

**Refugee Nutrition Information System (RNIS), No. 16 – Report on the  
Nutrition Situation of Refugee and Displaced Populations**



# Table of Contents

<b><u>Refugee Nutrition Information System (RNIS), No. 16 – Report on the Nutrition Situation of Refugee and Displaced Populations</u></b> .....	<b>1</b>
<u>HIGHLIGHTS</u> .....	1
<u>INTRODUCTION</u> .....	3
<u>SUB-SAHARAN AFRICA</u> .....	5
1. Angola (see Map 1 and Figure 3).....	5
2. Benin/Ghana/Togo Region.....	7
3. Burkina Faso and Mauritania – Malian Refugees (see Map 3).....	7
4. Burundi/Rwanda Situation (See Map 4 and Figure 3).....	8
5. Central African Republic.....	12
6. Djibouti (see Map 6).....	12
7. Ethiopia (see Map 7).....	12
8. Kenya (see Map 8).....	13
9. Liberia/Sierra Leone Region (see Map 9 a, b and Figure 3).....	13
10. Mauritanian Refugees in Senegal (see Map 3).....	16
11. Mozambique Region (see Map 11 and Figure 3).....	16
12. Somalia (see Map 12 and Figure 3).....	17
13. Sudan (see Map 13 and Figure 3).....	19
14. Uganda (see Map 14).....	22
15. Zaire (see Map 15).....	22
16. Zambia.....	23
<u>ASIA – SELECTED SITUATIONS</u> .....	23
17. Afghanistan Region (see Map 17).....	23
18. Bhutanese Refugees in Nepal (see Map 18).....	25
19. Refugees from Rakhine State, Myanmar in Bangladesh (see Map 19).....	25
20. Southern Iraq.....	26
<u>LISTING OF SOURCES FOR JUNE 1996 RNIS REPORT</u> .....	26
<u>LIST OF TABLES AND FIGURES</u> .....	30
<u>ANNEXES</u> .....	41
<u>Annex I: Results of Surveys Quoted in June RNIS Report (#16) – usually children 6–59 months</u> .....	41
<u>Annex II: Seasonality in Sub-Saharan Africa</u> .....	45
<u>MAPS</u> .....	46



# Refugee Nutrition Information System (RNIS), No. 16 – Report on the Nutrition Situation of Refugee and Displaced Populations

ACC/SCN, Geneva, 20 June 1996

## ACC/SCN REFUGEE NUTRITION INFORMATION SYSTEM

### UNITED NATIONS ADMINISTRATIVE COMMITTEE ON COORDINATION SUB-COMMITTEE ON NUTRITION

ACC/SCN, c/o World Health Organization, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland  
Telephone: [41-22] 791 04 56, Fax: [41-22] 798 88 91, EMail: ACCSCN@WHO.CH

This report is issued on the general responsibility of the Secretariat of the U.N.'s ACC/Sub-Committee on Nutrition; the material it contains should not be regarded as necessarily endorsed by, or reflecting the official positions of the ACC/SCN and its U.N. member agencies. The designations employed and the presentation of material in this publication do not imply the expression of any opinion whatsoever on the part of the ACC/SCN or its U.N. member agencies concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries

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, GOAL, ICRC, IFRC, MDM. MERLIN, MSF-Belgium, MSF-CIS, MSF-France, MSF-Holland, SCF-UK, UNHCR, UNICEF, USAID, WFP, and WV.**

## HIGHLIGHTS

*There has been an overall decrease in the number of refugees and internally displaced people in Sub-Saharan Africa requiring emergency food assistance. This is largely due to the attainment of self-sufficiency of many in Mozambique due to increased food production. Around 2 million people remain at heightened nutritional risk. This includes mainly people in Burundi, those affected by the crisis in Masisi, Eastern Zaire, and many in the Liberia/Sierra Leone region.*

***Angola** Sustained peace is allowing an expansion of relief and rehabilitation activities throughout the country. However, over one million people are still estimated to require emergency assistance until March 1997. Nutritional surveys generally show low levels of wasting although the nutritional status of some population groups appears to be declining as a result of several factors including, loss of crops through vandalism and insecurity, the withdrawal of emergency general rations which continue to be phased out in many areas, and poor harvests in certain locations.*

***Burundi/Rwanda/Eastern Zaire Region** With the exception of Burundi and the newly displaced from Eastern Zaire, the nutritional situation in the region appears to be stable. The escalation of violence in Burundi is now affecting virtually every province. Assessments are difficult so that the level of internal displacements are hard to assess. Many families are moving to Uvira, in Zaire and to Tanzania. Furthermore, numerous relief agency staff have been evacuated so that humanitarian aid deliveries are presently extremely limited. In Rwanda, the situation is stabilising further as returnees establish former subsistence patterns. There is however continuing insecurity in western areas bordering the Zairian camps. The most vulnerable population in Rwanda presently are refugees fleeing ethnic violence in the Masisi zone, and more recently, the Rutshuru zone of Eastern Zaire. Nutritional surveys show high levels of wasting amongst this refugee population. The nutritional situation of Rwandan refugees in Zaire and Tanzania is generally good, although there is continuing anxiety over host government statements regarding repatriation deadlines and the possible effects on food security of the ban on refugee movement and economic activities.*

**Liberia/Sierra Leone Region** The recent violence in Monrovia has led to large-scale displacement to “safe” buildings or areas within the capital. The nutritional and health situation of many of those displaced has until recently been extremely precarious. Attacks on NGO property and general abuse of humanitarian principles by the warring factions has led to the decision by many agencies to significantly scale down relief and rehabilitation measures. Relief activities have largely been focussed upon Monrovia, although attention is now turning to rural areas where there are frequent anecdotal reports of high levels of food security. In contrast, the situation in Sierra Leone appears to be substantially improving where a relatively stable security situation is allowing for more effective humanitarian activities. Most recent nutritional surveys show much lower levels of malnutrition than those reported earlier in the year.

**Mozambique** Pellagra, which has been reported to be a problem, particularly in some districts of Tete Province, is reportedly under control due in part to the distribution of fortified blended foods. The total number of people estimated to require emergency food aid has decreased drastically because of increased food production in most areas.

**Somalia** A combination of insecurity, poor crops in some areas and the effect of the monsoon on food prices and trader access, is causing marked food insecurity in a number of areas. Although there have been no recent nutritional surveys, populations in Mogadishu, Baidoa, Kismayo, Bardera and, in particular, Middle and Lower Juba, are reportedly most affected. The situation is extreme in the Juba valley with large-scale displacements. Recent press reports speak of several thousand women and children, some severely malnourished, moving into Kismayo.

**Sudan** The nutritional and health situation of the displaced populations around Greater Khartoum continues to deteriorate; under-five mortality rates of 4110,0001 day (13x normal) are reported with malnutrition considered a primary cause. This is attributed to the gradual impoverishment of this population, many of whom have been displaced for up to eight years. In many areas of southern Sudan security has remained quite volatile in the previous two months. Operation Lifeline Sudan has continued to face financial and government imposed restrictions which have impeded programme activities. Two recent nutritional surveys on both resident populations and displaced camp populations found very high levels of wasting of 15–25%. With the advent of the hungry season (between June and August), it can be expected that levels of malnutrition may rise to similarly high levels amongst displaced and conflict affected populations, particularly where current constraints on OLS are preventing targeted relief measures.

#### ADEQUACY OF FACTORS AFFECTING NUTRITION

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

- variety/micronutrients***									
9. Immunization	X	?	✓	✓	✓	O	X	X	
10. Information	✓	X	✓	✓	✓	O	✓	✓	

✓ Adequate O 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.

#### PLEASE NOTE

The **Report on the Nutrition Situation of Refugees and Displaced People** will now be published every three months. Updates on rapidly changing situations, and where new information is available, will be published every six weeks after each three monthly report. The information in the Updates will be mainly equivalent to that in Table 1 – population numbers in different nutritional risk categories – plus any new nutritional survey data, similar to the presentation in Annex 1 of the present reports. Further outputs will be developed in response to needs.

The Updates will, where feasible, be transmitted by e-mail in Word Perfect 5.1. If you want to receive the Updates, please *either* contact the ACC/SCN by e-mail (accscn@who.ch); *or* fill in the enclosed form to receive by mail; *or* write or fax to ACC/SCN at the addresses on the front cover.

The full report in its present form will be sent every three months

## INTRODUCTION

The UN ACC/SCN<sup>1</sup> (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 with the intention of raising awareness and facilitating 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 sixteenth of a regular series of reports. Based on suggestions made by the working group and the results of a survey of RNIS readers, the *Reports on the Nutrition Situation of Refugees and Displaced People* will be published every three months, with updates where information is available every six weeks. The box above gives further details.

<sup>1</sup> ACC/SCN, c/o World Health Organization, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland.

Telephone: (41-22) 791 04 56, Fax: (41-22) 798 88 91, EMail: ACCSCN@WHO.CH.

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, and figures at the end of the report can provide a quick overview. Table 1 gives an estimate of the probable total refugee/displaced/returnee population, broken down by risk category. 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. In Table 2, refugee and displaced populations are classified by country of origin and country of asylum. Internally displaced populations are identified along the diagonal line. 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.

### References

James W.P.T. and Schofield C. (1990) *Human Energy Requirements*. FAO/OUP.

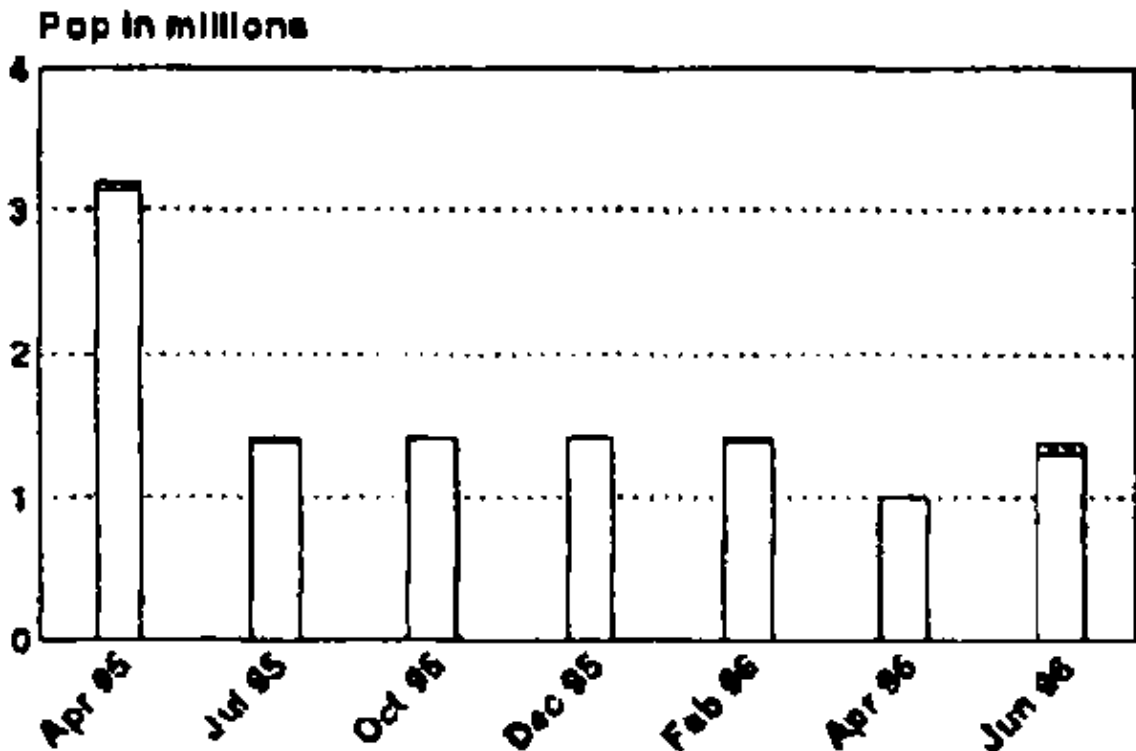
Schofield C. and Mason J. (1994) *Evaluating Energy Adequacy of Rations Provided to Refugees and Displaced Persons*. Paper prepared for Workshop on the Improvement of the Nutrition of Refugees and Displaced People in Africa, Machakos, Kenya, 5–7 December 1994. ACC/SCN, Geneva.

ACC/SCN (1994) *Update on the Nutrition Situation, 1994* (p81).

UNICEF (1994) *State of the World's Children* p.82. UNICEF, New York

## 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.

Since the signing of the Lusaka peace agreements in November 1994, security has largely remained stable in Angola allowing the opening up of new roads and an expansion of humanitarian assistance delivery. However, the use of these new routes has revealed populations in small villages and communes in urgent need of health care, food aid and basic household supplies. Moreover, many areas have remained inaccessible by road, and even by air, primarily for military reasons, so that large numbers of people still remain isolated.

A recent FAO/WFP Crop and Food Supply Assessment Mission concluded that 1,375,000 people will require emergency food aid from April 1996 to March 1997. This number included 804,000 war affected and displaced people, 100,000 returnees from neighbouring countries, 170,000 vulnerable persons, 301,000 disarmed and demobilised soldiers and 270,000 beneficiaries involved in rehabilitation activities. [FAO 23/05/96]. As the next planting season approaches, increased efforts are being made to resettle the internally displaced to allow

this population an opportunity to re-establish agricultural production [DHA 07/05/96].

A recent assessment of the output of foodcrops in Angola projected an overall increase in production of 84% compared to last year due to a variety of factors including, the provision of seeds and tools, and adequate rainfall. However, there are wide regional disparities. For example, the harvest on the Central Planalto is not expected to provide for more than half subsistence needs [ICRC 30/05/96]. Overall, food security remains poor because of a lack of purchasing power, a lack of infrastructure, and the still restricted movement of traders [FAO 23/05/96].

Some recent population displacements have been noted, and appear to be related to theft and vandalism of crops. For example, in Benguela province, displaced people were arriving in Chongoroi, reportedly fleeing loss of crops, and newly displaced people arriving in Cutembo were reportedly in extremely vulnerable nutritional condition. Food aid has been delivered to these newly displaced people. Extensive vandalism against crops has also been reported in Malange [DHA 07/05/96, WFP 24/05/96].

Recent evidence in some areas points to a deteriorating nutritional and health situation. For example, a survey in Maseca, *Kuando Kubango* showed a relatively low level of wasting and/or oedema (4.5%), but a high (3.6%) level of severe wasting and/or oedema (see Annex I (1a)). The survey team recommended targeted supplementary feeding to the most vulnerable groups in conjunction with an assessment of the crop situation as a basis for future seed and tool allocations [DHA 29/04/96].

In Jamba, *Kuando Kubango*, wasting and/or oedema was measured at 11.2% with 3.1 % severe wasting and/or oedema (see Annex I (1b)). Measures including supplementary, therapeutic and school feeding are being reinforced in response to these findings [DHA 29/04/96, 07/05/96, WFP 24/05/96].

A nutritional survey in *Malange* measured wasting and/or oedema at 8.1% with 1.1% severe wasting and/or oedema (see Annex I (1c)). This shows a marked deterioration in nutritional status compared to a survey carried out in October 1995 when wasting and/or oedema was measured at only 1.8%. This deterioration is largely attributed to destruction of up to 70% of crops by vandalism and the gradual reduction in food aid since January 1996 in response to prospects of a good harvest [CONCERN 25/04/96]. As a result of these findings, general rations of maize, pulses and oil will now be targeted between May and July to approximately 95,000 people including all those under 15 years of age, the elderly, the handicapped and other vulnerable groups [WFP 10/05/96].

There have also been reports of increasing numbers of malnourished people being seen in therapeutic feeding at Kuito hospital. This has been attributed to the poor harvest and sharp increases in food prices [WFP 07/06/96]. In contrast NGOs have closed down selective feeding centres in Huambo city due to evidence of improved nutritional conditions [DHA 27/05/96].

A nutritional survey in Golungo Alto, *Kwanza Norte* province found 6.8% wasting with 0.1% severe wasting (see Annex I (1d)). This shows substantial improvement compared to a survey conducted last October which found 20.4% wasting with 12% severe wasting [DHA 03/06/96].

High levels of wasting have recently been recorded amongst families of demobilised UNITA soldiers. In response to reports of malnutrition among family members of the quartered troops, nutritional assessments were undertaken in four of the quartering areas. The assessments showed levels of wasting and/or oedema ranging from 13.2% –20% with severe wasting and/or oedema varying from 1.4% – 8% (see Annex I (1e-h)). Selective feeding programmes are now being planned to improve overall food security of these families [DHA 29/04/96, 07/05/96]. The quartering process is likely to continue until October 1996 but food stocks are now reportedly inadequate to meet needs. Sugar is most urgently needed but stocks of beans and rice are also reportedly low [WFP 26/04/96]. Reports at the end of May indicate that the general ration has been doubled to address these nutritional problems [DHA 27/05/96].

In many areas such as *Zaire* province and *Menongue*, a continued lack of basic health services has been identified as a major factor contributing to persistent high levels of wasting. While substantive health interventions are being undertaken in many areas, e.g. immunisation campaigns in Malange, the urgent need to improve immunisation coverage and general health service provision is recognised in many areas of the country [DHA 22/04/96, UN-a Jan-Dec 96, WFP 12/04/96].

*Overall*, recent information points to an improvement in nutritional status in many accessible areas throughout Angola. Nevertheless, certain population groups have deteriorating nutritional status, and can be considered to be at moderate nutritional risk (category IIb in Table 1) probably due to crop losses and reductions in food

distributions. Pockets of very high wasting, such as those revealed in the surveys in some of the quartering areas (category I in Table 1), are likely to exist in Angola.

**How could external agencies help?** There are still highly vulnerable populations in Angola and recent survey data suggest that in some areas nutritional status is deteriorating. Requests made to establish and reinforce relief activities, especially targeted feeding programmes and in some cases the reintroduction of a general rations, where vulnerable populations are identified, need support. At this point in time, the families of quartered soldiers are at substantial nutritional risk and stocks of sugar, rice and beans need to be replenished in order to continue feeding this population group.

The recently launched United Nations Consolidated Appeal for Angola identifies certain priority areas for strengthening relief and rehabilitation initiatives nationally. These include support to continue the rapid assessment of the nutritional status of newly accessible populations.

In line with priorities outlined in the April RNIS report, the following needs continue to be important:

- restoration of basic health services in newly accessible areas to provide preventive and basic curative measures, including immunisation;
- prevention and control of communicable diseases with emphasis on malaria, trypanosomiasis, meningitis and cholera;
- targeted feeding programmes have been extended recently to other areas where nutritional survey results have indicated a need. Further extensions are likely to be needed, requiring external resources;
- increased immunisation coverage was also highlighted in an earlier RNIS report. Final preparations are now being made to immunise over 80% of children and women of child bearing age in the newly accessible northern region.

## **2. Benin/Ghana/Togo Region**

There are currently 106,800 assisted refugees in Benin/Ghana/Togo region, most of whom are of Togolese origin. The vast majority of this population left their country of origin in 1993 because of political disturbances and sought refuge in Benin and Ghana. Subsequent improvements in the political situation led to the spontaneous repatriation of most of these refugees. Organised repatriation of the remainder is now planned and it is hoped that this will be carried out in 1996.

*Benin* There remain 20,000 Togolese refugees in Benin, most of whom, it is expected, will opt for voluntary repatriation [UNHCR Apr 96].

*Ghana* There are approximately 71,000 Togolese refugees in Ghana, of whom 50,000 are expected to repatriate during 1996.

There are also 15,800 Liberian refugees in Ghana. The nutritional status of most of this population is reportedly adequate, including the 1,500 new arrivals who were refused disembarkation in several ports before arriving in Ghana [SCF 20/05/96].

*Overall*, the 106,800 refugees affected regionally 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 57,500 assisted Malian refugees in Burkina Faso and Mauritania.

*Burkina Faso* This group of refugees are continuing to spontaneously repatriate and it is currently estimated that 27,000 refugees remain in the country.

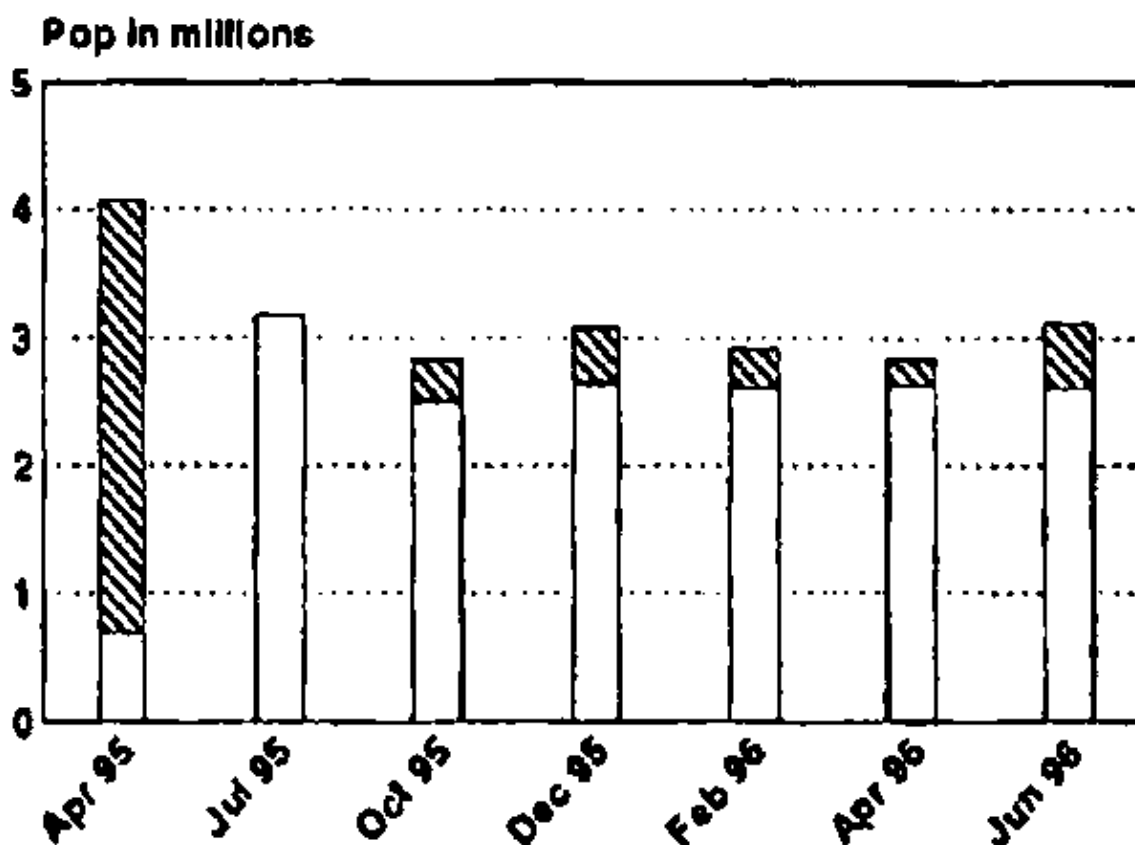
**Mauritania** There are 30,500 Malian refugees remaining in Mauritania. Both spontaneous and organised repatriation of this population had been taking place, but has been put on hold during the hot then rainy seasons. This process is planned to restart in September with 16,000 people reportedly registered to repatriate [UNHCR 04/06/96].

Most recent nutritional data on this population (reported in RNIS #15) showed a worrying situation with 14.6% wasting and/or oedema being recorded. Since this survey, the general ration has been maintained at close to 2,000 kcals/person/day. Furthermore, the number of admissions to selective feeding programme centres remained stable during the month of April, although there are high default rates (68% at supplementary feeding centres) which are felt to partly reflect poor understanding on the part of carers of the need for regular attendance and surveillance [MDM 21/05/96].

*Overall*, the refugees in Burkina Faso are not currently considered to be at heightened nutritional risk (category IIc in Table 1). The Malian refugees in Mauritania can be considered to be at moderate nutritional risk (category IIb in Table 1).

