

Proposition 1

“Severely malnourished children in OTP should be given a ration of RUTF equivalent to 200kcal/kg body weight/day”

- Accepted, 1 abstainer (non-nutritional person)
- Changes: CTC to OTP

Group 3

Nutritional Products & Protocols

Proposition 2a

“Before discharge from inpatient care to OTP there should be at least one day test of appetite and acceptability of RUTF only”

- Accepted, 1 abstainer (non nutritional person)
- Changes: at least one day; add in appetite and acceptability

Proposition 2b

“Based on current evidence from Africa, full-strength F100 should not be used in CTC programmes”

- 3 abstainers
- Issues: F100 diluted
 - Supply pipeline
 - Flexibility
 - To be more widely tested (other countries)

Proposition 3a

“When first screened, children <70% WFH, assessed to have no medical complication or oedema, and demonstrated to have good appetite, could be given RUTF and treated as outpatients”

- if used the word “should” 3 rejected (too strong)
- if used the word “could”: no rejections, 1 abstainer

Proposition 3b

“When first screened, children with oedema + (confined to the feet) and are $\geq 70\%$ WFH, assessed to have no medical complication and demonstrated to have good appetite, could be given RUTF and treated as outpatients”

- if used “should” 3 rejected, 1 abstainer
- if used “could”: no rejections, 1 abstainer

Prerequisites for RUTF

This is a complex topic that would need a 3day conference! There is a risk of oversimplifying the issue so should delay discussions (unanimous)

- Delay discussions as too complex
- What does “local” mean?
- Issue of whether local production should be commercial/should it be sold on the open market?
- How to integrate RUTF production to benefit local agriculture?

Other issues

- **Test CTC in more non African countries**
- **Test CTC in other countries with high oedema, high mortality**