PART 5:

LESSON 11

GUIDELINES FOR ORGANIZING A SUPPLEMENTARY FEEDING PROGRAM AS A NUTRITION-CENTERED HEALTH PROGRAM.

Nutrition-centered health assessment (NCH Assessment) is the use of a specialized relief feeding program for assessing and monitoring the full range of health problems. The method includes an initial assessment of health and nutritional status, and a long term surveillance of malnutrition, disease and water quality. The method also provides data useful for monitoring food supplies, logistics, water purity, and food quality.

A. Methodology

An NCH assessment focuses on the nutritional status of the disaster victims. If the people are in generally good condition and their health and nutritional status is near normal (as determined by certain indicators and standards), the emphasis of the assessment can then focus on

programmatic issues and cost efficiency considerations. However, if malnutrition is widespread and death rates are high, the assessment focuses on the delivery of foods and health services and on emergency relief (lifesaving) measures.

A beginning point of NCH assessment is an examination of the health status of "vulnerable groups". Since vulnerable groups reflect what is happening in the whole population, the need for wider surveillance is greatly reduced.

Step 1

To determine the status of vulnerable groups, an analysis is made of nutritional status, mortality (live birth rates and deaths), and morbidity (the incidence of disease). A standard survey technique has been developed to rapidly assess the status of vulnerable groups. First the arm circumference of all children under five in randomly selected families is measured.1 Arm circumference is a recognized technique used for rapid assessment. Although this method is limited and more accurate height-for-weight measuring procedures should be used to verify the

1 de Ville de Goyet, C.; Seaman, J.;, Geijer, U; The Management of Nutritional Emergencies in Large Populations, World Health Organization; 1978, Page ?.

Step 4

Next, water supply, sanitation, and general hygiene are evaluated. Of special interest are water quality and quantity; type, availability and average use of sanitary facilities (latrines); water portage and storage hygiene of the families; food storage and preparation hygiene; and personal hygiene and cleaning routines. Contamination anywhere in this "hygiene loop" can cause diarrhea, which will in turn affect health and nutritional status.

Step 5

Food supplies and consumption levels are then assessed. When food supplies reaching the affected population are adequate, problems of diarrhea and disease become the highest priority. If the food supplies are inadequate in the quality or quantity they become the focal point of concern. (Appendix 4 provides a checklist for examining problems of food supply.)

Together this information can present a very accurate picture of health and nutritional status and the likelihood that certain diseases may occur.

1. The objectives of an SFP are:

   a. To prevent deterioration of vulnerable groups by providing the extra nutrients needed for growth and lactating mothers' milk production.

   b. "On-the-spot" feeding of an additional meal to ensure that the right food reaches only the selected group.

   c. To aid recovery from disease.

   d. To educate the refugee population as to better nutrition practices.

2. Participants in SFP's in the camps should be:

   a. Children 5 years of age and under;

   b. Pregnant and lactating women;

   c. Malnourished individuals (any age);

   d. Selected medical cases.

b. Fresh fruit and/or vegetables should ideally be provided daily, where feasible.

c. Special cereal-based foods may be used for the supplementary feeding program. (See Appendix 19).

d. Dried skimmed milk and other milk products can be used as ingredients in cooked meals. (See Lesson 2 for a full discussion of the issues related to the use of milk powder as a food for vulnerable groups).

e. A drink should be provided to satisfy thirst, e.g. safe water, fruit juice, tea, etc.

5. Nutrient Content of SFP Meals

a. Foods are selected for their particular nutritional value. (See Appendices 8 and 9). An appropriate ration is, for example:

- 40 g dry skim milk (160 kcal) plus 50 g cereal-based special food or rolled oats (200 kcal) or

- 100g rolled oats or cereal-based special food (400 kcal) or

a. Each participant must be able to sit in an adequate space to eat his meal.

b. Each participant should be allowed to satisfy his immediate appetite at each meal.

c. Those with poor appetites should be closely supervised and encouraged to eat as much as possible (small children require particular attention, with help, where possible, from their own mothers).

d. Generally, each participant should receive one extra meal per day through the SFP. Selected cases may be given 2 or more meals per day.

e. Feeding will be conducted on a daily basis.

9. Staffing and Supervision of SFP Personnel

a. A plan for the staffing of the SFP should be developed by the agency responsible for the feeding program and approved by the nutrition coordinator.

