



## TECHNICAL PAPER ON THE FOOD INSECURITY SITUATION OF REFUGEES IN AFRICA – June 2014



*Fatouma, a refugee from Central African Republic, holds her 18-month-old daughter, Aishatou, who is being treated for malnutrition at Goré hospital in southern Chad. June 2014 / UNHCR / C. Fohlen*

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## ACRONYMS

GAM	Global Acute Malnutrition
JAM	Joint Assessment Mission
MICS	Multiple Indicator Cluster Survey
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHO	World Health Organization

## 1. SUMMARY

The deterioration of the security situation in South Sudan and Central African Republic has resulted in new major flows of refugees to neighbouring countries. Along with the existing caseload of protracted refugee situations across Africa, the total number of refugees displaced across international borders and need protection from UNHCR is alarming. Many refugee sites in Africa have experienced food ration cuts during the past year or are currently experiencing such cuts due to lack of funding or insecurity. In some cases, such as in South Sudan, the issue of funding and insecurity are intrinsically linked, where logistical, food delivery and convoy or warehousing protection costs increase with mounting insecurity levels. This results in a significantly higher cost for the same amount of food at the point of delivery<sup>1</sup>. UNHCR and WFP undertook a study to examine the extent of the food ration cuts, their effects on refugees, and to recommend possible solutions.

## RESULTS

- A total of 3,321,893 refugees in 293 sites in 40 countries are under UNHCR's mandate in Africa; there are more refugees in Africa living in urban and rural settings in these countries that are not included in this figure because they live outside of camp or camp-like settings<sup>2</sup>.
- As of June 2014, food assistance is provided by WFP to 2,398,177 refugees across 201 sites in 22 countries in Africa.
- Due to funding shortages and insecurity, food assistance by WFP in Africa has been cut in many refugee sites in 2014, the majority already experiencing high rates of malnutrition. Furthermore, the refugees have limited livelihood opportunities, and are thus particularly vulnerable to cuts in their food rations.
- As of June 2014, food ration cuts were reported in 52 (25.9%) of 201 sites in 9 (40.9%) of 22 countries affecting 787,727 (32.8%) of 2,398,177 refugees.
- As of June 2014, food ration cuts of >50 % of the initial ration were reported at 27 (13.4%) sites in 3 (13.6%) countries affecting 449,516 (18.7%) refugees.

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<sup>1</sup> Delays are also experienced due to bureaucratic blockages such as at ports, through customs clearance processes, at roadblocks as well as for environmental reasons linked to the rainy season for example.

<sup>2</sup> The refugees living in urban and rural settings tend not to receive food assistance.

- From December 2013 to June 2014, funding shortages and insecurity have resulted in refugees experiencing a food ration cut for one-month or more at 141 (70.1%) sites in 15 (68.2%) of 22 countries affecting 2,089,730 (87.1%) of 2,398,177 refugees.
- Ongoing monitoring of the nutritional status in 6-59 month old refugee children found that the majority of the sites had levels of global acute malnutrition (GAM), stunting and anaemia above acceptable.
- Nutritional survey data on children 6-59 months old were available from 141 sites in 22 countries representing a total of 2,201,157 refugees.
  - **GAM:** A total of 54 (38.3%) of the 141 surveyed sites in 16 countries, representing 1,121,615 refugees, met the UNHCR target of  $\leq 10\%$  GAM, and 30 (38.0%), of the 79 sites with available trend data, in 7 countries, representing 910,915 refugees, showed positive trends in GAM prevalence compared to the previous survey. Compared to MICS country data on the host population, the prevalence of GAM was worse or the same among refugees in 105 (74.5%) of 141 surveyed sites in 19 countries, representing 1,529,497 refugees (tables 1 – 4).
  - **Stunting:** A total of 19 (13.5%) of the 141 surveyed sites in 6 countries, representing 608,285 refugees, met the UNHCR target of  $\leq 20\%$  stunting, and 48 (64.9%), of the 74 sites with available trend data, in 11 countries, representing 1,219,095 refugees, showed positive trends in stunting prevalence compared to the previous survey. Compared to MICS country data on the host population, the prevalence of stunting was worse or the same among refugees in 97 (68.8%) of 141 surveyed sites in 16 countries, representing 1,197,810 refugees (tables 5 – 7).
  - **Anaemia:** Only 1 (1.1%), of the 92 surveyed sites with data on anaemia, in 1 country, representing 10,399 refugees, met the UNHCR target of  $\leq 20\%$  anaemia, and 42 (58.3%), of the 72 sites with available trend data, in 11 countries, representing 1,060,994 refugees, showed positive trends in anaemia prevalence compared to the previous survey. Compared to MICS country data on the host population, the prevalence of anaemia was worse or the same among refugees in 10 (11.8%) of 85 surveyed sites in 6 countries, representing 117,522 refugees (tables 8 – 10).

- In June 2014, 106 (60.5%) of the 177 sites in 23 (79.3%) of 29 countries representing 1,748,011 (73.7%) of 2,371,047 refugees responded to the survey on land availability for **agriculture** in and around refugee sites. Among those who responded, 69 (65.0%) sites in 16 (69.5%) countries representing 1,267,282 (72.5%) refugees, stated that there is access to adequate productive land for a family to produce food, should the possibility of using this land exist. Overall, 46 (67.0%) sites in 11 countries hosting 829,591 (65.5%) of refugees report moderate to high use of land by refugees at present (figures 6 and 7).
- In June 2014, 104 (58.7%) of the 177 sites in 19 (65.5%) of 29 countries representing 1,655,401 (69.8%) of 2,371,047 responded to the survey on land availability for **grazing** in and around refugee sites. Among those who responded, 45 (43.2%) of sites in 13 (68.4.0%) countries hosting 672,414 (40.6%) refugees report currently having access to adequate grazing land in or around the sites (figure 8).
- Overall WFP requires \$1.47 billion to meet the urgent food needs of 23.3 million highly food insecure and vulnerable people in 22 countries in Africa for the next six months (July-December 2014). Against this requirement the funding shortfall as of June 2014 was \$882.4 million.
- The total funding needed to meet the urgent food assistance requirements for the refugees in these 22 countries for the next six months (July-December 2014) is \$304.2 million. Against this requirement, WFP thus far has received 39% of the funding and the remaining **\$185.9 million is yet to be financed**.
- Additionally, UNHCR is seeking contributions towards the anticipated US\$ 39 million cost of providing nutrition support for malnourished and vulnerable refugees in Africa for the rest of 2014.

## CONCLUSIONS

- Ration cuts affect refugee populations especially hard, as they are unable to adequately cover the short term gap, whilst having limited access to productive agricultural land, pastoral grazing land and job markets, and food insecurity puts refugees at increased risk of resorting to negative coping strategies. Ration cuts are currently driven by a mixture of funding and security issues, with the two inextricably linked in certain situations such as South Sudan.

- UNHCR and WFP have made significant investments and advances in the food security and nutrition status of refugees during the past five years, particularly in the protracted refugee settings where refugees are partially or wholly dependent upon food rations. This investment must not be lost.
- The coping strategies being adopted are negatively affecting the consumption patterns and self-reliance of refugee populations, putting them at risk of adopting high risk strategies and depletion of their assets. This may compound their vulnerability to poverty, hunger and malnutrition. Thus, to preserve previous investments and build on positive trends in the reduction of malnutrition, stunting and anaemia it is critical that sufficient funds for food assistance are provided, and livelihoods opportunities for refugees are improved.

## **RECOMMENDATIONS**

### **1. Resource mobilization**

Continued funding is essential to meet the immediate and most severe needs of the refugees who are dependent upon food assistance, and to avoid reversing the positive results achieved in refugee nutritional status across Africa.

### **2. Targeting and prioritisation of the food assistance among refugees**

As funding for food assistance and humanitarian emergency assistance is difficult to predict, timely and informed targeting decisions must be taken based on clear vulnerability criteria to mitigate impact of reduced assistance on the most vulnerable refugees.

### **3. Enhance disaster preparedness and contingency planning for effective response**

The ability to trigger early action in response to conflict and insecurity is critical for reducing the impact and losses to refugees and host communities in hazard-prone areas and preventing high levels of malnutrition. Increasing emergency preparedness and contingency planning, especially in highly insecure areas, will increase response effectiveness and avoid future costs of delayed actions.

