

**Refugee Nutrition Information System (RNIS), No. 15 – Report on the
Nutrition Situation of Refugee and Displaced Populations**

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ACC/SCN, Geneva, 12 April 1996 – No. 15

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This report was compiled by the ACC/SCN Secretariat, with the help of Jeremy Shoham, London School of Hygiene and Tropical Medicine.

Funding support is gratefully acknowledged from CIDA, NORAD, UNHCR, and WFP, as are inputs in kind from UNICEF and Save the Children Fund, UK. UNHCR kindly provided many of the maps used.

We would like to thank all those agencies who contributed information to this report, particularly ACF, CONCERN, UN/DHA, FAO, ICRC, IFRC, MSF-Belgium, MSF-CIS, MSF-France, MSF-Holland, MSF-Switzerland, SCF-UK, UNHCR, UNICEF, USAID, WFP, WHO, and WV.

HIGHLIGHTS

There has been a decrease in the total number of refugees and displaced people in Sub-Saharan Africa over the last two months. This is largely due to the attainment of self-sufficiency of many in Angola with the recent harvest. However, the total number of those at high nutritional risk has increased, especially in the Liberia/Sierra Leone region and Zaire. In Mozambique micronutrient deficiencies persist.

Angola *The continued peace is allowing increasing access to formerly inaccessible populations. The resulting improved deliveries of humanitarian assistance in conjunction with the recent harvest appears to be leading to a pronounced improvement in the nutritional situation of most of the population.*

Burundi/Rwanda (Great Lakes) Region *There has been an escalation of pressure from both the Zairian and Tanzanian governments for full-scale repatriation of Rwandan refugees. The government in Zaire has taken some action to bring this about by restricting refugee economic activities. However, in recent weeks only limited numbers of refugees have returned to Rwanda with the majority being from Burundi where insecurity has been the main driving force. There is concern over both the level of insecurity in Burundi and its impact on certain population groups. The nutritional condition of Rwandan refugees in Zaire and Tanzania which appeared to be adequate in November 1995 has not been reported to have worsened.*

Liberia/Sierra Leone Region *Factional fighting in Monrovia has displaced tens of thousands of people and led to the evacuation of agency personnel. It is too early to assess the impact of this most recent fighting. Elsewhere in Liberia, sporadic insecurity is still rendering some populations inaccessible to humanitarian assistance and preventing the establishment of a clear time-frame for the planned repatriation programme. Pockets of malnutrition probably exist amongst those populations who remain cut-off from assistance. Mortality rates reported from some of these areas are up to ten times the normal rate. The recent election of a new president in Sierra Leone may lead to improvement. Yet the scale of devastation and displacement from the civil war means that enormous resources and humanitarian support will be needed for many months to restore basic needs provision. Recent nutritional surveys continue to demonstrate very high levels of*

wasting(23%) in some locations – particularly amongst urban population which host large numbers of war displaced people.

Mozambique The combined effect of the recent harvest and widespread targeting of food aid is contributing to a generally adequate nutritional situation for most of the population. However, pellagra in Mutarara district is still occurring as attempts to provide groundnuts in the general ration continue to experience administrative difficulties.

Sudan The poor 1995 harvest and continuing government restrictions on Operation Lifeline Sudan flight clearances will almost certainly be adversely affecting the nutritional status of displaced and other conflict affected populations in southern Sudan. There is also concern over the nutritional well-being of the displaced populations residing in camps around Khartoum where high levels of wasting and vitamin A deficiency have recently been reported.

Uganda Recent rebel activity in northern Uganda has led to some disruptions in the food supply to camps and settlements for Sudanese refugees. Levels of wasting were already quite high (16%) and increasing, particularly in the settlements, before these disruptions occurred. The situation could become critical in coming months.

Zaire Prevalences of wasting for those in Mwene Ditu displaced from **Shaba** remain very high at about 30%. A lack of funds could cause the feeding centres to close. Survey data from the **Masisi** region of Zaire, where recent ethnic violence has led to the internal displacement of up to 250,000 people, show a very high prevalence of wasting of over 30%. Humanitarian agencies presently only have limited access to this population. It is likely that emergency intervention is needed for several hundred thousand people.

Afghanistan Although fighting is continuing around Kabul resulting in civilian casualties and displacement to Jalalabad and other areas, the nutritional situation of those in the capital appears adequate. This is partly due to the largely completed winter airlift of relief items to targeted vulnerable groups and the opening up of some access routes in and out of the city. However, the remaining restrictions on transport and resulting food price inflation will be causing some hardship so that the nutritional situation must be closely monitored.

Nepal The provision of a full general ration including fortified blended foods, fresh vegetables and parboiled rice has been having a marked effect in reducing the incidence of micronutrient deficiency disease (particularly angular stomatitis) amongst the Bhutanese refugee population. Nevertheless, the low residual incidence of scurvy, beri-beri and other signs of B vitamin deficiency warrant further investigation and remains a cause of concern.

ADEQUACY OF FACTORS AFFECTING NUTRITION

Factor	Angola	Burundi	Rwanda	Tanzania	Zaire	Liberia	Mozambique	Sierra Leone	Somalia	S
1. Degree of accessibility to large population groups due to conflict	✓	0	✓	✓	✓	0	✓	X	✓	
2. General resources										
– food (gen. stocks)	✓	X	✓	✓	✓	✓	✓	✓	✓	
– non-food	X	?	✓	✓	X	✓	✓	✓	✓	
3. Food pipeline	✓	?✓	X	X	X	✓	✓	✓	✓	
4. Non-food pipeline	X	?✓	✓	✓	✓	✓	✓	✓	✓	
5. Logistics	0	0	✓	✓	✓	0	0	X	0	
6. Personnel*	✓	X	✓	✓	X	✓	✓	✓	0	
7. Camp factors**	✓	0	na	✓	✓	✓	na	? X	0	
8. Rations										

– kcals	✓	X	✓	✓	X	✓	✓	X	✓
– variety/micronutrients***	✓	? X	✓	✓	X	✓	X	X	✓
9. Immunization	X	?	✓	✓	✓	X	X	X	✓
10. Information	✓	0	✓	✓	✓	0	✓	X	✓

- ✓ Adequate
- 0 Problem in some areas
- X Problem
- ? Don't know
- ?✓ Don't know, but probably adequate
- ?X Don't know, but probably inadequate **na** not applicable

* This refers to both adequate presence and training of NGOs and local staff where security allows.

** This refers to problems in camps such as registration, water/sanitation, crowding, etc.

*** Rations may be inadequate due to inaccessibility.

Note: Situations for which detailed information is available are included in this table. Other potentially critical situations (e.g. Ethiopia or Shaba, Zaire) are not currently included due to a lack of detailed information. They will be included as more information becomes available.

INTRODUCTION

The UN ACC/SCN¹ (Sub-Committee on Nutrition), which is the focal point for harmonizing policies in nutrition in the UN system, issues these reports on the nutrition of refugees and displaced people normally every two months. Distributing this information is intended to raise awareness and facilitate action to improve the situation. This system was started on the recommendation of the SCN's working group on Nutrition of Refugees and Displaced People, by the SCN in February 1993. This is the fifteenth of a regular series of reports.

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Information is obtained from a wide range of collaborating agencies, both UN and NGO (see list of sources at end of report). The overall picture gives context and information which separate reports cannot provide by themselves. The information available is mainly about nutrition, health, and survival in refugee and displaced populations. It is organized by "situation" because problems often cross national boundaries. We aim to cover internally displaced populations as well as refugees. Partly this is because the system is aimed at the most nutritionally vulnerable people in the world – those forced to migrate – and the problems of those displaced may be similar whether or not they cross national boundaries. Definitions used are given in the box on the next page.

At the end of most of the situation descriptions, there is a section entitled "**How could external agencies help?**". This is included when there is enough information on current needs and opportunities, and when there is a substantial risk to nutrition.

The tables, figures and maps at the end of the report can provide a quick overview. Map A shows the location of the situations described and the shaded areas are those in a critical situation. Table 1 gives an estimate of the probable total refugee/displaced/returnee population, broken down by numbers at risk. Populations in category I in Table 1 are currently in a *critical situation*, based on nutritional survey data. These populations have one or more indicators showing a serious problem. Populations *at high risk* (category IIa in Table 1) of experiencing nutritional health crises are generally identified either on the basis of indicators where these are approaching crisis levels and/or also on more subjective or anecdotal information often where security and

logistical circumstances prevent rigorous data collection. Populations *at moderate risk* (category IIb in Table 1) are potentially vulnerable, for example based on security and logistical circumstances, total dependency on food aid, etc. Populations in category IIc are not known to be at particular risk. No information is currently available on populations in category III.

In Table 2, refugee and displaced populations are classified by country of origin and country of asylum. Major population groups in Africa (i.e. over 100,000 people affected from the country of origin) are included. Internally displaced populations are identified along the diagonal line.

Figures 1–3 display some of the data graphically. Figure 1 shows the data in Table 1 as a current snapshot of population numbers and estimated risk. Figure 2 shows trends over time in total numbers and risk categories for Africa. Figure 3 shows the same data for specific situations. Annex I summarizes the survey results used in the report.

INDICATORS

Wasting is defined as less than $-2SDs$, or sometimes 80%, wt/ht by NCHS standards, usually in children of 6–59 months. For guidance in interpretation, prevalences of around 5–10% are usual in African populations in non-drought periods. We have taken more than 20% prevalence of wasting as undoubtedly high and indicating a serious situation; more than 40% is a severe crisis. **Severe** wasting can be defined as below $-3SDs$ (or about 70%). Any significant prevalence of severe wasting is unusual and indicates heightened risk. (When “wasting” and “severe wasting” are reported in the text, wasting includes severe — e.g. total percent less than $-2SDs$, *not* percent between $-2SDs$ and $-3SDs$.) Data from 1993/4 shows that the most efficient predictor of elevated mortality is a cut off of 15% wasting (ACC/SCN, 1994, p81). Equivalent cut-offs to $-2SDs$ and $-3SDs$ of wt/ht for arm circumference are about 12.0 to 12.5 cms, and 11.0 to 11.5 cms, depending on age.

Oedema is the key clinical sign of kwashiorkor, a severe form of protein–energy malnutrition, carrying a very high mortality risk in young children. It should be diagnosed as *pitting* oedema, usually on the upper surface of the foot. Where oedema is noted in the text, it means kwashiorkor. Any prevalence detected is cause for concern.

A crude mortality rate in a normal population in a developed or developing country is around 10/1,000/year which is equivalent to 0.27/10,000/day (or 8/10,000/month). Mortality rates are given here as “times normal”, i.e. as multiple of 0.27/10,000/day. [CDC has proposed that above 1/10,000/day is a very serious situation and above 2/10,000/day is an emergency out of control.] Under-five mortality rates (U5MR) are increasingly reported. The average U5MR for Sub-Saharan Africa is 181/1,000 live births, equivalent to 1.2/10,000 children/day and for South Asia the U5MR is 0.8/10,000/day (in 1992, see UNICEF, 1994, p.84).

Food distributed is usually estimated as dietary energy made available, as an average figure in kcals/person/day. This divides the total food energy distributed by population irrespective of age/gender (kcals being derived from known composition of foods); note that this population estimate is often very uncertain. The adequacy of this average figure can be roughly assessed by comparison with the calculated average requirement for the population (although this ignores maldistribution), itself determined by four parameters: demographic composition, activity level to be supported, body weights of the population, and environmental temperature; an allowance for regaining body weight lost by prior malnutrition is sometimes included. Formulae and software given by James and Schofield (1990) allow calculation by these parameters, and results (Schofield and Mason, 1994) provide some guidance for interpreting adequacy of rations reported here. For a healthy population with a demographic composition typical of Africa, under normal nutritional conditions, and environmental temperature of 20 °C, the average requirement is estimated as 1,950–2,210 kcals/person/day for light activity (1.55 BMR). Raised mortality is observed to be associated with kcal availability of less than 1500 kcals/person/day (ACC/SCN, 1994, p81).

Indicators and cut-offs indicating serious problems are levels of wasting above 20%, crude mortality rates in excess of 1/10,000/day (about four times normal — especially if still rising), and/or significant levels of micronutrient deficiency disease. Food rations significantly less than the average requirements as described above for a population wholly dependent on food aid would also indicate an emergency.

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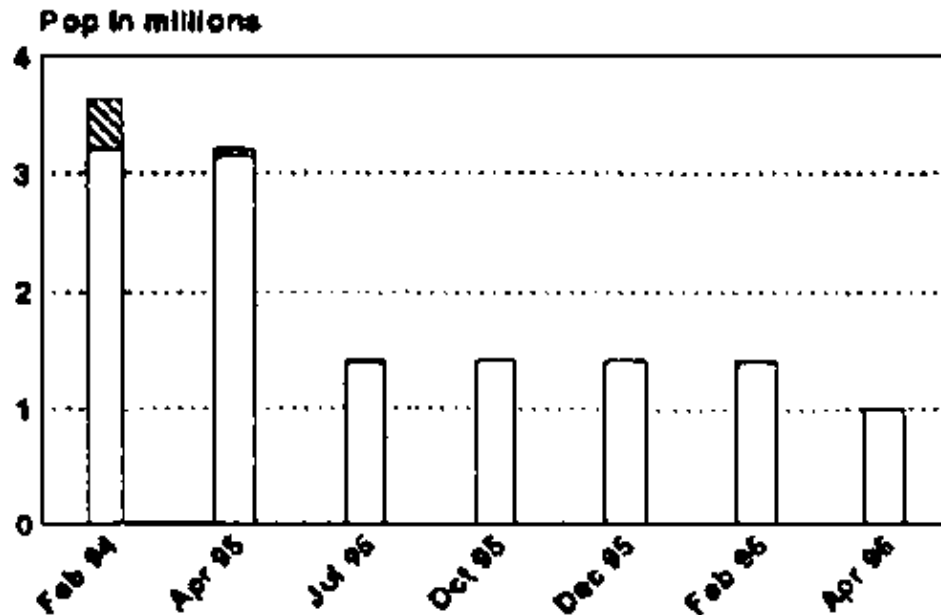
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SUB-SAHARAN AFRICA

1. Angola (see Map 1 and Figure 3)

Angola



Trend in numbers of displaced/war affected. Shaded areas indicate those at heightened nutritional risk.

Apart from a few minor incidents, the security situation throughout Angola has remained calm in recent weeks. Food availability in many areas is gradually improving as a result of the recent good harvest and increased access, particularly by overland transport, to populations requiring food aid. On average over 60% of relief item transport is now by road. However, political constraints have delayed the de-mining process in certain areas, thereby preventing the use of some key transport routes.

Reasonable harvests have led to the cessation of food assistance in areas such as Kwanza Norte and Gonguembo. The phasing out of general rations is also planned in numerous other areas where the nutritional situation appears to have improved. Programmes to re-integrate formerly displaced populations, involving support for agricultural rehabilitation activities, have been continuing successfully in many locations. Emergency assistance is now being provided to approximately 1 million internally displaced or war affected people and demobilised soldiers and their families [UNHCR 1995–7, WFP 17/11/96, 22/03/96].

It appears that levels of wasting decline rapidly in those areas where humanitarian agencies now have improved access. For example, overland humanitarian relief deliveries to *Moxico Province* began in mid-November 1995 at a time when prevalence of wasting was very high. Now, the most recent survey indicates a 6% prevalence of wasting and/or oedema with 1.4% severe wasting and/or oedema (see Annex I

(1a)) [UNHAA–a 04/03/96, USAID 01/03/96].

In *Kwanza None Province*, where many relief agencies have recently been working, a nutritional survey in Gonguembo showed 7% wasting and/or oedema with 1% severe wasting and/or oedema (see Annex I (1b)). Another survey in N'Dalatando showed 5% wasting and/or oedema with 2.2% severe wasting and/or oedema (see Annex I (1c)). [UNHAA 04/03/96, WFP 08/03/96]. In contrast to these encouraging results, a recent survey in Lucala, Kwanza Norte province revealed 17.1% wasting with 6.1% severe wasting (see Annex I (1d)). The survey team recommended an urgent intervention in health and nutrition amongst the population [UNHAA–a 25/03/96].

A survey in Calandula, *Malange Province*, showed 9% wasting and/or oedema with 3.1% severe wasting and/or oedema (see Annex I (1e)). This elevated level of wasting is attributed to a combination of health problems, poor dietary practices, and poor food security due to theft of the current harvest [UNHAA–a 04/03/96, WFP 08/03/96].

In Menongue, *Kuando Kubango Province*, a recent survey showed 9.3% wasting and/or oedema with 3.1% severe wasting and/or oedema (see Annex I (1f)). In light of these somewhat elevated levels of wasting, it was recommended to continue food aid distribution, along with seeds and tools [UNHAA–a 25/03/96].

A recurrent problem identified by agencies working in Angola is that vaccination coverage and health service provision is poor. For example, shortage of drugs for the treatment of trypanosomiasis is threatening the continuation of all programme to combat the disease which is particularly prevalent in the north of Angola while a recent UNICEF mission in Kwanza Sul indicated a severe lack of drugs in the province [UNHAA–a 11/03/96].

Overall, the affected population in Angola appears to be more food secure as a result of the recent harvest and levels of wasting declining in many accessible areas (category IIc in Table 1). It is likely, however, that some pockets of malnutrition exist in areas which are not yet accessible to outside assistance.

How could external agencies help? Now that the country is moving from an emergency phase to a more protracted rehabilitation phase, humanitarian agencies are involved in a variety of sectors and may need support for numerous activities. An imminent consolidated appeal to be issued by UN/DHA in April will specify which activities need resourcing. Priorities may include:

- continuing the restoration of health services to deal with major health problems i.e. malaria, diarrhoea, ARI, trypanosomiasis;
- targeted feeding programmes;
- mass immunisation campaigns, mainly for measles.

More specific needs include:

- drugs for the treatment of trypanosomiasis, which is prevalent in northern Angola;
- drugs to treat common illnesses in Kwanza Sul;
- improved delivery of health services in Calandula, Malange Province where high morbidity levels are thought to be contributing to elevated levels of wasting.

The long term need for immunisation programmes and improved health care delivery are now beginning to be addressed in Angola (see RNIS #14). The food pipeline for edible vegetable oil has been ensured (see RNIS #13).

2. Benin/Ghana/Togo Region

There are approximately 111,000 refugees in the Benin/Ghana/Togo region, the majority of whom are Togolese. They fled Togo in January 1993 but as the political conflict which gave rise to the exodus has largely been resolved, spontaneous repatriation has been occurring for some time. Plans for an organised repatriation are currently being prepared with funding being sought for different programme elements. It is now hoped that the majority of the refugees in the region will be repatriated by the end of 1996.

Benin There remain approximately 20,000 Togolese refugees in Benin. A few individuals are spontaneously repatriating, and a more comprehensive repatriation programme will begin once funding is secured. It is expected that the repatriation process will continue throughout 1996. Provision of food aid is planned until the end of the year. There is no reported change to the adequate nutritional status of these refugees [UNHCR 27/03/96].

Ghana Approximately 71,000 Togolese refugees remain in Ghana. There are 9,000 refugees who have already expressed their desire to return to Togo and who are expected to repatriate soon. Food aid provision is scheduled to continue until June 1996, when it is estimated that almost all the refugees will have repatriated. There is no reported change in the adequate nutritional status of this population [UNHCR 27/03/96].

The 14,000 Liberian refugees in Ghana have not yet begun to repatriate due to continued insecurity in Liberia. However, repatriation plans have been established for this population (see section #9 for further details). There are no reports of change to the adequate nutritional status of this refugee population.

Togo There are approximately 6,000 refugees from Ghana in Togo. There are no reports of any change to their adequate nutritional status.

Overall, the approximately 111,000 refugees in the region are not currently considered to be at heightened nutritional risk (category IIc in Table 1).

3. Burkina Faso and Mauritania – Malian Refugees (see Map 3)

There are approximately 60,000 assisted Malian refugees in Burkina Faso and Mauritania. This decrease in the total refugee population is due to repatriation.

Burkina Faso Some spontaneous repatriation is taking place among the Malian refugees in Burkina Faso and it is currently estimated that there are 27,000 refugees remaining. There is no reported change to the adequate nutritional status of this population [UNHCR 12/02/96].

Mauritania There remain approximately 33,000 Malian refugees in two camps in Mauritania. The decrease in number from the last RNIS report is due to a combination of spontaneous and organised repatriation [UNHCR 13/01/96, 27/03/96].

A recent survey conducted in the two camps between February and March 1996 showed an unstable nutritional situation. Wasting was measured at 14.6% and severe wasting was 1.4%. Oedema was measured separately at 1.6% (see Annex I (3a)). These results show no statistical difference to those obtained during the previous survey in May 1995. The crude mortality rate was 0.93/10,000/day (3 × normal) and the under-five mortality rate was 2.3/10,000/day (2 × normal). It is, however, possible that these rates are an under-estimate due to the observed reluctance to disclose information on mortality amongst this population. The most common cause of death was diarrhoea [MSF-F/MDM 12/03/96].

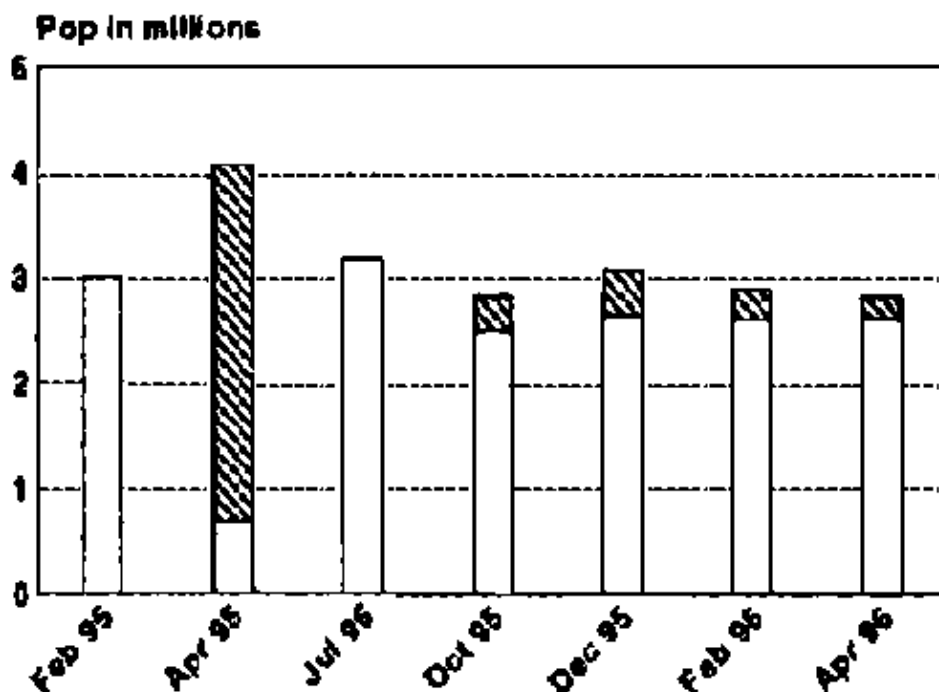
These nutritional problems are felt to be largely attributable to two main causes. First, the ration had been irregular and lacking in some commodities, such as pulses. More recently, however, food distributions were at 1950 kcals/person/day. Furthermore, many families with livestock which provided both milk and meat have returned to Mali, leaving remaining refugees largely without these food sources. Secondly, high levels of diarrhoea are probably also having an impact on wasting levels. Only a small percentage of families had access to parcels of land for crop production [MSF-F 04/04/96].

