A.37	Ready-to-use therapeutic food – severe acute malnutrition – EML and EMLc
Draft recommendation	☒ Recommended ☐ Not recommended Justification: SAM is an avoidable and treatable condition that affects millions of children globally. Its diagnosis is well established and easy to make with possibility of lay health staff being able to make diagnosis using simple health technologies (MUAC for example). RUFT is a simple and affordable solution to SAM. This application clearly states approaches to treatment and has been recommended by key organizations active in contexts where SAM is common. The application provides a solid body of evidence on effectiveness, harms, and toxicity from a Cochrane review (Schoonees 2019). A cost effectiveness review covering key regions with SAM concerns suggests RUFT is cost-effective and especially so in community-based programs. However, the body of evidence on use of RUFT and therefore recommendations for use, are missing for conflict or crisis or fragile perspectives. I recommend a further follow up on this.
Does the proposed medicine address a relevant public health need?	☒ Yes ☐ No ☐ Not applicable Comments: Rates of SAM in children have remained persistently high and progress towards the SDG of reducing child wasting (which includes children with both MAM and SAM by weight-for-height Z scores) to <5% by 2025 has been limited (2). SAM affects approximately 13.6 million children under the age of five on an annual basis in low and lower-middle income countries. Some of the highest prevalence rates of the condition are in countries in east and west Africa, however, the majority of children suffering from SAM live in Asia. Whilst SAM has typically been linked to humanitarian contexts, 3 out of 4 children suffering from SAM do not live in contexts affected by humanitarian crises demonstrating that this condition is a widespread public health concern.
Does adequate evidence exist for the efficacy/effectiveness of the medicine for the proposed indication? (this may be evidence included in the application, and/or additional evidence identified during the review process)	☒ Yes ☐ No ☐ Not applicable Comments: Two systematic reviews on the use of RUTF were published in 2013. Both reviews used GRADE criteria to assess the available evidence base. A Cochrane review update (Schoonees 2019) concludes that RUTF likely contributed to improved recovery and weight gain, however the effects on relapse and mortality remain unknown. Further qualitative evidence and DELPHI consensus is available conducted within the implementation by WHO and partners.

Does adequate evidence exist for the safety/harms associated with the proposed medicine? (this may be evidence included in the application, and/or additional evidence identified during the review process)	☒ Yes ☐ No ☐ Not applicable Comments: The 2013 Cochrane Review included a review of the safety of RUTF, including a comparison of the mortality, frequency diarrhoea, and adverse outcomes between RUTF and the standard flour porridge diet. There was no difference in mortality between the children who received RUTF and those who received standard diets (RR 0.97; 95% CI 0.46 – 2.05; n = 599). Similarly, there was no difference in the frequency of diarrhea (number of days of diarrhea in the first two weeks of treatment) between the children who received RUTF and those who received the standard diets (MD -0.6; 95% CI -1.30 to 0.10; n=352). In addition, the WHO guideline updates in 2013 stated that empirical data to suggest that RUTF either increases the incidence of diarrhea or worsens diarrhea among children with SAM. There were no further reports of adverse outcomes, including allergic reactions reported.
Are there any adverse effects of concern, or that may require special monitoring?	☐ Yes ☒ No ☐ Not applicable Comments:
Are there any special requirements for the safe, effective and appropriate use of the medicines? (e.g. laboratory diagnostic and/or monitoring tests, specialized training for health providers, etc)	☐ Yes ☒ No ☐ Not applicable Comments:
Are there any issues regarding cost, cost-effectiveness, affordability and/or access for the medicine in different settings?	☒ Yes ☐ No ☐ Not applicable Comments: On average, according to these studies, SAM treatment costs $262 per child with a median cost of $196. Total costs for the treatment service per child admitted range from $76 in Niger to $805 in Ghana. These costs include RUTF procurement and transportation, as well as costs of delivery including infrastructure, health worker time, additional drugs delivered with the treatment package, community outreach and screening activities and others. ***These costs will be unaffordable for families and households that are vulnerable to SAM without government policies to reduce or completely cover cost.*** The cost per DALY averted ranges from $26 in Bangladesh to $ 53 in Zambia. Given that these estimates fall below the GDP per capita in the countries where implemented, the intervention is considered to be cost effective. ***This builds a strong case for inclusion in the EML.***

Are there any issues regarding the registration of the medicine by national regulatory authorities? (e.g. accelerated approval, lack of regulatory approval, off-label indication)	☐ Yes ☒ No ☐ Not applicable Comments:
Is the proposed medicine recommended for use in a current WHO guideline? (refer to: https://www.who.int/publications/who-guidelines)	☒ Yes ☐ No ☐ Not applicable Comments: