

JOINT UNHCR & WHO REPORT October 2022



Greater Horn of Africa: The Impact of
Food Insecurity on the Health and
Nutrition of Refugees and Internally
Displaced People



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Below a list of acronyms that appear in this document.

Acronym	Definition
AWD	Acute Watery Diarrhoea
BSFP	Blanket Supplementary Feeding Program
CMAM	Community-Based Management of Acute Malnutrition
FRC	Famine Review Committee
GAM	Global Acute Malnutrition
GHoA	Greater Horn of Africa
HEV	Hepatitis E Virus
IDPs	Internally Displaced People
IPC	Integrated Phase Classification
MAM	Moderate Acute Malnutrition
MUAC	Mid-Upper Arm Circumference
NGO	Non-Governmental Organization
OCHA	United Nations Office for The Coordination of Humanitarian Affairs
OCV	Oral Cholera Vaccine
OTP	Outpatient Therapeutic Program
PCR	Polymerase Chain Reaction
PLW	Pregnant and Lactating Women
RDT	Rapid Detection Test
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SC	Stabilization Centre
SENS	Standardised Expanded Nutrition Survey
SFP	Supplementary Feeding Program
SMART	Standardised Monitoring and Assessment of Relief and Transitions
TFP	Therapeutic Feeding Program
TSFP	Target Supplementary Feeding Program
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WFP	World Food Program
WHO	World Health Organization
WHZ	Weight-for-Length/Height Z-Score

The Impacts of Displacement and Food Insecurity on Displaced Populations

A food insecurity crisis is a health crisis, with a lasting impact on the health of the displaced community. Health risks increase while access to healthcare is restricted. A significant increase in global and severe acute malnutrition among children in many internally displaced people (IDPs) and refugee settings has been recorded. Communicable diseases, including cholera, measles, yellow fever, and COVID-19 are a major public health concern, especially with the further displacements and disruption of living conditions and sanitation.

There are several threats that cause IDPs and refugees to flee their homes. Some reasons for fleeing are to escape violence, conflict(s), human rights violations, and other man-made or natural threats. States must protect the rights of IDPs, however, some states are unable or unwilling to do so, leaving IDPs and refugees facing food insecurity as well as threats to their health and well-being¹. Additionally, there is an evident inverted relationship as well, where food insecurity by itself can be a major contributing factor to becoming displaced².

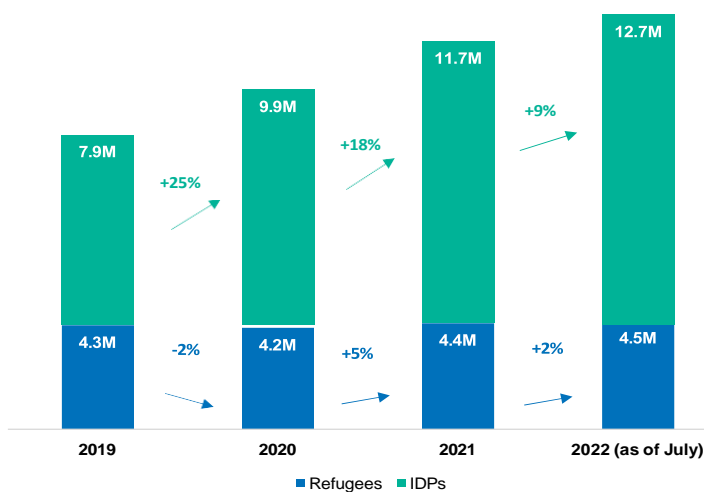
Refugees and IDPs are among the groups most vulnerable to acute food insecurity and malnutrition as well as other health risks resulting from the loss of assets and means of subsistence, disruptions to community-based safety nets, and disruptions to national social protection systems. At the same time, barriers to healthcare access also increase, reducing the coverage of affordable, available, and accessible healthcare services, threatening the effectiveness of health programs.



Displacement not only affects people's health but also their self-reliance, and physical, mental, and socio-economic well-being. In response to desperate situations, many people, especially women and girls, resort to coping strategies that are nutritionally harmful, such as skipping or reducing meals or opting for less nutritious food. According to literature these negative health effects are worse for women who are pregnant or lactating³. Self-reliance is reduced when community support systems or assets are lost resulting in increased household indebtedness. Self-reliance can be compromised by the selling of assets or taking interest-bearing loans. The threat of marginalization, abuse and exploitation, gender-based violence, and intercommunal tensions arises when those displaced cope by begging, engaging children in labor, interrupting education, resorting to child marriage to obtain alternative sources of income, or engaging in the sale of sex in exchange for food for instance¹.

