



Doctors Without Borders/Médecins Sans Frontières (MSF)

Press Teleconference Transcript:

FOOD IS NOT ENOUGH

Revolutionary Malnutrition Treatment Available Now, But Out Of Reach For Millions Of Children

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Michael Goldfarb: Thank you everyone, for joining us today. I'd like to welcome you to the Doctors Without Borders/Médecins Sans Frontières, or MSF, press teleconference titled: Food is Not Enough. Today, six days before World Food Day, Doctors Without Borders offices worldwide are issuing a call for increased and expanded use of new and revolutionary ready-to-use therapeutic foods, ideal for treating childhood malnutrition. Malnutrition kills 5 million children a year, and MSF is calling for a reorientation in global food aid programs toward a focus on nutrition and food quality for young children.

We will have brief presentations and then open up the call to questions and answers. First from our side is Dr. Buddhima Lokuge. He will address the inadequacies in current food aid and nutrition policies and the need for scaled-up implementation of ready-to use foods in food donations. Dr. Lokuge is the U.S. manager of MSF's campaign for Access to Essential Medicines. He is a medical practitioner who has worked as a clinician in Australia, and he worked with MSF in Afghanistan in the late 1990s.

Following Dr. Lokuge will be Dr. Milton Tectonidis, who will provide an overview of malnutrition in young children. Dr. Tectonidis is a nutrition advisor with MSF currently based in the organization's Rome office. He has been with MSF since 1992 and has participated in numerous field assignments throughout the world. He recently returned from Niger, in west Africa, where he observed MSF's nutrition program in the Maradi region.

Dr. Buddhima Lokuge: Good morning. Malnutrition is a medical crisis that exacts a massive deadly toll worldwide. There is a sense of complacency and fatigue around addressing malnutrition deaths, a complacency complicated by confusion between hunger - lack of food quantity - and malnutrition - the lack of nutritional quality of food. These factors have meant the crisis of malnutrition has been all but neglected by the international community and leading donors. For instance, as a 2007 farm bill progresses through Congress, there's been much debate on improving the delivery of food aid, including local sourcing, yet not a single proposal has been tabled to improve the effectiveness of this aid for young children most at risk of death.

Reform is urgently needed to ensure food aid has an impact on the five million deaths each year associated with malnutrition in children under five years of age. This is why MSF is speaking out today internationally. The importance of nutrients and the quality of food aid has to be addressed not only by international donors, including the U.S. government, but also by organizations that use pictures of malnourished children to raise funds without a focus on the nutritional quality of food. These images are being used in vain. Most importantly, today, innovative new therapies and supplements exist and are available that could have staggering results, if only a shift in nutritional programming occurred. The availability of ready-to-use foods (RUFs) therefore creates a unique opportunity, but also a responsibility, for international donors to act.

What is MSF calling for? Well, clearly, we need to treat the worst first. Yet, despite the proven effectiveness of RUFs, we estimate only 3 percent of the 20 million children with the severest forms of malnutrition—and therefore the highest risk of death—have access to treatment. In order to reverse this situation, production of therapeutic ready-to-use food has to increase. MSF estimates about 250,000 tons of ready-to-use foods are needed. While UNICEF and other organizations are working to establish many new production sites in the developing world, funds are urgently needed to support national programs and non-governmental organizations to purchase and distribute these products. The U.S. and international donors have a critical role to play in this scale up. However, we cannot wait until children become severely malnourished. Ready-to-use foods are adapted for use in resource-limited settings - many of the countries we work in.

They also provide an effective way not only to treat but to prevent malnutrition on a massive scale. But current aid by the U.S. government and also international donors limits the use of ready-to-use foods only to the severely malnourished, and this is far too narrow. Instead, the U.S. and donors use inferior, fortified blend of flours, like corn-soy blend (CSB) to prevent malnutrition, despite studies such as a recent extensive report of 82 supplementary feeding programs showing these products are failing many children. This occurs despite MSF's experience in Niger, as well as studies, for example, in Malawi, indicating ready-to-use foods to be far superior to fortified blended flours in preventing malnutrition.

In 2006 the United States provided 2.4 million metric tons of food aid to 82 developing countries. More than half of the world's food aid comes from the United States, and the United States is the largest contributor to the lead emergency food aid organization, the World Food Program. However, much of this food aid is in-kind donations. The U.S. therefore has a responsibility to ensure the products it provides in-kind have ready-to-use foods and are included in the food basket of aid provided. The current practice of using inferior fortified blended flours in food aid for young children has to change.