**4. Work with Governments to ensure sustainable livelihoods strategies for refugees that will also benefit host communities**

The integration of livelihoods strategies into refugee emergencies as early as possible is a crucial step to decreasing dependence on food assistance and in improving the resilience of refugee populations. UNHCR and WFP will work with Governments, development agencies and donors to improve access to productive agricultural and grazing land that will benefit host communities and refugees. Other interventions such as scaling up the provision of cash & vouchers for food assistance as a means to improve access to markets will be undertaken. Furthermore, advocating for refugees to have access to markets for small scale enterprises in protracted situations as a means towards increased self-reliance will be undertaken.



## 2. REFUGEES IN AFRICA

The deterioration of the security situation in South Sudan and the Central African Republic has resulted in new major flows of refugees to neighbouring countries. Along with the existing caseload of protracted refugee situations across Africa, the total number of refugees that has been displaced across international borders and need protection from UNHCR is alarming.

According to recent UNHCR statistics, the number of refugees under UNHCR's mandate in Africa reached a total of 3,321,893 in 293 sites in 40 countries by the end of 2013<sup>3</sup>; this accounts for 32% of UNHCR's refugee population of 10,500,241 (1). Note that there are more refugees in Africa that are not included in this figure because they live outside of camp or camp-like settings (heretofore, camps, settlements or camp-like settings will be referred to as sites).

### REFUGEES' ACCESS TO FOOD ASSISTANCE AND LIVELIHOODS OPPORTUNITIES IN AFRICA

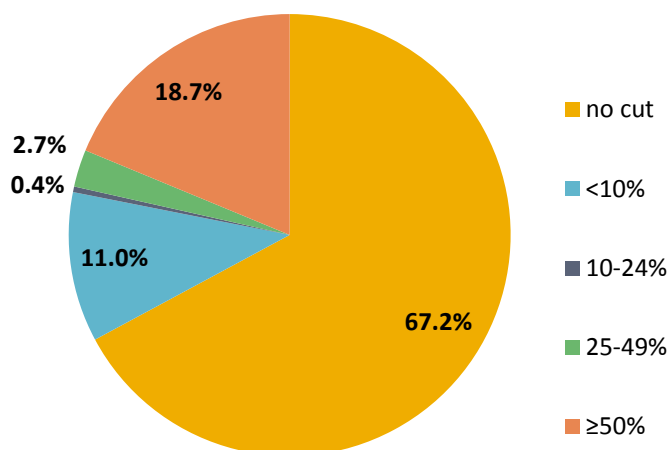
**An estimated 2,398,177 refugees in 201 sites in 22 countries are receiving food assistance provided by WFP as of June 2014.** Many refugee sites in Africa have experienced food ration cuts during the past year or are currently experiencing such cuts due to lack of funding or insecurity. **As of June 2014, ration cuts were reported in 52 (25.9%) of 201 sites in 9 (40.9%) of 22 countries affecting 787,727 (32.8%) of 2,398,177 refugees. Food ration cuts of < 10% of the initial (planned) ration were reported at 10 sites (5.0%) in 2 (9.1%) countries affecting 262,960 (11%) refugees. Food ration cuts of 10-24% of the initial ration were reported at 4 (2.0%) sites in 2 (9.1%) countries affecting 9,897 (0.4%) refugees. Food ration cuts of 25-49% of the initial ration were reported at 11 (5.5%) sites in 2 (9.1%) countries affecting 65,354 (2.7%) refugees. Food ration cuts of  $\geq$  50 % of the initial ration were reported at 27 (13.4%) sites in 3 (13.6%) countries affecting 449,516 (18.7%) refugees (figure 1 and table 1).**

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<sup>3</sup> The term Africa refers to the geographical Africa, thus it also includes refugees from Northern Africa. Countries covered by this report are covered by UNHCRs Africa and MENA bureaux. . The 2013 population figures do not include refugees from the recent outflows in 2014 from Central Africa and South Sudan.

Of the refugees affected by ration cuts, 27 (51.9%) of 52 sites affecting 57.1% (449,516) of 787,727 refugees have been cut by >50%.

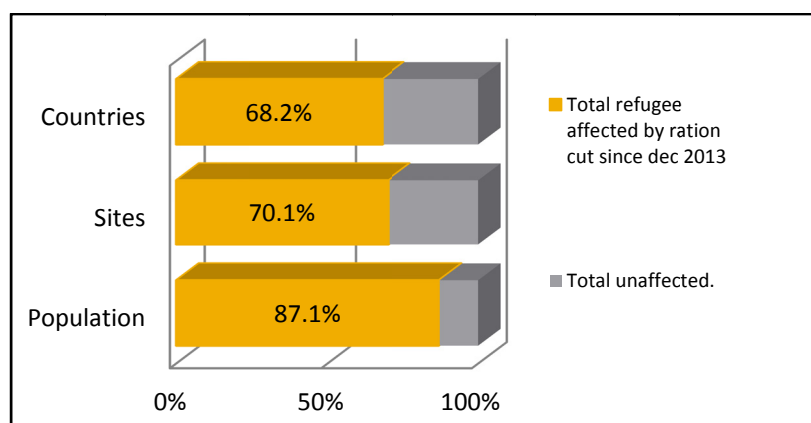
**Figure 1: Percentage of refugees currently experiencing food ration cuts (N=2,398,177), June 2014**



**Table 1: Food distribution by WFP to refugees by site, country, population, June 2014**

Level of reduction on 10 <sup>th</sup> June 2014	Sites		Countries		Refugee Population		Countries currently affected
	No.	% of sites	No.	%	No.	%	
no cut	149	74.1%	13	59.1%	1,610,450	67.2%	
<10%	10	5.0%	2	9.1%	262,960	11.0%	Mauritania & Uganda
10-24%	4	2.0%	2	9.1%	9,897	0.4%	Mozambique & Ghana
25-49%	11	5.5%	2	9.1%	65,354	2.7%	Liberia & Burkina Faso
≥50%	27	13.4%	3	13.6%	449,516	18.7%	CAR, Chad & South Sudan
Total	201	100%	22	100%	2,398,177	100%	

Since December 2013 until present, funding shortages and insecurity have resulted in refugees experiencing a food ration cut for one-month or more at 141 (70.1%) sites in 15 (68.2%) of 22 countries affecting 2,089,730 (87.1%) of 2,398,177 refugees (see figure 2).

**Figure 2: Percentage of refugees affected by reduction in food rations since Dec 2013 to present**

Even the smallest unforeseen reduction in the food ration or break in the food assistance pipeline can have long-term negative impacts on a refugee population's nutrition situation and capacity to cope. The resilience of refugees to food related shocks is already weakened by the displacement, whilst the availability of alternative food sources are often limited or not affordable to refugee populations. Ensuring a stable and adequate access to food assistance is a critical component to preventing malnutrition.

#### CASE STUDY – FRESH FOOD FOR NEW MOTHERS IN DADAAB, KENYA

WFP has been feeding refugees in Dadaab for more than 20 years with an in-kind food basket of dried grains, vegetable oil, salt, and corn soya blend. There are not many ways that refugees can earn income in the camps, so they rely almost entirely on the food WFP provides, and this “food basket” does not change much from month to month. As a result refugees’ diets typically lack diversity and this undermines nutrition, especially for pregnant and nursing mothers, and young children, whose bodies need more nutrients for proper growth and development.

In 2013 WFP began giving vouchers to pregnant and nursing mothers to improve the quality of their diet. Women collect the vouchers when they attend antenatal and postnatal care clinics offered by the 19 health posts in the camps. The programme reaches 9,000 women and their families (about 45,000 people in total). The vouchers are small, worth about US\$12 per month, enough for one family meal of meat and vegetables per week. Even so, the women say they appreciate choosing their own food and being able to break up the monotony of the typical food aid diet of sorghum and split peas.

The vouchers are redeemable at 69 local shops operated by Kenyan and refugee retailers in the camp markets. At the shops, women can choose which fruit, vegetables or type of meat they would like, and they negotiate prices directly with the retailer. The programme has been running now for 10 months, and the prices of fresh food have gone down in that time. There is more fresh food available in the markets than there was before the programme. Even retailers who are not participating in the programme are reporting increased volume of sales.

Retailers also say they have doubled the number of people they employ to meet the new demand generated by the programme. Livelihood opportunities are very limited in Kenya's camps and therefore increasing employment is an important outcome of the programme.

