VICTIMS OF WAR IN SRI LANKA

• A Quest For Health Consensus •

Conference Proceedings

International Conference on Health — Manning Hall, University of London Union, London

17 -18 September 1994

Jointly Organised by The Medical Institute of Tamils (MIOT) and The Tamil Information Centre (TIC)
in association with The Tamil Refugee Relief Organization (TRRO), California, USA

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Jointly organised by The Medical Institute of Tamils (MIOT) and The Tamil Information Centre (TIC)
in association with The Tamil Refugee Relief Organization (TRRO), California, USA

Many of those who participated and contributed to the proceedings have had first hand experience of the people who are unfortunate victims of war.

As far as possible, the content and style of their presentations have been retained without significant alteration to maintain their originality and the feelings expressed

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The front cover depicts refugees caught in the conflict, and a young Tamil child victim of the war

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ABOUT THE CONFERENCE ORGANISERS

The Medical Institute of Tamils

The Medical Institute of Tamils (MIOT) was founded in 1988 by Tamil speaking doctors interested in helping the Tamil community on health and related matters. MIOT has a wide range of expertise and experience in health matters. It also has wide links with professionals and organisations. MIOT supports health care projects in the Tamil homeland in Sri Lanka and is planning to provide assistance to the medical school and to run training programmes for medical and paramedical staff working in the health services.

The Tamil Information Centre

The Tamil Information Centre (TIC) is an institution for documentation, research and information services on the Tamil People of Sri Lanka. TIC is not affiliated to any government organisation. The Centre was established in the UK in the wake of the July 1983 pogrom in Sri Lanka as an organisation for people with interests in human rights, humanitarian assistance and political, social, economic and cultural development of the Tamil people.

TIC has an extensive network of individuals and organisations involved in human right and humanitarian work. It liaises with a wide variety of organisations to raise consciousness, to promote dialogue, understanding and more effective co-operation to promote human rights and to bring about a just solution to the Sri Lanka national conflict which will help the development of all peoples in Sri Lanka.

Tamil Refugee Relief Organisation, California, USA

The Tamil Refugee Relief Organisation (TRRO) is a charitable, tax-exempt organisation registered in the state of California, USA. It is an organisation founded in 1987 by expatriate Sri Lankan Tamils in the aftermath of the violence against the Tamil people. TRRO's focus is on displaced and deprived segments of the Tamil population. It functions to channel resources to existing self-help organisations and institutions involved in assisting displaced people.

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ABBREVIATIONS

B.D	—	Branch Dispensary
B.H	—	Base Hospital
C.D & M.H	—	Central Dispensary & Maternity Home
C.D	—	Central Dispensary
D.H	—	District Hospital
D.M.O	—	District Medical Officer
E.P.R.L.F	—	Eelam People's Revolutionary Liberation Front
F.H.W	—	Family Health Worker
I.P.K.F	—	Indian Peace Keeping Force
L.T.T.E	—	Liberation Tigers of Tamil Eelam
M.C.S	—	Medical Care Services
M.O	—	Medical Officer
M.O.H	—	Medical Officer of Health
NORAD	—	Norwegian Association for Development Research
N.E.P	—	North East Province
N.G.O	—	Non-Governmental Organisation
P.H.I	—	Public Health Inspector
P.H.M	—	Public Health Midwife
P.H.N	—	Public Health Nurse
P.H.S	—	Public Health Service
P.T.S.D	—	Post Traumatic Stress Disorder
P.U	—	Peripheral Unit
R/A.M.P/O	—	Registered/Assistant Medical Practitioner/Office
Rs	—	Rupees
S.P.H.I	—	Supervisory Public Health Inspector
S.P.H.M	—	Supervisory Public Health Midwife
S.P.H.N	—	Supervisory Public Health Nurse
U.N.C.H.R	—	United Nations Commissioner on Human Rights
U.N.H.C.R	—	United Nations High Commissioner for Refugees
V.S	—	Visiting Station

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INTRODUCTION

The spectre of ethnic conflicts within established states haunts the post cold war world; the crises in Bosnia, Rwanda and Chechnya are well known to the Western World, but a host of other similar conflicts equally tragic and brutal have not received sufficient coverage. One such conflict is the war in Sri Lanka, which arose primarily from the struggle of the Tamil speaking community for equality and justice.

For the past two decades the Tamil people have suffered from military campaigns, civil war and more recently an economic blockade. Human rights violations against Tamils have increased in ferocity over the years.

Over 10,000 Tamils have disappeared and over 40,000 Tamils have died. More than a million people have been displaced and billions of rupees worth of property has been destroyed. Displacement and the inability to return to homes have undermined the identity of the Tamil people.

Life for survivors in the Tamil Homeland of NorthEast Sri Lanka is a precarious struggle. Health, education and other basic services no longer exist in most areas. An estimated half of all the towns and villages have been destroyed.

The primary objective of the International Conference on the health status of the victims of war in Sri Lanka was to ascertain as far as possible the specific health and health care needs of the Tamil people of Sri Lanka, and to determine how best to meet them. The aims of the conference were:

i. To provide an opportunity for health professionals, health workers, health planners, service providers, human rights activists, donors, researchers and victims of war to share information about health needs and how well these are currently being met;

ii. To identify the special needs for medical and psychosocial support for displaced people, refugees, women, children, and elderly;

iii. To encourage and support self-help initiatives and to promote active coping strategies;

iv. To secure the best possible use of available resources to assist victims of war;

v. To urge the government to take positive action to make health care services equally available to all in need;

vi. To make serious efforts to fight against torture and to help victims to regain their place in society;

vii. To use the conference as a preparatory forum for a wider participatory health initiative in the Tamil Homeland in 1995.

Describing health, or absence of it, in a country such as Sri Lanka cannot be done without relating to the social, political and environmental determinants of the community's health. Describing health or disease in purely clinical terms is myopic and unhelpful. Recognising these realities, the conference organisers sought to get a broad spectrum from those working in the conflict areas. Thus, not only physicians and health professionals, but also social workers, relief workers and government officials, were invited to the conference. Their presentations gave a broader picture of the situation and enriched the information that has emanated from this conference.

Any reader of this report will discern a degree of bias in focusing on the Tamil victims of war. This should not be construed as a denial of the fact that there are victims of the war from all communities in Sri Lanka. But, it is also very clear that the communities that have been most severely affected are the Tamil and Muslim communities.

The programme for the two day conference was designed to focus on the nature and scope of the problem and to identify practical solutions to meet the health care needs of the war related victims. The conference identified the serious deficiencies in the infrastructure throughout the North Eastern region, both in community health services and access to hospital-based acute service sector. A prolonged history of under-funding and under-investment and the manpower exodus resulting from the war have led to serious deterioration of the health care for the people. The conference noted with concern the long term impact of the disruption in the manpower-training programmes in both the medical and paramedical fields.

The conference also extended its scope to identify not only the health problems of the internally-displaced within Sri Lanka, but also the impact of the war on health of refugees both in India and in the Western countries. Further more, experiences were shared by those involved in other conflicts, such as the Palestinian population in the occupied territories. The critical role of NGO's in alleviating the human sufferings and the role and responsibility of the media in conflict situations and issues surrounding their activities were debated.

The organisers and the editors wish to express their sincere thanks and gratitude to all participants of the conference, especially those working in the conflict areas in Sri Lanka, and with refugees in India and Europe. Their contributions have greatly enriched this publication. It is our hope that this Conference Proceedings will form a historical record of the impact of the war in Sri Lanka and on the health of the Tamil people,and serve as a source of information to governmental and non-governmental organisation and interested individuals to contribute in some meaningful manner to deliver a more effective and targeted health care to the "Victims of War".

HISTORICAL BACKGROUND

CHRONOLOGY OF EVENTS

1505: Portuguese occupy Sinhalese low country areas.

1621: Portuguese conquer and occupy the Tamil Jaffna Kingdom.

1656: Dutch occupy Sinhalese low country and Tamil areas.

1795: British take over maritime provinces from the Dutch.

1802: British crown colony established over Sinhalese low country and Tamil areas.

1815: Sinhalese Kandyan Kingdom ceded to the British.

1833: British unify Sinhalese low country and Kandyan Kingdom and the Tamil areas and established Government of Ceylon.

1885: Tamil leader Sir Ponnambalam Ramanathan calls for increased representation for Tamils rejecting the need for any separate Muslim representation for the expanded Legislative Council. Muslims demand separate representation, in view of the community's distinct ethnic and religious identity.

1915: Sinhalese-Muslim riots.

1931: Granting of limited internal self-government, and the establishment of a Board of Ministers under the Donoughmore Constitution. Jaffna Youth Congress resolves to seek complete independence for Ceylon.

1938: Sir Mohammed Macan Markar, one of the two prominent Muslim leaders, makes a statement implying Muslims can depend on the goodwill of the British and the Sinhalese for protecting Muslim interests but prefers the country to be ruled by the Sinhalese.

1944: State council of Ceylon passes a resolution recognising Sinhala and Tamil as the official languages. The Soulbury Constitution from the UK arrives in the country. Mr G.G. Ponnambalam, founder member of the Tamil Congress makes a demand for balanced representation before the commission, which is rejected.

1945: State Council appoints a Select Committee to look into the recognition of Sinhala and Tamil as official languages.

1946: The Select Committee reports on transition from English to Sinhala and Tamil as official languages.

1947: Mr. D.S. Senanayake, the leader of the State Council, urges the Tamils and other minorities to accept the Soulbury Constitution granting independence. He promised that the Tamil and other minorities need not fear at the hands of the majority Sinhalese in a free Lanka and no harm would befall them.

1948: British grant independence and power is transferred to the United National Party government dominated by Sinhalese elite, which proceeds to render stateless more than a million Plantation Tamils by the Citizenship Act; The Muslim community emerges as an important segment of the political system.

1949: Formation of the Federal Party (FP) as a breakaway group from the Tamil Congress; FP led by Mr S.J.V. Chelvanayakam, resolves to work unceasingly for the achievement of a Tamil state within a federal frame-work of a united Ceylon, as the way to ensure that the Tamil-speaking people in Ceylon live with hon-our and self-respect; An amendment to the election law disenfranchises the million Plantation Tamils ren-dered stateless in 1948.

1950: The majority Sinhala government embarks on developing river basins in the traditional Tamil Homeland of the North East and colonising it with Sinhalese from the south.

1951: The Federal Party (FP) holds its first convention, and declares its intention to campaign for regional

autonomy for Sri Lankan Tamils living in the North and East. Mr S.W.R.D. Bandaranaike forms Sri Lanka Freedom Party (SLFP) after breaking away from the United National Party (UNP)

1953: Sir John Kotelawela declares intention to amend constitution giving "parity of status" to Sinhala and Tamil as official languages.

1955: The SLFP announces its language policy as Sinhala with "reasonable use of Tamil". "Sinhala-only" enthusiasts hold processions and demonstrations. The Lanka Sama Samaya Party (LSSP) held a meeting at the Colombo Town Hall advocating the retention of equal status for Sinhalese and Tamils the meeting of which was attacked by Sinhalese Nationalists opposing this move.

1956: Sinhala is proclaimed the official language of Ceylon by the Official Language Act, reducing Tamil to an inferior status. Tamil leaders stage a peaceful demonstration near Parliament. Protesters violently attacked by Sinhalese nationalists backed by the government, resulting in the death of over 100 Tamils in anti-Tamil riots.

1957-1958: Prime Minister, S.W.R.D. Bandaranaike and FP leader, Mr S.J.V. Chelvanayakam reach an agreement ("B-C" pact) on comprehensive federal solution. The plan postulates wide-ranging devolution of power to the Tamil-majority region in the North and East. Mr J.R. Jayewardene of the UNP marches to Kandy against the "B-C Pact". The Pact is unilaterally abrogated by the Prime Minister, in the face of hysterical protests from the UNP and the Buddhist clergy; FP launches a campaign of civil disobedience in response; the state reacts with violence: police and military forces are sent to Jaffna to put down the agitation; A major anti-Tamil pogrom sweeps the Sinhalese majority areas. Hundreds are killed and over 12,000 Tamils are made homeless.

1959: Prime Minister S.W.R.D. Bandaranaike is assassinated by a Buddhist monk named Somarama Thero.

1960: Switch-over of administration to "Sinhala only"; The Throne Speech by the Governor General assures steps to elevate Buddhism, as the state religion; FP calls for a peaceful protest in the North East.

1961: Federal Party stages satyagraha (non-violent agitation) in Tamil areas. Muslims and in some place Sinhalese participate; FP inaugurates the Tamil postal service in Jaffna; Security forces unleash violence on Satyagrahis. FP MPs are arrested and detained.

1965: Senanayake-Chelvanayakan pact signed. The pact substitutes district councils for the regional councils of the "B-C" pact. The pact is once again unilaterally abrogated by the government.

1966: Government introduces "reasonable use of Tamil"; violence breaks out. Opposition parties call for strikes Demonstrators, led by Buddhist monks, march from the outskirts of Colombo to Parliament House in spite of a ban on meetings and processions.

1968: District Council bill published; District Council bill abandoned by government.

1969: FP withdraws their support to the government.

1970: General Elections. An unprecedented landslide victory for Mrs Sirimavo Bandaranaike's, SLFP-Left Coalition Front. The newly elected government cancels all University admissions (after students had received their notices for admission) and imposes a new system of standardisation in education where by Tamil students are required to achieve higher marks than Sinalese students.

1971: The Janatha Vimukthi Peramuna's (JVP, the Sinhalese youth movement of leftist ideology) rebellion against the government; Emergency declared and continued for six years.

1972: Ceylon becomes Republic of Sri Lanka. The Republican Constitution removes the constitutional protection accorded to national minorities; Buddhism is made the State religion; The constitution creates the conditions for the political alienation of Tamils. Formation of the Tamil New Tigers (TNT) in the Jaffna Peninsula by Tamil youths to safeguard Tamil rights; Federal Party (FP), Tamil Congress (TC) and Ceylon Workers Congress (CWC) jointly declare the formation of the Tamil United Front (TUF) in the face of continued discrimination and oppression.

1973: The government introduces a system of district quotas for University entrance in addition to standardisation, which deprives more Tamil students of university education.

1974: Police disrupt the Fourth International Tamil Conference on Tamil Research in Jaffna. Seven Tamils die in the ensuing stampede and electrocution. Government declines to appoint a commission to inquire into the incident.

1975: Company-owned plantations are nationalised under Land Reform Law and Tamil workers are subjected to discriminatory treatment and suffer difficulties under government management; Amnesty International visits Sri Lanka and meets Tamil detainees held without trial under Emergency Regulations for two and a half years.

1976: Formation of the Tamil United Liberation Front (TULF) with the objective to establish a separate State of Tamil Eelam based on the right to self-determination, being the only way to safeguard the very existence of the Tamil Nation. TNT is renamed and reorganised as Liberation Tigers of Tamil Eelam (LTTE) headed by Mr. Velupillai Prabhakaran.

1977: General election returns UNP) led by Mr J.R. Jayewardene with a massive victory; TULF contests the parliamentary election obtaining a popular mandate for its goal of a sovereign Tamil Eelam. TULF wins a massive victory in the Tamil homeland of the North-East and emerges as the major opposition party, and its leader Mr A. Amirthalingam becomes the Leader of the Opposition. Anti-Tamil riots erupt in Sinhalese-majority areas and over 450 Tamils killed.

1978: Mr J.R. Jayewardene becomes the first Executive President of Sri Lanka with the adoption of the Second Republican Constitution. Mr R. Premadasa is appointed Prime Minister; Tamil youths establish training camps in the jungles of the North. Police stations and the army camps in the North are attacked by the LTTE and other Freedom Movements that are banned by government orders.

1979: President J.R. Jayewardene orders the northern military commander to eradicate terrorism within six months; government enacts the Prevention of Terrorism Act; Emergency declared in Tamil areas; military occupies Jaffna District. Hundreds of Tamil youths are rounded up and tortured in torture camps by the police/army, even the Commander's residence is used as a torture centre.

1980: Sri Lanka becomes signatory to the International Covenant on Social, Economic and Cultural Rights and the International Covenant on Civil and Political Rights.

1981: Further anti-Tamil riots; military repression and violence against Tamils continue in the north, as negotiations between the government and TULF leaders fail to make headway. The party office of TULF and the house of the Jaffna MP are burnt. Jaffna public library with its 90,000 volumes and rare documents is burned by the police under the direction of government ministers. Sinhalese youths attack 43 plantation estates; many Tamils are killed and over 40,000 Tamils are made refugees.

1982: World Eelam Tamil Conference held in New York; J.R. Jayewardene extends life of Parliament to six years; Jaywardene is re-elected President.

1983: The worst anti-Tamil pogrom in Colombo and other Sinhalese areas in July. Tamils in the South flee to their homeland in the North. Over 3,000 Tamils are killed. Over 150,000 become refugees. Hundreds of Tamils flee to neighbouring India and the West. The Indian government speaks out in support of the Tamils. LTTE and other guerrilla organisations set up training camps on Indian soil. Thousands of radicalised youth join guerrilla movements. The TULF leadership, seen as ineffectual, opportunist and self seeking, begins to fade into political oblivion. Emergency Regulations empower Security Forces to shoot, kill and dispose of dead bodies without inquest or post mortem; Parliament passes the Sixth Amendment to the Constitution requiring an oath of allegiance to Sri Lanka and renouncement of separatism. Tamil MP's refuse to take the oath and lose their seats in parliament.

1984: Government summons an All Party Conference (APC) and places the District Development Councils proposal. In a calculated attempt to defeat the objective of devolution, the proposals link devolution to a second chamber, the majority of members of which would be appointed by the President. The proposals are rejected by Tamils.

1985: Tamil and Government representatives meet in Thimpu, the capital of Bhuttan under Indian auspices, during a three-month ceasefire. Tamil demand based on the recognition of the fundamental right of self-determination is rejected at the outset by the government. The security forces massacre Tamils in Vavuniya and Trincomalee while the Thimpu talks are in progress. Tamils withdraw from the negotiations.

1986: State repression and violence intensify in the Tamil Homeland; all-out war between the Sri Lankan state and the Tamils. LTTE emerges dominant among Tamil guerrilla groups, and takes effective control of Jaffna peninsula and other northern areas as state authority gradually collapses. Thousands of people, especially Tamils, die as the fighting takes on an increasingly brutal dimension. Hundreds of thousands of Tamils become refugees. Over 130,000 Tamil refugees flee to India and over 75,000 to the West and other countries; government convenes a Political Parties Conference (PPC) to discuss the new proposals for the establishment of Provincial Councils. The TULF refuses to participate as the proposals do not satisfy the aspirations of the Tamils; LTTE leader Mr Prabhakaran is flown to Bangalore for discussions with Indian Government Officials, Mr Prabhakran expresses interest only in the establishment of Eelam and the armed struggle as the means of achieving it.

1987: Sri Lankan security forces launch 'Operation Liberation' imposing an economic blockade in the North; Symbolic gesture by India in sending food and medicine by sea and the air-drops by the Indian Air Force over Jaffna results in calling off military offensive; USA and USSR show little response to government's request for assistance; Indo-Sri Lanka agreement signed without any consultation with the Tamils, although the agreement incorporates provisions affecting Tamils; New Delhi sends troops into the Tamil Homeland under the pretext of a 'peace-keeping' mission to disarm the LTTE, and to implement the provisions of the agreement; LTTE refuses to give up its struggle for full Tamil statehood and reject the Indian contention that the 'Indo-Sri Lanka accord' represents a final, definitive redressal of Tamil grievances and engages Indian troops in war.

1988: Indo-Tamil conflict drags on. Hundreds of combatants die on both sides. Worst affected is the Tamil civilian population, which is subjected to atrocities by the Indian occupation forces and their Tamil collaborators; the JVP in the south builds up its political and military forces; elections to the North-East Provincial Council are completed and the Eelam People Revolutionary liberation Front (EPRLF) and Eelam National Democratic Liberation Front (ENDLF) coalition obtains a majority in the Council; TULF protests over the Lankan government's continuing policy of state-aided Sinhalese colonisation of the North and East. Parliament enacts a law granting citizenship to all stateless persons of Indian origin born in Sri Lanka before 1 January 1964 amidst protest of Sinhalese Buddhist monks and students in Kandy; Sri Lanka invites UNHCR to discuss relief and rehabilitation work. Outbreak of cholera and other communicable diseases, acute shortage of medicines and other medical supplies including health personnel in the Jaffna peninsula, also a complete breakdown of communications are reported; Mothers Front in Batticoloa begins a fast unto-death campaign for peace; Tamil-Muslim tensions rise; concerns grow over welfare of refugees returning from India. UNHCR is urged to monitor whether refugees returned without coercion.

1989: Mr R. Premadasa becomes President of Sri Lanka; Tens of thousands of Sinhalese youths are massacred or 'disappear' in the Sinhalese areas as the Sri Lankan government cracks down on the JVP; President Premadasa invites the LTTE and JVP for unconditional talks. Several rounds of discussions are held between LTTE delegates and President Premadasa. Mr. Premadasa requests the IPKF to leave by July 29. In general elections, UNP sweeps to power; European voluntary agencies voice concern over UNHCR's Sri Lankan policy; violence flares up again in the hill country.

1990: North-East Provincial Council collapses after the Chief Minister declares Unilateral Declaration of Independence (UDI) of Tamil Eelam, and its members flee to India; Indian troops quit Sri Lanka ahead of schedule; The truce between Colombo and the Tigers breaks down and war breaks out again. Over 2,000 die and hundreds of thousands of Tamils become internally displaced or flee the country; Sri Lanka threatens to expel 80,000 Plantation Tamils granted Indian citizenship; Muslims massacred in the East; LTTE expels 40,000 Muslims from the North.

1991: In August 1991, Government imposes an economic embargo on the North and bans 42 items including medicines, fertilisers, chemicals and fuel under the Emergency (Restrictions on Transport of Articles) Regulations No.1 of 1991. Sri Lankan army imposes its own ban on several essential items to the East. The economic blockade causes great misery to the Tamil people and results in thousands of deaths. Civilian areas are regularly bombed from air and shelled from military camps and the sea, causing enormous destruction and hundreds of deaths. The aim of the government is to subjugate the Tamils by force and the economic blockade is viewed as an essential component of its strategy.

1992: Many civilians are killed in the North-East in Army operations and air force bombing. In June 1992 the estimate of widows as a result of civilian deaths in the Jaffna District alone is 6,000. India proscribes the LTTE.

1993: President Premadasa and opposition politician (and former UNP National Security Minister) Lalith Athulathmudali are assassinated. LTTE, despite strenuous and repeated efforts by the armed forces, holds on to its 'liberated territories' in the North and begins to gain gradual control in the East. LTTE leader Mr Prabhakaran calls for unconditional talks with the government, with a commitment to examine any federal proposal. President Wijetunga rejects the call and declares that war is the result of a 'terrorist problem', and that no ethnic/national question exists in Sri Lanka. The President also categorically rejects a merger of the country's north and eastern provinces (a minimum demand shared by all Tamil representatives) and reiterates his predecessor's often-stated commitment to a 'military solution' to the conflict.

1994: Governments of Switzerland and Sri Lanka sign agreement on 12 January for the repatriation of rejected Tamil asylum seekers amidst protests by Tamil refugees, concerned International refugee agencies and human rights organisations; Amnesty International reports that Tamils are targeted as an ethnic group, especially in Colombo. Most in police custody are Tamils and the government has released no figures for those in military custody; UN Human Rights Commission at its 50th sessions in Geneva is urged by NGO's to examine continuing human rights violations in Sri Lanka and to appoint a Special Rapporteur to monitor the country's future performance; General elections held. People's Alliance (PA) led by Mrs. Chandrika Kumaratunge, daughter of the former Prime Ministers Mrs. Srimavo Bandaranaike and the late Mrs. S.W.R.D. Bandaranaike, wins the elections by a narrow majority with a mandate to start talks with the LTTE and establish peace in the island.

(The Chronology reflects the developments pertaining to the events up to the end of September 1994).

ETHNIC CONFLICTS — THE FACTS

North-Eastern destruction and deaths in the ten year war (1983-1993)

Houses damaged or destroyed	150,000
Places of worship damaged or destroyed	1,479
Tamil civilians killed	35,000
Tamil civilians disappeared	10,000
Tamils held in prison without charge or trial for over 3 years	1,500
Tamils held in military camps (estimate)	5,000

Tamils displaced (as at August 1994)

Tamil refugees in the North-East	
Jaffna	244,000
Mannar	54,000
Kilinochchi	41,000
Vavuniya	11,000
Mullaitivu	30,000
Trincomalee	34,000
Batticaloa	77,000
Amparai	23,000
Total	514, 000
Puttalam	
Muslims displaced from the North	40,000
Colombo	
Tamils displaced from the North-East living in Colombo and suburbs	100,000
Tamil Nadu, India	
Refugees in camps	70,000
Refugees outside camps	100,000
Other countries	
Europe and North America Asylum seekers	400,000
Total number of Tamils displaced	**1224,000**

Orphans

With a total of 829,000 orphans in the country, 469,000 are due to the North-East War.

(Probation & Child Care Services Department, TIC 10.92)

Sri Lanka — Military expenditure

(Rupees millions)

	89	90	91	92	93	94
Total expenditure	8,445	13,956	16,394	15,960	24,990	29,000
As a % of current expenditure	14.8	19.4	20.2	18.9	-	-

Facts about donor aid

- Concern has been expressed that donor funds intended as humanitarian aid have been diverted to defence. In 1992 60% of donor aid had been diverted from key areas including health

  (Paul Isenman, World Bank, S. Asia Director (SLM 6.93; TT 15.7.93))

Sources:

Tamil Information Centre, London.

Ministry of Hindu Cultural Affairs, Sri Lanka - 1994

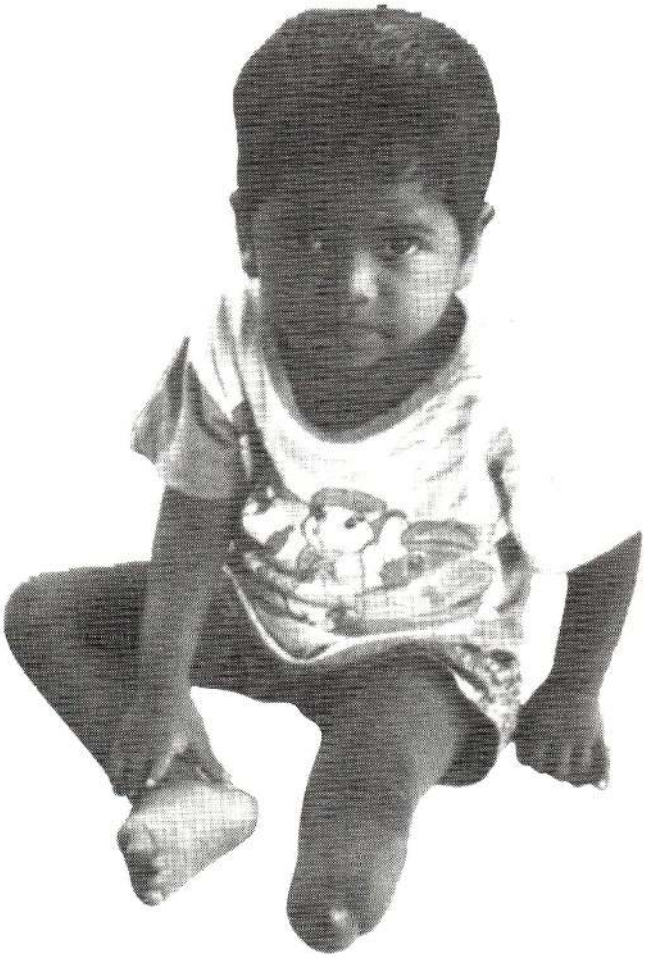
TT= Tamil Times (England)

SLM= Sri Lanka Monitor (British Refugee Council)

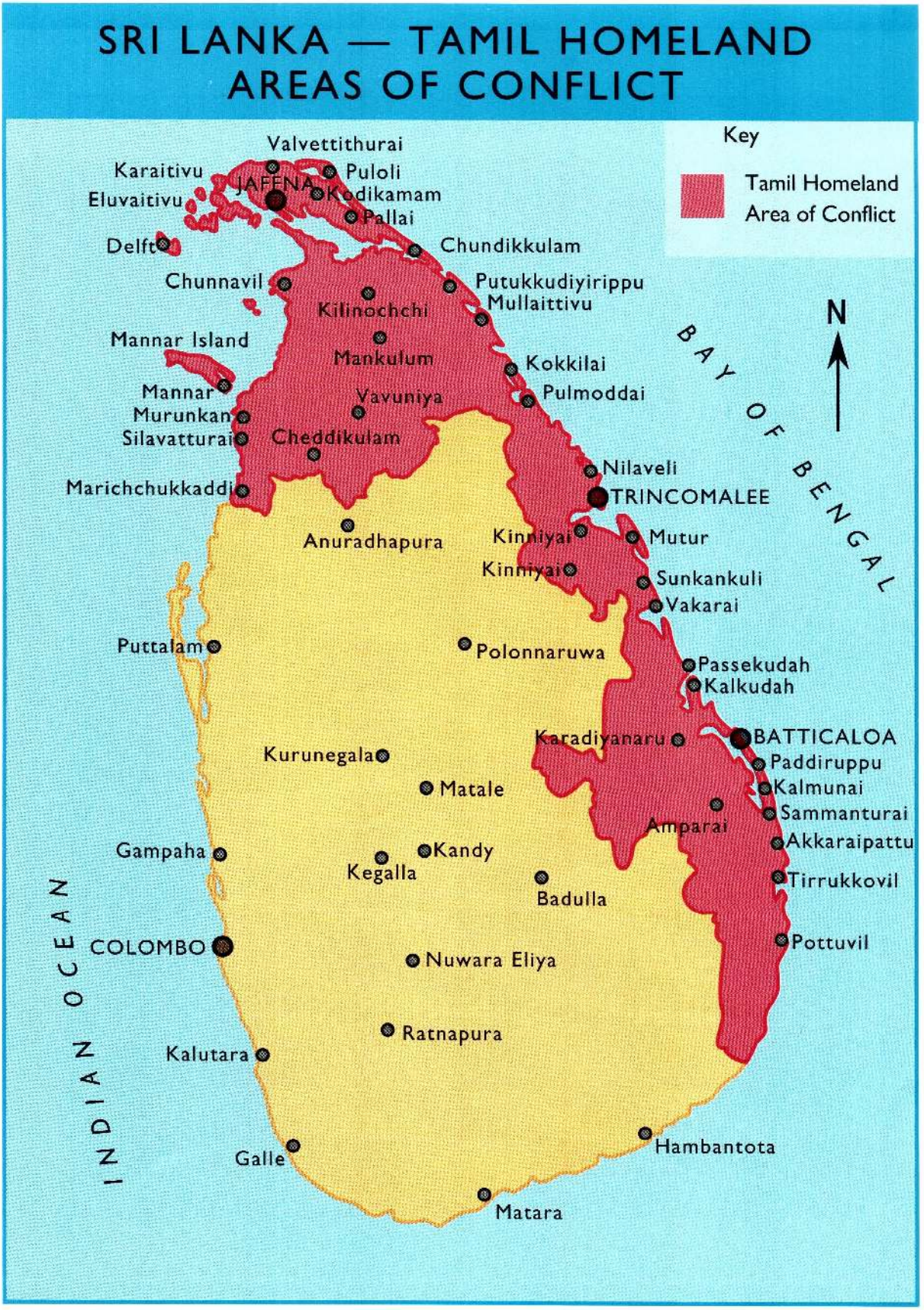
Day 1

SCENE SETTING

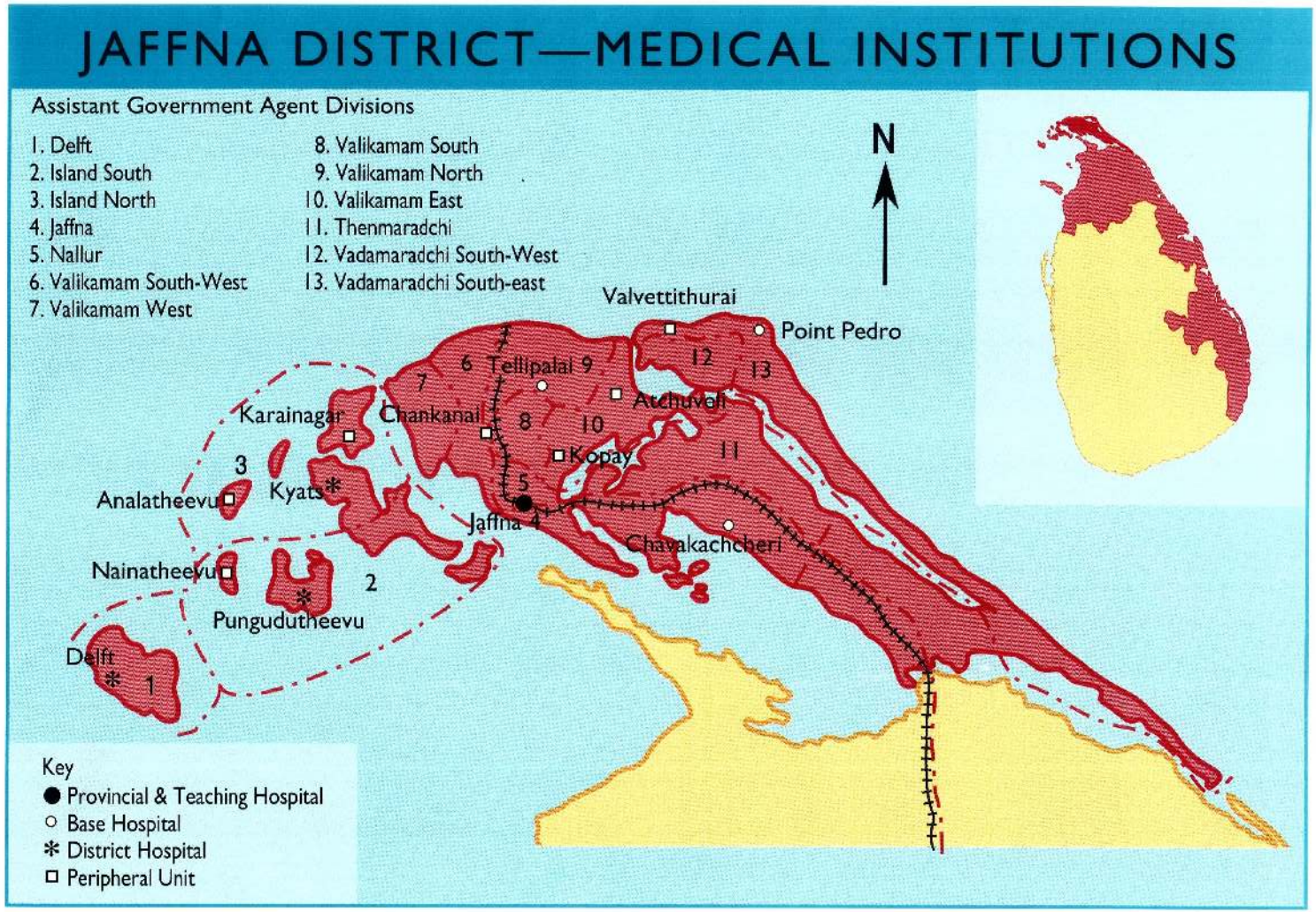
THE NATURE OF THE PROBLEM AND THE SPECIAL NEEDS OF HIGH RISK GROUPS IN THE ARMED CONFLICT IN SRI LANKA



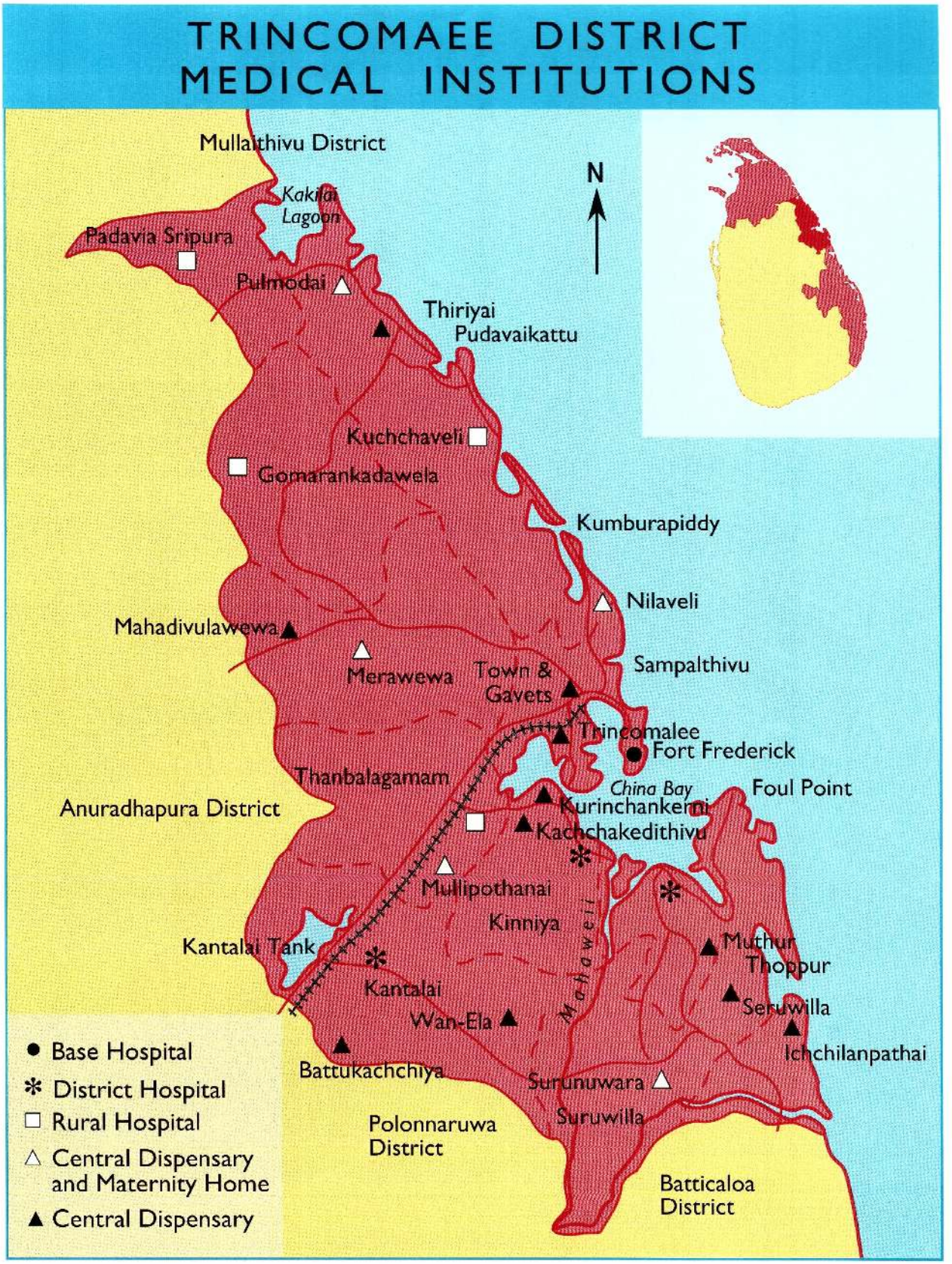
SRI LANKA — TAMIL HOMELAND AREAS OF CONFLICT



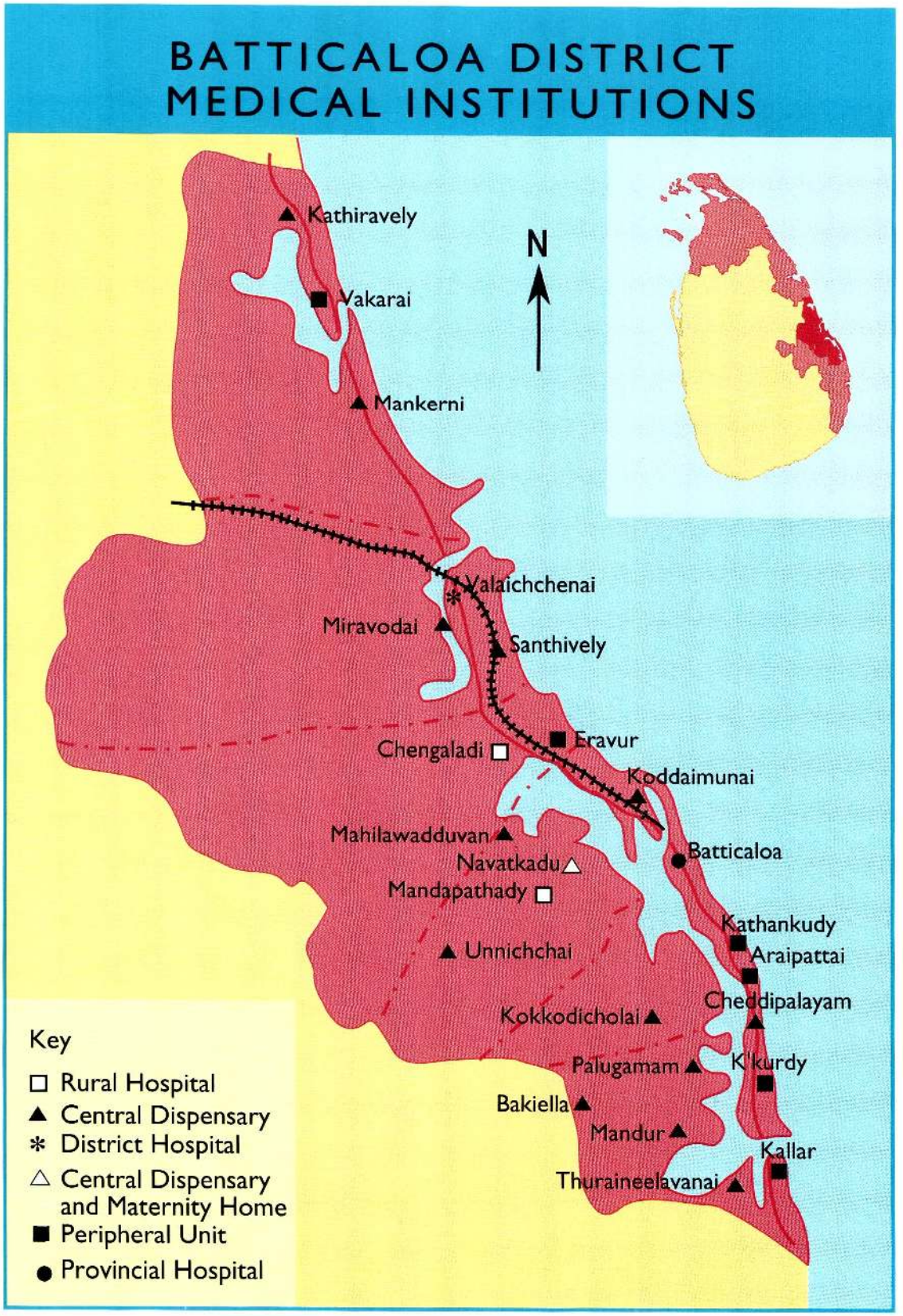
JAFFNA DISTRICT—MEDICAL INSTITUTIONS



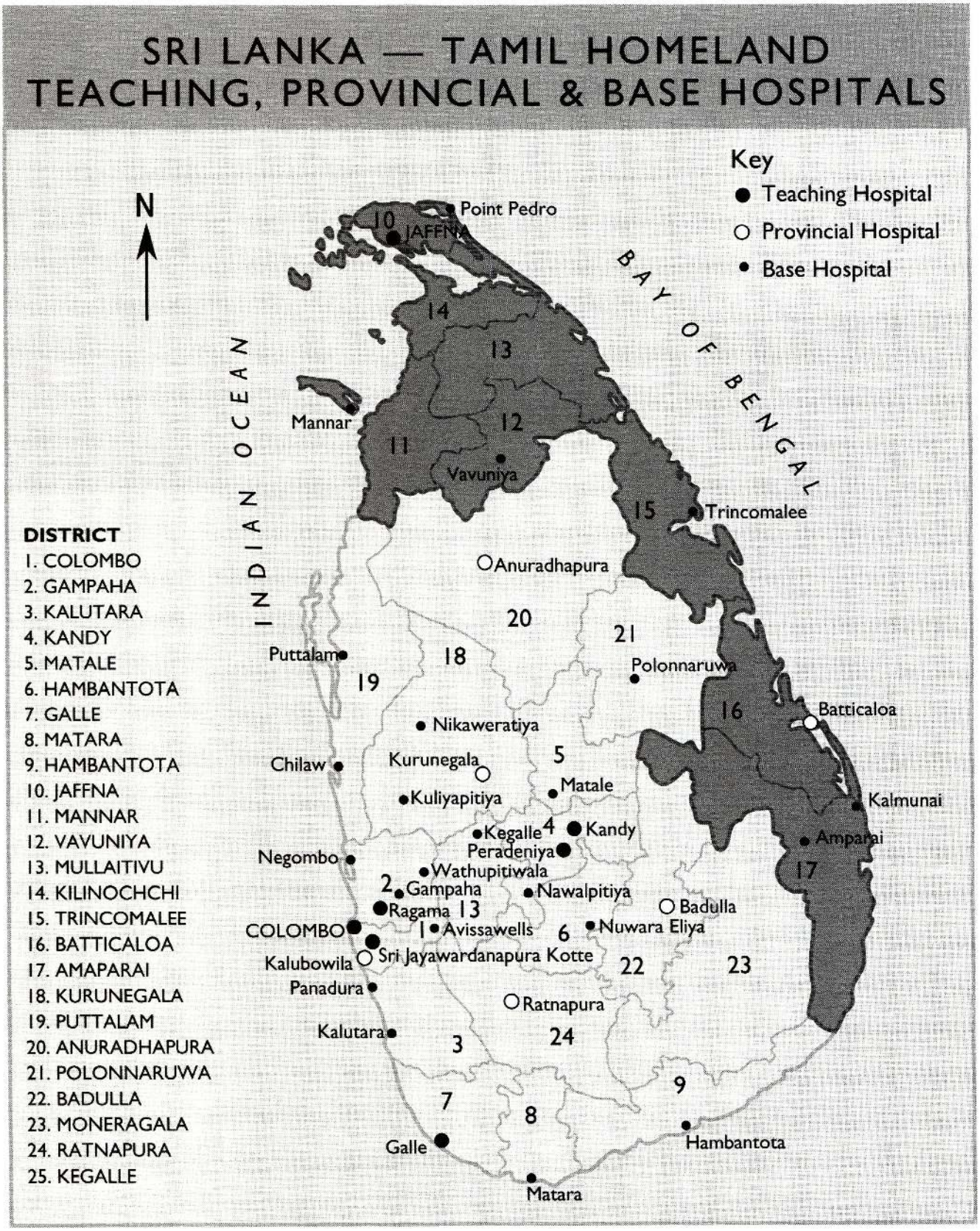
TRINCOMAEE DISTRICT
MEDICAL INSTITUTIONS



BATTICALOA DISTRICT MEDICAL INSTITUTIONS



SRI LANKA — TAMIL HOMELAND
TEACHING, PROVINCIAL & BASE HOSPITALS



DISTRICT

1. COLOMBO
2. GAMPAHA
3. KALUTARA
4. KANDY
5. MATALE
6. HAMBANTOTA
7. GALLE
8. MATARA
9. HAMBANTOTA
10. JAFFNA
11. MANNAR
12. VAVUNIYA
13. MULLAITIVU
14. KILINOCHCHI
15. TRINCOMALEE
16. BATTICALOA
17. AMAPARAI
18. KURUNEGALA
19. PUTTALAM
20. ANURADHAPURA
21. POLONNARUWA
22. BADULLA
23. MONERAGALA
24. RATNAPURA
25. KEGALLE

Day One
17 September 1994

WELCOMING ADDRESS

Mr V Sivapathasuntharam
President, Medical Institute of Tamils
Consultant Obstetrician and Gynaecologist,
Royal London Hospital, London UK

Ladies and Gentlemen, as the chairman of the organising committee, I welcome you all warmly to this conference. Let us first observe one minute of silence in memory of all those who have lost their lives in the war in Sri Lanka.

Friends, among us is his Worshipful the Mayor of Camden, Councillor Bill Budd. He is a good friend of the Tamils here. I am grateful for his presence and the opening address soon to follow. The Right Reverend Kenneth Fernando, Bishop of Colombo, Mr. Bryn Woulfe and Miss Liz Philipson have assisted us immensely in making this conference possible. Their willingness to Chair our plenary sessions adds value to our programme.

Ladies and gentlemen, war anywhere causes damage, destruction and human suffering. Human suffering is immeasurable, but we do know that during war human health needs multiply. We may not have direct control over the war, but we certainly have a duty to reduce the suffering of the victims of war.

This conference will explore how we might meet health needs under these difficult circumstances in Sri Lanka. All communities have suffered due to the war. In the Tamil homelands of Sri Lanka, where the war is being waged, human suffering is especially intense. As members of the Medical Institute of Tamils, the Tamil Information Centre, and the Tamil Refugee Relief Organisation in California, we decided early this year to forge a joint effort to address the health issues of the victims of war. Though we called the conference, support from the public and many other sister organisations for Tamils in the United Kingdom has been extremely positive. This truly is a community-wide effort.

Some of our participants are from Sri Lanka and India. Let me express a word of admiration and appreciation for your dedication and hard work within the war zone and among the refugees. I sincerely thank all of you for coming here to share with us the knowledge and experiences you have gained by working with the suffering masses. With your help we will get a more accurate assessment of the needs of the people and possible solutions.

Today and tomorrow we hope to carefully evaluate most aspects of the health and health care needs of the victims of war. Our programme is ambitious, intensive and purposeful. It is hard work, but I hope that sharing the burden will make it lighter. We hope to reach a consensus among all participants as we identify priorities, develop action plans, set targets and deliver. The change of regime in Sri Lanka provides a sign of light at the end of the tunnel. Perhaps our efforts too will help ease the pain of the victims of war, sooner rather than later.

OPENING ADDRESS

Councillor Bill Budd
Mayor of Camden

I am pleased to welcome you all to Camden, the Borough of London that I represent. I am very pleased to address you this morning in this illustrious building of the University College of London. I will now read to you the objectives of this two-day conference. It is intended to ascertain as far as possible the specific health and health care needs of the Tamil people in Sri Lanka and to determine how best to meet them.

The forty year-old conflict in Sri Lanka arose as a result of discrimination against the Tamil people in all aspects of national life. The conflict continues in the wake of the Tamil people's struggle for self-determination.

Thousands of lives have been lost in violence and many have been maimed, widowed and traumatised. Children are particular victims of the war and thousands have been orphaned.

Several governments and organisations have been involved in peace initiatives and their efforts continue. It is hoped that these efforts succeed and a just and lasting solution is reached.

This health conference is important in these circumstances, as health is a vital factor in the all-round development of the human being.

The participants in the conference include doctors, health, humanitarian and social workers, and government officers who are directly involved in assisting victims of war in Sri Lanka. Their contribution to the well-being of the people – risking their own lives amidst the violence – is immeasurable. Their courage and selfless dedication must be an example to everyone.

We are glad of their presence and it is certain that their participation will contribute towards the successful conclusion of the conference.

We hope that the conference will create consensus on the various actions that may help promote the health of the people belonging to all communities affected by the war in Sri Lanka.

Day One
17 September 1994

CHAIR'S ADDRESS

Rt. Reverend Kenneth Fernando
Bishop of Colombo
Chairman, National Christian Council, Sri Lanka

It is a singular honour to be here with you all this morning. When I received an invitation to this conference, I did not hesitate to put aside my other programmes and make arrangements to come here. I am greatly honoured to chair your opening session.

I think you have honoured me for two reasons. First, you recognise the efforts, that I have been making to bring about peace in Sri Lanka, especially my visits to Jaffna in 1993 and 1994. I am now making arrangements for my third visit, and I will continue to go to Jaffna and keep knocking on doors. I think this effort is appreciated by all who love peace in Sri Lanka.

Secondly, I think you recognise the role that Churches in Sri Lanka have been playing both in bringing relief and rehabilitation to affected persons in Sri Lanka and also in establishing peace in our country. I am the chairman of the National Christian Council of Sri Lanka, but I think in this matter I can also speak for the Roman Catholic Church. We have our shortcomings but we have done what we can to bring relief and rehabilitation to the people affected, and to work for peace. I assure you, our efforts will continue.

There are two small matters I would like to discuss. First, I want to make it very clear that my friend Mr Manickavasagar, Government Agent, Jaffna, was very keen on attending this conference. As he is a government servant, he sought permission of the government to come. But, I am personally aware that – as Mr Manickavasagar told me himself before I left Sri Lanka – that the Prime Minister persuaded him to remain in Sri Lanka because his presence is needed there at this time. He was not forbidden to come here, but rather the Prime Minister said that he was needed there because of all the activity in Colombo. I myself believe that this is why Mr Manickavasagar is not here and I plead with you to accept this reason.

You are all aware that the atmosphere in Sri Lanka is changing, and in the course of this consultation I hope to tell you more about it. I have been very close to the recent events and I believe that the Prime Minister is very keen on finding a solution to the ethnic conflict very soon. She is working very, very hard. At the moment, there have been many actions to build up goodwill on both sides, and I believe that this conference we are having now here in London will be an important contribution to that end. One of the ways that we can build up confidence on both sides is by participating together in relief/rehabilitation activities and in promoting health care for those affected. So this effort can also be a peace-building, peacemaking activity and I therefore consider it to be very important.

I thank you once again for the invitation to be here and I thank you for the singular honour you have done me in asking me to chair this session.

HEALTH AS A HUMAN RIGHT: THE IMPACT OF WAR ON THE STATUS OF HEALTH

Dr David Kausman MRCP, UK
Medical Coordinator, Amnesty International, UK

The Universal Declaration of Human Rights states that:

"Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services...."

(Article 25)

However, the body of humanitarian law that deals with the question of the health care of civilian populations during armed conflicts approaches the question not from the perspective of the right of the population to health, but from the perspective of the obligation of authorities to ensure that health care is available. Although this distinction is subtle, we shall see that it is important. International humanitarian law has been built up for the most part through treaties between states, and it is the states that have signed and ratified these treaties which it regards as answerable for these obligations.

International humanitarian law during armed conflict is embodied largely in the Four Geneva Conventions of 1949, which were expanded and supplemented by the two Additional Protocols of 1977. These documents deal with a wide range of protective measures, including measures to protect the right to health. The Geneva Conventions of 1949 represent a step in a process of development that began with the first Geneva Convention of 1864, which was concerned only with the protection of wounded and sick soldiers in the field. Further developments led to the protection of seamen in 1899, and of prisoners of war in 1929. In the aftermath of the Second World War the Four Conventions of 1949 introduced two innovations:

First, they dealt specifically with the protection of civilian persons and civilian populations for the first time. While the first three of the 1949 Conventions dealt with the groups that had already been covered in earlier Conventions - soldiers, sailors, and prisoners of war - the last was devoted to civilians.

Second, they introduced a distinction between circumstances of war between two or more states who were Parties to the Conventions, and circumstances referred to as 'armed conflict not of an international character.' The vast bulk of the Conventions is concerned with provisions for international conflict. A single article – known as Common Article 3 in all four 1949 Conventions – refers to non-international conflicts. As we shall see, Common Article 3 provides only minimal standards. The Additional Protocols of 1977 sought to elaborate further standards for non-international conflicts. While the first Additional Protocol dealt with international conflicts, the second was devoted entirely to protective measures for non-international conflicts.

Health Care Provisions During International Armed Conflicts

Let me start by looking at the measures to ensure provision of health care to civilian populations during international armed conflicts, contained in the Fourth Geneva Convention of 1949 and the First Additional Protocol of 1977. The Convention and Protocol require that wounded or sick civilians be protected and provided with the fullest medical care practicable. Medical considerations alone are to be taken into account in deciding on the provision of such care (4GC 16, 1AP 10). Similar provisions relate to individuals who have been interned (4GC 91).

In order to ensure that medical care is available for the civilian population, the Convention and Protocol go to some lengths to call for the protection both of civilian medical units and of the personnel who operate those units. The definition of medical units is broad, including not only hospitals but other medical installations such as preventive medical centres, blood transfusion centres and medical storage depots (1AP 8). Parties to the conflict may not attack these units and they should be situated away from military targets (4GC 18, 1AP 12). In addition, the Parties to the conflict may not act on pretext in order to attack or close down such units. The Convention and Pro-

tocol make it clear that the protected status of civilian medical units does not lapse if they treat wounded or sick combatants, if they are guarded, or if their personnel carry light weapons for self-protection (4GC IAP 13). Even if there is suspicion that civilian medical units are being used as a cover for military operations, the opposite party is required to give notice that it intends to withdraw protection from the unit, and it may withdraw protection only if this warning has not been heeded (4GC IAP 13).

The protection guaranteed to medical units is extended to medical transports, including transport of patients, medical personnel and medical supplies (4GC 21, IAP 21). Free passage is to be given to medical and hospital stores (4GC 23).

The Convention and Protocol also require the Parties to the conflict to respect and protect civilian medical personnel operating medical units (4GC 20, IAP 15). Once again, a generous definition is employed here. Medical personnel includes anyone assigned to the collection, transportation, diagnosis or treatment of sick or wounded patients, as well as those involved in administering medical units (IAP 8). Not only should medical personnel be protected, but Parties to the conflict should assist them in carrying out their duties in caring for the civilian population (IAP 15). They cannot be compelled to carry out tasks not compatible with their humanitarian mission (IAP 15).

It should be pointed out that in order to qualify for the protection described, civilian medical units and personnel must be authorised by one of the Parties to the conflict (4GC 18 & 20, IAP 8 & 12). The Parties to the conflict should ensure that such units and personnel are identifiable (IAP 18). However, only those medical personnel assigned by one of the parties to a medical unit or a medical transport qualify for this protection (IAP 8). Medical personnel who are not specifically assigned in this way benefit only from a general provision relating to medical activities that states that no person carrying out medical activities may be prevented from performing acts in accordance with the rules of medical ethics or may be compelled to perform acts contrary to medical ethics,and that medical confidentiality should be preserved (IAP 16).

The Convention and Protocol makes a special effort to ensure that, in the event of occupation of the territory of one Party by another, the health needs of the civilian population in the Occupied Territory will be met. The Occupying Power is under a clear obligation to maintain existing medical establishments and services, and to ensure that the basic requirements of the civilian population, including food and medical services, are supplied. The medical needs of the civilian population may not be sacrificed to supply the needs of the Occupying Power. Requisitions of supplies, equipment, etc. must be limited to those not required for the civilian population. The Occupying Power must also assist civilian medical personnel to carry out their duties (4GC 55 & 56, I AP 15).

Finally, the Convention and Protocol require the Parties to the conflict to facilitate the activities of Red Cross organisations and other humanitarian non-governmental organisations (4GC 63, IAP 81). They also call for the civilian population to respect the sick and the wounded, and state that civilians should not be punished for providing care to them (IAP 17). In summary, the Fourth Geneva Convention and First Additional Protocol set out an extensive series of regulations that seek to ensure that the civilian sick and wounded will receive protection and care, that the institutions in which such care is available and the personnel delivering it are protected, and that the civilian population in general continues to benefit from an acceptable level of medical services even during periods of occupation. In addition, the Convention and the Protocol lay down firm measures for enforcement of these provisions. They require the Parties to ensure that military commanders act so that these regulations are upheld. Breaches of the regulations for medical protection are defined as grave breaches of the Conventions and may be investigated by an international commission of inquiry. Finally, all parties to the Conventions are under an obligation to search for individuals alleged to have been responsible for such breaches and to bring them before their own courts regardless of nationality.

If, even so, there are circumstances in which civilian health rights are ignored with impunity, it is not because the Fourth Geneva Convention and First Additional Protocol lack enforceable provisions for protection of these rights, but because, as in many other areas requiring action at an international level, there is often a lack of political will to enforce obligations.

Civilian Health Care During Internal Armed Conflicts

However, this system of protection and enforcement applies only to international armed conflicts. The most common form of conflict in the world today is not conflict between states but conflict within states. Such conflicts have become an increasingly familiar feature of the world landscape since the end of the Cold War. In fact, the First Additional Protocol widens the scope of 'international conflict' to include armed conflicts in which a people are fighting for self-determination against colonial, alien or racist regimes. But the juridical interpretation of these terms means that very few internal conflicts qualify as such wars of self-determination. Virtually all of the internal conflicts taking place in the world today fall within the scope of Common Article 3 and the Second Additional Protocol, which tackle 'armed conflicts not of an international character.'

Common Article 3 only requires any Party that is a signatory to the Conventions to treat humanely all those who are taking no active part in hostilities and to care for the wounded and sick, in the case of a non-international conflict that is occurring either on its territory or on the territory of any other Party. Its extremely modest scope, compared to the exhaustive detail in the remainder of the Conventions, suggests that it was intended merely as the barest minimum standard to be applied to the difficult situation of an internal armed conflict. The Second

Additional Protocol attempted to develop this standard more fully.

Many of the provisions for civilian health care in the Second Additional Protocol echo those that we have seen for international armed conflict. The wounded and sick are to be protected and treated with no distinction among them other than those based on medical grounds (2AP 7). Medical units and medical personnel are to be protected (2AP 9 & 11). The general protection of medical activities is repeated – no one shall be prevented or punished for carrying out medical duties or compelled to perform actions contrary to medical ethical obligations (2AP 10). Finally, where the civilian population suffers due to a lack of medical or other essential supplies, humanitarian relief actions should be facilitated.

However, the Second Additional Protocol is much shorter than the first. Although its provisions are certainly a great improvement over the bare minimum contained in Common Article 3, closer examination reveals that there is a good deal missing from it. For instance, in contrast to the detail devoted to defining medical units and medical personnel in the First Protocol, no definitions are given here and no indication is given of who may accredit them in order to qualify for protection. A moment's thought will reveal that this omission is hardly likely to have been coincidental.

Let us recall that the Geneva Convention and Additional Protocols are instruments of international law that have been signed and ratified by states, and that it is on states that they impose obligations. If a government recognises the medical unit of an insurgent group as accredited and therefore liable to protection under the terms of the Second Protocol, does it thereby recognise the insurgent group to have obligations under the Second Protocol? If so, does the government thus recognise the opposition group itself as an entity in international law? Such a recognition would be unacceptable to almost any state engaged in internal conflict, since it would threaten its claim to sovereignty over its entire territory.

While lawyers may take a maximalist approach, interpreting the terms of the Second Protocol by reference to the definitions in the First Protocol, a state involved in suppressing an armed insurgency may not be so generous in its interpretation. But instead of making its intentions plain on this important question of issue of definition and accreditation, the Second Additional Protocol sidesteps it.

This apparent need to avoid being seen to confer any measures of legitimacy on non-governmental parties is felt throughout the Second Additional Protocol.

Although the Protocol devotes an article (2AP 3) specifically to the declaration that nothing in the Protocol may be invoked to affect the sovereignty of the signatory state, this caveat was not considered sufficient in itself by the majority of states represented at the Conference which drafted the document. As a result, the provisions of the Second Additional Protocol have been given a passive formulation. They refer to actions that should or should not be done but – unlike the First Additional Protocol – they do not say who should or should not do them. Once again, this avoids defining an opposition group directly as a Party responsible under international law. But it also avoids charging such groups directly with the humanitarian obligation to uphold the right to health.

It seems self-evident that, in order to provide protection to the civilian population in a situation of armed conflict, what the Protocol should have set out to do was to make all parties to the conflict responsible under international law, regardless of their conflicting claims to sovereignty.

And how are the Protocol's provisions to be enforced? While the First Additional Protocol devotes considerable space to provisions for enforcement, including the establishment of international fact-finding commissions, the Second Additional Protocol says nothing at all about this subject.

Finally, there is another fundamental question that arises as soon as one starts to talk about internal armed conflict. How is such a conflict defined? The Second Additional Protocol refers to conflicts

> *"which take place in the territory of a High Contracting Party between its armed forces and dissident armed forces or other organised armed groups which, under responsible command, exercise such control over a part of its territory as to enable them to carry out sustained and concerted military operations and to implement this protocol."*
>
> *(2AP 1)*

It specifically excludes: 'riots, isolated and sporadic acts of violence.' According to the Second Additional Protocol then, an armed opposition group fighting the government must fulfil two conditions for the situation to qualify as an internal conflict: it must exhibit the presence of a functioning command structure and it must demonstrate control of a territory.

Yet the conclusion that an armed conflict falls within this definition is in many cases an item of dispute, and a government may reason that if it does not recognise a specific conflict under this definition, it is not bound by the Protocol. A government may therefore refuse to recognise that an opposition group constitutes an organised armed group according to the conditions of the definition, referring to them instead as criminals, delinquents, gangsters, etc. The Government of El Salvador, which is a signatory to the Conventions and Additional Protocols, did precisely this in the 1980s when it refused to recognise the Farabundo Mart Front for National Liberation (FMNL) as an organised armed group, despite a number of international declarations that referred to the FMNL in those terms.

In such a situation, both the government and the insurgent group may feel themselves free to ignore the provisions protecting the civilian population in Common Article 3 and the Second Additional Protocol – leaving the civilian population without the protection of international humanitarian law.

In summary, although international humanitarian law, as developed in the 1949 Geneva Conventions and 1977 Additional Protocols, has gone a long way towards safeguarding the civilian right to health in situations of international conflict, its attempt to protect the health needs of civilian populations in conditions of internal armed conflict can only be described as embryonic. International humanitarian law is undercut by its own concern to protect state sovereignty and deny legitimacy to non-governmental entities. At its worst, despite the good intentions underlying it, this body of law can be characterised as an attempt to make undefined parties protect undefined institutions and personnel during periods of undefined internal conflict. Yet since the end of the Cold War internal armed conflicts are those that have multiplied – conflicts that are often of low intensity and long duration, imposing an enormous deprivation of health and other rights on civilian populations. Clearly, there is here a deficiency in the protection of the right to health by humanitarian law that needs to be addressed.

Abbreviations

4GC	Fourth Geneva Convention, 1949
1AP	First Additional Protocol, 1977
2AP	Second Additional Protocol, 1977

References

The Geneva Conventions of August 12, 1949 International Committee of the Red Cross, Geneva.

Protocols Additional to the Geneva Conventions of August 12, 1949 International Committee of the Red Cross, 1977.

AN OVERVIEW OF THE EFFECTS OF WAR IN NORTH EAST SRI LANKA

Mr S Srishnamugarajah
President, Dry Zone Development Foundation, Sri Lanka

In the past, I have served in Sri Lanka's ministries, the North-East Province Council, and a number of administrative departments. I was last Secretary to the Ministry of Planning, Youth Affairs and Human Resources Development in the North-East Provincial Council.

I am really happy that the Medical Institute of Tamils, the Tamil Information Centre, and the Tamil Refugee Relief Organisation of California have organised this effort to bring international attention to health issues in North-East Sri Lanka.

In the following pages, I will provide an overview of the effects of the war on the people of the North-East Province, based on my own experiences working in the region as well as on some specific information I have prepared regarding the Batticaloa District.

Background

Sri Lanka has a total land area of 25,333 sq. miles, populated by 17 million people. The 1981 census reported that 74% of the population were Sinhalese, 18% Tamil, and 8% Muslim. From the perspective of religious composition, 69.3% were Buddhists, 7.5% Christians, 15.5% Hindus, and 7.5% Muslims.

Sri Lanka is divided into twenty-five administrative districts. The North-East Province contains eight of these districts, which are further divided into seventy Divisional Secretary's Divisions and subdivided into 2187 Grama Sevaka Divisions. In 1990 the government created two communal Divisional Secretary's Divisions at Eravur and Kathankuddy, in the Batticaloa District.

From my work in the North-East Provincial Council, I recall that the population of the Province is around two million people, and that 45% of the population lives in the Jaffna District. Mr Manickavasagar, the Government Agent of Jaffna disagrees with claims that the population of Jaffna District has decreased and states that the number of residents has not changed.

The war has affected the different districts in the North-East Province in different ways. It may not be possible to generalise on what has happened in the Province as a whole, but I will describe the situation district-by-district. In the Jaffna District, the areas along the coast – Palaly, Kankesanthurai, Keerimalai, Mathagal, Vettilaikerni and the Islands – are controlled by the security forces of Sri Lanka. Freedom fighters control the rest of the district. The entire district of Kilinochchi is under the control of the freedom fighters. Except for the Island of Mannar, the Mannar District is controlled by the freedom fighters. In the Vavuniya District, Vavuniya South Sinhalese Division, part of Vavuniya South Tamil Division and Chettikulam are under the control of the security forces. Freedom fighters control the rest of the area. In the Eastern Province, Trincomalee District, the area north of the district, and a large number of other pockets are controlled by freedom fighters. Security forces control the rest of the area, which is highly populated by Sinhalese and Muslims. It is said that the entire district of Batticaloa is controlled by security forces, though the presence of freedom fighters can be felt throughout the district. In the Amparai District, where the Tamils are now a minority, they live in pockets such as Thirukovil, Akkaraiputtu, Komari and Pottuvil but the Sinhalese and Muslim areas are considered as cleared areas. These details cover the ground situation.

Batticaloa District

I will now discuss the major effects of the war, district-by-district, beginning with Batticaloa. Security forces have hampered agriculture in the district in several ways. Farmers must obtain a permit from security forces in order to cultivate the land. Security forces have not permitted farmers to use agricultural inputs such as urea as fertiliser. Farmers must inform the government of their employees. During harvest and threshing operations, the names of the labourers and the dates of harvest must be registered with the security forces. Once the crop is

harvested, farmers must travel many miles to Batticaloa town to obtain a permit from the Brigadier to transport paddy for sale. The security forces are often corrupt and need to be bribed. There is no communalism in these transactions requiring bribery and the security forces earn a lot of money while checking at various check points, This increases the cost to the farmers who suffer heavy losses. In 1992, security forces destroyed hundreds of acres of paddy fields just two weeks before harvest, under the guise of 'military operations.' The people and NGOs leaders protested to no avail.

Travelling through the district by public transportation is difficult. There are few buses, and they are overcrowded. To travel from Batticaloa to Thirukovil – a distance of 50 miles – passengers must get down at fourteen check points. At Kallar check point, all items are checked individually by the STF (Special Task Force of the Sri Lankan Army).

There are twenty-two NGO's in the district. Most of them are involved in relief work, but whether they are geared to undertake rehabilitation and development work is a big question. First of all, such work is a tedious job for the NGOs to undertake without institutional support. Secondly, the local NGOs may not have the finances to undertake such work. Our experience at the Dry Zone Development Foundation has led us to conclude that income generation activities alone may not fully rehabilitate refugees. We believe that health, education, nutrition, etc. are also part and parcel of the rehabilitation and development of a society. DDF recently surveyed 216 families for a sponsorship programme of the Christian Children Fund of America, and found that the heads of 194 families were having symptoms such as chest pain, etc. The health needs of the people are of paramount importance, but the government is unable to provide for normal health needs. The government cannot be expected to help war victims. The problem has to be tackled by dedicated people providing counselling, psychiatric treatment, etc.

The destruction of human life exceeds the damage to property. There are no reliable statistics available, but in my view, there are more than 5,000 widows in the district. 2,000 of these women are below the age of thirty with one or more children. How will we rehabilitate them? They cannot live on charity eternally. They are poor. Their parents are poor. They depended on their husbands for their living. They are willing to undertake any manual work, and we may have to find self-employment projects for them. This may be possible if funds are made available.

In addition to the conflict between the government and Tamil freedom fighters, Batticaloa district has felt the effects of clashes between Muslims and Tamils, with the security forces supporting the Muslims. The Muslims in Batticaloa are concentrated at Kathankuddy, Eravur and Oddumavadi. Along the borders of Muslim areas, the damage to Tamil lives and property is severe. Muslims could travel only three days a week under escort by security forces. Tamils could not travel through Muslim villages nor in Muslim vehicles, and vice versa. Such was the situation until mid-1993.

Since the Tamils could not enter Kathankuddy, Muslim traders of Kathankuddy had to take their goods to the border to sell them to Tamils. Likewise, since the laundry men and barbers of the area are Tamils, fourteen laundries and twelve barber saloons had to be established on the border of the Tamil village Arraipattai to service Muslim needs.

In Eravur, a good portion of the Muslims are farmers. Those with lands and livestock on the western shores of Batticaloa, where Tamils live, could not cultivate their lands. Their animals were killed by the security forces and the freedom fighters for food, while some Tamils took over part of the Muslim livestock. The lands were not cultivated for three years, and the Muslims had to come to terms with the Tamils and now describe their relationship as being similar to that of the 'scraped coconut and flour in Pittu,' i.e. different but inseparable.

Amparai District

Let us move on to Amparai District. There are 80,000 Tamils living there in Muslim and Sinhalese villages and their plight is worse because there are few NGOs to assist them, and no Tamil Members of Parliament to hear their grievances. Most of them have been refugees for more than three years. They must be resettled and assisted so that they may rejoin society as self-respecting human beings.

Trincomalee District

Trincomalee District is a bone of contention between the Tamils and the Sinhalese. The Sinhalese have been settled there to increase their numbers, enabling them to control Trincomalee town and thereby the district. Though the Sinhalese settlers left the district during the Eelam People's Revolutionary Liberation Front (EPRLF) regime, many more are now returning. The populations of the Tamils and Sinhalese in the district are equal at the moment. All fertile lands are in the hands of the Sinhalese, and the Tamils have little voice. A number of small local NGOs work enthusiastically in the area; they need financial assistance. We may all have to divert our attention to help the Tamils of Trincomalee.

Wanni areas

The Wanni areas consist of Mannar, Vavuniya and Mullaitivu Districts. Security forces control Mannar Island and parts of Vavuniya town, and there are constant conflicts in other areas. In a well-publicised move, the government brought Sinhalese ex-prisoners into Manal Aru and claimed they were civilian settlers. The Tamils feel that this is their fertile soil and that the outsiders must leave. The Tamils are grateful for the heroic struggle waged by the Tamil militants in these areas.

Despite constant controversy, the United Nations High Commission on Refugees (UNHCR) is running a large refugee camp at Madhu. But how long can the refugees

remain in the camps? Farmers do not have the inputs necessary to undertake cultivation and fishermen are not allowed to go to the sea to fish. They all have the health problems of refugees living in crowded camps without adequate food or sanitation. Such problems are the same in all Tamil districts.

Jaffna District

I went to Jaffna recently for the first time in three years. Travelling there from Colombo was an adventure. We left Colombo by train at 9:00 pm on Monday and reached Jaffna at 4:00 am on Wednesday – 31 hours of travelling in all. At Thandikulam, the army checked us, and we had to go to the army border by bus. Later, when the army allowed us to leave, we had to walk 2km to the freedom fighters checkpoint. They issued a visa to enter their territory, and we travelled by bus to Kilali. We went to the shore by tractor and waited after dark to board the boats. We got into a boat at 10:00 pm with twelve persons. The boats are not overloaded for safety reasons, and hundreds are available. We had to help push the boats until we reached a sufficient depth to start the engine, and we reached the shores after three hours of sea travel in the dark. Now, after the Poonerin disaster, the government security forces do not interfere with these passengers. We travelled by van to Jaffna, reaching home by obtaining a lift on bicycles for hire. With regard to goods, the security forces checked at Eratperiyakulam – three miles south of Vavuniya – and the freedom fighters checked 4 miles north of Vavuniya, item-by-item. The freedom fighters collect revenue by imposing duties on luxury items, e.g. the tax is Rs. 400/= for arrack and Rs. 2/= for cigarettes. On our return journey, our family card was entered and a visa was granted on payment of Rs. 100/=. At Kilali, the boats had to sail against the winds and we had two hours of saltwater shower baths.

The conditions in Jaffna provide much cause for concern. There is an 'economic blockade' on the flow of goods to the North. A number of items are banned from being sent to the North to disable the freedom fighters from making arms. The government expected the people in the North to revolt against the freedom fighters, to die of starvation, or both. To its dismay, the government could not achieve these goals, and the people of the North have withstood all such turmoil. The freedom fighters have helped the people. Though a war situation brings many problems, the people are cooperating with the freedom fighters except for some who have been personally affected.

In the past, farmers in Jaffna produced cash crops like onions and grapes to be sent to the Colombo market. With the closure of Elephant Pass, they are unable to send the goods. Due to the economic blockade, the freedom fighters have persuaded the farmers to produce crops for food. Earlier in 1990, the price of grapes was Rs. 10/= per kilo as they could not transport to Colombo. The Tamil Eelam Mempattu Kalagam TEMK – the economic wing of the freedom fighters – has experimented with the production of a number of food items. Large areas of land are cultivated with Kurakan, and they are producing Kurakan biscuits with and without sugar for both old people and children.

'Necessity is the mother of invention,' and the TEMK has invented a number of new appropriate technologies to overcome the shortage of supplies. They are running vehicles on a mixture of kerosene oil and thinner. There are no batteries to power the radios, but they have fixed dynamos to sewing machines so that when you pedal the machine, current is produced for the radios to function. There are 1,500 paid volunteers and 6,000 unpaid volunteers working with the economic wing of the freedom fighters.

The Tamil Eelam Mempattu Kalagam believes that it has organised the people of the Jaffna District sufficiently to produce a great number of food crops. They are planning to move more into the Wanni areas where their strategies will have to be different, as there is a larger extent of land populated by fewer people in those areas. They have been discussing potential strategies to increase food crops in the Wanni areas with social workers and the Agricultural Faculty in Kilinochchi. The militants are optimistic that in a few years time, they will be self-sufficient in food and will not need to depend on the government. This may become a serious obstacle to government efforts to achieve peace in the future.

Fishing in the Jaffna area has been affected badly by the war situation. As the Government Agent of Jaffna has stated in his report, 24,000 fishing families are suffering without employment and proper food. Malnutrition is on the rise.

A few remarks are in order regarding the administration of Jaffna. They have their own courts and police stations like the government of Sri Lanka, but with an important difference: their judgments are quick. They have their own public health officers, and they are arranging for a medical faculty, administrative service, training centres, banks, etc. All these functions are handled by boys, girls and elderly persons in some cases. Despite constant untargeted bombing, life even in this atmosphere is normal.

Conclusion

The war has created a number of other problems for the Tamil people. Families have been disunited. Many do not know where their children are; some have joined militant groups, others are refugees, and the whereabouts of some others are unknown. In our society in the past, we may not have allowed girls to move about alone, but now they are even travelling alone to the West to get married. Some parents travel to Colombo under great difficulty to contact their kith and kin in the West and the Middle East. Such travels require spending and even wasting a lot of money.

Such is the situation in the North-East, which presents many serious problems to be overcome. As a voluntary worker working in the North-East Province, I appeal to foreign health professionals, government donors and international NGO's to assess these needs and develop aid strategies for the suffering Tamils of Sri Lanka.

SPECIAL REPORT ON THE SITUATION IN THE JAFFNA DISTRICT

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This paper is based on the report provided to the Prime Minister regarding the situation in Jaffna District. It describes events in the district that led to the mass displacement of residents and destruction and loss of lives since the outbreak of violence in June, 1990.

Population

The population of this district reported in the 1981 Census was 738,788. The present population living in the district is around 750,000, spread throughout the 14 Assistant Government Agent divisions. An estimated 150,000 persons have left the district since the eruption of the disturbances to take refuge in areas outside North-East Sri Lanka and abroad.

Displacement

The renewal of operations by government security forces in June, 1990 caused mass displacement of residents. The sudden renewal of security operations took the people unawares and they had to leave their residences to take refuge in schools, temples and other public places, leaving behind their entire belongings. As security operations continued considerable areas of the district came under the control of the security forces; except for a negligible few residents evacuated from these areas.

Presently, 79,834 families – comprising 264,335 persons – have been displaced from their permanent residences. Out of these, 8,968 families – comprising 37,767 persons – are presently being accommodated in welfare centres, while the rest have found accommodation with well-wishers, relatives and friends.

The maintenance of welfare centres has become a difficult task: the tiny 10' x 12' cadjan huts constructed two to three years ago for each family have all decayed and are collapsing. These huts must now be reconstructed at an estimated cost of Rs. 10.25 million.

Death of civilians and destruction of properties

7,542 civilians have been killed and properties worth billions have been destroyed by the ongoing war in the district. Another 2,590 persons have been maimed for life.

Intensive security operations by land, air and sea have resulted in the deaths of many innocent civilians and colossal property destruction. Very often, security operations are carried out without definite targets. Random air strikes, shelling from security camps and cannon fire from naval boats have caused heavy civilian casualties. During the first eight months of 1994, security operations in the district caused 90 civilian deaths and 233 serious injuries. Whenever security forces suffer casualties or setbacks within the district or elsewhere, their random attacks on the district are especially heavy. Continuous aerial bombings have caused heavy destruction of factories, commercial establishments, temples, churches, schools and thousands of homes.

Loss of income

The majority of residents have lost their earning capacity due to the various events in the district. Except for public servants and the few traders who managed to continue their commercial activities by adjusting to the prevailing situation, the people of the district have been deprived of their livelihood.

Cultivators

Around 65,000 cultivators of the district who were actively producing subsidiary food crops, grapes and tobacco had to abandon cultivation due to the lack of electricity to power water pumps. Agro-chemicals and fertilisers were not available as well. A few who shifted to manual irrigation methods had to drastically reduce the extent of their cultivation. Engine-operated water pumps were found to be uneconomical due to prohibitive fuel costs.

Vast areas of formerly cultivated land have been occupied by the army. These include the entire areas of the Islands and considerable areas in the A.G.A. divisions of Sandilipay, Chankanai, Tellippalai, Kopay and Maruthankerny. These areas constitute the bulk of the fertile red soil which was cultivated year-round.

The few families who continue cultivating small areas amid the difficulties are unable to earn anything substantial to meet their living costs. The rest of the families – most of whom are displaced – face starvation and untold hardship.

Fishermen

Around 24,000 families in the district who depended solely on fishing have been badly affected by the government's total ban on fishing. In normal times Jaffna District produced 30% of the whole Island's requirement of fish. The major portion of this catch was sent to Colombo and also exported. The ban on fishing has deprived the entire fishing community of its livelihood. Most of the fishermen from the main island of Kayts and coastal areas of the peninsula Karainagar – Ponnalai, Mathagal, Keerimalai, Kankesanthurai, Myliddy, Palaly, Thondamannaru, Vettilaikerny and Kaddaikadu – have been displaced and now languish as refugees in welfare centres and other places. Fishermen who were affected by the fishing ban were at first issued free dry rations under the relief scheme for a short period, but were later disallowed from drawing this relief. In desperation a few of them defy the ban and venture out to sea; very often they lose their lives and fishing gear at the hands of the security forces. Their plight is very pathetic, as they have not only been denied their livelihood but also refused any relief.

Skilled workers

These include masons, carpenters, mechanics, technicians and welders. The bulk of the workmen in these categories lost their livelihood once building work of all forms came to a standstill due to the ban on building materials to the district. Due to the termination of the electricity supply and ban on fuel, vehicles, machinery and other heavy and small equipment ceased to function. Workshops, large and small factories, both State and private, and all other economic activities in the district came to a halt, stripping thousands of wage earners and self-employed persons of their employment. The approximate numbers affected in these categories are as follows:

Masons	2,227
Carpenters	1,725
Mechanics	1,050
Technicians	1,500
Welders	350
Others	3,900
Total	10,802

Poultry and Dairy Farms

There were quite large poultry and dairy farms in addition to many small units of the industry operated by self-employed persons in the district. When the establishments that produced poultry and cattle feed were forced to stop production, all these poultry and dairy farms were abandoned. Supplemental supplies from Colombo were also halted due to the closure of transport routes. A large number of families who depended on this industry have been affected, as these 1989 statistics on poultry and livestock in the district indicate:

Livestock and Poulrty	Numbers	Average monthly production
Milk cows	41,425	
Other cows	32,990	1,318,875 Litres of milk
Bulls	20,671	
Calves	34,380	
Goats	83,352	
Sheep	14,856	
Laying hens	189,160	
Other birds	289,588	2,478,500 eggs

Food supply to the district

Under normal circumstances the bulk of essential food supplies came to the district from Colombo. 10% of the rice requirement was produced in the district, and a fair percentage of rice was also brought to the district by private traders from the adjoining rice-producing districts of Kilinochchi, Vavuniya, Mullaitivu and Mannar.

The closure of road and rail routes to the district in June, 1990 totally disrupted the food supply. A crisis situation developed with acute shortages of essential and other food items. The price of rice shot up to Rs.60/= per kilo, flour rose to Rs.30/= per kilo and sugar rose past Rs.75/= per kilo. Even at these prices, it was difficult to procure these staples. The prices of subsidiary food items increased by many times as well.

At that time the Commissioner General of Essential Services came to the rescue, sending essential food items by ship beginning in August, 1990. Although this supply was a great relief, it was far short of the normal food requirement. Food stocks received by ship are used primarily for the issue of free dry rations as relief to displaced families. Whenever possible, balance stocks are issued for cash sale through the Multipurpose Co-operative Society's (MPCS) outlets. On an average 56,470 families received relief supplies per month in 1994.

Food stocks brought by ship require advance payments for each sale, but financial constraints prevent MPCS's from making such payments in advance. All food items are priced Rs.4/= above the Colombo price per kilo, and freight and handling charges contribute an additional Rs.4/= per kilo. Ironically, even flour shipped from Trincomalee to Jaffna is charged this additional freight and handling cost, whereas flour taken to Colombo from Trincomalee is sold at the fixed price. There appears to be some discrepancies in the method of pricing food and freight for items shipped to Jaffna. These must be investigated and rectified to enable the pricing of essential food items at Colombo prices in this district, as is the case in other districts outside Colombo.

The following schedule compares the districts requirement for essential food items to the quantity of food cargo shipped to Jaffna by the Commissioner General of Essential Services (CGES):

DISTRICT REQUIREMENTS FOR ESSENTIAL FOOD ITEMS
(In Metric Tons)

Item	Monthly requirement	Annual requirement
Rice	6,875	82,500
Flour	2,475	29,700
Sugar	1,512	16,144
Cereals	1,032	12,375
Total	11,894	142,719

STOCKS RECEIVED BY SHIP FROM CGES

Item	1990	1991	1992	1993	1994
Rice	8,170	30,145	20,077	33,200	9,949
Flour	5,977	26,773	30,012	34,405	23,418
Sugar	3,371	6,940	9,677	11,201	5,651
Cereals	1,287	1,822	920	2,353	1,259
Milk food	560	1,889	969	636	120
Total	19,725	67,569	61,655	81,795	40,397

Flour consumption in the district increased considerably while rice consumption dropped, as the high cost of rice encouraged most families to substitute bread for their meals. The scarcity and cost of firewood also contributed in a large measure to the preference of bread over rice.

Fuel and power supply to the district

Jaffna District was plunged into darkness when the hydro-electric power supply to the district was terminated in June, 1990. The Electricity Board made efforts to operate standby generators with the fuel in storage tanks at the Chunnakam Power Station to provide a restricted supply to essential service institutions like hospitals and water supply installations. This supply too was disrupted when the Air Force bombed the Chunnakam Power Station on 8th August, 1990.

All forms of fuel including kerosene were not permitted North of Vavuniya. Shortages were so acute in the latter half of 1990, 1991 and 1992 that the price of kerosene rose to around Rs.250/= per bottle. The majority of homes spent the nights in total darkness as they could not afford this price. In 1993, the government decided to allow the shipment of a monthly quota of kerosene to Jaffna; the quantity shipped began at 4,500 barrels per month but was later increased to 6,500 barrels per month. This fuel was distributed to the people in 2 to 4 litre rations. The price of kerosene dropped considerably in the open market to remain around Rs.60/= per litre in 1993. Kerosene supply was increased in 1994, and the open market price is now around Rs.45/= per litre. The kerosene received by the Government Agent from the CGES to be distributed to the people is priced at Rs.25/= per litre, over 100% higher than the Colombo price. This is due to the cost of empty barrels, freight and handling at both sides.

Health and sanitation

Both preventative and curative health services were completely disorganised and brought to a standstill with the outbreak of war in June, 1990. The Jaffna Teaching Hospital suffered severe damage from air attacks and shelling from Jaffna Fort. The entire staff of the hospital deserted the institution when the area came under heavy fire due to security force's attempts to secure the nearby Jaffna Fort Security Forces Camp between June and September, 1990. Tellippalai Hospital was brought under army control and ceased to function. Point Pedro Hospital also suffered damage. The Jaffna Teaching Hospital was temporarily moved to a private hospital at Manipay Green Memorial Hospital to function on a limited scale. However, this hospital too suffered aerial attacks in which patients and hospital staff suffered casualties. The peripheral units and rural hospitals also did not function properly due to widespread bombing and shelling. Many people perished during the latter half of 1990 and early 1991 without proper medical attention. The situation was highly critical.

In November, 1990 the Jaffna Teaching Hospital was reopened under the auspices of the International Committee of the Red Cross, with mutual recognition of a safety zone around the hospital premises. The Point Pedro Base Hospital also improved its services with medical personnel from the French voluntary organisation Medicine Sans Frontiere. However, the shortage of medical personnel remains acute even now and almost all the hospitals in the district are understaffed.

Preventative services too were badly disrupted. There were severe shortages of drugs, chemicals, equipment and transport to provide preventative services. The mass displacement of families and their accommodation in crowded welfare centres produced severe setbacks in sanitation facilities and the overall health situation. Drinking water and toilet facilities are inadequate, creating health and sanitation hazards. Infections and diseases are rampant.

Nutritional food has been scarce and expensive. The price of eggs soared to Rs.10/= each. Meat of all varieties was scarce and prices were above the reach of the common man: beef at Rs.120/= per kilo, mutton at Rs.160/= per kilo and chicken around Rs.250/=per kilo. Fish was a precious item with the total ban on fishing. Malnutrition has had its effect on the population of the district, and children are particularly affected.

Education

School going children have faced tremendous hardships with respect to their educational needs. At least 164 schools – including some leading schools – with over 65,000 students have been displaced and function in temporary sheds without basic needs such as furniture. Most of the leading schools in Jaffna city and suburban towns suffered heavy damages. Aerial bombing and frequent shelling cloud the atmosphere for regular studies at school and at home.

Lighting facilities for night studies – especially crucial for students – are very limited. Even kerosene lamps have been difficult to obtain at times. Most children suffer from malnutrition and are not physically fit for concentrated study.

Problems of the district requiring immediate attention

Loss of lives and destruction of properties

Loss of civilian lives and colossal destruction of civilian properties must be halted. The safety and security of the surroundings must be restored to relieve the people of the district of their sense of insecurity. They must be free from fear of air attacks, shellings from security camps around the district and cannon fire from naval boats.

Resettlement of displaced families

Almost one-third of the population of the district has been rendered destitute refugees, living in miserable conditions in welfare camps and at the mercy of relatives and friends. Resettlement of these families will be a huge and difficult task. Most of the houses in the areas occupied by the security forces are believed to be either destroyed or damaged. Reconstructing these houses and resettling these displaced families will take considerable time. Early action to create the conditions suitable for the commencement of a resettlement programme will infuse hope and succour among the grief-stricken thousands of families in the district.

Restoration of the earning capacity of people

The thousands of wage earners, traders, skilled workers, fishermen and cultivators who lost their earning capacity due to the war and the embargo on the district must be provided opportunities to make a living. The revival of normal economic activity requires the recommencement of building construction, the free movement of merchandise to and from the district, the restoration of power and fuel supply and the lifting of the ban on fishing. Most of the persons who lost their earning capacity have not been granted any relief as in the case of displaced families. They have been denied their means of employment and income without relief. It is necessary to urgently restore the conditions enabling them to earn an income and sustain their family members.

Food and other essential supplies

The statistics given in previous pages demonstrate that the supply of essential food items by ship from the CGES was less than half the annual requirement in the district in 1991 and 1992, and amounted to only 56% of the requirement in 1993. Every other source of supply to the district is meagre and cannot make any impact on the shortfall. The extent of starvation in the district can be assessed by this shortfall of supplies. Starvation and malnutrition have seriously affected the population and will continue to do so unless sufficient supplies of essential food items are sent to the district. The quality of the food items sent must also be improved; very often poor-quality rice and certain other items are sent and must virtually be forced upon the displaced families as relief issues. Urgent and immediate measures must also be taken to make available nutritional food at reasonable prices.

Health and sanitation needs

There are acute shortages of medical personnel in all hospitals of the district. Urgent and immediate steps must be taken to post the cadre of doctors and specialists required to restore normal health services. The restriction on medical supplies and equipment should be removed and all necessary supplies should be sent to the hospitals to enable the suffering people to receive medical treatment. The relaxation of restrictions on the transport of medical items to the private sector will enhance the services in the district and reduce costs. Many private medical institutions have ceased to function owing to their inability to obtain supplies.

Restoration of preventative services is equally important to bring widespread infections and diseases under control. The people of the district have paid heavily due to the disruption of preventative services. Infant mortality has been quite high in the last few years, especially among the children of displaced families exposed to infection. Adequate quantities of chemicals, equipment and transport necessary to effectively carry out the preventive services must be permitted in the district.

Transport

Transport of all forms, except for bicycles, came to a standstill with the ban on fuel and spare parts. A few vehicles – operated with kerosene – carried overloaded passengers on the trunk routes for travel outside the district. The cost of such transport, however, was prohibitive. The roads are all in appaling condition and even cycling along these roads is difficult. At present, the only access to the district through the Kilali lagoon is hazardous, expensive and time consuming. Improving the living conditions of the people requires free access to the district overland. Supply of fuel, spare parts and even new vehicles are necessary to resume transport services in the district. At the least, the trunk and suburban roads have to be repaired urgently to restore road transport within the district.

General

The cessation of war promised by the new government is urgently necessary to end the arbitrary loss of lives and colossal destruction of national wealth. The people of the district are very confident that the new Prime Minister will bring about peace and normality very soon. They are hopeful that their sufferings are coming to an end, and that they will soon be able to at least obtain the essentials for life and be spared the agonies they have undergone for so long.

CURRENT PATTERN OF HEALTH CARE AND RESOURCE ALLOCATION

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Introduction

For decades, Tamils in the island of Sri Lanka have complained of discrimination at the hands of the government dominated by the Sinhalese. The North East Province of the island, where the Tamils live, is a deprived area.

This brief study, *'Current Pattern of Health Care and Resource Allocation; North East Province Compared to Other Regions in Sri Lanka'* is a comparative analysis of factors affecting the healthcare of the people of the Northeast Province in the island of Sri Lanka.

The factors analysed include, allocation of funds, selection and training of healthcare professionals and technicians, primary care, specialised medical care, allocation of personnel and supplies, etc. In all areas examined the discrepancy is striking. Comparison between time periods show the level of care in the NEP to be declining, while the rest of the island of Sri Lanka to be progressing.

The effects of over a decade of restricted training of Tamil speaking healthcare workers is likely to continue for years to come, even if measures are adopted to reverse the discriminatory policies of the Sri Lankan state.

The Demography

The North East Province (N.E.P.) extends over an area of 18,347 Square Kilometres of the island of Sri Lanka.

There are five districts (Jaffna, Kilinochchi, Mannar, Mullaitivu and Vavuniya) in its northern section, and three (Trincomalee, Batticaloa and Amparai) in the southern section. The Jaffna and Kilinochchi Districts are often categorised as one, because it formed one health administrative region until a few months ago.

Table 1. shows these districts - the area in square kilometres with the proportion of each as a percentage of N.E.P., and the population in each district.

The Jaffna district, which is the smallest in area, has the largest population. Almost one third of the total population of the N.E.P. live in 7.4% of the land.

The other areas of the north, Viz. Mannar, Mullaitivu and Vavuniya are sparsely populated. The major healthcare facilities are located in the Jaffna District and are hence situated far away from the population in these areas. In the

Table 1 LAND AREA AND POPLUATION OF THE ADMINISTRATIVE DISTRICTS IN THE NORTH EAST PROVINCE AND THE CORRESPONDING PERCENTAGES

Administrative Area	Land area Sq. Km. (%)	Population 1981 Census	Population Est. Midyear 1993 (%)
Jaffna	1374 (7.4)	733,096	881,000 (34.3)
Kilinochchi	1155 (6.3)	95,920	120,000 (4.7)
Vavuniya	2193 (12)	95,920	117,000 (4.6)
Mallaitivu	1966 (10.7)	77,530	76,000 (3.8)
Trincomalee	2618 (14.3) 253,948	253,948	318,000 (12.4)
Batticaloa	2500 (13.6)	330,900	420,000 (16.3)
Amparai	4539 (24.7)	388,970	485,000 (18.8)
NEP	**18,347 (100)**	**2,085,304**	**2,569,000 (100)**
Sri Lanka	**64,6542**	**14,846,750**	**17,613,000**

Source: ABH 1992M/H SL
Ad. Report 1992 M/H NEP

southern part of the N.E.P., the area is divided more on ethnic grounds and the healthcare facilities differ accordingly.

Distribution of Government Medical Institutions

The number of hospital beds per1,000 population gives an indication of in-patient facilities available to the population.

Table 2. shows details of the types of hospitals, the number of beds available, and the rates for each of the districts in Sri Lanka.

As could be seen, while the national average is 2.8 beds per 1,000 population, the average for the districts in the N.E.P. (Range 1.0 - 2.0) is far less.

Even Jaffna, with a major teaching hospital, falls short of the national average.

Distribution of Doctors and Dental Surgeons

Table 3 shows the distribution of Doctors and Registered Assistant Medical Practitioners and Dental Surgeons in the island. In 1992 (the latest year for which official statistics are available), the national rate for doctors per 100,000 population was 17.1 and the rate for the district of Colombo was 55.5.

Six of the 8 districts in the N.E.P. (75%) have fewer than 5 Doctors per 100,000 population. In Southern Sri Lanka, 10 of the 17 districts have 10.1 - 25.0 Doctors per 100,000, and 5 have 5.1 - 10.0 doctors per 100,000 population. Only 2 of 17 districts in Southern Sri Lanka (11.8%) have fewer than 5. Jaffna now ranks 13th, with a rate of 9.1 (about half the national average.) Smaller, non-teaching areas such as Matara, Badulla, Polonnaruwa, Ratnapura, etc. now rank higher. The ratio in the other areas of the N.E.P. is very low compared to the national average.

The distribution of Assistant Medical Practitioners (AMP/RMP) in the N.E.P. is somewhat better. However, it must be noted that the training of newer Tamil recruits in this field at the Jaffna University has been stopped for the last five years. The situation will deteriorate by attrition, as the senior personnel retire.

Only in the Jaffna District (including Kilinochchi is the availability of Dental Surgeons satisfactory. In the rest of the N.E.P. have fewer than one dental surgeon per 100,000 population, whereas in the southern Sri Lanka only 2 of the 17 districts are similarly situated.

Distribution of Nurses

Table 3 shows the distribution of trained nurses on the island.

Table 2 DISTRIBUTION OF GOVERNEMT MEDICAL INSTITUTIONS AND BEDS*

District	Teaching Hospitals		Provincial Hospitals		Base Hospitals		District Hospitals		Peripheral Hospitals		Rural Hospitals		Maternity Homes ***/ Central Dispensaries		Other Hospitals***		Total Hospitals		Beds per 1,000	Central Dispensaries	MOOH/ DHOO
	Number of		Number of		Number of		Number of		Number of		Number of		Number of		Number of		Number of		Pop.		
	Inst	Beds	Inst	Beds	Inst	Beds	Inst	Beds	Inst	Beds	Inst	Beds	Inst	Beds	Inst	Beds	Insc	Beds			
Colombo	6	5176	1	624	1	343	4	373	6	327	1	22	-	-	7	2630	26	9497	4.8	22	11
Gampapha	1	1088	-	-	3	1049	5	711	4	188	3	56	11	117	6	1454	33	4663	3.0	30	14
Kalutara	-	-	1	596	1	372	5	683	5	250	6	139	2	10	-	-	20	2050	2.2	6	7
Kandy	2	2097	-	-	1	312	11	1002	10	419	23	649	3	31	1	44	51	4554	3.6	16	11
Matale	-	-	-	-	1	501	4	318	4	193	4	68	5	49	-	-	18	1129	2.7	13	9
Nuwara Eliya	-	-	-	-	1	213	12	985	3	147	1	14	3	42	-	-	20	1401	2.6	18	4
Galle	1	1146	-	-	-	-	6	655	8	366	6	136	5	52	1	11	27	2366	2.5	16	13
Matara	-	-	-	-	1	640	2	273	6	380	7	208	7	83	-	-	23	1584	2.0	12	14
Hambantota	-	1053	-	-	1	156	5	516	5	201	4	122	7	71	-	-	22	1066	2.0	8	7
Jaffna	1	-	-	-	1	222	5	391	7	291	2	47	10	80	-	-	26	1984	2.0	17	7
Mannar	-	-	-	-	1	183	1	30	1	26	1	16	1	14	-	-	5	269	2.0	4	1
Vavuniya	-	-	-	-	1	149	-	-	1	24	-	-	2	23	-	-	4	195	1.7	2	1
Mullaitivu	-	-	-	-	-	-	1	40	1	42	-	-	1	8	-	-	3	90	1.0	2	1
Batticaloa	-	-	1	618	-	-	1	82	5	173	1	26	-	-	1	132	9	11031	2.4	8	3
Ampara	-	-	-	-	2	453	3	158	7	202	1	71	4	38	-	-	17	922	1.9	28	6
Trincomalee	-	-	-	-	1	278	2	140	1	35	2	47	1	12	-	-	7	512	1.6	8	3
Kurungegala	-	-	1	1043	2	487	12	1204	16	631	4	89	4	49	-	-	39	3503	2.4	41	15
Puttalam	-	-	-	-	2	560	3	385	5	215	6	143	4	47	-	-	20	1350	2.2	16	6
Anuradhapura	-	-	1	839	-	-	4	356	7	413	22	463	4	48	1	15	39	2133	2.9	17	5
Polonnaruwa	-	-	-	-	1	365	2	236	2	114	6	205	-	-	-	-	11	921	2.8	9	6
Badulla	-	-	1	743	-	-	11	863	5	167	7	134	2	29	-	-	26	1936	2.7	15	11
Moneragala	-	-	-	-	-	-	9	642	1	49	5	79	1	10	-	-	16	780	2.2	9	6
Ratnapura	-	-	1	694	-	-	9	1160	11	354	2	34	2	30	-	-	25	2472	2.6	14	9
Kegalle	-	-	-	-	1	576	8	895	1	63	4	84	5	34	-	-	19	1652	2.2	19	10
TOTAL	11	10,452	7	5366	22	6858	125	12098	122	5270	118	2853	84	877	17	4285	506	48061	2.8	350	182

Includes:
*** Maternity homes in charge of Midwives
*** Mental, Chest, Leprosy

Excludes:
* Examination, Labour room beds and cribs, bassinets etc. used for healthy new borns.

Source: Medical Statistics Unit

Table 3 KEY HEALTH PERSONNEL BY DISTRICTS — 1st SEPTEMBER 1992

SHS Division	Medical Officers (Curative Services) (1)		Medical Officers (Admin & Preventive Services) (2)		Dental Surgeons (3)		Registered/Assistant Medical Officers		Nurses (4)		Medical Officers of Health		Public Health Nursing Sisters		Public Health Inspectors	
	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*
Colombo	1106	55.5	22	1.1	115	5.8	79	4.0	2960	140.4	14	0.7	22	1.1	52	2.6
Gampapha	245	15.9	6	0.4	24	1.6	83	5.4	855	55.4	16	1.0	11	0.7	72	4.7
Kalutara	125	13.1	19	2.0	18	1.9	55	5.8	477	50.1	13	1.4	16	1.7	54	5.7
Kandy	295	23.5	6	0.5	27	2.1	102	8.1	1125	89.5	16	1.3	9	0.7	70	5.6
Matale	53	12.5	2	0.5	6	1.4	41	9.7	194	45.9	9	2.1	4	0.9	23	5.4
Nuwara Eliya	44	0.3	-	-	5	0.9	51	9.6	159	29.8	6	1.1	1	0.2	14	2.6
Galle	151	15.0	6	0.6	24	2.5	64	6.7	594	62.0	12	1.3	9	0.9	36	3.8
Matara	72	9.2	3	0.4	9	1.1	46	5.9	326	41.5	15	1.9	4	0.5	43	5.5
Hambantota	21	4.0	2	0.4	5	1.0	37	7.1	141	26.9	9	1.7	-	-	31	5.9
Jaffna& Kilinochchi	89	9.1	7	0.7	21	2.1	67	6.8	402	41.1	3	0.3	1	0.1	13	1.3
Mannar, Vavuniya, Mullaitivu	12	3.5	2	0.6	3	0.9	34	9.9	56	16.3	2	0.3	-	-	-	-
Batticaloa	35	8.2	3	0.7	8	1.9	27	6.4	190	44.7	-	-	-	-	24	5.6
Amparai	17	3.5	-	-	4	0.8	51	10.4	160	32.5	3	0.2	-	-	29	5.9
Trincomalee	13	4.1	1	0.3	5	1.6	26	8.2	87	27.3	-	-	-	-	21	6.6
Kurungegala	146	10.1	7	0.5	20	1.4	119	8.2	728	50.4	1	1.2	12	0.8	84	5.8
Puttalam	39	6.4	3	0.5	9	1.5	50	8.2	219	36.1	6	1.0	4	0.7	24	4.0
Anuradhapura	69	9.5	4	0.5	12	1.6	71	9.8	385	52.9	6	0.8	2	0.3	37	5.1
Polonnaruwa	46	14.2	1	0.3	4	1.2	33	10.2	111	34.2	5	1.5	0	0.0	32	9.8
Badulla	72	10.1	4	0.6	14	2.0	56	7.8	391	54.6	7	1.0	5	0.7	37	5.2
Moneragala	11	3.1	1	0.3	5	1.4	37	10.4	106	29.8	4	1.1	0	0.0	35	9.8
Ratnapura	102	10.8	5	0.5	17	1.8	65	6.9	450	42.8	9	0.9	8	0.8	51	5.4
Kegalle	52	6.9	4	0.5	11	1.5	55	7.3	360	47.9	10	1.3	2	0.3	51	6.8
Special Campaigns	164	0.9	73	0.4	15	0.1	4	0.0	782	4.5	3	0.0	3	0.0	31	0.2
SRI LANKA	2979	17.1	191	1.0	381	2.2	1253	7.2	11214	64.4	185	1.1	113	0.6	864	5.0

1. Includes Specialists
2. Excludes Medical Offiers of Health (given separately)
3. Included Regional Dental Surgeon
4. Excludes Pupil Nurses

* *Rate per 100,000 population staff of the Ministry of Health and Women's Affairs*

Source: Medical Statistics Unit

The rates for nursing and midwifery personnel, that was less than national average in 1993, deteriorated even more.

Further declines in the availability of nurses and midwives are expected because of the curtailment of new recruitment and training in the Tamil medium (in Jaffna and Batticaloa). In the N.E.P. only Amparai (where there is a large Sinhala population) there are adequate numbers of Sinhala speaking midwives who are trained at the Nurses Training School in Badulla.

Only 3 districts in the whole island have rates less than 25 nurses per 100,000 population. All 3 districts are in the N.E.P. - Mullaitivu, Vavuniya, and Mannar.

Jaffna and Batticaloa districts with large general hospitals also have lower ratio (25.1 - 50.0) than the national average of 64.4 per 100,000.

Public Health Inspectors and Midwives

In the case of Public Health Inspectors, the entire northern section of the N.E.P. falls into the lowest ratio category. The southern part of N.E.P. is only slightly better.

In the case of Public Health Midwives (Table 5), all districts in the northern section and the Trincomalee district in the southern section are in the lowest ratio category, the rest of the N.E.P. being only slightly better.

Public Health Inspectors promote and maintain sanitation and health education, whereas Public Health Midwives provide primary care.

In an area where the war has created numerous public health hazards (Eg: Epidemics of Malaria. Diarrhoeal Diseases, Malaria, etc.), and where the curative services are hindered by lack of personnel and supplies, the hazards due to the shortage of public health personnel is exacerbated.

Specialised Medical Care

Most of the different types of medical specialties, that are available in other parts of Sri Lanka, are unavailable in the North East Province. Table 3 (A) shows the distribution of specialists by districts. Jaffna district has a teaching hospital, as do the districts of Colombo, Kandy and Galle. But the Jaffna General Hospital (Teaching) has the smallest number of medical specialists. The number of specialists in Jaffna (21) is about one tenth of that in Colombo (208), one third that of Kandy (59), and about half that in Galle (38). Even smaller non teaching general hospitals in the southern Sri Lanka (Eg: Ratnapura and Kurunegala) have more medical specialists than the Teaching Hospital in Jaffna. Since the publication of the data in this table one of the two surgeons at the Jaffna General Hospital has died, leaving only one General Surgeon to provide services to a population of nearly eight hundred thousand people. The problem is compounded by

Table 3(A) DISTRIBUTION OF SPECIALISTS BY DISTRICTS — 31st DECEMBER 1993

Specialty / District	General Physicians	General Surgeon	Obstetricians & Gynaecologists	Cardiologists	Neurologists	Dermatologists	Rheumatologists	Psychiatrists	Paediatricians	TB & Chest Physicians	ENT Surgeons	Eye Surgeon	Orthopaedic Surgeons	Paediatric Surgeons	Plastic Surgeons	Genitourinary Urinary Surgeons	Neuro Surgeons	Throacic Surgeons	Anaesthesiologists	Pathologists	Bacteriologists / Micorbiologists	Biochemists	Radiologists	Venereologist	Radiotherapists / Oncologists	Others*	TOTAL
Colombo	22	24	21	5	2	3	3	12	12	5	4	9	6	5	2	2	2	4	22	11	4	4	9	3	7	5	208
Campaha	11	11	10	-	1	1	-	1	7	1	2	1	-	1	-	-	-	1	3	2	-	-	1	1	-	-	55
Kaltara	3	3	4	-	-	-	-	-	1	-	1	2	-	-	-	-	-	-	1	-	-	-	-	-	-	-	15
Kandy	8	6	6	1	1	1	1	5	5	-	2	2	-	1	1	1	-	-	5	2	1	2	4	1	1	1	59
Matale	1	1	2	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	6
Nuwara Eliya	-	1	1	-	-	-	-	-	1	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4
Galle	9	6	5	1	1	1	-	2	2	-	1	3	-	1	-	1	-	-	2	1	-	-	1	-	1	-	38
Matara	3	2	2	-	-	1	-	-	1	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	10
Hambantota	-	-	1	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Jaffna	3	1	3	-	1	-	-	1	2	-	1	2	-	-	-	-	-	-	-	1	-	1	-	-	-	-	16
Mannar	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Vavuniya	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Mullaitivu	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Batticaloa	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Amparai	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Trincomalee	1	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	4
Kurunegala	4	3	3	-	-	1	1	1	2	-	1	1	-	1	-	-	-	-	-	1	-	-	1	-	-	-	20
Puttalan	1	1	2	-	-	-	-	-	1	-	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	7
Anuradhapura	2	2	2	-	-	-	-	-	1	-	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	9
Plannaruwa	1	1	1	-	-	-	-	-	1	-	-	1	-	-	-	-	-	-	1	-	-	-	-	-	-	-	6
Badulla	1	1	2	-	-	-	-	1	1	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	7
Moneragala	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Ratnapura	2	2	2	-	-	1	-	1	1	1	1	1	-	-	-	-	-	-	1	-	-	-	1	1	3	-	18
Kegalle	1	1	2	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	5
SRI LANKA	76	68	72	7	6	9	5	24	41	7	14	26	6	9	3	4	2	5	39	18	6	7	18	6	12	6	496

* *In curative care services: Includes Specialists of the Faculties of Medicine (working in Teaching)*

Source: Medical Statistics Unit

the war situation - esp. the bombing and shelling resulting in large scale civilian casualties - increasing the need for surgical services.

Allocation vs Availability of Medical Specialists

Table 4. shows the allocation (Cadre) Vs. actual availability of Specialists in the hospitals in the Northeast Province, for the year 1992/93. The hospitals shown are General Hospital (Teaching) Jaffna (GHTJ), General Hospital Batticaloa (GHB) and other Base Hospitals (BHH). General Hospital (Teaching) Jaffna - which includes specialists in the University Clinical Departments - has only 25% of the cadre filled. General Hospital Batticaloa, has only 10% of its specialist cadre filled. In 1983/84 General Hospital (Teaching) Jaffna had 44 specialists (92% of cadre). The decline in the numbers took place soon after 1983, primarily due to security reasons. The harassment of the general

Table 4 AVAILABILITY OF SPECIALISTS COMPARED TO CADRE 1992/93

Specialty	GHT I		GHB		BHH		NEP	
	Cadre	Available	Cadre	Available	Cadre	Available	Cadre	Available
General Surgery	7*	1	2	0	7	0	16	1
Orthopaedics	2*	0	1	0	-	-	3	0
Neuro Surgery	1	0	-	-	-	-	1	0
Thoracic Surgery	1	0	-	-	-	-	1	0
ENT	1	0	1	0	2	0	4	0
Ophthalmology	2	2	1	0	2	1	5	3
Dental	2	0	2	0	-	-	4	0
Forensic	2	0	1	0	-	-	3	0
General Physician	8*	5	2	1	7	1	17	7
Dermatology	1	0	-	-	-	-	1	0
Neurology	1	1	-	-	-	-	1	1
Psychiatry	3	1	1	0	1	0	5	1
Paediatrics	3	1	1	0	7	2	11	3
Pathology	4*	0	1	0	-	-	5	0
Obstetrics	5	3	2	1	6	1	13	5
Oncology	1*	0	-	-	1	0	2	0
Radioilogy	1	0	1	0	-	-	2	0
Anaesthesiology	3	0	2	0	1	0	6	0
TOTAL	48	14	18	2	34	5	100	21

* *Includes faculty members from the University Clinical Departments*

Table 5 KEY HEALTH PERSONNEL BY DISTRICT — 1st SEPTEMBER 1992

District	Public Health Midwives		Hospital Midwives		Pharmacists		Dispencers		Medical Laboratory Technologists		Radiographers		Physiotherapists		Attendants	
	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*
Colombo	193	9.7	206	10.3	134	6.7	41	2.1	157	7.9	113	5.7	80	4.0	1100	55.2
Gampaha	327	21.2	136	8.8	57	3.7	39	2.5	58	2.5	16	1.0	26	1.7	72	4.7
Kalutara	274	28.8	119	12.5	29	3.0	14	1.5	27	2.8	9	0.9	6	0.6	290	30.5
Kandy	355	28.2	198	15.8	5.2	4.1	60	4.8	29	2.3	23	2.2	12	1.0	404	32.1
Matale	143	33.8	56	13.2	10	2.4	23	5.4	7	1.7	2	0.5	2	0.5	159	37.6
Nuwara Eliya	98	18.4	53	9.9	4	0.8	22	4.1	6	1.1	2	0.4	1	0.2	119	22.3
Galle	215	22	141	14.7	27	2.8	32	3.3	26	2.7	10	1.0	19	1.0	223	23.3
Matara	248	4	122	15.5	21	2.7	28	3.6	16	2.0	4	0.5	2	0.3	154	19.6
Hambantota	218	31.6	70	13.4	11	2.1	21	4.0	7	1.3	3	0.6	-	-	87	16.6
Jaffna & Kilinochchi	88	41.6	57	5.8	50	5/1	36	3.7	22	2.2	3	0.3	5	0.5	223	22.8
Mannar, Vavuniya,	41	9.0	13	3.8	8	2.3	17	5.0	3	0.9	2	0.6	-	-	81	23.6
Mullaitivu	67	12.0	26	6.1	11	2.6	10	2.4	7	1.8	3	0.7	1	0.2	166	39.1
Batticaloa	114	15.8	48	9.8	9	1.8	27	5.5	6	1.2	2	0.4	-	-	108	22.0
Amparai	24	23.2	19	6.0	5	1.6	19	6.0	3	0.9	1	0.3	1	0.3	40	12.5
Trincomalee	387	7.5	238	16.5	33	2.3	66	4.6	31	2.1	8	0.6	6	0.4	359	24.8
Kurunegala	145	26.8	59	9.7	13	2.1	32	5.3	12	2.0	2	0.3	2	0.3	97	16.0
Puttalam	248	23.9	101	13.9	19	2.6	30	4.1	18	2.5	5	0.7	7	1.0	161	22.1
Anuradhapura	112	34.1	39	12.0	8	2.5	9	2.8	5	1.5	2	0.6	2	0.6	96	29.5
Polonnaruwa	200	34.5	90	12.6	15	2.1	34	4.7	15	2.1	7	1.0	4	0.6	173	24.2
Badulla Moneragala	95	27.9	41	11.5	-	-	18	5.1	1	4.1	1	0.3	-	-	84	23.6
Ratnapura	285	26.7	102	10.8	23	2.4	32	3.4	17	1.8	4	0.4	1	0.1	164	17.3
Kegalle	231	30.1	91	12.1	17	2.3	25	3.3	13	1.7	3	0.4	2	0.3	295	39.2
SPecial Campaigns	-	30.7	-	-	26	0.1	6	0.0	109	0.6	33	0.2	5	0.0	725	4.2
SRI LANKA	4108	23.6	2025	11.6	528	3.3	641	3.7	579	3.3	263	1.5	175	1.9	5710	32.8

Staff of the Ministry of Health and Women's Affairs

Source: Medical Statistics Unit

* *Rate per 100,000 Population*

public of Jaffna by the military personnel included physicians, and as a consequence the specialists left to find employment in safe settings elsewhere. Most of them went abroad because the riots of 1983 had shown even the southern Sri Lanka not to be safe.

Distribution of Paramedical Personnel

Only Amparai district (a Sinhala majority area) in the N.E.P. has Midwives (both public and hospital) in ratios comparable to the national average.

In the rest of the N.E.P., the availability of Midwives is very low. In 6 of the 8 districts, the ratio of midwives is less than 50% of the national average. The ratio of other paramedical personnel (Medical Laboratory Technologists, Pharmacists, Radiographers and Physiotherapists) in the N.E.P. is also low. The problem is compounded by the fact that the average age of these personnel in the N.E.P. is at or near retirement age.

Hospital Midwives

In Sri Lanka well over 80% of deliveries are conducted by midwives in hospitals. Shortage of trained midwives can adversely affect the quality of maternal care. The national average for hospital midwives is 11.6 per 100,000, which is in itself less than optimal. Table 5. shows the ratio in all the 5 Tamil speaking districts of the northern N.E.P. to be less than 6. In the southern N.E.P. the situation is slightly better, but this is partly due to the availability of Sinhala speaking midwives in the Sinhala areas of the southern N.E.P. The hospital midwives in addition to managing labour and delivery, also provide health education in infant care, breast feeding, maternal nutrition and

Table 6 AGE DISTRIBUTION AND RETIREMENT STATUS OF SELECTED PARAMEDICAL STAFF — GHTJ (1994)

Occupation	Cadre	Permanently Employed	On Extension	Re Employed	Mean Age	Age Range
MLT	20	2	6	7	57	50-62
Pharmacists	21	23	2	-	48	29-56
Radiographers	15	1	1	4	57	51-60
Physiotherapists	16	4	-	4	52	30-61
Nurses						
Basic trained	383	319	5	7		
Post trained	27	4	1	-		
NTS	8	4	1	-		

Source: Department of Community Medicine, Jaffna University

Table 7 KEY HEALTH PERSONNEL 1980-1992

Year	Medical Officers (1)		Dental Surgeon (2)		Registered Assistant Medical Practitioners		Nurses (3)		Public Health Nurses		Public Health Inspectors		Pubilc Health Midwives		Hospital Midwives	
1980	2055	13.9	218	1.5	1018	6.9	6123	41.5	213	1.4	913	6.2	1817	12.3	1533	10.4
1982	2033	13.4	275	1.8	911	6.0	6931	45.6	241	1.6	962	6.3	2296	15.1	1512	9.9
1984	1951	12.5	288	1.8	984	6.3	7400	47.4	209	1.3	916	5.9	3001	19.2	1538	9.9
1986	2217	13.7	318	2.0	1047	6.5	8018	49.7	189	1.2	966	6.0	3102	19.2	1463	9.1
1988	2316	14.0	355	2.1	1100	6.6	8317	50.1	154	0.9	977	5.9	3209	19.3	1531	9.2
1989	2456	14.6	333	2.0	1193	7.1	9486	56.4	146	0.9	943	5.6	3389	20.2	1641	9.8
1990*	2240	15.5	317	2.0	1074	6.8	8957	57.6	140	0.9	886	5.6	3321	21.2	1638	10.4
1991	2934	17.0	358	2.1	1201	7.0	9934	57.6	101	0.6	914	5.3	3583	20.8	1776	10.3
1992	3345	19.2	381	2.2	1253	7.2	11214	64.4	113	0.6	846	5.0	4108	23.6	2025	11.6
Rate of growth 1980-1982	62%		74%				83%						126%			

* *Excludes Northern Province*
Rate per 100,000 population

1 Includes Medical Officers in curative, administrative and preventive services
2 Includes Regional and Consultant Dental Surgeons
3 Excludes pupil nurses

Source: Medical Statistics Unit

family planning. Due to the shortage in the N.E.P., these functions are not being carried out. In fact, at times some deliveries in the hospitals in the N.E.P. are conducted by untrained hospital auxilliaries.

Age Distribution of Paramedical Personnel

Table 6 shows
(1) the number on cadre,
(2) the number in permanent employment
(3) the number on extension of service beyond retirement age of (55 Yr.)
(4) the number re-employed after retirement
(5) the mean age of those in service and
(6) the age range.

The situation for all groups of paramedical personnel, except Pharmacists, is precarious due to the lack of new recruitment and training. The situation for all groups of paramedical personnel, except Pharmacists, is precarious.

In the case of Pharmacists and Physiotherapists the mean age is lower than the rest because of one individual in each category being 29 and 30 years old.

There are only 4 nurses with post basic training of a cadre of 27 (15%). This is due to the fact that higher training is available only in one Nurses Training School situated in Colombo, where the training is done only in the Sinhalese Language. This also explains the dearth of teachers at the Nurses Training School (NTS) in Jaffna.

Growth in Health Care Personnel

In the island of Sri Lanka, an active programme for recruitment and training of health care workers has increased the number of key personnel, both in absolute numbers as well as in their ratios per 100,000 population.

Table 7 shows this growth of key healthcare personnel from 1980 to 1992. There has been a 50% growth in the number of doctors (specialist and non-specialist).

The rate for Public Health Midwives (PHM) increased by 100% (126% in absolute numbers).

The curriculum for PHMs was redrawn in 1979, and this category was renamed Family Health Workers, to cater to the WHO goal of "Health for All by the year 2000 through Primary Care."

However, as discussed earlier, this progress has not reached the N.E.P.

Health Manpower Training 1982-83 and 1990-1992

Table 8. shows that all paramedical training (except nursing) is conducted in schools in and around Colombo.

Nursing and Midwifery training are conducted in regional schools. The 2 Nurses Training Schools (NTS) in the N.E.P. (Batticaloa and Jaffna) conduct training in Tamil, and the other 6 in the south Sri Lanka conduct theirs in Sinhala.

The NTS in the N.E.P. admitted a total of only 18 students (5%) whereas the Sinhala medium schools admitted 337 students (95%) during this period.

As shown in the previous figure only 5% of those admitted for nursing were admitted to the schools in the N.E.P.

Table 9 shows that in 1990, 91 and 92 the total intake to NTS in the N.E.P. was only 126 (3.8%) of a total intake of 3337 for the island.

It is noteworthy that during this decade, when the admissions to NTS in the N.E.P. declined from 5% to 3.8%, the intake for the entire island increased 50% (Table 9).

The Table also shows that the intake for PHM training in 1990, 1991 and 1992 in the N.E.P. was zero (0), while 495 were admitted to other schools.

Table 8 HEALTH MANPOWER TRAINING 1982-1983

Catagory and duration	Training Institution		Annual intake		Annual output	
			1982	1983	1982	1983
Doctors (5 years)	Medical Faculty	Colombo	184	1186	166	92
		Peradeniya	70	92	88	79
		Jaffna	75	85	-	52
		Galle	90	90	90	78
Assistant Medical Practitioners (3 years)	Medical Faculty	Colombo			16	44
		Peradeniya	-	-	4	23
		Jaffna	-	-	4	-
		Kalutara	-57	-	-	50
Nurses (3 years)	NTS	Colombo	154	-	100	-
		Kandy	59	-	98	52
		Galle	54	-	83	113
		Ratnapura	27	-	30	36
		Kurunegala	30	-	69	49
		Anuradhapura	13	-	59	47
		Jaffna	09	-	13	50
		Batticaloa	09	-	13	22
Pharmacists	Medical Faculty	Colombo	73	-	-	55
Physiotherapists and Occupational Therapists (2 years)	School of Physiotherapists	Colombo	-	10	-	48
Radiographers (2 years)	General Hospitals	Colombo	-	-	-	52
MLT (2 years)	MRI	Colombo	-	-	-	70
PHNN	NIHS	Kalutara	-	46	-	-
PHII	NIHS	Kalutara	83	-	-	83
Dental Therapists (2 years)	School for Dental Therapists	Maharagama	25	-	22	18
PHMM	NTS and Field Training Areas		-	-	-	703

Source: Department of Community Medicine, University of Jaffna

The high output of nurses from schools in the N.E.P for the year 1992 is due to the clearing of a backlog of students, whose graduations were delayed in the previous years due to the disturbances caused by the war.

Health Care Expenditure 1977-1992

The total government expenditure for Sri Lanka increased from Rs. 8,812.8 M in 1977 to Rs. 150,079 M in 1992 (A seventeen fold increase). The expenditure on healthcare increased fourteen fold from Rs. 484.8M to Rs. 6,967M in the same period. Healthcare expenditure as a percentage of government expenditure, and as a percentage of the GNP remained the same over the years. The per capita expenditure on health care rose from Rs. 34.9 in 1977 to Rs. 400.4 in 1992. From 1991 to 1992 alone this rose from Rs. 315.3 to Rs. 400.4 (A 27% increase). Table 10 shows this.

Expenditure on Medical Supplies — Teaching Hospitals

Capital expenditure on healthcare facilities in the N.E.P. has been limited under the rationale that it is a war-torn area. All the capital expenditure in the N.E.P. was applied in Amparai, Kantalai and Trincomalee (Areas with a substantial Sinhala population).

Expenditure on medical supplies reveals the level and quantity of services offered and utilised. Table 11 shows expenditure on medical supplies in the major (teaching) hospitals in the island.

The expenditure in Jaffna for the year 1990 is artificially low because the Jaffna hospital was non-functional due to the extensive bombing of the area. For the major part of that year, health services were provided by the Green Memorial Hospital (Manipay) under ICRC. Only basic services were provided during that year due to the limitations imposed by the physical facilities at the Green Memorial Hospital. The Jaffna General Hospital resumed functioning in November, 1990.

The number of beds in each of the major hospitals is given for comparison only. All these hospitals have occupancy rates in excess of 90%.

As shown, the expenditure on medical supplies for Jaffna from 1991 to 1992 increased by 4%, whereas that for all the other teaching hospitals increased by over 50%.

Table 9 HEALTH MANPOWER TRAINING 1990-1992

Category	Duration of Training	Training Institution		Annual Intake			Annual Output		
				1990	1991	1992	1990	1991	1992
Doctors	5 years	Medical Faculty	Colombo	179	255	255	240	155	144
			Peradeniya	241	132	194	69	70	89
			Jaffna	93	108	102	66	51	68
			Ruhuna	219	105	164	93	102	86
			Kelaniya	-	106	147	81	99	64
Dental Surgeons	5 years	Faculty of Dental Services	Peradeniya	75	80	75	30	44	65
Assistant Medical Practitioners	3 years	Medical Faculty	Colombo	37	-	-	50	42	47
			Peradeniya	-	25	-	29	50	-
			Jaffna	-	-	-	19	-	-
		NIHS	Kalutara	23	-	-	66	70	26
Nurses	3 years	Nurse Training School	Colombo	162	161	190	177	181	184
			Kandy	176	164	178	155	307	149
			Galle	154	126	180	212	220	142
			Ratnapura	63	85	79	64	97	48
			Kurunegala	118	179	156	127	191	84
			Anuradhapura	120	91	119	55	-	-
			Jaffna	-	-	9	-	-	127
			Batticaloa	28	61	37	14	24	100
			Badulla	110	122	100	109	175	136
			Kandana	86	99	163	-	-	166
Pharmacists	2 years	Medical Faculty	Colombo	-	52	-	67	24	43
			Kalutara	-	41	-	35	-	41
Physiotherapists	2 years	School of Physiotherapy	Colombo	-	24	-	16	19	3
Occupational Therapists	2 years	School of Physiotherapy		-	8	-	3	2	3
Radiographers	2 years	School of Radiography GH Colombo	Colombo	-	19	-	19	22	-
Medical Laboratory Technologists	2 years	Medical Research Institute	Colombo	-	-	-	47	-	2
		NIHS	Kalutara	-	27	-	29	29	-
		Medical Faculty	Peradeniya	-	-	4	-	-	-
Public Health Nursing Sisters	1 years	NIHS	Kalutara	17	-	-	-	17	16
Public Health Inspectors	1 years	NIHS	Kalutara	-	63	-	136	-	-
Dental Therapists	2 years	Dental Nurses Training School	Maharagama	22	25	-	22	23	-
Family Health Workers (PHMM)	1 years	Nurses Training School	Colombo	133	-	-	172	128	-
			Kandy	97	-	-	214	97	-
			Galle	109	-	-	243	200	-
			Ratnapura	45	-	-	81	45	-
			Kurunegala	37	-	40	99	37	40
			Anuradhapura	20	-	-	-	-	-
			Jaffna	-	-	-	-	-	8
			Batticaloa	-	-	-	7	-	-
			Badulla	54	-	-	118	53	-

Source: Medical Statistics Unit

Table 10 SRI LANKA — EXPENDITURE ON HEALTH 1977-1992 (RS. MILLION)

Item	1977	1979	1981	1983	1985	1987	1989	1991*	1992*
Total Government Expenditure	8,812.8	20,330.3	29,485.6	41,790.0	67,103.0	67,829.2	77,634.0	109,724.0	150,079.0
Expenditure on Health	484.8	752.5	953.7	2,024.0	2,750.9	3,711.0	5,038.4	5,437.7	69 67.1
Health Expenditure as Percentage of Government Expenditure (actual)	5.5	3.7	3.2	4.8	4.1	5.5	6.5	5.0	4.6
GNP	34,432.0	49,542.0	76,831.0	108,762.0	146,005.0	173,395.0	222,399.0	331,742.0	376,660.0
Health Expenditure as percentage of GNP	1.4	1.5	1.2	1.9	1.9	2.1	2.3	1.6	1.8
Per Capita Expenditure Health (Rs.)	34.9	51.9	63.6	131.4	173.6	226.8	229.3	315.3	400.4

* *Provisional*

Source: Medical Statistics Unit

Table 11 EXPENDITURE ON MEDICAL SUPPLIES TEACHING HOSPITALS — SRI LANKA 1990-1992

Hospital	No. of beds	1990 in Rs. Million	1991 in Rs. Million	Percentage increase 1990-1991	1992 in Rs. Million	Percentage increase 1991-1992
Colombo	5250	77	167	116.8	272	62.9
Ragama	1084	14	28	100.0	43	53.6
Kandy / Perradeniya	2070	22	56	154.5	84	50
Galle	1093	19	43	126.3	67	55.8
Jaffna	1060	4*	25	525.0*	26	4.0

Medical supplies include:
1. Drugs
2. Dressings
3. X-ray supplies
4. Surgical consumables
5. Surgical non-consumables

* *Jaffna Hospital was closed in 1990 due to bombing*

Expenditure on Medical Supplies Via Provincial Councils

Provincial Councils are allocated funds by the central government, with amounts specified for healthcare. This is done taking into account the funds already allocated to the teaching hospitals.

Table 12 shows these allocations. This shows that provinces with teaching hospitals have lower allocations than those without teaching hospitals. This is because funds are allocated separately for the teaching hospitals.

Expenditure on Medical Supplies Per Person in Provinces with Teaching Hospitals - 1992

Colombo Group of Hospitals and Ragama General Hospital come under the Western Province; Kandy General Hospital and Peradeniya Hospital under the Central Province; Galle General Hospital under Southern Province and the Jaffna General Hospital under the North-East Province.

Table 13. shows the funds allocated to each province, via the Provincial Councils and the Teaching Hospitals, and also shows the per capita expenditure on medical supplies in each of these provinces.

Accessibility

In addition to the deprivations in healthcare, accessibility of available resources is a major problem.

The ongoing civil war has damaged or destroyed both private and state buildings and structures, due to bombing and shelling. This includes hospitals.

Furthermore, military camps are sited in close proximity to a number of hospitals and dispensaries. The public, due to fear of harassment by the security forces, generally shun such facilities.

Table 14 shows hospitals and dispensaries that are non functional due to this reason. All Dispensaries have an average attendance of over 100 patients per day. Institutions where the attendance has fallen below 20 are not included.

Conclusion

The data presented in this paper clearly identifies the dilapidated state of the health service in the North East Province. There has developed over the years a steady and systematic depletion of both medical and paramedical staff and a significant reduction in health care expenditure compared to the rest of Sri Lanka. This attrition in both health and manpower expenditure has had not unexpectedly, a detrimental effect not only on the health of the population but also on the effectiveness of medical education in the medical and nursing institutions in the Jaffna peninsula. This has been compounded by the implicit state policy of curtailing the intake of medical, paramedical and nursing entrants for training. Urgent and concerted action by governmental and non-governmental organisations is necessary to alleviate the situation.

Table 12 EXPENDITURE ON MEDICAL SUPPLIES PROVINCIAL COUNCILS, 1992 9RS. '000)

Provincial Council	RDHS Division	Population in Millions	Expenditure RDHS Div	Province	Rs. Per Person
Western Province*				76,333.8	1.68
	Colombo	4.546	22,232.1		
	Gampaha		33,843.1		
	Kalutara		20,258.6		
CentralProvince*		2.305		49,276.8	2.13
	Kandy		20,484.9		
	Matale		13,871.2		
	Nuwara Eliya		14,920.2		
Southern Province*		2.260		63,072.7	2.79
	Galle		19,243.7		
	Matara		28,425.8		
	Hambantota		15,403.2		
North Eastern Province*		2,558		68.190.9	2.67
	Jaffna		11,578.2		
	Vavuniya		7,935.4		
	Batticaloa		17,840.1		
	Amparai		20,330.3		
	Trincomalee		10,506.9		
Northwestern Province		2.062		77,444.6	3.67
	Kurungela		54,509.6		
	Puttalam		22,535.0		
Northcentral Province		1.040		69,376.9	6.67
	Anaradhapaura		52,570.9		
	Polonnaruwa		16,806.0		
UVA Province		1.101		53,777.0	
	Badulla		41,367.0		
	Moneragala		12,410.0		3.28
Sabragamuwa Province		1.730		56,737.6	4.89
	Ratnapura		38,714.3		
	Kegalle		10,023.3		
Total		17.5		514,210.2	

* *Provinces with Teaching Hospitals*

Source: Medical Supplies Division

Table 13 TOTAL AND PER CAPITA EXPENDITURE ON MEDICAL SUPPLIES IN PROVINCES WITH TEACHING HOSPITALS

Provincial Council	General Hospital Teaching	Expenditure on Medical Supplies	Expenditure per person
Western PC		7.63 M	61.51
	Colombo Group	271.95M	
	Ragama	43.16M	
Central PC		4.93M	38.61
	Kandy	59.79M	
	Peradeniya	24.28M	
Southern PC		6.31M	32.45
	Galle	67.02M	
Northeast PC		6.82M	12.97
	Jaffna	26.35M	

Table 14 NUMBER OF FACILITIES INACCESSIBLE DUE TO DESTRUCTION/CLOSE PROXIMITY TO ARMY CAMPS

RDH Division	No of Institutions	No. not in use	Percentage not in use
Jaffna	68	16	23.5
Mullaitivu	36	16	44.5
Trincomalee	19	5	26.3
Batticaloa	25	12	48
Amparai	45	11	24.4

Source: Department of Community Medicine, University of Jaffna

MENTAL HEALTH IN NORTHERN SRI LANKA — AN OVERVIEW

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Introduction

It is becoming increasingly clear from recent studies of civilian populations caught in war situations around the world that the impact on psychosocial health is immense. Prof. Raphael from Australia describes the effect of the war on civilians in her comprehensive treatise on disasters [1]

> *"However the greatest death and destruction, loss and grief, dislocation and relocation are associated with the man made disasters that have occurred through warfare. The slaying of man by man in either direct combat or through sophisticated weaponry bring cruel mutilating injuries and sudden, untimely, violent deaths. Such deaths bring little opportunity for the healing process of physicians or the healing rituals of grief. And, of course, warfare destroys the house and habitants, the livelihoods and even lives of many non-combatants... Mankind's capacity to create physical trauma through war, to create horrifying forms of warfare, has increased exponentially".*

Although life anywhere can be extremely stressful as many of us here will attest, war stress tends to be much more severe and chronic. Currans from N. Ireland found the existing life-event scales used to assess the degree of stress in civilian life pale into insignificance when applied to war stresses or civil violence [2].

In fact, modern warfare appears to have civilians as principal targets in an effort to establish authority and control through fear. Summerfield in a paper prepared at the Medical Foundation in London reports:

> *"In current armed conflicts over 90% of all casualties are civilians, typically from the poorest sectors of society. What predominates is the use of terror to exert social control, if necessary by disrupting the fabric of grass roots social, economic and cultural relations. The target is often populations rather than territory and psychological warfare is a central element"[3].*

However the psychological effects on combatants is also substantial. Though most authorities are reluctant to expose the extent of the problem within their ranks, probably due to fear that it will impair fighting morale and enthusiasm for the war[4]. Military psychiatrists estimate that on the average, the ratio of deaths: injuries: psychological disorders is respectively 1:4:1 world-wide for any conflict. Significantly, the understanding of war trauma has arisen out of experience gained from treating combatants, starting from World War I through World War II and subsequent conflicts[5]. Extensive studies of Vietnam war Veterans in the U.S.A.[6], paved the way for the development of the Post Traumatic Stress Disorder (PTSD) and its inclusion in the American DSM III, IV and WHO ICD 10 classification systems [7, 8].

The purpose of this paper will be to give an overview of the current Mental Health status and service in Northern Sri Lanka. Towards this end, the overall situation and specific at-risk population groups will be reviewed albeit within the constraints of a brief presentation. It should be pointed out that much of the research and clinical case studies pertain to the particular geographical location of the North and specific socio-political situations obtaining there at this time. Thus it reflects the typical problems encountered professionally in this area. Although patterns of Mental Health reactions to trauma may be similar across different cultures; the type of war stress, meaning and social support systems will vary. The situation in the East where the people faced direct military action; or in the South is different from the North since 1990, where apart from bombing and shelling, and the indirect stresses of war such as displacement, poverty, unemployment, effects of military embargo and besiege-ment, the internal dimension takes on a much more clinical importance.

Mental Health Services

Beginning with the pioneering work of the psychiatrist, Dr T. Arulambalam in the 1960's, the Mental Health Services had been gradually improving to reach its zenith in the early 1980's, when the University Psychiatrist Unit was established. At that time there were three full time

consultant psychiatrists in Jaffna, with two In-Door units at District Hospital (D.H.) Tellipallai (64 beds) and Base Hospital (B.H.), Pt. Pedro (40 Beds), as well as daily Out-Patient clinics at the General Hospital (G.H.), Jaffna; D.H. Tellipallai, and B.H., Pt. Pedro. There was also a psychiatric unit at G.H., Batticaloa. These units were the only facilities for the whole of the North and East of Sri Lanka and functioned as open peripheral psychiatric units to care for mild to moderate, acute disturbances as well as follow-up in the clinic. With the onset of the war, even these modest advances were halted and there has been a rapid deterioration in facilities and staff.

At present there is only one psychiatrist for the North (Catchment pop. 1,315,401) and that too only in the University. As a result the unit at B.H. Pt. Pedro is now without a visiting specialist. G.H. Batticaloa has been without a psychiatric consultant for over a decade (Catchment pop. 415,000). District Hospital, Tellipallai was abandoned due to fighting in the area and its functions were shifted to the Green Memorial Hospital in Manipay. We are grateful to this pioneering mission hospital for giving us refuge despite the social stigma attached to the mentally ill. Most of the valuable beds, instruments and material were left behind at Tellipallai during the move. There is no psychiatric House Officer at any of the psychiatric units. The work is covered up by Medical Officers and Registered Medical Officers, in addition to other duties. None of the nurses has received special psychiatric training except for the matron at General Hospital Jaffna and B.H. Pt. Pedro. There is not a single Psychiatric Social Worker, Occupational Therapist or community psychiatric worker. There is no functioning Electro Convulsive apparatus (ECT) at G.H. Jaffna or District Hospital Tellipallai. Drugs too are chronically in short supply and frequently out of stock (O/S).

For some incomprehensible reason, even psychiatric drugs are confiscated at the army check points when relatives try to bring a supply to the North. There are no psychiatric facilities in the private sector. Drugs are difficult to purchase, causing exorbitant prices in the northern pharmacies.

One major problem for the patients has been transport, particularly from peripheral areas outside the Jaffna peninsula.

Despite all these shortcomings, the Mental Health Services have continued to function as the overall statistics for the period, show (Table: 1, Table 2, and Fig 1).

Table 2 PSYCHIATRIC WARD ADMISSIONS (TOTAL)

Year	Tellipallai	Pt. Pedro	Total
1980	972	462	1,434
1981	872	371	1,243
1982	1,352	326	1,678
1983	1,221	316	1,537
1984	1,213	371	1,584
1985	1,188	264	1,452
1986	1,183	372	1,555
1987	904	366	1,270
1988	1,289	442	1,731
1989	1,261	313	1,574
1990*	805	394	1,119
1991	1,171	541	1,712
1992	1,336	497	1,833
1993	1,271	449	1,720
1994 to June	523	246	769

* - 1990 is incomplete

Schizophrenia

The acute treatment of schizophrenia (48% of admissions) and its long term management in the clinics continues to be the major Mental Health problem in Northern Sri Lanka [9], as in other 3rd World countries [10]. Unfortunately for us, it has been reported that Tamils are

Table 1 OUTPATIENTS CLINIC 1980-1994

Year	Tellipallai		Jaffna		Pt. Pedro		Total (North)	
	New	F/up	New	F/up	New	F/up	New	F/up
1980	358	5,578	492	8,728	399	n.a	1,189	14,306
1981	305	4,879	734	6,366	219	n.a	1,258	11,245
1982	552	4,795	725	9,079	196	n.a	1,473	
1983	625	5,876	983	8,894	178	2,897	1,786	17,577
1984	319	4,022	884	9,112	168	2,625	1,371	15,659
1985	594	5,950	865	14,000	178	2,257	1,637	22,207
1986	342	2,919	748	10,411	180	2,581	1,270	15,911
1987	358	10,333	548	7,165	72	1,437	978	18.935
1988	439	9,986	688	9,479	59	2,021	1,186	21,486
1989	297	10,135	374	10,854	77	2,136	748	23,125
1990	394	10,315	392	5,704	182	2,420	968	18,439
1991	365	10,207	697	9,205	104	2,852	1,166	22,264
1992	266	10,218	1,098*	10,021	131	4,755	1,495	24,994
1993	230	11,427	1,381*	10,911	169	5,758	1,780	28,096
1994 (to June)	214	6,898	809	5,755	110	3,082	1,133	

* - Includes ward referrals
n.a - Not available

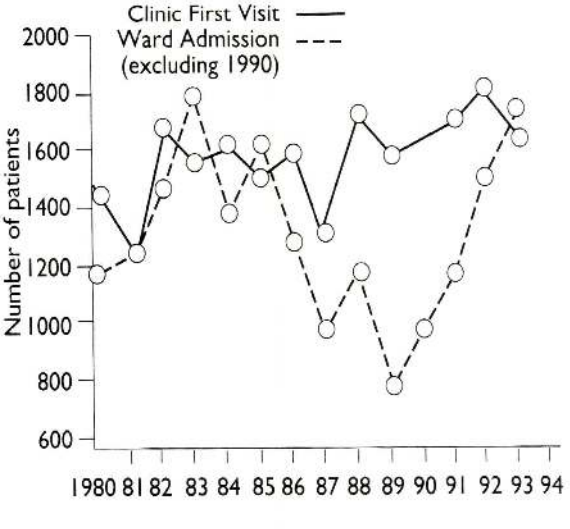

Fig 1. Psychiatric ward admissions and clinic first visits Northern Sri Lanka (1980-94)

at an increased risk to develop Schizophrenia[12]. In our study too, we found a high incidence - 34 per 100,000 population per year[9]. The long term management and rehabilitation of schizophrenia causes considerable difficulties due to the lack of facilities. The psychiatric units of Jaffna were designed as open peripheral units for the treatment of acute illness. Due to travel restrictions and other constraints, long term management of chronic patients too has been undertaken by the unit. There are no long stay institutions or half-way homes; but the extended family system was an important resource for managing all types of mental disorders in the home itself. However due to the war, extended families and even nuclear families have separated or broken up, and many are displaced, living in crowded refugee camps. In addition, we have had to deal with dangerous forensic cases for which open units and admission provisions are inadequate[13], while the staff are left completely unprotected. With the war, the legal system collapsed completely and the safeguards for the protection and compulsory treatment of psychiatric patients became non-existent. Many of our patients were shot, detained or tortured due to lack of understanding of their condition by the authorities[14]. The recent introduction of a Tamil Eelam legal system has made us again to try and create awareness for the forensic aspects of psychiatry. This has proven to be an uphill task.

Alcohol and Drug Abuse

Alcoholism among males continues to be a major medical, psychological, economic and social problem. There appears to be a recent increase in alcohol related problems, perhaps reflecting its local availability. A group therapy programme similar to Alcoholics Anonymous (A.A.) is functioning in Jaffna. Drug abuse, particularly Heroin, reached alarming proportions in the mid 80s, but has subsided to nil under the current, very strict prohibition. Many Tamil youth had picked up the habit or trade in Colombo or abroad for economic or political reasons and then imported and spread its use locally[16]. Drug abuse is a serious problem in Colombo, particularly worrying is its growing popularity among school children.

Gender

All our statistical figures of clinical attendance, in-ward treatment and community surgeries indicate that under the present situation, females are at an increased risk to develop psychological disorders. (Table: 3)

The cause for this may be traced to their higher proportion in the population due to migration, death, detention, disappearance or direct involvement in the conflict by young males, as well as the increased burden and responsibilities placed on the females to run the homes and look after children single handedly.

Elderly

Although the increase in the elderly population has not been so marked as in the west, we do see an increased number of them coming for treatment, particularly for

Table 3 PSYCHIATRIC MALE &FEMALE ADMISSIONS (TELLIPALLAI)

Year	Male ward	Female ward	Sex Ratio Male /Female	Sex Ratio Female/Male
1980	488	484	1.0	0.99
1981	472	400	1.18	0.85
1982	689	663	1.03	0.96
1983	623	598	1.04	.96
1984	644	569	1.13	0.80
1985	622	566	1.09	0.91
1986	607	576	1.05	0.95
1987	395	509	0.77	1.29
1988	589	700	0.84	1.19
1989	590	671	0.87	1.14
1990	533	272	-	-
1991	537	633	0.84	1.18
1992	595	733	0.81	1.23
1993	576	687	0.83	1.19
Total	7,427	7,789+	0.95	1.05*

* - 1st part of 2nd quarter only
\+ - excluding 1990

Acute and Chronic Confusional States and Dementing Illness. This can again be traced, as mentioned to the current situation where the extended and nuclear family support and care is no longer available. Many of the elderly have now to fend for themselves while their children are in Colombo or abroad. In addition, displacement from familiar surroundings due to the war, precipitates the confusional state. In contrast, many were left behind in their homes by fleeing relatives, when the army moved into the area.In some cases we were able to arrange for their reunion with their family through the ICRC[17]. Some homes for the elderly are being planned and have started. The geriatric dimensions of medical care will probably become one of our most pressing needs in the future. A poignant portrayal of this social problem was brought out by Kulanthai Shanmugalingam's drama "Enthayum Thayum". Many of you may have had the opportunity to see the drama here; or at least the video. I know personally of many cases where I have been asked to look after ailing parents in Jaffna, while their children are doctors and specialists, even geriatricians working abroad and unable to help them in their hour of need. It is an ironic tragedy of the situation that children are employed looking after elderly in the West while their own parents suffer at home. The elderly formed 4% of first visits (or 39 patients in the year) at the psychiatric out patients clinic in Jaffna, and 2.7% of the admission to psychiatric wards in 1983[18], while they formed 4% of the first visits at the out patient clinic at General Hospital Jaffna (30 patients in 6 months alone) and 3.3% of the admissions in 1994.

Children

Children under 5 years with psychiatric problems formed a small proportion of the cases in the clinic (5%) and an even smaller fraction of those (8%) admitted to the ward in 1983[18]. Reluctance to admit children to psychiatric units stems from the absence of paediatric psychiatric in-patient

facilities, the stigma attached to mental illness and lack of awareness of childhood behavioural disturbances[20]. In addition, the facilities in the North for special education and behavioural modification for mentally handicapped children, estimated at 3.5% of the population, is grossly inadequate. The only functioning unit is at ARK Udnuil, with provision for 50 moderately handicapped children[18]. There is a unit for handicapped children in Batticaloa caring for 60 boarders.

The trauma of war appears to have caused considerable problems in children and now we find an increasing number coming for treatment. For example, children (up to 18 years) formed 12.6% of first visits at the out-patient psychiatric clinic at the General Hospital Jaffna and 8% of admissions at District Hospital Tellipallai in 1994. Studies of the student population shows that this is just the tip of the iceberg and psychological problems are widely prevalent in the schools, up to and including the University[22,23,24]. It is significant that the Health Reach Programme at McMaster University is currently involved in a detailed study of children in the Eastern province of Sri Lanka, in addition to their studies in Yugoslavia, Palestine and Iraq.

Infancy

Although we have not carried out any systematic studies, the few cases we have seen in the clinic indicate that even infants are affected by war trauma, particularly if separated from parents; or if the parents are themselves psychologically disturbed. A few case histories have been reported elsewhere [16].

