

**Nutrition Information in Crisis Situations – Report Number VII, August
2005**

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Nutrition Information in Crisis Situations – Report Number VII, August 2005



United Nations System Standing Committee on Nutrition

Highlights

KENYA – SITUATION STILL PRECARIOUS IN NORTHERN TURKANA – According to a nutrition survey conducted in North–Eastern and North–Western Turkana in March 2005, the situation was still highly precarious, despite the provision of relief assistance. The situation has, however, improved in the North–Eastern zone, which was the more affected in February 2004. According to the households interviewed, the coverage of the general food distribution and of the blanket food distribution was higher than planned, probably due to inter household sharing. However, the food distribution was erratic: the quantity of food distributed was far below what was planned.

SOMALIA – POST *GU* 2005 ASSESSMENT – Overall the assessment reports that 919,000 people are in need of immediate assistance, including 197,000 people in a state of humanitarian emergency, 343,000 people who face an acute livelihood crisis and 377,000 displaced people.

The exceptionally good *Gu* rains, which followed good *Deyr* rains, confirm the end of the drought in Northern Somalia. However, the area is still considered to be in a state of acute livelihood crisis, given the severity of the previous emergency. In addition, twenty eight thousand destitute people, concentrated in pockets of urban areas and small towns remain in a state of humanitarian emergency. The improvement of the situation in the north is attributed to the combination of good rains and provision of humanitarian assistance. In the South, Northern Gedo and Juba riverine are considered to be in a state of chronic humanitarian emergency and the situation has deteriorated further in the past few months. In both areas the *Gu* crops were poor. In addition, North Gedo has experienced an influx of IDPs and trade disruptions.

SUDAN – POOR SITUATION – The food security situation is bleak in northern Bahr el Gazal. Food deficits started in March–April, especially for the poorest households, as a result of last year's poor harvest and reduced flood levels which has led to significant reductions of dry season food sources such as wild food and fish. Sorghum has also become scarce in the markets. The high number of returnees has further exacerbated the food insecurity. Furthermore, food aid requirements were not met, with less than 60% of the food aid required between January and May actually provided. Several random–sampled nutrition surveys showed critical prevalence of acute malnutrition in Bahr el Gazal and Upper Nile.

As of early July, there was an estimated 3.2 million people affected by the crisis in Darfur, including 1.88 million displaced people. The increase in the number of resident people who are affected is due to exhausted coping mechanisms, lean season conditions, improved humanitarian access and increased operational capacity. As of June, the coverage of the affected population was far below the needs in all of the sectors of humanitarian aid. Several random–sampled surveys conducted in the first semester of 2005 showed that the situation was still precarious.

NIGER – SCALING–UP OF EMERGENCY PROGRAMMES – The worsening of the crisis in Niger and the late response has raised concerns. However, the response to the crisis has intensified since July 2005 with several NGOs implementing emergency programmes. The UN organisations have recently increased their demand of funds to US\$ 81 m, of which about half was pledged as of late August. A total of 3 m people will receive free food aid from a number of organisations. Some areas have been added to the distribution plan recently, to take the current situation into account. Nevertheless, MSF warns that the proportion of the families who get free food distribution is insufficient to meet the needs of the population in some locations.

CHAD – SITUATION STILL CRITICAL IN SOME REFUGEE CAMPS – The current rainy season makes living conditions of the refugees difficult and hampers access to them. Three random–sampled nutrition surveys conducted in April–May 2005 in Am Nabak and Oure Cassoni refugee camps and in Cariari settlement

showed a precarious nutrition situation. Micro–nutrient deficiencies have been reported in some of the camps. Further investigations and adequate responses to micro–nutrient deficiencies should be put in place. Results of food basket monitoring conducted in some camps between April and July 2005 showed that on average the ration distributed was close to the theoretical ration for most of the distributions. Food–for–work activities have been implemented for the resident populations in some locations.

Risk Factors affecting Nutrition in Selected Situations

Situations in the table below are classed into five categories relating to prevalence and or risk of malnutrition (I – very high risk/prevalence, II – high risk/prevalence, III – moderate risk/prevalence, IV – not at elevated risk/prevalence, V–unknown risk/prevalence; for further explanation see section "Indicators and classification" at the end of the report). The prevalence/risk is indirectly affected by both the underlying causes of malnutrition, relating to food security, public health environment and social environment, and the constraints limiting humanitarian response. These categories are summations of the causes of malnutrition and the humanitarian response, but should not be used in isolation to prescribe the necessary response.

	ETHIOPIA Hartisheik and Fanfen IDP camps	ETHIOPIA Refugee camps in Gambella region	KENYA Northern Turkana	SUDAN Darfur	NIGER Parts of the South	UGANDA IDP camps in Gulu district	CHAD Oure Cassoni and Am Nabak refugee camps	WESTERN SAHARAWI REFUGEES IN ALGERIA
Nutritional risk category	II	II	II	II/I	II	III	II	III
FOOD SECURITY								
Households' livelihoods	☹	☹	☹	☹	☹	☺	☹	☺
External assistance	☹	☹	☹	☺	☺	☺	☺	☺
PUBLIC HEALTH ENVIRONMENT								
Availability of water and access to potable drinking water	☹	☹	☹	☺	?	☹	☹	?
Health care	☹	?	☹	☺	☹	☺	☺	?
Sanitation	?	☹	☹	☺	?	☺	☺	?
SOCIAL AND CARE ENVIRONMENT								
Social environment	☹	?	?	☹	?	☹	☹	?
Child feeding practices	?	?	?	?	?	?	?	☹
DELIVERY OF ASSISTANCE								
Accessibility to population	☺	?	☺	☺	☺	☺	☺	☺
Resources for humanitarian Intervention	☹	☺	☺	☺	☺	☺	☺	☺

Availability of information	☹️	☹️	😊	☹️	☹️	☹️	☹️	☹️
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😊 ADEQUATE ☹️ MIXED ☹️ INADEQUATE

Greater Horn of Africa



Djibouti

The situation is still precarious in Djibouti where high temperatures and continuing food deficits are putting many pastoralists at risk. The physical condition of livestock is deteriorating and rural exodus to urban areas has been witnessed (WFP, 12/08/05). Furthermore, prices in urban areas have exceeded the alert level for poor households (FEWS, 07/05). The food aid pipeline is not sufficient to guarantee proper distributions to the needy populations (FEWS, 07/05). A rapid assessment done in May 2005 in three sites in each of the five districts most affected by the drought, and where all the 6–59 month olds were measured, showed contrasting results. A significant level of acute malnutrition (up to 33%) was found in some of the sites surveyed, while the situation was acceptable in other sites. The populations the most at risk seemed to be the refugees from Ethiopia and the nomadic population which had lost their animals and were dependent on food aid (WHO/MOH, 05/05).

Ethiopia

Dire situations in some displaced and refugee camps

Hartisheik and Fanfen camps, Somali region, have hosted displaced populations for years. The IDPs have received erratic assistance. A nutrition survey conducted in March 2005 (SC–UK, 03/05) showed a poor nutrition situation (table 1), although it had improved compared to previous years (figure 1). Vaccination and vitamin A distribution coverage were low and the under–five mortality rate was near or above emergency threshold. At the time of the surveys, the IDPs had not received food aid since November 2004 and free access to health care provided by UNICEF had stopped as well as supplementary and therapeutic feeding programmes. They had received non–food items only once at their arrival at the camp in 2000. Access to clean water was reported as being poor, as were the sanitary condition. The IDPs have few income opportunities. Some rely only on begging (OXFAM, 06/05). The opportunity of including the IDPs in the general food distribution programme was still being debated as of July 2005, but the selective feeding programmes had restarted (OXFAM, 06/05).

TABLE 1 RESULTS OF SURVEYS IN IDP CAMPS IN SOMALI REGION (SC-UK, 03/05) AND IN REFUGEE CAMPS IN GAMBELLA REGION (UNHCR/JOINT, 05/05)

% Acute Malnutrition (95% CI)	% Severe Acute Malnutrition (95% CI)	Measles immunisation coverage (%)*	Vitamin A distribution (%)	Crude Mortality (/10,000/day)	Under 5 Mortality (/10,000/day)
FANFEN IDP CAMP, SOMALI REGION					
16.4	1.1	22.9	27.3	0.53	3.48
HARTISHEIK IDP CAMP, SOMALI REGION					
21.8	18.4	30.2	29.0	–	4.7
BONGA REFUGEE CAMP, GAMBELLA REGION					
19.3 (16.8–22.1)	2.0(1.2–3.2)	96.4	94.2	–	–
PUGNINO REFUGEE CAMP, GAMBELLA REGION					
20.7 (18.1–23.5)	2.2 (1.4–3.5)	91.8	97.8	–	–
PUGNINO/ANYUAK REFUGEE CAMP, GAMBELLA REGION					
21.9	7.0	–	–	–	–

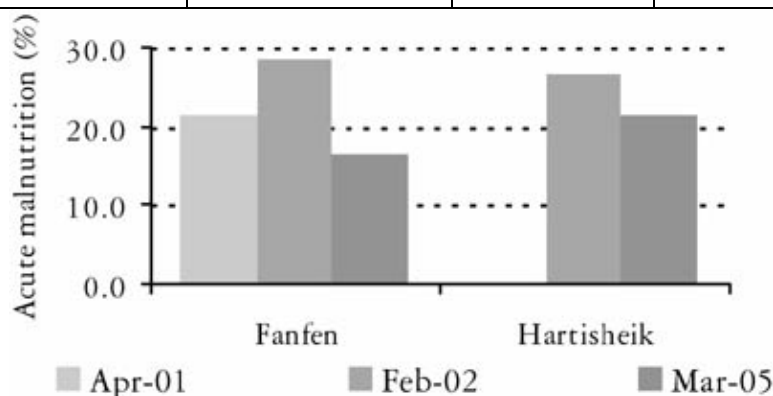


FIGURE 1 PREVALENCE OF ACUTE MALNUTRITION, IDP CAMPS, SOMALI REGION, ETHIOPIA

A joint UN Country Team mission is currently working towards the permanent re-integration of the IDPs in their home communities. However, the project is still not fully funded (UNCT, 31/07/05).

The camp of Hartisheik is located in an area which is highly vulnerable as a result of recurrent years of drought, and subsequent depletion in livestock numbers. Livelihood strategies have been eroded, resulting in wide-ranging vulnerability to food insecurity, an inability to cope with shock and the adoption of damaging coping strategies (OXFAM, 06/05). OXFAM recommends that actions on the longer-term than food distributions are implemented to strengthen people's livelihoods (OXFAM, 06/05).

Nutrition surveys carried out in two Sudanese refugee camps and a refugee settlement in Gambella region also showed a precarious situation (UNHCR/WFP/ARRA, 05/05) (table 1). The general food distribution had been scaled down and had experienced several delays. When the food distribution is delayed, people rely on borrowing food from merchants and must pay interests which range from 3 to 5 kg of food. It seems that the refugees are able in normal times to supplement the general rations with their own crops. However, the recent weather conditions have been bad and refugees are lacking seeds. Moreover, there seemed to have been problems with refugee registrations: some of them do not have a card and, in the settlement, children born after 2002 have not been registered. It also seemed that supply of water was inadequate and sanitary conditions were poor. Targeted nutrition programmes were provided in the camps. In response to the situation showed by the survey, food distributions have been increased and a blanket supplementary food distribution has been implemented for children under-five (UNNews, 21/06/05).

Recommendations

From the SC–UK survey in Hartisheik and Fanfen IDP camps

- Provide a full food basket general ration
- Improve sanitary conditions and access to water
- Establish selective feeding programmes
- Undertake a vaccination and vitamin A distribution campaign
- Improve access to health

From the UNHCR/WFP/ARRA survey in refugee camps in Gambella

- Improve GFD
- Improve general health system
- Strengthen the water supply and sanitation services
- Provide mechanical mills

Kenya

Ethnic tensions exacerbated by poor livelihoods

In mid–July 2005, about 70 people were killed in a clash between two ethnic groups in Marsabit district (IRIN, 01/08/05). In Mandera district, where the food security situation is very poor, ethnic clashes were reported at the beginning of the year. The poor situation is exacerbated by the presence of an estimated 17,000 refugees fleeing Somalia and sharing the meagre resources of the host community (IRIN, 01/08/05).

Prevalence of acute malnutrition still high in Turkana district

According to a nutrition survey conducted in North–Eastern and North–Western Turkana in March 2005 (OXFAM, 03/05), the situation was still highly precarious, despite the provision of relief assistance (table 2). The situation has, however, improved in the North–Eastern zone, which was the more affected in February 2004 (figure 2). Measles vaccination coverage was average, despite a measles vaccination campaign which took place in May 2004. Vitamin A distribution coverage seemed not bad, Vitamin A having been distributed during measles and polio vaccination campaigns. The under–five mortality rate was above alert threshold (table 2). Most of the households in the North–Eastern and North–Western zones were pastoralists (55% and 47%, respectively). The main additional livelihood groups were fisher folk (12%), employed (11%) and firewood/charcoal sellers (9%) in the North–East and firewood/charcoal sellers (21%), employed (16%) and traders (12%) in the North–West. When compared to the last "normal" year, which was 1997 according to the population,

pastoralists have lost a significant number of livestock. Overall, the food security situation and access to water were poor (box 1). According to the assessment, households in the North–East were more food insecure than households in the North–West. Seventy percent and 50% of the households in the North–East and North–West, respectively, were entitled to receive a full food basket of cereals, pulses, vegetable oil and salt (2,100 Kcal/pers/day). In addition, blanket supplementary feeding has been implemented for children under 12 years old, pregnant and lactating women, and the elderly population, equating to 62% of the target population of the general food distribution. According to the households interviewed, the coverage of the general food distribution and of the blanket food distribution was higher than planned (box 1), probably due to inter household sharing. However, the food distribution was erratic: the quantity of food distributed was far below what was planned (box 1). This was principally due to a WFP pipeline shortage. Treatment of severely malnourished and moderately malnourished children was available in some divisions.