Refugees and IDPs in the Greater Horn of Africa (GHOA)

Figure 1: GHOA Refugees and IDPs (2019-2022)

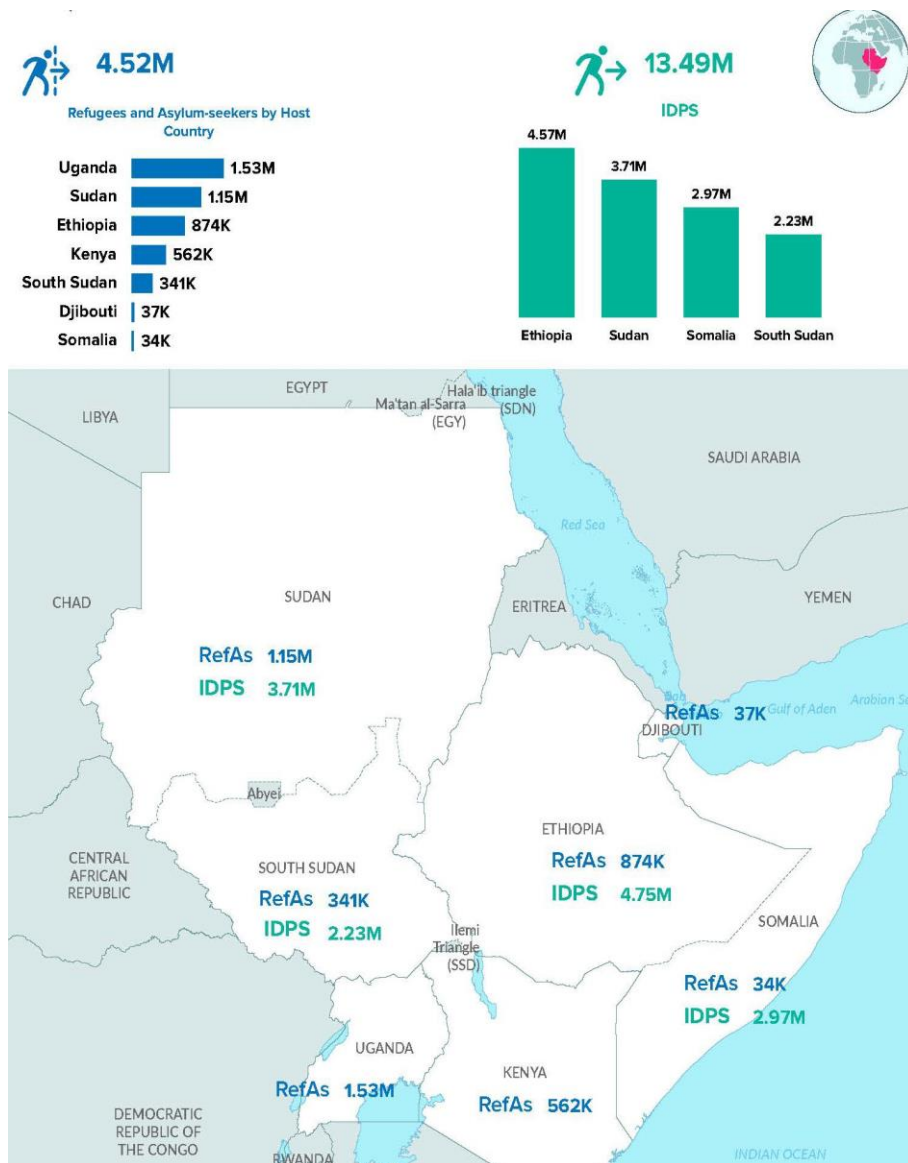


IDPs and refugees are vulnerable populations in the current food insecurity emergency in the GHOA (Djibouti, Ethiopia, Kenya, Somalia, South Sudan, Sudan and Uganda). Both groups face growing health risks of malnutrition, communicable diseases and are at risk of increased levels of morbidity and mortality, increasing the need for preventive and curative healthcare services. The rising food insecurity that has triggered a humanitarian crisis in the GHOA region is driven by a toxic mix of extreme weather events (4th consecutive year of drought with a forecast for a 5th year, as well as flooding in various areas), conflict, and the impact of the war in Ukraine (which has led to a reduction in the import of food).

The devastating levels of food scarcity are propelling displacement not only within countries, but also across borders. In Somalia alone, according to UNHCR, more than 1 million people have been displaced due to food insecurity, of which 750,000 this year, some of them remaining within the borders and others crossing into Kenya and Ethiopia⁴. The number of IDPs increased to 12.7 million, while refugees and asylum seekers reached 4.5 million in the seven countries of GHoA⁵. Over the last few months new influxes were observed, as a result on-going conflicts, weather shocks (prolonged drought, flooding) and the search for food, water, and pasture for their animals.

Ethiopia has the highest number of IDPs in the region (4.5 million), particularly in the northern and western parts of the country, followed by Sudan (3.7 million) in Darfur and South Kordofan, and Somalia (2.97 million)². South Sudan is the country where the highest number of refugees originate from (2.3 million) while Uganda hosts the highest number of refugees (1.5 million) in the 13 settlements across the country². Figures 1 and 2 provide a further insight into the number of refugees, asylum seekers and IDPs in the GHoA region.

Figure 2: GHoA Refugees, Asylum Seekers and IDPs (Aug 2022)



Communicable Diseases and Other Health Risks

All seven countries in the GHoA have been malaria-endemic countries for many years. Currently, six countries, Djibouti, Ethiopia, Kenya, Somalia, South Sudan, and Sudan are dealing with measles outbreaks. Immunization coverage is low in many countries in the region, especially in Somalia (46% for measles and 35% meningococcal vaccination). Cholera cases have been detected in Somalia, South Sudan, and Kenya. Anthrax cases have been reported from Kenya, South Sudan, and Uganda. Sudan and South Sudan are seeing cases of meningitis. There are yellow fever outbreaks in Kenya and Uganda. Hepatitis E Virus (HEV) cases have been reported from Sudan and IDP camps in South Sudan. Monkeypox cases have been reported in West Darfur, Sudan. Compromised living conditions, hygiene, and sanitation conditions of IDPs and refugees settings can make them more susceptible to communicable diseases.



