HEALTH RELIEF GUIDELINES

MINISTRY OF HEALTH

REPUBLIC OF SUDAN

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FOREWORD

The need for standardized health relief guidelines for Sudan has long been recognized by the World Health Organization and the Ministry of Health.

This collaborative effort has aimed to provide a set of simple health guidelines that address the most important health problems faced in emergency displacements.

We would especially like to express our appreciation to the many resource people in the Ministry of Health whose guidance has ensured that this document accurately reflects national health policy.

Gratitude must also be expressed to those specialists who shared their expertise in standardising the treatment regimens contained in the guidelines.

Particular mention should be given to the active contribution and support by staff members of the many non-governmental organizations involved in health relief. Their willingness to share information on "lessons learned" was invaluable in preparing the document.

We are deeply appreciative of the assistance and cooperation afforded by key national and international relief agencies, particularly the Commissioner of Refugees, U.N.H.C.R., UNICEF and the Emergency Unit, Ministry of Health presently seconded to the Commission for Relief and Rehabilitation.

Although we believe this booklet addresses the main priorities in health relief, we realize that there is still much to be learned in the fields of emergency preparedness and response. It is our hope that this and future editions will draw attention to the importance of emergency preparedness, and ultimately help strengthen the relief response capabilities of the health sector in Sudan.

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April 2nd, 1988
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TABLE OF CONTENTS

LIST OF ABBREVIATIONS AND SYMBOLS USED

ARI	Acute Respiratory Infection	MOH	Ministry of Health
BCG	Bacillus de Calmette-Guerin	Mos	Month
CBR	Crude Birth Rate	MUAC	Middle Upper Arm Circumference
CHW	Community Health Worker	NCHS	National Centres for Health Statistics
CI	Confidence Interval	NGO	Non-governmental organization
COR	Commissioner for Refugees	OPV	Oral Polio Vaccine
CMR	Crude Mortality Rate	ORS	Oral Rehydration Solution
CSM	Corn Soya Milk	ORT	Oral Rehydration Therapy
DPT	Diphtheria Pertussis & Tetanus	PHC	Primary Health Care
DSM	Dried Skimmed Milk	SFP	Supplementary Feeding Programme
EPI	Expanded Programme Immunizations	TB	Tuberculosis
HEd/HE	Health Education	TBA	Traditional Birth Attendant
IMR	Infant Mortality Rate	Tet tox	Tetanus toxoid
IU	International Unit	TFP	Therapeutic Feeding Programme
Kcal	Kilocalories	UNHCR	United Nations High Commissioner for Refugees
Kg	Kilogramme	W/H or Wt/Ht	Weight-for-height
MCH	Mother and Child Health	WHO	World Health Organization

SYMBOLS USED

$x < y$ = x is less than y

$x > y$ = x is greater than y

$x \geq y$ = x is greater than/equal to y

$x \leq y$ = x is less than/equal to y

» = increasing

« = decreasing

PART I

STATEMENT ON HEALTH RELIEF

The capacity to respond promptly to the emergency health needs of displaced groups is an important responsibility of the health sector.

However, health relief is viewed as one aspect of a broader multisectoral response to emergency displacements.In this context, health assistance should be closely coordinated with the efforts of other sectors to ensure that limited resources are used most effectively.

Active coordination of the different agencies involved is also a priority. This has already been enhanced by the introduction of the national *Health Coordination Protocol* which has strengthened the cooperation between non-governmental organizations and the Ministry of Health.

Furthermore, health relief should always be regarded as a valuable opportunity to strengthen the managerial capacity of the health sector, in addition to developing the self-reliant capabilities of the displaced group.

PART II

PREPAREDNESS AND EMERGENCY RESPONSE

II.A

BEING PREPARED

Preparedness is essential for rapid effective responses to health emergencies, particularly those associated with large or sudden population displacements.

