

**Refugee Nutrition Information System (RNIS), No. 18 – Report on the
Nutrition Situation of Refugee and Displaced Populations**

Table of Contents

<u>Refugee Nutrition Information System (RNIS), No. 18 – Report on the Nutrition Situation of Refugee and Displaced Populations</u>	1
<u>HIGHLIGHTS</u>	1
<u>INTRODUCTION</u>	3
<u>SUB-SAHARAN AFRICA</u>	5
1. Angola.....	5
2. Benin/Ghana/Togo Region.....	6
3. Burkina Faso and Mauritania – Malian Refugees.....	7
4. Burundi/Rwanda (Great Lakes) Situation.....	7
5. Central African Republic.....	12
6. Djibouti.....	12
7. Ethiopia.....	12
8. Kenya.....	13
9. Liberia/Sierra Leone Region.....	13
10. Mozambique Region.....	17
11. Somalia.....	18
12. Sudan.....	20
13. Uganda.....	22
14. Zaire.....	23
15. Zambia.....	23
<u>ASIA – SELECTED SITUATIONS</u>	24
16. Afghanistan Region.....	24
17. Bhutanese Refugees in Nepal.....	25
18. Refugees from Rakhine State, Myanmar in Bangladesh.....	25
19. Southern Iraq.....	26
<u>LISTING OF SOURCES FOR DECEMBER 1996 RNIS REPORT #18</u>	26
<u>LIST OF TABLES, FIGURES AND ANNEXES</u>	29
<u>Table 1. Information Available on Total Refugee/Displaced Populations (As of December 1996)</u>	29
<u>Table 2. Summary of Origin and Location of Major Populations of Refugees, Returnees and Displaced People in Africa – December 1996 – RNIS #18 (Population Estimates in Thousands)</u>	31
<u>Figure 1. Refugee and Displaced Populations – Selected Areas in Africa (December 1996)</u>	33
<u>Figure 2. Trends in Total Refugee/Displaced Populations by Risk Categories Africa: December 1993–December 1996</u>	33
<u>Figure 3. Shaded Areas Indicate those at Heightened Nutritional Risk Categories I and IIa in Table I</u>	33
<u>Annex I. Results of Surveys Quoted in December RNIS Report (#18) – Usually Children 6–59 Months</u>	39
<u>Annex II. Seasonality</u>	43
<u>LIST OF MAPS</u>	44
<u>Map A. Situational Map</u>	44
<u>Map 1. Angola</u>	44
<u>Map 3. Mauritania</u>	45
<u>Map 4. Burundi/Rwanda Region</u>	46
<u>Map 6. Djibouti</u>	47
<u>Map 7. Ethiopia</u>	48
<u>Map 8. Kenya</u>	49
<u>Map 9a,b. Liberia/Sierra Leone</u>	50
<u>Map 10. Mozambique</u>	51
<u>Map 11. Somalia</u>	54
<u>Map 12. Sudan</u>	54
<u>Map 13. Uganda</u>	55
<u>Map 14. Zaire</u>	56
<u>Map 16. Afghanistan</u>	57
<u>Map 17. Nepal</u>	58
<u>Map 18. Bangladesh</u>	59

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ACC/SCN

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HIGHLIGHTS

The total number of refugees and internally displaced people in Sub-Saharan Africa has declined over the last three months, mainly due to uncertainty over the number of people in Eastern Zaire requiring emergency humanitarian assistance. Micronutrient deficiency diseases have been seen in a number of refugee populations included in this report namely Kenya, Tanzania, Nepal, and Bangladesh.

Angola *As rehabilitation of transport and health infrastructure continues throughout the country, increasing numbers of those displaced by the civil war are returning home. In general, the nutritional status of those affected by the past conflict is stable and adequate.*

Burundi/Rwanda (Great Lakes) Region *The fighting which erupted in Eastern Zaire at the end of November led to the virtual emptying of all refugee camps in Goma, Bukavu and Zaire. Over 600,000 of these refugees returned to Rwanda and, with the help of humanitarian agency support, have mostly now settled in their communes of origins. Hundreds of thousands of Rwandan refugees and local Zairians remain inaccessible within Zaire. This population have received very little humanitarian aid, although surveys have not been possible, there is great international concern over their health and nutritional situation. Many refugees from Uvira have returned to Burundi and levels of severe wasting as high as 17% were seen in screenings as the returnees passed through transit centres. The high level of insecurity in Burundi continues to lead to large-scale internal displacements with limited access by relief agencies. There is concern over the nutritional and health situation of many of these displaced people. The continued influx of refugees from Zaire and Burundi into Tanzania has strained the holding capacity of existing refugee camps so that some population groups have experienced considerable hardship. Vitamin B deficiency has been noted in the Ngara camps. Meanwhile, the government's pronouncement over intended full-scale repatriation of refugees by the end of the year, is leading to a high state of preparedness amongst aid agencies who are pre-positioning food at commune level and planning way-station programmes.*

Liberia Region In spite of periodic cease–fire violations the peace process in Liberia is generally holding and some progress is being made towards disarmament and demobilisation. However, as previously insecure areas become accessible, extremely serious nutritional and health crises are being discovered. In one case under–five mortality rates were fifty times normal and severe wasting exceeded 30%. Nevertheless, even these disastrous conditions appear to respond well to concerted intervention by humanitarian agencies. The situation in Sierra Leone continues to improve although clashes are still regularly occurring between rebel and government forces. Although presently under–funded, humanitarian agencies are planning more development and rehabilitation oriented programmes in the coming months. As the rebel forces are pushed further to the West, populations held captive by the rebel forces for long periods, are emerging from the “bush”, often in a dire nutritional state.

Somalia Continuing insecurity, particularly in southern Somalia and poor harvests in some areas such as the Juba valley are placing various population groups at nutritional risk. Urban populations who are especially vulnerable to food price inflation are also at considerable risk as overall crop production is still 37% lower than the pre–civil war years. However, some areas have had bumper harvests and several NGOs have reported that in their project areas there has been a marginal improvement in the nutritional situation.

Sudan Although crop production in southern Sudan is higher than during 1995, the wide variation between states and persistent insecurity will render certain areas, such as Jonglei and Juba extremely vulnerable to food insecurity in the coming months. The nutritional situation in the Red Sea Hills in northern Sudan has reached famine proportions. Although, there has so far been only small scale “terminal migration”, the recent rain–failure has severely compounded a situation where food security has been declining for several years. Massive food price inflation and loss of livestock value amongst the largely pastoral population, has led to levels of wasting of almost 50% amongst some groups with high levels of vitamin A deficiency, as well as some cases of scurvy and beri–beri. Time will tell whether the resulting humanitarian aid intervention has been sufficiently timely and appropriate to prevent large scale displacement to camps with the inherent risks associated with such population concentrations.

Bhutanese Refugees in Nepal New cases of micronutrient deficiency diseases including scurvy, beri–beri, and vitamin B deficiency continue to be reported among this population.

ADEQUACY OF FACTORS AFFECTING NUTRITION

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

9. Immunization	O	?X	✓	✓	✓	O	O	O	✓
10. Information	✓	✓	✓	✓	✓	O	✓	O	O

- ✓ Adequate
- O Problem in some areas
- ✓ 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.

NOTE

The **Reports on the Nutrition Situation of Refugees and Displaced People** are published every three months. Updates on rapidly changing situations, and where new information is available, are published every six weeks after each three monthly report. The information in the Updates is 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 full reports. Further outputs will be developed in response to needs.

The Updates are, where feasible, be transmitted by e-mail in Word Perfect 5.1. If you would like to receive the Updates, please *either* contact the ACC/SCN by e-mail (accscn@who.ch); or write or fax to ACC/SCN at the addresses on the front cover. The full report in its present form is published every three months.

INTRODUCTION

The UN ACC/SCN¹ (Sub-Committee on Nutrition), which is the focal point for harmonizing policies in nutrition in the UN system, issues these reports on the nutrition of refugees and displaced people 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 eighteenth 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.

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

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

The tables, 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.

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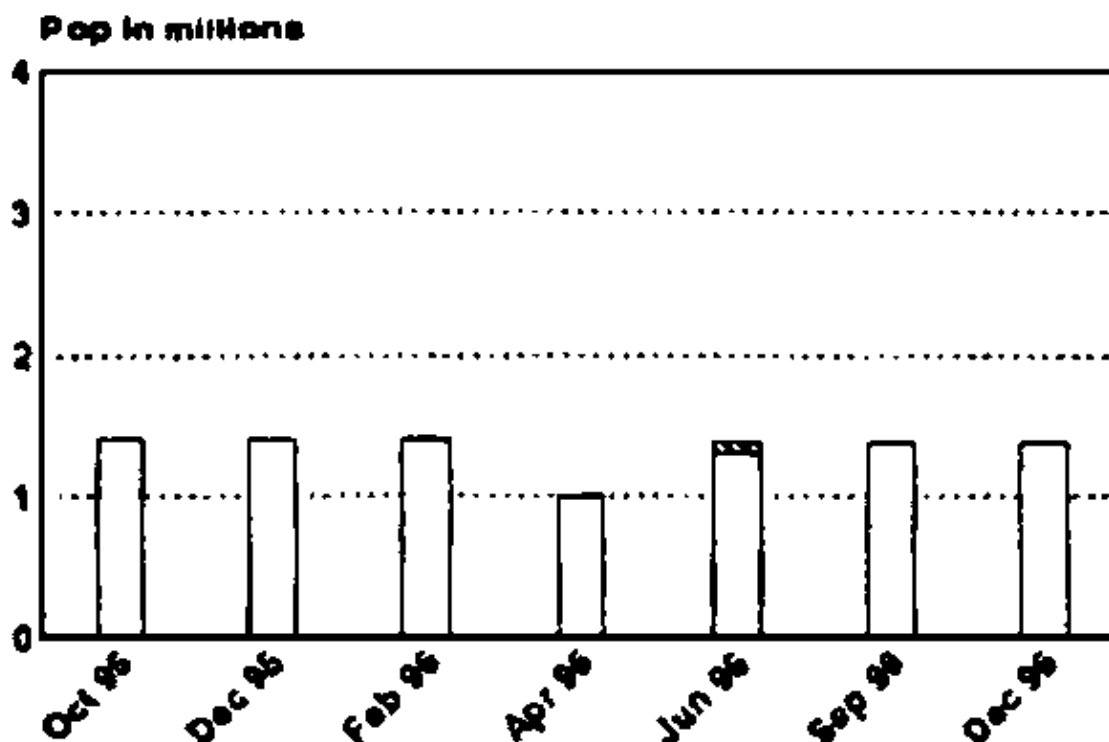
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SUB-SAHARAN AFRICA

1. Angola

(see Map 1 and Figure 3)

Angola



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

There are approximately 1.37 million war affected and/or internally displaced people in Angola, although this number is likely to gradually decline as more families return home. For example, it is estimated that in the past year 45,000 internally displaced people have left Saurano, Lunda Sul, to return to their home communities within the government controlled areas. Over 5,000 refugees returned home in October 1996 [DHA 07/10/96, 10/11/96].

In recent months the focus of humanitarian activities has been upon rehabilitation of village infrastructure to encourage the return of internally displaced people country wide. Several bridges have been rehabilitated and roads have been declared open thereby facilitating the free movement of people and goods throughout the country. It is now estimated that 75% of food transported since early 1996 has been by road, rather than air transport which is significantly more expensive [DHA 07/10/96, 10/11/96].

The nutritional situation in the country appears to be generally stable. For example, a recent survey in the areas around *Kuito* (excluding Kuito town) showed 9.7% wasting and/or oedema with 1.9% severe wasting and/or oedema (see Annex I (1a)). These results compare favourably with those from last year when wasting and/or oedema was measured at 28% [DHA 10/11/96]. The implementing agency recommended continuing health interventions to reduce prevalence of disease which is believed to be a significant contributing factor to current levels of wasting. Another example of an improving nutritional situation comes from Uige city where a 2% prevalence of wasting was found within a 15 mile radius (see Annex I (1b)). These results have led to a decision to phase down therapeutic feeding in Uige hospital [DHA 10/11/96].

However, there are still concerns over the food security of demobilised soldiers. Due to the prolongation of the quartering process, food stocks earmarked for soldiers and their families have been close to depletion. Urgent appeals to donors for more food pledges have been made [WFP 08/11/96].

Numerous initiatives in the health sector prevail in Angola with widespread support for immunisation campaigns and restoration of health infrastructure. However, periodic outbreaks of disease continue to be reported. For example, a measles epidemic was reported in an inaccessible area of Malango province killing 111 children. Immunisation to prevent the spread of the epidemic is underway [DHA 10/11/96]. In Huila province, a recent meningitis outbreak killed 30 people. Essential drug kits and chlororamphenicol were immediately distributed to local health posts.

Overall, this population is not currently considered to be at heightened nutritional risk (category IIc in Table 1)

Haw could external agencies help? As peace continues to hold, the extension of projects designed to encourage internally displaced people to return home, such as provision of seeds and tools, and rehabilitation of villages infrastructure are essential. Equally important is the process of demobilisation of soldiers. As this programme is taking longer than anticipated, food resources are dangerously low and need to be replenished immediately in order to avoid the type of nutritional crisis affecting families of former combatants described in earlier RNIS reports.

The task of rehabilitating the health infrastructure in country will require long-term commitment from donors although there are short-term priorities which still need to be addressed. Immunisation coverage, in particular and noted in earlier RNIS reports as inadequate, remains a problems in some areas. Efforts of the mobile immunisation teams therefore need to be supported, and in some cases enhanced.

2. Benin/Ghana/Togo Region

There remain approximately 33,000 refugees in the region. This number is comprised of 12,000 Togolese refugees in Ghana, 11,000 Togolese refugees in Benin, and 10,000 refugees from Ghana in Togo. The vast majority of this population left their country of origin in 1993 because of political disturbances and sought refuge in Benin and Ghana. A further group of people fled ethnic fighting in Ghana and took refuge in Togo. The refugee population affected in the region continues to decline due to repatriation which is being encouraged by a shift in humanitarian aid policy from relief to rehabilitation and the reduction in food aid allocations. It is hoped that in Togo the provision of seeds and also money for small businesses will lead to self-sufficiency of the entire refugee population [IFRC 14/10/96]. There are no reports of change to a generally adequate and stable nutritional status of this population (category IIc in Table 1).

3. Burkina Faso and Mauritania – Malian Refugees

(see Map 3)

There remain approximately 25,000 Malian refugees in *Burkina Faso*. The decrease in numbers from the previous RNIS report is due to repatriation. There are no reports of change to the adequate and stable nutritional situation of this refugee population.

Repatriation of Malian refugees has resumed from *Mauritania*, and it is currently estimated that there remain 28,000 refugees in one camp. Numbers are declining as the repatriation process continues; approximately 3,000 people repatriated in October 1996, bringing the total number of returnees since June 1996 to over 17,000. It is expected that the repatriation process will be completed by mid-1997 [UNHCR 22/11/96].

Overall, these refugees are not currently considered to be at heightened nutritional risk (category IIc in Table 1).

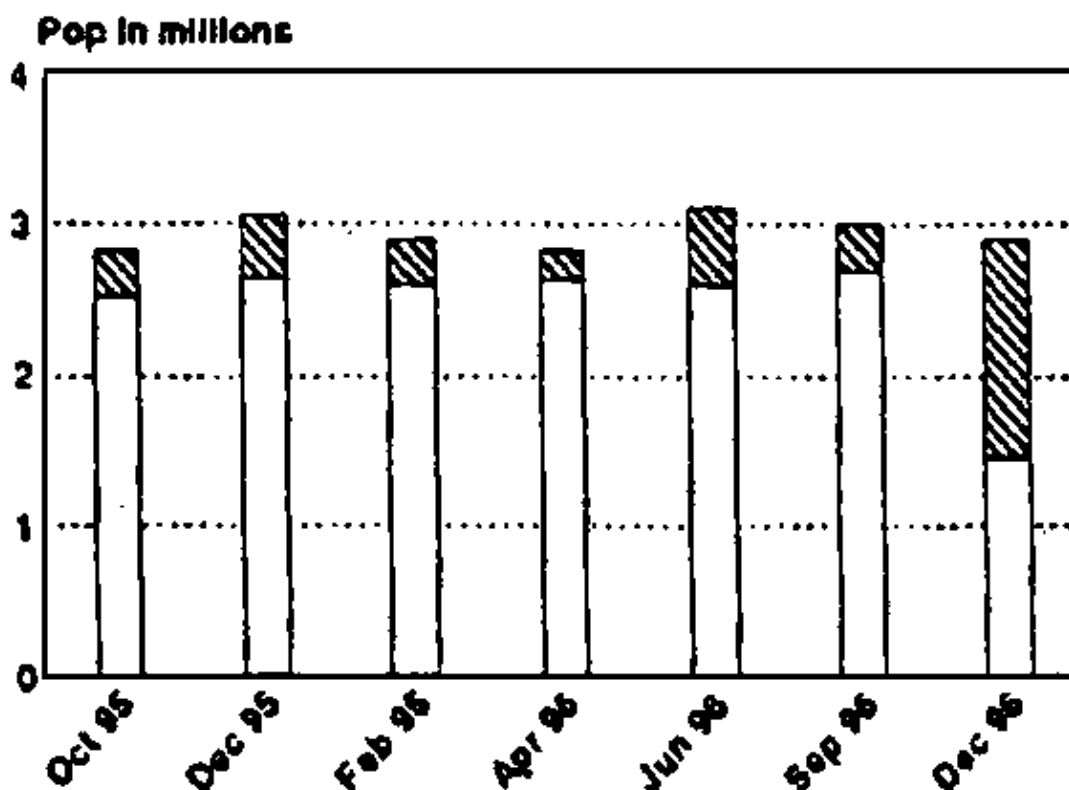
4. Burundi/Rwanda (Great Lakes) Situation

(See Map 4 and Figure 3)

This information is as of 14 December 1996.

Fighting which erupted in Eastern Zaire in early November led to the dispersal of most of the 1.2 million refugees in the region and also caused the displacement of an unknown number of Zairians. The insecurity resulted in approximately 600,000 Rwandan refugees returning home, mainly without incident. The large-scale returnee influx into Rwanda is generally being well-managed by the international community. The number of refugees remaining in Zaire and the number of internally displaced Zairians is unknown but likely to be in the hundreds of thousands. Some refugees have fled to Uganda while some Burundi refugees have returned home. The continued insecurity in Burundi is also causing tens of thousands of people to flee their homes, mainly heading for Tanzania. The Tanzanian government has served notice that it intends to repatriate the large refugee population by the end of the year.

Burundi/Rwanda Region



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

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

Location	Oct 95	Dec 95	Feb 96	Apr 96	Jun 96	Sep 96	Dec 96
Burundi	315,000	504,000	275,400	290,000	289,000	300,000	296,000
Rwanda	725,000	800,000	737,000	737,000	749,000	598,000	1,179,000
Tanzania	629,000	621,000	653,000	624,000	642,000	653,000	759,000
Zaire	1,158,000	1,146,000	1,211,000	1,166,000	1,419,000	1,444,000	668,000
Uganda	6,400	6,400	6,800	6,900	7,000	7,000	11,500
TOTAL	2,831,400	3,077,400	2,883,200	2,823,900	3,106,000	3,002,000	2,913,500

Eastern Zaire The recent outbreak of intense fighting between Tutsi rebels and the Zairian army in Eastern Zaire which flared up at the end of October, has resulted in major population movements. The Tutsi Banyamulenge joined forces with other Zairian rebels to form the Alliance of Democratic Forces for the Liberation of Congo-Zaire (ADLF). The conflict has led to the displacement of most of the 1.2 million refugees as well as large scale internal displacement of local populations. The three main areas of refugee concentration in the region – Goma, Bukavu and Uvira are now under rebel control. The vast majority of Rwandan refugees in Goma have reportedly left the camps with many believed to be in the area around Kisangani, west of Goma. Refugee camps in Bukavu and Uvira are also virtually empty. The fighting is continuing with rebel forces reportedly making significant gains. Aid agencies have recently been confined to Goma and Sake although there has been periodic access to other areas [IRIN 29/11/96]

Approximately 600,000 Rwandan refugees have returned home, mainly without incident, but the total number of refugees remaining in Zaire and the number of internally displaced Zairians remains unknown. It is believed

that there are up to 500,000 refugees gathered in at least five separate areas in Eastern Zaire and as many as 170,000 internally displaced. Some refugees have fled to Uganda while others have returned home to Burundi where the continued insecurity is also causing tens of thousands of people to flee their homes with many seeking refugee status in Tanzania [USAID 22/11/96, 12/05/96, IRIN 03–4/11/96 04/11/96, 08/11/96].

The high level of insecurity has forced most humanitarian agencies to evacuate the region and it is currently virtually impossible to deliver food and other relief supplies to the area. The risk of an emerging nutritional and health crisis increases daily as this situation persists [USAID 22/11/96, IRIN 03–4/11/96, 04/11/96, 08/11/96].

The plan to dispatch a multi-national military force, whose mandate would be limited to assisting food deliveries and the voluntary repatriation of refugees, has been "put on hold" partly so as not to interfere with the large-scale repatriation to Rwanda and also because of the enormous difficulties that are being encountered in locating hundreds of thousands of refugees and internally displaced people in the area. The security risk to such a force has also been a factor in the delay. Relief agencies have launched airlifts of high energy biscuits, medical supplies, plastic sheeting and blankets into areas where refugees have been located [USAID 22/11/96, IRIN 03–4/11/96 04/11/96, 08/11/96, 12/12/96].

Bukavu By mid-November the Bukavu refugee camps were reportedly empty although the whereabouts of the refugees was unclear. Very few of the returnees to Rwanda have been from the Bukavu camps and it is believed that most of this refugee population has moved westward [IRIN 22/11/96].

Agencies have been planning small-scale targeted distributions to vulnerable groups in hospitals, orphanages and to 8–9,000 refugees and internally displaced persons who are in or near Bukavu and in need of assistance. Out of this population, up to 4,000 are reportedly in a very bad condition [WFP 29/11/96].

Uvira Initial reports suggested that as fighting between rebel and government forces escalated all of the 220,000 refugees (143,000 Burundian and 73,000 Rwandan) fled the camps which were subsequently burnt. Up to 36,000 of the Burundi refugees in the Uvira area have reportedly returned to Burundi. Most of the Rwandan refugee appear to have moved north of Uvira with others fleeing south towards Fizi. A UN/NGO team was able to visit the town for the first time in early December and found the situation to be very calm with markets now re-opened and quite well supplied. There were no refugees visible on roads. Most of the refugees who were in the Uvira camps have not received food aid since the middle of October as access by relief agency staff has not been possible. High levels of malnutrition have been found among refugees who have returned to Burundi from Uvira [IRIN 08/12/96].

Rwanda Approximately 600,000 refugees returned to Rwanda by the end of November and were being assisted with food and non-food items during transit and on return to their communes of origin. Due to the scale and speed of return (200,000 returned between the 15–16th of November) it has not so far been possible to conduct nutritional surveys. However, the returnees are generally reported to be in good health, although more recent returnee children are said to be suffering from dehydration, exhaustion and hunger [IRIN 17/11/96, 22/11/96]. There are also approximately 576,000 people in Rwanda who will require emergency assistance probably until the harvest in January 1997.

Relief agencies established eight way stations between Gisenyi and Ruhengeri in Rwanda to address the needs of the returnee population. The size of the population precluded distribution of a general ration during transit so that returnees were allocated high energy biscuits. However, resupplying way stations has proven problematic at times due to refugee congestion on the roads. NGOs therefore began to restock warehouse after dark when the roads were clear for the night [IRIN 22/11/96].

General rations lasting between one to four weeks are being supplied to returnees on arrival at their communes of origin and the registration of the 600,00 Rwandan returnees is said to be continuing in the communes without major disruption. However, there have been some administrative problems with food distribution in Gisenyi and Ruhengeri [IRIN 03/12/96, WFP 21/11/96].

In spite of the fact that the nutritional state of the returnees has been generally better than expected, the need for supplementary feeding at commune level has increased due to the influx. However, in order to avert the need for establishing large numbers of feeding centres it has been decided to incorporate a 100 gms of UNIMIX/child/day into the general ration. There is also increasing concern over the food security situation in both Butare and Gikongoro prefecture where irregular rainfall during the past two months and increasing demand for food from refugee returnees from Burundi in July and August is increasing the pressures on food supplies [WFP 29/11/96].

A recent nutritional survey in *Kibangira* camp (approximately 3,000 Burundi refugees) in Rwanda showed 6.1% wasting with 2.8% severe wasting. No cases of oedema were seen (Annex 1 (4a)). The crude mortality rate was 0.4/10,000/day and the under-five mortality rate was 1.9/10,000/day. The ration distributed was 1950 kcals/person/day just prior to the survey while measles immunisation coverage was 97%. These indicators describe a generally adequate situation [MSF-B 11/10/96]

Burundi At least 46,000 Burundi refugees have recently returned to Bujumbura and Cibitoke provinces from Zaire with many reportedly in an appalling nutritional state. A recent screening among those arriving at *Gatumba* transit camp, regardless of age, showed 18.2% wasting with 4.2% severe wasting. Another screening showed 13% severe wasting for those under 15 years old, with 17.6% severe wasting for children under five years old (see Annex I (4b-c)). This situation is thought to be due to the combined effects of a reduced ration in the camps prior to departure and the lengthy period of transit from Zaire which may take up to one week. The transit camp is now reportedly empty as people return to their communes; food rations are being provided to returnees [IRIN 03-04/11/96, UNHCR 17/11/96, WFP 14/11/96].

A total of 3,000 returnees who transferred from the *Gatumba* transit camp are living on a site in Rugombo and are awaiting transfer to their home communes. Although this population has sufficient food, their limited access to water and sanitation is said to be alarming. A further 16,000 returnees are camped near Buganda and have not passed through *Gatumba* camp. They have therefore not received any assistance and are lacking both food and non-food items. Their lack of access to water and sanitation is also causing grave concern [WFP 29/11/96].

Widespread insecurity persists throughout Burundi with approximately 75,000 Burundians having fled to Tanzania in the first two weeks of November. Most of this population have come from the provinces of Bururi, Rutana, Gitega and Ruyigi. The slaughter of 298 Burundian returnees who were killed in Murumba church in Cibitoke province at the end of October received widespread media coverage. At the end of November the dramatic deterioration of security in Kayanza province led to a displacement of up to 100,000 people. Further large scale security induced displacements have also recently been reported in southern Bujumbura rural province and northern Bururi province [WFP 29/11/96].

There are estimated to be at least 250,000 internally displaced people in Burundi. Many of these people are inaccessible for varying periods of time due to insecurity and receive rations as and when security allows. A further problem for this population has been the inclusion of fuel and food aid on the list of items which sanctions preclude from entry into Burundi. As these restrictions have now been reduced it is hoped that humanitarian aid activities can increase in scale and scope [WFP 18/10/96, 01/11/96].

A survey among the internally displaced in *Karuzi* province, Burundi (affected population estimated at 50,000 in approximately ten camps) showed 13% wasting, with 2.7% severe wasting. Oedema was measured at 1.1% (see Annex 1 (4d)). Measles immunisation coverage was 85.6%. These somewhat worrying results can, in part, be explained by the fact that this population has little or no access to farmland, and that humanitarian food deliveries have often not been possible due to insecurity. In order to redress this situation, it has been proposed to increase the capacity of feeding centres, and to organise weekly food distributions. This is, however, only feasible where security allows [DHA 15/10/96, MSF-B 30/08/96].

Tanzania More than 100,000 refugees fleeing insecurity in Burundi and a further 35,000 from Zaire arrived recently in Tanzania in the Kigoma region. Tanzania now hosts more than 759,000 refugees including 535,000 Rwandans, 189,000 Burundi refugees, and 35,000 Zairian refugees [MSF 24/11/96, USAID 12/12/96].

Recent nutrition assessments have revealed generally low levels of wasting and oedema among the under-five population of refugees in Tanzania. However, cases of adult malnutrition were seen in most of the camps, which were determined to be largely attributable to medical and socio-economic problems. In addition, signs of micronutrient deficiencies were noted, particularly in the Ngara camps. Ration supplied during 1996 were on average 1880 kcals/person/day. Food distribution systems were changed in late 1995 from family to communal level distribution, based on community participation. This system is said to be more successful than previous ones as there is greater transparency and equity and refugee families do not have to spend such long periods distribution queues. Furthermore, agencies spend less time implementing the distributions. Provision of firewood remains a problem in many camps, with the notable exception of Kigoma [WFP/UNHCR Oct 96].

In *Kigoma* (estimated population 43,000), recent surveys showed levels of wasting which varied from 3.0-12.5% with 0.0-1.1% severe wasting. Almost no cases of oedema were seen (see Annex I (4e-h)).

Crude mortality rates varied from 0.17–0.33/10,000/day, and the under–five mortality rate was 0.3–1.14/10,000/day. Water supply is on average 15–30 litres/person/day. However, in Mtendeli camp where 40,000 Burundi refugees have arrived since the beginning of November, the most recent arrivals are reportedly in a poor nutritional state. Rates of malnutrition for children under five were recorded at almost 19%. The overall prevalence of wasting is 12.5%. A new camp has been opened to help accommodate the recent case load and despite what is described as overcrowded conditions, the health and food situations are reportedly under control. However, there are reports that only approximately 4 litres of water/person/day are available and that soap and blankets are in short supply [WFP/UNHCR Oct 96, WFP 29/11/96].

The most recent nutritional surveys for the *Ngara* camps (estimated population 490,000) are from September 1996. These surveys showed levels of wasting ranging from 1.9–3.6% with severe wasting from 0.1–0.3%. Oedema varied from 0.0–0.8% (see Annex I (4i–k)). Crude mortality rates were measured at 0.14–0.59/10,000/day and the under–five mortality rates were 0.39–1.96/10,000/day. Water availability ranged from 8–12 litres/person/day. This is below the recommended 20 litres/person/day. A survey amongst school children in the camps (6–15 year olds) found prevalence rates of angular stomatitis of 8.% to 15.5%. This suggests the need to review the availability of micronutrients in both the general ration, and through alternative (e.g. markets, gardens) [WFP/UNHCR Opt 96].

In *Karagwe* (estimated population 125,000), surveys showed wasting and/or oedema from 0.3–1.8% with severe wasting and/or oedema 0.0–0.4% (see Annex I (41–p)). No land is officially designated for farming, however many refugees have small home gardens. Water availability is problematic during the dry season when only 3–4 litres/person/day are available. During the rainy season, 8–17 litres/person/day are available [WFP/UNHCR Oct 96].

UN sources have said that the repatriation of the approximately 535,000 Rwandan refugees from Tanzania could take place before the end of the year. Indeed, it is reported that Rwandan refugees appear to be preparing to leave the camps, but in some cases there are population movements further into Tanzania, not toward Rwanda. Agencies are preparing for a large scale return to Rwanda by prepositioning food at commune level and high energy biscuits “en route” [IRIN 11/12/96, 12/12/96, WFP 22/11/96, 29/11/96].

Uganda There are approximately 11,500 refugees from Rwanda and Zaire in Uganda [USAID 05/12/96]. There are no current reports on the nutritional status of this population.

Overall, the returnees in Burundi are at high risk (category I in Table 1) due to elevated levels of wasting seen as they came through transit centre. The refugees in Ngara, Tanzania are also at high risk due to micronutrient deficiency diseases. The refugees and internally displaced people in Eastern Zaire along with those in Burundi can be considered to be at high risk (category IIa in Table 1) due to inaccessibility. New returnees to Rwanda and new arrivals in Tanzania can be considered to be at moderate risk (category IIb in Table 1). The population in Rwanda dependant on food aid until the harvest and the remaining refugees in Tanzania are not currently thought to be at heightened nutritional risk (category IIc in Table 1).

How could external agencies help? Until access to *Eastern Zaire* improves, perhaps facilitated through the dispatch of a multi–national military force, little humanitarian work can proceed. However, it can be surmised that the majority of those refugees and internally displaced people remaining in the region are increasingly in need of humanitarian aid support in the form of food, shelter, clean water and sanitation facilities, and health service provision. It is therefore vital that the relief community prepare for an intervention involving large numbers of malnourished and sick people. It is also essential that governments and UN agencies arrive at a clear policy regarding the ultimate destination of this newly displaced refugee population in order to plan for the most appropriate type of humanitarian aid support. Aid workers in the region have identified the following major impediments to resumption of humanitarian operations in Eastern Zaire once security problems are resolved; shortage of aid vehicles and logistic equipment, destruction of relief structures, chronic fuel shortages and poor road access.

In *Rwanda* there is an ongoing need for nutritional and food security monitoring in communes which are receiving large numbers of refugee returnees, This need is particularly acute in the prefectures of Gikongoro and Butare where poor harvests are posing an additional strain on food security. It is also important that agencies carefully monitor the equity of general ration distribution systems put in place as the speed of influx into communes may well necessitate distribution through commune leaders with an inherent risk of high levels of leakage to privileged groups.

In *Burundi*, the high level of insecurity continues to thwart efforts to adequately support newly displaced populations. These populations invariably require expanded selective feeding programme facilities and

general ration distributions and it is important that distribution systems are selected on the basis of posing least risk to beneficiaries while ensuring greatest likelihood of disbursement. The new influx of returnee refugees is an additional problem. Water and sanitization facilities need to be urgently improved at the transit camp at Rugumbo, while new returnees camped near Bugongo need to be urgently registered for food distributions and supplied with water and sanitation facilities.

In Kigoma region in *Tanzania*, the large influx of refugees leading to over-crowded camp conditions, insufficient water supplies and lack of soap and blankets in Mtendeli and newly established camps, is increasing the risk of outbreaks of cholera and measles. A high level of preparedness is needed in the event that such diseases occur. Furthermore, the high incidence of vitamin B2 deficiency leading to angular stomatitis indicates the need to review the quality of the ration and the efficiency of the distribution system.

5. Central African Republic

There are no reports of change to the nutritional situation of the 27,000 assisted Sudanese refugees in the Central African Republic. There are also approximately 5,000 assisted Chadian refugees whose nutritional status is believed to be adequate [UNHCR 16/01/96].

6. Djibouti

(see Map 6)

There remain approximately 2,500 assisted Ethiopian refugees in Djibouti, almost all of whom are reportedly now ready to repatriate [DHA Apr 96, UNHCR 96].

7. Ethiopia

(see Map 7)

There are an estimated 396,700 assisted refugees and internally displaced people in Ethiopia. This total is comprised of 72,000 Sudanese refugees, 287,000 Somali refugees, 8,700 Kenyan refugees, 18,000 Djibouti refugees and 11,000 internally displaced people from Kenya and Somalia who have moved into Moyale district of Ethiopia [DHA-a Sep 96]. There are an additional 30,000 unassisted refugees in Ethiopia.

The last RNIS report included details on an assessment mission to Ethiopia which revealed levels of wasting varying from 15.2%–21.1% among the Somali refugee population. These surveys showed a marked deterioration in nutritional status over the previous year. The nutritional situation for the Sudanese refugees, who are partially self-sufficient, was considered to be adequate and stable with levels of wasting varying from 6–8%.

Recommendations of the assessment mission, which included the extension of supplementary feeding programmes, diversification of the general ration for Somali refugees and a reduction in the ration in light of partial self-sufficiency for the Sudanese refugees, have not yet been implemented [DHA-a Sep 96, UNHCR 14/08/96].

Preparations are underway for the repatriation of the first 10,000 Somali refugees, which is expected to start before the end of 1996. The idea has reportedly been well received by the refugees and it is possible that many more than the 10,000 being targeted will register for the programme. Also, approximately 7,000 Kenyan refugees have expressed an interest in repatriating in the near future [DHA-a Sep 96, UNHCR 14/08/96].

Overall, the Somali refugees are in category I in Table 1 due to elevated levels of wasting and high crude mortality rates. Those in Fugnido camp in the west can be considered to be at moderate nutritional risk (category IIb in Table 1) due to continuing problems with water supplies. The remaining refugee and internally displaced populations are not currently thought to be at heightened nutritional risk (category IIc in Table 1).

How could external agencies help? Most of the recommendations of the earlier assessment mission, especially with regard to the Somali refugee population, have not yet been implemented. Specific interventions, many of which were noted in the September RNIS report, that still need to be implemented, include:

- the verification of the number of refugees in Ethiopia and the registration of Somali refugees without ration cards;
- the extension of supplementary feeding programmes in the Somali refugee camps;
- diversification of the ration for Somali refugees to include fortified blended foods;
- provision of non-food items such as soap, blankets and shelter material in the Somali camps.

As the Sudanese refugee population has attained some degree of self-sufficiency, a reduction in rations may be appropriate although the nutritional status of this population should be carefully monitored in order to detect any potentially adverse effect of such an action. Furthermore, this population should be encouraged to achieve a greater degree of self-sufficiency through:

- the more timely provision of seeds and tools;
- allowing wider access to arable land and water.

8. Kenya

(see Map 8)

There are approximately 167,000 refugees in Kenya comprised of 4,500 Ethiopian refugees, 130,500 Somali refugees and 32,000 Sudanese refugees. There has been a decrease in the number of Somali refugees due to repatriation, and an influx of Sudanese refugees. In August 1996, the Kenyan government announced that all Somali refugee camps would be closed by the end of 1996. It is however, unlikely that this deadline will now be met as it would involve the repatriation and/or resettlement of over 130,000 refugees over the next few weeks [IFRC 17/10/96, UNHCR 30/11/96].

The most recent RNIS report contained details of a nutritional survey in the Dadaab camps where there are approximately 113,000 Somali refugees. At that time it was reported that cases of scurvy were noted by the survey team. More recent information indicates an epidemic of scurvy with at least 700 cases being reported per month (5.8/10,000/month). Vitamin C tablets have been distributed amongst this population [MSF-B 06/11/96].

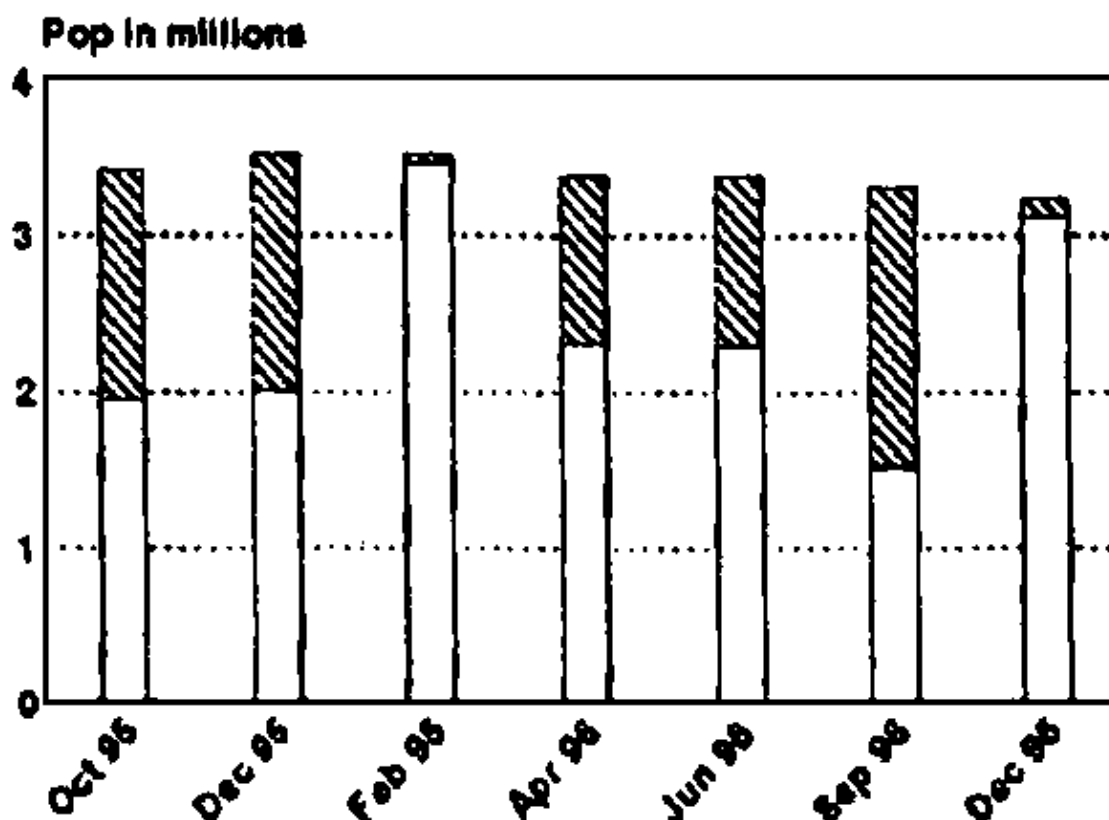
Overall, the refugees in the Dadaab camps are at high risk (category I in Table 1) due to micronutrient deficiency diseases. The remaining refugees are not currently considered to be at heightened nutritional risk (category IIc in Table 1).

9. Liberia/Sierra Leone Region

(see Map 9 a, b and Figure 3)

A fragile peace process in Liberia is holding although there have been some cease-fire violations. It is hoped that as the peace process advances with disarmament and demobilisation continuing, confidence will grow to a point where repatriation of refugees is possible. As hitherto insecure areas become accessible to humanitarian agencies, extremely high levels of wasting and mortality are being discovered. However, these situations appear to respond well to rapid emergency interventions. In Sierra Leone, there is a growing sense that despite some insecurity in the countryside and a continued need for targeted emergency relief, there is now scope to commence more developmentally oriented projects.

Liberia/Sierra Leone



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

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

Location	Oct 95	Dec 95	Feb 96	Apr 96	Jun 96	Sep 96	Dec 96
Liberia	1,900,000	1,900,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000
Sierra Leone	730,000	730,000	730,000	756,000	756,000	609,000	609,000
Cote d'Ivoire	305,000	305,000	305,000	305,000	305,000	305,000	305,000
Guinea	536,000	605,000	605,000	536,000	536,000	536,000	536,000
TOTAL	3,471,000	3,540,000	3,440,000	3,397,000	3,397,000	3,250,000	3,250,000

Liberia The peace process in Liberia is considered very fragile, and sporadic cease-fire violations continue to be reported throughout the country. For example, recent fighting in the Cape Mount region has led to the displacement of 3,000 people. Food distributions for this newly displaced population have been planned as security permits. There have also been security incidents involving humanitarian agencies in Monrovia and surrounding areas which have led to postponements in food distribution activities [WFP 08/11/96].

Implementation of the peace process is on-going. The disarmament programme began on schedule in November and is progressing slowly. Repatriation has not yet begun although it is hoped that as the peace process advances, refugees will be encouraged to return home [DHA 10/10/96, WFP 11/10/96, 06/12/96, UNHCR 19/11/96, USAID 30/09/96].

There are at least 1.8 million people affected by the war and its aftermath. Many areas of the country have been inaccessible for long periods of time and catastrophic nutrition and health situations are being discovered as these areas become accessible. For example, a recent joint assessment mission visited *Bo-Waterside* in Grand Cape Mount, where the population is estimated at 2,000, half of whom are thought to

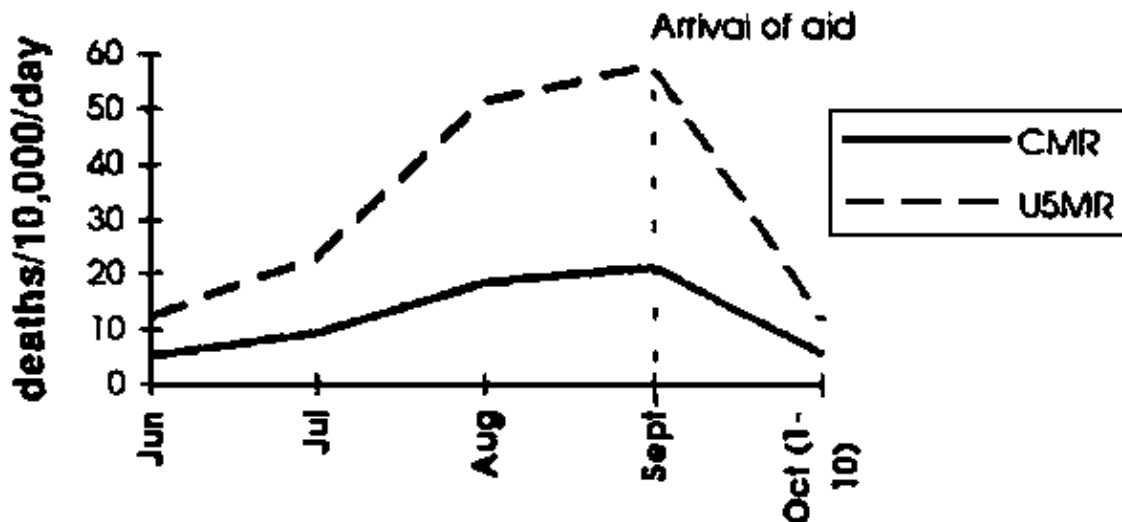
be Sierra Leonean refugees. A nutrition screening in the area showed 28% wasting with 11% severe wasting. Oedema was measured at 13% (see Annex I (9a)). Many people reported having access to arable land, but that much of the harvest had been taken by factional fighters. Refugees appeared to have less access to land than the local population. Some limited market activity was noted, but households seemed to depend heavily on foraged foods and would spend many days in the bush searching for wild foods. Households identified security and freedom of movement, food (but not without security from ECOMOG), medicines/health care, seeds and tools, as priorities for intervention. Individuals spoke of high levels of abuse by factional fighters, confiscation of food supplies and extortionate transport charges for moving products to market. Villagers in the area were adamant that no relief supplies should be delivered without the provision of security by ECOMOG forces. An outbreak of cholera in the area seemed to be subsiding although there were frequent reports of lack of drugs and medical supplies in health centres. Cholera cases have also been reported in Montserrado and Bomi County [DHA 10/10/96, 01/11/96].

