Malnutrition and ready-to use therapeutic foods

Position paper on community management of severe acute malnutrition without complications with the help of ready-to-use therapeutic foods

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Justification

- To offer delegates and chiefs of projects a new approach to community management of simple severe acute malnutrition (sSAM), as jointly recommended by the WHO and UNICEF since May 2007.
- To specify the appropriate use of ready-to-use therapeutic foods, particularly for the attention of donors.

Targets

- Document for those responsible for the zones, for delegations and health/nutrition chiefs of project.
- Document to be shared with institutional donors and others interested in this issue (NGOs, academics, UN agencies . . .)

Terminology

Ready-to-use therapeutic foods (RUTF) are remedies available at present in two forms: as biscuits (BP100) or as a paste in a sachet (Plumpy'nut®). Plumpy'nut® is a registered trademark of the Nutriset Company. It is a paste made of peanut butter, powdered milk, vegetable oil and a mineral/vitamin complex (MVC).

Terre des hommes is in favor of research into and production of "local" RUTF, at least for a group of countries (West Africa, for example). We support the initiatives of our partners in the south who are heading in this direction.

Summary

The new community approach to managing simple severe acute malnutrition (sSAM), jointly recommended by the WHO and UNICEF (joint declaration of May 2007), based on ready-to-use therapeutic foods, of which the currently best known is Plumpy'nut®.

This ambulatory approach is scientifically efficient in the hands of quality medical staff. It is not, however, quite without risk, particularly in regard to community work.

This position paper points out the risk of 'competition' between this community management of sSAM based on RUTF and activities linked to moderate acute malnutrition (MAM). **The new approach to management of sSAM is supplementary to Tdh's work with communities and does not replace it.**

For Tdh, acute severe malnutrition, in both its forms – simple (sSAM) or complicated (cSAM) – is a disease. In this capacity, **RUTF is considered to be a medicine and not just a simple 'energy' food.**

In consequence, RUTF should be prescribed in such a way that it is **used exclusively for the child in question** and not shared within his family. Health care professionals such as community agents should watch over the realisation of this objective. The current position of Tdh is that RUTF may not be used exclusively for more than 2 to 3 weeks. After this, the child should receive RUTF as a supplement to family meals until complete nutritional recuperation (up to 40 days' treatment or longer if necessary).

The present position of Tdh is to allow the **import of RUTF, whilst not forgetting the risks of dependency** that this might mean to the health system, which Tdh wants to support. Tdh is in agreement with research and production of RUTF at a local level, or at least for some countries (e.g. West Africa). We support the initiatives of our partners in the south who are heading in this direction.

Critical view

- Discussion in the coming years on the sustainability of RUTF, on the supervision necessary in communities, on support and technical training.

Decision and validation

- This positioning by Tdh is a revision of its position of June 2007 (version 1).
- This revision is based in particular on the advocacy work of the past two years as well as on the conference held on the subject of health in Tdh projects in Africa and Haiti which took place in Dakar on 11 – 15 May 2009, and on a meeting of the group for nutrition monitoring held on 22 June 2009 (Program Heads, persons in charge of zones, media/communication and experts/ resource persons).
- The task of revision was entrusted to J.-P. Papart and M. Roulet (experts/resource persons). It was reviewed by Pierre Zwahlen (communications service) and validated by Ignacio Packer on behalf of the Management.

Distribution

- Internal: programs departments, COGES, media and heads of communications.
- Available on KIT.
- No media expertise required from Head Office, but follow-up for potential awareness of the media in Switzerland as to technical developments and sustainability, as well as community support.
- An opportunity for an exchange of views and information with the groups currently involved in our advocacy: DDC, ECHO, MSF, Medicus Mundi, WHO technical committee, ministries of health in the (8) countries of intervention, and the general public in Switzerland.

Situation and position of Tdh

Today, Tdh has wide experience gained in the fight against acute malnutrition in children through numerous projects developed on three continents. There is concensus on a sectoral strategy of mother/child health (MCH) and nutrition – as well as on the means of action undertaken.

The initiative of Tdh on this subject has three themes:

1. support for the health system of the countries where Tdh works,
2. encouragement of autonomy in individuals and community partners of Tdh's interventions (empowerment), and
3. advocacy for the right of children to health and protection

Wherever the place of intervention and the content of Tdh's initiative, this threefold strategy makes sense of the participation of Terre des hommes in any project or program for MCH nutrition. As to the means of action used by Tdh in the majority of MCH nutrition projects, Tdh is usually active in the three programatic domains, i.e.

1. primary prevention of malnutrition
2. secondary prevention (treatment) of acute malnutrition and
3. promotion of community health

Each of these three measures of action should be part of the threefold strategy of our policy on this issue (support of the health system, empowerment, and advocacy).

