

# Acute Malnutrition in Protracted Refugee Situations: **A Global Strategy** UNHCR/WFP

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## Acronyms

AIDS	Acquired Immune-deficiency virus
ANC	Ante-Natal Care
ARRA	Administration for Refugee and Returnee Affairs
BFP	Blanket Feeding Programme
CHW's	Community Health Workers
CRC	Convention of Rights of the Child
CSB	Corn Soya Blend
DALY's	Disability-Adjusted Life Years
DFID	Department for International Development
EDS	Extended delivery Points
EXCOM	Executive Committee of UNHCR
FBF	Fortified Blended Foods
FGM	Female Genital Mutilation
GAM	Global Acute Malnutrition
IGA	Income Generating Activities
IP's	Implementing Partners
ITN's	Insecticide treated Nets
JAM	Joint Assessment Mission
MDG's	Millennium Development Goals
MND	Micro-nutrient Deficiency Disease
NFI	Non Food Items
NGO's	Non Governmental Organizations
PLWHA	People Living with HIV/AIDs
RDA	Recommended Daily Allowance
RUTF	Ready to Use foods
SBGV	Sexually Based Gender Violence
SFP	Supplementary Feeding Programme
TFP	Therapeutic Feeding Programme
UNHCR	UN High Commissioner for Refugees
UNICEF	United Nations Children Fund
VCT	Voluntary Counselling and Testing

WFP	World Food Programme
W/H	Weight for Height
WHO	World Health Organization

## Executive Summary

### Introduction:

This Global Strategy Report is the product of two independent international food security and nutrition experts hired by UNHCR and WFP to develop a global strategy to address acute malnutrition rates in protracted refugee situations<sup>1</sup>. This report represents the global aspect of a three part mission that assessed and reviewed the food security and nutritional situation in Kenya and Ethiopia between the 17<sup>th</sup> of November and the 17<sup>th</sup> of December 2005. The two country reports<sup>2</sup> can be obtained from UNHCR/WFP Headquarters. The mission and subsequent reports came out of a concern by both UNHCR and WFP over high malnutrition rates including micronutrient deficiencies (hidden hunger) among refugee women and children. Continuing gaps in the provision of food to meet all of the refugees' daily needs, including macronutrient and micronutrient requirements, and provision of related non-food needs, are unwelcome realities in many operations throughout the world. As such, a joint UNHCR/WFP session on malnutrition was held during UNHCR EXCOM in October 2005 where the worrying trends and consequences of increasing acute malnutrition amongst refugees in selected camps were discussed in-depth.<sup>3</sup> In the opening statement to the EXCOM, the High Commissioner Antonio Guterres said that tackling malnutrition would be a priority goal for UNHCR in 2006, a sentiment seconded by the Executive Director of WFP, James Morris.

**“Many refugees in Africa and Asia live in a unique harsh environment for extended periods while being heavily dependent on continuous international food, and other forms of assistance, often confined to camps. The international support needed to sustain their basic livelihoods has not always been forthcoming. These situations create precarious nutrition and protection situations.”**

**-Oluseyi Bajulaiye, Deputy Director of UNHCR Africa Bureau, EXCOM Nutrition Session<sup>4</sup>**

Consequently, prevention of malnutrition in refugee settings is included in the UNHCR High Commissioner's strategic objectives of 2006, 2007-2009.

In preparation for the mission, the Country offices of UNHCR/WFP in Ethiopia and Kenya drafted their own papers to assess the current problems surrounding malnutrition and examining specifically the use of complimentary foods to address the nutritional crisis. This mission was able to use those papers as a statement of many of the current nutritional and technical issues overwhelming the country offices, and the papers provided a background to and analysis of many of the issues addressed in this report.<sup>5</sup>

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<sup>1</sup> Refugee situations that have existed more than five years. UNHCR EXCOM.

<sup>2</sup>Addressing High Malnutrition Rates in Protracted Refugee Situations: The Nutrition and Food Security Situation in Selected Refugee Camps in Ethiopia: .A Joint UNHCR and WFP Mission from 2<sup>nd</sup> to 16<sup>th</sup> of December, 2005 Corbett and Oman, January 2006 and Addressing High Malnutrition Rates in Protracted Refugee Situations: The Nutrition and Food Security Situation in Selected Refugee Camps in Kenya: .A Joint UNHCR and WFP Mission from 2<sup>nd</sup> to 16<sup>th</sup> of December, 2005 Corbett and Oman, January 2006

<sup>3</sup> TOR for the 2005 Mission

<sup>4</sup> TOR for the 2005 Mission

<sup>5</sup> Nutritional Strategy papers, UNHCR/WFP Kenya and Ethiopia, October/November 2005

## **Objectives of the Report:**

The mission objectives were to assess the current provision of food, nutrition and related services to the refugees in Kenya and Ethiopia and to determine why there appears to be persistent high rates of malnutrition in these protracted refugee situations. It examined the interwoven issues of food security, self-reliance, health infrastructure, material support and other needs to determine the underlying causes of nutritional insecurity amongst the refugees. The mission then, using the Kenya and Ethiopia case-studies, has attempted to draw out commonalities in order to produce a global strategy paper that begins to address the nutritional needs of refugee children in particular.

## **Findings:**

The global strategies or recommendations of the mission address the fourteen central points or *issues*. The detailed case-specific recommendations for Kenya and Ethiopia are extensive and can be found within those two reports. The global strategies cover the following primary areas of concern: Technical Capacity; Nutritional Surveys/Surveillance and Monitoring; Infant Feeding Practices; Curative and Preventative Care; Treatment of Malnutrition; Malaria; Anaemia; HIV/AIDS and nutrition; Ration Adequacy; Ration Acceptability; Ration Management; Non-Food Needs; Self-Reliance Initiatives; and Gender Equality and Empowerment. As must be sadly acknowledged, there is simply not a single silver bullet that will instantly eradicate malnutrition from the refugee camps. The problem as well as the solution is multi-faceted, and each agency must address, to the fullest extent possible, the issues of direct concern to that agency. It is only through a strong group effort and a holistic approach that malnutrition can be addressed in the refugee camps worldwide. The mission would respectfully conclude that the high rates of malnutrition can no longer be accepted and that there is a responsibility to each malnourished woman, child and all other groups to improve their current lives and future by addressing these recommendations as a matter of urgency. The high rates of malnutrition need to be viewed as not a just a new health issue but as a serious protection and access to basic rights failure.

### **The common findings amongst protracted refugee situations with high levels of acute malnutrition include:**

1. Higher than acceptable rates of acute malnutrition are present in many protracted refugee camps, most notably Kenya, Ethiopia, Sudan, and some camps in Sierra Leone and Chad.
2. The anaemia levels for children and women in protracted refugee situations worldwide are higher than WHO standards for *severe public health issue* and must be addressed through provision of iron/folate as well as improved iron content and vitamin C in the diet.
3. There is insufficient nutritional technical support or nutritional expertise being given to Country/Regional programs by UNHCR and WFP. Joint Assessment Mission do not always have the benefit of a nutrition expert and often focus more on political issues related to durable solutions and refugee influx than on the malnutrition situation in the camps. There is often very poor follow-up to nutrition-related recommendations from JAM and nutritional surveys.

4. WFP Country Offices need/want enhanced headquarters support in making nutritional decisions, particularly in light reviewing the nutritional reports, handling pipeline breaks or addressing refugee needs in light of commodity absence/shortfalls.
5. There is often no comprehensive nutritional surveillance system or growth monitoring occurring in the camps, either due to poor implementing partner capacity or poor UNHCR technical assistance at country/regional levels.
6. Appropriate infant feeding practices that protect infants and promote their health are not being implemented due to poor training, lack of clear guidelines or lack of assessment of the problem. There is also a lack of appropriate weaning foods available to young children.
7. The nutritional services including selective feeding programs, infant feeding, community health worker outreach and nutritional education are not following standardized guidelines nor do they have sufficient coverage to support the refugee needs. There is often a low level of confidence in the health services, due to insufficient or inequitable care. This is often due to implementing partner capacity or lack of UNHCR technical assistance.
8. Water quality and quantity in many camps is well-below SPHERE minimum standards. The impact of water shortages on all aspects of nutrition cannot be underestimated (diarrhoeal diseases, water for cooking, water for drinking, water for basic hygiene and sanitation).
9. The level of morbidity and mortality associated with malaria is exceedingly high, with inadequate prevention of malaria and little adherence to international guidelines and protocols. The malaria burden in terms of anaemia, chronic poor health and eventual death cannot be over exaggerated.
10. HIV/AIDs nutritional support, advocacy, outreach and information are insufficient. Nutritional programs to support PLWHA need to be standardized and community support for the family should become routine.
11. The micronutrient quality of the ration in many protracted refugee situation is below standards in several key areas. Camps situated in dry or harsh environments or where land access is severely curtailed, must be given a ration that supports their food needs, *including micronutrients*. In many camps with acute malnutrition, there has not been the addition of **fortified blended foods (such as CSB or fortified wheat flour)** or **complimentary foods** by WFP or UNHCR. This must become standard.
12. The refugee caloric intake is well below minimum standards due in part to low acceptability of the ration and in part to sale of the ration to purchase other food and non-food items.
13. The incomplete food basket, inconsistent pipeline and late delivery of food have all contributed significantly to refugee malnutrition.
14. In some programs, the distribution system is not being monitored by WFP/UNHCR consistently which allows for food leakage, under/over scooping, multiple ration cards and food mismanagement.
15. In many programs, the provision of non-food items is well below minimum standards, including firewood, shelter materials and essential household needs. The provision of basic clothing is often very poor and falls far below SPHERE minimum standards<sup>6</sup>
16. Milling services and milling costs are not being sufficiently provided and having a negative impact on refugee food quantity.<sup>7</sup>

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<sup>6</sup> Review of documentation, interview of staff and personal observation, SPHERE Standards section 4, Right to Adequate Housing including NFI and Clothes.

<sup>7</sup> See MOU on milling obligations

17. Opportunities for refugee income generation or self-reliance strategies are basically insignificant. The small programs that are ongoing face severe or complete budget reductions.<sup>8</sup> This includes micro-agricultural initiatives and the provision of adequate land, seeds and tools.
18. There is an increase in negative coping strategies to meet dietary and economic needs including child labour, prostitution, illegal activities, and early marriage with associated bride prices.
19. Refugee girls and women face increasingly difficult daily lives and are disproportionately affected by proposed budget cuts in community services, IGA, micro-agricultural initiatives, firewood provision and anti-sexually based violence initiatives.
20. School feeding initiatives needs to encourage more broadly the continued enrolment of girls. Many girls leave school at an early age due to cultural pressures which negatively impacts on their future health status.
21. Girl-specific health issues such as FGM, SBGV, sanitary needs and pre-pregnancy counselling are seen as non-essential programs and often cut during budget shortfalls.

In conclusion, the current situation in many camps worldwide is dire, with special reference of this mission to camps in Kenya and Ethiopia. The current quality of life is very miserable and refugees face incredible daily hardships to meet their basic life needs and rights to food, water, shelter, non-food items, education and health. The Mission, after reviewing the program, would ask how the malnutrition situation could possibly **not** be so high considering the poor provision of essential goods and services. This is a highly dependent and vulnerable caseload that is entirely at the mercy of UNHCR, WFP and the Implementing Partners to meet their basic needs. They have no income, yet are faulted for selling the ration to help diversify a poor and monotonous vegetarian diet. They are given insufficient NFIs, yet are faulted for selling the ration to buy essential household goods. They are not provided with cooking fuel, so they face selling the ration or risking their safety to forage themselves. They want to grow vegetables to diversify the diet, yet are given no land, seeds or tools to support it. They want to work, but are often given no opportunity except for illegal activities that put them further at risk. The refugees in protracted refugee situations have been living in camps for as long as twenty years, many of course born in the refugee camps. If these children are malnourished, it is **our** responsibility, for not supporting them and their families sufficiently in terms of food and non-food needs, nutritional services, health education and outreach, water and sanitation. For not allowing their parents means by which to feed and cloth them through income generation, gardening and self-reliance activities. And for not allowing refugees the dignity of a basic quality of life for development and protection.

## Background

For many years there has been concern about the health of encamped refugees, particularly those in protracted situations who have neither the option to return home nor the support and opportunity to live in health and productivity in the country of asylum. While emergency operations can garner international focus and donations, protracted refugee situations are often incredible resource drains, demanding support for large populations to live under a care and maintenance situations year after year. Unfortunately, the nutrition and livelihood needs of refugees in protracted situations are often no less complex and extensive than refugees in

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<sup>8</sup> UNHCR Budget Review Document, IP interviews



an acute emergency. If refugees are encamped, with restrictions placed on their movement and access to livelihood activities, the high level of dependency that marked the initial emergency will continue year after year. While there is a common expectation among assisting agencies that refugees will need less attention, food and support as the years go on, the reality is actually to the contrary. Stop-gap measures to assist refugees in the short term such as plastic sheeting instead of durable shelter materials or firewood instead of alternative fuel sourcing, end up being costly both in terms of continued need for replacement as well as the further cost to refugees in terms of ill-health and the burden of disease and disability.

