



GRADUATE SCHOOL OF DEVELOPMENT STUDIES

The Effects of Internal Displacement on the Physical Health of Displaced
Children in IDP Camps. The Case of Southern Sudan

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DEDICATION

*To my mother Grace Ongaria, who sacrificed all she had, devoted
her entire life and energies for my education.*

*To My wife Christine and my adopted son Samuel who dearly
missed me and endured my absence for fifteen months and most
needed care and support.*

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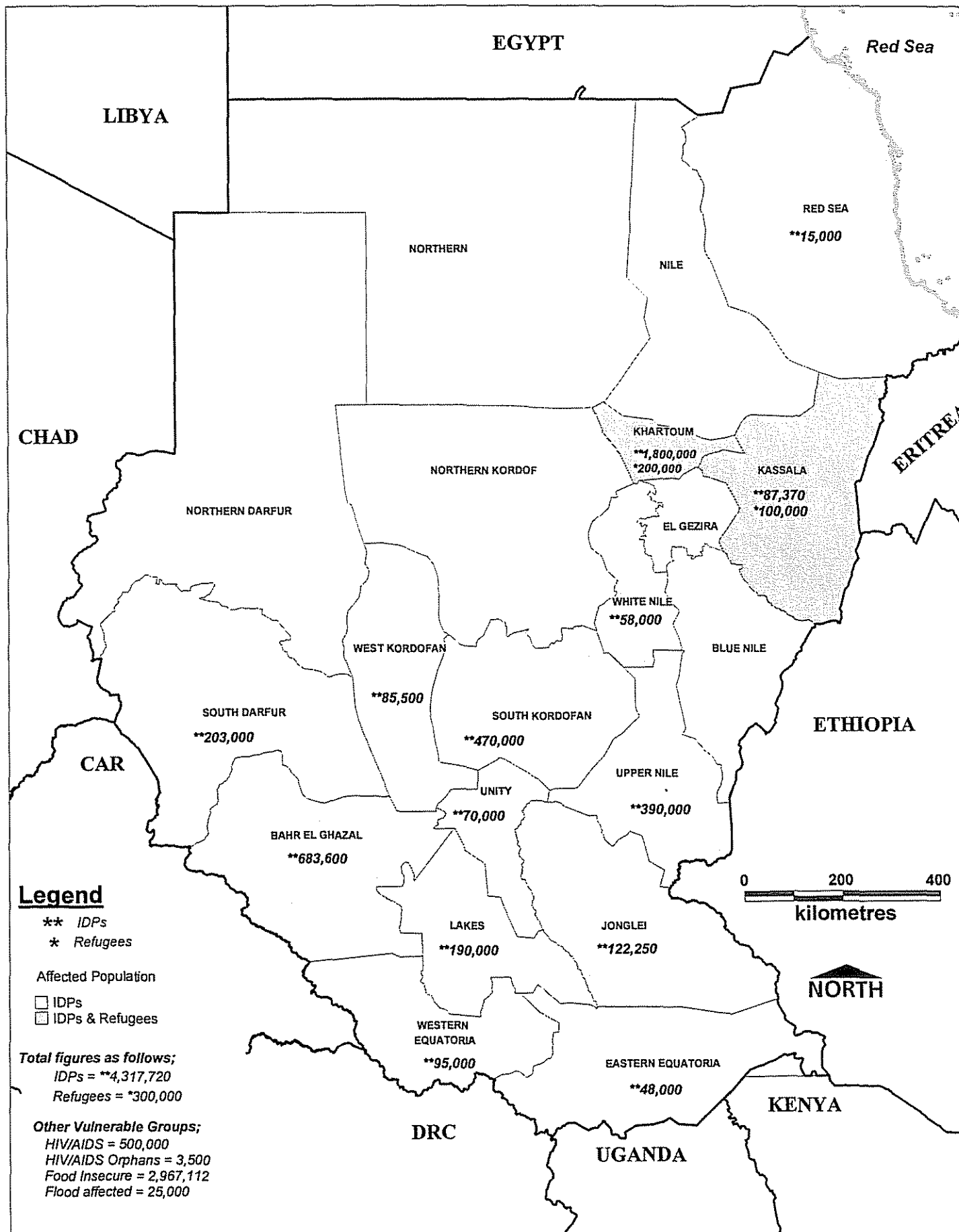
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LIST OF ACRONYMS

ANA	Annual Needs Assessment
CHEs	Complex Humanitarian Emergencies
FAO	Food and Agricultural Organisation
GIDPs	Guiding Principles on the Internal Displacement
GoS	Government of Sudan
ICCO	Inter-Church Organisation for Development Cooperation
ISS	Institute of Social Studies
IDPs/IDP	Internally Displaced Person(s)/population(s)
LRA	Lords Resistance Army
MICS	Multiple Indicator Cluster Survey
OCHA	Office of the Coordination of Humanitarian Affairs
OLS	Operation Lifeline Sudan
OMCT	The World Organisation against Torture
P&D	Population and Development
USAID	United States Aid in International Development
FEWSNET	Famine Early Warning System Networks Southern Sudan
UN	United nations
UNICEF	United Nations International Children's Emergency Fund
UNHCR	United Nations High Commissioner for Refugees
UNCRC	United Nations Convention on the Rights of the Child
SCIO	Sudan Catholic Information office
SPLM/A	Sudan People's Liberation Movement/Army
SOAT	Sudanese Organisation Against Torture
UNIRIN-CEA	United Nations International Reuters News-Central & East Africa
WFP	World Food Programme
WHO	World Health Organisation

Sudan

Affected Populations by District Internally Displaced and Refugees (August 2002)



The boundaries and names shown on this map do not imply official endorsement or acceptance by the United Nations

Prepared by OCHA Regional Support Office - CEA, Nairobi

ABSTRACT

Sudan is host to the biggest number of IDPs in the world today and is mostly due to armed conflict and tribal wars which have been fought for over three or four decades. This paper explores the impact of displacement herein associated to armed conflict to the physical health of displaced children in IDP camps in southern Sudan. The paper argues that, children have both in a short and long-run suffered in this war and yet they remained invisible in the statistics, in interventions and their experience with their parents in displaced persons camps seems to count less. This paper raises and as well tries to answer questions regarding pertinent issues fundamental to displaced children in IDP camps.

This study utilised data from various studies and surveys, reports on interventions in different parts of southern Sudan to justify and build an argument that displacement and subsequent life affect physical health of children. This study was conceived on the idea that displaced children undergo physical health problems in the course of their lives as displacement destroys the livelihoods of families which admittedly affects the capacities of parents to provide for the children's needs. Detailed examination of water and sanitation, hygiene and health conditions in camps, food problems, issues like health rights abuses and camps protection, security and insecurity problems are discussed in the study. Based on the findings, this study draws some conclusions that can help in reshaping interventions to strategically focus on not just immediate needs but long-term development issues. More important the study also emphasises the need for quality information collection which covers all IDPs and coordination of all humanitarian efforts.

CHAPTER ONE

1.0 INTRODUCTION

This chapter introduces the question of investigation. It contains the background to the paper, statement of problem, justification, the objective(s) and research questions. The second part discusses the methodology, data sources and analysis. The third, handles the scope, limitations and organisation of the study. Finally, last part defines concepts, introduce the analytical framework and theories.

1.1 Background

As the Cold War nightmare faded away more and more attention was paid to small wars fought within countries, between countries, ethnic groups using conventional weapons and for complex reasons. Africa is not only scared but has had terrible experience of such small wars. Richards (1996: xiii) argues that “factors internal to the continent are now being offered as explanations for this troublesome rise in modern low-level insurgency” which may be partly true and partly too simplistic. Episodes of bizarre conflicts in Liberia, Uganda, Rwanda, Democratic Republic of Congo, Sudan, Burundi, and formerly in Angola and Mozambique, were terribly devastating on children, many not knowing home life as a result of displacement.

For every person internally displaced by armed conflict, there is a story – 25 million different stories of fear, persecution, and loss of children, health problems and human suffering. Each year hundreds of thousands of people in different corners of the world are forced from the safety of their homes and compelled to take flight. The violence and direct personal threats of safety oblige individuals, families and entire communities to gather what they can of their belongings – if any – and depart for uncertain destinations with various problems awaiting (White Stacey et al 2002:3). For southern Sudan the displacement of children together with their families has happened more than once. But before embarking on the impact of displacement on the physical health of displaced children in IDP camps; let's introduce Sudan as a country.

Sudan is a name from Arabic word "*bilad al-sudan*", or land of the blacks, located at the centre of African continent and the largest most diverse countries in the continent home to deserts, mountain ranges, swamps and rain forests with an estimated population of 33.3 million people (Country Profile: Sudan :1). There are mainly two religions Islam and Christianity with Arabic as official language. Interestingly, about a half of the estimated 14.5 million people are under the age of 18 years (Watchlist Sudan: 2003: 1). The country is divided into about 20 administrative states with no average official population. Southern Sudan which is the area of focus, by 2000 had 58% of its population under the age of 18. According to available information, the total number of children in high-vulnerability areas was 2.7 million persons under age 18 in southern Sudanese states of Bahr el Ghazal, Eastern Equatoria, Western Equatoria and Upper Nile.¹

The conflict in southern Sudan has contributed to the deaths of an estimated 2 million people and has left more than 4 million people uprooted from their homes. Of the two million dead substantial proportions are children below 18 years and are not killed in battle fronts but die of hunger, famine and disease.

The conflict in the south is mainly between the Khartoum government dominated by Islamist Elitist Arabs of the north supported by local militias allied to it, pitied against largely animist and Christian black populations in the south. This conflict took a complicated shift and sparked renewed displacement when Khartoum government supported a rebel group which has been fighting the government of Uganda for the last 18 years (Lords Resistance Army led by Joseph Kony) by giving it sanctuary in the south as retaliation to Ugandan government support to SPLA. This scenario of events worsened the life of the local people triggering further mass displacement of already displaced thousands of people especially women and children now locked up in camps of internally displaced persons (IDPs) with lack of or inadequate sanitation facilities, squalid living conditions, problems with shelter, limited access to safe and clean drinking water while

¹ <http://www.watchlist.org/reports/sudan.reports.php> accessed on 28 June 2004

others pushed out as refugees to neighbouring countries of Uganda, Democratic Republic of Congo, Central African Republic, Kenya, and Ethiopia.

1.1.1 Problem Statement

Sudan is often-cited as an example of forced dislocation of civilians, the country currently host to the world's largest number of IDPs. "Government troops have been responsible for the aerial bombing of civilian targets – in many cases, as means of clearing areas for oil –production, construction of oil pipelines and/or as a means to fight opposition rebel movements" (IDP Global Survey 2002: 6).

According to Mandalakas early childhood vulnerabilities children are exposed due to displacement, 'may impact first on the child and secondly on the community for decades as these children become the adults challenged with rebuilding their societies and avoiding future conflicts and the resultant displacement' (Mandalakas 2001:100). And yet according to UN estimates, by August 2002 alone, there were over 4 million internally displaced persons camped in various areas within where they could get protection (see map). The cumulative totals are; 683,000 in Bahar-El-Ghazal, 70,000 in Unity, 390,000 in Upper Nile, 190,000 in Lakes, 122,250 in Jonglei, 95,000 in Western Equatoria, 48,000 in Eastern Equatoria states. More IDPs from southern Sudan were found further north and central in places like South Darfur, West Kordofan, South Kordofan, White Nile and Khartoum itself. These figures are estimates and are based on relief distribution and given the fact that Sudan has experienced continuous displacement of civilians since 1983. A little less than 50 percent (1.8 million) of the displaced in and around Khartoum (OCHA Sudan: 2002: 11).

Displacement leads to low agricultural production causing frequent food shortages according to *Famine Early Warning Systems Network USAID/FEWSNET* and other humanitarian organisations active in southern Sudan. The resultant outcome is poor nutrition and poor physical health development of children in particular and also adults at the worst deaths. Alarming and horrifying pictures of starving displaced children in camps who cannot be reached with urgently needed food have bombarded the front pages of western press or television screens. When fighting was intense food from

humanitarian agencies which people largely depend on could not be delivered to the starving IDPs because government was using food restriction and starvation as a weapon of war against millions of the displaced.

The other problem in the information available about the conflict in southern Sudan is that, it is always concentrated on the progress in fighting, peace talks and more often basic needs like food, shelter etc, but little attention or outright neglect of the fundamental effects of this war has/had on the health of children. This is especially against a background of severely destroyed and constrained health service delivery to the displaced children in the region. Lumped figures that are not disaggregated are readily available. Displaced children have specific needs and if those who report on the situation do not bring out clearly the various age groups, then this is an indirect way of ignoring the special needs of children in planning and provision.

1.1.2 Justification of the study

Children are a generation that needs to be groomed, protected and prevented from all kinds of situations that may affect their development. They are a 'ray of hope' for the future. Why are they the most vulnerable health wise? Why focus the attention on children? The overriding reason is "Millions of young people are 'at risk' today, many of the displaced children in camps make up approximately half of uprooted populations anywhere in the southern Sudan"² and secondly they are the most vulnerable and easy insults of diseases, abuse and health problems that may impact on them for their entire lives.

