

After Niger 2005

"...regular' starvation has to be distinguished from violent outbursts of famines..."

(Amartya Sen, Poverty & Famines 1981)

Dr Milton Tectonidis, Berlin 2006

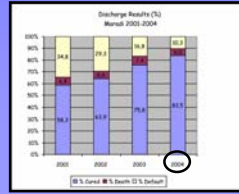
July 2001-2004 MSF Niger



Severe acute malnutrition + special cases only
Ready to Use Therapeutic Foods (RUTF)

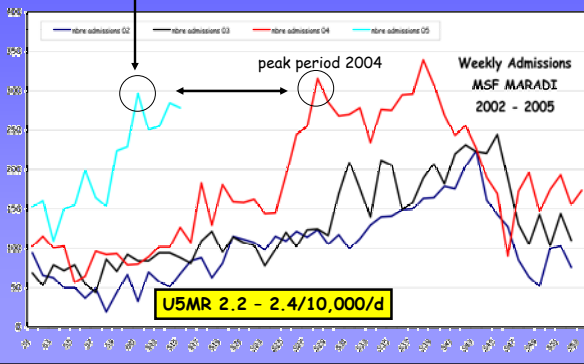
Six outpatient centres (Maradi region)
One inpatient centre (Maradi town)

2004 9,632 admissions (highly seasonal)
83.5% cure rate (90% below 85 cm)

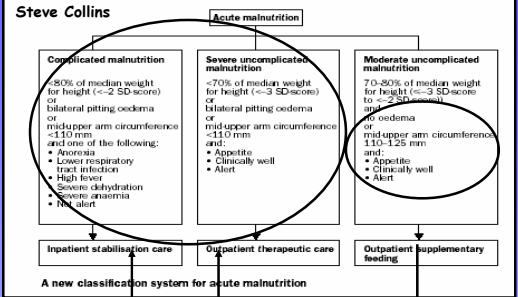


March - April 2005

Clear Signs (W12)



May 2005 MSF Niger Emergency Strategy

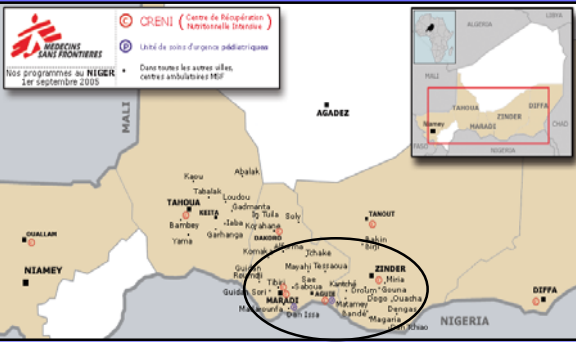


NEW SC & DTC (RUTF)
+ Protection & Discharge Rations

TARGETED BLANKET FEEDING (TBF)
late July 2005 (Maradi)
late Sept 2005 (Zinder)

July - October 2005

OPD + Pediatric units
Inpatient and outpatient centres
Family rations + targeted blankets