Overall, the refugees in Burkina Faso are not currently considered to be at heightened nutritional risk (category IIc in Table 1). In the two camps for Malian refugees in Mauritania high levels of wasting continue to be reported. These refugees can therefore be considered to be at high nutritional risk with elevated levels of wasting (category I in Table 1).

How can external agencies help? Continued high levels of wasting need to be investigated with a view to identifying and rectifying primary causes. In order to begin addressing the problem, the regular provision of a full general ration needs to be ensured and an assessment made of whether coverage of selective feeding programmes are adequate. Furthermore, the causes of high levels of diarrhoea should be ascertained, and appropriate action taken in the water and sanitation sectors.

4. Burundi/Rwanda Situation (See Map 4 and Figure 3)

Burundi/Rwanda Region



Trend in numbers of refugees/displaced and proportion severely malnourished or at high nutritional risk (shaded area).

The focus of discussions at a recently held summit meeting between the presidents of Rwanda, Burundi, Tanzania, Uganda and Zaire was on encouraging the repatriation of two million Rwandan and Burundi refugees, and to bring to a halt the emerging crisis in Burundi [WFP 22/03/96]. Fighting is continuing in parts of Burundi and placing those populations in insecure areas at nutritional risk. The government strategy of surrounding refugee camps in Goma and Bukavu with a view to restricting refugee activity and encouraging repatriation is continuing. However, in comparison to the overall number of refugees, there has been relatively little repatriation in recent weeks.

Current estimates of affected populations by country of present residence are given in the box below:

	Feb 95	Apr 95	Jul 95	Oct 95	Dec 95	Feb 96	Apr 96
Burundi	740,000	492,500	515,000	315,000	504,000	275,400	290,000
Rwanda	335,000	1,750,000	800,000	725,000	800,000	737,000	737,000
Tanzania	630,000	686,000	644,000	629,000	621,000	653,000	624,000
Zaire	1,290,000	1,130,900	1,202,200	1,158,000	1,146,000	1,211,000	1,166,000
Uganda	5,000	5,000	6,700	6,400	6,400	6,800	6,900
TOTAL	3,000,000	4,064,400	3,167,900	2,831,400	3,077,400	2,883,200	2,823,900

Burundi While the security situation in many areas of the country has reportedly been calm in recent weeks, fighting and other violent incidents have taken place in the provinces of Muramvya, Gitega, Kayanza, Karuzi and Buriri. Most recent reports indicate an overall decline in security with the southern most provinces worst affected [DHA 20/3/96]. The insecurity has led to further displacements of varying duration which make it difficult to determine with any degree of accuracy the total number of internally displaced within Burundi. Best estimates are that there may be 200,000 internally displaced people at any given time. Government and

humanitarian agency policy is to provide food aid on an ad hoc basis to newly displaced populations following an initial assessment [DHA—a 08/03/96, USAID 12/03/96, WFP 01/03/96, 22/03/96].

Security problems have also reportedly impacted refugees and internally displaced in recent weeks. For example, tensions between the refugees and militia have been reported in Rukuramigabo refugee camp following the announcement that the camp was to be closed in two weeks. With the exception of sporadic shootings in the surrounding hills, the capital has remained calm with banditry being the main security risk factor. There have also been reports of militia attacks on IDP camps in Bubanza province [DHA 13/03/96, WFP 22/03/96].

Repatriation of Rwandan refugees is continuing and it is currently estimated that there are just over 90,000 refugees remaining in the northern part of the country. The rations currently distributed to this refugee population provide 1,950 kcals/person/day. The most recent nutritional data available on this population comes from a survey in November 1995 in Rukuramigabo camp in Kirundo which showed levels of wasting and/or oedema at 1.7% and severe wasting and/or oedema at 0.2% (see Annex I (4a)) [UNHCR 1/03/96]. There have been recent reports of increases in the numbers of children attending selective feeding programmes in Magara and Rukuramigabo camps and that many of the new admissions have exhibited signs of kwashiorkor [UNHCR 07/03/96].

Nutritional survey data for internally displaced and resident populations in areas of insecurity indicate a more worrying situation. The last RNIS report noted levels of wasting in four camps for internally displaced people ranging from 15–18.2%. A more recent survey in Ngozi province (population 510,000) in December 1995 found 9.3% wasting with 1.2% severe wasting amongst a sample of resident and displaced households; oedema was measured at 1.8% (see Annex I (4b)). These elevated levels of wasting may partially be explained by the timing of the surveys which was in the “hungry season” just prior to harvest. However, limited access to food due to the effect of insecurity on agricultural activity has undoubtedly played a significant role. The survey also determined that coverage of selective feeding programmes in the province is very low (less than 2% of malnourished children were enrolled at feeding centres). Furthermore, default rates at the feeding centres were very high. This was mainly thought to reflect the financial difficulty imposed by participating in these programmes and difficulties of regular attendance due to insecurity [ACF Dec 95].

Since this survey, some roads in the province have been washed away by rains leading to a reduction in amounts of food delivered. Furthermore, the ration was recently reduced to 1,600 kcals/capita/day due to lack of stocks [UNHCR 06/03/96, WFP 16/03/96]. It is therefore likely that the nutritional condition of this population has continued to decline.

Rwanda The pace of repatriation of refugees sped up slightly during February, with a reported 23,000 refugees returning from neighbouring countries. The majority of returnees came from Burundi and Zaire [UN 15/03/96, WFP 08/03/96]. However, during the first half of March less than 3,000 refugees returned with most returnees coming from Zaire [WFP 28/03/96]. Refugees from the Masisi area of Zaire, where ethnic conflict has recently intensified, are continuing to arrive.

The security situation in most of the country is reported as calm with the exception of the western border areas with Zaire where regular incursions and security incidents, such as a recent attack on an NGO vehicle in Cyangugu province, take place. The UN peacekeeping force (UNAMIL) will reportedly not have its mandate renewed and troops will be withdrawn by April 19. Trials of those with suspected involvement in the genocide will also begin at this time. A small political office representing the UN will remain open in Kigali [DHA 08/03/96, IRIN 22/03/96, WFP 01/03/96, 12/04/96].

It is expected that food aid will be needed for approximately 737,000 vulnerable people, including displaced and returnee populations, in the first half of 1996. It is anticipated that the food supply situation will remain tight in parts of the prefectures of Kibungo, Gikongoro, and Butare and in areas of Cyangugu, Kibuye and Gitarama. Elsewhere in the country, although the harvests have been satisfactory and markets are well supplied, the low purchasing power in the post-war economy still results in inadequate food access for large sections of the population. During February WFP distributed food to approximately 296,000 persons in all prefectures of Rwanda. The largest share of food was distributed through food for work and income-generating activities. Some 45,900 people believed to be vulnerable to food shortages were provided with general food rations through targeted assistance and seed protection programmes. [FAO 28/12/95, FAO Jan/Feb 96, UN 15/03/96]. The health sector is reportedly recovering with most of Rwanda's 250 health centres and 36 hospitals now operating. Morbidity and malnutrition rates among children are now believed to be lower than pre-war rates [USAID 18/03/96]. Although there are no new nutritional survey data, the recent harvest and relatively unimpeded food aid programme suggests that the nutritional status of the majority of

people is likely to be satisfactory. However, it should be noted that short-falls of oil and sugar for food aid programmes are expected in April [WFP 08/03/96].

Goma, Zaire It is currently estimated that there are 695,000–714,000 Rwandan refugees in the Goma camps. At the end of February, the government of Zaire reaffirmed its position that it would continue to restrict economic activities of refugees and that all NGOs were to begin phasing down their programmes. The Zairian military had surrounded certain camps in Goma and Bukavu with a view to enforcing these restrictions and encouraging repatriation, and agencies working in the camps have been instructed to gradually replace Rwandan staff with Zairians. There is now anecdotal information that the military blockade of camps has eased [UNHCR–a 22/03/96, WFP 16/02/96, 08/03/96, 15/03/96, 12/04/96].

NGOs have also been informed of the closure of all selective feeding programmes for malnourished children in every camp except Kibumba, as a result of budgetary constraints. However, with the exception of Kibumba, where according to a survey in November 1995, levels of wasting and/or oedema are highest at 8.3%, the low levels of wasting are felt to warrant the closure of these programmes. Nutritional surveys are planned for May 1996 in order to verify that the closure of the centres has not had an adverse impact upon refugees [UNHCR 28/02/96, UNHCR–a 22/03/96, WFP 16/02/96, 08/03/96, 15/03/96].

As the refugee community fear and anticipate a general pulling out of relief agencies, the level of thefts and security incidents is reportedly increasing. Supplies of firewood have been severely reduced, in part due to the escalating conflict in the Masisi region of Zaire which has until now been a major source of wood. This has forced many refugees to illegally enter nearby nature preserves, in search of wood [WFP 15/03/96].

The ration has recently been increased from 1,520 kcals/person/day to 1,700 kcals/person/day to compensate for loss of agricultural wages. However, a break in the pipeline for com soy blend was predicted for mid–April leading to a decision to reduce quantities in the general ration in order to extend supplies for longer. Furthermore, the price of vegetable oil in all camps had increased by as much as 50% mid–March as it had been absent from the general ration for the preceding two weeks. It is anticipated that the oil ration will improve again in April [UNHCR–a 22/03/96, WFP 15/03/96, 22/03/96].

Bukavu, Zaire There are approximately 295,000–310,000 Rwandan refugees in Bukavu. Some camps have been surrounded by the Zairian military as in some camps in Goma, in order to restrict refugee economic activity and encourage repatriation. However, until now there has only been limited repatriation of refugees to Rwanda [UNHCR 28/02/96, WFP 01/03/96].

Rations have recently had to be reduced below 1,700 kcals/person/day and it is reported that stocks of vegetable oil, which were very low, have been replenished [WFP 01/03/96, 12/04/96].

Uvira, Zaire There are approximately 176,000 refugees in Uvira. Most of these refugees come from Burundi (roughly 110,000) while the remainder are from Rwanda. The number of new arrivals from Burundi has slowed in recent weeks, possibly due to the mining of the border area [WFP 23/02/96].

The health and nutritional status of this population appears adequate with low mortality rates recorded in the last RNIS report. More recent information is that there has been a steady decrease in the number of children at selective feeding programmes in the camps. Water supplies in the camps are mostly at or above the target minimum of 10 litres/person/day, although levels are still below the general accepted goal of 20 litres/person/day [UNHCR–a 22/03/96, 06/03/96].

Salt had been absent from the ration, but was re–introduced at the end of March [UNHCR 28/02/96].

Tanzania There are currently about 624,000 refugees from Rwanda and Burundi in Tanzania. Repatriation has been proceeding at a very slow pace over the past few weeks. General rations delivered in March provided 1900 kcals/person/day, although rations for a brief earlier period had been considerably lower. The current food stocks and expected deliveries are only adequate until the end of April [WFP 08/03/96, 22/03/96].

Recent reports from the camps for Rwandan refugees in **Karagwe** district show an adequate health and nutrition situation. In *Kagenyi* camp (estimated population 16,000) the crude mortality rate was recently measured at 0.81/10,000/day (about 2 × normal) and the under–five rate was 1.45/10,000/day (again about 2 × normal). In *Rubwera* camp (estimated population 26,000) the crude mortality rate was 0.28/10,000/day (normal) and the under–five rate was 0.69/10,000/day (just below normal) (see Annex I (4c,d)). The main current health problem in both camps is the high level of malaria and resulting anaemia [MSF–CH Feb 96].

There has been no new information on the nutrition situation in the refugee camps in **Ngara** district. It is therefore assumed that, as indicated in the previous RNIS report, the nutritional situation in these camps is adequate and stable. Refugees are not allowed to work outside of a four kilometer radius of the camps. However, some refugees flout this restriction and are cultivating land [LSHTM 05/04/96].

Uganda There are approximately 6,900 Rwandan refugees in Uganda whose nutritional status is reportedly adequate [UNHCR 25/03/96].

Overall, the internally displaced population in Burundi can be considered to be at heightened nutritional risk (category IIa in Table 1) due to insecurity. The refugees in Goma, Bukavu and Uvira, Zaire can be considered to be at moderate nutritional risk (category IIb) due to some security problems, and a lack of fuel for preparing food. The refugees in Tanzania and Uganda, along with the vulnerable population in Rwanda are not currently thought to be at heightened nutritional risk (category IIc in Table 1).

How could external agencies help? In Burundi needs include:

- regular nutritional surveys of internally displaced camp populations, especially in areas of insecurity in order to determine if food aid needs are being adequately met;
- increased coverage of selective feeding programmes in areas of insecurity, such as Ngozi, and a review of the appropriateness of feeding programme design, e.g. on site feeding may be more appropriate in areas with high levels of insecurity;
- funds for an aircraft operation which is essential to the distribution of relief commodities within Burundi;
- urgent need to supply sugar and oil for distribution during April.

In Rwanda needs include nutritional monitoring in those areas where food supply is known to be poor.

In Zaire needs include more donor pledges of com soy blend and oil for the general ration.

In Tanzania needs include development of a strategy for use of land for cultivation, particularly in Ngara.

A lack of cooking fuel for the people in the camps around Goma and Bukavu, Zaire was noted in RNIS #14 report, and although efforts have been made to bring in more fuel, supplies are currently still inadequate. The need for improved logistical capacity in Burundi (RNIS #14) has been partially addressed with the re-opening of Bujumbura port.

5. Central African Republic

There is a continuing influx of Sudanese refugees into the Central African Republic and it was recently estimated that there are just over 27,000 assisted Sudanese refugees in the country. There are also approximately 5,000 assisted Chadian refugees whose nutritional status is believed to be adequate [UNHCR 16/01/96].

6. Djibouti (see Map 6)

There are no reports of change for the approximately 25,000 Somali refugees in Djibouti whose nutritional status has been reported as adequate in recent RNIS reports.

7. Ethiopia (see Map 7)

The estimated number of refugees receiving food aid in Ethiopia is 376,000 people comprising 275,000 Somali, 63,000 Sudanese, 18,000 Djibouti and 9,000 Kenyan refugees and 11,000 internally displaced people around Addis Ababa. There are a further 35,000 unassisted refugees in Ethiopia (not included in Table 1).

Despite the dry season fighting in southern Sudan no significant increase in the rate of influx of refugees to western Ethiopia has been noted. Recent events in north–west Somalia and neighbouring eastern Ethiopia have sparked off tensions in some of the camps in Eastern Ethiopia and a spate of hijackings by the opposing clans has also made travel between Hartisheik and the Aware camps more hazardous [DHA Jan 96, Mar 96].

The food stocks and expected deliveries for the refugee programme is good for blended foods and resourcing for pulses and salt is now improving. However, there is concern that if arrivals of oil scheduled for March are delayed oil shortages will be faced, and there is a need to resource cereals for this programme [DHA Jan 96, Mar 96, WFP 12/04/96].

There are no new nutritional data available for any of these populations. The most recent information available (mid–1995) showed a variable nutritional situation with low to moderately high levels of wasting for the Somali refugees in the eastern camps and a generally adequate situation for the other refugee groups. It can be assumed that this situation has little changed.

Overall, since no information to indicate that the situation has changed is available, it is assumed that the populations in Fugnido, Kebre Beyah, and Darwonaji remain at high risk (category I in Table 1) and the populations of Hartisheik, Teferiber, Daror and Aisha can be considered to remain at moderate risk (category IIb in Table 1). The remaining refugee populations are probably not at heightened nutritional risk (category IIc in Table 1).

8. Kenya (see Map 8)

There are approximately 173,000 refugees remaining in Kenya. 126,000 of these are Somali, 41,000 are Sudanese and 6,000 are Ethiopian.

The nutritional situation in the Dadaab camps (Hagdera, estimated population 37,000, Ifo, estimated population 34,000 and Dagahaley, estimated population 32,000) appears to be adequate. The most recent nutritional surveys were carried out in August 1995 (details in RNIS #12) and showed levels of wasting and/or oedema ranging from 6.2–8.9%. Mortality rates recorded in October 1995 were at normal levels [MSF–B 18/03/96].

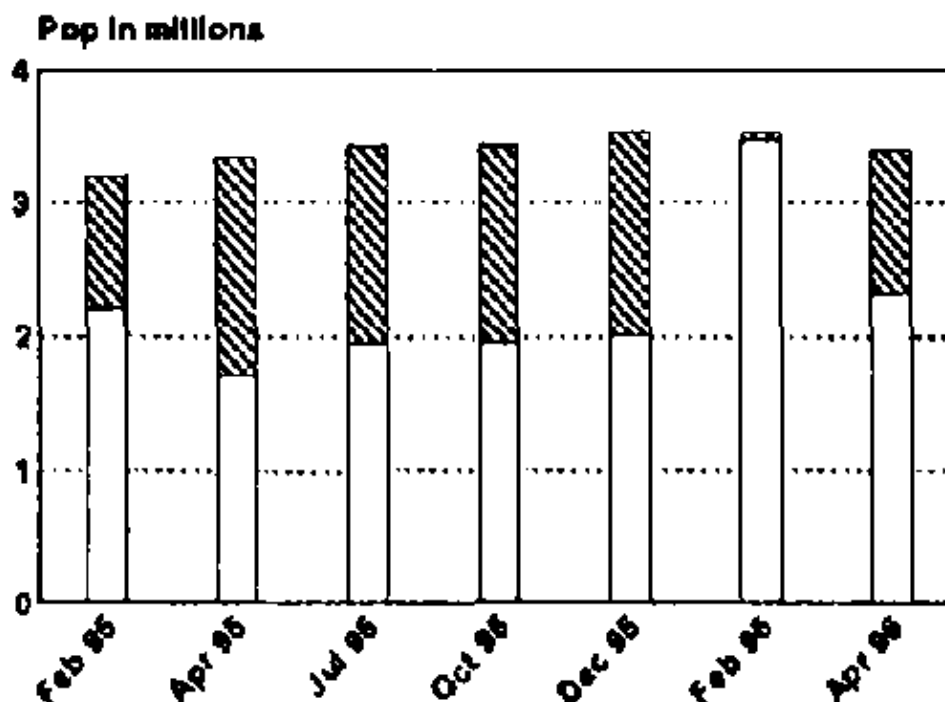
Since the August survey, the average general ration distribution has provided 2,000 kcals/person/day, although inequity in the distribution system is regularly observed through food basket monitoring. Furthermore, there has been no provision of com soy blend in the general ration since October 1995. This is particularly worrying given the scarcity of fresh fruit and vegetables in the region and the known vulnerability of this refugee population to outbreaks of micro–nutrient deficiency disease, in particular scurvy [MSF–B 18/03/96].

Overall, the refugees in Kenya are not currently thought to be at heightened nutritional risk, although it will be crucial to monitor the nutritional situation to detect signs of scurvy if CSB is not reintroduced in the general ration. This will be especially important towards the end of the summer and the autumn, when outbreaks of scurvy have occurred in the past.

How can external agencies help? Given the lack of availability of fresh fruit and vegetables to camp populations and the historical susceptibility to scurvy in these camps, there is a clear need to provide sources of vitamin C, and re–introduction of micronutrient fortified (including vitamin C) corn soy blend into the general ration, possibly on a seasonal basis.

9. Liberia/Sierra Leone Region (see Map 9 a, b and Figure 3)

Liberia/Sierra Leone



Trend in numbers of refugees/displaced and proportion severely malnourished and at high risk (shaded area).

Recent fighting in Monrovia is leading to large-scale displacement. It is too early to assess the nutritional impact of this most recent fighting. Elsewhere in Liberia, the security situation is making it difficult to establish a clear time frame for repatriation plans. Furthermore, several areas of the country remain periodically inaccessible to relief activity so that affected populations may be at nutritional risk. The recent election of a new president in Sierra Leone and subsequent talks with rebel leaders are giving rise to guarded hopes that the desperate situation in the country may begin to improve. However, given the shattered infrastructure, massive displacement to over-crowded urban centres and length of time that some populations have been cut-off from assistance, there will be a need for large-scale humanitarian support for many months to come even if political progress is rapid. Recent nutritional surveys in Sierra Leone (e.g. in Bo) continue to show extremely high levels of wasting amongst some urban populations.

Current estimates of the numbers of people affected in the region are summarised below:

Location	Feb 95	Apr 95	Jul 95	Oct 95	Dec 95	Feb 96	Apr 96
Liberia	1,800,000	1,900,000	1,900,000	1,900,000	1,900,000	1,800,000	1,800,000
Sierra Leone	506,000	500,000	730,000	730,000	730,000	730,000	756,000
Cote d'Ivoire	330,000	330,000	227,000	305,000	305,000	305,000	305,000
Guinea	568,000	603,000	578,000	536,000	605,000	605,000	536,000
TOTAL	3,204,000	3,333,000	3,435,000	3,471,000	3,540,000	3,440,000	3,397,000

Liberia Recently, an outbreak of factional fighting in Monrovia is causing tens of thousand to flee their homes, going for days without food or water. Agency personnel are currently being evacuated from the capital city. It is too early to assess the impact of this fighting will have on the population of Monrovia [UNHCR 12/04/96]. Although there had been considerable progress towards stability since the signing of the Abuja peace accord in August 1995, periodic outbreaks of insecurity throughout the country continue to pose a threat to the overall peace process. Advances have been made in deployment of ECOMOG peace-keepers and UNOMIL observers, the disarmament/demobilisation of soldiers and extension of central government administration throughout Liberia. However, in recent weeks insecurity and cease-fire violations have been reported in Lofa, Grand Gedah, Grand Kru, Maryland, Bomi and Cape Mount counties. In some cases this has led to the continued suspension of humanitarian activities. In other areas, such as Rivercess and Sinoe counties,

improvement in security has allowed displaced populations to return to their homes and to receive assistance from humanitarian agencies [DHA 04/03/96, UNHCR Jan 96, WFP 01/03/96].

There are an estimated 1.8 million refugees, displaced and war-affected people in Liberia. The recent crop assessment mission to Liberia found that massive population displacement had reduced production of rice to about one quarter of pre-war levels. Cassava production has also been adversely affected. The volatile security situation determines that those populations who are sporadically cut off from humanitarian aid are at some nutritional risk. For example, there have been anecdotal reports of increasing humanitarian needs in Bong Mines, and Grand Cape Mount. Acute shortages of food have also been reported in three camps for internally displaced people in Tieni, Bo Waterside and Sinje [FAO Jan/Feb 96, WFP 01/03/96].

In contrast, populations that have been easily accessible in recent months show a far more stable nutritional situation. For example, a recent survey carried out in Buchanan (estimated population 50,000 displaced living in camps and displaced sites and 50,000 resident people) showed 4.1 % wasting with 0.6% severe wasting. Oedema was measured at 0.5% (see Annex I (9a)). However, the crude mortality rate was 3.0/10,000/day (10 × normal) and the under-five mortality rate was 5.0/10,000/day (4 × normal). Main causes of mortality were diarrhoea and fever. Measles immunisation coverage was low at 52.7%. Over 80% of the population have been in receipt of a general ration [ACF Feb 96].

Another survey has recently been completed in Bong County (estimated population 141,000). Levels of wasting were measured at 6.1% with 1.4% severe wasting (see Annex I (9b)). There was no significant difference in levels of wasting between resident and displaced populations. In contrast to these low levels of wasting, mortality rates were extremely high. Crude mortality rates were 5.5/10,000/day (22 × normal) and under-five rates were 8.5/10,000/day (8.5 × normal). Measles immunisation coverage was very low at 6.2%. The food situation of this population was considered to be precarious as food stocks were low and the next harvest is not expected until July. Morbidity rates were also considered to be very high with fever and diarrhoea the most common complaint [ACF 22/02/96].

Plans for the voluntary repatriation of the approximately 750,000 Liberian refugees residing in neighbouring countries have been drawn up, but due to the fluid security situation in Liberia the proposed timing of the programme may well have to remain flexible. It is estimated that 623,000 refugees will wish to return and that approximately 70,000 of this population will return spontaneously without agency assistance [UNHCR Feb 96].

Sierra Leone Despite a marked decrease in security in many parts of the country which resulted in continued population movements, elections took place as scheduled, and Ahmad Tejan Kabbah was elected president in mid-March. There are hopes that this election will mark the beginning of a new period of peace with talks between representatives of the new government and rebel leaders already underway. Following improvement in the overall security situation and the declaration of an unconditional cease-fire by the RUF in mid-March many internally displaced have returned to their villages of origin in Bo and Magburaka provinces. [DHA 07/03/96, UNHCR 22/03/96, WFP 28/03/96].

It is currently estimated that there are at least 1.6 million internally displaced people in Sierra Leone requiring some sort of humanitarian assistance. Only approximately 210,000 of this population are in camps with the remainder living amongst local communities whose coping mechanisms are reportedly stretched beyond reasonable limits in their efforts to support the displaced. Populations of urban centres have increased dramatically, for example the population of Freetown has almost doubled. Similar situations are reported for the towns of Kenema, Makeni, Matru, Bonthe mainland, Kailahun, Segbwema, Zimmi and Dam. In each case the influx is causing over-crowding, outbreaks of disease and overburdening of social services. Food distributions have begun in many areas, for example Dam, Segbwema, and Zimmi [DHA-a Mar 96, ICRC 09/04/96].

The violence in the country has displaced farmers and cut-off greater and greater areas of cultivatable lands. Food has therefore become increasingly scarce, and when available, often appears in markets at prohibitively high prices. It is hoped that approximately 756,000 people will receive a general distribution in 1996, although it is recognised that emergency food aid activities must be a part of a larger strategy to increase food security for the entire population not just the displaced. It is also critical that donors support the process in a timely manner as the capacity of relief organisations to deliver assistance is greatest during the first half of the year i.e. the dry season [DHA-a Mar 96].

Difficulties that currently exist in implementing general ration distributions include problems with identification and verification and registration of beneficiaries, inability to establish a strategic grain reserve, lack of

consensus over composition of a food basket and weaknesses in the capacities of local NGOs to undertake traditional implementation roles [DHA—a Mar 96].

Public health, water and sanitation facilities are also in a critical situation in Sierra Leone. Only 16 percent of the country's health centres are said to be operational and during 1995, outbreaks of cholera and measles were reported in several urban centres [DHA—a Mar 96].

Reaching civilians in need outside the Western area has been enormously problematic as road transport has been severely disrupted due to insecurity. Airlifts have been undertaken as the only viable option. One very positive development has been the government's permission to begin cross-border delivery of relief supplies from Guinea into Kailahun area.

An assessment in June 1995 showed a very bad situation in Kailahun. At that time, most of the population was living in the bush and wasting, as measured by QUAC stick, was 33% and severe wasting was 29%. Furthermore, kwashiorkor and wasting were seen among older children and adults. Government clearance for food distributions was granted in February 1996. The food situation by then had improved somewhat. Many people had moved back to the villages and therefore had greater access to food. Currently, the farmers are beginning to prepare the land for planting, and agricultural inputs are urgently needed [ICRC 31/03/96].

The nutritional situation in large urban centres appears to be extremely variable and dependant on recent humanitarian agency access, employable coping strategies and the scale of recent displacements. For example, a survey in Bo town (estimated population 250,000) in November 1995 found wasting levels of 13.1% with 1.2% severe wasting. In the camps for the displaced (estimated population 16,000) wasting and/or oedema was 25.3% with 4.3% severe wasting (see Annex I (9c–d)). The survey found that nearly 30% of families claiming to be displaced were not registered and that almost 60% claimed to have never received a general ration distribution. Up to 30% of malnourished children were not enrolled in selective feeding programmes [ACF 11/11/95].

A more recent survey in March 1996 found little change with wasting and/or oedema rates of 12% with 1.2% severe wasting and/or oedema in the town and 23.8% wasting with 3.5% severe wasting and/or oedema in the camps (see Annex I (9e–f)). Since this survey it has been reported that coverage of the general ration distribution has improved significantly [MSF–B 18/03/96, 05/04/96].

In October 1995, levels of wasting in Bonthe Islands were reported to be almost 13% (see RNIS #14). More recent information indicates that wasting levels have declined substantially, although precise figures are not available [MSF–B 05/04/96].

The main highways to Bo, Kenema and Makeni have now been re-opened and food is being distributed to these urban centres. Recent survey data from Kenema show wasting at 6.3% in the town, with 1.0% severe wasting and/or oedema. In RTI camp, just outside of Kenema, wasting was measured at 8.6% with 0.2% severe wasting. No oedema was seen in either the town or in the camp (see annex I (9g–h)) [MSF–H 04/04/96].

Cote d'Ivoire There remain approximately 305,000 Liberian refugees in Cote d'Ivoire. Although some limited spontaneous repatriation may be occurring, it is believed that most refugees are crossing into Liberia during the day and then returning to Cote d'Ivoire at night with a view to retaining refugee status until there is greater confidence in the prospects of long-term peace and security in Liberia [UNHCR 22/03/96].

Guinea There are approximately 605,000 Liberian and Sierra Leonean refugees in Guinea of whom 536,000 receive food aid. [UNHCR 22/03/96]. In the past the nutritional security of much of this population has been described as adequate but precarious and highly vulnerable to any breaks in the food aid pipeline [RNIS #14].

Overall, the populations of Buchanan and Bong counties in Liberia are at high risk due to elevated mortality rates (category I in Table 1); the population in the camps around Bo are also at high risk due to elevated levels of wasting. The remaining displaced population in Sierra Leone is likely to be at heightened nutritional risk (category IIa in Table 1) due to insecurity. The population in Liberia that is inaccessible, or only periodically accessible can be considered to be at moderate nutritional risk (category IIb in Table 1) while the accessible population in Liberia and the refugees in Cote d'Ivoire and Guinea are probably not at heightened nutritional risk (category IIc in Table 1).

How could external agencies help? Effects of recent fighting in Monrovia could not be assessed as of 12 April. In Liberia needs include:

- strengthening nutritional survey capability so that levels of malnutrition can be quickly determined in newly accessible areas, for a rapid targeting of food aid where needed and feasible;
- survey reports (e.g. Buchanan County) continue to show very high mortality rates, due mainly to diarrhoea and fever in children, as well as malnutrition (oedema, kwashiorkor), which require urgent action, notably an extension of measles immunization coverage (e.g. 6% only covered according to survey results from Bong County).

A consolidated appeal for Sierra Leone, coordinated by UN/DHA, to be launched in April, along with the reports included here, suggest some needs. These include:

- sporadic general ration distribution, due to insecurity, are a continuing problem; on some occasions in the past demonstrations of high levels of malnutrition have helped in obtaining agreement for food distribution, indicating that further surveys could be useful;
- the coverage and equity of food distribution in large urban areas in being hampered by inadequate registration which needs improving;
- because of the sporadic general food distribution, selective feeding centres, mainly for children, are in operation, and expansion of this coverage may need to be considered;
- urgent distribution of farm inputs as in many areas the planting season will begin soon (April and May);
- investment in rebuilding and extending health, sanitation and water infrastructure throughout the country.

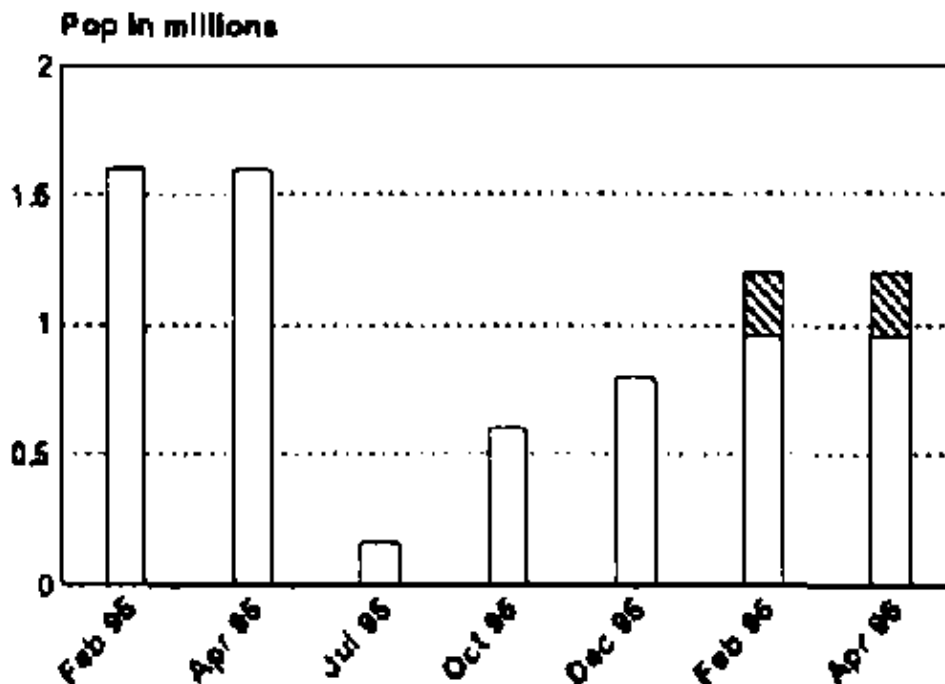
Recent reports indicate that the food pipeline for the region which was reported as inadequate in RNIS #14 has improved substantially in recent weeks. However, cash needs for monitoring and logistics support remain an urgent priority. It appears that the needs for increased measles immunisation throughout both Sierra Leone and Liberia have still largely to be met.

10. Mauritanian Refugees in Senegal (see Map 3)

There was a final food distribution to the approximately 52,000 Mauritanian refugees in Senegal in December 1995. This population is now considered to be self-sufficient and will no longer receive assistance [UNHCR 06/02/96].

11. Mozambique Region (see Map 11 and Figure 3)

Mozambique



Trend in numbers of returnees and demobilised soldiers.

Current estimates are that there are approximately 1.2 million returnees and drought affected people currently in need of food aid in Mozambique.

As household food stores dwindle between harvests, the increased demand for many foods together with inadequate supplies has driven up prices of commodities such as oil, sugar and rice significantly. The price of white maize grain and flour has risen even more. Thus, the average numbers of household meals is falling although other sources of income, particularly cashew and some harvests of cassava and sweet potato seem to have stabilised the nutritional situation in most areas of the country. Data up until January 1996 generally shows a stable nutritional situation in most areas of the country although there were exceptions, e.g. certain districts in Niassa province [MSF-CIS Jan 96].

The number of reported pellagra (niacin deficiency) cases in Mutarara district continued to rise in December. Consignments of groundnut which were purchased from Malawi in order to be added to the general ration in the district have still not reached the affected population due to administrative difficulties. Similar difficulties have been experienced with corn soy blend provision [MSF-CIS Jan 96, MSF-CIS Mar 96]. More recently, the rains have begun, and it is reported that the number of cases of pellagra is beginning to decline. It is assumed that there is additional food now available locally that is helping to improve the situation [UNHCR 04/04/96]

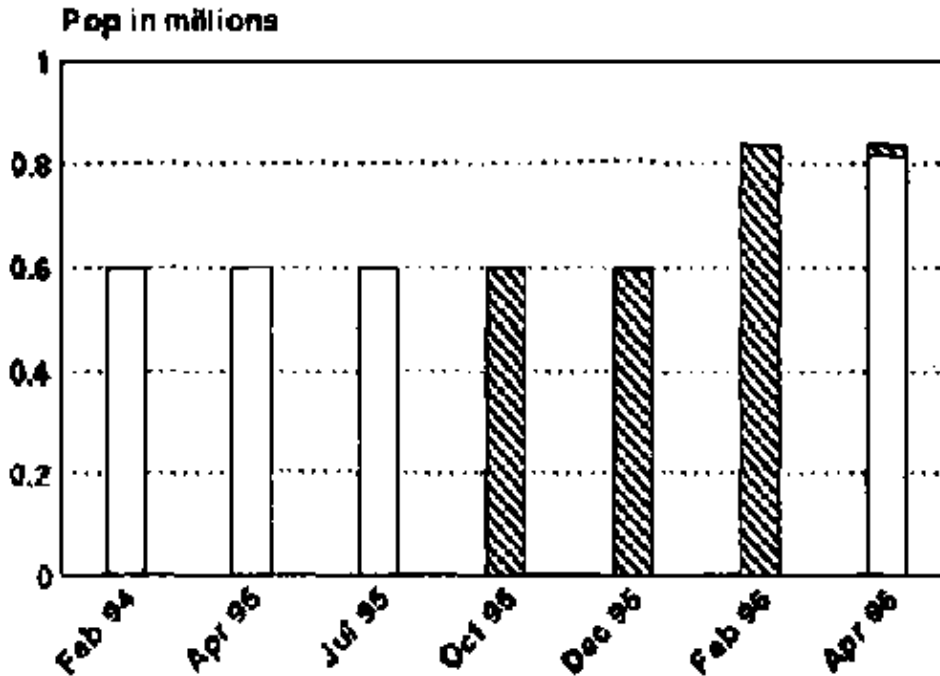
Information collected until the end of 1995 showed fairly good coverage of free food distributions for the most vulnerable populations although there continued to be some areas where vulnerable groups were either under-registered or inaccessible [MSF-CIS Jan 96]. Recent flooding may significantly impact food production, especially in the south, and may render new population groups vulnerable [UNHCR 04/04/96].

Overall, the population affected by niacin deficiency with 1–2% prevalence reported, is at high risk (category IIa) in Table 1. The remaining vulnerable population in Mozambique is not currently considered to be at heightened nutritional risk (category IIc in Table 1) although increasing prices are likely to cause some increase in child malnutrition.

How can external agencies help? Deficiency of the micronutrient niacin continues to be reported. Administrative difficulties have been preventing the delivery of groundnuts to areas where pellagra has been occurring for several months, e.g. Mutarara, and, despite a declining number of cases reported, this intervention remains urgent for preventing malnutrition.

12. Somalia (see Map 12 and Figure 3)

Somalia



Trend in numbers of returnees and internally displaced with proportion severely malnourished or at high nutritional risk in shaded area

An estimated 840,000 people comprising 600,000 returnees and 240,000 internally displaced people, currently require humanitarian assistance in Somalia. Food for work and other relief projects are being implemented throughout the country. The security situation remains fluid with factional clashes reported in different areas. For example, some UN personnel were recently evacuated from Bardera for a month due to insecurity. However, February has generally been described as a relatively calm month [FAO Jan/Feb 96, WFP 22/03/96].

Final reports on the recent “Deyr” harvest indicate that the estimated total national sorghum and maize production was slightly higher than the pre-war average. However, production varied significantly between regions with least favourable yields found in Gedo region. Humanitarian agencies have been focusing their attention on the Juba valley where some villages have been assessed as having a high level of food insecurity [DHA 06/03/96, FAO Jan/Feb 96, WFP 22/03/96].

Sharp rises in food prices in recent months, the accelerated devaluation of the national currency and periodic insecurity in parts of the country are creating hardship for large sections of the urban Somali population – and in particular the jobless. Aid agencies are operating large numbers of feeding centre in Mogadishu specifically targeted to women, children and orphans. However, in spite of these adverse factors a recent assessment of the internally displaced in over seventeen camps in North Mogadishu found wasting and/or oedema rates of only 2.1% (see Annex I (12a)) [DHA 06/03/96, FAO Jan/Feb 1996, WFP 22/03/96].

There have been no updates on the nutritional situation in Bardera since the previous RNIS report where levels of wasting were recorded at 19% in November 1995.

Cholera has been reported in some regions in Somalia but is apparently under control in all areas except Mogadishu where over 1,800 cases had been identified by the end of February [DHA 06/03/96].

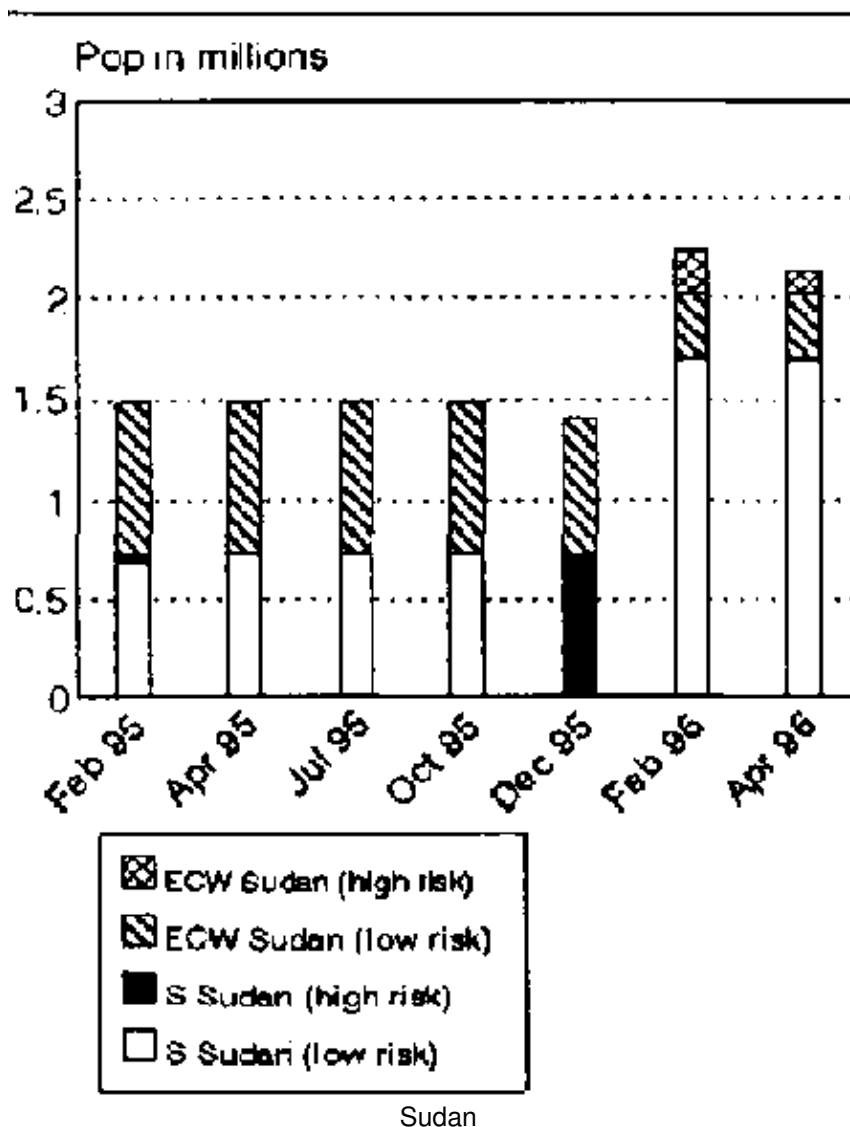
Overall, there are no specific reports to a change in the nutritional status of the vulnerable population; however relatively good harvest in some areas has probably helped the food security situation. The population

in Bardera is likely to continue with high prevalence of malnutrition (category I in Table 1). The remaining population is likely to be at moderate risk (category IIb in Table 1).

How could external agencies help? Feeding centres in urban areas appear to be contributing to maintaining a relatively good nutritional situation, and need continued support. Camp populations and the affected resident populations around the camps e.g. Bardera, probably have high malnutrition prevalences requiring additional interventions. There is also a need for improved logistical support for cholera treatment and prevention, particularly in Mogadishu.

13. Sudan (see Map 13 and Figure 3)

Sudan



The total number of people needing emergency assistance in Sudan is currently estimated to be 2.2 million. This number comprises 1.7 million displaced and/or war affected people in southern Sudan, 154,000 people in the transitional zone, 119,000 displaced people around Khartoum and 200,000 Ethiopian and Eritrean refugees mainly residing in the Eastern camps.

Fighting continues in southern Sudan and often inhibits relief programme activity. For example, only recently food and technical equipment were looted from a barge on the Sobat river. The barge convoy had to return without making its planned delivery. Aircraft operations have been severely curtailed since late November 1995 when the government temporarily banned all OLS and other relief flights due to insecurity. Although the flight ban was officially lifted in early December the government are still not granting flight clearance for the

main delivery craft and donors will not commit funds without assurance that the aircraft can be operated without clearance limitations [USAID 20/02/96, WFP 22/03/96].

In light of these restrictions on relief deliveries and the slightly poorer 1995 harvest which led to immediate and marked food price inflation, it can be expected that large numbers of people will be experiencing considerable nutritional stress in southern Sudan. However, there are no recent nutritional survey data to support this supposition. Nevertheless, on the basis of local reports, rapid food security assessments are frequently carried out and where need is identified, as was recently the case near Malakal, food, seeds and tools are distributed. Access to health services is extremely varied in southern Sudan with only 4% access in Bahr el Ghazal and 100% access in Western Equatoria [UNICEF 95].

A re-registration in the three camps for displaced people outside Khartoum has led to a revised estimate of 119,000 for this population. Unlike most of the 1.8 million displaced people living and working in the Khartoum area who are not in camps, this population receive some humanitarian assistance. Most recent information from the camps indicate "unacceptably high levels of malnutrition" among children in Al Salam and Wad Al Bashir camps. There have also been reports of high levels of vitamin A deficiency amongst this population (previous RNIS report) [USAID 20/02/96, FAO Jan/Feb 96, WFP 22/02/96].

A census is being conducted for the Ethiopian and Eritrean refugees, and results are expected at the end of April. There are no new nutritional data on these refugees; most recent information showed a somewhat variable situation with, for example, 15% wasting recorded in Shagreb camps (estimated population 33,000), and 7% wasting in Um Rakuba (estimated population 12,000).

Overall, the displaced population around Khartoum is in category I in Table 1 due to vitamin A deficiency. The affected population in Southern Sudan and in the transitional zone can be considered to be at moderate nutritional risk (category IIb in Table 1), although there are likely to be areas where the nutritional risk is very high. The remaining refugee population is probably not at heightened nutritional risk (category IIc in Table 1).

How could external agencies help? In southern Sudan needs include:

- nutritional surveys in areas where there is known displacement and/or recent incidents of conflict in order to identify most vulnerable groups needing assistance and to determine whether the poor harvest and limited relief deliveries are leading to a deterioration in nutritional status;
- re-doubled efforts to negotiate flight clearances with the government in order to increase relief activities in the south;
- new food aid pledges for 19% to make up current shortfalls;
- improving health service provision and access in all provinces except Western Equatoria where there is reportedly 100% access.

In camps around Khartoum high levels of wasting and vitamin A deficiency persist and feasible interventions need to be identified, e.g. improved general rations, expansion of selective feeding programmes, vitamin A prophylaxis, improved health service delivery.

14. Uganda (see Map 14)

There are currently almost 227,000 assisted Sudanese and Zairian refugees in Uganda, broken down as follows:

Origin	Feb 95	Apr 95	Jul 95	Oct 95	Dec 95	Feb 96	Apr 96
Sudanese Refugees	300,000	310,000	322,000	324,000	217,000	210,000	214,000
Zairian Refugees	313,000	13,000	13,400	13,700	11,800	12,300	12,300
TOTAL *	313,000	323,000	335,400	337,400	228,800	222,300	226,300

* Rwandan refugees in Uganda are included in section #4.

There has only been a slight influx of Sudanese refugees from southern Sudan in recent weeks. Efforts to decongest the refugee areas of Koboko and Adjumani are continuing [UNHCR 25/03/96].

