Nutrition Cluster Guidance Note: Emergency Nutrition Interventions to Returnees

04.01.2011 – Revised 18.03.2011

1.0 Context

There has been a steady flow of returnees from the North to states in the South since October 2010, leading up to the referendum which was held the week of the 9th January 2011. The estimated overall total number of returnees (as of 15th March 2011) is 259,012. A large proportion of this number has been received in Northern Bahr el Ghazal (51,152), Unity (57,104) and Upper Nile (42,001) States. The current pace of returns, however, has presented major challenges to humanitarian actors and government agencies on the ground to provide emergency assistance at transit sites and to move them on to their final destinations. Insecurity in parts of the South and along some returnees routes has hampered returns movements and humanitarian assistance.

The nutrition situation of returnees is likely has deteriorated in transit sites where returnees have resided since December 2010, depending on the availability of basic services at reception sites. Moreover, it can also be expected that vulnerable populations like women and children will need immediate nutrition support.

2.0 Purpose of Guidelines

The purpose of these guidelines is to provide support and guidance to Cluster partners on appropriate nutrition interventions for returnees and to ensure a well coordinated Nutrition Cluster response.

3.0 General Guidelines on Returns

1. **Actively promote early initiation of breastfeeding, exclusive breastfeeding for infants and timely and appropriate Complementary Feeding for young children at transit sites and final destinations.** Infants and young children are extremely vulnerable in emergencies, so special care must be exercised to properly feed and protect them. Interrupted breastfeeding and inappropriate complementary feeding heighten the risk of malnutrition, illness, and mortality, thus **all infants under 6 months should be fed exclusively on breastmilk.** Thereafter, to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods (i.e. nutritious porridge in small frequent feeds) while breastfeeding continues for up to two years of age or beyond. Introduction of water or milk formula, milk powder or solid food to infants below 6 months—especially in the emergency context—can lead to fatal diarrhoea. Use of feeding bottles and pacifiers (masasa) should be discouraged.

2. **Encourage movement to final destination.** Nutrition assessments and interventions shall maintain the goal of seeing returnees arrive safely to a place of final destination, and shall not contribute to protracted displacement in transit locations. 'Transit locations' are defined as temporary locations which are identified by the government and other agencies, especially within urban areas. 'Final destination' refers to alternate sites/land which is allocated to individual households within or outside the city/town limits or in different villages and bomas. Appropriate Nutrition interventions will vary according to need and location type.

3. **Intervention based on need.** Nutrition partners shall engage with returnee populations with no differentiation of their type (i.e. government-assisted, or spontaneous). Interventions shall be

based on the identified need and most appropriate intervention possible in the given scenario, taking into consideration Point 1, above.

4. **Pro-active engagement: The** Nutrition cluster encourages active liaison with all other stakeholders involved in the process of decision making, needs assessment, and the implementation of life saving interventions. This will ensure a integrated approach by the humanitarian community on-site, cooperation in identification of key gaps and provision of appropriate services at appropriate times to the returnees, and minimize duplication of work. The State Nutrition Cluster Focal Points (SNCFPs) should work closely with Nutrition Cluster Leads, and consult with them on a regular basis, to ensure the appropriateness of responses and the accuracy in the information provided to different actors, including state-level RCSOs, OCHA representatives, Nutrition partners, and other Cluster Focal Points.

4.0 Assessment Guidelines

Assessments form the basis of an appropriate, need-based response. Nutrition partners should coordinate assessments with SNCFPs and ensure the participation of all key stakeholders, including SSRRC and state and local authorities in conducting nutrition assessments. The objectives of the assessment should be made clear to all stakeholders and the findings and recommendations, technically cleared with SNC and Cluster Leads, before dissemination to appropriate humanitarian partners and local authorities.

4.1 Assessment in Transit Sites

Partners are encouraged to use the standardized Nutrition Cluster Initial Rapid Assessment (IRA) tool at transit sites and final destinations (See Annex 7). The purpose of the IRA is to provide a quick overview of the emergency situation in order to make rough estimates of the needs of the returnees and determine if a formal nutrition survey should follow.

Findings of the assessment should be presented, using the reporting template that accompanies the IRA tool and should be shared with humanitarian partners within 72 hours of conducting the assessment.

4.2 Assessment in Final Destination Sites

SMART Nutrition surveys are encouraged in areas where there is a large influx of returnees and available information is deemed inadequate and over 2 years old, following a quick review of nutrition information available for the location.

