

RSP DOCUMENTATION
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UNHCR, IslamabadMIRANSHAH AND MIANWALI EXPERIENCE: A CASE STUDY

BACKGROUND: Since the first arrival of the Afghan refugees in 1978, there has been a continuous influx of new arrivals settling down in areas nearest to the border i.e. South and North Waziristan in North West Frontier Province, and Pishin and Gulistan in Baluchistan. Coming to Pakistan entails months of travel, sometimes, on vehicles but most of the time by foot. To make matters worse they barely have food and if they have, it was just enough for survival. These physical and emotional trauma exert its greatest toll on women especially pregnant and lactating mothers, and children especially the under-five years old. This group is very vulnerable to malnutrition and eventually infection and death. Protein - calorie malnutrition, often combined with vitamin and mineral deficiencies causes impairment of intellectual development and physical growth. The increased susceptibility of the malnourished child to infectious diseases has also long been established. The situation is aggravated by the shortage of food and inadequate shelter upon arrival. It is therefore of paramount importance that immediate and life saving measures be undertaken should the need arise among the new arrivals.

NORTH WAZIRISTAN

1. This presentation will show how UNHCR responded to an emergency situation in North Waziristan, North West Frontier Province, and Mianwali, Punjab Province.
2. As part of a regular monitoring activity and in response to a Donor Agency's intention to assist the new arrivals, a needs assessment mission was undertaken in December 22-23, 1986.
3. OBJECTIVES: The objectives of the needs assessment mission were:
 - (a) To do a rapid health and nutritional assessment of children of new arrivals who were under five year old, pregnant and lactating mother;
 - (b) To do a situational analysis by ocular observation.
4. The rapid nutritional assessment was done on children from 1 year to 5 years old using the mid-upper arm circumference (MUAC). A weight for height measurement would have been preferable but due to lack of staff and time we resorted to MUAC.
5. METHODOLOGY:
 - 5.1: The entire camp was divided into 4 different sections. Each section was assigned 2 LHVs to do arm circumference, and filling up the form (Annex 1). They had to measure all children 1-5 years old in a house. Before fielding the staff, training was given on the appropriate technique of arm measurement, and were given their area of coverage.

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5.2 Our initial target was to survey at least 20% of the estimated population of less than five years old, which was 3,450.

5.3 There was an estimated 2900 families in the camp.

6. RESULTS:

6.1 Out of 2900 families, 750 or 26% were surveyed, and 1200 or 40% of the estimated children under-five year old were screened using the MUAC. 25% had a MUAC less than 12.5 cm indicating severe malnutrition, 40% had 12.5 - 13.5 cm (moderate) and 35% had more than 13.5 cm 60% had moderate to severe malnutrition.

7. SITUATIONAL ANALYSIS (OCULAR OBSERVATION):

7.1 Health Status: Malnutrition, diarrhoea, respiratory infections and anemia were the leading causes of morbidity based on observation and interviews of mothers. These conditions were highly prevalent because of their impoverished situation, unsanitary environmental conditions, poor housing and inadequate water supply.

7.2 Environmental condition: Except for one or two improvised latrines which were unsanitary, there was no proper excreta disposal. Human feces were seen all around and the smell of human feces hung in the air as a thick cloud.

7.3 Water Supply: Water was supplied by a tanker twice a day. Refugees said it was not enough as they had to use it for all purposes.

7.4 Housing: Three or more families were housed in a small improvised tent. Some of the tents were made up of thin cloth so water seeps in when it rains. Some of the tents had no walls.

7.5 Clothing: Some children were inadequately dressed for winter.

7.6 Shoes: Most children had no slipper or shoes which predisposed them to worm parasitism.

7.7 Personal Hygiene: Almost all children were dirty which may be due to lack of water supply.

|| 7.8 *No regular ration for 6 months*

8. RECOMMENDATIONS:

8.1 Food rations:

8.1.1 Regular general food rations.

8.1.2 In addition to the above a supplementary feeding ration to all children less than 80% weight for height consisting of:

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DSM	-	100 gms.
Sugar	-	60 gms.
Oil	-	50 gms.

This will supply 1055 Kcal per child per day.

8.1.3 The best method for the supplementary feeding is wet or on-the-spot feeding to ensure that the malnourished child gets the ration. However, if resources would not allow it, a second alternative is dry or take-home ration provided it is not given in bulk, to minimize rations being eaten by the family.

8.1.4 Medicines:

a) Vitamin A medication.

100,000 I.U. to children less than 1 year old.

200,000 I.U. to children more than 1 year old.

b) Folic Acid for pregnant mothers.