Tubmanburg (estimated population 22,000) in Bomi County became accessible in September 1996, after being cut off from humanitarian aid for many months. In response to obvious need, food distributions were started immediately while severely malnourished people were transported to Monrovia and targeted feeding programmes implemented by the end of the month.

A rapid health assessment was carried out in October which measured wasting and/or oedema at 38% with 32% severe wasting and/or oedema (see Annex I (9b)). Mortality rates were equally horrifying. In August 1996 the crude mortality rate was 18.5/10,000/day (40x normal) with an under-five mortality rate of 51.2/10,000/day (around 50x normal). In the first ten days of October, the CMR was 5.4/10,000/day (approximately 10x normal) and the under-five mortality rate was 11.8 (roughly 10x normal) [EPICENTRE Oct 96].

Although much reduced, the mortality rates in mid-October were still ten times normal and triggered a number of recommendations from the assessment team. These included the continued implementation of a general food distribution and supplementary feeding programmes, the implementation of a medical care programme, mortality surveillance and a follow up anthropometric survey in the coming weeks. The assessment team recognised that an important factor in the relative improvement in health and nutrition of this population, in addition to the provision of food aid, may have been the reduced harassment by factional fighters who still control the "bush". These fighters have benefited from the re-opening of roads, the assistance programmes, looting of food distributions, presence of their families in nutritional programmes and improved trading links with Monrovia [EPICENTRE Oct 96].

Crude Mortality Rates (CMR) and Under-five Mortality Rates (U5MR) In Tubmanburg, Liberia Between 1 June 1996 - 10 October 1996



Data from 'Demographic and Nutrition Assessment Tubmanburg, Bomi County, Liberia' Medecins sans Frontieres, EPICENTRE. October 1996.

Sierra Leone A cease-fire was signed on 30 November 1996, and it is hoped that the accord will pave the way for resettlement and rehabilitation programmes to begin. Inter-agency registration exercises in Kenema, Bo and Makeni have confirmed that while some internally displaced people have begun to return to their areas of origin, large numbers who are dependent on food aid still remain in camps and urban areas. For example, there are still 10,000 inhabitants in Gondama camp in Pujehun district [DHA Sep 96, DHA 11/11/96, WFP 06/12/96].

As rebel forces are increasingly being pushed to the west of the country, some alarming situations are being uncovered. For example, a group of 500 people who had apparently been held captive for up to four years and forced into slave labour by the RUF were recently discovered in *Blama*, near Kenema. Among this population, estimates of adult malnutrition were 25% (see Annex I (9c)). This group have now been moved to RTI camp near Kenema, where preparations had been made for their arrival. It is believed that there are at least a further 1500 similarly affected people hiding in the bush, whose nutritional status is likely to be deteriorating rapidly [MERLIN 07/11/96]. It is also believed that this situation is not unique and that there are many other brutalised captive populations throughout the country who will emerge from the "bush" in the coming months.

A recent survey in the camps for internally displaced around *Bo* (population estimated at 93,000) showed 21.8% wasting with 3.5% severe wasting; oedema was measured at 0.2% (see Annex I (9d)). These results are similar to those obtained from a January 1996 survey when wasting was measured at 23%. The ration provides approximately 1200 kcals/person/day, and it has been recommended that it be increased to 2100 kcals/person/day to improve the nutrition situation of this population. Measles immunisation coverage was almost 80% [ACF 03/09/96].

In *Bo* town (population estimated at 250,000), wasting was measured at 9.4% with 0.9% severe wasting; oedema was measured at 0.1% (see Annex I (9e)). Half rations of approximately 920 kcals/person/day have been provided for the past seven months. Since June 1996, CSB has also been distributed. Measles immunisation coverage was 74% [ACF 03/09/96].

Stocks of cereals are reportedly depleted in Freetown, and CSB and vegetable oil stocks are at extremely low levels. In addition, vehicles for implementing and monitoring programmes are urgently needed [WFP

08/11/96].

Guinea There are approximately 650,000 Liberian and Sierra Leonean refugees in Guinea, 536,000 of whom are assisted with emergency food aid. Overall, the health and nutrition situation of these refugees is considered to be adequate, and it is hoped that as the peace process in Liberia and Sierra Leone continues to progress, the refugees will begin to repatriate [UNHCR 19/11/96].

A survey carried out in August 1996 showed a much improved situation for the Liberian refugees in the eastern zone of Guinea Forrestiere. Wasting varied from 1.1–3.2% with virtually no severe wasting or oedema seen (see Annex I (9f)). These results compare favourably with those from 1995 when levels of wasting were 14.7%–16.4%. It was felt that the improved quality and regularity of general rations have been key factors in effecting this improvement [MSF–B Aug 96].

However, measles immunisation coverage varied from 50–72% which is below the minimum coverage recommended of 80% [MSF–B Aug 96].

Cote d'Ivoire There are approximately 305,000 Liberian refugees in Cote d'Ivoire whose health and nutritional status are reportedly adequate and stable [UNHCR 19/11/96].

Overall, the populations of Tubmanburg, Bo Waterside and the internally displaced population around Bo, Sierra Leone are at high risk (category I in Table 1) due to sharply elevated levels of wasting and mortality. The population outside of Monrovia in Liberia can be considered to be at moderate risk, while the remainder of the population affected regionally is probably not currently at heightened nutritional risk (category IIc in Table 1).

Haw can external agencies help? In Liberia, as new areas become accessible extremely high rates of wasting and mortality are being found. The international community has shown in Tubmanburg that if access is possible, these situations can be quickly brought under control. Efforts to rapidly assist newly accessible populations must continue to be supported. These interventions will most likely be comprised of general food distributions, targeted feeding, immunisation programmes and health service provision along with the provision of seeds and tools.

However, it is vital that allocation of food is only undertaken where ECOMOG forces can guarantee some level of protection for beneficiaries or lives may be put at risk. The efficiency of interventions therefore rely on political decisions regarding the creation of protection zones where access is allowed. ECOMOG may need further encouragement and support to act as an interposition force in some areas.

There remain many internally displaced people in Sierra Leone who are dependant on emergency food aid. Funds to support the continuation of these distributions, along with funds for monitoring and logistics, remain a priority. At the same time it is important to support programmes which will encourage internally displaced people to return home. For example, the distribution of seeds, tools and other agricultural input could be important incentives for potential returnees. To date, the response to consolidated appeals for returnee and rehabilitation programmes has been minimal, and in order to take advantage of the present opportunity to progress from relief to development, pledges are urgently needed from donor governments. Stocks of cereal, CSB and oil are in urgent need of replenishment.

In Guinea there is a need to continue general ration distributions to the refugee population or there is a risk that previous high levels of wasting, which were due to inadequate general ration allocations, may recur. Efforts to increase measles immunisation coverage also need to be supported, e.g. strengthen mobile teams and ensure that stocks of vaccine are replenished. The longer-term initiatives to encourage self-sufficiency amongst this population must also continue.

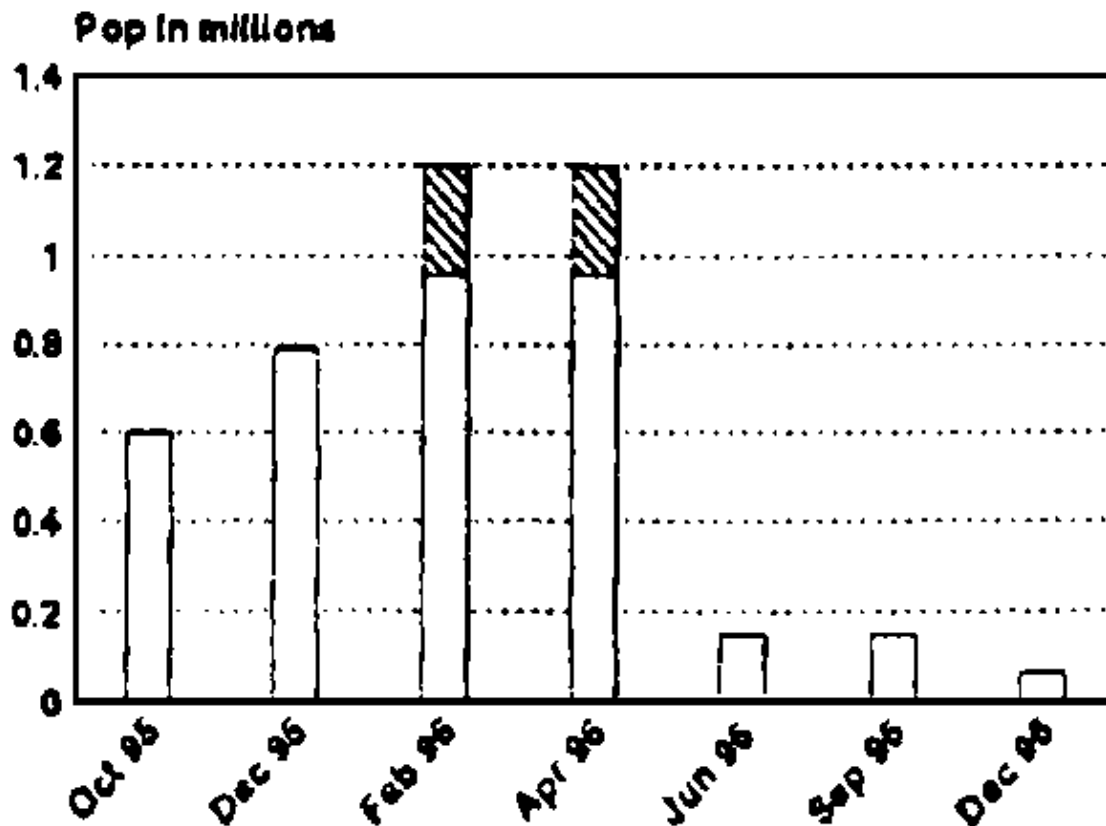
10. Mozambique Region

(see Map 10 and Figure 3)

Emergency food assistance is currently being provided to approximately 60–70,000 returnees and internally displaced people who returned too late in 1995 to clear and cultivate sufficient land to obtain a reasonable crop. It is hoped that these people will be self-sufficient after the harvest in April 1997. A 'Crop and Food Supply Assessment Mission' is planned for April 1997 to determine what, if any, the emergency food needs of

this population will be for the coming year [WFP-a 06/12/96].

Mozambique



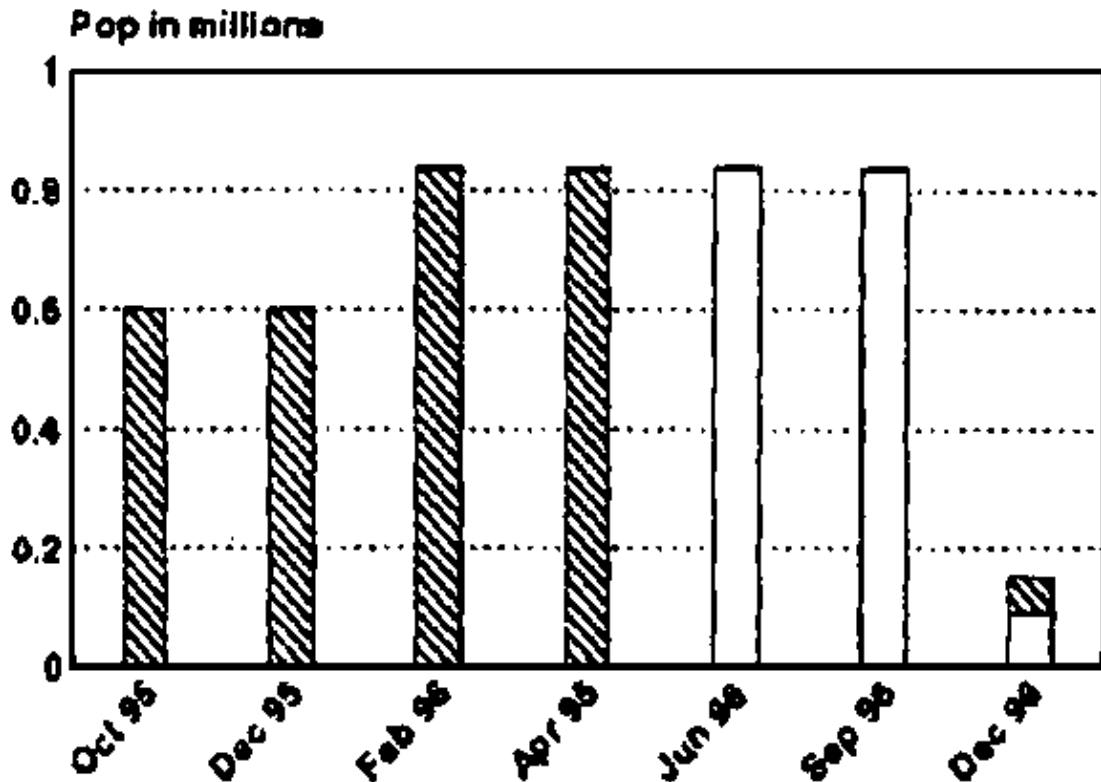
Trend in numbers of returnees and demobilised soldiers.

11. Somalia

(see Map 11 and Figure 3)

Despite the forecast improvement in the 1996/7 food crop harvests over 1995/6 levels, overall crop production is still 37% lower than the pre-civil war years and the food supply situation is described as precarious. Many areas of the country remain insecure, with sporadic fighting being reported in most areas of southern Somalia. It was estimated at the end of August 1996 that 150,000 people remained in need of emergency food assistance. The most vulnerable populations are probably those where the Gu harvest has been reduced and where an improvement in security is necessary to ensure that food aid can be transferred from surplus to deficit areas. For example, in the Lower Juba Valley the Gu harvest was predicted to only last two months. This, combined with insecurity and low purchasing power is causing extreme vulnerability in this population. Urban populations are also considered to be at risk [DHA-a 11/11/96, FAO 25/09/96].

Somalia



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

Mogadishu remains insecure, despite apparent progress made when the Kenyan president brought Somali factional leaders to the negotiating table in October. At that time warring factions agreed to end hostilities, however there has been no cease-fire apparent on the ground. There is concern that the food security situation for large numbers of unemployed people could rapidly deteriorate if food prices rise in the next few months. Despite the restrictions insecurity places on humanitarian activities and concerns for household food security, a recent nutrition survey showed 7% wasting and/or oedema in Mogadishu (see Annex I (11a)). In early November 1996 heavy flooding was reported in Mogadishu with the camps for the internally displaced reportedly worst affected [DHA 07/11/96, DHA-a 11/11/96].

Some NGOs are reporting a slight improvement in nutritional status in areas outside of Mogadishu. A recent survey carried out in the Bay region showed 13.1% wasting and/or oedema. Other surveys carried out in Dinsor, Berdale, and Quansaghare showed wasting and/or oedema at 11.8%, 4.6% and 14% respectively (see Annex I (11 b-e)) [DHA-a 11/11/96].

However, another survey in Bulla Huwa showed a very alarming situation. The town is situated near the Kenyan and Ethiopian borders and has an estimated population of approximately 59,000 people, which is at least double the 1992 population. More than 65% of the population are nomadic pastoralists. It is believed that many in the town are displaced from other parts of Somalia. Over 90% were living in temporary housing structures and most were only eating one meal a day. Wasting was measured at 37% with 10% severe wasting (see Annex I (11f)). This dramatic nutritional situation is partly explained by a lack of food at household level due to lack of employment opportunities and resulting poverty. Indeed, families are reportedly selling off personal possessions in order to be able to survive [Trocaire Oct 1996].

Overall, the population in Bulla Huwa can be considered to be at high risk (category I in Table 1) due to elevated levels of wasting. The remaining affected population is likely to be at moderate nutritional risk (category IIb in Table 1) due to continued sporadic insecurity leading to population displacements and lack of food availability in crop deficit areas. It should be noted that other population groups in Somalia may require emergency aid in the coming months in the wake of displacement caused by outbreaks of insecurity in

combination with crop failure.

How could external agencies help? Targeted feeding programmes are needed to bring the high levels of malnutrition recorded in Bulla Hawa under control as quickly as possible. Longer term solutions to the food insecurity in the area might include programmes designed to increase access to productive resources such as land for farming, water, equipment, and seeds and tools. Food for work programmes and subsidised food on the market are other possibilities.

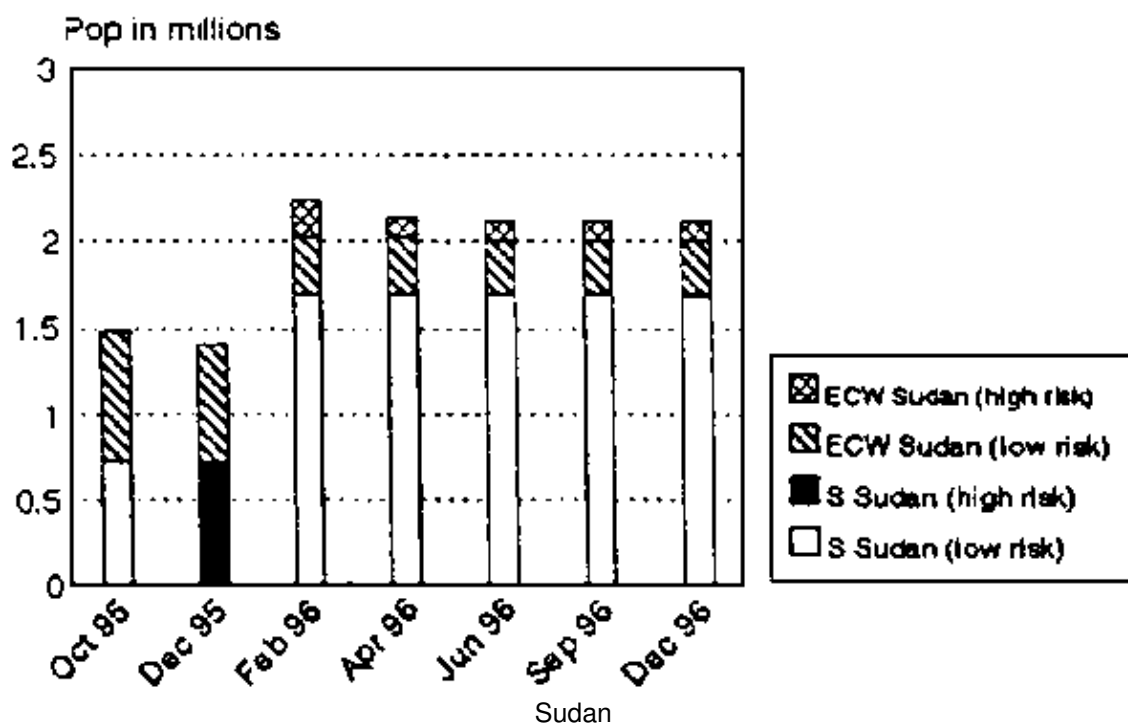
Throughout Somalia, there is a need for judicious use of food aid to support rehabilitation of flood control and irrigation schemes and provision of agricultural inputs through monetisation and food for work schemes. These activities should be prioritised in areas where agricultural production has been particularly poor. On-going nutritional surveillance in these areas is also important. Food security and resulting changes in the nutritional situation in urban areas also need to be carefully monitored, especially if food prices increase markedly.

12. Sudan

(see Map 12 and Figure 3)

There remain approximately 2.1 million people in Sudan requiring humanitarian aid. This total number is comprised of 119,000 displaced in camps around Khartoum (there are many more internally displaced people living among the local population in Khartoum), 1.9 million war-affected people in Southern Sudan and the transitional zone, and 150,000 assisted Ethiopian and Eritrean refugees. In addition, there are a further 240,000 people in the Red Sea Hills area in a catastrophic nutritional state experiencing exceptionally high levels of wasting and micronutrient deficiencies.

Sudan



Southern Sudan An FAO/WFP/UNICEF joint crop assessment mission to Southern Sudan was completed in early October and yields for 1996 are estimated to be higher than 1995. There are however, wide variations between states and persistent insecurity along with poor road conditions will most likely make transport from surplus areas of Western Equatoria state and parts of Upper Nile state to deficit areas such as Jonglei and Juba extremely problematic. As few coping strategies are available to the populations in Gongrial and Juba

(estimated population 500,000) where insecurity has resulted in cattle raiding and in high unemployment, the food situation in these areas is considered to be particularly critical. These problems are compounded by price rises of key cereals. For example, the price of sorghum in Juba is over 300% higher than at the same time last year [FAO 05/10/96].

An outbreak of measles has been reported in the western area of Upper Nile region, with another outbreak reported in areas of Bahr-el-Ghazal. A similar outbreak took place earlier this year and immunisation programmes have been on-going [OLS 23/10/96, 05/11/96].

A recent nutrition survey in *Bahr-el Ghazal* showed 21% wasting and/or oedema (see Annex I (12a)). Efforts to improve the situation are underway with food distributed to approximately 14,000 people. Many of these people are newly displaced due to insecurity in Thiek and Liethorn [OLS 05/11/96].

Red Sea State The food security situation in Sinkat and Tokar province has been markedly deteriorating for at least four months with food prices, particularly sorghum (300% in the past six months) increasing dramatically. These price increases were largely due to a lack of rain and subsequent harvest failure. Livestock prices have been declining simultaneously as households have been selling animals. This has resulted in a dramatic decline in the livestock: grain ratio. A recent survey showed a catastrophic nutritional situation which has led to some population displacement. There is concern that without significant humanitarian intervention, this displacement could become widespread [IFRC 22/10/96, Oxfam 23/10/96].

Food security in the area has been declining for many years now as successive drought have led to large numbers of livestock death which has significantly affected animal husbandry activities. Furthermore, employment opportunities and wages have been declining while the gradual reduction in food availability has affected traditional coping strategies such as community sharing [Oxfam 23/10/96].

The survey found wasting among the displaced people around Sinkat at 47.8% with 7.8% severe wasting. Results of a survey carried out among displaced people in Tokar are not yet available, but are likely to be as high as those seen in Sinkat. Surveys conducted in rural areas among the non-displaced populations near Sinkat showed 30.4% wasting with 7.4% severe wasting (see Annex (12b-c)) [Oxfam 23/10/96].

Micro-nutrient deficiency diseases were noted in both Sinkat and Tokar provinces. These included a serious epidemic of vitamin A deficiency and high levels of anaemia. In addition, some cases of scurvy were noted as well as isolated cases of beri-beri. Immunisation coverage was low at 30% [Oxfam 23/11/96].

A follow-up visit to the region three weeks after the assessment discussed above revealed no change in the situation. Indeed, displacements to urban areas was continuing and increased population movements were expected. With the onset of winter rains, it is anticipated that the situation will deteriorate [IFRC 11/11/96].

Refugees from Ethiopia and Eritrea Repatriation of Ethiopian refugees from camps is almost completed, and the repatriation of refugees living outside the camps has begun. It is hoped that 100,000 Eritrean refugees will be repatriated in 1997 [USAID 12/11/96].

Overall, the affected population in the Red Sea Hills and the displaced population in camps around Khartoum are in category I in Table 1 due to micronutrient deficiencies and sharply elevated mortality rates. Large numbers of people in Bahr-el-Ghazal where high levels of wasting are evident are also at high risk (category I in Table 1). The remaining affected population in Southern Sudan can be considered to be at moderate risk (category IIb in Table 1) due to diarrhoeal diseases and on-going difficulties with food aid delivery. The refugee population in Sudan is not currently considered to be at heightened nutritional risk (category IIc in Table 1).

How can external agencies help?

Southern Sudan There is a continued need for rapid assessments and interventions following new displacements, with particular attention to Juba and Gongrial where the food situation is believed to be especially critical. Periodic outbreaks of measles indicate that efforts to improve immunisation coverage must remain a priority.

Continued insecurity is hindering implementation of rehabilitation programmes and in many areas completely preventing these activities. However, progress towards self-sufficiency can be made with the continuation of initiatives to provide agricultural inputs, which remain in short supply as well as technical assistance to farmers for improving cultivation methods.

The recent OLS review suggests a number of ways in which response capacity can be improved. These include:

- a more aggressive pursuit of humanitarian access to war-affected populations;
- the use of relief/rehabilitation activities to strengthen coping capacities of local communities;
- strengthening integration between northern and southern sector programmes.

Red Sea Hills Extremely high levels of malnutrition, loss of traditional coping mechanisms coupled with severe food insecurity demand immediate intervention. The mortality risk of these populations is already very high and would only be increased if large numbers began crowding into camps for the internally displaced. Urgent intervention measures are therefore needed to deal with the existing problem and prevent a massive displacement. Some high priority interventions for the displaced would be:

- a general ration of 440 gms cereal, 50 gms pulses, 20 gms of oil and 50 gms of fortified blended foods;
- vitamin A capsule distributions;
- therapeutic feeding programmes to be implemented by the MOH but supported with donor resources;
- supplementary feeding programmes should admit all other children until wasting rates are below 25% at which stage these programmes should only feed those under 80% wt for ht. It may initially be optimal to establish on-site feeding given the immediate difficulties faced by the displaced in preparing nutritious foods;
- immunisation campaigns against measles as coverage is currently so low,
- shelter and blankets in Sinkat province.

Assistance to rural areas should include:

- adequate general rations for all those in rural areas and rural towns;
- support for destitute during the current agricultural season, e.g. transport to areas of cultivatable land and provision of agricultural inputs;
- strengthening health care provision in rural areas.

13. Uganda

(see Map 13)

There are approximately 429,800 refugees and internally displaced people in Uganda, broken down by country of origin as follows:

Origin	Oct 95	Dec 95	Feb 96	Apr 96	Jun 96	Sep 96	Dec 96
Sudanese Refugees	324,000	217,000	210,000	214,000	214,000	214,000	214,000
Internally Displaced Ugandans	–	–	–	–	–	20,000	200,000
Zairian Refugees	13,700	11,800	12,300	12,300	12,300	15,800	15,800
TOTAL*	337,400	228,800	222,300	226,300	226,300	249,800	429,800

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

Insecurity in Northern Uganda is escalating, with two separate rebel movements operating. Their attacks against the population are causing massive displacement of Ugandans and Sudanese refugees, and the

insecurity is hampering efforts of humanitarian relief agencies. It is now estimated that there are 200,000 internally displaced people. A major consequence of this displacement is that farmers cannot harvest their crops as they would normally be doing at this time. This has implications not only for the day-to-day survival of these people, but also for longer-term food security since they are not building up food stocks [DHA 04/12/96, WFP 29/11/96].

It has further been reported that many Sudanese refugees have been displaced from one camp to another. The growing insecurity has prompted changes in humanitarian aid delivery to these areas. Road transport has become dangerous, and most of the humanitarian aid is brought in by air, at a far greater cost [DHA 04/12/96].

There are no reports of change to the generally adequate and stable nutritional situation for the approximately 16,000 Zairian refugees in Uganda.

Overall, the Sudanese refugees and the internally displaced people in Northern Uganda can be considered to be at heightened nutritional risk due to escalating insecurity (category IIa in Table 1), while the Zairian refugees are not currently considered to be at heightened nutritional risk (category IIc in Table 1).

14. Zaire

(see Map 14)

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. 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. There are over 12,000 Ugandan refugees and a further 6,000 new arrivals whose refugee status unclear [UNHCR 17/01/96, 1995–1997].

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).

15. 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 1996–1997].

There are 1,000 refugees newly arrived from Zaire [USAID 05/12/96]. No further details are currently available on this population.

ASIA – SELECTED SITUATIONS

The most recent overview of the numbers of refugees and displaced people in Asia (as of the end of 1995) is as follows. There were an estimated 4.5 million refugees in Asia, of whom over 800,000 were Afghans in Pakistan and in Iran (1.5 million). There were reported to be 600,000 Iraqis in Iran. Other large groups were refugees from Myanmar in Bangladesh (36,000), Vietnamese in China (286,000), and Bhutanese in Nepal (90,000). No comprehensive data were available on the numbers of internally displaced populations in Asia, but they were certainly in the millions (UNHCR, 1995 '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.

16. Afghanistan Region

(see Map 16)

Sporadic fighting continues between warring factions north of Kabul, while the city itself is reportedly calm. Peace initiatives and conferences brokered by Pakistan, Iran and the UN Special Envoy continue. As the fundamentalist Taliban forces progressed across Afghanistan to Kabul, women were originally forbidden to work and attend school but these restrictions are now being relaxed in some areas. For example, WFP's women's projects, including the subsidised bakery project for women, have resumed. WFP have lifted the suspension of WFP food shipments into areas such as the north and parts of the south, west and eastern provinces, where relief activities in favour of men and when can continue largely unaffected by the Taliban pronouncements on women. However, UNHCR recently temporarily suspended their work in Kabul after what they described as 'weeks of harassment' [Agence France Press 21/11/96, DHA 20/11/96].

Kabul Thousands of people are reportedly leaving Kabul; for example over 6,000 people left the city between 20–26th of October, and over 3,000 departed in mid–November. There are a smaller number of returnees, some of whom are passing through Kabul on their way north. Programmes in favour of women, such as the bakery project have now resumed in the capital [DHA 12/11/96, WFP 01/11/96].

There are no new reports on the nutritional situation of the estimated 600,000 vulnerable people in Kabul. As winter approaches, aid agencies are stockpiling relief items which will be needed over the coming months.

Jalalabad The number of internally displaced people in the Jalalabad area is estimated at 160–200,000. There are a number of new arrivals who are either in the two camps or living among the local population. There are no recent reports on the nutritional situation of these people.

Pakistan There is a slight increase in the number of Afghan refugees in Pakistan due to new arrivals from Kabul.

Iran There are no reports of change in the situation for the 1.4 million Afghani refugees in Iran.

Overall, the vulnerable population in Kabul is at moderate nutritional risk (category IIb I Table 1), and the remaining affected population is not currently thought to be at heightened nutritional risk (category IIc in Table 1).

How could external agencies help? It is essential to stock enough relief items to last through the winter months. Important items include food aid, fuel for heating, and blankets. There is also a need to resupply hospitals ahead of the winter snows.

Some longer term projects, as outlined in the Consolidated Appeal for Afghanistan, focus on reconstruction and include:

- improving water and sanitation, particularly in Kabul;

- increasing agricultural production through the provision of farm inputs and the continuation of the defining process;
- rehabilitating of health infrastructure.

17. Bhutanese Refugees in Nepal

(see Map 17)

There are just over 90,500 refugees from Bhutan in Nepal. Any slight increase in population numbers are due largely to births in the camps; there are very few new arrivals. The nutritional situation is said to be stable and a recent screening of children under five years old showed 2.4% wasting with .06% severe wasting (see Annex I (17a)). However, cases of scurvy (incidence rate 0.59/1,000/month), beri-beri (3.31/1,000/month) and angular stomatitis (8.05/1,000/month) continue to be reported. Reasons for the continued presence of these micronutrient deficiencies in this population is being investigated [SCF Oct 96, UNHCR 22/11/96].

Overall, a proportion of these refugees is at high risk due to micronutrient deficiency diseases (category I in Table 1) while the remaining population is not considered to be at heightened nutritional risk (category IIc in Table 1).

18. Refugees from Rakhine State, Myanmar in Bangladesh

(see Map 18)

There remain approximately 36,000 refugees from Rakhine State, Myanmar in Bangladesh. This number continues to decrease due to the ongoing repatriation programme. It is anticipated that a further 16,000 people will have returned home by the end of 1996 and that the repatriation process will be completed by mid-1997 [UNHCR 22/11/96].

Preliminary results of a nutritional survey in the camps in Bangladesh showed a significant deterioration since the previous two annual surveys. Wasting was measured at 15.4% with 0.7% severe wasting (see Annex I (18a)). These results compare unfavourably with rates of 7.2% and 9.5% in 1994 and 1995 respectively. Despite a decrease in the prevalence of angular stomatitis, cases are still being seen indicating vitamin B2 deficiency. Measles immunisation coverage was 98.4%. Coverage of selective feeding programmes remain low at 55% [UNHCR 01/09/96]. Details of actions to rectify this situation will be forthcoming.

An increase in the number of cases of both bloody and watery diarrhoea in the camps has been reported. At the same time, it was discovered that stocks of blended food kept at camp level were infested and it was felt that this could be associated with the increase in cases of watery diarrhoea. Distribution of blended foods was discontinued although in order to compensate the general ration was readjusted to contain an additional 10 gms of pulses, 10 gms of oil and 5 gms of sugar in addition to high protein biscuits [UNHCR 18/11/96]. These measures will maintain the caloric level of the general ration at previous levels although the micronutrient content of the ration will be lower.

Overall, this population could be considered to be at high nutritional risk (category I in Table 1) due to elevated levels of wasting and the continuing diagnosis of new cases of micronutrient deficiency diseases, particularly vitamin B2. It is possible that the deterioration in the nutritional status of this population reflects the fact that the repatriation has left the most vulnerable households in the camps.

How could external agencies help? Stocks of blended foods should be replenished as soon as possible. Furthermore, measures to prevent future infestation should be taken. These might include fumigation as a preventive measure and adherence by supplying agencies to the practice of ensuring that the manufacture and expiry dates of the blended foods are clearly marked on each bag. Also, while blended foods are absent from the general ration particular attention should be given to methods of micronutrient deficiency surveillance within the camps.

19. Southern Iraq

There are no new reports on the situation for the Marsh Arabs in the south, who have been suffering a constantly deteriorating situation for many years. The systematic destruction of the traditional habitats, loss of livelihood, arbitrary arrests, detention and torture of this population have been regularly reported, and have most likely left this population of 200,000 with little or no propensity to cope.

There are no reports of change to the generally adequate nutritional status of the approximately 28,000 Iraqi refugees in Iran.

Overall, the Marsh Arabs inside Iraq are likely to be at high nutritional risk (category IIa in Table 1) while those who have crossed into Iran are probably not at heightened nutritional risk (category IIc in Table 1).

LISTING OF SOURCES FOR DECEMBER 1996 RNIS REPORT #18

Org*	Date	Title of Report
ACF	03.09.96	Nutritional Survey Displaced Camps and Town Bo, Bo District, Sierra Leone
Agence France Press		
Press	21.11.96	Media Report
DHA	Apr. 96	Monthly Information Report – Ethiopia
DHA	Sep. 96	UN Inter–Agency Appeal for Sierra Leone – Update
DHA	07.10.96	Humanitarian Assistance in Angola Week 39–40
DHA	10.10.96	Liberia – Humanitarian Assistance Report No. 43
DHA	15.10.96	Burundi – Humanitarian Situation Report No. 35
DHA	01.11.96	Liberia – Humanitarian Situation Report No. 46
DHA	07.11.96	Somalia Floods – DHA Information Report No. 1
DHA	10.11.96	Demobilisation and Reintegration in Angola No. 8–12
DHA	11.11.96	Sierra Leone Bi–Monthly Information Report No. 9
DHA	12.11.96	Assistance for Afghanistan Issue No. 193
DHA	20.11.96	Assistance for Afghanistan Issue No. 193
DHA	04.12.96	Humanitarian Situation Report on Uganda
DHA–a	Sep. 96	Monthly Information Report – Ethiopia
DHA–a	11.11.96	Bi–Monthly Information Report – Somalia
EPICENTRE	Oct. 96	Demographic and Nutritional Assessment Tubmanburg, Bomi County, Liberia
FAO	25.09.96	FAO/WFP Crop and Food Supply Assessment Mission to Somalia
FAO	05.10.96	Crop Assessment in Southern Sudan
IFRC	14.10.96	Benin/Ghana/Togo Health, Relief & Rehabilitation
IFRC	17.10.96	Kenya: Somali Refugees
IFRC	22.10.96	Sudan: Drought Emergency Intervention
IFRC	11.11.96	Sudan – Drought

IRIN	04.11.96	Emergency Update No. 6 on Eastern Zaire
IRIN	08.11.96	Eastern Zaire – Complex Emergency Fact Sheet #2
IRIN	17.11.96	Emergency Update No. 27 on Eastern Zaire
IRIN	22.11.96	Emergency Update No. 36 on Eastern Zaire
IRIN	29.11.96	Emergency Update No. 44 on Eastern Zaire
IRIN	03.12.96	Emergency Update No. 47 on Eastern Zaire
IRIN	08.12.96	Emergency Update No. 51 on Eastern Zaire
IRIN	11.12.96	Emergency Update No. 54 on the Great Lakes
IRIN	12.12.96	Emergency Update No. 55 on the Great Lakes
IRIN	03–04.11.96	Emergency Update No. 5 on Eastern Zaire
MERLIN	07.11.96	Blama, Sierra Leone Press Release
MSF	24.11.96	Sitrep #15 Kigoma
MSF–B	Aug. 96	Enquete nutritionnelle... dans la Population Réfugiée en Zone Est
MSF–B	30.08.96	Résultats de l'Enquete.... Province Karusi
MSF–B	11.10.96	Food Basket Monitoring – Camp de Réfugiés de Kibangira
MSF–B	06.11.96	Personal Communication – Kenya
OLS	23.10.96	OLS Southern Sector Update 96/42
OLS	05.11.96	OLS Southern Sector Update 96/44
		Food Security and Nutritional Assessment of Sinkat and Torkar Provinces, Red Sea
OXFAM	23.10.96	State, Sudan
SCF	Oct. 96	Monthly Report – Bhutanese Refugees in Nepal
Trocaire	Oct. 96	Population and Nutrition Survey of Bulla Hawa Town, Gedo Region, Somalia
UNHCR	1996	Repatriation and Reintegration of Ethiopian Refugees
UNHCR	16.01.96	Situation Report – CAR
UNHCR	14.08.96	Press Release: UNHCR prepares for Somali refugee repatriation Preliminary Survey Report of Nutrition Survey of Under 5 Refugee Children in
UNHCR	01.09.96	Camps in Bangladesh
UNHCR	17.11.96	Rapport de Mission 7–17 novembre (Burundi)
UNHCR	18.11.96	Temporary Suspension of Distribution of Blended Food
UNHCR	19.11.96	Personal Communication – Liberia/Sierra Leone Region
UNHCR	22.11.96	Personal Communication – Nepal, Bangladesh, Mauritania
UNHCR	30.11.96	Monthly Population Statistics – Kenya
UNHCR	1996–7	Appeal for the Repatriation and Reintegration of Angolan Refugees
USAID	30.09.96	Liberia – Situation Report #2
USAID	12.11.96	Sudan Complex Emergency – Situation Report #1
USAID	22.11.96	Great Lakes – Complex Emergency Situation Report #5

USAID	05.12.96	Great Lakes – Complex Emergency Situation Report #11
USAID	12.12.96	Great Lakes – Complex Emergency Situation Report #12
WFP	04.10.96	Weekly Update UN Consolidated Inter–Agency Appeal for Sierra Leone Update
WFP	11.10.96	Weekly Update
WFP	18.10.96	Weekly Update
WFP	01.11.96	Weekly Update
WFP	08.11.96	Weekly Update
WFP	14.11.96	Eastern Zaire Situation Report #18
WFP	21.11.96	Eastern Zaire Situation Report #25
WFP	22.11.96	Weekly Update
WFP	29.11.96	Weekly Update
WFP	06.12.96	Weekly Update
WFP–a	06.12.96	Personal Communication – Mozambique
		Draft of ‘Joint WFP/UNHCR Food Assessment Mission in the Great Lakes Region – Tanzania’
WFP/UNHCR	Oct. 96	

***Org**

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
IRIN	Integrated Regional Information Network (of DHA)
Min of Health	Ministerio da Saude, Republica de Mocambique
MSF–B	Medecins Sans Frontieres – Belgium
MSF–CIS	Medecins Sans Frontieres – Celula Inter–Seccoes
MSF–F	Medecins Sans Frontieres – France
MSF–H	Medecins Sans Frontieres – Holland
OLS	Operation Lifeline Sudan
SCF	Save the Children Fund
UNAA	United Nations Humanitarian Assistance for Afghanistan
UNHRCS	United Nations Humanitarian and Resident Coordinator for Somalia

UNECOSOC	United Nations Economic and Social Council
UNHCR	United Nation's High Commission on Refugees
UNICEF	United Nation's Children Fund
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision

LIST OF TABLES, FIGURES AND ANNEXES

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

Situation	Population Numbers					Total	Change from Jun. 96	Nutr Stat*	Comments
	Condition								
	I: High Prev	Ia: High Risk	Ib: Mod Risk	Ic: Not Critical					
Sub-Saharan Africa									
1. Angola				1'375'000	1'375'000	0	stat	Improved infrastructure facilitating the free movement of people and goods through Angola.	
2. Benin/Ghana/Togo Region				33'000	33'000	-73'800	stat	Decreased total due to repatriation.	
3. Burkina Faso/Mauritania				53'000	53'000	-4'500	stat	Decreased total due to repatriation. Ration increased to 2100 kcals/person/day not implemented.	
4. Burundi/Rwanda Region	536'000	918'000	706'000	753'500	2'913'500	-88'500	stat/det	Decrease in numbers is due to return of IDPs to Masisi and uncertainty over numbers of refugees and IDPs in Zaire.	
5. Central African Republic				32'000	32'000	0	stat		

6. Djibouti				2'500	2'500	0	stat	
7. Ethiopia	287'000		43'000	66'700	396'700	19'500	det	Previously reported high levels of wasting are not likely to have changed.
8. Kenya	113'000			54'000	167'000	2'000	det	Cases of scurvy reported among the Somali refugee population. Increased number of Sudanese refugees.
9. Liberia/Sierra Leone/Guinea/Cote d'Ivoire	117'000		676'000	2'457'000	3'250'000	0	imp	There are likely to be pockets of severe malnutrition in inaccessible areas in Liberia. There are also likely to be other people, like those in Blama, Sierra Leone, in a very serious nutritional state.
10. Mozambique Region				70'000	70'000	-84'000	imp	This smaller population is likely to require humanitarian assistance until the harvest in April 1997.
11. Somalia	59'000		91'000		150'000	-690'000	det	Far greater numbers are likely to require emergency food assistance, especially in large urban centres and crop deficit areas.
12. Sudan	137'000		1'840'000	200'000	2'177'000	4'000	det	Affected population in Red Sea Hills and displaced around Khartoumat high risk due to micronutrient deficiencies
13. Uganda		414'000		15'800	429'800	179'800	det	Increased number of IDPs in Northern Uganda. These

									IDPs, along with Sudanese refugees at heightened risk.
14. Zaire	260'000			156'000	416'000	0	det/stat		For displaced from Shaba in Mwene Ditu, nutritional status based on most recent survey data (end 1999). No indications of change.
15. Zambia				27'000	27'000	1'000	stat		Increase due to the arrival of Rwandan refugees from Eastern Zaire.
Total (Sub-Saharan Africa)	1'509'000	1'332'000	3'356'000	5'295'500	11'492'500	-734'500			
Asia (Selected Situations)									
16. Afghanistan Region			570'000	2'260'000	2'830'000	0	stat		
17. Bhutanese Refugees in Nepal	1'500			88'500	90'000	0	stat		A proportion (roughly 5%) of the population may be at high risk due to micronutrient deficiency diseases.
18. Bangladesh	36'000				36'000	-14'000	imp		Decreased total due to repatriation. Those remaining in the camps are at high risk due to elevated levels of wasting and the presence of micronutrient deficiencies.
19. Southern Iraq		192'000		28'000	220'000	0	det		Those in Marshes considered at high risk.

Table 2. Summary of Origin and Location of Major Populations of Refugees, Returnees and Displaced People in Africa – December 1996 – RNIS #18 (Population Estimates in Thousands)

From	Angola	Benin		Burundi		Eritrea	Ethiopia	Ghana	Guinea	Kenya	Liberia

			Burkina Faso		Cote d'Ivoire								
Angola	1'375												
Benin													
Burkina Faso													
Burundi				296									
Cote d'Ivoire													
Eritrea													
Ethiopia							11			4			
Ghana													
Guinea													
Kenya							9						
Liberia					308			16	408			1'700	
Mali			25										
Mauritania													
Mozambique													
Rwanda													
Sierra Leone									128			100	
Somalia							287			131			
Sudan							72			32			
Tanzania													
Togo		11						12					
Uganda													
Zaire													
Zambia													
TOTAL	1'375	11	25	296	308	0	379	28	536	167	1'800	0	

NOTES:

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

(2) Boxes on the diagonal (shaded) show internally displaced populations (total = 8.05 million).

(3) Numbers referred to in the text are usually by the country where the population is located (i.e. column totals). For the regional situations of Burundi/Rwanda and Liberia/Sierra Leone the description is by country of origin (i.e. row totals).

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

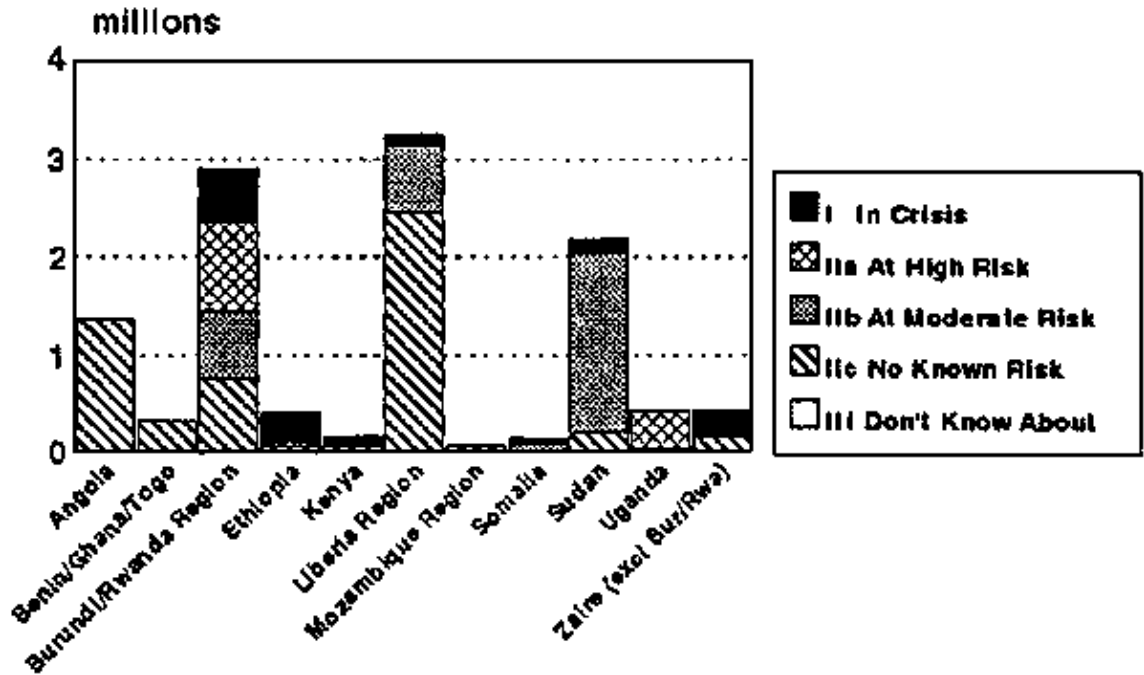


Figure 1. REFUGEE AND DISPLACED POPULATIONS – Selected Areas in Africa (December 1996)

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

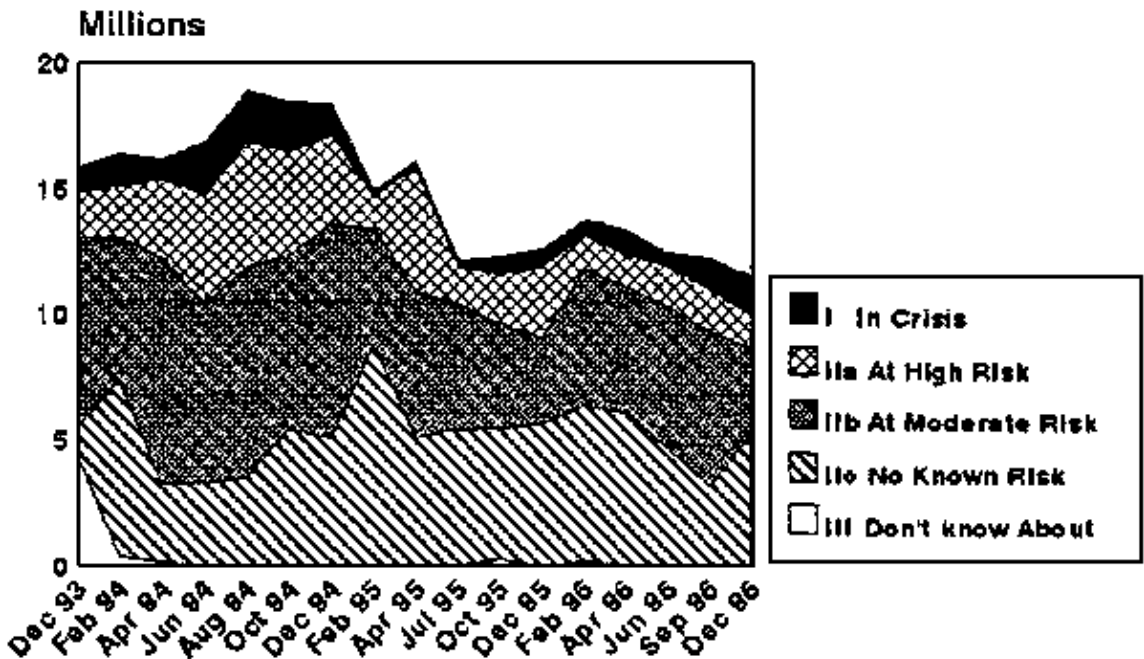
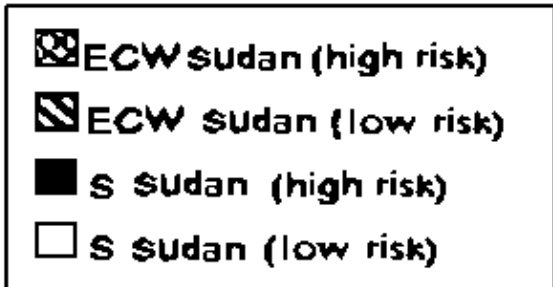
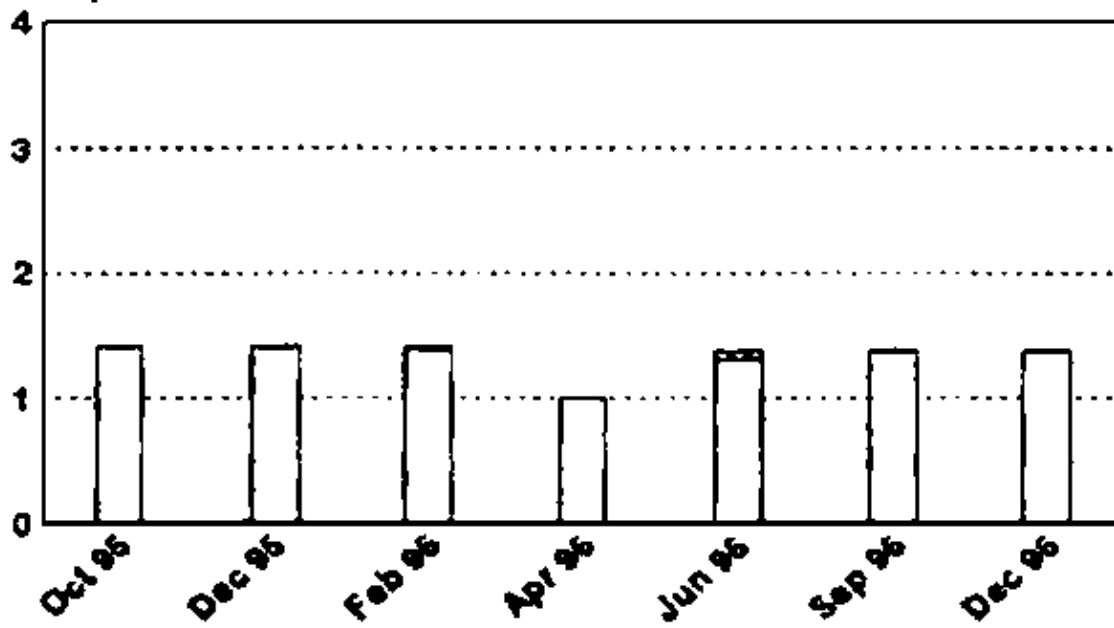


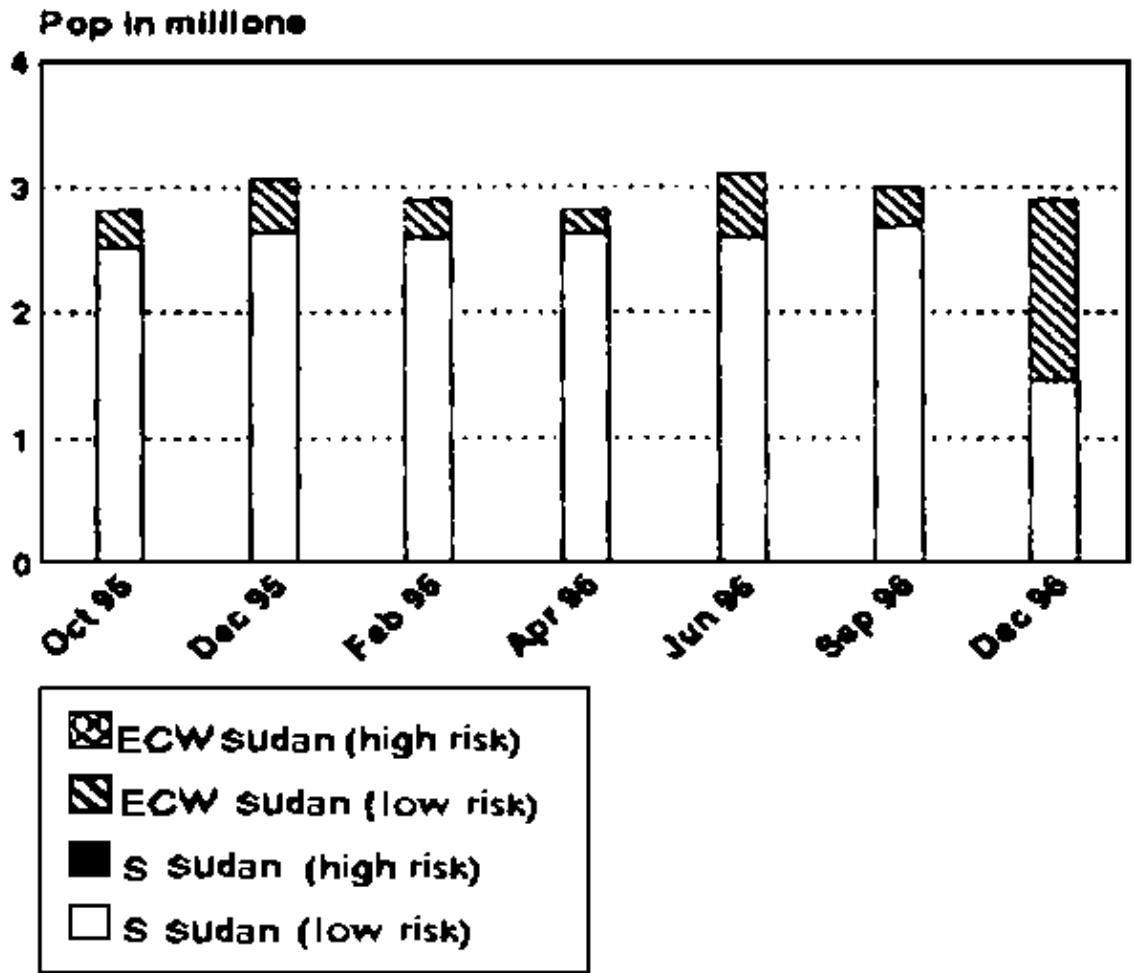
Figure 2. Trends in Total Refugee/Displaced Populations By Risk Categories Africa: December 1993–December 1996

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

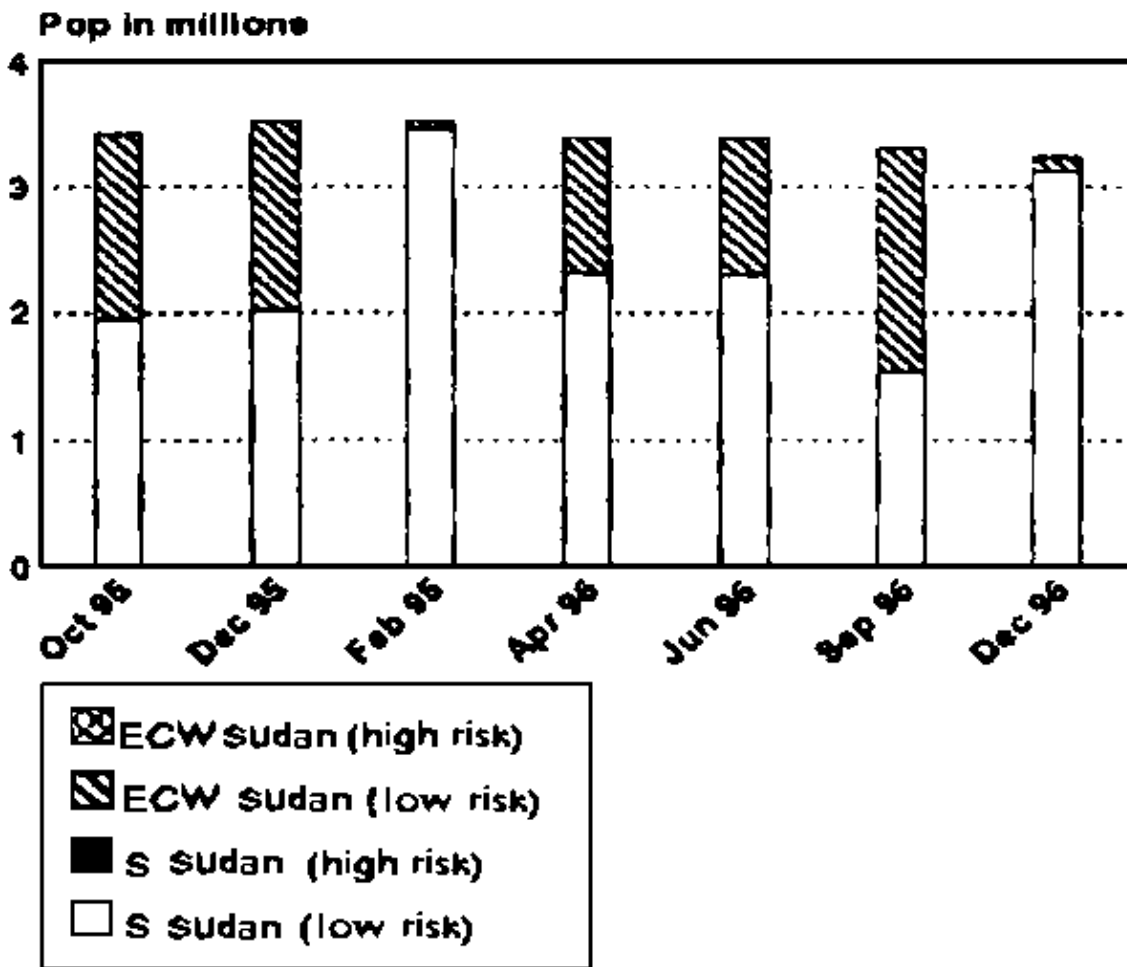
Pop in milltone



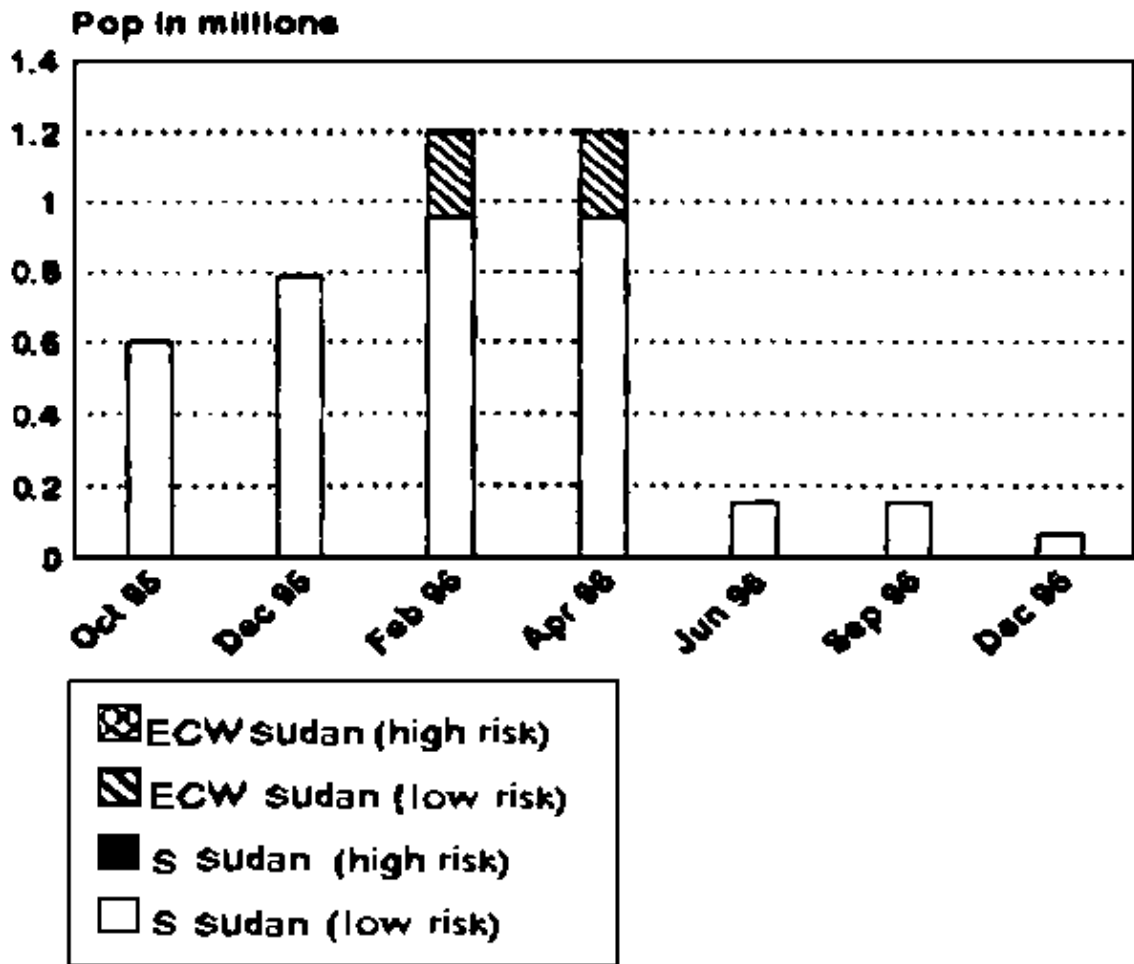
Angola



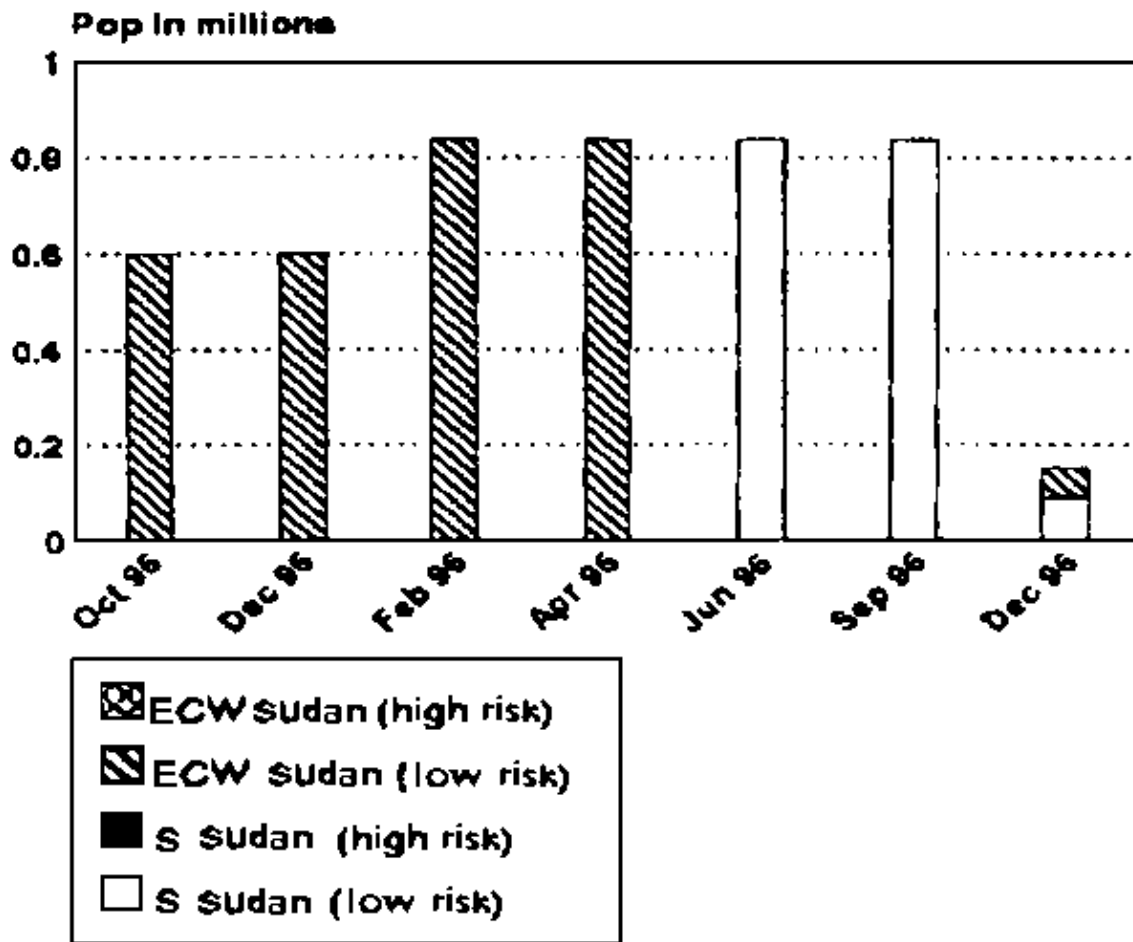
Burundi/Rwanda Region



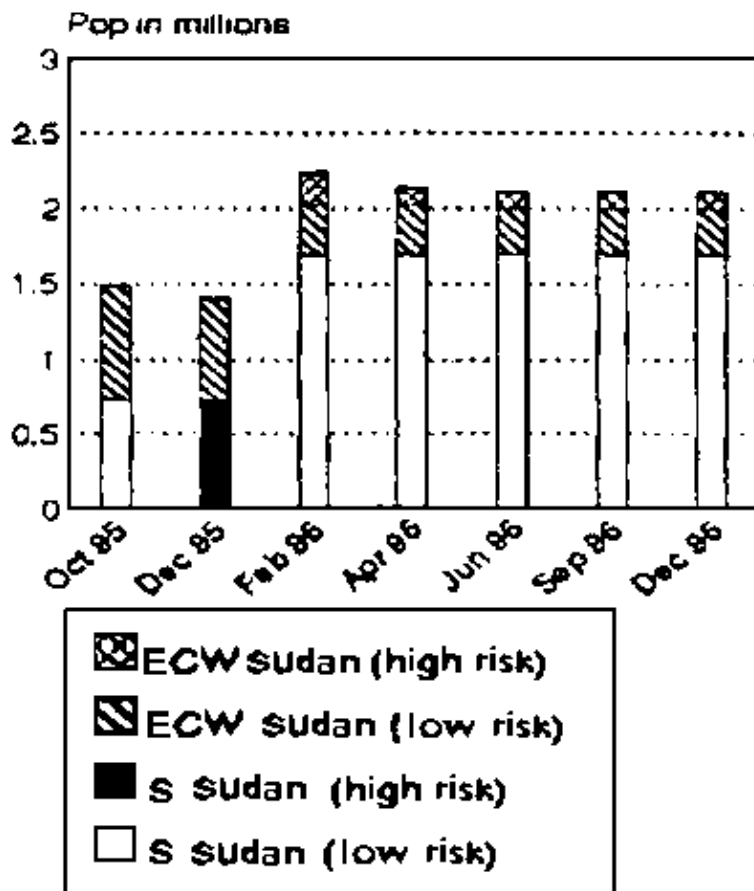
Liberia/Sierra Leone



Mozambique



Somalia



Sudan

Annex I. Results of Surveys Quoted in December RNIS Report (#18) – Usually Children 6–59 Months

<i>Survey Area</i>	<i>Survey Conducted by</i>	<i>Date</i>	<i>% Wasted*</i>	<i>% Severely Wasted*</i>	<i>Oedema (%)</i>	<i>Crude Mortality (/10,000/day)</i>	<i>Under 5 Mortality (/10,000/day)</i>
1. Angola							
<i>a. Kuito</i>	CARE	Nov.96	9.7**	1.9**			
<i>b. Uige</i>	MSF-E	Nov.96	2.0**				
4. Burundi/Rwanda Region							
<i>a. Kibangira Camp, Rwanda</i>	MSF-B	Oct.96	6.1	2.8	0.0	0.4	1.9
<i>b. Gatumba Transit Centre, Burundi</i>	UNHCR	Nov.96	18.2 (MUAC, all ages)	4.2			
<i>c. Gatumba Transit Centre, Burundi</i>	UNHCR	Nov.96		17.6 (MUAC<110)			
<i>d. Karuzi Province, Burundi</i>	MSF-B	Aug 96	13.0	2.7	1.1		
<i>e. Kanembwa, Kigoma, Tanzania</i>		Sep.96	3.8	0.6	0.0	0.17	0.3
<i>f. Mtendeli, Kigoma, Tanzania</i>		Sep.96	12.5	1.1	0.0	0.26	0.6
<i>g. Mkugwa, Kigoma, Tanzania</i>		Sep.96	5.3	0.0	0.6		
<i>h. Mtabila, Kigoma, Tanzania</i>		Sep.96	3.0	0.2	0.0	0.33	1.14
<i>i. Lumasi, Ngara, Tanzania</i>		Sep.96	1.9	0.3	0.0	0.14–0.59	0.39–1.96
<i>j. Lukoli, Ngara, Tanzania</i>		Sep.96	2.4	0.2	0.3	0.14–0.59	0.39–1.96
<i>k. Keza, Ngara, Tanzania</i>		Sep.96	3.6	0.1	0.8	0.14–0.59	0.39–1.96
<i>l. Chabalisa I, Karagwe, Tanzania</i>		Sep.96	0.3	0.3			
<i>m. Chabalisa II, Karagwe, Tanzania</i>		Sep.96	1.8	0.0			
<i>n. Rubwera, Karagwe, Tanzania</i>		Sep.96	0.4	0.1			
<i>o. Kegenyi, Karagwe,</i>		Sep.96	0.6	0.1			

<i>Tanzania</i>								
<i>p. Omukariro, Karagwe, Tanzania</i>		Sep.96	1.5	0.4				
9. Liberia/Sierra Leone Region								
<i>a. Bo–Waterside, Liberia</i>	WFP/UNHCR/ UNICEF/ ACF/CARE/ CONCERN/ WV/LIURD	Oct.96	28.0	11.0	13.0			
<i>b. Tubmanburg, Born County, Liberia</i>	EPICENTRE	Oct.96	38.0**	32.0**		5.4	11.8	
<i>c. Blama, Sierra Leone</i>	MERLIN	Oct.96	25.0***					
<i>d. Bo (displaced) Sierra Leone</i>	ACF	Sep.96	21.8	3.5	0.2			80
<i>e. Bo (resident) Sierra Leone</i>	ACF	Sep.96	9.4	0.9	0.1			74
<i>f. Guinea Forrestiere, Guinea</i>	MSF–B	Aug 96	1.1–3.2	0.0	0.0			
11. Somalia								
<i>a. Mogadishu</i>	MSF–Spain	Nov.96	7.0**					
<i>b. Bay Region</i>	WHO/IMC	Oct.96	13.1**					
<i>c. Dinsor</i>	IMC	Oct.96	11.8**					
<i>d. Berdale</i>	IMC	Oct.96	4.6**					
<i>e. Quansaghare</i>	IMC	Oct.96	14.0**					
<i>f. Bulla Hawa</i>	Trocaire	Oct.96	37.0	10.0				
12. Sudan								
<i>a. Bahr el Ghazal, Southern Sudan</i>		Nov.96	21.0**					
<i>b. Sinket, Red Sea Hills (displaced)</i>	OXFAM	Oct.96	47.8	7.8				30.
<i>c. Sinket, Red Sea Hills (non–displaced)</i>	OXFAM	Oct.96	30.4	7.4				30.
17. Bhutanese Refugees in Nepal								
<i>a. All Camps</i>	SCF	Oct.96	2.4	0.1				
18. Refugees from Rakhine								

State in Bangladesh							
<i>a. All Camps</i>	UNHCR	Nov.96	15.4	0.7			

* 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.

*** Adult malnutrition (details not specified).

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

NOTES on Annex I

1. Angola

a. This survey was carried out in the municipality of Kuito, excluding Kuito town, by CARE. 1026 children 0–59 months old were included in the survey. No further details are currently available.

b. This is a survey carried out by MSF–E in a 15 mile radius around Uige city. No further details are currently available.

4. Burundi/Rwanda (Great Lakes) Region

a. This survey was carried out by MSF–B in Kibangira camp in Rwanda. Wasting was defined as weight/height <–2 z scores, and severe wasting <–3 z scores. Oedema was reported separately.

b. This was a screening done by UNHCR on 10–11 November 1996 in Gatumba transit centre. All new arrivals were included in the screening.

c. This screening was conducted by UNHCR in Gatumba transit centre on 16 November 1996. Severe wasting was defined as MUAC<110 mm in children under five years old.

d. This survey was carried out by MSF–B in Karuzi Province, Burundi among the displaced. Wasting was defined as weight/height <–2 z scores, and severe wasting <–3 z scores. Oedema was reported separately.

e. This survey was carried out in Kanembwa camp in Kigoma, Tanzania on 28 September 1996. 565 children were included in the survey. Wasting was defined as weight/height <–2 z scores, and severe wasting <–3 z scores. Oedema was reported separately. This information was available through the draft report entitled ‘Joint WFP/UNHCR Food Assessment Mission in the Great Lakes Region – Tanzania’.

f. This survey was carried out in Mtendeli camp in Kigoma, Tanzania on 29 September 1996. 88 children were included in the survey. Wasting was defined as weight/height <–2 z scores, and severe wasting <–3 z scores. Oedema was reported separately. This information was available through the draft report entitled ‘Joint WFP/UNHCR Food Assessment Mission in the Great Lakes Region – Tanzania’.

g. This survey was carried out in Mkugwa camp in Kigoma, Tanzania on 29 September 1996. 20 children were included in the survey. Wasting was defined as weight/height <–2 z scores, and severe wasting <–3 z scores. Oedema was reported separately. This information was available through the draft report entitled ‘Joint WFP/UNHCR Food Assessment Mission in the Great Lakes Region – Tanzania’.

h. This survey was carried out in Mtabila camp in Kigoma, Tanzania on 21 September 1996. 607 children were included in the survey. Wasting was defined as weight/height <–2 z scores,

and severe wasting <-3 z scores. Oedema was reported separately. This information was available through the draft report entitled 'Joint WFP/UNHCR Food Assessment Mission in the Great Lakes Region – Tanzania'.

i. This survey was carried out in Lumasi camp in Ngara, Tanzania on 6 September 1996. 1038 children were included in the survey. Wasting was defined as weight/height <-2 z scores, and severe wasting <-3 z scores. Oedema was reported separately. This information was available through the draft report entitled 'Joint WFP/UNHCR Food Assessment Mission in the Great Lakes Region – Tanzania'.

j. This survey was carried out in Lukoli camp in Ngara, Tanzania on 4 September 1996. 619 children were included in the survey. Wasting was defined as weight/height <-2 z scores, and severe wasting <-3 z scores. Oedema was reported separately. This information was available through the draft report entitled 'Joint WFP/UNHCR Food Assessment Mission in the Great Lakes Region – Tanzania'.

k. This survey was carried out in Kital camp in Ngara, Tanzania on 6 September 1996. 965 children were included in the survey. Wasting was defined as weight/height <-2 z scores, and severe wasting <-3 z scores. Oedema was reported separately. This information was available through the draft report entitled 'Joint WFP/UNHCR Food Assessment Mission in the Great Lakes Region – Tanzania'.

l. This survey was carried out in Keza camp in Ngara, Tanzania on 7 September 1996. 967 children were included in the survey. Wasting was defined as weight/height <-2 z scores, and severe wasting <-3 z scores. Oedema was reported separately. This information was available through the draft report entitled 'Joint WFP/UNHCR Food Assessment Mission in the Great Lakes Region – Tanzania'.

m–q. These surveys were carried out in five camps in Karagwe in September 1996. This information was available through the draft report entitled 'Joint WFP/UNHCR Food Assessment Mission in the Great Lakes Region – Tanzania'. No further details are currently available.

9. Liberia/Sierra Leone Region

a. This information comes from a joint assessment by WFP, UNICEF, UNHCR, CARE, ACF, Concern, the Liberia Islamic Union for Reconstruction and Development (LIURD), and WVI. Wasting and severe wasting were measured in 197 children 1–5 years old using MUAC. Oedema was recorded separately.

b. This information comes from a demographic and nutritional assessment conducted by EPICENTRE and MSF in October 1996. Since an anthropometric survey was not feasible, estimates of prevalences of malnutrition were made. 'Moderate malnutrition' (here called wasting and/or oedema) was estimated as 10.6% of children admitted in kitchens plus those not admitted to kitchens with a MUAC between 110 and 125 mm divided by the sample size multiplied by 100. 'Severe malnutrition' (here called severe wasting and/or oedema) was estimated by the number of children in therapeutic feeding centres plus 21.2% of children admitted in kitchens plus those not admitted in nutrition facilities with oedema or MUAC < 110 mm divided by the sample size multiplied by 100.

c. This survey was carried out by MERLIN in Blama, and measured adult malnutrition. No further details are currently available.

d. This survey was carried out by MSF–B in August 1996. Wasting in children 6 months–5 years old was defined as weight/height $<80\%$ of the median and/or oedema; severe wasting was defined as weight/height $<70\%$ of the median and/or oedema.

11. Somalia

a. This survey was conducted by MSF–Spain in Mogadishu. No further details are currently available.

b. This survey was carried out by WHO and IMC in August. No further details are currently available.

c–e. These surveys were carried out by IMC. No further details are currently available.

f. This survey was carried out by Trocaire in October 1996. The sample for the survey was selected proportionately from 15 section of Bulla Hawa town, and 4 villages falling within a 5 km radius of the town. Wasting was defined as weight/height <80% and severe wasting >70%.

12. Sudan

a. This information is from the OLS update. No further details are currently available.

b. These surveys were carried out by Oxfam in October 1996. It was a cluster sample survey and wasting was defined as weight/height <80%, and severe wasting <–70%.

17. Bhutanese Refugees in Nepal

a. This information is from SCF's situation report for the month of October 1996. This was a nutrition screening of 4754 children under five years old. Wasting was defined as weight/height <80% and severe wasting <70%.

18. Refugees from Rakhine State in Bangladesh

a. These are preliminary results of a survey carried out by UNHCR with the help of MSF–F, MSF–H, CONCERN, and SCF–UK. This was a two–stage cluster sample survey which included 945 children.

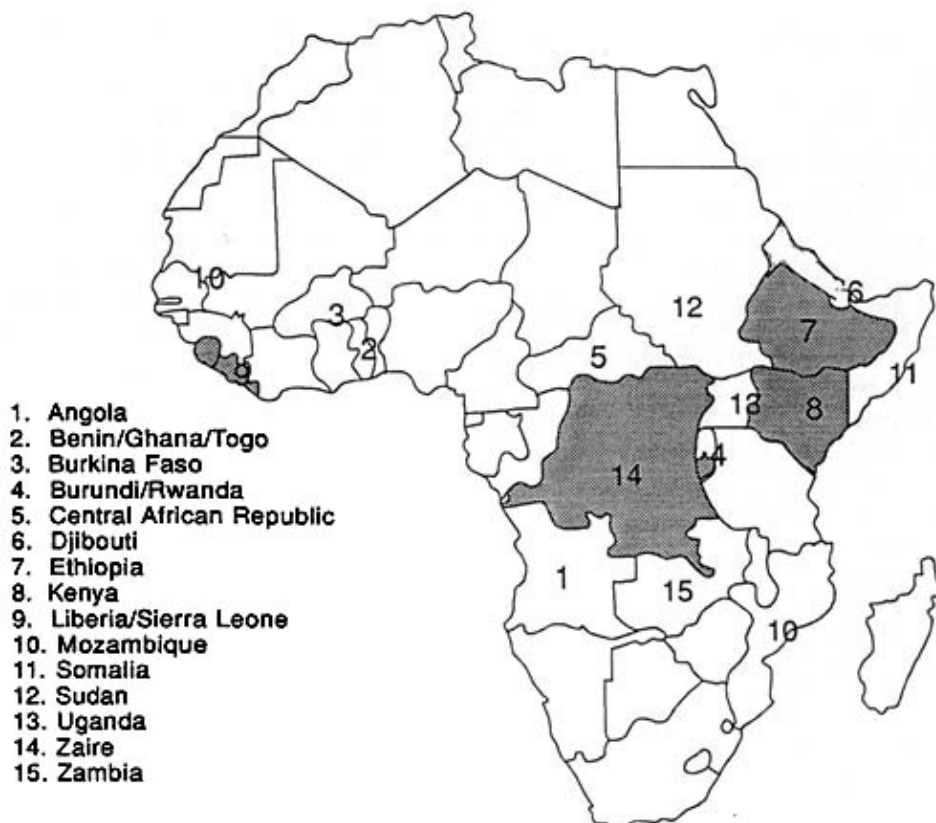
Annex II. Seasonality

Seasonality in Sub-Saharan Africa*	
Country	Climate/Rainy Season/Harvest
<i>Angola</i>	Coastal area desert, SW semi–arid, rest of country: rains Sept–April
<i>Burundi</i>	Three crop seasons: Sept–Jan, Feb–Jun, and Jul–Aug
<i>CAR</i>	Rains March–Nov
<i>Djibouti</i>	Arid Climate
<i>Ethiopia</i>	Two rainy seasons February to May and June to October
<i>Kenya</i>	N–E is semi–arid to arid, Central and SW rains: March–May and Nov–Dec
<i>Liberia</i>	Rains March–Nov
<i>Mozambique</i>	Coast is semi–arid, rest wet–dry. Harvest May
<i>Rwanda</i>	Rains Feb–May with Aug harvest and Sept–Nov with Jan harvest
<i>Sierra Leone</i>	Rains March–Oct.
<i>Somalia</i>	Two seasons: April to August (harvest) and October to January/February (harvest)
<i>Sudan</i>	Rains April–Oct
<i>Northern</i>	Rains begin May/June
<i>Southern</i>	Rains begin March/April
<i>Togo</i>	Two rainy seasons in S, one in N. Harvest August

<i>Uganda</i>	Rains Mar–Oct
<i>Zaire</i>	Tropical climate. Harvest in N: November; in S January
* SOURCES: FAO, “Food Supply Situation and Crop Prospects in Sub–Saharan Africa”, Special Report; No 4/5, Dec. 90 plus various FAO/WFP Crop and Food Supply Assessment Missions.	

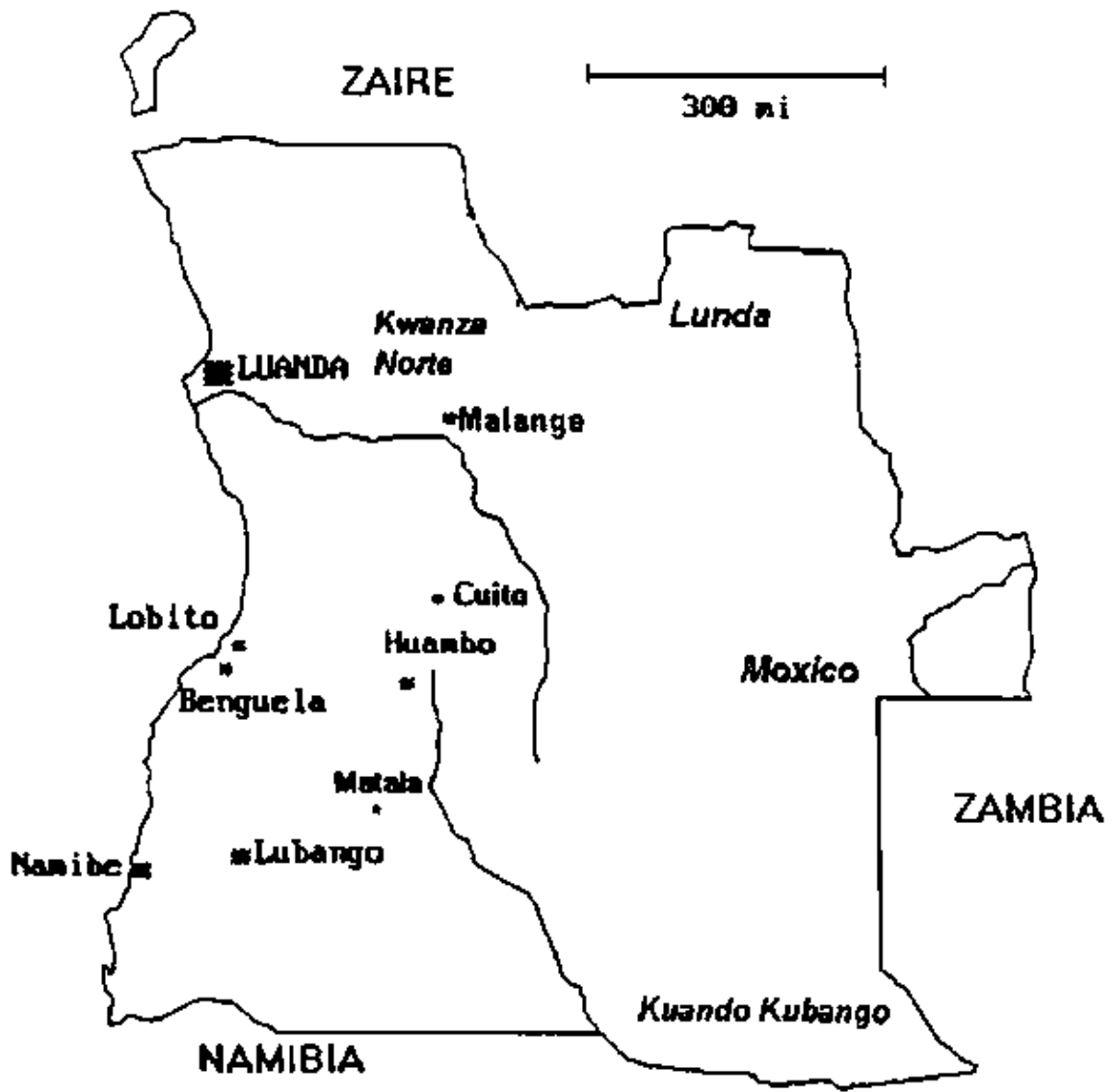
LIST OF MAPS

Map A. Situational Map



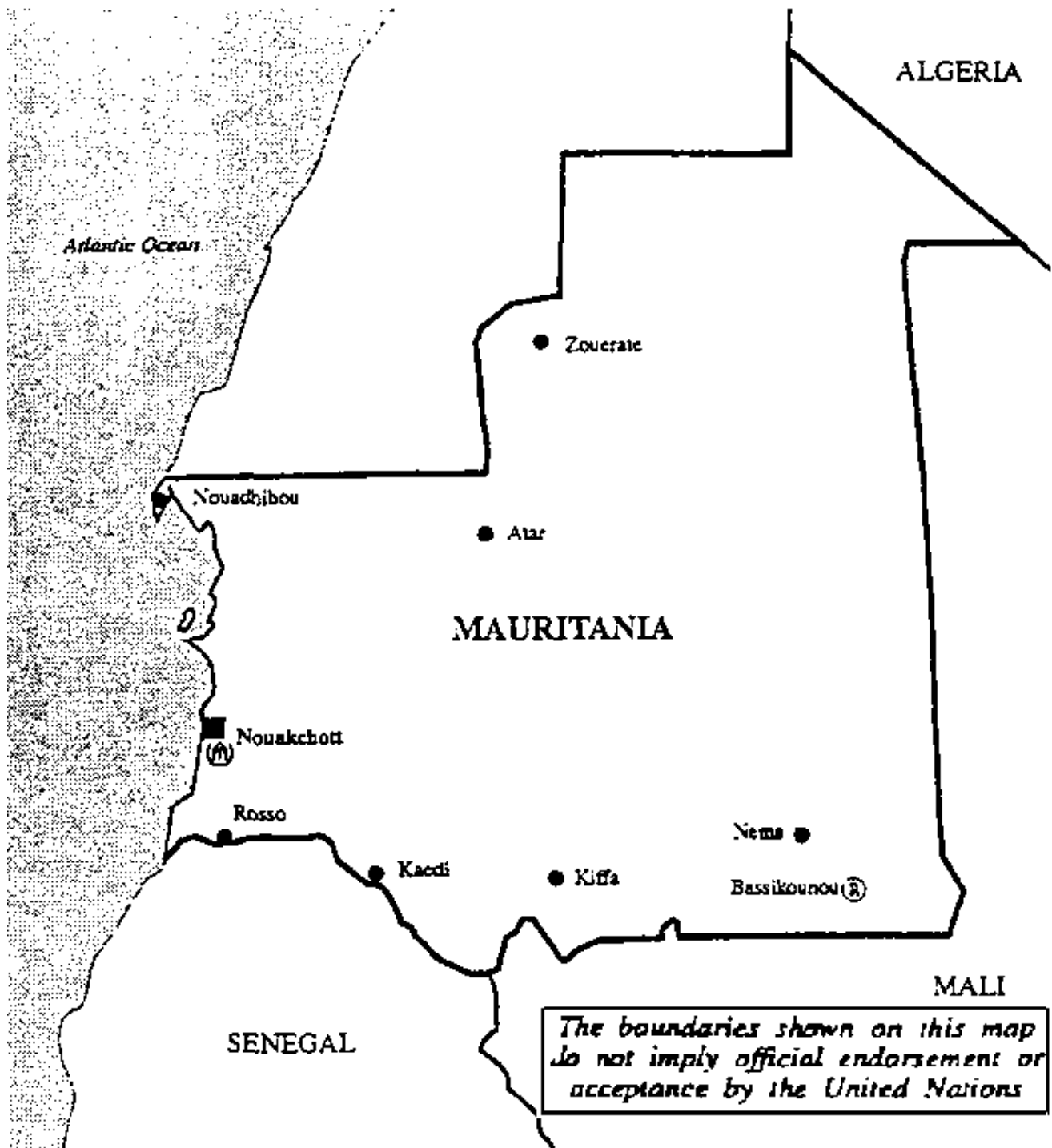
MAP A. Situational Map

Map 1. Angola



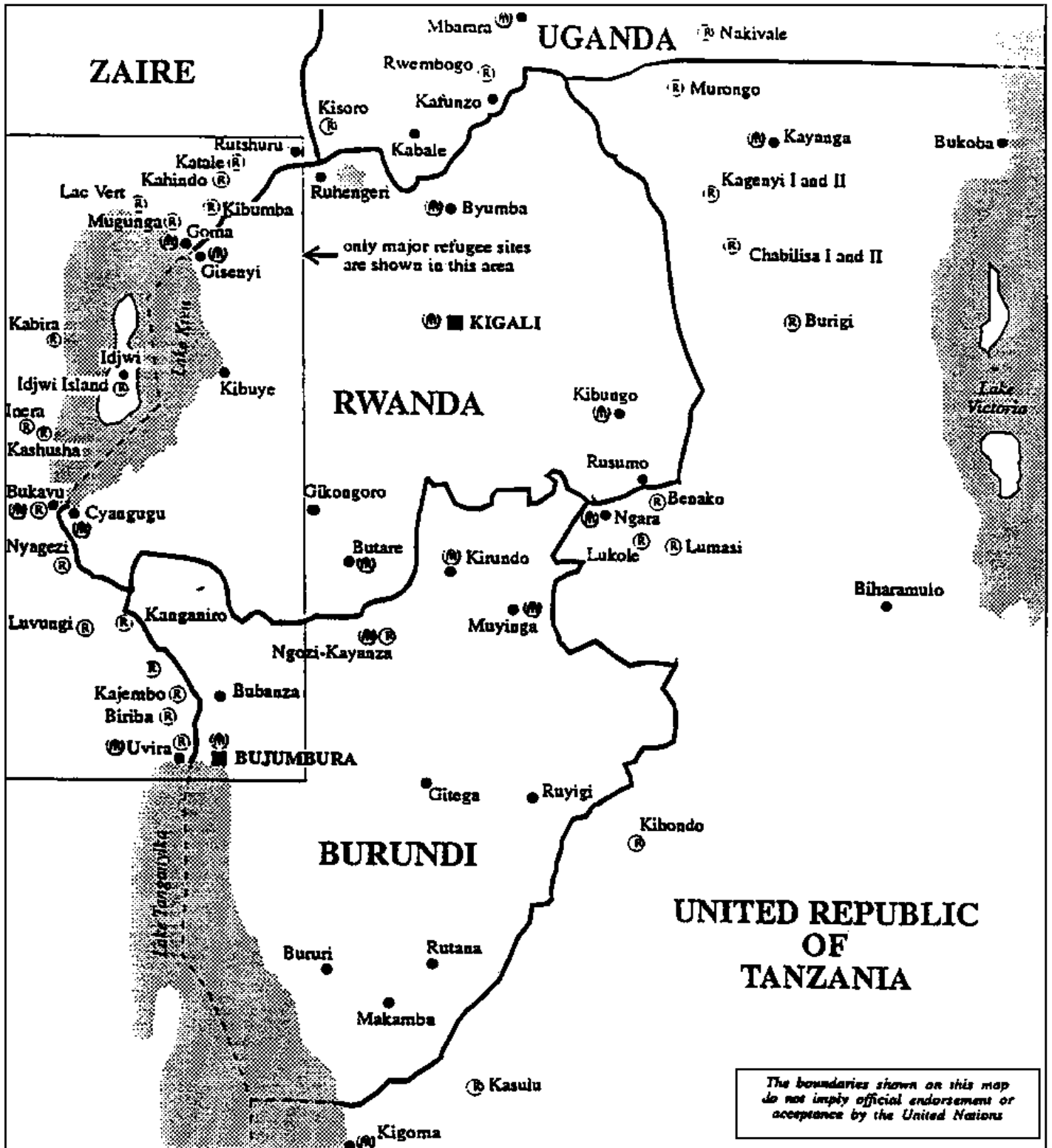
MAP 1. Angola

Map 3. Mauritania



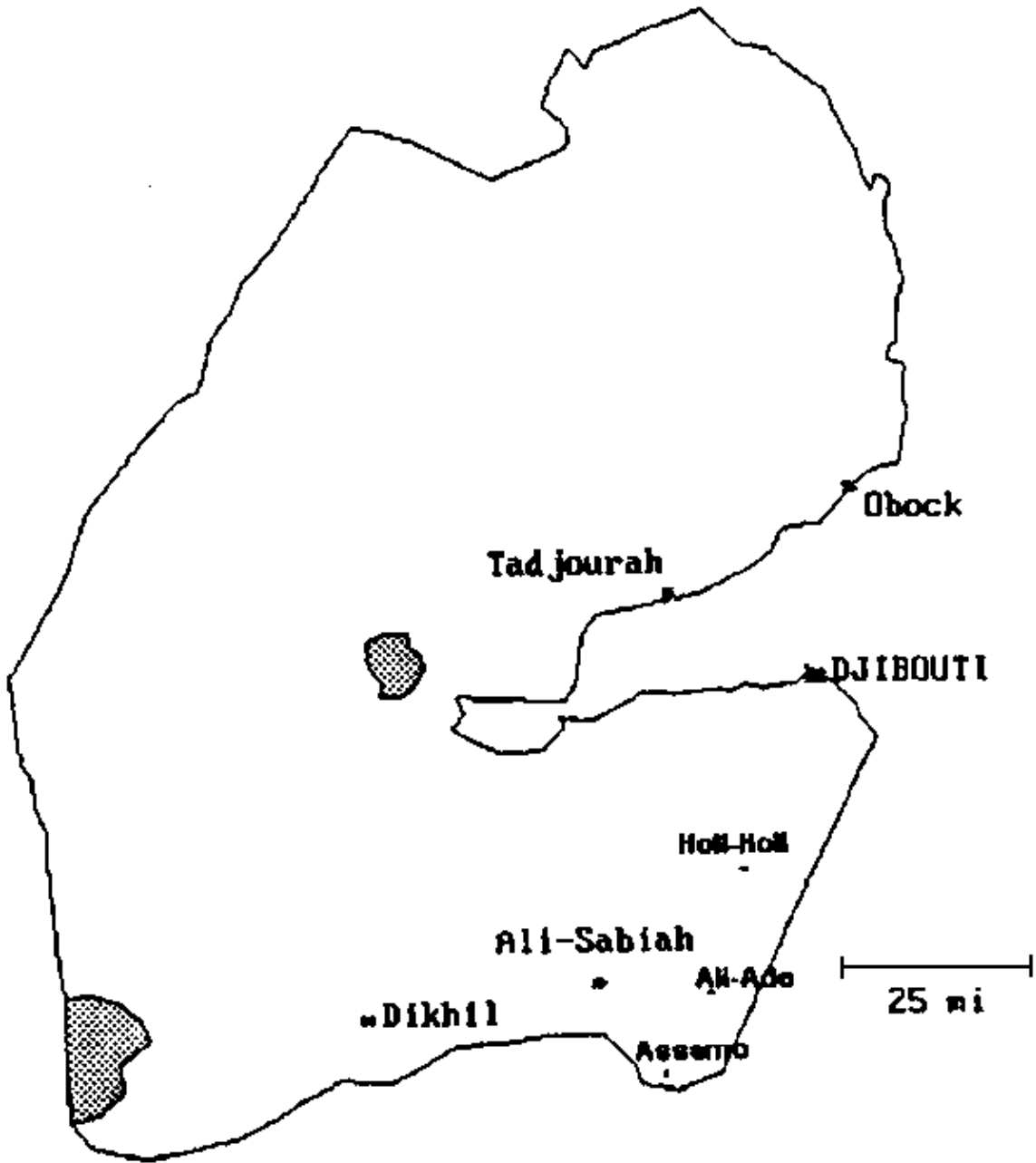
MAP 3. Mauritania

Map 4. Burundi/Rwanda Region



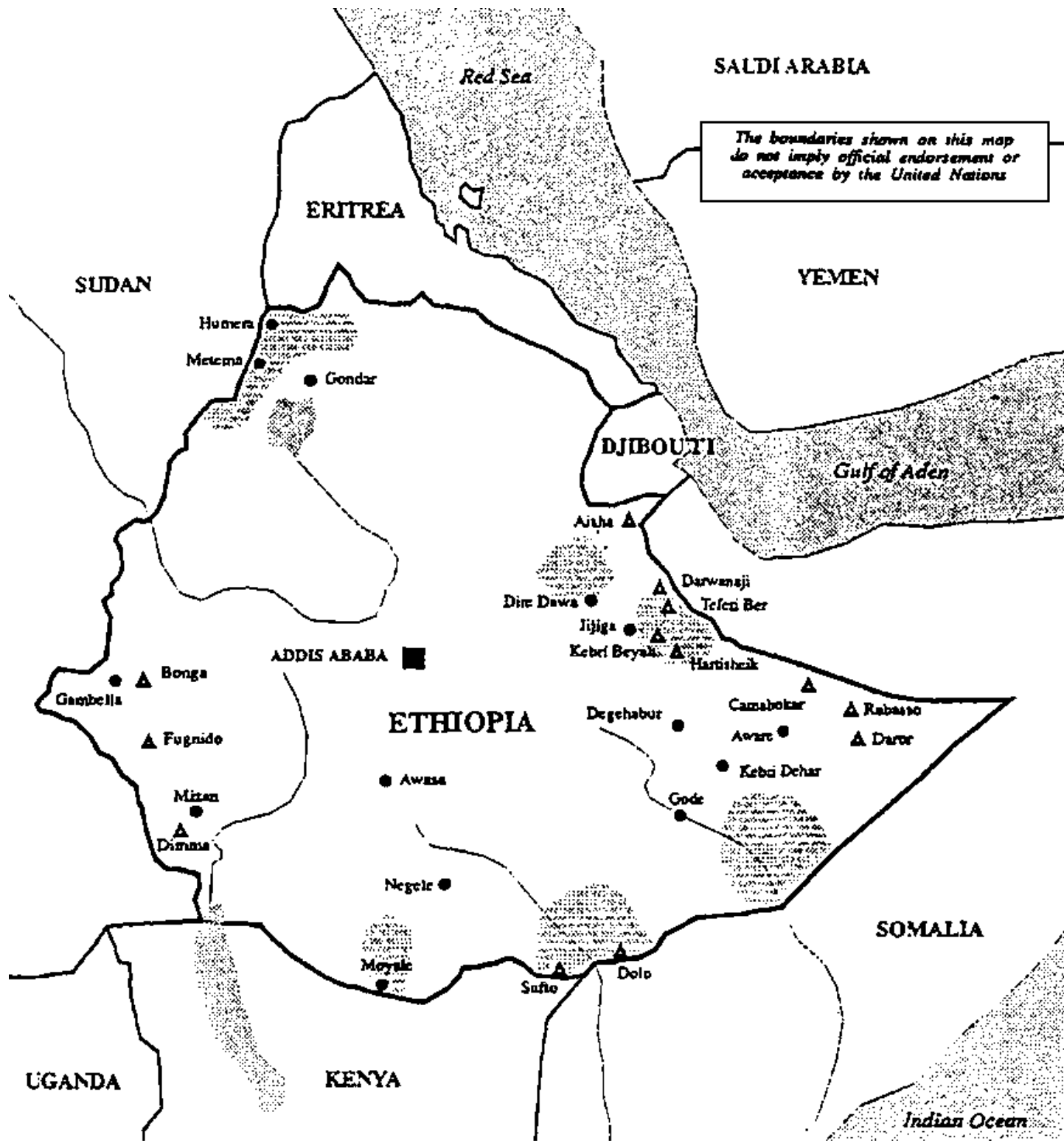
MAP 4. Burundi/Rwanda Region

Map 6. Djibouti

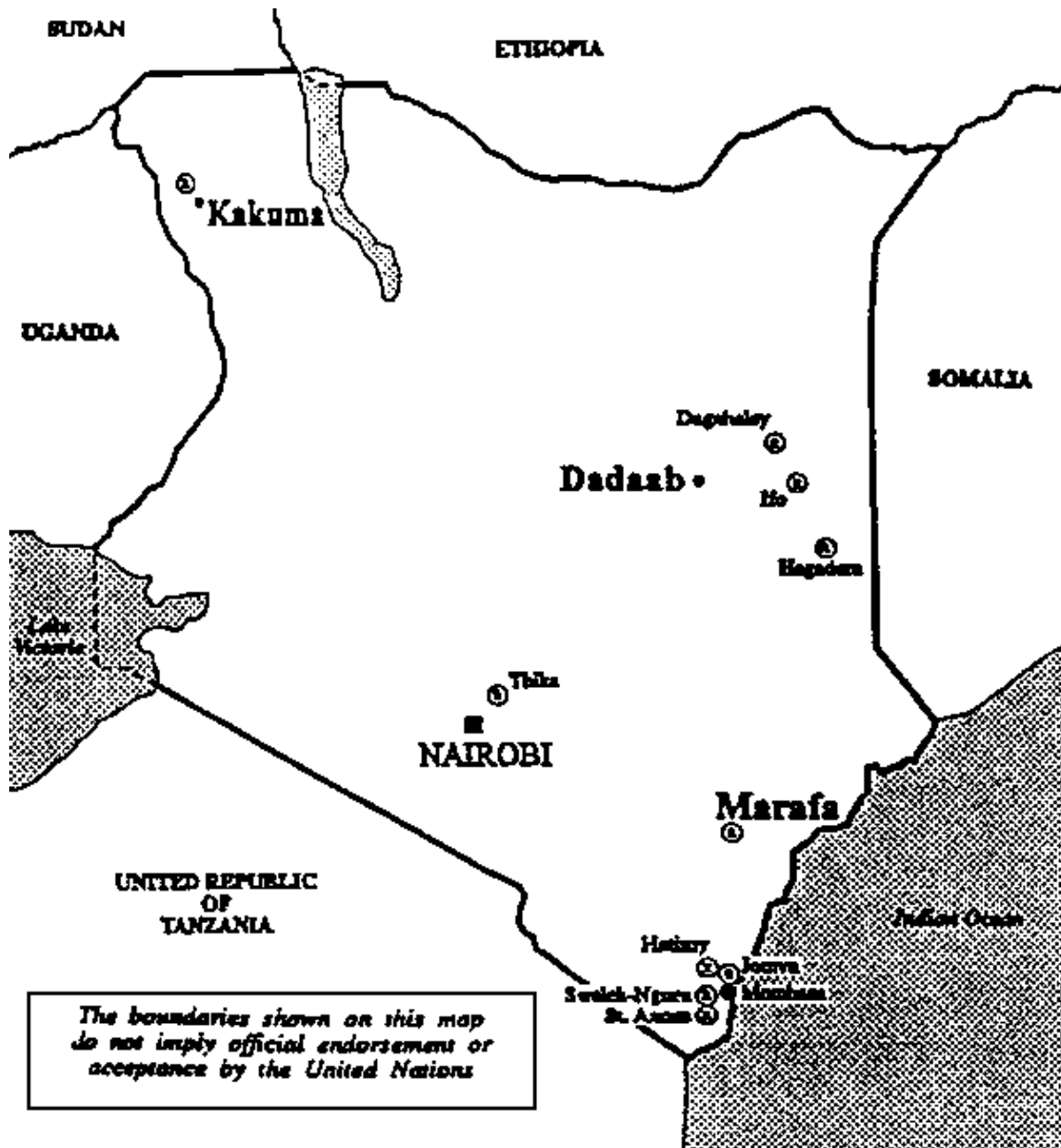


MAP 6. Djibouti

Map 7. Ethiopia

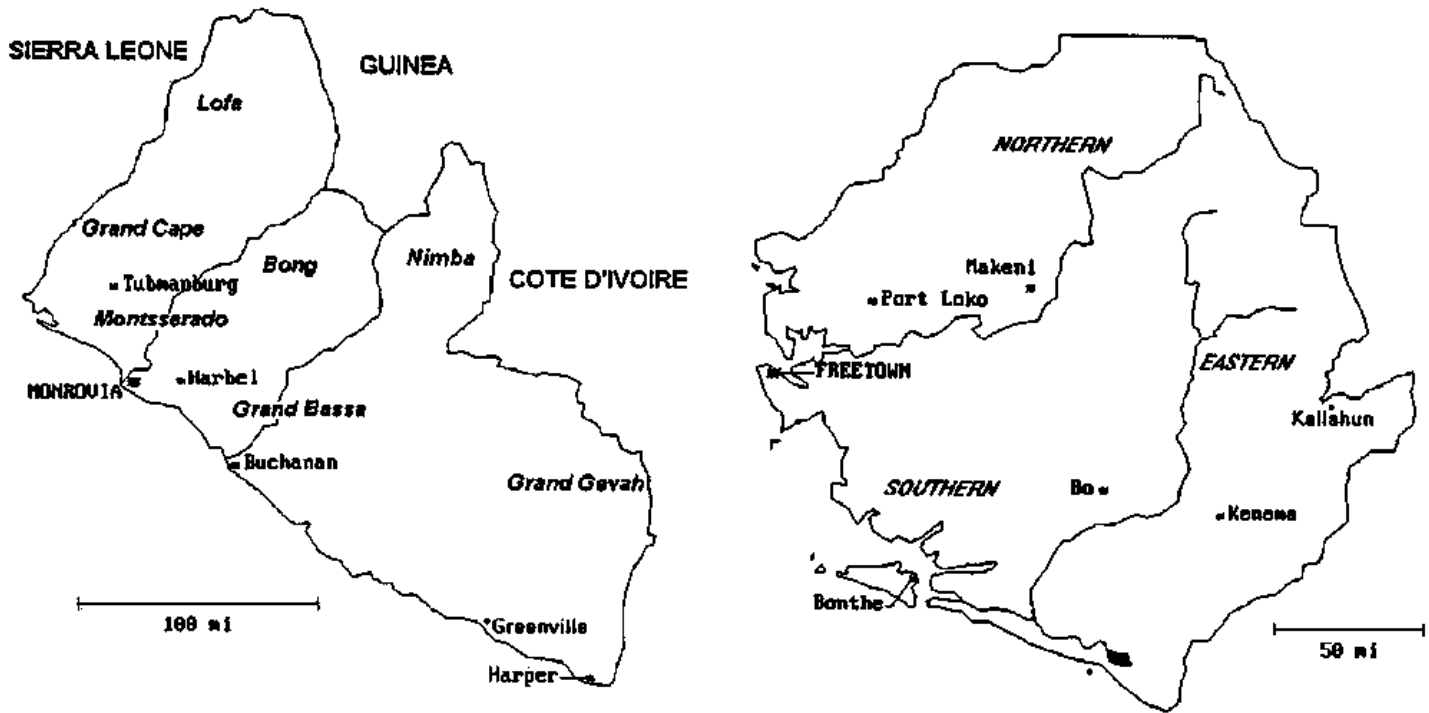


Map 8. Kenya



MAP 8. Kenya

Map 9a,b. Liberia/Sierra Leone



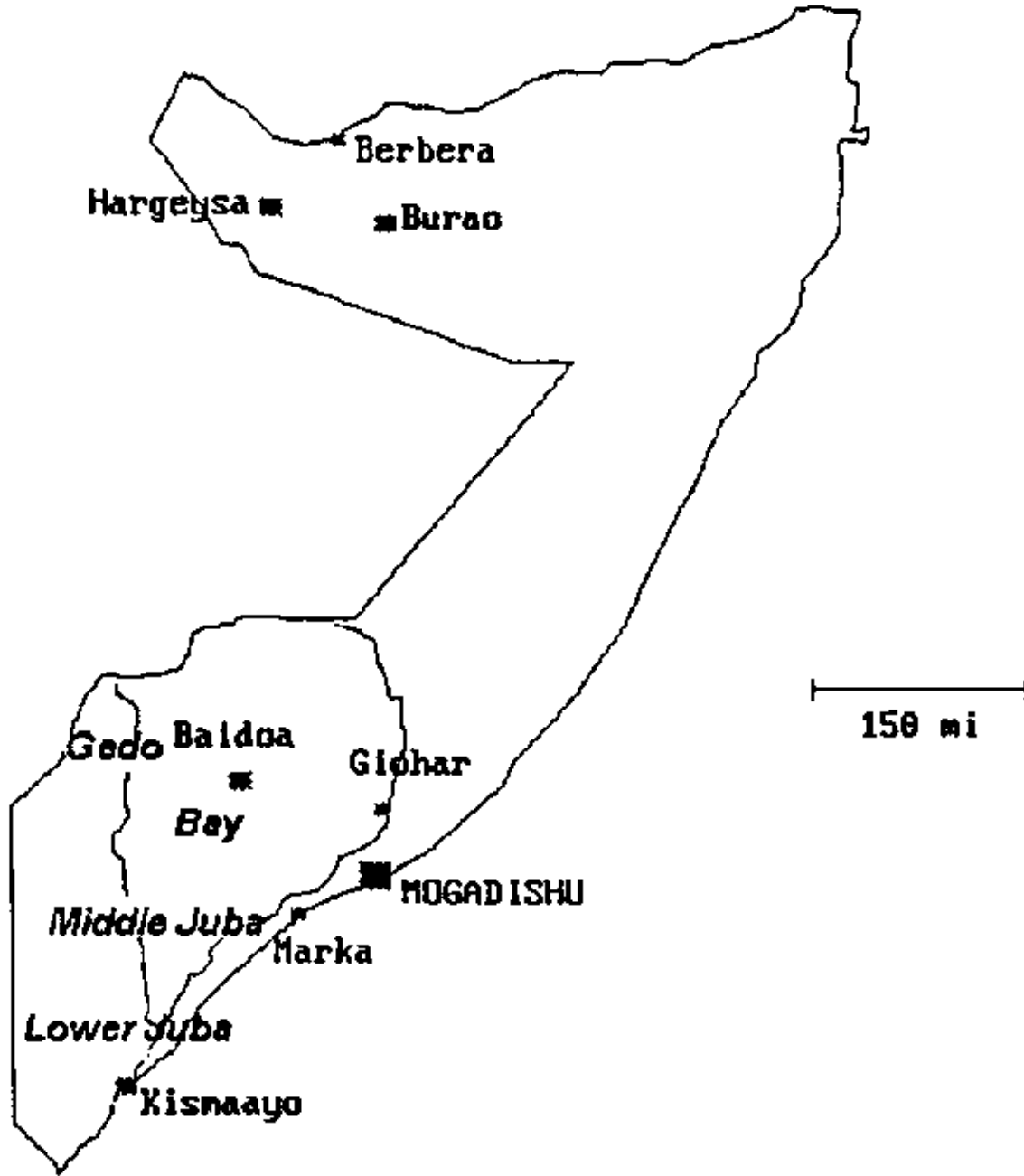
MAP 9a,b. Liberia/Sierra Leone

Map 10. Mozambique

MAP 10. Mozambique

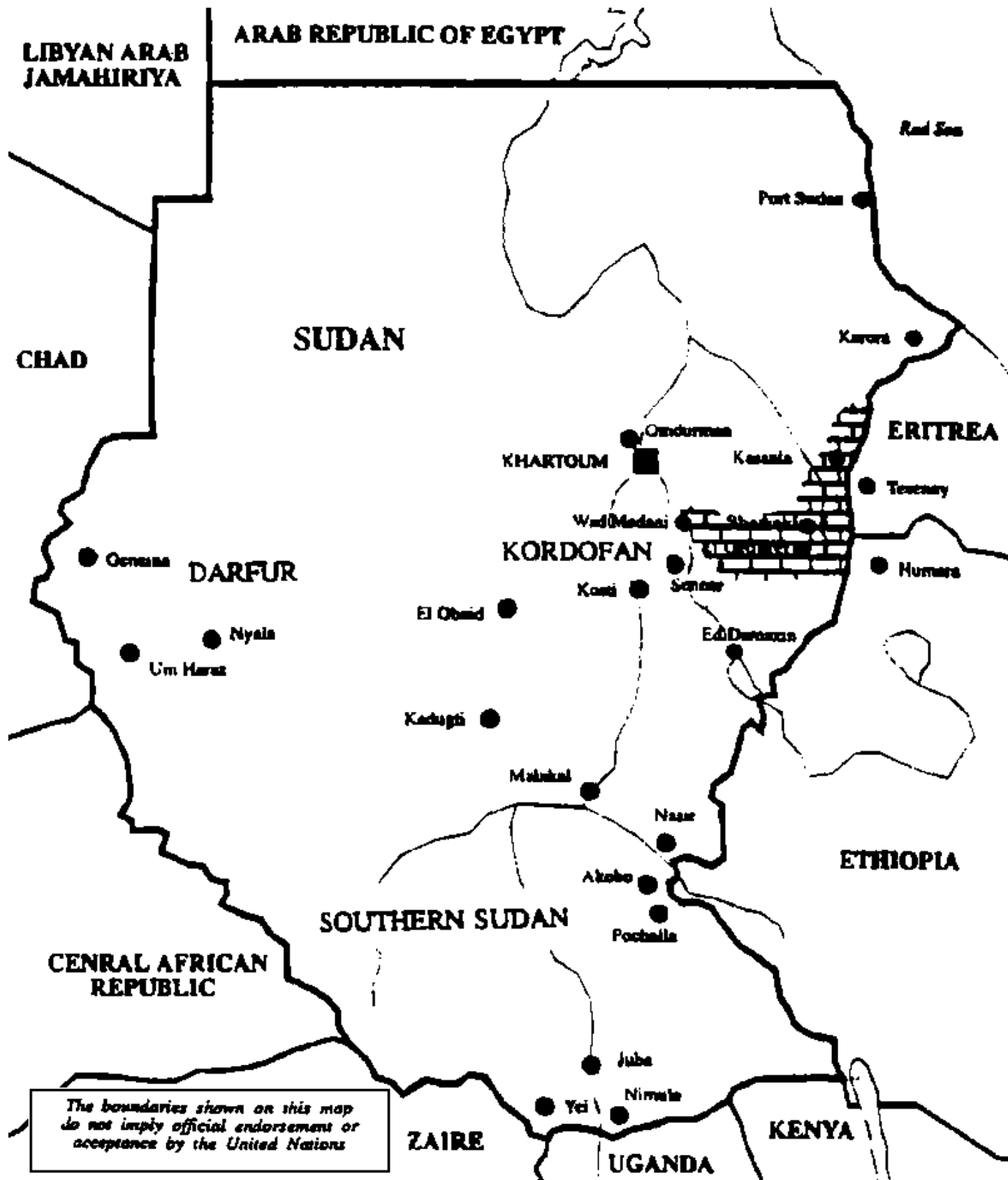
Map taken from MSF-CIS Bi-Monthly Bulletin

Map 11. Somalia



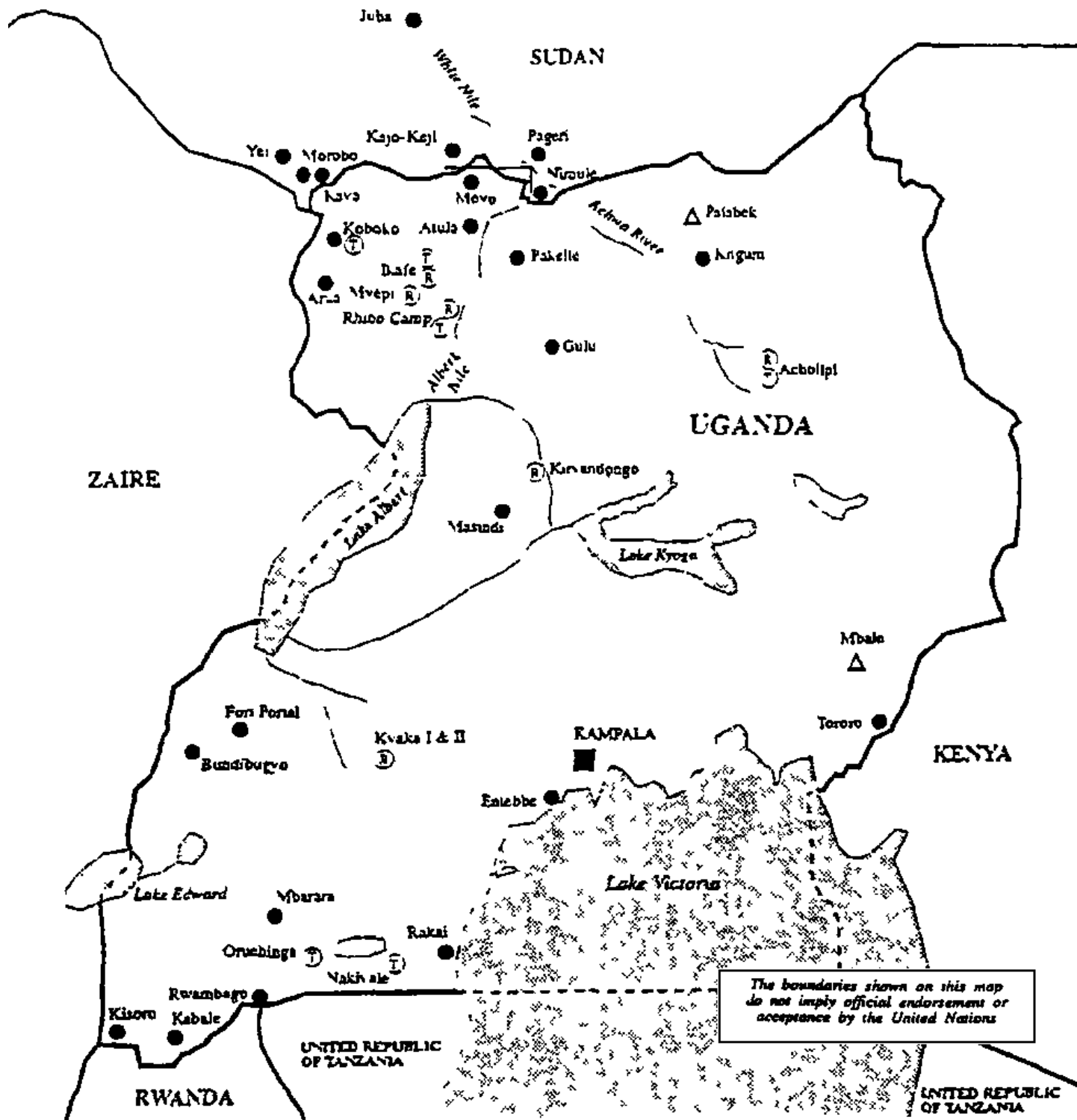
MAP 11. Somalia

Map 12. Sudan



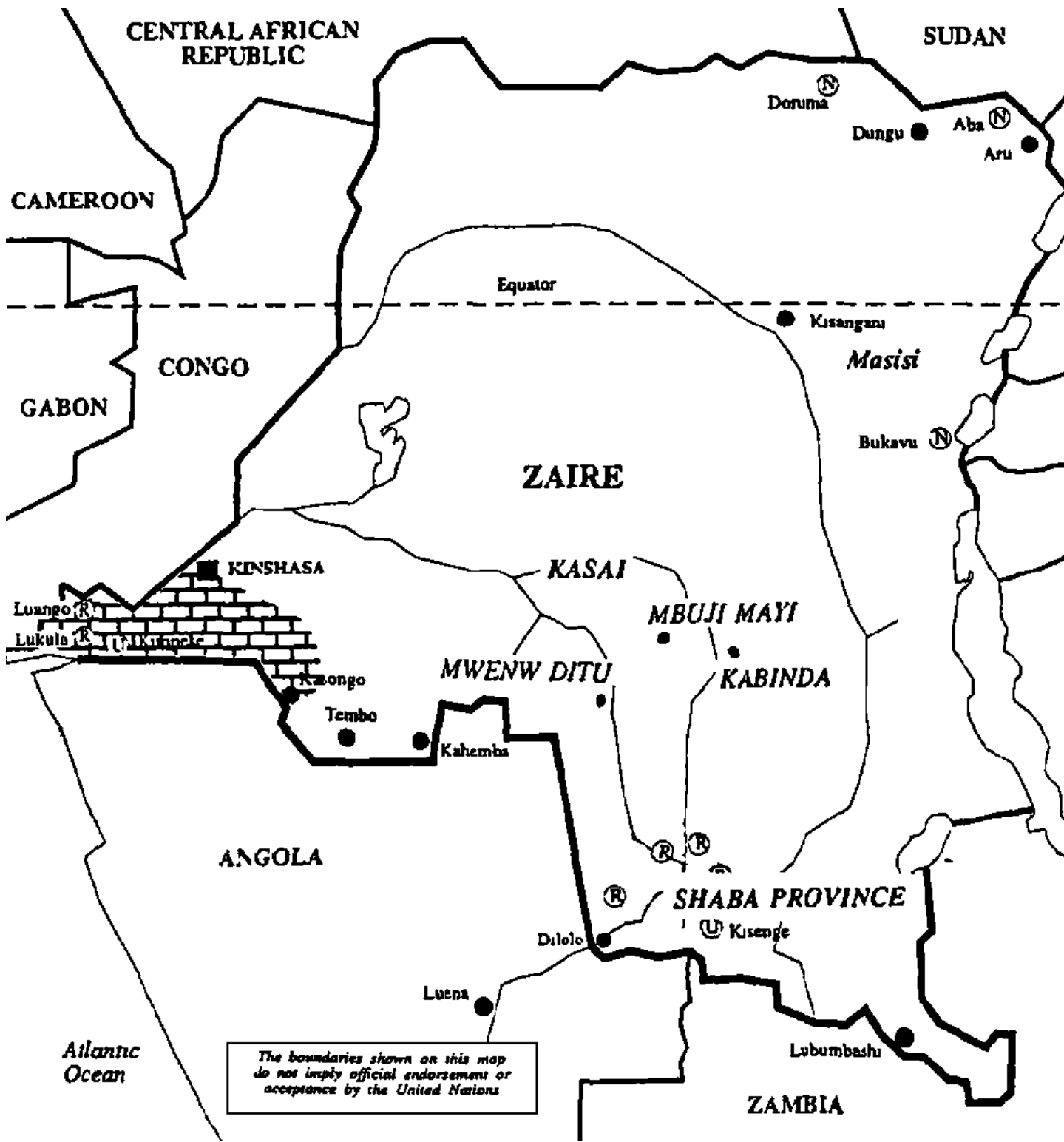
MAP 12. Sudan

Map 13. Uganda



MAP 13. Uganda

Map 14. Zaire



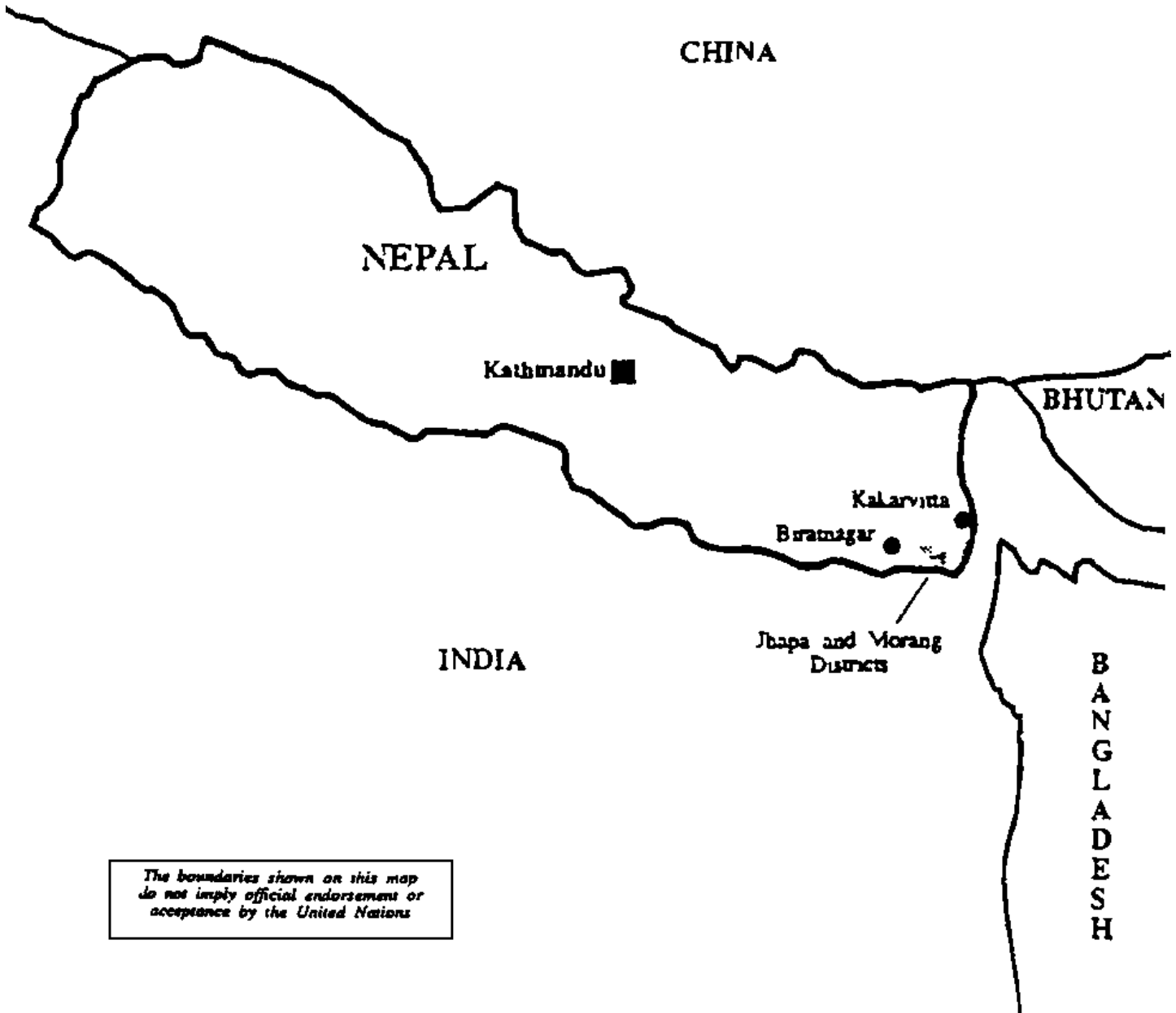
MAP 14. Zaire

Map 16. Afghanistan



MAP 16. Afghanistan

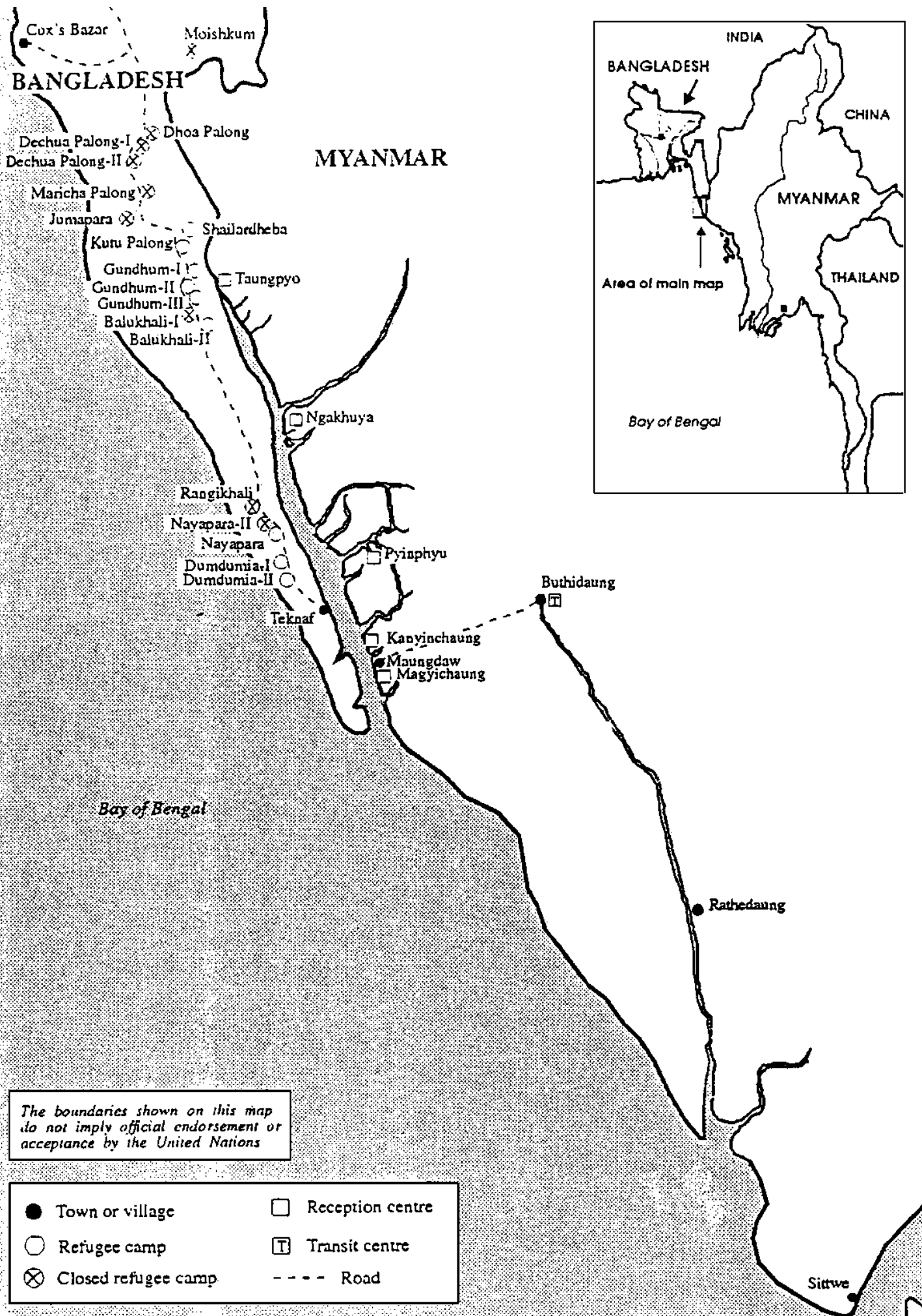
Map 17. Nepal



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

MAP 17. Nepal

Map 18. Bangladesh



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

- | | |
|-----------------------|--------------------|
| ● Town or village | □ Reception centre |
| ○ Refugee camp | ⊞ Transit centre |
| ⊗ Closed refugee camp | - - - Road |

MAP 18. Bangladesh