Suspected cholera cases and persistent transmission of the HEV continue to be reported in Bentiu IDP camp and Unity State in **South Sudan**. A multisectoral joint cholera and HEV response coordination is in place at the state level comprising of health, WASH, and other clusters. Surveillance is enhanced through the provision of refresher training, distribution of case definition, and other reporting tools. Case management is provided by the public health centers while severe cases are referred to the hospital.

Cholera and HEV messages were disseminated as part of risk communication and awareness activities. An oral cholera vaccine (OCV) campaign was implemented in the cholera hotspots, including Rubkona County where the Bentiu IDP camp is located. A coverage of 85% for the first round and 88% for the second round was achieved. An HEV vaccination campaign was conducted in Bentiu IDP camp targeting those aged 16-40 years, including pregnant women. A coverage of 91% for the first round and 82% for the second round was achieved, and a third round was recently conducted in October 2022.

In **Djibouti**, 68% of the refugees are women and children. In addition to the refugees, a large number of nomadic/semi-nomadic populations continue to cross the towns and rural areas looking for safety or basic necessities. Diarrhoea, dehydration, anaemia, malnutrition, fever, and pulmonary infection were the most common illnesses for both adults and children reported by the Ministry of Health (MoH).

In **Uganda**, WHO is providing technical guidance to the MoH on surveillance for all diseases with outbreak potential, capacity building for refugee hosting districts through rapid response trainings on surveillance and case management. In addition to the activities previously mentioned, 60 health workers were trained for OCV activities in Nakivale and Nyakabande and 40 health workers were trained in Isingiro district to strengthen mortality surveillance in both the host and refugee settlements. A total of 18,905 new arrivals ages 1-year and above have received a dose of the OCV beginning in June 2022. Additionally, deployment of 92,000 doses of OCV to Nakivale refugee settlement began in September 2022 and two cholera kits were deployed to Isingiro district. More than 15 suspected cases of monkeypox have been investigated in the refugee-receiving and hosting districts while continuous support for COVID-19 testing is being provided with rapid detection tests (RDTs) and 45,000 polymerase chain reaction (PCR) kits shipped to the central public health laboratory in Adjumani.



Heavy rainfall has been affecting most states in Sudan causing widespread floods that resulted in more displacement and damage as well as increased risks of water and vector-borne diseases. Almost 265,000 affected people, approximately 56,000 houses and 500 health facilities have been damaged or destroyed¹. In the Kalma camp, one of the largest camps in Darfur with 300,000 residents, the Darfur

camp coordination highlighted the complete collapse of more than 200 homes due to the heavy rains. Additionally, there has been an increase in the cases of malnutrition among children with 5,250 children affected. WHO is undertaking a risk mapping of potential cholera hotspots to prepare and initiate preventative OCV campaigns. WHO is also supporting health authorities by sending rapid response kits to health facilities, activating zero-reporting surveillance and water quality testing, carrying out vector control interventions, and disseminating hygiene materials.

Nutrition Situation Update

In the context of malnutrition, WHO maintains guidelines that include thresholds with important clinical implications (Figure 3). Wasting is defined as low weight-for-height. It often indicates recent and severe weight loss, although it can also persist for a long time. It usually occurs when a person has not had food of adequate quality and quantity and/or they have had frequent or prolonged illnesses. Wasting in children is associated with a higher risk of death if not treated properly. Stunting is defined as low height-for-age. It is the result of chronic or recurrent undernutrition, usually associated with poverty, poor maternal health and nutrition, frequent illness and/or inappropriate feeding and care in early life. Stunting prevents children from reaching their physical and cognitive potential.

Figure 3: Classification Prevalence Thresholds for Wasting and Stunting for Children Under 5 Years of Age⁶

Classification Prevalence Thresholds (%)	Critical situation	Serious situation (emergency)	Poor situation	Acceptable situation	
	Very High	High	Medium	Low	Very low
Wasting / GAM	≥15	10 - <15	5 - <10	2.5 - <5	<2.5
Stunting	≥30	20 - <30	10 - <20	2.5 - <10	<2.5

Figure 4: Classification Prevalence Thresholds for Anaemia for Children under 5 Years of Age⁶

Classification Prevalence Thresholds (%)	High	Medium	Low
Anaemia	≥40	20 - 39	5 - 19