Case History

A ten month old child had been separated from his mother during intense fighting in October 1987. The surrounding neighbourhood had suddenly come under intense shelling and gun fire at a time when his mother and brother had gone on a visit to a distant village. The fighting in the area went on for ten days preventing reunion of the family. The severely frightened grandparents who were screaming and disturbed themselves, had evacuated amidst the fighting to a refugee camp. The child was restless, constantly crying, refusing feeds, slept little, awakening frequently and developed diarrhoea that did not respond to treatment. Meanwhile the mother had been desperately trying to rejoin the child, distraught and inconsolable, insisting on going out to look for the child, although it was very risky. At the first opportunity she had frantically searched from place to place, though fighting was still in progress. She witnessed death and destruction all around, but persisted in her search, pleading with anyone she met to help her. She had feared the worst, but somehow she managed to find the child after 10 days. On seeing the mother, the child had leapt at her, hugging and clinging on to her, thereafter refusing to be separated from her. The family then fled to Colombo where they stayed for over a year. The mother had frequent re-experience of the traumatic event as intrusive memories during the day and dreams at night. She had been chronically anxious with disturbed sleep and appetite. She was hypersensitive to loud noises and became disturbed when exposed to stimuli resembling the original event - all classic signs and symptoms of PTSD. The husband was not available for support during this critical period as he had gone to Canada. When the child was brought to us three years later, he was found to have frequent crying spells, clinging onto his mother, never letting her out of sight. He was reported to scream at the sight of strangers and was extremely sensitive to loud noises. He is reported to be socially withdrawn, not mixing with anyone other than his own family. Preoccupied in thought and often saying he is afraid, he absolutely refused to go to the nursery. When his brother plays with toys or games resembling war, he becomes frightened and runs to the mother. He gets up screaming from his sleep. According to the mother, his development had been normal up to 10 months, but since then his milestones have been delayed.

Pre-school Children

Two small studies were carried out on three-six year olds. One was a detailed one year observational study of 76 children in the Kokuvil and Kondavil area identified as having been exposed to war trauma, out of whom 18 were from three to six years old[25]. In the second, randomly selected 50 pre-school children studying in the Montessories in the Vaddukoddai cluster area were studied. Common disturbances reported by parents and teachers are shown in Table 4.

School Children

An intensive study of the Vaddukoddai cluster schools in conjunction with the Department of Education showed wide prevalence of traumatization among students (43%) and a wide variety of behavioural disturbances reported by parents and teachers[22]. A salient finding was the pervasiveness of indirect stresses such as poverty, displacement, etc. A more detailed description will be found in the DR. S Sivapatha Sunderam memorial lecture on child trauma[27]. A summary of the most common symptoms is given in Table 5. The last few symptoms of hostility such as anger, aggressiveness, cruelty and indication of brutalization in the war milieu are very disturbing recent developments. Many of our children have been born during the war and continue to grow up amidst it. They have known no other world.

Table 4 COMMON SYMPTOMS IN PRE-SCHOOL CHILDREN

	Kokuvil-Kondavil, Vaddukoddai	
Crying	78%	
Sadness	40%	
Sleep disturbance	39%	55%
Irritability	44%	82%
Withdrawal from play	39%	30%
Clinging behaviour	44%	46%
Phobia for army or uniformed men	44%	
Phobia for sound or gunshots	61%	
Refusal to sleep alone	78%	64%
Listlessness		58%
Hyperalertness	5%	60%
Aggression		36%
Temper tantrum		70%
Symptoms of PTSD		22%

Table 5 COMMON SYMPTOMS IN SCHOOL CHILDREN (VADDUKODDAI)

Sleep disturbance	77%
Separation anxiety	40%
Hyperalertness	50%
Sadness	43%
Clinging	35%
Withdrawal	25%
Decline in school performace	60%
Irritability	73%
Aggressiveness	46%
Cruelty	30%
Anti-social behaviour	44%
War games	54%
War vocabulary	64%

Table 6 WAR STRESS IN ADOLESCENTS (PERCENTAGES)

	Jaffna	Vaddukoddai	Chavachchri Hindu College	Madduvil Mara Vidyalayam	Kilinochchy	Agricultural Faculty
Direct war stress						
Threat to life	9	5	27	20	48	45
Injury	2	3	7	8	10	15
Detention		12	7	3	4	13
Torture		7		3	4	9
War death of relative	16	15	50	23	31	60
Witnessing violence	14	6	47	22	35	32
Indirect war stress						
Displacement	56	26	22	32	44	61
Lack of food		19	5	20	5	33
Economic problems		25	25	25	48	52
Mean number of stress per person			2.9	3.3	4.2	5.4

Table 7 PSYCHOLOGICAL PROBLEMS IN ADOLESCENTS (PERCENTAGES)

	Jaffna	Vaddukoddai	Chavachchri Hindu College	Madduvil Mara Vidyalayam	Kilinochchy	Agricultural Faculty
PTSD	n=200	n=211	n=60	n=60	n=48	n=46
Somatisation	31	36	18	15	50	44
Anxiety	68	-	-	17	71	44
Depression	38	38	22	40	40	33
Hostility	25	36	30	17	27	44
Relationship problems	59	33	57	37	63	30
Alcohol & drug abuse	24	25	50	23	58	30
Functional disability	-	-	-	2	19	20
	-	33	78	20	54	35

Table 8

Cognitive impairment						
Loss of memory	46	28	57	48	65	37
Lack of concentration	33	35	58	55	60	57
Loss of motivation	-	-	60	35	56	50

Adolescents

Adolescence is a critical period of transition to adulthood when childhood developmental stages and identity formation comes to a climax. We have now several studies of youth in Jaffna and Killinochchi districts[23], while a study of the new entrants to the Jaffna University has only been completed in the Faculty of Agriculture. Common types of war stresses experienced by youth are shown in Table 6.

A great majority of the students had experienced multiple stresses and often the stresses were chronic. The psychosocial sequelae found in adolescent students is given in Table 7.

In our culture where education takes on an overriding importance (education related deprivation was one of the original causes of the war), disturbance in regular schooling, tutories and examinations have become a prominent stressor. Repeated changes in schools due to displacement; unavailability of classrooms due to destruction or use as camps; indefiniteness about national exams; lack of secure, calm, quiet and lighted environment for learning; irregular attendance due to transportation difficulties and disturbed situation; students being detained, shot, conscripted, recruited, indoctrinated or impelled to partake in political activities; seeing the emigration of fellow students; curtailed freedom of movement and lack of opportunity to continue their education (e.g., higher studies, refugee children without uniforms, exercise books, etc.) are common problems faced by students. The future appears bleak with nothing to plan for or look forward to. So much so that the earlier motivation to study, to excel in education and achieve a respectable occupation is slowly being eroded. Militancy or migration becomes an alluring alternative. The symptoms of cognitive impairment are particularly worrying (Table 8).

It would come as no surprise that among Tamils, the overall performance at the national G.C.E, `O' and `A' level exams[28] as well as university admissions has declined in recent years, particularly in Jaffna which once held the pride of place in educational attainment (fig. 2.1 - 2.8 at the end of this article). There may be complex reasons for this deterioration. As already mentioned lack of facilities and resources, frequent displacement and disruption, necessity to study by kerosene light and so on have been put forward as causes by the Jaffna University Sub-Committee on

Education[29]. Many of the more intelligent students have also left the area, similar to the brain drain among their elders. One telling fact was that only six students were admitted on the merit list for medicine from Jaffna district while this is usually around 36, according to the sub-committee.

Apart from the general surveys of students who show a considerable degree of brutalization, there have been individual adolescents with what we have termed Malignant PTSD coming in for treatment. Some had joined the freedom movement when very young and been exposed to massive trauma where they have witnessed gruesome deaths and mutilating injuries to many of their comrades or had themselves been badly injured, often carrying unremovable pieces in their head or body. They present with very disturbed, aggressive outbursts when they repeatedly overwhelm them in the form of flashbacks and vivid hallucinations. During these periods they completely lose control over themselves, becoming very violent and destructive.

Several cases where members of the security forces suddenly went out of control, killing men, women and children in a frenzied outburst have been reported since the mid 1980s, such as at Killinochchy railway station, the boat Kumuthini Chedikulam, Dolar and Kent Farm, Kokadidchcholai and Valvettithurai. Similar behaviour has been reported wherever war is being fought. In Vietnam where there was the Mai Lai massacre among others, Bosnia and Rwanda are well published current examples. One wonders whether such behaviour is a natural outcome of what war does to man, besides the training and indoctrination calculated to bring out the beast in him. Adolescents are particularly vulnerable during their impressionable, formative period, causing permanent scarring of their developing personality.

Case History

R., a pleasant looking 15 year old boy, came with complaints of insomnia, irrational talk, abnormal behaviour and aggressive outbursts towards camp mates. R., like any other boy, had a normal upbringing on a farm in Batticaloa. He had good relations with his family. He joined the freedom movement at the age of 11. He was given extensive training and taught that those who do not support the struggle are his enemies. When starting active combat duty, at first the killings affected him but gradually he became used to seeing blood and killing. After one attack where he lost many of his comrades he was shown videos of killed women and children and told his enemies had done this.

This group was then taken to attack Eastern villages inhabited by a different ethnic group. He took part in four village operations. When inactive he felt bored, restless and longed to go into combat and fight. He was obsessed with the sight of blood. Became easily irritable and broke out in sudden violent outbursts at the slightest thing. They found it difficult to control him. He felt anger and contempt when he was with people enjoying themselves at temples and wedding festivals.

Treatment of these disturbed adolescents was extremely difficult. They did not respond to high doses of any of the drugs available. The major tranquillisers, anti-depressants, minor tranquillisers and the anti-epileptic, Carbamazepine were all tried. Psychotherapy proved impossible as they were not accessible. Other forms of behaviour, occupational relaxation and expressive therapies also showed poor response. When the severity of re-experiencing subsided with time, a period of rest at home caused re-emergence of the disturbance with difficulties in relating to and adapting to the home situation. This difficulty in adapting to civilian life was reported frequently in Vietnam war veterans who became misfits in society [30].

The condition of malignant PTSD was first described by Resenbeck[31], where they come to feel most alive when they are in a situation of intense conflict or potential danger, and feel bored or depressed in the absence of such a situation. Many were anxious or paranoid in crowds or public places and could get irritated or argumentative in such situations [31].

In children, personality development can become permanently distorted and deformed due to their experience of violence. A SANMDA (South African National Medical & Dental Association) states that they "become incapable of imparting trust to their friends and associates and even to their own children at one point. They may develop smouldering bitterness and resentment, and a thirst for revenge which overwhelms them. They maybe unable to exercise control over their own feelings and may act out their impulses in anti-social ways"[32]. Thus children participating in violence maybe dehumanised in the process [33], to develop anti-social personality characteristics.

Some of them have shown the florid features of sadistic personality or preoccupation with death images and scenes, including their own, a condition described as necrophilia.

Case History

A 23 year old male presented at the psychiatric clinic at the Teaching Hospital Jaffna, with complaints of insomnia, numbness of head and flashbacks of dead friends. He had joined the freedom movement at the age of 14 and underwent extensive training. As he lost his friends one by one in missions, he became more withdrawn and preoccupied with thoughts of his dead friends. He also led a very tense life during active duty. He developed hatred towards people whom he was led to believe were traitors and who pass information to his enemies. He also had nightmares of his dead comrades being blown to pieces. His insomnia worsened and he began to take diazepam. He became addicted and started taking up to 40mg at a time. He introduced this to other boys. He also had a severe headache accompanied by numbness of the head. His drug abuse habit was detected by superiors who put him on punishment where he was physically beaten and kept in detention. When he was asked to draw a picture he chose a dark red crayon and drew blood drops, a hanging man, a knife stained with blood, a grave, and ghosts.

The immense problem of caring for these veterans and giving them a satisfying, safe role in society and re-integrating them back into community life is one of the immense problems facing us when the war finally comes to an end.

Family

The war has affected the functioning family unit in many ways. From the loss of one or both parents, separations and traumatization in one member, pathological family dynamics can adversely affect each member, particularly children. A common situation is where the father has been detained or killed but the family members are not sure of his fate. They are caught in the conspiracy of silence where further inquiries may lead to more problems for the father were he still alive. More recently, we have had to treat tragic cases of wives/children of husbands/fathers detained locally. This appears to entail much more trauma than detention by the army, probably due to the social rejection they feel. The need of children orphaned by the war for a warm, nurturing and peaceful upbringing free from the indoctrination of hate is something our society owes them.

Case History

An 11 year old girl was referred to the psychiatric clinic due to episodic fainting attacks for the last month. The Paediatrician had not been able to detect any organic abnormality. Her class teacher had observed that just before attacks, she said why did they kill my sister and then complained of numbness of head before fainting. The history revealed that her sister had been killed by a shell piece five years ago. At the time the whole family had taken refuge in the front of the house due to intense shelling in the area. The father was carrying the youngest sister on his shoulder, while the elder one was in his lap. The girl in the lap was struck and the gruesome death in a pool of blood had taken place in the presence of the whole family. Following this the family faced several problems such as displacement to a refugee camp, grandfather and granduncle killed and father detained and later released.

The father developed PTSD with re-experiencing and neurotic symptoms, particularly somatization (somatic complaints). The mother too developed PTSD with severe depression and anxiety. She lost interest in all activities, developed crying spells and was withdrawn from all social activity. She dragged on for the sake of the other children and often repeated "the same thing should not happen to them." She became very anxious at any noise particularly sound of a helicopter or aeroplane, when she would gather the family and run to a bunker; if they are not at home, she would become very frightened. At other times, if they are late in returning, she would anxiously wait for them at the doorstep.

As a family they avoided going to or looking at the place where the sister had been killed. They all refused to talk about the sister or the circumstances surrounding the event. On persistent probing they were found to have amnesiac gaps for significant details. The general impression was that the whole family had repressed the tragic memory so as to continue living, but this was manifesting itself as different symptoms in each member.

Torture

The worst forms of torture, organised and systematic is being practised by all parties to the conflict. In fact anyone detained appears to routinely undergo torture. So much so that this form of inhuman organised violence has become institutionalised particularly in our country. Most authorities and even professionals take torture for granted as an inevitable part of the war. Techniques have become more sophisticated causing maximum pain with minimum scars. There also appear to be special training in torture techniques. The social dimension of torture is quite clear from surveys of the community where 1% have undergone various forms of torture (Table 9).

Table 9 PSYCHOLOGICAL SIGNS AND SYMPTOMS FOLLOWING TORTURE

Signs and symptoms	OPD (n=65)	Community (n=98)
General tireness	139	86
General nervousness	135	84
Recurrent intrusive memories	128	83
Memory impairment or poor concentration	125	79
Loss of appetite	110	69
Intensification of symptoms by symbolic association with trauma	108	68
Extreme fear	106	66
Headache, giddiness, fainting	103	65
Low self esteem	92	59
Nightmares and sudden awakening	91	56
Extreme mistrust and suspicion	80	50
Irritability and aggresiveness	74	40
Sweating during interview	74	40
Suicidal thoughts	61	38
Social withdrawal	61	38
Crying or watering of eyes during interview	48	30
Sexual dysfunction	40	25
Suicide attempts	1	0.5

This is more common among youth (see Table 6). As Summerfield observed, modern warfare uses terror to control societies. From the earlier purpose of interrogation to obtain information, the current aim is to break the personality of the victim as a warning to the community. The situation here has been documented elsewhere,[16,54] a case history follows:

Case history

K. 45 years old, native of Trincomalee was a farmer. He is married with 4 children. In 1986, during an army round up he was caught and detained. He was released after 2 years, In 1989 he was arrested by the IPKF and detained for 6 months at Trincomalee. He was assaulted by hands, fists and kicked randomly, hit with sticks and the butt of a gun, hanged by the wrists from the roof and suspended naked, whipped and hit extensively; given electrical torture by a live wire being held to sensitive parts of his body; made to submerge his head under water till froth came from his mouth. Placed supine and naked, whipped with a chain and made to run until he fell exhausted K complained of insomnia, head numbness, chest pain and flash backs of torture episodes.

The common sequelae to torture found in a study of 160 survivors in Vavuniya is shown in Table 9. Re-experiencing is the most disturbing symptom, where the survivor continues to relive the terrible agony.

General Population

Apart from the specific studies mentioned above, we carried out a survey of the general population to be published in the British Journal of Psychiatry[34]. The findings give an idea of the background level of traumatization and psychosocial symptoms in the community (Tables 10,11,12).

We also looked at the problem in the out-patients departments (OPD) in Jaffna[35] and found a high prevalence of psychological problems presenting as somatization (Table 10). The level of traumatization and symptom formation was higher among out patients than in the general population, suggesting that many maybe covertly seeking help for their psychological problems in the OPD.

A total stress score was calculated summing the severity (0 = absent, 1 = mild, 2 = moderate, 3 = severe) multiplied by the gradation of stress on a 10 point scale (example: torture = 10; injury = 8; danger to life = 5; witnessing violence = 2 threat to property = 1). Similarly, a total somatisation score was calculated for the somatic complaints without organic basis, out of 33 specified items in the check list, by summing up their individual severity score (0 - 3 as above). There was a strong relationship between the stress score and the somatization score; the co-efficient of correlation (r) was 0.285 ($t = 2.9$ $p<.01$; significant). Similarly the co-efficient of correlation (r) was 0.42 (t - 4.1, $p<.01$; highly significant) between the stress score and psychosocial sequelae.

The mean stress score for the OPD attenders (41.4) was significantly higher than in the general population (36.2). Implications of these findings for the time cost of not treating these large numbers in the OPD and the need to address their real difficulties properly such as through counselling, relaxation exercises and socio-economic rehabilitation should be realised.

Table 10 DISTRIBUTION OF WAR STRESS IN OPD ATTENDERS COMPARED TO COMMUNITY (%)

Stress factor	OPD (n=65)	Community (n=98)
Direct stresses		
Injury to body	9	10
Detention	26	15
Assault	23	10
Torture	8	1
Bombing/shelling/gunfire	29	36
Witness violence	36	25
Death of friends/relatives	46	49
Injury to friends/relatives	48	38
Violence to friends/relatives	52	45
Loss of property	55	65
Indirect stresses		
Unemployment	55	44
Economic difficulties	85	76
Lack of food	68	55
Ill health	29	14
Displacement	69	69

Table 11 COMMON SOMATIC COMPLAINTS WITHOUT ORGANIC CAUSE IN OPD PATIENTS COMPARED TO THE COMMUNITY (%)

Somatic complaints	OPD	Community
Joint pain	31	19
Backache	35	22
Paraesthesia	45	19
Headache	57	40
Tremor	26	7
Palpitation	46	34
Loss of appetite	29	22
Loss of hair	34	30

Table 12 PSYCHOLOGICAL PROBLEMS IN OPD ATTENDERS COMPAIRED TO COMMUNITY (%)

Somatic complaints	OPD	Community
Somatisation	57	41
PTSD	43	27
Anxiety	48	26
Depression	35	25
Hostility	32	19
Relationship problems	28	13
Alcohol abuse	8	15
None	18	34

Displacement

One major stress in the current situation is displacement. It is estimated that over 50% of the population in the North East is displaced. In some areas this may reach 100%. Further, during the last decade of chronic conflict, most people would have been temporarily displaced at one time or another. The 1993 refugee population in the Jaffna District was estimated to be 118, 141, with 47,348 refugees in camps, of whom 19,002 are children [36].

The bonds to home, soil and village (in our Tamil culture) are very powerful. The home neighbourhood and community provides the points of reference, the daily rhythm and self-identity giving meaning to existence. Great indeed must be the forces that compel man to abandon his home and familiar environment, to seek refuge in a strange and foreign place. The fear of death and injury, the destruction and devastation of the homeland, the concern for safety of loved ones, the terror of persecution, detention and torture set in motion the basic biological mechanism of flight and the psychological trauma of being uprooted.

The psychological consequences of displacement begins with the handicap of the initial trauma with its attendant loss, death and destruction and other stressors. The immediate need is for safety and shelter and this is often sought with relations and friends or in refugee camps. These temporary arrangements, especially if prolonged, can be extremely stressful in themselves. The crowded conditions, sharing of inadequate facilities, inconvenience and

poor sanitation, lack of privacy and other interferenceís, perceived immorality and suspicion, spread of infectious diseases, poor quality, and inadequacy of food and rations, climatic changes like heat and rain, the ongoing war and the consequent fear and uncertainty can all produce tension and conflicts within the refugee population. Development of apathy and ennui; dependency on external help, resistance to outside interventions and internal quarrelling are well known sequelae in camps.

When families move in with relations and friends, in time their relationships can become strained due to overcrowding, lack of ongoing constructive activity or employment, minor misunderstandings and tangled interpersonal relationships.

Others may begin the long and complicated journey to foreign lands. The problems faced by refugees seeking asylum abroad are compounded by having to first face unsympathetic and hostile authorities, asylum issues and later adapt to a new culture and integrate into a different society. Sometimes called 'culture shock' the difficulties of acclimatisation to western life style by people coming from traditional societies can be immense [37].

In a study of the Kaithady refugee camp[23] apart from the direct trauma of war, the indirect stress like economical difficulties (89%) unemployment, (86%) and lack of food (80%) were accumulative problems. A very common sequelae was somatization - only 1% had no somatic complaints while 85% had over five complaints.

Similarly, an extensive survey of refugee camps and villages in Vavuniya, Colombo and Jaffna by the Norwegian psychiatrist, Dr. Harold Repreagaard[38], found that all the subjects had been traumatised, often with multiple and chronic stress. In Jaffna, he found that all had developed psychosocial symptoms where 18% had PTSD, 10% major depressive disorder, and 50% psychosomatic disorder, meeting the DSM III diagnostic criteria. Many had co-morbidity, that is they suffered from two or all three conditions. In Vavuniya and Colombo in contrast, major depression was more common while psychosomatic disorders were less common, perhaps reflecting their respective situations (i.e., exposed to direct conflict where survival takes a priority and out of it where reactive response can set in). Based on these findings he recommended training in counselling and befriending techniques, from the grass roots level up, to tackle the widespread psychosocial problems in refugee camps and villages.

Another study assessed the impact of displacement on functioning of the family system[39]. Psychological disturbances, particularly depressive symptoms, were much more common in displaced families than in those living in their own homes. Prevalence of depression, anxiety, sleep disturbances and somatoform disorder increases with duration of displacement and was more common among mothers who were more vulnerable and faced increased family responsibility. PTSD was independent of duration (as it is a reaction to extreme trauma) and more common in fathers who could be expected to be exposed to severe war trauma, such as detention and torture. In displaced children separation anxiety was common as were cognitive impairment, conduct disorders and sleep disturbances. Disturbances in family dynamics, particularly disputes and quarrelling between father and mother, was attributed to economic stress, lack of privacy and interference of others in over-crowded camps.

Refugees often report dreams of being back in their old homes, involved in former activities[37]. This is an indication of how much they yearn to go back to their old lives. The refugee population from all communities have become the forgotten symbols of the war, uncared for and rejected by all. In many ways, refugees are treated as outcasts by society. For example, in Jaffna we can see this attitude in schools, jobs and buses.

Suicide and Attempted Suicide

It was extremely worrying that Jaffna town recorded one of the highest suicide rates in the world in 1983, and that with a peak in youth[41]. Professor Ganeswaran attributed this phenomena to youth unrest. Perhaps one of the positive developments of the war has been the dramatic fall in the suicide rate shown in Fig. 3[42] as has been reported elsewhere in the world during war[40]. However, there is a noticeable increase in the numbers of attempted suicide, particularly with alary seeds[45].

The psychodynamic explanation describes suicide, similar to depression, as a form of aggression turned inwards towards self, whereas war provides an outlet for the aggression to be turned outwards towards the common enemy[42,44]. Burvill[46] hypothesised that war may provide an opportunity for suicidal behaviour but rejected it on the figures from Australia. However, some support for the view that participation in war can function as an alternative to suicide comes from clinical observations during the war here. Adolescents in a mental state caused by intense frustration or interpersonal conflict that made them think of suicide and would have led to suicidal attempts in normal times, often said that they would rather join the militants and die in combat, where at least their lives would have been of use to society. This gives a purpose or meaning to their death. Few patients said that then their face and names would have been honoured on posters (a common method of commemorating dead combatants here). The director of the only counselling centre in Jaffna, the Association for Health and Counselling or Shantiam, in a seminar for medical officers described the current social ethos as one where adolescents or youth faced with severe family conflict or environmental stress will at times threaten or carry out two possible alternatives: one is suicide and the other, join the militants. Of course, suicide is a very rare phenomenon, occurring in one person out of 100,000; and thus, these characteristics are not indicative of the great majority of adolescents.

The present study shows that the drop in suicide rate with war is more marked for males (by 300%) than females (by 180%) and is most marked for the 15 - 24 age group (from 62.4 - 25.4% per 100,000) and then the 25 - 34 age group (Fig.4.) Males in the adolescent age group 15-24 year range are the predominant majority joining the militants.

The unique phenomena of a high number of altruistic suicides by the militants is also noteworthy. A notable phenomenon of the war has been suicide squads and attacks by the Tiger Freedom Fighters and their ranks, committing suicide by biting cyanide capsules when faced with imminent capture, ostensibly to avoid giving information under torture. Durkheim described this form of suicide for a cause as altruism, with perhaps an admixture of what he called fatalism[43].

These major trends have been confirmed by a study of the causes of death in the whole Jaffna district, see Fig 4.

Management

Considering the enormity of the problems facing us; the lack of resources in terms of skilled personnel, drugs, materials and facilities; the ongoing war and social disruption; some of the methods adopted to address the current mental health problems are described briefly.

Schizophrenia

The long term management of schizophrenia continues to be the major mental health problem in the entire North East of Sri Lanka. Initially, during the recovery phase we have tried to build up the occupational therapy department to assist the patients to structure their time and activities in a useful way, learn social skills and occupational training for income generation, as well as to help re-integration into their families and society. In the absence of occupational therapists, we have been using volunteers with the help of various social organisations like the T.R.R.O. to meet this need. The Friends of the Psychiatric Patients, functioning from the 1960's, now renamed as Mental Health Society, has been very active in this connection, as well as in other patient welfare programmes.

Up to 50% of the relapses in schizophrenia are due to defaulting treatment consequent to lack of drugs, the long and risky journey involved to attend clinics, and poor compliance.We have tried to introduce parental monthly depot preparations but are hampered by lack of availability and high cost. Again, for some unknown reason, Modecate injections had been routinely confiscated at the army checkpoint. We have encouraged the family and extended family to get involved in the care and rehabilitation of the patients.

We have also tried to decentralise the long-term management of schizophrenia by co-opting the Family Health Worker (FHW) and Peripheral Medical Officer. Towards this end, the necessary knowledge and skills are being imparted during their training period. In addition, we have proposed that Modecate injections be made available at the Primary care level, according to the needs of their area.

As regards long-term care, a halfway home to look after chronic schizophrenic patients rejected by their families and society is in the offing. The NEST in Colombo has agreed to train some of our volunteers and support a small home.

Trauma

As all the studies mentioned show, the most widespread problem is that of war trauma. Both in its causative aspect and the consequent psychological sequelae, it can be considered a social problem. However, we do see a number of severely traumatised patients and children who need individual attention and skilled psychiatric help. Many come to us referred from other specialities, particularly medicine, neurology surgery, presenting with somatization, but who are found to have underlying PTSD. Others have a variety of neurotic disorders. We also see an increasing number who have attempted suicide due to war related indirect stresses such as poverty, hunger, displacement and unemployment. It is noteworthy that patients referred from other specialities at General Hospital Jaffna for psychiatric assessment and treatment have steadily increased from 383 in 1992 to 631 in 1993 and 392 up to June 1994. In fact, seeing ward referrals has become a major part of our work, the maximum being 15 referrals on a single day. We have also started a paediatric clinic at General Hospital Jaffna to deal with the problem in children.

To manage more severe PTSD cases we are trying to build up a multi-disciplinary team. Having no psychotherapists or child psychologists, the key member is a Counsellor. We have an experienced counsellor in Fr. S. Damien, now attached to our University department and several counsellors trained at Shantiham working regularly at the General Hospital Jaffna; District Hospital Tellipallai (now Manipay), Base Hospital, Pt. Pedro and Shantiham itself. In the absence of Psychiatric Social Workers, we have one volunteer filling this role, co-ordinating our treatment with social institutions, particularly arranging for rehabilitation, income generating projects, socio-economic assistance, residence etc. We have tried to encourage self-help initiatives. Then we have a group of trained volunteers to teach relaxation exercises. The physiotherapist doing this work at District Hospital Tellipallai (now functioning in Manipay) is supported by the SCF. In relaxation exercises we have incorporated the technically similar Yoga Asana methods, in particular Pranayama and Shanti Asana. A self-help pamphlet for this purpose is available in Tamil. We refer patients to the experienced Yoga Society, Nallur. Several of our members have been or will be going to Vivekananda Khendra school in Bangalore for extensive training, supported by the MADAM trust under Dr. Ponna Wignaraja. In the absence of an occupational therapist a staff Nurse and several volunteers supported by TRRO work with patients as already mentioned. Volunteers are also learning to work with traumatised children (and adults) using art and play therapy. In view of the increased vulnerability of women, particularly those who have lost their husbands, we have asked for the appointment of a Women's Affairs Officer. At present we are co-operating with the Centre for Women and Development in helping affected women through income generating projects and empowerment programmes. We are now in the process of recruiting a Drama Therapist to handle all aspects of creative art, including drama, music and dance. These various forms of expressive or emotive therapy are widely used in the treatment of traumatised individuals, the purpose being to facilitate catharsis and the

working through process. The psychological drama, "Annai Itta The" by Kulanthai Shanmugalingam and acted by our medical students was a pioneering attempt in social therapy. Our complete project proposal for a multi-disciplinary team, yet to be accepted for funding.

For the highly prevalent problem of traumatization in society we have adopted a community based approach by training grass root workers. At the Primary Health level all Medical Students, Nurses and Public Health Midwives (FHW) in Jaffna have their psychiatric training through our department. As such we are able to impart basic knowledge and skill in handling trauma. Unfortunately, the last recruitment for nurses in Jaffna was in 1992, and FHWs was in 1991. MOs, PHIs and FHWs already in the field come in for inservice training. Recently this was done with the UNDP help, but a more complete programme has been put forward to FORUT through the DPDHS, Jaffna based on Dr. Rappesgaard's recommendations.

Following the recognition of the seriousness of traumatization in students shown by several studies already mentioned, a detailed long-term programme has been instituted by the Department of Health, Health and Psychiatry, initially in the Chankanai Division. This is to be extended to other areas after feedback, evaluation and modification. A group of selected teachers (1 per 300 students) will undergo training as 'skilled helpers' to function as health promoters in schools. The module will be based on the UNICEF manual, 'Helping Children in Situations of Armed Conflict' prepared by the Child Psychiatrist, Dr. Anula Nikapota and Dr. Diyanath Samarasinghe[52]. A high level team from Jaffna underwent training recently to be trainers by UNICEF in Colombo. The second stage will be to create awareness in Chankanai area followed by in-depth training for a few teachers to function as teacher counsellors. Eventually, we hope to have at least one or two teacher counsellors for each school. The SCF (U.K.), FORUT and UNICEF have shown interest in funding the programme. In fact, we have already started work. Programmes for pre-school teachers have already been held in the Jaffna Municipality and Moolai Nursery Institute by Dr. Shivashankar, our Registrar, and others with funding from UNICEF.

As far as the general community, we have started running a 45 hour 'Introduction to Counselling' weekend course at the Extra Mural Studies Unit at the University of Jaffna. Already about 450 participants have been through this course. A much more in-depth training of counsellors for a year is undertaken at Shantiam. The last course was in Tamil with very positive results. We have been able to extend the counselling services to the periphery at Pt. Pedro, Kopay, Chavakachcheri and Innuvil with the help of these trainees. A request has also come from Killinochchi for an outreach centre there. But we have to extend these services to Manna, Mullaitivu and Vavuniya, as well as the East.

A detailed report of the work at Shantiham is to be presented by its secretary, Sister James Victorine. The Quaker Peace Service has come forward to support part of our counselling service. The Family Rehabilitation Centre has been doing similar work in Colombo and the East.

We are fortunate to have the services of Fr. Rajanayagam who is a trained Family and Marital Therapist. He helps many traumatised and otherwise disturbed children who have a problem family behind them. Pre-marital and marital counselling is also now available. To tackle the recently increasing alcoholic problem, we have started group therapy on the lines of Alcoholic Anonymous with an experienced group leader, Mr Ghandi. Much of this work is only at the preliminary stages and has grown in response to the needs. We hope we can develop and extend the variety of treatment options available. One positive development has been a gradual awareness of psychosocial problems and a growing network of trained health promoters in the community.

Medical Ethics

Despite all our very well meant efforts, it is very difficult to heal a traumatised patient in a war milieu. The situation will continue to generate more trauma and reminders of the earlier one, so that the person continues to be exposed to stress. Indeed this phenomena has been aptly termed Continuous Traumatic Stress Syndrome[53]. Further, the ongoing war will continue to produce more and more traumatised individuals. It may not be superfluous to compare our work with trying to fill the proverbial bucket with a hole in the bottom. Perhaps a few examples will clarify the situation.

Recently at G.H. Jaffna, Fr. S. Damian was counselling a client who had developed severe Anxiety Neurosis following supersonic bombings. He had managed to gradually calm the client and get her to relax. She had begun to ventilate and express her feelings. At that point, a supersonic bomber suddenly, without warning, flew low over the hospital with its characteristic high pitched sound to release its bombs some distance further on. There was pandemonium in the hospital, patients ran helter skelter, shouting, screaming, calling on their respective gods for protection, looking for shelter, creeping under tables and behind doors. When Fr. Damian turned to look at the client in front of him, she had also fled, never to return again.

In working with torture victims, we realise how very sensitive they are to reminders of their ordeal, even physical examination triggering off terrified reactions. In a study of ex-detainees at Vavuniya, all were found to have been tortured. They were found to be tense and anxious about being re-arrested, detained and tortured. As a consequence they were socially withdrawn and very suspicious[54]. Or take the case of the surgeon working painstakingly throughout the night to remove shell pieces one by one, resecting and anatomising the damaged intestine, amputating a leg, transfusing blood in a heroic effort to save the life of an injured victim. In a few days this fortunate patient may limp out of the hospital but be injured again in another attack and the poor surgeon has to start all over again. Wouldn't it be better to stop the ones firing the gun? They are also human beings and

amenable to reason. The British Faculty of Community Medicine has come to the conclusion that "Peace is a necessary precondition for health promotion"[55]. Wouldn't it be a positive step for all, if organisations doing humanitarian work at local and international levels could exert pressure on responsible parties for peace, to enable people to live in dignity.

After working in a war devastated area for over a decade and seeing the untold misery it causes, one begins to realise that nobody wins a war There are only losers. One has to only see the Eastern province to appreciate the enormous physical, psychological, social and spiritual cost of war. As members of the medical profession we have a responsibility towards our community as well as humanity at large. Our calling is to a healing profession, trying to give solace and comfort to those afflicted. It may be very heart warming to give into narrow ideologies founded upon ethnocentric identities and nationalistic fervour. But we must somehow raise ourselves above constricting loyalties and emotionally that may blind both our vision and reason, if we are to reach a humanitarian level. I can only understand too well the feeling of homesickness but this may not be unmixed with some feeling of guilt at having left the homeland in dire straits It becomes only to easy to assuage this feeling by generous donations for the most powerful and emotionally arousing causes. However, we must consider the long term consequences for our community. Internationally, many members of the medical profession, individually and as a group, have come out strongly against war. It must be remembered that the Medical Association for the Prevention of War, Medical Campaigns Against Nuclear Weapons and the International Physicians for the Prevention of Nuclear Wars have been very effective, even winning the Nobel Prize for peace for their work. Medical organisations such as the World Medical Association (WMA); Danish, Chilean and British Medical Associations, US Physicians for Human Rights, American Public Health Association and the South African National Medical and Dental Association (NAMDA) have clearly voiced their concern on the effects of organised violence and war, as well as reiterated their stand against such practices as torture. In this connection I would strongly recommend the book *Medical Ethics Today: Its Practice and Philosophy,* by the BMA[56]. The rights of the child to have been supported by many humanitarian organisations. The Convention on the Rights of the Child passed by the UN General Assembly is an example. There are several issues where we can make a contribution. One concerns arbitrary arrest, detention and torture being practiced by all parties in the conflict in Sri Lanka. The psychological consequences not only for the victim but for his family and children are immense as described elsewhere[16]. The other is involvement of children in the war. We have had to deal with the devastating effects on adolescents, particularly those who have been made to commit atrocities, resulting in the state of Malignant PTSD already referred to. The problem of their reintegration into society is a daunting prospect facing us.

The problems of those displaced in this war, inside and outside the country, and their resettlement and rehabilitation are gigantic challenges. In addition, we have to anticipate a rebound increase in psychological problems if there is a cessation of hostilities, when all the repressed and denied problems will start to surface[14].

We may feel rather weak and helpless as far as decision making or finding a solution is concerned. I have often heard many colleagues complacently say that this is inevitable - war is inevitable, torture is inevitable and that some external force will have to impose a solution. But recent experiences in the world should open our eyes; the miracle in South Africa and even the peace process in the intractable Palestine problem gives us hope. Health workers in areas of conflict have started emphasising that as health professionals we can't remain silent, we need to consider the ethics and take principled stand for victims and society.

Armenian from Beirut writes:

> *Considering that war is a disease at the social level, affecting the health of millions of individuals every year, it behoves us, as (public) health professionals, to be activists rather than bureaucrats. We should be concerned as much with prevention as with relief in dealing with this global problem.*
>
> *...But in the absence of an appropriate professional stand that aims at prevention rather than relief, no major impact by health professionals is expected in endemic situations. Public health practice in these wars has to be politically involved and assist in conflict resolution. Our concern for preventive action has to direct us towards efforts at identifying alternative approaches to conflict resolution and introducing change at (the) global level*[57].

The Medical Profession has a powerful and persuasive voice. Particularly, if we can transcend parochial boundaries and unite ourselves with other doctors across the line in raising one consistent voice for peace. Or, this can be in our day to day dealings and contacts, where we can take principled stands on issues and express our concerns. For ultimately war and peace are states of mind. If we change our "mind set" for peace, then eventually peace will come to prevail in our homeland.

PROPOSALS:

1. Multi-disciplinary Team

   To treat trauma victims and other psychiatric patients.

2. Training

Most of our staff and volunteers have not been fully trained. e.g. the psychiatric nurses have not had special training at Mulleriyawa. Perhaps training can be arranged at Vellore or other institutions abroad. This training could be available to all grades of staff, in particular the members of the above mentioned multi-disciplinary team. Fr. S. Damien needs to complete a MSc/Mphil in clinical psychology or allied field to be confirmed in his position at the university. Mr. T Arunakirinathan, teacher from the education

department, who has been working with us on the survey of students and subsequent training of teachers needs to do a BA/BSc in Child Psychology or allied field.

Mr. N. Canagaratnam, Matron at the G.H. Jaffna, is interested in working as a Psychiatric Community Nurse. He is an ideal person to organise the community based approach in mental health in our area. He will need training in this field, perhaps through the National Association for Mental Health in the U.K.

3. Long Stay Home

   For psychiatric patients.

4. Geriatric Care

   a. Home Care and visits by training attendants, perhaps for a fee.

   b. Home with provision for medical care when necessary. Again, can be for a fee.

5. Visits

   We welcome and need visits from specialists. Perhaps some can come for short periods on contract, etc., as done in India. We are in desperate need of teachers at the medical faculty, particularly in the para-clinical and clinical departments. Some departments are being run by just one person, and in a few cases one person is running two departments.

   Dr. J Ganeshamoorthy is running both Medicine and Pharmacology Departments, as well as anatomy, etc.

6. Peace initiatives and frank declaration of issues involved, which should include our own internal dimensions as well, that is to say inter- and intra-group reconciliation.

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Fig 2.1

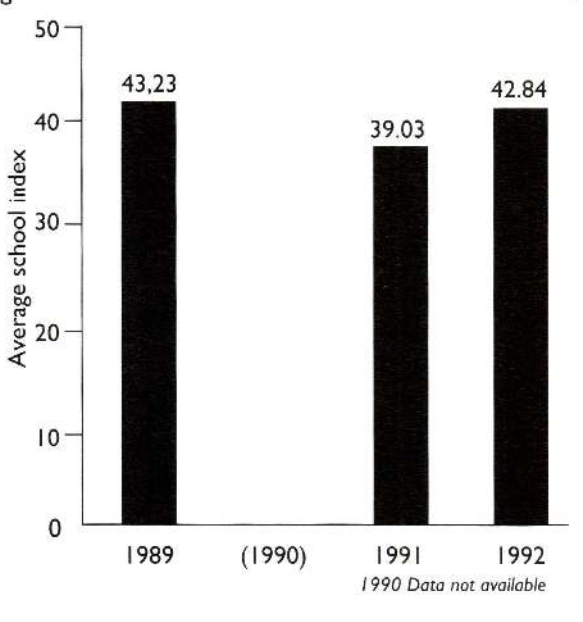


Fig. 2.1 Average school index for the years 1989, 1991 and 1992 in (GCE O/L) Jaffna District.

Fig. 2.2

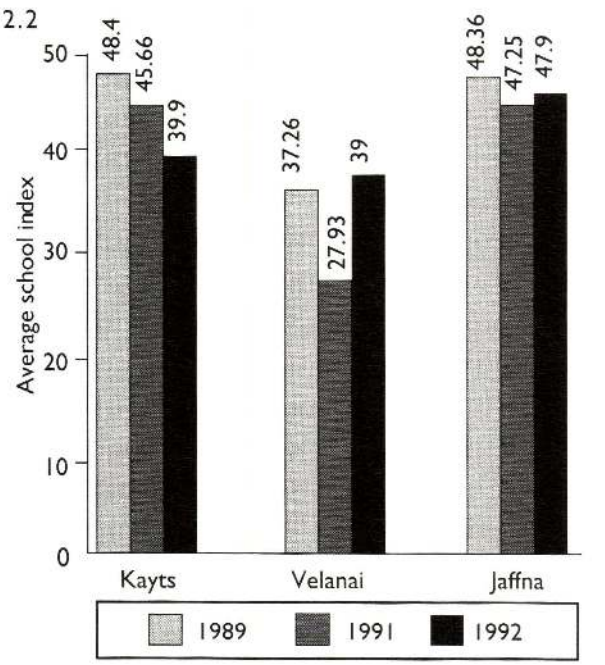


Fig. 2.2 Average school index for the years 1989, 1991 and 1993 in 3 educational divisions.

Fig.2.3

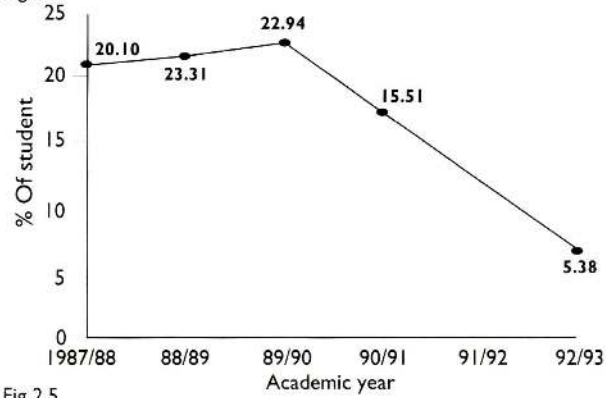
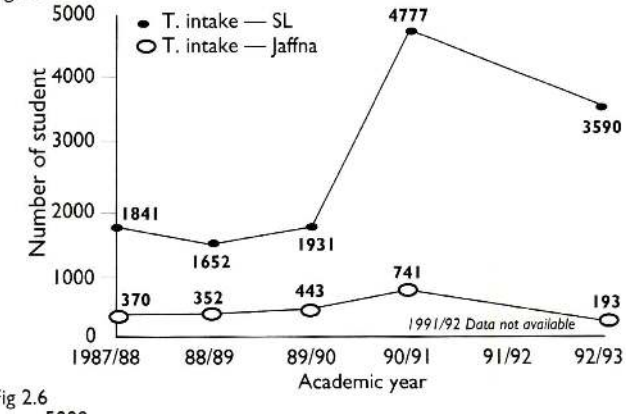


Fig. 2.4



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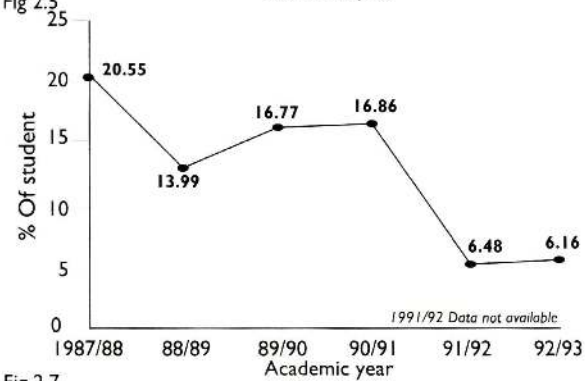

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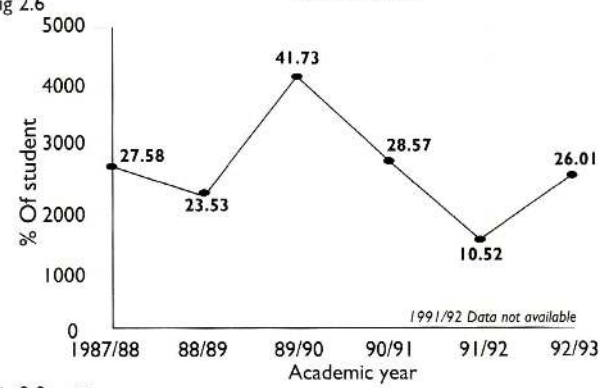
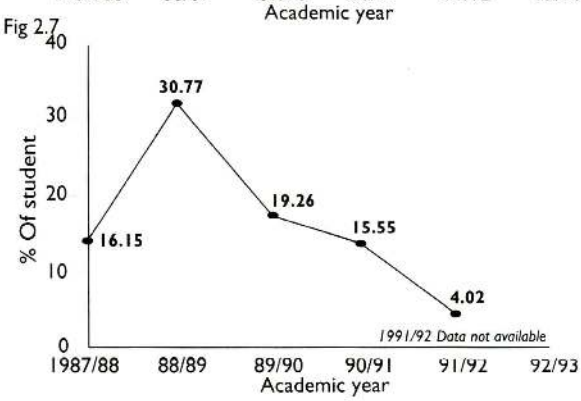


Fig 2.7



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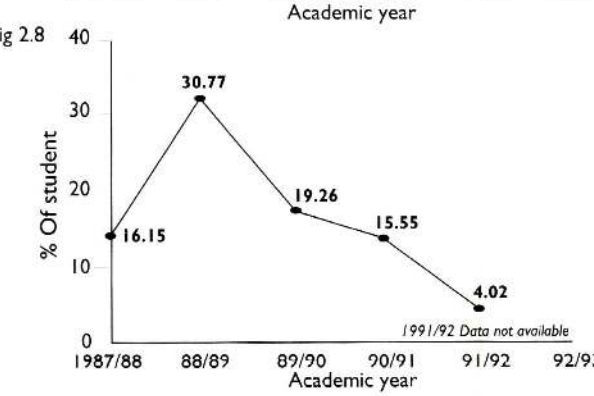
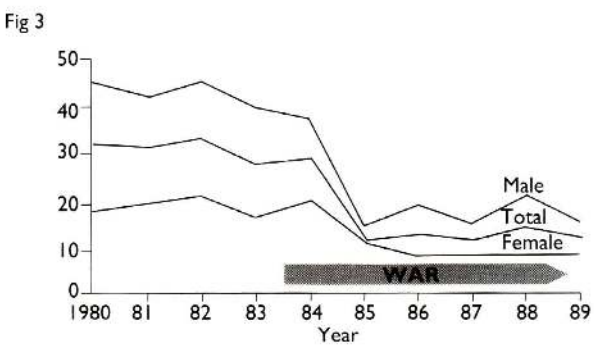


Fig 3



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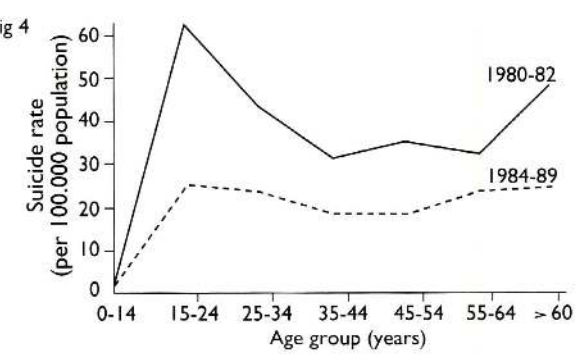

Fig. 2.3 Percentage of university admissions on merit from Jaffna district during the last 6 years.

Fig. 2.4 Island wide university admissions on merit and that from Jaffna district during the last 6 years.

Fig 2.5 Percentage of students selected for the course of medicine on merit from Jaffna district during the last 7 years.

Fig 2.6 Percentage of students selected for the course of engineering I on merit from Jaffna district.

Fig 2.7 Percentage of students selected for the course of arts on merit from Jaffna district during the last 7 years.

Fig 2.8 Percentage of students selected for the course of management on merit from Jaffna district during the last 7 years

Fig 3 Suicide rate in Jaffna town 1980-1989 (per 100,00 population).

Fig 4 Age specific suicied rate in Jaffna Town before and during the war (per 100,000 population)

MATERNAL AND CHILD HEALTH

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Introduction

Jaffna is not the same as it was a decade ago. As it has changed, the health status of the mothers and children of the district have changed as well – for the worse. This paper uses a few of the several indicators available to document the contemporary health status of the mothers and children of the region. Due to a lack of reliable data, the paper focuses on Jaffna only and not the entire North-East Province (NEP). It can be said, however, that conditions in the other Tamil-speaking districts of the NEP are worse.

Nutritional Status

Two decades ago Jaffna had the best child nutrition status and the lowest infant mortality rate (IMR) in all of Sri Lanka [1,2]. The IMR was so low that it was claimed to be better than that of Washington D.C.[3]. Today the pendulum has swung in the opposite direction. The racial riots of 1983, the occupation by the Indian Peace Keeping Force (IPKF) in 1987, the subsequent escalation of the war, and the economic blockade of 1990 have all contributed to this change. In the early 1990s, severely anaemic mothers and children with marasmus, kwashiokor and vitamin A deficiencies started appearing in clinics. Small scale studies showed that 60-100% of mothers were anaemic and that 25-75% of children were malnourished[4].

A nutrition survey of children under three years old living in the Jaffna district was carried out in February, 1993[5]. It revealed that:

18.9% were wasted (acutely malnourished)
31.4% were stunted (chronically malnourished)
40.0% were below the expected weight for age.

The following Table I. compares the nutritional status of children in 1975/76 to the Sri Lanka Demographic Survey (SLDS) of 1987 and the Jaffna District Nutrition Survey (JDNS) of 1993. The SLDS of 1987 did not include the NEP in its statistics.

Table I CHANGES IN NUTRITIONAL STATUS OF CHILDREN (IN %) BETWEEN 1975/76 AND 1993

	1975/76	1987	1993	% increase (+) % or decrease (-)
ACUTE MALNUTRITION (WASTING)				
Sri Lanka	6.6	12.9	n.a	(+) 96%
Jaffna District	3.7	n.a	18.9	(+) 411%
CHRONIC MALNUTRITION (STUNTING)				
Sri Lanka	34.7	25.5	n,a	(-) 21%
Jaffna District	28.4	n.a	31.4(+)	(+) 11%

As the data indicates, chronic malnutrition in Sri Lanka decreased by 21% between 1975/78 and 1987, while it increased in Jaffna by 11% between 1975/76 and 1993. In the case of acute malnutrition, which indicates the present extent of starvation, there was an alarming increase of 411% in Jaffna between those years.

The study also showed the percentage of malnourished children was higher in refugee camps (Fig.1), and that the percentage malnourished increased with the duration of displacement (Fig 2). The study also indicated that malnutrition was minimal among infants, maximal for those with low birth weight and increased as age advanced (Fig 3).

Although the economic blockade has contributed to this condition, other factors also have been responsible. Curtailment of fishing led to loss of employment and consequent lack of fish, which had been the main source of protein for children in the middle and lower social classes. The annual requirement for fish in Jaffna district is estimated at 6,605 metric tons, but in 1992 the estimated annual catch was only 1,094 metric tons. It should be noted that prior to the curtailment of fishing, the annual catch was 33,395 metric tons!

Another factor in the rise of malnutrition is the non-availability of protein supplements like 'Thriposha', an

Fig 1

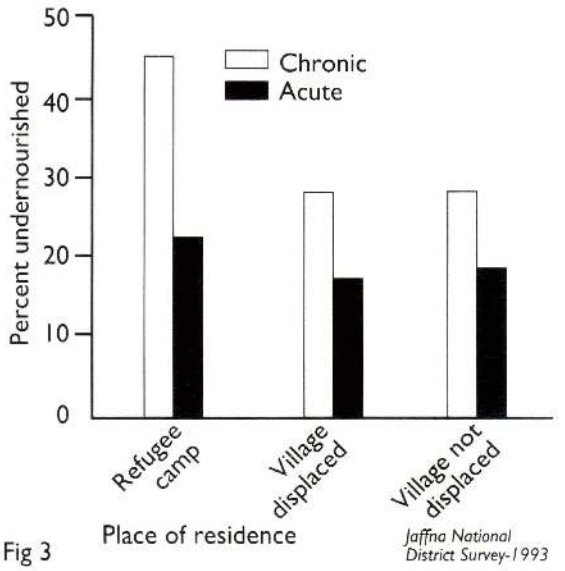
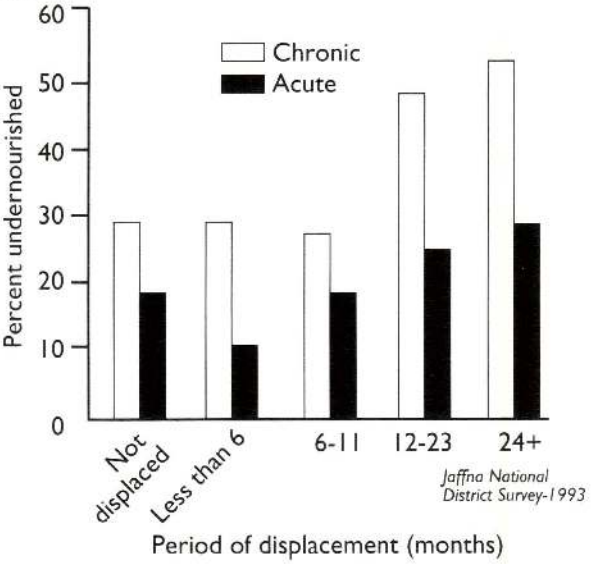


Fig 2



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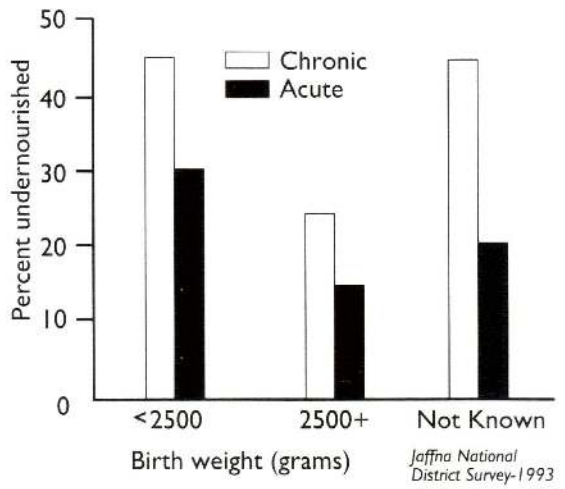


Figures 1,2,3 Prevalence of undernutrition (%) by place of residence, period of displacement and birth weight

integral component of maternal and child health services in Sri Lanka. The quantity usually supplied to Jaffna District was 24,000 master bags per year. Since 1990 the quantity of supplies sent to the Deputy Provincial Director of Health Services (DPDHS), Jaffna has been as follows:

1991 Nil
1992 2,945 master bags (12.3% of usual qty. supplied)
1993 5,438 master bags (22.7%)

In fact, the present requirement for protein supplements is two to three times the quantity approved earlier.

Low Birth Weight (LBW)

The number of low-birth-weight babies born in Jaffna is increasing, perhaps due to poor maternal nutrition. The percentage of LBW babies born at Teaching Hospital, Jaffna rose from 19% in the third quarter of 1989 to 23% in the third quarter of 1991, a 25% increase in two years[4]. The 1993 Jaffna District Nutrition Survey showed that 19% of the children born between 1990 and 1992 had a birth weight below 2.5 kilograms.

The increasing trend is clearly supported by available data on LBW babies born within the University Field Project area (Kokuvil-Kondavil Community Health Project area). The percentage of these LBW babies is generally lower than in the rest of the peninsula. However, an increase in the birth of LBW babies can be noted following the racial riots of 1983, IPKF operations of 1987 and economic blockade of 1990 (Fig 4). The percentage of LBW babies is steadily increasing, rising three-fold between 1989 and 1993.

Mortality

In 1974, Jaffna District boasted of the lowest infant mortality rate in all of Sri Lanka: 21 per 1,000 live births (Fig 5). During the past few years, state publications have excluded infant mortality data for the northern and eastern provinces of Sri Lanka. However, data available in the University Project area shows a 1993 IMR of 41.2 per 1,000 live births, which is double the IMR for Sri Lanka as a whole (23 per 1,000 live births). Jaffna District now ranks among the districts with high IMR (Fig 6). Most of the infant deaths have been due to acute respiratory infections, diarrhoea and septicaemia. Malnutrition and the restriction of transportation of antibiotics have contributed to the elevated infant death rate.

The maternal mortality rate (MMR) too has shown a deviation from the national figure for Sri Lanka (Fig 7). In 1982 and 1983 the MMR was 60 per 100,000 live births, as was the MMR for the country as a whole. But since 1984, the MMR for Jaffna District has been rising while the MM

for Sri Lanka has shown a slow downward trend. Following the IPKF operation in 1988, and in 1990 when the only available General Hospital was moved five miles away due to bombing and was functioning with limited resources, the MMR for Jaffna District showed sharp increases. There were 42 maternal deaths in 1988 and 25 maternal deaths in 1990; most of these deaths were related to delay or inability to reach the hospital.

Field Health Workers

The grassroots workers involved in maternal and child care in Sri Lanka are the public health midwives (PHM) and public health inspectors (PHI). Fig 8 documents the availability of PHMs and PHIs.

The North-East Province needs 852 PHMs and 255 PHIs. Today we have only 39% of the required number of PHMs and 34% of PHIs (including those who have retired and become re-employed; these are usually not included in the cadre). Public health midwives are the cornerstone of maternal and child health, and today they are in very short supply. The shortage is due to poor recruitment for and centralisation of training. The following table shows the number of PHMs who have graduated since 1983:

On average, 18 PHMs are trained yearly for the entire NEP, which is insufficient even to fill the vacancies due to retirements, resignation and deaths. The Jaffna District needs 331 PHMs, but today there are only 81 working in the district. There are 23 others who are working in the field after three months of training funded by Save the Children Fund (U.K.) although it is the responsibility of the government to provide adequate training and services.

Fig 4

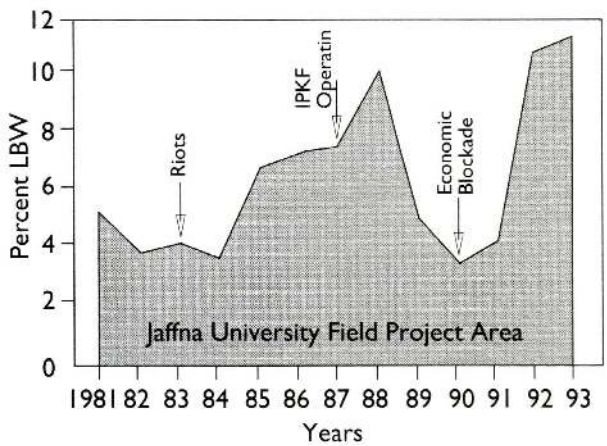
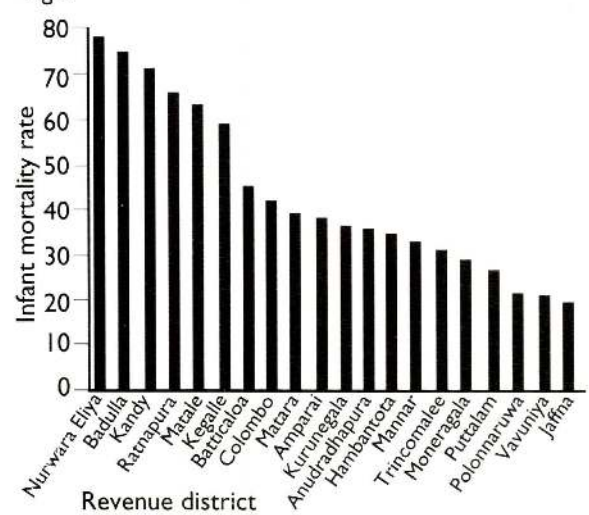


Fig 5



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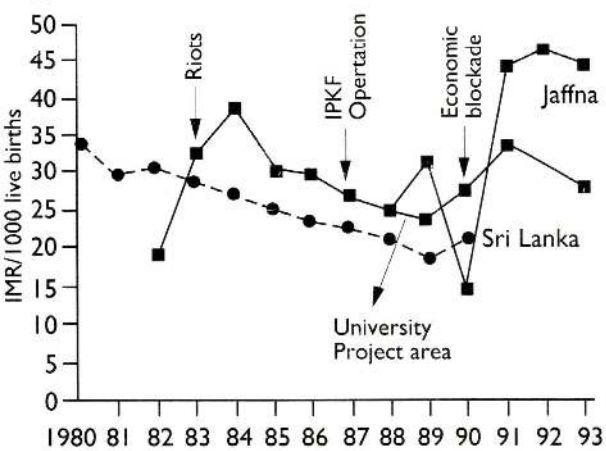
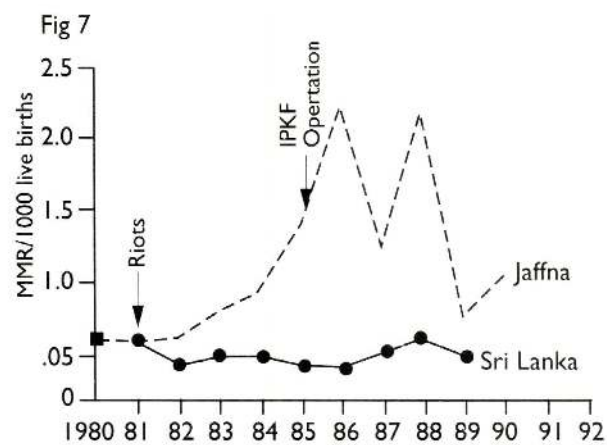
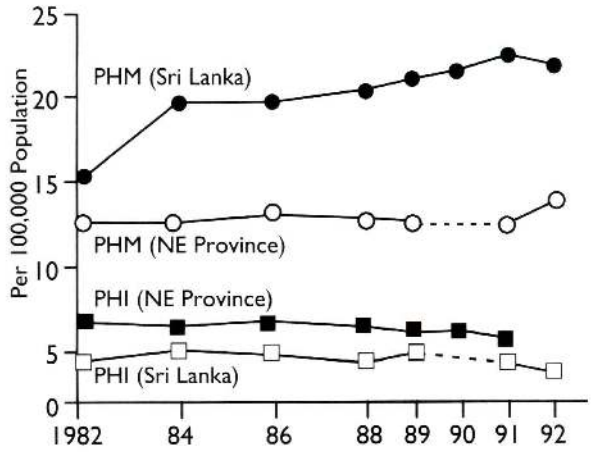


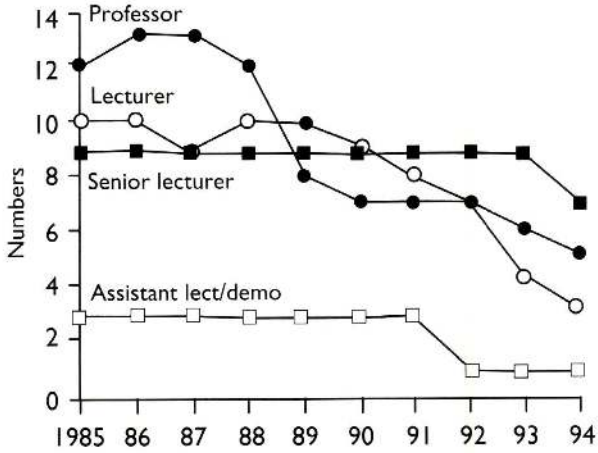
Fig 7



Source: Report of DRDHS, Jaffna
Source: Annual Health Bulletin 1992, Ministry of Health, Sri Lanka

Figure 4. Incidence of low birth weight (1981-93) Figure 5. Infant mortality rate, Sri Lanka 1974, Figure 6. Infant mortality rates 1980-93, Figure 7. Maternal mortality rates (MMR) 1982-92





Proper maternal and child care also depends on adequate undergraduate medical training. However, admission to the medical faculty in Jaffna has dropped drastically by almost 50% over the last two years. The academic staff position of the medical facility has also deteriorated during the past few years, as shown by Fig 9.

Conclusion

The maternal and child care services of Jaffna – once said to be the best in Sri Lanka – have deteriorated rapidly during the past decade. If this trend is not arrested immediately a catastrophe could be expected soon. The root cause of the problems is political, and only a political solution will effectively address them. In the meantime, however, international pressure should be applied to encourage the following measures:

1. The lifting of the economic blockade
2. The resettlement of refugees
3. The restoration of the fishing industry and agriculture
4. The decentralisation of undergraduate and paramedical training (including selection for training)

This is the hour of need. We cannot hold off our intervention until the situation resembles that of Ethiopia or Somalia and then tell the world "Now it's too late". It is time for all those who love their motherland to contribute manpower, material and money to avert a disaster.

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ACUTE TRAUMA AND REHABILITATION

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In the following pages, I will discuss the subject of acute trauma and rehabilitation, a field of great importance and urgent need in war-torn Sri Lanka. The fresh outbreak of ethnic violence and military operations in the country has caused an unprecedented rise in the number of innocent civilians to lose their limbs. In the General Hospital of Jaffna alone, a total of 786 amputations were performed between 1987 and 1993.

The Jaipur Foot Programme

The Colombo Friend-In-Need Society was founded in 1831 with the broad aims of helping fellow human beings. In 1985, the Society inaugurated the project of the Jaipur Foot Programme in Colombo.

The Jaipur Foot Programme focuses mainly on the rehabilitation of these unfortunate victims and others who have lost their limbs due to natural causes. This was a timely development since a large number of persons had lost their limbs due to the ethnic war in Sri Lanka. The Orthopaedic Workshop at General Hospital, Colombo had been employing a model of artificial limb unsuitable to the lifestyles of Asian peoples. Dr. P. K. Sethi's invention of the Jaipur Foot in 1970 and its introduction to Sri Lanka in 1985 was a landmark in the development of an ideal replacement for lost limbs that met the needs of the Asian way of life. The Jaipur Foot has many advantages over artificial limbs used in the developed countries:

1. Its simple technology can be fabricated with local materials at low cost.
2. It requires only a short time for fabricating and fitting.
3. It resembles a natural foot and allows a fair degree of mobility in all directions, fitting the barefooted lifestyle of Asian peoples and customs. The Jaipur Foot facilitates squatting on the ground, sitting cross-legged and removing slippers or shoes before going to temples and social gatherings.
4. It can be used on any type of terrain, under any environmental conditions.
5. It can be adjusted to stump variation.

The introduction of the limb-fitting program in Colombo brought very high demand and long waiting lists for artificial limbs. A few dedicated members of the Jaffna Mother's Front sought the help of the Colombo Friend-In-Need Society to organise a similar programme in Jaffna. The parent body cooperated enthusiastically to obtain the necessary funds from NORAD (Norwegian Association for Development Research) to start the project in Jaffna, and the Jaipur Foot Project, Jaffna was inaugurated on July 1st, 1987 by Mrs. Swarna Ferdinand, Project Secretary of the Colombo parent body. From then on, we have provided services with the help of a band of dedicated committee members and staff and the blessings and cooperation of the parent body. Looking back, we are proud of our seven years of service to the unfortunate victims of the war in North-East Sri Lanka.

The Jaffna programme has organised a spectrum of activities that cover a wide range of rehabilitation services. These include fitting of prosthetic limbs for amputees (arm and leg units), manufacture of foot pieces, provision of orthotic appliances, guidance and counselling services, medical care and hostel facilities and other rehabilitation projects.

Prosthesis

One of the main projects of the Jaipur Foot Programme is of course the fitting of artificial limbs for amputees and others who have lost their limbs. This activity can be broken down and analysed on several levels – type of limb fitted, age and sex of recipient, cause of amputation, geographic distribution.

The following table details the number of prosthetic limbs we have fitted as of 30 June, 1994.

As the figures demonstrate, the majority of beneficiaries of lower limbs were previously amputated below the knee. Similarly, the majority of those that received upper limbs were amputated below the elbow.

The large majority of beneficiaries of our artificial limbs have been males in need of prosthesis. 83% of our lower

Table 1

Lower limbs		Upper limbs	
Above knee	196	Above elbow	27
Below knee	601	Below elbow	50
Bilateral		Bilateral	
Above knee	6	Above elbow	2
Below knee	12		
Overgrown	79		
TOTAL	1,073	TOTAL	79

limb devices and 86% of our upper limbs were fitted onto males. This disparity can be explained by males higher exposure to the dangers of anti-personnel mines, shelling attacks and other war hazards.

Clients in need of prosthesis have had their limbs amputated due to a wide variety of causes, but the bulk of beneficiaries at the Jaipur Foot Programme lost their limbs due to war-related injuries, as the following statistics demonstrate:

Anti-personnel mines were the greatest cause of amputation of lower limbs, while shell blast injuries were the main cause of upper limb amputation.

Surveying prosthesis beneficiaries with respect to age group yields the following data:

The largest number of the beneficiaries were males and females between 11 and 20 years old, the main "at risk" group in the ethnic war. The group with the second-highest representation was between 21 and 30 years old.

Looking at the data district-by-district shows that the Programme has had clients from 10 districts in Sri Lanka:

The majority of clients came from 8 districts in North-East Province, with a very small number from Badulla and Puttalam as well. Jaffna District had the largest number of beneficiaries, followed by Batticaloa, Kilinochchi and others. Due to travel restrictions and poverty, many amputees from districts other than Jaffna may not yet have approached us. We hope that with improvement of the war situation and communications we will receive more

Table 2

Cause of amputation	Lower limbs	Upper limbs
Pressure mine	373	-
Bomb blast	33	4
Shell blast	112	52
Gunshot	63	12
Road, rail & Industrial accident	75	5
Diabetes	77	-
Leprosy	12	-
Gangrene	33	1
Fall from high elevation	6	-
Sword & knife cut	3	-
Congenital	4	3
Cancer	8	1
Cyclone victim	2	-
Attack from animals	4	-
Vascular degeneration	1	-
TOTAL	806	78

Table 3

Age group	Lower limbs	Upper limbs
1-10	431	1
11-20	308	38
21-30	183	25
31-40	91	9
41-50	74	4
51-60	74	1
61-70	34	-
71-80	11	-
TOTAL	806	78

applications from other districts. Present coverage extends only to Jaffna District but our work load will most likely be much larger in the coming years.

The above facts should demonstrate that our services have restored to normalcy the lives of a great number of youth who otherwise would have despaired for the rest of their lives. Fitted with prosthetic limbs, they can now lead fruitful and independent lives. Their full participation in and exhibition of their talents at two sports festivals we held in 1988 and 1994 bear ample witness to this fact. To aid economic and educational rehabilitation of the limb users we held competitions in self-employment projects and essay, story and verse writing. Prizes were distributed to the winners. We are pleased to have brought sunshine into those lives darkened by the trauma of injury and amputation.

Another important aspect of our prosthetics programme is the after-care service. Fitted limbs may need repairs at any time or replacement if they cannot be repaired. Limbs need replacement every 2 to 3 years, depending on the type of work of the recipient. Growing children need their limbs replaced every 1 to 1 1/2 years.

Production of Foot Pieces

Production of foot pieces began in October 1993. Between then and July, 1994, 80 foot pieces were produced with available materials, using a locally-made furnace rather than autoclave.

Table 4

District	Lower limbs	Upper limbs
Jaffna	492	51
Kilinochchi	72	6
Vavuniya	31	1
Mannar	27	5
Mullaithivu	37	1
Trincomalee	48	4
Batticaloa	90	8
Amparai	5	2
Badulla	1	-
Puttalam	3	-
TOTAL	806	78

Since the economic blockade began in 1990, demand for this aspect of our work has increased greatly. Short supply of raw materials combined with increased demand for foot pieces has made our task very difficult. Our Head Office in Colombo could not help us because they too faced heavy demand. However, due to the ingenuity and motivation of the Works Manager and other staff, old and discarded foot pieces were repaired and locally available alternatives were utilised innovatively to help tide over crises. Nevertheless, the number of people awaiting prosthetic limbs continues to grow alarmingly. We presently have about 150 amputees on a waiting list, but there are many more at large who still have not registered their needs. We must expand our production to cope with this demand in the future.

Services Provided by the Orthotic Workshop

Besides fitting and maintaining limbs according to the needs of users, we have provided orthotic devices to a large number of polio victims and other disabled persons. As of 30 June, 1994, the Orthotic Workshop had produced the following number of devices: Table 5

This unit has also provided services required for types of disability not directly related to the war. Quite a number of children were affected by polio in the last few years due to non-immunisation or ineffective immunisation due to poor vaccine storage conditions (failure of power supply, for example). Orthotic devices help these beneficiaries achieve nearly normal lives, making them mobile and thereby enabling them to generate income.

Physiotherapy Unit

With the help of Handicap International and later Save the Children Fund (U.K.), two trained rehabilitation workers provide the necessary back-up service for limb fitting and usage of orthotic devices. With basic equipment they help rehabilitate limb users and other disabled people to near-normal life. The Orthotic Workshop supports this unit by providing appliances to fit according to individual needs.

Table 5

DEVICES	
Calliper (leg braces)	30
Shoe elevation	113
Foot drop belts	139
Padding for crutches	41
Special belts	12
Walking aids	3
Elbow crutches	2
Splints	23
Wheelchairs	42
Tricycles	6
Perambulators	2
Exercise cycles	3
Steel Walkers	4
White canes	10

Guidance and Counselling Services

Our trained counsellor provides counselling for the beneficiaries before and after their limbs have been fitted, greatly helping them to face their new situation confidently. Vocational guidance is provided for those who need it. This service is linked to the income-generating and loan schemes.

Medical Services and Hostel Facilities

We coordinate our programme with the Jaffna Hospital. Transit Hostel provides facilities to accommodate up to five persons with free meals.

Follow-up Rehabilitation Programme for Beneficiaries

We conducted a survey of the beneficiaries who had limbs fitted or received other prosthetic and orthotic assistance at our centre, and found that many of them were unable to continue their profession or studies due to lack of funds. In July 1988, with assistance from World Vision–Lanka, we commenced a revolving loan scheme to help beneficiaries preserve their dignity and self-respect through the following means:

1. Loans to skilled persons to start self-employment projects.
2. Loan assistance to enable others to improve their existing trades.
3. Loans for self-employment training.
4. Educational grants to allow students to follow their studies.

The following table details the number of persons who have benefited from our rehabilitation assistance up to 30 June, 1994:

Due to disruptions associated with the war, we could not operate this programme for a certain period after June 1990. The programme resumed its normal course in 1993. We now continue this programme with financial assistance from Sri Lankan organisations abroad.

Towards the Future

Whether the war continues or peace returns to our areas, the demand for limbs and orthotic devices will

Table 6

REVOLVING LOANS	
No. persons in self-employment projects	77
No. projects on the scheme	14
Total amount paid	218,000.0
Recoveries to date	49,955.0
EDUCATIONAL GRANTS	
No. students who have received grants	24
Total amount paid	88,750.0

continue for years to come. Replacements for and repairs of these devices will be necessary for decades. Moreover, history has proven that even when people return to their homes and fields after a conflict has ended, many will fall victim to pressure mines for years afterward. Pressure mines remain dormant for years until triggered by human, vehicle or animal contact, and failure to remove such mines can have dangerous consequences.

With this in mind, we have planned to expand our services to meet the needs of the community in the coming years. Going by past statistics, we estimated the services we may hypothetically provide in the next four years. The following table summarises our predictions. Table 7

Table 7 ANTICIPATED BENEFICIARIES FOR 1995-1998

Beneficiaries of lower limbs	4,800
Beneficiaries of upper limbs	210
Provision of wheelchairs	150
Provision of tricycles	150
Provision of crutches	400
Provision of orthotic braces	700
Provision of orthotic appliances	1,000
TOTAL	17,010

Funds

We are deeply grateful to the many donors and well-wishers who have responded to our calls for help in this humanitarian effort. NORAD, DIAKONIA, S.C.F.(U.K.), World Council of Churches, Foreign Missions in Sri Lanka, Sri Lankan associations and Sri Lankans abroad, the general public, and government and non-governmental organisations in Sri Lanka all extended hands of goodwill to keep the wheels of the programme turning. Nonetheless, this level of funding has still been insufficient to meet increasing demand for our services.

Conclusion

This report has summarised the activities of the Jaipur Foot Programme to date and described some of our plans for the future. Workshops such as ours are not only an urgent necessity during a war and its aftermath, but are also a vital part of the modernisation of society. Hence, as a service to our community in Sri Lanka, we should further develop and sustain the Jaipur Foot Programme in Jaffna, keeping in mind the ideas for which it was founded *"They shall not suffer."* Our policy is to pave the path for independent living with dignity and self-respect for all handicapped people.

HEALTH OF WOMEN AND THE ELDERLY

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Women in National Development

As the main providers of health care in the family and community, as bearers and rearers of children, and as workers at home and outside, women play a vital role in health and development. But their health status cannot be improved without concurrent action to improve their social and economic well-being. When we speak of women's health we do not speak of medical issues alone. Issues such as education, nutrition, sanitation, water quality and availability, access to economic resources, decision making power and other socio-cultural factors are also very important. Although health programmes are addressed to all people, women are always the most severely affected by the combination of these factors. Furthermore, because women have special biological needs related to pregnancy, childbirth and lactation, socio-cultural patterns and values may expose them to health risks that differ from those faced by men.

As women become more economically active and more literate, their role in the community is becoming increasingly important. Women are organising themselves into various associations to advocate improved programmes for child survival and development and a wider role for women in development. These organisations also play a significant role by involving women in health programmes. Our grassroots organisation, the Centre for Women and Development, plays an important role in implementing primary health care at the local level, meeting peoples' immediate needs. Health education programmes are also beneficial because they reinforce new practices and aid their adoption.

Impact of the War on the Lives of Tamil Women

In the past years in Sri Lanka state forces have completely alienated the Tamils from every sphere of human activity, driving out a large number of people from their own soil as refugees. The destruction of the physical and social infrastructure has caused many problems in this region.

One of the major social problems caused by the violence is the creation of a large group of helpless widows, suddenly called upon to shoulder problems by themselves in a society that traditionally has been male-dominated. After the communal riots of 1983 and the violence of succeeding years, the number of widows continues to increase at an alarming rate. In 1991, an estimated 7,000 widows lived in a helpless state in this region, of whom 2,000 women faced severe economic circumstances.

Most of our women are housewives and they suffer many hardships, mental strain, financial difficulties, social degradation, etc. – when they lose their husbands, the breadwinners of the family. Restoring a normal life to these widows is a difficult task. Most of them come from poor families and cannot face such challenges without some kind of outside economic assistance. Furthermore, women who had worked in agriculture or the fishing community lost their jobs and earnings due to the economic restrictions imposed by the government.

The economic embargo has created many other problems for women in the region. Restrictions on fuel have increased the cost of firewood and made transportation difficult for women. Many women of all ages have had to learn how to ride bicycles to carry out their daily activities, while others who cannot ride bicycles must walk long distances to get things done. Pregnant women are also being taken to clinics on bicycles. Many pregnant women, however, stay at home without attending the clinics to avoid these hardships. As a result, their health is very badly affected.

War has its exhilarating moments for some, but for most people war is ugly, brutal and bloody; the tension and trauma created by this war have badly scarred many of our children and women. Women in most of the families live with high levels of tension. They fear that their children will join the liberation movement and die in combat. Women who live along the coastal areas fear that something may happen to their husbands when they go fishing. Many

children and women have recently developed mental disorders due to the war. Though some counselling programmes have been introduced they are under-developed; overall very little attention has been paid to this subject.

Displacement and a New Role For Women in Society

Large-scale displacement has exacerbated many of the social problems caused by the war. A total of 79,834 families were displaced from army-occupied areas, of which 8,968 families are living in a total of 188 camps. The rest are living outside with relatives or independently. People left their belongings and ran – for security reasons – empty-handed. Those who live with relatives could adjust somewhat, but those that remain in camps must face so many difficulties. Women suffer the most. Toilets are unavailable. Shortages of water, food, medicine and money aggravate the situation. Poverty brings with it ill-health, and women and children in the camps fall sick very often due to lack of nutritious food. The most common illnesses among the refugees are diarrhoea, skin diseases, anaemia, malaria, and recently a new form of eye infection which affects children. Complicated labour and heavy postpartum bleeding contribute to ill-health and death among them. The main causes of death in the camps include malnutrition and tuberculosis.

People of all ages now suffer from anxiety, nightmares and grief: reactions to a sense of hopelessness. Their working and earning capacity has been badly eroded. The stress on refugees in the camps is manifest through changes in their behaviour. Male frustration due to inactivity and changing power relationships has often resulted in increased domestic violence. Social values have changed due to the psychological stress caused by the break-up of families. The changes in lifestyle, the lack of social privacy and the sharing of common sleeping space among many families has resulted in a greater number of teenage pregnancies. The women of the camps must look after their children and walk long distances to gather water and firewood. Some women work outside the camps. All women in the camps lead very difficult lives. Although non-governmental organisations in Jaffna have taken responsibility for maintenance of the camps, their resources are limited. Humanitarian assistance now is neither sufficient nor appropriately directed towards meeting the needs of affected groups. New ways to ensure that these needs are met have not yet been found.

Although the literacy rate in Jaffna is very high (87%), many families cannot afford to educate all of their children. Displacement has increased the school drop-out rate, and the number of street children hunting for petty jobs to supplement family income has increased. Another development of great importance to the economy of the region has been the migration of males to foreign countries. Such migration has increased the burden on the women who stay behind in so many ways. Children sent abroad to live and even get married have also become a problem. For example, there are the 'parcel brides' sent from Jaffna to travel alone to their destinations, undergoing many hardships along the way. The war situation has brought about these social changes, and we must seriously consider the impacts of such migration – husbands separated from wives, children separated from parents – on marriage and family life.

Thus along with their traditional roles as wife and mother, the women of Jaffna have a new role to play in the light of new social responsibilities and economic needs of society. Socio-cultural norms are changing. Economic pressures and the loss of men to death and migration are overriding the patriarchal system, with major implications for domestic decision-making. A growing number of households are headed by women. Another remarkable change has taken place in the last few years: many women and young girls have come forward, breaking through social barriers to participate in the freedom struggle.

> *"Today, young women have taken up arms to liberate our land. They have made supreme sacrifices to this cause, to the amazement of the world."*
>
> *Adele Ann, "Women Fighters of Liberation Tigers," (p7, LTTE, 1993)*

Never before in history has such psychological, cultural and social changes taken place in Tamil society, and women must adapt to these changes, withstanding discrimination and bearing responsibility in an unsettled situation. These circumstances have made Jaffna women emotionally strong with great self-will and the courage to endure and manage any unexpected situations.

Although the young take part actively in the liberation struggle, the majority of women do not want to get involved in politics. They have been silent observers and do not show much interest in taking leadership positions. However, organisations like ours feel very much that women should be actively involved in politics and that their participation will have a great impact on motivating the peacemaking process and preventing future conflicts. Our organisation has made a start by giving leadership training to women, to at least give them the confidence to participate in social activities.

Care for the Elderly

Of the total population, in Jaffna 43,850 can be classified as 'elderly', i.e. aged 65 years or older, 21,240 are women. Historically, family patterns in Jaffna were quite different from those in other parts of Sri Lanka. The Jaffna Tamils had great respect for elders and always treated them well, while elders placed great importance on their own children. Generally speaking, most elders in Jaffna have close family relationships. However, the times of high standard of living and long life expectancy in Jaffna have ended, and the elderly face new social problems as their families unravel. With the break-up of the joint family system, elders live in alienation, and the younger generation simply ignore them across a widening generation gap. If elders say anything, the young simply say 'No' and walk away. Therefore, elders often feel frustrated and find themselves a burden to their families.

The present conflict has worsened the problem. The geographic distance between elders and their children has

grown vast. Many elders have money but no one to care for them. Children in foreign lands do send money but cannot send love and affection to their parents, which elders need in their old age. Other elders live with their children, but with no income. They too lack good care, facing deteriorating health due to lack of food and proper medical care.

In the past, when an elderly person could no longer support himself or herself, he or she could rely on the goodwill of relatives. However, amid the dispersed families of today, the elderly are socially isolated, and they lead unhappy lives of loneliness and frustration. They are often mentally depressed and easily fall ill. Institutional care for the elderly is not suitable to the culture in Jaffna; there are a few old-age homes, but the elders avoid them. It is therefore very important for the elderly to have access to public health and medical care facilities outside hospitals.

One alternative is to send social workers or nurses appointed by the Department of Social Services to visit the elderly at home. Another option is to develop programmes of home help service for elderly living independently at home. Persons employed by such programmes would visit the homes of the elderly and assist them with the work they are unable to manage alone: washing their clothes, helping them to dress, assisting them with personal hygiene, etc. A voluntary service organisation could carry out the task of developing such programmes. Pensioners' organisations can also function as pressure groups, providing the elderly with the means to influence service programmes and leisure activities.

Conclusion

In conclusion, I will suggest a few ways by which the international health care community can help us in this region. The services of additional medical personnel would be very valuable, as would assistance to improve primary health care and midwifery training services. Also, the establishment of nutrition centres to give food supplements and care to pregnant mothers and children should be made another top priority.

But we must also remember that good public health cannot be attained by the health sector alone. Especially in developing countries, economic development, anti-poverty measures, food production, water, sanitation, housing, environmental protection and education all contribute to health and human development. With this in mind, let us all initiate some concrete action-oriented programmes to improve the health status of the people in our region.

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COPING WITH STRESSFUL EVENTS AND MENTAL ILLNESS

A STUDY IN THE MENTAL HEALTH OF SRI LANKAN TAMIL REFUGEES

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Abstract

Fifty-one Sri Lankan Tamil refugees, living in South India, filled in questionnaires concerning health, coping styles, health locus of control, and optimism. In addition, they answered a number of open-ended questions about living in camps and the availability of support. Their health appeared to be rather poor. Maladaptive coping styles, especially denial, seemed to be related with poor health. Furthermore, the refugees mentioned a large range of problems within the camps. These problems occurred in all areas of quality of life. The development of a diagnostic quality of life instrument is advocated.

Introduction

The World Health Organisation (WHO), Division of Mental Health, Geneva, is coordinating a research program aimed at the development of a cross-cultural Quality of Life measure called 'World Health Organisation Quality of Life' instrument (WHOQOL). A large number of countries cooperate in this study, for instance, England, Panama, Zimbabwe, Russia, Croatia, India, Australia, and The Netherlands.

In the first stage of the WHO study, the focus was on the development of the so-called core instrument which consists of the basic aspects of quality of life (QOL), applicable to anyone. However, because of this general character, the WHOQOL group has indicated some priority groups for which add-on modules will probably be necessary. An add-on module will be used in addition to the core instrument and can contain one or more facets with accompanying items or new items to either replace or supplement inappropriate ones within the core instrument.

One of the priority groups are refugees who live in camps. This means that WHO aims to develop an instrument which will allow an inquiry into the perception of refugees of their own position in life in the context of the environment in which they live, and in relation to their goals, expectations, standards, and concerns. This instrument will be called 'World Health Organisation Quality of Life-Refugees' (WHOQOL-REF).

One of the reasons for considering refugees as a priority group is that they are very vulnerable[1, 2]. For instance, refugees are commonly not protected by a government, and they are often victims of violence. Furthermore, they are seldom economically secure. Another reason for conceiving of refugees as one of the priority groups is that until now the perceived quality of life of refugees has not been assessed properly. The WHOQOL-REF will be able to give an insight into the areas of quality of life that are particularly affected in refugees.

So, the present study was undertaken in order to get an indication about the necessity of a quality of life instrument specific for refugees. The way in which refugees cope with their 'new' life situation and the problems they have to face, are at the core of this study into the mental health of refugees.

Method

Subjects

Fifty-one Sri Lankan Tamil refugees, all living in South India, participated in this study; 23 men and 28 women with ages ranging from 16 to 67 years. Of them, 47 were living in refugee camps that are spread all over Tamil Nadu. They all fled from the ethnic conflict in their home country. All participants were recruited by the Organisation for Eelam Refugee Rehabilitation (OfERR), an organisation founded by refugees with the purpose of trying to improve the living conditions and health of the refugees living in the camps. The interviews all took place outside the refugee camps. In this study, the possible influence of age and gender on health status will not be examined due to the small number of respondents.

Measures

All respondents were interviewed using open-ended questions concerning the social support they receive in the

camps, personal traumatic experiences and loss suffered in Sri Lanka, and problems within the camps. Furthermore, five questionnaires were administered. When possible, the refugees filled in the questionnaires themselves. In the case of persons who could not read and write, the questionnaires were administered in the form of a structured interview by Tamil speaking Indians from the Department of Psychiatry, Medical College in Madras.

Health was measured by the Hopkins Symptom Checklist[3]. This instrument was selected because the 25 item version had proven to be useful in studies with refugees from other Asian countries[4, 5]. The response scale used was a 5-point Likert type scale derived from the HSCL-90[6]. The reason was that we wanted more differentiation in the responses. The HSCL-58 measures *somatization, obsessive-compulsive behaviour, interpersonal sensitivity, depression, and anxiety*. The somatization items reflect distress arising from perceptions of bodily dysfunction. Obsessive-compulsive behaviour refers to acts that a person has to do, does, and cannot stop. Feelings of personal inadequacy and inferiority in relation to other persons are represented by interpersonal sensitivity. The aim of the scales Depression and Anxiety is self-evident. Cronbach alphas for the scales were between 0.61 and 0.87 (see Table 2). This is only slightly lower than the internal consistency of the original scales, which have ranged from 0.84 to 0.87 [3].

The Life Orientation Test (LOT;7) measures dispositional *optimism*. Carver *et al.* (1993) have demonstrated that optimism has a substantial influence on the level of distress. In the present study the LOT was used to investigate the influence of optimism on levels of distress as measured by the HSCL-58. The original LOT consists of eight items with an internal consistency of 0.76. However, in this study Cronbach's alpha reached a modest 0.53 with four items, two positively phrased and two negatively phrased.

Coping strategies were assessed using the COPE[8]. This questionnaire was chosen because it measures a larger range of coping styles, including acceptance and religion, than other instruments. *Active coping* involves active steps to try to remove or circumvent a stressful event. *Planning* is thinking about how to cope with a stressor. *Suppression of Competing Activities* means staying focussed on the stressor. Another positive coping strategy is not acting prematurely *(Restraint coping). Seeking Social Support for Instrumental* (advice, assistance, information) or *Emotional* (moral support, sympathy, understanding) *Reasons* are two other coping styles measured by the COPE. Focussing on whatever distress or upset one is experiencing and ventilating those feelings, is called *Focus on and Venting of Emotions*. Two forms of disengagement are also measured: Behavioural Disengagement (reducing one's effort or giving up the attempt to deal with the stressor) and *Mental Disengagement* (distract oneself from thinking about the stressor through activities). The other coping strategies assessed with the COPE are *Positive Reinterpretation and Growth*, that is, coping aimed at managing distress emotions and construing something stressful into positive terms, *Denial* (refusal to believe that the stressor exists or trying to act as though the stressor is not real), and *Acceptance* (accepting that the stressor is real and accepting that one has a lack of good coping styles). The last two coping responses are *Turning to Religion,* which speaks for itself, and the *Use of Substances* like alcohol as a way of dealing with a stressful event.

Originally, the COPE consists of 53 items[9]. However, in this study, seven additional items were included; three items for assessing the use of substances and a four-item scale for measuring the use of *Humour* as a coping mechanism. These additional items were all suggested by Fontaine, Manstead, and Wagner, 1993[10]. Thus, the COPE, as used in the present study, contains 60 items. The internal consistency (Cronbach's Alpha) of the 15 scales ranged from 0.36 to 0.81 (see Table 1).

The measured coping strategies can be divided into two categories: *adaptive and maladaptive* strategies. Examples of adaptive coping styles are active coping, planning, suppression of competing activities, and seeking social support for instrumental and emotional reasons. Denial, focussing of and venting of emotions, and mental disengagement are examples of maladaptive coping styles.

The Multidimensional Health Locus of Control scale Form A (MHLC-A;11) was used to investigate which of three attribution styles (i.e., internal, powerful others, and chance) the refugees used to explain their health status. *Internal Health Locus of Control* (IHLC) refers to seeking the cause of health status in the own activities or ways of thinking. When one blames other persons for one's health status, one uses the attributional style termed *Powerful Other Health Locus of Control* (PHLC). Finally, when one believes that one's health status is dependent on chance and that the own behaviours can do nothing to influence health, one is using the attributional style called *Chance Health Locus of Control* (CHLC). The MHLC-A consists of 18 items; six for each attribution style. The Cronbach alphas for the scales in this study were good, namely 0.78 for IHLC, 0.74 for PHLC, and 0.69 for CHLC (see Table 1).

In order to measure the extent of Post-Traumatic Stress Disorder (PTSD), a delayed and/or protracted response to a stressful event or situation of an exceptionally threatening or catastrophic nature which is likely to cause pervasive distress in almost anyone, a scale was used consisting of items and scales from existing questionnaires. These items and scales were selected on the basis of the diagnostic criteria for PTSD as mentioned in the ICD-10 (WHO, 1992). The selected scales were the Depression and Anxiety scales from the Hopkins Symptom Checklist-58 (HSCL-58), the Substances scale from the COPE, and several items from the HSCL-58 that are relevant for PTSD but were no part of the Depression or Anxiety scales (Items7,9,24,28,44,47,52,55). The internal consistency of the PTSD scale was reasonably good (Cronbach's alpha is 0.75). The discriminant validity of the scale seems good, because respondents who have **experienced personal loss** (other than material loss) such as family members that have been killed or injured in Sri Lanka,

Table 1 INTERNAL CONSISTENCY AND NUMBER OF ITEMS FOR THE SCALES USED

Questionnaires	Number of items	Mean score	SD	Cronbach's Alpha
HSCL-58				
Somatisation	12	2.14	0.67	0.87
Obsessive - compulsive	8	2.66	0.68	0.74
Interpersonal	7	2.40	0.75	0.61
Depression	11	2.36	0.69	0.77
Anxiety	7	2.40	0.93	0.87
COPE				
Active	3	3.14	0.61	0.53
Planning	4	3.22	0.55	0.53
Suppression	3	3.12	0.57	0.39
Restraint	3	2.92	0.62	0.43
Instrumental social support	4	2.82	0.69	0.65
Emotional social support	4	2.63	0.66	0.59
Reinterpretation	4	3.07	0.54	0.45
Acceptance	3	2.14	0.69	0.36
Religion	3	2.89	0.86	0.77
Denial	3	1.87	0.72	0.51
Behavioural disengagement	4	2.04	0.71	0.59
Mental disengagement	4	2.26	0.71	0.56
Substance use	4	1.25	0.58	0.81
Humour	4	1.64	0.60	0.59
Emotional	4	2.55	0.75	0.66
MHLC-A				
Internal health locus of control (IHLC)	6	26.71	5.03	0.78
Powerful others health locus of control (PHLC)	6	25.09	5.29	0.74
Change health locus of control (CHLC)	6	17.92	5.42	0.69
LOT	4	2.09	0.69	0.53
PTSD scale	11*	2.33	0.61	0.75

** Includes two scales of the HSCL-58 (depression and anxiety), the substance scale of the COPE and eight individual items of the HSCL-58. Three of these individual items are from obsessive-compulsive, one from somatisation, one from interpersonel sensitivity and the other three were filler items. The HSCL-58 consist of 45 items belonging to the five scales and 13 filler items.*

scored significantly higher on the scale than respondents who had indicated not to have experienced such losses ($t = -2.57$; $p = .015$). Concerning respondents who did not versus respondents who had **personal traumatic** experiences lu like **being ill treated by the militants** or the Sri Lankan army, the difference in scores on the PTSD scale was not significant. However, the difference between the mean scores of the two groups was 0.39 ($p = .123$), while the number of respondents with personal traumatic experiences was only 7. If this number would increase, the difference might be significant.

Sense of coherence was measured with the adapted Sense Of Coherence scale (SOC-13; 12). Following Antonovsky (1988), sense of coherence (SOC) consists of three components: *comprehensibility, manageability,* and *meaningfulness*. High-SOC has been shown to be related to effective coping, reduced stress, and improved somatic health (Antonovsky, 1988). It seemed to be an appropriate measure for refugees, especially since it was originally based upon the study of persons who had survived the concentration camps in World War II and did not experience adversary effects. However, the reliability of the SOC-13 turned out to be low (internal consistency was around 0.30). Furthermore, a factor analysis showed that although the scree-plot indicated that a five-factor solution would reflect the 'ideal' structure, as in the original SOC-13, the items were loading totally different across the extracted factors. As a consequence, it was decided to exclude the SOC-13 from the analyses reported here.

Translation method

In this study, a forward-backward translation method was used. This method incorporated the following steps. First, a bilingual person translated the original questionnaires from English to Tamil. Subsequently, a second person translated the Tamil version back to English. Third, another person compared the two English versions of the questionnaires to establish schematic equivalence between the versions. Fourth, when items were not schematically identical, the Tamil version was adapted and translated into English once again. In that case, the comparison of the English versions was repeated. This procedure ended when the back translated questionnaires were semantically identical to the original ones.

Results

Before the links between the various variables such as PTSD and health status were scrutinised, the health status as such was examined. As Table 2 shows, a substantial number of respondents scored high (score 3 or more; possible range 1 - 5) on the respective subscales of the HSCL-58. More than ten percent had somatic complaints like headaches, faintness or dizziness, pains in the heart or chest, and feeling low in energy or slowed down. Looking at Obsessive-Compulsive Behaviour, more than one-quarter of the respondents scored high on the respective scale. Examples of symptoms are 'Feeling blocked or stymied in getting things done', 'Having to check and

Table 2 HEALTH STATUS

HSCL-58 sales	Number of respondents with a score in the range moderately to extremely
Somatisation	6 (11.9%)
Obsessive-compulsive	14 (27.5%)
Interpersonal sensitivity	10 (19.7%)
Depression	8 (15.8%)
Anxiety	10 (19.7%)

Note: The number of respondents are presented in parentheses

double check what you do', and 'Difficulty making decisions'.

Interpersonal Sensitivity, which focuses on a person's feelings of inadequacy and inferiority with respect to communicating with others, was substantially present in nearly 20 per cent of the refugees. Two examples of items are 'Feeling critical of others' and Feeling inferior to others'. Finally, nearly 16 per cent scored high on Depression, whereas one in five reported to be anxious. When one takes a somewhat wider perspective by looking at the number of respondents that scored 2 or more on the subscales (answering positive on all the questions within a subscale, irrespective of severity), an even more serious picture emerges. More than 40 per cent (41.4) indicated to suffer from somatic complaints. For the other subscales the percentages were 66.7% for Obsessive-Compulsive Behaviour, 59% for Interpersonal Conflict, 58.8% for Depression, and 43.2% for Anxiety. These figures indicate that the health status of the refugees was poor. A possible cause might be that a sizable number of the respondents suffered from PTSD.

Post-Traumatic Stress Disorder (PTSD)

As stated earlier, PTSD is a delayed and/or protracted response to a stressful event or situation of an exceptionally threatening or catastrophic nature which is likely to cause pervasive distress in almost anyone. In the case of refugees the stressful events are mostly 'witnessing the violent death of others' and 'being the victim of torture and/or terrorism' (WHO, 1992). The criteria used in the ICD-10 (WHO, 1992)[13] for diagnosing PTSD are that the onset must be within six months or longer, the clinical manifestations must be typical, and no alternative identification of the disorder should be plausible. In addition, there must be a repetitive, intrusive recollection or reenactment of the event in memories, daytime imagery, or dreams. Finally, conspicuous emotional detachment, numbing of feeling, and avoidance of stimuli that might arouse recollection of the trauma are not essential for the diagnosis.

Nearly all refugees who participated in this study had been in India for four years or longer. This means that a possible onset within six months of the traumatic events could not be verified.

Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. Excessive use of alcohol or drugs may be a complicating factor.

Twelve percent of the respondents scored high (score 3 or more; range 1 - 5). This percentage was even 46, when a score of 2 or above (meaning 'a little bit to extremely'; score 1 means 'not at all') was used as the norm. A more detailed inquiry into the kind of traumas that the refugees had experienced was made by means of two open-ended questions. One question asked about personal loss, while the other was concerned with personal traumatic experiences . The answers are summarised in Table 3.

Forty-one respondents had experienced **any** personal loss, of which nine mentioned loss of property like a house.

Table 3 EVENTS THAT HAPPENED IN SRI LANKA

Event	Number of times event was mentioned
PERSONAL LOSS	
Ethnic conflict	20
Death /injury of relatives	13
Material loss	9
Husband vanished	2
PERSONAL TRAUMATIC EXPERIENCE	
Shot at	1
Tortured	1
Wounded	4
Threatened	1
Forced to join a freedom group	1
GENERAL FEARS	
Suspected of being a Freedom Fighter	1
Fear of brainwashing by Freedom Fighters	1
Threatened with removing child/relative	1
Massive rape in nearby village	1

Note: n=51

In addition, many respondents indicated that the fighting between Freedom Fighters and the Sri Lankan army, the bombing, the random violence on civilians, threats, and the subsequent general fear and feelings of not being safe, all summed under the heading 'ethnic conflict', were reasons for leaving their home-country. Furthermore, one fourth of the respondents mentioned the death of relatives. A few of them had actually witnessed the killing of these relatives. For instance, one women told that she saw how her oldest daughter was killed by a bomb. A person who had worked in a hospital in Jaffna had witnessed how his colleagues were shot, because they were suspected of giving treatment to members of Freedom Fighters. Five others had witnessed serious bombing by the Sri Lankan army. For example, someone had seen how the house in which more than 50 of his relatives were present at that moment, was bombed to pieces. Someone else still became in a total state of panic, when hearing the sound of a helicopter.

With regard to *personal traumatic experiences*, nearly one-fifth of the refugees reported a critical event. For example, one woman recollected that she and her nephew had been captured by a group of Freedom Fighters. This group told her that they had to run for their lives. When they did, the Freedom Fighters started to shoot at them. The woman got away, but her nephew, in total panic, ran towards the shooting militants. She assumed that the boy was shot dead. Another refugee told the following. A Freedom Fighter group suspected him of working for the government; so they captured him. Subsequently, he was lined up with others in an execution line. The person next

to him was shot in the head which caused his brains to come out. Just at the moment that the narrator would be shot, the army came. Apart from such events, a few respondents generated *general fears* which had made them decide to leave Sri Lanka. For instance, one person mentioned hearing about a nearby village where many women had been raped. Consequently, her father decided to go to India.

Apart from telling about past experiences, the refugees also talked about how they felt around the time of the interview. All the *negative* feelings mentioned are presented in Table 4. In addition, some important reasons for the negative feelings are stated as well. As someone said: "every one in the camp is in great distress". Feelings of depression, guilt, worrying, hopelessness, and helplessness were mentioned most frequently. These extreme negative feelings, assessed by the Depression scale of the HSCL-58, were connected with experiences of personal loss, traumas, and PTSD.

Quite a number of respondents mentioned that they were worried about their relatives and friends who were still in Sri Lanka and about family members who lived in other refugee camps. Another cause of worrying was the future. One-fifth said they felt depressed. One refugee even explicitly said that he preferred dying in Sri Lanka above staying in a refugee camp in India. Whereas five persons said they felt guilty either about leaving friends behind in Sri Lanka or because not being able to pay the funeral honours to a relative who died in Sri Lanka.

Relationships between PTSD, coping styles, optimism, locus of control, and mental health

In order to examine the relationships between (a) the different variables, viz. coping styles, optimism, PTSD, and health locus of control, and (b) health, stepwise multiple regression analyses were used. It should be mentioned that the coping style Substance Use was only used as an independent variable in the analyses on Depression and Anxiety, since this coping style was incorporated in a person's PTSD score.

Table 4 NEGATIVE FEELINGS MENTIONED BY RESPONDENTS

Psychological health	Number of respondents
Worrying	17
Being depressed	11
Guilt	5
Being hopeless	3
Feeling hopeless	2
Weeping	2
Suicide thoughts	2
Memories about the past	2
Upset during festival seasons	2
Distressed about events that happened in Sri Lanka	1
Not able to cope with continuing stress	1
Anxious when hearing a helicopter/ plane	1
Feeling worthless	1
Fear of freedom group	1

Note: n=51

The analyses showed that the only aspects that explained a significant part of the variance in scores on the Somatization scale were PTSD and IHLC (Fig 1).

Low scores on IHLC and high scores on PTSD appeared to go together with higher Somatization. High scores on PTSD, in turn, were predicted by degrees of dispositional optimism, less use of humour, more use of denial, and attributing one's health status to chance and not to powerful others.

Refugees with high scores on PTSD and Positive Reinterpretation and Growth reported more Obsessive-Compulsive Behaviour (Fig 2).

With Interpersonal Sensitivity as dependent variable, making use of the coping styles Denial, Focussing on and Venting of Emotions, Positive Reinterpretation and Growth, and Suppression of Competing Activities predicted a large part of the variance (68.3%; Fig 3)

In the next two analyses, concerning Depression and Anxiety, PTSD was obviously not included, because the Depression and Anxiety scales of the HSCL-58 form a part of the PTSD scale. Being pessimistic and denying that stressful events have happened, explained significantly scores on the Depression scale (see Fig 4). Finally, the coping style Denial was the only independent variable that explained a significant part of the variance of Anxiety (see Fig 5).

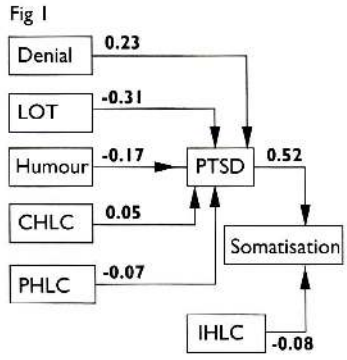
It is striking that the way in which people attribute their health (to themselves, powerful others, or chance) only played a direct role in somatization; not conceiving their own health status as being under their own control (low scores on IHLC) predicted 10.2 per cent of the Somatisation score. The other two attribution styles, however, played only an indirect role. Thinking that not powerful others but chance determines one's health status predicted a person's PTSD score.

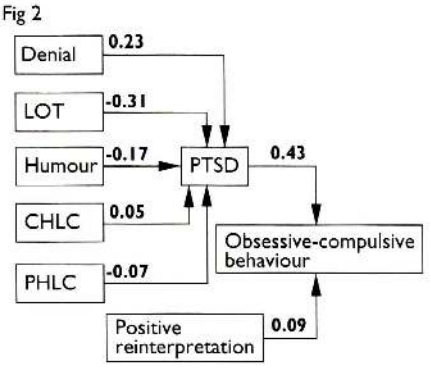
Another apparent finding is that using denial as a way of coping with stressful events, had a negative influence on health, either directly, as with interpersonal sensitivity and depression, or indirectly like with somatization and obsessive-compulsive behaviour. The same is true for being pessimistic (low scores on the LOT), with the exception of interpersonal sensitivity. However, a person's score on the Interpersonal Sensitivity scale was only predicted by four coping styles.

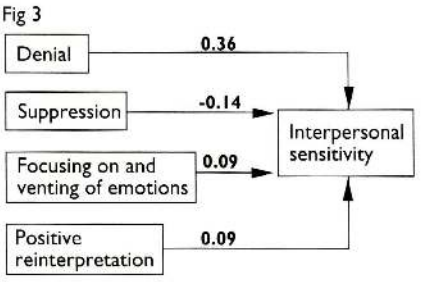
Up to now a number of aspects of the (mental) health status of refugees has been examined. However, health and negative feelings are in turn only one of the few aspects of quality of life (QOL).

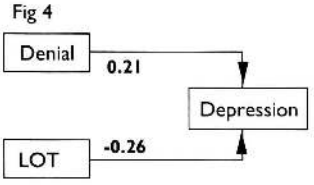
Quality of Life

As mentioned in the Introduction, WHO presently coordinates a cross-cultural study on quality of life assessment. In that study, quality of life consists of six domains: *viz.* Physical Health, Psychological Health, Level of Independence, Social Relationships, Environment, and Spirituality/ Religion/Personal Beliefs (WHOQOL Group, 1993). To get a preliminary idea about the importance of an add-on module for refugees, the issues mentioned









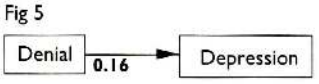


Figure 1 The relationship between health locus of control, PTSD, optimism, coping styles, and Somatization. The percentage of the variance in Somatization that was explained by PTSD and IHLC was 60.2%.

Figure 2. The relationship between health locus of control, PTSD, optimism, coping styles, and Obsessive-Compulsive behaviour. The percentage of the variance in Obsessive Compulsive Behaviour that was explained by PTSD and Reinterpretation and Growth was 52.3%

Figure 3. The relationship between health locus of control, PTSD, optimism, coping styles, and Interpersonal Sensitivity. The percentage of the variance in Interpersonal Sensitivity that was explained by Denial, Suppression, Focussing on and Venting of Emotions, and Reinterpretation was 68.3%.

Figure 4 The relationship between health locus of control, optimism, coping styles, and Depression. The percentage of the variance in Depression that was explained by Denial and LOT was 46.7%.

Figure 5 The relationship between health locus of control, optimism, coping styles, and Anxiety. The percentage of the variance in Depression that was explained by Denial was 16.3%.

by the refugees will be ordered according to the domains of quality of life (QOL) mentioned above. In this way, insight can be gained into the problem areas of quality of life within the camps. Table 5 shows that there are a number of problems in five out of the six QOL domains. Within the domain *Physical Health*, a number of problem areas emerged. For instance, respondents were either ill themselves or had family members who were ill. In addition, one-fifth of the refugees mentioned the lack of good basic needs such as water, food, and wood. That some respondents had sleep disturbances was already discussed in the section on PTSD. Within the WHOQOL-core instrument, *Physical Health* contains Sleep and Rest, Energy and Fatigue, and Pain and Discomfort. Only the first was mentioned by our respondents. The other two facets will also be relevant. However, a number of facets might have to be added. For instance, basic needs like food, wood, and water.

With respect to the *Psychological Health* of the respondents, only three persons made a positive remark. One said to be optimistic about the future, whereas someone else stated that worrying had no use. Another person reported that she derived a lot of pleasure in helping others. These aspects may be put under the heading Positive Feelings, which is one of the facets in this domain within the WHOQOL-core instrument. Negative feelings (another facet of the WHOQOL) were already mentioned in Table 4. It is our strong feeling that the facet Negative Feelings will have to be expanded in order to be able to encompass the broad range of negative feelings experienced by refugees. The other WHOQOL facets are self esteem, which is related to depression, and Body Image and Appearance. This last facet will not be very relevant for the refugees.

The domain *Level of Independence* consists of four facets within the WHOQOL-core instrument. Of these four (Mobility, Activities of Daily Living, Dependence on Medication or Treatment, and Working Capacity) none is really relevant for refugees. On the other hand, as Table 5 indicates, facets like Dependence on Drugs (such as alcohol) and Personal Space might be added.

Concerning *Social Relationships*, respondents were asked from which persons they got emotional support. Sixteen persons answered that they got support from friends and/or neighbours; one got support from elderly persons. Family members gave support to nine persons. It should be mentioned that some respondents received emotional support from friends/neighbours *and* family members. Eight persons said not to get any social support; for some this was by own choice. Financial help was given to 13 refugees; two of them received money from relatives living abroad. The WHOQOL-core questionnaire contains three facets with regard to social relationships: Personal Relationships, Social Support, and Sexual Activity. All facets seem very useful in relation to refugees, although the content of these facets will have to be expanded. For instance, concerning social support, contact with family members still in the home-country should be a useful addition.

In the *Environmental* domain two problems, mentioned by one-third of the subjects, were lack of money and educa-

tion. Concerning the former, this was not surprising when considering the fact that officially refugees are not allowed to work and the dole is very low (approximately $3 per family member). The problems regarding education are caused by the fact that refugees are not allowed to follow higher education. This was a major concern for many (former) students and their parents. Poor living conditions that people mentioned encompassed, among other things, housing and sanitation.

Table 5. Problems within the camps

In addition, five persons explicitly mentioned that one positive aspect of being in India was that one was safe in the camps, which was not the case in Sri Lanka. Most people only wanted to go back to Sri Lanka, when the fighting has been stopped. Until then, they expect not to be safe in Sri Lanka, because of the bombing and fighting and due to the fact that innocent people are still harassed by either the Freedom Fighters or the army. In spite of this, some refugees, although they said that they would not be safe in Sri Lanka, had registered to go back. They were doing this because they felt unhappy, helpless, depressed, and worried about relatives who had to stay in Sri Lanka. A number of respondents said that the Indian government was trying to force them to go back; directly, by means of harassment and saying that they should leave because they do nothing and eat for free, and indirectly, by deliberately delaying the dole. This situation of harassment by the Indian Government has started since the assassination of Rajiv Gandhi. Before that, the Indian people seem to have been supportive, sympathetic, and helpful. The core instrument of the WHOQOL contains the following facets: Physical Safety and Security, Home Environment, Financial Resources, Health and Social Care, Opportunities for Acquiring New Information and Skills, Participation in and Opportunities for Recreation/Leisure Activities, Physical Environment, and Transport. Only Physical Environment, meaning pollution, etc., will not be very relevant for refugees. The other facets mentioned, however, will be very important. In addition, adding a facet like Education and broadening the facet Home Environment with the inclusion of sanitation, might be very useful.

Table 5

Problems within the camps divided into domains of quality of life	No of persons
PHYSICAL HEALTH	
Health problems of family member/s	11
Poor basic needs	11
Health problems/valide	10
Sleeping disturbances	4
Sexual indulgence/promiscuity	4
Poor hygiene	1
PSYCHOLOGICAL HEALTH	
Whereabouts partner/relatives unknown	5
Negative feelings	see table 4
LEVEL OF INDEPENDENCE	
Alcoholism	4
Lack of privacy	4
SOCIAL RELATIONSHIPS	
Gossip by women	2
Lack of contact with family in Sri Lanka	2
Marriage against family wishes	1
Changing of social roles	1
All sorts of illegal/ immoral activities	1
ENVIRONMENT	
Lack of money	20
Education	16
Lack of (adequate) work	8
Climate (too hot)	8
Police harassment (insults)	6
Overcrowdedness	5
Poor living conditions	5
Inadequate treatment due to lack of money	4
Restrictions	3
False information about the situation in Sri Lanka	1
Little to do for women	1

Discussion

Quite a number of respondents had somatic complaints and/or problems with respect to their mental health. Especially obsessive-compulsive behaviour, being anxious, and the way in which the refugees communicated with each other, that is, their interpersonal sensitivity, were impaired. In addition, suffering from PTSD was a major predictor of somatic complaints and obsessive-compulsive behaviours. In turn, having a pessimistic view on life, denying that a stressful event has happened, not using humour as a way of coping, and attributing one's health status to chance and not to powerful others, predicted high PTSD scores to a very large extent (83.1%).

In general, it appeared that the way refugees coped with stressful events played a very substantial role in relation to their health status. The coping styles concerned were: (i) denying that a stressful event took place, which was related to three different aspects of health; (ii) reinterpreting the event positively which was related to two aspects of health; (iii) suppressing other activities in order to be able to focus completely on the stressful event; and (iv) focussing on and venting of emotions. Denial was positively related to interpersonal sensitivity, depression, and anxiety. Focussing on and venting of emotions was related to interpersonal sensitivity. The less refugees suppressed other activities, the higher their scores on interpersonal sensitivity. Finally, making use of positive reinterpretation and growth as a coping strategy was positively related to being more sensitive in interpersonal contact and showing more obsessive-compulsive behaviours. In short, using the maladaptive coping styles Focussing on and Venting of Emotions and Denial, and the adaptive coping style Positive Reinterpretation and Growth, and refraining from the adaptive strategy Suppression of other activities, predicted to a large extent (mental) health status.

Respondents themselves indicated that the events that happened back in Sri Lanka played a major role in their present physical and psychological health. Persons who have relatives living in Sri Lanka indicated that worrying about these loved ones caused anguish, negative feelings, and health problems.

Concerning the problems within the camps, it seemed that the quality of life of the refugees was affected in a large range of aspects covering all but one domain, Spirituality/ Religion/Personal Belief.

Future research

This study was only done with Tamils from Sri Lanka living in South India. Unfortunately, there is no reference point. It is not known how the health status of this group should be evaluated compared to, for instance, displaced persons within Sri Lanka or Tamils who still live in their own houses. A similar study within Sri Lanka could fill this void.

There appears to be a need for the WHOQOL-REF as a measure at the macro level and as a diagnostic instrument for use at the individual level. At the first level, the WHO-QOL-REF could be used as an indicator of the size of the problems that refugees have to face, on the basis of which adequate help could be offered. As a diagnostic instrument, the WHOQOLREF could be used to identify problem areas within the scope of quality of life. Then, when necessary, additional questionnaires that go thoroughly into the identified problem area should be used. Such an instrument does not yet exist[2], but will be useful and time saving. For instance, in the present study, respondents took at least one hour to fill in the questionnaires and half an hour for the interview. In the case of persons who could not read and write, the questionnaires took even more time. Another use of the WHOQOL-REF would be to evaluate interventions in terms of their effectiveness. In this case, the WHOQOL-REF should be used as a diagnostic instrument before and after an intervention

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WORKSHOPS

SUMMARY

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formerly Professor of Medicine, University of Jaffna

Introduction

The key objective of the workshops was to identify the extent of the health problems facing the Tamil community at large as a result of the ongoing turmoil in the homelands. It was envisaged that an open and honest discussion and an appraisal of the situation would result in the identification of key issues and highlight some proposals to alleviate the health situation of the "Victims of War".

The participants of the conference attended one of five workshops scheduled as parallel sessions. Each workshop was moderated by a team of facilitators and the output was presented in a plenary session by the lead facilitator (name in bold). Oral submissions made by selected individuals at some of the workshops and a few papers submitted to the conference by non-attendees are included as part of the outputs from the workshops. The focus of the workshops was to identify the scope of the problems in defined health related areas and to search for solutions to problems, either by enhancing existing practices or by targeting unmet needs.

WORKSHOP ONE

THE MENTAL HEALTH OF THE PEOPLE EXPOSED TO A VIOLENT ENVIRONMENT

Facilitators:

Dr (Mrs) S Parameswaran, – *Consultant Child & Adolescent Psychiatrist, Wexham Park Hospital, Slough, UK*

Dr. D. Somasundaram, – *Head of Dept of Psychiatry, University of Jaffna, Sri Lanka*

SCOPE OF THE PROBLEM

- The problem needs to be managed in the context of (a) the population in the North-East, (b) displaced population living in a culturally compatible environment eg camps in South India, (c) displaced population in an alien culture eg refugees in the West.
- The high prevalence of Mental Health problems in the Tamil community is well recognised. The impact of the war has been to significantly aggravate the problem, with the surfacing of problems for management in hitherto unrecognised groups.
- War has further confounded the long term management of the highly prevalent problem of schizophrenia amongst the Tamil speaking population.
- The migration of the population has resulted in the reduction of the extended and nuclear family support which has been the hallmark of Tamil society for generations. This has resulted in a small but significant increase in the presentation of the *elderly* with mental problems - especially acute and chronic confusional states. The management of the elderly will continue to be an ever increasing problem and needs special attention and focus.
- A substantial increase in the number of *children* presenting with a variety of problems; this included children of all ages. Symptoms suggestive of traumatisation and brutalisation were clearly identified.
- Sequelae to all forms of torture have been identified amongst the youth.
- The psychological consequences of displacement are probably the commonest and most under diagnosed mental health problem within the community. Many of the victims present with somatisation, making the underlying diagnosis extremely difficult.
- The problems of externally displaced communities in the West is a special problem and special attention needs to be paid to the management, with considerable involvement of health care workers who understand the cultural and behavioural characteristics of the community.
- The management of mental health problems has been significantly affected by the rapid deterioration in staff and facilities - eg only 1 psychiatrist in the North and one in the East. Shortage of psychiatric drugs has been further confounded by confiscation at checkpoints. The difficulties with transport has denied access to medical care.

PROPOSALS

- The key recommendation was that the target should be assistance to strengthen activities already in place rather than initiating new activities. To this effect the following projects/institutes need to be supported with personnel and financial assistance.

a) Shanthiham - The Association for Health & Counselling (page 138)

b) Multi-disciplinary Team for treatment of psychiatric patients.

c) Halfway home for psychiatric patients.

- The mental health of the externally displaced should be a focus of activity of relevant organisations (eg OFERR in South India; MIOT in UK).

WORKSHOP TWO

PHYSICAL DISABILITY, TORTURE AND REHABILITATION

Facilitators:

Dr. S. Sooriakumaran, – *Consultant in Rehabilitation Medicine, Queen Mary's University Hospital, London, UK*

Dr. (MRS) S. Theivendran, – *Hon Treasurer, Jaipur Foot Programme, Jaffna, Sri Lanka*

Mr. N. Kandasamy, – *Co-ordinator, Movement for Inter Racial Justice & Equality, Sri Lanka*

SCOPE OF THE PROBLEM

TORTURE

- Since 1979, approximately 10,000 people have been taken into custody (data from MIRJE). Detailed statistics on the various forms of torture and political assassinations are unavailable. The main reason for *torture* is to obtain confession.
- The type of torture varies according to the group involved (forces/freedom fighters). The severity varies from trivial forms to political assassination. Examples of physical torture range from burns, electrical shock, sexual assaults, suffocation, "dharma chakra" etc. Mental torture ranged from witnessing all forms of torture to the killings of relatives and family members.
- Only about 50% of the victims of torture undergo a medical examination. Some form of counselling is carried out, mostly by charitable organisations such as the church, "Shanthiham", University staff and the Centre for Women and Development. There is no formal or organised care for the victims and there is generally very little medical input to the care of the victims of torture. There is also inadequate legal redress and access to free legal aid.

PHYSICAL DISABILITY

- Special statistics on the prevalence of physical disability related to the war in the North and East are not available. The focus has been on physical disability resulting from the direct effects of the war (eg injuries due to bombing, land mines and explosion). However, it is important to note that during a violent political conflict, the infrastructure of the health services and basic human needs such as water supplies, sanitation, electricity and transport are disrupted resulting in increased disabilities of an indirect nature - neurological, musculo-skeletal, cardiovascular disorders etc.
- The primary care of the victims of the direct effects of war has been the acute management by the hospital related services and the excellent rehabilitation work of the JAIPUR FOOT PROGRAMME (page 44). The Jaffna branch of the Jaipur Foot Programme was inaugurated in 1987. It is now well established and provides prostheses (both upper and lower limbs), orthoses, physiotherapy, guidance and counselling and education and vocational rehabilitation - in essence a holistic approach to the rehabilitation of the victim.
- The work thus far has involved the supply of 1,073 lower and 79 upper limbs; callipers, surgical shoes, walking aids, splints, wheel chairs, tricycles and other rehabilitation aids from the orthotic workshops; employment projects for 77 persons and educational grants for 24 students.

PROPOSALS

TORTURE VICTIMS

- Raise awareness of issue through international organisations such as Amnesty International.
- Recognition and financial support for NGOs involved in counselling and care of torture victims - eg MIRJE, SHANTHIHAM.
- Identify and support a network of lawyers in Sri Lanka who will assist torture victims.
- Establish and financially support voluntary organisations in the North and East to assist rehabilitation of torture victims.

PHYSICAL DISABILITY

The conference recommended an enhanced support to the JAIPUR FOOT PROGRAMME.

The following short term needs were identified:-
1. 150 amputees awaiting prostheses,
2. Rs 3,000-5,000 per annum needed per person for self employment projects (approximately 380 individual projects)
3. Rs 750 per person for vocational rehabilitation
4. Rs 250 per person for educational grants
5. Rs 200,000 for an autoclave
6. Rs 200,000 for an ambulance
7. Rs 30,000 for foot moulds for the production of foot pieces
8. Rs 500,000 per year as administrative costs.

WORKSHOP THREE

ACUTE SERVICES ACCESS

Facilitators

Dr. A. Nageswaren, – *Formerly Senior Lecturer in Medicine, University of Jaffna, Sri Lanka*
Dr. (MRS) N. Kanagaratnam, –*Director, Teaching Hospital, Jaffna, Sri Lanka*
DR. J. S. Ehrlich,– *Paediatrician, New Jersey, USA*
DR. S. Shanmugathas, *Provincial Director of Health Services, NE Province, Sri Lanka*

SCOPE OF THE PROBLEM

The reduced availability of adequate acute services to the population of the North and East is a serious problem. It was felt by the conference that the focus has thus far been on the North but the situation in the East is considerably worse. Attendees were unsure of the position in the Vanni, Kilinochchi and Mannar areas.

The key areas for concern were identified as follows:
Shortage of trained medical and paramedical personnel.
Shortage of essential drugs and equipment.
Atrocious transport facilities for patients.

- **Personnel**

(see paper by Natchinarkinian; page 15)

There is a desperate need for trained and specialised medical personnel, particularly in surgery. Even graduates of the Jaffna faculty are reluctant to work in the North and East. There are no sub-speciality consultants - orthopaedics, thoracic surgery, neurosurgery, neurology and radiology.

The situation is even worse with respect to paramedical staff - radiographers, physiotherapists, midwives etc. Many of them are retirees on reemployment. Since there are no ongoing training programmes, there is no pool of trainees to tap into.

- **Drugs and Equipment**

Essential drugs are in short supply. The lack of electricity has meant that there are no appropriate storage facilities outside General Hospital, Jaffna (ie peripheral hospitals and for patients) for drugs such as Insulin. Anti-cancer drugs are unavailable and patients need to be sent under difficult conditions to Colombo for therapy.

Equipment identified to be of urgent need for General Hospital, Jaffna were autoclaves and sterilisers. For some specialised equipment, funds are available but there are no trained technicians to operate them.

- **Transport**

The grave position with respect to transport within the North has resulted in the denial of access to acute hospital care for seriously ill patients leading to fatal outcomes. There is an urgent need to provide care locally by resourcing peripheral hospitals and training health care personnel locally.

PROPOSALS

- Conference should urge the Government of Sri Lanka to:

— Meet the basic health care needs of the region

— Alleviate the transport difficulties of patients by lifting the fuel embargo and facilitation of free movement of people within the region

— Conference should appeal to the ICRC to extend their excellent effort in the North to involve the affected areas in the East.

— Action to be taken at the local level to involve and train indigenous practitioners in the management of acute services and train volunteers for paramedical work.

—The expatriate community should provide: - financial assistance towards a central fund (ideally linked to and administered by an NGO) to be utilised for training projects (as identified above); to provide assistance towards the transport of patients and towards the purchase of essential equipment.

—A concerted and coordinated effort towards trained medical and paramedical personnel to visit the North East on short term contracts to provide service and training assistance.

WORKSHOP FOUR

PUBLIC HEALTH AND COMMUNICABLE DISEASES

Facilitators:

Dr. R. Jayaratnam, –*Consultant in Public Health Medicine, UK*
Dr. C. S. Natchinarkinian, –*Lecturer in Community Medicine, University of Jaffna, Sri Lanka*
Dr. S. Sivayoham, – *Consultant in Public Health Medicine, UK*
Dr. M. Chandrakumar, –*Consultant in Public Health Medicine, UK*

SCOPE OF THE PROBLEM

Refer to papers by Natchinarkinian (pp15,) and Sivarajah (pp40)

- There has been a significant and serious decline of the basic health of the population in the North and East (eg increase in communicable diseases such as malaria and reduction in nutritional status). The decline in health status has been further confounded by the inadequacy of the provision of health care - shortage of Public Health workers, medical and paramedical personnel; damage to health care institutions in the rural areas; deteriorating sanitary facilities.
- Significant public health problems were identified also in the refugee camps in South India. Most of the

refugees were living in subhuman conditions with poor basic facilities; the conditions were aggravated by lack of an adequate income. The main health problems were identified as gastro-enteritis, including cholera; chest infections, especially in children; malnutrition; accidents; suicide; substance abuse; mental illness; dental problems.

The conference identified the following as key priorities for target: -

— Prevention of "preventable" diseases

— Improved nutrition

— Better sanitation and housing

— Improved maternal and child health care

PROPOSALS

- The conference was conscious of the fact that many of the medium to long term solutions are dependent on an integrated health care plan which needs to be designed and implemented with the relevant expertise and institutions from within the North East and overseas. Political stability is an essential prerequisite for the implementation of the plan. The following strategies and solutions were highlighted:

  1. Strategies for "preventable" diseases

  The key aim should be the control of malaria by relevant measures; an expanded Health Education programme with involvement in school curriculum; an aggressive immunisation programme.

  2. Improved nutrition

  Provision through NGOs of nutritious foods and education for staff and community on nutritional aspects of indigenous food.

  3. Better Housing and Sanitation Issues to be identified in the Health Plan:-

  Improved appropriate technology; better liaison with Public Health Engineers; provision of safe and clean water (special attention to desalination and bacterial contamination of present water systems); improved sewage disposal systems.

  4. Improved maternal and child health issues to be further defined in the Health Plan:-

  a) Maternal - institute risk assessment systems during pregnancy; prevention of anaemia; remedial actions for shortage of midwives and other professionals; health education for women.

  b) Children - Surveillance programmes; immunisation; nutritional programmes; special attention to mental health; health education in schools

The conference was of the opinion that in the short term a project be established with funds from the expatriate community and NGOs for the training of Primary Health Care workers. This could be instituted as an independent training programme outside the state sector.

WORKSHOP FIVE

HEALTH OF THE DISPLACED PEOPLE AND THE REFUGEES

Facilitators:

Dr. J. Henry, *Head of Food Science and Nutrition, Oxford Brookes University, Oxford, UK*

Mr. M. Ali Azeez, *Co-ordinator, Sri Lankan Muslim Refugee Assistance, Sri Lanka*

SCOPE OF THE PROBLEM

- The following health problems were encountered in the internally displaced population of the North and East.

  — Malnutrition was emerging as a serious problem in all age groups. There was a 30/40% reduction in age adjusted height and weight of children in the peninsula. There was an increased incidence of infants born with low birth weight. The prevalence of malnutrition was higher in those living in refugee camps.

  — Clinical evidence of vitamin deficiency has been documented in the region.

  — Malaria was a serious public health concern.

  — There was inadequate access to contraceptives. (Other associated health related problems have been identified in the output from the previous workshops.)

  —The poor living conditions and the rampant health problems of refugees living in the camps of South India were highlighted by several participants who had visited, and conducted surveys, in these camps.

  —-The sanitary conditions were appalling in many camps resulting in increased prevalence of diarrhoeal disorders and other infectious diseases.

  —Malnutrition is a significant problem; vitamin A deficiency and stunting of growth in children have been documented.

PROPOSALS

- Concerted action against malnutrition and vitamin A deficiency by NGOs.

  — Promote the distribution of retinol capsules. - Provision of Thriposha to all children and pregnant and lactating mothers.

  — Consider distribution of packaged premixed cereal food.

  — Technical advice and assistance for the cultivation of drought resistant food crops. Encourage the institution of home gardens to facilitate self sufficiency.

  — Financial assistance from expatriate community directly or through NGOs to target improvement in conditions in refugee camps.

  — Encourage coordinated visits by health care workers from expatriate community to assist in the management of the health problems of refugees, especially in South India.

SOCIO-PSYCHOLOGICAL MANIFESTATIONS AMONG TAMIL REFUGEES IN BRITAIN

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The World Health Organisation, definition of health is the state of complete physical mental and social well being, not merely the absence of disease or infirmity. To have the optimum capacity to control ones life, an individual needs a stable environment. There are thousands of people like, the Tamil refugees from Sri Lanka, who are unable to have any control over their health or well being due to the uncertainty about their future in Western Europe

Refugees flee with traumatic experiences of leaving their homeland at a time of political crisis, violence, oppression and war. When they come to an alien culture they can suffer high rates of mental disorders, especially among young people, due to a multitude of reasons. Mental health services in the UK are to a large extent fragmented. To give culturally appropriate care for the Ethnic minorities we need more research and understanding.

Concept of Health

The concept of health may differ due to the peoples culture, religious beliefs, environment and their way of life. But when a person has lost his/her identity, a place to live, state to care, authority to guide, friends to trust, institute to educate, place to worship and family to love, they can also loose the ability to think of themselves as valuable members of society.

Tamil community workers in London say that the increasing mental health problems among the Tamil refugees in the UK have led to various illnesses, distress and disabilities. The social change among the Tamil community is rapid and varies according to their outlook on life, the strength of the family structure, ties with their homeland and the ability to cope with the pressure of racism, sexism and unemployment.

The history of Tamils in UK to some extent is similar to that of the Asians in the Western countries. For instance the East African Asians who emigrated to the UK during the early 60s and 70s, it is only recently that problems related to their mental and physical health are surfacing due to the increased rates of hospital admissions for mental disorders. Statistically the rate of mental admissions due to mental illness is not clear. However various Asian community groups have expressed their concern about the escalating stress-related illnesses in their communities. Asian womens' group observations indicate that more Asian women suffer silently rather than seek help

Sri Lankan Tamils

Since the early 80's there have been many reports by various human rights organisations such as Amnesty International about the plight of Tamils in Sri Lanka[1]. The ethnic conflict still continues and yet there seems to be no way forward for a secure future for the Tamils in Sri Lanka or other countries where they are seeking political asylum. Human rights violations against Tamils in Sri Lanka are beyond anyone's imagination. Torture, rape, murder, abducting, looting and massacre continue unabated even though Article 11 of the constitution of Sri Lanka provides as one of the fundamental rights that,

> *"No person shall be subjected to torture or to creul, inhuman or degrading treatment or punishment"*

The Arrival of Tamil Refugees in the United Kingdom

The continued oppression of Tamils in Sri Lanka and the political chaos since 1958 has made about 500,000 Tamils seek safety around the world. Immediately after the 1958 violence a significant number of Tamil professionals who had English education came to the UK. Many of them were already familiar with the educational, political and social system of the United Kingdom and therefore settling in Western Europe was not a major problem for them.

The next group of Tamils who settled in the United Kingdom were the group of Tamils who came here as students and after having completed their further

education couldn't return home due to the political situation in Sri Lanka. This group of Tamils find it easier settling abroad in terms of finding jobs and housing.

According to recent reports there are 60,000 Sri Lankan Tamils in Britain and about 27,000 of them are refugees. The Tamil refugees who came during the mid 80s are mainly young males as the Sri Lankan government was hunting them down like animals in their homelands. Over 75% were under 25 years old and very few of them had families in Britain to care, advise and guide.

Many Tamils came here after a long term of suffering through the war against them by successive Sri Lankan governments. Many were in Sri Lankan prisons, persecuted and tortured. Also, many young Tamil groups had experienced horrendous injuries.

Many who came to the United Kingdom during 1986-1987, did not get any advice or help from the British government. Some were put in a 'prison ship', far away from London in Harwich and faced further humiliation. This group of young men came from various parts of the Tamil homeland in Sri Lanka and very few of them had Western education or any knowledge of the Western way of life. Therefore access to healthcare and support to prevent any mental stress were not available.

There is lack of research done on the health of Tamil refugees in the UK. One Tamil community group says that there are about 42 people with mental health problems who are treated at home and 38 of them are placed in hospital care in London. Most of the Tamil refugees live in the boroughs of Brent, Newham, Wandsworth, and Waltham Forest.

People living in London experience more mental health problems than people in rural areas. The resources are not enough and care in the community is not developed to give the service effectively.

According to reports there are less people from the Asian communities admitted to mental psychiatric care than Black people, but the true picture is not clear. Asians do not easily seek help for mental health problems. There are many causes for developing mental disorders[2]. Health professionals may think that Asian culture, family structure, strong religious beliefs and community spirit would help to have less mental illness. However, one can dispute this myth by saying that the above factors in fact can also act as the reason for mental illness among the Asian communities.

Most of the Tamil refugees have lived through war and lost the normalcy of life in their homelands and suffered various degrees of mental health problems. According to a study by Luxman and Selvaratnam from Jaffna University with 3-12 year old children, (1989) the potential for the development of mental health disorders in later life was discovered due to their experiences of living through a war [3]. This study was conducted over a period of one year. One hundred children (girls and boys) took part in the study. Some of their findings are as follows:

Received external injuries	77%
Witness to family members being injured	52%
Fear of darkness	83%
Moved to a place for safety	97%
Moved to a refugee camp	89%
Shell attacks	50%
Fear of army uniforms	37%
Fear of sleeping alone	58%
Lack of concentration while studying	59%
Less academic achievement	70%
Forgetfulness	64%
Behavioural disorders	83%
Anxiety	83%
Problems with sleeping	77%

The above study indicates that the increasing mental health problems among the Tamil refugees in London could possibly be high due to their experiences in Sri Lanka.

Racism and Health

Racism plays a major part in ethnic minorities' health and welfare in this country, particularly in a refugee's life when he is considered an unwanted person in the UK. The uncertain legal status and unfamiliar environment can lead some refugees into developing mental health problems.

Lack of social and historical knowledge about the ethnic communities can create difficulties in providing adequate services. Health professionals may hot have enough experience in dealing with Tamils who have mental health problems.

Getting help from the health professionals is not always easy or appropriate for the Tamils as they often consult with their elders in the family or at the temple and churches for illnesses. Most Asians, particularly Tamils believe that they have a very strong culture and feel that holding onto one's culture gives security and respect in the community.

Community workers in the Tamil community are helping a number of Tamil refugees in London who have post traumatic stress syndrome. Although a large number of Tamil refugees are making an effort to improve their lives regardless of their past experiences, social barriers sometimes hinder progress.

Tamil Family Structure

Most of the Tamil refugee women have to work to support their family in London. Large numbers of Tamil refugee women are bread winners in their family as they have lost their husbands, sons, and fathers in the war. There are over 15,000 widows in the Batticaloa District alone. They are working mainly in low paid jobs. In the UK the Tamil women often suffer from discrimination due to their colour, language problems, etc. Not being able to get jobs at the level of their educational standards can create feelings of worthlessness, unassertiveness and indecision.

As Stellman, J.M. stated, the human ego needs challenge and pride just as the human body needs nourishment and rest; failure to obtain such challenge and self-esteem is stressful [4]. Tamil refugee women work extra hard to repay their escape from Sri Lanka. This escape route, before it is

complete is fraught with difficulties like sexual abuse and physical hardship which often lead to stress and mental health problems.

Inter-Generational Conflict

Tamil refugee mothers often face conflict with their children who are going through a transitional period, particularly during adolescence. A large number of Tamil children who saw nothing but human rights violation often want to forget their past psychological trauma by cutting off from their past cultural roots.

The women are also worried about their refugee status in this country. Some of the Tamil refugees in Western Europe are having a difficult time with their children as the children are beginning to value the Western way of life above Eastern culture. Children are beginning to question their parents way of life, faith and culture.

Domestic Violence

Due to the cultural and religious barriers most cases of domestic violence cases among the Asian communities are not reported to the police. Therefore, there is no way of knowing the real numbers of domestic violence in Asian communities or the Tamil community in London. This issue has always been a taboo subject to talk about openly. Asian women's organisations suggest that the problem of domestic violence is escalating regardless of people's education, financial circumstances and religious beliefs.

Depression is often unreported and undiagnosed. Tamil refugee women in particular may not seek help until it is too late. Talking to her family about difficulties in married life or discussing the same with her children is not easy and she would keep it to herself until someone in the family noticed it. Recognising mental health problems and seeking help can alleviate further complications. Mental health problems make significant demands on the health service in the UK.

The Recommendations

- Encourage health professionals to have a better knowledge about Tamils and their cultural, socio-economic and religious backgrounds to provide culturally sensitive care for the Tamil people.
- Prevention of mental health is a key factor and appropriate intervention has to be explored.
- Health professionals should work with the Tamil community to prevent escalating alcohol misuse.
- Community groups should provide appropriate advice on education, employment, and medical services.
- Local authorities should provide venues for young Tamil refugees for leisure and entertainments.
- Counselling services should be provided for those refugees who have suffered from the trauma of war in Sri Lanka.
- Tamil community in London must work together to promote positive mental health among the Tamil refugees.

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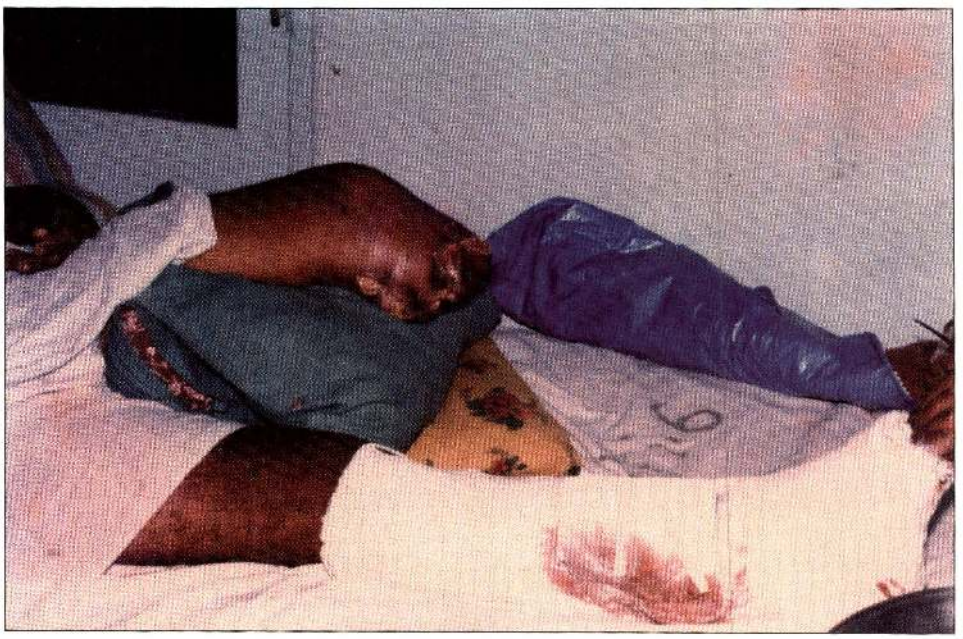

Photo C. — A shell blast victim who suffered a disruptive injury to his left leg and a fracture of the tibia and fibula of the right leg. Amputation of the left leg has been done.

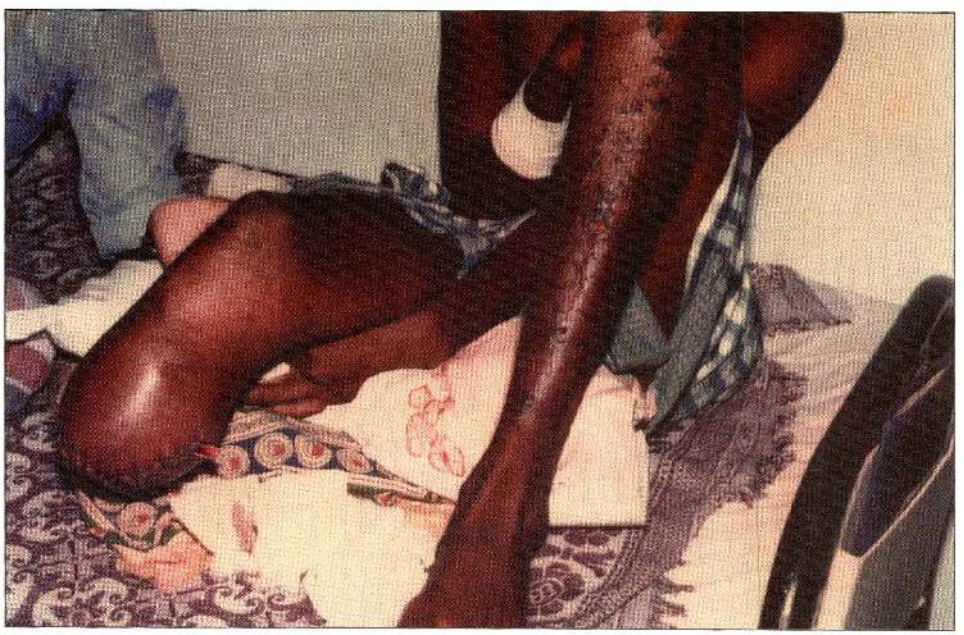

Photo D. — A victim of a small land-mine explosion, who sustained disruptive injury of the right leg is seen after amputation. Multiple healing lac-erations can be seen in his left leg.

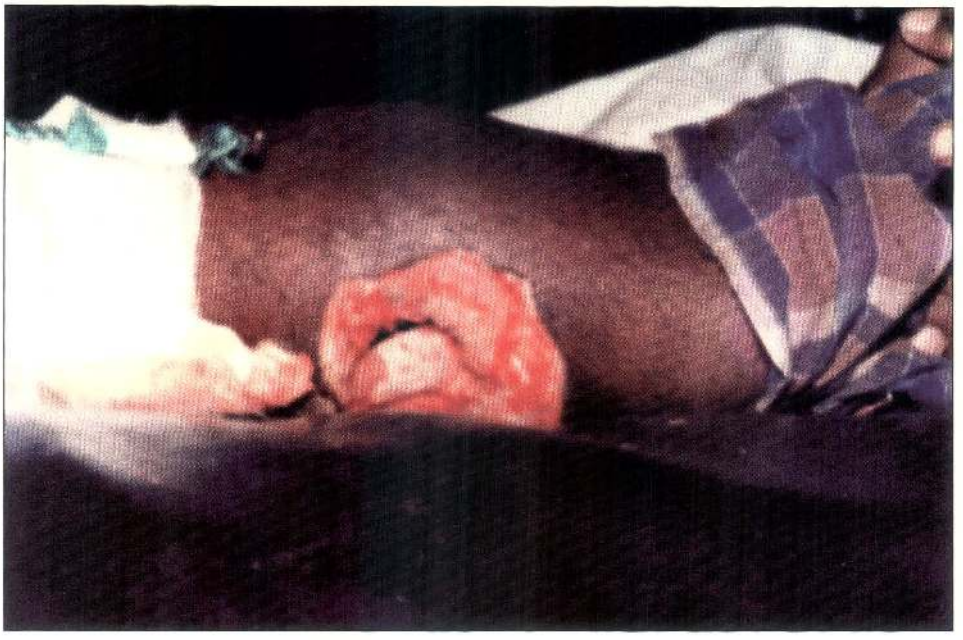

Photo A. — Deep penetrating wound of the left knee with a fracture of the lower end of femur and upper end of tibia, due to the shell blast at ward 20 of Jaffna General Hospital. The bone is visible. The Steinmann's pin inserted for traction of leg is also seen

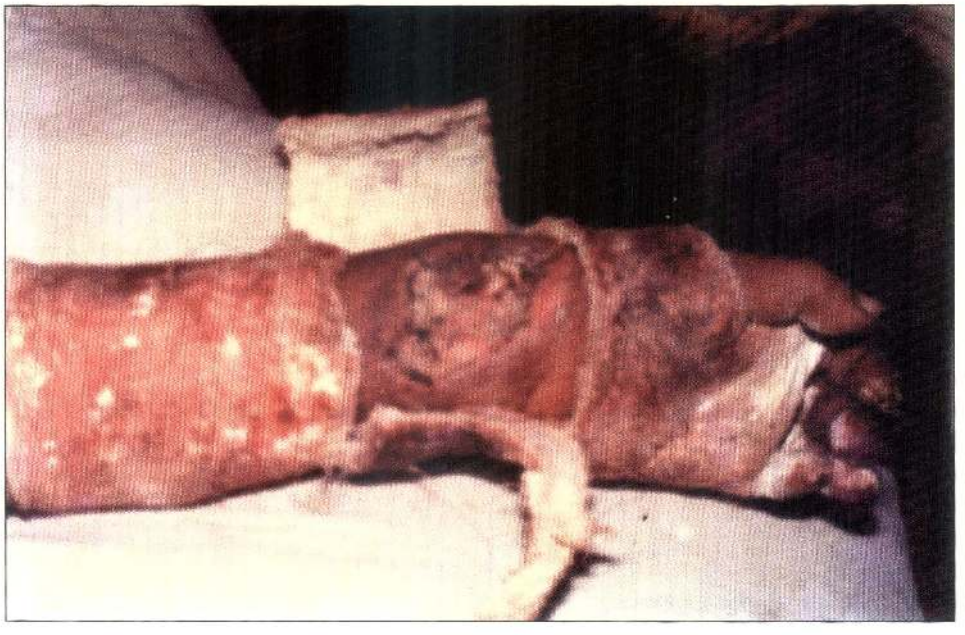

Photo B. — An infected deep penetration wound with a fracture of the lower end of the radius in the left forearm.

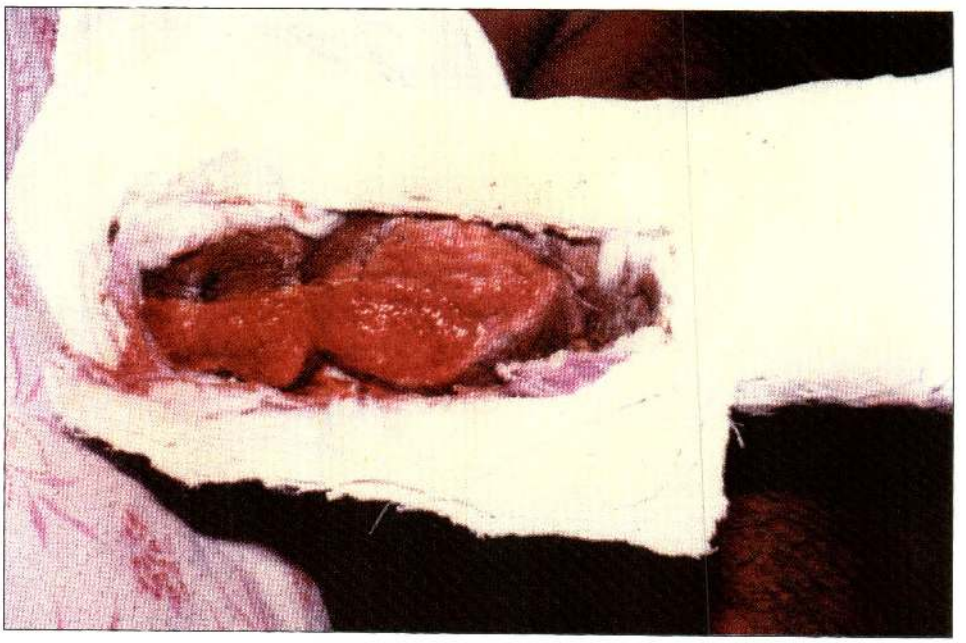

Photo E. — Extensive laceration of the right forearm of a hand grenade explosion victim. He had a comminuted fracture of the right ulna, amputation of the right little finger and laceration of the right arm.

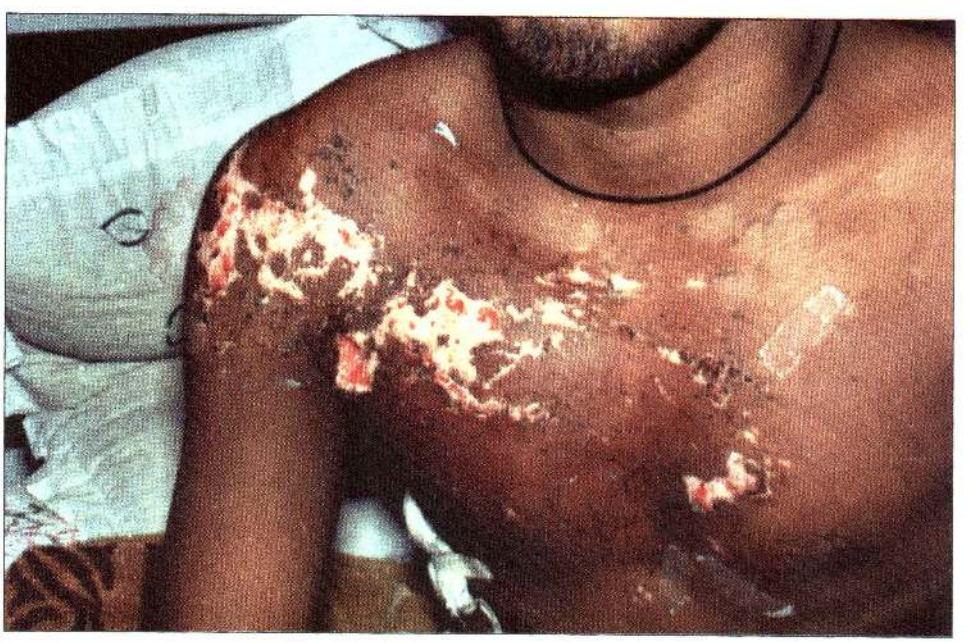

Photo F. — A victim of the shell blast, showing extensive laceration, abrasion and contusion - the characteristic triad.

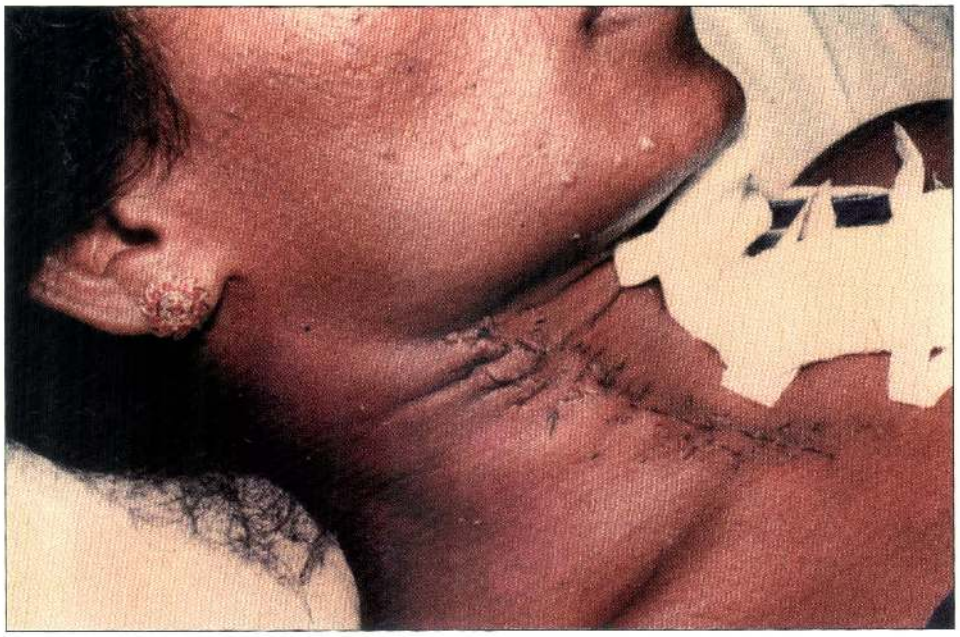

Photo G. — A victim of shell blast after surgery. She was approximately 25m away from the sight of the blast. She sustained a single penetrating injury at the right side of the neck which caused damage to the carotid artery.

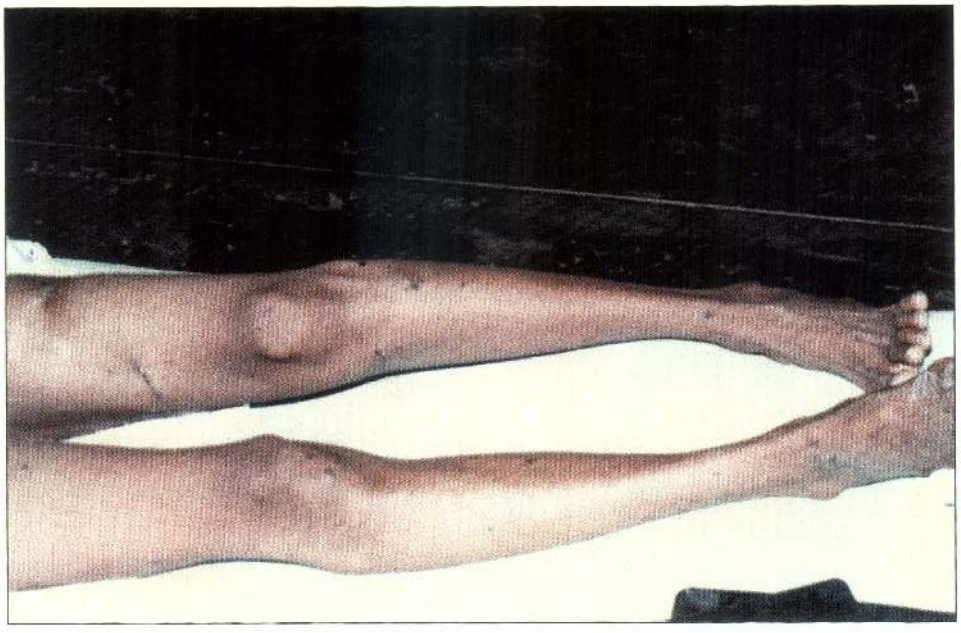

Photo H. — A victim of aerial bombing who sustained minor injuries due to falling masonry.

HEALTH STATUS OF TAMIL POLITICAL PRISONERS

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Introduction

This paper discusses the health status of Tamil political prisoners in Sri Lanka, in the light of the political history of the Sri Lankan Tamils and the current political situation in the country.Although it focuses on regulations framed under the Emergency, on the provisions of the Prevention of Terrorism Act and on its application to those who are placed under detention, the paper also documents the condition of detainees and the existence of undisclosed detention camps.

Background

The problems of contemporary Tamil prisoners are rooted in the political history of the Tamil struggle against Sinhala-dominated governments.The present crisis – and the immense suffering it has generated – culminates the repressive actions of the regimes that have successively ruled Sri Lanka since independence in 1948.

In 1948, the first such act of government repression effectively deprived the Tamil plantation workers who had resided in Sri Lanka for over a century of their citizenship. This was a tacit endeavour by the Sri Lankan government to reduce the strength of Tamil voters and to prevent them from claiming equal status.This legislation was followed by an amendment to the Elections Ordinance that deprived people of Indian origin of their rights in Sri Lanka.The plantation sector thereby lost seven of its representatives in Parliament, giving the majority Sinhalese political parties a dominant role in the future political environment.This action also paved the way for successive governments to adopt and implement chauvinistic and repressive measures without any regard for the aspirations of minorities.

The Sri Lankan ruling parties then initiated a state-sponsored Sinhala colonisation of the mainly Tamil areas of the Eastern and Northern Provinces, changing the demographic complexion of these two regions.Government measures to accelerate this colonisation affected the ethnic balance of these two regions and led to ethnic tension.

The death knell was sounded by the Sri Lanka Freedom Party government in 1956, when it declared through the Sinhala-Only Act that Sinhala shall be the official language of Sri Lanka.Public servants, large numbers of whom were educated Tamils, were thus required to become proficient in the Sinhala language.This legislation had a disastrous impact on the Tamils both in terms of employment and education, and became the most significant cause of hostilities between the communities. A non-violent campaign waged by the Tamil political parties to protest against this legislation was met by violence from state forces; shortly afterwards, the first of the anti-Tamil violence erupted.

Although attempts were made to redress the grievances of the minorities through treaties and pacts, such efforts were thwarted by chauvinistic elements within the ruling parties and the opposition.The policy of polarisation adopted by Sinhalese governments was manifest in 1971 in the national standardisation of education.This move prevented Tamil youths from entering institutions of higher education, thereby closing all means to employment in the government sector.

While Tamils expressed dismay and dissatisfaction over these issues, the coalition government of the day promulgated the new Republican Constitution of 1972. This document declared Buddhism the religion of the majority community and the state religion for the first time, thus undoing the secular character of the state.The 1972 Constitution also abolished the safeguards enshrined in the earlier Soulbury Constitution that prohibited the enactment of legislation detrimental to minorities.The gradual alienation of the Tamils led to greater ethnic polarisation and contributed to the rise of Tamil militancy.

The government of Sri Lanka responded to the emergence of Tamil militancy by resorting to state-sponsored violence, unleashing the armed forces and the police to perpetrate atrocities against the Tamils.The government deliberately took a hardline stance against the Tamil militants without recourse to conciliatory methods, enacting

repressive and draconian laws such as the Prevention of Terrorism Act, intended to be enforced for only one year but later made permanent law of the land.

Current Political Situation

The current political scenario emerged largely from the 1983 pogrom and its aftermath.The spate of violence sparked in July 1983 rendered many Tamils living outside the North-East destitute.The Sri Lankan government engineered the unprecedented level of violence unleashed against Tamils in 1983 throughout the country; prominent Cabinet Ministers were actively involved, giving directions to hoodlums and sections of the majority community that participated in the violence.The immediate effect of the 1983 violence was a mass exodus of Tamils into the Northern and Eastern Provinces and the flight of refugees into South India and Western and European countries. The violence also produced popular acceptance of Tamil militancy among mainstream Tamils and international recognition of the Tamil problem.

While on the one hand the government of Sri Lanka attempted to convince the international community that it favoured a negotiated settlement, on the other it beefed up its armed forces with the intention of suppressing the Tamils on the pretext of containing terrorism.The years between 1983 and 1987 saw a series of deliberations, discussions and parleys – both direct and through foreign mediation – fall apart due to lack of confidence, for which the Sri Lanka government was largely responsible. The internecine warfare among the various Tamil militant groups also retarded the liberation struggle.

The stalemate in negotiations, the sufferings of the people, the intensification of the military offensive in the North-East and the geopolitical implications of the conflict encouraged neighbouring India to intervene and force the Indo-Sri Lankan agreement of 1987 upon the Sri Lankan government.However, the Indo-Sri Lankan accord failed and the armed conflict between militant and government forces resumed in 1990 after fourteen months of unsuccessful negotiations. The problems of the Tamil minority in Sri Lanka remain unresolved and the violence and state repression continue unabated.

The Prevention of Terrorism Act

In the wake of an escalating Tamil militancy, the government of Sri Lanka promulgated the most repressive and draconian legislation, the Prevention of Terrorism Act No. 48 of 1979 (PTA).This legislation contains provisions repugnant to normal law and inconsistent with the tenets of democracy and the Rule of Law. The Act includes the following features which differ significantly from the provisions of other laws:

1. Arbitrary arrests were made permissible and justifiable. The unlimited powers conferred to law enforcement authorities and the state machinery were such that arrest and detention by the arms of the state could not be called into question in any judicial forum immediately after they occur.Mere suspicion was justifiable ground for any arrest, whereas normal law entitles a person to be informed of the reason for his or her arrest.

2. The amount of power vested with the arresting authorities precluded and curtailed the powers of the magistrate to deal with the question of any relief.Under normal circumstances the suspect should be produced before the magistrate within 24 hours of his or her arrest; under the PTA this time limit was extended to 72 hours initially, which could be followed by an order for a three-month detention issued by a person not below the rank of Assistant Superintendent of Police.Often such orders were renewed successively for up to eighteen months. Such deviation from normal law resulted in prolonged incarceration without trial.

3. The magistrate's power to grant bail was also curtailed.

4. Relatives and lawyers had no access to detainees during the first leg of their detention, as they could be held in any place that the arresting authority chose, such as police cells, army camps, or Special Task Force camps.Both the suspect and the family members endure psychological trauma during this period.

5. The trial under PTA is held without a jury and before a single judge.The admissibility of the confession of the suspect presents another deviation from normal law. The case proceeds against the suspect merely on the strength of the confession made to a police officer; such confessions are made invariably under duress, but the establishment of duress places an onerous burden on the part of defence.Under the Penal Code, in contrast, confessions are only admissible as corroboratory evidence.

6. The offences which could be tried under the normal laws of the country (the Penal Code) are being tried under the PTA when the alleged offenders are Tamils. As a result even a minor act of withholding information can subject a suspect to unduly harsh punishment.

Emergency Regulations

Although Sri Lanka has been ruled under Emergency for the last 17 years, the cumulative effect of these regulations are felt more by the Tamil people than by the general population.Some of the regulations under Emergency are framed mainly against Tamils, such as the mandatory registration of people from the North-East with the police.The condition of detainees can be arbitrarily regulated under the present Emergency laws, under which a suspect can be detained for three months without trial Emergency regulations 17/1, 17/2, 19/1 and 23/1 are some of the more obnoxious provisions affecting Tamil detainees. The Emergency regulations and the PTA are used to circumvent the time limit provided in normal regulations.The arrest and detention of Tamil suspects outside the North-East are made under Emergency regulations.

Present Situation of Tamil Detainees

The total number of detainees at Detention Camps and Rehabilitation Centres as of 13 September 1994 are:

Kalutura	67
Magazine	245
Trincomalee (Security Coordinating Unit)	240
Welikada	(female) 2
Batticaloa	80
Batticaloa Police	9
4th floor and other places	100

Health Status of Torture Survivors

The Family Rehabilitation Centre (FRC) is a non-governmental organisation in Colombo caring for victims of violence due to sociopolitical upheaval, regardless of race, caste or creed. These victims of violence include torture survivors and their family members, widows and children of war, and displaced persons living in welfare centres and elsewhere. FRC is an apolitical organisation. Personal communications with the Medical Officer (MO) of the organisation yielded the following information on the health status of torture survivors in Sri Lanka.

Since 1991 the MO has seen over 600 torture survivors.They include members of all communities in Sri Lanka, tortured by both state and militant armed groups. Most of the survivors seen at FRC had been tortured by state armed forces.The health status of these men and women depends on several factors: the type and duration of torture, the time lapse between torture and medical examination, their psychosocial prospects after release, and their age and other demographic features.

Torture survivors of all ages have been seen at FRC; the youngest was 17 years old and the oldest 62, but most were between 20 and 30 years old.Most of these people were men, but a few women were also seen. The torture survivors were mainly Sinhalese between 1987 and 1989, and mainly Tamil from 1990 onwards. Most of them were unemployed or self-employed.

These individuals have been subjected to a variety of painful and violent means of physical torture. They were blindfolded, and their hands and feet bound. They were assaulted with blunt objects such as batons, the butts of guns and S-lon pipes filled with cement. Beatings were administered to the soles of their feet, their joints, their chest and back, and to their heads, directly or after placing a book or a helmet on top to spread the force over a larger area.

Many were hung by their thumbs or feet and tortured by means of 'submarino'. Submarino includes both 'dry' and 'wet' methods: in the former, a shopping bag is placed over the head of the detainee and tied around the neck (chili or pepper powder is sometimes introduced as well); in the latter, the head is lowered into containers of (usually polluted) water. Such practice is continued to the point of suffocation, and asphyxiation is possible.

In the 'Dharma Chakra' method of torture, the subject's hands and feet were tied together and a pole was passed between the tied limbs and the body. The ends of the poles were placed on the edges of two tables, and the subject was rotated and beaten all over the body.

Various methods of sexual assault were also employed. These included the beating of the genitals, and the thrusting of bottles or other objects into the vagina. Young boys were repeatedly masturbated. Other methods of torture included slapping across the ears (known as 'telephone'), burning the detainee with lit cigarettes and pricking his or her nails. Torture survivors were also compelled to witness the torture and killings of other detainees.

Such torture was administered to the detainees in sessions that averaged three hours in duration. The total duration of torture experienced by those seen at FRC ranged from a few hours to three weeks; the average period was five days.

Between three months and five years had elapsed between the survivors' torture and their medical examinations at FRC.On average, torture survivors were seen at FRC three years after they had been tortured. At the time of their medical examinations, the torture survivors reported a number of complaints regarding their health. These include: chronic headache; weight loss; poor sleep and nightmares; poor appetite; chest and back pain; joint pain and pain in soles when walking; lifelessness and depression; easy annoyance and irritation; low sexual drive; poor vision; skin problems such as scabies and fungal infections.

The torture survivors have mixed psychological prospects for the future. Many report problems in their married life, and difficulties in obtaining employment and continuing their education. The threat of re-arrest, torture and death upon returning to their former residences is a significant concern. Much of their future psychological state depends on the attitude of fellow villagers towards the torture survivors; they need support from family, relations and friends.

The staff at FRC have taken a number of approaches to facilitate the recovery of torture survivors.These include medical screening and management, counselling, physiotherapy and relaxation therapy. FRC provides referrals for socioeconomic readjustment, self-employment and legal services, as well as skills training for self-employment. However, one can only expect a very slow recovery from the experience of torture. The torture experience creates long term problems of loss of confidence and difficulty with independent action in many survivors. The suffering undergone by these survivors should always be remembered in Sri Lankan political discussions.

INJURIES CAUSED BY BOMBS AND EXPLOSIVES IN JAFFNA DISTRICT

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Summary

63 cases who sustained injuries due to bombs and explosives were studied in the Jaffna District. There were 13 deaths and 50 survivors. Among the survivors, 12% were handicapped with the percentage loss of working capacity ranging from 5% to 60%.

82% of the total cases were victims of shell blast, while 14%, 2% and 2% were victims of aerial bombing, land mine and hand grenade explosions respectively. In every type of explosion, 75% of the victims were male, and the 16-30 age group was the most affected. While the majority of shell blasts took place between 12:00 midnight and 6:00 am, most of the aerial bombing occurred in the evening between 12:00 noon and 6:00 pm, and most of the land-mine and hand grenade explosions took place at night between 6:00 pm and 12:00 am. In the case of shell blasts, 50% of the victims were in the 4-10m range, while most of the victims of other explosions were within the 3m range.

All the cases sustained injuries due to flying missiles, while disruptive and flame burn injuries were seen in those within 3m of the explosion. Blast effect was seen in one person within 3m and in another in the 10-20m range. All the cases sustained soft tissue injuries while those who died suffered a relatively higher percentage of fracture and injury to vital organs. Most of the survivors suffered injuries to limbs, while those who died sustained injuries to the head and trunk.

Introduction

Injuries resulting from the explosion of bombs and other explosives are commonly known as 'blast injuries.' Such injuries can occur as a result of the explosion of bombs, land-mines, mortar or artillery shells, hand grenades, ammunition dumps, etc. Blast injuries have been increasing in Jaffna over the past few years, with a marked increase beginning in 1987. In fact, these injuries account for a considerable percentage of the unnatural deaths in the Jaffna Peninsula. This project was undertaken to study the pattern of injuries caused by bombs and explosives.

Methods and Materials

63 cases who sustained blast injuries and were admitted to the Jaffna General Hospital during a period of 8 days (23rd to 30th of March, 1987) were analysed. Among these 63 cases, there were 50 survivors and 13 deaths. Persons who died on the spot and were not brought to the hospital were excluded from this study, as were the 'disappearances.' Those who were treated in the Outpatients Department, in nursing homes and by general practitioners were also not included.

The data was collected by the history and examination of the patients, by interviewing the medical staff who attended on them and from patient investigation reports such as X-ray and case notes. In the case of deaths, data was collected from postmortem, coroner's and hospital police reports. The scene of disaster was visited in a few cases as when the explosions took place in the wards of Jaffna General Hospital.

Results

Among the 63 cases taken for analysis, 79% survived while 21% died. The deaths and survivors were analysed separately, and the significant differences between them are mentioned below.

Sex and Age Incidence
(Tables 1 and 2)

75% (47) of the cases were males, out of these, 36 survived and 11 died. Of the 16 (25%) female victims, 14 survived and 2 died.

Most of the victims fell within the 16-30 year age group. Among the deaths however, 39% occurred in the 31-45 year age group and 46% occurred among those over 46 years old.

Time of Disaster
(Table 3)

Nearly one-half of the incidents (49%) took place during the early hours of the morning, i.e. between 12:00 midnight

Table 1 SEX

Sex	Number of survivors	Number of deaths	Total number of victims
Male	36 (72%)	11 (85%)	47 (57%)
Female	12 (28%)	2 (15%)	16 (25%)
TOTAL	50 (100%)	13 (100%)	63 (100%)

Table 2 AGE

Age group	Number of survivors	Number of deaths	Total number of victims
0-15	4 (8%)	0 (0%)	4 (6%)
16-30	23 (46%)	2 (15%)	25 (40%)
31-45	10 (20%)	5 (39%)	15 (24%)
46-60	8 (16%)	3 (23%)	11 (1%)
Over 60	5 (10%)	3 (23%)	8 (13%)
TOTAL	50 (100%)	13 (100%)	63 (100%)

Table 3 TIME

Time	Number of survivors	Number of deaths	Total number of victims
12am - 6am	24 (48%)	7 (54%)	31 (49%)
6am -12 pm	12 (26%)	3 (23%)	16 (26%)
12pm - 6 pm	11 (22%)	3 (23%)	14 (22%)
6pm - 12am	2 (4%)	0 (0%)	2 (3%)

Table 4 AGENTS

Agent	Number of survivors	Number of deaths	Total number of victims
Shell blast	42 (84%)	10 (77%)	52 (82%)
Aerial boming	6 (12%)	3 (23%)	9 (14%)
Land mine	1 (2%)	0 (0%)	1 (2%)
Hand grenade	1 (2%)	0 (0%)	1 (2%)

Table 5 CAUSE OF INJURY

Cause	Number of survivors	Number of deaths	Total number of victims
Flying missile	50 (100%)	13 (100%)	63 (100%)
Falling masonary	16 (32%)	2 (15%)	18 (26%)
Disruption	2 (4%)	3 (23%)	5 (8%)
Blast	1 (2%)	1 (8%)	2 (3%)
Flame	1 (2%)	0 (0%)	1 (2%)

Table 6 SITE OF INJURY

Site	Number of survivors	Number of deaths	Total number of victims
Head	19 (38%)	8 (62%)	27 (43%)
Neck	4 (8%)	1 (8%)	5 (8%)
Upper limb	31 (62%)	9 (69%)	40 (64%)
Thorax	18 (36%)	10 (77%)	28 (45%)
Abdomen	13 (26%)	7 (54%)	20 (32%)
Lower limb	35 (70%)	9 (69%)	44 (70%)

and 6:00am. 26% occurred between 6:00am and 12:00 noon, while 22% took place in the afternoon between 12:00pm and 6:00pm.

Agents Which Caused the Blast
(Table 4)

During the study period, the majority of cases were victims of shell blasts (82%). 9 cases (14%) fell victim to aerial bombardment, among which 6 were affected by bombs dropped from aeroplanes and the other 3 by bombs dropped from helicopters. There was also one victim of a small land mine explosion, and one victim of an exploded hand grenade; both of these victims survived. Further details of the relationship between the agents which caused the blasts and other factors will be analysed separately.

Cause of Injury
(Table 5)

All victims sustained injuries due to flying missiles. 29% who were caught inside buildings had minor injuries like contusion, laceration and abrasion, due to falling masonry such as small concrete pieces, asbestos ceiling pieces, roof tiles and wooden pieces. 8% of the total number of victims sustained disruptive injuries; only 4% of the survivors sustained such injuries while as many as 23% of those who died suffered disruptive injuries. 3% sustained injuries due to blast effects, 2% had flame burns and 52% sustained injuries due to flying missiles.

Site of Injury
(Table 6)

Most of the victims sustained injuries to their limbs, *(see pictures A, B, C, D, E)* 70% to their lower limbs and 64% to their upper limbs. 45% sustained chest injuries *(picture F)* while 43%, 32% and 8% had injuries to the head, abdomen and neck respectively *(see picture G)*. When compared to the survivors, those who died suffered a higher percentage of injuries to the head, thorax and abdomen.

Type of Injury
(Table 7)

All victims, both survivors and those that died, sustained soft tissue injuries. Among the survivors 48% had bone injuries and 35% sustained injuries to nerves and blood vessels, 16% sustained lung injuries, while 14 %, 11% and 5% sustained injuries to abdominal viscera, brain and heart respectively. When compared to survivors, those that died suffered a relatively higher percentage of fractures and injuries to brain, lung, heart and abdominal viscera.

Table 7 TYPE OF INJURY

Site	Number of survivors	Number of deaths	Total number of victims
Soft tissue	50 (100%)	13 (100%)	63 (100%)
Nerves & vessels	15 (30%)	7 (45%)	2 (35%)
Fracture	17 (34%)	13 (100%)	30 (48%)
Abdominal viscera	5 (10%)	4 (31%)	9 (14%)
Brain	1 (2%)	6 (46%)	7 (11%)

Table 8 DISTANCE

Distance	Number of survivors	Number of deaths	Total number of victims
0 3m	10 (20%)	4 (31%)	14 (22%)
4-20m	24 (48%)	3 (23%)	27 (43%)
10-20m	5 (10%)	0 (0%)	5 (8%)
Over 20m	1 (2%)	0 (0%)	1 (2%)
Not known	10 (20%)	6 (46%)	16 (25%)

Table 9 DISABILITY

Age	Sex	Occupation	Amputation	% Loss of earning capacity
24yrs	Male	Tailor	Right forearm	60%
26yrs	Male	Preist	Right leg below knee	50%
27yrs	Male	Casual labourer	Right leg below knee	50%
45yrs	Male	Not known	Right index finger	10%
24yrs	Male	Not known	Right little finger	5%
20yrs	Male	Student	Third finger left hand	5%

Distance of Victims from the Blast
(Table 8)

43% of the victims were in the 4-10m range. 22% were within 3m of the blast and 10% were beyond 10m, while in 25% of the cases, the distance between the blast and the victims was not known. Among those who died, in 46% of the cases the distance between the victims and the blast was not known. In those cases where the distance was known, the majority of the victims were within 3m of the blast. Among the survivors, 48% were in the 4-10m range while the distance from the blast of 20% of the cases was not known.

The distance was measured in the following manner: The patient was asked to treat his bed as the point where he was at the time of the blast, and to treat another distant object as the point where the explosion took place. In all cases, the distance was judged by the author to minimise subjective error.

Disability
(Table 9)

12% of the survivors were handicapped, losing between 5% and 60% of their earning capacity. Disabilities suffered ranged from loss of finger to loss of leg below the knee to loss of arm below the elbow. No one suffered permanent loss of hearing or vision.

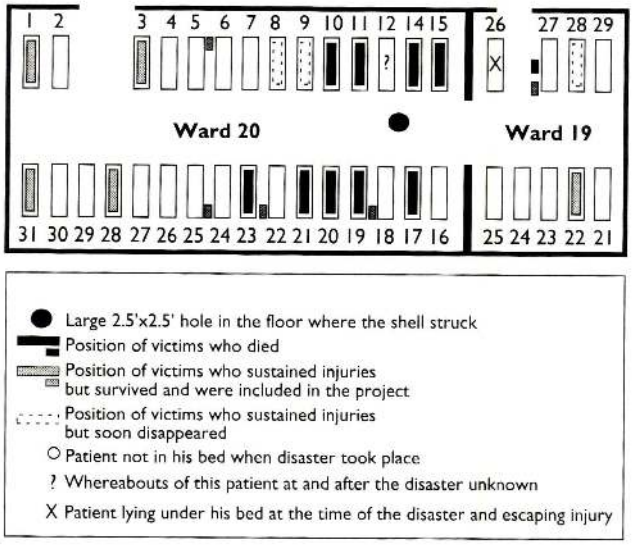

Figure 1: Blast at Jaffna General Hospital

Scene of disaster - Jaffna General Hospital

During the aerial bombing of the Jaffna town, Jaffna Hospital also became the target of the armed forces. The hospital building was damaged including the wards. In-patients were either killed or severely injured.

The scene of disaster with the positions of the victims in the wards of Jaffna General Hospital is shown here in Fig 1

Relationship between the different agents which caused blasts and other factors
(Tables 10-13)

In all of the explosions (shell blast, aerial bombing, land mine blast, hand grenade explosion), the 16-30 age group was the most affected.

While the majority of the shell blasts took place between 12:00 midnight and 6:00am, most of the aerial bombing took place in the evening between 12:00 noon and 6:00pm. However, both the land mine and hand grenade explosions took place at night between 6:00 pm and 12:00 midnight.

In the cases of aerial bombing, land mine explosion and hand grenade blast, most of the victims were within 3 meters of the explosion. In the case of shell blast, half of the victims were in the 4-10m range.

Most shell blast victims experienced all the effects of explosion except for flame burns. As the explosion here was not so severe, none experienced gross disruption, but some experienced dismemberment, decapitation or the mangling of a localised area. Blast effects in the lung were seen only in one case. Another victim complained of loss of hearing and tinnitus but improved later; when his ear was inspected, the tympanic membrane was red and inflamed but not ruptured.

The land mine victim experienced disruptive injuries and flame burns. He was the only victim to suffer direct contact with the explosion, and the only one who sustained flame burns (Table 4). An interesting aspect of his case was the discovery of a fine metal spring used for the land mine inside his body.

Table 10 AGE AND AGENT WHICH CAUSED THE BLAST

Age	Number of survivors				Number of deaths				Total number of victims			
	SB	AB	LM	HG	SB	AB	LM	HG	SB	AB	IM	HG
0-15yrs	3	1	-	-	-	-	-	-	3 (6%)	1 (11%)	-	-
16-30yrs	18	3	1	1	2	-	-	-	20 (39%)	3 (33%)	1 (100%)	1 (100%)
31-45 yrs	8	2	-	-	4	1	-	-	12 (39%)	3 (33%)	-	-
46-60yrs	8	-	-	-	2	1	-	-	10 (19%)	1 (11%)	-	-
Over 60 yrs	5	-	-	-	2	1	-	-	7 (13%)	1 (11%)	-	-

Table 11 TIME AND AGENT WHICH CAUSED THE BLAST

Age	Number of survivors				Number of deaths				Total number of victims			
	SB	AB	LM	HG	SB	AB	LM	HG	SB	AB	IM	HG
12am-6pm	24	-	-	-	7	-	-	-	31 (60%)	-	-	-
6am-12pm	13	-	-	-	-	3	-	-	13 (60%)	3 (33%)	-	-
12pm-6pm	5	6	-	-	3	-	-	-	8 (15%)	6 (67%)	-	-
6am-12pm	-	-	1	1	-	-	-	-	-	-	1 (100%)	1 (100%)

Table 12 DISTANCE FROM AND AGENT OF THE BLAST

Age	Number of survivors				Number of deaths				Total number of victims			
	SB	AB	LM	HG	SB	AB	LM	HG	SB	AB	IM	HG
0-3m	6	2	1	1	4	-	-	-	10 (19%)	2 (22%)	1 (100%)	1 (100%)
4-10m	23	1	-	-	3	-	-	-	26 (50%)	1 (11%)	-	-
10-20m	5	-	-	-	-	-	-	-	5 (10%)	-	-	-
Over 20m	1	-	-	-	-	-	-	-	1 (2%)	-	-	-
Not known	7	3	-	-	3	3	-	-	1 (19%)	6 (67%)	-	-

Table 13 CAUSE OF INJURY AND AGENT WHICH CAUSED THE BLAST

Age	Number of survivors				Number of deaths				Total number of victims			
	SB	AB	LM	HG	SB	AB	LM	HG	SB	AB	IM	HG
Flying missile	42	6	1	1	10	3	-	-	52 (100%)	9 (100%)	1 (100%)	1 (100%)
Falling masonry	14	2	-	-	2	-	-	-	16 (31%)	2 (22%)	-	-
Disruption	1	-	1	-	2	1	-	-	3 (6%)	1 (11%)	1 (100%)	-
Blast	1	-	-	-	1	-	-	-	2 (4%)	-	-	-
Flame burns	-	-	1	-	-	-	-	-	-	-	1 (100%)	-

Table 14 DISTANCE FROM THE BLAST AND CAUSE OF THE INJURY

Cause	Number of survivors					Number of deaths					Total number of victims				
	F/M	FM	D	B	FB	F/M	FM	D	B	FB	F/M	FM	D	B	FB
0-3m	10	4	2	-	1	4	1	1	1	-	52 (100%)	5 (28%)	3 (60%)	1 (50%)	1 (100%)
4-10m	25	5	-	-	-	3	1	-	-	-	16 (31%)	6 (33%)	-	-	-
10-20m	4	5	-	-	-	-	-	-	-	-	3 (6%)	5 (28%)	-	-	-
Over 20m	1	-	-	1	-	-	-	-	-	-	2 (4%)	-	-	1 (50%)	-
Not known	10	2	-	-	-	6	-	2	-	-	-	2 (11%)	2 (40%)	-	-

Note: Tables 10-13 SB= Shell blast, AB= Areial bombing, LM=Land mine, HG=Hand grenade.

Note: Table 14 F/M =Flying missile, FM= Falling masonry, D= Disruption, B = Blast, FB= Flame burns

Relationship of the distance of the victim from the blast and the effect of the blast. (Table 14)

Disruptive and flame burn injuries were seen in those within 3 meters of the explosion. Blast effect was seen in one person within 3 meters of the blast and in another person in the 10-20 meter range. Injuries due to flying missiles – composed of the triad of contusion, laceration and abrasion – and injuries due to falling masonry were mostly seen in those in the 4-10 meter range. *(see Photo H)*.

Discussion

In major explosions the identification of victims is an important problem but this is not so in this particular study as the explosions are relatively minor, even so, they occur very frequently creating 8 cases per day.

These injuries claimed the lives of 21% of the cases and 10% of the other cases became disabled. These facts illustrate the importance these disastrous incidents.

Among these disasters, a majority of the cases (83%) were victims of shell blast injuries. This emphasises the importance of preventative measures. In an ideal situation, one shouldn't expect bombing and shelling of the civilian population, but when this cannot be achieved, the next preventative step should be to protect the vulnerable civilians.

At the time of shelling and bombing, it is advisable to take shelter in a bunker or a trench. It has also been said that in an open space, those who lie flat in a prone position are less liable to get severe injuries than those who stand upright.

In this project, we have seen that 48% of those who sustained shell blast injuries were within half a mile from the place where the shells have been propelled, while 35% were in the 1 - 2 mile range. In some instances, the shell travelled as far as six miles. This illustrates that civilians living in a wider area around the war zone should be given protection by the warring parties. At the present rate of shelling and bombing in Jaffna District, there will be large scale civilian casualties. This study illustrates human suffering in a civil war.

There are certain shortcomings in this project, we have looked at only those cases admitted to Jaffna General Hospital.

Large numbers of civilians with minor injuries who were treated at the out patient department, and those we've treated at the private hospitals, district hospitals and by general practitioners were not included.

The Jaffna General Hospital was frequently targeted for aerial bombing and shelling. Civilians were frightened to come to hospital for treatment. Some of these injured civilians who were admitted for in patient treatment could not be followed up as they had 'disappeared' from the wards due to fear. This study grossly underestimates the extent of the problem in Jaffna District.

Photos: Dr. Kumaravet Pillai

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See colour illustrations between pages 65 and 66.

INTRODUCTION TO THE HEALTH SERVICE IN SRI LANKA WITH SPECIAL REFERENCE TO NORTHEAST PROVINCE

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Health Service is free at the point of delivery in Sri Lanka. There are good networks of medical institutions in the North East Province, National Health Service is complemented by private General Practitioners, private hospitals and indigenous medical practitioners.

At the outset itself it may be mentioned that even though Article 25 of the Universal Declaration of Human Rights states that,

"Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family, including food, clothing, housing and medical care...",

the constitution of Sri Lanka however does not provide for the acceptance of health as a fundamental right for all its citizens.

Yet with all the shortcomings, the government has signed with the World Health Organisation and the Charter for Health Development to provide health for all by the Year 2000 with primary health care as the key strategy.

The health services in the country are implemented at two different levels. One is the Preventive or Public Health Service while the other is the Curative or Medical Care Services.

Public Health Services (PHS)

The main function of the PHS is the prevention of communicable diseases and promotion of better health. This is carried out by maintaining satisfactory sanitary standards and through education in health affairs in schools, family health centres, and its enforcement of the Food Act which controls the sale of consumables to the public.

Certain diseases have also been made notifiable so that their spread may be limited and arrested completely. These diseases include polio myelitis, viral hepatitis, whooping cough, typhoid, dysentery, food poisoning, leptospirosis, malaria, tuberculosis, viral encephalitis, human rabies, measles and diphtheria.

This programme is implemented through 182 Health Units. Each Unit is headed by a Medical Officer of Health (MOH) who is assisted by Supervisory Public Health Inspectors (SPHI), Public Health Inspectors (PHI), Supervisory Public Health Nurses (SPHN), Public Health Nurses (PHN), Supervisory Public Health Midwives (SPHM), Public Health Midwives (PHM) and Family Health Workers (FHW).

Table 1 gives details regarding the population, area and density by provinces and district in Sri Lanka. Table 2 gives vital statistical details for Sri Lanka.

Manpower in the Public Health Service

Medical Officer of Health (MOH)

He is a Medical Officer (M.O.) who is trained in the implementation of the various programmes and campaigns under him.

Supervisory Public Health Inspector

A senior PHI who supervises other PHIs.

Public Health Inspector (PHI)

Undergoes training in all aspects of sanitation and prevention of communicable diseases and care of pre-school and school children, for a period of one and a half years.

Supervisory Public Health Nurse

A senior PHN who supervises other PHNs.

Public Health Nurse (PHN)

Under- goes the same training as the PHI's.

Supervisory Public Health Midwife

A senior PHM who supervises other PHMs.

Public Health Midwife (PHM)

Also referred as Family Health Worker (FHW) in the grass root level health worker for family care and provides a domiciliary service mainly for expectant mothers and infants. They maintain the link between the clinics and the community.

These officers are all trained at the National Institute of Health Services.

Table I POPULATION, AREA AND DENSITY OF PROVINCES AND DISTRICTS

Administrative area (province /district)	Land area (sq.km)		Percentage land area	Population	Population density persons per (sq.km)	Percentage distribution of population	Estimated mid-year population (in '000)
						1992	1993
SRI LANKA	64,652	100	14,846,750	230	100.00	17,405	17,613
Western Province	3,658	5.7	3,909,807	2,605	264.00	484,489	4,546
Colombo	652	1	1,699,241	506	114.00	1,994	1,999
Gampaha	1,399	2.2	1,390,862	554	94.00	1,543	1,578
Kalutara	1,607	2.5	829,704	354	56.00	952	969
Central Province	5,583	8.6	2,009,248	487	135.00	2,213	2,305
Kandy	1,891	2.9	1,048,317	164	71.00	1,257	1,313
Matale	1,988	3.1	357,354	401	24.00	423	435
Nurwara Eliya	1,704	2.6	603,577	36	42.00	533	557
Southern Province	5,513	8.5	1,882,661	101	27.00	2,268	2,260
Galle	1,674	2.6	814,531	86	55.00	958	945
Matara	1,246	1.9	643,766	220	43.00	786	784
Hambantota	2,593	4	424,344	165	29.00	524	522
Northern Province	8,685	13.4	109,404	1,072	75.00	1,322	1,346
Jaffna	2,072	3.2	830,552	994	56.00	979	1,001
Mannar	2,002	3.1	106,238	360	7.00	134	132
Vavuniya	2,645	4.1	95,428	180	6.00	6	117
Mullaitivu	1,966	3	77,189	341	5.00	93	96
Eastern Province	9,622	14.9	975,251	506	66.00	1,236	1,223
Batticaloa	2,465	3.8	330,333	128	22.00	425	420
Amparai	4,539	4	255,948	53	26.00	492	485
Trincomalee	2,618	4	1,704,334	39	17.00	319	318
North-Western Province	7,750	12	1,211,801	134	115.00	2,952	2,062
Kurunegala	4,773	7.4	492,533	96	82.00	1,445	1,454
Puttalam	2,977	4.6	849,492	254	33.00	607	608
North-Central Province	10,533	26.3	587,929	81	57.00	1,503	1,040
Anurahapura	7,129	11	261,563	82	40.00	728	720
Polonnaruwa	3,404	5.3	941,522	109	18.00	325	320
Uva Province	8,405	13	640,952	49	62.00	1,072	1,101
Badulla	2,818	4.4	640,952	246	43.00	716	738
Moneragala	5,587	8.6	273,570	77	19.00	356	363
Sabragamuwa Province	4,902	7.6	148,031	227	100.00	1,700	1,730
Ratnapura	3,239	5	797,087	102	54.00	948	954
Kegalle	1,663	2.6	684,944	402	46.00	752	776

Environmental sanitation for which the PHI is responsible, has two main aims. They are (*i*) clean potable water and (*ii*) proper toilet facilities for all by the year 2000.

Medical Care or Curative Services

Sri Lanka is provided with a large number of Medical Care Service Institutions although with varying facilities. It is claimed that a governmental, free western type health care unit can be found within three miles of one's dwelling. It should be noted here that this is only an average figure and that the true ground situation leaves much to be desired.

Since the devolution of power to the Provincial Councils, the responsibility of maintaining the health care units within provinces devolved on the respective councils. Health care institutions in Sri Lanka range from fully equipped Teaching Hospitals in towns to the simple Branch Dispensary (B.D.) or Visiting Stations (V.S.) in remote areas.

The different classes of Health Care Institutions are as follows:-

Provincial or General Hospitals

These are normally the largest hospitals in the provinces. All facilities available in these hospitals may vary according to the number of patients. But of late, after the opening of Universities in the provinces, and the consequent Medical Faculties in some of the provincial hospitals where medical students receive their practical training are called *Teaching Hospitals*

Base Hospitals (B.H.)

These are situated in important towns of a district far-away from the Provincial Hospital. There were 22 Base Hospitals in the island in 1992. The bed strength in these hospitals varied from 149 to 546. There is a wide variation of facilities available here. Although they must have specialised doctors in general medicine, surgery, obstetrics, paediatricians, eye, E.N.T., dermatology and cardiology, some base hospitals like Mannar, Vavuniya and Amparai function without any of these facilities though the minimum specialised services that should be available are in general medicine., surgery, gynaecology and paediatrics.

District Hospital

These hospitals are found in the more densely populated Assistant Government Agent or Assistant Divisional Secretaries areas of a district. These hospitals are headed by a District Medical Officer (DMO) and supported by a Medical Officer (M.O.), Registered/Assistant Medical Practitioners/ Officers, (R/A.M. P /O), Hospital Midwife and other supporting staff.

There were 125 D.H.H. in the country and the bed strength varied from 30 beds to 298. The D.H. at Tellipalai of Jaffna District had wards for psychiatric patients while the D.H. at Chavakachcheri also of Jaffna district had a T.B. ward. These two hospitals have been upgraded to Base Hospitals grade.

Table 2 VITAL STATISTICS BY DISTRICT

District	Crude birth rate 1991* (per 1,000)	Crude death rate 1991* (per1,000)	Maternal mortality rate 1988	Infant mortality rate 1988	Neo-natal mortality rate 1988
Colombo	25.7	6.8	0.2	24.6	17.1
Gampaha	15.0	5.3	0.0	14.9	11.1
Kalutara	17.4	5.3	0.3	15.4	9.8
Kandy	23.1	6.2	0.1	29.1	22.2
Matale	10.5	4.7	0.1	14.9	9.0
Nurwara Eliya	26.3	7.1	0.6	35.5	15.4
Galle	21.6	5.6	0.3	18.5	12.3
Matara	20.2	5.4	0.2	21.7	15.7
Hambantota	18.6	4.3	0.0	8.2	4.7
Jaffna/Kilinochchi	20.8	5.1	0.7	20.0	12.6
Mannar	22.9	5.5	0.7	16.9	7.9
Vavuniya	13.3	2.8	0.0	15.6	5.2
Mullaitivu	23.3	3.7	0.0	23.3	5.4
Batticaloa	26.9	7.2	0.8	8.5	5.6
Amparai	24.0	5.7	0.5	12.6	5.9
Trincomalee	17.7	3.3	1.2	9.3	5.2
Kurunegala	18.0	5.2	1.4	21.6	16.7
Puttalam	21.9	5.4	0.7	14.3	9.1
Anurahapura	22.0	4.5	0.5	24.9	18.6
Polonnaruwa	21.6	4.5	0.5	11.3	4.3
Badulla	26.3	5.2	0.5	24.2	17.0
Moneragala	20.7	3.2	0.4	7.0	4.1
Ratnapura	23.0	4.7	0.6	26.0	10.1
Kegalle	14.9	4.7	0.0	12.4	9.1
Sri Lanka	21.0	5.6	0.4	20.2	14.0

Peripheral Units (P.U.)

These hospitals are headed by an M.O. and supported by R/A.M.P/O, Hospital Midwife and other staff. These hospitals have separate wards for general practice, and maternity cases.

There were 122 P.U.U. in the country with a varying bed strength from 24 to 79.

Rural Hospitals

These hospitals are headed by an R/A.M.P/O and supported by a Hospital Midwife and other staff, but these hospitals do not have separate maternity wards.

There were 118 R.H.H. with bed strengths varying from 6 to 48.

Central Dispensaries and Maternity Homes

These institutions are headed by an R/A.M. P/O with the help of a Midwife and other supporting staff. But only out-door patients are treated here, but they provide in-patient treatment for maternity cases. A few of them had general practitioner ward for females. These institutions are generally under utilised. There were 877 institutions with the bed strength varying from 8 to 16.

Central Dispensaries (C.D)

There were 350 C.D's, headed by an R/A.M.P/O and helped by a Pharmacist or Dispenser along with a Sanitary Labourer and Watcher. They provide only out patient treatment for minor ailments, dressing of wounds, minor injuries and conduct family clinics also.

Branch Dispensaries or Visiting Stations (B.D/V.S)

These are located in remote areas where the population is small and does not justify the posting of a permanent resident medical team. The R/A.M. P/O of the closest C.D visits such places once or twice a week taking some important drugs to treat minor ailments, injuries and wounds.

Specialised Services and Institutions

Dental Health Services:-

The whole country is divided into 12 regions for this purpose, and the dental service in each region is planned and co-ordinated by the Regional Dental Surgeon. There were 381 Dental Surgeons.

There are Dental Clinics in all the hospitals. In addition to these there are 10 Adolescent Dental Clinics located in bigger schools providing treatment to children over 13 years.

There are Dental and Maxillary Surgeons attached to Teaching and General/Provincial Hospitals. There are 14 Dental and Maxillo-Facial Surgery Clinics in the country. The best equipped dental hospital is in Colombo - the Dental Institute. Apart from these there is also the School Dental Service providing preventive and curative care to children between 3 and 13 years. There are 310 such School Dental Service Clinics with 443 School Dental Therapists serving in these clinics.

Mental Hospitals

Mental patients are treated at two hospitals - Angoda and Mulleriyawa -(total bed strength of 1820). Some of the Teaching Hospitals, Provincial Hospitals and Base Hospitals have psychiatric wards.

Tuberculosis

Special sanatoriums are provided to treat T.B. Patients.

There were 21 Chest Clinics, one Chest Hospital at Ragama, and 15 T.B. wards in the general institutions.

Leprosy

There are two asylums that provide treatment for Leprosy. At Hendala (near Colombo) and Mantivu (an island off Batticaloa).

Cancer

Advanced Cancer cases are treated at Homagama Cancer Hospital, about 15 kms away from Colombo. Cancer at the initial stages of Cancer are treated in the large institutions of the Provinces. There are three Cancer Units at Jaffna, Kanday and Galle - and two Cancer Clinics at Anuradhapura and Kurunagala. *The Jaffna Cancer Unit is not functioning due to Army occupation.*

Rheumatology and Rehabilitation Hospital

The hospital at Ragama is the only hospital of its kind in Sri Lanka and it caters to the treatment of acute and chronic rheumatological disease. This hospital also caters to the treatment of neurological diseases, myopathies, paraplegia and quadriplegia patients, orthopaedic conditions, amputees and those requiring aids and appliances.

In Sri Lanka the various curative medical care institutions are utilised in various degrees, some being over utilised and some being under utilised. In the over utilised institutions it is usual to find a number of patients lying on the floor and thus are called floor patients.

Table 3 gives details of utilisation of the various institutions. It may be assumed that due to patient pressure, and better treatment the duration of stay in the larger institutions is shorter than the other institutions.

Manpower in the Medical Care Services

In Sri Lanka curative health is provided by personnel who have received training varying in depth and periods. Thus we have:-

Table 3 UTILISATION OF MEDICAL INSTITUTIONS BY DISTRICT — 1992

District	Teaching hospitals			Provincial hospitals			Base hospitals			Districts hospitals			Peripheral hospitals			Rural hospitals			CD and Maternity hospitals		
	Duration of stay	Bed turnover rate	Occupancy rate	Duration of stay	Bed turnover rate	Occupancy rate	Duration of stay	Bed turnover rate	Occupancy rate	Duration of stay	Bed turnover rate	Occupancy rate	Duration of stay	Bed turnover rate	Occupancy rate	Duration of stay	Bed turnover rate	Occupancy rate	Duration of stay	Bed turnover rate	Occupancy rate
Jaffna	6.2	60	102	-	-	-	5.2	56	80	4.1	59	67	4.1	58	65	5.3	35	51	3.5	21	20
Mannar	-	-	-	-	-	-	4.1	48	54	1.4	17	67	4.0	56	62	4.1	36	38	4.0	4	7
Vavuniya	-	-	-	-	-	-	5.0	5.0	35	-	-	-	4.6	90	113	-	-	-	4.3	41	48
Mullaitivu	-	-	-	-	-	-	-	-	-	4.5	196	245	5.3	65	95	-	-	-	-	-	-
Batticaloa	-	-	-	5.6	4.8	75	-	-	-	3.0	47	39	2.6	89	63	4.4	118	142	-	-	-
Amparai	-	-	-	-	-	-	4.3	72	86	2.6	95	67	3.6	96	95	3.7	49	49	3.8	4	3
Trincomalee	-	-	-	-	-	-	2.9	74	60	3.5	111	108	5.6	71	109	5.4	122	122	4.8	15	17
TOTAL	5.6	62	95	5.5	72	107	4.3	78	91	3.2	70	61	3.0	81	66	3.5	55	55	3.9	12	13

Source: Sri Lanka Medical Journal

Table 4 DISTRIBUTION OF PARAMEDICAL STAFF BY DISTRICT — 1st SEPTEMBER 1992

District	Public health midwives		Hospital Midwives		Pharmacists		Dispensers		Medical laboratory technologists		Radiographers		Physiotherapists		Attenders	
	No	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No	Rate	No	Rate	No	Rate
Jaffna/Killinochchi	88	9.0	57	5.8	50	5.1	36	3.7	22	2.2	3	0.3	5	0.5	223	22.8
Mannar, Vavuniya, Mullaitivu	41	12.0	13	3.8	8	2.3	17	5.0	3	0.9	2	0.6	-	-	81	23.6
Batticaloa	67	15.8	26	6.1	11	2.6	10	2.4	7	1.6	3	0.7	1	0.2	166	39.1
Amparai	114	23.3	48	9.8	9	1.8	27	5.5	6	1.2	2	0.4	-	-	108	22.0
Trincomalee	24	5.0	19	6.0	5	1.6	19	6.0	3	0.9	1	0.3	1	0.3	440	12.5
Sri Lanka	4108	23.6	2025	11.6	582	3.3	641	3.7	579	3.3	263	1.5	175	1	5710	32.8

Source: Sri Lanka Medical Journal

Table 5 DISTRIBUTION OF PARAMEDICAL STAFF BY DISTRICT — 1st SEPTEMBER 1992

District	Medical officers (curative services)		Medical officers Admin, and Prev. services		Dental surgeons		Registered assistant medcial officers		Nurses		Medical officers of health		Public health nursing sisters		Public health inspectors	
	No	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No	Rate	No	Rate	No	Rate
Jaffna/Killinochchi	89	9.1	7	0.7	21	2.1	67	6.8	4.2	41.4	3	0.3	1	0.1	13	1.3
Mannar, Vavuniya, Mullaitivu	12	3.5	2	0.6	3	0.9	34	9.9	56	16.3	2	0.6	-	-	-	-
Batticaloa	35	8.2	3	0.7	8	1.9	27	6.4	190	44.7	-	-	-	-	24	5.6
Amparai	17	3.5	-	-	4	0.8	51	10.4	160	32.5	3	0.6	-	-	29	5.9
Trincomalee	13	4.1	1	0.3	5	1.6	26	8.2	87	27.3	-	-	-	-	21	6.6
Sri Lanka	2979	17.1	181	1	381	2.2	1253	7.2	11214	64.4	185	1.1	113	0.6	864	5.0

Source: Sri Lanka Medical Journal

Specialists

They are Medical Officers who have specialised in fields chosen by them.

Medical Graduates With Diplomas

They are Medical Officers who have undergone post-graduate training and obtained M.D., or MSc or Diploma Certificates.

District Medical Officers

They are Senior Medical Officers and are in charge of District Hospital or Peripheral Units.

Medical Officers

They are medical graduates - M.B.B.S.- after completing their one year period of internship under senior doctors.

House Officers

They are medical graduates during their period of internship.

Registered Medical Practitioner/Officer

They are Assistant Medical Practitioners after a period of 15 years service.

Assistant Medical Practitioner/Officer

They undergo training in all branches of curative treatment but is limited to a period of three years. The standard of education required at the time of admission is also lower than that of Medical Graduates.

Hospital Midwife

A P.H.M. or F.H.W. attached to hospitals.

Medical Personnel

The following tables (Tables 4,5,6) give details of key health personnel, paramedical staff and specialists serving in the North-Eastern Province of Sri Lanka.

Table 6 DISTRIBUTION OF SPECIALISTS BY DISTRICT — 1st SEPTEMBER 1992

	Districts							
	Jaffna	Mannar	Vavuniya	Mullaitivu	Batticaloa	Amparai	Trincomalee	Sri Lanka
General physicians	3	-	-	-	1	-	1	78
General Surgeons	2	-	-	-	-	-	1	68
Obstetricians /Gynaecologists	4	-	-	-	1	-	1	72
Cardiologists	-	-	-	-	-	-	-	7
Neurologists	-	-	-	-	-	-	-	6
Dermatologists	-	-	-	-	-	-	-	9
Rheumatologists	-	-	-	-	-	-	-	5
Psychiatrists	1	-	-	-	-	-	-	24
Paediatricians	3	-	-	-	-	-	-	41
TB & Chest Physicians	-	-	-	-	-	-	-	7
ENT Surgeons	1	-	-	-	-	-	-	14
Eye Surgeons		-	-	-	-	-	-	26
Paediatric Surgeons	-	-	-	-	-	-	-	6
Orthopaedic Surgeons	-	-	-	-	-	-	-	9
Plastic Surgeons	-	-	-	-	-	-	-	3
Genito-urinary Surgeons	-	-	-	-	-	-	-	4
Neuro Surgeons	-	-	-	-	-	-	-	2
Thoracic Surgeons	-	-	-	-	-	-	-	5
Anaesthesiologists	-	-	-	-	-	-	1	39
Pathologists	1	-	-	-	-	-	-	18
Bacteriologists /Microbiologists	-	-	-	-	-	-	-	6
Biochemists	1	-	-	-	-	-	-	7
Radiologists	1	-	-	-	-	-	-	18
Veneriologists	-	-	-	-	-	-	-	6
Radiotherapists /Oncologists	-	-	-	-	-	-	-	12
Others	-	-	-	-	-	-	-	6
TOTAL	21	-	-	-	2	-	4	496

Source: Sri Lanka Medical Journal

Curative and Preventive Services

Table 7 Summarises the major services (curative and preventative provided at different medical institutions-excluding General Hospitals).

Table 8 Summarises the major preventive activities to control illnesses of public health importance.

Table 7 HEALTH SERVICE PROVISIONS

Major services	Projects				
	BH	DH	PU & RH	CD & MH	CD
Out-patient care	+	+	+	+	+
In-patient care	+	+	+	+	-
Antenatal care	+	+	+	+	+
Natal care	+	+	+	+	-
Post natal care	+	+	+	+	-
Infant care	+	+	+	+	+
Pre school care	+	+	+	+	+
Family planning care	+	+	+	+	+
Immunisation care	+	+	+	+	+
Control of communicable diseases	+	+	+	+	+
Screening for non-communicable diseases	+	+	-	-	-
Management of minor ailments	+	+	+	+	+
Simple rehabilitation	+	-	-	-	-
Mental health care	+	-	-	-	-
School health	+	+	+	+	+
Oral health care	+	+	-	-	-
Occupational health care	+	-	-	-	-
Prevention of blindness and visual care	-	-	-	-	-
Health education	+	+	+	+	+
Screening for TB	+	+	+	+	-
Screening for Malaria	+	+	+	+	+
Screening for Filaria	-	-	-	-	-
Provision of laboratory services	+	+	-	-	-
Screening for STD	+	+	+	+	-
Radiological examination	+	-	-	-	-

Table 8 HEALTH SERVICE PROVISIONS

Major services	Service delivery activities
School health	1. School medical inspection 2. Correction of defects detected 3. School santitation 4. Control of communicable diseases 5. School HE programme 6. School intervention
Port health work	1. Enforcement of international quarantine regulation 2. Grant of pratique 3. Provision of vaccination
Malaria	1. Screening for Malaria cases 2. Treatment of cases 3. Prophylactic treatment 4. Spraying of insecticide to houses
Leprosy	1. Screening of cases 2. Investigation and treatment 3. Investigation of contacts 4. Health education
STD control	1. Screening for cases 2. Treatment of cases 3. Investigation of contacts 4. Follow-up treated cases
Rabies control	1. Vaccination of dogs 2. Eradication of stray dogs 3. Vaccination of human contacts (AVR)
Food quality	1. Inspection of handling establishments 2. Inspection of adulterated food items 3. Despatching of food samples to the Government Analysts for investigation and report 4. Legal action against errant traders 5. Maintaining cordial relationship with food authority

Table 9 NUMBER OF INSTITUTIONS IN THE NORTH EAST PROVINCE WHERE ACUTE SERVICES ARE PROVIDED

	North	East	Total	Staff	Beds
Central dispensaries *Provide outdoor treatment for many acute medical conditions - First aid for injured. Only out-patient services.*	**25**	**44**	**69**	**1 AMO**	
Rural hospitals *Provide outdoor and indoor treatment for minor acute conditions. Primary health care services, maternity cases.*	**3**	**4**	**6**	**1 AMOO**	**12**
Peripheral units:- *Outdoor and indoor treatment of acute medical and surgical conditions. Small operating theatre for minor operations. No autoclave for sterilising dressing etc. Ambulance available*	**10**	**23**	**23**	**1. MO, 2 AMOO, 6-12 Nurses, IDS**	**Average 40**
District hospitals *Outdoor and indoor treatment- same as PU. Secondary health service. Ambulance available*	**7**	**13**	**13**	**Same as PU**	**Average 100**
Base hospitals *Outdoor and indoor treatment including specialist care. Ambulance available,*	**3**	**6**	**6**	**Surgeon, Physician, Obstetrician and MOO**	**300 to 500**
General hospital	**1**	**2**	**2**	**2**	**600 -1,000**

Outdoor and indoor treatment including specialist care:-

Specialists are available in the major specialties - medicine, surgery, eye, ENT, forensic medicine, radiology, pathology, psychiatry. In Jaffna Teaching Hospital there are additional specialists such as, orthopaedics, Neurosurgery, cancer therapy and thoracic surgeons. Since 1990 there has been acute shortage of specialists in the North East Province.

ACUTE SERVICES ACCESS - JAFFNA HOSPITAL

Dr (Miss) N Kanagaratnam
Director, Teaching Hospital, Jaffna, Sri Lanka

The struggling health care system in the North East is symbolised by the sad state of the once prestigious Jaffna Hospital.

Jaffna Hospital is the main teaching hospital affiliated to the Jaffna Medical Faculty. At present it serves a population of 800,000 people. Before the onset of ethnic conflict, the highly regarded Jaffna Hospital attracted patients from Trincomalee and Batticaloa districts well outside the Jaffna peninsula. Currently, military restrictions and interference to free travel within the North East province, the damage to the transport infrastructure and the threat to safety, deter patients from other districts travelling Jaffna Hospital for medical treatment.

Jaffna Hospital, situated in the heart of the Jaffna town, has faced shelling and bombing since the full blown war in 1983. Lives of the hospital staff have been under constant threat. In October 1987 the hospital was occupied by the Indian Peace Keeping Force (I.P.K.F.). At this time eighty-one people, comprising of medical staff, nurses, administrative staff and patients and their relatives, were killed and the dead bodies were burnt on the orders of I.P.K.F. No inquests or post-mortems were held before disposal of the bodies. The consequence of this threat to personal and family safety has been the exodus of health professionals from the North-East province.

Agreement was reached in November 1990 between Sri Lankan Government and Liberation Tigers of Tamil Eelam to create a safety zone around the Hospital under the supervision of I.C.R.C

Bed strength and extent of the services provided are as follows:

Services offered

- Patient care
- Teaching
- Under graduates
- Post Graduates Training for Medical Officers
- Nurses Training
- Family Health Workers Training

Patient Care

• Bed strength	1015
• Hospital Units	801
• University	214
• Wards	30
• Operating Theatres(only one functioning)	02

Special Units

- Emergency Unit
- Intensive Care Unit
  I Medical
  II Surgical
- Premature Baby Unit
- Endoscopic Unit
- Echocardiographic Unit
- Exercise E.C.G.

Infrastructure of the Hospital

Electricity

In June 1990 the main supply of electricity was cut off to the north of the North East province. As a result, Jaffna Hospital is dependent on generators for its electricity supply, and struggled with small generators until 1994 when arrangements were finally made to provide a 200KVA generator. This generator is a significant improvement in meeting the demands of the hospital, but still falls far short of meeting the whole requirement. Table 2.

Fuel

There is an embargo on most kinds of fuel. Kerosene is a vital all-purpose fuel for the people of the North East and is used for a variety of purposes including water pumps, cookers, and lamps. In the absence of petrol and diesel, kerosene is also being used to fuel motor vehicles.

Difficulties and delays in obtaining adequate supplies have been created because all fuel for the hospital (kerosene, diesel, petrol and engine oil), has to be approved by the

Table 2 ELECTRICITY SUPPLY AFTER 1990

Generators	1990	1991	1992	1993	1994
1. 10KVA	-	-	01	01	01	-
2. 15KVA	-	-	01	01	01	-
3. 27KVA	01	01	-	-	-	-
4. 37KVA	01	01	01	01	01	-
5. 55KVA	01	01	-	-	-	-
6. 85KVA	01	01	01	01	01	-
7. 200KVA	-	-	-	-	-	01

Table 3 FUEL SUPPLY TO GENERATORS AND STAFF

	Barrels			
Generators	1991	1992	1993	1994
Diesel	347	380	400	399
Kerosene oil (all staff)	202	299	210	240
Petrol				
(Doctors and Paramedics)	3	3	4	4-5
Engine oil	16	07	09	10

Table 4 GENERAL HOSPITAL JAFFNA

District	1990		1991		1992		1993		1994	
	Est	Rec	Est	Rec	Est	Rec	Est	Rec	Est	Rec
Injection Morphine 15mg	2000	200	2000	900	2000	1000	2000	1050	2000	900
Injection Pethidine 75mg	4000	500	4000	1100	4000	400	2000	1600	3000	400
Injection Pethidine 50mg	4000	500	4000	1650	4000	1250	3000	700	3000	1850
Injection Pethidine 100mg	4000	500	4000	2900	2000	1750	2000		2000	550
Cocaine powder	100		100		100	15mg			10mg	20mg

Est = Estimate Rec = Received

Table 5 SUPPLY OF GASES

	Cylinders per year		
Year	O^2 Oxygen	N^2O Nitrous oxide	Total No. of operations
1982	3176	1173	12,621
1983	2990	1065	13,155
1984	2764	1074	10,998
1985	1760	559	11,042
1986	873	329	12,268
1987	701	269	10,000
1988	1267	725	15.187
1989	-	-	10,654
1990	82	14	13,639
1991	159	41	18,377
1992	287	92	17,276
1993	283	80	17,677

military apparatus (J.O.C.). Since the embargo came into operation there has been a great scarcity of fuel on the open market causing difficulties for both hospital and staff. Table 3 gives figures since the embargo came into operation but unfortunately we do not have accurate pre-1991 figures for comparative purposes.

Drugs

Drugs are supplied quarterly from the Divisional Drug Stores in Colombo. A list of drugs required has to be sent to Colombo to the military apparatus (JOC) for approval. Hospital employee on secondment in Colombo must first seek permission from the JOC before collecting the drugs from the Divisional Drug Stores. These drugs are taken to Trincomalee harbour where they are sent by I.C.R.C. ship to Jaffna. Only one ship a week operates from Trincomalee to Jaffna and due to the weather and the war situation the operation of the ship is not reliable. Obtaining permission from the (J.O.C.) which is based in Colombo, creates additional delay to the supply of the drugs during emergency situations.

Certain drugs, e.g. Pethidine, Morphine, Ergometrine are curtailed to the Jaffna Hospital. Table 4.

While the number of operations due to war trauma have increased significantly the supply of Oxygen and Nitrous Oxide has been drastically reduced. Table 5.

Shortage of Medical Staff

There is an acute shortage of Surgeons in Jaffna Hospital and only one Surgeon north of Anuradapura is servicing more than one million people. There is no Consultant-led anaesthetic and paediatric service in the hospital. There is extreme difficulty in recruiting junior medical staff to work in the anaesthetic department. There is one paediatrician who is a Diploma holder in child health. There are no dental surgeons, thoracic surgeons, neurosurgeons, orthopaedic surgeons, neurologist or radiologist. Table 6.

Paramedical Staff

There is an acute shortage of paramedical staff and the hospital is managing temporarily by employing retired staff over the age of 55 (retirement age in Sri Lanka). Once these people take permanent retirement there will be an acute crisis as there is no new recruitment for the future. The position is very similar with regard to training for midwives, nurses and assistant medical practitioners. At present there are vacancies for thirty-four midwives, with only fourteen vacancies filled.

Promotion and pay rises is dependent on passing the Sinhalese language proficiency examination which is held in Colombo. Staff from Jaffna Hospital are finding it difficult to travel to Colombo due to the turbulent war situation. Notifications of the examination do not reach Tamil areas on time as the Government Gazette carrying the advertisement for the examination and recruitment for medical staff, arrives in the North East only after the examination is over.

Table 6 SHORTAGE OF STAFF — GENERAL HOSPITAL JAFFNA

	1985		1986		1987		1988		1989		1990		1991		1992		1993		1994	
	Approved cadre	Posts filled	Approved cadre	Posts filled	Approved cadre	Posts filled	Approved cadre	Posts filled	Approved cadre	Posts filled	Approved cadre	Posts filled	Approved cadre	Posts filled	Approved cadre	Posts filled	Approved cadre	Posts filled	Approved cadre	Posts filled
General Surgeon	3	3	3	3	3	3	3	3	3	3	3	2	3	2	3	2	3	2	3	1
Thoracic Surgeon	1	1	1	-	1	-	1	-	1	-	1	-	1	-	1	-	1	-	1	-
Orthopaedic Surgeon	1	1	1	-	1	-	1	-	1	-	1	-	1	-	1	-	1	-	1	-
Neurosurgeon	1	1	1	-	1	-	1	-	1	-	1	-	1	-	1	-	1	-	1	-
Neurologist	1	1	1	-	1	-	1	-	1	-	1	-	1	-	1	-	1	-	1	-
Paediatrician	1	1	1	1	1	1	1	-	1	-	1	-	1	-	1	-	1	-	1	-
Anaesthetist	2	2	2	2	2	2	2	2	2	1	2	1	2	-	2	-	2	-	2	-
Radiologist	1	1	1	1	1	1	1	1	1	1	1	1	1	-	1	-	1	-	1	-
JMO	1	-	1	-	1	1	1	-	1	-	1	-	1	-	1	-	1	-	1	-
Matron	3	3	3	3	3	2	3	2	3	3	3	3	3	2	3	3	3	3	3	3
Sister	-	-	22	4	22	3	24	2	23	2	24	1	24	-	24	-	24	3	24	3
Nurse	-	-	357	235	382	218	382	223	382	242	382	257	382	224	382	294	392	294	382	305
Midwives	-	-	32	16	32	16	32	21	32	19	32	19	32	17	32	16	32	16	32	16
MLT	20	24	20	24	20	24	20	23	20	23	20	15	20	15	20	12	20	8	20	8
Physiotherapists	14	10	14	10	14	10	14	10	14	9	14	9	14	3	14	3	14	3	14	3
Radiolgraphers	14	8	14	8	14	8	14	8	14	7	14	7	14	2	14	2	14	2	14	2
ECG Technicians	2	2	2	2	2	2	1	-	2	2	2	2	2	2	2	1	2	1	2	1
EEG Technicians	2	-	1	-	1	-	1	-	1	-	1	-	1	-	1	-	1	-	1	-
EME Foreman	1	1	1	-	1	-	-	-	1	-	1	-	1	-	1	-	1	-	1	-

Cancer Patients

The Cancer Unit in Tellipalai is no longer functioning due to the army occupation. Patients with cancer have to be transported to Maharagama near Colombo which is 240 miles away from Jaffna. These patients undergo immense difficulties since there is no direct transport to Maharagama Hospital. Problems are exacerbated by the difficulty in finding accommodation for both the patient and accompanying relatives. In addition to this they face the further problems of not knowing the Sinhalese language to facilitate communication.

Restrictions on drugs such as pethidine and morphine to Jaffna Hospital make it difficult to give adequate analgesia to terminally ill patients.

International Committee of Red Cross (ICRC)

ICRC has played a crucial role in keeping the communications open between Jaffna Hospital and the outside world. They have been promised security and assistance by the government and LTTE in running the Hospital. They have been helping in transporting drugs from Colombo via Trincomalee; transporting of patients from Jaffna to Colombo for specialist treatment and back to Jaffna. They provide communication facilities through radio messages, because the telephone link to Jaffna peninsula, which includes the Hospital link, has been cut-off.

In Conclusion

I wish to record special thanks to Non-Governmental organisations, the Sri-Lankan Government and our children, the Freedom Fighters for not interfering with our work and giving assistance in providing the service to the people.

LTTE is very considerate in giving 'passes' to go to Colombo without any difficulty (LTTE controls the Northern province and operates the pass system to control the migration of people from the north). Very often when we visit Colombo we are asked whether we treat tigers, we reply, "Yes, they too, when they come as patients, receive treatment..."

Special thanks to staff of Jaffna General Hospital and Dr. S. Sivakumaran, British, German and Canadian governments and expatriate Tamils who have been helping me with Aid. I express special thanks to all of them on behalf of the people of Jaffna.

Summary

Urgent Needs

- Shortage of Staff
- Auto Claves
- High Pressure Sterilisers
- Drugs
- Radiotherapy facilities for treatment of cancer patients
- General Surgeons

Some Solutions

- Short term contract for specialists from abroad to work in the specialties where there is no Consultant.
- Special allowance for those working in difficult areas as incentives.
- Special training and sabbatical abroad for short period for those working in difficult areas.
- Financial assistance to buy equipment such as a autoclaves and for travel for training abroad.

CURATIVE AND PREVENTIVE SERVICES TRINCOMALEE DISTRICT

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Trincomalee District, which is in the Northern part of the Eastern Province, with a land area of 2,618 sq. km. The major city in the District is Trincomalee with a harbour that is considered as one of the best in the South East Asia.

The last census held in 1981, recorded a population of 274,702. The estimated mid year population in 1994 and age distribution is shown in Table I. in the ethnic composition of Trincomalee District according to the 1981 census, Tamils from 36.4%, Sinhalese 33.6% and Muslims 29.0%.

The crude birth rate was 21.0% per 1,000 population and death rate 3.0% per 1,000 population. Infant and maternal mortality rates are shown in Table 2.

Table 1 HEALTH INDICATOR

Indicator	Year	Data
Estimated population	1994	329,000
Percentage of population		
- less than 15 years old	1981	35.3
- over 65 years old	1981	6.6
Urban population	1994	74,662
Percentage of population with safe water		
- Urban area	1993	46
- Rural area	1993	24

Table 2 HEALTH INDICATORS 1993

Crude birth rate (per 100,000 population)	21.0
Crude death rate (per 100,000 population)	3.0
Infant mortality rate (per 1,000 live births)	6.4
Maternal mortality rate (per 1,000 live births)	0.3

Health Facilities

The entire District Health Services are covered by the Deputy Provincial Director of Health Services, and has only one Medical Officer of Health (M.O.H.) for the Preventative Services.

Health Services are provided to the Public under two substantive programmes with the objective goal of attaining better health status for the people.

1. Curative Health Services or Patient Care Services.
2. Preventative Health Services or Community Health Services.

Curative Health Services

Curative Services are provided through a network of Medical Institutions. Trincomalee Base Hospital is the largest treatment centre and serves as a referral centre for secondary care The existing treatment centres with bed strength, number of ambulances and out patient attendances are shown in Table 3. Some small institutions are closed due to war.

A detailed map area (map D) showing the Health Institutions is available for easy reference.

The following facilities are provided by the Curative Services

- Indoor and Outdoor Medical Treatment in the Base Hospital, District Hospital, Peripheral Unit, Rural Hospital and Maternity Home.
- Outdoor treatment only at General Dispensary
- Ante and Post-Natal Care
- Specialist care in Base Hospital, Trincomalee.

Morbidity and Mortality Pattern in Base Hospital, Trincomalee

The top ten leading causes for morbidity and mortality are shown in tables 4. and 5.

Table 3 PHYSICAL PERFORMERS - CURATIVE SERVICES

Institution	Bed strength	No. of ambulances available	OPD Attendances 1993	Remarks
Base hospital , Trincomalee	176	2	284,054	
District hospital, Kantalai	77	2	116,054	
District hospital, Muthur	66	1	159,540	
District hospital, Kinniya	39	1	114,919	
Rural hospital, Gomarankadawela	24	1	18,553	
Rural hospital, Kutchchaveli	-	-	-	Closed
Rural hospital, Padavi Sripura	30	1	36,039	
Rural hospital, Thampalagamam	36	1	52,570	
CD and MH, Morawewa	-	-	-	Closed
CD and MH, Nilaveli	12	-	18,986	
CD and MH, Pulmoddai	12	*1	17, 949	*Under repair
Central dispensary, Cattukachchiya	-	-	18,630	
Central dispensary, China Bay	-	-	18,360	
Central dispensary, Ichchilampathai	-	-	5,791	Closed
Central dispensary, Kachchakodithivu	-	-	39,120	
Central dispensary, Mahadivulwewa	-	-	4,660	
Central dispensary, Mullipothana	-	-	8,052	
Central dispensary, Serunuwara	-	-	13,068	
Central dispensary, Seruwila	-	-	3,195	
Central dispensary, Thiriyai	-	-	1,307	
Central dispensary,Thoppur	-	-	17,644	
Central dispensary, Wan Ela	-	-	25,766	

Morbidity and Mortality Data is available only for patients seeking treatment as inpatients in Government Hospitals. Traumatic injury is the 3rd commonest case of hospital admission reflecting civil war in the district. These statistics refer only to diseases which are severe enough to seek treatment and judged by the doctors as being serious enough to necessitate hospital admission. Data is not available on admission to Ayurvedic Hospitals and Private Hospitals.

Dental Health Services

The organisation and administration of Dental Health Services are divided into curative and preventative services.

The Dental Curative Services consist of both out-door and in-door treatment of patients at the Dental Clinics attached to the Base Hospital and District Hospital, Kantalai. Outdoor dental clinics are conducted twice a week at District Hospital Muthur and Kinniya.

The chief component of Preventative Dental Services is the School Dental Services which is designed to provide regular treatment for school children between 5 and 13 years as well as pre-school children. The school dental services are carried out by School Dental Therapists.

Physical Performance -1993

Regional Administration

The Regional Administration staffing level is very inadequate. The following posts are vacant in the Regional Administrative Section.

1. Medical Officer, Maternal and Child Health
2. Regional Dental Surgeon
3. Divisional P.H.N.
4. Divisional S.P.H.I.
5. Supervising School Dental Therapist
6. Health Education Officer
7. Divisional Pharmacist
8. Statistical Survey Officer
9. R.M.O./A.M.C.
10. Food and Drug Inspector

Action Plan for Correction of Service Provision Deficiencies

We have tried to identify the key areas that need attention; Proposals to rectify these deficiencies and measures required are suggested to maintain equal accesses and services relevant to the local needs of the community in the district. During the period under review, the services of a Surgeon and two Consultant Anaesthetists have been obtained from Pakistan and they continue to serve in Base Hospital, Trincomalee. A volunteer Eye Surgeon from Holland served at Base Hospital, Trincomalee for one month in January.

Table 4 LEADING CAUSES OF HOSPITALISATION -1993

Diseases	No of admissions	% of total deaths
Malaria	5,070	11.7
Asthma	2,452	5.6
Traumatic injuries	2,402	5.5
Acute bronchitis and broncholitis	2,165	5.0
Other symptoms, signs and ill defined conditions	2,000	4.6
Other viral diseases	1,740	4.0
Diseases of the skin and subcutaneous tissue	1,252	2.9
Other diseases of the digestive system	1,245	2.8
Admitted for delivery but discharged before delivery	1,213	2.8
Pyrexia of unknown origin	1,058	2.5

Table 5 LEADING CAUSES OF HOSPITAL DEATHS -1993 (TOTAL NUMBER OF HOSPITAL DEATHS 289)

Diseases	No of deaths	% of total deaths
Acute myocardial infarction	26	8.9
Slow foetal growth	18	6.2
Other poisoning of toxic effect	15	5.2
Other ischaemic heart disease	14	4.8
Organophosphate and carbonate poisoning	14	4.8
Pneumonia, Bronchopneumonia	13	4.5
Hypoxia, birth asphyxia, and other respiratory conditions	13	4.5
Asthma	8	4.8
Pulmonary tuberculosis	6	21.0

Table 6 AT DISTRICT LEVEL

Service provision deficiency	Activities to be implemented in 1994 to resolve deficiency	Resource required
1. Inadequate laboratory facilities at district hospitals	i Establish a laboratory at DH Muthur ii Provision of laboratory equipment and chemicals to each district hospital	For laboratory equipment and chemicals
2. Inadequate dental services	iii Appoint Medical La. technicians Provision of dental unit at district hospital Muthur and Kantalai	Equipment for dental unit
3. Inadequate staff like MO's , Nurses, Midwives, and technicians	Appoint adequate staff	Salary
4. Inadequate mini operation theatre facilities	Establish mini operating theatre	Equipment for theatre
5. Inadequate X-ray facilities	Supply equipment for X-ray units	Equipment for x-ray unit

Table 7 CENTRAL DISPENSARIES AND MATERNITY HOMES

Service provision deficiency	Activities to be implemented in 1994 to resolve deficiency	Resource required
1. Poor notification of communicable diseases	Organise in service training for RMO's and AMO's	Travelling expenses and refreshments
2. Inadequate health education	RMO's and AMO's and dispensers should be given training separately	Travelling expenses and refreshments
3. Inadequate midwives care at CD and MH, Pulmddai and Nilavelai	Appoint adequate midwives	Salary

Table 8 PERIPHERAL UNITS AND RURAL HOSPITALS

Service provision deficiency	Activities to be implemented in 1994 to resolve deficiency	Resource required
1. Inadequate dental clinic facilities at PU Kinniya	i Supply the dental unit ii Appoint a dental surgeon at PU Kinniya	Equipment
2. Inadequate health education	Train nurses and PHM's to carry out health education	Refreshment and travelling expenses
3. Errors in maintenance of indoor morbidity and mortality returns and poor notification of communicable diseases	Train nurses and PHM's to assist MO's in maintaining registers and notification	Refreshment and travelling expenses
4. Inadequate nursing care at peripheral unit	Appoint adequate nursing officer	Salary
5. Inadequate FHW at rural hospitals	Appoint adequate midwives	Salary

The above tables identify service provision deficiencies and there suggested solutions.

Table 9 — Over the page, Action plan for correction of preventive services deficiencies, the table identifies deficiencies in Provincial services and the proposed solution.

Table 9 PREVENTATIVE SERVICES

Service provision deficiency	Activities to be implemented in 1994 to resolve deficiency	Community support	Resource required
1. Inadequate provision of latrines	Non governmental organisations to assist in the programmes		
2. Inadequate monitoring of water	Training should be given to PHII		Travelling expenses
3. No orientation classes for primary health care work and lack of health education seminar	i Appoint health education officer ii Provision of fully equipped vehicle to carry health education work iii Orientation classes for PHC works to be arranged		Salary and purchase of vehicle
	iv Arrange health education seminars		Travelling expenses
4. Poor coverage of students for school medical inspection	i Appoint adequatre PHI's ii All schools will be taken up for school medical inspection by PHI's iii Review the coverage of staff conference		Salary
5. Poor coverage of students for school dental therapy	i Appoint adequate school dental therapists ii Establish more school dental clinics iii Review the coverage of each staff conference		
6. Lack of fumigation facilities in quarantine works	i Appointment of trained personnel ii Provision of fumigation equipment		Salary and Equipment
7. Inadequate screening of Malaria cases	i Blood samples taken from all fever cases tested ii Appointment of microbiologist		Salary and Equipment
8. The Leprosy cases are late in seeking treatment	Strengthen the health education in schools and community organisations		Travelling expenses
9. Inadequate awareness of modern concept of leprosy control among practitioners	Organise orientation programmes for private practitioners in leprosy control		-
10. Inadequate attendance of patients at clinic	Strengthen health education in clinics		-
11. Lack of trained personnel in control of sexually transmitted diseases	The MO's of base hospitals are trained to conduct the clinics properly		Travelling expenses
12. Inadequate Vaccination drugs	i Arrangements to be made to immunise 80% of domestic dogs ii Provision of a van for carrying... iii Appoint to volunteers iv Equipment for vaccination	Through local health communities purchases of a van Salary Equipment	
13. Inadequate elimination of stray dogs	i Provision of a dog seizing vehicle ii Elimination of stray dogs to be carried out by local authorities		Purchase of vehicle
	iii Strengthen the education about rabies control to the community	Get assistance from community leaders	Travelling expenses
14. Inadequate efforts to improve growth monitoring and feed habits	Demonstration on preparation of nutritious feeds at village level	Cooperation with village level organisations	Travelling expenses
15. Inadequate communication by health workers with Janasaviya benificiaries	Selection of volunteers from Janasavia families and training them for improvement of health related services	Cooperation with Janasaviya benificiaries	Travelling expenses and refreshments
16. Inadequate provision of antenatal care in villages	Monitor the output of clinics	Get help form volunteers	-
17. Low registration of mothers and poor coverage of mother for post natal care	Appoint more PHW'S to vacant station	-	Salary
18. Poor coverage of infants for immunisation	Strengthen the health education at village level	-	Travelling expenses
19. Inadequate identification and reporting of infants and maternal deaths	Strengthen health education among others and community leaders to report these events	-	Travelling expenses

CURATIVE AND PREVENTIVE SERVICES BATTICALOA DISTRICT

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The population in 1991 was 424,000 and the projected population in the year 2,000 is 525,000. According to 1981 Census, the ethnic compostion of the population is as follows:-

Tamils 72.1%, Muslims 23.9%, Sinhalese 3.2%.

Like the rest of the Tamil districts in the North East, Batticaloa district has been affected by the war - in terms of loss of lives, displacement and physical and mental trauma.

The following data, even though an under-estimate of the real situation, gives some idea of the scope of the problem.

Number of People Families Affected by the Conflict During the Last 10 Years

Pre June, 1990 (due to ethnic conflict prior to June, 1990).

No. of families displaced/affected	90,000
Deaths	2,500
Injured	2,300
Missing	750

Post June, 1990 (1991-1994)

Persons in Refugee Camps/ Welfare centres	78,053
Persons with relatives	105.000

Housing

Houses destroyed/ damaged pre June, 1990	15,000

Effects of attacks by Security Forces and clashes between Muslims and Tamils in 1985 & 1990

Houses damaged in 1985	15,000
Houses damaged in 1990	27,000
No. of families requiring housing	32,000

Primary Health Care

In line with the rest of the country in Batticaloa district primary health care is provided at a domiciliary level and at institutions. People seek home care mainly for home deliveries. Home deliveries are conducted by Public Health Midwives.

Morbidity and Mortality Pattern in Hospital Admissions

Tables 1. and 2. give the first ten causes of hospital admissions and Table 3. is about commonest causes of hospital mortalities. Traumatic injuries is the second commonest cause of hospital admissions in 1992 and the third commonest in 1993. Deaths due to traumatic injuries have become the leading cause of death in Eastern province including Batticaloa Hospital, while in the rest of Sri Lanka mortality due to traumatic injuries is only the eighth leading cause.

Table 1 MORBIDITY —1992

	EP	BCO	AMPARA
1. Disease of respiratory tract	17,200	6,160	6,170
2. Traumatic injuries	13,500	4,240	5,380
3. Intestinal infection	11,730	2,310	7,150
4. Ill-defined conditions	10,800	2,270	5,110
5. Malaria	10,230	4,070	2,910
6. Disease of gastrointestinal tract	6,200	2,760	2,050
7. Disease of musculoskeletal system	5,980	2,800	1,580
8. Disease of urinary system	4,700	1,240	2,700
9. Disease of upper respiratory tract	4,700	-	4,000
10. Viral disease	4,150	-	2,040

Table 2 MORBIDITY — 1993

	% Of total deaths	No. of admissions
1. Malaria	5,070	11.7
2. Asthma	2,452	5.6
3. Traumatic injuries	2,402	5.5
4. Acute bronchitis and bronchiolitis	2,165	5.0
5. Other symptoms, signs and ill-defined condition	2,000	4.6
6. Other viral disease	1,740	4.0
7. Disease of the skin and subcutaneous tissue	1,252	2.9
8. Other disease of the digestive system	1,245	2.8
9. Admitted for delivery but discharge before delivery	1,213	2.8
10. Pyrexia of unknown origin	1,058	2.5

Table 3 LEADING CAUSES OF HOSPITAL DEATHS — 1992 (EP)

	EP	BCO	AMPARA	TRINCO
1. Traumatic injury	125	117	3	5
2. Ischaemic heart disease	106	41	28	37
3. Disease of circulation and other heart disease	61	43	1	17
	48	12	12	24
4. Pesticide poisoning	60	49	6	9
5. Other poisoning	47	32	-	15
6. Foetal malnutrition/immunity	41	23	-	18
7. Other respiratory disease	39	33	2	4
8. Disease of gastrointestinal tract	30	16	3	11
9. Pneumonia and bronchitis	17	16	-	-
10. Anaemis				

Self poisoning with pesticides has become one form of suicide in Batticaloa. Due to the war, bread winners in the family have been killed or have disappeared after arrest by the army. Loss of eminent family member, lack of financial support and uncertainty of the future have contributed to increased psychiatric morbidity, attempted suicide and suicide.

Only 30% of deaths in the eastern province occurs in the hospital. Civilians who are killed by the army or those who died outside the hospital due to lack of transport are not accounted for. Hospital figures are an under estimate of the extent of the problem.

Medical and Paramedical Manpower

Table 4 and Table 5 illustrate the current staffing patterns in the major Batticaloa Hospital. It can be seen that there is a similar pattern of shortage to that experienced in the rest of the North-East province.

Table 4 SERVICES: SPECIALISTS AT GH BATTICALOA

	ENT surgeon	Eye surgeon	General surgeon	Paediatrician	JMO	Psychiatrists	Obstetrics	Physicians	Anaesthesia	Pathology
1980	1	1	2	1	1	1	2	2	1	1
1987	0	0	0	0	0	2	1	0	0	0
1994	0	1	1	0	0	0	1	1	0	0

Table 5 PRIMARY HEALTH CARE TEAM AND PARAMEDICAL STAFF —1994

	PHM	PHM	PHM	PHM	PHM	PHM
Total requirement	156	47	11	368	12	3
Post filled	66	21	0	243	3	1
Vacancies	90	26	11	125	9	2

Deficiencies in Acute Care Facilities in Batticaloa District

- First port of call are the smaller institutions in the villages. There are no first aid facilities to deal with acute emergencies.
- Smaller institutions do not have blood bank facilities
- Lack of special care baby unit.
- Lack of sterilisation facilities.

Accident and Emergency Services

- One of the leading causes of admissions to hospital and hospital deaths is acute trauma due to war injuries but there is no separate accident and emergency service in any hospital.
- Closure of peripheral units and central dispensaries. Several smaller institutes have been closed for security reasons thus depriving the local population in several villages access to medical care.

Midwives

- Many small Districts have no resident midwives where a substantial proportion is home deliveries.

Special Needs of Batticaloa General Hospital

- Based on inpatient morbidity and mortality statistics, the major requirements of the Batticaloa General Hospital which is the secondary and tertiary referral centre in Batticaloa District, table 6.

Table 6 SPECIAL NEEDS OF GH BATTICALOA

1. Cardiovascular Diseases	- Cardiology Unit - Cardio Thoracic Surgical Unit
2. Trauma	- Accident Service - Neurosurgery, Orthopaedic Unit - Burns Unit - Plastic Surgery, Paediatric Surgery
3. Disability and Rheumatic Diseases	- Rheumatology Unit - Rehabilitation Unit
4. Maternal Morbidity and Mortality	- Modern Maternity Unit
5. Neonatal Morbidity and Mortality	- Special Care Baby Unit
6. Oral Health Problems	- Maxillo Facial Surgery Unit

ASSESSMENT OF THE HEALTH STATUS OF REFUGEES IN COLOMBO - SRI LANKA

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Introduction

The current estimate of the Sri Lankan refugees is approximately one million (of a total population of 17 million in Sri Lanka) of which 673,685 reside in Sri Lanka. 40% of the refugees residing in Sri Lanka are children, with 125,000 at school-going age.

The aims of this report are:

- to describe the physical and mental health problems prevalent in selected refugee camps in Colombo, the commercial capital of Sri Lanka;
- to assess the impact of congested accommodation and poor sanitary conditions in the camps on the health status;
- to describe the medical facilities available in the camps and identify short-comings.

Ethnic Conflicts and Consequences

Ever since Sri Lanka gained independence in 1948, Sri Lankan Tamils have nurtured grievances against the majority community, alleging systematic racial discrimination in the fields of education and employment. Introduction of Sinhala as the only official language in 1958 and allegations of state-aided colonisation of the traditional homelands of Tamils in the Eastern Province contributed to the Tamil's feeling of insecurity.

Periodic racial riots and the failure of successive governments to address the grievances of Tamils served to polarise Sinhalese and Tamils along the ethnic divide.

The emergence of militancy among Tamil youth resulted in the formation of guerrilla movements which have been engaged in covert operations against the government forces since 1977.

Guerrilla operations and retaliatory or defensive operations by armed forces – combining ground operations with aerial bombardment – have created the refugee problem in Sri Lanka. The refugee population mainly originates from the Northern and Eastern Provinces, but is not confined to Tamils only. Refugees include Muslims and Sinhalese who have fled their homes fearing reprisals by Tamil guerrilla movements.

The plight of Muslims of the Northern Province is pathetic. They have been forcibly evicted from their residences by the Tamil guerrilla movement. Unlike other refugees who moved out of their own volition, Muslim refugees were not given any choice and had to leave their homes within a few hours, leaving behind all their material belongings.

The exodus of refugees into South India from the Northern Province was cited as one of the grounds for India's intervention into Sri Lanka's internal conflict. India and Sri Lanka signed an accord in 1987 under which the Indian army occupied the Northern and Eastern Provinces as a peace keeping force for over one year. During this period, southern Sri Lanka experienced a separate uprising by a Sinhalese militant group, the J.V.P., which was fuelled by the presence of Indian forces on Sri Lankan soil.

A breakdown in negotiations between the L.T.T.E., the predominant Tamil militant group, and the government in June, 1990 signalled the outbreak of fresh violence in the Northern and Eastern Provinces. The violence has continued unabated, creating the current refugee problem.

Relief Organisations

The protracted conflict in Sri Lanka has spawned many relief organisations which may be classified into state agencies, political organisations, apolitical non-government agencies, international relief agencies, and bilateral relief agencies.

Scope of Survey

Colombo has 12 refugee camps accommodating 2,864 registered persons (as of 4/3/91). Although registration has been stopped since December, 1990, refugee camps have in fact continued to admit new displaced persons, although these persons do not benefit from the relief provided by the government.

The present survey was confined to the refugee camps in Colombo only, due to lack of resources and restricted access to refugee camps within or close to theatres of conflict. Though the refugee population living in camps located in Colombo is only 5,000, a minute proportion of total refugees resident in Sri Lanka, conditions in these camps are indicative of the conditions in other camps. It is likely that the camps located in the areas of conflict are worse off than the camps in Colombo because of constraints in the transportation of relief and inaccessibility to many relief organisations.

Methodology

This report is based on visits to the refugee camps in Colombo to observe the facilities available and identify the potential health hazards, supplemented by interviews with officials at the camps, representatives of voluntary organisations, and the refugees. A pre-designed, pretested questionnaire administered by the interviewer was used to collect information on morbidity patterns and psychological traumatic disorders. A representative sample of refugees were clinically examined to identify further health deviations.

Findings

Quality of Accommodation and Sanitary Conditions

The type of accommodation may be classified into two categories. The first category covers accommodation in temples, community halls, etc., which were not meant for overnight accommodation for large numbers. The second category covers accommodation in small huts spread over a relatively large area. Each hut accommodates a family unit.

Though temples and halls have solid roofs and cemented floors, they afford no privacy to inmates as they have no partitions to separate the living space of one family from that of the other. In the absence of partitions, the living space allocated to each individual is not demarcated, which results in overcrowding as numbers increase. In one community hall visited by the author it was found that there were 550 inmates in a space designed to accommodate 150.

The huts, though having the advantage of affording privacy to individuals, do not protect inhabitants from dampness and chilly weather. The huts have earthen floors covered by a polythene sheet to reduce dampness. Quite often these polythene sheets are infested with ants which are difficult to exterminate.

All the camps have a limited number of latrines; due to space constraints the number of latrines cannot be increased. It is common to find in many camps approximately four to five latrines serving 500 to 600 persons. Despite this limitation, through voluntary regular cleaning and use of disinfectants, basic hygienic standards are maintained.

In addition to pipe-borne water, portable water is stored in tanks and replenished at weekly intervals. Due to long intervals between replenishment, the water turns rancid after two or three days, compelling inmates to change over to pipe-borne water. The camps do have facilities to boil drinking water, though these facilities are seldom made use of for such purposes; they are instead used to brew tea.

The collection of refuse from the camp for ultimate disposal is the responsibility of the local government authority. Within the camp, sweeping is done on a rotational basis by camp inmates working in groups.

Flies and mosquitoes make their appearance seasonally during damp weather conditions. The poor sanitary conditions aggravate the seasonal phenomenon. As weather conditions change the fly and mosquito populations dwindle, affording some relief to inhabitants, unlike the case of rats and bed bugs which are perennial and difficult to eradicate.

Morbidity

Respiratory tract infections, influenza, scabies, fungal infections of the skin (tine infections) and arthritis are endemic and reach epidemic proportions periodically, possibly co-related with weather conditions. Except for arthritis, children are more susceptible to these diseases. Respiratory tract infections among children were found to be very high throughout the study period.

Arthritis was more prevalent among those over 40 years old, mostly among females.

Oral health problems such as periodontal disease and dental abscesses were also present and attributable to poor oral hygiene, which one would expect with the limited supply of water and short supply of toiletries.

Reported outbreaks of diseases include measles among children, chickenpox, mumps and conjunctivitis.

Only a few cases of gastroenteritis (diarrhoea) have been reported.

A significant proportion suffer from gastritis, peptic ulcer symptoms, bronchial asthma and worm infestation.

Though many of the refugees suffer from anaemia, other nutritional deficiencies such as avitaminosis and gross protein energy malnutrition were not found in significant numbers.

Psychological problems

The main problem among adults is depression caused by the loss of material belongings and a state of near-destitution with no prospects of compensation or resettlement.

Among women, the loss of breadwinners and the burden of maintaining their children with meagre sustenance results in anxiety states of varying degrees.

Among children, who are present in significant number (40%), common complaints are nightmares and exaggerated startle responses to noises such as crackers and overhead helicopter flights.

Health Care Facilities

Due to lack of resources and poor organisation, comprehensive health care, both curative and preventative is not possible. In fact, over a period of time some of the relief organisations which provide such facilities have ceased to do so, leading to deteriorating conditions. Some of the

camps are fortunate to have regular mobile clinics, though the quality of service is poor due to lack of personnel, drugs and proper documentation of case histories. A major problem is the non-availability of facilities for isolation in the event of outbreak of infectious diseases, with the result that a single infection can rapidly spread to many people. This problem could be alleviated if preventive measures are better organised.

First aid facilities in rudimentary form were available at the early stages and are now extinct.

There are no arrangements to provide immunisation facilities at the camp, though refugees can obtain this facility from clinics maintained by local government authorities for the city population.

Discussion

How Can the Health Status of Refugees in Camps be Improved?

Due to the protracted nature of the internecine strife, refugees are unable to return to their abodes. Though makeshift camps are not meant to accommodate large numbers for a long period, due to lack of resources alternative appropriate accommodation cannot be provided. At best, one could only alleviate the suffering and reduce the incidence of preventable diseases by striving to improve sanitary conditions and supply of medical facilities.

Outbreaks of communicable diseases such as measles, mumps, chickenpox, conjunctivitis and skin diseases have been observed only among refugees living in temples and community halls, while refugees living in huts have been spared. These communicable diseases may be classified according to the mode of transmission: chickenpox, measles, mumps, etc. are spread through air; skin diseases are spread through physical contact.

Obviously, manifestation of both categories among the exiles in temples and community halls is related to acute congestion, borne out by the fact that other refugees in huts who are akin to a control group in an experimental mode did not have any reported airborne or contagious diseases.

On the positive side there have been few reported cases of water-borne diseases such as gastroenteritis and typhoid, which is not surprising because the water supply to the camps in Colombo is exclusively pipe-borne.

Adequate supply of disinfectants, detergents, soap and water, together with education of the camp population on the linkage between hygiene and diseases can improve conditions. Steps already taken have borne fruit, though poor organisation and coordination have reduced their effectiveness. Similarly, the supply of medical assistance in the form of personnel, drugs, equipment, etc. is not properly organised to make best use of the meagre resources which various relief organisations have been able to harness.

It is difficult to draw meaningful inferences from the observation that many refugees did not exhibit gross nutritional deficiencies. There is no reliable data on the prior nutritional status of refugees to serve as a valid comparative. Therefore, one may not conclude that absence of gross nutritional deficiencies is an affirmation of the adequacy of food supply to camps.

In contrast to treatment of physical ailments at camp sites, treatment of psychological problems – which requires privacy, longer time per patient, and specially trained personnel – will have to take place in rehabilitation centres with congenial atmospheres located away from camps.

Such rehabilitation centres ought to function as both treatment centres and research/data centres receiving patients on a referral basis.

How Organised are Relief Measures?

As in the case of any endeavour, success depends on effective organisation of scarce resources. The multiplicity of relief organisations often leads to duplication of relief measures. Lack of coordination and proper planning results in poor stocking of drugs. Maintenance of adequate stocks of basic drugs requires the design and implementation of a good system of inventory control. This would enable procurement of basic drugs cheaply, avoidance of overstocking and regular monitoring of stock levels to ensure replenishment at appropriate times; all of which call for good planning and organisation.

Other aspects of poor organisation are the lack of appropriate documents – such as case histories and statistics on the refugee population – and the inability to allocate scarce resources according to established priorities.

Donor agencies are hampered by obscure demarcation between the role of governmental and non-governmental organisations which often work at cross purposes.

Conclusion

The plight of refugees is such that it evokes humanitarian response from any civilised society. An effective relief programme must successfully mobilise resources and ensure efficient and economic delivery of such assistance. It must also be comprehensive to provide an integrated solution to the social, economic and health problems of exiles. This report examined only the health aspects relating to rehabilitation of exiles. It is our belief that better organisation and greater reliance on non-governmental, apolitical, non-profit organisations as channels for delivery of assistance would provide the best results.

The viability of this depends on the supportive role played by a documentation/research centre which would disseminate up-to-date information on technology and therapeutic methods of dealing with the physical and mental health problems of refugees. International symposia provide an appropriate forum for exchange of views and agitation for greater allocation of resources to alleviate the suffering of exiles.

HEALTH OF SRI LANKAN TAMIL REFUGEE CHILDREN IN TAMIL NADU — INDIA

A STUDY OF CHILDREN AT THE AGE OF SCHOOL ENTRY

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Summary

This study was undertaken to document the health and nutritional status of a segment of the Sri Lankan Tamil refugee population living in camps in South India. Children at the age of school entry were studied.

Height and weight measurements were taken and a clinical examination was carried out on 246 children in refugee camps. The growth data obtained from the children was compared with standards from The National Center for Health Statistics, USA [2] and data from affluent Indian children [3].

The results indicate that the growth of refugee children is substantially stunted. There is a high incidence of preventable diseases. 26% of the children have clinical evidence of vitamin A deficiency and 41.4% have dental caries.

Sri Lankan Tamil children living in refugee camps in South India are significantly malnourished and also have other preventable health problems. This population of children are at high risk for impaired growth and development. The health status of these children would indicate that the population of refugees as a whole is likely to be substantially deprived and have correctable deficiencies.

Introduction

The displacement of large numbers of people from their traditional homes and lands due to war and political violence is a reality of the modern age. It is estimated that in 1992, 10,000 people became refugees daily. The world-wide total of refugees was estimated to be 18.2 million in that year. An additional 24 million people were estimated to be internally displaced, with the result that approximately one in every 130 people on earth had been forced into flight[1].The populations that do leave their traditional homes and lands do so with the hope and the assumption that better conditions of life awaits them in their new situation. However, information on the life situations of refugees is sparse and often coloured by political considerations and propaganda. This study was undertaken to gather information on the health and nutritional status of a segment of a refugee population.

The population studied is the Sri Lankan Tamil refugees who fled war and oppression and crossed the seas to seek refuge in South India. Since 1977, and particularly after the major episode of 1983, the Tamil communities occupying the North and East of Sri Lanka have been subjected to recurrent ethnic violence. The latest exacerbation of violence started in June 1991 and many refugees fled to South India around this time. Children at the age of school entry were the chosen subjects of this study. Their ages ranged from 5 years and 2 months to 7 years and 2 months.

The study was conducted in March 1993, at which time there were 80,663 refugees housed in 136 camps situated in 18 districts in Tamil Nadu. The refugees were housed in temporary huts made of palm leaves or tar sheets, or in larger disused buildings. Water was supplied from bore wells. Toilet arrangements were poor or nonexistent. The refugees purchased food from a financial grant given by the Government of India.

Materials and Methods

Children born in the years 1986 and 1987 and living in 8 of the 136 camps were studied. The choice of camps was based on practical considerations of accessibility (some camps were closed to non-camp residents because of security considerations) and the presence of an adequate number of children of the study age. The camps were selected from different locations in Tamil Nadu. Health workers working in the refugee camps felt that these children represented the refugee population as a whole, even though there was no statistical randomization. At least two factors account for this representability. The major determinant of nutritional status in the refugee situation is the availability of financial resources to buy food; the income of the refugees in all the camps is similar,

as all of them are given the same amount of financial assistance and food rations by the government. Additionally, the refugees from different camps had been mixed with each other for administrative reasons just prior to the study.

Determination of Age

The date of birth was determined by careful questioning of parents together with the examination of birth certificates and camp records. Those with uncertain dates of birth were not included in the study.

Anthropometric Measurements

1. Weight (kilograms). Children were weighed using the same spring scale previously tested for accuracy. They were weighed without shoes and with minimal clothing.

2. Height (centimeters). Heights were measured using the Harpenden pocket stadiometer. This device consists of a base plate, steel tape, head bar, and a window for reading. The subjects stand on the base plate with the heels together, stretching upward to the fullest extent with the arms hanging on the side. The head was aligned straight so that the lower rim of the orbit and the auditory canal were on a horizontal plane. The head bar was brought down and held against the top of the head and the reading was taken through the window.

3. Skin fold measurements. Skin fold thickness was assessed between the left olecranon and acromion process on the posterior of the arm. Assessment was characterized as normal, reduced, or wasted on a clinical basis.

4. Vision testing. Vision was tested using symbols on a chart currently used in South India. Symbols were such that they could be identified by children living in that particular culture. Visual acuity less than 6/9 was taken to be significant.

Table 1 COMPARISION OF MEAN HEIGHTS AND WEIGHT OF REFUGEE CHILDREN (RC) WITH STANDARDS FOR AFFLUENT INDIAN CHILDREN (AIC) AND NATIONAL COUNCIL FOR HEALTH STATISTICS (NCHS)

GIRLS				BOYS			
	Weight (kg)				Weight (kg)		
Age	RC	AIC	NCHS*	Age	RC	AIC	NCHS*
5.50	13.81	17.90	18.56	5.50	14.36	18.40	19.67
6.00	13.90	18.70	19.52	6.00	24.09	19.20	20.69
6.50	15.50	19.60	20.61	6.50	14.83	20.60	21.74
7.00	15.63	20.50	21.84	7.00	16.77	21.00	22.85
	Height (cm)				Height (cm)		
Age	RC	AIC	NCHS*	Age	RC	AIC	NCHS*
5.50	99.37	109.40	111.60	5.50	100.45	110.40	113.10
6.00	101.40	113.00	114.10	6.00	104.18	113.70	116.10
6.50	108.17	115.40	117.60	6.50	107.62	117.50	119.00
7.00	110.56	118.20	120.60	7.00	111.50	118.60	121.70

* The 50% percentile was used instead of the mean for NCHS data

Table 2 DISTRIBUTION OF HEIGHT AND WEIGHT OF REFUGEE CHILDREN (RC) WHEN PLOTTED IN GROWTH CHARTS OF AFFLUENT INDIAN CHILDREN (AIC) AND NATIONAL COUNCIL FOR HEALTH STATISTICS (NCHS)

GIRLS	<5		<10		<25		<50		<75		<97	
Weight	AIC	NCHS	AIC	NCHS	AIC	NCHS	AIC	NCHS	AIC	NCHS	AIC	NCHS
No of RC	77	107	21	9	12	9	14	4	5	0	0	0
Percent*	59.69	82.95	16.28	6.98	9.30	6.98	10.85	3.10	3.88	0.00	0.00	0.00
Cumulative percent*	59.69	82.95	75.97	89.92	85.27	96.90	96.12	100.00	100.00	100.00	100.00	100.00
Height												
No of RC	69	87	12	23	26	10	13	5	7	3	2	1
Percent*	53.49	67.44	9.30	17.83	20.16	7.75	10.08	3.88	5.43	2.33	1.55	0.78
Cumulative percent*	53.49	67.44	62.79	85.27	82.95	93.02	93.12	96.90	98.45	99.22	100.00	100.00
BOYS	<5		<10		<25		<50		<75		<97	
Weight	AIC	NCHS	AIC	NCHS	AIC	NCHS	AIC	NCHS	AIC	NCHS	AIC	NCHS
No of RC	84	105	14	6	14	6	5	0	0	0	0	0
Percent*	71.79	89.74	11.97	5.13	11.19	5.13	4.27	0.00	0.00	0.00	0.00	0.00
Cumulative percent*	71.79	89.74	83.76	94.87	95.73	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Height												
No of RC	73	92	12	11	22	11	7	1	1	2	2	0
Percent*	62.39	78.63	10.26	9.40	18.80	9.40	5.98	0.85	0.85	1.71	1.71	0.00
Cumulative percent*	62.39	78.63	72.65	88.03	91.45	97.44	97.44	98.29	98.29	100.00	100.00	100.00

** Number of refugee children in each percentile expressed as a percent of total sample*

Clinical Examination

History was obtained from the child's parents. Clinical examination was carried out by one of the authors with particular emphasis on the detection of correctable disorders such as vitamin A deficiency (xerophthalmia, Bitot's spots), squints, chronic ear infection, dental caries, and signs of caloric deficiency. The cardiovascular system and respiratory system were auscultated and the abdomen was examined manually. Gross neurological examination was done to look for focal neurological findings.

Development Assessment

Clinical assessment of development was made with the assistance of tests of copying figures, handwriting, and speech appropriate for age.

Results

246 children born in the years 1986 and 1987 (5 years, 2 months to 7 years, 2 months) were studied. There were 117 boys (46.6%) and 129 girls (52.4%). Table I gives the mean height and weight of the refugee children, compared with standards for affluent Indian children [3] and standards from The National Center for Health Statistics. (NCHS) [2].

Table 2 gives the distribution of the heights and weights of the refugee children when plotted on the growth charts of affluent Indian children and the NCHS standards.

Table 3 gives the clinical findings.

Table 3 CLINICAL FINDINGS

	Number	Percent
Vitamin A deficiency		
(Xerophthalmia, Bitot's)	64	26
Refractory errors	13	13.4
Strabismus	7	2.9
Ear discharge	8	3.7
Dental caries		
Minor disease - 1-2 teeth affected	50	20.3
Major disease - 12 teeth affected	52	21.1
Total =	102	41.4
Skin fold thickness		
Reduced	159	64.6
Wasted	40	16.2
Total =	199	80.9
Asthma/wheeze	7	2.8
Heart disease	1	0.4
Inguinal hernia	1	0.4
Undescended Testes	1	0.8
Developmental delay	5	2.0
Cerebral palsy	1	0.4
Motor deficit due to poliomyelitis	2	0.8

Discussion

Anthropometry is recognized as an effective tool in the epidemiological assessment of the nutritional status of a defined population of children. The NCHS standards were developed in the United States using different communities in that country. They have been recommended for use in developing countries by the World Health Organization as a single reference standard. The use of a single standard allows the comparison of different populations. The NCHS standard may, however, have limited value as an indicator of the potential for optimum growth of children in populations whose genetic background differs from that of the population studied to derive the NCHS standards. Growth standards for affluent Indian children developed from a population not subject to malnutrition or illness is a more valid indicator of the potential growth of children in the Indian sub-continent.

Using these two standards this study found a substantial number of children in the refugee population to be malnourished and thus at high risk for impaired growth and development.

Table I. shows that the mean height and weight at every age was substantially lower in refugee children than comparative standards. As an example, at 6 years of age the mean height and weight of the refugee girls were 12.7 cm. and 5.62 kg. lower than comparable NCHS standards and 11.60 cm. and 4.80 kg. lower than the means of affluent Indian children. The mean values for refugee boys at six years of age were lower by 11.92 cm. and 6.6 kg. when compared to the NCHS standard, and 9.52 cm. and 5.11 kg. when compared with affluent Indian children.

Table II. expresses the data differently. 59.69% of the girls and 71.79% of the boys were below the 5th percentile for weight. 53.49% of the girls and 62.39% of the boys were below the 5th percentile for height. When the data is plotted on the NCHS growth charts, 83.95% of the girls and 89.74% of the boys had weights less than the 5th percentile and 67.44% of girls and 78.63% of boys had heights below the 5th percentile.

The findings of significant failure to thrive among the refugee children may not be unexpected, since populations subject to impoverishment and persecution are known to give rise to children who fail to thrive. This study did not compare the nutritional status of the refugee population with either poor children in South Indian villages near the refugee camps or with children living in the war zones in Sri Lanka, since comparing cohorts of deprived populations would not in any way negate the fact of deprivation and the risk of sub-optimal growth in the subjects studied. This study indicates the potential stunting of refugee children in comparison to a genetically similar population of Indian children who were not subject to these same conditions. Thus, if optimum growth and development is a health goal, these children are failing to achieve that goal.

Clinical examination revealed a very high incidence of

correctable diseases. Vitamin A deficiency was noted in over one quarter of the population. These children had structural changes due to vitamin A deficiency such as xerophthalmia and Bitot's spots. The history of night blindness elicited by questioning was considered too subjective for children living in conditions of poor housing and inadequate lighting. But, had vitamin A deficiency been defined functionally or by blood levels, the incidence would have been much higher. Vitamin A supplementation is known to decrease morbidity and mortality of children in third world countries [4]. The high incidence of deficiency of this vitamin may have profound effects on unmeasured health parameters such as mortality and morbidity. The clinical examination also revealed a high incidence of dry skin, suggesting fat deficiency. This was not surprising as there was hardly any fat used in the diet of the refugee children. Fats are an expensive source of food in South India, and the only source of fat in the refugee diet is the oil used for cooking.

Other correctable conditions included refractive errors which were found in 13.4% of the children. These would interfere with learning. Squints were present in 2.9% of the population. It is known that the persistence of uncorrected squints can lead to amblyopia; there was thus a potential for these children to lose some visual function in the absence of correction of this defect. Given the status of refugees and their inadequate access to health care, such corrective measures are unlikely to occur. Ear discharges were present in 3.7% of the children, indicating the presence of chronic otitis media. These children were at risk for partial, if not total, hearing loss due to middle ear disease.

41.5% of the children were found to have dental caries, reflecting the absence of fluoride in the water supplies and poor dental hygiene. Comparative data from the children in the local population was not available. Only two children had the stigmata of poliomyelitis. The low incidence of poliomyelitis possibly reflects the high rate of immunisation in the refugee population. Refugee children with incomplete immunisation prior to arrival in India had it completed at the time of registration in India.

If the health status of children in a population is indicative of the health status of that population, the severe malnutrition in the children described is likely to be indicative of significant health problems in this population of refugees who, like most other refugees, are voiceless and disempowered. This conclusion is inescapable and obvious if one visits a refugee camp. Discussions with the refugees identify some of the causes of this malnutrition. One is the gross insufficiency of resources available for the purchase of food. Another factor is the recurrent infection to which children are subjected because of poor sanitary conditions.

A recent report of the Médicins Sans Frontiéres identified Sri Lankan Tamils as one of the populations in danger from inadequate health care.[5]. That report focused on the Tamil population living in Sri Lanka and victims of the ongoing war. The data presented by this study indicate that the Sri Lankan Tamil population living in refugee camps in South India should be considered, along with the rest of the Sri Lankan Tamil population, as being in danger from malnutrition and an absence of adequate health care.

Refuge from the war has not assured the members of this population of the nutrition that would allow them to grow and develop normally. Unlike the population trapped in war zones, the refugees in South India are more accessible to, and appropriate for, interventions that would improve their health and well-being.

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HEALTH STATUS OF DISPLACED MUSLIM REFUGEES

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Assalamu–alaikum This is the normal Islamic way of greeting, meaning 'peace on earth'. Before proceeding further, I would like to thank the organisers for giving me this opportunity to describe the plight of the Muslim refugees in our country, the people affected worst by the present ethnic conflict. In the following pages, I will discuss the conditions faced by these refugees and how they have coped with them over the past four years

Introduction

Beginning in 1985, Muslim refugees from the North and East of Sri Lanka flocked to Colombo and other cities to escape inter-ethnic attacks on their villages. Between July 1987 and March 1990, they came to the cities to avoid harassment by the Indian Peace-Keeping Forces (IPKF). However, when the situation eased and they were assured protection, they returned to their villages though under severe hardship and insecurity.

In October 1990, however, attacks from the Tamil freedom movement forced Muslims of the North to abandon their villages and move into camps that were established in the districts of Puttalam, Anuradhapura, Kurunegalla, Polonnaruwa and Colombo. At the same time many Muslims of the East and North-East also gathered together in the safety of camps situated in these areas. This influx of people was not voluntary, but forced upon them by the Tamil movement or 'Tigers' (LTTE), who claimed these areas exclusively for themselves and the Tamils. While frequent attacks were made on Muslim villages in the East, on or about or the 24th October 1990 the 'Tigers' announced over loudspeakers in all Muslim settlements in the North that the people should leave their homes after handing over all their valuables or face death. They had to leave within 48 hours; in Jaffna town the deadline was only 2 hours.

Describing this act of the 'Tigers,' the London-based *Tamil Times* states: They were herded into trucks and deposited outside the 'frontiers of Eelam.' Even by the standards of brutality that have characterised the Sri Lankan ethnic conflict, one cannot find another previous example of this type of deliberate and premeditated collective cruelty perpetrated upon an entire community of people... What was perpetrated upon the defenceless Muslim civilians was inhuman and immoral in the extreme. (quoted from the *Sunday Observer* of November 28, 1993.)

Prior to this time, brutal acts of terrorism were practised in order to drive out all Sinhala and Muslim inhabitants; massacres, arson, destruction of fields and business premises and kidnapping were frequent. Prominent Muslims – including Mr. Makbool of Mannar who was always sympathetic towards Tamil grievances – were killed. It is worth mentioning here that the massacres at Kathankuddy and Eravur in the Eastern Province were carried out against people who defied the order of the 'Tigers' to vacate their villages.

Background

The plight of the Muslim refugees is all the more unfortunate because for centuries they have lived side-by-side with their Tamil neighbours maintaining friendship and amity, just as those Muslims in the rest of the country have lived and still continue to live amicably with their Sinhala neighbours.

Of the total Muslim population of about 8% in Sri Lanka, about one-third from the North and East. Although they comprise only 6% of the population in the North, certain areas have a high concentration of Muslims. Their relationship with the Tamils has been cordial and 'based on mutual respect and mutual benefit.' The first signs of deterioration of this relationship appeared around 1984, and the climax came in 1990 when the Muslims in the North-East became refugees.

Present Conditions

The total number of refugees (Muslim, Sinhala and Tamil) is said to be a little over one-half million people, while the Muslim refugees number about 250,000. The majority live in

camps; in the Eastern Province they work in the fields under guard by day, and return to the camps at night.

Apart from those in camps, many displaced persons are living with relatives or in rented premises. Very often, they are the fairly well-to-do who have lost everything but are fortunate not to have to live in camps. Nonetheless, their plight is sad as they must adjust to a totally new life of not having enough money. The older people suffer from depression, having left their familiar environment and easy lifestyle, and find it difficult to cope. The position of these people is nothing but pathetic.

Assistance

The State provides rations; employment has been found wherever possible and schools have been found for children. In the recent elections, refugees were given facilities to vote. Many non-governmental organisations (NGOs) also assist the refugees; the Muslim organisations include the Jama'ath-e-Islami, the Young Men's Muslim Association Conference, the Women's Muslim Association, the Refugee Relief Organisation and Sri Lanka Muslim Refugee Assistance (UK).

The Camps

The camps were hastily established as a temporary measure in community centres, schools and on mosque premises. Outside the cities huts were built in open spaces. After four years little has been done to improve the conditions in these camps which have been described as 'subhuman.' Inadequate space is a major problem, as are inadequate water supplies and toilet facilities. The unsanitary conditions that result lead to frequent outbreaks of disease.

The refugees also face other problems such as insufficient food supplies (lack of nourishing food for the children and infants), lack of proper clothing and school supplies and lack of ready cash. They also have to cope with cases of trauma, depression and extreme despair. In addition, the refugees say that the bureaucratic procedures through which they must register themselves for assistance are far too rigid; they have to undergo much hardship and, no doubt, humiliation.

Education, a basic right of children stressed in the Holy Quran, is not properly available to refugee children. They do not have proper clothing or books, and in school they are identified as refugees and find it difficult to relate to other children.

The refugees also have to contend with the situation of widows, orphans and old people, who would have been the responsibility of the whole community back in their villages. As people from different social strata and all walks of life come together in the camps, many other social problems arise. Quarrels often lead to physical violence, and cases of rape and incest have been noted by social workers.

How They Have Coped

Life goes on in the camps. Weddings have taken place, births and deaths have been recorded. Madrasas as well as a few pre-schools are being run by NGOs. One or two persons have been chosen as the leaders and they are responsible for general welfare.

At first, the local people had been very helpful to the refugees, but now after four years relations have deteriorated. It appears that the locals feel that the refugees are getting a better deal and they resent this. They also feel that the refugees may never return home. Although some refugees have found work, most are willing to just drift along. NGO personnel say that the refugees have become dependent on them, but the refugees say that they do not wish to antagonise the local people. Locals have assaulted them or damaged the huts when enterprising persons had tried to earn a living by trading.

Some Suggestions

Most of the refugees wish to return to their villages, but until the time comes when they can return, something must be done to improve their lot. Apart from improving the conditions in camps, more training projects would help. The children, who appear to be the greatest losers of a happy childhood and proper schooling, should get a better deal: more food, proper clothing and health facilities. Many of the educated women and children would benefit from books and other reading materials. Most of all, the refugees wish and pray for peace of mind until they return.

Conclusion

The Muslim refugees have coped well under trying conditions. The change in Government brings hope of a settlement. It must be stressed that the best solution is for the refugees to return to their settlements; in fact, this is what they want.

The refugees have lived so many years in camps, wasted years no doubt, not only for them but for the country too. They have become insecure, fearful and suspicious, if not frustrated, depressed and despairing. Most of them have lived respectable lives and feel humiliated by the treatment meted out to them by the local people. Like everyone else they have a right to a good life. Therefore, when the time arrives for them to return and they require assistance, everything possible should be done for them. They will have to rebuild not only their homes but their lives. They will need funds as well as expertise, but most of all, they will need the assurance that they are safe, that they can live without fear and that their lives will not be so brutally disrupted again.

I will close by saying that this dialogue has made it possible for me to acquaint you with the plight of 15% of the total Muslim population of Sri Lanka, who without assistance would very well join the growing number of oppressed and forgotten people of this world.

THE HEALTH OF SRI LANKAN TAMIL REFUGEES IN INDIA

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Many members of the Tamil community in Sri Lanka responded to the acts of violence perpetrated by the Sri Lankan government and its armed forces by fleeing to South India by boat. They were received by Indian government authorities and housed in refugee camps situated all over Tamil Nadu. A smaller number of the refugees, often with better means, settled outside the camps.

Given the difficult and ever-changing situation of the refugees and the meagre resources available, a systematic collection of data to encompass all aspects of health and disease of those living in the refugee camps could not be accomplished. What has been attempted is a partial portrayal of the situation which however gives a good indication of the health status of this population

Method

The information presented in this paper was obtained by the following means.

A Data collected by health workers (the health worker programme is described elsewhere in this volume). Health workers systematically weighed Children in the refugee camps to obtain information on the weights of children. The medical unit of the Organisation for Eelam Refugee Relief (OfERR) carried out surveys of haemoglobin, hematocrit and stool testing. Qualified medical laboratory technicians of the OfERR medical unit conducted the testing. Two of the authors (Mr. Poongundran and Mr. Nadarajah, both of whom were medical students prior to becoming refugees) visit camps on a regular basis and examine children for vitamin A deficiency. They also carry out a programme of vitamin A supplementation by giving 60,000 units of vitamin A twice a year to each child. Information on vitamin A deficiency and the effects of the treatment were obtained from their data.

B Direct observation by all of the authors who have worked in a clinical setting in the refugee camps and among refugees who came to the medical clinic at Madras and Trichy.

C Interviews of health workers during examinations and at other times as part of the health worker training and examination process.

D Review of the health worker records. Health workers are required to keep daily logs of their activities and some information was obtained from their logs.

The situation of the refugees is characterised by constant change. Their numbers have continued to decline, mainly due to the repatriation to Sri Lanka. Thus, the numbers indicated in the data are representative of the particular time at which they were collected and may have changed since then. But even though the numbers have changed, the condition of those remaining behind (60-70,000 in February 1995) is well represented by the information provided in this paper.

Living Environment of the Refugees

When this paper was presented (September 1994) there were approximately 80,000 refugees living in around 130 camps. Table 1 gives relevant information from some of the camps in South India. These camps were chosen on a random basis and information obtained will give a representative picture of the situation.

Type of Accommodation

A variety of temporary shelters are used to house the refugees. These vary from a few cement buildings and old cyclone shelters to cadjan huts and sheds put up with tar sheets. In most instances the refugees were housed in temporary sheds. From a health point of view, it can be generalised that the housing given to the refugees inadequately protects them from the environments. In rainy season the dwellings invariably become damp and wet, giving rise to respiratory infections; in the hot seasons they become very hot and uncomfortable. Refugees live in these sheds without any furniture.

Drinking Water

Most communities draw their water from bore wells. River water is also a supplemental source in some areas with access to rivers. Few camps have overhead tanks. Bore wells (the commonest source of water) supply water that is relatively uncontaminated biologically, though the risk of contamination once out of the ground is high due to poor sanitation and overcrowding.

Latrine Facilities

Almost universally, the lavatory facilities are inadequate. In most places there are no lavatory facilities available and the refugees have to use the open air to relieve themselves. When there are constructed latrine facilities available, they are usually inadequate in numbers and lack privacy. The poor latrine facilities not only contribute to the spread of diseases, but are also a source of indignity and embarrassment to the refugees.

Accesss to Acute Health Care Services

Most refugee camps are situated in areas away from population centres. Some have public transportation facilities but many have inadequate facilities for transportation, especially at night. Thus, emergency services are difficult to obtain.

Overall, inadequate environmental and sanitary conditions are an almost universal feature of refugee life and have contributed to morbidity and mortality in the camps

Nutriton

Undernutrition (caloric/energy deficiency) manifest by stunted growth and the absence of subcutaneous fat is very evident on clinical examination. Both children and adults are subject to such undernutrition. Systematic weighing of infants and children in the camps by health workers provided quantitative information about the child population and supports the clinical observation.

Table 2. shows the distribution of the weights of 3,974 refugee children from birth to five years of age weighed in January, 1994. The weights of the children were plotted on a growth chart derived from a cross-section of the South Indian population. In order to make the information of the weight of the child more meaningful to the parents and clinician the formulators of the charts have given a nutritional interpretation to the weight of the child. Thus, these growth charts are divided into weights that represent overweight, weights that could be considered normal, and weights that would represent different states of undernutrition (slight, moderate and severe undernutrition).

It is important to point out that the refugee children's weights are plotted on a chart derived from the South Indian population, which itself is known to be undernourished. Using these criteria, 75% of the children fall in the category of undernutrition. 39% of the children have slight undernutrition, 27% have moderate undernutrition, and 3% have severe malnutrition. Thus, even in comparison with normal data for South Indian children, the refugee children are found to be undernourished based on their weight.

Table 2 compares the weights of children in the refugee camps in January, 1993 and January, 1994. The information is expressed as a percentage of children who belong to the different categories of nutritional state, based on their weight. The data is cross-sectional and different children's weights are represented in the two years. The data indicate that undernutrition in the camps has neither increased nor decreased from January, 1993 to January, 1994. This comparison was made to assess the impact of supplemental nutritional programmes started in 1992 (supported by Dutch Inter Church Aid). The fact that there was no decline in the overall weight status of the refugee children, despite the harsh living conditions and repeated respiratory and gastrointestinal infections among these children, may suggest a positive contribution by the supplemental nutrition programme.

In order to escape the dilemma of comparing two undernourished populations an attempt has been made (Table 4) to compare the weights of refugees to data obtained from a healthy population. The standards used are those of the National Council for Health Statistics (NCHS), developed in the U.S.A. using a cross-section of the children in the U.S.A. The World Health Organisation has advocated the use of the NCHS standard in different communities across the world. Use of this single standard helps to compare children across different cultures and in different countries. However, it will fail to make a fair comparison of children with different genetic potential due to ethnic origin. The South Indian chart comparing children to another malnourished group is also an inadequate tool to assess the status of the refugee children in terms of their genetic potential. While there is no one definite way of addressing this question, it is possibly only be of academic interest in the case of the refugee children because of the massive degree of deprivation that obviously exists in the camps.

When the refugee children's weights are plotted on the NCHS chart (Table 4), 75% of the children are below the 5th percentile line (the same percentage of children who are undernourished according to the South Indian chart). To classify and understand the distribution of weights of these children (who fell below the 5th percentile), their weights were further divided into a percentile chart. The child with the lowest weight was assigned the 1st percentile value, and the 5th percentile of the NCHS chart was assigned the 100th percentile value. The weights between these were divided into 100 equal segments and the weights of those below the 5th percentile were plotted in this percentile chart. When this is done, one finds that 42% of the refugee children fell between the 85th and 100th percentile point, while 22% fell between the 75th and 85th percentile and 11% fell below the 75th percentile line. This weight distribution seems to correlate well with the impression obtained by using South Indian charts: the majority of children are moderately to mildly undernourished. The inescapable conclusion to be drawn from these data is that there is widespread undernutrition of children in the camps. It is noteworthy that during all the examinations obvious clinical evidence of protein calorie malnutrition (kwashiokor) was not found.

The birth weights of children could not be systematically

followed because most births took place in the hospital, but as best could be found, the birth weight of a refugee child is around 2.5 kg, with many falling between 2.0 and 2.5 kg. Good information on the infant mortality rate is not available.

The statistical observation of undernutrition is not surprising if one looks at the availability of funds to purchase calories. Funding for food comes from a grant to each family given by the Indian government. The grant is as follows:

Head of family/per month	Rs. 150.00
Spouse/per month	Rs. 120.00
First child/per month	Rs. 75.00
Second child/per month	Rs. 37.50
Family of four/month	Rs. 382.50
Additional children/month	Rs. 18.25

In addition, families are provided with rice at a rate of 57 paise/kg. at the rate of 400 gm. for adults and 200 gm. for children under 12. Limited quantities of dry rations, cooking oils and kerosene are also supplied at a subsidised rate to be paid from the available monthly dole. In contrast, an average family of four needs the following:

The contrast between the availability of resources and the cost of food, as described above, accounts for the undernutrition that is widely prevalent.

Chronic undernutrition is likely to produce permanent stunting of growth among children. Prenatal and infantile undernutrition, is likely to result in decreased brain cell number as it coincides with the critical phase of cellular brain growth. The long term effect of this is unknown but may not be positive.

	Quantity per day	Cost per day (Rs)
Rice (subsidised and on ration)	1.2kg	0.80
Dahi	Quarter kr	4.60
Vegetables	Half kg	4.60
Coconut	One half	2.875
Spices		1.15
Firewood and kerosene		2.3
Other miscell.		3.8
TOTAL per day		Rs 18.70
TOTAL per month		Rs 561.00

Vitamin A Deficiency

Clinical examination of children from the camps revealed widespread prevalence of Bitot's spots and night blindness. These findings prompted a systematic programme to combat vitamin A deficiency. The programme is carried out under the supervision of two of the authors who make regular visits to the camps to examine children and administer 60,000 IU of vitamin A twice a year.

Many children in the camps exhibit dry skin and decreased or absent subcutaneous fat. Study of their diet

Table 1

CAMP	Kamarajar district Mallangina	VOC district Thapathy	VOC district Kullathu-waypatti	Kamarajar district Kullorsanthi	Kamarajar district Annaikuttam	Salem district - 4 camps	Thrichy district Vallavan-thankottai	Pasumpon district Akkur	TOTAL
Population	368	1346	323	1157	498	2240	1991	567	8490
Families	87	348	81	285	136	519	5222	156	2134
Children under 10 years	53	209	40	215	76	213	245	119	1170
Health workers	1	3	1	2	1	2	2	1	13
Vitamin deficiency mild	20	75	26	77	44	73	78	58	451
%	38%	36%	65%	36%	58%	34%	32%	49%	39%
Vitamin deficiency servere	14	62	2	68	10	18	91	23	288
%	26%	30%	5%	32%	13%	9%	37%	20%	25%
Dental caries and other	28	72	19	68	29	74	103	39	432
%	53%	34%	48%	32%	38%	35%	42%	33%	37%
Worm infestation	9	34	12	25%	14	14	120	54	367
%	17%	16%	30%	12%	18%	18%	49%	45%	31%
Type of accommodation	Poultry farm building	Tar sheet huts	Poultry farm building	Tar sheet huts and PWD cement houses	Cadjun huts and PWD cement houses	Tar sheet huts and cement houses	Tar sheet huts	Tar sheet huts	
Drinking water	Bore well and community well	Salty bore well and water from river bed	Bore well in camp	Bore well in camp	Overhead tank	Bore well	Bore well in camp	Bore well in camp	
Latrine facility	Available	None	None	None	Only PWD houses	None	None	None	
Hospital	12 Km	8 Km - No night transport	12 Km - No night transport	10 Km	12 Km	18 Km - No night transport	18 Km - No night transport	9 Km - No night transport	
Climate	Dry	Dry	Dry	Dry	Dry	Dry	Dry	Dry	

Table 2 DISTRIBUTION OF WEIGHTS OF REFUGEE CHILDREN — BIRTH TO 5 YEARS OLD

	Severe undernutrition	%	Moderate undernutrition	%	Slight undernutrition	%	Normal growth	%	Over weight	%	TOTAL
0 - 3 months	2	2	20	21	13	14	22	23	37	39	94
4 - 6 months	1	1	13	10	24	19	39	31	49	39	126
7 - 9 months	3	3	27	23	31	26	45	38	14	12	120
10 - 12 months	8	9	25	29	27	31	22	26	4	5	86
13 - 15 months	10	6	49	29	59	35	44	26	8	5	170
16 - 18 months	5	6	16	20	31	38	28	34	2	2	82
19 - 21 months	9	8	23	20	58	51	18	16	6	5	114
22 - 24 months	4	4	38	39	28	29	22	23	5	5	97
2 -2.5 years	16	5	58	16	172	49	97	27	11	3	354
2.5 - 3 years	14	3	107	26	199	48	84	20	9	2	413
3 -3.5 years	12	2	155	29	169	31	195	36	9	2	540
3.5 - 4 years	8	2	137	26	249	48	125	24	2	0	521
4 -4.5 years	10	2	178	27	279	42	190	29	5	1	662
4.5 - 5 years	36	6	220	37	206	35	133	22	0	0	595
TOTAL	138		1066		1545		1064		161		3974
	3%		27%		39%		27%		4%		100%

showed hardly any fat intake. Thus, the possibility of fat deficiency, which is often associated with vitamin A deficiency, has to be considered.

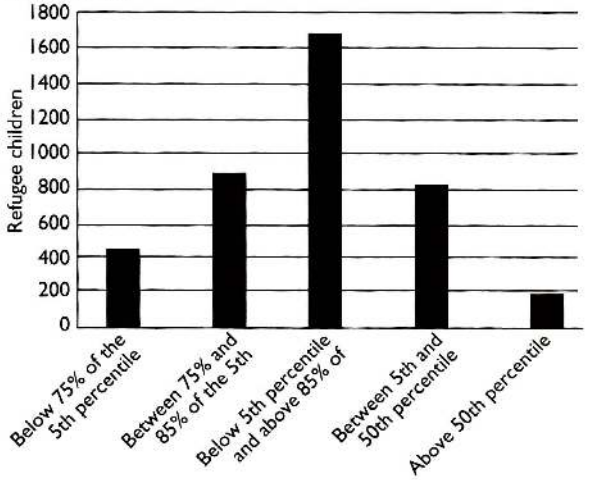
For the purpose of this paper, vitamin A deficiency was classified as mild and severe. Mild deficiency is indicated by dry skin and severe deficiency is indicated by Bitot's spots and/or night blindness. Using this criteria, in the eight camps presented in Table I, a total of 739 children (out of 1,170 under 10 years of age) were found to have some degree of vitamin A/fat deficiency. 25% of these children had severe vitamin A deficiency.

Table 5. presents data on children with severe deficiencies identified in the periods from May to July 1992, August to December 1993 and April to July 1994. These data are drawn from all the camps where vitamin A supplementation was given, and a decline in the severe deficiencies from 34.14% in 1992 to 16.82% in 1994 can be noted.

Table 3 WEIGHTS OF CHILDREN IN REFUGEE CAMPS JANUARY 1993 V JANUARY 1994

	1993		1994	
Severe undernutrition	134	3%	138	3%
Moderate undernutrition	1053	26%	1066	27%
Slight undernutrition	1547	39%	1545	39%
Normal growth	1080	27%	1064	27%
Over weight	165	4%	161	4%

Table 4 WEIGHT DISTRIBUTION BASED ON NCHS PERCENTILES



Anaemia

The children in the eight camps identified in Table I had fingerstick blood taken for estimation of hematocrit. Blood was taken by a trained laboratory technician using laboratory facilities of a medical unit. Haemoglobin values above 12 grams were considered normal, values between 10.5 grams and 12 grams were considered mild anaemia, 9 grams and 10.5 grams were considered moderate anaemia, and less than 9 grams were considered severe anaemia. Using this criteria, 30% of the children had normal haemoglobin and 70% had low haemoglobin, of which a full quarter of the population was judged to have severe anaemia.

Worm Infestation

Stool samples were obtained from children in the eight camps studied and 31% were found to have worm infestation. The commonest worm found was the round worm.

Immunisation Programme

Quantitative data is not available to describe the immunisation programme, but due to the diligent work of the health authorities when the refugees came into India and

Table 5 STATEMENT OF VITAMIN A DISTRIBUTION PROGRAMME

Vitamin A programme started		
May 92 — July 92		
No of children benefited in this period	2938	
Deficiencies identified	1003	34.14%
August 93 — December 93		
No of children benefited in this period	6267	
Deficiencies identified	1529	24.40%
April 94 — July 94		
No of children benefited in this period	6904	
Deficiencies identified	1160	16.80%

the work of the health workers in the camps, it is our impression that almost all children are immunised against diphtheria, pertussis, tetanus and polio. New cases of polio myelitis were not found in the camps. However, immunisations for measles, mumps, rubella and typhoid are not available to camp residents, and they continue to suffer from these preventable diseases because of the lack of available resources.

Birth Control and Fertility

The refugee population has no access to the active population control programme of the Indian government. Data available to the OfERR medical programmes seem to indicate a decrease in infant and child population. This decrease is more than what could be expected due to the decrease in refugee population, giving rise to a suspicion of decreased fertility. There have been instances in some camps of voluntary sterilisation of nulliparous women. Six of these women were interviewed, and it was found that they resorted to sterilisation because of the hopelessness of their life situation and their unwillingness to subject a child to refugee living conditions.

Infectious Diseases

Diarrhoea and respiratory infections are the most common recurrent infectious diseases in the camps. Thisimpression was obtained by looking through health worker casebooks and through discussions with health workers. The early use of oral rehydration solution (ORS) by the health workers has minimised the mortality resulting from diarrhoeal diseases. Respiratory diseases continue to pose a problem, particularly in the form of bronchospasmic diseases and pneumonitis.

Typhoid, tuberculosis and malaria are endemic in the camp population.

Cholera has been seen in epidemics. Skin infections such as scabies are widely present. Complications of scabies, streptococcal infections and acute lung infections are also seen. Conjunctivitis is another very common illness in the camps. Quantitative data for these conditions are not available.

Other Illnesses

Gastro-esophogeal reflux diseases seem to have a very high incidence, based on the clinical examination of those in the refugee camps by health workers. These are usually treated with antacids such as sodium bicarbonate. H2 blockers and other new forms of therapy are outside the reach of the average refugee. Diabetes is widely prevalent, as would be expected in any South Asian population. Coronary artery disease and other heart conditions, too, are prevalent, but no hard data on the incidence of these conditions is available.

Mental Health

Depression, adjustment reaction and anxiety are widely prevalent in the camp situation (Articles in other sections of this volume - *OFERR Counselling Programme, Coping with Stressful Events, Mental Health by J. De Vries and G.L. Van Heck - describe the situation).* Suicide, particularly among young females, seems to occur more frequently than in the general population. Quantitative and comparative data are not available but the impression is of a higher incidence than what would be expected in the general population. The most common mode of suicide is self-immolation. Drinking of organic phosphate poisons is the second-most common method.

Conclusion

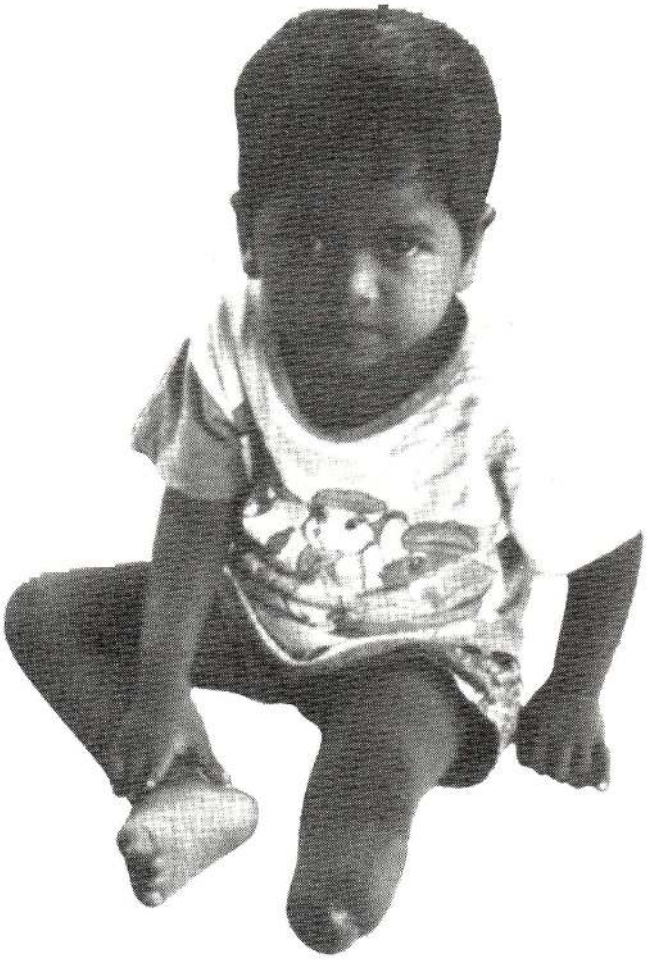
The disease spectrum seen in refugee camps and the health status of the refugees is to be expected from their life situation. They have escaped from the violence in Sri Lanka into a situation of poverty with social, cultural and nutritional deprivation and starvation in India. They have left Sri Lanka in a hurry, often to escape imminent danger to their lives. Having sold all their possessions and moved to India seeking refuge, they are subject to a hostile political and psychological climate in the camps with little hope for change and improvement given the intractable political situation in Sri Lanka. The fact that they have sought help from a third world country with a substantial population of its own citizens deprived of the basic necessities of life has aggravated and exacerbated the condition of the refugees.

A major reason for the absence of adequate measures to maintain good health among the refugees is their lack of any political power. Refugees are constituents without any representation and are looked after only because of the goodwill of a few individuals and institutions. They have minimal rights, and enforcement of these rights is almost impossible. International refugee organisations, which could act as supervisors of the local effort to ensure international standards, are not allowed to work in India.

While massive relief and rehabilitation efforts would help, all such efforts can only substitute poorly for good governance, justice and equality, and the opportunity for the refugees to determine their own future by democratic participation in their own governance.

Day 2

RESPONDING TO THE HEALTH AND HEALTH CARE NEEDS AND THE WAY FORWARD



Day Two
18 September 1994

WELCOMING ADDRESS

Dr S Pathupathy Rajah
Director, Tamil Information Centre, UK

Ladies and Gentlemen,

It is a great privilege to welcome all of you – participants, professionals, human rights activists, legal experts and various community and social workers – who have come at great personal inconvenience to contribute to this conference and make it a success.

Yesterday, we had a very fine day. The papers submitted were of great calibre and the workshops had high participation and enthusiasm. The workshop reports were of exceptional quality. I can assure you that the programme today will be as good as that of yesterday, that today's programme is only a natural continuation of yesterday's events. When we planned the date of this Conference, we never realised that circumstances in Sri Lanka would change so fortuitously so that this Conference could not have been more opportune. With the relaxation of the constraints placed on us and various government and non-governmental agencies, we should be able to work more positively for the betterment of our community. Another product of yesterday's deliberations was the conclusion that a programme for health development cannot focus solely on health. Health is interrelated to economic and educational progress, and all three of these community needs must go hand-in-hand; this came out very strongly yesterday. I shall also take this opportunity to thank the various participants who have come a long way to join us. The great distance they have travelled at personal inconvenience humbles us. I must make special mention of His Lordship Bishop Kenneth Fernando, who came all the way to be one of us; his contributions and his presence also humble us. I do not want to take any more time of this Conference. I invite Ms. Liz Philipson, Chair of War on Want, UK, to chair the meeting today.

Day Two
18 September 1994

CHAIR'S ADDRESS

Ms Liz Philipson
Chair, War on Want, UK

I am here today as Chairperson of War on Want, and we were particularly pleased to have been invited to chair this meeting today. War on Want has been working in areas of conflict since the early eighties and was perhaps one of the first NGO aid organisations to work in such areas. Aid organisations today are working increasingly in zones of conflict, and we have some experience in many such areas globally.

During the war in Ethiopia we sought to support the operation of health clinics in Eritrea. All the issues that came up in the first day of this conference were questions we and our partners faced in Ethiopia. Take for example, the issue of outside support work relying on indigenous skills. Very often we utilised indigenous skills in the area because these were available and you must work with what you have. Although we brought equipment and strategic, financial and moral support from outside, Eritreans did much of the actual groundwork. I have seen some amazing things we have accomplished in Ethiopia, and we are very proud to have been associated with those projects. The projects we started in the very early eighties have now continued into peacetime, and I hope that similar projects can be introduced in Sri Lanka soon. War on Want has also worked in the Gaza Strip with Palestinians, but I will leave discussion of that region to Dr. Swee Chai Ang, who has extensive experience working there.

The sessions today will continue the discussions of yesterday; hopefully they will lead towards a rather different future for North Sri Lanka than the frail hopes now generated by the political situation. People can make hope a reality. Hope is not founded on chance, and if enough people believe and work to make their hopes real, perhaps we can produce a very different context for some of the ideas we have been discussing.

INSTITUTIONAL ROLE AND CHALLENGES

Dr Karunyan Arulanantham, MD, FAAP, FACE
Medical Director and Paediatrician Sierra Medical Group, California, USA

The ongoing war in Sri Lanka and the preceding decades of discrimination and violence directed at the Tamils have had a devastating impact on the Tamil community. The response of the Tamils to this situation has varied from joining the armed resistance against the Sinhala state to fleeing to other countries as refugees or migrants. Some of the Tamil migrants and refugees to the stable and affluent western countries have organized themselves into groups such as the Medical Institute of Tamils, Tamil Refugee Relief Organization, the Standing Committee of Tamils, etc.; with the intent of making a positive contribution to improving the status of the Tamil community. Some of the programmes of these groups are directed towards improving the health status while others support different types of activities. In this paper I will make broad observations based on my experience in interacting with and assisting in the health program of a Tamil Refugee Organisation in South India, the Organisation for Eelam Refugee Rehabilitation (OFERR). This is not a comprehensive survey of all the activities undertaken by expatriate Tamil organisations and is only an attempt to share my thoughts and perspectives on this subject.

The Problem

It is estimated that between 30-50% of the Sri Lankan Tamil population have been displaced from their homes and their communities within a very short time because of war and violence. The majority of the displaced is within the island. Jaffna peninsula itself has around 250,000 individuals displaced from their homes because of the occupation of their villages by the Sri Lankan armed forces. The islands surrounding Jaffna have hardly any people left and the coastal areas occupied by the armed forces around Palaly, too, are devoid of any significant population. Around 175,000 individuals live in South India as refugees. At the height of the displacement, close to 120,000 of these individuals lived in hastily constructed camps all over Tamil Nadu, but due to repatriation, this number is now around 60,000. New Tamil communities have sprung up in Canada, France, Germany, Switzerland, and the size of the communities in Australia and the United Kingdom have substantially increased.

The health problems of those displaced and dispossessed within Sri Lanka and in South India stem mainly from physical deprivation of food and the environmental necessities for healthy living. They also suffer from the psychological consequences of acute trauma and indiscriminate violence. There is a high incidence of post traumatic stress disorders and adjustment disorders. The health problems of those displaced to more affluent countries do not stem from physical deprivations but rather from adjustment difficulties in the new environment and from requirements for new social and economic relationships. In this paper, my observations and opinions are primarily concerned with the activity of assisting those in the more deprived environment by the Tamil organisations in the west.

The extent of destruction of the infrastructure and deprivation cause by war and economic dislocation in north-east Sri Lanka is enormous. Evidence of the magnitude of the problem can be obtained by reading many of the articles contained in these proceedings. Some statistics may help to get a glimpse of the problem: In the Jaffna district alone there are over a 1/4 million individuals who have no homes either because they are displaced from their homes or because their homes have been bombed and destroyed. (Source: Jaffna Kachcheri/Save the Children Fund U.K.,6/94). The nutritional survey done by Dr.N.Sivarajah in 1993 revealed that 40% of children in the Jaffna district were stunted in growth as a result of chromi under-nutrition. 19% of these had a low weight for height, indicating more acute under-nutrition. It was estimated that in 1993 4,250 children in the Jaffna district alone had marasmus and Kwashiorkor, which are severe nutritional deprivations from starvation that are often fatal. The Mullaitivu district had close to 29,000 displaced people but has no functioning healthcare facility.

The refugee population in South India are housed in hastily constructed camps usually away from populated centres. Small mud house with thatched roofs crowded together in a small area make up the dwellings, which have minimal ability to protect the individuals from rain, heat or cold. They live in these dwellings without furniture. Most significantly, toilet facilities are non-existent, causing not only a health hazard but also a loss of dignity. The refugees purchase food from a monthly dole given by the Indian government. The total amount of dole is sufficient only to purchase only between 50-70% of the minimal caloric requirement for healthy living. Supplementation of income by working in the community outside the refugee camp is banned and these refugees suffer a great deal of economic deprivation. The result is very high incidence of malnutrition and other illnesses associated with poverty. A study done of 250 refugee children at the age of school entry in South India showed that 26% had signs of vitamin A deficiencies, threatening their eyesight; 40% of them had dental caries; and over 75% of the children were stunted in growth due to chronic malnutrition.

The war in Sri Lanka is being fought in an impoverished third would country where large segments of the population have never had adequate access to food and the environmental necessities that permit a healthy life, such as clean water. The poorer segments of the Sinhala community, in addition to the Muslim and Hill country Tamil communities suffer deprivation as the government squanders borrowed money on a self-destructive war. A UNICEF survey showed that 50% of the school children in the Sinhala areas were malnourished and 65% of the pregnant women were anaemic. A news report (Daily News, 24/7/92) quoted a physician as stating that there were 30,000 child prostitutes in Colombo. Attitudes of war and destruction learned for purposes of injuring individuals and communities labelled as "enemies" cannot be neatly confined to such purposes. Ironically, they often result in death and destruction in the community that teaches such attitudes. Thus, the European Human Rights Commission noted that around 60,000 Sinhala people were said to have lost their lives in intra-Sinhala conflicts. No Community in Sri Lanka is free of the sad effects of the decades of bad governmenance, but undoubtedly the Tamil community has suffered the most.

A Victim of the War

Fig. 1 is an attempt at schematically presenting the interaction of the various forces, internal and external to an individual, that impacts on a victim of the war. This is a theoretical attempt to portray the situation of some of the refugees that I have seen in the camps in South India. It should be noted that this is not the only type of response of those who are subject to violence and displacement.

An individual victim of the war who has lost all his/her property and has been separated from extended family ties that have traditionally supported the individual is impacted by economic, physical, psychological and spiritual forces that interact negatively with each other. Poverty and malnutrition increase susceptibility to illness. Inadequate access to medical care and decreased energy to work are associated with sickness and malnutrition and decrease the effectiveness of the individual in economic activities. Economic losses often include the loss of capital and life savings and the loss of economically able members of the family. The dispersal of family members to different parts of the world and the loss of family support cause not only psychological and spiritual crises, but also impacts an individual economically. Adjustment problems, including dependency syndrome, depression, and exacerbation of the already existing post traumatic stress disorder, etc., are described elsewhere in this volume. All these factors interact to create a loss of hope, loss of dignity and despair associated with a loss of vision and failure of belief in one's self and society. When survival becomes difficult because of one's identity and heritage, one tends to question his/her own identity and beliefs, causing further confusion and conflict, which impacts negatively on physical and psychological health.

The challenge to those who choose to intervene in this situation is to alter these dynamics in such a manner that a positive interaction of these forces will be created. Such changes in dynamics require patience and persistence.Healing of the injuries can only occur over a long time.

Goals of Intervention

If an ideal is to be stated for the goals of intervention it would be the empowerment of individuals and communities to solve their own problems. Such empowerment requires appropriate assistance, balanced with the creation of autonomy in the individuals and communities receiving the assistance. The challenge is to achieve this balance in the deprived situation and in the context of violent and displacement. A fundamental assumption of the goal of empowerment is that even dispossessed individuals have the ability to sustain themselves with appropriate decisions given an opportunity. But the reality is that many national and international forces work against empowerment of communities and individuals. The economic order sanctioned by the international community and individual states tend to exploit the weak, rather than empower them to become competitors or to demand more. In fact, the inability of the Tamil community to charter its own destiny autonomously is at the core of the political conflict that has resulted in the war. However, despite these larger forces, it is still feasible to work for the goal of empowerment of individuals and communities within limits. Assisting and interacting with these injured communities focusing on empowering them to solve their own problems should be the goal of expatriate organisations in the west.

Expatriate Organisations

While the desire and intent to assist and share in the problems of the Tamil community may be present in the expatriate Tamils, the existential problems of day to day living in the west have to be overcome to be able to focus attention on the problems of those left behind. First generation migrants to the west are often overwhelmed by the

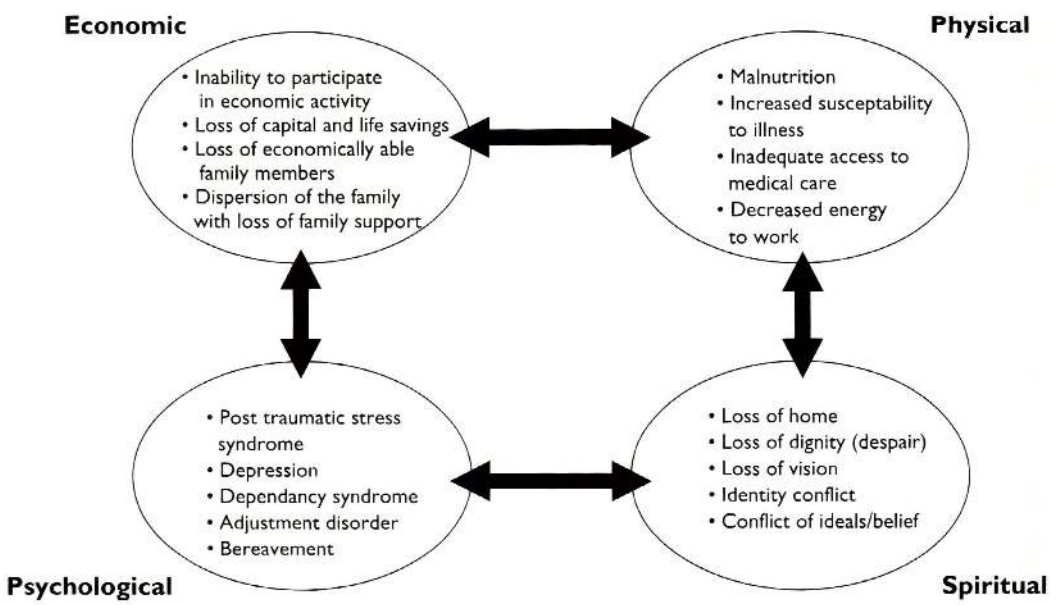
adjustments required to settle in a new country with a new set of rules and the challenge of rearing children in an alien culture. Thus, often the expatriate Tamil organisations seem to function primarily for the purpose of assisting in the adjustment of its members to the new country, rather than functioning to focus on the problem of those living in north east Sri Lanka or South India. As the new migrants and refugees continue to live in the west there is a real danger of losing touch with the realities on the ground which are changing at a very rapid rate. Ideas useful and relevant in the west in a highly industrialised society are often quite inappropriate in a third world situation. These difficulties of living in the west and imbibing their ideas and interacting with a different situation in impoverished Sri Lanka and India needing other ideas can be overcome if the existence of this problem of inappropriate ideas is acknowledged. Adequate study and being focused and goal oriented helps to overcome these obstacles. The biggest problem facing expatriate organisations is a lack of faith, vision, and more importantly, doubt of relevance in a seemingly hopeless situation. Such feelings and attitudes often lead to indifference and avoidance of participating in improving the situation for the victims of the war. Further, strong family ties often result in the expatriate Tamils helping other family members on an individual basis rather than cooperatively acting together as organisations.

On the other hand, many tangible attributes among the members of the expatriate Tamil communities can be very useful in the current situation. Foremost among them is the knowledge and experience of the highly educated expatriates in the west. Sharing their knowledge and participating and seeking new ideas in new situations are probably the most valuable contribution that can be made by the expatriate Tamils. This is particularly so in the health field. Enormous resources are available among expatriate health professionals but this is munderutilised for a variety of reasons, some political,some social and some personal. One of the most valuable contributions that has been made by expatriate physicians in the current situation is their participation in and enhancement of the health worker programme for the refugees in South India. Over 150 refugees in South India have been trained as health workers and have made a very tangible contribution to improving the health of these refugees. The expatriate community, including members of MIOT, shared their knowledge and ideas with the members of the OFERR medical team.

Ability to speak, write and articulate the problems of the Tamil community is another much needed contribution that can be made by the expatriates. Mediating between organisations on the ground in Sri Lanka and India and those in the west and explaining the context of the refugees and displaced people to those in the west are perhaps best done by individuals with life experiences in the two different situations. Bridging this gap is another major contribution that can be made.

The Interaction

Many new and some existing organisations work with the victims of war in Sri Lanka and India. Many are excellent organisations with highly dedicated leadership working under very adverse conditions to deliver assistance. However, given the number of organisations that do exist there is likely to be variability in the quality of leadership, vision and understanding. My own experience is mostly with OFERR, an organisation by the refugees in South India for the refugees in South India. OFERR is recognised as an excellent and stable organisation which has worked under a difficult



political environment to accomplish its goals, enhancing the lives of the refugees in the camps and other displaced Tamils in South India. Tamils Rehabilitation Organisation (TRO) works in the north-east of Sri Lanka, bringing relief and assisting in rehabilitation in a very effective manner. Feeding centre for undernourished children are run by TRO in Jaffna to combat malnutrition, and its programme is designed with the advice of local nutritional experts and physicians. Their nutritional and rehabilitation programmes are innovative in character. The Church of South India runs many children's homes and orphanages and is involved in relief and rehabilitation. They have a long track record. There are many other organisations, and this list is not comprehensive, but rather reflects my own information which is partial and incomplete. There are also many non-governmental agencies that have headquarters in the west which work in the war zone. Examples of these include Save the Children Fund, the Redd Barna and Canadian Children's Fund among many others.

Interaction of the expatriate organisations with local organisations is advisable for maximum results. Working with individuals who are not organised would be less effective. Strong family ties, which are characteristic of the Tamil society have functioned to assist numerous people on an individual basis, and have been valuable in the current situation. However, community development needs to be organisation based.

Interacting with these organisations on the ground will be more effective when certain attitudes are developed by the expatriate organisations. Proposal, policy and decision making cam be a problem, particularly when the funding source is from the west. When such funding is provided by an organisation in the west it should be accompanied by the delicate balance of requiring accountability in conjunction with allowing for maximum freedom for local initiative, decision-making and action. This is not always without conflict. The expatriate organisations need to learn to understand the ground situations and the difficulties that accompany running an organisation in those conditions. Successful interactions and the need to have programme that not only focus on health, but also on other factors that impair health, including economic assistance, tend to be more effective. This does not mean that more focused programme such as providing equipment for hospitals or funding for education of individuals do not play a useful role, but they are relatively limited in the extent of what they can accomplish for the community.

Many barriers exist in implementing these programmes. Foremost among these is the adverse political climate. An example of this is the farm established by the Standing Committee of Tamils in London in the early 'eighties'. This project was run over and destroyed by the Sri Lankan army within hours after years of hard work and sacrifice. Another example was a refusal by the Sri Lankan government to allow a large container of food and medicines in the Tamil areas consigned for refugees and medical institution to be unloaded in Colombo.

However, government actions of obstruction and destruction are not the only barriers to be overcome. Inadequate resources result in organisational difficulties, including the migration of trained individuals out of the areas. Differences in understanding missions and goals of individuals and organisations are also barriers to be overcome.

Overcoming these barriers requires patience, humility and non-judgemental attitudes. It is important to realise that strategies that are useful and relevant in the west may be of little value in situations of the victims of the war. This is particularly so in health care, where the primary health programmes include the participation of the people and are likely to be much effective than technology-based medicine as practised in the west. The most dramatic improvement in health in poor, third-world countries has been accomplished not by physicians, but rather by lesser-trained, but more available health workers. Thus the training of health workers and empowering individuals to look after their own health and prevent diseases will be more effective than transferring high technical knowledge.

Conclusion

Restoring health to traumatised communities in an austere environment is a difficult task. It is a long-term project. However, the rewards of satisfaction and accomplishment do await those who participate in the process creatively. The expatriate organisations have to commit themselves to the discipline needed to start the long march towards restoring health of the victims of the war with the vision that a march of a thousand miles begins with the first step.

HUMANITARIAN AID: REFLECTIONS ON HEALTH ASSISTANCE TO PEOPLE IN THE WAR ZONE

Dr Swee Chai Ang
Chief Orthopaedic Consultant at Newham General Hospital, London and Founder Member of the Medical Aid for Palestinians

Thank you for inviting me to this conference. When I was first asked to participate, I was highly honoured but also deeply embarrassed because I think I am the only one of all the participants who has never visited Sri Lanka and probably knows nothing about the situation there. But on the first day of the conference, as I sat down listening to speaker after speaker, I really got very upset. I went home with a terrible headache and just wondered: could I say anything? Was there any part of my experience that could actually bring some hope and encouragement to the conference attendees? But perhaps the conditions described here are not new to the world.

In 1982 I went to Lebanon equally naive. Lebanon is known as the horror of the Middle East. What brought me there was a war, an invasion where bombs were dropped onto communities. 20,000 people were killed and probably another 100,000 lost their homes. When I arrived as a surgeon, I saw blocks and blocks of destroyed buildings. The coastline was shelled to bits; that was probably how North Sri Lanka looks now or perhaps had looked at some other time. A vacuum bomb (a bomb with high TNT value) had sucked in a two-storey building so that all the rubble collapsed inwards, burying 200 people inside. When I saw that, I could only pray for those people who had died, because there was no way a doctor or even a batch of doctors, even thousands of doctors, could do a thing for the victims.

Shortly after that, a group called the Palestinian Liberation Organization (PLO) had to evacuate the area: 12,000 Palestinian fighters were forced to leave. But when you expel 12,000 men, you actually have 12,000 families without their bread-winners: women, children and old people left behind to fend for themselves. Thus there were 350,000 Palestinian refugees without any means of income.

I was working in a Palestinian hospital at the time, called Gaza Hospital. The Palestinians are a very proud people, and I have learned to respect them. As a Christian, I had many hang-ups regarding the Muslims and the Palestinians that I had to deal with. I could not come back and accuse the British or the Americans of being biased, for Iwas the most biased and bigoted of all people, having been raised as a fundamentalist Christian. But I had to work with Muslims, I had to meet with Palestinians. I learned about how they had been unfairly dealt with, probably just as the Tamil community has been dealt with in Sri Lanka. I learned to love them and to work with them. And I learned how the refugee camps have existed there for 40 years without resolution of the conflict.

People initially came to the camps when Palestine was not a state (it was a British Mandate - almost a colony that vanished to become Israel). 750,000 Palestinians lost their homes and were put up in these camps. They were initially housed in tents, but after 40 years of continued conflict the tents became shantytowns and the fourth generation of Palestinian children grew up in those towns. After the evacuation came the massacre. Perhaps I do not need to remind Sri Lankans what a massacre is. In three days, 3000 people were killed, their houses demolished, bulldozed and dynamited. Orphans were left behind, standing in front of the doors where their parents were killed, their brothers were killed. Children were left without homes to face the winter, old ladies came back only to find the dead bodies of twenty of their grandchildren.

So what is humanitarian aid? The first thing I want to say is that humanitarian workers, relief workers and doctors have to speak up. There are no two ways about it, whether in Sri Lanka, Palestine or elsewhere. If you give me such a situation, I have to speak up. It is not campaigning, nor is it a political act. It was my duty to come back to Britain and educate the British people about what was happening to the Palestinian people because thirteen years ago, I was like any other Briton: totally oblivious to what was going on. When you talk of Sri Lanka, many people walking in the street say: "O yeah, they are at each other's throats." But it is not like that at all. You must educate. So I went to Israel and all over the world speaking at about one and a half thousand meetings.

Providing aid is also an important thing. It doesn't mean money all the time. There is a beautiful building in a Palestinian refugee camp in Jordan, built ten years ago by the Chinese government. This camp was one of the biggest, housing half a million Palestinian refugees. Refugees asked the Chinese government whether they could build a school. China had no money, China was very poor. But what did China do? China sent 40 construction workers on a big ship, loaded up with building materials, to build this wonderful building. Many people around the world may not have millions of pounds to give to Sri Lanka, but you will find that the poorest country will befriend you if they want to help you and they support your cause.

Nonetheless, providing relief and medical aid is a painful thing. We have done a lot to help the Gaza Hospital. We opened it up after the massacre, but by 1985 it was burnt again. Some of us returned only to find that the nurses working in the hospital had been murdered in the mosque. The hospital was gone. We had to operate in people's homes with neither gloves nor masks. The wounded were lying everywhere, in people's kitchens, in underground shelters. Children were displaced; a cup of milk was the most important meal they could have for the day and yet we could not provide it for them.

However, disaster has two faces for the persecuted community: it is painful, but their friends must use the occasion to campaign and to educate. Because the siege of the camps in Lebanon went on for three years, people in Britain and all over the world came to hear of what was happening in Palestine. 150 doctors and nurses volunteered to join Medical Aid for Palestinians, and they volunteered themselves to work in Lebanon under very dangerous conditions. So one must not get depressed on encountering persecution; persecution can be made into an advantage. Meanwhile, the camps were systematically destroyed and in 1987, the International Year of Shelter, many houses were being demolished. In Lebanon, homeless people had to live in abandoned buildings with 20 to 25 people living together in a situation where there is no hope. There was no future there for NGO workers, but for the Palestinians it was not the end.

The situation continued in the Gaza Strip, with the uprisings against military occupation. The women's uprisings in the Gaza strip brought more attention to the Palestinian situation internationally. For the first time, people learned of the horrors of the refugee camps that had been there for 40 years. Children who were born as refugees would grow up and die as refugees unless a solution was found in this generation. Schools were shut for years and years. The people lacked food and sanitation. The barbed wire and curfews were in place for months and months, and the beatings and torture continued. Some 100,000 people were wounded by the time I arrived in Gaza Strip, and bullets, plastic bullets and tear gas rained down daily. The Palestinians depended on orange, lemon and olive trees for their livelihood; these trees were destroyed and burnt, however, just as the Tamil fishing industry was destroyed in Sri Lanka.

Most importantly, the brutality and uprisings allowed the world to see the faces of the Palestinian people. I saw them as human beings for the first time in 1982, but in 1989 the whole world had to see them with their own eyes. We saw them as people with aspirations, with rights to a future, entitled to a place in the world like all of us. Also, tremendous respect was developed for Palestinian doctors and nurses working against tremendous odds. Many of them were harassed daily, their families killed and their homes demolished. And yet they resisted the occupation and maintained their solidarity. When I arrived there the first thing they made for me was a jumper in the colours of the Palestinian and ANC flags.

In May 1989, 343 Palestinians were shot and 6 of them bled to death in our ward. It made me sick and I was very down. Perhaps, for the first time, I questioned God and Justice. And yet a beautiful tree blossomed in front of our hospital, and I wondered why. Now I know the answer. When I feel depressed about the situation in Sri Lanka, I think of this tree, do not forget that one day the flowers of Sri Lanka will blossom in the same way. You know that for the first time, the one million people in Gaza Strip no longer live under occupation. Today, the torture centres where they had been tortured – where their bodies were mutilated, where some died as a result of interrogation – are now open and flowers are being planted. It is a good beginning.

I will leave you with this message:

"Wherever you are, among your friendship groups or working among local communities, it is important to produce the international climate that makes it possible to lift embargoes, to stop massacres and to provide an environment where children can grow and flowers will blossom again."

THE ROLE OF UNHCR IN REFUGEE CARE:

PERSONAL SAFETY AND THE PROVISION OF HUMANITARIAN ASSISTANCE

Mr Bo Schack
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There have been two aspects of this conference that I have found extremely interesting. First of all, Dr. Swee Chai Ang's presentation on the Middle East demonstrated that the Tamil community represented at this conference understands that Sri Lanka is not necessarily the centre of the world. It is useful for us to learn that the little world of our concern may not be the only one with problems. Such perspective sometimes enables us to look beyond what has happened so far; accounts such as Dr. Ang's example of the trees blossoming in a land that had been war torn for many years can help us deal with what otherwise appears an impossible situation.

Second, I think it is quite important that for once we have not been participating in a seminar where one side is bashing the other and the third side is bashing the fourth and so on. For the duration of the conference, we have been looking for concrete measures, discussing a very difficult and delicate situation. But we have agreed that the Tamil community in refugee camps in India and back home in Sri Lanka has incredible needs that must be met. I will be very happy to relay this information to our people in UNHCR, and also to get the message to the refugee camps both in Tamil Nadu and in Sri Lanka that there are people outside Sri Lanka who are trying seriously to look for positive solutions to the situation.

I will now make a few comments regarding UNHCR. The agency was created in 1951 to protect and assist refugees by working with assisting governments. In total, UNHCR is probably involved somehow or other with some 20 million refugees worldwide. Like the whole United Nations Organisation, UNHCR was created by governments, which gives us a number of advantages. We are a diplomatic organisation. We normally have quite good access to senior government people, with whom we can discuss the status of refugees. But we must also realise that UNHCR has certain deficiencies. Therefore, it is important that we work together with governments and the different aspects of the NGO community.

At a working group meeting on the first day of the conference, we were discussing the question of oppressed people. Certain people have a difficulty in identifying the real problem. We have an excellent record of cooperation with all NGOs on the ground. I think there is a clear understanding among us regarding what we can do, what others can do and what you cannot tell others to do.

In my own work, I started off in West Africa and moved on to Hong Kong. I am now stationed in Geneva and sometime soon I will be standing in Sarajevo. I have been to Sri Lanka a number of times, as recently as December 1992. I also had the opportunity to visit Jaffna, to see the destruction there (especially around the Jaffna fort) but also to meet with a large number of people living there in miserable conditions. And yes, returning again to Dr. Ang's discussion of the Gaza Strip, it is amazing. You have incredible misery but at the same time you have a lot of smiling children, and you simply do not understand how they are able to survive.

This aspect of the refugee situation relates to another important contribution made by this conference that I will take home with me. Yes, food and that kind of assistance is important, but participants have also discussed mental health a great deal: the war mentality, psychiatric problems, etc. A very important part of the peace process is to change minds. There are many children who have seen nothing but war over their entire lives; to enable them to work and join a peaceful society, we must be attentive to their mental health. This will be a tremendous task to which I hope all of us can contribute.

Let us move on to a more concrete discussion of UNHCR involvement in Sri Lanka. UNHCR has offices in Jaffna, Trincomalee, Madhu, Vavuniya and on Mannar Island; our Head Office is in Colombo. We have been involved in refugee work in Sri Lanka since at least 1990, mainly by establishing what we call open refugee centres. These are centres on both sides of the frontline that provide for persons fleeing the fighting and the bombing the possibility of temporary refuge. These camps, however, have had the tendency – especially in the North and especially the Madhu

camp – to become permanent camps. We are now having a very interesting discussion on how to make that camp less temporary. We are making it very clear that nobody should be forced to leave these camps to go anywhere, but we also recognise (once again as Dr. Ang illustrated with respect to the Gaza situation) that life in a camp is not life. There is no future for those living in camps; their families are destroyed, and their children start doing whatever they want to do because they completely lose respect for parents who have nothing to do.

This situation must be changed as rapidly as possible, but such changes come about very rarely, as we have seen in India and Gaza. Together with the militants and the government we are now trying to find means for the persons of Madhu camp to return home. We are increasingly providing financial assistance to rebuild the infrastructure of the villages both north and south of Vavuniya. We had a project costing approximately one million dollars to rebuild health, nutrition and sanitation facilities and other infrastructure in those villages so that people do not solely face destroyed hospitals, roads and wells upon their return. This is only a drop in the ocean, and we certainly are not implementing all possible solutions. We are also certainly but regrettably committing errors daily in our activities. When people ask what I do with UNHCR, I reply that we try to find impossible solutions, or rather, that we find possible solutions in impossible situations. But we try to do our little bit, and we are always open to discussion and criticism. In fact, I participated in this conference in order to discuss these matters, and every day, officials in our Sri Lankan offices meet with the NGO and health care communities trying to find ways and means of alleviating the suffering.

Let us move on to the subject of refugee repatriation from India, which I know is a very delicate issue. In an early working group during this conference, I suggested strongly that those who go to India for refuge should go elsewhere. The repatriation of Tamil refugees from India started in January 1992. Both the Indian and Sri Lankan governments claimed that this repatriation was voluntary, that people were told that they had the opportunity to return. Let me say first of all that this is the major difference between repatriation from India and what is going on in Europe. In Europe, refugees can go back to their countries voluntarily but at the same time governments are talking about deporting persons who are not considered refugees. We have been telling the governments that they should not link the two, for they are two distinct situations. Those in the camps in India are refugees and they should be given a free opportunity to go back if they wish; they should not, however, be forced to return. In Europe, each refugee faces an individual status determination; if they are not considered refugees, they are told to go back.

After having gained an understanding of the situation, UNHCR has made it clear by pressuring the Indian government that we should act as an independent international observer and interview those who had apparently said they wanted to go back to Sri Lanka. We deeply regret that we had no access to the camps in Tamil Nadu, and we continued to parley with the Indian government on this issue in the days that immediately preceded this conference. I met with them regarding the repatriation scheduled to take place on 20 September 1994. Four boats were to travel from Madras to Trincomalee, with about 1,100 passengers on each vessel. If understood correctly, repatriation to Mannar would soon follow, though that was not yet finalised. Our task is to basically interview every one of those persons on those boats to determine whether the return is voluntary, and I think we can all say that those who really feared serious persecution would not have gone back. We do recognise that the situation in the camps in Tamil Nadu is far from perfect and there are most likely persons who try to abuse the situation to push people back to Sri Lanka in some way or another. I think and I hope that our involvement in the situation has at least prevented some people from having to return to persecution, but we must all work together to make it clear that the situation in the camps in Tamil Nadu should not force people to go back to Sri Lanka.

At the same time, I must also recognise that Tamil Nadu is certainly not Europe. Regretably, all over the world, living in refugee camps is a dreadful and very sad experience, a life that should be forced onto no one. There are probably also people in these camps who have seen the conditions both in the camps and in Sri Lanka and have said that they preferred to go back to their families. We have learned from the interviews that those who do go back are those who receive in one way or another letters saying that so-and-so is ill and they are needed to take care of the family, or husbands and wives or children who have been split for many years.

I will make one more comment on repatriation regarding the Swiss-Sri Lankan Agreement. We were concerned that a number of countries had returned persons to Sri Lanka without any respect for the proper way to do such things, even though these persons were not refugees and therefore not normally under our mandate. Some persons that were returned back were detained at the airport because they did not have their identity cards. UNHCR started discussions with the Swiss and Sri Lankan authorities on the question of deportation of those who were not considered to need the international status of refugee. We understood that the Swiss needed to send back persons who could go back, and we told them to let us find a way.

The agreement signed by the Swiss and Sri Lankan governments greatly improved the situation. Between June and September, only 34 persons going back from Switzerland were arrested upon their arrival in Sri Lanka. This is practically nothing compared to the number of persons arrested and detained in the airport after having been sent back under the bad old conditions by a few other European countries. Moreover, we have seen a marked change in the mood towards the Tamils in Switzerland. When I arrived in Geneva three and a half years ago, all the newspapers decried how nasty the Tamils were. They were raping our beautiful Swiss girls, they were doing nothing but robbing, stealing, trafficking drugs and so on. On the contrary, if I open a Swiss paper today I read about how wonderful Tamils are. The Tamils certainly have the hotel employers

organisation behind them; perhaps everybody is behind the Tamils in Switzerland. It is probably the only country where people have suddenly looked beyond their little noses to accept practical, if not obvious, solutions.

The final issue I must discuss is the possibility of United Nations involvement in the peace negotiations. This possibility must certainly be excluded for the moment. Generally speaking, I think that this conflict like all other conflicts should be dealt with by the people concerned. I am sorry that I am neither Tamil, nor Muslim nor Sinhalese. The first steps towards peace must be taken by the Sri Lankan people and their Government. Then, as we tried to do at an earlier stage, the UN can function as a catalyst for further efforts. We would be more than happy, for example, to assist with contact between the two sides when the peace process is too fragile to allow such contact. But there is no way that either UNHCR or the UN in general will be able to settle the conflict in Sri Lanka. The responsibility for settling the conflict, finding peace and shifting the thoughts of the children from war to peace belongs to the Sri Lankan people and their outside supporters assembled at this conference.

THE ROLE OF MEDIA IN THE ETHNIC CONFLICT AREAS

A SRI LANKAN PERSPECTIVE

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Introduction

This paper is an elementary exercise in the analysis of the role of the media in ethnic conflict. The context is a decade-old ethnic war that developed out of longstanding conflicts and intensifying tensions between three different communities: Sinhalese, Tamils and Muslims in Sri Lanka. The violation of human rights and humanitarian law at all levels, large-scale arbitrary arrests and detention of Tamil youths, torture of prisoners and reprisals against civilians (including bombing, shelling and killing) and disappearance of people have been matters of great concern nationally and internationally.

There have been extensive studies of ethnic conflicts made by anthropologists, sociologists and political scientists. The war in Sri Lanka has attracted the attention of specialists of conflict studies as well as social scientists and human rights organisations. However, there have not been any significant studies of the role of media in ethnic conflicts with a clear understanding of the aspirations and needs of the people of Sri Lanka.

Here, I have attempted to conceptualise and analyse trends in the role of the media in the Sri Lankan conflict on various levels, based on my own observations. One cannot ignore the fact that the whole weight of the mass media in Sri Lanka is thrown behind the oppressors and against the legitimate struggle of the Tamil people. The media in Sri Lanka has been ethnically and linguistically separated, and has tremendously aggravated the conflicts by strengthening the perception of threats and insecurity posed by the ethnic groups at large. As the editor of the largest Tamil newspaper owned by the Tamils of the country, my own role as a journalist has become vulnerable in many areas. I would now like to share my thoughts with you on these subjects.

The Media and Social Change

In a truly democratic society, the rise of national media produces a centripetal force among social organisations and formations. Such a media greatly enhances the ability to control vast expanses of country by introducing new trends. The importance of media in a normal democratic society can only be assessed based on the free flow of information. The public's right to know is the worn slogan of modern journalism. Democratic society enables the constitution of the public as a social formation through the dissemination of news, the right to comment and the shaping of public opinion.

The critical factor in the relationship between the public and journalism is that journalism is not an end in itself. Journalism can only be justified when the physical safety of the organisation and staff has been ensured, and when the press has sought to present matters in a nonpartisan manner that enables open comment. The possibility of the press itself falling victim to partisanship is an unfortunate and important phenomenon.

Today, all over the world, journalists are searching for a new role in a more complicated global scene, no longer divided between East and West, but marked by unfamiliar links and conflicts and an understanding that people move events independently of governments. A close analysis of the Sri Lankan situation sustains the conception of journalists as mediators between events and the public who prefer world order and deplore world disorders.

The Media in Sri Lanka

There is no censorship in Sri Lanka even though the country has been under Emergency Rule since 1983. But there are also no organisations that can monitor and assess the role of media in Sri Lanka. The efforts of some concerned individuals and academics to form an organisation called 'Council for Harmony Through Media' were effectively blocked by the State in 1983. Immediately after the Emergency was proclaimed in 1983, the Council had to terminate its activities due to anonymous telephone calls and threats. Before its closure, the Council published two documents with great difficulty, one on the role of the Sinhala press and the other a school textbook on communal rela-

tions in Sri Lanka. Both these documents remain landmarks in this field.

It should also be noted that the media and media studies have never attempted seriously to present the stories of both sides in a balanced manner. A careful study of newspapers in Sri Lanka and the way they reported conflict situations clearly illustrate that the newspaper has become a source of nationalist power. This has effectively prevented any meaningful interaction and understanding among the ethnic groups. Various communities in Sri Lanka remain segregated despite their prevailing commonalities

Historical Background

A brief background of Sri Lanka, I believe, would be conceptually helpful before I proceed further. Sri Lanka is a comparatively small nation with a multi-ethnic and multi-religious population of 16.5 million. The ethnic structure and the ethnic violence of the past due to historical hangovers and the fears and aspirations of the majority community have created this age-old national conflict.

The cycle of violence over the years can be better understood by considering two major aspects. The first is the ethnic divide between the two major linguistic groups, i.e. the majority Sinhalese and the minority Tamils. These two can be subdivided further into regional, religious and cultural groups with Buddhists, Christians, Hindus, Muslims, etc. The second aspect in this conflict is the growth of a younger generation with new material needs and expectations. Free education and widespread literacy naturally paved the way for high aspirations in life and for economic advancement. Amidst the limited resources and economic stagnation that mark the socioeconomic map of Sri Lanka, these two major factors have produced various suspicions regarding the material needs and aspirations of the literate minority.

These tensions eventually resulted in the emergence of Tamil rebels in the North-East of Sri Lanka. The conflict situation in Sri Lanka and the basis of this escalation needs to be studied in the context of these tensions to gain a clearer understanding of the whole process. The ethnic divide that cuts across all the institutions in Sri Lanka must be understood as an important factor. Additionally, the geographic concentration of the Tamils in certain areas and their dispersal into others must also be emphasise

The Role of the Media in the Ethnic Conflict

Although Sri Lanka's constitution upholds the freedom of expression – including publication – and Sri Lanka remains a signatory to the Civil and Political Covenant, the print and electronic media operate within certain constraints. One important constraint relates to the ownership of the media: the State has historically controlled the electronic media and now controls the Lake House Group which publishes several important dailies in English, Sinhala and Tamil. Moreover, independent newspapers like Virakesari, the Island Group and the Sunday Times Group have to operate within the broad framework of the guidelines provided to them by the publishers, and to that extent journalist freedom is compromised.

The problem of editorial constraint is further compounded in the reporting of sensitive political news such as developments in the north-east, the conduct of the war and the military and allegations of political corruption. Accordingly, the media is unable to play an effective role in raising public awareness on issues relating to corruption or mismanagement, and cannot undertake the sort of investigative journalism carried out by some newspapers in India.

Newspaper editors are also constrained by the budgetary controls imposed upon them by publishers. They are unable, for example, to engage foreign correspondents or provide travel support for journalists undertaking special reports without the prior authority of the management. This is not the case in the Western newspapers where editors have broad discretion with respect to travel, entertainment and other expenses related to collecting information for news reports. Legal constraints include the provisions of the constitution and the Parliamentary Privileges Act, which limits the publication of certain types of parliamentary proceedings or the reporting of proceedings considered false or perverted. Emergency regulations prohibit the publication of any materials deemed prejudicial to national security and the preservation of public order.

Censorship has also been imposed from time to time. The law has restricted certain political activities such as the pasting of posters or placards. The mainstream political press also tends to have familiar links with leading political personalities. The Sunday Times Group is headed by an uncle of a former prime minister and the Island Group is headed by a brother of Mrs. Bandaranaike. The Virakesari, managed by a group of businessmen with Indian community ties and a balanced national interest, tries to provide balanced information. With regard to the tabloid press, there are five tabloids in Sinhala and one in Tamil which are politically oriented. The Inland Revenue Department has tried to interfere with the work of tabloid presses such as Yukthiya, Ravaya, Lakdiva and the Atthta. The Free Media Movement has protested such harassment of the media.

Another problem regarding the media relates to the communal orientation of the mainstream Sinhala press, typified by publications such as the Divayina. News reports and commentaries in this paper have not been objective, tending to project hard-line majority viewpoints on the ethnic conflicts and the need for military solutions. The projection of this view to the exclusion of all other views has been very damaging. The recent elections have established that such views are held only by a minority of Sinhala people, but these newspapers have attempted to create the perception that they represent the sentiments of the overwhelming majority.

The emergence of regional papers has also been an important aspect of the aftermath of civil conflict. There are now five papers published in the North, which include Eela Nadu, Murasoli, Udayan and the Eela Natham. Two of these – Eela Nadu and Udayan are the leading papers in Jaffna. Eela Nadu, edited by Mr. Sabaratnam, has maintained very high literary and journalistic standards; although the paper focuses on news of local interest, it also provides for Jaffna

a perspective on national questions. The northern papers tend to reflect the views of the dominant groups in the north and under these conditions are unable to project a diversity of viewpoints. Nonetheless, our market survey suggests that in the Eastern Province and even in the North, newspapers such as Virakesari have had good readership. The absence of regional papers in the Eastern Province is linked to the economic conditions of the people.

The urban middle class is very limited and does not have the financial and intellectual resources to publish an independent newspaper. Nevertheless, with correspondents in most parts of the North and East, the Virakesari and regional papers are able to provide information on political developments there more effectively than the mainstream newspapers. National newspapers in Sinhala and English are able to reproduce official news releases, but they do not provide adequate factual information or in-depth analysis. In addition to adopting hard-line attitudes towards freedom fighters engaged in the armed struggle, these newspapers use terminology which tends to stereotype ethnic identities.

A final aspect of Sri Lankan media that must be considered is the emergence of regional radio and television stations in the North due to the conditions of economic and political isolation. Though their news programmes are intended only for a regional audience and often have strong political and ideological content, their service is important to the people of the affected areas. These stations provide information relevant to the economic activities of ordinary people, such as information on military operations like bombing and shelling.

WORKSHOPS

SUMMARY

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Introduction

The key objective of the workshops was to follow up the first days proceedings by identifying key areas pertaining to the Health and Health Care Needs of the Victims of War, so that appropriate action plans could be formulated. The workshops therefore considered measures to help displaced persons especially those facing repatriation, rehabilitation programmes for war related victims, the need for Development Assistance and the Community initiatives that need to be nurtured and supported.

The participants of the conference attended one of four workshops on day two, scheduled as parallel sessions. Each workshop was moderated by a team of facilitators and the output was presented in a plenary session by the lead facilitator (name in bold). Oral submissions made by selected individuals at some of the workshops and a few papers submitted to the conference by non-attendees are included as part of the outputs from workshops.

WORKSHOP 1

REPATRIATION: EXPECTATIONS AND THE REALITIES

Facilitators:

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Ms. Helena J. Whall, *Researcher, Tamil Information Centre, UK.*
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SCOPE OF THE PROBLEM

- Two principles are enshrined in international refugee laws. Firstly the expectation that any refugee returning will be able to return to his or her own home.
- Secondly they will be able to do so with dignity and safety.
- The continuing ethnic war has resulted in the displacement of several thousands of Tamil speaking people both to areas outside the North-East of Sri Lanka and abroad notably to South India and the West.
- Estimates relating to the Northern District in 1994 show that there were 79834 families comprising 264,335 persons displaced from their permanent residences. Of these nearly 9,000 families were being accommodated in temporary welfare centres (see Special Report on the Situation in Jaffna District)
- In 1994 there were about 80,000 Tamil refugees in about 125 camps in various parts of Tamil Nadu. It was estimated that another 100,000 refugees were living outside camps.
- Following the 1987 Indo-Sri Lanka accord the repatriation programme that was initiated showed lack of consideration of the Tamils' right to return to their own homes in safety and with dignity.
- The Swiss Government took a decision in 1994 to deport Tamil asylum seekers who had been rejected.
- In 1993 the new Asylum and Immigration Act was passed in the UK with its impact on the rights of Tamil Asylum seekers.

The workshop considered the plight of Tamils scattered in various countries, noting particularly the difficulties they were having in getting their refugee status recognised. The steps taken by some governments to repatriate Tamils disregarding the dangers they are likely to encounter on return to Sri Lanka was a matter of grave concern.

The presence of a representative from the United Nations High Commission for Refugees (UNHCR) at the workshop provided an opportunity for a frank exchange of views about the role of the UNHCR in the repatriation programmes from India and Switzerland. The UNHCR was perceived to be assisting the Indian and Swiss Governments to repatriate Tamil refugees who had a legitimate claim to stay. The UNHCR representative maintained that the issue concerned only those who were found not to be refugees by the respective Governments and not those who had

secured a right to stay. The UNHCR having accepted the reality that these persons were going to be deported wished to make sure that those who were returning did so with dignity and in safety.

They were conscious of the fact that although active intervention and monitoring on their part may benefit some who are returning, this may send the wrong signal to foreign governments who may think that because the UNHCR is looking after the deportees, more could be sent back.

Many participants in the workshop felt that the UNHCR had breached its protection mandate and lost the confidence of Tamils.

PROPOSALS

1. Specifically request that the UNHCR
   - 1.1 To conform to its protection mandate
   - 1.2 Review its involvement in the South Indian repatriation programme
   - 1.3 Ask western government not to forceably repatriate any Tamil refugees in the current circumstances
2. Make known to the international community thaat given the continuing war the situation in Sri Lankan is volatile and unpredictable the there is **no safe area for Tamils**
3. With respect to the refugee camps in India representation should regarding the following
   - 3.1 The conditions should be improved and secondary oercion to repatriate be removed
   - 3.2 The UNHCR and other NGO's should be allowed access
4. Adequate monitoring facilities should be put in place including a monitoring team at the airport
5. The experience of the Hill Country Tamils and their repatriation to Southern India should be studied and analysed in relation to current repatriation programmes to Sri Lanka
6. Any involuntary repatriation should be linked to development aid support. The campaign to secure increased assistance to war affected areas must be intensified.

WORKSHOP 2

REHABILITATION OF THE WAR RELATED VICTIMS

Facilitators:

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Dr. M. Jegarajah, *Consultant Chest Physician, Rochdale, UK.*

- Whereas the Sri Lankan Government had in place arrangements to take care of soldiers there is uncertainty about the extent of the services available to Tamil combatants. There is evidence that large numbers of freedom fighters either die or suffer serious disability due to the lack of adequate health care.
- The Jaipur Foot Programme in Jaffna fitted prosthesis for 884 amputees between 1987 and 1993. Of these 75% had sustained injuries due to bomb blasts and pressure mines. In late 1994 there were over 150 amputees on the waiting list for prostheses.
- The worst affected are ordinary civilian people, particularly those living in areas directly affected by the protracted war.
- There is severe disruption to civilian life with large numbers of people having to survive in refugee camps with extremely poor facilities or with grossly inadequate temporary arrangements far removed from their homes.
- The plight of children's needs to be particularly highlighted not only in relation to the immediate aftermath of battle but also because of the long term consequences. (see report from Dr.Ehlrich, Visiting American Paediatrician, who worked in Batticaloa providing the only Specialist Paediatric care for an area with population of around 400,000 and with 16 Refugee camps).
- The widows especially in the East were also reported to be a particularly vulnerable group and in need of urgent help. Estimates suggest that in the East alone there are over 3,000 widows, most of whom with more than one child, and under the age of 35, in need of urgent rehabilitation (see Health Care and Rehabilitation of Women, Youth and Children who are Victims of War in Batticaloa District Sri Lanka)
- Displaced Tamils in various countries in Europe who are also victims of war having had to flee from their homes and seek refuge in the West too are subject to exploitation in relation to matters such as Housing and Employment and constitute a vulnerable group.
- The elders among refugees have their own particular needs.
- There were contributions during the workshop by visitors who have been or are engaged in projects in the East of Sri Lanka.
- The workshop concluded that rehabilitation initiatives had to consider the physical, psychological and the socioeconomic impact of the war on individuals, families and the community as a whole.

PROPOSALS

1. The establishment of a rehabilitation centre in the East
2. Special consideration be given to projects greared towards the welfare of children *as this was identified as a particular and immediate need*
3. Urgent assistance to organisations such as the Dry Zone Development Foundation engaged in the rehabilitation projects in the East
4. Consider what help needs to be made available to freedom fighters when the war is over
5. From a long term point of view invest in the restoration of educational facilities with emphasis on industrial and agricultural development
6. Recognise the importance of spiritual aspects in the welfare of people. Assist in the restoration of places of worship that have been damaged or destroyed

WORKSHOP 3

DEVELOPMENT ASSISTANCE FOR BETTER HEALTH

Facilitators:

Dr. P. Arulanantham, *Paediatrician/Endocrinologist, Consultant OFERR programme, India. and Assistant Clinical Professor, UCLA, USA.*

Mr. M. Sri Shanmugarajah, *President, Dry Zone Development Foundation, Sri Lanka.*

Mr. S. Balakrishnan, *Executive Secretary, Centre for Development Alternatives, Kandy Consultant for Policy Research on Health Programmes in the Estate Rural Areas, Sri Lanka.*

Mr. D.P. Agastian, President, *North East Economic Development Society, Sri Lanka.*

- There has been severe destruction of the infrastructure as a result of the ethnic war in the North-East.
- The plantation areas had suffered even before the ethnic disturbances in terms of poor health care facilities.
- The ravages of the ethnic war continue and a number of contributory factors perpetuate the situation. Unemployment, low income, poor living conditions disruption of educational facilities were factors very much in evidence and signified by various indices such as rising infant and maternal mortality rates.
- While the Sri Lankan national average for Infant Mortality Rate was 20.2% (check denominator) in 1988, in the Nuwara Eliya District a key Tea plantation area, it was 35.5% (see Report-Health Situation in The Estate Sector)
- There was an acute shortage of health care personnel, buildings and other facilities had been damaged or destroyed, and drugs were unavailable or in short supply. (see Health Services in the Jaffna & Trincomalee Districts)
- Facilities for Health education and primary care were virtually non existent with the meagre resources being concentrated on the immediate care of the wounded, displaced or disposessed.
- The Workshop felt that while strenuous efforts continue to bring a just solution to the ethnic conflict, immediate requirements were a programme of restoration of the basic facilities in terms of buildings with the essential equipment and drugs and the securing of personnel.
- In the longer term the rebuilding of the wider infrastructure in terms of housing, roads and communication facilities and improved work opportunities in agriculture and industries were considered vital.

PROPOSALS

1. Immediate assistance to agencies currently working in the North East and in the Plantation sector
2. Immediate financial assistance to the Jaipur Foot Programme and Centre for Women and Development
3. Expatriates to urge, via their contacts with NGOs and other organisations in the West, for increased and immediate assistance to the North East and plantation areas in Sri Lanka
4. To identify means of enhancing the training of health care personnel in the short term - facilitate visits by professionals from abroad to provide advice and training
5. To assist local efforts aimed at providing rehabilitation to freedom fighters

WORKSHOP 4

COMMUNITY INITIATIVES IN THE HEALTH SERVICES

Facilitators:

Dr. S. Arunachalam, *Consultant Physician with Special Interest in the elderly, Edgware General Hospital, London, UK.*

Dr. Anna Doney, *Clinical Psychologist, Royal Hospital for Sick Children, Edinburgh, UK.*

Sister. Victorine James, *Lecturer, School of Nursing, Jaffna, Sri Lanka.*

- The affected areas in the ethnic war were divisible into three - areas controlled by the LTTE, those controlled by the Sri Lankan army and the areas where the armed conflict was active. The latter was the most affected in terms of disruption of health care.
- Organisations such as Shanthiham - Association of Health and Counselling were already engaged in very valuable work in the Jaffna District at present. (see Report on Shanthiham)
- Health must be considered on a holistic basis, including not only the physical but also the psychological welfare of people, in any initiative to assist the Health Services. Traditional methods of treatment and care should also be incorporated in efforts to help those who have suffered trauma. (see study on ex-detainees - Dr. Anna Donay)
- In the longer term too, efforts to reestablish an organised health care system must not be an exercise that simply mimics the West. It must be one that recognises the contribution ordinary people can make in shaping health care delivery. There should be an organised system of public consultation and community participation in the initiatives to reorganise health services.
- The workshop surveyed the situation regarding the availability of health care particularly in North and East of Sri Lanka. There were presentations from persons currently working in Jaffna and those who had visited recently and able to give a first hand account of the prevailing conditions.

PROPOSALS

1. To provide immediate assistance to Shanthiham to support their current ongoing community initiatives. Financial assistance to support the following projects.
   - 1.1 Continuation of counselling services
   - 1.2 Provision of outreach centres—Madipay, Chavakacheri, Point Pedro and Kilinochchi
   - 1.3 Library
   - 1.4 Ongoing training for counsellors
2. Have more public consultations and involve more representatives from the community in the planning machinery for the health services.
3. Provide financial and professional assistance to agencies currently involved in health education and primary care.
4. Collaborate with international organisations such as UNICEF who are currently ivolved in projects in the war affected areas

REPATRIATION OF DISPLACED TAMILS: VOLUNTARY OR MANDATORY

Ms Helena J Whall
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Introduction

Whilst the war in Sri Lanka has affected all of the ethnic communities on the island, the majority of persons who have been displaced, both externally and internally, have been Tamils. It is their expectations of repatriation and their actual experiences of both repatriation and deportation that this paper will therefore focus upon.

Tamils have been displaced from their original chosen places of residence and their homes of origin in various waves since the early post-Independence period. The Tamil community first experienced displacement after the 1958 riots in Colombo, which caused 10,000 Tamils living in the capital to flee to the Jaffna Peninsula. Another 12,000 Colombo-based Tamils were forced to find refuge in refugee camps in Colombo. Following the general election results of 1977, when the Tamil United Liberation Front (TULF) won the majority of votes in the North East Province on a platform of independence, thousands of Tamils were forced to flee to Jaffna for their safety and livelihood. After the most vicious government-instigated pogrom against the Tamils in Colombo in 1983, over 125,000 Tamils fled to the Northern and Eastern Provinces of the island. A further 30,000 Tamils – including 20,000 from plantations and 10,000 from Colombo – fled to South India. By 1985, 23,000 Tamil refugees were living in government-assisted refugee camps in South India, whilst another 75,000 Tamil refugees were living outside the camps with friends and relatives.

By the end of 1990, following the outbreak of war in the North East Provinces of Sri Lanka, over 100,000 Tamils had claimed political asylum in Europe and North America. Some 150,000 had fled to South India while at least one million people were internally displaced in the North East Provinces. Many of those displaced after 1990 were among the 25,000 Tamil refugees who were returned from South India to northern Sri Lanka between December 1987 and April 1989 as part of the United Nations High Commissioner for Refugees (UNHCR) Special Programme of Limited Assistance to Returnees in Sri Lanka. Since June 1990, over 200,000 Tamils have fled to Jaffna from the coastal belt and the small islands west of the Jaffna Peninsula, while some 150,000 Tamils have moved to Colombo to escape the war in the North East. Today, approximately 400,000 Tamils seek asylum in the West. 100,000 Tamils are currently residing in refugee camps in South India, while another 70,000 are living outside of camps. Approximately 500,000 persons are internally displaced in the Northern and Eastern Provinces of Sri Lanka. A further 100,000 displaced Tamils live in and around Colombo.[1]

Following the resumption of hostilities in 1990, approximately 30,000 Muslims who had resided in areas of the North controlled by the Liberation Tigers of Tamil Eelam (LTTE) were asked to leave their homes. The order was allegedly given on the grounds that the security of the Tamils was in danger due to the increased attacks on Tamils in the East by Muslim home guards. Whilst some managed to move to Colombo and find business, many Muslims were internally displaced to nearby Muslim villages and a large number went to refugee camps in Colombo, where many remain today.

A smaller number of Sinhalese living in predominantly Tamil-speaking areas in the Eastern Province were also displaced following the outbreak of hostilities in 1990. Compared to the displaced Tamil and Muslim communities, however, the displaced Sinhalese – housed on refugee camps directly supervised by the government in areas that have regular systems of transport and communication – have better access to systematic and effective relief assistance.

There are three conceivable ways by which a person ceases to be displaced: return to the original place of residence, integration with the local community or resettlement in a third area. In the case of refugees and internally-displaced persons, the solution deemed best is repatriation. For all displaced persons, the prospect of repatriation enshrines the expectation that they will not be forcibly returned to their original homes of residence

while the conditions from which they fled still prevail. Indeed, the principle that displaced persons will only be returned to their original homes once their safety and dignity can be ensured underpins the concept of repatriation of persons under international refugee law. In its thirty-sixth session, the Executive Committee of the UN High Commissioner's Programme resolved that:

> ...repatriation of refugees should only take place at their freely expressed wish; the voluntary and individual character of repatriation of refugees and the need for it to be carried out under conditions of absolute safety, preferably to the place of residence of the refugee in his country of origin, should always be respected.[2]

However, in response to the 500,000 refugees that currently arrive in Europe each year, Western governments are increasingly refusing asylum claims from people who have fled from countries suffering civil war. Since the UK passed the Asylum and Immigration Appeals Act in 1993, 78% of Tamil asylum-seekers in the UK have been refused asylum. Before the Act was passed, 95% of Tamil asylum-seekers had been given temporary refuge until conditions in Sri Lanka improved. Twenty rejected Tamil asylum-seekers have been detained in detention centres in the UK as a deterrent to future Tamil asylum-seekers.

The stand of the UNHCR on the return of rejected Tamil asylum-seekers in Europe to Sri Lanka has undergone a similar sea-change. A brief examination of the UNHCR's change of policy vis-a-vis rejected Tamil asylum-seekers in Europe will provide the backdrop for an examination of the UNHCR's involvement in the repatriation of internally displaced persons in Sri Lanka.

This discussion will set the scene for an analysis of Switzerland's recent response to the 'Tamil refugee problem' and its implications for the Tamil refugee population in the rest of Europe.

A Sea-Change in UNHCR Policy

During the early 1980s, the UNHCR adopted a firm stance towards rejected Tamil asylum-seekers in Europe and North America. In June 1986, the UNHCR communicated a clear policy concerning rejected Tamil asylum-seekers, stating that "it now appears very unlikely that any Tamil asylum-seeker can forcibly be returned to Sri Lanka without serious risk." It emphasised that *bona fide* refugee status should not be viewed as the sole grounds for deciding against the return of rejected Tamil asylum-seekers to Sri Lanka. Whilst fewer than 5% of all Tamil asylum applicants in Europe gained full refugee status during the late 1980s, most were given Exceptional Leave to Remain (ELR), allowing them to be returned to Sri Lanka when conditions improved. ELR – applicable in cases that warrant compassionate consideration but fall short of fulfilling the 1951 UN Convention definition of `refugee' – provides temporary protection from deportation but little long-term security. Nonetheless, few of those Tamils whose asylum applications were refused in the late 1980s were deported, as most Western countries adopted a `wait and see' policy.

However, in response to increasing pressure from Europe to resolve the problem of Tamil displacement, the UNHCR began to backslide on its firm stance of 1986. The signing of the Indo-Sri Lankan Accord signalled the greatest prospect for peace in Sri Lanka for over a decade, and in view of what it considered appreciable improvements in the security situation in Sri Lanka, the UNHCR indicated that Western governments should begin to decide for themselves whether or not to return rejected Tamil asylum-seekers to the island. The UNHCR declared that it was no longer opposed to the return of rejected Tamil asylum-seekers to the Mannar mainland, and that it could not take any responsibility for their safety on return.

Soon after the signing of the Indo-Sri Lankan Accord, however, fighting broke out between militant groups and the LTTE and the Indian Peace Keeping Force (IPKF) in the Northern and Eastern Provinces. As a result, the UNHCR declared that the return of groups of rejected Tamil asylum-seekers from Europe ought not to be contemplated for the foreseeable future, until the situation in Sri Lanka had been reevaluated. The UNHCR stated that the return of individual Tamils ought to be approached with special prudence in these circumstances.

As a result of the outbreak of war in June 1990, over 150,000 Tamils sought refuge in South India. Many of them were among the 29,000 Tamil refugees returned as part of the Indo-Sri Lankan government repatriation programme since January 1992. Another 50,000 Tamils claimed asylum in Europe during 1990-1991. In response, the Indian and European governments took appropriate measures to stem the flow of Tamil asylum-seekers. Open Relief Centres (ORC's) were set up in Mannar district with UNHCR assistantce to help the returnees and displaced persons affected by the fighting and to mitigate the immediate causes of future departures. Many European countries began to adopt new refugee procedures based on the UNHCR's Information Note of 16 June 1992, which recommended that a fair determination procedure could be observed by dividing Sri Lanka into 'safe' and `unsafe' zones. The new procedures enabled them to screen out Tamil asylum applicants who had an 'internal flight alternative' or who were from the so-called 'safe' areas.

This paper will now briefly examine the experiences of internally-displaced Tamils repatriated to the North Eastern Provinces of the island, in an attempt to determine the prevailing security situation in those areas and to what degree the conditions from which Tamil asylum-seekers initially fled have changed. In other words, the following pages will provide the background for an analysis of the consequences of the increasing incidence of mandatory return of rejected Tamil asylum-seekers to Sri Lanka from the West.

The Condition of Repatriated Persons in Sri Lanka

A total of 150,120 families were displaced in Sri Lanka at the end of 1993; the total number of displaced persons constituted 563,029. Over half of these persons were living outside of the welfare centres with either relatives or friends. Almost one third of the displaced persons were residing in Jaffna. The majority of the remaining displaced persons were concentrated in the North, North Central, North Western and Eastern Provinces. Another 17,000 displaced persons were living in the districts of Colombo and Gampaha.

Over the past two years, the Sri Lankan government has attempted to implemented a resettlement and rehabilitation project through the Ministry of Reconstruction, Rehabilitation and Social Welfare (MRR&SW). The project essentially consists of the `repatriation' of displaced persons back to their original places of residence when these areas are 'clear,' i.e. when they have been `cleared' of the LTTE by the military and declared safe for the resettlement of returnees.

The best solution to the displacement of internally-displaced persons and refugees is repatriation; this is ostensibly the premise of the Sri Lankan government's resettlement and rehabilitation programme.

The MRR&SW's Guidelines for Resettlement of Displaced Persons declares that:

> *...resettlement should not be understood only as moving the displaced population to their original places of residence. It is a process of moving the displaced population to their original places of residence, creating a congenial environment to live without fear and providing the necessary social and economic infrastructure for the resettlers to recommence their normal lives with confidence.*

The MRR&SW's Guidelines clearly uphold the principle that the process of repatriation should ensure that displaced persons are returned to their homes of residence in safety and dignity.

However, as with the repatriation of Tamils from South India, the voluntariness of the MRR&SW's repatriation programme has been questioned. Like in South India, conditions in the refugee camps in Sri Lanka have often been allowed to deteriorate so much that the displaced have no choice but to return to their homes of residence, despite the fear of being persecuted or victimised. Similarly, in an attempt to gain control of contested territory, the government has threatened to cut its provision of dry rations to the displaced in camps in LTTE-controlled areas to induce their return to 'cleared' (i.e. government-controlled) areas and facilitate strategic attacks on the LTTE. Moreover, the government is unwilling to repatriate displaced persons to their original homes of residence if these are in areas controlled by the LTTE.

While the displaced Tamil community is clearly a pawn in the government's political game, its interests at times have also taken second place to the LTTE's political objectives. The LTTE has regularly prevented or discouraged displaced persons from leaving LTTE-controlled areas in an attempt to keep hold of contested territory.

Since the UNHCR became involved in preventing displaced persons from fleeing Sri Lanka and providing protection and humanitarian assistance to them through the ORCs in the Mannar district after the outbreak of war in June 1990, it has encountered unprecedented difficulties due to its presence in the midst of an ongoing civil war. The UNHCR's efforts to provide humanitarian assistance to the internally displaced have been regularly obstructed, both by the LTTE and the government, either by the looting and shooting of food conveys or by restrictions on relief aid to refugee camps. The UNHCR has been unable to protect Tamils in its camps from arrest and killing or maintain the political neutrality of some of its camps.

The repatriation programme, clearly connected to the projected referendum on the continued merger of the Northern and Eastern Provinces and the presidential elections of November 1994, does not seem to hold the safety and dignity of the displaced Tamils returning to their original homes as its central concern. The relatively low turnout of voter in the Eastern Province elections of August 1994, due to the internal displacement of thousands of Tamils from their homes of origin, and the complete absence of elections in the Northern Province, clearly demonstrate the unrepresentative and inherently undemocratic nature of elections or referenda held amidst continuing war. As long as the repatriation programme is politicised and linked to a vigorous political programme, the displaced Tamils will continue to feel that their interests are not being adequately addressed by the government of Sri Lanka.

Clearly, the internal displacement of hundreds of thousands of Tamils in Sri Lanka hinders the government from providing its citizens with adequate protection and assistance. International relief aid and protection is therefore necessary. However, many displaced Tamils are concerned that the crisis of displacement in Sri Lanka is largely due to the government's consistent unwillingness to discharge its sovereign responsibility to treat all of its citizens equally and without discrimination. President Wijetunge's denial that there was an `ethnic' problem in Sri Lanka was a clear indication that the government was committed to finding a military solution to the Tamil national question. The international community needs to address the Sri Lankan government's unwillingness to protect all of its citizens equally, rather than assuming that responsibility itself, a practice which the displaced Tamils feel bestows legitimacy on the government's actions.

Situation of the Displaced Tamils in Europe

In its Information Note of June 16 1992 concerning its position on Sri Lankan asylum-seekers in Europe and North America, the UNHCR tacitly endorsed Colombo and southern Sri Lanka as `safe' for the return of rejected Tamil asylum-seekers:

> In general terms, the situation in Sri Lanka is marked by continued and protracted civil war and the absence, in the opinion of all observers, of any realistic

> expectations for a political settlement. In this context, and given the lack of an adequate monitoring capacity, it is recommended that the return of rejected asylum-seekers should be carried out by governments with prudence. UNHCR, therefore, would not object to mandated return provided basic safeguards of a fair determination procedure have been observed and the possible consequences of return have been assessed taking into account the relative risk of a changing mosaic of safe and unsafe areas.

Elaborating on its Information Note, the UNHCR recommended that a fair determination procedure could be observed by dividing Sri Lanka into four zones:

1 Areas not generally affected by the armed conflict, e.g. Colombo, Kandy and Anuradhapura;

2 Areas controlled by the government but where the situation is not normal and where sporadic skirmishes still occur, e.g. Mannar island;

3 Areas affected by armed conflict and only partly controlled by the government of Sri Lanka, e.g. Trincomalee, Batticaloa and Amparai; and

4 Areas essentially under the control of the LTTE, e.g. Jaffna and the Mannar mainland.

The UNHCR recommended that rejected Tamil asylum-seekers who originated from the first category, namely the Centre and South of Sri Lanka, could be returned in safety and dignity to the island; rejected Tamil asylum-seekers from the other three categories should be allowed to remain in the countries of asylum for humanitarian reasons. The UNHCR added that in order to determine whether an 'internal flight alternative' existed for rejected Tamil asylum-seekers originating from the Centre and South of Sri Lanka, factors such as the presence of close relatives, duration of previous residence and past employment must be taken into consideration.

Ignoring Amnesty International's press release of 5 March 1993 – which rejected the UNHCR's claim that Colombo and Southern Sri Lanka were safe for prospective returnees and argued that the majority of Tamils could not live in any part of the country in safety and dignity – and a European Parliament delegation's press release in Colombo on 6 October 1993 – stating that the current situation in Sri Lanka was not conducive to the return of rejected Tamil asylum-seekers from the West – the Swiss and Sri Lankan governments signed an agreement on 12 January 1994 initiating the mandatory return of rejected Tamil asylum-seekers from Switzerland to Sri Lanka.

The Swiss deportation programme, based on a simple 'last in, first out' deterrent formula, has targeted over 1,000 rejected Tamil asylum-seekers in Switzerland for deportation. Whilst only 34 have been deported so far, between 12,000 and 15,000 Tamil asylum-seekers who have arrived since July 1990 (the cut-off date) face deportation if refused. The Swiss government's lack of clarity surrounding the selection criteria for deportation has created a climate of uncertainty and fear within the Tamil community in Switzerland. Rejected Tamil asylum-seekers in Switzerland who have had their work permits removed are facing considerable psychological problems as they spend long periods of time on social aid waiting for their travel documents to be issued. Many Tamil asylum-seekers in Switzerland face humiliation at the loss of their professional standing, whilst others who were traditionally fishermen or farmers in Sri Lanka fear unemployment on their return. Others living in fear of deportation find it increasingly difficult to make any long-term plans regarding housing, education and employment.

Moreover, many Tamil asylum-seekers in Switzerland have gone underground since January 1994 and have sought asylum in other parts of Europe, including the UK. On their arrival in the UK, they have been refused asylum on the grounds that they have passed through 'safe third countries.' On the UK's appeal to the respective 'safe third countries,' France or Germany for example, they have been refused asylum on the grounds that they were only in transit on their way to the UK. They have accordingly been held in detention centres, as a deterrent to future Tamil asylum-seekers, until their fate has been decided.

The UNHCR holds that a certain number of Tamil asylum-seekers in Switzerland are not 'in need of international protection,' and that an orderly and safe return of such persons to Sri Lanka would help to 'safeguard the principle of asylum' in Switzerland. Nonetheless, the Swiss returnees are deemed to require 'passive monitoring' on their return to Sri Lanka in case they face 'security problems.' Indeed, the Swiss-Sri Lankan agreement was signed amidst the most unstable security conditions in the so-called 'safe' areas. Over 15,000 Tamils were arrested in Colombo and Southern Sri Lanka after President Premadasa was assassinated in May 1993. Amnesty International reported that after June 1993, there were 'several waves of arrests forming part of a pattern of human rights violations directed at the Tamil community, in which thousands of people appear to have been arrested on the basis of their ethnic origin.'[3] While the security situation in the capital appears to have stabilised since the election of Mrs. Chandrika Kumaranatunge as Prime Minister in August 1994, Colombo and Southern Sri Lanka remain hostage to the volatile and unpredictable forces of the civil war, thereby continuing to endanger the security of the Tamil returnees. Concerns have accordingly been raised over the UNHCR's capacity to 'passively monitor' the returnees, on the grounds that it is unlikely that returnees detained by security forces in Colombo would be permitted to contact the UNHCR and request its intervention. While the UNHCR has declared that its monitoring capacity in Sri Lanka is not 'adequate' and that 'the activities of UNHCR in Sri Lanka cannot be used by Governments to construe that Sri Lanka is now a generally safe country for rejected asylum-seekers to be returned,'[4] there is growing concern that Western governments are interpreting the UNHCR's presence in Sri Lanka as a green light for the safe return of rejected asylum-seekers.

For example, there has been a recent change in the policy of the UK Home Office with regard to Sri Lankan Tamil asylum-seekers. A recent 'test' case concerned the appeal of three Tamil asylum-seekers against a refusal to grant them refugee status in the UK. The special Adjudicator handling the case recognized that there were security problems in the North and North-East regions of Sri Lanka, but took recourse in the UNHCR's recommendation that a fair determination procedure could be observed by dividing the island into 'safe' and 'unsafe' zones. The Adjudicator declared that where it could be shown that the appellant had family connections in Colombo or in the South of the country, or had lived in that area for a 'reasonable period of time,' it was perfectly reasonable to argue that he should be 'returned to that area, being a safe region of the country...where he has either roots or connections.' The Adjudicator declared further, however, in the case of a Tamil who traditionally came from the North or North-East of Sri Lanka, had family connections there and had fled from that region for a Convention reason, it was unreasonable to say 'he should be returned to the Colombo region, where he may have no family or economic or social connections.' Those who were supporters of the Tiger movement, the Adjudicator added, were part of a terrorist organisation and therefore had no claim to protection for a Convention reason. This 'test' case has now been referred to the Immigration Appeals Tribunal.

In the UK, refugees are one of the most marginalised groups. Regrettably, refugees are often seen as being no different from any other migrant group. However, the stresses that most refugees have suffered – experience of escaping from war zones; institutionalised process of life in refugee camps; exposure to violence and torture; separation of families; delays and difficulties in applying for asylum; feelings of guilt often felt for friends and relatives left behind; frequent sense of isolation – put them at high risk of psychological and physical breakdown. Lack of specialised knowledge, training and resources to deal with refugees particular health concerns often results in inadequate and inappropriate health care services. Moreover, over 5,000 Tamil asylum-seekers in the UK are on Temporary Admission, and some must wait more than six to nine months for a decision; the health care needs of these people must be met by voluntary community organisations and local volunteers with meagre resources.

Institutional racism in employment and housing produces material disadvantages that augment the increasing pressures with which refugees are forced to deal. Coping with racism daily can have emotional and psychological effects such as anger, resentment and frustration, indifference and low self-confidence. As a result, refugee workers in the UK say, many young Tamils are drifting into petty crime and drug abuse, and there has been an increase in the number of broken marriages among Tamil refugees. It is critical that practitioners in health care and the social services acknowledge and understand the particular needs of both refugees and asylum-seekers and acquire the relevant knowledge and skills to administer the appropriate care and necessary medication.

Recommendations

This paper will conclude with a few recommendations that may help ensure that displaced Tamils, both inside and outside Sri Lanka, are able to return to their homes of origin in safety and dignity to lead productive lives.

It was recognized at the Fiftieth Session of the Commission on Human Rights that given the similarities between the situations of internally-displaced persons and refugees, many important principles can be drawn by analogy from refugee law for the protection of internally-displaced persons.

For instance, the right not to be forcibly returned to areas where the life or freedom of the displaced person could be threatened needs to be articulated. The development of procedural safeguards to ensure the voluntary nature of resettlement schemes needs to be considered. For example, those to be resettled could be required to sign a form declaring their wish to resettle, similar to that used by the UNHCR for its repatriation programmes. Returnees might also be guaranteed the right to be provided with adequate information on the security and welfare of their original home of residence. Moreover, efforts should be made to avoid giving misleading information to those to be resettled regarding the benefits they may expect from the resettlement. Such expectations only lead to disappointment and increase already increasing tensions. The right not to be identified as a displaced person, if that would result in discrimination, also needs to be assured; Tamil returnees from inside and outside of Sri Lanka with resettlement and rehabilitation grants could be targeted for extortion. The freedom of movement, especially in and out of the camps, needs to be addressed. Furthermore, the right to benefit from measures towards family reunification needs to be articulated.

While the government of Sri Lanka has legitimate security concerns to protect Colombo and Southern Sri Lanka, it must also protect all of its citizens by adhering to the procedural safeguards concerning arrest and detention that it agreed to in June 1993 with the Tamil parties. It must dismantle all illegal detention and torture camps and disband illegal armed gangs. It must also repeal the Prevention of Terrorism Act, which permits incommunicado detention, the risk of torture and disappearance and state and military impunity. Measures must also be taken to ensure that Emergency Regulations are not reinstated in Colombo. Despite the recent relaxation of items banned in the North of Sri Lanka, only a complete lift of the economic blockade will ensure that comprehensive relief assistance and rehabilitation work can take place among the displaced in the district of Jaffna. The health and sanitary infrastructure needs to be rebuilt and rejuvenated before Tamil refugees and displaced persons can return.

In order to avoid the risk of 'refoulement,' or the return of Tamils into the hands of a hostile government, the UNHCR must take a more active monitoring role for the Swiss returnees to Sri Lanka. The viability of the reception centre set up in Nugegoda for the protection of returnees from Switzerland needs to be reviewed, in light of the fact that many Tamil returnees are going underground on

arrival, in anticipation of fleeing once again. In the absence of adequate UNHCR monitoring, an additional monitoring unit or agency needs to be established at Colombo airport. Moreover, in order to reduce the insecurity and fear of the Tamil asylum-seekers in Switzerland, the Swiss government ought to clarify the selection criteria for deportation.

Sri Lanka is a party to the Geneva Convention relative to the Protection of Civilian Persons in Time of War of 12 August 1949, and is therefore bound by Article 3 to provide minimum standards of protection to civilians in situations of internal armed conflict. However, it has not signed Protocol II Additional to the Geneva Conventions (1977), relating to the victims of non-international armed conflicts. Sri Lanka should consider becoming a party to Protocol II Additional to the Geneval Conventions, which develops and supplements the protection given to civilians in armed conflicts. Similarly, if the LTTE's aim is to receive international recognition of the Tamil-speaking people's right to self-determination, then it should also respect and give effect to international standards of armed conflict.

Lastly, as Francis Deng, the UN Representative for Internally Displaced Persons, stated in his country profile on Sri Lanka, "it would seem that unless peace is restored, the process of return to one's home area is doomed to be precarious"[5]

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1 Figures taken from the Tamil Information Centre, London, as of August 1994

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5 Profile in Displacement: Sri Lanka.' Report of the Representative of the Secretary General, Mr. Francis Deng, submitted pursuant to Commission on Human Rights resolution 1933/95.

REHABILITATION FOR EX-DETAINEE SURVIVORS OF SYSTEMATIC VIOLENCE IN SRI LANKA

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Background

The following health survey of ex-detainees was conducted in 1988 during the formative stages of the Association for Health and Counselling (AHC) in Jaffna, Sri Lanka, with which the author was involved. As a result of this survey an integrated medical and counselling service for ex-detainee victims of systematic violence was initiated in the rural areas of North Sri Lanka. Medical students, trained on a two-week full-time course in counselling, made visits to rural areas to run screening clinics and to provide on-the-spot medical and counselling attention. A counsellor trained to Diploma or Masters standard accompanied the mobile clinic to offer more in-depth help to those screened and found to be needing urgent psychological help.

These clinics were run in the Vavuniya and Mannar areas and were open to all ex-detainees who came forward, irrespective of their cultural or ideological background. Medical-cum-counselling interviews were conducted privately and confidentially, generally lasting about 40 minutes. Chronic or acute medical or psychological problems requiring more specialist input were referred to the AHC or to Jaffna Hospital. Clients were given financial help for bus fares to Jaffna, and contact with the correct medical specialists at the hospital was facilitated by a medical student 'befriender'. Thus, people with multiple medical problems and psychogenic pain – in a state of fear and psychological trauma – were not passed from department to department and then unwittingly asked to 'come back next week'.

The client group

The ex-detainees in all areas of Sri Lanka requiring rehabilitation into their own communities probably number in the several hundreds of thousands. Rehabilitation for this client group was initiated in May 1988 in response to a newspaper advertisement in a North Sri Lankan newspaper calling for medical help for the ex-detainees in the Vavuniya District. The author, together with a group of medical students from the Medical Faculty, University of Jaffna, conducted a study of this group's needs (Puvinathan et al. 1989). 158 male and 2 female ex-detainees responded; all needed both medical and psychological care following detention in various police, army and militant group camps throughout Sri Lanka. More women had been detained than this ratio suggests, but they were far more reluctant to come forward openly for this survey.

The injuries to mind and body followed systematic violence and abuses of different forms. In almost all cases the injuries were accompanied by a fear of death and often involved the witnessing of death. Most of the Vavuniya-area group fell within the age range 20 to 25, although the age distribution was 16 to 65 years. Most had been released after the Indo-Sri Lankan Accord; therefore, most were released approximately 9 months before the survey, though the period since release ranged from 1 day to 62 months. The average period of detention was 13 months, ranging from 42 days to 5 years.

The World Medical Association (Declaration of Tokyo 1975) defines torture as 'the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority to force another person to yield information, to make a confession or for any other reasons.' This survey therefore covered a group of people who can be called torture survivors.

Physical methods of torture often had led to the death of detainees, but among these survivors physical torture had led to conditions such as: residual lesions, fractures and malunion of broken bones, chronic bone infections, head injuries, chronic ear infections and hearing loss, problems with vision, chronic headaches, respiratory tract infections, dental problems, haemorrhoids, difficulty in walking, chronic chest pain, peptic ulcers and generalised body pain. Psychological methods of torture had generally been aimed at weakening the prisoner, inducing a state of extreme fear, helplessness, hunger, apathy and exhaustion. These methods commonly destroyed

personalities, induced guilt, humiliation, and fear for the lives of family members and eroded faith and core social and political values.

Rehabilitation Work

The survey had several aims, most notably to characterise the medical and psychological care needs of this multiply injured group. Psychological counselling and medical models of intervention do not necessarily go well together, but this particular client group forced a merger of the two approaches. In any case, psychological counselling services were not familiar to the majority of Sri Lankans and therefore using the medical interview became an entry point to facilitate the introduction of psychological help. From an early stage, patients could be advised that once they had been medically treated, chronic stress conditions might best be remedied by alternative approaches. Long-term use of medication is costly for the many who can ill afford it, can have dangerous side-effects and also might not be properly supervised in rural areas where prescribed medication can be bought from pharmacies. Comorbidity of chronic stress reactions with drug and alcohol abuse is well known (Keane and Wolfe 1990).

From the outset a holistic approach was favoured since it is clear from work with survivors of systematic violence that physical scars are accompanied by psychological scars (Mollica et al. 1987; Somnier and Genefke 1986; Turner and Gorst-Unsworth 1993). The ex-detainees often had symptoms such as pain, memory loss and fatigue which were psychogenic in origin; however, a full medical check-up was necessary so that medical conditions were not overlooked. For other chronic stress-related symptoms such as asthma, chronic hyperventilation, peptic ulcers and sleep loss it was felt that psychological approaches such as relaxation training and ventilation of strong emotions such as grief and anger were sometimes indicated, instead of or in addition to medication.

