

MALNUTRITION IN HIGHLY INSECURE AREAS: CHALLENGES IN THE RESPONSE AND THE COMMITMENT TO DECENTRALIZED MODELS OF CARE.

The cases of Baidoa (Somalia) and Zamfara (Nigeria)



PHOTO:
Abdulrahman, with the support of his mother, is being treated for malnutrition at the therapeutic feeding centre at Sokoto Hospital in Nigeria.

NIGERIA © EHAB ZAWATI

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The articles reflect the the authors' opinions and do not necessarily necessarily represent the MSF or IECAH point of view

1

INTRODUCTION

MSF is deeply concerned about the impact of the malnutrition, food insecurity and health crisis we have witnessed in 2022 and 2023 on the populations we serve. MSF programs cover a range of health interventions for vulnerable populations, especially in conflict and violent settings. This includes responses to the nutritional situation, and the scale of food security and malnutrition needs have necessitated a significant scale-up of our activities in the past several years.

Globally, the volume of MSF's malnutrition management activity increased by 50% between 2021 and 2022, with approximately 500,000 outpatient cases and 126,000 hospitalizations in 2022. This increased volume in MSF health response is, however, only indicative of much greater needs globally. In the contexts where MSF Spain operates, malnutrition, food security, and health services have been deeply impacted by climate, global economic shocks, reductions in humanitarian assistance, and the ongoing conflicts and displacement that characterize the areas in which we focus our interventions. A main driver of food insecurity is conflict, with 70% of persons who do not meet their daily nutritional needs living in areas impacted by conflict and violence.¹

Malnutrition and health responses have been particularly challenging in highly insecure contexts, such as Somalia, Nigeria, South Sudan, Sudan, and Yemen among others, where our teams face severe access issues impacting our ability to reach those in need. Despite the use of a variety of models of care adapted to the difficulties of responding in conflict settings, we still face major obstacles in ensuring the provision of medical care to prevent and treat malnutrition. Some of the most severe humanitarian crises remain neglected, do not receive adequate responses to malnutrition and food insecurity needs, or the linked multi-sectoral needs (e.g., health and water, and sanitation). These are challenges that apply for the entire humanitarian sector and speak to the need for further investment and evolution in the overall response to this growing crisis.

This article explains the challenges we face in responding to malnutrition in highly insecure areas by focusing on two specific operations, including Baidoa (Bay region, Somalia) and Zamfara state (Nigeria). When MSF commenced health programs in these areas, the interventions focused on responding to the multiple health consequences of violence. Since 2022, we have scaled up our malnutrition response, to address the scope and urgency of the crisis in these contexts, as an important part of the response to the multi-faceted complex emergencies in these settings. Some highly insecure contexts where MSF works have among the highest levels of need globally, yet the humanitarian and health sectors have not adequately adjusted their programming to overcome the access issues and other specific challenges of these settings to align to the scale of the need. Without significant shifts, in light of the current and foreseen funding cliff for malnutrition in the next years, the situation for

MSF malnutrition and health responses have been challenging in highly insecure contexts, where our teams face severe access issues impacting our ability to reach those in need

¹ World Food Programme, *A Global Food Crisis*, available at <https://www.wfp.org/global-hunger-crisis>.

populations in highly insecure contexts will likely only worsen.

1.1. The global situation of food insecurity and malnutrition

Global food insecurity increased sharply between 2019 and 2020, from 25% to 29.6% of the population, and has remained at a higher threshold in 2021 and 2022. In 2022, records show that 2.4 billion people were moderately or severely food insecure, 900 million (11.3 %) of whom were severely food insecure.² It is estimated that, in 2022 and 2023, 265.7 million people in 60 countries are facing acute food insecurity.³

Malnutrition is one of the greatest threats to public health, especially for children and vulnerable populations.⁴ Nearly half of all deaths among children under the age of five are linked to undernutrition.⁵ When children suffer from acute malnutrition, their immune systems become incredibly impaired, making them more vulnerable to other diseases. In 2022, of the global population of children under five years of age, approximately 22.3% (148.1 million) were stunted and 6.8% (45 million) were wasted.⁶

Especially linked to concerns of malnutrition is the increase of disease outbreaks and high morbidities. A combination of factors has significantly increased the risk of outbreak in many countries, including the disruption of vaccine programmes during the Covid-19 period, as well as conflict and insecurity coupled with population movements, inadequate health systems, and poor access to water and sanitation. These both increase the risks of malnutrition and create health complications for individuals who are malnourished, which health actors need to monitor and respond to in addition to malnutrition.

Nearly half of all deaths among children under the age of five are linked to undernutrition

² WFP et al., *The State of Food Security and Malnutrition in the World*, July 2023, available at <https://data.unicef.org/resources/sofi-2023/#:~:text=Nutritional%20Access%3A%20Approximately%202.4%20billion,malnutrition%20is%20still%20alarmingly%20high>.

³ Development Initiatives, *GHA Report 2023, Characteristics of crisis: Need and funding* (Chapter 2). Available at <https://devinit.org/resources/global-humanitarian-assistance-report-2023/characteristics-of-crisis-need-and-funding>.

⁴ Such as pregnant and lactating women and People Living with HIV.

⁵ World Health Organisation, *Malnutrition Fact Sheet*, June 2021, available at <https://www.who.int/news-room/fact-sheets/detail/malnutrition>.

⁶ Child wasting occurs when body weight is too low concerning height, specifically with weight for height <-2 standard deviation from the median of WHO Child Growth Standards.

2

CHALLENGES PROVIDING MALNUTRITION AND HEALTH SERVICES IN HIGHLY INSECURE CONTEXTS

To respond to growing levels of malnutrition in a population, detection through regular screening and provision of stable treatment are considered most effective. In highly insecure contexts, the ability to provide these key elements of the response is exactly what is under stress. The question of access is central; this includes ensuring detection and treatment activities are conducted sufficiently close to the populations affected by malnutrition and that the families requiring a malnutrition response can access services and follow up regularly. To make the detection and treatment for malnutrition accessible in highly insecure contexts, MSF prioritizes the decentralization of nutrition activities, taking them as close as possible to the affected communities. However, there are limits; examples from our responses to the malnutrition crises in Northwest Nigeria and Baidoa region of Somalia enable a deeper understanding of these overall challenges.

MSF prioritizes the decentralization of nutrition activities, taking them as close as possible to the affected communities

In 2022, through collaboration with the MoH and the implementation of community models, MSF treated 202,718 malnourished children under five in Northwest Nigeria.⁷ In some areas of Zamfara state (in Northwest Nigeria) in 2022, we also managed 4,955 measles cases and conducted a reactive vaccination campaign for 138,835 children under 5 years old. In Baidoa city and the surrounding area (Bay Region, Somalia), where we provide services to a catchment population of 1.2 million persons, we treated 24,000 patients in ambulatory care for malnutrition and during the first 3 months of 2023 we screened 65,000 children resulting in more than 9,000 new admissions for treatment of moderate and severe malnutrition. In 2022, we also managed 5,755 measles cases and supported mass vaccination campaigns for the population in Baidoa town, including 300,000 recently arrived displaced persons. However, in both these contexts despite our experience working in insecure contexts, we are currently only able to directly access relatively small areas which are comparatively more secure. We continually try to overcome these access challenges by adapting our operational models in terms of security management and service provision, knowing that the scale of the needs outside these areas are likely more severe⁸ and that it would lead to better health outcomes if we could access more areas.

⁷ This included 28,049 children hospitalized with medical complications admitted to ITFCs and 174,669 children received by ATFCs. ATFC admissions remained well above the 2021 levels in Zamfara.

⁸ In Somalia, 49% of the population (8.3 million people) were expected to face high levels of food insecurity between April and June 2023, with the Bay region being one of the worst affected. Approximately 1.8 million children under 5 years old are likely to face acute malnutrition. OCHA, *Humanitarian Needs Overview 2023*, July 2023; See also, *Somalia: Acute Food Insecurity Situation January - March 2023 and Projection for April - June 2023*, available at <https://www.ipcinfo.org/ipc-country-analysis/details-map/en/c/1156238/>.

2.1 Access Challenges for the Population and Humanitarian Organisations

Access to all humanitarian assistance is particularly challenging in contexts like the Bay Region of Somalia and Northwest Nigeria due to the conflict, especially in areas affected by extreme violence and with the presence of various armed groups. In Zamfara (Nigeria), movements outside of Zurmi and Shinkafi localities (where we support the main hospitals) is extremely restricted, thus we face barriers scaling up our response to the primary health care (PHC) facilities and to decentralized community-level activities. Similarly, in the Bay region of Somalia aid agencies do not take the risk to operate beyond a radius of 10 km from Baidoa town. We limit our movements to ensure the safety of our staff and partners, who face important risks, due to attacks on facilities and medical supply depots, as well as kidnappings, threats, and attacks that similarly affect the population. While we find our response constricted in such contexts, we know that the population of the region also have difficulty coming to the facilities. Insecurity is a major concern, which also has an impact by increasing travel costs and creating other barriers that are difficult to overcome.

The limited presence of other support actors significantly stretches MSF capacity to respond to the intersecting health crises facing the population

When the population undertakes lengthy journeys to access the appropriate services for malnutrition, we hear of individuals traveling on foot for more than twenty days. Patients reported that journeys were often made due to malnutrition or health issues of children, with some travelling traveling up to 150 km. Patients have also reported that during the journey to Baidoa, they have lost family members, due to lack of food and other assistance, highlighting the severe consequences of the access barriers.

Furthermore, while MSF is providing a response to malnutrition in these regions of high insecurity, typically our response depends on a network of nutrition and food security so to ensure referral systems, specialized facilities, and other services for an overall effective approach to addressing malnutrition. However, we are finding a very limited presence of the actors needed for this needed support, even in the more secure parts of the region. Currently, in Northwest Nigeria and Bay region (Somalia) many of these relevant actors are not sufficiently present and able to develop approaches accessible to the populations most in need. In November 2022 in Zamfara (Northwest Nigeria), in addition to the response we had established to Severe Acute Malnutrition (SAM) cases, MSF extended its services to also address cases of Moderate Acute Malnutrition (MAM) due to the absence of other nutrition actors. This situation significantly stretches MSF capacity and resources to respond to the intersecting health crises facing the population. In 2023, in Baidoa (Bay region, Somalia), MSF extended its current response to support the admissions for the most severe cases at the referral facility, as the previous health actor supporting the regional facility reduced its presence and others are not available to provide the necessary support.

In addition to the challenges limited access in highly insecure contexts imposes on a malnutrition response, it also makes detection of cases and surveillance in regions that may be facing a crisis a significant challenge. This is because it is very difficult to collect and make data and information available for the humanitarian community, and consequently, impedes an effective and adequate overall response; this can create a vicious cycle whereby humanitarian aid is not adequately provided to address

needs in areas that likely have the greatest needs.

2.2 The impact of conflict on the health system and availability of healthcare for malnutrition responses

In addition to the multiple access challenges (highlighted above), malnutrition in highly insecure contexts creates conditions where the overall health system is strained beyond its existing capacity. Where insecurity prevails, the situation is often coupled with a lack of effective investment leading to weak primary health care systems and poor service delivery. This leads to a higher prevalence of malnutrition cases needing to be treated in the hospitals and specialized facilities.

One devastating trend is that individuals facing malnutrition in highly insecure contexts often only manage to access health services when their situation (or that of a family member) has already deteriorated significantly and requires more complex responses⁹. MSF observes this cycle again and again leading to the secondary facilities becoming central and overloaded with cases that could have been addressed earlier. At Anka General Hospital (Zamfara state, Nigeria)¹⁰ mortality analysis showed that the patients arriving had a higher probability of dying during admission. An MSF analysis linked this high mortality risk to the lack of early identification and inpatient treatment at primary level given its limited availability.

Also, situations of population displacement to more secure towns lead to a higher population depending on the hospitals for services. In 2022, Baidoa Town's population is estimated to have doubled due to IDP influxes, reaching 1.2 million people. These individuals were fleeing drought, insecurity, and lack of access to basic services and assistance, and arrived already extremely depleted and vulnerable. At the time of this displacement, MSF project data highlighted a very high scale of MAM (30%) and SAM (9%).

While an ideal response to reduce the high prevalence of complex cases of malnutrition that need to be seen in hospital would be to support the primary facilities and ensure access to outpatient and community-based care in responding at earlier stages, this has been significantly limited option in Bay region (Somalia) and Zamfara state (Nigeria). Such situations put intense pressure on the existing facilities in the more secure areas and end up further disrupting weakened health systems.

⁹ The most severe malnutrition cases, including cases with complications, generally require multiple phases of malnutrition treatment and systematic medical screening and management for: measles and other EPI conditions and other comorbidities (e.g., vitamin A deficiency, HIV and TB), which may necessitate administration of antibiotics and vaccinations and initiation onto treatments. The supply of medical commodities and human resources needed for management of the most severe cases is thus quite burdensome logistically and financially even under normal circumstances; this is particularly complex to ensure in a timely and consistent manner where there is high insecurity, or where the security situation is volatile.

¹⁰ In Anka, MSF provides support for the most severe malnutrition cases, including hospitalisation.

Individuals facing malnutrition in highly insecure contexts often only manage to access health services when their situation has already deteriorated significantly

2.3. Supply chain disruptions

The supply chain for the provision of malnutrition services has its own set of challenges in highly insecure contexts, especially linked to the provision of large quantities of supplies (like Ready-to-Use Therapeutic Food -RUTF-) to areas that have poor access (as discussed above).

In Somalia and Nigeria, insecurity along routes disrupts logistics and transportation making it far more difficult and burdensome to ensure the delivery and provision of emergency nutrition supplies from the capital to the local level, where communities are most in need. Especially concerning is for MSF staff and partner Community Health Workers (CHWs) carrying medicines who become easy targets because medical supplies are considered valuable. This factor in itself, puts limits to the extent we can provide the needed community-based services for a more effective malnutrition response.

In Baidoa (Somalia), the insecurity also imposes exponential costs for the lifesaving interventions. To avoid notoriously dangerous routes, medical and nutrition supplies must be airlifted, significantly increasing the financial cost. For example, a 5-tonne-capacity aircraft costs approximately \$15,000 to charter, whereas a 20-tonne-capacity truck would cost roughly the same amount in more secure conditions. This not only impacts the cost of a specific intervention, but these challenges of high insecurity reduce the overall coverage of limited humanitarian funding and capacity across sectors (e.g., malnutrition, health, water and sanitation, protection). In an environment of reductions in available aid, such costs have far-reaching impact.

Restrictions on importation and other bureaucratic impediments can also have an important bearing on the supply chain, including where we are required to purchase malnutrition supplies locally, even when the demand is higher than the local market supply. Restrictions on the importation of vaccinations can also hinder the responses to outbreaks. MSF has faced situations where such supply chain impediments have led to shortages, even during severe crises.

The insecurity, the restrictions on importation, and other bureaucratic impediments can also have an important bearing on the supply chain

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APPROACHES ADOPTED TO OVERCOME CHALLENGES IN HIGH-INSECURITY CONTEXTS

For Zamfara state (Nigeria) and Bay Region (Somalia), MSF has sought to implement adapted operational approaches that allow for an effective and impartial provision of nutrition and other health services while managing the inherent security risks. These approaches, focused on implementing decentralized responses, have helped to increase the access of populations to the needed services but have limits in their success and dilemmas to contend with in such highly insecure contexts.

As a starting point, we can take note that the operational responses in the two countries have a different overall management set-up, whereby upon MSF resuming operations in

Somalia in 2017, it was decided to use a remote management system for the Baidoa project.¹¹ This is a rare set-up for MSF but was considered necessary due to the extreme access challenges linked to the high insecurity. Otherwise, MSF aims to ensure its staff are in close proximity to the populations affected by violence and present in the health facilities to ensure a maximum in quality and continuum of care.

MSF has implemented decentralized nutrition activities which have shown to improve access to care in highly insecure contexts. This includes support for community activities, such as training, support and incentives for Community Health Workers (CHWs), Community Mental Health Workers, and traditional birth attendants (TBAs) residing in hard-to-reach areas. Community health workers refer patients to either the community sites or the main hospital, depending on the care required. The CHWs have been crucial in screening and effectively detecting malnourished children, pregnant and breastfeeding women in their areas and within the PHCCs; the CHW activities have effectively expanded access to nutrition services in these complex areas. For example, a significant increase in ambulatory treatment admissions (78%) was observed in Zurmi (Nigeria) in July 2022, which is largely attributed to screening and referral activities of the CHWs.

Implementing decentralized responses at the community level has helped to increase the access of populations to the needed services

In addition to training and other support, MSF provides medical supplies and other commodities in pre-identified community sites to be used by CHWs and set up by the community leaders. For example, in 2021 we supported 32 community sites located in the IDP camps in and around Baidoa city (Bay region, Somalia) to facilitate the screening, monitoring, and identification of severe cases and make referrals to treatment in other primary and secondary health facilities; access to water, sanitation and hygiene were also integrated. Project data has shown that this approach has been significant in addressing mortality rates in the IDP camps.¹² We also used this model in Zumri and Shinkfi (Zamfara state, Nigeria), to better respond to increased malnutrition and health needs in some isolated areas.

An additional community approach utilized in difficult-to-reach areas is family MUAC, which provides training for family members or caregivers to perform screening to detect malnutrition in children (MUAC screening), who can then measure childhood thinness on a more regular basis, enabling earlier detection and treatment before malnutrition occurs. This approach can be empowering for families and has been shown to vastly expand screening and coverage as a complement to CHW detection activities.

While the provision of services at the community level has made curative and preventive medical care more accessible in highly insecure contexts, community-based models also impose challenges, due to the risks of violent attacks and kidnapping. Our staff and CHWs are subject to the same risks as the rest of

¹¹ Critical decision making, related to security and resources - the main sources of risk in Somalia-are made by the coordination team in Nairobi to reduce exposure of the locally hired staff whereas day-to-day management and decision making is done in Baidoa.

¹² An analysis of our project data from 2019-2020 found that there were five times greater mortality in the IDP camps as compared to the host community. However, after we started the decentralised model of care in 2021, our data showed a closing of the gap in mortality between the two groups. This is associated mainly to the decentralised program.

the population and thus we must assess if we can sufficiently mitigate these to support the sites adequately and develop specific management frames to properly support the CHWs who often live in the communities.

MSF runs mobile clinics to provide decentralized support services and move to different locations, to support populations that cannot access health facilities. In Nigeria and Somalia, the mobile clinics respond to emergencies and provide services in sites where there are new arrivals to provide consultations on prevalent diseases, perform MUAC screening, and referrals to community sites, feeding centers or hospitals, as appropriate. In Baidoa, about 900 children are seen by our outreach programmes on a weekly basis, highlighting the impact of the community activities on an effective malnutrition response in this setting.

However, mobile clinics also impose risks to volunteers and staff as they may be targeted if seen to have resources. Maintaining sufficient engagement and ensuring a person and community-centred approach may also be a challenge depending on movement restrictions.

Community-based models also impose challenges, due to the risks of violent attacks and kidnapping. Our staff is subject to the same risks as the rest of the population

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FUNDING AND CAPACITY FOR NUTRITION AND HEALTH PROGRAMS

Globally, although the total international humanitarian aid increased by 27% in 2022 to \$46.9 billion, the scale of the needs meant that the overall funding gap to meet them was the largest on record at \$22.1 billion. Decreased funding availability for emergency contexts is linked to the contraction of economies and shifts in the priorities of donor countries. This has a severe impact on the food security sector, which was the most expensive by far even before the current crisis. Global inflation has also significantly impacted programmatic coverage. For example, WFP's monthly operating costs have increased by 44% since 2019,¹³ greatly reducing coverage capacity.

Throughout 2022 and 2023 the time-bound emergency funding from the international community allocated to address the global food insecurity and malnutrition crisis has been a lifeline to support programming, especially the No Time to Waste programme and the one-time injection from the US Congress of \$4.348 billion (Ukraine Supplemental Funding).¹⁴ However, the scale of malnutrition needs has continued to surpass funding and pushes the limits of the response capacity of the humanitarian sector. In 2023, MSF

¹³ World Food Programme, *A Global Food Crisis*, available at <https://www.wfp.org/global-hunger-crisis>.

¹⁴ Congress. *Ukraine Supplemental Appropriations Act, 2022*. <https://www.congress.gov/bill/117th-congress/house-bill/7691/textProvided>. May 2022 to respond to the effects of the war in Ukraine on food systems. Much of this funding has been allocated to WFP and UNICEF for food assistance and nutritional funding.

has further stretched its operational capacity for malnutrition responses and will likely have for MSF Spain an additional 10% of overall malnutrition admissions in our project areas compared to 2022.

In 2023 and 2024, amidst the increasing needs that are foreseen to be extreme, the decreases in available nutrition funding are very worrying. In addition to the non-renewal of the aforementioned streams, there are significant institutional funding cuts. For example, 30% of institutional cuts are foreseen for USAID, the largest donor for these sectors. Overall, a funding cliff for nutrition is foreseen in 2024, when there is a need to have more actors present and implement approaches to allow for responses in insecure areas. Further, there is more investment needed to develop preventive responses to this ever-growing crisis.

Considering the foreseen malnutrition and health needs in 2024-2025 and the dwindling availability of global resources, MSF is concerned about the impact on the most vulnerable populations we serve, particularly in highly insecure contexts where very few actors are likely and able to respond. The limitations of available sector capacity and funding to support adequate responses in highly insecure contexts thus remains unresolved, which continues to severely impact these populations.

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5

CONCLUSIONS/ RECOMMENDATIONS FOR THE INTERNATIONAL COMMUNITY AND DONORS

As highlighted above, the challenges in highly insecure contexts are complex. These are challenges also experienced by MSF, who has implemented some—albeit imperfect—approaches to increase programmatic coverage and access to health services in such contexts. Concerted sector-wide efforts and strategies are required to improve service delivery for malnutrition and health in highly insecure settings. MSF urges the international (humanitarian and health) community to:

- Ensure the availability of adequately resourced responses to address the extremely vulnerable populations living in highly insecure contexts, impacted by conflict/violence, and put in place adapted approaches to reach them in line with ensuring SPHERE¹⁵ standards, and essential malnutrition and health services are available, at minimum.
 - Ensure adequate food security responses, at minimum ensuring adequate general food distribution in response to wide-scale crises to prevent and mitigate malnutrition crises
 - Implement approaches that adequately respond to the full range of nutrition needs, including the most severe cases, management of moderate cases, and ensuring protocols are

¹⁵ Sphere Project. *Humanitarian Standards*. Available at <https://spherestandards.org/humanitarian-standards>

Concerted sector-wide efforts and strategies are required to improve service delivery for malnutrition and health in highly insecure settings.

meeting the needs of highly insecure contexts.

- Increase support to strengthen health systems in such contexts, including primary health care and surveillance, and strengthen emergency preparedness and response (including outbreaks).
 - Consider the inclusion of adults in malnutrition surveillance for crisis events, particularly pregnant and lactating women, as well as other vulnerable groups.
- Increase allocation and programming to support preventive measures, to avert malnutrition crisis and mortality in fragile contexts, including ensuring routine vaccination provision and facilitating catch-up to address coverage gaps in highly insecure areas.

PHOTO:

Pascaline is three years old and has been a patient of malaria and malnutrition. In the picture she is having her last nutritional consultation.

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