There is also a need for more research and development. Ready-to-use foods are specifically adapted to the delivery of nutrients to young children in resource-limited settings. However, given the spectacular results in treating the most severe cases, more research is needed to expand the applications into supplementary feeding during weaning but also in recovery from acute diseases—infectious diseases and chronic infectious diseases, like TB and HIV—but also in pregnant women.

So, to conclude, at a time when global forces are driving up the price of milk and many staple foods, the challenges posed to children in malnutrition hot spots, parts of Asia and southern Asia and Africa, are increasing. If we are to prevent the crisis of malnutrition worsening, but also reverse the millions of deaths that occur each year, a sense of urgency is needed in the scale up of treatment programs with ready-to-use foods and the expanded use of these products in prevention. We believe highly nutritious ready-to-use foods to prevent malnutrition and promote healthy development should not be a luxury item. Thank you.

Michael Goldfarb:

Thank you, Dr. Lokuge. I'd like to now hand it over to Dr. Milton Tectonidis, who's going to provide an overview of malnutrition in young children and a perspective from the field.

Dr. Milton Tectonidis:

I'm going to be brief because I prefer to answer questions than try and speak like this freely. But we are launching this campaign as doctors involved in international health because we see a number of things happening. One is this confusion between hunger and malnutrition. For us, as doctors, malnutrition is a disease. It's not just the problem of a lack of food. It's a disease caused by deficiencies in nutrients. The human body needs up to 40, even more than 40, essential nutrients for health. And this disease is mostly striking very young children.

Why? Because they're dependent. They can't feed themselves. Because they have very special tastes. A kid will not eat anything. It will not eat a big piece of meat, obviously, or a big potato, so it needs to have specially prepared foods. And because the kids are growing fast they're the ones that are the first to show symptoms and signs when their diet is not sufficiently nutritious. And this is why it's killing, mostly, these kids.

And the second reason why we're launching this campaign right now and trying to speak out is because the current policies are not addressing this specific problem of malnutrition as a disease. They tend to address hunger. And, therefore, they dump more food in these parts of the world which have high rates of malnutrition, and they're not having much success in reducing the rates of malnutrition and the death that goes along with it in young children. So we want to bring back the focus not on quantity of food but quality of food available to specific vulnerable populations. And the most vulnerable populations are young children of rural, poor families in large parts of Asia and Africa, who are dying by the millions. So we'd like to bring this focus back.

And the final reason why we're launching this now is because, over the last five or ten years, a new type of product has been developed which is perfectly adapted to this age group and to these types of situations of families of rural poor who live without refrigeration, without electricity, and to whom we cannot give something like powdered milk, for example, which is what's given in the States to poor families. So these products have revolutionized our practice as doctors, and they are showing extremely, extremely positive results.

And yet we're very worried. Although the United Nations and other agencies now are really stepping up their response and have signed on to these new products, we're very worried that, by themselves, they will not be able to scale up the production and distribution and use of these products quickly enough. And, secondly, we're very worried that for all sorts of policy reasons and for the miscomprehension of what is going on in malnutrition we will be limiting these products. They will be limited to children who are almost half dead already, what we call severe, acute malnutrition. They are the ones who are really at high risk. And we have more and more evidence from our practice that these same products or slight variations in their presentation or formulation or the quantities we give can prevent the children from becoming severely wasted to the extent where they're almost half dead. So we really would like to get the focus back on this problem, the specific problem of malnutrition in young children.

I'll just give you a briefing of how we got to this stage. MSF, in general, has been using these products for five to ten years now, but the Niger experience was really a determinant in our desire to run this campaign and to speak out. We have been present in Niger since 2001. But the crisis in 2005 attracted a lot of international attention. And it changed. It really changed. It started the change towards the better right now. It was a severe crisis in Niger in 2005, and it was huge numbers of severely malnourished children that were treated with these new products. And they got the attention in the

international press which was very positive. MSF treated 60,000 children that year in Niger—severely malnourished children—that is, children that were almost half dead at presentation and we rehabilitated them with an over 90 percent cure rate. So that was a real shock. I mean, MSF had never treated that many people in a nutritional crisis.

These products can do it because they can be administered at home. Unbelievably, many of the most severe cases can nevertheless be treated at home. And this is the only way to go where there's so many of them. There's no way we can hospitalize all of them. So this was a turning point. And in 2006, with all the international attention, many other people came to Niger to help out and permitted us to take further steps.

So, in the next year, when there were many other people present and the coverage was much better and, actually, the crisis in terms of nutrition was less severe, we decided to extend the use of these products to children before they got severely malnourished. And we had extremely good results giving these products to kids with what we call moderate malnutrition. Again, with over 90 percent cure rates, we treated 65,000 kids.