A recent survey of the transit centres in Adjumani, Moyo district (total estimated population of transit centres and settlements is 77,000) found 11.8% wasting and/or oedema with 2.0% severe wasting. The situation was slightly worse in settlements in this area where wasting and/or oedema was measured at 16.4% with 5% severe wasting and/or oedema (see Annex I (14a,b)). These figures indicate a relatively high prevalence of malnutrition, moreover, higher than previous surveys. The nutrition situation may be becoming critical. The food ration is currently set at 1900 kcals/person/day and at the time of the survey (mid-February) supplies had been sufficient for approximately six months. The survey concluded that some of the settlements are not viable and that people who have settled there will never achieve independence from external food aid and so will continue to be highly vulnerable to any disruption to the general ration or their ability to purchase food locally [MSF-CH 13/02/96].

It was also noted that the re-enumeration which took place in October 1995 led to a reduction by some 40% in the planning figure for refugee assistance. Although this has led to more equitable distribution of food aid, it has also reduced the capacity of refugees to exchange part of their ration for other essential non-food items. Measles immunisation coverage in the area of Adjumani is thought to be almost 100%, although only between 50-64% of those surveyed had an immunisation card [MSF-CH 13/02/96].

Since this survey, rebel activity in northern Uganda has increased and led to some disruption of food deliveries to the camps and settlements [UNHCR 25/03/96]. It is therefore probable that the nutritional situation for these refugees has worsened further.

There has been no reported change to the adequate nutritional situation for the 12,300 Zairian refugees in Uganda.

Overall, the refugees in Adjumani can be considered to be at high nutritional risk (category I in Table 1) due to elevated levels of wasting and decreased general ration supplies. The remaining Sudanese refugees are considered to be at moderate nutritional risk (category IIb in Table 1) due to decreased food supplies, while the Zairian refugees are probably not at heightened nutritional risk (category IIc in Table 1).

How could external agencies help? There are indications of increasingly urgent nutritional needs in Northern Uganda, with very recently some disruption of food aid deliveries. The situation may require watching closely, with increased food deliveries as security allows.

15. Zaire (see Map 15)

Refugees in Zaire (excluding Rwandans and Burundis included in section #4) There are an estimated 169,000 Angolan refugees in Zaire of whom 50,000 are assisted in some way. It is hoped that most of the unassisted population will spontaneously return to Angola now that the situation has improved there. Organised repatriation for the 50,000 assisted refugees is scheduled to begin by mid 1996 [UNHCR 17/01/96, Jun 95-Dec 97].

There are approximately 94,000 Sudanese refugees receiving some assistance in Zaire. The slight increase is due to a small number of new arrivals fleeing the continued insecurity in southern Sudan [UNHCR 17/01/96].

There are over 12,000 Ugandan refugees and a further 6,000 new arrivals whose refugee status unclear [UNHCR 17/01/96].

Displaced from Shaba, Zaire There are approximately 600,000 people who have been displaced by ethnic violence which erupted in the Shaba region at the end of 1992. This population fled north into the Kasai region where many had ancestral links. During the migration large numbers stopped temporarily in villages along the route north, while others settled permanently at these sites.

Currently, there is little further displacement from the Shaba region and the most recent set of nutritional survey information shows that the level of self-sufficiency obtained by this migrant population varies enormously. Most recent survey data were included in RNIS #14. These surveys showed low levels of wasting

among most of these people.

The exception to this was in Mwene Ditu where in October 1995 wasting was measured at critically high levels of about 43% in the displaced population, estimated at 40,000 people, and 17% in the local affected population (estimated at 220,000). It has recently been reported that the nutrition situation in and around Mwene Ditu has not improved. Over 6,000 children are included in supplementary and therapeutical feeding centres and financial support for these centres is apparently running out [MSF-B 09/04/96].

Masisi Region, Zaire Since November 1995, there has been a marked escalation in a conflict in Masisi zone of North Kivu (estimated population 500,000–600,000). The conflict is between the Banyarwanda people (Rwandese origin), most of whom are Hutu, and Zairians of mostly Hunde ethnic origin. Although lack of access precludes an accurate assessment of numbers, many people are undoubtedly being killed and tens of thousands displaced from their homes. Estimates of the total number of displaced people vary widely and range from 100,000 to 250,000. The reason for this dramatic explosion of conflict at the end of last year appears to have been related to the threatened expulsion of Rwandan refugees in December 1995 [DHA 26/02/96, WFP 16/02/96].

The area has been inaccessible to humanitarian organisations since January due to the high level of insecurity. Poor roads and the risk of being associated with one faction also make it very difficult for humanitarian agencies to work in the area. Many of the displaced people are surviving by living among extended families or friends and using marginal land to cultivate their own crops. A nutritional survey carried out in Kinchanga, where some 12,000 displaced people are gathered, showed an extreme crisis with wasting and/or oedema rates measured at 31 % with 13% severe wasting and/or oedema (see Annex I (15a)) [MSF-H 13/02/96].

Most recent reports are that fighting is continuing in the Masisi region and that some of the conflict incidents are occurring closer to Mugunga refugee camp in Goma [WFP 15/03/96].

Overall, the displaced and resident affected populations in Mwene Ditu is in category I in Table 1 due to elevated levels of wasting, as is the population in the Masisi region. The remaining displaced population from Shaba and the refugees are not currently considered to be at heightened nutritional risk (category IIc in Table 1).

How could external agencies help? In Mwene Ditu, financial support to continue the functioning of feeding centres is one priority.

More information is needed from the Masisi area where ethnic violence is leading to large scale displacement. Very probably interventions including emergency food and health assistance are urgently needed for several thousand people.

16. Zambia

Organised repatriation of the approximately 26,000 assisted Angolan refugees in Zambia is scheduled to begin in 1996 and will be completed over a fourteen month period. Before departure refugees will undergo health and nutrition screening and be given updated health cards while children under five will be vaccinated. There are a further 70,000 unassisted refugees who have been considered self-sufficient for a long time, and are expected to repatriate without assistance [UNHCR Jun 95–Dec 97].

ASIA – SELECTED SITUATIONS

The most recent overview of the numbers of refugees and displaced people in Asia (as of the end of 1994) is as follows. There were an estimated 5.0 million refugees in Asia, of whom 1.1 million were Afghans in Pakistan and in Iran (1.6 million). There were reported to be 610,000 Iraqis in Iran. Other large groups were refugees from Myanmar in Bangladesh (120,000), Vietnamese in China (290,000), Chinese (Tibet) in India (110,000), and Bhutanese in Nepal (100,000). No comprehensive data were available on the numbers of internally displaced populations in Asia, but they were certainly in the millions (UNHCR, 1994 'Populations of Concern to UNHCR').

This section of the report aims to give updated information on some of these situations. The current situation for the Afghan refugees/displaced populations, the largest single group in Asia with approximately three million affected people, is described. Available information on the Bhutanese refugees in Nepal and refugees from Myanmar in Bangladesh are included because of previous reports of micronutrient deficiencies. As in the past, we also include information on Southern Iraqi refugees in Iran.

17. Afghanistan Region (see Map 17)

There are approximately three million people affected regionally by this fifteen year old conflict. Many of those affected are refugees either in Iran or Pakistan, and are currently considered to be self-sufficient.

Kabul Since the resumption of hostilities between the Taliban forces and government in September 1995 over 60,000 people have fled Kabul. Most recent reports are that fighting is continuing around the capital resulting in numerous civilian casualties. The current round of fighting has disrupted normal patterns of trade and commercial deliveries to the city so that there is concern that high food prices in the markets of Kabul are making it increasingly difficult for residents to feed themselves properly. Although some of the main roads leading into Kabul are now open, heavy taxes are being levied at certain entry points with the cost being passed onto consumers thereby keeping prices high. It is generally felt that the situation will continue to worsen unless the factions agree to allow the access routes to Kabul to open permanently.

In January 1996, the roads leading to Kabul were once again blocked by the warring parties, and food prices consequently began to rise. These price increases meant many staple foods, although available on the markets, are outside the purchasing power of many people. Information from dispensaries in Kabul showed that 42% of the children attending were wasted (using arm circumference measurements – QUAC stick). Although this is not representative of the population of Kabul, it does point to a downward trend in the nutritional status as compared to data gathered from dispensaries in 1990 (22.3% wasting) [ICRC Feb 96].

The winter distribution of relief food, which started at the beginning of February, has almost been completed. The main target groups have been the elderly, widows, orphans, and other needy groups including families whose main income earner is disabled. The original planning figure for this vulnerable population was 100,000 people although 160,000 people were eventually targeted [BAAG 28/02/96, UNHAA 27/02/96, 06/03/96, 11/03/96].

A subsidised bakery project which aims to assist 200,000 people with daily bread at reduced price. This is reportedly working well in reducing the basic cost of living for many families [ICRC Feb 96].

Displaced in Jalalabad There are no reports of change in the situation for the 120,000–200,000 displaced people in two camps in Jalalabad. The most recent nutritional survey recorded in the previous RNIS report was in New Hadda camp where prevalence of wasting was only 4%. However, with the continued fighting around Kabul it can be assumed that displacement to Jalalabad is continuing. There are no current data on the nutritional status of new arrivals to the area.

Refugees in Pakistan There remain approximately 860,000 Afghan refugees in Pakistan. The steady decline in numbers of this population is due to repatriation. Most of the remaining refugees are considered to be self-sustaining and thus the general feeding programme has been replaced by a targeted feeding programme. Vulnerable groups such as the disabled, children, the elderly, families without an able-bodied adult males and refugees who arrived in 1992–3 (approximately 180,000 people) will benefit from this programme. There is a concern that not all vulnerable groups have access to the feeding programmes, and ways of improving implementation are being investigated [UNHCR 19/03/96].

A nutritional survey carried out in September/October 1995 in Baluchistan, NWFP and Punjab found overall levels of wasting of 6.0%, 5.3% and 2.7% with 0.9%, 1.1% and 0.7% levels of severe wasting respectively. These rates are considerably lower than those found amongst children in Pakistan (9% in 1995), but do show a slight deterioration compared to a survey carried out in April 1994. The decline in nutritional status is not being solely attributed to the gradual withdrawal of food rations which began in 1990. Other factors, such as high levels of diarrhoea, are also believed to have played a significant role [UNHCR Oct 95].

Refugees in Iran There are approximately 1.4 million Afghan refugees in Iran. While an estimated 20,000 live in camps and receive assistance, the remaining population is scattered among the local population and receive no general ration support [UNHCR 19/03/96].

Recently, food prices for most commodities in Iran have increased and this is believed to pose a particular problem for Afghan refugees, especially for those living outside the camps. The worsening economic situation in Iran is making even low paying jobs difficult to find and capacity to increase expenditures on essential foods is limited in this population [UNHCR 19/03/96].

How can external agencies help? In Kabul, the main problem appears to be a lack of purchasing power. Therefore, interventions that aim to increase the real income are needed. In light of this, it would be useful to:

- continue to support subsidised bakeries;
- increase the number and scope of income generating projects in Kabul.

There is a need to review the basis for targeting the general ration to refugees in Pakistan with a view to determining whether all vulnerable groups are included. It may prove appropriate to select additional target groups for ration distribution. Given the possible decline in nutritional status, it may be prudent to implement more frequent surveys (e.g. every six months instead of annually).

The recent removal of the government subsidy on bread in Iran is likely to adversely affect the nutritional well-being of those refugees who are not supported in camps and who may not be able to afford any extra expenditure on food. Consideration should be given to strategies for protecting the food security of this population. Possibilities include the establishment of fair price shops or food coupons.

18. Bhutanese Refugees in Nepal (see Map 18)

There are approximately 90,000 Bhutanese refugees living in camps in Nepal. An additional 15,000 refugees reside outside camps and do not receive humanitarian assistance. The next round of bilateral talks between the Bhutanese and Nepali governments concerning the refugee situation is scheduled to take place in April 1996.

Levels of wasting reportedly remain low among this refugee population. However, despite regular and complete general ration deliveries, including fortified blended foods, fresh vegetables and parboiled rice, a few cases of beri-beri, scurvy and angular stomatitis continue to be reported. The reasons for this are currently being investigated. The crude mortality rate amongst this refugee population in February 1996 was 0.11/10,000/day, and the under five mortality rate was 0.23/10,000/day. Both these rates are considered low [UNHCR 14/03/96, 19/03/96].

Overall, the population is not currently considered to be at heightened nutritional risk (category IIc in Table 1), although a small number of people are at risk due to micronutrient deficiencies.

19. Refugees from Rakhine State, Myanmar in Bangladesh (see Map 19)

There are approximately 50,000 refugees from Rakhine State, Myanmar in Bangladesh. Repatriation of this refugee population is continuing at a very slow rate. For example, in February 1996, only approximately 500 refugees repatriated [UNHCR 19/03/96].

A recent review of the assistance programme throughout 1995 showed a generally satisfactory nutrition situation for these refugees. The distributed general ration varied little during the year and contained on average about 2,200 kcals/person/day. The percentage of children enrolled in selective feeding programmes ranged from 10–15% during 1995. A slight increase towards the end of the year was attributed to improved case finding and the policy of discouraging repatriation for those families with malnourished children [UNHCR 1995].

The most recent nutritional survey was carried out in August 1995 and found 9.5% levels of wasting which is a slight increase from the previous survey which found 7.2% prevalence of wasting. This change in the populations' overall nutritional status was partly attributed to the ongoing repatriation of least vulnerable families as well as other factors affecting basic needs provision in the remaining camps [UNHCR 1995]. This population are almost entirely dependent on the food ration provided so that any small break in the general ration pipeline can have an adverse effect upon nutritional status.

Availability of blended foods, fish and dal in the general ration has undoubtedly had a role in reducing B vitamin deficiency (seen as angular stomatitis). Prevalence rates of angular stomatitis were 6.9% in August 1995 compared to 21.6% in the previous year. Subsequently, rates have further declined. It is not clear why signs of the deficiency persist among this population. One suggestion has been that certain families exchange vitamin B rich general ration commodities for other items thereby rendering their household vulnerable to deficiency [UNHCR 1995].

Measles immunisation coverage stood at over 98% in 1995 [UNHCR 1995].

Overall, this population is not currently considered to be at nutritional risk (category I Table 1), however, there is a small percentage of people at high risk due to the presence of micronutrient deficiencies.

How could external agencies help? As it is difficult to supply fresh vegetables to this population the regular supply of blended foods must be guaranteed. Its provision in recent months has probably been the most important factor in reducing the incidence of micro-nutrient deficiency disease. The general ration pipeline for blended foods must therefore be ensured while support for the local production of blended foods must continue. UNHCR should advise/request WFP to procure blended foods locally as long as the price remains competitive. Reasons for the continued presence of low levels of micronutrient deficiencies need to be investigated.

20. Southern Iraq

Although there is very little direct information, it can be assumed that the nutritional and health condition of the 220,000 Marshland Arabs continues to be undermined by the systematic destruction of their traditional habitat in conjunction with other measures of persecution. Loss of livelihood, arbitrary arrest, detention and torture, as well as attacks on habitats have stretched the survival capacity of this population. Approximately 28,000 people have managed to cross the border into Iran, and their nutritional status is reportedly adequate [UNHCR 19/03/96].

There have been a succession of reports describing a declining nutritional situation for the majority of Iraqi people partly as a result of economic sanctions. As the Marsh Arab population is currently one of the most vulnerable in Iraq, it can be assumed that their nutritional situation is worse than that of the rest of the country which is increasingly being described as very poor.

A very recent report describing the health and nutrition situation in the country since sanctions were imposed in 1991 described a catastrophic situation. "A large number of ad hoc nutrition surveys have been conducted on children in different governorates in Iran, and the results have been consistently dismal. Moderate and severe malnutrition is widely prevalent. Kwashiorkor and marasmus, the most alarming forms of protein-energy malnutrition reappeared in Iraq in 1991. Nutritional anaemia and vitamin A deficiency are now common occurrences" Mortality rates have reportedly increased six-fold and incidence of malaria, cholera and typhoid, to cite a few examples have also increased dramatically [WHO Mar 96].

Overall, the Marsh Arabs who are refugees in Iran are probably not at heightened nutritional risk (category IIc in Table 1), while those remaining in the Marshes can be considered to be at high nutritional risk (category IIa in Table 1).

LISTING OF SOURCES FOR APRIL 1996 RNIS REPORT

Org*	Date	Title of Report
ACF	Nov.95	Nutritional Survey of Bo Town (Sierra Leone)
ACF	11/11/95	Nutritional Survey of Bo Town
ACF	Dec.95	Enquete Nutritionnelle Anthropométrique, Province de Ngozi, Burundi
ACF	Feb.96	Nutritional Survey, Buchanan, Liberia

ACF	22/02/96	Anthropometric Nutritional Survey in Bong County, Liberia
AI	20/02/96	Rwanda/Burundi: Urgent Steps Needed to Resolve Refugee Crisis
BAAG	28/02/96	Afghanistan Report
DHA	Jan.96	Monthly Information Report – Ethiopia
DHA	Mar.96	Monthly Information Report – Ethiopia
DHA	04/03/96	Humanitarian Situation Report – Liberia (No 3)
DHA	06/03/96	Bi-Monthly Information Report – Somalia
DHA	07/03/96	Bi-Monthly Information Report / Sierra Leone (No 2)
DHA	08/03/96	Rwanda Issues Paper
DHA	13/03/96	Humanitarian Situation Report – Burundi (No 10)
DHA	26/02/96	Situation Report Masisi, North Kivu, Zaire
DHA	31/01/96	Monthly Information Report – Rwanda
DHA	Jan/Dec 96	Consolidated Interagency Appeal for Sudan
DHA-a	Mar.96	Inter-Agency Appeal for Sierra Leone (Mar 96 – Feb 97)
DHA-a	08/03/96	Humanitarian Situation Report – Burundi (No 9)
FAO	28/12/95	FAO/WFP Crop Assessment Mission to Rwanda
FAO	Jan/Feb 96	Foodcrops and Shortages
ICRC	Feb.96	Report on Kabul
ICRC	04/03/96	ICRC Launches Field Operations in the East (Sierra Leone)
ICRC	09/04/96	Personal Communication – Sierra Leone
ICRC	21/02/96	Afghanistan: Flying food
ICRC	31/03/96	Assessment in Kailahun, Sierra Leone
IRIN	22/03/96	Weekly Roundup of Main Events in the Great Lakes Region
LSMTH	05/04/96	Personal Communication – Ngara. Tanzania
MSF-B	05/04/96	Personal Communication – Sierra Leone
MSF-B	09/04/96	Update on Mwene Ditu
MSF-B	18/03/96	Update on Kenya, and Bo Town
MSF-CH	Jan.96	Activity Report, Karagwe District, Tanzania
MSF-CH	Feb.96	Activity Report, Karagwe District. Tanzania
MSF-CH	13/02/96	Nutritional Survey – Adjumani, East Moyo District (Uganda)
MSF-CIS	Jan.96	Bi-monthly Update
MSF-CIS	Mar.96	Personal Communication – Mozambique
MSF-F	04/04/96	Personal Communication – Mauritania
MSF-F/MDM	12/03/96	Résultats Préliminaires de l'Enquete Nutritionnelle. Camps réfugiés en Mauritanie
MSF-H	04/04/96	Nutritional Survey Report – Kenema, Sierra Leone

MSF-H	13/02/96	Survey Results – Kichanga, Masisi Region, Zaire
OLS	Feb.96	Monthly Information Report – February 1996 (Sudan)
UN	15/03/96	UN Situation Report, February 1996 (Rwanda)
UNHAA	06/03/96	Weekly Update (No 158) Afghanistan
UNHAA	11/03/96	Weekly Update (No 159) Afghanistan
UNHAA	27/02/96	Weekly Update (no 157) Afghanistan
UNHAA-a	04/03/96	Humanitarian Assistance in Angola – week 6
UNHAA-a	11/03/96	Humanitarian Assistance in Angola – week 7
UNHAA-a	25/03/96	Humanitarian Assistance in Angola – week 9
UNHCR	1995	Food and Nutrition Situation at Myanmarese Refugee Camps in Bangladesh
UNHCR	01/03/96	Burundi Update (from Bujumbura)
UNHCR	Oct.95	Nutrition Survey – Pakistan (Afghan Refugees)
UNHCR	Feb.96	Appeal for the Repatriation and Reintegration of Liberian Refugees
UNHCR	02/01/96	Assessment of Refugee Settlements in Uganda
UNHCR	03/03/96	Statistiques situation nutritionnelle février 1996
UNHCR	04/04/96	Update on Mozambique
UNHCR	06/02/96	Food and Nutrition Situation Report: 1995 (Refugees in Bangladesh)
UNHCR	06/03/96	Nutrition Update – Burundi
UNHCR	06/03/96	Sitrep Eau, Assainissement, infrastructure février 1996
UNHCR	07/03/96	Update on camps in Burundi
UNHCR	10/01/96	Sitrep (Uganda)
UNHCR	12/02/96	Situation Report – Burkina Faso
UNHCR	12/04/95	Personal Communication – Monrovia
UNHCR	13/01/96	Rapport de Situation – Décembre 1995
UNHCR	14/03/96	Situation Report – Nepal
UNHCR	16/01/96	Situation Report – CAR
UNHCR	17/01/96	Situation Reports (Zaire)
UNHCR	19/03/96	Personal Communication – Iran, Pakistan, Nepal, Bangladesh
UNHCR	1995–7	Appeal for the Repatriation and Reintegration of Angolan Refugees
UNHCR	20/02/96	Update on Bangladesh
UNHCR	21/03/96	Update on Angular Stomatitis, Bangladesh
UNHCR	22/03/96	Personal Communication – Liberia/Sierra Leone Region
UNHCR	25/03/96	Personal Communication – Uganda
UNHCR	27/03/96	Personal Communication – Benin/Ghana/Togo Region
UNHCR	28/02/96	Updated Numbers in Great Lakes Region
UNHCR	29/02/96	Updated Numbers of Refugees in Uganda

UNHCR	Jan.96	Plan of Operations – Repatriation and Reintegration of Liberian Refugees
UNHCR–a	22/03/96	Personal Communication – Great Lakes Region
UNICEF	1995	Review of Operation Lifeline Sudan
USAID	01/03/96	Situation Report #2 – Angola
USAID	12/03/96	Burundi Complex Emergency Situation Report #2
USAID	18/03/96	Situation Report #1 Rwanda – Complex Emergency
USAID	20/02/96	Situation Report #2 – Sudan – Civil Strife/Displaced Persons
USAID	24/01/96	Fact Sheet #1 – Angola – Complex Emergency
WFP	01/03/96	Weekly Update
WFP	08/03/96	Weekly Update
WFP	12/04/96	Comments on Draft
WFP	15/03/96	Weekly Update
WFP	16/02/96	Weekly Update
WFP	16/02/96	Weekly Update
WFP	17/11/95	Weekly Update
WFP	22/03/96	Weekly Update
WFP	23/02/96	Weekly Update
WFP	28/03/96	Weekly Update
WHO	Mar.96	Report on Iraq

***Org**

ACF	Action Contre la Faim (formerly AICF)
AI	Amnesty International
BAAG	British Agencies Afghanistan Group
CONCERN	
DHA	Department of Humanitarian Affairs
FAO	Food & Agricultural Organization of the United Nations
GOAL	
ICRC	International Committee of Red Cross
IFRC	International Federation of Red Cross
IRIN	Integrated Regional Information Network
Min of Health	Ministerio da Saude, Republica de Mocambique
MSF–B	Medecins Sans Frontieres – Belgium
MSF–CIS	Medecins Sans Frontieres – Celula Inter–Seccoes
MSF–F	Medecins Sans Frontieres – France
MSF–H	Medecins Sans Frontieres – Holland
OLS	Operation Lifeline Sudan