State Nutrition Cluster Focal Points should support partners in the coordination of SMART Nutrition surveys and consult with Cluster Leads should challenges arise or if any technical, financial and logistic support is required.

5.0 Intervention Guidelines

The table below provides a range of appropriate Nutrition interventions in transit sites and final destinations. The table assumes that an initial rapid assessment has been conducted and the need of the activity has been identified. Partners should note that the recommended activities can be subject to revisions based on the realities on the ground and are encouraged to consult with Cluster Leads should

challenges in intervention decision making arise. These guidelines are in line with MOH and/or international standards.

6.0 Recommended Interventions

No.	Activity	Target	Action
1.	MUAC screening	All children (6-59 months), Pregnant and Lactating mothers	To be screened during registration at returnee transit points. See **MUAC data forms and guidance for taking MUAC in Annex 2-3**
2.	Vitamin A supplementation and Measles vaccination	All children 6-59 months should be provided with vitamin A along with measles vaccination campaign.	Dosage for all children 6-59 months at transits sites: 6-11 months, 1 blue capsule (100,000 IU) 12-59 months, 1 red capsule (200,000 IU)
3.	Management of children with severe acute malnutrition without complications	Children 6-59 months, with MUAC less than 11.5cm (in red color) OR Bilateral pitting oedema grades 1 or 2 and APPETITE	Provide Ready to Use Therapeutic Food (RUTF) or Plumpy nut to these children based on the guideline attached as Annex 5, for the expected duration of their stay in the transit site, educate the mother/caregiver on use, and refer the child to the nearest health facility or Outpatient Treatment Programme (OTP) at the final destination for follow up. In areas where there are no nutrition treatment facilities the child should be given full ration for 14 days and refer to mobile clinic in the transit centre or nearest health centre.. **See Annex 5 for RUTF routine medicines protocols**
4.	Management of Severely Malnourished children with complications	1) Children (6-59 months) with: - Bilateral pitting oedema grade 3 (severe oedema) - MUAC less than 11.5 cm and bilateral pitting oedema grades 1 or 2 (marasmic kwashiorkor) - MUAC <12.5 cm OR bilateral pitting oedema plus one of the following: medical complications; NO appetite 2) Infants less than 6 months old	Refer the child immediately to the nearest health facility for proper care and follow up.
5.	Management of moderate acute malnutrition in: - Children 6-59 months - Pregnant and Lactating mothers	Children with MUAC between 11.5 and 12.5 cm or in yellow band. Pregnant and Lactating Mothers with MUAC between 21.0 cm and 23.0cm or in yellow band. This is applicable to returnees, IDPs and host populations	Provide 1 tablet of Albendazole to each child Provide BP 5 for each child, and for the pregnant and lactating women **Please see Annex 6 for BP 5 use** Provide supplementary feeding 50g CBS, 25g oil, 15g sugar per day **DO NOT GIVE BP5 TO CHILDREN WITH SEVERE ACUTE MALNUTRITION WITH OR WITHOUT COMPLICATIONS.**
6.	Distribution of iron folate or multiple micronutrients	All Pregnant and Lactating women	Provide one month supply (30 tablets) and refer to ANC services at the nearest health facility.
7.	Blanket Supplementary Feeding	All children 6-24 months, Pregnant and Lactating Women at final destinations	Blanket supplementary feeding when justified by a nutrition survey - For children 6-24 months provide Plumpy Doz, 4 pots per month for 3 months - For Pregnant and Lactating Women provide 100g CSB, 30g oil and 20g sugar per day for last the 6 months of pregnancy and first 6 months of lactation (12 months total)
8.	Promotion of appropriate Infant and Young Child Feeding Practices in Emergencies	All Pregnant and Lactating women and care givers	Use IEC materials provided by MOH GOSS/UNICEF on Infant and Young Child Feeding in Emergencies to promote exclusive breastfeeding for infants 0-6 months, and timely introduction of appropriate complementary feeding for children from six months until 2 years of age

Annex 1: Supplies Required at Transit Site

From UNICEF	From WFP
1. MUAC tapes 2. Electronic scales 3. Height boards 4. Vitamin A (through EPI) 5. Albendazole 6. Iron folate or multiple micronutrients 7. Plumpy Nuts 8. IEC materials for promoting IYCF practices	1. Plumy Doz 2. CSB, oil and sugar