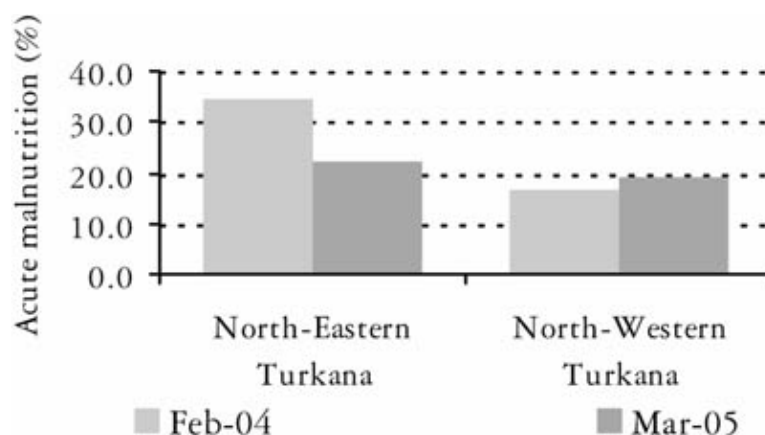


FIGURE 2 PREVALENCE OF ACUTE MALNUTRITION, TURKANA DISTRICT, KENYA

TABLE 2 RESULTS OF SURVEYS IN TURKANA DISTRICTS, RIFT VALLEY PROVINCE, KENYA (OXFAM, 03/05)

% Acute Malnutrition (95% CI)	% Severe Acute Malnutrition (95% CI)	Measles immunisation coverage (%) [*]	Vitamin A distribution (%)	Crude Mortality (/10,000/day)	Under 5 Mortality (/10,000/day)
LOKITAUNG, LAPUR & KIBISH DIVISIONS, NORTH-EASTERN TURKANA					
22.1 (18.5–26.2)	1.5 (0.7–3.2)	86	95	1.86	2.40
KAKUMA, OPROPOI & LOKICHOGGIO DIVISIONS, NORTH-WESTERN TURKANA					
19.2(15.8–23.1)	1.5 (0.7–3.2)	75	80	1.51	2.85

* According to cards or mothers' statements

BOX 1 FOOD SECURITY AND WATER SOURCES, NORTH-EASTERN AND NORTH-WESTERN TURKANA, KENYA (OXFAM, 03/05)

FOOD SECURITY

FOOD CONSUMPTION

ONE MEAL: 63%/77%

SOURCES OF FOOD

Purchase: 58%/69%; Gift from relatives: 16%/14% Own production: 15%/9%

SOURCES OF INCOME

Livestock products: 32%/16%, Charcoal/firewood: 17%/46%;

Wage labour: 15%/9%; Petty trade: 6%/22%

FOOD DISTRIBUTION

Households having received food aid: 92%/83%

Households having received blanket supplementary food: 87%/77%

However, only 59%, 10%, 28% and 26% of the planned cereals, pulses, oil and UNIMIX was actually distributed. School feeding and food-for-work programmes also implemented in some divisions

WATER SOURCES

Boreholes: 64%/33%

Riverbanks: –/51%

¹ According to household interviews; first figures refer to North-Eastern Turkana, second figures refer to North-Western Turkana

Recommendations

From the OXFAM survey in Turkana district

- Continue to provide a full general food ration to a minimum of 75% of households if the long rainy season fails
- Continue to provide blanket supplementary feeding to under-five year olds, pregnant and lactating women
- Continue support to severely malnourished children and improve the referral system in the North-West
- Continue to support existing health facilities
- Implement cash-for-work and food-for-work programmes
- Continue to support the provision of safe water
- Support livestock development
- Incorporate peace-building and conflict-reduction activities at community level

Somalia

The Transitional Federal Government and the President have relocated to Somalia. The President, the Prime Minister and part of the government have moved to Jowhar because they believe that Mogadishu must be secured before they can relocate there. Another section of the government strongly disagrees with this (IRIN, 09/08/05). There seems also to be disagreement inside the government about the proposed deployment of peacekeepers. For the first time in years, there have been no cholera outbreaks in Somalia. This was partially attributed to good coordination among partners, and preventive action taken during the rainy season (UN, 07/05).

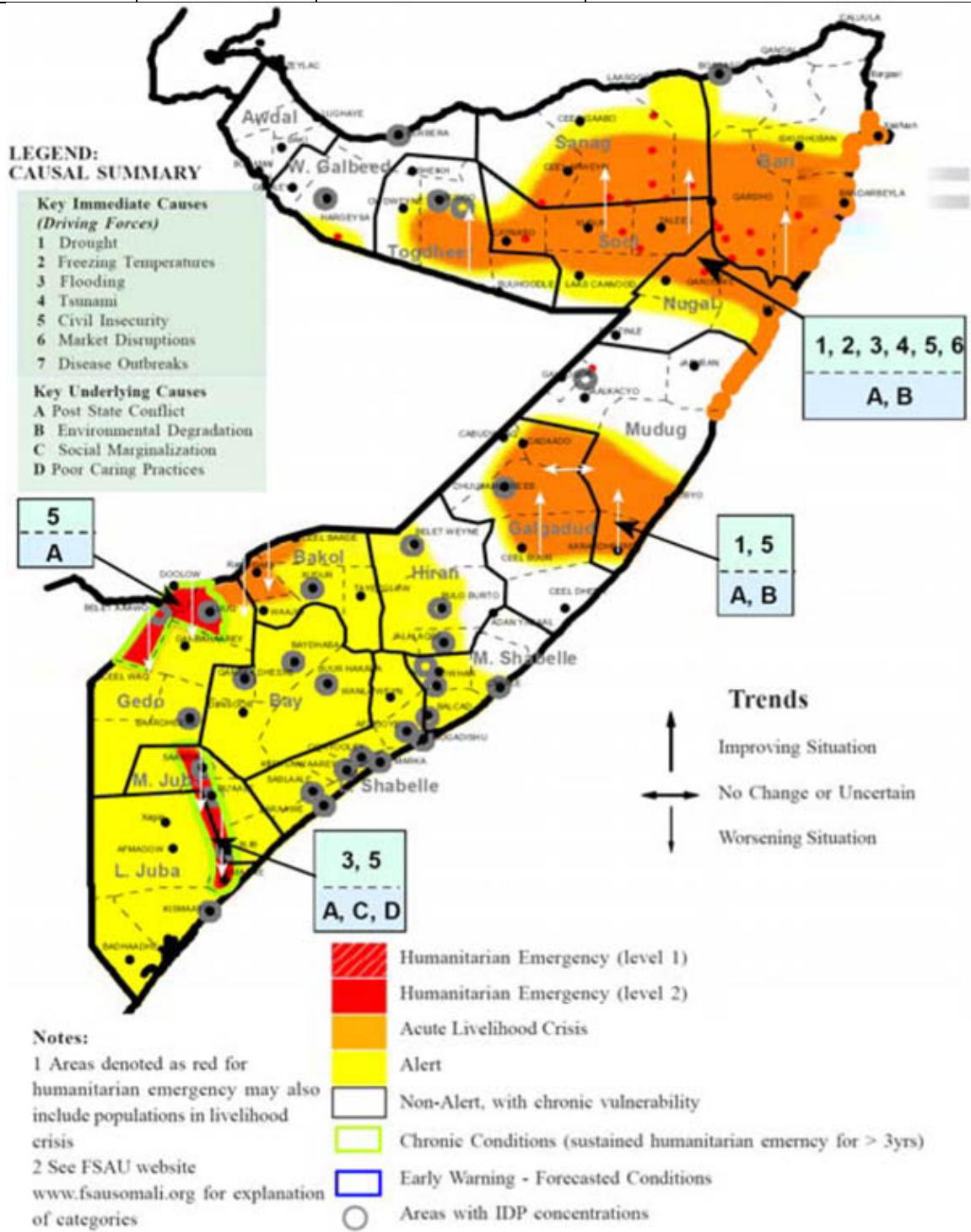
Post Gu 2005 seasonal assessment

Overall the assessment reports that 919,000 people are in need of immediate assistance, including 197,000 people in a state of humanitarian emergency, 343,000 people who face an acute livelihood crisis and 377,000 displaced people (table 3 and map) (FSAU, 08/05).

TABLE 3 PEOPLE IN NEED OF ASSISTANCE, SOMALIA (FSAU, 08/05)

Regions	Livelihood crisis	Humanitarian emergency	Affected population as % of total population
North			
Bari	38,000	8,000	19
Nugal	16,000	3,000	19
Sanag	45,000	9,000	28
Sool	40,000	8,000	25
Togdheer Central	36,000	0	12
Galgadud	38,000	0	12
Mudug South	19,000	0	10
Bakol	12,000	0	4

Gedo	59,000	53,000	30
Lower Juba	6,000	37,000	13
Middle Juba	14,000	197,000	20



MAP: POST-GU 2005 FOOD SECURITY PHASE CLASSIFICATION (FSAU, 08/05)

Improvement of the situation in the North and Central regions

The exceptionally good *Gu* rains, which followed good *Deyr* rains, confirm the end of the drought in Northern Somalia (FSAU, 08/05). However, the area is still considered to be in a state of acute livelihood crisis, given the severity of the previous emergency (see map). In addition, twenty eight thousand destitute people, concentrated in pockets of urban areas and small towns remain in a state of humanitarian emergency.

Sentinel sites surveillance confirms this tendency: acute malnutrition declined in all the sites between April and June, except in IDP camps (FSAU/N, 06/05) (figure 3). The mortality rates seemed under control.

A nutrition survey conducted in Taleex and Hudun districts, Sool region, in June 2005 showed a precarious nutrition situation, but one which is within the range usually seen in similar populations in the area outside time of crisis (FSAU/N, 06/05). The prevalence of acute malnutrition was 10.6% (8.7–12.8) including 0.8% (0.3–1.7) severe acute malnutrition. Measles vaccination and vitamin A distribution coverage was poor: 64.3% and 44.6%, respectively. The under-five mortality rate was above alert threshold: 3.16 deaths/10,000/day (FSAU/N, 07/05).

The improvement of the situation in the north is attributed to the combination of good rains and provision of humanitarian assistance (FSAU/N, 06/05).

A "sustainable livelihoods and drought mitigation programme" will be implemented in north Somalia and will have different components such as soil and water conservation, rehabilitation of water sources, supporting livestock health services and promoting income-generating activities (UNDP, 07/05).

The two consecutive good rainy seasons have also had positive influence on the central areas which are no longer considered to be in a state of humanitarian emergency (see map).

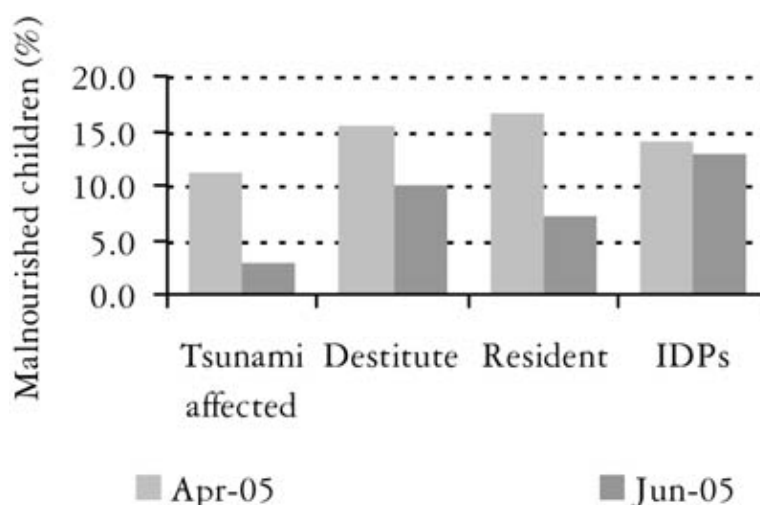


FIGURE 3 MALNOURISHED CHILDREN IN SENTINEL SITES, NORTH REGION (FSAU/N, 06/05)

Worsening of the situation in the affected areas of the south

Northern Gedo and Juba riverine are considered to be in a state of chronic humanitarian emergency and the situation has deteriorated further in the past few months (FSAU, 08/05) (see map). In both areas the *Gu* crops were poor. In addition, North Gedo has experienced an influx of IDPs and trade disruptions.

Sudan

South Sudan

The death of John Garang, the leader of the SPLM/A (Sudan's People's Liberation Movement/Army) in a helicopter crash was followed by a few days of rioting between northerners and southerners in major towns such as Khartoum and Juba (AFP, 03/08/05). Salva Kiir took over from John Garang as head of the SPLM/A, vice president of Sudan and president of the autonomous Southern Sudan. Riek Machar was appointed as vice president of Southern Sudan (IRIN, 23/08/05). The accession of these two leaders who have less antagonistic rapport with the SSDF (the government-aligned South Sudan Defence Force) than the former leader might help to solve the outstanding issue of how to deal with other armed groups in southern Sudan (IRIN, 23/08/05).

The food security situation is bleak in northern Bahr el Gazal. Food deficits started in March–April, especially for the poorest households, as a result of last year's poor harvest and reduced flood levels which has led to significant reductions of dry season food sources such as wild food and fish (FEWS, 29/07/05). Sorghum has also become scarce in the markets. The high number of returnees has further exacerbated the food insecurity (FEWS, 07/05). Furthermore, food aid requirements were not met, with less than 60% of the food aid required between January and May actually provided (FEWS, 13/07/05). Although the pipeline improved later, it is still

insufficient to meet the needs.

The process of the current planting season is positive so far, but the harvest will not take place before October (FEWS, 04/08/05). In the meantime, households will need a significant amount of aid.

Several random-sampled nutrition surveys showed critical prevalence of acute malnutrition in Bahr el Gazal and Upper Nile (figure 4) (AAH-US, 04/05; AAH-US, 06/05; MSF-CH, 03/05). In the three locations where the surveys were conducted, last year's harvest was poor. On the other hand, a nutrition survey conducted in Eastern Equatoria showed an average nutrition situation (figure 4) (AAH-US, 06/05).

In the GOS-controlled town of Wau and the surrounding IDP camps, the nutrition situation has remained stable over the last years but is still precarious, especially among displaced people, while measles vaccination coverage and mortality rates were average (table 4) (ACF-F, 04/05).

According to random-sampled surveys conducted in the GOS-controlled towns of Bentiu and Rob Kona in February 2005, the situation has also remained stable within the last years and was precarious (ACF-F, 02/05). **The prevalence of acute malnutrition was 16.2% (13.0–19.9), including 1.0% (0.4–2.6) severe acute malnutrition and 16.1% (12.9–19.9), including 2.1% (1.0–4.0) severe acute malnutrition in Bentiu and Rob Kona, respectively.** Fighting and cattle looting in nearby areas in March 2005 resulted in a wave of displacements to Bentiu, Rob Kona and Nhialdiu. The number of admission to TFCs and SFCs in Rob Kona and Bentiu increased three fold. A rapid nutrition assessment (non-random sampled) in these three towns revealed that about 34% of the 6–59 month-old children surveyed in Rob Kona and Bentiu were acutely malnourished, including about 7% of children severely malnourished, and that 42% of the children surveyed in Nhialdu were acutely malnourished, including close to 10% severely malnourished (ACF-F, 05/04). Some food distributions have been implemented.

