WFP
World Food Programme

CMAM 2021
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VIRTUAL CONFERENCE

Continuum of Care, Integrated and Responsive Nutrition Services

Linking to services for moderate wasting

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Department of Foreign Affairs and Trade

Why treat moderate wasting in children 6-59 months?

1	All degrees of anthropometric deficit are associated with increased risk of U5 mortality. Mortality risk increases along a continuum with exponential rise in the severe state
2	Moderately wasted children have a heightened risk of death compared to healthy peers
3	Significant morbidity has been observed in children with moderate wasting. Sick moderately wasted children have increased risk of death
4	An important proportion of children with moderate wasting without intervention fail to recover or decline to severe wasting, in both food-secure and insecure environments
5	Evidence around spontaneous recovery is limited

Treatment of moderate wasting – Global policy and programme framework

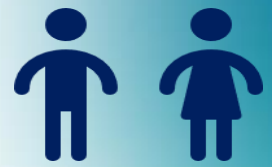
- CTC model (1998)
- WHO guidelines on SAM treatment (1999)
- Joint UNICEF-WFP-WHO statement (2007) - CMAM: focus on SAM

- Memorandum of Understanding between WFP- UNICEF (updated in 2011)
- WHO Technical Note on supplementary food products (2012)
- MAM Decision tool in emergencies (GNC, updated in 2017)
- UNICEF-WFP partnership framework to address child wasting (2020)
- GAP on child wasting (2020)

- No WHO normative guidelines for MAM treatment

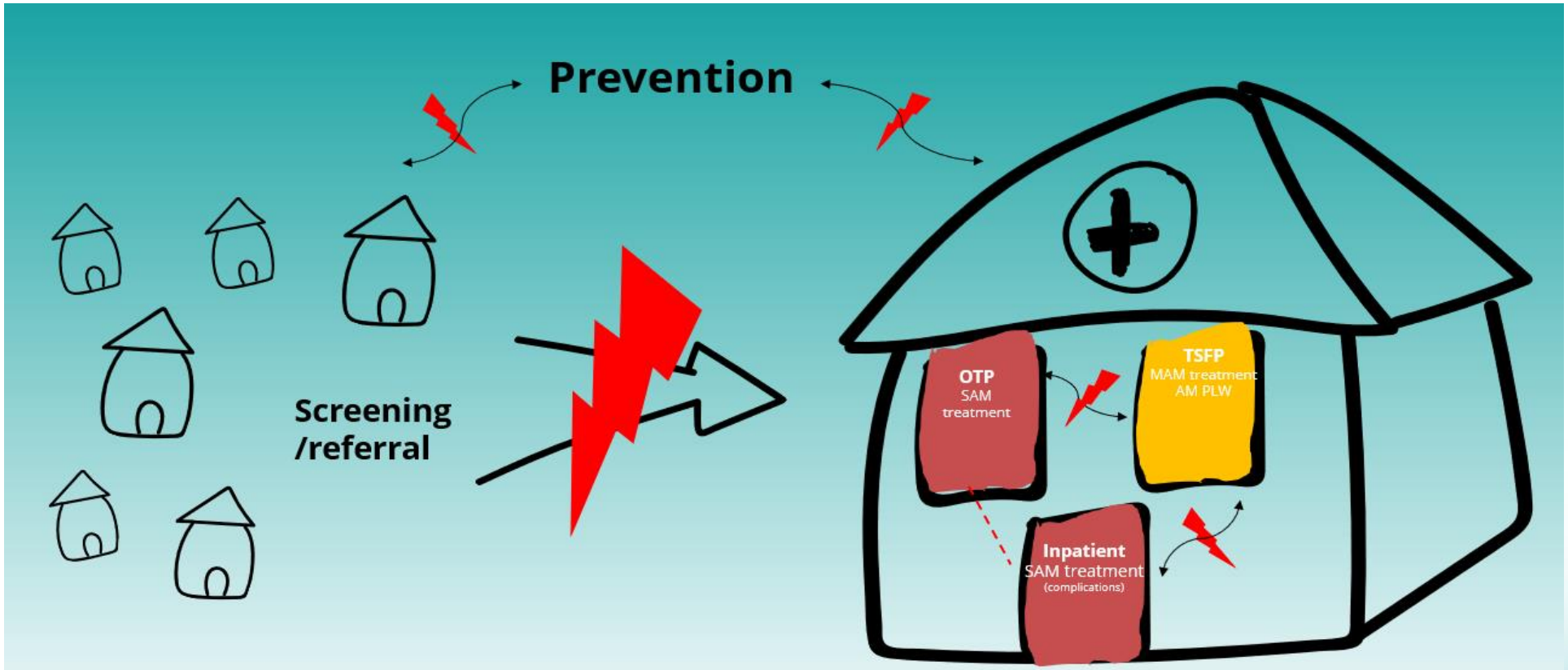
WFP- supported integration of moderate wasting within continuum of care