**How could external agencies help?** Pull general ration provision (noted as a priority in the April RNIS), has been maintained in recent weeks. However, there are high rates of default in selective feeding programmes.

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



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

The total number of people affected by the regional emergency has remained virtually constant at about three million. Repatriation of Rwandan refugees is continuing at a very slow rate from Zaire and Tanzania, and both host governments are demonstrating increasing frustration with the lack of progress (i.e. the recent curtailment of economic activities in Zaire). The situation in Burundi has deteriorated significantly over the last few weeks, with insecurity spreading to almost every province of the country. As food and nutrition assessments are sporadic and dependant on the prevailing security situation, it is difficult to determine the effect of the insecurity on nutritional status of the population in Burundi.

Serious disruptions in the food supply to the region are anticipated between September and December 1996. Currently there are limited supplies of corn soya blend (CSB) for the general ration and vegetable oil is lacking

in several locations due to sporadic supplies and transport problems.

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

	<b>Apr 95</b>	<b>Jul 95</b>	<b>Oct 95</b>	<b>Dec 95</b>	<b>Feb 96</b>	<b>Apr 96</b>	<b>Jun 96</b>
<b>Burundi</b>	492,500	515,000	315,000	504,000	275,400	290,000	289,000
<b>Rwanda</b>	1,750,000	800,000	725,000	800,000	737,000	737,000	749,000
<b>Tanzania</b>	686,000	644,000	629,000	621,000	653,000	624,000	642,000
<b>Zaire</b>	1,130,900	1,202,200	1,158,000	1,146,000	1,211,000	1,166,000	1,419,000
<b>Uganda</b>	5,000	6,700	6,400	6,400	6,800	6,900	7,000
<b>TOTAL</b>	<b>4,064,400</b>	<b>3,167,900</b>	<b>2,831,400</b>	<b>3,077,400</b>	<b>2,883,200</b>	<b>2,823,900</b>	<b>3,106,000</b>

*Burundi* The security situation in Burundi, which was described as tense at the end of April, has deteriorated markedly since that time. Peace talks in continue to be held, but there is little or no progress toward ending the escalating violence in Burundi. The United Nations Secretary general has appealed to member nations to develop contingency plans for a standby force to intervene for humanitarian purposes, should the violence escalate further [DHA 17/05/96, KIN 26/04/96, 07/06/96, USAID 23/05/96].

Violent incidents including assassinations, attacks by armed rebels on military positions, and targeting of aid personnel, have been reported in almost all of the 15 provinces [IRIN 12/04/96, DHA 27/04/96]. One very serious incident involved the alleged massacre of 375 people, many of whom were women and children, in Bubanza Province; another involved the ambush and death of three ICRC workers in Cibitoke Province, while another reported massacre at the end of May where 50 people, mainly women and children, were killed in an IDP camp in Ruyige province. The violence has led to further large scale displacements and evacuation of many relief agency staff. The increasingly hazardous security conditions on the most important national routes and their frequent closures because of mines have seriously hampered movement of both staff and aid convoys [IRIN 3/05/96, 19/04/96, DHA 06/05/96, ICRC 04/06/96].

By mid-May an estimated 23,000 Burundi people had crossed into the Uvira camps in Zaire since the end of April fleeing the increasing violence in the country. A further 85 people per day were moving into Tanzania where numbers at transit centres were reportedly approaching capacity [WFP 17/05/96]. Numbers of internally displaced people are difficult to estimate as the situation remains so fluid. Also, many people flee their homes for only short periods of time. Best estimates are that there are 200,000 internally displaced people at any one time. There are approximately 89,000 Rwandan refugees in camps in northern Burundi [WFP 10/05/96].

The current crisis of security in the country is almost certainly affecting food availability because of transport constraints and the uncertainty of maintaining adequate relief staff in areas where violence is occurring. Over the last few months, lack of funding has been jeopardising continuation of WFP aircraft operations which have provided transport for the humanitarian community. This programme is vital as attacks on main roads are currently so frequent. Last minute donations will now enable the aircraft programme to continue for the next six months [IRIN 26/04/96, UNHCR 18/06/96].

*Rwanda* UNIMIR, whose mandate expired on the 8th of March, are to be replaced by a UN office which will be charged with helping to promote national reconciliation, strengthening the judicial system, facilitating the return of refugees and rehabilitating the country's infrastructure. Approximately 737,000 vulnerable people, including displaced and returnee populations, are expected to require assistance during the first half of 1996 [DHA 18/04/96, USAID 23/05/96].

The security situation in most of the country is calm, with the exception of the western prefectures where there continue to be serious incidents involving planned attacks by interhamwe militia and RPA forces and frequent land-mine detonations. Cross border incursions into western areas appear to have intensified and to be better organised. Furthermore, transport companies are increasingly reluctant to deliver food aid and monitoring and evaluation activities in the area have been curtailed as a result of the insecurity [ICRC 03/06/96, IRIN 26/04/96, WFP 26/04/96, 10/05/96].

According to a recent survey by WFP/FAO and the Ministry of Agriculture, the food security situation in Rwanda appears to be improving with only an estimated 10% of the population structurally vulnerable due in large measure to unequal land distribution [WFP 10/05/96]. The largest share of WFP food allocations are

now made though food for work and income generating activities (69%) but there are still some targeted general ration deliveries to vulnerable groups [DHA 18/04/96].

Approximately 46,000 refugee returnees arrived between Jan–April 1996, with the majority from Burundi (20,000) and Zaire (18,941) [WFP 10/05/96]. The number of returnees fell dramatically during the month of March, with only 5,700 people arriving as opposed to 23,000 during February. Intimidation and propaganda in camps were reportedly major factors in discouraging return of refugees [DHA 18/04/96].

Approximately 12,000 refugees from the Masisi and Rutshuru area of Zaire are currently being assisted in camps but as many as 50,000 may have crossed the border into Rwanda [WFP 17/05/96, IRIN 26/04/96]. Anecdotal reports indicate “serious levels of malnutrition” amongst this recent wave of refugees [WFP 10/05/96]

*Masisi Zone, Zaire* In recent weeks, ethnic conflict in Masisi zone appears to have diminished in intensity partly due to depopulation and partly due to the presence of the Zairian military. Whole villages are reported to have emptied as civilians have fled towards Sake and Goma. However, the conflict between Rwandan Hutus and Zairian people now appears to have spread to Rutshuru zone in the East and is moving further south. ICRC estimate that 65,000 have been displaced from homes in Rutshuru since April and they are distributing non–food assistance to several thousand people [DHA 10/05/96, IRIN 19/04/96].

It is estimated that up to 200,000 people overall have now been displaced by the fighting and that there are at least 116,000 people being assisted in the area. It is probable that many thousands of unassisted people require aid but are inaccessible. Measles is reportedly at epidemic levels but given the current population flux, a vaccination campaign is not being considered at this time [DHA 10/05/96, WFP 03/05/96, 24/05/96].

There are many constraints affecting humanitarian operations in the region. The most significant are insecurity, continuous population movements, and the high degree of ethnic polarisation leading to accusations of ethnic bias against relief agencies seen to be assisting any particular population group. These problems are further compounded by poor quality roads in the area [DHA 10/05/96].

There are approximately 12,000 people who have crossed the border into Rwanda and are currently considered as refugees. A recent nutritional survey conducted in the camp showed 17% wasting and/or oedema with 7.4% severe wasting and/or oedema (see Annex I (4a)). Measles immunisation was begun as the refugees arrived, and the current coverage is estimated to be 90%. Selective feeding programmes are under way in the camp [MERLIN 02/06/96].

*Goma, Zaire* It is currently estimated that there are 723,000 Rwandan refugees in the refugee camps in the Goma area. The Zairian Prime Minister recently announced a new deadline of July 1996 for the repatriation of Rwandan refugees [WFP 12/04/96, 20/06/96].

A number of security incidents have been reported throughout the month of May including mine explosions near the airport and ambushing of vehicles. As a result some food distributions have been interrupted [WFP 07/06/96]. Conflict in the Rutshuru area is also threatening security around Katale camp and its extended delivery point. The enforcement of a ban on refugee economic activities has led to the arrest of several refugees who have breached the new regulations on work, and markets in all four camps are now closed [WFP 19/04/96].

Wood distribution in the camps continues to be insufficient and women are often seen to risk their lives in foraging for fuel supplies [WFP 12/04/96]. Firewood distribution in the camps is expected to fall dramatically in the coming weeks due to tribal fighting in the Rutshuru area [WFP 10/05/96].

Although there are no new nutritional data on this refugee population, the continued restriction on economic activities in conjunction with anecdotal reports of malnutrition related mortality in Mugunga camp [WFP 19/04/96] indicate that the nutritional situation of this refugee population may be deteriorating and needs to be closely monitored. Latest data on water availability in the Goma camps also indicates a worrying situation with less than 14 litres per person per day in all camps and less than 10 litres/person/day in Kibumba and Katale [UNHCR 07/04/96].

The availability of oil for general ration distributions is currently threatened by gaps in the food aid pipeline [WFP 19/04/96].

*Bukavu, Zaire* There are approximately 313,000 refugees in the camps in Bukavu. The general security situation around the camps is said to be tense [WFP 19/04/96].

Although the nutritional and health situation for the majority of refugees is described as satisfactory and the current ration is being maintained at 1600 kcals/person/day, the food and fuel supplies transport is difficult due to the continued border closure between Burundi and Zaire. Furthermore, due to programme restrictions imposed by the Zairian government, only limited essential services are being supplied to all camps. As a result, most camps are suffering from a lack of shelter [UNHCR 20/05/96, WFP 19/04/96, 26/04/96]. If this situation persists, the nutritional situation of this population may deteriorate.

*Uvira, Zaire* During May, Burundi refugees continued to arrive fleeing the escalation of violence back home. It is currently estimated that there are 183,000 refugees in the camps of whom 25,000 are recent new arrivals. Over 27,000 Burundian refugees arrived in Uvira camp in the first two weeks of May [WFP 10/05/96].

There are mixed reports on the health and nutrition status of the new arrivals. In some reports, new arrivals are said to be in reasonable health. Other reports indicate obvious signs of malnutrition among the new arrivals, especially among women and children [UNHCR 18/04/96, WFP 10/05/96, 17/05/96].

Surveys conducted in nine camps in March show levels of wasting of below 10% in all camps except Kagunga where 11 % wasting with 3.5% severe wasting was recorded (see Annex I (4b-j)). This compares with a level of 4.4% wasting recorded in October 1995 in the same camp. Apart from Kagunga, levels of wasting have risen slightly in only two camps since surveys undertaken at the end of 1995 and have diminished in the other six camps surveyed [UNHCR Mar 96]. Some further investigation into the reason for this atypical deterioration may be advisable.

The closure of the border with Burundi is having an adverse impact on supplies in Uvira. For example, transfer of salt and sugar from Bujumbura is currently more difficult because a more circuitous route must be used. There is also a shortage of diesel fuel that could affect the water supply as water pumps are diesel powered [DHA 15/05/96, WFP 26/04/96, 20/06/96].

*Tanzania* The number of refugees in Tanzania has been increasing steadily with the on-going influx of refugees from Burundi. Many of the new arrivals claim that the Burundian army are conducting operations against Hutus. Current estimates are that there are now 642,000 refugees in Tanzania but this number will need to be updated as the influx continues [WFP 17/05/96, 20/06/96].

A recent nutritional survey in Chabalisa camp II in **Karagwe** showed 2% wasting (see Annex I (4k)) [WFP 03/05/96]. The nutritional situation for refugees in the **Ngara** camps is also reportedly adequate and is largely attributed to maintenance of the 1900 kcal/person/day ration, in spite of periodic breaks in the food aid pipeline, and economic and agricultural activities of the refugees. The largest single source of income in the camps is said to come from those who work for international agencies [SCF 23/03/96, WFP 26/04/96].

However, a new government decree that refugees are no longer permitted to cultivate land or conduct business activities beyond a four kilometre radius of the camps will certainly reduce food security [WFP 26/04/96]. There is also continuing concern over the delivery of poor quality maize grain and the absence of mills in the Ngara region. Recommendations have been made to increase the quantity of beans in the general ration at the expense of maize grain and that, where possible, grain should be substituted with maize meal. Distribution of salt in the region has been very sporadic [UNHCR 10/04/96].

*Uganda* There is no reported change to the adequate nutritional situation of the approximately 7,000 Rwandan refugees in Uganda [UNHCR 23/05/96].

*Overall*, the nutritional status of the affected populations in Rwanda, Tanzania, and Goma and Bukavu, Zaire appears to be stable (category IIc in Table 1). However, the curtailment of refugee economic activity in Zaire and Tanzania will necessitate careful monitoring in order to determine whether this situation changes in the coming weeks. The refugees from the Masisi area in Rwanda are at high risk (category I in Table 1), and the affected populations in Burundi and in Masisi Zaire are likely to be at heightened nutritional risk (category IIa in Table 1) due to escalating insecurity.

**How could external agencies help?** Pronounced shortfalls in food supply for the region are currently anticipated from September 1996. Food aid pledges are therefore urgently needed. As potential new food pledges will only arrive toward the end of the year, immediate cash donations to procure food in the region are required. Furthermore, exemption of humanitarian goods from the closure of the Burundi/Zaire border is

important for the continued expeditious transfer of humanitarian aid from Bujumbura to Zaire. Some specific needs by country are highlighted below.

In *Rwanda* there continues to be a need (RNIS 15#) for nutritional surveys in western areas where insecurity may be adversely affecting food availability especially in areas to which refugees have returned.

In Zaire, needs include:

- additional cooking fuel distribution in the Goma camps;
- additional pledges of edible oil for the general ration for the Goma refugee population;

In *Tanzania*, lack of milling facilities for maize has been reported as a problem in the Ngora camps for the last two years, probably contributing to nutritional risk. Maize meal may have to be substituted for grain. The proportion of beans in the ration may also be too low.

The need for additional funding for aircraft deliveries in *Burundi* was highlighted in the last RNIS report as a problem. Funding has now been secured for the next six months. Other priorities identified previously such as regular nutritional surveys of IDP camp populations and increased coverage of selective feeding programmes in areas of insecurity, have not been achievable due to the marked increase in insecurity in recent weeks.

## **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)**

Repatriation of Ethiopian refugees is continuing from Djibouti, with almost 1,500 people returning in one week in March. Reports indicate that almost all of the remaining 2,500 refugees are now ready to repatriate [DHA Apr 96, UNHCR 96].

## **7. Ethiopia (see Map 7)**

There are an estimated 376,000 refugees and internally displaced people in Ethiopia receiving food aid. This number is comprised of 275,000 Somali refugees in the east, 63,000 Sudanese refugees in the west, 18,000 Djibouti refugees, 9,000 Kenyan refugees and 11,000 internally displaced people. There are at least a further 35,000 unassisted refugees in Ethiopia. Reports of an influx of 10–15,000 refugees, mainly women and children, to the Asosa area as a result of fighting in southern Sudan have not been confirmed [DHA Apr 96].

There are no new nutritional data available for any of the refugee 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. The last survey conducted on the internally displaced around Addis Ababa (January 1995) found very low levels of wasting of 3.2%. There are no indications that this situation has changed significantly [GOAL 31/05/96].

*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 176,000 refugees remaining in Kenya, comprised of 125,000 Somali refugees, 45,000 Sudanese refugees and 6,000 Ethiopian refugees. The slight increase in the total number is due to a small influx of Sudanese refugees [UNHCR 31/05/96].

There are no recent nutritional survey data on the Somali refugees in Kenya. However, fortified blended foods are still absent from the general ration and as there have frequently been reports of scurvy amongst this population, especially in the August–October period, there may be some cause for concern that case of scurvy re-appear [UNHCR 11/06/96]

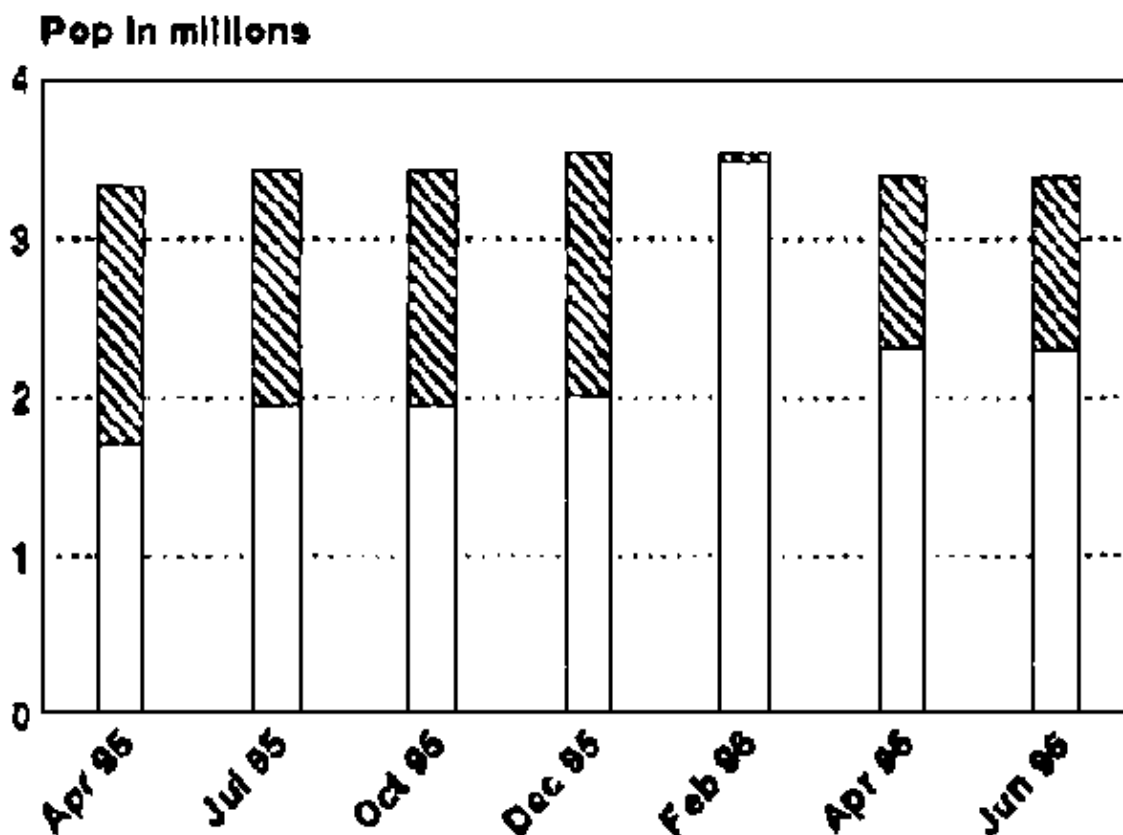
There has recently been a security incident at Kakuma camp (for Sudanese refugees) where two food distribution centres were destroyed. These were erected in order to facilitate a move away from general ration distributions through group elders to distributions to heads of families [WFP 19/04/96].

Micronutrient fortified blended foods have not been included in the general ration. Since there have often been reports of scurvy among this population, especially in August–October, the lack of fortified blended foods is causing concern [UNHCR 11/06/96].

*Overall*, the refugees in Kenya are not currently thought to be at heightened nutritional risk (category IIc in Table 1).

**How could external agencies help?** Efforts should be made to reintroduce micronutrient fortified blended foods into the ration to avoid possible cases of scurvy in the August–October period, when outbreaks have occurred in the past. The need for such an initiative was also noted in the April RNIS report.

## 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 violence in the Monrovia has led to large scale displacement within and from the capital to and serious disruption to relief and rehabilitation work throughout Liberia. In recent weeks most agency activity has been focused upon Monrovia. The current insecurity has meant that plans for voluntary repatriation of Liberian

refugees have been put on hold. Recent attempts at political mediation have failed and the overall security situation is currently extremely fluid. In contrast, the security situation in Sierra Leone has improved in recent weeks. This has led to improved humanitarian agency access to populations resulting in signs of improving nutritional and health status amongst conflict affected populations.

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

Location	Apr 95	Jul 95	Oct 95	Dec 95	Feb 96	Apr 96	Jun 96
<b>Liberia</b>	1,900,000	1,900,000	1,900,000	1,900,000	1,800,000	1,800,000	1,800,000
<b>Sierra Leone</b>	500,000	730,000	730,000	730,000	730,000	756,000	756,000
<b>Côte d'Ivoire</b>	330,000	227,000	305,000	305,000	305,000	305,000	305,000
<b>Guinea</b>	603,000	578,000	536,000	605,000	605,000	536,000	536,000
<b>TOTAL</b>	3,333,000	3,435,000	3,471,000	3,540,000	3,440,000	3,397,000	3,397,000

*Liberia* Although there had been considerable progress towards enduring peace since the signing of the Abuja peace accords in August 1995, eruption of fighting between the NPLF and ULIMO–Krahn on April 6th in Monrovia has placed the whole peace process in jeopardy. Within a few days, many areas of the city had been looted and thousands of inhabitants had been displaced. Most humanitarian operations ceased and comprehensive assessment of needs has still not been possible. Factional fighting spread up–country to Bong Mines and Greenville. Most expatriate agency staff were evacuated from Monrovia and the majority of UN and NGO offices were completely devastated making rapid resumption of relief activities throughout the country problematic [WFP 19/04/96].

By the end of May the security situation had improved, and ECOMOG troops had been redeployed in Monrovia. Simultaneously, cross–border deliveries of food from Cote d'Ivoire into Nimba and Bong counties began, and shipments of humanitarian aid by land and sea have commenced out of Monrovia. However, 12 NGOs have adopted a common position on scaling down relief activities in the country due to widespread looting of property and abuse of humanitarian principles. As a result, the NGOs decided that the resumption of full activities is not possible and instead will only undertake targeted and life saving interventions [WFP 14/06/96]. There are approximately 1.8 million people in Liberia in need of humanitarian assistance [WFP 19/04/96, WFP 31/05/96, USAID 11, 12, 16, 24/05/96].

Fighting had displaced at least 80,000 people within the capital with an estimated 20,000 in Greystone compound in the US embassy. The health status of this over–crowded population has been extremely worrying with reports of diarrhoea, and measles. Concerted efforts have now been taken to improve water availability and sanitation in this compound. The situation for the displaced in Barclays Training Centre (BTC) in Monrovia has also been critical particularly with regard to water, health and sanitation. Both Greystone and BTC have periodically been cut off from outside agency assistance during April and May as lulls in fighting have given way to major skirmishes in nearby areas. New checkpoints manned by NPLF and ULIMO–K fighters have also made the city centre and Greystone camp periodically inaccessible to WFP food relief convoys. Large numbers of displaced have sought refuge in Bushroad Island [WFP 10/05/96] while others are reported to have fled to Kakata, Toteta, Ganta and Gbarngé [USAID 16/05/96, 21/05/96, WFP 10/05/96, 17/05/96].

In Monrovia, water and food provision are now the main concern. Some mini–markets are appearing although food prices are up to four times normal. It is hoped that food distributions for an indicative target of 692,000 will continue on a temporary and contingent basis until order is re–established [WFP 26/04/96]. Cholera outbreaks continue to be reported in the capital while the incidence of measles is another concern [USAID 24/04/96, 7, 8/05/96].

ECOMOG troops have withdrawn from bases in Bo Waterside and Tiene in Cape Mount county where 29,000 and 70,000 internally displaced people were sheltered. Lack of ECOMOG presence in the county will make it extremely difficult to bring relief assistance as civilians are being directly targeted by the warring factions. Cross–border food convoys have now resumed from Cote d'Ivoire to Nimba and Bong country and the government is now urging a shift in focus of relief from Monrovia to rural areas [DHA 14/05/96].

The improved security situation is allowing for some assessment of the nutritional situation of those who have been isolated for many weeks or months. A serious deterioration of the nutritional situation is reported in Tubmanberg, where over 50,000 people last received food aid in January 1996. There are reports of up to ten

people a day dying of starvation and disease [WFP 07/06/96]. There have also been reports that some of the population in Lofa country is in urgent need of food aid [DHA 09/06/96]

An unconfirmed number of Sierra Leonean refugees in the Cape Mount area have spontaneously repatriated. There are reports of an estimated 5,000 Liberians having fled by boat to neighbouring countries with an unknown number fleeing to Sierra Leone over land [DHA 14/05/96, UNHCR 24/05/96].

*Sierra Leone* A cease fire announced just after the election of the new president is generally holding although some serious breaches in security have taken place such as the rebel attacks on villages in Bo district where over 100 civilians were killed in the first week of May [WFP 17/05/96]. The recent peace talks have made considerable progress but there still remain contentious issues that are stalling the move towards enduring peace [WFP 14/06/96]

It is currently estimated that there are 1.6 million internally displaced people in Sierra Leone, 756,000 of whom require emergency food aid assistance. The remaining approximately 800,000 people (not included in Table 1) are thought to be either living among local communities or with relatives and able to procure their own food [UN Mar 1996].

The generally improved security is allowing for greater effectiveness of humanitarian work. The main highways to Segbwema, Bo, Kenema and Makeni are now open and food is being delivered to up country. Affected populations in Segbwema and Zimmi had not received relief food for several months due to insecurity but distribution was planned to begin in May [WFP 19/04/96]. Nutritional surveys in Kenema town and the RTI camp (included in RNIS #15) showed improvement in nutritional status. As in Bo and Western area camps, resumption of general food distributions and NGO selective feeding programmes using WFP airlifted food are considered to be a contributing factor [WFP 17/05/96].

A survey carried out in the Bonthe Islands (estimated population 14,000) showed 5.6% wasting and/or oedema with 0.6% severe wasting and/or oedema (see Annex I (9a)). This compares favourably with a survey carried out in October 1995 when levels of wasting and/or oedema were measured at 13%. It is reported that many of the displaced people have returned to the mainland, and their nutritional status is not known. Measles immunisation coverage was estimated at 22.8% [MSF-B Mar 96].

The cease fire is also allowing for the return of some internally displaced people to their homes. Up to 85% of the residents of the RTI camp in Makeni have returned and significant numbers of people have reportedly returned to districts in Bo [DHA 18/04/96]. There are still areas, such as Kono district, where food security is believed to be very poor and malnutrition is reported to be widespread [DHA 03/06/96].

*Côte d'Ivoire* There are approximately 305,000 Liberian refugees in Cote d'Ivoire, whose nutritional status is reportedly adequate and stable. The recent fighting in Liberia has not reportedly led to any large-scale influx of refugees [UNHCR 24/05/96].

*Guinea* There are approximately 605,000 Liberian and Sierra Leonean refugees in Guinea of whom 536,000 receive food aid. There are no reports of change to their adequate and stable nutritional situation. The recent fighting in Liberia has not reportedly led to any large-scale influx of refugees [UNHCR 24/05/96].

*Overall*, those in Liberia living outside of Monrovia are likely to be at high nutritional risk (category IIa in Table 1) since many areas have now been cut off from humanitarian aid for several weeks and lack of protection for agencies is preventing improved delivery of relief items. Although, some cross-border deliveries from Cote d'Ivoire are occurring, the decision of many NGOs to stream-line activities to a minimum as a result of looting and lack of respect for humanitarian principles may also have serious repercussions for the food security of populations affected by the conflict outside of Monrovia. The affected population in Monrovia can be considered to be at moderate risk (Category IIb in Table 1), as the situation is apparently coming under control. Those requiring emergency food aid in Sierra Leone can be considered to be at moderate risk (category IIIb in Table 1) due to continued sporadic insecurity. 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?** As attention of the humanitarian agencies has shifted to Monrovia in recent weeks, there is little information on the needs of populations outside of the capital. It is, however, clear that actions similar to those identified in the April RNIS (strengthening nutritional surveillance capacity for newly accessible areas and an extension of measles immunisation coverage in selected areas) have been precluded. When agencies are able to re-establish their operational bases within Liberia, large scale humanitarian needs may become apparent. At that point, agencies may need substantial additional resources

for widespread needs assessments and the provision of humanitarian relief items. As NGO rehabilitation activities are being scaled down due to insecurity, nutrition and health risks may increase; every means of protecting and supporting NGO activities should therefore be considered.

With continuing insecurity in Monrovia, adequate supplies of clean water, food and medical care, especially cholera and measles prevention, are urgently required, notably for the 80,000 or so people in Greystone compound and the Barclay Training Centre.

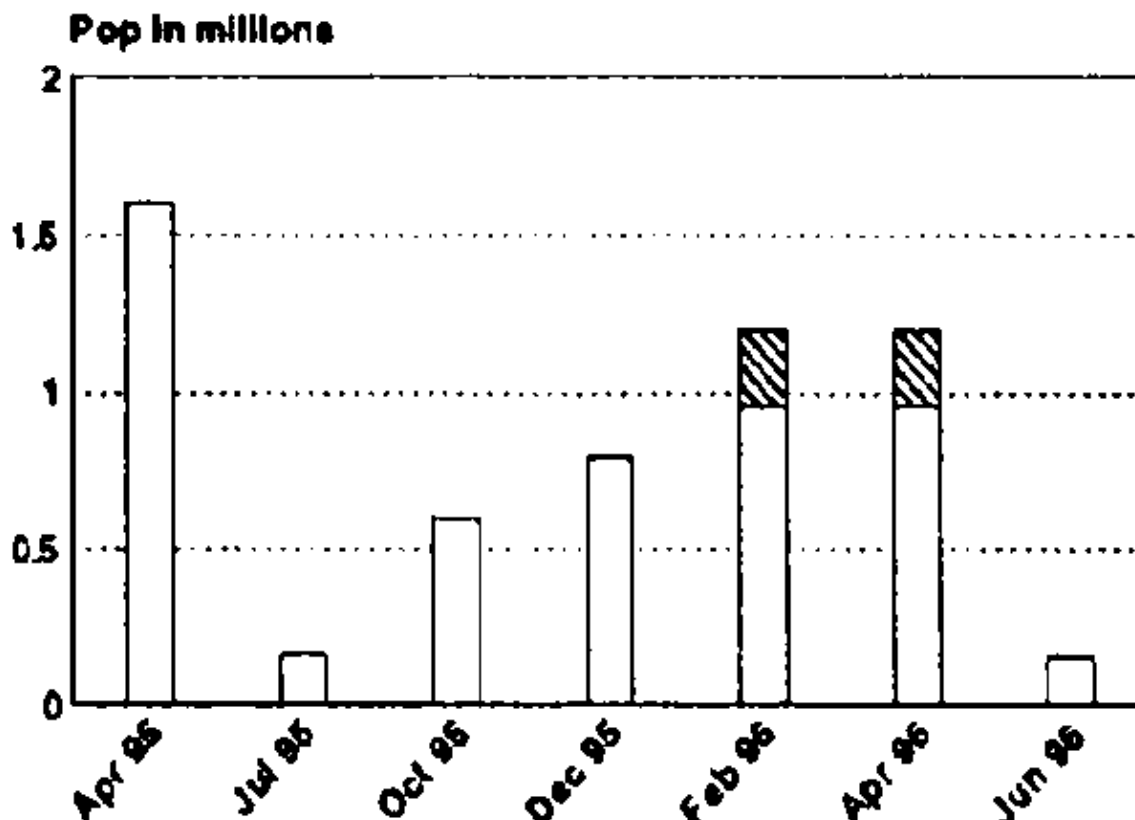
Based on a recently launched UN consolidated appeal, the last RNIS report highlighted certain necessary activities in Sierra Leone, including the possible expansion of selective feeding programmes, and investment in rebuilding and extending health, sanitation and water infrastructure in the country. To date, the response to the appeal has been minimal; for example only 5% of the food needs projected by WFP have been pledged. If this situation persists, delays in programme implementation will be encountered.

Other specific needs in Sierra Leone include an immunisation campaign in the Bonthe Island area, and an assessment of the nutritional status of those populations who have recently returned home.

### 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. These refugees are longer included in Table 1.

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



Mozambique – Trend in numbers of returnees and demobilised soldiers.

In view of the considerable increase in food production in most areas, emergency food requirements are estimated to be substantially less than last year. It is anticipated that the emergency relief operation in Mozambique will begin to be scaled down, and an average of 154,000 returnees and drought affected people will be targeted for food aid over the next year (May 96/Apr 97) in Mozambique [FAO 31/05/96].

With some notable exceptions, the nutrition situation in the country is generally adequate. Initial estimates for the main grain harvest indicate excellent production in the north and centre of the country while bumper crops in neighbouring countries will also help to ensure lower prices for any imported grain [FAO 31/05/96, MSF-CIS Feb 96].

However, principally due to flooding at the confluence of the Limpopo river early in 1996, conditions have deteriorated in the province of Gaza. As a result of the floods, emergency distributions were cut off to the district of Chigubo where virtually 100% of the population is dependent on food aid, so that many people had to resort to gathering wild foods. Similar, though less grave, conditions were developing in Guro (Manica). Up to 38,000 persons were displaced in February 1996 in three districts, where the flooding was most severe, and sanitation conditions of the displaced were reportedly very poor [MSF-CIS Feb 96].

In some areas of Mozambique health indicators have begun to show worrying trends. In nearly all coastal districts as well as some interior areas, malaria is reported even more prevalent than usual. Also, high rates of diarrhoea are reported in Gaza province due to contaminated water supplies as a result of the floods [MSF-CIS Feb 96].

A survey conducted in February in Memba district (*Nampula province*) found 13.2% wasting with 3.0% severe wasting (see Annex I (11a)). This high prevalence seems to be related to poor sanitary conditions and in particular widespread measles, lack of health care and low income earning opportunities. Poor nutritional status has also been reported in many districts of *Tete province*. A nutritional survey in January showed 11 % wasting with 2.3% severe wasting (see Annex I (11b)) in Chiuta district [MSF-CIS Feb 96].

The number of cases of pellagra reported in Mutarara district has dropped considerably. This is thought to be due in part to the rainy season. The long-awaited micro-nutrient enriched corn soy blend now being distributed through hospitals, nutrition centres and to food aid beneficiaries is likely to have contributed to this improvement [MSF-CIS 27/05/96].

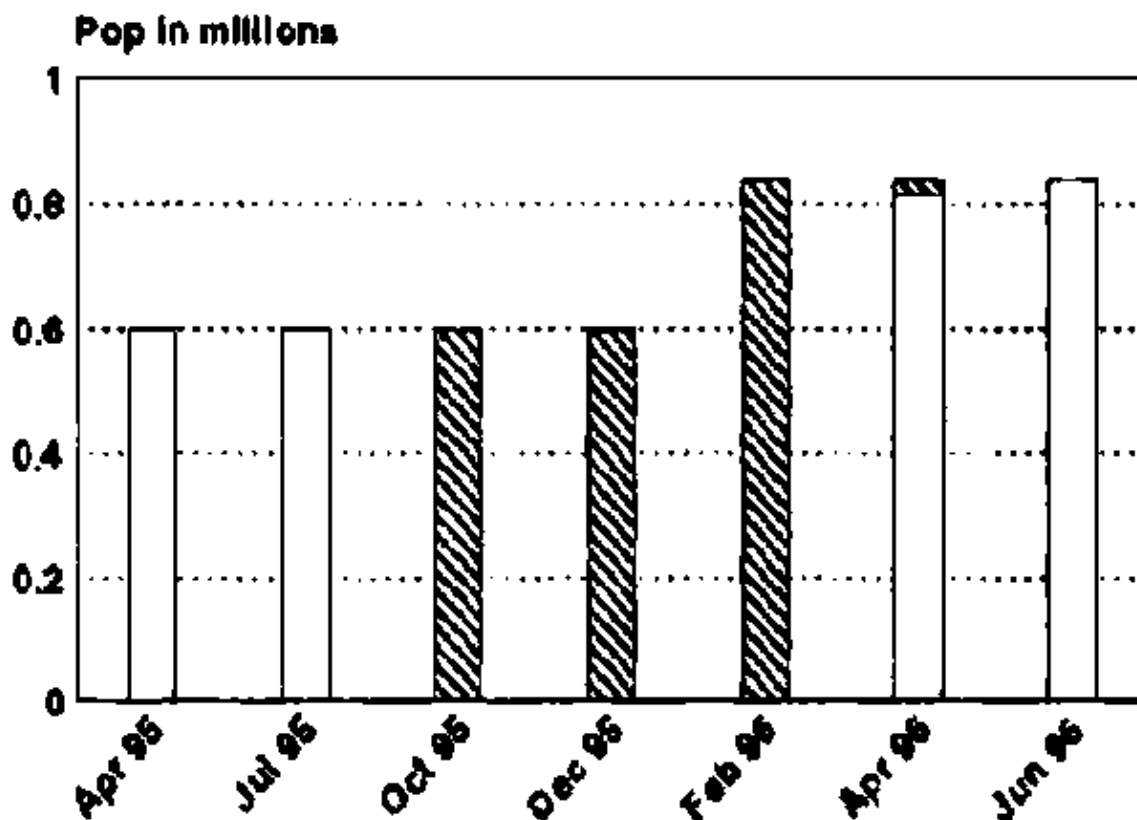
*Overall*, those requiring emergency assistance in Mozambique are not currently considered to be at heightened nutritional risk (category IIc in Table 1), although some areas show slightly worrying levels of wasting and should be closely monitored.

***How could external agencies help?*** There are three main types of programmes that currently need instigating or strengthening within Mozambique:

- supporting those communities adversely affected by recent flooding by providing general rations and seeds (where crops have been lost) and restoring safe water supplies;
- strengthening health service provision, particularly for malaria control in coastal zones, and immunisation campaigns where vulnerability to measles outbreaks are likely to be greatest;
- strengthening logistic capacity in areas where poor roads and lack of transport and storage capacity have undermined the general ration distribution programme, e.g. several districts in Gaza province.

Distribution of enriched CSB has now been accomplished (after the resolution of administrative problems), contributing to the successful control of pellagra.

## **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 in Somalia are currently receiving emergency food aid. This number is comprised of approximately 600,000 returnees and 240,000 internally displaced people.

Since the withdrawal of UNOSOM forces was completed in March 1995 the worst fighting has been in Mogadishu, Baidoa and Kismayo. A recent example is heavy inter-factional fighting which erupted again in early April in South Mogadishu. An estimated 140 people had been killed and 650 injured by the end of the month. The conflict affected humanitarian operations in the south of the city with some agencies relocating to the north. The situation in Baidoa is also described as very tense [USAID 09/04/96, DHA 22/04/96, 03/05/96].

The recent rise in insecurity due to factional fighting in conjunction with port closures is adversely affecting the ability of already vulnerable groups, particularly internally displaced people, to purchase food. There are currently 54,000 internally displaced people living in 109 camps in Mogadishu. To offset a rise in food insecurity WFP continues to deliver food aid through alternative ports in Mogadishu since the main port has been closed for the sixth month in a row. The monsoon season from May to June is expected to drastically reduce the ability to deliver food, thereby having a marked effect on food prices and supplies for southern Somalia. Agencies are currently providing supplementary feeding for 17,000 malnourished children in the capital [USAID 09/04/96].

The 20,000 people displaced following a September 1995 invasion of Baidoa by General Aideed and the ensuing insecurity, resulted in an estimated 67% reduction in food production from pre-war levels. Most economic activity has ceased and there is reportedly no sorghum in markets in the Bay region. A further 2,000 people have recently been displaced to Beletweyne due to fighting in the Bay and Bakool regions [DHA 22/04/96, 03/05/96].

There are reports that the Kismayo food supply situation continues to be erratic with transportation of foods often interrupted by insecurity [DHA 22/04/96].

Rainfall is reported to be sporadic and localised and as of mid-April a cereal supply gap in the range of 74,000 mt is predicted. This most likely to began affecting the poorest populations in May. Crop failure is already being reported in the Lower and Middle Juba regions of Somalia and there have already been reports of significant movements of reportedly malnourished people toward Kismayo. An inter-agency food security task force has prepared a plan of action to urgently respond to this situation and to prevent IDP movements to urban centres and refugee outflows to Kenya [DHA 06/06/96]. One of the major constraints in delivering

assistance to this area continues to be logistics. A combination of poor roads and insecurity make it very difficult to move food and other items outside of Kismayo town to needy families in the valley [DHA 22/05/96]. Returnees from Kenya are affected by this third crop failure and it is feared that this may lead to further population displacements [WFP 24/05/96]. Recent press reports speak of several thousand women and children moving into Kismayo, some severely malnourished and prospects of famine in the Juba Valley if the forthcoming harvest fails and fighting continues [IHT 20/06/96].

Levels of cholera are on the decline nationally although in some areas, such as Kismayo, cases continue to be reported. There have been over 9,000 suspected cases since the outbreak began early in the year. Case fatality rates are still considered to be high in some areas. It is reported that there are now adequate medical supplies in Somalia to treat the anticipated case load [DHA 22/04/96, 3/05/96, MSF-B 08/05/96].

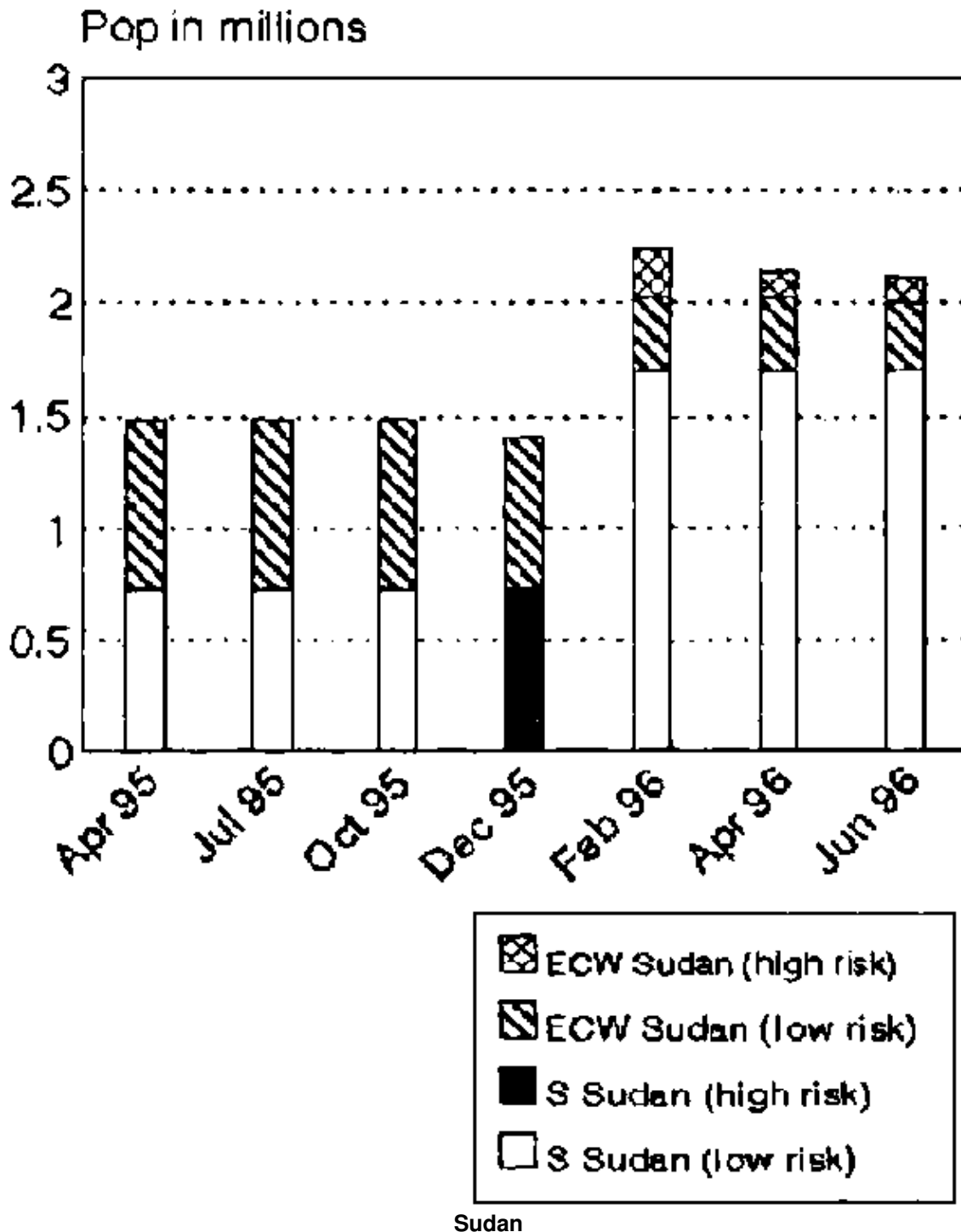
*Overall*, the affected population in Somalia can be considered to be at moderate nutritional risk (category IIb in Table 2) due to continued insecurity and crop failures in the Juba valley. There are likely to be people at high nutritional risk, but numbers are not yet available.

***How could external agencies help?*** As food price rises associated with the monsoon season begin to take effect, populations in Mogadishu, Baidoa, Kismayo, Bardera, and the Lower and Middle Juba areas, already vulnerable from the effects of insecurity, will come under increasing stress. Where possible, expanded food for work and income generating projects should be supported in these areas in order to improve the food security of vulnerable groups. There may also be a need to expand selective feeding programme capacity in these areas. Such initiatives may be required particularly urgently in the Juba valley where the current food shortage is leading to widespread displacement and may eventually lead to the creation of a new refugee influx into Kenya. Recent returnees from Kenya will also need monitoring and may require extra support.

Efforts to improve the quality of water supplies in areas such as Bardera should be supported.

Attempts to improve the treatment of cholera patients should be targeted at those health centres and hospitals where case fatality rates are known to be high. Drug supplies for treating cholera were earlier in short supply (April RNIS), however, adequate supplies are now reported to treat the anticipated number of cases.

### **13. Sudan (see Map 13 and Figure 3)**



The total number of refugees, internally displaced and war affected people in Sudan requiring emergency assistance is estimated to be just over 2.1 million. This number is comprised of 1.7 million displaced and/or war affected people in southern Sudan, 154,000 people in the transitional zone, 119,000 displaced people in camps around Khartoum and approximately 150,000 Ethiopian and Eritrean refugees.

The current health status of the displaced in greater Khartoum is said to be very poor. A major cause of mortality is malnutrition with excessive rates reported among all displaced communities. Other main causes of death are diarrhoea, lower respiratory tract infection and malaria. The displaced camps are significantly more affected than the squatter areas and resettlement areas and have under five mortality rates of over 4/10,000/day (13x normal). An historical review of nutritional survey data since 1988 shows a very clear deteriorating trend in nutritional status in the displaced camps over the years. The most recent survey in September 1995 found wasting levels of 21% although it should be noted that seasonal factors have always led to higher wasting levels in September and lower levels in March [MSF-H 05/05/96].

In general, the deteriorating health and nutritional situation amongst the displaced is largely attributed to



increased poverty resulting in reduced access to food. Likely causes are frequent dis–possession as a result of camp demolitions and relocations and camps being moved further away from income earning opportunities and relocated where minimal services are provided. Provision of water and sanitation, food, selective feeding and curative health care has been increasingly poor. Co–ordination of health services between NGOs is also recognised to be limited [MSF–H 05/05/96].

In spite of the official cease–fire between concerning Southern Sudan, the security situation has remained quite volatile for most of April and May in many areas, especially northern Bahr el Ghazal and Jonglei/Upper Nile. Many incidents have hampered Operation Lifeline Sudan (OLS) relief work [OLS Mar 96].

The most recent nutritional surveys show a variable situation depending on location.

A nutritional survey in six villages of the Attar region (Upper Nile/Jonglei) found levels of 25.6% wasting with 5.8% severe wasting (see Annex I (13a)). Most of the 1995 harvest was reportedly lost due to flooding and household food stores are low. Most people were surviving on wild foods, and it was reported that fishing equipment was in short supply. Measles immunisation coverage was reportedly low [MEDAIR Mar 96].

A survey in Mangalore camp for internally displaced people showed wasting at 16% with 1.8% severe wasting (using MUAC). No cases of oedema were seen (see Annex I (13b)). Food distributions have regularly supplied a 50% ration and the situation was not considered to be worrying providing food rations can be maintained. [MSF–H Mar 96].

An outbreak of diarrhoeal diseases has been reported in large pans of Jonglei and Northern Bahr el Ghazal and in June there were reports that a cholera epidemic had killed at least 700 people in the last 7 weeks [OLS May 96].

As part of OLS, agencies have continued to target food aid to displaced populations and those requiring support for agricultural activities [OLS Mar 96]. However, WFP operations in southern Sudan face critical food shortfalls from June. Contributions are also urgently required to cover transportation and monitoring costs associated with carry–over stocks. Operations from Lokichokio remain severely curtailed due to restricted access and continued lack of clearance by the Sudanese government for major airlift/airdrop operations using C–130 aircraft which have been banned since mid–1995. Use of other aircraft during the hungry months from June to August would prove less efficient and much more expensive [WFP 17/05/96, USAID 10/06/96].

Preliminary results from a census conducted in most Eastern refugee camps in April 1996 show that there are 15,000 assisted Ethiopian refugees and 133,000 assisted Eritrean refugees. There are a further 270,000 unassisted refugees. There are also 4,400 assisted Chadian refugees in western Sudan. There are no new nutritional data on these refugee populations; the most recent survey information showed a situation that varied considerably between camps with wasting rates ranging from 7–15% [UNHCR 01/05/96].

The repatriation of Ethiopian refugees is ongoing. Organised repatriation of Eritrean refugees is not yet underway, but spontaneous repatriation is reportedly occurring [UNHCR 23/05/96].

*Overall*, the displaced population around Khartoum is in category I in Table 1 due to vitamin A deficiency and sharply elevated mortality rates. The affected population in Southern Sudan and the transitional zone can be considered to be at moderate nutritional risk (category IIb in Table 1), although there are areas of high risk (i.e. Attar) where population numbers are not currently available. The refugee population is not currently considered to be at heightened nutritional risk (category IIc in Table 1).

**How could external agencies help?** There are several ways in which the nutrition and health status of the displaced population around Khartoum could be improved. These include:

- increased use of medical and nutritional data for external advocacy purposes, and also to support co–ordinated lobbying activities for more resources for relief purposes;
- increased co–ordination of activities between different NGOs;
- critically monitoring feeding programme capacity of responsible agencies in displaced camps in order to improve programme performance;
- implementing seasonal feeding programmes to address periodically high levels of wasting and vitamin A deficiency.

The need for new food aid pledges for southern Sudan in 1996 (first noted in the April RNIS report) still remain unmet. There is also an urgent need for increased cash contributions for transportation and monitoring for Operation Lifeline Sudan. Right clearances and lack of aircraft for transporting food aid remain constraints on programmes. There has not been any improvement in this situation.

More specifically, in the Attar region, selective feeding programmes are needed for malnourished children. Measles immunisation should be a priority before the wet season begins. There should also be a review to determine whether increased general ration levels are needed for this population.

#### 14. Uganda (see Map 14)

The total estimated number of refugees in Uganda has remained constant over the last two months at 226,300. This number is broken down by country of origin as follows:

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

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

The security situation in northern Uganda remains precarious. This is periodically hindering the transport of food, particularly cereals which are the bulkiest items, so that when security permits, as much as possible is transported to create a small reserve. This insecurity is also slowing the transfer of refugees from the more crowded areas of Koboko and Adjumani [UNHCR 23/05/96].

Information from the Koboko refugee camps suggest that the disruptions due to insecurity are not having an adverse impact on health status of the population. Crude mortality rates continue to show a slight improvement which began in December last year and in March 1996 were 0.21/10,000/day (slightly below a normal rate). Similarly, the under-five mortality rate continue to improve and was 0.75/10,000/day in March (see Annex I (14a)) [MSF-H Mar 96].

*Overall*, the refugees in Uganda are not currently considered to be at heightened nutritional risk (category IIc in Table 1) as there are no indications that periodic problems with food deliveries due to insecurity are adversely affecting these refugees.

#### 15. Zaire (see Map 15)

*Refugees in Zaire (excluding Rwandans and Burundis included in section #4)* There are an estimated 50,000 Angolan refugees in Zaire; an estimated further 119,000 are unassisted (and not included in Tables 1 and 2). 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, 1995-1997].

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 based on the most recent set of nutritional survey information, it is believed that many of these people are self-sufficient and no longer require humanitarian aid. The exception to this was in Mwene Ditu where critically high levels of wasting of about 43% in the displaced population, estimated at 40,000 people, and 17% wasting in the local affected population (estimated at 220,000) are reported [MSF-B 09/04/96 – from RNIS #15].

*Overall*, the displaced and resident affected populations in Mwene Ditu are in category I in Table 1 due to elevated levels of wasting. The remaining displaced population from Shaba is no longer considered to require assistance and so is not included in Table 1. 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 a main priority.

## **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* Fighting between government and Taliban forces continues in areas south and southeast of Kabul. Despite this, people are returning to the capital city. For example, over 4,000 people returned to Kabul during the last week in May. Food convoys continue to enter the city, and markets are likely to be adequately stocked [UNHAA 06/06/96].

A massive immunisation campaign, which began in November 1994, is continuing, and the next round of immunisations is scheduled for June, then July. The July campaign will immunise and also distribute vitamin A [UNHAA 06/06/96].

*Displaced in Jalalabad* There are approximately 160–200,000 displaced people in five camps near Jalalabad city. The majority have fled Kabul and surrounding areas since 1992.

Nutritional surveys were conducted between December 1995 and February 1996 in two camps as well as in Jalalabad city and Shenwar district, to determine if there had been any adverse nutritional effects since the reduction in general ration programme for the displaced. The surveys showed a reasonable nutritional status amongst the displaced and local populations. In *New Hadda* camp (estimated population of 30,000) low levels of wasting and/or oedema of 4.0% with 0.6% severe wasting and/or oedema were measured (see Annex I (17a)). Measles immunisation coverage was estimated to be 79%. In *Sarshahi* camp (estimated population of 80,000) wasting and/or oedema was measured at 4.7% with 1.6% severe wasting and/or oedema (see Annex I (17b)). Measles immunisation coverage was estimated at 80.7%. These rates were slightly higher than those measured in the surrounding local population living in Jalalabad city (3.2%) and Shenwar district (2.6%) [MSF-H.28/03/96].

According to food basket monitoring data, general rations received by those in the camps in the previous three months supplied 25% of caloric needs. Food stocks at household level seemed satisfactory but the survey was conducted immediately after a general ration distribution. Selling assets, borrowing money and goods and selling labour were observed to be the main sources of cash income for the camp populations. The average income only covered about 63% and 47% of the cost of the minimum diet in Sarshahi and New Hadda camp respectively. The survey concluded that the way internally displaced people are coping at present by selling personal assets is increasing their vulnerability; that the food security situation of the IDPs is precarious especially in New Hadda where income earning opportunities and food security are very poor [MSF-H 28/03/96]. More recently, food for work opportunities are being offered to improve food security [WFP 20/06/96].

The observed incidence of diarrhoea recorded in the camps and among the local population is very high especially given that March is not a peak season for diarrhoea. The main reasons are thought to be poor environmental sanitation and lack of knowledge of hygiene and cleanliness practices [MSF-H 28/03/96].

*Refugees in Pakistan* There remain approximately 860,000 Afghan refugees in Pakistan. It is expected that 250,000 will repatriate in 1996 and a further 300,000 in 1997. Most of the remaining refugees are considered to be self-sufficient so that general ration distributions have been replaced by a targeted feeding programme called a "safety net programme". This programme provides edible oil to refugee mothers attending Basic Health Units and female children attending primary schools. Oil rations are also provided to women involved in NGO-assisted training centres, the handicapped and new arrivals [UNHCR 21/05/96].

Approximately 8,000 refugees in Pakistan who arrived since 1994 are not yet considered to be self-sufficient and this group receives a more comprehensive general ration [UNHCR 21/05/96].

A nutrition survey conducted in refugee villages in Pakistan carried out in March and April 1996 showed a relatively adequate nutritional situation amongst the refugee population with overall levels of wasting having declined since October 1995. Levels of wasting and/or oedema varied from 1.8–3.6% with 0.6–1.1% severe wasting and/or oedema (see Annex I (17 c–f)). In all surveyed areas, children between 60–77 cms in height (less than 2 years) were found to have highest levels of wasting, which were attributed largely to poor weaning practices [UNHCR Mar–Apr 96].

The survey also found that the occurrence of diarrhoea had declined compared to October 1995 and that all refugee populations had reasonable access to water although maintenance of supplies was sometimes difficult [UNHCR Mar–Apr 96].

*Refugees in Iran* There are approximately 1.4 million Afghan refugees in Iran of whom 20,000 live in camps and receive assistance. The remaining refugees live and work amongst the local population. It is possible that deteriorating economic conditions in Iran will place an increasing strain upon those refugees living outside the camps. Rising prices, limited job opportunities and dwindling purchasing power may begin to adversely affect the nutritional status of this population. In 1996, the ration to those refugees in camps has been increased by including sugar and rice. A nutritional survey is planned for the end of June 1996 to determine whether there has been any change in the nutritional status of these refugees [MSF-F 04/06/96, WFP 20/06/96].

*Overall*, the population affected regionally is not currently considered to be at heightened nutritional risk (category IIc in Table 1), although the population in Kabul will need to be monitored if there are further disruptions to the food supply.

***How could external agencies help?*** Considerable support has already been received for a national immunisation project in Afghanistan. However, some additional support and initiatives are still needed for this project. For example:

- there remains a budget shortfall of US\$600,000;
- a substantial publicity campaign is needed within Afghanistan to help mobilise communities through broadcasting the benefits of immunisation;
- publicity aimed at convincing the warring factions of the need for a period of tranquillity so the immunisation campaign can be carried out.

Current general ration levels should be maintained in the camps for the internally displaced around Jalalabad in order to avoid any deterioration in nutritional status. Furthermore, agencies should focus on saving limited assets of IDPs by providing other opportunities of earning income/food. There also needs to be an expand EPI coverage and an investigation into the reasons for high levels of diarrhoea in the camps. A follow-up nutrition survey should be undertaken in six months time to allow establish a different seasonal baseline.

There is a need to expand the “safety net system” food ration system amongst Afghan refugees in Pakistan so that families with malnourished children also receive the edible oil. This would necessitate developing a nutritional surveillance programme to serve the dual purpose of estimating the prevalence of wasting and identifying malnourished children for inclusion in the programme. Simultaneously, the ‘basic health unit’ system needs to be strengthened so that it can act as a channel for the provision of edible oil to all families identified with malnourished child. This will involve identifying additional CHWs to conduct nutritional monitoring in order to refer malnourished children to local health unit.

### **18. Bhutanese Refugees in Nepal (see Map 18)**

There are approximately 90,000 Bhutanese refugees living in camps in Nepal and a further 15,000 living outside the camps who do not receive humanitarian assistance.

The nutritional and health situation of this population remains essentially adequate. 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 [UNHCR 21/05/96].

*Overall*, this population is not considered to be at heightened nutritional risk (category IIc in table 1), although a small number of people are at high nutritional risk due to the existence of micro-nutrient deficiency diseases.

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

There are approximately 54,000 refugees from Rakhine State Myanmar in Bangladesh. There have been approximately 5,500 new arrivals from Myanmar during the months of April and May. The majority of these new arrivals appear to be fleeing poverty in their home country. It is currently being discussed whether these new arrivals should be considered as economic migrants (and hence not under the protection of the international community) or refugees.

A recent report on the security and human rights situation inside Rakhine State stated that “UNHCR is playing a key role in helping to ensure conditions in Rakhine State are conducive to the return of the refugees....” [ECOSOC 05/02/96], however, repatriation is still only continuing at a slow pace.

There is no reported change to the generally adequate nutritional and health status of this population although low levels of angular stomatitis persist despite the availability of blended foods, fish and dal in the general ration [UNHCR 21/05/96].

*Overall*, this population is not currently considered to be at heightened nutritional risk (category IIc in Table 1), although a small number of people are at high nutritional risk due to the existence of micro-nutrient deficiency diseases.

## 20. Southern Iraq

A report by the Special Rapporteur for Iraq in March 1996 is one of a recent series describing “a constantly deteriorating situation for most of the population, especially the most vulnerable segments, comprised of children, pregnant and nursing mothers, the elderly, the disabled, and the increasingly large numbers of destitute.” [ECOSOC 04/03/96]. The report describes how food prices increased by over 300% in 1995, while salaries and wages remained unchanged. Although the government has continued distribution of its subsidised food basket of five essential food items, a large percentage of the population is estimated to have a shortfall in calorie intake of over 50% of requirements. Recent nutrition surveys throughout the country have consistently found widely prevalent moderate and severe malnutrition and vitamin A deficiency among children.

It must be assumed that the nutritional and health status of the 220,000 Marshland Arabs in particular is being critically undermined by the economic situation in Iraq. This population have experienced 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 further stretched the survival capacity of this population.

A recent agreement between the international community and the government of Iraq that the latter will purchase food and medicine in exchange for oil has raised some cautious hopes that the nutritional and health situation of the Iraqi population will improve [WFP 24/05/96]. However, the Marsh Arabs have in the past been one of the most ostracised groups within Iraq so that it is unlikely that any increased availability of foods and medicine will directly benefit this highly vulnerable population.

There is no reported change to the adequate nutritional status of the approximately 28,000 Marsh Arabs who have fled the southern marshes and are now residing in camps in Iran [UNHCR 21/05/96].

*Overall*, Those remaining the marshes are likely to be at high nutritional risk (category IIa in Table 1) while those who have crossed the border into Iran are probably not at heightened nutritional risk (category IIc in Table 1).

### LISTING OF SOURCES FOR JUNE 1996 RNIS REPORT

Org*	Date	Title of Report
CONCERN	28/04/96	Nutrition Survey Report for Malange City
DHA	22/04/94	Bi-Monthly Information Report – Somalia
DHA	03/06/96	Humanitarian Assistance in Angola (week 22)
DHA	Apr. 96	Monthly Information Report – Ethiopia
DHA	27/04/96	Burundi – Humanitarian Situation Report
DHA	03/05/96	Bi-Monthly Information Report – Somalia
DHA	27/05/96	Humanitarian Assistance in Angola
DHA	06/05/96	Burundi – Humanitarian Situation Report No 17
DHA	06/06/96	Bi-Monthly Information Report – Somalia
DHA	09/06/96	Humanitarian Situation Report–Liberia
DHA	07/05/96	Humanitarian Assistance in Angola (week 18)
DHA	10/05/96	Situation Report on Masisi and Rutshuru, North Kivu, Zaire
DHA	12/05/96	Humanitarian Situation Report – Liberia No 15
DHA	14/05/96	Humanitarian Situation Report – Liberia No 16

DHA	15/04/96	Bi-Monthly Information Report – Somalia
DHA	17/05/96	IRIN Weekly Roundup of Main Events in the Great Lakes Region
DHA	18/04/96	Bi-Monthly Information Report No3 Sierra Leone
DHA	18/04/96	Monthly Information Report – Rwanda
DHA	22/04/96	Humanitarian Assistance in Angola (week 12–14)
DHA	29/04/96	Humanitarian Assistance In Angola (week 15–17)
ECOSOC	04/03/96	Report on the Situation of Human Rights in Iraq
ECOSOC	02/05/96	Report on the Situation of Human Rights in Myanmar
FAO	31/05/96	FAO/WFP Crop and Food Supply Assessment Mission to Mozambique
FAO	21/05/96	Special Alert No 268 – Liberia
FAO	23/05/96	FAO/WFP Crop and Food Supply Assessment Mission to Angola
FAO	28/12/95	FAO/WFP Crop Assessment Mission to Rwanda
GOAL	31/05/96	Personal Communication – Ethiopia
ICRC	03/06/96	Tension on the Zaire/Rwanda Border
ICRC	05/06/96	Afghanistan: Merciful (and Timely) Action
ICRC	04/06/96	Three ICRC Delegates Killed in Burundi
ICRC	30/05/96	Angola: ICRC on the alert to prevent food shortages
IHT	20/06/96	With Clan Wars Hindering UN Food Aid, Somalis are Fleeing
IRIN	12/04/96	Weekly Roundup of Events in The Great Lakes Region
IRIN	19/04/96	Weekly Roundup of Events in The Great Lakes Region
IRIN	26/04/96	Weekly Roundup of Events In The Great Lakes Region
IRIN	03/05/96	Weekly Roundup of Events in The Great Lakes Region
IRIN	07/06/96	Weekly Roundup of Events in The Great Lakes Region
MDM	21/05/96	Monthly Report – Malian Refugees in Mauritania
MEDAIR	Mar.96	Nutritional Assessment Attar Region, Southern Sudan
MERLIN	02/06/96	Nutrition Survey – Petite Barriere, Gisenyi, Rwanda
MSF–B	01/03/96	Sherbo and York Islands (Bonthe) Sierra Leone
MSF–B	08/05/96	Rapport Intermediare Epidemie de Cholera 1996 Kismayo, Somalie
MSF–CIS	Feb. 96	Report No 41 – April 96
MSF–CIS	27/05/96	Personal Communication – Pellagra In Mozambique
MSF–F	04/06/96	Personal Communication – Iran
MSF–H	Mar. 96	Mortality Figures – Koboko Camps
MSF–H	Mar.96	Rapid Nutritional Assessment Sudanese Internally Displaced Mangalatore Camp
MSF–H	05/05/96	Trip Report – Khartoum
MSF–H	28/03/96	Nutrition and Vaccination Survey – Nangarhar Province, Afghanistan

OLS	Mar. 96	Monthly Information Report – Sudan
OLS	May. 96	Monthly Information Report – Sudan
SCF	20/05/96	Personal Communication – Ghana
SCF	23/03/96	Refugee Food Security in Ngara
UN	Mar. 96	United Nations Consolidated Inter–Agency Appeal (or Sierra Leone
UN	Jan–Dec 96	United Nations Consolidated Inter–Agency Appeal for Sudan
UN–a	Jan–Dec 96	UN Updated Consolidated Inter–Agency Appeal for Angola
UNHAA	06/05/96	Humanitarian Assistance for Afghanistan Weekly Update Issue No 166
UNHAA	06/06/96	Humanitarian Assistance for Afghanistan Weekly Update Issue No 170
UNHAA	13/05/96	Humanitarian Assistance for Afghanistan Weekly Update Issue No 167
UNHAA	27/05/96	Humanitarian Assistance for Afghanistan Weekly Update Issue No 169
UNHCR	01/05/96	Preliminary Results of Cencus
UNHCR	16/01/96	Situation Report –CAR
UNHCR	17/01/96	Situation Report – Zaire
UNHCR	Mar. 96	Summary of Survey Results – Uvira
UNHCR	Apr. 96	Appeal for the Repatriation and Reintegration of Togolese Refugees
UNHCR	04/06/96	Personal Communication – Mauritania
UNHCR	10/04/96	Food Supply in Tanzania
UNHCR	11/06/96	Personal Communication – Kenya
UNHCR	18/06/96	Comments on Burundi/Rwanda
UNHCR	18/04/96	Summary of Mission Report – Great Lakes Region
UNHCR	1995–1997	Appeal (or the Repatriation and Reintegration of Angolan Refugees
UNHCR	20/05/96	Food Situation in Bukavu
UNHCR	21/05/96	Personal Communication – Iran, Pakistan, Nepal and Bangladesh
UNHCR	23/05/96	Personal Communication – Sudan and Uganda
UNHCR	24/05/96	Personal Communication – Liberia
UNHCR	Mar–Apr 96	Nutrition Survey of Afghan Refugees In Pakistan
UNHCR	1996	Repatriation and Reinteration of Ethiopian Refugees
USAID	24/04/96	Liberia Complex Emergency Fact Sheet #10
USAID	07/05/96	Liberia Complex Emergency Fact Sheet #16
USAID	08/05/96	Liberia Complex Emergency Fact Sheet #17
USAID	13/05/96	Liberia Complex Emergency Fact Sheet #19
USAID	24/05/96	Liberia Complex Emergency Fact Sheet #21
USAID	10/06/96	Situation Report #3 Sudan
USAID	09/04/96	Somalia – Complex Emergency Situation Report #2
USAID	16/05/96	Liberia Complex Emergency Fact Sheet #20



USAID	21/05/96	Liberia Complex Emergency Fact Sheet #21
USAID	23/05/96	Situation Report #3 Burundi
WFP	03/05/96	Weekly Update
WFP	31/05/96	Weekly Update
WFP	07/06/96	Weekly Update
WFP	14/06/96	Weekly Update
WFP	20/06/96	Comments on Draft
WFP	10.05.96	Weekly Update
WFP	12/04/96	Weekly Update
WFP	17/05/96	Weekly Update
WFP	19/04/96	Weekly Update
WFP	21/05/96	Personal Communication – Afghanistan
WFP	24/05/96	Weekly Update
WFP	26/04/96	Weekly Update
WFP	26/04/96	Weekly Update
<b>*Org</b>		
ACF	Action Contre la Faim	
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	
IHT	International Herald Tribune	
IRIN	Integrated Regional Information Network (from DHA)	
Min of Health	Ministerio da Sauda, 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	
UNAH	United Nations Humanitarian Assistance Coordination Unit (Angola)	
UNECOSOC	United Nations Economic and Social Council	

UNHAA	United Nations Humanitarian Assistance for Afghanistan
UNHCR	United Nation's High Commission on Refugees
UNHRCS	United Nations Humanitarian and Resident Coordinator for Somalia
UNICEF	United Nation's Children Fund
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision

## LIST OF TABLES AND FIGURES

Table 1: Information Available on Total Refugee/Displaced Populations (as of June 1996)

Situation	Population Numbers				Total	Change from Apr. 96	Nutr Stat*	Comments
	Condition							
	I: High Prev	Ila: High Risk	Ilb: Mod Risk	Ilc: Not Critical				
<b>Sub-Saharan Africa</b>								
1. Angola (id/wa)	81'500		1'293'500		1'375'000	375'000	det	Pockets of malnutrition are still being found in newly accessible areas. Some evidence of increasing levels of wasting in accessible areas. Demobilised soldiers and dependents at high risk.
2. Benin/Ghana/Togo Region				106'800	106'800	-4'200	stat	Decreased total due 10 repatriation.
3. Burkina Faso/Mauritania			30500	27'000	57500	-2'500	stat	Decreased total due to repatriation. High levels at wasting likely to be decreasing.
4. Burundi/Rwanda Region	12'000	489'000		2'605'000	3'106'000	282'100	stat	Increased total due to influx into Uvira, Zaire and Tanzania of

									Burundi refugees.
5. Central African Republic				32'000	32'000	0	stat		
6. Djibouti				2'500	2'500	-22'500	stat		Decrease due reparation.
7. Ethiopia	81'000		173'000	122000	376'000	0	stat		Nutritional risk from mid-1995 data; reported unchanged.
8. Kenya				176'000	176'000	3'000	stat		A possible risk scurvy exists for this population, and the situation needs to be monitored, especially August-October when outbreaks have occurred in the past. Increase due to slight influx of Sudanese.
9. Liberia/Sierra Leone/Guinea/Côte d'Ivoire		1'100'000	1'456'000	841'000	3'397'000	0	stat/det		Many in Liberia both in Monrovia and in the country, expected to be at increased risk.
11. Mozambique Region				154'000	154'000	-1'046'000	imp		Decreased number of beneficiaries due to better food production in most areas. Flooding is increasing risk for some.
12. Somalia			840'000		840'000	0	det		Continued insecurity resulting in vulnerability, Juba Valley at high risk due to crop failure and conflict.
13. Sudan	119'000		1'854'000	200000	2'173'000	0	det		Decreased total due to revised number of internally displaced in camps around Khartoum Thos in the south and

								<i>transitional zone may be at increasing risk due to poor harvests and constraints on OLS activities.</i>
14. Uganda				227'000	227'000	0	det	<i>Some disruptions to food aid delivery in to north, no apparent adverse effects on nutritional status,</i>
15. Zaire	260000			156'000	416'000	-464'000	det/stat	<i>The high risk group includes those from Mwene Ditu based on end 1995 data: reportedly unchanged. Others displaced from Shaba no longer receiving assistance.</i>
16. Zambia				26'000	26'000	0	stat	
<b>Total (Sub-Saharan Africa)</b>	553'500	1'589'000	5'647'000	4'675'300	12'464'800	-930'100		
<b>Asia (Selected Situations)</b>								
17. Afghanistan Region			570'000	2'260'000	2'830'000	0	stat	<i>Generally adequate nutritional status for refugees in Pakistan and displaced in Jalalabad.</i>
18. Bhutanese Refugees in Nepal				90'000	90'000	0	stat	<i>Low levels of micronutrient deficiencies continue to be reported,</i>
19. Bangladesh				50'000	50'000	0	imp	<i>Decreasing prevalence of riboflavin deficiency (angular stomatitis).</i>
20. Southern Iraq		192'000		28'000	220'000	0	det	<i>Those in Marshes considered at</i>

*I: High Prev* – Those reported with prevalences of malnutrition (where available >20% wasting) 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 (e.g. wasting).

