



Report of the WFP-UNHCR Rapid Joint Assessment Mission

[Liberia]



[Oct-Nov, 2014]

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Acknowledgements

The rapid JAM team would like to acknowledge the support of all staff of WFP and UNHCR in Monrovia, Saclepea, Zwedru and Harper for their involvement in planning, participation, administrative and logistic assistance prior to and during the JAM. The Heads of Offices in three locations are to be thanked for their key role in the smooth running of the mission and accompanying the team to meetings and briefing sessions. The JAM team would like to appreciate the Government of Liberia represented by Liberia Refugee Repatriation and Resettlement Commission (LRRRC), African Humanitarian Action (AHA), International Rescue Committee (IRC), Danish Refugee Council (DRC), Cooperative for American Remittances to Europe (CARE), Save the Children, Adventist Development And Relief Agency (ADRA) for their valuable contribution during visit and for participating in Key Informant Interviews (KII).

The team is thankful to the senior management of UNHCR and WFP for their guidance and approval for the JAM. Special thanks to Hanna Mattinen, Senior Food Security and Liaison Officer and Heiko Hering, Senior Public Health Officer, UNHCR Headquarter in Geneva for providing us with technical support.

Last but not least we are extremely grateful to the refugees who participated in Focus Group Discussions (FGD) and Household (HH) interviews and were willing to give an insight into their life during difficult situation in Ebola outbreak.

Acronym

AHA - Africa Humanitarian Action
ADRA - Adventist Development and Relief Agency
AIRD - African Initiative for Relief Development
ART-Ant-Retroviral Therapy
CARE - Cooperative for American Remittances to Europe
CDI – Côte D'Ivoire
CHO – County Health Office
CHW –Community Health Worker
CSB – Corn Soya Blend
DRC - Danish Refugee Council
FGD – Focus Group Discussion
GAM – Global Acute Malnutrition
GFD – General Food Distribution
GoL-Government of Liberia
HH – Household
INGO-International Non-Governmental Organisation
IP – Implementing Partner
IRC - International Refugee Committee
JAM – Joint Assessment Mission
LLIN – Long Lasting Insecticide Treated Net
LRD – Liberian Dollar
LRRRC – Liberian Refugee Repatriation and Resettlement Commission
LW – Little Wlebo Camp
MAM – Moderate Acute Malnutrition
MoA – Ministry of Agriculture
MoHSW – Ministry of Health and Social Welfare
MUAC – Mid Upper Arm Circumference
NFI – Non-Food items
PMTCT-Prevention of Mother To Child HIV Transmission
SCI - Save the Children International (SCI)
SEARCH - Special Emergency Activity to Restore Children's Hope
SENS – Standardized Expanded Nutrition Survey
SFP – Supplementary Feeding Programme
UNHCR – United Nations High Commissioner for Refugees
UNICEF – United Nations International Children's Emergency Fund
WASH – water, sanitation and hygiene
WFP – World Food Programme
WHO – World Health Organization

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Executive summary

Political turmoil and violence in Côte d'Ivoire (CDI) after the disputed 2010 presidential election resulted in over 224,000 Ivoirians fleeing across the border to seek refuge in Liberia.

In 2011, the Liberian and Ivorian governments and UNHCR signed a tripartite agreement committing to the voluntary repatriation of Ivorian refugees. Between January 2012 and July 2014, UNHCR facilitated the return of over 205,000 Ivorian refugees back to CDI (36,380 assisted returns and 168,719 spontaneous returns). Roughly 31,000 refugees remain living in camps and about 7,000 in among the general population of Liberia.

The outbreak of the Ebola Virus Disease (EVD) in West Africa began in Guinea in December 2013, hit Liberia in March 2014, most of April and May were stable but another wave came in June, rapidly surged in July with peaks in September in the primary affected countries of Guinea, Liberia, and Sierra Leone. The ongoing outbreak has become the largest ever reported. On 8 August 2014, the World Health Organization (WHO) declared the situation an International Public Health Emergency. Against this backdrop, the Governments of the affected countries adopted a Joint Declaration outlining measures to eradicate the virus in the sub-region.

The health crisis for EVD is having immediate humanitarian implications in the sub-region. The disease and containment efforts have disrupted trade and the rain-fed agricultural season, two primary livelihood sources for host community and for the refugees in Liberia. Traditional cross-border and inter-country supply routes have been disturbed as entire geographic areas are cordoned off and other countries in the region close borders and access points (sea, land, air). The crisis is evolving in a context of chronic fragility with high poverty, high market dependency, poor crop yields, and low health indicators; the situation is made further complicated by the continued fragility following from decades of conflict and civil strife.

These difficult conditions were compounded by the fact that from July 2014, the beginning of the agricultural lean season, WFP had to reduce rations for refugees residing in three refugee camps in Liberia due to serious food pipeline breaks. Therefore, essentially refugees are facing a double problem – that of reduced rations compounded by the, largely economic, effects of EVD. As a result of this, UNHCR and WFP conducted a rapid JAM in October and November, 2014 that focused on the changes to refugee's lives and livelihoods in light of the Ebola epidemic.

The first is that the cut in rations in July 2014 added considerable extra strain on refugee food security. This was then compounded by the EVD outbreak which further restricted sources of income. FGDs (Focus Group Discussions) reported that food was extremely scarce (because of the ration cuts) and that EVD income generating activities were much more difficult because of travel restrictions, closed markets and reduced contact with host communities. The analysis of a small Household (HH) surveys back those sentiments up.

The results of the HH survey indicated that lack of food availability is particularly severe. Majority of interviewed households (80%¹) reported having poor or borderline food consumption, a particularly worrying trend that is bound to have nutritional health consequences. In 2012, the HHs having poor

¹ The household survey involved conducting a total of 30 HHs interviews which was an indicative sample and not statistically representative.

or borderline food consumption was just 38%². An analysis of dietary consumption patterns shows that roughly three fourths (75%¹) of HHs with poor and borderline food consumption had not eaten any sources of protein in the past 7 days and that most of them (80%¹) had not eaten any oils or fats in the past week.

The analysis of sources of income shows that there has been a distinct shift toward people looking for income to replace the role of food assistance with roughly half of the interviewed HHs (54%¹) are using either labor or business/trading to supplement their incomes. This trend is further highlighted the fact that only 23%¹ of respondents reported about their dependency on food assistance, whereas, it was 60%² in 2012. Among all HH interviewed, 40%¹ of them informed that food was obtained by own production, purchase and traded goods/services and barter.

The 2014 coping strategies show a trend of increased ratio of families who choose to restrict food consumption as their main coping strategy. Opportunities to borrow food have decreased in 2014 as has the amount of food received as gifts (this is particularly significant because for particularly vulnerable households gifts are an important source of food, and also may show the effect of the closed boarder with CDI.) The selling of assets, both domestic and productive, has increased and the number of people decreasing their expenditure on food has decreased as people are already close to a breaking point and simply cannot afford to spend even less on food, so fewer refugees find decreasing food expenditure a viable option.

Despite the hit of EVD, provision of health care services to the refugees continues from the camp clinics. However, the number of consultation has reduced and the referrals are being a challenge due to shut down of secondary and tertiary referral centers. There is also disruption in screening for nutrition program due to 'no touch' policy in EVD outbreak. Therefore, the number of beneficiaries enrolled in nutrition program has also been reduced. Schools are closed following Government policy. Water, Sanitation and Hygiene services have been strengthened as a preventive measure for EVD. Ebola preparedness and response activities are ongoing in all three camps in line with Government of Liberia plan, WHO roadmap and UNHCR West Africa Regional plan following four main objectives; coordination and advocacy, social mobilization, disease control and surveillance.

This report makes the following recommendations:

1. Refugee feeding be immediately resumed at full rations and re-evaluate the situation in 6-12 months;
2. Supplementary feeding for pregnant and lactating women and children under 5 years of age should resume as soon as possible;
3. Ebola prevention and response activities should be continued
4. Strengthen community sensitization on backyard gardening
5. Strengthen livelihood activities

² The household survey in 2012 JAM involved conducting a total of 90 HHs interviews which was also an indicative sample and not representative.