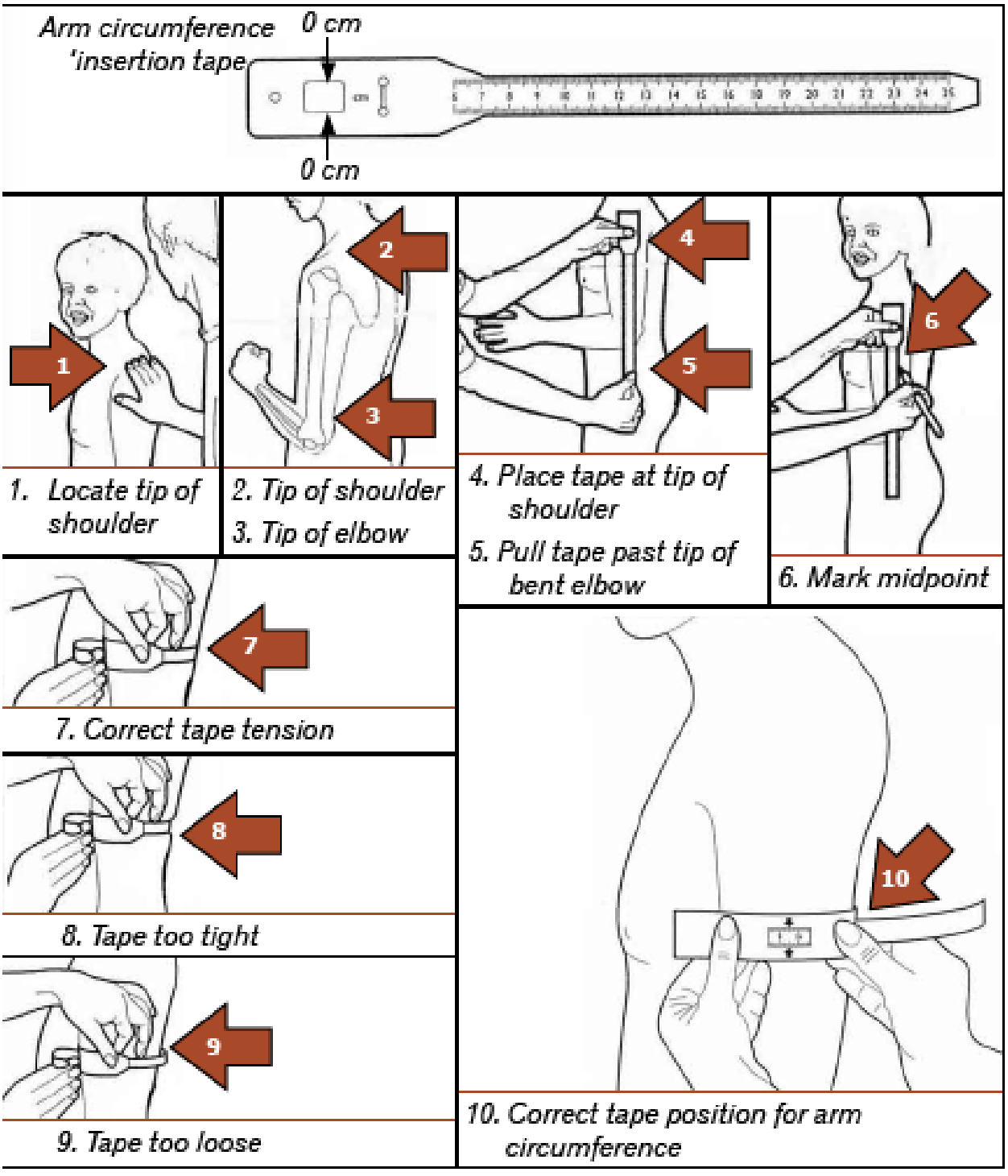
Annex 2: MUAC data collection form for children 6-59 months, for use at Transit Site

Date:		**State:**	**County:**		**Transit location:**	
Serial No	**Sex M/F**	**Age in months**	**Oedema Y/N**	**MUAC cm**	**1 = Severe 2 =Moderate 3= Normal**	**Destination Location**
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
Summary Results children 6-59 months						
	Oedema	<11.5cm (Red)	>=115-<125 cm (Yellow)		> =12.5 cm (Green)	Total
Numbers						

Annex 3: MUAC data collection form for Pregnant and Lactating Mothers, for use at Transit Site

