GUIDELINES FOR RAPID ASSESSMENT

Refugee and Displaced Populations

Introduction

Refugees, who have left their country of origin and crossed into a neighbouring country (termed the "host" country), may either move as a large group over a short period of time or else move in small groups at a time over a period of months or years. Large numbers (sometimes hundreds of thousands) arriving abruptly in the host country create a health emergency. An assessment is usually done in response to an urgent call for help from local administrative or military officials in a border region.

Refugees may be found in the following situations:

- scattered in small groups beside a long stretch of border, in many instances living with local villagers who may be of the same ethnic group as the refugees or even relatives;
- massed in a relatively well-defined area near the border;
- located in transit camps organized by local officials not far from the border; or
- in some cases, refugees may have fled by boat and arrived in small groups scattered along the coast of the host country.

Internally displaced populations may have moved en masse to a defined area in a neighbouring region after a natural disaster or, more commonly, be scattered widely among the local population, having fled in small groups over a period of time, especially if fleeing armed conflict. Large concentrations may be found in poor, peripheral, and under-serviced sections of large cities.

In both internally and externally displaced populations, families are usually intact with the possible exception of the young men, who may be actively involved in the armed conflict which the refugees are fleeing. In many cases, whole villages move as one unit.

The time needed to perform an initial assessment of a refugee influx will depend on the remoteness of the location of the refugees, the availability of transport, the security situation in the area, the availability of appropriate specialists, and the willingness of the host country government to involve external agencies in refugee relief programs. In small countries with good communications facilities and secure borders, the assessment might be performed in 4 days, in other countries it might take up to two weeks.

STAGE I: PREPARATIONS

Before the field visit, certain information may be obtained from local ministries or organizations based in the capital city. International organizations such as UNICEF, WHO, and the Red Cross/Red Crescent may have demographic and health data concerning the refugee population. In addition, relief agencies, such as UNHCR, UNICEF, the World Food Program, and the Red Cross/Red Crescent may have already ordered or even procured food, medical, and other relief supplies which are intended for the refugees or displaced persons.

STAGE II: FIELD ASSESSMENT

1. Health status of population

1.1 Demographic characteristics

Information required:

Total refugee or displaced population

Age-sex breakdown.

Identification of at-risk groups, e.g children <5 years of age, pregnant and lactating women, disabled and wounded, and unaccompanied minors.

Average family size.

Why the information is needed:

This data is essential for planning relief programs. The total population is the denominator for all mortality, injury, morbidity, and malnutrition rates which might be estimated later. It also enables the calculation of quantities of relief supplies. Breakdown of the population by age and sex enables the targeting of special interventions (e.g., immunization).

Source:

1.1.1. Seek out camp authorities if camp administration structure established, examine registration records.

1.1.2. Look at records of local government officials, if registration has taken place.

1.1.3. Find refugee leaders who may have records, especially if whole villages have fled. In addition, in some situations political groups, liberation movements, etc. may have organized an exodus and may have detailed lists of refugee families.

1.1.4. A walk through the settlement or camp may give some visual impression of the demographic composition of the population, e.g., whether there are many adult men, etc.

1.1.5. A small survey may be performed whereby a sample of refugee dwellings is visited, e.g., 50 houses. Rather than visit adjacent houses, it would be preferable to start at a randomly chosen point in the camp or settlement, and then visit every 5th or 10th house until 50 houses have been visited, recording the number of family members, age and sex of each member, and the number of pregnant and lactating women (see **Appendix I-A** for guide to sampling). This will give a rough estimate of the demographic composition of the population. If the average number of persons in each house is estimated from this survey, then the total number of dwellings could be counted and thus a rough estimate made of the total population. At least, this quick survey should give a rough estimate of the proportion of the total population made up of "vulnerable" groups, i.e., children under 5 years of age and women of child-bearing age.

1.1.6. To determine the total population, a census may need to be performed later. In the meantime, a registration system for new arrivals should be established immediately. This should record names of household heads, number of family members by age and sex, former village and region of residence, and ethnic group if applicable.

