Refugee Nutrition Information System (RNIS), No. 13 – Report on the Nutrition Situation of Refugee and Displaced Populations

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ACC/SCN

UNITED NATIONS ADMINISTRATIVE COMMITTEE ON COORDINATION SUB–COMMITTEE ON NUTRITION

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HIGHLIGHTS

Overall, *the total estimated numbers of refugees and displaced people and the proportion of these at high nutritional risk* (*categories I and IIa in Table 1*) *in Africa declined during the first part of 1995 mainly due to the cessation of hostilities in Angola and revised estimates for Southern Sudan. The numbers appear to be increasing slightly in the second half of the year* (*see Figure 2*). *The estimated number of internally displaced people in Burundi has risen and more people are receiving food aid in Mozambique. The recent increase in nutritional risk is largely due to the appearance of kwashiorkor in some camps in Tanzania, pellagra among those in Mozambique, and deterioration in Somali.*

Angola *A number of surveys show that the nutritional situation is continuing to improve slowly. This is mainly due to the enduring peace across most of the country which is allowing relief programme access to greater numbers of people. However, there is also evidence of residual nutritional vulnerability amongst populations still inaccessible due to insecurity many of whom are simultaneously experiencing the pre–harvest "hungry season".*

Burundi/Rwanda Region *The nutritional situation for many of the three million people affected by civil conflict in the region appears to be stable. Surveys indicate a low prevalence of wasting in the majority of the refugee camps in Goma, Zaire and the Karagwe region of Tanzania. However, widespread insecurity in Burundi and resulting displacement are placing increasing numbers at risk especially where these internally displaced are cut–off from relief provision. Many are crossing the border into the Uvira camps in Zaire. The nutritional situation in several of these camps has been erratic in recent weeks with several camps reporting unusual levels of oedema, an indicator of kwashiorkor which carries a high mortality risk. A number of factors may be responsible, including poor health service provision leading to high levels of morbidity, and a poor diet.*

Liberia Region *As peace continues to hold in Liberia, greater numbers of people are receiving emergency relief support. Surveys are showing that this is having a markedly positive effect on nutrition* (*e.g. as marked by the prevalence of wasting*). *However, the expanded relief programme appears to placing some strain upon scarce international relief resources in the region. The situation in Sierra Leone is far less promising as*

periodic upsurges in the civil conflict continue to render large sections of the population, particularly in the south and west of the country, inaccessible to relief agencies. In recent weeks prevalence of wasting has been at levels indicating a serious situation (almost 20%) in and around a number of urban centres including Bo and Segbwema. The situation seems to have improved quickly when general rations have been delivered to the affected population as in Kenema where levels of wasting dropped from 23% to 1.8%. Recent reports of Ebola fever outbreak in Cote d'Ivoire cannot be evaluated as of 12 December.

Mozambique *A combination of targeted relief programmes and a variable harvest throughout the country appear to be maintaining a stable nutritional situation. However, there is still concern about those areas where harvests have been poor and which have received large numbers of refugee returnees in recent months. For example, reports from the district of Mutarara, whose population has increased by 400% over the past two years, indicate an outbreak of pellagra throughout the past four months. It is not clear whether such outbreaks are isolated events or are symptomatic of a more wide–spread problem in other areas.*

Somalia *Although there are favourable harvest prospects in eight of the major crop producing areas, a combination of insecurity and economic factors continues to place large numbers of people at nutritional risk. The most vulnerable populations appear to be those in large urban centres such as Mogadishu, Kismayo and Baidoa. Recent refugee returnees are likely to be especially vulnerable. Anticipated poor crop yields in Juba valley and Bay region will also place populations in those areas, including Kismayo town, at increased nutritional risk.*

Sudan *The situation in southern Sudan appears to be deteriorating once again as the effects of constraints on Operation Lifeline Sudan (OLS), poor harvests in many areas, and continued insecurity begin to be felt. It has recently been estimated that the entire crop in the southern states will supply less than half of consumption needs for the population rendering many increasingly dependant upon OLS. The effect of any disruption to relief provision is already being demonstrated by surveys. For example, in Labone camp for the displaced, where general rations were stopped for three months due to insecurity, prevalence of wasting in children under five has recently been reported at over 20%.*

Nepal *Low levels of micronutrient deficiencies, including beri–beri, scurvy and angular stomatitis, continue to be reported amongst the Bhutanese refugee population in spite of the provision of vegetables and CSB in the general ration. There was recently a marked increase in incidence of beri–beri which has subsequently decreased. There is a need to review the factors that may affect the nature of household vulnerability to these nutritional deficiency diseases.*

ADEQUACY OF FACTORS AFFECTING NUTRITION

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

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

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

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

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

**** Rations may be inadequate due to inaccessibility.*

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

INTRODUCTION

The UN ACC/SCN[1] (Sub–Committee on Nutrition), which is the focal point for harmonizing policies in nutrition in the UN system, issues these reports on the nutrition of refugees and displaced people normally every two months. Distributing this information is intended to raise awareness and facilitate action to improve the situation. This system was started on the recommendation of the SCN's working group on Nutrition of Refugees and Displaced People, by the SCN in February 1993. This is the thirteenth of a regular series of reports.

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

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

The tables, figures and maps at the end of the report can provide a quick overview. Map A shows the location of the situations described and the shaded areas are those in a critical situation. Table 1 gives an estimate of the probable total refugee/displaced/returnee population, broken down by numbers at risk. Populations in category I in Table 1 are currently in a *critical situation,* based on nutritional survey data. These populations have one or more indicators showing a serious problem. Populations *at high risk* (category Ha in Table 1) of experiencing nutritional health crises are generally identified either on the basis of indicators where these are approaching crisis levels and/or also on more subjective or anecdotal information often where security and logistical circumstances prevent rigorous data collection. Populations *at moderate risk* (category IIb in Table 1) are potentially vulnerable, for example based on security and logistical circumstances, total dependency on food aid, etc. Populations in category IIc are not known to be at particular risk. No information is currently available on populations in category III.

In Table 2, refugee and displaced populations are classified by country of origin and country of asylum. Major

population groups in Africa (i.e. over 100,000 people affected from the country of origin) are included. Internally displaced populations are identified along the diagonal line.

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

INDICATORS

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

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

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

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

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

References

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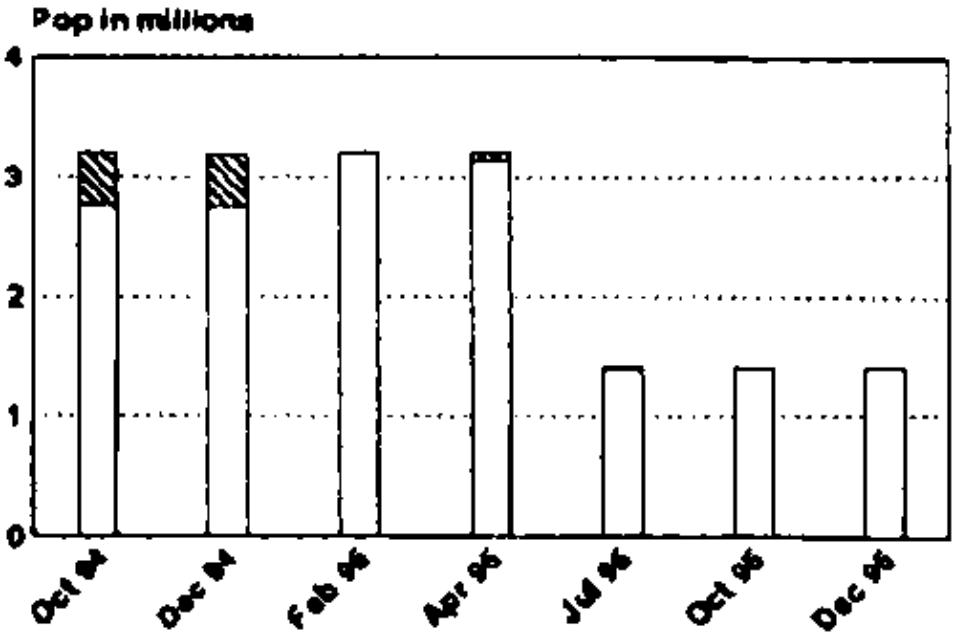
Sub–Saharan Africa

1. Angola

(see Map 1 and Figure 3)



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

The overall security situation in Angola remains calm and the first practical steps towards registering UNITA fighters in Angola's demobilisation and reintegration programme are underway [WHO 15/11/95]. Emergency assistance is still being provided to approximately 1.4 million internally displaced people, returnees and/or war–affected people and agreement has recently been reached with donors to provide for the food needs of an average of one million people each month from March 1996 until March 1997. It is anticipated that this food will assist the transition from widespread emergency food assistance to more targeted developmental reconstruction and rehabilitation activities [WFP 20/10/93, 3/11/95, 17/11/95].

The relative calm in Angola is allowing increased deliveries of food aid by road thereby reducing the overall cost of transport. Only 22% of transport was by air in the first week of November. As the country is entering the pre–harvest hungry season it is important that current food delivery schedules be maintained. There are some areas where relief deliveries remain problematic. In certain cases this is due to logistical difficulties such as poor runways in Caconda in Huila province, while in other areas, for example in Cabir in northern Huila province, insecurity is preventing access. Nevertheless, population access is generally improving with the needs of formerly inaccessible towns and cities being increasingly met [WFP 20/10/93, 3/11/95, 17/11/95].

The nutritional situation appears to be adequate in areas where relief supplies are being maintained. For example, a recent survey in Malange measured wasting and/or oedema at 1.8% with severe wasting and/or oedema at 0.2% (see Annex 1 (1a)). These low levels of wasting in Malange have now been maintained for the last year and appear to reflect high levels of access to safe farm land and sources of income which supplement the general ration. Less than three percent of children surveyed were consuming an inadequate diet. Nevertheless, the population is still believed to be dependant on the existing level of general ration provision. It is feared that any decrease in the food supply could lead to an increase in mine accidents as people might be forced to farm unsafe areas [CONCERN 17/10/95, WHO 15/11/95].

Another example of improved nutritional status is in Cafunfo, Luanda Norte Province. In April 1995, when the area first became accessible, levels of wasting were as high as 20% (see RNIS #11). Emergency general ration provision and therapeutic feeding were immediately implemented. A follow up survey in July 1995 showed only 2.8% wasting with 0.6% severe wasting (see Annex 1 (1b)). No cases of oedema were seen and measles immunisation coverage was recorded at 72.7%. This marked improvement is believed to reflect a combination of factors including, previous mortality of children under five years old, food relief, renewal of the diamond business and improved supplies of food by traders [AICF 11/07/95].

However, in areas that are newly accessible or where access is difficult, malnutrition is often still a serious problem. In Matala for instance, wasting and/or oedema were measured at 15.4% with 6.7% severe wasting and/or oedema among the displaced and resident population (see Annex 1 (1c)). Only the former are currently receiving food aid [WFP 10/11/95]. Preliminary results from a recent survey in Galungo Alto showed 20.4% wasting and/or oedema and 12% severe wasting and/or oedema (see Annex 1 (1d)). It was noted that road access has been difficult since the onset of the rains [WV Oct 95].

WFP are facing funding shortages for their light aircraft which are essential for transporting personnel to areas that remain inaccessible by road in both government and UNITA held areas. A rupture in the food pipeline is creating expectations of a shortage of oil in the food basket during November and December [WFP 3/11/95].

Overall, the majority of the 1.4 million people dependant on food aid in Angola could be considered to be at moderate nutritional risk (category IIb in Table 1). The pre−harvest “hungry” season may exacerbate vulnerability amongst particular groups, e.g. those inaccessible to relief supplies or not in receipt of any general ration support.

How could external agencies help? Priorities include increased funding for aircraft transportation in Angola and ensuring adequate pledges to address the current vegetable oil shortage in the general ration pipeline. Nutritional surveys in newly accessible areas are important, with contingency resources held over in order to be able to respond to identified needs. There may also be a need to provide general rations to resident populations where these are hosting large numbers of displaced as in Matala town.

2. Benin/Ghana/Togo Region

There are currently approximately 124,000 refugees in Benin and Ghana. Most of this population arrived from Togo in January 1993 and now that the situation which led to the refugee crisis has apparently stabilised, repatriation has begun and will continue into 1996.

Benin There is reportedly no change in the adequate nutritional status of the 28,000 Togolese refugees remaining in Benin. Repatriation of these refugees has begun [UNHCR−a 17/11/95, WFP 05/12/95].

Ghana There are approximately 82,000 assisted Togolese refugees remaining in Ghana. The reduction from 98,000 reported in the previous RNIS is due to some spontaneous repatriation, and a recent verification exercise of existing ration cards. The nutritional situation of this population is reported to be adequate and repatriation is also planned during 1996 for these refugees [UNHCR 21/11/95, WFP 05/12/95].

There are 14,000 assisted Liberian refugees in Ghana whose nutritional status reportedly remains stable. There are currently no plans for repatriation of these refugees [UNHCR 21/11/95].

Overall, the approximately 124,000 refugees in this region are not currently considered to be at heightened nutritional risk (category IIc in Table 1).

3. Burkina Faso and Mauritania − Touareg Refugees

(see Map 3)

There are approximately 68,000 assisted Touareg refugees in Burkina Faso and Mauritania. Numbers have declined recently with the spontaneous repatriation of approximately 5,000 refugees from Mauritania.

Burkina Faso There is no change reported in the generally adequate nutritional situation of approximately 33,000 Touareg refugees from Mali and Niger.

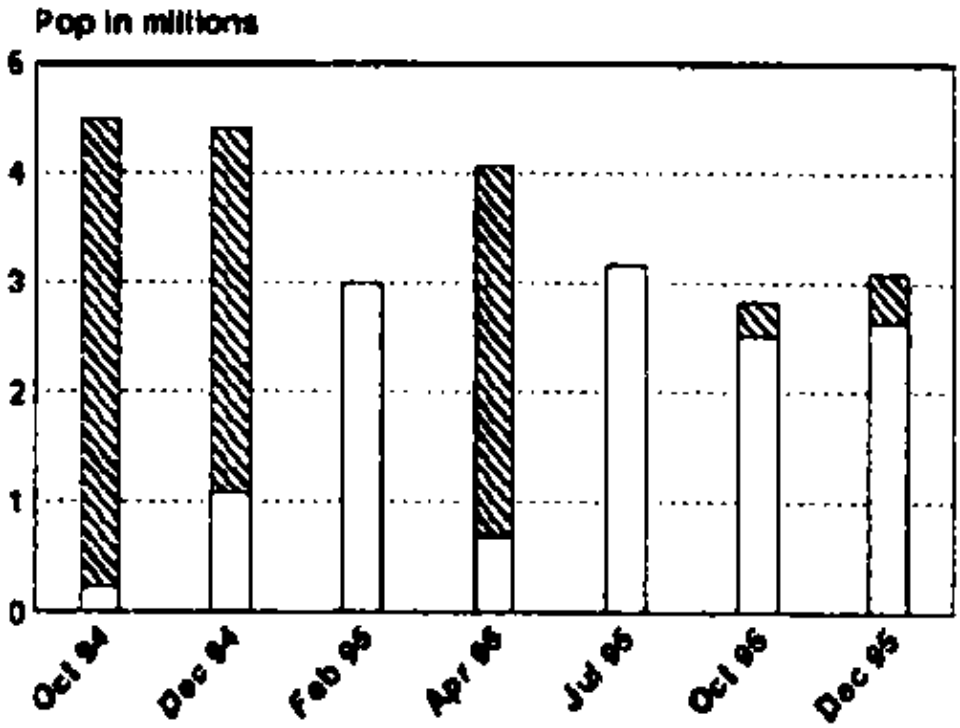
Mauritania There are approximately 35,000 Touareg refugees from Mali in Mauritania. The recent spontaneous repatriation of 5,000 refugees will allow for the closure of one of the three camps. Organised repatriation is now being planned, and it is hoped that a pilot repatriation of about 150 people will take place before the end of 1995. Large scale repatriation will hopefully be completed in 1996 [UNHCR 21/11/95].

There has been no update on the nutritional condition of this population since a survey conducted over five months ago found levels of wasting in excess of 17% and crude mortality rates of 6 times normal. This situation was largely attributed to poor general ration supplies and high rates of diarrhoea. However, as an improved general ration of 1900 kcals/person/day has been delivered for at least the three previous months, it can probably be inferred that the nutritional condition of this population has improved [UNHCR 21/11/95].

Overall, the Touareg refugees in Burkina Faso and Mauritania are probably not at heightened nutritional risk (category IIc in Table 1).

4. Burundi/Rwanda Situation

(See Map 4 and Figure 3)



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

The nutritional situation for approximately three million people affected in the region remains generally adequate with low levels of wasting reported in most surveys carried out in recent months. However, the security situation in Burundi is reportedly deteriorating and causing displacement of people, may of whom are inaccessible to relief. The high level of insecurity is said to be affecting planting for the next rice crop. There are also health problems in a number of refugee camps in Uvira some of which are still showing elevated levels of wasting. Levels of oedema appear high in several camps. Repatriation from Tanzania and Zaire is continuing although there has been confusion over the Zairian government announcement that all refugees must be repatriated before the end of the year.

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

	Oct 94	Dec 94	Feb 95	Apr 95	Jul 95	Oct 95	Dec 95

Burundi	770,000	1,200,000	740,000	492,500	515,000	315,000	504,000
Rwanda	2,500,000	2,500,000	335,000	1,750,000	800,000	725,000	800,000
Tanzania	556,000	556,000	630,000	686,000	644,000	629,000	621,000
Zaire	1,240,000	1,240,000	1,290,000	1,130,900	1,202,200	1,158,000	1,146,000
Uganda	10,000	10,000	5,000	5,000	6,700	6,400	6,400
TOTAL	5,076,000	5,076,000	3,000,000	4,064,400	3,167,900	2,831,400	3,077,400

Burundi High levels of insecurity persist in parts of Burundi with continuous clashes between the military and rebels reported. Most incidents have been reported in the northern and western provinces and have led to substantial displacement. The worst incident recently reported involved over 250 deaths in Tangara near Ngozi. The violence is also having a considerable impact on the existing internally displaced population many of whom are being forced to relocate and as a result have no access to food or shelter. There are anecdotal reports of high levels of malnutrition in the area. A further consequence of the insecurity has been the constraint on October planting of rice in areas like Bubanza which is one of the main rice growing areas of the country producing up to 30% of the national crop [WFP 13/10/95 –08/12/95].

The level of violence has affected relief activities and only recently, following the death of an aid worker near Cibitoke, a decision has been taken to temporarily suspend all humanitarian activities in Cibitoke and Bubanza. Nevertheless, security permitting, agencies continue to provide relief items to recently displaced populations on receipt of requests for assistance from local authorities. For example, at the end of October one off distributions of food were made to 6,300 displaced families in rural Bujumbura and a further 3,000 beneficiaries in Karuzi in Central Provinces. It is difficult to determine the number of internally displaced in Burundi due to the continuous process of displacement and the lack of access to problem areas. However, current food stocks appear to be adequate to feed up to 504,000 beneficiaries of whom 214,000 are Rwandan refugees [WFP 13/10/95 – 17/11/95].

A small number of Rwandan refugees continue to return home with the total repatriating during 1995 having reached 20,639. At the same time new refugee waves are being created in areas like Cibitoke where populations are fleeing to Uvira in Zaire. In the last week of October an estimated 2,520 people left for Uvira [WFP 13/10/95 –17/11/95].

Recent information from three camps for Rwandan refugees shows a generally adequate nutritional situation. In *Magara* camp wasting and/or oedema was measured at 2.6% with 0.4% severe wasting and/or oedema. Wasting and/or oedema was also low in *Ruvumu* camp at 3.6% and in *Kibezi,* wasting and/or oedema was measured at 3.5% (see Annex 1 (4a–c)) [AICF Oct 95].

The recently reported cholera outbreak(see RNIS #12) is affecting rural Bujumbura, Bururi and Bubanza. [WHO 7/12//95]. The condition may also be occurring in some inaccessible areas.

Rwanda Security incidents involving clashes between the Former Rwandan Government Forces (FRGF) and RPA continue to be reported inside Rwanda. There have also been numerous land–mine explosions – particularly in western areas bordering Zaire. There are constant reports of sabotage related incursions by FRGF rebels from the Zairian camps into Rwanda. Judicial processes for those participating in the genocide are expected to start in the near future [WFP 27/10/95 – 17/11/95].