Internally Displaced Persons

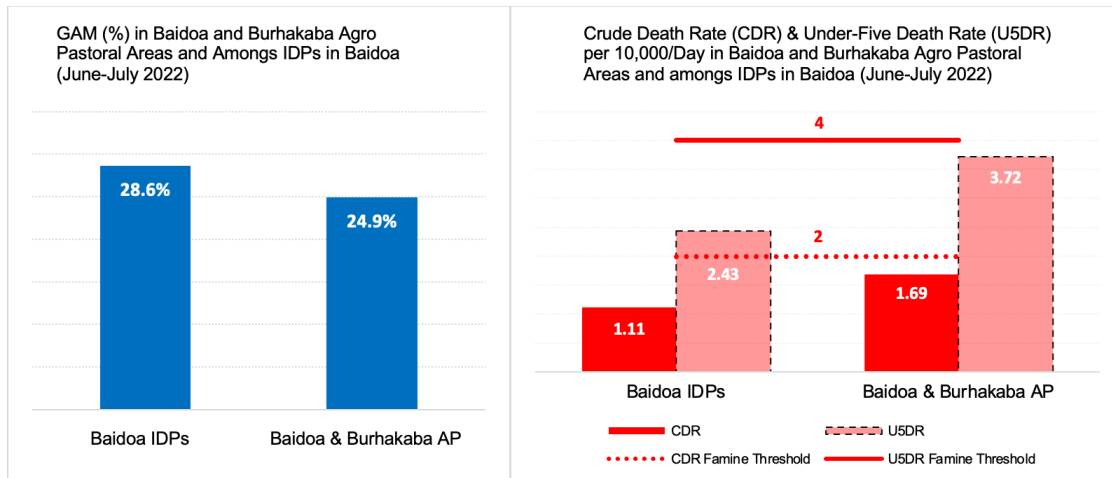
In **Somalia**, newly internally displaced populations are experiencing a very serious nutrition and health crisis. Acute malnutrition in children is at critical levels. Data from 11 selected IDP sites in Baidoa and Diinsor revealed that global acute malnutrition (GAM) based on mid-upper arm circumference (MUAC) ranges from 21% in Khada to 28% in Baidoa, 63% of severe acute malnutrition (SAM) cases are attending an outpatient therapeutic program (OTP) and 53% of moderate acute malnutrition (MAM) cases attending an OTP or supplementary feeding program (SFP)⁷.

Based on integrated food security, nutrition, and mortality surveys conducted in June and July 2022 and subsequent IPC analysis, agro pastoral populations in Baidoa and Burhakaba districts and displaced populations in Baidoa town of Bay Region in Somalia are projected to face famine (IPC Phase 5) between October and December 2022 in the absence of significant humanitarian assistance reaching people most in need⁸. This projection was made by a multi-disciplinary team of technical experts working as part of the Somalia IPC Technical Working Group (IPC TWG). The analysis and evidence for the famine projection were subsequently reviewed and technically vetted by the Famine Review Committee, a panel of independent international food security and nutrition experts.



The humanitarian situation in the Bay region and other parts of Somalia has been deteriorating in recent months as the level of humanitarian assistance fails to keep pace with rising needs, and the coping capacity of the most vulnerable is exhausted due to the combined impact of four consecutive seasons of poor rainfall, sharp increases in food prices, and conflict. The results of the integrated surveys conducted in June and July 2022 in Baidoa and Burhakaba districts and among IDPs in Baidoa town indicate levels of GAM and mortality that are indicative of an emergency (IPC Phase 4) (Figure 5)⁹.

Figure 5: A Comparison of GAM and Crude Death Rate



Refugees and Asylum Seekers

Around 81% of refugees and asylum seekers are women and children below the age of 18 years in the GHoA region, the most vulnerable group to food insecurity, malnutrition, and other morbidities. Evidence from UNHCR Standard Expanded Nutrition Survey (SENS) conducted in the region, noted 'critical' levels of different types of malnutrition (wasting, stunting, and anaemia) reported among refugee children aged 6-59 months in the refugee sites in Ethiopia, Kenya, Sudan, South Sudan, and Uganda.

Ethiopia hosts over 870,000 refugees, according to the results of the 2021 SENS conducted in 18 refugee camps in the country. The prevalence of GAM among children aged 6-59 months reported 'serious' and 'critical' levels in approximately 70% of the camps. In nearly 35% of the camps, the prevalence of SAM was reported as 'critical' levels (>2% critical level UNHCR classification)¹⁰. The prevalence of stunting or chronic malnutrition among children aged 6-59 months was reported as 'high' and 'very high' in 50% of the camps. The prevalence of anaemia is at 'critical' levels (more than 40% prevalence) in nearly 35% of the camps (Figure 4).

According to the nutrition screening (based on MUAC/Oedema/WHZ) conducted among the new arrival refugees from Somalia in Dollo Ado, Ethiopia from January to June 2022, out of 3,126 children aged 6-59 months screened for acute malnutrition, critical levels of GAM (>15%) and SAM (>2%) have been observed¹¹.

Additionally, the results of recent UNHCR SENS surveys conducted in the five refugee camps in Dollo Ado, **Ethiopia** indicated a deterioration of the nutrition situation when compared to past three years, where the GAM prevalence increased to above the 'critical level' of 15% in four camps, and the SAM prevalence reached 6% in three camps¹¹.



The trends analysis of new admissions of acutely malnourished cases in the on-going nutrition program in the five refugee camps in Dollo Ado indicated significant increases in the admissions of SAM and MAM cases among refugee children aged 6-59 months during 2022 when compared to the past three years (Figure 6A and 6B on SAM admissions in the therapeutic feeding program (TFP) and MAM admissions in the targeted supplementary feeding program (TSFP))¹¹.



