© Tdh / Christian Brun

Mother and child health.

Thematic policy.

Terre des hommes
Helping children worldwide. tdh.ch

IMPRESSUM

RESPONSIBLE FOR PUBLICATION:
Jean-Pierre Papart

LAYOUT: Isabel Hediger
TEMPLATE: Olivia Wermus
PRODUCTION: Laure Silacci

PRINTING: Mengis Druck
und Verlag AG. Printed on chlorine-
free paper.

VERSION: Brochure in French,
Spanish and English.

Second version on the basis of
a learning process from tdh field
projects. A large number of Tdh
and partner organisations' staff
were involved, namely through the
thematic meetings: Dakar (2002);
Cartagena (2003); Kathmandu
(2004); Casablanca (2006); Cairo
(2007) and Dakar (2009).

Tdh Management Validation:
February 2010

Contents

Introduction

Health constitutes one of the two priority domains of intervention for the Terre des hommes Foundation, along with protection. Since its creation in 1960, Tdh has always given strong priority to the health of children.

From the beginning of 2001, and with the publication of the Project Cycle Management Manual (PCM), we have increasingly felt the need to translate more concretely our policy in the area of health, i.e. the way that we at Terre des hommes work in health projects. The capitalization effort made in this period helped us to develop a health sector strategy in March 2005. This first version of the sector strategy built on major capitalization work on our institutional experience in health (identification of successes, failures, and lessons learnt), undertaken over a two-year period (between January 2002 and January 2004), and thanks to several regional workshops, in Africa (for Africa/Haiti: Dakar Nutrition Capitalization Report, Senegal, June 2002), in Latin America (Latin America Nutrition Capitalization Report, Cartagena, Colombia, April 2003) and in Asia/Middle East (Asia Nutrition Capitalization Report, Kathmandu, Nepal, January 2004).

This present document, now titled *Health Thematic Policy*, is largely a rewording and adaptation of the sector strategy developed in 2005. In effect, we confirm the pertinence of the three strategic axes:

- support for the national health system of the countries in which we work;
- empowerment through a community approach;
- advocacy for the right to health.

The health thematic policy is in accordance with Tdh's current child rights approach. As the rights of the child to health (Convention on Children's Rights) stipulates the responsibility of signatory States (the *party States*), it was thus logical for us to intervene in support of the State and not, as had been the case, in substitution of it. Furthermore, the historical experience of all those who struggle for human rights shows that rights are not just received but are the result both of the mobilization to the right holders (from where our empowerment approach comes), and of a claim made through advocacy.

This new presentation document on the health thematic policy has strongly benefitted from the regional health-nutrition workshops for Africa and Haiti (Casablanca, May 2006, and Dakar, May 2009) and for Asia-Middle East (Cairo, December 2007).

The objective of this document is to inform colleagues, partners and donors on the type of interventions put into place or supported by Tdh in the area of the right to health; the driving principles which guide these interventions; the models of action and options for sustained work; analysis tools for implementation and monitoring; and key partners.

Section 1 briefly explains the major problems of children's health globally. The reasons for Tdh's engagement relative to this problematic and the context of its action are also presented.

The second section focuses more specifically on the general directions of Tdh's action in the area of health. It presents the guiding principles of this action, and then describes the vision, the objectives and target groups of the action. Finally, this section highlights the principle models of action currently operating in the Foundation's health projects.

The third section provides information on the action established or supported by Tdh. It emphasizes the importance of the use of project cycle management. It then analyzes in greater detail the areas of activity linked to mother-and-child health/nutrition projects and other health projects.

1

Children's health according to Tdh

At *Terre des hommes* we are fundamentally concerned by the injustice represented in the death of children. To confront this problem, we have long attacked its principal determinant: malnutrition. The problem remains a central concern in half of our health projects. But death is not the only negative consequence of a lack of access to health. The suffering of the child is also unacceptable, which is why Tdh is also present in countries where, even if malnutrition is better controlled, access to health rests problematic for a large proportion of children. Tdh wants to be present in those contexts where access to basic care is far from generalized, where children and their families are confronted with situations of poverty, injustice and violence which fundamentally inhibit their potential for growth and development.

1. The health problems of children

This chapter introduces first of all the problem of children's health at a global level. The reasons for Tdh's engagement are given with respect to this problematic.

The global situation

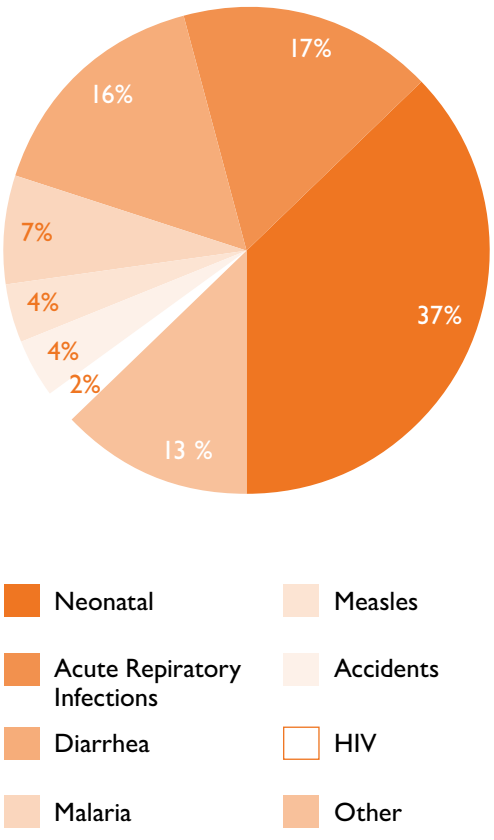
• How many children die? First of all – after over fifty years existence of the Foundation – it need to be said that undeniable progress has been made in child mortality. Where in 1960 25% of children in the world died before reaching their 5th year of age, this proportion dropped to 12% in 1980, 10% in 1990, to 7% in 2000, but then stagnated at this level in 2010.

During 1990, 11,700,000 children under the age of 5 lost their life; 10,500,000 in 2000. One important part of the improvement between 1990 and 2000 is due to the drop in mortality from diarrhea, from 3,300,000 deaths in 1990, against 1,500,000 in 2000. This calculates as 1,800,000 lives saved during the decade thanks to improvements in the cover of oral rehydration therapy, from 40% in 1990 to 69% in 2000.

If, as we have just seen, important progress has taken place in care for children's illnesses, neonatal mortality and malnutrition remain fundamental problems.

• What do children die from? At present, the risk of death is the highest during the first months of life. Giving birth in good hygiene conditions and effective neonatal care play an essential role in this respect. Premature birth, asphyxia at birth and infections are at the source of most newborn deaths. Between one month and five years, the principal causes of death are still pneumonia, diarrhea, malaria, measles and HIV (cf. Figure 1). Malnutrition is an aggravating factor which plays a key role in half of children's deaths. If malnutrition contributes to one third of the under 5 mortalities, then 3,500,000 deaths are attributable each year to malnutrition. Around half of all malnutrition cases are acute severe; the other half are moderate, both acute and chronic (growth stunting) forms.

Figure 1: Causes of mortality in the under 5 years



Malnutrition contributes towards more than one third of deaths in the under 5 years.

Source: World Health Organization, 2008

• How widespread is malnutrition? Severe acute malnutrition (SAM) affects 15 million children in the world: 3 million in complicated severe acute malnutrition, SAMc, must be cared for in hospital; 12 million in simple severe acute malnutrition (SAMs) may be treated in the community with ready-to-use therapeutic food (ATPE). Children with a ratio of weight relative to height less than -3 standard deviation (SD), according to the WHO norms, have a high risk of death, over nine times that of children whose weight-height index is over -1[1]. This is the same when the brachial perimeter is less than 115mm. The high risk of death observed under these levels shows the importance of nutritional and intensive medical care. Moderate acute malnutrition (MAM) affects 60 million children. Even chronic malnutrition, more justly termed growth inhibitor, affects 195 million children. This condition deeply affects the possibility of development for the children who suffer from it. The conditions of moderate malnutrition (MAM and/or delayed growth), even if they are less associated with mortality, and given the large number of children affected, in absolute numbers are even more deadly than severe acute malnutrition.

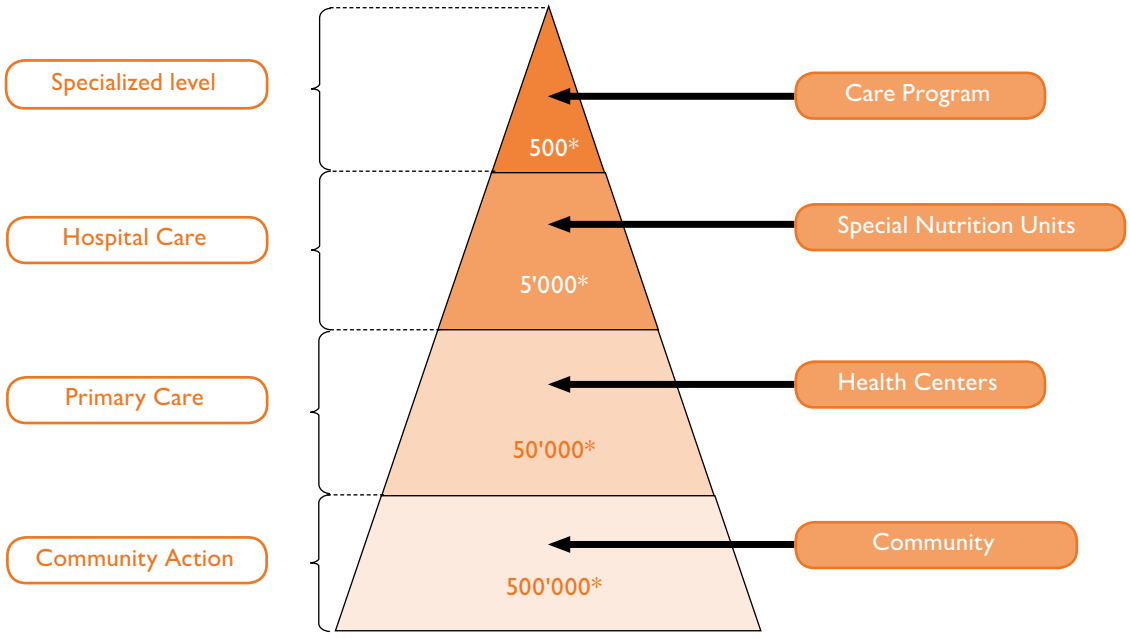
The current estimates are that of the 6.2 billion human beings living on our planet today, between 1 and 1.2 billion suffer from hunger.