SCF	Save the Children Fund
UCHAA-a	United Nations Humanitarian Assistance Coordination Unit (Angola)
UNHAA	United Nations Humanitarian Assistance for Afghanistan
UNHRCS	United Nations Humanitarian and Resident Coordinator for Somalia
UNECOSOC	United Nations Economic and Social Council
UNHCR	United Nation's High Commission on Refugees
UNICEF	United Nation's Children Fund
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision

LIST OF TABLES, FIGURES AND ANNEXES

Table 1. Information Available on Refugee/Displaced Populations (As of April 1996)

<i>Situation</i>	<i>Population Numbers</i>				<i>Total</i>	<i>Change from Feb. 96</i>	<i>Nutr Stat*</i>	<i>Comments</i>
	<i>Condition</i>							
	<i>I: High Prev</i>	<i>Ila: High Risk</i>	<i>Ilb: Mod Risk</i>	<i>Ilc: Not Critical</i>				
<i>Sub-Saharan Africa</i>								
<i>1. Angola (id/wa)</i>				<i>1'000'000</i>	<i>1'000'000</i>	<i>-400'000</i>	<i>imp</i>	<i>Decreased total number and improved nutritional slams largely due to improved harvest. Pockets of malnutrition an still being found in newly accessible areas.</i>
<i>2. Benin/Ghana/Togo Region</i>				<i>111'000</i>	<i>111'000</i>	<i>1'000</i>	<i>stat</i>	<i>Increased total due to improved estimate.</i>
<i>3. Burkina Faso/Mauritania</i>	<i>33'000</i>			<i>27'000</i>	<i>60'000</i>	<i>-8'000</i>	<i>stat</i>	<i>Decreased total due to repatriation.</i>

								<i>High levels of wasting continue to be recorded in Mauritania; nutritional situation is not improving.</i>
<i>4. Burundi /Rwanda Region</i>		<i>200'000</i>	<i>1'256'000</i>	<i>1'367'900</i>	<i>2'823'900</i>	<i>-50'100</i>	<i>stat</i>	<i>Decreased total due to some limited repatriation.</i>
<i>5. Central African Republic</i>				<i>32'000</i>	<i>32'000</i>	<i>-6'800</i>	<i>stat</i>	<i>Decrease in total due to a decreased estimate for Chadian refugees in CAR.</i>
<i>6. Djibouti</i>				<i>25'000</i>	<i>25'000</i>	<i>0</i>	<i>stat</i>	
<i>7. Ethiopia</i>	<i>81'000</i>		<i>173'000</i>	<i>122'000</i>	<i>376'000</i>	<i>0</i>	<i>stat</i>	<i>Nutritional risk based on most recent survey data (mid-1995).</i>
<i>8. Kenya</i>				<i>173'000</i>	<i>173'000</i>	<i>0</i>	<i>stat</i>	<i>A possible risk of scurvy exists for this population, and the situation needs to be monitored, especially in late summer and autumn when outbreaks have occurred in the past.</i>
<i>9. Liberia/Sierra Leone/ Guinea/Cote d'Ivoire</i>	<i>258'200</i>	<i>828'800</i>	<i>757'000</i>	<i>1'553'000</i>	<i>3'397'000</i>	<i>-43'000</i>	<i>stat/det</i>	<i>Decreased total due to the exclusion of some unassisted refugees in Guinea. Those in Sierra Leone are likely to be at heightened nutritional risk due to insecurity.</i>

10. Mauritania/Senegal					0	-52'000	stat	No longer receiving assistance. Will no longer be included in this table.
11. Mozambique Region		250'000		950'000	1'200'000	0	det	Displaced in Mutarara at high risk due to pellagra. More vulnerable people due to lower than expected harvests, and subsequent lack of food stocks.
12. Somalia	26'000		814'000		840'000	0	stat	Continued insecurity resulting in vulnerability
13. Sudan	119'000		1'854'000	200'000	2'173'000	-127'000	det	Decreased total due to revised number of internally displaced in camps around Khartoum. Those in the south and transitional zone may be at increasing risk due to poor harvests and constraints on OLS activities.
14. Uganda	77'000		137'600	12'400	227'000	5'000	det	Increase due to continued arrival of Sudanese refugees, deteriorating nutritional situation in Moyo, particularly in Adjumani camps, due largely to constraints on food

								deliveries.
15. Zaire	435'000			496'000	931'000	226'000	det/stat	Increased total due to inclusion of those in Masisi region, who are at high risk. For displaced torn Shaba in Mwene Ditu, nutritional status based on most recent survey data (end 1995). No indications of change.
16. Zambia				26'000	26'000	0	stat	
Total (Sub-Saharan Africa)	1'029'200	1'278'800	4'991'600	6'095'300	13'394'900	-454'900		
Asia (Selected Situations)								
17. Afghanistan Region			570'000	2'260'000	2'830'000	-270'000	stat	Decreased total due to the repatriation of refugees in Pakistan.
18. Bhutanese Refugees in Nepal				90'000	90'000	0	stat	Low levels of micronutrient deficiencies continue to be reported.
19. Bangladesh				50'000	50'000	0	imp	Decreasing prevalence of riboflavin deficiency (angular stomatitis).
20. Southern Iraq		192'000		28'000	220'000	0	det	Those in Marshes considered at high risk.

I: High Prev – Those reported with high prevalences of malnutrition and/or micronutrient deficiency diseases and sharply elevated mortality rates (at least 3x normal).

Ila: High Risk – At high nutritional risk, limited data available, population likely to contain pockets of malnutrition.

Ilb: Mod Risk – Moderate risk, may be data available, pockets of malnutrition may exist.

IIc: Not Critical – Probably not at heightened nutritional risk.

III: Unknown – No information on nutritional status available.

** Indicates status of nutritional situation. Imp = improving; det = deteriorating; stat = static (i.e. no change).*

Table 2. Summary of Origin and Location of Major Populations of Refugees, Returnees and Displaced People in Africa – April 1996 – RNIS #15 (Population Estimates in Thousands)

<i>From</i>	<i>Angola</i>	<i>Benin</i>	<i>Burkina Faso</i>	<i>Burundi</i>	<i>Cote d'Ivoire</i>	<i>Eritrea</i>	<i>Ethiopia</i>	<i>Ghana</i>	<i>Guinea</i>	<i>Kenya</i>	<i>Liberia</i>
<i>Angola</i>	1'000										
<i>Benin</i>											
<i>Burkina Faso</i>											
<i>Burundi</i>				200							
<i>Cote d'Ivoire</i>											
<i>Eritrea</i>											
<i>Ethiopia</i>							11			6	
<i>Ghana</i>											
<i>Guinea</i>											
<i>Kenya</i>							9				
<i>Liberia</i>					305			14	408		1'700
<i>Mali</i>			27								
<i>Mauritania</i>											
<i>Mozambique</i>											
<i>Rwanda</i>				90							
<i>Sierra Leone</i>									128		100
<i>Somalia</i>							275			126	
<i>Sudan</i>							63			41	
<i>Tanzania</i>											
<i>Togo</i>		20						71			
<i>Uganda</i>											
<i>Zaire</i>											
<i>Zambia</i>											
TOTAL	1'000	20	27	290	305	0	358	85	536	173	1'800

NOTES: (1) This chart is intended to include major population groups in Africa (i.e. over 100,000 people affected from country of origin).

(2) Boxes on the diagonal (shaded) show internally displaced populations (total = 9.2 million).

(3) Numbers referred to in the text are usually by the country where the population is located (i.e. column totals).

For the regional situations of Burundi/Rwanda and Liberia/Sierra Leone the description is by country of origin (i.e. row totals).

Figure 1. Refugee and Displaced Populations – Selected Areas in Africa (April 1996)

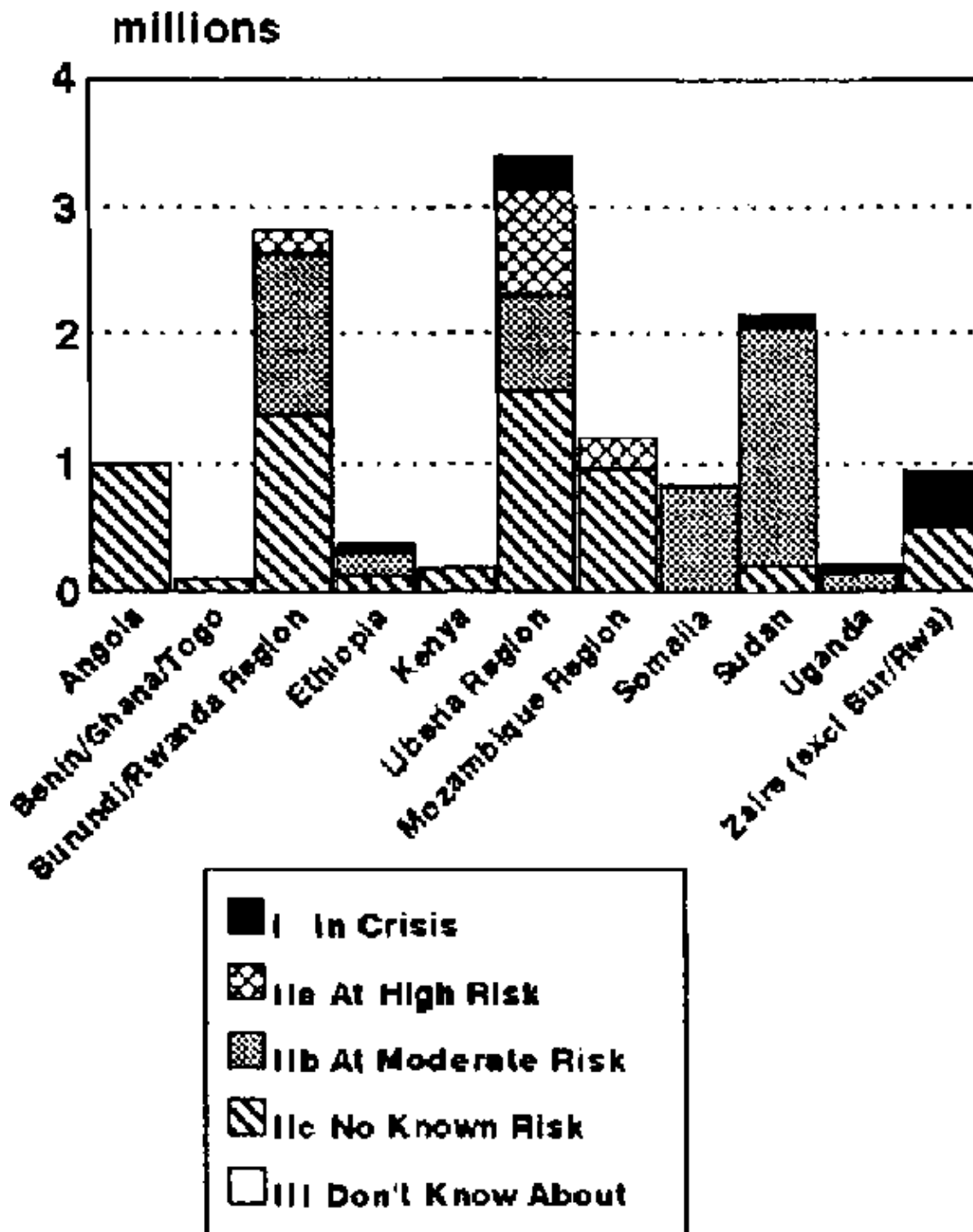


Figure 1. REFUGEE AND DISPLACED POPULATIONS – Selected Areas in Africa (April 1996)

Figure 2. Trends in Total Refugee/Displaced Populations by Risk Categories – Africa: December 1993–April 1996

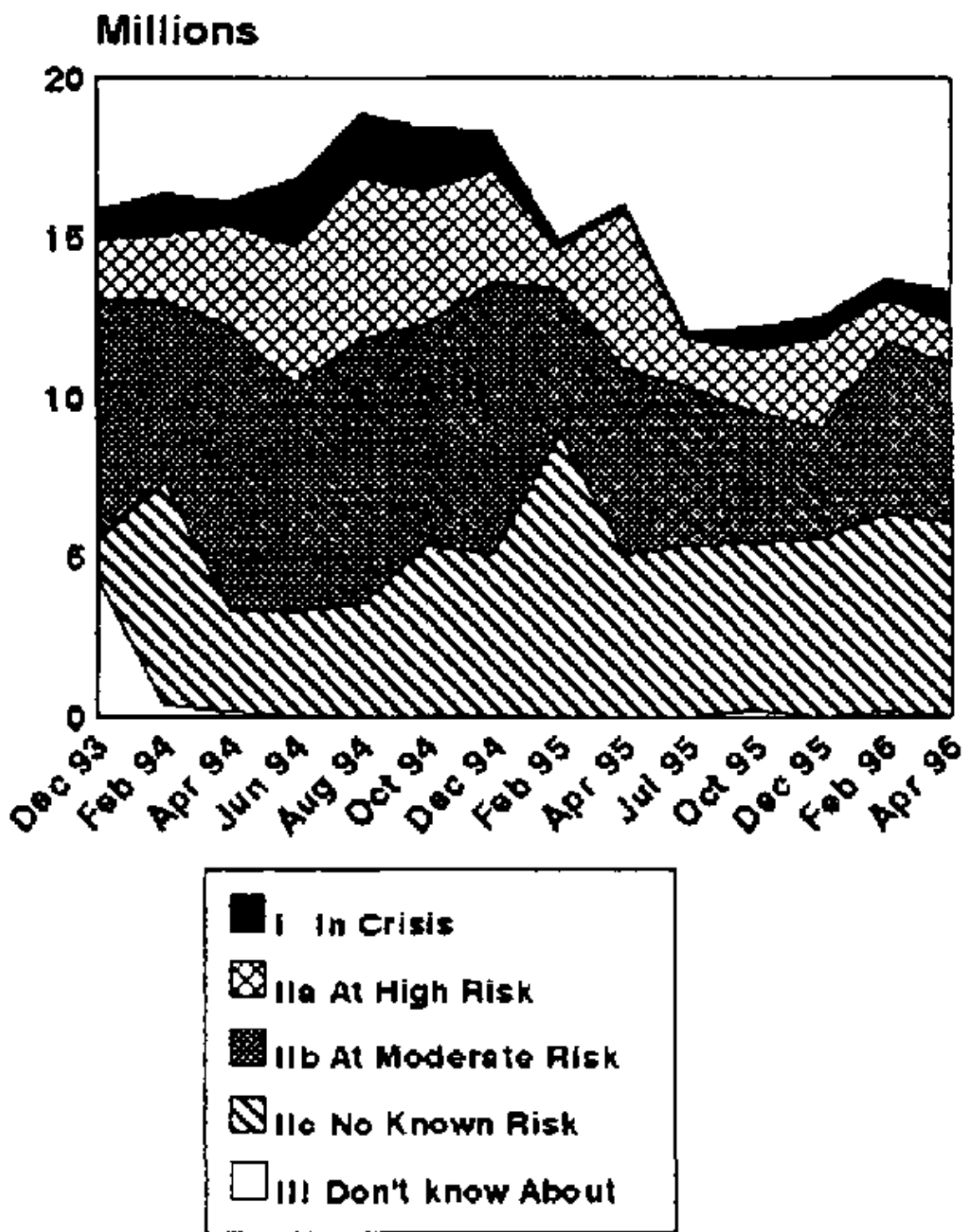
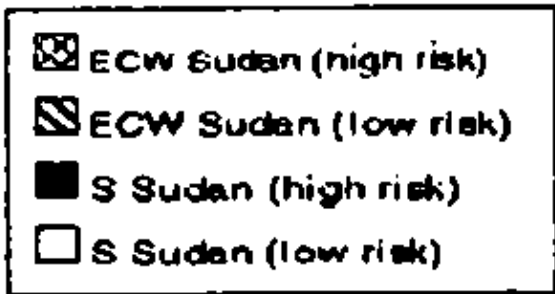
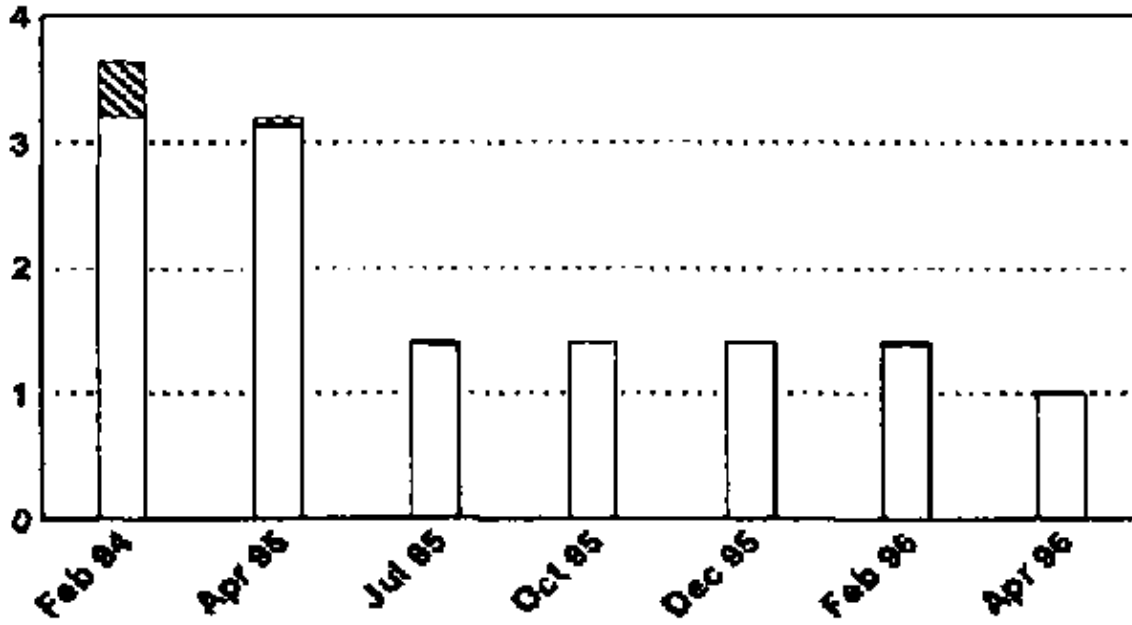


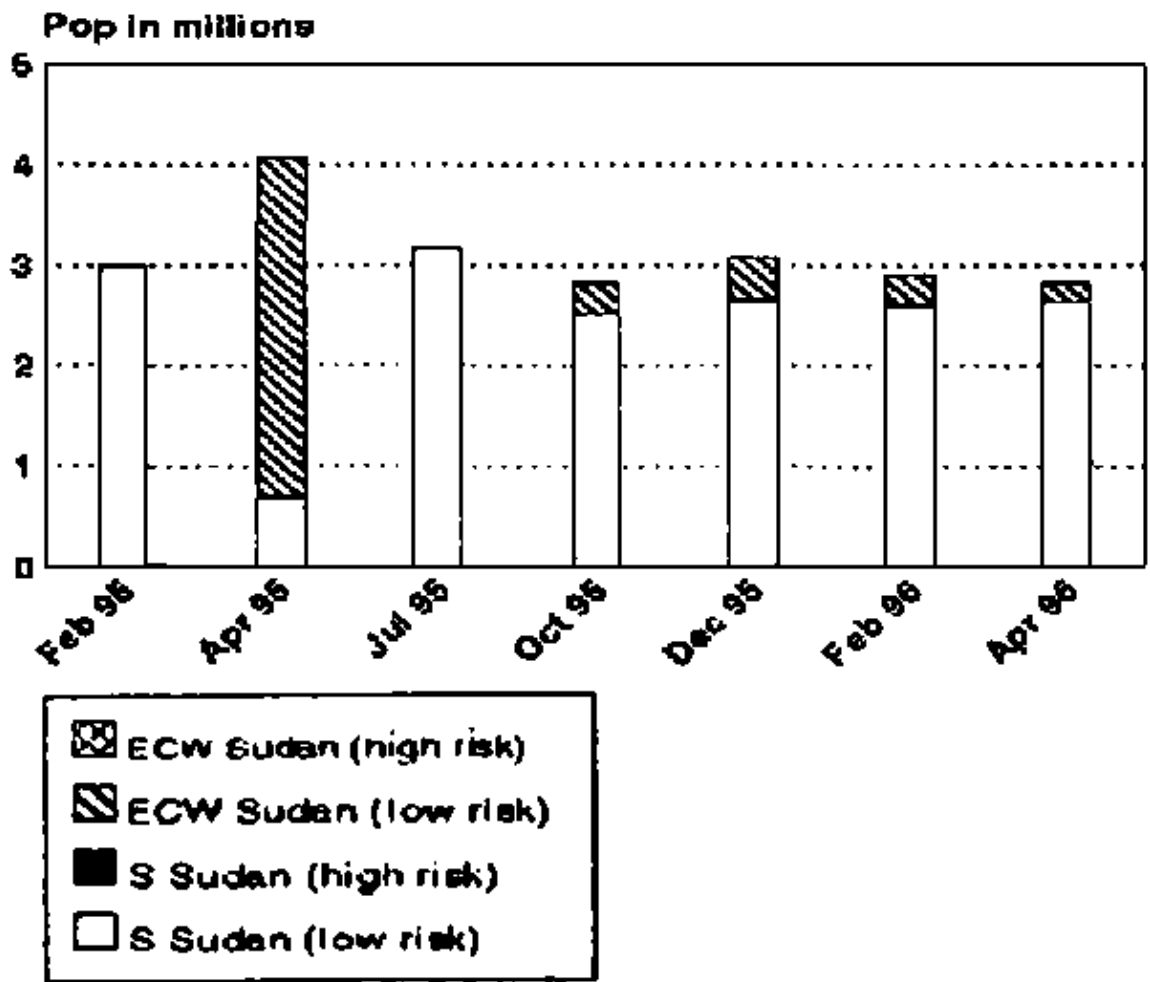
Figure 2. Trends in Total Refugee/Displaced Populations By Risk Categories – Africa: December 1993–April 1996

Figure 3. Shaded Areas Indicate those at Heightened Nutritional Risk Categories I and IIa in Table 1)