Contributing factors resulting in the reported increases¹¹:

- Deterioration in the nutrition situation during 2022 when compared to the past three years - increases in GAM prevalence to above 15% in 4 out of 5 camps
- New arrival of refugees from Somalia during 2022 with critical levels of GAM above 15% of emergency among children aged 6-59 months
- Measles outbreaks
- On-going food ration cuts (50% cut in recommended 2100 kcal/p/d)
- The negative impacts of the drought and increases in food prices
- Challenges related to childcare practices specifically infant and young child feeding, health, and WASH

Kenya is hosting over 550,000 refugees, with high levels of different forms of child malnutrition reported; GAM is high between 10-15% (Figure 7) in 2 out of 5 camps, and the prevalence of anaemia among children aged 6-59 months was reported as "critical" above 40% of public health significance in all camps¹². In addition, the prevalence of anaemia among non-pregnant women aged 15-49 was reported as 'critical' above 40% of public health significance in 2 out of 5 camps¹³.

Figure 6A: SAM Admissions in OTP/SC (TFP) - Melkadida (2019-2022)

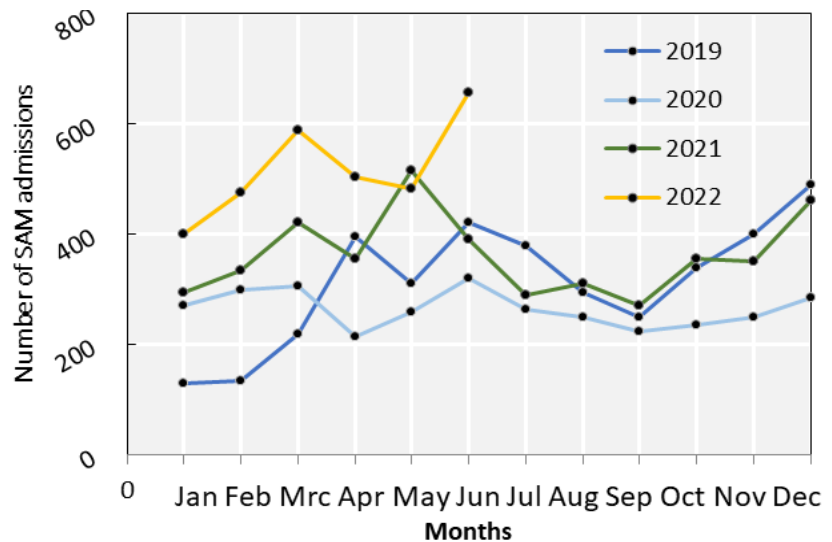
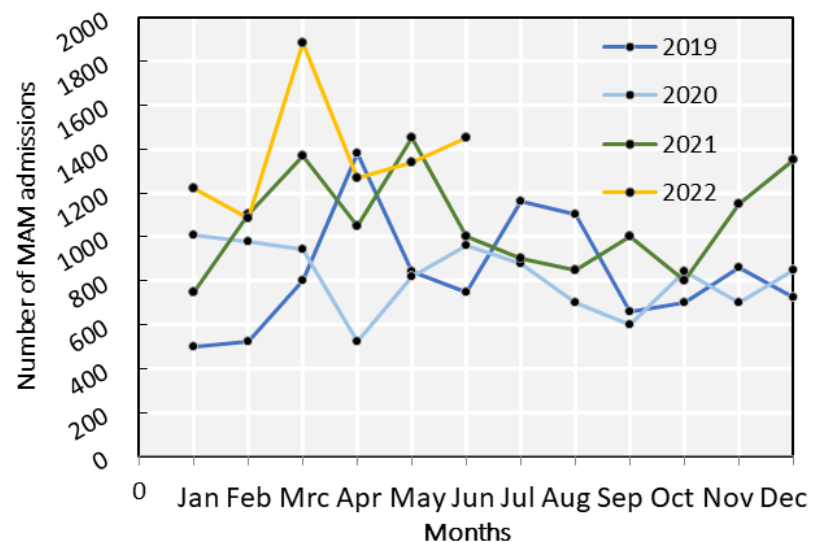


Figure 6B: MAM Admissions in TSFP - Melkadida (2019-2022)



Even so, 'critical' levels of acute malnutrition were reported among newly arriving refugee children in Kakuma, Kenya (nutrition screening, based on MUAC/Oedema/WHZ among new arrivals refugee children aged 6-59 months from April to August 2022).

The origin of new arrivals is mostly from South Sudan followed by Burundi and the DRC. Out of 1,779 children aged 6-59 months screened for acute malnutrition, a 'critical' level of GAM (>15%) and SAM (>2%) have been observed (Figure 7)¹. This has contributed to the increase in new admissions in the ongoing nutrition program in Kakuma. The review of the trends in new admissions of SAM and MAM cases in nutrition program in the refugee camps in Kakuma, Kenya also indicated significance increases during 2022 when compared to the past three years (Figure 8A and 8B.)