The complexity of these issues has not been lost on UNHCR. In 30<sup>th</sup> Meeting of the Standing Committee, the Executive Committee of the High Commissioner's Programme developed a paper on Protracted Refugee Situations. Within the paper, the challenges, consequences and responses to the problem is addressed. The paper acknowledges that protracted refugee situations are very difficult for all actors, including the host country, the international agencies and particularly the refugees.

- If it is true that camps save lives in the emergency phase, it is also true that, as the years go by, they progressively waste these same lives. A refugee may be able to receive assistance, but is prevented from enjoying those rights- for example the freedom of movement, employment, and in some cases education- that would enable him or her to become a productive member of society.  
-Protracted refugee situations also waste lives by perpetuating poverty...Poverty can lead refugees, as well as other, to resort to a gamut of negative survival tactics, such as child labour, the degradation of the environment or prostitution.  
-The prolongation of refugees' dependence on external assistance also squanders precious resources of host countries, donors and refugees. Spending on long term situations are often characterized by what has been termed the 'plastic sheeting syndrome' ...Spending on short-term fixes, however, yields only fictitious savings. Spending on care and maintenance, rather than on solutions, while often necessary, is a recurring expense, and not an investment in the future. It can only ensure that such situations are perpetuated, not solved.  
- From UNHCR Protracted Refugee Situations, 30<sup>th</sup> Meeting of the Standing Committee p4

However difficult the reality of protracted refugee situations, the obligations to those refugees who find themselves living in a camp in host country for years on end, are very real and pressing. Refugees have the right to assistance and to be supported at the minimum level of standards and failure of the international community to meet these basic obligations is unacceptable.

Concern over the high rates of acute malnutrition including micronutrient deficiencies in protracted refugee situations was the impetus for this Mission. A joint UNHCR/WFP commitment to understand the causes of malnutrition and develop a global strategy to addresses these causes is a priority issue for both agencies in 2006. The Mission has sought to identify the gaps in the current provision of services in context of the priority needs of the refugees and to develop a series of recommendations that can form a global strategy plan to help reduce the level of malnutrition to within the 10% or below rate in operations with high acute malnutrition rates that The High Commissioner for Refugees has set as a measurable target for UNHCR in 2006.

## **Justification:**

### **Global implications of malnutrition**

Worldwide malnutrition is an extremely serious issue particularly affecting the under five population. It is estimated that half the 12 million under five deaths that occur worldwide are associated with malnutrition<sup>9</sup>. Malnutrition is a consequence of poverty and also leads to poverty. Even children with mild malnutrition are at between 2-8 times higher risk of mortality from common childhood illnesses than normally nourished children. The toll of malnutrition is that it causes death and long-term disability in whole populations.

Malnutrition is a consequence of not enough quantity of the right nutritious food, ill-health and underlying factors such as environmental health (water/sanitation), poor health infrastructure and the caring practices within the home and community. It leads to both macro and micro nutrient deficiencies. Diet deficient in macronutrient such as protein, carbohydrates and fats or deficient in key micronutrients both lead to “wasting”, where the child is much thinner than for its height or age, and sometimes nutritional oedema known as Kwashiorkor. Micronutrient deficiencies is often called “silent malnutrition”, as it is not visible at all for some of the micronutrient deficiencies (type II deficiency) or until the deficiency is very severe with clinical signs and symptoms (type I deficiency) such as anaemia, scurvy or iodine deficiency.

In protracted refugee situations where the population is often extremely dependant on the humanitarian assistance and food aid, the value of the food will greatly determine their nutritional status. It is essential that highly dependent refugee populations are given sufficient macro and micro nutrients to support growth and development. It is no longer appropriate to just discuss kilocalories, fat and protein; micronutrients must be included in sufficient quantities if the food basket is to fully support the refugee nutrition needs. While sufficient food in quality and quantities is essential, it is not the only factor in health and nutritional security. Infant feeding practices, access to sufficient health services, clean and ample water, access to fuel, clothing and cooking equipment are all implicated alongside inadequate food as causes of endemic malnutrition. The long-term consequences of an inadequate varied diet, poor caring practices and poor infrastructure often leads to intergenerational malnutrition. A newborn baby girl with a low-birth weight, if she survives is likely to remain underweight, may have stunting (chronic malnutrition), become pregnant in early adolescent life and produce an underweight baby. Therefore it is extremely important to tackle malnutrition in particular in the under-five population and women, and in particular pregnant and lactating women.

Anaemia due to iron deficiency is a major public health issue worldwide. Every age group is vulnerable. It impairs cognitive development in children and affects the immune system. During pregnancy it has huge implications on the mother and infant, with increased risk of haemorrhage, sepsis, maternal mortality, peri-natal mortality and low birth weight. Severe Vitamin A deficiency leads to severe eye complications, leading to blindness and a compromised immune system. Iodine deficiency is also of public health concern in most developing countries and normally pregnant women and young children are most vulnerable. Iodine deficiency/surplus is associated with stillbirths and miscarriages in pregnancy and with

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<sup>9</sup> UNICEF, The silent emergency, [www.unicef.org/socw98/](http://www.unicef.org/socw98/)

preventable brain damage in young children. However other micronutrient deficiencies such as Vitamin C and the vitamin B's are found in camp environments also.

It is difficult to measure the long-term impact of poor nutrition on these populations. Where refugees have been in camps for over 10 years a substantial percentage of the population were born into this environment, and must suffer the effects of poor services for many years. Although we only speak of acute malnutrition, in these protracted refugee situations, chronic malnutrition also needs to be measured and addressed as the strategies for dealing with acute and chronic malnutrition are very different.

### **International standards/instruments**

There are approximately 25 million children uprooted from their homes in the world today. Several international instruments currently exist to underline international agencies obligations to refugee children and their right to food. The UN Convention on the Rights of the Child (CRC) provides a critical standard against which the treatment of refugee children can be assessed. This treaty was drafted to identify and protect the best interests of the child. Article 24 of the treaty that recognizes “the right of the child to the highest attainable standard of health” is immensely important. State parties commit to taking steps toward ending child and infant mortality, and eliminate the circumstances that lead to child death including illness and malnutrition. Governments must provide children with food and water security. This treaty ties the rights of the mother to the well-being of the child. Article 24 acknowledges the mother's right to appropriate pre and post-natal, as well as access to information and education regarding child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation.<sup>10</sup>

Article 22 of the CRC grants special protection to refugee children. Like all children, they are also entitled to all other rights granted under the Convention including the rights to life, physical integrity, adequate food and medical care, education, and to be free from discrimination, exploitation, and abuse<sup>11</sup>.

Under the International Covenant on Economic, Social and Cultural Rights<sup>12</sup>, refugees should be provided in the same public relief as the nationals of the country they take refuge in. Refugee children also have full rights guaranteed within the Universal Declaration of Human Rights (article 25, paragraph 1).

***Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.  
Universal Declaration of Human Rights (article 25, paragraph 1).***

Every human being has the right to be free from hunger, the right to adequate food and the right to clean, safe drinking water. There are many other rights that are closely related to, and

<sup>10</sup> Human Rights Learning Centre: Study Guide on the Human Right to Food and Water

<sup>11</sup> Convention on the Rights of the Child (1989). Details taken from UNICEF UK Position papers and Policies.

<sup>12</sup> International Covenant on Economic, Social and Cultural Rights

in many cases cannot be separated from the right to adequate food. These include: 1) the right to enjoy the highest standard of physical and mental health. This right is unattainable without adequate food and clean water; the right to enjoy the benefits of scientific progress. There are many scientific developments regarding food and clean water; and the right to freedom from discrimination. This addresses the concern that under some circumstances food distribution is not equal between genders and age groups.

In order to fulfil the rights and obligations within the international instruments, international agencies have incorporated many of the basic human rights principles into their mandates and policies. United Nations agencies such as UNHCR, WFP, WHO and UNICEF all promote the basic rights of children. The rights of children living in protracted refugee situations are also of primary concern and the support needed to care for them can be grounded in the obligations surrounding these basic rights. While WFP does not use the rights based language in its programming, food and nutrition services are among its core policies.

**WFP:**  
The core policies and strategies that govern WFP activities are to provide food aid:

- To save lives in refugee and other emergency situations;
- To improve the nutrition and quality of life of the most vulnerable people at critical times in their lives; and
- To help build assets and promote the self-reliance of poor people and communities, particularly through labour-intensive works programmes.

-WFP Mission Statement.

UNHCR is committed to the rights of refugees and UNHCR’s primary purpose is to safeguard the rights and well-being of refugees. UNHCR strives to ensure that everyone can exercise the right to seek asylum and find safe refuge in another state, and to return home voluntarily.

**UNHCR**, the United Nations refugee organization, is mandated by the United Nations to lead and coordinate international action for the world-wide protection of refugees and the resolution of refugee problems.

UNHCR’s primary purpose is to safeguard the rights and well-being of refugees. UNHCR strives to ensure that everyone can exercise the right to seek asylum and find safe refuge in another state, and to return home voluntarily.

By assisting refugees to return to their own country or to settle in another country, UNHCR also seeks lasting solutions to their plight.

UNHCR’s efforts are mandated by the organization’s Statute, and guided by the 1951 United Nations Convention relating to the Status of Refugees and its 1967 Protocol.

International refugee law provides an essential framework of principles for UNHCR’s humanitarian activities.

UNHCR Mission Statement (excerpt)

## Millennium Development Goals<sup>13</sup>

Malnutrition has serious developmental implications. At the Millennium Summit of the United Nations in September 2000, all member nations joined in a formal commitment to reduce global deprivation, including poverty, hunger, poor health and abuses of human rights. That commitment was translated into a series of Millennium Development Goals (MDGs). According to the World Bank, "...the MDGs cannot be reached without significant progress in eliminating malnutrition..." This is not just rhetoric: such statements are grounded in an accumulation of evidence documenting the importance of nutrition not just as an outcome of development, but as underpinning the development process itself. Good nutrition underpins progress towards each of the first six MDGs. The evidence suggests that good nutrition status reduces poverty by boosting productivity throughout the life cycle and across generations (MDG 1), that it leads to improved educational outcomes (MDG 2), that dealing with malnutrition typically empowers women (MDG 3), that malnutrition is associated with over 50% of all child mortality (MDG 4), that maternal malnutrition is a direct contributor to poor maternal health (MDG 5), and that good nutrition status slows the onset of AIDS in HIV-positive individuals, increases malarial survival rates (MDG 6) and lowers the risk of diet-related chronic disease (related to MDGs 1, 4 and 6).<sup>14</sup>

### **Nutrition's contributions to the attainment of the Millennium Development Goals (MDGs)**

#### *Goal 1: Eradicate extreme poverty and hunger*

Malnutrition erodes human capital, reduces resilience to shocks and reduces productivity (impaired physical and mental capacity).

#### *Goal 2: Achieve universal primary education*

Malnutrition reduces mental capacity. Malnourished children are less likely to enrol in school, or more

Likely to enrol later. Current hunger and malnutrition reduces school performance.

#### *Goal 3: Promote gender equality and empower women*

Better-nourished girls are more likely to stay in school and to have more control over future choices.

#### *Goal 4: Reduce child mortality*

Malnutrition is directly or indirectly associated with more than 50% of all child mortality. Malnutrition is the main contributor to the burden of disease in the developing world.

#### *Goal 5: Improve maternal health*

Maternal health is compromised by an anti-female bias in allocations of food, health and care. Malnutrition is associated with most major risk factors for maternal mortality.

#### *Goal 6: Combat HIV/AIDS, malaria, and other diseases*

Malnutrition hastens onset of AIDS among HIV-positive. Malnutrition weakens resistance to infections and reduces malarial survival rates.

<sup>13</sup> This whole section on MDG was borrowed outright from A Brief Investigation of Nutrition in Protracted Refugee Populations, Leah Richardson, December 2004

<sup>14</sup> SCN 2004 5<sup>th</sup> Report on the World Nutrition Situation: Nutrition for Improved Development Outcomes

Malnutrition's main contribution to mortality is through disease. Infant and maternal underweight together rank as the leading risk factor in the global burden of disease, together contributing an estimated 170 million disability-adjusted life years (DALYs).<sup>15</sup> Women are equally affected by malnutrition: iron-deficiency anaemia contributes to hundreds of thousands of maternal deaths each year and stunting is a major factor in obstructed labour during childbirth, another cause of maternal mortality. When a body's ability to resist infection is impaired, severe illness may result, which in turn decreases appetite and reduces the absorption of nutrients. The interaction between nutrition and disease is especially critical in relation to TB and HIV/AIDS (MDG 6). There are equally important though less direct interactions exist between malnutrition and poverty (MDG 1), education (MDG 2) and gender equality (MDG 3). Productivity losses in developing countries from the combined effects of stunting and iodine and iron deficiencies are equivalent to as much as 4 percent of gross domestic product per year. This effect is largely due to the impact on wages, productivity and low labour force participation resulting from absenteeism linked to ill-health.