WFP has also setup a “hotline” and invited the women to call if they were experiencing any problems with the programme. The hotline receives about 50 calls each month from the women in Dadaab. Most are just asking for information, but they also do use the line to report retailers who are not giving them the level of service that they expect.

## NUTRITIONAL STATUS OF REFUGEES IN AFRICA

Over the past five years, concerted efforts to prevent and treat acute and chronic malnutrition in a multi-faceted manner have brought about improvements in macro- and micronutrient malnutrition among refugees in many countries. However, in many of the high burden countries that host the majority of the refugees in Africa, global acute malnutrition (GAM)<sup>4</sup> prevalence remains at critical levels according to the World Health Organization's (WHO) emergency standards (2). Furthermore, stunting and anaemia<sup>5</sup> are at critical levels in the majority of the refugee sites, affecting an even larger proportion of the children compared to acute malnutrition, and increasing the risk of irreversible and inadequate physical and cognitive development and low economic productivity (3).

**Using the most recent refugee nutrition surveys from 2011 to 2013 among refugees in sites dependent upon food assistance, data were available from 141 sites in 22 countries, representing 2,201,157 refugees.** Countries include Algeria, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Djibouti, Ethiopia, Ghana, Kenya, Liberia, Malawi, Mauritania, Mozambique, Niger, Rwanda, South Sudan, Sudan, Tanzania, Uganda, Zambia and Zimbabwe.

### GAM

Amongst children 6-59 months old<sup>6</sup>, GAM prevalence from the 141 surveyed sites in 22 countries ranged from 1.2% in Tongogara, Zimbabwe to 25.2% in Berhale, Ethiopia with a median of 12.4%. A total of 54 (38.3%) of the 141 surveyed sites in 16 (69.6%) of 22 countries representing 1,121,615 (51.0%) of 2,201,157 refugees<sup>7</sup> met the UNHCR target of  $\leq 10\%$  GAM<sup>8</sup> (Figure 3 and table 2). Therefore, 87 (61.7%) of the surveyed sites in 12 (54.5%)

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<sup>4</sup> Global acute malnutrition: weight-for-height z-score  $< -2$  SD from the median of the WHO 2006 growth standards or oedema.

<sup>5</sup> Stunting: height-for-age z-score  $< -2$  SD from the median of the WHO reference. Total anaemia in 6-59 months old children: Haemoglobin  $< 11$  g/dl.

<sup>6</sup> The 6–59-month-old child is considered the most sensitive to acute nutritional stress. Thus, this age group is chosen, to give an indication of the severity of the situation in the whole population.

<sup>7</sup> This represents the refugee population in the concerned sites, not the population of children 6-59 months. It therefore does not represent a figure of number of children who are suffering from acute malnutrition.

<sup>8</sup> The WHO define a prevalence of wasting ( $< -2$  z-scores) between 10 – 14% as a critical situation as being  $\geq 15\%$  wasting. The UNHCR target of  $< 10\%$  encompasses WHO's severity definition of acceptable and poor.

of 22 countries<sup>9</sup> representing 1,079,542 (49.0%) refugees did not meet the UNHCR target of  $\leq 10\%$  GAM.

**Table 2: Proportion of sites, countries and refugee population meeting GAM targets**

GAM	Sites		Countries		Refugee Population	
	No.	%	No.	%	No.	%
$\leq 10\%$	54	38.3%	16	69.6%	1,121,615	51.0%
$> 10\%$	87	61.7%	12	54.5%	1,079,542	49.0%
	141	100.0%	22		2,201,157	100.0%

Data from two consecutive surveys comparing the most recent GAM prevalence in a given refugee population to the previous survey was available for 79 sites in 16 countries for 1,995,941 refugees. A positive trend was noted for 30 (38.0%) of the 79 sites in 7 of 16 countries representing 910,915 (45.6%) of 1,995,941 refugees<sup>10</sup>. A stable trend in GAM prevalence was seen in 29 (36.7%) sites in 12 countries representing 684,134 (34.3%) refugees, and a deteriorating trend was observed in 20 (25.3%) sites in 10 countries representing 400,892 (20.1%) refugees<sup>11</sup>.

**Table 3: Changes in GAM in refugee surveys when comparing two consecutive surveys**

GAM	Sites		Countries		Refugee Population	
	No.	%	No.	%	No.	%
Positive	30	38.0%	7	43.8%	910,915	45.6%
Stable	29	36.7%	12	75.0%	684,134	34.3%
Deteriorating	20	25.3%	10	62.5%	400,892	20.1%
	79	100.0%	16		1,995,941	100.0%

<sup>9</sup> Note that some countries will have some sites that meet the standard and others that may not, thus the number of countries for those that do and do not meet the standard may not add up to the total number of 22 countries.

<sup>10</sup> This represents the refugee population in the concerned sites, not the population of children 6-59 months. It therefore does not represent a figure of number of children who are suffering from acute malnutrition.

<sup>11</sup> The prevalence was considered to be stable if the change in prevalence from the previous survey was less than  $\pm 2\%$ .

The latest GAM prevalence in the surveyed refugee sites was compared to host country GAM prevalence data using the latest available Multiple Indicator Cluster Survey (MICS) data<sup>12</sup>. The prevalence of GAM was worse (i.e., higher) or the same among refugees in 105 (74.5%) of 141 surveyed sites in 19 countries representing 1,529,497 (69.5%) of 2,201,157 refugees. The prevalence of GAM was better (i.e., lower) among refugees in 36 (25.5%) sites in 10 countries representing 671,660 (30.5%) refugees<sup>13</sup>.

**Table 4: Comparison of GAM between refugee surveys in sites and MICS national data**

	Sites		Countries		Refugee Population	
	No.	%	No.	%	No.	%
Stunting						
Worse or same amongst refugees	105	74.5%	19	86.4%	1,529,497	69.5%
Better amongst refugees	36	25.5%	10	45.5%	671,660	30.5%
Total	141	100.0%	22		2,201,157	100.0%

## STUNTING

Stunting prevalence from the 141 surveyed sites in 22 countries ranged from 6.5% in Kobe, Ethiopia to 64.9% in Shagarab, Sudan with a median of 43.5%. A total of 19 (13.5%) of the 141 surveyed sites in 6 countries representing 608,285 (27.6%) refugees<sup>14</sup> met the UNHCR target of ≤ 20% stunting (Figure 4 and table 5).

**Table 5: Proportion of sites, countries and refugee population meeting stunting targets**

	Sites		Countries		Refugee Population	
	No.	%	No.	%	No.	%
Stunting						
≤ 20%	19	13.5%	6	27.3%	608,285	27.6%
> 20%	122	86.5%	19	86.4%	1,592,872	72.4%
Total	141	100.0%	22		2,201,157	100.0%

<sup>12</sup> MICS: Multiple Indicator Cluster Survey. [http://www.unicef.org/statistics/index\\_24302.html](http://www.unicef.org/statistics/index_24302.html)

<sup>13</sup> The Confidence Intervals (CI) of the refugee surveys were compared to the point prevalence of the MICS surveys. Where the MICS prevalence fell inside the CI, the surveys were considered not to be different (same). Where the point prevalence of the MICS data was higher than the upper confidence level of the refugee survey, the host population prevalence was deemed to be higher and where the point prevalence of the MICS survey was lower than the lower confidence interval of the refugee survey the refugee prevalence was deemed to be higher.

<sup>14</sup> This represents the refugee population in the concerned sites, not the population of children 6-59 months. It therefore does not represent a figure of number of children who are suffering from stunting.

**Data from two consecutive surveys comparing the most recent stunting prevalence in a given refugee population to the previous survey was available for 74 sites in 17 countries for 1,867,052 refugees.** Positive trends were noted for 48 (64.9%) of the 74 sites in 11 countries representing 1,219,095 (65.3%) refugees. A stable trend in stunting prevalence was seen in 12 (16.2%) sites in 8 countries representing 256,109 (13.7%) refugees and a deteriorating trend was seen in 14 (18.9%) sites in 9 countries representing 391,848 (21.0%) refugees. Although only 14.7% of the surveyed sites reached the UNHCR target for stunting, positive trends are found in almost two-thirds of the surveyed sites, recognising a great opportunity to further reduce stunting prevalence, and thus sustaining previous investments in stunting reduction.