Figure 7: Nutrition Screening (MUAC/Oedema/WHZ) Among New Arrivals - Kakuma (Apr-Aug 2022)

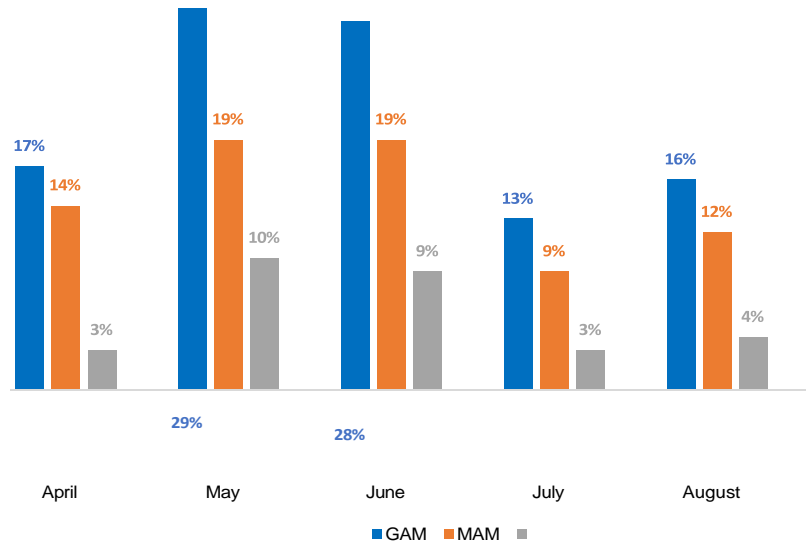
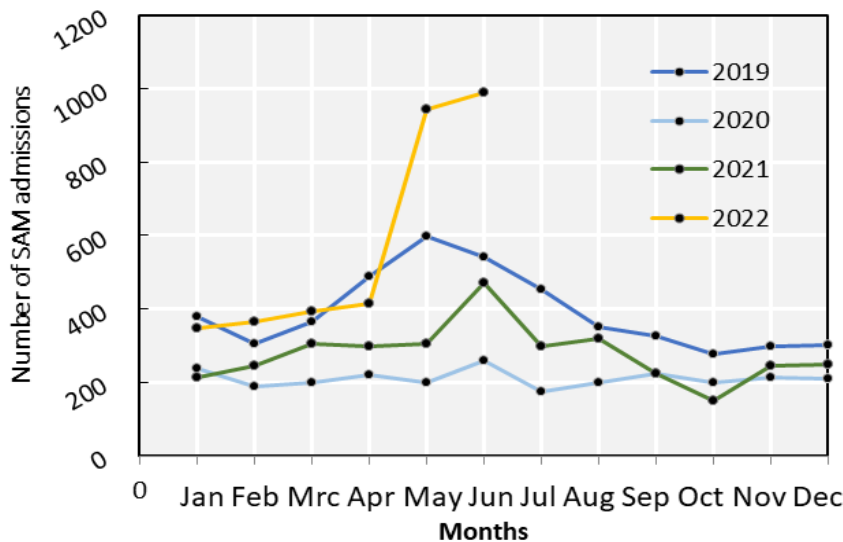
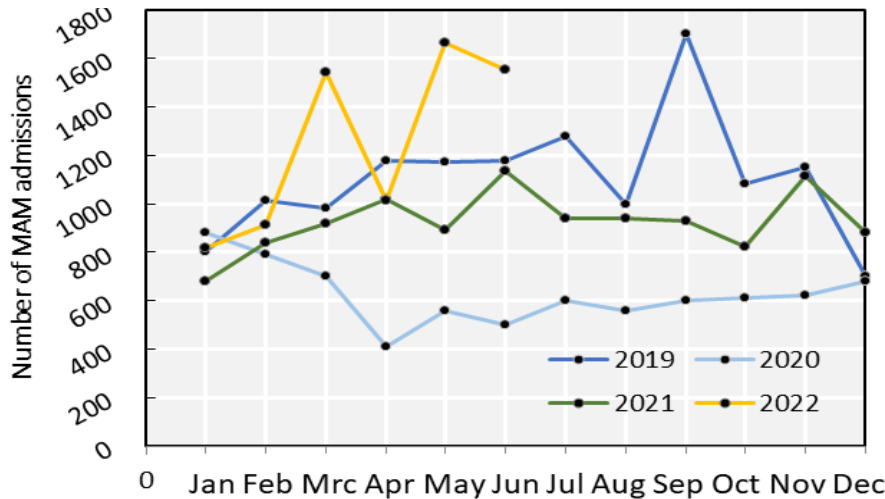
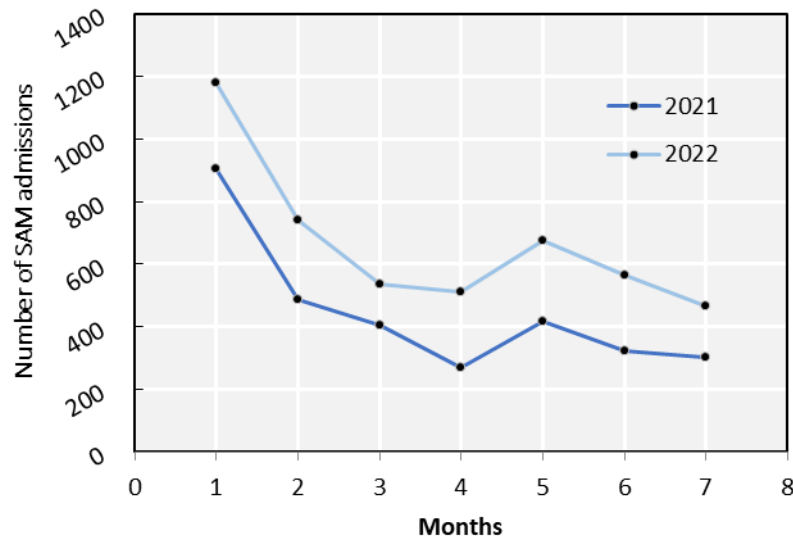


Figure 8B: SAM Admissions in OTP/SC (TFP) – Kakuma; **Figure 8B:** MAM Admissions TSFP - Kakuma



At the refugee camps in Dadaab, Kenya, a significant increase was reported in the new admissions of SAM cases in the nutrition program during Jan-Jul 2022 when compared to the same time in 2021 (Figure 9).