• Asides from malnutrition, what are the other determinants affecting a child's health? Half of humanity still does not have easy access to water of an acceptable quality, nor to health services (because they are inexistent, not functional, or financially inaccessible). For reasons of politics and of economic injustice, a large part of humanity lives in contexts of war, insecurity and violence. These latter determinants also fundamentally affect health and the chances of children's development.

The main concern for Tdh

For Tdh, the rights of the child begin with the right to live. Since its creation in 1960, Tdh has always been firm in its engagement for the right to life and health for all the children of the world.

Figure 2: Levels of Tdh intervention in health.



* Number of beneficiaries (children and mothers)

As figure 2 shows, *Terre des hommes*' action in health extends across the four levels of the health pyramid, from the community level to primary health care and secondary level (district hospital), to specialized health care (see *Terre des hommes* specialized health care program).

With regard to its engagement for children's health, Tdh has a vision of the problem that is not just technocratic but profoundly humane. It sees the child as not just a ravaged body, but as an individual human being, sharing his/her humanity with his/her family, community and the entire human species. It is with this ethical vision that Tdh has progressively constructed a so-called *community* approach to its action.

While today health has become a global commercial good, the action of Tdh in health is resolutely centered on the child in all his/her humanity. It is thus protected from all forms of instrumentalization. The focus of Tdh's action is on the child him/herself.

2. Reasons to act

This chapter justifies the reason for which Tdh acts in the struggle for children's health.

Tdh is motivated by the principles of its Charter and guided by the International Convention on the Rights of the Child (CRC).

The Tdh Foundation's Charter (1960) states that wherever a child is exposed without help to hunger, misfortune, abandonment, poverty or sorrow, the Terre des hommes movement will go to his/her aid immediately and to the fullest extent of its ability.

The Convention on the Rights of the Child (1989) requires that:

Article 24§1: States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.

Article 24§2 : States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technolgy and through the provision of adequate nutritious food and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. Contexts of intervention

Overall, we can consider two types of intervention contexts for Terre des hommes' health projects:

- Projects within mother-and-child health where the nutritional problematic is central,
- Other health projects.

The stakeholder analysis

Mothers, parents, families, children and communities are Tdh's priority partners in all its projects. Tdh also privileges relationships with local and national health authorities, with the aim of interventions that are negotiated and conform to national health policies, and focuses on complementarity, not the substitution, and viability over the long term. In addition, Tdh privileges relationships with NGOs and local and national health associations, international agencies – Unicef, WHO – and international NGOs (ACF, Care,

World Vision, Save the Children, Africare, Helen Keller International, MSF, …)

Particular attention is given to links with academic institutions (e.g. INSE in Guinea, ICDDR'B in Bangladesh) in order to allow for quality analyses of current interventions and potential research-actions in some areas. In all these cases, Tdh tries to work within networks and in collaboration with all sectors in the area of health, in order to promote the sharing of experience, the identification of lessons learnt, and complementarity. Where necessary, Tdh does not hesitate to initiate networking at local and national levels.

Tdh's added value

• Local and international expertise. In the last few years, Tdh has completely revised the content of its interventions in mother-and-child health and nutrition. This revision has been based on the capitalization of experience, setting our practices against the scientific literature, and in dialogue with other institutional partners, (in particular SDC, Medicus mundi, l'WHO, IFE core group, MSF Switzerland and Belgium, and UNICEF…)

Since mid-2006 a huge effort has been underway to improve our support in the following interventions:

• Special nutrition units which specifically look after severe acute malnutrition in the special nutrition units (quality assurance evaluation, putting into place a monitoring system);

• Management of moderate acute malnutrition at the community level (establishment of monitoring systems, supervisions, longitudinal studies (including publications) to measure the effectiveness of the community approach, and participation in a WHO experts debate on this theme);

• Integrated management of childhood illness (IMCI). This dimension of our Mother and Child Health/Nutrition projects, which received insufficient attention for a long time, has strongly grown in priority overall in Mother and Child Health/Nutrition projects (training, monitoring, logistics support, supervision);

• Particular situation analysis with technical assistance for the development of SMART surveys.

Since December 2007, and following the internal validation of a policy for simple severe acute malnutrition based on ready-to-use therapeutic food (RUTF) in July 2007 (see appendix 2 July 2009 version), this new approach has been progressively integrated in several projects.

Since 2009 we have been more deeply invested in the following problematics:

• Stunted growth (also known as chronic malnutrition);

• Lack of financial access to public health services.

From 2010 and in the coming years we will further investigate our understandings of the community approach and especially the place of promoting the social community link in health promotion.

The dialogue with other institutional partners, mentioned above, has taken different forms:

• With the WHO: Participation in two expert meetings on moderate malnutrition (30 September – 3 October 2008 and 23 – 25 February 2010);

• With MSF: advocacy for our MAM community approach (coordination for the Guinea project, invitation to the meeting of MSF resource people for Europe (Brussels, 5 – 6 June 2009);

• With SDC: invitation to present our RUTF policy (Bern, 8 June 2009);

• With the IFE Core Group: participation in the annual conference of the Global Nutrition Cluster (London, 20 – 21 October 2009);

• With UNICEF: holding a training trainers of nutrition for Guinea (Conakry, 16 – 29 August 2009).

2

The Tdh interventions

The second section focuses more specifically on the general directions for Tdh's action in the area of health. It first presents the driving principles which guide this action. It then describes the vision, the objectives and target groups for this action. Finally, the section highlights the principal models of action currently in place in the Foundation's health projects.

4. Tdh guiding principles

The guiding principles of Tdh's action in the area of health are the following:

• Health: a fundamental human right (§24 CDE) and not a commercial good (importance of advocacy to support public services);

• A holistic vision of health which integrates the concept of socio-economic and cultural determinants of health;

• Health promotion (Ottawa Charter – 1986);

• Primary healthcare (Alma Ata Declaration – 1978);

• The importance of coupling community interventions with interventions that support health services (the supply as much as the demand);

• Support at the level of one or more health districts, or the urban equivalent;

• Taking into account the life cycle (mother-child); the importance of the biological couple of mother-child and thus of reproductive health for the health of the child;

• The respect for universally recognized technical standards (international guidelines, WHO where available) and for health policies at the national level;

• Attention paid to the humanization of health services;

• The community approach with community participation and respect of community culture (understanding of its sources);

• Coordination with other actors (Ministers of Health, NGOs, local associations, research centers);

• Training and development of the skills of those engaged in projects;

• The viability of interventions (except for interventions in crisis contexts and in particular cases).

5. Vision, mission and target groups

The vision and the mission

The vision of Terre des hommes is the improvement of the state of health of children in the world.

The Foundation's mission relative to health:

• Contribute to the survival and best possible development of children from 0 to 5 years of age;

• Contribute to the improvement of health and nutrition of pregnant and breastfeeding women;

• Contribute to the reduction of maternal mortality.

The target beneficiaries

Children from 0 to 18 years of age (the Convention on the Rights of the Child declares that a child is aged under 18), with a concentration on the vulnerable period from 0 to 5 years (0-3 years for certain mother-and-child/nutrition projects), and on women of procreative age, with focus on pregnant and breastfeeding women.

The analysis of the context, the actors and the available resources determines the final choice of the target group of beneficiaries. Ideally, women of procreative age and not just pregnant and breastfeeding women should be included in the target group (in order to work more universally on reproductive health). Nevertheless, in 3-year project cycles, and given the context and available resources, priorities need to be made.

The immediate environment of the child is certainly an integral part of any intervention strategy. Consequently, the parents, grandparents, local leaders, for example, should be increasingly involved in projects, given their key role in health behavior.

6. Strategic axes for the thematic policy

As mentioned in the introduction, the content of this document corresponds more to a refinement of the sectoral strategy developed in 2005. Our health thematic policy is laid out along three strategic axes:

- Support for the health system in the country of our intervention,

- Priority given to the empowerment of communities and beneficiaries of the projects,

- Priority given to advocacy for the right to health.

The thematic policy is what we aim for in all actions, and no action should be planned out of its scope. To evaluate the integration of the thematic policy thus implies that in every action and at every level of execution, we need to verify that there has been support for the health system, empowerment and advocacy. For example, when the mother of a family is supported in a health center by a community agent to receive her right to care for herself or her child, this action responds to each of the three axes of our thematic policy.

Both the axis for the support of the health system and those for empowerment and advocacy of our thematic policy come out of our institutional strategic plan: the *rights* approach. Everyone at Tdh believes that we do not want to intervene by substituting ourselves for local actors and institutions – parents and State – as duty bearers of the child's rights, but in support of them.

Historically, our foundation has initiated many institutional innovations – pediatric centers for the treatment of malnourished children, reception centers for abandoned children (children living on the street), etc. - but our position is becoming more and more that of *providing support* rather than *replacing*. In effect, it is because of this strategic choice that we have been engaged in a process of progressive retreat of health professionals working directly for Tdh and ensuring their integration in public health structures (for example, the Special Nutrition Unit of the Nouakchott Central Hospital in Mauritania).

7. Our models of action

Half of our health projects currently follow a model of mother-and-child health centered on the problematic of acute malnutrition. Other projects follow other models of action, and an effort to investigate and analyze is currently underway in order to propose a versatile model capable of better helping their planning, establishment and monitoring.

