Version 1

REACH

Ending Child Hunger and Undernutrition

Acting at Scale: Implementation Case Studies

Therapeutic Feeding

August 2008

Context

The following document is part of the REACH *Acting at Scale* set of materials

- The documents' aim is to provide highly condensed information and lessons learned for scaling up REACH-promoted interventions to support field practitioners and other interested parties
- They are intended to become a living set of materials, updated periodically by the REACH Global Interagency Team
- These materials are a first step towards a larger REACH Knowledge Sharing service, which will be developed over time

The full set of *Acting at Scale* materials includes

- *An Intervention Summary*
  - An overview document containing key facts for all of the 11 promoted interventions
- *Intervention Guides* for each of the interventions[1]
  - Containing rationale, lessons learned, costs and further resource lists
- *Implementation Case Studies* for each of the interventions[1]
  - Initial set of details and lessons learned from programs implemented at scale
- *Resource Lists*
  - Lists of key documents, organizations and programs at scale
  - Included at the back of each *Intervention Guide* and in Excel spreadsheets available from the REACH Global Interagency Team

These materials represent a preliminary version, to be validated and refined via additional consultations

- Prepared in Summer 2008 by the REACH Global Interagency Team, based on inputs from 56 practitioners and experts, as well as extensive desk research
- A revised Version 2 of these documents will be released in late 2008 or early 2009, incorporating feedback from initial recipients

If you have questions or feedback on these materials, please

- Contact your local REACH facilitator in Lao or Mauritania, or
- Contact the REACH Interagency Team Coordinator, Denise Costa-Coitinho, at Denise.CostaCoitinho@wfp.org

1. Breastfeeding and complementary feeding have been combined into a single document due to strong linkage in delivery

Case study: Therapeutic feeding (I)

Community-based Therapeutic Care (CTC), Malawi

Intervention:	Therapeutic feeding					
Program name:	Community-based Therapeutic Care (CTC), Malawi			**Type:**	Physical component	
Location:	Malawi, countrywide scale-up			**Setting:**	X Rural	x Urban
Start year:	2002 (pilots), 2006 (scale-up)	**Duration:**	Ongoing	**Ongoing?**	X Yes	No
Target group:	• 46,500 severely acute malnourished (SAM) children <5 (i.e. 2.9% of the <5 population of 2.3 M) • 69% of treated children with SAM were released successfully					
Total costs:	$224 (174 €) per child treated[1]	**Other resources used:**	N/A			
Metrics:	• Number of children treated; coverage of severely malnourished children • Recovery, default, death, transfer and non-recovery rates of the therapeutic feeding program					
Lead & partner organizations:	• Ministry of Health (national and district level): implements through the Nutrition Rehabilitation Units • Concern Worldwide: Implements • Valid International: offers assistance and advice to Concern in implementation and evaluation of the program • UNICEF and WHO: program support and guidance					
Description of specific country situation & social context:	• Very high levels of stunting and wasting, according to the national nutrition survey – 48% of children are stunted (18% severely stunted) – In several districts >10% of children are moderately or severely malnourished • Due to the high number of children suffering from SAM and the low bandwidth of the therapeutic feeding facilities only 20% of SAM children are reached by health care • 95 Nutrition Rehabilitation Units (NRUs) are in place in Malawi to offer facility-based therapeutic feeding					

1. Including 90$ for RUTF, $24 for local capacity building, and $ 36 for capital and durable equipment
Note: N/A denotes 'not available' as of yet via research
Source: "The rationale for scale-up in Malawi." Concern; REACH analysis

Case study: Therapeutic feeding (II)

Community-based Therapeutic Care (CTC), Malawi

Policy and coordination processes and organization[1]:

- A CTC Steering Committee was established for decision-making and as an advisory board
  - Comprised of representatives from MoH, WHO, UNICEF, USAID, Concern, Save the Children and Valid
- Government will include RUTF in the essential drugs list to enable procurement, warehousing and delivery by Central Medical Stores
- Government integrated CTC into its Essential Health Package (EHP) on the national, district and community level

Communication, advocacy and change management:

