HEALTH ASPECTS OF DIE REPATRIATON OF DISPLACED CIVILIAN POPULATION IN WAR AND DROUGHT-AFFECTED AREAS OF ETHIOPIA

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INTRODUCTION

A historical perspective of draught and famine in Ethiopia, "The Challenge of Draught - Ethiopia's Decade of Struggle in Relief and Rehabilitation" , gives an account of the different episodes that the country has had to suffer from this type of natural calamity. After reviewing the medieval situation, it progressively reaches to the great famine of the period from 1988-1992.

The review includes in its analysis the situation in the highlands and also the situation in pastoralist areas of the country where, according to the observations, such incidents happen, in a cyclical manner every ten years.

S.P. Petrides, in "The Boundary Questions between Ethiopia and Somalia , gives an account of how many major conflicts the country had to face between 1932 and 1935/6. The impressive list includes not less than 34 major conflicts involving at one time or the other; the west and north-west, the north, the east and the southern parts of the country. This list excludes the internal conflicts which were numerous, according to Tekle Tsadik Mekuria the well known Ethiopian historian.

REPATRIATION

The narrow and strict definition of repatriation, in the present presentation, is being enlarged to also include:
-those displaced within the boundaries of the country;
-those displaced within the limit of their respective administrative regionslawraja (sub-districts);
-those people to be moved to settlement/- resettlement areas.
Repatriation can be subdivided into three phases:

A) CENTRIPETAL Phase;
B) JOURNEY Phase with single/multiple stop overs;
C) CENTRIFUGAL Phase.

While phase (B), the journey phase, may have its own inherent difficulties (organization, logistics, administration, distance between stopovers, length of the travel, etc.), its medical implications are within the reach of middle level medical staff, unless there is a vehicle accident or explosion on the line. The other two phases are of a different nature. Although the medical action in both is to keep the displaced person in good health, success in either case varies due to the fundamental differences of their respective outcomes. These include: span of life, geographical distribution, interaction with the surroundings, concentration of means and delegation of power in problem- solving, political benefits as well as the focus of the nation, the political leadership at their different echelons, and by way of extension, the focus of international attention.

CENTRIPETAL PHASE

It is a well known fact that draught victims only leave their localities when there are no more resources for survival available. They are in absolute necessities to leave to search for the means of survival. Victims who are displaced due to armed conflicts, on the other hand, are out of their homes sometimes in a matter of a few hours. When natural and man-made disasters are allied, as our country has often experience in

.Relief and Rehabilitation Commission. Addis Ababa, Ethiopia

the last few decades, then the condition of survival has even a bleaker outlook for those stricken in this situation. It is simply a nightmare.

The movement of these victims generally leads them to the main communication roads, regular market locations or the boundary gates, where the displaced have a stopover to rest and wait for those behind. Soon small groups are formed to exchange the ways and means for solving their immediate and life-threatening situation.

Some determinants (traffic load, existence of water source, availability of firewood, etc.) invite the travellers to remain where they are, and they end up by attracting the attention of the concerned authorities.

It is here and in the given conditions then, that the authorities have to cater to and assist the displaced population by: erecting shelters; providing food, water, and logistical facilities; creating storage space and health facilities (including nutrition and sanitary components); setting up the needed administrative structure;
and ensuring the essential linkages with the concerned authorities.

These operations are executed under hectic and dramatic conditions. In general, the dominant feeling in these precarious shelters is of a dehumanized atmosphere:
-the assisted people are the colour of the soil and this in turn creates in them the feeling that they are "dirt" and have lost their identity;
-there is an absence of protection against the morbid curiosity of the outside world;
-people are pushed and pulled with no regard, or consideration;
-there is a total disruption of traditional respect and regard among themselves;
-signs of belonging and affection to their loved ones are suppressed;
-they are denied the care and support to alleviate the burden of their disabilities or handicaps (i.e. blindness, polio, rickets, extensive burns etc.).
In sum, they are handled as an entity with no soul or desire.

The shelter population, helped by promiscuity, becomes gradually acculturated to its new cohort loosening the traditional prevailing inter-relation-ships now governed by cultural breaks. This leads to behavioral changes mainly characterized by a loss of dignity.

It is against this background that the health service delivery system for the displaced is evolving. This includes the handling of common findings, for instance, that communicable diseases (which account for the major part of the medical problems and are the leading causes of mortality and morbidity) worsen in the appalling conditions of daily shelter life.

People in shelters feel lonely among the masses and are unoccupied).. Over-crowding worsens the overall condition of this human dramatic venture and sentences dozens of innocent victims daily with no appeal. (Tables 1, 2, 3, and 4).

The Magnitude of the Problem Between 1977 and 1992 some 9.5 million civilians were displaced, excluding refugees and returnees, due to draught/famine. and armed conflicts (fables 5a and 5b).

Displacement was also due to settlement schemes. To cite but one example, from November 17 to September 5, 1985, some 604,905 people were moved from five administrative regions to six other administrative regions (fables 6a, 6b, 6c, 7a and 7b). As of February 27th, 1992, some 90,092 people were displaced in Sidamo alone due t\1 inter-ethnical conflicts (Table. 8a, 8b and 8c). As elsewhere, however, massive population movements in Ethiopia do not go without heavy losses in human lives. According to the records
of the Relief Department of the Relief and Rehabilitation Commission (RRC), some 72,055 deaths occurred in the three fiscal years of 1984, 1985 and 1986, and out of these, at least 44.7% were under 15 years of age (fables 9a, 9b and 9c).

According to further reports of the Information Centre of the RRC, the situation in the shelters is a nightmare:

-from 2.18.84 to 9.11.84,1,218 children under 15 years of age died, and of these, 73% were below six years of age;
-in the same period (2.10.84-9.11.84) the total number of deaths was 545 for the three sites, (i.e., in the shelters, feeding centre and in the town of Korem), and of these, children from 0-6
[years of age represented 39.26% (fables 8a, 8b and 8c)
It is recorded in the reports forwarded from the branch offices of the RRC for three consecutive years (1985, 1986, and 1987) that the country also lost some 1 ,344,628 domestic animals (cattle, goats, camels, horses, mules and donkeys) (fable 10).

INVOLVEMENT OF PUBLIC HEALTH IN CATERING TO THE DISPLACED POPULATION
Health manpower is an obligatory component of all activities catering to the displaced population.

It is the single most important activity for those members who are living under permanent stress, stretched to the maximum through endurance and hardship. Unfortunately, the displaced population are often failed by extreme shortages of drug and medical equipment supplies. The tools forwarded to the medical manpower in this type of undertaking have, in my experience, fallen far short of the needs. Operational expenses, in particular for an effective medical intervention, have been very low and difficult to obtain (fables 5a, 5b, and 14). The following points are the highlights in which the field medical professionals were involved.

Setting up a shelter
-locations are not always adequate nor are they always chosen with the knowledge of health professionals the few exceptions are Bete in Northern Shoa, Kobo, and Alamata);
-participation in their design is to allow for an easy flow of people and goods.

2.setting a medical activities quarter within the generation sheltercomprising:
-an OPD (out-Patient Department)
-inpatient area with due consideration to aeration, light, etc.
3. Providing isolation areas, for patients with:
-measles; whooping cough; hepatitis; diarrhoeal diseases; TB. Also orphans may require a separate facility as does a feeding centre (the size depending on the under-five population) with its different components, in particular the therapeutical (super internal, intensive, supplementary, etc.), feeding (Table 11).
4. Providing for delousing:
-steaming of clothes;
-mass treatment for scabies;
-shaving (Table 12).
5. Select auxiliaries (youth, boy scouts), to:
-search for sick people within and outside the shelter premises;
-search for defaulters;
-distribute drugs;
-register patients;
-translate;
-spray DDT, etc.
6. Providing for the adjustment of medical personnel to the demand (an extreme fluctuation in the shelter setting was a known trend, hence the need for a radio network.)
-In Ibenat, at the end of April 1985, the number of people was around 48,000 people.
-From 29.4.85 to 2.5.85 the number increased to 60,000 people, and in early June 1985, the.population reached 125,000.
-At the end of June 1985 the population decreased to 20,000. In Korem, 600 patients were admitted in August 1984, while in September 1984 the number was 1,263 of this increase necessitated that a third ward be opened at this time).
In Debre Berhan on February 9, 1985 the estimated number of draught victims in the camp was 3,000 people. Some 1500 people had found shelter in the rooms and in the eight tents supplied by the Kebeles. The remaining

people were sleeping outside; their thin clothing inadequate to protect them from the cold nights of the highlands. The number of new arrivals averaged 150 per day.

From the 17th of November 1985 to the 26th of December 1985, the RRC used Debre Berhan camp as a transit camp where drought victims from northern areas would spend one night on their journey by bus to settlements in the south. Some 41 transit operations occurred during the aforementioned period involving some 109,500 people on their way to settlement areas. (Tables 8a and 8c).

7 .Developing a water supply

8. Providing sanitation:

-during the dry season there was no problem;

-during the rainy season latrines were filled up very quickly, the ground water level rose, and new latrines had to be dug on a continual bases.

9 .Providing clothing

In Ibenat from January to March 1985 there were some 48,000 people living outside the shelter in 200 tiny huts and 50 tents. "These 48,000 were living under dreadful conditions in tiny huts made from sticks, straw and maize stalks."

The same observation was made for those displaced people living around the shelters in Korem, Harbu, Debre Berhan, etc.

10. Providing energy:

-kerosene burners with a supply of kerosene were provided when possible;

-firewood was also provided (out of RRC's experience it is calculated at the rate of $1m^3$ for 500 people in a shelter situation).

11. Providing a grinding mill

In Korem during October 1984, the rate of in-patient admission was 50 to 70 per day. The report during that period states that most of the people ate the grain obtained from the dry ration distribution directly without grinding it. Naturally one would not expect the grain to be absorbed.

12. Protecting the minor from Psychological

What are the Problems encountered generally and the activities Performed in shelter situations?

a) People suffer from communicable diseases
b) Outbreaks of epidemics occur
c) Malnutrition increases
d) Vaccination programmes are needed
e) Prophylactic treatment (RF -Malaria) is given
f) Deliveries are performed
g) Cooperation between agencies is straightened

What are the shortcoming

a) Insufficient health manpower
b) Failure of the flow of food supply for drivers due to:

-the unavailability of food;

-the inaccessibility of the areas to be assisted;

-a shortage of vehicles;

-food spoiled by rain;

-misunderstandings creating an imbroglio between donors and the RRC;

-security problems, be they inter-ethnic group conflicts in the shelter or conflicts between the shelter population and local people;

-obligations to change shelter locations; for example from Ibenat to Addis-Zemen in January 1985 because the road from Addis Zemen to Gondar was closed for several weeks in January 1985.

In general, when displacement is caused by an armed conflict the shelters become attractive for the enemy. Therefore, the displaced population may sustain more casualties than a dispersed population because of the

concentration of people. On the other hand, there is always a risk that conflicting parties will spoil the already heavy atmosphere of shelters by open or undercover operations and activities sweating their goals.
c) Shortage or lack of funds for medical activities and operational expenses (i.e. per diem, vehicle, fuel, etc.)
d) Shortage of drug and medical equipment
e) Overlapping of resources -generally an existing health structure in the vicinity of shelters is not requested to close down temporarily to transfer all its supplies in the shelter set-up.
f) Shortage of water supply and supplies for individual hygiene (i.e. soap, clothing, etc.)
g) Total lack of social/occupational activities
-rehabilitation, in principle, should start as soon as people are in the shelters
h) Outbreak of epidemics.
In IBENAT alone, the following outbreaks were witnessed:
-in March 1985 an epidemic of measles accounted for the majority of the 243 deaths which occurred;
-in June 1985 there was another epidemic and 3568 children were vaccinated;
-from August to September 1985 an outbreak of meningococcal meningitis resulted in 22 cases and five deaths.
In Harbu from 5.l1.84 to 27.12.84100 of the 1848 deaths which occurred were due to hepatitis (1.11.84 to 14.12.84).
Inconsistency in the calculation of rate individual ration rates (Table 13):
-during 1982-1983:
-grain: -700 gm/day/person for pastoralist adults, 500 gm/day/person for other adults, 125 gm/day/person for children below 10 years, 250 gm/day/person for children 10-14 years;
-supplementary: -100 gm/day/person for children below 10 years;
-vegetable/butter oil: -10 gm/day/person for all adults, 5 gm/day/person for children below 10 years, 10 gm/day/person for children 10-14 years.
-in 1984 at Harbu:
-grain: -15 kg/person/month for all adults, 7 1/2 kg/person/month for children 6-15 years;
-supplementary: -100 gm for children 0-14 years;
-vegetable/butter oil: -20 gm only for adults.
The EWS and Planning Department of the RRC acknowledged this fact in the operation implementation review of 1986 and expressed their preoccupation as follows:
..." A problem of which the RRC has been aware for some time and which can be noted clearly from the voluntary agencies response during this latest planning exercise is the widely differing daily ration distribution rate used from agency to agency.

Such an occurrence may lead to an insufficient use of resources, misunderstandings amongst beneficiaries living in the same area receiving different rations and, in some cases, basic survival rations not being covered.

The RRC will be studying this problem and with the relevant expert advice, will be proposing a National Standard Ration Rate which will be followed in all dry rations distribution programmes throughout the country.
"

On the other hand there are different type of combinations, as for example:
-premix;
-family ration;
-individual ration, etc.

CENTRIFUGAL PHASE
This phase starts with the official evacuation of the displaced people from the shelters where they had been cared for up to that time. The alternatives in this kind of operation are as follows.

1. Those for whom the vicious circle is perpetuated
The displaced people in Dessie shelter from 1974 to 1984 (originally 30,000 people) were evacuated to other shelters in Korem after they had already experienced ten years of shelter life.
2. Those displaced returning to their original residential areas

In Mekele and Quiha camps 45,817 people were evacuated to their respective awraja at the end of 1985 EC (Ethiopian Calendar); In the Ogaden 15,956 people were evacuated from Kebri Dehar and Kelafo camps, in 1984 EC.

3.. Those displaced people having migrated to neighbouring administrative regions

In Ibenat, Gondar Administrative Region, ill July 1985 EC some 166,127 people were repatriated. Their composition was: 58% from Wollo Administrative Region, 1% from Tigrai Administrative Region, and 41 % from Gondar Administrative Region.

The logistical needs to repatriate the displaced was complex and the condition was worsened by the inaccessibility of some areas of repatriation. By foot the shortest distance for those displaced from Wollo was a three day journey. The returnee needed to have at least a one month ration of grain when they left the shelter (15kg/-person/month). The evacuation of Debre Berhan camp on 17 March, 1985 involved some 8,510 people originating from Tigrai, Wollo, Gondar and Shoa.

4. Those displaced moving to settlement areas include the following:

Examples of displaced people moving from highlands to lowlands.

-910 people were moved by helicopter from Ibenat to Metema (both in Gondar administrative region) on the 26th, 27th and 28th of April, 1985;

-the settlers from Sidamo were moved to Metekel (Gojjam administrative region);

-around 13,000 displaced highlanders of Wollo moved to Bale after three months of stopover in the Denakillowlands between 1985-1986. For people moved to settlement areas the journey was generally long, and varied between 10 to 15 days.

Expected Medical Participation in the Course of Evacuating Shelters

In spite of a general evacuation there are always displaced people who remain in the shelters. These are:

-handicapped people, crippled, elderly patients;

-children under therapeutic nutrition rehabilitation;

-unaccompanied and orphaned children.

For example there were 3,616 people still in Mekele and Quiha in August 1985 and 5,982 people still in Ibenat in July 1985.

Thus, medical care has to continue for those left behind in the shelters. Medical care was also offered during the journey and stopover with some cases referred to health facilities on the way.

Those better off as far as the immediate medical care is concerned, from all those repatriated are the settlers for evident politico-economical reasons and impacts.

Behavior or Local Population at Destination

A feeling of encouragement and/or resentment can be felt as substantiated by the ICARA II mission in the Ogaden (1987), with the settlers in Gode.

Settlers in conventional settlements cause a narrowing of the available arable land from the local farmers thus decreasing their potential income. This is an underlying reason for the resentment of the local population against the newcomers as substantiated by the research of Alemneh Dejene ("Peasants, Agrarian Socialism and Rural Development in Ethiopia, 1987)

When settlers are moved, all the needed necessary public health majors are not taken into account. For example:

-prophylactic treatment; vaccinations before departure, etc. ;

-preventive measures at the final destination point, i.e. spraying DDT in malaria endemic zones, protecting water sources, etc.

SUMMARY

Medical experience in handling displaced people in Ethiopia is far-reaching. A solution to the lack in the flow of information flow, however, should be found particularly when displaced people are called to be moved from their normal ecological areas to newer ones.

Since its inception in 1974, the Relief and Rehabilitation Commission (RRC) has catered to several hundred thousand displaced civilians in conjunction with the Ministry of Health (MOH) and the donors' community. In fact, its actions have covered all administrative regions at one time or another in its 18 years of existence. Repatriation of displaced civilians has and still is one of the major tasks and responsibilities of the RRC in collaboration with other authorities and collaborating agencies concerned.

The health field in these endeavour has played and continues to playa prominent role. The general condition and the degree of dependency of displaced civilians calls attention to the medical profession to come up with tangible and affordable solutions to mitigate the degree of casualties on the basis of sound retro- spective and prospective analysis. This in turn will help to alleviate the forcible causes of morbidity and mortality related to civilian population movements, including their repatriation.

This presentation is an invitation to medical professionals to move towards retrospective analysis, as they are aware of the scarcity of published materials in this area. Yet a wealth of information is lying unused in the archives of many institutions in the country.

It is also an invitation for thorough epidemiological studies along with possible unusual clinical and/or social manifestations of diseases, since the present population movements are likely to be one of the challenges for health professionals for the coming decades. What will be needed, in an ever increasing way, is their utmost methodological analyses with particular exigence in the flow of information with respect to their findings and observations.

My plea goes to the liberation fronts, political party leaders as well as the Transitional Government authorities, to help the health professionals perform and achieve their duties by allowing them to reach those in need presently found in different parts of the country.

We will never be able to have an accurate estimate of the lives lost and the number of cases of malnutrition with its devastating effect on the population, had we been provided with safe access to mitigate the casualties.

To the teaching institutions my plea is to insist on the fact that research papers should also focus on health matters related to repatriation aspects. Lastly, my plea is also addressed to the donors' community, that along with their generous interventions in other fields of support for the Country, they also help our health manpower capability building by sponsoring research undertakings including those studies of research related to repatriation.

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Table 1. Inquiry commission findings 24/7/1965-28/1965 EC (Ethiopian Calendar)

Sub-district	Displaced	Ill	Dead
Wadla Delanta (Wollo)	3317	1500	29
Werehimenu (Wollo)	866	2373	66
Borena Saint (Wollo)	4420	3068	19
Yejju	3743	-	-
Total	12343	6941	144

Table 2. Displaced people assisted in Shelter (Fiscal Year 1984)

Adm. Regions	0-6	6-15	>15	Total
Eritrea	59	100	7464	7623
Tigrai	346	577	2938	3861
Wollo	771	1345	5188	5188 6012 11200
Gondar	47	79	762	888 4163 5051
Hararge	2713	4260	8983	15956
Total	3644	5874	21959	43961

Ser. No.	Regions	0-6		6-15		>15		Total		Grand Total M & F
		M	F	M	F	M	F	M	F	
1	Eritrea	133596	150059	165476	169011	381836	354894	680908	673964	1354872
2	Tigrai	133628	152120	172441	184210	36369144	435334	675213	771664	1446877
3	Wollo	272991	218451	260703	278015	686479	763514	1120173	1259980	2380153
4	Assab	8499	8861	8861	8420	14622	15962	31982	33028	65010
5	Gondar	25125	33142	38550	32705	71495	62050	135170	127897	263067
6	Shoa	33122	34285	105368	100044	213157	219269	351687	353598	705285
7	Hararghe	52080	51674	70455	66572	111245	112032	233780	230278	464051
8	Sidamo	31444	32867	57520	50656	107944	99527	196908	183050	379958
9	Gamo Gofa	10720	11482	28012	24372	38686	38957	77418	74811	152229
10	Bale	14774	19015	13870	16165	35214	44296	63858	79476	143334
11	Gojjam	98	140	120	128	257	346	475	614	1089
	Total	716077	711881	921376	930298	2030079	2146181	3567572	3788360	7355925

Table 4. People assisted in different Administrative Regions (1977 report, Relief Dept. Page 2)

No.	Adm. regions	Dry rations	Shelter	Total
1	Eritrea	1354877	2179	1357051
2	Tigrai	1446877	108528	1555405
3	Wollo	2380153	102559	2482712
4	Assab	-	-	65010
5	Gondar	263067	5046	268113
6	Shoa	705285	3855	709140
7	Hararghe	464058	-	646058
8	Sidamo	379958	-	379958
9	Gamo Gofa	152220	-	152220
10	Bale	143334	-	143334
11	Gojjam	1089	-	1089
	Total	7355932	222167	7578099

Table 5. (a)

Year	1977-1978		1980	1982	1983	1984	1985	1986	1991		1992	
Distribution and number of displaced people	Bale Sidamo Harar Eritrea Gondar Arsi	600000 250000 1200000 458000	in several Adm. Regions 2400000	in several Adm. Regions 1651000	in several Adm. Regions 410000	in several Adm. Regions 100000	in several Adm. Regions 63700	No shelter	Total	1571794	Total	845637
									Ogaden	350000		152
									Tigrai	83970		43366
									Wollo	12930		100784
									Diredawa	2964		88915
									Gondar	299350		100000
									Shoa	52210		115989
									Wellefa	5510		431150
									Assosa	14860		18689
									Addis Ababa	750000	Gambella	17688
											sidamo	22842
											North Omo	500
											W.Gojjam/ Metekel	8210
											Borena	136504

Medical assistance requirement					
1982	1984	1985	1986	1991	1992
Drug and equipment worth 3294640	2084 who kit (per kit US $ 7,225 = US $ 15056900	5 mobile med. team	Drug worth Birr 5,000,000	147 Expatriate specialists 221 different med. equip. 106 types of drugs	4,072 WHO Kit (per kit = US $ 7,225) =US $ 33971950
	Drugs worth	8,920,000			
	1986				
	309 Med. staff Drugs worth Birr 16300000 worth drug				

Fire wood: (1984)

91,728 m^3 of fire wood

At a cost of Birr 20 [m^3= Birr 1,834,560/1m^3 for 500 people in a shelter for 1 year]

Table 5 (b). Assistance requirement different areas.

Year	Population in need of	Food assistances requirement			Total
		Grain	Supplementary	Veg./Butt./Oil	
1992	5,584,197	967,748	165,046	32,991	1,264,759
1991	5,594,756	-	-	-	1,002,149
	7,472,612				
1988	5,214,400	938,529	88,229	19,898	1,046,719
1987	2,500,000	367,248	34,081	7,874	409,203
1986	6,500,000	1,080,000	116,000	23,420	1,243,777
1985	6,323,100	1,124,876	97,984	37,984	1,260,855
1984	6,372,180	1,127,300	93,980	27,344	1,248,620
	5,264,298	4,561,462	384,530	106,009	505,200
1983	5,464,430	872,380	65,809	14,645	878,087
1982	4,709,500	402,479	-	10,758	701,296

Table 6 (b) Settlers movement from November 17/84 to September 5/85

Settlers regional destination	Origin of settlers																	
	Wollo			Tigrai			Shoa			Gojjam			Gondar			Total		
	Heads of household	Dependents	Total	Heads of household	Dependents	Total	Heads of household	Dependents	Total	Heads of household	Dependents	Total	Heads of household	Dependents	Total	Heads of household	Dependents	Total
Illubabor	25509	46717	72226	21343	24372	45715	8907	19368	28275	-	-	-	-			55759	90457	146216
Wellega	69489	151147	220636	12472	8895	21367	3648	7631	11279	-	-	-	-			85609	167673	253282
Keffa	19418	32313	51731	7576	15058	22634	2977	3692	6669	-	-	-	-			29971	51063	81034
Gojjam	10981	18858	29839	-	-	-	15332	36526	54858	3344	13081	16425	-			29657	71465	101122
Shoa	-	-	-	-	-	-	2505	3644	6149	-	-	-	-			2505	3644	6149
Gondar	-	-	-	-	-	-	-	-	-	-	-	-	2183	4204	6387	2183	4204	6387
Total	125397	249035	374432	41391	48325	89716	33369	73861	107230	3344	13081	16425	2183	4204	6387	205684	388506	594190

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Settlers regional destination	Origin of settlers																	
	Wollo			Tigrai			Shoa			Gojjam			Gondar			Total		
	Heads of household	Dependents	Total	Heads of household	Dependents	Total	Heads of household	Dependents	Total	Heads of household	Dependents	Total	Heads of household	Dependents	Total	Heads of household	Dependents	Total
Illubabor	19715	37110	56825	20332	23657	43989	8540	18688	27228	-	-	-	-			48587	79455	128042
Wellega	67489	151147	220636	12472	8895	21367	3648	7631	11279	-	-	-	-			85609	167673	253282
Keffa	11682	21457	33139	7027	14955	21982	2858	3656	6514	-	-	-	-			21567	40086	61653
Gojjam	3610	5654	9264	-	-	-	15290	37449	54739	333441	13081	16425	-			22244	58184	80428
Shoa	-	-	-	-	-	-	2505	3644	6149	-	-	-	-			2505	3644	6149
Gondar	-	-	-	-	-	-	-	-	-	-	-	-	2183	4204	6387	2183	4204	6387
Total	104496	215368	319864	39831	47507	87338	32841	73068	105909	333441	13081	16425	2183	4204	6387	182695	35	535941

Table 6(c) settlers movement from December 25/87 to May 25/88.

Settlers regional destination	Origin of settlers								
	Wollo			Gondar			Total		
	heads of household	Dependents	Total	Head of household	Dependents	Total	Heads of household	Dependent	Total
Gojjam	2501	2851	5352	-	-	-	2501	2851	5352
Gondar	-	-	-	1764	3599	5363	1764	3599	5363
Total	2501	2851	5352	1764	3599	5363	4265	6450	10715

Table 7 (a).

Year of selection	Original residence Adm. Reg.	Previous Occupation	Number of head family	
			Male	Female
1967	Shoa	Jobless		
	Keffa	Farmers	6968	
	Wollo	Nomads		
1968	Keffa			
	Shoa	Jobless		
	Wellega	Farmers	7200	
	Arsi			
	Wollo			
	Hararge			
	Sidamo			
	Gamo Gofa			
1972	Keffa	Farmers	4949	300
	Illubabor			
	Wellega			
	Shoa			
	Tigrai			
	Gondar			
1975	Gondar	Farmers	480	2

Table 7 (b)

Location of settlement	Justification
Anderacha, Lemu, Dedessa, Gojeb, Kiche, Djeweha, Tedele, Z/W, Asaita	To Create jobs for jobless people who have left Wollo and are looking for jobs in other localities. Those who have had problems of arable land to gather nomads
Limu, Dedessa, Gojeb, Wesen-Kerke	To assemble jobless people displaced because of a lack of arable land
Negesso, Awara melka Abderba, Addis Ketema, Meki, Dedessa, Kersa, Waleme, Techmerei-Betcha, golgota, Dubti, Shenile, Dama Arota, Tchano, Degra	Those farmers whose land has been taken over by state farms to gather nomads
Anderacha, Gambella, Angrutine, Assosa	To gather those affected by drought and man-made disasters and those unable to find arable land
	To gather minorities populations and help them to organize themselves
Humera	To assemble those drought victims (from Gaint Awraja)

Table 8 (a). Need for radio network

Regions	Figures of the National Appeal Nov.-Dec. 1991	As of 27/2/92
Wollo	43,366	87,804
Gondar	115,989	210,075
Gojjam	8,210	9,110
Hararge	85,915	179,151
Wellega	18,689	15,239
Sidamo	22,842	90,092
Gambela	17,688	22,905
Shoa	312,699	31,899
Total		646,275

Table 8(b). One month rations complied from daily radio transmissions.