Technical reminder

The model of action is defined in the Project Cycles Manual (PCM) as *the approach which the project wishes to adopt vis-à-vis its beneficiaries*. Technically, a model of action applicable to a health project is a theoretical model of public health centered on the problematic. As with any theoretical model, a model of action proposes a particular narrative of *reality* (itself inaccessible by definition). In order to operate within *reality*, it is necessary to conceive a representation instrument that is sufficiently simple in order to be useful for professionals in charge of planning, implementation and follow-up of projects.

A good representation model is not defined by its proximity to *reality* but by its capacity to help us identify effective actions. That is to say, the resolvent assumptions of the problematic for which the project was intended. Numerous *good* models are thus possible. With regard to malnutrition, we can conceive two natural histories in the relation of malnutrition and childhood illnesses (measles, diarrhea, respiratory infections, etc.).

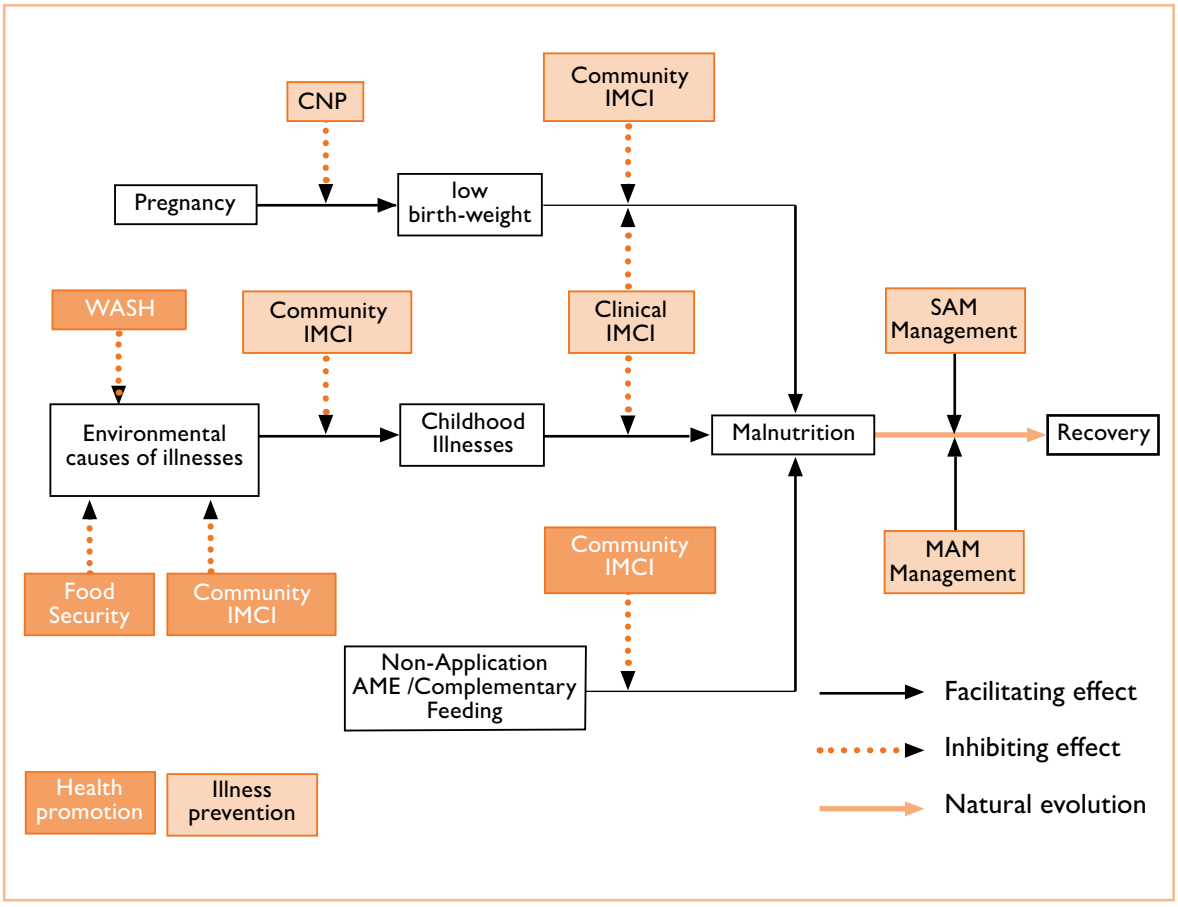
We can represent malnutrition whether as the cause, whether as the consequence, of childhood illness, without forgetting that many other elements (causes and consequences) also play a part. We will no doubt be much closer to the reality if we represent a retroactive effect of malnutrition and childhood illnesses – which indicate that the two representations are identical.

The Mother and Child Health/Nutrition Projects

The experience, since its creation, of *Terre des hommes* in the right to health has been centered on nutrition. This option for public health is based ethically on the unacceptable nature of hunger and malnutrition among children. We have here a characteristic – an added value, a trademark – in Tdh's action. This option remains absolutely defendable wherever acute malnutrition is an important problem. This is the case, according to WHO criteria, if the prevalence of acute malnutrition goes beyond 10% among children of under 5 years. Where, in certain countries of intervention, we note a significant reduction in the prevalence of acute malnutrition beyond this level, it may become pertinent to conceive other models of action where malnutrition no longer has such a central position (e.g. health projects in Benin since 2009, the Santo Domingo de los Colorados health project in Ecuador).

Historically, the WHO has engaged in its normalization work with a separation between childhood illness and malnutrition. With the promotion of its Integrated Management of Childhood Illness policy (IMCI), the WHO has integrated the management of malnutrition with the management of childhood illness. Obviously, experts have always been very conscious of the vicious circle of illness – malnutrition – illness – malnutrition – illness, etc. In terms of a theoretical model, where the action focuses principally on the illness (although severe acute malnutrition is an illness), the preference is for illness prevention models. Where the action is focused principally on malnutrition in general, the preference is for health promotion models. The important point today is to consider that, whatever the theoretical model used to plan the projects, there must be action not just on nutrition but also on the illnesses which can affect children (and which are concurrent in source and outcome with the malnutrition of children). Today, in most of our mother-and-child health nutrition projects we have integrated the struggle against illness.

Figure 2: The Mother-and-Child Health Nutrition Model



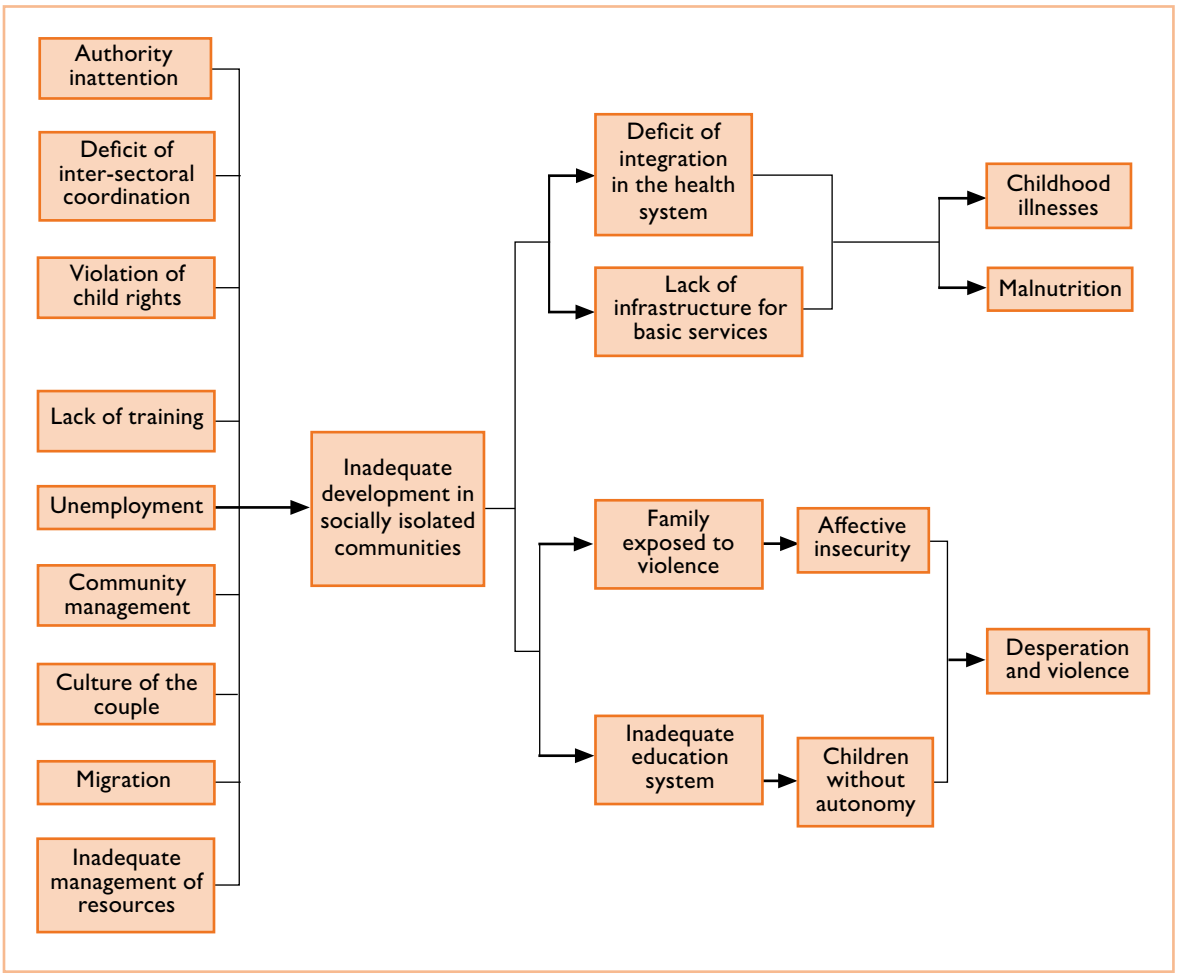
In the model of action presented in figure 2, malnutrition has been placed at the center of the model. The management activities of moderate and severe acute malnutrition (SAM and MAM, respectively) constitute secondary prevention (treatment) of malnutrition. The model identifies three causes of malnutrition: childhood illnesses, low birth-weight (<2.5kg) and the non-application of adequate nutritional measures for the child, including exclusive maternal breastfeeding (EMB) up to 6 months and alimentary diversification after 6 months. Monitoring of pregnant women to prevent low birth-weight, monitoring of children with low birth-weight through reinforced community IMCI, clinical IMCI for sick children (diarrhea, malaria, respiratory infections, etc.) and the promotion of EMB and alimentary diversification are all primary preventative measures for malnutrition. Other measures indicated in the model (the dark orange boxes) return to health promotion measures which can protect children against the causes of malnutrition.