1. Introduction

The Government of Liberia, supported by UNHCR and the international community, established a number of designated refugee camps in the counties bordering CDI, namely in Nimba, Grand Gedeh, and Maryland. Living in close proximity to the border was perceived to be advantageous to many refugees because it enables better access to information (Ivorian radio channels and mobile networks, interaction cross-border migrants, etc). In addition, living in close proximity to the border enables refugees to regularly visit their communities of origin in order to monitor their farms and engage in other livelihood activities. Considering the strong ethnic ties between Ivoirians and Liberians in the border areas in both countries, cross border movement has been fluid and frequent. Population movement was also facilitated by the highly porous borders between the two countries.

As of November 2012, the refugee operation in Liberia primarily focused on supporting these refugees. In addition, very limited assistance was provided to other host communities located along the CDI border.

In 2011, the Liberian and Ivorian governments and UNHCR signed a tripartite agreement committing to the voluntary repatriation of Ivorian refugees. Between January 2012 and July 2014, UNHCR facilitated the return of over 205,000 Ivorian refugees back to CDI. (36,380 assisted returns and 168,719 spontaneous returns.)

In late 2012 UNHCR and WFP conducted a Joint Assessment Mission (JAM) of the refugee camps in order to gain a deeper understanding of the refugee situation. The 2012 JAM looked at four camps (Little Wlebo, PTP, Solo and Bahn – Solo camp has closed since March, 2014) and was a ‘cross boarder’ mission, looking at refugees and their activities on both sides of the border, as well Ivoirians living with host communities.

In 2013 the Government of Liberia declared that Ivorian refugees living among host communities should no longer receive support from WFP. Consequently WFP support was limited solely to those refugees living within the camps.

The outbreak of the Ebola Virus Disease in West Africa began in Guinea in December 2013 but was not detected until March 2014. The number of cases and areas affected has rapidly surged since July 2014 in the primary affected countries of Guinea, Liberia, and Sierra Leone. The ongoing outbreak has become the largest ever reported. On 8 August 2014, the World Health Organization (WHO) declared the situation an International Public Health Emergency.

Against this backdrop, the Governments of the affected countries adopted a Joint Declaration outlining measures to eradicate the virus in the sub-region – including quarantine of contact cases and special measures to isolate border areas and high-risk zones where the highest incidence of Ebola is reported and where cross-border movement and trade is a primary factor contributing to propagation of the virus.

The health crisis is having immediate humanitarian implications. The disease and containment efforts have disrupted trade and the rain-fed agricultural season, two primary livelihood sources for the refugees. Traditional cross-border and inter-country supply routes have been perturbed as entire geographic areas are cordoned off and other countries in the region close borders and access points (sea, land, air). The crisis is evolving in a context of chronic fragility with high poverty, high market dependency, poor crop yields, and low health indicators; the situation is made further complicated by the continued fragility following from decades of conflict and civil strife. Poor

infrastructure remains a particular problem in Liberia with roads becoming virtually impassable, thus restricting movement of goods and services – and income opportunities for refugees. These already difficult conditions are yet further compounded by the fact that from July 2014, the beginning of the agricultural lean season, WFP had to reduce rations due to serious food pipeline breaks.

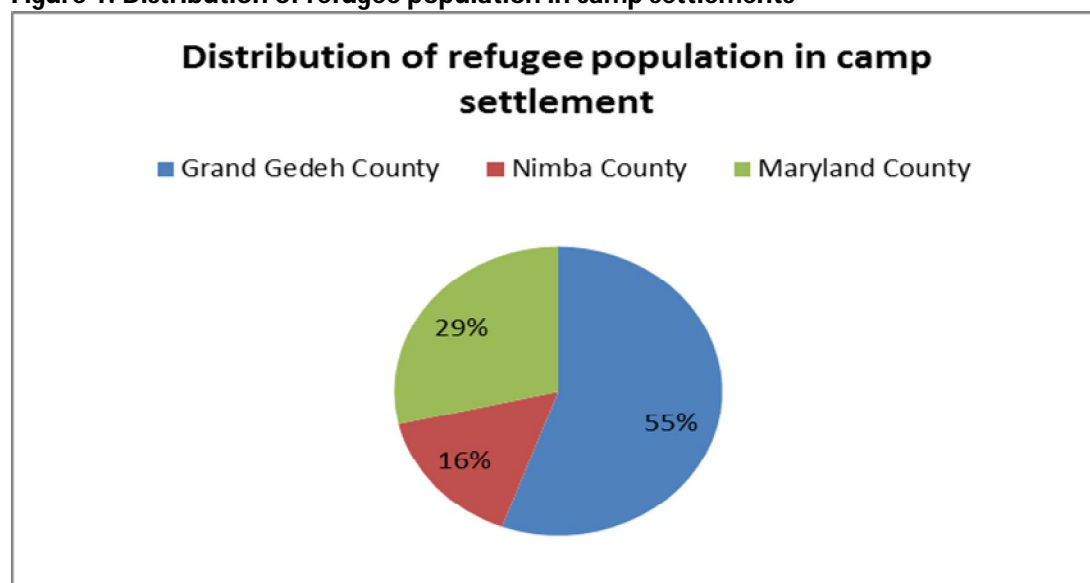
Therefore, essentially refugees face a double problem – that of reduced rations compounded by EVD.

As a result of this UNHCR, WFP and donors felt it imperative to have an update on the 2012 JAM findings. Therefore, in October 2014 UNHCR and WFP conducted a brief JAM that focuses on just the changes to refugee's lives and livelihoods in light of the Ebola epidemic.

Refugee numbers and demography:

According to the latest proGres database (UNHCR), the total number of refugees in the three camp settlements in Grand Gedeh, Nimba and Maryland and in communities in River Gee and Montserado in Liberia is 38, 428. Among them, a total of 29,357 (31,000 planning figure) refugees are residing in camp settlements, namely: Bahn (Nimba), PTP (Grand Gedeh) and Little Wlebo (Maryland). Solo camp in Grand Gedeh closed end of March 2014

Figure 1: Distribution of refugee population in camp settlements



The refugee population represents a high percentage of children (57%, under 18 years of age) and nearly 80% of the population consists of women and children. The crude birth rate at the end of 2014 was 2.2 (number of live births per 1000 population per month) which is slightly lower than the Liberia national crude birth rate of 2.8.

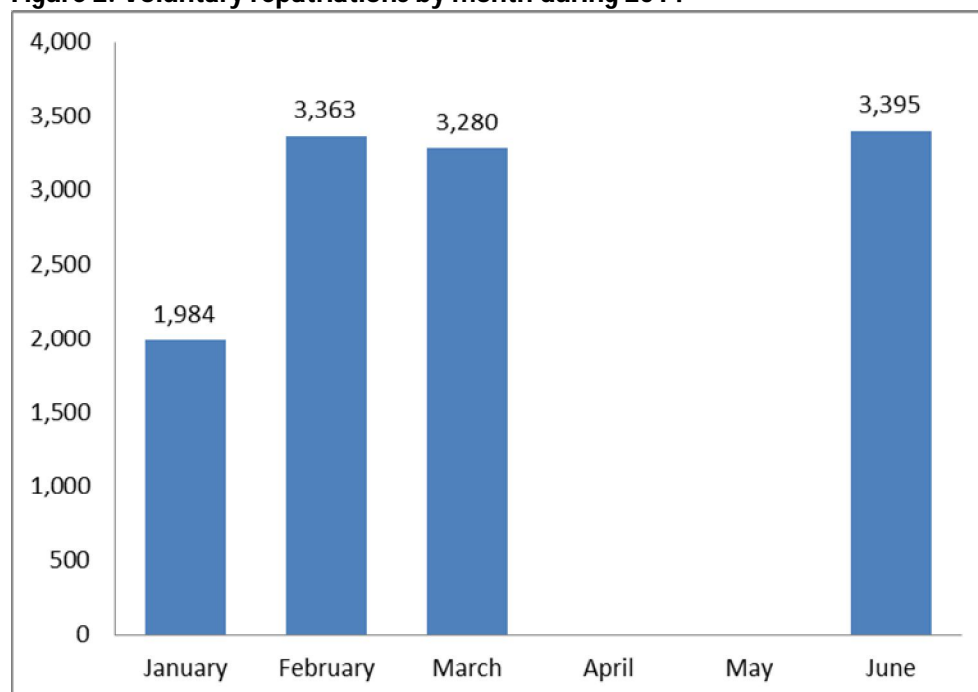
Locations	Gender		Total
	Female	Male	
Grand Gedeh			
PTP Camp	7,304	4,229	11,533
Communities	2,895	5,608	8,503
NIMBA			
BAHN Camp	2,728	1,614	4,342
Communities	335	1,023	1,358
Maryland			
Little Wlebo Camp	4,730	2,639	7,369
Communities	909	2,041	2,950
RIVER GEE	993	793	1,786
MONTSERADO	231	356	587
TOTAL	20,125	18,303	38,428

Repatriation:

Until the outbreak of the EVD in Liberia in March 2014, the operational strategy of UNHCR in Liberia focused mainly on voluntary repatriation, access to basic needs and essential services and self-reliance/sustainable livelihoods. UNHCR had assisted 8,627 refugees to voluntarily repatriate to Cote d'Ivoire and the Solo camp had been closed. Furthermore, during the first wave of the outbreak in northern Liberia led a two month halt in voluntary repatriations during April and May. Convoys were restarted in June but had to stop again with the second wave of the outbreak in July. At the end of July 2014, the total number of refugees who opted for voluntary repatriation was 12,022.

