

Chapter 6

Well-being and living conditions of refugees: case studies**Introduction**

Since 2005, the Statistical Yearbook has provided more quantitative insight into gaps in protection and the well-being of people of concern, as well as into some of the major operational constraints UNHCR faced in addressing the issues at hand. In maintaining this approach, the 2008 Yearbook attempts to illustrate the potential of the data for evidence-based decision making in the humanitarian field. By showing the gaps and analysing the policy and operational implications of the findings, the Statistical Yearbook supports the decision-making process including the planning and prioritization of activities.

However, analysis of this kind is useful and sustainable only if continuous efforts are made to improve data quality. With the introduction of new results-based management tools for planning and reporting, as well as the continuation of the Operational Data Management Learning Programme⁵⁹, UNHCR's ability to conduct evidence based analysis of its programmes and performance will increase.

Ensuring meaningful geographical and time-based comparisons are difficult as data are not always fully compatible; various data collection methodologies and changes in the reporting instruments make the provision of a global picture of UNHCR's performance in protection and assistance challenging. Nevertheless, over the past years, the statistical reporting on living conditions and the well-being of UNHCR's beneficiaries has improved significantly.

Country case studies using comparable methodologies and data are presented in this chapter to illustrate some of the legal and physical protection concerns faced by refugees and IDPs.⁶⁰ Most of the data used in this chapter was derived from UNHCR's Health Information System (HIS) and the 2008 Standards and Indicators (S&I) Report. The HIS system collects systematic data on health and related indicators in 16 countries, primarily focusing on camp-based populations. The S&I Report sets minimum standards to assess protection, living conditions and the well-being of populations of concern, and ensures that this type of information is reported in a consistent manner across UNHCR operations. Other data sources include the registration software *proGres*, the result-based management software *FOCUS*, ad-hoc nutritional surveys undertaken by UNHCR and its partners, as well as reports from UNHCR health coordinators and other protection data collection mechanisms.

This chapter contains two main parts. The first reflects nutrition and health-related indicators for refugees, with a focus on food, malnutrition and anaemia. The second part provides insight into a recent UNHCR study on the secondary movements of Eritrean and Somali refugees and asylum-seekers. Both parts are structured as follows: a short explanation of the topic's relevance; current and potential data sources; levels and trends in refugee and/or refugee-like situations based on available information; and potential implications of the findings.

59 This Programme, introduced in 2009, has trained more than 100 staff in 40 operations who are directly involved in data collection and management.

60 The previous Yearbooks included case studies on topics such as HIV/AIDS, water and sanitation, the protection of women and children, and sexual and gender-based violence.

A Nutrition and Food Security

Background and indicators

Nutrition and food security are fundamental to human well-being and important in achieving the Millennium Development Goals (MDGs) related to child mortality; poverty; education; gender equality; maternal health; and HIV and AIDS. The prevalence of acute malnutrition is a widely used indicator of the severity of humanitarian crises, and is recognized as such by the United Nations, donors, national governments and international agencies.

The year 2008 was marked by a global food crisis affecting millions of people, particularly the most vulnerable, among whom are persons of concern to UNHCR. UNHCR worked closely with governments, United Nations and other humanitarian agencies, particularly the World Food Programme (WFP), to ensure that persons of concern to the Office continue to have access to food assistance.

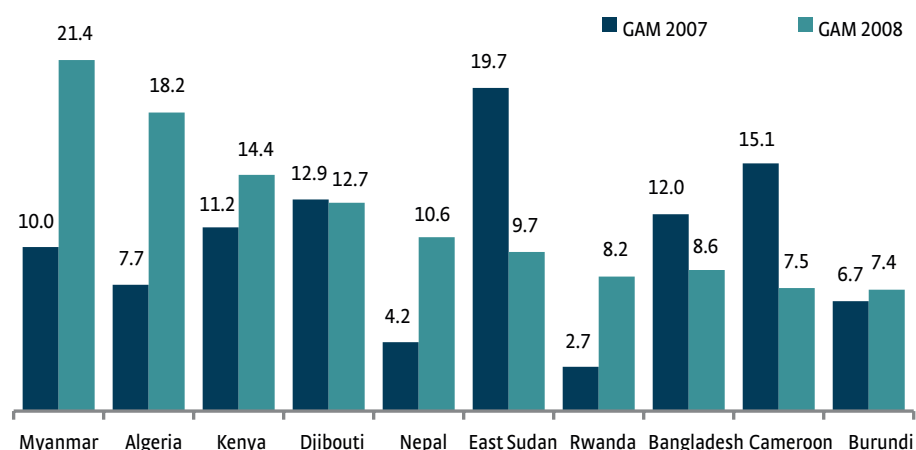
Data used in this section were primarily derived from nutritional surveys and the HIS system. The role of the HIS is to generate, analyse and disseminate routine public health data in order to rapidly detect and respond to health problems and epidemics, to monitor trends and address public health priorities, and to evaluate the effectiveness and quality of interventions and service coverage.

Malnutrition: Levels and trends

Ensuring adequate nutrition is an essential part of protection for people of concern to UNHCR, in particular for refugee children and women; standards in relation to nutrition, food security and public health have not always been met, particularly in some protracted refugee situations.

Data on malnutrition levels and trends were available for a limited number of countries in Africa and Asia. Most of the countries shown in Figure VI.1 below did not meet UNHCR's standard of maximum five per cent for global acute malnutrition (GAM) and maximum two per cent for severe acute malnutrition (SAM) at the end of 2007. In east Sudan, Bangladesh, Djibouti, Kenya and Myanmar, the GAM prevalence is 10 per cent or more. The SAM prevalence in many countries varied between 2 and 5.4 per cent, and was in some cases far above the standard.

Fig VI.1 Trends in GAM and SAM 2007-2008 (in %)



However, statistics from 2008 show reductions in the prevalence of global acute malnutrition in a number of countries or regions including in Bangladesh, Chad, Ethiopia, the United Republic of Tanzania, Uganda, Yemen, and east Sudan. Most notably, Ethiopia saw a marked improvement in GAM rates between 2007 and 2008, with a total decrease of 5.2 percentage points, from 8.8 per cent in 2007 to 3.6 per cent in 2008. Yemen also saw a significant reduction from 10.1 in 2007 to 5.0 per cent in 2008. Lastly, the situation in east Sudan improved with GAM rates dropping from 19.7 per cent in 2007 to 9.7 per cent in 2008.

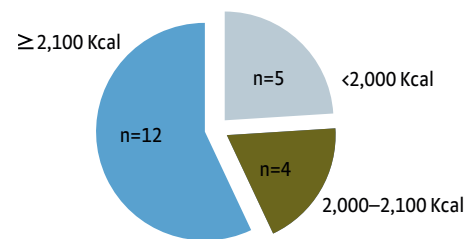
However, in many countries, the malnutrition indicators were still above acceptable levels for stable operations receiving food aid, or even worsening in some operations. After an almost halving between 2006 and 2007 from 20.6 to 11.2 per cent GAM and from 2.9 to 1.4 per cent SAM, Kenya saw a rise in GAM levels in 2008 to 14.4 per cent and to 1.8 per cent SAM. Similarly, Nepal's GAM rate of 4.2 in 2007 rose again to 10.6 per cent in 2008, while Rwanda saw a worsening of GAM rates increasing from 2.7 per cent in 2007 to 8.2 per cent in 2008. Similarly, in Algeria the prevalence of GAM more than doubled from 7.7 per cent in 2007 to 18.2 per cent in 2008.

In addition, in some countries, SAM rates increased from 2007 to 2008 beyond the maximum 2 per cent standard. Among these are Algeria (5.4%, up from 2.3% in 2007), Djibouti (2.9%), Sierra Leone (2.7%), Myanmar (2.6%), Zambia (2.6%), Namibia (2.5%), and Rwanda (2.3%).

Access to food

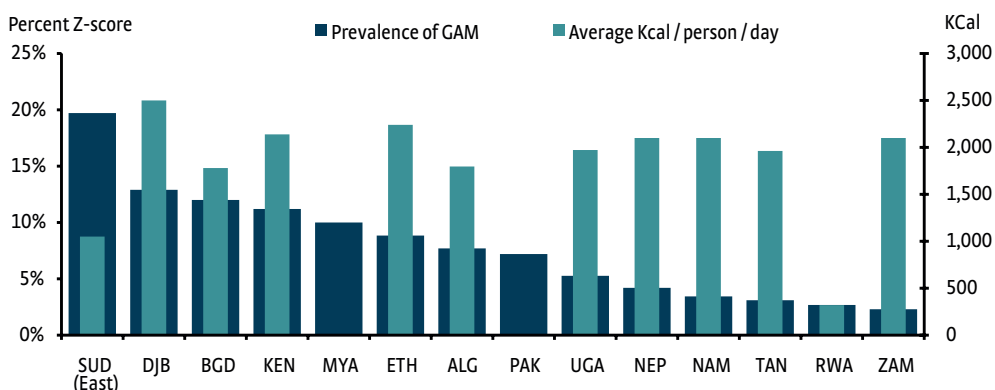
Improving the nutritional situation of refugees living in camp settings requires among other things that minimum food rations are available. Daily food rations provided to refugees in 2008 met the minimum standard of 2,100 kilocalories per person per day in 12 out of 21 country operations from which data were available (57%). Due to a number of reasons, including security concerns, pipeline issues, and access to other sources of food, five country operations distributed less than 2,000 kcal per person per day, while the remaining four provided between 2,000 and 2,100 kcal per person per day.

Fig VI.2 Total average number of Kcal/person/day provided by UNHCR operations, 2008



Despite efforts to maintain a full ration for refugees in the major operations, WFP encountered food pipeline breaks that led to ration reductions in many operations. In Uganda, 150,000 refugees received an average of 1,600 kcal per person per day throughout the year; in Gambia, the Senegalese refugees' ration was cut by 30 per cent; in Kenya, rations were cut by 30 per cent

Fig VI.3 Comparison of GAM to average KCal / person / day



between April and June 2008; and in Zambia, the 3,000 vulnerable Angolan refugees in Mayukwayukwa and Meheba refugee settlements received 75 per cent ration per day during the last three months of the year. There were some concerns related to the food pipeline for Algeria, Ethiopia, Nepal, and Yemen but the situation improved during the course of the year due to higher resources made available for those countries.

Despite the fact that the rations for most country operations either met or were close to the minimum caloric standard, the prevalence of GAM ranged from 3.1 to 14.4 per cent in 2008. As can be seen in Figure VI.3, even among countries with rations of similar caloric content, GAM rates varied greatly. The weak correlation between rates of malnutrition and kcal per person per day provided, suggests that GAM rates are not linked only to the average kcal per person per day, and that other factors are involved such as distribution mechanisms, and the need for improving micronutrient status and promoting infant and young child feeding.

Anaemia

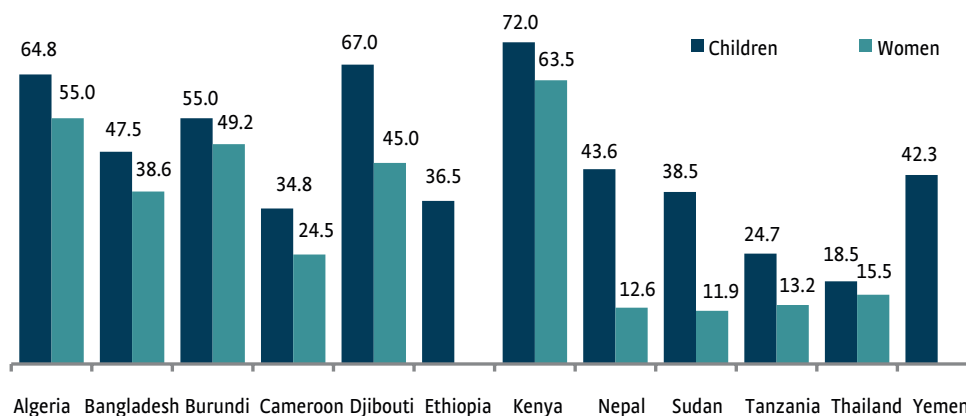
Iron deficiency anaemia (IDA) is one of the world's most widespread micronutrient deficiencies. Caused primarily by insufficient iron intake, malaria, and/or intestinal parasites, it is a particular risk for children under the age of five years and for women of reproductive age.

The difficulties of accurately measuring iron status in the field have led to the use of anaemia (low haemoglobin count in blood), regardless of etiology, as a proxy indicator for iron deficiency anaemia and for micronutrient malnutrition in the broader sense. Nutritional surveys conducted in refugee camps demonstrated that the prevalence rates of anaemia were of significant public health concern, with many surpassing stable situation acceptable levels of 20 per cent.

Anaemia prevalence levels above 40 per cent represent a serious public health concern and rates of 60 per cent and above are considered an acute emergency requiring immediate action. Figure IV.4 highlights the need to address this problem in a number of countries. The anaemia rate in surveys conducted during 2008 were found to be as high as 72 per cent among children under five years of age in Kenya, which was already an improvement over the 2007 rate of 83.9 per cent. In the refugee camps in Algeria and Djibouti the prevalence of anaemia among children also surpassed the 60 per cent threshold, with rates of 64.8 and 67.0 per cent, respectively.

Trend analysis demonstrates that there had been some improvement in anaemia prevalence in several countries. Ethiopia saw a significant reduction in anaemia among children, from 55.4 per cent in 2007 to 36.5 per cent in 2008. A similarly significant decrease was seen in Yemen, where rates among children under age five fell from 63.4 per cent in 2007 to 42.3 per cent in 2008. An improvement in anaemia status among

Fig VI.4 Prevalence of anaemia among children and women, 2008 (%)



women of reproductive age was seen in Sudan; in 2007, 52.0 per cent of women were found to suffer from anaemia whereas in 2008 only 11.9 per cent of women were found to be anaemic. No less important was the somewhat smaller decrease in the prevalence observed in the United Republic of Tanzania, where the rate of anaemia among children dropped from 35.3 per cent in 2007 to 24.7 per cent in 2008, while the rate among women of reproductive age fell from 29.6 to 13.2 per cent.

In 2008, anaemia reduction programmes, which included the use of micronutrient powder as a supplement to food rations, were established in Bangladesh, Kenya, and Nepal. These pilot programmes contributed to the improvement witnessed in Kenya, and the improvement in anaemia rates in Bangladesh, where prevalence fell from 65.4 per cent in 2005 to 47.5 per cent in 2008.

Implications and response strategy

Over 2.3 million refugees and returnees and over 5 million IDPs received an average ration of 1,980 kcal per person per day in 30 countries in 2008. In addition to this, pilot projects of multi-storey gardens were initiated in two refugee camps in Ethiopia with the hope of expanding to other operations in the near future. Joint assessment missions and nutritional surveys were undertaken in 13 countries. All of these interventions contributed to ensuring an acceptable level of access to food assistance for persons of concern to UNHCR throughout 2008.