In conclusion, refugees in protracted refugee situations are often the victims of extreme poverty leading to their high level of dependency and subsequent high level of malnutrition. Refugees enjoy the protection of international rights instrument both in their special status as refugees and as human being. Refugees have a right to receive the highest attainable level of support and to live in refugee camps with dignity and health. In assisting refugees, it is imperative that their basic needs are met, not only in terms of protection and asylum, but also in terms of food, water, nutrition, health, shelter, sanitation and education. The MDG further challenge the international community to respond to the linked needs of refugees and create a strategy that can enhance the quality of life of refugees worldwide.

## **Highlighted Strategies:**

### **Management of Malnutrition:**

- **Improve UNHCR/WFP Technical Capacity at Country and Regional level through hiring of nutritionists and improved coordination with technical unit at headquarters.**
- **Develop Regular and Consistent Nutrition Surveillance/Surveys and Monitoring through developing in-country nutrition surveillance capacity.**
- **Standardized Information and Training around Infant and young child feeding practices by initiating a trainer of trainers program for refugee health providers.**
- **Improve the nutrition interventions for the treatment of moderate and severe malnutrition in the refugee camps by implementing guidelines and promoting community-based care practices.**

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<sup>15</sup> WHO. 2002. *The World Health Report*. Geneva.

### **Health Services and Environmental Health Access:**

- **Strengthen the preventative care component of health care by improving resources, training and technical support.**
- **Improve technical capacity of JAMs by including senior nutrition, health and water/sanitation staff and overcome gaps in data collection.**
- **Develop a strategy for the prevention and treatment of malaria in refugee settings by providing 80% bed net coverage, spraying and new line drugs.**
- **Reduce Alarming Anaemia Rates by systematizing iron and folate supplementation and improving the diet with iron and vitamin C.**
- **Improve Water and Sanitation quality and quantity to meet minimum standards.**
- **Mainstream HIV/AIDs and nutrition support for PLWHA in all protracted refugee situations by introducing camps to basic standards and guidelines.**

### **Food Security:**

- **Improve Ration Adequacy (micro and macronutrients, demographic considerations, quantity and quality, and milling) by increasing and diversifying the general ration with fortified blended foods, complimentary foods, double fortified salt and fortified flour.**
- **Improve Ration Acceptability by Providing Priority Foods by ensuring refugees receive culturally appropriate and accepted commodities, and conducting information campaigns on use and value of new commodities.**
- **Improve Ration Management (late arrival of food, pipeline problems, distribution) by employing strategies to ensure a regular food ration.**

### **Quality of Life:**

- **Promote and Expand Self-Reliance by prioritising micro-agriculture, MSG and IGA activities in protracted refugee situations and guaranteeing funding to promote self-reliance.**
- **Improve the provision of Non-food items by securing funding that links NFI directly to nutritional outcomes. NFI must be considered *essential to* life and distributed to refugees in dependent protracted situations in a timely and adequate manner.**
- **Promote Gender Equality and Empowerment by enhancing and supporting programs to assist women and girl children in terms of health, education, cultural practices and income generating activities.**

## Introduction

### Why a global strategy is needed

This Global Strategy Report is the product of two independent international food security and nutrition experts hired by UNHCR and WFP to develop a global strategy to address acute malnutrition rates in protracted refugee situations. This report represents the global aspect of a three part mission that assessed and reviewed the food security and nutritional situation in Kenya and Ethiopia between the 17<sup>th</sup> of November and the 17<sup>th</sup> of December 2005. The two country reports<sup>16</sup> can be obtained by UNHCR/WFP Headquarters. The mission and subsequent reports came out of a concern by both UNHCR and WFP over high malnutrition rates including micronutrient deficiencies (hidden hunger) among refugee children. Continuing gaps in the provision of food to meet all of the refugees' daily needs, including macronutrient and micronutrient requirements, and provision of related non-food items, are unwelcome realities in many operations throughout the world. As such, a session on malnutrition was held during UNHCR EXCOM in October 2005 where the worrying trends and consequences of increasing acute malnutrition amongst refugees in selected camps were discussed in-depth.<sup>17</sup> In the opening statement to the EXCOM, the High Commissioner Antonio Guterres said that tackling malnutrition would be a priority goal for UNHCR in 2006, a sentiment seconded by the Executive Director of WFP, James Morris.

A protracted refugee situation is one in which the refugee population has sought refuge in a host nation for five years or more. Worldwide, there are over twenty-eight protracted refugee situations. The following is a list of the current protracted refugee situations as of January 2005.

#### Major protracted refugee situations, 1 January 2005

Country of Asylum	Origin	end-2004
Algeria	Western Sahara	165 000
Armenia	Azerbaijan	235 000
Burundi	Dem. Rep. of the Congo	48 000
Cameroon	Chad	39 000
China	Viet Nam	299 000
Congo	Dem. Rep. of the Congo	59 000
Côte d'Ivoire	Liberia	70 000
Dem. Rep. of the Congo	Angola	98 000
Dem. Rep. of the Congo	Sudan	45 000
Egypt	Occupied Palestinian Territory	70 000
Ethiopia	Sudan	90 000
Guinea	Liberia	127 000
India	China	94 000

<sup>16</sup>Addressing High Malnutrition Rates in Protracted Refugee Situations: The Nutrition and Food Security Situation in Selected Refugee Camps in Ethiopia: .A Joint UNHCR and WFP Mission from 2<sup>nd</sup> to 16<sup>th</sup> of December, 2005 Corbett and Oman, January 2006 and Addressing High Malnutrition Rates in Protracted Refugee Situations: The Nutrition and Food Security Situation in Selected Refugee Camps in Kenya: .A Joint UNHCR and WFP Mission from 2<sup>nd</sup> to 16<sup>th</sup> of December, 2005 Corbett and Oman, January 2006

<sup>17</sup> TOR for the 2005 Mission



India	Sri Lanka	57 000
Islamic Rep. of Iran	Afghanistan	953 000
Islamic Rep. of Iran	Iraq	93 000
Kenya	Somalia	154 000
Kenya	Sudan	68 000
Nepal	Bhutan	105 000
Pakistan	Afghanistan*	960 000
Rwanda	Dem. Rep. of the Congo	45 000
Saudi Arabia	Occupied Palestinian Territory	240 000
Serbia and Montenegro	Bosnia and Herzegovina	95 000
Serbia and Montenegro	Croatia	180 000
Sudan	Eritrea	111 000
Thailand	Myanmar	121 000
Uganda	Sudan	215 000
United Rep. of Tanzania	Burundi	444 000
United Rep. of Tanzania	Dem. Rep. of the Congo	153 000
Uzbekistan	Tajikistan	39 000
Yemen	Somalia	64 000
Zambia	Angola	89 000
Zambia	Dem. Rep. of the Congo	66 000

Note: This table refers to refugee situations where the number of refugees for a certain origin within a particular country of asylum has been 25,000 or more for at least five consecutive years. Industrialized countries are not included.

Data includes both UNHCR-assisted and non-assisted refugees.

\* UNHCR estimate.

Source: UNHCR.

While all of those listed above are protracted situations, not all of them have high rates of malnutrition. This is an important issue. The issue of protractedness does not automatically lead to high malnutrition rates, nor of course are all refugee situations with high rates of malnutrition *protracted situations*. In fact in most cases, emergency situations are far more likely to have acute malnutrition due to the effects of flight and upheaval. One purpose of this report is to determine why in relatively stable refugee populations without emergency conditions, and with a health infrastructure and food delivery system, high rates of malnutrition exist.

For many years there has been concern about the health of encamped refugees, particularly those in protracted situations who have neither the option to return home nor the support and opportunity to live in health and productivity in the country of asylum. While emergency operations can garner international focus and donations, protracted refugee situations are often incredible resource drains, demanding support for large populations to live under a care and maintenance situations year after year. Unfortunately, the nutrition and livelihood needs of refugees in protracted situations are often no less complex and extensive than refugees in an acute emergency. If refugees are encamped, with restrictions placed on their movement and access to livelihood activities, the high level of dependency that marked the initial emergency will continue year after year. While there is a common expectation among assisting agencies that refugees will need less attention, food and support as the years go on, the reality is actually to the contrary. Stop-gap measures to assist refugees in the short term such as plastic sheeting instead of durable shelter materials or firewood instead of alternative

fuel sourcing end up being costly both in terms of continued need for replacement as well as the further cost to refugees in terms of ill-health and the burden of disease and disability.

The complexity of these issues has not been lost on UNHCR. In 30<sup>th</sup> Meeting of the Standing Committee, the Executive Committee of the High Commissioner's Programme developed a paper on Protracted Refugee Situations. Within the paper, the challenges, consequences and responses to the problem is addressed. The paper acknowledges that protracted refugee situations are very difficult for all actors, including the host country, the international agencies and particularly the refugees.

- If it is true that camps save lives in the emergency phase, it is also true that, as the years go by, they progressively waste these same lives. A refugee may be able to receive assistance, but is prevented from enjoying those rights- for example the freedom of movement, employment, and in some cases education- that would enable him or her to become a productive member of society.
- Protracted refugee situations also waste lives by perpetuating poverty...Poverty can lead refugees, as well as other, to resort to a gamut of negative survival tactics, such as child labour, the degradation of the environment or prostitution.
- The prolongation of refugees' dependence on external assistance also squanders precious resources of host countries, donors and refugees. Spending on long term situations are often characterized by what has been termed the 'plastic sheeting syndrome' ...Spending on short-term fixes, however, yields only fictitious savings. Spending on care and maintenance, rather than on solutions, while often necessary, is a recurring expense, and not an investment in the future. It can only ensure that such situations are perpetuated, not solved.
- From UNHCR Protracted Refugee Situations, 30<sup>th</sup> Meeting of the Standing Committee p4

However difficult the reality of protracted refugee situations, the obligations to those refugees who find themselves living in a camp in host country for years on end, are very real and pressing. Refugees have the right to assistance and to be supported at the minimum level of standards and failure of the international community to meet these basic obligations is unacceptable.

Host governments play a central role in the policies and decisions that directly effect refugee programs. For example, the initial placement of camps will greatly impact on whether refugees will have opportunities for agriculture, contact with local markets and services, as well as general security. Government policies guide unrestricted movement, access to imported items such as used clothing, legal economic opportunities and even issues such as whether anti-mosquito spraying can occur. WFP and UNHCR must work together to lobby the host governments in supporting policy decisions and refugee laws that support and enhance the legal status of refugees and govern their quality of life.

Donor governments supply both UNHCR and WFP with the bulk of their funding that is used to support all aspects of refugee lives including provision of health and education services, access to water and sanitation, shelter materials and other essential non-food items, income generating projects and micro-agricultural inputs, and food. Without donor support the programs could not continue, yet for many protracted refugee programs, donor commitment is lessening as donors grow fatigued with the seemingly unending refugee situations. Unfortunately, as highlighted in this document, the needs of the refugees remain constant or even enhanced. Therefore it is essential that WFP and UNHCR work together to prepare

strategies, such as this one, that can then be presented to donors, underlying the needs of refugees and the positive impact of sufficient funding to address these needs in a creative and sustainable fashion. Many donors complain that there is little to show for the past years of support, particularly to programs where there remain high rates of malnutrition, regardless of the money being given. It is to these donors in particular, who feel that their support has yielded few results, that this new global strategy should be targeted. The idea is to show a holistic set of inputs that are needed, and that taken together with a coordinated approach by the agencies, will allow for significant positive impact. In the past, the support of one program was too often at the expense of another, so in the end the two programs cancelled one another out. A good example is sufficient funding for food but zero finding for non-food items, which within the refugee household, cancel one another out as the food is then sold to purchase the essential other needs. The sixteen issues highlighted in this report will offer a comprehensive strategy to address the high rates of malnutrition in the refugee camps and lead to levels of self-reliance that can support refugee nutritional security in the future. Donor funding is a fundamental part of improving the current situation in the camps and a joint UNCHR/WFP appeal to donors will strengthen both the request and the ability of the agencies to fulfil the strategies outlined.

