UNHCR The UN Refugee Agency | EMERGENCY HANDBOOK

Designing nutrition programmes in emergencies

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Key points

- In emergencies, where malnutrition is a concern, implement nutrition interventions to improve the immediate food security, health, and nutritional well-being of displaced populations
- Design the response to consider various factors influencing nutritional status, including environmental factors, Water Sanitation and Hygiene (WASH), access to health services, food and nutrition security, and shelter, with close collaboration among sectors
- Focus on stabilizing the situation and preventing/reducing malnutrition prevalence, especially among vulnerable groups like women and young children
- Take decisive actions to ensure access to safe and sufficient nutritious food, address acute malnutrition, tackle micronutrient deficiencies, and support optimal breastfeeding and appropriate complementary feeding of infants and young children during emergencies

1. Overview

Designing and managing nutrition programs in emergencies involves a range of interventions to prevent and treat malnutrition among displaced populations. A person's nutritional status is influenced by various factors, including access to safe and nutritious food, water sanitation and hygiene (WASH), public health services, and shelter. Where these are inadequate, the risk of malnutrition increases. The overall objective of the nutrition response in emergencies is to stabilize the situation, reduce malnutrition prevalence to acceptable levels, and improve nutrition opportunities, particularly for vulnerable groups like women and young children. To achieve this, nutrition sub-sectors work closely with public health, WASH, shelter, food security, and livelihoods sectors, to address immediate and underlying causes of malnutrition while seeking long-term solutions. Key nutrition-specific objectives include ensuring access to safe and

sufficient nutritious food, managing acute malnutrition, addressing micronutrient deficiencies, and supporting breastfeeding and appropriate complementary feeding practices.

2. Relevance for emergency operations

Interventions that prevent and treat malnutrition in emergency operations are of paramount importance due to their direct impact on the health and well-being of displaced populations, especially vulnerable groups like women and young children. By addressing malnutrition, these interventions prevent life-threatening deterioration of nutrition status and enhance the overall humanitarian response. By implementing comprehensive nutrition programs in conjunction with other sectors like public health, WASH, shelter, and food security, emergency operations take a holistic approach to tackle the root causes of malnutrition. This integrated approach not only stabilizes the nutrition situation during the crisis but also builds resilience within the affected communities, leading to a more sustainable and effective response in the long run. Furthermore, targeting the specific nutrition needs of vulnerable groups and promoting self-reliance through complementary feeding practices ensures a faster recovery and contributes significantly to efforts to prevent the crisis from exacerbating further.

3. Main guidance

1. Emergency Phase

As refugees continue to arrive, it is crucial to implement a comprehensive nutrition response plan to address the needs of vulnerable populations. This plan outlines key points to ensure rapid screening, estimation of people in need, and appropriate interventions to combat malnutrition and improve the nutrition situation among refugees. Additionally, coordination with relevant partners and regular monitoring are essential to achieve successful outcomes. Lastly, certain risks and challenges need to be considered to ensure the plan's effectiveness and sustainability.

Rapid nutrition screening: To ensure the well-being of refugees, upon arrival, conduct initial rapid nutrition screening to identify individuals at immediate risk. Continuously screen for acute malnutrition at transit, reception centres, and within the community to monitor the nutrition situation and to identify individuals who need treatment and or nutrition support. Refer to the sectoral coordination: UNHCR Public health tool kit for specific details.

Co-ordination with relevant sectors and partner/s: To facilitate a coordinated approach and maximize efficiency, establish strong coordination among public health subsectors including general health, reproductive health, mental health and psychosocial support and nutrition programs to ensure seamless coverage of all needs. Collaboration with education, WASH, Shelter, Protection is also crucial. Facilitate referrals and individual follow-ups to ensure continuity of care.

Estimating people in need: To accurately assess the scale of nutrition assistance required, gather relevant data from registration section or UNHCR ProGres to determine the target group

proportions, including, children aged 0-6 months; children aged 6-23 months; children aged 0-59 months and pregnant and breastfeeding women. If disaggregated data for children aged 0-59 months is unavailable, assume this group represents 20% of the population. Assume that among children aged 0-59 months 10% are aged 0-6 months and 30% are aged 6-23 months. Assume 7% of the total population are pregnant and breastfeeding women, with 4% being pregnant.