**Table 6: Changes in stunting in refugee surveys when comparing two consecutive surveys**

	Sites		Countries		Refugee Population	
Stunting	No.	%	No.	%	No.	%
Positive	48	64.9%	11	64.7%	1,219,095	65.3%
Stable	12	16.2%	8	47.1%	256,109	13.7%
Deteriorating	14	18.9%	9	52.9%	391,848	21.0%
Total	74	100.0%	17		1,867,052	100.0%

**The latest stunting prevalence in the surveyed refugee sites was compared to host country stunting prevalence data using MICS data.** The prevalence of stunting was worse (i.e., higher) or the same among refugees in 97 (68.8%) of 141 surveyed sites in 16 countries representing 1,197,810 (54.4%) of 2,201,157 refugees. The prevalence of stunting was better (i.e., lower) among refugees in 44 (31.2%) sites in 15 countries representing 1,003,347 (45.6%) refugees.

**Table 7: Comparison of stunting between refugee surveys in sites and MICS national data**

	Sites		Countries		Refugee Population	
Stunting	No.	%	No.	%	No.	%
Worse or same amongst refugees	97	68.8%	16	72.7%	1,197,810	54.4%
Better amongst refugees	44	31.2%	15	68.2%	1,003,347	45.6%
Total	141	100.0%	22		2,201,157	100.0%

**ANAEMIA**

The anaemia prevalence from the 92 surveyed sites in 20 countries representing 2,119,937 refugees ranged from 15.2% in Tongo, Ethiopia to 84.4% in Buduburam, Ghana with a median of 46.2%. Only 1 (1.1%) of the 92 surveyed sites with data on anaemia in 1 country representing 10,399 (0.5%) refugees<sup>15</sup> met the UNHCR target of  $\leq 20\%$  anaemia (Figure 5 and table 8). Thus, the nutritional situation in terms of anaemia is categorised as having medium to severe public health significance in all except 1 site.

**Table 8: Proportion of sites, countries and refugee population meeting anaemia targets**

Anaemia	Sites		Countries		Refugee Population	
	No.	%	No.	%	No.	%
$\leq 20\%$	1	1.1%	1	4.8%	10,399	0.5%
$> 20\%$	91	98.9%	20	100.0%	2,189,538	99.5%
Total	92	100.0%	20		2,199,937	100.0%

Encouragingly, however, positive or stable trends in anaemia prevalence were observed for the majority of the sites, highlighting the ongoing efforts by UNHCR and partners to prevent and treat micronutrient deficiencies. **Data from two consecutive surveys comparing the most recent anaemia prevalence in a refugee population to the previous survey were available for 72 sites in 12 countries for 1,795,574 refugees.** A positive trend was observed in 42 (58.3%) of the 72 sites in 11 countries representing 1,060,994 (59.1%) refugees. A stable trend in anaemia prevalence was noted in 11 (15.3%) sites in 7 countries representing 201,069 (11.2%) refugees and a deteriorating trend was noted in 19 (26.4%) sites in 7 countries representing 533,511 (29.7%) refugees.

**Table 9: Changes in anaemia in refugee surveys when comparing two consecutive surveys**

Anaemia	Sites		Countries		Refugee Population	
	No.	%	No.	%	No.	%
Positive	42	58.3%	11	91.7%	1,060,994	59.1%
Stable	11	15.3%	7	58.3%	201,069	11.2%
Deteriorating	19	26.4%	7	58.3%	533,511	29.7%
Total	72	100.0%	12		1,795,574	100.0%

<sup>15</sup> This represents the refugee population in the concerned sites, not the population of children 6-59 months. It therefore does not represent a figure of number of children who are suffering from anaemia.



**The latest anaemia prevalence in the surveyed refugee sites was compared to host country anaemia prevalence data using MICS data.** The prevalence of anaemia was worse (i.e., higher) or the same among refugees in 10 (11.8%) of 85 surveyed sites in 6 countries representing 117,522 (6.1%) refugees. The prevalence of anaemia was better (i.e., lower) among refugees in 75 (88.2%) sites in 15 countries representing 1,815,964 (93.9%) refugees.

**Table 10: Comparison of anaemia between refugee surveys in sites and MICS national data**

Anaemia	Sites		Countries		Refugee Population	
	No.	%	No.	%	No.	%
Worse or same amongst refugees	10	11.8%	6	33.3%	117,522	6.1%
Better amongst refugees	75	88.2%	15	83.3%	1,815,964	93.9%
Total	85	100.0%	18		1,933,486	100.0%

Anaemia is highly prevalent in both host country and in refugee populations, highlighting a major public health problem. This is both due to the magnitude of the problem and the adverse impact anaemia has on both short and long-term health. Evidence from the refugee data however shows that anaemia reductions have been possible with significant investment, concerted efforts and multisectoral actions. It is therefore, of utmost importance that ongoing programmes aiming to reduce micronutrient deficiencies such as anaemia, as a minimum, are continued or further improved. Furthermore, it is crucial to the current and future health of refugees that the positive trends seen at many sites are sustained, since many resources have been invested in reversing the negative trends in anaemia.

Despite some sites showing positive trends in the prevalence of GAM, stunting and anaemia compared to surveys conducted in previous years, the nutrition situation in many refugee sites receiving food assistance remains critical and needs sustained attention.

Nutritional outcomes are underpinned by a multitude of factors including availability and/or access to food, care and feeding practices and the health and sanitation environment. Immediate causes of malnutrition remain inadequate and insufficient food intake and disease and their interactions. Although reduced access to food is not the only contributor to malnutrition in a refugee context and that combatting malnutrition needs to be

supported by effective health, WASH and community activities, access to adequate food is certainly a major contributing factor.

The chronic undernutrition experienced by refugees in countries such as Chad, South Sudan and Burkina Faso can have profound effects on human development; especially during the first 1,000 days from conception. Ensuring stable access to adequate and appropriate food assistance will contribute greatly to reducing this human cost.

#### **CASE STUDY - RESPONSE TO ANAEMIA IN KAKUMA, KENYA**

Anaemia in Kakuma refugee camp in Kenya has been regularly surveyed since 2003, showing unacceptable levels in children under 5 years old. In 2008, UNHCR's anaemia strategy was activated to ensure improved coordination between nutrition and reproductive health programmes, as well as to reinforce diagnosis and treatment of anaemia and acute malnutrition. Concerted efforts were made in malaria prevention and control, improvement in infant and young child feeding and care practices, the use of specialized nutrition products and improved detection and treatment of malnutrition, improved vaccination programmes and water, sanitation and hygiene interventions. Remarkable anaemia reductions have been recorded in Kakuma since the initiation of the anaemia strategy. Total anaemia has reduced from 73% in October 2008 to 34.4% in November 2012, representing a 53% overall decrease. The most impressive reductions have been observed in the more clinically meaningful moderate and severe anaemia levels, which have reduced by 70% with almost inconsequential levels of severe anaemia now existing among the refugee children.

