MIGRATION AND HEALTH
(Refugees and Returnees in Ethiopia)

Ephrem Assefa* MD

1 INTRODUCTION

There are in the world today more than 30million refugees and internally displaced persons within the borders of their own countries, most of whom are currently dependent on international relief assistance for their survival. Conflicts and famine are among the most frequent causes of these forced mass population movements. These are people who have not only lost everything, but in addition, must struggle for survival simply to recover their dignity as human beings.

With its more than five million refugees and about two million displaced people, Africa is the continent today most affected by the consequences of conflict or natural disaster. During recent years wars have increased in number, causing an entire population of completely destitute people to leave their houses Drought has affected all the countries of the Sahel as well as extensive regions in east and southern Africa emptying the countryside and villages of their residents.

Undoubtedly, however, human distress throughout the last decade has been the most severe in the Horn of Africa, particularly in Ethiopia and the Sudan. The United Nations High Commissioner for Refugees and the entire international community have been mobilized to provide the necessary assistance to hundreds of thousands of victims without delay and despite tremendous logistical problems.

The Horn of Africa has experienced major socio-political upheavals, which have triggered mass refugee displacements and migrations. Situated at the core of this volatile region, Ethiopia in the past decade has witnessed the steady influx of hundreds of thousands of refugees and returnees from neighboring Sudan
and Somalia. In fact, while Ethiopia has pursued a generous policy of hospitality to refugees throughout the ages, it has at no time in its history been inundated with such a huge caseload of refugees as in the past decade.

Ethiopia has been home for all system seekers irrespective of their nationality, race, religion or sex since time immemorial:
-The Jews in the first half of the 2nd century B.C.;
-The followers of Islam in the 2nd half of the 7th century A.D.;
-The Armenian Christians in the 2nd half of the 19th century A.D.

Ethiopia acceded to the 1951 UN convention and its 1967 protocol relating to the status of refugees in 1969, and to the OAU convention governing the specific aspects of refugee problems in Africa in the year 1973.

The first refugee influx of the current caseload started coming into ltang, Gambella Administrative Region in southwest Ethiopia from south Sudan in mid-1983 and the Somali refugees into East Hararge in mid-1988. The refugee population in Ethiopia has been escalating at a very alarming rate as evidenced by the increase from 40,000 by the end of 1983 to 1,062,000 Sudanese and

Somali refugees by the middle of 1991. At present, as of February 1992, there are 495,472 Somali and 10,000 Sudanese refugees in the country , as well as 500 urban refugees in Addis Ababa who come from different parts of the world.

The situation in Somalia has also caused the sudden and spontaneous flight of about 250,000 Ethiopian returnees since the beginning of 1991.
The refugees are exposed to many factors, which put both their physical and mental health at risk. The flight into exile brings its own hardships: a long journey, often on foot, over difficult terrain and in conditions of great insecurity.

---

*Administration Refugee-Returnee Affairs Addis Ababa. Ethiopia.

Fleeing with the few goods and possessions they can carry, most of the refugees arrive in a severely debilitated state. These refugees have moved into the remote and inaccessible area." of the country, where relief programmes are difficult to organize. Hence Ethiopia, which finds it difficult to provide the basic needs of its own people, is struggling to bear the burden imposed by hundreds and thousands of refugees.

Assistance to the refugees and returnees in Ethiopia is provided through the cooperative and complementary efforts of the government of Ethiopia (principally the Administration for Refugee-Returnee Affairs and the Ministry of Health), the UNHCR, other members of the UN family (especially the World Food Programme),
and a number of non-governmental organizations.

Budgeted at $61 million dollars for 1991, the UNHCR/Ethiopia Programme is the largest one in dollar terms in the world. This is due to the nearly full dependence of the refugees on international assistance, to the high costs of distributing water and food, and to the fact that as an extremely poor country itself, Ethiopia cannot afford to cover the administrative costs of the refugee Programme.

2. INTERNATIONAL LAW AND COUNTRY POLICY TOWARDS REFUGEES AND RETURNEES.

2.1. International Law

A brief account is given below of refugee law and humanitarian law. Reference is also made to human rights as they apply to the situation of any person, including displaced individuals. It will be seen that a substantial corpus of international law has been developed over the last 40 years, essentially within the framework of the
United Nations system or in the form of regional agreements.

A. Refugee Law

The universally accepted definition of a refugee is that of a person who finds himself outside his country of origin or habitual residence owing to a well-founded fear of persecution on account of his race, religion, nationality, membership of a particular social group, or political opinion. (1951 UN convention on Refugees and 1967 Protocol).