The «other» health projects

Tdh support is also engaged in health projects where acute malnutrition cannot be identified as the predominant problem. Two recent models of action include: the Niñez y Vida team in Ecuador in the Santo Domingo de los Colorados project (Figure 3), and the Chhimeki team in Nepal for the Kathmandu project (Figure 4).

Unlike the model of action presented in figure 2, this model does not show any resolutive activities (these last are nevertheless identified and presented in the action diagrams established at the time of planning the new phase of the project).

Figure 3: Model of action for the Santo Domingo de los Colorados health project



This model reflects the problematic identified by the participants at the summer planning workshop: the inadequate development of children living in socially isolated communities (marginalized socially, economically and culturally).

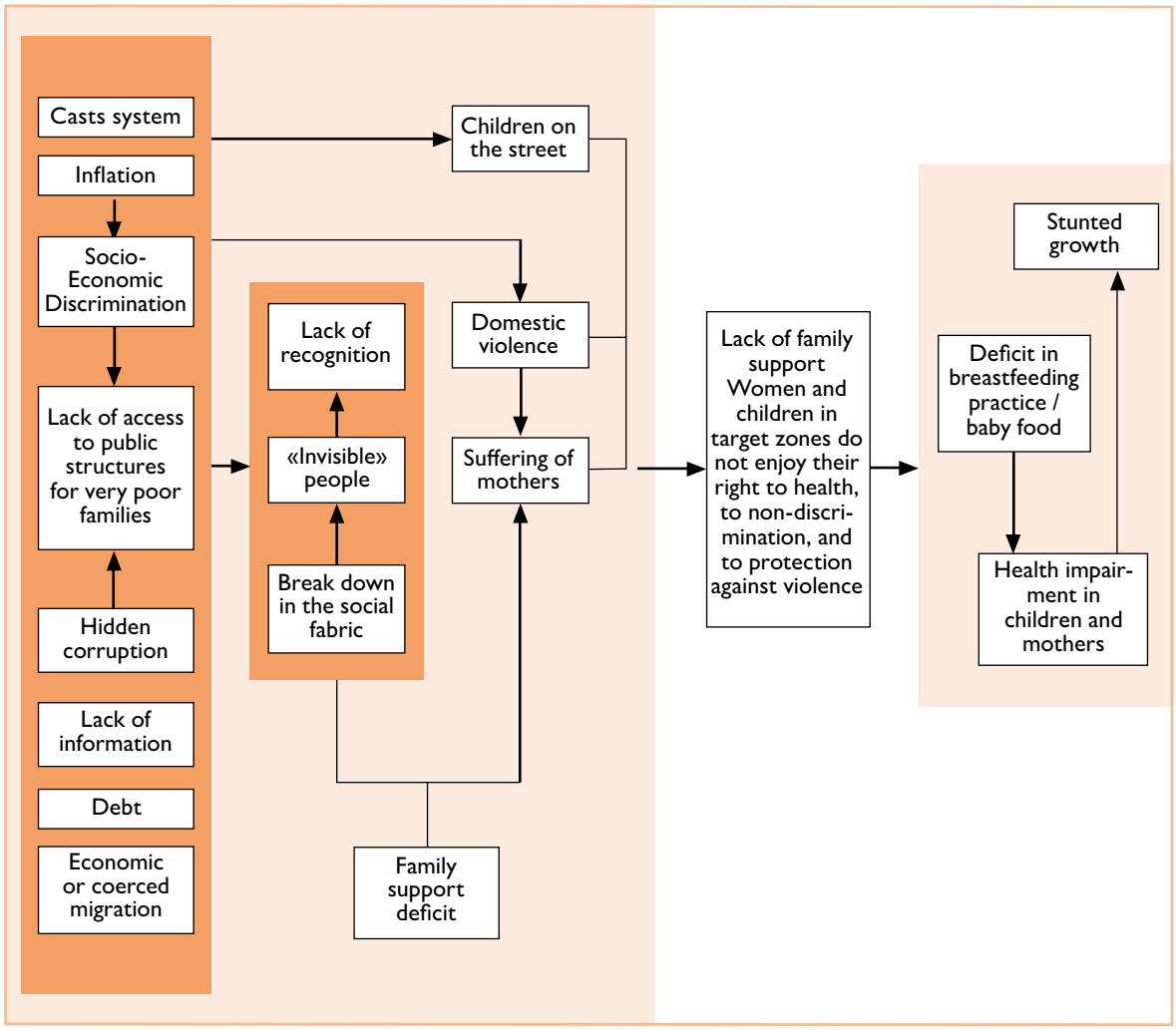
The Chhimeki health project in Kathmandu, Nepal, wanted to keep an important place for malnutrition in its model (stunted growth) but as a consequence of the identified problem: women and children do not benefit from rights to health, to non-discrimination and protection against violence.

Nevertheless, to give nuance to the model and indicate the important psycho-social dimension of the project, the planning workshop participants defined the project's objective as: using nutrition as an entry point to work with women and children to attain a complete state of health by improving their social and economic situation in the target areas.

The model presented in figure 4 does not show resolutive activities (these, as for the Santo Domingo project, were identified and presented in the action diagrams established during the planning workshop).

In the following months, and with a a view to a more ambitious recasting of our thematic policy, we will collectively study the possibility of identifying a unifying model of action which allows us to better harmonize our health projects which are not directly focused on acute malnutrition.

Figure 4: Model of action for the Chhimeki health project in Kathmandu



3

Tdh in practice

The third section gives information on the actions established or supported by Tdh. It emphasizes the importance of management by project cycle. It goes on to analyze the domains of activity linked on the one hand to mother-and-child health/nutrition projects, and on the other to other health projects.

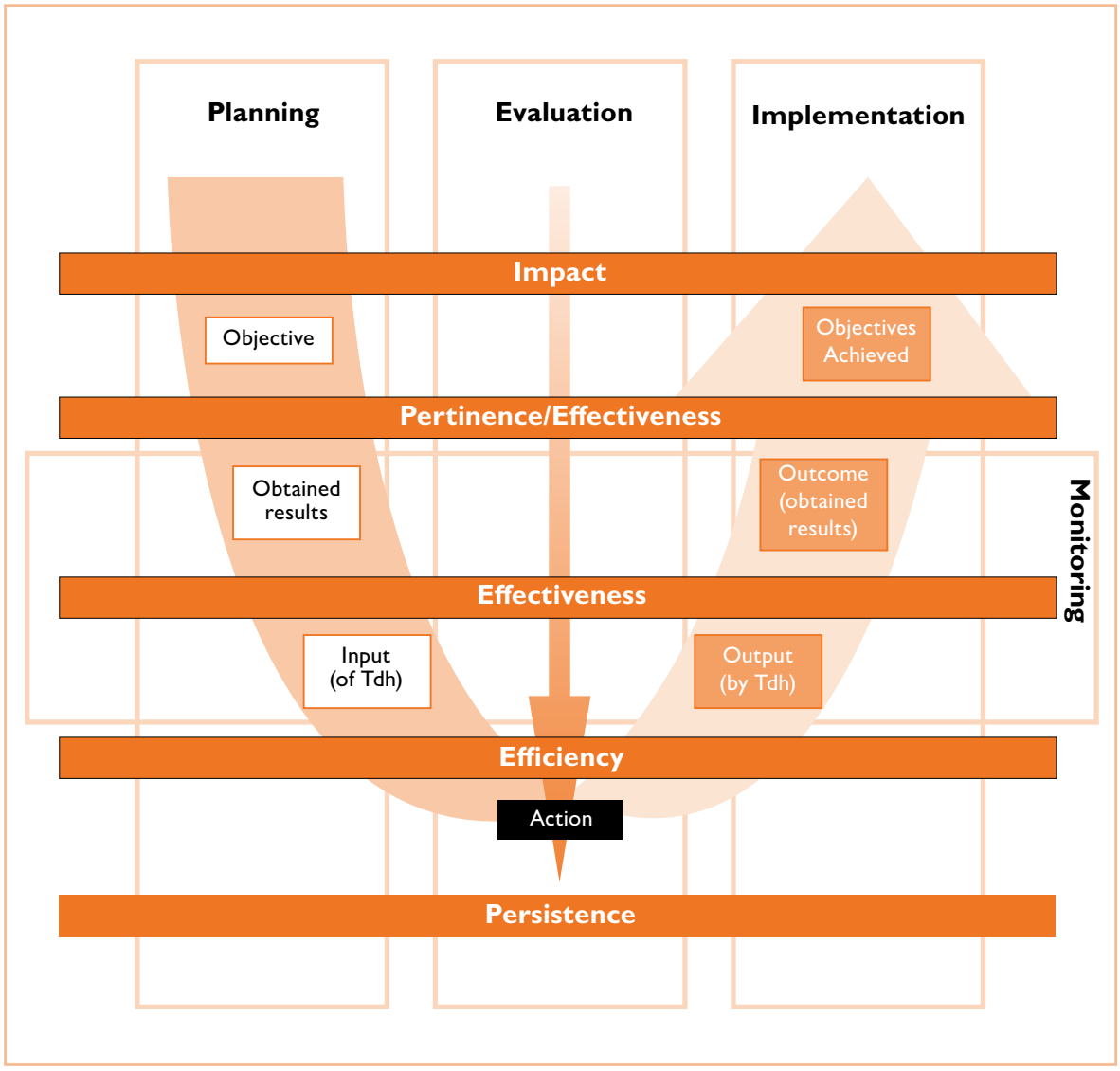
8. Our PCM approach

The health projects, like all Tdh projects, follow a management by project cycle (PCM). These cycles are ideally of three years' duration, and are reproducible each time the situation requires it and the necessary means are accessible.