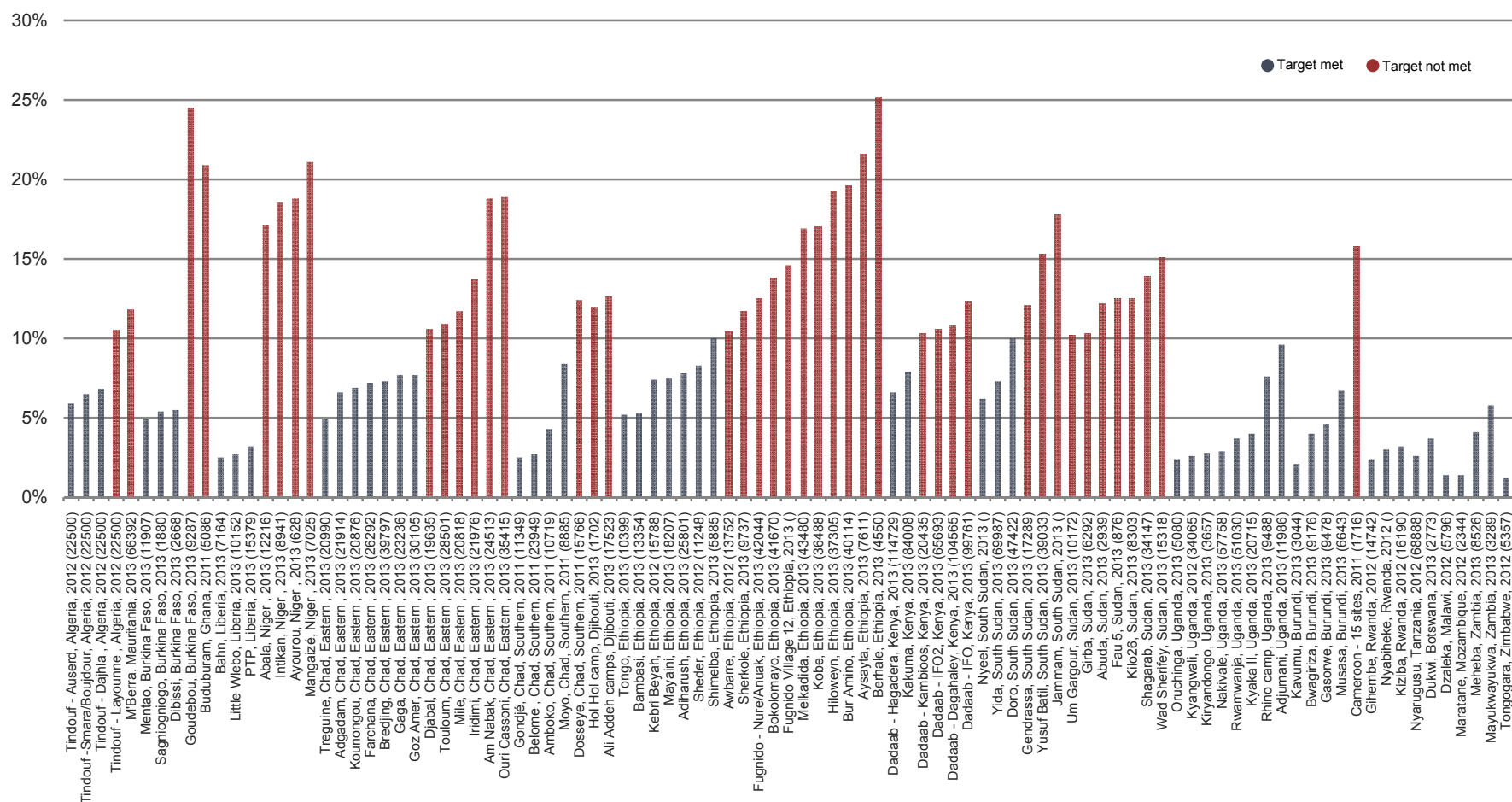
**Figure 3: Prevalence of global acute malnutrition for 6-59 month old children, by site (sorted by region), 2011-2013**

Figure 4: Prevalence of stunting for 6-59 month old children, by site (sorted by region), 2011-2013

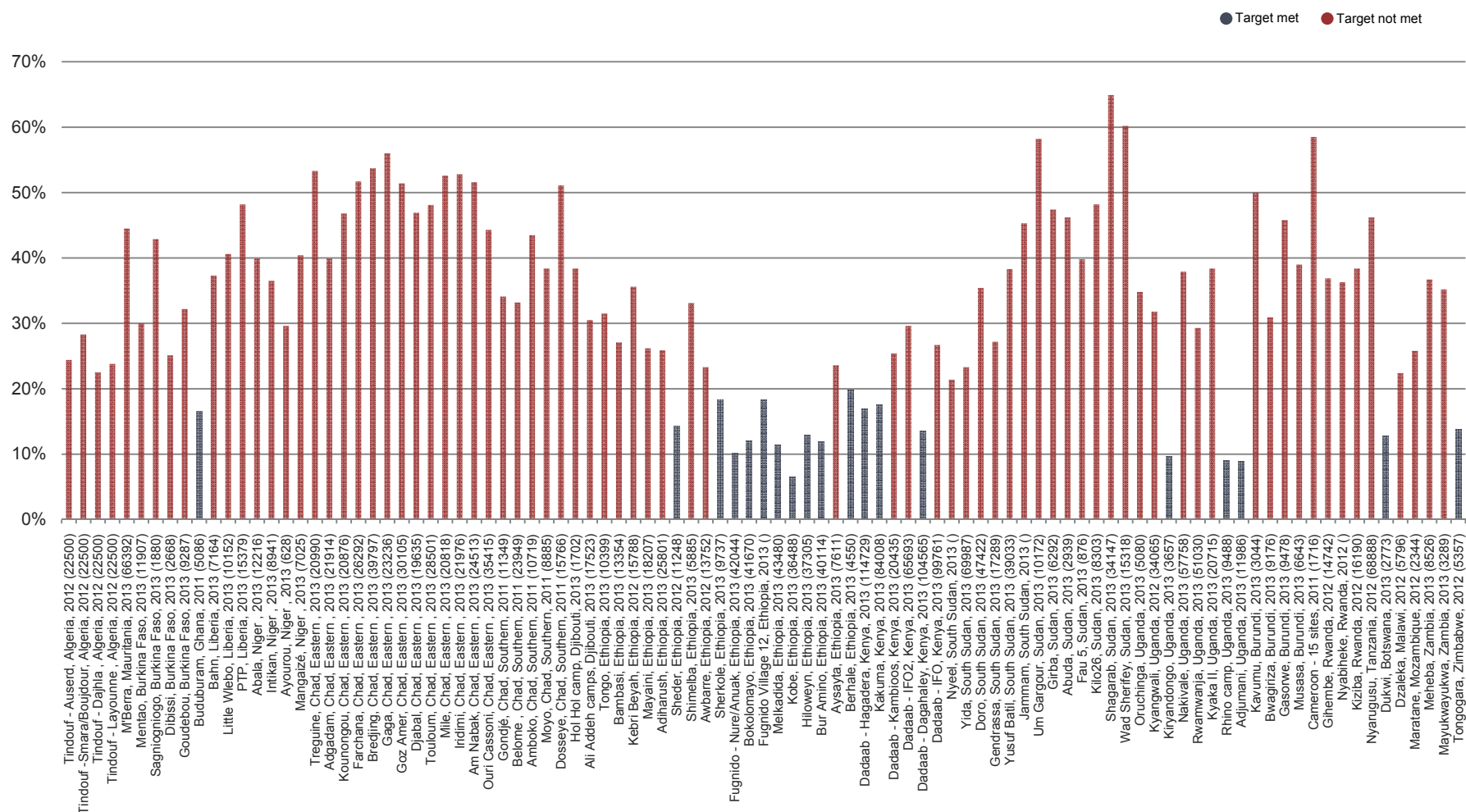
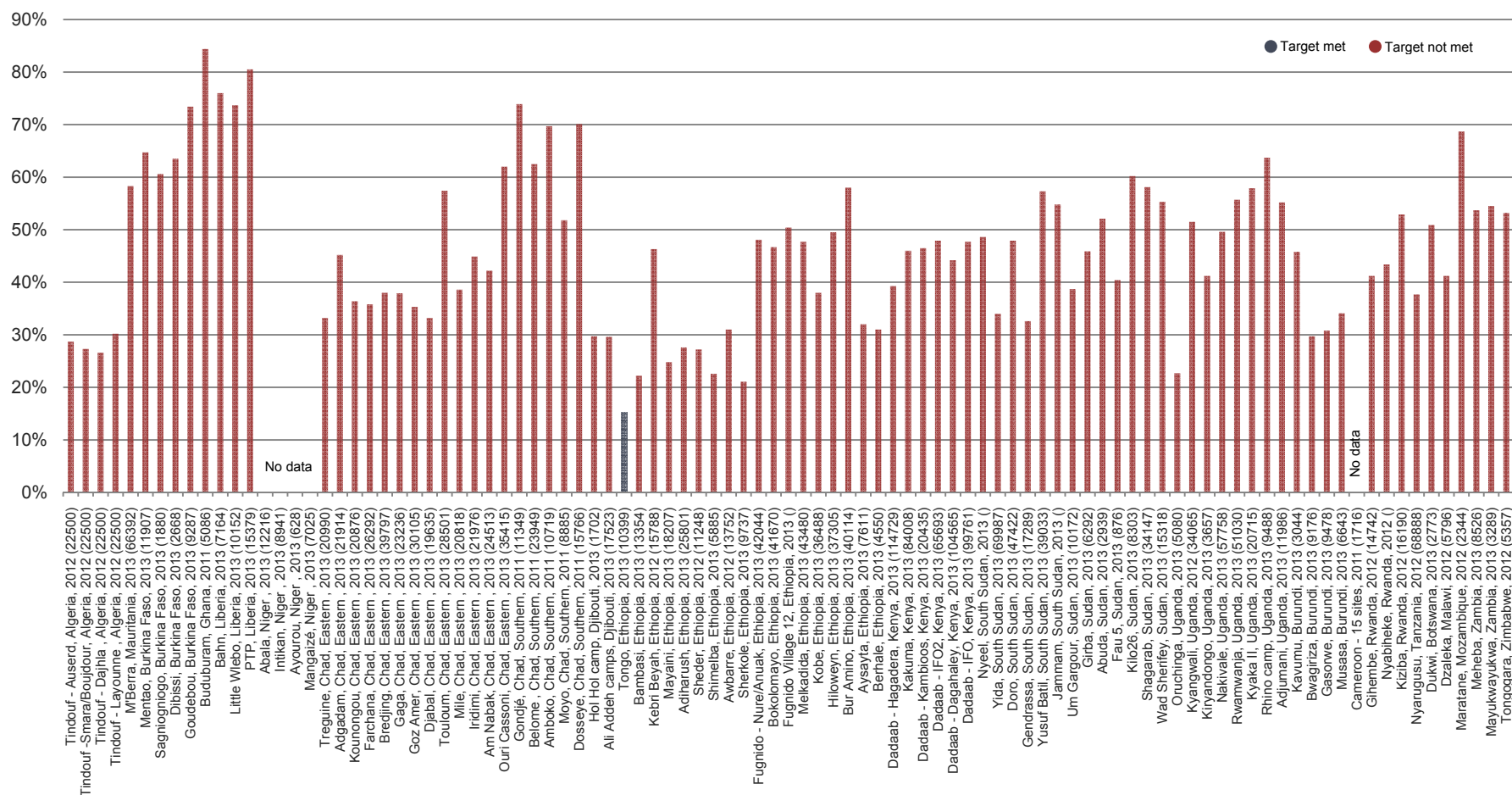


