



**Food, nutrition and mortality situation of IDP's in Dubie,
Katanga 23-25 March 2006
MSF**

'Ketudi Byakudya'

We don't have enough food

Abbreviations

AASF	Association Agricole Sans Frontieres
ACF	Action Contre la Faim
CI	Confidence Interval
CMR	Crude Mortality Rate
DRC	Democratic Republic of Congo
ICVA	International Council of Voluntary Agencies
IDP	Internally Displaced Person
MSF	Medecins Sans Frontieres
MUAC	Mid-Upper Arm Circumference
NGO	Non-Governmental Organisation
OCHA	Office for the Coordination of Humanitarian Affairs
U5MR	Under-Five Mortality Rate
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHO	World Health Organisation

Executive summary

At the end of 2005 militia attacks and government military operations caused large population displacement in the province of Katanga in the Democratic Republic of Congo (DRC). Among them, approximately 16 000 people are temporarily residing in three camps in Dubie, a town in Katanga Province.

MSF has been working in Katanga since 1988, supporting hospitals, fixed and mobile clinics in many locations, including Dubie since 1996.

Due to decreasing food security in Dubie, Medecins Sans Frontieres (MSF) conducted a nutrition and mortality survey among 563 households. In order to explore the issues from the perspective of the population further, the survey was complemented with 15 household interviews. Data from the World Food Programme (WFP) food distributions was also reviewed.

The mortality rates over a 90-day recall period (since Christmas 2005) were:

Crude Mortality Rate (CMR): 4.3 / 10 000 / day (CI 3.5-5.3)

Under-Five Mortality Rate (U5MR): 12.7 / 10 000 / day (CI 10.1-16.3)

This is above the emergency threshold of CMR > 1 and U5MR > 2 and therefore indicates a catastrophic situation.

The prevalence of global acute malnutrition (< -2 z-score and/or presence of oedema), was 19.2% (CI 15.7-23.3%) and of severe acute malnutrition (< -3 z-score and/or presence of oedema) was 5.0% (CI 3.2-7.6%). A global malnutrition of 10-15% indicates a crisis in food security.

Discussions with people in the camps underline the on-going lack of food, with sporadic and limited food distributions compounded by limited working opportunities within Dubie and restrictions on movements. There is neither enough food in Dubie nor adequate access to any food that might be found outside Dubie.

WFP distributions have not only been untimely but insufficient – and significantly less than their own recommended daily intake of 2,100 kcal / person / day. In WFP's December / January distribution to the IDPs of Dubie, only 9.9 days of food were given. The next distribution of 1,050 kcal / person / day for one month started on 27th March – some seven weeks after the first distribution. At present, there are no plans being made to change this situation – despite the obvious food insecurity, growing levels of malnutrition and catastrophic mortality rates in Dubie.

MSF first reported on the situation in Katanga in December 2005, going as far as briefing the UN Security Council. Since then, little has changed on the ground. WFP, the United Nations and donors have neglected both Dubie's displaced and host populations for too long. Immediate assistance is critical.

1. INTRODUCTION

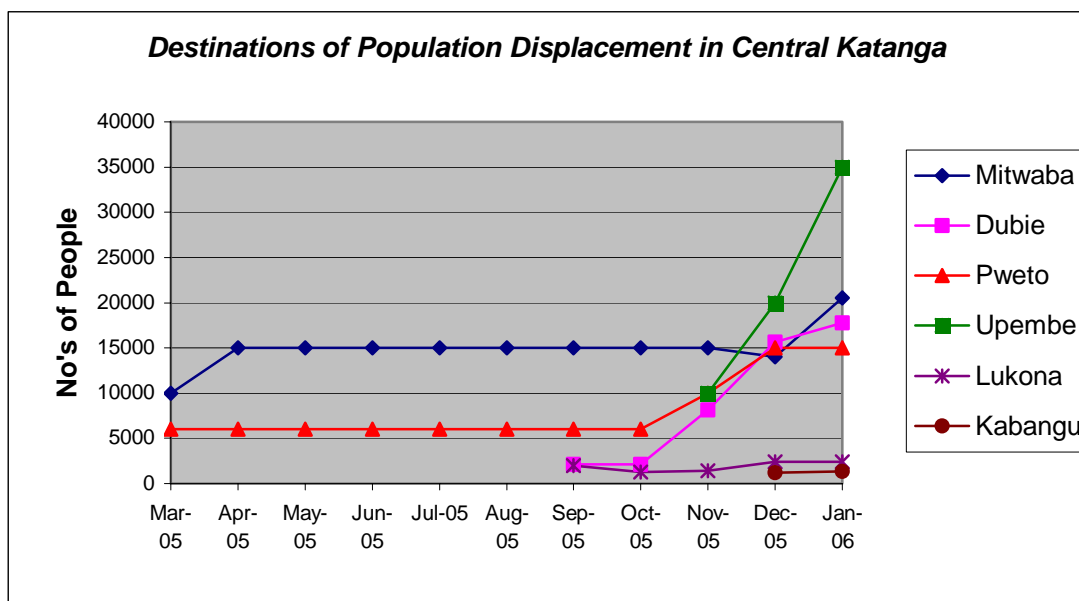
1.1 Background to Population Displacement

Dubie is a community with a population of 10,000 in the Pweto district and Kilwa health zone of Haut Katanga. The main occupation of the population is agriculture plus petty trading, although due to limited infrastructure, insecurity and long distances, this occurs on a small-scale.

Between July and October 2005, as a result of conflict, banditry and violence against civilians in nearby villages, approximately 1,000 displaced people settled in Dubie. They achieved a certain level of integration, providing daily labour for the host population and acquiring small plots of land for their own agricultural activities. However, in the following three months (starting in mid-November), due to an intensified campaign by the Congolese military against the Mai Mai and consequent looting and pillaging by both sides, the numbers of displaced rose dramatically. Dubie became host to approximately 3 200 internally displaced people (IDPs) in November, increasing to 14 000 by the end of December and 16 400 by mid January.

Overall in central Katanga, in less than a year, approximately 92,000 persons have been displaced. Their destinations are shown in *Graph 1* below. This displacement has to be added to pre-existing levels of displacement in these and adjacent zones in central and northern Katanga, much of which remains unknown.¹

Graph 1



Since January, Dubie's IDP population has remained relatively stable at around 16,000 people, with another 3,000 living nearby in Lukona. In Dubie the IDP population is split between three camps. The older, more established IDPs live in camp I (1100 families) while the more recent and more vulnerable arrivals live in camp II (810 families) and camp III (3230 families).

1.2 The Problematic

Over the last few months, food insecurity and growing malnutrition have been identified as the main problems seen by MSF. By the end of 2005, survival strategies available to the initial displaced people were not available to the rapidly increasing IDP population. Almost all the available agricultural land was already utilised, the

¹ Population movements and context are documented in "Running For Their Lives - Repeated Civilian Displacement in Central Katanga, DRC" produced in February 2006, MSF.

pressure on wild food collection increased and the opportunities for other forms of income generation through casual labor remained limited.

In November and December 2005, MSF conducted a measles vaccination campaign, which was accompanied by a Mid Upper-Arm Circumference (MUAC) survey that indicated worrying levels of malnutrition². In mid-February 2006 Action Contre la Faim (ACF) carried out a rapid survey of the nutritional status in Dubie that indicated alarming levels of malnutrition.³

MSF observation also indicated that the population was experiencing a food crisis, being forced to sell possessions necessary for basic survival in order to buy food in a limited market.

1.3 Reactions So Far

MSF responded initially to the influx in November by scaling up its medical intervention, adding shelter, water and sanitation activities and distributing plastic sheeting, cooking sets, blankets, jerry cans and other small non-food items, mostly supplied by the United Nations International Children's Fund (UNICEF). Additionally MSF requested more Non-Governmental Organisation (NGO) and UN assistance at an early stage, reinforcing these calls with a briefing of the UN Security Council in January 2006, a paper entitled "Running For Their Lives - Repeated Civilian Displacement in Central Katanga, DRC" produced in February and on-going vigorous lobbying at local, national and international levels.

In response to the worsening food situation, MSF increased capacity in the therapeutic feeding centre (specialised unit for severely malnourished children)⁴ and distributed high-energy biscuits, donated by UNICEF. In January, Caritas Congo (with a donation from Caritas Zambia) made a partial distribution of food to host and displaced families. This was followed by another distribution by the World Food Programme in early February where the ration equalled less than 10 days food, at the internationally recognised, and WFP recommended, requirement of 2,100 Kcal per person per day⁵. It only targeted around 13 000 people when the population estimate was closer to 16 000.

Despite on-going and constant demands for additional international intervention, donors and UN agencies have reacted inadequately. In order to encourage international agencies to respond, MSF conducted a nutrition and retrospective mortality survey complemented by qualitative semi-directive interviews. The information was gathered between the 23rd - 25th March 2006 in the three camps of Dubie.

² MUAC of all 1135 children aged 6 to 59 months: MUAC < 125 mm and /or oedema 12.8%; MUAC < 110 mm 2.1%; 0.2 % had oedema

³ MUAC sample of 647 children from 12 to 59 months: MUAC < 110 mm and / or oedema 14.7%; MUAC < 125 mm or oedema 39.7% ACF, 21/02/2006

⁴ At the time of writing MSF had 75 children admitted in the TFC.

⁵ Food and nutrition needs in emergencies, WFP, UNHCR, UNICEF, WHO; 2004

2. METHODOLOGY

An anthropometric and mortality survey was combined with semi-structured interviews and existing reports on food aid.

The estimated population size was 15 682, living in 3 394 households which were numbered for the purposes of the survey. The proportion of children under 5 years of age was estimated at 17%, giving in total 2 666 children and an average of 0.78 children under 5 years per household. The prevalence of malnutrition was estimated at 15%. The aim was to have a precision of 3% and standard error 0.5% which gave a required sample size of 450 children or 573 households.

A systematic sample was taken of every 6th (573/3394) household. In households without children only the mortality questions were asked. No one refused to participate; when a household was empty, the team returned in the afternoon and if unsuccessful, the next household was approached.

Local Red Cross volunteers who normally function as community health workers in the camps received a two-day training on communication and documentation prior to undertaking the survey. Despite this training, there may have been misinterpretations of language. There were 4 teams of 5 people including a supervisor.

The data was entered in Excel and later exported to Epiinfo version 3.02 for analysis of the anthropometric data.

To gain an impression of the IDPs' perspective on general concerns, particularly food security, a semi-structured interview (see annex for all data collection tools) was conducted with 15 households, 5 from each camp. The households were chosen at random by spinning a bottle and then going to the seventh household. The person interviewed was the household head or another adult. One household (headed by a girl of 15 years) refused to participate in the discussions.

The interviews were performed through a translator and an international staff member. It should be noted that this information attempts to add a qualitative element to the survey findings and cannot be generalised.

Data on food aid was obtained from WFP and their implementing partner, Association Agricole Sans Frontières (AASF).

3. RESULTS

3.1 Population Characteristics

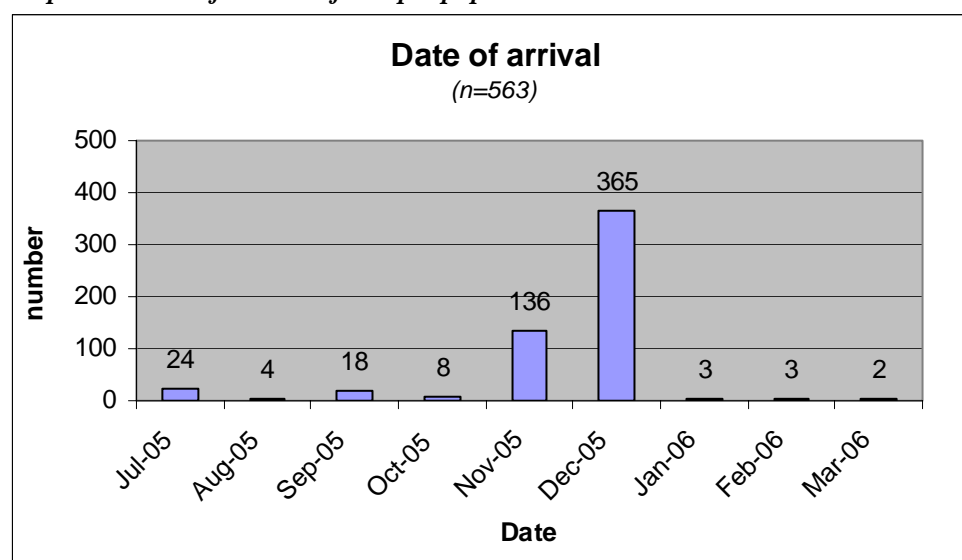
The total number of households interviewed was 563. These households equate to 1 980 persons, of whom 532 were children under five years, representing 27% of the sample population - higher than the expected proportion of under-fives.

Table 1. Description of the population

Description of the sample	Number
Total Study Population	1980
Number of families included	563
Number (percentage) of children under-five years	532 (27%)
Average family size	3.5

Of those interviewed, the majority of families arrived in the months November and December 2005 (24% and 65% respectively).

Graph 2 Month of arrival of sample population



3.2 Mortality

In the recall period of 90 days (26th of December 2005 - 24th of March 2006) 39 babies were born and 78 people died, of whom 62 were under five years. The crude mortality rate is 4.3 / 10 000 / day and the under-five mortality rate is 12.7 / 10 000 / day. These figures are catastrophic.

