Introduction (Special Supplement 2)

Glossary

ACF    Action Contre la Faim
CHA    Community Health Assistant
CHAM   Christian Health Association of Malawi
CNW    Community Nutrition Worker
CTC    Community Therapeutic Care
DFID   Department for International Development
DHO    District Health Officer
DPPB   Disaster Preparedness and Prevention Bureau
DPPC   Disaster Preparedness and Prevention Committee
EGS    Employment Generation Scheme
EPI    Expanded Programme for Immunisation
FGD    Focus Group Discussion
GMP    Growth Monitoring Programme
HBC    Home Based Care
HBT    Home Based Treatment
HSA    Health Surveillance Assistant
MAM    Moderate Acute Malnutrition
MoHP   Ministry of Health and Population
MSF    Medecine Sans Frontiere
MUAC   Mid Upper Arm Circumference
NRU    Nutrition Rehabilitation Unit
OTP    Outpatient Therapeutic Programme
PLWHA  People Living With HIV/AIDS
PPS    Population Proportional Sampling
RUTF   Ready to Use Therapeutic Food
SAM    Severe Acute Malnutrition
SFP    Supplementary Feeding Programme
TBA    Traditional Birth Attendant
TFP    Therapeutic Feeding Programme
WFP    World Food Programme
WHO    World Health Organisation

We would like to say a special thanks to Concern Worldwide whose brave decision to back the CTC idea with core funding, field site for testing and general support and advice from the beginning made the programme possible and was a central feature contributing to the success of the programme.

Although Nicky Dent, Ann Walsh and Paul-Rees-Thomas are not authors in this supplement they were crucial in supporting and implementing these programmes.
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1.1 Scope of the supplement

Trading in markets is a vital livelihood activity for many families in Ethiopia.

This supplement presents a collection of articles written by people who have been involved in Community-based Therapeutic Care (CTC) programmes. The contributions come from Valid International's CTC research and development team, operational agencies implementing CTC programmes, independent practitioners and academics involved in the research and development of CTC. There has been substantial accumulated experience of CTC over the past four years (see Table 1). Many of these programmes have included specialised research inputs from anthropologists, food technologists, health systems specialists, ethicists, economists, statisticians, epidemiologists and sociologists providing a wide range of evidence-based perspectives on CTC.

Table 1 CTC projects and approximate numbers of severe acute malnourished (SAM) and moderate acute malnutrition (MAM) treated

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Agency</th>
<th>Ongoing or completed</th>
<th>No. SAM treated (OTP + SC)</th>
<th>No. MAM treated (SFP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia - Wolayita</td>
<td>2000</td>
<td>Oxfam</td>
<td>Completed</td>
<td>1185</td>
<td>-</td>
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<tr>
<td>Ethiopia - Hadiya</td>
<td>2000</td>
<td>Concern</td>
<td>Completed</td>
<td>170</td>
<td>3000</td>
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<tr>
<td>N Sudan - Darfur</td>
<td>2001</td>
<td>SCUK</td>
<td>Completed</td>
<td>806</td>
<td>25633</td>
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<tr>
<td>N Sudan - Darfur</td>
<td>2002</td>
<td>SCUK</td>
<td>Completed</td>
<td>446</td>
<td>6019</td>
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<td>Malawi - Dowa</td>
<td>2002</td>
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<td>Ongoing</td>
<td>1900</td>
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<td>Ethiopia - South Wollo</td>
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<td>Ongoing</td>
<td>794</td>
<td>11573</td>
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<td>3346</td>
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<td>4359</td>
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<td>Ethiopia - Sidama</td>
<td>2003</td>
<td>SCUS</td>
<td>Ongoing</td>
<td>1232</td>
<td>3571</td>
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<td>2003</td>
<td>SCUK</td>
<td>Completed</td>
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The supplement aims to provide a broad range of opinions and experiences of CTC to inform a wide audience about the CTC model of intervention and its relationship with other humanitarian interventions. In presenting these perspectives, we hope to define clearly what CTC is and how it works, clarify CTC's relationship to Centre-based Therapeutic Feeding, and clarify the differences between CTC and other more recent models of Home-based Treatment. The supplement aims to share some of the difficulties and lessons we have learnt during the process of developing the CTC approach and also presents some of the initial monitoring data collected from CTC programmes.

This supplement is organised into sections based on field experiences relating to CTC. Section 2 describes CTC approach. Section 3.1-3.4 describes four country programme experiences of CTC, while sections 4.1- 4.5 deal with technical and management issues of CTC including articles from NGOs starting up CTC programmes and a discussion of cost issues. Finally sections 5.1- 5.4 use case studies to address issues around cultural, horizontal (across programmes), institutional and temporal integration. CTC was initially adapted for emergency interventions, thus most of the articles in this supplement describe experiences and the lessons learnt in emergency settings. More recent work has focussed on adapting the approach to the longer-term problems of food insecurity and malnutrition related to HIV/AIDS. The articles on the 'demand drive model', CTC and HIV, CTC in Malawi and integrating CTC with local people, infrastructure and agriculture explore the issues arising from these 'newer' forms of CTC.

