CHALLENGE:

TO REDUCE MALNUTRITION

Change of paradigms:

From clinical treatment approach to prevention

“You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete.”

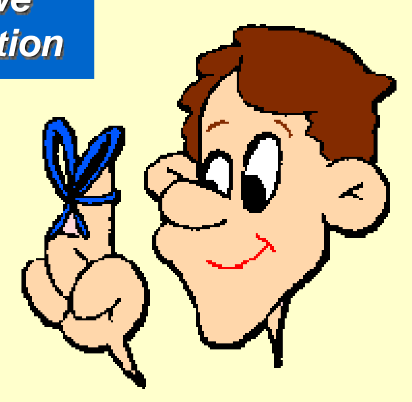
Buckminster Fuller

PARADIGMS

A set of comprehensive ideas, theories, believes, feelings, values and afirmations that give sense to our experience.

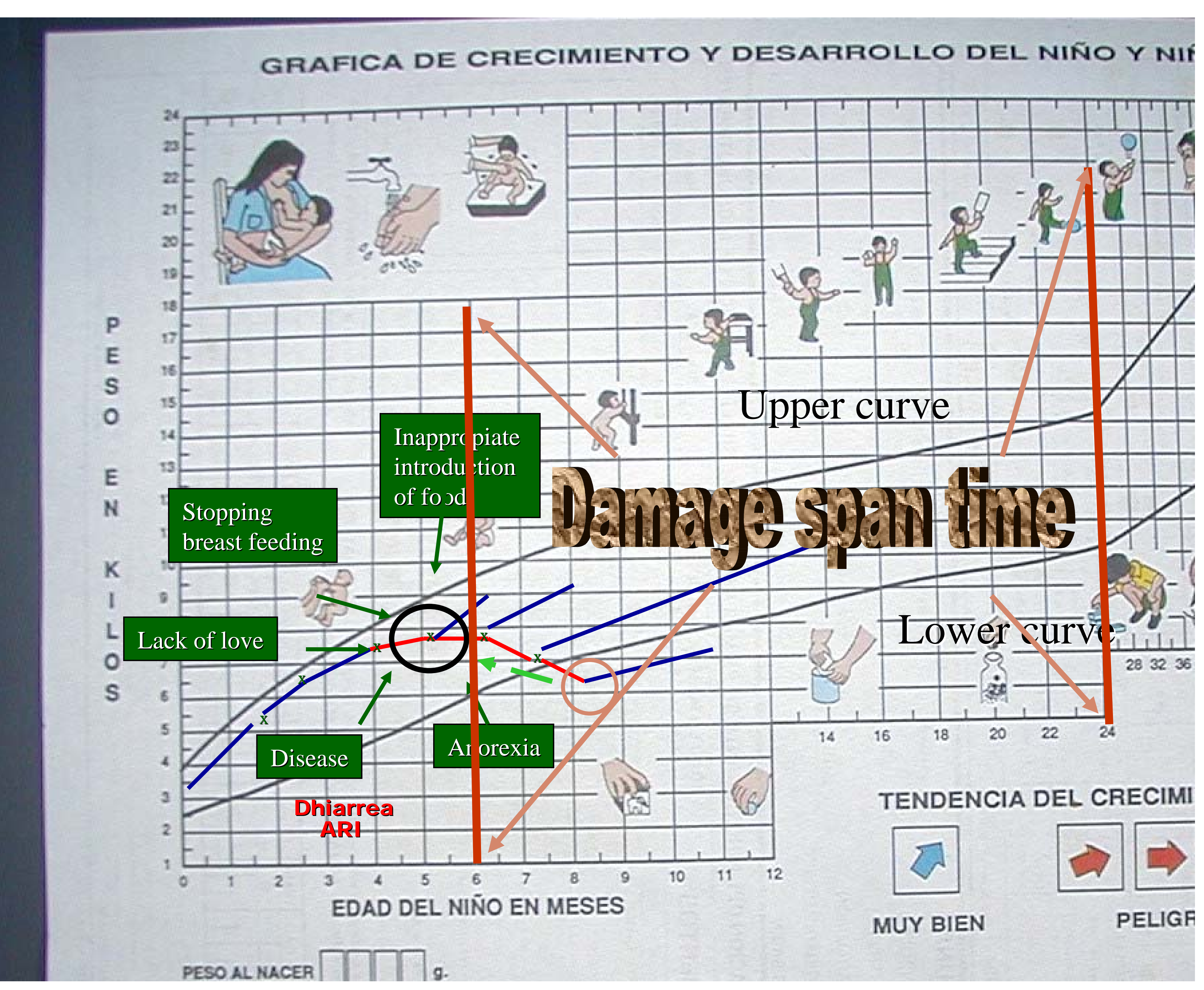
- PARADIGM
- Determine what we percieve
- Determine how we process information
- Determine what we think
- Determine avaliable alternatives to take decisions
- Determine what To expect / believe
- Determine actions we take

I will see it when I believe It; I will believe it when I see it.