1.2 Background health information

Information required:

Main health problems in country of origin.

Previous sources of health care, e.g., presence of traditional healers.

Important health beliefs and traditions, e.g., important food taboos during pregnancy.

Social organization, e.g., whether the refugees are grouped in their traditional villages and whether a political organization exists among the refugees.

Strength of public health programs in country of origin, e.g., immunization coverage.

Why the information is needed

This kind of information is essential for the most effective planning of health services for displaced populations. Planners need to be aware of traditional beliefs, taboos, and practices in order to avoid mistakes such as not providing sufficient privacy for female outpatients, providing unacceptable foods in supplementary feeding programs, omitting traditional midwives from health worker training programs.

Source: Interview refugee leaders, household heads, women leaders (e.g., traditional midwives), health workers among the refugees.

Obtain documents/reports from host government, international organizations (WHO, UNICEF, Red Cross) and NGO/PVOs on endemic diseases and public health programs in region of origin of the displaced population.

Seek information from other development agencies, private companies (such as oil exploration companies), missionaries, etc. having experience with displaced population.

1.3 Nutritional status

There is ample evidence that nutritional status of displaced populations is closely linked with their chances of survival. Initial assessment of nutritional status serves to establish the degree of urgency of delivering food rations, the need for immediate supplementary feeding programs, the presence of micronutrient deficiencies which require urgent attention, etc.

Information required:

- Prevalence of protein-energy undernutrition in under-5 population.
- Nutritional status prior to arrival in host country.
- Prevalence of micronutrient deficiencies in under-5 population.

Source:

(1) If refugees are still arriving at the site, then initiate nutritional screening of new arrivals immediately. Measure all children (or every 3rd or 4th child, if insufficient trained personnel or refugees arriving too rapidly) for mid-upper arm circumference or, if time and personnel permit, weight-for-height. Estimate the proportion undernourished using methods described in Nutritional Emergency protocol. Also, look for clinical signs of severe anemia, and vitamin A and vitamin C deficiencies. If refugees are continuing to arrive, set up a permanent screening program of new arrivals.

(2) If refugees are already located in a settlement:

Walk through the settlement visiting houses randomly and observing the nutritional status of the children <5 years of age. The visual assessment of malnutrition, however, is problematic unless the observers have had a lot of experience with this problem. It is preferable to use some kind of objective measurement as described below. Make sure you enter the houses you visit, as the most malnourished children are probably bed-ridden.

Review the records of local hospitals are treating the displaced population, looking at admissions or consultations for undernutrition and deaths recorded as due to undernutrition.

Interview refugee leaders to establish food availability prior to displacement, how long the journey from the village of origin to the present location has taken.

(3) "Quick and dirty" survey: Make a nutritional assessment by measuring either the arm circumference or weight-for-height of children during the visits to the 50 houses described in section 1.1 above.

In order to gather baseline data for evaluation of feeding programs, plan a random, cluster sample survey of the population to be performed as soon as possible (within two weeks). Appropriate technical expertise will be needed for the implementation and analysis of results of such a survey.

1.4 Mortality rates

Information required:

Crude, age-specific, and cause-specific mortality rates

Sources: Check local hospital records

Check graveyards for new graves, interview community leaders, and check the records of local burial contractors.

If mortality rates are to be calculated, then population numbers need to be determined (as described in 1.1). In the initial phase, mortality rates are usually expressed as deaths/10,000/day, so that changes may be monitored on a daily basis.

If not in place, a mortality surveillance system needs to be established immediately. This could be achieved by designating a single burial site for the camp, employing 24 hour guards, and training them to record each death and interview families to determine approximate age and probable cause of death using a standard questionnaire.