Health sector preparedness for such displacements depends on:

- adequate information for decision-making
- clear responsibilities for decision-making
- contingency plans prepared in advance
- trained personnel
- adequate buffer stocks of essential drugs, emergency food supplies
- logistic capacity for rapid response
- information on emergencies common to Sudan

1) Information for decision-making

Health workers at all levels should be aware of the *early warning signs* that suggest impending displacements, particularly those due to food shortages.

In the health sector, these signs may include:

- increased numbers of paediatric hospital admissions with malnutrition - in excess of seasonal expectations
- increasing childhood malnutrition detected at routine growth monitoring sessions or in nutrition surveys
- declining attendance at health centres,in drought-affected areas as out-migration begins
- *increasing* numbers of newly arrived malnourished women and children *from* drought-affected areas seeking medical attention, suggesting a displacement has started

Such information should be shared with provincial and regional health officers, promptly conveyed to representatives of regional government and the RRC so that the need for food relief can be quickly assessed.

2) Contingency plans - prepared in advance

In areas likely to become the destination for emergency displacements, health officers should prepare simple contingency plans in advance, allowing them to:

- rapidly assess the health status of new arrivals, population size and composition

- review adequacy of local health response:

  - health manpower, equipped facilities
  - vaccine stores,(especially measles), ORS
  - Vitamin A capsules, emergency drug supplies

- coordinate with local government on adequacy of local food supplies

- coordinate with locally operational relief agencies on their capacity to assist.

- promptly communicate assessment findings to local government, and MOH officials at provincial, regional and central levels

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When developing regional health emergency plans give careful thought to:

- those diseases with the greatest epidemic potential in emergency conditions (consider seasonal and environmental risk factors)

- the use of prompt and effective reporting systems (i.e the nearest radio, travel by car/donkey/camel to district/provincial hospitals)

- the practical aspects of emergency preparedness (i.e training needed for health workers and civil officials, buffer stocks of emergency drugs, vaccines and relief foods)

- the immediate actions which should be taken in emergency displacements, and who to take responsibility, i.e:

  - nutrition interventions
  - immediate vaccination
  - safe water supply to meet minimum needs
  - effective human waste disposal

* *

3) Trained personnel, buffer stocks and logistics

Prompt access to buffer stocks of food, emergency drugs and Vitamin A capsules, expedites an effective emergency health response.

However, the effectiveness of relief also depends on the availability of health personnel who are *trained to rapidly assess* an emergent situation, and *implement immediate relief measures.*

4) Information on emergencies common to Sudan

Population displacements can occur for different reasons.

These can include:	*For example:*
■ disasters of rapid onset	- floods
■ slow-developing disasters	- severe food shortages
■ chronic emergency conditions	- civil strife

Good contingency planning requires that regional and provincial health officers are aware of the common emergencies which might result in population displacements in their areas, so they can make plans in advance.

II.B

EARLY ACTION

Whenever possible, timely relief efforts aim to *prevent* population displacements - particularly those caused by drought-associated food shortages.

The diagram below is one example of how ongoing nutrition surveillance information might be used for the targeted distribution of early food aid.

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- random nutrition surveys in a drought-affected area show that the percentage of malnourished children has risen from 13% to 17% of under-fives in the past three months *(Realy warning sign)*

- agricultural indicators verify the poor food security of the area (low rainfall, falling livestock prices, poor crop yields)

- information channelled to regional & central MOH, regional government and RRC

- targeted food relief approved and distributed to affected areas

- ongoing nutrition surveillance through surveys to monitor adequacy of food relief channelled to MOH and RRC

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II.C

EMERGENCY HEALTH RESPONSE: DISPLACEMENTS IN RURAL AREAS

In rural areas, population movements can occur for many reasons. However, when a community is suddenly displaced due to natural or man-made disasters, it becomes particularly vulnerable.

For the displaced whose health and nutritional status is depleted by malnutrition, communicable diseases or exhaustion, and who lack access to basic resources, health and food relief are an immediate priority.