- More than 40 countries as per national protocol
- In 2020:
  - 6.5 million children with moderate wasting
  - 5.5 million children with prevention
  - 6.5 million PLW/G



- 80% in fragile and humanitarian context

Scalability and integration of moderate wasting treatment: systemic issues



Despite progress, challenges remain in the delivery of services and provision of continuum of care (prevention – treatment – prevention)

Scalability and integration of moderate wasting treatment: access and coverage in fragile settings

Nutrition programs are integrated into the local healthcare system.

...in times of complex crisis, capacites are lost and insecurity prevents access.

- **at least half of world's population do not have essential health service coverage with poorest and conflict-affected countries faring worst**
- **globally, < 20% wasting treatment coverage**

Alternatives to specialized nutritious food for treatment of moderate wasting

Author, Year, Study design	Location, sample size, target age and admission criteria	Intervention Treatment	Control treatment	Food product better than control?
(Nikièma et al., 2014) Cluster RCT	Burkina Faso n=1974 6-24 months, WHZ <-2 & ≥ -3	1.Locally produced RUSF 2.Supercereal Plus	Child-centred counselling (CCC)	Yes – better anthropometric recovery due to lower default
(M. Hossain, Ahmed, & Brown, 2012; M. I. Hossain & Ahmed, 2014; M. I. Hossain & Yasmin, 2016) (conference abstracts) Cluster RCT	Bangladesh n=227 6-24 months, WHZ<-2 & ≥ -3	1.Cereal-based supplement (SF) 2.Cereal supplement and psychosocial stimulation (SF+PS)	1.Health education & micronutrients at hospital (HC) 2.Health education & micronutrients at clinic (CC) 3.Psychosocial stimulation (PS)	Maybe -Not possible to distinguish between benefits of supplement vs psychosocial stimulation
(Javan et al., 2017) RCT	Iran n=70 9-24 months, WHZ <-2 & ≥ -3 & referred for treatment	Blended flour supplementary food (chickpea, rice, wheat, barley, sugar) + multivitamins + nutritional counselling (SF)	Multivitamins + nutritional counselling (C)	Yes – better recovery, weight gain and WLZ gain
(van der Kam, 2017) RCT	Nigeria n=2213 (25% of sample had MAM at enrolment) 6-59 months, Diagnosed with malaria, diarrhoea, or LRTI	1.RUTF, one sachet/d	1.Micronutrients, two sachets/d (MNP) 2.No supplement (C)	No – incidence of SAM was same for RUTF group to MNP group and no supplement group.
(Roy et al., 2005) Cluster RCT	Bangladesh n=282 6-24 months, Weight-for-age 61% - 75% of median (NCHS)	1.Intensive nutrition education + supplementary feeding (INE+SF)	1.Standard nutrition education (C) 2.Intensive nutrition education (INE)	Yes- better immediate and sustained recovery
(Fauveau et al., 1992) RCT	Bangladesh n=134 6-12 months, MUAC >11.0 & <12.9cm, & living in bamboo structure	Supplementary food (rice, wheat, lentils and oil) (SF)	Nutrition education (C)	Maybe -Food group have larger weight gain in first 3 months but not whole 6 months
(M. I. Hossain, Nahar, Hamadani, Ahmed, & Brown, 2011) RCT	Bangladesh n=507 (81% of sample had WHZ<-2 at baseline) 6-24 months, WAZ<-3 (NCHS) & recovered from diarrhoea at the hospital	1. Health education & micronutrients at clinic + cereal-based supplement (C-SF) 2. Health education & micronutrients at clinic + cereal supplement and psychosocial stimulation (C-SF+PS)	1.Health education & micronutrients at hospital (HC) 2.Health education & micronutrients at clinic (CC) 3. Health education & micronutrients at clinic + psychosocial stimulation (C-PS)	Yes, better WLZ and LAZ gain.
(Heikens, Schofield, Dawson, & Grantham-McGregor, 1989) RCT	Jamaica n= 82 3-36 months, WAZ <80% of median (NCHS)	High energy supplement for 3 months plus weekly home visits and micronutrient supplements for 6 months (HES)	Home visits and micronutrient supplements for 6 months (HV)	Yes, better WAZ after 3 months but no difference after 6 months. But better HAZ after 6 months
(Schlossman et al., 2017) Pilot cluster- RCT	Guinea Bissau n=681 6-59 months, WHZ<2 or WAZ<1 or HAZ<2	1.RUSF with 15% protein 2.RUSF with 33% protein	No intervention (C)	No – controls improved an equal extent to food group
(Christian et al., 2015) Cluster RCT	Bangladesh n=5421 6 months, All infants in the catchment area	1.RUSF-R, rice-lentil based 2.RUSF-C, chickpea based 3.RUSF-S, soy based 4.Wheat-soy-blend++ (WSB)	1.Nutrition counselling (C)	Yes for RUSF-S, No benefit of WSB++ over counselling
(Grellety et al., 2012) Prospective cohort	Niger n=2238 (18% of sample WHZ<-2) 6-23 months, All children 60-80cm length	1. RUSF-soy (LNS-MQ)	1.No supplementation (failed to register) (C)	Yes, better MUAC and WLZ gain and lower mortality rate