Since the voluntary repatriation service stopped because of the expansion of the EVD outbreak, UNHCR was unable to facilitate the return of an additional 8,000 refugees as originally planned. The operation in Liberia is, therefore, providing protection and assistance to this additional number of refugees.

Figure 2: Voluntary repatriations by month during 2014



ICRC continues to provide support to refugees who otherwise can still contact relatives back home through its family contact program.

Coordination:

UNHCR in collaboration with the Government of Liberia through the Liberia Refugee Repatriation and Resettlement Commission (LRRRC), ensures the protection of refugees, including the voluntary nature of repatriation. It supports and coordinates the basic humanitarian assistance activities of partner agencies and works together with Africa Humanitarian Action (AHA), Care International, CARITAS, Danish Refugee Council (DRC), International Refugee Committee (IRC), African Initiative for Relief Development (AIRD), Adventist Development and Relief Agency (ADRA), Save the Children International (SCI) and then Special Emergency Activity to Restore Children's Hope (SEARCH).

2. Major findings from 2012 JAM

The 2012 JAM found:

- Eighty one percent of the refugee population is composed of women, and children under the age of 18;
- In all locations visited during the JAM, food availability did not appear to be a major issue. Various food items were available in markets within refugee camps, reflecting the fact that both Liberians and refugees are engaged in petty trade activities;
- The JAM findings showed that refugee expenditure is predominantly on fresh vegetables, fish and condiments, which are purchased to complement WFP food rations along with non-food items (NFIs). The JAM revealed how refugees commonly exchange a portion of their WFP general food distribution (GFD) for fresh food items in local markets. Overall, refugees reported exchanging 20% of rations;
- A high proportion of refugees living in camps had found work in surrounding fields as wage laborers; whilst others engaged in petty trade. Those who sell prepared food in markets are doing better than their counterparts, earning on average 300 LRD (Liberian dollars) per working day (2012 Rates). Some refugees were involved in petty trade activities by borrowing start-up capital from Liberians. Others are engaged in selling firewood, vegetable gardening, tailoring, motorbike taxis, hairdressing and charcoal production. During the focus group discussions (FGDs), women were hesitant to disclose more sensitive coping strategies. However, some admitted to living with Liberian men in order to benefit from perceived protection and support;
- Analysis of HH interviews revealed that approximately one in five refugees (18%) living in camps rely on wage labor as their main source of income. However, in contrast, 15% exclusively live on food assistance, as they do not have access to any other source of income;
- In refugee camps, the main source of food is from WFP assistance (60%). The rest of HH requirements come from direct purchase (30%); from the sale of some of the rice or other commodities provided from food assistance; and from income gained through engaging in other livelihood activities; and
- Refugees living in camps have access to comprehensive, integrated and free primary healthcare services, including nutrition, HIV/AIDS, reproductive health, malaria prevention and control program, mental health/psychosocial support, and WASH services.

3. The Rapid Joint Assessment Mission: objectives and methodology

Objectives: The mission had four main objectives for the rapid and brief assessment:

- a) To compare and make comparisons with the information collected through joint assessment mission in 2012 with conditions in 2014;
- b) To determine how Ebola Virus Outbreak (EVD) had impact on food security situation of refugees;
- c) To assess the impact of Ebola Virus Outbreak (EVD) on services for the refugees in camps including health, water, sanitation and education; and
- d) To collect information about coping mechanisms for the reduced food rations and for limited livelihood opportunities due to Ebola Virus Outbreak (EVD) situation.

Methodology

The mission reviewed available secondary data (food, health, nutrition, WASH reports, email and phone communications, nutrition survey report, 2012 JAM report). The primary data collection was limited to Focus group discussions, key informant interviews, facility visits, and a small household survey due to restrictions of movements for the Ebola virus outbreak situation.

Focus Group Discussions (FGD): The mission conducted two focus group discussions (FGDs) in each camp; one with all male and another with female participants. Each FGD comprised of 12-16 participants. The participants were selected from different block, different age group (18 years and above), and various income sources, and included members of particularly vulnerable groups – disabled people, the elderly and single mothers.

Key Informant Interviews (KII): The team undertook a series of interviews with the 'institutional' actors involved in the refugee operation. These included the Government of Liberia (LRRRC), non-governmental organizations and UN agencies.

Facility visits: The mission visited health and WASH facilities in PTP and Little Wlebo camp. However, the team was not able to visit facilities in Bahn due to limitations of time.

Household survey: From each camp, a purposive sample of 10 households was randomly selected for a small household survey. This method was included to collect information related to source of income, expenditure and food consumption from refugees that were not captured in focus group discussions. The survey was conducted with the support from UNHCR field colleagues in all three locations. The number of households interviewed was chosen to match that of the 2012 JAM so that relative comparisons (trends) could be made in conjunction with information collected through FGDs and KIIs.

4. Findings

Focus group discussions were held in all three camps to look at Market Access, Food Availability, Prices, Access to Land and coping strategies.

Two groups were interviewed in each camp – one comprising of males and the other of females. The groups were chosen by UNHCR staff and covered a reasonably representative sample of the camp including youth, the disabled and other particularly vulnerable groups. The discussions were open and frank and lasted for two to two and half hours. Markets inside the camps were also visited.

After the interviews a small household survey was conducted to determine Sources of Income; Sources of food; Expenditure patterns; Food Consumption Scores; Dietary Diversity; and, Coping strategies.

Market access, food availability, prices and access to land

I. Market access

The 2012 survey found that refugees had good access to markets both within the camps with traders from both CIV and Liberia were operating camps offering a variety of foods and NFIs, and in nearby towns (on average 12-15km away), enabling access to bigger markets where a wider range of commodities can be found.

In 2014 the JAM found that overall, with the exclusion of Bahn camp (which operated a self-imposed quarantine); this was still the case in PTP and Little Wlebo camps. All camps reported that the prices in camp markets were roughly the same as prices outside the camps. However, both PTP and Little Wlebo camps reported an increased reluctance to visit external markets either as a precaution against EVD or lack of welcome from the host communities.

Little Wlebo reported that although size and number of markets within the camp had almost doubled in the past year, (because of inputs from the market community and the market association.) Market inputs, however, posed a serious problem with the borders closed and movement restrictions. So there was no real economic or access gains.

II. Food availability

The JAM visit coincided with the onset of the 2014 harvest in the same timeframe as the 2012 survey, although in 2014 the onset of the harvest was slightly delayed.

In much the same vein as the 2012 survey, in 2014 it was found that refugees predominantly purchase fresh vegetables, fish (dry and fresh), meat and condiments to complement the food ration which they receive from WFP. Market visits and focus group interviews revealed that a small portion of WFP rations (mainly rice) are exchanged by refugees on the market in order to obtain fresh food items. Exchange of food rations represents the main mechanism used by refugees to diversify their diet, in response to a gap in the provision of fresh items by development agencies.

In the focus groups most people agreed that since the reduction in food rations in July 2014, the beginning of the agricultural lean season, it became increasingly difficult to sell sufficient rations to buy the other things they needed – in particular food.

In all the focus group discussions camp residents complained of WFPs response, citing that the food was too little, and distributions were not regular.