Estimating the number of people in need of nutrition assistance: To determine the extent of nutrition assistance required, use the prevalence of Global Acute Malnutrition (GAM) along with standard thresholds and historical data to estimate the number of people in need. Focus attention on refugee situations categorized as of medium to extremely high concern for malnutrition, breastfeeding, and food consumption to guide decision-making. See the various severity categorisation under the standards and indicators annex.

Estimating the **prevalence of Global Acute Malnutrition (GAM)** for a response plan over 12 months: To plan for a sustained response, obtain prevalence estimates of GAM from reliable nutrition surveys such as SENS (Standardized Expanded Nutrition Survey), SMART (Standardized Monitoring and Assessment of Relief and Transitions), or MICS (Multi Indicator Cluster Survey). If only MUAC (Mid-Upper Arm Circumference) data is available from rapid assessments, use the proportion of children with MUAC <12.5cm (MUAC malnutrition) as the estimated prevalence. Use the prevalence and estimated incidence to calculate the total number of people to be included in the response plan for 12 months. If incidence data is not available at the beginning of an emergency, apply an incidence correction factor of 2.6 for both severe and moderate acute malnutrition. Calculate specific incidence estimates using longitudinal program data when programs have been running for 6-12 months, and heterogeneous conditions are expected. See additional details under the standards and indicators section.

Key nutrition-specific interventions: To ensure adequate nutrition for all refugees, ensure access to safe and sufficient nutritious food through in-kind or cash assistance. Provide dry ready-to-eat meals (e.g., high energy biscuits) and water in the first 72 hours at border points, hot meals at transit/reception centres, and general ration when cooking is possible at the household level. Offer targeted complementary food as indicated for groups with increased nutrition needs, such as pregnant and breastfeeding women, children under five, and people living with chronic diseases (e.g., HIV/TB). This can be through blanket supplementary feeding or cash for nutrition. Support optimal breastfeeding practices and appropriate complementary feeding for infants and young children. Micronutrients reduction initiatives like Vitamin A supplementation among children, iron and folate supplementation among pregnant and breastfeeding women and deworming should also be considered as indicated by the context.

Monitoring the nutrition situation: To track progress and respond to emerging needs effectively, regular monitoring should be established to track changes in nutrition status and effectiveness of interventions in place. Conduct follow-up assessments to measure the impact of interventions and adjust strategies as needed. Ensure collaboration with other sectors and stakeholders for integrated data collection, joint monitoring, analysis and feedback to inform coordinated responses.

Related risks:

- Inadequate resources or a shortage of skilled personnel will curtail an effective nutrition response including for example hindering comprehensive screening, leading to potential undetected cases of malnutrition and subsequent increased risk of disease and deaths.
- Lack of communication and collaboration among partners may result in fragmented services and gaps in the nutrition response.
- Reliance on incomplete or inaccurate data may lead to an underestimation or overestimation of the population in need, impacting resource allocation.
- Solely relying on historical data may not account for changing conditions or emerging nutrition challenges.
- Limited access to accurate survey data may affect the precision of prevalence estimates.
- Supply chain disruptions or logistical challenges may hinder the timely delivery of food and nutrition supplies.
- Inconsistent monitoring or insufficient data collection may impede the ability to track progress and identify emerging nutrition concerns.

Post emergency phase

As the emergency progresses to the post-emergency phase, collaborate with development partners and local authorities to ensure a smooth transition and sustainable nutrition solutions for the affected population while proactively integrating inclusive approaches into national systems from the outset to enhance long-term resilience and equity.

Checklist for Designing nutrition programmes in emergencies

- Conduct rapid nutrition screening among new arrivals and ensure continuous screening.
- Gather data on target groups in need of assistance.
- Estimate the number of people in need based on GAM prevalence, food security situation and identified infant and young child feeding issues.
- Provide safe and sufficient nutritious food through in-kind or cash assistance.
- Provide complementary food and micronutrient supplements to vulnerable groups with increased nutrition support needs.
- Support optimal breastfeeding and appropriate complementary feeding.