Repatriation from Zairian, Tanzanian and Burundi refugee camps is continuing with over 11,000 returnees reported during October. Over 200,000 refugees have now repatriated between January and September 1995. WFP and UNHCR have recently agreed to distribute an initial two–month food ration to all returnees in way stations and transit centres, instead of the previous one month ration, in order to provide additional time for the planning of follow–up distributions once the returnees have reached their final destination. Food aid is also distributed though food for work and income generating activities (68% of food distributed), targeted feeding (8% of food distributed) and institutional feeding (14% of food distributed) [WFP 27/10/95 – 17/11/95].

Despite the partial recovery in food security inside Rwanda due to the August 1995 harvest, as many as 800,000 people may still be vulnerable to food shortages as the prospects for the January harvest remain poor. These vulnerable families are mainly female headed households, returnees without land and remaining refugees and internally displaced groups [FAO Oct 95].

A recent nutritional survey conducted in Kigali showed an adequate nutritional situation. Wasting was measured at 5% and severe wasting was 0.6% in children. Oedema was measured at 0.3% (see Annex 1 (4d)). Measles immunisation coverage was 98% and the under−five mortality rate was 0.17/10,000/day (below normal). Adult wasting was measured at 10.7% with severe wasting at 0.5% (see Annex 1 (4e)). The crude mortality rate was very low at 0.09/10,000/day [AICF Sep 95].

Tanzania Current estimates are that there are 621,000 Burundi and Rwandan refugees in Tanzania. Small scale repatriation has been taking place and approximately 28,000 refugees from Rukira commune in Benaco camp have expressed their willingness to return to Rwanda as a group. However, due to the deteriorating security situation in Burundi, contingency plans are also being made for a possible influx of refugees from Burundi into Tanzania [WFP 17/11/95, 08/12/95].

The nutrition situation in the **N'Gara** camps seem to show a pattern of low levels of wasting and elevated levels of oedema. For example, a recent nutrition survey carried out in *Musuhura Hill* camp (estimated population 77,000) showed 3.5% wasting with 0.2% severe wasting. Oedema was measured in 1.7% of children under five (see Annex 1 (4f)). These results show no statistically significant change in prevalence of wasting since a survey carried out in July 1995. Such low levels of wasting have been maintained despite the inadequate general ration receipts recorded in August and September of 1,570 and 1,440 kcal/person/day respectively. General ration deliveries reportedly improved during October. The survey also found that coverage of the therapeutic feeding programmes has improved from 22.4% in July to 49% in November and that measles vaccination coverage was 87% [MSF−H 04/11/95].

A survey in *Benaco* camp showed 4.3% wasting with 0.2% severe wasting. Oedema was measured at 1.6% (see Annex 1 (4g)). Measles immunisation coverage was 82.6%. The crude mortality rate was 0.56/10,000/day and the under−five mortality rate was 1.61/10,000/day. Both of these rates are slightly above normal [AICF 23/09/95].

In *Kitali* camp, a recent survey showed wasting at 5.2% with 0.4% severe wasting. Oedema was measured at 2.1% (see Annex 1 (4h)). The ration has varied between 1400−1900 kcals/person/day. Feeding centre coverage was only estimated to be 26.9%. It was noted that there are approximately 1,000 new arrivals how have not been registered and therefore have no access to food distributions or medical services [AICF 01/10/95].

Recent reports from the camps in the **Karagwe** district show a generally satisfactory nutritional situation although mortality rates are slightly elevated in some camps. A nutritional survey in *Omukariro* (estimated population 8,600) showed 1.02% wasting with no severe wasting (see Annex 1 (4i)). The crude mortality rate was 0.15/10,000/day, and the under−five mortality rate was 0.37/10,000/day. These are both below normal levels. The distributed ration provided 1700 kcals/person/day [MSF−CH 14/10/95, MSF−CH Oct 95].

In *Kagenyi* camp (estimated population 16,000) the crude mortality rate was 0.81/10,000/day (about twice a normal level) and the under−five mortality rate was 1.92/10,000/day. The ration provided 1500 kcals/person/day. In *Ruberwa* camp (estimated population 26,000) the crude mortality rate was 0.55/10,000/day and the under−five mortality rate was 2.12/10,000/day (about twice normal). The ration provided 1600 kcals/person/day [MSF−CH Oct 94].

Goma, Zaire Continued small scale repatriation and a registration/verification exercise have reduced the estimated number of refugees in the Goma camps from 707,758 at the start of September to 695,750 by mid−November. The speed of repatriation has to some extent been influenced by conflicting messages from the Zairian government regarding the deadline of the 31st of December for all refugees to return to Rwanda. It now appears that this deadline will not be altered. A recent assessment in *Kahindo* camp found that about 80% of the adult male returnees are elderly while the remaining are young uneducated men returning to rural areas. Many of the women repatriating are heads of households or are leaving their husbands behind [WFP 3/11/95−05/12/95].

Recent surveys indicate a generally stable nutritional situation in the camps. This could be the effect of the balance of two opposing factors. On the one hand, improved food deliveries to the area due to the opening of a new access road probably has had a positive effect on the nutritional situation, but on the other hand the ban on refugee economic activity introduced by the Zairian authorities in early October would most likely have had an adverse effect. Levels of wasting varied from 2.1−4.3% in children under five (see Annex 1 (4j−m)). The exception to this is *Kibumba* camp, where wasting was measured at 8.3% including 4.8% severe wasting. Oedema was measured at 1.4% (see Annex 1 (4n)). This is not statistically different from the previous survey, but does show a trend toward deterioration of the nutritional situation [UNHCR 30/11/95]. There has however

been a reported assessment of special feeding programs in the Goma camps with a view to discontinuing the operations and where appropriate integrating the beneficiaries into general food distributions [WFP 3/11/95–27/11/95].

Bukavu The security situation for the approximately 310,000 refugees in Bukavu remains tense due a variety of factors including confiscation of fake ration cards, news of numerous landmine explosion around the Goma camps, and the continuous fear of forced repatriation. Small scale repatriation is occurring, although, as in Goma, rates have been affected by the confused messages concerning the December 31st deadline.

Improved food deliveries to the area has allowed the accumulation of buffer stocks in warehouses and ensured adequate ration provision [WFP 27/10/95]. The nutritional situation is assumed to be stable.

Uvira The situation for the approximately 140,000 refugees in Uvira is described as tense, with reports of robbery and assault on international relief agency property and staff [WFP 20/10/95].

A recent set of surveys reveals a pattern of low levels of wasting, but high levels of oedema. For example, a survey in *Runingo* measured wasting and/or oedema at 7.1%, and oedema was measured at 3.7% (see Annex 1 (4o)). A similar situation was found in *Kajembo* camp where wasting and/or oedema was measured at 7.5% and oedema was 3.6% (see Annex 1 (4p)). These results nonetheless show an improvement since surveys in August in the two camps found prevalence of wasting of 21 % and 12% respectively [UNHCR 30/11/95].

Lack of access to general rations, the existence of cholera and dysentery, and the hungry season have all been identified as factors contributing to these somewhat elevated levels of wasting. More recent anecdotal reports indicate that poor health care, sanitation and water supplies are still causing health problems in some camps which in turn is adversely affecting nutritional status [UNHCR 15/10/95].

Uganda There are approximately 6,400 Rwandan refugees residing in two separate sites in Uganda. The nutritional status of these refugees is reportedly adequate. It is hoped that about 1,000 of these refugees will repatriate in the near future [UNHCR 16/11/95].

Overall, the internally displaced population in Burundi is probably at heightened nutritional risk (category IIa in Table 1) due to limited access to this population by relief agencies, while the refugee population in Burundi is probably not at heightened risk (category IIc in Table 1). The vulnerable population in Rwanda and the refugees in Uganda are probably not currently at heightened nutritional risk (category IIc in Table 1). The refugees in Tanzania can be considered to be at moderate nutritional risk (category IIb in Table 1) due to high levels of oedema and elevated mortality rates. The Rwandan refugees in Goma are probably not currently at heightened nutritional risk (category IIc in Table 2) with the exception of those in Kibumba camp, who are at moderate risk with elevated levels of wasting and oedema (category IIb in Table 1). The refugees in Bukavu, Zaire are also probably at moderate nutritional risk (category IIb in Table 1) due to the enforced curtailment of their economic activities, while some of those in Uvira can be considered to be at high risk due to high levels of oedema (category I in Table 1).

How could external agencies help? There is a general need for increased nutritional monitoring of internally displaced and returnee populations in the region. This is particularly important in parts of Burundi where the displaced may be cut off from relief assistance for long periods due to insecurity, and also in Rwanda where large numbers of returnees may be vulnerable to food insecurity. There is an urgent need to conduct an extensive review of the health situation in the Uvira camps in order to determine how and whether health systems should be strengthened and the impact of health status on nutritional well–being of the population. This is especially important given the continued influx of refugees from Burundi. Agencies need to investigate the factors leading to the existing unusual prevelances of oedema indicating kwashiorkor in certain refugee camps in Goma, N'Gara, and Uvira, with a view to improving preventive measures, presumably including a better diet. There is a need to improve coverage of the selective feeding programmes in Musuhura Hill and Kitali camps in Tanzania. This may be achieved by improving the outreach of the primary health care programme.

5. Central African Republic

Most recent estimates are that there are 13,300 Chadian refugees and 25,500 Sudanese refugees in the CAR. There are no reports of any change in the stable nutritional situation of these refugee populations.

6. Djibouti

(see Map 6)

There are approximately 25,000 Somali refugees in Djibouti whose nutritional status is reportedly adequate. There are currently no plans for repatriation of these refugees [UNHCR 20/11/95].

7. Ethiopia

(see Map 7)

There are approximately 388,000 assisted and a further 35,000 unassisted refugees in Ethiopia (not included in Table 1).

Current estimates are that there are 275,000 assisted Somali refugees in camps in Eastern Ethiopia and a further 35,000 Somali refugees in the Dolo area and in urban centres who are not assisted. The camp population in the East rose sharply (by 90,000 or more) between the end of 1994 and August 1995 due to the renewed outbreak of fighting in north west Somalia. A slow but steady influx has continued during the past two months. This fighting has hindered the prospects for voluntary repatriation and has made it necessary to upgrade care and maintenance activities in the camps [UNHCR–a Sep 95]. There have been no recent reports of nutritional surveys on this population.

There are approximately 60,000 Sudanese refugees in Western Ethiopia. This population has not grown as rapidly as might have been expected given the level of fighting in southern Sudan. Unlike many other refugee situations, where the majority tend to be women and children, the Sudanese refugee settlements in Ethiopia range from this usual gender distribution in Bonga to the largely male settlement of Dimma. The overall objective of this programme is said to be the promotion of partial self–sufficiency in local settlements through increased crop/animal production, education and income generating activities and decreased dependence on external services and supplies [UNHCR–a Sep 95].

Current estimates are that there are 18,000 Djibouti refugees in Ethiopia, mostly in the Afar Region 2 of the country. This population are mainly Afar pastoralists and due to the inaccessibility of the area and scattered nature of the population it has been difficult to conduct any kind of demographic survey. Given that these refugees are unlikely to repatriate in the near future, the overall objective for this caseload is said to be to streamline care and maintenance activities in the critical sectors such as food, health and education, while avoiding the creation of camps [UNHCR–a Sep 95].

There is no new information on the approximately 11,000 displaced in camps around Addis Ababa or on the approximately 24,000 Somali and Kenyan refugees in the south of the country.

A recent funding appeal by the UNHCR for repatriation and reintegration of Ethiopian and Somali refugees and returnees has been made. This appeal states that responses to similar earlier appeals have been extremely poor so that many activities have been curtailed if not stopped altogether. The appeal goes on to warn that if adequate support for the repatriation and reintegration programme fails to materialise then the need for care and maintenance programmes in the refugee camps in Djibouti, Ethiopia, Kenya and Sudan may continue indefinitely [UNHCR–a Sep 95].

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

8. Kenya

(see Map 8)

The total number of assisted refugees in Kenya has decreased over the past two months to just over 186,000 people. This number is comprised mainly of 140,000 Somali refugees, 40,000 Sudanese refugees and 6,000 Ethiopian refugees. There are an additional 51,000 unassisted refugees in Kenya (not included in Table 1) [UNHCR 16/11/95].

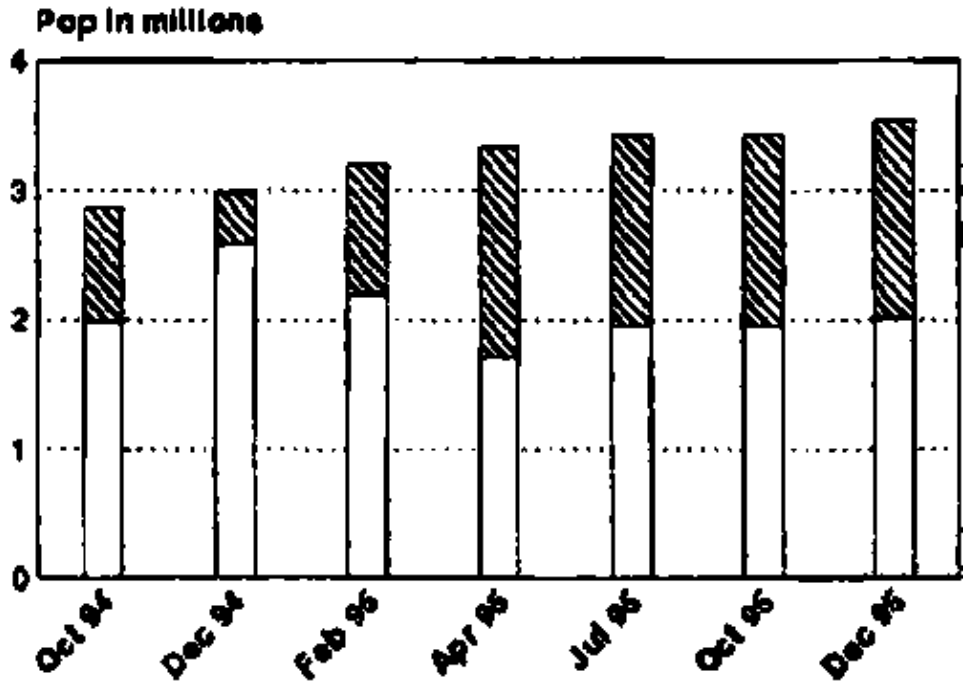
The number of Somali refugees in Kenya continues to decline with a further 8,000 repatriating during October bringing the total population repatriated during 1995 to over 40,000. The reduction in Somali refugee numbers will allow the closure of Marafa camp (coastal camp) in the near future [UNHCR 16/11/95].

The recent reduction in the ration for this population from 2100 kcals/person/day to 1800 kcals/person/day in conjunction with the discontinuation of CSB in the general ration requires careful monitoring for any potential negative impact on nutritional status [UNHCR 16/11/95].

Overall, the refugee population in Kenya is probably not at heightened nutritional risk (category IIc in Table 1).

9. Liberia/Sierra Leone Region

(see Map 9 and Figure 3)



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

The present peace accord appears to be holding in Liberia, despite some skirmishes in the countryside. However, these security incidents mean that many areas remain inaccessible to relief activities. A few recent nutritional surveys indicate low levels of wasting in accessible areas. Intense fighting is continuing in Sierra Leone with only occasional periods of calm. Much of the country is inaccessible and it is reported that levels of malnutrition are particularly high in affected regions (southern and eastern).

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

Location	Oct 94	Dec 94	Feb 95	Apr 95	Jul 95	Oct 95	Dec 95
Liberia	1,692,000	1,615,000	1,800,000	1,900,000	1,900,000	1,900,000	1,900,000

Sierra Leone	300,000	506,000	506,000	500,000	730,000	730,000	730,000
Cote d'Ivoire	325,000	330,000	330,000	330,000	227,000	305,000	305,000
Guinea	534,000	534,000	568,000	603,000	578,000	536,000	605,000
TOTAL	2,851,000	2,985,000	3,204,000	3,333,000	3,435,000	3,471,000	3,540,000

Liberia Despite several reports of skirmishes in Liberia, the faction leaders still appear committed to the peace accords. Unfortunately, delays in pledging for ECOMOG and its deployment in new areas has resulted in the postponement of the disarmament process until December 1995 [WFP 13/10/95, WFP 10/11/95].

Many parts of the country are not yet fully accessible by road due to security concerns. Insecurity has affected some relief programmes. For example, a food convoy in Gbaranga was postponed due to fighting in early October while much needed selective feeding programmes have been adversely affected by lack of access to the Bong area. Nevertheless, assessment missions are continuously being planned and implemented in formerly inaccessible areas. Current estimates are that there are 800,000 affected people in Liberia who are accessible, and a further million inaccessible people in need of humanitarian aid. There are also approximately 100,000 Sierra Leonean refugees in Liberia [WFP 13/10/95, WFP 10/11/95].

The expanded relief requirements that arise from improved access to populations will pose numerous logistical challenges for relief agencies while increased donor efforts will be required for timely delivery of food commodities and cash pledges to cover resettlement and reintegration activities. Currently, delays in pledges/arrivals have meant that WFP Liberia is nearly out of stocks of vegetable oil and pulses and only cereal (bulgur wheat) is available for distribution. However, it is hoped that with the arrival of the harvest season, some areas may no longer require general ration support [WFP 13/10/95, WFP 10/11/95].

Continued fighting in neighbouring Sierra Leone has led to further refugee influxes into Cape Mount and Bomi during October.

Recent nutritional surveys have shown a much improved situation in many parts of the country. Indeed, concern that high rates of wasting may be found in newly accessible areas such as Greenville and surrounding villages has not, in some cases, been borne out by the evidence [WFP 27/10/95].

A survey carried out in Buchanan (estimated population 50,000) showed 8.9% wasting with 1.0% severe wasting. Oedema was seen in 0.3% of the children measured (see Annex 1 (9a)). This prevalence of wasting was comparable to that measured in an earlier survey in January 1995. There was no significant difference found in wasting rates between the resident and displaced population and the majority of families were found to have general ration distribution cards. Crude mortality rates varied from 0.8–3.7/10,000/day (2–10x normal) and the under five mortality rate was 1.4/10,000/day (a normal level). Main causes of death cited were diarrhoea and fever [MSF–F/AICF Jul 95].

Recently an outbreak of yellow fever has been reported in the area, and a massive vaccination campaign is underway. It should be noted that only an estimated 20% of Liberia's pre–war health facilities are currently operating making such primary health care activities extremely difficult [WHO 15/11/95, 27/11/95].

A survey was recently carried out in Lower Bong and Upper Margibi to evaluate the impact of a general ration distribution and targeted feeding programme implemented after a survey in July 1995 showed a critical nutrition situation with 19.1% wasting and 37.1% oedema (see RNIS #12). The more recent survey showed 6.4% wasting and/or oedema and 0.7% severe wasting and/or oedema (see Annex 1 (9b)). This is a remarkable improvement and is largely attributed to the general ration of 1800 kcals/person/day which has been reaching an estimated 96.5% of the population since July. However, coverage of the targeted feeding programme has been far less effective with only an estimated 20% of malnourished children attending the supplementary feeding facilities. Measles vaccination coverage was also low at 43.6% with communities off the main road particularly badly served [MSF–H 21/10/95].

Sierra Leone Recent reports on the security situation in Sierra Leone indicate that while the northern and eastern regions remain relatively calm, there has been an upsurge in rebel activities in the southern region. As a result, villages in the Bo and Moyamba districts have suffered devastation. These attacks have reportedly precipitated influxes into Bo at an average of 100 displaced persons a day since mid–October. WFP operations in the entire country are reportedly being adversely affected by problems of poor control over registration and insecurity at WFP stores. It is currently estimated that 730,000 people are affected in the country.

Over the past few months the nutritional situation has been alarming amongst the displaced populations in Kenema, Segbwema, Dam and Bonthe Island with rates of wasting and/or oedema as high as 27%. Even higher levels of wasting are feared in the districts of Kailahun and Pujehun which are under RUF control and therefore still inaccessible to relief assistance.

However, preliminary results from a more recent survey in Kenema showed a much improved situation over that seen in an August 1995 survey. At that time, wasting levels were measured at 23–37%. In this follow–up survey, wasting and/or oedema in Kenema town were measured at 1.8% with 0.5% severe wasting and/or oedema. In RTI camp for the displaced, wasting and/or oedema were measured at 5.6% with 0.9% severe wasting and/or oedema (see Annex 1 (9c–d)) [MSF–H 27/11/95]. These much improved levels of wasting are almost certainly attributable to recent general ration distributions to this population.