1) First Priorities

In an emergency displacement,the steps in health relief are:

■ Verify lines of authority /reporting and health coordination	- refugee populations: one lead health agency/camp - internally displaced - report to local/ /regional/central MOH
■ Do rapid epidemiological assessment	- population distribution, age, sex health - problems? nutritional status? - trained health workers? TBA's,others? - presence of local disease vectors?
■ Screen new arrivals/ existing population	- identify health resource people - vaccination, with special attention to measles (p 8) - ORT for rehydration (p 19) - Vitamin A capsules (Annex 1.3) - nutritional assessment (p 9)
■ Assess water, sanitation/ food/shelter needs	- quality/quantity of water supplies - gardens/markets, domestic animals? - household possessions/cooking utensils? - defaecation areas, refuse disposal
■ Set up selective feeding (see pp 33-38)	- supplementary feeding - therapeutic feeding
■ Set up ongoing mortality /morbidity surveillance	- monitor burial sites/grave watchers - rapid reporting of outbreaks - report weekly in emergency - calculate mortality as rate/10,000/day
■ Ensure coverage by community health services	- divide community into sectors ->assign CHW's for specific areas 1:500-1000 pop. - household-household visiting for prompt case detection

1.1 Coordination/reporting

Emergency health relief to displaced groups potentially involves:

- Ministry of Health
- Local councils, regional and central governments
- Commission for Relief and Rehabilitation
- Commissioner for Refugees
- Non-governmental organizations
- International agencies
- Donor agencies

From the beginning of relief, procedures *must be introduced* for coordinating the assistance efforts of these bodies both vertically and horizontally.

At every level, focal points should be identified for collecting, compiling and channelling information on all aspects of health / nutrition relief for a targeted population:

For Instance

■ In a refugee camp	- **one lead health agency should coordinate all health efforts/compile campwide health information**
■ In a village relief programme	- **all health activities should be coordinated through district/provincial/ regional health officers**

Furthermore, channels should be established for coordination with other sectors such as:

- camp steering committees
- village/district councils

* *

When relief is implemented by non-governmental agencies, *one agency* should be assigned responsibility for health activities in a specific location whenever this is possible.

Only under extreme circumstances should more than one NGO be permitted to operate in one location.

When this does occur,health coordination can be achieved either by:

- the various agencies involved *nominating a lead agency* to be responsible for reporting and coordinating on behalf of the other agencies

- or, through the appointment of qualified national health personnel by the government agency responsible for health relief

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1.2 Rapid Epidemiological Assessment

In an emergency population displacement, the first priority is to carry out a rapid epidemiological assessment. This is essential for identifying:

- *immediate* health and nutrition problems
- *potential* health problems due to behavioural or environmental risk factors

a) Collect information on:	*Useful for determining:*
■ population composition	- size of at-risk groups
■ nutritional status	- nutrition programme priorities
■ mortality/morbidity	- main health problems
■ local disease patterns	- risk of disease transmission

b) Other assessment information

Also gather information on:

- the resources available to the displaced group, such as; cooking utensils, livestock, materials for shelter
- the conditions during displacement (to determine health needs of later arrivals) and estimates of numbers still to come

- the way they regroup (i.e by family or village) and leadership structures
- the local environment (food/water sources, bush/trees for fuel and shelther)
- capacity of local health services to respond (measles vaccine, Vitamin A capsules, ORT, trained health personnel)

c) Organizing a rapid assessment

In refugee displacements, such assessments should be a joint exercise, involving representatives of:

- the Ministry of Health
- Commissioner of Refugees
- United Nations High Commissioner for Refugees
- health agencies already at the site

In other rural displacements, rapid health assessments should involve: representatives of:

- the Ministry of Health, especially regional health authorities
- international/non-governmental relief agencies, if already operational in the area
- representatives of local government

A joint approach to rapid assessment encourages a coordinated relief response. The findings from such assessments should be *immediately shared* with decesion-makers at local, regional and central levels so rapid action can be taken.

