Refugee Nutrition Information System (RNIS), No. 20 – Report on the Nutrition Situation of Refugee and Displaced Populations

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ACC/SCN REFUGEE NUTRITION INFORMATION SYSTEM

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HIGHLIGHTS

Angola *International humanitarian agency programmes are now shifting their emphasis to reconstruction and rehabilitation of this war damaged country. Support for displaced and war–affected people will continue and large scale resettlement programmes have been drawn up. The nutritional condition of this population is stable and as peace consolidates this is expected to continue.*

Great Lakes Region *As rebel forces gained control of the country in mid–May, large numbers of Rwandan refugees and displaced from the Democratic Republic of Congo faced enormous hardship as camps were disbanded and newly displaced populations were inaccessible to humanitarian assistance. Mortality rates 20–40 times normal were recorded among these groups. However, many refugees have now returned to Rwanda and extremely high levels of malnutrition have been reported in transit camps. In Rwanda, food security is threatened by food price inflation and insecurity, which remains a problem particularly in prefectures receiving large numbers of recent returnees. In some cases, food distributions at commune level have been impeded. In Burundi, recent assessments show that populations in many of the "regroupment" camps as well as those for the displaced are living under conditions of very poor food security. The situation is made worse by economic sanctions and insecurity. Although there are few data, the nutritional situation in many of these camps is likely to be extremely poor. In Tanzania, logistical difficulties have adversely affected relief programmes for the refugee camps in the Kigoma regions. However, nutritional survey data generally shows a stable and adequate situation with levels of wasting less than 7% in all camps.*

Ethiopia *A recent survey in the long–standing returnee area of Gode showed a catastrophic situation with over 50% wasting, and 10% severe wasting. Recommendations were made to implement supplementary feeding programmes immediately, and to initiate programmes to encourage self–sufficiency for the longer term.*

Kenya *Lack of supplies of corn soy blend have prevented its distribution in the general ration for Somali refugees in the Dadaab camps. This is extremely worrying given the rates of wasting of 30% in these camps reported in the last RNIS. Nutritional assessments in the Kakuma camps showed levels of wasting of 40% among 6–11 year olds, and 20% among the 12–20 year old age group. The prevalence of anaemia was*

estimated to be between 75–85%. School feeding programmes are being implemented to remedy the situation.

Liberia/Sierra Leone *The nutritional situation in Liberia has continued to improve in line with the increased stability in the country. Almost all areas are now accessible and most recent nutritional surveys show marked reductions in levels of malnutrition (to under 10% wasting) compared to previous surveys. There is still much reconstruction work to be undertaken in the country and as the hungry season approaches, it is likely that levels of wasting will increase. We have no information following the recent coup in Sierra Leone. Widespread violence in Sierra Leone, which preceded a coup d'etat forced many organisations to scale down or close operations in the country. It is unclear how this will impact the health and nutrition situation of the population.*

Somalia *Following the recent drought and reduced "Der" harvest food security has been deteriorating rapidly in Somalia. Food price inflation has been dramatic and levels of malnutrition appear to be on the rise with health centres reporting many more admissions of malnourished children. Water shortages are also affecting many areas and cholera cases are being reported in a number of major towns.*

Sudan *A bumper harvest in Sudan should ensure adequate food security for most of the country although some of the traditionally food deficit areas may still experience food shortages later in the year. There have recently been significant advances made by the SPLA in the south which along with rebel activity in northern Uganda has led to large numbers of returning refugees. Nutritional surveys show a widely varying situation amongst the displaced camps in southern Sudan. In some case levels of wasting are more or less normal while in other situation near famine conditions prevail with levels of wasting above 30%. These appalling conditions are mainly due to poor general ration deliveries and limited possibilities for supplementation of the ration.*

Afghanistan *Food shortages have recently been acute and food security appears to be deteriorating throughout the country. Food price inflation has been very pronounced putting the cost of bread beyond the means of large sections of the urban population. The coming harvest may also be poor in many areas and so may not alleviate this food stress. However, a recent nutritional survey in Kabul shows that nutritional status has not so far been adversely affected by the current food insecurity.*

ADEQUACY OF FACTORS AFFECTING NUTRITION

Factor	***Angola***	***Burundi***	***Rwanda***	***Tanzania***	***Dem Rep Congo***	***Liberia***	***Sierra Leone***	***Somalia***	**S. *Sudan***	
1. Degree of accessibility to large population groups due to conflict	✓	O	O	✓	X	✓	✓	✓	O	X
2. General resources										
– food (gen. stocks)	✓	✓	✓	✓	✓	✓	✓	✓	X	X
– non–food	✓	✓	✓	O	✓	✓	✓	✓	X	?X
3. Food pipeline	X	✓	✓	✓	✓	✓	✓	✓	X	X
4. Non–food pipeline	✓	✓	✓	O	✓	✓	✓	✓	X	?X
5. Logistics	✓	X	O	X	X	O	✓	O	O	X
*6. Personnel**	✓	?✓	?✓	O	✓	✓	✓	✓	O	✓
7. Camp factors"	✓	X	✓	O	X	O	✓	O	O	?X
8. Rations – kcals	✓	X	O	O	O	?✓	✓	O	O	X
*– variety/micronutrients****	✓	X	O	O	O	?✓	✓	O	O	X
9. Immunization	✓	?X	✓	✓	✓	X	O	O	X	✓
10. Information	✓	X	X	✓	O	✓	✓	O	O	O

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

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

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

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

Note: *Situations for which detailed information is available are included in this table. Other potentially critical situations* (*e.g. Ethiopia or Shaba, Democratic Republic of Congo*) *are not currently included due to* a *lack of detailed information.*

They will be included as more information becomes available.

NOTE

The ***Reports on the Nutrition Situation of Refugees and Displaced People*** are published every three months. Updates on rapidly changing situations, and where new information is available, are published on an 'as needed' basis, depending on the current situation. The information in the Updates is mainly equivalent to that in Table 1 – population numbers in different nutritional risk categories – plus any new nutritional survey data, similar to the presentation in Annex 1 of the full reports. Further outputs will be developed in response to needs.

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

INTRODUCTION

The UN ACC/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 with the intention of raising awareness and facilitating action to improve the situation. This system was started on the recommendation of the SCN's working group on Nutrition of Refugees and Displaced People, by the SCN in February 1993. This is the twentieth of a regular series of reports. Based on suggestions made by the working group and the results of a survey of RNIS readers, the Reports on the Nutrition Situation of Refugees and Displaced People will be published every three months, with updates on rapidly changing situations on an 'as needed' basis between full reports. The box above gives further details.

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

The tables, and figures at the end of the report can provide a quick overview. Table 1 gives an estimate of the probable total refugee/displaced/returnee population, broken down by risk category. Populations in category I in Table 1 are currently in a critical situation, based on nutritional survey data. These populations have one or

more indicators showing a serious problem. Populations at high risk (category IIa in Table 1) of experiencing nutritional health crises are generally identified either on the basis of indicators where these are approaching crisis levels and/or also on more subjective or anecdotal information often where security and logistical circumstances prevent rigorous data collection. Populations at moderate risk (category IIb in Table 1) are potentially vulnerable, for example based on security and logistical circumstances, total dependency on food aid, etc. Populations in category IIc are not known to be at particular risk. In Table 2, refugee and displaced populations are classified by country of origin and country of asylum. Internally displaced populations are identified along the diagonal line. Figure 1 shows the data in Table 1 as a current snapshot of population numbers and estimated risk. Figure 2 shows trends over time in total numbers and risk categories for Africa. 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. Data from 1993/4 shows that the most valid predictor of elevated mortality is a cut off of 15% wasting (ACC/SCN, 1994, p81).

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.) Equivalent cut–offs to –2SDs and –3SDs of wt/ht for arm circumference are about 12.0 to 12.5 cms, and 11.0 to 11.5 cms, depending on age.

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

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

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

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

References

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

Schofield C. and Mason J. (1994) *Evaluating Energy Adequacy of Rations Provided to Refugees and Displaced Persons.*

Paper prepared for Workshop on the Improvement of the Nutrition of Refugees and Displaced People in Africa, Machakos, Kenya, 5–7 December 1994. ACC/SCN, Geneva.

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

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

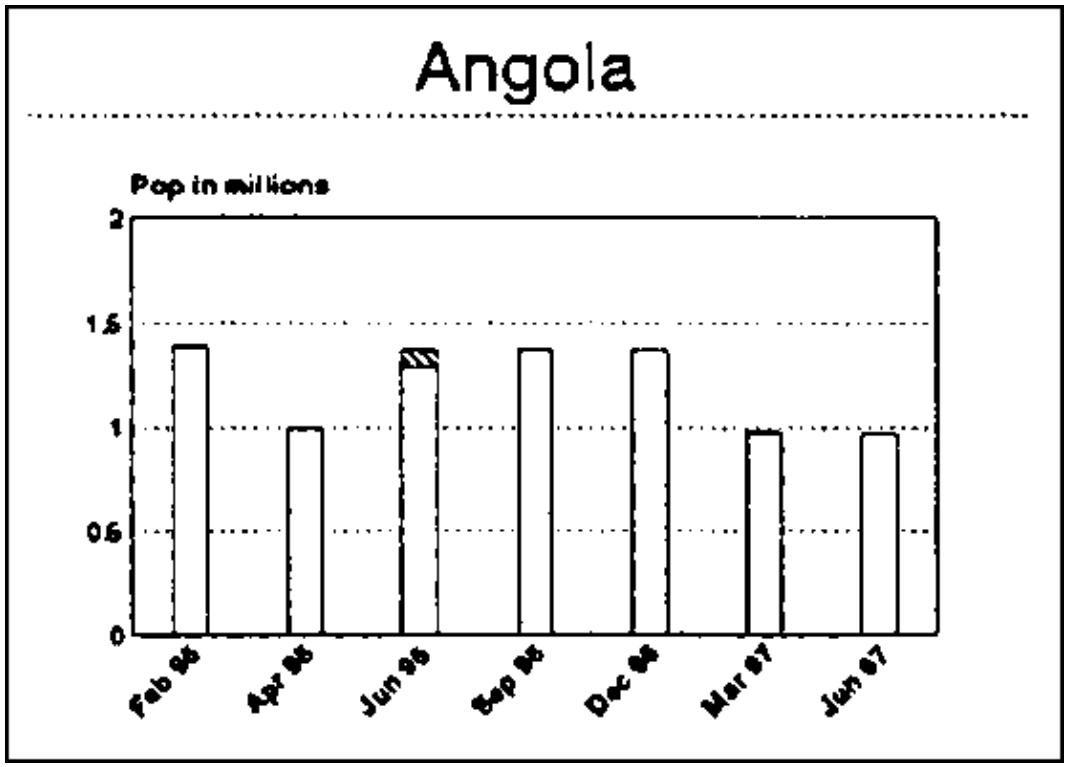
SUB–SAHARAN AFRICA

1. Angola

(see Map 1)

As peace in Angola slowly consolidates, epitomised by the swearing in of the Government of National Unity and Reconciliation, the focus of humanitarian aid programmes is shifting from emergency assistance to development and reconstruction. The mandate of the peacekeeping force has been extended by the UN Security council until the end of June 1997. Much has been accomplished in recent times including:

- the provision of food aid to 1.2 million people;
- the provision of seeds and tools to 500,000 families;
- expansion of humanitarian activities, including immunisation programmes, to large sections of the population;
- continuation of the demobilisation process.



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

However, many of these programmes will need to continue in order to ensure an enduring peace and a successful end to the long−standing humanitarian crisis [UN 1997, WFP 18/04/97].

It is estimated that 977,000 war−affected or displaced people, and demobilised soldiers will require humanitarian assistance in 1997. This assistance will be in the form of food aid for vulnerable groups, as well as for ex−combatants and their families. The goals of the programme will be to facilitate the process of return and reintegration into society. Therefore, assistance must be carefully targeted once people return home. Large−scale resettlement programmes are already scheduled to begin in June in Huila province [UN 1997, IOM 28/04/97, WFP 02/05/97],

Despite a generally calm situation in the country, some areas are reporting insecurity. For example, areas of Benguela province have been virtually deserted due to attacks on villages with large numbers fleeing to Cubal town. There are now an estimated 200,000 IDPs in the province. IDPs are also arriving in Malange from areas north of Lombe city. This population movement is however believed to be due to the increase in free movement in UNITA areas. A most recent report indicates that the Angolan army has moved into north−western areas over the past week to take back territory under the control of the former rebel group UNITA. A number of fatalities occurred during the fighting and there are fears that the fragile peace accord between the government and former rebels could be threatened by this action. There are reports that up to 3,000 people are newly displaced in the northeast [DHA 30/03/97, IRIN 27/05/97, 06/06/97].

Reports indicate drought−related crop damage in many coastal districts and absence of rain in Cuanza Norte Province; in eastern provinces, better rainfall has led to higher production. Data used for comparison purposes is known to be incomplete, however best estimates are that while production has increased for many crops, yields remain far below domestic needs. The provision of seeds and tools has led to an increase in areas under cultivation; however shortages of fertilizers, hand tools and animals are constraints to increasing production [DHA 30/03/97, FAO 12/05/97].

The above−mentioned problems are not thought to be adversely affecting the stable and adequate nutritional status of the population. This was reflected in a recent assessment in the Kuito/Cunningha regions where all children registered in an agricultural rehabilitation programme were weighed and measured. Among this group there was an improvement in nutritional status compared to results of an earlier assessment conducted in August 1996 [CONCERN 19/05/97].

A recent survey in Luena, Moxico province, showed 4.4% wasting, with 1.0% severe wasting among a centre for returnees. Oedema was measured at 0.6% (see Annex I (la)). Measles immunisation coverage, as confirmed by a vaccination card, was 38.8%. Among the resident population, wasting was measured at 6.6% with 1.2% severe wasting. Oedema was measured at 1.2% (see Annex I (1b)). Measles immunisation coverage, as confirmed by a vaccination card, was 48.2% [MSF−B 20/04/97].

Food stocks were reportedly low in mid−April with maize, CSB, pulses, oil and sugar stocks expected to run out shortly. Shortages could seriously affect the programmes for demobilisation and for the displaced and war affected [WFP 14/03/97].

Overall, the affected population in Angola is not currently thought to be at heightened nutritional risk (category IIc in Table 1).

How could external agencies help? A recently launched United Nations Consolidated Appeal for Angola highlights much of the work that needs to be done in Angola. The overall objective of programmes is to build up capacity in country so that national institutions can take full control of the rehabilitation and reconstruction efforts. Specific activities include:

- strengthening the health information system;
- provision of seeds and tools for returnees, along with fertilizers;
- restoration of primary health care structures;
- provision of essential drugs;
- training of health workers.

Low food stocks as of mid−April could jeopardise assistance to soldiers and the war−affected population. The survey s from Moxico province indicates a need to improve measles immunisation coverage in the area. This could be a more generalised situation that needs attention in Angola.

2. Benin/Ghana/Togo Region

There remain approximately 13,500 assisted Togolese refugees in Benin and Ghana. These refugees originally fled political unrest in Togo in 1993. Repatriation began once the political situation allowed, and in 1996, 50,000 people returned to Togo from Ghana and almost 9,000 people from Benin. It is anticipated that, providing the political situation remains stable, all but a very few people will have repatriated by the end of 1997. This population is not considered to be at heightened nutritional risk (category IIc in Table 1).

3. Burkina Faso and Mauritania – Malian Refugees

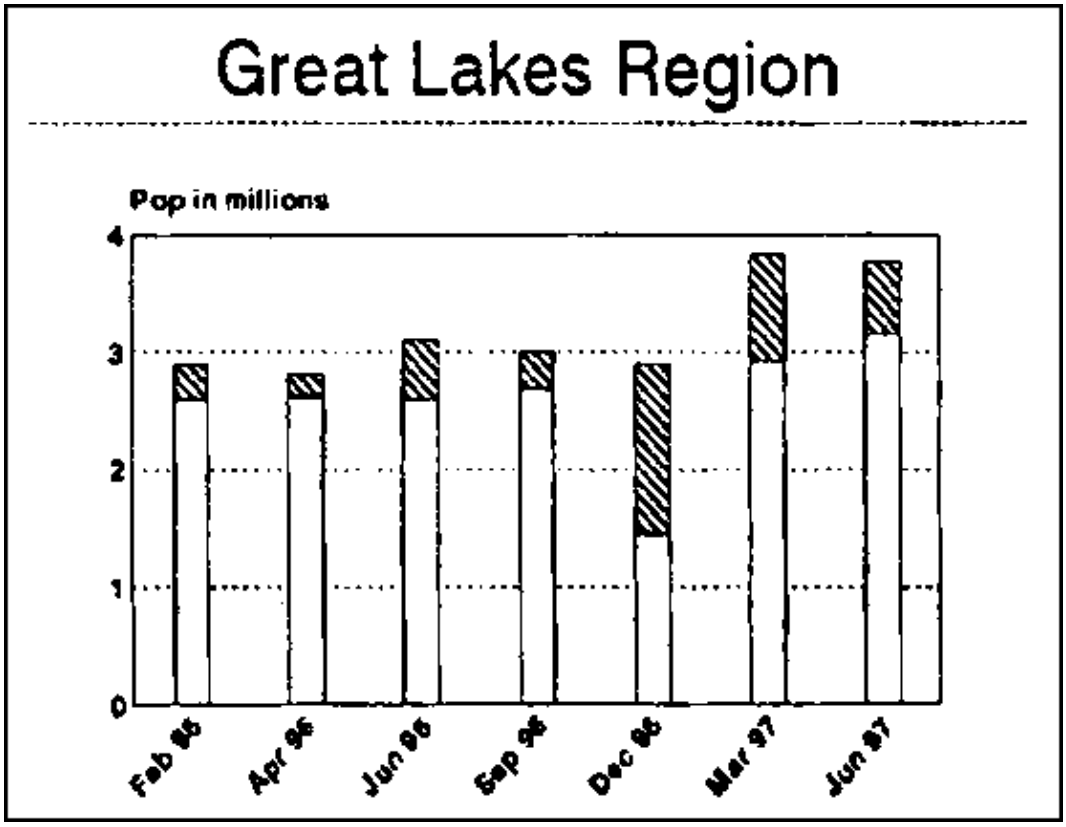
Burkina Faso There are approximately 24,000 Malian refugees remaining in Burkina Faso [UNHCR 26/05/97]. There are no reports of change to what has been described as an adequate and stable nutritional status of this population.

Mauritania There remain approximately 22,500 Malian refugees in Mauritania, comprised largely of women and children, the men having already repatriated. This population is considered to be almost totally dependent on food aid, and the ration is set at 1900 kcals/person/day. Repatriation, which is scheduled to be completed by the end of 1997, is on–going, with approximately 1,000 people returning each month [WFP 01/04/97].

4. Burundi/Rwanda (Great Lakes) Situation

(See Maps 4 and 14)

As rebel forces swathed across Democratic Republic of Congo, assuming control of the country in May, thousands of Rwandan refugees and former Zairians were displaced. There were numerous reports of high mortality and malnutrition rates among these populations as a result of arduous journeys and lack of access by humanitarian agencies. However, many refugees have now been repatriated, although returnees passing through transit camps in Rwanda are in a poor nutritional state. There is currently a high level of insecurity in Rwanda, partly fueled by the large number of returnees. Food price inflation is also causing concern. The food security situation among populations in Burundi living in regroupment camps is currently very poor and is exacerbated by the continuation of some level of sanctions and insecurity. Water and sanitation are also problems in many of these camps. In Tanzania, is spite of logistical difficulties with food and water provision for the Kigoma camps, refugees appear to be in a stable nutritional situation.



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

Estimates of populations affected regionally are summarised in the box below:

Location	Feb 96	Apr 96	Jun 96	Sep 96	Dec 96	Mar 97	Jun 97
Burundi	275,400	290,000	289,000	300,000	296,000	300,000	265,000
Rwanda	737,000	737,000	749,000	598,000	1,179,000	2,600,000	2,600,000
Tanzania	653,000	624,000	642,000	653,000	759,000	344,000	390,000
Democratic Republic of Congo	1,211,000	1,166,000	1,419,000	1,444,000	668,000	599,000	514,000
TOTAL	2,883,200	2,823,900	3,106,000	3,002,000	2,913,500	3,843,000	3,769,000

Democratic Republic of Congo The Alliance of Democratic Forces for the Liberation of Congo (ADFL), led by Laurent−Desire Kabila swept across the country, arriving in Kinshasa on the 16th of May 1997. After a series of negotiations, Mobutu left Kinshasa leaving the way open for Kabila to assume control of the country. A number of governments, including those of Kenya, Angola, Sudan, Lybia, Rwanda and Burundi, have acknowledged the new government. Over the past weeks there have been numerous allegations levelled against the ADFL of human rights abuses including incidents involving massacres of Rwandan refugees [ERIN 17−18/05/97].

The advances westward of Kabila's forces meant that refugees were continually forced to move from one makeshift camp to another, with barely enough time between moves for the delivery of humanitarian aid. There were reports of lack of food and water in these make−shift camps and of cases of cholera. Many groups of refugees emerged from arduous journeys requesting repatriation. For example, a group of 20−30,000 people who were believed to originate from Katale and Kahindo camps, emerged near Sake [IRIN 01/04/97, WFP 04/04/97].