Other methods include mandatory registration of deaths, the issuing of shrouds to families of the deceased to help ensure compliance, the monitoring of records of private burial contractors, or the employment of volunteer community informants who report deaths in a certain defined unit of the population (e.g., 50 families). The population needs to be assured that death registration will have no adverse consequences (e.g., ration cutting). A sample mortality surveillance form is presented in **Appendix III-A.**

1.5 **Morbidity** (Major causes of illness)

Data on severe morbidity may help plan an effective preventive and curative health program for refugees. It will also assist the procurement of appropriate medical supplies, the recruitment and training of appropriate medical personnel, and focus environmental sanitation efforts (e.g., toward mosquito control in areas of high malaria prevalence).

Sources: The records of local clinics and hospitals if refugees have access to them.

Where a clinic, hospital, or feeding center has already been established within the camp, patient records or registers should be examined and common causes of morbidity tallied.

Interviews with refugee leaders, health workers in refugee population.

As soon as any curative service commences in the camp, a simple surveillance system should be established (see **Appendix** III-A for Surveillance form). Make sure to include feeding centers in system.

Certain public health actions need not await the appearance of a disease to commence; e.g., measles immunization should be implemented immediately and not await the appearance of measles cases in the camp.

2. Environmental Conditions

Information on local environmental conditions affecting the health of displaced populations will help relief planners create priorities for public health programs.

Information required:

Climatic conditions, e.g., average temperatures, rainfall pattern;

existing shelter for the refugees;

geographic features--soil, slope, drainage, availability of wood for shelter and cooking fuel;

local disease epidemiology: endemic infectious diseases, e.g., malaria, typhus, schistosomiasis;

availability of local materials for shelter;

water sources: local wells, reservoirs, rivers, tanks;

local disease vectors: mosquitoes, flies, ticks, including breeding sites;

existing sanitation arrangements: latrines, open areas, etc.

This assessment is largely made by visual inspection. The use of an itemized checklist facilitates this and other visual assessments (**see Appendix III-B**). In addition, interviews with local government and military officials will yield important information. In some cases special surveys need to be performed, e.g., by entomologists for local disease vectors, water engineers to assess water sources.

3. Resources Available

3.1 Food supplies: Attempt to assess the quantity and type of food currently available to the population. If food is already being

officially distributed, calculate the average per capita caloric intake over the period of time for which records are available.
Inspect any local markets for food availability and prices
Conduct a quick survey of dwellings and estimate the average food stores in each household. Look for obvious inequalities between different families or different ethnic or regional groups.

3.2 Food sources: local, regional, and national markets need to be assessed. The cash and material resources of the displaced population should also be assessed in order to estimate their local purchasing power.

3.3 Food logistics: transport availability, storage facilities (size, security, etc.), state of access roads.

3.4 Feeding programs: Look for any established feeding programs (mass feeding, supplementary feeding, therapeutic feeding). These may have been set up by local officials, non-governmental organizations (NGO), church groups, or local villagers. Assess attendance criteria, enrollment and attendance figures, quantity of food being provided, competence of organizers, quality of food, availability of water, utensils, storage)

3.5 Local health services:
Ease of access by refugees, official attitudes, location.
Condition and size of facilities.
Extent and appropriateness of medicines, equipment
Type and number of personnel
Cold storage facilities, vaccine supplies.

3.6 Camp health services

Type of facility (clinic, hospital, feeding center)

Size, capacity, structure (tent, local materials, etc)

Adequacy of health facility water supply

Refrigeration facilities, fuel, generator

Essential drugs (whether generic or brand-name) and medical supplies

Essential vaccines and immunization equipment

Type of health personnel (doctors, nurses, nutritionists, sanitarians, etc)., relevant experience, skills, etc.

Storage facilities;

Adequacy of transport, fuel, and communications

Health workers in refugee population (traditional healers, birth attendants,"modern" practitioners)

Interpreters

Appendices III-C and D are examples of forms used to interview camp administrators and health workers to obtain some of the information outlined above.

An itemized summary of the findings should be prepared, following the sequence of activities outlined in this document.