On a worldwide basis, the number of children violently uprooted from their homes and either 'internally displaced' within their own countries...may be as high as 25 million, southern Sudan the focus of this paper, alone contributes about four million to this total the highest in the world. There are children who were born and grew up in camps with wanting and limited hygiene and sanitation, shelter, clothing, beddings or basic meals (basics) to which UNICEF Sudan country report (2002) attributed as the explanation for

² www.unchr.ch/children/ accessed June 28th 2004

the high “incidences of diarrhoea, dysentery, underweight children, and malnourishment among displaced children under the age of five and mortality rank of 95 in the world”³

Displacement has significant disservice to agricultural production. Families are forced out of their farmlands and are confined to congested camps with no land to grow their own food and raise their own animals which according to aid agencies has disrupted the nutrition pattern of children. As a result, families entirely become dependant on relief food ratios provided by humanitarian organizations. But not everyone sees this food as entirely good as a woman noted it us in 1996 in Rumbek IDP camp “this food may not be good to raise children on as compared to locally grown food.” Getting used to what they called ‘foreign food’ let alone learning how to prepare has caused health problems to children. In a food security report of August 2002, it was reported that food security situation remains precarious in most camps of the southern Sudan with continued armed conflict and renewed displacement of people to other parts of the south forcing them to leave behind ready food for harvest in their gardens. It was indicated that the situation had deteriorated in IDP camps in Jonglei and Upper Nile regions and was not expected to improve before September-October period of the same year. The report indicated that there would be a major problem in provision of adequate food for families by parents. At the same time significant ‘increases in sorghum and other food grains prices’ continued to affect access to food in IDP camps in Rumbek within Lakes state and people spent a lot more time to search for food. This reduced meals and care for children by parents who were always moving for long distances to look for grains to feed their families.⁴

The problems of reporting and aggregation of statistics because it overshadows those below 18 years who do not have same needs like an adult persists in statistics. This major weakness in the available data negatively shapes the planning process. This paper emphasises comprehensive data collection and make prepositions to that effect (various age cohorts), so that organizations that target child and their needs, can easily plan for such interventions with readily available statistics. The issue of who the duty bearers are

³ http://www.unicef.org/infobycountry/sudan_statistics.html#0 accessed June 29th 2004

⁴ <http://www.fews.net/centers/current/monthlies/report/?f=sd&m=1000997&=en> accessed July 1st 2004

in providing such needs comes in and health rights of child are violated and by who? I hasten to add that, physical health cannot be looked at in isolation of food/nutrition, shelter, hygiene, clean and safe drinking water that indirectly or directly impact on it. Therefore this paper is not about the effects of armed conflict in southern Sudan, rather on the impact of displacement on the physical health of displaced children in IDP camps.

1.1.3 Overall research objective

Overall, purpose of this paper is to explore on how the effects displacement affect the physical health of displaced children in IDP camps in southern Sudan. Specifically the study seeks to examine environmental and health conditions in IDP camps that are detrimental to children, the interventions, gaps, violation of health rights of displaced children and other related issues using the available demographic and health information.

1.1.4 Research question

The paper seeks to answer the following research questions;

- Do IDP camps provide security or insecurity and do they provide environmental hygiene or are they sources of environmental hygiene problems that may be problematic to physical health of displaced children in IDP camps?
- Do IDP children in camps have access to free or affordable health care, or there are no health care services available at all in the camps?
- Do IDPs have easy access to food or can they produce their own to feed families/children? How does the shortfall affect health of children in camps?
- How are the health rights of children in IDP camps violated and who are the duty bearers or actors to protect such abuse?
- And what conclusions can be drawn and recommendations?

1.2 Research methodology

This study is essentially descriptive and based on the review of secondary data in websites of the UN agencies and other humanitarian aid agencies active in southern Sudan. Other relevant surveys like global IDP surveys and literature were reviewed.

1.2.1 Data sources

To answer the questions I set out in the paper, I have reviewed and used both quantitative and qualitative data available in UNHCR, WFP, UNICEF, USAID/FEWSNET, FAO, Internally Displaced People Global Surveys 2002/2003 and other websites on Southern Sudan. The information varied according to an organisation which was both to my advantage and disadvantage. The UNICEF 1998/2003 data, Global IDP Survey 2002 and UNCHR 1995/2002 data provided valuable information on displacement as it evolved over years of work in southern Sudan. Much of this data is aggregated figures which do not give the true picture of the situation of displaced children in IDP camps in southern Sudan. Global IDP survey is largely qualitative information. UNHCR, has data on refugees but little or non on IDPs.

To answer the question on food access, availability, production and prices, though not limited to, I used reports from USAID/FEWSNET, FAO and WFP. These reports indicate the monthly food requirements for IDPs and projected situations. The problem however was the lack of disaggregated information according to various states or camps and the assumption that all those displaced have homogenous needs.

Other quantitative and qualitative data from websites of Oxfam, War affected children Canada, Watchlist on children and armed conflict, WHO, and working papers were consulted. I critically reviewed the literature by looking for supportive evidence, contradictions and omissions if any and assumptions. This methodology helped me provide answers to the research questions.

1.2.2 Method of analysis

The analysis borrows the principle embedded in Bongaarts 'proximate determinants' or what Davis and Blake refer to as 'intervening variables' framework to understand how different variables operate through others in affecting child health and specifically displaced children in camps. Bongaarts argued that the relationship between proximate variables and the outcome is complex, not direct and can only be seen through offshoots of variables they operate through. For example, when people are displaced by armed conflict, their agricultural productivity is disrupted, food availability declines, food prices because of scarcity hit their highest limits, even access and distributing food relief becomes a problem because of road blockades, landmines or outright access denial to

IDPs. With this scenario of food scarcity, children access to food inside camps reduced. Originally, camps were created as peace villages, food access channels but as the war intensified in late 1980s throughout the 1990s, the reverse happened; access denied, camps bombarded which sent people running, intensive recruitment and abduction of young children, relief food distribution centres bombed, aid workers abducted and sometimes caught up in the fighting and end up being murdered, airstrips for air food deliveries bombed and destroyed for planes to land and above all air flight restrictions. On a visit to some camps nearer Uganda – southern Sudan border, one could see how poorly malnourished children were and yet they were not sure of their next meal. Therefore, the analysis tries to understand the causal relationship between the various proximate variables on one side which are directly caused by displacement through direct variables which specifically affect the health of displaced children in IDP camps.

1.3 The scope, limitation and organisation of the study

1.3.1 The Scope

Overall the discussion is limited to the impact of displacement on the physical health of children (displaced children in camps). Generalisation was made on the age of children and gender, also on geographical locations of camps of displaced children because according to available information, IDP children in camps in rebel controlled and government areas in southern Sudan underwent similar problems at times even most severe in government controlled zones. Generally, the information available indicates that the conditions of displaced children in IDPs camps whether in semi-urban or urban settings, rural remote areas or in government or SPLA controlled areas of southern Sudan showed no significant differences. It is beyond the scope of this paper to make comparisons of any kind because considering the IDP camps in southern Sudan and the displaced children, in my personal experience in these camps, there is no one good or other bad situation all IDP camps were the same. If it is lack of water, food, medical services, or sanitary facilities the same scenario runs through all with at times urban IDP children in severe shortage and diseased situations.

1.3.2 Limitations

I need to emphasise that, this study would have been well nourished if primary data was collected. The very fact that the study relied heavily on secondary data posed a challenge on the analysis and drawing of conclusions because it was difficult to extrapolate scanty aggregated data on entire displaced children in camps. My biggest limitation as such, was on non-availability of relevant data and secondly the available information was not disaggregated.

1.3.3 Organisation of the paper

This paper comprises five chapters. The first chapter is an introduction focusing on the background, statement of the problem, justification, methodology, analytical framework, concepts and magnitude of displacement in the southern Sudan. The second, third and fourth chapters do the presentation, analysis and interpretation of data and the fifth is conclusion.

1.4 Definition of concepts

1.4.1 Displacement (internally displaced persons and refugees)

The concept displacement (internal displacement) is used here to mean the process of uprooting people from their homes forcefully or moving in fear of being killed or running away from war or conflict. Those who fall victim of such a process are 'internally displaced persons.' Such populations/persons settle within places referred to as 'camps of internally displaced persons...' (Cohen and Deng 1998:1, UN GIDPs). Though Holbrooke calls such definitions as "outdated, and what was needed according to him ...is responsibility for the displaced, regardless of where they are found themselves, regardless of frontiers."⁵ Internally displaced persons (IDPs) are 'persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, civil strife, situations of generalised violence and systematic abuse of human rights, or man-made disasters and have not crossed an internationally recognised state border' (UN Guiding Principles on Internal Displacement 1998 GIDPs: 191, Deng Francis 1998: 1).

⁵ <http://www.refugees.org/world/articles.html> accessed July 3rd 2004

1.4.2 Physical health

Literature consulted does not give a definite definition of physical health. Physical health is understood in relation to the various physical components and signs seen on a person are used to explain ones health as having problems. In this paper, physical health is used to mean the bodily appearance of a person free from psychological stress, physical damages on the body and progressive growth in mass, height and weight. According to Centre for Disease Control and Prevention (CDC) survey (2002) on volunteers and fire-fighters who participated in World trade centre fire fight, many presented physical health effects like 'psychological stress, environmental toxins, and other physical hazards like lower and upper respiratory symptoms.'⁶ 'To have good physical health is associated to eating a variety of healthful foods and getting enough exercise and rest. Therefore, some things people take into their bodies from the environment can hurt their physical health.'⁷ In other words some diseases that actually harm our physical health are caused by germs from the environment we dwell in. According to Church Magazines, 'eating disorders cause a deadly state of mind, dramatic loss of energy, appetite loss, and loss of weight or wasting'⁸ are attributes of impaired physical health. Immunisation of children, proper nutrition and diet, adequate sleep and play for children can help achieve good physical health which is a key weapon for disease prevention.

1.4.3 Child(ren)

Child(ren), according to the United Nations (1989) definition, children are those below 18 years of age (UNCRC: Art.1: 2). Grittins points out that there is no universal agreement as to when childhood ceases and adulthood begins (Grittins 1998:3). Ben White in support of Grittins wrote, "We may rightly question the usefulness, for either analytical or policy purposes, of this broad category which lumps together people who have very little in common (a 17 day old and a 17 year old 'child', for example)..." (White 2003:4). It is not the interest to go into categorization for practical purposes but considers the 18 years bracket. It is easy to forget their interest and argue that if those of their parents are catered for then children are equally covered. In using a broad definition

⁶ www.cdc.gov/mmwr/preview/mmwrhtml/mm5335a1.htm accessed July 3rd 2004

⁷ www.sciencelinks.com/benchmark_sub.cfm?benchmarkID=6&Grade=k-2#5 July 3rd 2004

⁸ www.providentliving.org/content/list/1011664,2411-,0.html accessed July 3rd 2004

of 'child' am aware of both the advantages and dangers in this inadequacy, what Ben White termed as 'globalization of childhood' (ibid: 6). This is because it is difficult to reconcile the diverse country definitions (for example in Sudan Children are those below 17 years) with globally accepted standard. The way a 'child' is defined reflects the politics and interests behind these categorizations.

1.4.4 IDP camp(s)

IDP camp(s) denote 'shelter for persons displaced by war or political oppression or for religious beliefs.'⁹ There are many typologies of camps; my focus will be based on those created by war or armed conflict. The compositions of these camps according to humanitarian organisations id mainly the elderly, the women and children particularly forming the majority, men remain behind to protect the villages, join the rebels to fight the government and its supported militias.

1.5 Current magnitude/data of displacement in southern Sudan

Since the end of the Cold war, the number of refugees has declined while internally displaced populations have increased a trend which suggests a correlation. The data available in World Refugee Survey 2003 Country Report indicates the following facts on displacement in southern Sudan;

- Nearly 4.5 million Sudanese were uprooted at the end of 2002, including an estimated 4 million internally displaced persons mostly from the south, children making up to 56 percent and some 475,000 Sudanese who lived as refugees and asylum seekers.
- The distribution of the figures is as follows; 683,000 in Bahar-El-Ghazal, 70,000 in Unity, 390,000 in Upper Nile, 190,000 in Lakes, 122,250 in Jonglei, 95,000 in Western Equatoria, 48,000 in Eastern Equatoria provinces/states in the south.
- In January 2002 alone estimated 550,000 southern Sudanese fled their homes due to attacks by Khartoum government in southern oil-rich regions, including many people who were already displaced by earlier fighting/violence in previous years. For example due to government military offensive and militia raids against the local

⁹ www.coesoci.princeton.edu/cgi-bin/webwn accessed 5th July 2004

populations in Bahr el-Ghazal, 120,000 new and long-term displaced persons congregated near the government held town of Wau.

- Battles for the town of Torit in Eastern Equatoria province forced more than 10,000 people to leave their homes in 2002.
- In the same year over 20,000 people were displaced by Ugandan rebel group, Lords Resistance Army (LRA), supported by the Sudanese government, roamed through southern Sudan looting villages and massacring. (World Refugee Survey Report 2003, Benetti: 2003: 1-2).¹⁰

The main problem with this statistics is their inability to give detailed information how many are children below 18 years apart from saying 56 percent are children. Therefore, like White Stacey et al pointed out "...the well-being of IDPs is impossible to quantify as statistics rarely reflect the gravity of humanitarian needs. Because detailed information about welfare of IDPs specifically children is piecemeal at best." (White et al: 2002: 6). The statistics offer an indication of the limited capacity of local and central government, humanitarian organisations and even resident populations to respond and absorb the needs of the displaced.

1.6 Theories of Displacement and analytical framework

Mobility is an intrinsic attribute of human beings and based on mobility status people can be classified into five categories: permanent migrants, long-term migrants, temporary migrants, transfers and non-migrants (Hamid 1996:11). Since the early 1980s, population displacements in the Sudan have been instigated by life threatening situations like famines and civil wars or armed conflict (involuntary migration) with wide socio-economic ramifications. Of the various categories of involuntary migrations, this study is concerned with that triggered by armed conflicts or civil war which has been the cause of displacement within Sudan. Displacement is experienced as a calamity that affects a large area, often forces the flight of most people in the affected area, results in the substantial loss of assets, and homelands of displaced persons are either deserted or destroyed (Hamid 1996:14). Apart from armed conflict, natural disasters or what Hamid calls 'acts

¹⁰ <http://www.refugees/world/countrysrpt/Africa/2003/sudan/htm> accessed 6th July 2004

of God' like drought, floods, earthquakes, plagues, and natural slides can cause temporal involuntary displacement of people.

1.6.1 Psychoanalytic and cognitive theories

'Based on their age, children have varying degrees and sources of vulnerability to their physical and mental health development during complex humanitarian emergencies (CHEs)' like displacement (Mandalakas 2001:99). The classical psychoanalytic and cognitive theories of Erikson and Piaget are ideal to provide 'contextual frameworks within which to examine and understand the impact of internal displacement due to war on child development' (ibid). Mandalakas goes further to say that, in displacement children separated from adults caretakers have consistently been a vulnerable subgroup. According to the psychoanalytic theory, 'children develop either a sense of trust or mistrust during the first year of life. For them to do so, they require a feeling of physical comfort and a minimal amount of fear about the future. Sensitive caretakers must meet the child's/infants basic needs. Separation with adult caretakers during the first year of life, children may not successfully develop their sense of trust instead a sense of mistrust that will impact on all future relationships' (ibid) Erikson's psychoanalytic stages (which I will not discuss here) are ideal theoretical supports the risk of number of poor long-term physical health outcomes in all children involved in emergencies like displacement.

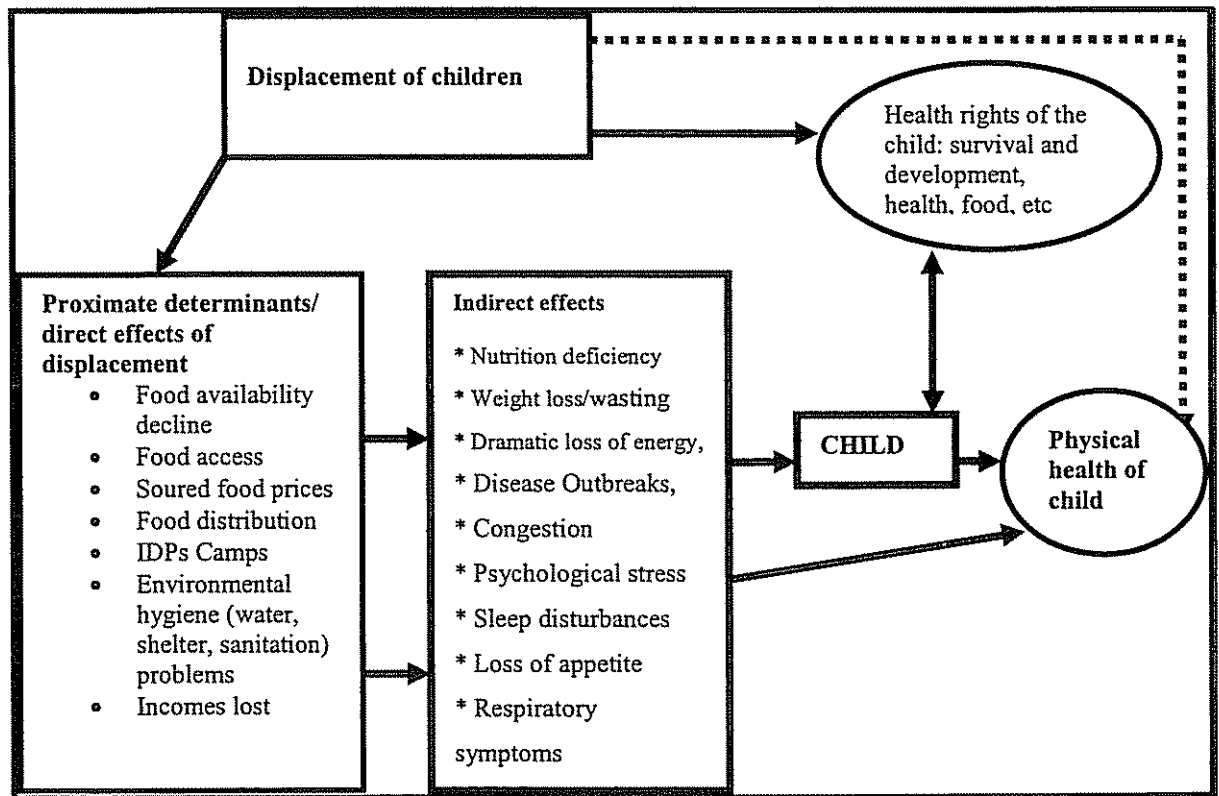
Piaget's cognitive theory does provide another 'theoretical support and insight into the long-term impact of displacement on children' (ibid: 99). According to this theory young children or adolescents involved in various acts do not care about the implications of their actions. They can be exploited heavily at this stage. Adolescents involved in displacement and the traumatic life and conditions in IDP camps 'may have difficulty achieving formal operational thinking' (ibid: 100). These combined with deficient nutrition and continued abuse permanently and physically impact on the health of a child.

1.6.3 Analytical Framework

As explained in the analysis section, the analytical framework heavily borrows principles from Bongaarts framework of proximate determinants to establish a causal relationship between variables. Meaning that there are direct effects of displacement like food

availability decline, food access problems, encampment of people, environmental hygiene problems which in return produce indirect effects nutrition deficiencies, disease outbreaks, congestion, inadequate sleep, psychological stress, acute respiratory symptoms, eating disorders, and weight loss/wasting The framework below helped show relationship between variables.

Figure1: Analytical framework on displacement and physical health of children



CHAPTER TWO

2.0 CONDITIONS IN IDP CAMPS VERSUS CHILD HEALTH

"All internally displaced persons have the right to an adequate standard of living. All the minimum, regardless of the circumstances, and without discrimination, competent authorities shall provide displaced persons with and ensure safe access to: essential food and portable water; basic housing and shelter; appropriate clothing; and essential medical services and sanitation." (Principle 18: UN Principles on Internal Displacement 1998)

2.1 Introduction

This chapter discusses the conditions in camps in relation to security and insecurity for displaced children living in them. The chapter once again does not discuss the differences between IDP camps because the data and information available does not give any comparative that can help me show differences between camps. For instance IDP camps near government garrison towns in the south are easy targets to night attacks, kidnapping and abductions of young boys and girls just as those within SPLA. The chapter also discusses provision of clean water and sanitation facilities in IDP camps, essential health services in the camps and basic housing and shelter for the IDPs in the camps.

2.1.1 IDP Camps: Places of Security or Insecurity for children?

More than 30 years of civil war conflicts have caused tremendous suffering for the child Sudanese population and generated one of the worst IDP situations in the world in general. Since the conflict escalated in 1983 and subsequent recurrence, IDP camps were created and recreated. The exact number of IDP camps in southern Sudan is not known because of the security situation and secondly, the continued displacement and re-displacement. According to Global IDP survey, UNHCR, OCHA Sudan, IDP camps are littered in various locations throughout the seven states in the south. The number of IDP children is not known but estimates are up to 54 percent of IDPs are children age of 18. Recent evidence has it that, IDPs in southern Sudan comprise mostly of women and children and well over 75 percent of the entire IDPs. Approximately 75 percent of IDPs in Mabia camp for instance are children. (Watchlist: 2003:15).

Some of the camps were created by government during the war in early 1990s as 'peace villages' where for example indigenous Nuba communities were forcibly moved, while others were created by SPLM/A in areas they control. But over the past years, the international community has expressed its concern about the protection of such peace villages, 'particularly in light of reports of forced Islamisation of the non-Muslims by authorities, abduction of children for recruitment into rebel ranks and government backed militias, or sold into slavery, girls sexually exploited and abused,' (Benetti: 2003, Global IDP Survey Report: 2002:75, Korn: 2000: 15). For example according to UNICEF (2001) report, 4000 to 6000 children forcibly recruited and abducted from IDPs camps were in SPLM/A controlled areas despite the release of 3500 child soldiers in February 2001 (UNICEF, August 2001, UN, November 2001 p82).

Since 1998, there has been regular government bombing of civilian targets, including hospitals providing services for IDP children, food-air drop zones and IDP camps. During 2001-2002, human rights observers reported increase of gross violations on international humanitarian law in Equatoria, Bhar el Ghazal and oil-rich Western Upper Nile. In February 2002, Akuem IDP camp was bombed by government warplanes during a World Food Programme (WFP) food distribution to over 18,000 IDPs, aerial bombings on Nimme, and later on a relief centre in Bieh, killed scores of civilians half the number children including Médecins Sans Frontières (MSF) staff. (WFP, February: 2002). These killings complicated the humanitarian assistance delivery to IDPs and many organisations were forced to stop their relief operations.

In an August 2000 Sudan Monthly Report, the armed conflict in Sudan assumed an extremely dangerous dimension. The Sudan government took the war to the defenceless civilians and there seemed to be no room to escape even when it was aware that children are the majority of the displaced housed in IDPs camps. Bombs, bombs rained indiscriminately on moving object or settlements in SPLA held territories in southern Sudan: Nuba Mountains, Wau, Torit, Aweil, Gogrial,¹¹ killing and physically maiming

¹¹ These towns host over 35,000 IDPs each and their control in years has shifted from GoS & SPLA and vice versa.

displaced children and women in these camps. Those who survived the report says live in fear, 'there are thousands of children,...who cannot do anything but keep their ears and eyes wide open for the slightest sound of the now familiar Antonov aircrafts synonymous with cruelty' (Sudan Catholic Information Office, August 2000). This psychologically stresses children, causes sleep disturbances and fear to play. The same report adds that even 'domesticated animals; dogs, cats and chicken in IDP camps caught in this human tragedy, were equally terrified by the Antonov and always lead the way to 'bunkers' (underground bomb shelters) at critical moments.'¹² In July of the same year "250 bombs were dropped on at least 33 separate attacks on IDP camps in the south" (ibid, 2000:1). Children have had a fair share of bombs and perhaps the message by Khartoum to the whole world is that 'we are killing our people and you have no business poking your nose' catholic priest once expressed. The popular conception that camps are created as safe areas for food relief deliveries and other services, has and been a living myth in southern Sudan until 2003 when a peace agreement was signed in Kenya. IDP camps exposed IDPs to aerial bombardments and easy militia targets for attack which often left thousands homeless and scores dead or injured and children abducted.

In mid 990s during the height of the conflict in southern Sudan, the Human Rights Watch (HRW) report, *Sudan: In the Name of God, Repression Continues in Northern Sudan*, stated that the government rounded up hundreds of boys displaced by war, mostly southerners, in markets, in government gazetted IDP camps in Khartoum, and on streets. The boys were 'summarily dispatched to religious camps.' While in those camps, they were beaten for small breaches of discipline and given a religious (Islamic) education regardless of their or their families' beliefs. And 'at age 15 the boys were reportedly incorporated into the government militia' (Watchlist March 2003:15). This was done under the pretext of 'taking care of street children'. However, no attempts were made to contact the boys' families or to follow the UNCRC or any juvenile law procedure for removing a child from his or her family. In the education camps, medical treatment was rarely available, young boys who could not cope with the poor feeding and hygiene died.

¹² http://www.peacelink.it/africa/scio/month_51.html accessed 12 July 2004

In summary, often southern Sudanese displaced children in IDP camps are not provided with basic protection and in some instances are targets of violent attacks. Several kinds of abuses meted include GoS plane bombing of IDP camps and relief operations, GoS forces and government backed militias are known to recruit displaced children into their ranks, abduct, rape and other atrocities against IDP children. The SPLA is no saint either in these abuses of children in camps. They systematically diverted food and taxed food intended for displaced persons,¹³ raped IDP women and girls, recruited IDP children and other abuses. World Organisation Against Torture (OMCT) reported that orphaned children and unaccompanied IDP girls in camps are particularly vulnerable, as in other displaced populations. Boys living in camps are often kept together as groups living in villages within the camps. The girls on the other hand are placed within guardians for protection, but due to 'rampant poverty girls are often viewed as valuable commodities' that can be sold off for bride price. 'Sexual abuse, forced marriages and beatings are reportedly widespread, even among girls living with 'guardians' in IDP camps.'¹⁴ The early marriage of young girls is attributed to the high maternal mortality by UNICEF in both GoS and SPLA controlled areas in south (see figure 2). If children escape being abducted in camps, they may not escape abuse or starvation or nutrition deficiency and poor health. Although security is at times even more important for the displaced children than food, it has been given far less attention. Roberta Cohen and Francis Deng in *The Forsaken People* noted that UN personnel acted as if the most and sometimes the only essential undertaking was the delivery of relief goods, whereas food itself could be of little use to populations in danger and fear of mass slaughter or displacement (1996:6)

2.1.2 Clean – safe water, sanitation and health of children.

When the displaced flee and settle in rural areas, they inevitably wreck havoc on the environment, polluting streams and groundwater sources and stripping forests and grasslands for fuel. Likewise when IDPs flee to urban centres, as they have in large numbers (e.g. 1.8 million in Khartoum) the result is overcrowding in the camps created and sometimes the doubling or stripping of a city's population. Often such IDP camps in

¹³ In one particular incident in a feeding centre established by MEDAIR in Wau town to cater for 200 children, SPLA soldiers raided it and swept all the food stores meant for the badly malnourished children picked from the camps (SCIO: July 2001 report).

¹⁴ <http://www.watchlist.org/reports/sudan.reports.php>. Accessed 12th July 2004

the 'outskirts of major cities where people settle are without access to sanitation, clean running water' and medical, educational or other services (Korn: 2000: 18). IDP camps are supposed to function in enhancing the provision of minimum services to IDPs, the experience of Eastern Europe and the displacements in Balkans of 1990s one can argue certainly functioned so, but for southern Sudan the opposite is the reality on the ground. Until recently much of the world's attention had been on Eastern Europe, Afghanistan, Palestine, Iraq and little on the suffering displaced children in IDPs camps in Southern Sudan. A colleague of mine working with Oxfam once told me that the attitude among western humanitarian agencies and governments was so negative 'Africans are seen as savages who should be left kill themselves'.

According to the UN November 2003, 'low level of access to clean water continues to be a major problem in IDP camps with more than...70% of the IDP population in southern Sudan drinking unsafe water' (UN, 18 November 2003). The table below illustrates the low water coverage and environmental conditions in seven sampled IDP camps in southern Sudan.

Table 1: Water and environmental sanitation in 7 IDP camps in southern Sudan

Average of Coverage	New water points	Pumps repaired	Latrines and sanplats	Water points fenced
Rumbek and Cuibet	2	22	7	14
Awelis	8	6	-	3
Yambio and Tambura	4	5	-	-
Nuba	-	4	-	-
Nyal	-	9	-	5
Total	14	46	7	22
Estimated pop. reached	14,000	46,000	Less than 100	22,000

Source: UNICEF Monthly report May 2004 (UNICEF operations in southern Sudan)

In the table above out of seven IDP camps have no pit latrine or sanplats. In 1995 and then again in 2001 when I visited Awelis, Rumbek and Nyal IDP camps, the smell of human refuse greets you one kilometre away from the camp. The outcomes such conditions in IDP camps can be summarised by a recent documentary shot in southern Sudan by BBC broadcast on June 15th 2004 that "30 displaced children die every week at Rumbek Hospital due to vibro-diarrhoea caused by drinking contaminated water" (The State of children in War areas: June 2004).

The consequence of limited clean water sources in IDP camps relegates the task of fetching water for domestic use mainly on girls and women. Water collection typically entails average daily travel for about two to four hours away from the camps. For young girls, the task involves carrying heavy water containers for long distance in one way or the other affects their good physical health development (UN, November 2002 as quoted in Global IDP project database, 2003). Even the time given for care of young children in camps by parents is limited. With no clean water, dirty sources like swamps, logged water in camps, rivers turn out to be the immediate alternative sources where they exist.

While this problem would have been alleviated by providing a significant proportion of the IDP camps in Southern Sudan with increased access to clean water and sanitation facilities, insecurity and accessibility to the camps have hindered interventions to construct water supply facilities in camps in Jonglei, Upper Nile and some parts of Bahr el Ghazal. The low coverage of safe water supply to IDP camps is not only due to the lack of water supply facilities but due to high proportion of non-functioning facilities. In IDP camps and the surrounding areas, 70% of the available hand pumps and water yards need rehabilitation and repair (UNICEF May 2004 monthly report). A 2000 UNICEF study found that only '26% of IDP households in southern Sudan had access to safe drinking water during the dry season' (UNICEF MICS: 2003).

Given such a situation, water borne diseases are a major health hazard that kills dozens of IDP children everyday in IDP camps. For instance, southern Sudan hosts '80% of Guinea Worm cases' in the world, Jonglei state being the worst affected state with 40% of those infected are IDP children living in IDP camps. 'Guinea worm has made many children handicapped and some physically disabled because of repeated recurrence of the worm though they were born physically healthy. '670,000 children die in Sudan from preventable diseases and guinea worm infection each year of which 56% are IDP children in camps in the south. 40% of under-five displaced children die of diarrhoeal diseases' caused by poor hygiene in IDPs camps and lack of access to safe drinking water' (Global IDP Database: 2003). UNICEF therefore attributed 'lack of safe water and inadequate

sanitation' as underlying causes of high infant mortality rates among displaced children in IDP camps (ibid: 13).

As shown in the table above, the sanitary facilities are totally inadequate in seven biggest selected IDPs camps. Comparatively the sanitation coverage in the country in general is low with 'about 65% of the population have no sanitary facilities' (Global IDP Project March 2004). The Watchlist likewise reported that 'less than 35% of IDPs in camps in the south have access to adequate sanitation (March 2003: 13). The Multiple Indicator Cluster Survey (MICS) conducted in 2000 indicated that in GoS-controlled areas of southern Sudan which is host to about 400,000 IDPs, only 60% of population had sanitary means of excreta disposal, but IDP camps least provided. Despite the work of Operation Lifeline Sudan¹⁵ agencies in advocating IDPs to use latrines in the SPLM/A controlled areas, open defecation was still widely practised where communal areas outside the camps are used as informal latrines. When rains fall, all this litre is washed back into the camps. With such conditions prevalent in camps, many children developed different kinds of respiratory problems, scores had low body mass, bad sight, physically weak and vibro-diarrhoeal infections which are detrimental to good physical health.

2.2 Essential Health services for IDP children in Camps

'The wounds inflicted by armed conflict on children – physical injury, gender-based violence, psychological distress, are affronts to every impulse that for example inspired the United Nations Convention on the Rights of the Child' (UNCRC: 1989). Displacement affects all aspects of child health and development – physical, mental and emotional which accumulate and interact with each other. Article 24 of the UNCRC states that, "States parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States parties shall strive to ensure that no child is deprived of his or her right of access to such health care services" (UNCRC 1989). States, the article adds, are obliged to diminish infant and child mortality in whatever situations (IDP children included), ensure provision of necessary medical assistance and health care to all children

¹⁵ Operation Lifeline Sudan is a code name given to all humanitarian efforts by UN agencies and other partners like ICRC, MSF, MEDAIR, Oxfam, etc.

emphasising the development of primary health care. Table two below indicates how such child rights have not been fulfilled by stakeholders, the principle stakeholder – GoS - especially in the south of the country where under-five mortality rates stagger at an average of 170 deaths per 1000 live births of displaced children in IDP camps far much higher than the national average of 94-deaths per 1000 for under-five in 2002 and the infant mortality rate estimated at 64 (UNICEF Country Statistics), 68 per 1000 live births (Global IDP Database). The differences are not for my emphasis, but the severity of the problem in IDP camps is my concern in this paper. According to the data in table 2 the major causes of high child mortality is the high incidence of malaria, measles, and other waterborne diseases like diarrhoea and above all acute respiratory infections which are common in displaced children living in camps with poor environmental hygienic conditions, congestion, poor shelter and limited warm beddings.

Malaria endemicity is highest in the IDP camps in the south, high as ‘45 percent of all reported illnesses presented by displaced children with fatality rate of over 4 to 7 percent (1 to 3 percent ratio)’ (Global IDP Database March 2004). At the same time WHO morbidity figures show that malaria is the main cause of attending hospitals and outpatients’ clinics 67 percent in Juba, Wau and Malakal cities in the south with dozens of camps housing tens of thousands of IDP children.

Table 3: Basic facts and statistics on health for IDP children in camps in southern Sudan

Under-five mortality rates	<ul style="list-style-type: none"> • 670,000 die in Sudan each year (whole country) • 104 per 1000 live births in IDP camps in GoS areas in southern Sudan in 1990s. • 170 per 1000 live births in IDP camps in SPLM/A areas in southern Sudan e.g. Blue Nile Sate. • Measles outbreaks are cyclical and killed 125 displaced children in Nuba areas in July 2002 alone.
Leading causes of child morbidity among IDP children in SPLM/A areas of southern Sudan	<ul style="list-style-type: none"> • Malaria 15-67% of deaths (varies from camp to camp) • diarrhoea 13-35% of deaths • Respiratory infections 11-15% of child deaths in IDP camps.
Maternal mortality in southern Sudan	<ul style="list-style-type: none"> • 509/100,000 live births in GoS areas of southern Sudan. • 94% of deliveries in IDP camps take place outside the reach of health facilities.
Medical personnel availability in southern Sudan	<ul style="list-style-type: none"> • One doctor for 100,000 people. • Western Upper Nile and Bahr el Ghazal have no doctors. • Lack of medical personnel and security had mean the closure of 12 health centres, 170 dispensaries and 700 primary health care units in rural and semi-urban southern Sudan. (Alier 1990:262)

Source: Reconstructed from data available on Global IDP Database adopted from Safe Motherhood Survey (1990 – 1999).

Cole P. Dodge, in *Health Implications of war in Uganda and Sudan*, equally discussed how severe the situation was. "Normal health service delivery systems were broken down forcing doctors, nurses and other health professionals into towns, cities or neighbouring countries in search of peace and employment" (July 2002: 4). These meant that scores of hospitals, health centres and dispensaries were abandoned, destroyed or looted and closed down in southern Sudan. Preventive public health services such as immunization for displaced children and provision of potable drinking water were all discontinued leaving the already children living in IDP camps susceptible to controllable infectious diseases and epidemics like diarrhoea, respiratory infections and measles killing children (see table two above) the highest in the region. The table indicates that in Bhar el Ghazal and western Upper Nile there were no doctors, Equatoria had 100,000 people per doctor yet there was only one available.

Displaced children are the most vulnerable to collective assaults on health and well-being. Curfews imposed by both SPLA and GoS military made access to medical facilities that remained functional difficult to reach by the displaced and thereafter were forced to close down. GoS continued often to slap 'restrictions on travel which hampered the distribution of drugs and other medical supplies to IDP camps medical posts in the south by humanitarian organisations and regional local governments' causing health services referral systems for IDP children and logistic support to break down.¹⁶ More so, the health services meant to cater for the displaced in the camps of southern Sudan were diverted to the needs of the military casualties. The UN report of 2000, reported that 'the few operational hospitals in the south are forced to neglect the regular care of patients or shift them (civilians) to health centres or facilities established by humanitarian agencies like International Committee of the Red Cross (ICRC) with only three main health facilities, doctors without borders (MSF), MEDAIR (which by 2000 started mobile response teams in Upper Nile) themselves limited in capacity, coverage and resources to reach all IDP camps.' The concentration on military needs in total neglect of children injured in the violence, those who fall ill in IDP camps meant that they were not given

¹⁶ <http://www.un.org/rights/impact.htm> accessed 13th July 2004

effective treatment or rehabilitation and hence high child mortality. The picture below of a young 11 year boy who lost one hand and severely damaged the other in a hand grenade accident in a camp in south eastern Sudan in 2000 that appears in UNICEF May 2004 monthly speaks volumes of physical health problems children in IDP camps are exposed.



UNICEF/Ben Parker

Source: May 2004 UNICEF Monthly Report. Deng, 11 showing his physical problems. There are hundreds of children like him who have been maimed and physically handicapped in southern Sudan.

For Deng, a dangerous implication of the breakdown of health facilities due displacement means that he could not receive treatment and was lucky to survive because many of the children who have gone through the same experienced in camps have ended losing their lives. Displacement also means disruption of vaccination programmes for displaced children in camps and their mothers in the war-torn southern Sudan. The camps are real ideal places to provide such services but as earlier on mentioned the restriction, the poor roads, the anti-personnel landmines planted on roads, IDP camps in remote and inaccessible places; hamper the ability of aid agencies to reach those who need the service. Though the report for the first five months shows expanded vaccination outreach by UNICEF and planned to outreach to 48,000 children under one year with DTP vaccine 3 and other vaccines, the majority of IDP children can not be reached with the service because of insecurity, bad roads and GoS restrictions (UNICEF 2004:3).

2.3 Basic housing and shelter

Health is made at home and only repaired in health facilities when it breaks down. How can health be made at home if the basic housing and shelter in IDP camps is rudimentary made of grass and reeds with no beddings? In the 1990s and early 2000 the shelter in IDP camps which I physically saw, was concealed sometimes under big trees or thick undercover for concealment from GoS military planes because they were targets for bombardment. People were reduced to sleeping in the open cold or dig rudimentary bomb bunkers which proved a health hazard for children because many developed pneumonia and acute respiratory infections. New IDPs arriving in new towns or villages for example are reduced to sleeping under trees the lucky squeeze with relatives. Benetti reported that IDPs living in slums outside the planned areas in Khartoum were systematically expelled and their houses destroyed by GoS for reasons best know to it. UNICEF, MSF-Belgium, MEDAIR, WHO, ICRC and other health providers in southern Sudan attribute 'the high prevalence and frequent death of children as a result of acute respiratory infections due to poor shelter and crowded environments.' In Magwi IDP camp host to about 34,000 IDPs one camp I visited, 65 percent were children below 18 years and on making quick scan through ICRC health centre records and registers, more than half of the 2000 children treated in just two months of March and April of 2001 by the unit, was respiratory infections. Surprising in the data was that 80 percent of those treated died within two days of attempted treatment. The medical personnel also reported high incidence of malaria and pneumonia in children. Because of the poor housing and shelter in the camps, children were prone to malarial attack. ICRC by then was planning to purchase treated mosquito nets for all the households to protect children from mosquito bites.

The shelters in camps were constructed using tarpaulins, plastic materials but covered with grass and reeds collected from nearby forests to avoid detection from above. They were typically temporal structures which can not provide adequate warmth and protection from the cold and against the incessant mosquitoes.

Conclusion

“Children require a safe, stable environment in which to grow, an environment that gives them a sense of physical and emotional security. The creation of a sense of community, with provision of surrogate parents for displaced minors, is essential to foster normal growth and development” (Mandalakas 2001:100). The absence of basic housing and shelter, inadequate water and environmental sanitation in crowded IDP camps turn to be the very source of health problems to children. Essential health services like immunisation programmes for children become more of a privilege than a fundamental right for every child as Mandalakas seems to argue. Moreover these services are the ideal backbone of good physical health of children. As explored in the chapter the lack/inadequacy of these services has dealt a big blow to child health. Humanitarian agencies may think that their efforts are not being appreciated, certainly yes, they are doing a good job, but in southern Sudan there is a big difference between assumed situation and the daily reality on the ground.

CHAPTER THREE

3.0 FOOD PRODUCTION, ACCESS, DISTRIBUTION & HEALTH OF CHILDREN

3.1 Introduction

In this chapter I discuss food production, food availability decline, food access, food prices and food distribution in southern Sudan and how they impact on the health of IDP children. These are proximate determinants or direct effects of displacement which themselves operate through other variables to impact on physical health of children. Food production is used here to denote ability of people to grow or cultivate their farmlands to produce their own food. The section points out how decline in food production is occasioned by displacement of people from their farms and gardens. Food availability decline means scarcity of food in an area. The scarcity may be due to decline in production, reduced access to food or poor distribution channels, prices could have gone high due to permanent or temporal scarcities of food which occur can happen when people are displaced. There can be other factors to explain food availability decline but these are of no concern in this paper. The chapter tries to establish the link between displacement and these variables and what consequences thereof which impede on physical health of children.

3.1.1 Historical perspective of famines and food shortage in Sudan

Figure two below traces the history of food shortages and famines and deaths that have ravaged Sudan as a country but also on individual state. Food shortages and famines date back to 1684 the year of the 'great famine' (Um Lahm) which affected Sinnar region in eastern part of the country. "The impact of famine and food shortages were rather unusual; actually, most regions in Sudan; Kordofan, Darfur, Equatoria, and all states in the south of the country were surplus producing areas until late 1960s" (El Sammani 1989: 177, Marakis 1998, Ahmed 1987: 142, O'Brien 1985: 26-7). The causes of the increasing decline in food production include; Sahelian drought and unfavourable rains which and sometimes caused floods, food production abandoned in favour of cash crops with the forceful 'encouragement' of the state, people reduced their production of staple

food grains in order to produce sesame, groundnuts, and other crops (Ahmed 1987:142, O'Brien 1985: 30).

As indicated in the last three rows of figure two below, displacement is another single causality of food shortages and famines, especially the displaced persons in camps remain vulnerable every year. Though food shortages in Sudan has wide ranging causality, the situation in south is attributed to continued recurrence of displacement during the last three decades which Hassaballa and Eltigani explained that during the drought of 1983-85, the rural societies that had been pushed (displaced by war) into fragile ecosystems were the first to starve (Hassaballa and Eltigani: 1995:73). The figure below summarises the history of food situations in the country, but I pay much attention to the last three rows running from 1988 to 2002.

Figure 2: Years of food shortages, famines and drought in the Sudan (1684 – 2002)

Years of Drought or famine	Name and Damage	Area extent	Source
1684	"The Great Famine" (Um Lahm)	Sinnar region	O'Fahey and Spaulding (1974)
1835-38	"Years of Famine"	Central Sudan	Hill (1970)
1836	Cholera spread throughout the country	Central Sudan	Hill (1970)
1885	Slight famine	Central and eastern Sudan	Al-Gadal (1983)
1888-89	Hundred of thousands died	Central, northern, eastern and western Sudan	Slatin Pasha (1896)
1888-89	No rain for a year, crops failed and grain became increasingly scarce. Prices rose to US/40 and then to US/60 for two sacks of dura (sorghum). People sold their children as slaves to save their lives and later bought them back with higher prices.	Central, northern, and eastern Sudan	Duncan (1952), Farwe (1967), Churchill (1899), Holt (1896)
1888-89	Thousand die of hunger and disease	Central, northern, eastern and western Sudan	Mac Michael (1934)
1890	Locusts and mice consumed the products	The Nile area	Farwell (1967), Duncan (1952)
1913	Poor rain, corn brought from India and issued free of charge in distressed areas and cheaply elsewhere.	Mainly northern Sudan	Mac Michael (1934)
1914	"The year of the floor" (floor brought from India because of poor rains	Central Sudan	Honderson (1965)
1920-21	Kurbajet	Eastern Sudan	Egeimi (1996), Krzywinski (2001)
1927	Slight famine	Central and eastern Sudan	Al-Gadal (1983)
1940-41	Fouliya	Eastern Sudan	Egeimi (1996), Krzywinski (2001)
1947-49	Sirar Hokyokoyia	Eastern Sudan	El Sammani (1989), Egeimi (1996)
1958-60	American	Eastern Sudan	El Sammani (1989), Egeimi (1996)
1967-68	Food shortage		Mohammed Salih (1999: 59, 1992: 14-15)
1970-72	Kiloiate	Eastern Sudan	Egeimi (1996, Krzywinski (2001)
1973	Ifza'unna, food shortage	Darfur	Markakis
1984/85	el-Khawaga (eastern, western Sudan) 250,000 died	Darfur, Kordofan and the eastern region	El Sammani 1989, Gore 1991
1988-1991*	About half of the 26 million people are suffering from hunger	Western and southern Sudan	F. Ibrahim (1991)
1991-1999*	War-induced famines 1.5 million died	Southern Sudan	Mohammed Salih (1999)
1994-2002*	War induced famines		Goldsmith et. al (2002: 217)

Source: El Zain, M. (Ph.D. thesis, forthcoming) Environmental Scarcity and the Changing formula of the Nile Hydro politics, The Hague: Institute of Social Studies.

Before 1988, the figure shows that food shortages and associated deaths and malnutrition were a phenomenon of other parts of the country. The south was a food sustaining region; the situation began to show a dent when war and mass displacement was at it's highest in

southern states around the late 1980s. Mohammed Salih wrote that 1.5 million people died of famine in southern Sudan between the periods 1991 to 1999 (see second last row) and he adds that 58 percent of the dead were displaced children in IDP camps (Salih 1999: 14).

3.1.2 Food production

Let me now focus my energies to explain in more detail the above variables of displacement and their direct and indirect effects on health of displaced children. One of the most immediate effects of displacement is the disruption of food production. 'Farmers, who are often women and older children, become fearful of working on plots of land too far from their homes that is if they have not been sent fleeing from their homes/villages.'¹⁷ Displacement reduces the area under cultivation, and the water sources, systems of irrigation, flood control are also destroyed and generally control and care of agricultural land (see table 3 below). Restrictions on movement have limited access to such necessities as seeds and fertilizers and prevent farmers from taking produce to market or access what they need to supplement their requirements because most households in southern Sudan rely on market purchases to meet their food needs and farm inputs. For example sorghum which is the main staple cereal consumed had a small area under production as compared to available land between 1996 and 1998 despite the fact that the area progressively increased (see table 3 below). Other crops like millet, sesame and groundnuts exhibit no good results too. Economic disarray on other hand has heightened unemployment reducing people's ability to buy food. Hassaballa and Eltigani have equally attributed low food production to displacement. They argue that 'though concentration on export crops had put great pressure and practical constraints on the human and natural resources to produce food, in the long run leading to food shortages and famine, the situation was worsened by displacement of local people from their farmlands...' (1995: 28). It was at this same period (1996-98) when the conflict intensified and mass displacement heightened in the region. This meant that the originally rich diet for children in southern Sudan was greatly affected; food available for consumption became scarce because the yields declined, starvation and deaths mostly children in IDP camps was like daily bread and other health problems among displaced

¹⁷ <http://www.un.org/rights/impact.htm> accessed 12th July 2004

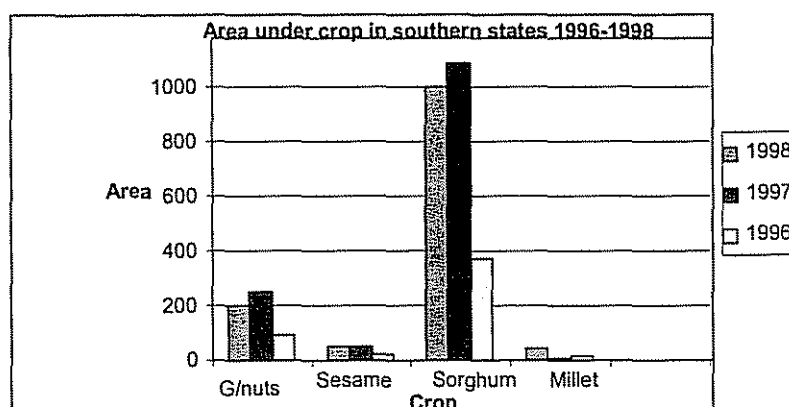
children like wasting, skin diseases related to weakened body immunity due low calorie intake bad signals of health.

Table 3: Southern states crop production, area and average yields statistics 1996 – 1998.

Crop	Year 1998			1997			1996		
	Area	Prod.	Yield	Area	Prod.	Yield	Area	Prod.	Yield
Groundnuts	200	7	67	250	24	135	94	14	159
Sesame	50	1	40	50	2	57	24	1	30
Sorghum	1000	125	147	1085	178	206	368	49	135
Millet	40	4	108	10	1	100	15	1	25

Source: Reconstructed from statistics from tables 5, 7, 8 & 12, Sudan Statistical Yearbook 2000
Area in (000) of Feddans, Prod. In (000) metric tons and yield in Kg/feddans.

Figure 3: Area in thousands of feddans suitable for cultivation in the south.



Sometimes, as it has often happened, deliberate damage to stored food or crops in gardens by GoS forces and the allied tribal militias affected food production and availability. For example in the early 1990s ‘the government’s scorched earth policies in the south destroyed hundreds of thousands of acres of food – producing land. Landmines were panted in agricultural land to prevent farming activities which meant that food stocks dropped, families could not have adequate food, the young and growing bore the consequences. Figure three gives the entire summary and the picture of the four major food crops, that is, decline in area under crop over a period of three years (1996 – 1998) for the main three staple food crops for people of southern Sudan.

Figure 4: Crop production and yield estimates for southern Sudan after displacement

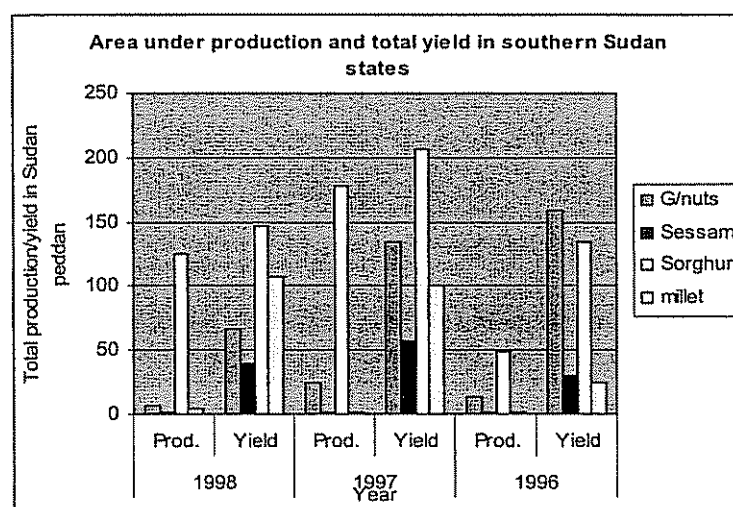


Figure four indicates the trend in area under production and low crop yield during the same period. It is also within this same period that the IDPs in camps in southern Sudan experienced severe food shortages and thousands of young underfed and malnourished children died in their biggest numbers. Table eight shows that 200,000 displaced persons in IDP camps died in southern Sudan children accounting for 68percent of the deaths. Therefore a decline in food production as a result of displacement is like an ignition key to food shortages, price hikes, food availability decline that in a short run and long run affect nutrition or calorie intake hence malnutrition, and other food deficit related diseases which in their own right have a direct bearing on the physical health of displaced children.

Recent assessment findings by WFP (July 2002) revealed that because of fighting in Wau and the capture of Kapoeta town by SPLA forces, caused retaliatory aerial bombardments by GoS disrupting farming and weeding activities in the surrounding areas. Most of the households in the area lost that year (2002) cultivation season and the harvest certainly making them food insecure in the coming year. Trading activities equally stopped since the town capture, access to it by road was extremely difficult due to landmines. Some people may rightly argue that if food production declines in an area then the markets will cover the deficit. This has not been easy in southern Sudan because both SPLA and GoS restrict civilians from crossing from one area controlled by one to the other including

food supplies. Any food which manages to enter is either confiscated or never given back or you loose your life altogether for breaking the rules. Safe passage and free movement of IDPs was only permitted in 2002 when peace talks kick in Nairobi but still the roads are mined and risky.

Displacement also took its long hand of severity on the livestock. 'Around Kongor area, the massacre of cattle of IDPs reduced livestock from around 1.5 million to just 50,000' (ibid: 2), this created particular problems for young displaced children of the Nuer tribe in camps who rely heavily on milk as their basic diet. The resultant outcome was high levels of malnutrition (table four below) among displaced children of Nuer tribe in three big IDP camps situated in their outskirts (Benetti Cathy, March 2003). What these mean is that children involved in what Mandalakas refers to as 'complex humanitarian emergencies' (like displacement), 'are at risk for a number of poor long-term outcomes. Children exposed to malnutrition during the first two trimesters and early in life are at risk for poor cognitive, behavioural and psychological function' (Anna Mandalakas 2001:97).

Table 4: Acute Malnutrition rates in November 2002 among displaced children in IDP camps

Town	Malnutrition rates	IDP Population
Rubkona	38.4%	25,004
Bentiu	24%	26,575
Jonglei State	30%	100,053

Source: From Benetti, Cathy, (March 2003) Sudan: IDP Crisis Worsens in Norwegian Refugee Council.

3.1.2 Food access and distribution

In a report by Operation Lifeline Sudan – Southern Sudan Sector¹⁸ a combination of flight bans, restrictions due to flooded airstrips and insecurity, resulting from tribal violence in parts of Unity, Western Upper Nile and Eastern Equatoria regions denied access to 140,000 targeted beneficiaries' displaced persons in IDP camps from receiving urgently needed food assistance. In an earlier survey (September 1999) undertaken by MSF – Belgium in Wanding and Akobo districts (see table 5 below) Jonglei province,

¹⁸ Operation Lifeline Sudan is divided into two sectors Southern Sudan sector for areas under SPLA control and Northern sector for areas under GoS control both in the south and the rest of the country. And Operation Lifeline Sudan is an emergency response by UN agencies and its partners to the crisis in Sudan.

indicated that though there were no cases of oedema, but severe wasting was still high at 2.8 and 2.0 percent and wasting at 21.2 and 17.0 percent of 60,000 IDP children surveyed respectively.¹⁹ Overall malnutrition rates ranged between 23 and 39.9 percent in displaced children in camps in southern Sudan in 2002 while at the same time 30 percent of the displaced children and adults in the south had food intakes below minimum energy requirements (UN, November 2002: 102). In another survey of displaced children in IDP camps in Jonglei state - Bei town, IDP children suffered the highest levels of malnutrition, the highest rate (40 percent) reported in southern Sudan after fleeing from oil rich areas (OCHA 17th November 2002). At the same time conditions for IDPs around Mayom whose diet depends on cattle products, had deteriorated dramatically due to insecurity, displacement and restricted grazing movements (Benetti, March 2003: 6). Korn adds his voice that in some IDP camps “child malnutrition rates record as high as 70 percent in mass displacements” (Korn 2000: 16). From the survey results presented in table five below, displaced children in IDPs camps are susceptible to malnutrition and mortality which has to do with limited access to food and manipulated distribution mechanisms a manifestation of reduced food production. 4000 displaced children were surveyed by MSF-Belgium in two IDP camps and the results are summarised in the table below.

Table 5: Results of nutritional assessments of 4000 displaced children in IDP camps in Jonglei state 1998-1999

Indicator	Wanding	Akobo
Wasting	21.2%	17.0%
Severe wasting	2.8%	2.0%
CMR (25/12/1998 to 9/9/1999)	2.7/10,000/day	2.0/10,000/day
Under-five mortality (25/12/98 to 9/9/1999)	1.9/10,000/day	2.5/10,000/day
Food distribution in August	53.2%	68.7%

Source: OLS Southern Sector – survey by MSF-Belgium in September 1999.

The survey results indicated that ‘the problems of nutrition in these areas was still high by September 1999 as compared to an earlier survey in April of the same year when wasting was at 33.4 percent’ (ibid). The situation had improved by time the survey was completed because it was after a harvest and a general food distribution.

¹⁹ <http://www.unsystem.org/scn/achieves/rmis29/ch08.htm> accessed on 14th August 2004

Good physical health of a child depends on food; how it is distributed/accessed, the way children are fed, hygiene and the time parents have available to care for their children. It is a broad day fact that malnutrition can affect all aspects in a child (physical mental and psychological), it causes the greatest mortality and morbidity among young children, especially those under three years of age (see table 2 above). During displacement mothers experience hunger, exhaustion and distress that make them less able to care for their children, endangering breast feeding tradition because of mother's inability to produce milk. Artificial feeding is particularly risky at all times, and is even more dangerous in IDP camps where there is limited access to clean safe drinking water; hygiene is wanting and poor sanitation. Therefore food availability and access to mothers in situations of displacement determine child survival. The general disruption in routine by displacement separates mothers from their children for long periods as they move out to look for food, water and other necessities, breakdown of social structures and networks.

Not only does displacement disrupt normal food production, it also cuts off relief food distribution lines and increases food requirements with continued fighting and un-safety of the roads. In the south, the manipulation of food supplies has always been a significant weapon of war against the displaced civilian population recently ruthlessly adopted. For example in the 1980s and 1990s, the Sudan government employed scorch-earth tactics to destroy hundreds of thousands of acres of food-producing land. Grain stores were targets of bombing campaigns by Khartoum government.²⁰ For example in July 2002 FEWSNET reported that because of fighting in Bieh area of Jonglei state that resulted in death of one aid worker and three others abducted, all on going humanitarian interventions were subsequently suspended which worsened already high malnutrition rates and disease incidence among displaced children in camps in Jonglei state because food security, food distribution and access to safe water in the area which had been entirely dependant on food aid since 1999 was affected. Mothers became helpless and unable to meet the nutritional needs of their children resulting in the severe wasting and wasting for displaced children in Bieh IDP camp (table above). The lack of food

²⁰ <http://www.unicef.org/sowc96/5famdis.htm> accessed on 15 August 2004

combined with stress of flight, have killed 20 times more children than have armaments. Narbeth Simon and Mclean Calum rightly observed that the displaced are often disadvantaged in terms of their access to public facilities, compared to host or the indigenous (Narbeth and Mclean 2003:1). And when 'displacement is combined with drought and corrupted food distribution processes, restrictions and denials, (the access to humanitarian assistance and ability to survive and regain their economic security) the death toll of displaced children in camps is enormous.' (Gidske Andersen 2001: 35). For southern Sudan during 1992, a UNICEF (The State of the World's Children 1996) study established that half or more of all the displaced children in IDP camps under five on first January were dead by 31st December of the same year – and around 90 percent of the dead was from the interaction between malnutrition and disease (UNICEF: 1996).²¹ At the same time WFP annual needs assessments for 2002 and 2003 (table six below) revealed that the outlook in most regions was favourable than in previous years. People previously displaced by conflict and suffered acute food security had mostly returned home and become agriculturally productive again)²². An indication that displacement inactivates people's ability to produce their own food, disrupts the markets, livelihoods and income earning systems reducing them to mere dependants on relief food aid but if given chance to go back to their farmlands the situation changes. Table six on WFP, ANA and FAO assessment for food estimates for 2003 shows the variations in food requirements for IDPs per state over the year. The levels of food relief requirements had reduced from state to state and according to the assessment this was because of the increased return of previously displaced people to agricultural production again and ability of majority of households to afford grain in markets due to opened up trade routes from south and east of the southern Sudan a key achievement of peace agreement between SPLM/A and GoS (WFP, FAO January 2003).

²¹ <http://www.unicef.org/sowc96/5famdis.htm> accessed on 20th August 2004.

²² (<http://www.unsystem.org/scn/archives/rnis29/ch08.htm> accessed on 19th July 2004

Table 6: Food Estimates for 2003 from WFP, ANA and FAO Crop Assessment Mission

Region	WFP Food (MT)	FAO Food (MT)
Upper Nile/Jonglei	32,286	42,000
Bhar el Ghazal/Lakes	33,500	82,000
Equatoria	5,636	15,000
South Blue Nile	2,263	--
Nuba	6,955	--
Total	80,640	139,000

Source: FEWS NET Southern Sudan; Food Security Report January 2003 (Annual Needs Assessment)

The assessment also cited constraints in all areas regarding enhancing food and livelihood security for instance there were not enough farm tools and seeds for full utilisation of areas cleared and pest attacks reduced crop yields in some areas like Upper Nile, Jonglei, Bhar el Ghazal and Lakes, therefore generating supplementary food requirement. Furthermore, during the first half of 2001, the GoS launched an offensive in the Nuba Mountains systematically ransacking, burning homes, crops and food grains stored (IDP Global Survey: 2002: 75). As this was going on in Nuba Mountains, 50,000 new people were displaced by fighting in Liech in Unity State; they were reported selling their livestock in exchange for grain to survive (FEWSNET 20 Feb 2003). Many IDPs especially in these areas spend all day looking for food, struggling to survive on a diet of wild foods and water lilies according to FEWSNET. As a continued security threat and spiral of population movements continued, many areas and particularly those displaced remained short of food in 2002.

The food security situation varied across southern Sudan at the start of January 2003. There were significant pockets of high food insecurity following poor harvest attributed to erratic rains and more worse insecurity which had caused fresh displacements and re-displacement of people already uprooted from their homes. As a result, FEWSNET reported that a total of 1,850,000 people were projected to be food insecure until the harvest period in September of the same year. Out of these, 700,000 would be highly food insecure and are mainly IDPs facing food deficits of 20-30 percent of annual food needs even after expanding all available food sources (FEWSNET: March 2003:2). In places like Magwi, Yei, Kajo Keji, Juba, Torit in Equatoria continued attacks by the Ugandan rebel group, Lord's Resistance Army (LRA) kept farmers away from their

fields in 2002, reducing cultivated land by 65 percent. In addition, the LRA and deserters from SPLA looted food reserves. Els de Temmerman confirms the LRA mayhem in IDP camps on her visit to LRA camps while searching for 30 children abducted in a school in northern Uganda. "The LRA child recruits are sent to steal their food from the Dinka people in south Sudan who are themselves starving" (de Temmerman: 2001:81). In response the Dinka people have armed themselves to protect their camps from LRA looting and killings. But success in ending the conflict in northern Uganda would have a positive impact on food security in both Magwi, and Torit areas of southern Sudan as this would facilitate both increased food production by IDPs who return to their homes.

From the discussion and data presented above, IDPs in southern Sudan are very vulnerable to food shortages and hunger because they are widely dependent on sporadic humanitarian aid. The food situation worsened in March 2002 when up to "45 locations in the south were cut off-limits to aid agencies, depriving 870,000 IDPs food aid" (IDP Global Survey Regional profiles: 2002: 78). At the same time, UN appeal for Sudan was under-funded during 2000/2001 and 2001/2002 – three quarters of food budget provided, a third of non-food items was funded, as a consequence two problems were faced: one as food supplies were reduced malnutrition in states with highest IDPs (Bhar el Ghazal, Upper Nile, Equatoria and Unity) recorded 30 to 40 percent malnutrition rates some camps even peaked 70 percent, secondly long-term projects meant for IDPs women were faced out (ibid). In September of 2001 alone, surveys conducted by UN in five IDP camps in northern Bhar el Ghazal (which hosts the biggest number of IDPs in the south) revealed a dramatic under-five mortality rate of 6.5 per 10,000 everyday.