8.1.5 Mass Immunization: The priority is measles vaccination to cover at least 80% of all children under 5 years old. It would be disastrous and fatal for a measles epidemic to occur in a malnourished population. All LHVs can be mobilized to do this mass immunization rather than just the vaccinator doing the routine vaccination.

8.1.6 ORS Distribution: Pre-packed ORS should be distributed by the LHVs during their home visits.

8.1.7 Sanitation: The proper authorities should be asked to remedy the situation.

8.1.8 Health Care Services: At least one day a week should be set aside by the nearest BHU to go to the camp of new arrivals, and offer especially MCH services.

8.1.9 Housing: Appropriate tents be given to each family.

8.1.10 Blankets should be provided to each family at least.

9. Basing on these recommendations, the Sub Office, Peshawar took action, coordinated with proper authority as CCAR and

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WFF, and requested assistance from Union Aid for staff. Within 4 days every thing was organized and ready for shipment to Miranshah; proper representations were made with the FSMO and PA in Miranshah and 2 days after arrival of the materials, 2 feeding centres were fully operational. By January 21, 1987, two supplementary feeding centres were set up in North Waziristan, one in Dargamundi and another in Serbangkei, a transit camp where refugees were pre-registered. There '5s an initial enrollment of 400 in Dargamundi and 200 in Serbangkei which increased to 740 and 436 respectively at the time of closure.

MIANWALI - PUNJAB

1. This transfer of malnourished children to Punjab created a need for a similar service to be set up in the said province. The Programme Officer in Punjab requested UNHCR Islamabad to make possible the provision of such service.
2. In order to determine who could be benefited by the feeding centre in the camp in addition to those children coming from Miranshah, a rapid nutritional assessment was done in Kot Chandna camp, the methodology of which was similar to that done in N. Waziristan.
3. Results of the rapid nutritional assessment: Out of the estimated 2600 new arrived families, 1051 or 40% were surveyed and 1517 or 57% of the estimated under 5 year old population was screened. 29% had a MUAC of less than 12.5cm; 31% had 12.5-13.5cm; and 40% had above 13.5cm, 60% had moderate to severe malnutrition.
4. Housing was not a problem as every family was provided a tent.
5. After the assessment mission was done, except for the provision of a general food ration which the refugees already have, basically the same recommendations as that for North Waziristan were made for Mianwali.
6. The Programme Officer in Punjab, the Project Director (Health), a Volag, The League of Red Cross, and UNHCR sat down and laid down some implementing details more specifically on funding and handing over the project for implementation to the Volags basing on UNHCR's recommendations.
7. Unlike that of N. Waziristan new arrivals, that of Mianwali were receiving their regular rations.

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8. To date, there are 600 children enrolled in this feeding centre.
9. This centre is planned to be assessed early part of June, 3 months after the start of operation.

RATIONS GIVEN

1. For both North Waziristan and Mianwali feeding centre, a mixture of DSM (100 gms), Sugar (60 gms) and Oil (50 gms) providing 1055 kcal per child per day were given.
2. In Mianwali an alternate mixture was given consisting of Dal (100 gms) Rice (100 gms) and Oil (60 gms) providing 1100 kcal per child per day. These mixtures were given alternately weekly.
3. In Miranshah, Dal was also given to pregnant and lactating mothers (one kg. every week).
4. The ration was given every other day. The first day ration was pre-mixed consisting of DSM, Sugar and Oil mixture packed in one package; the second day ration was dry with just DSM and Sugar mixed and Oil in another package.
5. As a general rule the daily supplement is based on the adequacy or inadequacy of the general food ration:
 - a. if there is an adequate general ration, the supplement of a moderately malnourished child is 300-500 kcal/child/day.
 - b. if the general food ration provides less than 1500 kcal/person/day, the daily supplement is 500-1000 kcal/day.
6. The type of ration depends on the culture and food habits of the recipients. They should be acceptable and palatable especially to the children.
7. As much as possible, local foods should be incorporated in the feeding mixture.

PHYSICAL SET-UP

1. All the 3 supplementary feeding centres have 3 sections:
 - 1.1 Physical and clinical assessment section.
 - 1.1.1 Children with MUAC below 12.5cm were referred to this section. Weight and height were taken and recorded in a chart. Lifewise questions on duration of stay in Pakistan, tribe, weaning practices and presence of diarrhoea were asked from the mothers upon admission (Annex 2). These

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data although not an essential part of the assessment, are useful for research purposes. At this moment I am unable to give you an analysis of these data. It will be available in the near future.

1.1.2 Proper referrals are made in this section. The following cases are subject to referral for therapeutic feeding or medical management:

- a. those less than 60% weight for height.
- b. Kwashiorkor cases
- c. Marasmic - Kwashiorkor
- d. those who has edema irrespective of their weight.
- e. those who cannot tolerate food.

