Community Therapeutic Care

Outline

- CTC and acute malnutrition
- How CTC works
- Outcomes to date
- Emerging issues
- Conclusions
- Next steps

CTC is a selective feeding strategy primarily addressing acute malnutrition in emergencies

Links relief to development by providing a platform for longer-term intervention
Features of severe acute malnutrition

1. Economic deprivation
   - Poverty
   - High work loads (esp. Women)

2. Social exclusion
   - Clustered in poorest families
   - Malnourished siblings

3. Re-occurring
   - Chronic vulnerability

4. Individual pathological changes
   - Reductive adaptation
   - Immunosupression

TFC Care at Present

- Emphasis on medical
- Social, economic & long-term factors ignored
How does it work?
Hierarchy of nutritional interventions

- **General ration**
- **Supplementary feeding**
- **Therapeutic feeding**

 Increasingly intensive individual treatment
Poorer costs benefit

Increasing coverage and population level impact
Better cost benefit

**Higher priority**
**Lower priority**

CTC – early stages

Decentralisation

Starting CTC

Stage 1 - Outpatient Therapeutic Program (OTP)
Screen severely malnourished
Identify & register
Wristband
Ready to use therapeutic food
Systematic protocol
Antibiotic
Vit A, measles vaccination
folic acid, mebendazole
Education

Increasing community involvement

N Darfur
2001

Access to treatment
- Early presentation
- Fewer complications
- Easier to treat
- Better results
Is OTP effective?

SPHERE standards for severe malnutrition

<table>
<thead>
<tr>
<th>Project</th>
<th>Cure %</th>
<th>Death %</th>
<th>Default %</th>
<th>Other %</th>
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</thead>
<tbody>
<tr>
<td>Sphere standards</td>
<td>75</td>
<td>10</td>
<td>15</td>
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OTP results

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<tr>
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<tr>
<td>Ethiopia 2000*</td>
<td>170</td>
<td>85</td>
<td>4.1</td>
<td>4.7</td>
<td>6.5</td>
</tr>
</tbody>
</table>

* Collins & Sadler – Lancet 2002

No phase one care

64 kwashiorkor / marasmic kwashiorkor
2 deaths
<table>
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<th>Default %</th>
<th>Other %</th>
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<td>85</td>
<td>4.1</td>
<td>4.7</td>
<td>6.5</td>
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<tr>
<td>Sudan 2001</td>
<td>806</td>
<td>81</td>
<td>2.9</td>
<td>10.1</td>
<td>5.6</td>
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</table>

17 admitted for inpatient care
Prudhon index corrected mortality rate - 50% of that expected in well run TFC

OTP compared to TFC in N. Sudan 2001 (SC-UK)

OTP in Ethiopia 2000
Concern Worldwide
N = 170

Length of stay
SPHERE international standards
OTP in Ethiopia
Rate of weight gain
Effectiveness of OTP

- Low mortality
- High acceptance
- High coverage

80 : 20

- Low rates of weight gain
- Long length of stay

Emerging Issue 1

Need to reclassify acute malnutrition

Traditional classification

- Acute malnutrition
- Severe malnutrition
  - TFC
- Moderate malnutrition
  - SFP
Treating most cases of severe acute malnutrition is simple

- Care in community – not as inpatient

Caring for people in their communities

- Strengthens social fabric and capacity
- Links with existing community interventions
- Facilitates exit strategies
- Frees up resources

The evolution of CTC OTP - CTC

Outpatient Treatment
- Specialized food (RUTF)
- Simple medical protocols
- From existing health infrastructure
- To ALL severe acute malnutrition

Increasing Care
- Increasing community involvement
- Case finding, referral, management follow up & prevention
- Intensity of care (Inpatient)
Presentation by Steve Collins, Valid International to USAID, July 2003

**Increasing community involvement**

**Outpatient treatment to community care**

**Identify successful mothers**
- Work with mothers to develop syllabus
- Mother to mother mobilisation
- Follow-up, support & case finding
- Link with local networks