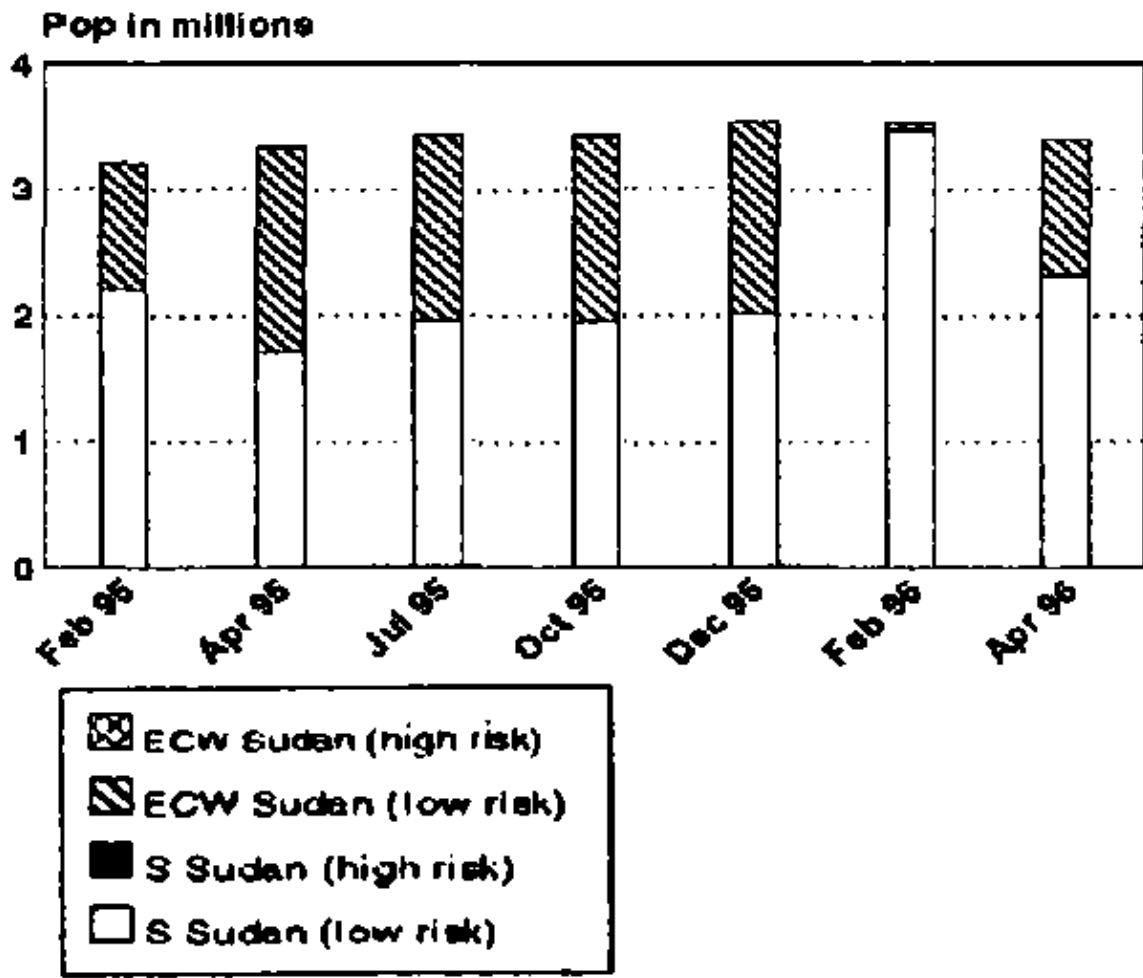
Pop In millions



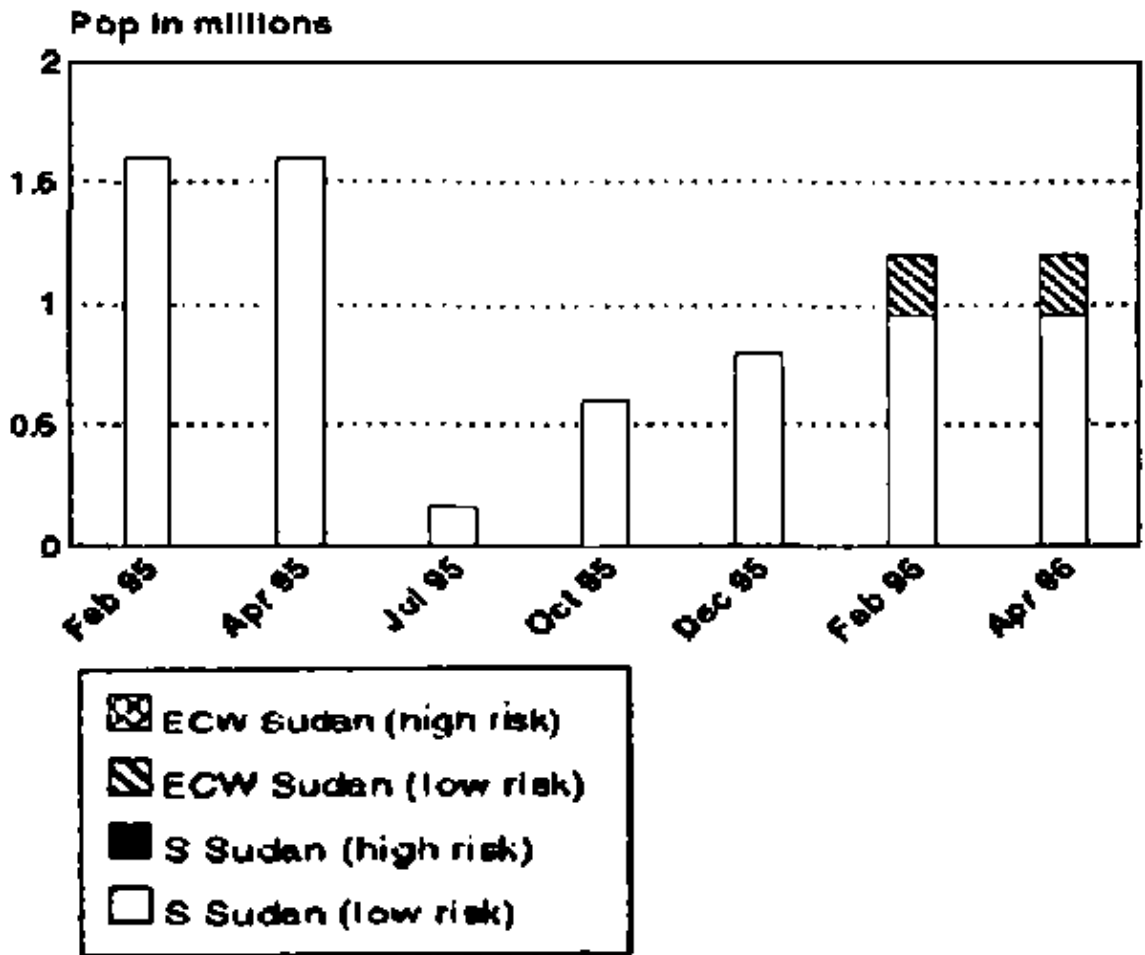
Angola



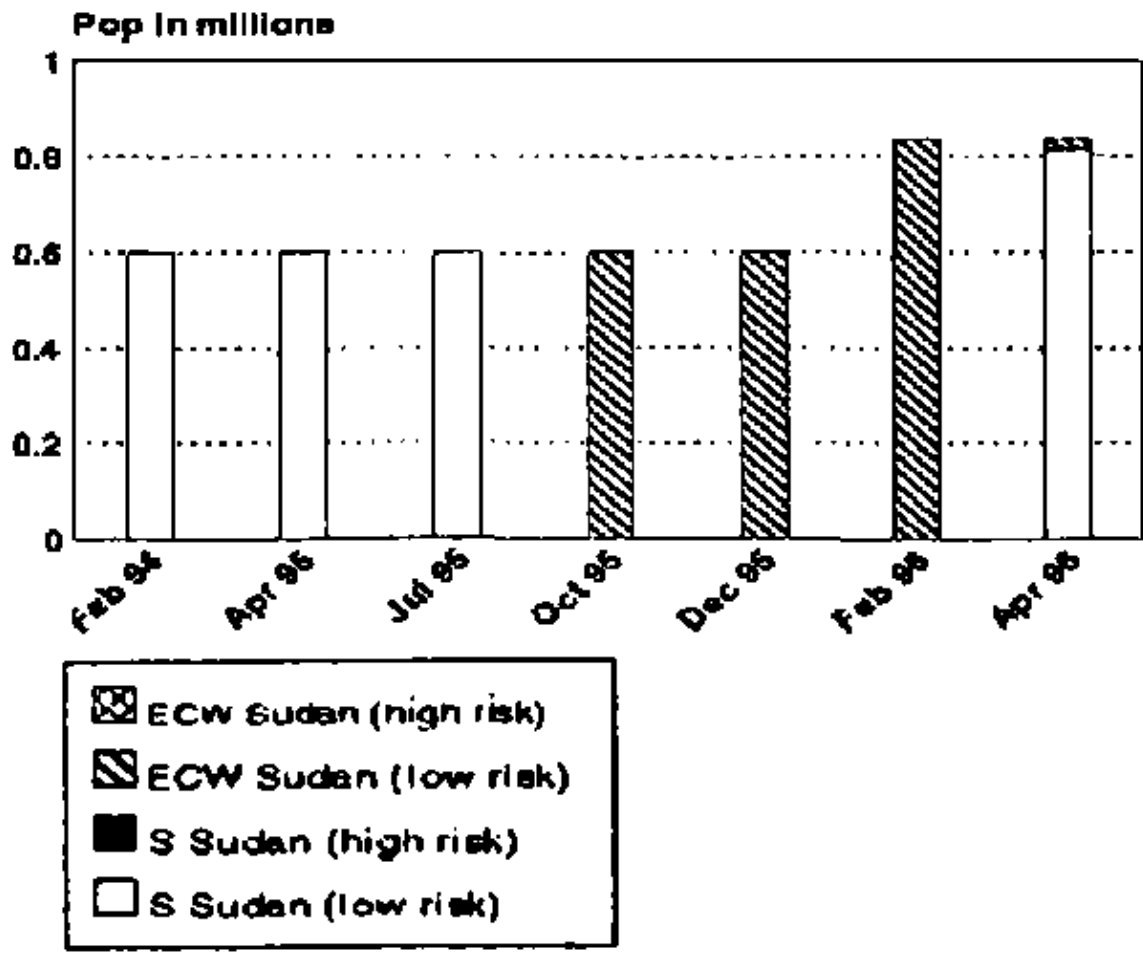
Burundi/Rwanda Region



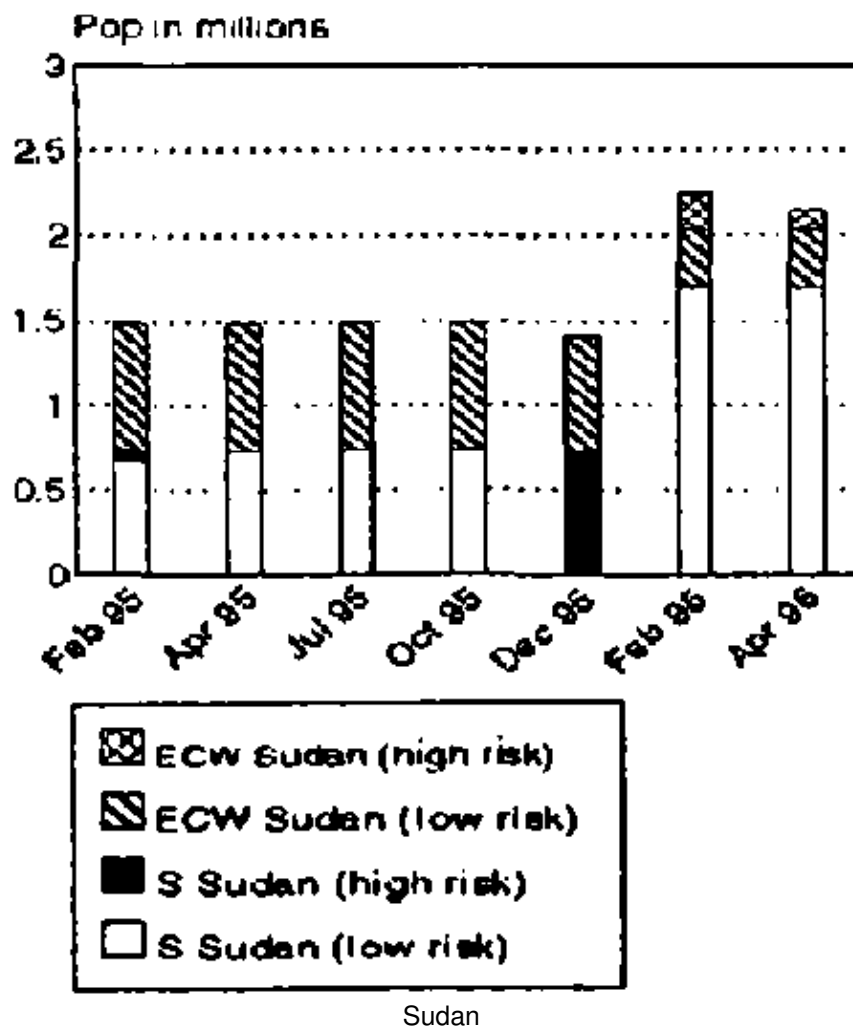
Liberia/Sierra Leone



Mozambique



Somalia



Annex I. Results of Surveys Quoted in April RNIS Report (# 15) – Usually Children 6–59 Months

Survey Area	Survey Conducted by	Date	% Wasted*	% Severely Wasted*	Oedema (%)	Crude Mortality (/10,000/day)	Under 5 Mortality (/10,000/day)	Me Immu Cov
1. Angola								
a. Moxico Province	MSF-B	Feb.96	6.0**	1.4**				
b. Gonguembo, Kwanza None Province	ACF	Feb.96	7.0**	1.0**				
c. N'Dalatando	WV	Feb.96	5.0**	2.2**				
d. Lucala	WV	Feb.96	17.1**	6.1**				
e. Calandula, Malange Province	MSF-H	Feb.96	9.0**	3.1**				
f. Menongue	CARE	Feb.96	9.3**	3.1**				
3. Mauritania								
a. Malian Refugees	MSF-F/MDM	Mar.96	14.6	1.4	1.6	0.93	2.3	

4. Burundi/Rwanda Region								
<i>a. Rukuramigabo Camp, Kirundo</i>	IHA	Feb.96	1.7**	0.2**				
<i>b. Ngozi Province, Burundi</i>	ACF	Dec.95	9.3	1.2	1.8			
<i>c. Kagenyi, Karagwe, Tanzania</i>	MSF-CH	Feb.96				0.81	1.4	
<i>d. Rubwera, Karagwe, Tanzania</i>	MSF-CH	Feb.96				0.28	0.7	
9. Liberia Region								
<i>a. Buchanan (Liberia)</i>	ACF	Feb.96	4.1	0.6	0.5	3	5	53.7
<i>b. Bong, Liberia</i>	ACF	Feb.96	5.1	0.4	0.9	5.5	8.5	6.2
<i>c. Bo Town (Sierra Leone)</i>	ACF	Nov.95	13.1**	1.2**				
<i>d. Bo, Displaced Camps (Sierra Leone)</i>	ACF	Nov.95	25.3**	4.3**				
<i>e. Bo Town (Sierra Leone)</i>	MSF-B	Mar.96	12.1**	1.2**				
<i>f. Bo Displaced Camps (Sierra Leone)</i>	MSF-B	Mar.96	23.8**	3.5**				
<i>g. Kenema Town</i>	MSF-H	Feb.96	6.3**	1.0**				
<i>h. RTI Camp (near Kenema)</i>	MSF-H	Feb.96	8.6	0.2	0.0			
12. Somalia								
<i>a. Northern Mogadishu (Displaced)</i>	MSF-S	Mar.96	2.1**					
14. Uganda								
<i>a. Adjumani, Moyo District (Transit Centres)</i>	MSF-CH	Feb.96	11.8**	2.0**				100.0
<i>b. Adjumani, Moyo District (Settlements)</i>	MSF-CH	Feb.96	16.4**	5.0**				100.0
15. Zaire								

<i>a. Masisi Region</i>	MSF-H	Jan.96	31.0**	13.0**				
17. Afghanistan Region								
<i>a. NWFP, Pakistan</i>	UNHCR	Oct.95	5.3	1.1				
<i>b. Punjab, Pakistan</i>	UNHCR	Oct.95	2.7	0.7				
<i>c. Balochistan, Pakistan</i>	UNHCR	Oct. 95	6.0	0.9				
19. Refugees in Bangladesh								
<i>a. All Camps</i>	UNHCR	1995	9.5					

* wt/ht unless specified; cut-off = n.s. means not specified but usually -2SD wt/ht for wasting and -3SD wt/ht for severe wasting

** Oedema is included in this figure.

NOTE: see box on pg 4 for guidance in interpretation of indicators.

NOTES on Annex I

1. Angola

a. This survey was carried out by MSF-Belgium in Moxico Province. No further details are currently available.

b. This survey was carried out in Gonguembo, Kwanza Norte Province by Action Contre la Faim (ACF). No further details are currently available.

c. This survey was carried out by World Vision in N'Dalatando. No further details are currently available.

d. This survey was carried out by World Vision in Lucala. No further details are currently available.

e. This survey was conducted by MSF-Holland in Calandula, Malange Province. No further details are currently available.

f. This survey was conducted by CARE in Menongue. No further details are currently available.

3. Burkina Faso/Mauritania

a. This survey was carried out jointly by MSF-France and Médecins du Monde in the camps for Malian refugees in Mauritania in early March 1996. It was a cluster survey that included 909 children 6-59 months old. Wasting was defined as wt/ht <-2sd and severe wasting wt/ht <-3sd. Oedema was recorded separately.

4. Burundi/Rwanda (Great Lakes) Region

a. This survey was carried out by IHT in December 1995 in Rukuramigabo Camp, Kirundo (Burundi). No further details are currently available.

b. This survey was carried out by Action Contre la Faim (ACF) in Ngozi Province, Burundi in December 1995. It was a two-stage cluster survey which included 1043 children 6–59 months old. Wasting was defined as wt/ht <–2sd and severe wasting <–3sd. Oedema was recorded separately.

c–d. This information comes from a MSF–CH (Switzerland) Activity Report.

9. Liberia/Sierra Leone Region

a. This survey was carried out by Action Contre la Faim (ACF) in Buchanan County, Liberia in February 1996. It was a two stage cluster sample survey which included 935 children 6–59 months old. Wasting was defined as wt/ht <–2sd and severe wasting <–3sd. Oedema was recorded separately.

b. This survey was carried out by Action Contre la Faim (ACF) from 20–22 February 1996 in Bong County, Liberia. It was a two stage cluster sample survey which included 955 children 6–59 months old. Wasting was defined as wt/ht <–2sd and severe wasting <–3sd. Oedema was recorded separately.

c–d. These surveys were carried out by Action Contre la Faim (ACF) in November 1995 in Bo Town, and Bo Camps for Displaced People. It was a cluster survey that included 891 children 6–59 months old in Bo Town, and 884 children 6–59 months old in the camps. Wasting was defined as wt/ht <–2sd and severe wasting <–3sd. Oedema was recorded separately.

e–f. These surveys were carried out by MSF–Belgium and Action Contre la Faim (ACF) jointly in January 1996 in Bo Town, and in the camps for displaced people. Results were expressed as wt/ht <–2sd and/or oedema, and wt/ht <–3sd and/or oedema.

g–h. These surveys were carried out by MSF–Holland in Kenema town, and RTI camp outside of Kenema in February 1996. This was a systematic sample survey on children 6–59 months old. 587 children were included in the survey in Kenema, and 463 in the survey in RTI camp. Wasting was defined as wt/ht <–2sd and severe wasting <–3sd; oedema was included in the total figure (wasting and/or oedema).

12. Somalia

a. This survey was conducted by MSF–Spain in the camps for displaced people in Northern Mogadishu. No further details are currently available.

14. Uganda

a–b. These surveys were carried out from 12–13 February 1996 by MSF–Switzerland in the transit centres and settlements in Adjumani, East Moyo District. These were two stage random cluster sample surveys and 632 children 6–59 months old were surveyed from the transit camps, and 603 children 6–59 months old from the settlements. Results were expressed as wt/ht <–2sd and/or oedema, and wt/ht <–3sd and/or oedema.

15. Zaire

a. This survey was carried out by MSF–Holland on 26 January 1996, wasting was defined as wt/ht <–2sd and/or oedema, and severe wasting was <–3sd and/or oedema.

17. Afghanistan Region

a–c. These surveys were conducted in October 1995 by UN High Commissioner for Refugees in three areas of refugee concentration in Pakistan. These were cluster sample surveys, and children 6 months to less than five years old were included (49–105 cms). In Balochistan, the sample size was 2513 children; in NWFP it was 2449 children; and in Punjab it was 2434 children. Wasting was defined as wt/ht <–2sd and severe wasting <–3sd.

19. Refugees in Bangladesh

a. This was a review of the health and nutrition situation for these refugees. Wasting was defined as wt/ht < -2sd.

Annex II. Seasonality

Seasonality in Sub-Saharan Africa*	
Country	Climate/Rainy Season/Harvest
<i>Angola</i>	Coastal area desert, SW semi-arid, rest of country: rains Sept–April
<i>Burundi</i>	Three crop seasons: Sept–Jan, Feb–Jun, and Jul–Aug
<i>CAR</i>	Rains March–Nov
<i>Djibouti</i>	Arid Climate
<i>Ethiopia</i>	Two rainy seasons February to May and June to October
<i>Kenya</i>	N–E is semi-arid to arid, Central and SW rains: March–May and Nov–Dec
<i>Liberia</i>	Rains March–Nov
<i>Mozambique</i>	Coast is semi-arid, rest wet–dry. Harvest May
<i>Rwanda</i>	Rains Feb–May with Aug harvest and Sept–Nov with Jan harvest
<i>Sierra Leone</i>	Rains March–Oct.
<i>Somalia</i>	Two seasons: April to August (harvest) and October to January/February (harvest)
<i>Sudan</i>	Rains April–Oct
<i>Northern</i>	Rains begin May/June
<i>Southern</i>	Rains begin March/April
<i>Togo</i>	Two rainy seasons in S, one in N. Harvest August
<i>Uganda</i>	Rains Mar–Oct
<i>Zaire</i>	Tropical climate. Harvest in N: November; in S January
* SOURCES: FAO, “Food Supply Situation and Crop Prospects in Sub-Saharan Africa”, Special Report; No 4/5, Dec. 90 plus various FAO/WFP Crop and Food Supply Assessment Missions.	