Referral slip forms are used (Annex 3)

1.1.3 A ration card (Annex 4) is given too with proper indication when to come back for re-assessment.

1.1.4 The growth chart and admission forms plus a permanent register book serve as the permanent record of the child.

1.2 Health Education Section:

1.2.1 The children come to this section from the physical assessment section.

1.2.2 An actual demonstration on the preparation of the ration for feeding was made here. In addition, short talks on nutrition, proper weaning foods for children, causes of malnutrition, the preparation and importance of ORS, personal hygiene and immunizations were given. Usually a group of 10-15 mothers sat in for each session.

1.2.3 After the session the LHM signed the ration card indicating that the mother had received health education. This is the main reason why we do not give rations to children without their mothers. Our aim is not only to feed but more to teach the mothers what and how to feed their children.

1.2.4 After the session they go to the ration section.

1.7. Ration Section:

- 1.3.1 The LHV, after making sure that the mothers have received health education, gives the ration, then countersigned the date the ration is received. The date when to come back for re-supply is also indicated.

1.4 Immunization:

- 1.4.1 This is an optional yet a very important part of a feeding centre.
- 1.4.2 Proper coordination between the feeding centre personnel and the immunization personnel is of utmost importance.

RE-ASSESSMENT

1. A follow-up reassessment was done weekly. Weight and height were taken and recorded in the growth chart. If the child's weight either decreased or remained static, a more detailed clinical evaluation was done to discover the cause, and a serious talk with the mother was done warning her on the possible outcome if the child does not improve; inquiry from the mother whether the ration was given or not to the child.
2. We expect the child to gain 8-10 gm per kg. per day assuming that the ration is given and the child has no super-imposed infection.
3. A severely malnourished child is expected to reach the expected weight and height within 6 weeks of admission.

CRITERIA FOR DISCHARGE

1. Children who reach more than 85% weight for height for 2 consecutive weighings 2 weeks apart may be discharged.

REPORTING

The following data need to be reported every month:

1. Number of children who attended for the month.
2. Number of children who increased in weight.
3. Number of children who decreased in weight.
4. Number of children whose weight are static.
5. Number of drop-outs.
6. Number of malnourished children per category.

EVALUATION OF THE FEEDING CENTRES

1. Serbangkei Feeding Centre:

1.1 As of February 28, 1986, ^{22%} there were 436 enrolled children. 95 of them had been discharged because they were 85% weight for height. Out of the remaining 341 children, 85 or 25% were serverely malnourished (less than 70% weiaight for height), 42.8% or 401 children were moderately malnourished (less than 80%), and 110 or 32.3% were more than 80% weight for height.

2. Dargaimundi Feeding Centre:

2.1 As of February 28, there were 740 children enrolled. Of these, 29.8% were less than 70% weight for height; 280 or 37.8% were 70-80% weight for height and 32.4% were more than 80%. 114 were discharged because they were over 85% weight for height. ^{15%}

2.2 255 children were regularly coming to the centre. Reassessment showed the following: ^{34%}

60% or 150 children increased in weight.
28% or 70 did not show any changes.
14% or 35 had decreased in weight.

2. Mianwali Feeding Centre:

2.1 As of March 30, there were 575 children enrolled. 90% were moderate to severely malnourished.

2.2 After 2-3 weeks in the feeding centre, 60.8% increased in weight, 8.8% decreased and 3.6% static, 26.8% were defaulters.

2.3 After 3-4 weeks in the feeding centre, 71% increased weight, 5.9% decreased, and 6.0% static weight, 17% were defaulters. [↓] [↑]

CRITERIA FOR CLOSURE

1. Once the malnutrition rate has decreased to less than 10% of children under 5 years old, the services may be taken over by same facilities provided the following criteria are fulfilled:

1.1 the general ration is adequate and regular.

1.2 public health disease control measures are effective.

1.3 no seasonal, deterioration in health condition can be anticipated.

2. Monitor the remaining malnourished children during the pleasing out stage.

3. Follow-up survey shall be done to prevent deterioration of the present situation especially when there is influx of new arrivals.

CONCLUSION:

I wish to emphasize that the establishment of supplementary feeding centres is only an emergency intervention scheme to meet the immediate needs of the vulnerable groups. It should in no way be intended for long term interventions except a nutritional need exists. Efforts should be exerted to improve distribution of the regular food ration to new arrivals.

The success of this project depends a great deal on the interest and involvement of the Chief of the respective offices and an awareness on the importance of nutrition in the refugee situation. I am happy to say that such interest and involvement are remarkably shown by the Chief of Mission and staff of UNHCR, Islamabad and the Chiefs of Sub-Office, and staff of Peshawar and Punjab.