APPENDIX A: WEEKLY SURVEILLANCE REPORTING FORM

Region: _____ Agencies Reporting: _____ From: __ / __ / __

Camp: _____ _____ To: __ / __ / __

_____

I. CAMP POPULATION

	MALES	FEMALES	TOTAL
A. Total population at end of last week	____	____	____
B. New arrivals and births	____	____	____
C. Deaths	____	____	____
D. Departures	____	____	____
E. Total population at end of this week	____	____	____

II. MORTALITY

Reported Primary Cause of Death	AGE / SEX: 0-11 months M F T	12-59 months M F T	5-14 years M F T	≥15 years M F T	Total M F T
Diarrheal Disease	_ _ _	_ _ _	_ _ _	_ _ _	_ _ _
Respiratory Disease	_ _ _	_ _ _	_ _ _	_ _ _	_ _ _
Malnutrition	_ _ _	_ _ _	_ _ _	_ _ _	_ _ _
Malaria	_ _ _	_ _ _	_ _ _	_ _ _	_ _ _
Measles	_ _ _	_ _ _	_ _ _	_ _ _	_ _ _
Trauma	_ _ _	_ _ _	_ _ _	_ _ _	_ _ _
_____	_ _ _	_ _ _	_ _ _	_ _ _	_ _ _
_____	_ _ _	_ _ _	_ _ _	_ _ _	_ _ _
_____	_ _ _	_ _ _	_ _ _	_ _ _	_ _ _
Other/Unknown	_ _ _	_ _ _	_ _ _	_ _ _	_ _ _
TOTAL	_ _ _	_ _ _	_ _ _	_ _ _	_ _ _

	MALES	FEMALES	TOTAL
AVERAGE TOTAL MORTALITY RATES (Deaths/10,000 Total Population/Day)	____	____	____
AVERAGE UNDER-FIVE YEAR OLD MORTALITY RATES (Deaths/10,000 Total Population/Day)	____	____	____

III. MORBIDITY

Primary Symptom/Diagnosis	Number	Percentage
Diarrhea/Dehydration	_____	_____
Fever with cough	_____	_____
Fever and chills/Malaria	_____	_____
Measles	_____	_____
Trauma	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Other/Unknown	_____	_____
TOTAL	_____	_____

IV. COMMENTS

_____

_____

_____

_____

APPENDIX B: VISUAL INSPECTION CHECKLIST

(* Items to be photographed)

Things to observe about site

- Layout and organization (esp. living areas)
- Overcrowding
- Cleanliness
- Excessive feces on ground
- Waste receptacles*
- Signs of gardens, "cottage" industries, markets*
- Refugees' freedom to enter/leave camp (Note watchtowers, barbed wire, locked gates, etc.)*
- Signs of flooding/drainage problems, now and in rainy season (yes ___/no ___)*
- Level of relief agency activity (e.g., people actively working, presence of relief supplies, trucks, etc.)

Things to note about people

- Overall condition (healthy, active, obviously malnourished, etc.)*
- Friendliness/hostility/fear
- Presence of men (as percentage of total population)
- Presence of children less than 5 years
- Activity levels in women, children
- Wounds
- Signs of fuel-gathering off-site (people cutting or carrying firewood, areas of deforestation)*
- Presence of food animals or draught animals*
- Presence of weapons

Things to note about shelter

- Type of construction*
- Condition*
- Overcrowding*
- Ventilation
- In-shelter cooking*
- People sleeping/living outside shelters*
- Cleanliness of area inside/outside
- Bedding
- Flooding/drainage problems*

Things to observe about water

- Source (if on or near site)*
- Discoloration of water
- Water storage and distribution points*
- Method of transporting water to camp*

Latrines

- Type (trench latrines, deep pit latrines, individual shallow pit latrines, chemical toilets, aqua privies, other _____; none _____)*
- Number
- Cleanliness

- Signs of use, level of use
- Feces near entrance
- Lighting
- Distance to water supplies
- Maintenance/disinfecting
- Distance from shelters
- Defecation zones/areas

Warehouse

- Size*
- Supplies on hand
- Cleanliness
- Condition of food stores/evidence of pests
- Is food on ground or pallet?*
- Security
- Record-keeping (obtain copy of forms)

Food Distribution

- Foods distributed
- Methods of distribution
- Orderliness of food lines*
- Condition of food (fresh, moldy, etc.)
- Registration system