A survey in Bo (estimated population of residents and displaced 250,000) showed 19.8% wasting with 2.4% severe wasting. Oedema prevalence was measured at 1.3% (see Annex 1 (9e)). Measles immunisation coverage was estimated at 36.6% but as this was based solely upon presentation of a vaccination card, this may be an under–estimate [AICF Jul 95]. Since this survey general food distributions have been implemented in Bo as well as in Segbwema, Daru, Maken. It is therefore likely that the nutritional situation will begin to improve in these areas [WFP 27/10/95, WFP 10/11/95].

Cote d'Ivoire[2] There are approximately 305,000 Liberian refugees in Cote d'Ivoire. At present only small scale spontaneous repatriation is occurring. The two tier general ration system for old case load refugees and newer arrivals is continuing and is believed to be serving the needs of this population adequately [UNHCR 17/11/95].

[2] Due to a miscommunication, the previous RNIS report described a July 1994 survey in Cote d'Ivoire as a survey which took place in July 1995.

Guinea There are approximately 605,000 refugees from Liberia and Sierra Leone in Guinea of whom 536,000 receive food aid. Following a joint WFP/UNHCR assessment mission, a reduction in rations is planned for the refugees who arrived before the end of 1993, as it is believed that they have attained some degree of self–sufficiency [UNHCR 17/11/95, WFP 05/12/95].

Overall, the population in Bo, Sierra Leone can be considered to be at high risk with high prevalence of wasting (category I in Table 1). The remaining population in Sierra Leone and the inaccessible population in Liberia can be considered to be at high risk (category IIa in Table 1) and the accessible populations in Liberia and the populations in Guinea and Cote d'Ivoire are probably not at heightened nutritional risk (category IIc in Table 1).The inaccessible population in Liberia can be considered to be at moderate nutritional risk (category IIb in Table 1).

How could external agencies help? In Liberia, ECOMOG may need increased support. Increased pledges from donors for supplies of oil and pulses would help to ensure adequacy of the general ration pipeline. Projects to help rehabilitate the devastated primary health care infrastructure in the country may be of priority. Improved coverage of selective feeding programmes and measles immunisation in the Lower Bong and Upper Margibi is required. In Sierra Leone it is important that, security permitting, nutritional assessments are carried out in areas which are periodically cut off from relief activities, e.g. Bo, Kenema, etc. As in Liberia, support for primary health care infrastructure and activity is essential. For example, in Bo there is an urgent need to increase rates of measles immunisation coverage.

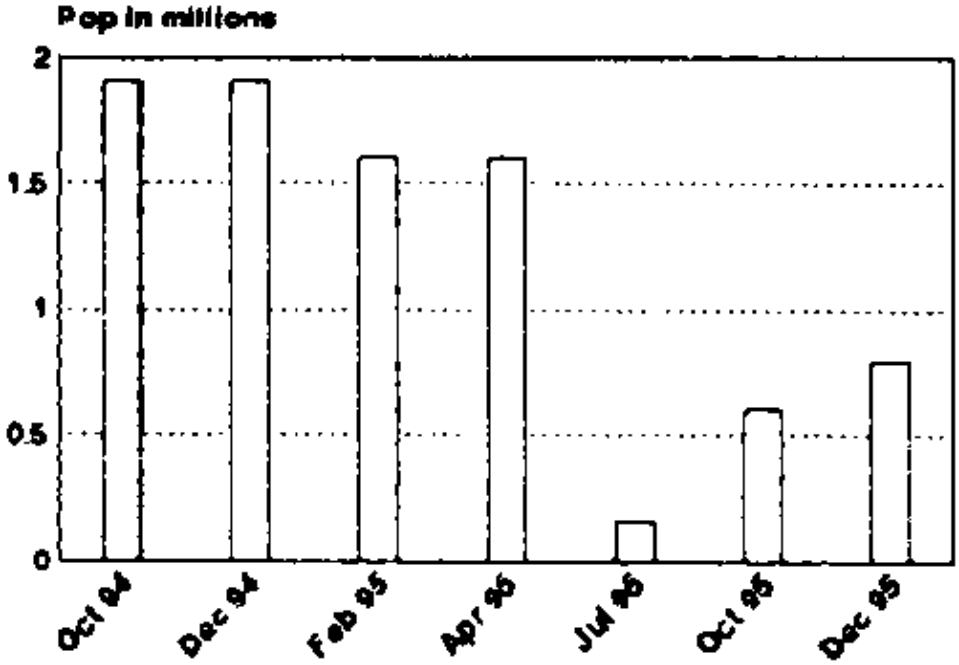
10. Mauritania Refugees in Senegal

(see Map 3)

There are no reports of change in the situation for the approximately 52,000 Mauritanian refugees in Senegal currently receiving humanitarian aid. There are plans to phase out this assistance by the end of 1995, by which time it is hoped that the refugees will either have reached self–sufficiency or been repatriated.

11. Mozambique Region

(see Map 11 and Figure 3)



Mozambique – Trend in numbers of returnees and demobilised soldiers.

The number of returnees, demobilised soldiers and drought affected people requiring food aid in Mozambique has risen to 790,000 [MSF–CIS Nov 95]. This is a planned increase in beneficiary numbers following an initial food security assessment earlier in the year which anticipated the limited food stocks from the harvest being used by this time of the year.

Food reserves at household level are variable. Districts in northern provinces continued to report harvests into September. By contrast, households in the provinces of Maputo, Gaza and Inhambane reported almost no harvests during these months and reserves and markets reflected a rapidly deteriorating food security situation. In numerous districts in these provinces the only foods consumed were reported to be famine foods and in August the province of Gaza proclaimed a state of emergency [MSF–CIS Oct 95].

The nutritional situation in the northern provinces of the country remains more or less stable. Surveys undertaken in districts of Sofala and Nampula province found very low prevalence of wasting (approximately 3%) [MSF–CIS Oct 95].

The nutritional and health situation has however been preoccupying in two provinces. An epidemic of meningitis in Nampula province continued to spread and to claim lives during August, although by the end of September the epidemic was reportedly under control. Measles immunisation coverage in the province was only 11% [MSF–CIS Nov 95].

In Mutarara in Tete province, an outbreak of pellagra amongst returnees has been reported continuously since August. The population of Mutarara district increased form 50,000 to at least 200,000 due to the returning refugees population from Malawi. The number of reported cases at clinics had been steadily increasing with 169 cases reported in the first few weeks of November. It is felt however, that cases may be under–reported as many people do not have easy access to health centres. In response to the outbreak, WFP will provide groundnuts to the returnees in Mutarara. There are no plans currently for a population wide distribution although, should pellagra be confirmed amongst the resident population, additional intervention measures may be required [MSF–CIS 04/12/95].

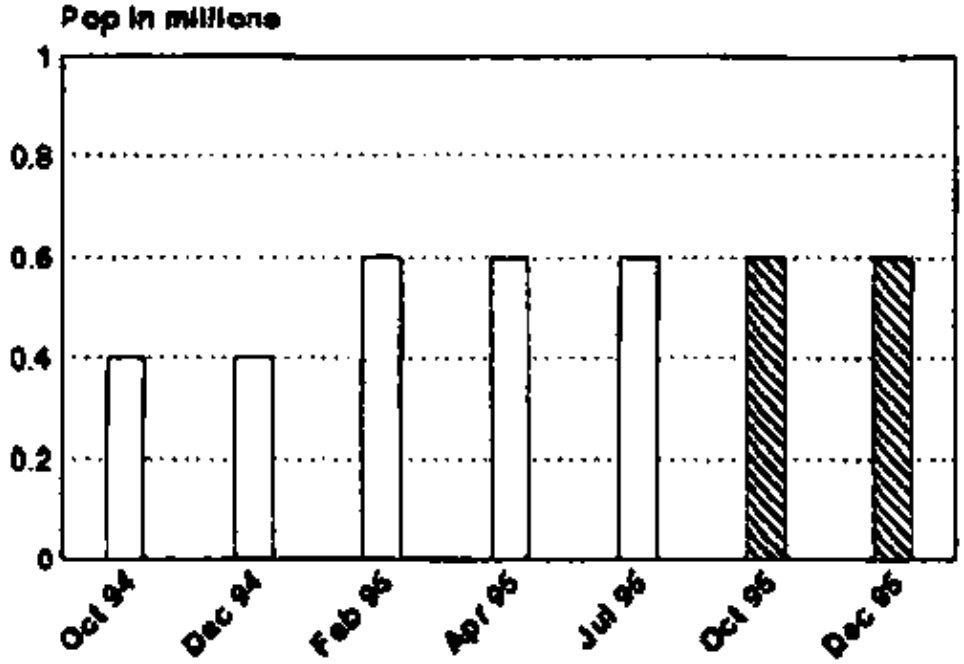
A recent nutritional survey in Mutarara showed wasting and/or oedema in 5.2% of children included in the survey. Severe wasting and/or oedema were measured at 0.1% (see Annex 1 (11a)) [MSF–CIS 04/12/95].

Overall, the returnee population in Mutarara is at high risk due to pellagra (category I in Table 1). The remaining vulnerable population in Mozambique is probably not at heightened nutritional risk, although pockets of malnutrition may exist.

How could external agencies help? Nutritional monitoring should be supported in areas where there are large numbers of returnees, especially where harvests are known to be poor. Problems appear to be related to distribution and targeting of beneficiaries. There is also a need for careful follow up and assessment of the impact of ground–nut provision on the rates of pellagra being reported in Mutarara district. Furthermore, there should be some form of proactive monitoring of pellagra in similarly vulnerable areas, e.g. where there are large numbers of recent returnees, perhaps through careful checking of health centre records and interviews with health staff. Improvement of measles immunisation coverage should be pursued.

12. Somalia

(see Map 12 and Figure 3)



Somalia – Trend in numbers of internally displaced and proportion severely malnourished or at high nutritional risk (shaded area).

The security situation in Somalia remains tense, especially in and around many of the cities. For example, there have been continuing attacks on Aideed's forces occupying Baidoa which in turn has severely disrupted land preparation and planting for the "deyr season" in the contested area between Baidoa and Burhakaba. Initial prospects for the coming Deyr harvest are however favourable in eight of the major production areas, particularly in the Shabelle regions. Anticipated crop production in the Bay and Juba valley region is less promising and may well compound the situation brought about by poor crop yields in these areas during the previous Gu harvest. In the Bay regions Gu harvest yields were reduced by an estimated 77% compared to pre–war production.

The closure of Mogadishu port for eight months since UNISOM departed has led to massive price inflation of most food commodities in the town and outlying regions. As outlined in the last RNIS report, this has been one of several aggravating factors in leading to a high prevalence of wasting in the city. In mid–November WFP were finally able to deliver food to Mogadishu by vessel through the port of El Ma'an which is about 35 kms north of the city. There is continued support for feeding programmes in Mogadishu targeting over 20,000 beneficiaries per month in hospitals, mother/child health clinics and orphanages. Food security cannot have been helped by the fact that in early November 1995, heavy rains and flooding caused extensive damage in parts of Mogadishu. The camps for the displaced were among the worst affected areas [DHA 07/11/95, WFP 17/11/95, WFP 03/11/95].

The situation for the displaced and resident population in and around Kismayo town also remains precarious. A recent assessment found that many households are not self–sufficient. Prices are reportedly rising and with limited employment opportunities, especially since the departure of UNISOM, effective demand is very limited. With the expected poor Deyr harvest in the Juba valley, it is likely that prices will continue to rise. Wasting is said to be widespread among the displaced population, and may be a high as 50% of children, although there

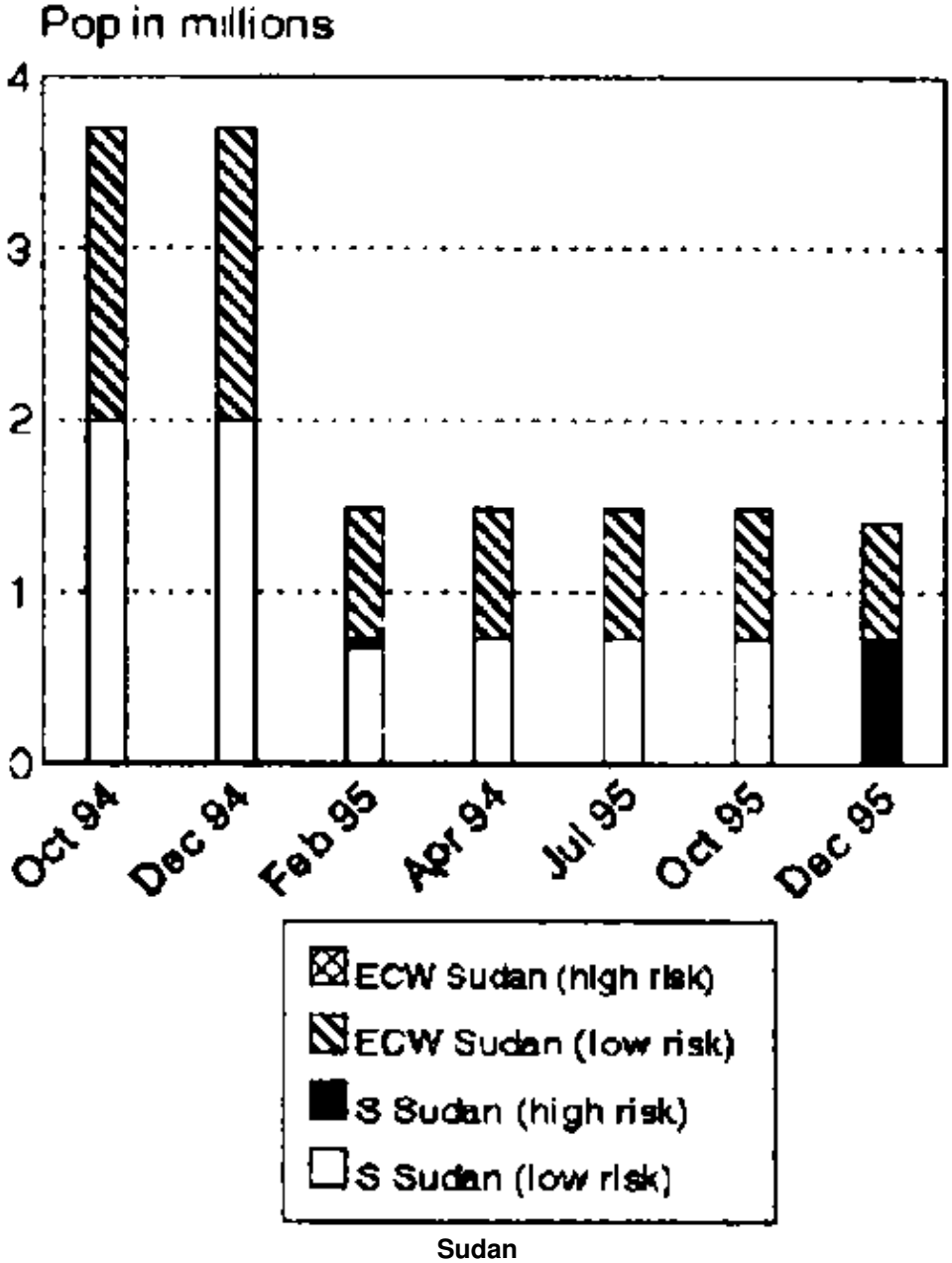
is as yet very little severe wasting. An earlier survey conducted in July found 17.8% prevalence of wasting with 2.7% severe wasting in the town with lower levels of wasting (11.6%) among the displaced in camps (estimated population 9,000). A food distribution for this population is planned until the next harvest is due in January [ICRC 21/11/95].

Overall, food security has continued to deteriorate in many areas of Somalia over the last two months. A significant proportion of displaced and resident households in Mogadishu and Kismayo are probably at heightened nutritional risk, although planned food distributions should help improve food security. Other populations at risk may exist in contested areas, e.g. around Baidoa, and where harvests are expected to be poor, e.g. the Bay and Juba valley regions.

How could external agencies help? With the expected poor harvest in some areas, and the increasing prices of commodities in the markets in large urban centres, an assessment is needed to identify nutritionally vulnerable groups so that food aid can be appropriately targeted. This may include portions of the resident as well as displaced populations.

13. Sudan

(see Map 13 and Figure 3)



Sudan

The situation for many people in southern Sudan is precarious following a year when excellent harvests and improved relief access had created relatively stable food security for most of the population. The deteriorating circumstances have been due to a combination of constraints on OLS, poor rains in June and July leading to reduced planting, and increased levels of insecurity.

The estimated total number of refugees, displaced and war affected people in need of food assistance in the Sudan has not changed from the 1.4 million cited in the last RNIS report. This number is comprised of 200,000 Ethiopian and Eritrean refugees, 720,000 displaced and war affected people in southern Sudan, 94,927 displaced in the transitional zone (just north of Southern Sudan) and 240,000 displaced in four settlements in Khartoum and an additional contingency for 125,000 war−affected people in other areas. A census exercise in the camps for the remaining Ethiopian and Eritrean refugees is likely to be completed by the end of November so that adjustments to the 200,000 caseload "working figure" may subsequently be made. The total number of people in Sudan in need of non−food assistance is estimated to be 4.25 million [DHA 24/05/95, WFP 20/10/95].

Insecurity in Southern Sudan has continued to disrupt Operation Lifeline Sudan (OLS) activities. For example, insecurity determined that in the case of Juba, food has had to be delivered by air rather than river while relief programmes to all areas of Jonglei and northern Bahr El Ghazal were delayed during October [WFP 20/10/95, 10/11/95].

The outcome of the 1995 crop season in southern Sudan has been worse than expected due to a combination of pest attack and unfavourable weather conditions. The entire crop is estimated to cover less than half of the consumption requirements for the southern states. Price differentials between surplus and deficit areas are already wide (as much as five times) and will render a large proportion of food deficit households vulnerable as the purchasing power of the majority of the population has been sharply reduced during this long−term civil conflict. In recent years the switch from livestock agriculture to subsistence agricultural production has meant that large sections of the population become dependent on food aid when even small reductions in production due to drought or pest attack occur [FAO 10/11/95],

This type of vulnerability is amply demonstrated by a nutritional survey in Labone camp for the displaced coming from Ame and Atepi (estimated population 38,000). The survey, which was conducted in August, and followed the first general ration distribution (1,775 kcals/person/day) in three months, found 22.6% prevalence of wasting with 3.3% severe wasting. Oedema was measured at 0.2% (see Annex 1 (13a)). General rations had been suspended in the previous three months due to insecurity. Coverage of the selective feeding programme in the camp was only 25.4% [AICF 30/08/95].

A survey carried out in September 1995 in Tonj (estimated population 150,000) in Bahr el Ghazal found 9.7% wasting and 2.4% severe wasting. No cases of oedema were seen (see Annex 1 (13b)). These levels of wasting are slightly higher than those seen in April 1995 (8.2% wasting and 1.8% severe wasting), and may be partly explained by the timing of the survey which took place just before the harvest. Security constraints on sampling methodology determined that these results cannot be extrapolated to the whole of Tonj county. Measles immunisation coverage had increased from 10.2% in April to 28.3% in August [WV Sep 95].

There has been no further information since the last RNIS report on the displaced population around Khartoum. At the time this population were described as under increasing nutritional and health stress due to overcrowding in remaining camps and the relative isolation of these camps from centres of economic and market opportunity.

Overall, the displaced population in Labone camp are at high risk due to elevated levels of wasting (category I in Table 1) and the remaining affected population in southern Sudan can be considered to be at heightened nutritional risk due to disruptions in OLS operations (category IIa in Table 1). The displaced in and around Khartoum can be considered to be at moderate risk (category IIb in Table 1) while the refugee population are probably not currently at heightened nutritional risk (category IIc in Table 1).

How could external agencies help? Continued support for Operation Lifeline Sudan is essential. The continued problem of identifying vulnerable populations also needs to be addressed in southern Sudan. Where possible, nutritional assessments should be carried out as a priority on populations in areas where harvest failure has been substantial and significant food price inflation is evident. There is a need to improve coverage of selective feeding programmes in Labone camp for the displaced and to continue the measles immunisation campaign in Tonj county.

14. Uganda

(see Map 14)

A census in October 1995 in Uganda has led to a reduction in the number of assisted Sudanese and Zairian refugees. Current estimates are summarised in the box below:

Origin	Oct 94	Dec 94	Feb 95	Apr 95	Jul 95	Oct 95	Dec 95
Sudanese Refugees	268,000	274,000	300,000	310,000	322,000	324,000	217,000
Zairian Refugees	16,000	16,000	313,000	13,000	13,400	13,700	11,800
TOTAL*	284,000	290,000	313,000	323,000	335,400	337,400	228,800

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

Following the recent census, the number of Sudanese refugees in Uganda is estimated to be 217,000. New settlements are currently being established farther away from the Sudanese border in order to decongest existing camps –particularly Koboko camp with an estimated population of 71,000 people [UNHCR Sep 95, UNHCR 16/11/95].