HOW DO WE CHANGE CURRENT PARADIGMS FOR REDUCING MALNUTRITION?

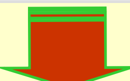
How the malnourishment process happens and when is the right time to act!


GRAFICA DE CRECIMIENTO Y DESARROLLO DEL NIÑO Y NI
PESO EN KILOS
Upper curve
Damage span time
Inappropiate introduction of food
Stopping breast feeding
Lack of love
Disease
Dhiarrea
ARI
Anorexia
Lower curve
EDAD DEL NIÑO EN MESES
TENDENCIA DEL CRECIMI
MUY BIEN
PELIGR
PESO AL NACER
g.

Changing old paradigms: Develop a new set of paradigms according to the new approach

OLD PARADIGM:

Malnourishment is a status,a state of being

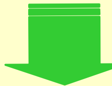


A child is malnourished when his weight or height/age point is under the third percentile

So, malnutrition has been defined as a state, a static situation, a point in the growth chart

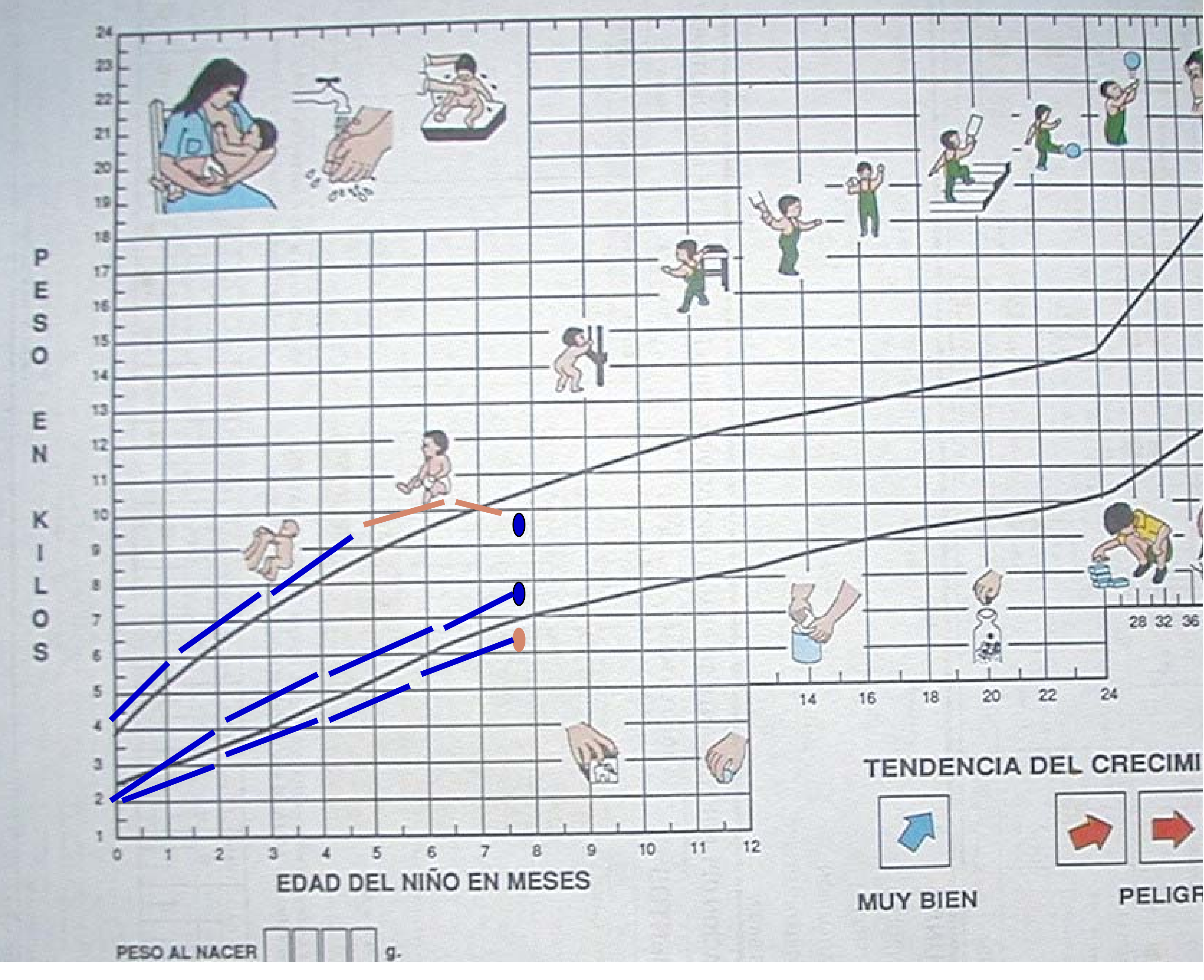
NEW PARADIGM:

Malnourishment is a process, a tendency



A child is starting to be malnourished when he/she is not gaining the expected weight

This applied no matter where on the growth chart the point is. Growth monitoring of an individual child is based on his/her own pattern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g.

Changing old paradigms: Develop a new set of paradigms according to the new approach

OLD PARADIGM:
Childhood malnutrition is always (or very often) a problem of lack of food in the home

When a child is malnourished it is assume that his/her family is poor and does not have the money to buy food, nor the capacity to produce it

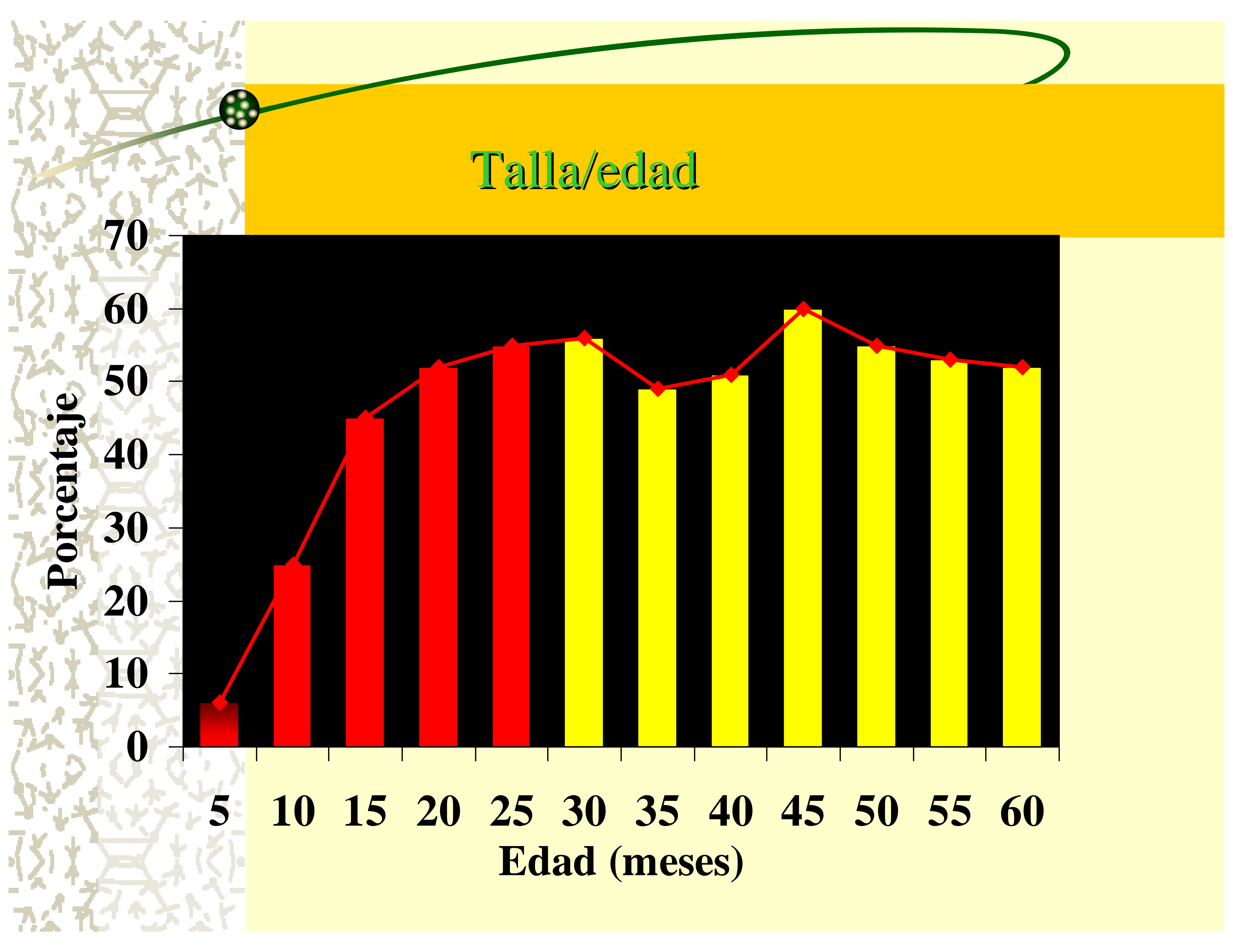
So, the solution is give and/or produce food to solve the problem