Health Facilities

- Types (hospital, clinic, etc.)
- Conditions
- Utilization/overcrowding
- Staff
- Equipment

Special Feeding Centers

- Facilities*
- Food preparation
- Registration
- Weighing/measuring equipment and activities*
- Waste disposal
- Cleanliness of site
- Condition of people
- Refugee workers

APPENDIX C: **ON-SITE INTERVIEW DATA SHEET: ADMINISTRATOR OR SENIOR RELIEF OFFICIAL**

Date _____ How Long at Site _____

Name _____ Address _____

Position _____ _____

Organization _____ Telephone _____

Name of Interviewer _____

A. BACKGROUND

1. Name of camp: _____

2. Location: _____

3. Total Population: _____

4. Date site established: _____

5. People in camp classified as refugees _____, illegal immigrants _____, other _____.

6. Within last month:
   (a) arrivals _____
   (b) deaths _____

   Within last week:
   (a) arrivals _____
   (b) deaths _____

7. Within last 24 hours:
   (a) arrivals _____
   (b) deaths _____

8. Data source (count, estimate, rumor, etc.): _____

9. Estimated distribution of adult population: men _____% women _____%

10. Size of campsite (estimated square meters _____; hectares _____; acres _____; other _____)

11. Description of campsite: _____
    _____

B. WATER

12. Source: _____

13. Distance to source: _____

14. Quantity available (estimate liters per day): _____

15. Purification/Treatment:
    (a) at source: _____
    (b) at campsite: _____

C. FOODS IN CURRENT USE

16.	Food Item	Distribution Basis	Supply On Hand (Tons, Weeks, Etc.)
Ex:	Rice (polished)	3 kg/per family/per week	240 tons
(a)			
(b)			
(c)			
(d)			
(e)			

17. Agency with overall responsibility for providing bulk rations:

18. Estimated daily calories provided per person (if known):

19. Are infant feeding bottles in use?

20. Are there special feeding programs for young children or malnourished persons? Yes ____ No ____. If yes, which agency is in charge of these? _____

D. SANITATION

21. Type and number of latrines, if any: _____

_____

22. Distance from shelters: _____

23. Lighting: Yes ____ No ____

24. Frequency of maintenance: _____

25. Who maintains? _____

26. Other place(s) of defecation: _____

27. Estimate of latrine use (well used, not used, etc.): _____

E. HYGIENE

28. Bathing facilities? Yes _____ No _____

29. Is soap available? Yes _____ No _____

30. Facilities for utensil washing? Yes _____ No _____

31. Method of garbage disposal? (Collection, burning, etc.): _____

32. Frequency of garbage collection? _____

APPENDIX D:

ON-SITE INTERVIEW DATA SHEET: SENIOR HEALTH WORKER

Date _____ Time at Site _____

Name _____ Address and/or Phone _____

Position _____ _____

Organization _____ Name of Interviewer _____

A. BACKGROUND

1. Name of camp: _____

2. Location: _____

3. Total population: _____

4. Date site established: _____

5. People in camp classified as: refugees _____, illegal immigrants _____, other _____.

6. Within last week:
   (a) arrivals: _____
   (b) deaths: _____
   Within last 24 hours:
   (a) arrivals: _____
   (b) deaths: _____

7. Number of childhood deaths (under 5 years) in last week: _____

8. Data source (exact count, estimate, rumor, etc.): _____

9. Estimated distribution of adult population: men _____%
   women _____%

10. Size of campsite (estimated square meters _____;
    hectares _____; acres _____; other _____)

11. Description of campsite: _____
    _____

B. WATER

12. Source: _____

13. Distance to source: _____

14. Quantity available (estimate liters per day): _____

15. Purification/Treatment:
    (a) at source: _____
    (b) at campsite: _____

C. FOODS IN CURRENT USE

16. Food Item	Distribution Basis	Supply On Hand (Tons, Wk., Etc.)	Notes
Ex: Rice (polished)	3 kg/per family/per wk.	250 tons in camp	Supplies irregular
(a)			
(b)			
(c)			
(d)			
(e)			

17. Agency with overall responsibility for providing bulk rations:

18. Estimated daily calories provided per person (if known):

19. Are infant feeding bottles in use?

20. Are there special feeding programs for infants or malnourished? Yes ____ No ____. If yes, which agency is in charge of these?

