A Qualitative Investigation of Plumpynut® Consumption and Access in Adults enrolled in an MoH/MSF HIV Programme in Kenya

Filippo Dibari *, **
Contact: filippo@validinternational.org

Supervision: Andrew Seal* & Paluku Bahwere**
Field supervision: Isabelle Le Galle*** and Ali Ouattara***
Support in method design: Saul Guerrero**

*Centre of International Health and Development, Institute of Child Health, UCL, University of London, ** Valid International – United Kingdom, *** MSF/Homa Bay, Kenya

Background - In 2007, the United Nations officially approved the use of a ready-to-use therapeutic food (RUTF) for the treatment of acute malnutrition in children. Only a paediatric formulation is currently available. Nonetheless, RUTF is also widely used in nutrition and health programmes in developing countries targeting other groups such as adults with HIV/AIDS and BMI<17. Hence in 2007 MSF-France provided 2000 Kcal/day (4 sachets of peanut-based RUTF, Plumpynut®) to 702 HIV positive adults, presenting with BMI<17 kg/m^2 and/or MUAC<185mm and/or oedema in the hospital of Homa Bay, Kenya.

Objective - The purpose of this study was to determine the acceptability of peanut-based RUTF to HIV+ adults, plus any issues that arise from its access, distribution and consumption.

Subjects and Method - 56 patients and 8 MoH/MSF employees were involved in the study. The patients had been or were still enrolled in the nutritional program. The research team used qualitative methods such as key informant interviews (22 patients), focus groups (18 patients; 8 health staff members) and direct unobtrusive observations (6 in-patients). The tools were pre-tested and the surveyors previously trained. A triangulation of the results highlighted themes common to all three methods at the same time.

Results - 60% of the patients were female, 85% were over 30 years of age and 32% were widowers. 72% of the patients were still receiving RUTF at the time of the study. Of these patients, 45% came to the clinic with a buddy or a carer, and 83% came on public transport (average journey was two hours). The main physical barrier for adherence was distance to the HIV clinic. Due to the weight of the product and patient frailty, those without a carer could only take a two-week supply. Most of the patients only came back after a month (to coincide with their next appointment to collect the antiretroviral drugs) and so reduced the prescribed intake per day to make the available amount last. The patients were enthusiastic about their weight gain and the possibility of going back to daily labour activities. However, half of them declared it was impossible to comply with the full prescription due to the taste of the product, diet boredom and clinical conditions associated with HIV (oesophageal thrush, lack of appetite, nausea and vomiting). The patients reported that they felt stigmatised for consuming RUTF, more so than for HIV drugs. Sharing the RUTF ration with other household members was common, mainly due to poverty and household food insecurity. The patients tended to mix the product with other foods of their own accord, both to facilitate its consumption (in the case of thrush) and break diet boredom.

As a largely common practice, multi-micronutrients tablets are provided without advice on the correct amount and duration (in spite of the prohibition in the MSF nutrition protocol), and patients reported and were observed mixing left-over RUTF with highly micronutrient-fortified porridges, provided after discharge. In case of full compliance to

the RUTF protocol, patients are exposed to a dangerous excess of micronutrients supplementation. The medical staff did not receive training on the nutrition therapy and expressed a lack of understanding about the effectiveness of the treatment. They did not counsel the patients on why, when, or how to take the RUTF. Several references document the challenge in estimating height in severely malnourished adults. Staff had difficulties in estimating height in the patients observed in this study, which lead to inaccuracies in BMI as admission and discharge criteria.

Conclusions An improved approach to treat malnourished HIV positive adults living in limited resources context is needed. Such new approach must take into consideration the differences existing between the traditional outpatient programme designed for children and the challenging reality of malnourished adults, including the identification of strategies to support patients without a carer at his/her first appointment; the testing/trialling of RUTF more adequate to adults' taste, reducing nausea/vomiting and easier to swallow also in presence of oesophageal thrush; a training to health staff on RUTF-related dietetic issues and micronutrients-related risks; systems to estimate height more accurately in patients unable to stand properly need to be introduced too.