And then, finally, this year, we went one step further. We said that there's no way that these under-resourced, overworked health services in poor countries are going to manage to handle all these cases. We have to find a way to reduce the burden of disease and not dump all these cases onto health services that are underfinanced, under-resourced, overburdened, and under-motivated because they don't get paid properly and they don't get the drugs. So we figure that the best way is to distribute a similar type of this product as a supplement to the child's diet. In other words, it's no longer treatment; it's the small quantity of a similar product that they use in addition to their regular foods and that, nevertheless, brings everything—all the nutrients that are missing in their regular diet—into their diet and, therefore, prevents them from wasting and stunting. And we haven't analyzed all the results, but objectively, from what we're seeing with the kids and the mothers, we seem to have had drastically reduced the incidence of malnutrition, which usually occurs seasonally in Niger when food gets short in the home. So this is our Niger experience, and this is why we really want to make sure that these products are not limited to the most severe cases.

Michael Goldfarb: Thank you, Dr. Tectonidis. We can now open it up to Q&A.

Question: I was just hoping you could go over again what specific problems or symptoms or syndromes you see in the children that are chronically malnourished that we're discussing here. And, secondly, a different question. When looking at the idea of changing the type of aid that's provided by the United States, for example, since that's where we are, could you talk about how that might occur from a policy standpoint and how that stacks up against the kinds of aid that is used now? And, if you all have any ideas of how the United States might transition to this new kind of aid, given the political realities and the kind of discussions that have been going on this year with the farm bill about modalities of aid. Thank you.

Michael Goldfarb: We'll have Dr. Tectonidis answer the first part of your question on the medical side. And then Dr. Lokuge to respond to the second part.

Dr. Milton Tectonidis: Malnutrition is a huge category, so there are different forms. The most common ways that we see it present in young children is that they stunt. In other words, they don't grow—growth failure. When there are not enough nutrients in their diets, they stop growing. And this is affecting one-quarter of the world's population of children. In Niger, for example, over 50 percent of children are stunted. That means they're not as high as they should be for their age. And this is an indication of sickness. It's not just, well, they're short. No. And it's not just the fact that they stop growing. If those nutrients are not present and they've stopped growing, you can be sure that it's affecting their immune

system as well. And you can be sure that it's affecting their general metabolic health. So, as it gets worse, the body starts to eat its own tissues to provide the nutrients, because these nutrients are stored in muscle. They're stored in lean tissue. So not only the fat, but the body breaks down its own muscle and bone to get the nutrients back into the blood that are essential for life. And this we call wasting. They start losing weight. And so they become low weight for their age. So stunting and wasting are two of the prime indicators of something severely wrong in the child's diet. Stunting is affecting over 150 million children. Wasting – the World Health Organization (WHO) estimates some 60 million children are affected.

Question: That's globally?

Dr. Milton Tectonidis: That's globally. And then there is a category that we call severe acute malnutrition. And these are a special category of severely wasted—so that's one which is diagnosed by taking their weight or height or their mid-upper arm circumference, and the kwashiorkors—the nutritional edemas. And these are the real high risk cases. These are the cases that, without direct and immediate nutritional intervention, have a very high risk of death. So these classically have been the ones that humanitarian agencies have focused on. And the WHO is estimating them at 20 million in the world at any one moment of time. That's a prevalence.

Question: And is that largely in sub-Saharan Africa?

Dr. Milton Tectonidis: No. The majority are actually in India, Bangladesh, and Pakistan, and a few countries of Asia. Not everywhere in India. There's a certain number of states in India that are doing just as poorly as African countries are in terms of responding to this.

Dr. Buddhima Lokuge: If I can address, then, the second question in terms of policy failure and how this would happen: I think the first thing is we have a very simple message. Unless light is shone on the fact that malnutrition is about nutrients and not food quantity, then we can't go the next step of changing policies. And that is really our very simple message today. Malnutrition—the 5 million deaths associated with malnutrition in the world today—is a question of the quality of food that young children are eating, not the quantity. And, as I said, in policy discussions, this issue, which we believe is critical, is relegated to a footnote in a large document. So this has to change. So, today, that's what we are trying to do - shine a light on that issue.

But, in terms of shifting policies, USAID actually funded early research into the use of ready-to-use therapeutic products, into effectiveness trials, and, also, since the early 2000s, has actually identified the limitations of corn-soy blend, for example. In fact, when corn-soy blend was developed in partnership with the U.S. Department of Agriculture, USAID, and the National Institutes of Health, it included powdered milk. And so there has actually been a lot of work by U.S.-funded agencies to look at how to address nutritional deficits in young children. But, as I said, unless the first issue is addressed, the fact that malnutrition is a question of nutrients, and awareness is raised of this, then the next steps in terms of policy change cannot occur.