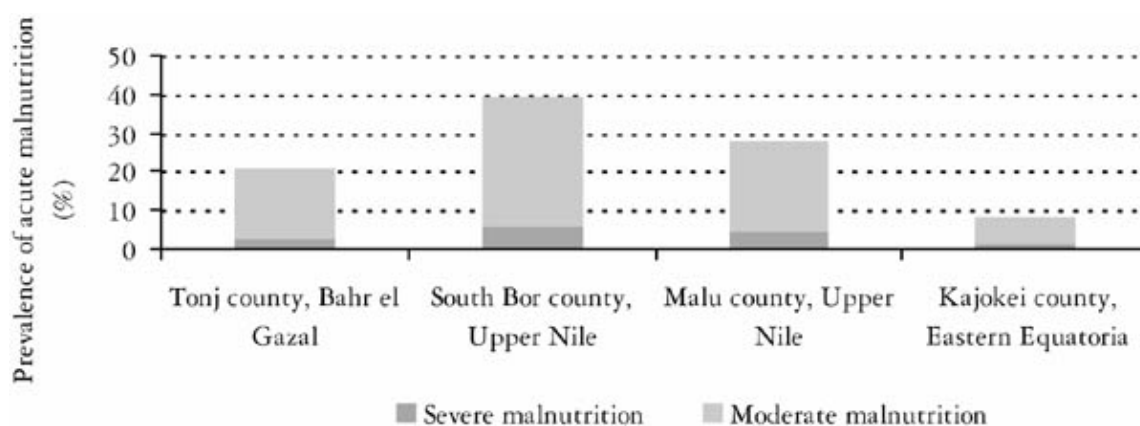


FIGURE 4 RESULTS OF NUTRITION SURVEYS IN SOUTHERN SUDAN (AAH-US, 04/05; AAH-US, 06/05; MSF-CH, 03/05)

TABLE 4 RESULTS OF SURVEYS IN WAU TOWN AND CAMPS, WESTERN BHAR EL GAZAL (ACF-F, 04/05)

% Acute Malnutrition (95% CI)	% Severe Acute Malnutrition (95% CI)
WAU TOWN	
13.1 (10.2–16.7)	2.7 (1.4–4.7)
EASTERN BANK IDP CAMP	
25.0	3.8
MARIAL AGIETH IDP CAMP	
16.6	4.0
BAR YAR IDP CAMP	
16.4	1.1

SALVATION IDP CAMP	
21.2	0.0

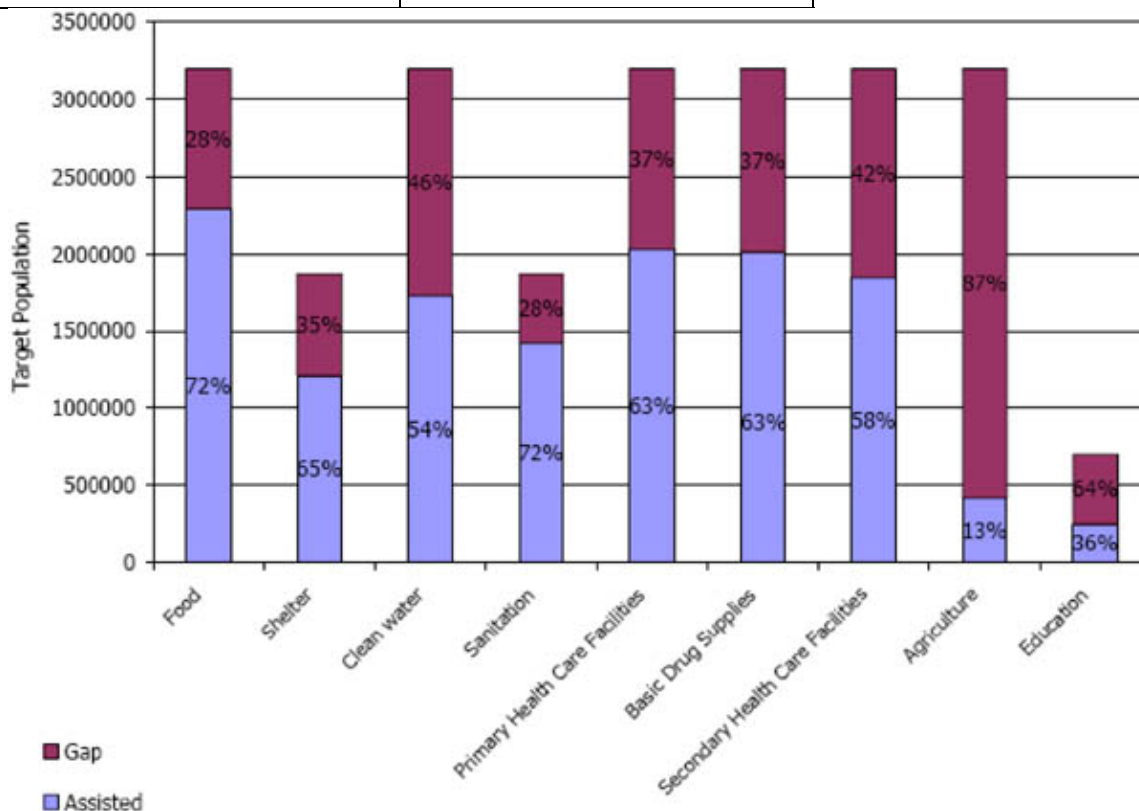


FIGURE 5 ESTIMATED SECTORAL NEEDS AND GAPS IN DARFUR IN TERMS OF BENEFICIARY NUMBERS (UNRHC, 01/07/05)

Darfur

As of early July, there was an estimated 3.2 million people affected by the crisis, including 1.88 million displaced people (UNRHC, 01/07/05). The increase in the number of resident people who are affected is due to exhausted coping mechanisms, lean season conditions, improved humanitarian access and increased operational capacity. According to UN security rules, 96% of the affected population was accessible in June 2005 in North and West Darfur, while only 77% of the population was accessible in South Darfur (UNRHC, 01/07/05). A deficit in humanitarian presence was noted in North Darfur. Moreover, MSF stated that while the situation has improved in the biggest displaced camps and settlements, the aid has not reach geographically remote areas or rebel-held territories to the same extent (MSF, 27/07/05).

As of June, the coverage of the affected population was far below the needs in all of the sectors of humanitarian aid (figure 5). The security is still highly volatile with continued attacks on civilians, and banditry (UNNews, 16/08/05). Sexual violence is also widespread (MSF, 27/07/05). Insecurity has also been experienced in camps during registration processes (UNSC, 11/08/05). Insecurity hampered access to the affected population (MSF, 27/07/05).

Several random-sampled surveys conducted in the first semester of 2005 showed that the situation was still precarious (ACF-F, 02/05; ACF-F, 05/05; ACF-F, 06/05; Concern, 02/05; GOAL, 05/05; NCA/joint, 07/05; SC-US, 06/05; SMH, 03/05; SMH, 06/05; Tearfund, 03/05). The prevalence of acute malnutrition was more than 15 % in most of the areas surveyed (figure 6). The situation seemed under control in Mornei camp in February 2005, where a regular general food distribution was implemented (Concern, 02/05). However, it seems that due to security problems, the general food distribution has recently been suspended for two months (MSF, 27/07/05). Mortality rates were below emergency threshold in all the locations surveyed (figure 6).

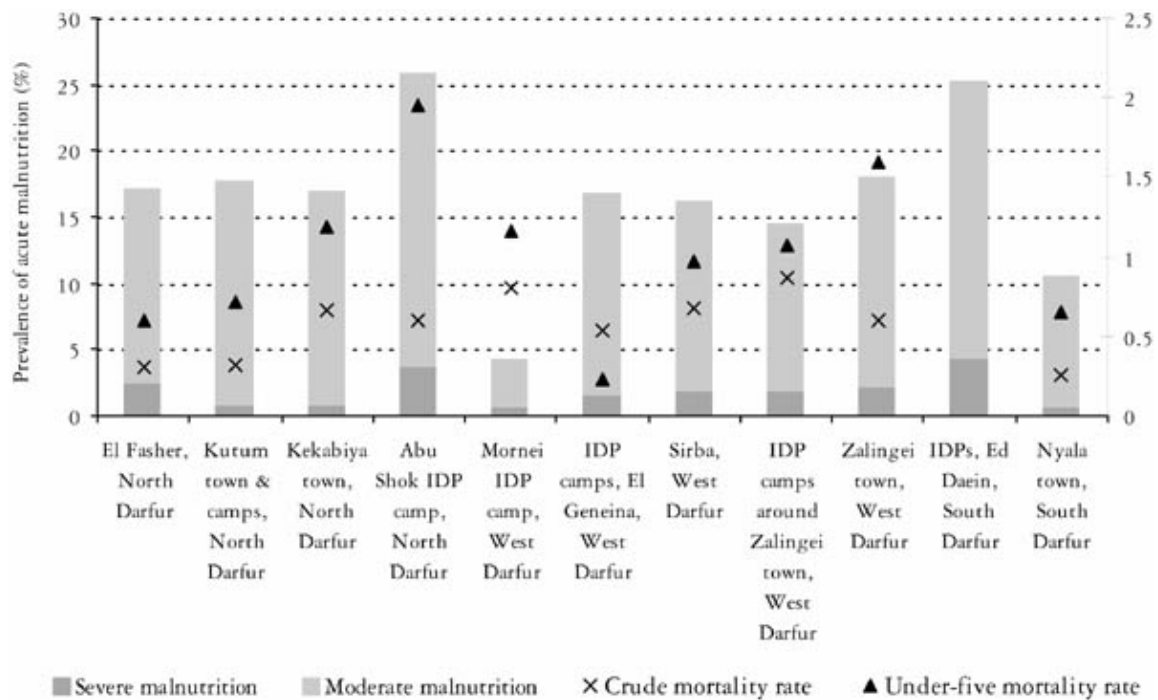


FIGURE 6 RESULTS OF NUTRITION AND MORTALITY SURVEYS, DARFUR, FIRST SEMESTER 2005 (ACF-F, 02/05; ACF-F, 05/05; ACF-F, 06/05; CONCERN, 02/05; GOAL, 05/05; NCA/Joint, 07/05; SC-US, 06/05; SMH, 03/05; SMH, 06/05; TEARFUND, 03/05)

When compared with data from surveys conducted in 2004, it seems that crude mortality rates have decreased (figure 7).

A survey conducted by WHO in all three states of Darfur reported the same pattern, with an overall crude mortality rate of 0.8/10,000/day between November 2004 and May 2005 (WHO, 07/05). One third of the total deaths were due to injury.

The evolution of the nutrition situation is more varied, with improvement in some situations while others have remained stable or have even worsened (figure 8).

The number of admissions to supplementary and therapeutic feeding centres have increased in 2005 compared to 2004 (UNICEF, 15/07/05). This might, however be due to a higher availability of facilities.

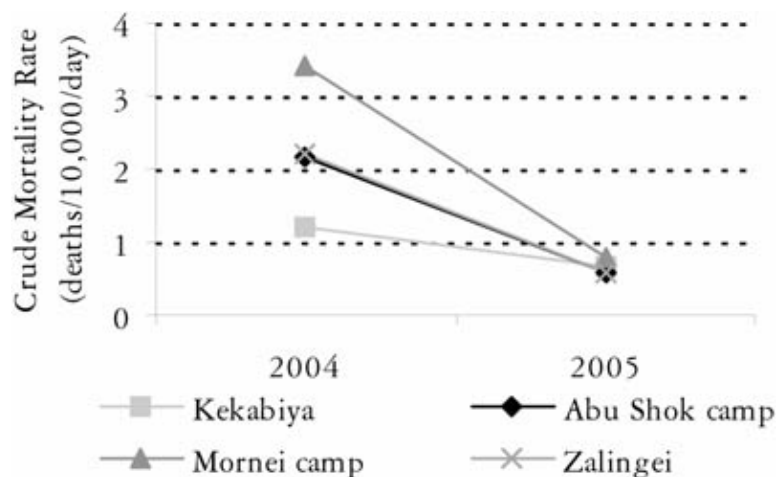


FIGURE 7 EVOLUTION OF THE MORTALITY RATES, DARFUR, SUDAN

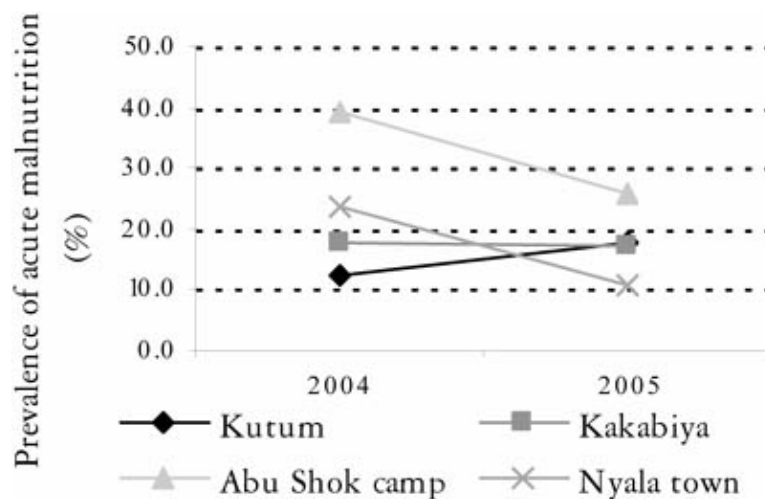


FIGURE 8 EVOLUTION OF THE PREVALENCE OF MALNUTRITION, DARFUR, SUDAN

In the IDP camps in Ed Daein, South Darfur, only 32.9% of the IDPs had access to latrines, 20% had soap and 65% were registered for general food distribution (Tearfund, 03/05). It seems, however that a new registration of IDPs for general distribution was conducted after the survey.

In El Fasher, the food security situation was precarious as well as in Kutum.

In Sirba, 70% of the population was receiving a general food distribution as of June 2005 (SC-US, 06/05). However, the residents of Seraf Gidad (a part of Sirba) were not receiving any food distribution and were more food insecure than the rest of the population. In the three locations, insecurity was a significant concern for the population: it prevented them from cultivating, fetching wood for cooking or looking for medical care at night.

Overall

Despite some improvements in Darfur, the situation remains highly precarious and violence is still widespread. In Southern Sudan, food insecurity will affect a significant proportion of the population during the lean season and especially in Northern Bhar el Gazal. The pipeline for food distribution is insufficient to meet all needs.

West Africa



Liberia

Repatriation of refugees and displaced people is under way with about 209,100 displaced people and 38,380 refugees repatriated as of end August 2005 (UNMIL, 31/08/05; UNHCR, 30/08/05). The poor road conditions, especially at the onset of the rainy season, makes repatriation and delivery of assistance difficult (ACF-F, 06/05; UNMIL, 08/05). There seems to be funding shortfalls to repatriate 64,000 displaced people gathered in spontaneous settlements (IRIN, 31/08/05). Some malfunction of the process has been reported. For example, there is a lack of a coherent strategy for displaced people unwilling to return home, which leaves these people without proper shelter and assistance (RI, 18/07/05). In some districts, such as Kolahun district, Lofa county, there is no transit centre to host the returnees before they reach their own houses (ACF-F, 06/05). Returnees also face many problems when at home, such as the lack of materials to repair their houses (ACF-F, 06/05). The situation is not optimal for the more than 100,000 IDPs who have not been repatriated yet and are still in camps. The basic infrastructure in the camps are poor and the monthly food ration distribution is insufficient. Most NGOs have scaled down their activities in the camps (ACF-F, 06/05).

Niger

Late and insufficient response to the crisis

The worsening of the crisis in Niger and the late response has raised concerns. According to the Humanitarian Policy Group, the slowness of the donors' engagement is not the only factor (HPG, 08/05). Alerts on the potential gravity of the situation were late and the early response to the crisis, which was the sale of subsidised cereals, was not sufficient to avoid a deterioration in the situation. The amount of the subsidised cereals sold was not enough to have a significant impact on the price of food, which remained at more than twice the price of last year. Moreover, the most impoverished Nigerians could not afford to buy this food. Part of the problem might be that, in the assessment of the crisis, the food availability approach prevailed over the "food access" approach: food was available during the crisis but was too costly for impoverished people.

The government of Niger was afraid that emergency assistance such as free food distributions would undermine the development process and market mechanisms. It also seems that there was a lack of capacity to react to the Niger crisis; humanitarian organisations being already involved in big crises such as Darfur and the Tsunami.

Scaling-up of emergency programmes

The response to the crisis has intensified since July 2005 with several NGOs implementing emergency programmes.

The UN organisations have recently increased their demand of funds to US\$ 81 m, of which about half was pledged as of late August (IRIN, 25/08/05). WFP began free food distribution for 1.85 m people at the beginning of August (WFP, 23/08/05). A total of 3 m people will receive free food aid from a number of organisations. Some areas have been added to the distribution plan recently, to take the current situation into account (WFP, 02/09/05). However, MSF warns that the proportion of the families who get free food distribution is insufficient to meet the needs of the population in some locations, and that the ration distributed lacks fortified blended food; a food more suitable for young children than whole grains (MSF, 22/08/05).