Table 2. Under-five and Crude mortality rates

	Number	MR/10,000/day	CI*
Under-five mortality	62	12,7	10.1-16.3
Crude mortality	78	4,3	3.5-5.3

Calculations:

CMR= deaths/mid-term population = deaths / (total population + half of deaths-half of births) x 10000 / 90 = 78 / {1980 + [(0.5 x 78) - (0.5 x 39)]} x 10000 / 90

U5MR= deaths/mid-term population = 62 / {532 + [(0.5 x 62) - (0.5 x 39)]} x 10000 / 90

*Confidence Intervals were derived using Epiinfo software.

3.3 Malnutrition

In total 442 children under five years old were included in the anthropometric survey, 52.3% were male and 47.7% were female. This difference in gender is not statistically significant. The numbers of people per age group is as expected. The gender and age distribution of the survey sample, indicate a representative sample.

Table 3. Breakdown by age of the survey sample

Age Group (months)	Number	Percent
6 – 17	86	19.5
18 – 29	93	21.0
30 – 41	121	27.4
42 – 53	92	20.8
54 – 60	50	11.3
Total	442	100

Regardless of how the malnutrition is defined, the prevalence of acute malnutrition is high, indicating a serious nutritional situation. The prevalence of oedema also reflects an unbalanced nutritional intake.

Table 4. Prevalence of acute malnutrition among 6-59 months children expressed as Z-score (n=442)

Z-score	Number of children	Percentage (95% C.I.)
Global malnutrition	85	19.2 (15.7-23.3)
Severe malnutrition	22	5.0 (3.2-7.6)

Definition:

Global malnutrition = weight/height: < -2 z-score and/or presence of oedema

Severe malnutrition = weight/height: < -3 z-score and/or presence of oedema

Table 5. Prevalence of acute malnutrition among 6-59 months children expressed as percent of the reference median (Weight for Height Median) (n=442)

% median	Number of children	Percentage (95% C.I.)
Global malnutrition	72	16.3 (13.0-20.1)
Severe malnutrition	18	4.1 (2.5-6.5)

Definition:

Global malnutrition= weight/height: < 80% and/or presence of oedema

Severe malnutrition = weight/height: <70% and/or presence of oedema

Table 6. Prevalence of oedema alone

	Number of children	Percentage (95% C.I.)
Presence of Oedema	13	2.9 (1.6-5.1)

The results of the MUAC findings (below) are presented for the sake of completeness; in the knowledge that weight-for-height is a more appropriate measurement for acute malnutrition.

Table 7. Prevalence of acute malnutrition among 13-59 months children according to Mid Upper Arm Circumference (MUAC) including oedema

	Number of children	Percentage (95% C.I.)
MUAC < 12.5 cm and/or presence of oedema	33	8.6 (6.1-12.0)
MUAC < 11.0 cm and/or presence of oedema	12	3.1 (1.7-5.5)

Definition:

Global MUAC malnutrition= MUAC < 12.5 cm and/or presence of oedema

Severe MUAC malnutrition = MUAC < 11.0 cm and/or presence of oedema

3.4 Food Security

From discussions with IDPs in the camps, the over-riding concern was lack of food. This was mentioned by everyone – particularly among the relatively more recently arrived IDPs of Camps II and III.

All the IDPs with whom MSF discussed, mentioned only eating one meal the day before: either cassava meal (fufu) and cassava leaves, or quite simply dried cassava skins – *‘something I would normally feed to the pigs’*, in the words of one man, or *‘throw away’* according to another woman.

3.4.1 Constraints on Survival Strategies

Many of the IDPs reported having initially been able to work in the fields of Dubie’s host community during the planting season, on a part-time basis in exchange either for a small amount of money or food (usually cassava roots). However, these opportunities progressively diminished. As one woman expressed: *‘now there is very little employment. The owners of the food keep the food themselves...it’s the end of the rainy season and the cultivating has stopped’*.

Others have attempted to go further afield in search of employment, perhaps 14 – 30 km away, but here too, they complain of restrictions on movement and/or being forced to hand over part of whatever they have earned to soldiers at checkpoints outside the camps. As one woman pointed out: *‘you always have to give something to the soldiers – but it’s so difficult to hand over the food’*.

Meanwhile, only a very small minority of people has managed to maintain some form of petty trade or semi-skilled work (such as tailoring). Virtually all of the IDPs with whom MSF discussed, spontaneously reported selling all their belongings including most of the non-food items they had received in order to purchase basic staples on the market. In the words of one man:

‘We received clothes, but we remain with nothing because we exchanged everything for food. I exchanged blankets, cooking pots, plates, cups, spoons and buckets. We remain with only one tent. We have kept our mosquito nets because there are many mosquitoes and they will kill our children. Since we don’t have any food and we don’t have any money, I might have to sell my tent’.