Figure 5: Prevalence of anaemia for 6-59 month old children, by site (sorted by region), 2011-2013



## **THE HUMAN COST OF UNDERNUTRITION**

The human and economic costs of undernutrition are enormous, affecting most the very poor and women and children. In developing countries, nearly one-third of children are underweight or stunted (low height-for-age). Undernutrition contributes to over one-third of all child deaths and increased frequency, severity, and duration of infectious disease.

Globally, undernutrition is more common when household income is low, and is associated, within households, with chronic food shortage, diets lacking in diversity, high rates of infectious diseases and inappropriate infant feeding and care due to lack of knowledge.

Those who experience undernutrition between conception and 24 months of age have a higher risk of lifelong physical and mental disability, and are often not able to make a full contribution to the social and economic development of their households, communities and nations. Thus, the economic costs of undernutrition, in terms of lost national productivity and economic growth, are significant—ranging from 2 to 3% of GDP in some countries. (4)

The cost of chronic hunger and undernutrition on health, education and productivity in the long-term can be socially and economically profound. This following section is based on evidence presented by the Lancet Maternal and Child Undernutrition series 2008 and 2013 (5,6). The World Bank Nutrition report - Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action (7), the Save the Children report, Food for thought - Tackling child malnutrition to unlock potential and boost prosperity (8), and the UNICEF publication Improving Child Nutrition: The achievable imperative for global progress (9).

### **Increased episodes of illness and risk of death**

Compared to children with adequate weight and height, undernourished children face a higher risk of death. Undernutrition weakens the immune system, making children more susceptible to diseases, and reducing their chances of surviving illnesses, such as diarrhoea, pneumonia and malaria. It is estimated that undernutrition contributes to more than a third of child deaths. Children who do survive, face a cycle of recurring illness and growth faltering, irreversibly damaging their physical development and mental capacity (8).

### **Impaired cognitive development**

The 1,000 days from the start of a woman's pregnancy until her child's second birthday are a critical time for brain growth. During this period, malnutrition affects the development of the brain, directly affecting cognitive development. It also has an indirect impact, affecting the ways children learn and their ability to interact and engage with the world (8).

Impaired cognitive development, can affect the child's performance in school. Research shows that students who are undernourished are also more likely to drop out of school than those who experience healthy childhoods.

Malnutrition can also affect cognitive development by influencing children's experiences and the stimulation that they receive. For example, infants whose mothers suffer from severe anaemia show symptoms of lethargy that may affect their ability to explore their surroundings (10).

Once children get behind in their cognitive development, this can be reinforced by parents focusing their attention towards those children who show stronger potential. A study in Mexico found that mothers of malnourished children behaved differently from other mothers towards their children – they were less likely to reward their children's successes, were less affectionate and spent less time talking to them (11). Children who are malnourished may also receive lower levels of stimulus as a result of poor health – for example, missing opportunities to learn through increased frequency of illness.

Growing evidence suggests that maternal iron deficiency in pregnancy reduces foetal iron stores, perhaps well into the first year of life (12). This leads to greater risk of impairments in future mental and physical development.

Iron deficiency is a strong risk factor for both short-term and long-term cognitive, motor and socio-emotional impairment. Furthermore, longitudinal studies consistently indicate that children who are anaemic during infancy have poorer cognition, lower school achievement and are more likely to have behaviour problems in later childhood – an effect that could occur as a result of direct biological processes or as a result of the impact of anaemia on children's learning experiences (10). Anaemia, as shown in the previous section is also a major feature of nutritional deficiencies observed amongst refugee populations.

### **Intergenerational perpetuation**

In addition to the long-term impacts of undernutrition during the first 24 months of a child's life, malnourished mothers are more likely to give birth to low birth weight infants who will likely go on to be stunted, perpetuating an intergenerational cycle of hunger and malnutrition. In the context of protracted refugee situations this is of real concern.

### **Earning potential and economic consequences of undernutrition**

A study in Guatemala found that, men who had benefited from a nutritious drink when they were aged 0 to 24 months in the early 1970s, were – 30 years later – earning wages that were 46 percent higher than those of men who had received a less nutritious drink at the same age (13).

A recent series of reports analysing the cost of hunger in Egypt, Ethiopia, Swaziland and Uganda (14) estimated that cutting the prevalence of under-nutrition to half of the current level by the year 2025 would generate annual average savings from US\$3 million to US\$376 million. The reports further estimated that a reduction to 10 percent stunting and 5 percent underweight could yield annual average savings from US\$4 million to US\$784 million.

In addition to recent reports on Africa, a group of Nobel Laureates (15) in economics ranked a series of core and proven nutrition interventions among the highest return on investment solutions to global development challenges, including micronutrient supplementation (Vitamin A and zinc), micronutrient fortification (iron and salt iodization), de-worming, nutrition programmes at school and community-based nutrition programmes. The per capita cost of these interventions is estimated at less than US\$10; with relatively high cost-benefit returns. A global investment of US\$60 million per year for vitamin A and zinc supplementation, for instance, would yield benefits of US\$1 billion. Clearly compelling evidence that early preventative interventions are cost effective compared to treating the outcomes of hunger and malnutrition.

The World Bank estimates that malnourished children are at risk of losing more than 10 per cent of their lifetime earning potential, while this is costing poor countries up to 3 per cent of their annual GDP. Malnutrition is thus leading to a significant loss in human and economic potential.



## LIVELIHOODS IN REFUGEE SITES IN AFRICA

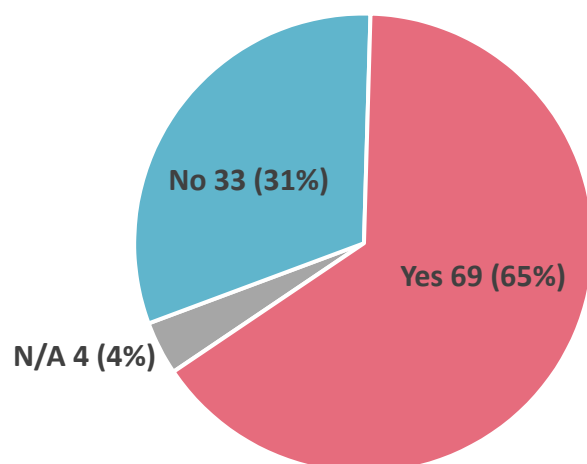
After having been driven from their homes and lands by conflict or fear of persecution, refugees are forced to leave behind their livelihoods and productive assets. Once they arrive in the country of refuge their movement is often restricted, access to land limited and economic capital exhausted. Refugees rely mainly on the assistance provided by the host community, sovereign government and international community.