- Coordinate with relevant partners and use key tools for planning.

- Monitor the nutrition situation to review progress and adapt response to the evolving situation.

4. Standards

Interpretation of key nutrition indicators to guide decision-making on addressing acute malnutrition in the short and long term.

Severity scale	Low	Medium	High	Very High	Extremely high
	Acceptable /Minimal	Alert/Stress	Serious/Severe	Critical/Extreme	Extremely critical / Catastrophic
Prevalence of GAM based on WHZ<-2 and/or bilateral pitting oedema among children 0-59 months	< 5%	5.0 to 9.9%	10.0 to 14.9%	15.0 to 29.9%	≥30%
Prevalence of GAM based on MUAC <125mm and/or bilateral pitting oedema among children 6-59 months	<5%	5 to 9.9%		10 to 14.9%	≥15%
Prevalence of GAM based on MUAC <210/230mm among Pregnant and Lactating Women (PLW)	<12.6%	12.6-19.9%	20-24.9%	25-34.9%	>35%
Prevalence of stunting based on HAZ <-2 among children U5	<2.5	2.5 to 9.9%	10.0 to 19.9%	20.0 to 29.9%	≥30%
Prevalence of anaemia (Hb <11g/dL) in children 6-59 months	< 5%	5.0 to 19.9%	20.0 to 39.9%	≥40%	
Prevalence of anaemia (Hb <11g/dL) in women	< 5%	5.0 to 19.9%	20.0 to 39.9%	≥40%	
Exclusive breastfeeding for infants 0-5 months	>70%	50-70%	30-49.9%	11-29.9%	<11%
Infants 0-5 months that are not breastfed who have access to Breast Milk Substitutes supplies and support in line with the Code and the IFE Operational Guidance's standards and recommendations	>60%	40-60%	20-39.9%	10-19%	<10%
Food consumption score	Acceptable and stable	Acceptable but deterioration from typical	Borderline	Poor	Poor

Source : https://www.nutritioncluster.net/resources/nutrition-humanitarian-needs...

Key formula for estimating people in need of nutrition assistance.

Severe acute malnutrition cases for under five children (with and without medical complications) Number of SAM children 6-59 months in need treatment (SC and OTP) = SAM prevalence x population of children 6-59 months x K (SAM incident factor)

Moderate acute malnutrition cases for under five children Number of MAM children 6-59 months in need = MAM prevalence x population of children 6-59 months x K (MAM incident factor)

Severe acute malnutrition cases for women (without medical complications) Number of SAM PLW in need = SAM prevalence x population of PLW

Moderate acute malnutrition cases for pregnant and lactating women Number of MAM PLW in need = MAM prevalence x population of PLW

Exclusive breastfeeding (EBF) in emergencies for children 0-6 months Number of children 0-5 months in need of EBF support = Population figures x % of children 0-5 months x (1- EBF proportion)

Women (pregnant and lactating) in need of feeding counselling and support Number of PLW counselled (one-on-one) on IYCF = Population figures x % of PLW x Proportion of PLW individually counselled on IYCF

Children in need of supplemental feeding support to prevent malnutrition Number of children 6-23 months in need of Blanket Supplementary Feeding Program (BSFP) or Fortified Nutrition Supplement (FNS) = Population of children aged 6-23 months x Expected coverage for BSFP or FNS

Pregnant and lactating women in need of supplemental food support to prevent malnutrition Number of MAM PLW in need of BSFP or High Energy Biscuits (HEB) = population of PLW x Expected coverage for BSFP or HEB

Annexes

Global Nutrition cluster/UNICEF/USAID, Nutrition humanitarian needs analysis guidance, 2018

UNHCR, UNICEF, WFP and WHO, Food and nutrition needs in emergencies, 2004

The Sphere Handbook, 2018

5. Links

NutVal.Net WHO, Food and nutrition needs in emergencies Harmonised Training Package (HTP): Resource material for training and learning ... Sphere handbook- Food security and nutrition

6. Main contacts

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