In the last years the health projects have benefited from more particular attention with regard to several PCM instruments: planning, evaluation and monitoring.

Figure 5 – a synoptic diagram of project management – synthesizes the principal technical elements engaged in project management:

Figure 5: Synoptic representation of project management



In the planning phase, the objective is the final product of strategic planning which was developed on the double basis of a situation analysis and of our institutional identity (our vision, our mission, and our health thematic policy). The operational plan must then provide two products: the expected results and the action plan (expected outputs from the commitment of Tdh to its partners). Everything is ready for the action once the resources (expertise, time, staff, and financing) are available. The development of the project can be seen in the execution of engagements such as those planned in the Gantt chart and through the monitoring of obtained results (outcomes). If the project is relevant, if the results are as expected, and if these have been obtained with the required level of performance, then the impact of the project must be where intended.

The evaluation of the project (at mid-term, at the end of the cycle or of the project, or even annually, whether the evaluation is self-managed or entrusted to an external third party) must have an impact both on the quality of the planning and on the quantitative and qualitative development of the action programmed. The following elements must be covered by the evaluation: pertinence, effectiveness, efficiency and sustainability (viability, durability) and, if possible, the impact of the project.

The monitoring manages three informational needs: the monitoring of obtained results (outcomes), the monitoring of the performance in the development of activities undertaken to achieve results, which means verifying that the execution of the constituent tasks reaches the expected performance level (quality assurance), and the monitoring of Tdh's assistance commitments (outputs) vis-à-vis beneficiaries and partners (monitoring the time-plan and budgeted expenses).

9. Our Mother-and-Child Health/Nutrition action

We have seen above (in 7. Our models of action) that around half of Tdh health projects share a model of action centered on the problem of acute malnutrition.

We have stated above (in 4. Driving principles) that every action should strictly respect universally recognized technical standards (international guidelines, WHO when available) and health policies at the national level. Consequently, we will not retain any activities in our projects other than those based on scientific evidence (evidence-based practices) which have proved their effectiveness. These scientific data are in general easily accessible in the form of guidelines and can be supplemented by other sources from socio-sanitary databases (e.g. PubMed, Cochrane Library, etc.) (Table 1).

Table1: Activities of primary and secondary prevention of malnutrition which have been evaluated for their effectiveness (Lancet, May 2008).

Nº	Intervention	Effectiveness
01	Prescribing zinc to pregnant women	Reduction of premature births by 14%
02	Prescribing Albendazole to pregnant women in the second quarter	Increase of haemoglobin at term by 6g/l.
03	Prescribing 2 doses of sulphadoxine-pyrimethamine to pregnant women	Risk reduction of anemia at term by 12%
		Increase of child birthweight by 100g.
		Risk reduction of low birthweight (<2.5kg) by 37%
04	Use of impregnated mosquito nets by pregnant women	Risk reduction of low birthweight (<2.5kg) by 23%
05	Prescribing iron / folic acid to pregnant women	Risk reduction of low birthweight (<2.5kg) by 16%
		Risk reduction of anemia at term by 73%
		Increase in hemoglobin at term by 12g/l.
06	Prescribing Ca++ to pregnant women	Risk reduction of pre-eclampsia (hypertension) by 48%
07	Promotion (individual or collective) of breastfeeding	Increase by +/- 50% of the rate of exclusive maternal breastfeeding
08	Child management in SAM(s+c) according to WHO guidelines	Reduction of the mortality rate associated with SAM (in comparison with conventional treatment) by 55%
09	Child management in SAMs by RUTF	Mortality rates (in 23'511 cases of 21 programs): 4.1%; recovery: 79.4%; withdrawal: 11.1%
10	WASH (including washing of the under-5s)	Risk reduction of stunted growth at 36 months by 2%
		Incidence reduction of acute diarrhea in the under-5s by 33%

Nº	Intervention	Effectiveness
11	Prescribing zinc to children under 5 (99% coverage)	Incidence reduction of acute diarrhea by 14%
		Incidence reduction of persistent diarrhea by 25%
		Incidence reduction of pneumonia by 20%
		Mortality reduction by 9%
		Risk reduction of stunted growth at 36 months by 17%
12	Education on complementary feeding practices for breastfeeding of 6-24 month olds	Risk reduction of stunting by growth at 36 months by 15%
		In situations of nutritional security, improvement of the average height age index by 0.25 SD
13	Feeding distribution for 6-24 month olds	In situations of nutritional insecurity, improvement of the average height age index by 0.41 SD
14	Prescribing Vitamin A to children under 5	Risk reduction of height mortality in the under-5 by 5% (but no impact on morbidity and anthropometry)
15	Prescribing Albendazole to the under 5	Risk reduction of anemia by 5-10%
		Light positive effect on weight (+200g) and on height (+1mm)
16	Prescribing zinc to the under 5 in cases of diarrhea	Reduction of the duration of diarrhea by 15-24% (-1 day)
17	All preventative nutritional and illness preventative interventions	Risk reduction of stunting growth at 36 months by 36%
		Risk reduction of mortality at 36 months by 24%

Among those possible activities to counteract the problem of acute malnutrition in the child, two are at the forefront: secondary prevention activities against acute malnutrition (Figure 5) and primary prevention of malnutrition (Figure 6).

Figure 6 presents the 9 activities linked to the function of secondary prevention of acute malnutrition:

1. The community monitoring for acute malnutrition of children under 5 years (3 years).

2. Referral of children suspected of malnutrition towards primary health structures;

3. Triage at the level of primary healthcare of children with severe acute malnutrition (SAM) and moderate acute malnutrition (MAM);

4. The evaluation at the level of primary healthcare of the severity of SAM with an appetite test and a search for signs of severity in order to distinguish between *complicated* cases (SAMc) and *simple* cases (MASs);

5. The transfer of children with complicated SAM (SAMc) to the special nutrition unit (SNU) at the district hospital (DH);

6. Management of children with complicated SAM (SAMc) by the special nutrition unit (SNU) until stabilization;

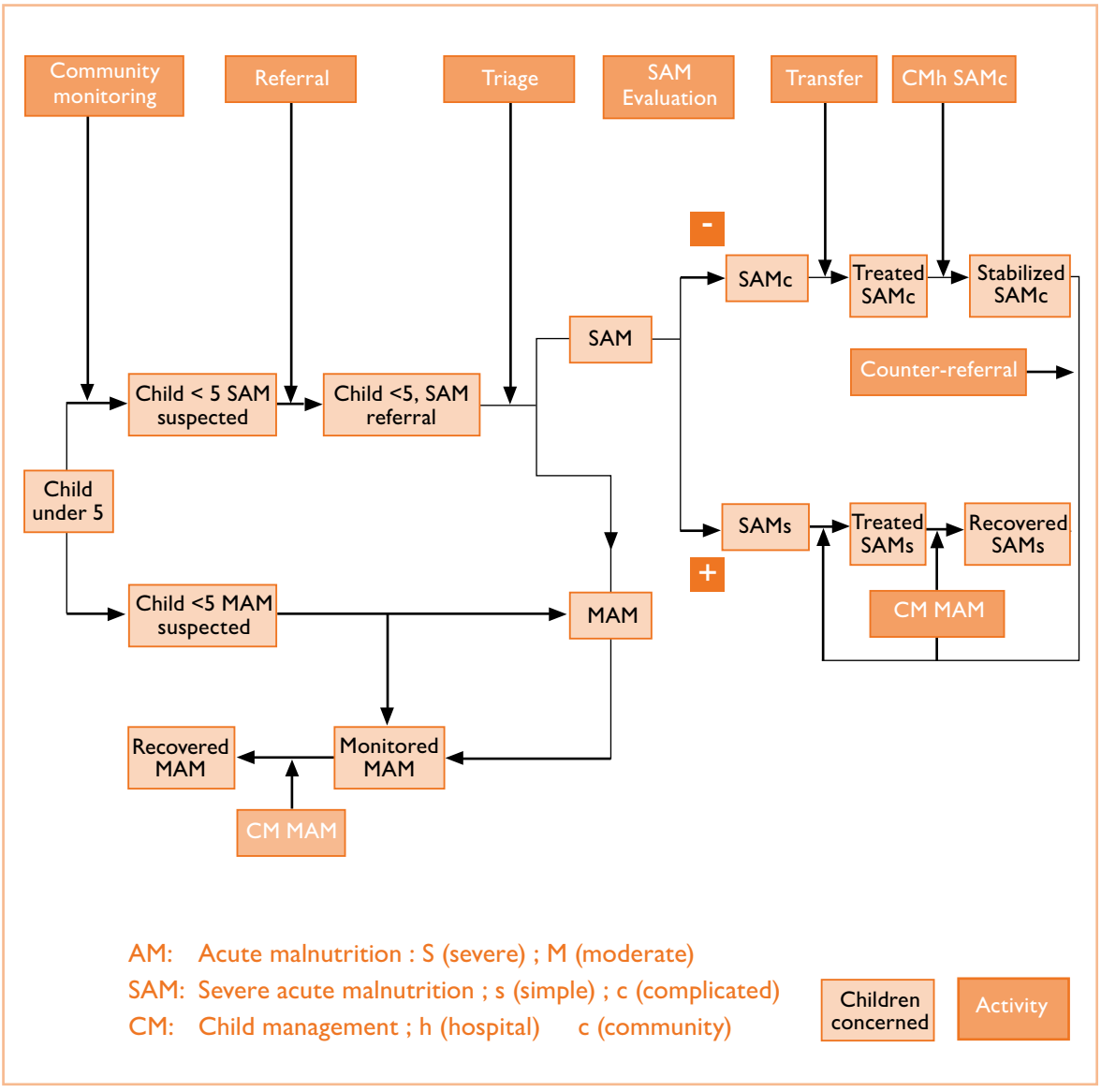
7. Management of children with simple SAM (SAMs) and stabilized cases of MASc at the level of primary health structure and their community (Mobile therapeutic program - MTP);

8. Counter-referral to the MPT of MASc children once stabilized.

9. Community management and monitoring of MAM children.

We have seen above in the model of action that the mother-and-child/nutrition projects were intended to act on three causal factors of acute malnutrition: low birthweight (< 2500g), childhood illnesses, and nutritional practices impeding the better development of the child. The prevention of low birthweight

Figure 6: Secondary prevention activities for acute malnutrition



may be in part guaranteed by monitoring during pregnancy (prenatal care). Childhood illnesses can be effectively treated by integrated clinical management of childhood illness (clinical IMCI) and their prevention through community IMCI (see table 2 for their concrete content). Good nutritional practices of the child (absorption of the collostrum, exclusive maternal breastfeeding until 6 months, and complimentary feeding to maternal breastfeeding from 6 to 24 months) are sustained through post-natal care activities and community IMCI.