In March, ex−FAR and Interhamwe elements reportedly separated from the refugees, moving toward borders on neighbouring countries. Refugees started to gather along the rail lines clustered in several groups near Kisangani, where it was periodically possible to deliver emergency food aid to at least 90,000 refugees. By mid−April the number of refugees and IDPs being fed in the Kisangani area were 141,000. The ration delivered to these refugees and displaced people was 2050 kcals/person/day. However, reports at that time

indicated that the refugees were still weak and sick with some cases of cholera being reported. The mortality rates varied from 11.4– 20/10,000/day (see Annex 1 (4a)). These rates are 20 to 40 times normal, and well above the 2/10,000/day which indicates a crisis. By mid–April, the planned evacuation of 80–100,000 refugees and internally displaced people had begun [IRIN 03/04/97, 23/04/97, 11/04/97, 18/04/97].

Repatriation and resettlement are continuing, both by air and land transport. The most vulnerable and weak are transported by air. Many refugees arrived in Biaro, south of Kisangani, to await repatriation. There were anecdotal reports that malnutrition rates were as high as 60% amongst this population. All refugees in Biaro have now been moved to Kisangani and repatriation efforts will now be farther south. Approximately 45,000 refugees have been airlifted back to Rwanda, using planes to carry food into the former Zaire, and then carry people out. Despite guarantees given by rebel authorities, access and safe passage for staff and vehicles carrying relief assistance for Rwandan refugees has often been problematic [IRIN 02/05/97, 5–11/05/97, 21/05/97, 03/06/97, USAID 11/04/97, 16/05/97].

There are also other concentrations of refugees. Thirty thousand refugees have been reported to be assembled at the Angolan border, and a further 65,000 are on their way to the Central African Republic. These are refugees from the former Tingi Tingi camps. There is a growing number of refugees in the CAR with refugees from Rwanda, Democratic Republic of Congo and Sudan arriving in Mboki camp [IRIN 15/05/97].

There are also 8,000 refugees who have crossed into the Congo, with a further 13,000 gathered on the border. There had been 50,000 Rwandan refugees in the Mbandaka area, which is near the Congolese border, a certain number of whom crossed into the Congo as the rebels took the area. Many of these refugees were reportedly in very poor condition and extremely hungry. Mortality rates reported are extraordinarily high. Repatriation by air of some of those near the border has begun. As many as 5,000 of those refugees currently in the Congo were impossible to reach due to the marshy condition of the land. This population lacked food, water and shelter and cases of cholera were being reported from the area. Access to these populations varies with what appears to be a deteriorating security situation in the Congo [IRIN 09/05/97, 5–11/05/97, 19–25/05/97, 03/06/97, 06/06/97, WFP 18/04/97].

Approximately 3,400 refugees have also arrived in Northern and Luapula provinces of Zambia. The vast majority are nationals from the former Zaire although this population does include some Rwandans and Burundians. These refugees are generally in good health and adequately nourished [IFRC 04/03/97].

The nutritional situation in the Eastern part of the country remains precarious. A nutritional survey at the beginning of the year in Sake located 20 km from Goma (population 21,800) found 10.7% wasting with 3.6% severe wasting of which 2.3% presented with oedema (see Annex I (4b)). Over half of the Sake population were displaced from the Masisi inter–ethnic conflict. The rate of wasting among the displaced was 13.5% with 20.4% wasting amongst female headed households. The cause of malnutrition was believed to be largely due to a lack of food. Measles immunisation coverage was low with less than 10% of children having documentary evidence of immunisation [MSF–H 01/02/97].

A nutritional survey conducted in Rwanguba health zone situated on the border with Uganda and Rwanda found an extremely alarming situation. Rates of wasting were 12.6% yet prevalence of severe wasting and/or oedema was extremely high at 9.4% (see Annex I (4c)). The malnutrition was largely attributed to ah unbalanced diet and in particular a shortage of beans. There was limited feeding centre capacity in the area and measles vaccination coverage was very low [MSF–H 16/03/97].

Recognising that these population figures change rapidly, it is estimated that 382,000 refugees remain in Democratic Republic of Congo. With all the recent large scale population movements, estimates of the number of IDPs are uncertain. The last RNIS report indicated that there were 132,000 IDPs, although some have now returned home [IRIN 02/05/97, 5–11/05/97, 21/05/97, USAID 11/04/97, 16/05/97].

Rwanda It is currently estimated that 2.6 million people in Rwanda will require food aid assistance for the first six months of 1997. This total number includes recent returnees, previous returnees who will have to leave farm areas they currently occupy and other vulnerable groups (i.e. widows, the elderly, orphans). Although the level of insecurity in Rwanda remains high, food distributions during March were not adversely affected. Tensions remain particularly high in the prefectures of Gisenyi and Ruhengeri with many of the repatriated refugees from Democratic Republic of Congo arriving at communes within these prefectures. Numbers of returnees from Democratic Republic of Congo, which were low in March, increased in April. Efforts are being made to pre–position food at transit centres so that new returnees can be provided with a one month's ration before returning to their home communes. All returnees are provided with high energy biscuits and wet

feeding while at the transit centres. Any further distributions will be carried out at commune level and be overseen by local authorities. By April, rains were affecting the delivery of food in many parts of the country and hampering project activities. Most recent reports indicate that insecurity in Ruhengeri has led to suspension of all distribution activities [FAO 23/12/96, WFP 14/03/97, 04/04/97, 18/04/97],

Market prices of food throughout the country continue to rise due largely to the increased demand of the returnees. Other inflationary pressures come from the poor harvest in both Rwanda and southern Uganda and the ongoing trade embargo with Burundi [WFP 28/03/97]. Prices of staple foods have increased by 30% compared to the same time last year.

Seeds have been widely distributed in Rwanda. However, although all the planned distributions for beans were carried out there were shortfalls in the distributions of sorghum and sweet potatoes. As sweet potatoes are a staple food in the Rwandan diet, it is likely that this will have a negative impact on the already fragile food security situation in the country. There have also been recent reports of lack of maize meal and pulses in the country due to railway delays. This has led to a shortage of pulses in Runda transit centre, thereby slowing the return of returnees from the centre to their home communes [IRIN 23/04/97, WFP 28/03/97].

There have been some recent nutritional data on children screened at transit centres. In Nkamira, levels of wasting amongst under fives screened between the 31 st of March and 6th of April were extremely high with large numbers of severely malnourished children. A similar screening exercise in Musange transit centre in the first two weeks of April also found very high levels of wasting and unusually high levels of severe wasting and/or oedema. As screening was not systematic these results must be viewed with caution; however, the degree of measured severe wasting alone gives grave cause for concern about the nutritional situation of this returning population [MSF−B 25/05/97].

There have been recent discussions regarding the establishment of a food assessment unit in the country which will help to identify pockets of poverty and areas considered to be vulnerable. This should also allow for some follow−up with the severely malnourished people seen at the transit centres and lead to better targeted food aid interventions in the future [WFP 02/05/97].

Before the large−scale repatriation in November and December 1996, there were approximately 16,000 refugees from the Masisi region in Democratic Republic of Congo in Umumbo camp who were moved to Kibiza. Following some repatriation, approximately 12,000 remained at the new site. A screening (using MUAC) of this population in December 1996 showed 9.7% wasting with 1.0% severe wasting (see Annex I (4d)). Oedema was measured at 0.3%. There are a further 3,000 Burundi refugees in Rwanda housed in two camps [MSF−B 01/01/97, UNHCR 28/04/97].

Burundi It is currently estimated that there are 600,000 internally displaced people in Burundi. Some of this population are either living with family or friends, or are near enough to their farms to cultivate land and therefore do not require emergency assistance. An estimated 265,000 therefore require emergency assistance. The security situation remains volatile with recent incidents including a mine explosion in Bujumbura, an attack on a regroupment camp in Cibitoke, and an attack by rebels in Bururi in southern Burundi. These security incidents continue to cause population displacements [DHA 09/04/97, FAO 04/03/97, IRIN 03/06/97, WFP 28/03/97, 09/05/97].

Regional sanctions have been somewhat relaxed against Burundi, with food and food products, education and construction materials, medicines and agricultural inputs now exempted [WFP 18/04/97],

A recent FAO/WFP Crop and Food Supply Assessment Mission reported a precarious food security situation in the country following several years of civil unrest and below average agricultural production. The report also argued that the situation had been exacerbated by the economic embargo. Aggregate food production for the first 1997 season is estimated at 18% below the pre−crisis average for 1988−93. The outlook for the second and third season suggests *a* recovery in output although the overall food supply situation remains extremely tight. On average, food prices increased by more than 40−50% compared to the beginning of 1996, whilst that of beans alone has more than doubled in most areas since July 1996, reflecting a reduced harvest [FAO 04/03/97].

Large numbers of people are still living in regroupment camps, which are similar to camps for internally displaced people. For example, in Bubanza province, 86,190 people are grouped in 36 displaced and regroupment camps where most have access to their fields and military escorts are provided for harvesting. A good harvest is anticipated. In Cibitoke province, 60% of the population (100,000 people) presently reside in regroupment camps. Owing to the insecurity in the province, the population does not have access to land and

there is little opportunity to supplement rations [FAO 04/03/97].

A rapid evaluation team recently visited 70 sites housing displaced persons in nine provinces. Findings on food resources and agricultural production were that in 45% of sites the population was considered to be highly vulnerable. This was defined as having one meal a day, living mostly on roots and with poor access to land, seeds and tools, reduced time spent farming due to insecurity, and a projected reduction in harvests. Thirty seven percent were considered moderately vulnerable since they are living on food left from last year's poor harvest and have limited access to land and farm inputs [FAO 04/03/97].

Piece−meal nutritional data indicate that some populations are in an extremely poor nutritional state. For example, there are reports of people who had been hiding in forests for long periods emerging in a desperate nutritional state. Anecdotal reports for north Bubanza province indicate that 20% of new hospital admissions are for cases of adult malnutrition [IRIN 5−11/05/97]

At the end of February, a nutrition survey carried out in Karuzi showed 16.9% wasting with 3.1% severe wasting. Oedema was measured at 1.8% (see Annex I (4e)). Since then a mission to camps for the displaced or regrouped in Karuzi and Gitega provinces found "appalling" food water and sanitation conditions [MSF−B Feb. 97, WFP 28/03/97].

There are reports of at least 20,000 cases of typhus in Burundi, the worst outbreak since World War II [IRIN 5−11/05/97].

Tanzania The total number of refugees from the Democratic Republic of Congo and Burundi in Tanzania is estimated to be 390,000, comprised of 105,000 refugees in Kagera and 285,000 in Kigoma regions. There are still population movements across the borders between Democratic Republic of Congo and Burundi in both directions, with new arrivals and spontaneous repatriations being reported. A larger scale repatriation of refugees to the Democratic Republic of Congo is envisaged within three months [IRIN 03/04/07, WFP 04/04/97, 09/05/97].

Poor road conditions and limited trucking capacity are hampering food deliveries in the Kigoma region. Furthermore, these problems in early March made pre−positioning of food before the worst of the rainy season quite difficult. As a result, rations have been below the recommended levels. A shortage of beans has been experienced in all the Kigoma camps. Supplies of water to the camps have also been affected by these logistical difficulties as has movement of newly arrived refugees to camps. Agencies are still operating with very limited capacity in terms of human resources and materials [UNHCR May 97, WFP 14/03/97, 09/05/97, 23/05/97].

Despite these difficulties, indicators available point to a generally adequate health and nutrition situation. For example, in Nyarugusu camp for refugees from the former Zaire (estimated population 44,000) wasting and/or oedema was measured at 5.3% with 0.6% severe wasting and/or oedema (see Annex I (40). The CMR was 0.5/10,000/day; however the under−five mortality rate was 1.78/10,000/day, almost twice the normal level. Water availability was low at 9−12 litres/person/day [UNHCR 25/03/97].

In Mtendeli camp for Burundi refugees (estimated population 66,000), the CMR was 0.7/10,000/day and the under−five mortality rate was 1.51/10,000/day. Water availability was again low at 7 litres/person/day (see Annex I (4g)). Under five mortality rates in Lugufu camp are also high and are over 2/10,000/day. Most of the deaths are attributed to malaria and anaemia [UNHCR May 97, 25/03/97]

Preliminary results from surveys conducted in five camps showed a similarly adequate nutritional status. Levels of wasting and/or oedema varied from 1.8−7.2% with severe wasting and/or oedema varying from 0.0−0.8% (see Annex I (4h−l)). Further details are not yet available [UNHCR 13/05/97]

Feeding programmes are proceeding well in all camps with the exception of Muyvosi camp. Stocks of therapeutic milk were reportedly due to run out by the end of May 1997 [UNHCR 25/03/97].

A task force is being established in Kigoma to make preparations for the organised repatriation of refugees from the former Zaire from Tanzania [WFP 23/05/97]

Overall, the affected population around Sake can be considered to be at moderate nutritional risk (category IIb in Table 1) while the remaining refugee and displaced populations in Democratic Republic of Congo can be considered to be at heightened risk (category IIa in Table 1). The vulnerable population in Rwanda can be considered to be at moderate risk due to some insecurity, although it is possible that those in Ruhengeri are at

high risk. In Burundi, those described as highly vulnerable in a recent assessment are in category IIa, those described as moderately vulnerable are in category IIb in Table 1, and the remaining affected population is not currently though to be at heightened risk (category IIc in Table 1). The refugees in Tanzania are not currently thought to be at heightened nutritional risk.

How can external agencies help? In *Democratic Republic of Congo,* agencies will need to continue to seek out the displaced and provide full humanitarian support. Agencies should also support the repatriation process and provide food, water, shelter, and health services to those waiting for repatriation. In Sake, food distributions need to be established for the displaced population and reasons for poor food security of the displaced and in particularly female headed households need to be investigated. Low coverage of feeding programmes need to be improved. This may be achieved through improving active case finding or by switching from on−site to take home supplementary feeding. In Rwanguba health zone selective feeding programmes should be urgently implemented and the nutritional situation needs to be carefully monitored.

The monitoring of food security in *Rwanda* should become a priority. Food prices in particular should be monitored as inflation appears to be rampant. Given the large numbers of recent returnees to Ruhengeri and Gisenyi, and especially given the interruptions in food deliveries to Ruhengeri due to insecurity, food security and nutritional status should be carefully monitored in these two prefectures. High levels of wasting seen in the transit camps need to be addressed, most probably in their home communes where selective feeding programmes may need to be rapidly established.

In *Burundi,* high and moderately vulnerable regroupment camps need urgent attention. Many of these camps need improved food, water and sanitation provision. Nutritional and mortality surveillance should also be rapidly established in these camps. More specifically, more fortified blended food for the 'emergency selective feeding programmes currently operating should be provided.

In *Tanzania,* there is an urgent need to improve trucking capacity in the Kigoma region as well as to improve storage capacity. Efforts should also be made to provide maize meal as a priority in place of whole grain and preference also given to white maize to improve acceptability among the recipients. Consideration might also be given to providing rice once or twice a month to diversify the diet.

5. Central African Republic

There are approximately 32,400 assisted Sudanese and Chadian refugees in the Central African Republic. This total number is comprised of 5,000 Chadian refugees and 27,400 Sudanese refugees. See section on the Great Lakes Region for information pertaining to new arrivals from the Democratic Republic of Congo.

There are no reports of change to what has been described as an adequate and stable nutritional situation for these refugees (category IIc in Table 1).

6. Djibouti

There are 2,500 Somali and Ethiopian refugees in Djibouti being assisted. There are no current details on the nutritional status of this refugee population.

7. Ethiopia

(see Map 7)

The total number of assisted refugees in Ethiopia has decreased since the last RNIS report to 49,700 due to the repatriation of some Somali refugees and a re−registration in the Sudanese camps leading to a revised estimated population figure. This total number is comprised of 285,000 Somali refugees, 36,000 Sudanese refugees, 8,700 Kenyan refugees, 18,000 Djibouti refugees, 11,000 internally displaced people around Addis Ababa, and an additional 135,000 people in the Dollo region, including those in Gode.

The total number of Somali refugees in the nine camps in Eastern Ethiopia has decreased slightly to 285,000 people. This slight reduction in numbers is due to a pilot repatriation to Northwest Somalia. There are unconfirmed reports of spontaneous returnees from some camps in March 1997 [DHA Mar. 97]. There are no reports of change to the poor nutritional status of this group, although feeding programmes for all children under five years old are on−going.

A re−registration exercise is now complete in the Sudanese camps in Western Ethiopia, and the revised number of refugees is 36,000, a marked decline from previous estimates. A survey conducted in Fugnido camp showed 17% wasting, and is Sherkole camp, wasting was measured at 17% (see Annex I (7a,b)) [DHA Mar. 97]. Similarly high rates of malnutrition have been seen in Fugnido camp. In June 1995 wasting was measured at 17.6%, but had decreased to about 8% in 1996.

There are approximately 125,000 Kenyan and Somali refugees who have arrived in the Dolo region of Ethiopia, largely as a result of drought in their areas of origin. Assistance is being provided to this group [DHA Mar. 97].

A survey in Gode (estimated population 10,000), where international assistance had been suspended, showed a catastrophic situation. Wasting was measured at 52.3% with 10.1% severe wasting, oedema was measured at 0.6% (see Annex I (7c)). Recommendations were made to implement supplementary feeding programmes, and programmes to encourage self−sufficiency are also indicated [MSF−B May 97].

Overall, the Sudanese refugees, and those from Kenya and Djibouti, are probably not at heightened risk (category IIc in Table 1). There are no reports of change to the nutritional status of the Somali refugees, and they can be considered to be at heightened risk (category IIa in Table 1), with the exception of those in Fugnido and Sherkole camps, who are at high risk (category I in Table 1). The population of Gode in also in category I in Table 1. Little is known about the nutritional status of the newly identified population in the Dollo region.

8. Kenya

(see Map 8)

There are approximately 173,500 refugees in Kenya in need of assistance. This total number is comprised of 131,000 Somali refugees, 38,000 Sudanese refugees and 4,500 Ethiopian refugees.

The last RNIS report contained results of a nutritional survey carried out in the Dadaab camps (estimated population 115,000) for Somali refugees which showed a very serious situation with levels of wasting ranging from 26.0% to 33.3%. In response to this situation, a fortified blended food was distributed to improve the quality and caloric content of the general ration. However, stocks ran out in mid−April so distributions have now been discontinued [UNHCR 15/05/97].

Reports of an unusually high prevalence of anaemia among boys aged between 8−20 years in Kakuma camp (estimated population 32,000), contained in the last RNIS report, prompted a nutritional survey which was carried out in April 1997. This nutritional survey included school age children between the ages of 6−11 years who were assessed using weight−for−height and 12−20 year olds who were assessed using body mass index (BMI). Among the 6−11 year old age group, wasting was measured at 40% with 7% severe wasting (see Annex I (8a)). Anaemia prevalence was 69%. In the 12−20 year old age group wasting was measured at 19.8% with 0.8% severe wasting. Refer to Annex I for details pertaining to cut−offs used in this survey. Anaemia prevalence was 75−86%. There were no significant difference between the sexes, nor between those living in foster care and unaccompanied minors. Based on this survey, the problem of wasting and anaemia extended to all school age children. Since the survey a school feeding programme has been started in the camp and a fortified blended food (UNIMIX) will be re−introduced to the general ration in order to improve the situation [IRC Apr. 97, UNHCR 15/05/97].

A survey among children between 6−59 months old was also carried out. Levels of wasting were 14.0% with 0.6% severe wasting (see Annex I (8c)). However, oedema was measured at 5.0% and signs of anaemia and vitamin B complex deficiencies were noted. Levels of wasting in September 1996 were only 10.4% with 2.3% severe wasting. Crude mortality rates over the last six months have been 0.3/10,000/day. Measles immunisation coverage was 93% [IRC Apr. 97, UNHCR 14/04/97].