LESSONS LEARNED:

1. Health and nutritional assessment of new arrivals should be done as part of a regular monitoring activity. This should be done if possible upon arrival to prevent further deterioration of the health condition of the vulnerable group.
2. Prompt registration to facilitate regular general food ration, alleviate the critical situation. Early provision of tents also will minimize the incidence of respiratory infections.
3. An emergency stock of food commodities should be available at all times without necessarily going through tedious and long administrative procedures.
4. Staff should be available if possible from the Volags, who could be tapped in case an emergency arises.

Assessment on Agency staff before arrival.

I thank you.

Country A 1

NUTRITION ASSESSMENT FORM FOR NEW ARRIVALS

DISTRICT _____

CAMP _____

HOUSE _____

Children Under 5 *	ARM Cir-cumference	EDEMA		Night Blindness		Diarrhoea		Showering	
		Yes	No	Yes	No	Yes	NO	Yes	NO
1									
2									
3									
4									
5									
6									
7									

Number of pregnant mothers in house

Number of lactating mothers in house

Dr. Aurora Fermo
Nutritionist/Epidemiologist

* only children above one year old
is included.

NUTRITION ASSESSMENT FORM

- 1) No: _____ 2) Date: _____
 3) Name: _____ 4) Age: _____ 5) Sex: _____
 6) Tribe: _____
 7) Date of arrival in Pakistan: _____
1. Breast fed? 8) Yes _____ 9) No _____
 2. How long? 10) 6 months 12) 12 months to 18 months
 11) 6 to 12 months 13) 18 months & more
 3. Weaning food given? 14) Yes _____ 15) No _____
 4. If yes, at what age was it started?
 16) Less than six months
 17) six months to one year
 18) one year to two years
 19) More than two years
 5. Is the child having diarrhoea now? 20) Yes _____ 21) No _____
 6. Is the child having night blindness? 22) Yes _____ 23) No _____

PHYSICAL AND CLINICAL ASSESSMENT

24) Ht. _____ 25) Wt. _____ % of median _____

EYES - Conjunctiva

- 26) Very pale
 27) Slightly pale
 28) Not pale

MOUTH - Angular stomatitis
 Bleeding gums

- 29) Yes _____ 30) No _____
 31) Yes _____ 32) No _____

EXTREMITIES

- Muscle wasting
 Edema
 Thin subcutaneous fat

- 33) Yes _____ 34) No _____
 35) Yes _____ 36) No _____
 37) Yes _____ 38) No _____

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REFERRAL SLIP

To BHU/HOSPITAL: _____

NAME _____ NUMBER _____

CAMP _____ DATE _____

COMPLAINTS:

REASONS FOR REFERRING:

NAME _____

DESIGNATION _____

To FEEDING CENTER: _____

NAME _____ NUMBER _____

CAMP _____ DATE _____

ACTION TAKEN:

DIAGNOSIS :

RECOMMENDATIONS:

NAME _____

DESIGNATION _____

an exp of
RATION CARD

Name: _____

No. _____

<u>JANUARY</u>			<u>FEBRUARY</u>		
1.	11.	21.	1.	11.	21.
2.	12.	22.	2.	12.	22.
3.	13.	23.	3.	13.	23.
4.	14.	24.	4.	14.	24.
5.	15.	25.	5.	15.	25.
6.	16.	26.	6.	16.	26.
7.	17.	27.	7.	17.	27.
8.	18.	28.	8.	18.	28.
9.	19.	29.	9.	19.	
10.	20.	30.	10.	20.	
		31.			

RATION CARD

No. _____

Name: _____

<u>JANUARY</u>			<u>FEBRUARY</u>		
1.	11.	21.	1.	11.	21.
2.	12.	22.	2.	12.	22.
3.	13.	23.	3.	13.	23.
4.	14.	24.	4.	14.	24.
5.	15.	25.	5.	15.	25.
6.	16.	26.	6.	16.	26.
7.	17.	27.	7.	17.	27.
8.	18.	28.	8.	18.	28.
9.	19.	29.	9.	19.	
10.	20.	30.	10.	20.	
		31.			

Dr. Naveeda Bano Wed 8 July

UNHCR Health Coordinator N'WFP since 1982.

1981 - Beatrice, German, ?
Hans Beter, German, UNHCR Hlth Coord.
↓
3-4 mo gap
L? seconded by Germans

?82 Dr. Levi Roque

↓
gap ? 1 yr

?84 Dr. Alex Furo Seconded by SCF

Previous post - Army Captain for 2 yrs.

UN post - advertised, knew nothing of UNHCR before this job.

Dr. Aurora Fermo

"I don't care what happens - I leave in Sept.
The next person will have their own strategy."