There are no new nutritional data currently available, but the food supply situation has reportedly improved with most refugees now receiving an adequate ration. However, the food pipeline in not assured after December 1995 [UNHCR Sep 95, UNHCR 16/11/95].

The current focus of the refugee programme is to improve agricultural access and subsequent productivity, water supplies and school services. New boreholes have been drilled in many of the camps, and more are planned for 1996. It is hoped that refugees will attain self–sufficiency as soon as possible. Indeed in some settlements, including Kiryandongo, food rations and dependency on external assistance have already been reduced [UNHCR Sep 95, UNHCR 16/11/95].

It is currently estimated that there are 11,800 Zairian refugees in Uganda, although this number appears to fluctuate with movements between Uganda and Zaire. It is hoped that repatriation of these refugees will be realisable in 1996 [UNHCR 16/11/95].

Overall, the nutrition and health situation for the Sudanese refugees in Uganda appears to be improving due to better food deliveries and water supplies (category IIc in Table 1). The nutritional situation for the Zairian refugees appears to remain stable (category IIc in Table 1).

15. Zaire

(see Map 15)

Refugees in Zaire (*excluding Rwandans and Burundis included in Section #4*) The nutrition situation of approximately 14,000 Ugandan refugees in Zaire is reportedly stable. Many of these refugees are eager to repatriate, but agreement has yet to be reached on how this will take place [UNHCR 18/09/95].

These have been no reports of any change in the situation of the approximately 50,000 Sudanese and 41,000 assisted Angolan refugees in Zaire.

Displaced from Shaba, Zaire There are approximately 600,000 people who have been displaced by ethnic violence in the Shaba region of Zaire in 1992. This population fled the area and moved into the Kasai region farther north where many of their ancestors lived. Large numbers stayed in towns, e.g. Mwene Ditu and Likasi, along the route north to the Kasai region.

There are no reports of change to the nutritional situation of the population. In the last RNIS report, the displaced population in Mwene Ditu was considered to be at high nutritional risk due to elevated levels of wasting, and the displaced populations in Likasi, Mbuji Mayi or Kabinda (combined population of 158,000) were thought to be at moderate risk.

16. Zambia

There are approximately 10,000 Angolan refugees assisted in Zambia. There are an additional 86,000 refugees who are not assisted and about whose nutritional status little is known. It is hoped that with the current positive political situation in Angola that many of these refugees will repatriate spontaneously [UNHCR 14/06/95]. There are no reports of change to the reportedly adequate nutritional situation for the small number of Zairian refugees in Zambia.

ASIA – Selected Situations

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

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

17. Afghanistan Region

(see Map 17)

There has been little new information received on the situation in Afghanistan since the last RNIS report. This report described periodic outbreaks of hostility as the Talaban, who control two thirds of the country, resumed offensives against the government and civilian populations in Kabul.

The main problem identified in this report was the effect of the resettlement of refugee returnees upon local populations. An estimated 500,000 resident Afghans are affected as many refugees return to urban areas rather than resuming agricultural activities [DHA 09/10/95].

There are approximately 3.1 million people affected regionally, either as refugees or internally displaced people [UNHAA 06/08/95]. An estimated 2.7 million are refugees in neighbouring Iran and Pakistan. There are a further 500,000 returnees and resident populations affected by their return.

Nearly 200,000 displaced persons continue to live in the Jalalabad camps in Afghanistan, relying on the international community for food and basic services. Efforts are being made towards promoting self–sufficiency amongst this population through income generating projects and vocational training with a view to phase out food distribution in the spring of 1996 [DHA 09/10/95]. The most recent nutritional information on this population comes from a survey in July in New Hadda camp (population 80,000) which found 11.1% wasting with 1.5% severe wasting.

Overall, the affected population in Afghanistan can be considered to be at heightened nutritional risk due to insecurity (category IIb in Table 1), while the refugees in Iran and Pakistan are probably not currently at heightened nutritional risk (category IIc in Table 1).

18. Bhutanese Refugees in Nepal

(see Map 18)

It is currently estimated that there are 90,000 Bhutanese refugees in Nepal (an increase of 3,000 recently to account for births in the camps, not an influx of new refugees). Although talks between the governments of Nepal and Bhutan are ongoing, there are currently no plans for the repatriation of these refugees [UNHCR 16/11/95, WFP 30/11/95].

The nutritional situation of these refugees is reported to be improving. A recent screening of children under five years old showed 2.8% wasting with 0.1% severe wasting (see Annex 1 (18a)). Over 5,000 beneficiaries are enrolled in supplementary feeding programmes but only 9% are children. There have been some recent concerns that the supply of oil in the general ration is inadequate [SCF 15/11/95, WFP 30/11/95].

Reported cases of micronutrient deficiencies are declining. For example, the incidence of beri–beri (both mild and severe) has decreased from 0.005/10,000/day in June 1995 to 1.83/10,000/day in August 1995 to 0.85/10,000/day in October 1995. This rate is, however, still higher than the 0.005/10,000/day reported in June 1995. The incidence of scurvy continues to decrease from 0.63/10,000/day in June to 0.23/10,000/day in August to 0.12/10,000/day in October 1995. This incidence is still higher than that recorded in December 1994. Fresh vegetables and CSB are included in the general ration [SCF 15/11/95].

There had been a significant increase in cases of acute respiratory infection (ART). In August the incidence was 22/10,000/day. In–patient clinics were opened in response to this escalation in cases and by October the incidence rate had fallen to 7.7/10,000/day. Mortality rates, while still considered to be low, have begun to rise. In August, the crude mortality rates was 0.06/10,000/day and the under–five mortality rate was 0.2/10,000/day. Both of these rates show a sharp increase from those reported for July which probably reflects the increased incidence of ARI cases [SCF 15/11/95, UNHCR 16/11/95, WFP 30/11/95].

Overall, the nutritional status of this population appears to be improving, despite the presence of decreasing number of cases of micronutrient deficiencies (category IIc in Table 1).

How could external agencies help? The continued presence of low levels of micronutrient deficiencies suggests that there may be households who lack access to the fresh vegetables and/or CSB in the distributed ration or who have additional nutritional needs. It may also be due to seasonal factors or work or disease patterns This may require further investigation. Regular surveillance for these deficiencies should be maintained.

19. Refugees from Rakhine State, Myanmar in Bangladesh

(see Map 19)

Repatriation of these refugees is continuing slowly, and there are currently approximately 50,000 refugees from Myanmar remaining in Bangladesh. It is estimated that the repatriation process will be completed in 1996. Food supplies to the remaining camps continue to be adequate and nutritional status of the population appears stable [UNHCR 16/11/95].

20. Southern Iraq

There has been very little information in recent months on the condition of the 220,000 Marsh Arabs in southern Iraq. Although a small proportion of this population have assumed refugee status by crossing the border into neighbouring Iran, the majority continue to endure extreme hardships in the southern marshes and are mostly inaccessible to aid agencies. Continued destruction of their traditional habitat and resulting loss of livelihood and means of subsistence are compounded by various forms of persecution including arbitrary arrest, military attack, torture, and executions [UNECOSCO 04/09/95].

Recent information on the declining food security and nutritional well–being of much of the Iraqi population would imply that the highly vulnerable Marsh Arabs are likely to be in an even worse situation. At the end of September a UN inter–Agency humanitarian programme review reported an “increasingly disastrous” situation

in the country. At the same time WFP were reporting that more than 4 million people including 2.4 million children under five were at severe nutritional risk and that they were about to double their target beneficiary population from 1 million to 2.15 million from October 1995. UNICEF have also been reporting that the number of low birth−weight babies and monthly averages of mortality and morbidity among children due to diarrhoea, malnutrition and pneumonia have increased to alarming levels [DHA 31/10/95, FAO 1995].

There are no immediate prospects for an improvement in the situation nationally as disagreement continues on implementation of Security Council Resolution 986 which would guarantee revenue from the sale of Iraqi oil, to be used to import humanitarian goods under UN supervision [DHA 31/10/95].

Listing of Sources for December 1995 RNIS Report

Org*	Date	Title of Report
AICF	01/10/95	Rwandese and Burundese Refugee Camp, Kitali Camp, Ngara District, Tanzania
AICF	Jul.95	Nutritional Survey − Bo, Sierra Leone
AICF	Sep.95	Enquetes Nutritionelles Anthropometriques − Kigali Ville
AICF	Oct.95	Enquetes Nutritionelles Anthropometriques...Refugies Rwandais au Burundi
AICF	11/07/95	Anthropometric Nutritiona; Survey in Cafunfo
AICF	23/09/95	Rwandese Refugee Camps, Benaco Camp, Ngara District, Tanzania
AICF	30/08/95	Nutritional Survey, Labone Camp, South Sudan
CONCERN	17/10/95	Nutrition Survey Report for Malange
DHA	07/11/95	Somali Floods − DHA Information Report No. 1
DHA	09/10/95	Information on Afghanistan
DHA	24/05/95	Sudan Emergency Profile
DHA	31/10/95	The Humanitarian Bulletin
FAO	1995	Evaluation of the Food and Nutrition Situation in Iraq
FAO	Oct.95	Food Supply Situation and Crop Prospects in Sub−Saharan Africa
FAO	10/11/95	FAO/Giews Crop Assessment Mission to Southern Sudan
ICRC	21/11/95	Personal Communication − Somalia
MSF−CH	Oct.95	Activity Report, Karagwe, October 1995
MSF−CH	14/10/95	Nutritional Survey − Omukariro
MSF−CIS	04.12.95	Personal Communication − Mozambique
MSF−CIS	Oct.95	Bi−monthly Bulletin
MSF−CIS	Nov.95	Summary Report − September 1995
MSF−F	Jul.95	Demographic, Mortality, Vaccination and Nutritional Survey (Liberia)
MSF−H	04/11/95	Nutrition Survey Report.. Musuhura Hill Camp
MSF−H	21/10/95	

		Nutrition Survey – Lower Bong, Upper Margibi Counties, Liberia
MSF–H	27/11/95	Survey Results – Kenema
SCF	15/11/95	Personal Communication – Nepal
UNECOSOC	04/09/95	Situation of Human Rights in Iraq
UNHAA	06/08/95	Humanitarian Assistance to Afghanistan
UNHCR	Sep.95	Uganda Refugee Network
UNHCR	15/10/95	Personal Communication – Uvira
UNHCR	30/11/95	Survey Results – Goma, Uvira
UNHCR	14/06/95	UNHCR, Angola to Promote Voluntary Repatriation
UNHCR	16/11/95	Personal Communication – Uganda, Kenya, Nepal, Bangladesh
UNHCR	17/11/95	Personal Communication – Guinea
UNHCR	18/09/95	Personal Communication – Uganda
UNHCR	20/11/95	Personal Communication – Djibouti
UNHCR	21/11/95	Personal Communication – Ghana, Liberia, Sierra Leone, Mauritania
UNHCR–a	Sep.95	Country Operations Plan (1996/97) Ethiopia
UNHCR–a	17/11/95	Personal Communication – Benin
WFP	01/12/95	Weekly Update
WFP	03/11/95	Weekly Update
WFP	08/12/95	Weekly Update
WFP	10/11/95	Weekly Update
WFP	05/12/95	Personal Communication
WFP	13/10/95	Weekly Update
WFP	17/11/95	Weekly Update
WFP	20/10/95	Weekly Update
WFP	27/10/95	Weekly Update
WFP	30/11/95	Update on Bhutanese Refugees
WHO	10/11/95	Situation de Cholera au Burundi
WHO	07/12/95	Personal Communication – Burundi
WHO	15/11/95	Press Release – Yellow Fever
WHO	15/11/95	Rapport de Mission – Province de Malange
WHO	27/11/95	Personal Communication – Burundi, Liberia
WV	Sep.95	Nutritional Survey, Tonj County, Bahr el Ghazel, Southern Sudan
WV	Oct.95	Monthly Report – October (Angola)

*Orq	
AICF	Action International Contre la Faim
CONCERN	
FAO	Food & Agricultural Organization of the United Nations
GOAL	
ICRC	International Committee of Red Cross
IFRC	International Federation of Red Cross
IOC	Integrated Operation Centre Kigali
Min of Health	Ministerio da Sauda, Republica de Mocambique
MSF−B	Medecins Sans Frontieres − Belgium
MSF−CIS	Medecins Sans Frontieres − Celula Inter−Seccoes
MSF−F	Medecins Sans Frontieres − France
MSF−H	Medecins Sans Frontieres − Holland
SCF	Save the Children Fund
UCAH	United Nations Humanitarian Assistance Coordination Unit
UNHAA	United Nations Humanitarian Assistance for Afghanistan
UNECOSOC	United Nations Economic and Social Council
UNHCR	United Nation's High Commission on Refugees
UNICEF	United Nation's Children Fund
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision

List of Tables, Figures and Annexes

Table 1: Information Available on Total Refugee/Displaced Populations (as of December 1995)

Situation	***Condition***					***Population #s***		***Nutr Stat****	***Commen***
	I: High Prev	***IIa: High Risk***	***IIb: Mod Risk***	***IIc: Not Critical***	***III: Unknown***	***Total***	***Change from Oct.95***		
Sud−Saharan Africa									
1. Angola (*id/wa*)			*1'400'000*			*1'400'000*	*0*	*imp*	*Pockets of malnutritio are likely t exist in inaccessib areas.*
				124'000		*124'000*	*−33'000*	*stat*	

2. Benin/Ghana/Togo Region									*De to re*
3. Burkina Faso/Mauritania				*68'000*		*68'000*	*–6'000*	*imp*	*Nu st pr im du im ra*
4. Burundi/Rwanda Region		*430'000*	*1'003'000*	*1'644'400*		*3'077'400*	*246'000*	*stat*	*In to in es nu di Bu*
5. Central African Republic				*38'800*		*38'800*	*0*	*stat*	*So pr sit er ar in wa*
6. Djibouti				*25'000*		*25'000*	*2'000*	*stat*	*In to nu So re*
7. Ethiopia	*81'000*		*173'000*	*134'000*		*388'000*	*8'000*	*stat*	
8. Kenya				*186'000*		*186'000*	*–11'000*	*det*	*De nu to re So re*
9. Liberia/Sierra Leone/ Guinea/Cote d'Ivoire	*250'000*	*1'280'000*		*2'010'000*		*3'540'000*	*69'000*	*stat/det*	*Po ma ma Li in ar de se nu sit Si*
10. Mauritania/Senegal				*52'000*		*52'000*	*0*	*stat*	*Fo as be ou en*
11. Mozambique Region	*150'000*			*640'000*		*790'000*	*190'000*	*det*	*Di Mu hig*

									to pellagra Problems harvest deficit area
12. Somalia	*138'000*	*462'000*				*600'000*	*0*	*det*	*The numbe of vulnerab people wh are not displaced probably much high*
13. Sudan	*38'000*	*682'000*	*480'000*	*200'000*		*1'400'000*	*0*	*det*	*Those in th south high vulnerable*
14. Uganda				*228'800*		*228'800*	*–108'900*	*imp*	*Reduced estimated numbers c to census October.*
15. Zaire	*60'000*		*340'000*	*305'000*		*705'000*	*0*	*stat*	*Includes internally displaced form Shab and refuge excluding refugees from Burur and Rwan*
16. Zambia				*12'700*		*12'700*	*0*	*stat*	
Total (Sub–Saharan Africa)	*717'000*	*2'854'000*	*3'396'000*	*5'668'700*	*0*	*12'635'700*	*356'100*		
Asia (Selected Situations)									
17. Afghanistan Region			*370'000*	*2'730'660*		*3'100'000*	*0*	*stat*	*Unknown number of displaced have returned home.*
18. Bhutanese Refugees in Nepal				*90'000*		*90'000*	*3'000*	*imp*	*Low levels micronutrie deficiencie continue to be reporte*
19. Bangladesh				*50'000*		*50'000*	*–2'000*	*stat*	*Repatriatio for these refugees is continuing*
20. Southern Iraq		*192'000*		*28'000*		*220'000*	*0*	*det*	*Those in Marshes considered high risk.*

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

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

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

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

III: Unknown – No information on nutritional status available.

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

Table 2: Summary of Origin and Location of Major Populations of Refugees, Returnees and Displaced People in Africa

From	***To/In***										
	Angola	***Benin***	***Burkina Faso***	***Burundi***	***Cote d'Ivoire***	***Ethiopia****	***Ghana***	***Guinea***	***Kenya***	***Liberia***	***Ma***
Angola	1'400										
Benin											
Burkina Faso											
Burundi				290							
Cote d'Ivoire											
*Ethiopia**						11			6		
Ghana											
Guinea											
Kenya						24					
Liberia					305		14	477		1'800	
Mali			33								
Mauritania											
Mozambique											
Rwanda				214							
Sierra Leone								128		100	
Somalia						275			140		
Sudan						60			40		
Tanzania											
Togo		28					82				
Uganda											
Zaire											
Zambia											
TOTAL	1'400	28	33	504	305	370	96	605	186	1'900	0

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

(*2*) *Boxes on the diagonal* (*shaded*) *show internally displaced populations* (*total = 8.2 million*).

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

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

** Includes Eritreans*

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

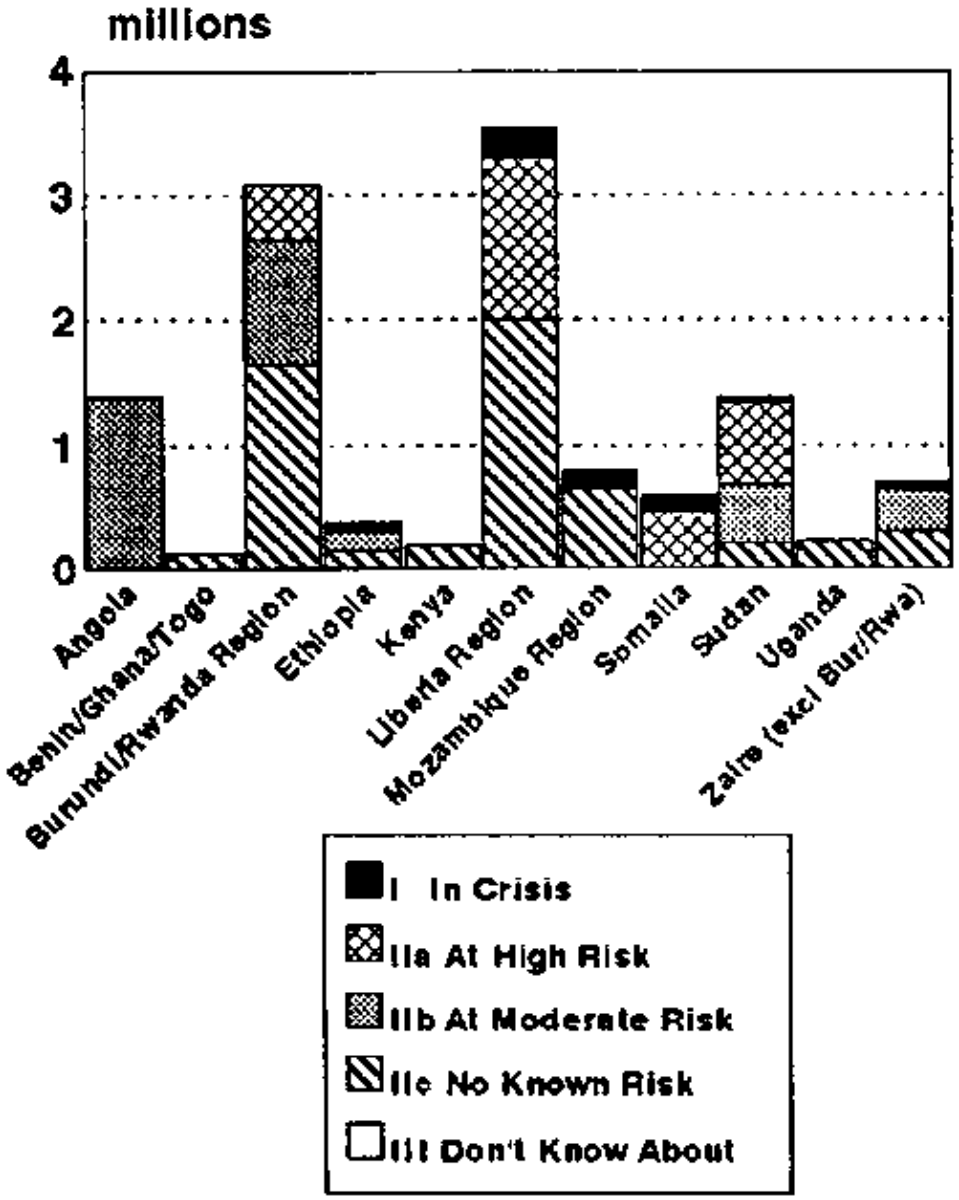


Figure 1 **– REFUGEE AND DISPLACED POPULATIONS – Selected Areas in Africa (December 1995)**