_____

D. PROTECTION/PERCEIVED RISK

21. Is there real or perceived risk from:

(a) cross-border military action?
(b) local military action?
(c) violence among refugees?
(d) violence among local/host population?

E. HEALTH FACILITIES

22. What facilities are in the camp (health centers, OPDs, hospitals, etc.)? _____

(a) Mobile medical team? (yes ____/no ____)

(b) Aid station or out-patient facility? (yes ____/no ____)

(c) Clinic or hospital with beds for in-patients? (yes ____/no ____). If yes, how many beds? _____.

(d) Hospital for referrals accessible? (yes ____/no ____). If yes, travel time _____ hours; or distance _____ kilometers.

(e) Supplemental feeding center? (yes ____/no____)

(f) Therapeutic (intensive) feeding center for severely malnourished? (yes ____/no ____)

F. MOST COMMON ILLNESS

23. Illness — Method of Treatment

(a) _____ _____
(b) _____ _____
(c) _____ _____
(d) _____ _____
(e) _____ _____

24. Are any of the following being seen:

Xerophthalmia	Yes____/No____
Beri-beri	Yes____/No____
Scurvy	Yes____/No____
Pellagra	Yes____/No____

G. DEATHS

25. Most common causes of death:

(a) _____
(b) _____
(c) _____
(d) _____

H. OTHER HEALTH CONCERNS

_____
_____
_____

I. HEALTH PROGRAM GUIDELINES IN USE? GOBI (UNICEF) _____

Other(s) _____

J.

IMMUNIZATIONS	Date of Last Mass Program	Adequate Supplies?
(a) Measles	_____	Yes _____/No _____
(b) Polio	_____	Yes _____/No _____
(c) DPT	_____	Yes _____/No _____
(d) BCG	_____	Yes _____/No _____
(e) Other	_____	Yes _____/No _____

26. Has a cold chain been established? Yes ____ No ____

27. Have there been problems in maintaining the cold chain? Yes ____ No ____

K. WHAT STANDARD DRUG LIST IS IN USE?

WHO/UNHCR _____; ICRC _____; Other _____; None _____.

L. ARE THERE ADEQUATE SUPPLIES OF THE FOLLOWING?

(a) Bandages? (yes ____/no ____)
(b) Vitamin A (200,000 IU UNICEF capsules)? (yes ____/no ____)
(c) Oral rehydration supplies? (yes ____/no ____)
(d) Antibiotics? (yes ____/no ____)
(e) Soap or antiseptics? (yes ____/no ____)
(f) Other: _____

_____

_____

M. SPECIAL FEEDING PROGRAMS

28. Supplemental feeding: Yes _____ No _____

(a) Number of children enrolled _____
(b) Number of children usually attending _____
(c) Method of measuring Height for weight _____;
arm circumference _____; weight for age _____
(d) Content of meals: _____
(e) Frequency: _____
(f) Feeding on-site or take-home? (Circle one)
(g) Approximate percentage severely malnourished when admitted _____%
(h) Approximate percentage (of admitted) severely malnourished at present _____%
(i) Is there an outreach program to identify children who should be enrolled? (yes ____/no ____)

29. Therapeutic feeding: Yes _____ No _____

(a) Number of children enrolled _____
(b) Frequency: _____
(c) Feeding on-site or take-home? (Circle one)
(d) Approximate percentage severely malnourished when admitted _____%
(e) Approximate percentage (of admitted) severely malnourished at present _____%

N. HEALTH SCREENING

30. Are new arrivals given a health screening before they enter camp and mix with those already in the camp? _____

31. Are potentially infectious new arrivals isolated and treated?
Yes _____ No _____