**High Rates of Malnutrition and Micronutrient Deficiencies**

There are higher than accepted rates of malnutrition in UNHCR/WFP supported protracted refugee situation world wide, including Chad (up to 18% GAM), Eritrea (18.9% GAM), Ethiopia (up to 19.6% GAM), Kenya (up to 20.6% GAM), Sierra Leone (16.0% GAM) and Sudan (16.0% GAM)<sup>18</sup>. The question of the why the high rates of malnutrition exist despite agency intervention, implementing partner programming and donor assistance is troubling. It is also unsettling to note that of the protracted refugee situations worldwide, only the camps in Africa have malnutrition rates consistently above 15%, while the Asia camps usually level out below 12% GAM.

The following table, compiled by the UNHCR nutritionist, shows the most updated nutrition figures for several UNHCR/WFP supported programs (it is in draft form awaiting final figures). Interestingly, it included malnutrition rates for the local population as a source of comparison. In some situations refugees are doing far worse than their host counterparts, though in a few situations their status is slightly better. It is important to not overly analyse the data without being able to ground it in the actual country situation, but it does offer food for thought. Additionally, the chart looks at anaemia rates wherever possible.

Country <sup>19</sup>	Local Population %	Refugees %	Refugees % Anaemia Children	Refugees % Anaemia Women
Algeria	7.5	7.7	68	66
Bangladesh	10.3	<b>12.8</b>		
Chad	11.2	<b>Up to 18</b>		
Eritrea	14.4	<b>18.9</b>		
Ethiopia	11.3	<b>Up to 20</b>	43	43
DRC	9.4	Up to 5		
Kenya	26.8	<b>26.3</b>	80	80
Nepal	9.7	<b>Up to 12</b>		

<sup>18</sup> WHO, Global Database on Child Growth and Malnutrition. UNHCR, Standard and Indicators.  
<sup>19</sup> WHO, Global Database on Child Growth and Malnutrition. UNHCR, Standard and Indicators.

Sierra Leone	9.9	<b>Up to 16</b>		
Tanzania	5.4	2.8	40.5	30
Sudan	16.9	<b>Up to 16</b>		
Uganda	4.1	Up to 10		
Zambia	5.0	3.4		
Nigeria	9.7	<b>11</b>		51

As can be seen the malnutrition rates are generally unacceptable which takes a terrible toll on the growth and health of the refugee children living in those camps. Worldwide malnutrition is an extremely serious issue particularly affecting the under five population. It is estimated that half the 12 million under five deaths that occur worldwide are associated with malnutrition<sup>20</sup>. Malnutrition is a consequence of poverty and also leads to poverty. Even children with mild malnutrition are at between 2-8 times higher risk of mortality from common childhood illnesses than normally nourished children. The toll of malnutrition is that it causes death and long-term disability in whole populations.

Malnutrition is a consequence of not enough quantity of the right nutritious food, ill-health and underlying factors such as environmental health (water/sanitation), poor health infrastructure and the caring practices within the home and community. It leads to both macro and micro nutrient deficiencies. Macronutrients such as protein, carbohydrates and fats lead to “wasting”, where the child is much thinner than for its height or age, and sometimes nutritional oedema known as Kwashiorkor. Micro-nutrient deficiencies is often called “silent malnutrition”, as it is not visible at all for some of the micronutrient deficiencies (type II deficiency) or until the deficiency is very severe with clinical signs and symptoms (type I deficiency) such as anaemia, scurvy or iodine deficiency.

In protracted refugee situations where the population is often extremely dependant on the humanitarian assistance and food aid, the value of the food will greatly determine their nutritional status. It is essential that highly dependent refugee populations are given sufficient macro and micro nutrients to support growth and development. It is no longer appropriate to just discuss kilocalories, fat and protein; micronutrients must be included in sufficient quantities if the food basket is to fully support the refugee nutrition needs. While sufficient food in quality and quantities is essential, it is not the only factor in health and nutritional security. Infant feeding practices, access to sufficient health services, clean and ample water, and access to fuel, clothing and cooking equipment are all implicated alongside inadequate food as causes of endemic malnutrition. The long-term consequences of an inadequate varied diet, poor caring practices and poor infrastructure often leads to intergenerational malnutrition. A newborn baby girl with a low-birth weight, if she survives is likely to remain underweight, may have stunting (chronic malnutrition), become pregnant in early adolescent life and produce an underweight baby. Therefore it is extremely important to tackle malnutrition in particular in the under-five population and women, and in particular pregnant and lactating women.

Anaemia due to iron deficiency is a major public health issue worldwide. Every age group is vulnerable. It impairs cognitive development in children and affects the immune system. During pregnancy it has huge implications on the mother and infant, with increased risk of haemorrhage, sepsis, maternal mortality, peri-natal mortality and low birth weight. Severe

<sup>20</sup> UNICEF, The silent emergency, [www.unicef.org/socw98/](http://www.unicef.org/socw98/)

Vitamin A deficiency leads to severe eye complications, leading to blindness and a compromised immune system. Iodine deficiency is also of public health concern in most developing countries and normally pregnant women and young children are most vulnerable. Iodine deficiency/surplus is associated with stillbirths and miscarriages in pregnancy and with preventable brain damage in young children. However other micronutrient deficiencies such as Vitamin C and the vitamin B's are found in camp environments also.

It is difficult to measure the long-term impact of poor nutrition on these populations. Where refugees have been in camps for over 10 years a substantial percentage of the population were born into this environment, and must suffer the effects of poor services for many years. Although we only speak of acute malnutrition, in these protracted refugee situations, chronic malnutrition also needs to be measured and addressed as the strategies for dealing with acute and chronic malnutrition are very different.

### **Global Issues: the commonality of suffering**

What one finds when a survey of protracted refugee situations is reviewed, is that there are certain common elements, certain trends in the programs that have less than 10% global acute malnutrition rates and those that have higher than acceptable rates. For example, a 2004 study undertaken by WFP<sup>21</sup> looked at four countries with protracted refugee situations, Bangladesh, Kenya, Tanzania and Nepal. The study, reviewing available nutrition reports, Joint Food Assessment reports and other documentation, found that seven<sup>22</sup> clear statements could be made about the relationship between protracted refugee situations and malnutrition:

- 1. Problems with the food pipeline are associated with higher rates of malnutrition**
- 2. Rations that are inadequate in micronutrients are associated with a prevalence of micronutrient deficiencies and diseases (MDD).**
- 3. Micronutrient deficiencies are implicit in protracted refugee situations.**
- 4. Inclusion of fortified blended foods (FBF) in food aid routinely through the years is associated with lower levels of stunting among populations receiving that food aid.**
- 5. A well balanced food basket in terms of fat, protein, and energy content does not alone guarantee positive nutrition outcomes in protracted refugee populations.**
- 6. A well functioning health care system with both curative and preventative services is associated with low prevalence of malnutrition.**
- 7. Living conditions (shelter, water, sanitation, access to income) affect malnutrition rates with a positive correlation.**

Across four different camps, in different parts of the world, these issues are absolute: if refugees do not receive timely, adequate and appropriate food and care, their malnutrition rates will increase. These findings are further supported by the findings of this Mission which found generally that the same problems existed in both Kenya and Ethiopia, and that the same recommendations and strategies could be used to address them. In addition to the seven listed above, this report would add an additional four:

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<sup>21</sup> A Brief Investigation of Nutrition in Protracted Refugee Populations, Leah Richardson, December 2004

<sup>22</sup> This report is citing seven of nine, excluding discussion of 'wealth groups' point H and I p.7.

- 8. Host government encampment policies seriously constrain the opportunities for self-reliance in terms of agricultural initiatives and income-generating activities. Further, when these programs do exist, UNHCR support is highly inadequate.**
- 9. Poor nutritional technical capacity at the country level and limited nutritional technical support from headquarters impacts nutritional security.**
- 10. Where there is a strong nutritional monitoring and surveillance system, there is less acute malnutrition.**
- 11. Where there are programs following standardised guidelines to prevent and treat malnutrition such as infant feeding, Community based approaches to treatment of severe malnutrition, TFP/SFP/BFP, the nutritional impact of food shortfall on children will be greatly mitigated.**

Obviously, none of these issues are new to individuals who have been working in international nutrition, but whether new or old, there is still no comprehensive strategy to address them, both systematically and cohesively. There are plenty of standards to follow and excellent guidelines that have been drafted, but still the high rates of malnutrition persist and the overall nutritional security of refugees in protracted situations is not improved. There needs to be a comprehensive strategy that can incorporate the expertise of different agencies, their areas of concern and action and provide linkage between them to begin to truly address these problems.

## **Issues**

### **Issue #1: Poor Technical Capacity**

It is essential that the services offered to the refugees are of high quality and address the needs of the population. UNHCR is overall responsible for the care and well being of this population. Most operational activities such as running health services, feeding programmes and water/sanitation activities are conducted by implementing partners (IPs), both national and international NGO's.

WFP is overall responsible for mobilizing food for the general ration and selective feeding programmes and transporting to the extended delivery points (EDS) where IPs are responsible for final distribution. However a special pilot study is being conducted whereby WFP is responsible for the final distribution of the basic food ration in five countries.

The technical capacity within these NGO's varies substantially and therefore programming varies substantially. Monitoring of the health and nutrition programmes is normally in the form of annual nutrition surveys and a variety of monthly, quarterly and annual reports. There is a complete lack of regular monitoring visits of the programmes by external UN technical staff except during official surveys. Although issues are often identified during the surveys the recommendations seem to fall between the UN agencies and the IP's and no action seems to happen.

Unfortunately, UNHCR and WFP have very few nutritionists working in refugee situations worldwide. Most Senior Programme Officers have little or no nutrition training and are unable to make programmatic decisions with sufficient understanding of the effect on the nutritional status of refugees. Due to the lack of technical capacity within UNHCR and WFP

at country and sub-office there is a lack of monitoring and technical support to implementing partners. This seriously affects quality of programming.

**Nutritional Decision ?:** In Ethiopia the general ration was reduced from January 2005 to August 2005 from a cereal ration of 15kg/p/m to 10kg/p/m in two refugee camps due to pipeline constraints without any clear nutritional consideration. No nutrition survey had been conducted in 2 years due to insecurity in the region and the UN had had no access to the population for over a year. There was no discussion with HQ nutritionists and the decision was taken without proper evaluation. The May survey then showed alarming malnutrition rates in one of the camps, most likely due to the ration cut, that have still not diminished.

### **Strategy: Improve Technical Capacity**

- **Recruit UNHCR Country and Regional Nutrition Posts** essential for overseeing nutrition programmes and offering technical support in areas where there are complex or protracted refugee situations
- **UNHCR/WFP Headquarters need to give ongoing and active nutritional support to the programs.** Managers have asked for guidance beyond guidelines and policy papers.
- **There needs to be a standard procedure for re-evaluating the nutritional impact of ration changes** for refugees highly dependent on the general ration. Breaks in the pipeline, late deliveries and commodity non-delivery need to be evaluated in light of the current nutritional situation by nutrition experts.
- **Joint Assessment Missions need to include a senior nutritionist**, ideally from both UNHCR and WFP to ensure that nutrition issues and food security concerns are closely examined in order to develop balanced recommendations.

### **Issue #2: Assessments- Lack of senior nutrition, health and water/sanitation staff involved in assessments (JAM's) and gaps in data collection**

The regular Joint Assessment Missions (JAM) is the main tool for compiling data on a regular basis, taking a holistic approach. Data are collected on overall political, economic and social aspects of the refugees, and the environment they are in. Data are collected on actual numbers in the camps, numbers repatriated or relocated over the period since the previous JAM. The JAM also collects data on the different sectors: health and nutrition, food access and availability, food pipeline and targeting and self reliance activities. It includes reviewing documentation and visits to the field.

Following on from the Jam decisions are made in regard to the needs of the refugees and the services available. These JAM's are a forum for decision making around the programme looking at the nutritional status and health of the population. They are an important tool for deciding on the general food ration in relation to the population as well as non-food items and self-reliance activities.

However the JAM's are as good as the people involved in the assessments. It is important that senior staff is involved in the assessments in particular in the health, nutrition and water/sanitation sectors to identify gaps and needs. It is also essential that the conclusions and recommendations are actually addressed, with systematic detail of who is responsible for the changes, and the resources. Otherwise each assessment may end up with similar recommendations but actually no improvement in programming.

It is also important that gaps in knowledge are addressed during these assessments, particularly in relation to infant and young child feeding practices as they differ among cultures, and malnutrition starts early in a child's life.

**Strategy: Include senior nutritionists, health officers and water/sanitation experts in Joint Assessments Missions and develop check lists for data collection of specific areas**

- Bi-annual JAM's for all protracted refugee programmes
- Ensure Nutrition, Health and Wat/San senior technical staff involved in JAM's
- Identify players responsible for taking forward recommendations during the assessments
- Develop check list for data collection on infant and young child feeding practices

**Issue #3: Lack of Regular and Consistent Nutrition Surveillance/Surveys and Monitoring:**

Nutrition surveys are conducted annually to collect data on rates of acute malnutrition. This is an extremely useful tool for monitoring the impact of the interventions and looking at trends over time. It measures acute malnutrition which is normally measured during emergency situations. In some countries other data is collected during the surveys, such as information around infant feeding practices. In protracted refugee situations it would also be very beneficial to look at chronic malnutrition, as this is an indication of the success/failure of the long-term interventions.