MAM treatment using food and counselling: a systematic review

- 7 / 11 studies in this review found that food products resulted in greater anthropometric gains than counselling or micronutrient interventions.
- 2 studies found no benefit, 2 studies inconclusive
- This was especially true if the supplementary food provided was of suitable quality and provided for an adequate duration.

Lelijveld et al. (2019). Systematic review of the treatment of moderate acute malnutrition using food products.

Enablers to scaling up treatment of moderate wasting in fragile settings

- To change the mindset and move away from MAM/ SAM dichotomy
- To aim for universal treatment and care coverage of <u>all forms of wasting</u> (with or without SNF)
- To "Localize" wasting treatment
- To commit to a multi system approach: social protection, food, health

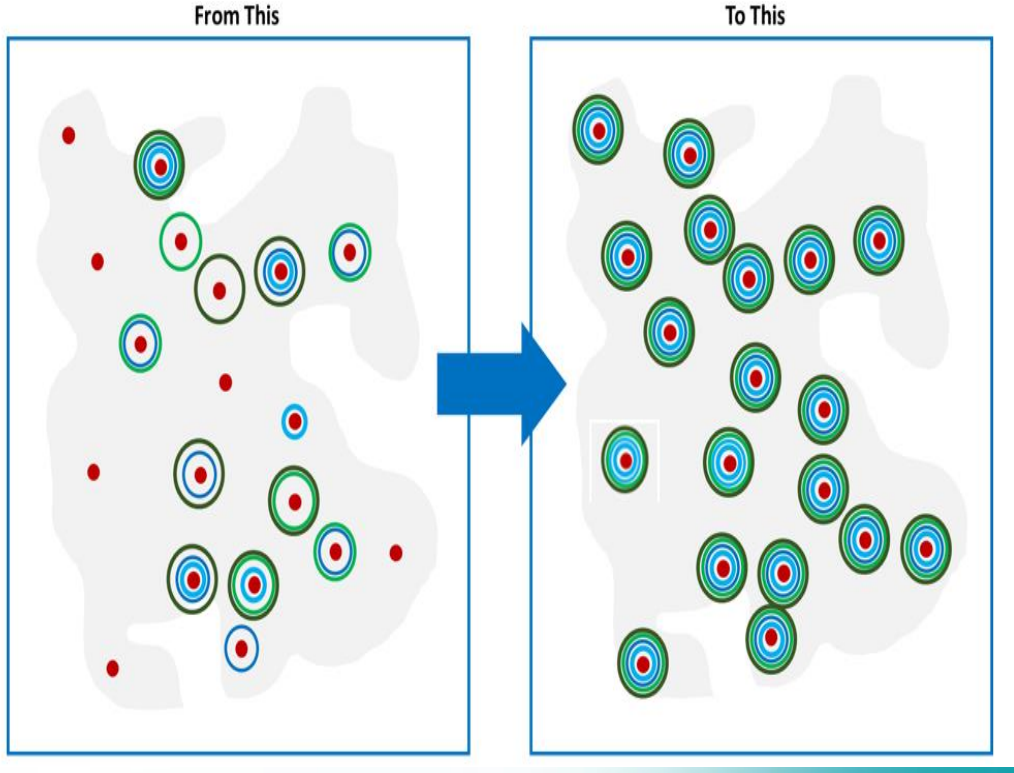
Nutrition screening and treatment is provided through every contact opportunity.

Scaling up moderate wasting treatment within continuum of care

Cameroon

- No. children reached doubled
- MAM admissions match estimated caseload
- Total cost/ child (~US$21) half TSFP (~US$ 41)

South Sudan/ Yemen/ Somalia



South Sudan

- 97% MAM/ SAM co-location (up from 45% 2014)
- 2.6-fold increase in children reached

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Thank you

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