III. Prices

According to monthly market monitor bulletins published by WFP in partnership with the Ministry of Agriculture (MoA) and the Liberian Institute of Statistics and Geo-Information Services (LISGIS), the 2014 data shows that the price of local rice had decreased across Liberia from October to November, partially due to the rice harvest which was underway. However, the price of a 50kg bag of imported rice did not indicate massive inflation.

While palm oil prices generally remained stable between October and November, at around \$L27 per pint, average cassava flour prices rose from \$L22 in October to \$L36 in November. These increases are, however, in line with expected seasonality fluctuations in the price of cassava flour. In the south eastern region of Liberia, where the refugee camps are located, cassava flour prices peaked at \$L39 during November, the highest in the country.

Manual labor wages did not change drastically over the period between October and November. However, focus groups reported that there was a major drop in both income levels and income opportunities. The hardest hit was in Bahn camp, because of the self-imposed quarantine, where groups recorded reductions from roughly LRD 800 per week before EVD (compared to the national average of LRD 1,015) to virtually nothing. Bahn camp residents reported that there were very few opportunities to earn money and the only people in work were working for NGOs at a rate of US\$3 per day. Another income scheme was chopping wood at \$L30 per day. The other camps also reported that there were far fewer opportunities to generate income, however, because they were not quarantined – did not suffer the same degree of hardship.

Borrowing rates differed from camp to camp as did the quantities available to borrow, Bahn reported that the cost of borrowing 1kg of rice was 2kg – a ratio of 1:2, Little Wlebo reported 5:8 or 10:15 and PTP reported 10:15 or 1:1.5. In the focus group discussions both men and women reported that the price of food was roughly the same both in camps and neighboring communities. However, it was also mentioned that most commodities were bartered for. All camps also reported an increase in transactional sex for food/money.

IV. Access to land

In 2012 the JAM reported that for the refugees living in camps, access to farm land remained a critical issue. It expressed concern that land access issues could create tensions between refugees and the host communities. UN agencies and International Non-Government Organizations (INGOs) have only managed to negotiate access to a minimal amount of land for agricultural cultivation in the vicinity of the refugee camps, as the investment required to clear available land is extremely high.

In Bahn camp, local authorities in partnership with community structures had allocated 10 hectares of land for refugees to live on and conduct small scale farming. In PTP, 28 hectares of land was cleared by UN agencies for refugees to farm. However, overall the ratio of refugee HHs to available land for farming remained extremely low. As a result, most refugee HHs do not have access to land, with levels of self-reliance achieved remaining minimal.

In 2014 focus group discussions reported different concerns, mainly to do with the quality of available land. Many reported that people had moved into the forests where soils are richer to cultivate and that they feared that they could contract EVD as a consequence. Bahn camp reported that about 25% of camp residents had access to some land and that they managed to harvest

37.5mt of rice from a 15Ha plot. Little Wlebo reported having access to 250 acres of very poor land; refugees complained that they needed to use a lot of fertilizer to make the land work. PTP said that they have 32Ha for the cultivation of rice, cassava and maize.

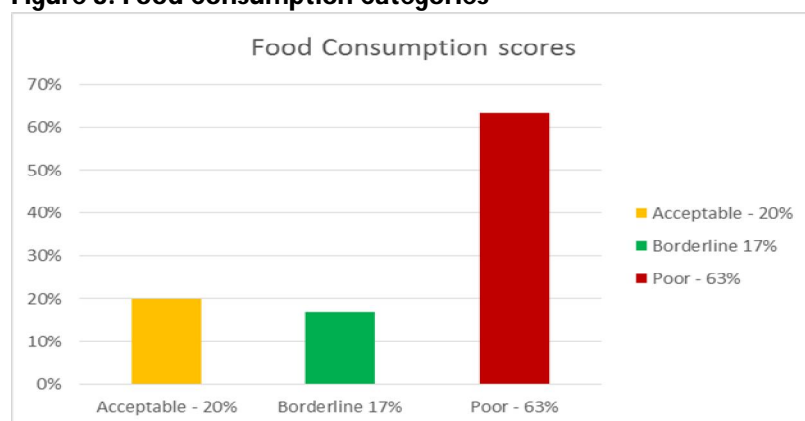
Food access

i. Food Consumption

As with the 2012 JAM the data collected from HH interviews is not statistically representative, but it may be indicative of the conditions being faced by many refugees.

The 2014 analysis shows a shocking reversal in trends from the 2012 findings. In 2012 around 3%² of refugees in camps have poor food consumption, whilst in 2014 this has shot up to 63%¹. In 2012 35% had borderline food consumption, which is at 17%¹ in 2014. This means that 80%¹ of refugees in camps do not have an adequate balanced diet, and thus remain extremely vulnerable to economic and environmental shocks. The reason for the high proportion of refugees having inadequate food consumption would be unavailability of food from all sources as reported in FGDs. Just 20%¹ of refugees in camps reported having acceptable consumption, mainly a result of food assistance and dietary diversification funded by a complementary income sources to augment food needs. See Figure 3: Food Consumption Categories

Figure 3: Food Consumption Categories



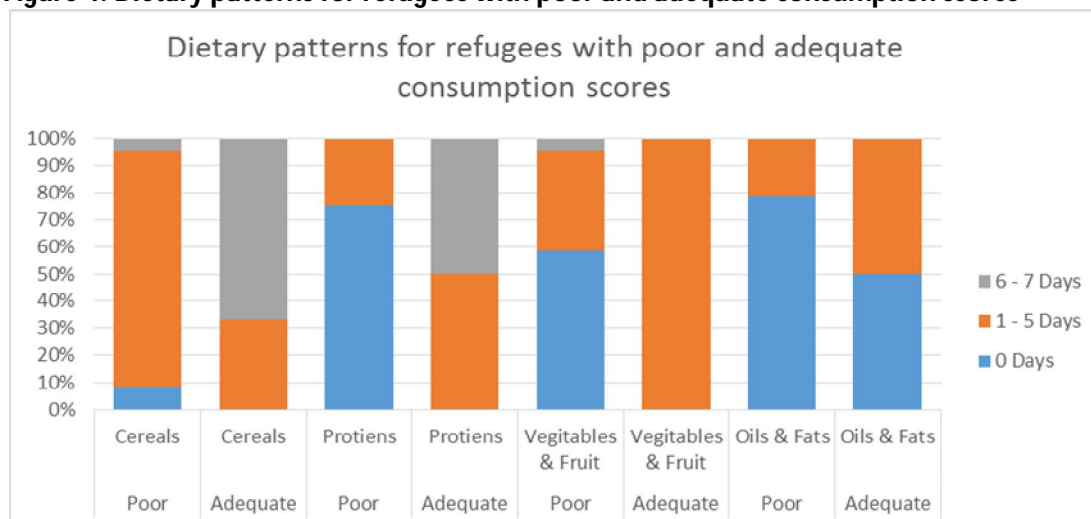
Refugees' food consumption mainly consists of rice or cassava, green leaves and fish. Whilst fish is widely consumed, in many cases the quantities eaten are so small, they merely provide flavor to the soup and offer little nutritional value. With many refugees unable to complement their food ration, some exchange a portion of the rice or pulses that they receive for other food commodities and NFIs, reducing the amount of food that they consume.

ii. Dietary Diversity

The ban of selling and consuming bush meat (previously a major source of proteins and income for refugees, because of EVD and the risk of transmission), has had a serious effect on food consumption scores.

A refugee family with poor food consumption mainly eats rice or cassava on a daily basis, green leaves and pulses two to three days a week, with an absence of or minimum amount of animal protein. See Figure 4: Dietary patterns for refugees with poor and adequate consumption scores.

Figure 4: Dietary patterns for refugees with poor and adequate consumption scores

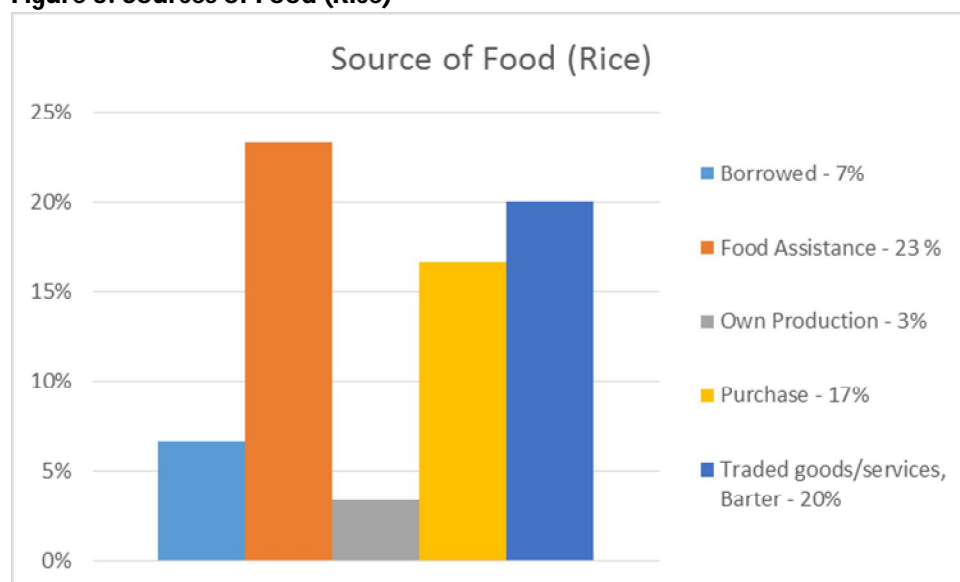


iii. Sources of Food

According to the HHs interviewed in the camps, the main sources of food have changed dramatically shifting from food assistance (60%² in 2012 to 23%¹ in 2014) to trading goods or barter 20%¹ as opposed to just 1%¹ in 2012; 17%¹ of food is from direct purchasing (down from 30%² in 2012); with the remaining secured from own production, 3%; and borrowing/gifts 7%.

These changes of reliance on food assistance and on trade/barter can be seen as a consequence of the reduction of WFP food rations in 2014. The trend of shift from direct purchase can be interpreted as an effect of reduced income because of EVD. See Figure 5: Sources of Food (Rice)

Figure 5: Sources of Food (Rice)



iv. Sources of income

The 2012 JAM analysis of HHs interviews revealed that in refugee camps, as many as 1 out of every 5 refugees (18%) relies on wage labor as their main source of income. 15% of HHs have no income source, and live exclusively on food assistance. 12% of HHs interviewed declared that they mainly

rely on gifts from neighbors and relatives, and 9% on remittances (from CDI). This means that over 30% of HHs is extremely dependent on others and in need of support.

In 2014 the figures were very different: 29%¹ (up from 18%) of respondents to the HH survey reported that wage labor as their main source of income. 22%¹ (up from 15%) reported to have no source of income at all and rely solely on food assistance or begging. 25%¹ relied on petty trade or small businesses and 15%¹ reported 'other' as one of their main sources of income. The data also shows an increase of 7% (from 15% to 22%) of HHs who rely on food assistance or begging as part of their income strategy. These could well be the result of firstly the reduction in ration sizes and lack of access to food from other sources due the effects of EVD. See Figure 6 (A): All Reported Sources of Income and Figure 6 (B): Primary Sources of Income and Figure 6 (C): Grouped Sources of Income

Figure 6 (A): All Reported Sources of Income

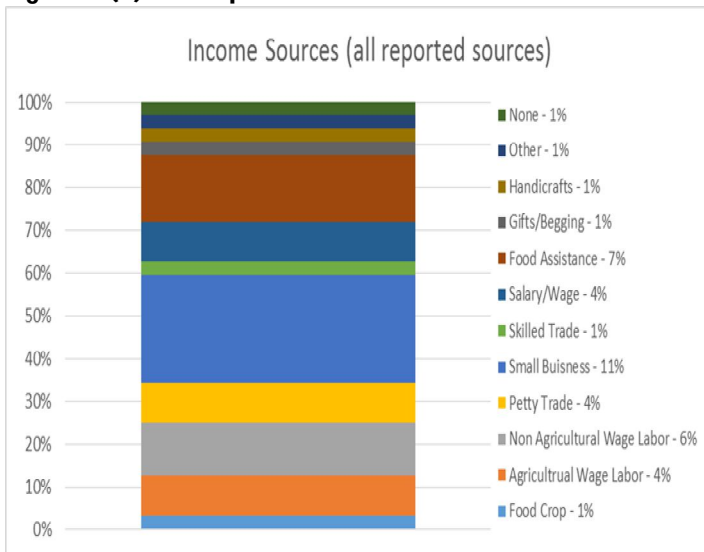


Figure 6 (B): Primary Sources of Income

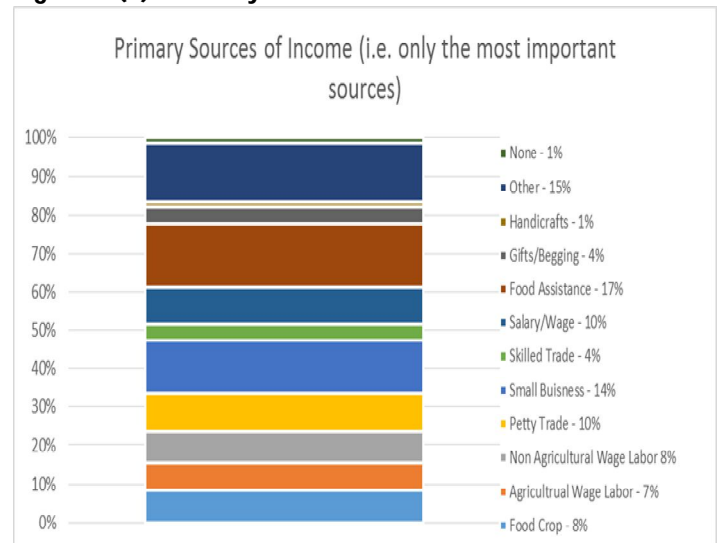
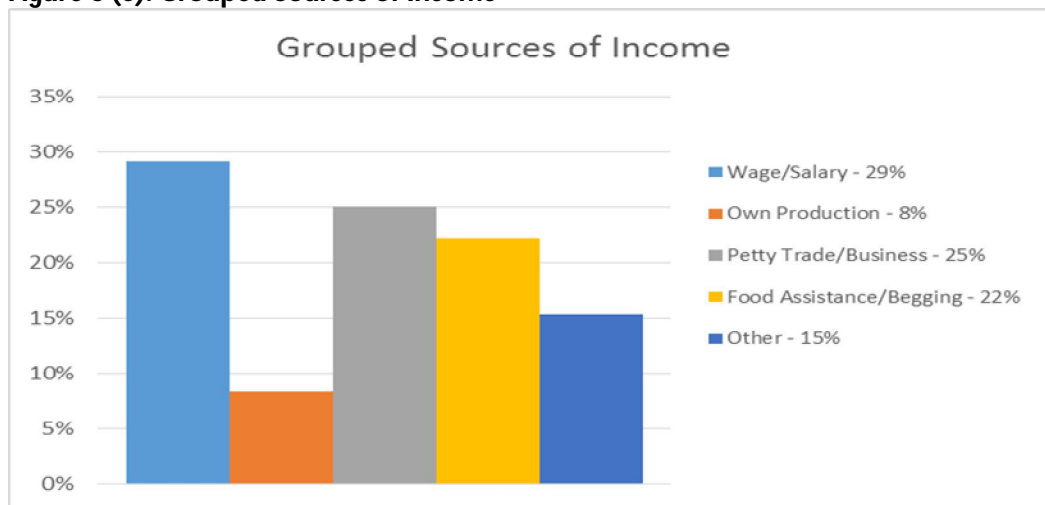