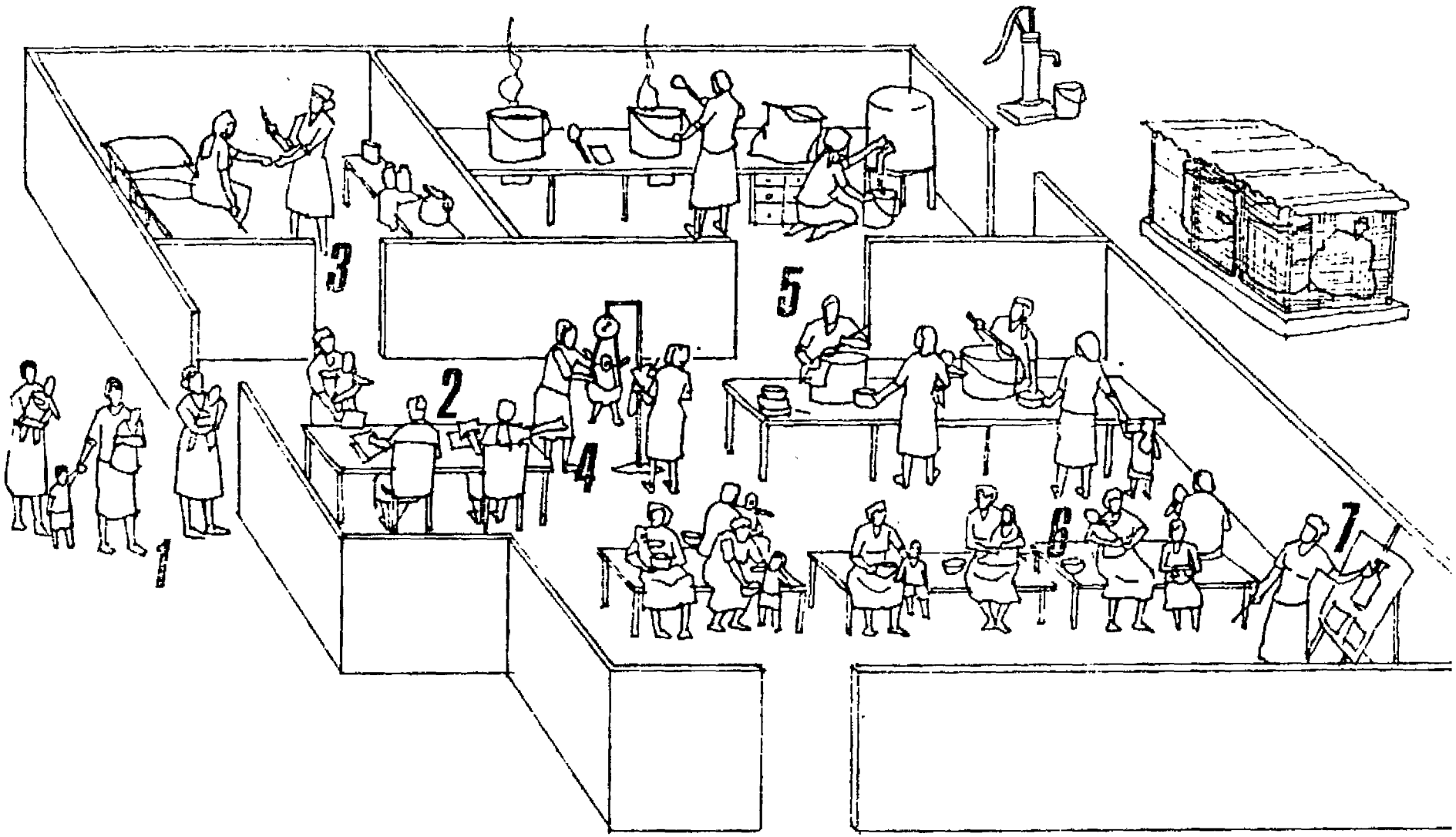

Figure 11-1. SFP Center Layout

a. Close to an outpatient clinic to facilitate cooperation between the 2 services.

b. Cater to not more than 3,000 participants.

12. Registration of participants

New admissions to the SFP should be advised to attend at a certain time for registration and individual advice.

A registration book should be kept in each center. This book is used to record the following information for each participant:

a. A registration number.

b. Name, age and sex.

c. Date of admission to the program.

d. Category (e.g. under 6 years, pregnant, etc.)

e. Referral source, if any (e.g. from clinic, etc.)

f. Group leader and household number (if available to facilitate home visits).

sisters or brothers, their cards may survive handling for an extended period of time. It is useful to have a combined card for feeding and follow-up.

14. Preventive Health Activities

Activities focused on prevention of disease should be initiated as soon as possible. The provision of adequate latrines, a water supply, and washing facilities is a basic requirement in any camp. It is as important as the provision of basic medical care.

In the NCH concept, the SFP is the focal point for most of the activities of the preventive health program which is run in close collaboration with other (curative) health activities.

Volunteer refugee workers should play a major role in every aspect of preventive health, and orientation and training schemes for extension workers should be initiated as soon as possible.

a. Home visiting outreach: Every household in the SFP catchment area should be visited to refer participants to the feeding center. Follow-up visits should be made at regular intervals, particularly where domestic problems have been

for the management of such programs, which should be carried out in complete cooperation with the camp medical coordinator.

c. Advisory room: this facility should be arranged for those with particular problems, e.g. malnourished children or women with failure of lactation. This allows time for special attention and advice and extra meals if necessary.

d. Assessment of progress of the malnourished: this entails the regular weighing of those classified as malnourished on admission to the program. This information must be recorded in the SFP register at 2-week intervals, and will be reviewed regularly by the nutrition coordinator.

e. Public Health Education: regular, informal, education sessions on health and nutrition for small groups of women should be organized. Discussions and practical demonstrations can cover a variety of topics (see Appendix 18).

f. Mass distribution of medicines such as vitamins, iron preparations and de-worming agents should be under the direction of the camp medical coordinator.

Organization for the management of the supplementary feeding program is as follows:

1. Camp Feeding Program Coordinators (FPC)

In each camp, a feeding coordinator should be appointed. The FPC in each camp is responsible for seeing that all feeding counters maintain a good standard of service. The FPC inspects the SFPs, their records, and their surveillance statistics.

2. Camp SFP Coordinating Committee

In larger camps, when 2 or more organizations are involved in the SFP, a coordinating committee will be established to coordinate activities and work out problems relating to the logistics, facilities, personnel, and quality of foods in the SFP.

3. Lead Agencies

If several agencies are providing supplementary feeding services at different sites in a camp, it is advisable to designate a lead agency in each of the camps to serve as the "model" agency for the delivery of services in that camp. All agencies in the camp offering supplementary feeding

Activities or programs which may be part of or linked to SFP's fall into 4 general categories:

1. Evaluation of the overall feeding program.

2. Provision of maternal-child health services and/or other services to high risk groups.

3. Data collection for disease surveillance, growth monitoring or program evaluation.

4. Education activities for nutrition and health.

1. Evaluating the Feeding Program

In evaluating the overall feeding program, it is important to answer the following questions:

a. Evaluation of supplementary feeding:

i. is program coverage (registration) in relation to identifiable needs high?
ii. is program participation high?
iii. is program follow-up (of non-participants) high?
iv. is program success (in terms of growth of numbers of participants) high?

b. Oral rehydration salts: SFP's can provide both ORS packets and education about diarrhea and ORS (see below) to mothers.

c. Prenatal Care: SFP's and prenatal care programs can work together to insure cross-referral and follow-up of specific problems. The SFP can be a site for a tetanus immunization program for pregnant women.

d. Screening and referrals for other health services:
   i. advisory feeding program (usually part of SFP)
   ii. therapeutic feeding programs (see Lesson 1)
   iii. inpatient or outpatient health facilities

e. Other programs as dictated by local conditions or disease control program needs.

3. <u>Data Collection for Disease Surveillance and for Program Evaluation.</u>

An SFP which has achieved a high population coverage can provide a large proportion of the health and nutrition information needed for disease surveillance and program management. This information falls into several categories.

4. Educational Activities

Because of the nature and target group(s) of an SFP an opportunity and obligation exists to provide health and nutrition education either as part of the SFP or closely coordinated with it. For example, the monitoring of child growth is an important way of evaluating the effect of the program and also of teaching the mother the relationship between good feeding and growth (Appendix 12 explains how to take and interpret body measurements).

The child should be weighed at least monthly, his weight recorded for the center's records and also plotted on a growth chart (see Appendix 13). If the mother keeps the chart (in a plastic bag) she can follow her child's progress and will be more likely to attend the center regularly, feed the child his rations and improve his home diet. Education activities fall into 3 broad categories:

A. Nutrition education

B. Health education

C. Training in SFP/Health activities

A. Nutrition Education