NEW PARADIGM:
Lack of food in the home is not the (main) cause of childhood malnourishment

To be poor means lack of knowledge

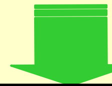
UNICEF has estimated more than 50% malnourishment children is not a problem of food in the home

So, a child not growing well, the problem is not lack of food until the opposite is demonstrated


Talla/edad
Porcentaje
70
60
50
40
30
20
10
0
5
10
15
20
25
30
35
40
45
50
55
60
Edad (meses)

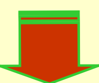
Changing old paradigms: Develop a new set of paradigms according to the new approach

OLD PARADIGM:	***NEW PARADIGM:***
Detection of malnourished children,especially severely affected (III Grade)	**Childhood malnourishment is not only a problem of food in the home**
Treat them through conventional clinical disease approach	Detect children with adequate growth or early growth faltering
Donate food/Promote family food production	Educate the mother how to produce healthy growth and correct the incipient malnutrition using available resources



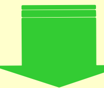
Changing old paradigms: Develop a new set of paradigms according to the new approach

***OLD PARADIGM*:**
Priority are children less that 5 years old



Older children severely malnourished are the priority

***NEW PARADIGM*:**
Priority are children less that 2 years old, especially since the first six month

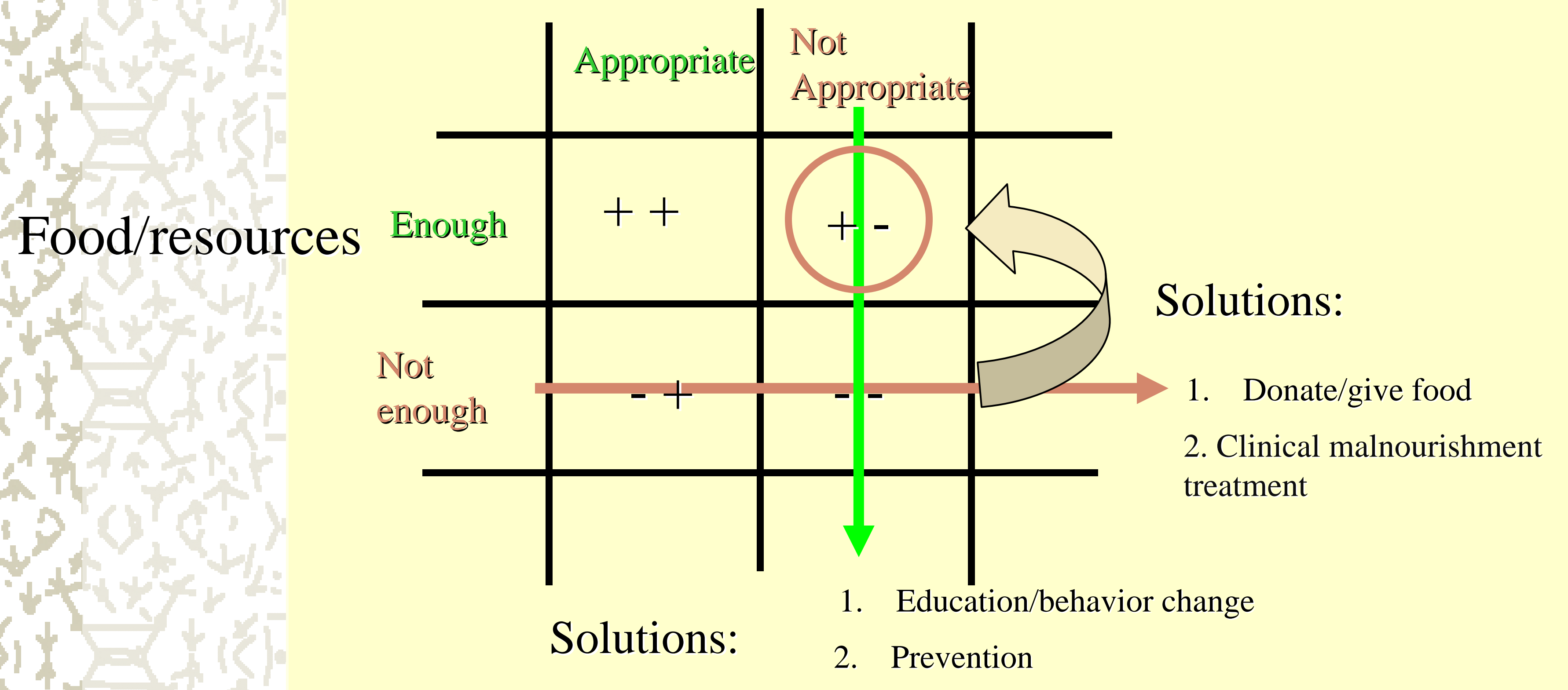


Malnourishment is an 18 month process occurring from the 6th to the 24th month of age

Correction of growth faltering is easer at the start

PARADIGM CHANGE

FROM FOOD TO KNOWLEDGE



INTERESTING PARADOXES

During many years we have talked how to alleviate world hunger!!

However the problem is that the malnourished child is not hungry, on the contrary: SHE/E IS ANOREXIC.

And the mother neither recognizes the problem nor knows how to manage it

INTERESTING PARADOXES

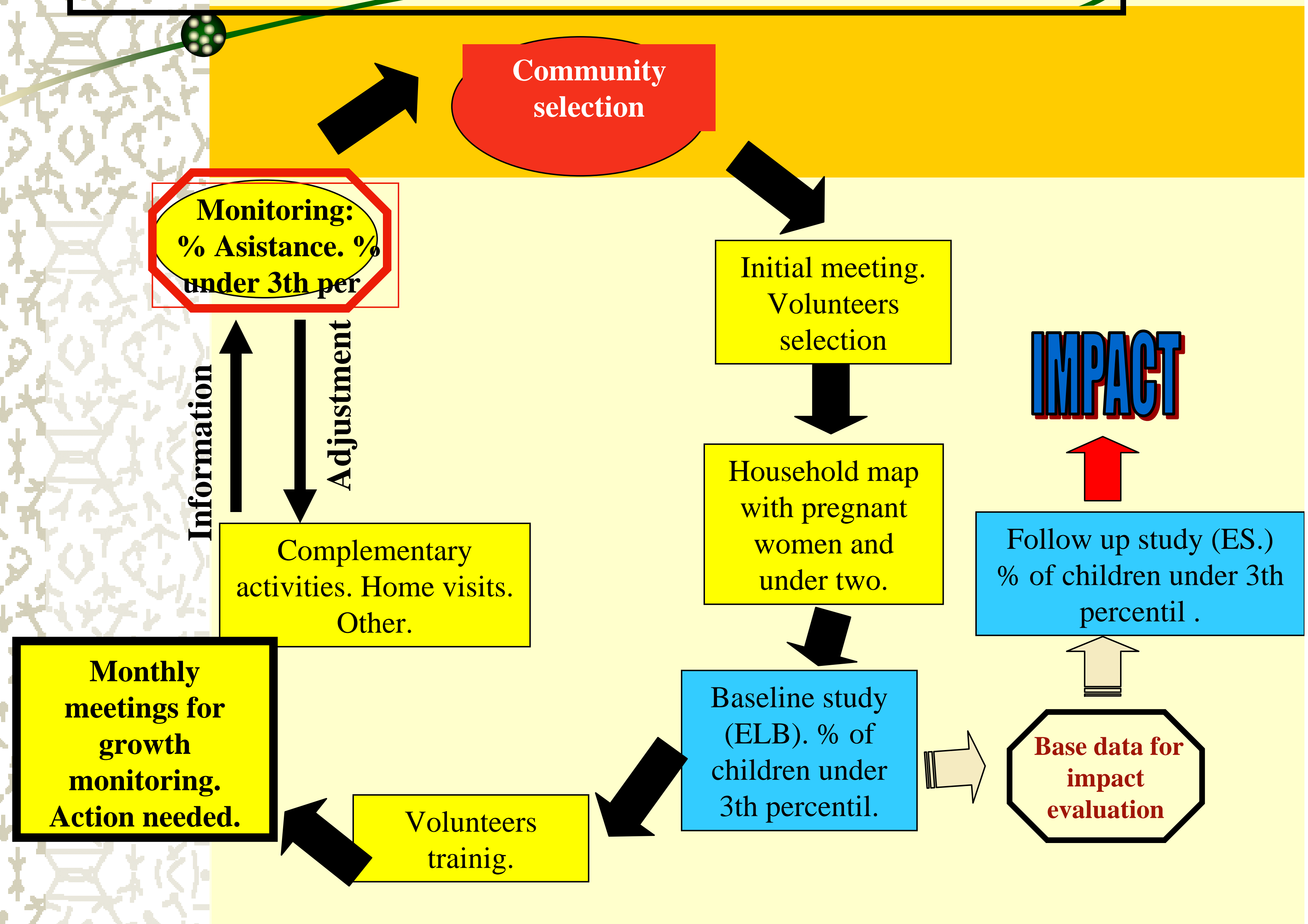
Every body is talking about how to increase food production to prevent malnutrition!!