The 1969 OAU Convention Governing the Specific Aspects of Refugee Problems in Africa:

Taking into consideration the specific political and social circumstances in Africa, refugees are also defined as those persons who flee from external aggression, occupation, foreign domination or events seriously disturbing public order.
Regional legal instruments with broader concepts of the term "refugee" also exist in Central America and Asia.

B. International Humanitarian Law
The Geneva convention of 1949, in particular article 3 and the fourth convention, offer a basic protection to the civilian population in armed conflict situations.

C. Human Rights Instruments
The 1948 United Nations Universal Declaration of Human Rights offers the basis for a "Standard of Humanity" which must apply in all situations, at least in regard to the so-called group of inalienable human rights.

2.2. Policy Towards Refugees/Returnees
Ethiopia's policy towards refugees has always been governed by an innately humanitarian compassion for the suffering, and hence, is marked by the generous provision of asylum, protection and assistance to all those who come to seek refugee in its territories without ethnic, religious and/or other biases. In fact, it is a country which pursues an open-door policy towards refugees and an equally open-door policy with regard to returnees. It thus promotes the policy of voluntary repatriation as the most durable global solution to the refugee problem be it in terms of receiving its own citizens living in exile or refugees in Ethiopia who seek to
return to their respective countries of origin.

In strictly legal terms, Ethiopia's policy towards refugees and returnees per se is governed by the principles and tenets enshrined in the 1952 UN convention relating to the status of refugees and its 1967 protocol to which it acceded in 1969, as well as the organization of African Unity (OAU) convention governing the specific aspects of refugee problems in Africa which it ratified in 1973.

Furthermore, with regard to services in all aspects of its programmes to refugees, the country strictly adheres to UNHCR's policy "that refugees are to be neither more nor less privileged than the host population".

This approach serves to avoid the tensions and jealousies that would result from providing a higher level of care to refugees.

3. REFUGEE IN ETHIOPIA
The refugee programmes in Ethiopia can be classified into three broad categories:
-Care and maintenance Programme for Sudanese refugees in the west;
-Care and maintenance Programme for Somali refugees in the east;
-Emergency refugee Programme.

3.1. Sudanese Refugee
Though the history of Sudanese refugees in Ethiopia dates back to the 1970's and even earlier, their numbers were not so significant as to attract the attention of the international community. Since 1983, however, the influx of Sudanese refugees has been growing at a rather alarming rate

to reach a total of over 400,000 around the end of April, 1991. The Ethiopian government with UNHCR established four camps to shelter these refugees. These are Itang (June 1983), Dima (August 1986), Assosa (May1987) and Fugnido (December 1987).

The refugees are coming from the Eastern Equatorial, Lower Upper Nile, and Bahar ElGhazal regions of the Sudan. The dominant groups are the Dinka and Nuer with the rest made up of Shilluk, Anuak, Murle, Toposa, Didinga, Uduk and Latuka peoples.

Though most are agro-pastoralist from the rural areas, there are a number of urban southern Sudanese who form the bulk of the teachers and health workers. A noticeable feature of these camps is the disproportionate numbers of males and unaccompanied young boys.

The areas where these camps are situated, i.e., within 70-80 miles of the Sudan border, are comprised of low tropical forest and savannah land criss-crossed by rivers originating in the high plateau of western Ethiopia. Each camp is situated near perennial rivers that constitute the main source of water for the refugees. The Gilo
(Fungido) and Baro (Itang) rivers flood annually during the main rains in July through September. This flooding is particularly acute in Itang where it poses a major health hazard. The supply of potable water to refugees in the Sudanese camps is only satisfactory in Dima, where a system has been installed in which the
river water is pumped and sedimentation filtration and chlorination take place. An average of 7.7 liters per person per day is provided.

May 1991 was marked by dramatic events and significant political development. This was also a period during which peace and stability was disrupted in the country temporarily. Hence, out of a sense of insecurity, the vast majority of the Sudanese refugees evacuated their camps so that there are now only some
10,000 or so Sudanese refugees remaining.

Yearly and cumulative influxes of Sudanese refugees in Ethiopia (1983-1992).

Year end	itang	Pugnido	Dimma	Assosa	Total
1983	40000	-	-	-	40000
1984	65433	-	-	-	65433
1985	85303	-	-	-	85303
1986	121042	-	10986	-	132010
1987	146948	19065	33167	22142	221322
1988	221101	45003	35243	29978	331325
1989	239394	69703	33243	41279	385619
1990	280611	85081	35091	-	400783
Apr. 30, 1991	280783	86188	35127	-	402098
February 1992	10000	-	-	-	10000

Demographic composition of south Sudanese refugees in Ethiopia as of April 30,1991

Age group	Male	Female	Total	Percentage

0-5	24542	24137	47679	12
6-15	70851	34711	105562	26
16-45	185003	54127	239130	60
46	8138	1589	9727	2
Total	288534	113564	402098	100%
Percentage	72%	28%	100%	

3.2. Somali Refugee

While the influx of Somali refugees into Ethiopia initially started in mid-1987, when the refugees were settled in Harshin, the most massive influx actually occurred in 1988. UNHCR assistance to the refugees started in May, 1988 and the refugees in Harshin were transferred to Hartisheik, currently the largest Somali refugee camp in the country .The other camps, namely Camaboker (July 1988), Rabasso (August 1988) and Daror (August 1988), were simultaneously established in the Aware region to accommodate the increasing number of Somali refugees.

August 1989 saw another influx of Somali refugees into Biyo Gurgur Aisha camp (October1989) in the Dire Dawa region. The escalation of the conflict situation in Somalia around February 1991 resulted in yet another additional influx of some 275,000 refugees along different entry points across the border; Teferi Ber and Derwonani in East Hararge, Arabi in Dire Dawa, Dolo Odo and Melka Suftu in Borena and Kelafo; Mustahil and Gode in the Ogaden region. New refugee camps had to be subsequently established in most of the areas up to mid-May 1991.

The refugees are coming from the northwest of Somalia. The dominant groups are the ISAAKs with the rest being ISSAs, Gadabursi, Hawiya and many other small clans.

Most of the refugees are nomads, and semi- nomads. However there are a lot of city dwellers from Hargeisa and Burao. This urban group comprises the elite of northern Somali. Most of the health workers in the camps are from this group.
The areas of these camps are arid and devoid of water and vegetation. An average of 800,000 liters of water per day is transported from Jijiga town and Jerrer valley by water tankers to Hartisheik, Teferi Ber and Derwonaji camps. The Aware camps depend on earth darns for their water supply, which frequently dry up during the dry season.
Due to the recent political development in the country and especially the disruption of law and order in the meanwhile, the smooth conduct of refugee operations in east Ethiopia was temporarily disrupted much the same as in western Ethiopia.
However, the situation of Somali refugees has not changed as drastically as is the case with the Sudanese refugees. A considerable number of no less than 480,000 Somali refugees are still residing in the various camps and remarkable reductions in population figures is noted only in Daror.

Number of Somali refugees in Ethiopia as of February 1992.

1. Hartisheik 246,522
2. Camaboker 66,615
3. Rabasso 26,181
4. Daror 31,622
5. Teferi Ber 50,000
6. Derwonaji 45,000
7. Aisha 19,362

8. Arabi 10,170
Total............495.472

3.3. **Care and Maintenance Programmes for Refugees**
Basically, the refugee care and maintenance programmes constitute a standard survival package of food, shelter, water, health and other social services as well as fundamental logistical and delivery support systems.

UNHCR is the foremost agency of concern providing emergency care and maintenance assistance to the refugee populations in the country with full support from the government and material contributions from selected NGO's. "This multi-sect oral assistance is primarily intended to ensure a minimally acceptable living
standard in terms of food, water, shelter and health services. Although other essential social services, such as education, community welfare, and social counseling are rendered, these are not as developed as required.

FOOD: The food ration for refugees consists of the following:

Cereals	500 gm (person/day)		
Pulses	50 gm	"	"
Oil	30 gm	"	"
Sugar	20 gm	"	"
CSM/FAFA	30 gm	"	"
Salt	5 gm	"	"

Food distribution has been regular with most commodities available except for shortages in oil and blended food.
WATER: The unsatisfactory water situation in all the camps (except Dima) is the major threat to the health of the refugee population. The daily average water supply ranged from 2-3 liters per person, which is far below the recommended requirement.

3.4. **Health Services to Refugees**
Health services to the refugees is based on a four-tier system linked by referral and supervisory arrangement and is consistent with the policy of the Ministry of Health (MOH).
Level One: Community-based health services, using CHA and TBA. (CHA: 1000 and, TBA:2500)
Level Two: Satellite clinics staffed by nurses and health assistants; one satellite clinic services 10-30,000 refugees and is responsible for the supervision of 10-30 CHA's working under its catchment area.
Level Three: Health centers and/or field hospitals depending on the number of satellite clinics; staffed by medical doctors, nurses, health assistants, sanitarians, pharmacy and laboratory technicians. The health center is responsible for the supervision of the satellite clinics under its zone.
Level Four: Regional and central MOH hospitals: where patients requiring further investigation and treatment are referred. The basic operation of the health delivery system relies more on community-based health service programmes. The preventive services are based on:
-Appropriate vector control (malaria); fully implemented by the malaria control of the MOH.,

-Health and nutritional screening of new arrivals coupled with mass vaccination for measles and vitamin A prophylaxis;
-Maternal Child Health (MCH) clinics integrated with: growth monitoring, BPI, ORT corners, supplementary feeding programmes for under-fives, pregnant and lactating women, pre and post-natal check ups, delivery services;
-A camp sanitation Programme: camp cleaning on a weekly basis, building pit-latrines and refuse disposals, health education, vital statistics via grave watchers and TBA's;
-Active surveillance for epidemic potential diseases from the community up to the hospital level (Annex 1);
-Curative services with OPD and in-patient facilities (1 hospital bed per 2000 refugees);
-Standard treatment protocols with essential drug lists in place.

3.5. **Health Status of the Refugees**.

As with all refugee populations, the health Status has to be compared with the levels Achieved before immigration and also with those of the neighboring host population.

The health and nutritional status of the refugees under the care and maintenance Programme, both in the east and westb1eon- the whole and at least comparable to, if not better than, that of the local population. This is manifested by the low CDR (Crude Death Rate) and malnutrition prevalence rates.

The CDR in all the camps is, on average, below 20/1000/year and the malnutrition prevalence rate is below 10% less than 80% WFH (Weight For Height) (excluding the camp of Teferi Ber which is 18% less than 80% WFH).

Comparison of CMR in various refugee and host country non-refugee population

Refugees	Refugees	Pop.	Period	Refugees	Country
Somali (Ali Matan)	Eth.	60000	Aug-1980	30.4	1.8
Sudan 8 Eastern Campus	"	220000	Jan.-Mar.1985	16.2	1.7
Ethiopia Hartisheik Somalia	Somali	1700000	Feb-Apr. 1989	6.6	1.9
Displaced Ethiopia Korem	-	100000	Oct.-Dec. 1984	60-90	2
Shoa (famine victims in villages)		380000	Feb.-Oct.1985	8.2	2

Out-patient statistics indicate the most common diseases treated are malaria, acute respiratory infections, tropical ulcers, diarrhoeal diseases, eye infections and intestinal parasites. Furthermore, the most common causes of death are diarrhoeal diseases, malaria, respiratory tract infections (including tuberculosis) and trauma.

4. **RETURNEES IN ETHIOPIA**

Durable solutions to the refugee problem have traditionally centered on voluntary repatriation, local settlement and third-country resettlement of these three, voluntary repatriation is considered the preferred solution.
Two categories of returnees are distinguished: Spontaneous and Organized returnees. Very little is known about the spontaneous returnees but most observers expect their number vastly to exceed that of the organized returnees.

4.1 Historical Background

Spontaneous and organized repatriations have occurred since as far back as 1983.

Information on the spontaneous returnees is scanty. However, it is recorded that there were:

a) Spontaneous returnees from the Sudan into Eritrea in 1983, and these were assisted by the League of Red Cross and RRC;

b) Spontaneous returnees from Somalia into the Ogaden in 1983-5, and these were assisted by WUSC and RRC. The population of these returnees is estimated around 400,000.

Organized repatriation programmes have been concluded since 1984. These include:

a) 33,000 Ethiopian refugees who were repatriated from the Republic of Djibouti in 1984, via Shinile;

b) 15,400 Ethiopian refugees who were repatriated from Somalia from December 1986-1990,via Dollo;

c) 4,501 Ethiopian refugees who were repatriated from northwest Somalia in 1991, via Teferi Ber.

4.2 Current Returnee

Further to the organized repatriations mentioned above, a plan of action was worked out to repatriate some 160,000 Ethiopian refugees from Somalia as per the provisions of the Tripartite agreement concluded in December 1989 between Ethiopia, Somalia and the UNHCR. Unfortunately, however, the escalation of the conflict situation in Somalia since February 19911ed to an abortion in the organized repatriation. Since then, over 370,000 spontaneous returnees have entered the country along different entry points. These returnees are currently found in Kelafo, Kebridehar, Gode, and Mustahil in the Ogaden region, Arabi in Dire Dawa, Kebribeyah, Derwonaji, Teferi Ber and Babile in Eastern, - Hararge, Dolo, Qdo, Melak Suftu and Moyale.

4.3. Assistance to Returnees

-Food distribution

-Travel and rehabilitation cash payment

-Follow-up in reintegration area

A. **Food**

The returnees are entitled to food rations for one year .The food distribution standard is the same as for refugees.

B. Travel grant

Two adults from one family are entitled to 100 Birr each. All registered dependents are given 50 Birr/person.

C. Rehabilitation grant

Two adults from one family are entitled to 240 birr each. Registered dependents are entitled to120 Birr each.

4.4. Health Services to Returnees

Unlike the refugee health service, the returnee health service is mainly geared to:

a) First-aid on their way from the border to the reception center;

b) Health and nutrition screening in the reception center (15 days duration);

c) Referral of the severely ill patients.