Nutrition surveys conducted in May 2005 in parts of Tahoua and Maradi showed a critical prevalence of acute malnutrition, and under-five mortality rates above alert threshold (table 5) (Epicentre/MSF, 05/05). The surveys showed a worse situation than in Maradi and Zinder regions in January 2005 (HKI/WFP, 01/05). The situation has probably deteriorated further since May and as of August 2005, admissions to therapeutic feeding centres were still on the rise (MSF, 22/08/05).

A more recent survey conducted in the rural surroundings of Zinder town in August 2005 also showed a critical situation (table 5) (Epicentre/MSF-CH, 08/05). Moreover, the prevalence of acute malnutrition among the 6-29 month old children was appalling: 32.6% (27.0-38.2). The crude and under-five mortality rates were above emergency threshold (table 5). Moreover, it seemed that the mortality was higher in the recent months than at the beginning of 2005.

According to the families interviewed in the surveys in Maradi and Zinder, access to subsidised cereals or free cereal distributions seemed low with only about 10% of the families having access to them (Epicentre/MSF–F, 05/05; Epicentre/MSF–CH, 08/05).

The onset of the rainy season, which is good so far, is raising hope for the future with good harvests expected, as well as a replenishment of pasture (FEWS, 01/09/05). Humanitarian aid and support to livelihoods will, however, be needed until the households recover from the crisis.

TABLE 5 RESULTS OF SURVEYS IN NIGER, 2005 (EPICENTRE/MSF–F, 05/05; EPICENTRE/MSF–CH, 08/05)

% Acute Malnutrition (95% CI)	% Severe Acute Malnutrition (95% CI)	Measles immunisation coverage (%)*	Crude Mortality (/10,000/day)	Under 5 Mortality (/10,000/day)
NORTH–EAST OF MARADI REGION				
193 (15.6–23.6)	2.4(1.2–4.6)	65.9	0.83	2.2
CENTRE–WEST OF TAHOUA REGION				
18.8 (14.7–24.0)	2.8(1.6–4.6)	86.5	0.96	2.4
RURAL SURROUNDINGS OF ZINDER				
18.6(15.4–21.8)	3.0(1.7–4.2)	67.1	1.5	4.1

Central Africa



Burundi

Elections, which ended the period of the transitional government, ran smoothly and the political wing of the Force for the Defence of Democracy (FDD), a former rebel group, won the majority of seats at the local elections (AFP, 23/06/05), national assembly (AFP, 06/07/05) and senate (AFP, 29/07/05). Pierre Nkurunzira of the FDD was elected president and named a new cabinet composed of a 60–40 ratio of Hutus to Tutsis, in accordance with the new constitution (IRIN, 31/08/05). Nevertheless, the lone remaining Hutu guerrilla army (Front for National Liberation) has continued their attacks in Bujumbura and in western provinces of Bubanza and Cibitoke (AFP, 01/09/05; WFP, 02/09/05).

Repatriation of refugees from Tanzania is under way and the number of returns has rocketed following the elections: 6,000 and 15,000 people returned in July and August 2005, respectively (WFP, 02/09/05). An agreement was signed for the repatriation of about 7,000 Burundian refugees in Rwanda (UNHCR, 19/08/05). As of mid–August, 2,100 refugees had been repatriated.

On the other hand, there have been concerns about forced returns of some 8,000 Rwandan refugees in Burundi (IRIN, 15/07/05).

The food security situation is precarious in the northern province of Kayanza and Ngozi (ACF–F, 08/05). These provinces count the highest number of chronically food insecure households (30% against a national average of 16%). The coffee crop was poor this year and estimated to have decreased by 78% compared to 2004. Moreover, the "cassava mosaic virus" destroyed most of the cassava plants in Ngozi province and bean crops were poor in June 2005. The price of beans rose by 30–40% between June 2004 and June 2005. The number of admissions to TFCs in both provinces was far higher in the first semester of 2005 than in the same period in 2004. ACF recommends that food distributions targeted at the most vulnerable households be implemented, that supplementary feeding centres be fully functional, and that nutrition surveys be implemented in October 2005.

Democratic Republic of the Congo

Improvement of the situation in Shabunda health zone, South Kivu

A random–sampled nutrition survey conducted in May 2005 showed improvement, compared to previous years, of all the indicators measured, such as the prevalence of acute malnutrition among the 6–59 month–old children, the nutrition status of the under–six month olds and the chronic energy deficiency among adults (figure 9) (AAH–US; 05/05). The crude mortality rate has also declined but was still at the alert level (1/10,000/day). The number of admissions to the therapeutic feeding centre in the first semester of 2005 was lower than in 2004 and 2003.

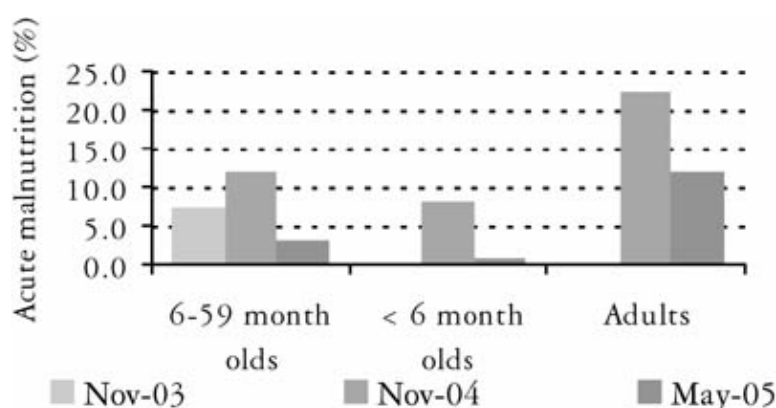


FIGURE 9 NUTRITION STATUS IN SHABUNDA HEALTH ZONE, SOUTH KIVU

Average to precarious nutrition situation in South Ubangui district, Equateur province

According to nutrition surveys conducted in five health zones of South Ubangui district, the nutrition situation was average to precarious, depending on the health zone (table 6) (Pronanut/AHA/UNHCR, 06/05). Mortality rates were below alert threshold in most of the health zones but measles vaccination coverage was very varied (table 6). The poorest situation was in Zongo health zone, with more than 10% acute malnutrition,

including 2.3% oedema and an under-five mortality of 2.1/10,000/day.

TABLE 6 RESULTS OF SURVEYS IN SOUTH UBANGUI, EQUATEUR PROVINCE, DRC, JUNE 2005
(PRONANUT/AHA/UNHCR, 06/05)

% Acute Malnutrition (95% CI)	% Severe Acute Malnutrition (95% CI)	Measles immunisation coverage (%)*	Crude Mortality (/10,000/day)	Under 5 Mortality (/10,000/day)
BWARMANDA HEALTH ZONE				
6.7 (4.9–8.4)	1.6(0.8–2.3)	95.5	0.5	1.6
GEMENA HEALTH ZONE				
8.5 (6.3–10.6)	3.7 (2.5–5.6)	80.5	0.7	1.9
KUNGU HEALTH ZONE				
4.0(2.6–5.7)	1.0(0.3–1.9)	25.8	0.6	1.7
LIBENGE HEALTH ZONE				
8.5 (6.5–11.2)	2.4(1.4–4.0)	59.4	0.6	1.5
GEMENA HEALTH ZONE				
10.2 (7.8–12.9)	3.2 (2.0–5.1)	33.8	0.6	2.1

Uganda

Northern Uganda

A random-sampled nutrition survey conducted in all but four IDP camps in Gulu district in June 2005 showed a nutrition situation under control (AAH-US, 06/05) and one which has remained stable over the last two years (figure 10). The crude mortality rate was under alert threshold. The under-five mortality rate was not recorded, but had been very high in previous surveys (see NICS 6). The amount of available safe drinking water was 5.5 l/pers/day, well below the recommended target. Sanitation coverage varied depending on the camp. Random-systematic surveys conducted in IDP camps in Kitgum district showed a precarious nutrition situation in most of the camps (prevalence of acute malnutrition > 10%) (WFP/IMC/UNICEF/MOH, 06/05).

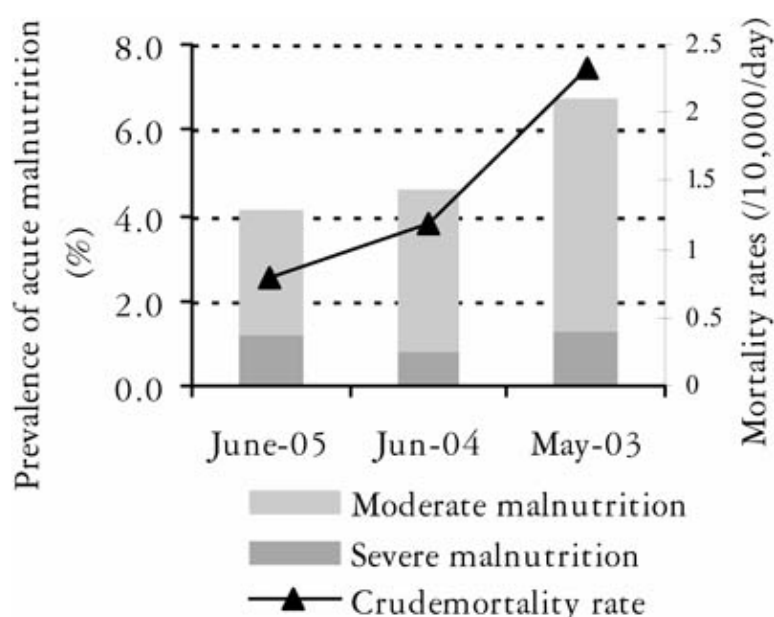


FIGURE 10 RESULTS OF SURVEYS, GULU IDP CAMPS, NORTHERN UGANDA

The prevalence of acute malnutrition varied from 4.9% to 18.0% depending on the camp. The situation has remained stable compared to last year (see NICS 4). Vitamin A supplementation and measles vaccination coverage were acceptable.

As of August 2005, WFP was facing a funding gap of US\$ 13 million to maintain the food pipeline for the IDPs (WFP, 02/09/05).

Teso region

According to a nutrition assessment conducted in Teso region (Kabeamaido, Soroti and Katakwi districts), the nutrition situation seemed under control (CNC/WFP/MOH/UNICEF, 06/05). The region has not experienced any incursion of the Lord's Resistance Army since the beginning of 2004.

Karamoja region

Last year crop was poor in Karamoja and food aid distributions have been implemented (see NICS 3).

A rapid food security assessment in Kotido district of Karamoja region in May 2005 concluded that the situation was not precarious and that food aid appeared to have enabled households to protect assets such as livestock (OXFAM, 05/05). Moreover, this year's crop seemed good and the general food assistance will probably be phased out (Fews, 08/05).

Chad

Sudanese refugees

The current rainy season makes living conditions of the refugees difficult and hampers access to them (WFP, 26/08/05). Three random-sampled nutrition surveys conducted in April-May 2005 in Am Nabak and Oure Cassoni refugee camps and in Cariari settlement showed a precarious nutrition situation (figure 11) (AAH-US, 04/05; AAH-US, 05/05). The nutrition situation has worsened in Oure Cassoni and Cariari, compared to December 2004. However, refugees in Cariari settlement have been transferred to Oure Cassoni and will now get the general food distribution.

Results of food basket monitoring conducted in some camps between April and July 2005 showed that on average the ration distributed was close to the theoretical ration for most of the distributions (table 7) (AAH-US, 04/05-07/05). However, there were some variations in the amount of food received per family, with some families receiving less than 95% of the ration, or even less than 80% (table 7). During post distribution monitoring in Iridimi, Kounougou, Oure Cassoni and Mile camps, between April and June 2005, some refugee families claimed that some members of their families were not registered on their distribution card (AAH-US, 04/05-06/05). The assessments also showed that, depending on the camp, between 20% and 40% of the families had a source of income. Food aid was the main source of food and was supplemented by purchase from the market, and gifts. The milling of cereals seemed to be a problem, with people having to give a portion of the cereals to pay for the milling. Part of food aid (between 10% and 30%) was sold or bargained for other food items. The most purchased foods were onions, gumbos, tomatoes, sugar and meat. People were also purchasing clothes, soap and shoes.

A lot of families were relying on credit from the traders or members of the family to buy food and non-food items. They intended to repay their debts with food rations, gifts or from income. Refugees said that their major problems were insufficient food and money. They were keen to receive aid in form of credits to engage in income-generating activities or to receive help to engage in agriculture and livestock rearing.

It seems that the implementation of the protocol for the treatment of severe malnutrition has improved (WHO/UNICEF/WFP/UNHCR, 06/05). However, the rate of absconding from the nutrition programmes is very high in some of the camps (WHO/UNICEF/WFP/UNHCR, 07/05).

Micro-nutrient deficiencies have been reported in some of the camps: one case of vitamin C deficiency and two cases of vitamin A deficiency in Touloum camps, one case of vitamin C deficiency in Djabal and iodine deficiency in Farchana, Touloum and Iridimi camps (WHO/UNICEF/WFP/UNHCR, 07/05). In Farchana, a survey of children aged 5 to 15 years showed that 75% of the children examined had goitres. Further investigations and adequate responses to micro-nutrient deficiencies should be put in place.

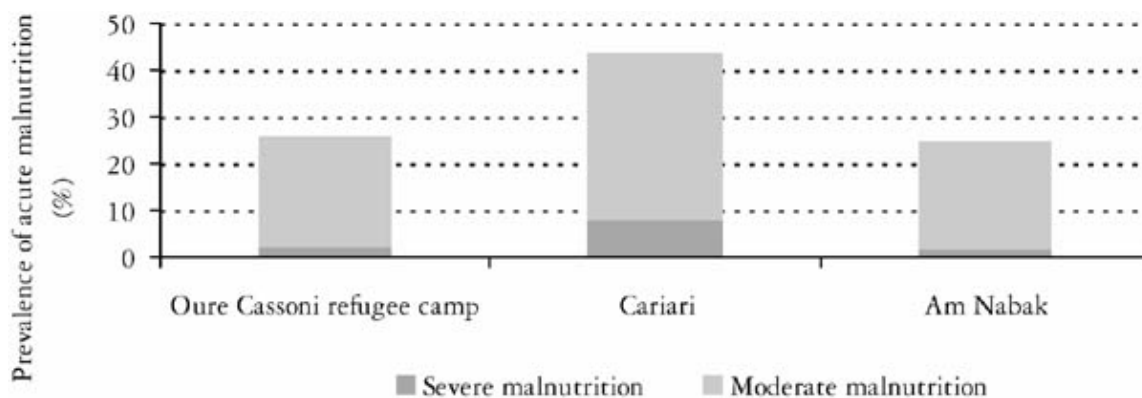


FIGURE 11 RESULTS OF NUTRITION SURVEYS, REFUGEE CAMPS, CHAD, 2005 (AAH-US, 04/05; AAH-US, 05/05)

TABLE 7 FOOD RATION DISTRIBUTED ACCORDING TO FOOD BASKET MONITORING, REFUGEE CAMPS, CHAD (AAH-US, 04/05-07/05)

Camps	Date	Food ration available according to WFP pipeline Kcal (% of theoretical food ration)	Food ration distributed (measured by food basket monitoring) Kcal (% of theoretical food ration)	Percentage of households having received < 95% of the food ration available according to WFP pipeline
Am Nabak	April-05	2,063 (100%)	1,713 (83%)	49.1
Am Nabak	June-05	2,063 (100%)	2,080 (100%)	25.2
Kounoungou	April-05	2,128 (103%)	1,982 (96%)	37.4
Kounoungou	June-05	2,063 (100%)	1,957 (95%)	61.5
Touloum	April-05	2,063 (100%)	1,862 (90%)	61.0
Touloum	June-05	2,063 (100%)	2,050 (99.4%)	33.2
Iridimi	May-2005	2,063 (100%)	2,062 (100%)	20.5
Iridimi	July-2005	2,009* (97%)	1994 (96%)	35.1
Mile	May-2005	2,063 (100%)	2,059 (100%)	34.0
Mile	July-2005	2,063 (100%)	1,998 (98%)	47.2
Oure Cassoni	May-2005	2,063 (100%)	2,075 (100%)	17.0
Oure Cassoni	July-2005	2,009* (97%)	2,000 (97%)	25.4

* No sugar available

Food-for-work activities have been implemented for the resident populations of Abeche, Farchana, Iriba, Guereda and Bahai as well as blanket supplementary feeding in some locations (WFP, 28/08/05).