- A CTC Review workshop was held in 2006 to convene all stakeholders to facilitate scale-up
  - 38 district health managers, senior officials from MoH and 40 partners from various organizations were invited
  - Purpose of the meeting was the introduction of the CTC Advisory Services (CAS), the planning for the scale-up and an exchange of lessons learned

Measuring, tracking and reporting progress:

- Contracting Valid for the evaluation of the program ensured highly professional evaluation services

Funding and resource mobilization:

- Needed to secure long-term donor support; essential to ensure ability to purchase of RUTF
  - RUTFs relatively expensive, making payment by beneficiaries and local government unfeasible
  - Reliable funding is necessary for set-up of production facilities and for ensuring continuous supply

Capacity building:

- A CTC Advisory Services (CAS) group comprising five staff members was established to facilitate scale-up
  - Provides additional training of staff needed for scale-up
  - Develops training materials, also in local languages
  - Organizes learning sessions to share experiences and establish best practices and documents results

Private sector engagement:

- Nutriset was brought in to set up the local production in Blantyre
  - Transfer of production know-how and appropriate quality management techniques

1. Including NGO/civil society engagement

Source: "The rationale for scale-up in Malawi." Concern.; REACH analysis

Case study: Therapeutic feeding (III)

Community-based Therapeutic Care (CTC), Malawi

Details on delivered intervention incl. delivery channel/ method:

- CTC approach was first introduced in the Dowa and Nkhotakota districts and then implemented in 16 districts
- Inpatient therapeutic care is provided through the 95 Nutrition Rehabilitation Units (NRUs)
- Children released from the therapeutic feeding program are referred to the supplementary feeding program
- Community sensitation for outpatient therapeutic care is promoted through various community members
  - Health Surveillance Assistants (HSAs), Community Growth Monitors (CGMs) and Community Development Assistants (CDAs) were provided food and nutrition information materials and were trained for case finding and referral
  - Extension workers form the Departments of Agriculture & Irrigation as well as Gender, Child Welfare and Community Services were trained in order to increase outreach and active case finding
  - Traditional authorities and traditional healers
- Ready-to-use therapeutic food (RUTF) is produced locally in 3 production facilities at ~$ 3.6/kg
  - Being scaled-up for country-wide roll-out of CTC
  - Valid operates one facility in Lilongwe with 2 metric tons capacity per day
  - A Malawian NGO operates the Blantyre production in partnership with Nutriset (1 metric ton capacity per day)
  - USAID provided production equipment to scale-up facilities

Description of monitoring & evaluation:

- Reporting is done on a continuous basis: Each child's admission is registered and recovery, default, transfer, death registered
- National nutrition surveys are used to assess the overall state and improvement of the nutrition situation

Lessons learned (intervention & overarching processes):

- If NRUs where RUTFs are picked up are too distant from the communities, children might drop out early due the long travel distances
- National harmonization of roles and protocols is necessary for multiple NGOs to implement CTC successfully across various districts
- Local RUTF production requires rigorous demand estimates to ensure supply and demand will match
  - Local demand per year is estimated at 800-900 metric tons and maximum planned capacities after scale-up are 1,000 metric tons
  - Supplies such as dried milk should be ordered in advance to avoid RUTF shortages as procurement and importation is time-consuming
- Commercial suppliers of RUTFs should be contracted to cover excess demand
  - e.g. Rab Processors has already shown that they can quickly step in if the market increases

Contacts:

- Paluku Bahwere, Valid International, paluku@validinternational.org

Key documents:

- "The rationale for scale-up in Malawi." Concern.
- "Special supplement. Community-based therapeutic care." ENN, 2004.
- "CTC in Malawi." Presentation by Concern.
- "Community-based therapeutic care in Malawi." Presentation by Stanley Mwase.