Assessment of psychological sequelae in Sri Lankan ex-detainees

Massive psychological traumatisation as a consequence of violence or natural disasters can result in a range of characteristic psychological symptoms. This psychological response to catastrophe has been recognised for some time and is characterised by the American Psychiatric Association (1987) and the World Health Organisation (1979, 1992) as Post-Traumatic Stress Disorder (PTSD). The psychological sequelae in torture survivors from around the world has been found to be well-described by the PTSD construct. For this survey the definition of PTSD was taken from the APA's Diagnostic and Statistical Manuel of Mental Disorders (1987) and the various symptom descriptions were translated into Tamil and made up into a Yes-No questionnaire. It was important to assess the relevance of this description of psychological trauma to the Sri Lankan context so that literature dealing with assessment and therapy for PTSD from elsewhere in the world could be applied in a more informed way. The questionnaire also covered other areas, notably relating to depression and physical health.

All 160 ex-detainees filled in the questionnaire, either by themselves or with the help of relatives, and answered questions related to how they were feeling at the time. They were then given a medical and counselling interview and the correspondence between the self-filled questionnaire and the reporting symptoms was checked.

Results:

Post-Traumatic Stress Disorder symptoms in ex-detainees

There is an overlap between the symptom patterns consistent with a diagnosis of depression, anxiety disorder and post-traumatic stress disorder, and this survey suggested a high comorbidity. PTSD, however, cannot arise spontaneously but must follow a 'distressing experience that is outside the range of usual human experience.' It requires the presence of symptoms in three broad descriptive categories:

1. Re-experience of the trauma in a variety of ways, namely through intrusive images, memories, flashbacks and dreams;
2. Reduced responsiveness and involvement with the environment, diminished interest and avoidance of intense feelings;
3. New trauma-related physical symptoms of nervousness, startle response, sleep disturbance, avoidance behaviours and concentration and memory problems.

The percentage of those having psychological problems of various types are given in the following table, along with some of the general observations made during the interview. The most common to least common categories of emotional disturbance are listed in descending order.

Psychological symptoms

	No	%
General and deep sadness	139	86
General tiredness	139	86
General nervousness	135	84
Recurrent intrusive memories	128	83
Memory impairment or poor concentration	125	79
Loss of appetite	110	69
Symptom intensification with reminders of trauma	108	68
Extreme fear	106	66
Headaches, giddiness, fainting	103	65
Low self-esteem	92	59
Nightmares and sudden awakening	91	56
Extreme mistrust and suspiciousness	80	50
Unusual irritability and aggressiveness	74	46

	No	%
Sweating profusely during the interview	74	40
Suicidal thoughts	61	38
Behavioural changes leading to social withdrawal	61	38
Crying or watering of eyes during the interview	48	30
Sexual dysfunction	40	25
Suicide attempts	1	0.5

Discussion

The range of these debilitating features surpasses anything normally seen in either anxiety or depressive disorders. The symptom patterns arose as a consequence of imprisonment and closely resembled those described in the classification of PTSD. 137 (85%) of the 160 ex-detainees had a sufficient symptom range and severity to reach the diagnosis criterion for PTSD.

Thus the large majority of the ex-detainees were showing post-traumatic stress symptoms which greatly disrupted the normal course of their lives, affecting employment (almost all were unemployed) and family relationships. Half the group were distrustful to an extent that might normally be considered paranoid and this tended to affect even their closest relationships as well as leading to social withdrawal. It is the profound loss of trust in others and the acquired dislike of being touched which led some to have problems with sexual functioning. The figures in the table above give a catalogue of the deep psychological damage suffered in detention. It is not surprising that many had low self-esteem and nearly all felt that a general deep sadness had overtaken their lives. General tiredness, poor concentration and loss of memory appeared to be a real problem for many, and seriously hampered study, employment training and earning capacity. It was significant that nearly half of the group felt that they were much more likely to be irritable and aggressive than before their prison experience. Many of these people – unemployed, angry and with feelings of suicidal hopelessness – may well have re-entered the cycles of violence that Sri Lanka is suffering.

Conclusions

The combined counselling and medical approach was found to be greatly helpful to many of the ex-detainees who responded to the survey and the following rehabilitation work very positively. A holistic, multidisciplinary approach to the rehabilitation of this group might usefully follow three stages: 1. joint medical and psychological screening in local clinics with preliminary remedial care; 2. referral, where necessary, to more specialised centres for further assessment, medical treatment or psychological counselling; and 3. introduction to alternative agencies involved in social work, occupational education or employment.

The diagnostic category of post-traumatic stress disorder was found to be relevant to the Sri Lankan context. Chronic stress reactions following trauma are extremely debilitating to the sufferer and it is crucial that the symptoms are identified correctly and responded to appropriately. Post-traumatic stress reactions are likely to be found in wide-ranging sections of the Sri Lankan population, including children (Pynoos and Nader 1993) since all ages and cultural backgrounds have been directly exposed to violence during civil conflict over the past decade. Sri Lanka has ratified the UN Convention on the Rights of the Child (1989) and therefore requires objective measures of psychological trauma in adults (as care providers) and children so that it may satisfy its responsibility to those in the category of 'children in difficult circumstances' and to those 'children who are affected by an armed conflict' as categorised by Article 38. It is suggested that world literature on PTSD assessment, prevalence, case management and therapeutic intervention is looked to for development of service provision in Sri Lanka.

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HEALTH STATUS AMONG THE HILL COUNTRY TAMILS

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Despite its low per capita income of US$ 400 (1988), Sri Lanka can boast of a high quality of life. Life expectancy is as high as 69.5 years for males and 74.2 years for females, and the literacy rate is equally high at 89.7% for males and 81.3.% for females. The aggregate infant mortality rate, another indicator of physical quality of life (PQL), is 20.2% a rate that is remarkably low. However, these standards of living are not shared by all sections of the population. There are, indeed, deprived groups within the population of Sri Lanka: the plantation workers make up one such easily-identifiable group. Women in the plantations are worse off than their male counterparts, and their status in relation to female-specific welfare indicators such as maternal health is very low.

Historical Background

The low physical quality of life of the plantation workers owes much to the origins of the plantation structure and its subsequent evolution. Plantations were opened in the mid-nineteenth century by British colonialists with foreign capital and technology on land acquired by the appropriate legislative measures. Under the Crown Land Ordinance of 1841 all lands not under cultivation and to which people could not produce acceptable titles were declared Crown Lands and sold at very cheap prices to prospective investors to be opened up as plantations. Since indigenous labour did not show much interest in working for wages on these plantations, the necessary labourers were brought from India, initially on a seasonal basis but later as permanent settlers. As the plantations were located in the difficult terrain of the central highlands and the labour settlements were in the middle of large estates, communication became difficult. In order to ensure an uninterrupted supply of labour and prevent any labour unrest due to outside intervention, it became necessary for the management of the estates to provide the workers as well as their families with certain basic amenities. Housing was provided in barrack-type rooms. Rudimentary health facilities later basic educational facilities were also provided under legislation enacted especially for this purpose.

Almost every estate provided services and amenities such as housing, water supply, and medical, educational and other welfare services. However, the quality of the services provided varied a great deal from one estate to another, depending on the inclinations of the management. But generally, it can be said that the quality of these services was far from satisfactory and began to deteriorate after the sixties, as declining commodity prices, increasing tax burdens and escalating costs of inputs eroded the economic base of the estates.

These facilities continued to remain primitive, very often failing to satisfy even the basic needs of the labourers and their families. This situation is reflected today in the various welfare indicators relating to the estate sector. Although these labourers have better access to wage-employment, their physical quality of life as revealed by the various welfare indicators is well below the national average.

Recent Measures to Improve Conditions

After the nationalisation of the estates in the 1970s, the welfare of the plantation workers became the responsibility of the State. Consequently, the State began to show a great concern for the health, housing and general living conditions of plantation workers. The intervention of UNICEF and other agencies such as the World Bank, the Asian Development Bank and some donor countries (Sweden, Norway and the Netherlands) with material assistance and well-formulated programmes has stimulated the State to take a greater interest in the welfare of plantation workers. In each of the two State-owned management companies, the Janatha Estates Development Board (JEDB) and the Sri Lanka State Plantation Corporation (SLSPC), Social Development Divisions (SDDs) were opened to organise the welfare services. The Medium Term Investment Programme (MTIP 1985-89)

	No of schemes	Expenditure (Rs. 1000s)
Child and health care buildings	157	14,086
Staff houses	93	23,280
Water supply schemes	211	56,061
Latrines	347	56,842
Re-roofing line rooms	662	119,595
TOTAL	2,470	296,864

for the plantation sector, for instance, earmarked a sum of Rs. 625.6 million (or 17% of the total planned investment) for the development of the social welfare infrastructure. Construction of new houses, rehabilitation of line rooms and improvement of water supplies and medical facilities were included under this project. The project was expected to enhance the health standards and the welfare of estate workers and their families by improving housing, water supply, sanitation and medical facilities.

Two Social Welfare Improvement Programmes (SWP's) were planned in the early 1990s. The first programme for the period 1990-92 was completed in the last quarter of 1993, and consisted of the following projects: see table above.

The second programme (SWP II, 1992-94) is now being implemented. However, the period in which these investments are planned and implemented is one of considerable change and uncertainty in the sector. In this period the estates have been privatised and the two giant corporations which had controlled the sector since nationalisation, the JEDB and the SLSPC, have handed over control of most estates to private sector companies. With the privatisation of management, the institutional basis for the implementation of social welfare investments has completely changed. The Plantation Housing and Social Welfare Trust (PHSWT) has replaced the Social Development Divisions of the two corporations as the implementing agency for the SWP II investments. Investments in social welfare facilities are no longer implemented by a single hierarchical organisation such as the JEDB or the SLSPC, but instead through the joint involvement of separate organisations such as the PHSWT, the management companies and the Ministry of Plantation Industries.

These structural changes in the sector have had an inevitable impact on the implementation of investments. The level of support from the regional offices particularly declined during the transition period when the management of the sector changed. This caused confusion and uncertainty in the provision of welfare services. Welfare functions on the estates are being conducted as usual and the PHSWT is yet to introduce its specific programmes of activities.

Contemporary Health and Nutritional Status of the Estate Sector

Undoubtedly, all these measures taken to improve health standards in the plantation sector have produced some positive results, but they do not sufficiently meet the total requirements in the field of health. Available statistics demonstrate the need for special and specific interventions in order to improve the health standards of this sector to the level of national health standards. For example, in the Nuwara Eliya District, a key plantation area where nearly half of the population are plantation workers, the maternal mortality rate in 1988 was 0.6, infant mortality was 35.5 and neonatal mortality was 25.4, compared to national figures of 0.4, 20.2 and 14.4 respectively. All the studies conducted so far on the pattern of health facilities in different Health Regions of Sri Lanka, including the plantations, has revealed that the health facilities on the plantations are poor. The percentage of key health personnel and paramedical personnel serving in the plantation regions is far below the national average.

With regards to nutritional status in the plantation sector, four groups are particularly vulnerable to nutritional deficiency: infants below the age of five, schoolgoing children, pregnant women and lactating mothers. The following reasons may be considered as causes of malnutrition and disease among these groups:

- Low income (wages);
- Bad weather conditions, low ambient temperature and poor working conditions;
- Poor living conditions: bad housing, poor sanitary facilities, poor environment, and unsafe and polluted water for consumption;
- Lack of knowledge on nutrition, disease and preventive methods;
- Lack of proper health care education and welfare.

The statistics from a survey conducted by the Department of Census and Statistics indicate the relative percentage of expenditures on food within the total home budget of various sectors of the population.

The figures clearly demonstrate that families in the estate sector spent over three-quarters of their income on food in 1980, and that this figure increased both absolutely and relative to other sectors of the population in the twenty preceding years. Another survey conducted by a research team led by K. Kugathasan and L. B. Beddewela interviewed a sample of 500 working families with three schoolgoing children. They found that the average total income of

Sector	1969/70	1973	1980
All island	54.7	55.2	70.1
Urban	48.2	47.4	63.3
Village	56.4	57.6	69.6
Estate	59.3	59.6	76.7

Source: Socio-Economic Survey of the Department of Census Statistics

husbands (manual workers) and wives (tea pluckers) in this sample amounted to Rs. 1545.00 per household. Of this total, the households spent an average of Rs. 1352.00 on food, and Rs. 216.50 on electricity, clothing, personal care, etc. Their expenditures regularly exceeded income by Rs. 62. Although they spent 86.1% of their earnings on food, they still did not get the basic minimum of nutrition they needed. The caloric intake of the families was calculated at 1,638 grams per day, well below the desirable intake of 2,217 and the 3,000 recommended by the World Health Organisation. Their daily protein intake was 38.9 grams, compared to the desired 50 and the recommended 55. Children in these families were particularly malnourished. (Ceylon Daily News: 27/9/91)

The spiralling cost of living has adversely affected the nutritional status of plantation workers and their families, particularly since no corresponding pay increases have been granted. In fact, government policy reforms of the recent past, especially the introduction of an open economic policy in lieu of the welfare state policy after 1977, have had an adverse impact on the nutritional status of the people. The total lifting of price controls has left price structures entirely in the hands of the traders who are now free to dictate the prices. The prices of most consumer goods are so high that they are not within reach of the average consumer of the estate sector.

The elimination of food subsidies, coupled with the non-availability of cheap rice rations and other food items like green gram, dhal, dried fish, etc. at concessionary rates has completely changed the meal patterns of the people. The removal of the subsidy on infant milk foods has a direct bearing on infant nutrition. The renewed encouragement of breast feeding alone may not sufficiently cushion the adverse effects.

At the national level, 34.7% of the population faced endemic malnutrition in 1981; while the average malnutrition rate in the village sector was 30.8%, fully 62.4% of the people in the estate sector were malnourished. (Economic Review: March 1982) With the rapid increases in the prices of essential commodities, the situation of malnutrition among estate workers has worsened.

Special Burdens on Women

Women are the worst affected section of the plantation community due to their low income levels. Several researchers have proven that females in general consume less food than their male counterparts, despite the fact that they spend more time in manual work in the field and at home. Women in the plantations follow the practice of eating their food after feeding the others in the family. In the event of food shortage, a common feature among plantation families due to their low income, women are deprived of their proper food. This situation has been a major cause of protein deficiency among the women of the estate sector.

Several studies conducted among the female workers of the plantations have proven that pregnant women and lactating mothers do not take as much food as is medically recommended. Further, the female workers do not play a role in planning home budgets or controlling the flow of monies. They may not even know about the level of their wages, which are usually collected by the male heads of the families. The subordinate gender status of the plantation women is the main factor that pushes their needs to the bottom of the family agenda.

Women work the longest hours in the field, even during the rainy season with its low temperatures in the high-grown and mid-grown tea areas. They are not in a position to invest in warm clothing and are therefore exposed constantly to chilly and damp weather conditions. As a result, bronchitis, pneumonia, pleurisy and asthma are the most common respiratory diseases among the plantation workers living in the wet zone. In addition, their low level of nutrition makes them more susceptible to infection.

Housing and Sanitation

The majority of plantation workers live in congested line rooms measuring 10 x 12 with a common verandah or two small rooms, most of which are overcrowded. Although programmes to improve housing in the plantation sector are being implemented, housing in general is totally unsatisfactory. The plans to improve housing are moving rather slowly and therefore it may take several decades to ensure proper housing for the workers.

Sanitary conditions in the majority of plantations are inadequate to and unhygienic. Almost half of the estate workers do not use latrines. The use of common latrines among the workers is a proven failure. However, wherever family latrines are constructed and proper instructions regarding their maintenance are given (such as some estates in the Nuwara Eliya District under IRDP), the results have been positive. The Central Bank reports that toilets are available to only 52% of the plantation population; this situation coupled with widespread water pollution exacerbates the prevalence of bowel disorders among the estate population. Medical records prove that the incidence of scabies is very high in plantation communities. Scabies is highly infectious and spreads rapidly under poor hygienic conditions; the congested living conditions of the plantation population certainly contributes to its spread. Other diseases caused essentially by the lack of personal hygiene and poor environmental conditions include diarrhoea and worm infections.

There is adequate documentation that estate workers are a significantly neglected and deprived segment of the Sri Lankan population in spite of their contribution to the economic welfare of the country. Corrective measures have not been taken because of the absence of a political will to solve the problems of this marginalised segment of the population.

HEALTHCARE AND REHABILITATION OF WOMEN AND CHILDREN IN THE BATTICALOA DISTRICT

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The armed conflict between the Sri Lankan Government forces and the minority Tamils demanding a separate state or autonomous region for Tamils, waged intensively since 1983, has devastated the people and the countryside. Hundreds of people have lost their lives, hundreds more are injured. Thousands of people have lost their properties, and thousands more live in scattered camps for refugees. Hundreds of women, especially young women with children, have lost their husbands to the war. Male and female youth fleeing to the West as refugees have suffered untold hardships. Thousands of people, especially widows and children, have been affected mentally. Facilities are not available to treat these victims of war.

Background

One of the eight districts in the North-East Province is Batticaloa District. The district lies on the Eastern coast of Sri Lanka, and was the provincial capital of the then Eastern Province. The population of the district in 1991 was 433,776, of which 25% were Muslims. The Rattamkuddy Muslim village lies in the most densely populated rural area, with over 5,000 people per sq. km. Agriculture and fishing are the main occupations of the people: 31% of the active population is engaged in agriculture and 18% in fishing. However, the unemployment rate has increased from 10% in 1981 to 22% in 1991, mainly among the 15-35 year age bracket. Of the total population of the district, 65% live on food stamps, i.e. below the poverty line. The district has the lowest per capita income in Sri Lanka of US$ 221.50 annually, which has further deteriorated due to the destruction of life and property produced by the civil strife.

The average literacy rate in Batticaloa was 57.0% in 1981, compared to a national average of 78.5%; while the national rate rose to 86.5% in 1991, the literacy rate in Batticaloa rose to 66.1%.

The average life expectancy at birth rate is 61.13. The district has the highest prevalence of concurrent acute and chronic malnutrition among pre-school children (6 to 60 months old). In 1981, 10.3% of these children were undernourished, compared to a national average of 6.6%. In the same year, 7.0% of these children in Batticaloa faced concurrent acute and chronic undernutrition, compared to 2.6% nationally.

A similar situation prevails among primary-school children; 45.3% of the school going children are undernourished and 15.4% suffer from concurrent active and chronic undernutrition. This situation has further deteriorated with the restrictions imposed on the movement of fishing craft, as fish has ceased to be the main source of nutrition.

The civil strife, especially after 1990, led to serious loss of life and property; more than 90% of the people had to flee as refugees. Hundreds of young men in refugee camps were arrested and were either killed or are found missing. An estimated 3,000 young women, mainly less than 35 years of age with and with children, became widows overnight; almost all of them are poor and have to be accommodated by their equally poor kith and kin.

In the more remote interior areas (west of the lagoon), the few infrastructural facilities – hospitals, schools, community centres – were also destroyed. There are no qualified doctors to look after the patients, nor drugs with which to treat them. This problem is being temporarily addressed by the mobile clinics of the Red Cross Society and Medicine Sans-Frontiers. Overall, the destruction has been more intensive and systematic in Batticaloa than in other affected areas.

Meeting Health Care and Rehabilitation Needs

Many refugees are returning to their villages where their homes stand destroyed. Government and non-governmental organisations (NGOs) are trying to help them by providing relief, assistance for their resettlement and assistance for income-generating activities. The international agencies may claim to assist the government in providing infrastructural facilities essential for development, but such assistance

does not help ordinary citizens restart their shattered vocations. The scanty resettlement assistance provided by a number of NGOs to affected people is of no real benefit to recipients. If these organisations tried to reach out to small but integrated and well-organised groups or communities rather than trying to provide assistance to large numbers of people simultaneously, they may be able to record positive results. Any gaps generated by such an approach could be filled in by new donors.

At the moment, there are no positive statistics available with any institution. The poor people suffer in silence. They blame their fate and endure their sufferings. In the words of a learned doctor, 'tension has decreased, the situation is near normality and a large number of affected people are returning to their homes, merely because the length of time, their faith in God Almighty and their acceptance of the inevitable.'

To address the suffering of the people, a number of steps must be taken to improve health care and rehabilitation efforts. The government and non-governmental organisations have long been discussing the lack of normal medical and health aid in the district. However, we have failed to take notice of the mental and psychological conditions of the affected people, as well as the hidden physical injuries caused to men and women attacked by the security forces and armed groups. The affected people need counselling, psychiatric treatment, orthopaedic treatment, herbal baths (to cure body pains) and social and community integration to overcome their traumatic experiences. More broadly, the following needs can be clearly delineated:

- An intensive survey and classification of the types of affected people is needed, though the government may not be geared to conduct such a survey. Ad hoc studies indicate the urgent necessity for such a study: classifying the affected people into various categories will facilitate the process of funding suitable treatments.

- The district does not have any medical personnel to conduct psychiatric clinics. There are no trained personnel to counsel the patients; a training programme may have to be organised for trainers to train local counsellors. With regards to herbal baths, a workshop may have to be arranged in the district. The government may also be persuaded to post a psychiatrist and an orthopaedic surgeon to the Batticaloa District.

- The Batticaloa District has the highest prevalence of concurrent acute and chronic malnutrition in Sri Lanka. Security concerns have restricted the supply of fish and malnutrition has worsened. NGOs may be encouraged to organise nutritional programmes in the villages.

- It may seem that the state has the necessary infrastructural facilities to care for the population , but in practice such facilities are unavailable in Batticaloa. Resources lacking in the district include medical personnel, paramedical personnel, buildings, drugs and means of transport.

- Besides, the additional facilities needed for the victims of war cannot be provided by the government. To attend to these needs on a priority basis, the non-governmental sector must step in to fill the gap. Persons may be trained on a short-term basis as 'bare-foot doctors,' but donors may not be willing to fund the payment of their wages year in and year out after a few years. Therefore, such programmes must be matched with village-level income-generating programmes to sustain them in the long-run. Moreover, providing for the health needs of victims of war may not bring about healthy social conditions unless the beneficiaries of the health programme have regular and sufficient income to maintain their families. All efforts to rehabilitate them in the health sector may be fruitless if they are not economically satisfied.

Activities of the Dryzone Development Foundation

The Dryzone Development Foundation (DDF) is an NGO engaged in development and rehabilitation work in the district. DDF conducted an ad hoc survey at Rannespuram, and has discussed rehabilitation measures with the other NGOs, religious leaders, social workers and state officials working in the area. DDF has formulated the following programme to assist the victims of war to live as healthy citizens and engage in income-generating activities: Programme Components Counselling: Ten counsellors will talk to three persons per day every week for six months; there will be four batches over two years, and 720 persons will be reached.

- Nutritional programme for 1,000 children in groups of 50 for two years.
- 30 'barefoot doctors' will be trained and posted to look after 500 families in a G.S. Division. These volunteers may have to supervise income-generating projects as well, and after two years, the community organisations will be in a position to pay the 'barefoot doctors.'
- Herbal bath programme will be operated for 18 months; after the end of the programme, village people may be able to continue without any assistance. Five trained persons may be able to assist 3,000 people.
- Rehabilitation and Development will assist participants in the health programme:

Vegetable cultivation	32 families
Banana cultivation	40 families
Goat rearing	20 families
Cane basket weaving	10 families
Mat weaving	15 families
Handloom	30 families
Lathe and welding	20 families
Small business	40 families
Packing of foodstuffs	25 families
Processing of rice	20 families
	252 families

Implementation

The DDF along with the Medical Officer of Health will select:

- 10 persons to be counsellors
- 20 persons for nutritional programme
- 30 persons as 'barefoot doctors'
- 5 persons to perform herbal baths

These persons will be trained in Jaffna by the University and by participants of the International Seminar on Health.

Community Organisation

The trained persons will be allocated to the savings clubs of the DDF that are or will be established. The trained persons will be selected from the village to which they will be posted or a village nearby, and they will engage in close dialogue with the patients and the clubs.

After two years, the savings clubs may be in a position to pay for the allowances of the volunteers working in the programme. These volunteers will assist in the implementation of the development programmes.

Duration

While the trainers are trained in Jaffna University the process of selecting the participants will commence. The development projects will also commence simultaneously. External project funding will end after two years and from then onwards the DDF will sustain the programme through its village savings clubs.

Evaluation

A team of consultants will be appointed after one year to evaluate the project and to make amendments if necessary. The same consultants or a different team will again make an evaluation when the project ends after two years.

Responsibilities

The Dryzone Development Foundation will be responsible for the programme. The DDF will submit regular reports as agreed. At the end of the project, the DDF will provide a detailed report to the donor.

SHANTHIHAM

THE ASSOCIATION FOR HEALTH AND COUNSELLING

Sister Victorine James
Lecturer, School of Nursing, Jaffna, Sri Lanka

Introduction

When Sri Lanka gained independence from the British in 1948, the island had a population of six million people, of which 65% were Buddhists, 18% Hindus, 8% Christians and 7% Muslims. A surge of ethno-religious nationalism among the majority Sinhala Buddhists of Sri Lanka in the early post-independence era and the whole series of political developments over the last few decades have resulted in repeated ethnic violence and unrest in the country.

This continuous unrest led to an unjust and senseless war in the North and East of Sri Lanka which has lasted four years as of June, 1994. This ethnic war still shows no sign of ending and is seriously damaging the fabric of the society. The visible effects of this war are not confined merely to the deaths of the thousands of boys and girls dying in the battlefield (6,000 militants), or to the many more thousands of civilians (over 38,000) killed due to aerial bombings and shellings, or to the destruction of properties. This damage is modest compared to the invisible, irremediable and longstanding psychological effects and trauma of this war suffered by the surviving population.

Jaffna Today

The 800,000 people still surviving as virtual prisoners on the Jaffna Peninsula face a host of paralysing, crippling threats which prevent them from living healthy lives. They are refugees in their own homeland, isolated from their dear ones due to the lack of social communication: no transport, no postal service, no telephone service. They have no hope of ever seeing their relatives who have taken refuge in almost every continent of the world, while at home they must watch their children grow with neither proper food nor education. The high cost of living amid sanctions and economic embargoes is compounded by the loss of job opportunities. People live in constant fear of aerial bombing, artillery shelling and infectious diseases, while drugs and medical care are lacking. There are many widows, orphans and unmarried girls. People must cope with loss of limbs, bad body image, low self-esteem and a host of other problems.

Birth of Shanthiham

In the past, the death of a loved one brought the whole village or the entire neighbourhood together to grieve for weeks or even months. Now there are so many losses that everyone in the society has faced a death in one way or the other, and the people do not know which loss to mourn. Such social conditions have generated profound personality changes, disrupting the day-to-day lives of people at home, school, work, etc. People feel a great need to express their loss, cry, grieve and mourn for their loss, accept the loss for what it really is, and move forward to face the future with renewed courage and self-confidence.

On October 4, 1987 at the Annual General Meeting of the Jaffna Medical Association, Rev. Fr. Damien presented a paper on Post-Traumatic Stress Disorders, highlighting the need for counselling services for the victims of war in this region. In response to this need felt in North Sri Lanka, *Skilled Helpers* was started in April, 1988 under the able leadership of Dr. Anna Doney of the Quaker Peace and Service and Rev. Fr. Damien, supported by some doctors, medical students, priests and nuns. With minimum basic training in listening skills and the art of counselling, this group made itself available at the Centre for Better Society at 4th Cross Street, Jaffna, to cater to all those who sought solace there.

In the latter part of 1988, the *Skilled Helpers* formed themselves into the *Association for Health and Counselling* (AHC) and moved its centre – 'Shanthiham' – to 1st Cross Street, Jaffna. The Association drafted a Constitution in 1988 and in due course was registered as a non-governmental organisation. Due to the generous aid received from NORAD (A Norwegian NGO) in 1989-90 it was possible to give counselling services free of charge to 230 clients, as well as train the first batch of short-term

counsellors in 1989. Unfortunately, the building was completely demolished in an aerial attack by the Government Air Force on August 8, 1990. Before the end of the year, however, Shanthiham was able to function once again in a house at 15 Kachcheri-Nallur Road, Jaffna.

To serve people in need, Shanthiham is open from 9:00 a.m. to 4:30 p.m., seven days per week. In addition to the services they provide at Shanthiham, the counsellors also go out to Government General Hospital, Jaffna and to the Psychiatric Hospital at Manipay (it houses the Tellipallai Psychiatric Hospital which has been displaced due to the army occupation). Apart from counselling people one-to-one, the counsellors also conduct awareness programmes at schools, centres of education and non-government organisations

Philosophy and Objectives

Shanthiham takes a holistic approach to education, counselling and supervision. Our approach is intrapersonal and interpersonal. Our academic and professional training and our clinical supervision are informed by an integrated perspective. Five main objectives guide our work:

- To give psychological counselling to those who seek help at the centres of AHC.
- To identify those who need professional medical or psychological help and referral services.
- To offer training in counselling to people who need counselling skills in their workplaces, such as teachers and health workers.
- To conduct awareness programmes in schools and in centres of education aimed at preventing psychological trauma.
- To provide peer group support to those trained persons involved in counselling.

Content of Work

There are four major areas that define the scope of our work at Shanthiham. Our Education programme provides initial and ongoing training for counsellors and conducts seminars, workshops and public awareness programmes. Our Counselling programme focuses on counselling for individual adults, marriage and family counselling, group therapy for alcoholics and play therapy for affected children. Supervision includes individual supervision, case conferences and peer support groups. Lastly, we conduct Research on victims of torture, traumatised children and the effects of war on school children. We will now elaborate more fully on each of these programme activities:

Education

We conducted short-term training programmes in English for counsellors in 1989, 1991 and 1992. Our fourth training programme, started on January 15, 1994, was conducted for the first time in Tamil. Applications were solicited through the local newspapers, inviting those who had already attended the Foundation Course in Counselling conducted by the extra-mural studies unit of the University of Jaffna. Regular training updates are conducted for members of Shanthiham on a monthly basis, concerning matters such as management of PTSD and cognitive behaviour therapy.

We have conducted seminars and workshops in a variety of settings: at colleges (Jaffna Hindu, Union, Ramanathan, Inuvil Central, Holy Family Convent); at the Jaffna Cathedral Youth Centre, the Tamil Writers' Union, the Jaffna Hindu OBA; and for preschool teachers (in Sarvodhaya, Malvam and Manipay), hospital para-volunteers and Red Cross volunteers. Our awareness programmes have reached out to members of Shanthiham, medical and paramedical personnel, teachers and the general public. In addition to the above, Shanthiham collaborated with the Psychiatric Unit of Jaffna to prepare a curriculum on basic counselling and communication skills and to conduct a training programme for student nurses at the General Hospital as part of their regular psychiatric training programme. Similarly, the staff of Shanthiham drew up a curriculum and a 45-hour foundation course in counselling for two groups (250 in number) at the Extra-Mural Studies Unit, Jaffna University.

Counselling

Shanthiham sees two types of clients: those who are self-referred, and those who are referred by psychiatrists, other medical practitioners, counsellors, and other social workers. As of December, 1993, 970 clients have attended Shanthiham. The number of clients and visits is broken down in table1.

In addition, 243 clients were seen at hospitals in 1993 and

Table 1

Year	Adults (M)	Adults (F)	Children	Total	Sessions	Case conference
1991	126	134	20	280	692	20
1992	159	156	32	347	781	18
1993	151	146	46	343	769	15
	436	436	98	970	2242	53
Jan-May 1994	65	49	23	137	333	6

Table 2

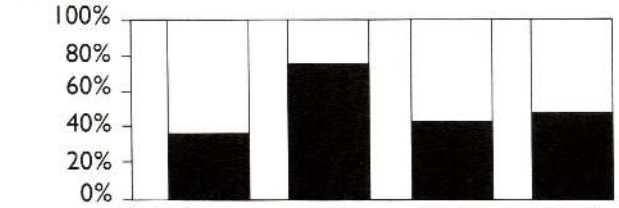
Post-traumatic stress disorder	267	20.68%
Psychosomatic disorders	42	12.96%
Suicide survivors	12	3.70%
Crisis intervention	7	2.16%
Separation anxiety	30	9.26%
Loss	30	9.26%
Grief and bereavement	27	8.33%
Disturbed adolescence	54	16.67%
Problem children	27	8.33%
Family relationship problems	17	5.25%
Alcoholism	11	3.40%

227 in the first five months of 1994.

The client base at Shanthiham can also be understood with reference to the type of psychological problems they had experienced. A survey of our past clients suggested that the most common problems among clients were PTSD, psychosomatic disorders and adolescent disturbance. Table 2 offers a broader psychological profile of our clients and the psychological problems they commonly experience:

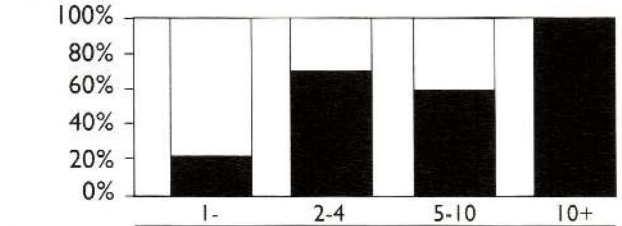
Typically, those who come for counselling meet their counsellor once a week. The counselling session lasts 45-55 minutes with a usual minimum of five sessions, though some may need additional sittings. All counselling (except for family counselling) is conducted on a one-on-one basis, and a separate file is maintained for each client; a strong emphasis is laid on confidentiality and regular supervision. Apart for individual counselling, Shanthiham also provides marriage and family counselling, child therapy and group psychotherapy for alcoholics.

Fig 1 Age



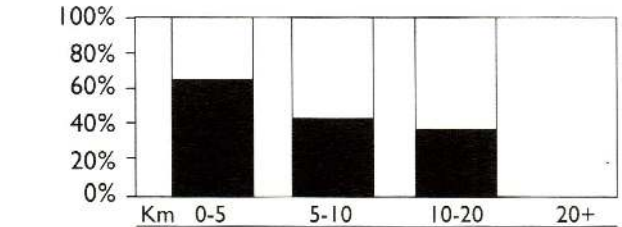
Years	0-14	15-29	30-44	45-60
No improvement	12	6	7	4
Improvement	3	15	5	4

Fig 2 No. of sessions

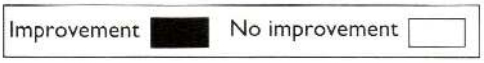


	1-	2-4	5-10	10+
No improvement	12	5	2	0
Improvement	3	15	3	4

Fig 3 Distance



Km	0-5	5-10	10-20	20+
No improvement	10	8	3	0
Improvement	17	6	2	0



Supervision

The counselling trainees undergo individual supervision. They maintain a file for each client that includes a verbatim report of each counselling session, giving details of all the facial and oral expressions, body posture of the client, as well as any feelings surfaced in the client and the trainee counsellor. Arrangements are made for regular supervision between sessions as well.

Weekly case conferences are held on Sunday mornings where two or three counsellors present their clients case files. This process enables counsellors to learn from the experience of others. Aside from these conferences, a senior counsellor is available to consult with counsellors if they need guidance. Since we do not have personnel to supervise counsellors a lot of stress is laid on peer group meetings where counsellors can discuss the problems they face among themselves.

Research

At Shanthiham we conduct ongoing research on a number of subjects pertinent to the war and its effects on the populace. Our primary intention in conducting survey or research projects is not scholarly study but the therapeutic purpose of improving our service to the community. Research projects have focused on: victims of torture (in Vavuniya, Chettikulam and Mannar); physical fitness of ex-detainees; traumatised children (in Kokuvil and Kondavil); the effects of war on children; environmental changes and pre-schoolers; war and the adolescent; and the efficacy of counselling.

A recent survey conducted in the hospitals of the North indicated an increase in psychiatric patients in recent years. Psychiatric patients at the Teaching Hospital, Jaffna increased 4.26% from 1991 to 1992, and an additional 9.82% from 1992 to 1993. Tellipalai showed a similar increase between 1992 and 1993 of 10.94%. It is also evident that living in a war-torn area – experiencing loss of home, breakdown in family ties, separation from home, school, friends and relatives – has caused a lot of stress for children and adolescents, and their stress has manifest in the form of post-traumatic stress disorder.

Healthy and valuable counselling work requires periodic analysis of client data to evaluate the success of past efforts. In 1993, we conducted a survey of our client base to assess the efficacy of our counselling efforts and determine the importance of different variables on our efficacy. 20% of a client pool (60 out of 298) were randomly selected, of which reliable data was found for 44 clients. The rate of improvement among these clients was then assessed with respect to seven variables: age, sex, distance between residence and Shanthiham, educational status, attitude, referral and number of sessions attended.

Overall, 57% of the clients surveyed registered improvements in their psychological status. Counselling proved beneficial to a greater fraction of female clients than male clients: while 65% of the female clients surveyed indicated some improvement, only 44% of male clients indicated

improvement. The group of people that experienced the greatest improvement were between 15 and 29 years of age as Figure 1 indicates. Clients with a positive attitude experienced a much greater rate of improvement than clients with a negative attitude: while 66% of the former registered improvement, only 27% of the latter did so. The value of counselling sessions at Shanthiham was affirmed by the general increase in rate of improvement as the number of sessions increased (Figure 2).

Finances

Finances are a vital part of any organisation, and we have received strong support from a number of donors over the years of our operation. The activities of our first year were sustained by Quaker Peace and Service and by local donations. NORAD funded our second and third years of work; unfortunately, however, NORAD is unable to monitor our work in Jaffna due to the unrest and difficulties in travelling, and funds have been frozen. For our fourth and fifth years, we financed operations by conducting a local fund raising raffle, producing a drama and gaining donations from clients and well-wishers. In our sixth year (1994), we have received support from the Canadian High Commission

Our Vision and Mission for the Future

Psychological counselling on a one-to-one basis is a time-consuming process of stimulating personal growth. Clients seeking help for one problem may become painfully aware of deep-seated developmental issues and may need ongoing sessions. Our experience over the past few years has shown that follow-up therapy has declined due to non-availability of public and private transport. A survey done to evaluate the efficacy of counselling indicated that the client drop-out rate increased with distance from the counselling centre: those living 20 km or more from the centre had a 100% dropout rate. Figure 3 This demonstrates that the efficacy of our counselling efforts decreased as the distance from the counselling centre increased. Consequently, there is a need to establish small centres at the periphery, e.g., Manipay, Chavakachcheri, Point Pedro, Thalaiyady, as well as outside the Peninsula.

There is a need for ongoing training for our counsellors. As this is a new field in Sri Lanka, however, the chances for further training are nil. We also need to build up a library with facilities for lending; once again, however, because counselling is a new field in Sri Lanka, it is impossible to get any such books.

Shanthiham has grown from humble beginnings slowly and steadily. As we have journeyed through a war-torn area over the last few years, the benefits of counselling service have taken root in the hearts and minds of the people at large. We are all human and we are wholly dedicated to human development, to work productively with individual human beings unique in their own eyes.

We want you all to walk with us in our struggles to join the suffering people and just listen to them. We want you to help us train more people who can listen attentively and emphatically, who can ask the questions that enable others to open up to themselves and their potential and find meaning in the suffering and pain they face in their lives. I am sure that all of us who have gathered at the conference on 'Victims of War in Sri Lanka' are consciously aware of the ravages of the war to some extent. Coming from war-torn Jaffna, having lived, worked and experienced the agony and helplessness of the war for seven years, I appeal to all those assembled at the conference to ensure that all the time we have spent in study, fact-finding and sharing finds an echo in the lives of the victims of war.

COUNSELLING PROGRAMME FOR SRI LANKAN TAMIL REFUGEES IN INDIA

Ms S Sooriyakumary
Secretary OFERR, Tamil Nadu, India

Mr R Manickavasagar
Programme Director, OFERR, Tamil Nadu, India

Genesis of the Programme

Due to the ethnic violence unleashed against the Tamils of Sri Lanka, thousands of these Tamils fled to Tamil Nadu to seek refuge. After the signing of the Indo-Sri Lanka accord in 1987 the refugees housed in the camps returned to their homeland. However, many refugees who lived outside the camps continued to remain in Tamil Nadu. Those refugees who had been cared for in the refugee camps were those who had lost their belongings, their jobs and also close relatives and family members. These destitute refugees were cared for by the Indian Government-initiated relief measures with additional assistance being provided by NGOs. The trauma of escape and displacement associated with the boredom and the feeling of worthlessness and helplessness in the refugee camp situation tended to lead to brooding and depression.

OFERR and counselling services

OFERR was founded and began functioning in 1984 initially to help Sri Lankan Tamil students compelled to pursue their education in Tamil Nadu. In order to ascertain the various difficulties faced by the refugees, OFERR deployed volunteers in the city and suburbs to survey the needs of the refugees. This initial survey did not bring to the fore the need for counselling that perhaps should have been apparent. The reasons for this could be because the survey itself may not have been properly conducted or perhaps the problem was not serious at that time or the organisation was insensitive to it. Another factor may have been the youthful nature of the volunteers, who perhaps could not comprehend and understand the complex nature of the problems the refugees were facing. But by 1988 the need for counselling was realised and remedial steps were taken. The management of OFERR took over the task of finding suitable volunteers to provide such services and decided such volunteers should be suitably trained and equipped.

The counselling training gave us an in-depth insight into the problems of the refugees and the trauma of becoming a refugee. Those who sought counselling services were required to complete a questionnaire at the OFERR office. Based on information gleaned from the completed forms, OFERR provided relief assistance within the capacity of the organisation. It did not take long for us to realise that mental trauma had adversely affected not only the psychological health, but also the physical health of the refugees seeking help. Those refugees affected by a deep sense of frustration showed signs of mental disorders, such as depression, anxiety, stress, etc. The organisation also made arrangements to provide medical care to those who were in need of such services.

The OFERR leadership thus conceived the idea of reaching out to those in need of counselling services. After going through several phases, the counselling effort has evolved into a full-fledged programme. At first it was difficult to find skilled personnel to guide in counselling matters effectively. However, despite these inadequacies, the programme slowly but surely gained momentum. The phases through which the programme grew can be described briefly as follows:

Phase 1: Around 1988/89, when small numbers allowed us to give refugees individual attention.

Phase 2: Between about April 1990 and 1991, beginning soon after the withdrawal of the IPKF and resumption of hostilities in June, 1990. During this period an avalanche of refugees came to India.

Phase 3: The post Rajiv Ghandi assassination period, a crucial time for OFERR when most NGOs withdrew their refugee services and OFERR was called upon to shoulder the burden of refugee services almost single handedly.

Phase One

The youths involved in different freedom movements were one group of persons who remained in Tamil Nadu, continuing to stay in the training camps run earlier by their

respective movements. The freedom fighters who took to arms to liberate their homeland were thus pushed into a new situation; though at one time they had been brought up under the control and discipline of their parents, teachers, etc., they were now left to fend for themselves by the movements that had left them high and dry. Admittedly, all the liberation movements aimed to liberate their homeland and fight for justice and equality for the Tamil race. But divisions arose among the freedom movements as each one claimed or wanted to be the sole liberator of their homeland. Moreover, even within the individual groups internal squabbles surfaced, resulting in the formation of factions within the group. These conflicts brought about an exodus of the youth cadres from the freedom organisations.

These persons thereafter formed smaller groups among themselves with the sole motive of survival. They thought that by organising themselves in this manner they could solve the problem of finding food, clothing and shelter for themselves. In other words, they wanted to ensure that they had the basic requirements for their existence. However, it was not easy. They found that the sources of their funding had dried up and they began to indulge in criminal activities in order to make out an existence. Except for those who had funds from remittances sent by their friends and relatives living in affluent foreign countries, the refugees found living in India to be very difficult. They sold off whatever possessions, such as jewels and other valuables they had brought with them during their exodus from Ceylon. After converting whatever they could into cash and exhausting that money, the refugees outside the camps faced a tough situation. Almost all of them had been living in financially comfortable situations in their homeland. They could not share the problem of penury with others and this gradually reduced many of them to a state of acute mental depression. Such a state of mind caused not only frustration but also led to physical weakness, sickness and ill health.

In the difficult task of finding suitable trainers and counselling experts, the Inter-Church Service Agency (ICSA) came forward to help us in our endeavours. ICSA assisted us by training volunteers to engage in the important OFERR counselling programme. Mrs. Soulina Arnold and Dr. Moses Manoharan conducted the counselling classes very effectively. Rev. Dr. Kambar Manickam also provided valuable input at some of the counselling training programmes. Furthermore, a survey done by a research student gave valuable insights to the fledgling programme. Workshops were also held to discuss the practical problems encountered, so as to improve the programme and provide maximum benefit to those in need of counselling.

Phase Two

The withdrawal of the IPKF in June, 1990 caused a fresh influx of refugees to India and generated a need for services. Many refugees were found to be idling in the camps and several programmes were started to ensure that they did not sink into a state of dependancy and refugee syndrome. To keep the refugees informed and knowledgeable, libraries were established to enable them to read books, magazines, periodicals, newspapers, etc. Sports activities were encouraged to help the refugees break out of their boredom. Cricket, volleyball, football, netball and carrom were introduced in the camps. Friendly tournaments between camps and within the districts were organised to promote healthy competition. The counselling programme also promoted cultural activities among the refugees in the camps, as it is internationally accepted that cultural activities go a long way in arresting depression and other forms of mental trauma affecting refugee communities.

Another counselling effort provided technical training for youth to equip them for useful vocations. The refugees who availed themselves of this vocational training were `drop-outs' from freedom movements. Vocational training focused on radio, TV, mechanics, motor rewinding, motor pumps, maintenance of motor vehicles, and computer training for men, and sewing and training in handicrafts, etc. for women. These efforts were undertaken with the active cooperation of other NGOs, including Quaker Peace and Service, CSI Council for Technical & Vocational Training (CTVT), and Madras Christian College. The Quaker Peace and Service Association with CTVT conducted a training programme for youths who had dropped out of their movements and were left high and dry. These youths were trained in rewinding, house wiring, water pump maintenance, and tractor driving. Thirty-five youths participated in this training programme, conducted in March 1988 at the CSI agricultural farm (situated at Kasam near Vellore in the north Arcot District). The Madras Christian College (MCC) organised radio and TV repair, motor mechanics, and computer training programmes in 1988, 1989 and 1990. Training centres included the MCC school at Chetpet and the Jain College premises at Guindy.

We are able to say with pride that many ex-militants have come out of the gun culture and are now living as useful members of society.

Phase Three

The ground swell of sympathy for the unfortunate Tamil refugees who fled Sri Lanka to take refuge in Tamil Nadu evaporated soon after the dastardly assassination of Mr. Rajiv Ghandi, when the LTTE was a suspect in the killing. Many of the NGOs that had provided rehabilitation services for the refugees withdrew their services, including those that had counselled the refugees. Therefore, it was left to OFERR to shoulder the burden of caring for the refugees almost single handedly. The ban on NGOs working among the Ceylon Tamil refugees in the camps was also ordered during this phase. The order caused a lot of confusion among the NGOs. However, OFERR continued to render its services to the refugees in the camps. NGO coordination through the annual statewide meeting and the coordination committee has somewhat encouraged the continuance of the refugee services in general and the counselling services in particular.

Counselling Programme to Combat Suicidal Tendencies

Many reports of suicides from the refugee camps motivated us to consider a suicide prevention programme on an urgent basis. The entire programme to combat suicidal ten-

dencies through counselling can be classified under four structural headings:

1. Identification of suicidal tendencies through the medical unit programme and the participation of health workers.

The subject of suicide was first brought up during the first viva voce examination conducted by Dr. Karunyan Arulanantham to test the health workers. One of the examiners was asked whether there were any cases of suicide in the camp. The answer to the query revealed that there had been two recent cases of suicide. This prompted further inquiry into incidence and an analysis of the causes leading to suicide and the identification of those showing suicidal tendencies among the camp refugee population.

A consultant psychiatrist in the United Kingdom, Dr. Satkunanayagam was approached for assistance, and during his visit to Madras in July, 1993 he gave us valuable advice on conducting suicide-prevention courses. He stressed the importance of counselling to the prevention of suicides. He took the opportunity to introduce Dr. O. Somasundaram, a retired consultant psychiatrist and ex-Director of the Institute of Medical Health in Madras. This contact was very valuable as Dr. Somasundaram introduced us to one of his former students, Dr. Suresh Kumar, who is presently a consultant psychiatrist at the Institute of Medical Health. He, along with his fellow consultant Dr. Nambi, were doing research on suicides among the Sri Lankan refugee population in the camps on the outskirts of Madras city. Dr. Suresh Kumar persuaded the Director of the Institute of Mental Health, Dr. Bashyam, and one other doctor to participate as resource persons in a workshop conducted on the subject of suicide and its prevention.

The workshop was held at the AICUF Hall, and participants included OFERR health workers, district social service workers of the camps situated around Madras, and the staff members of OFERR-Madras. The four doctors at the meeting stressed the importance of counselling. They quite capably held the attention of the participants, inspiring lively sharing sessions following the presentations of the resource persons. Several clarifications were also sought on the subject under discussion. Dr. Suresh Kumar consented to give a Tamil translation of the article on suicide and its prevention written by Dr. Satkunanayagam. Dr. Suresh Kumar was also requested to compile a section on psychiatry in Tamil to be included to the handbook provided to the health workers, and to conduct workshops at the district level as well.

Though Dr. Suresh Kumar has left for the U.S.A. to obtain further specialised training, the services of the other psychiatrists are available for the programme. OFERR was also able to obtain the services of Dr. Ravindran, a consultant orthopaedic surgeon in Australia. He displayed his keen interest in refugee welfare work by conducting a couple of clinics in a few camps.

2. Training of counselling workers.

As an initial step it was decided to select counselling helpers from the refugee camps in the Tamil Nadu. Two hundred refugees were selected from the refugee camps and were provided with a one-day exposure at Madurai, Trichy, Bhawani and Madras. The one-day exposure briefly covered the subjects of a) the basics of personality and b) understanding ones potential. Lectures on the latter subject discussed strength bombardment, self-worth and Johari's window.

At the close of the days programme a questionnaire was given to each participant and they were expected to complete and forward it to Dr. Kambar Manickam to plan a suitable syllabus for the trainees. The other members of the committee were:

1. Dr. S. Rajkumar
2. Fr. Jothy of Layola College
3. Mrs. Saulina Arnold, TNVHA
4. Fr. Michael Jeyaraj
5. Dr. Suresh Kumar
6. Dr. Nambi
7. Mr. Moses Manoharan
8. Dr. V. Satkunanayagam

The questionnaire will be used to analyse the potential of the participants and to select suitable counsellors for intensive training.

The next counselling programme we are planning will conduct a 15-day counselling course for selected refugees. It is proposed to identify 50 participants for the course and a committee of leading counsellors headed by Rev. Dr. Kambar Manickam has been formed for this purpose. The programme will be conducted at two regions: the Southern region and the Northern region. It has been suggested that Madurai be the centre for the Southern region, and either Madras or Vellore for the Northern region. Of the 50 participants to be identified for the 15-day counselling programme, 25 will be selected from each of the two regions. Attached hereto is a complete formulation of the 15-day counselling programme.

3. NGO coordination and access to counsellors

The NGO's response to counselling needs and training has already been covered under the three phases described in this report. The ICSA deputed two of their experts, Mrs. Saulina Arnold and Dr. Moses Manoharan, to conduct counselling classes. Refugee volunteers were trained at these classes. The Chairman of the NGO Coordination Committee, Rev. Dr. Kambar Manickam, has taken charge of the counselling programme, the district-level training programmes and the proposed 15-day counselling course. His efforts to prepare counselling trainees for the difficult task of meeting the requirements of the refugee population are indeed laudable. Mrs. Saulina Arnold, who has her own programme – Tamil Nadu Voluntary Health Association (TNVHA) – has offered to help us meet counselling needs through this organisation as well.

The statewide NGO coordination meeting also discussed counselling as a priority and has chalked out NGO participation on an urgent basis to help meet the counselling

needs of the refugees.

4. Statistics and identification of causes

Statistics obtained by the health workers indicate that the main cause of mental illness among the refugees is depression. In order to overcome their depression even temporarily, some of them take to alcohol while others brood by themselves, developing a sense of hopelessness. A few of them take the extreme step of ending their lives. The refugees in the state of depression require counselling and psychiatric help. While those acutely affected are referred to the psychiatric clinics at the respective Government Headquarters hospitals or to Medical College hospitals, less severe cases are handled by health volunteers trained in counselling.

OFERR has maintained the records of 120 people from various camps who have either attempted suicide or have shown signs of suicidal tendencies. All these people have been counselled by the health workers trained in counselling and some have also been referred to psychiatrists in order to wean them away from their suicidal tendencies.

The counselling programme was started as a response to a felt need among traumatised and displaced people with what ever resources that were available to them. It can however be said that it has been of great value to the refugee community even though it was carried out with meagre resources. A case report illustrates the assistance given by OFFER.

Case Study

T. P a Sri Lankan Tamil refugee was from a farming family of Palugamam in the Eastern Province of Ceylon. He had six brothers and three sisters. His father had expired recently. He said he had passed his GCE 'O' levels. He had been a member of a militant group and quit because of clashes within and among the groups. He had been an inmate at Mandapam, Peravurany and Trichy refugee camps. In 1988, on his way to Madras to see his friends to obtain financial assistance, he was arrested by the police and detained for four months. Though he was offered job opportunities in various places, he had not stuck to any job. He used to write letters to OFERR very often. These letters showed his mental imbalance and a confusion in his thinking. Based on these observation he was enrolled in the OFERR's medical unit and was started on treatment. In addition to his medication, he was taken for counselling at ICSA and to the psychiatry department of the General Hospital of Madras. The awareness of mental illness and the availability of services made it possible for OFERR to help this refugee who had no other support.

THE WAY FORWARD

A STRATEGY FOR HEALTH CARE

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1. Introduction

1.1

Sri Lanka has enjoyed a unique position in Asia in terms of health status and health care. The political strife has, however, compromised this situation, giving rise to the emergence of significant regional inequalities, especially with regard to Tamil-speaking communities.

1.2 In this paper I reflect upon the present situation and propose a possible way forward which would embrace existing structures and newly emerging local ones. This paper may also have wider application to the rest of the country.

2. A Health and Welfare Charter

2.1 Background

In recent history, Sri Lanka had some eminence in health care in the region, and some of that infrastructure still remains and indeed functions, despite the political turmoil and its consequences. Amongst those practitioners who currently operate in Tamil-speaking areas and others who have a professional interest, there is a general sense of agreement that

- Health care is a fundamental human right
- It is feasible to propose some basic minimum standards
- There is a basic infrastructure which could be built upon
- What is needed is a way forward

2.2 A Blueprint for Action

A Health and Social Welfare Charter would provide aims and objectives which would be 'owned' both by practitioners and by the community being served.

I believe that there is already, among practitioners and the community, some degree of consensus as to key areas of need and priorities. What is needed is to identify these in more detail and to develop a plan of action. For this task a smaller group is needed, consisting of practitioners and community representatives whose deliberations, essentially apolitical, could be expected to command the respect and assent of fellow practitioners and of the community at large.

2.3 Timespan

The Charter should specify aims and objectives to be achieved by the year 2020. Why 2020? We know that it is realistic to plan health strategies over a period of 20-25 years. The overall strategic plan will, however, need to work on smaller time units in order to have clear short-term targets whilst allowing for the necessary flexibility in the longer term.

A series of 5 year plans would allow for planning the phases of development, and I would suggest that we need to develop some overall outline for the first four plans in the near future, with the first one, obviously, in much more detail.

2.4 Issues to be Addressed in the Charter

From my own experience, I would wish to include :

- Targets for health care outcomes which are realistic in the context of Sri Lanka
- Systems for monitoring and evaluation of programmes, to measure achievements and ensure they operate in line with the aims and objectives of the Charter.
- Consideration of the appropriateness and the effectiveness of systems established, so as to ensure responsiveness to the needs of the society and its expectations.
- Issues of equity in health care, in terms of geography and race, to ensure equality of access and outcome to all, irrespective of their standing
- Identification of key areas eg:

  General health status
  Social factors influencing health
  Lifestyle factors
  Morbidity and mortality as related to diseases of priority

- Key programmes and the balance between them in:

  Community and primary health
  Maternal and child health
  Mental Health
  Hospital care
  Environmental health

- Special groups eg

  Women, orphans and the elderly
  The disabled and handicapped

  Displaced people (the repatriated and those in refugee camps).

3. The Overall Strategy and the Strategic Plans

3.1 The overall strategy needs to take into account the current social, economic and political realities as well as the existing health care infrastructure. Within this context, this section (Section 3) will look at some suggestions for progressing the Charter, and some thought on the practical implications in it. Section 4 will look at the structures and institutions which will play an important role. Section 5 will put forward suggestions for the establishment of a School of Public Health. Section 6 will examine some further thoughts and implications, and section 7 will build on these, looking in further detail at the First Five Year Plan (see para 2.3).

3.2 *Setting up an Expert Committee*

An expert committee should be set up embracing the key stake-holders, to work on this Charter. This committee would be responsible for the coordinated development of the Charter and setting out the means to achieve its aims and objectives. Thus, its responsibility is to draw up the Charter, identify the overall strategy, set priorities, develop a series of five year plans and monitor progress.

3.2.1 In doing so , it will need to consider the roles of different players in the process, such as the government of Sri Lanka, the Freedom Movement, Non-governmental Organisations (NGO's), international institutions, donor governments and agencies, professionals and academics in relevant disciplines. Some mechanisms for their involvement in appropriate ways will have to be agreed. There will also be, at the operational level, a role for specialist committees set up on an ad hoc basis and reporting to the central (or 'expert') committee, to work on specific programmes or issues. When disbanded some residual aspects of their role may need to be built into the regular structure by then established. (see also section 6 for structures and institutions with a role to play).

3.3 The Five Year Plans

To ensure that the aims and objectives of the Charter are met, the committee needs to address the management of change. (see para 2.3). Each of the five year plans would:

- Identify key areas of need
- Explore the balance between primary and secondary care.
- Propose programmes to meet the needs identified
- Identify realistic targets.
- Build on what exists/has already been achieved.
- Build in a process of continuous evaluation.

4. Structures and Institutions with a Role to Play

4.1 Mention has been made of the infrastructure already existing and of the key stake-holders whose involvement is essential. Some further developments in infrastructure are required, and some thoughts on these and on various agencies are offered here.

4.2 Community Health Councils

No work should or could be carried out by people without clear local mandate, participation and leadership. Local committees should be created with participation from all interested parties and stake-holders. These should be apolitical and address health and welfare issues. Outside expertise is available and should be used and integrated into these committees. The role of these local committees is to agree local priorities within the overall strategy, with the help of specialist advisers, and to monitor the implementation of an annual rolling programme.

4.2.1 The active participation of Community Health Councils would help to address the issue of accountability by increasing the influence of those at grass-root level. Any programme which requires outside funding from a variety of sources can run into problems of diffuse and even conflicting accountability. The requirements and aspirations of donors have to be recognised and respected, but the balance of power must be seen to lie within the country.

4.3 Community Health Care Centres

The establishing of centres in the villages for primary, community and preventive care, as well as the care of the environment, is for me one of the cornerstones of what is proposed at the operational level. This would revolutionise health care, and is a concept which might come to be seen as appropriate more widely than just in the North East.

4.3.1 The focus must be on health and not on disease. The days of peripheral units and central dispensaries are gone. These Community Health Care Centres should be outposts linked in one form or another to the administration, but also closely to the Resources Centres and the School of Public Health (see below). They should come under the authority of the local Community Health Councils.

4.3.2 These centres could be sponsored by different sources, such as the former pupils of the local school, doctors from the district who may form a consortium, an NGO or other bodies interested in the welfare of that area. It should be possible for a whole variety of primary health care professionals to work in these centres from time to time, on secondment.

4.4 Mobile Units

The use of mobile units can increase access to the population at risk. Such units could help in a range of areas,

from emergency to more basic care such as immunisation, child surveillance, and nutritional programmes. They need not be large units, but could in some cases consist of practitioners on motorbikes. Again, sponsorship could come from a variety of sources.

4.5 Resource Centres

The limited resources and manpower that is available could be more effectively utilised by the setting up of local resource centres, no more than three at first, at District or even Supra-District level. They would be called upon by Community Health Councils and Community Health Care Centres. They would be non-clinical, but would hold information on unmet needs, priorities, vacancies, and local voices, as well as stock health information packs, health reports etc. Each could be manned by an individual with communication networks. The centres would improve the exchange of information and avoid duplication of effort. They would have a "clearing house" function, serving as the first port of call for help and response and even advice. The Resource Centres are identified separately from the activities in health intelligence of the School of Public Health (see below) as they are essentially local in nature.

4.6 NGO Forum

There needs to be a forum which has the crucial role of bringing together NGO's so as to ensure that their efforts are put to maximum benefit. As much as etiquette will permit, there must be created synergism between the various organisations and local structures and people. This network should liaise closely with Resource Centres locally and the School of Public Health which would (see below) be set up in Jaffna with a branch in the Eastern Province.

4.7 The government has a major role to play and its support is essential. It:

- Is responsible for the provision of comprehensive health care
- Must accept its responsibility for health and welfare of all its people.
- Should provide equity in care irrespective of geography and ethnicity
- Must ensure that basic facilities are provided
- Needs to be "open" and explicit in its policy and procedures.

4.8 The Freedom Movement has to accept the apolitical nature of health care and social welfare and should be supportive of developments in these areas for they are fundamental to the future prosperity of the region. There are many strands to the development of the North East that are of strategic importance. Health and social welfare are crucial ones, which should be allowed to take root.

5. A School of Public Health

5.1 As we are dealing primarily with health, it would be prudent to develop a multidisciplinary School of Public Health within the University of Jaffna, with a branch in Eastern Province. It would embrace the role of Public Health / Community Medicine, as well as involve input from Departments of Sociology, Social Administration, Social Work, Social Anthropology, Statistics and Economics and others of relevance.

5.2 The activities and role of the School of Public Health would be significant in the health revolution. It has to provide academic and practical support for the new philosophy and culture required in Health Care (see para 6.4.3). It has to set the curriculum and train a new breed of staff. It has to provide the base for improved health care intelligence.

5.3 Training and Education

The School would serve as a focus for training personnel to address the health needs of the population .This includes Public Health Practitioners , Mental Health Workers, Public Health Doctors, Social Scientists, Health Economists and Information Scientists, to name but a few. However, I am not referring here to the model of a western school of Public Health, but to one that is geared to local needs and local priorities, with the basic disciplines taught in the applied context of the people of the land.

5.3.1 Training Facilities Abroad

The response to the challenges that face health and welfare in Sri Lanka could potentially yield interesting and innovative models for use in other developing countries. There is always a need for scholars and practitioners to share experience. Travelling bursaries, stipends and scholarships need to be established to train not only in the West but also in relevant centres in the developing countries, especially in India. Disciplines other than medicine need to be addressed, such as rehabilitation, remedial therapy, health psychology and health economics.

5.4 Health Intelligence, Research and Development

These must be an integral part of any system that is sensitive to its core business. One is referring to applied research rather than the esoteric kind of exercise with which the term 'research' is sometimes associated. In order to foster the 'culture of evidence' (see para 6.4.3) there needs to be reliable information gathered and made available. This information is needed as evidence in order to make a case, establish base lines, monitor progress, and assess outcomes in terms of efficiency and effectiveness.

5.4.1 Simple health and social welfare information systems will have to be set in place to measure baseline figures on a range of subjects. These would cover vital statistics, activity, manpower, facilities, and to an extent, outcomes.

5.4.2 Simple appropriate systems for the collection, dissemination and sharing of material related to the health and welfare of communities, do not require vast amounts of resources. The natural setting would be that of a library or archive, and it may be possible to make shared use of the facilities of other local organisations.

5.5 Publications

A variety of publications could assist the developments in the various fields. One obvious organ would be an academic

one centred on the University of Jaffna, and the School of Public Health. It would be possible to set a scenario that peer-reviewed papers are published on a quarterly basis on subjects of interest. Needless to say, this would have advantages in opening avenues of communication, collaboration, sharing, learning, and particularly of bringing empirical evidence to the world stage about the health and social welfare of the nation.

6 Some Thoughts on Practical Implications

6.1 The Training of Doctors

Though not directly within its remit, the school of Public Health would have some contribution to make because of its role in the proposed new health care structure. Medicine is held in great esteem in Sri Lanka, and therefore doctors have a significant role to play in the emergence of any health reforms. There has to be some rethinking of curriculum and training approaches so as to produce practitioners who really are equipped to meet and indeed relish the challenges that will face them in building the new care structure to serve their fellow citizens. Though clinical (and intellectual) freedom must be assured, the new emphasis will be on responsiveness to local need through accountability at a more local level than previously.

6.2 Manpower Needs

There has to be a fresh examination of manpower requirements. I am of the opinion that we would focus on health and not medicine. We have (and should continue to produce) excellent doctors, but with health and accessibility of care in mind, we have to orientate ourselves to health practitioners, mental health workers and environmental workers. We need to consider the serious gaps that exist today in various kinds of medical and health care personnel.

6.2.1 Many of these health care personnel could be trained on average in 2 years to fulfil the first contact needs of the population. A specialist cardiothoracic surgeon, in term of health gain is equivalent to 20-30 health practitioners who deliver basic health care. This does not preclude the need in hospitals to provide 'bread and butter' services and to a limited extent 'high tech' medicine.

6.2.2 Creation of a Manpower Bank

Some gaps could be filled temporarily by 'visiting' staff for specific periods. Specialists in the field of Health and Social Sciences from both Sri Lanka and non-Sri Lankan backgrounds exist in reasonable numbers, who wish to provide services to Sri Lanka. This goodwill should be harnessed to the benefit of the people. The period of service necessary to contribute useful work will vary depending on the area of work and the circumstances of the project. In some cases a two -week attachment would be adequate, whilst in others anything less than 3 months would be disruptive. The flow could be two-way with resources found for those coming out of Sri Lanka.

6.2.3 There is an urgent need for surgeons, psychiatrists and other specialists, and also for specialist trainers to train nurses and others in various fields. To ensure the maintenance of quality, there must be standards and codes of practice set up for this purpose. This issue is particularly apposite at the present time, because we can expect that a number of trained people who have been outside the country for some time, will wish to offer their services. They need to know what to expect and what is expected of them.

6.3 Resources.

This area is always a problematic one, and whatever the goodwill of the providers, there will always be a shortfall between plan and reality.

The following ideas may be useful in considering ways to encourage donations and sponsorships.

6.3.1 Health Currency Units (HCU).

It should be possible to devise a method of costing an activity in crude terms. For example, one basic HCU might be defined as equivalent to a 3-month component of the training of a Public Health Practitioner, or the immunisation of (say) 1,000 children. Though there would be some monetary value attached, the practical effect would be that the donor would purchase/sponsor specific units and thereby identify with a specific activity. Donations would cease to be amorphous, and it may be possible to link a donor with a particular area and project.

6.3.2 Sponsorship.

Every doctor, for example could sponsor a trainee Public Health Practitioner. This would be a good deed in return for what one has received from the country, its people, and the education system. We could seek sponsors for orphans to be placed locally rather than in orphanages. These are ancient concepts which we could revitalise.

6.4 Towards a Positive Climate

There are a number of ways in which the climate in which we are working needs to change. Some depend on political will, others are 'cultural' in the sociological sense (often used nowadays in business and management). meaning attitudes and expectations about the way things are done.

6.4.1 Health Care as a Fundamental Human Right.

Few people would disagree with this in principle. Acceptance of this in practice means that progress can be made despite the political situation in Sri Lanka at the present time. There must be created a climate of trust, freedom, openness and safety for those involved in humanitarian work such as health care.

6.4.2 Allied to the above is freedom of access and opportunity to participate and contribute by individuals, groups, organisations and institutions which have welfare as there objective. There must be freedom of movement for bone fide practitioners, as well as freedom (and indeed encouragement) for professionals, academics and interested groups to communicate and establish peer networks and links within the country and in the world at large. International communication is important because, while there are many positive aspects at home which need to be nurtured

(and this paper has emphasised local involvement and accountability) a policy of self-reliance should not lead to an isolation which in the long run would be detrimental to the nation.

6.4.3 A 'culture of evidence'

We need to create a culture where empirical evidence informs the philosophical and political debate, and so, ultimately, decisions. Our present culture has tended to value the collection of empirical evidence. To operate in a business mode with clear plans and agreed objectives, time frames and quantifiable outcomes, there must be a robust culture which values and emphasises the collection and interpretation of relevant information.

6.5 Problems of Coordination

Resources are limited and real expertise especially so. It is necessary that the whole structure of health care provision and management ensures effective coordination at all levels. Effective coordination is a matter of identifying what is required and selecting the 'best fit' from the resources available, so as to maximise the likelihood of meeting objectives successfully and cost- effectively. Enthusiasm is one of the resources to be harnessed and I anticipate that there will be a great deal of it for such a pioneering healthcare approach. It must not be dissipated by poor coordination but neither must it be wasted in untrammelled individualism in the name of high ideals.

7. Towards the First Five Year Plan

7.1 in this section I am putting forward some ideas based on my professional experience, which may be of use in getting to grips with the first five year plan. They are grouped under the topics of Key Areas, The Balance of Care, and Key Programmes (see para 2.4).

7.2 Key Areas of Need

I see these as being , for the first plan:
Community and primary care
Maternal and child health
Mental health
Hospital care
Environmental health
Rehabilitation

7.2.1 Community and Primary Care

This area undoubtedly gets priority as it should be the basis to attain satisfactory health status for the population at large. In particular:

- The setting up of community health centres is crucial here, and in the first year we should be able to set up three pilot centres. These would serve as the first port of call for people, and so be accessible. They would cater for most health needs and certainly for the preventative programmes.
- Training needs to be established for the new breed of Health and Public Health practitioners, the latter trained in preventive medicine.
- A business plan has to be produced for the development of the School of Public Health
- Health promotion and education material should be suitably produced and made available for distribution. In the first instance, this should aim at parasitic diseases which are so prevalent in Sri Lanka. If we could eliminate worm infestations by the year 2000 it would be a public health achievement of great significance.

7.2.2 Maternal and Child Care

This is also a priority area in the current situation. The following need to be covered: family planning, antenatal care, obstetric care. In addition, particular reference has to be made to special circumstances surrounding orphans, single parents, displaced families etc. as above. The community health centres would be the focus for this work locally. Action points in this area would be :

- Urgent attention should be paid to the poor nutritional status of children and pregnant mothers.
- Measures should be taken to develop indigenous nutritional supplements locally to meet future needs.
- The establishment and training of Public Health Practitioners in this field.
- The creation of a pool of health professionals: doctors , midwives, health visitor equivalents and nutritionists who would be available in these early stages of development, to meet skill shortages.

7.2.3 Mental Health

Mental health was identified as a priority at the conference. The levels of suicide and self-inflicted injury are significantly high. The cause still remains.

The pressures of existence in a land with devastation, difficult economic circumstances and incidents such as rape, loss of significant other, loss of wealth, displacement and the loss of social networks, are bound to contribute to mental distress and illness. While developing strategy to build a service to cater for these needs in the interim the following measures would help:

- Mental health workers trained to provide primary mental care such as counselling, psychological support, remedial therapies. Training to be done locally with the help of specialist trainers from abroad, particularly India.
- Creation of a pool of psychiatrists and other mental health professionals who would be able to travel and provide help. They must be trained for these challenges.

7.2.4 Hospital Care

This is the natural focus for attention in most communities and of most professionals too. In fact it is the tier where intervention is the least effective in terms of health. The situation, however, is tragic as the basic infrastructure has been dismantled. Basic secondary care has to be restored while planning for the more esoteric specialities.

Some essential points are:

- Immediate steps have to be taken to create a pool of hospital doctors who would be available to serve for a period of three months or more.

- Life-saving drugs and equipment must be available to supplement those supplied by the government. This should not take over from the official supply. There is an urgent need for an autoclave and measures have to be explored to obtain one, though it is the government's duty to provide such heavy equipment.
- Communication links are needed with appropriate organisations outside as well as inside Sri Lanka to end the present relative isolation and stimulate exchange of ideas and models of good practice. An obvious model in this respect is Vellore in India.
- I feel there could be a new and vibrant role for the mission hospitals that exist in the North. These have contributed significantly in the past and could have a revitalising role in training and the provision of specialist care.

7.2.5 Environmental Health

A clean and healthy environment is so central to health and welfare that considerable attention must be paid to the Public Health aspect of it. As the conflict has disrupted the terrain, issues relating to clean water supply, drainage, sewage and refuse disposal, control of pest and other forms of pollution have to be addressed. The lack of certain commodities required for essential hygiene, and the lack of transport and trained personnel, further compound the proper execution of these functions.

Major action points are:

- There has to be a programme which is focused on the environment, in which priorities are worked out within the aims and objectives of the Charter.
- The establishment and training of Environmental Workers would be a significant step and should also contribute to the rehabilitation programme.
- We need an effective sewage disposal system, especially in the Jaffna District..

7.2.6 Rehabilitation

This is a key area that requires special attention

Rehabilitation embraces different dimensions: physical, mental, social and spiritual. This cannot be done through an isolated medical model. It has to be in the setting of a political resolution followed by an economic and social revival. However, one has to address the strands as they apply to the health scene:

- One needs to establish support for physical rehabilitation in ensuring the supply of prosthesis equipment etc.
- There is need for occupational therapy not only for those with physical injury but also for those who have suffered mental impairment and consequential disability and handicap.
- Revenue earning projects could be established, for example in cottage or light industries, whose earning potential could be enhanced by NGO's and expatriates promoting the products. For example, some might be 'sheltered' projects providing work for people unable to compete in the open market. Others might be schemes aimed at assisting individuals or groups to become self-supporting, by helping them to set up a small business.
- Provision of psychological support with manpower in terms of counselling etc. (see also para. 7.2.3)
- We also need to introduce programmes of rehabilitation for orphans, widows, repatriated groups and those in refugee camps.
- Serious consideration must be given to providing for religious and spiritual support as well. This is a subject that has not been given due consideration in modern times.

7.3 The Balance of Care

7.3.1 The ideal health care system for the future is, in my opinion, unlikely to mirror the system that was in place in peace times. That system, largely modelled on the British one, was exemplary in the 60's and early 70's in certain fields. Its appropriateness to the Sri Lanka situation, however, was always suspect. It has deteriorated further, and the present situation requires a system that will address a less developed environment coupled with the effects of civil disturbance. To meet the needs of today, the health care system needs to reassess and refocus.

7.3.2 The balance has to shift towards community and primary care with much emphasis on health promotion, prevention of disease, control of communicable diseases, immunisation and vaccination. This does not take away the tremendous need for hospital services, mental health, maternal and child health, rehabilitation and environmental health.

7.3.3 Priorities within secondary care should reflect the needs of today such as emergency care, surgery, orthopaedics, child health and nutrition, rehabilitation and mental health rather than specialities that embrace tertiary care. We need to address the issues of support services, such as paramedical services, transport of patients and drugs equipment etc.

Conclusion

This concluding paper has outlined a number of proposals that it is hoped could be useful as a basis for further development. To the Tamils of Sri Lanka, to all who have their welfare at heart or their destiny in their hands, I offer these, the thoughts and reflections of a public health practitioner.

Why have we got to address?

- Firstly, one cannot but respond for humanitarian reasons
- Secondly, one cannot but be prepared to respond when the opportunity knocks
- Thirdly, to know where you are, where you wish to get to, and how.