However surveys only take a snapshot of the nutritional situation at a given time, and the status can change rapidly, and alter seasonally. It is important to have a better understanding of the nutrition situation at different times of the year. It is important to set up a surveillance system in long-term protracted refugee camps to better understand the dynamics affecting the present high rates of acute malnutrition.

It is important to introduce a better system for monitoring the growth of individual children over time. This should be done in the form of growth monitoring using the "road to health" cards. Children attend clinics for immunization, treatment of illnesses and this would be an ideal opportunity to measure and record weights and therefore identify children at risk of becoming malnourished.

UNHCR as the overall agency responsible for the health and well being of the refugee population also needs to actively monitor and support the health and nutrition interventions and give technical support as necessary



Annual nutrition surveys are not adequate for monitoring the nutrition status in refugee camps. Acute and chronic malnutrition needs to be analysed. Ongoing monitoring is not being done

Tanzania and Nepal refugee programmes both have ongoing surveillance systems that allow them to understand the current nutrition situation at any point between surveys.

### **Strategy: Develop Regular and Consistent Nutrition Surveillance/Surveys and Monitoring:**

- **Develop a nutrition surveillance system** which will be able to closely monitor the nutrition situation over time and address the particular needs of long-term protracted refugee populations.
- **Introduce “road to health initiative”** where individual children are weighed regularly and poor weight gains are recognised and treated early
- **Introduce regular technical visits by UNHCR to nutrition/health programmes** to give technical support to IPs, monitor activities, identify issues and training support

### **Issue #4: Little or No Information and Training around Infant and Young Child Feeding Practices:**

Infant feeding practices are instrumental for good nutrition. It is recommended that all infants should be exclusively breast-fed for the first six months of life (WHO). It is then important to introduce appropriate complementary foods at six months. However this rarely happens. Other foods/fluids are often introduced much earlier and the consequence of this is illness and reduced breast-feeding, leading to weight loss.

Appropriate varied complementary foods, with small and frequent feeding is also recommended for infants at six months. This is a difficult task particularly in refugee settings where the general food ration is limited, CSB is often not part of the ration therefore there is really no suitable food in the ration for young children. Even in settings where CSB is given along with other local appropriate foods to children under 2 years, foods rich in micronutrients particularly Vitamin A are required to ensure the micronutrient RDA is achieved. A study in Haiti<sup>23</sup> showed that even though fortified cereal blends such as CSB improved the nutritional quality of complementary foods it did not meet the high iron and zinc needs in the younger children, the 6-8 month olds, and the zinc levels were low in the 9-11 month age group.

There is a lack of systematic data collected on the infant and young child feeding practices. Some countries collect data on infant feeding practices during their annual nutrition surveys. In one camp in Kenya only 4% of women were exclusively breast-feeding at six months<sup>24</sup>. In Ethiopia there is no reliable data on infant feeding practices.

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<sup>23</sup> Ruel MT, Menon P, Loechl C, Pelto G, Donated fortified cereal blends improve the nutrient density of traditional complementary foods in Haiti, but iron and zinc gaps remain for infants. Food Nutr Bull. 2004

<sup>24</sup> Nutrition Survey Report, Dadaab, 2004

Health workers are poorly trained in breast feeding techniques, breast disease and counselling mothers on breast feeding and introducing complementary feeding. There are many incorrect perceptions and taboos around nutrition and breastfeeding, breastfeeding and illness and often the health workers exacerbate the situation.

The Somali mothers in Dadaab stated they give young children tea, biscuits and “injera”, not CSB or vegetables. Vegetables were seen as unsuitable for children. In both Kenyan refugee camps mothers stated that they did not give young children split peas, as they perceived that it “caused diarrhoea” in young children. This seriously affects the nutritional value of complementary food being given to young children.

There is a lack of knowledge around infant feeding practices in refugee situations. Health care workers are ill-informed and ill-equipped to address many of the issues around breast feeding and complementary feeding. Malnutrition often starts as early as in the first few months of life.

**Getting the word out:** A UNHCR/Care initiative is being piloted in Dadaab camp, Kenya. An infant feeding specialist has conducted a training of trainers’ course with a cross section of health workers. The idea is for the information and support around infant feeding to be given whenever a new mother enters the health system. Refugee health workers are responsible for reaffirming positive feeding messages after learning about the health risks in negative cultural practices that discourage exclusive breast feeding and the introduction of complementary foods. The initiative is a low cost, highly participatory method of changing health behaviour and improving infant survival.

### **Strategy: Standardized Information and Training around Infant and young child feeding practices:**

- **Expand and mainstream the Infant and Young Child Feeding Practices** piloted by Care to improve Infant Feeding practices.
- **Routinely collect data on infant feeding practices during nutrition surveys** to have accurate information and tailor programme to address needs

### **Issue #5: Water and Sanitation minimum standards not being met**

Water is life. It is important to have both quality and quantity in supplying water to refugees. Not alone is it enough to supply safe drinking water but there is a need to ensure that the water remains safe in the household. Most water contamination happens in the home. Therefore it is essential that refugees have containers for storing water and that the containers are clean and covered. Hygiene promotion is a strong component in any programme to try and maintain safe water at household level.

Secondly quantity is also extremely important. The Sphere Minimum standards suggest that individuals should have a minimum of 15litres/p/d, during emergency but this should be increased in long-term protracted situations. It is also recommended that people should only have to wait around 15 minutes for water.

Sanitation needs to be addressed at start up of camps, with community participation to understand culturally what is acceptable. If communal latrines are built then hygiene promoters/cleaners are instrumental to ensure toilets are maintained. Ideally in long-term protracted situations family latrines are more acceptable, but these need to be considered early on in camp design. Often overcrowding makes construction of family latrines difficult.

It is recommended that hygiene promoters/ community mobilisers are recruited; optimally two per 1,000 population and training material, training and work plans are developed.

As water and sanitation go hand in hand ideally it is preferable to have the one IP responsible for both so as to prevent overlaps or gaps on interventions. In all of the programmes in Kenya and Ethiopia minimum standards in water quantity were not achieved. Hygiene promoters is available are limited. There is overcrowding at water points and the water points are not well maintained. Lack of technical capacity of UNHCR staff in water/sanitation is a serious weakness, leading to lack of monitoring and supporting IP's and their interventions.

**Access to Adequate Water:** Water for the three ethnic group sites in Fugnido camp is far below Sphere minimum standards of 20litres/p/d. Currently the Anuak side get approximately at 3.2-4.7l/p/d, the Nuer side 8-12L/p/d and the Dinka side approximately 13l/p/d. This leads to increased levels of diarrhoea. People, women in particular, spend valuable time waiting at water points for the meagre water resources. Refugees can be seen scooping up muddy run off water into jerry cans to use for bathing and cooking. With malnutrition rates at over 20%GAM in May, MSF cited restricted water sources as one of the central factors in the poor response to nutritional

**Strategy: Improve water and sanitation activities and UNHCR technical support to the sector**

- Recruit regional (hub) water/sanitation technical Experts
- Recruit a water/sanitation technical expert at each country office
- Improve quantity/quality of water
- Improve data collection and reporting
- Improve hygiene promotion

**Issue # 6: Over Emphasis on Curative Care and with lack of Resources in Preventative Care:**

Health care facilities are essential for the treatment of illnesses, reduce mortality and improve well-being. In these facilities there are normally preventative services also. These include vaccinations for children and pregnant/lactating mothers, ante-natal and post natal services and health education sessions.

**Provision of Services:** Tanzania and Nepal refugee programs both have a complete health system with curative and preventative services available. They rely on competent NGOs to run the programs, demanding a high quality of service. The health systems work and the malnutrition rates remain consistently low. In Ethiopia and to some extent Bangladesh, UNHCR's health counterpart is a government agency and UNHCR is not able to exert as much influence in terms of provision and care and guidelines as might be needed. While capacity building is ongoing, the protracted health services remain below standard with commiserate higher rates of malnutrition.

However the corner stone to the well-being of refugees is to try to keep people well rather than curing their illnesses. Community health workers are instrumental in this process as they are the link between the community and the health services.

Environmental health is determined by the services offered to the community. This includes adequate safe drinking water, latrine construction and waste management.

Other public health issues include malaria prevention programmes with distribution of ITN's and residual insecticide spraying.

To support good nutrition it is necessary to promote diversification of diet, support mothers with infant feeding and complementary feeding for their young children. Screening is essential to detect malnourished children for inclusion in special nutrition programmes.

In the refugee camps in Ethiopia and Kenya the number of Community Health Worker's is far below the required numbers as identified by Sphere. This seriously impacts on the level of community interventions. Furthermore the CHW's are often utilised in the health services therefore not available for their communities. CHW's do not always have monthly work plans and therefore get either over-stretched or under utilised. Many cited they had not received any training for many years. No health education/promotion material was available to any of the CHW's interviewed.

**Training for the Future:** Not only are Community Health Workers a cornerstone of successful prevention programs in refugee camps, but the CHW of today will become the health expert of tomorrow in repatriation situations. All of the work and training that a CHW receives will pay back his/her community ten fold by carrying the health knowledge back across the border to assist their underserved communities.

**Strategy: Strengthen the preventative care component of health care with resources, training and technical support**

- **Develop and/or strengthen integrated preventative care programmes** where strong weight is given to preventative activities such as immunization, health promotion, vector control and nutrition well-being
- **Improve the CHW programs** in both camps including number of CHWs (increase by 50%), increase number of female CHWs, improved and clear work plans and job descriptions, data collection and training and supervision especially in infant feeding practices, PMCTC and nutrition.

- **Increase water and sanitation resources to acceptable minimum standards,** Water needs to be good quality and adequate quantity. Hygiene promotion activities to ensure water remains safe in the household is essential

### **Issue #7: Nutrition Interventions for the Treatment of Moderate and Severe Acute Malnutrition are Below Minimum Standards**

The treatment of severe malnutrition has been researched for many years with huge gains in reducing mortality with the appropriate treatments. The UN bodies, NGO's and governments have developed guidelines around the most appropriate treatment for severe acute malnutrition. It normally requires admission into a centre for a period of approximately a month, either a day care or 24hr care facility. The time spent in the centre with one sick child is a huge burden on the mother or carer as normally there are many other children at home to care for.

In the last few years a new initiative has been researched called "community-based management of severe malnutrition", whereby only the severe complicated cases are admitted into a centre and the others are treated at home in their community with a special food called "ready to use food" (RUTF). This has been very successful with cure rates similar to a centre based approach. The added bonus to this type of intervention is that it is possible to get a much higher coverage of the feeding intervention as the mothers do not need to spend a long period in a centre.

In the Kenyan and Ethiopian refugee camps the standard guidelines for the treatment of severe malnutrition are not being adhered to, including the use of the correct foods, accurate measurements of amount of specialised milk given especially in the early stages of admission. Standard drug protocols are not being given including routine broad spectrum antibiotic on admission. The coverage of the programme is extremely low in some of the camps, only between 20-30% of malnourished children are actually being treated in the feeding centres. It is unclear what happens to those children not admitted, do they recover at home or do they die?

The Supplementary Feeding Programme (SFP) is the forum for the treatment of moderate malnutrition which means attending a centre either weekly or bi-weekly for a dry take home ration of CSB, oil and sugar already pre-mixed. Children are weighed and measured, health promotion is given and routine medicines such as de-worming, and Vitamin A and iron supplementation are often given. Other groups are often included in the SFP including pregnant/lactating women and the chronically ill.

**Poor Quality/Poor Coverage:**

In the Kenya Camps children were attending the SFP weekly, but often with other siblings rather than the mother due to her high work load. Routine medications were not given. There was no regular health/nutrition promotion. The SFP coverage was around 50%, meaning that only half the moderately malnourished children in the camp had been identified and admitted into the programme.

## **Strategy: Improve the nutrition interventions for the treatment of moderate and severe malnutrition in the refugee camps**

- **Improve the nutritional services in the Refugee camps.** A technical review of the current nutrition interventions in refugee camps would be extremely beneficial to improve programming. Ensure standard international/national guidelines are in place for the treatment of severe malnutrition with standard admission drug protocols, standard feeding protocols and clear admission/discharge criteria.
- **Introduce the “Community-based Management of Severe Malnutrition” approach to treatment of severe malnutrition.** UNHCR HQ needs to roll out this concept in suitable programme areas and ensure funding/resources for training and RUTF available.
- **Improve SFP services and Coverage.** Technical review of supplementary feeding interventions to ascertain low coverage and why malnutrition remains a problem. Look at quality of programming such as routine drug protocol adherence, frequency of distributions, distance of intervention from refugee population and prevention/education activities.