Figure 7 presents the eight activities linked to the function of primary prevention of acute malnutrition:

1. Community monitoring of pregnant women in order to detect pregnancies at the start of their first quarter;

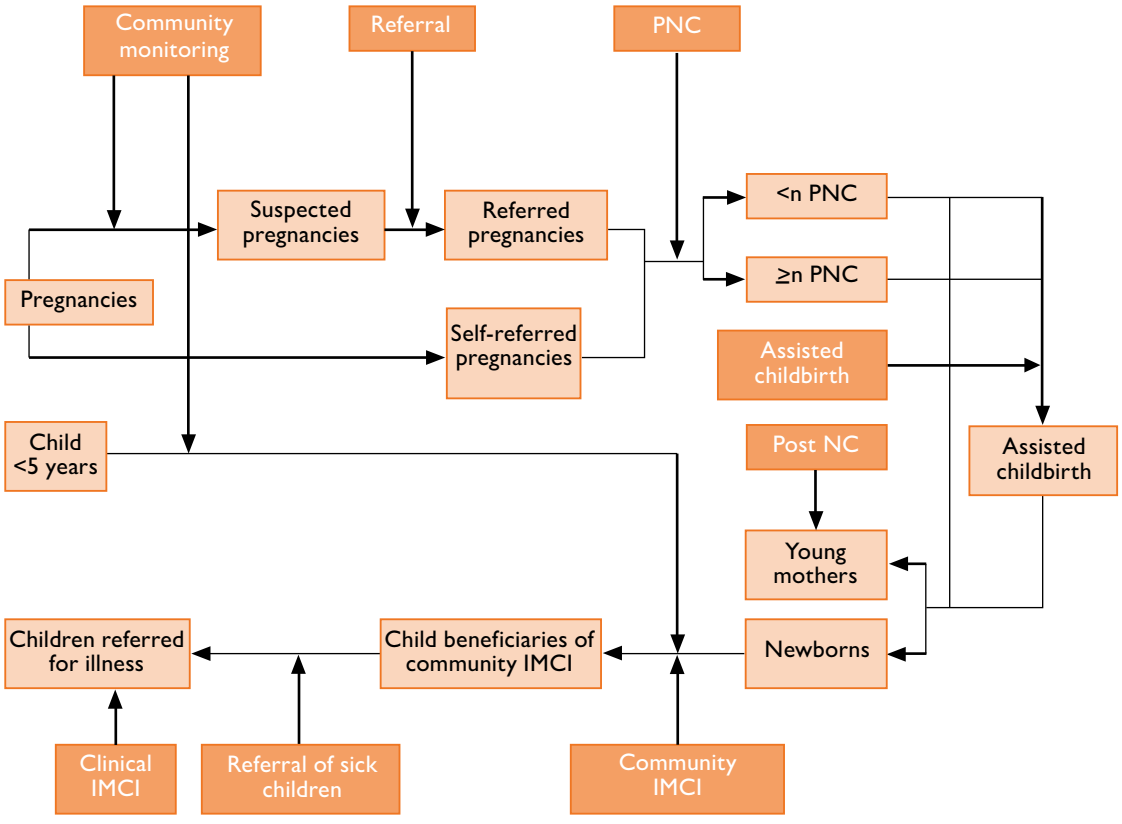
2. Referral of pregnant women to the primary health structure;

3. Prenatal care (PNC);

4. Assisted childbirth;

5. Post-natal care (post NC);

Figure 7: Primary prevention activities for acute malnutrition



PNC: Prenatal care
Post. NC: Post-Natal care
IMCI: Integrated management of childhood illness

6. Community IMCI;

7. Referring sick children to the primary health structure;

8. Clinical IMCI.

The clinical and community activities linked to IMCI are listed in Table 2. According to the situation, these activities can be complemented or modified in order to answer to local health needs.

This list of activities is nevertheless only an aide memoire since, in reality, the IMCI policy intends to make available to every child all the integrated preventative and curative care to which he or she has a right in order to assure not just survival but the best physical, mental and social development.

10. Our other health actions

We have seen above (7. Our models of action) that around half of our health projects follow a mother-and-child health model centered on the problematic of acute malnutrition, and that we are also engaged in projects which follow other models of action. We have presented two of these models of action which were the focus of recent development during two planning workshops.

Tablea 2: Integrated Management of Childhood Illness (IMCI)

Clinical IMCI	Community IMCI
1. Management of diarrheic illnesses and of secondary dehydration	1. Promotion of maternal breastfeeding (< 6 months) and of maternal breastfeeding complementary feeding (6-24 months)
2. Management of acute respiratory infections	2. Promotion of the use of additional micronutrients (iron, iodine, vitamin A, zinc) and anti-parasites
3. Management of fever (including malaria and measles)	3. Protection against fecal dangers
4. Management of ear pain and other frequently occurring health problems	4. Vaccination promotion (completed at one year of age)
5. Management of malnutrition (MTP for SAMs and monitoring of MAMs)	5. Physical protection against malaria (impregnated mosquito nets)
6. Expanded Program on Immunization	6. Stimulation of psychological and social development through speech, care and games
	7. Continuation of feeding and increase of liquid absorption during illness
	8. Care at home in case of illness
	9. Reference to a health structure in case of illness (4 alert signs)
	10. Sanitary education for parents

Many of the projects belonging to the category now identified as *other health actions* include numerous activities which are not yet well contained within a formal model of action which can authorize adequate planning and monitoring. We term many of these as *psycho-social*. This should be reviewed in a near future.

• Activities promoted in these projects: in the Santo Domingo de los Coloradoes health project in Ecuador, activities in relation to the model of action presented above are centered around four project functions: access to health; water and sanitation; the struggle against maltreatment (promotion of *buen trato*); and community development.

In the Chhimeki health project in Katmandu, activities are organized around four functions: family protection; secondary prevention of moderate malnutrition (MAM and stunted growth) among children; secondary prevention of maternal suffering; and promotion of the overall development of the child.

Examples of the projects in this area:

Country	Health Project
Nepal	Health promotion – nutrition and social integration
Ecuador	Health promotion, fight against maltreatment and community integration
Benin	Promotion of financial access to health for the poor
Afghanistan	Psychosocial approach to maternal health
Sri Lanka	Health promotion among displaced people
Peru	Psychosocial approach to stunted growth in children
Colombia	Global support for the community
Morocco	Psychosocial approach of MCH among migrants
Palestine	Psychosocial approach to stunted growth in children

4

Appendices

Tdh policy on the protection, promotion and support of maternal breastfeeding and appropriate feeding of infants and young children (July 2007)

Introduction

Article 24 of the Convention on the Rights of the Child stipulates that every child has the right to *the highest attainable standard of health*. The promotion, support and protection of maternal breastfeeding and appropriate feeding of infants and young children is fundamental to the improvement of the survival, growth and development of children, and thus to protect the health of the child.

In the framework of Tdh's strategy on mother-and-child health/nutrition, advocacy for appropriate nutrition for infants and young children is at the core of the Foundation's activities; in the field, in Switzerland, and internationally.

The recommendations of the World Health Organization (WHO) with regard to the feeding of infants and young children (the WHO global policy on the feeding of infants and young children, 2003, www.who.int) are key to the work of the *Terre des hommes* Foundation.

With a view towards the protection of the health of the child and to do no harm, the *Terre des hommes* Foundation is responsible for ensuring the quality of the use of all milk products made available. This means respecting the requirements of the International Code and later pertinent resolutions of the World Health Assembly with regard to the purchase, distribution and use of maternal milk substitutes and of milk products, as well as commercial food for babies and products destined for infant nutrition (www.who.int/nutrition/publications). This responsibility applies to all collaborators, at all levels.

The Foundation is a member of an international working group on the feeding of infants and young children in emergency situations (IFE Infant Feeding in Emergencies Group, coordinated by the ENN Emergency Nutrition Network).

This group has developed operational guidelines with regard to the feeding of infants and young children in emergency situations. The site www.ennonline.net contains information on the working group's activities, access to the operational guidelines in several languages, as well as the list of organizations which subscribe to them.

This *Terre des hommes* policy document is a summary of the essential points regarding the protection, promotion and support of maternal breastfeeding and appropriate feeding of infants and young children. Many of the key points of this document come from the Operational Guidelines. Most points contained in the latter are applicable as much in an emergency situation as in a stable situation. The Operational Guidelines also contain many useful definitions as well as references to find out more. This document replaced the Tdh policy document (September 2002) with regard to the use of milk products.