Returnee operation areas in Ethiopia 1991

A. Eastern operation (Hararge)

I. Arabi	3,000
2. Habile	21,000
3. Teferi Her	27,500
4. Dernowaji	58,000
5. Degehabour	18,500
6. Kebribeyah	30,000
Total	**150,000**

B. South Eastern operation (Ogaden)

1. Kelafo	25,088
2. Kebridehar	22,631
3. Gode	13,753
4. Mustahil	13,402
5. Hurkur	5,560
6. Shilabo	2,510
7. Warder	2,532
8. Debe Wayne	3,003
Total	**88,479**

C. South operation (borena)

I. Dolo-Odo	104,674
2. Suftu	29,217
Total	**133,891**
Grand total	**372,370**

4.5. Health Status or the Returnees

As outlined above, the main activities of the health sector is geared to screening, and as the returnees are reintegrated into their area of origin, it is quite difficult to mention the health status of the returnees.

However, in those unfortunate instances where returnees are kept in camps their mortality and malnutrition rates are very high. For instance the CDR among returnees is57.6/1000/year in Teferi Ber with a malnutrition
rate of 25% < 80% WFH. In Dernowaji the CDR and malnutrition rates are 55.6/1000/yearand 28% < 80% WFH respectively. Crude death rate and malnutrition rates in Kebribeyahare 58/1000/year and 60% .In Dolo and Suftu CDR and malnutrition rates are recorded to be93.6/1000/year and 60% < 80% WFH.

4.6. Potential Returnees

Currently there are over 800,000 Ethiopian refugees in the Sudan.

Host Country	Years of influx	Origin	population
Sudan	1976-1984	Eritrea (Ethiopia)	500000
Sudan	1984-1985	Ethiopia	340000

5. HEALTH CONSEQUENCES OF MIGRATION

Acute movements of large populations into areas with insufficient resources have precipitated health crises that have demanded prompt, well-targeted responses. On too many occasions, mortality -much of it preventable -has been exceedingly high during the early phases of relief operations.

Migration facilitates the transmission of disease by spreading causative agents and/or by changing the environment. Migrants may have lowered resistance to diseases and/or may be exposed to new diseases. In certain circum-stances, diseases may actually cause migration Diseases in refugee camps can be broadly classified into the following categories: -
Endemic disease in country of origin;-diseases encountered at time of transit;
-Endemic disease in host country;
-Diseases that is likely to arise due to over-crowding and living conditions in the camps.

When refugees flee to developing countries that are characterized by low income and poor health indicators, they exert an additional burden on the frail health delivery system precipitating a health emergency.

In a refugee situation the "emergency" phase is the period during which mortality rates are higher than those experienced prior to displacement. This phase varies from 1-12 months. The emergency phase is considered to be over when CMR (Crude Mortality Rate) drops to less than 1 per 10,000 per day.

In the post emergency phase, mortality rates generally return to that of the surrounding population.

Most mortality in refugee populations has been caused by measles, diarrhoeal diseases, under-nutrition, acute lower respiratory infections and malaria, the same diseases that affect non-refugee populations. Although outbreaks of cholera, meningitis and typhus are potentially serious, they have not caused many deaths. Thus, it is not the type of illness but rather the incidence and high mortality rates that makes these populations remarkable; this vulnerability being explained by under-nutrition and nutrient deficiency. Other factors, such as crowding, poor water supply, personal hygiene, physical trauma and psychological stress may also contribute to the mortality rate in these situations. Although complex social, political, and economic issues affect the well being of refugees, implementation of the following might help them survive the acute phase of their displacement.
1. Provision of food rations containing adequate calories, protein, and essential micronutrient. Although supplementary feeding programmes are often popular with relief agencies, their effectiveness in refugee camps in the absence of adequate general food rations is questioned.
2. Provision of clean and adequate water. The provision of adequate quantities of clean water bas resulted in the reduction of diarrhoeal disease morbidity.
3. Implementation of appropriate interventions for the prevention of specific communicable diseases;
-Immunization of children against measles;
-Malaria control;
-Prompt identification and treatment of symptomatic individuals by health screening.

4. Institution of appropriate curative programmes with adequate population coverage, with standardized treatment protocols and an essential drugs list. Proper management of diarrhoeal diseases, URTI, etc.
5. Establishing a simple but effective health information system with active surveillance for mortality, nutritional status and important epidemic diseases such as measles and cholera. Furthermore, health services for refugees should be integrated, as much as possible, within health programs for host country nationals.

6. IMPACT OF REFUGEE/RETURNEEPRESENCE

The refugee hosting areas in Ethiopia, be they in the east or west, are located in very remote peripheries which lack the most basic infrastructure and natural resources.
The impact of refugee/returnee presence in these areas can be summarized as follows. (This list is not complete but is intended to arouse discussion and to show that it is multi-dimensional.)

6.1. Environment and Eco-system

The increased caseload of humans and cattle will affect:
-Wild-life in proportion to increased population,(i.e. hunting);
-Forests in proportion to increased demand for firewood and construction of houses;
-Grazing land in proportion to the increased number of cattle, (i.e. the graze land will be over loaded).

6.2. Economy

-Shortage of commodities in proportion to increased demand;
-Decrease in 'l>rice of agricultural products in proportion to refugees selling their rations.

6.3. Health

-Shortage of health manpower in proportion to the deployment of staff to the refugee camps;
-Increased case loads in referral hospitals in proportion to the referral of refugees.

6.4. Roads

-Dilapidation of roads in proportion to heavy traffic to and from the refugee camps.

7. PROGRAMM~ OF MUTUAL BENEFIT TO REFUGE~ AND NATIONALS HEALTH

HEALTH
7.1 The health services rendered to the refugees are equally shared with nationals living around the refugee camps. This also includes medical care, feeding programmes, EPI, etc.

7.2. There are two projects currently underway to upgrade the hospitals of Jijiga and Gambella to render more surgical services to the referred refugees and nationals. These projects are funded by the European Economic Commission (EEC) and are implemented by MSF. There is also a plan to upgrade Mizan Hospital surgical services.

7.3. A health center is to be built and handed over to the MOH in Kebribeyah, which is mainly to assist the reintegration of returnees.

REFERENCES

1. Report on Ute Round-Table on "The Movement of People, New Developmenla" International organization for Migration, May 1990.
2. ToIle, M.J. and R.J. Waldman. "Prevention of Excess Mortality and Refugee and Displaced Populations". JAMA. June 27, 1990; 263 (24).
3. Toole, M.J. and R.J. Waldman. "An Analysis of Mortality Trend. Among Refugee Populations in Somalia, Ute Sudan and Thailand". Bull. WHO. 1988; 66 (2): 237-247.
4. Moore, P.S., et .1. "Surveillance and Control of Meningococcal Meningitis Epidemic. in Refugee Populations". Bull. WHO. 1990; 68(5): 587-596.
5. "Review of Health and Nutrition Programme for Western Ethiopia Refugee Camps". TSS Mission Report 90/08, Geneva.
6. "Review of Health and Nutrition Programme for Eastern Ethiopia Refugee Camps". TSS Consultancy Report 89/40, Geneva.
7. "Health and Nutrition Programme Review". TSS Consultancy Mission Report 90/27, Geneva.
8. "Report of Ute Multi-donor Technical Mission on Refugee. and Returnees", Feb. 1991.
9. "Profile for Refugee Emergency-prone Countries -Sudan". Office of Ute UNHCR, Nov. 1987.
10. "Somalia -An Emergency Preparedness Profile". Office of Ute UNHCR, Oct. 1987.
11. "Profile for Refugee Emergency-prone Countries -Ethiopia" . Office of Ute UNHCR, June 1985.

ANNEX I

ADMINISTRATION FOR REFUGEE AFFAIRS

MONIH: ....
WEEK: I II IV
DATE ....TO.............

WEEKLY NOIFIABLE DIEASES
RADIO REPORT

	CASES		DEATHS	
	<5YRS (A)	≥5YRS (B)	<5YRS (C)	≥5YRS (D)
1. Measles	______	______	_______	______
2. Relapsing Fever	______	______	_______	______
3. Suspected Meningitis	______	______	_______	______
4. Suspected Yellow fever	______	______	_______	______
5. Suspected Cholera	______	______	_______	______
6. Suspected Typhoid fever	______	______	_______	______

7. Suspected Hepatitis` ______ ______ _______ ______

N.B: All reported cases should be based on Physician's opinion.

Annex III

Figure 10

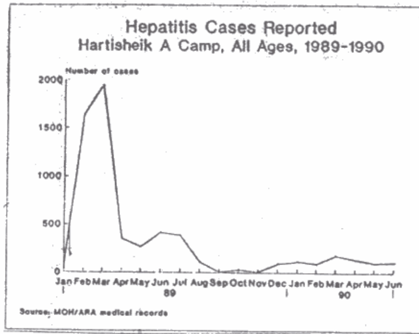


Figure 4

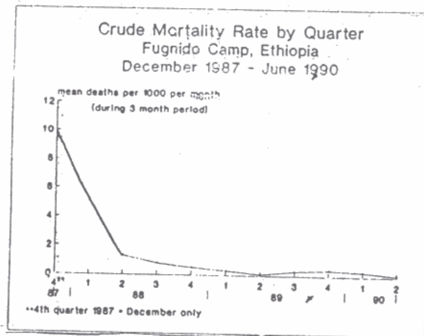
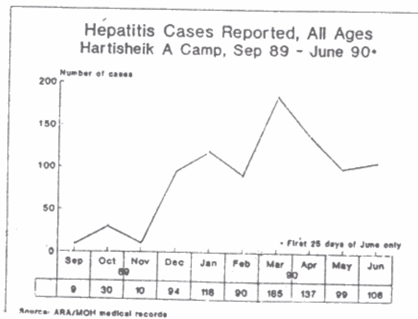