Each of these three models of intervention can be broken down into various activities, according to planning needs.

Secondary prevention of acute malnutrition (MA) includes screening and community management of moderate acute malnutrition (MAM) through coordination between community health agents and basic health centers. It also includes management of severe acute malnution (SAM) by Community-based Therapeutic Care (CTC) and specialized nutrition units, these last being at least partly integrated in the public pediatric services. Secondary prevention aims to reduce the period of acute malnutrition and thus to lower its prevalence.

In order to reduce the incidence of child malnutrition, primary prevention of malnutrition includes in general – with variations – the following measures:

- promotion of prenatal check-ups to lessen the frequency of low weight at birth (a major factor in child malnutrition) in particular
- encouragement of exclusive breastfeeding up to 6 months (maternal post-natal support)
- encouragement of supplementary feeding from 6 months on,
- vaccination and integrated management of children illnesses (IMCI) – (these two elements combine to prevent malnutrition as well as to improve children's general health).

The encouragement of community health includes at least four kinds of activity:

- education in nutrition,
- promotion of child rights to health and protection,
- encouragement of hygiene in the environment (where possible with integrated water and sanitation programs (WASH)), and
- furthering of social community links.

It is a matter of targeting a new activity to be integrated within two existing activities for the treatment of SAM. Until the end of 2007, all identified cases, whether at a community level or in basic health centers, were hospitalized in a specialized nutrition unit, ususally in the pediatric department. The new approach –

recommended by WHO and UNICEF since 2007 and integrated in many of our projects – consists of firstly distinguishing between two forms of SAM, one called 'simple' (sSAM) and the other called 'complicated' (cSAM), to differentiate their treatment.

The simple form (sSAM) is characterized by a MUAC index (mid upper arm circumference) of less then 110mm according to Valid International; (a document jointly published by WHO and UNICEF in May 2009 proposes 115mm for this measurement) or if the weight of the child is 70% below the average weight expected for its height (or < -3 types), without other associated complications. The complicated form (cSAM) shows additional symptoms – nutritional (third degree oedema) or medical. The clinical test is loss of appetite (negative appetite test). It is at the same time the most sensitive and the most specific – and thus the most valid – to identify the simple character of a SAM.

Today, WHO and UNICEF recommend community management for sSAM. This involves the following elements:

- identification of children affected by SAM in the community and
- referral to / consultation with a a basic health structure authorized to carry out a nutrition evaluation, involving a test of appetite.

When SAM has been confirmed and the test of appetite is negative, the child should be referred to a specialized hospital structure. If the child's SAM is not complicated and the appetite retained (positive test of appetite), the child can be put into community care, i.e. his/her parents are given a product named 'ready-to-use therapeutic food' (RUTF) for the child, to be eaten at home in the prescribed quantities.

Amongst the advantages of this new approach, named Community-based Therapeutic Care (CTC), far more children suffering from SAM can be treated satisfactorily.

CTC demands supplementary investment from us in training and monitoring. But on the basis of our experience in 2008 in Haiti, Guinea and Burkina Faso, our organization appears to be in an excellent position to take up this new challenge. However, this expertise reminds one that CTC is anything but a sinecure and is not without danger, especially for the quality of community work. This position paper points out the risks of 'competition' between community management of sSAM based on RUTF and community activities against moderate malnutrition. The ambulatory therapeutic program against sSAM is in addition to Tdh's community work and does not replace it.

In order to offer the benefits of a better life to children and the communities where Terre des hommes helps, and to avoid the risks inherent in the introduction of a new remedy, the position of Terre des hommes (never inviolable) includes the following elements:

1. Severe acute malnutrition, in both its forms – simple or complicated – is a disease. In this capacity, its treatment is the responsibility of health professionals. Ready-to-use therapeutic food (RUTF) is a medicine and not an 'energy' food.
2. In consequence, RUTF should be prescribed for the exclusive use of the child concerned, and not to be shared within its family. Professional health staff, such as community agents, should make certain of this exclusive usage.
3. Tdh advises the use of RUTF exclusively for only 2 to 3 weeks. Afterwards, the child should receive RUTF with family meals until full nutritional recuperation is reached (up to 40 days treatment, or longer if necessary).
4. Tdh can accept the import of RUTF, despite the risks of dependency which this might signify for the health systems which Tdh wishes to support. Tdh encourages the local, or at least regional, research and production of RUTF (on the scale of West Africa, for example). We support the initiatives of our partners in the south who are going in this direction.
5. Tdh is aware that teams in the field will have need of increased technical support in order to take up this new challenge.