Regions	Date E.C.	Pop.	Gr. Food	Supp.	Oil	Total
Eritrea	1-30/5/78	4779	56.08	2.01	21.14	82.23
	1-30/10/78	592	16.06	0.75	0.73	17.54
Tigrai	5/78-10/78	55141	454.32	467.64	36.63	958.59
		13675	459.41	81.12	32.38	572.91
Wollo	5/78-10/78	128800	3504.00	223.53	71.37	3798.95
		40971	3849.30	292.12	102.14	4243.58

NB. 1) Quantity is in quintals
2) Quantities computed for an administrative region are generally lower than the actual figures because radio transmission may lag behind the actual state of food distribution because of power interruption. (e.g. shortage of fuel)

3,500 Ethiopian returness	Tigrai	-	-	152,000
- in Ogaden	S. Wollo	43,366	-	-
83,970 -in Tigirai	E.Hararge	-	100,784	-
12,930 -in Wollo	Diredawa	-	-	85,915
2,964 -in Diredawa	Ogaden	-	100,000	-
299,350 -in Gondar	N.Gondar	115.98	-	-
52,210 -in Shoa	Addis Ababa	43,150	-	-
5,510 -in Wellega	Wellega/Assosa	18,689	-	-
14,860 -in Asossa	Gambella	17,688	-	-
750,000 -in Addis Ababa	Sidamo	22,842	-	-
1,571,794-in Total	N.Omo	500	-	-
	W.Gojjam/Metekel	8,210	-	-
	Borena	-	136,504	-
	Total	270,434	337,288	237,915

Table 9. (a). Deaths reported from regional office as victims of draught and re;ated diseases. (1984 fiscal year/8.7.83-7.7.84)

Adm. Regions	Sub-district	<15	>15	Total
Wollo	Waga	1824	916	2746
	Lasta	171	240	411
	Wadladelanta	5	51	56
	Ambassel	15	33	48
	Rayana Kobo	17	30	47
	Kalu	-	23	23
Total		2035	1266	3331
Shoa	Merabete	7	10	17
	Yererna Kereyu	-	-	6
	Menzna Geshe	1	2	3
Total		8	12	36
Sidamo	Welayta	-	-	326
Hararge	Warder	8	13	21
	Kebri-Dahar	6	2	8
Total		14	15	29

Table 9. (b). Deaths from natural calamities (1985)

Adm. Regions	0-15		>15		Total
	M	F	M	F	M & F
Eritrea	37	46	63	49	195
Wollo	1116	971	1308	1391	4786
Gondar	406	158	164	133	861
Tigrai	642	42	2	94	1165
Shoa	-	-	-	-	2169
Hararge	-	-	-	-	9
Sidamo	-	-	-	-	132

8/7/4986-7/7/7987 (1987 Fiscal Year)

Adm. Regions	0-6		6-15		>15
	M	F	M	F	M & F
North Gondar	-	-	-	5	5
Eritrea	-	-	-	3	3
Shoa	3	-	-	2	5
Hararge	8	9	9	52	69

Table 10. Domestic animals victims of draught (1985 and 1997)

TYPE	1977			GONDAR			WOLLO			HARARGE			ASSAB			SHEWA			SIDAMO			GAMO GOFA	BALE	TOTAL
	1977	1978	1979	1977	1978	1979	1977	1978	1979	1977	1978	1979	1977	1978	1979	1977	1978	1979	1977	1978	1979	1977	1977	
CATTLE	21492	78	3004	89	538	6	121072	150	-	61517	140	11950	-	-	-	23945	-		35539	-	-	10237	3000	292754 97,584
HOURSE , MULE MONKEY (PACK ANIMAL)	14394	33	21	-	635	10	33843	-	-	4061	49	400	-	-	-	77356	-		2640	-	-	100	10	248050 133192 44397
GOAT	-	-	-	-	-	-	90677	-	-	110084	300	500	3000	-	-	31391	-		3692	-	-	8402	-	27433 248050 82683
SHEEP AND GOAT	-	-	8	-	-	25	-	-	-	-	-	27400	-	-	-	-	-		-	-	-	-	-	352475 27433 3144
SHEEP	-	-	-	-	-	-	236763	-	-	94427	-	200	3000	-	-	14875	-		2944	-	-	266	-	25022 352475 117491
CAMEL	10	-	-	-	-	-	-	-	-	15931	-	5780	-	-	-	1819	-		682	-	-	-	800	265702 25072 8340
COMBIN ATION	187192	698	-	-	1130	-	-	-	-	-	-	77366	-	-	-	14	-		-	-	-	-	-	265702 88567

Table 11 From 7/7/84 to 8/7/85 Feeding center beneficaries (only selected shelters).

		Mothers	Children <5 years	Others	Total
Wollo	Bati	916	2261	1708	4485
	Korem	818	23962	1922	26702
	Habru	675	2245	3027	5947
Gondar	Ibnat	3104	12260	3084	18448
Eritrea	Hamassen	624	15518	87	16229

Measurements

Sites	Korem	Gondar	Enderta Tigrai	Gamo-Gofa
60%	3734	111	8082	2821
	724	2	408	38
60-79%	1642	46	3181	441
>80%	1365	63	4463	2342

Table 12.

Date	shaving	scabies treated	Health educ.	Delivery	Abortion	Death	OPD	Injection	Dressing	In-patient	Measles	Hepatitis	Typhus
14.5.84 to 14.6.84	2816	1594	1892	15	4	9521	44831948	44421441	1441123	1441123			
1 to 30.7.84	7420	1807		21		11128	3318	3219	230	43377			
8.8.84 to 8.9.84	8451(6869 new 157)	1970	1320	14	12	111	19433257	2354	366	579			
6.9.84 to 30.9.84	4890 (shaved 942)	2414	844	53	7	72347	21275843	13192437	215709	3151263	707	41	
1.10.84 to 30.9.84	2995	3949			5	551	4871	3534	593	2290	153	40	
1.10.84 to 30.11.84	shaving 4890 Steaming 1234	933		82	12	477	104555	5636	1101	2915		16	30 deaths
1.12.84 to 8.1.85	Saving 7098 steaming	4961				432	11918	10734	1171	2534			

Table 13. Rate of ration distributions in different years.

Year	Grain					Supplementary		Veg. Butter oil		
	Adult									
	Pastoralist	others	Under 10 yrs	10-14 yrs	All	10-14 yrs	under 14 yrs	10-14 yrs	under 14 yrs	Adult
1982/83	700gr	500gr	125gr	250gr	-	-	100gr	10gr	5gr	10gr
1984	700gr	700gr	4 to 14 350gr	-	-	100gr	100gr	-	-	20gr
1986	-	-	-	-	500gr	100gr	100gr	-	-	20gr
1987	-	-	-	-	500gr	100gr	100gr	-	-	20gr
1988	-	-	-	-	500gr	100gr	100gr	-	-	20gr

Table 14. Drug and medical equipment distributed of different administrative region.

Ser no	Date	No. of	Total	Bale	Wollo	Tigrai	Addis Ababa	Gondar	Keffa	Wellega	Hararge

		sites									
1	1/11/74	8	413230.78	65302.24	35222.29	3397.00	19458.35	-	14958.61	23370.29	20524.75
2	1/2/75-30/4/75	41	290921.78	7573.80	5297.67	-	-	-	-	-	10981.95
3	25/4/75 - 20/7/75	68	203540.00	433.39	16594.50	3859.20	9.99	28708.80	1278.56	14797.82	2352.74
4	21/7/75 - 20/9/75	28	447013.14	80748.43	29304.64	-	18699.11	35031.41	22189.22	155542.63	17284.47
5	1/11/76 - 30/10/77	in 13 adm. reg.	5134000.72 + 2937 box	-	-	-	-	-	-	-	-
6	1/5/78-18/7/80	in 18 adm. reg.	11750.54	-	3138	-	33219.83	15307.90	-	67429.15	12397.96

N.B. US $1=2.07Eth birr

DISCUSSION

Chairperson -Dr. Hailu Kefenie
Speaker -Dr. Tamirat Retta
Rapporteur -Dr. Yemane Berhane

The speaker started his presentation by reminding the audience that displacement and repatriation are not new to Ethiopia. He explained that the Ethiopian people have suffered from armed conflicts and natural calamities for a long time.

Repatriation in this presentation included those displaced within the boundaries of the country, those displaced within the limit of their respective administrative regions/awrajas (sub-districts) and those people to be moved to settlement or resettlement areas. The repatriation process was explained to have three phases:

a) Centripetal Phase - the time victims leave their localities when no more resources are available for their survival;
b) Journey Phase - the movement of displaced people with single or multiple stopovers;
c) Centrifugal Phase -thee start of an official evacuation of displaced people from the temporary shelters where tltey received emergency care to places where they can be assisted better, for example to settlement areas.

The medical problems associated with the journey phase are determined by the length of the journey, the distance between the stopovers and the availability of basic infrastructure in the area. Generally, medical problems occurring in this phase were handled by mid-level medical staff, unless vehicle or explosive accidents occurred on the line.

CENTRIPET AL PHASE

The victims of either war or drought leave their localities when no more resources are available for survival. They mostly move following main communication roads, regular market locations or main boundary gates. On the road, victims form small groups to help each other . The journey usually ends in places where victims find some means for survival or in places which enable them to attract the attention of the concerned authorities. In such places the crowd quickly gets bigger and the authorities in the vicinity are forced to erect shelters and to provide food, water and other essential care, including medical care. These operations, most of the time, are executed under hectic and dramatic conditions with no respect and regard to the victims.

Although communicable diseases are known to be the leading cause of morbidity and mortality in the shelters, the cultural, social and psychological breaks caused by the shelter life are beyond imagination. Unfortunately, these do not receive enough attention by the care providers in the shelters. Displacement in Ethiopia in the last two decades was mainly due to drought, war, settlement schemes and inter-ethnical conflicts.

Between 1977 and 1992 some 9.5 million civilians were displaced in this country , excluding refugees and returnees. It was also mentioned that in only three years (1976-78 EC) some 72,055 deaths were recorded by the relief department of the RRC. Of these, about 44.7% were children under 15 years of age. Other
specific events were also discussed in greater detail.

The health professionals who are stretched to their maximum capability to provide care to the displaced people are living under permanent stress. No information is provided to them or nor are they consulted until an overt medical problem prevails in the shelters. Most often the health service providers fail to alleviate the
health problems and their consequences due to an extreme shortage of supplies, insufficient manpower, or lack. of operational expenses.

The major health problems encountered in the shelters of the displaced people were communicable diseases, with outbreaks of epidemics and malnutrition. To alleviate these problems vaccination, prophylactic treatment, particularly for relapsing fever and malaria, basic medical care at the outpatient and in-patient level, provision of water and sanitary facilities and food distribution were undertaken with some success.

Shortcomings of the shelter health service delivery:

1. Insufficient health manpower .
2. Failure of flow of food supply due to:

-unavailability of food
-problems in food distribution operations
-lack of infrastructure
-security problems
-inconsistent allocation of rations for individuals.

3. Shortage or lack of fund for medical expenses; i.e., supplies, drugs and operational expenses .
4. Shortage of water supply and supplies for individual hygiene, like soap.
5. Total lack of social/occupational support.

6. Outbreaks of epidemics -measles and meningococcal meningitis outbreaks were the major ones causing considerable human suffering and death.

CENTRIFUGAL PHASE

This phase marks the official evacuation of the displaced people from the shelters. The alternatives in this kind of operation were discussed as follows:

1. Those for whom the vicious cycle is perpetuated.

-these are people who are moved from one shelter to another shelter [i.e. from shelter life to another shelter life].

2. Displaced people in the shelter returning to their original residential areas.
3. Displaced people in the shelter moved to settlement areas.

Complex logistic requirement and inaccessibility of some areas of repatriation are the main problems in this phase. The journey to repatriate the displaced people is usually long varying from three days to 15 days, with multiple stop-overs. The returnee must have at least one month of rations when they leave the shelter (15 kg/person/month). In spite of the general evacuation operation, there are always displaced people who will
remain in the shelters. These are handicapped, elderly people, and children who are either sick or unaccompanied. Therefore, medical care had to continue for those left behind in the shelters. Of all the repatriated, settlers are assumed to receive better immediate medical care for obvious political reasons. Still, these people suffer from endemic diseases like malaria for simple lack of prophylactic treatment and preventive measures before and at the final destination. The behaviour of the local people at the destination
point has also caused considerable psychological damage to the settlers.

In general, the speaker emphasized that medical experience in handling displaced people in Ethiopia is rich. But, he mentioned that a lack of the floe of information has blocked the wide-spread use of those rich experiences. Therefore, he invited medical professionals to retrospectively analyze the information lying unused in the archives of many institutions to further enrich the knowledge in this area since the problems associated with displacement and repatriation are still among the major problems of the country. Lastly the speaker requested:

-liberation fronts, political parties and the Transitional Government authorities to help the health professionals to perform and achieve our duties by allowing us to reach those in need presently in different parts of the country;
-teaching institutions to focus on health matters related to repatriation in their research works;
-the donor's community to support our manpower capability building by sponsoring research undertakings including studies of research related to repatriation.

FURTHER DISCUSSION

At the end of the presentation the following comments and questions were entertained. Two people from the audience expressed their appreciation to the speaker for presenting the situation so nicely and for the effort done so far to help the displaced people. They also expressed their feeling about the need to develop early warning systems and suggested that the report of this workshop be sent to the concerned government authorities.

The other comment emphasized the complexity of the health impact of population movements, dealing only with emergency situations. Starting from now we have to divert our attention from crisis management to planned management of such situations. It was also mentioned that we have to expect problems associated with diseases with a long incubation period, which may not yet have exerted their effect on the society.

Another comment was focused on the concept of self-reliance. It was explained that as we have become perpetual beggars, donors seem to be tired of us. Therefore, effort must be consolidated to try to contain the problems ourselves as far as possible.

Q. What has been done in the past and what is the plan in regard to disaster prevention/early warning?
A. We believe that prevention is better than a cure. So, to mention some, a detailed report was submitted to the central government before the disaster of 1984, but due to the prevailing other priorities, there was no reply. The same year (March, 1984) the RRC applied to the international donor community but resources appeared only after five months. This disaster was aggravated by cheap apathy and politicization. In the future, since the problem is multifaceted and not the domain of only medical people, our appeal is to the Transitional Government and to political organizations to let us do our job and help us with the rest.

Q. Can you elaborate on the relationship between the Ministry of Health (MOH), the Ethiopian RRC Cross society and the RRC? A. The medical department is one of the main departments in the RRC, and its activities are well coordinated with the MOD and other health related organizations. There are about 47 NGOs working with the RRC with the permission of the MOD.

A. Regarding the emergency situations, we have no problem because our policy is clear. We also have tried to support the MOH even in its planned activities.

Q. What is the RRC involvement in capacity building (rehabilitation) of displaced people? Do you deal with the psychosocial problems?
A. We mainly deal with emergency situations because of the limited resources we have. Nevertheless, we have tried to help the displaced people by providing farming tools and seeds, and by helping in irrigation and land protection activities. The unfortunate thing is what little we have done and the considerable number of health infrastructure that has been destroyed by the war .

Finally, the moderator closed the session by suggesting to the organizers of the workshop that they pass the knowledge gained in this workshop to the concerned authorities and institutions. He also emphasized that such matter cannot be fully tackled at once, and therefore needs follow-up.

Participating Organizations

1. Department/Regional Heads, Institutes, Ministry of Health
2. Ethiopian Public Health Association
3. Department of Community Health, Faculty of Medicine, AAU
4. McGill-Ethiopia Community Health Project
5. Ethiopian Red Cross Society
6. United Nations High Commission for Refugees (UNHCR)
7. Relief and Rehabilitation Commission (RRC)
8. Christian Relief Development Agency (CRDA)
9. Ministry of Interior
10. The Commission for the Rehabilitation of Members of the Former Army & Disabled War Veterans
11. United Nations Development Program (UNDP)
12. World Bank
13. All Africa Leprosy Training Center (ALERT)
14. National Research Institute of Health (NRIH)
15. Ethiopian Nutrition Institute (ENI)
16. International Red Cross Society
17. World Health Organization (WHO)
18. Food Agriculture Organization (FAO)
19. World Food Program (WFP)
20. UNICEF