



Federal Ministry of Health Sudan

**RAPID NUTRITION ASSESSMENT
GUIDELINES**

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Developed with support from



Rapid Nutrition Assessment Tool for Sudan

**Developed by the Ministry of Health with support from UNICEF and the Nutrition
Coordination group in Khartoum.**

Overview:

Rapid assessment tools are essential in countries with high vulnerability to shocks where populations are at risk of malnutrition. This is particularly relevant in Sudan with recurrent shocks such as ongoing conflict and natural disaster (drought, flooding, locusts etc). They provide a means of identifying in a very short space of time areas of risk of malnutrition, the need for a more detailed assessment such as a nutrition survey and the need for emergency interventions.

Criteria:

This tool aims to be used in situations where concern has been raised over the nutritional situation, such as recent displacement, or previously inaccessible areas becoming accessible, or additional shocks such as floods, drought etc. In addition if an agency have phased out of an area and want to monitor if there is a need to re establish programmes then this can be used. This tool can be used in assessment lasting from a few hours to a few days depending on the size of the team and the level of information available. In addition it can be used for one or more villages/camps again depending on the time and size of team available

Team:

Ideally **the tools should only be used by experienced and trained nutrition staff**. At a minimum at least one experienced nutritionist should lead the assessment with a team of pre-trained colleagues to do the data collection. However where necessary community health workers can be trained on the ground on the day if the size of the assessment area and population warrants many staff members. Often when conducting a rapid assessment there is limited time or space to carry many team members so this needs to be taken into account. However it is **essential** that whoever is leading the assessment ensures that all those collecting data are appropriately trained, particularly because MUAC and oedema measurements can be very subjective. For the questions on food security, health and water and sanitation again it is necessary to have a member of the team with experience in participatory rural techniques in order to get good quality reliable data.

Methodology:

The most appropriate method for determining nutritional status in a rapid assessment is using **MUAC** both for children from 1 to 5 years, checking for oedema and if there is sufficient time and staff and a concern then also for pregnant and breast feeding mothers. In addition to nutrition, key informant interview and focus group discussions need to be held to gather additional information of health, food security, water and sanitation, child care practices and security where relevant.

Unlike nutrition surveys the sampling does not have to be done in a statistically significant way. However the following steps have been identified to give a rough estimate of the nutritional situation using MUAC: *(A tally sheet for both children and pregnant and breast feeding mothers is provided in annex 1 and 2)*

- 1 Children 1-5years can also be roughly estimated to measure between **75-110cm**. Therefore in order to reduce the time identifying the correct age, which is not always easy, a pole can be made marked with the height of both 75 and 110cm for ease of selection.
2. On arrival in the location initially estimate the total number of the households in the village/ camp though discussions with the sheikhs/ camp coordinators:
 - If the **total** number of households is **less than 100** - go to ALL households and measure the MUAC of the ALL children aged 1-5 years (75-110cm)
 - If the **total** number of **households is >100** – randomly select 100 children 1-5yrs – this can be done by going to the edge of the settlement/ camp/village and traveling from one

edge to the far side and measure ALL the children in the households to your right along that line.

- If 100 children are not reached when you get to the edge of town then change direction and follow a different line from the edge of town and repeat this until a total of 100 children are measured. This will ensure the new arrivals on the outskirts of towns are included as well as those in the centre.
 - If there are insufficient staff and time to cover 100 children then cover as many children as is possible in the time available. Aim to do so randomly and by visiting the households to measure the children. Do not collect all the children in one location (to avoid bias towards children who can walk).
2. MUAC must only be taken on the **LEFT** arm
 3. All children should also be checked for oedema - if a case is suspected then this **MUST** be confirmed by the team leader. If it essential that all staff are well trained in checking for oedema. If a child has bilateral oedema (on both feet/legs) then the MUAC should not be taken and the child should be recorded in the “oedema” column of the tallysheet only.
 4. To avoid repeating a measurement on the same child when there are more than one measurers - a marker pen can be used to leave a visible small mark on the child once measured such as on the left upper arm or fingernails.
 5. If information on the pregnant and breast feeding mothers nutritional status is required then the mothers of the children measured can also be measured.
 6. During this walk observations on the living conditions, food availability and preparation, asset ownership, water and sanitation facilities etc should be taken into consideration which can then be discussed when holding an informal FGD or KI interview
 7. If any severely malnourished children are discovered they should be referred to the nearest facility or agency responsible for therapeutic care for treatment immediately. The team should have already decided on a process for this before the assessment goes ahead and if possible carry with them referral papers so that the centre knows that they were referred from the assessment team.

Additional Information

Nutrition data in isolation is not sufficient to determine the situation of the affected populations and what type of assistance if any is needed therefore additional question relating to food security, water and sanitation, health, shelter and security need to be included to provide a more holistic picture of the situation and therefore lead to a more appropriate analysis. Many rapid assessments will be multi sectoral so there may be experts from the other sectors to compliment the nutrition sector however in some cases this may not be the case. There are plans to consolidate a more comprehensive rapid assessment tool with inputs from food security and health sections in the near future (FAO, WHO) but until then the Sphere handbook - Minimum Standards in Disaster Response, 2004 Edition has very useful checklists for Health, Water and Sanitation, Shelter and Non food items, Nutrition and Food Security, all of which are available in the annexes of each chapter mentioned. If copies of the checklist are required they can be available from UNICEF. Below is an outline questions from the nutrition checklist - they are included in the draft reporting format. These questions can be asked though a key informant interview when related to specific topics like the health situation, access to water, market prices and agriculture, and can be cross checked in a focus group discussion with a cross section of members of the community. Again staff conducting focus group discussions should have previous experience in doing so as experience and skills are required to guide the discussion and obtain the information needed without simply asking a list of questions.