According to UNIRIN – CEA, GoS flight denials obstructed the opportunity to assist displaced children in IDPs camps in Upper Nile, Bhar al Ghazal and Equatoria as such WFP was only able to deliver two-thirds of food ratios and in Bhar al Ghazal 150,000 IDPs were out of reach by WFP (UNIRIN –CEA 12 July 2001). Likewise, SPLM/A restricted access by humanitarian agencies to IDPs in GoS controlled areas and often confiscated food or took control of distribution inspite of the December 1999 tripartite agreement signed by the UN, the GoS, and the SPLM/A to allow unfettered access to

displaced children in IDP camps. In response to the situation where aid agencies were caught up in the middle, two measures were initiated: one start two separate programmes one in GoS controlled areas; Operation Lifeline Sudan – Northern Sector and the other operating in SPLM/A controlled areas called Operation Lifeline Sudan – Southern Sector. The main loophole in these operations was the failure to observe the principle of neutrality which so much affected the operations and at times attracting bans and denials. More worse the food was not reaching those it was intended because the commanders diverted the food and distributed it according to their will not need.

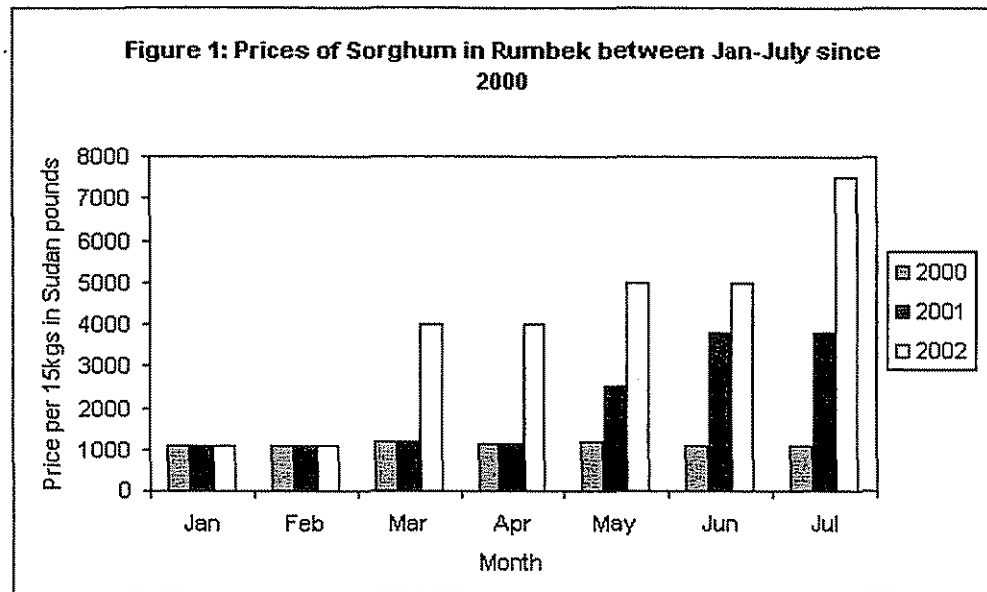
3.1.3 Food prices

Apart from affecting the availability, access, distribution, and food production of a population, displacement is closely linked to price inflation of food stuffs in markets in southern Sudan because of scarcity in supply. Alex de Waal writing in his book, *Famine Crimes* pointed that, apart from drought and other natural disasters, the 1990/91 famines in southern Sudan were exacerbated by speculation and government crack down on traders which led to price hikes of main staple grains. The food prices he argues rose by a factor of four between June and September and therefore frequently no grain at all was available in the market (De Waal: 1997:100-101). Though GoS has often been adamant and wanting to control prices of grains below reasonable limits, it has always failed because the traders buy off all grain available in markets and stock speculating when the situations worsens or when humanitarian organisations want to purchase for distribution to IDPs in camps, for planting and food. This speculation affected the displaced that did not have land to cultivate their own food and dependant on their labour as the only source of income. The table below shows how prices of the staple grain for southern Sudan fluctuated in a period of three years.

Table: 7: Sorghum prices in Sudan pounds for the first seven months in Southern Sudan 2000-2002

Year	Jan	Feb	Mar	Apr	May	Jun	Jul
2000	1100	1100	1200	1150	1200	1100	1100
2001	1100	1100	1200	1150	2500	3800	3800
2002	1100	1100	4000	4000	5000	5000	7500

Sources: World Food Programme/Technical Support Unit data



Source of Data: WFP/TSU

The figure illustrates the increases in sorghum prices in Rumbek town (Lakes region) since February through March of 2002, the highest recorded since 2000. This significant increase in sorghum prices continued to affect access to food in Rumbek with about 75 percent of its habitants IDPs hence increasing time allocated in search for food. At the same time FEWSNET reported that livestock prices had fallen significantly worsening terms of trade for IDP households that must purchase their cereals. Actually some households were forced to consume meat increasingly, while others opting to sell livestock at very low prices. Other IDP households were walking long distances to the northern parts of west Equatoria region of Mudri to purchase grain where it was reportedly cheaper (FEWSNET: August 2002:4). In another report it is mentioned that "IDPs in Wau town could afford to supplement WFP half food ration due to high sorghum prices rise" (Global IDP Database)²³. As such, parents spent most of the time working to feed their children and meals per day were reduced to one which is not sufficient to provide a growing child with calories it requires for physical health growth of a child. In 2001, while on a humanitarian visit to some IDP camps in southern Sudan, I had chance to talk to some displaced children in camps on the meals they had per day. Even without an answer you could visibly see recognisable effects of one meal a day of sometimes watery maize porridge on child's physical appearance. Access to the main

²³ <http://www.db.idproject.org/sites/idpSurvey.nsf/wViewContries/39858A30B4B5...> accessed 24th/7/2004

staple of sorghum in the Lakes state, particularly in Rumbek with over 100,000 IDPs remained low due to reduced availability leading to extremely high prices as shown in the figure above. In another related incidence, attacks in July 2002 by GoS planes and government backed militia in Jonglei/Upper Nile, displaced populations into East Bhar el Ghazal and lakes region leaving behind their crops in fields un-harvested. Though part of these people had fled with their cattle, they certainly were not able to meet their food needs during the hunger period when grain is scarce and highest in price. Created food shortages has been used as an opportunity for political population control, because those who die are mainly displaced children without stable livelihoods for their parents, so if you want to survive you either support us or die.

Conclusion

The long-running proliferation of displacement in southern Sudan apart from breaking down survival mechanisms continued to exacerbate the situation by impeding farming activities and distribution of food relief assistance especially to the economically unstable IDPs. The data and qualitative evidence presented in this chapter points to three conclusions; first, displacement has a direct impact or effect on food production, food availability decline, food access and distribution, and on food price fluctuations because of scarcity created. Secondly, the available family resources of the displaced are overstretched because there are no fall back positions. Thirdly, 'despite the effort of the international community and the WFP, high rates of malnutrition, including protein energy malnutrition and micronutrient deficiencies, have been consistently ravaged displaced children and populations' (Mandalakas 2001:99). The ability of the displaced in camps to maintain their food intake and ensure survival of their children is put to test and most often overwhelmed explaining the high malnutrition rates. The empirical evidence on this may be limited due to limitations that have to do with data availability and dependence on secondary data, but the fact remains that displaced children in IDP camps are vulnerable to slight shocks on food situation.

CHAPTER FOUR

4.0 HEALTH RIGHTS OF CHILD: VIOLATION AND SERVICE PROVIDERS

4.1 Introduction

This chapter discusses health rights of displaced child and how such rights are violated or abused in camps. The analysis and presentation relies on documented evidence by humanitarian and rights organisations active in the area. It is great importance to note that health rights can not be looked in isolation of other rights like right to life and development, right to food and the right to be protected from abuse and other violations.

4.1.1 Health rights of displaced child in IDP camp

'Sudan ratified the Convention on the Rights of the Child on August 1990' (OMCT October 2002: 9), though it has not taken action on other optional protocols and Conventions like the African Charter on the Rights of the Child. In a Government second Report submitted to Committee on the Rights of the Child, Sudan had made the Convention part of national legislation, thereafter binding law and commitment to children's rights. According to OMCT sources²⁴, 'there is still a concern on the inadequacy of such instruments to serve to protect especially displaced children right to health in IDP camps' (ibid: 10). According to the International Crisis Group, "the reality is that generations of children, particularly in the southern Sudan have never had sustained opportunities to access basic health care...clean water or adequate food."²⁵ Therefore, it is not the absence of laws or legislation that displaced children suffer such injustice and negligence but deliberate lukewarm and passiveness of the state to act.

In chapter two I discussed on how health facilities were destroyed sending health workers fleeing for safety. I also mentioned how necessary health services like immunisation programmes were disrupted depriving children from the most needed vaccines that are important to prevent them from diseases. And despite the efforts by MSF-France, MSF-

²⁴ Sources include Sudanese Organisation Against Torture annual report (2002), Amnesty International Annual Report 2001-2002, Human Rights Watch.

²⁵ The international Crisis Group is a private, multinational organisation working in 5 continents through Field-based research and advocacy to prevent and contain conflict (<http://www.crisisweb.org>).

Belgium, MEDAIR, UNICEF, ICRC and to some extent local regional governments to provide health services to displaced children in IDP camps, the insecurity and the number that needs the services is overwhelming make the services inadequate. UNICEF for example managed to immunise only 48,000 displaced children in the first five months of this year and yet there are millions out there. The previous year (2003) UNICEF coverage was even worse, like wise MEDAIR, ICRC. (UNICEF Monthly Report May 2004). Though the Convention on the Rights of the Child obliges governments or fighting factions to allow health services to displaced children, the opposite has been practiced in southern Sudan, for example IDPs in Abyei were discovered in a survey that they needed health services and general health education in 2001. The health facilities are few; ICRC has only 3 hospitals, and few more health centres, dispensaries and primary health care centres. It's until 2003 that MEDAIR started mobile health care services targeting displaced children UNICEF has also a few functional health facilities and with a ceasefire agreement they started renovating those destroyed during the war late last year (2003). Because of the limited facilities and services, both major and minor ailments for displaced children in camps cannot be attended to which may incapacitate a child's health permanently.

4.1.2 How health Rights of child violated in IDP camps?

Good physical health of a child entails many things. Article 6 of CRC emphasizes that "every child has the inherent right to life" (CRC: 3, African Charter article 5). The state is obliged to ensure child survival and development at home or in displacement. The contrary happens, for example, 2.7 children die everyday in IDP camps other camps experience as high as 6.5 deaths everyday, let alone dozens who die out there and are not recorded. This death rate is associated to explosive epidemics of diarrhoeal disease caused by *Vibrio cholerae* 01 and *shigella dysenteriae* type 1 and malnutrition as high as '62.2 percent in IDP camps like Panthou and Pakor, 61.4 percent Global Acute Malnutrition' (UNICEF Newslines 2001, FEWSNET July 2004).

After three weeks of displacement in renewed fighting in June-July 2002, acute malnutrition rates among children under 5 years old ranged between 18 and 23 percent. It is also common that displaced children with a recent history of dysentery and those in

households headed by women in IDP camps were at higher risk of malnutrition. A recent documentary by BBC revealed that “30 children die every week in Southern Sudan (Rumbek Hospital) due to diarrhoea caused by a *vibro* contracted from dirty contaminated water” (BBC: 15th June 2003). Any loss of a child’s life is a violation of that child’s right to survival and development. This is reason WHO (2001) has argued that, ‘the prevention of such high mortality due to diarrhoeal disease epidemics in displaced populations relies primarily on the prompt provision of adequate quantities of disinfected clean water, basic sanitation, community outreach and effective case management of ill patients’²⁶ This has not been possible in extreme displacement situation in southern Sudan, and aid workers who have tried to make an effort end-up being kidnapped or denied access to children, sometimes supplies looted or even killed.

Article 32 protects the child from performing work that is hazardous to their physical health and what may be directly harmful to a child (CRC: 10). Children are forcefully recruited or conscripted into the fighting ranks of the either party to the conflict. Paul Richards (1996) gives the example of Sierra Leone, Els de Temmerman (2001) narrates the story in northern Uganda, UNICEF (2003) reports of 15,000 children serving in SPLA and just about 3,500 were demobilized. There are true stories of children and young people who have experienced the brutality of adult world. Temmerman narrates in her book a saddening story of 30 young girls who were abducted from their school in northern Uganda by rebels of Lords Resistance Army and ended up in rebel camps in southern Sudan where they were handed over to top rebel commanders as “wives” and gifts for allegiance (Temmerman: 2001: 25). The psychological trauma such children go through impacts on their physical health, ‘regress developmentally; they start bedwetting, hyperactive or inattentive...’ symptoms of impaired health (Mandalakas 2001:101)

According to International Crisis Group (2002) report, “...humanitarian assistance was manipulated cynically and devastatingly as a war strategy by both sides in southern Sudan, throughout the nineteen-year old war. On average, the GoS had denied access to approximately 25 locations of IDP camps in the south per month, in violation of

²⁶ http://www.who.int/disasters/hbp/general/documents/hum_case_fire_2001.pdf accessed 20th July 2004

international law, including the Convention on the Rights of the Child and Geneva Conventions, which call for the special protection of children in armed conflict. Food and medical treatment denials, along with other war tactics have endangered children's physical and mental well-being."²⁷ Combatants have regularly 'manipulated the massive amounts of humanitarian relief sent to encamped populations in southern Sudan. Government officials have placed tight controls on aid deliveries, often blocking food shipments to needy displaced children, while many rebel commanders regularly have confiscated a percentage of food relief distributed in the south.'²⁸ These tactics have been consistently used, particularly during periods of drought and seasons when aid is most necessary. And yet articles 24 and 27 oblige Sates Parties to "take appropriate measures...to combat disease and malnutrition...through, *inter alia* ...through the provision of adequate nutritious foods...' (OMCT 2002:14). This is what is on paper, but reality on the ground shows that such programmes and support has eluded the displaced children of southern Sudan. Starvation internationally is illegal, but for southern Sudan can be said is legal. Children who are the most vulnerable members of displaced persons suffer in the advent of deprivation of sufficient, nutritious quantities of food necessary for their good physical health and development. For example, 60 percent of those who died in Mariam and Aweil IDP camps were malnourished children below 5 years (table below). These deaths occurred because of violation of displaced children right to food.