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

*Ilc: 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 June 1996 – RNIS #16 (population estimates in thousands)**

<b>From</b>	<b>To/In</b>										
	<b>Angola</b>	<b>Benin</b>	<b>Burkina Faso</b>	<b>Burundi</b>	<b>Côte d'Ivoire</b>	<b>Eritrea</b>	<b>Ethiopia</b>	<b>Ghana</b>	<b>Guinea</b>	<b>Kenya</b>	<b>Liberia</b>
Angola	1'375										
Benin											
Burkina Faso											
Burundi				200							
Cote d'Ivoire											
Eritrea											
Ethiopia							11			6	
Ghana											
Guinea											
Kenya							9				
Liberia					305			16	408		1'70
Mali			27								
Mauritania											
Mozambique											
Rwanda				89							
Sierra Leone									128		10
Somalia							275			125	
Sudan							63			45	
Tanzania											

Togo		20						71				
Uganda												
Zaire												
Zambia												
TOTAL	1'375	20	27	289	305	0	358	87	536	176	1'800	0

NOTES: (1) This chart is intended to include major population groups in Africa (i.e. some groups of less than 50,000 are not included).

(2) Boxes on the diagonal (shaded) show internally displaced populations (total = 8.2 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/Guinea/Côte d'Ivoire the description is by country of origin (i.e. row totals).

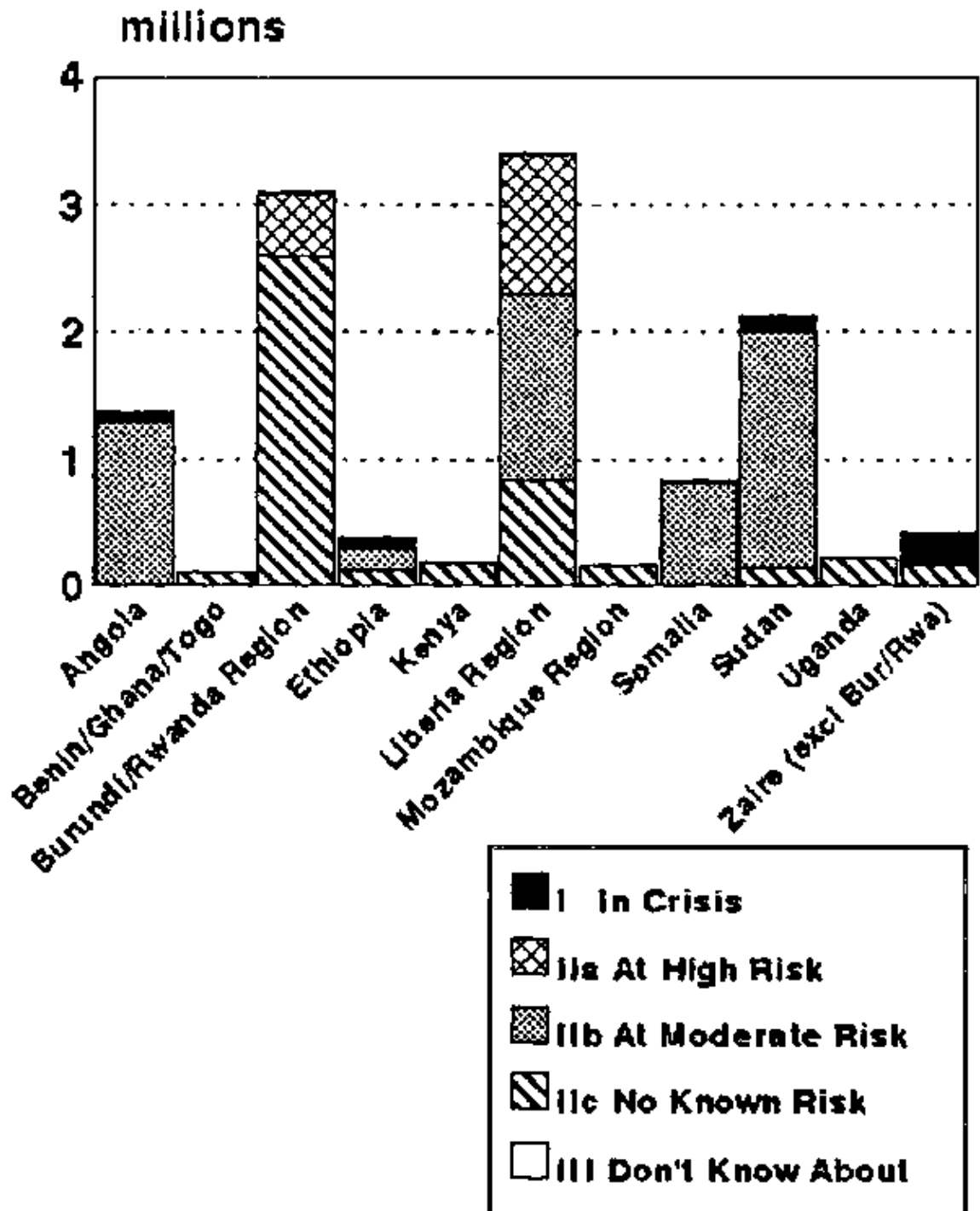


Figure 1 – REFUGEE AND DISPLACED POPULATIONS Selected Areas in Africa (June 1996)

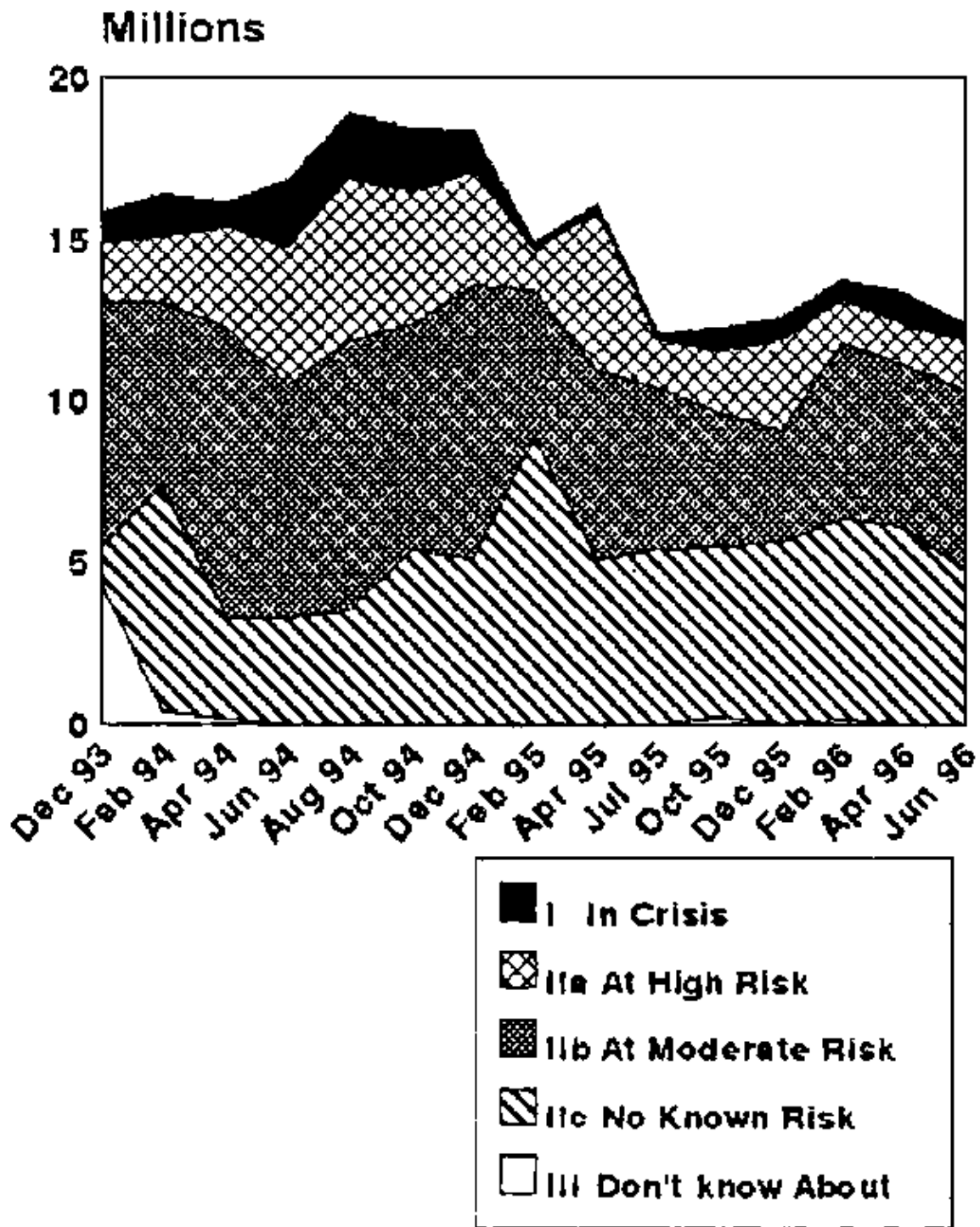
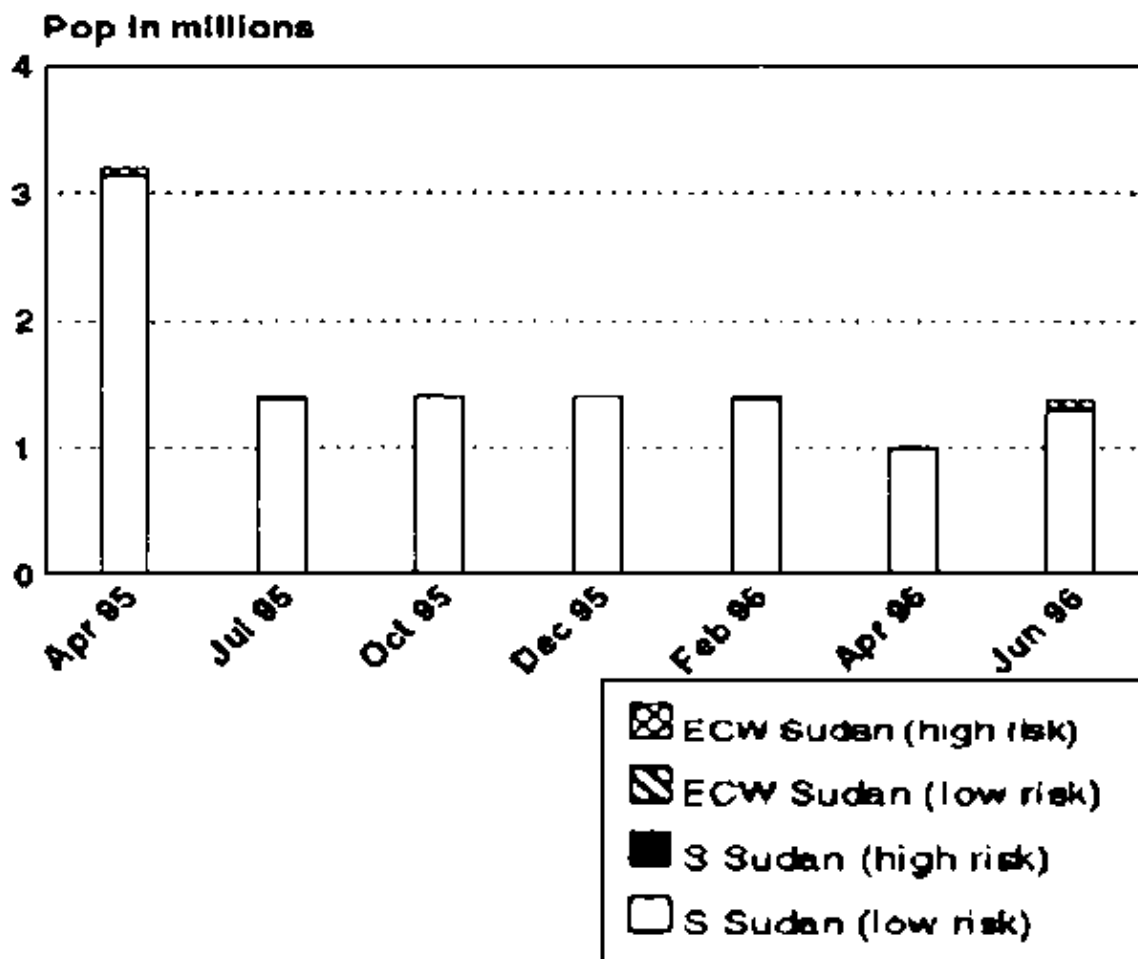


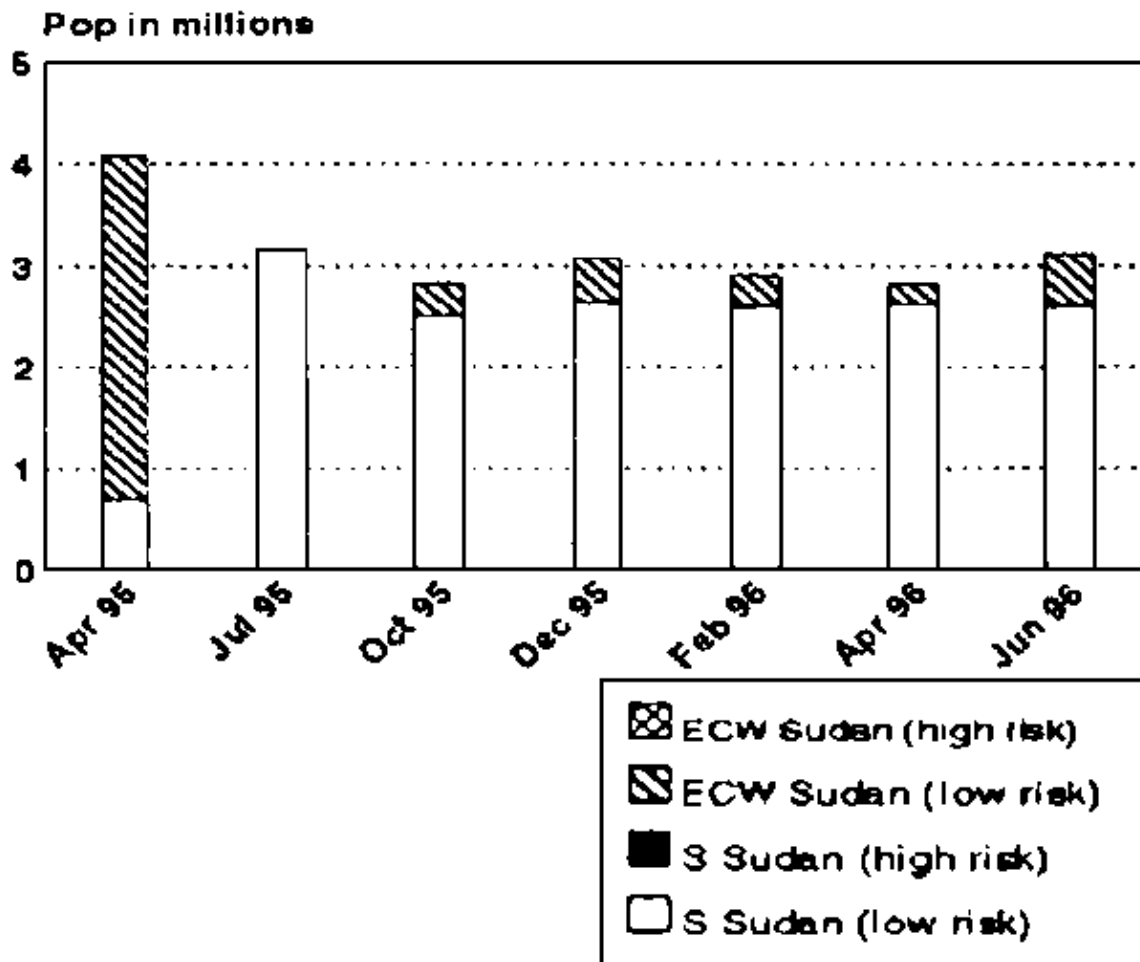
Figure 2 Trends in Total Refugee/Displaced Populations By Risk Categories Africa: December 1993–June 1996

Figure 3 – Shaded areas indicate those at heightened nutritional risk (categories I and IIa in Table 1).