3.4.2 Inadequate Food Distributions

In a press release on 7th December, the UN committed to send 109 tonnes of food to Dubie.⁶ The World Food Programme’s implementing partner (AASF), began a distribution that commenced on the 28th January and was

⁶ DRC: Military Activity in Central Katanga Displaced 25,000 Civilians; 7th December 2005; OCHA.

completed two weeks later. The latter targeted 12 993 people out of an IDP population of 15 686 people (according to the 15th February figures), for a period of one month. The distribution was a planned 50% ration for one month – or 1,050 kcal per person per day – although the WFP states that 2,100 kcal is the baseline daily food requirement for each and every beneficiary. According to WFP's local implementing partner's distribution report, the ration actually consisted of the following:

- 200g maize flour / person / day (18 days ration given)
- 60 g peas / person / day (29 days ration given)
- 15 g oil / person / day (18 days ration given)
- 3 g salt / person / day (30 days ration given)

This equates to 19.8 days of food at the WFP planned intake of 1,050 kcal per person per day – or 9.9 days of food at the WFP recommended intake of 2,100 kcal. As one woman told us: *'at the end of January we received food. It was very good, but it didn't last long...for the big families it lasted only one week, although for some it lasted two weeks'*.

According to WFP's own reports, 108.397 tonnes were dispatched from Lubumbashi to Dubie for the first distribution of December / January; of these only 94.775 tonnes arrived in Dubie, whilst even less – some 72.891 tonnes – were recorded as being distributed by WFP's implementing partner – representing a shortfall of more than 35 tonnes (or 30%) of food between dispatch and distribution. On the 24th March 2006, MSF international personnel observed one of the WFP contracted trucks carrying food from Lubumbashi to Dubie being unloaded by military personnel in the military base in Dubie.

Another half-ration distribution, also intended to last for one-month, was planned for March, and started on the 27th March. This second distribution of half-rations comes at least seven weeks after the first which is late and too little.

4. DISCUSSION

According to the joint Office for the Coordination of Humanitarian Affairs (OCHA) and International Council of Voluntary Agencies (ICVA) report: 'the national and international response to the evolving humanitarian crisis in the Congolese province of Katanga remains woefully inadequate', despite implementation of the new UN 'cluster system' for humanitarian emergencies which allocates lead responsibilities to different UN agencies in the expectation that they coordinate the response to emergency needs and, in extreme cases, become 'provider of last resort'.

To date, only the IDPs' capacity to obtain casual labour and sell donated non-food items to buy food have prevented malnutrition from reaching greater proportions. This capacity is now exhausted. Given that the IDPs do not have robust survival strategies to complement food distributions and are not likely to see a dramatic change in their food security situation in the immediate-medium term, adequate and timely external assistance is needed now. With the pressure on the host community increasing, their situation should not be ignored.

The mortality and nutrition data from the survey underline the appalling situation of this vulnerable and neglected population. This survey did not attempt to look at the causes of mortality; therefore, the causes of death remain unclear. However, there have been no major outbreaks of disease in the period of recall. MSF morbidity data show that malaria is the most frequent reason for consultation, followed by diarrhoea. From the beginning of December until the end of February in MSF clinics serving the Dubie camps, 35% of children under 5 years were treated for malaria, while diarrhoea represented 21% of consultations.

Despite having set up health facilities to serve the population, MSF acknowledges that we have been unable to adequately address the high mortality although daily monitoring since February has shown a decreasing trend in mortality. However, food needs remain to be addressed.

5. *CONCLUSION*

Despite continuous lobbying for international assistance at the provincial, national and international levels including at the UN Security Council by MSF over the past few months, the populations of Dubie remain desperately neglected.

MSF has communicated both privately with WFP and publicly about the food insecurity in Dubie, and specifically, the inadequacy of the WFP ration. Despite this, there has not been a revision of the half-ration policy. A full monthly ration general food distribution to the IDPs of Dubie is needed now, and should include the logistical means necessary to manage and monitor it appropriately.

In the words of one woman: *'I have nothing more to say. Just tell them that we are suffering from hunger'*.

Annex Data collection tools

FAMILY QUESTIONNAIRE / RETROSPECTIVE MORTALITY SURVEY

Team n° Camp Date/...../.....

[illegible]

Anthropometric Data collection sheet

6 months – 59 months (< 5 years)

Team n° Camp: Date:/...../.....

[illegible]