Source: "The rationale for scale-up in Malawi." Concern.; REACH analysis

Scale-up needs government involvement and local production

Case study: Community-based Therapeutic Care (CTC), Malawi

Program overview

National nutrition surveys in Malawi indicated high levels of stunting and wasting

- 48% of children are stunted
- In several districts >10% of children are malnourished

Concern International, with various partners, piloted and scaled-up a community-based therapeutic feeding program

- Ministry of Health contributes through mainstreaming therapeutic feeding into its health policies and providing Nutrition Rehabilitation Units
- Valid International advices on program implementation and evaluation
- UNICEF and WHO provide program support and guidance

Therapeutic care is provided as inpatient and outpatient treatment

- Inpatient treatment in 95 Nutrition Rehabilitation Units
- Outpatient treatment as take-home RUTF rations

Community sensitization is promoted through various community members to strengthen case finding

- E.g. Health Surveillance Assistants (HSAs),
- E.g. extension workers form other ministries
- E.g. traditional authorities and healers

Lessons learned

Engage government to ensure scale-up

- Included RUTF in the essential drugs list
- Integrated CTC into its Essential Health Package
- Involved in the CTC Steering Committee
- Contributed to harmonization of roles and protocols on a national level as several NGOs implement CTC in various districts

Employ a CTC Advisory Services (CAS) group to engage and build capacity of stakeholders

- Provides additional training of staff
- Develops training materials, also in local languages
- Organizes learning sessions to share experiences

Consider locally produced RUTFs as a lower-cost alternative to imported RUTFs

- Locally produced at $3.6 per metric ton whereas imported costs $4.5 per metric ton
- As long as quality is consistent, same positive nutrition and health impact

Contract commercial suppliers of RUTFs to absorb excess demand

- E.g. Rab Processors has already shown that they can quickly step in if the market increases

Source: "The rationale for scale-up in Malawi." Concern International

Case study: Therapeutic feeding (I)

Community-based Therapeutic Care (CTC), South Wollo, Ethiopia

Intervention:	Therapeutic feeding				
Program name:	Community-based Therapeutic Care (CTC), South Wollo, Ethiopia		**Type:**	Physical component	
Location:	Ethiopia, South Wollo		**Setting:**	X Rural	Urban
Start year:	2003	**Duration:** Ongoing	**Ongoing?**	X Yes	No
Target group:	• All severely malnourished children measured by MUAC; initially 2,500 children were targeted				
Total costs:	N/A	**Other resources used:**	N/A		
Metrics:	• Number of children treated in hospital and home-based; coverage of severely malnourished children – Achieved 77% coverage • Recovery, default, death, transfer and non-recovery rates of the therapeutic feeding program				
Lead & partner organizations:	• Concern Worldwide: provides supplementary feeding and outpatient treatment; trains MoH staff for inpatient treatment and community volunteers for case-finding • MoH of Ethiopia: Provides health system infrastructure and personnel for inpatient treatment • Valid International: Provides technical support to Concern during program set-up				
Description of specific country situation & social context:	• Acute malnutrition levels in Ethiopia rose to 17.2% in late 2002 • Harvests were 25% under normal and about 50% of the population was in need of food assistance • South Wollo is an inaccessible region with a widely dispersed population of 450,000 • Culture facilitated a community-based approach – General ethos of self-reliance – Population have basic confidence in the government health structure – Women have reasonable household decision-making power				

Note: N/A denotes 'not available' as of yet via research

Source: "Operational challenges of implementing community therapeutic care." ENN, 2005.; "Review of the Concern Worldwide South Wollo Emergency." Khara, 2004.; "Special supplement. Community-based therapeutic care." ENN, 2004.

Case study: Therapeutic feeding (II)

Community-based Therapeutic Care (CTC), South Wollo, Ethiopia

Details on delivered intervention incl. delivery channel/ method:

- Inpatient treatment was provided in the existing MoH hospitals
  - Concern established good working relationships with nurses and doctors through meetings and trainings
- Outpatient therapeutic program operated through 18 decentralized sites using existing SFP sites, clinic or health centre facilities
  - Consisting of a weekly health check, provision of RUTF, standard medical treatment, and basic nutrition education for carers
  - Medical supervision fwas split between Concern Medical Workers and MoH supervisors seconded from district health offices
  - 95% of children could be treated via outpatient program
- Operated complementary supplementary feeding program via decentralised sites providing ration to moderately malnourished children
- Outreach activities focused on case-finding
  - House-by-house visits by outreach workers using a checklist for discussion and observation
  - Identification of key informants/local authorities who subsequently can refer health workers to mothers/children at risk
  - Mothers whose kids were succesfully treated were mobilized to encourage others to participate in the program
  - >2,000 community volunteers were used to pass on health education and make MUAC-based referrals
  - Mobilization of MoH staff and SFP workers