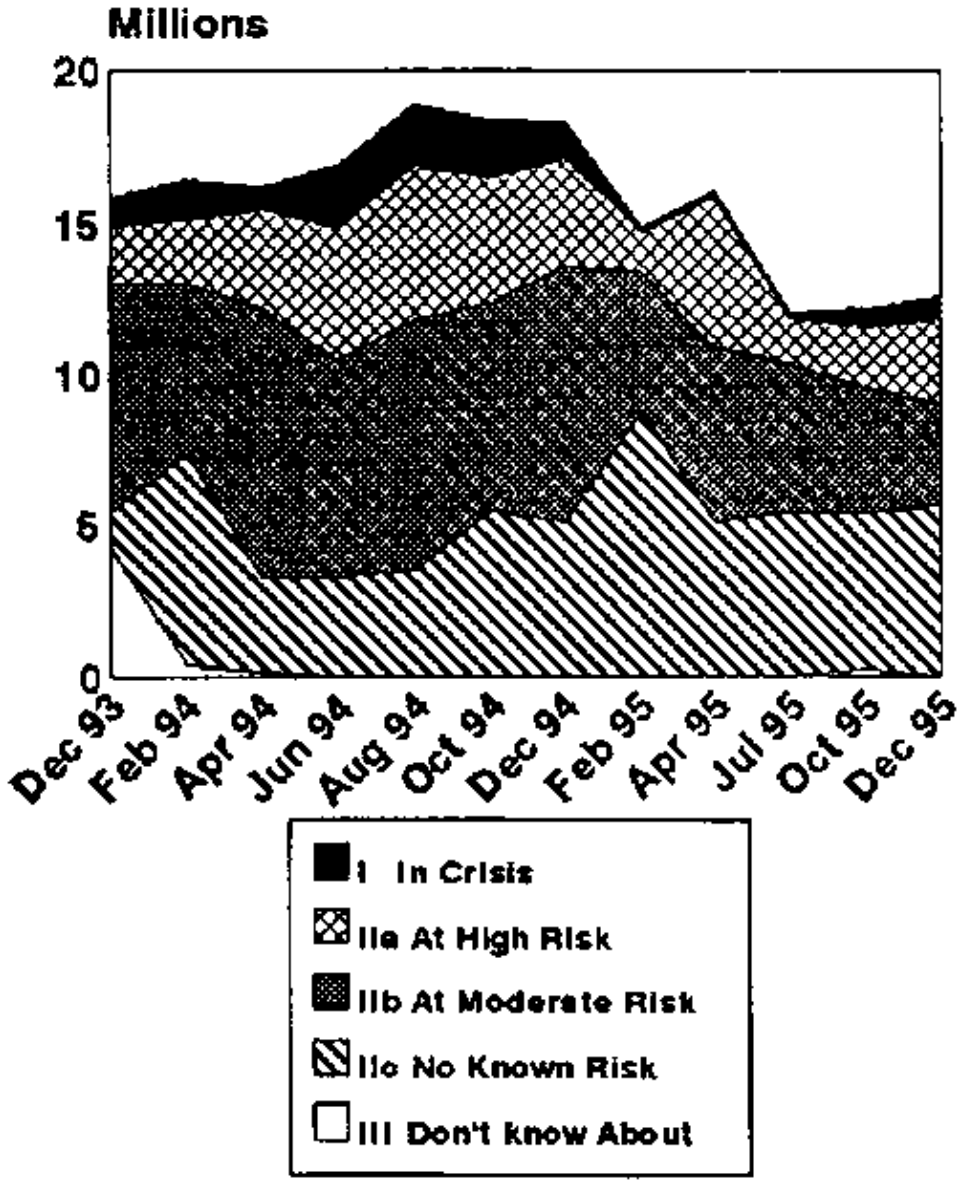


Figure 2 – **Trends in Total Refugee/Displaced Populations – By Risk Categories Africa: December 1993–December 1995**

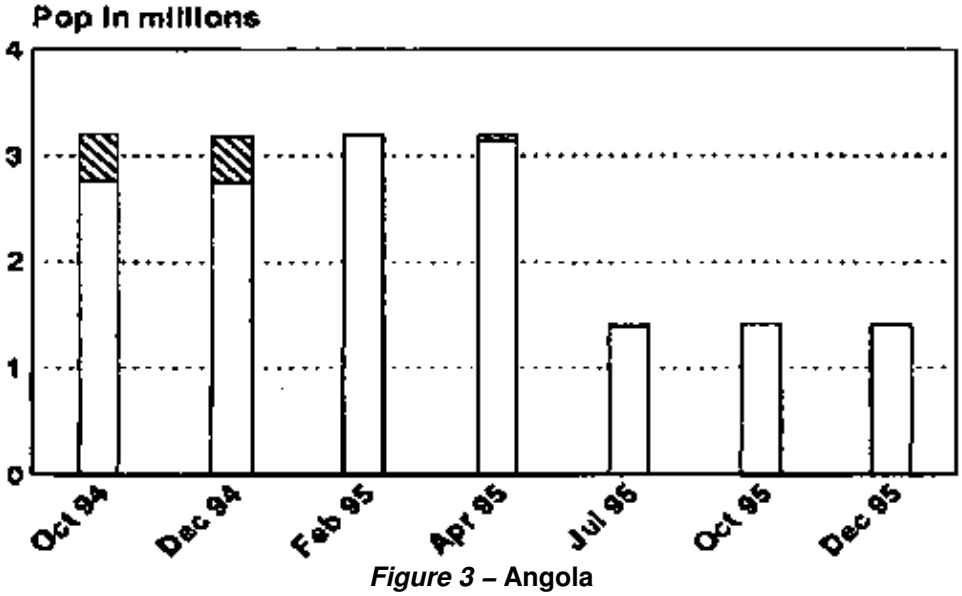


Figure 3 – **Angola**

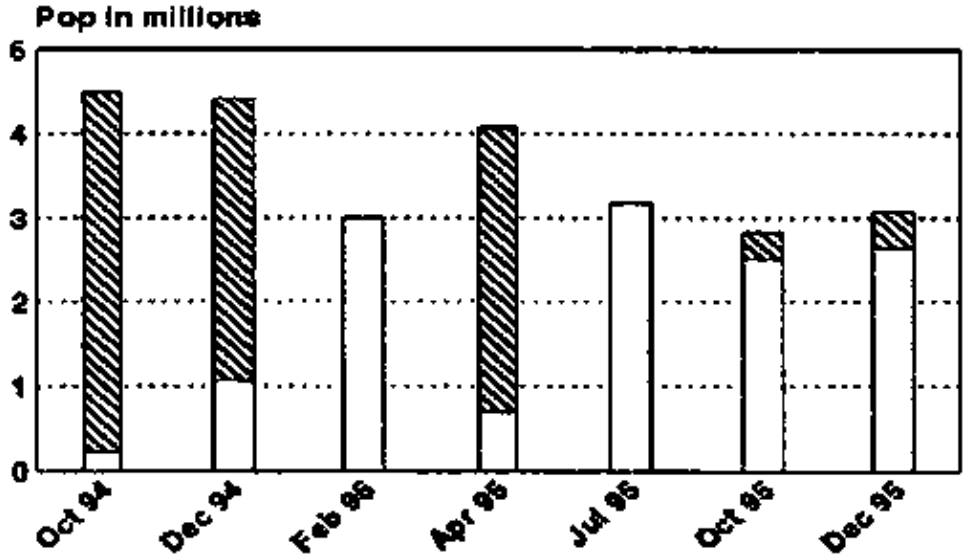


Figure 3 – Burundi/Rwanda Region

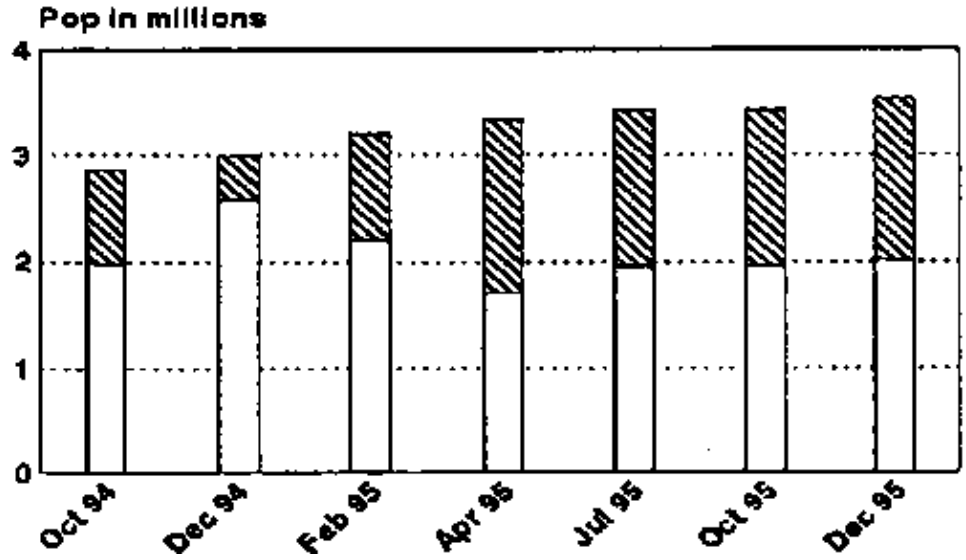


Figure 3 – Liberia

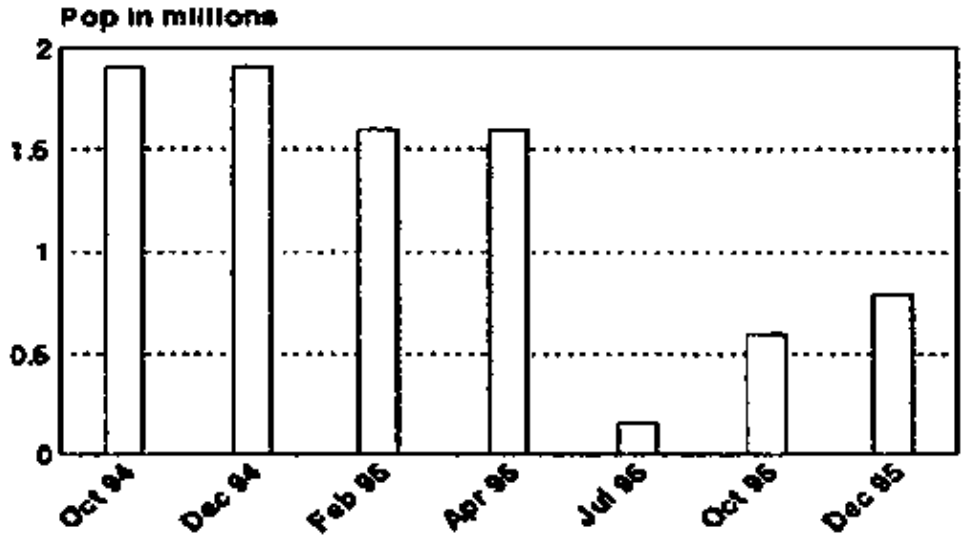


Figure 3 – Mozambique

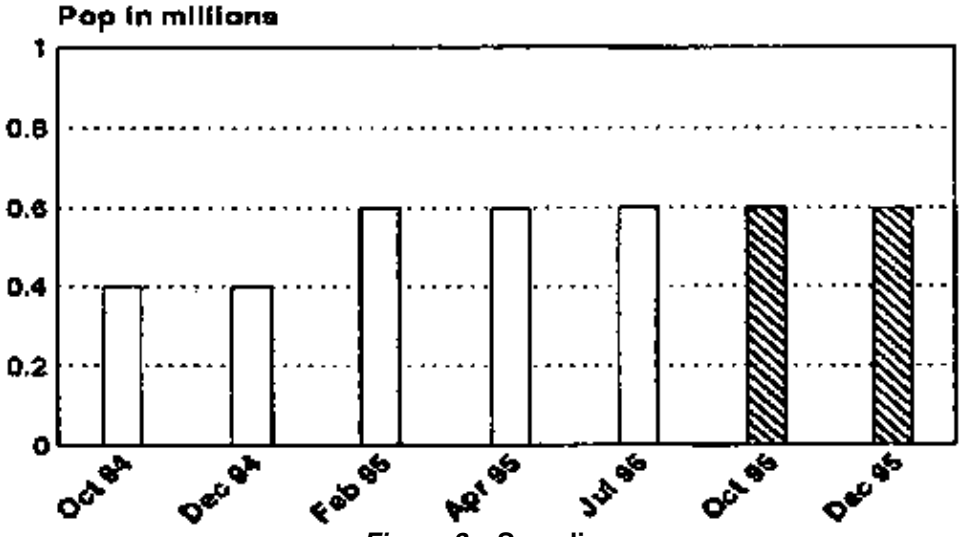


Figure 3 – Somalia

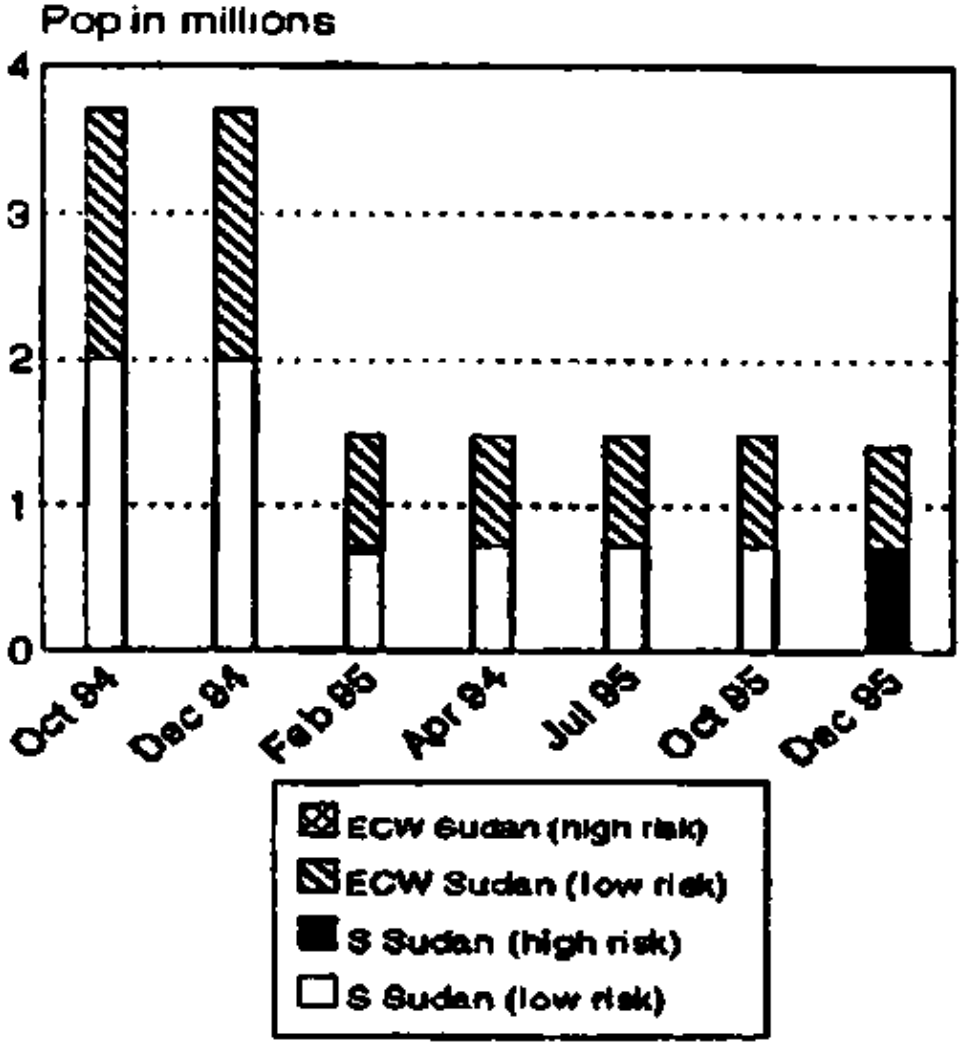


Figure 3 – Sudan

Annex 1: Results of Surveys Quoted In December 1995 RNIS Report (#13) – usually children 6–59 months

Survey Area	*Survey Conducted by*	*Dale*	*% Wasted**	*% Severely Wasted**	*Oedema (%)*	*Crude Mortality (/10,000/day)*	*Under 5 Mortality (/10,000/day)*	*Im*
1. Angola								
a. Malange	CONCERN	Oct.95	1.8**	0.2**				

	b Cafunfo, Lunda Note Province	AICF	Jul.95	2.8	0.6				72.7
	c. *Matala*	CARE/MSF–S	Oct.95	15.4”	6.7**				
	d. Galungo Alto	WV	Oct.95	20.4”	12**				
4. Burundi/Rwanda Region									
	a. Magara (*Burundi*)	AICF	Oct.95	2.6**	0.4”				
	b. Rumuvu (*Burundi*)	AICF	Oct.95	3.6”					
	c. Kibezi (*Burundi*)	AICF	Oct.95	3.5”					
	d. Kigali, Rwanda	AICF	Sep.95	5.0	0.6		0.09	0.17	96.0
	e. Kigali, Rwanda	AICF	Sep.95						
	f. Musuhura Hill Camp (*Tanzania*)	MSF–H	Nov.95	3.5	0.2	1.7			
	g. Benaco (*Tanzania*)	AICF	Sep.95	4.3	0.2	1.6	0.56	1.61	82.6
	h. Kitali (*Tanzania*)	AICF	Oct.95	5.2	0.4	2.1			
	i. Omukariro (*Tanzania*)	MSF–CH	Oct.95	1.0	0		0.15	0.37	
	j. Mugunga, Goma (*Zaire*)	UNHCR	Nov.95	2.1	0.7				
	k. Katale, Goma (*Zaire*)	UNHCR	Nov.95	3.2**	1.2**	0.7			
	l. Lac Vert, Goma (*Zaire*)	UNHCR	Nov.95	4.3”	1.9**	02			
	m. Kahindo, Goma (*Zaire*)	UNHCR	Nov.95	2.6	0.5				
	n. Kibumba, Goma (*Zaire*)	UNHCR	Nov.95	8.3**	4.8**	1.4			
	o. Runingo, Uvira (*Zaire*)	UNHCR	Nov.95	7.1”	4.5**	37			84.7
	p. Kajembo, Uvira (*Zaire*)	UNHCR	Nov.95	7.5”	4.3**	3.6			93.7
	q. Kagunga, Uvira (*Zaire*)	UNHCR	Nov.95	4.4”	1.2**	0.8			96.4

	r. Luberizi, Uvira (*Zaire*)	UNHCR	Nov.95	3.3**	1.3**	1.3			
	s. Rwenena, Uvira (*Zaire*)	UNHCR	Nov.95	6.2**	3.1**	3.1			
	t. Kamnyola, Uvira (*Zaire*)	UNHCR	Nov.95	3.1”	1.6**	1.6			
	u. Biriba, Uvira (*Zaire*)	UNHCR	Nov.95	59”	3.8**	28			
	v. Lubarika, Uvira (*Zaire*)	UNHCR	Nov.95	0.0	0.0				
	w. Luvungi, Uvira (*Zaire*)	UNHCR	Nov.95	5.4”	1.8**	0.9			
9. Liberia Region									
	a. Buchanan (*Liberia*)	MSF–F/AICF	Jul.95	8.9	1.0	0.3	0.8–3.7	1.4	
	b. Lower Bong/Upper Margibi (*Liberia*)	MSF–H	Oct.95	6.4”	0.7**				
	c. Kenema Town (*Sierra Leone*)	MSF–H	Nov.95	4.8”	0.5”				
	d. Kenema RTI Camp (*Sierra Leone*)	MSF–H	Nov.95	5.6”	0.9**				
	e. Bo (*Sierra Leone*)	AICF	Jul.95	19.8	2.4	1.3			
11. Mozambique									
	a. Mutarara, Tete Province	MSF–B	Nov.95	5.2**	0.1**				
13. Sudan									
	a. Lobone Camp	AICF	Aug.95	22.6	3.3	0.2			
	b. Tonj. Bahr el Ghazal	WV	Sep.95	9.7	2.4				
18. Bhutanese Refugees in Nepal									
	a. All 8 Camps	SCF	Aug.95	2.8(%Median)	0.1(%Median)		0.1	0.2	

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

** Oedema is included in this figure.

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

NOTES on Annex 1

1. Angola

a. This survey was carried out in Malange by CONCERN in October 1995. It was a two stage cluster survey which included 839 children between 6–59 months old. Wasting was defined as wt/ht <–2z scores and severe wasting was defined as wt/ht <–3z scores. Oedema was measured separately.

b. This survey was carried out by AICF in July 1995 in Cafunfo, Lunda Norte Province. This was a transversal study using systematic sampling. The sample size was 323 children 6–59 months old (or 65–110 cms). Wasting was defined as wt/ht <–2z scores and severe wasting was defined as wt/ht <–3z scores. No cases of oedema were found.

c. This survey was conducted by CARE and MSF–S in Matala, and no further details are currently available.

d. The results of this survey were included in the WV monthly report. No further details are currently available.

