NUTRITION ADVOCACY IN PUBLIC INTEREST-India
(NAP*i*)

11th August, 2017

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To
Sh. Devendera Fadnavis
Hon'ble Chief Minister, Govt. of Maharashtra,
Mumbai.
CM@maharashtra.gov.in chiefminister@maharashtra.gov.in

SUB: Concerns on the Introduction of the use of energy dense nutritious foods (EDNF) up to the project level as quality nutritious food for children with severe acute malnutrition under ICDS scheme.

Dear Sir,

We have noted with great concern issuance of a tender (TE NO: ICDS / SNP / 01 / 04 / 2017) to procure and distribute above said EDNF products to children suffering from Sever Acute Malnutrition (SAM) and Moderate Acute Malnutrition(MAM) in Maharashtra, under the supplementary nutrition program in ICDS. This EDNF is intended to be used in 6-72 month age group as a 'specialized food' for children with SAM and MAM as a medical protocol for community based management of SAM. It is proposed to be distributed in all the 34 districts of Maharashtra at an estimated annual cost of more than Rupees 38 Crores.

The rationale of EDN Fuse is stated to be that children with SAM are at nine times risk of dying and children with MAM at three times the risk of dying and this intervention would serve to reduce under-five mortality due to malnutrition. **BUT the scientific evidence does not seem to suggest so.**

We bring to your attention these 2 studies conducted in India to look for solutions.

1. The results of a recently completed large, multi-centric, robust efficacy trial[i] in Indian children with uncomplicated SAM, comparing ready to use commercial therapeutic foods (RUTF) with home based foods, shows that 1.1% of over 1,00,000 screened children between 6 months and 5 years of age had severe acute malnutrition (SAM). In view of lower recovery rates following distribution of specially formulated diets, the advisory committee had to recommend paid workers for services to help feed the child 8 times/day (after 1/3rd phase of the trial) and extend the treatment to 16 weeks (the longest duration for any SAM feeding trial). **This means that severe acute malnutrition cannot be sufficiently countered in the field without directly supporting the act of**

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feeding. The results also show that the differences between home augmented foods group and commercial RUTF group were not significant. The locally created 'ready to use therapeutic food' group (this being different from commercial ready to use therapeutic foods only in texture) was inexplicably better than home augmented achieving a 57% recovery rate as compared to 43% in 16 weeks. **However, 16 weeks after the intervention, the overall proportion of children cured had dwindled to 15%. And there was NO difference in mortality in 3 groups.**

2. A new study[ii] has been published more recently in the 'Indian Pediatrics' on "Survival and recovery in severe malnutrition ". It is done with the objective to evaluate recovery and survival of severely wasted children in two rural blocks of Uttar Pradesh. Out of 18463 children under five who were clinically examined; prevalence of severe wasting (weight height <-3Z) was found to be 2.2%. These 409 children with severe wasting were followed up for survival and repeat anthropometry. Parents and caregivers of severely wasted children were given appropriate nutrition counseling by the project staff and referred to nearest PHC. There was no special CMAM programme for these children. In this study on 409 children only 11 children died during 1 to 7.4 months follow up. **This resulted in a low case fatality rate. In this study, 1.2% children died within one month of follow up and 2.7% within 7.4 months.**The earlier perception is that these mortality rates are very high (30-50%).According to the authors, such perceptions of mortality risks of untreated severely wasted children have been drawn from studies that are 2 to 4 decades old. Among survivors, spontaneous recovery occurred with only 30% remaining severely wasted.

Thus, the 1st Indian research clearly shows that **choice of dietary product is largely irrelevant for sustained recovery.** Gains were unacceptably transient with use of products (exactly the same as proposed EDNF), since the cure rates declined to 15% (4 months after stopping treatment) and no difference in mortality among three groups. The 2nd study breaks the myth that severe acute malnutrition carries a very high risk of mortality.

These two studies provide sufficient and important evidence for decision making on use of RUTFs/EDNF.

Sir, Children with SAM do need urgent and immediate interventions, which could include nutritional support as a supplementary measure. The more important and longer term solution is much greater investment in the prevention of malnutrition with sustainable solutions.

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We also believe that use of RUTF is expensive and diverts resources. More information can be seen http://napiindia.in/docs/Use-of-RUTF-for-Managing-Severe-Wasting-SAM-Key-Concerns.pdf

Considering these factors, we believe action to reduce the number of malnourished children through holistic measures that include prevention should constitute a priority in planning for SAM and MAM.

We therefore request to re-consider your decisions to procure EDNF and drop this idea in the best interest of children and the exchequer.

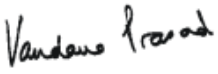
We would be happy to assist you.

Truly Yours,

NAPi.


Sh. Keshav Desiraju


Dr. Arun Gupta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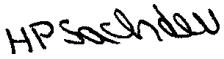
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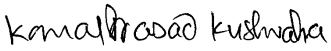
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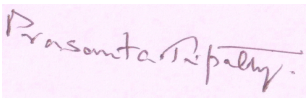
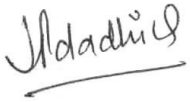

Dr Prasanta Tripathy


Prof. Umesh Kapil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[i] [i] http://gh.bmj.com/content/1/4/e000144
[ii] http://www.napiindia.in/docs/SAM-Survival-(3).pdf