Without the means to be productive, right to work or ability to earn an income refugees remain dependent on food assistance, whilst human potential is left to waste rather than developed as economic capital. By having access to land and productive resources, refugees would increase their self-reliance and decrease long-term need for food assistance.

To better understand current and potential future land usage by refugees in sites, UNHCR undertook a simple survey of 177 sites in 29 countries representing 2,371,047 refugees in Africa: **106 (60.5%) of the 177 sites in 23 (79.3%) of 29 countries representing 1,748,011 (73.7%) of 2,371,047 responded to the survey on land availability for agriculture and grazing in and around refugee sites.** Among those who responded, 69 (65%) sites in 16 (69.5%) countries representing 1,267,282 (72.5%) refugees responded that there is access to adequate productive land for a family to produce food (**agriculture**) should the possibility of using this land exist. Overall, 46 (67%) sites in 11 countries hosting 829,591 (65.5%) of refugees report moderate to high use of land by refugees at present (figures 6 and 7).

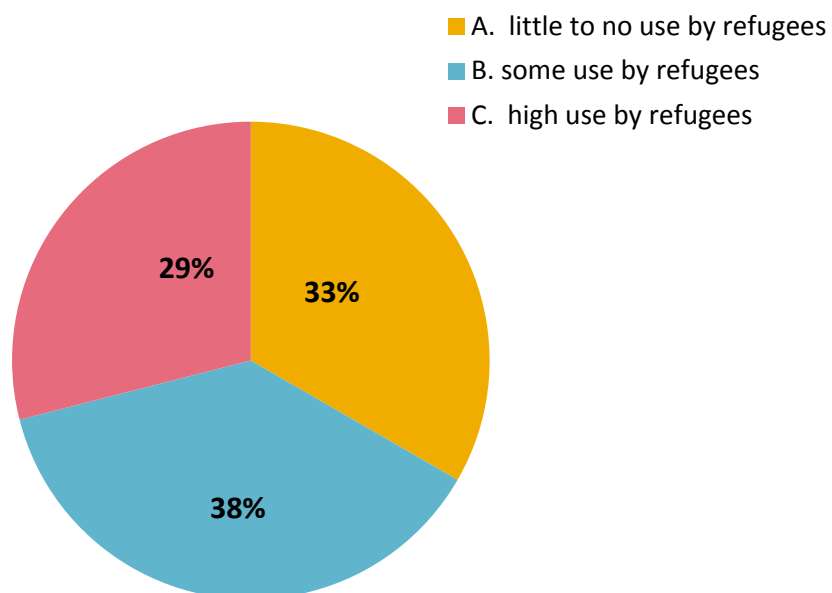
**In addition, 104 (58.7%) of the 177 sites in 19 (65.5%) of 29 countries representing 1,655,401 (69.8%) of 2,371,047 responded to the survey on land availability for agriculture and grazing in and around refugee sites.** Among those who responded, 45 (43.2%) of sites in 13 (68.4%) countries hosting 672,414 (40.6%) refugees report currently having access to adequate **grazing** land in or around the sites (figure 8).

**Figure 6: Proportion of sites with adequate productive land available if access provided, June 2014 (N=106)**

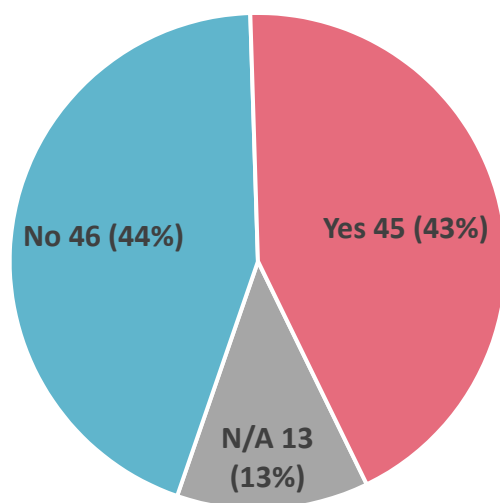


N/A = not available

**Figure 7: Current situation of land usage by refugees (%), June 2014 (N=69)**



**Figure 8: Proportion of sites with access to adequate grazing land inside or around sites if access provided, June 2014 (N=104)**



N/A = not available

#### CASE STUDY – LIVELIHOODS OPPORTUNITIES IN EASTERN AND SOUTHERN CHAD

The refugees in Chad are among the worst affected by the current challenges that WFP are facing in delivering adequate food rations. According to data provided by WFP on the food distribution in the refugee sites in Eastern and Southern Chad, refugees are receiving as little as 850 kcal per person per day; only 40 percent of the required daily amount. However, the livelihood opportunities in Eastern and Southern Chad differ greatly. In Eastern Chad the livelihood opportunities of the refugees from Darfur, Sudan are limited as the refugee sites are situated in the desert. In the southern part of the country the sites are located in an area with more fertile land. The Chadian government is providing arable land to the refugees from the Central African Republic in the southern sites. Thus, the refugees in the southern sites are integrating with the local markets and taking advantage of agriculture opportunities.

It is likely that this discrepancy between the East and South contributes significantly to the differences seen in the nutritional status between the sites. Higher proportions of children suffering from acute malnutrition are found in the sites in Eastern Chad compared to those in Southern Chad (figure 3).

The majority of the refugees in sites who depend upon food assistance have limited access to livelihoods opportunities or productive means such as arable land and market-oriented activities. Without adequate food assistance, these refugees are particularly vulnerable and may resort to negative coping strategies. Thus, the likelihood of them entering into a vicious cycle of poverty, food insecurity, deterioration of nutritional status, increased risk of disease, and risky coping strategies is exacerbated. Ultimately, on a household and community level, this leads to longer-term attrition of their minimal resources, social instability and loss of resilience, which is a major protection concern to UNHCR and WFP. Therefore, improving livelihoods opportunities and food security early on in the displacement experience is paramount to breaking this vicious cycle, and ensuring that previous investments and advances in nutrition and food security are preserved.

## REFUGEE COPING MECHANISMS

In any population, the loss of entitlements caused by conflict or natural disasters lead men and women to adopt different coping strategies to meet their food needs. The severity of their situation dictates the types and duration of coping to which they resort.

The Joint Assessment Missions (JAM) in 13 countries of Africa from 2012-2014 regularly documented the reduction in average quality, variety and size of meal as common approaches to coping with lower levels of food consumption – as illustrated by the JAM in Liberia in 2012, which documented that refugees used food consumption related coping strategies, including: reducing portion sizes; reducing number of meals; eating less preferred foods or consuming less diversified food items. JAM reports also highlight that women are usually at highest risk of negative impacts associated with changing food consumption patterns, as they often prioritize feeding their families over feeding themselves.

In Tigrina, Ethiopia, refugees reported that rations do not support 3 meals a day; as a result households employ a consumption coping strategy dubbed the “11/5 system”. They wake up late – because few people work – and eat a late brunch at 11, after carrying out the daily tasks; they then eat an early dinner around 5pm (16). In the long-term this approach to food consumption can lead to issues such as chronic health problems and without access to income or to safety nets, refugees are even more at risk. Consumption related coping can deal with the effects of acute hunger, however the chronic consequences may lead to profound long-term effects for the health and productivity of people.

In Uganda, SENS data from 2012 still showed that on average 84% of refugees were not consuming any vegetables, fruits, meat, eggs, fish/seafood, and milk/milk products and that the household dietary diversity score for all sites was equal or below the minimum threshold. This has partly been attributed to the time-based targeting, which results in a reduction in the refugees’ ration based on time in the site rather than a specific vulnerability based criteria.

As well as changing the food consumption habits, the income and expenditure patterns of the population dramatically change. In Liberia, in order to survive on their low incomes, refugees begin to rely on borrowing food or taking food on credit or cutting non-essential

expenditures, whilst in Burkina Faso the three most common short- and long-term coping strategies adopted by both the refugee and host populations are to go into debt in order to buy food, sell more animals than usual and depend on occasional labour. The short-term consequences of these strategies are outweighed by the immediate need for households to feed their families.

This is a common situation with refugees in Africa; inadequate and/or low diversity of diet will be a significant contributor to the high levels of anaemia found in refugee populations. Even a small unexpected change in ration can further impact on expenditures and leave refugees to resort to more harming coping strategies.