4. Burundi/Rwanda Region

a–c. These three surveys were conducted by AICF in October 1995 in Magara, Rumuvu and Kibezi camps for Rwandan refugees in Burundi. Children 6–59 months old were included. Wasting was defined as wt/ht <–2sd and severe wasting was defined as wt/ht <–3sd. Oedema was not given as a separate figure.

d–e. This survey was carried out by AICF in Kigali in September 1995. It was a two stage cluster sample survey which included 900 children 6–59 months old. Wasting was defined as wt/ht <–2sd and severe wasting was wt/ht <–3sd. Oedema was recorded separately. In the second part, 842 women 15–87 years old were included. Wasting was defined as BMI<18.5 and severe wasting BMI<16.

f. This survey was carried out by MSF–H from 3–4 November 1995 in Musuhura Hill camp for Rwanda refugees in Ngara, Tanzania. Children 65–110 cms were included in the survey and the sample size was 403. A systematic random sampling method was used. Wasting was defined as wt/ht <–2z scores and severe wasting was wt/ht <–3z scores. Oedema was reported separately.

g. This survey was carried out by AICF in Benaco Camp by AICF in September 1995. It was a random cluster sample which included 923 children 6–59 months old. Wasting was defined as wt/ht <–2sd and severe wasting <–3sd. Oedema was recorded separately.

h. This survey was carried out in Kitali camp by AICF in October 1995. It was a random cluster survey that included 939 children 6–59 months old. Wasting was defined as wt/ht <–2sd and severe wasting <–3sd. Oedema was recorded separately.

i. This survey was conducted by MSF–Switzerland in October 1995. A systematic sampling method was used and 196 children 6–59 months old were included. Wasting was defined as wt/ht <–2z scores and severe wasting was <–3z scores. Oedema was recorded separately.

j–n. This surveys were conducted by UNHCR in the Goma camps. Wasting was defined as wt/ht <–2z scores and severe wasting was defined as wt/ht <–3z scores.

o–w. These surveys were conducted by UNHCR in October and November 1995 in Uvira. Wasting was defined as wt/ht <–2sd and severe wasting was defined as wt/ht <–3sd.

9. Liberia Region

a. This survey was carried out in Buchanan, Liberia in July 1995 by AICF and MSF–F. This was a two–stage cluster sample survey. 911 children were included in the survey. Wasting was defined as wt/ht <–2z scores and severe wasting was <–3z scores. Oedema was measured separately.

b. This survey was carried out in Lower Bong and Upper Margibi Counties in Liberia by MSF–H in October 1995. Children 65–110 cms were included for a total sample size of 818. Wasting was defined as wt/ht <–2z scores and severe wasting <–3z scores. Oedema was not recorded separately.

c–d. These are preliminary results from a survey conducted by MSF–H in November 1995 both in Kenema Town, and in RTI camp for the displaced which is outside Kenema. No further details are currently available.

e. This survey was carried out by AICF in Bo, Sierra Leone in July 1995. This was a random, two–stage cluster survey. A total of 898 children 6–59 months old were included. Wasting was defined as wt/ht <–2sd and severe wasting <–3sd. Oedema was measured separately.

11. Mozambique

a. This survey was carried out by MSF–B in November 1995. Wasting was defined as wt/ht <–2z scores and severe wasting was defined as wt/ht<–3z scores.

13. Sudan

a. This survey was carried out by AICF in August 1995. This was a two stage random cluster survey which included children 65–115 cms because of their Dinka origins. A total of 892 children were included in the survey. Wasting was measured as wt/ht <–2sd and severe wasting <–3sd. Oedema was measured separately.

b. This survey was carried out by WV in September 1995. This was a random cluster survey which included 421 children 75–115 cms. Wasting was defined as <80% of the median and severe wasting was <70%.

18. Bhutanese Refugees in Nepal

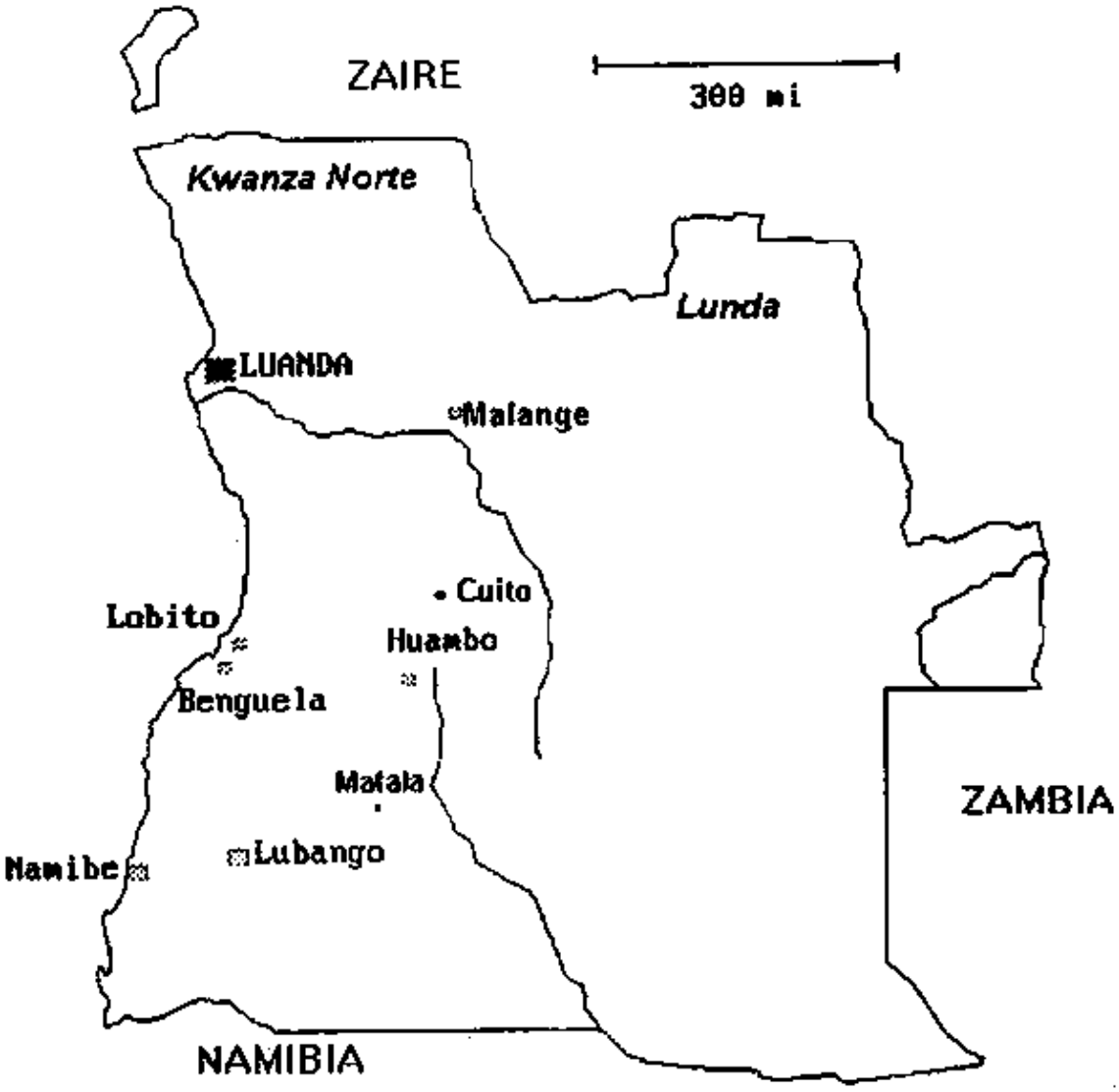
a. This information comes from a screening exercise done in August on children under five by SCF. Wasting was defined as <80% wt/ht and severe wasting <70% wt/ht.

Annex 2

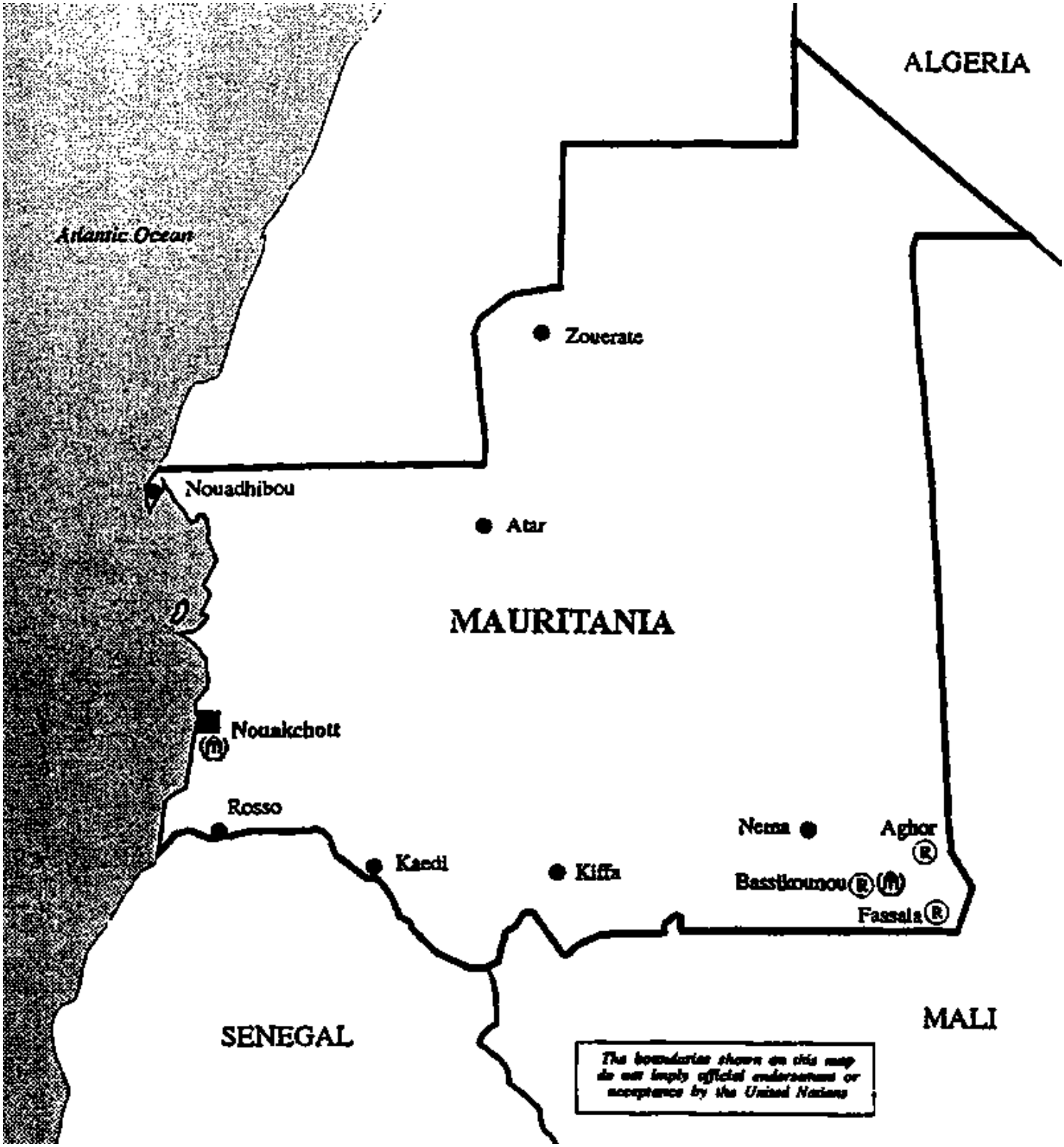
*Seasonality in Sub–Saharan Africa**	
Country	***Climate/Rainy Season/Harvest***
Angola	Coastal area desert, SW semi–arid, rest of country: rains Sept–April
Burundi	Three crop seasons: Sept–Jan, Feb–Jun, and Jul–Aug
CAR	Rains March–Nov
Djibouti	Arid Climate
Ethiopia	Two rainy seasons February to May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

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

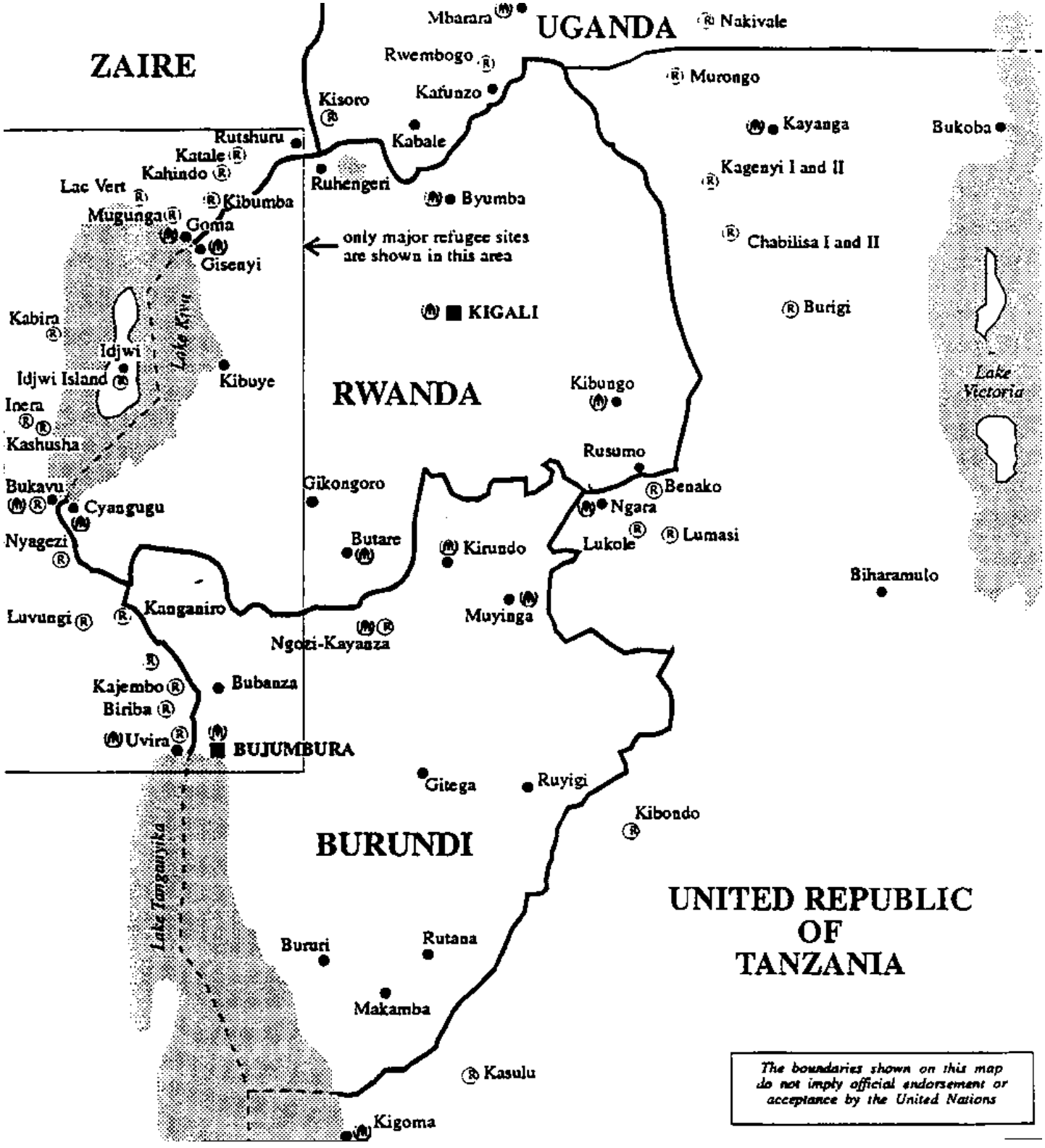
MAP A Situational Map


ZAIRE
300 mi
Kwanza Norte
Lunda
LUANDA
Malange
Cuito
Lobito
Huambo
Benguela
Matala
ZAMBIA
Namibe
Lubango
NAMIBIA