Date:	**State:**	**County:**	**Transit location:**	
Serial No	**Lactating or pregnant (L or P)**	**MUAC cm**	**1 = Severe 2 =Moderate 3= Normal**	**Destination Location**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
	<21.0 cm (Red)	>=21.0-<23.0 cm (Yellow)	> =23.0 cm (Green)	**Total**
Number				

Annex 4: Guidance on taking MUAC



Annex 5: Plumpy Nut Ration Table for Management of Severely Malnourished Children

Class of weight (kg)	PLUMPY'NUT®	
	sachets per **day**	sachets per **week**
3.0 - 3.4	1 ¼	8
3.5 - 4.9	1 ½	10
5.0 – 6.9	2	15
7.0 – 9.9	3	20
10.0 - 14.9	4	30
15.0 – 19.9	5	35
20.0 – 29.9	6	40
30.0 - 39.9	7	50
40 - 60	8	55

Annex 6: Routine Medicines Protocols for Severely Malnourished Children without Medical Complications

Medicine/Supplement	When to Give	Age / Weight	Prescription	Dose
ANTIBIOTIC	On admission	All beneficiaries	**Amoxicillin** 50-100 mg/kg bodyweight/day	3 times a day for 5 days
ANTIMALARIAL (artemisinin-based combination therapy [ACT])	Test on admission; Repeat test later if initial test negative and malaria suspected. If no test, rely on symptoms.	All beneficiaries	**Artesunate** (AS) 50 mg and **Amodiaquine** (AQ) 153 mg: ½ AS and ½ AQ 1 AS and 1 AQ	Once a day for 3 days
ANTIHELMINTHIC DRUG*	After 1 week	< 12 months	DO NOT GIVE	NONE
		<10 kg	**Albendazole** 200 mg	Single dose
		≥10 kg	**Albendazole** 400 mg	
MEASLES VACCINATION**	Inpatient care: On admission and discharge Outpatient care: On week 4 (or upon discharge)	From 6 months	Standard	Single dose, or repeated dose**
VITAMIN A*** SUPPLEMENTATION	On week 4 (or upon discharge)	6 months ≥12 months	100,000 IU 200,000 IU	Single dose

Annex 7: Look up Table BP 5 for Moderately Malnourished Children and Adults

Age	Bars/Day	Kcal/day	Bars/week	Boxes /week
½ - 1	3	768	21	2
2 - 3	4	1,016	28	3
4 - 6	5	1,270	35	4
7 - 8	6	1,524	42	5
Adult (female)	8	2,032	56	6

Annex 8: Nutrition Initial Rapid Assessment (IRA) Tool at Final Destination

NUTRITION CLUSTER INITIAL RAPID ASSESSMENT TOOL

Date	County	Payam	Boma	Village

1.1 Key informant and other information sources

1.2 Existing capacities and activities

	Activity specification (present / absent)	List organization or person(s) implementing these programs NOW	# children enrolled in the nutrition program	# pregnant and lactating women in the program	Geographic coverage	Comments
1.2.1 Management of severe acute malnutrition (facility or community based)	□ **Inpatient therapeutic feeding (TF) only** □ **In- & outpatient TF** □ **Outpatient TF only**					
1.2.2 Management of moderate acute malnutrition	□ **Targeted supplementary feeding** □ **Blanket supplementary feeding**					
1.2.3 Micronutrient supplementation programs (e.g. vitamine A, iron)	□ **Yes** □ **No**					
1.2.4 General food distribution	□ **Yes** □ **No**					
1.2.5 Other nutrition programs	**Specify** _____					

1.3 Have infant milk products and/or baby bottles/teats been distributed since emergency?

□ Yes □ No	If YES, by whom? _____

1.4 Has the community/health staff identified any problems in feeding children <2 years since crisis started?

Exclusive breast feeding (0-6months)	□ Yes □ No	If YES, what problems? _____
Initiation of complementary feeding (6-8months)	□ Yes □ No	If YES, what problems? _____
Child feeding practices (9-23 months)	□ Yes □ No	If YES, what problems? _____

(Minimum 100 children (6-59 months or 65 to 110cm) otherwise if <100 screen all the children in the location being surveyed)

Date:	**County:**	**Payam:**	**Boma:**	**Village:**		
Serial No.	**Sex M/F**	**Age in months**	**Oedema Y/N**	**MUAC cm**	**1 = SC/OTP 2 = SFC 3 = None**	**1 = Resident 2 = Returnee 3 = IDP**
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
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11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						
26.						
27.						
28.						
29.						
30.						

