

## Refugee relief rations

SIR—Since 1992, 117 000 Somali refugees have settled in three refugee camps located in drought-stricken, northeastern Kenya. By the end of 1993, the high rates of mortality and malnutrition that had prevailed among refugees on arrival at the camps were brought down to acceptable levels. In November, 1996, we conducted an epidemiological investigation in one of these camps at Hagadera, and extracted quantitative data from the routine epidemiological surveillance system, which was set up according to international standards.<sup>1</sup> Focus-group discussions were held to assess the health perception of the refugees.<sup>2</sup>

The refugees identified three key features of the inadequate food supply as causes of ill-health in the camp. First, the quantity of food: "the main problem is lack of food, and drugs cannot replace food". Second, the quality of the diet: "children are always given the same . . . which is not a balanced diet". Third, the inedible cereal distributed since August, 1995: "there is no treatment for the diarrhoea which you get from UN's food". Acceptance of this cereal was low. Many refugees sold part of their ration to buy rice, at the expense of their calorie intake.

Between August, 1995, and December, 1996, the official World Food Programme daily food ration was gradually decreased from 2100 to 1700 kcal per person. This reduction corresponded to an increase in the number of severely malnourished children from the camp who were admitted to hospital each month (2.8 per 1000 in August, 1995, 17.9 per 1000 in August, 1996, and 32.7 per 1000 in January, 1997)\* and an increase in acute malnutrition (12.1% (95% CI 9.1–15.9) in August, 1995, 18.2% (14.7–22.2) in August, 1996, and 28.0% (24.0–32.0) in January, 1997). Scurvy is a constant problem in the camp; during one outbreak between July and October, 1996, 508 cases were reported.

Malnutrition levels are now back to those seen during the emergency phase when refugees arrived at the camp. Despite international commitments to provide adequate relief rations,<sup>3</sup> today's refugees are paying the price for low food reserves and unclear policy.<sup>4</sup> But hunger will not force the refugees to return home, because return is "not an issue of food, but of stable government. If there was a president . . . we would walk even tonight, back to Kismayo".

\*Figure of daily food ration and monthly admission rate for severe malnutrition in children, September, 1994, to November, 1996, available from the authors or *The Lancet*, on request.

In the absence of a political solution, we believe that there are only two ethical alternatives. Preferably, more autonomy should be granted to the refugees and aid should be targeted towards restoring their livelihoods. Such a change would probably involve dividing the camps into smaller, integrated groups within an economically more resourceful environment.<sup>5</sup> Alternatively, an adequate food supply, both in quantity and quality, should be guaranteed by the international community.

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- 1 CDC. Famine-affected, refugee, and displaced populations: recommendations for public health issues. *MMWR CDC Surveill Summ* 1992; **41**: 1–76.
- 2 Dawson S, Manderson L, Tallo V. The Focus Group Manual. TDR/SER/MSR/92.1. Geneva: WHO, 1992.
- 3 Toole MJ, Nieburg P, Waldman RJ, et al. Adequacy of refugee relief rations. *Lancet* 1989; **ii**: 268.
- 4 Editorial. "Food for all": slogan or worthy goal? *Lancet* 1996; **348**: 1109.
- 5 Van Damme W. Do refugees belong in camps? Experiences from Goma and Guinea. *Lancet* 1995; **346**: 360–62.

## Attitudes to xenotransplantation

SIR—Mohacs and colleagues (April 5, p 1031)<sup>1</sup> report the results of a survey of Australian's attitudes to xenotransplantation. I sent a questionnaire to over 850 dialysis patients known to the British Kidney Patient Association. The four questions were straightforward and were listed after a full explanation of the process of xenotransplantation with transgenic pigs. The results showed that 663 (78%) were willing to accept a pig's kidney, 144 (17%) were unwilling to receive a graft from a transgenic pig, and 43 (5%) stated that they were unsure. Most of those who were against the use of pigs' organs showed their concern that any animal should be bred solely for the purpose of organ donation, and the remainder of the no's were for religious reasons. Because pigs are bred to be killed for our own consumption, I was not surprised that so many of the patients who have waited long years for a cadaveric graft could see no difference between pigs being bred to save the lives of human beings or being bred to satisfy the cravings of the stomach.

Although the 113 patients who were approached in Australia certainly did

not give encouragement to the continuation of the programme, renal patients in this country are both enthusiastic and supportive, as indeed are we at the British Kidney Patient Association.

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- 1 Mohacs PJ, Thompson JF, Nicholson JK, Tiller DJ. Patients' attitudes to xenotransplantation. *Lancet* 1997; **349**: 1031.

## The illness of Gerard Manley Hopkins

SIR—We agree with Flegel (April 5, p 1017)<sup>1</sup> that typhoid fever is unlikely to have been the disease underlying Hopkins' sickness and death. However, we were surprised that Flegel did not discuss coeliac disease, which is associated with iridocyclitis<sup>2</sup> and could provide an explanation for Hopkin's "gout or rheumatism of the eyes".

In the past 20 years of his life, Hopkins suffered from chronic non-specific diarrhoea, progressive weight loss, fatigue, and weakness, which are all symptoms present in the clinical picture of coeliac disease in adults.<sup>2</sup> The absence of abdominal pain in his history is unusual in longstanding Crohn's disease, but not in coeliac disease. The recurrence of his symptoms also fits well with the clinical course of coeliac disease before the therapeutic effect of a gluten-free diet was discovered.<sup>3</sup> Although fever is not a feature of coeliac disease in adults, it could have resulted from intestinal infections that, even nowadays, are an important factor in triggering the symptoms of the disease.<sup>4</sup> Alternatively, abdominal lymphoma or ulcerative jejunoileitis<sup>5</sup> could account for the fever and have caused the final, fatal ileus. Importantly, during 1 month of low gluten intake ("beef tea and chicken jelly diet") Hopkins felt better.<sup>1</sup> Ulcerative jejunoileitis responds clinically, but not histologically to a gluten-free diet.<sup>5</sup> All these facts suggest that coeliac disease, complicated by ulcerative jejunoileitis, abdominal lymphoma, or both, could be a more likely explanation than Crohn's disease for both the illness and the cause of Hopkins' death. Anyway, as Flegel points out, "it is unlikely that we will ever know for certain which one was present".

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- 1 Flegel KM. My winter world: the illness of