## **Issue #8: In Malaria endemic areas there is no Clear Strategy for Curative and Preventative Care**

Malaria is one of the leading causes of mortality and morbidity particularly in developing countries. Over 1 million people die of malaria each year and the vast majority of these are children under five years, killing a child every 30 seconds<sup>25</sup>.

In keeping with the **UNHCR strategic plan for malaria control 2005-2007** and its commitment to the treatment and reduction of malaria through nine strategic objectives, see below, steps need to be taken to address the issues within the camps without delay.

1. Protection: To protect the right to health of refugees and other populations of concern, with special reference to malaria
2. Participation: To promote beneficiary participation in malaria control programmes
3. Assessment and planning: To conduct standardised assessment and planning of malaria control programmes
4. Access to treatment and prevention: To ensure that refugees living in malaria endemic areas have access to effective prevention, diagnosis and treatment, according to international standards
5. Capacity building, training and supervision: To build capacity of UNHCR, partners and refugees to control malaria
6. Monitoring and evaluation: To monitor and evaluate malaria control programmes
7. Advocacy and resource mobilization: To advocate for inclusion of populations of concern into malaria control programmes and to mobilize resources for malaria control for refugees and displaced populations
8. Coordination: To coordinate malaria control activities locally, regionally and internationally
9. Durable solutions: To ensure that return, repatriation, rehabilitation and reconstruction programmes include malaria control

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<sup>25</sup> Looking forward, The Roll back Malaria

To address malaria a preventative and curative approach is required. Prevention is the key to success. Over the years there has been much research and success with indoor residual insecticide spraying, larval control and insecticide treated nets. Treatment for malaria has also changed mainly due to the development of resistance to drugs. New multi-therapies have been developed and although many countries have adapted these therapies in their national malaria strategies the drugs remain very expensive.

Most of the present protracted refugee caseload is in developing countries, with a substantial proportion in Africa. Camps are often in isolated rural, malaria endemic areas with poor infrastructure. The Kenyan and Ethiopian refugee camps are in highly endemic areas with long seasons of constant malaria. On the health clinic statistics suspected malaria was by far the biggest cause of morbidity. Mortality data is not well recorded so it is difficult to know if malaria is a primary cause.

**Malaria Crisis:**

In Shimelba refugee camp, Ethiopia, in November 2005 almost 42% of all consultations were suspected malaria cases. The hospital was overflowing with patients. Three people had died of suspected chronic malaria within a six hour period, just prior to the visit of this mission to the camp. The ARRA camp manager said that he was fearful of getting malaria himself.

In Ethiopia residual spraying was done in the western camps but not allowed in the northern camps (government policy). It is unclear why there are two different policies in the one country. In Dadaab camp in Kenya residual spraying is planned for twice yearly but in 2005 was only done once due to budgetary constraints.

Insecticide treated nets are distributed in an adhoc fashion. In some camps almost no nets have been distributed, mothers receive nets after delivery of babies rather than during pregnancy when malaria can cause life-threatening complications. The under-five children do not seem to get any particular preference. There is a debate that to have good community protection and reduce mosquito levels that up to 80% of the households need mosquito nets<sup>26</sup>.

The multi-therapies for the treatment of malaria have now become standardised in many countries due to high resistance to other drugs. This requires a substantial extra budget to pay for this treatment as it is extremely expensive with one treatment costing up to eight USD. The budget for malaria treatment may be higher than the total drugs budget for any refugee camp health programme. Although in Ethiopia and Kenya these drugs are now officially the first line treatment for malaria the budget or drugs are not available from UNHCR for refugees.

**An Ounce of Prevention:** In Kenya, the cost of the new line malaria drugs *per treatment* is **double** the cost of a single mosquito net.  
1 treatment = Ksh 500    1 mosquito net= Ksh 250.

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<sup>26</sup> Christopher P. Curtis, General issues and challenges for current malaria vector control and personal protection. LSHTM.

**Strategy: A clear strategy needs to be developed for the prevention and treatment of malaria in refugee settings**

- **Develop a strategy to address the extremely serious issue of preventative and curative care for malaria** in malaria endemic areas including provision of sufficient bed nets (ITN) and residual insecticide spraying. A concerted effort needs to target mosquito impregnated bed-nets to households with young children and pregnant/lactating women. This needs urgent attention.
- **Resources need to be made available for multi-therapies for the treatment of malaria.** It is now recognised that in many countries the present drug treatments are not effective, due to high resistance. The new therapies need to also have equipment for testing for malaria and training for health workers.

**Issue #9: There are extremely high levels of anaemia in children under five and pregnant women in some refugee camps.**

Anaemia due to iron deficiency is a major public health issue worldwide. Every age group is vulnerable. It impairs cognitive development in children and affects the immune system. During pregnancy it has huge implications on the mother and infant, with increased risk of haemorrhage, sepsis, maternal mortality, perinatal mortality and low birth weight.

WHO states that anaemia levels greater than 40% in a population is a major public health issue. It is difficult to determine anaemia levels in populations as it requires an invasive procedure to take a blood specimen from individuals being researched/ tested. Micro-nutrient studies were conducted in refugee camps in three countries during 2001-2002, Kenya, Ethiopia and Uganda. Children under five years, pregnant and non-pregnant women and some adolescents were also included in the study. In all but two camps in children under five the anaemia prevalence was between 60-70% which is astonishingly high. A follow up study in Kakuma camp, Kenya in 2004 showed anaemia levels as high as 83% in the under five population. In Dadaab camp in Kenya anaemia was around 75% for pregnant and non-pregnant women.

Although there is an awareness of the high levels of anaemia in protracted refugee populations, the present health/nutrition interventions do not actively try to address the issue. There is no strategy to systematically address the high levels of anaemia. Routine iron supplement is not systematically given to all pregnant and lactating women. In the Kenya and Ethiopia refugee camps although pregnant and lactating women were in the SFP they did not automatically receive iron supplementation in practice. Children under five are not routinely de-wormed and children attending the SFP do not routinely receive iron supplementation.

The present general food ration, depending on the cereal in the ration gives around 100% of the iron requirements. However the iron is mainly contained in the cereals with low bioavailability, due to phytates present in cereals/grains. Haem iron present in meat, poultry, fish and seafood is a rich source of iron but is not available in the refugee general ration. Vitamin C enhances absorption of Iron however there is no Vitamin C in the general ration if CSB is not part of the ration. Also Vitamin C is an unstable component and the CSB loses its



Vitamin C value with the length of time it has been fortified. Tannins present in tea, coffee, cocoa and herbal infusions also inhibit the absorption of iron.

Malaria, the biggest single cause of morbidity in the Ethiopian and Kenyan refugee camps has a major impact on anaemia causing the destruction of red blood cells during episodes of malaria illness and thereby increasing anaemia.

**Case study:**

In Ethiopia the health information statistics in Shimelba recorded on average 50 cases of anaemia monthly over a six month period in 2005 (clinical anaemia). In November there were 114 cases of clinical anaemia in Fugnido camp.

At Kakuma refugee hospital laboratory about ten patients are tested daily for anaemia, normally only tested when severe clinical signs and symptoms are present. This would equate to potentially around 200 anaemia cases a month. Looking at the results over a month period many of the cases had very severe anaemia with Haemoglobin as low as 3g/dl. In Dadaab, 140 emergency blood transfusions were conducted in August 2005 due to haemoglobin levels below 6g/dl.

**Strategy: Reduce Alarming Anaemia Rates**

- **To reduce anaemia rates**, continue to target P/L women for feeding as a safety net but also ensure iron/folic is distributed systematically throughout pregnancy, linking in properly with ANC facilities. Conduct study to understand extent of the current anaemia problem.
- **De-worming in under five children and school age children**, will help to reduce levels of anaemia
- **Malnourished children must systematically receive iron supplementation**
- Introduce “complementary foods” especially tinned tomatoes to improve Vitamin C content in the general ration

**Issue #10: Lack of main-streaming HIV/AIDS activities to support the prevention of HIV/AIDS and support people living with HIV/AIDS is high risk**

The importance of prevention and treatment of HIV/AIDS is unquestionable. In protracted refugee situations the need for main-streaming is even more important as the refugees may go from areas of low prevalence to high prevalence and therefore need to be aware of the issues and risks in becoming infected.

Due to the dependency factor some refugees resort to risky behaviour to support families, such as brewing local beer, prostitution and early marriages. Most deliveries are conducted in the home where hygienic conditions may not be optimal. Female genital mutilation (FGM) is high in some communities and increases HIV/AIDS risk, one among many other problems related to FGM. Although the uptake of condoms in the Shimelba camp in Ethiopia has increased so has the incidence of sexually transmitted diseases (STD's) which is a precursor to increase in HIV/AIDS.

Lack of NFI's, in particular firewood makes it necessary for women to go outside the camp to collect firewood, which often leads to hostility with the host community and can lead to attacks and rape.

### **Strategy: Mainstream HIV/AIDS services in all protracted refugee situations**

- **VCT services available in all refugee camps, and strengthen programmes around awareness of HIV/AIDS**
- **Develop nutrition interventions targeting PLWHA**
- **Ensure updated information on PMTCT is available in all programmes**

### **Issue #11: The Ration is Inadequate in terms of Quantity and Quality**

Currently the provision of the general ration is based on a figure of 2100 Kcal, with an official ration scale developed for the refugee camp. While the ration might appear sufficient on paper, the reality of what is actually delivered and distributed to refugee is often very different.

#### **Ration on Paper versus Ration Received:**

In Chad, despite a 25% GAM, only 17% (May 2005) of refugees received the full 2063 kcal ration distributed, and only 25% in June 2005. ( NICS August 2005)  
In Kenya, the ration widely fluctuates per month. There were distributions where refugees only received 1434 kcal for fifteen days and had only 14% of their calcium needs, 83% of their iron and 0% of their vitamin C needs met, despite a 2170kcal ration on paper. For a population facing critically high levels of anaemia and malnutrition, a month with poor quality ration is highly significant.

Unfortunately, even the official ration is often not sufficient in terms of calories, fat, protein, and key micronutrients. For refugees in dependent protracted situations, it is important that the ration is sufficient in quantity and quality to meet the needs, because often the refugees do not have access to other food stuffs to diversify and supplement their diet. One issue is in terms of key micronutrients. Many refugee programmes prioritise basic calories over micronutrients, and while a ration might be sufficient in the first, it is often badly lacking in the second. Refugees living in harsh climatic environments without adequate means for

gardening and vegetable production are going to need to obtain their vitamins and minerals from the general ration. Because of this, UNHCR and WFP have an agreement for the provision of blended foods (WFP) and complimentary foods (UNHCR).

4.1 WFP is responsible for mobilizing the following commodities, whether for general or selective feeding programmes: cereals; edible oils and fats; pulses (or other sources of protein when appropriate and jointly agreed upon); blended foods; salt; sugar; and high-energy biscuits. Where beneficiaries are totally dependent on food aid, WFP will ensure the provision of blended foods or other fortified commodities in order to contribute to preventing or correcting micronutrient deficiencies.

4.2 UNHCR is responsible for mobilizing complementary food commodities when recommended by JAMs or on the basis of specific health/nutritional and/or social assessments, particularly when refugees have limited access to fresh food items. These complimentary commodities include local fresh foods and therapeutic milk (to be used in selective feeding programmes). UNHCR may mobilize spices and tea, when recommended.<sup>1</sup>

Ideally all refugee programs would benefit from these additions, as they add essential elements to the diet, as well as making the food more palatable and acceptable. Unfortunately, up until now, complimentary foods have been given in very limited quantities, primarily to programs in Asia and Eastern Europe.

**Equal ration for all?** When micronutrient deficiencies were detected among the Bhutanese refugees in Nepal, it prompted changes in the general ration. Polished rice was swapped for parboiled rice, blended foods were added, and the complimentary food being given by UNHCR switched from radish to green/yellow leafy vegetables. When WFP decided to end the blended food in the ration, it supported a home gardening project instead and funded a women refugee group to promote the growing of sprouted chick peas to improve the diet. The current ration scale is 410g parboiled rice, 60g pulses, 25g oil, 20g sugar, 7.5g salt and 100g fresh vegetables from UNHCR. The malnutrition rate hovers around 8.0%. Ethiopia refugees receive 500g cereal grain, 50g pulses, 30g oil and 5g salt and the current malnutrition rate in Fugnido camp is around 21% GAM, with high levels of anaemia and probable vitamin C deficiency.

A second issue has to do with the quantity of food in the basic. The 2100kcal average was intended to be the average per person caloric need, not the actual needs of a single individual. In most families, this average is very useful because the smaller children can share their calories with the adult members of the family. However, in situations where the demographics are greatly skewed, it is important that the enhanced caloric needs of the population are taken into account when determining the appropriate ration scale.