Figure 9: SAM Admissions OTP/SC (TFP) - Dadaab (Jan-Jul 2021 vs 2022)



Contributing factors resulting in the increase in the number of new admissions of SAM and MAM cases in the on-going nutrition program in the refugee camps in Kenya during 2022 when compared to the past three years¹³:

- Critical levels of GAM among new arrivals refugee children aged 6-59 months during 2022.
- Newly arrived refugees were hosted in two reception centers with limited space. At the peak, 8000 persons were hosted in reception centers with capacity of only approx. <3000. Likely at least in part due to crowding and strained WASH conditions, high numbers of AWD cases were reported from these centers.
- A stock-out of nutrition supplies at national level, specifically RUTF and F100 therapeutic milk during the peak of acute malnutrition likely also contributed. Required supplies are now in place with UNICEF and UNHCR support, including a buffer to cover possible gaps.
- On-going food ration reductions for refugees (50% food ration cuts of the recommended 2100 kcal/p/d).
- Increases in food prices due to drought and other conditions, and other negative impacts of the ongoing drought in the country.
- Increase in new admissions of SAM and MAM cases from the surrounding host communities in nutrition program in the refugee camps.
- Challenges related to childcare practices especially infant and young child feeding, health, and WASH.



In **Sudan**, hosting over 1.1 million refugees and asylum seekers from neighboring countries, the result of recent UNHCR SENS surveys (May-June 2022) in the ten South Sudanese refugee camps in White Nile state indicated 'critical' levels of GAM (>15%), SAM being above 2%¹⁴.

Due to funding shortfalls since July 2022, the camp-based refugee population in Sudan is facing 50% food ration cuts in the recommended 2100 kcal/p/d, which will contribute to a further deterioration of the already concerning food security and nutrition situation.

In **South Sudan**, hosting over 340,000 refugees and asylum seekers, the results of the latest UNHCR SENS surveys (Sept. – Dec. 2021) in the seven refugee camps indicated 'high' prevalence of GAM (10% - <15%) in four camps, with SAM prevalence being >2% of critical in the two camps.

The prevalence of stunting was reported as 'very high' in one camp (>30%), 'high' in one camp (20% - <30%), and 'medium' level in five camps (10% - <20%). The prevalence of anaemia among children aged 6-59 months ranges between 41% – 70% indicated 'high' level (above 40% of public health significance) in five camps, while in the rest of two camps it stands between 20% – 39% 'medium' public health significance¹⁵. The high prevalence of anaemia is also a key concern among non-pregnant women aged 15-49 years, in one camp it is as high as 68%, in three camps it is between 20% - 39% 'medium' public health significance, while in three camps at 'acceptable' level of <20%.

Despite multiple challenges and the high levels of acute food insecurity and malnutrition in South Sudan, the refugee population is facing food ration cuts in the recommended 2100 kcal/p/d which began with a 30% cut in November 2015 and increased to a 50% cut in early 2021.

UNHCR and WHO Support

UNHCR, in coordination and collaboration with partner UN agencies (WHO, WFP, UNICEF), NGOs and national nutrition program at MoH, is conducting regular periodic assessment and monitoring of nutrition and food security situation among refugee populations in the refugee sites (camp and settlement-based refugees) through SENS, the joint assessment mission, trends in new admissions in nutrition program, and nutrition screening among new arrival refugees in the region. For the assessment and monitoring of refugees in out-of-camp settings UNHCR advocates for their inclusion in the national level SMART nutrition surveys and access to the national level nutrition program.

During 2021, UNHCR conducted 30 SENS surveys in three country operations in the region (among them 18 SENS surveys in 18 refugee camps in Ethiopia, 5 SENS surveys in refugee camps in Kenya, 7 SENS surveys in refugee camps in South Sudan).

As of end of August 2022, 37 SENS surveys have been conducted; five in Dollo Ado, 2 in Afar, 3 in Jijiga region in Ethiopia, 10 in White Nile and 4 in Gadaref state in Sudan, 13 in refugee settlements and surrounding host community in Uganda. Additionally, SENS surveys are in progress in Jujiga, Assosa and Gambella in Ethiopia.