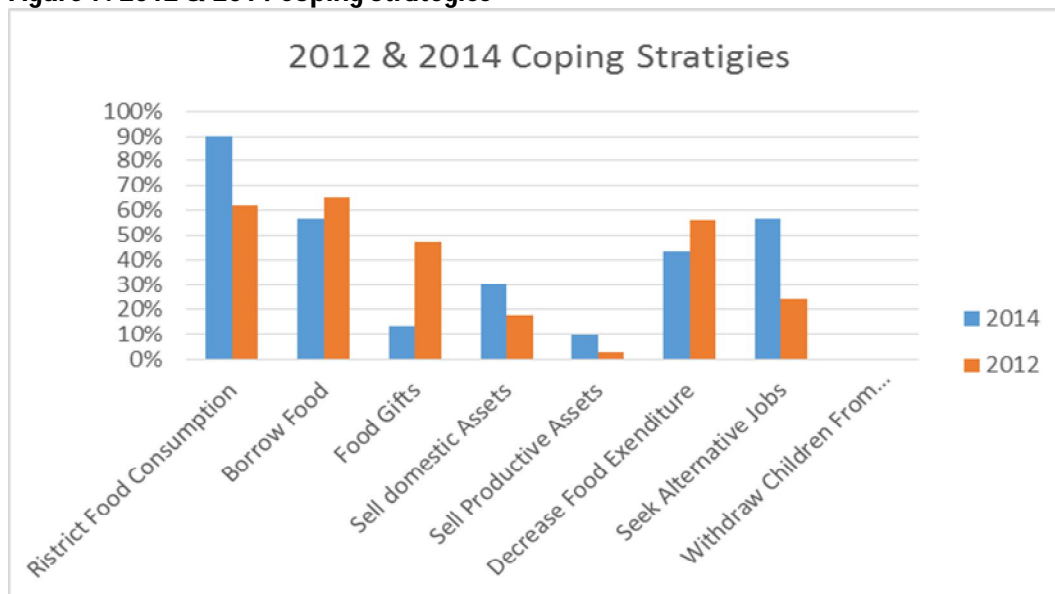
Figure 6 (C): Grouped Sources of Income



v. Coping strategies

It's important to remember that the effects of the EVD crisis were combined with serious ration reductions – to just 1,310 Kcal in July 2014. This double crisis partially explains some of the changes in the trends.

Figure 7: 2012 & 2014 Coping Strategies



Restricting food consumption rose from 62%² in 2012 to 90%¹ in 2014. This can be explained by the fact that there was considerable less food available to the refugee community, WFP rations were reduced and the EVD crisis closed markets and restricted movements³ – hence people simply did not have access to the same levels of food that were around in 2012.

³ Focus Group Discussions in all three camps, October, 2014

Borrowing food – again the reduced availability of food to the whole community means that there are fewer opportunities to borrow food than in 2012, (65%² in 2012 to 47%¹ in 2014).

Food gifts – it is reasonable that as there is less food in circulation then there will be fewer gifts. Also the closure of the border with CIV will have had a major impact on food gifts (which can be seen as a form of remittance.)

Selling domestic and productive assets – likewise these are going to increase because of the reduced income (caused by EVD) and food caused by ration cuts. It has also been reported in FGDs that refugees are selling Long Lasting Insecticide Treated Nets (LLIN), cooking pots, shovel and cleaning materials³.

Decreasing food expenditure- The natural expectation would be for this to rise (more people are finding it harder to feed their households – so more will reduce the amount of money they spend on food.) However, the findings actually show a trend of decrease (56%² in 2012 down to 43%¹ in 2014). This again can be explained by the lack of capital and food in the refugee camp communities. As reported in FGDs, more people are already close to a breaking point and simply cannot afford to spend even less on food, so fewer find decreasing food expenditure a viable option³.

Seeking alternative jobs- As conditions are much harsher than they were in 2012, more people will be actively looking for higher paying income generating activities. This is further highlighted in shows that as the food ration declined more people resorted to either paid work or trading/business than before. Therefore, more people are looking for other opportunities to be paid more. However, seeking jobs outside camps often poses refugees to security risks.⁴

Health and Nutrition

Nutrition and food security

The 2013 Standardized Expanded Nutrition Survey (SENS) in the four refugee camps (Bahn, PTP, Solo and Little Wlebo) indicated that malnutrition rates are of public health significance (especially stunting and anaemia). The rate of Global Acute Malnutrition (GAM) in children aged 6-23 months was found 5.4% which is slightly above the WHO maximum acceptable level (5%). There was no severe wasting or oedema observed during the survey. However, stunting among 6-59 months remained very high (WHO cutoff, $\geq 40\%$) at 43.1% which indicated chronic food insecurity and or chronic malnutrition. The prevalence of anaemia among children aged 6-59 months remained critical in all camps at 78%. The prevalence was higher in children aged 6-23 months with overall 82%. The total anaemia among non-pregnant women in reproductive age is 50%.⁵ Nutritional screening is conducted for children less than five years of age, pregnant and lactating mothers in outpatient consultations, home visits by community health workers (CHWs) and during relocation and repatriation movements. MUAC (mid upper arm circumference) measurement is used to screen at the community level and children with low weight for height are admitted into feeding programs. However, the regular nutrition program has also been interrupted in EVD. The screening activities have been limited due to 'no touch' policy. The number of beneficiaries enrolled in supplementary

⁴ Key Informant Interviews in all camps, October, 2014.

⁵ According to WHO cut-off points, $>40\%$ of population with anaemia describes as 'severe public health problem' and $>60\%$ describes as 'public health emergency'.

feeding program has also been reduced. It was reported in KIs that some refugees have left camps and moved to closer to border areas for the fear of Ebola⁴. Treatments of both moderate and severe cases of malnutrition are conducted in camp clinics. Severe cases of malnutrition with medical complications are referred to the nearest government health facilities in the three counties.

Anaemia screening is done by checking conjunctiva and palmer pallor in the community and at the outpatient unit of the clinic using Haemcucue machine secondary to the clinical signs. Severe anaemic cases are referred to government health facilities for blood transfused which has been a major challenge in the EVD outbreak⁴. Although the WFP/UNHCR feeding program guidelines recommend such cases to be enrolled in the feeding program to boost levels of haemoglobin, the recommendations were not followed because of limitation of resources.

The Supplementary Feeding Program and outpatient therapeutic programs are operational. Blanket supplementary feeding is ongoing to address the issue of anemia among children aged 6-23 months. However, refugees residing in the camps have been reluctant to come to the center to collect supplementary foods from nutrition centers⁴. Distribution of Corn Soya Blend (CSB) to pregnant/lactating mothers has stopped because of budgetary constraints. Provision of special diets for diabetic patients and patients with special needs have also ceased from the beginning of this year. Clinic staff reported that patients on antiretroviral (ARV) therapy want to stop taking medicine because they do not get the nutritional support to recover from side effects.

Since January 2014, the general ration in the refugee food basket has been decreasing due to instability in the WFP food pipeline. The food basket contains only four commodities; cereals, pulses, vegetable oil and salt. Cereals were maintained in the food basket but at decreasing rates. The analysis in the table below indicates a down trend from 88% of the targeted ration in January to 62% in July. The ration was maintained at 77% with only cereals and salt in the refugee food basket in all months. All four commodities were present in the food basket only from August to November. On average, refugees were receiving 77% of the intended Kcal and severely reduced micronutrients at 37% iron, 12% Vit A and 11% riboflavin of the minimum targeted ration. However, with the negotiation between UNHCR, WFP and donors, refugees received ration of 94% in November but there is an uncertainty for the provision for the next period.

Table 2: Refugee Rations during 2014

Month	Cereals (Kg/p/m)	Pulses (Kg/p/m)	V.Oil (Kg/p/m)	Salt (Kg/p/m)	Total (Kg/p/m)	Average (Kcal/p/day)	% Ration (Kcal/p/day)
January	13.5	1.95	-	0.15	15.6	1,837.75	88%
February	13.5	1.5	-	0.15	15.15	1,787.50	85%
March	13.5	-	-	0.15	13.65	1,620.00	77%
April	13.5	-	-	0.15	13.65	1,620.00	77%
May	13.5	-	-	0.15	13.65	1,620.00	77%
June	13.5	-	-	0.15	13.65	1,620.00	77%
July	9	-	0.78	0.15	9.93	1,310.10	62%
August	9	1.46	0.78	0.12	11.36	1,488.00	71%
September	9	1.46	0.78	0.11	11.35	1,488.00	71%
October	9	1.46	0.78	0.11	11.35	1,488.00	71%
November	12	1.95	1.05	0.15	15.15	1,975.00	94%
Average	11.73	1.63	0.83	0.14	13.14	1,623.12	77%

The joint mission team was informed about the delays in food delivery, missing commodities and lack of communication problems related to food ration supply for the refugees in Bahn camp. The food ration for two months (September and October) was distributed together to limit convergence at distribution points during EVD. The reduced quantities of commodities were inadequate for the two-month period. Therefore, the distributed food ration has been consumed in a month⁴.