Table 8: Reported deaths due to famine and disease – 1988 in Southern Sudan

Place	Number of deaths
IDP camps bordering Uganda	250,000
El Mairam IDP camp	1,000
Aweil IDP camp	8,000
Total Deaths Southern Sudan 1998	200,000

Source: Abdel Ghaffar M. Ahmed, The Human and Ecological Impact PP 123, last row Sudan catholic Information office data July 2000.

From the table areas bordering Uganda are controlled by SPLA and GoS banned all flights to the area whether humanitarian as a punishment for people because they

²⁷ <http://www.watchlist.org/reports/sudan.report.php> 2003 accessed 24th June 2004

²⁸ http://www.refugees.org/world/articles/wrs02_Africa4.cfm#sudan. Accessed 24th June 2004

supported SPLM/A. It is also the first places where people were relocated and placed under camps for protection from government troops and militias by SPLA. The other two are counties in Bhar el Ghazal and Jonglei.

“Armed conflict is a major public health hazard that cannot be ignored.”²⁹ And as already discussed in chapter two, Children succumb to infection of preventable and treatable diseases and malnutrition, because the health infrastructure in southern Sudan has been destroyed. Furthermore, trained health personnel and medicine are not available or looted. For example, had it not been for the ICRC, MSF-Belgium, France, UNICEF, MEDAIR and others trying to run health facilities (temporal) and only two hospitals in such a vast area twice the size of Uganda, the situation would be worse. This is a breach of guidelines on the treatment of displaced children in armed conflict and article 24 of CRC which states that, ‘the child has a right to the highest standard of health and medical care attainable.’ (CRC Art. 24: 7). In Southern Sudan, the first things that GoS war planes targeted according to Mohammed Salih, et al 1990, Sudan Catholic Information Office monthly reports of 1998, health facilities were looted, bombed and remain dilapidated with no services.

Every child has a right to grow up in a family and in the protection of parents. In 2000, it was estimated by UN agencies in Sudan that, more than 50,000 children in the south had lost both their parents as a consequence of the civil war and another 170,000 had no information about their biological parents as a result of displacement (Opcit: 6). There are hundreds of children for instance in Ethiopia, northern Uganda, Kenya refugee (e.g. Kakuma) camps and even within southern Sudan or in Khartoum camps unaccompanied and denied the right to a family and care derived. Young girls commonly regarded as wealth due to traditions of bride price, once orphaned are particularly at risk of being exploited. They are pushed to forced child marriages, abduction, and slavery particularly common in IDP camps in the south and reportedly worse in Khartoum where parents marry their daughters to wealthy Arabs in the north to survive (HRW 1999: 14). Early marriage is not good for a young girl who is physically still growing and subjecting such a body to early child birth lead to maternal mortality (see rate in chapter two).

²⁹ <http://www.un.org/rights/impacts.htm> accessed 18th July 2004

One of the most neglected right of displaced children is the right to protection while in displacement. Roberta Cohen (1998:65) wrote, 'when children and women are internally displaced, however, they have no comparable legal or institutional structure to turn to. Because they remain within their countries of origin, it is generally assumed that they will receive the protection of their governments.' But not all governments have resources or if they have it, they are not willing to spend it to protect and assist their own citizens; Sudan government has even deliberately obstructed international access to displaced populations with humanitarian aid. Organisations pick and choose the situations in which they wish to become involved on the basis of their mandates, resources and other criteria. The result is that the needs of displaced children are met in varying degrees in some countries but neglected in others. When this happens, children rights are heavily violated.

4.1.3 Who are the duty bearers?

Someone somewhere is responsible for inaction or for the mess and the violations of children health rights. The table below summarises the identified actors/service providers (though not complete) active in Sudan in four major categorisations; relief food providers, health providers, rehabilitation, and human rights watchdogs.

Relief food	Health	Rehabilitation	Human rights
ICRC WFP MEDAIR FEWSNET/USAID FAO Tear Fund Merlin Supraid	ICRC HealthNet International MEDAIR WHO GoS/Provisional governments UNICEF MSF Belgium, France, etc Mercy corps	Oxfam Save the Children Mercy Corps GoS FAO World Vision	OMCT (SOAT) Human Rights Watch GoS UNICEF

The functions are not fixed; some actors provide more than one service or perform more than one function. Government is under obligation to provide all the above services. Each of these should be judged by what they have done for the displaced children. GoS the would be provider is also behind the displacement in the first place.

Conclusion

Internally displaced children need protection and ensuring that their health rights are provided. Recurrent displacement which separates children from their families and communities, denies children the right to family and the protection and care that these social structures provide. Whether on their own or with their families, internally displaced children are typically in greater risk and danger of malnutrition and disease because their right to food and medical services have been violated. Displaced children in IDP camps suffer the violation of their right to good and warm shelter, the right to clean safe drinking water, the right to free playing environment free from violence, basic medical services immunisation inclusive, the right to warm clothing, and the right to live in a clean hygienic environment that ensures their survival and development. The international community is guilty of doing nothing or little to save the dying children in IDP camps in southern Sudan and to provide for their fundamental rights.

CHAPTER FIVE

5.0 CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter concludes the discussion in the paper. The conclusions are based on the findings, empirical data presented in chapters two, three and four above. Last but not least, make some recommendations.

5.1.1 Conclusions of the study

I have discussed the conditions in camps and how they impact on the health of children in chapter two. Conditions such as water and sanitation, security and insecurity in camps, essential health services in camps, basic housing and shelter for children. In chapter three, the discussion focussed on food distribution, access, production, prices and food availability decline in relation to how they impact on the physical health of displaced children. The fourth and last chapter of presentation, analysis and interpretation of data relating to children, camps and health handled the inherent rights of the child to health and health care services. From the findings I draw the following conclusions;

1. Actors in humanitarian emergencies like displacement do not recognise explicitly children's vulnerability. Recognition of this vulnerability helps in minimizing what Mandalakas (2001:97) called 'children's risk of poor long-term outcome...attributed to a number of factors, including limited reserves, involvement in critical periods of physical and cognitive growth...' on their physical health.
2. Secondly, the data points to the direction that there are differences and recognisable variability in displaced children's resilience and coping tendencies. The variability is determined by different factors or conditions that can be changed and not changeable.
3. The data on precarious food shortage situation among displaced in IDP camps and the severe nutritional insults on children points to their great physical health development problems. Along the same reasoning, Mandalakas (2001:99) argues that 'such deficiencies may be capable of increasing the risk of antisocial

behaviours in displaced children.’ This is too dangerous for southern Sudan where widespread severe nutrition deficiency is exacerbated by war induced displacement especially after societies are resettled (later life after displacement).

4. Though camps are indisputably corridors of safe relief passage and other services access to children, the insecurity, the bombardment of civilian targets and lack of respect for humanitarian organisations has led to first the physical health problems to children and secondly to the loss of many lives due to diseases rampant in congested, overcrowded with limited clean water and sanitation facilities. Displacement has will remain a danger to the health rights of the child and must be fought politically, economically and socially if its long-term effects on children have to be avoided in the first place and overcome altogether.

5.1.2 Recommendations

The efforts by the many actors or service providers trying to alleviate the suffering of displaced children in southern Sudan IDP camps, is a job well-done. They have within their capacities to provide food, shelter, delivered emergency medicines and medical services, established temporary feeding centres for the severely malnourished displaced children, advocated for the rights of these children, and importantly lost lives of their workers to the cause of displaced children. Despite all the above, let me make the following critical recommendations to GoS, humanitarian relief agencies and other actors.

1. Children caught up in displacement should not be viewed only as victims or witnesses of the situation affecting whole communities but their agency and hence participation must be enshrined in the work of all service providers. The agency of the displaced child has for long been ignored in complex humanitarian emergencies like displacement and yet the main actors claim to be using a rights based approach to implement their activities or in design of interventions.
2. There is an urgent need for service providers to address the security and protections needs of displaced children and their parents. It is unfair to only focus on immediate needs like food, shelter etc when the displaced are living in fear of being slaughtered or attacked overnight. Much of the work of humanitarian agencies in southern Sudan for the displaced has been focussed on immediate

needs without caring for the security needs. But even in providing the so called immediate needs, the displaced have no input in it. It is imperative and important as Wendy Davis has argued "...find out what internally displaced people themselves perceive to be their needs and what their aspirations are" (Wendy 1998: xi). There is need to undertake both advocacy and practical measures to give IDPs more protection.

3. It is the recommendation of this paper that during information collection, to avoid disparities in data between the various groups of displaced persons and the designed interventions, agencies and government needs to invest in the information collection process. IDPs tend to be regarded in numerical terms rather than as women, men and children or age cohorts with unique needs and abilities. Roberta Cohen singled out what data is required for; 'data is required on the number of single women, female headed households, girls of school age, children of various age cohorts and pregnant women to facilitate programming' (Cohen: 1998:68). These must be seen as central to planning and implementation of relief responses. It's probably true that there is difficulty in collecting accurate consistent information regarding displaced children in camps, but it should not be a scapegoat for not doing it all. A simple rapid registration method can be useful in volatile situations like continuous displacements. The duty bearers are encouraged to invest in accurate information collection and quality data management systems for IDPs in general.
4. Today there is a fundamental question one may ask, 'are relief operations mounted for the displaced focussed on technical interventions and a programme that was/is provided for people rather than with people?' (Demusz, 2000:15). This is characteristic of emergency programmes for IDPs, where the priority is on life-saving measures and large-scale response and where top-down solutions are imposed rather than in a participatory manner. This may be because what IDPs want is often unclear and the voices especially of children are lost in the process. Interventions always make assumptions about children's basic needs in setting up services. Field personnel who work everyday in specific contexts feel that they are in touch with the IDPs needs even if beneficiaries have not been involved. A

displaced woman in Indonesian war ravaged Kilinochchi district summed it up when she said,

“Our problem is not a shortage of cooking pots or shelter or food. Our problem is the war and displacement. If you offer cooking pots, we will take them; but if you ask what you can really do for us, we will say help stop fighting. If you can do anything to help bring peace we will be able to take care of ourselves and our children in particular and stop being a burden to you” (ibid 2000:17). It is the recommendation of this paper that the beneficiaries’ voices be the basis of emergency programmes for children displaced.

5. David Korn, Roberta Cohen and Francis Deng criticised humanitarian agencies for ineffective coordination of interventions in southern Sudan. Korn particularly wrote, ‘everyone is in favour of coordination but no one wants to be coordinated’ (Korn 2000:57). The lack of coordinated efforts created a sense of competition and tendencies to impress donors therefore serving their interests not of IDPs. This could explain why there is insufficient reintegration and development support for IDPs – interest is quick quantifiable interventions that are temporal and short term – there is need for successful return and rehabilitation of especially displaced children. It is my recommendation that quick impact projects like what UNHCR did with Mozambican returnee refugees to restore roads, schools, health care facilities and counselling services for children are adopted. But above all there is need to provide income-earning opportunities to IDPs which are long-term projects for self-sustenance even in camps or appropriate exit strategies for sustainability.
6. Finally, more research into the long-term impact of displacement on the physical health of children after encampment should be done to examine the relationship more closely. Health rights are fundamental to displaced children and any denial is tantamount to criminal act against child physical development.

5.2 Final conclusion

Numbers of people highlight the "problem" of child health in countries such as the Sudan a reserve of social capital that the country will need to rely upon when the war ends. If a generation of children is effectively incapacitated psychologically, socially and developmentally, what is the fate of the country in a time of reconciliation, resettlement and reconstruction? Displacement is therefore a symptom of a serious crisis in nation building which has international ramifications. Displaced children are a microcosm, a sample of the wider community devastated by the indiscriminate and destruction characteristic of most internal conflicts often compounded by racial, ethnic and religious animosities that provide political entrepreneurs with tools for manipulation. While refugees have an established system of international protection and assistance, the internally displaced fall under the domestic jurisdiction and responsibility of the state, without specific legal or institutional basis for their protection and assistance. For the same reason, internal displacement which has devastated the health of children poses a challenge to the international community to develop norms, institutions and mechanisms in the first place preventing it, addressing its consequences on children physical health and finding durable solutions.

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