
The Centre

2. BACKGROUND

2.1 Malnutrition in Refugee Camps

Although refugee populations are provided food aid during emergencies and protracted refugee situations, widespread malnutrition and health problems have been evidenced in refugee camps. Various circumstances, including funding shortages, natural disasters, civil conflicts, environmental degradation, incorrect donor and government policies, under-funding of programs, inadequate assessment and delivery systems and the unequal distribution of wealth and resources have created and perpetuated malnutrition in camps (WHO 2003a; Marchione 2002). In addition, high rates of HIV/AIDS, malaria and tuberculosis in refugee populations negatively impact health and interact with nutrition status (WHO et. al 1999, p.16). Furthermore, due to limited water supply and availability of traditional foods, as well as the psychological trauma and the disruption of typical family and cultural associations with food, refugees are often unable to obtain adequate micronutrients and the energy requirements needed for proper functioning and healthy development (Burns et al. 2000, p.231).ental degraonEMC /7 <</M

including infections, hypothermia, hypo-glycemia or dehydration (WHO et. al 1999, p.16). Whether a refugee child has been exposed to a short-term emergency situation or a protracted refugee situation will impact the extent and form of malnutrition.

2.3 Emergency and Protracted Refugee Situations

In most emergencies, as nutri

commodities are considered (WFP & UNHCR 1999). Based on the results of the nutrition assessment, as well as the local conditions, a selective feeding program may be implemented to target the most vulnerable groups (typically children). Additional interventions include supplementary, therapeutic or school feeding programs, incentive payments and ration cards (MSF-UAE 2002). Furthermore, specialised programs may be introduced to promote breast-feeding of infants, provide extra food rations and drinking water for pregnant and lactating women, supply iodised salt and distribute high-energy micronutrient-rich foods to children over six months of age (WHO 2003b).

2.5 Inadequacy of Food Aid

Despite the efforts of the international community, programs to promote child health and nutrition in refugee camps have not prevented malnutrition. The politics involved in food donation, inconsistent assessment methods (i.e., whether nutrition is measured by arm circumference or Body Mass Index), as well as the economic situation of the host country, influence the effectiveness of food aid in refugee camps (Tomczyk et al. 2004; Marchione 2002). Food aid effectiveness is further limited by the quantity of rations provided by donors, the quality and diversity of those rations (i.e., micronutrient content and cultural appropriateness) and the challenges of coordinating food delivery (Marchione 2002). In complex emergencies, refugee populations dependent on food aid have exhibited protein-energy malnutrition, anaemia, vitamin A deficiency, and iodine deficiency disorders, as well as disorders such as beriberi (thiamine deficiency), scurvy (vitamin C deficiency) and pellagra (niacin deficiency) (WHO 2003c). Protein-energy malnutrition (PEM) has been linked with death in refugee populations, largely because this type of malnutrition increases vulnerability to disease (ENNO 2005).

2.6 Malnutrition in Refugee Camps Sub-Saharan Africa

In refugee camps in Sub-Saharan Africa children are at significant risk of malnutrition and micronutrient deficiencies. A 199649907 Tm(e663 0.79 204.49907 .12 129.64479 204.49 stud, lyss) Fe

Malnutrition rates in refugee camps in Sub-Saharan Africa are among the highest in the world. In Somalia (1980), Ethiopia (1988-89) and Kenya (1991), malnutrition rates of higher than 20% have been reported in refugee populations (ENNO 2005). In the Kakuma Refugee Camp in Kenya, a study by Gregory (2002) revealed unacceptably high levels of acute global malnutrition (17.2%) and chronic malnutrition (12.6%) in children six to 59 months of age

have been in Australia for less than 12 months, DIMIA funds the Early Health Assessment and Intervention (EHAI) program. While this program provides short-term interventions for refugees with physical and psychological health problems, it does not typically include nutrition-related services (DIMIA 2005b). Although all refugees granted visas are eligible for Medicare from the date of their arrival, the infrequency of post-arrival medical screenings and the barriers to access make it difficult for newly arrived refugees to navigate the health care system and address nutritional issues (VFST 2000, p.8). Many health providers that focus on children, such as the Children's Hospital at Westmead, do not retain a Dietician on staff but instead provide nutritional assessments and nutrition advice for refugee children and their families through a referral system (Warren M, 2005, pers. comm., 8 October).

The limited focus on health and nutrition issues upon arrival and during resettlement, along with existing cultural, language and economic barriers, contributes to ongoing malnourishment and inadequate nutrition for refugee children settled in Australia. Refugee families frequently experience several challenges, including difficulties in finding inexpensive supplies of culturally appropriate foods, dislike of typical "Australian" foods and unfamiliarity with foods available locally (RPH 2003). Moreover, a lack of knowledge of food preparation and changes to eating and shopping habits can perpetuate nutrition issues for the family (RPH 2003). Detailed information regarding nutrition issues in refugee children, adapted from *Good Food for New Arrivals* (RPH 2003), is compiled in Appendix 3.

3.3 Policy Documents

In Australia, a common policy and framework for early childhood services, which comprehensively addresses the special needs of refugee children, does not exist. Several policy documents address issues of nutrition, but the needs of refugee families and children are not adequately addressed. For example, *Eat Well Australia: An Agenda for Action for Public Health Nutrition 2000–2010* provides government and non-government organisations (NGOs) with a strategic framework and an agenda for action on public health nutrition, yet refugee children are not specifically mentioned (NPHP 2001). Moreover, the *National Public Health Strategic Framework for Children 2005–2008,* designed by the Australian government to strengthen the nation's capacity to promote good health amongst children, does not address the unique needs of refugee children (NPHP 2005). Similarly, while the Australia *National Food and Nutrition Policy* acknowledges the special needs of "migrant groups," it does not address the special needs of migrant children (DHHCS 1994, p.5). Despite obvious shortcomings,

these policy documents do provide a basis to justify further cooperation and action among service providers. Several recommended strategies (i.e., improved educational curriculum

nutrition-related illnesses and diseases, into health and wellness programs available for all refugees. Detailed and specific recommendations for this are included in Appendix 1. It is hoped that, building on the excellent resources already developed, continuing work and awareness can be directed to the issue of nutrition for newly arrived refugee children.

5. NOTES

In 1990, at the World Summit for Children, the largest gathering of world leaders in history pledged to improve maternal and child nutrition and reduce or eliminate vitamin A, iodine and iron deficiencies (UN 1997). Then, in 1991, at the Ending Hidden Hunger Conference, global representatives vowed to reduce micronutrient malnutrition (World Bank 1993). By 1992, at the International Conference on Nutrition, representatives from 159 countries and the European Community, 15 United Nations organisations and 144 non-governmental organisations (NGOs) set goals for a worldwide reduction in malnutrition (FAO 1992). At the World Food Summit in 1996, 186 countries committed to adequate food and freedom from hunger for all people (FAO 1996c

6. REFERENCES

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APPENDI

11. Service providers should implement creative approaches to promote independence in food purchasing and preparation for newly arrived refugees. Some suggestions, many of which are recommended by the Royal Perth Hospital (2003), include:
    - developing handouts with diet