**Demographics in Shimelba Camp, Ethiopia:** Over 71% of the population is male, many of them single and the 2100kcal ration scale does not adequately address their food needs. Interviewees, when asked to point out vulnerable households in all camps, usually point to HH size 1 as the most nutritionally stretched. If a refugee man (between ages 15-59 years as are 60% of the male population) in Shimelba is regularly receiving 1918 kcal/day (after milling costs), then he is 662 kcal short per day, assuming he able to consume 100% of the 1918 kcal. This level of kcal deficit will have serious long term effects on his health, his ability to ward off diseases (particularly in a malaria endemic zone), and his ability to function at full capacity to meet life needs (firewood and water collection, income generating activities etc.). The 2100 kcal standard is an *average* and not actually the exact needs of any single group. It is assumed most refugees are a family unit, with children sharing excess calories with adults. When this is not the case, the 2100kcal standard needs to be readjusted.

A final issue is around the issue of milling. As stated in the MOU, WFP is responsible for cover the cost of milling by providing an additional 10-20% of the cereal grain in the ration. As well, WFP is charged with ensuring that adequate and affordable sites are available in the camps. Milling costs can greatly diminish the value of the ration basket and must be calculated into any ration where cereal grain is given.

#### **Strategy: Improve Ration Adequacy**

- **The ration must be sufficient to meet the basic macro and micronutrient needs of a dependent population.** This includes sufficient calories, fat, protein, iron, vitamin A, vitamin C, iodine, vitamin B1, B6, B12. The specific demographics of the population must be identified, and caloric increases made from the 2100kcal minimum if necessary.
- **Decrease caloric loss to refugees from milling** by providing additional cereal (70g) or additional calories (170 kcal) to cover the cost associated with milling whole grain cereals. Ensure milling facilities for all camps
- **The micronutrient quality of the ration is essential.** The ration should meet all basic standards through the standardized inclusion of a fortified blended food (minimum 40g) and complimentary foods (minimum 50g). In areas of severe micronutrient stress, additionally fortified flours and double fortified salt be considered.
- **Food Diversity is important.** The addition of complimentary foods diversifies and enhances a monotonous diet, both in terms of nutrients and palatability.

#### **Issue #12: The Ration is not eaten**

Few issues can cause as much anger and concern with donors than the misuse or sale of a donated commodity. While food from the ration is sold for a variety of reasons (surplus, lack of essential non-food items, and purchase of complimentary foods), one central cause of ration sale is the dislike or devaluation of a foodstuff. The most common problem is the sale of one cereal to purchase a second one. Cereal acceptability is deeply rooted in cultural

practices and beliefs, some of which have developed within the refugee camps themselves. For example, the Somali refugees in Dadaab prefer wheat flour (see box test). In fact, it's possible to say that they openly dislike yellow ground maize and when that is the distributed commodity they will try to sell it to purchase wheat. This has, unfortunately, become a highly controversial and contentious issue with donors disparaging the preference and claiming it will not be indulged. It is difficult to fully understand the vitriol behind the issue. WFP would not distribute maize to the refugees in Bangladesh, because it is not an accepted or valued commodity. Refugees have a right to have a preference in terms of cereal, and should be given, whenever possible, the cereal of choice. Nutritionally, it is better to give a group a preferred cereal, because they are more likely to eat it.

The same thing is true of pulses. In many programs refugees are receiving a form or pulses or beans that they dislike. Because they dislike it they tend to sell it or trade it at very low terms of trade (because no one likes it). Therefore they might be losing the only significant protein in the ration. This is really not appropriate and every effort should be made to improve the choices of commodities so that they prioritise refugees eating habits.

**Fugnido Camp, Ethiopia:**

*I can't give my child (17m) the white beans because they cause diarrhoea. I can't give her the maize grain because it is too hard to chew, so she has biscuits when I can buy them or tea.*

Refugee mother interview

**In Dadaab Camp, Kenya:**

The refugees so prefer wheat flour to maize that they will sell it at very poor terms of trade. A family size five would sell 5kg of maize to buy 1 kg of wheat or selling approximately 17,500 kcal to obtain less than 3,500 kcal of food

As mentioned above, fortified blended foods offer an excellent source of calories and nutrients to the diet. There are questions over the use and acceptability of blended foods. In many programs the refugees are not properly educated or informed about the blended food and do not realize its nutritional content or worth for the whole family. It is extremely important that information campaigns are held to introduce refugees to new food commodities. Blended foods in particular are an ideal breakfast food and the use of the food to make porridge is very simple. Refugees, particularly in protracted situations, are very interested in obtaining knowledge and information and particularly anxious when faced with change. These groups need to be informed, ideally through a food and nutrition committee, in order to better support their use of diversified foods.

**Strategy: Improve Ration Acceptability by Providing Priority Foods**

- **Improve ration acceptability and improve caloric intake** of the ration by offering refugees the preferred commodity, either cereal or pulses, whenever possible.
- **Improve CSB acceptability** by conducting an information campaign around its use and value.

**Issue #13: Improve Ration Management**

Without question, programs that experience frequent pipeline breaks, late delivery of food items or unmonitored distribution of goods face higher malnutrition rates. The management

of the ration is in many ways as important as the ration itself, because mismanaged food often means an inconsistent or incomplete food basket.

Refugees who are highly dependent on the food ration carefully budget their food needs from one distribution cycle to the next. If the food arrives late or does not arrive at all, the refugees will be left without options and often will have to skip meals, reduce meal size or develop other difficult coping strategies.

**Paying for late deliveries:** In Bonga Camp, Ethiopia if the ration is late, as it was five months out of twelve in 2005, the Uduk refugees go to the local market and borrow food. Once the general ration arrives, the refugees then pay back the food to the market at a 35-50% mark up. They lose approximately one third to one half of the ration due to the late deliveries, and reduce the meal size and frequency to make up for the shortfall.

Food is late for several reasons, either having to do with breaks in the pipeline, late vessels, poor road conditions, unreliable transporters or some other unpredicted event. While exact logistic problems are difficult to predict, it is less difficult to realize that there are many places something can go wrong and that steps need to be taken to minimize the possibility of something going awry. Strategies such as food pre-positioning, in-country buffer stocks, road repair and transport contracts can all mitigate unforeseen food problems and ensure that the refugees are not left without food.

The overall issue is that some country programs are able to ensure the timely provision of food, while others are not. Pre-positioning food, maintaining buffer stocks, contingency planning for pipeline breaks and borrowing from national stocks are all standard practice in a well run operation and should be encouraged. WFP has initiated a process to improve further on this to ensure up front funding and food availability for new operations but if donors do not pledge the food, no amount of planning will help. When pledges are on time and fill requirements, WFP rarely has difficulty getting food to people on time, barring the exceptional. Country programs with stable food pipelines generally show lower malnutrition rates than programs with chronic food problems.

**Pipeline Problems:** In Nepal and Tanzania, the relief food pipeline is stable, functioning in Nepal at close to 100% and in Tanzania with in-country buffer stocks to smooth any pipeline disruptions. The malnutrition rates are 8.0% and 3.0% (on average), respectively. In Ethiopia and Bangladesh, the pipeline is inconsistent and not unremarkably the malnutrition rates for those two programs hover up to 20% and 13%, respectively. Food delays and pipeline breaks cause nutritional stress on the population.

Once the food is available in the camp for distribution, it is essential that the food distribution system is transparent, participatory and fair. On-site monitoring of the distribution by both UNHCR and WFP should occur. Food leakage, under and over scooping, multiple rations

cards and ration card fraud should all be forcefully addressed. Women refugees must be given a central role in the distribution process.

**Distribution Monitoring:** In camps with active distribution monitoring, the process for refugees is more equitable, more transparent and safer. While distribution monitoring does not guarantee low malnutrition rates, only programs with good monitoring have low malnutrition rates.

**Multiple Ration Cards:** During the December distribution in Shimelba camp, refugees were arriving at the registration table with two and three cards and receiving ration vouchers for each one. There was no on-site monitoring or verification by UNHCR or WFP presence at the distribution.

Poorly managed and monitored distributions cause insecurity and uncertainty among refugees. It allows for the stronger and more powerful to reap additional benefits from the process. Improving the distribution system can ensure that food is reaching the intended beneficiaries and can have a positive effect on malnutrition rates.

Post-distribution monitoring is also essential. This is currently being carried by WFP in many programs worldwide. Unfortunately the current program is not as effective as it could be due to poor questionnaires, poor training and lack of sufficient financial support. This post-distribution monitoring gives insight into the use, acceptability, and sufficiency of the ration. The information is of primary concern to both WFP and UNHCR, as it helps identify vulnerable groups, protection issues, programming gaps and strengths and refugee needs. It would be highly beneficial if UNHCR worked with WFP to fund and support post-distribution monitoring in order to improve and expand the current knowledge base around food, nutrition and relief in the camps.

#### **Strategy: Improve Ration Management**

- **Programs with chronic delivery issues need to engage in basic strategies to improve the timely delivery of the food**, including buffer stocks, pre-positioning and transport contracts.
- **A joint UNHCR and WFP strategy to work with donors to develop solid commitments for the timely provision of needed food aid should be developed.**
- **The link between food delivery and distribution and nutrition must be acknowledged by non-technical staff** to encourage more effective refugee involvement and support.
- **Distribution monitoring must occur by UNHCR/WFP at all distribution sites.**
- **Post-distribution monitoring should be streamlined and standardized in all camps and collected by a joint UNHCR/WFP initiative.**

## Issue #14: Enhance Self-Reliance Initiatives

One of the most central issues to stable malnutrition rates in protracted refugee situations is whether or not refugees have access to income or micro-agricultural initiatives to help support their needs. In host countries that support or encourage refugee productivity, such as Tanzania, Zambia, Nepal and to some extent Bangladesh, refugees are far more self-reliant, independent, and by extension, healthy.

UNHCR and WFP speak of encouraging refugee economic capacity, yet very little programming dollars are given to fully realize this potential. UNHCR needs to work closely with host governments that are reluctant to allow for refugee agricultural initiatives in order to encourage these programs, reasoning that without some self-reliance activities, refugees are not able to live at a minimum standard. This would include relaxing of strict encampment policies, allowing for some agricultural production (such as the 4km planting belt established in Tanzania) and authorizing income generating activities in-camp or formal sector employment outside of camp.

**Zambia Example:** “Refugees are meant to receive a full food ration, but shortages in the food pipeline have occurred many times. Fields around the camp are available to the refugees for cultivation and home gardens are widespread. Refugees are allowed access to work outside of camp and there are some income generating activities in the camp such as bakeries, blacksmiths and small shops.” NICS, August 2005  
The current GAM is 1.5% for the refugees.

For refugees in protracted situations, it is simply not possible to rely on WFP and UNHCR to provide for 100% of food and non-food needs. Refugees must have the opportunity to diversify their diet, purchase items for the household as well as reserve money for emergencies or periods of stress. Income generating activities allow for skills building, money generation and hope in the future. As most refugees arrive in camps destitute, there is often a need for start-up money to begin projects that will become self-sufficient over time. UNHCR, WFP and implementing partners needs to support these small ventures to help enhance refugee future self-reliance.

Multi-story gardening and other micro-gardening initiatives offer opportunities for refugees to produce for their own needs, diversify their diet and add much needed micronutrients to the donated food. While all backyard garden initiatives are important, multi-storey gardening is particularly suited to dry and harsh environments where land quality is poor and water resources limited. This program has been piloted in Kenya and is an excellent intervention that can be reproduced in protracted refugee setting worldwide. There are many benefits of the MSG project. These include:

1. **Dietary diversification:** refugees are able to add both nutrients and taste to the monotonous diet.



2. **Nutritional education component:** refugees learn about aspects of diet, sanitation, child feeding, complimentary foods and food nutrient values.
3. **Women's empowerment:** women are targeted, learn the skills and reap the benefits
4. **Income generation:** successful women growers are given additional MSG and encouraged to sell surplus vegetables
5. **Community promotion and health:** will develop a "model gardener project" where motivated women will become change promoters in their communities and offer nutrition and growing advice to others
6. **Self-reliance:** the affect of MSG on mental health can not be overrated. Protracted refugee encampment offers very little possibilities for hope and self-reliance. Families with garden can begin to have some control over their own diet and resources.

Refugees involved in the project are very enthusiastic and are clear about the very real impacts it has made on their lives.

