HEALTH AND DEVELOPMENT FOR DISPLACED POPULATIONS IN ETHIOPIA

(An Overview)

1. GENERAL

According to the United Nations classification Ethiopia is one of the 31 least developed among the developing countries of the world. The vast majority of its people, accounting for nearly 90% of the total population, live in the rural areas which lack even the most basic and minimal socio-economic infrastructures and facilities. The life of the Ethiopian people as a whole is characterized by extreme poverty further exacerbated by the ravages of decades of internecine conflict, civil war, recurrent drought and famine as well as misguided policies. Consequent to all these debilitating factors, the overall health status in the country has been and still remains very poor by all standards. Communicable diseases and malnutrition are widespread problems and are further exacerbated by the very high birth rate.

While accurate and comprehensive statistical data are hard to come by, recent estimates put the total population of Ethiopia at a little over 47,000,000 of which 46.5% are reported to be under the age of 15. The average life expecancy rate is recorded to be 46 years for females and 43 years for males. Infant, child and maternal mortality rates are 139/1000, 257/1000. Crude birth rate stands at 46.9% while the crude death rate is 18.4%. The average rate of population growth is about 3% per annum.

The vast majority of the people live in the rural areas engaged in subsistance farming and animal husbandry. The agricultural sector accounts for almost 50% of the Gorss Domestic Product and employs more than 80% of the population while industrial activity accounts for only 11% of the GDP and employs only 3% of the working population. Average per capita income is only USD 140. The overall rate of economic growth in the country has been minimal and steady economic crisis enhanced by the ravages of war and famine has been a characteristic phenomenon over the decades.

It is against this grim backgroud that Ethiopia has also been host to huge caseloads of refugees mainly from nighbouring Sudan and Somalia. Local displacement caused by war and famine and affecting a significant proportion of the population in practically all parts of the country has also been prevalent over the past three decades or so.

Currently, Ethiopia is hosting some 500,000 Somali refugees in some seven camps scattered in the Eastern Hararghe and Dire Dawa regions along with 17,000 Sudenese refugees in the Kaffa and Gambella area. In addition to these, there are some 450,000 Ethiopian returnees who have come from Somalia consequent to the intensification of the civil war in that country beginning early 1991. These returnees are scattered in various parts of the Ogaden, Eastern Hararghe, Bale, Sidamo and Borena regions. Another 170,000 Ethiopian returnees who are reported to have come from the Sudan over the past two years or so are also found in the northern parts of the country, mainly Tigray, Gondar and Wello. The current drought and famine, which is reported to have affected some 8 million people, has also been the cause of displacement to a significant

proportion of the victims though no accurate data in this regard are immediately available. While it is known that population displacements have been caused by localized conflicts, reliable figures have proven hard to come by.

On the whole, the phenomenon of displacement in Ethiopia is quite rampant and involves refugees, returnees as well as persons displaced by drought, famine and conflict. Despite this, however, there exists in Ethiopia no defined health policy particularly targeted as such at displaced populations of whichever category. The national health policy based on the principles of Primary Health Care applies to all sectors of the population including local communities and displaced persons of all categories.

Hence, all health and development issues pertaining to displaced populations cannot be considered in distinction but as a component of the whole. This paper will, therefore, attempt to give an overview of the national health policy along with related issues and problems with particular reference to the situation and problems of displaced populations.

2. HEALTH POLICY AND INTER-SECTORAL COOPERATION

Ethiopia's health policy as a whole is geared towards a reinforcement of all endeavours for the provision of health services which ensure the full and meaningful life of the people. The national guideline in this regard emphasizes the need to involve the people, in line with the principles of democratization and self-reliance, in all efforts aimed at the expansion of health services. This guideline has been further reinforced through the official adoption of the global

resolution and motto of "Health for all by the year 2000" along with the Primary Health Care Strategy designed to lead to its attainment.

Based on this strategy, the Ministry of Health has elaborated its policy by underscoring three key areas of concentration which are crucial to the successful implementation of primary health care as follows:-

1. Provision of health services with particular emphasis on prevention and control;

2. Expansion and upgrading of health services;

3. Promotion of self-reliance and full community participation along with the use of appropriate technology.

The health policy in Ethiopia as a whole underlines the importance of enhancing the self-relinance of communities in health matters. Under this policy, the Community Health Agent (CHA) and the Traditional Birth Assistant (TBA) comprise the most vital health manpower component. Accordingly, a target has been set of placing one TBA and one CHA in each community.

Furthermore, the policy stresses the fact that the expansion and development of health services alone cannot improve the health status of a population since any discernible development in health is closely linked with development in other sectors such as education, communication, water supply, sanitation etc. leading onto overall economic development. It, therefore, calls for viable inter-sectoral linkage and complementarity wherein advances in the various sectors contribute to improved health and vice-versa.

The this end, the policy advocates Integrated Rural Development to ensure which several mechanisms have been developed by setting up inter-sectoral coordination bodies all the way from the national to the district level.

3. HEALTH DELIVERY SYSTEM AND FACILITIES

The national health delivery mechanism and infrastructure in Ethiopia is based on a six-tier system linked by referral and supervision arrangements on all lower levels and may best be illustrated as a pyramid with the broad base representing health services at the grass-roots community level and the apex the central hospitals.

As such, the health care facilities and services nation wide consist of the following:-

1.	Central hospitals with major specialities	6
2.	Regional hospitals	26
3.	Rural hospitals	43
4.	Health centres	140
5.	Health stations	1,850
6.	Community health services (CHA's and TBA's)	5,000

These facilities and services are said to provide approximately 43% of the population with access to some form of health care within a radius of about 12kms.

On the whole, Ethiopia is estimated to have only 33% of the required trained manpower. Official statistics put the total physician/population ratio at

1:63,301 and the nurse/population ratio at 1:18,990. Nevertheless, owing to unbalanced distribution in favour of urban areas whereby most physicians work in the cities, it is estimated that the actual physician/population ratio in the rural areas is 1:130,000. While total hospital beds are estimated at 11,296, the bed/population ratio is 1:4072. Maternal and child health services are believed to reach an estimated 14% of mothers and 10% of children under 5 years of age.

In general, health facilities and services are far too inadequate and the health coverage is far too low by any standards to ensure the maintenance of even the most minimal level of acceptable health status among the people. This already grim reality is yet compounded by extreme poverty and backwardness wherein the most basic contributory factors to health such as safe water supply, for instance, are accessible to a very small minority of the people and there is an acute shortage of food resulting in severe and moderate malnutrition among 38% of all children under five.

4. HEALTH STATUS

The determinants for health status in Ethiopia are much the same as those of most developing countries and rest broadly on cultural, socio-economic, environmental, nutritional, political and demographic factors. In general, the poor health status prevaling in Ethiopia today is essentially a direct relection of overall backwardness compounded by decades of civil strife. While the country is predominantly agrarian and its economy is largely based on subsistance agriculture, this vital sector has recently been adversely affected

by the ravages of recurrent drought. The annual rate of growth in agricultural production over the past decade has been no more than 1% in most cases.

Though recent years have seen marked growth in adult literacy, ignorance and superstition with regard to elementary rules of hygiene are still rampant. Nearly all the rural population and the majority of the urban population have no access to sanitary facilities. Less than half the population have access to health care facilities. Under the circumstances, therefore, the majority of the population relies on traditional medicine.

Total government health expenditure over the past decade or so has been no more than 3.5 - 4.5% with an average per capita health expenditure of about USD 1.00 with striking variations between the rural regions ranging from USD 0.40 to USD 9.8 in urban centres.

The major urban centres which account for only 4.4% of the total population enjoy the services of 47.8% of total hospital beds, 39.5% of all medical doctors and 65% of all specialist physicians in the country.