LIST OF MAPS

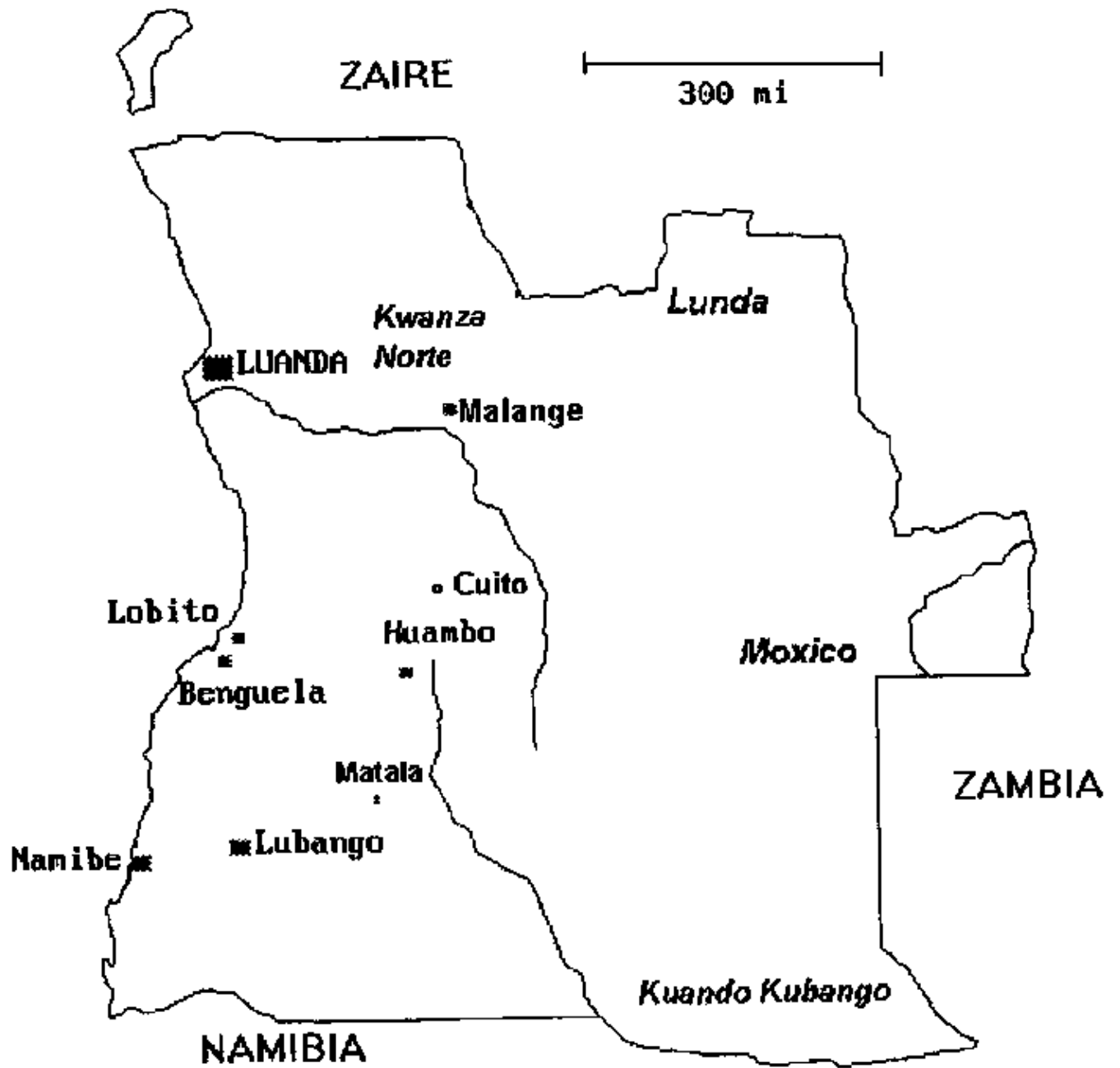
Map A. Situational Map



Map A. Situational Map

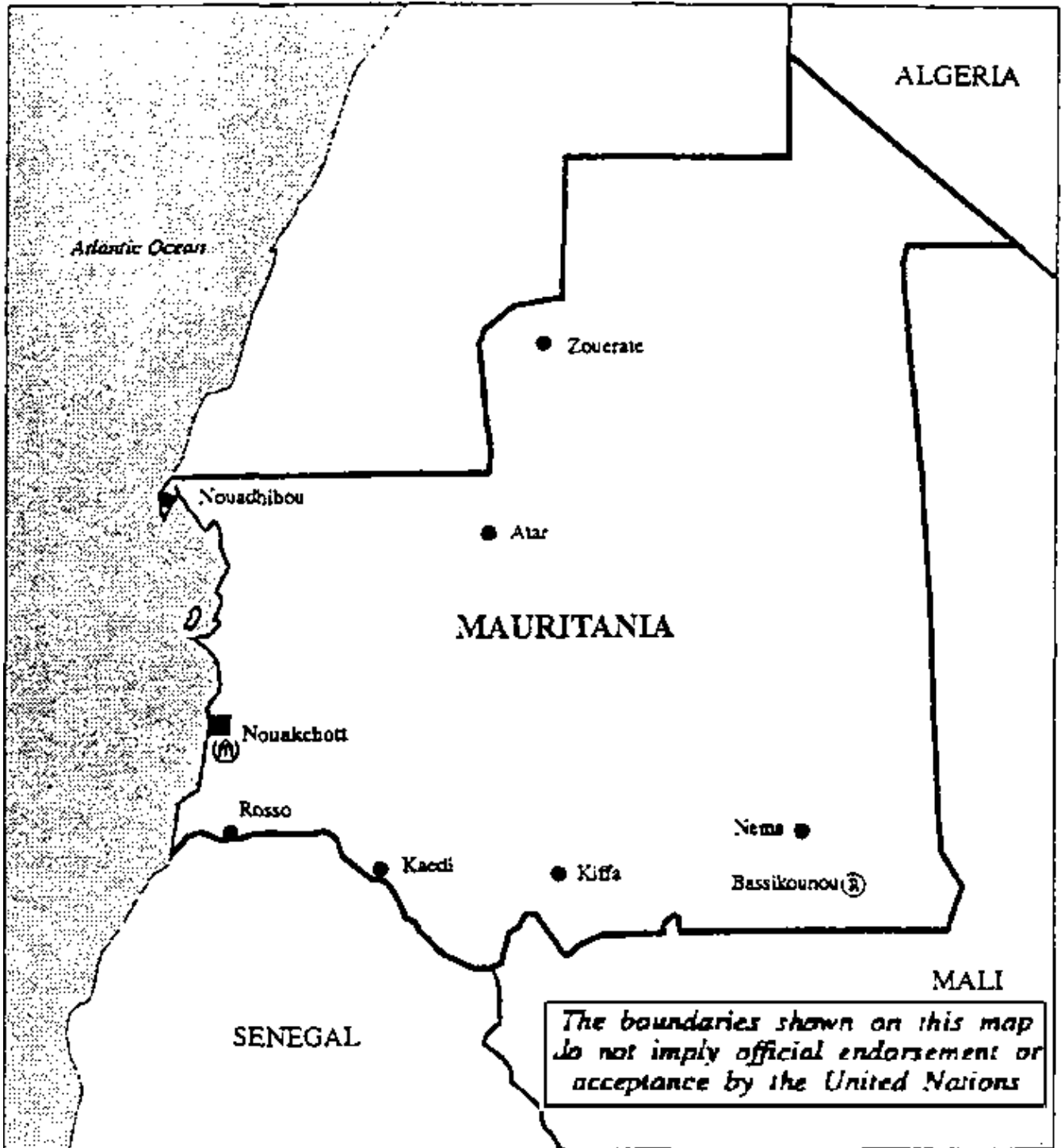
1. Angola
2. Benin/Ghana/Togo
3. Burkina Faso
4. Burundi/Rwanda
5. Central African Republic
6. Djibouti
7. Ethiopia
8. Kenya
9. Liberia/Sierra Leone
10. Mauritania
11. Mozambique
12. Somalia
13. Sudan
14. Uganda
15. Zaire
16. Zambia

Map 1. Angola



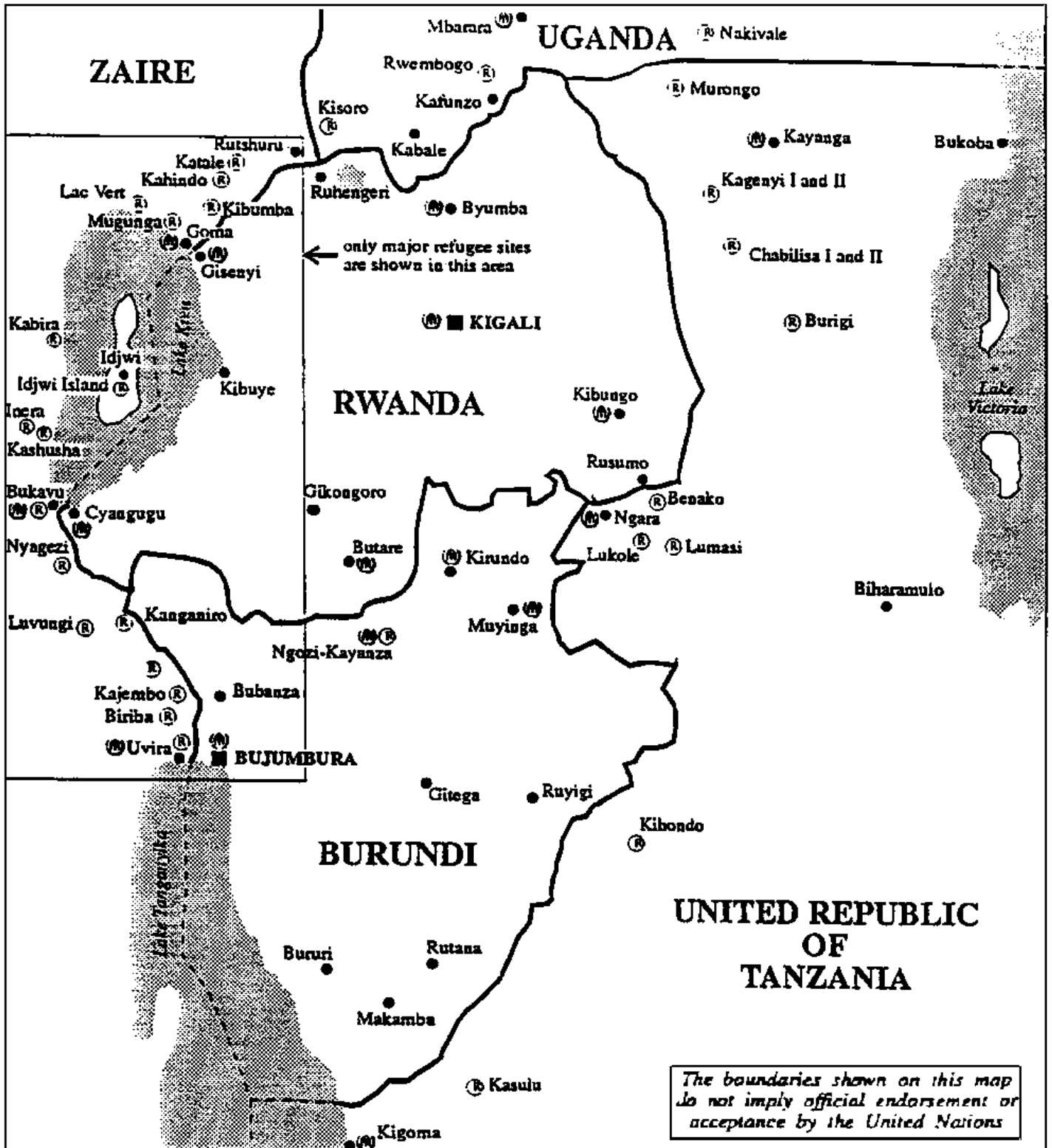
Map 1. Angola

Map 3. Mauritania



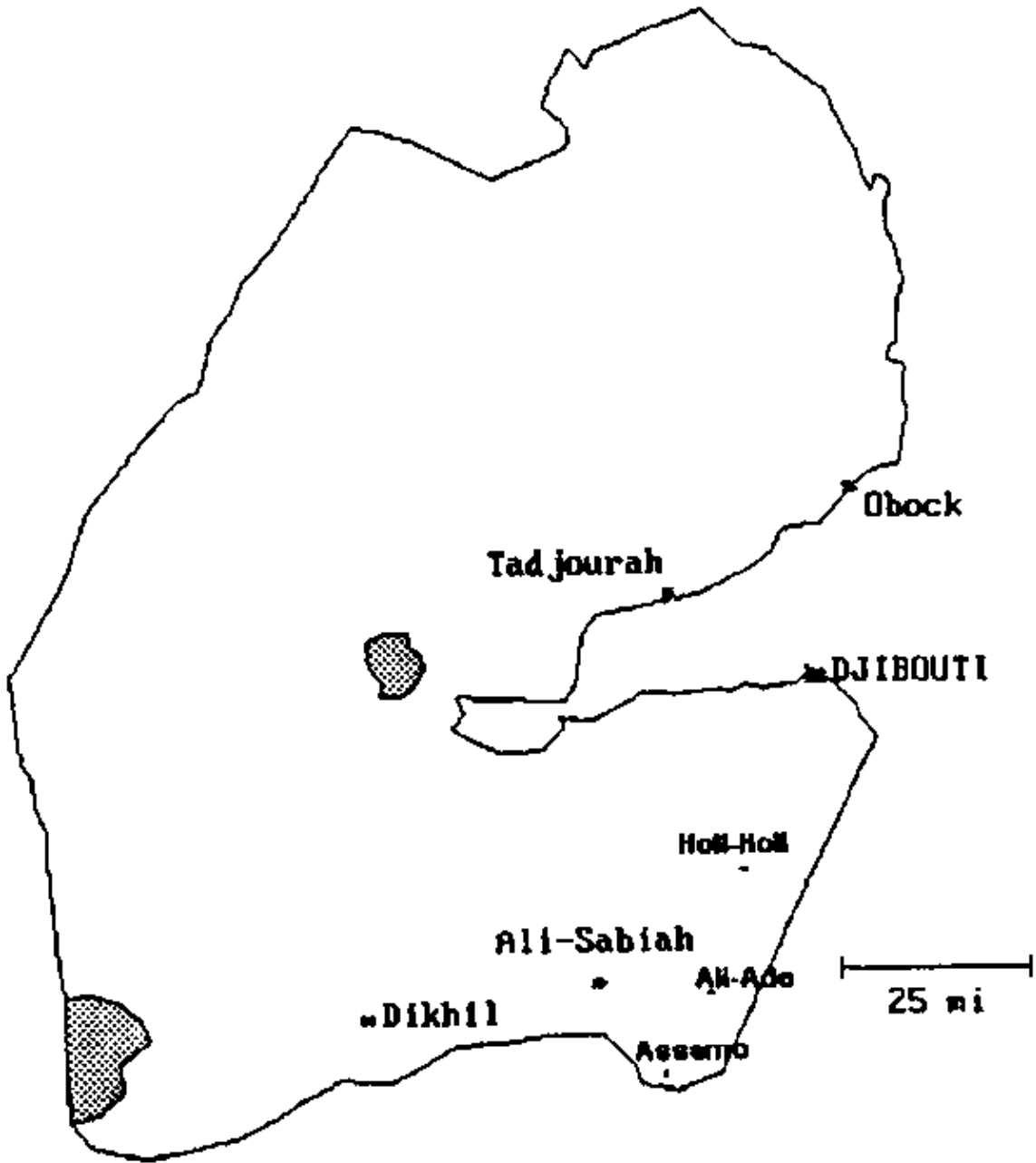
Map 3. Mauritania

Map 4. Burundi/Rwanda Region



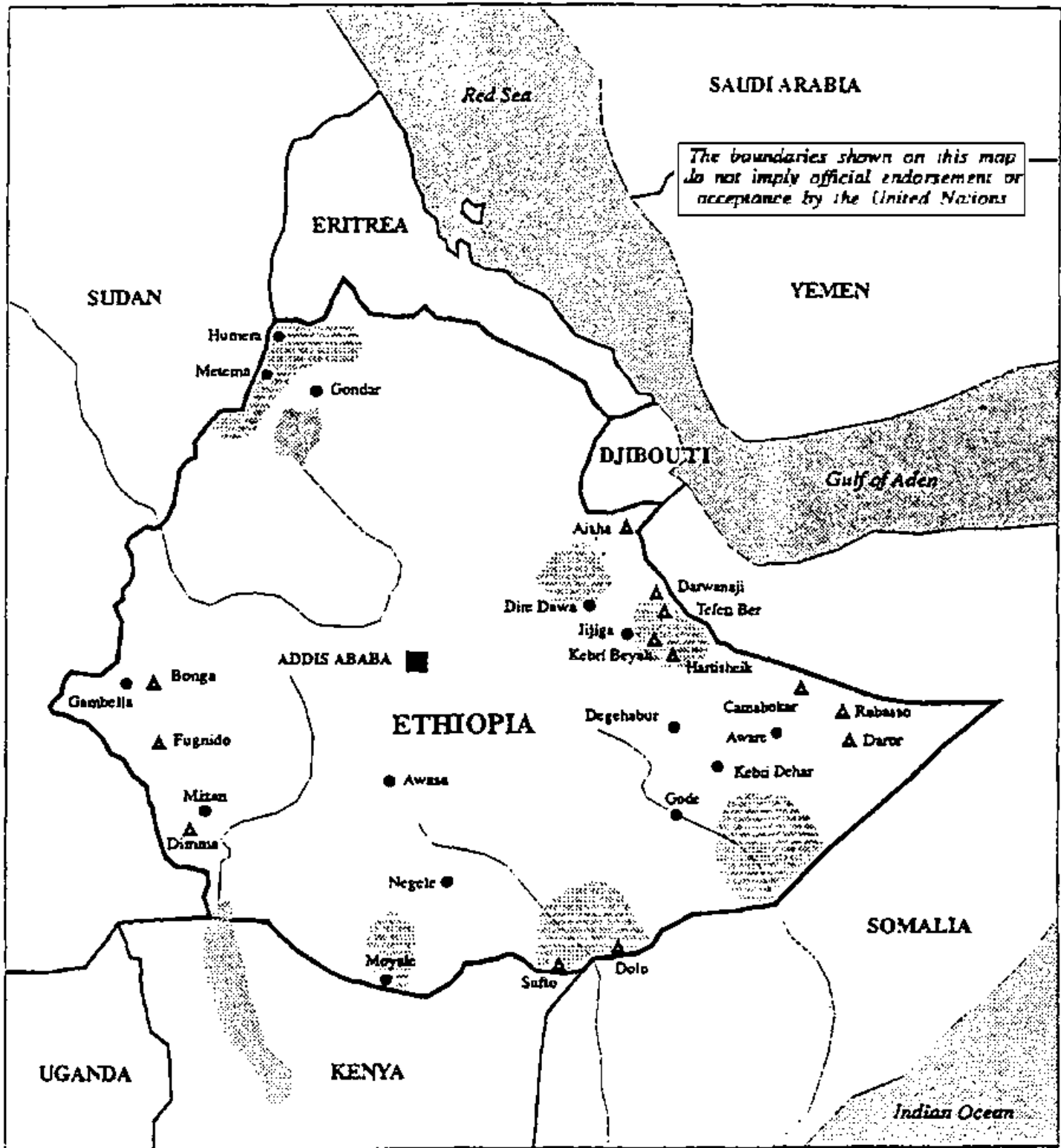
Map 4. Burundi/Rwanda Region

Map 6. Djibouti



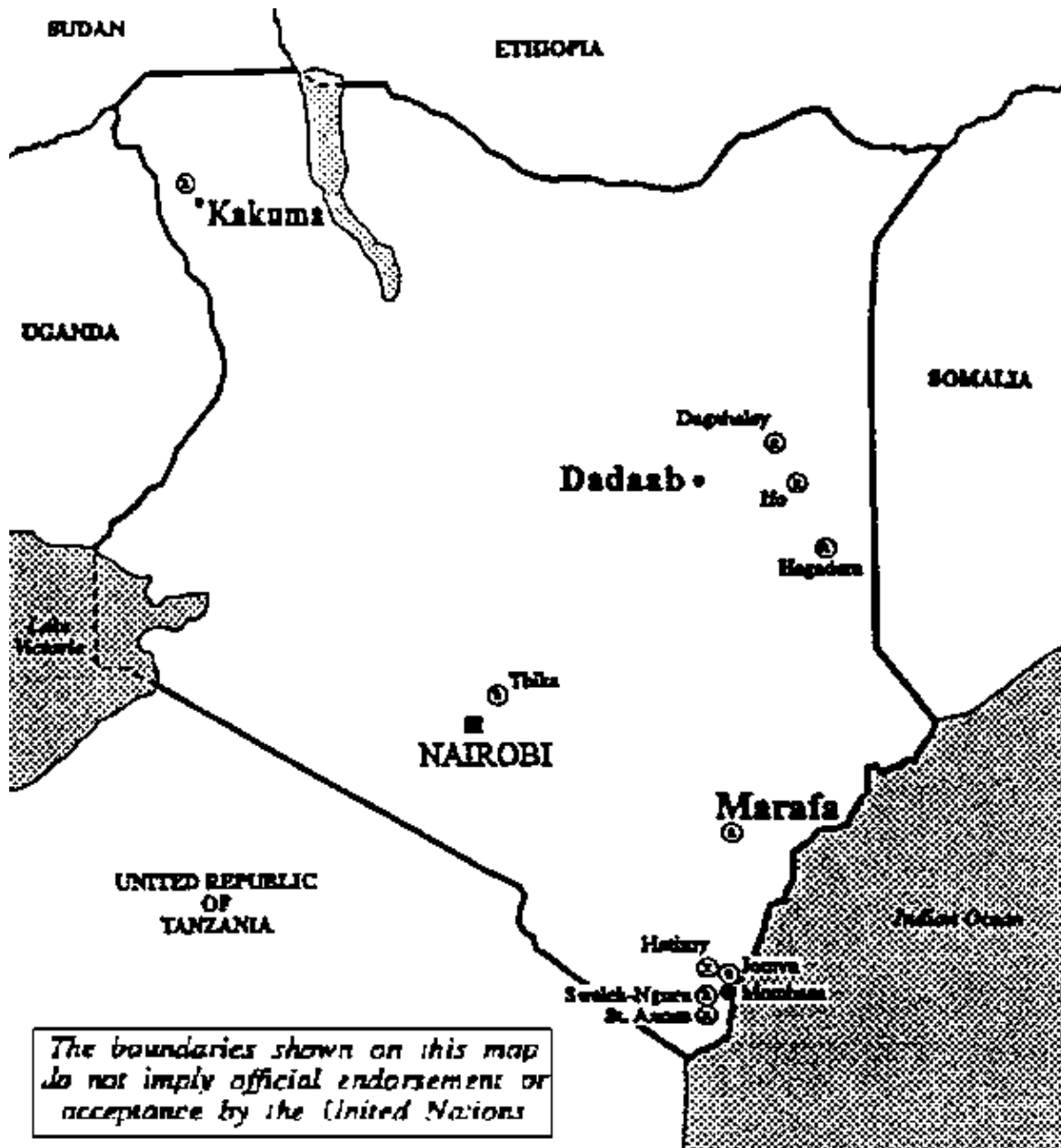
Map 6. Djibouti

Map 7. Ethiopia



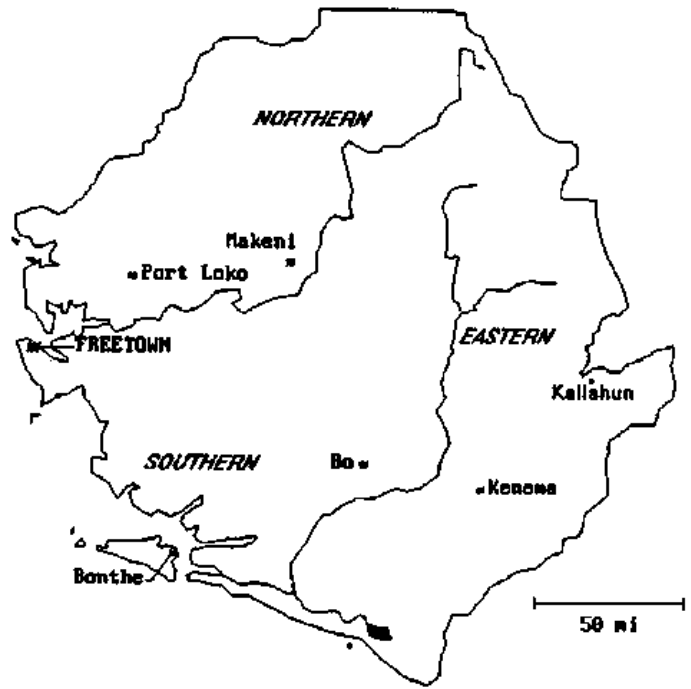
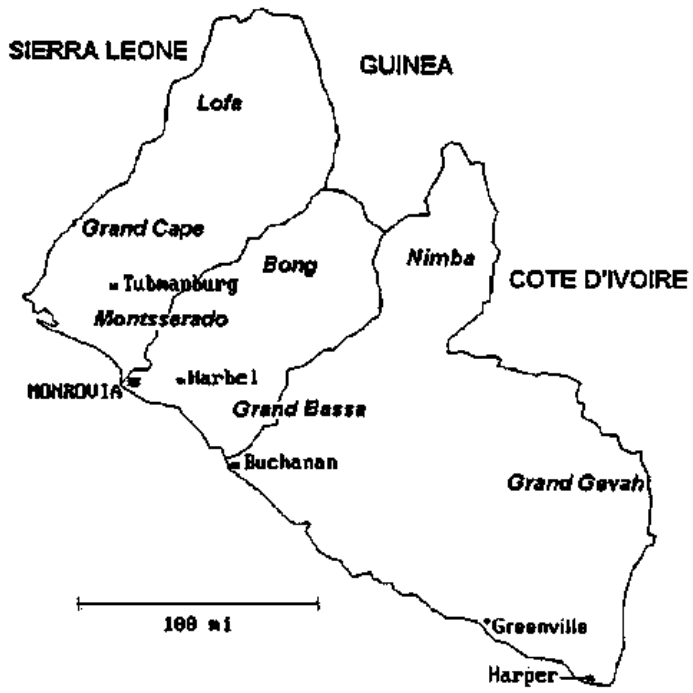
Map 7. Ethiopia