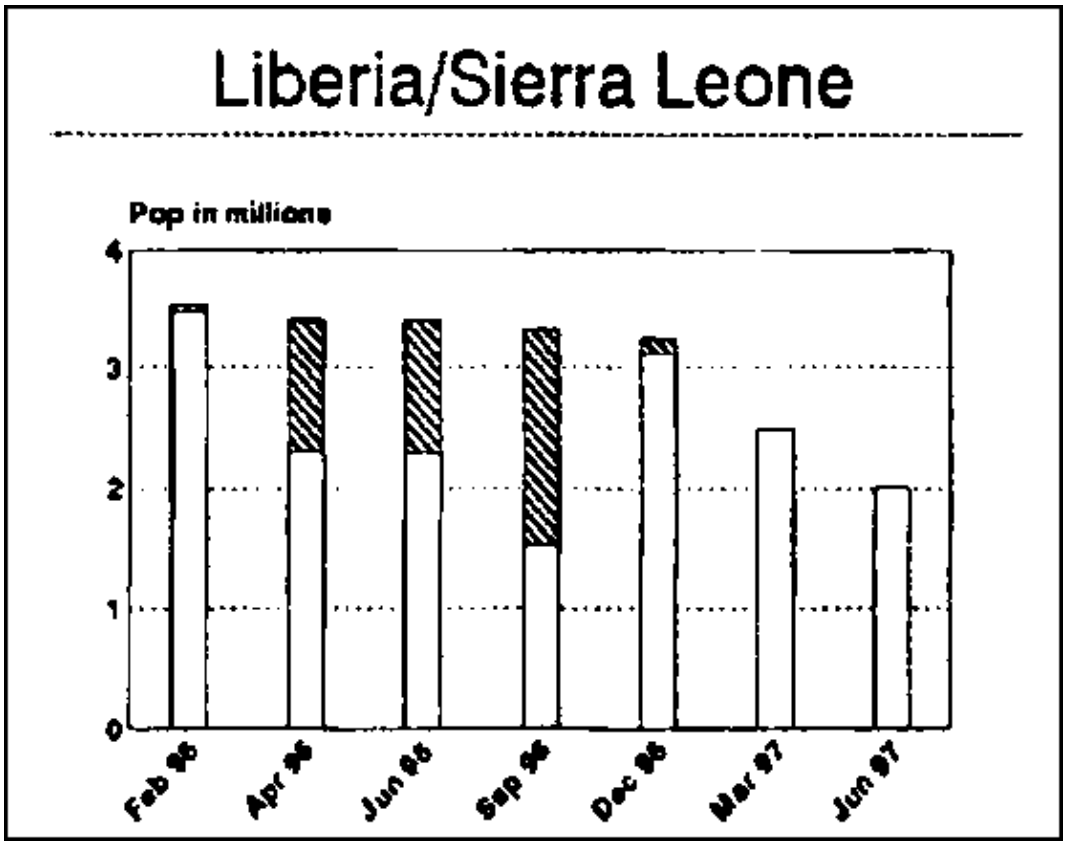
Overall, the refugees in the Dadaab area are likely to remain at high nutritional risk. Those in Kakuma camp are also at high nutritional risk (category I in Table 1). The remaining refugees are not currently considered to be at heightened risk (category DC in Table 1).

How can external agencies help? Fortified blended foods need to be re–introduced into the general ration in the Dadaab area camps as soon as possible to improve the quality and caloric content of the ration. There also needs to be an analysis of why levels of malnutrition are so high amongst all school age children and adolescents in Kakuma refugee camp and an assessment of whether the current school feeding programme is beginning to address the appalling nutritional situation found in the recent survey. Nutritional surveys should also be conducted on adults above the age of 20 years of age to determine whether the problem is only confined to school children and adolescents. It may be that there needs to be a considerable improvement made to the level of general ration provision.

9. Liberia/Sierra Leone Region

(see Map 9 a, b)

Despite a number of security incidents, the overall situation in Liberia is improving with signs of continuing stability. Although delayed, the electoral process is moving ahead in Liberia. A recent coup d'etat in Sierra Leone has meant humanitarian activities have been put on hold, however prior to the coup, people were returning home, either from within the country or from neighbouring countries. There are approximately 2 million people affected regionally.



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

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

Location	Feb 96	Apr 96	Jun 96	Sep 96	Dec 96	Mar 97	Jun 97
Liberia	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,100,000	710,000
Sierra Leone	730,000	756,000	756,000	609,000	609,000	548,000	453,000

Cote d'Ivoire	305,000	305,000	305,000	305,000	305,000	305,000	305,000
Guinea	605,000	536,000	536,000	536,000	536,000	536,000	545,000
TOTAL	3,440,000	3,397,000	3,397,000	3,250,000	3,250,000	2,489,000	2,013,000

Liberia The security situation in Liberia is improving and the disarmament process is now completed. These two factors are giving rise to optimism and small numbers of refugees and IDPs are returning home. Elections, which were scheduled for the 30th of May, have been postponed until July 1997. It is not currently felt that this alone will encourage large numbers of people to return. An estimated 710,000 people in Liberia presently require emergency food assistance. Most areas of the country are now accessible. In fact Grand Kru County remains the last inaccessible area in Liberia. WFP are continuing to support the peace process by providing food for work and support to demobilised child soldiers [DHA 01/05/97, RPG Mar 97, WFP 10/02/97].

Assessments are taking place throughout the country and find widely different circumstances. For example, the findings of an assessment in Sinoe, Grand Gedeh and Maryland Counties were that the population appeared fairly well−nourished although there were signs of widespread poverty. All the pre−war hand pump wells were either non−functional or had been looted by fighters so that the population was dependent on shallow open wells and streams, increasing the risk of diarrhoeal diseases. Farming, fishing, hunting and petty trading were the main economic activities in the region and there were reports of refugees returning from Cote d'Ivoire. However, many were homeless, their villages and towns having been completely destroyed during the war. These returnees urgently needed a resettlement package. In contrast, an assessment in Nimba county found signs of a fairly rapid economic recovery in the northern and central areas. There was considerable small−scale economic activity. In rural areas there was less economic activity due to the lack of transport infrastructure [DHA 01/05/97].

Nutritional surveys throughout the country generally show an improvement compared to previous surveys, largely due to improved security, general ration distributions, selective feeding programmes, and harvests. However, as the rainy season approaches some decline in nutritional status can be expected. Many areas of the country are also now being visited to assess the health infrastructure in order to determine rehabilitation needs.

A survey was conducted in Monrovia in February 1997 as a follow up to a survey conducted in July 1996. The February survey showed 6.1 % wasting with 0.9% severe wasting among the community (estimated population 954,000). Oedema was measured at 0.1%. Measles immunisation coverage confirmed by possession of a vaccination card was 35.1%. Among the displaced (estimated population 254,000), wasting was measured at 13.2% with 0.9% severe wasting. Oedema was measured at 1.3%. Measles immunisation, confirmed by possession of a vaccination card was 38.6% (see Annex I (9a,b)) [ACF Feb. 97].

These survey results show a dramatic improvement over those seen in the July survey when wasting and/or oedema was measured at 15.3% in the community, and 24.7% in the displaced shelters. This is likely to be due to a number of factors including a general improvement in the security situation in Monrovia and an increased availability of food in the November−April period due to the harvest. Other factors contributing to the improvement may have been the intensive feeding programme in the capital and the general ration distributions carried out in the shelters. However, malnutrition rates are still high among the displaced population, and information on the food security situation of these people may help indicate the best way to ensure continued nutritional improvement [ACF Feb. 97].

A recent survey in Gabrnga, Bong County (estimated population included in the survey: 166,570), showed 9.1% wasting with 1.0% severe wasting. Oedema was measured at 1.2% (see Annex I (9c)). These results compare favourably with a survey conducted in August 1996 when wasting and/or oedema was measured at 26.8%. This improvement is felt to be due to an improved security situation, improved availability of food from a harvest and the food distributions in the area. As the rainy season begins and in the three months leading up to the harvest an increase in prevalence of wasting can be expected. Measles immunisation coverage, as confirmed by possession of a vaccination card, was 37.6% while coverage of supplementary and therapeutic feeding centres was only 22% and 21% respectively [ACF 05/03/97].

An earlier survey in Buchanan, Grand Bassa County (estimated population in the town 50,000) showed 14.2% wasting with 0.4% severe wasting. Oedema was measured at 0.1%. Measles immunisation coverage confirmed by possession of a vaccination card, was 45.3%. Among the population in the shelters (estimated at 13,000), wasting was measured at 6.1% with 0.3% severe wasting. Oedema was measured at 0.1%. Measles immunisation coverage, confirmed by possession of a vaccination card, was 52.4%. These results

show an improvement from a survey conducted in July 1996, when wasting and/or oedema among the entire population was measured at 47.6% (see Annex (9d,e)). Possible factors contributing to this improvement include the on–going feeding programme, a harvest, and the resumption of fishing activities. It should be noted that food distributions in the shelters were designed on the assumption that there were nine in a family while among the community, the family size was assumed to be four, resulting in higher food receipts among the populations in shelters [ACF 13/12/96].

The common needs in the country side are for safe water, basic health care including immunisation, and seeds and tools. In addition, in many areas the repair of roads and bridges is a priority since these are currently inadequate and hamper the movement of people and goods [DHA 02/04/97, 16/04/97, 23/04/97, 01/05/97].

Sierra Leone After a year of relative calm, a coup d'etat occurred at the end of May 1997. Prior to this, there had been widespread violence in the country causing many agencies to close down operations. During May, there continued to be reports of occasional hostilities, particularly in eastern regions. For example, there were reports of an ambush near Makeni which left one person dead, and of fighting in Kenema which resulted in at least 25 deaths, and the evacuation of humanitarian agency staff. It is estimated that up to 25,000 people have been displaced by the renewed violence. Many of these people had returned, built houses and planted fields before being uprooted. It is further reported that about 8,000 people have crossed the border into Guinea [DHA 14/04/97, RI 30/05/97, WFP 02/05/97, 09/05/97, UNHCR 16/05/97].

Prior to the coup, efforts were being focused on setting the stage for the continued return of approximately 453,000 internally displaced people, and eventually refugees from neighbouring countries. During 1997, food aid provision was planned to focus more on targeted feeding in the form of food for work, food for training, emergency feeding, and vulnerable group feeding. These initiatives will be community based on the assumption that IDPs and refugees will continue to return home [UN Mar 97, Feb. 98, WFP 01/04/97. 09/05/97]. It is unclear to what extent and for how long this current crisis will disrupt plans to continue repatriation and reintegration programmes.

Cote d'Ivoire There are approximately 305,000 Liberian refugees in Cote d'Ivoire. There are reports of some people returning to Liberia, but exact numbers are not available. It is believed that many refugees are returning to Liberia to verify the situation before deciding to go back for good [UNHCR 16/05/97].

Guinea There are estimated to be 545,000 Sierra Leonian and Liberian refugees in Guinea. Some spontaneous repatriation is reported, although since the coup d'etat in Sierra Leone, repatriation has apparently stopped, and 8,000 new arrivals have been registered [RI 30/05/97, UNHCR 16/05/97].

Overall, those affected regionally are not currently thought to be at heightened nutritional risk regionally (category IIc in Table 1) with the exception of the displaced in Monrovia and of those in Sierra Leone. These internally displaced people are likely to be at least at moderate nutritional risk due to the recent evacuation of some agencies.

How could external agencies help? In Liberia, road and bridge repair will be important to allow for the transport of people and goods. Once road conditions allow for unhindered movement, other priorities will be reestablishing the health care system, provision of clean water, seeds and tools.

As we are entering the traditional "lean season" in Liberia people have little or no food reserves and a deterioration in nutritional status is likely. In Monrovia, continuing efforts should be made to improve measles immunisation coverage. The high rates of wasting in the displacement shelters also need to be investigated. If necessary, rations to this population may need to be increased. Feeding centre coverage should also be improved by strengthening the outreach system. In Gabrnga, Bong County coverage of the dry ration distribution targeting the most vulnerable should be improved and it would be helpful to find out more about the present food security situation and reasons for low attendance at feeding centres. In Buchanan, measles immunisation coverage needs to be improved.

In Sierra Leone, prior to the recent coup d'etat, there was a shift away from emergency relief activities to more development oriented activities with a view to building capacity in communities so people don't return to areas devoid of services. Specific areas of concentration outlined in a recent UN Consolidated Appeal that will require support include:

- agricultural support to help move toward self–sufficiency;

• targeted feeding programmes, including food for work;

• rebuilding health infrastructure and particularly re−starting measles immunisation programmes;

• improvement of clean water supply and sanitation facilities.

Support for these initiatives once the current crisis is resolved will be essential to ensure a lasting peace and to help the population move towards self−sufficiency.

10. Mozambique Region

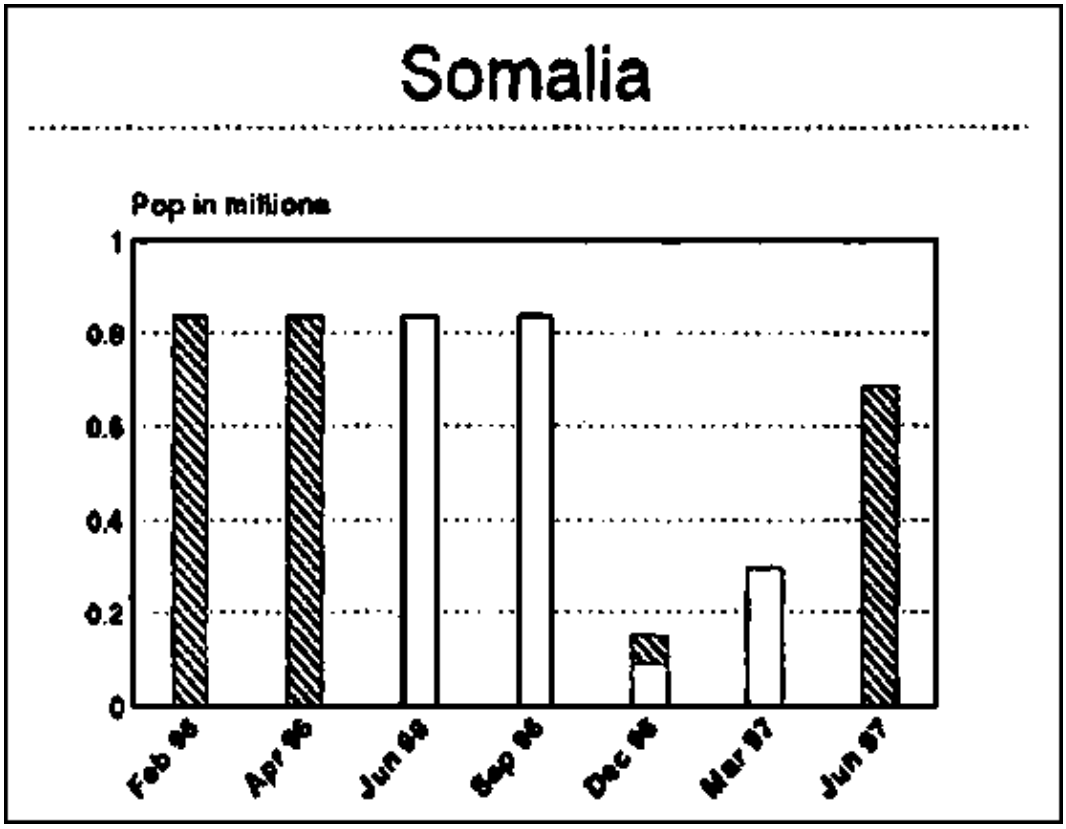
The returnees dependant on emergency assistance were thought to attain self−sufficiency with the harvest in April. While there remains a number of people requiring emergency assistance in Mozambique due to flood damage of crops, these are not returnees and are therefore will no longer be included in this report.

11. Somalia

(see Map 11)

There continue to be reports of fighting and related insecurity in Somalia, particularly in Mogadishu and Kismayo. It is now the dry season, the effect of which, combined with low rains earlier in the season, means that many people are without adequate food and water supplies. This is leading to some degree Of population displacement, although it is not clear whether these people are in need of emergency humanitarian assistance.

According to an FAO special alert issued on the 8th of May, the food situation in Somalia has been deteriorating rapidly following the drought reduced Der season harvest and continued civil conflict. Cereal production was some 60% lower than last year's normal level. Meanwhile, recent rains have made the transportation of emergency food aid to drought affected areas difficult. From April to June the communities which experienced a poor Der harvest will have to rely on other means for food until the next harvest season in July and August [WFP 16/05/97, DHA 02/05/97].



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

Emergency aid is programmed for 688,000 vulnerable people in Somalia. These people are considered vulnerable due to a lack of coping mechanisms, the presence of internally displaced people, distance from markets, and security issues, are expected to require assistance through July 1997. Numerous maternal health centres are reporting increasing numbers of wasted children among new admissions. For example, in Kismayo, Lower Juba, MCH centres are finding an increase in the percentage of children admitted with malnutrition for the fourth month in a row. In Hiran region a screening exercise showed an increased level of malnutrition in January and February [WFP Feb. 97, 28/05/97].

Screening results in Qansaxdhere District of the Bay region show much higher levels of malnutrition in March 1997 when compared with results a year ago. There are anecdotal reports of a further deterioration in the nutritional status in this district [WFP Feb. 97, 20/04/97, 16/05/97].

This apparent decline in nutritional status is likely to be exacerbated by a number of factors. Prices of grains, which normally decrease after the harvest have continued to rise since September and cereal stocks are reportedly depleted, particularly in the south. The price of sorghum has quadrupled since September and is beyond the purchasing power of large sections of the population. Conversely, prices of livestock have declined in rural areas due to increased sales as a result of shortages of water and fodder. There are reports of population movements mainly from Bay and Bakool regions towards the Juba valley, Mogadishu and Kenya. The nutritional situation is reported to be alarming in the recently established settlements for the displaced in Baidoa town. Food and water shortages have also resulted in a deterioration in the health situation of the population, with cases of cholera and tuberculosis on the increase [FAO 08/05/97].

In Mogadishu, numbers of admissions to feeding centres had either decreased or remained stable in February. However, in March increasing numbers of malnourished children were being seen mainly among recently displaced people arriving from Bay region. [FAO 08/05/97, WFP Feb. 97, Mar 97].

Cholera has been reported in Mogadishu, Kismayo, and Merca. In Wanlaweyn in the south, efforts are being made to improve the water supplies following an outbreak of cholera [ICRC 03/04/97, WFP Feb. 97].

WFP and the Food Security Assessment Unit (FSAU) will establish a nutritional surveillance system which will work with NGOs to provide an early warning system in vulnerable areas for the detection of any significant deterioration in nutritional status amongst vulnerable groups.

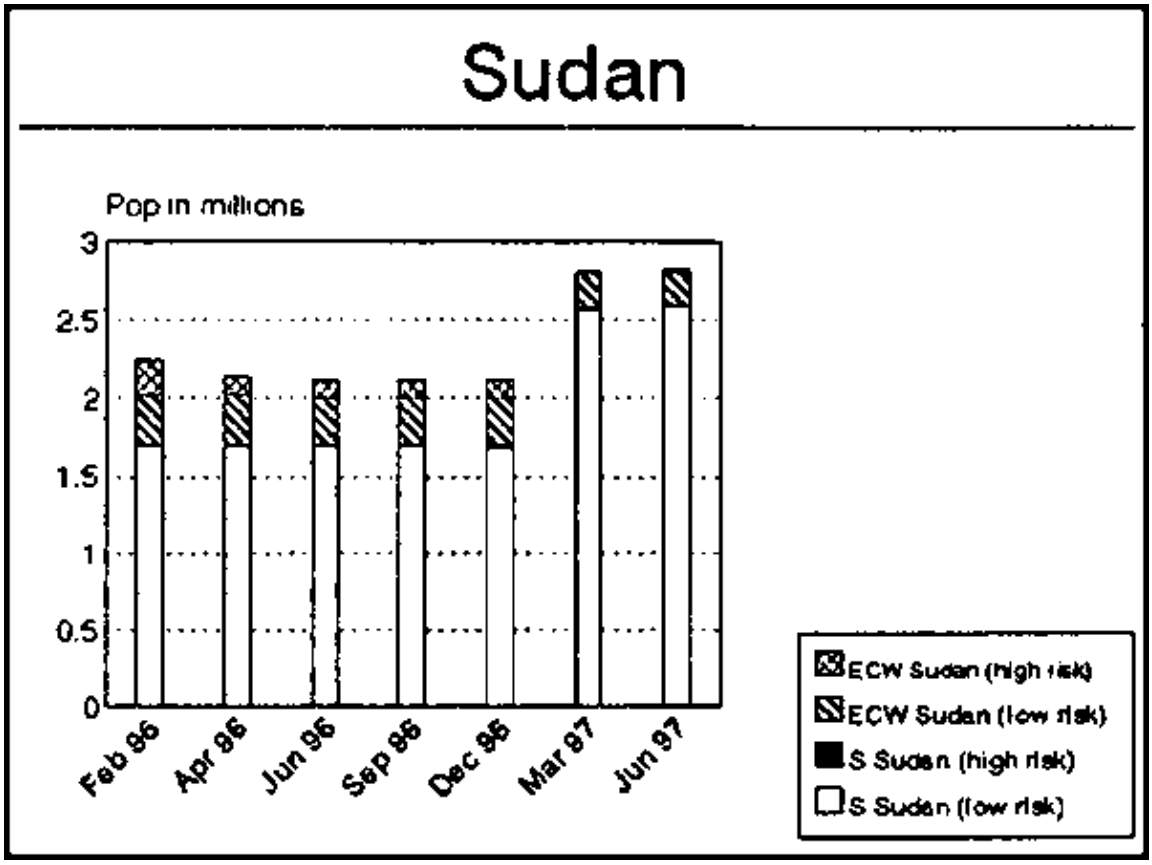
Overall, the assisted population can be considered to be at nutritional risk (category IIa in Table 1) due to recent poor harvests, and some logistical and security problems with food deliveries.

How could external agencies help? Given the declining food security situation in much of the country, nutritional surveys should be urgently undertaken to determine whether the nutritional situation is deteriorating in areas outside of Mogadishu. Water supplies should also be monitored in order to identify where and whether there is need for improvement. This may well mean more boreholes are needed. Support for food distributions is currently needed including support for logistical operations. As food price inflation is so pronounced, consideration may be given to ways of boosting effective demand, e.g. food subsidies or food stamps. Also, as livestock forms such an important part of the asset base of rural populations in Somalia, it may be appropriate to consider ways of improving fodder and water provision for livestock herds.

12. Sudan

(see Map 12)

Emergency food aid for 1997 will be needed for an estimated 2.7 million displaced and war–affected people. This total number is comprised of 2.2 million people in southern Sudan (an increase of 300,000), 374,000 in the transitional zone, 78,800 in Khartoum and the White Nile states, and approximately 138,000 Eritrean and Ethiopian refugees. A primary focus of the United Nation's approach to humanitarian aid in 1997 will be to broaden access to vulnerable populations and to improve the delivery of assistance.



Harvests for 1996/97 are projected to be quite good, with yields in excess of those seen during the bumper harvest of 1994/5. However, the overall food security situation in the country will most likely remain uneven as transferring crops from surplus to deficit areas remains problematic. In addition, chronic food deficit areas such as the Red Sea Hills and areas of Darfur and Kordofan are expected to suffer food shortages in 1997.

Khartoum Somewhat improved access to the internally displaced population in and around Khartoum has allowed humanitarian agencies to begin to address high levels of wasting and several therapeutic and supplementary feeding centres have now been opened. Priority interventions will include improving the supply of clean water and essential drugs, and establishing nutritional surveillance systems.

Southern Sudan Recent successful advances made by the SPLA, along with rebel activity in northern Uganda and eastern Democratic Republic of Congo, have led to the spontaneous return of many refugees. Reports indicate that two of the largest Sudanese refugee camps, Koboko (with a population of 26,516) and Ikafe (with a population of 55,162), had virtually emptied in March and that as many as 60,000 returnees arrived in Southern Sudan. A major area of returnee concentration is Yei, with estimates of up to 100,000 returnees and internally displaced people. Food is being dispatched for 100,000 people to cover needs from April–August 1997 and a measles immunisation campaign is underway. Although bombs were repeatedly dropped on Yei during April, OLS activities have continued [OLS 06/05/97, 20/05/97, WFP 28/03/97, 11/04/97, 09/05/97].

Many of the returnees and IDPs are moving from Yei to Juba, where an airlift operation has been initiated to deliver emergency food aid. Displaced persons and refugees in Juba (caseload of 162,000) are receiving full rations. Nutritional status in Juba is reported as stable [IRIN 27/03/97, WFP 11/04/97, 09/05/97].

The nutritional situation in Southern Sudan appears to be variable. For example, a survey in Mongole camp in March 1997 showed 11.9% wasting with 0.9% severe wasting. Oedema was measured at 0.5% (see Annex I (12a)). These results are similar to those from a survey conducted in May 1996 when wasting and/or oedema were measured at 12.9%. Only 65.2% of children found malnourished during the survey were registered in a feeding centre. These camps benefit from a programme which provides seeds and tools in an effort to promote self–sufficiency. It is planned that this cultivation will provide a two month ration over the year – 75% of the target was achieved last year. The ration has been set at 1800 kcals/person/day, but deliveries over the past year have been erratic. For example, a full ration was delivered in December 1996 and February 1997 while no ration was delivered during January. Ration deliveries can be inadequate for a number of reasons, but are most often due to insecurity or inadequate food pledges in southern Sudan. Measles immunisation coverage is estimated to be 72% [ACF 01/03/97].

In Nimule Town, wasting was measured at 12.1% with 0.8% severe wasting. No cases of oedema were found (see Annex I (12b)). Feeding centre coverage was 62.5% and measles immunisation coverage was 58.4% [ACF 01/03/97].

The situation seen in Labone camp in March 1997 was quite different. Wasting was measured at 34.4% with 3.4% severe wasting. Oedema was measured at 0.2% (see Annex I (12c)). Only 60% of malnourished children were registered in feeding centres. Here, too there is a policy to encourage self–sufficiency through a programme which provides seeds and tools for farming. A strategy of ration reduction has been in place since July 1996 with the ration set at 1700 kcals/person/day. However, deliveries have been erratic and in January 1997 approximately 600 kcals/person/day were delivered. Rations improved again in February when approximately 1600 kcals/person/day were delivered. While the health status and caring practices of the community may be factors contributing to these high levels of wasting, it seems likely that the combination of low planned general ration levels and erratic deliveries of this ration have also adversely affected nutritional status and that the coping strategies developed by the refugees have not been adequate to supplement the recent ration [ACF 10/03/97].

There are also reports of high levels of malnutrition in Bahr–el–Ghazal. Relief interventions that began after an assessment, delivered enough food to last until the end of May and then were suspended due to insecurity. Flights were temporarily suspended in early May, but clearance was given before the end of the month allowing for timely deliveries of seeds and tools in the area [OLS 06/05/97, 20/05/97].

However, a recent suspension of flight clearances into southern Sudan for WFP and UNICEF humanitarian flights will undoubtedly adversely affect needy populations at a time when assistance is crucial. Talks at the highest levels are taking place in an attempt to resolve this problem. At the end of March WFP food stocks for the displaced in southern Sudan and refugees in northern Uganda were at a critically low level [WFP 09/05/97, 06/06/97].

Ethiopian and Eritrean refugees There are approximately 138,000 assisted Ethiopian and Eritrean refugees in Sudan. There are no reports of change to the somewhat mixed nutritional situation, with levels of wasting as high as 15% being reported in some camps (see RNIS #19).

Overall, internally displaced populations around Khartoum can be considered to be at moderate risk as can the affected population in Southern Sudan. There are likely to be pockets of high risk in Southern Sudan, for example Labone camp, but population numbers are not available. The displaced in the Red Sea Hills are at high risk. Refugees from Ethiopia and Eritrea are not likely to be at heightened nutritional risk (category IIc in Table 1), although some camps were reporting elevated levels of wasting.

How could external agencies help? Improved access to IDPs near Khartoum should allow for the assessment of some specific needs of this population including:

- a supply of clean water and sanitation;
- a regular supply of essential drugs;
- a nutrition surveillance system.

As little has been done to improve the high levels of wasting (over 40%) seen in recent months in the Red Sea Hills, action to redress this situation is imperative. Interventions to improve the food security of the affected population, including some general ration deliveries, would be helpful. This area is expected to remain a chronic food deficit area in spite of excellent national harvests, and once the current problem is addressed, close nutritional monitoring should be carried out to ensure that the catastrophic nutritional situation witnessed earlier in the year does not recur.

In the South, assistance to recent returnees is essential to prevent their return to Uganda. The needs of those currently residing in returnee camps should be thoroughly assessed. A lack of adequate sanitation and safe drinking water remain a problem in many areas in southern Sudan. There are also difficulties with the air transport component of OLS including delayed clearances for flights and funding problems. More specifically, there is a need to improve feeding programme and immunisation coverage in Mongole camp and Nimule town. In Labone camp where levels of wasting are extraordinarily high, coping strategies need to be assessed as far as possible with a view to increasing current general ration levels. Feeding centre coverage also needs to be improved.

13. Uganda

(see Map 13)

A recently improved security situation in southern Sudan and an upsurge in rebel activity in northern Uganda have led to the spontaneous return of approximately 50,000 Sudanese refugees. There is however, reportedly some population flux between Sudan and Uganda making it difficult to determine exact numbers. It is estimated that 165,000 Sudanese refugees remain in Uganda. In addition, there are approximately 350,000 people displaced by rebel activity in northern areas, 150,000 of whom require emergency assistance. Between 180–185,000 displaced Ugandans were identified after a registration exercise in Gulu district. There are just over 17,000 Rwandan refugees and approximately 21,000 refugees from the Democratic Republic of Congo in south–western Uganda [FAO 08/04/97, WFP 28/03/97, 04/04/97].

Origin	Feb 96	Apr 96	Jun 96	Sep 96	Dec 96	Mar 97	Jun 97
Sudanese Refugees	210,000	214,000	214,000	214,000	214,000	225,000	165,000
Internally Displaced Ugandans	–	–	–	20,000	200,000	200,000	150,000
Rwandan Refugees (formerly included in Section #4)	6,800	6,900	7,000	7,000	11,500	14,500	17,000
Refugees from Democratic Republic of Congo	12,300	12,300	12,300	15,800	15,800	28,800	21,000
TOTAL	229,100	233,200	233,300	256,800	441,300	468,300	353,000

An increase in rebel activity in February and March 1997 led to the displacement of approximately 100,000 people in the west Moyo area. It is estimated that 50,000 of these people returned to southern Sudan and the other 50,000 either moved to other camps and settlements or are living among the local population. However, relief food stocks have been low which has affected distribution activities and the relocation of Sudanese refugees from transit centres to settlements.

However, there are reports that approximately 10,000 of those who went to southern Sudan subsequently returned to Uganda. Food and non–food assistance is being provided to these returnees and transport is being organised to home areas [WFP 23/05/97].

The insecurity which has been particularly bad in Kitgum district, has also hampered food deliveries in northern Uganda. This may also have been a factor contributing to decisions by refugees to leave. At the end

of May, the security situation had reportedly improved slightly [UNHCR 15/05/97, WFP 16/05/97].

A survey in Gulu and Kitgum showed 27% wasting and/or oedema (see Annex I (13a)). The July harvest is predicted to be poor so that emergency aid will be needed throughout 1997. Food distributions are being carried out in the Gulu and Kitgum districts [FAO 08/04/97, WFP 09/05/97].

Overall, the affected population in Northern Uganda can be considered to be at moderate nutritional risk due to insecurity and low crop yields. There are likely to be pockets of severe malnutrition, particularly among the internally displaced, but population breakdowns are not available. The refugees from Rwanda and the Democratic Republic of Congo are not currently thought to be at heightened nutritional risk (category IIc in Table 1).

How could external agencies help? Food stocks in Uganda are critically low, particularly for operations for the internally displaced. Fledges are urgently needed so relief activities can be carried out as security allows.

14. Democratic Republic of Congo (formerly Zaire)

(see Map 14)

Refugees in Democratic Republic of Congo (excluding Rwandans and Burundis included in section #4). There are an estimated 160,000 Angolan refugees in Democratic Republic of Congo, most of whom do not require assistance. It was hoped that most of the assisted population will spontaneously return to Angola after the signing of a peace treaty in 1994, but to date, there has been no significant return. There are approximately 111,000 Sudanese and 18,500 Ugandan refugees receiving some assistance in Democratic Republic of Congo [UNHCR May 97].

Displaced from Shaba, Democratic Republic of Congo There are approximately 600,000 people who have been displaced by ethnic violence which erupted in the Shaba region at the end of 1992. This population fled north into the Kasai region where many had ancestral links. During the migration large numbers stopped temporarily in villages along the route north, while others settled permanently at these sites. Currently, there is little further displacement from the Shaba region and based on the most recent set of nutritional survey information, it is believed that many of these people are self−sufficient and no longer require humanitarian aid. The exception to this is in Mwene Ditu where critically high levels of wasting of about 43% in the displaced population, estimated at 40,000 people, and 17% wasting in the resident population (estimated at 220,000) were reported [MSF−B 09/04/96 − RNIS #15].

However, as fighting in Eastern Democratic Republic of Congo moved further into the interior of Democratic Republic of Congo, this already vulnerable displaced population is likely to have experienced increasing hardship:

Overall, the displaced and resident affected populations in Mwene Ditu are in category 1 in Table 1 due to elevated levels of wasting. The remaining displaced population from Shaba are no longer considered to require assistance ad so are not included in Table 1. The refugees are not currently considered to be at heightened nutritional risk (category IIc in table 1).

15. Zambia

There were reports of the arrival of at least 8,000 refugees from the Democratic Republic of Congo into Zambia ahead of rebel advances. Contingency plans are being made for the arrival of a greater number of refugees [IFRC 04/03/97, IRIN 31/03/97, USAID 11/04/97].

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

ASIA – Selected Situations

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

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

16. Afghanistan Region

(see Map 16)

The fifteen year long conflict in Afghanistan continues and approximately 2.1 million people are affected regionally. This includes at least 1.5 million people in Afghanistan, 300,000 of whom are in Kabul, 330,000 people in Pakistan, and 322,000 refugees in Iran who require assistance.

The Taliban have made major advances in northern Afghanistan and now control two thirds of the country. Fighting is continuing in northern and central areas of Afghanistan, in particular in the Badghis region and is leading to population displacements. For example, there are at least 34,000 displaced people in Herat. There are also reports of increasing opposition in some parts of the eastern region with an increase in military activity in the area. While this fighting is reported to be intense, some areas of the country are relatively calm so that plans for reconstruction and rehabilitation are being made [DHA 15/04/97, DHA 30/04/97, ICRC 09/04/97].

A nutritional survey conducted in Kabul during the second half of December 1996 found 5.1% wasting with 0.8% severe wasting and/or oedema (see Annex I (16a)). Since that time, food shortages have been acute and food security is generally reported to be deteriorating throughout the country. The price of wheat, the staple of the Afghani diet, has increased dramatically and the price of bread in Kabul had shot up by 350% over the last year. Signs of hardship have been increasing with the number of people begging on the streets for bread rising. Many households have now sold everything that can be sold in order to purchase food [ACF 30/12/96, DHA 15/04/97, 30/04/97, ICRC 09/04/97, WFP 11/04/97].

Shortages are mainly due to two factors. First, a shortage of wheat in Pakistan has reduced imports and led to the closure of the border in March and second, this is traditionally the lean season just before the June harvest. It was hoped that the coming wheat harvest would improve matters, but a combination of factors like flooding in western and northern areas, a shortfall of rain and snowfall in Mazar–i–Sharif and widespread displacement of farmers due to fighting north of Kabul, will lead to a greater deficit in the harvest than last year [DHA 15/04/97, 30/04/97, ICRC 09/04/97, WFP 11/04/97].

In the meantime, WFP will continue to expand its bakery subsidy programme aimed at providing low cost bread to the poorest people in Kabul and Jalalabad, where it already feeds 450,000 people every day. Authorities in the Taliban controlled areas have requested WFP's help in dealing with the situation to prevent starvation among the most vulnerable parts of the population. However, WFP's own stocks, if not replenished will run out by early summer [DHA 15/04/97, 30/04/97, ICRC 09/04/97, WFP 11/04/97].

Pakistan There are a total of 330,000 Afghani refugees in Pakistan requiring assistance. Most of these (300,000 people) receive assistance through a "safely net" rehabilitation programme. Thirty thousand newer arrivals receive emergency food assistance. There has been a serious shortfall of wheat due to failure of rains and delays in import shipments [WFP 11/04/97].

Iran There are no reports of change to the generally adequate nutritional status of the approximately 322,000 Afghani refugees in Iran.

Overall, the affected population in Afghanistan can be considered to be at moderate nutritional risk (category IIb in Table 1) due to problems with food security. The refugees in Iran and Pakistan are not currently thought to be at heightened nutritional risk (category IIc in Table 1).

How could external agencies help? As detailed in a recently launched Consolidated Appeal for Afghanistan, there is scope for much rehabilitation work to be carried out in the country, as many areas are now relatively calm. A widespread problem throughout the country is inadequate supplies of safe water, and rebuilding the water and sanitation systems in the country should be a priority. The health care system is also barely functioning, and there is an increase of communicable diseases throughout the country. Rebuilding and restocking medicines and vaccines in the health care system would be likely to have a profoundly positive effect on the Afghani population.

Donors should now come forward to provide food commodities for monetization to markets in Afghanistan, either directly or through traders. Given the deteriorating food security currently being seen in many parts of the country and reflected in massive food price inflation, nutritional surveys should be carried out in large urban centres such as Kabul and Jalalabad where so much of the population depends on markets. Furthermore, WFP food stocks for vulnerable group feeding programmes urgently need to be replenished.

17. Bhutanese Refugees in Nepal

(see Map 17)

There are approximately 92,000 Bhutanese refugees and asylum−seekers who sought refuge in Nepal in the early 1990s. Results of recent Food Economy Assessment and Food Assessment missions are expected to be released shortly.

18. Refugees from Rakhine State, Myanmar in Bangladesh

(see Map 18)

There are approximately 21,000 refugees from Rakhine State, Myanmar remaining in two camps in Bangladesh. This decrease in total number is due to repatriation [UNHCR 06/06/97].

19. Southern Iraq

Under Security Council Resolution 986, the Government of Iraq is authorised to sell oil to procure essential humanitarian goods, including food and medicines. Food distributions are meant to ensure a daily ration of 2,030 kcals/person/day. The World Food Programme is responsible for distributions in the north and the Government is responsible for distributions in the central and southern regions. WFP is however, responsible for observing the equity, efficiency and adequacy of distributions throughout the country [UNECOSOC 21/02/97, WFP 28/03/97].

The first distribution of wheat flour was undertaken on the 2nd of April 1997 in the central and southern areas of Iraq [WFP 18/04/97].

It is hoped that these food distributions will allow for access to the Marsh Arabs, and could be the opportunity for assessment of this population. Anecdotal information on the desperate state of this population has been filtering out over the past few years. There have been continual reports, of destruction of habitats, arbitrary arrests and torture but due to inaccessibility, no surveys or assessments have been carried out.

Overall, the population remaining in the marshes is likely to remain at high risk, while the population in Iran is not thought to be at heightened risk as the assistance they receive is likely to be adequate (category IIc in Table 1).

20. Sri Lanka

(see Map 20)

Apart from some notable periods of calm, the conflict in Sri Lanka has been ongoing in the north of the country for the past 14 years. The fighting has led to the displacement of large numbers of people, many of whom have been displaced several times. At least 135,000–210,000 people sought refuge in India, and those who are in government run camps are being assisted by the Government of India.

However, an escalation in fighting in the Jaffna peninsula which began in 1996 led to fresh waves of population displacement. The most recent upsurge in May 1997 is due to a government offensive. Although the numbers change rapidly as areas of intense fighting move, it is estimated that approximately 410,000 people are internally displaced. Most of those displaced within. Sri Lanka are living with relatives or friends and while some assistance is needed, little food aid is necessary. There are approximately 150,000 people who live in "welfare centres" which are similar to open refugee camps. These people receive food distributions from either the government or WFP although they are not believed to be fully dependent on these distributions for all their food needs [FAO 09/04/97, WFP 10/02/97].

There has also been about 8,000 new arrivals who have fled to India as a result of renewed fighting. This population joined the existing 92,000 refugees already in India and is the first exodus in recent years. Approximately 56,000 people are housed in camps, while 36,000 people live outside the camps [UNHCR 01/11/96].

A survey carried out in a welfare centre in April 1996 showed 16.4% wasting with 0.6% severe wasting. Oedema was measured at 0.4% (see Annex I (20a)). These results compare with those seen in December 1995 when wasting was measured at 12.6%. It was felt at the time that the ration provided by the government was not adequate and although it was not meant to be a complete ration there is a growing sense that the population was becoming increasingly dependent on this as it's main source of food. In addition, ongoing fighting at that time was leading to a continuous stream of newly arrived displaced people [MSF–H 06/04/96].

In April of 1997, a nutritional survey was carried out in two open relief centres (ORC) in Mannar district in response to a general impression that the nutritional status had deteriorated and due to concerns about the quality and regularity of food distributions. Wasting among this displaced population was measured at 14.6% with 0.8% severe wasting. No cases of oedema were seen (see Annex I (20b)). Anaemia which was suspected to be a problem was seen in 0.8% of the children although assessment of this condition was "rather subjective". These results are comparable to nutritional conditions amongst the local population [MSF–F 07/04/97].

Reports of the return of people from the Wanni district to Jaffna at the end of April have been received. These people cited a lack of medical care, schooling, and insufficient water as reasons for their return. Many areas in the north are reporting stable food prices and adequate availability of food commodities on the markets [CARE 23/04/97. However, an upsurge in fighting in May could disrupt this apparent return to stability.

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

How could external agencies help? Although levels of wasting are in line with those expected in the local population, they are still somewhat high and efforts to decrease this, including expanding supplementary feeding programmes, and improving the quality and timing of the food distributions, would be useful.