In general, the overall backwardness and extreme poverty prevalent in the country is a cardinal factor in the poor health status of the population. Life expectancy at birth (46 years for females and 43 years for males) is one of the lowest in the world. Nearly 60% of all deaths in Ethiopia occur among mothers or children under the age of five years which in absolute numbers represents half a million child deaths and some 30,000 maternal lives lost each year.

Health and nutrition surveys carried out over the past decade categorically indicate that communicable diseases constitute the major health problem in Ethiopia. Many of the diseases are said to be caused by poor personal and environmental hygiene and the lack of safe water supply and adequate sanitation. Malnutrition is also reported to be a major problem not only because it leads to a higher prevalence of deficiency diseases but also because it encourages the spread of communicable diseases.

Despite the non-availability of reliable and comprehensive mortality and morbidity data, it is estimated that as much as 75% of the disease incidence in Ethiopia may be attributed to two causes - poor sanitation and malnutrition, and that 60% of childhood morbidity is caused by preventable diseases.

5. DISPLACED POPULATIONS

5.1 Locally Displaced Populations

Poverty, war, civil disturbances, drought and famine have long been the cause of population displacement in Ethiopia. Historical accounts of drought and famine in Ethiopia date as far back as the ninth century and reveal a continuous succession of droughts over the centuries. Factors directly responsible for the outbreak of famine have been identified as drought, the outbreak of rinderpest, plagues of locusts and caterpillars. Epidemics almost always followed or accompained famine. While drought and famine actually dealt the last blow culminating in the devastations, evidences show that the regions affected on the whole are underdeveloped and have poor records of

agricultural production compounded with destabilization by civil strife and conflic. Famine is thus the last stage in a whole gamut of interrelated natural and socio-political processess leading to population displacement.

Such population displacements have occured repeatedly, the most recent being those of 1973/74 and 1984/85. The problem as a whole has always been magnified by the perpetual shortage of relief resources and related faciliteis.

Ethiopia is once again in the grips of a debilitating famine which, according to the Relief and Rehabilitation Commission (RRC) of the Government has affected some 8 million people even though the majority of these are not displaced.

Although there exist no reliable data for the overall size of displaced poplations, it is known that many thousands are scattered in various parts of the country consequent to the current drought and famine as well as civil disturbances and localized ethnic conflicts.

5.2 Refugees and Returnees

Currently, Ethiopia is hosting about 500,000 Somali refugees and some 17,000 Sudanese refugees in the eastern and western parts of the country respectively. All these refugees are provided with care and maintenance assistance under the UNHCR.

With regard to returnees, there are now some 450,000 returnees from Somalia and another 170,000 from the Sudan. Preparations are also under way to

expedite the repatriation of some 160,000 Ethioian refugees from the Sudan in the very near future.

6. HEALTH SERVICES TO DISPLACED POPULATIONS

6.1 General

Ethiopia has no distinct health strategy in favour of refugees, displaced, returnee and host populations. The national health strategy is equally applicable in all cases with slight variations in actual implementation involving various governmental and non-governmental organizations.

While the health services rendered to the various categories of displaced populations in general fall within the national health delivery network, health services to refugees are slightly different in that they are better organized and funded centrally by the UNHCR.

6.2 Health Services to Refugees

The health services rendered to refugees are based on a four-tier system linked by referral and supervisory arrangements in consistency with the national health policy. On the first level, there are community based health services involving CHA's and TBA's. On the second level are to be found satellite clinics staffed by nurses and health assistants. The third level comprises of health centres and/or field hospitals and on the fourth level are to be found regional and central hospitals which provide referral services.

The basic operation of the health delivery system relies more on community-based health service programmes with preventive services based on appropriate vector control, health and nutritional screening, MCH clinics integrated with growth screening, EPI and ORT corners, supplementary feeding programmes for underfives, pregnant and lactating women, pre- and post-natal check-ups and delivery services, camp sanitation programmes together with health education and active surveillance against epidemic diseases along with curative services with OPD and in-patient facilities. The health and nutritional status of the refugees under the UNHCR care and maintenance programmes is quite stable on the whole, except in the case of new arrivals, and it is at least comparable with if not better than that of the local population.