**Community Care**

MOBILISE, INTEGRATE, & EDUCATE
Addressing malnutrition with complications

Stabilisation care

Stabilisation centres

- Inpatient
- Phase one care
  - Maximum 7 days
- Small & intensive
- Provision for “failure to respond”
  - Home-based care

Full Community Therapeutic Care

MOBILISE, INTEGRATE, & EDUCATE
Emerging issue 2

Prioritization

Malawi prioritisation

First priority

CTC in Malawi 2002 - 3
Mass screening

290 admissions

Mother-to-mother
Negative feedback

0 50 100 150 200 250 300
August 02 March 03

Distribution round

ADMISSIONS
EXITS
TOTAL IN PROGRAM
CTC Impact in first 16 weeks

- 290 patient admitted
- ± 7% mortality – 20 deaths
- ± 75 – 80% cure rate
  
  218 cured

- Met all SPHERE standards

Impact of 16 weeks of poor coverage

- Target - 1000 severely malnourished:
  - Coverage @ 30%
    
    700 untreated

- Mortality / month untreated = 10%
- Unaddressed mortality = 10% * 4 * (700-800)

  280 deaths outside project
First priority

Outpatient Therapeutic Feeding

Supplementary feeding

Ethiopia prioritisation

Mobilisation & information

Stabilisation centres

Early mobilisation in Ethiopia

Mobilisation

High priority

At start of projects

Profound
Prioritization

- Community mobilisation before intense clinical care
- Public health approach

The evolution of CTC

Phase one care when capacity allows

Effectiveness CTC

Coverage
Cure rates

Malawi 2002 – 2003
Coverage of CTC and TFPs in Malawi
March 2003

<table>
<thead>
<tr>
<th>Programs</th>
<th>CTC in Dowa</th>
<th>TFP in Mchinji</th>
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<tbody>
<tr>
<td>n children in feeding program</td>
<td>111</td>
<td>148</td>
</tr>
<tr>
<td>Coverage</td>
<td>81</td>
<td>41</td>
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<tr>
<td>Confidence interval (%)</td>
<td>73%</td>
<td>28%</td>
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<tr>
<td></td>
<td>63.6-80.8%</td>
<td>20.8-35.8%</td>
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Malawi Aug 02 – June 03

<table>
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<tr>
<th>exit</th>
<th>Stabilisation Centre</th>
<th>%</th>
<th>OTP</th>
<th>%</th>
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<tr>
<td>In project</td>
<td>101</td>
<td>316</td>
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<td></td>
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<tr>
<td>discharged</td>
<td>1056</td>
<td>90%</td>
<td>791</td>
<td>85%</td>
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<tr>
<td>death</td>
<td>73</td>
<td>6%</td>
<td>35</td>
<td>3%</td>
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<tr>
<td>default</td>
<td>19</td>
<td>2%</td>
<td>225</td>
<td>18%</td>
</tr>
<tr>
<td>referred to hospital / NRU</td>
<td>29</td>
<td>2%</td>
<td>152</td>
<td>12%</td>
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<tr>
<td>other</td>
<td>2</td>
<td>0%</td>
<td>23</td>
<td>2%</td>
</tr>
<tr>
<td>total</td>
<td>1179</td>
<td>1226</td>
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Monitoring data
Monitoring data

TFC n = 329
CTC n = 211

IMPACT

3 * TFC coverage
Better mortality rates
Local production of RUTF

Decentralised
SFP
OTP
CTC

Local production of RUTF

Community Therapeutic Care

MOBILISATION
Conclusions

CTC is a feasible model for selective feeding in emergencies

Paradigm shift
SUCCESSFUL MOTHERS
COMMUNITY-BASED CTC MOTHERS GROUPS

Community organisations
- church groups
- local NGOs

External facilitation
- co-ordination
- technical support
- funding for commodity purchase

Community healthcare workers
- clinics
- group visits

Next steps
- Scaling up
- Dissemination
- HIV
- Integration General Ration targeting
- Transition to development
- Sustainability