Description of monitoring & evaluation:

- Tally sheets from the Malawi CTC program were used including metrics for number of children treated, recoveries, defaults, deaths, transfers and non-recovery rates
- Tally sheets were filled by health workers in the outpatient sites and the inpatient treatment sites
- One data assistant was employed to check tally sheets, manage the Excel database and also train field workers in filling the tally sheets

Lessons learned (intervention & overarching processes):

- Leveraging informants in the community to refer health staff to children in need is more efficient than house-by-house visits for case-finding
- Efforts should be made to understand the reasons for absence and drop-out from the program and address these
  - One reason is the fear of critique by health staff after being absent one time and returning: program staff was advised to avoid scolding
  - Another reason is distance from the distribution site: for those living far away the distribution was shifted to bi-weekly instead of weekly
- Using MUAC and presence of edema as entry criteria is easier for project staff and more popular with communities
- Admission critieria and treatment procedure changes should be avoided and if they have to be made they have to be clearly communicated to all health workers and community members in order to avoid confusion
- Stock control sheets should be introduced to ensure continuous supply of RUTFs
- Key success factors of the volunteer referral program were the democratic selection process of the volunteers and the commitment to quarterly training
- Partnership with the existing hospitals proved very successful as CTC program was able to focus efforts on case-finding and treatment in OTP and sustainability is created as hospitals are supported through continuous training and support

Contacts:

- N/A

Key documents:

- "Review of the Concern Worldwide South Wollo Emergency." Khara, 2004

Source: "Operational challenges of implementing community therapeutic care." ENN, 2005.; "Review of the Concern Worldwide South Wollo Emergency." Khara, 2004.; "Special supplement. Community-based therapeutic care." ENN, 2004.

Scale can be reached through strong community involvement

Case study: Community-based Therapeutic Care (CTC), South Wollo, Ethiopia

Program overview

Acute malnutrition levels in Ethiopia rose to 17.2% in late 2002

- Harvests were 25% below normal
- 50% of the population was in need of food assistance

The Ministry of Health and Concern Worldwide responded to the crisis with a community-based therapeutic feeding program, featuring supplementary feeding (SFP)

- MoH provided health system infrastructure and personnel for inpatient treatment
- Concern managed outpatient treatment through decentralized sites using existing SFP sites, clinics or health centre facilities
- Valid International also provided program support

The program focused on rapid scale-up via active case finding and community sensitization

- Organized house-by-house visits by outreach workers
- Identified community volunteers to refer at-risk children
- Mobilized >2,000 community volunteers to make MUAC-based referrals and pass on health education
- Mobilized mothers whose children were successfully treated

Lessons learned

Leverage community volunteers to refer health staff to vulnerable children

- More efficient than house-by-house visits for case-finding

Strengthen impact of community volunteer program by employing a democratic volunteer selection process and fostering commitment via quarterly trainings

Use MUAC and presence of edema as entry criteria

- Easier for project staff
- More easily accepted by beneficiary communities

Quickly identify and address drivers of absenteeism and program drop-out, e.g.

- Where fear of health staff rebukes after absences led to drop-outs, program staff was advised not to scold
- Where far distances led to drop-out, distribution frequency shifted from weekly to bi-weekly

Ensure clarity and consistency in admission criteria and treatment procedures

- Clearly communicate any changes to all health workers and community members to avoid confusion

Source: "Operational challenges of implementing community therapeutic care." ENN, 2005.; "Review of the Concern Worldwide South Wollo Emergency." Khara, 2004.; "Special supplement. Community-based therapeutic care." ENN, 2004.

Experts consulted

- **Denise Costa-Coitinho**, REACH coordinator, former Brazil Ministry of Health and Bolsa Alimentacao
- **Bruce Cogill,** UNICEF nutrition cluster
- **Ian Darnton-Hill,** UNICEF micronutrient expert