A rapid assessment can be carried out by using survey techniques, or during *health screening* activities.

1.3 Health Screening

In a malnourished displaced population, health screening should be initiated as quickly as possible. Its purpose is both to identify those with the greatest health need - and to prevent the spread of communicable diseases. In refugee populations, a thorough health screening eliminates the need for enforced quarantine during an emergency.

It also is an excellent opportunity for identifying potential health workers and people with management/organizational skills.

It involves the following:	*Comments*
1. Give measles immunization to all children 9 months-3 years	- refer to "Emergency Measles Immunization Protocol", p 8
2. Give Vitamin A Capsules to children ≤15 years old	- 200,000 IU for children > 12 months 100,000 IU for children < 12 months
4. Identify severely ill people, and refer for treatment.	- i.e people with cerebral malaria, medical/surgical emergencies
5. Identify dehydrated children, and give ORS	- refer p 19 for treatment of dehydration
6. Screen all children under-five for malnutrition and refer	- use MUAC for rapid screening use - use weight-for-height for referral to selective feeding

a) Emergency Measles Immunization Protocol

Experience from past emergencies has shown that severely malnourished children with measles may experience case fatality rates as high as 50%. The risk of spread is even greater in crowded and unsanitary conditions.

In any displacement where people are crowded together, an emergency measles immunization campaign should be carried out as quickly as possible.

Option 1	*Option 2*
Where there are high rates of malnutrition	Where there are moderate or mild rates of malnutrition
Optimal coverage is 6 months - 5 years (30 - 40% total pop)	Optimal coverage is 9 months - 59 months (15 - 20% total pop)

Calculate dosage required

Total population x(estimate of target pop) + vaccine wastage factor =20%

Vaccine Dosage Estimates

Size of displaced population	Doses Needed for: high malnutrition rates
1,000	250
5,000	1,200
20,000	4,800
50,000	12,000

All children aged 6, 7,and 8 months old immunized against measles in an emergency campaign *mus reimmunized* between 9 and 12 months for lifelong protection.

In emergency measles immunization campaigns, there should always be careful consultation with E. officers to ensure vaccination is carried out in accordance with national E.P.I. policies and protocols.

IMPORTANT: Measles immunization is an immediate vaccination priority.

In emergency displacement, immunization against cholera is NOT indicated.

b) Nutrition Assessment/Screening

In the emergency phase, nutrition assessment has two objectives:

- to indicate the population's overall nutritional status
- to identify nutritionally vulnerable individuals, and those needing nutritional rehabilitation

i) Assessing community nutritional status

This is best accomplished by weight-for-height surveys of children under five years [or less than 1 height] (refer Annex 1 1 4 for sampling suggestions)

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Weight-for-height survey findings can estimate a population's nutritional status

* *

For instance:

The percentage of children surveyed:	*indicates*
■ less than 70% wt/ht	- the degree of severe malnutrition
■ 70% - 79% wt/ht	- the degree of moderate malnutrition
■ less than 80% wt/ht	- the *overall malnutrition rate*

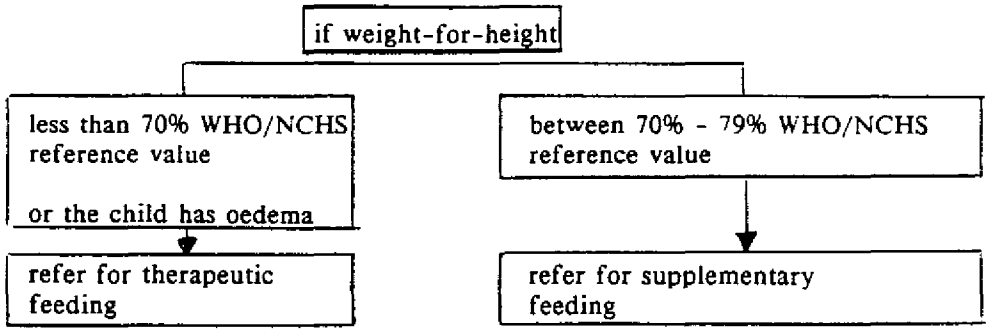
When time and resourses are limited, a rough rapid nutritional assessment can be gained by measuring the *Middle Upper Arm Circumference* (MUAC) of children between 1-5 years.