Figure 11



DISCUSSION

Chairoperson: Dr. Charles Larson.
Speaker: Dr. Ephrem Assefa, Administration
for Refugee-Returnee Affairs.

1. INTRODUCTION

There are in the world today more than 30 million refugees and internally displaced persons within the border of their own countries. Conflicts and famine are among the most frequent causes of these forced mass population movements. The Horn of Africa has experienced major socio-political upheavals which have triggered mass refugee displacements and migrations. The refugee population in Ethiopia has been escalating at a very alarming rate, as evidenced by the increase from 40,000 by the end of 1983 to 1,062,000 Sudanese and Somali refugees by the middle of 1991. The situation in Somalia has also caused the sudden and spontaneous flight of about 250,000 Ethiopian returnees since the beginning of 1991.

2. LAW AND POLICY

Ethiopia's policy towards refugees and returnees is governed by the principles and tenets enshrined in the 1952 UN convention relating to the status of refugees and the OAU convention governing the specific aspects of refugee problems in Africa which it ratified in 1973.

3. REFUGEE IN ETHIOPIA

The refugee programmes in Ethiopia can be classified into three broad categories: -care and maintenance programme for Sudanese refugees in the west;
-care and maintenance programme for Somali refugees in the east;
-emergency refugee programme.

3.1. Sudanese Refugee

Although the history of Sudanese refugees in Ethiopia dates back to the 1970's, it was in 1983 that there was the beginning of an alarming influx which reached a total of 400,000 refugees around the end of April, 1991. The Ethiopian government with UNHCR established four camps to shelter these refugees. These are Itang
(Iune 1983), Dima (August 1986), Assosa (1987) and Fugnido (December 1987). Each area is situated near perennial rivers that constitute the main source of water for the refugees. Flooding is particularly acute in Itang where it poses a major health hazard during the rainy seasons.

A noticeable feature of these camps is the disproportionate numbers of males and unaccompanied young boys. Most of the refugees are agro-pastoralists from the rural areas. Currently, there are only about 10,000 Sudanese refugees remaining in Ethiopia, the vast majority of them having evacuated their camps after the May 1991 political development in Ethiopia.

3.2. Somali Rerfugee

While the influx of Somali refugees into Ethiopia initially started in mid-1987, the most massive influx actually occurred in 1988. August 1989, and the escalation of the conflict in Somalia around

February 1991, resulted in an additional influx of 250,000 refugees. Most of the refugees are nomads and semi-nomads. The
camp areas are arid, devoid of water and vegetation. An average of 800,000Iitres of water per day is transported to these camps. A considerable number of no less than 480,000 refugees are still residing in the various camps.

3.3. Care and Maintenance Programme for Refugee
This programme constitutes a standard survival package of food, shelter, water, health and other social services and fundamental logistical and delivery support systems. Food distribution has been regular with most commodities available except for shortages in oil and blended food. The unsatisfactory water situation in all the camps (except Dima) is the major threat to the refugee population.

The daily average water supply ranges from two to three litres per person, which is far below
the recommended requirement.

3.4 Health Services to Refugees
Health services to the refugees is based on a four-tier system linked by referral and supervisory arrangement and is consistent with the policy of the MOH. The four-tier system includes community-based health services, satellite clinics, health centres and regional or central referral hospitals. The basic delivery of the health system relies more on community-based health services pro- grammes. The preventive services are based on appropriate vector control (malaria), health and nutrition screening of new arrivals coupled with mass vaccination for measles and vitamin A prophylaxis, integrated MCH clinics, a camp sanitation programme, active surveillance for epidemic potential diseases and curative services with OPD and in-patient facilities.

3.5. Health Status of the Refugee
The health and nutritional status of the refugees under the care and maintenance programme, both in the east and the west, is quite stable on the whole and at least comparable to, if not better than, that of the local population. This is manifested by the low CDR malnutrition prevalence rate which is below 10% less than 80% WFH (Weight For Height).

Out-patient statistics indicate that the most common diseases treated are malaria, acute respiratory infections, tropical ulcers, diarrhoeal diseases, eye infections and intestinal parasitosis. Furthermore, the most common causes of death are diarrhoeal diseases, malaria, respiratory infections (including tuberculosis) and trauma.

