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

A Joint UNHCR and WFP Review,

January 2006

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[1]. 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 17th of November and the 17th of December 2005. The two country reports[2] 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.[3] 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[4]

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.[5]

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[1] Refugee situations that have existed more than five years. UNHCR EXCOM.

[2] 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 2nd to 16th 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 2nd to 16th of December, 2005 Corbett and Oman, January 2006

[3] TOR for the 2005 Mission

[4] TOR for the 2005 Mission

[5] 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[6]
16. Milling services and milling costs are not being sufficiently provided and having a negative impact on refugee food quantity.[7]
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.[8] This includes micro-agricultural initiatives and the provision of adequate land, seeds and tools.

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[6] Review of documentation, interview of staff and personal observation, SPHERE Standards section 4, Right to Adequate Housing including NFI and Clothes.
[7] See MOU on milling obligations
[8] UNHCR Budget Review Document, IP interviews

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 taheir 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 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 30th 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, 30th 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[9]. 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 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

[9] UNICEF, The silent emergency, www.unicef.org/socw98/

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.[10]

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[11].

Under the International Covenant on Economic, Social and Cultural Rights[12], 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 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.

[10] Human Rights Learning Centre: Study Guide on the Human Right to Food and Water
[11] Convention on the Rights of the Child (1989). Details taken from UNICEF UK Position papers and Policies.
[12] International Covenant on Economic, Social and Cultural Rights

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 used 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[13]

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

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

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).[14]

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.

Malnutrition's main contribution to mortality is through disease. Infant and maternal under-weight together rank as the leading risk factor in the global burden of disease, together contributing an estimated 170 million disability-adjusted life years (DALYs).[15] 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

[14] SCN 2004 5th Report on the World Nutrition Situation: Nutrition for Improved Development Outcomes
[15] WHO. 2002. *The World Health Report*. Geneva.

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:

<u>Management of Malnutrition</u>:

- **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.**

<u>Health Services and Environmental Health Access:</u>

- **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.**

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.

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