MUAC measurements:	*suggest a child is:*
■ greater than 13.5 cm	- adequately nourished
■ between 12.5 cm and 13.5 cm	- at-risk
■ less than 12.5 cm	- malnourished

A rapid random wt/ht nutrition survey is *always recommended* when rough MUAC findings suggest significant levels of moderate or severe malnutrition.

Nutritional screening of individuals

Weight-for-height assessment is also the recommended method for identifying children in need of supplementary or therapeutic feeding.



1.4 Assess needs for water, food and sanitation

A realistic assessment of basic water, food and sanitation is a *multisectoral activity*. Therefore, there should be close consultation between local officials, rural councils, representatives of assistance agencies and the displaced population to decide on practical ways to meet these basic needs.

Ideally, 15 - 20 litres of *water* is recommended per person daily. Although this objective may not be feasible in many emergency situations, there should be immediate efforts to protect existing water sources from contamination.

Restoring *food security* is an early priority. It is recommended that displaced groups without access to food resources should receive - as a minimum - food assistance that provides:

- 2,000 kilocalories and 50gms protein per person per day

This can be acheived by:	400 gms cereal	1400 kcal
	50 gms pulses	175 "
	50 gms oil	450 "
	Total	2025 kcal

Elaborate *sanitation* arrangements may not be workable in an emergency. However, in cooperation with the community's leaders, it is important to designate defaecation areas that are easily accessible - especially to women and children.

Right from the start of an emergency response, it is essential to involve the community in improving environmental sanitation.

1.5 Selective feeding priorities

The most urgent nutritional priority in emergency displacements is to restore basic food security as quickly as possible.(ie through adequate food rations,access to markets, gardening etc).

Selective feeding should be seen as a *temporary measure*, for meeting the needs of the *nutritionally at-risk and malnourished* because a community lacks enough food.for basic survival.

The key considerations in emergency feeding are listed below (greater technical detail is given in Part III.6, *Nutrition Programmes)*

	Comments
■ Programme scope and size	- rapid nutrition surveys for estimates of target groups (see Annex 1.1)
■ Type of feeding - on-site - take-home	- consider total numbers to be fed - cooking utensils, fuel available to households? - what foods are available? - logistic demands of each approach?
■ Target groups	- moderately/severely malnourished children - pregnant/lactating women - other vulnerable groups, ie TB patients
■ Appropriate foods	- culturally acceptable, familiar - easily prepared, safe?
■ Nutrition education	- practical and simple messages
■ Community coverage	- shelter-shelter visiting to detect malnourished individuals - home follow-up of non-attenders
■ Monitoring/evaluation	- % to gain,lose, maintain weight/month - % attendance of those registered/month - death rates in therapeutic feeding

1.6 Mortality/Morbidity Surveillance

a) **Vigilant mortality surveillance must be carried out in all emergency displacements. Because mortality of young children is a sensitive indicator of the effectiveness of relief, serious efforts should be taken to count all deaths of children below 5 years.**

Possible approaches to the collection of mortality data include:

- *24 hour/day monitoring of burial sites by grave watchers.* They should be trained to conduct and record a simple "oral autopsy" for each death. (i.e "fever with cough"," fever with chills")

  This not only gives a useful indication of total deaths. It also gives valuable information on communicable diseases patterns -for assessing the effectiveness of relief.

