Replies

All Indian scientists will agree with Dr De, that the indigenously produced 'RUTF' should be used for home based management of severe acute malnutrition (SAM) as there are many distinct advantages of utilizing the same over the imported RUTF. It would be worth mentioning here that the word "food" in the term "Ready to Use Therapeutic Food" (RUTF) is a misnomer. The children suffering from severe malnutrition (SAM) suffer from a "Nutritional Disorder" and hence require Medical Nutrition Therapy (MNT) for which Therapeutic Nutrition (TN) is needed (not the food). Intervention with TN is required only for a short duration of 4-8 weeks, to meet the routine nutritional requirements and to support the catch up growth. Once the child nutritional status is built up, TN is to be discontinued.

The cereal legume based mixture *Khichri* , is a routine food for a young child in northern region of India and it's present form, may not have the qualities and properties which TN should "have" for home based treatment of children with severe malnutrition. These properties have been mentioned earlier(1,2). The comparison of Imported RUTF with Khichri was possibly not appropriate as it was like comparing "apples" with "oranges".

WHO has also recommended that the therapeutic nutrition for treating severe malnutrition should be produced locally by each country, keeping in view the International Standards, and Indian scientists should do the same(3).

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2. Kapil U. Ready to use therapeutic food (RUTF) in the management of severe acute malnutrition in India. Indian Pediatr 2009: 46: 381-382.
3. Ashworth A. Efficacy and effectiveness of community-based treatment of severe malnutrition. Food Nutr Bull 2006; 27: S24-48.

In general, we agree with the views by Dr De and Dr Kapil in the correspondence. Firstly, there should be distinction between what the researchable questions are, for complementary feeding, and the therapy of severe malnutrition as defined by the World Health Organization. In the former case, the principal mode of complementary food should be home based.

The question is what is the best way to deal with severe acute malnutrition, when hospitalization is not possible, or is restricted to treatment of acute complications and stabilization of about 1 to 2 weeks. It seems to us that under ideal circumstances, when multiple feeds can be prepared and offered, one could successfully rehabilitate these children but there is a proposition by some that it is advantageous to have an energy-dense, easy to administer, nutritionally balanced, easy to store and transport, therapeutic food. Let us state the obvious first, that if such a view were to have any merit based on well planned, multicentre trials, the RUTF must be made in India and affordable.

The research questions can be of a concept or of a specific product and it is the former we are interested in. Nevertheless, we endorse the view that any systematic evaluation of RUTF in severe acute malnutrition must be with an India based product, as that would test the concept as well as a product. If the concept is proved, the Indian industry or the cottage sector can be helped to produce good quality RUTF. We should endorse the need for scientific investigations of such type, as research done well by credible Indian investigators for clarity always makes us wiser in the long run. We do hope our esteemed colleagues agree with this broader view.

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