Listing of Sources for June 1997 RNIS Report #20

Org*	Date	Title of Report
ACF	Dec.96	Nutritional Survey – Kabul, Afghanistan
ACF	Feb.97	Nutritional Survey – Monrovia Community and Shelters Liberia
ACF	1.03.97	Nimule Town and Mogale Camps Anthropometric Nutritional Surveys

ACF	5.03.97	Nutritional Survey Gbarnga, Bong County, Liberia
ACF	10.03.97	Labone Camps Anthropometric Nutritional Survey
ACF	13.12.97	Nutritional Survey Buchanan, Grand Bassa County, Liberia
CARE	23.04.97	Report on Food Security
CONCERN	19.05.97	Nutrition Information (Angola)
DHA	Mar.97	Monthly Information Report Ethiopia March 1997
DHA	30.03.97	Humanitarian Assistance in Angola
DHA	2.04.97	Liberia – Humanitarian Situation Report No 65
DHA	9.04.97	Burundi – Humanitarian Situation Report
DHA	14.04.97	Bi–Monthly Information Report – Sierra Leone (No. 04/97)
DHA	15.04.97	Afghanistan Weekly Update Issue No. 212
DHA	16.04.97	Liberia – Humanitarian Situation Report No 67
DHA	23.04.97	Liberia – Humanitarian Situation Report No 68
DHA	30.04.97	Afghanistan Weekly Update Issue No. 213
DHA	1.05.97	Liberia – Humanitarian Situation Report No 69
FAO	23.12.96	FAO/WFP Food Crop and Food Supply Assessment Mission to Rwanda
FAO	4.03.97	FAO/WFP Crop and Food Supply Assessment Mission to Burundi
FAO	8.04.97	FAO/WFP Crop and Food Supply Assessment Mission to Uganda
FAO	9.04.97	FAO/WFP Crop and Food Supply Assessment Mission to Sri Lanka
FAO	8.05.97	Special Alert – Somalia
FAO	12.05.97	FAO/WFP Crop and Food Supply Assessment Mission to Angola
ICRC	3.04.97	Somalia – ICRC acts to curb cholera outbreak in the south
ICRC	9.04.97	Afghanistan: Over 400,000 people receiving ICRC assistance
IFRC	4.03.97	Zambia – Zairean Refugees
IOM	28.04.97	Angola Update No. 2
IRC	Apr.97	Nutritional and Body Mass Index Surveys for Kakuma Refugee Camp
IRIN	27.03.97	Emergency Update No 137 on the Great Lakes
IRIN	31.03.97	Emergency Update No 139 on the Great Lakes
IRIN	1.04.97	Emergency Update No 140 on the Great Lakes
IRIN	3.04.97	Emergency Update No 142 on the Great Lakes
IRIN	11.04.97	Emergency Update No 147 on the Great Lakes
IRIN	18.04.97	Emergency Update No 152 on the Great Lakes
IRIN	23.04.97	Emergency Update No 156 on the Great Lakes
IRIN	2.05.97	Emergency Update No 163 on the Great Lakes

IRIN	9.05.97	Emergency Update No 168 on the Great Lakes
IRIN	15.05.97	Emergency Update No 172 on the Great Lakes
IRIN	21.05.97	Emergency Update No 178 on the Great Lakes
IRIN	27.05.97	Emergency Update No 182 on the Great Lakes
IRIN	3.06.97	Emergency Update No 186 on the Great Lakes
IRIN	5.06.97	Emergency Update No 188 on the Great Lakes
IRIN	6.06.97	Emergency Update No. 189 on the Great Lakes
IRIN	17–18.05.97	Emergency Update No 175 on the Great Lakes
IRIN	19–25.05.97	Weekly Round–Up 5–97 (19–25 May 1997)
IRIN	5–11.05.97	Weekly Round–Up 3–97 (5–11 May 1997)
MSF–B	1.01.97	Evaluation nutritionelle – Kibiza
MSF–B	Feb.97	Nutritional Survey – Karuzi, Burundi
MSF–B	24.04.97	Nutritional Survey – Luena, Moxico Province Angola
MSF–B	May.97	Nutritional Survey – Gode
MSF–B	25.05.97	Information Returnees to Rwanda
MSF–F	7.04.97	Nutrition Survey Madhu & Palampidi ORC
MSF–H	6.04.96	Kilinochchi Nutrition Survey (April 1996)
MSF–H	1.02.97	Nutritional Survey at Sake, North Kivu
MSF–H	16.03.97	Health Zone Rwanguba Nutritional Survey
MSF–H	26.05.97	Survey Results – Kichanga (Zaire)
OLS	6.05.97	OLS Southern Sector Update 97/18 6 May 1997
OLS	20.05.97	OLS Southern Sector Update 97/20 20 May 1997
RI	30.05.97	Field Report Sierra Leone No. 1
RPG	Mar.97	Participation of Refugees and Internally Displaced Persons in the Liberian Elections
UN	Mar 97–Feb 98	United Nations Consolidated Appeal for Sierra Leone
UN	1997	UN Consolidated Appeal for Angola
UNECSOC	21.02.97	Report on the Situation of Human Rights in Iraq
UNHCR	1.11.96	Sri Lanka
UNHCR	25.03.97	Mission Report 17–25 February and 3–22 March 1997
UNHCR	14.04.97	Health and Nutrition Services in Kakuma Camp
UNHCR	28.04.97	Rapport de Mission 14–28 avril 1997
UNHCR	May.97	Mission Report – Tanzania
UNHCR	9.05.97	Personal Communication – Sri Lanka and Nepal
UNHCR	12.05.97	Rapport de Mission 6–12 mai
UNHCR	13.05.97	Preliminary Results of Surveys in Tanzania

UNHCR	16.05.97	Personal Communication – Liberia, Sierra Leone
UNHCR	26.05.97	Number of Refugees in Benin and Burkina Faso
UNHCR	06.06.97	Personal Communication – Bangaldesh
UNHCR	15.05.97	Personal Communication – Kenya and Uganda
USAID	11.04.97	Great Lakes Complex Emergency – Situation Report 30
USAID	16.05.97	Great Lakes Complex Emergency – Situation Report 35
WFP	Feb.97	Food Security Assessment Unit – Report No. 2
WFP	Mar.97	Food Security Assessment No 3 (Somalia)
WFP	14.03.97	Weekly Update
WFP	28.03.97	Weekly Update
WFP	4.04.97	Weekly Update
WFP	4.04.97	Weekly Update
WFP	11.04.97	Weekly Update
WFP	18.04.97	Weekly Update
WFP	20.04.97	Nutritional Situation in Bay Region – Highlights
WFP	2.05.97	Weekly Update
WFP	9.05.97	Weekly Update
WFP	16.05.97	Weekly Update
WFP	23.05.97	Weekly Update
WFP	May.97	Weekly Update
WFP	28.05.97	Update on Vulnerable Populations and Cereal Food Needs for Somalia
WFP	6.06.97	Weekly Update
WFP	30.05.97	Weekly Update
WFP	10.02.97	Regional Reports
WFP	1.04.97	Resourcing Needs

* Org	
ACF	Action Centre la Faim
AI	Amnesty International
BAAG	British Agencies Afghanistan Group
CONCERN	
DHA	Department of Humanitarian Affairs
FAO	Food & Agricultural Organization of the United Nations
FSAU	Food Security Assessment Unit for Somalia
GOAL	
ICRC	International Committee of Red Cross

IFRC	International Federation of Red Cross
IRIN	Integrated Regional Information Network (of DHA)
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
MSF−S	Medecins Sans Frontieres − Spain
OLS	Operation Lifeline Sudan
RI	Refugees International
SCF− UK	Save the Children Fund (United Kingdom)
UNAA	United Nations Humanitarian Assistance for Afghanistan
UNHRCS	United Nations Humanitarian and Resident Coordinator for Somalia
UNECOSOC	United Nations Economic and Social Council
UNHCHR	United Nation's High Commissioner for Human Rights
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

Table 1: Information Available on Total Refugee/Displaced Populations (as of June 1997)

	Population Numbers							***Nutr Stat****	
Situation	***Condition***					***Total***	***Change from Mar.97***		***C***
	I: High Prev	***IIa: High Risk***	***IIb: Mod Risk***	***IIc: Not Critical***	***III: Unknown***				
Sub−Saharan Africa									
1. Angola				*977'000*		*977'000*	*−3'000*	*Imp*	*Dec due atta self- and retu*
2. Benin/Ghana/Togo Region				*13'500*		*13'500*	*0*	*slat*	
3. Burkina Faso/Mauritania			*22'500*	*24'000*		*46'500*	*−3'500*	*stat*	*Dec due*

									repatriation.
4. Burundi/Rwanda Region		*611'200*	*3'157'800*			*3'769'000*	*–74'000*	*det*	*Decreased due to retur some refuge from Zaire.*
5. Central African Republic				*32'400*		*32'400*	*0*	*slat*	
6. Djibouti				*2'500*		*2'500*	*0*	*stat*	
7. Ethiopia	*23'000*	*272'000*		*62'700*	*136'000*	*493'700*	*–38'800*	*stat*	*Decreased due to re–registrati of Sudanese refugees, ar repatriation some Soma refugees.*
8. Kenya	*147'000*			*26'500*		*173'500*	*7'500*	*det*	*Those in Kakuma and Dadaab can at high risk.*
9. Liberia/Sierra *Leone/Guinea/Cole d'Ivoire*			*732'000*	*1'281'000*		*2'013'000*	*–476'000*	*imp*	*Decreased number requiring assistance i Liberia. Som new displacemer Sierra Leon due to Coup*
10. Mozambique Region						*0*	*–162'600*	*imp*	*The returnee are now considered to be self–sufficie*
11. Somalia		*688'000*				*688'000*	*388'000*	*del*	*Increased estimate of vulnerable population d to insecurity presence of IDPs and la of coping mechanism*
12. Sudan	*4'000*		*2'652'800*	*138'000*		*2'794'800*	*0*	*slat*	*Pockets of malnutrition likely to exis Southern Sudan, Criti situation in R Sea persists*
13. Uganda			*315'000*	*38'000*		*353'000*	*–115'300*	*det*	*Slight decre in number o Sudanese refugees, ar*

									revi esti num IDP tota
14. Democratic Republic of Congo	*260'000*			*179'500*		*439'500*	*23'500*	*det/stat*	*For from Mwe nutr stat mos surv (enc indi cha*
15. Zambia				*40'000*		*40'000*	*8'000*	*stat*	*Incr new from Zair*
***Total* (*Sub–Saharan Africa*)**	*434'000*	*1'571'200*	*6'880'100*	*2'815'100*	*136'000*	*11'836'400*	*–446'200*		
						0			
***Asie* (*Selected Situations*)**						*6*			
16. Afghanistan Region			*1'500'000*	*652'000*		*2'152'000*	*–30'000*	*stat*	*Dec num requ assi Iran Pak*
17. Bhutanese Refugees in Nepal				*92'000*		*92'000*	*0*	*stat*	*A pr the may risk mic defi dise*
18. Bangladesh		*24'000*				*24'000*	*0*	*imp*	*Dec due repa Tho rem cam high due leve*
19. *Southern Iraq*		*192'000*		*28'000*		*220'000*	*0*	*slat*	*Tho Mar con be a*
20. Sri Lanka				*500'000*		*500'000*		*stat*	

I: High Prev–

Those reported with high prevalences of malnutrition (where available >20% wasting) 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 packets of malnutrition (e.g. wasting).*

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; del= deteriorating; stat= static (i.e. no change).*

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

June 1996 – RNIS #20 (population estimates In thousands)

	To/In											
From	***Angola***	***Benin***	***Burkina Faso***	***Burundi***	***Cote d'Ivoire***	***Dem Rep Congo***	***Eritrea***	***Ethiopia***	***Ghana***	***Guinea***	***Kenya***	***Liberi***
Angola	*977*					50						
Benin												
Burkina Faso												
Burundi				*265*		40						
Cote d'Ivoire												
Dem Rep Congo						392						
Eritrea												
Ethiopia								11			4	
Ghana												
Guinea												
Kenya								71				
Liberia					305				16	408		*71*
Mali			24									
Mauritania												
Rwanda						342						
Sierra Leone										137		10
Somalia								347			131	
Sudan						111		36			38	

Tanzania											
Togo		4							9		
Uganda						19					
Zambia											
TOTAL	977	4	24	*265*	305	954	0	465	25	545	173

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 = 8.7 million*).

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

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

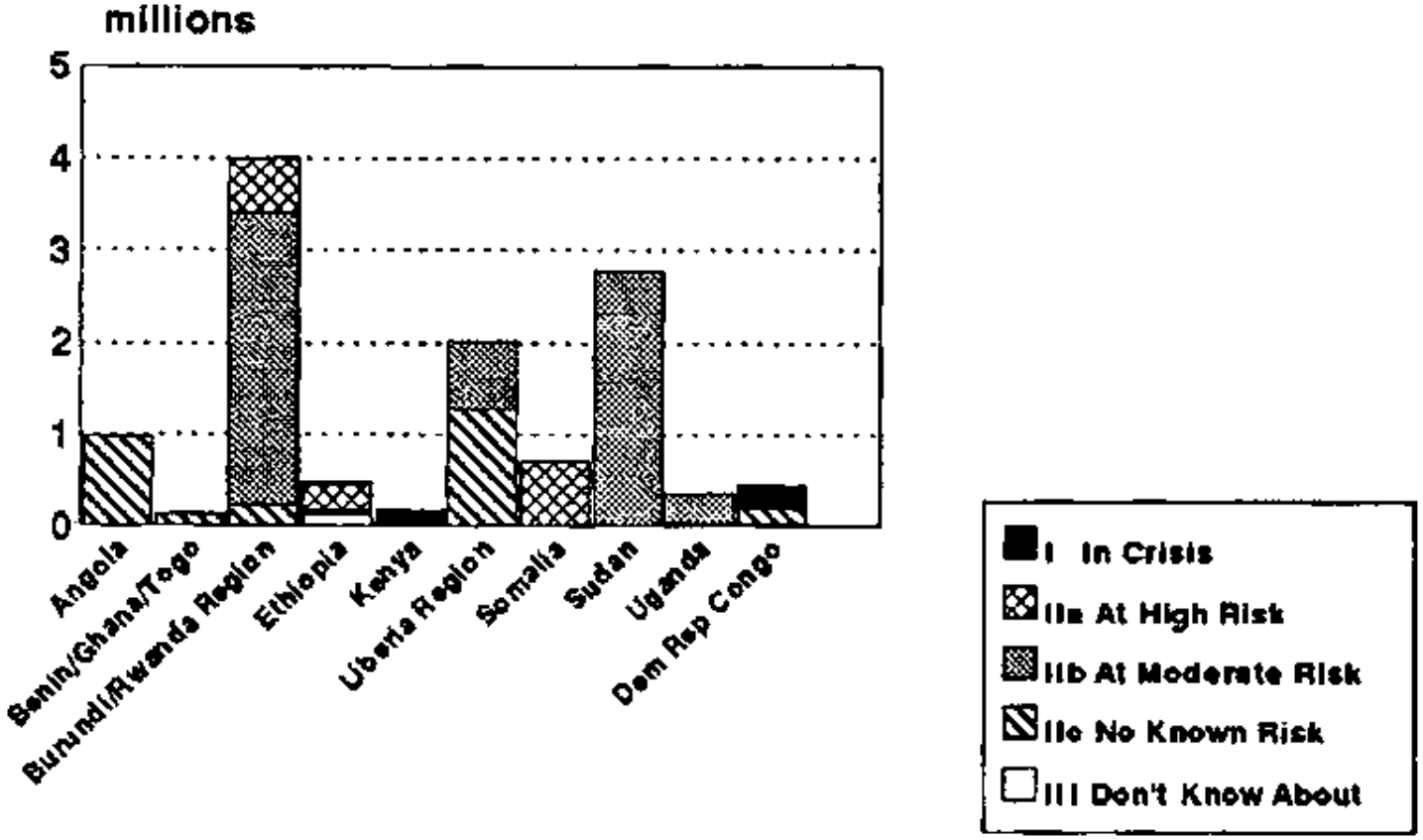


Figure 1. **REFUGEE AND DISPLACED POPULATIONS**

Selected Areas in Africa (June 1997)

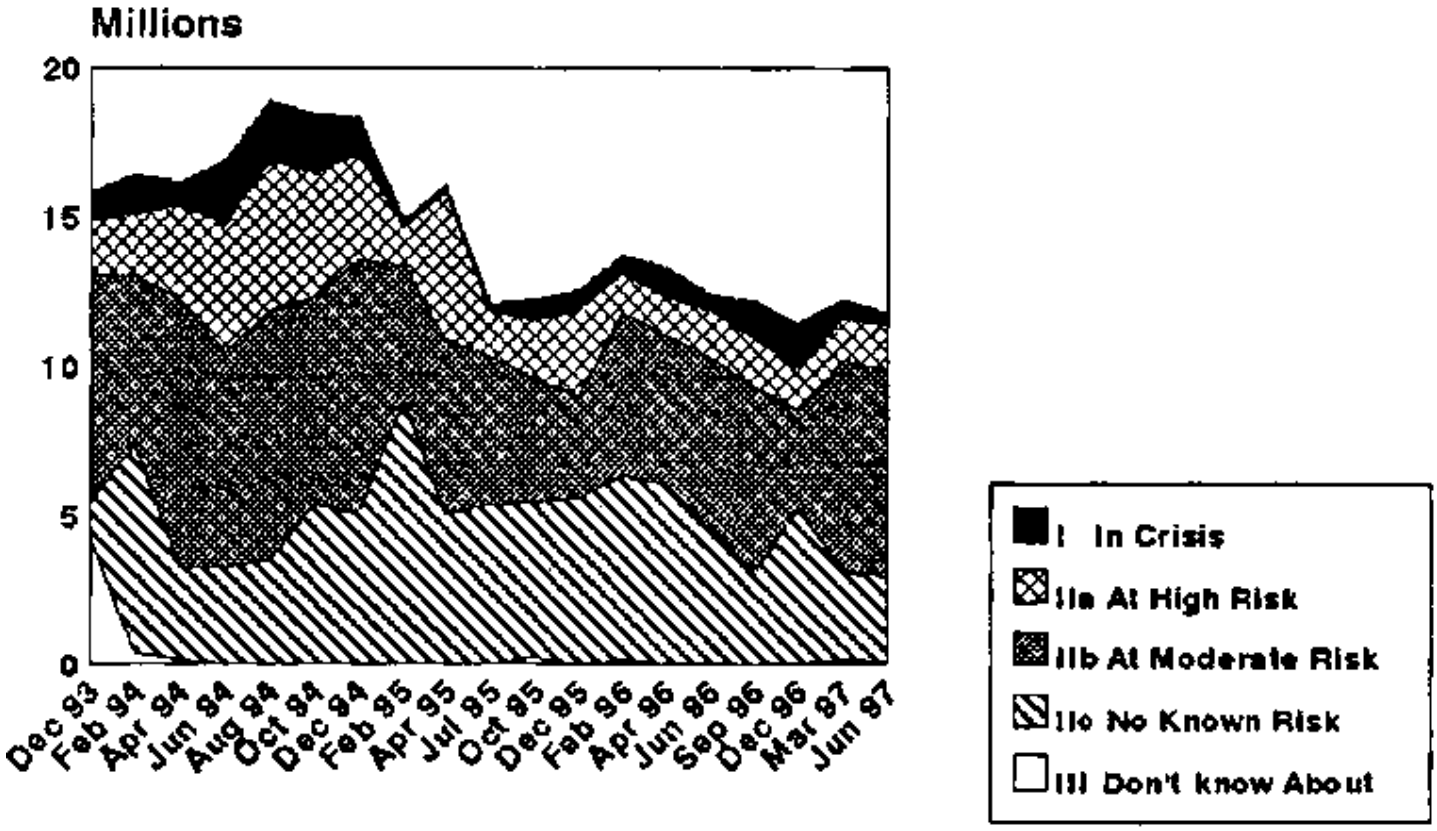


Figure 2. **Tends in Total Refugee/Displaced Populations**

By Risk Categories
Africa: December 1993–June 1997

Annex I: Results of Surveys Quoted in June 1997 RNIS Report (#20) – usually children 6–59 months

Survey Area	***Survey Conducted by***	***Date***	***% Wasted****	***% Severely Wasted****	***Oedema (%)***	***Crude Mortality (/10,000/day)***	***Under 5 Mortality (/10,000/day)***	***Measles Immunisation Coverage***
1. Angola								
a. Luena, Moxico Province (*returnees*)	MSF–B	Apr.97	4.4	1	0.6			38.8%
b. Luena, Moxico *Province* (*residents*)	MSF–B	Apr.97	6.6	1.2	1.2			48.2%
4. *Burundi/Rwanda Region*								
a. Between Kisangani & Umbundo, E Zaire		Apr.97				11.4–20		
b. Sake	MSF–H	Feb.97	84	1.3	2.3			47.8%
c. Rwanguba Health Zone	MSF–H	Mar.97	3.4 9.4	0.2	9.2	1.2	27	31.4%

d. Kibiza, Rwanda	MSF–B	Jan.97	(MUAC <125)	1.0 (MUAC <112)	0.3			
e. Karuzi, Burundi	MSF–B	Feb.97	16.9	3.1	1.8			
f. Nyarugusu, Tanzania	UNHCR	Mar.97	5.3"	0.6"		0.5	1.8	
g. Mtendeli Camp, Tanzania	UNHCR	Mar.97				0.7	1.5	
h. Metandle, Tanzania	UNHCR	May.97	3.3"	01"	1.3			
i. Kanembwa, Tanzania	UNHCR	May.97	3.0"	00	09			
j. Nuduta, Tanzania	UNHCR	May.97	7.2"	0.0	0.7			
k. Mukgwa, Tanzania	UNHCR	May.97	1.8**	00	2.2			
l. Lukole, Tanzania	UNHCR	May.97	3.9**	0.8				
7. Ethiopia								
a. Fugnido		Mar.97	17.4					
b. Sherkole		Mar.97	17.0					
c. Gode	MSF–B	May.97	52.3	10.1	06			
8. Kenya								
a. Kakuma Camp (6–11 years old)	IRC	Apr.97	40.0	70				
b. Kakuma Camp (12–20 years old)	IRC	Apr.97	19.8	08				
c. Kakuma Camp (6–59 months old)	IRC	Apr.97	14.0	06	5.0			
9. Liberia/Sierra Leone Region								
a. Monrovia (Residents)	ACF, CONCERN, LWF/WS, OXFAM, SCF(UK), MOH	Feb.97	6.1	0.9	0.1			35%
b. Monrovia (Displaced)	ACF, CONCERN, LWF/WS, OXFAM, SCF(UK), MOH	Feb.97	13.2	09	1.3			39%
c. Gabrnga, Bong County, Liberia	ACF	Mar.97	91	1.0	1.2			38%
d. Buchanan, Grand Bassa,	ACF	Dec.96	142	04	0.1			45%

Liberia Residents)								
e. Buchanan, Grand Bassa Liberia (*Displaced*)	ACF	Dec.96	6.1	0.3	0.1			52%
12. Sudan								
a. Mongole Camp, S Sudan	ACF	Mar.97	11.9	09	0.5			73.0%
b. Nimule, S Sudan	ACF	Mar.97	12.1	08	00			58.4%
c. Labone, S Sudan	ACF	Mar.97	34.4	34	0.2			
13. Uganda								
a. Gulu, Kitgum, N Uganda	ACF	Apr.97	27.0					
16. Afghanistan								
a. Kabul	ACF	Dec.96	5.1	08	00			
20. Sri Lanka								
a. Kilinochchi District, Wanni Region	MSF−H	Apr.96	16.4	06	0.4			
b. Mannar District	MSF−F	Apr.97	147	08	0.0			

* 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.