The milk used by the Tdh Foundation in its own projects, or that supplied to partners, generally comes from the SDC (Swiss Development Cooperation). The latest version of the Criteria for Use of Milk Products in Feeding Assistance (SDC, August 2006), must thus be respected. These criteria were revised in collaboration with the Tdh Foundation to be better aligned with the Operational Directives.

Every zone manager, delegate and health/nutrition coordinator for the Terre des hommes Foundation must be in possession of and have read the Tdh policy document of July 2007 (the present document), the operational guidelines on the feeding of infants and young children in emergency situations (February 2007), the SDC's Criteria for the Use of Milk Products (August 2006), and the Tdh Position Paper on the management of SDC milk products (July 2007). Any new delegate must be informed of these issues of feeding of infants and young children, as well as on the use of milk products.

In particular, during an emergency situation – whether in a new project managed by the emergency cell, or a crisis occurring in a country in which Tdh is already present with management by the delegation and the corresponding zone – every collaborator must respect the Tdh policy and the operational guidelines, and be informed on these questions. Before any intervention which requires milk products, headquarters (health/nutrition resource sector and the zone manager) must be consulted.

In the case of milk products supplied to a Tdh partner, it is important to take into account the fact that Tdh must ensure not just the quality of use of milk

products, but also respect of the Tdh Child Protection Policy, and the Tdh rules for good governance.

Guidelines

1.1 The WHO recommends exclusive maternal breastfeeding up to 6 months, and continued maternal breastfeeding up to 2 years or more with, from the age of 6 months, the introduction of appropriate complementary feeding. The *Terre des hommes* Foundation is committed to protecting, promoting and supporting maternal breastfeeding and appropriate feeding of infants and young children in all of its projects, and globally at an institutional level (protection of mothers at work). See the Global Strategy on the Feeding of Infants and Young Children, WHO 2003, which includes support for the Baby-friendly Hospital Initiative.

1.2 Following an institutional decision taken in 2002, where powdered milk is used for infants in a project, Tdh must also ensure that staff is trained to advise on feeding in order to ensure that this milk is not mistakenly given to mothers who would be better assisted with quality advice on maternal breastfeeding. Counseling on maternal breastfeeding is not just a question of messages on breastfeeding: it is a real, practical support and counseling by people trained in the subject (with a minimum of 40 hours training as per the WHO / Unicef courses on breastfeeding). Every intervention targeted at the support of non-breastfed infants must include an intervention to support and protect maternal breastfeeding.

1.3 Substitutes for maternal breastmilk are destined only for infants who are in need of them, and following an evaluation by a qualified health/nutrition professional who has been trained in the issues of feeding infants and young children and in maternal breastfeeding. The needs evaluation must take into consideration the possibilities of feeding by wet nurses or with expressed milk.

1.4 The criteria for temporary or long-term use of maternal breastmilk substitutes are: absent or deceased mothers, mothers suffering from serious illness or recovering their ability to lactate, mothers carrying HIV who have decided not to breastfeed, wherever the criteria for replacement feeding have not been fulfilled (see section II), children rejected by their mother, mothers who have chosen not to breastfeed, and mothers who have been victim of sexual violence and who do not wish to breastfeed. Mothers who use maternal breastmilk substitutes should not be stigmatized.

1.5 The use of breastmilk substitutes must always be accompanied by educational measures and monitoring: person-to-person demonstration and practical training in the safe preparation of milk, and monitoring of the distribution site and the home by trained health personnel. The monitoring must include a regular control of the infant's body weight at the moment of distribution (not less than twice per month). It must be possible to give powdered milk to infants who are in need of it and as long as neccessary (until breastfeeding is re-established or until at least 6 months or at most 12 months of age). This means that *one-off* distributions or gifts (single-box or sample supplies) to mothers are prohibited.

1.6 Because of the strong risk of contamination and difficulties in storage, the use of bottles and pacifiers must be actively discouraged, in general and above all in emergency situations when there are serious risks during preparation. Preference should be given to the use of cups.

1.7 No type of milk (maternal milk substitutes, whole or skimmed milk) should be generally distributed, including bottles and pacifiers. Maternal milk substitutes and other milks should only be distributed in strict conformity with the recognized criteria, and should only be supplied to mothers and caregivers for the infants who need them. Targeted but *one-off* distributions (single distribution) should not be carried out, in order to avoid potential changes in practices and the encouragement of needs that cannot be fulfilled.

1.8 Before setting up a home-based program targeted for infants requiring maternal milk substitutes, the supply of fuel, water and equipment necessary for the safe preparation of breastmilk substitutes should always be ensured. Where these resources are unavailable, and the correct preparation and use of these substitutes are impossible, a supervised program of preparation and consumption of foodstuffs should be developed on-site.

1.9 To avoid their use as substitutes for maternal milk, and to avoid contamination, powdered milk (skimmed or whole) must never be provided as such to take home. The operational guidelines which Tdh adheres to, and Tdh's own policy, have not been followed if milk powder is distributed as such, even to

a particular sub-group of the population, or even in a particular case of a crisis context. Take-home distribution is only acceptable if the powdered milk is mixed with a cereal flour.

1.10 Every program must respect the WHO's International Code on the Commercialization of Maternal Milk Substitutes and later resolutions (hereafter termed *the Code*). In principle, to be in conformity with the Code (Resolution WHA 47.5: *no free or subsidized distribution of maternal milk substitutes at any level, even in the healthcare system*), Tdh must not provide any powdered powder for infants in health structures (dispensaries, hospitals, public or private). The necessary quantities must be locally bought on a needs basis. This avoids easy recourse to these milks, linked to their availability and their lack of cost.

1.11 To respect the Code, the type and source of breastmilk substitutes should be taken into account. In particular:

- The use of generics (not brand names) is recommended, followed by locally available products.
- The use-by date should be at least 6 months after receipt of the product.
- Labels on products for infants should be in the appropriate language, mention the superior nature of breastfeeding, caution against dangers to health, and should not include an image of infants or an image idealizing the use of products for infants.
- The distribution of just one single box of breastmilk substitutes (including samples) to mothers should not occur, for as long as the single box is not part of a continuing supply of products for infants.

1.12 In respect of the Code, there should be no promotion of breastmilk substitutes at distribution points, including shelving of products or articles with the logo of a milk-producing company; breastmilk substitutes should not be used as a way to promote sales.

1.13 Violations of the Code should be reported to the national office of the WHO, and can also be reported to the International Code Documentation Center (ICDC) (see page 19 of the Operational Guidelines for details). It should be noted that in certain countries Tdh participates in Code monitoring surveys in collaboration with other organizations. In many countries, the Code is totally or partly incorporated into national legislation and monitoring of the Code is an effective way to check on the application of the Convention on the Rights of the Child (CRC).

1.14 In crisis situations, as with any situation, Tdh must refuse any donations (solicited or not) of milk products and especially powdered milk for infants. Donations can harm the health of children. Every intervention focused on non-breastfed children should be in parallel with an intervention to support maternal breastfeeding, particularly in crisis situations. Providing food for mothers, giving them a private space to breastfeed, and providing advice and support on breastfeeding are interventions to be envisaged and planned.

The case of use of milk products in HIV/AIDS projects and cases

2.1 In cases where any powdered milk for infants or other milks are used for the prevention of mother-child transmission of the HIV virus, and for HIV-positive mothers, headquarters should be informed in order to ensure that the criteria of use of such products are in alignment with the most recent WHO recommendations. These recommendations change over time and with the arrival of new data from scientific research.

2.2 The most recent recommendations of the World Health Organization on HIV and infant nutrition are the following (WHO, October 2006, Technical Consultation on HIV and Infant Nutrition):

- Exclusive breastfeeding during the first 6 months is recommended for mothers infected with HIV, for as long as alternative feeding methods are not acceptable, practicable, financially affordable, safe and sustainable for mother and child.
- Where the feeding substitute is acceptable, practicable, financially affordable, safe and sustainable, it is recommended that HIV-infected mothers do not breastfeed.
- If, when the infant has reached 6 months of age, the feeding substitute is still not acceptable, practicable, financially affordable, safe and sustainable, it is recommended to continue breastfeeding along with complementary feeding. In addition, the nutritional conditions of the mother and child should be regularly evaluated. Breastfeeding should cease

completely as soon as it is possible to feed the child without maternal milk in a nutritionally appropriate and safe manner.

- The mother of an infant or young child who is known to be infected with HIV, should be strongly encouraged to continue to breastfeed.

- The governments and other relevant stakeholders should intensify the protection, promotion and support of breastfeeding among the general population. They should also actively support mothers infected with HIV who choose exclusive breastfeeding, but also take measures to ensure substitute feeding for HIV-positive women (who have chosen this option).

Management of acute severe and moderate malnutrition

3.1 Skimmed and whole powdered milk should be used for the preparation of formulas F75 and F100 for the management of acute severe malnutrition (WHO, 2000, Management of Acute Severe Malnutrition, www.who.int)

3.2 Skimmed powdered milk should remain the first choice in the management of acute severe malnutrition. While whole powdered milk can be used in F100 and F75 formulas to manage severe malnutrition, skimmed powdered milk has a longer shelf-life (less risk of oxidation due to less fat content). In addition, for the same quantity of F100 or F75, the need for skimmed powdered milk is less than for whole powdered milk. The use of skimmed powdered milk implicates simply a higher need for locally available oil. This means a quantitatively lower dependency on powdered milk in the case of skimmed powdered milk.

3.3 Whole or skimmed powdered milk can also be used in preparations for the management of moderate acute malnutrition, based on powdered milk and cereals, for distribution to homes (dry feeding), or in on-site meal preparations based on cereals (wet feeding), according to the recommendations of the WHO and Sphere. These milks should never be distributed as-is, nor in a targeted manner, nor as part of a general distribution, in order not to damage feeding practices for infants and young children, as well as breastfeeding. This also applies particularly to crisis situations, which are often in common with sanitary situations.