We have found that family with children less than 2 years old and not consuming enough food (calories and proteins per day) can, with some specific advice, augment their children intake by about 300 calories per day with the already food available in the home and reach 100% of their calories and proteins needed.

INTERESTING PARADOXES

We have worked in preventing children's death through child survival activities!!

I t has been found that the probability of a malnourished child dying of the same diseases we are trying to avoid, is many fold higher even in mild states of nutrition damage



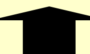
AIN-C. BASIC OPERATIVE MODEL
Community selection
Initial meeting. Volunteers selection
Household map with pregnant women and under two.
Baseline study (ELB). % of children under 3th percentil.
Volunteers trainig.
Monthly meetings for growth monitoring. Action needed.
Complementary activities. Home visits. Other.
Information
Adjustment
Monitoring: % Asistance. % under 3th per
Base data for impact evaluation
Follow up study (ES.) % of children under 3th percentil .
IMPACT

MONITORING:RESULTS

MONITOR: HEALTH AREAS

MONITORIA

1. % OF ASISTANCE
2. % UNDER 3TH PERCENTIL (WEIGHT/AGE.)



INDICATORS: PROVIDERS/SUPERVISOR

PROCESS AND SURVEILLANCE

- % OF ASISTANCE(2/1)100.
- % UNDER 3TH PERCENTIL (WEIGHT/AGE.) (5/2)100.

EPIDEMIOLOGY SURVEILLACE

4. % WITH INAPPROPRIATE GROWTH ((3+4)/2)100.
5. % WITH PERSISTANCE INAPPROPRIATE GROWTH(4/2)100.)