In 2008, UNHCR reaffirmed its commitment to fighting malnutrition and micronutrient deficiencies in protracted refugee situations and formulated the Strategic Plan for Food Security and Nutrition 2008-2012, which called for programmes to be scaled up and to focus on the links between nutrition and food security. As a member of the United Nations High Level Task Force on Food Security (HLTF), UNHCR advocated for refugees and IDPs to be included in safety net programmes developed together with national governments. Furthermore, UNHCR ensured that refugees and IDPs were included in all of the humanitarian components of the HLTF's Comprehensive Framework for Action and secured WFP commitment to give food aid priority to vulnerable groups, including refugees.

In relation to anaemia, the strategic plan called for the reinforcement of already existing activities such as the treatment and prevention of acute malnutrition and iron deficiency, the provision of supplementary fresh foods, the monitoring of nutritional status through periodic surveys, and the prevention and treatment of malaria and intestinal parasites. Additional efforts were made towards the capacity building of health and community workers; improved diagnostics for anaemia; the delivery of activities aimed at improving prenatal care and infant and young child feeding and care practices; and the promotion of food security projects.

B Secondary movements of Eritrean and Somali refugees and asylum-seekers

Background

The issue of secondary movement⁶¹ and fatalities occurring during dangerous journeys by sea continue to make the headlines. It is frequently Somali and Eritrean nationals who undertake these movements across the Gulf of Aden and the Mediterranean. A Working Group on Secondary Movements of Somalis and Eritre-

61 Secondary movement refers to the physical movement from a first country of asylum to a third country regardless of whether the person has or could have applied for asylum in the first country of asylum. This could involve more than one move and journeys over a number of countries.

ans was created by UNHCR in early 2009 to contribute to the development of appropriate policy and operational guidelines on this matter and to enhance the availability of protection responses.

Data and methods

As a first step, a study of existing information, data and literature was conducted to gain better insight into this phenomenon. The Working Group gathered original data from 12 UNHCR country offices and the corresponding regional desks at Headquarters, using a questionnaire to examine the conditions which could be driving secondary movement. The research provided data on the protection environment and processes, documentation, basic needs and essential services, durable solutions, the perception of Eritrean and Somali refugees and asylum-seekers, impressions on the scale and nature of secondary movements, and how UNHCR offices approach secondary movements. The questionnaire collected both quantitative and qualitative data. The countries surveyed were Djibouti, Egypt, Ethiopia, Greece, Italy, Kenya, the Libyan Arab Jamahiriya, Malta, South Africa, Sudan, Turkey, and Yemen, which were all key countries of first asylum, transit or destination for these populations.

Patterns of movement and key findings

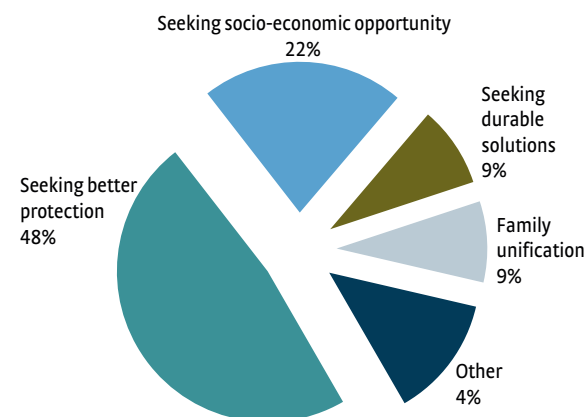
Kenya and Sudan are key hubs for secondary movement. The former is the main asylum country for Somali refugees (259,000 at end-2008) while the latter receives Eritrean refugees (125,000 at end-2008). The survey indicated that asylum-seekers arrive in these countries from Eritrea or Somalia and then seek avenues for onward movement, suggesting the existence of established networks and routes.

Four out of the 12 surveyed countries anticipated more than 80 per cent of the Somali refugees and asylum-seekers will seek to move onwards. Three countries expected 40-59 per cent of the Somali refugees on their territory to move onwards. In Djibouti, for instance, it is estimated that between 3,500-5,000 Somali refugees and asylum-seekers move on after entering the country.