3.4 Powdered milks can also be used to prepare glasses of liquid milk, or preparations based on milk and cereals and used as nutritional supplements for the sick, the aged, and young children (below 2 years of age). Glasses of milk should however be avoided where the milk is not in the normal feeding practices of the population concerned. Preference should always be given to local foodstuffs. Dependence on external foodstuffs should always be avoided.

3.5 In certain cases, powdered milks are used as ingredients in the preparation of complementary foodstuffs for young children (mixed with a cereal flour), but in most cases the necessary quantities are minimal and it is preferable to use local foodstuffs, or buy small quantities of the necessary powdered milk on the local market. If the aim is to promote appropriate complementary foodstuffs among local populations, the ingredients must be available at low cost on the local market. If not, this becomes the promotion of external ingredients that are difficult to obtain locally and are culturally inappropriate.

Acute malnutrition and ready-to-use therapeutic food (version 2: July 2009)

Rationale

- Offer to delegates and project heads a new approach to the community management of simple severe acute malnutrition (SAMs), recommended in conjunction with the WHO and Unicef since May 2007.

- Provide details on the adequate use of ready-to-use therapeutic food, notably for the attention of donors.

Target

- This document is aimed for zone and delegation managers, and heads of health/nutrition projects.

- The document is to be shared with institutional donors and other actors in the area (NGOs, academia, UN agencies, etc.).

Terminology

Ready-to-use-therapeutic-food (RUTF) are those medications which exist today in two forms: a biscuit (BP100) or a paste in a sachet (Plumpy'nut®). Plumpy'nut® is a trademark of the Nutriset company. It is a paste manufactured from peanut butter, powdered milk, vegetable oil, and a mineral and vitamin complex (MVC).

Terre des hommes favors the research and production of *local* RUTF for a number of countries (western Africa, for example). We support our partners' initiatives in the South which take this direction.

Critical Perspective

- A discussion over the coming years on the durability of RUTF, on the community framework necessary, and on support and technical training.

Decision and confirmation

- This revision is based notably on the advocacy work of the last two years, as well as on the health thematic meeting in Dakar for the Tdh projects in Africa and Haiti (May 11 to 15, 2009) and on a meeting of the nutrition monitoring group on June 22, 2009 (program directors, geographic area managers, media/communication managers, and resource experts/persons).

- The task of revision was given to J.-P. Papart and M. Roulet (resource experts/persons). It was reviewed by Pierre Zwahlen (communication service) and validated by Ignacio Packer on behalf of the management.

The new community approach to simple severe acute malnutrition (SAMs), recommended conjointly by the WHO and Unicef (common declaration, May 2007), is based on ready-to-use therapeutic food. Currently, the best-known product is Plumpy'nut®.

This mobile approach is scientifically effective in the hands of quality care personnel. It is nevertheless not without risk, especially for the quality of community work.

This position paper brings attention to the risk of *competition* between community management of SAMs based on RUTF, and activities linked to moderate acute malnutrition (MAM). *The new approach to the management of SAMs is additional to Tdh's community work and does not replace it.*

For Tdh, severe acute malnutrition in its two forms – simple (SAMs) or complicated (SAMc) – is an illness. For this reason, *RUTF is considered as a medicine and not as a simple energy food.*

As a consequence, RUTF will be prescribed such that it is *used exclusively by the child concerned* and not shared among the family. Health professionals such as community agents will ensure this objective. The current position of Tdh is that RUTF should only be used exclusively for 2 or 3 weeks. Following this period, the child receives RUTF with the family meal, and until complete nutritional recuperation (up to 40 days of treatment, or more if necessary).

The current position of Tdh is to admit the *import of RUTF, while taking into account the risk of dependency* which this can entail for the health system which Tdh wants to support. Tdh favors local research on and production of RUTF, or at least for several countries (western Africa, for example). We support our partners' initiatives in the South which take this direction.

Distribution

- Internal: program departments, COGES, media and communication heads.

- Available on KIT.

- No media expertise required, but monitoring for

the potential sensitivity in Swiss media with regard to technical developments and durability, as well as on community support.

- Opportunity for exchange and information among the current actors in our advocacy work: SDC, ECHO, MSF, Medicus Mundi, WHO technical committee, health ministries in (8) countries of intervention and the general public in Switzerland.

Tdh Context and Position

Tdh has today a long accumulated experience in the struggle against acute malnutrition in children, with many projects developed across three continents. There is consensus on a sectoral strategy on mother-and-child health (MCH) and nutrition – as well as on the action models engaged.

The Tdh thematic action has three axes

1. Support for the health system in the countries in which Tdh acts.

2. Promotion of autonomy of individuals and community partners in Tdh interventions (*empowerment*).

3. Advocacy for the rights of the child to health and protection.

No matter where the place of intervention or the content of Tdh's action, this tripartite strategy gives sense to the participation of Terre des hommes to all MCH-nutrition programs. With regard to the action models Tdh uses in most MCH-nutrition projects, Tdh is most frequently present in the three program areas of:

1. Primary prevention of malnutrition.

2. Treatment (or, secondary prevention) of acute malnutrition

3. Promotion of community health.

These three action models must contain the tripartite strategy of our policy thematic (support of the health system, empowerment and advocacy).
Each of these three modes of intervention can be broken down into various activities as per the planning needs.

The secondary prevention of acute malnutrition (AM) includes the tracking and community management of moderate acute malnutrition (MAM) through the coordination of community health agents and basic health centers. It also includes the management of severe acute malnutrition (SAM) through mobile therapeutic programs (MTP) and specialized nutritional units. The latter are at least partially integrated in public pediatric services. Secondary prevention aims to reduce the duration of acute malnutrition, and thus to reduce its prevalence.

In order to reduce the frequency of child malnutrition, primary prevention of malnutrition generally includes – with variations – the following activities:

- Promotion of pre-natal check-ups, to reduce in particular the frequency of low birthweight (a major determinant of malnutrition in children
- Encouragement of exclusive maternal breastfeeding up to 6 months (post-natal support of the mother.
- Promotion of complementary food after 6 months of age.
- Vaccination and integrated clinical management of childhood illnesses (IMCI) – (these two elements both aim to prevent malnutrition as well as improve the health of the child in general).

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

- Nutritional education.
- Promotion of the rights of the child to health and protection.
- Encouragement of environmental hygiene (if possible, integrated with water and sanitation programs: WASH).
- promotion of community social links.

This entails targeting a new activity to integrate with two existing activities in the treatment of SAM. Until the end of 2007, all identified cases – whether at the community level or in basic health centers – were hospitalized in a specialized nutritional unit, usually within a pediatric service. The new approach – recommended by the WHO and UNICEF since 2007 and integrated into several of our projects – consists first of all in distinguishing two forms of SAM, the *simple* (SAMs) and the *complicated* (SAMc), in order to differentiate their management.

The simple form (SAMs) is characterized by a MUAC index (mid-upper arm circumference) of less than 100mm, according to Valid International (a document published jointly in May 2009 by the WHO and UNICEF proposes 115mm), or a weight of the child at less than 70% of the median weight expected for that size (or less than -3 sample-types), without other associated complications. The complicated form (MASc) manifests additional symptoms, as much nutritional (grade 3 edema) as medical. The clinical test is loss of appetite (negative appetite test). It is the most sensitive and the most specific – and thus the most valid – test with which to identify the simple character of a SAM case.

For SAMs, both the WHO and UNICEF currently recommend community management. This entails the following elements:

- Identification of children with SAM in the community.
- Referral to a basic health structure equipped for a nutritional evaluation, with an appetite test.

Once the SAM is confirmed and the appetite test is negative, the child is referred as necessary to a specialized hospital structure. If the child's SAM is not complicated and some appetite remains (positive appetite test), the child will then be managed in the community, i.e. the parents will receive a product labeled *ready-to-use therapeutic food* (RUTF) which the child consumes at home, following prescribed quantities.

One of the advantages of this new approach, called Mobile Therapeutic Program (MTP), is that many more children with SAM can be cared for satisfactorily.

The MTP requires that we make additional investments in training and monitoring. However, on the basis of experience in 2008 in Haiti, Guinea and Burkina Faso, our organization seems to be in an excellent position to take on this new challenge. Nevertheless, this expertise leads us to wonder whether the MTP is no small issue and not without risk, especially in regard to the quality of work in the community. This position paper highlights the *competition* risks between community management of MASs on the basis of RUTF, and community activities to combat moderate malnutrition. The mobile therapeutic program against SAMs is additional to Tdh's community work, and does not replace it.

In order that the children and communities with whom Tdh works can have a better life, and in order to avoid the risks inherent in the introduction of new medication, the explicit position of Tdh includes the following elements:

1. Severe acute malnutrition, in both its forms – simple or complicated – is an illness. In this regard, its management is the responsibility of health professionals. Ready-to-use therapeutic food (RUTF) is a medication and not an *energy* food.

2. Consequently, RUTF should be prescribed to be used exclusively by the child concerned, and not shared among family members. Health professionals such as community agents should ensure this exclusive use.

3. Tdh recommends the exclusive use of RUTF for only 2 to 3 weeks. Following this time, the child should receive RUTF with the family meal, and only until complete nutritional recovery (up to 40 days of treatment, or longer if necessary).

4. Tdh can allow the importation of RUTF, despite the risks of dependency which this can entail for the health system which Tdh wishes to support. Tdh encourages research and production in RUTF at a local level, or at least regionally (for example, on the scale of West Africa). We support our partners' initiatives which take this direction.

5. Tdh realizes that field teams have a need for strong technical support in order to face this challenge.

Footnotes section 1

[1] *Black R. et al, Maternal and Child Undernutrition: Global and regional exposures and health consequences, The Lancet, vol. 371, n°9608, 19 January 2008, pp. 243-260.*

© Tdh / François Struzik / IOD

Terre des hommes
Helping children worldwide. tdh.ch

Siège | Hauptsitz | Sede | Headquarters
Avenue de Montchoisi 15, CH-1006 Lausanne
T +41 58 611 06 66, F +41 58 611 06 77
www.tdh.ch, CCP: 10-11504-8