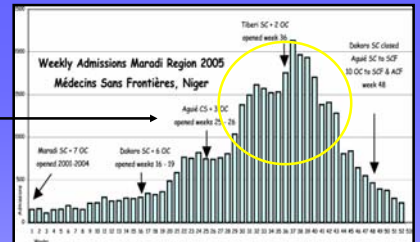


2005

Hunger gap
60% of admissions in 13 weeks

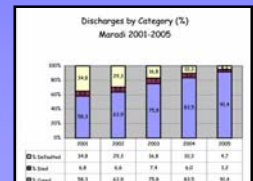
Maradi region

39,158 admissions
95% of admissions < 3 years

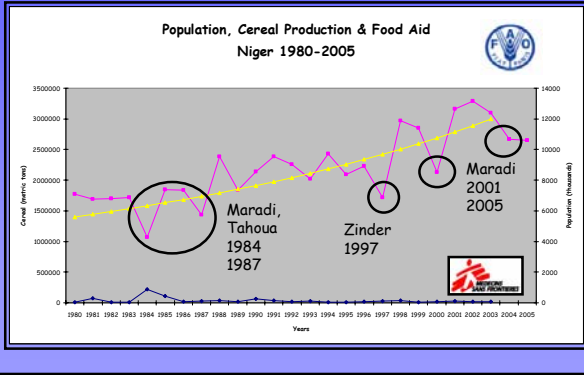


Program indicators

2005
91.4% cure rate
3.2% death rate
4.7% default rate

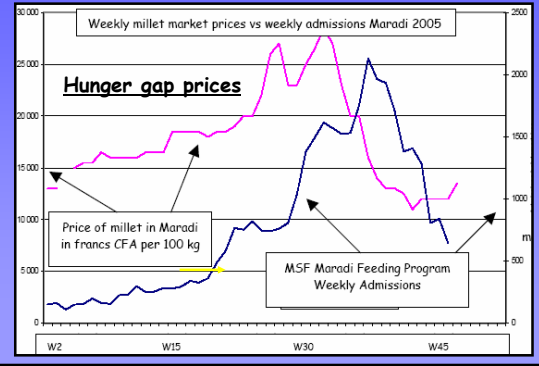


Cereal availability in Niger 1980-2004

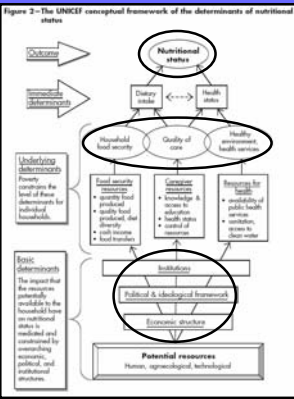


Millet accessibility in Maradi 2005

It is graphically clear that for the poor, working for others, whether nearby or on seasonal migration, is the mainstay of their household budget. In other words, the poorer you are, the more you depend upon cash!



Malnutrition conceptual framework



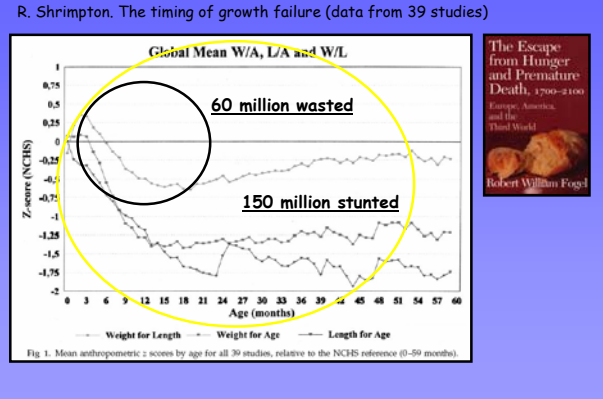
Myth 1: Malnutrition is primarily a matter of inadequate food intake. Not so. Food is of course important. But most serious malnutrition is caused by bad sanitation and disease, leading to diarrhea, especially among young children. Women's status and women's education play big parts in improving nutrition. Improving care of young children is vital.

CARE PRACTICES
Health & Sanitation
Quantity & quality of food

The most common cause of protein-energy malnutrition is parents' poor child feeding and caring practices...."

World Bank 2006

Growth failure & malnutrition



Nutrient deficiency growth & malnutrition

Type I nutrients
specific signs of deficiency

iron, copper, selenium
calcium, iodine
vitamins A, B, D, E, K



Type II nutrients
growth failure

nitrogen, essential amino acids
sodium, potassium, chloride
phosphorus, sulphur
zinc, magnesium

tissue repair & growth ceases
no convalescence from illness
anorexia and wasting



Mike Golden

Ready to Use Therapeutic Foods (RUTF)

Nutrient dense (F100), calorie dense (5 kcal/g), ready to eat pastes
Low water content (contamination), no added water
Facilitated transport & storage, convenient packaging

- Increased capacity**
Outpatient treatment
Multiple, decentralized sites
Include the "moderates"
- Improved results**
Early diagnosis (recruitment)
Expanded coverage
Quality referral care

Designed to encourage rapid weight gain

RUTF & Acute malnutrition

the end of the TFC/SFC distinction ?

