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# BMJ Paediatrics Open

## Management of acute malnutrition in young infants and young children: New guidelines from the World Health Organization and remaining challenges

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4 **from the World Health Organization and remaining challenges**  
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7 Rohloff P<sup>1,2</sup>, Gupta SS<sup>3</sup>, López Canu W<sup>1</sup>, Rodríguez Gómez W<sup>1</sup>, Sridhar S<sup>2</sup>, Venzor Strader A<sup>1,4</sup>  
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33 PR drafted the manuscript. SSG WLC WRG SS and AVS critically revised the manuscript. All  
34 authors approved the final version. PR is responsible for and guarantees the overall content.  
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44 Nutrition and Dietetics (USA) to conduct research on interventions to improve child growth and  
45 development. No other authors declare any competing interests.  
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14 There are many operational challenges to achieving this recommendation including: (a)  
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16 pervasive sentinel-center, tertiary-care referral models which concentrate and restrict access to  
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7 language and behaviors towards caregivers; visitation policies that isolate primary caregivers  
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9 leisure activities and other in-hospital support services.

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22 Equity must be considered in the implementation of these guidelines and operationalized with  
23 intentionality, particularly when considering integrated care and wrap-around services. For  
24 instance, it is noted that “Health workers tasked with making these treatment decisions must  
25 have the training and expertise to recognize and act on the signs and symptoms described in this  
26 recommendation and detailed below.” In many contexts, community-based services are provided  
27 by CHWs who are not always provided adequate training and mentorship. This problem is often  
28 exacerbated in rural areas resulting in decreased access to and quality of care. Systems and  
29 financing structures will need to be put in place so that providers have nutrition and pediatric-  
30 specific training, and have access to the appropriate support in rural communities. Otherwise,  
31 inequity in access to and quality of care will be widened. We hope that as these guidelines are  
32 operationalized, further attention is focused on equity; and that concrete, actionable  
33 recommendations are made for overcoming barriers to care, especially for those from distinct  
34 cultural or linguistic backgrounds and with prior negative experiences with biomedical care.  
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3 One final area that must be addressed is the fact that RUTFs, ready-to-use supplementary foods  
4 (RUSFs), and specially formulated foods (SFFs) feature extremely prominently in the guidelines  
5  
6 both for SAM and for MAM. While not diminishing the body of scientific evidence supporting  
7  
8 these products, it should be noted that they are largely produced in higher-income settings, often  
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10 commercially, and sourced to countries through bilateral aid agreements and other forms of aid  
11  
12 subsidy. In addition to the ethical challenges posed by the commercialization of global nutrition  
13  
14 products, the use of these products to some degree contradicts healthy nutrition practices for  
15  
16 children because of their high-energy, high-fat, and high-sugar composition.<sup>(5)</sup> In some settings  
17  
18 such as India, which contains a large proportion of the global burden of acute malnutrition,  
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20 concerns from clinicians and policy makers about how these products may displace whole food  
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22 interventions and lead to a preference for processed foods has severely limited uptake. Guidance  
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24 and advocacy are urgently needed to improve local, sustainable food solutions for acute  
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26 malnutrition.  
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35 The updated WHO guidelines have the potential to dramatically curb the incidence of acute  
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37 malnutrition and provide comprehensive community-based nutrition care. However, it is  
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39 essential that the implementation of these guidelines is done thoughtfully and intentionally with  
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41 full financial and administrative support from local ministries of health and implementing  
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43 partners.  
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# BMJ Paediatrics Open

## New WHO Guideline on the prevention and management of acute malnutrition in infants and young children: remaining challenges

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33 Contributorship:

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35 PR drafted the manuscript. SSG WLC WRG SS and AVS critically revised the manuscript. All  
36 authors approved the final version. PR is responsible for and guarantees the overall content.  
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49 With the introduction of these new guidelines, a group of global health practitioners and child  
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51 nutrition experts met to review the guidelines critically, with a particular emphasis on  
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53 emphasizing social pediatrics and child rights. Our primary goal was to offer insights into the  
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3 challenges of implementing these directives, drawing from our varied experiences in lower  
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5 resourced settings around the world. Each team member conducted a thorough review of the  
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7 guidelines and contributed key talking points, which were subsequently synthesized.  
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35 economic direct and indirect costs that inpatient pediatric care imposes on families, including  
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37 lost wages, the need to arrange childcare for siblings, and transportation costs. These expenses  
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39 are often overlooked and continue to deter families from accessing care.  
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47 Equity must be considered in the implementation of these guidelines and operationalized with  
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49 intentionality, particularly when considering integrated care and wrap-around services. For  
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51 instance, it is noted that "Health workers tasked with making these treatment decisions must  
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53 have the training and expertise to recognize and act on the signs and symptoms described in this  
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3 recommendation and detailed below.” In many contexts, community-based services are provided  
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5 by CHWs who are not always provided adequate training and mentorship or even formal  
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7 employment status. This problem is often exacerbated in rural areas resulting in decreased access  
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9 to and quality of care. Systems and financing structures will need to be put in place so that  
10  
11 providers have nutrition and pediatric-specific training, and have access to the appropriate  
12  
13 support in rural communities. Otherwise, inequity in access to and quality of care will be  
14  
15 widened. We hope that as these guidelines are operationalized, further attention is focused on  
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17 equity; and that concrete, actionable recommendations are made for overcoming barriers to care,  
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19 especially for those from distinct cultural or linguistic backgrounds and with prior negative  
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21 experiences with biomedical care.  
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28 One final area that must be addressed is the fact that RUTFs, ready-to-use supplementary foods  
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30 (RUSFs), and specially formulated foods (SFFs) feature extremely prominently in the guidelines  
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32 both for SAM and for MAM. It should be noted that these products are largely produced in  
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34 higher-income settings, often commercially, and sourced to countries through bilateral aid  
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36 agreements and other forms of aid subsidy. In addition to the ethical challenges posed by the  
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38 commercialization of global nutrition products, the use of these products to some degree  
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40 contradicts healthy nutrition practices for children because of their high-energy, high-fat, and  
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42 high-sugar composition.<sup>(5)</sup> In some settings such as India, which contains a large proportion of  
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44 the global burden of acute malnutrition, RUTFs are not commonly used because clinicians,  
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46 policy makers, and advocacy organizations have convincingly argued about how they about how  
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48 they may displace whole food interventions which can be deployed with equal efficacy and a  
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3 higher degree of sustainability.(6) More advocacy is urgently needed to continue to improve  
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5 local, sustainable food solutions globally.  
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10 The updated WHO guidelines have the potential to dramatically curb the incidence of acute  
11 malnutrition and provide comprehensive community-based nutrition care. However, it is  
12 essential that the implementation of these guidelines is done thoughtfully and intentionally with  
13 full financial and administrative support from local ministries of health and implementing  
14 partners. It is also essential that these general guidelines not cause clinicians to lose sight of the  
15 necessity to individualize care to each child and family, which is essential for the management  
16 and prevention of acute malnutrition, and which includes a need to act quickly on risk factors  
17 and early onset of growth faltering long prior to the diagnosis of MAM and SAM.  
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