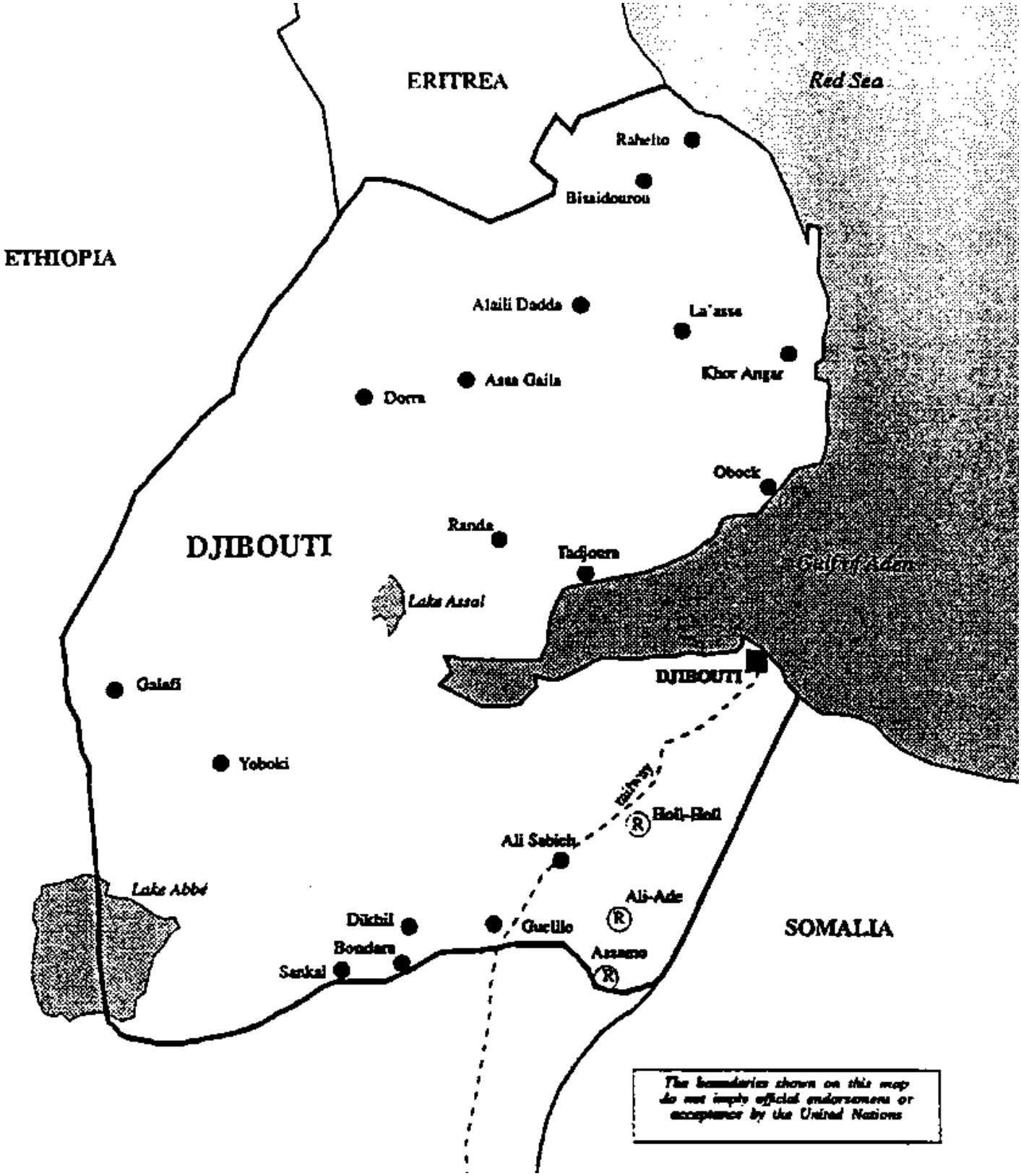
MAP 1 Angola



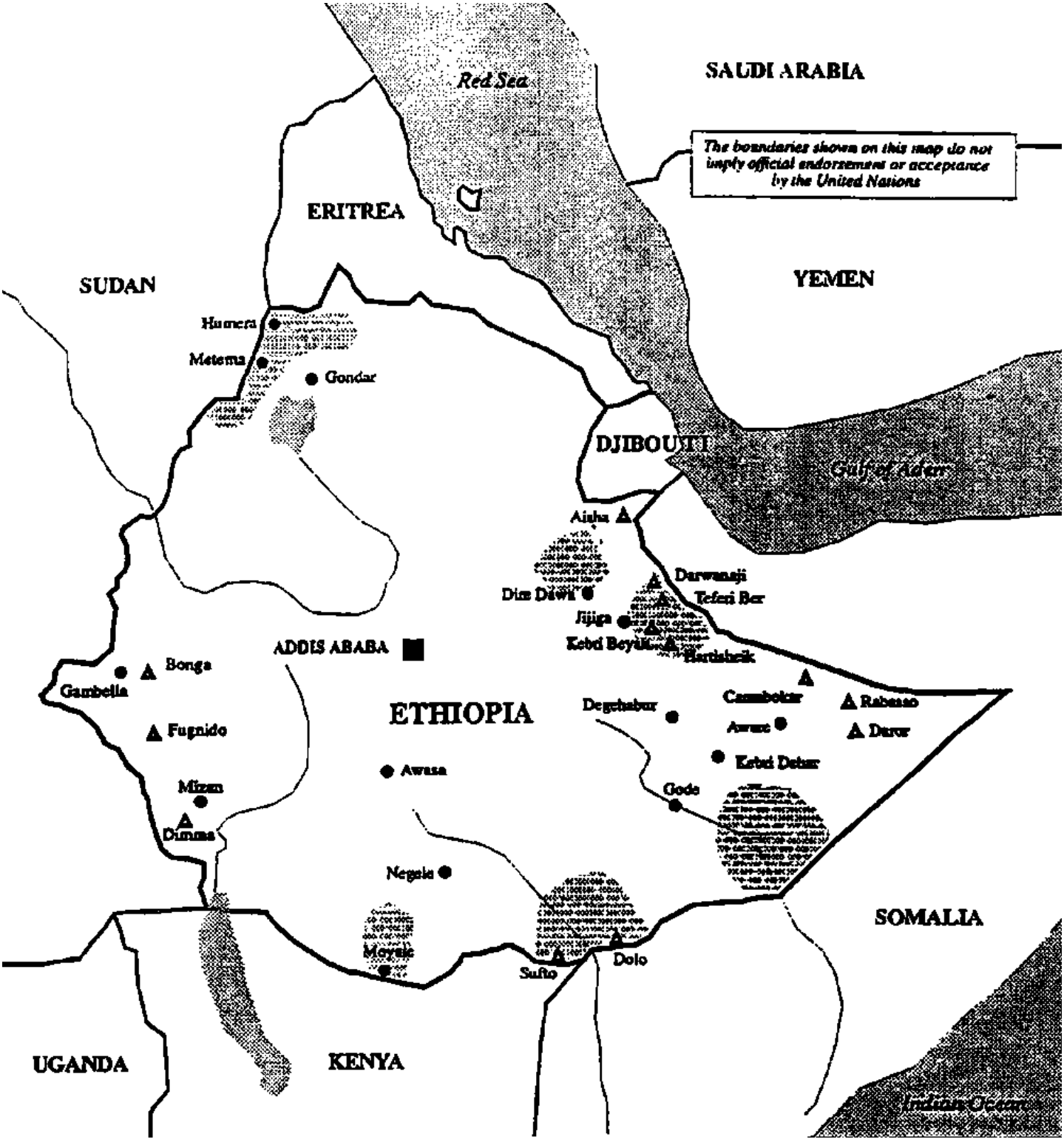
MAP 3 Mauritania



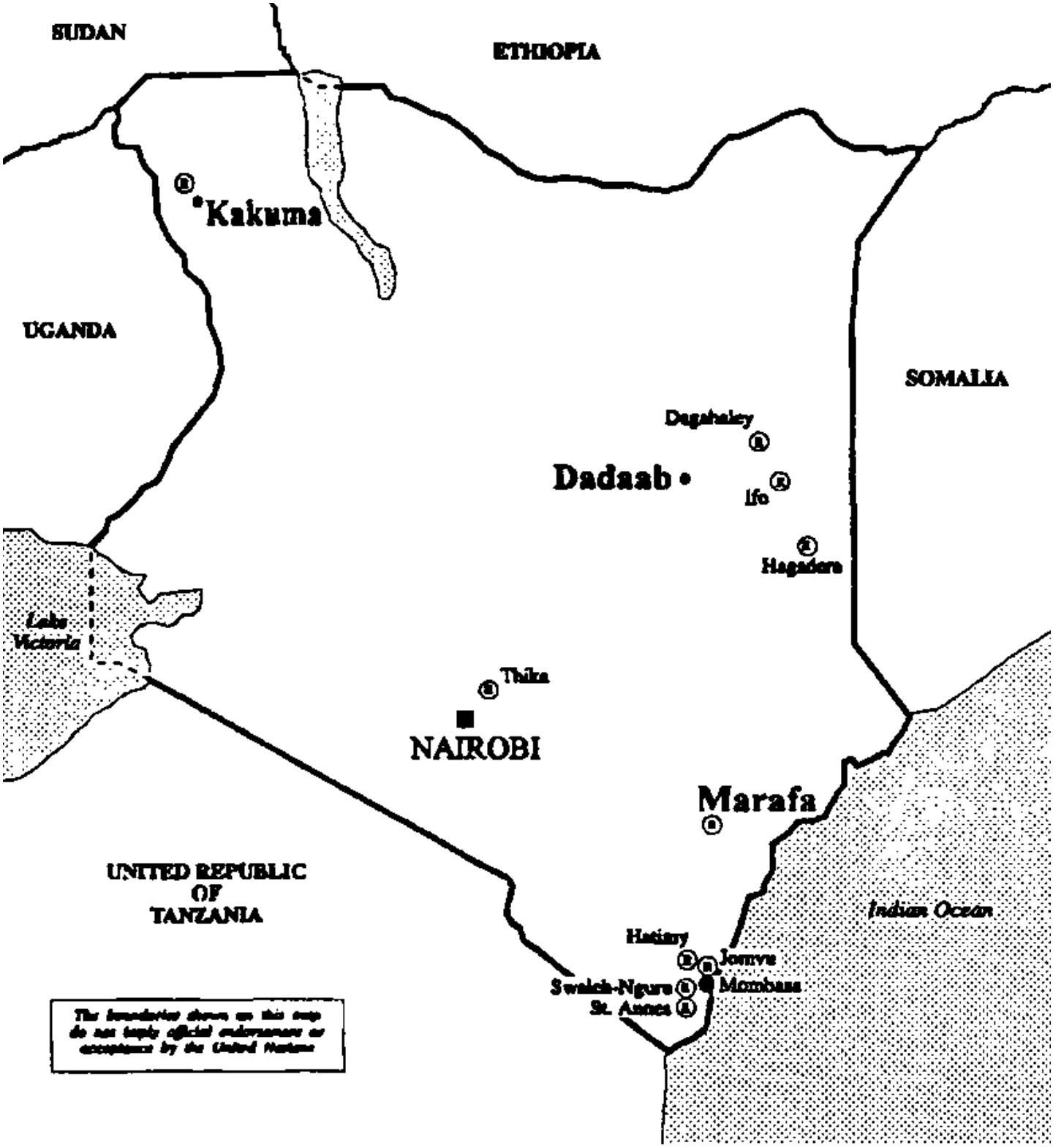
MAP 4 Burundi/Rwanda Region



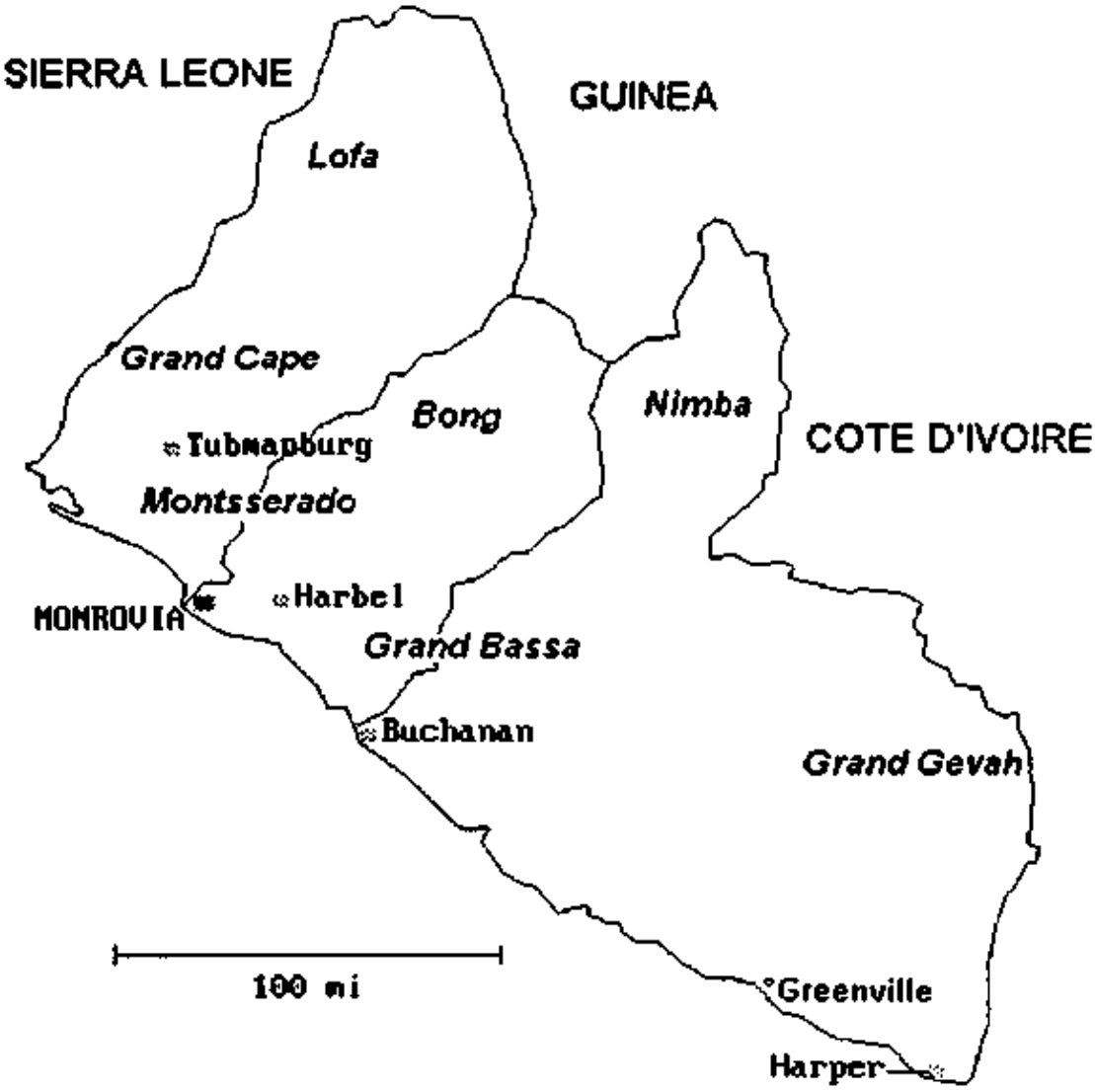
MAP 6 Djibouti



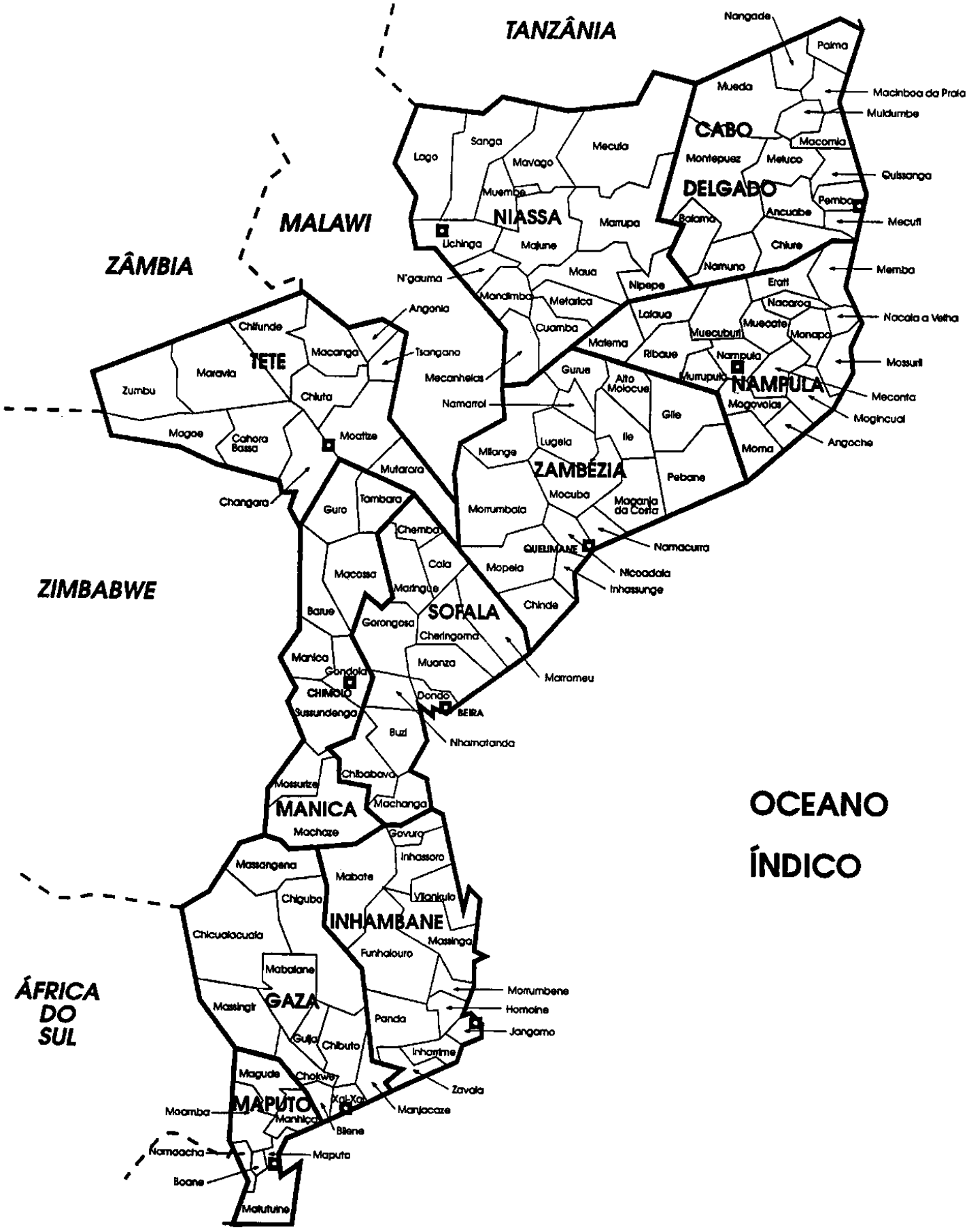
MAP 7 Ethiopia


SUDAN
ETHIOPIA
Kakuma
UGANDA
SOMALIA
Dagahaley
Dadaab
Ifo
Hagadera
Lake Victoria
Thika
NAIROBI
Marafa
UNITED REPUBLIC OF TANZANIA
Indian Ocean
Hatimy
Jomvu
Mombasa
Swaleh-Ngure
St. Annes