Refugees from CAR

A new wave of refugees from the Central African Republic has entered Southern Chad recently. At least 6,000 people have fled a new onset of violence with attacks on villages in northern CAR (UNHCR, 07/09/05). Rains hamper the efforts to reach the new arrivals and to transfer them to refugee camps.

Southern Africa



Angola

Angola is recovering from a 27-year civil war which ended in 2002. As part of the Food Plus Initiative led by WFP, in collaboration with other agencies, a nutrition survey was conducted in Kuito municipality, Bie province, in December 2004. The survey showed an average prevalence of acute malnutrition (table 8) (MOH/joint, 12/04). The mortality rates were under control (table 8). 14.3% of the women (15–49 years old) had chronic energy deficiency (BMI < 18.5) including 3.4% severe chronic energy deficiency (BMI < 16).

Anaemia was a public health problem in both children and women (table 9).

TABLE 8 PREVALENCE OF ACUTE MALNUTRITION AND MORTALITY RATES, KUITO MUNICIPALITY, BIEH PROVINCE, ANGOLA (MOH/CICH/WFP/MSF-B, 12/04)

% Acute Malnutrition (95% CI)	% Severe Acute Malnutrition (95% CI)	Crude Mortality (/10,000/day)	Under 5 Mortality (/10,000/day)
7.2(5.1–9.5)	1.1 (0.2–2.0)	0.22	0.47

TABLE 9 PREVALENCE OF ANAEMIA, KUITO MUNICIPALITY, BIEH PROVINCE, ANGOLA, DECEMBER 2004 (MOH/CICH/WFP/MSF-B, 12/04)

N	Mild anaemia (%) (95% CI)	Moderate anaemia* (%) (95% CI)	Severe anaemia* (%) (95% CI)	Total anaemia* (%)
6 –59 MONTHS OLD CHILDREN				
251	27.9(23.2–33.1)*	37.8 (30.9–45.3)*	2.0 (0.7–5.6)*	67.7 (60.6–74.1)*
NON PREGNANT WOMEN (15–49 YEARS)				
108	10.2 (5.9–17.1)#	14.8 (8.7–24.0)#	0.0#	25.0 (17.7–34.1)#

* Mild anaemia: Hb = 10.5–11.4 g/dl; moderate anaemia: Hb = 7.5–10.4 g/dl; severe anaemia: Hb < 7.5 g/dl

Mild anaemia: Hb = 11.5–12.4 g/dl; moderate anaemia: Hb = 8.5–11.4 g/dl; severe anaemia: Hb < 8.5 g/dl

Although only one case of clinical pellagra in children and two cases in women were detected during the survey (which was not designed to evaluate the prevalence of clinical signs of pellagra), niacin deficiency detected by biochemical analysis was significant. Moreover, the MSF–B pellagra clinic received a significant number of patients with clinical symptoms: about 800 patients were treated between January and August 2004.

Zambia

Zambia currently hosts 175,000 refugees from Angola, the Democratic Republic of the Congo, the Great Lakes region and other countries (UNHCR, 26/07/05).

A random–sampled nutrition survey was carried out in Nangweshi refugee camp, Western province, in July 2004 (ICH/TDRC/WFP/UNHCR/CORD, 07/04). The camp hosted around 26,000 Angolan refugees, as of June 2004. Refugees are meant to receive a full food ration, but shortages in the food pipeline have occurred several times. Fields around the camp are available to the refugees for cultivation and home gardens are widespread. Refugees are allowed access to work outside the camp and there are also some income–generating activities in the camp, such as bakeries, blacksmiths and small shops.

One of the aims of this survey was to assess the impact of the distribution of on–site fortified maize meal which was implemented in September 2004 as a replacement of maize grain, by comparing the results of the 2004 survey with the result of the 2003 survey (see NICS 1 &2).

The anthropometric survey revealed a good anthropometric nutritional status: 1.5% (0.6–3.7) of the children surveyed were acutely malnourished, including 0.3 (0.0–2.0) severely malnourished.

Moreover, the distribution curve of the weight–for–height index of the children surveyed in the camp was similar to the distribution curve of the population used as a reference (healthy American children, National Center of Health Statistics). The prevalence of acute malnutrition was within the same range as in July 2003.

Assessment of anaemia showed that it was of medium public health significance in all age groups (table 10). Vitamin A deficiency affected 20% of the adolescents (table 11). When compared to 2003, mean haemoglobin was significantly higher in children and adolescents but had not changed in women (table 12). The prevalence of anaemia has only significantly decreased among children. Vitamin A deficiency and retinol concentration have significantly improved in adolescents (table 12). The study concluded that the introduction of fortified maize meal was associated with improvements in the micronutrient status of children and adolescents, which remained significant after controlling for potential con–founders.

TABLE 10 PREVALENCE OF ANAEMIA, NANGWESHI REFUGEE CAMP, ZAMBIA, JULY 2004 (ICH/JOINT, 07/04)

Population group	N	Mild anaemia (%) (95% CI)	Moderate anaemia (%) (95% CI)	Severe anaemia (%) (95% CI)	Total anaemia (%) (95% CI)
6–59 months*	136	10.3 (5.7–16.7)	12.5 (7.5–19.3)	1.5 (0.2–5.2)	24.3 (17.3–34.4)
10–19 years	176	14.2 (9.4–20.3)	6.8 (3.6–11.6)	3.4 (1.3–7.3)	24.4 (18.3–31.5)
Non–pregnant women#	97	7.2 (3.0–14.3)	10.3 (5.1–18.1)	5.2 (1.7–11.6)	22.7 (14.8–32.3)

* Mild anaemia: Hb = 10.0–10.9 g/dl; moderate anaemia: Hb = 7–9.9 g/dl; severe anaemia: Hb < 7 g/dl

Mild anaemia: Hb = 11.0–11.9 g/dl; moderate anaemia: Hb = 8.0–10.9 g/dl; severe anaemia: Hb < 8 g/dl

TABLE 11 VITAMIN A STATUS OF ADOLESCENTS (10–19 YEARS), NANGWESHI REFUGEE CAMP, ZAMBIA, JULY 2004 (ICH/JOINT, 07/04)

Vitamin A Deficiency			
N	Total % < 0.7 µmol/L (95% CI)	Medium Risk % 0.35–0.69 µmol/L (95% CI)	High Risk % < 0.35 µmol/L (95% CI)
204	20.3 (14.6–27.1)	19.8 (14.1–26.5)	0.6 (0.0–3.2)

TABLE 12 COMPARISON OF MICRO-NUTRIENT DEFICIENCIES, NANGWESHI REFUGEE CAMP, ZAMBIA, JULY 2003–JULY 2004 (ICH/JOINT, 07/04)

	Mean Haemoglobin (g/dL)	Total anaemia (%) (95% CI)	Mean retinol (µmol/L)	Total Vitamin A deficiency (%) (95% CI)
6 –59 MONTHS OLD CHILDREN				
Base line	10.9(10.6–11.2)	47.7 (39.7–55.9)		
Follow up	11.8(11.6–12.1)	24.3 (17.3–34.4)		
Change	+ 0.9	–23.4		
P	< 0.001	< 0.001		
ADOLESCENTS (10–19 YEARS)				
Base line	12.9(12.7–13.2)	19.2 (14.2–25.2)	0.73 (0.69–0.77)	46.4 (39.4–53.4)
Follow up	13.1 (12.8–13.3)	24.4(18.3–31.5)	0.94 (0.89–0.98)	20.3 (14.6–27.1)
Change	+ 0.2	+ 5.2	+ 0.21	–26.1
P	0.043	>0.05	< 0.001	< 0.001
NON PREGNANT WOMEN (15–49 YEARS)				
Base line	13.0(12.6–13.5)	17.4(11.0–25.6)		
Follow up	12.9(12.4–13.3)	22.7 (14.8–32.3)		
Change	–0.1	+5.3		
P	>0.05	–		

Western Saharawi in Algeria

About 160,000 people from Western Sahara are still refugees in camps in the area of Tindouf in Algeria (see RNIS 40) (WFP/UNHCR, 01/04). Isolation and the hostile environment of the area make humanitarian aid difficult to deliver and impede refugee self-sufficiency. A random-sampled nutrition survey was conducted in the camps in February 2005 (UNHCR/WFP/INRAN, 07/05). The prevalence of acute malnutrition was average and has remained stable when compared to 2002 (figure 12). Stunting has also remained stable (figure 13).

High level of micronutrient deficiencies

On the other hand, anaemia has risen compared to 2001 and 2002 and especially among children (figure 14). This might be explained by the interruption of nutrition interventions, which were aimed at improving micronutrient deficiencies.

Clinical signs of micronutrient disorders were also looked at. Bleeding gums, a sign of scurvy was present in 27.4% (18.4–36.5) of the 15–49 year old non-pregnant women examined; night blindness, a sign of vitamin A deficiency, was reported by 20.6% of the women and goitres were detected in 6.4% of them. Goitres were more likely to be due to an excess of iodine than to iodine deficiency. In fact, the survey conducted in 2002 reported extremely high urinary iodine excretion in adolescents. Iodine content of water was analysed during the present survey and was found to be high to extremely high, depending on the source of water. The highest concentration of iodine can even cause toxicity problems.

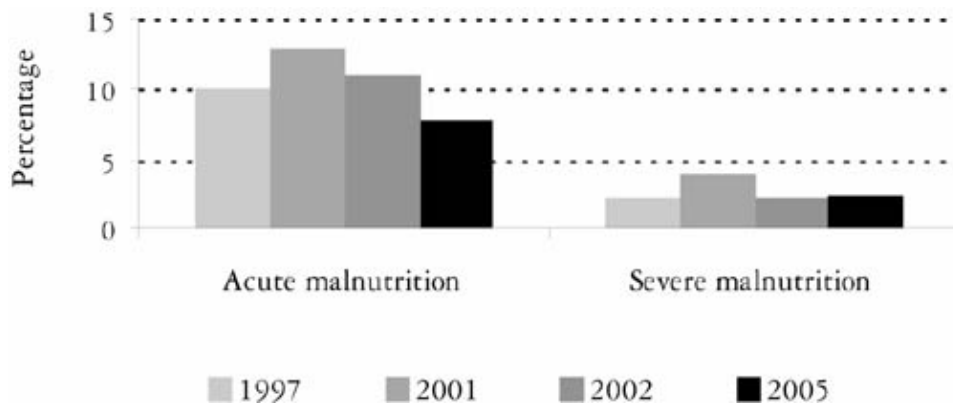


FIGURE 12 PREVALENCE OF ACUTE MALNUTRITION, SAHARAWI REFUGEE CAMPS, ALGERIA

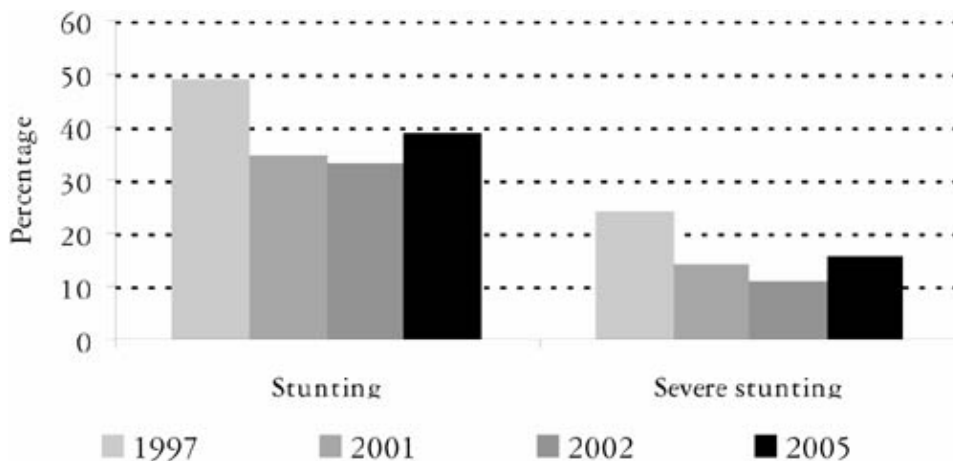


FIGURE 13 PREVALENCE OF STUNTING, SAHARAWI REFUGEE CAMPS, ALGERIA

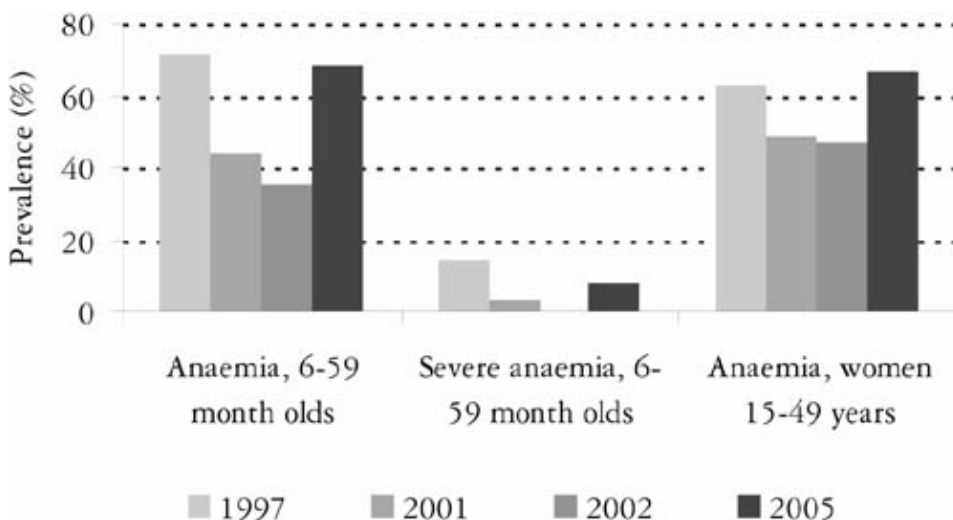


FIGURE 14 PREVALENCE OF ANAEMIA, SAHARAWI REFUGEE CAMPS, ALGERIA

The study team found it difficult to track records of food distributions. According to the WFP/UNHCR Joint Assessment Mission, conducted in January 2004, the food basket was composed of 450 g of cereals, 60 g of pulses, 25 g of oil, 30 g of sugar and 5 g of salt/pers/day (WFP/UNHCR, 01/04). No blended food was meant to be distributed. This was confirmed by the present survey, although some food is distributed by other partners on top of the general food distribution. It seems that no list of beneficiaries for food distribution was available.

