Ethics of Use of Ready-to-use-Therapeutic Foods

Ethics of Use of Ready-to-use-Therapeutic Foods, Charlotte Dufour, Groupe URD, In : *Field Exchange*, November 2002 Issue 17.

Dear Editor,

I have been following the debate of the ethics surrounding the research on Community Therapeutic Care (CTC) and Ready to Use Therapeutic Foods (RUTFs), and was wondering whether the issue of **ethics** in the **current use of RUTF's** in the field is also being discussed, as this also could have effects on the quality of the research and effectiveness of future CTC programmes.

Back from a 5 week mission throughout 3 regions of **Afghanistan**, as part of the Quality Project implemented by Groupe URD, I was struck to find a large number of NGOs **distributing RUTFs** (e.g. Plumpy Nut supplied by UNICEF) to severely malnourished children **in Supplementary Feeding Programmes (SFPs)**, sometimes with fortnightly distributions (mothers receiving 30 to 60 Plumpy nut packets at a time), and most often with very little if any specific medical supervision of severely malnourished patients (sometimes including pregnant or lactating women, admitted according to MUAC).

Have the following issues been raised?

- Is it **ethical** to distribute a (very expensive) product for which the protocol is not yet fully tested and approved, and the efficiency of which is not proven outside the TFC?
- How can we deal with the **commercial interests** lying behind the distribution of RUTFs ? Is Afghanistan a potential new market for such foods, and what is the role of NGOs in these strategies?
- How is this product being used within households (sold? shared?) and how may these practices **hinder the future proper use** of RUTFs in research programmes or actual CTC programmes, once the protocol is developed ? Is RUTF a food or a medical treatment, and if it is to be the latter, can it be freely distributed without careful monitoring and supervision?

I was concerned, because many SFPs where RUTFs are distributed are implemented by agencies or field personnel that do not necessarily have nutritional training, are not familiar with the specificities of severe malnutrition nor aware of the issues surrounding CTC. Furthermore, the monitoring, when it is done, tends to show **poor results**, with very high rates of defaulters (up to 70% in some centres) which probably include mortality cases, and weight gains (when they are calculated) around 2 to 4g/kg/day (of course, there can be wide differences in results between programmes).

Many staff who were asked about the pertinence of distributing RUTFs say "it's that or we do

nothing". The Afghan context indeed makes it very difficult to implement TFCs: distance for beneficiaries, difficult access to remote areas for agencies, difficulty for women to leave their home, the lack of staff (expat and Afghan) trained in nutrition, and the lack of NGO capacity to implement TFCs are all severe constraints. But **is the distribution of RUTF (in SFPs) better or worse than nothing?**

I feel concerned about this issue, as I have seen a similar example of RUTF distributions in SFPs or even blanket distributions in Ethiopia, and imagine that other examples must be widespread, given the "publicity" made around CTC & RUTFs.

Mike Golden mentions in his answer to Steve Collins (NutritionNet on 04/06/02) that "Now that we have RUTF, these programmes (CTC) are feasible, but we must go sufficiently slowly to learn the lessons". It will surely take time to do the research on the appropriate use of RUTFs, but with the products already on the market, is the practice not going too fast? And if so, what can be done to ensure these new products are "properly" used until the research yields more results ?

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