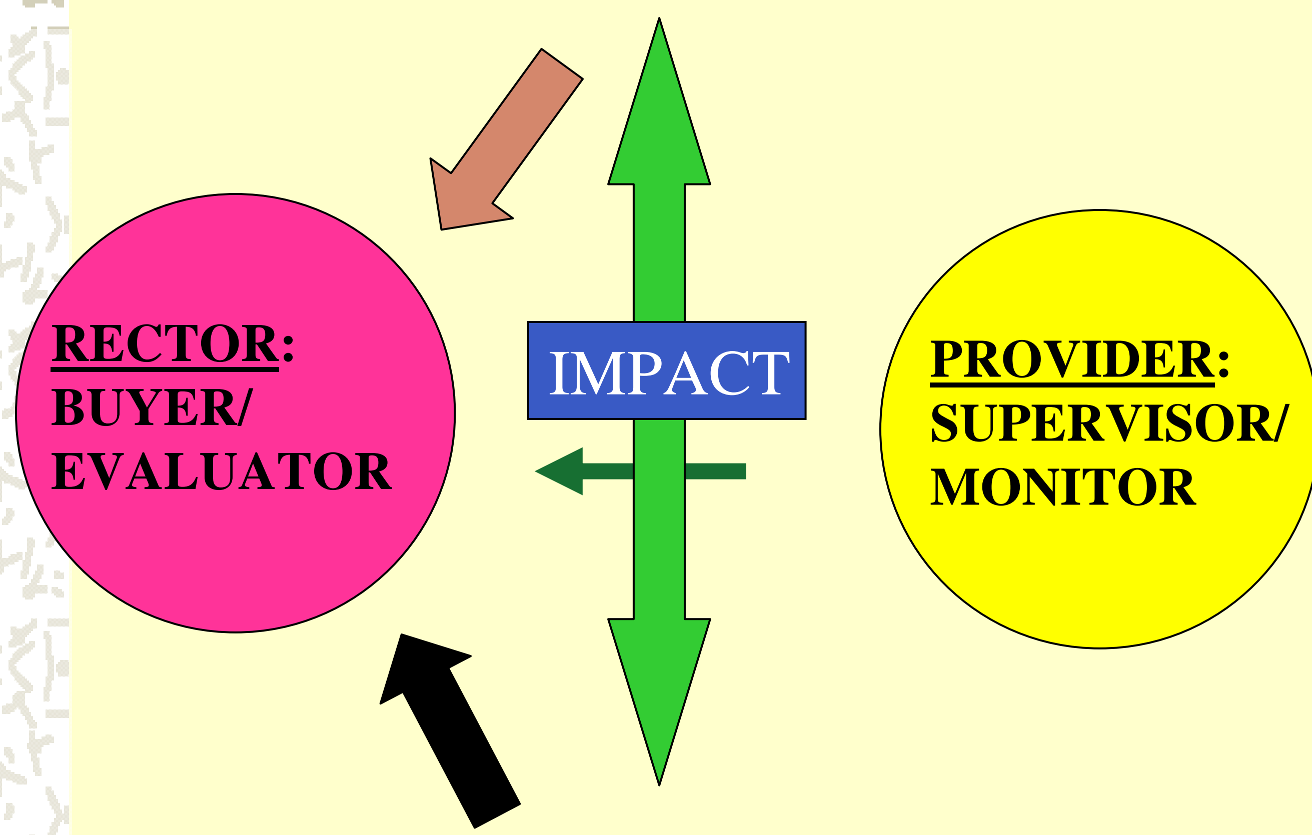
INFORMATION: LOCAL PROVIDER/VOLUNTEER

1. NO. CHILDREN ANNOTATED IN THE REGISTRATION LIST
2. NO. WHO ASISTED THIS MONTH.
3. NO. CHILDREN WITH INNAPPROPRIATE GROWTH.
4. NO. CHILDREN INNAPPROPRIATE GROWTH THIS MONTH AND FORMER.
5. NO. CHILDREN UNDER 3TH PERCENTIL

EVALUATION: IMPACT

FOLLOW UP STUDY(ES)

1. % UNDER 3TH PERCENTIL (WEIGHT/AGE.)
2. % UNDER 3TH PERCENTIL (HEIGTH/AGE.)



1. % UNDER 3TH PERCENTIL (WEIGHT/AGE.)
2. % UNDER 3TH PERCENTIL (HEITH/AGE.)

ESTUDIO DE LÍNEA BASE (ELB)

AIN-C INDICATORS

INDICATOR	NAME	DESCRIPTION	NORMAL VALUE	FRECUENCY
IMPACT (EVALUATION)	Heigth/edad	% under 3th Percentil. Studies comparison	3 %	Every three months and one or two years
RESULT (MONITORIA)	Peso/edad	% under 3th Percentil. Studies comparison And regular data	3 %	Every month and one or two years
EPIDEMILOGY SUVEILLANCE	Inappropriate growth	No. Inappropriate growth /No. weigthed	0 %	Every month
	Inappropriate persistent growth	Inappropriate persistent growth /No. weigthed	0 %	Every month
PROCESS	Assistance	No. weigthed/ No. anotated	100 %	Every month
	Oportunity	No. Anotated first three month/No. Anotated	100 %	Every month
	Performance quality	Base on quality standars	Specific ranges	Variable
MANGEMENT	AIN-C implementation	% of implementation/ No. programmed	100 %	Every six months or a year

What does "participation intensity" mean?

- Intensity of attendance at weighing/counseling sessions
- Percentage of weighings out of possible 12 per year (or total months of life)
- Non-participants have 0% participation intensity

Additional Z-score increment with increasing AIN-C participation intensity

Index	Each additional month of participation	100% participation
Weight-for-height	0.03	0.4
Height-for-age	0.03	0.3
Weight-for-age	0.04	0.5