NOTES on Annex I

1. Angola

a. This survey was carried out by MSF−Belgium in Luena, Moxico Province in Angola among returnees from 19−20 April 1997. This was a cross sectional survey using a two stage cluster sampling method which included 498 children 6−59 months old. Wasting was defined as weight/height <−2SD and severe wasting <−3SD. Oedema was recorded separately. Global acute malnutrition is defined as weight/height <−2 SD or oedema and was measured at 5.0% (CI 2.3−7.7%). Severe acute malnutrition is defined as weight/height <−3 SD or oedema and was measured at 1.6% (CI 0−3.2%).

b. This survey was carried out by MSF−Belgium in Luena, Moxico Province in Angola among residents from 19−20 April 1997. This was a cross sectional survey using a two stage cluster sampling method which included 515 children 6−59 months old. Wasting was defined as weight/height <−2SD and severe wasting <−3SD. Oedema was recorded separately. Global acute malnutrition is defined as weight/height <−2 SD or oedema and was measured at 7.8% (CI 4.5−11.1%). Severe acute malnutrition is defined as weight/height <−3 SD or oedema and was measured at 2.3% (CI 0.5−4.1%).

4. Burundi/Rwanda (Great Lakes) Region

a. This information is from UNICEF, as of the end of April 1997. No further details are currently available.

b. This survey was carried out by MSF−Holland in Sake from 30 January−1 February 1997. It was a cluster survey including 30 clusters of 30 children per cluster. A design effect factor of 2 was used in calculating the required sample size. 925 children 6−59 months old were included. Wasting was defined as weight/height

<–2SD and severe wasting <–3SD. Oedema was recorded separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 10.7% (CI 8.1–14.0%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 3.6% (CI 2.1–5.8%).

c. This survey was carried out by MSF–Holland in Rwanguba Health Zone from 13–16 March 1997. It was a cluster survey including 30 clusters of 30 children per cluster. A design effect factor of 2 was used in calculating the required sample size. 913 children 6–59 months old were included. Wasting was defined as weight/height <–2SD and severe wasting <–3SD. Oedema was recorded separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 12.6% (CI 9.7–16.1%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 9.4% (CI 6.9–12.6%).

d. This survey was carried out by MSF–Belgium in January 1997. and included all children under five years old in the camp. Wasting was defined as MUAC<125mm and severe wasting MUAC <110mm. Oedema was recorded separately.

e. This survey was conducted by MSF–Belgium in Karuzi, Burundi in February 1997. It Used a two– stage cluster sample methodology, and 711 children 6–59 months old were included. Wasting was defined as weight/height <–2SD and severe wasting as weight/height <–3 SD. Oedema was measured separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 18.8% (CI 14.8–23.3%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 4.9% (CI 3.0–7.9%).

f. This survey was carried out in Nyarugusu Camp in Tanzania. Wasting (weight/height <–2 SD) and oedema are reported as one figure. Severe wasting (weight/height <–3 SD) and oedema were similarly reported as one figure. This information was available through a mission report.

g. These mortality rates were included in a mission report to Mtendeli Camp in Tanzania.

h. These are preliminary results from a survey carried out in Metandle camp in Tanzania in May 1997. 760 children were included. Wasting (weight/height <–2 SD) was reported at 3.3% (CI 1.9–4.7%). Severe wasting (weight/height <–3 SD) was reported at 0.1% (CI 0.0–0.8%). Oedema was reported separately.

i. These are preliminary results from a survey carried out in Kanembwa camp in Tanzania in May 1997. 635 children were included. Wasting (weight/height <–2 SD) was reported at 3.0% (CI 1.9–4.7%). Severe wasting (weight/height <–3 SD) was reported at 0%. Oedema was reported separately.

j. These are preliminary results from a survey carried out in Nuduta camp in Tanzania in May 1997. 935 children were included. Wasting (weight/height <–2 SD) was reported at 7.2% (CI 5.6–9.1%). Severe wasting (weight/height <–3 SD) was reported at 0%. Oedema was reported separately.

k. These are preliminary results from a survey carried out in Mukgwa camp in Tanzania in May 1997. 168 children were included. Wasting (weight/height <–2 SD) was reported at 1.8% (CI 0.4–5.5%). Severe wasting (weight/height <–3 SD) was reported at 0%. Oedema was reported separately.

l. These are preliminary results from a survey carried out in Lukole camp in Tanzania in May 1997. 923 children were included. Wasting (weight/height <–2 SD) was reported at 3.9% (CI 2.2–4.7%). Severe wasting (weight/height <–3 SD) was reported at 0.8%. Oedema was reported separately.

7. Ethiopia

a,b. These surveys were reported in a DHA Monthly Information Bulletin for March 1997. Wasting was measured as weight/height <80%.

c. This survey was carried out by MSF–Belgium in May 1997. It was a random two stage cluster sample survey and included 771 children 6–59 months old. Wasting was defined as weight/height <–2SD and severe wasting <–3SD. Oedema was recorded separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 52.9% (CI 47.7–58.1%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 10.8% (CI 7.9–14.5%), using a design effect of 2.

8. Kenya

a. This survey was carried out by International Refugee Committee (IRC) in Kakuma camp, Kenya. It included 256 children 6–11 years old. Wasting was defined as weight/height <–2 SD and severe wasting weight/height <–3 SD.

b. This survey was carried out by International Refugee Committee (IRC) in Kakuma camp, Kenya. 1191 people 12–20 years old were included in the survey. Wasting was defined as BMI<14, and severe wasting BMI<12.

c. This survey was carried out by International Refugee Committee (IRC) in Kakuma camp, Kenya. It was a cluster survey, including 30 clusters of 30 children per cluster. A total of 790 children 6–59 months old (or 65–115 cms) were included. Wasting (weight/height <–2 SD) was reported at 14.0% (CI 12.0–17.0%). Severe wasting (weight/height <–3 SD) was reported at 0.6% (CI 0.2–2.0%). Oedema was reported separately.

9. Liberia

a. This survey was conducted jointly by Action contre la Faim, CONCERN, LWF/WS, OXFAM, Save the Children Fund (UK) and in consultation with the Ministry of Health. The two–stage cluster survey was carried out from 10–15 February 1997 among the resident population of Monrovia. 922 children 6–59 months old were included. Wasting was defined as weight/height <–2SD and severe wasting as weight/height <–3 SD. Oedema was measured separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 6.2% (CI 4.2–8.9%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 1.0% (CI 0.3–2.5%).

b. This survey was conducted jointly by Action contre la Faim, CONCERN, LWF/WS, OXFAM, Save the Children Fund (UK) and in consultation with the Ministry of Health. The two–stage cluster survey was carried out from 10–15 February 1997 among the displaced population of Monrovia. 924 children 6–59 months old were included. Wasting was defined as weight/height <–2 SD and severe wasting as weight/height <–3 SD. Oedema was measured separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 14.5% (CI 11.4–18.2%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 2.2% (CI 1.1–4.1%).

c. This survey was carried out by Action Contre la Faim in Gbarnga in March 1997. This was a cross–sectional survey using cluster sampling (30 clusters of 30 children). 900 children 6–59 months old were included in the survey. Wasting was defined as weight/height <–2SD and severe wasting as weight/height <–3 SD. Oedema was measured separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 10.3% (CI 7.7–13.7%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 2.2% (CI 1.1–4.2%).

d. This survey was carried out by Action contre la Faim among the resident population of Buchanan, Grand Bassa County in December 1996. It was a two–stage cluster sample survey, including 30 clusters of 30 children 6–59 months old for a total sample size of 917. Wasting was defined as weight/height <–2SD and severe wasting as weight/height <–3 SD. Oedema was measured separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 14.4% (CI 11.3–18.1%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 0.5% (CI 0.1–1.9%).

e. This survey was carried out by Action centre la Faim among the displaced population of Buchanan, Grand Bassa County in December 1996. It was a two–stage cluster sample survey, including 30 clusters of 30 children 6–59 months old for a total sample size of 782. Wasting was defined as weight/height <–2SD and severe wasting as weight/height <–3 SD. Oedema was measured separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 6.3% (CI 4.7–8.3%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 0.1% (CI 0.0–1.9%).

12. Sudan

a. This survey was carried out by Action contre la Faim in Mogale camp and included 951 children 6–59 months old or 65–144.9 cms. It was a two–stage cluster sample survey (30 clusters of 30 children). Wasting was defined as weight/height <–2SD and severe wasting as weight/height <–3 SD. Oedema was measured separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 12.2% (CI 9.4–15.6%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 1.2% (CI 0.4–2.7%).

b. This survey was carried out by Action contre la Faim in Nimule Town and included 758 children 6–59 months old or 65–144.9 cms. It was a two–stage cluster sample survey (30 clusters of 22 children). Wasting was defined as weight/height <–2SD and severe wasting as weight/height <–3 SD. Oedema was measured separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 12.1% (CI 9.1–16.0%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 0.8% (CI 0.2–2.5%).

c. This survey was carried out by Action contre la Faim in Labone camp and included 951 children 6–59 months old or 65–144.9 cms. It was a two–stage cluster sample survey (30 clusters of 30 children). Wasting was defined as weight/height <–2SD and severe wasting as weight/height <–3 SD. Oedema was measured separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 34.7% (CI 30.2–39.4%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 3.7% (CI 2.2–6.0%).

13. Uganda

a. This is information is included in a recent *FAO/WFP Crop and Food Supply Assessment* report. This is a survey using MUAC to defined wasting. No further details were available.

16. Afghanistan

a. This survey was carried out in Kabul by Action contre la Faim in December 1996. It was a two– stage cluster sample survey including 882 children 6–59 months old. Wasting was defined as weight/height <–2SD and severe wasting as weight/height <–3 SD. Oedema was measured separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 5.1% (CI 3.3–7.8%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 0.8% (CI 0.2–2.3%).

20. Sri Lanka

a. This survey was carried out by MSF–Holland in three divisions of Kilinochchi district in the Wanni region in April 1996. Details are included here as background to the situation. It was a random sample survey which included 467 children 6–59 months old. Wasting was defined as weight/height <–2SD and severe wasting as weight/height <–3 SD. Oedema was measured separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 16.9% (CI 13.6–20.8%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 1.1% (CI 0.4–2.6%).

b. This survey was carried out by MSF–France in relief centres in Mannar district. A total of 382 children 6–59 months old were randomly sampled for inclusion in the survey. Wasting was defined as weight/height <–2SD and severe wasting as weight/height <–3 SD. Oedema was measured separately. Global acute malnutrition is defined as weight/height <–2 SD or oedema and was measured at 147% (CI 11.3–18.8%). Severe acute malnutrition is defined as weight/height <–3 SD or oedema and was measured at 0.8% (CI 0.2–2.5%).

