinated approach to accelerating the prevention and treatment of wasting.

We will engage with national governments, development and humanitarian partners, bilateral and multilateral organizations, non-governmental organizations, civil society and the private sector in order to break historical silos and to create a more holistic and comprehensive Global Action Plan to achieve a goal that can only be achieved with a multi-sectoral, multi-stakeholder action. To do so, we will leverage existing coordination mechanisms within and across sectors at a global, regional and national level, to prioritize commitments and identify additional actions and commitments necessary to accelerate progress on the prevention and treatment of child wasting in response to context-specific needs. Furthermore, we will actively encourage national governments and their partners to prioritize and adequately resource the services and actions necessary to address these context-specific needs and opportunities.

To work more effectively and efficiently in supporting the implementation of this Framework, the UN Agencies will lead and coordinate their efforts in a more streamlined and impactful manner, building on their specific mandates, expertise and capacities.

- **The Food and Agriculture Organization (FAO) will take the lead to transform food systems to deliver sustainable and healthy diets for all, in particular women of reproductive age and young children, to effectively prevent wasting.** FAO will prioritize fragile and conflict affected countries to build the development-humanitarian nexus using a livelihood approach. To that end, by 2022, 16 priority countries affected by conflicts and protracted crises will have enhanced analytical and response capacity to prevent child wasting by systematically employing established international-endorsed tools and mechanisms (e.g. IPC Acute Malnutrition). By 2025, FAO will have partnered with UN Agencies and other relevant stakeholders to ensure that food systems deliver sustainable and healthy diets for young children in an additional 10 countries with prevalence of child wasting above 10 percent.

- **UNHCR will support the lead agency for normative guidance and the lead agency to prevent and treat wasting and the lead agency to transform food systems to effectively prevent and treat wasting - with a special focus on refugee contexts or other people in conflict-generated humanitarian situations including host populations.** To that end, UNHCR commits to working together in support of the roll-out and effective implementation of the GAP Roadmap for Action

and to play a pivotal role in ensuring the inclusion of refugees and other people under the mandate of UNHCR in global and national policies, plans and activities to improve the effectiveness and efficiency of prevention and treatment of maternal and child wasting following the principles of the Global Compact On Refugees.

- **UNICEF will be the lead, coordinating agency at a global, regional and national level for the operationalization of efforts to prevent and treat child wasting in all contexts.** To that end, UNICEF commits to lead and coordinate the development of a multi-year, multi-country, multi-stakeholder GAP Roadmap for Action by August 2020, including establishing a multi-stakeholder accountability and reporting mechanism, and to oversee and coordinate support for its implementation under the Decade of Action on Nutrition (2016-2025).

- **The World Food Programme (WFP) will play a supporting role in ensuring the lead agency for normative guidance and lead agency to prevent and treat wasting are able to address wasting in all contexts - with a special focus on fragile contexts where government systems are fractured or not fully functioning.** To that end, WFP commits to support the roll-out and effective implementation of the GAP Roadmap for Action and to play a central role to improve the effectiveness and efficiency of prevention and treatment of maternal and child wasting under the Decade of Action on Nutrition (2016-2025).

- **The World Health Organization (WHO) will be the lead agency at a global, regional and national level for the development of normative guidance and tools to support governments on the prevention and treatment of child wasting in all contexts**. To that end, WHO commits update normative guidance for the prevention and treatment of wasting by the end of 2021, to support the review and update of national guidelines by 2023, and to oversee all future research and policy efforts on child wasting under the Decade of Action on Nutrition (2016-2025).