Map 8. Kenya



Map 8. Kenya

Map 9a,b. Liberia/Sierra Leone



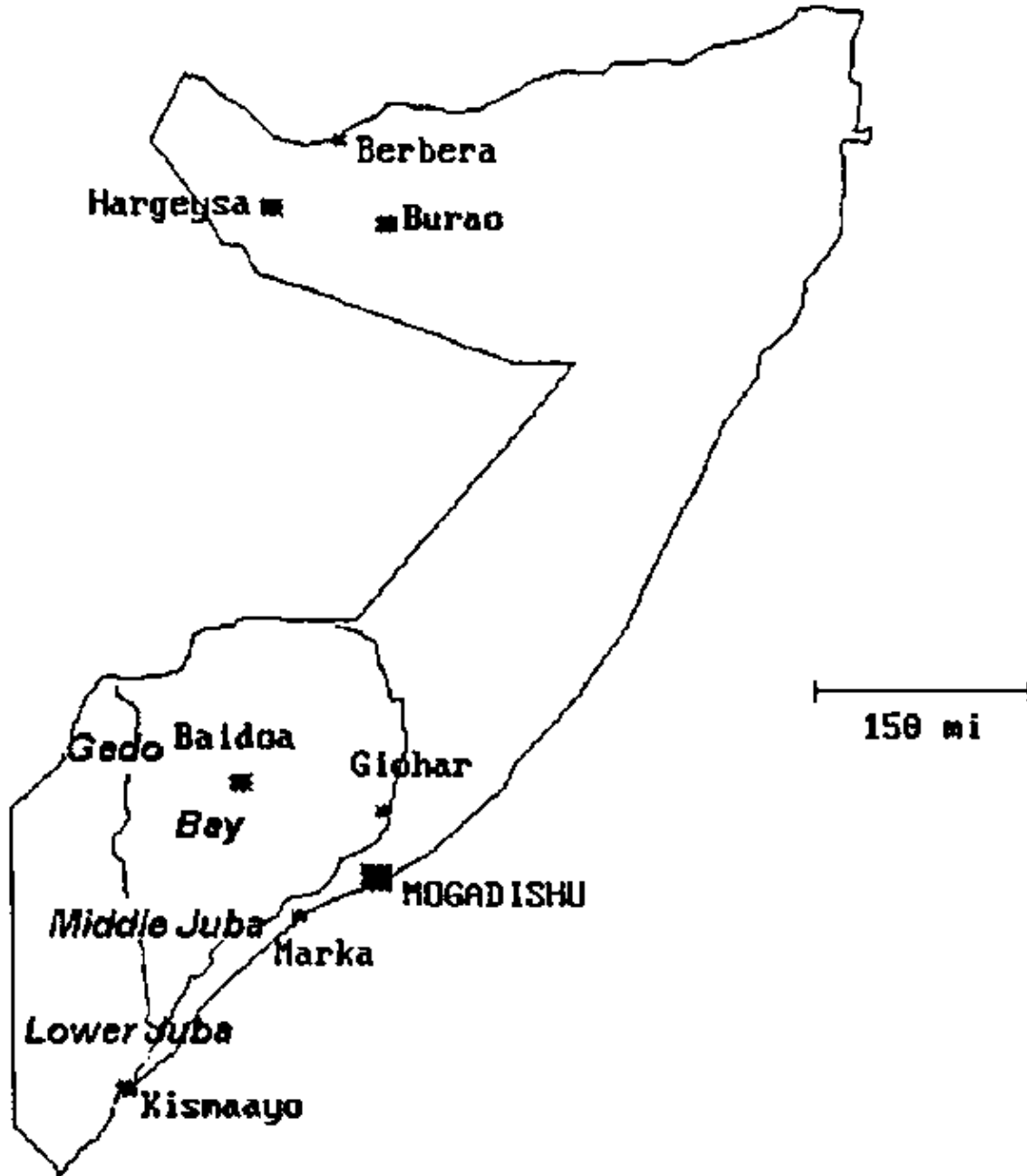
Map 9a,b. Liberia/Sierra Leone

Map 11. Mozambique

Map 11. Mozambique

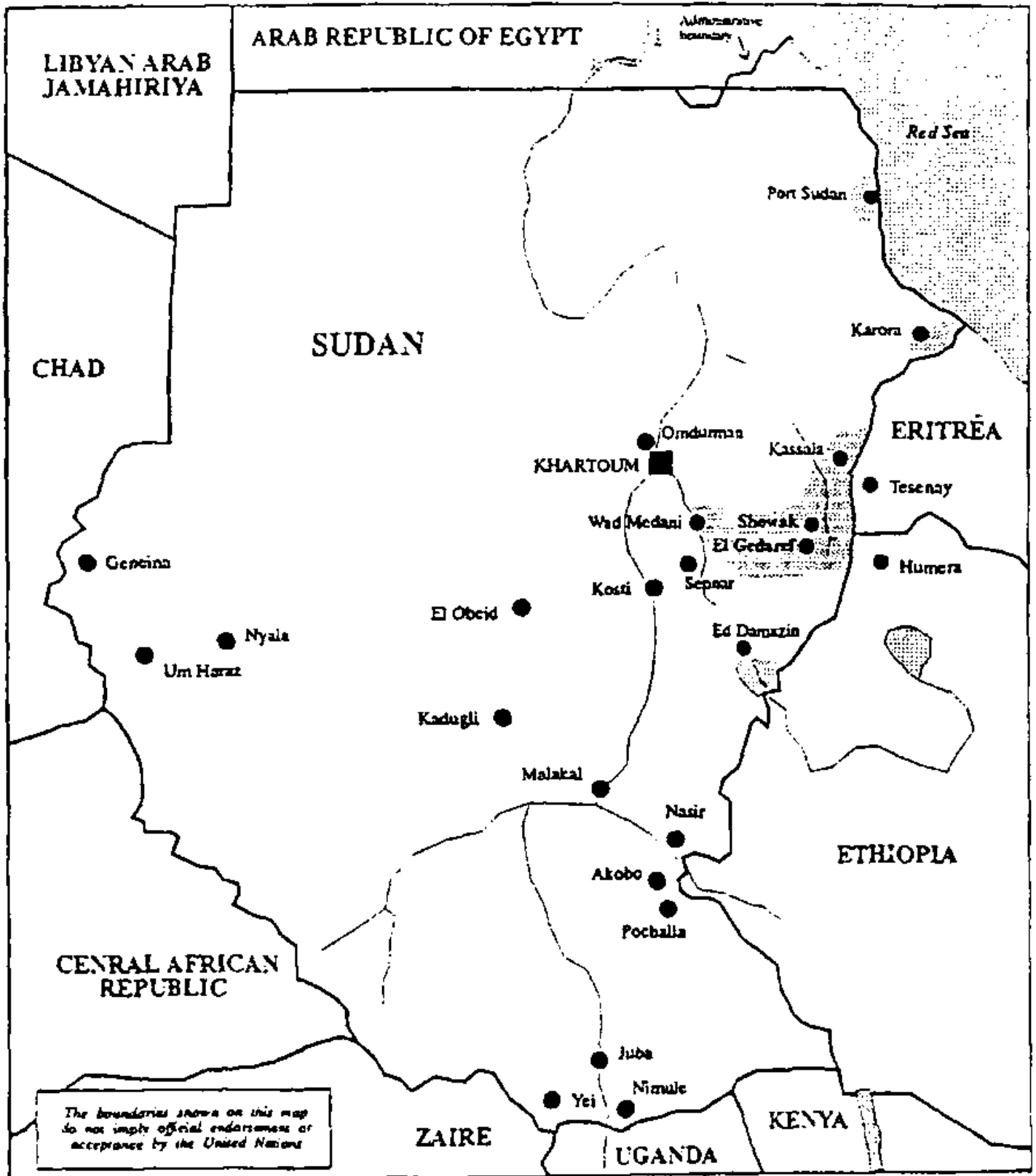
Map taken from MSF-CIS Bi-Monthly Bulletin

Map 12. Somalia



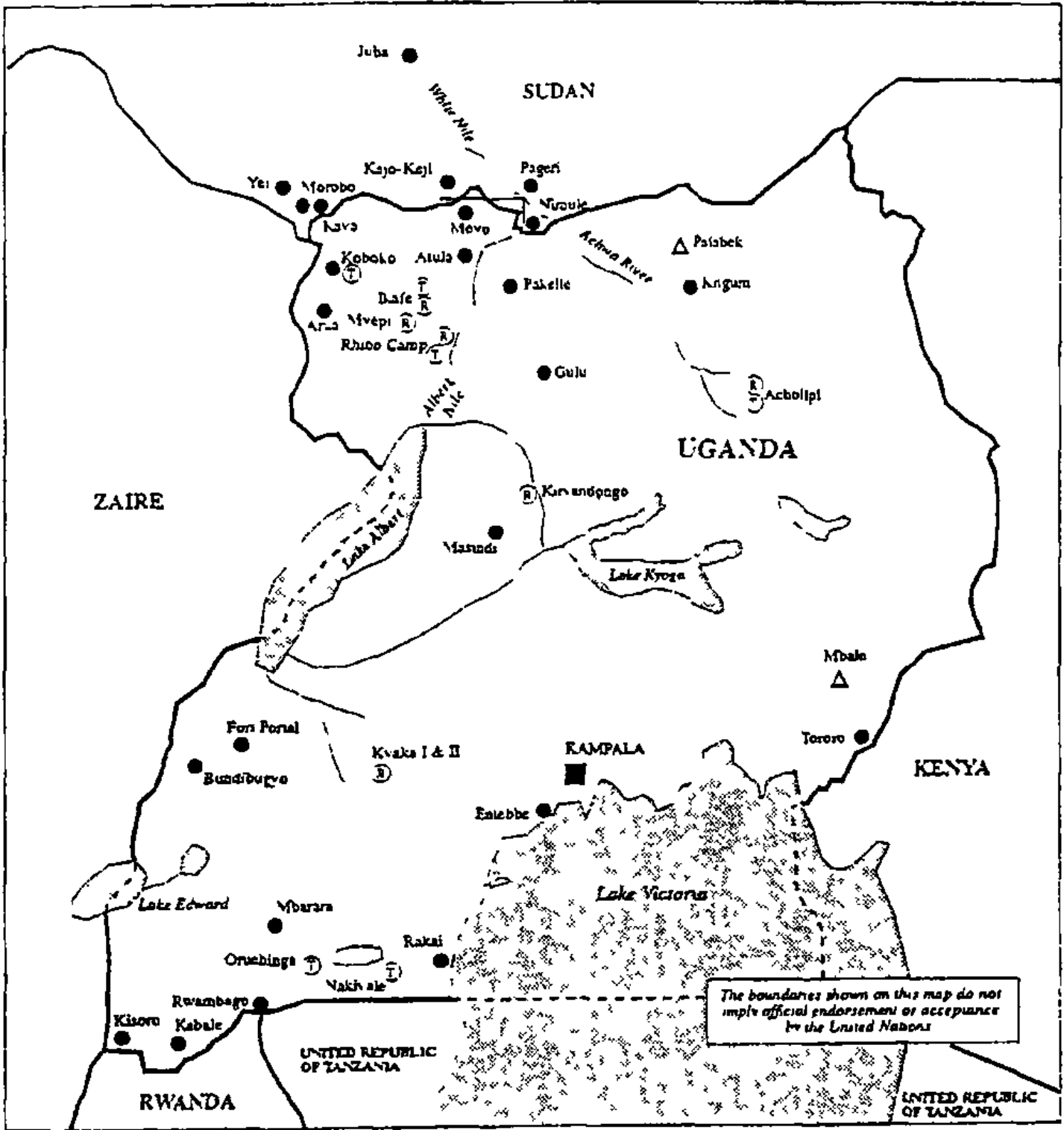
Map 12. Somalia

Map 13. Sudan



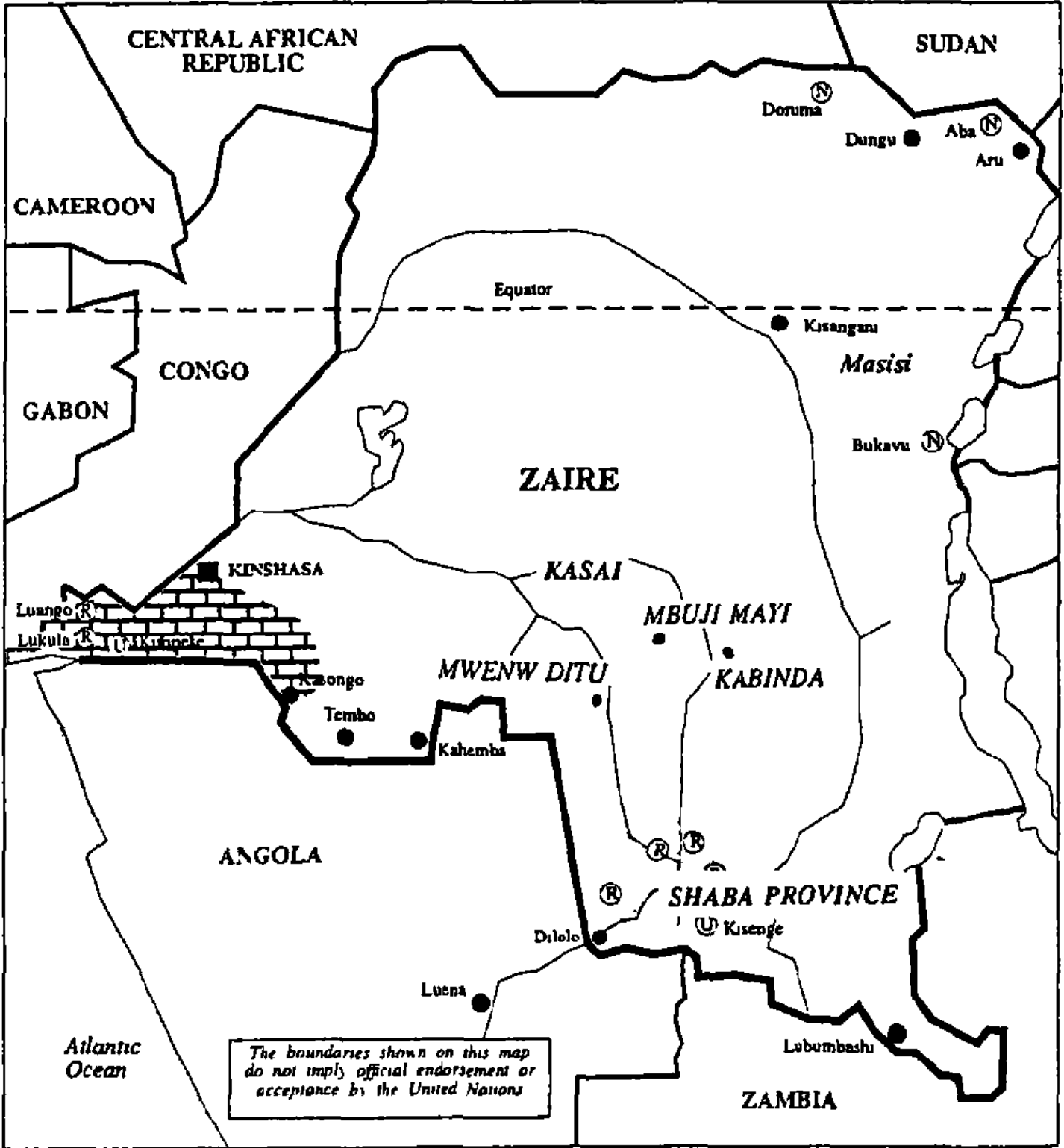
Map 13. Sudan

Map 14. Uganda



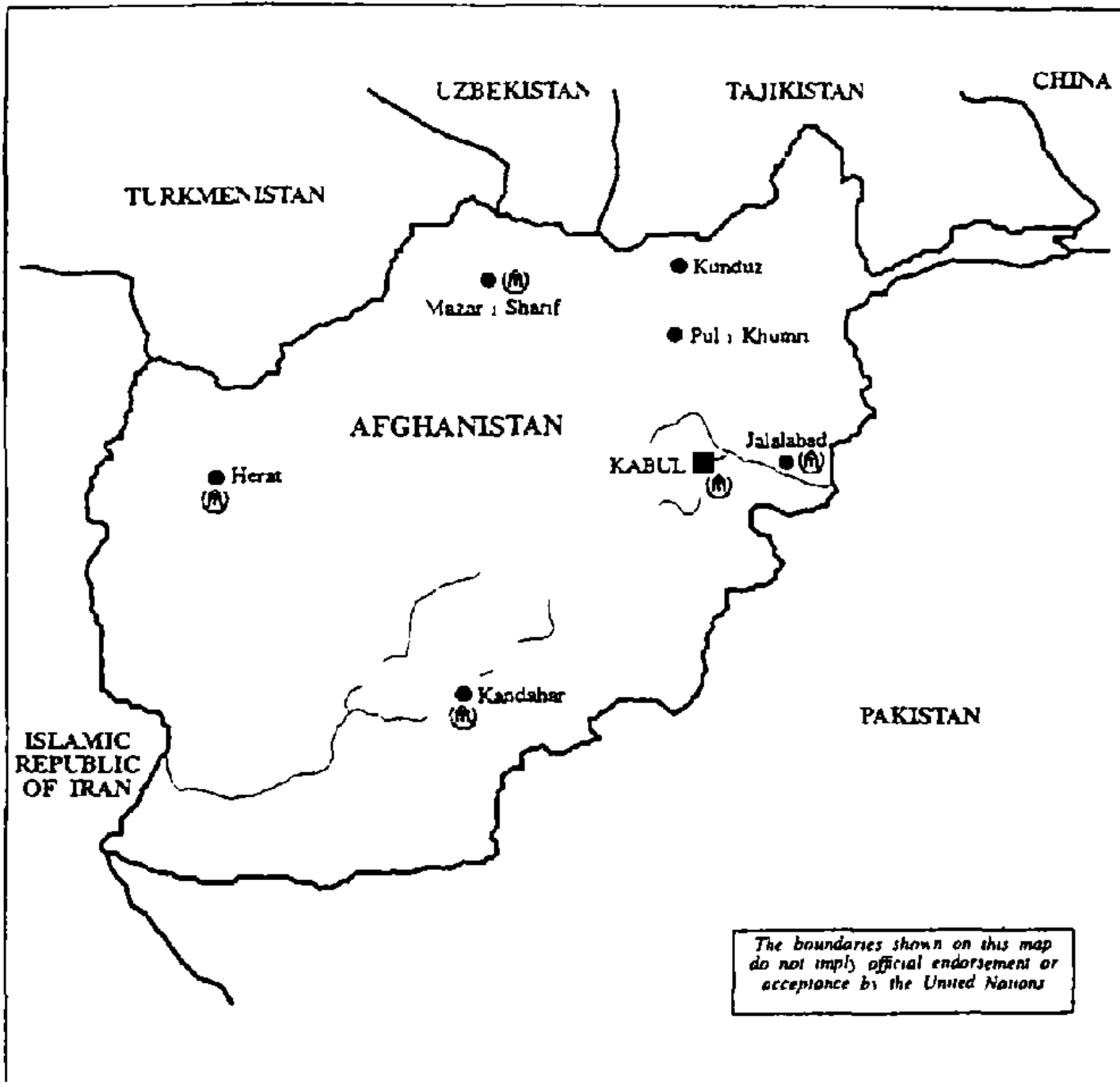
Map 14. Uganda

Map 15. Zaire



Map 15. Zaire

Map 17. Afghanistan



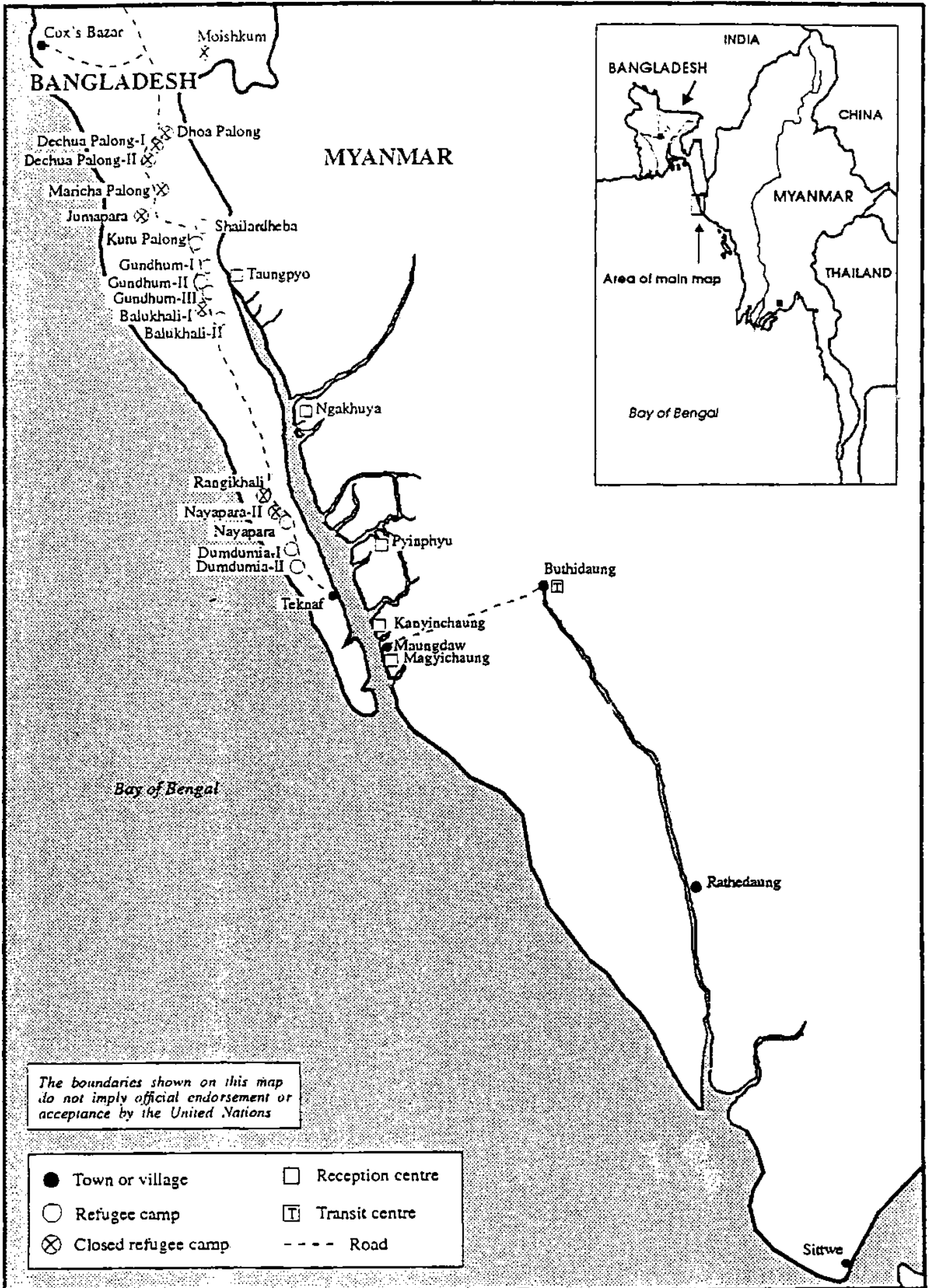
Map 17. Afghanistan

Map 18. Nepal



Map 18. Nepal

Map 19. Bangladesh



Map 19. Bangladesh