Health service

Refugees have access to basic and comprehensive health services in the camps and to the secondary and tertiary health care centers through referral. However, referral remains a major challenge due to the weak public health infrastructure in the country. Services provided as comprehensive primary health care in the camps include nutrition, HIV/AIDS and reproductive health. African Humanitarian Action (AHA) implements health program in Bahn and International Rescue Committee (IRC) implements the health program in PTP and Little Wlebo camp.

According to the Health Information System report, the total number of consultation in camp clinics from January to November is 44,971 with Liberian Nationals constituting 13%. The health facility utilization rate is 1.7 (new visits/refugee/year) and consultation per clinician per day is 28. The major diseases prevalent are malaria, respiratory tract infection, skin disease and anaemia. There was a diarrheal disease outbreak during this year.

The number of consultations in camp clinics has reduced significantly with the outbreak of EVD from 500/week to 240/week in Bahn clinic. The consultation rate has decreased because of the fear of transmission of EVD from contacts with clinic staff or other patients. The number of referral cases had also decreased and now are limited only to emergency cases. The situation is similar in other two camps. It has been reported that patients are seeking care to the traditional healers instead of visiting health facilities⁴. Referrals for patients with chronic conditions have been postponed because of a severe shortage of clinical staff and medical supplies in government health facilities and also to limit hospital consultations to mitigate the risk of transmission of Ebola. According to the medical coordinator in Bahn camp, the average number of referral cases reduced from 12/week to 2-3/week with the outbreak of EVD. However, all camp clinics are still operational with full staff whereas most of the health facilities in the country become nonfunctional with the onset of the outbreak.

The primary referral hospital, Saclepea Comprehensive Center, is closed because of a driver being infected and dying of EVD. A registered refugee who was working in this hospital as a cleaner tested positive for Ebola and died in the treatment center at Gbanga.

The constructions of Community Care Centers are ongoing to provide care and isolation from the camp and surrounding communities for suspected cases of EVD. There is a well-organized contact tracing system, task force mechanism and referral system in place for the Ebola preparedness and response mechanism.

Severe cases of anaemia require blood transfusions which has been a major challenge because of the unavailability of donor and blood banks in primary referral centers. A blood donor needs to be arranged and paid US\$29 when there is a need for transfusion. The condition has become worse in Ebola situation because people are afraid of blood donation and transfusion. The primary referral center for Little Wlebo camp clinic, J. J. Dawson Hospital, has severe shortages of the medical supplies and clinic staff required to operate properly. The secondary referral hospital for the south

east region in Tapita is closed due to lack of human resources who left because of the outbreak of Ebola.

Within camps – medical supplies are adequate both for treatment and infection prevention. Staffs have demanded increased salaries and hazard pay.

UNHCR Ebola Preparedness and Response activities

The UNHCR operation in Liberia and its partners are working with relevant Government and other organizations in all camps and refugee host communities with the goal of preventing the spread/transmission of the Ebola Virus among people of concern and staff to reduce the morbidity and related mortalities in line with the Government of Liberia's National Response Plans.

The preparedness and response activities are focused on four (4) main objectives:

- i. Coordination and Advocacy-Coordination with the government and other UN agencies continues with UNHCR Representation in Liberia and its partners are fully represented at various planning and coordination meetings ;
- ii. Social Mobilization-Massive awareness campaigns continue in all camps and refugee host communities. Additional Community Health Workers both in camps and refugee host communities were recruited to intensified social mobilization on Ebola. IEC materials were adopted and translated into French for awareness using a peer support group and door to door approach;
- iii. Disease Control-Temporary Isolation Centers which are now referred to as Community Care Centers (CCCs) are been constructed on the outskirts of all three camps with additional health care workers to respond to Ebola cases, if any. Clinicians have been and continue to be trained on Ebola preparedness, case identification and management. PPEs, drugs and assorted medical supplies have been procured and are available at various camp clinics and CCCs; and
- iv. Surveillance – A call system has been set up and is available in all camps and urban areas to call in emergency cases, and linked to government facilities. Surveillance teams for various camps have been established for case detection and monitoring.

All three camps have so far remained Ebola free due to the Ebola Preparedness and Response activities. Two cases of EVD from host communities were referred from the Bahn camp clinic. The cases were confirmed and died while receiving treatment in ETU (Ebola Treatment Unit). The first case was identified in the camp through the surveillance system. The second case came to the camp clinic to seek health services.

One case was suspected in PTP refugee camp (who also had other medical conditions), the case came from a nearby town and died two days after admission, the patients specimens were collected but not tested because of impassable roads to the laboratory. The family members were quarantined for 21 days in the camp quarantine center and all were released, showing no signs and symptoms.

WASH

WASH services are implemented by CARE International in PTP and Bahn and by the Danish Refugee Council (DRC) in Little Wlebo camp.

All refugees in the camps have access to potable water as per the minimum SPHERE standards. The average water consumption was 19.9 liters / person / day, ranging from 19.3 liters/per/person /day

in PTP camp to 19.0 liters/per/person /day in Little Wlebo camp and 21.6 liters per /person /day in Bahn camp. At least 63% of families consumed 20 liters per person per day. The proportion of households using improved drinking water sources is 98.7%.

Bahn and PTP camps run parallel water systems (motorized and hand pump) but Little Wlebo has a single water system (hand pump). The motorized system consists of a borehole well with a submersible pump installed and connected to a reservoir and then distributed to tap stands by gravity. The motorized systems run for 7 hours in Bahn and 15 hours per day in PTP. Water consumption has recently been increased at 26.6 liter/person/day due to hand hygiene as a preventive measure for EVD. This increased consumption of water requires provision of extra fuel for pumping additional water. It has been reported that the demand for soap has also increased at around 10% and soap utilization by WASH committee has increased at 13%. Water watch teams are functional in all three camps to guard water points. To promote water quality, monitoring of chlorine residual is being done on a daily basis and biological test on a monthly basis. The County Health Team conducted independent physical, chemical and biological test for all new wells constructed as part of quality control.

The ratio of people per latrine varies from camp to camp. The average latrine to person ratio is 20.1:1 (PTP-23:1, Bahn-21:1, LWC-16:1) persons/drop holes; Although a few latrine have been decommissioned with the UNHCR emergency fund for Ebola, there is still need for 94 filled latrines in Bahn camp and 82 in PTP to be decommissioned. Waste management- constructed 29 garbage pits in PTP and 21 garbage pits in Bahn. The garbage pit to population ratio is 185p/p (PTP-256, Bahn-93, LWC-208) while the ratio of showers is 38 people per bath cubicle (PTP-28, Bahn-66, LWC-22). A total of 1,119 Bath houses (PTP-546, Bahn-108, LWC-465), and 523 laundry slots (PTP-72, Bahn-250, LWC-101) are available in the camps. All these facilities need to be extended to accommodate the pressure of the population since voluntary repatriation is unlikely to resume until the EVD emergency situation is declared over. The Participatory Hygiene and Sanitation Transformation (PHAST) and the Child Hygiene and Sanitation Transformation (CHAST) strategies are being implemented in the camps. The hygiene promoters are also involved in community sensitization for EVD outbreak.

Education

Free primary school education remains available to all refugee children in refugee camps and is provided by UNHCR and its partners; Save the Children, DRC and Finish Church Aid. The children also have access to secondary school. The DAFI scholarship program was launched in late 2013, allowing young deserving Ivorian refugees to obtain tertiary education. However, while access to education has been improved, due to the ongoing EVD epidemic, the education system including refugee schools remain closed in line with the Liberian Government Policy, resulting refugee children unable to enjoy rights to education. Moreover, the stoppage of school feeding program, at the request of WFP donors, might precipitate the deterioration of malnutrition situation in the camps.

The parents are even showing reservations in sharing names of their children for pre-school registration. The situation may increase exploitation and abuse of refugee children if any activities alternative to the schooling is not introduced. Unlikely for some children from community whose parents arrange private tuition for their children, children in refugee camps are solely dependent on school teachers provided by partners.