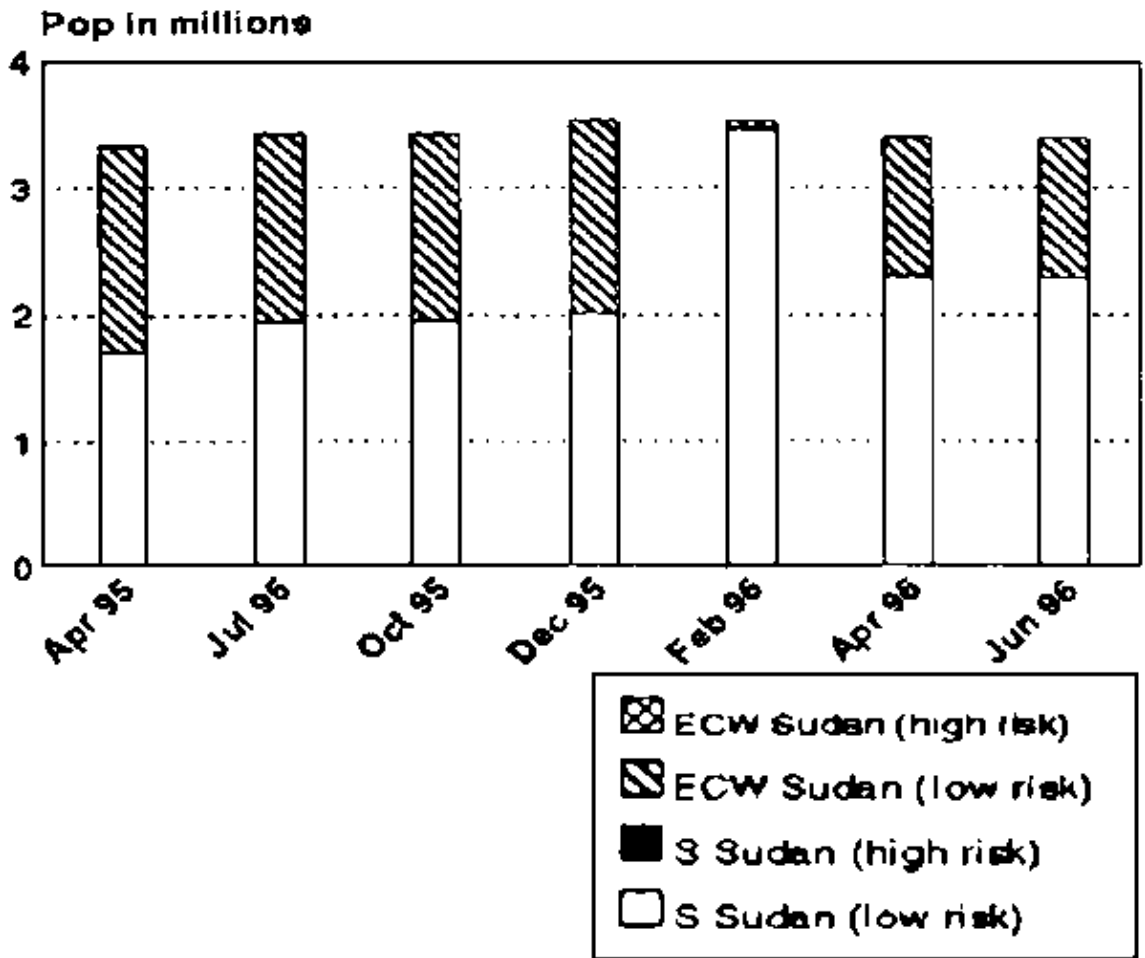




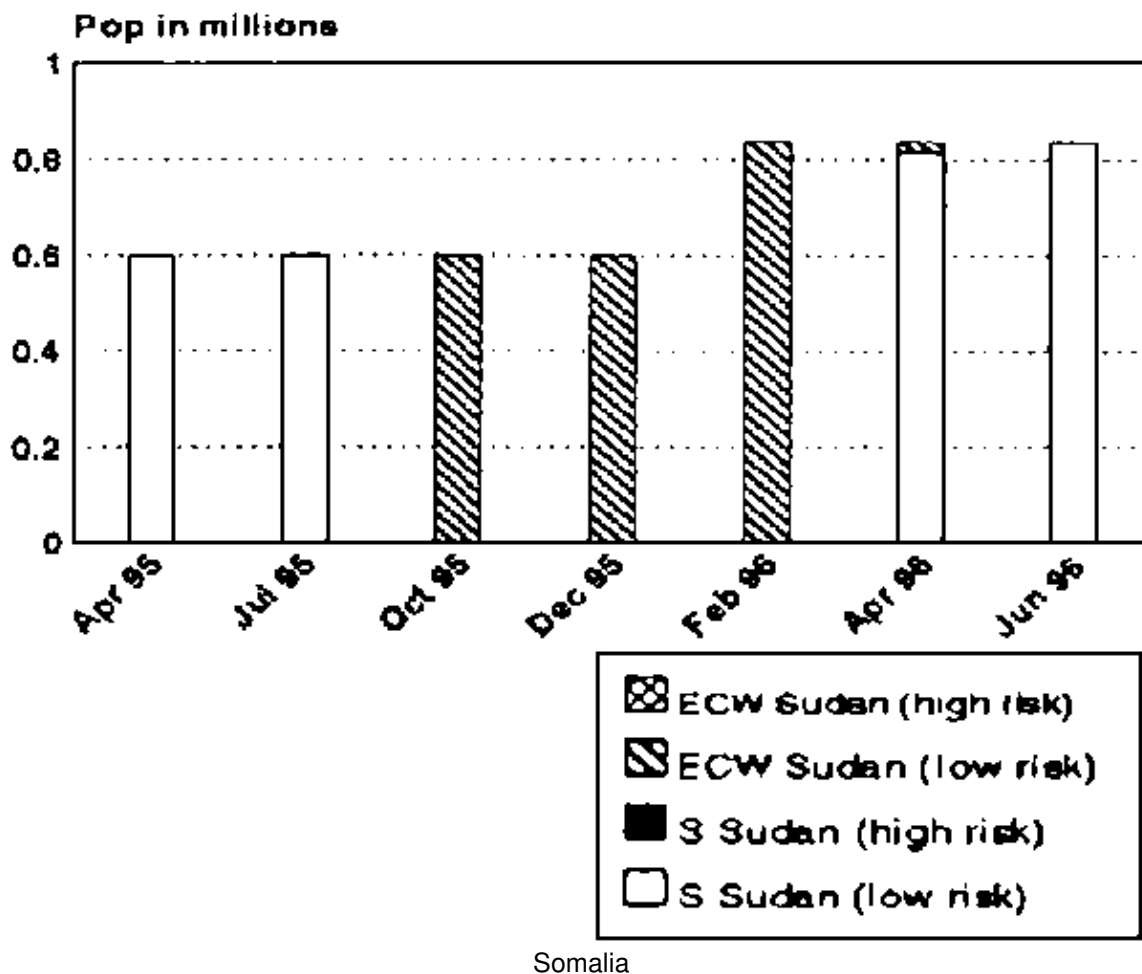
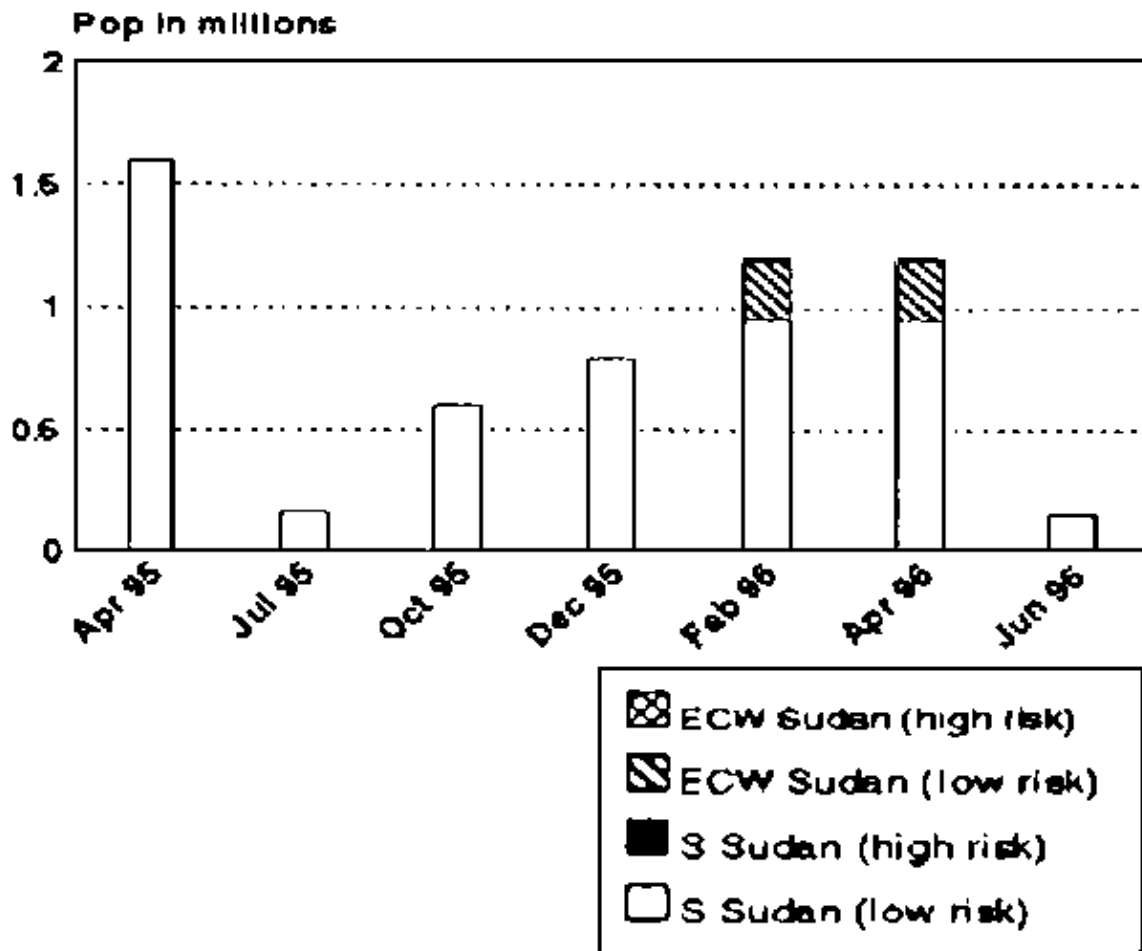
Angola

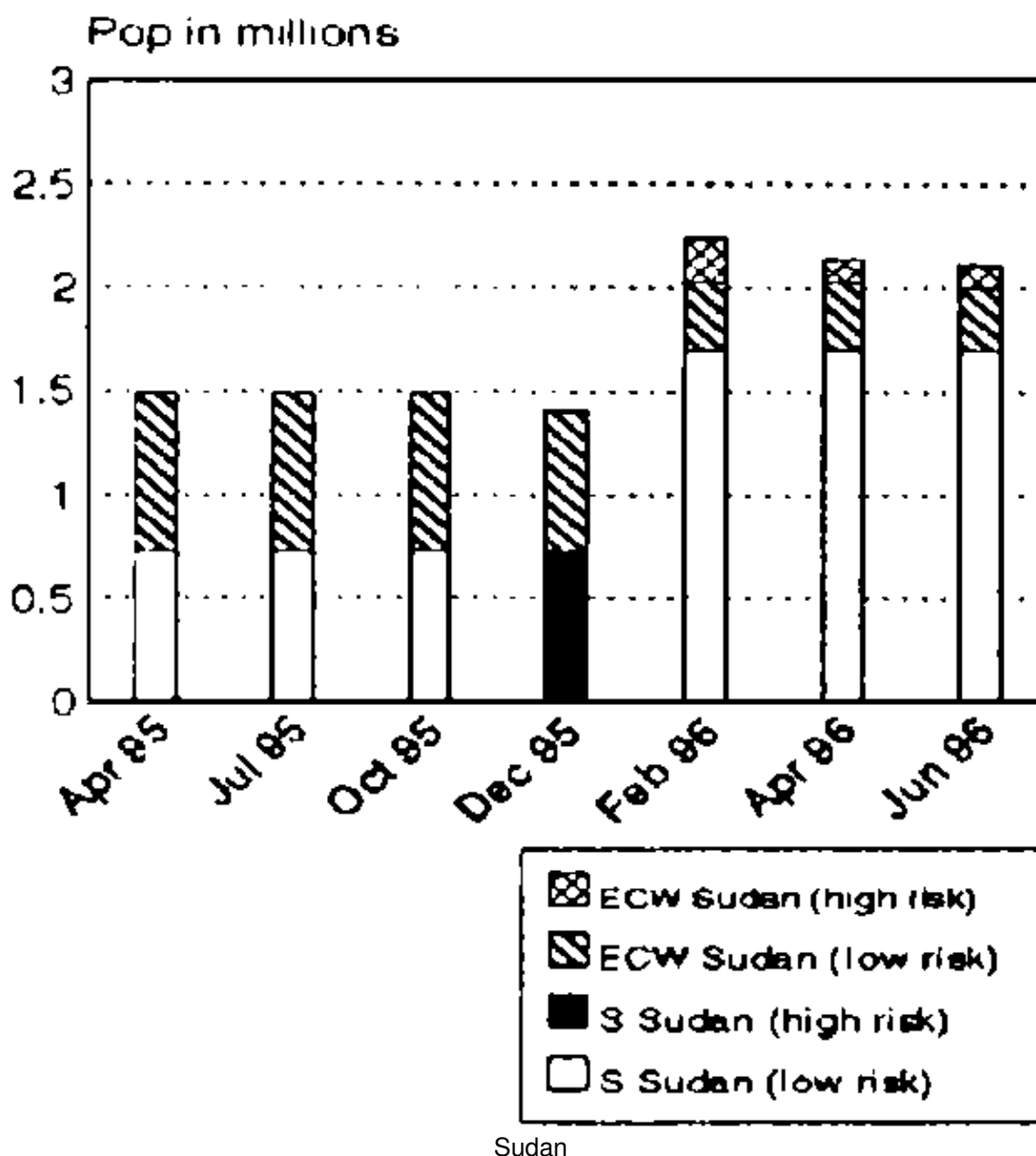


Burundi/Rwanda Region



Liberia/Sierra Leone





## ANNEXES

### Annex I: Results of Surveys Quoted in June RNIS Report (#16) – 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 Cove
<b>1. Angola</b>								
<i>a. Maseca, Kuando Kubango Province</i>	CARE	Apr. 96	4.5**	3.6**				
<i>b. Jamba, Kuando Kubango Province</i>	CARE	Apr. 96	11.2**	3.1**				

<i>c. Malange</i>	CONCERN/MSF-H	May. 96	8.1**	1.1**				
<i>d. Golungo Alto</i>	WV	May. 96	6.8**	1.8**				
<i>e. Vila Nova (quartering area)</i>	UNITA/NGOs	May. 96	15.7**	5.4**				
<i>f. Negage (quartering area)</i>	UNITA/NGOs	May. 96	13.2**	1.4**				
<i>g. Piri/Quibaxe (quartering area)</i>	UNITA/NGOs	May. 96	15.6**	4.6**				
<i>h. Londuimbali (quartering area)</i>	UNITA/NGOs	May. 96	20.0**	8.0**				
<b>4. Burundi/Rwanda Region</b>								
<i>a. Petite Barriere Camp, Rwanda</i>	MERLIN	Apr. 96	17.0**	7.4**				
<i>b. Runingo, Uvira</i>	UNHCR	Apr. 96	8.3	0.5	0.5			
<i>c. Kajembo, Uvira</i>	UNHCR	Apr. 96	5.9	0.8	0.0		1.4	
<i>d. Kagunga, Uvira</i>	UNHCR	Apr. 96	11.0	2.3	0.9		0.7	
<i>e. Kibogoye, Uvira</i>	UNHCR	Apr. 96	9.7	0.9	0.9			
<i>f. Luvungi, Uvira</i>	UNHCR	Apr. 96	5.6	0.4	0.9			
<i>g. Biriba, Uvira</i>	UNHCR	Apr. 96	4.8	0.7	0.0			
<i>h. Kanganiro, Uvira</i>	UNHCR	Apr. 96	2.6	0.0	0.4			
<i>i. Rwenena, Uvira</i>	UNHCR	Apr. 96	4.2	0.5	0.9			
<i>j. Luberizi, Uvira</i>	UNHCR	Apr. 96	2.3	0.5	0.5			
<i>k. Chabilisa 11, Tanzania</i>		May. 96	2.0					
<b>9. Liberia/Sierra Leone</b>								
<i>a. Bonthe Islanda</i>	MSF-B	Mar. 96	5.6**	0.6**				22.8%

<b>11. Mozambique</b>								
<i>a. Menba District, Nampula</i>	MSF-CIS	Mar. 96	13.2	3.0				
<i>b. Chiuta, Tete</i>	MSF-CIS	Jan. 96	11.0	2.3				
<b>13. Sudan</b>								
<i>a. Attar Region, S Sudan</i>	MEDAIR	Mar. 96	25.6 (<80%)	5.8 (<5.8)				
<i>b. Mangalatore Camp, S Sudan</i>	MSF-H	Mar. 96	15.0 (MUAC)	1.8 (MUAC)				
<b>14. Uganda</b>								
<i>a. Koboko Camps</i>	MSF-H	Mar. 96				0.21	0.75	
<b>17. Afghanistan Region</b>								
<i>a. New Hadda Camp, Jalalabad</i>	MSF-H	Dec. 95	4.0**	0.6**				7
<i>b. Sarshahi Camp, Jalalabad</i>	MSF-H	Dec. 95	4.7**	1.6**				8
<i>c. NWFP, Pakistan</i>	UNHCR	Mar. 96	3.3**	0.9				
<i>d. Balochistan, Pakistan</i>	UNHCR	Mar. 96	2.6**	0.6**				
<i>e. Punjab, Pakistan</i>	UNHCR	Mar. 96	1.8**	0.8**				
<i>f. Nasir-Bagh, Pakistan</i>	UNHCR	Mar. 96	3.6**	1.1**				

\* 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 CARE International in Masseca, Kuando Kubango Province. Specific cut-offs were not given, but it is likely that wasting is defined as wt/ht <-2 SDs and severe wasting <-3 SDs. Oedema is added to figures for wasting. No further details are currently available.

b. This survey was carried out by CARE International in Jamba, Kuando Kubango Province. Specific cut-offs were not given, but it is likely that wasting is defined as wt/ht <-2 SDs and severe wasting <-3 SDs. Oedema is added to figures for wasting. No further details are currently available.

c. This survey was jointly carried out by CONCERN and MSF-H in Malange. It was a two stage cluster survey which included 768 children. Wasting is defined as wt/ht <-2 SDs and severe wasting <-3 SDs. Oedema is added to figures for wasting.

d. This survey was carried out by World Vision International in Jamba, Kuando Kubango Province. Specific cut-offs were not given, but it is likely that wasting is defined as wt/ht <-2 SDs and severe wasting <-3 SDs. Oedema is added to figures for wasting. No further details are currently available.

e-h. These surveys were jointly carried out by UNITA health teams, UCAH and some NGOs (not specified) in four of the family camp areas of the quartering areas. Specific cut-offs were not given, but it is likely that wasting is defined as wt/ht <-2 SDs and severe wasting <-3 SDs. Oedema is added to figures for wasting. No further details are currently available.

#### 4. Burundi/Rwanda (Great Lakes) Region

a. This survey was conducted by MERLIN in the Petite Barriere Camp in Rwanda on 25 March 1996. 460 children were included in the survey and wasting was defined as wt/ht <80% and severe wasting wt/ht <70%.

b. This survey was conducted by UNHCR on 20 March 1996 in Runingo camp, Uvira. It was a random sample survey including 218 children 6-59 months old. Wasting was defined as wt/ht <-2 SDs and severe wasting <-3 SDs. Oedema was recorded separately.

c. This survey was conducted by UNHCR on 21 March 1996 in Kajembo camp, Uvira. It was a random sample survey including 237 children 6-59 months old. Wasting was defined as wt/ht <-2 SDs and severe wasting <-3 SDs. Oedema was recorded separately.

d. This survey was conducted by UNHCR on 26 March 1996 in Kagunga camp, Uvira. It was a random sample survey including 172 children 6-59 months old. Wasting was defined as wt/ht <-2 SDs and severe wasting <-3 SDs. Oedema was recorded separately.

e. This survey was conducted by UNHCR on 27 March 1996 in Kibogoye camp, Uvira. It was a random sample survey including 226 children 6-59 months old. Wasting was defined as wt/ht <-2 SDs and severe wasting <-3 SDs. Oedema was recorded separately.

f. This survey was conducted by UNHCR on 25 March 1996 in Luvungi camp, Uvira. It was a random sample survey including 233 children 6-59 months old. Wasting was defined as wt/ht <-2 SDs and severe wasting <-3 SDs. Oedema was recorded separately.

g. This survey was conducted by UNHCR on 23 March 1996 in Biriba camp, Uvira. It was a random sample survey including 147 children 6-59 months old. Wasting was defined as wt/ht <-2 SDs and severe wasting <-3 SDs. Oedema was recorded separately.

h. This survey was conducted by UNHCR on 26 March 1996 in Kanganiro camp, Uvira. It was a random sample survey including 232 children 6-59 months old. Wasting was defined as wt/ht <-2 SDs and severe wasting <-3 SDs. Oedema was recorded separately.

i. This survey was conducted by UNHCR on 22 March 1996 in Rwenena camp, Uvira. It was a random sample survey including 213 children 6-59 months old. Wasting was defined as wt/ht <-2 SDs and severe wasting <-3 SDs. Oedema was recorded separately.

j. This survey was conducted by UNHCR on 22 March 1996 in Luberizi camp, Uvira. It was a random sample survey including 220 children 6-59 months old. Wasting was defined as wt/ht <-2 SDs and severe wasting <-3 SDs. Oedema was recorded separately.



k. This information was reported in the WFP weekly report. No further details are currently available.

#### 11. Mozambique

a–b. These surveys were conducted by MSF–CIS. Cut–offs for wasting are wt/ht <–2 SDs and severe wasting <–3 SDs. Oedema is added to figures for wasting.

#### 13. Sudan

a. This survey was carried out by MEDAIR in the Atar region of Southern Sudan from 6–9 March 1996. All children 65–115 cms were included in the survey for a total of 293. Wasting was defined as wt/ht <80% and severe wasting <70%.

b. This survey was carried out by MSF–Holland in Mangalatore camp, Southern Sudan in March 1996. This was a modified cluster sample survey and included 390 children 6 months to 110 cms. Wasting was defined as MUAC <125 mm and severe wasting MUAC <110 mm. Bilateral oedema was added to wasting figures.

#### 14. Uganda

a. This information comes from MSF–Holland.

#### 17. Afghanistan Region

a. This survey was carried out by MSF–Holland from 6–12 December 1995. It was a two stage cluster sample survey and included 527 children 65cms to 110cms. Cut–offs for wasting were wt/ht <–2 SDs and severe wasting <–3SDs. Oedema was added to figures for wasting.

b. This survey was carried out by MSF–Holland from 16–22 December 1995. It was a two stage cluster sample survey and included 493 children 65cms to 110cms. Cut–offs for wasting were wt/ht <–2 SDs and severe wasting <–3 SDs. Oedema was added to figures for wasting.

c. This survey was carried out by UNHCR in NWFP, Pakistan. It was a random cluster survey and included 1614 Afghan refugee children 60 cms–100 cms. Cut–offs for wasting were wt/ht <–2 SDs and severe wasting <–3 SDs. Oedema was added to figures for wasting.

d. This survey was carried out by UNHCR in Balochistan, Pakistan. It was a random cluster survey and included 1570 Afghan refugee children 60 cms–100 cms. Cut–offs for wasting were wt/ht <–2 SDs and severe wasting <–3 SDs. Oedema was added to figures for wasting.

e. This survey was carried out by UNHCR in Punjab, Pakistan. It was a random cluster survey and included 1502 Afghan refugee children 60 cms–100 cms. Cut–offs for wasting is wt/ht <–2 SDs and severe wasting <–3 SDs. Oedema was added to figures for wasting.

f. This survey was carried out by UNHCR in Nasir Bagh, Pakistan. It was a random cluster survey and included 440 Afghan refugee children 60 cms–100 cms. Cut–offs for wasting were wt/ht <–2 SDs and severe wasting <–3 SDs. Oedema was added to figures for wasting.

### Annex II: Seasonality in Sub–Saharan Africa

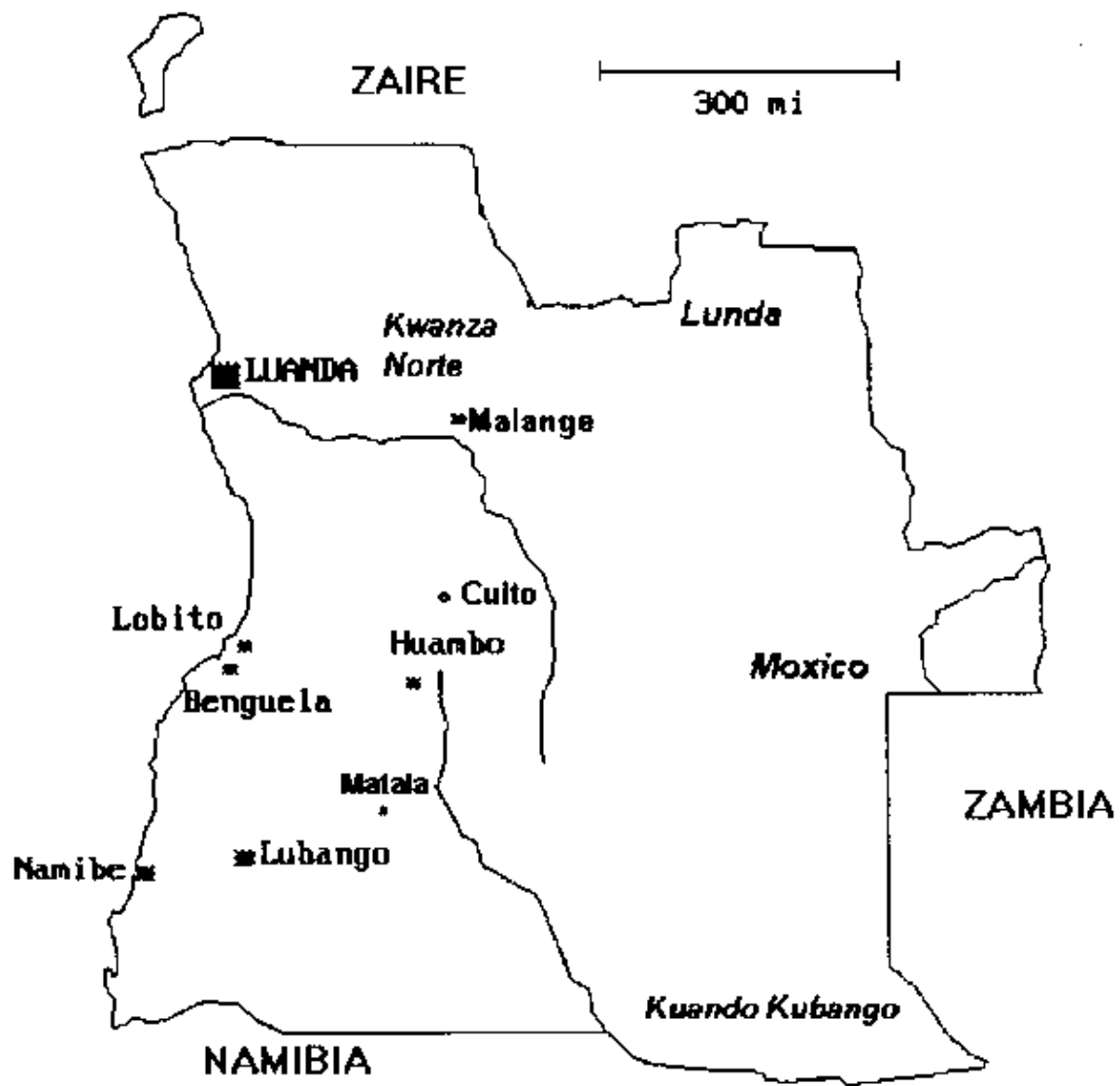
<i>Seasonality in Sub–Saharan Africa*</i>	
<i>Country</i>	<i>Climate/Rainy Season/Harvest</i>

<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.	