1.2 Changing the way we manage acute malnutrition

Foreword by Steve Collins

The development of the CTC model of care has aroused considerable controversy and professional
disagreement. These tensions may be viewed as manifestations of the classical debate between clinical healthcare and public health provision. Up until the start of the CTC programme, the predominant influence behind therapeutic feeding was clinical, with important developments achieved by clinicians, clinical nutritionists or pathophysiologists. The focus was on understanding the disease process in malnutrition, and on researching and developing effective, curative, clinical regimes (1;2). Progress was spectacular. In the past 15 years, new treatment regimes, in particular using F75 and F100, implemented through TFCs, have had major impacts in reducing case fatality rates and improving recovery for severely malnourished individuals (3). By contrast, there has been little improvement in the population level impacts and every year, acute food insecurity and famine still kills thousands of children and adults (4). The CTC approach is rooted in public health principles and has focused on the sociological, epidemiological and food technology aspects of interventions. It provides a framework that better harnesses the interventions that we already have, to achieve impact at the population level (5).

Without effective, individual level interventions, public health measures cannot be successful. The clinical and medical advances, and more recently, the development of solid F100 (RUTF), have been essential stepping stones towards developing the CTC approach. However, the optimal strategies to address SAM require that clinical knowledge and curative regimes be fitted into a broader public health framework. This requires balancing individual medical issues with broader concerns, such as coverage, cost, uptake, compliance and impact. The reality is that many TFC programmes fail to deliver large scale public health impact due, in large measure, to poor coverage (6).

The first formulation of CTC started in 1998 during the famine in South Sudan. In particular, during an extensive evaluation of the MSF Holland’s selective feeding programmes in Bahr El Gazal, it became clear that the current centre-based model of care could not deliver impact and instead, placed the population at additional risk. Despite their professional approach, MSF-H’s programmes had failed to deliver. In such an extreme situation as South Sudan during 1998, the only way to achieve substantial impact was to focus on ensuring that those who were treatable with simple, quality supplementary feeding were admitted to and remained in programmes. In other words, to prioritise coverage of the masses of acutely malnourished over inpatient care.

![Children waiting to measured in Ethiopia.](image)

While most people find the idea of programmatic triage - whereby programmes are tailored to prioritise coverage even at the expense of those at the point of death- distasteful, the reality is that in the majority of scenarios where humanitarian agencies intervene, resources and capacity are insufficient to provide the state of the art inpatient care to all of those who require it. Programmes that do not take the resource and capacity realities of nutrition crises into account not only achieve sub-optimal impact, but also risk making a situation worse. TFCs and NRUs are high risk environments; the patients are immuno-suppressed and often infected; the conditions are cramped, and water and sanitation are often difficult. In these conditions, water, hygiene, sanitation, medical and nutritional protocols must be scrupulously adhered to, if cross infection is to be avoided. Although this might be possible for the large INGOs implementing TFCs, the vast majorities of TFCs are implemented by smaller, less experienced...
NGOs or local hospitals and in these, standards are often not met. The result is high levels of morbidity within units, as well as low coverage of the population outside of units. There are many examples of this: Somalia in 1992 (7) where congregation of populations and epidemics of measles and shigella decimated the populations, Liberia in 1996 (8), S Sudan in 1998 (9) and Ethiopia in 2000.

Prioritising interventions according to public health and developmental principles, rather than prioritising individual cure rates, will require a reanalysis and rethink and a commitment to change at all levels within organisations engaged in therapeutic feeding. This will take time as TFCs are large scale interventions, employing large numbers of NGO workers and absorbing large amounts of donor funding. They are well adapted to the volunteer model of humanitarianism that flourished in the 1990s. There are generic models of implementation as encapsulated in many of the INGO nutritional guidelines. This all makes TFC implementation relatively independent of culture and a well run TFC in Somalia appears very similar to a well run TFC in Angola. This means that with good health training, even first time volunteers can implement TFCs relatively effectively, if they have access to one of the high quality manuals that agencies such as MSF and ACF have produced. By contrast, CTC implementation must be highly tailored to the context in which it operates; it is more dependent on local staff, and relies much more fundamentally on community participation and the local infrastructure. The success of CTC requires culturally specific negotiation and facilitation with local communities and local structures. Such negotiation requires compromise and understanding on the part of the whole team and consequently, is not really suitable work for inexperienced volunteers, however enthusiastic and no matter what manual they have.

In conclusion, it is hoped that this supplement will allow the readers to see CTC in context, as building upon and complementary to TFC care and the clinical management of acute malnutrition, while at the same time, a shift away from the individual focus towards a public health approach.

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