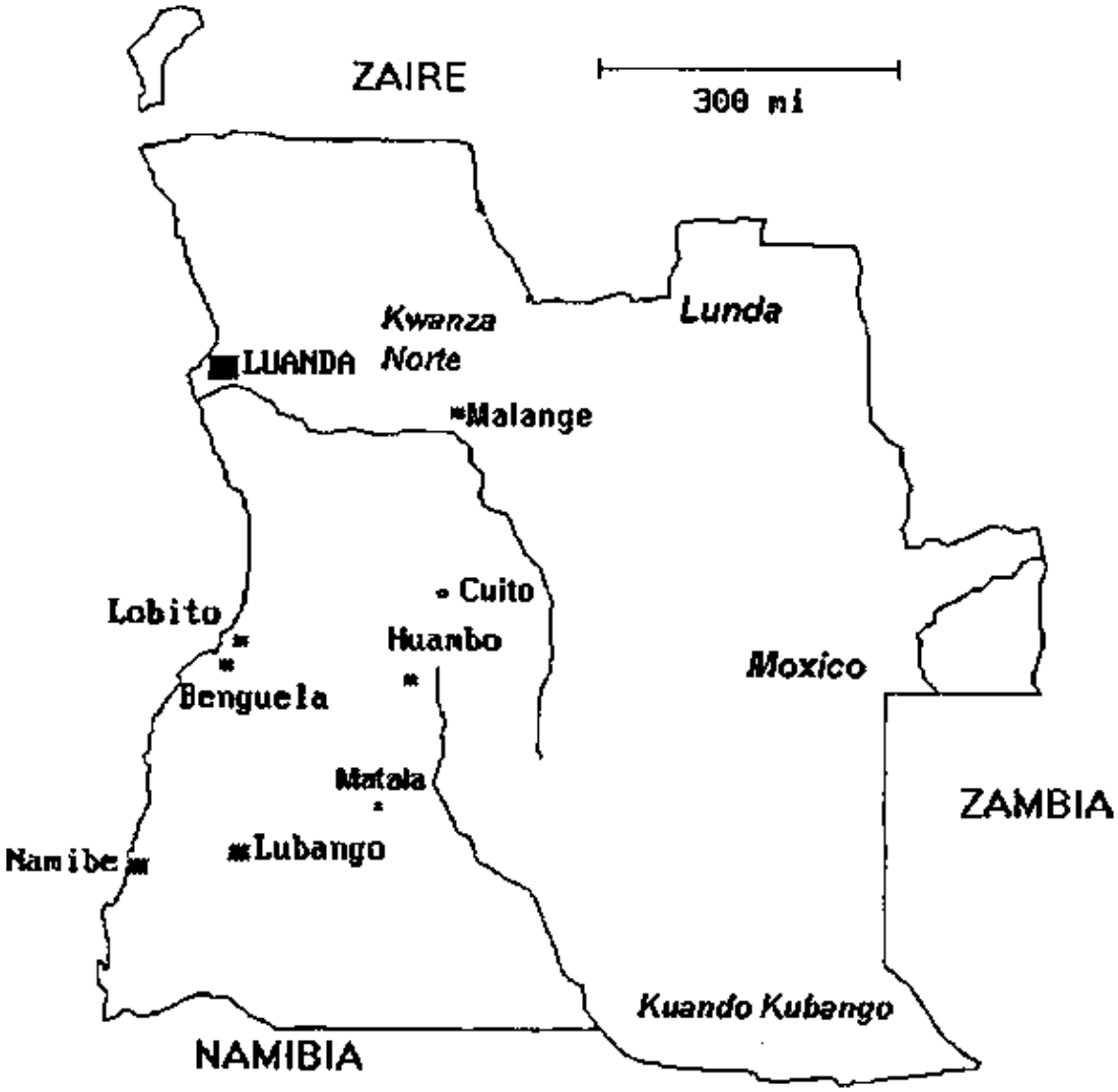
Annex II: Seasonality

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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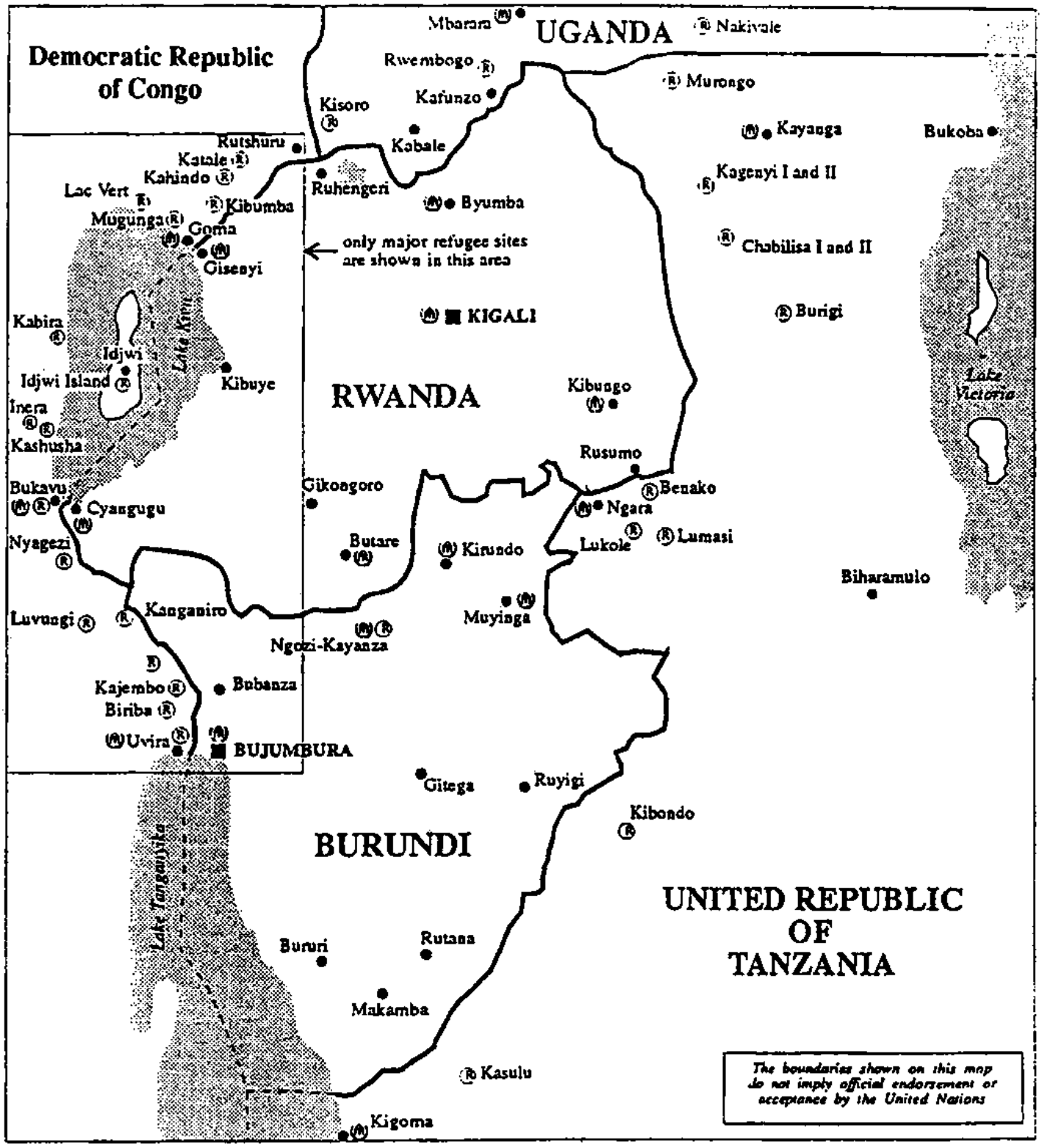
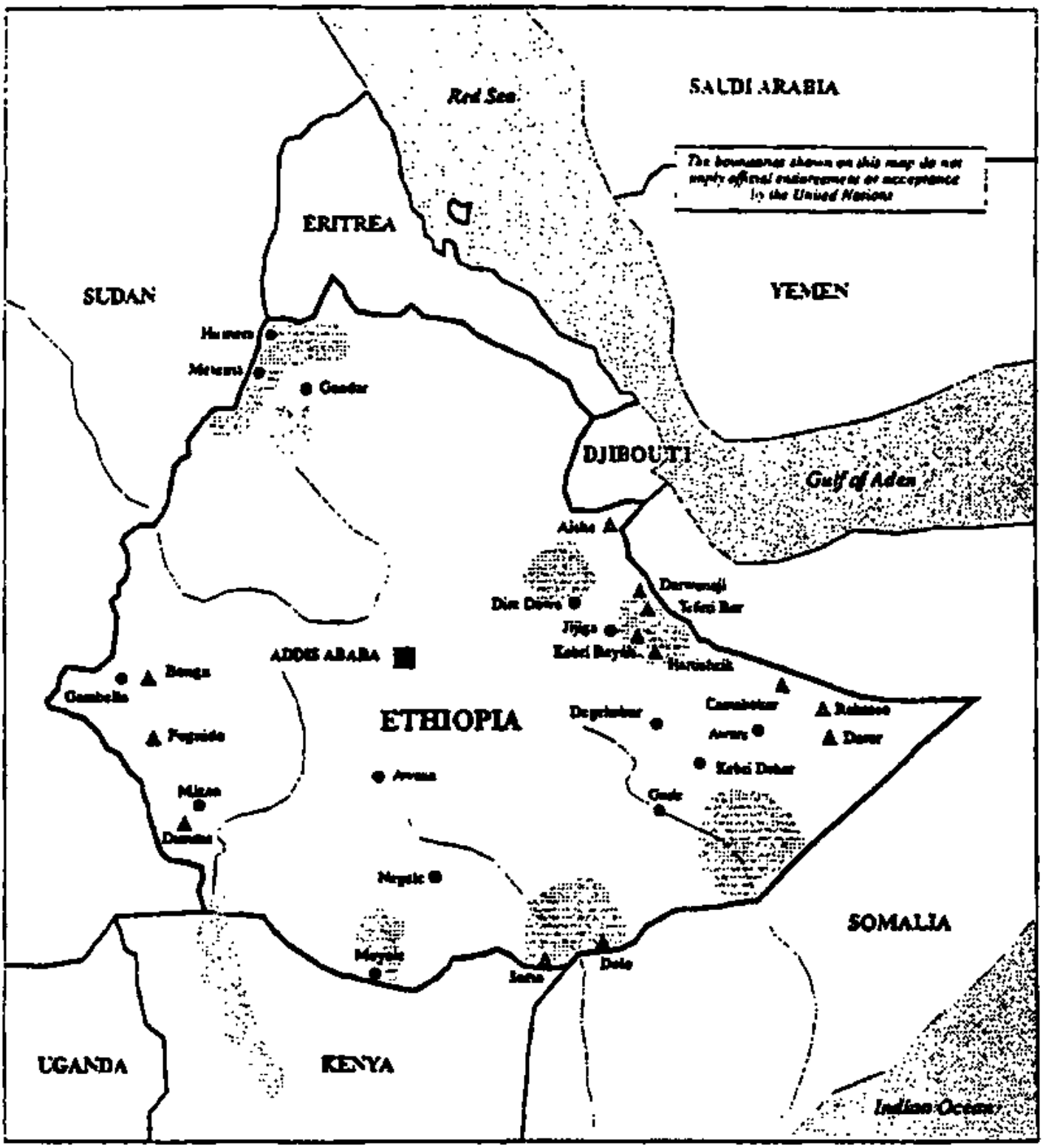
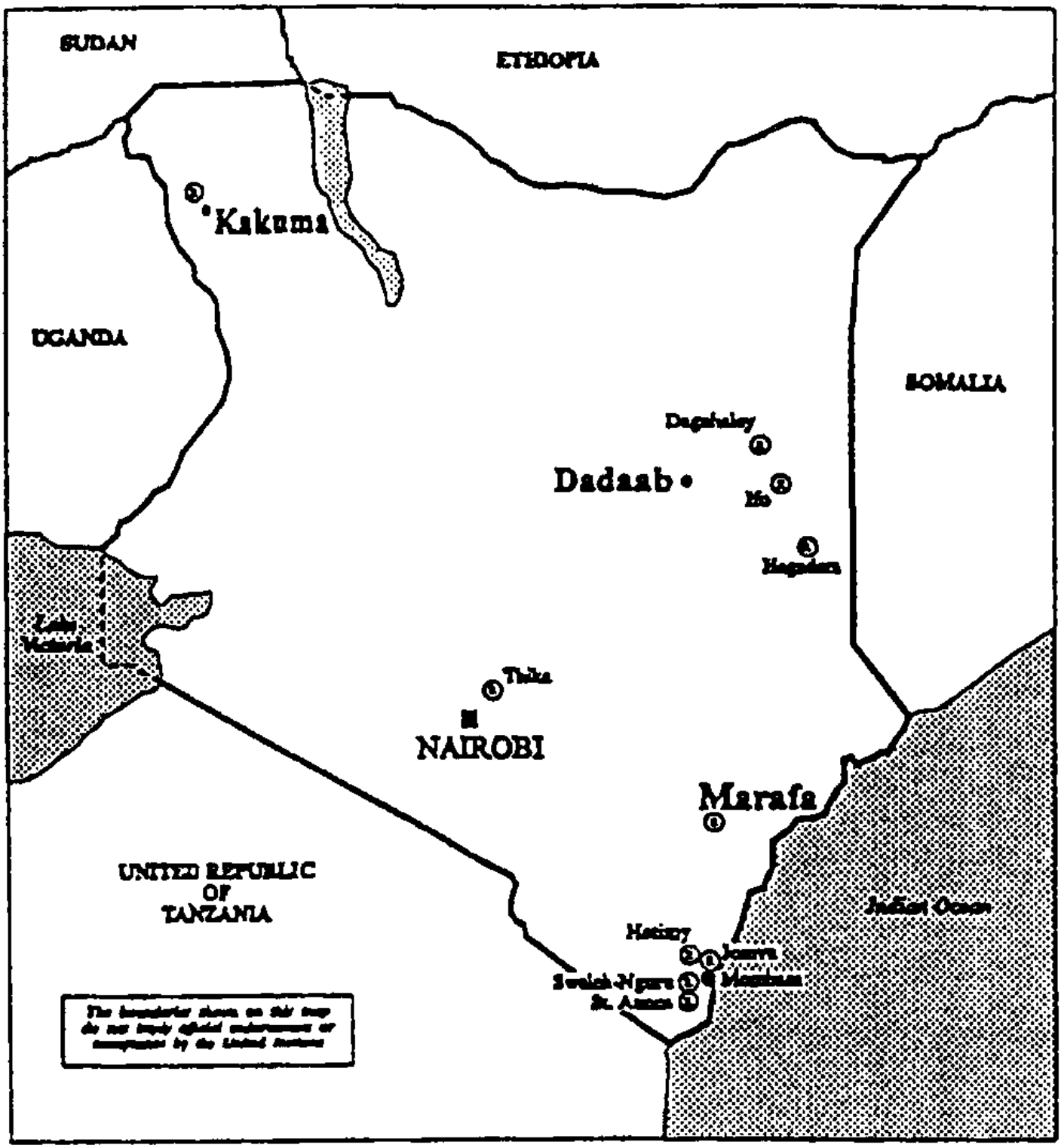
MAP 1. Angola



MAP 4. Burundi/Rwanda Region



MAP 7. Ethiopia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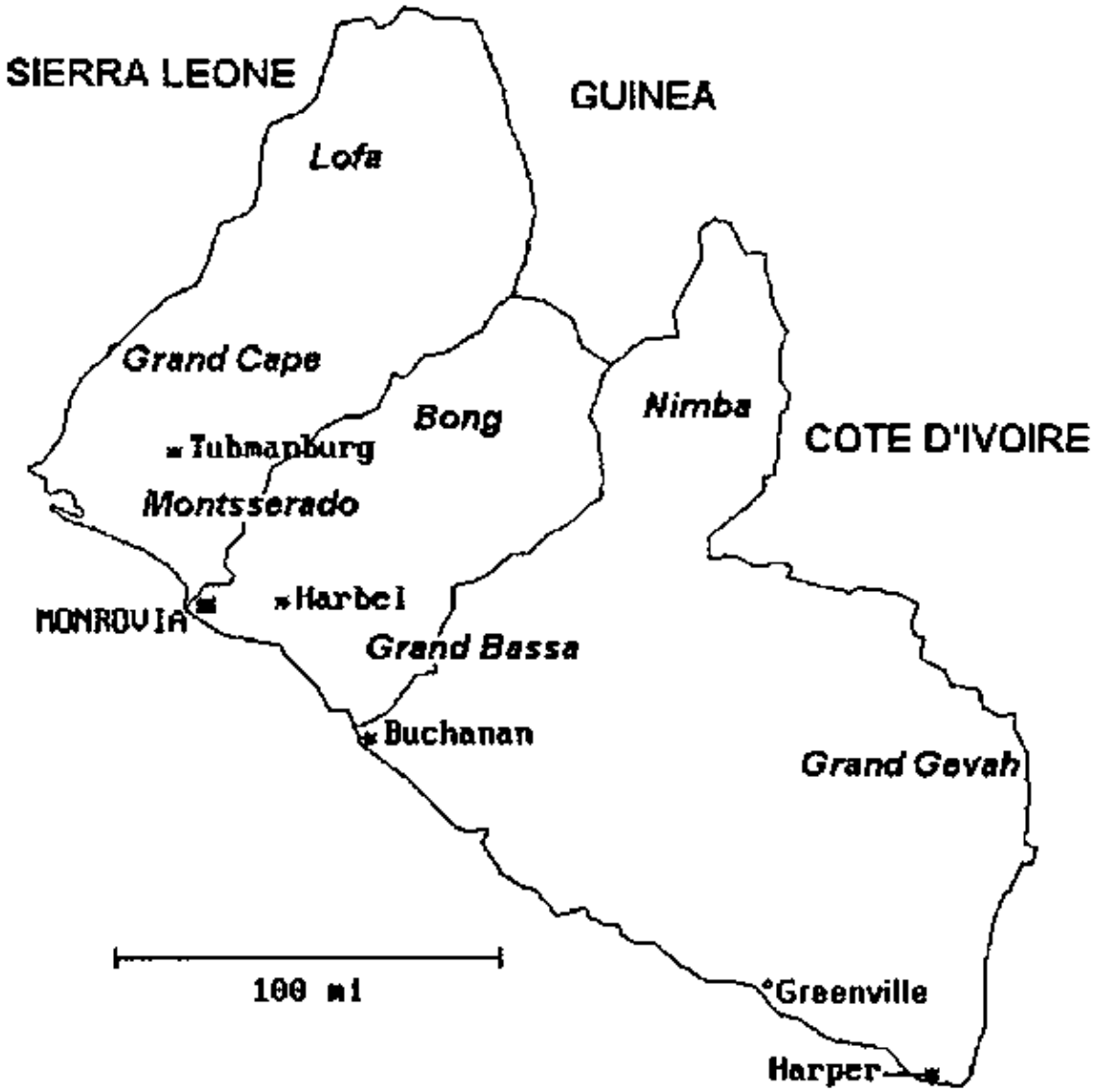
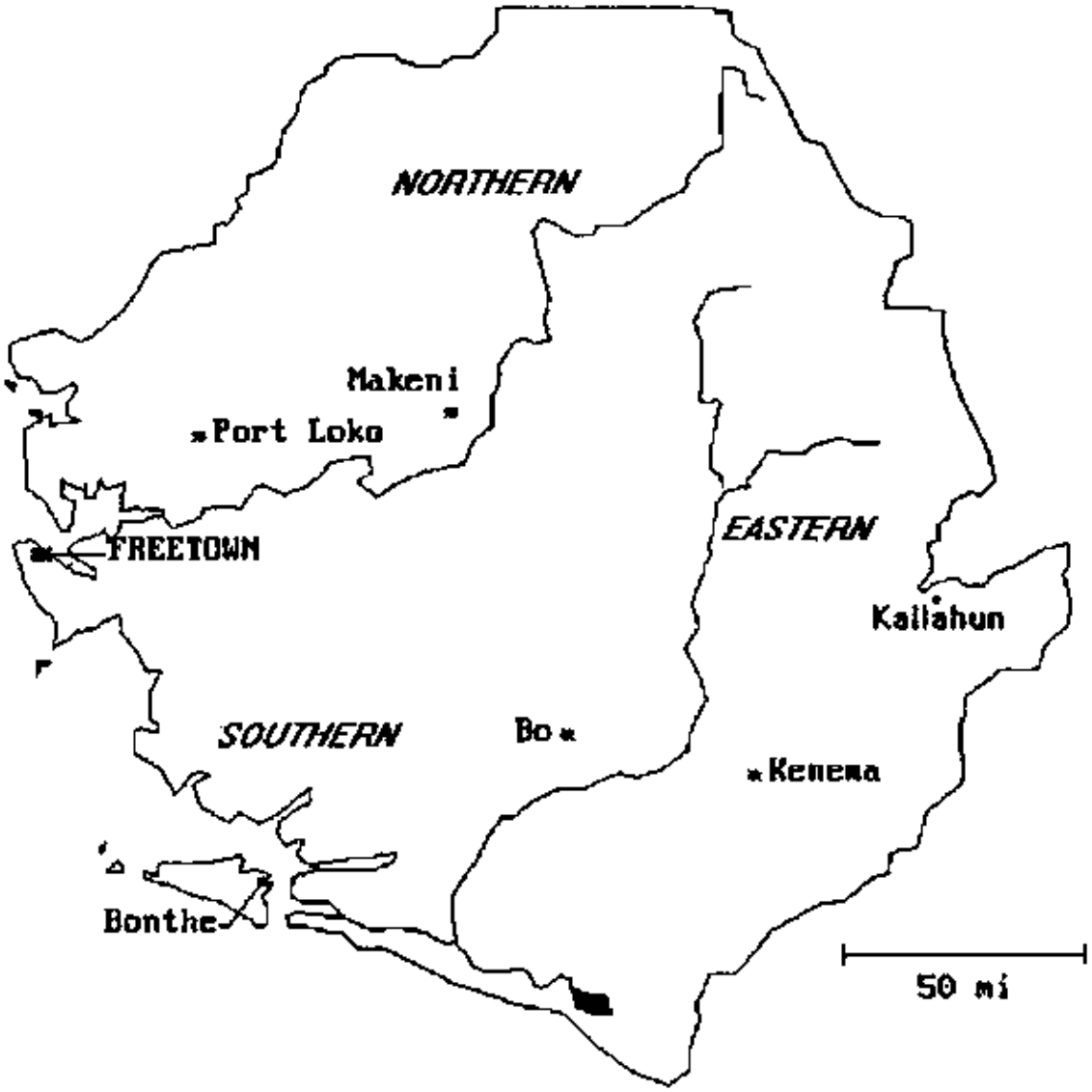
Dadaab
Thika
NAIROBI
Marafa
UNITED REPUBLIC
OF
TANZANIA
Indian Ocean