MAP 8 Kenya

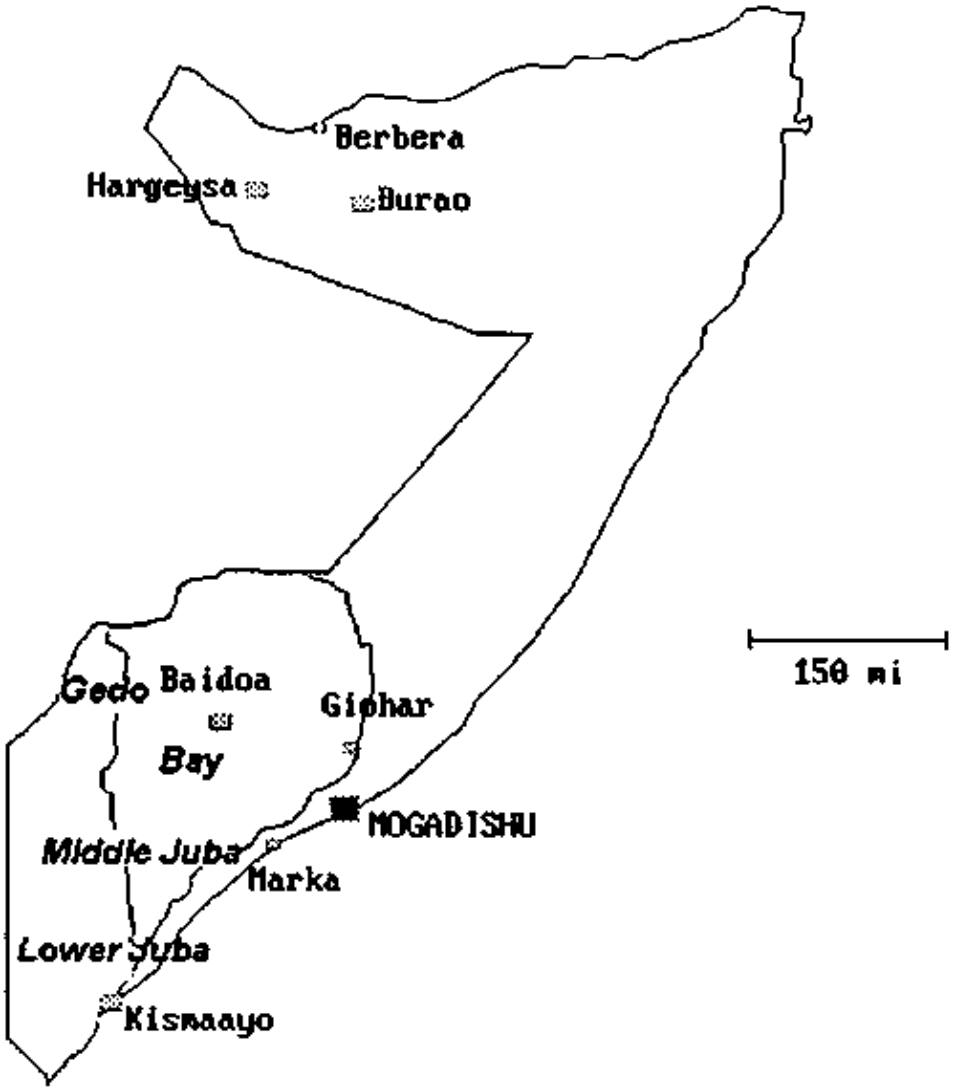


MAP 9 Liberia/Sierra Leone

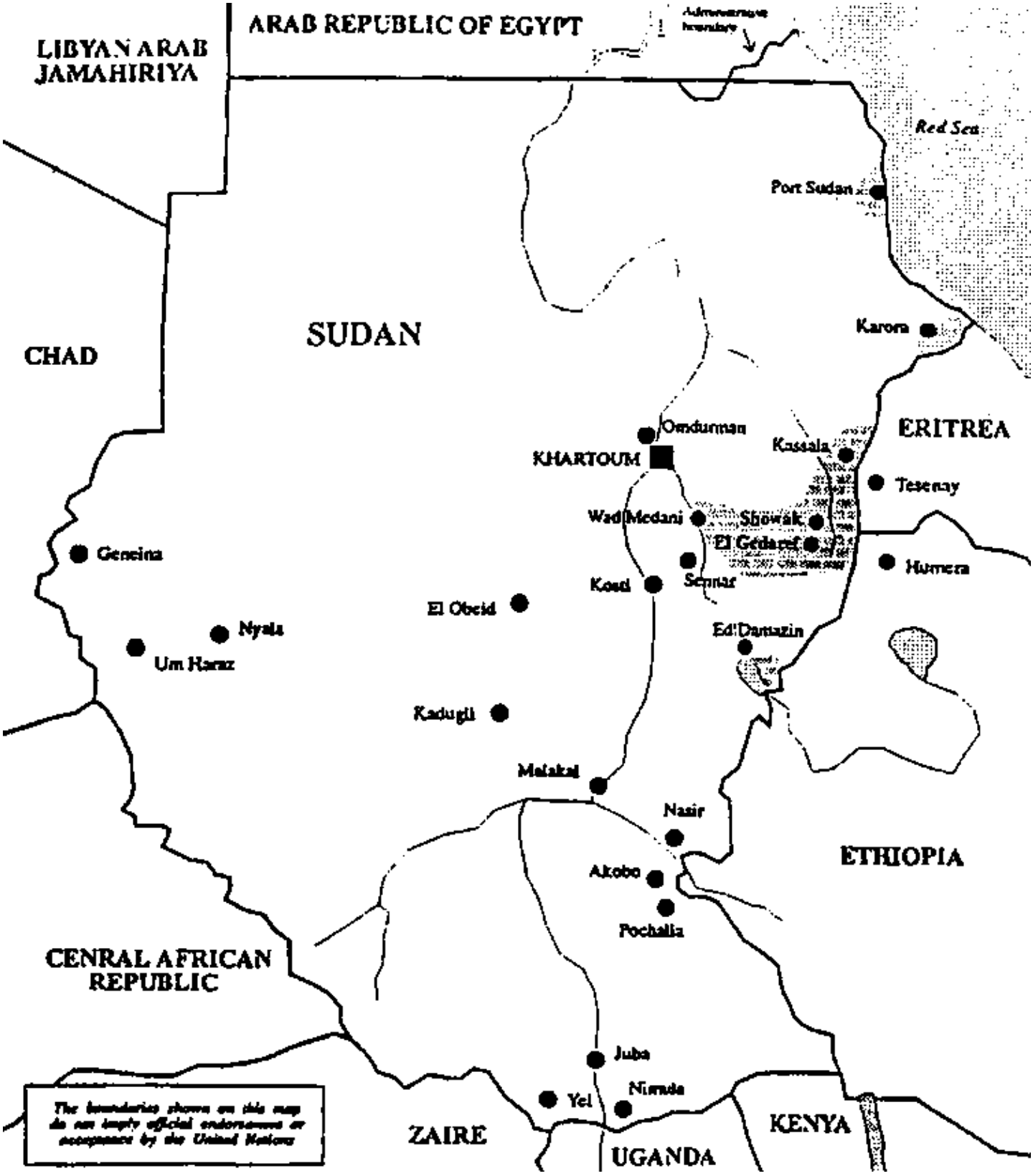


MAP 11 Mozambique

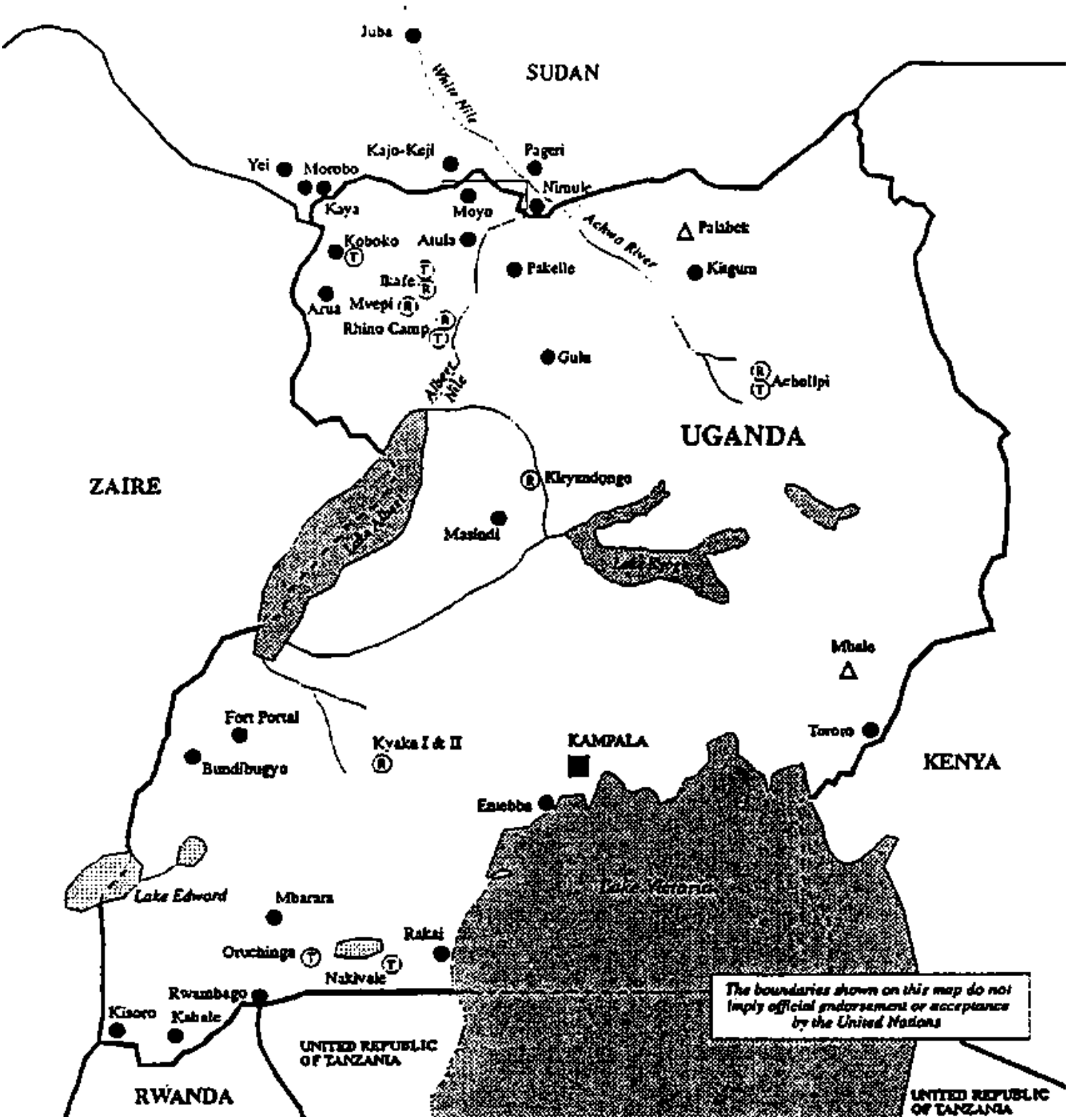
Map taken from MSF–CIS Bi–Monthly Bulletin



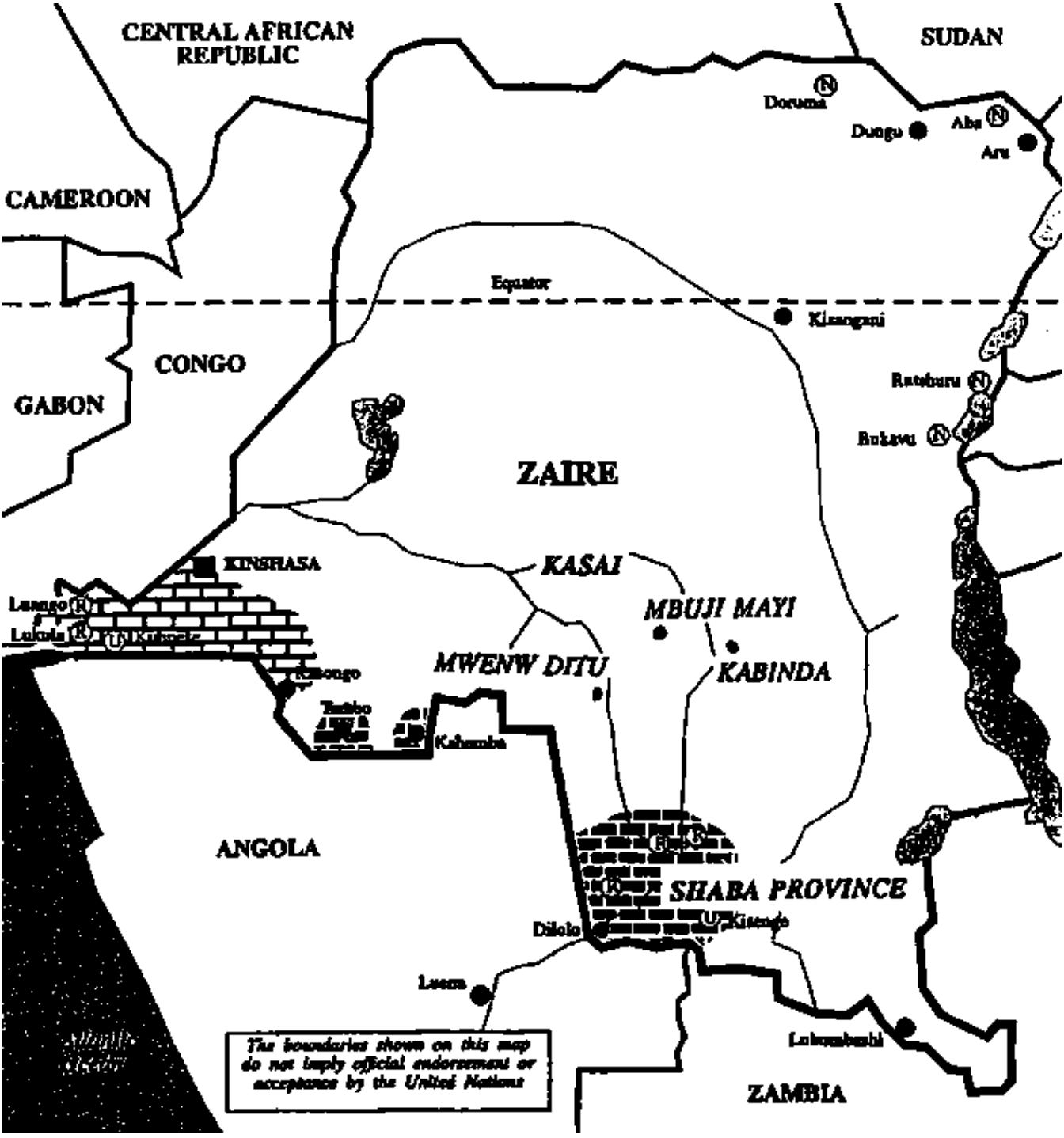
MAP 12 Somalia


LIBYAN ARAB JAMAHIRIYA
ARAB REPUBLIC OF EGYPT
Red Sea
Port Sudan
SUDAN
CHAD
Karora
ERITREA
Omdurman
KHARTOUM
Kassala
Tesenay
Wad Medani
Showak
El Gedaref
Humera
Geneina
Kosti
Sennar
El Obeid
Nyala
Um Haraz
Ed Damazin
Kadugli
Malakal
Nasir
ETHIOPIA
Akobo
Pochalla
CENRAL AFRICAN REPUBLIC
Juba
Yei
Nimule
ZAIRE
KENYA
UGANDA
The boundaries shown on this map do not imply official endorsement or acceptance by the United Nations

MAP 13 Sudan

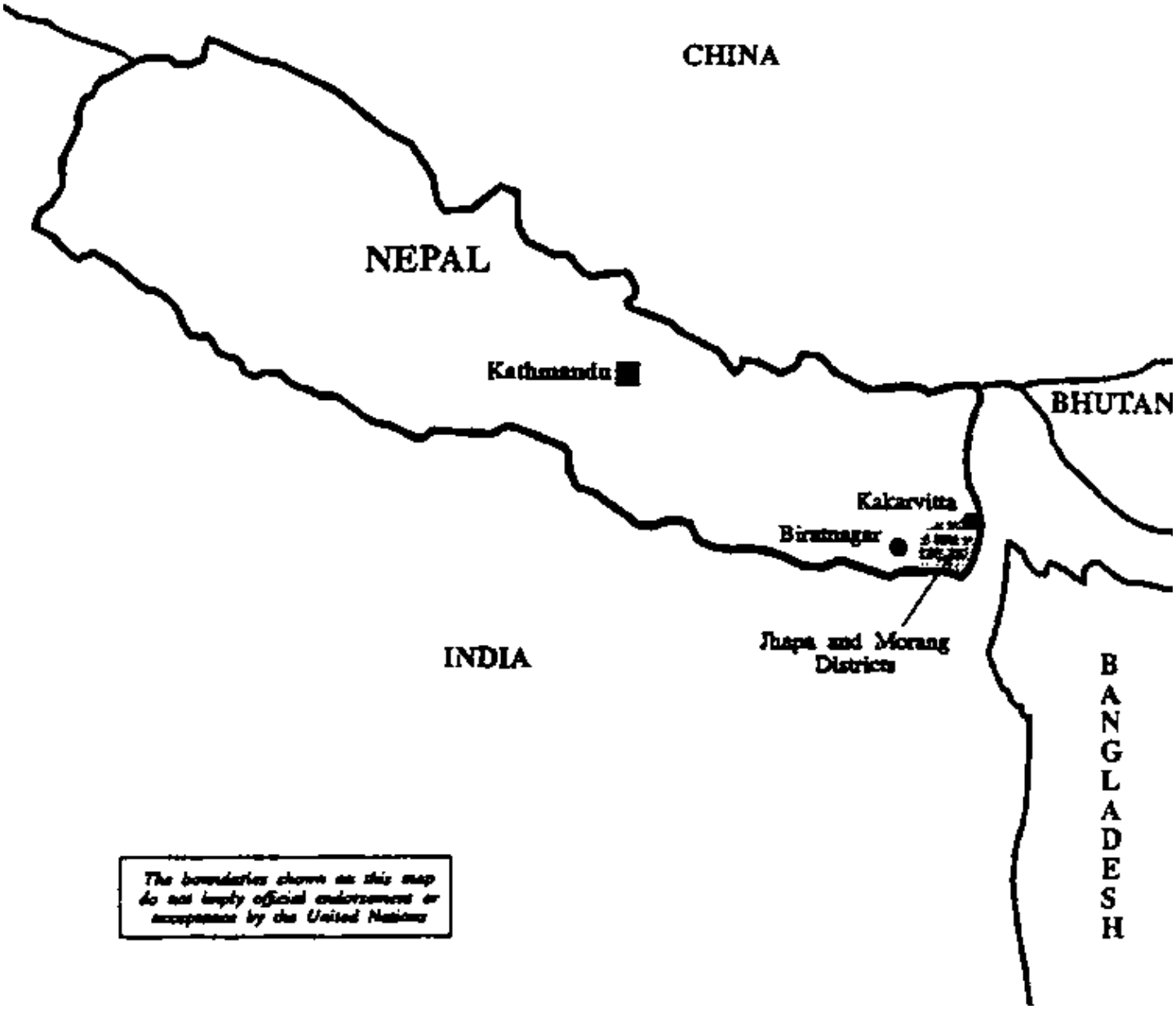


MAP 14 Uganda

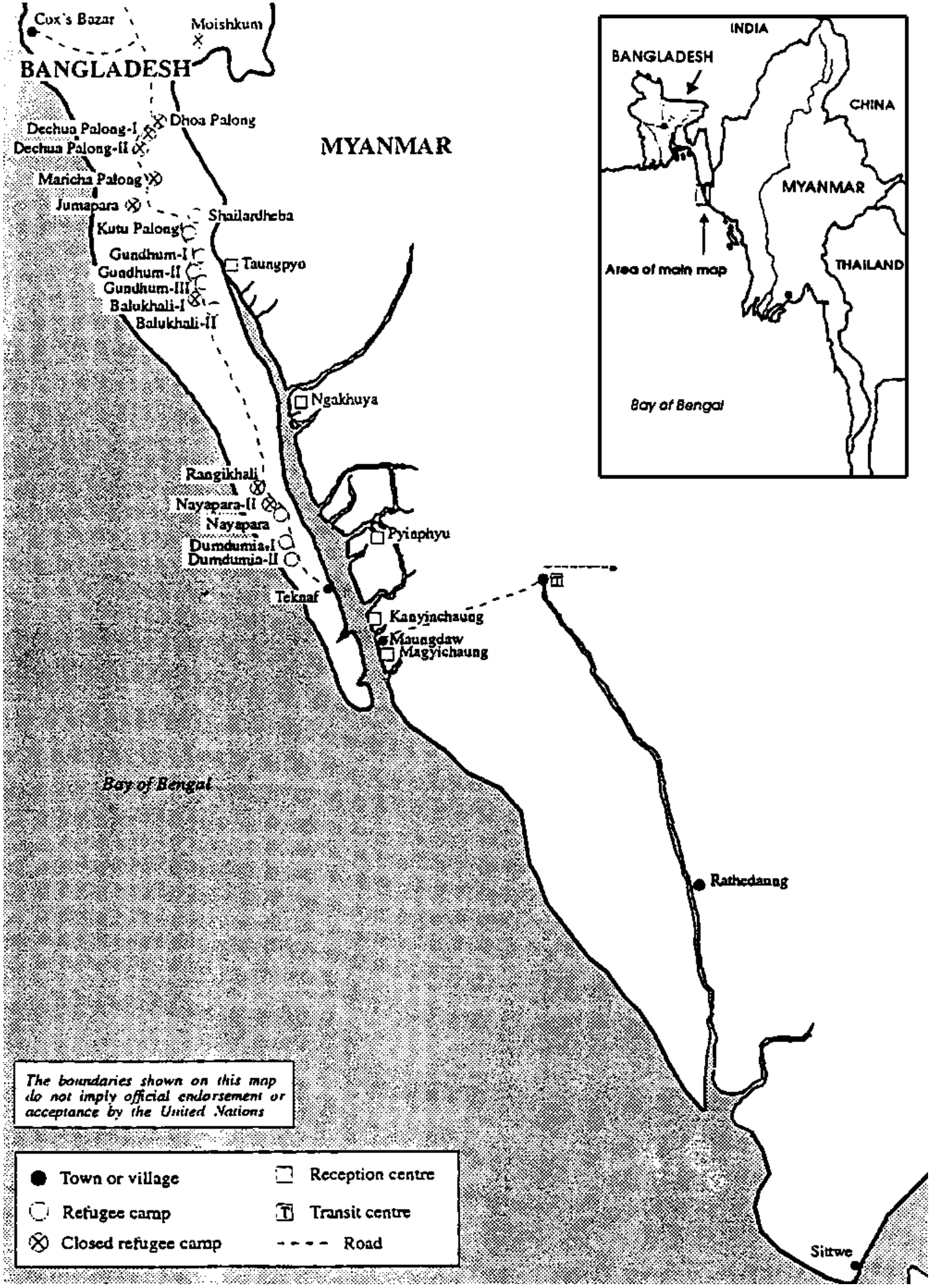

CENTRAL AFRICAN REPUBLIC
SUDAN
Dorumi
Dungu
Aba
Aru
CAMEROON
Equator
Kisangani
CONGO
GABON
Butembo
Bukavu
ZAIRE
KINSHASA
KASAI
MBUJI MAYI
KABINDA
MWENW DITU
Kahemba
ANGOLA
SHABA PROVINCE
Dilolo
Kisenge
Luena
Lubumbashi
ZAMBIA
The boundaries shown on this map do not imply official endorsement or acceptance by the United Nations

MAP 15 Zaire

MAP 17 Afghanistan


CHINA
NEPAL
Kathmandu
BHUTAN
Kakarvitta
Biratnagar
Jhapa and Morang Districts
INDIA
BANGLADESH
The boundaries shown on this map do not imply official endorsement or acceptance by the United Nations

MAP 18 Nepal


Cox's Bazar
Moishkum
BANGLADESH
MYANMAR
Dechua Palong-I
Dechua Palong-II
Dhoa Palong
Maricha Palong
Jumapara
Kutu Palong
Shailardheba
Gundhum-I
Gundhum-II
Gundhum-III
Balukhali-I
Balukhali-II
Taungpyo
Ngakhuya
Rangikhali
Nayapara-II
Nayapara
Dumdumia-I
Dumdumia-II
Pyinphyu
Teknaf
Kanyinchaung
Maungdaw
Magyichaung
Bay of Bengal
Rathedaung
Sittwe
INDIA
BANGLADESH
CHINA
MYANMAR
THAILAND
Area of main map
Bay of Bengal
The boundaries shown on this map do not imply official endorsement or acceptance by the United Nations
Town or village
Refugee camp
Closed refugee camp
Reception centre
Transit centre
Road

MAP 19 Bangladesh