- *close cooperation with community leaders for mortality information*

- *reporting of deaths by home visitors*

In an emergency displacement, mortality for a specific population should be calculated weekly and monthly in *rates/10,000/day* for:

- children under 12 months
- children under 5 years
- total population

These reports should be promptly forwarded to appropriate health officers in the Ministry of Health, the RRC and COR.

b) Morbidity surveillance / outbreak reporting

Accurate morbidity information is difficult to collect in an emergency. Emphasis should always be placed on diseases of public health importance.

In Sudan, the following diseases must be reported to District, Provincial, regional and Central Ministry of Health officers *within 24 hours* of detection:

cerebro-spinal meningitis	plague
cholera	haemorrhagic fevers
typhus	

Reported information should include the *number of cases and deaths,* as well as the name, age, sex and location of each case

Because of the increased risk of disease transmission in crowded relief conditions, the first case of the following diseases should also be reported to appropriate health officials:

- measles
- diphtheria

Weekly communicable disease reporting

At the end of each reporting week, information on the communicable diseases listed below must be received at the Regional and Central Ministries of Health

cerebro-spinal meningitis	chicken pox	diphtheria
infective hepatitis	influenza	influenza
kala azar	malaria	measles
polio	rabies	relapsing fevers
tetanus	typhoid	haemorrhagic fevers
human immunodeficiency virus		

This information should include both *positive* (number of cases) and *negative* (no cases) reports.

Monthly, the following health information should be gathered and compiled in one place at the field level - and *reviewed* so that corrective action can be promptly taken:

- mortality rates per 10,000/day
- communicable disease morbidity
- nutritional status of under-five year olds
- % attendance in feeding programmes
- measles immunization coverage

1.7 Coverage by health services

The effectiveness of health relief depends on whether it actually *reaches the target population*

Two strategies should be applied for achieving population-based coverage:

a) Dividing the camp or community into sections and assigning one community health worker to a population of 500 - 1,000 people (100 - 200 families)

b) Decentralising basic health services to serve target populations of 10,000 - 15,000 people (combining basic curative, nutrition and mother-child health activities in a one place)

In an emergency situation where there is crowding, high rates of malnutrition and risk of communicable disease spread, basically trained home visitors should go from household - household to:

- detect and refer malnourished and sick individuals
- identify potential outbreaks of communicable disease
- give basic health information on immunization, food distribution, location of defaecation areas

Active outreach is absolutely essential right from the beginning to control communicable disease spread and identify at-risk individuals.

II.D

POST-EMERGENCY PRIORITIES

If relief measures are implemented effectively, morbidity and mortality rates should reach pre-emergency levels within several weeks or months.

At this point, there should be a careful situation review, involving members of the displaced community, local Ministry of Health officers, representatives of COR and UNHCR (in instances where refugees have been displaced), and RRC (where an internal displacement is concerned).

The following factors should be considered:

1) present food security/access to markets/agriculture
2) needs for continued selective feeding
3) long-term organization of health programmes
4) training requirements for health workers
5) standardised Ministry of Health health reporting requirements

At this stage, it is important that health activities, treatment protocols and reporting procedures are standardised as closely as possible with Ministry of Health guidelines.

Key treatment protocols, reporting requirements and drugs for use by primary health care workers are given in Part III.

II.E

URBAN PRIORITIES

Many of the recommendations given for managing displacements in rural areas also apply to urban conditions.

The following are especially important:

- *active community outreach by home visitors*

- providing simple health education on hygiene, sanitation, safe water storage, preparation of appropriate weaning foods and ORS

- advising on times and location of immunization and growth monitoring sessions

- identifying and referring sick, malnourished or vulnerable indivduals for evaluation and treatment

- *growth monitoring of under-fives*

- *active nutrition surveillance* through six monthly nutrition surveys in areas receiving new arrivals

Refer to PART III for further details on these activities