The Sphere Nutrition Checklist Questions are broken down into 6 categories:

1. What information on the current nutritional status exists? (e.g. any recent nutrition surveys, feeding centre statistics, health centre statistics)
2. What is the risk of malnutrition related to poor public health? (any disease outbreaks, estimated measles and Vitamin A vaccination coverage, mortality rates, seasonal disease – malaria, diarrhoea, prevalence of HIV/AIDS etc)
3. What is the risk of malnutrition related to inadequate care (change in women’s work patterns, change in composition of the household, infant feeding practices, access to baby food, HIV/AIDS)

4. What is the risk of malnutrition related to reduced food access? (how do households normally access food, how has this been affected by the shock, did they carry any assets with them, how do they get money, are there any markets available, what is for sale, what prices etc)
5. What formal and informal local structures exist through which potential interventions could be channeled (capacity of MoH, other local international Organisations, UN agencies, CBO, what is the available in the food pipeline, are the population likely to move in the near future - conflict, pastoralist etc)
6. What nutrition or community interventions were in place before the shock that could be supported?

Reporting:

Reports should be short and should be released within 1-2 days of the rapid assessment being completed, especially if the situation is of concern. A draft template is shown in Annex 3 and outlines the key areas to be covered in the report.

When reporting on the nutritional status it is essential to report both the absolute numbers and percentage of each cut-off point in MUAC. However the numbers **MUST NEVER BE REPORTED IN % GLOBAL ACUTE MALNUTRITION or % SEVERE ACUTE MALNUTRITION**. This classification can only be reserved for a statistically significant nutrition surveys otherwise the figures may be quoted out of context and therefore misinterpreted.

Reports must always state the methodology, the tools used and that this is a rapid assessment, therefore cannot be interpreted in a statistically significant manner. Where necessary if the rapid assessment is indicating an area of concern, recommendations for a more detailed assessment such as a nutrition surveys should be made.

Discussion and dissemination of findings:

The findings of the rapid assessment should be shared with the MoH, UNICEF and other actors as necessary – usually this will include all members of the Nutrition Coordination meeting (WFP, WHO, NGOs working in the area). Other relevant stakeholders should be informed about the assessment findings particularly if there are recommendations related to their area of expertise, eg WES, MoSW.

Annex 1

Tally Sheet for Rapid MUAC Screening of Children 1- 5 years of Age.

Name Village / Camp / Location: _____ Date: _____ Name of Screener: _____

Children under 5years (MUAC only to be measured on children 1 year and above or 75-110cm standing)

<11cm	11-12.4cm	12.5-13.4cm	>/=13.5cm	Oedema	Clinical signs (under 1 yr)
Total	Total	Total	Total	Total	Total

Total number of children screened: _____

Total Number children referred for SFP: _____

Total number children referred for TFC: _____

Annex 2.

Tally Sheet for Rapid MUAC Screening of Pregnant/ Lactating Women.

Name of Village: _____

Date: _____

Name of Screener: _____

Always measure MUAC on the left arm

<18.5cm	18.5-21.4cm	21.5-22.4cm	>/=22.5cm
Total	Total	Total	Total

Total number women screened: _____

Total Number women referred for SFP: _____

Annex 3

Example Report Summary Table

Village / Camp	
Locality	
State	
Team/ Agency carrying out assessment	
Name of report author	
Date of Rapid Assessment	

Overview of recent events leading to need for rapid assessment (provide numbers if recent displacement)	
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Methodology followed Team composition Sampling procedure Sample size & makeup Training	
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Health Situation: Top 3 current illnesses Any recent outbreaks Health services available	
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Water: Source, Quality, Quantity of drinking water currently available.	
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Sanitation: Facilities available Facilities being used	
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Social and care environment: Vulnerable groups – who, where? Caring practices Gaps	
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Shelter: Condition of shelters inhabited, adequacy in terms of size, current climatic conditions, etc	
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Food Security Livelihood strategies (now & before the event) Sources of food now Different foods being consumed now Sources of income now Any threats or risks associated with these	
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Current nutritional status in surrounding area or original population: (previous surveys, feeding centre statistics etc) Reference sources	
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Current partners on the ground and activities NGO, UN, Govt agencies are on the ground and what services are being provided. Gaps and overlaps.	Agencies:	Activities:
Nutrition Programmes Closest for referral (agency, location). Recent trends in admissions /recovery/ defaulters etc. Any support needed	Supplementary	Therapeutic (inpatient TFC or outpatient OTP)

Food aid Date of last distribution:	Ration size: Cereal Pulses Oil CSB Salt	Coverage: (no / % of hhs targeted)
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Summary of Nutrition Status: - Children 1 to 5 years

MUAC (cm)	Nutritional status	Number	%
>13.4cm	OK		
12.5cm to 13.4cm	At risk of Malnutrition		
11.0cm to 12.4cm	Moderate Malnutrition		
< 11.0 cm	Severe Malnutrition		
Oedema	Severe Malnutrition		

Summary of Nutrition Status: - Pregnant and lactating women

MUAC (cm)	Nutritional status	Number	%
>22.5cm	OK		
21.5cm to 22.4cm	At risk of Malnutrition		
18.5cm to 21.4cm	Moderate Malnutrition		
< 18.5 cm	Severe Malnutrition		
Oedema (bilateral)	Severe Malnutrition or other health problem		

Main Problems Identified: (summarise the key findings)

Time bound Recommendations for Follow Up: (this can be for all sectors it does not have to be agency or sector specific)