Globally, we see there are other uses now for corn products, and so the excuses for why we still have to use less effective products today to address the crisis of malnutrition is, I believe, less relevant.

Question: Can you just tell me what the ready-to-use foods are made out of?

Dr. Milton Tectonidis: They provide the full spectrum of calories, energy, and nutrients that are needed in the child. So, essentially, they can be made from anything, as long as they can get to that. We

know what the child needs. This was done over tens of years of research by professors like Professor Mike Golden, who developed these formulas. So this current product is made from oil, from peanuts, from powdered dry skim milk, and with a nutrient mix that is added to bring all the vitamins, minerals, and trace metals. But there are many other ways to make the same thing. And, actually, we need more variety. We cannot rely on one type. And the big advantage of these products -- they have almost no water in them, so they're almost anhydrous. So they're basically impossible to contaminate. Nothing can live in there. Bacteria can't live in there. That is why they're so adapted to these situations where malnutrition exists. We could have given powdered milk. We would have solved the problem ten years ago, if they had had ways of getting access to clean water, to refrigerate. But the problem is, to give powdered milk in some of these situations, we may do more harm than good. Now we finally have an equivalent --- an adapted equivalent type of intervention to provide this type of nutritious food to these places.

Dr. Buddhima Lokuge: And what's important is also the technology. Again, USAID has funded, for example, in Malawi, local production of ready-to-use foods. The technology is easily transferable. But children are dying today and we need to scale up production. Whether it occurs in the U.S. or in Malawi is not so much an issue. But it's getting these products to children and getting them at an affordable price.

Question: Do you have any sort of assessment of how politically feasible in the short to medium term this kind of shift might be here in the United States?

Dr. Buddhima Lokuge: We have seen the scale up of ready-to-use foods, and I think there is a lot of attention now being focused on this issue. And, once the increasing research and evidence is available on their effectiveness, it really will be hard to argue against their use.

Question: I just need some better understanding, also, of who makes this ready-to-use food, how much it would cost to provide the amount that you believe is needed, who the providers would be, would this be done through donors? Would this be done through MSF? What would be the vehicle for providing it? Just a little bit more clarification of how it needs to be done or who would do it, as well as where it's going to come from and who makes it.

Dr. Buddhima Lokuge: In terms of production, we're seeing now many different producers in the market. And we hope there will be many more. Currently, there is production occurring in Europe, in Malawi, in Niger, and also in India there is planned production. UNICEF has an ambitious plan to create 70 production sites in Africa alone. But these timeframes have to be accelerated so that we can see the production scaling up from the current 12,000 to 15,000 metric tons that are produced today, to, as I said, 250,000 metric tons. But this will happen. All it requires, really, is the mobilization of funds and political will, given that the crisis is so pressing today. I think it's a matter of these steps occurring with urgency.

How much? So in terms of vehicles for providing it, again, UNICEF is working with Ministries of Health. There are established systems. But these are details that will be developed as production is scaled up. Currently, there are numbers of different ways that ready-to-use foods are being used as therapies for the severest children. And we need to also now find ways to deliver ready-to-use foods, as we said, in the prevention and in supplementary treatment - in early treatment of less severe children.

Milton, would you like to add something?

Dr. Milton Tectonidis: I don't think the solution is people like MSF delivering this all over the world. It is national health programs. And there is success already. In Ethiopia and Malawi, for example, the governments are, actually, with UNICEF's help, treating a lot of children. Ethiopia, I think, is treating up to 25,000 children a month already. But what we're

worried about is that it's being limited to the severest cases right now. I don't think that's justified. But Ethiopia, a really poor country, is managing to treat, with UNICEF's help, by itself, 25,000 children a month. India, for example, has all the competence it needs to treat tens of thousands of kids. In fact, they are treating kids - many, many kids in India, but with the wrong product! So, I mean, all they have to do is switch the product. So I think that the solution is that it's got to be put into national health programming. And then they have to get assistance for sustainable financing. There are initiatives that are existing and are being set up that can easily provide that.

Question: How do these foods compare in costs to the other ones that are typically used by Title 2-supplied programs?

Dr. Buddhima Lokuge: Well, firstly, on the treatment side, the cost of treatment we estimate to be in the range of \$35 to treat a severely malnourished child with a **one-in-five** risk of dying without treatment. So, from our perspective from our work in different places, this, to us, is why we feel there's an urgent need to scale up production and availability. The previous approach required hospitalization. It required mothers to be away from their families. And so, on the cost side, there are a lot of other costs that this can avoid.