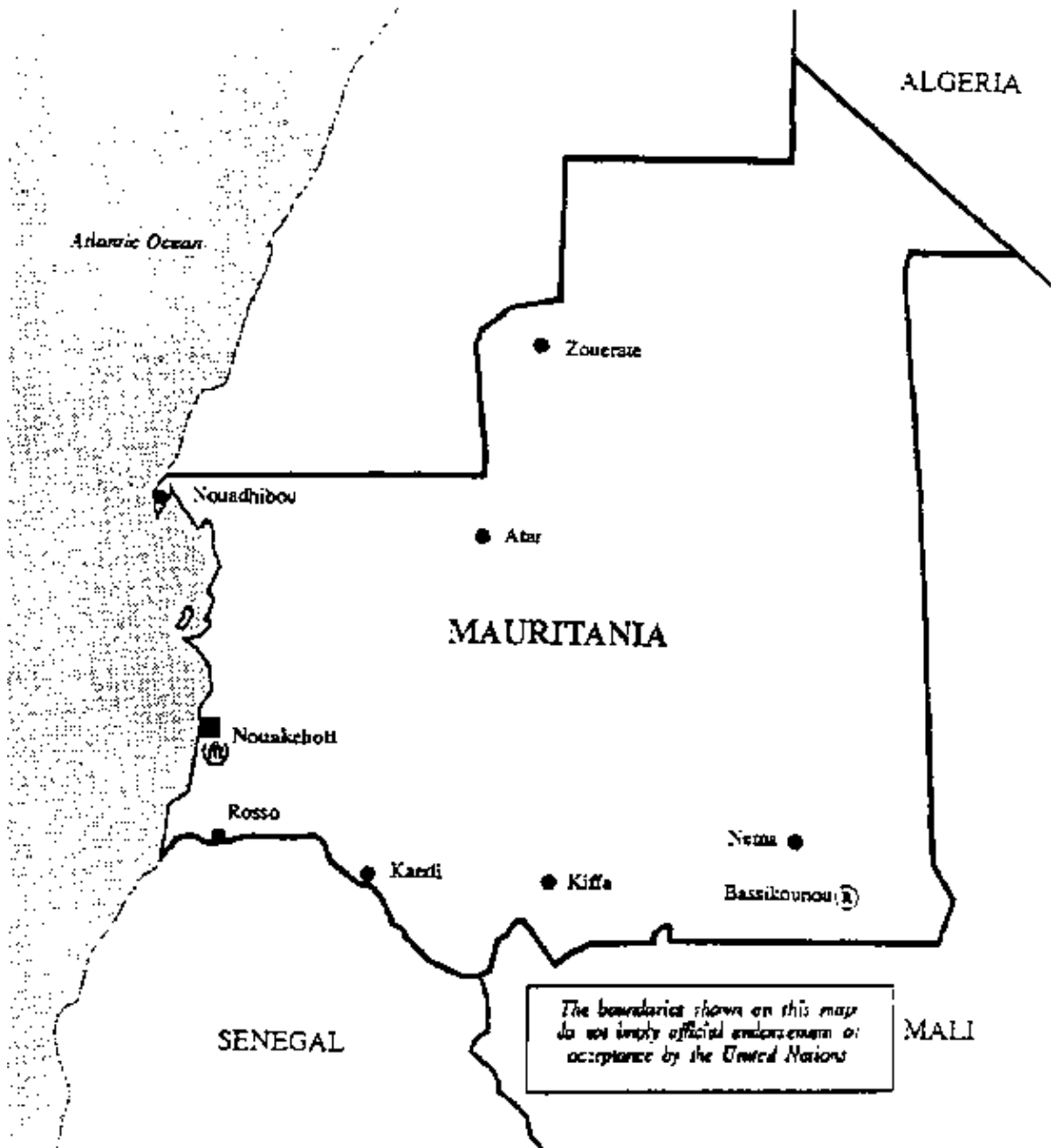
## MAPS



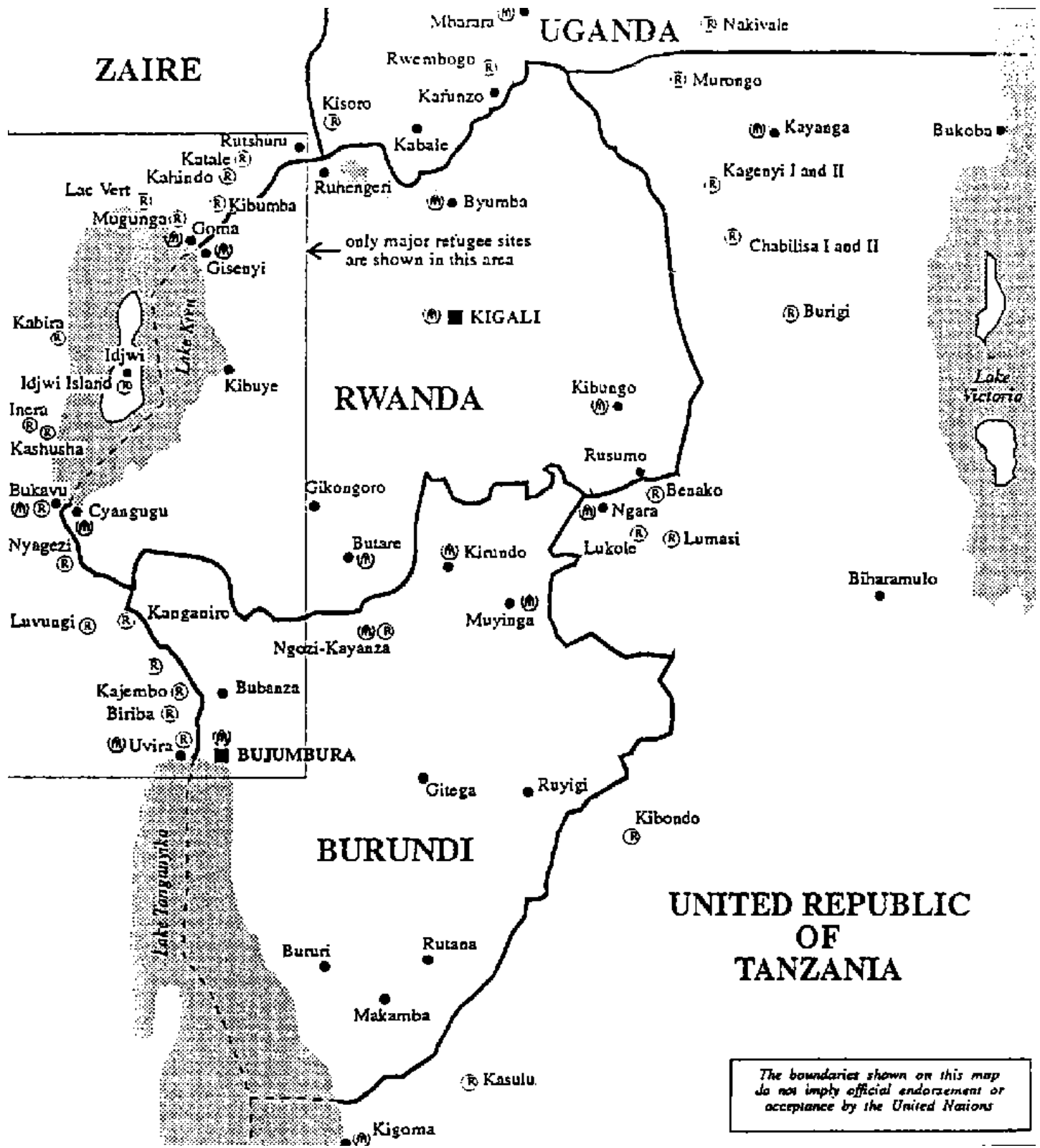
**MAP A Situational Map**



MAP 1 Angola

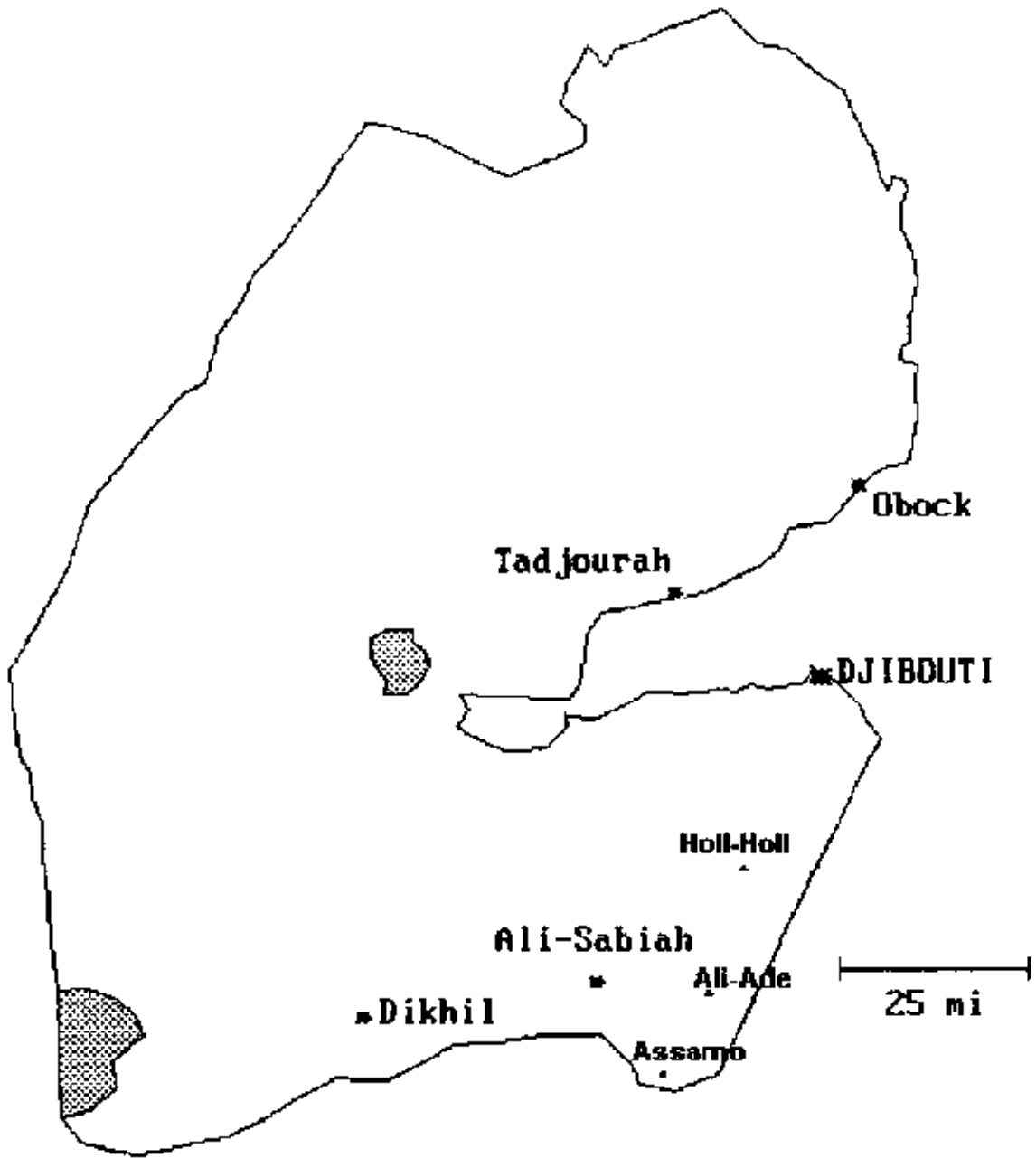


MAP 3 Mauritania

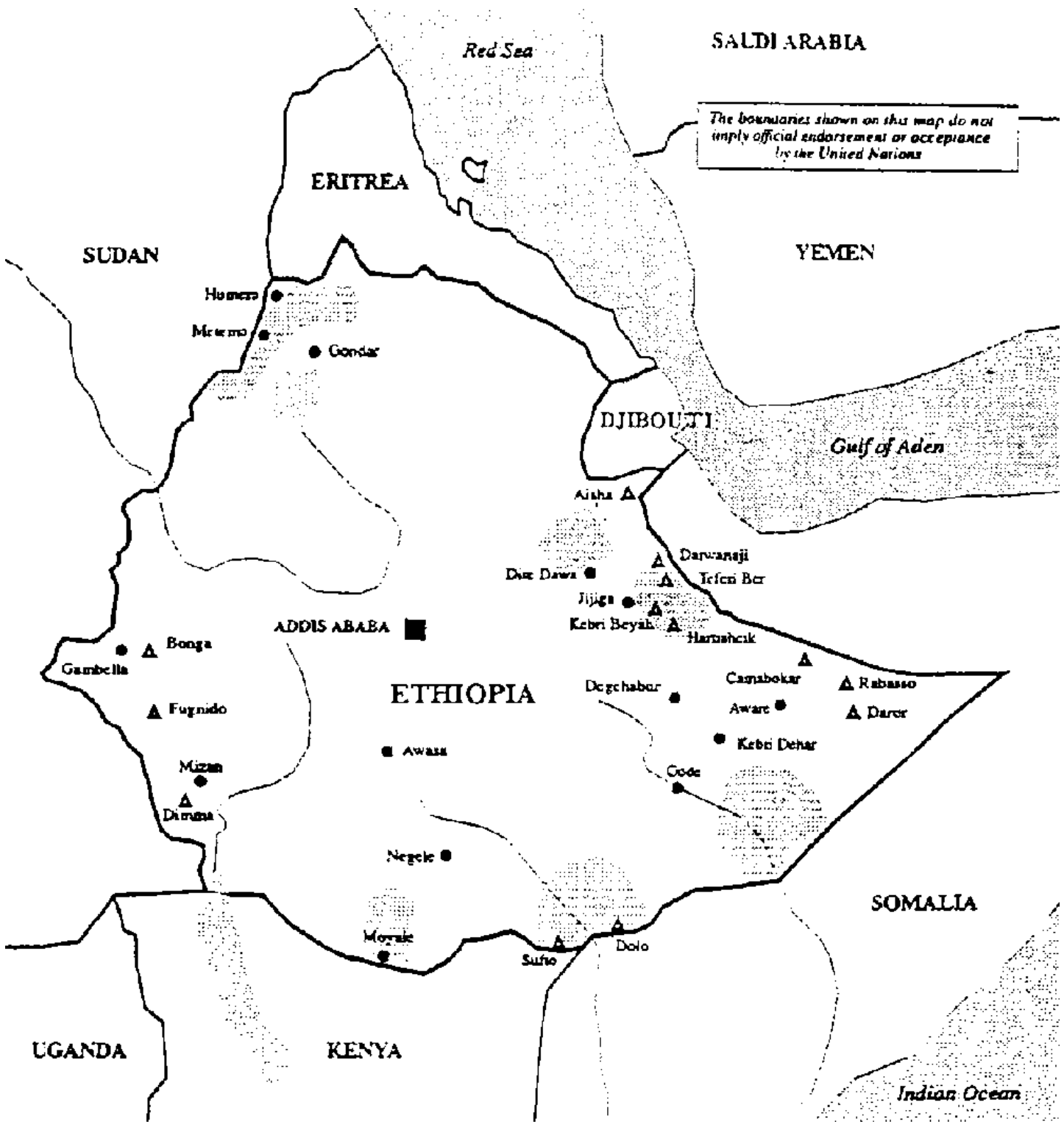


*The boundaries shown on this map do not imply official endorsement or acceptance by the United Nations*

MAP 4 Burundi/Rwanda Region

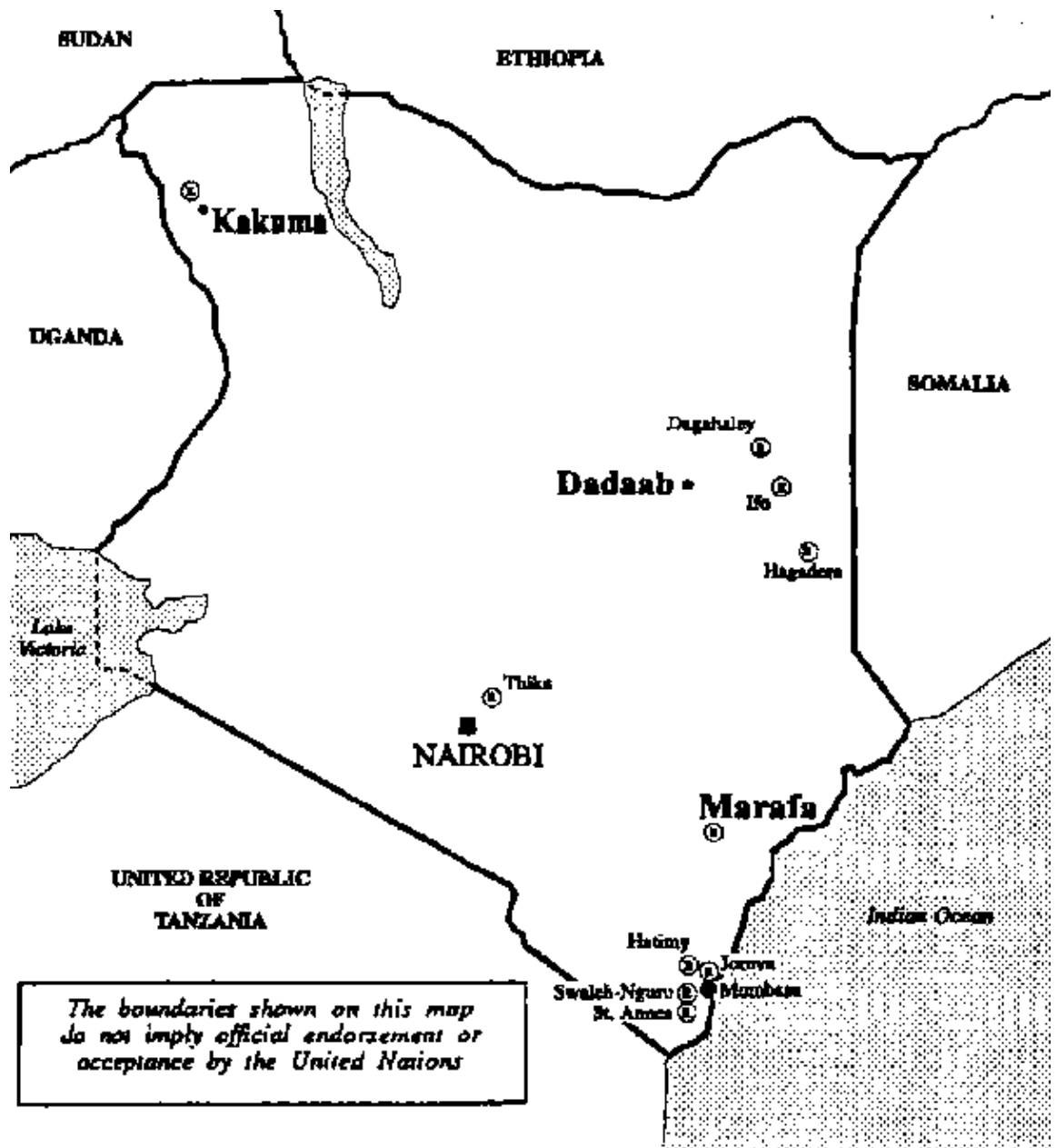


MAP 6 Djibouti

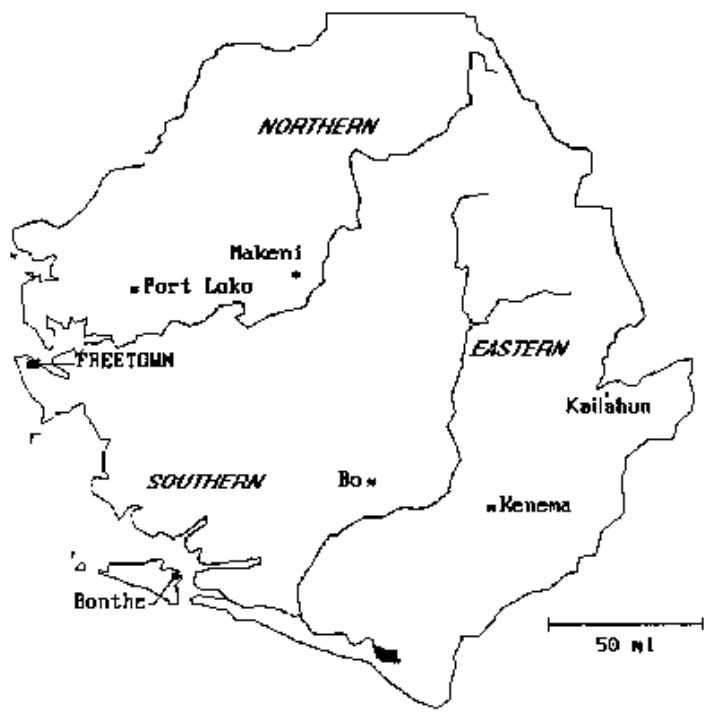
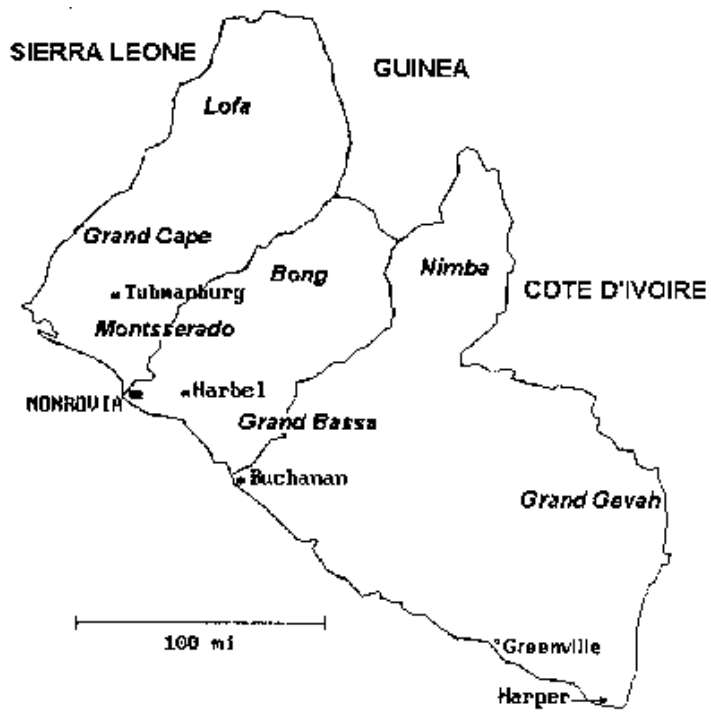