***Halima Mohammed Aliyow, MSG Woman Gardener, Dadaab Camp***

I have a family size of fifteen, including two children under five and three nieces and nephews under five. I also have an older disabled son and my blind father living with me. I was very concerned because we never had quite enough to eat and the old man in particular was tired of always having the same food each day. I began with five sacks, but I enjoyed it so much I asked GTZ for an additional five more which they gave me. I am growing okra, spinach, tomatoes, coriander and Kenyan spinach. I grow enough for everyone in the house to eat, plus I can give a little away to the neighbours. I feel like my family is healthier, we are happier and I don't have to worry so much about feeling hungry. I used to sell a lot of the ration to buy things like tomatoes and spinach, but now I don't have to do that. I would like to become a Model Gardener for my block. I could teach people about growing and cooking the vegetables. If I could double my plants I could sell the excess to my neighbours, already people come by and ask me about my garden and if I have anything to sell. I use run-off water from the tap stand to water my plants, and they just grow and grow and grow.

Finally, there is a need to seek creative work opportunities for refugees in protracted refugee situations, especially where movement is restricted. One possibility is the creation of macro-enterprise that can employ large numbers of refugees in a service or production enterprise. Examples of this would be a women-run catering firm that produces food for the employees of aid organizations, or for meeting and workshops. A second possibility would be a factory, such as a soap factory, that could produce the soap that UNHCR gives for the sanitary napkin project. UNHCR could buy the soap directly from the refugees, both reducing transport costs and support refugee self-reliance.

Whether income generation, MSG, or micro-agriculture, it is essential that refugees be made players in their own futures. It is degrading and debilitating to be a long time recipient of assistance and to not have any possibility of self-reliance and self-respect. Self-reliance activities enable refugees to have input into their own food and nutrition outcomes and to look towards a possible future. Unless UNHCR and WFP is able to guarantee refugees 100% assistance for the duration of their encampment, then self-reliance activities provide refugees

with a much needed cushion when the provision of food or non-food items is inadequate and refugees must provide for themselves.

#### **Strategy: Promote and Expand Self-Reliance Activities**

- **Develop essential budget lines to actively promote income generation activities in all refugee camps.**
- **Hold policy discussions with host governments to ease restrictions on refugee movement and to support agricultural and economic activities.**
- **Provide, without exception, seeds, tools and training to all refugees in all protracted refugee situations who wish to engage in micro-agricultural initiatives.**
- **Develop funding for the MSG project, particularly in camps with limited land and water.** Begin Model Gardener project to support women's income generation and empowerment
- **Seek new and innovative macro-industries for inside the camp, such as a soap production factory.**
- **Ensure that self-reliance activities are closely examined during Joint Assessment Missions to improve accountability and determine level of self-reliance achieved.**

#### **Issue #15: Essential Non-Food Needs**

Currently the provision of non-food items by UNHCR and implementing partners in protracted refugee situations is highly inconsistent. NFI refer to all of the essential needs of a dependent refugee beyond the general food ration, including plastic sheeting, blankets, kitchen sets, jerry cans, soap, clothes, cooking fuel needs. UNHCR's commitment is to distribute the NFIs once every two years (except soap which is ongoing).

Non-Food Items have a direct impact on the nutritional intake of refugees, because if they are not provided routinely, or if they are not sufficient, then the refugees will have to purchase these items themselves, and often they will sell the ration to do so. The key to understanding non-food items is understanding that these are *essential* items and for dependent groups without economic purchasing power, these items *must* be provided to support basic health and welfare standards. NFI must be considered alongside the food ration as an essential part of the assistance package.

**Selling Food for NFI/Selling NFI for Food:** A good example that illustrates the intertwined nature of NFI and food occurred in Fugnido camp in 2005. At the beginning of the year, refugees were receiving only 66% of their food needs. There were high malnutrition rates and refugees were hungry. During this time UNHCR conducted a mass NFI campaign and provided jerry cans and other NFI to the whole population. Refugees sold these jerry cans to purchase grain at a terrible price (EB2.00). In September, the ration was restored to 100%. Refugees then sold the cereal at a terrible price (EB4.00/kg) to buy jerry cans (EB10.00). This example shows that you can't have food without NFI or NFI without food, because both are essential to health and well-being.

Clothes are also an integral part of the NFI package. Like most of society, refugees have a right and a desire to have appropriate clothing for the weather and cultural conditions. While many might argue that clothes are not *essential*, one would not die without them, they become *essential* if refugees demand them as an integral part of their self-respect and dignity. Refugees should be provided with clothes, at least one full set, as recommended by the SPHERE standards. Refugees who do not receive clothes will be forced to purchase these clothes, often at great nutritional sacrifice because the ration will be used where no income is available.

Cooking fuel and firewood are also basic needs in protracted refugee situations. The ration package given usually contains only raw food that must be cooked. For refugees to meet their food needs, they must also be able to meet their cooking fuel needs. As environmental degradation becomes more pronounced worldwide, the use of firewood and charcoal is becoming less and less advantageous. It is the responsibility of UNHCR to determine its fuel policy for the future. Refugee protection issues are becoming more extreme when they leave camp boundaries to gather firewood, competing with the local population for scarce resources. The cases of rape and attacks on refugee women collecting firewood have increased over the last ten years and host governments are becoming more serious about restricting refugee movement outside the camp borders. In areas where firewood is not scarce and regulations do not prohibit collection, refugees are relatively ensured cooking fuel. However, in protracted situations where the firewood is not available, such as Chad, Kenya, parts of Ethiopia, and Algeria, UNHCR is obligated to provide sufficient cooking fuel to the refugees either in terms of kerosene, ethanol or a firewood distribution system. Where UNHCR does not fulfil this obligation, refugees will be forced to purchase cooking fuel at a detriment to their income or ration or to collect fuel themselves at a risk to their personal safety.

**Alternative Fuel:** Project Gaia/UNHCR has piloted clean cooking stoves in Shimelba camp that use ethanol as the fuel, which can be obtained cheaply from a sugar cane factory.  
Benefits include-

- reduced firewood gathering so more time for IGA, child care, vocational training
- reduced confrontations with the local population
- less burden on girl children
- less backbreaking labour for women and children
- reduced environmental degradation
- reduced health affects of smoke including cough and tearing eyes

While the provision of NFI do not guarantee low malnutrition rates (food and NFI must be linked), there are no programs with low malnutrition rates that do not also have decent, regular and sufficient NFI. In Nepal and Tanzania, the provision of NFI is adequate and regular and these protracted refugee situations have very low rates of malnutrition. In Bangladesh, the provision of NFI is good, but the pipeline is poor so the rate of malnutrition is around 13%. In Kenya and Ethiopia where the provision of NFIs is very poor and the ration and health services are not good, the malnutrition situation is alarming.

Non-Food Items can also be seen in light of refugee basic human rights. The Humanitarian Charter and subsequent SPHERE standards outline the very minimum standards that are important for health, human dignity and communal life. The right to adequate housing covers not only the idea of shelter needs and material, but also safe drinking water, refuse disposal, protection from the cold, damp, heat, rain and wind and other threats to health. The right to adequate shelter is greatly curtailed if plastic sheets are not available for roofs or blankets and mats are not provided for sleeping.

***Sphere Standards for Non-Food Items include***

**Standard 1:** Clothing and Bedding (A full set of clothes for each person, and sufficient blankets/bedding for the family to sleep separately if customary)

**Standard 2:** Personal Hygiene (250g bathing soap/person/month, 200g laundry soap/person/month, sanitary pads for women and girls)

**Standard 3:** Cooking and Eating Utensils

**Standard 4:** Stoves, Fuel and Lighting (including fuel for artificial lighting of home)

**Standard 5:** Tools and Equipment (including impregnated mosquito nets for every member of the household and digging tools)

Lack of non-food items effect refugee health, nutrition and human dignity. Refugees will buy the essentials that are not provided, even at the detriment to their own food intake. If refugees are to be supported at minimum standards in protracted refugee programs then they must be given replacement non-food items to ensure the most basic needs are met.

**Strategy: Non-food items must be considered *essential to life* and distributed to refugees in dependent protracted situations in a timely and adequate manner.**

- **NFI must be distributed regularly** and consistently to dependent refugee populations and their link to food and nutrition must be taken seriously.
- **Clothes should be understood as essential** items and provided so that refugees can live in dignity.
- **Non-food items needs assessments should be undertaken to determine priority items and individual needs.**
- **The provision of adequate cooking fuel is an essential part of refugee care.** For refugee populations dependent on UNHCR cooking fuel, sufficient fuel should be provided to discourage negative coping strategies including illegal firewood gathering and sale of food to purchase cooking fuel.
- **UNHCR needs to develop its global strategy around cooking fuel**, in light of environmental degradation, refugee dependency and cost. This strategy is key to identify future fuel provisioning.

## Issue #16: Lack of Gender Equality and Empowerment

Refugee girls and women have special and enhanced needs within the protracted refugee camp situation. Women are normally in charge of most of tasks surrounding water gathering, food preparation, child care, firewood collection, and household work. While their days are filled with high levels of physical work to ensure the survival of the family, they also face stresses around pregnancy and lactation, sexually based violence, FGM, and discriminatory treatment. Opportunities for income generation, education, adult literacy and incentive work within the camp are often not possible due to low literacy levels or high work loads. Both UNHCR and WFP recognize the special needs of women and have put into place policies and programs that seek to highlight the needs of women and girls and support their empowerment.

Unfortunately, despite efforts of gender mainstreaming and women's programming, many of the commitments to women that have been drafted are not being actualised in the refugee camp setting. More effort needs to be made to offer women and girls equal access, equal participation and equal benefits and to recognize the particular obstacles that block women's empowerment.

It has been well documented that the educational level of the mother is the single most influential factor in infant and child health. By supporting the girls and women of today, we are also supporting the next generation of children. Ill-health and malnutrition can become generational curses passed on through micronutrient deficiencies, low birth weight, and inadequate access to services.

Refugee girls and women face increasingly difficult daily lives and are disproportionately affected by proposed budget cuts in community services, IGA, micro-agricultural initiatives, firewood provision and anti-sexually based violence initiatives. These activities greatly enhance the quality of life of women and girls, and moreover protect girls from dangerous cultural practices and negative coping strategies.

**FGM:** Amongst the Kunama refugees in Shimelba camp, Ethiopia, rates of FGM remain at around 100%. There are two types of cutting, but many Kunama still practice complete FGM where a young girl between the ages of 5 and 10 is fully infibulated, her legs are tied together and she is not allowed to move for ten days while she heals. This is to ensure that the vagina is scarred closed and cannot reopen without additional cutting.

Where food rations and non-food support are insufficient, there is an increase in negative coping strategies to meet dietary and economic needs including child labour, prostitution, illegal activities, and early marriage with associated bride prices. Most of these strategies disproportionately affect girl children.

There remains poor female representation in the higher primary and secondary schools and in refugee camps. The mission would recommend WFP consider an incentive program of school materials and/or oil for girls who complete school after grade five when enrolment figures for girls drop sharply due to early marriage, pregnancy and household labour. Clothes are also an issue of concern and camps that do not currently have a uniform program are

encouraged to begin one to ensure that clothes are not discouraging girls in particular from attending school.

**Sanitary Pads:** Before we were given the sanitary pads, I didn't go to school for one to two weeks every month. I would stay at home and work, and every day, five or six times, I would get water to wash out the rag I used. If I couldn't use the rag, I would find leaves or even a stone to use. My mother tells me I should still stay home, but when I get pads, I prefer to go to school. *Interview Kunama girl in Ethiopia, age 13*

In general, more needs to be done to continue to promote gender balance, equality and empowerment. Special reference needs to be given to the girl child who faces additional hardships and often bears the brunt of negative coping strategies due to extreme poverty.

### **Strategy: To Promote Gender Equality and Empowerment**

- **Expand the budget for the promotion of women-focussed activities** including MSG, IGA, sanitary pads, school uniforms and school incentives.
- **Improve activities that protect and promote women's health rights** including FGM, SBGV, birth control, HIV/AIDS, reproductive health.
- **Use school feeding to promote girl enrolment in school and then use school as an avenue to promote nutritional health.**
- **Create special programs to address the needs of the girl child**, particularly in terms of associated negative coping strategies that appear in protracted refugee situations where the standard of living is very poor. This would include equal access to food, education, health services and other activities.
- **Ensure that data collected in all programs and projects is disaggregated by sex and age to improve impact and future programming.**

## **Conclusion**

Malnutrition including micro-nutrient deficiencies has sadly been a factor for many years in some of the protracted refugee camps. The cost on the population is difficult to measure but for sure it has had serious negative implications.

As can be seen from the global strategy report there is a glimmer of hope that this situation can be improved with commitment from the different actors involved in refugee support and care. A multi-sectoral approach is necessary and support from different levels including head-office, country offices and sub-office level of UNHCR and WFP. The implementing partners must also take responsibility for improving the present poor nutritional status.

Furthermore both financial and technical resources from UNHCR/WFP are essential to ensure that progress is made to help reduce the level of malnutrition to within the 10% or below rate in operations with high acute malnutrition rates that The High Commissioner for Refugees has set as a measurable target for UNHCR in 2006.