Screened by_____

Date:	County:	Payam:	Boma:	Village:		
Serial No.	**Sex M/F**	**Age in months**	**Oedema Y/N**	**MUAC cm**	**1 = SC/OTP 2 = SFC 3 = None**	**1 = Resident 2 = Returnee 3 = IDP**
31.						
32.						
33.						
34.						
35.						
36.						
37.						
38.						
39.						
40.						
41.						
42.						
43.						
44.						
45.						
46.						
47.						
48.						
49.						
50.						
51.						
52.						
53.						
54.						
55.						
56.						
57.						
58.						
59.						
60.						

Screened by_____

Date:	County:	Payam:	Boma:	Village:		
Serial No.	**Sex M/F**	**Age in months**	**Oedema Y/N**	**MUAC cm**	**1 = SC/OTP 2 = SFC 3 = None**	**1 = Resident 2 = Returnee 3 = IDP**
61.						
62.						
63.						
64.						
65.						
66.						
67.						
68.						
69.						
70.						
71.						
72.						
73.						
74.						
75.						
76.						
77.						
78.						
79.						
80.						
81.						
82.						
83.						
84.						
85.						
86.						
87.						
88.						
89.						
90.						

Screened by_____

Date:	County:	Payam:	Boma:	Village:		
Serial No.	**Sex M/F**	**Age in months**	**Oedema Y/N**	**MUAC cm**	**1 = SC/OTP 2 = SFC 3 = None**	**1 = Resident 2 = Returnee 3 = IDP**
91.						
92.						
93.						
94.						
95.						
96.						
97.						
98.						
99.						
100.						
Summary of Results						
	Oedema	**<11.5cm**	**> or = 11.5 and <12.5 cm**	**> or 12.5 and < 13.5 cm**	**> or = 13.5 cm**	**Total**
Numbers						

Screened by_____

Purpose and objectives of an initial rapid assessment:

The purpose of the rapid assessment is to provide a quick overview of the emergency situation in order to identify the immediate impacts of the crisis, make initial rough estimates of the needs of the affected population for assistance, and define the priorities for humanitarian action. It should also identify aspects for which more detailed follow-up assessments would be needed.

Data collected through rapid assessments is preliminary. The assessment does not give prevalence rates of malnutrition representative of the population but only an idea of the situation. The assessment should identify what types of more detailed assessments should be conducted in order to obtain reliable information for further program planning and implementation.

Steps in carrying out an initial rapid assessment:

There are several steps in conducting an initial rapid assessment:

1. ***Decision on doing the initial rapid assessment***

The presence of a likely acute crisis may be brought to the attention of the government and humanitarian agencies based on reports from the field from various organizations, surveillance reports if present, abnormal increase in the number of admissions in hospitals and other reliable sources. All relevant actors including the cluster coordination committee along with the ministry of health need to agree that an assessment is needed

2. ***Compile and review available secondary data***

Where it is possible, secondary data should be assessed. The data could be either quantitative or qualitative data. There are several sources of secondary data. Data from the period prior to the crisis could be examined for baseline information. During the crisis period, data could be collected through various means and compared with the baseline information.

3. ***Plan the coordination of activities***

Conducting an assessment involves many actors and good coordination is essential. Coordination includes making administrative, logistic and other operational arrangements, managing security issues, overseeing the scheduling of the assessment and reporting processes, and ensuring adequate participation of relevant actors in the assessment. Coordination should be done both at the central coordination level and in the field sites.

4. ***Decide on the objectives***

The overall objective for conducting a rapid assessment is to collect in very short time reliable information on the nutritional status of a population to help plan appropriate strategies to address the crisis. The specific objectives are to answer the following main questions:

- Is there an emergency situation?
- Who is likely to be the most vulnerable and why? How many people are affected, and where are they?
- Are interventions required? If so, what are the top priorities?
- What are the continuing or emerging threats?
- What resources and capacities are already present (e.g., infrastructure and institutions), and what are the immediate capacity gaps?

- What are the key information gaps that should be addressed in follow-up assessments?

5. Determine the timeframe for the assessment

The rapid assessment should be launched as soon as possible after the onset of an acute crisis, normally within 1 to 3 days

6. Suggested members of key informants

Local administration office, SSRRC office, Health office, Agriculture office, community representative and women representative.