In terms of supplementary foods, really, I think we have to look at also the question of effectiveness. And, until production is scaled up, until different mechanisms are established to subsidize the price of milk, for example, then current prices are approximately \$2.5 to \$3 per kilogram, which currently is above the price of the alternative approaches. But, clearly, price is an issue only if effectiveness is equal. And, at the moment, we know that that's not the case.

Dr. Milton Tectonidis: There's also the fact that CSB (corn-soy blend), for example, I think costs something like \$350 a ton. But you have to count in all the transportation costs. It's a bulky product, and it's shipped over long, long distances. And, like Buddhi says, its effectiveness is very limited. So it's usually given over months and months of time with limited effectiveness, whereas these new products cure the children very quickly, so they get out of the program. So we have to factor in a whole bunch of other costs in the pure costs of the product by kilo itself.

What we want is that these products get produced and that the price gets lowered. Most of the cost of the product is raw materials. There's not that much cost beyond the raw materials. So we have to try and find ways to bring down the costs so that it can be used more widely. And there are ways. I don't know how much highly nutritious food like milk is destroyed every year because it's over quota, even in India. India is the second-biggest milk producer in the world. Almost every milk-producing country destroys milk. Why can't that be used, for example, for treatment? So there should be ways to be able to reduce the price by finding innovative, creative ways of getting some of these raw materials at a reduced price or even for free.

Question: Let me just be clear on what the obstacle is. Is it lack of motivation on the part of the donors, lack of a response, political, competition from U.S. farmers? What is the obstacle right now?

Dr. Milton Tectonidis: I really think that a lot of the obstacle is actually a paradigm shift that is needed. If you take people in USAID, for example, there are many people in nutrition technical assistance units that understand very much the questions. But I have a feeling that, policymakers and politicians don't quite understand this distinction between hunger and malnutrition. I think that's the first battle. They've got to understand that malnutrition is a disease of nutrient deficiency that has to be treated in a specific way. That is the first battle. Surely there are other obstacles, but I don't think those are the principal ones.

I really think that we've been running on a paradigm that malnutrition occurs because there's not enough food in a country, and therefore we have to help them. And it's been done not just with political intent but with a real humanitarian intent from American people and even American policymakers. I think they really feel that they're trying to help by sending food to countries that are missing food. So I think if we can convince them and show them properly-- I have a feeling that is the biggest obstacle. And that's why we are speaking out as doctors.

Question: Would it be fair to say that the food that is being sent is not very useful and is not helping the children out?

Dr. Milton Tectonidis: No. Food aid responds to food shortage, and that occurs, obviously. It occurs mostly in humanitarian crises, but it occurs on a chronic level too. There are many adults in many parts of the world that don't eat enough to be able to work properly and be functional. So there is a role for food aid. But when it comes specifically to the problem of malnutrition in young children, quantity of food becomes a lot less important than quality; for one thing because the child eats a very small quantity of food every day. And that quantity that they eat has to be quite highly nutritious, otherwise, it's not going to provide for their needs; whereas an adult eats a lot more. But, certainly, there's a place for food aid in the world. It is extremely important what the American people are supporting in the world for food crises, for chronically food-insecure areas. So that has to be maintained. We're not at all trying to criticize food aid for its proper target: food insecurity and global food shortages. What we're trying to say is that, in the young children, and specifically for the problem of malnutrition in young children, we have to look much more closely at quality than quantity.

Dr. Buddhima Lokuge: If I can add to that, the product we're talking about—the blended flour—is about 10 percent of current food aid. So it's really the products that are targeting malnutrition in the highest risk children where there is a real window of opportunity for intervening.

And, to go back to Milton's point about a paradigm shift, I think that that is really important. We have seen this in many other issues that we've worked with. For example, when the HIV/AIDS pandemic was occurring and there were effective treatments available in the West, we heard many sorts of questions about whether people in the developing world could take treatment regimes. And many questions were raised, and we were able to prove by good epidemiological data from our field projects that actually effective treatments—as effective as HIV patients we treat in the West—could be delivered in the developing world. And now we have the funds mobilized, and we have more than two million people, for example, on treatment in the developing world. But a paradigm shift was needed - a change in thinking. And that's really the first obstacle that we encounter.

Michael Goldfarb: Okay, that concludes our call. Many thanks to you for joining us. All of the issues that we discussed today and much more, and in greater comprehensive detail, are available on our Website: www.doctorswithoutborders.org. We've issued a press release today as well on this topic, and that, along with other substantive information is available on our homepage. Thank you again.