Deinstitutionalise
Demedicalise
Simplify

ACUTE MALNUTRITION

W/H < 80%
MUAC < 110 mm
Edema

MUAC/edema only ?
adjustable thresholds
include other age groups

COMPLICATED

Inpatient

ANOREXIA
Severe pathology
Apathy

strengthen referral capacity
discharge quickly

NON-COMPLICATED

Outpatient

APPETITE
No severe pathology
Alert

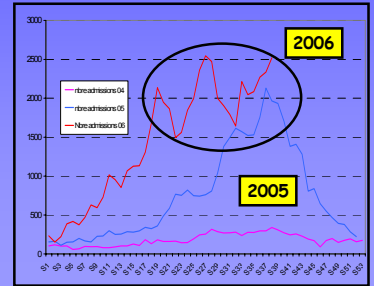
adjust discharge criteria
lighten follow-up

2006 January to September (9 months)

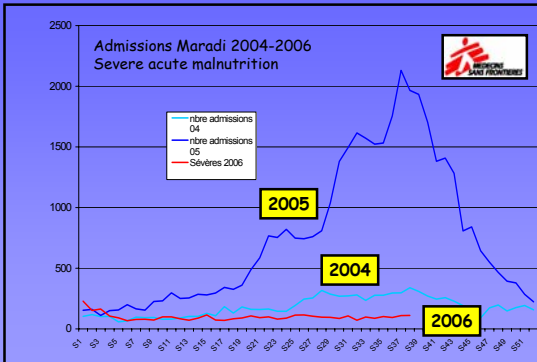
RUTF program extended to all acutely malnourished
Southern Maradi region

54 375 admissions
93,1% moderate
90,6% ambulatory

45 485 discharged
95,9% cure
0,8% died

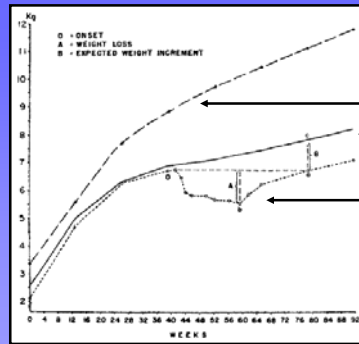


Massive reduction in SEVERE acute malnutrition 2006



Anthropometry - individual risk

Extend benefits



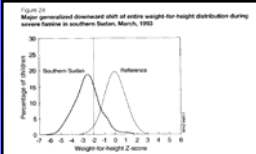
"healthy" reference children
rural village age peers
child with pertussis

RUTF ?
Treatment by
illness episode ?

poor & incomplete catch-up growth

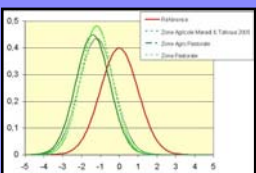
Anthropometry - population risk

Extend benefits



South Sudan 1993
Herwaldt et al
70% UB < -2 ZS

RUTF ?
Therapeutic Blanket ?



Maradi Niger 2005
Up to 25% incidence of severe
malnutrition (50% for < 85 cm)

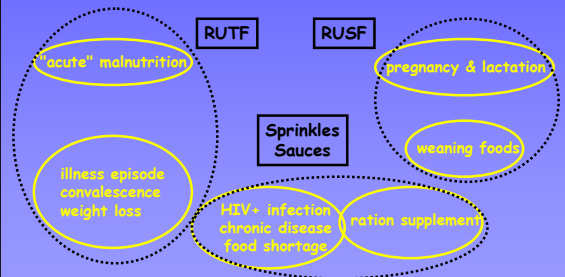
Districts / Cantons	Incidence of admissions by district/canton Maradi 2005		
	Under 5 pop	Admissions	Incidence (/1000/yr)
District Guidan Roumdji	78452	11 303	144,1
District Bourkibane	2397	111	47,7
District Bourkibane	1901	2741	143,3
District Bourkibane	1895	1244	65,7
District Bourkibane	18432	4040	219,2
District Bourkibane	14879	1802	120,7
District Bourkibane	15027	1549	102,8

MSF & Nutrition

new therapeutic products & home-based strategies

RAPID WEIGHT GAIN

TARGETED SUPPLEMENT



micronutrients +/- calories

MSF emergency nutrition



Strategy (who is at risk?)

Targeting (what supplement?)