A nutrition program is in place in all refugee camps / settlements using community-based management of acute malnutrition (CMAM) approach with a focus on nutrition preventive and curative interventions as an integrated part of public health services and linkages with other services in the refugee sites. The UNHCR CMAM program in the refugee sites in the region includes the following components:

- **Community based outreach** activities include nutrition screening at community level for active case finding, referral of SAM and MAM cases, PLW and other vulnerable groups, sensitization/awareness raising on different nutrition/health topics, support and promotion of infant and young child feeding practices, mother-to-mother support groups, follow-up of absentees from nutrition program.
- **Preventive blanket supplementary feeding program (BSFP)** to PLW and for young children aged 6-23 months / where GAM prevalence is above 15% of emergency threshold and resources available covering all children aged 6-59 months (considering the emergency nature of refugee response).
- **Management of MAM** in TSFP.
- **Management of SAM cases without medical complication** in OPT using ready to use therapeutic food (RUTF).
- **Management of SAM cases with medical complications** in in-patient Stabilization Centre (SC).

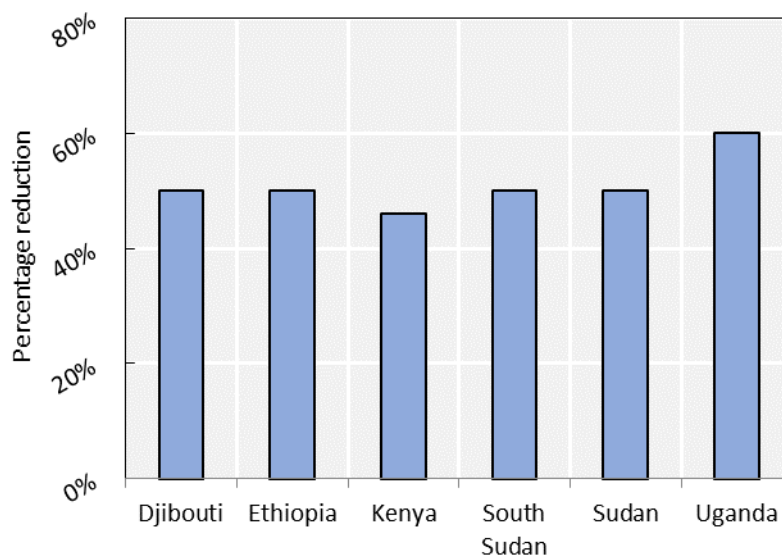
WHO supports the drought and food and insecurity emergency in the GHoA countries with medical assistance required, directly related to malnutrition. This ranges from food and vitamin supplements to life saving secondary care. Moreover, WHO supports countries to prepare for outbreaks of diseases related to food and water insecurity, displacement and subsequent crowding including cholera, measles, and malaria. This includes strengthening surveillance systems for communicable diseases to identify and respond to new outbreaks in a rapid fashion.

But these also include vaccination campaigning targeted at vulnerable populations, training activities to local actors and coordination of collaborative health responses. In addition, WHO leads on the coordination of the purchase of life-saving medical supplies to those areas and populations in need. These supplies include medicines as well the equipment needed to treat children who are severely malnourished.

Gaps and Challenges

Funding shortfalls for provision of basic needs remain a key challenge in the region which resulted in significant food ration cuts in the by WHO recommended daily food basket of 2100 kcal/p/d (Figure 10). The consequences of failure to access a nutritious diet will be seen in reduced immunity, poor health outcomes among pregnant and lactating women, increased caseload of acute malnutrition among children and even adolescent/ adults in the nutrition program, as well as an increase in hospitalization.

Figure 10: Percentage Reduction in Recommended Daily Food Basket (2,100 kcal/p) at Refugee Sites - (Aug 2022)



There is a need for continued training and capacity building of health and nutrition staff working in the CMAM programs specifically the SC at the health facility level on the management of SAM with medical complications. Regular supplies of required nutrition kits and nutrition products for management of SAM in both out-patient and in-patient settings, especially with the continuous influx of refugees.

Additionally, there have been limited resources regarding vaccine doses to support the response to the numerous outbreaks including measles and cholera. The global shortage of OCV vaccines has led to limited access in countries in GHoA.

Recommendations and Key Advocacy Messages

WHO emphasizes the essential and underrecognized role of health in a food insecurity crisis. The morbidity and mortality in such crises are of unprecedented levels.

Joint advocacy for fundraising for the provision of basic health and nutritional needs to forcibly displaced populations in the region (to make sure provision of health care, nutrition services, recommended food assistance 2100 kcal/p/d, required nutrition products, including capacity-building of MoH and other partners).

Joint intersectoral and coordinated efforts to strengthen emergency preparedness and response of new influxes of forcibly displaced people in the region.

Joint efforts for inclusion and integration of forcibly displaced population in the national level health and nutrition interventions that are broad and encompassing.

Any health and nutrition response needs to be broad and based on inter-cluster/sectoral collaboration, coordination and needs, to cover the following domains:

1. Enhanced national and sub-national coordination and collaboration among partners and sectors for stronger agreement about strategic priorities and effective operationalization.
2. Increased collection and use of timely and accurate health and nutrition data for early warning, IPC-CH classification, assessment of service delivery capacities and barriers, guidance for decision-making, prioritization, planning and enabling monitoring and evaluation of interventions.
3. Effective prevention and control of additional and interdependent epidemics and other health emergencies, including seasonal increases in morbidity that are likely to occur during food-security crises.
4. Increased and integrated availability of essential nutrition actions for effective prevention, detection and treatment of malnutrition.
5. Capacity of priority health services scaled up and adapted to the increased health needs, risks and access barriers to health care in food insecurity crises.



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JOINT UNHCR & WHO REPORT OCTOBER 2022

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