According to the information which could be found during the survey, it seems that the minimum energy requirements were met but that very low amounts of riboflavin, vitamin C, calcium, iron and vitamin A were available. Only a few families had sources of income, some were receiving remittances. Although vegetables were present in the market, families mostly bought cereals, pulses, oil and sugar because the food distribution was not, according to them, sufficient.

Poor child feeding practices

Child feeding practices were not optimal, especially worrying was the exclusive breastfeeding rate (26.6%), which, however, seemed higher than in 2002 when it was only about 2%. Infant formula was given to about half of the infants who were not exclusively breast-fed. Moreover, 19.5% of the 0–23 month olds were at least partly bottle-fed, which is known to carry a high risk of contamination resulting in intestinal infection.

Asia



Afghanistan

Security conditions are still highly volatile (BAAG, 31/07/05). The wheat harvest was expected to be very good and the second largest in nine years (Fews, 29/06/05). However, while surpluses are likely to occur in the northern area, 19 of 32 provinces, especially in the central, east and west regions will experience wheat deficits. Wheat prices were higher in 2005 than in 2004 (Fews, 29/06/05). Pakistan has decided to close the refugee camps located in the "tribal region" of Pakistan for security reasons: to curb militancy in the tribal zone (AFP, 11/09/05). The refugees have been given the choice of being repatriated or moved to another camp in Pakistan. Most have chosen to return to Afghanistan. The closure within a short time frame has posed huge problems of repatriation. About 171,000 people have been registered for repatriation.

National anthropometric and micro-nutrient survey

The first ever national nutrition survey was conducted in Afghanistan in June–July 2004 (MOH/UNICEF/joint; 05/05). **The prevalence of acute malnutrition was average: 6.7%.** 20.8% of the women (non-pregnant women aged 15–49.9 years) had chronic energy deficiency (BMI < 18.5) and 15% were overweight. Anaemia was of medium public health significance among children and was of moderate public health significance among non-pregnant women (table 13).

Urinary iodine level was low among children and was even lower among women (table 13). Analysis of iodine in salt at household level showed that only 28% of the salt was iodised. It seemed that iodised salt was more present in urban households (especially in Kabul) than in rural households. Of 286 labelled salt packages, 62% were labelled as iodised. Only 88% of these, however, tested positive for iodine. Although 85% of the oil and 96% of the ghee were labelled as vitamin A fortified at household level, testing for the presence of vitamin A of samples of oil and ghee labelled vitamin A fortified available in Afghan markets, showed that only 10% were actually fortified.

TABLE 13 MICRO-NUTRIENT STATUS, NATIONAL SURVEY, JUNE–JULY 2004, AFGHANISTAN (MOH/UNICEF/JOINT, 05/05)

	Median urinary Iodine (µg/L)	Urinary Iodine deficiency (% < 100 µg/L)	Anaemia* (%)
Children 6–59 months	–	–	37.9
Children 7–11 years	49.0	71.9	–
Non-pregnant women 15–49 years	42.0	74.7	24.7
Men 16–60 years	–	–	7.1

* Anaemia defined as Hb < 11 g/dL in children, Hb < 12 g/dL in women and Hb < 13 g/dL in men

Nepal

Bhutanese refugees

Some 100,000 Bhutanese refugees are still hosted in seven camps in eastern Nepal. The annual nutrition survey conducted in July 2005 showed that the nutrition situation has remained stable and was average (AMDA/UNHCR, 07/05) (figure 15). The prevalence of stunting was 26.5% and has also remained stable over the past six years. Measles vaccination and vitamin A distribution coverage was near 100%. Prevalence of angular stomatitis was 6.7% and was within the same range as in the previous years (figure 16). More than half of the families stated that they had a regular source of income and 82% of the families were supplementing the food distribution, mostly with vegetables but also eggs/meat and dairy products.

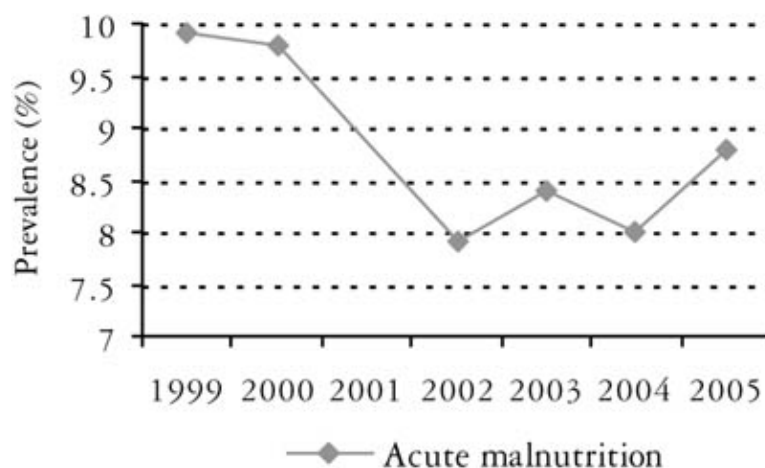


FIGURE 16 ACUTE MALNUTRITION IN BHUTANESE REFUGEE CAMPS, NEPAL

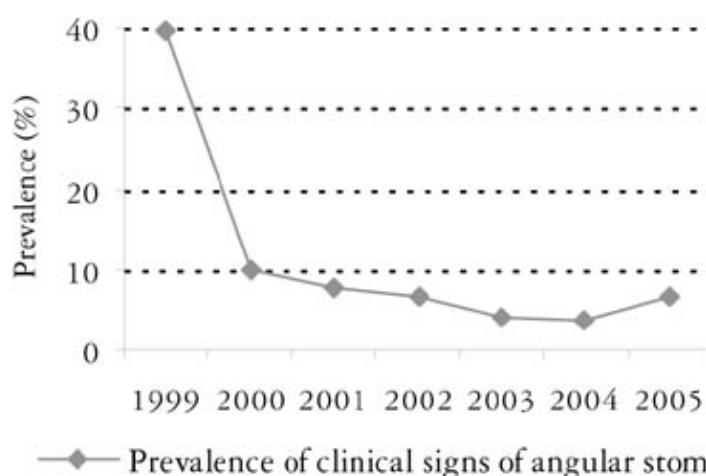


FIGURE 17 ANGULAR STOMATITIS IN BHUTANESE REFUGEE CAMPS, NEPAL

Nepalese crisis

The Maoist insurgency is still on-going. Estimates of the number of displaced in Nepal vary from 200,000 to 500,000 (RI, 11/07/05). They are difficult to evaluate as a number of displaced are reluctant to identify themselves out of fear of retaliation. For this reason, it is also difficult to assess the conditions in which IDPs are living and to provide aid targeted at them. It seems that IDPs are virtually indistinguishable from the equally vulnerable urban poor and that IDP response could be concentrated on assistance to the poor, regardless of their status. RI also states that the government is virtually non-functional in many areas controlled by the Maoists (up to 80% of the country) and that provision of services by NGOs and UN agencies is required on an emergency basis. RI appeals to emergency NGOs for implementing programmes beside existing development programmes. A joint appeal might be soon launched by OCHA (WFP, 09/09/05).

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WFP	09/09/05	WFP Emergency Report No 37

Results of surveys

Survey Area	Date	Population	Estimated Population	Survey Conducted by	Acute Malnutrition*	Severe Acute	Oed (
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									Malnutrition
			Number		(%)	(95% CI) [§]	(%)	(95% CI)	
GREATER HORN OF AFRICA									
ETHIOPIA									
Hart–Sheik IDP camp, Somali region	Mar–05	Displaced	–	SC–UK	21.8		3.4		
Fafen IDP camp, Somali region	Mar–05	Displaced	–	SC–UK	16.4	–	1.1	–	
Pugnido refugee camp, Gambella region	May–05	Refugees	–	UNHCR/WFP/ARRA	20.7	18.1–23.5	2.2	1.4–3.0	
Pugnido–Anyuak refugee settlement	May–05	Refugees	–	UNHCR/WFP/ARRA	21.9	–	7.0	–	
Bonga refugee camp, Gambella region	May–05	Refugees	–	UNHCR/WFP/ARRA	193	16.8–22.1	2.0	1.2–3.0	
KENYA									
Kakuma, Oropoi & Lokichoggio divisions, North–Western Turkana district	Apr–05	Residents	92,150	OXFAM	19.2	15.8–23.1	1.5	0.7–3.0	
Lokitaung, Lapur, Kaaleng & Kibish divisions, North–Eastern Turkana district	Apr–05	Residents	69,400	OXFAM	22.1	18.5–26.2	1.5	0.7–3.0	
SOMALIA									
Taleex & Huddun districts, Sool region	Jun–05	Residents	60,700	FSAU/joint	10.6	8.7–12.8	0.8	0.3–1.5	
SUDAN									
NORTH DARFUR									
El Fasher	Mar–05	Residents/Displaced	221,500	SMH/joint	17.1	13.7–20.5	2.4	1.4–3.0	
Kutum town, Kasab IDP camp, Fata Borna town and IDP camp	May–05	Residents/Displaced	66,860	GOAL	17.7	14.8–21.0	0.8	0.3–1.5	
Kekabiya town	May 2005	Displaced/Residents/	–	ACF–F	17.0	13.7–20.8	0.7	0.2–1.5	
Abu Shok IDP camp	Jun–05	Displaced	–	ACF–F	25.9	22.0–30.2	3.6	2.2–5.0	

WEST DARFUR									
Mornei IDP camp, El Geneina	Feb-05	Displaced	94,040	CONCERN/joint	4.3	3.2–5.9	0.6	0.3–1.4	
Ardamat, Dorti, Riyadh and Abu-Zar IDP camps, El Geneina	Jun-05	Displaced	73,900	SMH/joint	16.9	14.5–19.6	1.5	0.8–2.6	0
Sirba, West Darfur	Jun-05	Residents/Displaced	99,149	SC-US	16.3	13.9–18.7	1.8	0.8–2.8	0
IDP camps surrounding Zalingei town	Jul-05	Displaced	–	NCA/ACT/Caritas	14.5	12.3–16.6	1.9	1.1–2.8	
Zalingei town	Aug-05	Residents	–	NCA/ACT/Caritas	18.1	15.8–20.5	2.1	1.2–3.0	
SOUTH DARFUR									
Nyala town	Feb-05	Displaced/Residents	–	ACF-F	10.6	8.0–13.9	0.6	0.1–2.0	
IDPs, Ed Daein	Mar-05	Displaced	–	Tearfund/Joint	25.2	21.6–29.2	4.3	2.9–6.3	0

* Acute malnutrition (children aged 6–59 months): weight–height < – 2 Z–scores and/or oedema

** Severe acute malnutrition (children aged 6–59 months): weight–height < – 3 Z–scores and/or oedema

§ 95% Confidence Interval; not mentioned if not available from the survey report

NOTE: see at the end of the report for guidance in interpretation of indicators

Survey Area	Measles immunisation coverage (%)#		Micro–nutrient deficiencies	Vitamin A distribution coverage, within the past 6 months	Women's anthropometric status (%)	Crude Mortality (/10,000/day) (95% CI)§	Under 5 Mortality (/10,000/day) (95% CI)§
	Proved by card	Card + history					
GREATER HORN OF AFRICA							
ETHIOPIA							
Hart–Sheik IDP camp, Somali region	0	30.2	–	–	–	0.81	4.67
Fafen IDP camp, Somali region	0	22.9	–	–	–	0.53	3.48
Pugnido refugee camp, Gambella region	–	91.8	–	94.2	–	–	–

Pugnido–Anyuak refugee settlement	–	–	–	–	–	–	–				
Bonga refugee camp, Gambella region	–	96.4	–	97.8	–	–	–				
KENYA											
Kakuma, Oropoi & Lokichoggio divisions, North–Western Turkana district	46	76	–	80	–	–	–				
Lokitaung, Lapur, Kaaleng & Kibish divisions, North–Eastern Turkana district	53	86	–	95	–	–	–				
SOMALIA											
Taleex & Huddun districts, Sool region		64.3	–	44.6	–	–	–				
SUDAN											
NORTH DARFUR											
El Fasher	52.2	88.8	–	93.3	–	0.3	0.6				
Kutum town, Kasab IDP camp, Fata Borna town and IDP camp	20.5	83.5	–	98.7	–	0.32	0.71				
Kekabiya town	28.3	79.7	–	–	–	0.66	1.19				
Abu Shok IDP camp	9.9	78.7	–	–	–	0.6	1.95				
WEST DARFUR											
Mornei IDP camp, El Geneina					10.9	66.9	–	–	–	0.8	1.16
Ardamat, Dorti, Riyad and Abu–Zar IDP camps, El Geneina					11.8	78.8	–	89.0	–	0.53	0.23
Sirba, West Darfur					5.7	20.9	–	60.7	–	0.67	0.97
IDP camps surrounding Zalingei town					–	–	–	–	–	0.87	1.07
Zalingei town					–	–	–	–	–	0.6	1.6
SOUTH DARFUR											
Nyala town		39.5	78.4	–	–	–	0.26	0.65			
IDPs, Ed Daein		10.2	73.1	–	79.4	–	–	–			

Measles vaccination coverage for children aged 9–59 months

Survey Area	Date	Population	Estimated Population	Survey Conducted by	Acute Malnutrition*		Severe Acute Malnutrition**		Oedema (%)
					(%)	(95% CI) [§]	(%)	(95% CI) [§]	
BHAR EL GAHZAL									
Tonj county	Mar-05	Residents	212,780	MSF-CH	20.9	19.7-22.0	2.8	1.3-4.3	0
Wau town	Apr-05	Residents/Displaced	-	ACF-F	13.1	10.2-16.7	2.7	1.4-4.7	0.4
Eastern Bank IDP camp, Wau surroundings	Apr-05	Displaced	-	ACF-F	25.0	-	3.8	-	-
Mariai Agieth IDP camp, Wau surroundings	Apr-05	Displaced	-	ACF-F	16.6	-	4.0	-	-
Wau surroundings	Apr-05	Displaced	-	ACF-F	16.4	-	1.1	-	-
Salvation IDP camp, Wau surroundings	Apr-05	Displaced	-	ACF-F	21.2	-	0.0	-	-
UPPER NILE									
Baidit & Jalle II district, South Bor county	Jun-05	Residents	23,670	AAH-US	39.3	34.7-44.1	5.9	4.0-8.6	0
Palombit & Koladar districts, Malu county	Apr-05	Residents	7,800	AAH-US	28.1	23.4-33.3	4.5	2.6-7.4	0
EASTERN EQUATORIA									
Kajoikei county	Jul-05	Residents	34,680	AAH-US	8.3	6.0-11.4	1.5	0.6-3.3	0.1
UNITY STATE									
Bentiu town	Feb-05	Residents/Displaced	-	ACF-F	16.2	13.0-19.9	1.0	0.4-2.6	0
Rob Kona town	Feb-05	Residents/Displaced	-	ACF-F	16.1	12.9-19.9	2.1	1.0-4.0	-
WEST AFRICA									
NIGER									
Maradi region	Jan-05	Residents	-	HKI/WFP	13.4		2.2		-
Zinder region	Jan-05	Residents	-	HKI/WFP			2.7		-
North-East of Maradi region	May-05	Residents	233,000	Epicentre/MSF-F	19.3	15.6-23.6	2.4	1.2-4.6	0
Centre-West of Tahoua	May-05	Residents	140,000	Epicentre/MSF-F	19.6	16.0-23.6	2.9	1.6-5.0	0.4

region									
Rural surroundings of Zinder town	Aug-05	Residents	440,353	Epicentre/MSF-CH	18.6	15.4-21.8	3.0	1.7-4.2	
CENTRAL AFRICA									
DEMOCRATIC REPUBLIC OF CONGO									
Bwamanda health zone, Equateur province	Jun-05	Residents/Refugees	160,290	PRONANUT/joint	6.7	4.9-8.4	1.6	0.8-2.3	
Gemena health zone, Equateur province	Jun-05	Residents/Refugees	236,270	PRONANUT/joint	8.5	6.3-10.6	3.7	2.3-5.6	
Kungu health zone, Equateur province	Jun-05	Residents/Refugees	146,190	PRONANUT/joint	4.0	2.6-5.7	1.0	0.3-1.9	
Libenge health zone, Equateur province	Jun-05	Residents/Refugees	154,010	PRONANUT/joint	8.5	6.5-11.2	2.4	1.4-4.0	
Zongo health zone, Equateur province	Jun-05	Residents/Refugees	53,273	PRONANUT/joint	10.2	7.8-12.9	3.2	2.0-5.1	
Shabunda health zone, South Kivu province	May-05	Residents	166,020	AAH-US	3.2	1.8-5.3	0.7	0.2-2.1	