7. PROBLEMS OF INTERVENTION PROGRAMMES

As in the case of most developing countries, the health problems in Ethipia are almost endless as they are compounded by and intertwined by the problems of all other sectors. The problems become even more complex and daunting in the special case of displaced populations inclusive of refugees and returnees.

On the whole, morbidity is high and the large number of diseases in itself constitutes a continuous threat to the well-being, health and longevity among all sectors of the population. Infectious and parasitic diseases are common and ignorance, superstition and malpractice contribute to further complicate the situation.

Health authorities and institutions trying to combat and control these problems are furthermore faced with severe lack of trained personnel and adequate resources, particularly in the rural areas, where in many cases the whole infrastructure of health services and other facilities such as communications, schools, sanitation, community development and administration are almost non-existent.

While concerted endeavours involving the government, host communities non-governmental organizations are under way through the assistance and support of international agencies (UN agencies, bilateral donors) and the international community as a whole to cope with the problem of refugees, returnees, displaced and host communities collectively through emergency relief and long-term maintenance programmes, serious problems are encountered as elaborated hereunder:

1. The recurrence of drought and famine coupled with wars and conflicts has generated a continuous process wherein existing facilities and programmes have become perpetually insufficient and coping mechanisms are neither effective nor sustainable.

2. The existence of too many organizations charged with the responsibility for the welfare of the different categories of the displaced (refugees, returnees, displaced and host communities) and the lack of coordination amongst them has also created a serious hurdle. This situation has created confusion among aid agencies in the determination of correct or viable counterparts.

The absence of distinct and clear guidelines has resulted in the mismanagement of scarce funds, poor information flow and exchange of experiences and, sometimes, in inter-agency rivalries in the case of both national and international agencies.

3. Failures in the delivery of support and assistance to displaced populations of all categories at the right time and place have been contributory factors in mounting health hazards and severe malnutrition. Support in most cases is said to arrive after the disaster has reached crisis levels and when it has eventually arrived, it reaches the beneficiaries in trickles and, therefore, fails to achieve the desired impact.

4. The insufficiency and unsustainability of financial and material inputs for long-term programmes and services for displaced populations as a whole is also a major constraint. The phasing out of assistance programmes before the attainment of set objectives and the termination of assistance with no follow up arrangements is reported to have contributed to perpetual dependence.

5. The relief shelters or camps accomodating displaced persons are in most cases afflicted by sub-standard service delivery, lack of qualified manpower, shortage of vital relief supplies such as food, clothing, clean water supply as well as construction materials, counselling and social services.

8. SUMMARY AND RECOMMENDATIONS

It is has already been noted that consequent to the overall backwardness prevailing in Ethiopia, there exists very little difference in the general health and development problems of the general population and displaced communities including refugees, returnees and displaced persons. Under the circumstances, therefore, the problems of displaced populations should be tackled within the broader framework of national development.

The government, relief and development agencies and the international community at large should consider possibilities for developing relief programmes that could ultimately integrate into the broader national development plans instead of treating the subject of displaced people, refugees, returnees and host communities distinctively.

Since poverty and famine are the major causes of population displacement, long-term Integrated Rural Development schemes are required if future population displacements are to be prevented.

In an impoverished community where general undernourishment and child malnutrition are high, the encampment of populations in relief shelters would be an exercise in futility unless it is tangibly supported by sustained assistance and follow-up leading onto long-term development programmes. Despite this, however, the provision of support and assistance beyond the relief phase has constantly remained difficult to organize or maintain. Even when the provision of such assistance has been initiated, its sustainability becomes so costly that very few agencies are willing and/or capable to carry it through.

The welfare of displaced populations in all its aspects including health calls for a concerted, multi-agency and multi-disciplinary approach and inter-sectoral coordination that closely links short-term relief with long-term development.