Once the reversible coping strategies become exhausted, the ability for refugees to plan ahead and make informed decisions on how to manage their lives and livelihoods becomes far more difficult. An unforeseen cut in a ration can have long-term consequences. Often food rations are used as collateral to borrow from traders, so a reduction in the ration can reduce access to informal credit, because they can no longer use the ration as debt repayment (17). Refugees who are able to engage in agricultural-based livelihoods are likely to prioritize accessing casual work to cover their immediate needs, rather than engage in planting of crops, if the ration is reduced.

When spending is curtailed, health care becomes less affordable, even when refugees have access to local services and medication, which can place a burden on the food consumption. In Chad it has been reported that in peak season for malaria and with the cuts in food rations, patients struggled to recover, as the malaria treatment is very strong and if the patients do not eat, they can become sick.

In Liberia it was noted during the JAM, that although primary education is freely provided in refugee sites, teachers reported that some children of school age are not attending schools and in Mauritania, the JAM found that only 30% of school age children attend school. The reason for this was not undernutrition, but the coping strategy to deal with inadequate food and income. This was seen with Malian refugees in Mauritania, where children were required to look after younger siblings or made to participate in household activities, whilst the adults went to seek work.

As food insecurity increases, people sell their non-productive assets to raise the income to afford food. Refugees have fewer assets, often arriving at transit centres with next to nothing. The current crisis in the Central African Republic has seen refugees and returnees arrive in the Democratic Republic of Congo, the Republic of Congo, Chad and Cameroon in general exhausted without personal belongings, limited financial means and often in very bad health and poor physical condition. (18)

Even when less severe coping strategies become exhausted, people start to resort to riskier and life threatening strategies. *Choosing to starve* (19) is a decision taken by populations when the choice is to go hungry or sell the remaining productive assets. In Burkina Faso, one in 10 refugees reported during the JAM going whole days without eating, as compared to 5 percent of the host population. The refugee population, having already exhausted common coping strategies and not having the local social protection mechanisms, were forced earlier into difficult decisions.

As a situation progressively worsens and people find it harder to access food there is an increased concern that people can turn to risky activities. Several JAMs have reported theft as a more severe coping strategy adopted during periods of stress on food. The looting of food stocks from warehouses in South Sudan by armed groups also underlines risks faced when food insecurity increases. In addition to anti-social behaviour, evidence suggests that crises lead to an increase in the number of children living or working on the street and the number of children entering into commercial sexual exploitation in order to assist their parents financially (20). Without productive assets or safety-nets to fall back on, refugees are less resilient to shocks and are more vulnerable to exploitation. This is particularly reflected in Uganda in January 2014, where sudden cuts in the food rations may have resulted in increased child prostitution<sup>16</sup>.

Even when accessing food assistance, a refugee is more vulnerable to the negative impacts of a cut in food ration and the risk of hunger, as they don't have access to the traditional safety-nets mechanisms. Unstable rations experienced by Somali refugees in Dollo Ado,

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<sup>16</sup> This point comes from multi-stakeholder discussions with partners and UNHCR staff held on May 22, 2014 in Hoima, Uganda. Beltramo. May, 30, 2014. "Pre-JAM Mission- Recommendations in advance of 2014 Uganda JAM".

resulted in refugees adopting various coping strategies such as sale of fuel wood, skipping meals and taking loans. Even though they recognised that income from the sale of fuel wood is not a viable option for the long-term and led to depletion of the local environment as well as increased the risk of conflict arising among refugees and host community, they still felt the short-term needs outweigh the long-term risks.



### 3. FUNDING FOR PROTRACTED REFUGEE SITUATIONS AND NEW EMERGENCIES

Global food assistance needs and funding requirements in emergency and protracted relief and recovery contexts have increased considerably in 2014. For WFP in particular, funding requirements worldwide will top US\$7.8 billion in 2014, 17% higher than in 2013. The numbers are staggering, given the unprecedented nature of the situation with a protracted and significantly large Syria crisis putting pressure on limited humanitarian aid resources. The potential impact of this situation is significant on the vulnerable population groups in Africa who are at risk of not receiving life-saving humanitarian assistance, particularly the refugees.

In 2013 official development assistance reached about \$134.7 billion – which is a record. Humanitarian Assistance component at \$10.6 billion is also a record, but not enough to address the current context of unprecedented humanitarian emergencies around the world. Addressing humanitarian needs emerging from the latest crises in the world should not be at the expense of other vulnerable places or people who may be in even more desperate yet protracted situations. We acknowledge that meeting current and future humanitarian needs is a massive task that requires collective and innovative financing solutions.

While needs are increasing globally and indeed attention has recently focused on other regions, in Africa specifically for the next six months - the 2nd half of 2014 - WFP emergency and protracted relief and recovery operations, most of which include refugees, returnees, and internally displaced persons are severely underfunded.

**Table 11: WFP Net Funding Requirements (22 Countries, July-December 2014)**

		Total	
		(US\$M)	(%)
IDPs, Refugees and Returnees	Requirements	1,470.7	
	Net Funding Shortfall	882.4	
Refugee Component	Requirements	304.2	100%
	Net Funding Shortfall	185.9	61%
	Net Funding Received	118.4	39%

Overall WFP requires US\$1.47 billion to meet the urgent food needs of 23.3 million highly food insecure and vulnerable people in 22 countries in Africa for the next six months (July-December 2014). Against this requirement the funding shortfall as of June 2014 was US\$882.4 million.

Looking more specifically into the refugee situation, the total funding needed to meet the urgent food assistance requirements for the refugees in these 22 countries for the next six months (July-December 2014) is US\$304.2 million. Against this requirement, WFP thus far has received 39% of the funding and the **remaining US\$185.9 million is yet to be financed**.

In order to provide both preventative and curative nutrition support and food security activities to refugees in the 22 concerned countries, **UNHCR is seeking contributions towards the anticipated US\$ 39 million cost of covering these services** for the period July – December 2014.

## **4. KEY RECOMMENDATIONS**

### **1. Resource mobilization**

Continued funding is essential to meet the immediate and most severe needs of refugees dependent upon food assistance, and to avoid reversing the positive results achieved in refugee nutritional status across Africa.

### **2. Targeting and prioritisation of the food assistance among refugees**

As funding for food assistance and humanitarian emergency assistance is difficult to predict, timely and informed targeting decisions must be taken based on clear vulnerability criteria to mitigate impact of reduced assistance on the most vulnerable refugees.

### **3. Enhance disaster preparedness and contingency planning for effective response**

The ability to trigger early action in response to conflict and insecurity is critical for reducing the impact and losses to refugees and host communities in hazard-prone areas and preventing high levels of malnutrition. Increasing emergency preparedness and contingency planning, especially in highly insecure areas, will increase response effectiveness and avoid future costs of delayed actions.

### **4. Work with Governments to ensure sustainable livelihoods strategies for refugees that will also benefit host communities**

The integration of livelihoods strategies into refugee emergencies as early as possible is a crucial step to decreasing dependence on food assistance and in improving the resilience of refugee populations. UNHCR and WFP will work with Governments, development agencies and donors to improve access to productive agricultural and grazing land that will benefit host communities and refugees. Other interventions such as scaling up the provision of cash & vouchers for food assistance as a means to improve access to markets will be undertaken. Furthermore, advocating for refugees to have access to markets for small-scale enterprises in protracted situations as a means towards increased self-reliance will be undertaken.

## 5. LIMITATIONS

1. When associating the nutritional status indicators between country and refugee sites, we compare at two different levels (i.e. the country level estimates does not account for the variation within a country). However, the nutritional status among the host communities surrounding the refugees was not available.
2. The nutritional surveys for the refugee populations are conducted annually; hence the indicators for nutritional status are not necessarily reflecting the current food security situation and cuts in rations.
3. When comparing the nutritional status indicators between country and refugee sites, the two figures are based on different age categorisations. The MICS' data for nutritional status are based on 0-59 month old children, whereas UNHCR's data for refugee children are based on the age group 6-59 months. Thus, when comparing country and refugee site data, the refugee data is likely to be marginally inflated.
4. When analysing the MICS' country data and the data from the refugee sites, the indicators of nutritional status are not always collected in the same year.
5. The population figures provided for the protracted refugee sites are from the end of 2013, and may have changed since then. The population data from the emergency settings in South Sudan and the Central African Republic are very fluid, as are the refugees' nutritional situation.

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