* Acute malnutrition (children aged 6-59 months): weight-height < - 2 Z-scores and/or oedema

** Severe acute malnutrition (children aged 6-59 months): weight-height < - 3 Z-scores and/or oedema

§ 95% Confidence Interval; not mentioned if not available from the survey report

NOTE: see at the end of the report for guidance in interpretation of indicators

Survey Area	Measles immunisation coverage (%)#		Micro-nutrient deficiencies	Vitamin A distribution coverage, within the past 6 months	Women's anthropometric status (%)	Crude Mortality (/10,000/day) (95% CI)§		Under 5 Mortality (/10,000/day) (95% CI)§	
	Proved by card	Card + history							

BHAR EL GAHZAL									
Tonj county	–	–	–	–	–	0.9		3.4	
Wau town	50.4	82.9	–	–	–	1.52		2.49	
Eastern Bank IDP camp, Wau surroundings	40.9 ¹	63.6 ¹	–	–	–	0.57 ¹		1.29 ¹	
Mariai Agieth IDP camp, Wau surroundings	40.9 ¹	63.6 ¹	–	–	–	0.57 ¹		1.29 ¹	
Wau surroundings	40.9 ¹	63.6 ¹	–	–	–	0.57 ¹		1.29 ¹	
Salvation IDP camp, Wau surroundings	40.9 ¹	63.6 ¹	–	–	–	0.57 ¹		1.29 ¹	
UPPER NILE									
Baidit & Jalle II district, South Bor county	32.3	73.1	–	–	–	–		–	
Palombit & Koladar districts, Malu county	10.4	32.7	–	–	–	0.24		–	
EASTERN EQUATORIA									
Kajoeki county	2.1	10.5	–	–	–	0.25		–	
UNITY STATE									
Bentiu town	24.4	67.4	–	–	–	0.07		0.16	
Rob Kona town	25.9	65.0	–	–	–	–		–	
WEST AFRICA									
NIGER									
Maradi region	–	–	–	–	–	–		–	
Zinder region	–	–	–	–	–	–		–	
North–East of Maradi region	34.4	65.9	–	–	–	0.83		2.2	
Centre–West of Tahoua region	44.4	77.7	–	–	–	0.96		2.4	
Rural surroundings of Zinder town	18.6	67.1	–	–	–	1.5	1.1–1.8	4.1	3.2–5.0

CENTRAL AFRICA									
DEMOCRATIC REPUBLIC OF CONGO									
Bwamanda health zone, Equateur province	–	95.5	–	–	–	0.5		1.6	
Gemena health zone, Equateur province	–	80.5	–	–	–	0.7		1.9	
Kungu health zone, Equateur province	–	25.8	–	–	–	0.6		1.7	
Libenge health zone, Equateur province	–	59.4	–	–	–	0.6		1.5	
Zongo health zone, Equateur province	–	33.8	–	–	–	0.6		2.1	
Shabunda health zone, South Kivu province	39.9	75.0	–	79.9	BMI ¹ <16:1.3 BMI ¹ < 18.5: 12.0	1.03		–	

¹ Male and female of more than 18 years, excluding pregnant and lactating women

* Measles vaccination coverage for children aged 9–59 months

Survey Area	Date	Population	Estimated Population	Survey Conducted by	Acute Malnutrition*		Severe Acute Malnutrition**		Oedema (%)
					(%)	(95% CI) [§]	(%)	(95% CI) [§]	
UGANDA									
IDP camps, Gulu district	Jun–05	Displaced	524,800	AAH–US	4.1	2.6–6.4	1.2	0.5–2.8	0.7
CHAD									
Am Nabak refugee camp, Ouda–Fira department	Apr–05	Refugees	16,130	AAH–US	24.6	20.8–28.9	1.8	0.8–3.6	0.0
Oure Cassoni refugee camp	May–05	Refugees	18,000	AAH–US/IRC	26.0		2.1		0.1

Cariari refugee settlement	May-05	Refugees	-	AAH-US/IRC	43.9		7.9		0.0
SOUTHERN AFRICA									
ANGOLA									
Kuito, Bie province	Dec-04	Residents	310,000	MOH/ICH/WFP/MSF-B	7.2	5.1-9.5	1.1	0.2-2.0	0.8
ZAMBIA									
Nangweshi refugee camp	July-04	Refugees	26,060	ICH/joint	1.5	0.6-3.7	0.3	0.0-2.0	-
WESTERN SAHARAWI IN ALGERIA									
Refugee camps, Tindouf province	Mar-05	Refugees	-	UNHCR/WFP/NIRFN	7.7	4.1-11.2	2.3	0.7-4.0	-
ASIA									
AFGHANISTAN									
Nation-wide	2004	Residents	-	MOH/joint	7.0		-		-
NEPAL									
Refugee camps	Jul-05	Refugees	-	AMDA/UNHCR	8.8		-		-

* Acute malnutrition (children aged 6-59 months): weight-height < - 2 Z-scores and/or oedema

** Severe acute malnutrition (children aged 6-59 months): weight-height < - 3 Z-scores and/or oedema

§ 95% Confidence Interval; not mentioned if not available from the survey report

NOTE: see at the end of the report for guidance in interpretation of indicators

Survey Area	Measles immunisation coverage (%)#		Micro-nutrient deficiencies	Vitamin A distribution coverage, within the past 6 months	Women's anthropometric status (%)	Crude Mortality (/10,000/day) (95% CI)§	Under 5 Mortality (/10,000/day) (95% CI)§
	Proved by card	Card + history					
UGANDA							
IDP camps, Gulu district	83.1	99.1	-	-	-	0.8	-
CHAD							

Am Nabak refugee camp, Ouda–Fira department	–	–	–	–	–	1.06	–
Oure Cassoni refugee camp	–	–	–	–	–	–	–
Cariari refugee settlement	–	–	–	–	–	–	–
SOUTHERN AFRICA							
ANGOLA							
Kuito, Bie province	–	–	See p 17	85.9	BMI ¹ < 16: 3.4 BMI ¹ < 18.5: 14.3	0.22	0.47
ZAMBIA							
Nangweshi refugee camp	–	–	See p 17	–	–	–	–
WESTERN SAHARAWI IN ALGERIA							
Refugee camps, Tindouf province	–	–	See p 18	–	–	–	–
ASIA							
AFGHANISTAN							
Nation-wide	–	–	See p 20	–	BMI ¹ < 18.5: 21% BMI ^{1 2} ? 25: 15%	–	–
NEPAL							
Refugee camps	–	99.3	See p 20	97.8	–	–	–

¹ Non pregnant women aged 15–49 years

* Measles vaccination coverage for children aged 9–59 months

Survey methodology

The Greater Horn region

Ethiopia

FANFEN & HARTISHEIK IDP CAMPS

Exhaustive surveys were conducted by SC–UK in March 2005. 477 and 854 children between 6–59 months were measured in Fanfen and Hartisheik IDP camps, respectively. The surveys also estimated measles

vaccination coverage and retrospective mortality rates over the 3 months prior to the survey.

PUGNIDO & BONGA REFUGEE CAMPS & PUGNIDO/ANYUAK REFUGEE SETTLEMENT

The surveys were conducted by UNHCR/WFP/ARRA in May 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 906 and 905 children between 6–59 months in Pugnido and Bonga, respectively. An exhaustive survey was conducted in Pugnido/Anyuak settlement and 484 children between 6–59 months were measured. The survey also estimated measles vaccination and vitamin A coverage.

Kenya

TURKANA DISTRICT

Two surveys were conducted in North–Eastern Turkana (Lokitaung, Lapur, Kaaleng & Kibish divisions) & North–Western Turkana (Kakuma, Oropoi & Lokichoggio divisions) by OXFAM in March 2005. Two-stage cluster sampling methodologies of 30 clusters were used to measure 942 children and 946 between 6–59 months in North–Eastern and North–Western Turkana, respectively. The surveys also estimated measles vaccination and vitamin A coverage, crude and under–five mortality rates and various food security and public health indicators.

Somalia

TALEEX & HUDDUN DISTRICTS, SOOL REGION

A random–sampled nutrition survey was conducted in Taleex and Huddun districts by FSAU/joint in June 2005. A two-stage 30–by–30 cluster sampling methodology was used to measure 897 children between 6–59 months. The survey also estimated measles vaccination and vitamin A distribution coverage, mortality rates and various food security and public health indicators.

Sudan

KEBKABIYA, NORTH DARFUR

The survey was conducted by ACF–F in May 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 960 children between 6–59 months. The survey also estimated measles vaccination coverage and retrospective mortality rate over three months prior to the survey.

ABU SHOK CAMP, NORTH DARFUR

The survey was conducted by ACF–F in June 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 960 children between 6–59 months. The survey also estimated measles vaccination coverage and retrospective mortality rate over three months prior to the survey.

KUTUM TOWN, KASAB CAMP & FATA BORNO, NORTH DARFUR

The survey was conducted by GOAL in May 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 955 children between 6–59 months. The survey also estimated measles vaccination and vitamin A distribution coverage, retrospective mortality rate over two and a half months prior to the survey and various food security and public health indicators.

EL FASHER, NORTH DARFUR

The survey was conducted by State Ministry of Health/UNICEF/ACF_F/WFP/SMA/CHF/WHO in March 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 958 children between 6–59 months. The survey also estimated measles vaccination coverage, retrospective mortality rate over three months prior to the survey and various food security and public health indicators.

ARDAMAT, DORTI, RIYAD AND ABU–ZAR CAMPS, EL GENEINA, WEST DARFUR

The survey was conducted by the State Ministry of Health/UNICEF/Concern/SC–US in June 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 902 children between 6–59

months. The survey also estimated measles vaccination and vitamin A distribution coverage, retrospective mortality rate over three months prior to the survey.

MORNEY IDP CAMP, WEST DARFUR

The survey was conducted by Concern/State Ministry of Health and UNICEF in February 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 949 children between 6–59 months. The survey also estimated measles vaccination cover– age and retrospective mortality rate over three and a half months prior to the survey.

KUTUM TOWN, KASAB CAMP & FATA BORNO, NORTH DARFUR

The survey was conducted by SC–US in June 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 891 children between 6–59 months. The survey also estimated measles vaccination and vitamin A distribution coverage, retrospective mortality rate over two and a half months prior to the survey and various food security and public health indicators.

ZALINGEI TOWN & CAMPS, WEST DARFUR

The surveys were conducted by NCA/ACT/Caritas in July/August 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 988 and 993 children between 6–59 months in town and camps, respectively. The surveys also estimated retrospective mortality rate over three months prior to the surveys.

ABU MATARIQ, EL FIRDOUS, EL NEEM & KHOR OMER IDP CAMPS, ED DAEIN, SOUTH DARFUR

The survey was conducted by Terafund/State Ministry of Health/UNICEF and SUDO in March 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 966 children between 6–59 months. The survey also estimated measles vaccination coverage and various food security and public health indicators.

NYALA TOWN, SOUTH DARFUR

The survey was conducted by ACF–F in February 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 960 children between 6–59 months. The survey also estimated measles vaccination coverage and retrospective mortality rate over three months prior to the survey.

TONJ COUNTY, BHAR EL GHAZAL

The survey was conducted by MSF–CH in March 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 910 children between 6–59 months.

TONJ COUNTY, BHAR EL GHAZAL

The survey was conducted by MSF–CH in March 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 910 children between 6–59 months.

ATHOC: BAIDIT & JALLE II DISTRICTS, SOUTH BOR COUNTY, UPPER NILE

The survey was conducted by AAH–US in June 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 916 children between 6–59 months. The survey also estimated measles vaccination.

PANOMBIT & KOLADAR DISTRICTS, MALUT COUNTY, UPPER NILE

The survey was conducted by AAH–US in April 2005. A two-stage cluster sampling methodology of 30 clusters was used to measure 673 children between 6–59 months. The survey also estimated measles vaccination and crude mortality rate over the three months prior to the survey.

KAJOKEI COUNTY, EASTERN EQUATORIA

The survey was conducted by AAH–US in June/July 2005. A two–stage cluster sampling methodology of 30 clusters was used to measure 915 children. The survey also estimated measles vaccination and crude mortality rate over the three months prior to the survey.

BENTIU & ROB KONA, UNITY STATE

The surveys were conducted by ACF–F in April 2005. A two–stage cluster sampling methodology of 30 clusters was used to measure 953 and 956 children between 6–59 months in Bentiu and Rob Kona, respectively. The surveys also estimated measles vaccination coverage and retrospective mortality rate over three months prior to the surveys.

WAU TOWN AND SURROUNDING IDP CAMPS, BHAR EL GAZAL

The surveys were conducted by ACF–F in February 2005. A two–stage cluster sampling methodology of 30 clusters was used in Wau town to measure 943 children between 6–59 months. Exhaustive surveys were conducted in the four camps. The surveys also estimated measles vaccination coverage and retrospective mortality rate over three months prior to the surveys.

West Africa

Niger

MARADI & ZINDER REGIONS

The surveys were conducted by Hellen Keller International and Word Food Programme in January 2005. A two–stage cluster sampling methodology of 30 clusters was used to measure 901 children in Maradi and in Zinder.

PARTS OF RURAL AREAS OF MARADI & TAHOUA REGIONS

The surveys were conducted by Epicentre/MSF in May 2005. A two–stage cluster sampling methodology of 30 clusters was used to measure 901 and 951 children between 6–59 months in Tahoua and Maradi. The surveys also estimated measles vaccination coverage and retrospective mortality rate over three months prior to the surveys.

RURAL SURROUNDINGS OF ZINDER TOWN

The survey was conducted by Epicentre/MSF–CH in August 2005. A two–stage cluster sampling methodology of 30 clusters was used to measure 908 children between 6–59 months. The survey also estimated measles vaccination coverage and retrospective mortality rate over seven months prior to the survey.

Central Africa

Democratic Republic of Congo

SOUTH UBANGI, EQUATEUR PROVINCE

Five surveys were conducted in Bwamanda, Gemena, Kungu, Libenge and Zongo health zones by Pronanut, Africa humanitarian action and UNHCR in June 2005. A two–stage cluster sampling methodology of 30 clusters of 40 children was used. The surveys also estimated measles vaccination coverage and retrospective mortality over the previous 12 months.

SHABUNDA HEALTH ZONE, SOUTH KIVU

The survey was conducted by AAH–US in May 2005. A two–stage cluster sampling methodology of 30 clusters was used to measure 980 children. The survey also estimated measles vaccination and vitamin A coverage, retrospective mortality over the previous 3 months and nutritional status of adults and infants.