MAP 7 Ethiopia





MAP 8 Kenya

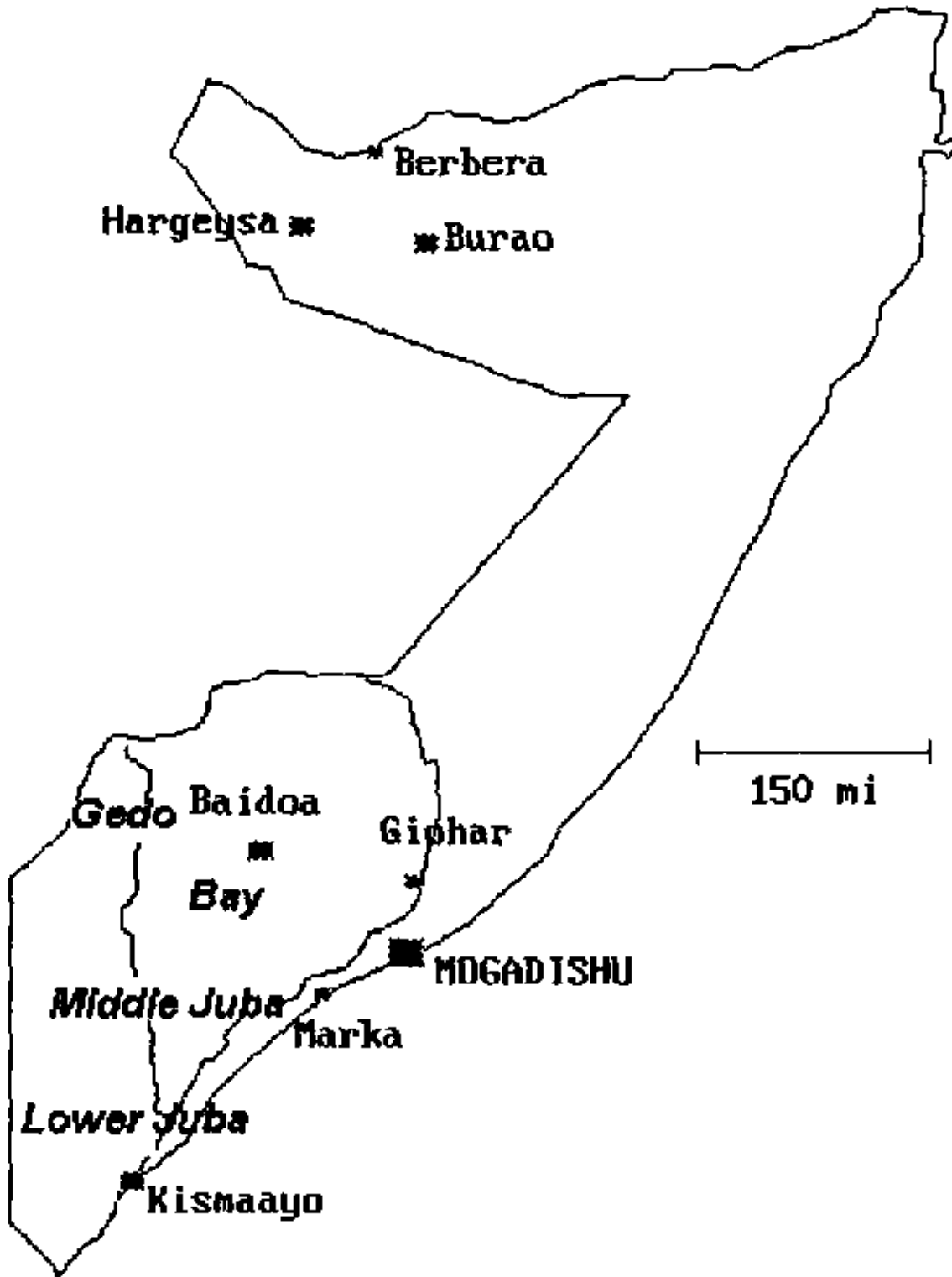


MAP 9 a, b Liberia/Sierra Leone

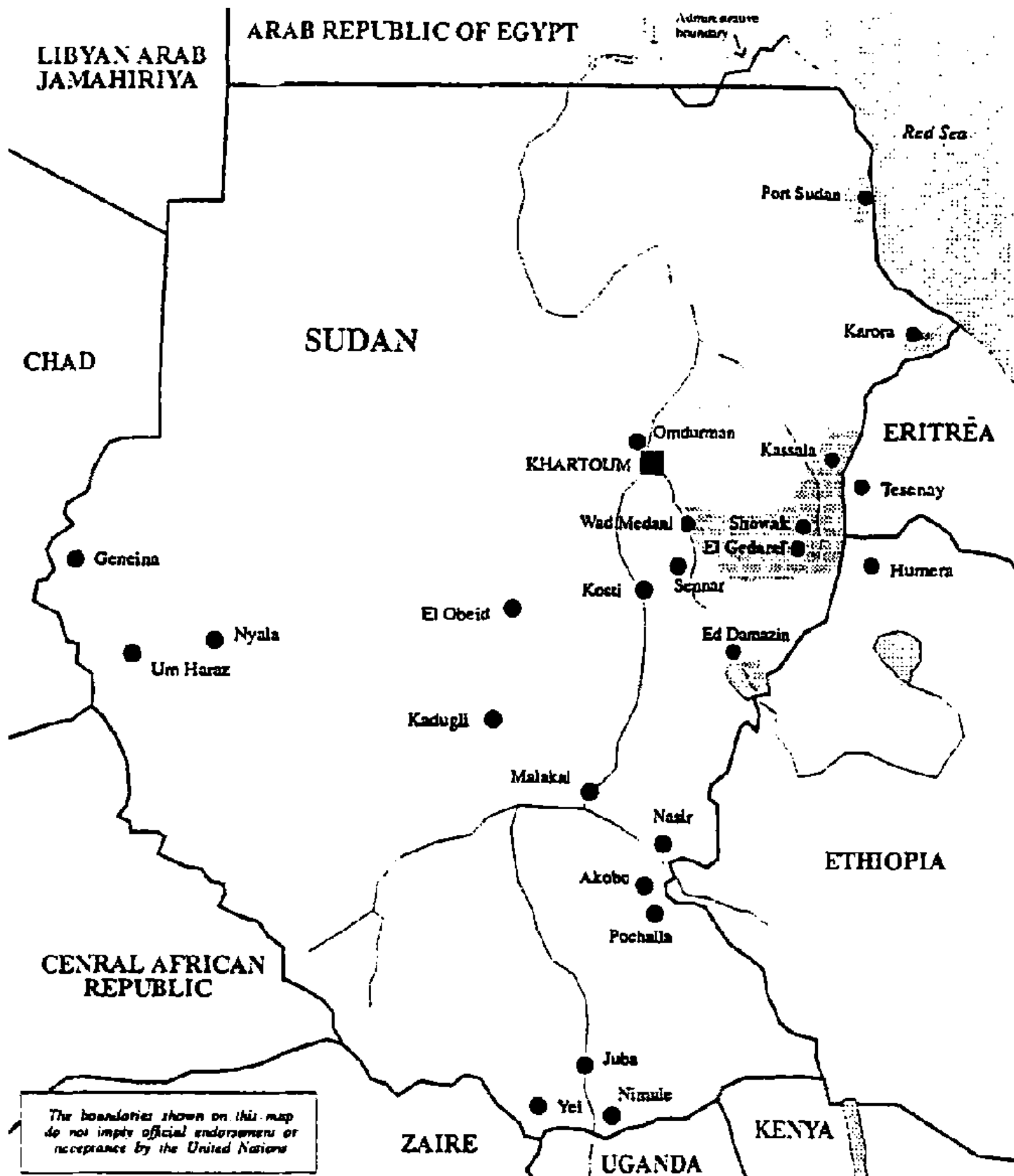


MAP 11 Mozambique

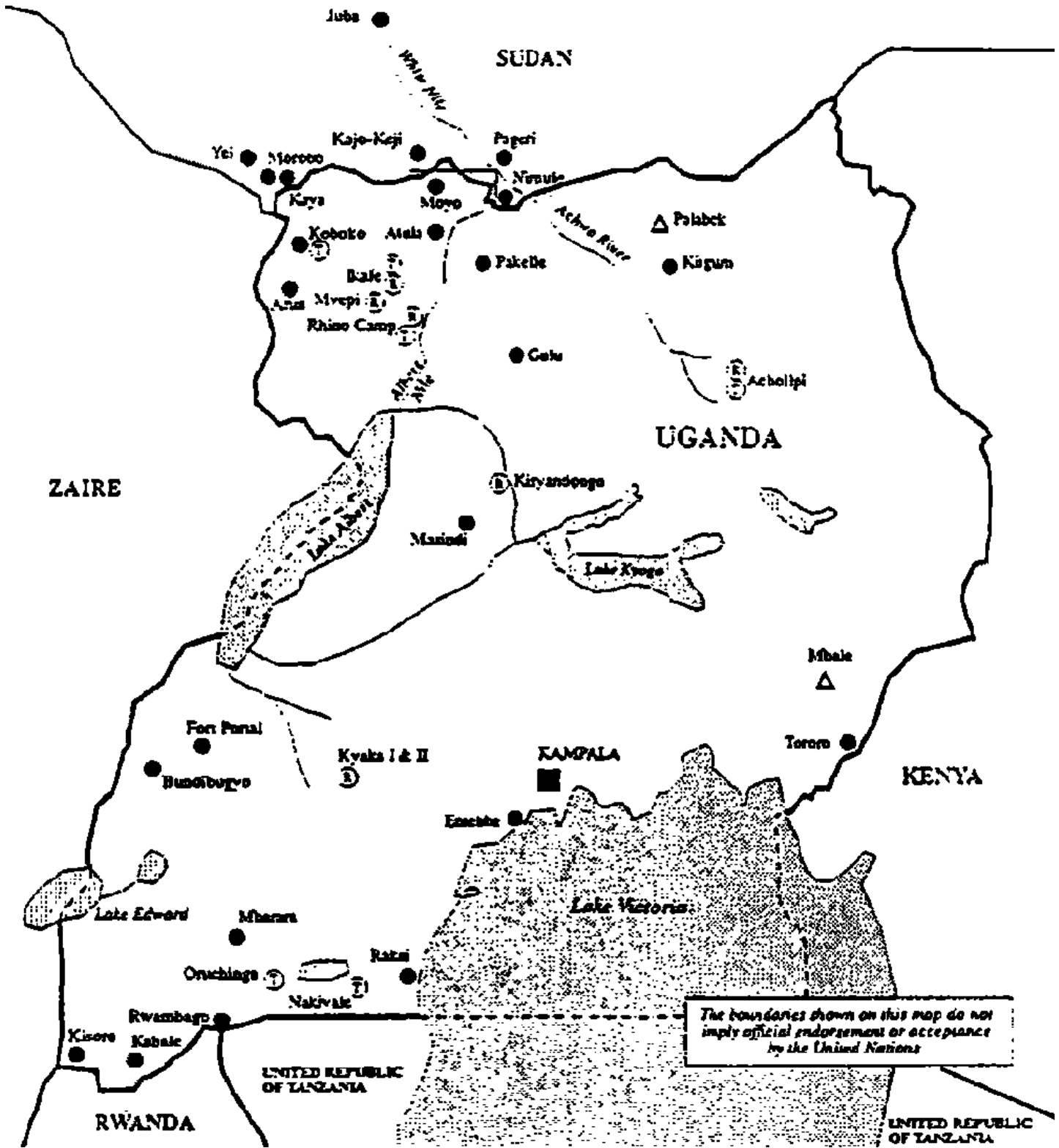
Map taken from MSF-CIS Bi-Monthly Bulletin



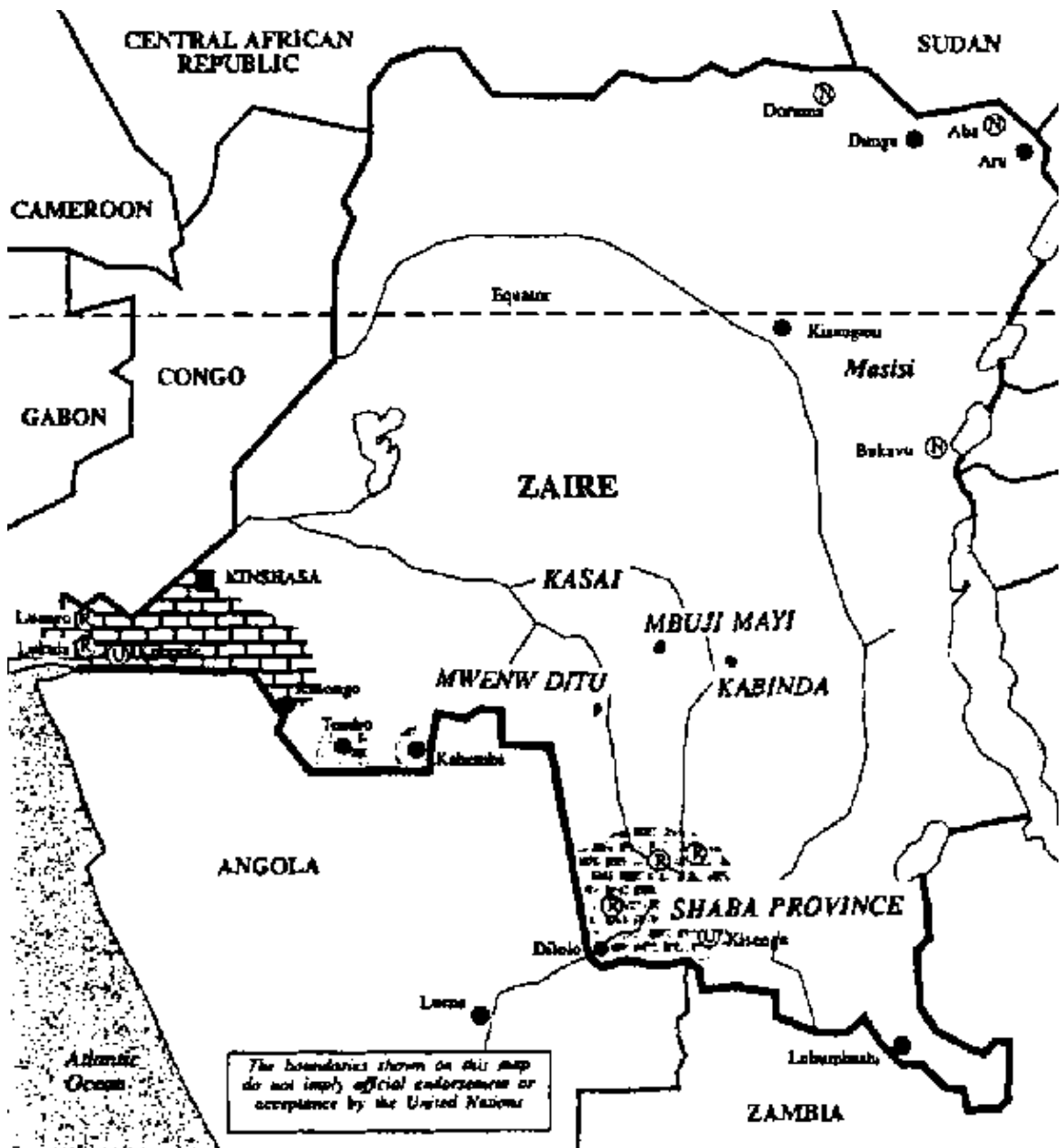
MAP 12 Somalia



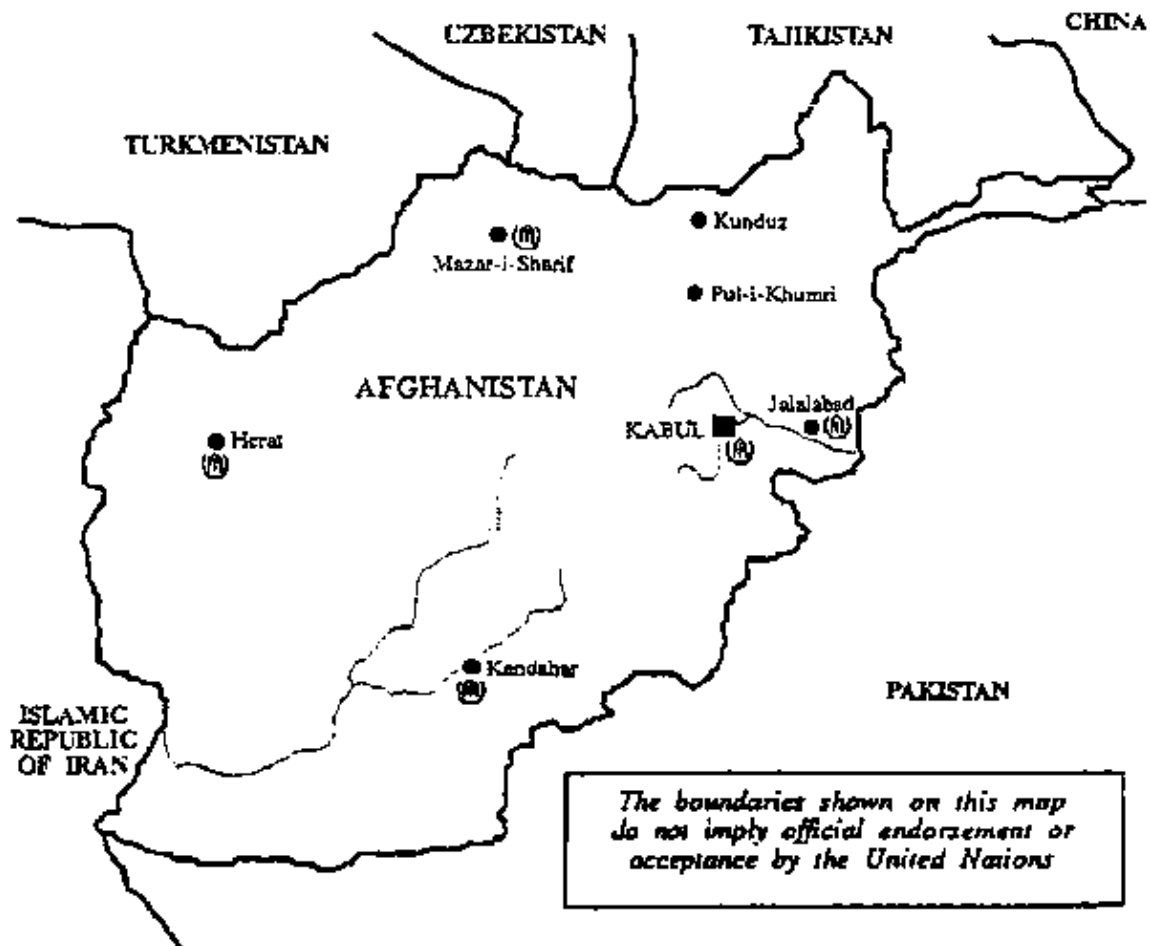
MAP 13 Sudan



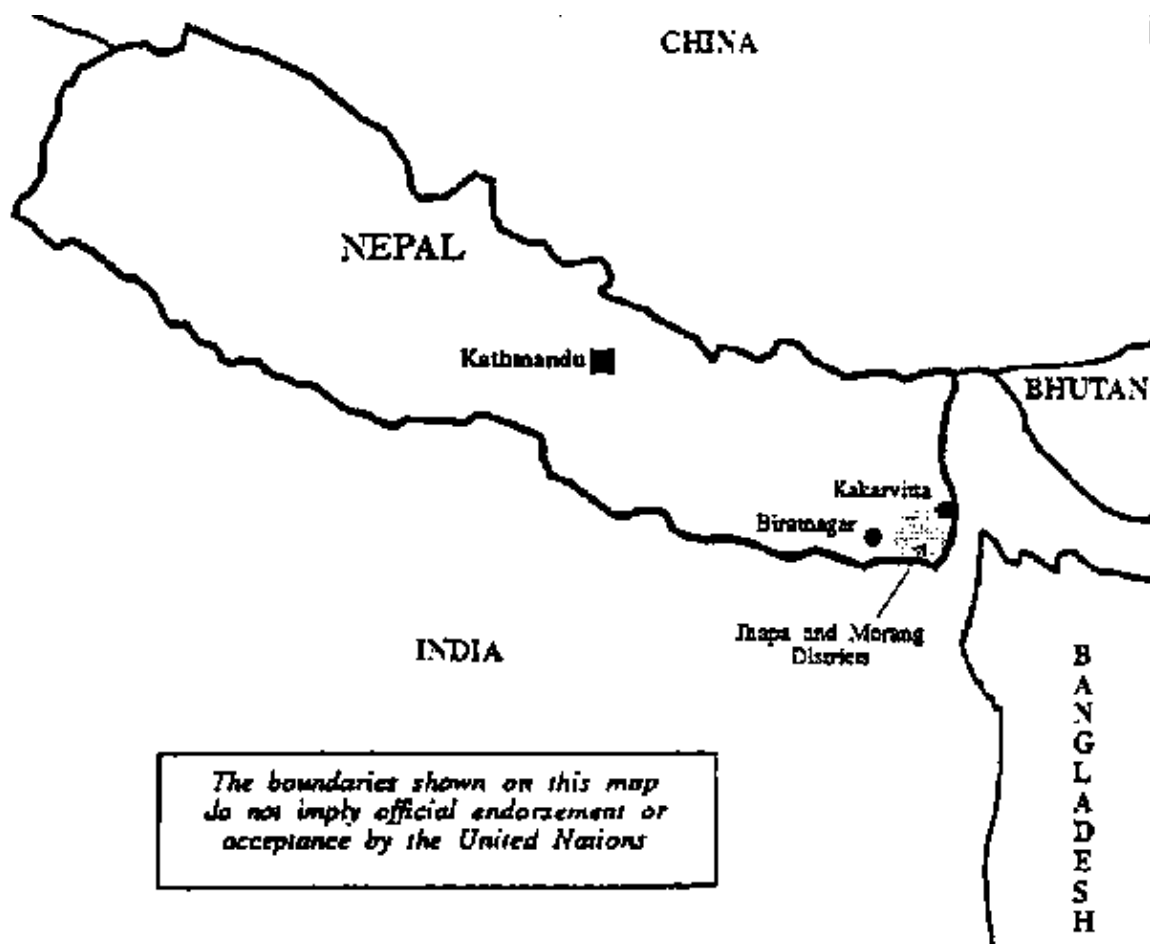
MAP 14 Uganda



MAP 15 Zaire



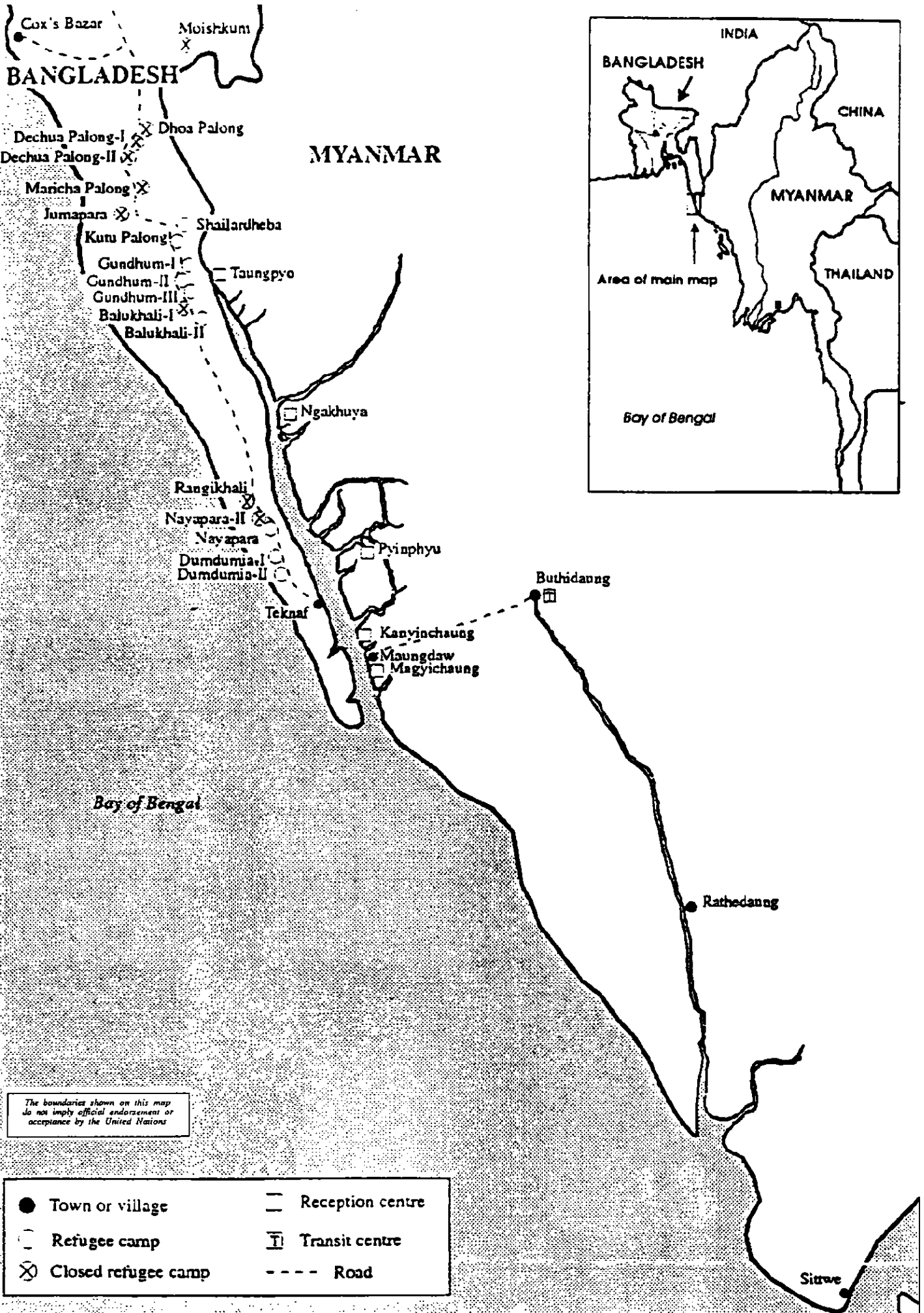
MAP 17 Afghanistan



MAP 18 Nepal







**MAP 19 Bangladesh**

Printed by The Lavenham Press Ltd., Lavenham, Suffolk, England.