7. Define the population group and geographic area for the assessment

MUAC measurements should be carried out in children between 6 to 59 months. A sample minimum of a 100 children should be included per location. Initially, define the affected area through discussion with the key informants. If the estimated total number of children under 5 is 100 or less, measure exhaustively all children in the location. If the affected area has more than 100 children, identify if the area is homogenous or heterogeneous. If homogenous, randomly select 3-4 villages that satisfy the sample frame of 100 children and measure the required number of children. If the area has heterogeneous villages, then randomly choose 3-4 heterogeneous villages. The number of children in each village needs to be allocated proportionate to population estimate. Recruit guides from the area. In the selected site, measure children randomly.

8. Choose the data collection methods

Anthropometric measurements (MUAC and oedema), key informant interviews, observation, group discussions and household interviews should be used

9. Identify and train staff

If nutritional assessment is conducted as part of a multi-disciplinary team, two people one with technical nutrition assessment skills and the other locally recruited thus has good knowledge of the area being surveyed would be needed per team.

10. Collect necessary equipments, supplies and tools

Tools needed include numbered/colored MUAC tapes. Equipment and supplies needed for the survey include transport, stationery and, field worker per diems. Copies of questionnaires, absentee forms and forms for referral of moderately or severely malnourished cases to supplementary feeding and therapeutic feeding programs (if they exist) should be prepared.

REFERRAL FORM

To _____ OPT/SPF

Screening Date: _____

Referral No: _____

Site/Payam: _____

MUAC Measurement: _____cm

Oedema : Y/N

Logo/Name of Agency

11. Conduct the assessment

The fieldwork plan should include the following decisions:

- Number, size and make-up of the assessment teams;
- Allocation of assessment teams to specific locations;
- Preliminary sequence of visits to specific locations;
- Frequency of interim reporting from field teams;
- Time to allow for travel;
- Time to allow for fieldwork at each location;
- How teams will travel; and
- Where teams will eat and sleep.
- Refer SAM & MAM cases to the respective feeding centre (if any)

12. Performing data analyses, report writing and presentation

A child with MUAC <11.5cm and/or oedema is considered to be severely malnourished and a child with MUAC between 11.5 and 12.5cm and with no oedema is considered to be moderately malnourished:

	MUAC (cms)
Severe	<11.5cm and/or oedema
Moderate	≥11.5-<12.5 cm and no oedema
Global	<12.5cm and/or oedema

The final report should have the areas where the survey was held, type of emergency, main changes brought about by emergency, survey subjects, sample sizes and sampling method, number of subgroups analysed, indicators and cut-off point used, findings and interpretation and conclusions and recommendations. All together, the report is intended to be used to make recommendations and formulate plans for further action.

13. Reporting requirement

Findings of the assessment should be presented, using the reporting template that accompanies the IRA tool and should be shared with humanitarian partners within 72 hours of conducting the assessment.

Annex 8: Reporting Template (Nutrition IRA Tool)

REPORTING TEMPLATE FOR RAPID ASSESSMENT OF NUTRITIONAL STATUS

Title of the report: (include Village / Camp, Boma, Payam, State)	
Names of report author /Team/ Agency carrying out assessment:	
Contact address:	
Date of Rapid Assessment:	
Date of Report:	

1. **Acknowledgements**

2. **Summary** (objectives, methodology, main results and recommendations)

3. **Introduction** (including area description, overview of recent events leading to need for rapid assessment)

4. **Objectives**

5. **Methodology** (sampling procedure, sample size, survey team composition, survey planning, training)

6. **Results:** (including tabular presentation of age distribution and MUAC measurements of children from 6-59 months, nutrition services and beneficiary numbers, food aid, partners in the area with their respective activities)

7. **Summary of key findings** (in bullets)

8. **Recommendations** (time bound)

9. **Annexes (optional)** (assessment data, attendance sheet, photos, etc)

Additional information

Table for Age distribution

Age category (months)	Number of children	%
6 to <17		
18 to <29		
30 to <41		
42 to <53		
54 to <59		

Table for MUAC measurement result

MUAC (cm)	Nutritional status	Number	% (i.e. proxy indicator)
>13.5	Well nourished		
12.5cm to <13.5	At risk of Malnutrition		
11.5cm to <12.5	Moderate Malnutrition		
<11.5	Severe Malnutrition		
Oedema	Severe Malnutrition		