4. REfURNE~ IN ETJDOPIA
Two categories of returnees are distinguished: spontaneous and organized returnees. Spontaneous and organized repatriations have occurred as far back as 1983. Spontaneous returnees from Sudan and Somalia in 1983-1985 were estimated to be more than 400,000. Three organized repatriation programmes were concluded in 1984 from Djibouti and Somalia, and the number of returnees was estimated to be 53,000. A plan of action was worked out to repatriate some 160,000 Ethiopian refugees from Somalia. However, the escalation of the conflict situation in Somalia since February 1991100 to an abortion of the organized repatriation resulting in over 370,000 spontaneous returnees entering the country .The returnees are entitled to food rations for one year , a travel

grant of 50 birr/person and a rehabilitation grant of 120 birr for each registered dependent. Health services to the returnees are mainly geared to first-aid on their way from the border to the reception centre, health and nutrition screening in the reception centre and referral of the severely ill patients.

4.1. Health Status or the Returnees As the returnees are reintegrated into their area of origin it is quite difficult to mention the health status of the returnees .However, in those unfortunate instances where returnees were kept in camps their mortality and malnutrition rates were very high. The CDR ranged from 55.6 - 93.6/1000/year and malnutrition rates ranged from 25%-60% < 80% WFH. Currently there are 800,000 potential returnees who are refugees in the Sudan.

5. HEALTH CONSEQUENCES OF MIGRATION

Migration into areas with insufficient resources has precipitated health crises that have demanded prompt, well targeted responses. It facilitates the transmission of diseases by spreading the causative agent and/or by changing the II environment. Migrants may have lowered resistance to diseases and/or may be exposed to new diseases. Thus, a high incidence of disease and mortality rates makes these populations remarkable. Part of this vulnerability is explained by under-nutrition, and other factors such as crowding, poor water supply and personal hygiene, physical trauma and psychological stress. When refugees flee to developing countries that are characterized by low income and poor health indicators, they exert an additional burden on the 184 frail health delivery system precipitating a health of emergency. Among the major impacts of a refugee/returnee to the host country are increased population, increased depletion of ilia. forest, shortage of commodities and increase burden to the health situation.

FURTHER DISCUSSION

Q. How often are you able to recruit health workers including CHWs from among yourrefugees?
A. It depends on the occupation of the refugees.Some health workers are recruited from the refugees.
Q. Do you pay the CHWs -it will influence thesustainability of community health services -or is there any material incentive?A. Because of the high rate of absence we havestarted paying the CHWs. Their salary is 103 birr per month.
Q. You have mentioned that the reports from the CHWs were more valid than the health center report -what about the quality of the reports of the CHWs?
A. This was mentioned in relation to the incidence of diseases. Since the CHWs did house-to-house visits the report of incidence of diseases was more valid. The health centre report is a passive report and did not include all new cases in the community.
Q. What kind of reproductive health service did you provide? How did you follow the vital statistics?
A. I. No family planning service is provided at present. This is because of a lack of acceptability of family planning in the "Somalia camp". In the "Sudanese camp" there were more males and we found that it was not acceptable by the refugees.
A. 2. Vital statistics is reported by TTBAs and "grave watchers". The TTBAs report births and the "grave watchers" report deaths. The reports from the "grave watchers" is checked by the health workers. The refugees are afraid to report deaths because rations will be decreased. They tend to report more births to increase the amount of rations they receive.
Q. Do physicians report the weekly notifiable diseases? A. We insist on physicians' opinions and they do
report.

Q. Was the recruitment of CHWs related to refugees or returnees?
A. Refugees.
Q. Is there any change in the policy of UNHCR to development programmes particularly in relation to long-term assistance? A. Refugees are not permanent residents, hence, it is difficult to build long-term projects.

The other problem is there are no sufficient funds to initiate and maintain development programmes. Resources are mainly directed to the care and maintenance programmes of the refugees. Comment: Yes, we are doing something in development programmes. In Gambella Hospital we have built the MCH block and extended the operation theatre; we intend to improve the sewerage system. Similar projects are carried out
in Jijiga. While we have no direct responsibility to provide permanent development projects, some measures have been taken in limited areas. With regard to development projects for both local people and refugees, we are only catalysts of community-based activities.

Comment: To compensate for the work load in Gambella Hospital some instruments were provided by the UNHCR, but these were taken back by the refugees. We need more instruments than mentioned.
A. We will provide.
Q. Did you see yellow fever?
A. No.
Q. How is the flow of the health information system?
A. We have a link with the MOH and data is accessible to the MOH through the health institutions.
Comment: The regional health department did not get reports from your health institutions. Please send the reports regularly.
A. Well taken. We will send the reports regular-