Uganda

IDP CAMPS, GULU DISTRICT

The survey was conducted by AAH–US in May 2005. A two–stage cluster sampling methodology of 30 clusters was used to measure 976 children between 6–59 months in 44 out of the 48 IDP camps. The survey also estimated measles vaccination coverage and retrospective mortality rate over three months prior to the survey.

Chad

OURE CASSONI REFUGEE CAMP AND CARIARI SETTLEMENT

Exhaustive surveys were conducted by AAH–US/IRC in May 2005. 2,948 and 380 children between 6–59 months were measured in Oure Cassoni and Cariari, respectively.

AM NABAK REFUGEE CAMP

The survey was conducted by AAH–US in April 2005. A two–stage cluster sampling methodology of 30 x 30 was used to measure approximately 958 children. The survey also estimated retrospective mortality over the previous 3 months.

Southern Africa

Angola

KUITO MUNICIPALITY, BIEH PROVINCE

The survey was conducted by MOH/joint in December 2004. A two–stage cluster sampling methodology of 30 clusters was used to measure 627 children between 6–59 months. Anthropometric measurements were also performed among 119 non pregnant women (15–49 years old). Measurement of haemoglobin was performed using a portable Hemocue Photometer. The survey also estimated retrospective mortality over the previous three and a half months.

Zambia

NANGWESHI REFUGEE CAMP

The survey was conducted by ICH/joint in July 2004. For the anthropometric survey, a systematic random sampling was used to measure 326 children aged 6–59 months, children between 6–59 months old). For the comparison of micro–nutrient deficiencies with the baseline survey conducted in 2003, the same households as in 2003 were surveyed. Measurement of haemoglobin was performed directly in the household using a portable photometer 'Hemocue B–hemoglobin' Photometer. Peripheral blood collection was collected from a finger prick made using a safety lancet (Hemocue). Vitamin A status was assessed by the measurement of serum retinol in finger–stick blood samples. Analysis was performed using High Performance Liquid Chromatography (HPLC). It is well known that vitamin A status can be affected by the presence of infection. This can lead to levels appearing to be lower than otherwise and can result in people with marginal status being falsely classified as deficient. To allow correction for this effect serum samples were analyzed for the presence of elevated levels of C–reactive protein (CRP) using a test involving antibody binding (ELISA).

Western Saharawi refugees in Algeria

The survey was conducted by INRAN/joint in February 2005. A cluster sampling methodology of 30 clusters was used to measure 793 children between 6–59 months. Measurement of haemoglobin was performed using a portable Hemocue Photometer. The survey also estimated various indicators of food security and public health.

Asia

Afghanistan

NATION WIDE

The survey was conducted by MOH/UNICEF/joint in June–July 2004. A cluster sampling methodology of 32 clusters was used to measure 971 children between 6–59 months. Measurement of haemoglobin was performed using a portable Hemocue Photometer. The survey also estimated various indicators of food

security and public health.

Nepal

BHUTANESE REFUGEE CAMPS IN NEPAL

The survey was conducted by AMDA/UNHCR in July 2005. A systematic sampling methodology was used to measure 626 children between 6–59 months. The survey also estimated vitamin A distribution and measles vaccination coverage and the presence of angular stomatitis.

Abbreviations and acronyms

AAH–US	Action Against Hunger USA
ACF–F	Action Contre la Faim France
ACT	Action by Churches Together
AFP	Agence France Presse
BAAG	British Agencies Afghanistan Group
BMI	Body Mass Index
CMR	Crude Mortality Rate
< 5 MR	Under–five Mortality Rate
FEWS	Famine Early Warning System
FSAU	Food Security Analysis Unit for Somalia
HKI	Helen Keller International
HPG	Humanitarian Policy Group
ICH	Institute of Child Health
IRIN	International Regional Information Network
MOH	Ministry of Health
MSF	Médecins Sans Frontières
MSF–CH	Médecins sans Frontières. Switzerland
NCA	Norwegian Church Aid
RI	Refugees International
SC–UK	Save the Children–United Kingdom
SC–US	Save the Children–United States
SMH	State Ministry of Health
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNHCR	United Nations High Commission on Refugees
UNICEF	United Nations International Children's Emergency Fund
UNMIL	United Nations Mission in Liberia
UNRC	United Nations Resident Coordinator

UNSC	United Nations Security Council
WFP	World Food Programme
WHO	World Health Organization

Indicators and risk categories

The methodology and analysis of nutrition and mortality surveys are checked for compliance with internationally agreed standards (SMART, 2002; MSF, 2002; ACT, 2002).

Most of the surveys included in the Reports on Nutrition Information in Crisis Situations are random sampled surveys, which are representative of the population of the targeted area. The Reports may also include results of rapid nutrition assessments, which are not representative of the target population but rather give a rough idea of the nutrition situation. In that case, the limitations of this type of assessments are mentioned. Most of the nutrition survey results included in the Reports target children between 6–59 months but may also include information on other age groups, if available.

Detailed information on the methodology of the surveys which have been reported on in each issue, is to be found at the end of the publication.

Nutrition indicators in 6–59 month olds

Unless specified, the Reports on Nutrition Information in Crisis Situations use the following internationally agreed criteria:

- WASTING, defined as weigh–for–height index (w–h) < –2 Z–scores.
- SEVERE WASTING, defined as weigh–for–height index < –3 Z–scores.
- OEDEMATOUS MALNUTRITION OR KWASHIORKOR, diagnosed as bilateral pitting oedema, usually on the upper surface of the feet. Oedematous malnutrition is always considered as severe malnutrition.
- ACUTE MALNUTRITION, defined as the prevalence of wasting (w–h < –2 Z–scores) and/or oedema
- SEVERE ACUTE MALNUTRITION, defined as the prevalence of severe wasting (w–h < –3 Z–scores) and/or oedema.
- STUNTING is usually not reported, but when it is, these definitions are used: stunting is defined as < – 2 Zscores height–for–age, severe stunting is defined < – 3 Zscores height–for–age.
- MID–UPPER–ARM CIRCUMFERENCE (MUAC) is sometimes used to quickly assess nutrition situations. As there is no international agreement on MUAC cut–offs, the results are reported according to the cut–offs used in the survey.
- MICRO–NUTRIENT DEFICIENCIES Micro–nutrient deficiencies are reported when data are available.

Nutrition indicators in adults

No international consensus on a definitive method or cut–off to assess adult under–nutrition has been reached (SCN, 2000). Different indicators, such as Body Mass Index (BMI, weight/height²), MUAC and oedema, as well as different cut–offs are used. When reporting on adult malnutrition, the Reports always mention indicators and cut–offs used by the agency providing the survey.

Mortality rates

In emergency situations, crude mortality rates and under–five mortality rates are usually expressed as number of deaths/10,000 people/day.

Interpretation of indicators

Prevalence of malnutrition and mortality rates are late indicators of a crisis. Low levels of malnutrition or mortality will not indicate if there is an impending crisis. Contextual analysis of health, hygiene, water availability, food security, and access to the populations, is key to interpret prevalence of malnutrition and mortality rates.

Thresholds have been proposed to guide interpretation of anthropometric and mortality results. A prevalence of acute malnutrition between 5–8% indicates a worrying nutritional situation, and a prevalence greater than 10% corresponds to a serious nutrition situation (SCN, 1995). The Crude Mortality Rate and under-five mortality rate trigger levels for alert are set at 1/10,000/day and 2/10,000/day respectively. CMR and under-five mortality levels of 2/10,000/day and 4/10,000/day respectively indicate a severe situation (SCN, 1995).

Those thresholds have to be used with caution and in relation to contextual analysis. Trend analysis is also recommended to follow a situation: if nutrition and/or mortality indicators are deteriorating over time, even if not above threshold, this indicates a worsening situation.

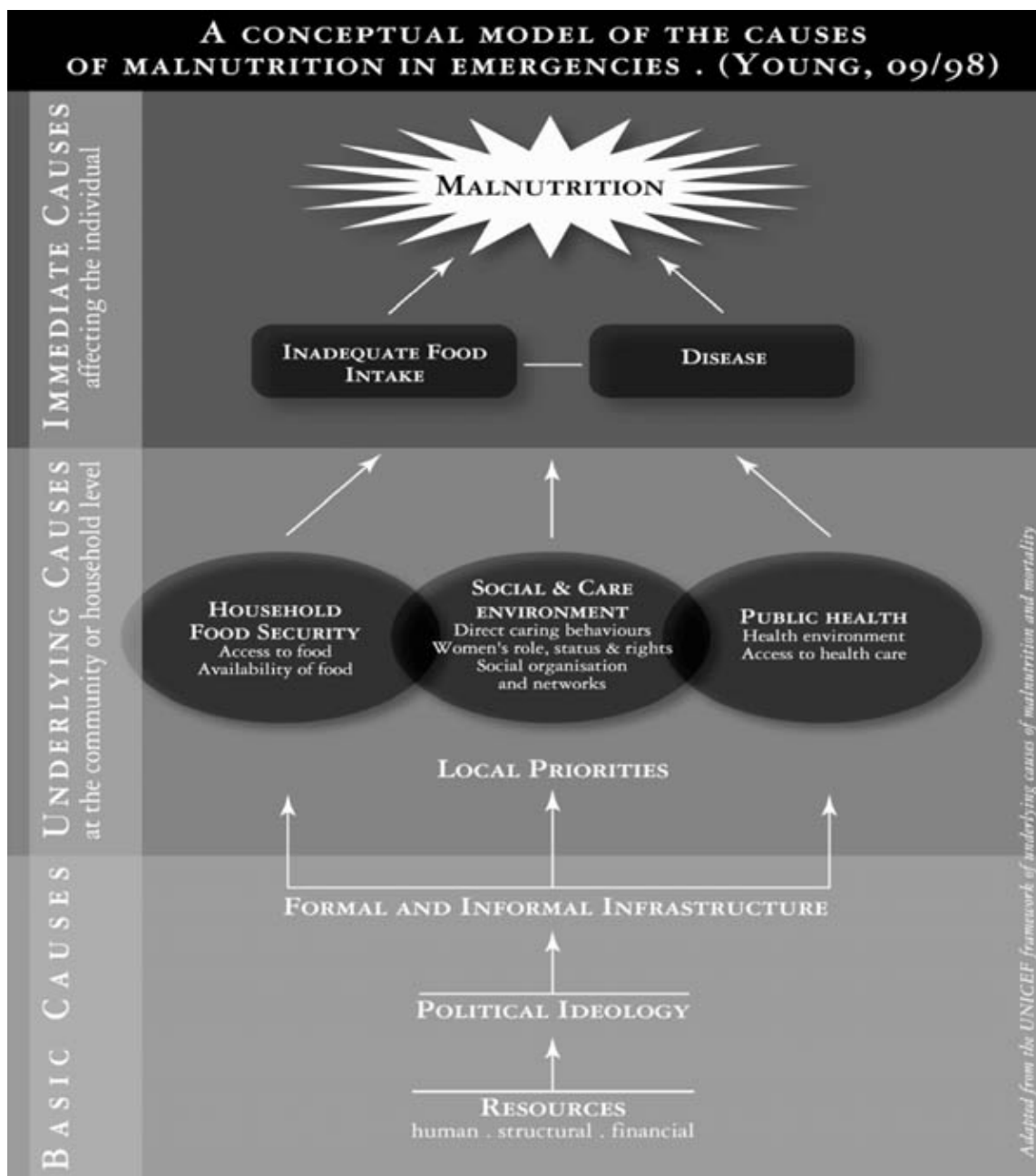
Classification of situations

In the Reports, situations are classed into five categories relating to risk and/or prevalence of malnutrition. The prevalence/risk is indirectly affected by both the underlying causes of malnutrition, relating to food, health and care, and the constraints limiting humanitarian response. These categories are summations of the causes of malnutrition and the humanitarian response:

- Populations in *category I* – the population is currently in a critical situation; they either have a *very high risk* of malnutrition or surveys have reported a very high prevalence of malnutrition and/or elevated mortality rates.
- Populations in *category II* are currently at *high risk* of becoming malnourished or have a high prevalence of malnutrition.
- Populations in *category III* are at *moderate risk* of malnutrition or have a moderately high prevalence of malnutrition; there maybe pockets of high malnutrition in a given area.
- Populations in *category IV* are *not* at an elevated nutritional risk.
- The risk of malnutrition among populations in *category V* is *not known*.

Nutrition causal analysis

The Reports on Nutrition Information in Crisis Situations have a strong public nutrition focus, which assumes that nutritional status is a result of a variety of inter-related physiological, socio-economic and public health factors (see figure). As far as possible, nutrition situations are interpreted in line with potential underlying determinants of malnutrition.



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NICS quarterly reports

The UN Standing Committee on Nutrition, which is the focal point for harmonizing nutrition policies in the UN system, issues these Reports on Nutrition Information in Crisis Situations with the intention of raising awareness and facilitating action. The Reports are designed to provide information over time on key outcome indicators from emergency-affected populations, play an advocacy role in bringing the plight of emergency-affected populations to the attention of donors and humanitarian agencies, and to identify recurrent problems in international response capacity. The Reports on Nutrition Information in Crisis Situations are aimed to cover populations affected by a crisis, such as refugees, internally displaced populations and resident populations.

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. Based on suggestions made by the working group and the results of a survey of the readers, the Reports on Nutrition Information in Crisis Situations are published every three months.

Information is obtained from a wide range of collaborating agencies, both UN and NGOs. The Reports on Nutrition Information in Crisis Situations are put together primarily from agency technical reports on nutrition, mortality rates, health and food security. The Reports provide a brief summary on the background of a given situation, including who is involved, and what the general situation is. This is followed by details of the humanitarian situation, with a focus on public nutrition and mortality rates. The key point of the Reports is to interpret anthropometric data and to judge the various risks and threats to nutrition in both the long and short term.

Back Cover

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

This report was compiled by Dr Claudine Prudhon of the UNS/SCN Secretariat
Sarah Philpot assisted in the editing.
Design concept: Marie Arnaud Snakkers

The chairman of the UNS/SCN is Catherine Bertini

The SCN Secretariat and the NICS Coordinator extend most sincere thanks to all those individuals and agencies who have provided information and time for this issue, and hope to continue to develop the excellent collaboration which has been forged over the years.

If you have information to contribute to forthcoming reports, or would like to request back issues of the report, please contact:

Claudine Prudhon, NICS Coordinator,
UNS/Standing Committee on Nutrition
20, avenue Appia, 1211 Geneva 27, SWITZERLAND
Tel: +(41-22)791.04.56, Fax: +(41-22)798.88.91,
Email: scn@who.int
Web: <http://www.unsystem.org/scn>

Funding support is gratefully acknowledged from the Canadian International Development Agency, the Department of Foreign Affairs, Ireland, the Royal Ministry of Foreign Affairs, Norway and UNHCR. This report was also made possible through the support provided to the Food and Nutrition Assistance (FANTA) Project by the Office of Program, Policy and Management at the Bureau for Democracy, Conflict and Humanitarian Assistance and the Office of Health, Infectious Diseases and Nutrition at the Bureau for Global Health at the U.S. Agency for International Development, under the terms of Cooperative Agreement No. HRN-A-00-98-00046-00 awarded to the Academy for Educational Development (AED). The opinions

expressed herein are those of the authors and do not necessarily reflect the views of the US Agency for International Development.

ISSN 1564-376X