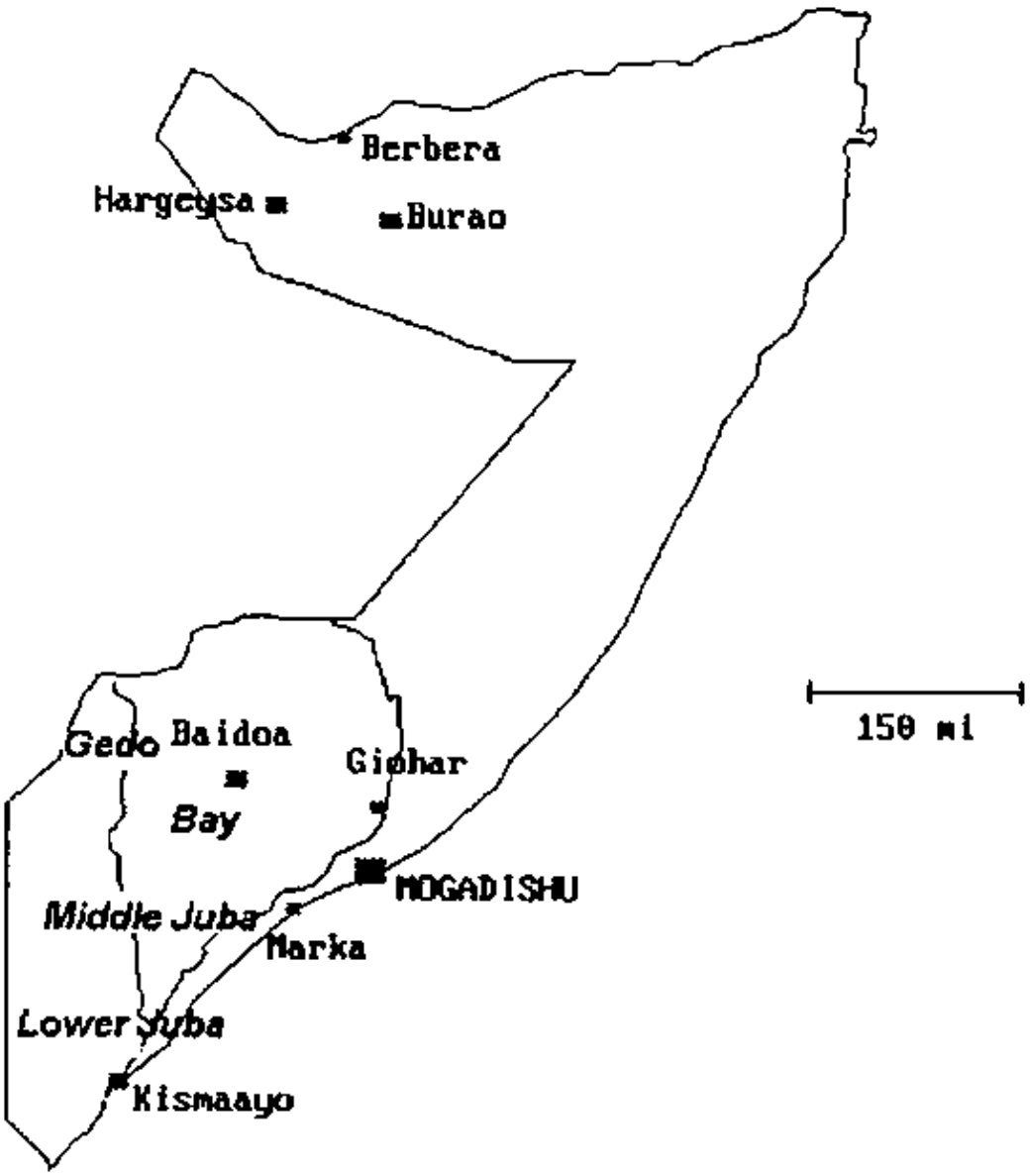
MAP 8. Kenya



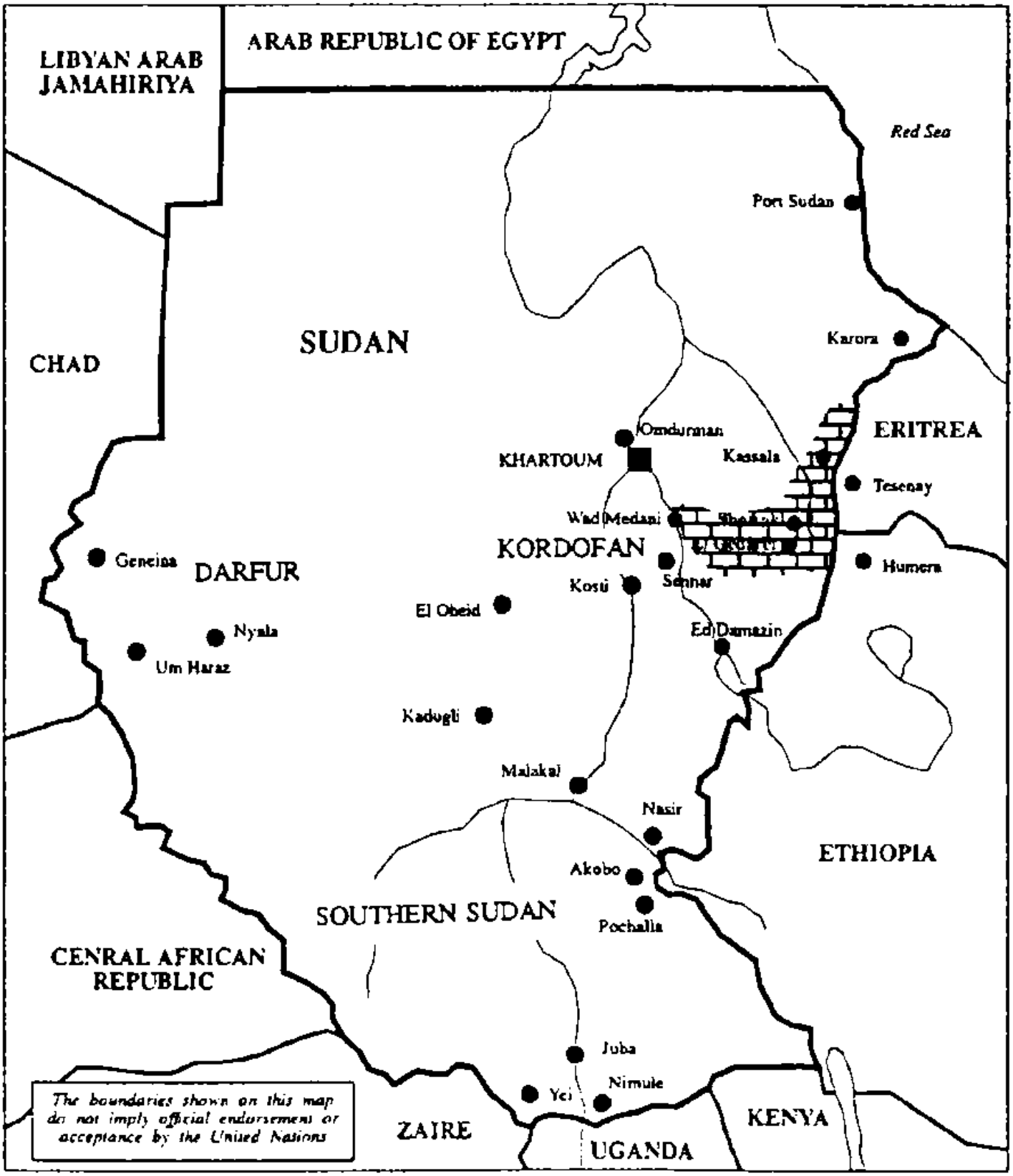
MAP 9a. Liberia



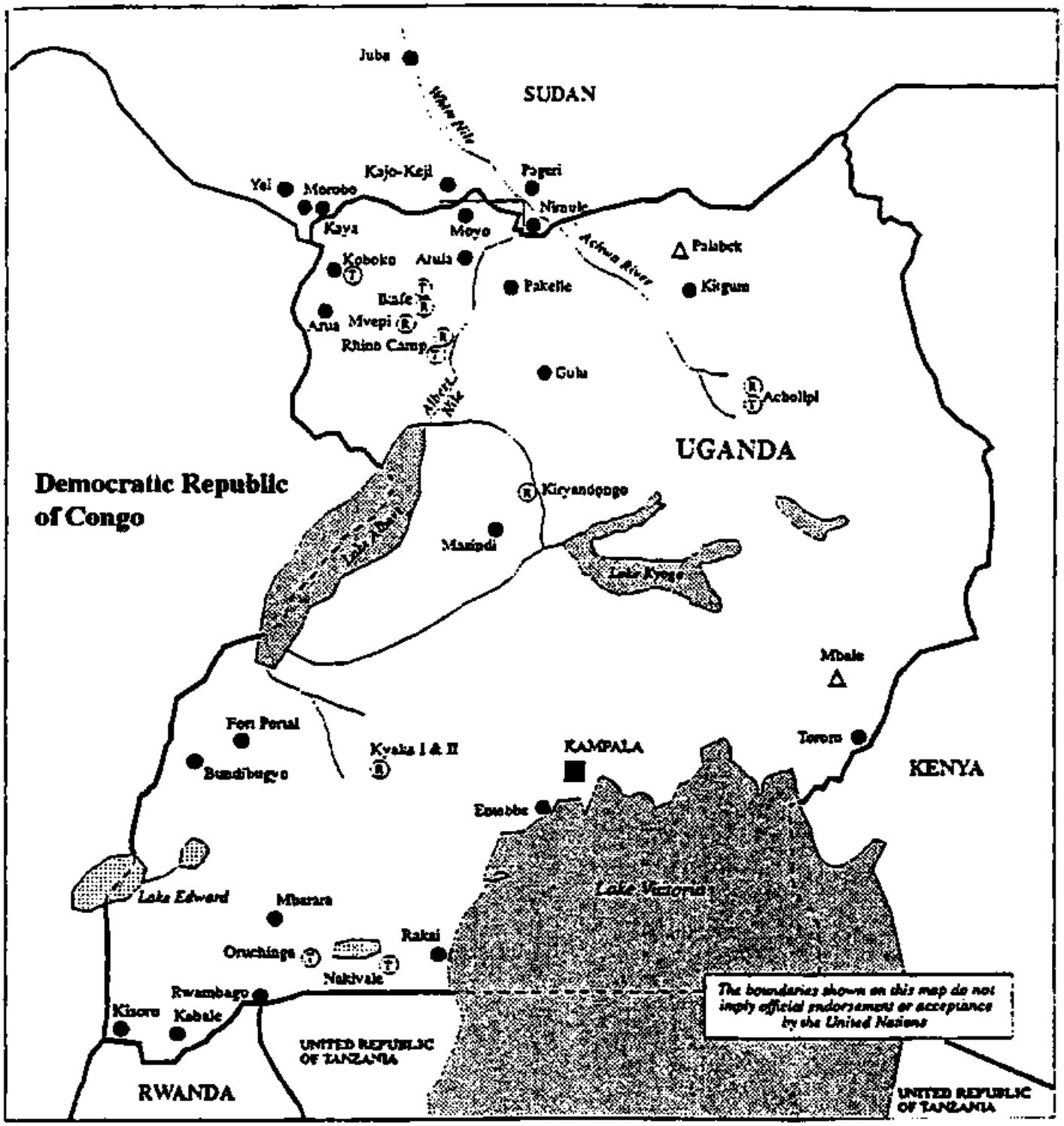
MAP 9b. Sierra Leone



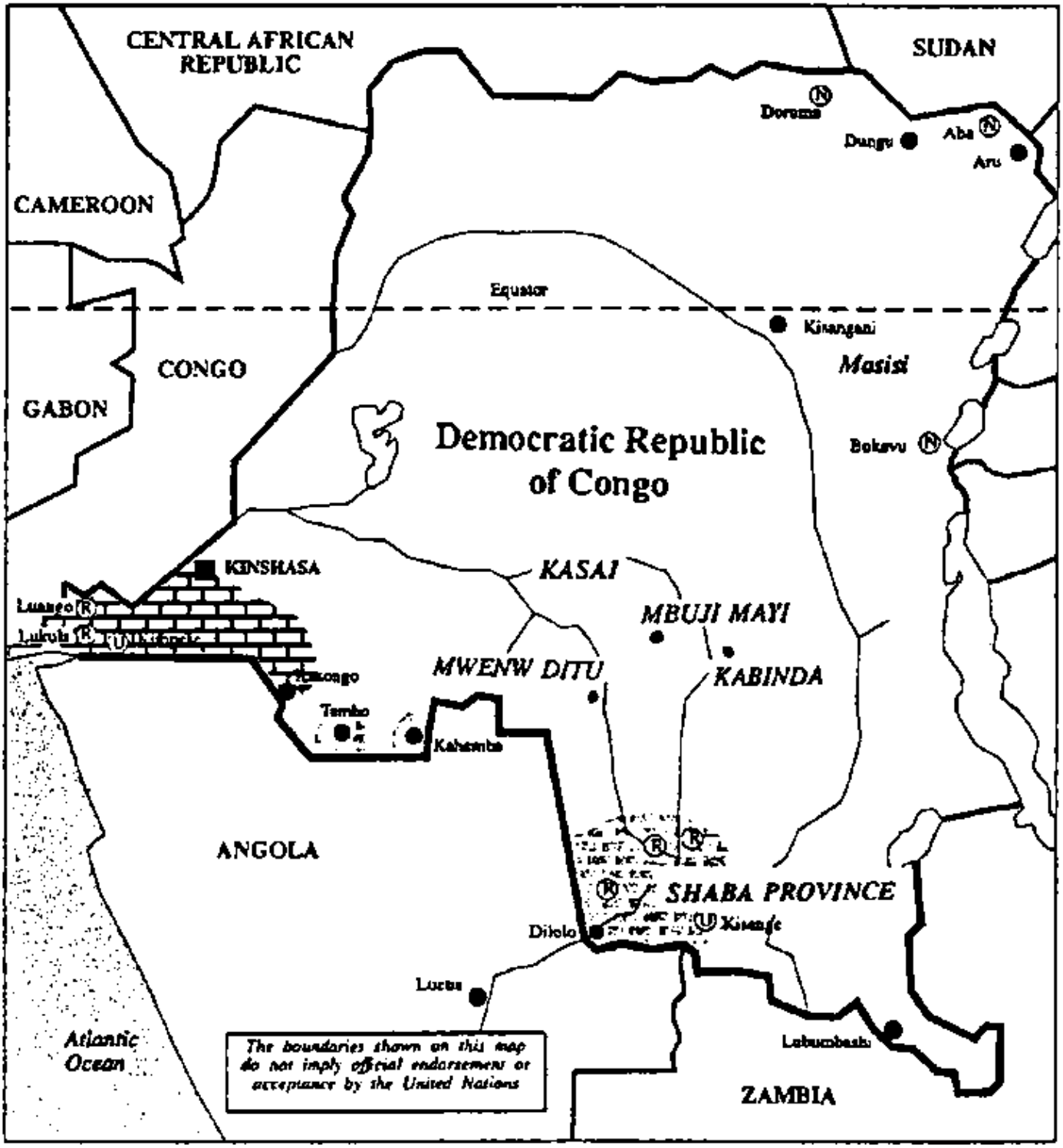
MAP 11. Somalia


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

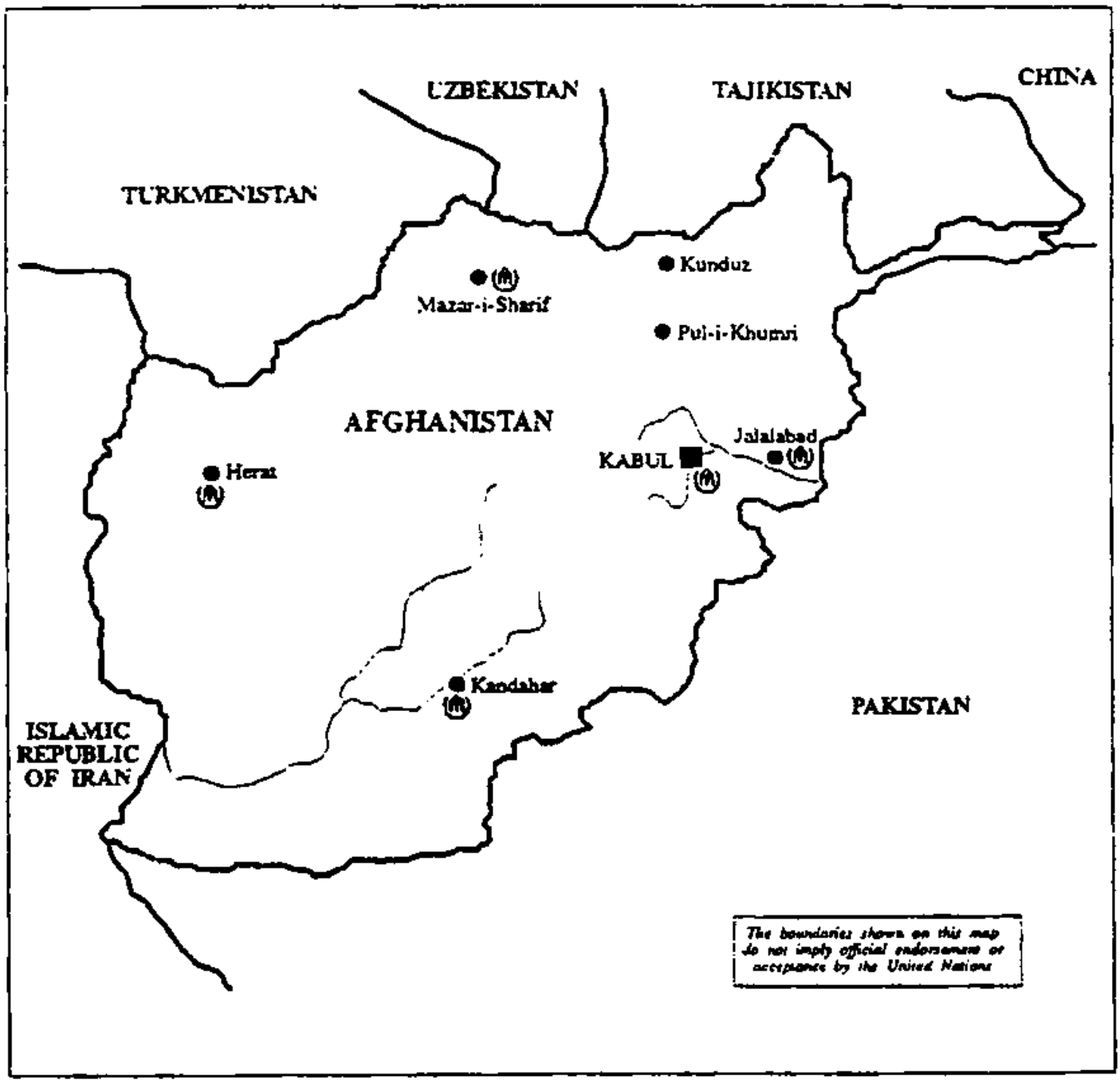
MAP 12. Sudan



MAP 13. Uganda



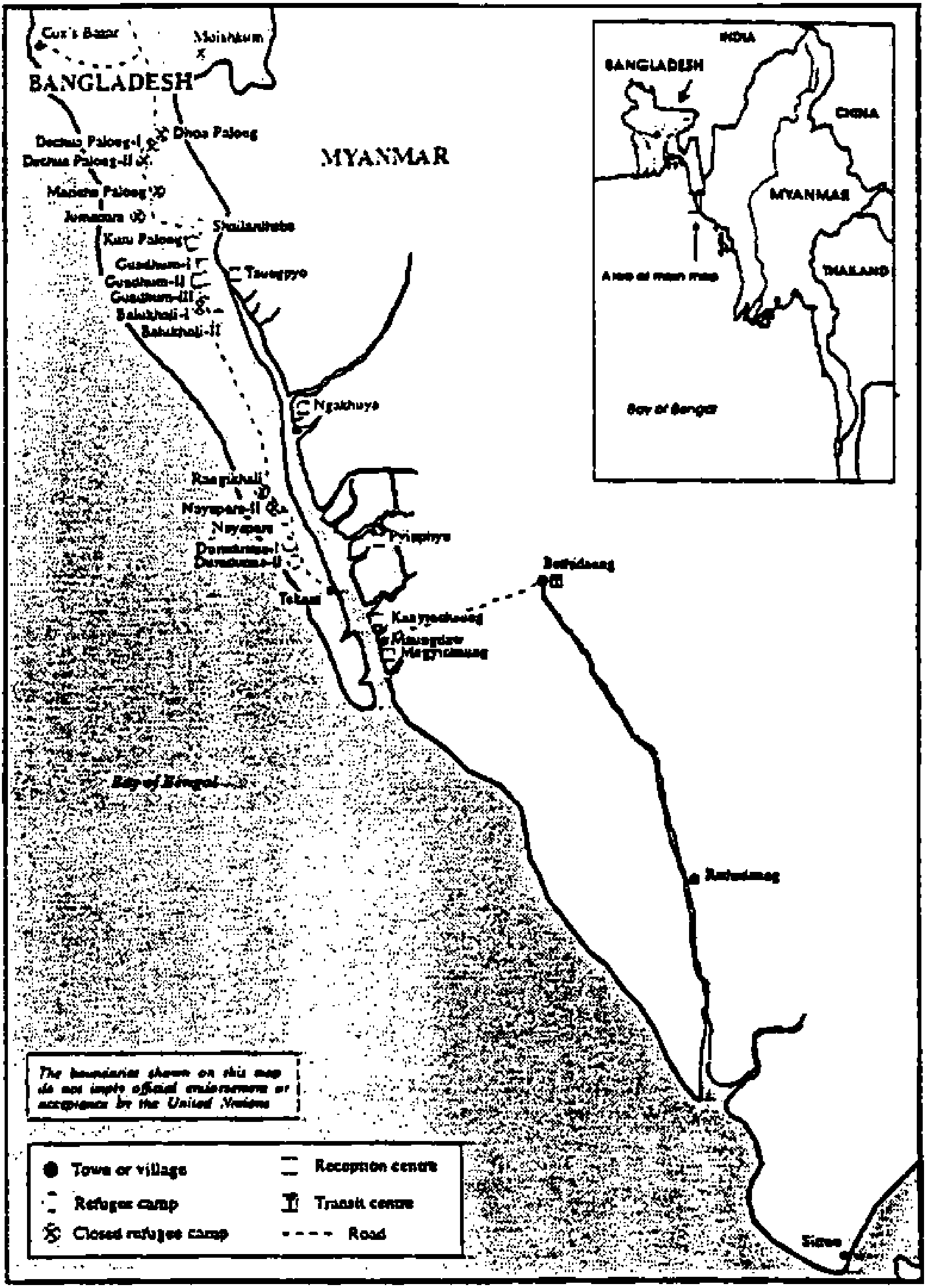
MAP 14. Democratic Republic of Congo



MAP 16. Afghanistan

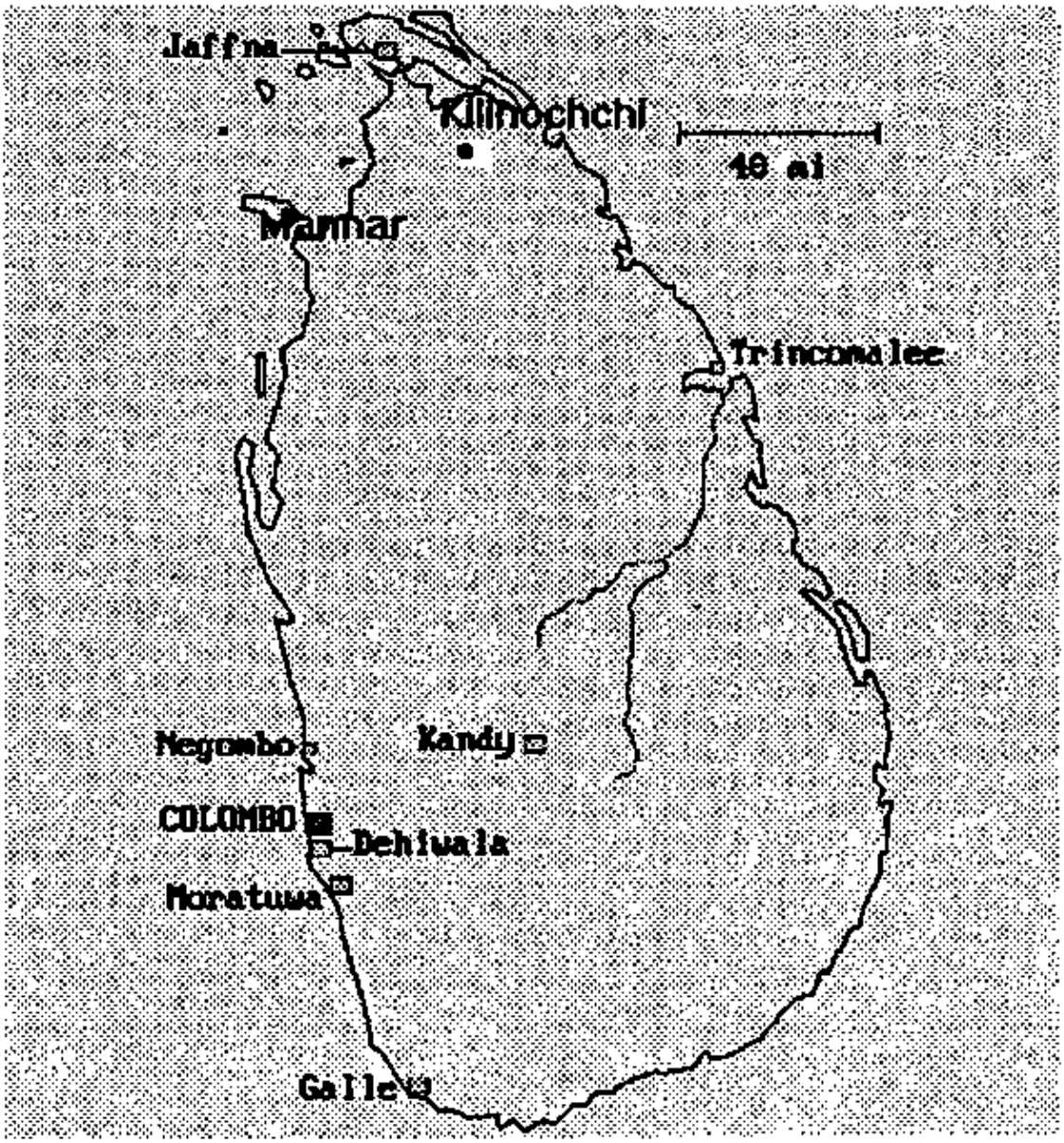

CHINA
NEPAL
Kathmandu
BHUTAN
Kakarvitta
Biratnagar
Jhapa and Morang
Districts
INDIA
BANGLADESH
The boundaries shown on this map do not imply official endorsement or acceptance by the United Nations

MAP 17. Nepal



Cox's Bazar
BANGLADESH
MYANMAR
Kutu Palong
Balukhali-I
Balukhali-II
Taungpyo
Ngakhuya
Nayapara
Tekkaf
Buthidaung
Rathedaung
Sittwe
INDIA
BANGLADESH
CHINA
MYANMAR
THAILAND
Area of main map
Bay of Bengal
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 18. Bangladesh



MAP 20. Sri Lanka