Livelihood opportunities and vocational training

To improve the self-reliance and sustainable livelihood for refugees, in 2014 UNHCR involved ADRA in Bahn and PTP camps and DRC in Little Wlebo camps to implement livelihood project activities. The targeted households in the camps have access to technical, vocational and entrepreneurial skills training; such as vegetable, rice, cassava and corn production, soap production, poultry rising, carpentry, tailoring, tie-dying, computer and IT skills, masonry, small business development and micro-loan management. However, the opportunities for using these skills have reduced with the outbreak of EVD. Vegetable seeds supply from CDI has become a challenge due to the closure of the border. Refugees in Little Wlebo organized 'susu' groups which have become nonfunctional in this situation as participants are unable to keep up with payments.

Facility Visits

Due to time limitations the mission facility visits had to be kept to a minimum. However, the mission did briefly visit each of the camp's CCC facilities; they were in various stages of construction with the most advanced being in Little Wlebo which was almost completed. One factor was the condition of the roads to the nearest ETU which at the time of the JAM were extremely difficult and would cause delays if there needed to be a transfer.

The camp clinic was visited in Little Wlebo and was found to be in good order with sufficient staff, medications, and maternity facilities. The triage area in the clinic needs to be improved.

WASH facilities were visited in PTP including water reservoirs, water points, hand washing points and latrines. The concern of necessity for decommissioning of latrines was raised which needs to be addressed soon.

5. Conclusions and recommendations

Conclusions

Although this report is much less extensive than the 2012 JAM and very small sample size has been selected for the household survey, the conclusions can be made by triangulating the data from FGD and KII.

The first is that the cut in rations in July 2014 added considerable extra strain on food security situation. This was then compounded by the EVD outbreak which further restricted sources of income. FGDs all reported that food was extremely scarce (because of the ration cuts) and that because of EVD income generating activities were very limited due to travel restrictions, closed markets and reduced contact with host communities.

The lack of food availability is particularly highlighted in the FGDs that reported about reduction in food ration and limited opportunity in exchange of a portion of the ration to obtain diversity in diet. In addition to that, majority of interviewed households reported of having poor or borderline food consumption, a particularly worrying trend that is bound to have nutritional health consequences. The trend also showed that roughly one fourth of interviewed households with poor and borderline food consumption had not eaten any sources of protein in the past 7 days and majority of them had not eaten any oils or fats in the past week.

The results from HH survey and FCGs also showed that the proportion of refugees who depended on food ration as a source of food has been reduced due to reduction in the quantities of food ration. That puts refugees in a situation to look for opportunities for trading goods or barter. The lack of income generating activities resulted decrease in purchasing power. Therefore, refugees have restricted their food consumption, have been selling their domestic and productive assets and trying to look for job opportunities, although the opportunity of getting job is very limited in EVD situation. A very small proportion of refugees are involved in livelihood activities and production of their own food. The concern of high interest rate of borrowed food was also raised by the refugees.

The JAM has also identified the impact of EVD situations on health, nutrition and WASH services for the refugees. Although the health facilities in the camps are fully functional even in EVD outbreak, the consultation rates have been reduced as refugees are reluctant to go to these facilities and are seeking care from traditional healers instead. The enrolment rate of beneficiaries in nutrition program has also been decreased. Refugees have access to referral services but the services are hampered with shut down of most of the referral facilities due to EVD. The Ebola preparedness and response activities are ongoing in all camps with the full participation of all actors.

Recommendations

1. Refugee feeding be immediately resumed at full rations and re-evaluate the situation in 6-12 months;
2. Supplementary feeding for pregnant and lactating women, children under 5 years of age and people with special need should resume as soon as possible;
3. Ebola preparedness and response activities should be continued;
4. Strengthen community sensitization on backyard gardening and sensible eating; and livelihood activities
5. Follow up the recommendations from Nutrition Survey report, February 2014.

Household Questionire for Rapid JAM, 2014

Sources of Income											
	HH 1	HH 2	HH 3	HH 4	HH 5	HH 6	HH 7	HH 8	HH 9	HH 10	
Food Crop											
Cash Crop											
Agricultural Wage Labor											
Non Agricultural Wage Labor											
Petty Trade											
Small Buisness											
Skilled Trade											
Salary/Wage											
Remittances											
Food Assistance											
Gives/Begging											
Handicragts											
Hunting/Fishing											
Other											
None											

Instructions: Please ask "what are the most important sources of money for your family - give me the most important first and the next most important second, then the third, etc" Then write '1' in the row that corrisponds the most important, '2' for the second, '3' for the third, etc.

Household Questionire for Rapid JAM,2014

Expenditure											
	HH 1	HH 2	HH 3	HH 4	HH 5	HH 6	HH 7	HH 8	HH 9	HH 10	
Food											
Soap											
Transport											
Fuel											
Electricity											
Communications											
Alcohol/Tobaco											
Medical											
Clothing											
Education											
Debt Repayments											
Celebrations											
Agricultural Inputs											
Savings											
Construction											

Instructions: Please ask "what are the most important expenditure for your family - give me the most important first and the next most important second, then the third, etc" Then write '1' in the row that corrisponds the most important, '2' for the second, '3' for the third, etc.

Household Questionire for Rapid JAM, 2014

Coping Strategies

	HH 1	HH 2	HH 3	HH 4	HH 5	HH 6	HH 7	HH 8	HH 9	HH 10
Ristrict Food Consumption										
Borrow Food										
Food Gifts										
Sell domestic Assets										
Sell Productive Assets										
Decrease Food Exenditure										
Seek Alternative Jobs										
Withdraw Children From School										

Instructions: Please ask "what is the first thing your family will do when your income is very low. Please give me the first thing you will do, e.g. reduce meals, to the most extrem." Then write '1' in the row that corrisponds, '2' for the second, '3' for the third, etc.

Household Questionire for a Rapid JAM, 2014

Food Consumption/Dietary Diversity + Sources of Food

I would like to ask you about all the different foods that your household members have eaten in the last 7 days. Could you please tell me how many days in the past week your household has eaten the following foods?

(for each food, ask what the primary source of each food item eaten that week was, as well as the second main source of food, if any)

Food Item	HH 1		HH 2		HH 3		HH 4		HH 5	
	DAYS eaten in past week (0-7 Days)	Sources of food (see Food item codes below)	DAYS eaten in past week (0-7 Days)	Sources of food (see Food item codes below)	DAYS eaten in past week (0-7 Days)	Sources of food (see Food item codes below)	DAYS eaten in past week (0-7 Days)	Sources of food (see Food item codes below)	DAYS eaten in past week (0-7 Days)	Sources of food (see Food item codes below)
#.1 - Maize										
#.2 - Rice										
#.3 - Bread/wheat										
#.4 - Tubers										
#.5 - Groundnuts & Pulses										
#.6 - Fish (eaten as a main food)										
#.7 - Fish powder (used for flavor only)										
#.8 - Red meat (sheep/goat/beef)										
#.9 - White meat (poultry)										
#.10 - Vegetable oil, fats										
#.11 - Eggs										
#.12 - Milk and dairy products (main food)										
#.13 - Milk in tea in small amounts										
#.14 - Vegetables (including leaves)										
#.15 - Fruits										
#.16 - Sweets, sugar										

Food Item	HH 6		HH 7		HH 8		HH 9		HH 10	
	DAYS eaten in past week (0-7 Days)	Sources of food (see Food item codes below)	DAYS eaten in past week (0-7 Days)	Sources of food (see Food item codes below)	DAYS eaten in past week (0-7 Days)	Sources of food (see Food item codes below)	DAYS eaten in past week (0-7 Days)	Sources of food (see Food item codes below)	DAYS eaten in past week (0-7 Days)	Sources of food (see Food item codes below)
#.1 - Maize										
#.2 - Rice										
#.3 - Bread/wheat										
#.4 - Tubers										
#.5 - Groundnuts & Pulses										
#.6 - Fish (eaten as a main food)										
#.7 - Fish powder (used for flavor only)										
#.8 - Red meat (sheep/goat/beef)										
#.9 - White meat (poultry)										
#.10 - Vegetable oil, fats										
#.11 - Eggs										
#.12 - Milk and dairy products (main food)										
#.13 - Milk in tea in small amounts										
#.14 - Vegetables (including leaves)										
#.15 - Fruits										
#.16 - Sweets, sugar										

Food source codes:
Purchase = 1 Own production = 2 Traded goods/services, barter = 3 Borrowed = 4 Received as gift = 5 Food aid = 6 Other (specify) = 7