Two countries expected more than 80 per cent of the Eritrean population on their territory to travel on while two others expected 60-80 per cent to move onwards. It is estimated that up to 16,000 Eritreans could move on from Sudan in 2009. Successful interventions to manage secondary movement could have a far-reaching impact.

Among the countries surveyed, the search for better protection was mentioned more frequently than any other factor as a driver of secondary movement.⁶² This counters the common belief that secondary movement is primarily motivated by a search for better opportunity, which only constituted 22 per cent of the listed reasons. Figure VI.5 shows the main reasons for secondary movement by Eritreans, as reported in the surveys. The proportions are similar for Somalis. The lack of local integration possibilities (and other durable solutions) and family reunification (9 per cent of respondents each) were also among the main reasons for onward movements.

Fig VI.5 Reasons for Eritreans moving onward



62 Protection as referred to here includes access to asylum procedures, the quality of reception conditions, enjoyment of human rights, fair RSD procedures and recognition rates, the extent of police abuse, xenophobia, and better safety and security.

Fig VI.6 Destinations for Somali secondary movers

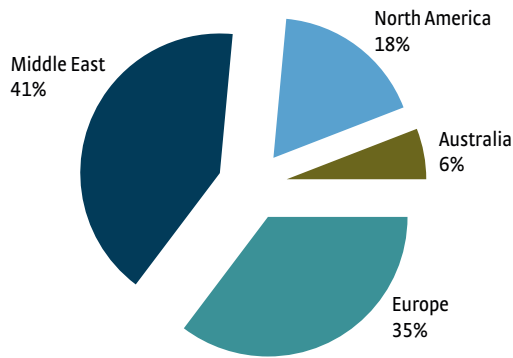
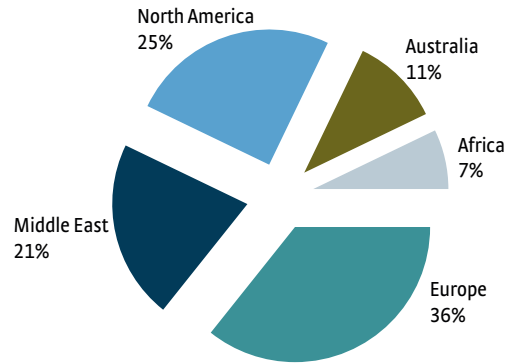


Fig VI.7 Destinations for Eritrean secondary movers



The Middle-East/Gulf, Europe and North America are the most frequently listed onward destinations for both groups. When UNHCR offices were asked to list the potential final destination of those moving onward, 41 per cent indicated the Middle-East/Gulf region for Somali refugees/asylum-seekers. For Eritreans, Europe was the anticipated prime destination (see Figures VI.6 and VI.7).

In many of the surveyed countries, the chances of achieving a durable solution⁶³ are low. While the possibilities for voluntary repatriation to either Eritrea or Somalia are low for the foreseeable future, three-quarters of the countries surveyed do not offer local integration⁶⁴ and in most of the surveyed countries, refugees do not find the resettlement approach to be acceptable.

Implications and response strategy

This study constituted an initial attempt to gain a better understanding of Eritrean and Somali secondary movements. With the scope of the study limited to perceptions and opinions expressed by UNHCR staff rather than refugees/asylum-seekers themselves, further research is required, including the direct participation of the groups concerned to better understand patterns of Eritrean and Somali secondary movements.

One of the main conclusions of the study was the need for a coherent policy approach to be crafted in order to ensure consistency. Responses to secondary movement ought to be coordinated across the region, as actions in one country can affect other countries, inadvertently creating push and pull factors, and adding yet more complexity to the already challenging task of effectively providing protection to those who need it.

63 See Chapter 3 for more details on the three durable solutions.

64 Viable local integration is seen by refugees as including access to work, access to education, access to health, and better living conditions.